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Health and Wealth: The contribution of welfare state policies to economic growth

Speech prepared for the Expert Conference *Best Practices in Progressive Governance*, Stockholm 28 - 29 June, 2001.[1]

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Introduction

I am delighted to have been invited here to share with you some thoughts and ideas about the progressive agenda. As academics and policy experts, you are all well informed about the intellectual and political landscape, that I will now enter. What I will try to add is the perspective of an economic-historian, with futures studies as profession. It is my conviction that we need to reflect on both past experience and future challenges, when we discuss the problems of our own day.

Minister Pagrotsky has already introduced my theme – by pointing to the strength of progressive values – also from an economic point of view. I agree, and I will develop this discussion further. The focus of my talk is the role of people, or human capital in economic development. I want to make the case that investments in people, and in particular investments in health, play a major role in promoting economic growth. My point of departure is recent empirical research about the role of health and demography in processes of economic growth worldwide.

For most people, it is quite natural to perceive health as an important basis for our economies. Policymakers, as well, are well aware of the difference that health makes. If we look back at the history of industrialized welfare states, for example, it is striking how health policy measures stand out in national strategies for development. Sweden, where we meet today, is a case in point. Already in the early 20th century,

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[1] I am thankful to professor David E. Bloom, Harvard School of Public Health, who has shared his results and given valuable support during the preparation of this speech.

Sweden, by then one of the poorest nations in Europe, had succeeded in attaining the lowest infant mortality rate in the world, and a surprisingly long life expectancy. This was a decisive factor behind the subsequent Swedish catch-up, when this country, in less than fifty years, developed into one of the richest nations in the world. In Sweden, public health was a top priority, and so it was in many other welfare states as well. Battles against death and disease have accompanied economic progress.

Nevertheless, we have witnessed in the last twenty years an upswing for economic theories and strategies, that in fact neglect the importance of health. A potent discourse of economic liberalism has permeated contemporary political thought, even among progressives.

According to the liberal economic policy discourse, the major force behind wealth creation is market competition or "competitiveness". Higher living standards, including improvements in health, are thought to be best attained through the process of economic growth. Therefore, market forces should be given greater play in the allocation of resources. The conventional wisdom, that state intervention is needed to correct market failures and to secure public goods, as for example public health, gets little support in the liberal policy paradigm. State interventions in the spheres of production and reproduction, in particular traditional welfare state policies, are strongly criticized.

What recent research shows, however, is that these liberal ideas about wealth creation and how it should be promoted are inadequate, when confronted with empirical data. Market competition is indeed conducive to growth, but it explains only a part of the difference between successful and less successful economies. In fact, health status is far more important as a predictor of subsequent economic growth.

From health to wealth

[Figure 1. Life Expectancy and Income in 1990. From D. E Bloom and D. Canning, The Health and Wealth of Nations, *Science*, February 2000.]

One of the best-known relationships in international development is the positive correlation between health and income per capita. Most often, this correlation is thought to reflect a causal link running from income to health. According to this view, higher income gives

greater command over a number of resources that promote good health, for example better nutrition and access to good quality health services.

What recent research teaches us, is that this relationship between health and income also reflects a causal link running the other way – from health to income. Health helps to create wealth. Two distinguished economists, David E. Bloom and David Canning, were among the first to pay attention to health as an input to growth. In an article, published in *Science* last year, they conclude that the impact of health status on economic growth is strikingly large, and that it emerges consistently across empirical, cross-country studies. Recent comparative economic analyses indicate that a 5-year advantage in life expectancy will result in 0.3-0.5 per cent more rapid growth per year. This represents an important boost to economic development, considering that countries experienced an average per capita income growth of only two percent in the period 1965-1990. Most poor countries can also expect to gain much more than five years in life expectancy. Since the mid-20th century, life expectancy in the world has increased by approximately 17 years.

Bloom and Canning identify four mechanisms that can account for this strong relationship between health and income: productivity, education, investment in physical capital, and "the demographic gift".[2]

[Figure 2. Healthier is wealthier. From David E.Bloom, The Health and Wealth of Nations, 7th Canadian Conference on International Health, Nov. 15, 2000, Hull, Quebec]

Productivity. Healthier populations tend to be more productive. This is so because healthy workers are physically stronger and mentally more robust. They also suffer fewer lost workdays due to illness and they need to care for sick family members less often.

Education. Education promotes greater productivity and results in higher incomes. Good health is an important mechanism to stimulate educational progress in a society, since healthy people, who expect to live long, have stronger incentives to invest in education. In addition, good health promotes school attendance and improve children's' abilities to learn.

