

Incorporating equity into decisions that affect health: Quantification and trade-offs matter

David Buck

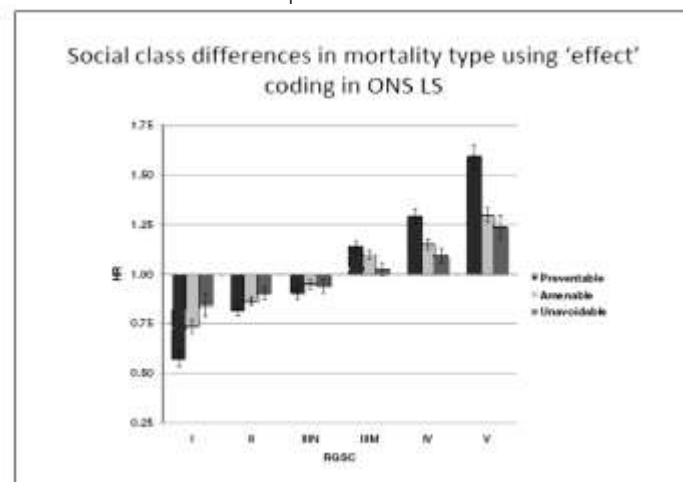
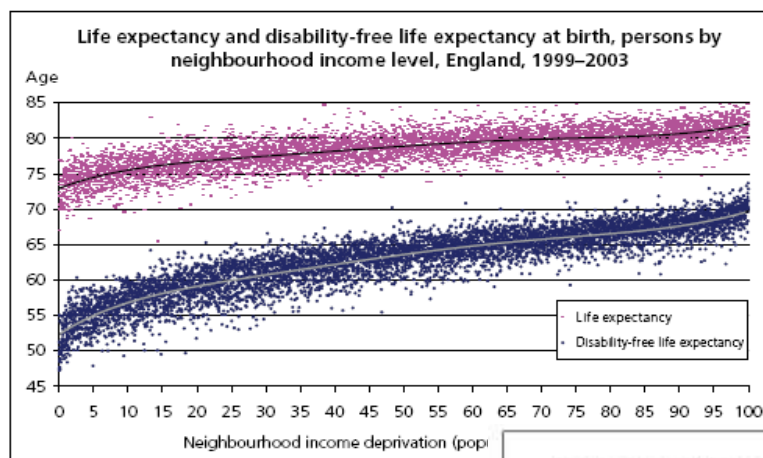
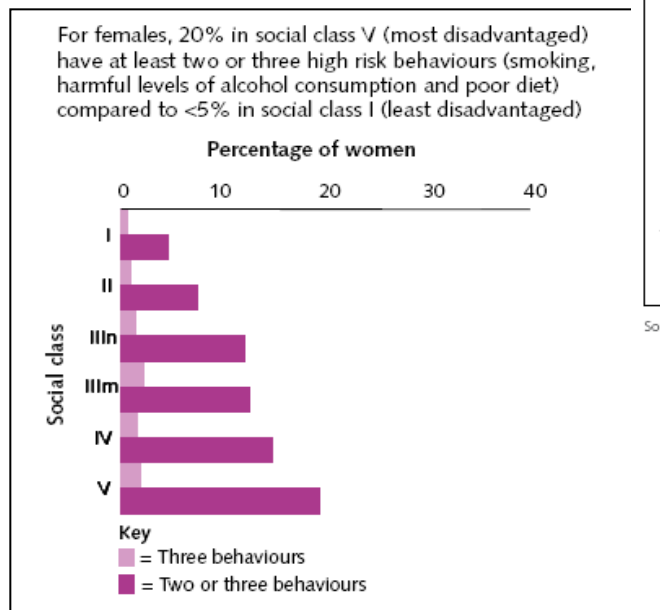
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EU Joint Action on equity meeting: London 14th -15th November

Why it's not enough to simply know more
and more about the causes (of the
causes) of inequalities in health

