Health and Health Policy

1. Nature of Health & Health care

- Health care as a commodity: first-best economy does not hold
  - Asymmetric information: health care consumption depends on doctor's prescription → requires professional & expert knowledge to evaluate a 'good' health care service
  - Supply creates demand: new treatment, medicine & technology leads to new consumption
  - Health *insurance market* is inefficient: adverse selection (those who are likely to be unhealthy purchase more health insurance)
  - Third party (principle-agent) issues in health insurance: private insurance companies cannot monitor or regulate health care providers (doctors), consumers (patients) have more incentive to use health care when insured → overconsumption of health care
  - Externality: my health affects others' health (pandemic), overall healthy workforce contributes to economic growth
  - "Ill health in 'left behind' areas costs England £30bn a year, says report", The Guardian (13.01.2022)
- Public health: health improvement (general health), health protection (prevention & cure of diseases, coping with pandemic), health services
  - Related to broader social aspects: living & working conditions, public hygiene, health behaviours, socio-economic inequalities
  - Treating illness vs preventive approach/general health/well-being
  - NHS (focuses on diagnosis & treatment) vs Public Health England

2. Social Inequalities of Health

- Health inequality: measured by disparities in health outcomes (mortality risk, life expectancy, incidence of diseases, BMIs, heights) across socio-economic status (gender, race, social class, education, income & regions)

  - Increased in the UK, US & Europe over the 20c (Bartley, 2016)
  - "How the pandemic has affected people based on age, gender, vaccination status and ethnicity" The Guardian (16.01.2022)
  - Not expected despite the existence of universal health care: general health of a population is more likely to determined by *social factors & lifestyles* than just medical care → need for *preventive* approach
- 'Fundamental causes' approach to health inequality: what should health policies target for reducing health inequality?
  - Income: Lack of material resources? Poor infrastructure? (Sanitation, housing, electricity…) – income & mortality risk show high negative correlation but is the income a cause or a simple correlation?
  - Level of education: access to information & capacity to process it → determines your health behaviour
  - Culture & behavioural differences: some risky behaviours (less exercise, drinking, substance use) are not just an outcome of rational choice in the given environment but also a group-based identity (gender, ethnic groups, minority…)
  - Psychosocial factors: low relative social status (& related stress) – health disparities are even found within the same occupation, may be related to different social status & hierarchy
  - Life course approach: early life events have long, persistent impacts – health shocks in early age, infant nutrition, parenting, pre-natal health
  - Reverse causation: health outcomes can be social but also genetic – high achievement & socioeconomic status are due to inherent health
- Political economy: health inequality between countries (or jurisdictions)
  - Welfare regimes & population health: education, access to decent quality health & social care, housing, unemployment support system
  - Covid fatality rate different between countries: strongly related to the level of socio-economic inequalities
  - "Why have some places suffered more covid-19 deaths than others?" The Economist (31.07.2021)

3. Health Care Financing & Governance

- Population health has been improved steadily but health care *spending* (public & private) has also risen continuously
  - Politics: medical profession exercise some power in medical spending; invention of new medical technology & medicine
  - Population ageing, new diseases (new virus but also related to socio-economic development – obesity)
  - Public expectations of health care needs: cutting-edge treatment, new medicine, social recognition of new conditions (i.e., mental health)
- Two ideal types of healthcare systems: but always beware of different socio-cultural, political contexts, different concepts of same terminology

Ideal-type	Financing	Provision	Regulation	Examples
National Health Service model	Direct (income) and indirect forms (consumption) of public taxation	Public	Top-down, command-and-control by the state bureaucracy	UK, Denmark, Sweden, Finland, Italy (since 1978), Spain (since 1986)
Social Insurance model	Public contributions based on income	Private and public providers	Corporatist model of collective bargaining between providers and purchasers	France, Germany, Austria, Belgium, Netherlands

