CHAPTER

2 Why Is It Critical for Macroeconomists to Understand Health Issues?

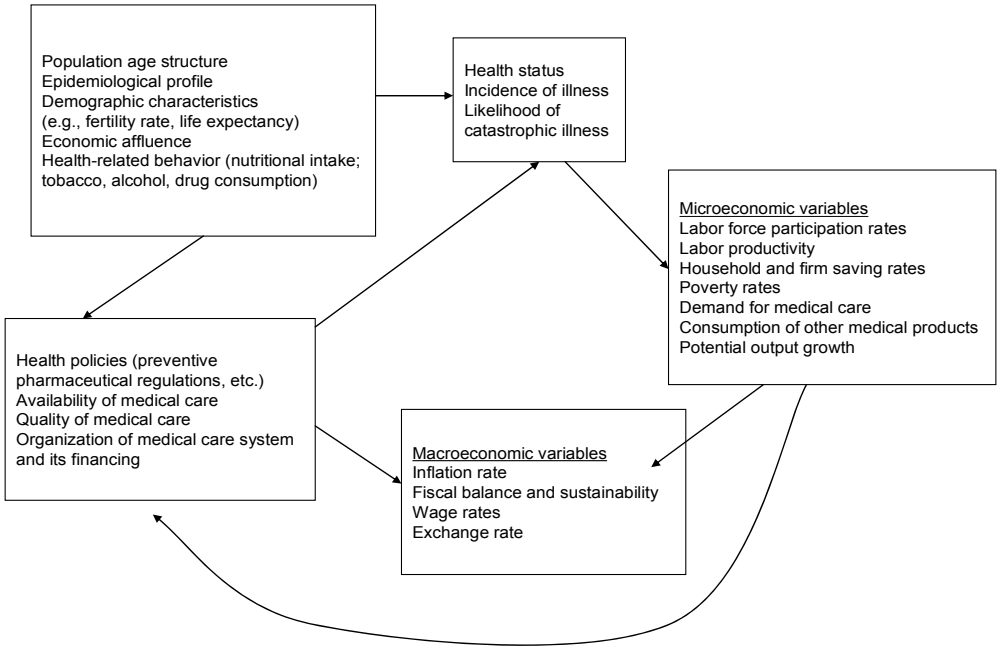
As a general rule, issues of health care policy have not generally been seen as the domain of macroeconomists. Only in recent years, with the report of the World Health Organization's (WHO) Commission on Macroeconomics and Health (CMH) (WHO, 2001, 2002), has there been a greater focus on why health issues are relevant to macroeconomic policymakers and, in particular, ministers of finance. That report also provided further support for the prominence of health goals (for example, reduced infant and maternal mortality rates as well as reduced prevalence rates for HIV/AIDS, malaria, and tuberculosis) in formulating the MDGs. The CMH initiative principally sought to demonstrate that progress in improving health in low-income countries could be a critical factor influencing the growth potential of a country. In particular, the CMH report explored the various ways in which better health status could improve the quality of the labor force; enhance productivity, in both the short and the long run; limit the extent to which catastrophic illnesses can lead to households falling into poverty; raise household saving rates; and reduce fertility rates.[3]

In what follows, a broader set of arguments is laid out to further strengthen the case for macroeconomists to put issues of health care policy on their agenda as they seek to understand the functioning of the macroeconomy. Such arguments pertain not only to low-income countries but to middle-income and advanced economies as well. The principal focus will be on how issues of health influence the macroeconomy.

A shorthand version of the argument is shown in Figure 2. One starts with the recognition that the health status of a population is fundamentally influenced by its age structure, its exposure to various epidemiological vectors (in part owing to geographic factors), its degree of affluence, its behavior (concerning nutrition and exposure to adverse epidemiological

[3]These points were developed principally by the report of Working Group I of the CMH (WHO, 2001, 2002).

Figure 2. Channels through Which Health May Influence Macroeconomic and Microeconomic Variables



factors), and its demographic characteristics (for example, high or low fertility rates). This starting point will obviously influence the demands placed on a country's health care system. And, as noted by the CMH, the population's health status is likely to have an important influence on various microeconomic labor market and saving variables, which can influence the state of the macroeconomy.

