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From Health to Wealth: How Accessible Health Care Fuels Economic Development

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Abstract

The perception of awareness in today's society has been changing from the saying "health is wealth" to the more updated version "wealth is health". New findings in research indicates that longer life expectancy and greater health are now seen as means, not ends, of economic growth; rather, they are seen as a method to decrease poverty and advance economic development. Better health therefore does not need to wait for an economy that is doing well; rather, actions to lower the cost of illness, lengthen life expectancy, etc., will help to make economies wealthier by increasing production, productivity, and employment numbers. This is known as universal health coverage where everyone should be able to afford the necessary, high-quality healthcare without being driven into poverty to obtain it. For this the government intervention will play a crucial role. Government engagement in health services is justified by the idea that, by lowering the costs of healthcare for the impoverished, public policy promotes more justice, better health outcomes, and a decrease in poverty. Given that the free market is unable to generate goods that have negative externalities, the government can accomplish greater results than it can. This study examines the relationship between health and economic growth, emphasizing how investments in education and health may boost productivity. It is discovered that there is a strong correlation between the health status indicator and economic performance. The study examines the complex relationships that exist between economic growth and health, as well as the pertinent links with productivity, family planning, and educational spending. It looks into the relationship between health and education and how they affect economic growth. The interaction between health and economic growth is examined in this research. Economic development and health improvement can be facilitated by public financing and policy. The study finds that improvements in health indicators lead to improvements in people's socioeconomic status. The results indicate that a decrease in crude death rates or infant mortality rates had a favourable impact on per capita income growth and slowed the rate of population expansion.

Keywords: mortality, health, externalities, education, government intervention.

JEL: I00, H39, I30, J24

Introduction

Good health is a crucial part of well-being, but spending on health can also be justified on purely economic grounds. Better health has four main benefits for economic growth: it lowers production losses from worker illness; it allows the use of natural resources that were previously completely or almost completely unavailable due to disease; it increases child enrolment and improves their learning potential; and it frees up resources that would otherwise

need to be used for illness treatment. Health, reflected by mortality of infants and adults, affects economic performance through human capital investments, physical capital accumulation, population growth, productivity and female labour force participation. However, mortality per se depends on better economic development of countries as they can afford better health system (Strittmatter, 2011). Health within the home increases quickly when people get beyond poverty and low levels of education. Beyond the household, every society's health services are affected by its national income, and its ability to acquire and apply new scientific knowledge depends on the level of schooling in the population (World Bank, 2015). Income and level of education influence on health and longevity among the poor than among the rich. Then income redistribution from rich to the poor, within countries, or between countries, will improve population health (Preston, 1975). Income inequality, or other related social inequalities with which it is correlated, may be directly hazardous to individual health (Deaton, 2003). Recent literature shows that unlike inequality in the society equal societies have more social cohesion; they offer their citizens more public goods, more social support, and more social capital; and they satisfy humans' evolved preference for fairness. That equal societies are healthier is an argument particularly associated with Richard Wilkinson, as well as the collection of papers edited by Ichiro Kawachi, Bruce Kennedy, and Wilkinson. In a study, Lynch et al (1998) claim that, in the United States in 1990, the loss of life from income inequality "is comparable to the combined loss of life from lung cancer. According to statistics, the death toll from wealth disparity "is comparable to the combined death toll from lung cancer, diabetes, car accidents, HIV infection, suicide, and homicide in 1995."

In addition to poverty, environmental pollution is another factor contributing to health disparities. The focus of health care systems is mostly on curative treatment, with little attention paid to the preventative effects of environmental contaminants on human health. The most dangerous environments for health are those lived in by the impoverished or those who reside in developing nations. Poor households typically reside in homes with high indoor air pollution levels, inadequate drainage and waste disposal, inadequate hygiene, and poor sanitation and water supply, all of which pose serious health hazards. This type of environment in developing countries accounts for nearly 30 per cent of the total burden of disease. By providing public health programmes, clinical services, information on self-care, reducing poverty, and facilitating and stimulating private sector action, governments can deploy potent mechanisms to improve this environment (World Bank, 1993). Women's capacity to play a critical role in establishing wholesome families is significantly strengthened by education. Mother's schooling affects child's health much more than father's schooling. Data for thirteen African countries between 1975 and 1985 show that a 10 per cent increase in female literacy rates reduced child mortality by 10 per cent, whereas changes in male literacy had little influence. Demographic and Health Surveys in twenty-five developing countries shows that, all else being equal, even one to three years of maternal schooling reduces child mortality by about 15 per cent, while a comparable degree of paternal education results in a 6% decrease. Following birth, the children of educated mothers continue to enjoy other health-enhancing advantages: better domestic hygiene, which reduces the risk of infection; better food and more immunization, both of which reduce susceptibility to infection; and wiser use of medical services (World Bank, a 1993). Healthier workers earn more because (as research in Bangladesh has demonstrated) they are more productive and can get better-paying jobs.

