Why People Hate Health Economics – Two Psychological Explanations

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Introduction

Most people dislike the idea of “health economists” having influence on medical decision making and who gets what when it comes to health care. Health economics is often thought of as inhumane, promoting efficiency at the expense of more profound moral values, such as equality and need. The fact that allocations solely based on cost-effectiveness are unlikely to be compatible with public views has been illustrated in experimental studies (1, 2). Moreover, lessons from the Oregon experience on priority setting illuminated that rationing decisions based on health maximization are likely to conflict with the view of the general public. For an economist this can be hard to understand, why is not the quest to maximize the value for money something that strikes a chord with the general public? Here we will outline two fundamental psychological mechanisms that will help to explain why people hate health economics.

The two psychological mechanisms – taboo-tradeoffs and compassion fade – are emotional phenomena that bias decision-making. These biases are of amplified by the fact that health is of special moral importance to most people. Not only our own health, but other people’s health as well. Moreover, decisions on how to allocate scarce resources in health care also ultimately lead to policies that carry life and death consequences. Thus, health care rationing elicits strong emotions making it an area of decision-making where emotion and reason often diverge. We will argue that health economics at large has been oblivious to the core aspects of human nature outlined in this paper, and this has limited the use of health economics as a productive input in health policy.
Sacred values and taboo-tradeoffs

A major area of research within psychology evolves around trade-off thinking. It is well known that actively pitting costs and benefits against each other when making a decision is one of the most mentally depleting tasks there is. Most people therefore commonly use heuristics (i.e. rule of thumbs) to avoid engaging in mentally burdensome trade-off thinking. Thereby looking only at one relevant dimension involved in a decision problem, e.g. only price or benefit but not both. Making trade-offs with regards to health is arguably even more mentally depleting since health is by many considered to be of special moral relevance to us. Health is what could be labeled as a *sacred value* (3, 4). Sacred values are those that people are knowingly reluctant to trade off no matter what the benefits of doing so may be. For example, people may be unwilling to let a patient die, even if it means saving many others individuals. From the view of economics, sacred values are biases when they prevent society from maximizing overall welfare.

A decision about whether or not to publicly fund treatment for a particular disease involves a trade-off between better health (for some) on the one hand and less consumption (for the healthy) on the other hand. While health is a sacred value, any form of consumption is what people intuitively think of as a "vulgar value". Many studies have pointed out that people seek to avoid situations where they have to make such *taboo trade-offs* (See e.g. (3, 4)). Moreover, merely knowing about trade-offs between sacred and vulgar values is psychologically disturbing to many people. Why? People are unwilling to place a monetary value on health and life because it undermines their self-image as moral individuals. Many feel that moral dilemmas such as choosing one life over another is a difficult decision, but trading material wealth against health feels impossible and even morally appalling.
The aim of health economic evaluations is to provide decision makers with information for them to maximize value for money. However, a fundamental part of health economics is also to make trade-offs between health and other values explicit – to uncover taboo tradeoffs. A cost-effectiveness ratio is no more than a price tag for increasing health in society – pitting a sacred value against vulgar values. This we would argue is a major reason for why health economics often is frowned upon as a morally disgraceful. It is also a major reason for why it is so hard to engage in open priority setting, because choices involving sacred values are often driven more about how the sacred entity (i.e. health) should be treated rather than by the consequences.

The unwillingness to acknowledge and discuss inevitable taboo tradeoffs within health care is also very much prevalent in the ethical discussion about justice and equity, which has focused on access to health care and on defending a general moral right to health care. Largely neglecting the existence of cost and scarce resources. As Williams (5) writes

There is a regrettable tendency for equity arguments to be conducted within a rhetorical framework in which it appears to be possible to “do good” at no opportunity cost whatever. It generates a great deal of righteous self-satisfaction for the romantic escapists, and it puts economists back in the role of the dismal scientists always stressing the sacrifices, but it does not help the hard-pressed decision-makers who grapple with the issues in real life every day.

A fundamental premise of economics is that of opportunity cost (6, 7). Using resources for one thing is always done at the expense of using those resources for something else. When thinking about opportunity cost in terms of money spend on consumer goods it is fairly straightforward
to assess what would be the next best use of money spend. Evaluating opportunity costs requires the decision maker to actively generate alternatives that are not explicitly provided. When alternative choices are not explicitly represented they are often ignored or underweighted (8-10). In health care priority setting such opportunity cost neglect is especially likely to be present among physicians making rationing decisions at the bedside. The resources spend on prioritized patients or treatments are often not made explicit at the point of decision. Further the alternative uses of resources are often abstract in concept. At the policy level opportunity cost neglect is likely to be less prevalent compared to at the bedside. Herein lies part of the psychological explanation for why people hate health economics, i.e. the disconnect for how people think and make decisions about the individual versus how people think and make decisions about aggregated groups.

