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SOCIAL COSTS RELATED TO POLICY DECISIONS IN HEALTH CARE

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Abstract: *The aim of this study is to discuss how social costs in health social policies can be evaluated. Which are implications of health policy decisions, embodied in what I have called the social costs of these decisions? Among the social costs that we can intuitively detect are poor indicators of health status and poor indicators of health system, poor indicators in equal distribution of services. Are these enough indicators to measure social costs in health social policies? Economical definitions of social costs refer a cost to society because of an action or a policy change, referring to negative externalities. How health policy decisions generate social costs?*

Keywords: *social costs, social policy, health care, negative externalities.*

What social costs in health are?

Economical definitions of term refer to social cost as a cost to society as a result of an action or a policy change. It includes negative externalities (Glossary of International Economics, 2014), i.e. those negative consequences, the cost being borne by society.

Nash C. A. talks about a social cost for alternatives to action in relation to social policy outcomes (Nash C. A., in Pearce W. D., 2013, p. 8-30). According to him, social cost measurement theory has been at the center of controversies over the last decades, and debates have focused on the divergence of social / private costs and implications for the role of the state in a market economy, but also on the principles on which social cost measurement are based.

The difference between private and social costs implies, according to Nash (apud Pearce, 2013), accepts that individuals will ignore certain costs for society in their decisions, in order to make profit or seek their own utility. State intervention is therefore needed to limit these costs. One of the means can be the use of taxes and subsidies, but also other types of policies. However, in order to impose such taxes it is necessary to measure the social costs. The author wonders if the use of cost-benefit analysis is enough to measure them.

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Debates on negative externalities have gradually emerged, along with the economic growth in the past decades and the need for the state's involvement in reducing them. With the development of the welfare state, a consensus has been built in Europe that the excesses (or externalities) of the market economy must be reduced and provide citizens a certain degree of security, a vision based on the assumption that the state has resources to provide social services and centralized and affordable health services, because of the high price these services would have on the free market, and because the state has a vision of areas where it must act through health policy to improve health indicators.

Regulating demand and supply in health care

These issues cannot be left to be regulated only by demand and supply in the private market. Also, in Europe, there was a consensus that health should not be to a certain degree an object of consumption like any other for which to pay directly from your pocket, for a few reasons:

1. Health should not be a luxury. In the absence of insurers, the pocket payment of the care, request at the time of the purchase of the service may result in the consumer being unable to pay and health becomes a luxury.
2. There is an unpredictability of needs and costs in health care. The unpredictability of the needs makes it difficult to plan the costs. A young man should in principle have low needs, but the need for healthcare may arise. On the other hand, life in the 21st century implies certain risks to be ensured: traffic accidents, accidents at work etc.
3. Costs for treating a serious illness outweigh the savings of an average grade family if these costs should be paid out of the pocket.
4. There is a lack of knowledge about the services that should be purchased. Unlike buying a current consumer good, people have little knowledge of what they buy when health services are needed. There is an asymmetry of information between the buyer and the vendor. Even when they have the choice, patients choose between what the doctor proposes as variants. The request is therefore directed by the physician, not by the consumer. (Bodenheimer S.T., Grumbach K, 2009)

Health care has therefore been classified as a good for which the state has to intervene. Also in this category of intervention are all goods considered collective and social. Collective goods respond to two characteristics: the lack of exclusivity of supply and the absence of rivalry in terms of consumption. Among the collective assets, the epidemiological status of the population, the quality of the environment can be mentioned etc.

Collective assets resulting from the activity of an economic agent may be positive (eg, vaccination of children) or negative (environmental pollution, with health effects). The government can resort to taxes, subsidies, regulations to favour or limit these phenomena. Taxes on tobacco, alcohol, unhealthy food, junk food are examples of taxes passed by some governments to discourage the consumption of such products. This fee is normally intended to finance government health programs. On the other

hand, contemporary public issues are sometimes generated by conflicts between private and public interests. In the field of health, there can be conflicts between the interests of pharmaceutical industries and the fight against pandemics through vaccination, for example.

