The price of health

Sermon preached by Stephen Duckett at Trinity College Chapel, 12 March 2017
Jeremiah 22:13-16
Matthew 25:31-46

Our reading from Jeremiah today is about a bad king, Shallum or Jehoiakim, and contrasts his rule with that of his father, Josiah. There's lots in this excerpt, including what might be called the Domino's verse about making a person work without pay. But I want to highlight what is said here about a good king:

He did what was right and just,
so all went well with him.
He defended the cause of the poor and needy,
and so all went well.
Is that not what it means to know me?"
declares the Lord (Jeremiah 22: 15-16, NIV).

In contrast, Jehoiakim spent money on a vast palace, with windows panelled in cedar. So update this to 2017 and we have the choices for the rulers or the government: the cause of the poor and needy or spending money on luxuries for some?

Matthew makes it clear what we are to do. This sheep and goats parable is just one of the many with the same theme in the gospels: we should be walking with the outcasts, the hungry, and the destitute. We should be looking to see Jesus in the face of the poor, and our policies should be pro-poor (Pontifical Council for Justice and Peace 2004). A focus on social justice, remembering the poor (Galatians 2:10), has been part of the Christian mission from the very beginning (Longenecker 2010), although the language we use for the poor may change (Rieger 2013).

But this is all very well on a Sunday in a church or chapel, but does it have any relevance in my professional field, which is about health policy, informed by health economics, on a weekday?

I'm going to talk about a few areas where I think Jeremiah and Matthew have something to say to health economists and policy makers.

About one in every ten dollars in the Australian economy is spent in the health system, phrased another way, about one in every ten dollars of income earned - either by individuals or companies – is earned from health care. This identity – that every dollar of spending is a dollar of income – is an important one (Duckett 2014) because it influences the policy debate in this country: vested interests abound, dressing up support for their income as altruism. Unfortunately, many of these stakeholders are often more interested in cedar panelling than in the poor and needy.

Except for the small amount of funding sourced from overseas, all money spent in the health system comes from Australian households. Two thirds is from taxation, about 9 per cent through private health insurance, about twice that, almost 18 per cent, from individuals directly through out-of-pocket costs (Australian Institute of Health and Welfare 2016). For low income Australians, these out-of-pocket costs compete with food, housing, kids' school excursions and other family expenses that must be met on tight budgets.

Out-of-pocket costs

Australia has one of the highest out of pocket cost shares among advanced economies, the result being that many people report deferring or missing out on medical visits or prescriptions because of cost – the proportion varying between 5 and 12 per cent depending on the study (Duckett and Breadon 2014).

When we take our Christian faith seriously, we have to be very wary about proposals to increase the out-of-pocket proportion because of the unequal burden on the poor.

A very famous American study of health insurance tested the impact of higher levels of out-of-pockets and found three things. First, that higher out-of-pockets reduced service use, as economic theory would predict. Second, that this impact was greater among poor families compared to wealthier ones, as one would expect. And third, that service use was reduced equally among visits that professional assessors through were necessary and ones they thought were not (Newhouse and the Health Insurance Experiment Group 1993). This latter finding leads to the view that increasing out-of-pockets as a strategy to reduce health expenditure is not only wrong but foolish as any short term gain may inflict long term pain as the visits that should have occurred – those necessary ones – may have led to early intervention saving longer term costs.

Increasing the proportion of privately funded health care – even if funded by health insurance rather than out-of-pockets – carries other risks too, such as differential access and embedding a two-tiered system. We now know that a higher proportion of procedures done privately is associated with longer public sector waiting times (Duckett 2005).

Increasing the proportion of health care funding from out-of-pockets has two important redistributive effects: responsibility for funding health care is redistributed from the wealthy (who would otherwise pay more taxes) to the poor (who pay a greater proportion of their income out of pocket) and from the healthy (the vast majority of the population and hence the vast majority of taxpayers) to the sick (who will pay more out of pocket). Neither sound like the principles that Jesus was talking about in the parable of the sheep and the goats, nor what Jeremiah was talking about when he called out Jehoiakim for not defending the poor and the needy.

Prioritising efficiency

But does this mean that all spending on health care should be supported? My answer is not.

But first, a little about economics. Economics is a science about scarcity, about setting priorities. An important idea in economics is the concept of 'opportunity cost', which is the cost of opportunities foregone. If you spend your money on one thing, you can't spend it on another.

This leads economists to focus on efficiency. I'll pose a question. Should an inefficient public hospital be paid more to do a hip replacement than an efficient one? Long ago, I came to the conclusion that the answer to that question was a resounding no. As a result I advocated paying all hospitals the same for doing the same things, a policy then known as casemix funding – because a hospital was paid for the mix of cases or patients it treated – but is also known as activity-based funding because a hospital is paid for its activity.

I would argue that pursuing efficiency is part of being good stewards: we need to manage our resources well. If we don't, if we spend too much money on cedar panelling - or inefficiency – then we won't have enough money to defend the cause of the poor and needy, harking back to Jeremiah's words.

