IMPORTANCE OF HEALTH ECONOMICS IN WORLD ECONOMY

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ABSTRACT

Health economics is a growing field within the discipline of economics. Health economics deals with issues related to the financing and delivery of health services and the role of such services and other personal decisions in contributing to personal health. Unlike the opening of department stores and car dealerships, there is no grand opening for a new field in a discipline such as economics. It is a branch of economics concerned with issues related to efficiency, effectiveness, value and behavior in the production and consumption of health and health care. Here an analytical study has been done to check the role of health economics. The study employs secondary data sources. The research work is descriptive and analytical in nature. The study ends with the conclusion which is based on the cost-benefit analysis.

Keywords: Cost-Benefit analysis, Health Economics, Health Services

INTRODUCTION

From a Public Health point of view, health economics is just one of many disciplines that may be used to analyse issues of health and health care, in particular as one of the set of analytical methods labelled health services research. But from an economics point of view, health economics is simply one of many topics to which economic principles and methods can be applied. So, in describing the principles of health economics, we are really setting out the principles of economics and how they might be interpreted in the context of health and health care. As Morris, Devlin and Parkin (2007) put it: Health economics is the application of economic theory, models and empirical techniques to the analysis of decision-making by individuals, health care providers and governments with respect to health and health care.’

There are many different definitions of economics, but a definition given in a popular introductory textbook (Begg, Fischer and Dornbusch, 2005) is instructive: The study of how society decides what, how and for whom to produce. In analysing these issues, health economics attempts to apply the same analytical methods that would be applied to any good or service that the economy produces. However, it also always asks if the issues are different in health care.

Production, Resources, Scarcity and Opportunity Cost

The definition of economics above includes the term ‘to produce’, emphasising that economics deals with both health and health care as a good or service that is manufactured, or produced. All production requires the use of resources such as raw materials and labour, and we can regard production as a process by which these resources are transformed into goods:
The inputs to this productive process are resources such as personnel (often referred to as labour), equipment and buildings (often referred to as capital), land and raw materials. The output of a process using health care inputs for example health care professionals, therapeutic materials and a clinic - could be, for example, an amount of health care of a given quality that is provided. How inputs are converted into outputs may be affected by other mediating factors, for example the environment in which production takes place, such as whether the clinic is publicly or privately owned.

The key observation of economics is that resources are known to be limited in quantity, but there are no known bounds on the quantity of outputs that is desired. This both acts as the fundamental driving force for economic activity and explains why health and health care can and should be considered like other goods. This issue, known as the problem of scarcity of resources means that choices must be made about what goods are produced, how they are to be produced and who will consume them. Another way to view this is that we cannot have all of the goods that we want and in choosing the basket of goods that we will have, we have to trade off one good for another.

The term economic goods are sometimes used to describe goods and services for which economic analysis is deemed to be relevant. These are defined as goods or services that are scarce relative to our wants for them. Health care is such an economic good: first, because the resources used to provide it are finite and we can only use more of these resources to create health care if we divert them from other uses; and secondly, because society wants for health care, that is what society would consume in the absence of constraints on its ability to pay for it, have no known bounds. Nowhere in the world is there a health care system that devotes enough resources to health care to meet all of its citizens’ wants. Of course, in a national health system, it is likely that the aim is to meet needs rather than wants; this distinction is discussed below. But it is also the case that meeting one need may mean that another is not met and that no-one has discovered a limit to need. To summarise: in the economy as a whole, there are not enough scarce resources to meet all of the wants that people have, so we have to choose which wants are met and which are not met; in the health care system there are not enough health care resources to meet all of the health needs that people have, so we have to choose which needs are met and which are not met.

OBJECTIVES OF THE STUDY

The study analyses Demand and Supply of health services, Government intervention and the importance of health Economics.

LITERATURE REVIEW

As an academic field of inquiry, there was virtually no health economics research before 1945, and relatively little after that date until the 1960s (Phelps 1995; Fuchs 1996). During the early 1960s, two Nobel laureates published papers that had an important impact on the development of health economics as a field. One was the seminal paper by Kenneth Arrow emphasizing the role of uncertainty in determining key institutional features of the health sector (Arrow 1963). The other was Gary Becker’s treatise on human capital, which provided the theoretical foundation for economists to analyze the role of health care in the production of health (Becker 1964). Since the early 1960s, health economics has enjoyed several decades of remarkable growth, and the future of this field looks extremely bright as well (Fuchs 2000).
Importance of Health Economics

Everyone is affected by health and personal health care services in important ways. Your health affects your enjoyment of life, your ability to contribute to your family well-being and to be productive member of the workforce, and, earlier in life, your ability to be productive in school. Most people receive at least one persona health care service annually. By midlife, and certainly later in life, the consumption of personal health services tends to be much higher than for younger adults. When employed, you probably will pay taxes that finance health insurance and personal health care services. Given the importance of the health sector in many countries, many of you will eventually find employment in an organization involved in health care provision or financing, or be involved with health care as an attorney, a business leader, or a government official. The impact of health economics is felt not only within the discipline of economics but also outside the field. Health economists are as likely to be cited in scholarly journals and other publications outside the economics literature, such as in medical, public health, and public policy books and journals, as they are in economics publications. Fuchs (2000) attributed this phenomenon to the “two-hat” nature of health economics. On the one hand, health economics is a behavioural science: high-quality research in this field advances the discipline of economics in general and, more broadly, all the social science disciplines. On the other hand, health economics provides valuable insights into and empirical evidence on important health policy issues and health services research, a general field in which experts in clinical practice and public health are engaged.

