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Comment

Reflecting on 'Equity in health care: the Irish perspective'

JEREMIAH HURLEY*
Department of Economics, McMaster University, Hamilton, Ontario, Canada

In 'Equity in health care: the Irish perspective', Smith and Normand present a fascinating exercise in forensic economics investigating equity in the Irish health system. What, they ask, is the guiding equity definition, or principle, for the Irish health care system? To find out, they examine both stated preferences – the equity principles espoused in recent Irish health policy documents – and revealed preferences – crucial features in the design of the Irish health care system. Their main findings won't surprise anyone who has been involved in health policy very long. Even in the health policy documents alone, rather than a single guiding equity principle, they find a confusing mix of conflicting equity definitions: "This analysis of one country's policy commitment on equity outlines an unclear, inconsistent and varied definition, … at one point, the strategy is concerned with equality in access and opportunity (to achieve full health potential), at another it is concerned with equality in health status, and at yet another it is concerned with distribution of resources according to need" (Smith and Normand, 2011: 211). Moreover, they find a health care system that, in many respects, is incongruent with the articulated definitions (e.g. high rates of cost sharing that inhibits access to needed care). At least with respect to equity, Irish health policy is rife with irrationality, prompting Smith and Normand to offer the Irish system as a cautionary tale for other countries. One suspects, however, that many other countries would fare little better under such scrutiny. The precise nature of the irrationalities and inconsistencies would differ, but they would no doubt be present.

There are, of course, many reasons for the inconsistencies that Smith and Normand discover, especially those between the stated equity definitions and the actual system design. At any point in time a system design reflects an amalgam of historical decisions made in varying contexts by different governments that pursued differing equity objectives. Any single government cannot simply

*Correspondence to: Jeremiah Hurley, Department of Economics, Centre for Health Economics and Policy Analysis, Kenneth Taylor Hall, Rm 430, McMaster University, 1280 Main Street West, Hamilton, Ontario, Canada L8S 4M4, ext. 23822. Email: hurley@mcmaster.ca

erase inherited artifacts of previous governments. Further, even within a single government, equity is only one among many objectives pursued by health policy makers. As Smith and Normand observe, equity is only one of four guiding principles in the Irish National Health Strategy (the others being people-centered care, quality of care and clear accountability); and, more generally, health policy is only one component of overall government policy, necessitating trade-offs between health and other goals. Finally, in assessing equity commitments in health policy, exercises like Smith and Normand's must confront the counter-factual problem: the observable design is the outcome of a complex policy process, and one cannot know, for instance, how badly an original policy proposal from the Ministry of Finance violated the stated equity principles for health care and how challenges by health policy makers brought the implemented policy into greater, albeit still imperfect, conformity with relevant health equity objectives. To the extent these and related factors are at work, discrepancies between stated principles and actual design don't reflect intellectual failings; they simply reflect the realities of real-world policy making.

More interesting and potentially more damning are the inconsistencies in stated equity principles, especially those within a single national health policy document such as that (DOHC, 2001) on which Smith and Normand draw heavily. Under the prevailing approaches to analyzing health equity, inconsistencies such as citing multiple, conflicting equity principles presumably do represent an intellectual failing – laziness at best and lack of understanding at worst. Hence the warning to other countries.

Although we cannot rule out that what Smith and Normand find is simply muddled thinking, I want to argue that such a multiple-criteria approach to equity can be coherent, may better reflect how people actually think about equity, and, from an economic perspective, may be a more sensible way to frame equity. The dominant mode of equity analysis historically has been purely conceptual: conceptual arguments in support of specific definitions of health equity, analyses of the relationship among (and often, conflicts between) alternative definitions and the articulation of the logical implications of alternative equity definitions. Sen (1982), as Smith and Normand note, emphasized that any compelling equity definition argued for equality of *something*, and the different definitions simply argue for equality with respect to different outcomes. The implied goal of the debate and analysis has been to identify *the* single definition by which equity should be assessed – equal access, equal resources for equal need, equal health and so forth. The take-home message of Culyer and Wagstaff's (1993) seminal paper is that *one has to choose*: alternative equity definitions conflict in irreconcilable ways. Within this intellectual tradition, it is only natural for Smith and Norman to seek 'the' guiding equity definition for Irish health policy, and to be disappointed on finding multiple, conflicting, equity definitions.

Recent empirical evidence, however, shows that this is not how typical citizens think about equity. People do find compelling aspects to each of the most

prominent equity definitions, and they do recognize conflicts among them; however, rather than resolving the conflicts by choosing a single definition as the 'winner' for all contexts, they opt for a multi-criteria approach that includes multiple definitions and that assigns weights to each, which vary depending on the context. Drawing on this evidence, Konow has gone the furthest to develop a more integrative approach to justice and equity, arguing that people's judgments about justice, or fairness, are governed primarily by appeal to a small number of principles "that must be weighted, and context provides the weighting scheme in specific cases" (2003: 1190). As he notes, although details differ, such integrative approaches have been developed earlier in social psychology (Deutsch, 1985) and political philosophy (Miller, 1976), and the importance of context to judgments of justice and fairness has been emphasized by many writers (Walzer, 1983; Elster, 1992; Young, 1994). The specific context of Konow's work – social justice – is broader than the focus here – equity in health – but the central ideas of his multi-criteria, integrative approach are relevant.

