BETTER POLICIES FOR BETTER LIVES

The Economics of Prevention

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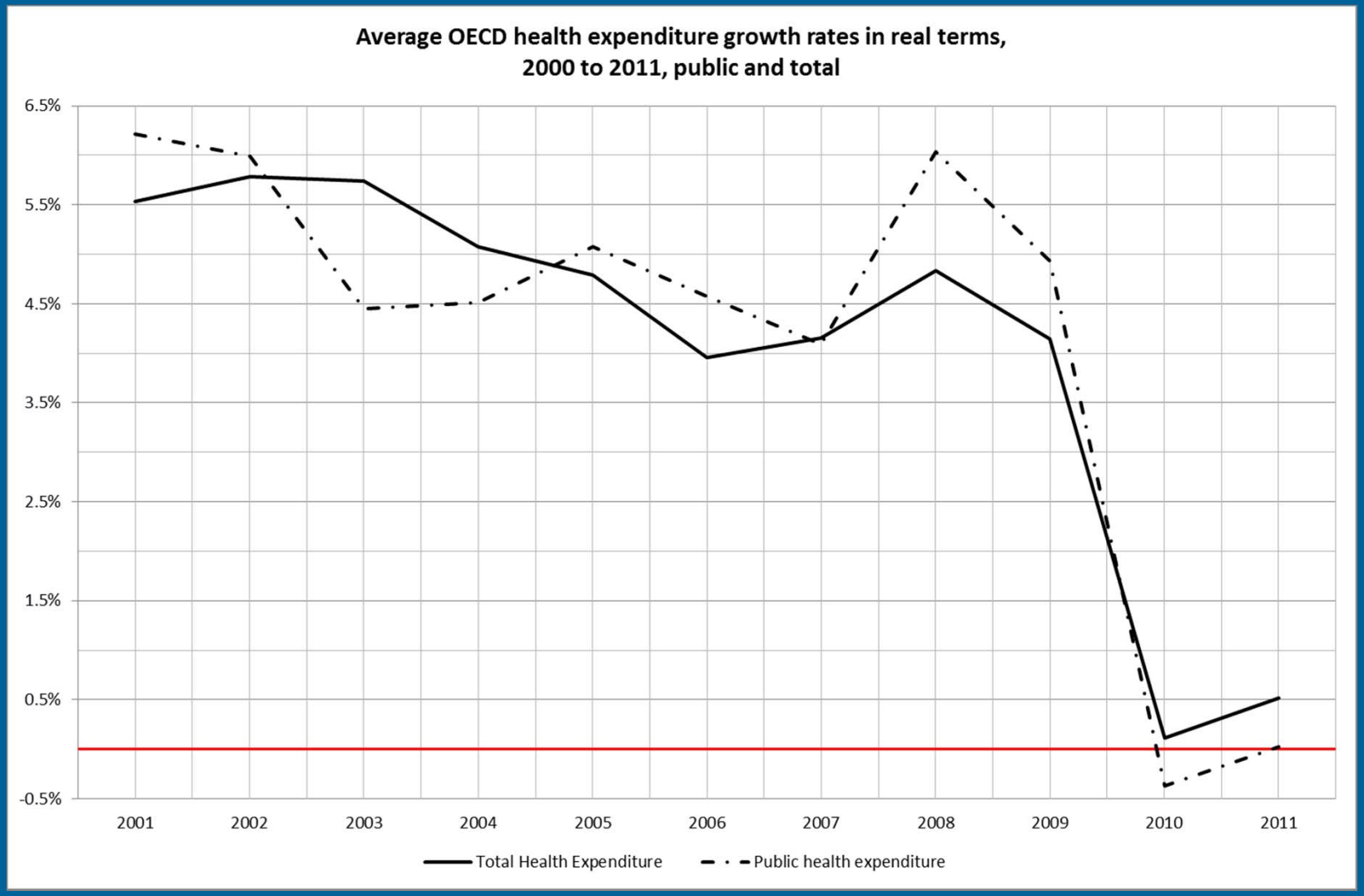
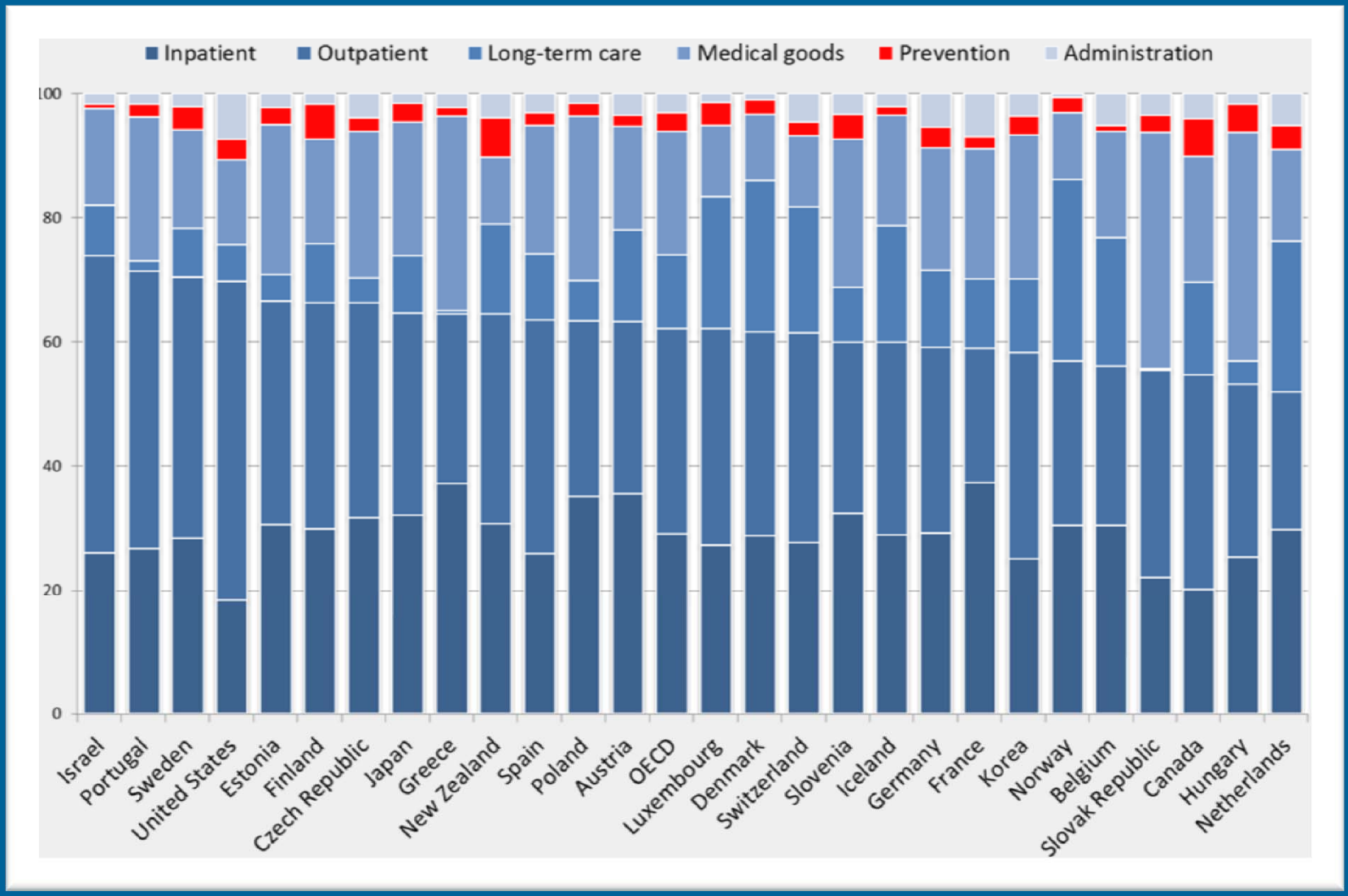
OECD – Health Division

