LSE Health

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The LSE Companion to Health Policy

Edited by **Alistair McGuire** and **Joan Costa-Font**

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Introduction

Alistair McGuire and Joan Costa-Font

Health policy attempts to explore the range of aims and objectives pursued in financing, producing and distributing health care to any given population. The analysis of health policy covers the implementation of specific policies as they attempt to target the delivery of health care to different individuals, assesses the equity and efficiency of this process and evaluates the outcomes as a means of increasing the health of specific populations. As such, health policy is a wide-ranging subject covering many academic disciplines, employing many different methodologies and, given the importance of the specific institutions financing, producing and delivering health care, tends to be country or even population specific. For these reasons the range of analytical coverage is vast.

What most studies in health policy have in common is an interest in applying theory to improve practice. That the theory underlying health policy attempts to model a complex interplay of individual, community and society-wide behaviours means, not surprisingly, that the field encompasses many different ideas and analytical approaches, and advocates different practices depending on which of many analytical stances are adopted. It is a difficult area of study subject to many biases and flaws.

Yet most health policy analysts would support the broad principle that policy ought to be evidence based. The aim of the chapters in this book is to bring to bear some evidence on a range of central areas within health policy. There is no doubt that the range of areas covered is not comprehensive, but we have attempted to incorporate the most important ones. Consequently the text is broken into six parts covering Quality, Access and Inequalities; Supply and Health Care Markets; Insurance and Expenditures; Pharmaceuticals and New Technologies; Ageing and Long-term Care; and Behaviour and Health Production.

In the section on Quality, Access and Inequalities, Hernández-Quevedo and Costa-Font review the various explanations of why health inequalities exist, analysing measurement issues and empirical evidence along the way. They highlight the persistence of health inequalities across different countries. In discussing the persistence of such inequalities despite the major policy efforts directed towards alleviating them, they highlight that the policy responses are inhibited for various reasons. Most importantly, they explore the difficulties in accurately measuring the different aspects of health inequality, including problems arising from limited data and those relating to the self-reporting of health status and the biases inherent in such subjective measures issues. They conclude that, without sound data it is difficult to target policy responses and incentivizing individual behaviour.

This is clearly illustrated in a practical manner in the following chapter by Gibbs and Campbell, who focus on a specific attempt to strengthen community participation in primary health care – an objective that has been the focus of health policy in a number of low-income countries where problems of ensuring supply in the face of low funding levels and of access dominate. The authors look at a case study located in Southern

Africa, highlighting the practical difficulties of widening primary health care participation in areas where the goals of health policy are constrained by traditional hierarchies and values. The case study highlights the importance of ensuring that providers are motivated before access can be assured, and emphasises the role of monetary incentives in furthering participation generally.

This theme is taken up by Elgazzar, who considers the case of health policy as it attempts to widen access in middle-income countries generally. The argument is that middle-income countries face challenges distinct from those of low-income countries. While ability to pay for health care and lack of safety nets remain common issues in low- and middle-income countries, Elgazzar argues that there is growing income availability, while the diseases faced are increasingly different. Middle-income countries are increasingly facing similar diseases, cardiovascular disease and diabetes being examples common in the wealthier countries of the world. This changing disease pattern requires changes in the institutional delivery of health care in middle-income countries, and the chapter questions the ability of institutions to adapt rapidly to changing disease patterns. The persistence of health inequalities in middle-income countries is also discussed, where, developing the theme of earlier chapters, the role of traditional (social) influences is emphasised, although it is argued that these are exacerbated by the prominence given to responding to the preferences of a growing middle class.

The final chapter in this section develops further the issue relating to measurement problems, and here the case of measuring the performance of the primary care sector is examined. Effective health policy can only be developed if the effects can be adequately assessed, and this requires building on sound data. Kossarova notes that, while attention has been increasingly devoted to measuring the performance of the health sector in responding to the needs of chronic care, there has been less attention devoted to measuring the performance of ambulatory or outpatient care. She finds that similar problems arise in this area of care, including a difficulty in measuring quality of health care partly stemming from adequately defining the different dimensions of care. She argues that these problems are not insurmountable and considers one way forward through the use of avoidable mortality as a measure of performance.

