Why don’t we live as long and healthily as we could: social values and decision making

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Welcome to this Public Health Expert Blog. This blog is going to consider what we could do, and what we probably should not do, to improve public health. We will traverse the range from birth to end of life care and death, efficiency versus equity, learning from our history to future gazing, opportunity costs, climate change and aging populations, genetics to social determinants, and much more. Myself and academic colleagues will blog about issues of the day, and issues that should be issues of the day. We undertake to make this blog informative, relevant, and as evidence-based as possible.

If I was Minister of Health (and everything else), I guarantee you that I could make life expectancy in New Zealand the best in the world within ten years. Simple. Tax the killers – raise taxes further on tobacco and alcohol and introduce new ones on sugar, salt and saturated fat. Then make it super easy for people to cycle and walk to work by good urban design and high congestion charges on vehicles in cities (and yes higher fuel taxes too). Perhaps even provide free mass treatment to middle age people with a sprinkling of aspirin and lipid lowering drugs – all in just one tablet a day. So why don’t we do this?

Many reasons, not least of which I am never going to be the Minister of Health with absolute power. And more substantively, we live in a society with social values that are not just about maximization of longevity and health at all cost.

The issue of this blog is social values, and in particular the criteria that we should use in making funding decisions in health. PHARMAC is currently consulting on the criteria it uses for deciding which drugs we as taxpayers subsidise. PHARMAC is probably the world’s most successful example of a Government agency ensuring maximum bang for buck (i.e. efficiency) within a given funding envelope. So successful that from 2015 it will take on

medical devices (e.g. hip prostheses and heart valves) as well. Like any other prioritisation agency within health (e.g. the National Health Committee in New Zealand, or the National Institute of Health and Care Excellence (NICE) in the UK), it has criteria that it looks to when deciding what to fund and what not to fund – and just occasionally what to stop funding. PHARMAC has nine criteria, including the health needs of all New Zealanders and Māori and Pacific in particular, effectiveness and safety of the drug (device), cost-effectiveness, financial impact for Government and public, Government priorities and "other criteria" as PHARMAC sees fit.

What is interesting about the current consultation, especially in light of the opening paragraph of this blog, is the nudge-nudge wink-wink directive in the consultation material for feedback on whether to more formally include severity of disease as a criterion. If someone is really sick, should we spend more money on them? Even if we do not get much health gain? Indeed, we know this happens all the time. We tend to spend lots on third and fourth line treatments in cancer, and high expenditure at end of life is common in all countries. Form a hard-nose technocratic public health point of view, there is a massive opportunity cost here – we could have spent the same resource on prevention or treatment of less severe disease and actually saved more healthy years of life. But other social values kick in. Hard working health professionals want to try and rescue the severely sick. And most people would choose achieving a given health gain among a seriously ill person over the same total quantum of health gain spread among several mildly unwell people. We, as individuals and society, seem to have social values other than just efficiency maximisation, or perhaps we just don't think enough about the alternatives of prevention or good primary health care?

Professor Anthony Harris Monash University penned a discussion paper that accompanies PHARMAC's consultation. Much of his discussion is about incorporating an additional criterion for 'high needs' or people with severe disease. But here is an interesting twist from a public health perspective. Such a 'health need' perspective can be used at both an individual (equity) level, and at a population health (equity) level. Thus – and as articulated by Harris – 'health need' could easily be extended to include remaining expected years of life by social group, most notably Māori versus non-Māori, giving an additional weighting to people (and population groups) with less remaining life expectancy. Indeed, this is something we are working on in our new Burden of Disease Epidemiology, Equity and Cost Effectiveness programme. The idea merits scrutiny – we could develop a criterion that meets both an individual- and population-level concern for fairness, and assists to reducing the wider social health inequalities in NZ. Take a look at PHARMAC's consultation.

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