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SOME TOPICS IN HEALTH ECONOMICS THAT BECOME DISTORTED *CLICHES* FOR HEALTH POLICY

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SOME TOPICS IN HEALTH ECONOMICS THAT BECOME DISTORTED *CLICHES* FOR HEALTH POLICY

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Introduction.

The purpose of this paper is to pick up some of the best known *clichés* that surround the translation of the equivalent topics in health economics into health policy. These topics used to be distorted due to the inertia of the past, as a sort of some repetaed classic mantra (C), to the lack of a proper understanding by some of the health care agents in the policy and management fields (L) and some others result from ideological prejudices and the distortion relates to malevolence (M).

We have selected a bunch of them according to our forty years' experience in crossing the bridge from health economics to health policy and vice versa.

Topics, *mantras* and *clichés.*

1-The comparative efficiency of health systems when the objectives of social protection differ among them. (L)

What a country aims as its social protection network is always a combination of efficiency and equity, individual and mutual responsibilities, assuring individual equality of opportunities to different extent, in each moment, throughout the lifetime, etc. Its actual implementation responds to a collective decision that is expressed legitimately by the political options of the governments in power and their parliamentary support. It goes from the policies of 'the good Samaritan' to those who believe that 'you should not want the person managing trains making decisions on your health'. For the country comparisons it may be more or less liked from the respective options, but it does not morally legitimize the imposition of one option over another. And we already know that in Economics, in order to analyze efficiency we need to identify first an objective (the *isoquant*) and identify thereafter the relative costs (*isocosts*) to achieve it.

2-The interpretation that by generalizing regional health autonomy social cohesion is undermined with an increase in the health spending variance. (L and M).

This argument is used by both naive and malicious people. After the decision (in 2001 in Spain) to proceed with the senseless, in our opinion, transfer of health competences to all the Autonomous Communities regardless of their size, or level of competences, we cannot compare anymore what it was a single observation (INSALUD direct management), which consolidated in a mean value the deviations of 10 Autonomous Communities (from La Rioja to Madrid), with the remaining per capita expenditure of the historic before transfer Communities. There is a statistical effect of the increase in variance. Some people think that the simple transfer, from one year to another, has increased inequality in spending and then questioning social cohesion. Neither inequalities increase overnight nor has Spanish decentralization been the vector of any social breakdown. On the contrary, fiscal decentralization allows for a political reading of the differences in per capita spending (with the *foral* regimes as unattainable hare) which has generated a process of emulation feeding public health spending, and bringing it closer to what some consider a European benchmark.

3-The political comfort of settling in health equity as equality of access, omitting opportunity costs other than prices, or ignoring that consumption equality or outcomes equality involve a rather unacceptable level of intervention in a democratic society. (C)

Equal access sounds good. It is easy to define on a political scenario and does not condition the public managers too much: they simply comply by making services available to citizens. For politicians, it is comfortable since it does not require discrimination: 'everyone is called, even if not all are cared'. However, this principle forgets that potential access is not necessarily effective consumption, nor derived from it, an identical result is achieved. Between access and utilisation a set of opportunity costs are operating surpassing even the absence of monetary prices. For instance: geographical barriers and access discriminators, time, regulation, waiting lists. And other monetary values: an illegal immigrant queuing in a health center bears the cost of not earnings and maybe not eating that day; for a self-employed worker, there is lost income; for a pensioner it can even become a benefit, an opportunity to socialize or overcome loneliness. Education, architectural barriers, the lack of an elevator in humble housing, the lack of help to make medical appointments are factors too. Ignoring what is not expressed in usage is an “ostrich policy”, unintelligently if the objective is population’s health.

4-An econometric analysis of health systems performance with no adjustment for variables that are not attributable to health care management (lifestyle, some risky behaviors, decisions about premature babies, terminal care ...). (L)

It is very tempting to judge systems efficiency through the analysis of factors that affect the results of each agent participating in them. Evaluation by benchmarking shows residuals, which separated from estimation errors, may identify the least productive (if the variable analyzed is the activity) or the most

inefficient ones (due to higher unit costs if this is the case). However, the analysis will depend decisively on the adjustment variables, the exogenous explanatory variables included in the econometric regressions. Omitting these variables it is assumed that they are endogenous and therefore under the responsibility of health care managers. Depending on countries, smoking may be a clear case (up to prohibition?), excessive alcohol or sugar consumption (tax is not enough?), risky behavior (with or without supplementary private insurance that compensates in income the higher observed costs), leisure associated with fast food (for low income people that cannot afford the price of the bistro), etc. We see, therefore, the senseless situation, for example, of attributing as health system's inefficiency a greater number of infant deaths derived from the mandate of intensive care and up to the limit of premature babies, drugs costs raised by generous prices by favoring the national pharmaceutical industry, or attributing as successes of the system the reduction of perinatal mortality thanks to the acceptance of abortion. All these factors, insofar as they are considered social rather than individual preferences, are beside the direct responsibility of health managers and even politicians. This means that they should be placed on the right side of the regression; among the adjustments from which we cannot hold responsible those in charge of the variables we are trying to explain in this analysis.