Escalating evidence of the impact of inequalities on care and health outcomes

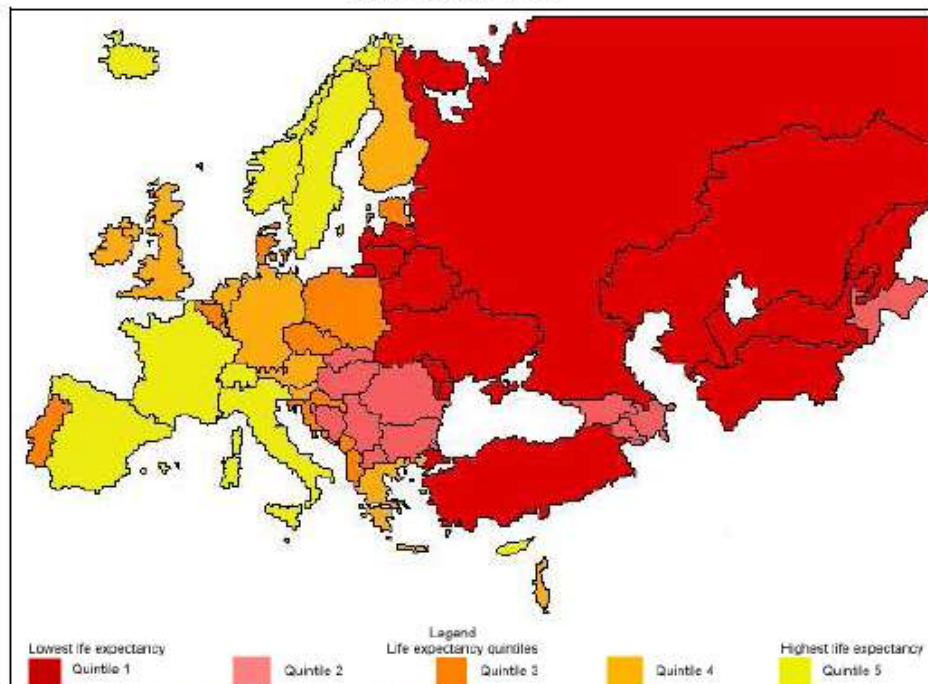
- Multiple poor lifestyles cluster by class, disability-free life expectancy and preventable mortality are sharply skewed by income and class.



... no-one is exempt

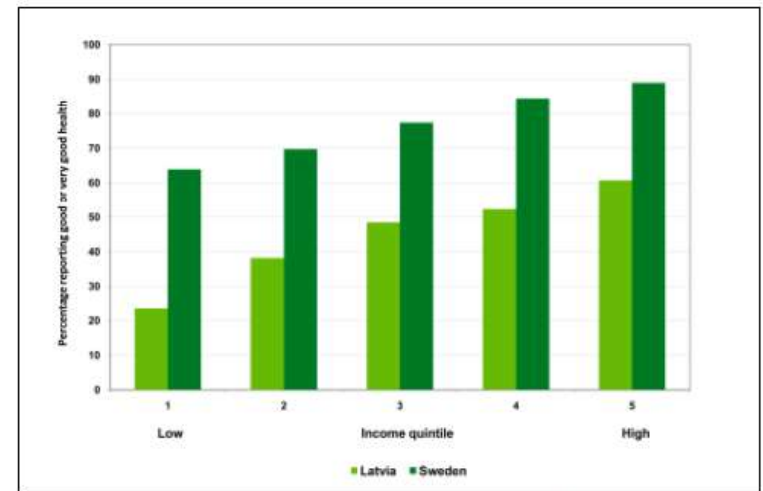
- › Even amongst “best performers” inequalities persist

Fig. 1. Life expectancy in years for countries in the WHO European Region, 2008 or latest available year



Source: European Health for All database [online database] (9).

Fig. 4. Percentage reporting their health as being good or very good by household income quintile in Latvia and Sweden, 2008



