

Health that is real
wealth



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“ It is health that is real wealth and not pieces of gold and silver.” It’s on these terms that Mahatma Gandhi gave prominence long time ago to the crucial role of the health in the daily life of each other. Indeed, the production of health presents a central concern to the public policy. Nowadays, the health ratio to GDP is always growing (average of 8, 9% for the OECD countries in 2009 against less than 6, 5% in the 1970s) and, for example, the health care spending in USA is four times the amount spent in national defence. This is why; a good health management is a big issue for our society. Throughout this essay, we’ll focus on how health is produced and how useful is current resource allocation to health care in light of that production process. So before to go the heart of the matter, it should define what health is really. According to the World Health Organization (WHO), “ health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”, a definition which was not amended since 1948[1]. Nevertheless, we’ll analysis if this definition is sufficient or not. The production, as for it, is explained by a production function which corresponds to a mathematical way to describe the relationship between inputs and outputs, here the health. Thus, we’ll begin to analysis the health production in light of health care production but not only and we’ll deal about the health measure. Then, in a second part we’ll discuss about this process and will speak about, among other, its efficiency, equity, accessibility and consequently if health care is the good way to work about health.

Health production is not an ordinary production. Indeed, health is not a classic output, the way to produce or maximize it is not common and the

way to measure it neither. Firstly, to define really what health is and to use it in a production function we need more than the WHO definition. If anyone has an idea of what the term means it's more difficult to really define the concept itself. First of all, it's a multidimensional concept; we need economic, medical, demographic, geographic or socio-economic notions to have a preview of the health. Health determinants are multiples: heredity, environment, medical care, socio-economic determinants, public policies, etc... Then, it's definitely a subjective concept and it's rather difficult to measure it because of the different health states existence for example. Anyway, health is an important factor for the public policy and for the “health makers” and the economists are tried to build some models to understand and above all predict it. The Grossman model (1972) is probably the most famous; he assumes rational health demand. Health is treated as a stock which degrades over time in the absence of “investments” in health, so that health is viewed as a sort of capital, actually this model is an adaptation of the Becker's model. Health is both consumption (it makes people feel better) and an investment good (stock of health determining life, healthy time). The model makes predictions over the effects of changes in prices of health care and other goods, labour market outcomes such as employment and wages, and technological changes. Anyway, when we talk about health production we distinguish the inputs where health care is substantial nowadays and the output, the health. Indeed, health care appears as the most important determinant because of the money that it generates and some studies showed during the past (Fuch, 1930) that health care investment could bring some progress in health. Health care is so the most important determinant of health status according to the economists, it

means, broadly speaking health care produces health. Here we heard health as a combination of health care, lifestyle, environment, human biology among other. Indeed, it was important to add other criteria to avoid an analysis focused only on health care. Thus, we have a growing curve, health is an increasing function of health care. Nevertheless, we have to notice the marginal product of health care is diminishing in size[2]. Anyway, with health and health care, the supply and demand classic vision doesn't work. Health is a very special output and health care is different than the normal inputs. We used to say " Health is an imponderable". Indeed, the health market must take in account some characteristics which don't exist usually and the market is not corresponding to a pure and perfect concurrence. Thus, health market is different because of at least six differences. Firstly, externalities play a very important role within this market, environment can influence on the population health but also the vaccination since people who are not vaccinated benefits also of the treatment. This point provides a first source of market failure. Secondly, the asymmetry of information is huge between for example the doctor and his patient and that cancels another hypothesis of the free market. Thirdly, the health market is rather a monopoly. Indeed, economic agents cannot enter in the market freely, it exists some barriers as licensure, fees, laws and huge innovations. Then, the health market is characterised by an uncertainty where moral hazard is important. Health care are frequently expensive and it's impossible to predict when we'll be ill that's why people can choose to take an insurance. Nevertheless, behaviour are not the same when people know they have an insurance. Consumers who are insured have an incentive to over-consume health care to demand treatments which they would not choose if they were directly paying for

them. Doctors behaviour is also not the same when they take care an insured patient, they know that the costs of treatment are covered by insurance so the temptation to over-prescribe medicines for their patients can be high. Moreover, illness is unprevisibile, can arise every time and during an time more ou less longer. Otherwise, demand for health or health care is rather irreguar because essentially of the uncertainty of the illness, we can easily assume that in winter, health demand is more significant, or at least totally different than in summer. Finally, we can wonder if health care is a public good e. g. a good or service that can be consumed simultaneously by everyone and from which no one can be exculded[3] or non rival and non excludable. Actually, health care is not a public good because a care is obviously rival and excudable nevertheless the information relative to this good can be considered as a public good. This is why the public good problematic can interfer in the sphere of health economics and provoke an other market failure. We have juste seen the difficultties to theorize about the health care market and we'll see that economists meet the same difficulties to measure health. Indeed, as we saw earlier, the concept itself is not easy to define and most of the benefits are intangible as them on the quality of life. At present, it doesn't exist an indicator which can reveal the level of health of a country. Actually, several indicators, ratios are used to only get to an estimation of this level. Thus, health expenditures ar frequently used as different rates (mortality, natality, fecondity...) or indicators trying to combine different aspects and not only health care. QALYs (Quality adjusted life year) and ICIDH-2 try do that including body, individual and social dimensions[4]. Indeed, once again, it's important to not focus only on health care to measure health.