But the health status of a population is also influenced in part by the nature of the health policies pursued by a government—the provision of public goods (such as immunizations and vaccinations), the quality of the regulatory policies with respect to pharmaceuticals, and the extent of activism in the control of public "bads" (such as antidrug or anti-tobacco policies)—and by the quality and quantity of the medical services available to the population (whether from the public or private sector). In general, it is reasonable to assume that the health status of individuals is positively influenced by the activities of a country's health care system.

Yet how a society organizes itself in terms of the implementation of its health policies and in the financing of the provision of health care is also likely to have a direct and *independent* impact on macroeconomic variables, recognizing that the extent of the impact will differ across countries (depending on the

size and relative importance of the health care sector). And of course, the state of the macroeconomy—the level and distribution of income in particular—will influence the capacity of a government and the private sector to provide health care and implement health policies.

The channels through which health policies, and the organization of the medical sector and its financing, can influence macroeconomic variables include but are not limited to the following relationships.[4]

- *Pressures for the introduction of new medical technologies and drugs:* As new technologies and drugs become available to address medical problems, it is likely that doctors and medical practitioners will wish to prescribe them and that patients will demand their availability. In a government-financed health system, or one under which third-party payers (employer-financed insurance systems) bear the cost of health care, there will be pressures from the public or insured populations to accommodate these demands, which will give rise to budgetary pressures. The higher cost of such new products and procedures may ultimately be reflected in the consumer price index (see Lubitz, 2005).
- *Other underlying demand pressures for increased health spending:* Whether from the impact of an aging population or the effects of a high prevalence of a specific disease (for example, HIV/AIDS), pressures from increased demand for health care will develop. Again, particularly when the government intermediates the financing of health care, pressures on the budget will emerge. Recent projections by the Organization for Economic Cooperation and Development (OECD, 2006) of rising fiscal outlays on the health sector illustrate this phenomenon. For example, the OECD projects that for Korea and Mexico, health and long-term-care spending will rise from 3.3 percent of GDP in 2005 to 11.9 percent by 2050 in the absence of cost-containment policies (and as high as 9 percent of GDP even with the implementation of such policies). Smaller but nevertheless substantial increases (on the order of 40–100 percent) in the share of health spending in GDP are projected for many other industrial countries.[5]

[4]There are obvious questions to be raised concerning the relationship between the set of health policies and health care organization prevailing in a country and its impact on the health status of the population. Does the health care system actually deliver results in terms of improving the population's health status (often measured in terms of either quality-adjusted or disability-adjusted life years)? What factors determine the composition of spending on health care? Who in the society decides what is provided in the way of health care, both in terms of curative and preventive interventions?

[5]Also see Follette and Sheiner (2005).

- *The "Baumol effect" on the relative cost of the health care sector:* If there is less capacity in the medical sector for increased productivity relative to that in the rest of the economy (given its labor intensity), one would observe relative price increases in the sector, as sectoral wages, rising at the rate of national productivity growth, outpace sectoral productivity gains.
- *Pressures on health financing may give rise to a need to raise tax or insurance rates or product prices:* Governments may seek to address the fiscal imbalances associated with higher health spending by raising tax rates (for example, the payroll tax rate), with potential adverse effects on efficiency (reflecting the excess burden created by higher tax rates). Companies that provide insurance coverage for their employees or retirees may find that rising health care costs constitute an increasingly large share of compensation costs, putting pressure on product prices and raising competitiveness concerns. This may also lead to an increase in the copayment rates borne by employees.
- *Organization of the financing of health care will influence key macroeconomic variables:* The relative balance struck between out-of-pocket financing by households, social health insurance (with alternative copayment provisions, such as among employee, employer, and government), and publicly financed provision (through general tax revenues) can have obvious differential effects in terms of the level of tax rates and the saving rate. It can also influence the potential for health care costs to influence whether serious health incidents cause households to fall into poverty (because the cost of care depletes assets or from the loss of income experienced as a consequence of the illness episode).
- *Prospects of higher medical costs may be a factor influencing household saving decisions:* There is some evidence in the United States suggesting that the elderly may be saving more than would be expected, given their stage in the life cycle, to ensure the availability of resources to finance catastrophic or long-term care in later years. In countries reliant on household savings to finance health care, one may observe the introduction of 401(k) types of saving incentive schemes or even compulsory saving mechanisms (for example, Medisave in Singapore).
- *"Externality effects" of spending in the health sector:* Many low-income countries are now the recipients of significant external grants to finance expanded health service delivery in relation to HIV/AIDS treatment. In the short run at least, the need to substantially increase salaries to attract and retain medical sector workers may create pressures for higher wages for skilled workers in other parts of the public sector.
- *Capital market issues:* If a country's future fiscal sustainability appears to be jeopardized by the prospect of the coincidence of an aging population and rising health care costs, sovereign risk questions may arise in financial markets, leading to a higher risk premium on government borrowing.

