Economics and public health: an arranged marriage

Jan J. Barendregt

Economists are often defined as people who know the price of everything, and the value of nothing. After reading ‘Economics and public health: Engaged to be happily married!’ (Werner Brouwer et al.) one might want to add that economics is not a good training for marriage consultancy. Where WB et al. see marital bliss, I see the relationship between public health and economics more like an arranged marriage, based on considerations other than the mutual attraction of the partners.

Certainly, as WB et al. argue, in principle economics has much to offer to public health. Economics has developed a large body of theory in the field of making optimal choices under resource constraints, and that, of course, is exactly the problem public health is facing. So why is there no love lost between economics and public health?

It is, so to speak, a matter of character. Public health has, from an economic point of view, a very difficult character. Patients are not consumers, health service deliverers hardly behave as producers, there is no market for health services where a price is set by supply and demand. Which means that much of that nice economical toolbox, based on assumptions of a utility maximising consumer and a profit maximising producer, simply does not apply in public health.

This fact does not stop economists, and this is the public health point of view, from being pushy. An economic evaluation is a quantitative exercise, and by definition comes up with some number, e.g. Euros per QALY (and perhaps even a quantified uncertainty range around it). Economists expect this number to be taken seriously. However, the amount of arbitrary assumptions and decisions that go into the evaluation makes it difficult to swallow it as such. Economics is a quantitative science, but not an exact one.

An extreme example is provided by my experience with the Queensland Evaluation Group. This Group is one of a few that judges applications by pharmaceutical companies for admittance of a drug to the Australian Pharmaceutical Benefits Scheme (PBS). Such an application is required to include an economic evaluation, and as an advisor to the Group I frequently get the opportunity to peek into the kitchen where the company economists are cooking the books.

The outcome of such an evaluation, needless to say, always falls within the PBS guidelines. The creative ways the results are obtained, however, are often a cause of much merriment in the advisory group meetings. But the sobering message is that the economic evaluation of health care provides so much leeway for the researchers that any evaluation, even when no conflict of interest is present, should be judged with great care.

A good example of the (perceived?) pushiness of health economists is provided by an article on screening for Down’s syndrome.1 The article compares a number of different screening strategies, and recommends to choose from four options that are on the efficiency frontier.

In an accompanying commentary Wallace and Mulvey raise a couple of technical issues, but end their comments by scolding Gilbert et al. for ignoring in their analysis the preferences of the pregnant women. Several letters (and a host of rapid responses) question the results on similar grounds, among others that women do not behave as the study predicted.2

Such a mismatch between the results of an economic evaluation and the convictions and experience of stakeholders and experts is quite common, in particular in the field of reproductive health and child health care, and passions can run high. The third edition of ‘Health for all children’ of the Child Health Surveillance (CHS) in the UK muses that ‘We have tried to reconcile the research evidence, the understandable scepticism of purchasers and fundholders, the passionately held views of many professionals, the clearly expressed concerns of parents and voluntary organizations’.3 This reconciliation was apparently not easy.

In such debates the quantitative result of an economic evaluation tends to prevail over the often just qualitative arguments of experts. That may bolster the economists’ ego, but the difference of opinion should get them worried.

Because of the inherent arbitrariness of economic evaluation, the result’s exactness is more apparent than real. Some health economists acknowledge the limitations of their methods, and foster debate.4 But too many simply follow the recipe of one of the guidelines, and crank out yet another cost per QALY.

Nobody has to convince me of the necessity to use economic evaluation in public health, but let’s not get carried away, and see the pair for what it is: two partners that find themselves in an arranged marriage. The best we can hope for is that the partners will get used to one another, and learn to live with each other’s character deficits. But to call that ‘bliss’ only confirms that economists do not know the value of a happy marriage.

References


doi:10.1093/eurpub/ckl075

Advance Access published on October 26, 2006

School of Population Health, University of Queensland, Brisbane, Australia

Correspondence: Jan J. Barendregt, School of Population Health, University of Queensland, Brisbane, Australia, e-mail: j.barendregt@sph.uq.edu.au

Advance Access published on October 26, 2006