

PRODUCTION OF HEALTH

EE 474 Health Economics

Semester 1/2013

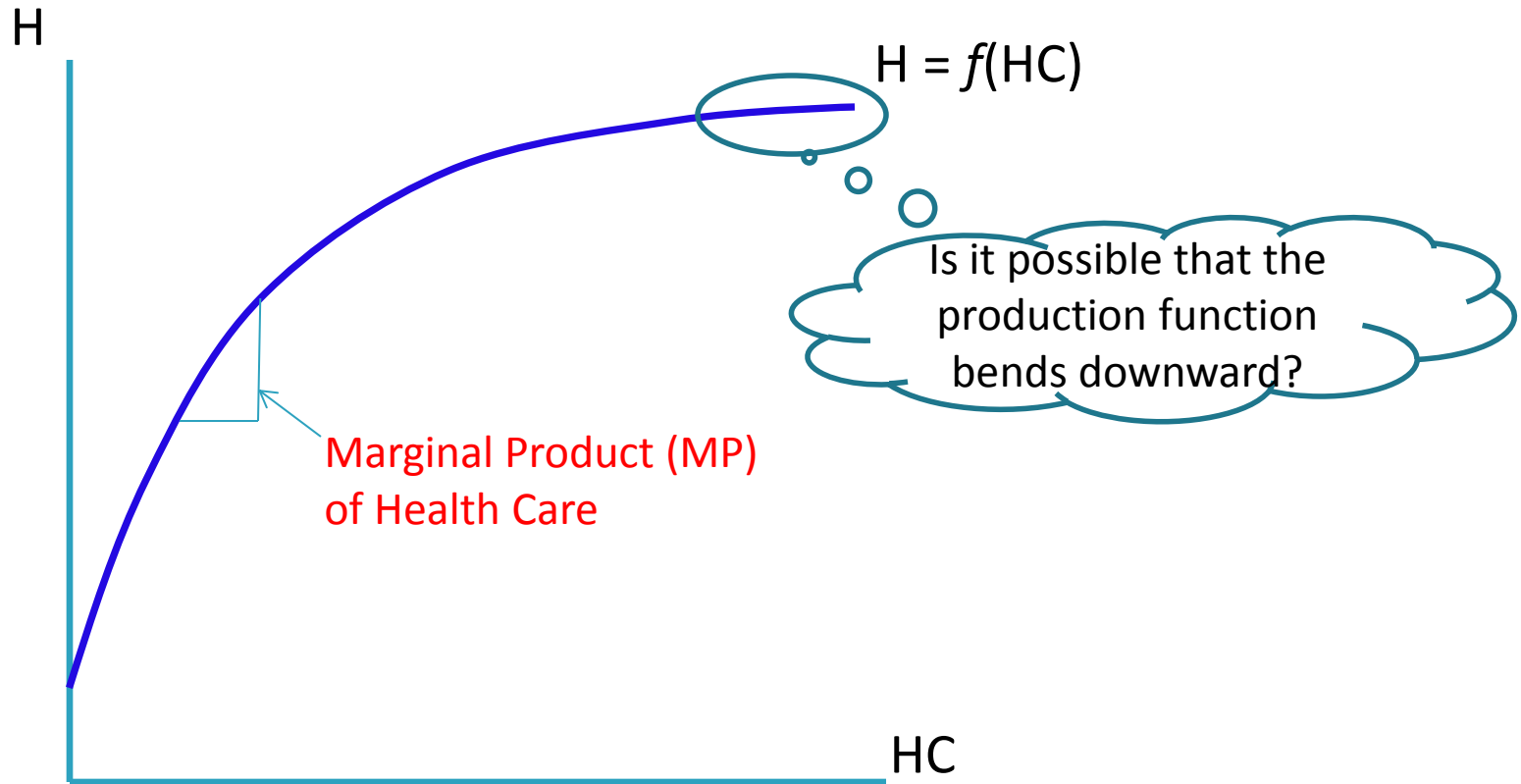
Topics

- Production function of health
- Health as a function of health care
 - Technical efficiency
 - Allocative efficiency
 - Some empirical evidence
- Fuchs' (1974): *Who Shall Live?*
- Other inputs in the health production

