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Economic Upturns are good for Your Heart but Watch out for Accidents: A Study on Swedish Regional Data 1976-2005

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Abstract: This paper explores the relationship between the regional unemployment rate and total and cause-specific mortality in Sweden during 1976-2005. Overall mortality is unrelated to changes in the unemployment rate, while the biggest cause of death (heart disease) decreases when the unemployment rate decreases. At the same time other accidents, including job-related accidents, increase when the unemployment rate decreases. Swedish evidence provides no support for the US research findings that short-term increases in the unemployment rate are bad for your health in general.

Keywords: Determinants of Health; Mortality; Unemployment

JEL codes: E32, I12

I. Introduction

In a series of papers in the 1970s Brenner (1971; 1975; 1979) used time-series evidence and found that there was a fluctuation in the trend of decreasing mortality rates that could be explained by changes in the business cycle. He found that there was an even larger decrease in mortality rates during economic upturns. However, other authors' argued that Brenner had some flaws in his analysis. Correcting for these flaws, a time-series approach by McAvinchey (1988) reached an opposite conclusion to Brenner.

More recently, there has been a growing series of papers that have studied the relationship between short-term changes in the unemployment rate and total and cause-specific mortality, using mostly panel-data techniques. In the panel data approach different economic developments in each region are compared to changes in mortality rates in the same region. Hence, the effect of business cycles on the mortality rate is measured by exploring within-unit changes compared to other within-unit changes, an approach that in many cases is beneficial in attempts to control for omitted variable bias. It began with an important paper by Ruhm (2000) who used state level data in the US and found that mortality actually increased in economic upturns (pro-cyclical relationship). In a follow-up Ruhm (2003) used individual level data and confirmed the finding of the aggregate state-level study that good times make you sick (or make you die). Other authors have followed and using regional data the same pro-cyclical relationship has been documented for most causes of death in Germany (Neumayer, 2004), Spain (Tapia Granados, 2005) and France (Buchmueller *et al.*, 2007). In a more recent paper Ruhm (2006) looked specifically at mortality in acute myocardial infarction (heart attacks), which is one of the main causes of death, and found that a one percentage point decrease in the unemployment rate increased heart attack mortality by 1.3%.

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3 The pro-cyclical relationship has also been documented using cross-country data from 23
4 OECD countries (Gerdtham and Ruhm, 2006).
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8 These pro-cyclical trends were also found in recent time-series applications by Tapia
9 Granados (2004) using Swedish data for the period 1800 to 1998 (even though he found that
10 the effect faded over the last 50 years). In another paper Granados (2005), using time-series
11 techniques again, found a pro-cyclical pattern on US data for the period 1900 to 1996. Most
12 papers in the literature use the unemployment rate as the only proxy for the business cycle,
13 but Granados (2005) argued that it cannot for certain be assumed to be true that the
14 unemployment rate is the best proxy for the business cycle. Hence, he tested three other
15 proxies for the business cycle, but found the same qualitative results as using the
16 unemployment rate.
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29 There are two exceptions to the consensus that is beginning to emerge from the literature
30 cited above, but they also differ in some respects, making them difficult to directly compare
31 with the pro-cyclical findings. One paper by Gerdtham and Johannesson (2005), using
32 individual level data from Sweden, studied whether national business cycle indicators were
33 related to the probability of death. In many cases they found no such relationship, but for
34 males they found a counter-cyclical relationship for four business cycle indicators.¹ In a
35 recent paper Svensson (2007) uses the same statistical approach as the papers that report a
36 pro-cyclical relationship, but finds that there is no pro-cyclical relationship between
37 incidence, mortality and lethality in heart attacks and the business cycle in Swedish regions.
38 Instead, a counter-cyclical relationship is found for individuals of prime-working age, i.e.
39 between 20 and 49. There are also contrasting results regarding the association between the
40 unemployment rate and some cause-specific mortality rates. As an example, in contrast to his
41 overall findings, Ruhm (2000) found that suicides increased when the unemployment rate
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¹ The unemployment rate was not one of these indicators, but was rather insignificant in all estimations.

