Medical Spending, Health Insurance, and Measurement of American Poverty
Gary Burtless and Sarah Siegel
in Race, Poverty, and Domestic Policy
Published in print: 2004 Published Online: October 2013
Item type: chapter

This chapter discusses health care expenditures, particularly on the effects of three basic methods of including household spending on health care in the measurement of poverty. The first is the method embodied in the official poverty statistics. The other two are based on the recommendations of the National Academy of Sciences (NAS) Panel on Poverty and Family Assistance. The chapter begins with the definition of poverty, followed by alternative approaches to treating household medical spending in an assessment of family needs and resources. It also describes the theoretical approach proposed by the NAS poverty statistics panel and then outlines the alternative methods suggested for this approach. The treatment of health insurance and health care expenses in the definition of poverty are then discussed. The chapter ends with an analysis of statistical results and a brief conclusion.

Moral Hazard in Health Insurance
Amy Finkelstein
Published in print: 2014 Published Online: November 2015
columbia/9780231163804.001.0001
Item type: book

Moral hazard—the tendency to change behavior when the cost of that behavior will be borne by others—is a particularly tricky question when considering health care. Kenneth J. Arrow's seminal 1963 paper on this topic (included in this volume) was one of the first to explore the implication of moral hazard for health care, and this book examines this issue in the context of contemporary American health care policy. Drawing on research from both the original RAND Health Insurance
Experiment and personal research, including a 2008 Health Insurance Experiment in Oregon, the book presents compelling evidence that health insurance does indeed affect medical spending and encourages policy solutions that acknowledge and account for this.

An International Look at the Medical Care Financing Problem
David M. Cutler

in Health Care Issues in the United States and Japan
Published in print: 2006 Published Online: February 2013
Item type: chapter

This chapter emphasizes that, as populations age and medical spending rises, medical systems will account for an increasing part of economic activity. It is noted that demographic change will present a financing hurdle for all developed countries. It is also assumed that medical costs increase at all ages by 1 percent per year above the rate of per capita gross domestic product (GDP) growth. Continued increases in costs result in disproportionately large increases in the size of the medical sector. There are three possible ways to pay for the coming medical care burden: firstly, increase revenues from people currently alive to pay for medical care in the future; secondly, wait until the future and then tax working generations to pay for the increased medical care burden that future elderly will incur; and, finally, make people pay more for medical care when they use services, especially at older ages.

Total Lifetime Costs of Injuries
Eric A. Finkelstein, Phaedra S. Corso, and Ted R. Miller

in The Incidence and Economic Burden of Injuries in the United States
Published in print: 2006 Published Online: September 2009
Item type: chapter

This chapter quantifies the total lifetime costs of injuries that occurred in 2000, defined as the sum of medical spending and lost productivity due to morbidity and mortality. The magnitude of total costs is driven by several factors, including the initial incidence and severity of injury, the resultant period of physical impairment and disability, and, for fatal injuries, the number of life years lost. The contribution of each of these factors determines the allocation of total costs between medical spending and lost productivity. In addition to presenting total cost
estimates stratified across many dimensions, this chapter demonstrates how the relative burden changes as the focus shifts between incidence, medical costs, lost productivity, and total costs.

Insurance and new technology
Mark V. Pauly and Adam Isen

in The Economics of New Health Technologies: Incentives, organization, and financing
Published in print: 2009 Published Online: February 2010
Publisher: Oxford University Press
Item type: chapter

There is a correlation between growing real income and growing medical spending, but the process that might link the one with the other is unknown. This chapter explores whether and how the linking mechanism is affected by health insurance. It hypothesizes that changes in health insurance in individual countries and variations in health insurance across countries might be expected to influence the pace, shape, and cost of technological change. It derives some economic models of the relationship between insurance, and the demand for and supply of new technology in a market-based setting with a private supply of both medical care and insurance.

