



Health system goals: A discrete choice experiment to obtain societal valuations ^{☆☆}

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ABSTRACT

Objective: To improve previous approaches to health system goals valuation.

Methods: We reviewed literature on health system performance and previous comparative performance assessments, and combined this with literature on process utility to create a theoretical foundation for health system goals. We used a discrete choice experiment to elicit goal weights. To obtain social justice weights respondents were placed behind a 'veil of ignorance'. To ensure that respondents understood their task, we instructed them in a classroom setting.

Results: We identified five health system goals. All five goals significantly affected choice behavior. An equitable distribution of health obtained the highest weight (0.34), followed by average level of health (0.29) and financial fairness (0.24). Both process outcomes (utility derived from the process and its distribution) received much lower weights (0.07 and 0.06, respectively).

Conclusions: Our framework adds to that of the World Health Organization. We demonstrated the feasibility of measuring societal valuation of health system goals with a multi-attribute technique based on trade-offs. Our weights placed much greater emphasis on health and health inequality than on process outcomes. Our study improves the methodology of international health system performance comparison and thereby enhances global evidence-based health policy information.

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1. Introduction

Health systems around the world have contributed to better health and life expectancy with varying degrees of success. Even in countries with seemingly similar resources outcomes vary markedly [1]. To date, policy effects on

the performance of health systems remain largely unclear. Monitoring and evaluating performance can generate this vital policy information. Moreover, cross-country comparisons enable countries to learning from others.

The challenge, however, is how to assess health systems that are extremely complex and have multi-dimensional goals. This complex task has been explored by the World Health Organization (WHO) and the Organisation for Economic Co-operation and Development (OECD).

Our aim is to improve the valuation of health system goals. To do so, we first unify literature on health system goals, equity, and process utility to create the underpinnings of a theoretical framework for health system evaluation. Second, we review previous approaches to deriving relative weights for health system goals. Third, we suggest an enhanced methodology based on a multi-attribute choice technique to elicit goal valuations using a

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'veil of ignorance' perspective. Last, we present goal valuations for the Netherlands based on our proposed method.

2. Theoretical framework for health system goals

Until the 1990s health economics was dominated by the assumption that 'health' was the dominant outcome of health systems. This links with the consequentialism moral theory, which focuses solely on outcomes irrespective of the process that led to them, and Jeremy Bentham's 'act utilitarianism', which states that the greatest amount of happiness for the greatest number of people determines choice behavior. Although utility derived from health is an obvious outcome of a health system, research showed that people also care about the processes that precede health outcomes, irrespective whether they affect health [2–4]. Therefore, processes are not just means to an end, not just instrumental to an intrinsic goal, but are an intrinsic goal of the health system.

This utility derived from processes, procedural utility, has a base in social sciences. Parsons' social action theory (1937) already described the necessity of the subjective dimension of human action [5]. Psychologists have developed a comprehensive notion of basic psychological needs for the human self, evident in the "self-determination theory of intrinsic motivation" by Deci and Ryan [6,7]. The theory maintains that human motivation originates from three innate needs: autonomy, competence, and relatedness; individual well-being therefore depends on procedures that address them [6,7].

The theory of procedural utility can be directly applied to health care. Consequently, both health outcomes and the process attributes of non-health outcomes are health system goals. Furthermore, it is widely recognized that health systems' costs should be related to capacity to pay rather than the risk of illness [8]. Therefore, health systems have three independent outcome-oriented objectives: health utility, process utility, and financial fairness.

2.1. Health utility

Health systems aim to improve health and strive for the highest possible health status of the entire population, taking both morbidity and mortality into account. Behind a 'veil of ignorance' the distribution of health also matters; empirical evidence indicates that the public is willing to trade efficiency for social objectives such as equity [9–11]. Therefore, health utility consists of two goals: average level of health and the equitable distribution of health.

2.2. Process utility

Procedural utility can arise from two sources [12]. First, interaction between people can generate utility since people evaluate actions by how they are treated by others. Second, people have preferences for good institutions in addition to health outcomes (e.g. preferences on allocative and redistributive decisions) that address the innate needs of human motivation (autonomy, competence, and relatedness). Institutions also establish the fundamental rules for

societal decision making. As a result, process attributes of health systems are twofold: utility derived from interaction between people and the health system ("how people are treated by the health system"), and utility obtained from living under institutions ("how allocative and redistributive decisions are taken"). Although distributional fairness of process utility is not well founded in moral theory, we followed the WHO framework and therefore included both process utility and its distribution in our framework.

2.3. Financial fairness

Murray et al. [13] claim that a health system is fairly financed "if the ratio of total health system contribution of each household through all payment mechanisms to that household's capacity to pay is identical for all households, independent of the household's health status or use of health system." This signifies two key challenges. First, households should not pay an excessive share of their income for health care or become impoverished [14]. Second, wealthy households should contribute more than poor households reflecting vertical equity and an element of progressivity.

3. Existing international frameworks

Several countries, such as the USA, United Kingdom, the Netherlands, Australia, and Canada, have designed and implemented national schemes and indicators to measure health system performance [15]. Cross-country comparison, however, requires a comprehensive international framework such as those of the OECD and WHO.

OECD framework. The three main goals of the OECD framework are (i) health improvement and outcomes, (ii) responsiveness and access, and (iii) financial contribution and health expenditure [16]. Without suggesting any relative importance of the system goals it provides a framework to measure performance in several dimensions that seem to be based on the historical development of health systems. A composite score requires, however, each goal to be independent. The OECD framework consists of input and output variables, and intermediate as well as end goals. Consequently, using the OECD framework gives rise to methodological problems when weighing goals.

WHO framework. The WHO framework for performance measurement consists of three intrinsic goals of health systems: health, responsiveness, and fairness in financing [1]. The first two are assessed on both level and fairness of the distribution. The framework satisfies the required conditions (i.e., a complete set of intrinsic goals) to facilitate global performance assessment.

WHO's health system goals closely resemble those identified for our own theoretical framework. Health utility and its distribution are reasonably comparable to WHO's level and the distribution of health. Our two sources of process utility can be described by WHO's assessment of quality and equity of responsiveness. Last, one could suggest that financial fairness reflects WHO's fairness in financing.

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