Primer for macroeconomists

Health sector’s unique characteristics argue for right mix of government, private sector roles

In a recent IMF Working Paper, What Should IMF Macroeconomists Know About Health Care Policy: A Primer, William Hsiao examined the implications of health sector policy for equity, growth, and poverty reduction strategies. Hsiao, who is K.T. Li Professor of Economics at Harvard University and Director of the Program in Health Care Financing at Harvard’s School of Public Health, talks with the IMF Survey about his findings.

IMF Survey: Why should macroeconomists, such as those at the IMF, be interested in the health sector?

Hsiao: For several reasons. First, macroeconomists—including those from the World Bank—cannot do their jobs properly without compatible and coordinated policies on the macroeconomic side. Second, economic development is not the ultimate end in itself. We want higher incomes so we can have better lives, and for that we need better health. And, third, there is a practical matter: steady economic growth needs a stable political environment. When health and health care are distributed unequally, people become unhappy, which can lead to social instability and, in turn, political unrest. We have witnessed this relationship in China, Kenya, and the Philippines, among many countries.

Low-income countries in particular suffer from having top economic policymakers say they don’t have time to worry about sectors like health. You just cannot provide people with reasonably good health care and protect them from impoverishment caused by catastrophic medical expenses without compatible macroeconomic policy.

IMF Survey: What roles do the private sector and government have in the health sector?

Hsiao: Economists often assume that the health sector operates like any other economic sector, but it does not. The free market that we rely on for economic activities addresses only efficiency issues, not equity issues. We all recognize the need for government to intervene in some sectors because we are not all created equal in health and in economic circumstances. Some people are healthier than others, and some are born with handicaps.

There are often two schools of thought on finance and delivery of health services: “Let the government do it,” or “Let the market provide it.” My paper argues that both the market and the government have serious failures in financing and delivering health services. Dozens of countries have put themselves up as natural experiments on how the private market can finance health care and provide health services. These natural experiments attest to the severity of the market failures.

In the United States, for example, the market enables people who are employed and earn average incomes to have health insurance. But the less healthy, the elderly, the disabled, and the poor are not insured by the market, and the U.S. government found it had to step in to finance health care for these groups. In the United States, 17 percent of the population is still uninsured because they are unemployed, partially employed, or work in low-wage jobs. The market has not been able to solve this problem. In the economic boom of the past decade, the number of people uninsured in the United States increased rather than decreased.

Why is this so? Well, the answer lies in the political economy. People who already have insurance and good incomes say, “Health insurance isn’t an issue for me; why should I pay more taxes to support those other people?” The United States is the country that has gone furthest in relying on the market to finance and deliver health care. The market skimmed the cream off the top and left the rest for the government. The government was not able to withdraw and let the market take over. Right now, 45 percent of total health expenditures are financed by the government, a sizable percentage of the population remains uninsured, and there is no political support to do something universal.

On the delivery side, too, there are serious market failures—including the ability of health providers to induce demand. We go to our physicians for their expertise, follow their advice, and allow them to order tests. The health sector is driven by the supply side. The more surgeons we produce, the more operations we have. The United States has an oversupply of surgeons, and close to 20 percent of its surgery is unnecessary.

By contrast, the United Kingdom and many low-income countries depend on the government to organize and produce health services. This, we found, can be even worse than letting the market do it. Bureaucracy and politics seep into a vast system that delivers services on a daily basis. Governments just do not have the capacity to manage such a system efficiently or for the benefit of the patients. As patients, we want some compassion when we are ill, and government-managed services usually cannot provide that.

The world’s experiences have taught us that on the financing side, we need significant government involvement. On the delivery side, government can set down strict rules and control supply, but should then
allow the market to operate. Experience demonstrates that the health sector is extremely complex and that the right combination of government and market involvement is needed.

IMF Survey: Are there certain countries whose health sectors can serve as models?