Health Spending Stagnates



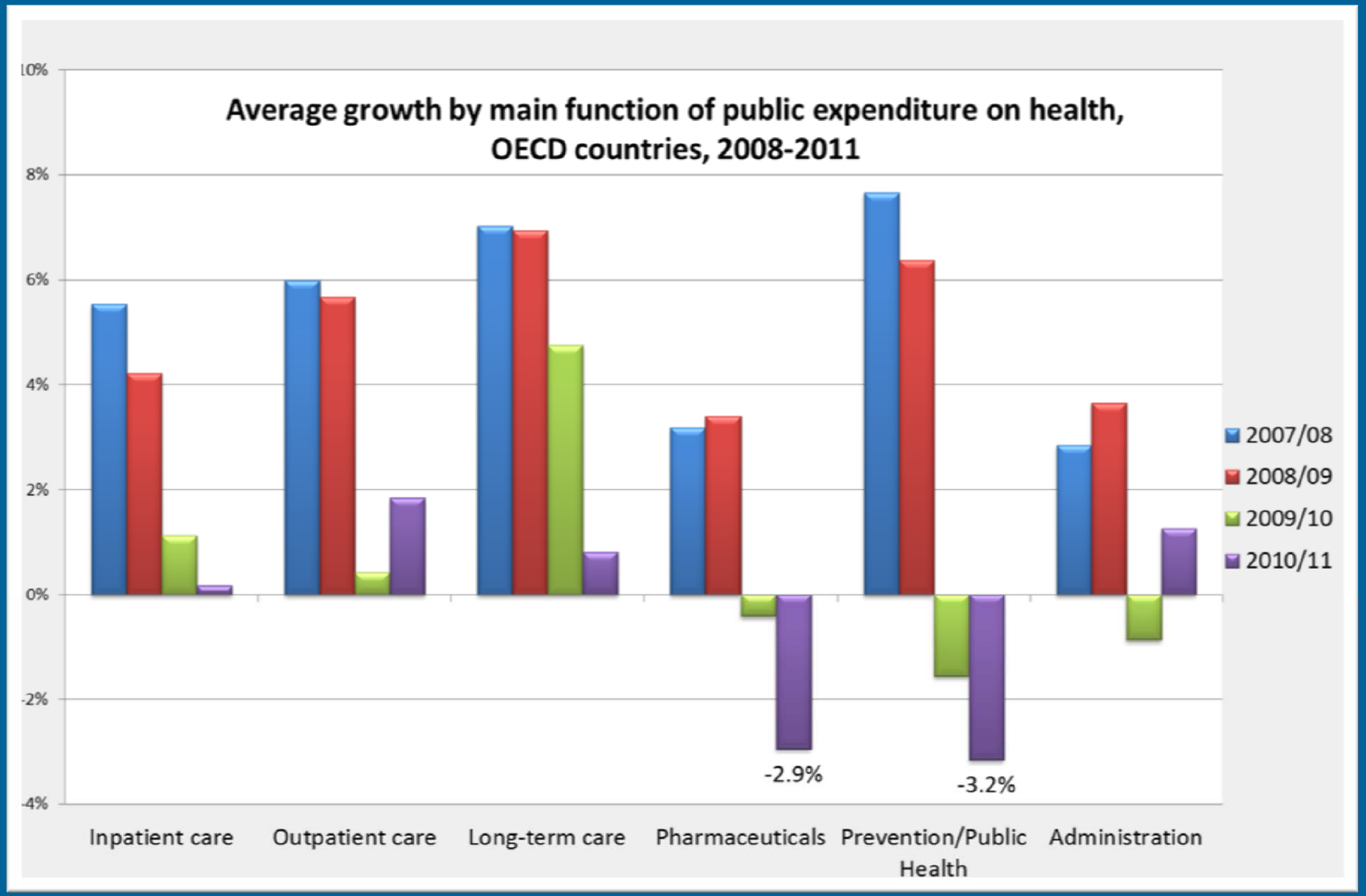
Source: OECD Health Statistics 2013

Prevention – Small Share of Spending



Source: OECD Health Statistics 2013

Prevention First To Be Hit



Source: OECD Health Statistics 2013

The Goals of Prevention

Prevention may offer opportunities to:

- Increase social welfare
- Enhance health equity

Relative to a situation in which chronic diseases are treated when they emerge

Was Rose Right?

"It is better to be healthy than ill or dead. That is the beginning and the end of the only real argument for preventive medicine. It is sufficient".

(G. Rose, 1992)

Is Prevention Justified?

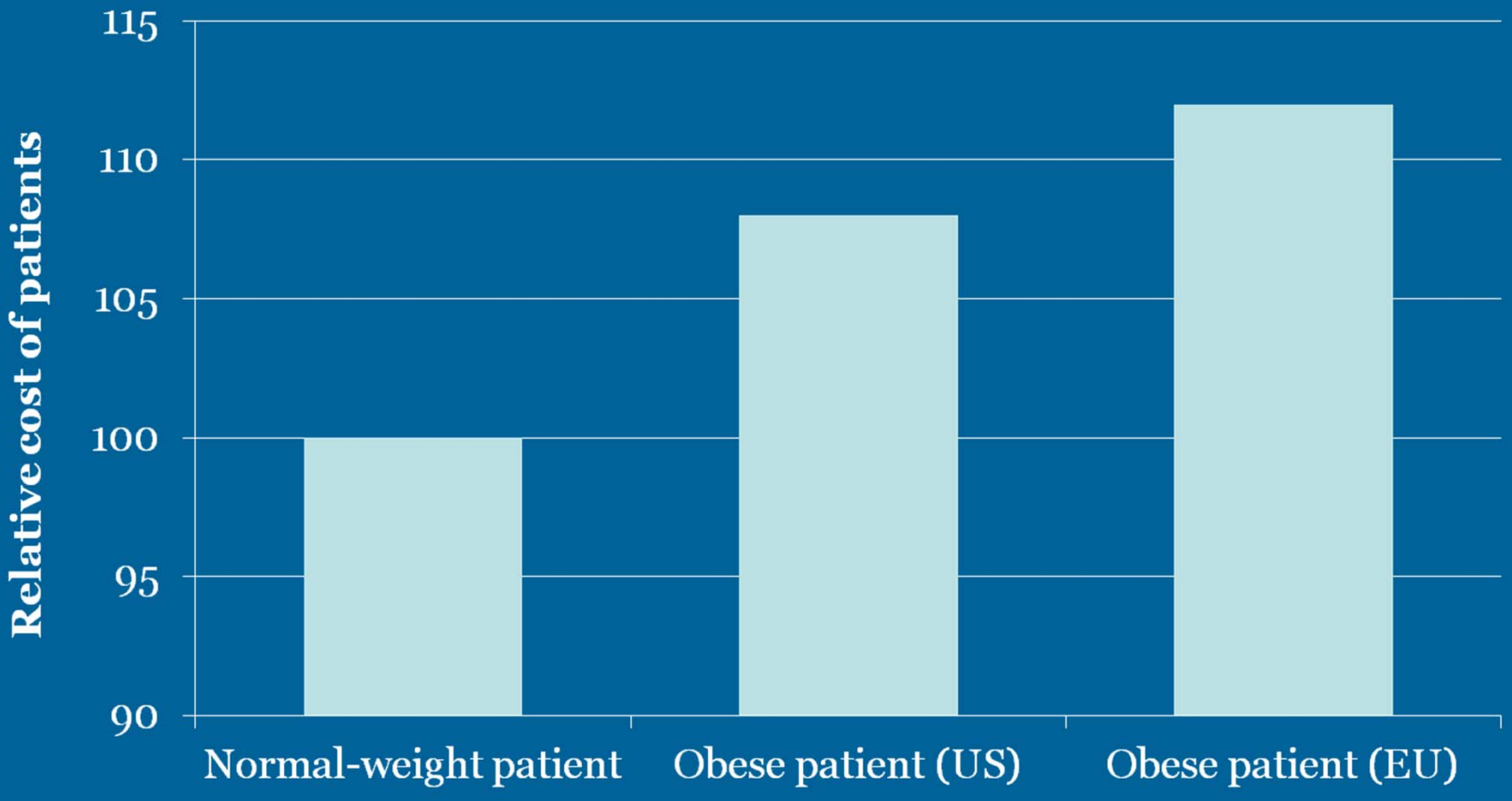
"Maintaining good health is an important goal for most individuals, but health is by no means the only outcome that individuals value when they choose how to lead their own lives. Individuals wish to engage in activities from which they expect to derive pleasure, satisfaction, or fulfilment, some of which may be conducive to good health, others less or not at all. [...] An assessment of the role of prevention must not ignore those competing goals" (Sassi and Hurst, 2008)

