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Editorial

Ethical Perspective: Five Unacceptable Trade-offs on the Path to Universal Health Coverage

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Abstract

This article discusses what ethicists have called "unacceptable trade-offs" in health policy choices related to universal health coverage (UHC). Since the fiscal space is constrained, trade-offs need to be made. But some trade-offs are unacceptable on the path to universal coverage. Unacceptable choices include, among other examples from low-income countries, to expand coverage for services with lower priority such as coronary bypass surgery before securing universal coverage for high-priority services such as skilled birth attendance and services for easily preventable or treatable fatal childhood diseases. Services of the latter kind include oral rehydration therapy for children with diarrhea and antibiotics for children with pneumonia. The article explains why such trade-offs are unfair and unacceptable even if political considerations may push in the opposite direction.

Keywords: Health Policy, Universal Healthcare, Equity, Ethics, Rationing

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Introduction

Universal health coverage (UHC) is at the center of current efforts to strengthen health systems and improve the level and distribution of health and health services. Recently, I chaired the World Health Organization's (WHO's) Consultative Group on Equity and Universal Health Coverage. This work was part of the response to more than 70 low- and middle-income countries that had requested policy support and technical advice for UHC reform from the WHO. The consultative group was an unusual combination of ethicists, philosophers, economists, health-policy experts, and clinical doctors, spanning thirteen nationalities. This helped the group address fundamental ethical issues and difficult trade-offs head-on in an unconventional way. The report, entitled "Making fair choices on the path to universal health coverage" addresses the key issues of fairness and equity that arise on the path to UHC by clarifying these issues and offering recommendations for how countries can manage them.[1]

The report makes two controversial claims.[2,3] First, that priority setting is unavoidable on the path to UHC. Although the first step in UHC reform is to expand the fiscal space, this expansion will be incremental and expansion of services will, therefore, also be incremental. Many UHC advocates and other global health actors do not acknowledge this fact. Interestingly there is to my knowledge no other report discussing the need to set priorities and to define which services should be part of UHC. The second controversial, but I believe correct claim is that some common ways to define and implement UHC involve trade-offs that are unacceptable from an ethical perspective. One example from low-income countries is that it would be unfair to expand coverage for low- or medium-priority services such as kidney transplants or renal dialysis before there is near-universal coverage for high-priority services such as vaccines, treatment for pneumonia or HIV.

In short: there are fair and unfair ways to move towards UHC. My aim in this brief note is to discuss the unfair paths that are rarely scrutinized. Before I do so I will present and discuss some key definitions and summarize the recommendations for making fair choices on the path to UHC.

Fairness

Fairness and equity are crucial values for public policy, and they are powerful ideas in social, political, and legal debates.[4-6] There is no consensus on the precise boundaries of the concepts of fairness and equity or on their precise content, and the two terms are often used interchangeably. Fairness has a focal role in the context of UHC.[7-10] When UHC cannot be realized immediately, making progress fairly becomes imperative. More specifically, when countries expand priority services, include more people, and reduce out-of-pocket (OOP) payments, they must seek to do so in a fair manner. Fairness is fundamentally concerned with the overall distribution of benefits and burdens in society. Equity in health has traditionally been most concerned with equitable access to services regardless of socio-economic status. Fairness is a broader concept. We all react to unfairness: it is unfair if some with a very severe disease is denied coverage for a high-priority service simply because he or she is poor and unable to pay. In more technical language, we may say that a fair system will expand service coverage with financial risk protection by giving priority to policies benefiting the worse-off, where the worse-off are defined both in terms of health itself and in terms of socio-economic status.[11,12]

Fair health systems are concerned with the worse-off in terms of health, socio-economic status, or overall well-being. One motivation can be that the worse-off so defined are at a lower absolute level and typically have a greater need for the benefits

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that comes with improved coverage.[13,14] Another, related motivation can be the promotion of equality.[5,15] Priority to the worse-off can also be motivated by the right to health.[16] When considering the worse-off in terms of health or well-being, there are good reasons to adopt a population perspective and focus not merely on those *currently* worse-off but also on the people who are expected to be worse-off over their lifetime.[15,17]

Fairness and equity are closely related to the right to health.[18,19] Every country in the world has ratified at least one treaty that specifies obligations regarding the right to health. Under international law, states have an obligation to adopt appropriate measures to realize the right to health or the right to healthcare on a non-discriminatory basis. This obligation involves a strategy and plan of action for how to achieve that goal as well as mechanisms for oversight and redress.[20] Parties to specific international treaties have obligations to allocate sufficient resources to realize the right to health. In other words, progressive realization of UHC can contribute to progressive realization of the right to health. Accordingly, many different approaches, including those based on fairness or rights, can endorse and encourage the urgent pursuit of UHC.

Universal Health Coverage and the Need for Priority Setting

UHC is defined by the WHO as all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services.[21] We argue that given resource constraints, this cannot entail all possible services but a comprehensive range of key services that is well-aligned with other social goals.