Improved health increases productivity of labour besides influencing the way work is organised and carried out. With a healthy work force, employers can reduce the costs of building slack into their production schedules, invest more in staff training, and exploit the benefits of specialisation. Without a doubt, education results in increased salaries. Four years of primary education boosts farmers' annual productivity by 9 per cent on average, and workers who do better at school earn more. Poor health and nutrition reduce the gains of schooling in three areas: enrolment, ability to learn, and participation in other co-curricular activities. Children with better health and nutrition during early childhood are more ready for school and more likely to enrol. A study in Nepal has found that the probability of attending school is only 5 per cent for nutritionally stunted children, compared with 27 per cent for those at the norm. Health and nutrition problems affect a child's ability to learn (World Bank, b, 1993). Nutritional deficiencies in early childhood can lead to iron deficiency and anaemia reduces cognitive function, iodine deficiency causes irreversible mental retardation, and vitamin A deficiency is the primary cause of blindness among children. When retested after treatment, those same children did almost as well as the uninfected children.

Pathways from Health to Economic Development

It is often stated that economic development can contribute to better health as wealthier countries have better capability to afford health system. However, there are reasons to believe the relationship also runs in the other direction, i.e., health improvements can contribute to economic development. Reasons include:

- **Improved productivity:** Better health can make workers more productive, either through fewer days off or through increased output while working.
- **Improved learning:** Better diet and less illness, especially in the early years of life, promote better cognitive development, which improves learning. Improved learning via either of these methods will increase human capital, which is a crucial factor in determining economic growth (DSAED, 2010).
- **Reduced family size:** By lowering the size of families, investments in sexual and reproductive health can contribute to a decrease in poverty. Since its ground-breaking launch in 1952, the family planning program has seen significant changes. Its clinical approach has given way to a reproductive child health approach, and the National Population Policy (NPP) 2000 introduced a holistic, goal-free approach that has contributed to a decrease in fertility (GoI, 2014–15).
- **Health and investment:** Healthier individuals have ability and incentive to save more, this saving fuel growth through investment. Similarly, companies may be more likely to invest when workforces are healthier or better educated ((DSAED, 2010).
- **Increased availability of land for productive use:** Removing certain disorders might make previously unutilized land suitable for farming or other uses.
- **Reduced treatment burden:** Early treatment taken by the government to prevent certain illnesses would protect the poor from falling into a trap of poverty, as the poor have no headroom to bear downside risks. Such initiatives would increase the productivity of the poor and make them economically sound.

There is evidence showing that child malnutrition has adverse impact on adult economic outcomes. One Brazilian study shows that children stunted by malnutrition earned an estimated

30 per cent less than the average worker (Grantham, et al, 2007). Similarly, studies of malaria in Latin America show the disease impacting on learning and adult income. The author of one malaria study concluded that: "persistent childhood malaria infection reduces adult income by 40 to 60 per cent (Bleakly, 2006). Meanwhile, in the case of malaria, a study of adult infection in malaria endemic areas found the disease reduced labour supply by about 5 per cent (Boom, 2009). Evidence shows child malnutrition reducing adult wages both through impaired educational attainment and through contribution to adult health problems. International studies show family planning playing a role in increasing economic development (Joshi, 2009).

Health and income level is positively related to each other. People with poor health and low level of income have no headroom to bear downside risks. Educated people tend to make choices that are better for their health; there is often a strong relation between schooling, health, economic development and income. It is explicitly clear from Table 2 that infant mortality rate and population growth rate are inversely related to literacy rate. Being realising the importance of small family, access to public health programmes, and clinical services infant mortality rate declines. Decline in population growth rate helps in enjoying the fruits of economic growth rate. Increase in life expectancy rate and literacy rate lead to decline in poverty ratio as it is explicitly clear from Table 2. Health indicators of different states show that when life expectancy ranges between 67.0 years to 74.0 years, poverty lies between 8.4 to 15 per cent. Both Tables show that improvement in health indicators improve socio-economic position of people as GDP growth rate increases, which leads to increase in the productivity per unit of labour. Low levels of education and health are of concern in their own right, but they merit special attention when they accompany material deprivation. Amartya Sen defines deprivation as anything that significantly limits a person's "capabilities that a person has, that is, the substantive freedoms he or she enjoys to lead the kind of life his or her values." This includes deprivation in the form of health, education, noiselessness, and powerlessness. Increasing the voice and involvement of the impoverished helps to better focus health and education initiatives while also addressing their sense of exclusion (World Bank c 2001).There is another, equally compelling argument for health investment when it comes to the objective of eliminating poverty. When the family's primary provider falls ill, other family members may first adjust by working longer hours and cutting back on their own consumption, sometimes even on food. The family's overall health may be harmed by these changes. If free health care is not available through public policy, the costs of treatment may drive a household deeper into debt (World Bank d, 1993). Consequently, a person who was living above the poverty line may fall into the trap of poverty. Furthermore, women's position, money, and talents have a significant impact on health in any community. Because of these interrelations, Ministry of Health and Family welfare undertook various activities during 2013-14 like launch of "National Health Portal" [http://nhp.gov.in] on 14th November 2014 to provide healthcare information to the citizens of the country and various videos on health information Ported on YouTube. Accessible health services for all will accelerate income growth and reduce poverty in developing countries (GoI a, 2014-15).