Is Prevention Justified?

- Market and rationality failure:
  - Externalities
  - Information failures
  - Supply-side market failures
  - Failures of rationality
- Existing policies have undesired effects
- Health inequalities

Fiscal Externalities

In any given moment, obese patients cost more



Source: Brunello et al., 2008
Bhattacharia & Sood, 2005

Production Externalities

- It is widely assumed that prevention may lead to a healthier and more productive workforce
- Prevention has two effects:
  - Increase in years lived in good health (diseases are prevented or delayed)
  - Increase in years lived with chronic diseases (premature mortality is prevented)
- Overall effect largely depends on labour markets' ability to absorb the former

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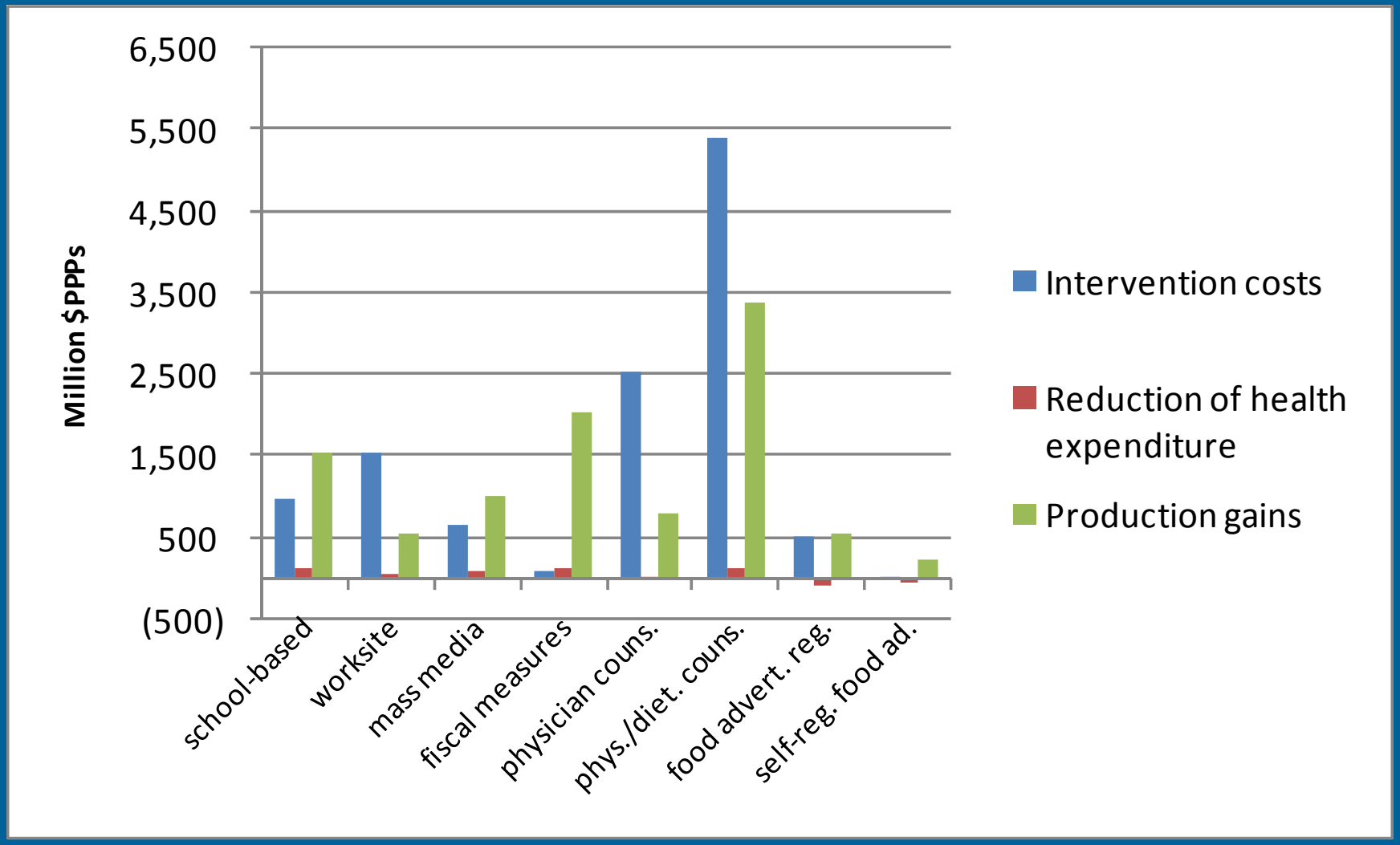
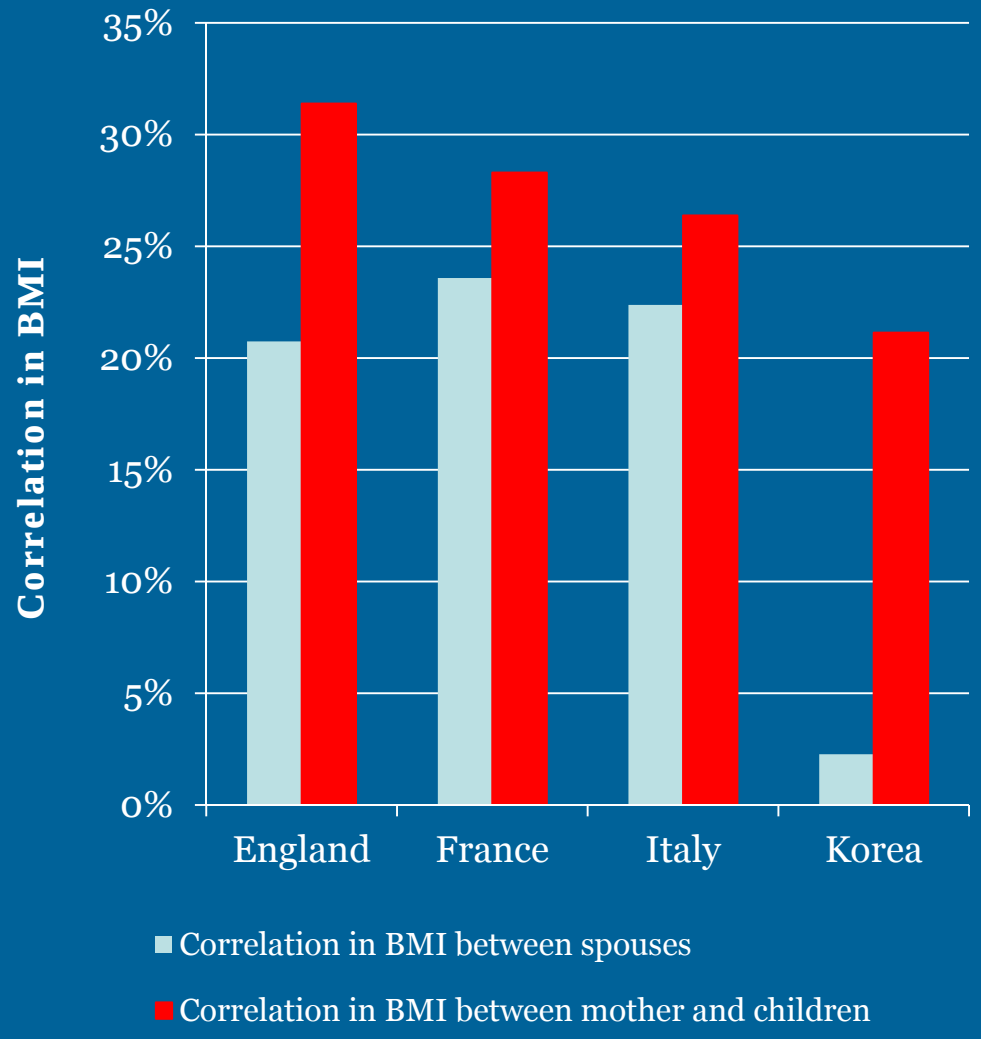
Production Externalities