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3 increased. However, a paper by Andrés Rodríguez (2005) specifically looking at determinants
4 of suicide rates does not show a statistically significant effect in the full model.
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8 The goal of this analysis is to further explore the relationship between mortality and the
9 unemployment rate in Sweden, extending previous analyses to a longer time period (1976-
10 2005) and focusing on ten specific causes of death. The two Swedish studies finding
11 contradicting results in the literature are not directly comparable to the studies documenting a
12 pro-cyclical relationship. Gerdtham and Johannesson (2005) use business cycles that are
13 national in scope and focus on initial surveys taking place from 1980 to 1986. Svensson
14 (2007) uses the same regional fixed approach as Ruhm (2000; 2003), Neumayer (2004) and
15 Gerdtham and Ruhm (2006), but instead concentrates on a more detailed study of heart
16 attacks only.
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29 The research field exploring links between health and economic conditions, lifestyles
30 and socioeconomic status, is an important one with major public health interests. As an
31 example, Thornton (2002) showed that lifestyles and socioeconomic status are far more
32 important determinants of public health in the US compared to more medical care utilization.
33 Hence, health care policy should not only be about medical care provision.
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41 The specific analysis in this paper is also important for at least three main public policy
42 reasons. (1) To be used in a broader societal perspective on changes in the unemployment
43 rate. Unemployment has direct financial effects, but also has indirect effects on e.g. property
44 crime rates (Edmark, 2005). The latter type of effects, which could include health effects, are
45 important to analyze so that public policy on, e.g. labour market issues may take all the
46 relevant effects into consideration. (2) If it is found that mortality, or some cause-specific
47 mortality, is closely associated with the business cycle, this can serve as an instrument in
48 public health and health care planning, e.g. increasing resources for heart diseases in
49 economic upturns or adjusting road safety regulations to different traffic demands etc. (3) To
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3 serve as an element of knowledge for potential public health information, e.g.
4 increased/decreased risk of heart disease related to the business cycle, and, as mentioned
5 above, as a possible input in a broader health care policy.
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10 The analysis in this paper reveals that no robust relationship can be found between total,
11 age or gender-specific mortality and the business cycle. The ten specific causes of death
12 indicate that this is reasonable, considering that the effects are different for different causes.
13 Two robust results are found in the cause-specific analysis. Primarily *Other Accidents*,
14 including job-related fatalities, significantly increase in economic upturns, while *Heart*
15 *Disease* mortality, the most common cause of death in Sweden as well as in many other
16 developed countries, tends to decrease in economic upturns.
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27 The rest of the paper is structured as follows. Section two provides a brief background to
28 the expected mechanism between mortality and the business cycle. The third section describes
29 the data and the methods used in the empirical analysis, which is conducted in the fourth
30 section. The last section concludes the paper with a discussion.
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40 **II. Mechanisms through which the business cycle may** 41 **affect mortality** 42 43 44 45

46 There are several mechanisms through which the economy may affect the mortality rate and
47 some of them are listed below.
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50 **Stress:** In good times unemployment decreases and this may imply less psychosocial
51 stress due to less economic insecurity (Fenwick and Tausig, 1994). However, stress may also
52 increase in good times for the average individual if overtime becomes more frequent and job-
53 stress increases. Hence, stress might increase in bad times for some and in good times for
54 others. It is generally known that stress is a risk factor, especially for cardiovascular
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3 diseases/mortality (Black and Garbutt, 2002; Brenner and Mooney, 1983; Elisaf, 2001;
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5 Fenwick and Tausig, 1994; Krantz and McCeney, 2002; Pickering *et al.*, 2003).
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8 **Unhealthy behavior:** Using a large individual level dataset over a period of 11 years in
9
10 the US has helped to show that binge drinking increases in recessions (Dee, 2001). The same
11
12 result is found using regional data for Finland (Johansson *et al.*, 2006). By contrast, Ruhm
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14 (2005) and Ruhm and Black (2002) have shown that binge drinking and smoking increase
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16 during economic upturns. Ruhm and Black (2002) argue that this is mainly due to heavy
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18 drinkers consuming less in recessions and not movements into and out of drinking in general.
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20 They maintain that this is to some extent an income effect leading to less drinking in short-
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22 term economic downturns when unemployment increases. That behavior such as binge
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24 drinking is important for mortality rates even in the short-run was documented as early as
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26 during WWII when alcohol-related mortality decreased quickly when alcohol consumption
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28 decreased, see e.g. Johansson *et al.* (2006) and Ruhm and Black (2002).
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34 **Health investments:** Longer working hours in short-term economic upturns could make
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36 it more costly for individuals to invest in health enhancing exercises and to eat healthier food,
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38 which might be more time-intensive in preparation (Chou *et al.*, 2004; Ruhm and Black,
39
40 2002). However, once again there is some conflicting evidence; it has been found that better
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42 economic conditions produce a decrease in BMI in Finland (Böckerman *et al.*, 2006). There is
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44 also an indication that economic upturns, and the longer working hours that result from them,
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46 lead to lower investments in sleep time (Biddle and Hamermesh, 1990), which in turn is
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48 linked to higher levels of stress and increases in psychological illness (Sparks *et al.*, 1997).
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53 Further, in good economic times it is also possible that traffic intensity increases and
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55 hence the risk of traffic-related mortality. The same link could be argued to potentially exist
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57 between job-related fatalities and the business cycle. In good economic times there is more
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3 work done, and potentially at a faster pace, so job-related accidents, also with fatal outcomes,
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5 might increase.
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8 Given that the evidence above indicates that there are several mechanisms linking the
9
10 business cycle and mortality, and they might move in opposite directions, it becomes an
11
12 empirical issue to determine which effects dominate, if any. Finally, it should be noted that
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14 the effects described above primarily concern the health effects of short-term economic
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16 upturns or downturns. In the long-term economic growth and innovation are major causes of
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18 increased health and longevity. The difference compared to the short-term impact is that long-
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20 term growth is the result of technological improvements that are not associated with more
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22 intensive use of labor and health inputs. As an example it has been estimated that 50 to 70
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24 percent of the increased survival in cardiovascular disease between 1984 and 1999 may be
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26 explained by improved medical technology (Cutler *et al.*, 2006). Topel and Murphy estimate
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28 that the economic value of e.g. medical research, possibly due to long-term economic growth,
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30 is enormous. An example, the value of reduced heart disease mortality in the US was worth
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32 around \$1.5 trillion per year over the period 1970 to 1990.
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42 **III. Data and Method**

