

BIAC Discussion Paper
Economics of Prevention

Healthcare costs have been rising for decades at higher rates than GDP growth. They are expected to continue to do so mainly due to life style changes, increased life expectancy, and advances in health care. On the one hand, they pose an increasing burden for public, individual and company resources. On the other hand, the growing health market and investments in innovation have significant potential to improve quality of life which in turn benefits the overall economy.

Accordingly, it is necessary to foster stable health care systems for the future by increasing the efficiency of research and the speed at which innovation is of use to society and to use new models of health promotion and disease prevention to finance innovation in health care. For this, competition among health insurers and service providers, both in terms of cost and quality, needs to be encouraged so that, similar to health care providers, they have incentives to develop the best models for health promotion and disease prevention and to offer them at best prices. It is important to search for efficiency gains at every stage of the health care chain and between its different steps.

In this context, there have been calls for a more prominent role for disease prevention and health promotion, which now only accounts for a small fraction of health expenditures, some 3% according to OECD. Within the limited funds available for health care, special attention should be given to the added benefits to be gained from the economics of prevention and preventive healthcare.

Population-based prevention benefits individuals. Yet, the efficiency and cost effectiveness of possible approaches require further analysis as OECD studies on prevention report mixed results and call for further research and exchange of experiences. The following questions require answers: What types of prevention are or are not cost effective, with what expenditure levels (health care system, government budget, employers, individuals) paying for the cost, and in what settings should prevention be considered.

There are various health care risks, diseases and environments effectively addressed by prevention. Prevention includes a wide-range of approaches, for example: smoking cessation,

screening tests for mammography or colorectal screening, vaccinations, workplace safety, sanitation, hand washing, weight reduction, and eating healthy. Education (lifelong learning) has an important role to play in this area. The “what, where, when and how” of prevention varies greatly among different approaches. For example, workplace safety is an area of shared responsibility above all of employers and employees but also government. Other areas, such as smoking involve efforts to change personal behaviour with differing interference into personal freedom. Moreover, prevention needs to deal with emerging health problems, such as obesity, the lack of physical activity and an unhealthy diet – sometimes labelled as an epidemic – that penetrate all segments of the population and threaten the sustainability of health care systems. In these areas, responsibility for prevention lies primarily with the individual.

There is an economic rationale for employers and all aspects of society for prevention. It is generally recognized that healthy employees are key to supporting economic growth and prosperity. A healthy workforce fosters increased labour productivity, can lead to a better labour share in enterprise income (LIQ), and reduces short and long-term absenteeism. This in turn favours profitability of enterprises and thus provides the economic reasoning for higher wages. More generally, healthier employees have a better employability and hence are better prepared to meet the challenges and changes of modern society and economic globalisation. Finally, with people being healthier until a much older age, prevention – as part of the general health system – provides a strong argument for later retirement. This in turn will provide society the return on its considerable investments in health care in general and prevention in particular. In sum, prevention as part of health care can contribute to a virtuous circle, beneficial for all: the individual, the company and society in general.

The workplace plays a central role at certain times in the lives of citizens. Hence, it presents unique prevention opportunities. This does not imply that the conditions which this prevention seeks to address should be characterized as caused by the job. For example, the concept 'occupational diseases' regularly prompts debate as it implies a workplace cause. While this may be appropriate for classic monocausal complaints with clear cause and effect, it is different with more recent health threats, the source of which primarily lie outside the workplace, and might involve aggravating workplace factors interacting with personal vulnerabilities. A direct causal link between a health threat and the workplace is, furthermore, a precondition for burdening employers with further responsibilities. The responsibility for individual or social health threats should not be externalised to employers. Guidelines then are increasingly important as they are based on scientific evidence regarding the nature and level of the aggravating health factors. Notably lifestyle related health risks require that the individual should be the primary target for prevention activities.

In general, government intervention should only take place in cases of market failure, and then focus on first best solutions, compensating market failure as close to its cause as possible. In the case of lifestyle choices, this normally means that, once information about the health risk is provided for, incentives should target the individual. Changes of individual behaviour often will lead to changes at the aggregate level, as demonstrated by experience with food producers adjusting their product lines to a shifting demand towards healthy food. Summing up, any preventive intervention should be measured according to its cost efficiency, effectiveness and least possible interference on personal choices, such as lifestyle. The necessary analysis should look at what institution carries the financial burden of a measure and take into account the effects of further burdening companies with mandatory preventive measures for their competitiveness.

Finally, prevention should not be considered in isolation, but in the context of the health care chain, starting with health promotion and disease prevention, and leading to treatment, cure and care. If the OECD continues work on the economics of prevention, prevention should be broadly defined, including, for example, all aspects of health promotion and disease prevention, such as education programmes, (preventative) surgeries and (preventative) treatments, as well as incentives through health insurance premiums for people to take responsibility for their own well-being.

Such studies should address the following questions and issues:

- i) Develop a better understanding of the welfare economics of preventive interventions into people's lifestyles, and examine the market failures that are likely to be involved in diet and exercise;
- ii) Study the evidence and learn from interventions which seek to discourage unhealthy lifestyle choices, such as smoking, inappropriate use of alcohol and other drugs, and to reduce (local, regional, national or international) health inequalities. Analyse and compare the cost efficiency of such measures, especially the danger of duplicating prevention and curative interventions. The results of relevant work undertaken by the European Commission as well as the U.S. and several U.S. states and other countries should be shared with the OECD;
- iii) Share experiences with different types of best practices and approaches and identify obstacles to adopting preventative approaches within the health care sector and/or within the social security area;
- iv) Develop a better system of evidence-based prevention. 'Red tape' and administrative burdens must be eliminated and the economic value of prevention must be demonstrated in the earliest stage possible;

v) Study the use of ICT to foster the efficiency and effectiveness health care interventions delivered in the area of prevention; and

vi) Study ways to increase the attractiveness of prevention for private investors and private companies. This should include not only providers of goods or services, but also (health) insurers. Increasing investment in prevention should not only come from the public sector but can be boosted by private investors.

An OECD Labour/Management Programme (LMP) meeting would offer an opportunity for an in-depth discussion with OECD and member governments on key topics of their programme of work. Should prevention be chosen as the topic for an LMP meeting at the beginning of 2008, the scope must be as broad as possible, based on the fact that we are living in aging societies, and everybody's participation is necessary in order to uphold our standard of welfare and well-being. It is critical that employers not be compelled to pay individually or collectively for ever enlarged preventive activities beyond the traditional workplace related diseases. Additional preventive measures, which are often beneficial for workers, employers and society, should be promoted on a voluntary basis and should allow employers to differentiate themselves from competitors.