State intervention through social policies to limit market effects is therefore necessary for several reasons related to distortions and limits of the market economy as Zamfir Cătălin mentions (Zamfir C., Zamfir E., 1995):

In terms of demand, there are distortions in the sphere of production and consumption:

- Demand in the market is shaped by the consumption needs of the population. Thus, consumption is characterized by two features: rivalry (the fact that someone consumes a product excludes another person from having it), and exclusivity (those who cannot pay for that product do not have access to the product). Regulated only by the market, access to medicines and medical services would be limiting for the population.
- There are cost / benefit distortions. These are social costs that the collectivity pays. Market calculation (profit growth) does not take into account social costs and consequences for the community. The effects of health pollution or the effect of the use of food additives and preservatives on health are such an example. The economic profit of a group may have a bad effect on the health of a large community. State intervention is necessary in regulating rules to reduce / limit these effects, which can be considered as social costs.
- There are monopoly distortions. Monopoly leads to high prices, making inaccessible some socially important products. Therefore, the state intervenes to make some monopolistic services and products available.

There are health systems in which the market plays a leading role. This is primarily about demand and supply of medicines. Manufacturers of medicines, sanitary supplies and appliances are private entities. State intervention to reduce market effects is by compensating or fully covering the price of medicines for certain categories of patients. The monopoly of some pharmaceutical manufacturers, in the case of some products, vaccines, increases the costs that the healthcare system must compensate or cover, with direct consequences on other costs in the system (and in the context of ongoing growth of costs with health care).

There are therefore products and services that are not optimally produced by market mechanisms:

- Social / public goods. While responding to individual needs, the consumption of social goods is collective.
- Desirable social goods. Social benefits tend to be sub-optimal. There are goods that have significant positive effects but will not appear on the market in the form of individual requirements. Preventive health care, for example. The long-term needs seem remote for the individual and he is not motivated to pay now. The young and

healthy individuals will be tempted to postpone the payment of health insurance because they believe that they shall not benefit from health services in the near future. For these reasons, the state has introduced compulsory health insurance for all employees. Another example is the obligation to vaccinate in order to prevent epidemics.

- Undesirable social goods. Goods consumed by individuals with negative social effects and which the state wants to discourage. For example, discouraging alcohol consumption. Alcohol consumption has adverse effects not only on the individual but also on the social, through the potential of delinquency included.
- Goods with social costs that tend to be overproduced. Such an example is environmental pollution, with health effects. (Zamfir C., Zamfir E., 1995).

Social costs deriving from economics may be economic or non-economic: for example, the degradation of the health of the community through the action of a number of factors: pollution, inadequate lifestyle leads to non-economic social costs: physical degradation of the population Consequences on the community with direct economic costs are: increased cost of health care and social protection (early retirement, sick leave, etc.) and a less-fit labour force.

The unequal distribution of resources, with large gaps between individuals, leads to social inequalities. Limitations on individual income earning capacity, inequalities related to structural social factors that do not belong to the individual lead to the need that the state intervene in correcting these inequities. On the other hand, there is an imbalance between needs and access to resources, an imbalance that needs to be corrected through policies. The child and the elderly are, for example, health care consumers who need to be protected. The child needs protection to ensure a healthy adult (curative and preventive medicine) and social emotionality is high related to the sick child. The old man is an important consumer of resources compared to the young man. Its needs are higher than its resources and must therefore be protected. Other vulnerable groups that may be exposed to imbalances in the supply of healthcare goods and services are geographically isolated people, or with difficult access to physicians, people with disabilities or various disabilities and inconvenient medical problems, families with many children, poor families, families with the unemployed persons, low-income employees.

Technological progress have not produced improved health at the level of expectations

Michel Foucault mentioned that we are witnessing a medical crisis that can be formulated in the following terms: technological progress and new social and economic functioning of medicine have not produced improved health at the level of expectations.

There are some aspects of the current crisis as he stated (Foucault, 2003):

– the difference between the science of medicine and the positivity of the effects (efficacy of medicine)

Medicine also has the capacity to kill. Until the recent age the negative effects were ignored. The degree of harm is directly proportional to its degree of ignorance. The tools available to medicine also cause uncontrolled effects. Anti-infectious treatment, antibiotics have led to a decrease in the sensitivity threshold of the body to aggressive agents, there is a disruption of the ecosystem.

There are some changes in 20th century, according to Michel Foucault:

- The emergence of a medical authority that is not just an authority of knowledge, of erudition, is a social authority that can make decisions with a social impact. It is a representation of the manifestation of state medicine.
- The emergence of a distinct disease prevention intervention fields: air, water, food, sewerage, construction, transportation, etc.
- Introduction of a collective medical unit in the form of hospital. Prior to the eighteenth century, the hospital was not a medical institution, but the assistance of the poor in anticipation of death.
- Introduction of the medical management and impact assessment systems of the medical system: data registers, statistics.