Source: OECD analyses, EUR-A WHO region

“Social Multiplier” Effect in BMI



- Clustering of overweight and obesity within families and social networks suggests interaction between genetic factors and social environments
- “Social multiplier” effect
  - Negative externalities, which may potentially turn into positive externalities
  - Initiatives involving peer-groups or families may exploit the social multiplier effect

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Health-related Behaviours

- Driven by social norms
  - Peer, social, family influences
  - Commercial advertising
- Myopic, inconsistent time preferences
  - Awareness of risk, but procrastination
  - Perception of risk is generic, biased
- Habit-forming
  - Decisions based on heuristics
  - Rational addiction

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What Policy Options?

- Increase choice
- Information, education, change established preferences (nudging)
- Raise the price of unhealthy choices
- Ban unhealthy behaviours

New Policy Approaches?

- Changing default options
  - Product layout in supermarkets, canteens
  - Portion size
  - Alcohol and sport events
  - Family-based interventions
- Commitment devices
  - Incentives for enrolment in expensive “behaviour change” plans
- Weaning from heuristics and rational addiction
  - Prices and other financial incentives

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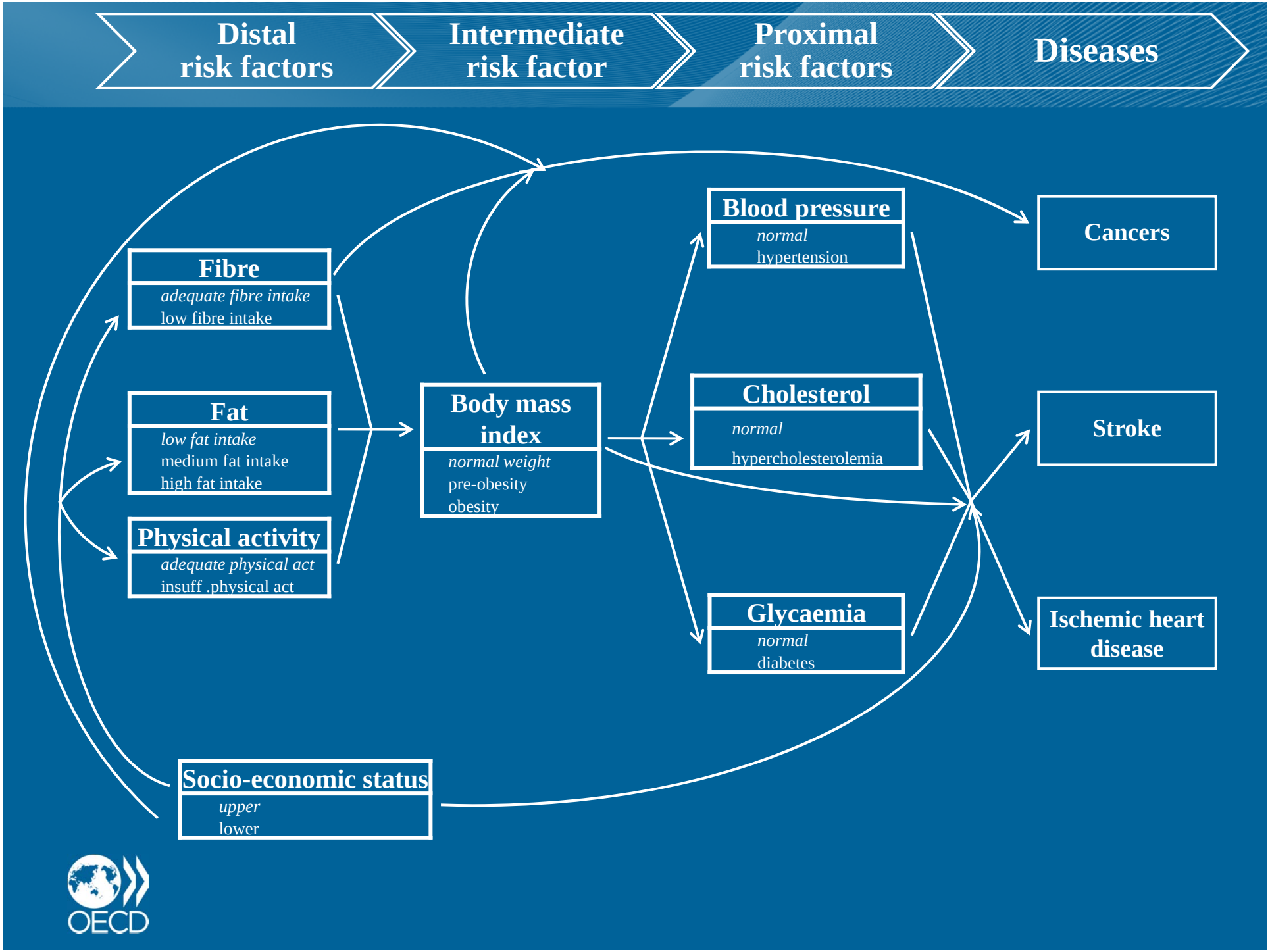
Making an Economic Case

- Interventions, not diseases
- Need for high-quality evidence on:
  - Epidemiology
  - Effectiveness
- Population models of health and economic impact