Judged by their participation in the public policy arena and the media, health economists have had an important presence. Of course, our advice has been disregarded. A more often than, it has been followed. Practical political considerations often weigh much more heavily in actual public policy decisions than they do in economists’ policy recommendations. Also, new public policy directions are much more likely to be undertaken when there is a crisis. At other times, inertia prevents the adoption of even sound new ideas. Health economists investigate positive issues — empirical relationships among variables as they are — more frequently than they do normative issues, or policy recommendations about how resources should be allocated and distributed. Examples of research on positive issues are inquiries into the response of demand to changes in the price of personal health care services, individuals’ choices among several health insurance plans, the decision to start or stop smoking, the decisions pharmaceutical manufacturers make about investments in research and development, determinants of physicians’ fees, and hospitals’ price and output decisions.

The Growth of Health Economics

There is no common metric to measure the growth of a research field. Two alternative measures are among those that can be used to gauge the tremendous expansion of the field of health economics in the past several decades. First, the number of PhDs awarded annually in health economics has increased rapidly over time. For example, in the United States, the number of dissertations on health economics increased eleven fold from 1965 to 1994. By contrast, the number of dissertations in all fields of economics increased only 2.5 times during the same period (Fuchs1996). A similar pattern is evident from lists of doctoral dissertations in economics published in the Journal of Economic Literature, which reveals a high rate of growth of health economics in terms of the number of dissertations completed during 1991 – 2008.

Second, by a number of metrics, the supply of health economists and of health economics, measured in terms of books and papers published, public testimony, editorials, and other media reports, has increased. Growth in the supply of PhDs in health economics has enabled many professional schools, government agencies, and research institutes to attract health economists to their staffs, which in turn has increased the capacity for health economics research and policy development.

The share of National Bureau of Economic Research (NBER) working papers devoted to health economics has grown from 1.2 percent in 1986 to 12 percent in 2006. The number of professional journals devoted to health economics has also increased. The first professional journal in the field, the
Journal of Health Economics, began in 1982. By 2006 there were seven journals specializing in health economics. Particularly in view of the growth of both real expenditures on personal health care services worldwide and the growing number and size of public health programs, it seems reasonable to expect these trends to continue.

**Demand for health care services**

If we are considering the market for health care, we will be interested in the demand for health care. However, in considering this demand, it is important to recognise that health care has special characteristics that may make it different from other goods. One factor is that health care is not usually demanded because it is in itself pleasurable; in fact it may be unpleasant. Instead, it is demanded mainly to improve health. So, even if health care is in itself unpleasant, it leads to more pleasure than would otherwise have been the case.

If health care is only demanded in order to improve health, then, is there a demand for health improvements? Health can indeed be regarded as a good, in fact a fundamental commodity that is essential to people’s well-being, leading to a demand for improvements in it. Health does have characteristics that more conventional goods have, it can be manufactured; it is wanted and people are willing to pay for improvements in it; and it is scarce relative to people’s wants for it. However, its relationship with the demand for health care is not one-to-one, because although health is affected by health care, it is also affected by many other things and it also affects other aspects of welfare, not just health care. As a good, health is even more peculiar than health care, because of its characteristics. It is less tangible than most other goods and cannot be traded, it cannot be passed from one person to another (although obviously some diseases can.)

In the context of ordinary goods and services, economics distinguishes between a *want*, which is the desire to consume something, and effective demand, which is a want backed up by the willingness and ability to pay for it. It is *effective demand* that is the determinant of resource allocation in market, rather than wants. But in the context of health care, the issue is more complicated than this, because many people believe that what matters in health care is not wants or demands, but *needs*. Health economists generally interpret a health care need as the capacity to benefit from it. Not all wants are needs and vice versa. For example, a person may want nutrition supplements, even though these will not produce any health improvements for them; or they may not want a visit to the dentist even if it would improve their oral health.

The conclusion from this is that the demand for health care can be analysed as if it were any good or service, but it has peculiarities that may mean that the usual assumptions about the resource allocation effects of markets do not hold. Moreover, it may well be that people wish resource allocation to be based on the demand for health or the need for health care, neither of which can be provided in a conventional market.

**Supply of Healthcare Services**

The supply side of the market is analysed in economics in two separate but related ways. One is related to the resource input / goods output model outlined above, looking at how resource use, costs and outputs are related to each other within a firm. Some of the issues that this illuminates concern efficiency in production, which will be discussed below. Others include issues such as economies of scale are there any cost savings through having larger general practices, for example productivity how many more surgical operations can a hospital provide if it hires an extra nurse - and factor substitution does allowing dental hygienists to replace dentists in undertaking certain tasks lower the costs of producing dental care?

