

Impact case study (REF3)

Institution: London School of Economics and Political Science		
Unit of Assessment: 30 - Philosophy		
Title of case study: Making fair choices on the path to Universal Health Coverage		
Period when the underpinning research was undertaken: 2007-2019		
Details of staff conducting the underpinning research from the submitting unit:		
Name(s): Alex Voorhoeve	Role(s) (e.g. job title): Professor of Philosophy	Period(s) employed by submitting HEI: 2004 to present
Period when the claimed impact occurred: 2014-2020		
Is this case study continued from a case study submitted in 2014? No		
1. Summary of the impact (indicative maximum 100 words)		
<p>Professor Alex Voorhoeve's arguments for a pluralist egalitarian view of distributive justice have shaped a landmark report by the World Health Organization's (WHO) Consultative Group on Equity and Universal Health Coverage, marking a departure from a previous focus on cost-effectiveness. The report's principles have shaped WHO guidance to member states. They have been adopted by public actors to guide health resource allocation in many countries, notably in Latin America, Norway, and Ethiopia. They have been used by international actors and professional organisations to evaluate interventions. They are also the guiding principles of a five-year, £5m training and priority-setting programme in Ethiopia and Zanzibar. The effect of these principles' adoption is more equitable access to key health interventions around the world.</p>		
2. Underpinning research (indicative maximum 500 words)		
<p>Universal Health Coverage (UHC) is a priority for the World Health Organization (WHO) and is key among the Sustainable Development Goals. Due to resource constraints, countries must make difficult choices on the path to UHC. In response to requests from more than 70 countries, the WHO Consultative Group on Equity and UHC was founded in 2012 to provide guidance on how to make these choices fairly; that is, in accordance with compelling principles of justice. The group consisted of 18 philosophers, economists, health policy experts, and clinical doctors of 13 nationalities. Professor Alex Voorhoeve was asked to join due to his expertise in distributive justice. The Group's Report, <i>Making Fair Choices on the Path to Universal Health Coverage</i> [1], was published in 2014.</p> <p>Voorhoeve substantially influenced the principles adopted. The group members brought different views to the process. Some were <i>utilitarians</i>, who advocated an exclusive focus on maximising health-related well-being. Others were <i>purely relational egalitarians</i>, who held that the health sector should help ensure that citizens are free from domination, discrimination, and marginalisation, but were unconcerned with distributive equality (except insofar as it contributes to eliminating such relational evils). In contrast, in a series of articles (co-authored with LSE colleague Professor Michael Otsuka, Professor Nir Eyal of Rutgers University, and former LSE Lachmann Fellow Professor Marc Fleurbaey, now of Princeton University), Voorhoeve has defended a <i>pluralist egalitarian</i> theory of distributive justice, and applied this to priority-setting in health and the design of health insurance [2] [3] [4] [5] [6].</p> <p>This pluralist theory gives novel justifications for a distributive theory that integrates and balances (when they are in tension) the concerns of the utilitarians and relational egalitarians on the panel, while supplementing them with the distributive egalitarian aim of reducing inequality in both expected well-being and well-being outcomes. Voorhoeve grounds this theory in a concern for improving well-being and for its fair distribution, as well as in respect for both the unity of the individual (which directs us to do things that maximise the quality of each person's prospects, as utilitarianism requires) and the separateness of persons (which directs us to give extra weight to gains in well-being that accrue to those who are worse-off than others, as egalitarianism requires). Voorhoeve also argued that distributive egalitarianism and relational egalitarianism are complementary, so that a full theory of distributive justice should endorse them both. Voorhoeve's contributions over two years to the committee's deliberations, his written revisions to drafts, and his articles played a central role in the Report's endorsement of a form of pluralist egalitarianism. They showed how the apparently competing concerns of utilitarians, relational egalitarians, and</p>		

distributive egalitarians could be integrated in a consistent and well-grounded overarching view, which also represented a principled compromise given the committee members' diverse viewpoints.