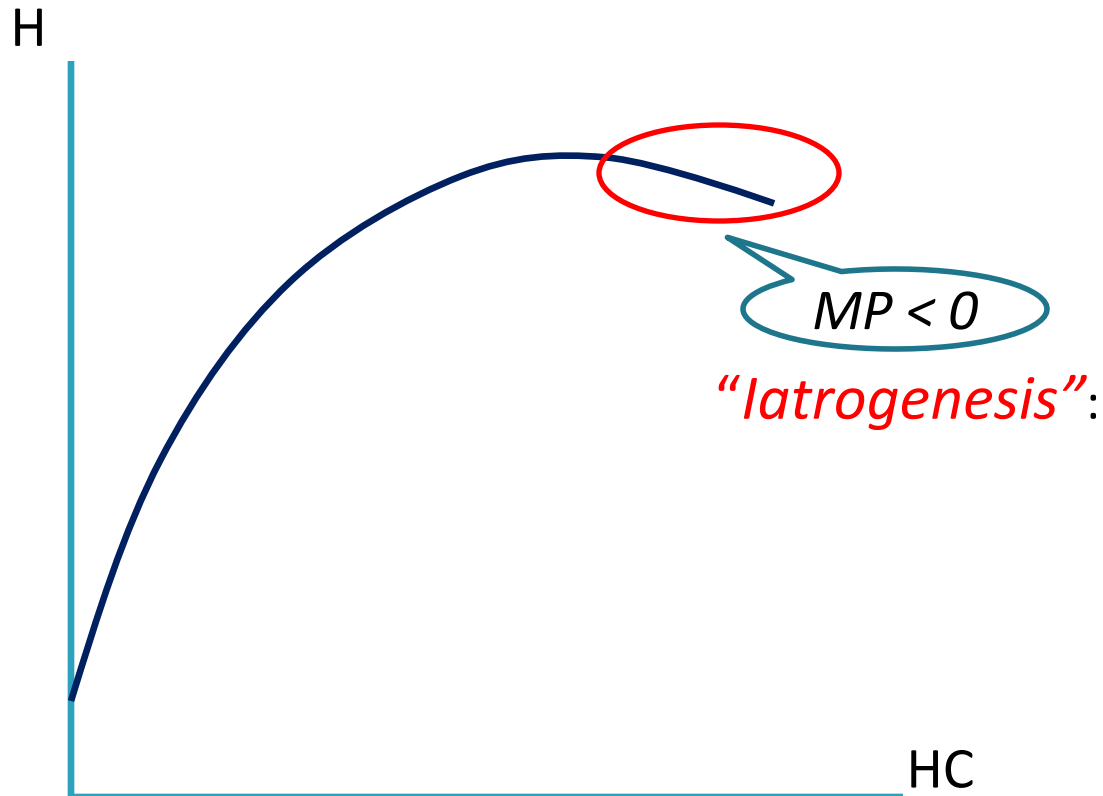
Production of *Health*

- Last time, the output of production was *health care*.
- In this lecture, *health (or health status) is an output*.
- What are possible inputs in the health production?
 - $H = H(???)$
 - $H = H(\text{health care, disease, nutrition, lifestyles, environment, public health, ...})$
- In this context, *health care is an input* in the production of health.

