Key factors that influence government policies and decision making about healthcare priorities: Lessons for the field of eating disorders

Ruth Striegel Weissman

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Key factors that influence government policies and decision making about healthcare priorities: Lessons for the field of eating disorders

Harvey Whiteford, PhD | Ruth Striegel Weissman, PhD

1 School of Public Health, University of Queensland, Queensland, Australia
2 Institute of Health Metrics and Evaluation, University of Washington, Seattle, Washington
3 Department of Psychology, Wesleyan University, Middletown, Connecticut

Abstract
Worldwide, the demand for healthcare exceeds what individuals and governments are able to afford. Priority setting is therefore inevitable, and mental health services have often been given low priority in the decision-making process. Drawing on established economic criteria, and specifically the work of Philip Musgrove, key factors which influence government decision-making about health priorities are reviewed. These factors include the size of the health burden, the availability of cost-effective interventions to reduce the burden, whether private markets can provide the necessary treatment efficiently, whether there are “catastrophic costs” incurred in accessing treatment, whether negative externalities arise from not providing care, and if the “rule of rescue” applies. Beyond setting priorities for resource allocation, governments also become involved where there is a need for regulation to maintain quality in the delivery of healthcare. By providing field-specific examples for each factor, we illustrate how advocates in the eating disorder field may use evidence to inform government policy about resource allocation and regulation in support of individuals with an eating disorder.

KEYWORDS
advocacy, cost-effectiveness, cost of illness, eating disorder, public policy

1 INTRODUCTION

There has been longstanding and vigorous debate about how best to contain healthcare costs and, within this debate, what healthcare governments should provide or subsidize and what should be left to individuals and market forces. Governmental health funding allocations can sometimes be dictated by the need for an urgent response in a politically sensitive area, for example escalating suicide rates among a specific group. However, in the usual deliberative priority setting process, government involvement favors those programs and services deemed most important. Yet the factors that influence this decision-making process are often opaque. This commentary discusses seven factors that have been identified as commonly playing a role in health financing decisions, drawn from the experience of researchers at the World Bank (Beeharry, Whiteford, Chambers, & Baingana, 2002). These factors include the size of the health burden arising from a disease or health condition, the availability of cost-effective treatments, the ability of private markets to efficiently deliver health services for the condition, catastrophic costs associated with treating the condition, negative externalities associated with non-treatment, and the “rule of rescue.” Not all factors are considered each time financing decisions are made, they are not given equal weight, and they can be subsumed by political considerations. For each factor (framed here in the form of questions), consideration is given to how it might apply to eating disorders. We hope that our description of the factors, along with specific eating disorder examples, will be helpful to readers interested in designing strategic science studies or undertaking advocacy efforts to influence health or mental health priorities.

2 WHAT IS THE MAGNITUDE OF THE HEALTH BURDEN?

First, the size of the health burden at the population level is important and usually considered early in the decision-making process. Mental disorders have never been a global health priority, especially when mortality rates were the measure of the burden and showed that infectious diseases, and non-communicable disorders such as cancer and cardiovascular disease, were the biggest causes of premature death.
This changed to some degree with the Global Burden of Disease (GBD) Studies which use a metric, the disability adjusted life year (DALY), that combines premature mortality and years lived with disability. The GBD studies have consistently shown the significant burden caused by disabling disorders that do not have high levels of mortality attributed to them. In the GBD 2015, mental disorders account for 7% of total global DALYs and 21% of total years lived with disability (GBD DALYs & HALE Collaborators, 2016), even more in younger age groups. Mental and substance use disorders as a group are the leading cause of disability globally. The combined burden from anorexia nervosa and bulimia nervosa made eating disorders the 12th leading cause of physical and mental health-related DALYs in females aged 15–19 years in high income countries, and the global burden from eating disorders is growing (Erskine, Whiteford, & Pike, 2016).

3 | ARE THERE COST-EFFECTIVE INTERVENTIONS?

Second, the size of the burden should not determine the proportion of the health budget allocated to that disorder (Chisholm, 2016). The crucial questions are how much burden from a particular disorder can be avoided through prevention or treatment, and at what cost of delivering the preventive or therapeutic intervention (Musgrove & Fox-Rushby, 2006). A disorder can be responsible for high mortality or morbidity in a population, but if there are no effective interventions, or if interventions are extremely expensive in relation to the reduction in mortality or disability, then large-scale investment in services would be ineffective compared to what could be achieved if that funding was allocated to other conditions causing similar (or even less) burden where cost-effective interventions are available. Cost-effective interventions exist for most mental disorders, even in low resource settings (Patel et al., 2016).