Investment in physical capital. Healthy populations tend to promote investments. When people live longer, they will save more of their income. This is so because older workers tend

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[2] David E. Bloom and David Canning, The Health and Wealth of Nations, *Science*, February 2000.

to have higher incomes than younger ones and fewer dependents to provide for. In addition, they have a greater need to save for their own retirement. Insofar as increased savings are used for productive investment, average incomes will rise. Furthermore, a healthy and educated work force attracts foreign direct investment. This adds to a virtuous spiral of economic growth.

"The demographic gift". In particular in less developed countries, health improvements also operate through changes in the age structure of the population. This happens through an important process of demographic change, that tends to appear in all countries as they modernize, *the demographic transition.*

[Figure 3. The Demographic Transition. From David E. Bloom, The Health and Wealth of Nations, 7th Canadian Conference on International Health, Nov. 15, 2000, Hull, Quebec]

During the demographic transition both mortality and fertility rates go down from high levels, typical of populations in traditional societies, to low levels, which characterize modern populations. Fertility rates lag behind, however, and this creates one or several enlarged cohorts of children. Such "baby-boom" cohorts can make a significant, and unique, contribution to economic growth, as they reach working age. This contribution is "a demographic gift", to be collected only once. An illustrative example of the impact of health investments on demography and growth is the recent "economic miracle" in East Asia.

[Figure 3B. Ratio of Workers to Dependents. From David E. Bloom, The Health and Wealth of Nations, 7th Canadian Conference on International Health, Nov. 15, 2000, Hull, Quebec.]

In East Asia the working age population grew much faster than the dependent population in the period 1960 to 1990 (see figure/comparison with Africa). This "demographic gift" was the result of rapidly falling mortality rates among children and infants from the 1950s. Both the development of antibiotics and classic public health improvements contributed to reducing the death rates. "Baby-boom" cohorts emerged. Equally important, however, was the subsequent fall in birth rates. Asian women chose to have fewer children, as infant mortality rates declined, and incomes rose. The fertility decline was unusually rapid, which added to the impact of the "baby-boomers". The child dependency rate declined significantly.

It has been estimated that the Asian baby boom generations account for as much as one third of East Asia's phenomenal economic achievements in the post-war era

(1960-1990). This implies that health investments must be seen as one of the major pillars upon which East Asia's economic miracle was based.[3]

[Figure 4. Age transition in East Asia]

The process of age structure change in Asia is illustrated in this figure that shows the shift from an early stage in the age transition, when the child dependency burden was very high, to the favourable intermediary phase of the transition, when the working age population multiplies. If we look into the future, we can observe that East Asia, according to present population projections, will enter a phase of ageing already within a few decades. As the large cohorts born in the early phase of the demographic transition enter old age, the old-age dependency rate will rise dramatically. Some countries in the region, notably Japan, are already getting grayer. The same holds true for many other industrialized countries, in particularly in Europe, as you all know.

East Asia is a successful example of how "virtuous spirals" can develop, with health improvements promoting higher incomes, which in turn promotes better health. In particular, mothers and children benefit. In traditional societies, a major share of women's investments in the sphere of reproduction is wasted, due to death and poor health. To bring up a child demands large temporal and financial resources that are lost to society if the child never grows up to become a working adult. As rising incomes cause fertility to decline, however, this situation changes. In economic terms, the productivity of women's reproductive work, such as breastfeeding and caring, rises dramatically. There are increased resources for each child, less stress on women's reproductive systems, and greater opportunities for women to work outside the home.

[Figure 5. Age transition in sub-Saharan Africa]

Sub-Saharan Africa is the only continent in the world that has not yet entered the age transition. Death rates among children have fallen dramatically, but fertility rates are still high. The result, as you can see, is a very unfavourable age structure, with extraordinary high

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[3] David E. Bloom and Jeffrey G. Williamson, "Demographic Transitions and Economic Miracles in Emerging Asia", *World Bank Economic Review*, 12 (3), 1998.

child-dependency rates. In most countries in sub-Saharan Africa, the child-dependency rate is higher than 40 percent.

Regions with young populations, such as sub-Saharan Africa, tend to suffer high rates of youth unemployment. This is often thought to reflect a surplus of labour. According to a standard economic growth model, Africa would do better with fewer people. With a smaller labour supply the capital to labour ratio would increase, it's then presumed that labour productivity go up and average income rise.