Besides, in this following part, we'll see why it's not a good thing to analysis health in term on health care only. Even if, Fuchs attributed the continued decline in infant mortality from 1935 to 1950 to advances in health care and the continued improvement in living standards. Despite that, the contribution of health care to the health status of populations has been difficult to quantify[5]. In terms of efficiency, effectiveness and equity among other we'll observe that health care shoudn't be the reference to discuss the population health i. e. for example, that an increasing of health level doesn't correpond necessarily to an rise of health care. Broadly speaking, as Folland, Goodman and Stano said: Are health care market healthy ? Are they efficient, equitable and effective?

The definition of efficiency used by economists is named after the Italian economist, Vilfredo Pareto, who formulated it. He said that an allocation of resources is efficient if it is impossible to change that allocation to make one person better off without making someone else worse off. Thus, inefficiency exists when resources could be reallocated in a way which would increase the health outcomes produced. We can distinguish three kind of efficiency : technical, productive and allocative[6]. The first one refers to the pysical relation, thus an intervention is technically inefficient if the same outcome could be produced with less of one type of input. Medical care's are, for most of them, efficient considering the hospital budgets for example.

Nevertheless, the moral hazard can influence an insured patient to ask a most expensive care or a doctor to prescript an expensive care knowing that his patient is insured. Productive efficiency refers to the health in terms of outcomes and cost minimization. In health care system, it's not possible to

compare the cost of different outcomes at broader level, health outcomes are incommensurate. Indeed, the choice between cost and effectiveness in matters of health care is definitely not possible. Finally, the allocative efficiency is a superior step of the efficiency study since it takes an account the distribution of the outcome produced. Thus, allocative efficiency is achieved when resources are allocated maximizing the welfare of the community.

The big issues probably take place in term of equity about the health care system. Thus, " Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, housing, and medical care and necessary social services," states Article 25. 1 of the Universal Declaration of Human Rights. Equity refers to a system of justice based on conscience and fairness; it's not the same thing as equality which refers to a state of being equal. It's a particular interpretation of equities, we're talking about vertical equity. Horizontal equity means providing equal healthcare to those who are the same in a relevant respect). Vertical equity means treating differently those who are different in relevant respects (Culyer, 1995). In matter of health the equity is quite difficult to obtain since lots of factor, sometimes exogenous, come into play. We have to distinguish different kinds of equity to analysis if health care system is really equitable or not. Indeed, we have to be met with, at least, two main equity problems which can permit to resume health to health care. First, an equal access to health care for everyone and secondly we have to consider the health status of everyone which is not the same because of the social position, the heredity, the gender...According to a OECD study[7], in the majority of

countries, there is no evidence of inequity in the distribution of GP visits across income groups. The picture is very different with respect to consultations of a medical specialist. In all countries, controlling for need differences, the rich are significantly more likely to see a specialist than the poor, and also more frequently. The story emerging for inpatient care utilization is more equivocal. The study finds also a pro-rich distribution of both the probability and the frequency of dentist visits in all OECD countries. This study permits to put in evidence another subtlety. We have to separate the equal access for equal needs and the equal utilization for equal needs of health care often different according to the social position. These equality problems include the problematic of equal waiting time, equal nurse cost per bed ration... Thus, individuals are not equal face to the health care; incomes play a decisive role in the way to use them. Public health care policies have to correct this, giving to everyone means to have the same solution, possibility face to a disease. Otherwise, the other main issue concerning the equity is how we can make converge the life expectancy. Indeed, several studies lead in the nineties by Nolan or O'Shea showed that socio-economic determinants play a significant role on the health. For example, poor workers die faster than the others because of their life quality. Moreover, the Whitehall study in 1988 found a strong association between grade levels of civil servant employment and mortality rates from a range of causes. Thus, there were higher mortality rates in men of lower employment grade specifically due to coronary heart disease, as well as increased mortality rates due to all causes for lower status men. The equal opportunity for health problematic seems to be the most difficult to reach. For example, it'll have

always an inequality between men and women which have both a significant different life expectancy.

To sum up, we have just seen that to analysis the health care market as a free market doesn't make sense. Health care is not a good like the others it brings some problems to analysis it, measure it and perfection it. Otherwise, to come down health to health care study can led to some problems and interpretation mistakes. Indeed as we saw, the level of health care expenditure, the investments or the innovation don't show anything about the population health. Indicators, to be efficient, have to integrate several dimensions and not only the health care but social integration, waiting time, cost, access... Moreover, to be efficient in health economics seems rather difficult, indeed compare effectiveness and cost of a care doesn't make sense if this care is necessary. The cost effectiveness analysis is totally different than with a " normal" good. Health production is frequently resumes to health care because this variable is one of the most appreciable among the other health indicator. Nevertheless, it's not the only way to produce health. Thus, for example, create a tax on soda as San Fransisco city did it can contribute to increase population health. Health promotion which is rather intangible is also very performing to improve health population. Anyway, if the production and the allocation are determinants in health economics, at the present time the big issue relative to health is the financing of the health care system. Indeed, find new revenue to cover health expenditures and health care program costs which are growing appears very difficult for the countries. The current US reform could maybe give us some answer about this.

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