To date, few cost-effectiveness studies have been conducted in the eating disorder field (for review, see, Weissman & Rosselli, 2017). Evidence supports the cost-effectiveness of cognitive behavioral therapy guided self-help for the treatment of bulimia nervosa or binge-eating disorder (BED) (Crow et al., 2013; Lynch et al., 2010; Wilson & Zandberg, 2012). Because of the high costs of hospital-based treatment (Striegel-Moore, Leslie, Petrill, Garvin, & Rosenheck, 2000; Toullary et al., 2015), data are needed to determine when and whether outpatient care is a safe and effective alternative. A population-based randomized clinical trial in England compared three approaches for the treatment of adolescent anorexia nervosa: inpatient care provided by eating disorder specialists, outpatient care in an eating disorder program, and outpatient care in a general mental health setting. Clinical outcome (based on a rating of improvements in core symptoms) did not differ across the three care conditions; however, cost-effectiveness analyses favored outpatient specialist care (Byford et al., 2007; Gowers et al., 2010). In regards to specialist outpatient treatments for adolescent anorexia nervosa, a study in the United States (US) found no differences in clinical outcomes (percent of ideal weight and remission) when comparing family-based therapy (FBT) and systemic family therapy (SyFT), yet FBT was more cost-effective than SyFT (Agras et al., 2014; Lock et al., 2016).

4 | CAN PRIVATE MARKETS WORK?

Third, the availability of cost-effective interventions does not automatically mean governments should provide or subsidize them. Many economists argue that while an intervention may be cost-effective, public provision is less important if a private market, where the individual or their insurance pays for the interventions, can work effectively (Laxminarayan et al., 2006; Musgrove, 1999). However, for private markets to work, private demand must be adequate, and this is rarely the case for mental healthcare (Saxena, Thornicroft, Knapp, & Whiteford, 2007) and is a major issue for treatment of eating disorders. Stigma, lack of information, and the impact of the mental disorder itself on the individual’s ability to engage in treatment all contribute to a failure of private demand (Ali et al., 2017). Globally, most people with an eating disorder do not access treatment (Hart, Granillo, Jorm, & Paxton, 2011; Kessler et al., 2013) and in countries with a large private sector such as the US, the availability of health insurance is identified as a barrier to adequate treatment (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001; Escobar-Koch et al., 2010).

5 | ARE THERE “CATASTROPHIC COSTS” IN ACCESSING TREATMENT?

Fourth, governments are more likely to become involved in providing or subsidizing services if the individual incurs excessively high costs accessing treatment for the disorder. Mental disorder can result in substantial and sustained disability, social exclusion, unemployment, residential insecurity, and poverty (Gustavsson et al., 2011; Knapp et al., 2006). The risk of high costs does not necessarily imply the need for public provision, if health insurance is available. However, as noted above, private insurance markets do not operate well for mental healthcare. Even in high income countries where insurance is available, it may not cover treatment for mental disorders and/or the chronicity of the disorder can result in treatment costs exceeding insurance coverage caps. Individuals and their family may then need to deplete savings to maintain care.

Cost-of-illness studies in eating disorders have documented the considerable economic burden experienced by individuals with an eating disorder and their caregivers (for review see, Weissman & Rosselli, 2017). Comparisons across studies are difficult because of widely varying research designs and differences in healthcare costs across countries. Inpatient or residential treatment is the major cost driver of healthcare costs in eating disorders. Whether these costs are “catastrophic” depends, of course, on the resources available to the person needing care (if costs are born by the patient or family) or the organization responsible for payment. The few studies published on the cost of hospitalization do suggest, however, that hospitalization is costly. For example, a multicenter treatment study of anorexia nervosa conducted in Germany found almost fourfold greater costs (£13,625) in patients
who had a hospital care episode compared to patients who had received only outpatient treatment (€499, 2008 value) (Stuhldreher et al., 2015). A Canadian study extracted patient-level cost data as well as hospital overhead costs in adolescent anorexia nervosa, using consecutive admissions over a 3.5 year period. The mean cost (in Canadian dollars, CAD) per stay was CAD51,349 (SD = CAD26,598, 2013 value) (Toulany et al., 2015). It bears noting, however, that the cost averages obscure sizeable individual differences; for example, the Canadian study found that costs ranged from a “low” of about CAD16,000 to a high of about CAD200,000 (depending on length of hospital stay). A study of the household economic burden of eating disorders and cost-related non-adherence to treatment in Australia, a country with national health insurance and parity coverage for mental disorders, found over 96% of respondents reported economic hardship with 17.8% reporting some cost-related treatment non-adherence (Gatt et al., 2014).

