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Health Care in Social Economics

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health care in social economics

A social economics approach to health, health care and health economics begins with recognition of the special place health holds in the configuration of human NEEDS. It develops an alternative method for valuing health care to that based on market values, and proceeds to a critical examination of market institutions surrounding the provision of health care in modern economies. Among the casualties of this form of analysis are the atomistic conception of human individuals, traditional supply and demand reasoning regarding health care, and Pareto-efficiency welfare recommendations.

Human needs and health

In their comprehensive and systematic analysis of human need, Doyal and Gough (1991: 54) treat physical health and personal autonomy as the two chief preconditions for human action and interaction in any CULTURE, and thus as the two most basic human needs. Physical health in a POPULATION can be defined as the minimization of death, disability and disease. It concerns the simple question of survival and capacity for ordinary human activity. However, autonomy, as the ability to deliberate and make informed choices, also has a health dimension, as is evident in its requirements as the minimization of mental disorder, cognitive deprivation and restricted opportunities (Doyal and Gough 1991: 172). Thus, broadly speaking, health is not only at the root of any understanding of human need, but it is also subtly intertwined with our view of the human individual. Individuals, whether in economic life or other domains, act most characteristically as we

understand human beings to do when they are healthy.

Disability-adjusted life years

Not surprisingly, then, health has been the focus of many studies of human need, including those generated by a variety of national and international organizations interested in promoting human development. For example, the World Bank's *World Development Report: Investing in Health* (1993), produced in conjunction with the World Health Organization, examines the impact of national and international public finance and public policy on the state of world health. This report describes the overall burden of disease and physical impairment on a country-by-country basis, in terms of lost disability-adjusted life years (DALYs). DALYs combine the number of healthy life years lost because of premature mortality with those indirectly lost as a result of disability. One advantage of such measures as the DALY is that they provide an understanding of the health states of individuals in quantity-quality terms. Another advantage is that such measures permit us to value the benefits of health care in need-based rather than market-based terms.

Quality-adjusted life years

DALYs are one type of quality-adjusted life year (QALY) measure used in cost-utility analysis (CUA) to capture the benefits of a quantity of life years gained, weighted by a measure of quality of life, resulting from health care. QALY measures may be constructed using any number of characterizations of quality of life, such as disability, discomfort, limited functioning and so on, that allow discrimination between socially perceived levels of well-being. For example, Kind, Rosser and Williams (1982) distinguished eight categories of disability and four categories of distress to create a thirty-two-cell grid of distinguishable health states. Here the disability factors examined include such things as whether one is unconscious, bedridden, in a wheelchair, unable to perform market work or housework, go

outdoors without assistance, and so on; and distress ratings were "none", "mild", "moderate" or "severe". To value these different health states, they then conducted surveys in which individuals were asked to rank these thirty-two health states numerically on a scale from 1 (perfect health) to 0 (death). The resulting median scores were used as social benchmark measures to judge the possible benefits of different types of health care according to the health states they might produce.

QALY values need to be generated through reliable survey methods, so as to reflect the broadest opinion about health needs across all groups and income classes in society. They can then offer a basis for determining how society ought to invest in alternative health care programs. For example, a given investment in early preventive care services is preferred to an equal investment in services for late-life surgical interventions that marginally improve life for a smaller number of individuals for only a few years. This is because preventative care is more likely to produce good health for many individuals for many years. The cost per QALY gained is lower for preventive care.

QALY measures compared with cost-benefit analysis

COST-BENEFIT ANALYSIS (CBA) evaluates benefits in money terms. CBA represents the benefits of alternative health investment plans in terms of the money value of days of work gained, rather than quality of life as avoidance of disability and improvements in basic human functioning. Using CBA, wealthy individuals with high incomes would be able to argue that there ought to be more investment in medical technologies that produce late-life marginal improvements for a small number of individuals, since the money benefits of their gained work days often outweigh the money benefits of work days gained by lower income individuals.

Thus, QALY measures, when designed to elicit judgments regarding basic needs, permit social valuation rather than market valuation of the benefits of health care, and such a social

economics of health care combines theorization about quality of life (see, for example, Nussbaum and Sen 1993) with empirical examination of the ways individuals actually value the QUALITY OF LIFE. Moreover, since social and market valuations of the benefits of health care generally support different distributions of health care for modern economies, a social economics of health care also examines how MARKETS distort the distribution and provision of health care.

Income distribution and need fulfillment

A DISTRIBUTION OF INCOME contrary to universal need fulfillment affects high and low income individuals differently. The former pursue luxury consumption, but are able to postpone their transactions, while the latter are constrained to transact for necessities in as short a time as possible. This implies that prices for luxuries are lower and prices of necessities are higher than would be the case were income distributed to fulfill needs. At the same time, differences in income lead the market to overproduce luxuries and underproduce necessities.

Neoclassical supply and demand market analysis rejects these conclusions, because it ignores the distinction between wants and needs, and thus ignores the way in which income distribution in modern economies undermines need fulfillment. This in turn leads it to treat individuals atomistically, as if they were free of social ties that support need fulfillment, and as if differences in income were unrelated to the ability to satisfy needs. The traditional supply and demand view of markets is consequently one of free exchange between equally advantaged, single individuals. However, actual markets for health care services hardly function according to this model.

Health care providers have significantly better understanding of health care technologies than their patients. Individuals seeking health care often feel so much anxiety about their care that they wish to defer decision making to their care providers; and paying for

health care often involves social and private insurance systems that separate the purchaser and consumer of health care in time and in person.

Health care institutions

A social economics approach to health and health care seeks to understand the characteristics of health care provision in terms of real world individuals who occupy different sorts of social institutional frameworks arranged to deliver and distribute health care. Though markets often play a role, they must be seen to operate within a larger context that reflects past institutional history and social values. A social economics approach may compare alternative investment strategies according to a needs-based evaluation of prospective benefits. The value of particular health care services, as determined in exchange relationships, should be seen to reflect a process of social valuation that places exchange in a history of constructing social institutions to address health needs. This broader context includes such values as fairness, HUMAN DIGNITY and responsibility as elements in a full account of welfare. Needless to say, this approach goes beyond the narrower view of welfare inherent in the Pareto view of social welfare.

See also:

health inequality; health and safety in the workplace; social economics: major contemporary themes

Selected references

- Doyal, L. and Gough, I.A. (1991) *A Theory of Human Need*, New York: Guilford.
- Kind, P., Rosser, R. and Williams, A. (1982) "Valuation of Quality of Life: Some Psychometric Evidence," in M. Jones-Lee (ed.), *The Value and Safety of Life*, Amsterdam: North Holland.
- Nussbaum, M. and Sen, A. (1993) *The Quality of Life*, Oxford: Clarendon Press.
- World Bank (1993) *World Development Report*:

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Investing in Health, New York: Oxford
University Press.

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