HOW CAN HEALTH SYSTEMS ADVANCE ECONOMIC AND FISCAL OBJECTIVES?

By: Jonathan Cylus, Govin Permanand and Peter C. Smith

Summary: The health system is one of the most important contributors to population health that lies within the direct control of policymakers. Yet when seeking additional funding for their health systems policymakers are often met with scepticism by those in charge of the finances. In this article we explore the evidence that health systems can advance economic and fiscal objectives, including good stewardship of public resources, macroeconomic growth, societal well-being and fiscal sustainability. We argue that a better understanding of the linkages between health systems and economic and fiscal outcomes may be useful when advocating for adequate, stable funding for health systems.

Keywords: Health Systems, Health Financing, Efficiency, Well-being, Sustainability

Facing the sceptics

The 2008 Tallinn Charter on Health Systems for Health and Wealth states that:

Beyond its intrinsic value, improved health contributes to social well-being through its impact on economic development, competitiveness and productivity. High-performing health systems contribute to economic development and health.

This assertion should not be controversial. Scholars such as Nobel Laureate Robert Fogel have established that improvements in health over time have made a major contribution to long-term productivity gains. He argued that reduction of malnutrition, especially at younger ages, was the principal driver of this result.

From a policy perspective, a key research question is therefore whether these findings can be extrapolated to modern economies in which health services have made an increasingly important contribution to health improvements.

Yet health policymakers who seek to make the case for increased financing for their health systems are often met with scepticism within governments. This scepticism may be explained in part by a belief amongst some finance policymakers that health systems do not support (or may even undermine) key economic and fiscal objectives, as summarised in Box 1. The ‘Health Systems, Health, Wealth and Societal Well-being’ model developed for the 2008 Tallinn conference described the pathways through which the health system and national prosperity are linked, and summarised counter-arguments to scepticism about the economic rationale for health spending.
Box 1: Why is there resistance in some countries to spending more on health systems?

There are wide variations in health system spending between countries with apparently similar circumstances, often due to a belief amongst some economists and other financial advisors that health spending is to a large extent an unproductive ‘drain’ on the economy. According to this view, the health sector consumes an increasingly high proportion of national income with few measurable returns compared to investment in other sectors. Specific concerns might include the following:

1) Because of widespread market failures, health systems consume more of the nation’s income than is socially optimal. In particular, systems that provide generous health care coverage encourage excess expenditure because patients have little financial incentive to moderate their demands on the health system.

2) At a certain point, extra spending on health systems does not contribute markedly towards improved health. Many of the most important determinants of health lie outside the health system, so improvements in health might be better achieved through other programmes.

3) All health systems have numerous examples of misallocated resources and waste, and in some cases elements of corruption. It is argued that such inefficiency and misuse of finances should be eliminated, or that greater proof of efficient spending is provided, before considering increased spending.

4) The scope for productivity growth in health services is low relative to other sectors of the economy. While wage growth in the health sector keeps pace with other sectors, its level of output per worker does not. Over time it thus has a natural tendency to attract a higher proportion of national expenditure at the expense of other potentially more productive industries.

5) Much of the spending on health services contributes to longer lives that are not necessarily spent in good health. This creates a societal burden in the form of not only health services, but also long-term care, pensions, and other social programmes, sometimes for people who have minimal quality of life.

In this article we argue that the economic and fiscal objectives of finance policymakers are in many respects actively promoted by health systems, or at least could be, if adequate, stable resources were made available and health policy were developed with broader economic objectives in mind. Our policy brief, prepared for the recent WHO Tallinn Conference*, seeks to support health policymakers by framing available evidence and structuring arguments in a way that is likely to resonate with finance policymakers. The intention is to help health policymakers secure a ‘fair hearing’ in governmental debates about public spending.

Our review of the mission statements and policies of finance and economic ministries of finance in the WHO European Region suggests four broad objectives that are relevant to health ministries: (1) the stewardship of government funds; (2) pursuit of macroeconomic growth; (3) promoting societal well-being; and (4) assuring fiscal sustainability. Using this as a basis, we summarise evidence on the extent to which health systems can promote these objectives, and the challenges that might arise when seeking to persuade economic policymakers of the health system contribution.