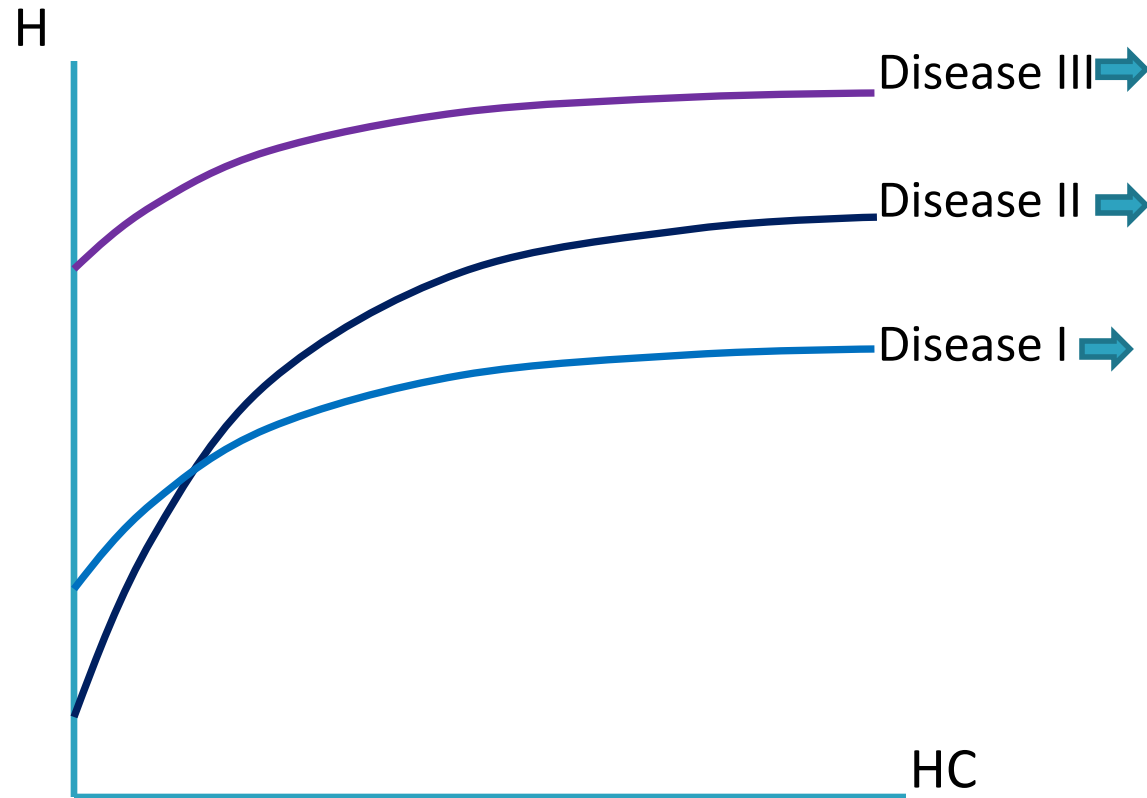
Production Function of Health



Production Function of Health When $MP_{HC} < 0$



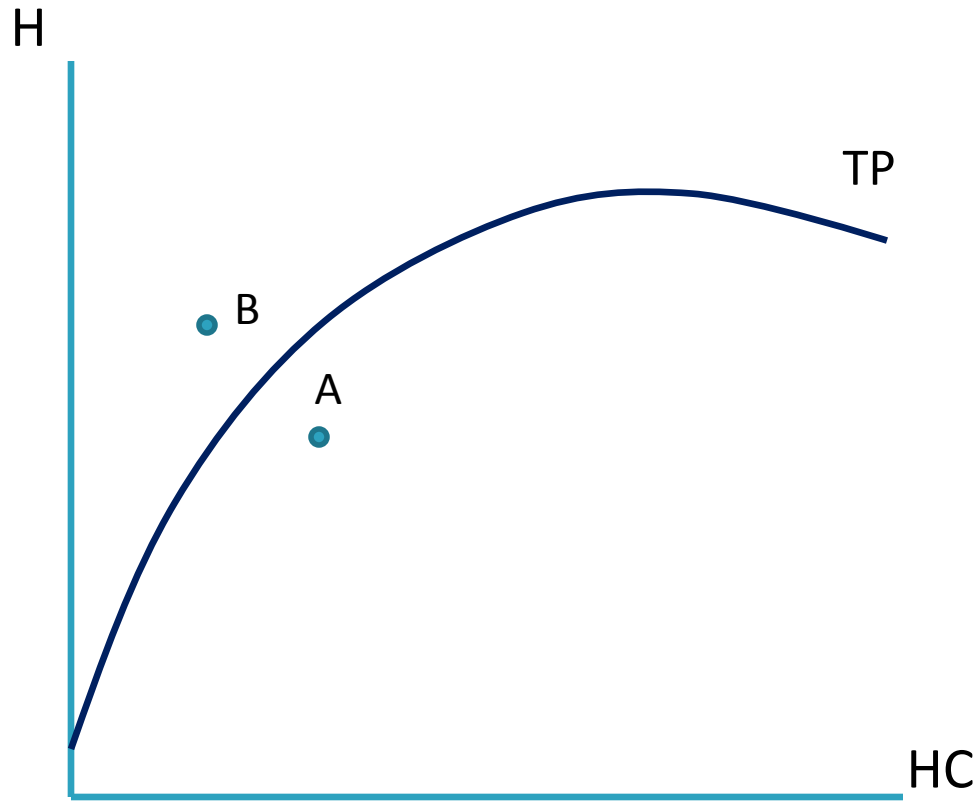
Production Function of Health for Different Diseases



Technical Efficiency

- **Technical efficiency** :
 - Produce the maximum amount of output from a given amount of inputs – *not wasting resources*
- The production function shows the maximum that can be produced by any set of inputs.
- So, the **production function of health** includes only *technically efficient* input-output combinations.