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45 To estimate the short-term impact of business cycle fluctuations on mortality, I use aggregate
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47 data for all 21 Swedish regions, all of which are also independent providers of health care.
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49 Data covers these 21 regions between 1976 and 2005, giving a balanced sample of 21 cross
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51 section units followed for 30 years and a total number of 630 observations. The main
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53 dependent variable of interest is the natural log of the mortality rate per 100,000 individuals in
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55 each region. In addition to exploring the mortality for males and females and for different age
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57 categories, I will also look at ten cause-specific mortality rates, for (ischemic) heart disease,
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3 suicides, homicides, traffic accidents, influenza, cancer, two different alcohol-related
4 mortality rates, falling accidents and finally “other accidents”, including many types of job-
5 related fatalities. The full model to estimate in the paper is:
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$$\ln y_{jt} = \alpha_t + u_{jt}\delta + \mathbf{x}_{jt}\beta + R_j + R_j \cdot T + e_{jt}, \quad (1)$$

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10 where y_{jt} is the mortality rate in region j at time t , and α_t is a year-specific effect and R_j is the
11 regional-specific intercept. $R_j \cdot T$ is a regional specific time trend. The business cycle proxy is
12 u , which is the regional unemployment rate from Statistics Sweden (SCB, 2005). The
13 unemployment rate is measured as the unemployed as a share of the labor force. In contrast to
14 most other developed countries, Sweden does not count students actively looking as
15 unemployed. Using the unemployment rate as a business cycle proxy is most common in the
16 literature (Gerdtham and Ruhm, 2006; Neumayer, 2004; Ruhm, 2006). Finally in equation (1)
17 \mathbf{x} is a vector of other covariates and e_{jt} is the error term.
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32 Within-region changes in the variables are calculated in the fixed-effects panel data
33 model and these are then compared region-wise to estimate the particular impact of the
34 business cycle fluctuations on mortality. The main benefit of the fixed-effects model as
35 described in equation (1) is that it can control for omitted variable bias in a way that a cross-
36 section or time-series model is not capable of doing. In equation (1) R_j controls for factors that
37 differ among regions (such as lifestyles), but do not change over time, and α_t controls for
38 factors that change over time in the same way in all regions, such as improved medical
39 technology or new and more efficient pharmaceuticals. $R_j \cdot T$ controls for changes over time,
40 but allows these changes to be different, and/or occur at different times, e.g. if new medical
41 technology is introduced earlier in some regions.
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56 Finally in this section descriptive statistics of the variables and their sources are found in
57 Table 1.
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[Insert Table 1 here]

The mean mortality per 100,000 individuals is 1,125 over the full time period. There was a decrease in the mortality during the time period 1976 to 2005. In 1976 the mortality was 1,101 per 100,000, which decreased to 1,060 per 100,000 in 2005. The mortality rate also varied significantly between the regions; in 2005 the mortality rate was 815 per 100,000 in the region of Uppsala, close to the capital region of Stockholm, compared to 1,263 per 100,000 in the rural and northern region of Västernorrland. The unemployment rate, on a national level, increased during the time period from 1.6% in 1976 to 6% in 2005. This time period is also of particular interest to study, since it also contains a time period with unusually large business cycle swings, e.g. from 1990 to 1996 the unemployment rate increased from approximately 1.6% to 8%. Figure 1 below shows the unemployment rate over the time period 1976 to 2005, as well as cause-specific mortality in heart disease and cancer, with data from 1976 to 1996.

[Insert Figure 1 here]

Other covariates included are the shares of the young and elderly, which are assumed to have negative and positive impacts on mortality respectively. This is included to control for different age-structures in the region, considering that the dependent variable is not age-adjusted.² Migration may be potentially important in these type of studies (Ruhm, 2006) since regions that have a more positive business cycle impact may attract more individuals in pursuit of better employment opportunities that might be e.g. healthier than the average. The share of foreigners in each region may be important due to evidence of health gradients

² I have experimented with different types of age controls, and the results in section four are robust for other uses of age controls as well.

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3 (Banks *et al.*, 2006) even though they tend to be lower in Sweden compared to other countries
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6 (Gerdtham and Sundberg, 1998; van Doorslaer *et al.*, 1997).
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10 11 **IV. Results**

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15 Before studying cause-specific mortality rates, Table 2 below begins by showing the results of
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17 exploring the business cycle effect on total, male and female mortality rates.
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22 [Insert Table 2 here]
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26 The results when using three different specifications are shown. The first specification
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28 includes year dummies and the unemployment rate as independent variables. The second
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30 specification adds the other covariates, and the third specification estimates the full equation
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32 (1), including regional specific time trends as well. Generally, no robust relationship can be
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34 found. In the more simplistic specifications there are some indications that female mortality
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36 decreases when the economy weakens (a higher unemployment rate is related to a decrease in
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38 the mortality rate). But this is not significant in the full model. The age-variables behave as
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40 expected; an increasing share of young individuals decreases mortality, while an increasing
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42 share of elderly increases mortality. Somewhat surprisingly, a higher share of non-Swedish
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44 born individuals is associated with a decrease in mortality in some specifications, albeit not
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46 significant in the full model. As was discussed in section two, there are some mechanisms
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48 likely to increase mortality, and some likely to decrease mortality, in good times. Hence, the
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50 non-robust and weak relationships in Table 2 are not particularly surprising. Considering the
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52 weak results, I move on to age- and cause-specific mortality.
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[Insert Table 3 here]