- *Possible current account effects of spending in the health care sector:* There are a number of ways the health sector may affect the current account of the balance of payments. For some advanced countries, the health care and pharmaceutical sectors may be a source of export receipts (through the export of drugs or the purchase of health care services from local providers). Medical tourism and the export of medical personnel may also be a source of foreign exchange receipts for some low- and middle-income countries. For countries where medical sector spending is a significant share of GDP, one could speculate as to whether it is more or less import-intensive than other forms of spending.
- *Political economy dynamics arising from the health care sector:* Policies in the health sector may give rise to important political economy effects. In countries with social health insurance mechanisms, businesses may attempt to shift a higher share of the cost of financing health care provision to the government.
- *Health status issues may limit the capacity of government to implement other policy reforms:* If there is a high incidence of disability among the older members of a country's workforce, this may constrain a government's capacity to raise the formal retirement age of its public pension system.

It is not easy to be definitive about the strength of the respective roles of government and the private sector in the financing and provision of health care in terms of intermediating these relationships. On the one hand, if the government is heavily engaged, there may be political economy pressures for higher spending on health care. In contrast, it might be thought that if the private sector is the principal source of financing of health care (with only a limited role for government), then, although there may be pressures for higher spending, these may be constrained by the capacity of the private sector to bear these costs. But the empirical evidence suggests otherwise because of market failure. Certainly in low- and middle-income countries, where the private sector plays a dominant role, the pressures for spending remain strong. Households go into debt or deplete both their own and their relatives' assets to finance the purchase of medical care. For example, in China, less than 15 percent of national health expenditure is financed by tax revenue. Yet that has not prevented real health expenditures from rising by 15 percent annually, substantially in excess of GDP growth.

The role of macroeconomists in relating to government policies in the health sector is also a challenging question. The above discussion suggests that both the health status of a population and health care delivery systems can influence key macro variables—the fiscal balance, tax rates, wage rates and competitiveness, prices, and possibly even interest rates and the current account. Again, one could argue that in a system where the government does not intermediate in the financing of the health sector, the decision of households regarding the share of their income devoted to health care should

not be distinguishable from the decision of households to allocate their income to other forms of consumption. If individuals attach a high value to being healthy, to living a longer and healthier life, and if health care interventions can deliver these "goods," it should be a matter of indifference to macroeconomists whether the share of national income devoted to health care is 10 percent or 25 percent (see Cutler, 2004). Yet the role of market failure in the health sector suggests that the pressure for higher spending derives from more than demand factors, such that any adverse macroeconomic effects from the expansion of the sector cannot be downplayed as simply an unfortunate consequence.

But in most advanced countries, and indeed in many middle-income countries, governments *do* heavily intermediate the financing of health care. Therefore, it does matter who bears the burden of financing of health care (particularly if it leads to impoverishment of families). It also matters that such spending may have macroeconomic effects. These are particularly problematic issues because the benefits of health care will inevitably accrue to some segments of the population (say, retirees) as opposed to those who bear a disproportionate share of the financing (say, wage earners or general taxpayers) or to those who may be affected by the macroeconomic effects of higher spending on health care. These issues become even more difficult in light of the relative effectiveness of alternative approaches to organizing health care delivery or financing, or of the value of different interventions in influencing health status. Macroeconomic policymakers (or the IMF, in the context of exercising its surveillance responsibilities) cannot be wholly indifferent to the question of why some countries allocate significantly greater shares of their output to health care and yet do not observe commensurately better levels of health status (say, as measured in quality-adjusted or disability-adjusted life years).