

The complexity of resource allocation for health



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In *The Lancet Global Health*, Stephen Resch and colleagues' study benchmarks 12 countries' government expenditure on HIV/AIDS.¹ This important research emphasises that many governments are not meeting spending goals, and in many countries the financing gaps are so great that, even if they met the spending goals, expenditure would still fall short of what is needed (expenditure would cover only 64% of estimated future funding requirements, leaving a gap of around a third of the total US\$7.9 billion needed). Quantification of the gaps in domestic spending encourages us to consider whether the amount of funding is appropriate and how much more could and should be done to fight HIV/AIDS. The important question of how governments make allocation choices also comes to the forefront. The aim of this Comment is to draw attention to the many dimensions that contribute to the complexity of these decisions on health resource allocation.

The allocation of governmental resources is a multi-faceted balance between competing tradeoffs. In the 12 low-income and middle-income countries focused on by Resch and colleagues, government resources are sparse.² Taking this into consideration, Resch and colleagues' benchmarking exercise uses internationally set targets, economic forecasts, and burden of disease estimates to establish the appropriateness of spending patterns. In addition to these factors, governments face several competing considerations when allocating health resources. We believe that this complexity boils down to five key factors: disease burden, cost-effectiveness, external parties' ability and willingness to pay, intertemporal tradeoffs, and health equity.

The disease burden, as noted by Resch and colleagues, should affect how resources are allocated in the health sector. In general, a larger avertable health burden necessitates more resources. Ongoing improvements and timeliness of global burden of disease data can be an informative diagnostic approach for policymakers and researchers alike for this purpose.³

Cost-effectiveness is the mechanism that transforms financial resources into health gains. Inherently, attainment of the greatest health effect possible with the finite resources available is of the utmost importance to policy makers. A push to prioritise the most cost-effective interventions can lead to substantive health

gains.⁴ However, more work is needed to develop comparable, comprehensive, and context-specific cost-effectiveness estimates, since they are not available for some causes and many interventions, especially in low-income and middle-income countries.

External parties' ability and willingness to fund health interventions is also an important factor in how governments decide on their spending priorities. Historically, development partners have funded prevention and treatment for a key group of diseases.⁵ Furthermore, a diverse set of barriers prevents the private sector from providing a comprehensive set of services to all people.⁶⁻⁸ Governments have a part to play in addressing the disease burden that is ignored or only partly covered by the private sector and donors, and governments are wise to spend in a manner complementary to other major funders.

Governments also consider intertemporal trade-offs when investing in health. Investments such as surveillance, workforce development, disease eradication, and building of hospitals and clinics have potential to prevent death and disability in the future, although funding for these interventions is necessary now. Implementation of these projects needs a balance between future and present health gains.

Finally, allocation decisions must strive to achieve health equity. Governments need to protect those least able to protect themselves—often women, children, poor people, and otherwise marginalised groups. In many cases, to reach these populations entails investments that are not the most cost-effective or not concentrated on the greatest share of burden but are still of great importance.

In view of the many factors that affect how governments allocate their resources for health, what good are international benchmarks? First, as evidenced by the Millennium Development Goals, international goals, targets, and benchmarks align efforts, focus the public's attention, and mobilise external funding streams.⁹ Second, these efforts stimulate the ongoing conversation about the rationale underpinning governmental allocation decisions, including the need for additional data and analysis. The work by Resch and colleagues draws attention to 12 governments that are falling short of some HIV/AIDS spending targets, and

brings special attention to important gaps that would remain even if these countries met the targets. These allocation decisions are underpinned by complex and competing considerations, and many explanations exist for a range of health spending priorities. Additional data and research in these areas will help us to disentangle the complexity of these decisions and better establish whether governments, along with the international community, are on track to meet population health targets.

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