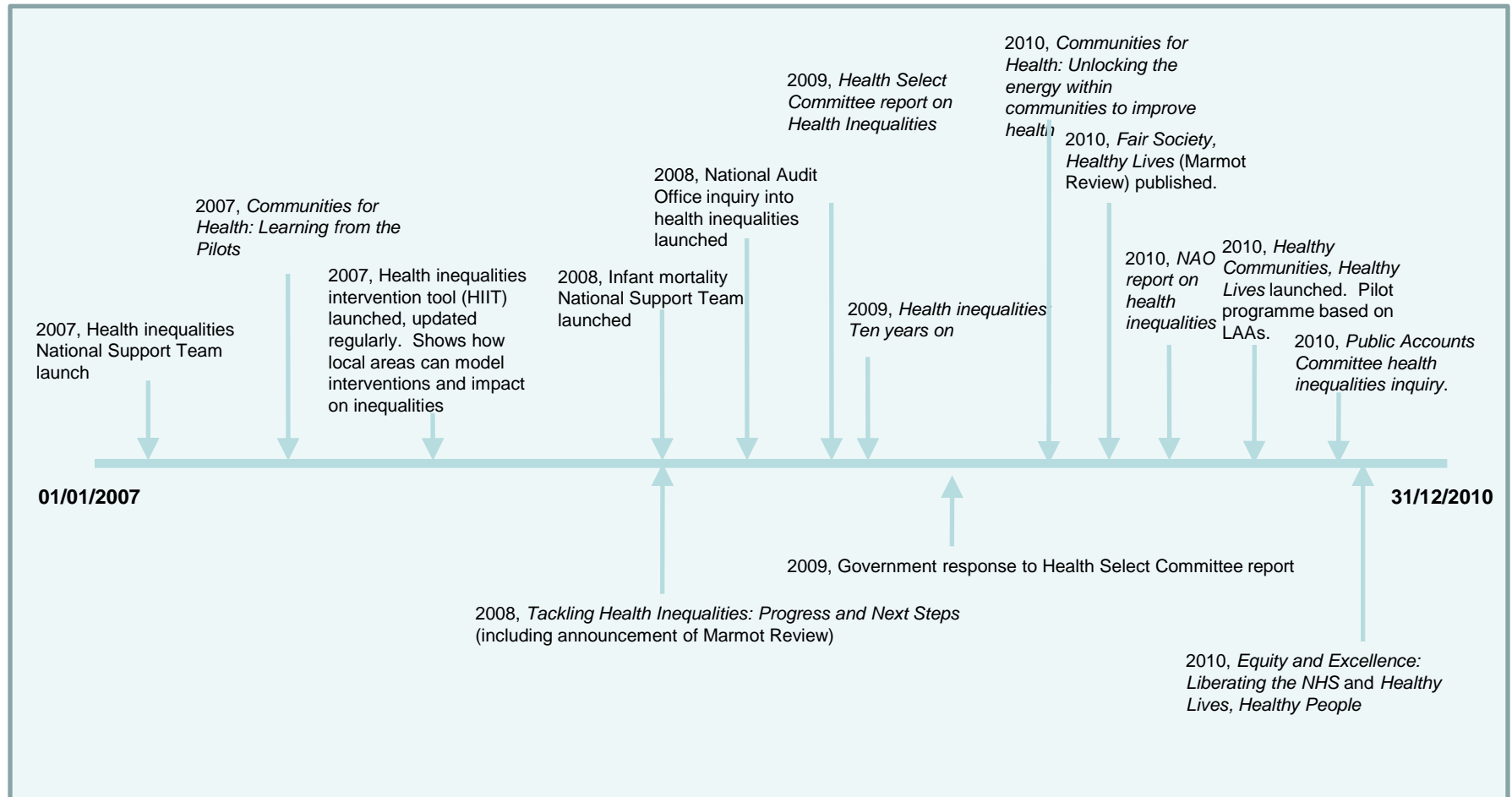
Source: personal communication, Jonathan Bradshaw and Emese Mayhew, University of York, United Kingdom, using 2007 data from: European Union Statistics on Income and Living Conditions (EU-SILC) [online database] (17).