Production Function (1 Input)



Technical Efficiency (2 inputs)

	Health	Health Care	Exercise
A	50	5	5
B	50	4	6.25
C	50	7	5

Which combination is technically inefficient?



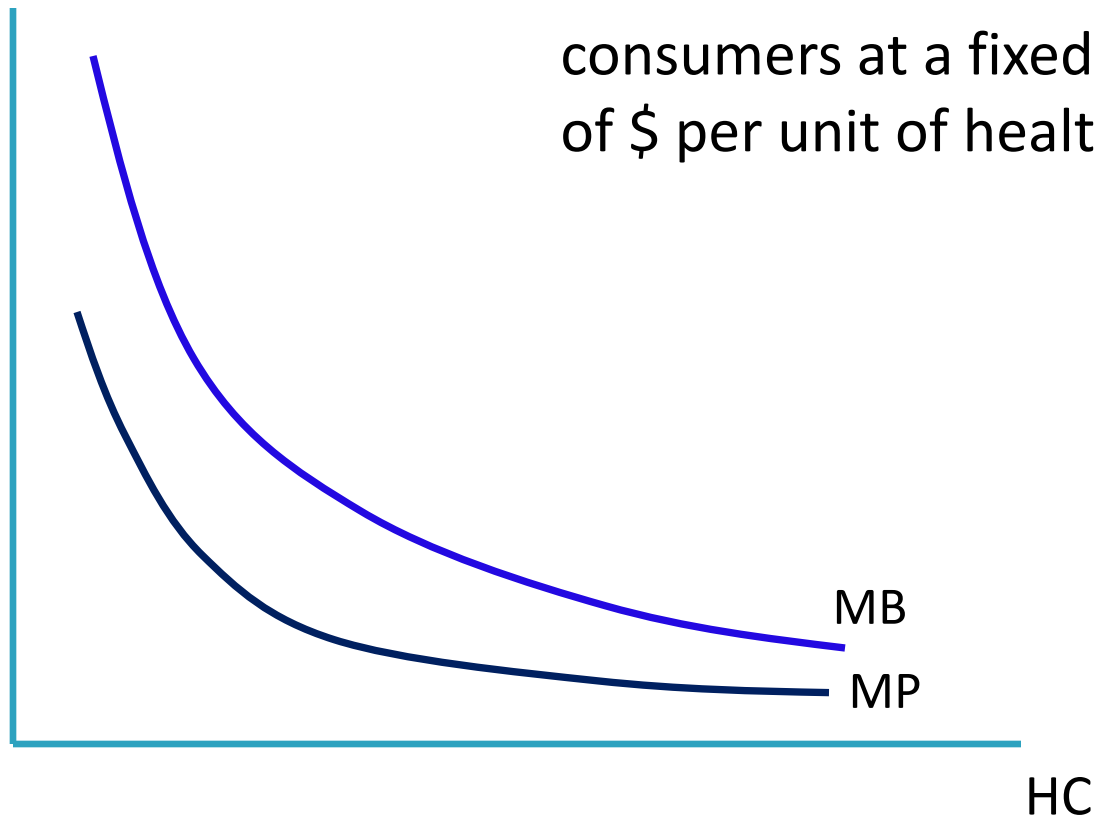
Is Health Care Worth It?

- Now, we turn to the society's perspective on the health production.
- Are we producing on the “*flat of the curve*”?
 - i.e. Is $MP_{\text{health care}} = 0$?
- What is the optimal level of health care for society to produce and use?
 - Need to know:
 - MP of health care
 - How much value of the health generated
 - How much each additional unit of health care costs

