

The conservative world of health economics

When a person is in one place she cannot be in another. When she is doing one thing she cannot be doing anything else.

These statements are so obvious that most people see no point in making them. For health economists, however, they are inspirational.

The idea is:

- People’s resources for being and doing are limited (you can’t be everywhere and you can’t do everything);
- Choices have to be made about where to be and what to do;
- Choices involve sacrifice;
- A thing is not of value unless something else has been given up to get it.

Harmless truisms? Academic trivia? Not to Valerie.

Valerie left school as soon as she could, became pregnant as soon as she could, got her flat as soon as she could—and is growing old much sooner than she should. She is single, has two toddlers and no job. She carries on for the kids, and her daily six-pack of high-alcohol lager.

Not a good life, most people would say. Valerie had wanted to see the world. She’d be an air hostess, she said. But her friends just laughed, slapped her down to earth, and led by example.

Most people would hope for something better for Valerie, but health economists turn away. They can hardly do anything else. They say Valerie must value *this* situation more than any other because she has spurned the alternatives. The facts, they say, speak for themselves—there is no room for sentiment in science.

But health economics is not value-free. Of all the possible ways to conceive of the value of life, economists think it worth nothing more than opportunities forsaken: a miserable outlook which can define something as good only by labelling other things as worse.

Health economics implies that whatever a person is doing must be valuable so long as she could be doing something else. So health economists are blind to the fact that *any* realistic choice open to a person in poverty could be defined as undesirable were the social world a better place. Spelt out, their thinking is not only daft —Valerie values her life better than a life of travel and fulfilment because she prefers to get drunk every night—it is downright reactionary.

Health economics’ conservatism affects us all. ‘Cost-effectiveness’, ‘rationing’, ‘QALYs’, and ‘value for money’ are economic terms, and each has the effect of justifying a shrinking health system. If patients will accept day-care rather than in-patient care; if patients will accept ‘care in the community’, rather than structured rehabilitation programmes; if people will accept trolleys rather than beds, then they must value these things.

Health economics takes a deeply neurotic view of the world, one in which innovation becomes almost impossible to countenance because there are so many potential losses to weigh against it. What if the government were to refuse to purchase any new pharmaceuticals for five years? A health economist could barely imagine such a thing because his first thought is bound to be: how could we possibly justify sacrificing these promising therapies? Of course, if the economist could think of better alternatives then he might say the sacrifice is worth it, but this would be to forget the psychology of economics. The economist's first thought is 'what will we miss?', and since what we already have is valuable by definition the economist tends to require very good reasons to give it up.

That health economics is seriously regarded as a means to progress in health care shows how easily we will accept simplistic 'approaches' to deeply complex human problems. We are landed with health economics (health markets, health management, health gain and the rest), and so stuck with the status quo, because we have lost the spirit of adventure. Pioneers setting out to explore new countries were fired by imagination, inspired by the possibility of something better. They didn't think of 'opportunity cost'. If they had, I suspect they would never have set sail.