Rationales for Government Interventions

India is a poor country where as per Rangarajan committee, June 2012, 29.5 per cent people are still living below poverty line, costs of medicines and health care services are very high.

On this background the government must intervene in the economy to protect the poor and make availability of health care services at low cost so that the poor should not fall prey to diseases as continuous expenditures on diseases make them poor. The rationales for government interventions in providing health services are based on: reduction or alleviation of poverty provides a straightforward rationale for public intervention in health. The poor's productivity and educability increase when their health is improved. Success in reducing poverty requires two equally important strategies: encouraging the poor to use their labour, which is their most valuable resource, and building their human capital by giving them access to basic healthcare, education, and nutrition. Investing in the health of the poor is an economically efficient and politically acceptable strategy for reducing poverty and alleviating its consequences, as World Development Report 1990 emphasised. Since poor are more sensitive to the price of medical care and also suffer a greater burden of disease than the non-poor, access to free or low-cost care can make them more healthy and wealthy. Public goods[1] and externalities are forms of market failure that may justify government intervention (World Bank e, 2001). Many public health interventions, such as wide-area control of disease vectors and radio-based health information campaigns, are nearly pure public goods for which only the government can ensure provision. The right choice of interventions and the proper level of provision of any public good require careful analysis of the health benefits in relation to the costs. Prices do not reflect the value of benefits since public commodities are not supplied by private markets. While they might provide such things, non-profit nongovernmental organizations (NGOs) cannot entirely replace government action. In addition to protecting the patient who is paying for the treatment, disease curing limits the spread of the illness across society. For instance, treating a person of TB also stops the illness from spreading. If the externality is not taken into account, treatment will be priced too high in private markets, and too little treatment will be given. Subsidies for treatment are therefore justified. A third reason for government intervention is the failure of the health care and health insurance markets, which leads to increased efficiency and, in the case of the health insurance market, increased equality (World Bank e, 2001). The three justifications for government involvement in the health sector are basically equivalent to three distinct service categories: public goods supply, poverty alleviation, and market failure. First, the services classified as public goods, and some of those characterised by large externalities, constitute what is known as "public health." Second, the inclusion of health care as part of a strategy for combating poverty justifies public financing of "essential" clinical or individual services. These are highly cost-effective services that would greatly improve the health of the poor. Since poor people typically cannot buy such care for themselves, there is a straightforward case for government intervention (World Bank f, 2001). Third, the rationale that the government should intervene in health care markets because of significant market failures applies particularly to the regulation of health care and health insurance. Since the government cannot finance all medical, should emphasise on providing health care for all vulnerable section of the society and the poor, as they are comparably more susceptible to diseases.

Strategies for Economic Growth through Universal Health Coverage

People's capacity to take better care of themselves is heavily influenced by their level of education and money. Governments must to devote their efforts toward improving health care

and education, particularly for women, in order to accelerate economic growth (World Bank g, 2001). Poor people are vulnerable to disease not only because of poor living conditions but often also for work-related reasons. Government must also intervene in the environment in which poor people are compelled to work. The poor cannot always afford cost of their health care; government must intervene here in providing health services to the poor. By providing health services to the poor government not only helps improving health of the poor but also improving their productivity and their participation in economic production. Besides, government helps the poor from falling into the trap of poverty by investing in the poor's health. By providing health services to the poor Government intervention in providing health services may be categorized in two ways: i) direct provision of health services to the poor, ii) concentrate resources on compensating for market failures and efficiently financing services that will particularly benefit those living below poverty line and the above poverty line. Government must regulate all private health services and contain costs while enhancing consumer satisfaction. Certain acts that advance health generate significant positive externalities or are pure public goods. They would either not be produced at all or produced insufficiently on private marketplaces. Government action can increase wellbeing by enhancing the functioning of the health care and health insurance markets, as these markets are failing (World Bank h, 2001). Government is intervening through National Health Mission (NHM) to improve health of people. The National Rural Health Mission (NRHM) and the recently established National Urban Health Mission (NUHM) are the two Sub-Missions that make up the National Health Mission (NHM). Their main areas of interest include infectious and non-communicable diseases, reproductive, maternal, neonatal, child, and adolescent health, and improving the health system in both rural and urban regions. NRHM aims to give rural residents access to high-quality, reasonably priced healthcare. The vision is focused on establishing a fully functional, community-owned, decentralized health delivery system with inter-sectoral convergence at all levels in order to ensure simultaneous action on a wide range of health determinants, including water, sanitation, education, and nutrition, social and gender equality, and other issues. By enabling their access to first-rate primary healthcare, NUHM hopes to enhance the health of the urban population overall and specifically that of the urban poor and other marginalized groups.

