INVESTING IN HEALTH

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Abstract: *Investment in health – in human capital – is a clear prerequisite for the new EU members and the EU in order to meet the requirements for accession. The EU has the means and mechanisms to simultaneously make a major impact on the quality of human capital formation within the newly- admitted countries and protect the interests of the Union's existing citizens. The key constraints appear to be the willingness of the new member states to regard resources committed to health as investment in the future of their people and the willingness of the EU to give the same amount of attention to the protection of human health in other policies as it shows toward the protection of the environment.*

There is one factor above all others that makes the accession of countries to the EU unlike any other. This is the issue of the economic performance of the new members. There is still a wide gap between the incomes of the current 15 Member States (EU 15) and the new countries.

The central and eastern European candidates' gross domestic product (GDP) per head as a percentage of the EU average, measured in purchasing power parities, went up from 38% in 1999 to 39% in 2000. It is arguable that this gap is the biggest single challenge to the accession process.

The EU has experience as far as the accession of relatively poor

countries is concerned. In this context, the accessions of Ireland (1973), Greece (1981), Spain (1986) and Portugal (1986) are the most relevant examples. Ireland is often quoted as the most stunning success story of Europe: on accession, Ireland's income per head was 54% of the EU average. But over the last decade the country has achieved a real growth rate of around 6.5% per annum. Eurostat estimates that in terms of GDP per head in purchasing power parity (PPP) terms, Ireland reached over 120% of the EU average in 2002. Greece, Spain and Portugal have also achieved significant economic progress from low levels of income per head on accession (62% of the EU average in the case of Greece, 71% for Spain and 55% for Portugal) (European Commission 2001a).

But even putting these issues aside, there are a number of important differences between accession then and accession now. First, and as indicated above, the accessions of Ireland, Spain, Greece and Portugal were from an economic "starting base" significantly above the average levels of the current newly-admitted members.

Finally, the "rules of the game" are different in this accession round. As the Commission has put it: previous rounds of EU enlargement are only to a limited degree comparable to the present round. The economic structures of the countries and the rules and implications of the EU membership were then very different.

(European Commission 2001a)

Although the newly-admitted members are expected to grow in a faster rhythm, in many cases this growth is insufficient to make a significant impact on the process of "catching up". At these rates of growth, only five of the new members (Cyprus, Czech Republic, Estonia, Hungary and Slovenia) will have achieved 75% of the EU average income by 2027. Bulgaria, Lithuania, Malta, Poland, Romania will each take in excess of 30 years to achieve a GDP per head of 75% of the EU mean (European Commission 2001a).

This part argues that investment in health has an important, but so far neglected, part to play in such a new, ambitious programme for the candidate countries. This could take place by

directly investing in health care or by paying stronger attention to the impact on health of the other policies in the accession process**.**

The gap between the new EU members and the "old" Member

States in terms of their health status is wide and well documented. Furthermore, there is little evidence that this gap is narrowing. Why does this matter?

At one level, inequality itself is a strong argument for action. There is a significant issue about the extent to which existing Member States and the new members can be regarded as participants in a single community while such inequalities persist.

Secondly, there is the (essentially self-interested) argument that the existing old Member States should be concerned about the state of health among their new partners because of the risks of some "export" of health problems (particularly those relating to infectious diseases) as a result of the fact that the movement of individuals becomes easier after the accession.

But there is a third argument: there may be a link between health and economic performance. This suggests that action to improve health may be important – perhaps even necessary – to address the problems oft the process of economic "catch up" above mentioned. This argument justifies a close examination of the link between health status and economic performance. Data from a large number of countries shows that there is a strong positive statistical connection between income per head (economic performance) and a range of indicators of health status. However, a close look at this relationship reveals an interesting and important fact for the CEE newly-admitted members. It has been argued (Hager and Suhrcke 2001; UNICEF 2001) that the performance of these countries in terms of health status is better than would be "suggested" by their level of economic development.

There is strong evidence that as well as the investment in infrastructure and industry, economic growth requires societies to invest in human capital. A major World Bank study (Thomas et al. 2000) has concluded that no country has ever achieved sustained development

without substantial investment in the education and the health of its people. For example, there is a great deal of evidence (de la Fuenta and Ciccone 2002) for the role that *education* can play in promoting growth; a recent study of the spectacular growth record of the Irish economy confirms the importance of this form of human capital investment for the economies of the new members (Ferreira and Vanhoudt 2002/01). The idea of investment in *health* also has a long academic tradition (Grossman 1972) and in the least developed countries the work of the Commission on Macroeconomics and Health (2001) has made a powerful case for the importance of investment in health as a driver of economic development.

An important Working Paper for the Commission (Bloom et al. 2001) concluded in a study of more than 100 countries that improvements in health have a significant positive effect on aggregate output. The measure of "health" used in this study was life expectancy, and within the least developed countries these arguments are clearly understandable. For

instance, the AIDS pandemic in Africa will cause a decline in life expectancy in 51 countries in the next two decades, which is a demographic effect essentially without precedent in modern times. Seven countries in sub-Saharan Africa now have life expectancies of less than 40 years. In Botswana, life expectancy is now of 39 years, instead of the 72 it would have been without the emergence of AIDS. By the end of this decade, 11 countries in the region will have life expectancies close to the age of 30. But the argument that investment in human capital through health care and other factors that improve health increases economic growth in more developed economies may seem less convincing. Could similar arguments which establish a connection between health and economic performance be applied to the "developed" and in transition economies?