5-Using figures of health per capita expenditure to derive conclusions of unacceptable inequity between regional health systems. (M)

We consider this to be a malicious cliché because it is no much difficult to understand that if state's funding, in behalf of the equitable distribution of resources, no follows an identical per capita funding, the expenditure figures cannot be identical either. Regional finance weights the population by age and gender, and since age groups differ over the territory, their expenditure figures must also differ. In addition, state's basic funding allows for a ceiling that Autonomous Communities can complete, from its overall revenue capacity, fiscal effort (taxes and copayments included) or from the prioritization of this item, above other pieces of spending. Deriving from differences in per capita spending equity conclusions without taking into account the income side is simply a *boutade*!

6- Not to answer the question of "*If not for profit for what*" it forgets that there is always a surplus in all the economic activities, and it ignores that what is relevant is not whether this occurs, but its dimension and who takes advantage of it. (C)

In any market transaction in which there are identifiable prices, it must appear a surplus. To the extent that in the demand, the additional benefit being the marginal utility decreasing, gives validity to the surplus. Indeed the price shows a benefit for initial amounts, a surplus, a willingness to pay above the price or opportunity cost of use, until the point of equilibrium in which voluntarily, given the price /cost of access, is no longer consumed. The net consumer surplus caused by this exchange, or that of the producer if we are talking about supply / production (and not demand / consumption), either goes to one of them or it is shared among them. The more competitive is the offer, the less the surplus will go to the producer. In other circumstances, that little triangle that marks each point of the demand above the

price until the point of equilibrium, can be 'emptied' too in favor of the inefficient producer, who, by substituting the competition for a monopoly, works above the minimum possible costs. It is clear that the higher costs (more slack, less pressure, more perks or even corruption) is at the expense of someone else, and the consumer / citizens / users in particular. Hence, this raises the question of "if it is not for profit, why other reasons are going to move the incentives?" In favor of the monetary incentives we can say that these are identifiable, they can be monitored, susceptible to be taxed, etc. On the other hand, those associated with inefficiency are usually hidden costs and usually end up benefiting the most daring, or less involved in a better public management, parasitizing what belongs to everyone and to no one at all.

7- To consider an ambiguous interpretation of co-payments by mixing up their role as a ticket moderator, deterrent of expenditure or as a complement to financing, and this being borne by the user where there is no longer funding from the taxpayer. (C)

Copayments are related to decisions that, on one hand, may justify that user's participation lead to less consumption, stop what has been critically considered as an abuse, unnecessary, inappropriate use, even iatrogenic… so that its best effect is that the co-payment does not collect any revenue at all. This would happen in case of having an impact on very elastic demands, so that the effect would ultimately be a reduction in expenditure and not higher income. On the other hand, there may be co-payments that would seek to raise more to better fund public spending where the fiscal effort is no enough and it makes sense for users to supplement the cost because of some particular benefits. It is better then, that these co-payments affect inelastic demand and that unlike the previous co-payment to moderate consumption, they should be of low intensity and extensive the less rigid the demand is (unlike the intensive ones focused on superfluous consumption) and with higher rate. In short, the name does not make the thing, but its virtue rather depends on its function.

8- Identifying co-payments with private prices and not with tax expenditures (fiscal deductions) or fees (for a better financing of public expenditure). (M)

Copayments are not private prices in order to finance private spending. It is more about participations in regulated prices that contribute to the funding of public expenditure where the taxpayer's effort is not enough. A co-payment is not much different from a fee (that's how we call them in higher education) and even from a tax deduction ('you pay first and then recover part of that expense paying lower taxes'). With no doubt they correspond both to the user's willingness to pay, and this is usually directly related to individual income. In addition, acting on tax expenditures in the income tax, and limiting them to certain taxpayers, exempting some (chronic) collectives or linking them to their income with a stop loss clause that limits disbursements, regressive effects that may arise can be partially ameliorated.

9- To state that all co-payments are inequitable while assuming that general taxes are always fair. (L or M)

Almost everything in economics depends on what is compared to and on what function the instrument serves. Indirect taxes are regressive: VAT and special taxes represent a proportionally higher burden for low income people since their consumption is in percentage terms a higher proportion of their income with little chance to save. In addition, it may make sense that general taxes do not accompany any type of expense independently of its cost-effectiveness or relative effectiveness. It cannot be justifiable that they should be mutualized and funded by all the taxpayers. This may be the case even simply because we are dealing with preferences, such as reference prices for some drugs that have generic versions or bioequivalent. For this a co-payment is not only efficient to limit an objectively unnecessary expense to an equivalent substitute, but it is also equitable, since it avoids to finance through taxes (which generate welfare losses associated with the so-called excess burden) and reducing economic capacity to those taxpayers who renounce to unnecessary consumption. In addition, on the equity side, it may be the case that the benefits are partially internal just for the users (as with university fees). This means that we have to identify always the benefits of the consumption to draw that kind of conclusions can be derived from taxes versus fees, which other funding source is available at equal revenue, where we apply fees according to the target (to reduce consumption or to raise revenues).