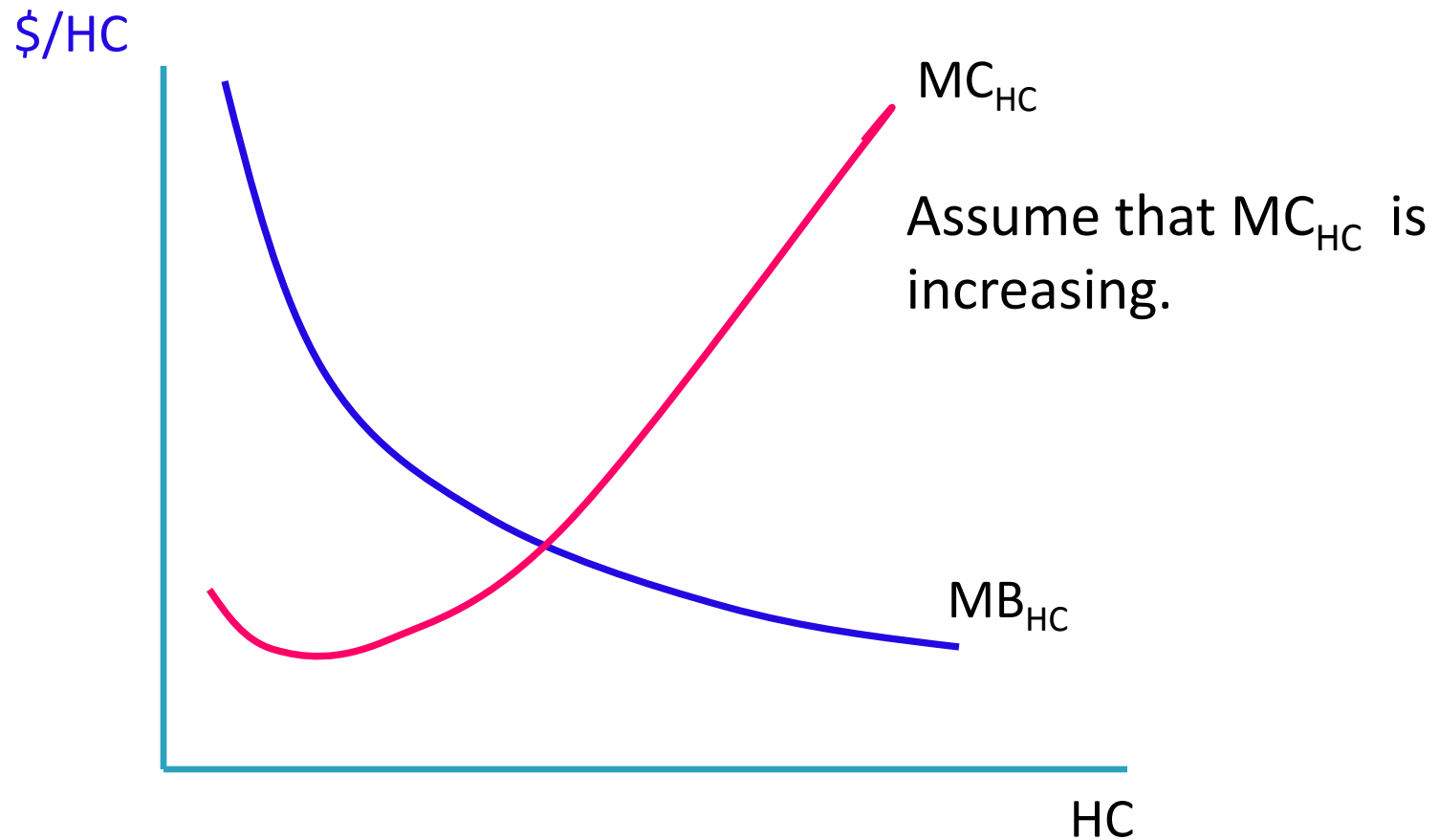
Marginal Product and Marginal Benefits of Health Care

MP (H/HC),
MB (\$/HC)

Assume health is valued by consumers at a fixed amount of \$ per unit of health: V_H .



Add Marginal Cost Curve



Allocative Efficiency

- Why is HC^* optimal?
 - Because it maximizes the net benefit of health care.
- If $HC < HC^*$, $MB > MC$:
 - By consuming more HC, total net benefits _____.
- If $HC > HC^*$, $MC > MB$:
 - By consuming less HC, total net benefits _____.
- At $MB = MC$, *allocative efficiency* is achieved.

Allocative Efficiency under Constraints

- Last example illustrates a situation of the unconstrained choice – we could use as much HC as we'd like.
- In reality, due to *scarcity* of resources, any choices are **constrained** by available resources.
- To achieve allocative efficiency, we need a *new rule* to allocate spending over all the possible inputs for the health production, until the budget is used up.

Constrained Choice

- Rule for allocative efficiency under constraints:
 - Allocate spending over all different inputs for the health production so that *the value of the health gain from the last \$ spent on each input is the same*:
- If inequality exists (e.g. $MB_{HC}/MC_{HC} > MB_{Exercise}/MC_{Exercise}$), then spend **more on health care** and **less on exercise**.
 - MP of health care will decline & MP of exercise will increase.
 - Eventually, the benefit per \$ spent on each input will be equal.

