101 Apt Aphorisms for Health Economists

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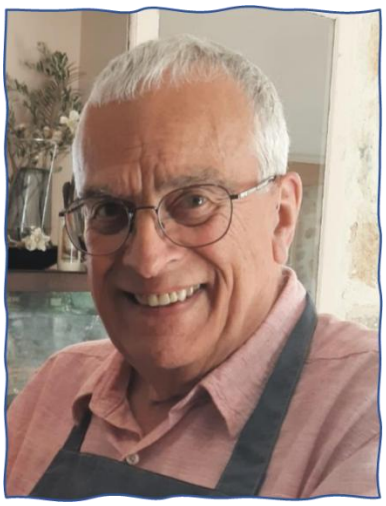

Aphorisms, or apophthegms, or just plain '*words to the wise'*, are pithy assertions, *dicta*, preferably memorable, that should provoke thought and that may amuse. They encapsulate a single thought. They sometimes employ linguistic schemes like assonance, paradox, alliteration, rhyme and spoonerism, and usually exploit the rhythmic possibilities of a language. Many intend to surprise. Some are designed even to shock. Most have a serious message to impart. Others may offer a whimsical angle on a serious topic or be explicitly educational. Yet others are light-hearted fragments of ideas. All are uttered with the relentlessly confident air of an unwarranted authority. A collection of aphorisms should be sampled like an *amuse bouche*; it doesn't include the main course.

Aphorisms do not abound in the work of health economists, with notable exceptions like Robert G Evans ("The tunnel at the end of the light", "The deception that rules the proof"), Alan Williams ("Health economics – the cheerful face of the dismal science", "Cost-effectiveness analysis is an aid to thought not a substitute for it"), or Jack Wiseman ("What is the question? *That* is the answer!"), so what follows is intended to make good this deficiency. I have included some that apply elsewhere at least as well as they do to health economics and health economists. While some are aimed at my colleagues and students of economics, many are also for those whom we seek to advise.

To explain any aphorism resembles explaining jokes to the uncomprehending, which always spoils the joke. I therefore refrain from any elaboration. To say it again, the idea is to provoke thought. Aphorisms may also provoke speculation about the reasoning that led the author to compose them in the first place. They may provoke mild or even major disagreement. They may provide useful mnemonics for students. They may, if I'm lucky, invoke "Spot on!" or "Hear, hear!" Or they may simply puzzle one (work on it!). Best of all, they may provoke a smile. All such reactions are grist to my mill.

So far as I dare admit, these are all original, though subconscious borrowings can never be fully ruled out.

Words to the Wise

Health economics is not a special kind of economics, it's merely a special application of it.

ooOoo

Good health economics needs vision more than description, imagination more than enumeration.

ooOoo

Inter-disciplinary research on health topics is much too important to be left to those who have failed in the mainstream. So is multi-disciplinary research.

ooOoo

Learning health economics without learning economics is like learning to ride without the bike.

ooOoo

Health economics embraces two hard-to-reconcile cultures: one as a sub-speciality in economics, the other as a supplement to pharmacy or epidemiology. They have *some* things in common.

ooOoo

Mike Cooper[1] and I were troglodytes. In those days (1960s) we worked in an intellectual cave.

ooOoo

In the early days of health economics, one had only to sneeze and they would publish it.

ooOoo

The early debate between "marketeers" and the "anti-marketeers" was initially centred around the question of whether health care was so very different from other goods and services that government provision and finance were necessary. The anti-marketeers said yes, emphasizing special characteristics; the marketeers attempted to show how markets could cope efficiently with each special feature in turn. However, neither side had satisfactory descriptions of the objectives of a health system. The former lacked one because in the never-never land of the perfect market, with which socialized systems of health care were usually compared, no such specification was needed: the outcomes would be whatever individuals wanted and were prepared to pay for. The anti-marketeers lacked such a description because they talked of world in which men and women of good will set about meeting the reasonable needs of their clients, avoiding such troublesome questions as the meaning of "needs," what was "reasonable," who the "clients" should be, and how such "needs" might best be met. Here, then, was an agenda for health economics.

ooOoo

The distinctive essential syllabus of Health Economics: health in the social welfare function; health as capital; the demand for health; the demand for health care; agency; supplier-induced demand; uncertainty, health insurance and the demand for care; moral hazard, adverse selection and cream skimming; professions and non-profit institutions; provider incentives and behaviour; production and pricing of pharmaceuticals; the health production function; measuring health and health gain; externality; publicness; efficiency; economic evaluation of health care technologies; determinants of population health; the health gradient; equity in health and health care. All else is either general economics, epidemiology or local description.

