Extended Abstract

The economic consequences of poor health are centered on the notion of the satisfaction that human beings derive from being healthy. In the event of sickness, an individual is forced to shift time away from work to seek treatment which on the flipside implies that he has less time to focus on productive activities. The implications could range from reduced working hours; hence reduced income as well as a reduction in labour force participation. Similarly, poor health outcomes could result to poverty in the event that individuals are forced to draw down on their savings in a bid to address their health needs. The relationship between labour force and health outcomes is a complex one. First, there is no universal definition of what health really comprises of and the idea of 'being healthy' differs from one person to another. Secondly, measuring the reverse relationship between health and labour force participation remains an empirical question.

With this background, my work tries to model this relationship with individual disease groups among the Kenyan working-age population. The specific questions that my research addresses include: i) is general health status important in explaining labour force participation? ii) do specific health conditions differ with regards to labour force participation? and iii) is the reverse relationship between health and labour force participation relevant in as far as specific conditions are concerned? In order to address these questions I will first apply a naïve model of general health status and then proceed to an advanced model (Instrumental Variable method) that takes the reverse relationship between health and labour force participation into consideration. The possible pitfalls are the choice of which variables to use that explain labour force participation directly but only affect health in an indirect way. The distance to the nearest health facility is what has been used as a factor in this relationship.

The analysis results suggest that acute health status is important in explaining labour force outcomes among the working age population among both the males and females.

General health status is associated with a significant lower propensity to participate of (0.859) among the male population compared to 0.486 among females. Generally, poor health significantly affects the males more than the females across all disease groups; with the exception of respiratory diseases which significantly affects female labour force participation.

The main contribution of this paper to the wider literature is the effect of individual disease groups on labour force participation and the paper also highlights the gender gap within this context. The interaction between health and labour force participation is important because the results will help inform policy on the disease groups that pose a bigger burden to the society. This information is be very useful in estimating diverse cost benefit analysis of certain medical conditions resulting to efficient resource utilization.