10- Not to understand that in a universal system effective consumption depending on social gradient can either be pro-poor or pro-rich. (C)

We tend to congratulate ourselves on having a universal system that allows access regardless of economic capacity, thus visualizing that the poor 'can' (unlike other less universal health systems). But the truth is that with universalism, and even more if it is 'open bar', high-income individuals can access such services in a less restrictive way. So if the universal system is to be defined as progressive, redistributing pro-poor, it must be because the rich for some reason - other than being healthier - use it less than the poor. The fact that the poor use it more (remember, use, not simple access) is not defining progressivity either, since it must imply a level of utilization above that indicated by their relative levels of health need, thus standardizing on the basis of the health status of the population. If they use the system more than their proportional weight as a population group, but less than they would use either according to the average consumption patterns of the total population or with respect to the best observed practices, we would not be redistributing pro-poor on this side of spending. With this we mean that the effective use will mark the redistributive result. This is, of course, sensitive to the circumstances (the price and income elasticities differ between groups and may respond differently to, say, a crisis or economic boom period), to the ability to reduce the opportunity costs of access (out of the regular profiles), better knowledge on the functioning of the system, education to identify needs etc.

The key point to emphasize here is that the drivers of consumption (by population groups and service modalities) are not under the direct control of managers and politicians. This gives them comfort in their day to day work but does not allow them to focus and monitoring the desirable effects in a better

focused health system. This universalism –the first arriving is the first served, 'open bar' by supplying what is in the kitchen as long as there are stocks- has certainly disadvantages not being accompanied by prioritization either by relative need and / or means test.

11- Austerity (health care containment, reduction) of public health expenditure (rather unemployment or poverty) kills. (M)

The most rigorous studies allow us to identify the real problems caused by the crisis and its possible solutions: poverty and unemployment can have more negative effects on public health than cuts in health care expenditure. One has to be very careful indeed when establishing causal relationships. Using observational and cross-sectional data in examining the deterioration of health, if any, cannot be attributed causally to the crisis. This calls into question the association between cuts in public health care and increased mortality, summarized in Spain with the claim that "austerity kills", which has been extended in some medical literature and in political sectors, as well as among health system workers. The main empirical conclusions that different authors highlight from the analyzed literature are: the austerity measures adopted in the healthcare sector in Spain have been mild, compared with those applied in countries such as the United Kingdom and Germany. This has to do, among others reasons, with the variability of policies in the different Autonomous Communities (a cushion for slack) and with some social reactions (improving the productivity of health professionals).

12- To put much emphasis in the cost details, and take a too rough approximation of the effectiveness in the economic evaluation of some health treatments. (L)

Health economists may be wrong by overemphasizing the approach to cost-effectiveness in health prioritization. Putting the cost issues first makes effectiveness appear blurred. First, because it is difficult that economic cost leads a clever clinical discussion in the context of the prevalent cultures in our societies being likely to short-circuit the debate. Relative effectiveness is perhaps a better way forward. At least, to begin with, given its relevant effects on health, many more than those derived from more or less correctly computing an indirect cost or a frictional productivity. The scale impacts of actually moving from efficacy (which is what we know more or less in our studies) to focus on (i) biomarkers that shed light on the current uncertainty about safety and effectiveness of treatments and their beneficiaries, (ii) to improve indications, with a plus of follow-up in control of adherence, (iii) to learn from good practices and ex post feedback of results, are much more decisive possibly for a good allocation of resources in order to improve population health. This is due to the fact that its effects are multiplicative (and not additive as in the case of costs). A greater balance in the cost effectiveness binomial is then probably required to health economists in the field of economic evaluation.

13- "Prevention policies always generate savings of resources". (C)

This statement is a bold derivation of the expression "common sense" - the one that tells us that the earth is flat - enunciated as "Better safe than sorry" or "An ounce of prevention worth a pound of cure".

Although it is widely proved that some preventive health services, when they are adequately provided, offer an excellent value, nothing allows us to generalize these results, stating that anything done in behalf of prevention is always cost-effective. It is easy to give examples of cases that prove the arithmetic inconsistency of assuming that many interventions of scarce cost are always more profitable than a high-cost repair avoided. It is probably harder to appreciate the pathophysiological inconsistency that too often guides the link between prevention and to avoid harm. As an example, the proof of the innocuousness of many silent prostatic tumors or some breast lesions that have been preventatively detected and eliminated, without real benefits, has been making its way in recent decades, despite the strong opposition of those involved in the prevention industries.