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6 Regarding age-specific mortality the results in Table 3 tell a similar story to the one in Table
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8 2, and hence reveal no significant overall effect. Looking at cause-specific mortality, most
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10 causes show no significant correlation with respect to the unemployment rate. One of the
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12 main causes of death, cancer, is probably not likely to be affected by short-term changes in
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14 the business cycle. However, a non-significant effect on *Traffic Accidents* is perhaps more
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16 surprising. The non-significant effect on *Suicides* might intuitively be surprising, but is
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18 consistent with recent evidence based on European data (Andrés Rodríguez, 2005).
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23 There are two major exceptions to the non-significant results regarding *Heart Disease*
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25 and *Other Accidents*. The results relating to *Heart Disease* are of major importance since this
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27 is the cause-specific category with most deaths. Considering that it is a semi-log model, the
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29 coefficients should be interpreted as that the exponent of the coefficient is the percentage
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31 increase in mortality from a one percentage point increase in the unemployment rate. In the
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33 full model, as in equation (1), this implies that a one percentage point higher unemployment
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35 rate increases ischemic heart disease mortality by approximately 1%. *Other Accidents* picks
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37 up different types of accidents, but they tend to be of the job-related sort. Hence, the pro-
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39 cyclical result, a decrease in *Other Accidents* mortality when the unemployment rate
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41 decreases, is quite intuitive. The coefficient of the full model indicates that a one percentage
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43 point increase in the unemployment rate decreases *Other Accidents* mortality by 13.9%.
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49 For *Heart Disease* and *Other Accidents* I also perform some dynamic analysis, in which
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51 I use the average unemployment rate in each region 3 years prior to the year of interest
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53 regarding mortality. I also check for the very short-term impact in this model by calculating
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55 the deviation in the employment rate in year t compared to the average employment rate in
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57 year $t-1$ to $t-3$. This is similar to the approach to dynamic analysis in Ruhm (2006), an
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59 argument for which is that changes in the business cycle will affect health in many respects
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3 and not only in the short-run. Further, there is a correlation between the unemployment rate in
4 year t and the unemployment rate in the preceding years, which means that the analysis in
5 Table 2 might pick up some of the medium-term trends.
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12 [Insert Table 4 here]
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17 The results in Table 4 indicate that there is an impact of the average unemployment rate 3
18 years prior to the current year, and in addition to the short-term impact. The coefficients imply
19 that a one percentage point higher unemployment rate during the last 3 years increases
20 mortality in *Heart Disease* and decreases mortality in *Other Accidents* with approximately
21 2.7% and 11.3% respectively. Regarding the short-term impact the coefficients imply that a
22 one percentage point increase in the unemployment rate during a given year, compared to the
23 average unemployment rate during the last 3 years, increases mortality in *Heart Disease* by
24 1.7% and decreases mortality in *Other Accidents* by 9.2%.
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40 V. Discussion and Conclusions

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43 This paper, using the same methods as Ruhm (2000), Neumayer (2004), Gerdtham and Ruhm
44 (2006), finds approximately the same results with Swedish data as Gerdtham and Johannesson
45 (2005) who used a different approach, namely a non-existent overall relationship between the
46 unemployment rate and mortality, and a counter-cyclical result for heart disease.³ It also
47 points in the same direction as the results in Svensson (2007), who found that a one
48 percentage point increase in the unemployment rate increases heart attack mortality by 7.8%.
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60 This paper contradicts the results on Swedish data by Granados (2004), but he used times-
series data for almost 200 years, and the pro-cyclical effect faded after WWII. The non-

³ This was found for men in Gerdtham and Johannesson (2005) for some of the business cycle indicators.

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3 significant overall effect is explained by the fact that of ten cause-specific mortality rates, the
4 unemployment rate indicate a pro-cyclical relationship in some cases, and in other cases a
5 counter-cyclical relationship. Two causes of death tend to be statistically significantly related
6 to the unemployment rate. As mentioned above, the most common cause of death (ischemic
7 heart disease), indicates a counter-cyclical relationship and other accidents, which includes
8 job-related fatalities, indicate a pro-cyclical relationship. The dynamic analysis also indicates
9 that it is both a very short-term impact and a short/medium-term relationship.
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20 Hence, the results in the paper indicate that the pro-cyclical results based on US,
21 German and Spanish data cannot be taken to be universally true in other settings. A counter-
22 cyclical result has also been documented regarding alcohol-related mortality in Sweden's
23 neighbour Finland (Johansson *et al.*, 2006). The same has been found regarding general health
24 in Finland, where BMI increases during economic downturns (Böckerman *et al.*, 2006). Other
25 possible explanations for the contrasting results in Sweden might be that large parts of
26 Sweden have a very low population density, and e.g. the strong effects of increased traffic
27 fatalities due to economic upturns as documented in the US (Granados, 2005; Ruhm, 2000),
28 cannot be seen to be significant for Sweden in this paper. There are simply no congestion
29 effects, with increased accidents, on most roads in Sweden in economic upturns. However,
30 this cannot explain the opposite and significant effect on *Heart Disease* found in this paper.
31 A potential explanation can be found in the paper by Gerdtham and Ruhm (2006), who find
32 that the pro-cyclical effect on OECD countries is weaker in countries with extensive social
33 welfare systems and more rigid labor markets. Compared to the US, Sweden certainly has
34 more of a social welfare system and rigid labor markets. However, the same results as found
35 in the US have also been documented in Germany and France (Buchmueller *et al.*, 2007;
36 Neumayer, 2004), which are also countries with rigid labor markets and "social-democratic"
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welfare systems. Exactly why the results differ in the Nordic countries (Sweden, and evidence of it in Finland as well) needs further research.

