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Comment Amitabh Chandra

In a series of penetrating papers, Jim Smith and collaborators have demonstrated that Americans are sicker than their British counterparts and that these differences are not the consequence of better diagnosis in the United States. Nor are they the consequence of the United States having larger minority or immigrant populations, for these groups were excluded from their analysis. What we do not know is why are Americans at a health disadvantage? Simple explanations such as diet, drinking, and smoking are insufficient explanations. Americans are not always lagging in these behaviors, and the implied health effects of these behaviors are not large enough to explain the puzzle that Banks, Oldfield, and Smith have confronted us with. And so, we wonder—what explains these cross-national health gradients? And how much of the higher medical spending in the United States is a consequence of greater disease burden?

This chapter suggests that the answer might be the differential impact of conditions early in life and in childhood. There is now a well-developed literature on the importance of the “fetal origins” hypothesis and the long reach of childhood insults on adult health outcomes. This chapter invokes these mechanisms to demonstrate that they may be also explain cross-national differences in adult health outcomes.

My summary of the chapter is this: there is a 7 percentage point difference in the prevalence of major diseases (with the United States being the disadvantaged country); these are diseases such as cancer, lung disease, stroke, angina, heart attack, and heart failure, and 40 percent of this difference is explained by childhood socioeconomic status and disease. For diseases such as angina, heart attack, heart failure, hypertension, and diabetes, the difference in prevalence is 11 percentage points, 30 percent of which is explained by these factors. The chapter does not separate the role of in utero factors from those that emphasize the role of childhood factors, so we should think of it as assessing the fullness of both these influences and the role of early circumstance more generally.

Explanations for worse early childhood probably lie in three categories—policy differences, environmental influences, and genetic differences. While differences in gene expression have been shown to predict health outcomes, my reading of the genetics literature is that these characteristics are sufficiently diffuse and their effects too small and too fragile to account for

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cross-national differences in health outcomes. More likely is the role of policy and the environment, and I explore these channels next.

One reason for England's superior performance during childhood may be the presence of better health care, especially for the most vulnerable children. The National Health Service (NHS) was created after World War II in England. It offered universal coverage for hospital services and primary care. Most relevant for child health were that its provisions included maternity and child welfare clinics, vaccination, and immunization programs. There were "health visitors," community health nurses who provided families with information on infant caring and feeding, and evaluations of development. In contrast, the United States created the Medicaid program almost twenty years after the United Kingdom (in 1965). Medicaid is a needs-based program whose generosity is substantially less than what the NHS offers, and so while it is targeted, it targets children and not their parents. Despite these limitations, Janet Currie and Jonathan Gruber have found large effects of Medicaid expansions on the dimension of infant mortality. Infant mortality is only one (rather extreme) dimension of childhood health, so it's possible that the protective effects of these expansions are larger than what has been measured. It may also be the case that it is not the health insurance per se that improves child health, but the preventative care and surveillance that came with the NHS but rarely accompany health insurance contracts in the United States. So one explanation for United States-England differences in health are consistent with the interpretation that England offered more comprehensive health care than the United States and that these investments pay off in later life.

One implication of my suggestion that health care and health insurance affect childhood well-being is that the English advantage in health should not be the consequence of selective survival, where vulnerable infants die early. Thankfully, the authors earlier work rules out this channel. But what is troubling for my explanation is table 9.1. If the NHS and associated interventions were responsible for the English advantage, we should see reduced prevalence of childhood illnesses for cohorts born after the introduction of the NHS. That evidence is not there in my reading of this table. Either the channel that I have posited is not at work, or we're asking too much of the data in being able to discern cohort level differences in the prevalence of self-reported medical conditions (an exercise where idiosyncratic variation in reporting may swamp the signal that we're chasing). Perhaps someone will examine the effect of the NHS on child health more directly.

Alternatively, there is the role of the physical and social environment. Janet Currie, Ken Chay, and Michael Greenstone have been chipping away at this problem, and their work proves that reductions in air pollution, even from a very low base, can exert large effects on infant mortality. Are there other such environmental stressors that harm American children? Relatedly, the social environment can matter for adults, and through this channel, their

children. I'm thinking here of issues concerning work-life balance that affect adult stress, depression, and anger, as well as aggravators such as financial security and job insecurity that affect parents' ability to concentrate on children's health needs, allergies, and well-being. Is it possible that Americans are materially better off, but on these margins of performance, we lag the English? Clearly, we have much work to do in sorting out these channels.

As you can tell, I've enjoyed this chapter very much. There is much to like about this work and research program, and I look forward to the next installation from this wonderful team.