HEALTH ECONOMICS IN DEVELOPING COUNTRIES

Steve Onyeiwu
Department of Economics, Rensselaer Polytechnic Institute, Troy, New York, USA

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Summary

This article reviews the ways in which neoclassical economics is applied to health issues in developing countries. It identifies some of the problems that arise from the application of standard neoclassical theory to the health sector of developing countries. This theory, while helpful in some respects, does not seem to be adequate for understanding the complexities of the health issues facing the less developed countries. The article discusses the ways by which investment in health can accelerate the economic development of developing countries, and stresses the role of nutrition and education in strengthening the health profiles of developing countries. The various methods of resource allocation are reviewed, and their implications for the health care sector of developing countries are analyzed. The article takes a cursory look at the AIDS epidemic in less developed countries, identifying some of the reasons for the explosion of the disease in developing countries. The implications of relying on the market mechanism for resource allocation in developing countries are also explored.

1. Introduction: Conceptual Issues in Health Economics

Health economics can be viewed as the application of the theories, concepts, and methods of economics to the health sector. Its major focus is on the allocation of resources between various health-enhancing activities; the quantity of resources used in health service delivery; the organization and funding of health service institutions; the efficiency with which resources are allocated and used for health purposes; and the effects of preventative, curative, and rehabilitative health services on individuals and society.

Although health economics involves the application of economic theory—a theory that is believed to be universally applicable—it is being applied in developing countries in ways that are substantially different from its application in developed societies. Much of

neoclassical economics is based on the experiences, institutions, values, and social structures of developed Western societies. For instance, neoclassical economics regards health as a "normal good" whose demand increases as the level of income or economic development accelerates. In other words, the demand for health care is treated in much the same way as the demand for tangible goods such as cars, travel, houses, etc. Thus, neoclassical economics regards health as part of consumers' utility function in the sense that health can be perfectly substituted for other goods such that consumers attain the maximum possible satisfaction. Neoclassical economics also tries to equate the "marginal value" of more health to the marginal value of other goods that give consumers utility.

It would be a gross mischaracterization, however, to regard health in developing countries as simply a normal good or an argument in the utility function. These countries are characterized by low labor productivity, caused in part by very poor health conditions of the population, which makes them prone to absenteeism and short working hours. Unlike developed countries, a slight improvement in the health profile of the inhabitants of developing countries has the potential to significantly boost productivity and output. There is ample empirical evidence to support the notion that the influence of health factors on output is quantitatively large than that of other factors. For instance, a study of 36 countries in Asia and Latin America commissioned by the International Labour Organization (ILO) in 1964 found that 69% of the change in growth rates was unexplained by growth in labor and capital inputs. Given this barrage of evidence, it seems more appropriate to regard health as an argument in the production function in developing countries.

In developed countries, health economics has typically been the domain of microeconomists, who apply the tools of economic theory to resource allocation in the health sector. In contrast, development economists are primarily responsible for health economics in developing countries. This difference might be explained by the fact that development economists who work in poor communities have realized that economic growth cannot be accelerated or sustained in developing countries without an improvement in the health conditions of the populace. In the 1960s, for instance, many developing countries achieved very impressive growth rates, some even higher than those stipulated by the United Nations (U.N.) in its "First Decade of Development." However, development economists discovered to their utter dismay that those impressive growth rates were accompanied by a high prevalence of preventable diseases, infant mortality, deteriorating health profiles, and abject poverty. They thus realized that structural change can only be achieved when attention is paid to health, poverty, unemployment, etc.

Health economists in developing countries have therefore gone beyond the expansion of the theoretical body of knowledge, and have tended to focus on advising health practitioners on planning and implementing health programs. They have also focused on those specific health issues and problems that are of interest to developing countries. It is thus not uncommon to find studies on the cost of specific diseases, as well as on the costs of their control and eradication. In recent times, economists in developing countries have also concentrated on health care financing, primary health care, and appropriate technology.

In recognition of the centrality of health in the development process, the U.N. has introduced the human development index (HDI) as an alternative measure of development to the conventional per capita gross national product (GNP). The HDI is a composite index made up of three variables: the real GNP per capita, literacy rate, and life expectancy (which depends on the health profile of a population). The U.N. then ranks countries all over the world on their performance in respect to these variables. Thus, a country may be doing very well in terms of traditional economic indicators, but doing woefully in terms of the HDI. Indeed, gains in material consumption and technology apparently do not ensure gains in health. Developing countries have consistently ranked very low on the HDI.

The Nobel prize winner Amartya Sen has viewed the development process in terms of capabilities, which he defines as the ability of individuals to (1) develop their mental and intellectual capabilities, (2) live a decent and fruitful life, (3) make the best use of the resources available in their environment and use those resources for raising their living standards, and (4) acquire self-confidence, self-esteem, and self-respect. To Sen, the three sources of capabilities are health, income, and education.

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Biographical Sketch

Steve Onyeiwu received his Ph.D. in economics from the University of Connecticut, USA. He is currently an assistant professor of economics at Allegheny College, Meadville, Pennsylvania. He has taught previously at the University of Port Harcourt, Nigeria, Wesleyan University, Trinity College, and Rensselaer Polytechnic Institute in the United States. His research interests include economics of innovation and technological change, as well as economic development.