Distal risk factors
Intermediate risk factor
Proximal risk factors
Diseases
Fibre
adequate fibre intake
low fibre intake
Fat
low fat intake
medium fat intake
high fat intake
Physical activity
adequate physical act
insuff .physical act
Body mass index
normal weight
pre-obesity
obesity
Blood pressure
normal
hypertension
Cholesterol
normal
hypercholesterolemia
Glycaemia
normal
diabetes
Cancers
Stroke
Ischemic heart disease
Socio-economic status
upper
lower
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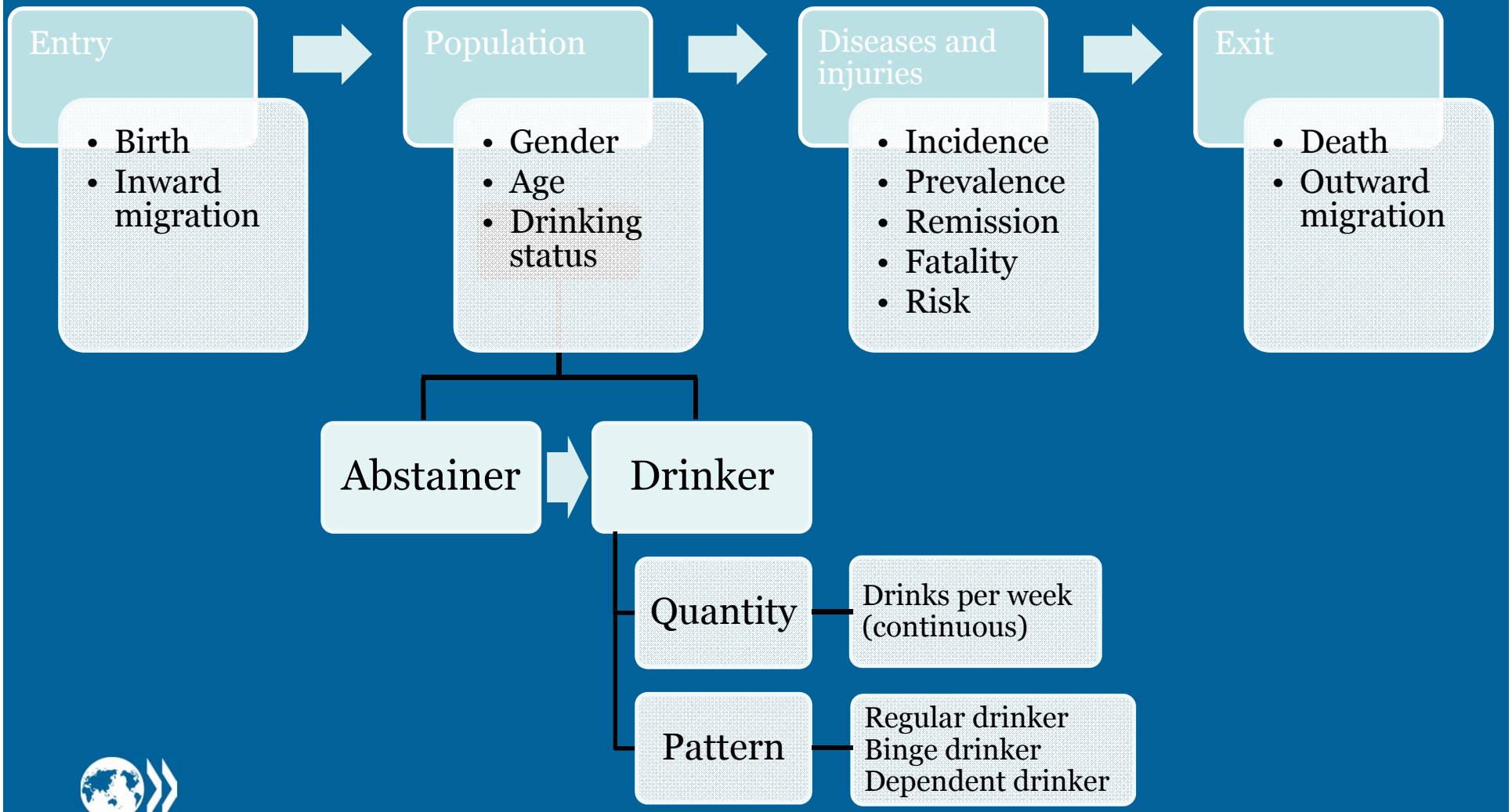
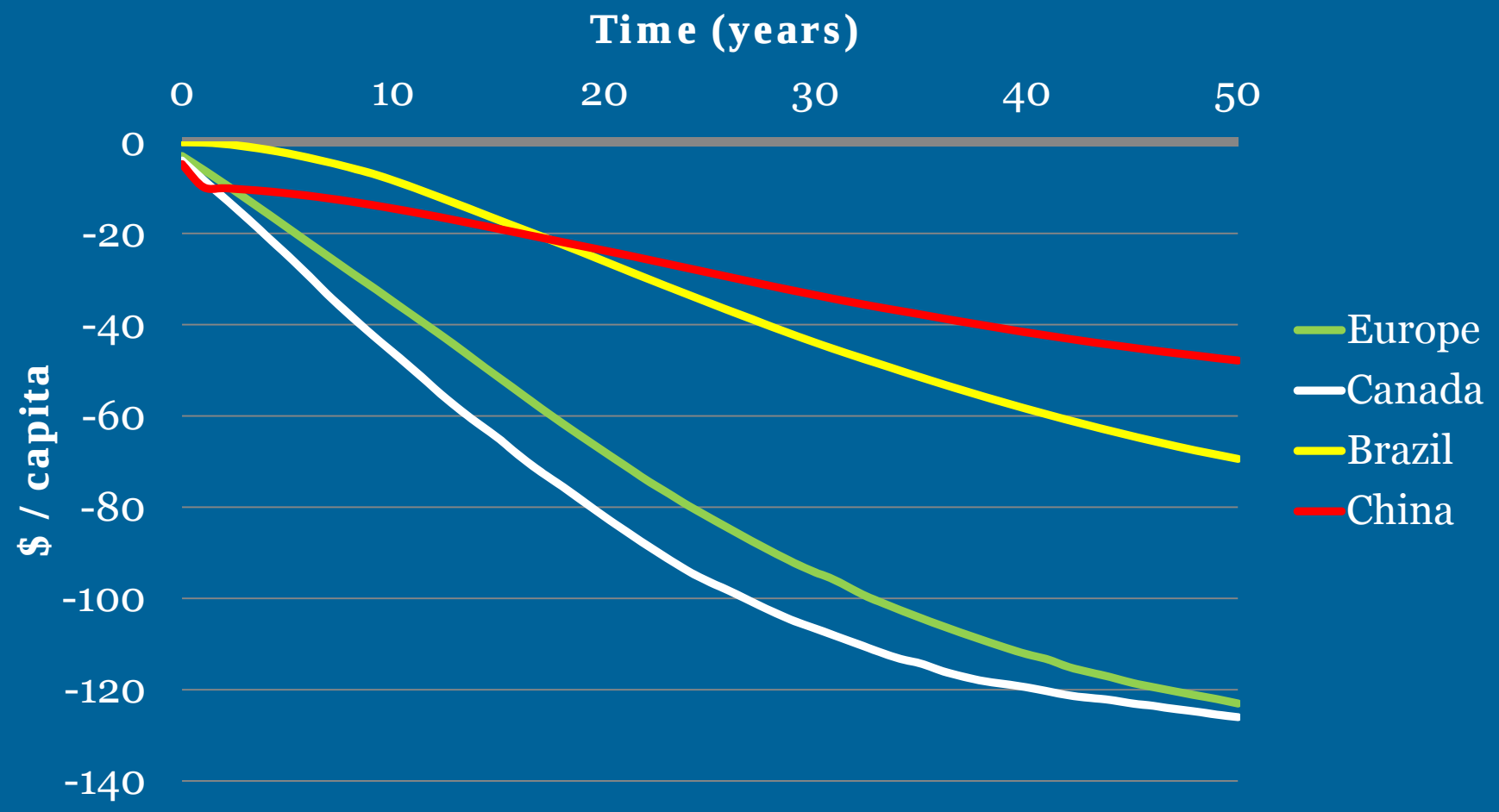
The CDP-Alcohol Model



Is Prevention Cost-Effective?