ooOoo

Private finance and private provision, or private finance and public provision, or public finance and private provision, or public finance and public provision. An embarrassment of riches!

ooOoo

Some things – health's one – are good things both inherently and instrumentally.

ooOoo

There can be no right to health but there can be a right to health care.

ooOoo

You run the country's public expenditure and you have £10m. Which is better: £10m extra spent on defence, or £10m extra spent on defence, or £10m extra spent on health care, or £10m extra spent on social care, or £10m extra spent on secondary education, or £10m extra spent on affordable housing, or £10m extra spent on law and order, or … £1m spent on each of ten such activities? (The correct answer is none of these.)

ooOoo

[1] Michael Hymie Cooper (1938-2017), a pioneering English health economist of the 1960s. First at Exeter University, later at Otago University in New Zealand.

The World Health Organisation, bless it, thinks that 'health' is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity. An immensely immodest claim.

ooOoo

We need a pragmatic measure of health. It should be a qualitative or even quantitative indicator of someone's physical and emotional capability. It's quintessentially multi-dimensional and should always be checked for acceptability in any given context.

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The idea that health *is* utility means you can't say, as I would prefer, that health, along with much else, can be measured *like* utility.

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Utility's neither welfare nor health.

ooOoo

Measured utility gives an order of what: willingness to pay, preference, taste, desirability, goodness, choice, satisfaction, contentment, welfare?

ooOoo

Maximising human satisfaction has less ethical appeal than maximising human flourishing.

ooOoo

Utility-maximising theory's not a very good basis for predicting behaviour but a tolerably good one for prescribing it.

ooOoo

It's what's *in* your utility function, not merely that you have one, that defines you as selfish or unselfish.

ooOoo

Health and wealth are both capital.

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The value of health rises when interest rates fall.

ooOoo

The NHS Constitution: "We maximise our resources for the benefit of the whole community". A slogan, bless them, wholly empty of implications for the size or allocation of the NHS budget!

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Platitudes protect the powerful from probing.

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What are hospitals supposed to maximise?

ooOoo

What do hospital managers maximise?

ooOoo

What do hospital doctors maximise?

ooOoo

All health insurance systems must find a solution to the problem that health is, in aggregate, positively related to income, and premiums are related positively to expected demand, so those facing the highest premiums are those least able to afford them.

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The market's a phenomenon to be understood, not idolised.

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The NHS solves reasonably well the problem of how most fairly to pay for health care, but it still – and despite NICE – fails to address seriously the problem of what to include in the benefits package.

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Public ownership is not an end; it's a means, to be tested for its cost-effectiveness.

ooOoo

A public good is one whose benefits, if there are any, are necessarily shared, like public health measures and the King.

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Health is part private and part public. The public part includes the pleasure from the relief of another's suffering, reduced communicable disease, protection from fraud and ignorance, and legislated safety for all.

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Ill-health can generate so many negative public externalities, physical and psychic, that health care can be treated as a quasi-public good.

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Public health's a great protector of private health.

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Prevention is better than cure *only* when it is relatively cost-effective.

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The theory of public goods, properly understood, complements the theory of markets.

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Some partly private goods are often better produced publicly, like trains and health care.

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Public goods are not of their very nature to be publicly produced and paid for, but it usually saves a lot of bother if they are.

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Public ownership of the institutions of health care is not an end; it's a means, to be tested for its cost-effectiveness.

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The critical difference between public and private ownership, in health care as elsewhere, is the freedom to buy or sell one's part of it.

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The most effective treatment is not automatically to be included in the publicly financed healthcare package; it must not be at the cost of alternatives that would deliver more health or more fairly distributed health for the same money.

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A major disadvantage of charging for health care is that until there has been a diagnosis, what the patient needs is not known. A charge is a deterrent to finding out.

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The NHS should provide cost-effective health care, and *only* cost-effective health care.

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New interventions that reduce health inequalities are welcome – but only if they are cost-effective (a) at reducing the inequalities and (b) at increasing people's health.

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Cost-effective medicine is needed by patients as well as by sellers.

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Cost-ineffective medicine is needed only by sellers.

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All medicine offered by the NHS must be effective - but so is much medicine it rightly does not offer.

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Too high a Cost-Effectiveness Threshold means the NHS will be both inefficient and underfunded.

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The Secretary of State needs always to ask, “is it effective enough to be afforded?”

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Not all effective medicine can be, or should be, afforded by the NHS.

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Cost-effectiveness is only a necessary condition for the NHS to offer a service.

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The question for NICE: if the NHS spends on something new, what is displaced?

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It’s easy to recommend some new way of spending NHS money if the losers are anonymous and invisible. Easy but not right.