Hsiao: My paper divides country experiences by income level. For high-income countries, most nations see the Canadian system as one of the best. It provides universal financial access to health services and offers patients a choice of primary care doctor and hospital. Choice is important because medicine is both a science and an art, and there will always be issues of personality, empathy, or culture. And in terms of results, by every measurable statistic, Canadians’ health is as good as, or better than, other countries; Canadians are satisfied with the speed and kind of services they receive; and Canada has kept its health care costs under control.

IMF Survey: What type of health economics issues do low- and middle-income countries face and which countries come closest to meeting their needs?

Hsiao: My paper argues that health care is a means to an end. Societies universally want a health care system to improve people’s health. Most countries also want good health distributed equitably, so that the rich don’t live to be 100 while the poor die at 40. And, because a major health problem can bankrupt a family, societies generally seek to protect their people from catastrophic medical expenses and financial ruin. Also, the quality of care, and people’s satisfaction with it, is a consideration in many societies.

Low-income countries, of course, have fewer financial and medical resources, and their health care outcomes are not as good as those in high-income countries. Many experts, however, tend to think that what works in the United Kingdom should work in India or Uganda, and they advise countries without factoring in all the resources, human knowledge, and institutions required to make the U.K. system work in a low-income country. When we equate high-income and low-income countries, we give inappropriate advice.

But what does work in low-income countries? Well, Sri Lanka—despite war and a shaky economy—has been able to maintain an effective health care system. Compare it, for example, with India. India spends 6 percent of its GDP on health care; Sri Lanka spends about 3 percent. But Sri Lanka produces much better results in terms of health outcomes, risk protection, and satisfaction. How? The structure of the health care system matters.

Sri Lanka has emphasized preventive services, such as immunization and education, and done a particularly good job in training mothers in proper hygiene and in identifying high-risk mothers early. Sri Lanka provides a very low level of hospital care, and about 85 percent of its people rely on government-run hospitals. But Sri Lanka, alone among the low-income countries I have studied, has been able to instill a sense of esprit de corps among its health care professionals.

Both India and Sri Lanka, for example, allow their doctors to maintain private practices. In India, however, many doctors don’t show up at the public hospitals or cut back on their hours there. You rarely see that in Sri Lanka, where the health care professionals work full shifts and do the best they can with very few resources. Sri Lanka has been able to maintain the dedication of its health care professionals and develop real bonds between these professionals and the people they serve. Their midwives visit expectant mothers and families with children. When girls become teenagers, these midwives instruct them in sex education and hygiene. That human relationship makes a great difference.

Middle-income countries are usually much better off than low-income countries because they have a greater economic capacity. They have more ways to tap financial resources, such as social insurance, and more extensive managerial skills to organize public and private activities. But these countries confront a double problem. In slums and rural areas, the rate of infectious diseases (tuberculosis, diarrhea) remains high while chronic conditions (arthritis, diabetes, cancer, heart disease) increase among the largely urban middle and upper classes, who are living longer. Typically, it is the urban elite in these countries who capture the public resources. They want MRIs [magnetic resonance imagings] and other expensive diagnostic procedures, although these may not result in a cure or even better treatment for their ailments. This is equivalent to the dilemma we will soon see as a result of the human genome project. Over the next two decades, we will spend billions more testing people for diseases we cannot yet treat or cure.

Among middle-income countries, Costa Rica has done very well for its people. It decided very early on to adopt an integrated financing strategy for all income groups rather than pursue separate Band-Aid solutions for the urban middle class, the farmers, and the poor and unemployed. Their integrated financing plan took everyone into account and allowed for differences in health services but guaranteed a minimum level of service. Initially, Costa Rica’s social insurance ran its own facilities, but over time it found that efficiency declined and the quality of services became uneven. The country then converted its facilities into autonomous institutions that were nonetheless required to perform certain social functions. For example, visiting nurses provide immunizations that the government pays for.