The widespread concern about iatrogenesis, and the more asserted claim that "no health intervention is totally innocuous" should help to restrain a statement as questionable as that of the headline.

14- To set population objectives in health plans, implementing an information system based on activity (patients), a control system focused on inputs and maintaining a finance of providers under budgetary incremental / decremental strategy. (C)

The design of coherent organizational structures implies to solve in a coherent way the different systems that integrate them. So it is illogical a health system that works with a planning based on population health objectives (outcomes) but where the information system focuses only in care activity (outputs and mainly spatially segmented); and at the same time, the control is done by inputs (how much has been paid for materials) and the financing is done through a global incremental budget (a lower spending today meaning fewer resources for the next budget).

15- Identifying the maximization of Quality Adjusted Life Years as the goal of our health systems. (L)

If we were serious in the 'maximizing' of QALYs, life expectancy or similar health indicators, we would foreseeably do things that we do not want to do, such as focusing resources where productivity is maximum and the capacity to deploy health (QALYs gain) is greater, delaying attention to fragile groups, premature babies, with genetic or overdue disabilities, aged people, etc. The simple application of the Williams' equity criterion of 'fair innings' would condition the former maximization exercise by respecting a minimum endowment of QALYs that would correspond to each person, not susceptible of being traded off with that of anyone else, and conditioning then more 'productive' investments. This is also a warning so that in the comparisons between countries we should better identify first what are the social goals of the health care systems.

16- *Seventeen Spanish Autonomous Communities, seventeen different health policies*. (M)

Health policies usually respond to 'political' positions. So there cannot be 17 policies but a maximum of three or four political, ideological ways of understanding social protection in health. Thus we know that left wing parties tend to support public provision with its own production (statutory, administered services), liberal centrists are usually willing to open the scope from public provision to contracted-out

private production (usually being non-profit and limited temporary-annual contracting of services) and conservatives accept that private productions can be granted for longer periods to private companies, including those for profit. All this can be done in systems that maintain regulation and public financing. The evaluation of its relative efficiency, considering here elements such as preferences and free choice, which are difficult to evaluate objectively, is eminently empirical and they may be interpreted according to the ideology of the representative government. In Spain, usually one Community leads and the others follow in each of those three ideological streams. The appeal to the chaos of 17 policies is brought together by some agents who are against decentralization - either from the left wing or right wing side- and by some suppliers who would prefer to escape the increase in transaction costs associated with the supply of regional suppliers. Its complication can be an advantage for public funding if what is lost from the supposed advantages of joint purchasing and monopsony is compensated by a higher pressure of cost consciousness, bilateral negotiations, incentives to innovation, information transparency and emulation of the best bargaining practices.

17- Ageing as a vector of expenditure and proximity to death as an inevitable exogenous factor of its growth. (C)

It is a worrying perception distortion to understand aging as a problem, instead of seeing the increase in life expectancy as a social success, partly attributable to the health care system itself. The observation that with age health's cost increases pushed in the past to use multipliers that gradually raised the cost over population average for different age groups. In the Spanish calculations and in the absence of longitudinal data, from the same individual throughout his life, these incremental factors were calculated for different cohorts but at the same moment in time. It is a different computation from the desirable one since it is done by looking at the technology and care practice in a given moment without taking into account past records of its evolution for the foresight of the projected interest.

It is already well known that age intervals are not what push health spending up in a sequential manner, but rather it is the proximity to death, at any age, which asymptotically increases spending throughout a person's life. And being this close care received near to death the decisive factor, it become endogenous and not independent of the care practices. So there is nothing irremediable that condemns health spending to ageing. It will depend on how we approach prioritization in terminal situations regarding the cost of very low-effectiveness medications or treatments that embitter rather than palliate patient care.

18- To attribute inequality and not polarization the threat of social cohesion breakdown. (L)

Social cohesion has unstable definitions, because it is about consensual relationships, but its collapse is recognized when talking about conflicts, as polarization of the parts. Inequality, and not only its increase, can crumble the assumed cohesion, but it is not the only plausible explanation. Polarization, as divergence towards extreme points, causing a disappearance of intermediate options, also supposes a breakdown of cohesion. In this sense it is not surprising that in the analysis of samples of countries, polarization and inequality ranks may differ until they intersect. Fleeing the temporary temptation of

reducing these phenomena to situations of territorial identity, ethnic or religious, it is not difficult to see scenarios after the beginning of the economic crisis in which the role played by economic inequalities may be less than those associated with the polarization, from spurious difference logics. An unequal distribution but with high proportions in each section is less dangerous for social cohesion than two poles that group two clusters very homogeneous internally and extremely heterogeneous between them.