We have powerful policy analysis too

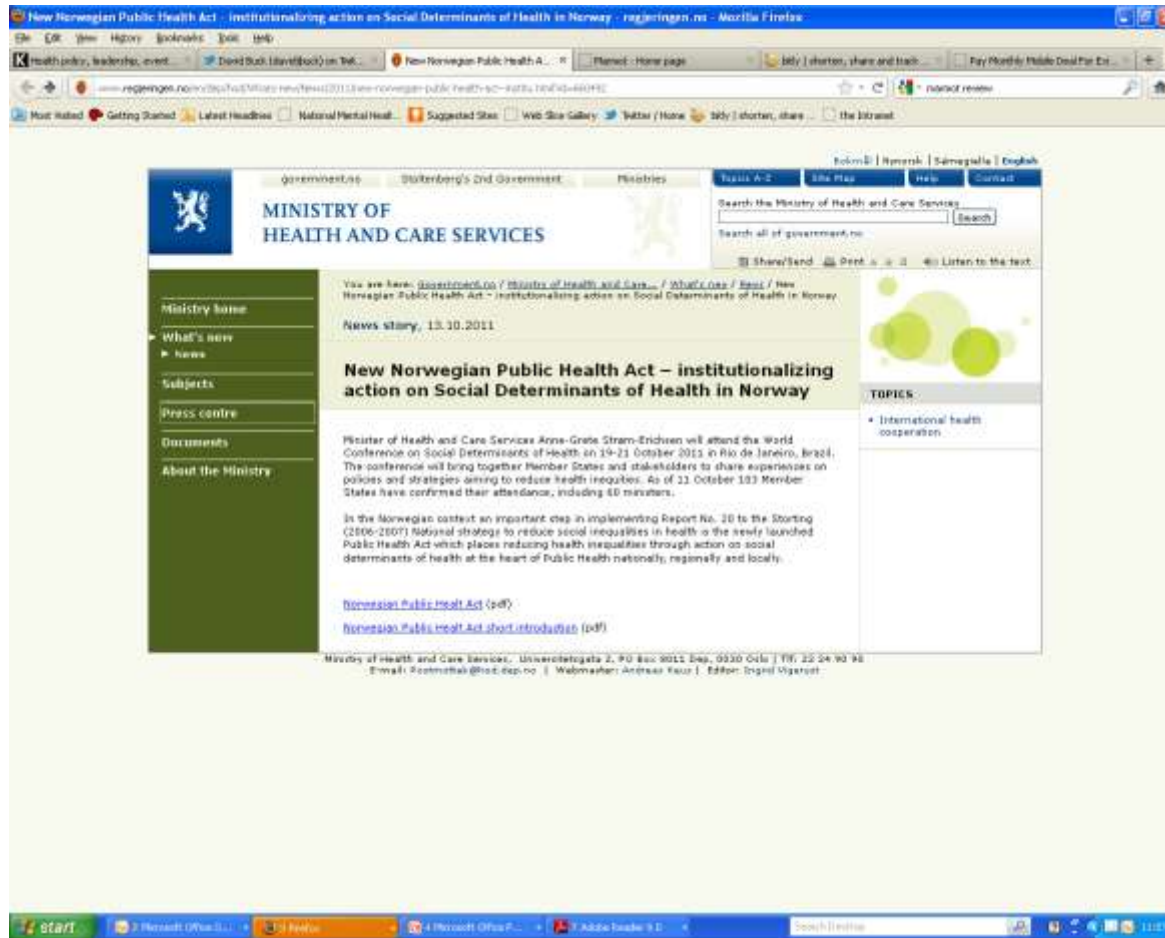


- **Inclusive and broader focus**
 - From life to health and quality of life support
 - From the bottom to the gradient of health
 - From some communities to all
 - Measurement framework
- **Policy recommendations**
 - More investment in early years of life
 - Reducing inequalities in education and skills
 - Improving numbers in quality employment
 - A minimum income for healthy living
 - Sustainable communities and building social capital
 - A higher proportion of cross-govt spend on prevention

... and various governments have been trying hard



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But...

- › We have little evidence on **what actually works in tackling inequalities in health**, be it a healthcare or other intervention
- › We know less – and sometimes don't want to ask – **what the costs of doing that are, versus the costs of not doing other valuable things** with the resources
- › We know very little on **how our populations actually value or weigh the benefits of inequality reduction** versus other uses of those resources



To address these questions we need some form of quantification, to be at least clear about the impacts of our decisions

Quantification its benefits... and risks

- › We will **be clearer about the benefits** and decision-makers at all levels will be able to demonstrate a good chance that this will actually change health
- › It will be **much harder to argue against policies that have a large impact** on demonstrably reducing inequalities
- › We become **part of the prioritisation process rather than being outside it**, seen to be special pleading

