Health economists and social value judgments – on being humble economists

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Corruption

Scientists, including social scientists, often commit two immoral acts:

- Immoral Act No. 1: Lending a spurious authority to their values by virtue of being a scientist, doctor, or some other morally irrelevant qualification
- Immoral Act No. 2: Assuming unaccountable ethical roles and bypassing legitimate routes (e.g. those via due diligence, open process, democratic vote or legitimate appointment)

Some basics

- Almost all decisions about the *design* of health and social care system as well as those to do with their *continuing operation* are deeply imbued with social values, that is, value judgments about what is good for society.
- They are not necessarily value judgments *by* society. But they are judgments of value *about* society.

- ***THESE JUDGMENTS ARE NOT FOR US AS SOCIAL SCIENTISTS TO DECIDE***

- ***UNLIKE THE FOLLOWING JUDGMENTS:***
- There are other kinds of judgment that relate, for example, to the selection of methods of analysis (was the science *good* science?), to the quality of the evidence used to support particular ways of doing things (how precise are the data and can they be *trusted*?) and to the construct validity of the measures used (is the thing we use to measure health and its value, or changes in that value, a *truly* valid measure of it?)
- Yet other judgments may relate only indirectly to social values and have instead a focus upon factual consequences, predictions, addressing questions like “what is likely to happen if…”

Social value judgments

- are *social*. That is, they relate to groups of people *and the relationships between them*
- they can relate both to processes (how things are done) and to outcomes (the consequences that flow from what is done) – means and ends
- social value judgments are nearly always entwined in the ends sought, such as population health gain, elimination of avoidable inequalities of health, protection from financial risk when utilising care, or the favourable treatment of people with multiple deprivations. Means, however, are usually to be judged in terms of their effectiveness in enabling ends to be realized: only the end can justify the means

... cont. (and some problems in separating ends and means)

- Are health and social care inherently good *as well as* being instrumental for more ultimate good things?
- Is the integration of health and social care a means to the end of better health more fairly distributed, or something that is *inherently desirable*.
- Being treated with kindness and dignity reflects a social value judgment about the processes of health and social care (i.e. means). Treating employees with fair terms of service and adequate wages and salaries is also a social value judgment about process (they are inputs and therefore means to the end of output).
- Valuing a health gain for a very deprived person more than the same gain to a person not at all deprived is a social value about the *outcome* of a process of care. So is valuing an extension of life over an increase in the quality of life with no extension (i.e. ends may entail mutual conflict).

The method of confrontation

I shall pose some issues entailing social value judgments. I'll present them as conflicts. This both sharpens them through contrasts and more or less forces one to take sides.

A high level confrontation: Liberalism versus libertarianism (what sort of economist are you?)

- Unlike the informal, US, usage of 'liberal' as any more or less left leaning political view, liberalism is the doctrine that seeks to combine two values that sometimes clash:
  - respect for individual liberty (of thought, speech, religion, and political action; freedom from government interference with privacy, personal life, and the exercise of individual inclination) and
  - maintaining a democratic society controlled by citizens, in which inequalities of political and economic power and social position are moderated through progressive taxation, public provision of a social minimum, and the insulation of political affairs from the excessive influence of the powerful
- Libertarianism is a doctrine that exalts the claim of individual freedom of action, and asks why any state power at all should be permitted - even the interference represented by progressive taxation and public provision of health care, education, and a minimum standard of living.

The market versus the state

Market failure

Is health care special?

Suppose we have these three objectives

(a) maximising population health (out of the resources allocated to health and social care)

(b) ensuring that avoidable inequalities in health are minimized and

(c) providing only *effective* health and social care

What is the most cost-effective way of delivering these objectives?

Public versus private insurance

Insurance is in general a 'good thing'. But:

- What's in the insured bundle? Who should decide?
- The socio-economic gradient (the neediest face the highest premiums)
- Moral hazard (ex post and ex ante) (the 'illusory' excess burden?)
- Adverse selection (the death spiral)

Common options:

1. Specify minimum coverage, community rating rather than risk-discrimination in premium setting, cap premiums, subsidize insurers.
1. Specify minimum coverage, divorce contribution and benefit sides by using the tax system to collect revenue and either commission private providers of care or to locate the provider side within the public sector.

Which is better? What's worse: market failure or state failure?

Equity versus equality

Economists can bring clarity to moral questions:

- *Horizontal equity* refers to the fairness (or equality) in the treatment of apparent equals (such as persons with the same income).
- *Vertical equity* refers to fairness in the treatment of apparent unequals (such as persons with different incomes or needs) and concerns *fair inequalities*.
- Criteria of relevance (likeness and unlikeness)
- Distribution of financial burdens?
- Health or health care?
- Cheapness or equality of access?