The Report [1] advised that, to achieve UHC, countries must advance in at least three dimensions: they must expand priority services, include more people, and reduce out-of-pocket payments. In each of these dimensions, they face a critical choice in terms of which services to expand first, whom to include first, and how to shift from out-of-pocket payment toward prepayment and pooling of funds. It recommends a three-part strategy for making these choices fairly:

1. Categorise services into high, medium, and low-priority classes using at least three key criteria:
 - 1.1 *Health benefit maximisation*. This involves generating the greatest total health-related well-being gain. For a given budget, one maximises total health gain by choosing the most cost-effective interventions: the ones that cost the least per unit of health-related well-being gained.
 - 1.2 *Extra weight to gains to the worse-off*. Special consideration should be given to the needs of those who are worse-off than others with respect to health prospects and outcomes, access to health services, income and wealth, or social status.
 - 1.3 *Fair contribution and financial risk protection*. Payments towards necessary coverage and services should align with ability to pay and should be independent of individuals' health risk profile. Moreover, economic hardship due to healthcare costs and illness-related loss of income should be minimised.
2. First expand coverage for high-priority services to everyone. This includes eliminating out-of-pocket payments for these services 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, marginalised minorities, and rural populations.

The Report also argued for robust public accountability for priority-setting decisions [1].

Principles 1.1-1.3 embody the pluralist egalitarianism defended by Voorhoeve.

3. References to the research (indicative maximum of six references)

[1] Ottersen, T., Norheim, O., Berhane, F., Chitah, B., Cookson, R., Daniels, N., Eyal, N., Flores, W., Gosseries, A., Hausman, D., Hurst, S. A., Kapiriri, L., Ord, T., Reis, A., Sadana, R., Saenz, C., Segall, S., Sen, G., Tan-Torres Edejer, T., Voorhoeve, A., Wikler, D. and Yamin, A. E. (2014). *Making fair choices on the path to universal health coverage: final report of the WHO consultative group on equity and universal health coverage*. World Health Organization. ISBN: 9789241507158. Available at: https://www.who.int/choice/documents/making_fair_choices/en/

[2] Otsuka, M. and Voorhoeve, A. (2009). Why It Matters that Some Are Worse Off Than Others: An Argument Against the Priority View. *Philosophy & Public Affairs*, 37(2), pp. 171-199. DOI: 10.1111/j.1088-4963.2009.01154.x.

[3] Eyal, N. and Voorhoeve, A. (2011). Inequalities in HIV Care: Chances versus Outcomes. *The American Journal of Bioethics*, 11(12), pp. 42-44. DOI: 10.1080/15265161.2011.615890.

[4] Voorhoeve, A. and Fleurbaey, M. (2012). Egalitarianism and the Separateness of Persons. *Utilitas*, 24(3), pp. 381-398. DOI: 10.1017/S0953820812000040.

[5] Voorhoeve, A. and Fleurbaey, M. (2016). Priority or Equality for Possible People? *Ethics*, 126(4), pp. 929-954. DOI: 10.1086/686000.

[6] Voorhoeve, A. (2019). Why Health-Related Inequalities Matter and Which Ones Do. In Norheim, O. F., Emanuel, E., and Millum, J. (Eds.) *Global Health Priority Setting: Beyond Cost-Effectiveness* (pp. 145-162). Oxford University Press. ISBN: 9780190912765.

Voorhoeve's defences of pluralist egalitarianism have been published in leading peer-reviewed journals and recognised by the field. [2] was the topic of a conference at the University of Manchester and a special issue of the journal *Utilitas*, and [5] was selected as one of the "ten best" papers of 2016 in all areas of philosophy by *The Philosophers' Annual*.

4. Details of the impact (indicative maximum 750 words)

The Report [1] has had three principal impacts, described in detail below. The significance of the contribution of the Voorhoeve research [2] [3] [4] [5] [6] has been acknowledged by Dr Trygve Ottersen, Executive Director of the Norwegian Institute of Public Health (NIPH) and a lead author of the Report:

“Drawing on his well-known academic work on distributive justice...Voorhoeve was a key voice advocating that the Report adopt pluralist egalitarian principles...His input substantially shaped the Report and the way it was subsequently received in the academic community and among health policy professionals.” [A]

1. Worldwide change to the WHO’s guidance and policy advice to member states, with subsequent adoption by Argentina, Ethiopia, and Norway

The most important impact of the Report [1] has been to place pluralist egalitarian principles for health coverage design at the heart of the WHO’s guidance and policy advice to member states, and the subsequent adoption of these principles by national governments and government agencies.

The Report - endorsed in full by then Director-General of the WHO, Dr Margaret Chan [B], and also translated into Spanish and French - marked a shift in emphasis for parts of the WHO concerned with advising countries on what to include in packages of covered services. It is hosted on the WHO-CHOICE website. (The WHO-CHOICE project was developed in 1998 with the objective of providing policymakers with evidence for deciding on interventions and programmes which maximise health given available resources. Its acronym stands for CHOosing Interventions that are Cost-Effective.) This project was initially primarily devoted to advocacy of cost-effectiveness as a priority-setting criterion. The Report recommended supplementing this criterion with egalitarian criteria for determining which interventions should be covered by publicly supported health programmes.

