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Making Choices on the Journey to Universal Health Care Coverage: From Advocacy to Analysis

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Universal health care coverage (UHC) is now an integral part of the global health agenda, with the adoption of a resolution of the United Nations by most country governments in 2012 that committed to attain and sustain UHC for their populations [1]. The subsequent commitment to health intervention and technology assessment at the 2014 World Assembly (the World Health Organization's [WHO's] decision-making body) [2] and the numerous public statements by leaders at the WHO and the World Bank to the same effect reinforced this view. At the center of UHC is "a set of services that is available when needed without causing financial hardship to the population" [3]; indeed, the UN resolution describes UHC as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost," and also calls for UHC to deliver equitable opportunities for the "highest attainable standard of physical and mental health." The obvious questions remain: How best may countries determine what is truly "key"? How might that judgment change as time passes and further development happens? By what trajectory might the barriers to access be removed and full population coverage achieved—not merely in name but also in reality?

For countries to deliver on their UHC aspirations, they need to be able to create fit-for-purpose institutions and processes through which either advice will be given or decisions made. Common desirable features of such processes include the use of the best possible evidence, the participation of relevant stakeholders, and sufficient transparency for decision makers to be held to account. Countries also need to decide which services and interventions are the main priorities. To do this it will be necessary to describe and justify the associated resource requirements, target budgets and payments, and the expected outcomes for the public of reforming service delivery and supply chains. Countries also need to determine the preferred mix of public and private agencies within their systems. Within global targets and metrics, it will be up to countries themselves to explicitly determine and adjust their priorities for public spending on

health to achieve UHC goals, such as selecting a benefits "package," determining social insurance entitlements and short-term co-payments, and using instruments such as the Essential Medicines List to good purpose [4–7].

In 1991, Australia announced that economic evaluations would be required from 1993 onwards by its Pharmaceutical Benefits Advisory Committee, which advises ministers on the national drug formulary of publicly subsidized medicines [8]. Since then Canada, Sweden, and England and Wales established similar procedures, which became increasingly applied to interventions beyond the realm of pharmaceuticals, and today about half of the European Union, together with Australia, Canada, and New Zealand, has similar agencies. Moves are afoot in several states in the United States and in several low- and middle-income countries also to create such prioritizing procedures and to adapt the criteria embodied in economic evaluation to their own circumstances. Thailand leads the way with its Health Intervention and Technology Assessment Program, a technical and process body responsible for advising the national health insurer on technologies and services, including prevention and health promotion, to be paid for under the country's successful UHC [9].

More recently, the International Decision Support Initiative (iDSI) has been formed. This is an international collaborative network for providing policymakers with coordinated support in priority setting as a means to UHC. The initiative shares experiences, showcases lessons learned, and identifies practical ways to scale technical support for more systematic, fair, and evidence-informed priority-setting processes. It brings together academic, analytical, and practitioner expertise from various decision-making agencies, universities, and development think tanks, all involved in priority-setting as a means of approaching UHC in a way that maximizes the impact of limited resources on the welfare of the population. iDSI partners include NICE International (United Kingdom), the Health Intervention and Technology Assessment Program (Thailand), the Centre for Global Development (United States), PRICELESS/Wits (South Africa), as well as

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Imperial College London, University of York, London School of Hygiene & Tropical Medicine, Mahidol University, China National Development and Research Centre (CNHDC) (China), and others. (Please visit www.idshealth.org.)

In this issue of *Value in Health*, a wide range of authors from academic, think tank, and policymaking institutions look at the implications on health care policymakers and health economic researchers of the policy trends in UHC in rich and poor countries. Many of them form part of the iDSI.

Woods et al. [10] explore the meaning of cost-effectiveness thresholds as decision rules driving investment in resource-constrained low- and middle-income health care systems. They argue that thresholds should be based on estimates of the forgone benefit, most often health-related, associated with alternative investments that consequently cannot be implemented as a result of the commitment of resources to the priority interventions (for additional material, see [11]). Global norms, such as the 1 to 3 times the gross domestic product per capita threshold range that has been recommended by the WHO, have no such empirical basis and their aspirational nature encourages countries to offer a range of services that, given their existing budgets or health care infrastructure, are simply unaffordable. As a result, health care resources have a much lower impact on people's health than they could or should [12].

Drawing on their work in empirically estimating the actual benefit forgone in the English National Health Service (NHS), Woods et al. apply income elasticities of the demand for health care to derive indicative country-specific thresholds. These turn out to be much lower than those put forward by the WHO. At the same time, they offer practical ideas of how more robust estimates of thresholds could be generated in poorer country settings. It has been a fairly widely held perception by politicians and policymakers (and sometimes even researchers) that the WHO thresholds are about advocacy and aspiration rather than about evidence and analysis. Although not seeking to offer the definitive answer to the question “What is good value for money?” in each country setting, this work will provoke a rethink of generalized thresholds by global organizations and should trigger further country-specific research on what is a topic of crucial policy importance for UHC.