However, if we look at the population of Africa from the point of view of human capital investments, we can interpret the situation in a very different way. What the population structure of Africa indicates is that large investments in health, and in education, have been made during an extended period of time. Millions of children have survived, many of them have attended school, and as baby-boom cohorts in other regions, these children and youth have a potential to make important contributions to the future of Africa.

What makes the situation difficult is that fertility rates have not yet fallen to substantially lower levels. The dependency burden remains high, and as a consequence average incomes are low. Only a tiny share of the population is in their middle years, the period in life when most people are able to generate savings for investment. There is a serious shortage of capital. Many inhabitants of Africa are caught in poverty traps. The virtuous spirals, that create positive interactions between health and income, have not yet developed.

Furthermore, Africa is now struck by the AIDS epidemic, a disease that threatens to impose incredible economic burdens on a region that is already in a demographically very critical situation. 80 percent of global AIDS mortality occurs among people of working age. Africa, that so strongly needs a larger adult population, is now losing millions of citizens in their prime years. Adults die and leave orphans with vastly reduced prospects. The threat imposed by AIDS is daunting, not only when we think about people struck by the disease today, but also when we consider future generations. As one observer notes: Health can promote virtual spirals of economic development, as in East Asia, but spirals go down, as well as up. Poor health is the surest way into a disastrous

poverty trap, and therefore, African countries must make huge process against the health problems they face, in order to develop competitive and stable societies.[4]

The divergent demographic situations of East Asia and sub-Saharan Africa teach us how important it is to be aware of the age structure of a population. Insights about the demographic transition offer a powerful planning and management tool. If policymakers come to understand the substantial ways in which the demographic transition operate across multiple sectors, they will be better equipped to make use of the "demographic gift" of a surplus working population, when it appears, and they will also be better prepared for the subsequent period of ageing, when there is no longer any "demographic gift" to collect.

[Figure 6. Age transition in South America]

South America is one of the regions in the world that is well into its demographic transition. As you can see, however, the process is not as drastic as in East Asia. The younger cohorts stabilize in size, but they are not becoming smaller in absolute numbers, according to our population projections. In South America, there is a "demographic gift" to collect in years to come. It is a matter of policymaking, however, to take full advantage of the opportunity. Health is key, for several reasons. The size of the “demographic gift” depends on falling fertility, and this will happen faster in a healthy population. Health education also helps to reduce fertility rates. Furthermore, the AIDS epidemic can result in serious economic reversals not only in Africa, but also in South America. If AIDS develops into a more serious epidemic in South America this will reduce the size of the working population in particular with a reduction of the “demographic gift” as a result. To combat the development of such as a scenario is clearly a top priority, as noted by the Brazilian government and in their report on health for this conference.

-------- *Turn out light*

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[4] David E. Bloom, *Treatment of AIDS: a global perspective*, speech at the AIDS conference in Durban, July 2000.

Ageing and the crisis of the welfare state

If we turn to Europe, we face a radically different demographic situation. In Europe, a process of ageing has been under way for a long time. In particular in the 1970s and 1980s, several countries - among them Sweden and the UK - experienced substantial ageing, as the large baby boom cohorts born in the early 20th century retired.

Ageing is associated with a major structural shift in the economy. Cross-country studies show that population ageing has a significantly negative effect on economic growth, and it is also closely connected with growing public expenditure, tax increases, and budget deficits. In Sweden, with its pronounced process of ageing from the 1970s onwards, the correlation between ageing and welfare state growth is evident indeed. In particular, expenditures for old age care and services and health care have expanded. If we differentiate between different groups of old aged, people above 80 years of age stand out as particularly costly.[5]

Politically, ageing coincides with a crisis for the welfare state, and I would argue that the negative impact of ageing goes a long way in explaining why the liberal policy paradigm, with its critique of non-dynamic, expansionary welfare states, has been so widely accepted. In an ageing society, the link between human capital investments and growth are no longer as evident as in a youthful economy. Furthermore, policymakers and citizens must face the bitter fact, that the "demographic gift" has already been collected.

This more difficult situation does not imply, however, that welfare state policies are no longer needed. On the contrary. The crucial question for progressive leaders in ageing societies is instead to find out how policymaking can contribute in this specific demographic situation, with the knowledge that health and demography are among the most potent influences on economic growth.

