

Economic evaluation of medical interventions: Answering questions people are unwilling to ask?

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Even under conservative assumptions, total health care expenditures rising faster than GDP have been shown to be “affordable” in most, if not all, OECD countries for the next several decades (Chernew et al. 2003; Schlander et al. 2004). However, there has been increasing concern about public sector spending on health care owing to the well-known tendency towards inefficiency of non-market based resource allocation mechanisms.

Scarcity of resources in the public sector, partially driven by cost-containment policies, has fueled interest in the economic evaluation of medical interventions as a tool to support rational allocation decisions, the common variants being cost-effectiveness or cost-utility analysis (CEA or CUA) and cost-benefit analysis (CBA). While, at a sufficiently high level of abstraction, the underlying analytical framework, including an accepted Social Welfare Function (SWF), is flexible to incorporate any social arrangement that contributes to well-being, in practice, such analyses usually rest on relatively simple consequentialist utilitarian assumptions: under a set of given resource constraints, the maximand of extrawelfarists is aggregated health (QALY) gain measured in cardinal terms (CUA), whereas welfarists seek a (potential) Pareto optimum of ordinal individual utilities (CBA). Yet, in health care compensation of losers (for health services they did not receive) is impractical, if not completely impossible, thus effectively preempting any separation of distribution and net benefits.

From a decision analytical perspective, it is notable that there is no consensus on the objectives of publicly financed health care systems as is assumed by conventional “prescriptive” economic theory: instead, mounting empirical evidence has been found for social-ethical preferences with respect to, among others, contextual factors (such as the “rule of rescue” and non-discrimination of people in “double-jeopardy”), severity of a health state per se, and communitarian values (“solidarity”), even at the expense of efficiency (cf. Nord 1999, Ubel 2000). Apparently, here the public rejects specific features of utilitarianism, i.e., its inherent neglect of a person’s autonomy and integrity (cf. Sen & Williams 1982) and its assumption of “distributive neutrality” (cf. Rawls 1971; in health care: Nord et al. 1995).

From a normative perspective, a “decent basic minimum” of health may be understood as a “conditional good”, enabling persons to pursue their life with a normal range of opportunities (e.g., Daniels 1985). As such, it coincides with the ethically inspired notion

of primary goods and basic liberties (cf. Rawls 1971) or capabilities (cf. Sen 2001). Traditional and present stated objectives of many public health care systems seem to lend support to this observation of conflicts between theoretically assumed and actual objectives.

Ironically, it appears entirely possible that, in light of the above, conventional economic evaluations might be least useful precisely in some of those parts of health care systems that are publicly financed and most plagued by resource constraints. Unless these conflicting goals have been reconciled in innovative ways, we may indeed be “just kidding ourselves” (Drummond 2004) about the full potential of health economic evaluations of medical interventions.

Needless to say, these conclusions do not imply invalidation of health economic evaluations as a tool providing additional insights – yet they indicate far-reaching implications for any attempt to interpret their findings in a “normative” way.

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