The other way in which supply is analysed is so called market structure how many firms are there supplying to a market and how do they behave with respect to setting prices and output and making profits. There are two well-known theoretical extremes of market structure. Perfect competition has very many firms in the market so that none has any real economic power, none makes any profits,
prices are as low as they can be and output is as high as can be. A monopoly has only one firm, which has great market power, makes as large profits as can be had and has higher prices and lower output. Other models are somewhere in between. The behaviour of some health care organisations, such as pharmaceutical companies, providers of services like dentistry, ophthalmic services and pharmaceutical dispensing and for-profit insurance companies can relatively easily be analysed using these models. It may be more difficult for other organisations. However, they may provide relevant insights, for example regulation of the UK provider sector is increasingly guided by the use of market forces involving contestability to provide some competitive pressures for efficiency.

Government Intervention

The World Health Organization (WHO) at one time ranked countries’ health systems in terms of their performance. These rankings reflected the performance of the public sector of the countries in health care as well as other factors. The WHO indicates that it no longer produces a ranking table because of the complexity of the task. Although individual rankings can be debated, it is noteworthy that France, Italy, Spain, Austria, and Japan were in the top ten of the WHO’s ranking in 2000. The United States ranked thirty-seventh, which was about the same ranking as Canada, Finland, Australia, Slovenia, and Cuba. In the bottom ten, ranked 181–190, were low-income countries, mainly in Africa.

Government’s Roles in Achieving an Equitable Distribution of Resources

Governments throughout the world have been more active in health care than in most other sectors of their economies. High levels of government activity in healthcare have created substantial demand for policy analysis by health economists.

A major reason for government intervention is redistributive. The underlying notion is that in just societies, people should have minimal access to certain goods, irrespective of their ability to pay. Historically, such goods were provided by private philanthropy, but apparently in insufficient amounts, providing a rationale for government intervention. Absent government intervention, market forces may lead to a situation in which less affluent population and population disadvantaged for other reasons, such as geographic remoteness of locations at which health services are delivered relative to where persons work and live, may have inadequate access to personal health care services. Governments have a choice whether or not to transfer resources to disadvantaged populations in the form of income or in kind transfers.

Economists typically prefer income transfers, leaving it to the recipients of the transfers to allocate the subsidies in a way that maximizes well-being from the household’s perspective (Currie and Gahvari 2008). However, for merit wants, societies clearly prefer to redistribute in kind out of a concern that households will under consume the very goods and services to which societies attach the highest priority. Income transfers may be allocated to other goods and services instead of physician visits and other types of personal health care services. Countries differ in how in-kind transfers are made. Many countries mainly rely on direct provision through public clinics and hospitals. Some high-income countries, including the UK, Denmark, Norway, and New Zealand, as well as low income countries, such as those in sub-Saharan Africa, rely on direct government provision of personal health care services. Governments subsidy the production of personal health care services in the form of free clinics and hospitals.

In countries with limited resources, there may be few government-sponsored facilities, and the few that exist may be geographically remote from much of the country’s population. Because of the high cost, many persons may obtain care only after their diseases have reached an advanced stage, if they receive care at all.

Facilities receive budgetary allocations from the government on a regular basis. The limiting factors are the facilities’ budgets and physical plant. Higher-income persons may obtain care from private providers who are not subsidized by the government.
Some countries have single-payer government financing, combined with private provision. Health insurance is provided as social insurance. In these countries, insurance coverage is universal or nearly so and provided without regard to a person’s ability to pay. Examples of countries with single-payer systems are Canada and Taiwan. In Germany, which has had a social insurance system for health care since the late nineteenth century, coverage of employees below a certain monthly salary is mandated by law. Although such health insurance is provided by private sick funds, coverage attributes are subject to strict government oversight and regulation. For persons not employed, there is welfare-based insurance coverage similar to Medicaid in the United States. A third alternative is the private provision of insurance, as is common in the United States. However, even in the United States, about half of expenditures on personal health services are financed by public funds.

CONCLUSION

In summary, Health Economics is just one of many disciplines that may be used to analyse issues of health and health care, in particular as one of the set of analytical methods labelled health services research. Health economics is a growing field within the discipline of economics. It deals with issues related to the financing and delivery of health services and the role of such services and other personal decisions in contributing to personal health. Health economics is concerned with the connection between health and the resources needed to promote it. Resources here involve not just money, but also people, materials and time.

Government can promote health economics by tax and government transfer policies or by regulations that require private parties to undertake various precautions, for example that a child be vaccinated before enrolling in school or that a manufacturer eliminate or reduce pollutants arising from the manufacturing process.

REFERENCES

3. Folland, S. et al. (2008), The Economics of Health and Health Care (Fourth Edition), Pearson Education.
6. https://mitpress.mit.edu/sites/default/files/titles/content/9780262016766_sch_0001.pdf