
Introduction

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The aim of the *Elgar Companion to Health Economics* is to take an audience of advanced undergraduates, postgraduates and researchers to the frontier of research in health economics, by providing short and readable introductions to key topics. The second edition brings together 54 chapters written by more than 100 contributors from around the world. The second edition is expanded and updated: chapters that appeared in the first edition have been updated and four new chapters have been added. Contributions to the *Companion* are concise and focus on specific concepts, methods and key evidence.

The *Companion* is intended to provide a comprehensive and authoritative reference covering theoretical and empirical issues in health economics; with a balanced range of material on equity and efficiency in health care systems, health technology assessment and issues of concern for low and middle income countries. It is organized into two broad sections. The first deals with the economics of population health and of health care systems, analysed with both equity and efficiency goals in mind. The second covers the conceptual and practical issues that arise in the evaluation of health care technologies: these are most often applied to pharmaceuticals but are also relevant for other interventions.

Many of the contributions address topical and policy-relevant issues: the economic causes of the growth of obesity in the West, the link between illicit drug use and crime, the consequences of leaving people uninsured against the costs of health care, the impact of globalization on the international trade in health care services, the role of informal payments in many health care systems, what 'equal treatment for equal needs' means in practice, whether direct to consumer advertising of pharmaceuticals is desirable, and how economic evidence is influencing the way that new technologies are made available to patients. Other chapters stress the research done by health economists to develop theoretical models and empirical methods that illuminate the workings of health care systems.

The boundaries of health economics stretch beyond the 'economics of health care' to encompass the broader social determinants of health and the interactions between health, labour markets and other aspects of economic activity. Economists have made contributions to the analysis of public health interventions and primary prevention, along with the analysis of healthy and unhealthy behaviours, including diet and drug-use. Health economics is deeply rooted in applied microeconomics but contributions to the *Companion* show that the macro-economy has consequences for population health and that health services have an impact on the macro-economy and international trade.

The desire for a long and healthy life creates a demand for health care and, as the incidence of health problems is uncertain, a demand for insurance against these risks. People value insurance as a protection from risk and for the expanded range of opportunities it brings. But insurance markets bring with them the problems described by the economics of information, which helps to understand the mix of public and private financing

of health care. Economists can draw on sophisticated empirical methods to model the choices that consumers make about their payments for health care and their use of health services.

Economics traditionally focuses on the efficiency of resource allocation, but health policy-makers often place a heavy emphasis on equity goals and distributional issues. In response health economists have shown how notions of equity in health and health care can be put into practice – making value judgements explicit – and used to perform broad international comparisons of the empirical evidence.

The organization of health care systems balances the – often competing – goals of those who provide medical care and those who pay for it. Interactions between health care providers and payers can involve elements of choice-driven competition, direct negotiation and bargaining between the parties, explicit contracting and the management of waiting times. Doctors play a special role in health care systems due to the principal–agent relationship that exists between doctor and patient. Economists are well placed to assess the implications of the menu of options available for the reimbursement of health care providers, and to assess the best way to use available data in designing such systems. In doing so it is important to assess the impact on (hard-to-measure) aspects of the quality of care, as well as on the volume of activity. Measuring the performance of health care systems at local, national and international levels has become a major focus for policy-makers around the world. But the design of these measures should be handled with care and needs to recognise that those being measured are not passive participants in the process.

Evaluation of health care technologies and policies requires an assessment of costs and benefits. Health economists have helped to pioneer the development of stated preference methods to measure benefits; developing the theoretical foundations of these methods and testing their robustness in practical applications. These developments fall into the two broad camps of health-related quality of life (HRQoL) and of willingness to pay (WTP) with, more recently, discrete choice experiments (DCE) and applications of the capabilities approach to health. Recent years have seen substantial progress in the understanding and use of statistical methods – both classical and Bayesian – in economic evaluation. The challenge is to provide information in a way that informs better decision-making, taking into account the special features and sources of variation in statistical data on costs and outcomes, and the differing objectives of health care policy. Health economists are actively debating how the principles of economic evaluation of health care technologies, in particular cost-effectiveness analysis, can be translated into decision-rules, setting priorities for future research and for medical practice at different levels of responsibility – from the clinical to the national or international.