As noted above, there is clear evidence of a correlation between health and economic performance. The issue for middle income countries is whether good health causes good economic performance – or good economic performance causes good health. In practice, both are probably

true. A number of academic studies on the causes of growth have now indicated that health and health care can play an important causal role in improving economic performance (Hager and Suhrcke 2001).

Why should investment in health have this effect? Most obviously, spending on health care per se contributes considerably to the national output. Just like any other valuable service (including those of bankers, teachers and restaurant owners), the activity in the sector adds directly to the sum of output and incomes in society. Across the EU as a whole, approximately 8.5% of national output is provided by the health care sector. The equivalent figure for the newly-admitted countries was around 5.8% (WHO 2002). But there are other important arguments beyond the direct expenditure effect.

First of all, whether through investment in health care (McKee 1999), through public health interventions or through initiatives of showing the impact of health in other policies, better population health can lead to important induced growth effects. Some individuals will choose to devote their additional health capital (additional healthy life years) to market activities (working longer, more productively or with lower levels of absenteeism) which have a direct impact on GDP.

Secondly, regions or countries that have a poor health status, and often poor health care facilities, may find it harder to attract or retain productive enterprises or individuals. This will also have an induced effect on income and growth levels. Thirdly, investment in efficient health services will ensure that the long-term budgetary cost of care of a given quality is lower than it would otherwise have been. The improved output of these services (better health) should also reduce the costs of future social interventions (in health itself, disability, unemployment and so on).

Finally, there are also some intriguing insights from a "new" perspective on the determinants of growth that have received much attention in recent years. This is the notion that alongside physical and human capital, the level of growth and development within a country or region is also dependent on its level of *social capital*.

Social capital refers to the institutions, trust relationships and norms that shape the quality and quantity of the social interactions of a society. Social capital is not just the sum of the institutions that make up society – it is the "glue" that holds them together. The core of the social capital argument is that economic and social development thrives when representatives of the state, the corporate sector and civil society create means through which they can identify and pursue common goals and where relationships between individuals (and between individuals and institutions) are characterized by trust (including the absence of corruption and "fair" treatment of individuals by public authorities).

Empirical studies of the impact of social capital are limited, but there is now some evidence that shows that social cohesion and trust are critical elements if societies are to prosper economically and if development is to be sustainable (Puttnam 2002). It is arguable that investment in the health sector has an important role to play in the development of social capital. In the first place, the "social solidarity" aspects of public health care can make a significant contribution to cohesion and trust. This underpins, for example, the importance of eliminating corruption in health services and the key issue of social solidarity in health care financing. Greater responsiveness of health services to individual and collective aspirations could also play a role in building social capital.

For example, if individuals believe that health services will be "there when they (or their family) need them" they may prove to be more geographically mobile in search of employment. This is in the knowledge that decent services will be available for those family members who move to a new location, as well as for more dependent members of the family left behind. Finally, health is an important focus for activities of interest and voluntary groups in civil society, another important area for the development of social capital.

Overall, therefore, there are some strong arguments for the proposition that investment in improvements in health could be important in promoting economic growth within the candidate

countries. In this context, it is important to build on the "head start" (or comparative advantage) that these candidates have in relation to their health performance.

What is the priority for investment in health in the process of accession?

Against this background, it might be expected that the priority attached to investment in health during the accession process would be high. In fact the opposite is true. Within the CEE new member countries, investment in health continues to take low priority for two main reasons.

Firstly, the importance of human and social capital investment compared to physical capital investment is still not appreciated in finance ministries.

Resources for health are still often regarded as a form of consumption rather than investment expenditure. Taking into account the fact that the policy objective of many candidate countries is to reduce public sector deficits and contain public spending, health is often seen as a drain on national resources rather than as a means of adding to them. Slow progress in the reform of health care is also often stated as a constraint on additional investment in the sector.

Secondly, there has been an overemphasis on the narrow *acquis* issues in much of the enlargement debate. The fact that health care services are a matter of national competence within the EU (that is, subject to subsidiarity) has tended to discourage consideration of the role that more effective services could play in boosting health and economic potential. More generally, the impact of *acquis* issues on wider health considerations has tended to be ignored during the negotiations for accession. This represents a missed opportunity both for the new countries and for the old Member States. The lack of concern for health within the new countries is neither economically nor legally justified.

What could be done by Members States and the new member states to address this missed opportunity? Firstly, and in relation to direct investment, a proportion of EU post-accession funding for admitted countries could be reoriented towards investment for health improvement.

In addition, a greater orientation on the health consequences of other policies, including those implicit in the accession process, is required. Many of the policies required to implement successfully the *acquis* have consequences for health – and some of these are negative. There is a clear danger that the economic advantages of accession could be undermined by unintended and disadvantageous consequences for health. This will frustrate, rather than support, the economic convergence that candidates and Member States alike seek from accession.

Investment in health – in human capital – is a clear prerequisite for the new EU members and the EU in order to meet the requirements for accession. The EU has the means and mechanisms to simultaneously make a major impact on the quality of human capital formation within the newly-admitted countries and protect the interests of the Union's existing citizens. The key constraints appear to be the willingness of the new member states to regard resources committed to health as investment in the future of their people and the willingness of the EU to give the same amount of attention to the protection of human health in other policies as it shows toward the protection of the environment.