This approach simultaneously represents both a more pragmatic and a richer, more sophisticated approach to thinking about equity in the allocation of health resources. Although acknowledging that conflicts among the principles exist, it recognizes that the sharpness of the conflict is contingent, and so should be the way the principles influence an equity judgment. In some situations, the principles may not even conflict. Allocation according to need does not conflict with equalizing health if those with the greatest need are systematically in poorer health. Equalizing access is often consistent with, and indeed a necessary condition for, allocation according to need. When there is a conflict, choice depends on the nature of the conflict and on the specifics of a situation. Research indicates that people often use conditional rules when assessing allocation problems. The weight given to different principles may differ when there is a severe resource constraint than when resources are sufficient to meet most needs, or when some people's baseline level of health is very low than when all individuals are relatively healthy. Crucially, the empirical literature documents that the weighting is not arbitrary – it can be linked to specific features of an allocation context, and people can provide explicit explanations for why they vary the weights as they do with specific features of the context.

Such an approach is also more consistent with economic analysis of choice, which assumes that people have smooth, convex preferences over competing, desirable goals. To make an analogy, economists don't insist that individuals choose income or leisure. They assume that people smoothly trade them off and allocate their time to work and leisure in ways that reflect the importance of each to an individual; or to pick an example closer to this context, we do not expect society to choose between the often-conflicting goals of maximizing total health and achieving equity in the distribution of health. We opt for social welfare functions that value both and accommodate different weights on each, as is consistent with the empirical evidence that people care about both and are willing to

trade-off the total amount of health for a more fair distribution of health so long as the cost (in terms of foregone health) of a fairer distribution is not too great. People choose combinations of total health and the distribution of health that reflect their degree of inequality aversion, and the rate at which the two are traded off depends on the levels of each.

Are governments like people? Do Smith and Normand's findings for Irish health equity commitments reflect such an integrative approach across multiple equity definitions? Although acknowledging this possibility, we must avoid a kind of Panglossian optimism that assumes all such references to multiple definitions of equity reflects a thoughtful, integrative approach. The only way to distinguish coherent multi-criteria approaches from muddled thinking is to extend the kind of forensic exercise undertaken by Smith and Normand. This more challenging task requires not just documenting stated definitions, but analyzing how the relationship amongst the alternative definitions is discussed. Does the discussion acknowledge a weighting among them?[1] Does it explain how the weights may change according to the allocation context? Answering such questions likely requires more than simply analyzing policy documents. It may call for engaging with policy makers directly to probe their equity-related reasoning, just as the empirical literature has done with members of the public. Only through such research can we understand the extent to which both the equity principles articulated and the policies implemented reflect a systematic consideration of relevant factors. This work is important not only to assess the rationality of policy makers approaches to equity in the health sector, but to increase our understanding of how people incorporate the impact of context into equity assessments, and whether policy makers think about this in ways that both accord with reason (can they be defended by appeal to compelling, logical arguments) and the reasoning of the public.

As exemplified by its decision to publish Smith and Normand's thoughtful paper, for 10 years *HEPL* has played a vital role in supporting such research falling precisely at the intersection of economics and policy that is *HEPL*'s niche. On this 10th anniversary of *HEPL*, it is vital to emphasize and strengthen *HEPL*'s role in promoting innovative work at this intersection.

References

Culyer, A. J. and A. Wagstaff (1993), 'Equity and equality in health and health care', *Journal of Health Economics*, **12**(4): 431–457.

Deutsch, M. (1985), *Distributive Justice*, Binghamton, NY: Vail-Ballou Press.

DOHC (2001), *Quality and Fairness: A Health System for You*, Dublin: Stationary Office.

1 In this context, Smith and Normand's observation (drawing on Oliver, 2005) that the English National Health Service holds multiple equity definitions *and* indicates their relative weighting is interesting (the central objective is equal access for equal need; secondary objectives include improving health outcomes and reducing inequalities in health outcomes).

Elster, J. (1992), *Local Justice*, New York, NY: Russell Sage Foundation.
Konow, J. (2003), 'Which if the fairest of all? A positive analysis of justice theories', *Journal of Economic Literature*, **41**(4): 1188–1239.
Miller, D. (1976), *Social Justice*, Oxford: Clarendon Press.
Oliver, A. (2005), 'The English National Health Service: 1979–2005', *Health Economics*, **14**(Supplement 1): S75–S99.
Sen, A. (1982), *Inequality Re-Examined*, Cambridge: Harvard University Press.
Smith, S. and C. Normand (2011), 'Equity in health care: the Irish perspective', *Health Economics, Policy and Law*, **6**(2): 205–217.
Walzer, M. (1983), *Spheres of Justice*, Oxford: Basil Blackwell.
Young, H. P. (1994), *Equity in Theory and Practice*, Princeton, NJ: Princeton University Press.