UHC must be understood in a comprehensive way.[22] The goal of UHC calls for quality services of many kinds, for strengthening the entire health system, and for intersectoral action.[23] UHC goes beyond clinical and curative services to include public health and population measures and promotive, preventive, and rehabilitative services.[24,25] Public health coverage and population measures include, for example, informational campaigns on hygiene and food safety, vector control, and tobacco regulation.

Under most interpretations, available resources in every country fall short of what is required to meet all needs. Therefore, it is crucial that resources are concentrated on the most important set of services and that the resources devoted to the pursuit of UHC do not jeopardize other important social goals. Fair priority setting for UHC means choosing which services should be offered to everyone, in what order they should be included in the essential package, and for which services co-payment should be eliminated first.

Fair Choices on the Path to Universal Health Coverage

The following three-part strategy can be useful for countries seeking fair progressive realization of UHC. Countries can do the following:

1. Categorize services into priority classes. Relevant criteria include those related to cost-effectiveness, priority to the worse-off, and financial risk protection.
2. First expand coverage for high-priority services to everyone. This includes eliminating OOP payments while increasing mandatory, progressive prepayment with pooling of funds.
3. While doing so, ensure that disadvantaged groups are not left behind. These will often include low-income groups and rural populations.

Fair progressive realization of UHC requires tough policy decisions. Reasonable decisions and their enforcement can be facilitated by robust public accountability and participation mechanisms. Robust public accountability is essential in policy formulation and priority setting and specifically in addressing the critical choices on the path to UHC and the trade-offs between dimensions of progress. These mechanisms are also crucial in tracking resources and results. To properly play these roles, public accountability and participation should be institutionalized, and the design of legitimate institutions can be informed by the Accountability for Reasonableness framework.[26]

A strong system for monitoring and evaluation is also needed to promote accountability and participation and is indispensable for effectively pursuing UHC in general. Countries must carefully select a set of indicators, invest in health information systems, and properly integrate the information into policy-making. The selection of indicators should be closely aligned with the goal of UHC and in most settings include at least four types of indicators: indicators related to the priority-setting processes, indicators of service coverage and financial risk protection, and indicators of health outcomes. The latter three types of indicators should reflect both average levels and distribution.

Unfair Choices on the Path to Universal Health Coverage

Policy choices always involve trade-offs between competing goals; this is the core of priority setting. A trade-off can be seen as a compromise between two or more desirable but competing considerations. It thus involves a sacrifice made in one dimension to obtain benefits or ensure respect for rights in other dimensions. Ethical theory is not always fine-grained enough to specify which trade-offs are acceptable and which are not. However, the considerations described above can help countries to identify many clearly unacceptable trade-offs, within and across dimensions. More specifically, at least the following five trade-offs can be considered *generally unacceptable* and incompatible with fair progressive realization of UHC. Other unacceptable trade-offs may also be identified, but we chose to highlight those that are particularly important from a fairness perspective.

Unacceptable trade-off I: *To expand coverage for low- or medium-priority services before there is near universal coverage for high-priority services. This includes reducing OOP payments for low- or medium-priority services before eliminating OOP payments for high-priority services.*

High-priority services are the most important services, partly because they tend to be the most cost-effective and to benefit the worse-off. It is, therefore, generally unfair to expand coverage for low- or medium-priority services before there is universal coverage for high-priority services or all reasonable measures to that end have been taken. For example, in a low-income country it would be unacceptable to expand coverage for coronary bypass surgery before securing universal coverage for skilled birth attendance and services for easily preventable or easily treatable, fatal childhood diseases. High-

priority services would include oral rehydration therapy for children with diarrhea and antibiotics for children with pneumonia.

Lack of coverage for high-priority services tends to be concentrated among disadvantaged groups. To first expand other services in such situations is particularly problematic and unfair. High-priority services are also those for which it is most important that OOP payments are reduced. In most circumstances, OOP payments for those services should, therefore, be eliminated before such payments are reduced for other services.

The considerations that lead to the judgment that trade-off I is unacceptable, suggest that certain other important trade-offs are acceptable. Specifically, they suggest that it is acceptable not to first address coverage gaps or inequalities in coverage for low- and medium-priority services if that would undermine efforts to expand coverage of high-priority services or to reduce inequalities in coverage of such services. For example, less than universal coverage of certain advanced cancer treatments with marginal health benefits—and associated inequalities in access to those treatments—can be acceptable if necessary for securing universal coverage of highly effective HIV treatment. The unacceptability of trade-off I further indicates that it is acceptable not to first reduce OOP payment for low- and medium-priority services if that would undermine efforts to reduce OOP payments for high-priority services. For example, OOP payments for open-heart surgery can be acceptable if they are necessary for removing OOP payments for cesarean sections.

