From health services economics to health economics: for debate

Sirs,

Liverpool City Council and Health Authorities recently launched their City Health Plan, a five-year strategy to improve health and well-being in Liverpool, building on the foundations of the WHO Healthy Cities initiative. This strategy addresses the following key areas: housing for health, poverty and unemployment and health, health and the environment, health action for children and young people, heart disease, cancer, substance misuse, accidents, mental health and sexual health. As an intersectoral approach to improving the health of the population, the Liverpool City Health Plan furthers the city's heritage in public health established in the city by the United Kingdom's first Medical Officer of Health, William Henry Duncan (Medical Officer of Health for Liverpool 1847-1863). As health economists we have been asked to consider how health economics can contribute to this intersectoral strategy for health.

As we consider each of the key areas in turn, and refer back to the health economics literature to discern what has been done in each area, it is becoming clear that what we know as health economics is in fact health services economics focused on the evaluation of medical technologies. In terms of evaluating non-medical determinants of health, there are large tracts of territory which need examination upon which health economists may neither be focused, nor indeed as yet have the tools to tackle.

As national health strategies such as Health of the nation recognize, the utilization of medical services is only one determinant of health, and probably minor as compared with factors such as socioeconomic class, education, housing and lifestyle. There is therefore a need for health economists to widen their perspective and develop the necessary tools if they are to contribute to improving the nation's health from scarce resources. The Department of Health has acknowledged this need with the recent publication of its document 'Policy appraisal and health' which outlines how public sector agencies can assess the anticipated impact of its policies on health.

However, there remains much work still to be done if health economists are to be able to tackle questions such as 'what are the costs and health outcomes, however measured, of, for example, improving housing, reducing speed limits in built-up areas or providing information on benefits for the unemployed?

Outcome measurement is difficult enough when comparing the outcomes of different clinical interventions, particularly where quality of life measures are used. These difficulties apply equally, if not more so, to the measurement of the health outcomes of public sector spending initiatives, but should not be viewed as insurmountable.

If health economists are to contribute to the debate over the spending of public monies, whether through the National Health Service (NHS), government departments, or local government, an interdisciplinary approach must be taken. This will involve collaboration with colleagues in housing, transport and environmental economics as well as the medical profession and those in the social sciences involved in health impact assessment.

Health economists could have much more to offer, in terms of providing evidence on the cost-effectiveness of different ways to improve the health of the population, if horizons are broadened beyond the evaluation of medical technologies. Our endeavours to date have focused on providing purchasers within the NHS with evidence on the relative cost-effectiveness of health care services. However, if we shift our focus from health services economics to health economics, then purchasing decisions must be viewed within the wider public policy context and reflect the many nonhealth sector determinants of health.

References
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UK Baby Friendly Initiative

Sirs,

Some hospitals in the United Kingdom will see the achievement of full Baby Friendly accreditation
impossible in the short term because the Global Award requires a 75 per cent breastfeeding rate at discharge. In view of this fact, the UK Baby Friendly Initiative has introduced the UK Standard Award for Baby Friendly Hospitals (Appendix). Although the award still requires that all Ten Steps to Successful Breastfeeding are fully implemented, the hospital should have a breastfeeding rate at discharge of at least 50 per cent. This will enable more hospitals to work toward the 'gold standard' of the Global Award and a higher breastfeeding rate.

References


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Appendix

The UK Baby Friendly Initiative – a three-staged approach

In recognition of the fact that many hospitals in the United Kingdom will see the achievement of the global criteria, including a 75 per cent breastfeeding rate at discharge, impossible in the short term, a three-staged approach provides incentive and encouragement for these hospitals to work towards the Global Award.

1. The Global Award for Baby Friendly Hospitals

requires:

1. full implementation of the Ten Steps to Successful Breastfeeding, assessed by a Baby Friendly Hospital assessment team using the global criteria of the Baby Friendly Hospital Initiative;
2. a minimum breastfeeding rate at discharge of 75 per cent.

2. UK Standard Award for the Baby Friendly Hospital Initiative

requires:

1. full implementation of the Ten Steps to Successful Breastfeeding, assessed by a Baby Friendly Hospital assessment team using identical criteria to those used for assessing the Global Award;
2. a minimum breastfeeding rate at discharge of 50 per cent;
3. continued improvements over subsequent years and commitment to strive for a breastfeeding rate at discharge of 75 per cent.

3. Certificate of Commitment

The certificate of commitment recognizes that a health facility is working to bring its practices into line with the Ten Steps to Successful Breastfeeding. It is also a health care facility's statement of commitment to make improvements to the services it provides to mothers and babies. The Certificate will feature the signatures of the Chief Executives of the health facility and the main purchasing body.

A health care facility will be awarded a Certificate of Commitment if it:

1. appraises its practices (the Baby Friendly Initiative's Self-Appraisal Tool can be used);
2. develops a plan and schedule to achieve baby friendly status, including a system of monitoring progress towards baby friendly status;
3. adopts Steps 1, 7 and 10 from the Ten Steps to Successful Breastfeeding;
4. commits itself to show continued improvement and to work towards full assessment within a year;
5. introduces a formal auditing mechanism for recording breastfeeding statistics.

Additional requirements for all hospitals

These requirements aim to ensure continued improvements in standards and to maintain high quality of care and support to mothers and babies:

1. all health care facilities working towards or having been awarded a Baby Friendly Initiative award must keep statistics on their breastfeeding rates (initiation, discharge and at 6–8 weeks) and report them at 12-monthly intervals to the UK Baby Friendly office.
2. All awards will be reassessed one year after the initial assessment. If the reassessment shows that any of the Ten Steps is no longer being fully implemented, the hospital will at this point be required to take steps to bring its practices back into line with the requirements of the Baby Friendly Initiative.
3. A drop in standards could lead to any Baby Friendly Initiative award being reassessed and/or withdrawn at any point.