Among the transition economies, very few have worked out a good solution yet. When a socialist economy transforms itself into a capitalist one, government revenues and services shrink drastically, and the average

Choice is important because medicine is both a science and an art, and there will always be issues of personality, empathy, or culture.

©International Monetary Fund. Not for Redistribution
person lacks resources, too. In addition, the average person resents paying for something that the government had provided as a part of an implicit contract between government and people. In these countries, the people had accepted lower cash wages in return for greater lifetime fringe benefits. Now the government is not honoring its commitments. Transition economies really have to struggle—making small, incremental, politically acceptable changes rather than drastic ones.

**IMF Survey:** How can best practices be replicated?

Hsiao: I’m quite optimistic about replication as long as we do not push for overly simplistic solutions. We must remember that the health sector is not like shoe manufacturing. It does have special characteristics. We can’t say, “Just privatize it!” or “Leave it to the free market.” Of course, we also have people on the other extreme saying, “Let government pay for it!” or “The government must control it!”

IMF economists, who interact with finance ministers and central bankers, can create a strong understanding in the minds of key decision makers. I would urge IMF economists not to draw simply on their home countries’ experiences and to resist the temptation to give simple advice for this complex sector. There is no magic bullet to solve health care issues. Countries need a coherent and integrated public and private system to finance and deliver health care, and the system must be compatible with their culture and level of economic and social development.

**IMF Survey:** What would your advice be, then, for macroeconomists?

Hsiao: Don’t treat the health sector as just another sector. Recognize that it has certain serious market and government failures. And acknowledge that health, like education, involves serious equity issues, and the free market simply does not deal with equity issues. So, the government’s role has to be thought through carefully, and you will need to combine market and government roles. Also, while you cannot treat countries at different socioeconomic levels in the same way, you can design generic models that work at different income levels. My paper gives greater details about these key points and evidence to support them.

I don’t expect IMF economists to become experts in health care, but if they take the health sector’s unique features into account while giving advice to the key economic and financial decision makers, they could help the host country and its people, and facilitate the work of the World Bank.

---

**Copies of Working Paper No. 00/136: What Should IMF Macroeconomists Know About Health Care Policy: A Primer, by William Hsiao, are available for $10.00 each from IMF Publications Services. See page 292 for ordering information.**

---

**Need for further reform**

**Recovery takes hold in Czech Republic; authorities begin to address structural problems**

A recovery has taken hold in the Czech Republic, following a protracted recession that set the country apart from other advanced transition economies in the region that have enjoyed robust growth in recent years. The recession in the Czech Republic had its roots in serious structural problems that the authorities have begun to address. Much remains to be done, however, and perseverance will be essential in sustaining needed reforms.

**Inadequate reforms**

In 1997, the Czech Republic slipped into a recession that deepened over the following year (see chart, page 300). In hindsight, it is clear that the difficulties were rooted in reforms that did not deal in depth with the underlying structural problems and led to widening internal and external imbalances that culminated in a May 1997 currency crisis. The resulting tightening of monetary and fiscal policies controlled the crisis successfully but also triggered the onset of recession. The tight policies remained in place until late 1998, partly because of concerns about contagion from the Russian crisis. These policies helped sharply reduce the country’s current account deficit and inflation (see table, page 299), but at a cost to economic activity.

However, serious structural weaknesses were at the heart of the country’s problems. Incomplete reforms in the banking and enterprise sectors seriously impaired the supply side of the economy. The banking system saw a large accumulation of nonperforming loans—a result of supervision and regulation that had not kept pace with a rapidly growing sector and an incentive structure guiding lending decisions that was not conducive to prudent lending. In the enterprise sector, weak corporate governance—the product of a diffuse ownership structure that emerged from the voucher privatization scheme—delayed much-needed restructuring and, together with excessive credit growth, encouraged large real wage increases, misguided investments, and, in some cases, outright asset stripping. When enhanced bank supervision and prudential regulation as well as the prospect of privatization forced banks to restrict lending, many enterprises were brought to the verge of collapse.