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Many cancer drugs, new and old, convey miserly benefits at the cost of using health care resources that would transform others’, including children’s, lives.

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NICE was nice.

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Health economists, like other experts, are in general no more expert than anyone else at making, as distinct from identifying, value judgements.

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All health economists interested in technology evaluation should understand the difference between *sensitivity* and *specificity* in epidemiology.

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All epidemiologists interested in technology evaluation should understand the difference between *average* and *marginal cost* in economics.

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It’s scarcely surprising that cost-effectiveness analysis in health policy, conceived loosely and conducted carelessly, is not cost-effective.

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The framework of cost-effectiveness analysis is like a battery-operated light, it brings illumination only with insertions - of context and value judgments.

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The right answer in health care, as elsewhere, always depends on the context – as well as the arithmetic.

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Economic efficiency is not intrinsically good. Whether it *is* good depends on what you’re being efficient *at*.

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A cost-effective extermination camp is an abomination.

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Cost is not merely a forgone alternative; it is the *most valued* of all *feasible* alternatives.

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What’s feasible for a decision-maker depends on context: their position in a hierarchy, the rules that bind them, the information available to them, the discretion allowed them, and relevant law and custom.

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Good policy guidance in health care requires the combining of heterogeneous evidence, of greater and lesser relevance, qualitative and quantitative, reliable and unreliable, with known and unknown biases, oral and written; together with thoughtful stakeholder meetings, good briefing, good chairing, and opportunities for discussion and debate. That's all!

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Judge a policy by whether it's likely to work, not by its advocates' hopes.

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'Impact' doesn't always mean 'making a difference'; 'no change!' is sometimes the best kind of impact.

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Consequentialists don't say that consequences are the *only* things that matter.

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A good debate's informed by evidence (but rarely complete), by expert witnesses (but rarely free of bias) and should involve all important stakeholders (especially otherwise disempowered voices).

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Deliberation is participative meditation.

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Changing the decision *context* changes consequences and thereby changes both opportunity costs and benefits.

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Clear thinking and clear procedures are dangerous. They may expose vengeful incompetence.

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Never imagine that your algorithm embraces all possible cases. It doesn't, so make contingency plans.

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Scientific evidence in health care, as elsewhere, relates to the testing of hypotheses, uses recognised and replicable means of doing so and is analysed and interpreted using further recognised and replicable methods. Evidence lacking these features is worth little, even when it's the *only* evidence available.

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Costs are not facts, available like jetsam to any diligent beachcomber.

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The faster the planned change the greater the cost.

ooOoo

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ooOoo

The long run can be made the short run – if you throw enough resources at it.

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Don't take the 'long run' or 'fixed factors' literally. They're just convenient conceits recognising the truth that some factors of production take more time and resources to change than others.

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In 1892, the 213 miles of the Great Western Railway's old broad-gauge track between Exeter and Penzance was changed to the standard narrow gauge in one weekend. 177 miles of it also had

to be altered from the old longitudinal timbers to the familiar cross-sleepers. It took 4,200 platelayers to do it. So much for a 'fixed factor'!

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Cost in health economics is primarily (but not only) someone's health forgone.

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There's much mileage in the idea that the cost of squeezing the last bit of benefit from anything (like abolishing malaria) approaches infinity.

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Greed. Bias. Self-interest. Every bit of health care expenditure, public or private, total or incremental, is income for someone or other. $E=I$, $\Delta E=\Delta I$. Remember your national accounting identities most especially when you hear impassioned advocacy for increased spending.

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When you hear 'equality' always ask "of what?"

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Equality is not always equitable, and what's equitable is not always equal.

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Vertical fairness usually requires inequality.

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To be born with a harelip's a misfortune but not an unfairness. To have access to surgical closure of harelip only if you are white and middle class is unfair.

ooOoo

Scientists, especially environmentalists, economists and physicians, invariably exceed their authority on topics where they have none. So do non-scientists, like ethicists. Preachers all!

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Why do failed philosophers become ethicists?

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If you really want to 'follow the science' first understand it sufficiently well to interrogate the scientists.

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Never be guided by scientists; learn instead how to interrogate them.

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Alarm: academic authors are absolutely awful at authoring abstracts.

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The trouble with written English is that they can't see the English twinkle in your English eye.

ooOoo

You'll mean what you say only if you're able to say what you mean.

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A good idea badly expressed is a bad idea.

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You may not have much to say but at least strive to say it well.

ooOoo

I owe my life, but not my living, to the pharmaceutical industry.

ooOoo

Show respect for aged economists: they've likely forgotten more economics than you've ever learned!