6 | ARE THERE EXTERNALITIES WHEN TREATMENT IS NOT PROVIDED?

Fifth, governments are concerned about negative externalities from not providing services. An externality is the impact on an individual or group from the activity (or lack of activity) of an unrelated individual or group. The failure to provide healthcare for certain disorders can impact on individuals who do not have that disorder. An example in this regard is infectious disease, as the failure to be immunized increases the risk of other people contracting the disease. In mental health, the most commonly recognized externality is where the behavior of individuals with untreated severe mental disorder places others at risk of harm. However, only a minority of individuals with a mental disorder are dangerous to themselves or others, so the scale of these externalities is limited. A much bigger issue is the impact on the family and friends of an individual with a mental disorder, especially where the family members provide much of the care and this has been shown to be a major challenge for the families of individuals with an eating disorder (Hibbs, Rhind, Leppenan, & Treasure, 2015; Raenker et al., 2013). Another potential negative externality is the impact of experiencing an untreated eating disorder may have on the children of the affected person. Off-spring of parents with an eating disorder are at elevated risk for developing an eating disorder (Bulik, Kleiman, & Yilmaz, 2016). The extent to which children’s risk could be reduced by treating their parents’ eating pathology has not yet been examined (Lydecker & Grilo, 2016). Eating disorders typically onset in adolescence (Favaro, Caregaro, Tenconi, Bosello, & Santonastaso, 2009; Volpe et al. 2016), a prime time for pursuing education. For example, the average onset age of anorexia nervosa is 16 years (Steinhausen & Jensen, 2015). A recent study found that for girls (but not boys), a history of adolescent eating disorder predicted curtailed educational attainment, lower income, and lower likelihood of home ownership in adulthood (Tabler & Utz, 2015). The outcomes such as lower educational attainment may not only be personal adverse consequences but may be a negative externality in as much there are societal costs or benefits associated with a person’s educational attainment.

7 | DOES THE “RULE OF RESCUE” APPLY?

Sixth, governments may become involved in providing services when the disorder is perceived to fit the “rule of rescue” (Jonsen, 1986; McKie & Richardson, 2003), that is where the need to intervene is seen as urgent to prevent a serious adverse outcome, specifically the risk of death. The main application of this criterion to mental health has been in the area of suicide and here the rule of rescue does apply. Eating disorders have a high suicide rate (Kostro, Lerman, & Attia, 2014; Suokas et al., 2014) but also have the highest death rate among all mental disorders (Crow et al., 2009). A long-term follow-up study of over 5,000 patients who required inpatient treatment found a standardized mortality ratio of 5.35 for anorexia nervosa, 1.49 for bulimia nervosa, and 1.50 for binge eating disorder (Fichter & Quadflieg, 2016).

8 | IS THERE A NEED FOR REGULATION?

Governments become involved where there is a need for comprehensive laws to ensure coverage of health and mental healthcare and regulation about the ways in which health or mental health services are delivered. Provisions for the treatment of eating disorders vary widely worldwide (as they do for mental health treatment more generally). Mental health services in the public and private sectors in virtually all countries require a mechanism to determine the minimum standard for who can be a provider of services and who deliver certain treatments, for example prescribing pharmacological agents. This usually means that governments have a role in the registration of healthcare providers and the work with professional organizations on scope of practice, for example prescription of pharmaceuticals. This regulation is needed to maintain an acceptable quality of service and remains a major challenge even in countries such as the United Kingdom where government is the dominant healthcare provider (Escobar-Koch et al., 2010). Well-designed studies are critically important for informing policy decisions. One current debate in the field, for example, is whether regulatory action is needed to ensure transparency in the marketing of for-profit treatment centers or whether self-regulation will be sufficient to protect consumers from unethical practices (Attia, Blackwood, Guarda, & Marcus, 2017). Related, experts have called on treatment facilities or programs to collect from all patients uniform outcome measures and to regularly publish outcome data to allow consumers to make informed decisions when choosing a treatment center (Attia, Marcus, Walsh, & Guarda, 2017).

9 | CONCLUSION

In summary, there are compelling reasons for government involvement in mental healthcare, using accepted economic criteria, and these reasons apply as much to the treatment of eating disorders as other
mental disorders. The burden of mental disorders is high and there is increasing evidence that cost-effective interventions can be delivered, including in low and middle income countries. Private markets, without regulation, do not deliver mental health services equitably. The costs of accessing treatment, if born by the individual or their family alone, can be debilitating. If services are not provided, there are costs (externalities) to the community, and the outcome for the individual in these circumstances is increased disability and even premature death. Finally, mental health services require some degree of government regulation to help ensure quality treatment and care is delivered.

REFERENCES


