Essentials of Health Economics

Part III—Developing health care policies

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The previous part of the series (part II)¹ was concerned with the questions of choice in the context of financing systems. This and the next two parts are again concerned with choice, the central issue of economics. Here (part III) we discuss some of the ways in which economics has been and can be used within the National Health Service to assist in developing health care policy. How to plan the supply of "inputs" to health care (the subject of part IV) and the evaluation of different treatment choices (discussed in part V) are closely related issues.

Planning in health care

Until the mid-1970s much of what passed for planning in the NHS was little more than crudely based estimates of the need for physical facilities, in particular hospital beds. Some efforts at planning medical manpower had been attempted from time to time but there was little conscious effort at policy planning. Perhaps the reasons for this are plain enough. A legacy existed from the early days of the NHS that, with a zero-priced system providing the best health care for all, the stock of ill-health in the community would decline, the demands made on the services would fall, and the proportion of the gross national product required for health care would diminish. Despite clear evidence to the contrary in the first two decades of the NHS, there was a lack of willingness to face up to the need for choice not only in what services to provide but also in which not to provide. Certainly the NHS had been through a period in which it had received substantial growth monies; this in turn meant that the initial legacy appeared to be partly supported by the argument, "If we can't do it this year we'll manage to fit it in next year." Choices existed; but they were made without full awareness of the trade-offs and hence the opportunity costs concerned. In other words, the presence of value judgments in decision making and the need to make values explicit is only brought home when the going gets tough.

By the early 1970s, however, four changes were taking place. Firstly, there was a growing awareness that increasing investment in the acute sector did not appear to be having much impact on health. Secondly, and perhaps partly in response to this, more and more consideration was given to the view that prevention might be "better" than cure (and more cost effective). Thirdly, and perhaps as part of a more general feature of

industrialised western society, the technological frontier was too often seen (particularly by the medical profession²), as the place to be. This view emerged despite its doubtful relevance, when judged in terms of medical effectiveness, and its doubtful value, when considered in terms of the vast expense incurred. Fourthly, with all these pressures straining the original all-encompassing, "all-need-to-be-met" view of the NHS, there was a growing concern about the extent to which the nation would continue to agree to forgo benefits elsewhere (by way of private or public consumption) to meet the escalating costs of health care.

Against this background health care in the UK began to discover economics at least more formally than hitherto and the Department of Health and Social Security appointed their first two economists in 1970 largely in response to specific concern about the possible effects of new technology on overall growth in expenditure.³ More generally, however, in the 1970s the need for a more systematic approach to health care planning taking into account the economist's perspective was acknowledged.

What is health?

Underlying the problems of all planning in health care are certain basic issues regarding health and health care. Firstly, what is health? The World Health Organisation⁴ has defined it as "a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity." While the elegance of such a definition can be admired it is less easy to use it in practice. Even if defining health in some appropriate, operational way is difficult, perhaps none the less we can measure it. But again there are two main problems. Firstly, it is not health by itself that is desirable to society; it is the increased opportunity it gives us to lead more fulfilling and satisfying lives that is desirable. Secondly, health comes in all sorts of shapes and sizes—decreased mortality, decreased morbidity, increased care and comfort, reduced pain, increased mobility, reduced mental confusion, hundreds of different diseases with varying severities possible for all. Consequently, attempting to measure health means trying to take account of all these different value-laden dimensions of health.⁵ Where economists have made an important contribution to this task is in emphasising the value-laden nature of health and the need to distinguish between technical and value judgments in such measurements.⁶

What is need?

Perhaps it is in the closely related context of the debate on the need for health and health care that economists have made a greater contribution.⁷ Once the concept of opportunity cost and the importance of viewing the world "at the margin" is accepted, then the idea that all need can and should be met is seen to be erroneous. Need is neither absolute nor static; nor can it be determined "objectively." It is a relative, dynamic, value-laden

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concept. "Need," as Cooper⁸ remarked, "is in the eye of the beholder." Some needs will yield large benefits if met, some will be expensive to meet. Need should be met in different ways and to different extents and weighed up in terms of the costs and benefits of different courses of action. If this economists' view is accepted, then the concept of need can become a cornerstone of health service planning and, not as so often in the past, a millstone of absolutism denying the basic logic of choice.

Conclusions

Thus, perhaps the only need that is absolute is the need to banish the view that the health service should be about meeting total need. Such an attitude, abhorrent to the economist, results in confused thinking and romanticism in health care planning. Economists would, therefore, advocate a cost-benefit approach to health care planning—that is, the weighing up of benefits and costs of different patterns of care. The methodology for doing this will be discussed in detail in part V. It is simply not possible nor efficient, however, to apply cost-benefit techniques to all possible health care options. More pragmatic approaches also

need to be developed and some of these will be discussed in next week's article.

Next week's article will continue to examine the development of health care policies.

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Letters to a Young Doctor

Finishing up the preregistration year

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Securing the second post in the preregistration year usually does not have the same problems as finding the first. You will have come to understand the system and how to work it for your advantage. You will probably be able to clinch the second job at the same time as the first. If you make a success of the first job—say, in surgery—you will be able to approach the physicians in the same hospital with a view to moving into one of their posts after the surgical one. Moreover, you will have the backing (or otherwise, if you have not performed well) of your surgical consultant. You may be sure that the physicians whom you are hoping to influence in your favour will ask him what he thinks of you and your capabilities.

For domestic reasons you may wish to work as a house officer in a region that you do not know. The postgraduate dean is probably the best person to contact. He knows all the other postgraduate deans personally and can obtain advice for you from them about how posts are filled and where they are in hospitals in his region. You can scarcely expect to obtain a post in the teaching hospital for they will usually be reserved for graduates of the parent medical school, but every region has excellent district general hospitals, and it is for posts in them that you should apply after obtaining advice. Even more imperative, you should visit the hospitals and consultants to whom you wish to go. In your own region the network of consultants is known to each other. They can seek advice about you from the

local medical school and its records of your academic progress. They can find out what your teachers thought of you as a person while you were a medical student. This is not so easy if you wish to work in another region. Nevertheless, if you visit the consultant concerned he can make his own assessment of you—and you of him—and he can write to ask for references from someone who knows you. This person may often be the postgraduate dean of your own region, who may have met you and who has access to your academic records and to the people who have taught you.

Posts abroad

Similar considerations apply if you wish to work abroad in your preregistration year. As with moving to another region, there is little difficulty about this. Your medical school or faculty determines whether the posts in your preregistration year give appropriate experience and supervision sufficient to round out your undergraduate education. So if the officers (usually the dean or postgraduate dean) agree that a post abroad is suitable they will sign the certificate of satisfactory experience when it is ready to be sent to the General Medical Council. Graduates who wish to take these first posts abroad are usually residents of the country to which they wish to go and have contacts in hospitals there and so can arrange their posts or have someone locally to do it for them.

They must, however, convince their own dean or postgraduate dean of the suitability of the post to which they intend to go. This usually has to be done by asking the overseas dean of the medical faculty to give a brief account of the post to which you

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