WORLD HEALTH ORGANIZATION

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Ministerial round table

Priority setting in the health sector: challenges to ministers

1. Throughout the world, public resources are insufficient to meet the demand for health care. The gap between what is needed and what can be afforded means that priority setting is a necessary feature of all health systems, rich and poor.

2. To frame the debate about priority setting and resource allocation, it is helpful to think about different types of decisions. Critical choices to be made will concern:

- the proportion of revenues allocated to health
- the distribution of the health budget between geographical areas
- the allocation of resources to different levels of the health service and to specific disease control programmes
- the forms of treatment which should be available through public funding
- the definition of who should be eligible to receive such treatment
- the definition of the amount to be spent on individual patients
- the proportion of available funds spent on capital development relative to operating costs
- the allocation of the recurrent budget between salary and nonsalary expenditures.

3. What then is the basis for these decisions, given competing claims and conflicting values? At what level of the health system should they be made? And who are the key actors involved?

4. Before addressing these questions, it is important to acknowledge a number of characteristics that set the world's poorer nations apart from their more wealthy counterparts. Most obviously, the level of health care spending is dramatically different - compare per capita spending of US$ 6 to US$ 10 in a number of sub-Saharan African countries with over US$ 1000 in northern Europe and US$ 2700 in the United States. Second, of the US$ 6 to US$ 10 spent in the poorest countries, one-third or more usually comes from foreign aid, whether in the form of grants or low-interest loans. Third, national institutions and management systems are generally weak, and poor countries lack well-trained personnel. Fourth, in many low-income countries

civil society does not always have an effective voice or veto in the priority-setting process. And lastly, sectoral policies are usually made without reference to a realistic overall resource framework.

5. Paradoxically, it is the international donor community which has helped governments avoid making difficult resource allocation decisions. Donor agencies have traditionally financed and supported separate projects based on their own priorities. These priorities may be expressed in terms of particular geographical areas, particular diseases, particular levels of health care (e.g. primary care and public health, rather than hospital services), particular types of interventions (e.g. immunization or contraceptive supplies), particular management systems (e.g. drug supply), or particular parts of the population (e.g. pregnant women, children under five). This has to some extent undermined aid-receiving governments' ability to develop coherent sectoral policies and allocate resources accordingly. But although there is little explicit priority setting by governments, implicit rationing by default takes place all the time by health care personnel at the level of service delivery. This may take many forms, such as denial of treatment, selection of beneficiaries or delay in providing services to those who need or request them.

6. Efforts to introduce scientific methods in the decision-making process received a significant boost in the early 1990s, with the impetus coming from the World Bank's *World Development Report 1993: Investing in health*. The report advocated an approach involving quantitative analysis of the burden of disease, analysis of the cost-effectiveness of alternative interventions, and identification of an essential package of interventions based on these analyses.

7. A number of low- and middle-income countries embarked on these exercises, often with significant technical support from the Bank and other organizations. However, there is little evidence that these methods have significantly influenced health spending. A study conducted in 14 countries found that in all cases, the packages developed were too expensive in relation to available resources. Moreover, rather than encouraging greater efficiency, the reaction of governments has been to seek increased contributions either from the international community or from their own citizens. The reallocation of resources and the development of strategies for improving technical efficiency and strengthening institutional capacity have taken the back seat.

8. In the industrialized world, a number of countries, particularly those with well-developed social security and health care systems, have undertaken explicit priority-setting exercises as the scope of their publicly financed health services came under review. The first phase of these exercises has been characterized mostly by the search for systems which would rely on complete and noncontradictory sets of rational decision rules. These would tell decision-makers precisely how a given service should be prioritized in relation to other services, and what the core services and the basic benefits package should be. Quality-adjusted life years, or the initial Oregon approach are examples of this ideal. The basic premise is that decisions are legitimate because they are made by following the rules of the system. If the rules are rational, the argument goes, so are the decisions.

9. However, as the gap between national frameworks for priority setting and implementation has become more apparent, it has also become clearer that the idea of relying on a simple set of rules based on scientific methods is flawed. As a result, thinking about priority setting has shifted significantly in a variety of ways:

- more attention on the **process** rather than the **product** of priority setting, recognizing its inherent political nature

- **new forms of dialogue** between politicians, health professionals and the public

- C replacement of tight specifications of inclusions and exclusions, with **a looser definition of core services**

- C greater emphasis on **procedural rights** as distinguished from substantive rights in terms of entitlements

- C development of broad-based guidelines encouraging the use of **evidence-based medicine at the level of the clinician** in order to achieve better practice and reduce variations in performance

- C more emphasis on reform strategies for doing more with less and for **increasing efficiency**.

10. The countries of the North have come to realize that rational methods have an important place in the scheme of things, but they are not the be-all and end-all of priority setting. It is worth asking whether, as a result, the case for imposing rationalism on low-income countries has been weakened. There is growing concern that the preoccupation with the basic package has diverted attention from the need to develop transparent national health accounts and sound financial management systems. Knowing where the money is coming from and where it is going to must be a top priority for developing countries. Without this information, priority setting and resource allocation will remain opaque.

11. Toward this end, there are also new developments in the way donors are providing health sector support to low-income countries, starting with the articulation of a realistic resource framework from all sources, and engagement of all partners in a technically, institutionally and politically informed process of negotiating spending priorities. As with the new thinking in the industrialized world, this shift offers poorer countries a sensible middle way between muddling through and exclusively rational approaches.

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