Delivering Health: Clinical, Management Delivery, and Policy Challenges

Lecture 3: The Economics of Prevention
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Emerging Priorities
- Reframe health form “ill health as a burden” to “good health as an asset”
- An ounce of prevention is worth a pound of cure – Benjamin Franklin, 1736
- 40% of the burden on health services in England is preventable but only spend 4% of health budget on prevention
- This is comparable across high-income countries

Spending on prevention
- Funding pressures facing NHS – projected gap between funding and spending
- Widening gap accounted for by hospital admissions for chronic conditions across all age groups, not just caused by older people
- Many of these conditions would be largely preventable through action on those determinants
- While the NHS is now in its most austere decade in its history, it is widely recognized that we have to do more for public health

Comparisons
- NHS ranked first on all measures, but on the Healthy Lives ranking the UK is ranked at #10
- Hard to make a case to spend more money when there is none to spend
- The deficit of NHS providers is growing
- Health Foundation predicts post-Brexit, department of health budgets may be worse than expected
- Need to make the economic case for spending on anything

Top 10 Tips for Better health (1999)
- Don’t smoke, have a healthy diet, be active, manage stress, etc.

Alternative Top 10 from the University of Bristol
- Don’t be poor, don’t live in deprived area, don’t be disabled, etc.

How much do our health care services have control over these above factors? None

Need to make the case that health is everyone’s business and make the case for health
- Costs of mental health in the UK over a year – 21.3 billion on social and health care services, 30.3 billion lost economic productivity, 53.6 billion human cost and monetary valuation of reduced quality of life
- A huge issue when making the economic case is the time frames that we look at. We think in terms of annual budgets and parliamentary terms where MPs want to show
change within their term, but we need to look over a longer time frame to see the full benefits of health prevention
- Ex: Over time the cost to the NHS of smoking prevention reduces per smoker; in the long-term we actually see savings for the NHS and health gains

Barriers to investing in prevention
- Austerity and opportunity costs
- Costs and benefits falling in different areas
  - People may say that prevention is something for the NHS to invest in, but we have seen that business benefits will also accrue. However, when budgets are separate how do we get people to work together in the interest of improving health? Maybe through devolved administrations?
- Whose business is health?
  - Should be everyone’s responsibility across sectors. Speak to sectors in way that is important to them
- Short horizons and annual budgets
  - If policy makers are thinking in year-long time frames, the value for money doesn’t look as good over a long period
- Complexity of quantifying benefits – what’s important to who?
  - Subjective Quality of life, social benefits and community subjective measures and are so complex. Can these concepts be put in an economic measure?
- Social value and equity – preventive action is consistent with the value of equality, but sometimes we only look at the economic value when making cuts to costs. If cuts are necessary, have to ensure that we’re not taking away from the people who need it most
- Demand
  - Why isn’t there more talk about preventive action from MPs? The answer is that MPs don’t hear about it from their constituents. How do we make health prevention something that’s valued by the public? Generate the demand and value in the population
  - Part of it is the time horizons, hard to think about something that may or may not happen to you in 20 years time

Summary
- Strong case for prevention
- Making case the case for prevention is not straightforward
  - Need to think across budgets and sectors
  - Medium or long term
  - Issues value and demand need addressing

Dr. Anita Charlesworth, Head of Economics and Research, The Health Foundation

British Cohort Study – how adult life satisfaction is affected by child outcomes
- Emotional health is very important alongside intellectual performance in determining adult outcomes
• Physical and mental health in adults are very much affected by childhood outcomes and family
  o Child emotional health and mother’s mental health are correlated with physical and emotional health of a person at the age of 42

• Adult life satisfaction is predicted by adult outcomes
  o Physical and mental illness are incredibly important for adult life satisfaction
  o Though physical illness is important, emotional health and mental illness are very important. Yet when we talk about prevention, we don’t talk about health promotion in relation to health prevention while there is a strong case to show that life satisfaction is driven by emotional wellbeing
  o Look at the educational system, the focus has gone back to focusing on intellectual performance with little focus on emotional health. In the health sector, we haven’t done enough to hold the public sector to account for importance of mental health and wellbeing. This means not just treating mental illness when it occurs, but promoting good mental health throughout the lifecourse

• Adult life satisfaction and family background
  o There are indicators that show that reducing the father’s unemployment, more protection for family income, tax credits etc. all contribute to adult life satisfaction
  o BUT the mother’s mental health has a bigger impact on emotional wellbeing of child with the effect being the strongest at the youngest age

• What affects life satisfaction over age 50?
  o Loneliness doesn’t get enough attention in health promotion prevention. It is hard to live and adapt well if one is lonely
  o What does the NHS take seriously and invest in? They talk about sleep quality but it’s very important for functional capability.

• Rising State Pension Age
  o The state pension age is rising, particularly for women where the age has gone from 63-67
  o This is a problem because while life expectancy is rising, health expectancy is below retirement age
  o Employment rates for men and women 50+ are lower, particularly for women, as pension age increases

• Breakdown of aggregate total wealth
  o People at lowest end of the wealth scale have no assets to fall back on and have to wait until 67 to get state pensions
  o There is a compounding effect of being old and having a disability
  o Mental health issues are growing in importance, but the NHS is not addressing this; interaction of mental health and low education is high
  o Need timely access to mental health care

Conclusions
• Poor health outcomes are significant factors limiting process on key public policy goals
• Looking at life satisfaction and emotional wellbeing, would public health priorities change?
  o Is there a case for much more focus on the promotion of positive mental health for children, young people and parents?
  o Tackling isolation in older age?
  o Low skills, poor mental health and worklessness in middle-age?

Discussion

Thoughts on still not having minimum unit alcohol pricing when evidence shows that doing so has benefits at lower end of the gradient. Barriers?
• It comes down to the power of the retailers and distributors. Question for us in health promotion/prevention – where can we find an alignment of goals? An example is where we have been successful in addressing teenage pregnancy. The goals of reducing teen pregnancy fit with the education, health, and poverty sectors

What do you do about conflicting economic issues?
• Different priorities are important at different times. Need to be ready to align priorities when the opportunity arises for when it’s your moment.

Scarring effect of unemployment
• If unemployed before age of 25, your earnings trajectory never reach the same earning level as someone who wasn’t unemployed. Public policy should invest heavily in reducing unemployment below 25
• Would probably find similar patterns/findings for mental health. Want to target mental health in young adulthood because it effects trajectory so much in later life

The case for prevention is undeniable, there must be vested interest that stops the spending on prevention. What is stopping progress?
• Don’t have extra money to fund new prevention interventions and can’t just stop the treatment that is ongoing. Have to encourage the government to invest in long-term prevention

Health care costs of people living longer
• “The cheapest patient is a dead patient.” Health economists are not after the cheapest possible option. For a sustainable system, health is an asset. Dead people don’t work or contribute economically or socially so one of the problems with the discourse in the NHS is the view that spending on health is a burden that needs to be reduced. If you think of another example, we’re spending more on leisure now, but that doesn’t mean that it’s a burden. The issue with health is that it’s not valued