Considering the magnitude of the results, a one percentage point lower unemployment rate decreases *Heart Disease* mortality by approximately 1% and increases *Other Accidents* by 13.9%.⁴ An economic estimate of the effect may be obtained by monetizing this in terms of the number of fatalities and using the value of a statistical life year (VSLY), or the value of a statistical life (VSL) (Mishan, 1971; Schelling, 1968; Thédié and Abraham, 1961).⁵ In frequencies the mean annual national number of deaths in (ischemic) heart disease between 1976 and 1996 was 28,705 (SCB, 2006a). A decrease of 1% corresponds to 287 reduced deaths. Monetizing 287 reduced deaths using a recent US estimate of VSLY of \$100,000 (Viscusi and Aldy, 2003), as a lower bound estimate, puts this at \$28.7 million. Using a recent estimate of Swedish VSL (Hultkrantz *et al.*, 2006) puts this at a higher bound of \$832 million.⁶ Regarding *Other Accidents* there was an average of 843 annual fatalities between 1976 and 1996 (SCB, 2006b). A one percentage point lower unemployment rate increases this by 13.9%, which corresponds to circa 117 increased fatalities, with a monetized value of \$11.7 million and \$340 million using VSLY and VSL estimates, respectively.

These are of course very crude estimates, but are meant as indications of the relevant economic values related to changes in health status. They also indicate, as stated in the

⁴ The magnitude of Heart Disease mortality is different from the results in Svensson (2007), but that study only focused on acute myocardial infarction (heart attacks), whereas in this paper heart disease refers to all cardiovascular-related mortality. Svensson (2007) was also based on a different time period and only on individuals aged 20-49.

⁵ If one life-year is assumed to be saved, VSLY is the appropriate estimate, which can be thought of as the willingness to pay to increase longevity by one year. If many life-years are saved, VSL, or something in between VSLY and VSL is the appropriate estimate. These estimates (VSL) can be considered as the willingness to pay to prevent one (unidentified) fatality. Hence, in a situation where e.g. 10 unidentified fatalities can be prevented, the total monetized value is the value per prevented fatality multiplied by 10.

⁶ This should only be interpreted as a very crude indication of how one may go about monetizing the effects, something that has not been discussed previously in the literature on business cycles and mortality rates. The VSL estimate from Hultkrantz *et al.* (2006) is translated to US dollars only using the exchange rate (not PPP-adjusted). An effect of equal magnitude of reduced deaths in the US would render higher monetized effects, given the higher income in the US compared to Sweden (VSL is assumed to increase with income). It should also be noted that an assumption is that transferring values from the transport sector is OK (the VSL estimate is from the preventing fatalities in the transport sector, which may not necessarily be the same as preventing fatalities from heart disease).

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3 introduction, how a broader societal concept of unemployment may be calculated. With
4 unemployment comes not only financial loss, but an increase in heart-related mortality and
5 other effects as well, such as increased property crime rates (Edmark, 2005). This is important
6 for public policy to take into consideration when evaluating the labour market and labour
7 market policy.
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15 It is also sometimes argued that national accounts should be extended to include
16 environmental values that might be destroyed in economic production, e.g. called green
17 national accounts, or that a total economic wealth of nations should include estimates of
18 natural capital, see e.g. The World Bank (2006). However, taking such steps would logically
19 also have to lead to including monetized health effects of long-term growth. As in the results
20 reported here, or as e.g. Cutler et al. (2006) have shown, longevity is related to investments in
21 medical care that has tremendous value in itself. This implies that we underestimate the true
22 value of long-term economic growth, and monetized health improvements included in
23 national accounts would indicate even larger growth rates than those reported in regular
24 national accounts.
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39 Reiterating further the policy relevance discussed in the introduction, the results can be
40 summarized by saying that an increase in the unemployment rate may be regarded as being
41 related to an increase in health care demand for heart-related problems. Hence, if budget
42 issues are a concern in recessions, the results here indicate that it is important not to cut back
43 on health care related to heart diseases; rather the opposite, to plan for higher demand in
44 weaker economic times. Further, in good economic times it will be beneficial to improve job-
45 related safety, or to increase monitoring of newly employed workers, who have less
46 experience and might be a reason for some of the increase in job-related fatalities in economic
47 upturns (Breslin and Smith, 2006).
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For Peer Review

