

Editorial

Fairness in service choice: an important yet underdeveloped path to universal coverage

R. Baltussen¹, O. F. Norheim² and M. Johri^{3,4}

¹ Department of Primary and Community Care, Radboud University Nijmegen Medical Center, The Netherlands

² Department of Public Health and Primary Health Care, University of Bergen, Norway

³ Department of Health Administration, University of Montreal, Canada

⁴ International Health Unit, University of Montreal Hospital Research Centre, Canada

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Achieving universal coverage – defined as access to needed health services without the associated risk of financial hardship (World Health Organization 2010) – is at the core of international discussion on strengthening health systems and the struggle to achieve the health MDGs. WHO's most recent World Health Report (WHR) 'Health systems financing: the path to universal coverage' (World Health Organization 2010) highlights the importance of strengthening health systems and health financing mechanisms to ensure access to services for everyone.

As argued in the WHR, universal coverage incorporates three dimensions: population coverage, service coverage and cost coverage. Although the definition of universal coverage requires that all three dimensions eventually be satisfied, they are conceptually distinct and choices about which to privilege will define distinct paths to achieving universal coverage. Current discussions (e.g. in the WHR) have focused on how to achieve coverage of a greater proportion of the population and protection from the financial consequences of ill health through prepayment and pooling of resources, thereby concentrating on population and cost coverage (World Health Organization 2010). We believe that consideration of factors related to service coverage i.e. 'which services are covered', and 'for which services should coverage be improved' should also play a critical role in setting policy directions, as the choice of services has a profound impact on the coverage by the health system.

Obviously, a choice to use mobile clinics in HIV/AIDS control much improves service coverage among remote areas. Likewise, a choice to provide food subsidies to foster the adherence to antiretroviral treatment improves service coverage among the poor. Prioritizing services that target disadvantaged groups in society, even if more costly, may be a fairer way to foster universal coverage. This strategy

goes one step further than what is advocated in the WHR, ensuring access to the same services for all. It recognizes the important principle of fairness in health that all people – irrespective of health status and socio-economic status – should have as much of a fair chance to live a healthy life (Daniels 2008). In other words, we flag an important but yet underdeveloped path to universal coverage – through fairness in service choice.

Fairness in service choice may require that policy makers give higher priority to those in rural areas that are hard to reach, to the youngest who have enjoyed least life years, to the poorest who disproportionately die from pneumonia, diarrhoea or malaria – compared to older, richer and less hard-to-reach persons with increased risk of cardiovascular disease. For example, researchers from the Lives Saved Tool collaboration have estimated that in Burkina Faso, Ghana and Malawi achieving national coverage targets for just four or five high-impact childhood interventions could reduce under-five mortality by at least 20% by 2011, relative to 2006 levels (Bryce *et al.* 2010). In Malawi, current coverage for treatment with antibiotics for pneumonia is only 29%, treatment with ORS and zinc for diarrhoea is 55%, malaria prevention with insecticide-treated nets is 23% and malaria treatment with artemisinin combination therapy (ACT) is 27%. The national coverage target for pneumonia is 67%, for diarrhoea 85%, for mosquito nets and ACTs 69% (Bryce *et al.* 2010). These are all feasible and cost-effective strategies with high impact on child mortality. Contrast this with improving coverage for treatment of hypertension among the adult, urban, richer population of the capital Lilongwe. Off-patent antihypertensive drugs may be equally cost-effective in Malawi as the above-mentioned strategies to reduce child mortality (Robberstad *et al.* 2007). For which services should coverage be improved?

R. Baltussen *et al.* **Editorial**

The choice of services is often dominated by concerns of efficiency only, to maximize population health (World Bank 1993; Evans *et al.* 2005; Jamison *et al.* 2006). Less attention has been paid to the ways in which choice of services can affect the fairness of service delivery. These perspectives do not necessarily coincide, and provide challenges for policy makers in the definition of their strategies: Interventions that target disadvantaged groups in society may be more costly and/or yield less health effects, and will not necessarily optimize population health outcomes. Policy makers thus need to strike a balance between efficiency and equity objectives in health when setting priorities.

Unfortunately, there is only limited explicit recognition of equity concerns in the allocation of resources, possibly because equity is a complex and multidimensional concept (Daniels 2008), hampering policy makers to take these concerns into account. We call for a more explicit consideration of equity criteria in the prioritization of health services. A large variety of equity-related criteria exist – e.g. severity of conditions, rarity of conditions, potential to benefit, magnitude of health gains, socio-economic status, area of residence, ethnicity, gender – and there is a need to clearly distinguish and define them. In a simple application, these could then find their way in an easy-to-use checklist of criteria for policy makers, to guide their priority setting process. When a policy maker is presented with cost-effectiveness information on a specific intervention, the tool could probe him or her with a series of questions on the relevance of equity criteria – these concerns would then influence the policy makers' willingness to allocate resources to particular groups. Context-sensitive concerns for equity may in some cases suggest a substantially different ranking of health interventions as compared to cost-effectiveness alone. As a reference, the Dutch commission on the reimbursement of health services accepts services with a cost per QALY of €80,000 in case

these target very severe diseases and less in case they do not (Ministry of Health, Welfare and Sports, The Netherlands 2009).

In conclusion, we call for more emphasis on fairness in service choice as an important yet underdeveloped path to achieve universal coverage, in addition to the present discussion on ensuring access for all. There are different paths to achieving universal coverage. Equity-based choices make a real difference in improving access for those who are especially vulnerable.

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Corresponding Author Rob Baltussen, Department of Primary and Community Care, Radboud University Nijmegen Medical Center, The Netherlands. E-mail: r.baltussen@sg.umcn.nl