Inequalities of health versus inequalities of health and social care

- We might reasonably expect greater equality of health to require inequality in the distribution of health and social care services.
- But: what is the impact of different distributions of resources (e.g. across social classes or geographical areas) on reducing health inequalities? (That will depend on the underlying population health and demography and the effectiveness of resources in preventing and tackling ill-health of the locally prevailing kind.)
- What is the cost-effectiveness of interventions in health and social care? We know something about health care – but social care?.
- Distributional CEA: even something as simple in concept as identifying a baseline distribution of population health, applying a health and social care intervention, measuring the post-intervention distribution of health, and attributing the change to the intervention, is something not yet possible in practice

Equity versus efficiency

- Is ‘efficiency’ a good thing?
- Efficiency at doing what?
- Health frontiers and healthy rays
- Does efficiency conflict with equity?

EBM versus explicit ethics

- There is nearly always an absence of some scientific research (clinical, economic, social) evidence.
- There is often a narrow interpretation of 'scientific' evidence (e.g. excluding economic evidence)
- Such evidence as may exist may be irrelevant in part or whole
- The evidence available needs interpretational skills that is not available (e.g. multidisciplinary material or evidence from disciplines not represented in the decision-making group)
- The evidence may be of poor quality
- The evidence may have come from one context but is to be applied in another
- The evidence may be dated
- Even high quality evidence may have ambiguous outcomes conditional on unknown factors
- The evidence may be controversial and contested by expert researchers in the field
- The evidence may be of high quality when judged by internal validity but poor when judged by external validity
- The evidence may be of one level in its epidemiological quality but of another in its economics
- Research-based evidence may need supplementing by the practical experience of professionals to fill gaps or to form judgments about the quality and relevance of such research as there is
- Whether an effective technology is *sufficiently* effective to warrant use involves social values
- Whether a technology's probable benefits justify its costs or risks is a social value judgment
- How much uncertainty to accept and how best to hedge against risks is a value judgment

Needs versus wants

'Wants' are preference-based.

'Need' is not, though evidently thoroughly impregnated with values. Its meanings are legion. Its persuasive power probably derives from a combination of two factors:

- the embodied implication that the entity asserted to be needed is actually *necessary*
- that this needed entity *ought* to be provided/received.

To elucidate what any particular writer may mean, try asking what the thing said to be needed is needed *for*, and *by* whom, and *with* what purposes of whoever is specifying that it is needed. Ask whether there are other means than the one asserted to be needed–especially ones that may be more effective, or more cost-effective, and whether the person specifying the need is appropriately qualified (e.g. by training, accountability or responsibility). One may also enquire as to the social value, moral worth, etc. of the *outcome* for which the thing said to be needed is necessary (if it *is* necessary!).

Prices versus rationing

- rationing: allocating resources according to a rule or administrative arrangement
- prices: monetary expressions of either the highest amount someone is willing to pay for a slightly higher rate of consumption/use or the lowest amount someone is willing to accept to provide a slightly higher level of supply (occasionally both).

- common principles: marginal willingness to pay vs pop health max
- think about levels of decision making. What rationing criteria are appropriate at each level?
  - between health and social care on the one hand or education on the other–the level of broad public sector budget setting?
  - the CADTH/NICE level at which decisions are made as to which procedures and interventions are to be available–to be used at the professional discretion and judgment of individual professionals in the light to individual patient circumstances
  - the allocation of commissioning budgets to providers for populations in a specific locality
  - the individual, face-to-face level of patient and professional, where the professional will have to think about how best to deploy the resources at his or her disposal

Agents versus principals

- A principal is the person on whose behalf the service is being provided, the agent provides the service or advises the principal concerning it.
- More generally, the agent is anyone acting on behalf of a principal, usually because of *asymmetry of information*. The agent knows more about the technical characteristics of the service while the principal knows more about the values, needs, circumstances, and fears of the client
- The distinction between 'demand' and 'supply' becomes blurred–the agent (often the supplier) tells the principal what is needed and effectively becomes not only the supplier of the service but also its demander.
- In health and social care, the role of a physician or other health professional lies in determining the client's best interest and acting in a fashion consistent with it. Other examples include service managers acting as agents for their principals such as owners of firms or ministers, regulators as agents for politically accountable ministers, ministers as agents for the electorate. Thus many people find themselves being *both* agents and principals
- Supplier-induced demand.

Agency cont…

The critical social value question here lies in creating a trusting relationship throughout the chain of principals/agents in which the principal's interests are always to the fore and the agent's reward is either linked to the satisfactory meeting of the principal's needs (payment for results) or separated entirely from it with reliance being placed on the dutiful observance of professional codes of practice, clinical guidelines, QOF (Quality & Outcomes Framework), pride in practice, and associated monitoring and 'enforcement', by professional associations, royal colleges, statutory regulators and the like..

Universality versus selectivity

Universality: entitlement to use the service or a package of insured services without user charge, or with only nominal charges. 'Universal' customarily implies 'everyone', (all citizens, residents, resident citizens…?)

Selectivity implies that those with the means to pay either for insurance cover or out of pocket for services are excluded from the subsidized provision, or may access it at some additional charge to the nominal changes paid by those entitled to universal coverage.

The ethical tension between the two arises because the public expenditure implications of universal coverage are higher than under selective systems, so it appears not to be a cost-effective way of subsidizing health care utilization, while social cohesion or solidarity are better served by universality than selectivity. This is a direct clash of values: cost-effective support for the needy on the one hand (with the associated 'spare' resources that would be available for other social purposes) versus the sense of 'we're all in it together' and this sense being embodied in well-loved institutional forms (like the NHS in the UK).