It is important to stress here that driving inefficiency out of the system is not the same as cutting funding.

Prioritising what works

But what I've talked about so far is the price of health care, rather than the price of health. And as we move to putting a price on health, things get much more tricky.

If you have a given budget, it obviously makes sense to ensure it is spent efficiently. But for economists, efficiency is not simply about looking for savings in the way we do things. It is also about whether we are doing the right things at all, this latter concept is sometimes called social or allocative efficiency.

A number of research studies have shown that an arthroscopy for osteoarthritis of the knee doesn't lead to any benefit to the average patient compared to doing nothing (I'm here drawing on (Duckett et al. 2015). So we need to figure out what health treatments actually benefit patients, and as health policy people and economists working in the health sector, develop policies to address inappropriate care.

New health spending has to be assessed in terms of whether it is worth it, and this should involve rigorous assessment using what is known as a randomised controlled trial where one group gets the intervention and another doesn't. This approach has a good biblical authority: the first such trial being designed by Daniel in the time of Jehoiakim and Nebuchadnezzar and described in Daniel 1:3-16 (Neuhauser and Diaz 2004; ØStbye and Rochon 1993).

The place of cost-effectiveness

Sometimes, as in the knee arthroscopy example, the answer has become clear. But what if there is some benefit for the average person? In economic evaluation, the benefit is often

assessed in terms of average additional years of life that result from the intervention, and what is the level of disability associated with those years added. The metric is called 'Quality-Adjusted Life Years' or 'QALYs'.

Then comes the hard part, how much should the taxpayer pay for a one year average extension of life, a one month average extension of life or an average of just one day extension of life? The process is known as cost-benefit analysis as it involves analysis of costs and benefits. We are now at the sharp end of putting a dollar value on life. Cost-benefit analysis is not without its controversies (Gray and Wilkinson 2016), including issues like how do you value the life of someone not in the workforce (Krol et al. 2016), and is it possible to take the differential impact of interventions on different socio-economic groups into account (Broome 1999; McKie et al. 1998). It only makes sense as a process for priority setting if we are dealing with people in the abstract, so called 'statistical lives'. When a person is trapped in quick sand a 'rule-of-rescue' comes into play and immense resources are willingly devoted in that once-off event to save them (McKie and Richardson 2003).[1]

New drugs to be listed on the Pharmaceutical Benefits Scheme in Australia are assessed using cost-benefit approaches, as are new procedures to be listed on the Medicare Benefits Schedule. A new drug might be listed if the cost of one additional good year of life can be obtained at a cost to taxpayers of less than $100,000 per year, say (George et al. 2001) and not generally funded otherwise.[2]

Is this consistent with Jeremiah or Matthew? As taxpayers we need to be sensitive to such questions. I think in this circumstance it is an appropriate policy, although we also must recognise that there are very clear risks to letting money be our main way of measuring value (Goodchild 2009; Welby 2017). Tax funding is not unlimited and at the margin one will always have to make a trade-off about value. If taxes were higher our funding threshold might relax, we'll fund drugs which cost $200,000 a year per QALY rather than $100,000 a year, but I doubt there would be much voter support for increasing the threshold infinitely.

We have to be rational stewards of health care resources. We need to ensure that taxpayer dollars are invested wisely, lest we face a voter and taxpayer backlash leading to arbitrary cuts, service reductions or significant increases in out-of-pocket costs.

Factoring in equity

We are talking here about rationing government spending. Everybody is in the same boat here – both the wealthy and the poor are supported, and, therefore both the wealthy and the poor have an interest in making sure the system works. We all benefit in a society where everyone can get their health needs met.

Jeremiah gives us a clue. We are not looking for a cedar-panelled health care mansion, but we are looking to ensure care for the poor and needy. We want the ruler, our government, to do what is right and just. And in this context we need to recall that the Mosaic concept of justice

which pervades the Hebrew Scriptures is one of distributive justice, one of redistributing social goods and social power.(Brueggemann 1997: 736)

In a sermon such as this I cannot touch on every critical issue in the price of health and health care, but what I want to leave you with is a clear message. Economics is about priority setting, and about the values behind priority setting. In the language of behavioural economics (Angner 2016), if we are to listen to the word of God as expressed in many places in the Bible, Christians should be expected to have different profiles of social preferences about altruism, fairness and justice compared to the social preferences exhibit in a society which focuses on material gain. I would also argue that it is the Christian's job to advocate for social policies consistent with that different social preference profile.

Sure, economics is about efficiency. But it is also about equity. Efficiency and equity are intertwined, it is not one or the other, both are important. A simple emphasis on efficiency cannot be supported.

For we have to come back to the parable Jesus told in Matthew: 'Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me.' (Matthew 25:40).

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[1] Of course, big Pharma is adept and trying to convert 'statistical' lives into human stories.
[2] There are some exceptions with special arrangements for 'life saving' drugs for very rare conditions, see http://www.health.gov.au/lsdp.