Compassion fade and aggregation

"If I look at the mass I will never act. If I look at the one, I will." Mother Teresa

“One death is a tragedy; one million is a statistic.” Joseph Stalin

The above quotes, by Mother Teresa and Joseph Stalin captures an essential aspect about the human psyche. They also give us a clue for why public views often are incompatible with the logics of economic thinking when it comes to health care rationing. A fundamental assumption within health economics is that more is better than less. Saving two lives is better that saving 1 life; Gaining 10 Quality Adjusted Lifeyears (QALYs) is better than gaining 9 QALYs. What should be guiding when setting priorities according to the rationale of health economics are the aggregate consequences. Although most people agree with this general idea when contemplating about it on an abstract level (11), a different story emerges when looking at real behavior. Numerous studies have shown that as the number of people in need increases, the
degree of compassion people feel for them ironically tends to decrease (12, 13). This phenomenon has been termed the compassion fade (14). This happens because emotions are not triggered by aggregates. “Statistical victims” at the aggregate level fail to spark emotion and compassion, while many feel strong compassion towards the single victim whose needy plight comes to their attention.

The issues of “statistical victims” and compassion collapse could not be more central than it is to debates of health care rationing. Where health economic considerations and policy decisions typically concern statistical patients at the aggregate level while public debate and ethical discussions typically evolve around individual cases. Dual-process models of thinking in social cognition commonly identify two distinct modes of thinking, sometimes referred to as System 1 (intuitive thinking) and System 2 (analytical thinking) (15, 16). The effect to feel stronger for identifiable single patients seems to result from these divergent modes of thinking, where groups of patients and aggregate information are less able to invoke the affective system.

Emotions are typically viewed as something positive and the lack of emotions could be de-humanizing and eroding of moral motivations and compassion for others. However, research exploring the effect of emotions on decision making has exposed some limitations in dealing with quantities that is important to acknowledge. For example, Hsee & Rottenstreich (17) found that participants were willing to pay similar amounts to save one vs. four pandas. Importantly, Hsee and Rottenstreich (17) found that this insensitivity was stronger when the good to be valued is processed affectively: When people focus on their emotions, they become scope insensitive. In the context of health care, Wiss et al (18) found that as many as 33 % chose not to maximize benefits in a situation where they could give potentially lifesaving vaccine to either one or five children (for the same cost). For an economist, all these findings are very perplexing.
But what are the implications of these findings for health policy? First of all it is very evident that the process mode for making decisions about health care priorities at a policy level is fundamentally different compared to the same kind of decisions at a bedside level. Policy decisions focus on the aggregate and is driven by System 2 analysis. Bedside decisions focus on the individual and are driven by System 1 emotions. The effect to feel stronger for identifiable single patients result from these divergent modes of thinking, where groups of patients and aggregate information are less able to invoke the affective system.

Thus, although cost-effectiveness might seem like a sensible approach at the policy level it is likely not to be in accordance with preferences at the bedside level or when the context invokes more emotions. At the bedside level many feel that equity requires priority to the most urgent patients – they are viewed to be in the greatest need, and healthcare patients at the bedside level are therefore often prioritized in terms of need. Health economics as a tool for priority setting is very much blind for the needs of the individual since it has an impersonal focus which gives little or no concern for individual needs unless it affects the well-being of society as whole. The aggregated or community oriented scope of health economics is in sharp contrast to the scope of traditional medical ethics, which has a long tradition of focusing on protecting the rights and needs of the individual. This difference in scope between traditional medical ethics and health economics is seldom explicated in health policy. This difference is scope is also echoed in the public debate and media coverage on health care priority setting. For health policy, this hinders an informed public discussion regarding health care priority setting.

**Conclusion**

Health economics (for better or worse) is blind for the emotions triggered by the necessary
tradeoffs in health care decision making. Any plan for how to distribute healthcare resources must take human nature into account if it is to be acceptable to society and it is time for health economists to realize this. Sadly, many critics of health economics continue to bring forward arguments that say that it is wrong to put a monetary value on people’s lives or health states. For health economics, it is therefore important to acknowledge that the decisions involved in health care priority setting are difficult and carry profound consequences. But refusing to think about the cost and benefits involved will lead to even worse consequences. It is not possible to get away from the difficult choices involved in health care rationing. It is the role of the health economists to provide coherent and transparent input so that decision makers can justify their decisions. It is not the role of health economists to make moral judgments but to facilitate the process of making them. However, health economists can increase acceptance for health economics by understanding the taboo-tradeoffs and compassion fade and how it affects the views of people when it comes to health care priority setting.

References


