

EDITORIAL

Incremental choices, system-wide impact on health system performance

Rocco Friebe¹ and Iris Wallenburg² 

¹Department of Health Policy, London School of Economics and Political Science, London, United Kingdom and ²Erasmus School of Health Policy Management, Erasmus Universiteit Rotterdam, Rotterdam, Netherlands

Corresponding author: Rocco Friebe; Email: r.friebe@lse.ac.uk

(Received 13 October 2025; revised 13 October 2025; accepted 13 October 2025; first published online 23 October 2025)

Health systems and their performances emerge from the aggregation of many discrete decisions. Whether a clinician prescribes a particular therapy, whether a border official permits passage to medical care, whether a researcher adheres to protocol, or whether an economic evaluation captures spillover effects. Each choice appears marginal when viewed in isolation. Yet, their cumulative effect determines fundamental health system attributes, including safety, efficiency, equity, and institutional legitimacy. In this issue of *Health Economics, Policy, and Law*, we highlight this micro to macro linkage, demonstrating how institutional design can channel individual decisions toward the collective objective of a high-performing health care system.

We start with a paper on the off-label prescription of the probably most debated drug of the past year: Ozempic (Glucagon-Like Peptide-1 (GLP-1) drug). Registered as a drug to treat diabetes patients, Ozempic is increasingly prescribed to achieve rapid weight loss and combat obesity. In many debates, which are often played out in the popular media, the central issue is the scarcity of Ozempic and how cosmetic goals seem to take precedence over medical urgency. Callaghan et al. (2025) take a somewhat different perspective by investigating the broader issues surrounding ‘off-label description’ beyond just supply concerns. Their survey among US adults demonstrates that off-label prescription and drug use are valued differently among citizen groups, differentiating between political party preference, age, religion, and health status. They show that only a minority of the adult citizens is in favour of off-label drug use; a majority expresses concerns, of which patient safety is the most important one. They also warn that off-label prescription can harm public trust in public health authorities, showing how micro-level decisions impact public perspective on health system performance.

The second paper by Crudo Blackburn and Haeder (2024) addresses a distinct but conceptually related challenge: the intersection of immigration enforcement and healthcare access at interior border checkpoints. The empirical findings reveal broad public support for medical exemptions, particularly for emergency care, paediatric patients, and obstetric emergencies. From a health systems perspective, the critical issue is not immigration policy per se, but rather the unintended consequences when non-health actors become de facto gatekeepers to care. Each checkpoint delay represents a marginal increase in time-to-treatment; aggregated across populations and geographies, these delays translate into substantial morbidity and mortality. The policy response requires procedural clarity, including explicit protocols for medical passage, training for enforcement personnel, systematic audit procedures, and transparent reporting of access denials. Such mechanisms ensure that legitimate security concerns do not inadvertently compromise population health.

In our third paper, Timmers and Földes (2025) examine the tragic case of *Traskunova v. Russia*, where a 57-year-old woman with mental illness died during her participation in clinical trials for a schizophrenia drug, to argue that ensuring research safety constitutes a state obligation under international human rights law. The authors demonstrate how human rights law extends state accountability beyond regulatory compliance to encompass effective implementation and enforcement. However, while institutional review boards and informed consent remain foundational, they prove insufficient without broader institutional infrastructure that includes adequate funding for monitoring, enforcement mechanisms with deterrent effect, and timely public disclosure of adverse events. Each unreported protocol deviation or under-investigated adverse event may seem minor, yet their accumulation determines whether a research ecosystem merits public trust and produces reliable evidence.

The contaminated blood inquiry analysis by Warren et al. (2025) presented in our fourth paper documents consequences that extend beyond immediate clinical harm. The affected individuals and families experienced not only infection but also stigmatisation, economic hardship, and an erosion of institutional trust. This broader accounting suggests that post-harm response (or ‘redress’), should constitute an essential component of health system performance. The design of redress mechanisms involves many possible choices, including the adoption of disclosure protocols, compensation mechanisms, the provision of ongoing support, and approaches to institutional accountability. These choices either compound the original harm through inadequate response or initiate repair. It is important to also consider the possible future benefits of comprehensive redress by embedding learning processes, and reforming practices that reduce recurrence risk. From this perspective, redress investment yields return through both trust restoration and risk mitigation.

Environmental health hazards, exemplified by lead exposure in low- and middle-income countries, demonstrate how micro-exposures generate macro-level economic consequences. The modelling presented in paper five by Ericson and Brown (2025) quantifies the lifelong productivity losses from childhood lead exposure via impairments on cognitive development. The analysis underscores how environmental exposures translate into high economic losses, with East Asia bearing the largest absolute costs (38% of total) despite lower per-GDP impact than Sub-Saharan Africa. The policy insight from this work extends beyond establishing causation to reframing prevention as human capital investment. Each environmental inspection completed, or each contaminated product intercepted marginally shifts population cognitive trajectories. Sustained over time, these interventions compound into higher educational attainment, increased labour productivity, and reduced healthcare utilisation.

Finally, the methodological innovation of incorporating carer quality of life into health technology assessment, presented in our final paper by Kanters et al. (2024), exemplifies how evaluation frameworks shape resource allocation. The conventional focus on patient outcomes alone systematically undervalues interventions that reduce family burden, which falls disproportionately on women and lower-income households who cannot purchase substitute care. By maintaining dual reporting (with and without carer effects), the proposed approach preserves analytical comparability while acknowledging broader social consequences. This technical adjustment to economic modelling can carry important distributional implications, possibly redirecting resources toward interventions that reduce informal care requirements and their associated opportunity costs.

Taken together, these six papers illustrate a coherent narrative about health system performance. Individual decisions by clinicians, officials, researchers, policymakers, and evaluators may appear disconnected. Yet, they operate within institutional structures that can either amplify or reduce their collective impact. The challenge for health system governance lies in shaping institutions that make beneficial micro decisions more likely, visible, and valuable. Specifically, it requires deliberate institutional design, including the careful construction of rules, incentives, monitoring systems, and feedback. This deliberate institutional design must be informed by rigorous empirical analysis of the type presented in this issue in *Health Economics, Policy, and Law*.

References

- Callaghan T, Motta M, Stein M and Goidel K** (2025) The prevalence and consequences of support for off-label Ozempic prescriptions. *Health Economics, Policy and Law*, 1–14.
- Crudo Blackburn C and Haeder SF** (2024) US public opinion about interior border checkpoints and health care access for undocumented immigrants. *Health Economics, Policy and Law*, 1–24.
- Ericson B and Brown MJ** (2025) Lead-attributable productivity losses in low- and middle-income countries. *Health Economics, Policy and Law*, 1–12.
- Kanters TA, Van Hezik-Wester V, Boateng A, Cranmer H, Kvamme I, Santi I, Al-Janabi H and Van Exel J** (2024) Including carer health-related quality of life in NICE health technology assessments in the United Kingdom. *Health Economics, Policy and Law*, 1–13.
- Timmers M and Földes MÉ** (2025) Safety of scientific medical research is a State obligation. *Health Economics, Policy and Law*, 1–13.
- Warren E, Cyhlarova E, Carlisle J, Knapp M and Nolte E** (2025) The contaminated blood scandal in England: exploring the social harms experienced by infected and affected individuals. *Health Economics, Policy and Law*, 1–16.