Questions remain as to the extent to which the methods used in the relatively homogeneous and data-rich English NHS can be applied to much more resource-constrained and fragmented settings with, oftentimes, large and perhaps distortionary private sectors, and significant out-of-pocket contributions by patients and their families. With economists increasingly making the case for UHC [13] and donors and national policymakers turning to methods such as cost-effectiveness analysis to assess the comparative value of interventions and services in benefits packages, there is an urgent need for a simple, scientifically sound, and realistic algorithm to help policymakers determine what their own thresholds should be. Here is a rich vein of research potential for graduate students in low- and middle-income countries who want to make a real policy impact.

Wilkinson et al. [14] set out an international reference case for economic evaluation from the perspective of donors as well as researchers and country decision makers. Their report describes a year-long process commissioned by the Bill and Melinda Gates Foundation to inform economic analyses funded by the foundation, which drives multibillion investment choices at country and global levels. Drawing on the US panel [15], the UK's National Institute for Health and Care Excellence, and the WHO, Wilkinson et al. make a case for being prescriptive to be useful to policymakers while still allowing, through a principles-based approach, enough flexibility for an iDSI Reference Case that is capable of being used by researchers and policymakers operating in very different settings around the world. This work has triggered a

series of methodological research into present major unknowns such as ways of judging generalizability of evidence across settings and the importance of nonbudgetary constraints. This work is ongoing and is led by a consortium of universities including York, the London School of Hygiene & Tropical Medicine, Glasgow, and Erasmus.

Wilkinson et al. look at the application of the reference case specifically to Ethiopia, a country whose leadership is openly committed to UHC and to achieving this through a due process using sound economic principles. As a global public good, the reference case aspires to make a significant impact on the role of economic evaluation in decision making in low- and middle-income countries and consequently improve their capacity for accountable, equitable, and efficient use of limited health funds as they move toward UHC.

The work of Wilkinson et al. [14] complements that of Revill et al. [12] nicely, the former discussing the “right” principle-based approach to economic analysis from the perspective of those having to make decisions, and the latter discussing the “right” decision rule by using the results of international comparisons to inform investment decisions.

In the next article, Glassman et al. [16] review the progress and the challenges of applying economic analysis to vaccine evaluation, which remains a major global health priority topic. In middle-income countries, vaccines against pneumococcal disease, rotavirus, and human papilloma virus are in general more costly, not necessarily cost saving, and less consistently cost-effective than earlier generation vaccines against measles, diphtheria, tetanus, and pertussis. With public spending in countries adopting new vaccines being roughly double that of countries that have not adopted them, budget impact is plainly significant, making weighing the costs and benefits of investment decisions all the more important. Glassman et al. discuss ProVac, an initiative aimed at strengthening technical capacity for evidence-based decision making on new vaccine introductions via the development of cost-effectiveness models and collaborative work with government-led teams, mostly in Latin America. They evaluate the strengths and weaknesses of the ProVac approach, particularly addressing the issue of nonvaccine comparator technologies, the extrapolation of effect sizes, and the challenges in identifying unit costs and in differentiating average cost-effectiveness ratio from incremental cost-effectiveness ratio. They also briefly discuss some governance aspects of vaccine evaluation and the characteristics required of a technical analysis for it to inform the decision process before a political mandate.

This analysis has lessons for both rich and poor countries in a time of recession and when new initiatives such as European Union pooled procurement or guaranteed prices for countries transitioning from GAVI support are set up and rolled out.

As part of the process of achieving UHC, low- and middle-income countries have been encouraged to determine an explicit benefits package. Smith and Chalkidou [17] discuss the value of an explicit benefits package for the English NHS, a high-income country with UHC, but without an explicit benefits package. They describe the implications of two extreme scenarios in any priority-setting process. One is in which the treatments to be funded, and the circumstances in which patients qualify for the treatment, are specified in great granularity and are mandatory. In the other, which is closer to Western European countries' realities, priorities are expressed in broad terms, with limited or no compulsion or other levers to encourage adherence. They discuss considerations in determining the “explicitness” of benefits package specifications including the quality of information about the costs and benefits of treatments, the heterogeneity of patient needs and preferences, the financing and provider payment arrangements, and the nature of supply-side constraints—issues raised elsewhere [18]. Using the English NHS

as a case study, this article explores the arguments for and against setting an explicit benefits package, and discusses the circumstances in which increased detail in specification is most appropriate. A picture is given of an “intelligent” benefits package, specified through guidelines, performance measures, and payment mechanisms, which strives to maintain an appropriate balance between clarity (when the evidence warrants) and flexibility (when it does not). They recommend that the NHS should seriously consider a more explicit menu of benefits, or entitlements, for its population, especially as financial pressures mount and demand rises.

Perhaps the English NHS will be the first of the rich countries’ health care systems to effectively put into wider practice the principles of cost-effectiveness analysis through a well-established reference case, authoritative clinical guidelines informed by cost-effectiveness evidence embodying conditions for equitable distributions of financial contribution and of health outcome, a more empirically based threshold [19], and a mature process, in which politics follows evidence. If it did, maybe that would usher in the world’s first truly universal, maximally effective, distributively fair, and sustainable universal health service.

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