Part II considers the growing importance of seeing health policy within the context of market-based incentives. In a number of countries a separation between institutions funding health care and institutions providing health care has been increasingly formalised. On occasion this has been coupled with attempts to improve the expression of patient preferences through motivating patient choices across providers of care. Zigante, Costa-Font and Cooper review the recent European literature in this area and argue that there is increasing evidence to support the role of competition among providers and of patient choice in improving both the efficiency of the delivery of health care and equity of access. They argue that the responsiveness of health care systems to patients' wants is enhanced through the introduction of policies that enhance choice and competition at the patient level.

Of course such policies do not generally rely on a price mechanism to allocate health care resources. Most systems are dominated by some other form of rationing process, the most common being waiting times. Morton and Bevan in Chapter 6 examine the reasons behind the use of waiting times as a rationing device. They argue that different health care systems justify waiting times in different ways – ways that are consistent with their own institutions and objectives. They do not think that these various explanations are conceptually inconsistent, and suggest a conceptual framework to categorise waiting times. They also argue that the various policies aimed at manipulating waiting times are shaped by the specific institutional context giving rise to waiting times experienced by any given health care system.

In the last chapter in this section Allin and Masseria examine a specific indicator relating to access to health care. They argue that the issue of self-reported unmet need is an important leading indicator of access. They discuss the various problems associated with defining such subjective measures of health needs by examining a specific data set. In highlighting measurement issues in particular, they argue that any single indicator of health system performance is rarely capable of adequately capturing all dimensions of care. They conclude that any comprehensive assessment of health policy requires an array of performance measures.

Part III opens with an examination by McGuire, Serra-Sastre and Raikou of the reasons why health care expenditure has been rising globally. In examining the trends in health care expenditure across high-income countries, they emphasise the role of technology adoption and diffusion. The chapter concludes with a discussion of whether future cost containment is necessary or indeed will prove effective. Emphasis is given to supply-side measures, such as the recent introduction of diagnosis-related group (DRG) hospital reimbursement and health technology assessment across a number of countries.

This theme is picked up by Papanicolas, who examines the effectiveness of performance payment structures. In reviewing the literature, she finds that, while such policies are increasingly common forms of payment structure in a number of countries, there is limited evaluation of the variety of schemes in place. While theory and intuition suggest that such payment mechanisms should lead to increased efficiency in the delivery of care, this is one of many areas in health policy where the actual evidence to support this policy is seen to be rather weaker than actually perceived.

The section concludes with a consideration of social protection in low- and middle-income countries by Mladovsky. They review the four principal mechanisms for financing health care in low- and middle-income countries, tax-based NHS systems, social health insurance, private health insurance and community financing, suggesting that no single model is likely to provide all the answers. Each mechanism is associated with strengths, but also serious weaknesses that limit the likelihood of its achieving successful social health protection in many country contexts.

Part IV considers the role of new health care technology and, in particular, pharmaceuticals in delivering health care. Given the importance, noted earlier, of health care technology in driving health expenditures, Serra-Sastre and McGuire highlight the lack of knowledge about the process of adoption and diffusion of new technology in this sector. Some explanatory factors are exposed; for example the structure of health insurance, hospital size and market competition have been shown to speed technology take-up. However, the general conclusion is that more evidence is required on how new health care technologies diffuse, how this might be regulated and what is the specific impact on health care expenditure.

Varol, Costa-Font and McGuire pick up on the role that regulatory responses might have in technology diffusion, specifically considering the case of pharmaceuticals. They investigate how the regulatory environment impinges on the launch strategies of pharmaceuticals in the main OECD markets during the period 1960–2008. The general finding is that regulation does inhibit diffusion. Thus there is always a trade-off between regulating new technology for safety and efficacy reasons, and the timing of access to new medicines.