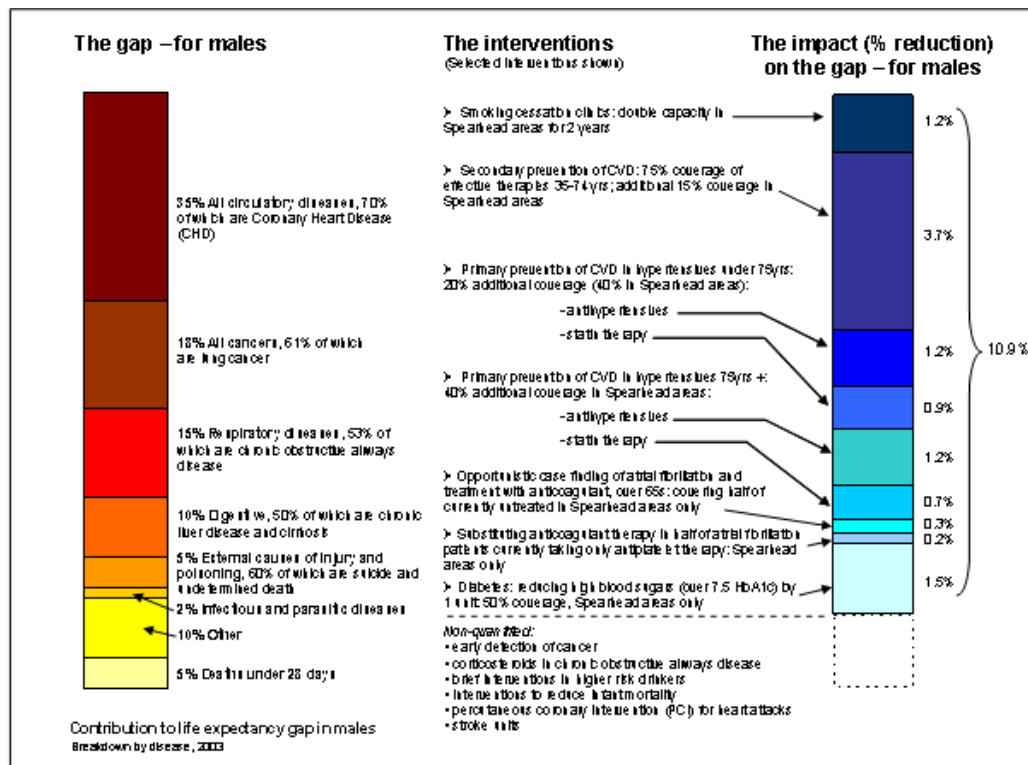
But...

This is challenging, sometimes things we think reduce inequalities won't and sometimes reducing inequality will be too expensive.

Some good examples of quantification

✔ NHS health inequalities intervention tool

- › The quickest way to cut inequalities in health is through pro-active secondary prevention in primary health care



☑ analysis of policy approaches: social welfare spending vs private sector growth



MIKE KEMPTON/PICTURES/CORBIS

Budget crises, health, and social welfare programmes

Governments may feel they are protecting health by safeguarding healthcare budgets, yet **David Stuckler, Sanjay Basu,** and **Martin McKee** argue that social welfare spending is as important, if not more so, for population health

- › Across OECD countries, a given change in social welfare spending has **7x** the effect as the same change in economic growth on mortality.



- › Government's need to factor in changes to health when making social welfare changes

☑ Equity weights in cost-benefit analysis

Evidence from “The relative societal value of health gains to different beneficiaries”
Paul Dolan et al. 2008

The aim of this study was to generate a set of equity weights for QALYs from the preferences of the UK general population, which could be fed into a social welfare function (SWF).

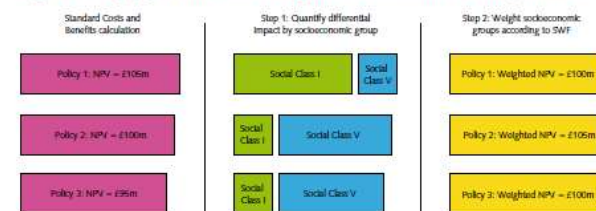
The SWF allows QALYs to be weighted differently for two reasons: first for the degree to which inequalities in health matter, i.e. we may be willing to sacrifice some overall health for more equal distribution of health, and second is the degree to which responsibility for health matters, i.e. we may be willing to give greater weight to illness that results from bad luck as opposed to bad choices.

Based on analysis of results from 688 respondents:

- There is a general aversion to inequality. The marginal benefit to a group with a life expectancy of 75 is worth about 30% more than the same benefit to a group with a life expectancy of 82.
- There is a general preference to take account of responsibility: if “bad luck” is given an weight of one, then “some bad choices” is given a weight of 0.92 whilst “NHS causes” is given a weight of 1.23.
- Labelling has some effect with obesity-related conditions receiving less weight than some bad choices: about 0.80 compared to 0.92.
- As life expectancy varies by social class, the inequality aversion weights could be applied to the different social classes to generate implied weights for inequality by social class. This generates the following weights relative to social class V:
- The extent to which lower social groups would receive more weight for a particular intervention depends also on whether lifestyle choices are a factor, although even in the most extreme examples, classes II to V will be favoured over social class I.



Figure 1: Apply Trade-off Weights to account for Inequalities



NPV = Net Present Value. Here a positive value is assumed to represent a benefit.

SWF = Social Welfare Function. This reflects the equity weightings given to adjust for aversion to inequalities.