Obesity Prevention and Health Expenditure



Source: OECD, HWP 48, Fit not Fat & Food Chain Network, 2012

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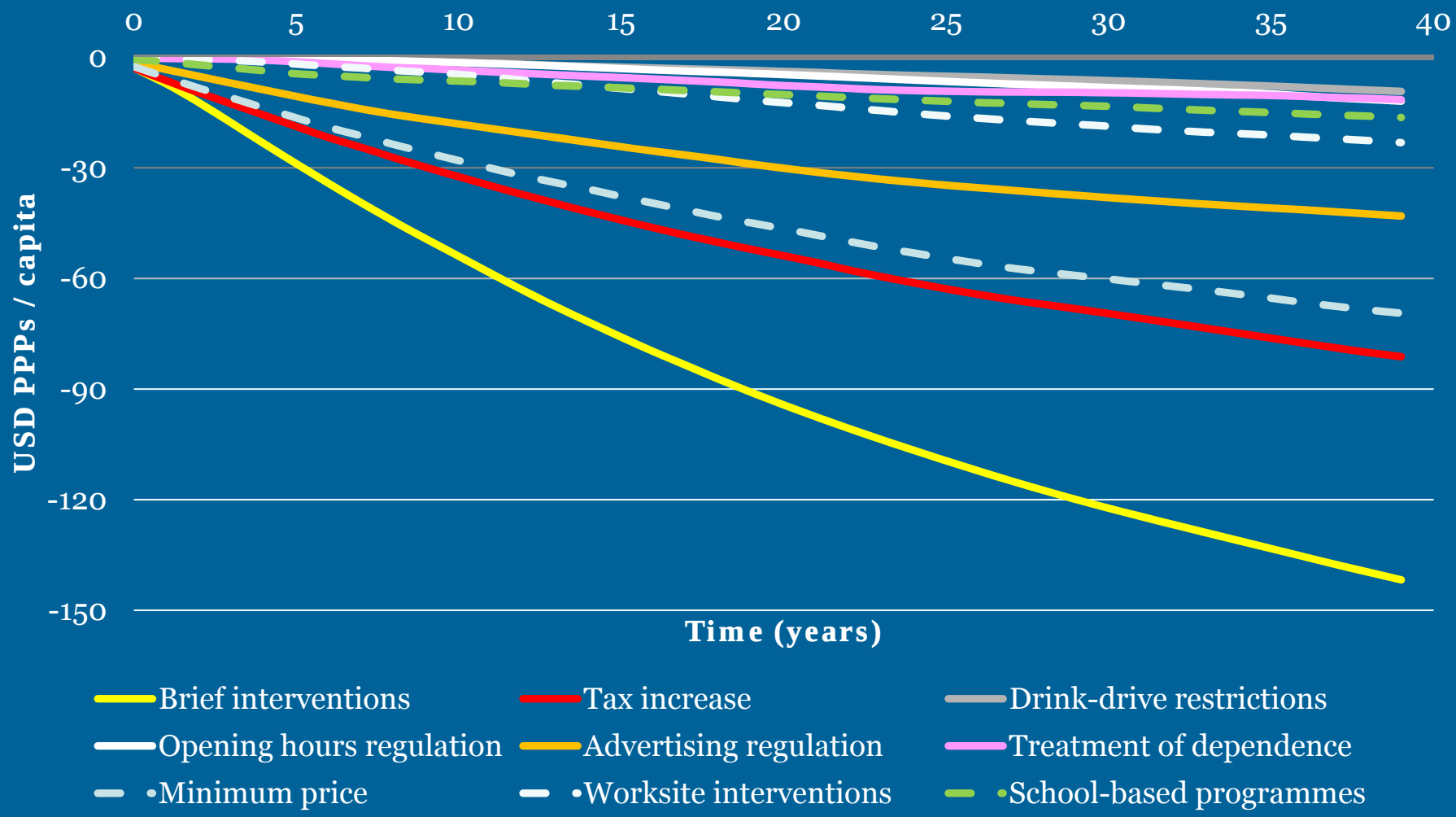
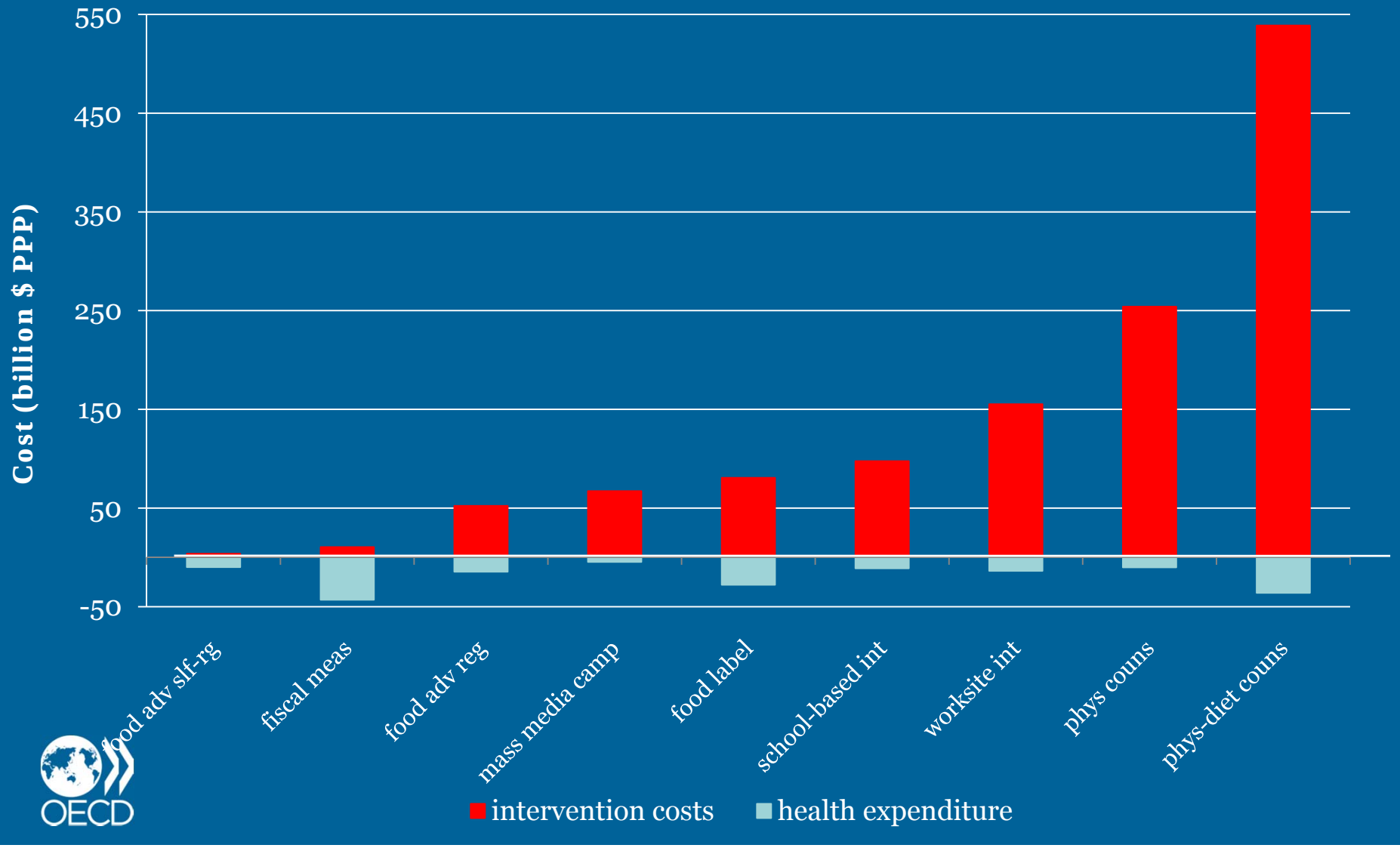
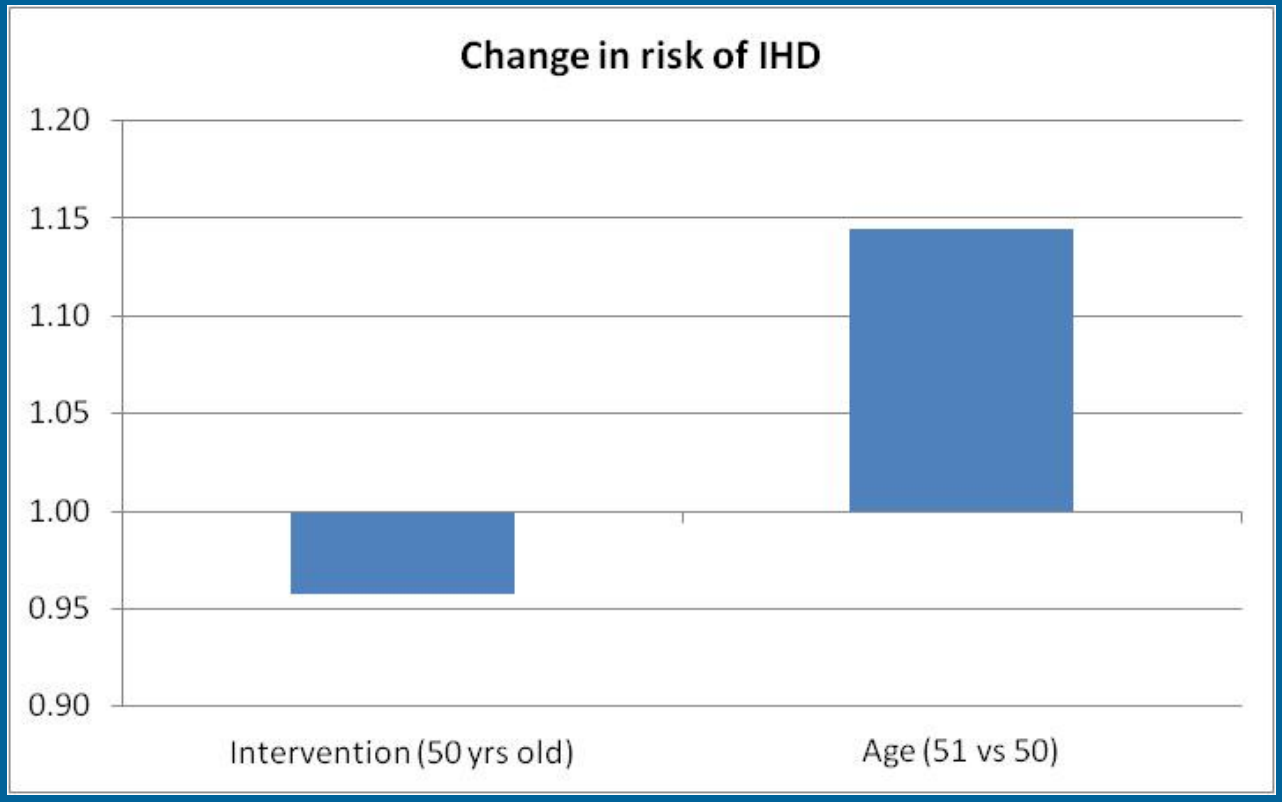
Alcohol Policies, Germany