In Part V Murphy examines the impact of proximity to death on health care costs. He notes that health care costs rise significantly in the final year of life, a finding that holds consistently across time and health care systems. Given increasing life expectancy in a number of countries, he examines the literature to determine whether the impact on aggregate health care costs can be determined. While the evidence is mixed, he argues that there is a tendency towards health status improvement in the elderly that may push back the health care costs, such that the last year of life remains the most important determinant, but he warns that this may be accompanied by increasing social care costs.

Expanding on this theme, Henderson reviews the literature on the health and social care divide within the UK. As well as analysing the reasons for this divide, she discusses the consequences for the users of health and social care services and for the wider public. She then considers potential remedies proposed to overcome this divide by examining the international and UK-specific evidence.

The theme of how to pay for long-term social care is further analysed by Comas-Herrera and colleagues. Having discussed the various options available for individuals to finance long-term care, they conclude that none is optimal and all require substantial government intervention. Whether this is forthcoming will depend not only on health policy objectives but also on the ability of the government to raise adequate funds to cover this expenditure. They also note that these are likely to be safety-net levels of expenditure and that there will be evolving equity problems as the wealthier extend access to possible private insurance finance.

In Part VI Di Cesare and Murphy then turn to examine the use of historical time series to present consistent data that allow policy makers to examine trends in improvement in health. They do so by examining trends in mortality over time in England and Wales. They point out that even with high-quality data such as these, there are still inconsistencies over time. They examine means of smoothing such inconsistencies, noting that considerable effort must be undertaken to do so. The general point is that if data on mortality require such attention, it is likely that even greater attention to detail must be paid to other data trends for these to be useful for policy making.

Rudisill then considers the importance of individual understanding of risk with respect to health interventions. To the extent that health policy relies to a large extent on motivating individuals to change behaviour, if individuals do not understand the importance or quantitative influence of risk on behaviour, policy will undoubtedly be limited. Having first examined various conceptual means of examining risk preferences, she concludes by outlining the policy implications for what risk research can tell us about health-related behaviours and decision making.

The final chapter by Stavropoulou examines a central institution common to all health systems: the doctor–patient relationship. Reviewing the literature on this relationship, she contends that attention has been devoted to the physician's role. She argues that increasing attention to the patient's role in this relationship is warranted. This seems particularly pertinent at a time when patients have greater access to information than ever before.

In common with the general coverage of health policy, the text covers a wide range of conceptual and practical issues from a number of different perspectives. While we can only introduce the reader to the vast literature that analyses the complexities of health policy, it is hoped that this will stimulate the appetite for further reading in this area.

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PART I

QUALITY, ACCESS AND INEQUALITIES

1 Inequalities in health: why do we care? How do we care? What can we do about them?

Cristina Hernández-Quevedo and Joan Costa-Font

1. INTRODUCTION

A widely accepted governmental goal in Western countries is that individuals should enjoy good health, through ensuring equitable access to health irrespective of each individual's social position. This takes place primarily by lowering (and ideally removing) barriers to health care access so as to reduce the socioeconomic vector in health access and financing, and thus achieve health equity standards. The World Health Organization performance framework, introduced in *The World Health Report* (2000), establishes that the main goals of a health care system are: health attainment, by ensuring access to care; responsiveness to population needs from health care services; and a fair distribution of financing. To accomplish health equity goals, health systems typically design programmes and institutions that attempt to lower existing barriers to health care, primarily those affecting its financing and general access – and to a lesser extent preventive programmes. Fairness in health financing is addressed by providing comprehensive coverage and limiting the use of direct payments. Similarly, barriers to health care access are normally addressed through programmes that improve the delivery of health care and prevention, although public programmes are seldom capable of dealing with pre-existing unequal conditions. Equity in health, however, has been considered an undesirable policy objective because it would impose many restrictions on individuals' choice of how to live their lives (Oliver and Mossialos, 2004). Hence interest focuses on the differences of levels of health outcomes across individuals with different socioeconomic characteristics, such as income, job status, education or geographical area, with the desirable policy objective of attaining a less unequal distribution of health outcomes.