Empirical Evidence on the Relationship between H and HC

- Hadley, J. (1982). *“More Medical Care, Better Health?” An Economic Analysis of Mortality Rates.*
- RAND Health Insurance Experiment (HIE)

Hadley (1982)

- Estimate the impact of health care on health by using county-level data from 1970
- Regression function:

$\text{Mortality rates} = f(\text{HC expenditure, educ, income, ..})$

- Elasticity of health w.r.t. health care expenditure:

$E = (\% \Delta \text{Mortality rate}) / (\% \Delta \text{HC expenditure})$

- Found small but significant elasticities: -0.12 to -0.17
 - A 1% increase in health care expenditure results in a 0.12% to 0.17% reduction in mortality rates.

Possible Biases in Estimating the Relationship between H and HC?

- Selection bias
 - In the health production function, we assume that an increase in HC leads to an increase in H.
 - But many people choose to consume more HC when they are sick, i.e. decrease in H causes an increase in HC.
 - This is called *reverse causality bias* → underestimation.
- Omitted variable that is correlated with H and HC:
 - Example: “Employment” – People who are employed are more likely to be healthy and use more health care because they have health insurance (or can afford health care).
 - Sometimes, this omitted variable is not observed.

RAND HIE

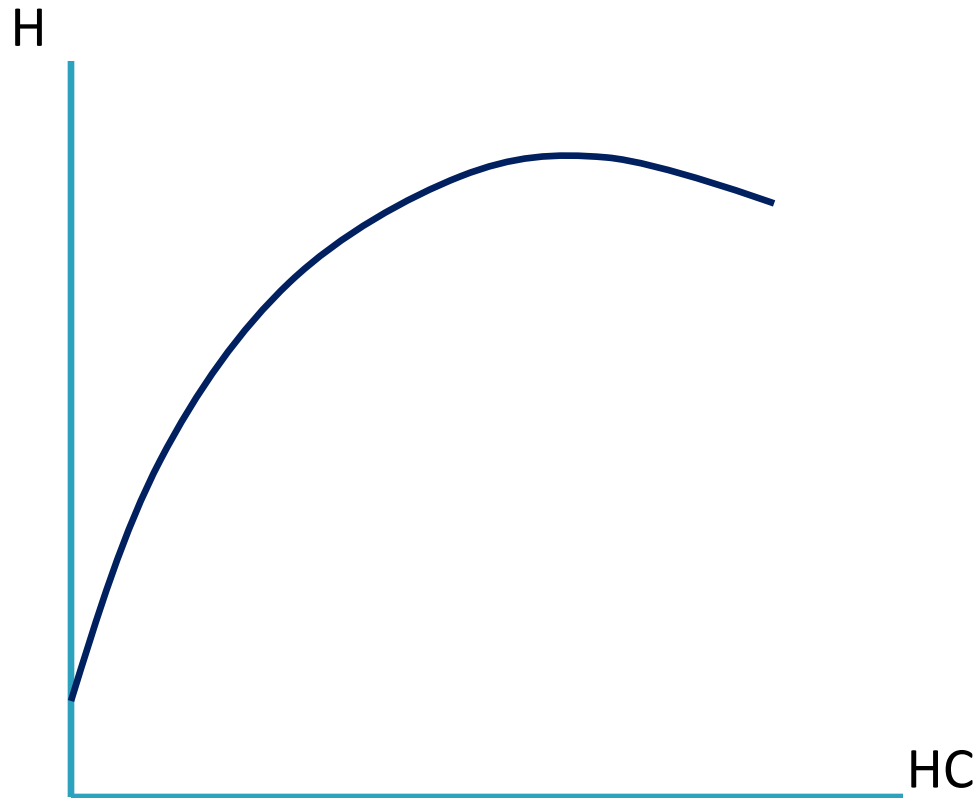
- To reduce the possible biases from **observational data**, an alternative to use **experiments**.
 - **Natural experiments** – expansion of health insurance coverage
 - **Randomized controlled trials** (RCTs)
- **RAND HIE**:
 - Designed to test the impact of different health insurance policies on demand for health care and health status
 - Participants are assigned to health insurance plans:
 - $c=0$, $c=0.25$, $c=0.5$, or $c=0.95$
 - Found: people assigned to cost sharing spend 40% less on health care, compared to people who pay nothing ($c=0$).