Is spending on health systems a good use of government resources?

The contribution to health outcomes

The prime objective of health systems is, naturally, to improve population health. There is a strong and growing evidence base that, especially where spending levels are currently low, additional health system spending does contribute to better health outcomes. There is also evidence that health promoting interventions that carefully target proximal behavioural risk factors such as tobacco, alcohol, unhealthy diet and physical inactivity also have important effects on health outcomes. Such public health interventions, including tax policy, should be included in any consideration of health system effectiveness. However, in spite of well-established research on social inequalities and health, policy interventions that target more distal socio-economic factors, such as education and income, often show less convincing evidence of positive health effects. In short, the best focus for policy action to improve health and health inequalities appears to be health systems.

Tackling inefficiencies

However, inefficiencies exist in most health systems, as they also do in all other sectors, with estimates of between 20–40% of resources being wasted according to the World Health Report 2010. More recently, in OECD countries, when broken down into clinical care (e.g., unneeded hospital procedures), operational issues (e.g., reliance on branded rather than generic medicines or unnecessary hospital referral) and governance issues (e.g., administration), it was estimated that a fifth of all health care spending is ineffective. This raises the question of whether additional health spending is likely to be put to good use. One way to demonstrate that money is being well spent is to monitor health system efficiency. While there is no single set of indicators that will give the complete picture of health system efficiency in a country, there exist many diagnostic indicators that can shed light on the efficiency of discrete parts of a health system and guide remedial action. Health policymakers have indeed made increasing use of efficiency metrics. However, it is important to note that it is possible to

* The WHO high-level meeting, Health Systems for Prosperity and Solidarity: leaving no one behind, took place in Tallinn, Estonia 13–14 June 2018.
have highly efficient elements within an inefficient health system – for example, the hospital sector may exhibit low unit costs, but be treating many patients who should be treated at much lower cost in a primary care setting. Therefore, whilst no single metric can give a complete picture of a health system's efficiency, careful analysis can use a range of such metrics to diagnose the main sources of inefficiency.

**Achieving value for money**

Beyond efficiency measurement, health systems can demonstrate their commitment to responsible use of resources. For example, securing an efficient allocation of resources within the health system has been an important focus of health technology assessment (HTA), particularly in the form of cost-effectiveness analysis (CEA). In their simplest form, these methods seek to identify whether a specific intervention should be funded when seeking maximum health gain for a limited publicly funded health services budget. The principles of CEA have secured widespread acceptance amongst policymakers, and its use can be a signal that health systems are becoming serious about making hard choices, rooting out inefficient practices and being good stewards of public funds.

There are numerous other ways of signalling to ministries of finance that health systems are serious about achieving good value for money. These may include identifying and reducing unjustified treatment variations, more flexible use of human resources (such as task-shifting), better procurement policies (such as negotiating lower medicines prices), or reorganisation of hospitals, just to name a few.

**Are health systems an important driver of macroeconomic growth?**

Quantifying the total contribution of the health system to the broader macroeconomy will always be challenging due to the many direct and indirect ways (often interlinked) in which the two might interact, including through the multiple macroeconomic consequences arising over time from increased life expectancy and changes in incentives to work, accumulate savings, etc. Therefore, rather than trying to estimate the full contribution of the health system to national prosperity by attempting to model all the dynamic feedback effects, it makes sense to consider particular ways in which the health system creates direct and indirect economic benefits at the micro level, where the evidence is more clear-cut.

**Positive benefits for a country's workforce**

Health systems can affect the economy indirectly (via better health) through effects on the workforce, which materialise through multiple pathways throughout the life course. Numerous studies have shown that individuals in better health enjoy improved opportunities for economic participation (including through later retirement) and earnings compared to their less healthy counterparts. Research looking at the role of chronic diseases and associated proximal behavioural risk factors finds strong evidence that obesity and smoking, in particular, have adverse effects on employment, wages and labour productivity. While some policies to prevent these risk factors lie outside the immediate control of health care service providers, there remains a key role for the health system in its preventative function, and in limiting the progression and impact of chronic disease once established. Where health systems could perhaps be doing more is by addressing the major causes of disability amongst working age people, such as mental illness and musculoskeletal disorders.