Several challenges must be met. In an ageing population, demands for medical care and services increase among the elderly, in particular among the "oldest old". To respond to this demand, is a necessary commitment. Equally important, however, is to secure the health status of the working population, and of parents and children. In a society where resources are getting scarcer, due to ageing, there is a risk that the needs of the

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5 Bo Malmberg and Lena Sommestad, "The Hidden Pulse of History. Age transition and economic change in Sweden, 1820-2000, *Scaninavian Jouranl of History*, 1-2, 2000; Thomas Lindh and Bo Malmberg, "Age Structure Effects and Growth in the OECD, 1950-90", *Journal of Population Economics* 12, no. 3.

younger population are not adequately met. If we let this happen, the future of our societies is at risk.

A second major challenge for industrialized welfare states is to counter-act the process of ageing itself, so that is does not lead develop into a development trap. Today, fertility rates are low and declining in most European countries, and within a few years, the European labour force will start to decrease in absolute numbers. In order to deal with this challenge, several inter-related policy measures will be necessary. Gender equality policies, more generous family support, and labour migration are possible solutions.

The industrial welfare states, as we know them today, were built 50 years ago or more. At that time, our societies had far lower old age-dependency ratios than today. To rebuild them for the challenges of the new century is - without doubt - one of the major tasks for progressive governance.

Conclusion

The breakthrough for the liberal policy paradigm has been hurtful for many citizens in industrialized welfare states, which have suffered the consequences of welfare cuts and increasing inequality.

It is worse, though, to contemplate that the liberal policy paradigm has had an even more serious impact on less developed countries, where AIDS and other infectious diseases are now resurging. The most serious case is sub-Saharan Africa. Still in the early 1990s, it was argued that the effect of AIDS on economic labor was marginal, since the surplus of labor was so large. Economist Mead Over stated, for example, that if the only effect of the AIDS epidemic were to reduce the population growth rate, it would increase the growth rate per capita in any plausible economic model [6]. We now know that this view was entirely mistaken. Similarly, the liberal paradigm has contributed to a tragic, downward spiral of ill-health and poverty in Russia and other emerging market economies. In the mid-1990s, life expectancy for Russian men had fallen dramatically, and was below the average for developing countries. Poor diet, increased alcohol consumption, mental stress

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[6] Mead Over, The Macro-Economic Impact of AIDS ub Sub-Saharan Africa, Wordl Bank, 1992, p.27.

and a poorly financed health system, added to the Russian health crisis. All in all, we now witness a serious reversal in global health trends.

The situation is problematic, but the good news is that we know, from past experience, that death and disease can be fought with success, if concerted efforts are made. The battles against tuberculosis in the US and Europe, from the late 19th century and onwards, is an illuminating example. Here, progressive leaders have a role to play. Moreover, many countries in the developing world, not least in Asia, are at present experiencing rapid economic growth. If these growth trends are not reversed, the capacity to combat death and illness will improve remarkably.

Globalization poses problems, but also new possibilities. The transmission of AIDS has followed economic flows, within and between countries. The more open a developing economy is to the world economy, the more serious is its AIDS problem. To fight the disease, national initiatives are no longer enough. Broad partnerships, that include national and international agencies, as well as private enterprise, are needed.

At the same time, however, globalisation helps to develop new patterns of communication. Information technology strengthens a process of global co-operation within the health sector that goes from the bottom up. Already today, information technology influence health systems and how they are run in multiple ways. Some experts believe that this will have a tremendous effect on tomorrow's health.

To conclude: Successful political action depends on multiple factors in the policymaking process, such as political dedication and strategic abilities. However, successful action also builds on a clear understanding of the problem that needs to be solved, and in this respect, the recent rise of a new growth paradigm, focused on human capital instead of market competition, offers an important opportunity. In contrast to the liberal policy model, the human capital approach can tell why investments in people, for example health care, are important not only to secure social justice, equal opportunities and quality of life, but also as a mechanism for wealth creation. In short, it closes the gap between economic and social goals.

I do believe, that the future of progressive governance is promising. Lessons from the past teach us that demands for progressive reform gain tremendously in strength, if they can be motivated not only with reference to rights and needs, but also with economic arguments. And this possibility is now, once again, at hand.

We contribute to an important tradition of progressive thought. Here in Sweden, in particular, the welfare state was once built on an impressive understanding of population dynamics and the role of welfare state policies in economic growth. Economists of the time, such as Gunnar Myrdal, did not run the regressions that my fellow economists do today, but nevertheless, they identified the same mechanisms, and they drew the same conclusions. In order to develop our societies, we need to invest in people, and in particular in children, and we should not regard expenses for health care, day care, schools or public health as consumption, but as investment.