19- The supposed financial sustainability for an insolvent system of spending rules for fiscal consolidation. (C)

Spending is always the product of price (or unit cost of provision) factor times quantities (consumption of services). Control spending as a whole is to a certain extent making clean slate of two very different dynamics: the efficiency in costs and changes in utilization. It does not make sense to subject both factors to the same rule since at least services inflation (for example, in medicines, recipes per capita) has a poorer prognosis for health than price inflation of drugs. And within the latter, considering only a single differential, it treats equal the unequal (innovative drugs, cost effective, adding quality of life…). This can discourage innovation. For the rest, these crude expenditure rules, if they were to effectively consolidate fiscal health spending should not be implemented by service plots but globally, and would require intertemporal consistency, being linked not to GDP but to tax collection; that is, it would consider the income elasticity of tax revenues.

20- Confusions between civil, public, administrative, social, state. (C)

The famous "*Piove, governo ladro!*", which became popular a century and a half ago, embodied in a simple way all the public guilt and responsibility. Today that imputation must be assigned more precisely to different levels of government, its administrative structures, social agents, citizenship or the whole society. But it does not seem we are very fine yet with this issue given the frequent confusion in these attributions. Similarly, too often only services provided directly by the administration are considered public, rental cars with a driver are still labeled as "public service", while private franchises granted by the administration are considered as private businesses. Without a greater discriminating effort between the different responsibilities of each form of management adopted - and its possible alternatives - we risk oversimplifications that only contribute to perpetuating an undesirable *statu quo* that is obsolete or, at least, inadequate for the present realities. Public is not that of everyone's citizen but what the government administers, and social spending is only what goes through budgets. These are just some examples of such confusion.

21- Not distinguishing between social welfare (spending) and residual welfare in family income capacities after the payment of taxes and monetary and in-kind subsidies. (M)

There is a tendency to value social spending in its amount more than in its destination. In the end, a low social expenditure over GDP comes to be considered by some a neoliberal curse when it can be that it is

simply reflecting a very vigorous income growth and a lower demand for spending on unemployment benefits, minimum rents, and less need for social protection. This emphasizes the need to know more about this expense: if they are global monetary transfers, the free use of resources in uncontrollable destinations will predominate; if they are conditional transfers (i.e. just for housing) and supplemented by the individual, a saving effect will be generated that will be more focused on the destination, although with income effects (when the subsidy is released to that destination, resources that can now be used freely for other reasons). If the expense finances an in-kind benefit, the choice capacity of the citizen is more limited, and the person who renounces to the use of the services loses its benefits while still contributing to its financing. Finally, the implementation of a voucher retains part of the consumer's sovereignty, it may be addressed to services access (does not allow an unconditional expenditure), and it allows to recover in favor of certain services not publicly provided what was previously a strictly private cost (which now, being subsidized, would encourage consumption). Residual welfare, net of payment of taxes, prices and regulated co-payments, with consideration of the welfare yield for preference or public benevolence, should be the basic count of public policies analysis.

22- To ignore that taxes always generate excess burden and unnecessary loss of welfare that must be traded off to the alleged gains on the spending side. (L)

Showing the benefits of spending by ignoring the cost on the revenue side is a classic of those who do not distinguish the absolute, differential budget incidence (substituting one expense for another with equal financing) or a balanced budget (each increase in an expense must be justified with the corresponding revenue increase). Certainly, public spending adds welfare, which, if it affects fiscal progressivity, would add more revenue capacity (or would substitute need for spending) to families with less income. But it should not be ignored that taxes reduce such spending capacity for families (residual revenues or net income from taxes) which certainly reduces welfare accessible to one's own criteria. In addition, any tax distorts, affecting the behavior of those affected, can reduce taxable bases, frustrates free choice (undoubtedly a component of individual well-being), in what is called excess of burden (in the sense that it exceeds the obtained revenue collection) of the tax, as avoidable loss of welfare (unavoidable is just the income-reducing effect) if the tax were neutral. But of course, we do not want neutral taxes that would be efficient but very unfair; so much that they do not exist in any country or in any fiscal system.

23- Overlooking that regulation, funding and provision are alternatives of the same attempt of public protection, with different effectiveness depending on the situations. (M)

Regulating is easy for the State and it assumes little cost beyond informing and enforcing what has been legislated. Regulation shifts the cost of compliance to individuals (so for compulsory vehicle insurance, ITV for cars, security restrictions on buildings, against pollution, etc.). Public provision causes the administration to be involved in entrepreneurial production of services. If public provision is made

under private contracted-out production, to the lower cost of production of the latter it must be added the transaction costs. And with public production, the State becomes the ultimate holder of all managerial and technological conflicts. However, even when all the above modalities do not require the same involvement nor are they reflected equally in budgetary figures of expenses and revenues, they can equally serve the same objective. The decision of contracting-out or producing services is an issue in itself. If we regulate inputs or we do it by results the discussion is open as well. This has led some analysts to ignore public spending over GDP figures as indicators of the effective degree of public intervention in the economy. Some authors thus speak of social spending by incorporating the effects of that mandatory regulation, separating it from the administrative one, and considering whether it is net or before taxes, subtracting other non-tax financing (public prices, copayments) that has financed that expense, as all of them respond to the logics of different interventions (degree of voluntariness, individually appropriable benefits, social externalities...).

