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Comment

Utilisation as a measure of equity by Mooney, Hall, Donaldson and Gerard

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1. Introduction

In a recent Note in this Journal, Mooney, Hall, Donaldson and Gerard (1991) – hereafter MHDG – argue that almost all empirical work by economists on equity in the delivery of health care is misguided, because it is based on an inappropriate notion of equity: that persons in equal need of health care should be treated the same. The appropriate notion, argue MHDG, is that of 'equality of access'.

2. What do policy-makers really think?

One of MHDG's arguments is that equity goals in policy documents are almost always couched in terms of access rather than utilisation. As anyone who has consulted policy documents in this area knows, the picture is typically far murkier than MHDG imply. Le Grand (1982), for example, has argued convincingly that some British policy documents seem to imply a

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commitment to equality of treatment for those in equal need; others a commitment to equality of access; yet others a commitment to equality of health Such ambivalence is not confined to Britain. the same is true of several other OECD countries [van Doorslaer, Wagstaff and Rutten (1992)] and, one suspects, of at least some of the non-OECD countries in MHDG's list.

Part of this ambivalence reflects, we conjecture, the fact that the distinction between 'access' and 'utilisation' which MHDG make, whilst perfectly logical, is less sharp in the minds of policy-makers than MHDG would have us believe The notion of 'access', they argue, refers to the *opportunities* open to people and is best thought of in terms of the *costs* people incur in using health services. It is self-evident that even if everyone enjoys the same access to health care (i.e face the same costs of securing care), persons in equal need may end up consuming different amounts of care (and types of care), simply because their demand curves differ. That policy-makers who have been successful in eliminating inequalities in access would regard such demand-led differences in utilisation as of no consequence, as MHDG imply, is far from self-evident. We conjecture that policy-makers would want to know the resons for the differing demand curves before they make their judgement We suspect that differences in demand curves that are attributable to differences in income would certainly be a matter for concern. MHDG might respond to this by saying that when they talk about 'costs', they mean costs in utility terms rather than in money terms, to the extent that differences in income are reflected in differences in the marginal utility of income, differences in income would automatically be picked up in their measure of access But what of differences in demand curves that reflect differences in education? Suppose that the poor have the same opportunities to receive preventive care as the rich, but have a lower take-up rate simply because they are not as well informed about health matters. Wouldn't policy-makers be concerned?

We suspect they would. It is surely no accident that though policy-makers *talk* about access to health care, policy *measures* are typically defined in terms of health care itself Ironically, Mooney and McGuire (1988) themselves put the point rather well In the context of a discussion of RAWP in Britain, they remark 'The point is that equity, as associated with government distributive policies, is not about equality of output with regard to health care. *Ostensibly*, it is concerned with equality of opportunity. Yet in reality, given the problem of reconciling expenditure with opportunity, the policy is largely concerned with equality of inputs, albeit weighted by some proxy of need' (p. 74, italics added.) Is the switch from access to health care itself really because of 'the problem of reconciling expenditure with opportunity' (whatever that may mean), or because policy-makers really mean 'health care' despite the fact they say 'access'? We conjecture the latter.

It is also surely no accident that academics on both sides of the Atlantic who have set out to examine 'access' have without exception actually examined 'utilisation'.[1] It may well be that Mooney (1983) is right: the authors of these studies are simply confused. But how can such confusion have persisted for so long? And amongst such eminent researchers? The list includes, after all, Rudolph Klein, a well-respected British social policy analyst, and Karen Davis, the American economist and former adviser to President Carter. At a recent conference on equity in health care organised around an ongoing EC comparative project,[2] Davis had a simple explanation of why the American research group preferred to refer to its study as a study of equality of access even though its methods were basically those outlined in Wagstaff, van Doorslaer and Paci (1991) in the United States there is and never has been any distinction drawn between the two concepts.

3. Assessing the 'superiority' of rival distributive principles

But MHDG do not rest their case just on what policy-makers appear to think. They also offer some arguments of principle as to why, in their view, equality of access is 'superior' to 'equal treatment for equal need'. There is some unhappy mixing of positive and normative propositions in their list on p. 478, but the gist of their argument seems to be this to insist on equal treatment for equal need in the presence of different demand functions implies that individuals' preferences are to be ignored in health care, that medical practices for given conditions would have to be standardised, and that uniform compliance would have to be enforced. MHDG's objection to all of this is that ignoring preferences implies acceptance of the view that health care is a merit good and this would constitute 'a radical departure from traditional welfare economics'. They proceed to examine what they claim to be the 'theoretical underpinnings of equity' by examining various models of altruistic externality

Models of externality are, it has to be said, a red herring. They say nothing about equity and distributive justice. Nor do they purport to As one of us [Culyer (1980)] argued long ago, there is a world of difference between what people regard as just, and what they regard as desirable, even desirable to an altruist. The latter may depend on what they regard as just, but will certainly depend on their degree of compassion and on their economic situation. The whole point of making a judgement about justice is, after all, to frame it in a way that it is a judgement made independently of the interests of the person making it. That is precisely why Rawls (1972) and

[1] See, for example, Salkever (1975), Collins and Klein (1980), and Puffer (1986)
[2] Cf van Doorslaer, Wagstaff and Rutten (1992)

philosophers since him have been so attached to the notion of the 'veil of ignorance', despite all its shortcomings.