Unacceptable trade-off II: *To first include in the universal coverage scheme only those with the ability to pay and not include informal workers and the poor, even if such an approach would be easier.*

Not only the total number of people included in a scheme matters. Who those people are and who is left behind also matter. It would generally be unacceptable to include only formal workers and the non-poor in the early stages of the pursuit of universal coverage. Instead, as discussed, there are many reasons why informal workers and the poor should have priority in the early stages, to the extent that this does not jeopardize the financial sustainability of the scheme. One is the ideal that coverage and use of services should be primarily based on need and not on ability to pay or political power. More specifically, including informal workers and the poor from the outset can counteract "the inverse equity hypothesis." This hypothesis suggests that a new health intervention tends to increase inequities because it initially reaches those who are already better off.[27]

Unacceptable trade-off III: *To give high priority to very costly services (whose coverage will provide substantial financial protection) when the health benefits are very small compared to alternative, less costly services.*

Coverage of very costly services can often offer substantial financial risk protection by reducing OOP payments. One example can be experimental treatment for advanced cancer. However, when the health benefits are very small compared to alternative, less costly services, there are at least two reasons why it would be generally unacceptable to give high priority to the very costly services. First, by so doing, one would sacrifice many health benefits that could otherwise have been secured with the same resources. This is unfortunate because health benefits are highly valuable by themselves, but it is also unfortunate from the perspective of financial risk protection because health benefits tend to provide such protection indirectly. Health improvements can prevent certain OOP payments downstream and can increase productivity and the income-earning potential in the beneficiaries and their families.[28] Second, even immediate financial risk protection can often be secured more cheaply and fairly than through coverage of very costly services with limited health benefits. One reason is that even small OOP payments for non-costly services can be a significant financial burden on the poor, and more of these services can be covered within a fixed budget.[28] In addition, it is also fairer to purchase financial risk protection for the poor and disadvantaged.

The reasons why trade-off III is unacceptable suggest that certain other, important trade-offs are acceptable. Specifically, in many circumstances it can be acceptable not to cover very cost-inefficient services even when such coverage would provide substantial financial risk protection.

Unacceptable trade-off IV: *To expand coverage for well-off groups before doing so for worse-off groups when the costs and benefits are not vastly different. This includes expanding coverage for those with already high coverage before groups with lower coverage.*

It is difficult to justify expanding coverage for well-off groups before worse-off groups if the policies are largely similar in other respects. This is especially the case if the services in question are high-priority services, if the worse-off group is very badly off, or both. One example is further expansion of reproductive health services or tuberculosis detection and treatment in the big cities before expansion in rural areas. To expand coverage for well-off groups first would typically conflict with ideals of equity and a special concern for the worse-off.

These considerations suggest that certain other trade-offs are acceptable. For one, it is acceptable not to expand coverage for well-off groups if that would undermine efforts to expand coverage for worse-off groups. Moreover, the argument indicates that it could be acceptable to expand coverage for well-off groups before worse-off groups if the costs or benefits are vastly different. For example, expanding coverage for a given service from 90% to 100% in certain heard-to-reach areas can sometimes be extraordinary difficult and costly. If the resources involved could produce vastly larger improvements in coverage and health outcomes in areas that are only somewhat better off, that may be acceptable. However, it must be ascertained that all other feasible steps have been taken and that the evidence strongly and unambiguously suggests that those policies are the best overall.

Unacceptable trade-off V: *To shift from OOP payment toward mandatory prepayment in a way that makes the financing system less progressive.*

One of the problems with OOP payments is that they tend to be regressive with respect to income; that is, the poor pay proportionately more than the rich. Subsidizing tertiary care is another example of potentially regressive financing. When shifting from OOP payment toward mandatory prepayment with pooling of funds, this shift should, therefore, be done in ways that do not make the overall financing system less

progressive. This is supported by the idea that contributions to the system should increase with ability to pay.

Beyond the generally unacceptable trade-offs, there are several constraints on the pursuit of UHC that do not involve a compromise between two desirable ends and thus are not trade-offs. Central among these constraints is the prohibition on discrimination based on race, ethnicity, religion, gender, political beliefs, and sexual orientation. Discriminatory practices of these types are morally and legally indefensible, as suggested by widely accepted ethical theories, human rights frameworks, and many bodies of law.[16,29] For example, it is impermissible to deny access to HIV treatment simply due to sexual orientation.

Conclusion

A three-part, overall strategy can be useful when countries are seeking fair progressive realization of UHC. As part of this or any other overall strategy, countries must carefully make choices within as well as across dimensions of progress. These priorities will partly depend on context, and several different pathways can be appropriate. However, some trade-offs are generally unacceptable from an ethical perspective. Although policy-makers will also take political feasibility into account, fairness and efficiency may suffer. Robust public accountability and participation mechanisms are, therefore, essential when deciding on the overall strategy and the appropriateness of central trade-offs on the path to UHC.

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Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

OFN is the single author of the manuscript.

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