Thirty years ago, Swedish Prime Minister Olof Palme summarized the same insight as follows:

"We should not look upon economic growth and social policy as though they were enemies. Instead, I think, social policy stimulates growth. And at the same time, growth is a prerequisite for the solidarity that feeds social policy. We should unite them, as friends."[7]

Thank you.

Figures follow

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[7] Speech by Olof Palme in 1971, quoted in Jenny Andersson, *En produktiv socialpolitik*, PhD-manuscript, Dept. of Economic History, Uppsala University, 2001.

Figure 1

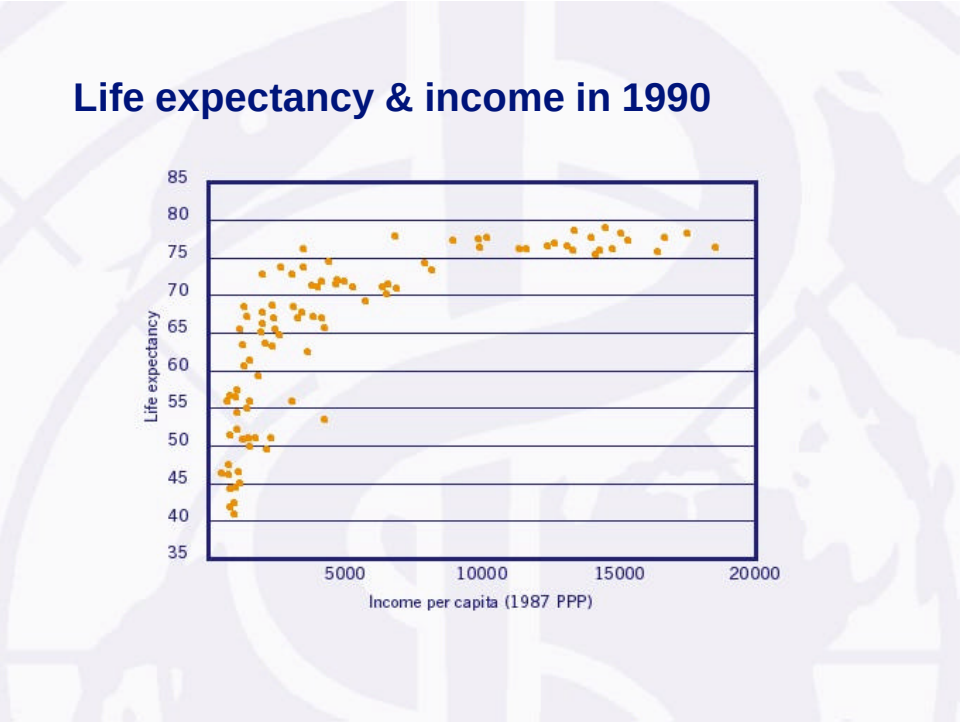


Figure 2

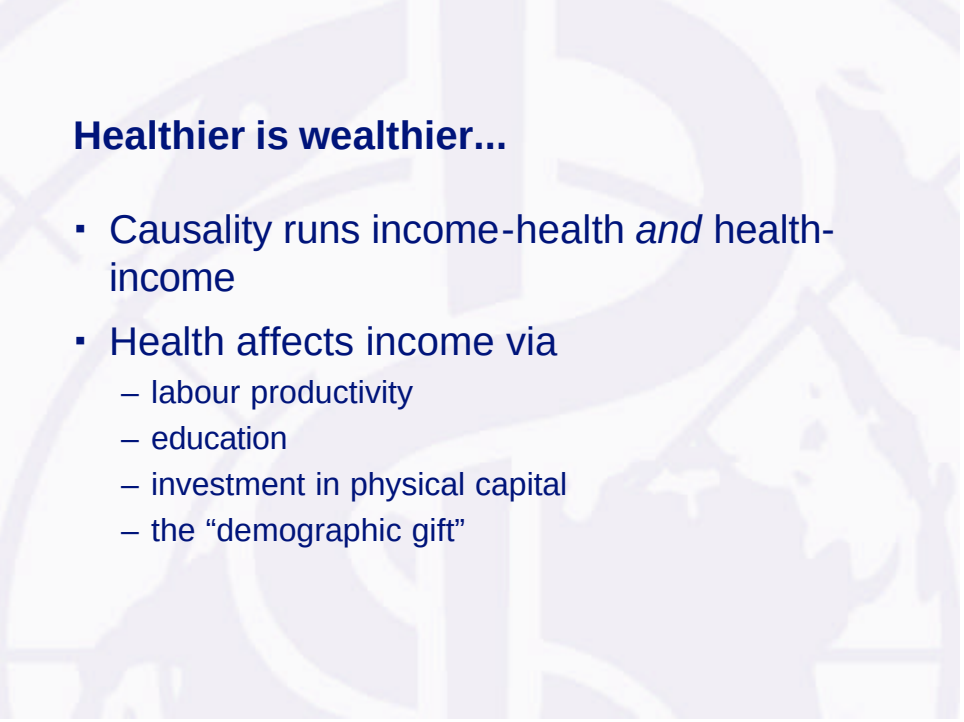


Figure 3

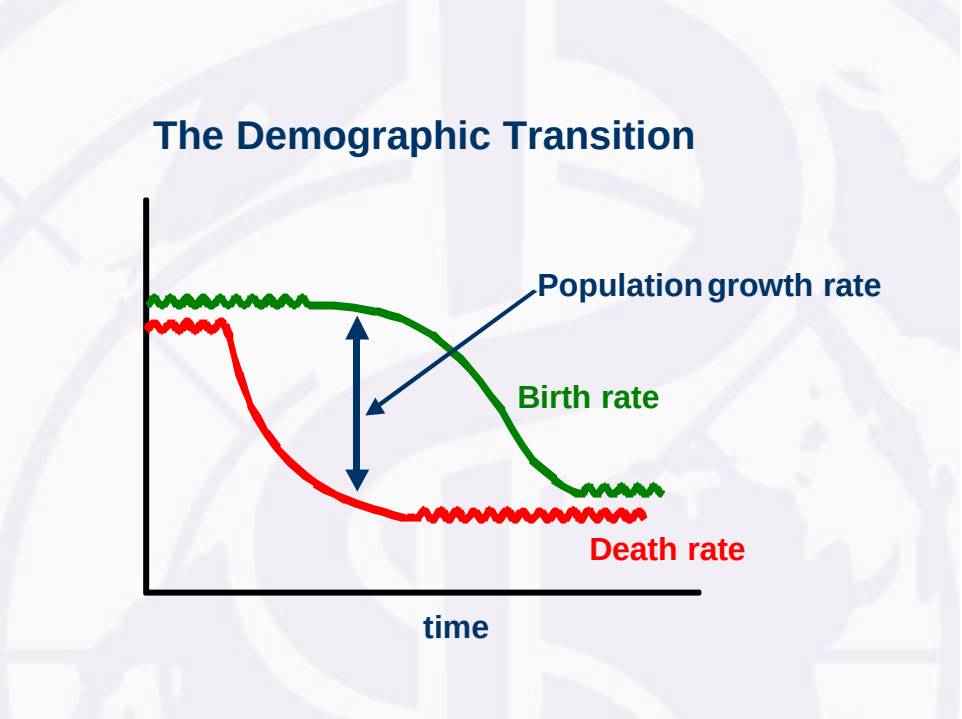


Figure 3B

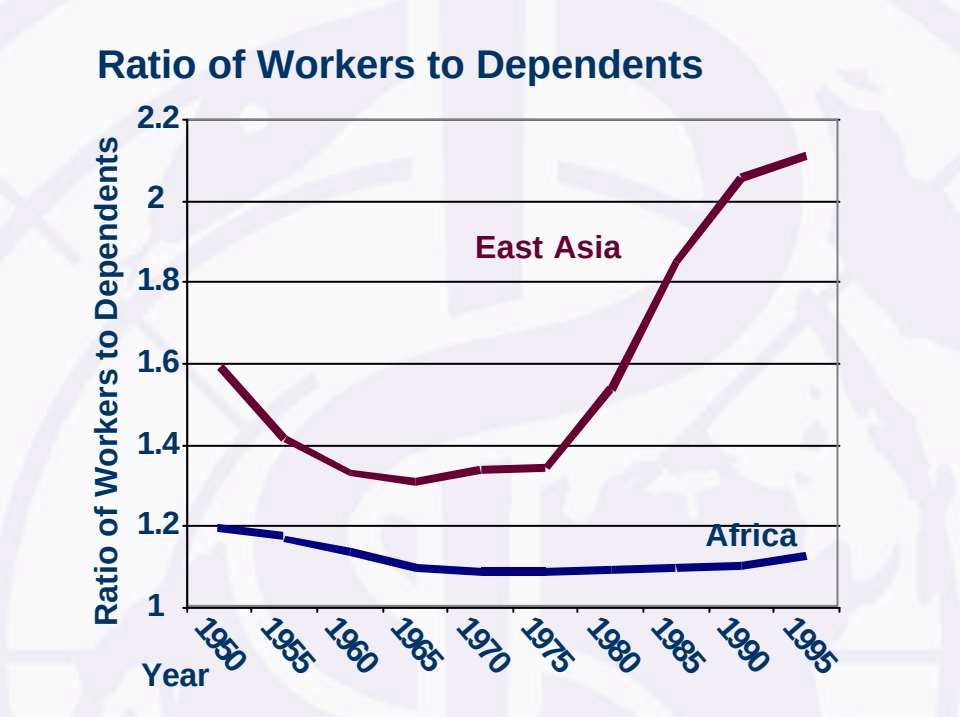


Figure 4

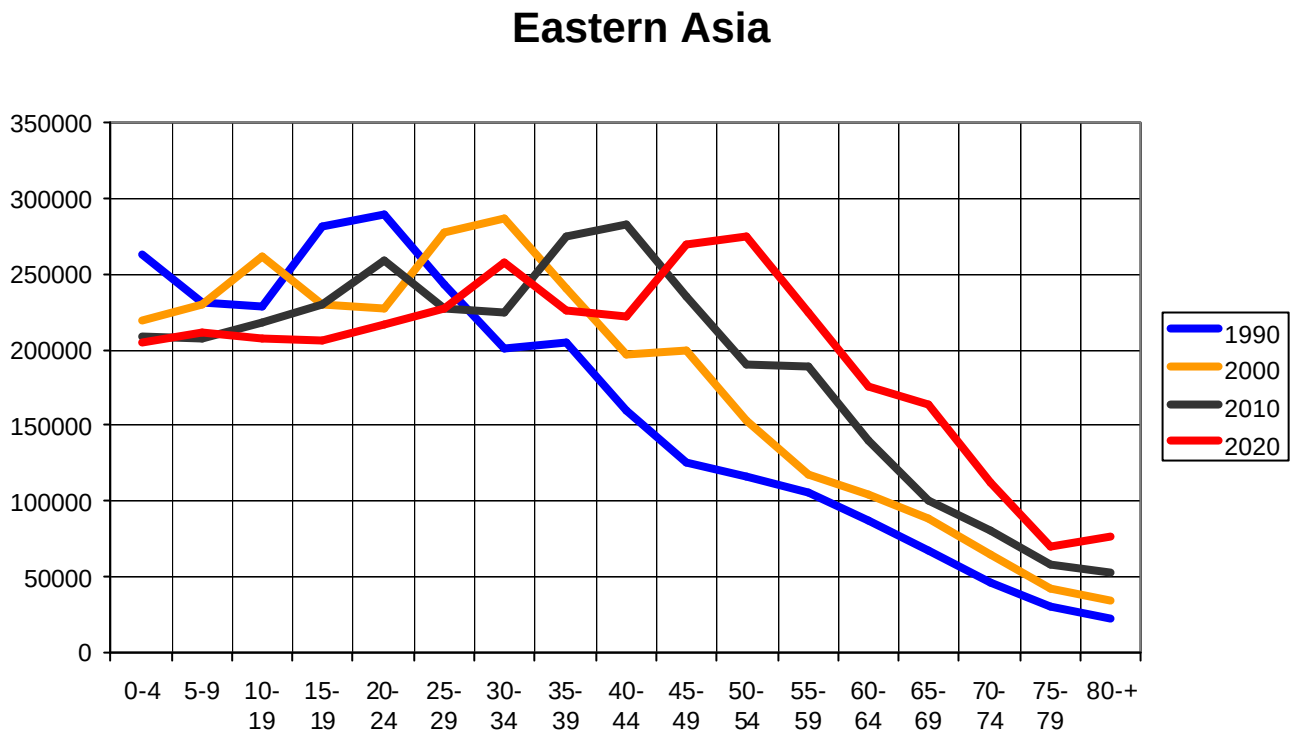
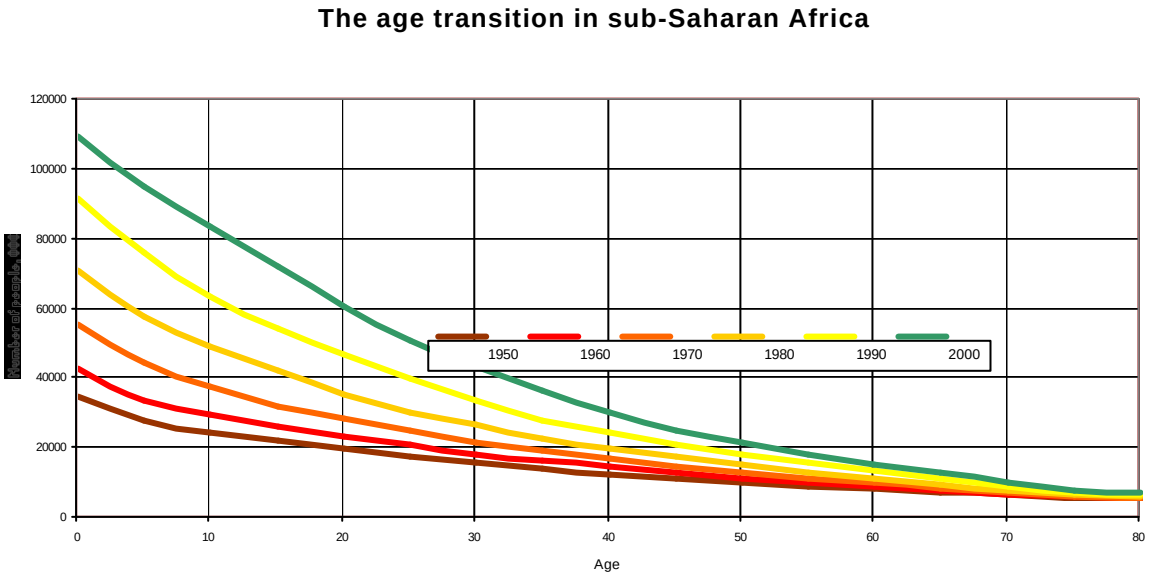


