The Health and Wealth of Nations

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June 5th, 2007

ABSTRACT

People who live in richer countries live longer than people who live in poor countries. Over the last century and half, or perhaps longer, income and longevity have increased together in the now rich countries, so that people got healthier as they got wealthier. Within both rich and poor countries, people who are richer live longer. Why is there such a close correlation between wealth and health, and why does it matter?

One reason to care about health and wealth is that it changes the way that we should think about poverty and deprivation. We are rightly concerned about poverty because we do not think that people should have too little income to meet basic necessities or to live a decent life. But the poor not only do not have enough money, they also have shorter lives, and lives that are more often diminished by sickness. They are poor not only in money, but also in health. If we are driven by humanitarianism, or by justice, to help the income-poor, those reasons have greater force once we realize that, taking income and health together, the poor are even poorer than we thought, and we, the rich, are richer than we thought.

If health is so strongly related to wealth, then perhaps better health *causes* wealth or perhaps it is the other way round, that economic growth automatically causes people to be healthier, what has come to be known as the "wealthier is healthier" hypothesis. I shall argue that while it is true that healthier people are undoubtedly more productive, it is not true that better health causes higher rates of economic growth. The solution to Africa's poverty is not to improve African health systems, however desirable that may be on other grounds. The other causal link, from income to health, is harder to dismiss; it is not for nothing that the infectious diseases and childhood diseases that plague much of the world are called "diseases of poverty." Yet the important question here is the design of policy: should we emphasize economic growth and let health look after itself, or should we instead focus on the direct provision for better health through collective action in public health and the provision of healthcare? Recent experience from India and China suggests that growth and health improvements are not well-synchronized over time. Indeed, recent high rates of economic growth in India have been associated with *declines* in some nutritional indicators, including child wasting, and per capita calorie consumption. A wider, cross-country perspective is also not consistent with any direct, short-run causality from income to health, but rather suggests that countries that are well-governed and have good institutions are also countries that capable of delivering good performance in both growth and in health.

The within-country relationship between income and health is often taken to mean that poverty and material deprivation are the fundamental causes of poor health, so that better health requires political and economic action to redistribute income and wealth. As Rudolf Virchow wrote in the 19th century, "Medicine is a social science, and politics nothing but medicine at a larger scale." But there are many processes that cause health and income to be related, and these often lead to quite different policy conclusions. I shall focus on three of these. First, there is the obvious, but often neglected, mechanism that runs from health to income. Almost by definition,

people who are disabled are not able to earn as much as people who are fit and healthy. This is true in poor countries and rich countries alike, though some rich countries have relatively good disability and sickness benefits that protect income when someone is sick, at least for a while. These mechanisms help prevent people who fall ill from becoming poor in consequence, and help reduce the relationship between health and wealth. Other mechanisms, such as health savings accounts in the US, will have the opposite effect, sharpening the relationship between health and wealth.

The second process that leads to a relationship between health and wealth is the influence on health and earnings in adulthood of health in early childhood. Children who are better nourished show better cognitive function throughout their lives, they are taller, they are better educated, and they earn more. They are also less likely to die young.

The third process, which is perhaps the least understood, is the way in which education affects health. There is increasing evidence that people who are better educated are better able to protect their health, through avoiding behaviors—such as cigarette smoking—that shorten their lives, and perhaps also through a greater ability to use the preventative and curative medical system to the best advantage.

Of course, none of these arguments about the operation of “third factors” that affect both income and health, or of a causality running from health to income, rule out the possibility that people can directly use income to buy better health. Indeed, in countries such as the United States, it is certainly possible to use money to buy better healthcare, reducing both morbidity and mortality. At the other end of the spectrum, there is evidence that the rise in real wages in India has liberated people from the heavy manual work in agriculture, and that this induces a (temporary) negative relationship between economic growth and calorie consumption.

To the extent that education and income help people take advantage of scientific and medical knowledge, as well as to make the best use of the medical system, the size of the health differentials across different groups will be largest in periods when there are new innovations in health-knowledge or in medical procedures. More educated, smarter, and richer people are likely to benefit first from new knowledge and methods. In England before 1750, dukes and their families could not expect to live any longer than the rest of the population, if anything the reverse. Yet in the wake of the Enlightenment, as new knowledge about public and personal health began to spread, including variolation against smallpox and better obstetric care, a gap began to open up between the aristocracy and the common people, a gap that has not closed to this day. Later, after 1850, when the increase in life expectancy spread to the whole population, and then to the other countries of Europe and North America, enormous health inequalities opened up across the world at around the same time as enormous *income* inequalities were opening up between rich and poor countries.

What is the role of economics in understanding the relationship between health and wealth? I believe that there are several. One is our statistical skills. We are good at working with large, representative, publicly-available data sets, which is a very different tradition from the often small, sometimes special, and typically privately-owned data sets that are more common in medical sciences and epidemiology. In the United States and Europe, the American National Institutes of Health, and particularly its National Institute on Aging, have recognized this by helping to fund the collection of new longitudinal data sets in which economics and health are fully represented. But perhaps more importantly, economists understand better than most that "correlation is not causation," and that an understanding of processes is necessary as a basis for policy. That various measures of health are correlated with almost any measure of socioeconomic

status, whether it is income, education, occupation, rank, or whether or not you win an Oscar, is not by itself knowledge that is useful for policy.