References

- Andrés Rodríguez, A. (2005) Income inequality, unemployment, and suicide: a panel data analysis of 15 European countries *Applied Economics*, **37**, 439-451.
- Banks, J., Marmot, M., Oldfield, Z., and Smith, J.P. (2006). The SES Health Gradient on Both Sides of the Atlantic: NBER Working Paper No. 12674.
- Biddle, J.E. and Hamermesh, D.S. (1990) Sleep and the Allocation of Time, *Journal of Political Economy*, **98**, 922-943.
- Black, P.H. and Garbutt, L.D. (2002) Stress, inflammation and cardiovascular disease, *Journal of Psychosomatic Research*, **52**, 1-23.
- Brenner, H.M. (1971) Economic changes and heart disease mortality, *American Journal of Public Health*, **61**, 606-611.
- Brenner, H.M. (1975) Trends in alcohol consumption and associated illnesses. Some effects of economic changes, *American Journal of Public Health*, **65**, 1279-1292.
- Brenner, H.M. (1979) Mortality and the national economy. A review, and the experience of England and Wales, 1936--76, *Lancet*, **15**, 568-573.
- Brenner, H.M. and Mooney, A. (1983) Unemployment and health in the context of economic change, *Social Science & Medicine*, **17**, 1125-1138.
- Breslin, F.C. and Smith, P. (2006) Trial by fire: a multivariate examination of the relation between job tenure and work injuries, *Occupational and Environmental Medicine*, **63**, 27-32.
- Buchmueller, T., Grignon, M., and Jusot, F. (2007). Unemployment and Mortality in France, 1982-2002: Dept. of Economics, McMaster University.
- Böckerman, P., Johansson, E., Helakorpi, S., Prättälä, R., Vartiainen, E., and Uutela, A. (2006) Does a Slump Really Make you Thinner? Finnish Micro-Level Evidence 1978-2002, *Health Economics Letters*, **16**, 103-107.
- Chou, S.-Y., Grossman, M., and Saffer, H. (2004) An economic analysis of adult obesity: results from the Behavioral Risk Factor Surveillance System, *Journal of Health Economics* **23**, 565-587.
- Cutler, D.M., Landrum, M.B., and Stewart, K.A. (2006). Intensive Medical Care and Cardiovascular Disease Disability Reductions: NBER Working Paper No.12184.
- Dee, T. (2001) Alcohol abuse and economic conditions: Evidence from repeated cross-sections of individual-level data, *Health Economics*, **10**, 257-270.
- Edmark, K. (2005) Unemployment and Crime: Is There a Connection?, *Scandinavian Journal of Economics*, **107**, 353-373.
- Elisaf, M. (2001) The treatment of coronary heart disease: an update – Part 1: An overview of the risk factors for cardiovascular disease, *Current Medical Research and Opinion*, **17**, 18-26.
- Fenwick, R. and Tausig, M. (1994) The Macroeconomic Context of Job Stress *Journal of Health and Social Behavior*, **35**, 266-282.
- Gerdtham, U.G. and Sundberg, G. (1998) Measuring Income-Related Health Inequalities in Sweden, In *Advances in Health Economics* P. Zweifel (Ed.) (pp. 119-138).
- Gerdtham, U.G. and Johannesson, M. (2005) Business cycles and mortality: results from Swedish microdata., *Social Science & Medicine* **60**, 205-218.
- Gerdtham, U.G. and Ruhm, C.J. (2006) Deaths Rise in Good Economic Times: Evidence From the OECD, *Economics & Human Biology*, **4**, 298-316.
- Granados, J.A.T. (2004). Mortality and economic fluctuations in Sweden, 1800-1998: The University of Michigan.
- Granados, J.A.T. (2005) Increasing mortality during the expansions of the US economy, 1900-1996, *International Journal of Epidemiology*, **34**, 1194-1202.