The Report is now extensively promoted by the WHO and its agencies. For example, Dr Carla Saenz, WHO’s Regional Bioethics coordinator for Latin America, describes how it has informed training, highlighted inefficiencies and inequities, and helped to provide a principled basis for selecting interventions:

“[The Report] has been presented and thoroughly discussed at several meetings of the Latin American network of health technology assessment (HTA) agencies, in many regional training sessions on HTA and ethics, and many national meetings, including in Argentina, Chile, Colombia, Costa Rica, Mexico, Peru, and Trinidad and Tobago (including the presentation of the guidance and several successive meetings discussing with various stakeholders how to implement the recommendations). Particularly valuable experiences include Peru (where one session was led by EsSalud, the public health system’s Health Technology Assessment team, and a second was held on request of the Ministry of Health (MoH) on rare and ‘orphan’ diseases), Colombia (as part of its MoH’s efforts to determine what is covered in the national package), and Argentina, where the head of the HTA, Dr Pichón Riviere, has used them to argue that Argentina wrongly prioritised expensive cancer treatment over preventative interventions. It led an important reflection in Chile about the fact that many services that were clearly high-priority based on the recommendations were not being covered while very low-priority ones were, just because they had moved forward in a disorganised way. Also, it has helped reflections in Costa Rica about how priority-setting decisions are being handled by their public health system.” [C]

Saenz also notes that the long-term effect of the Report and its widespread adoption will be to *“institutionalise improved and more equitable methods of priority-setting in health and thereby to offer improved and more equitable access to key health services throughout Latin America and the Caribbean” [C].*

The World Bank has also joined the effort to ensure uptake of the Report’s principles, discussing how they might be applied to health financing more broadly. Christoph Kurowski, the Lead for Health Financing at the World Bank Group, which provides around GBP1 billion per year of health financing, used the Report’s principles as the basis for the UHC Financing Forum 2018 (organised

by World Bank and USAID) [A], the theme of which was “Greater Equity for Better Health and Financial Protection”.

Agencies in countries around the world have adopted the Report’s principles for priority-setting. Prominent examples are Argentina, Ethiopia, and Norway. The Report’s framing of key questions and its principles for priority-setting were endorsed in full by Professor Adolfo Rubinstein, first as Argentina’s Secretary of State for Health Promotion, Prevention and Risk Control and later in his capacity as Minister of Health [D] [E]. As noted by Saenz, they were also endorsed by Dr Pichón Riviere, head of the Argentinian HTA agency, in a report he authored on Best Practice for the Latin-American Forum on HTA [F].

In Ethiopia, Professor Ole Norheim (lead author of the Report) was commissioned by the MoH to advise on its revision of its essential health services package (EHSP) in 2018-19. Together with Ethiopian collaborators, he ran an open and inclusive consultation which resulted in the adoption of seven priority-setting criteria, among which are the three central criteria proposed in the Report. These criteria were employed to rank 1,018 potential interventions and classify 594 of them as high-priority. The MoH committed to providing 540 of these free of charge [G].

In Norway, the Report’s principles were followed in an advisory report to the government: “Open and Fair: Priorities in Health”. The commission which authored this advice was led by Prof Norheim. Its pluralist egalitarian approach to priority-setting was subsequently endorsed by the Norwegian Parliament and is now employed by the NIPH, which carries out health technology assessment for the Norwegian government. It is also used by the NIPH in its work to support decision-making, priority-setting, and health technology assessment in lower- and middle-income countries and in global institutions [A].

2. Changes to the practice of evaluating specific health interventions around the world

The take-up of the Report’s principles by actors to guide their decision-making has led to concrete changes in the way specific health interventions are evaluated. For example, GAVI, the Vaccine Alliance, which helps vaccinate around half of the world’s children, has appealed to the Report’s conception of equity to motivate investments to boost demand for immunisation among individuals and communities [H]; the Spanish Academy of Dieticians has used its principles in its evaluation of whether to include dieticians in interdisciplinary health teams in the Spanish National Health system [I]; the MoH in Colombia has used it in decision-making on insurance coverage for and access to health services to its 8.5 million adolescents [J]; the Ethiopian MoH used it to completely revise its policy for the provision of health services for 108 million Ethiopians [G]; and the NIPH employed it in its assessment of treatments for multiple sclerosis, a disease which afflicts 11,000 Norwegians [K].