Putting the jigsaw together

The role of government's, systems and incentives

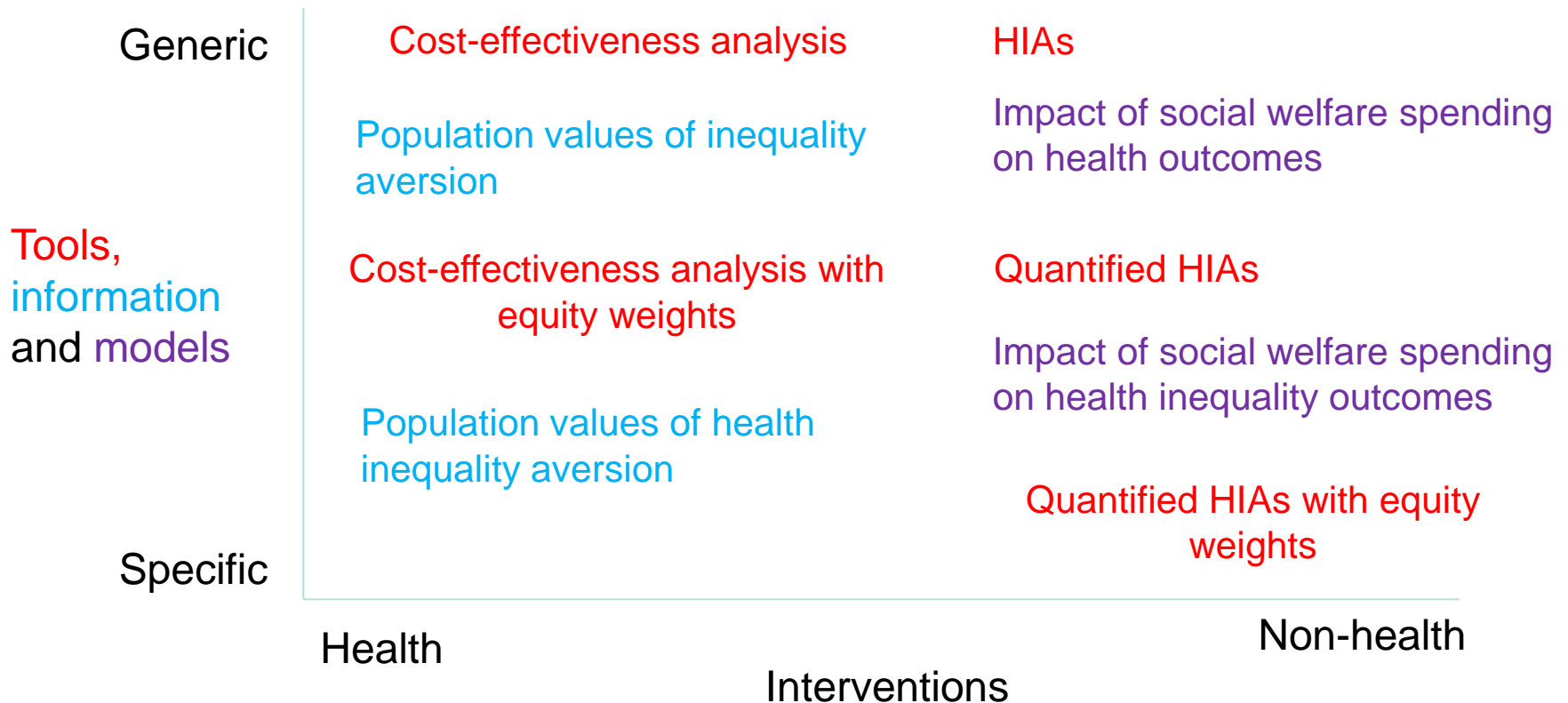
- › A raft of policy changes in England,
 - New duties in legislation on reducing inequalities
 - Outcomes frameworks for NHS and public health with inequality reduction at the heart
 - New methods including payment by results for reducing inequalities
 - A sub-Committee on public health with responsibility for govt policy on addressing health inequalities



Creating demand for “**how does that impact on health inequalities?**” in the health care sector, local authorities and in central government

Information, concepts, tools and models

- › Being clear about which pieces of the jigsaw we've got and who needs them



Integrating the jigsaw in the policy context

› Need to put this together...

Better information + people's values + clear concepts and definitions + good tools and models = quantified impacts

in...

a policy environment with the right incentives and accountabilities for outcomes

means...

better decisions for health equity are more likely to be made