The Risk of Out-of-Pocket Health Care Expenditure at the End of Life
Samuel Marshall, Kathleen McGarry, and Jonathan S. Skinner (eds)
in Explorations in the Economics of Aging
Published in print: 2011 Published Online: February 2013
Publisher: University of Chicago Press
Item type: chapter

The chapter analyzes the magnitude, variation, persistence, and composition of out-of-pocket medical expenditures among older households. It highlights the extent to which high out-of-pocket burdens represent temporary financial shocks, such as from a more sudden acute illness, or persistent financial burdens, such as from a long-term chronic illness. The chapter also adds perspective on the broader changes in finances that are likely to affect individuals in the period leading up to death, and that may explain changes in asset holdings that are larger than out-of-pocket spending for health care. The chapter takes a note of transfers to children, charitable donations, perhaps travel, and lost
earnings (by self or spouse) as illustrations of how asset profiles might be altered by terminal illness.

Introduction
Ana Aizcorbe, Colin Baker, Ernst R. Berndt, and David M. Cutler

in Measuring and Modeling Health Care Costs

Medical care costs accounts for nearly 18% of Gross Domestic Product (GDP) and 20% of government spending. As a country, we know a lot about where the medical dollar goes. 38% of medical care dollars are paid to hospitals, 31% is paid for professional services, 12% is for outpatient pharmaceuticals, and so forth. But this is not really what we value. The goal of medical care is not to poke, prod, or take pictures of our insides; rather, it is to improve our wellbeing. To really understand health care, we need to determine what it is doing for our health. Health accounting is not easy. Academics and statistical agencies have struggled with it for decades. Questions range from the mundane—how do colonoscopy prices vary across payers? —to the fundamental—to what extent is medical care improving the population’s health? With this much uncertainty about the value of medical care, it is incumbent on public and private researchers alike to regularly survey the landscape. What do we know about medical care costs and output? Where can we make improvements in our measurement systems? What areas remain unexplored? These issues are studied in this volume.

The Burden of Injuries
Eric A. Finkelstein, Phaedra S. Corso, and Ted R. Miller

in The Incidence and Economic Burden of Injuries in the United States

This chapter provides an overview of the results and discusses trends in incidence and costs by comparing the results to those reported in the 1989 report. It also includes a discussion of key limitations and areas for future injury research and prevention.
The Simultaneous Effects of Obesity, Insurance Choice, and Medical Visit Choice on Health Care Costs

Ralph Bradley and Colin Baker

in Measuring and Modeling Health Care Costs

Published in print: 2018 Published Online: January 2019
Item type: chapter

While previous studies on obesity’s effects on healthcare costs conclude that obesity increases costs, they do not control for the endogeneity of insurance and estimate a tobit model for the corner solution when individuals have no medical expenditure. This study recognizes that there are unobserved heterogeneous factors that guide choices on health insurance, body mass index (BMI) and visiting a provider. Therefore, neither health insurance nor BMI can be treated as exogenous in estimating a cost function and a tobit model must be used to account for corner solutions when the individual does not visit a provider and incurs no medical costs. We find that obesity raises medical costs by $430.33, and that a 10% reduction in the BMI of each obese person would only lower costs by $45.28. The obesity elasticity with respect to cost is only .0115%.

Evidence for Significant Compression of Morbidity in the Elderly US Population

David M. Cutler, Kaushik Ghosh, and Mary Beth Landrum

in Discoveries in the Economics of Aging

Published in print: 2014 Published Online: January 2015
Item type: chapter

The question of whether morbidity is being compressed into the period just before death has been at the center of health debates in the United States for some time. Compression of morbidity would lead to longer life but less rapid medical spending increases than if life extension were accompanied by expanding morbidity. Using nearly 20 years of data from the Medicare Current Beneficiary Survey, we examine how health is changing by time period until death. We show that functional measures of health are improving, and more so the farther away from death the person is surveyed. Disease rates are relatively constant at all times until death. On net, there is strong evidence for compression of morbidity based on measured disability, but less clear evidence based on disease-free survival.