3. Changes in research-led policymaking and capacity-building among policymakers

The Report’s principles are the basis of a five-year, GBP5 million programme of research-led priority-setting and capacity-building in Ethiopia and Zanzibar funded by the Gates Foundation and NORAD 2017-2023. (Voorhoeve is a participant in these grants.)

The Ethiopian government asked members of the Consultative Group to give research-led advice on a basic package of health interventions for its expansion of health insurance and to provide long-term capacity-building in priority-setting. To this end, it has set up a Center for Medical Ethics and Priority-Setting at Addis Ababa university. The research is done by an international team, including Ethiopian academics from Ethiopia, University of Bergen, Harvard, University of California at San Francisco, University of Washington, and LSE. This funding includes, at the request of the MoH of Zanzibar, plans for an expansion of the policy advice and capacity-building to this country [L].

Members of the Consultative Group, including Voorhoeve, have provided training in Ethiopia twice per year since 2017. Those enrolled must complete four week-long sessions and coursework over a two-year period to graduate with a certificate in medical ethics and priority-setting. (Thirty-one professionals, principally lecturers in medicine at universities throughout Ethiopia and MoH staff have enrolled and completed substantial parts of the course; 23 of them completed in 2019.) The Report’s principles have also been disseminated to practitioners and institutions through co-authoring with key policymakers two articles that apply its principles to cases. Co-authors include

the General Director of the Ghanaian Ministry of Health, MoH staff of Burundi, Malaysia, Morocco and Thailand, the WHO, the World Bank, and the Results for Development Institute. These case studies are used in teaching on priority-setting at Bergen, Harvard, LSE, Oslo, and Ethiopia.

In sum, the widespread adoption of the Report's pluralist egalitarian principles has led to a marked change in the evaluation and prioritisation of health interventions around the world. This will help secure more equitable access to key health interventions in many countries, including many countries in the Global South.

5. Sources to corroborate the impact (indicative maximum of 10 references)

[A] Supporting statement from Executive Director of the Norwegian Institute of Public Health, 4 March 2020.

[B] [Article](#) by the then Director-General of the WHO, Dr Chan, endorsing the Report's principles.

[C] Supporting statement from Regional Bioethics Advisor, Pan American Health Organization, World Health Organization, 12 March 2020.

[D] "[El camino hacia la Cobertura Universal de Salud en Argentina](#)" (Argentina's Path to Universal Health Coverage) by Prof. Rubinstein as Secretario de Promoción de la Salud, Prevención y Control de Riesgos, Republica de Argentina (2017) – relevant slides 4 and 5. (In Spanish.)

[E] "[Hacia una Agencia de Evaluación de Tecnologías Sanitarias](#)" (2018) by Prof. Rubinstein as Health Minister of Argentina - relevant slides 7, 8, and 25. (In Spanish.)

[F] "[Buenas prácticas en la aplicación de la Evaluación de la Tecnología Sanitaria para la toma de decisiones en el Mundo. Background paper for the first Foro Latinoamericano de Políticas en Evaluación de Tecnologías Sanitarias](#)" by Dr Pichón Riviere (head of the Argentinian HTA agency) et al, 18-19 April 2016. (In Spanish.)

[G] Getachew Teshome Eregata et al. (2020). Revision of the Ethiopian Essential Health Service Package: An Explication of the Process and Methods Used. *Health Systems & Reform*, 6(1), e1829313, <https://doi.org/10.1080/23288604.2020.1829313>.

[H] GAVI. (2017). "[Smart investments that improve immunization equity](#)" (p. 2, footnote 3).

[I] "[Evaluación del impacto y coste-beneficio de la inclusión de dietistas-nutricionistas en equipos interdisciplinarios del Sistema Nacional de Salud: revisión rápida de revisiones sistemáticas. Documento de postura del Consejo General de Colegios Oficiales de Dietistas-Nutricionistas y de la Academia Española de Nutrición y Dietética](#)" (p10). (In Spanish.)

[J] Presentation by Ministerio de Salud de Colombia (2019). Aseguramiento y acceso a servicios de salud a adolescents (p. 14). (In Spanish.)

[K] Norwegian Institute of Public Health (2019). "[Health Economic Evaluation: Disease modifying treatments for relapsing remitting multiple sclerosis](#)" (p. 9).

[L] Memoranda of understanding with Ministries of Health in Ethiopia and Zanzibar. Available on request, but confidential.