24- To perform ambiguous expenditure comparisons, sometimes in terms of GDP, as a percentage of total expenditure, per capita terms, by levels, absolute and relative growth rates, indexed on some basis year or period of convenience, varying the scale of representation axes graphic, etc. (L & M)

Undoubtedly within the health care expenditure, salary rewards must have the GDP as a reference (in fact labor remunerations are a primary part of this GDP). It is not, however, equally evident that GDP should be the reference for spending on medicines and some other inputs. If we believe that we are in a single market, per capita expenditure should prevails since at least prices are not fully linked to GDP. In fact, in a situation of price convergence (of international reference prices, for instance, to avoid parallel trade) and to a large extent of practices, knowledge is globalized despite the fact that the budget constraint remains 'local'. The percentage reference of these items to the amount is very sensitive to the total expense, whether public or not, whether financed by public co-payments offering alternative social responsibility frameworks or not.

The game of illustrating the conclusion by empirical data, at each's interest, may focus either on rates or levels, variation of rates term by term or by annualizing the quarter; over the previous quarter or the same quarter of the previous year, anchoring the values to specific years (base one hundred) or plotting with discontinuous axes ... is already part of another framework, more linked to the misuse of data than to the here commented topic.

25- Confusing *prices* (notional) with *unit costs* (effective). (C)

We want to refer here the fact that between the agreed theoretical price and the final cost for the producer there is a chasm, so it is good to avoid such confusion (for instance with regard to high prices in the USA versus Canada, reimbursement and final prices in Spanish hospitals). In competitive markets this may depends on *who* buys (global or individually, in a monopsonistic strategy or not, for own use or for third parties), *how* to buy (auction procedures, more or less restricted contest ...) and *how late* to pay (the supplier capitalizing where appropriate the expected financial cost due to delay), in presence of

pay-back formulas, discounts, bundling or packages of inputs with linked purchases in the short or long term, etc.)

26-Not knowing that what is not offered in a public catalogue of services in a democratic society is not prohibited, thus transferring a one-hundred-percent co-payment to the purchaser. (C)

Co-payments produce several misunderstandings and confusions. Not only it's possible to see them just when they appear from the first time but not so much after a slight variation. It also blinds the view that the exclusion of a product from public benefits because its cost is not considered to be affordable, means an automatic 100% co-payment for all those who decide - and can – to consume it. To curl the loop, when the vision of that blind spot is recovered it is usually argued that the false solution that what is not financed should not be authorized. Something that, in addition to not improving anything other than the bad conscience of its supporters, is difficult to translate into reality in a democratic country with internationally agreed rights of citizens and trade.

27- The ecological fallacy that what is representative of the group is also representative of each of the parts that make it up. (C)

The so-called ecological fallacy refers to an erroneous inference due to the lack of distinction between the different levels of organization. A correlation between the variables based on group characteristics (ecological) is not necessarily reproduced between variables based on individual characteristics; an association at one level can disappear into another or even be reversed. Thus, this can be seen for instance in an ecological study that examines the relationship between per capita income and car accident risk in different populations and appreciates positive correlation between the average income and the risk of damage, it is easy to fall into this fallacy. Without an observation of the individual values it would not be appreciated that in all the groups the accidents occurred only in people of low income. Or a study that finds a correlation between the quality of drinking water and mortality rates from heart disease, it would be an ecological fallacy to infer from this that exposure to water of certain hardness influences necessarily the individual possibilities of dying because of a heart disease.

28- MUFACE as equivalent to private insurance and that exposed registration (opeen enrollment) is antidote enough to avoid risk selection (ignoring services selection). (C)

Risk selection is intrinsic to capitation financing. If it is aimed at private for profit insurance, the incentive to expel high risks is even greater. But risk selection also exists in public systems when population groups are assigned or professionals are located at different health centers of which we know of their lower healthcare pressure, with more educated and less likely actual patients, with a higher percentage of complementary private insurance, etc. The truth is that the capitation payment is at the base of the agreements of the public *Mutualities*, so the regulator must be aware to neutralize that perverse type of incentives, contrary to a system that wants to cover the total population without exclusions. Thus, the antidote is usually that the insurer cannot choose the insured. The insurance

company hence cannot see the affiliated, nor to screen his genetics nor can they demand franchise periods. Therefore, affiliated freely choose insurers (in the Spanish *Muface* on January 31 of each year). However, this open registry may be eroded by a selection of 'services' that make it more attractive for some population groups that are known to be at lower risk to choose more 'complete' insurers in certain services than in others (see for chronic, oncological, rare diseases).