- 1
2
3 Hultkrantz, L., Lindberg, G., and Andersson, C. (2006) The value of improved road safety, *Journal of Risk and Uncertainty*, **32**, 151-170.
- 4
5
6 Johansson, E., Böckerman, P., Prättälä, R., and Uutela, A. (2006) Alcohol-related mortality, drinking behavior, and business cycles: Are slumps really dry seasons?, *European Journal of Health Economics*, **7**, 215-220.
- 7
8
9 Krantz, D.S. and McCeney, M.K. (2002) EFFECTS OF PSYCHOLOGICAL AND SOCIAL FACTORS ON ORGANIC DISEASE: A Critical Assessment of Research on Coronary Heart Disease., *Annual Review of Psychology*, **53**, 341-369.
- 10
11
12 McAviney, I.D. (1988) A Comparison of Unemployment, Income and Mortality Interaction for five European Countries, *Applied Economics*, **20**, 453-471.
- 13
14
15 Mishan, E.J. (1971) Evaluation of Life and Limb: A Theoretical Approach, *Journal of Political Economy*, **79**, 687-705.
- 16
17
18 Neumayer, E. (2004) Recessions lower (some) mortality rates: evidence from Germany *Social Science & Medicine*, **58**, 1037-1047.
- 19
20
21 Pickering, T., Clemow, L., Davidson, K., and Gerin, W. (2003) Behavioral Cardiology - Has Its Time Finally Arrived?, *The Mount Sinai Journal of Medicine*, **70**, 101-112.
- 22
23
24 Ruhm, C.J. (2000) Are Recessions Good for your Health?, *Quarterly Journal of Economics*, **115**, 617-650.
- 25
26
27 Ruhm, C.J. and Black, W.E. (2002) Does drinking really decrease in bad times? , *Journal of Health Economics*, **21**, 659-678
- 28
29
30 Ruhm, C.J. (2003) Good times make you sick, *Journal of Health Economics*, **22**, 637-658.
- 31
32
33 Ruhm, C.J. (2005) Healthy living in hard times, *Journal of Health Economics*, **24**, 341-363.
- 34
35
36 Ruhm, C.J. (2006). A Healthy Economy Can Break Your Heart: NBER Working Paper No. 12102.
- 37
38
39 SCB (2005). AKU-definitioner och förklaringar för perioden 1987-mars 2005.
- 40
41
42 SCB (2006a) SCB statistikdatabaser: Dödsorsaksregister.
- 43
44
45 SCB (2006b) SCB statistikdatabaser: Regionalräkenskaper.
- 46
47
48 SCB (2006c) SCB statistikdatabaser: Arbetsmarknad, Befolkning, Utbildning och forskning.
- 49
50
51 Schelling, T.C. (1968) The Life You Save May Be Your Own, In *Problems in Public Expenditure Analysis* S.B. Chase (Ed.), Washington D.C.: The Brookings Institution (pp. 127-162).
- 52
53
54 Sparks, K., Cooper, C., Fried, Y., and Shirom, A. (1997) The effects of hours of work on health : A meta-analytic review, *Journal of occupational and organizational psychology*, **70**, 391-408.
- 55
56
57 Svensson, M. (2007) Do not go breaking your heart: Do economic upturns really increase heart attack mortality?, *Social Science & Medicine*, **65**, 833-841.
- 58
59
60 Tapia Granados, J. (2004). Mortality and economic fluctuations in Sweden, 1800-1998: The University of Michigan.
- Tapia Granados, J. (2005) Recessions and Mortality in Spain, 1980-1997, *International Journal of Population*, **21**, 393-422.
- Thédié, J. and Abraham, J. (1961) Economic Aspects of Road Accidents, *Traffic Engineering and Control*, **2**.
- Thornton, J. (2002) Estimating a health production function for the US: some new evidence, *Applied Economics*, **34**, 59-62.
- van Doorslaer, E., Wagstaff, A., Bleichrodt, H., Calonge, S., Gerdtham, U.G., Gerfin, M., Geurts, J., Gross, L., Häkkinen, U., Leu, R., O'Donnel, O., Propper, C., Puffer, F., Rodriguez, M., Sundberg, G., and Winkelhake, O. (1997) Income-related inequalities in health: some international comparisons *Journal of Health Economics*, **16**, 93-112.
- Viscusi, K. and Aldy, J.E. (2003) The Value of a Statistical Life: A Critical Review of Market Estimates Throughout the World *Journal of Risk and Uncertainty*, **27**, 5-76.

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WorldBank (2006). Where is the Wealth of Nations? Washington D.C.: The World Bank.

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Tables

Table 1: Descriptive statistics

Variable name	Description	Mean	Std. Dev.
Mortality	Mortality per 100,000 individuals	1125.10	120.52
Male mortality	Male mortality per 100,000 men	1184.80	144.00
Female mortality	Female mortality per 100,000 females	1065.53	121.94
Heart Disease	Ischemic heart disease mortality per 100,000	360.08	70.83097
Suicides	Suicide mortality per 100,000	17.82	4.01
Homicides	Homicide mortality per 100,000	1.11	0.77
Traffic Accidents	Traffic accident mortality per 100,000	10.23	3.70
Influenza	Influenza mortality per 100,000	3.15	3.56
Cancer	Cancer mortality per 100,000	241.94	22.01
Alcohol	Alcohol psychosis & addiction mortality per 100,000	3.48	2.59
Alcohol 2	Alcohol poisoning mortality per 100,000	1.67	1.47
Falling Accidents	Falling accidents mortality per 100,000	15.17	5.23
Other Accidents	Other accidents mortality per 100,000	9.81	3.22
Unemployment	Unemployment in %	4.41	2.48
Foreign	Share of non-Swedish citizens in each region (%)	3.94	1.92
Migration	Net migration as share of population (%)	0.15	0.35
Young	Share of population aged 0 to 20	26.58	1.47
Old	Share of population aged 65+	17.74	1.73

Notes: All data are from Statistics Sweden (SCB, 2005, , 2006c, , 2006a). Number of observations are 630 for all variables except cause-specific mortality rates where the observations number 441. Data on mortality rates are mean values among the regions and not weighted for population, which mean that the figures do not necessarily correspond to national data (which are in fact lower).

Table 2: Business cycle effects on incidence and mortality: panel data fixed effects estimations

Dep. Var.	Total mortality			Male mortality			Female mortality		
Unemployment	3.86E-04 (0.002)	0.003* (0.002)	-7.51E-04 (0.002)	-0.003 (0.003)	-0.003 (0.003)	0.002 (0.003)	-0.006* (0.003)	-0.005* (0.003)	-0.002 (0.004)
Foreign	-	-0.001 (0.003)	-0.004 (0.005)	-	-0.023*** (0.004)	0.001 (0.005)	-	-0.021*** (0.005)	-0.008 (0.006)
Young	-	-0.004 (0.004)	-0.002 (0.005)	-	-0.017** (0.006)	-0.008 (0.007)	-	-0.009 (0.006)	-0.010 (0.007)
Old	-	0.038*** (0.004)	0.018*** (0.005)	-	0.011*** (0.005)	3.99E-04 (0.006)	-	0.003 (0.005)	0.010 (0.007)
Migration	-	0.006 (0.005)	0.002 (0.005)	-	0.008 (0.007)	-0.006 (0.007)	-	0.010 (0.008)	-0.002 (0.007)
Year dummies	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Region specific time trend	No	No	Yes	No	No	Yes	No	No	Yes
N	630	630	630	630	630	630	630	630	630
R ²	0.34	0.59	0.69	0.57	0.60	0.76	0.71	0.73	0.82

Notes: Two-tailed tests significance levels: *** 0.01, ** 0.05, * 0.10, based on robust std. errors.

