Research Directions for UK Health Economists: a discussion paper

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I General Comment on the Questionnaires

Rather than merely catalogue the opinions of our colleagues as I have gleaned them from the questionnaire I shall first set out a few preliminary bold and bald remarks which may help us to structure our discussion and, at the very least, initiate it.

One thing that I expected to emerge from the questionnaires was that we would have broadly three different directions of approach, though I have not believed them at all to be mutually inconsistent. Some respondents have a clear policy orientation with their major recommended research thrusts being determined either by current problems in the NHS (e.g. PPBS, budget allocation to area health boards) or by longer term policy changes that they may anticipate (e.g. the role of private insurance for health care). I expected others' suggestions to derive from this immediate association with medical colleagues but was surprised at being unable to fit any of the responses into this ratherparochial category beyond the occasional plea for plenty of medical collaboration. We all seem to take a healthy "in the large" view of things. The third approach, and this does emerge from the questionnaires, is a more "economic" orientation, in which people are concerned primarily with the special conceptual and analytical problems that arise in developing economic analysis for application to health problems - the distinction (and its significance) between "demand" and "need" is one example of this; the concept of health capital and its measurement is another. Overwhelmingly, however, some form of policy orientation appeared to be the principal motivating factor; this may

comfort our colleagues in the DHSS - or, indeed, it may worry them! Within this policy orientation most of us seem to feel that the current problems of the NHS should determine our principal research endeavours, even if the payoff to such research is not likely to arrive for a long time (e.g. output measurement which was much stressed by most respondents). Although there was some interest in international comparative types of research, there was not, I think, enough - we seem to take an unfortunately insular approach. For one thing, the international comparison of different institutional structures and their consequences (e.g. for utilisation by social class; for institutional efficiency) strikes me as providing a fascinating area of study and one from which we could (being ultimately insular) learn a great deal. There really is very little material of this sort available and this at a time when every major western country (I don't know about the eastern) is currently reorganising or preparing to reorganise its health care delivery system. A second aspect of this same point is that some countries are engaging in the most fascinating experiments. The current US interest in health problems by many economists is not something we should isolate ourselves from by concentrating mainly on parochial issues. Moreover, the forthcoming OEO multi-million dollar experiment in different types of medical care insurance is probably the nearest thing the world will ever get to testing some of the propositions many of us have debated, rather theoretically, for a very long time.

It may be that we get channelled into particular research endeavours according to the purposes for which research funds are made available but we should not miss out on the chances of international

collaboration which are now presenting themselves. Nor should we avoid some of the fundamental conceptual questions that may appear rather "academic" but which ultimately determine our ability to contribute something distinctive and new as a profession. In this, some of us are clearly constrained by the terms of our appointments. Those of us that are not should, I feel, try to ensure that the traditional scientific aspirations of internationism and pure speculation are sustained in health economics research as in other areas of endeavour.

One or two respondents emphasised the great desirability - even necessity - of close collaboration with medical professionals (and far less with the administrators). I am personally sceptical about the powerfulness of this argument. On the one hand it is clearly necessary for economics to be informed about medical technology (supposing such a thing to exist!), moreover we have to sell our ideas to the medical profession if we wish ever to see them in action. On the other hand, however, it seems to me that there is a very great number of research projects in which clinical expertise may not only be irrelevant but even a hindrance. There frequently comes a time - sooner or later - where the joint input of medical and economic expertises is essential. That does not seem to me in general to warrant the setting up of interdisciplinary teams *ab initio*, though there may well be some projects where this is necessary. Economists are not noted for their humility, but doctors are even less modest in their pretensions and can easily intimidate a non clinical innocent!

One thing I have *not* done is to attempt to assess the order of priorities among items in the research agenda. That should emerge from our discussion, as will the omissions.

Finally, several respondents have emphasised the importance of defining health economics precisely and one has urged the early

establishment of a chair in health economics. I suspect that if we agree on nothing else we shall not only say Amen to that but ask - "Why only one?"!

II The Research Agenda

I have attempted to classify the proposals for future activity under seven collectively exhaustive (I hope) heads. Naturally the heads are not mutually exclusive.

A. Descriptive and Recording Studies

Management Information Systems
Area morbidity and health status data collection
Area resource allocation and needs measurement
Comprehensive survey and review of existing data on NHS.
Medical record linkage
International comparative studies of delivery systems and manpower planning
Health care and the social accounts
Consumption of health care, social class and other determinants of utilisation
Case studies of delivery systems
The redistributive impact of the NHS
Historical study of the relationship between health and politics
Health needs of families by socio-economic class
Forecasting models of manpower availability and general future resource requirements
Measurement of health care provision outside the NHS, e.g. family care, self-medication

B. Institutions and Behavioural Models

Models of hospitals
Models of group practices
Factors affecting distribution of doctors between specialties and regions
The medical profession and incentives
Centralisation and decentralisation of health policy decision taking
Optimal size of geographical administrative units
Optimal location of DGH's
The actual and the proper role of political decisions in health policy
Division of function between general practice and hospitals

C. Production and Cost Functions, Factor Supplies

Production functions for health institutions

Optimal size of hospitals, group practices, etc.

Optimal input mixes of medical, technical and paramedical manpower

Cost functions for individual health and social services

Capital - labour ratios in health services

Determinants of the supply side of the medical labour market especially nurses, auxiliaries and domestic staff

Hospital and AHA cost comparisons

D. Conceptual Problems

What is distinctive about health economics?

Demand vs. need

Social costs of sickness

The value of good health/the value of life

Better health - consumption or investment?

The concept of health capital

The notion of "efficiency" in health care allocation

The role of time as an allocation/discrimination device

Integration of efficiency and equity in health care

In what sense is there, has there been or can there be a "market" for health care?

Human capital theory and health investment

Theory of collective decision making and health

Theory of labour markets and health care

A £20 fine for anyone who writes "let x be a vector of health service activities"! (Dick Morley)

E. Financing Questions

Optimal size of health expenditure

Reconciling requirements for audit and control with PPBS

Allocation of budgets to area health boards, teaching hospitals

International comparisons of expenditure

International comparisons of financing methods

Methods of finance and their effects on utilisation and cost

Use of shadow prices and financial incentives and constraints in NHS instead of administrative fiat

Relative price effect on both aggregate spending and by area

Expenditure forecasting - both aggregate, regional and by service and client groups

Scope for private and governmental health insurance schemes

F. Cost-benefit and Planning Methods

Cost-benfit and Cost-Effectiveness studies of specific services, especially those for the elderly and the mentally ill.

State of Health Indicators

Cost-benefit of industrial disease

Cost-benefit of community versus institutional care (esp. for psychiatric patients)

Valuation of patients' time

Development of 'need' targets and 'service performance' measures

Use of PPBS and output budgeting in health care

Design of management financial information systems and departmental accounting

Development of output measurement techniques

Rate of return on medical manpower training

Manpower planning

The contribution of health care to economic growth

The measurement of manpower input substitutability

The interpretation and use in planning of hospital waiting lists

The real production costs of absence from work due to sickness and the difference in costs between a scheduled and an unscheduled absence

Social costs of restricted physical activity

The social value of preventive care

G. Models of Health Care Systems

General equilibrium relationships between health subsectors and the rest of the economy

Computer simulation of interdependent systems - the health care sector, households and firms

EEC and health policy harmonisation

Mobility of health service labour in the EEC