Why Prioritize When There Isn't Enough Money?

Cost Effectiveness and Resource Allocation

Commentary

Why prioritize when there isn't enough money?

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Abstract

In an informal address to the 4th International Conference on Priorities in Health (Oslo, 23 September 2002), Professor Jeffrey Sachs – Chairperson of the WHO Commission on Macroeconomics and Health – maintained that the real causes of the inability of the world's poorest people to receive help for the lethal diseases that burden them did *not* include the "usual suspects" (corruption, mismanagement, and wrong priorities). Rather, the root cause was argued to be an inherent lack of money, indicating that the burden of disease would be lifted only if rich countries gave more money to poor ones.

Without taking exception to anything that Sachs said in his address, there nevertheless remain a number of justifications for efforts to improve priority setting in the face of severely shortages of resources, including the following three defenses: prioritization is needed if we are to know that prioritization is insufficient; prioritization is **most** important when there is little money; prioritization can itself increase resources.

Introduction

In an informal address to the 4th International Conference on Priorities in Health (Oslo, 23 September 2002), Professor Jeffrey Sachs maintained that the real causes of the inability of the world's poorest people to receive help for the lethal diseases that burden them did *not* include the "usual suspects:" corruption, mismanagement, and wrong priorities. The reason that people suffering from AIDS, malaria, and tuberculosis in the poorest countries was not that their governments were spending health care funds on tertiary-care hospitals when they should have emphasized primary care or vaccinations. It was that the governments and the people did not have enough money. Even if these countries adopted the most perfect priorities, expanded their capacity to use health care funds effectively, and ran their health systems with exemplary competence and honesty, according to Prof. Sachs, they still would not be able to afford the minimal set of interventions recommended by WHO's Commission on Macroeconomics and Health, which he chaired. They simply lacked the funds. The solution was not to be found in better priority-setting or management. The burden of disease would be lifted only if rich countries gave more money to poor ones.

To members of the sponsoring professional society on health care prioritization, Sach's message hit home. The theme of the biannual congress at which he gave his address was priority-setting in developing countries. Was this all a waste of time? Were the earnest and detailed proposals offered by participants akin to re-arranging the deck chairs on the Titanic as the great ship sank?

Sachs's address was the subject of corridor conversation for the remainder of the conference. He had meant to refocus the participants' attention, and he succeeded. But they need not have given up heart. Without taking exception to anything that Sachs said in his address, there are

fully adequate justifications for efforts to improve priority setting in the face of severely shortages of resources. Here are three.

Three defenses of priority-setting

Prioritization is needed if we are to know that prioritization is insufficient

Professor Sachs's message was that the poorest countries could not afford even the most basic package of drugs and other interventions that the WHO Commission had identified as "best buys", just as they had been unable to pay for the very low-cost benefits discussed in the World Bank's World Development Report of 1993. These influential reports were, of course, examples of prioritization. Through their efforts, it became clear that large reductions in the burden of disease were possible at very little expense (by international standards). Without priority-setting, this message could not have been made clearly or forcefully.

Prioritization is most important when there is little money

The title of this commentary, "Why prioritize when there isn't enough money?" is meant to provoke: for when else would prioritization be needed? Yet not all priority-setting has the same moral significance. Previous meetings of the professional society for prioritization focused almost exclusively on the health systems of the richest countries. Among the topics that most animated many of the participants were whether the national health systems of northern Europe should offer Viagra on a universal basis. With no prejudice toward those who suffer from male sexual dysfunction, it is easy to judge the relative threat to well-being posed by denial of Viagra to an otherwise-healthy and contented septuagenarian in Norway versus refusal to fund DOTS for a young mother in sub-Saharan Africa. Spending too large a share of national health funds, however meager they may be, on tertiary care facility while higher-priority needs go unfunded is literally lethal in the poorest countries. This is where priority-setting matter most. Professor Sach's thesis does not suggest otherwise. Priority-setting may be insufficient, but it is necessary.

Prioritization can itself increase resources

Prioritization makes resources go further, but it can also lead to greater provision. In this way it addresses Professor Sachs's point directly: if the solution lies in increasing the funds available, setting priorities in the right way is one way to make this happen. The reason is that donors like to see their funds being used effectively and wisely. There is no point to handing over money if it will be stolen, squandered, or frittered away. This is as clear to taxpayers as it is to governments and philanthropists willing to offer aid across international boundaries. Providing assurance that priorities have been set wisely is one way to reassure donors and to maintain or increase the flow of funds.

Perhaps the most widely studied exercise in priority setting was the Medicaid rationing intiative undertaken by the state of Oregon, in the United States, over a decade ago. Medicaid is the national program of health insurance for the poor. The program offers a good package of benefits, but due to provisions in the statues that created the program, about half of those Americans whom the government classifies as poor are ineligible. Oregon officials sought to "ration services, not people", promising to insure every poor citizen in the state with an attenuated set of services. Priority setting would ensure that those who received this insurance would get most of the benefit that was delivered in the standard Medicaid package. Oregon embarked on an elaborate, time-consuming project of priority-setting, involving many thousands of hours by members of the Oregon Health Services Committee and by volunteers from the community. After some false starts, the committee delivered a plan to the citizens of the state that was accepted by Washington and proved to be enormously popular. The Oregon legislature, whose limits on Medicaid spending had provoked the initiative in the first place, found the new program worthy of extra financial support.

However, when the program was evaluated by external observers (including the Office of Technology Assessment – an agency of the United States Congress – and numerous individual scholars, including this author), the process of priority-setting lost some of its apparent rationality and its ability to save money. In the end, what accounted for the program's popular (and deserved) acclaim may have been the extra funds appropriated by the legislature.

A second example is the previously-mentioned World Development Report of 1993, whose pioneering effort in priority-setting, identifying a highly effective package of basic services at very low cost, is said to have been among the influences on Bill Gates in choosing international public health as the target of philanthropy.

A third example is, once again, WHO's Commission on Macroeconomics and Health. Professor Sachs, its chair, hopes to use the evidence it brought to bear on priority-setting to win the commitment of the richest countries to contribute billions of dollars in aid.

Conclusion

Is priority-setting a waste of time, a distraction, even – since it uses funds that could be spent on care – a glaring example of wrong priorities? At some level of expenditure, the answer would have to be affirmative, but there is little reason to think that this has been reached yet. The fact that the major problem is a lack of money and that the most important solution is much more money does not demonstrate that priority-setting, when there is little

money and great need, is pointless. This is when it has the greatest potential benefit, as long as the activity does not distract us from the much more pressing and important task of raising more money. This is unlikely because of the division of labor between those who work on technical aspects of priority-setting and those who work in the political and financial arenas (though in Prof. Sachs and a few others there is some overlap). It would not be appropriate to tell a conference of dermatologists that they could save more lives if they took up emergency medicine or oncology, though this might make them sorry that they chose the specialty they did. If they do a good job, dermatologists and priority-setting specialists alike can take pride in the relief of suffering. That they do not solve all the problems with which they, like others, are concerned, shows only that the combined efforts of many parties will be needed before the problems are solved.