RAND HIE

- Studies from the experiments show that the increase in health care had no effect on health.
 - *Brook et al. (1983)* found that the decrease in HC caused by cost sharing did not have any effect on H, except for worse corrected vision and worse blood pressure.
 - *Newhouse et al. (1993)* found that 40% increase in health care used by the fully insured had little or no effect on adults' health status (measured from work loss days).

Plan	Mean of Work Loss Days	s.e.
Free (c=0)	5.47	0.42
Intermediate (c=0.25, 0.5, 0.95)	4.82	0.37
Individual deductible	4.54	0.36

Summary of Empirical Evidence



Question:
Where are we,
according to Hadley's
and RAND HIE's
studies?

Fuchs' (1974): Who Shall Live?

- One of the early studies on what inputs produce health—the health production function
- Fuchs' observations:
 - Not until the 20th century that health care had a substantial contribution on health.
 - Most of the gains in health in the 1800s and early 1900s were due to **increased income**, and **improvements in public health** (e.g. chlorination of water and pasteurization of milk) and **better hygiene**.
 - The development of **pharmaceutical products** (e.g. antibiotic and vaccine) increased health and also increased the productivity of physicians.

Fuchs' (1974): Who Shall Live?

- Fuchs' observations (continued):
 - *Now (at the time of his writing),* health gains are not associated with income or public health programs
 - Many of the diseases that people are dying of (e.g. heart disease and cancer) *cannot be cured* by medical care.
 - Instead, they can be **prevented** by consumers following **healthy lifestyles**.
- Fuchs argued that these diseases were related more to **lifestyle** than **lack of health care**. Thus, *changes in lifestyle are the most productive inputs in the health production function*.

A Tale of Two States

- Studied the population health outcomes during 1960s in two adjacent states:
 - Utah – low rate of alcohol and tobacco use
 - Nevada – known for high alcohol and tobacco consumption
- Showed the “excess” death rates in Nevada compared to those in Utah:
 - Age-specific death rates, by gender and age
 - Cause-specific death rates for liver cirrhosis (associate with heavy drinking) and lung cancer (associate with tobacco smoking)

Excess of Death Rates in Nevada compared with Utah, Average for 1959-61 and 1966-68

Age Group	Males (%)	Females (%)
< 1	42	35
1 -19	16	26
20 – 39	44	42
40 – 49	54	69
50 – 59	38	28
60 – 69	26	17
70 – 79	20	6

Source: Reproduced from Fuchs (1974), Who Shall Live? Health Economics, and Social Choice: Chapter. 2

Excess of Death Rates in Nevada compared with Utah for Cirrhosis of the Liver and Malignant Neoplasm of the Respiratory System for 1966-68

Age Group	Males (%)	Females (%)
20 – 39	590	443
40 – 49	111	296
50 – 59	206	205
60 – 69	117	227

Source: Reproduced from Fuchs (1974), Who Shall Live? Health Economics, and Social Choice: Chapter. 2

Lessons from Fuchs' Study

- The comparison of death rates in the two states show a big difference favoring *Utah*.
 - Lifestyles matter!
- Fuchs' study was the first to put health care spending in the health production function, and to recognize that there might be other and better options for obtaining health than buying additional health care.
 - We could apply allocative efficiency rule.
- This study was path breaking because it contributed to the recognition that we consumers have a great deal of influence on our own health.

Other Inputs in the Health Production

- From Fuchs' study, we saw that **lifestyle behavior** and **environmental pollution** affect health.
- Other determinants of health are:
 - **Family characteristics:**
 - Maternal lifestyle, knowledge, etc., affect children's health.
 - **Income:**
 - Should have positive effects, but the relation between income and health is complex.
 - **Social capital:**
 - Increase healthful behavior and reduce risky health behavior
 - **Education:**
 - Education has a strong association with health status.

Education and Health

- 2 Theories about the role of schooling:
 - *Michael Grossman's* (1972a, 1972b) theory of demand: Better-educated persons tend to be economically more efficient producers of health status.
 - *Victor Fuchs* (1982): People who seek out additional education tend to be those with lower discount rates, and at the same time people with lower discount rates will be more likely to invest in education and in health as well.
- Empirical studies support the argument that education makes persons more efficient producers of health (Lleras-Muney, 2002).