Neurological disorders are currently among the top causes of disability adjusted life-years (DALYs) and deaths globally. A vast increase in disease burden is projected, particularly in low- and lower middle-income countries (LLMIC). Paradoxically, in LLMIC settings, neurological disorders are often neglected, underdiagnosed, receive insufficient funding, and limited research. To combat the growing burden of disease, increasing focus must be placed on management of neurological disorders. Cost-effectiveness analyses of epilepsy (acute- and long-term management), migraine (first-line treatment, prophylaxis), Parkinson’s disease (drug treatment, physical therapy), and dementia (diagnosis and follow up, drug treatment, caregivers interventions) were performed to inform policy makers in Ethiopia, Malawi, and Tanzania. Health system costs were collected through a top-down microcosting method. Costing and coverage data were collected with expertise of East African neurologists and medical experts. Efficacy estimates were gathered by estimating the mortality or disability reduction, based on meta-analyses or systematic reviews. The cost-effectiveness analyses, calculating the incremental cost-effectiveness ratio (ICER), were conducted with FairChoices: DCP Analytics Tool. The health benefits of the interventions were estimated in DALYs averted. Cost-effectiveness analyses identified the long-term management of epilepsy (ICER: 0.35), self-managed treatment of migraine (ICER: 45.93), and support for dementia caregivers (ICER: 0.0004) as the best-buy interventions. Parkinson’s disease and the other dementia interventions were not deemed cost-effective in resource-constrained settings, because of their high costs or limited individual benefits. However, these interventions can be significantly impactful for patient’s families, indicating the need for further exploration of the non-health benefits using alternate methodology. The current findings support that an impact in managing neurological conditions can be made by scaling-up the identified cost-effective interventions in resource-constrained settings. By including these considerations carefully, a revision of the essential health benefit package can initiate a prime step forward in pursuit of poverty reduction and health equity.

**Objective**

In the Netherlands, an increasing number of effective but extremely expensive cancer treatments are (temporarily) not reimbursed through mandatory basic health insurance. It seems that access to such treatments is currently limited: patients are often not allowed to pay out of pocket, and health insurers do not offer voluntary additional health insurance (VAHI) to cover such cases (Calcoen et al., 2017). However, patient might benefit from and prefer such insurance. Why is this not provided?

**Methods**

In this paper, we provide a normative analysis, specifically from the perspective of social justice, of the question whether the Netherlands (and countries with similar healthcare systems) should change this policy and allow VAHI.

**Results**

While the Dutch healthcare system has a strong egalitarian ethos, and allowing VAHI will lead to unequal access to potentially beneficial treatments, we argue that there are no in-principle justice-based objections against the provision of additional insurance. As long as mandatory basic health insurance covers all medically necessary treatments that societies owe their members on the basis of justice, denying citizens access to additional treatments based on considerations of equality would invoke the raising-up objection (Eyal, 2013), and may not be just.

We then consider how the introduction of VAHI to cover expensive cancer treatments in practice might lead to objectionable changes to the healthcare system. We suggest that it should be possible to maintain the current Dutch full population coverage, extensive service coverage, and relatively moderate cost sharing. Yet, whereas only an affluent clear minority of citizens has the ability to pay for top-up payments, a considerable majority may be able to afford VAHI. This might lead to a problematic two-tiered healthcare system, that reinforces existing class differences and undermines equal social standing of citizens with low income that cannot afford VAHI (Cf. Fourie, 2016).