Estimations are based on equation (1) with region fixed effects and year dummies, and also including regional specific time trends in one model.

Table 3: Business cycle effects on age subgroups and cause-specific mortality: panel data fixed effects estimations

Dep. Variable:	Unemployment coefficient	Unemployment coefficient	Unemployment coefficient
Mortality Age 20-49	0.002	-0.007	-0.003
Mortality Age 50-64	0.006	0.002	0.004
Mortality Age 65+	0.004	-1.64E-04	-8.01E-04
Heart Disease	0.018***	0.010*	0.010**
Suicides	0.025	0.024	0.027
Homicides	-0.501	-0.481	-0.722
Traffic Accidents	0.001	-0.029	-0.031
Influenza	-0.312	-0.287	-0.246
Cancer	0.003	-0.002	-0.003
Alcohol	0.030	-0.108	-0.117
Alcohol 2	0.557	0.102	0.012
Falling Accidents	-0.020	-0.015	-0.030
Other Accidents	-0.084***	-0.120***	-0.130***
Fixed Effects	Yes	Yes	Yes
Year Dummies	Yes	Yes	Yes
Region Specific Time Trend	No	Yes	Yes
Other covariates	No	No	Yes

Notes: Two-tailed tests significance levels: *** 0.01, ** 0.05, * 0.10, based on robust std. errors. Other covariates refer to those used in Table 2 except for the age-specific mortality regressions which do not use the variables *Old* and *Young* as covariates. For cause-specific mortality the panel data covers all regions for years 1976-1996, which implies 441 observations.

Table 4: Dynamic Effects

Dep. variable	3-year prior unemployment rate	Short-term impact
Heart Disease	0.027***	0.017**
Other Accidents	-0.107**	-0.088**

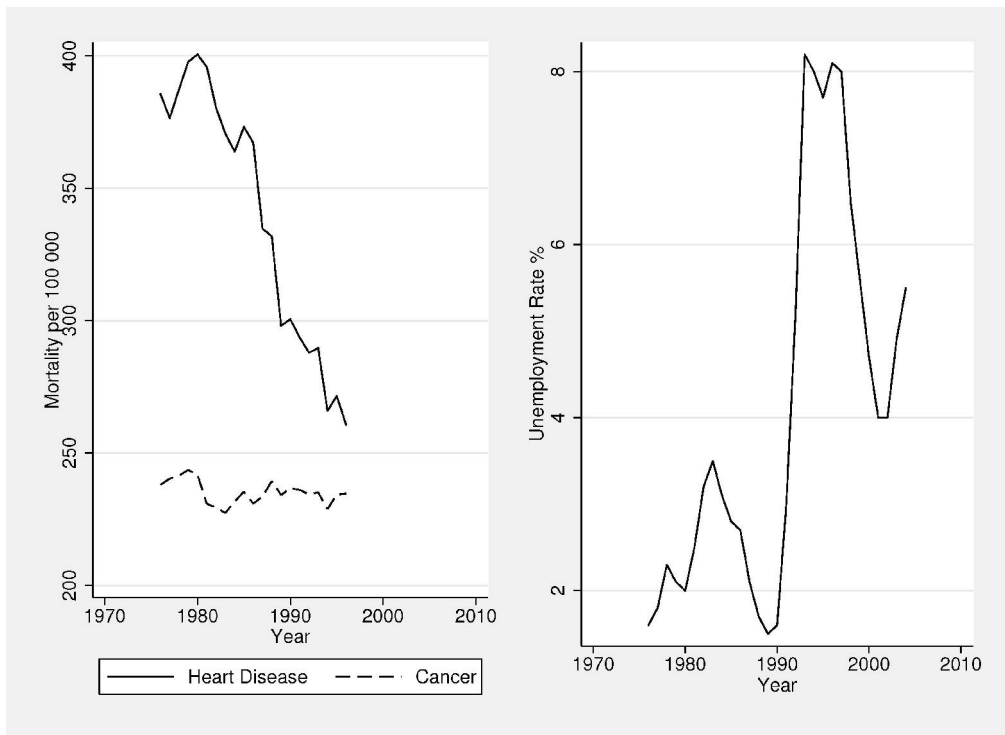
Notes: Two-tailed tests significance levels: *** 0.01, ** 0.05, * 0.10, based on robust std. errors. Other covariates included in the model, but not shown here. The 3-year prior unemployment rate refers to the average unemployment rate in year $t-3$ to $t-1$ where t is the survey year. Short-term impact refers to the deviation of the unemployment rate during the survey year compared to the average for the 3-year priors to the survey year.

Figures

Figure 1: Heart Disease and Cancer Mortality per 100,000 & Unemployment Rate in Sweden

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Heart Disease and Cancer Mortality per 100,000 & Unemployment Rate in Sweden
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