Figure 5



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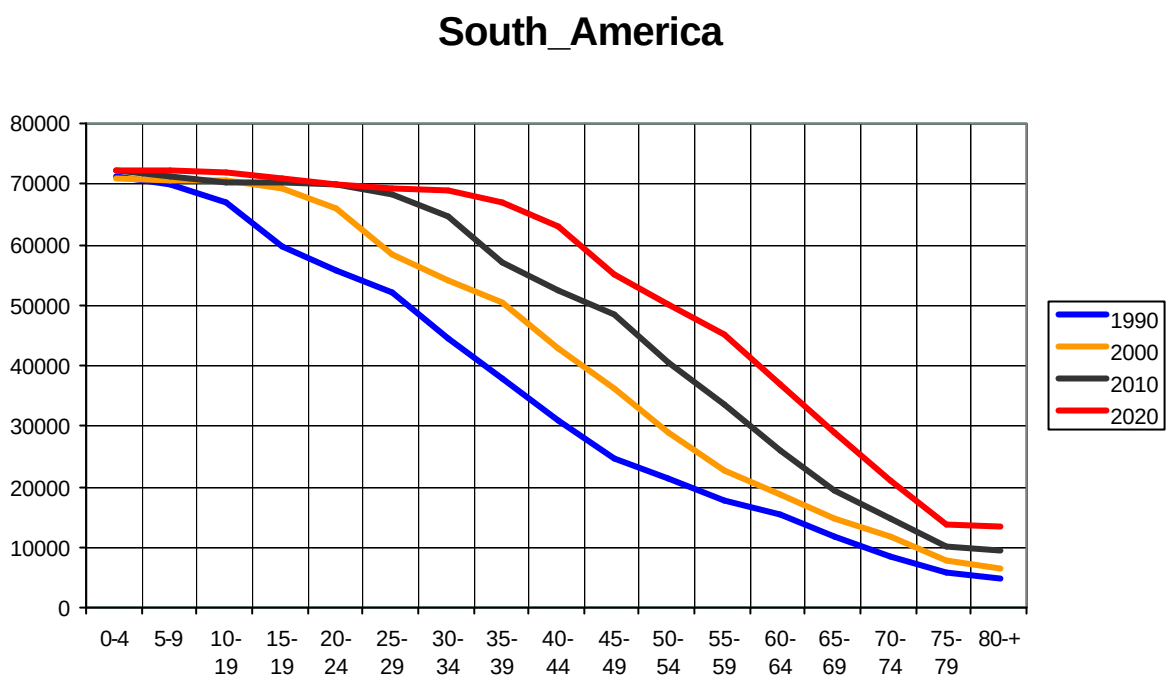

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