Modern medicine is related to some economic aspects. Today, health generates money in the market economy as long as it is a desire for a part of the population to ensure health and a luxurious living for others. Health is an object of consumption, which can be produced in pharmaceutical laboratories, consumed by actual or potential sick individuals and thus entering the market. (Foucault, 2003).

The human body enters the market twice: when it offers its labor force and then it consumes health. At this point, health system dysfunctions also occur. The introduction of the body into health consumption did not proportionally raise the level of health as hoped. It has been noticed that environmental variables, food consumption, education, income are related more to rate of mortality than drug consumption. (Foucault, 2003).

It sounds cynical, but market economy and power structures work in health, and once marketed in health, the issue of social equity, morality has lost ground. The most eloquent case is that of pharmaceutical companies and pharmaceutical distributors for whom very thing means maximizing profits, driving campaigns to promote products to patients and physicians, or even "corrupting" physicians in the system through incentives such as the payment of congresses or these all generate social costs. Moreover, decisions on social policy in health are politically determined, as well as the appointment of leadership from major health units: large urban hospitals, county public health departments, etc.

Health care as part of a historical complex, linked to power

Medicine is therefore part of a historical complex, linked to power. According to the social conflict theory (Radulescu, 2002), the medical system is seen as an institution of

domination and power, the product of tensions and disagreements between groups with different interests, and individuals belonging to the underprivileged minority are sicker than others because they have less access to medical services and other welfare resources: housing, work, etc. Thus, the social system gets to work better in favour of privileged groups.

Health institutions, pharmacies and doctors are dominated by two contradictory motivations: their own financial or other interest, the deduction of expenses and the health insurance.

The various types of financing of sub-parts of the health system generate different "perverse" behaviors, with financial implications:

- payment per capita - adverse effect: attempt to increase the number of patients treated in the unit, not accent on the quality of the medical act,
- DRG (diagnosis related groups) - adverse effect: treatment of certain types of patients
- practice of informal payments-adverse effect: selecting a larger number of patients with prosperous material on their own list.

Some physicians hide the conflict of interest: they are shareholders or work at clinics, private labs, to whom they send patients from the public system.

Another issue that arises is: who benefits from the social funding of health care? The answer is after Foucault, (Foucault, 2003) the big pharmaceutical companies. Therefore, the pharmaceutical industry is supported by collective health financing, through social security institutions (state systems reimburses / finances drug costs) and doctors become intermediaries between demand and supply.

Another issue related to social morality is that insurance systems have failed to reduce the barrier between the rich and the poor in terms of the health inequality of health services as expected. Rich people continue to use health services more than poor and have better access to services in most countries. Therefore, the level of medical consumption expected from social security remains a desideratum.

The state healthcare sector remains the one that bears the high cost: difficult interventions, expensive diseases such as cancer, HIV etc. The private sector, opposed to the public health sector, remains profitable because it does the admissions for less serious reasons, those that require high expenses, very expensive appliances are rather uncovered by the private sector and transferred to the public sector, which is supported by the social financing.

Talking about evaluation of social costs, Mooney (Mooney G. in Pearce W. D., 2013, p. 120-140) refers to attempts to evaluate elements of human life or suffering. Saved lives or increased life expectancy and quality of life involved are very different outputs in a dialysis project, for example, what it would mean in an advertising project on child traffic safety. Despite this, consistency in terms of opportunity costs is needed in all policies that concern life-saving policies. On the other hand, outputs can be defined in

different ways. For example, improving roads can save lives, reduce the risk of death or reduce driving anxiety. An advocacy campaign that increases the level of risk perception of crossing the street by the elderly has a beneficial effect because it saves lives but it can at the same time increase the anxiety level for elderly pedestrians.

All these topics are related to the appropriate social welfare function. There are various such functions that emerge as policy objectives change. Health system outputs are usually composed of increased life expectancy, decreasing rates of morbidity, increased comfort, mobility. In most cases, the patient only has little knowledge of his or her state of illness, or of the future state of health without or with treatment. Part of the output of the health system is information. But how can the consumer rationally play value on health care? For example, a woman going to a clinic for a screening about the possible detection of a cervical cancer is dependent on medical advice as well as on the effects of screeching. So, to what extent should consumer sovereignty be applied to health services?

There are several types of cost benefit analysis and the choice between methods is finally an ethical one. Even if the individual is the best judge of utility, he may nevertheless not make the required judgments. In health care, some treatments are very complex, some therapies, with side effects.

