SESSION I

VALUING STATISTICAL LIVES

Moderators' Notes

Moderators: Nathalie Simon and Nicole Owens (Environmental Protection Agency)

Currently, in order to value mortality risks associated with foodborne illness, analysts in various Federal agencies rely on the existing economic literature in this area, comprised primarily of hedonic labor market studies. The resulting values from these compensating wage studies have a number of shortcomings in the context of valuing food safety risks. First, the risks addressed by the labor market studies generally befall prime-aged males, whereas the populations most susceptible to foodborne mortality risks are children and the elderly. Second, the mortality events in the labor market studies are accidental and are therefore preceded by short, if not non-existent, morbidity periods. Foodborne mortality events in contrast can sometimes follow extended and very painful morbidity periods that vary in length from one illness to another. The discussion in the breakout session focused on the shortcomings of existing statistical measures and the need for more appropriate measures (either pulled from a re-examination of the existing literature or new VSL studies). Before embarking on a quest for new estimates on the value of a statistical life, however, several issues need to be addressed:

1. How should the agencies define "high-quality" VSL studies? Is there a set of characteristics that should be present for a study to be characterized as such? If so, what features are included in this set?
2. Which foodborne illnesses pose the greatest mortality risk to the population and what are the characteristics (symptoms, population at risk, length of morbidity period, etc.) of these illnesses?
3. Should VSL estimates be developed for deaths resulting from specific illnesses? If so, for which illnesses should specific values be estimated?
4. Should the mortality event be treated separately from the morbidity period that often precedes a death due to foodborne illness? Are there circumstances in which it is appropriate to value the illness as a whole (morbidity + mortality)? If so, what are these circumstances?
5. Should new VSL studies focus on risk reductions for specific illnesses or is it more appropriate to focus on risk reductions resulting from a particular program? That is, should we be valuing health endpoints or programs?
6. How can analysts more adequately transfer VSL estimates derived from studies in which the magnitude of the risk reduction is stated explicitly to situations in which the magnitude of the risk is very uncertain.