But what is especially surprising is MHDG's apparent belief that because the notion of 'equal treatment for equal need' implies a departure from welfare economics, it must automatically be inferior to the notion of 'equality of access' – a notion that doesn't imply such a departure. This view is particularly surprising in view of the importance MHDG attach to the revealed preferences of policy-makers. If there is one revealed preference 'experiment' in health care whose results are unequivocal, it is surely this: that, by going to such great lengths to sever the link between ability to pay and receipt of health care, policy-makers in most OECD countries and many others have signalled their unequivocal rejection of the traditional Paretian value judgements in the context of health care [cf Williams (1976)]. That 'equal treatment for equal need' is inconsistent with such value judgements may, therefore, actually be a point in its favour rather than one against it, for it is at least a candidate, if not the only one, for what might supersede the Paretian value judgements

A more appropriate question, then, is not 'Which distributive principle accords most closely to the value judgements of Paretian welfare economics?' but rather 'Which distributive principle appears to be considered most just?' Gillon (1986) has considered the applicability of the various theories of social justice to health care and concludes that of the various distributive principles 'distribution according to need' commands the greatest support amongst physicians and others working in the medical field.

'Equal treatment for equal need' also appears – at least on the face of it – to be consistent with a rejection of another value judgement of traditional welfare economics. that social welfare depends on, and only on, the utility levels of the various individuals who together make up 'society'. Rejection of this is implied by the apparently widely held view amongst policy-makers that the business of health services is (primarily) improving health – a view that implies a commitment to what one of us [Culyer (1989)] has termed 'extra-welfarism' rather than to the 'welfarism' of traditional welfare economics [Sen (1979)]. This view is to be found in Britain, where Health Authorities in the NHS are now being charged with assessing the need for health care and of procuring appropriate packages of health care to meet these needs, as well as in the United States, where concern is frequently expressed about the failure to translate high per capita expenditures into superior health outcomes

In the extra-welfarist view, health care is merely a means to an end (viz. improving health) and the ethical justification of favouring one means of distributing health care rather than another (e.g. distribution according to need) has to be sought in the ethical justification of the associated distribution of health. The same is true of access, which in this view is also a

means to an end, the normative significance of which is that it enables people to receive health care, which in turn improves their health. Opting for one method of determining access (such as giving everyone the same access, or determining access in line with need) can also therefore be defended only in terms of the ethical justification of the final distribution of health it gives rise to.

Adoption of the extra-welfare stance thus commits researchers to analysing the fairness and efficiency of alternative distributional rules in terms of their implications for the distribution of the entity in which policy-makers are ultimately interested (which is, we conjecture, health), rather than in terms of how well the rules square with an inappropriate set of value judgements underlying modern welfare economics. Since it seems hard to justify aiming at a distribution of health other than equality (indeed the case for 'distribution according to need' seems usually to have been that its adoption promotes equality), the analysis from an equity standpoint must inevitably involve asking the question 'Which principle is most consistent with the pursuit of equality of health?'. Clearly such an analysis requires a precise definition of 'need', as well as an appropriate analytical framework. Elsewhere two of us [Culyer and Wagstaff (1991)] have sought to do just this: we have suggested that need is best defined as the amount of medical care expenditures required to reduce a person's capacity to benefit to zero. If this is accepted, it can be quite easily demonstrated, however, that distributing medical care expenditures according to need is, in general, *unlikely* to promote equality of health and may well *increase* inequality. So, although being in need remains a necessary condition for the receipt of health care in an equitable system, allocation proportionately to need is neither necessary nor sufficient for equity in the distribution of health care

Of course, the empirical literature that purports to examine 'equal treatment for equal need' does not in practice do this. Rather it seeks to establish the extent to which persons in equal *health* are treated similarly, which is a different principle from both equality of access and 'equal treatment for equal need'. But unless the scope for improving health via the application of medical expenditures is the same for the individuals concerned, the promotion of equality of health will require treating persons with the same health *unequally*

4. Where does this leave 'access'?

This does *not* mean, of course, that adoption of 'equality of access' will necessarily be more successful in promoting equality of health than either 'equal treatment for equal need' or 'equal treatment for equal health'. Indeed, enough has been said to make it clear that the problem with distributive principles such as 'distribution according to need' and 'distribution according

to initial health' is not that they entail discrimination amongst those who have gained access to the health care sector, but rather that they discriminate inappropriately, failing to discriminate where they should, discriminating where they shouldn't, and not discriminating enough where discrimination is required. Whilst 'equality of access' is almost certainly required in order that needs can be *assessed*, it is clear that it is not, in an extra-welfarist world, a *sufficient* distributive principle Nor, indeed, is it a *necessary* principle in decisions concerning who should get what once needs have been assessed. Thus whilst we would not disagree with MHDG that measuring equality of access is an important item on the research agenda in this area, we would strongly disagree that such research is all that is required

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