

## Maynard the Globe Trotter

**Jane Hall**

*Jane Hall is Professor of Health Economics and Director of Strategy at the Centre for Health Economics Research and Evaluation (CHERE), University of Technology, Sydney. She was the founding Director of CHERE.*

Alan is a frequent guest speaker in different parts of the world. However his hosts, be they policy makers, clinicians or health service managers, are seldom soothed by congratulations on their latest reform attempts or offered the latest panacea from the National Health Service in England. Rather, they are challenged to specify their objectives and to support their strategies with data and evidence. Alan was always particularly annoyed at reorganisation that passed as reform – successive “re-disorganisation” as he termed it – which consumed scarce resources in terms of funds and labour.

A systematic approach to international comparative health policy became possible with the advent of national health accounts. The collection, classification and publication of health care expenditure data was not implemented until the 1970s. Once introduced, this allowed for valid comparisons

of healthcare costs weighed against what was achieved in terms of life expectancy. It was soon demonstrated that higher health spending was not an assured path to improving health outcomes, at least as reflected by longevity. Developments in the range of data collected, the number of countries using the same systems of classification, and econometric techniques for analysis have led to increasingly sophisticated forms of international comparison, but also more opportunities for drawing misleading conclusions. A great deal of effort has been directed towards determining the ranking of nations' performance. And a common international belief has been that increasing funding and reorganising governance and delivery systems will solve the problems. But one of Alan's insights in the international policy arena was that the performance of health systems across the world is actually very similar, *despite* great differences in history, culture and the public-private mix of funding and provision.

All countries are facing challenges with increasing cost pressures, reducing unwarranted variations in practice, improving the provision of effective treatment, generally increasing technical efficiency, and above all, ensuring value for money. This has given a focus to international comparisons based on reform within the system, or within particular parts of it. The publication of Alan's edited volume on the public-private mix for health is an eminent example of this endeavour, digging beneath and around the data to understand the context, but not replacing facts by anecdote or opinion.<sup>1</sup> "Management by measurement" is the Maynard approach. Alan has always emphasised that the patient should be at the centre of why we are trying to manage healthcare better. For many years he has been a staunch advocate of patient relevant outcomes, seeing them

as the most important indicator of success of healthcare. Now PROMS – Patient Reported Outcome Measures – and PREMS – Patient Reported Experience Measures – are increasingly routinely collected, reported and used in healthcare systems worldwide.

A recurring theme in many of Alan’s writings over the years is the importance of getting the incentives right. For too long the debate addressed the contrast between fixed budget or capitation approaches versus payment for activity/fee for service approaches. The evidence that fixed budgets encourage risk selection and skimping on activity, while paying for the volume of services delivered leads to higher levels of activity, has been clear for decades. And neither approach provides positive incentives for quality improvement. Over recent years, more interesting experiments have emerged in many countries, using blended payments to ameliorate the perverse incentives of any single payment mechanism. Early attempts were often quite blunt and tended to have little effect as the incentives were poorly designed and the rewards too small; or they were extremely costly and often over-rewarded existing practice. Careful attention to the design of payment schemes with clear identification of the objectives and rigorous evaluation with an eye open to unintended effects, remain as important as ever. Alan has set the precedent for health economists in this regard.

Health reform is often beset by ideology passing as reform and self-interest passing as principles. Alan and I published a piece in 2005, analysing the Australian conservative government reforms that expanded the reach of the private insurance sector, with significant public subsidies, in the face

of an electorally popular, publicly funded comprehensive set of entitlements under Medicare.<sup>2</sup> The proposed benefits of relieving pressure on public hospitals, providing the public with more choice of provider, and reducing private insurance premiums remained illusory; yet the politics were successful. This represents another of Alan's contributions to international health policy and reform – the recognition of the power of ideology in shaping how problems are conceptualised and solutions are developed. Different ideologies are more or less prevalent in different countries, but in all there is a rivalry at the heart of the system as private providers seek to protect and advance their interests.

In his book, *The Public-Private Mix for Health*, published in 2005, Alan could conclude that the challenges of health care reform, although better articulated over the previous twenty years, remained largely unmet. “The characteristic of health care”, he wrote, “is its resistance to change.” A few years later writing in the *Oxford Handbook*, he noted various successes of health economics in making inroads to system reform.<sup>3</sup> First, health technology assessment has become commonplace through the role of the National Institute for Health and Care Excellence (NICE) in the UK, the Pharmaceutical Benefits Advisory and the Medical Services Advisory Committees in Australia and in a number of other countries. Second, the development of routine patient reported measures, PROMS and PREMs, as noted already, has become common in many countries. Third, there is wider adoption of incentive compatible payment systems, whether it is activity based funding for hospitals, or blended payment methods for providers. A further addition I will make is the end of the widespread belief that the problems of health care worldwide can only be solved by

increased funding. However, that seems to be due more to the exigencies imposed by the Global Financial Crisis of 2007 – 08, than the proselytizing of health economists.

Now, more than ever, we must have clarity around the goals of efficiency, equity and expenditure control. Reform should be evidence based, cautious in implementation and subject to rigorous evaluation. These are challenges that Alan has always posed to the politicians involved in successive “re-organisations” of healthcare systems; but they also set the agenda for us as health economists wishing to make the same contribution to the international policy debate as Alan has done for many years.

## References

1. Maynard A (ed). *The Public-Private Mix for Health*. 2005. The Nuffield Trust.
2. Hall J. and Maynard A. Healthcare lessons from Australia: what can Michael Howard learn from John Howard? *British Medical Journal* 2005, 330–357.
3. Maynard A. Bloor K. Health economics and policy: the challenges of proselytizing, in Glied S. and Smith PC. (ed). *The Oxford Handbook of Health Economics*. 2011.