Conclusion

Health and financial security are intimately related. Therefore, the government must pay particular emphasis to improving health. The influence of environmental contaminants on human health from a preventative perspective is not taken into account by health care systems, which are primarily focused on curative care. Although good health is an important part of achieving economic development, however a nation's economic development may be attained by investing public funds on health and education. Enhanced well-being and increased earning potential are two benefits of improved health outcomes. Not only does more education promote happiness, but it also raises earnings and results in improved health. An economy may grow more quickly when its population is healthy, and this has a cascading impact on the economy's overall development. There are two methods in which health services engage with homes. Programs for public health targeted at certain demographics or groups to address health issues. Their goals are to avert illness or harm and to disseminate knowledge about self-healing and

the value of obtaining medical attention. Clinical services are provided in response to specific requests. Usually, their goal is to heal the ill or lessen their suffering. Health systems have increased their offerings of increasingly effective therapies in response to the demand for improved health. Because health and education have beneficial externalities on society, the government becomes involved in these areas.

Notes

1. The key characteristic of public goods are non-rivalrous and non-excludable. Good for which the marginal cost of its provision to an additional consumer is zero is called non-rivalrous good. A good is non-exclusive if people cannot be excluded from consuming it once it is produced; the goods can be enjoyed without directly payment.

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Table 1: Health Indicators and Relationship to Poverty and Wealth

States	Life Expectancy at birth (2002-06)	IMR (2010)	MMR (2007-09)	Total Fertility Rate, TFR (2010)	Poverty Level (2004-05)	Per capital NSDP (2008-09) in Rs.	Per capital Health Expenditure in Rs.#	Literacy Rates in Per cent (2011)
Kerala	74.0	13	81	1.8	15.0	35457	2950	94.0
Punjab	69.0	34	172	1.8	8.4	33198	1359	75.8
Maharashtra	67.2	28	104	1.9	30.7	33302*	1212	82.3
Himachal Pradesh	67.0	40	-	1.8	10.0	32343	1511	82.8
Haryana	66.2	48	153	2.3	14.0	41896	1078	75.6
Tamil Nadu	66.2	24	97	1.7	22.5	30652	1256	80.1
Karnataka	65.3	38	178	2.0	25.0	27385	830	75.4
West Bengal	64.9	31	145	1.8	24.7	24720	1259	76.3
Andhra Pradesh	64.4	46	134	1.8	15.8	27362	1061	67.0
Gujarat	64.1	44	148	2.5	16.8	31780*	953	78.0
India	63.5	47	212	2.5	27.5	25494	1201	73.0

Notes: NSDP – Net State Domestic Product
National Health Accounts (NHA) 2004-05
*2007-08
IMR – Infant Mortality Rate; MMR – Maternal Mortality Rate.
Source: Annual Report to the People on Health, Government of India, Ministry of Health and Family Welfare, December 2011. Sources for literacy rates are taken from Economic Survey 2021-22. Government of India.

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Table 2: Relationship between Infant Mortality Rate; Population Growth Rate and Literacy Rate

Year	Infant Mortality Rate per thousand birth	Population Growth Rate (%)	Literacy Rate (%)	GDP Growth Rate in per cent
1971	129	2.2	34.45	2004-05 (8.0)
1981	110	2.22	43.57	2005-06 (7.0)
1991	80	2.14	52.21	2006-07 (9.5)
2001	66	1.97	65.38	2007-08 (9.7)
2008	53	-	-	2008-09 (6.5)
2009	50	-	-	2009-10 (8.4)
2010	47	-	-	2010-11 (7.0)
2011	44	1.64	74.04	2011-12 (6.2)
2012	42	-	-	2012-13 (4.5)
2013	40	1.24	-	2013-14 (4.7)@
2014@	37	1.1	-	7.4
2018@	30	1.0	74.37	6.5
2019@	28	1.0	-	3.7
2020@	27	1.0	-	-6.6

Note: @ Base year changes growth rate to 6.9 per cent

Source: Compiled from Annual Report to the People on Health, Government of India, Ministry of Health and Family Welfare, December 2011; Annual Report 2014-15, National Health Mission, Department of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India; http://Infochangeindia.org; www.modern.gov.in; The Times of India, August 2012, Twelfth Five Year Plan, Planning Commission, Government of India; and www.erewise.com.

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