29- The need to adjust the risk as much as possible in the differences in population expenditure, using for this the individualized consumption of the previous year (leading to the "Garbage in, garbage out" result). (C)

The best predictor of future health consumption is the one carried out in the past. So in the formulas of prospective payment to providers it is very tempting to use as explanatory variables the expense observed by the patient, specific territory, particular provider, in our health systems. But this confuses the explanatory with the predictive power. If it is adjusted by what is observed, the extrapolation does not correct the observed values (inefficiency, overuse, high costs) being projected into the future. This finding has caused the confusion of believing that population risk adjustments based on variables such as age composition, gender and social aspects of deprivation had very low explanatory capacity of the variations in population expenditure, in view of their low R-squared, in order to substantiate a transfer of adequate financial risk to suppliers. In fact, the part explained by these variables should refer not to 100 (garbage in, garbage out) but to the part of the expenditure variation once excluding the inefficiency component that we don't want to project.

30- To overlook the primary care of different NHS, omitting the different incentives that underlie their different professional guidelines. (M/ L)

The partial - and biased - comparisons are ubiquitous, but some of them go through health debates with a reverse effect on their old prejudices. When certain features of primary care from other countries are envied, it is common to compare the salaries of their professionals with those in force in our national health system (remuneration for covered population or alternatively by salaries), omitting any adjustment for time commitment or size of the respective shares. It also refers to the different status of the professionals in terms of self-organizational capacity and assumption of risk (self-employed / salaried status) and the different flexibility in the extension of the benefits, extent of dual practice etc. This ignores much of the intrinsic differences between National Health Service models and Social Security based Health Care Systems.

31- To account as inequality that care that public regulation itself has ruled out because it is not much cost efficient or simply less efficient. (L)

It is not clear in the literature that those who are most assured complementary to public coverage are the sickest. In fact, some studies show that the willingness to pay, in addition, is usually associated with the degree of individual risk aversion. But the more fearful the person is to suffer a health contingency,

the more he or she can worry about self-care and prevention, which is what explains part of the business of private insurance (*cherry picking*). What does not make sense is to consider that public coverage is well prioritized (effective cost is included) and yet consider the use of the excluded, and paid by the pocket of the hypochondriac or the more risk averse, even that care of doubtfully effectivity, as part of the indicators of inequality. If we agree that the consumed out of catalogue is not 'worth what it costs' in the social option of coverage, it does not make sense that we account it thereafter as valuable for health when we associate utilization with equity.

32- To equate utilization with demand, when the former is already the result of the interaction between supply and demand for care. (C)

Data on utilization is too often interpreted as demand. But the consumption of services is already a result of the balance between the available supply, the expressed demand, the induced consumption based on the estimation of need, etc. Still, some scholars and too many professionals, such as those on the "more minutes" platforms, continue to insist that the number and duration of visits is an exogenous problem to consultations. This is still the claim despite the fact that most interactions respond to the pattern of dubious reviews of arbitrary periodicity and scarce evidence if any.

33- There are thirty millions of uninsured poor people in the US due to lack of public spending/GDP. (M)

Many of the citizens who do not have coverage are self-employed workers and illegal immigrants. The first, given the high prices of health insurance cannot or do not want such coverage assuming therefore risks that can be catastrophic (this was the target of the *Obama Care* to facilitate such coverage). The really poor are covered by the public MEDICAID program. It is crystal clear that still with the US public budgets countries such as Spain and many European health systems not only cover poor people and over 65 years, but the entire population. At any rate the American system allows access accompanied by the free willingness to pay for technologies and services without waiting lists or without restrictions as those imposed on European systems. At least for some!. Even if this seems very bad to us, these are options that come from social choices in democracy to be respected.

34- To increase the budget - the fraction of it - devoted to an efficient activity (for example in Primary Care) by assuming that this will always mean an improvement. (M)

In general, any increase in costs that exceeds the benefits obtained implies a reduction in efficiency. When prior efficiency is used as an endorsement to claim more resources, it is usually neglected both the objective to which they are intended to serve and the mechanism by which they are expected to result in a comparable benefit. In the case of Primary Care, intensive in professional work, it is easy to see that increasing professional remuneration would satisfy the claim, but it is risky to assume that this

redirection of resources will automatically translate into appreciable improvements in patient outcomes.