Widespread evidence consistently points towards the existence of a socioeconomic gradient in health. Several competing explanations have been offered to explain this empirical behaviour. Hence, in most countries, despite public health system coverage being in place, significant inequalities in health and health care remain pervasive over time (Marmot, 2000). Empirical methods to identify and measure the extent of income-related dispersion of health status have evolved widely to incorporate advances of regression-based decompositions. Finally, given that health is a multidimensional concept, different measures of health arguably measure different dimensions of health as a construct. Indeed, in the UK, for instance, the so-called widening mortality gap between professional and unskilled manual men is well acknowledged (House of Commons Health Committee, 2009). This has motivated policy actions to make sure that future health improvements are shared by the population. However, in order to justify policy actions, the right evidence on the right data must be provided. This is the underlying rationale of this chapter: to assist the debate by organising it and to evaluate the state of the art.

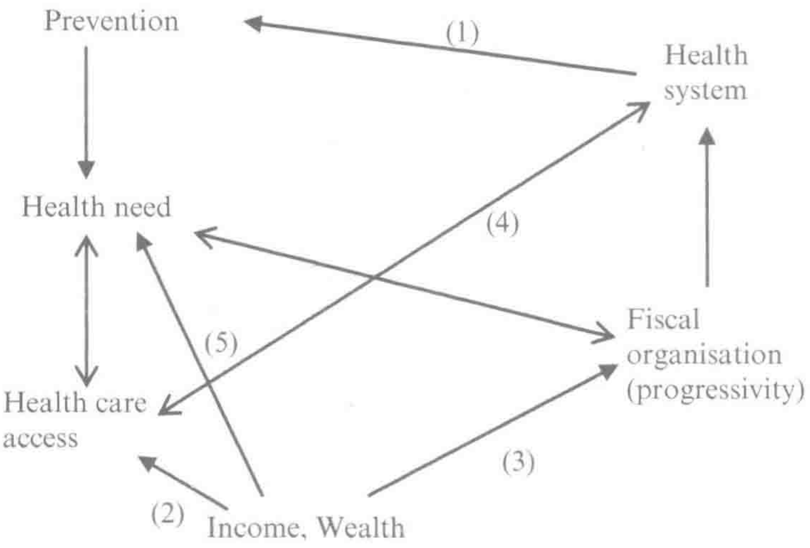
In particular, this chapter will attempt to explain the origins of inequalities in health, along with the key findings. Measurement issues, evidence, policy debates and ways forward are also discussed. We attempt to provide an overview of the state of the art of the literature on health inequalities. We draw upon and bring together advances from the economics, social science and epidemiological literature to suggest ways forward and policy implications.

First, the sources of a social gradient in health are outlined in Section 2; Section 3 follows with measurement of inequalities in health outcomes; Section 4 discusses data requirements; Section 5 covers policy implications; and Section 6 concludes with ways forward.

2. SOURCES OF A SOCIAL GRADIENT IN HEALTH

The reduction of inequalities in health and in the access to health services is one of the main objectives of any health care system. Economists have developed empirical methods that allow us to quantify the degree of inequality in the distribution of health measures and health care utilisation, and to compare inequalities over time and space, identifying those factors that lead to inequalities, thus providing some evidence to policy makers. Figure 1.1 summarises different sources of health inequalities. Indeed, an income gradient in health needs might arise due to an income gradient in prevention (1), in the use of health care (2), in the finance of health care, or might have a direct effect (4), or an alternative might well be the result of institutional barriers to access (5), among other sources. The empirical evidence is vast and cannot be summarised in a chapter; generally speaking, this chapter will cover some of the relationships summarised in Figure 1.1.

Economic and social hierarchies in society influence individuals' health status, which



Source: Author's elaboration.

Figure 1.1 Sources of health inequalities