- Dimensions (financing, provision, regulation) & ideal types (Crinson, 2012)
  - Finance: tax-based (UK, Sweden), state-regulated social insurance (Germany), private insurance (US) & out-of-pocket payment
  - Regulation: top-down by the state (bureaucratic, providers & financers) vs collective bargaining by social partners & medical professions
  - Provision: public (e.g., NHS), private (for-profit & voluntary)
- Corporatist structure (SI model): similar historical process as in other welfare systems (pensions, unemployment insurance)
  - Relative autonomy of social partners (industrial sectors, unions): more complexity (various SI schemes) and higher cost of management

  - State coordinates decision-making, provides guidelines for contracting, contribution rates, coverage & memberships of workers
  - Not necessarily bottom-up: state still monitors services, provides incentives for competition, regulates private insurance funds
  - Better patient choice than the gatekeeper (GP) British model
- Additional ideal types: social insurance & private services (Canada, Korea), private finance & private services (US, Brazil)

4. National Health Service in the UK (England-focused)

- Pre-1948: fragmentary mix of charity hospitals, local government & market provision → failed to meet health care needs
  - National Health Insurance (1911): only covered those in employment
- NHS founded in 1948; free & universal access; general tax-funded (partly with NI contributions & small charges)
  - Recent increase in private payment (skipping waiting list, private beds)
- Organisation & commissioning: Department of Health (Secretary of State for Health): overall political head

  → NHS England: oversees commissioning & allocation of resources

  → Local commissioning bodies: Clinical Commissioning Groups (local GPs, clinicians): allocate local resources to various kinds of services

  → Service provision by NHS & Foundation trusts
- Regulations & monitoring: control safety, quality & cost-effectiveness
  - National Institute for Health & Care Excellence (NICE): assess & provide guidance to specific treatments & interventions, to reduce variations in clinical management between health authorities (regions)
  - Care Quality Commission: monitors services & hospital conditions
- Different levels of *treatment*: primary care (GP; gatekeeping) – secondary service (hospital); tertiary (specialist); accident & emergency
  - Gatekeeping system by GPs: doctors determine medical needs of hospitalisation & specialist treatment
- Provider-purchaser split:

  - Commissioners: NHS England (central); Clinical Commissioning Groups (local); other regional health authorities
  - Service providers: NHS trusts, for-profit & voluntary organisations
  - *Payment* by results: providers remunerated for volume of treatment
- Current system is based on the Health & Social Care Act 2012 (Coalition)
- Spending on the NHS has steadily grown, accelerated in the New Labour period (1997-2010), but has fallen afterwards (austerity ~ 2019)
- Introduction of internal markets (*marketisation*) since the 1980s: local health authorities (commissioners) purchase services from providers
  - GPs became fundholders: make contract directly with suppliers
  - Hospitals, ambulance & community health services became *NHS trusts*, independent from local health authorities in their management
  - Contracting out non-essential services (cleaning, catering) & staff
  - Intended for efficiency & flexibility but unintended costs: transaction costs, monitoring services, extra bureaucracy for budgeting
- New Labour: democratic self-governance and decentralisation – partnerships at local levels, freedom to manage and innovate
  - Introduction of Primary Care Groups: Local GPs & other primary care providers are directly funded by the central government and gather to manage the budget for health care services
  - Internal market abolished for partnerships & collaboration, but the purchaser-provider separation (thus competition) was maintained
  - Introduction of independent sector: private & voluntary providers can compete for NHS-funded out-of-hour GP and hospital services
  - “NHS paying £2bn a year to private hospitals for mental health patients” The Guardian (24.04.2022)
  - But tension between PCTs and health authorities: in practice, health authorities exercised substantial power in budget use (Klein, 2013); local decision-making heavily influenced by central government targets (reduce waiting times, efficiency, accountability…)
- Criticisms for NHS structures:

- Fragmentation between different pillars: lack of coordination between NHS, social care bodies & local authorities: failure to respond quickly in the early phase of the pandemic → care home disaster (Daly, 2020)
- Funding allocation: does not sufficiently account for different health needs across regions → source of regional inequality
- Incentives for cost-containment & budgetary pressures: waiting lists, restricting demand (gatekeeping), slow in adopting innovation
- Different organisational structure by the devolved governments
- “The Case for ditching the NHS” The Economist (23.10.2015)