

# AUTHOR ACCEPTED MANUSCRIPT

## FINAL PUBLICATION INFORMATION

Setting Priorities, Building Prosperity through Universal Health Coverage

The definitive version of the text was subsequently published in

Health Systems & Reform, 2(1), 2016-01-21

Published by Taylor and Francis and found at <http://dx.doi.org/10.1080/23288604.2016.1125265>

**THE FINAL PUBLISHED VERSION OF THIS MANUSCRIPT  
IS AVAILABLE ON THE PUBLISHER'S PLATFORM**

This Author Accepted Manuscript is copyrighted by World Bank and published by Taylor and Francis. It is posted here by agreement between them. Changes resulting from the publishing process—such as editing, corrections, structural formatting, and other quality control mechanisms—may not be reflected in this version of the text.

You may download, copy, and distribute this Author Accepted Manuscript for noncommercial purposes. Your license is limited by the following restrictions:

- (1) You may use this Author Accepted Manuscript for noncommercial purposes only under a CC BY-NC-ND 3.0 IGO license <http://creativecommons.org/licenses/by-nc-nd/3.0/igo>.
- (2) The integrity of the work and identification of the author, copyright owner, and publisher must be preserved in any copy.
- (3) You must attribute this Author Accepted Manuscript in the following format: This is an Author Accepted Manuscript by Evans, Timothy G.; Palu, Toomas *Setting Priorities, Building Prosperity through Universal Health Coverage* © World Bank, published in the Health Systems & Reform 2(1) 2016-01-21 CC BY-NC-ND 3.0 IGO <http://creativecommons.org/licenses/by-nc-nd/3.0/igo> <http://dx.doi.org/10.1080/23288604.2016.1125265>

PMAC Commentary from the World Bank Group.

Authors: Tim Evans, Senior Director, Health, Nutrition and Population  
Toomas Palu, HNP Practice Manager, East Asia and the Pacific

## **Setting Priorities, Building Prosperity through Universal Health Coverage**

Since 2000, a growing number of governments around the world have made the political commitment to undertake reforms toward Universal Health Coverage (UHC). According to our analysis, UHC efforts in 24 frontrunner countries have been massive and transformational.<sup>1</sup> And with the recent adoption of UHC as a target in the Global Goals for 2030, policy makers are more than ever making it a priority to ensure that all their citizens have access to quality, essential health services and that no one falls into or remains in poverty because of paying for the care they need.

The World Bank Group has embraced the goal of UHC because the links between poverty and poor health are clear. Countries as diverse as Turkey and Thailand have shown that through UHC, not only can they expand lifesaving care, they can also reduce poverty and drive economic growth and opportunity.

### *UHC: Driven by values and priorities*

The growing global support for UHC is driven first and foremost by the fact that it reflects values related to the right to health and health care, as embodied in the WHO constitution. But the UHC movement also reflects the values that underpin the World Bank Group's twin goals of ending extreme poverty and boosting shared prosperity by 2030. This focus on the poorest and most vulnerable populations and on achieving equity in health and development should guide the rapid growth of health systems everywhere.

The pursuit of UHC brings into focus the translation of these underlying values of the right to health and equity in the context of finite resources. Through financing reforms that focus on prepayment and pooling, UHC provides an opportunity for policymakers to make informed choices about where to allocate resources to meet the health needs of their population as equitably and efficiently as possible. This contrasts markedly with health systems that have no significant pooling and where priorities reflect the decisions of individuals when they fall sick. Such "pay when you have to" financing systems are both inequitable and inefficient.

### *Priority setting: a rapidly maturing science that must tackle new frontiers*

Ensure that resources pooled in UHC are used most effectively points to the need for better criteria to inform allocation. The rapidly growing science related to rational choice and relative cost-effectiveness will help inform better decision-making. For example, analysis that proves a new drug is not cost-effective may lead to a decision not to include it in a universal benefit package and/or help to negotiate a much lower price with the manufacturer.

There is also growing evidence as to how the organization and management of health

---

<sup>1</sup> Cotlear et al., *Going Universal*, World Bank, 2015.

delivery systems can save - or squander - scarce resources. Examples include effective management of supply chains that prevents stock-outs of life saving drugs on the front lines or "demand-side" payments to poor mothers to access health promoting interventions for their children. These results- or performance-based approaches are forcing the science of priority setting to stretch beyond the "what" of single disease interventions and embrace the "how" of health service delivery.

#### *Prioritizing priority setting*

Of course, priority-setting is never easy. Constitutional amendments related to right to health that often accompany reforms towards UHC can be interpreted in ways that place the right of the individual to health at odds with rational approaches to priority setting for the population. Furthermore, as the recent Ebola crisis in West Africa revealed, health needs are often not predictable and/or do not lend themselves to rational priority setting due to overwhelming uncertainty, a lack of evidence of what works and a need to respond immediately. Likewise, despite strong evidence of what constitutes "best buys" for a health system, there are a set of de-facto realities that can distort priorities. For example, well-staffed institutions like tertiary care hospitals are capable of billing for curative care, procedures and diagnostics at such high volumes that they can skew allocation priorities away from primary and preventative care. In addition, priority setting – which is often focused on national needs -- must be able to reflect diverse contexts such as decentralization and the needs of specific populations, such as those living in urban slums.

#### *Building capacity for priority setting is a top priority*

Thus, countries must build their core capacity to enable effective priority-setting. Driven by new health technologies, consumer demand, demographic and epidemiologic transitions towards aging and chronic disease, there will be growing calls for more explicit criteria to justify decisions on the use of scarce resources. Unfortunately, too many health systems lack the requisite reservoir of capacity to meet this fast growing agenda for evidence-based policymaking.

There are three critical types of investments to build capacity. First, individual capacities must be nurtured through the development of strong cohorts of students well-versed in decision sciences. Second, institutional capacities for priority setting must be secured in all countries drawing on leading-edge models, such as the United Kingdom's NICE or Thailand's HITAP, and drawing on regional networks for sharing and learning. Third, and too often forgotten, is the need to invest in the information capacities of a country to generate the core demographic, epidemiologic and economic data required. Good quality and timely data are essential to harnessing the opportunity for evidence-informed priorities that will accelerate progress towards UHC.

Last but not least, development partners also must be on board and ensure that their priorities are well-aligned with those of their country partners. This will be increasingly important as countries prepare to transition economically from low to middle income, and face a declining share of official development assistance relative to their domestic resources. But by "prioritizing priority-setting," we can all help countries realize the

promise of UHC for their citizens.