LETTERS TO THE EDITOR

Research into purchasing health care: time to face the challenge

SIR—I should like to support the overall thrust of the paper in the December 1996 issue of the Journal,¹ which is to encourage greater priority being given to research on NHS health care purchasing. However, I should like to rectify the impression given in this paper that the national evaluation of GP total purchasing pilot projects (the latest extension of the fundholding concept) will miss the opportunity to compare GP total purchasing with other approaches to purchasing. The study design includes a variety of comparisons depending on the service area in question but includes comparisons between total purchasing projects and populations whose services are purchased by health authorities both with and without the presence of standard fundholding. Since some of the comparison health authorities include locality commissioning schemes within their boundaries, it will be possible, albeit in a limited way, to include these alternative devolved approaches in the reporting of the evaluation.

The evaluation team has endeavoured to incorporate appropriate comparisons, although it is true to say that the NHS Executive's prime interest in commissioning the work was to assess the marginal costs and benefits of total purchasing over standard fundholding. A leaflet describing the study design is available from the King's Fund Policy Institute and a preliminary report, *Total Purchasing: A profile of national pilot projects*, was published by King's Fund Publishing in January 1997 and is available from the Bournemouth English Book Centre (tel 01202 715555).

NICHOLAS MAYS
King's Fund Policy Institute,
11-13 Cavendish Square, London W1M 0AN.

1 De Wildt G, Bhopal R, Lavender M. Research into purchasing health care: time to face the challenge. *J Epidemiol Commun Health* 1996; 50:611-12.

Discounting the future: influence of the economic model

SIR—Unfortunately almost everything Dr West writes about economics seems to be founded on misapprehensions.¹ Perhaps this explains his evident distaste for the theory and its practitioners. Yet economic theory is important. Anyone who wants to contribute to health policy needs to understand it or risks being ignored. Despite this, Dr West manages to reach a conclusion with which I can readily agree. Nevertheless, it is important to point out some of his more glaring misunderstandings.

1. Economics is not "the study of the economy" (I am not even sure what Dr West means by "the economy"), it is more correctly the study of choice under conditions of scarcity. It is axiomatic in economics that there is always scarcity, therefore it might be correctly

described as the study of choice. If I choose A over B, then to me, A is more valuable than B.

2. Economic theory does not apply only to paid employment as West implies. It is certainly easier to model economic activity which involves a universal currency of exchange, just as it is easier to describe the epidemiology of heart disease if all cardiac events corresponding to a single definition are regarded for the purpose of analysis as equivalent. But even if the history of epidemiology is linked to the history of the classification of illness, epidemiology is certainly more than this. Economic models are just as applicable to human activities which do not involve currencies. Indeed a "Robinson Crusoe economy"—a single person, producing what he himself consumes—is the starting point for many of its explanatory models.

3. Economics is considered a "science" because it has a tradition of systematic enquiry, theoretical conjecture, and refutation. Economics, also has a core of theory. In this respect it is quite unlike epidemiology—which is simply an investigative methodology—and rather more like biology (where the core theory is of natural selection). If we reject the core of economic theory, there is little point in using economic analysis to throw light on our decisions, as it is central to the kind of economic analysis which is used in health economics. Of concern is the fact that West uses the results of economic analysis to dispute the theory. This presumes that he is using another method to assess these results, but he fails to explain what this model is. Would it be equally sensible to suggest that because an epidemiological investigation produced a result which was counter-intuitive or which we did not like we should reject epidemiology?

4. Economics is one of a number of social sciences, it would be absurd to suggest (as West does) that one social science provides a "better" description of human activity than another. Different social sciences describe different aspects of human behaviour, just as pathology and epidemiology describe different aspects of disease. Economics, for example, ignores questions of meaning and for economic theory to be normative rather than simply descriptive, requires a number of explicit value judgements.

5. The theoretical basis of economics is individual choice. By definition, what any individual chooses is rational to them. This is called consumer sovereignty. People prefer things differently at different times. This has always been the case, if only because crops are seasonal, because life is uncertain, and because our wants and desires change with time. The discount rate is simply a means of reflecting time preference. The discount rate may be positive, negative or zero. Robinson Crusoe will have to eat during the winter when he cannot grow food, so his discount rate during the summer when food is abundant may even be negative. In other words, one potato in December when he may be starving, may be worth 10 to him now when he has many.

6. A particular discount rate is not part of any economic "creed", although it is assumed (and corroborated by observation) that time has an influence on our choices. There is no requirement that social conditions should be stable (although stability or its absence affects the discount rate). If we conduct economic analysis to evaluate the implications of collective decisions, the discount rate should

simply be a reflection of collective time preferences. If people borrow and lend money in a perfect market, according to economic theory, the real interest rate (that is, the interest rate minus the inflation rate) should reflect an equilibrium. This is the "price" of money in the future: the financial discount rate. If we lived in a world where all goods could be traded in perfect markets, this would be equivalent to the discount rate in any sense.

7. Only a very naive economist would suggest that financial markets are free from distortion. As a result there is a divergence between the financial discount rate and the theoretical "free market" discount rate. Firstly, income from lending (savings) is taxed which skews conditions to favour borrowing, this is offset by higher interest rates. Secondly, interest rates in national banks are set by government and do not reflect market rates. In welfare economics the debate therefore focuses on whether the true social discount rate should be higher or lower than the financial discount rate. Nevertheless, we all use the principle of time preference. If I invest 100 a month for 25 years (ignoring inflation and assuming a 3% real interest rate) I will have a total of £43 000 when I am finished, despite the fact that I only invested a total of £30 000. I will therefore be able to pay for my very "real" house in 25 years, although I could not afford it now. The same applies to paying for "real" doctors, "real" buildings etc.

8. West discusses the human capital model of valuing life at some length. However, he quite erroneously relates this to the principle of time preference. Because the basis of economics is individual choice, the human capital model for valuing life is widely considered to be unsound. All valuations in economics are subjective valuations and economics is always about deriving valuations, never about imposing them. The phrase "... society stands to gain most ..." which West uses, implies an "objective" evaluation of social benefit, this has no place in economics. The value system which informs economics is explicitly subjective—consumer sovereignty. Social benefit in welfare economics is simply the sum of individuals' *subjective* preferences. Contrary to West's perception, individuals value people for a wide variety of reasons, not simply for their income generation. A more theoretically consistent model for evaluation of anything which is not bought and sold (such as health) is that of implicit valuation. This means that we derive the people's own evaluations from their behaviour. If, by their actions or statements, a person clearly puts a higher value on the life of a child than on their own, then, to that person, a child's life is more valuable than their own.

Given all this, how do I arrive at the same conclusion: that we should use a zero discount rate?

Why people prefer "jam today" to "jam tomorrow" is an interesting question. Part of the answer lies with the attitudes to uncertainty. We prefer jam today because tomorrow we may not enjoy it. There is a great deal of economic theory devoted to describing behaviour under conditions of uncertainty.

If I am a smoker, I may or may not benefit from stopping. My decision to stop depends (among other things) on how I weigh up the present disadvantages of stopping against the future possibility that I may benefit. Individuals vary in their assessments of these outcomes. Anything which alters an individual's perception of the risks and benefits