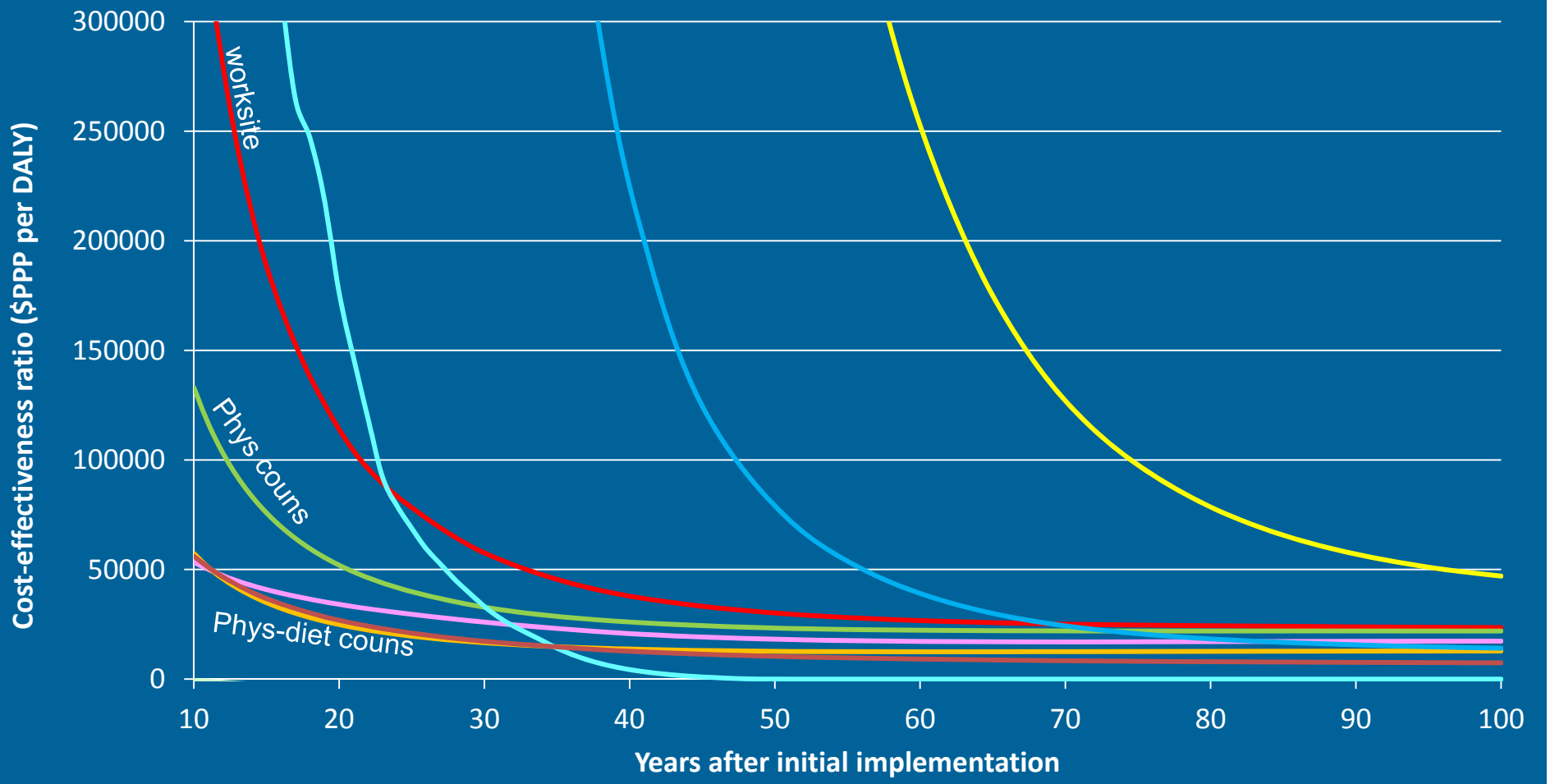
Financial Impacts



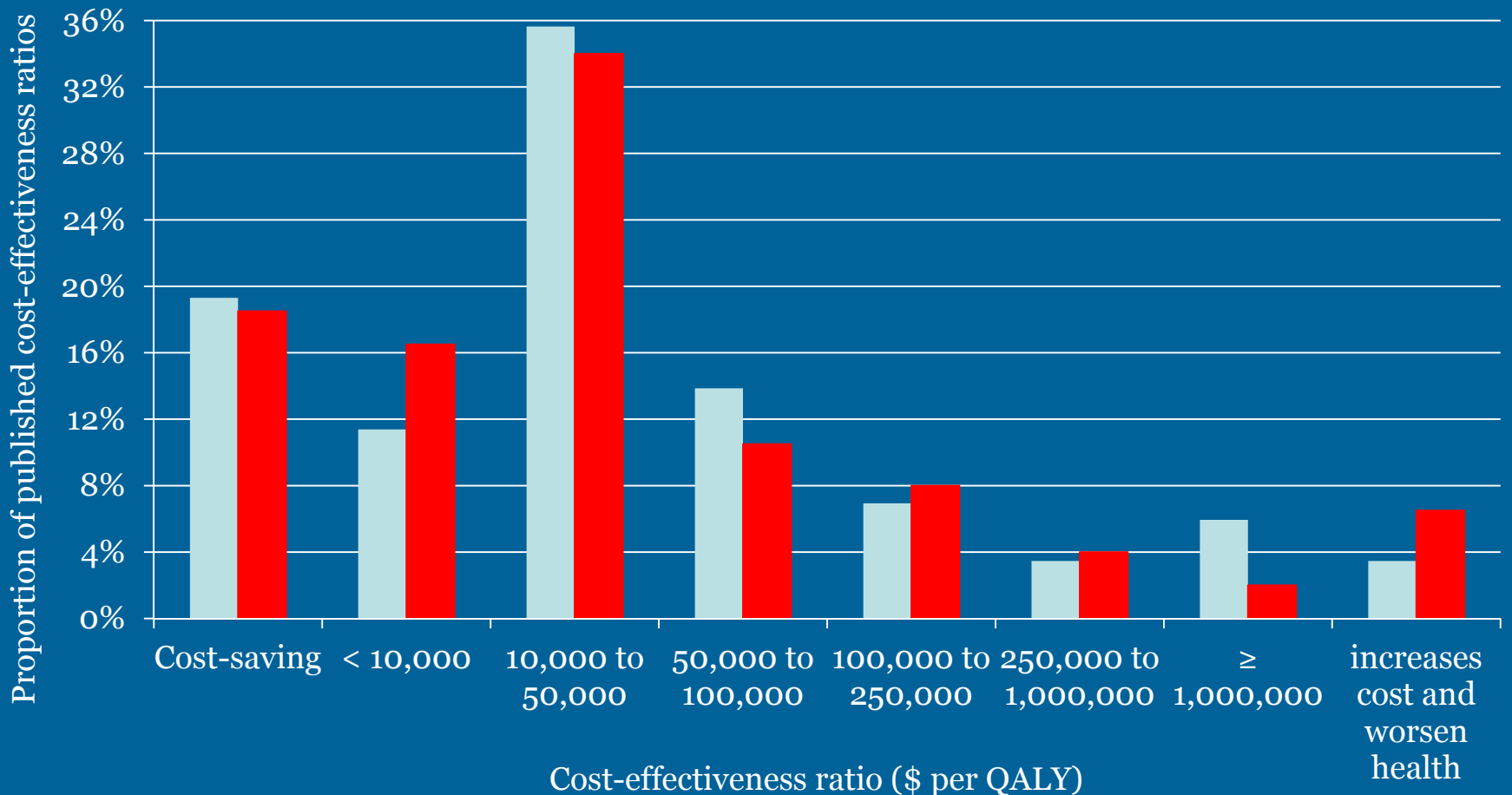
Prevention vs. Age



Cost-Effectiveness of Prevention



Cost-effectiveness of Prevention



Adapted from Cohen JT, et al. NEJM 2008;358(7):661-3

Monetary Values for Health?

- Intersectoral resource allocation requires an assessment of the value of the benefits of interventions
- Cost-benefit analysis is not simply a version of CEA with monetised health outcomes…
- …but, valuing health outcomes in monetary terms is a necessary condition for assessing impact on social welfare
- Inconsistent practices for valuing life and life years

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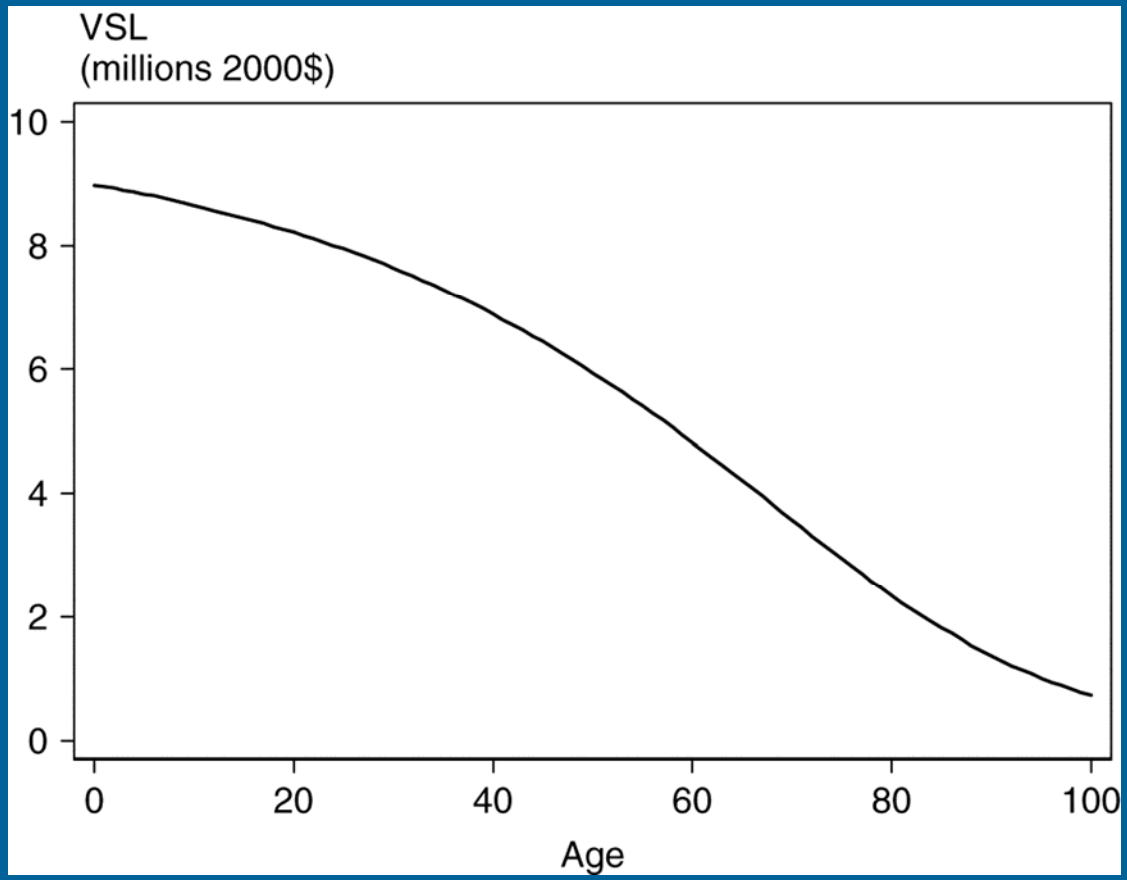
Value of a Statistical Life



Aldy, J. E. et al. Rev Environ Econ Policy 2007 1:241-260; doi:10.1093/reep/rem014

Age–VSL pattern over the life cycle based on VSLY. Notes: The age-specific VSLs are constructed by the authors assuming a VSLY of $300,000, a discount rate of 3 percent, and age-specific life expectancy based on the 2002 US Life Tables

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Public Health Actions

- Improve life and health expectancy
- At a low cost per capita
- Generally cost-effective
- May reduce health expenditures
- May improve health inequalities

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Economics of Prevention @ OECD

- OECD Obesity series
- OECD/WHO-Euro/Europ. Observatory book
- OECD health working papers HWP 32, 45, 46, 48, 66
- Lancet papers on NCDs and priority interventions
- WHO/OECD “Best buys” paper for the UN Summit on NCDs

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