**Spinoff benefits**

The health system can also further economic growth through its influence on the health of those who do not participate in the formal labour market, such as children, older people or those who depend on caregivers. For example, children in ill-health may be less able to attend school regularly or to develop the cognitive skills needed for many jobs, and older adults in ill-health may be unwilling or unable to invest in their human capital if they believe that their productive life expectancy is likely to be cut short by illness or death, making the returns not worthwhile. Health systems can also play an important role in ‘freeng up’ working-age caregivers whose formal employment opportunities are limited due to the need to look after those requiring care, particularly in countries with large informal care sectors. Furthermore, many of those whose health status is improved, even if they do not participate in the formal labour market, will be able to make greater informal economic contributions, in the form of, for example, voluntary work and informal care.

**Do health systems support societal well-being?**

**Improving health**

Notwithstanding their prime focus on the economy, an increasing number of finance ministries include more general objectives of societal wellbeing in their missions. Health systems support societal well-being through a number of direct and indirect channels. The most tangible way is by improving health, a fundamental element of all concepts of well-being. Securing a long and healthy life makes an essential contribution to well-being in itself, and is also a prerequisite for fully realising an individual’s potential, and there is wide recognition that good health makes a crucial contribution to human welfare. This is reflected in countless commentaries and instruments such as the Human Development Index, which rests on three pillars of health, education and wealth. Health is both valued in itself, enabling people to enjoy a long and rewarding life, but also as a prerequisite for maximising intellectual development and employment opportunities.

**Enhancing social protection**

Most publicly funded health systems also make a fundamental contribution to wellbeing by improving social protection and reducing impoverishment associated with ill-health. This ‘insurance benefit’ afforded by universal health coverage (UHC) takes at least three forms: ex ante reassurance that future adverse health shocks will not be financially ruinous for an individual’s household; ex post avoidance of catastrophic expenditure when a health shock does occur; and the contribution to solidarity arising from the knowledge that others are similarly protected. The level of protection offered appears to be a major determinant of
the population’s satisfaction with their health systems. This important benefit of the health system was for a long time not properly recognised, and yet it can now be seen as a major reason for the widespread push towards universal health coverage. Note also that most systems of UHC implicitly transfer resources from the healthy and the rich to the sick and the poor, in line with many people’s concept of fairness and equity.

**Quality of life**

The narrow metrics of prosperity traditionally used in many economic debates, such as per capita GDP are profoundly inadequate as a measure of social well-being. They ignore improvements in well-being not captured by measures of income, most notably the increase in quality of life arising from health improvement. They positively rate economic activities which may be detrimental to health and well-being, such as from heavy industry, notwithstanding the environmental effects. They also ignore the contributions to the economy made outside of paid employment, for example in the form of child care and caring for family members in ill-health. The value placed on such factors should in principle be included in any comprehensive measure of national prosperity. Examples of how this might be addressed include the Sarkozy Commission’s 2009 report, which explicitly states the need to shift emphasis from measuring economic production to measuring people’s well-being, and the OECD’s ongoing ‘Better Life Initiative’ which includes “measuring well-being and progress”.

**How does the health system influence fiscal sustainability?**

Sustainability addresses whether tax revenues will be sufficient to maintain the proposed level of public expenditure in the long-term. But sustainability on its own is not a meaningful objective without a statement of what is to be sustained. Indeed, taking a very rigid perspective, spending absolutely nothing can be considered perfectly sustainable.

In many respects, sustainability transcends the otherwise separate objectives described in this article. For example, ministries of finance may seek to reduce taxes in order to promote economic growth. They may therefore take the viewpoint that reducing public spending on health – and thus reducing their financial obligations – is an important prerequisite in the short-term with a view to promoting longer-term sustainability.