Selective systems also imply that there would be a greater role for private insurance cover and private provision of care for those excluded from, or opting out of, the universal system.

Experts versus citizens

- Social values are nearly always involved in decisions, so it becomes important to figure out ways of introducing them into decision-making processes. This will often involve the creation of bodies–boards, advisory councils and the like–on which 'lay' people are represented.
- It is an important value (I contend!) that the social value judgments of scientists, clinicians, social workers and 'experts' in general, are no more worthy of special weight than those of ordinary citizens.
- But 'expert' groups rarely admit to any humility when it comes to expressing social value judgments! As far as medicine and social care are concerned, rocket scientists, famous painters, head teachers and archaeologists are all lay people!
- Expertise of any kind is not required for one to be able to articulate a social value judgment. Just 'being' is enough.
- OPeople with potentially conflicting interests ought to be excluded from some levels of community participation.
- Other personal characteristics can usually be identified as suitable criteria for selection, criteria such as ability to express an opinion in a semi-public situation, not having a domineering personality, ability to listen in a focused way to arguments and evidence for reasonable periods of time.

Key messages

- The key messages are all questions that ask “what is the social value content?” and “what implications does it have for the design and running of health services?”
- Other, unquestionably related, questions abound: what clinical, managerial and governance arrangements *work*, or *work best*, always lurk alongside the moral questions

Key questions

- What, if anything, makes health and social care significantly different in ethical terms from other goods and services?
- Are the big questions of social value regarding health and social care to do with their objectives, their processes, or both?
  - If objectives, is it possible to articulate what the social values involved are?
  - If processes, is it possible to articulate which processes most need attention?
- Is a "fair distribution of health" a suitable objective? What kind of equalities and inequalities might achieving such a fair distribution entail?
- Whose social value judgments should NHS and social care procedures embody: those of politicians? Patients? Potential patients? Informal carers? Taxpayers? Professionals (which ones)? Other 'experts'? Citizens? Residents?
- Ought the design of systems of health and social care be seen as a response to a general feeling of sympathy and caring that people have for the welfare of fellow humans, or simply as an efficient and fair system of insurance for essentially selfish people?
  - If the former, what implications are there for the design of the services
  - If the latter, what implications are there for the design of the services?

and…

- What issues of social value arise in deciding the best balance to strike between reliance on private and public insurance?
- What issues of social value arise in deciding the best balance between private non-profit, private for-profit and public health and social care providers?
- What issues of social value arise in deciding the share for each of health and social care in their overall budgetary envelope?
- Is the integration of health and social care valued for its own sake or because it can lead to better and more fairly distributed set of outcomes?
  - If for its own sake, what is the ethical reasoning here?
  - If for its consequences for health, what other questions of social value arise?
  - If for both, does this raise ethical conflicts that need resolving?
- What issues of social value arise in choosing between publicly owned service providers and ones managed through contracts with independent care providers?

and…

- What issues of social value in health and social care arise in deciding the size of financial contributions to come from individuals and families?
- Should the principles determining client payments for service (or exemptions therefrom) be the same in health and social care?
- What issues of social value arise in deciding the best balance to strike between reliance on public and private providers of health and social care (assume that both public and private insurance will give access to the care needed)?
- What issues of social value arise in considering the decisions that ought to be delegated to local bodies and those that should be retained at the centre?
- What issues of social value arise is deciding who may participate in public decision-making in health and social care service provision and planning, the mode of that participation and the level of decision-making?
- What issues of social value arise in allocating resources to commissioners and providers of health and social care in the regions of the country?
- What issues of social value arise in choosing between competition and collaboration between providers?

and…

Social value questions of a more specific nature

- What issues of social value arise in deciding which health and social care procedures and interventions shall be available?
- Ought the health and social services *ever* provide cost-ineffective care?
- If the opportunity cost of providing more care of one kind is the outcome lost through providing less of another kind, how may one compare and evaluate the outcome gain and the outcome loss?
- What issues of social value arise in deciding the balance to strike between services provided without user payments and those with, or groups who would not pay and other groups who would?

…and finally

- Do people who have multiple disadvantages deserve especially favourable treatment in terms of health and social care even though their capacity to benefit may be small?
- What issues of social value arise in selecting ways of rationing health and social care when demand outstrips supply?
- What issues of social value arise in deciding whether long *waits* for treatment are better or worse than long *waiting lists* (few people waiting ages versus many people waiting a short while)?
- What issues of social value arise in choosing measures such as changes in mortality, morbidity or QALYs as outcome indicators?
- What issues of value arise in translating needs for health and independent living into needs for health and social care?
- What issues of social value arise in selecting alternative methods of pay for health and social care professionals: fee-for service, rewards for meeting targets, salaries?

Humble economists are there to

Help those charged with making decisions like those we've discussed to make them:

- More clearly
- More consistently
- With relevant evidence
- With relevant consultation and participation
- Accountably

Isn't that enough?