According to Stephen Gillian (Gillian S. et al., 2012, p. 119), the cost-effectiveness assessment should take into account that value in money is not the only cost, and saving lives is not the only benefit. Costs and benefits need to be accurately measured and compared between different interventions and outcomes. How do we determine if 10 lei spent for the program to improve the treatment of cardiovascular diseases are more efficient than the 10 lei spent on cancer treatment? Economic assessments help in making decisions by considering the results of interventions that are in competition with the resources they consume. The relevant results have to be defined, the measured costs. The economic assessment can be defined as a comparative analysis of the alternatives for action in terms of costs and consequences. Costs are generally of two types: direct (associated with activity, eg ten-minute cost of a family doctor, cost of recipe) and indirect (more difficult to measure, may include eg office maintenance costs where doctor works). The opportunity costs are the amount lost by not using the resource (labor, capital) in the best alternative to use.

Conclusions

Health of human capital is important for economic and social development of a nation, and the relationship between the two indicators is closely related. On the one hand, human capital in poor health condition negatively affects economic development by reducing work capacity and driving to high costs of providing public health services. On the other hand, economic development increases the standard of living of the population, the impact on human health and the resources available for investment in health care. We could say that there is a vicious circle between health status and health resources available in investing in health for poor countries. The circle could be broken by an additional effort of resources in the health system and considering long-term health policy as a priority.

The challenge for states is to find paths for reducing negative impact of social policies or lack of policies in terms of social costs and find an optimal ratio between responding to health needs and organizational and financial constraints. The health systems are complex administrative ones, with a low degree of flexibility and resistance to change and a great resource consumer. It is difficult to find an optimal health system structure. Each system has advantages and disadvantages, but a qualitative threshold for service delivery must be established.

Analyzes on the social equity of health policies are centered on fiscal, administrative and benefit policies. There are some types of theories explaining the programs, among which the most popular:

1. Political culture theory (explains policy preferences to certain health services, how health and causes of illness are defined), public policy skills to respond to health improvement, and possible solutions to the problem.
2. Structuralist theories: explores the political power of organizations to ensure policy changes. Political coalitions explain programmatic changes. The analysis of the groups participating in these coalitions explains a type of egalitarian policy.

The question arises how public affairs issues and the influence of the public agenda are manifested by collective consciousness. Are actual problems different from the issues reflected in collective consciousness? Zamfir C. talks about the cyclicity of social problems. See the crisis caused by a problem that erupts in the media, pointing to the deficiencies of the health care system. The analyzed social problem has a peak, and then it falls into disgrace in terms of media coverage. The problem persists, but is only socially cyclically aware through the media, and it is cyclically restored to the attention of the community. Are social policy measures influenced by these eruptions at the level of collective consciousness? Would these eruptions open an opportunity window?

Citizens expect governors to make informed decisions that these decisions are the result of a vision. Making smart decisions means operating in a coherent setting, which often does not happen. Decisions should be taken in a frame. Policies are value-dependent. The mere fact of selecting a fact as a problem is based on some values. Policies usually do not respond to an isolated problem, most often responding to a set of problems. This is what governments choose to do or not to do, in order to minimize social costs. (Cace S, 2004)

On the other hand, governments have at their disposal a wide range of instruments: information campaigns (advertising campaigns), tax, subsidize, regulate, set up agencies to address the issue directly. Although policies change over time, instruments have their inertia. For example, health policy is changing in the sector, but the essential elements: medical units, public spending as a mechanism remain essential, they cannot change. Instruments may be influenced by what is considered legitimate or not. When policy is radically changed, tools can change. Legitimacy is also related to cultural factors. Instruments may also be subject to legal restrictions or international agreements or other forums such as the European Union. Policies must show internal consistency and vertical coherence, ie the actions that flow from politics must be logically coherent, coherent. Horizontal coherence is manifested through consistency between public policy areas.

The lack of adequate treatments leads to long-term disabilities and suffering and the persons can be transformed from social active/employees to socially protected and disabled persons. These are categories that could be highlighted in a study: those who do not recover from accidents or diseases, but would have recovered if treated to the maximum level of medical competence, not accessible to every social group and regional area. The process of transforming these persons into social assistants could be significantly reduced by proper social policies. On the other hand, lack of coherence of prophylactic measures and community and primary health care programs brings indirect social costs, through a series of illnesses, the lack of recovery for people who already have a disability start, or the lack of coherent programs to prevent unwanted pregnancy followed by abandonment of children, entering the social protection system.

By intervening through social policies, we are dealing with a process by which it is decided to assign values to a group. The number of assigned values is lower than the number of existing values, leading to insufficient competition between values and recipients: either the economy does not have sufficient resources, or only some values are considered desirable.

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