Keeping the above in mind, population ageing is often the source of concerns about fiscal sustainability in many countries, related to expenditure not only on health services but also on other publicly funded programmes. Health policymakers can convincingly argue that a healthy older population is likely to be less costly for publicly funded health programmes than one that is in poor health for a number of reasons, including lower health and social care costs, an ability to remain in paid work (and continue to contribute greater tax revenues) for longer, deferred pensions, fewer claims for disability benefit payments, among others. In general, the future health care costs of an ageing population have been found to be highly dependent on how healthy that population can remain in older age. A crucial issue for fiscal sustainability going forward may therefore be the success (or otherwise) with which health systems can compress the period of morbidity (especially multi-morbidity) experienced by older people. In short, if carefully targeted to address sustainability concerns, the health system could make a positive contribution to fiscal sustainability across a wide range of public programmes.

**Conclusions**

This article has sought to demonstrate that much of the scepticism about the virtues of health system spending is misplaced, or capable of being addressed through careful formulation of health policies. We conclude by summarising the most important issues relevant to a health ministry seeking to have a constructive dialogue with a finance ministry:

1. Acknowledge the concern about inefficiencies in the health system and put in place (a) measurement instruments to expose and target sources of inefficiency and (b) policies known to be effective in reducing inefficiency.
2. Underline the key role of health systems in improving health, especially through their potential to delay the onset of disease and promote improved health-related quality of life. Note especially the potential for targeting risk factors and diseases that affect (a) labour force participation and (b) levels of dependency.
3. Underline the key role of the health system in promoting social protection, solidarity and equity, brought about by universal health coverage. Emphasise the key contribution to social welfare of improved health and financial protection created by the health system.

There are currently some weaknesses in almost all health systems that should be addressed to reassure finance ministries that health system funding is well spent. For example, public health programmes have not always been designed, targeted and evaluated as well as they might be. Few countries have developed large scale programmes specifically to target morbidity compression or conditions that are frequently associated with leaving the labour force, including mental health and musculoskeletal conditions. And it will always be difficult to provide evidence relating to the contribution of the health system to the economy as a whole, especially if reliance is placed on GDP as a metric of success. However, we feel that organising arguments and policies around the four areas described above may create a useful basis for constructive dialogue.

**References**

Policy Brief Series on Health Systems for Prosperity and Solidarity

Making the economic case for investing in health systems. What is the evidence that health systems advance economic and fiscal objectives?

By: Jonathan Cylus, Govin Permanand and Peter C. Smith

Copenhagen: World Health Organization 2018 (acting as the host organisation for, and secretariat of, the European Observatory on Health Systems and Policies)

Freely available to download at: http://www.euro.who.int/__data/assets/pdf_file/0010/380728/pb-tallinn-01-eng.pdf?ua=1

Good health is a fundamental goal of all societies. Although health is determined by a large number of factors throughout the life course, the health system is one of the most important contributors to population health that lies within the direct control of policy-makers. Yet, health-policy-makers who seek to make the case for increased financing for their health systems are often met with scepticism within governments. This scepticism may be explained in part by a belief among some finance-policy-makers that health systems may not support (or may even undermine) key economic and fiscal objectives.

This policy brief contends that, despite these common concerns, strong arguments can be made that health systems can play an important and largely favourable role in the economy. In fact, it finds evidence that the economic and fiscal objectives of finance-policy-makers are in many respects actively promoted by health systems or that this could be achieved if adequate, stable resources were made available.

This brief seeks to support health-policy-makers by framing available evidence and structuring arguments in a way that is likely to resonate with finance-policy-makers to help health-policy-makers secure a “fair hearing” in governmental debates about public spending.

To that end, the evidence and arguments presented in this brief are centred around the key objectives of the finance ministries within the WHO European Region as found in their mission statements and reflected in their policies: (1) stewardship of government funds; (2) macroeconomic growth; (3) societal well-being; and (3) fiscal sustainability.