35- Assuming that some inequalities have an unambiguous sign with respect to equity, despite the conceptual framework of reference. (L)

Assessing inequality does not mean to identify a breach of equity. Thus, it is too common to assume that a greater ease of access or pro-rich utilization of specialized care is a benefit for that group. Only in a framework in which Primary Care plays a resolute role, more access to the specialists could be interpreted as better assistance. Otherwise, as we have seen in some cases, the most well-off groups show more frequent urological consultations and in a greater proportion to carry out questionable prostate screenings, the inequalities observed in that assistance are "objective", but do not necessarily reflect inequity. From the conceptual framework of reference, it is not evident that inequality, when it occurs, always harms those who receive fewer health services. In the limit, the greater use of inadequate services by a certain group does not imply worsening equity, since the waste is not subject to moral rules on its distribution, and being in any case immoral.

36- The *ad hoc* classification of private and public management disregarding aspects sanctioned by the nature and the *status quo*. (M)

In repeated works that deal with the level of "privatization" present in the different health systems, the volume of purchases of services and even concessions and franchises usually are taken as such. Nothing is said about those aspects of the provision of services that do not seem to be perceived as private production and management. Thus, pharmaceutical distribution, classically a quarter of public health spending, has always been franchised to regulated private providers, without major scandal or having attempted a public reversal.

37- Variations in expenditure that make to conclude that more is always better (L)

Studies of aggregate utilization of services have already gained some attention, but there is still less attention to unravel the types of health care that makes up those aggregates. This is particularly the case regarding whether the important changes found in effective care are translated into different health outcomes, which is not always so obvious for the different levels of spending. The variability of health care utilization has passed in a short time of being absolutely denied to be comfortably used like alibi. The differences in expenditure attributable to the variability of practices are generally attributed to the mere availability of resources and almost never to professional or institutional preferences out of place. But although the variability is associated to the volume of available resources in each area, it also does it to their productivity.

The judicious use of the data allows to identify unjustified differences in the use of technologies or procedures of scarce, doubtful or null clinical value, pointing out those providers that move systematically above what was expected. This should be the objective of the corrective policies to

reduce the high opportunity cost that results from its high intervention rates. And for this reason there is more stretch within each Community than between Communities. Otherwise, improving research that does not lead to action is also wasting resources that are always scarce.

38- The concern about the labeling of policies, rather than the effects produced by the specific policies. (L)

Simplifying helps to shortcut difficult judgments, although approached with predictable biases that sometimes lead to serious systematic errors. But the hasty use of simplified labeling prevents judging the situations with better criteria. Thus, although we know that it is convenient to redefine the size and scope of many harmful and hypertrophied services, the news of a reduction by an unpopular government leads to disqualify the concrete action and even its mere application. It does not matter so much the level of adequacy with which it has been carried out. It is enough the disqualification of a policy despite the fact that in certain formats has been claimed in other moments under less hard-wired labels. Avoiding incurring in these inertias should point out the line of demarcation between opinion leaders of all conditions and researchers in health economics.

39- The requirements in the authorization and pricing procedures that obviate the lack of control of off-label uses. (C)

We often like to point out the rigor of authorization controls for new drugs, subject to the scrutiny of drug agencies, which the industry is seeking to relax. We even occasionally criticize the opacity and noncompliance of the Public Committees on Drug Prices, which seems to show the lack of publication of motivated resolution reports on financing and price. But very rarely do we point out that once a drug is approved - with its corresponding meticulously priced indications - and its price is fixed -very occasionally related to its potential market-, our concern for its real efficiency ends. However this is something really foolish, particularly when one would want to preserve a questionable form of "freedom of prescription", practically without any responsibility. Even if that is the intention, it should be considered to discourage the promotion of misuse.

40- A free, public system, universal, and of the best quality. (C)

To end this list, we will highlight a legitimate topic as a desire, but in its current state, dissenting with the evidence about its reality. The best known rejection approach of this assertion is the economic one: resources are scarce and everything for everyone is impossible. More interesting because it is less known is the normative approach. The public health system is not universal. And it is not since long before the Royal Decree 16/2012, paradigm of de-universalization. The Spanish National Health Service was not normatively endowed with universal scope. It was not until the promulgation of General Law of Public Health 33/2011, that in its sixth additional provision was decreed the extension "*of the right to access to public health care to all Spanish residents in the national territory*" although its development

was pending regulatory[1]. Regarding gratuity, it is often forgotten that the preamble of the General Health Bill states that "*for reasons of economic crisis that need not be stressed, it does not generalize the right to obtain such benefits free of charg*e". This Is something that can be remembered each time a payment is faced, under different formats, at the time of access, dental care, pharmaceuticals, orthoprothesis, etc. And as for "the best quality", even recognizing the achievements of the National Health Systems, it is worth remembering that our system comparatively "fails" in some fields such as childhood obesity, new HIV infections, or smoking prevalence.

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[1] The General Health Bill: …those entitled with the right of healthcare protection and attention, all Spanish people and foreign citizens having their residence in national territory. Art. 1.2


NOVARTIS