

High-Level Consultation on the Financial and Economic Crisis and Global Health

The Financial Crisis and Global Health

1. The **financial crisis**, which was triggered by difficulties within the sub-prime mortgage market, and which has seen the near collapse of the international banking system, continues to spread. Some countries have already received large-scale emergency funding from IMF, others are in discussions that could lead to this support. Many other countries are known to be facing severe financial problems. The resulting massive reduction in wealth has now tipped several OECD member countries into recession (defined as two successive quarters of negative growth in gross domestic product). World trade is shrinking for the first time since 1980. The recession is not yet global, but a knock-on effect in low-income and middle-income countries is inevitable. Even if its form, magnitude and duration currently remain unclear, many experts are concerned that the world risks the largest economic downturn since the 1930s.

2. In global health there has been significant progress towards achieving the **Millennium Development Goals** but many challenges remain. There have been reductions in child mortality and gains in the treatment and prevention of HIV/AIDS, tuberculosis, malaria, poliomyelitis and neglected tropical diseases. In contrast, there has been little change in maternal and newborn mortality, especially in Africa; nutrition has been relatively neglected; and there remain many countries in which less than half the population has access to adequate sanitation or essential medicines. Several countries, notably in Africa, have taken advantage of economic growth to increase levels of domestic spending on health. Aid for health has more than doubled in recent years, coming both from traditional and innovative sources. The economic consequences of the global financial crisis put these achievements at risk and will jeopardize progress on the challenges that remain.

3. In response to questions raised by Member States and other partners on the impact of the crisis on global health, the Director-General has convened a high-level consultation on 19 January before the opening of the Executive Board session. The **purpose of the consultation**, for which this information note has been prepared, is:

- (a) to build awareness of the ways in which an economic downturn may affect health spending, health services, health-seeking behaviour and health outcomes;
- (b) to make the case for sustaining investments in health; and

- (c) to identify actions – including monitoring of early warning signs – that can help to mitigate the negative impact of economic downturns.

IMPACT OF THE CRISIS ON HEALTH

4. Although **poor populations** in *all* countries are likely to be the first and hardest hit by any downturn, it is not just the poorest countries that will be affected by the current crisis. This section briefly examines how different countries are likely to be affected. It then traces, on the basis of past experience, how an economic downturn is likely to have an impact on health.

5. The **pathways** through which a recession in rich economies can affect other countries are becoming evident. Export growth may decline – this is already reflected in a major fall in commodity prices; foreign direct investment is likely to be reduced; sudden and dramatic falls in exchange rates are possible, although not inevitable; access to capital may become more difficult as interest rates and risk premiums rise; remittances may fall; and, most critically for the poorest countries, aid from donors may be significantly delayed or reduced.

6. Even in periods of “global” recession not all parts of the world or even particular regions are affected equally. The 2001–2002 recession had major effects in some Latin American countries. The 1997–1998 recession was felt most strongly in Asia. Some countries start falling into recession early, some move out quickly, while some never suffer negative growth.

7. Many **high-income and upper middle-income countries** will experience negative real income growth and substantial increases in unemployment, with their consequent impact on health. In those countries where the financial crisis has required IMF emergency assistance, the situation is likely to be particularly serious for health service financing, if spending restrictions are imposed during loan repayment. Before the current crisis, many **low- and middle-income countries** were badly affected by increases in food and fuel costs, others prospered during the boom in commodity and oil prices. With a fall in demand, prices have fallen, to the advantage of net importers but to the detriment of those more dependent on export revenues.

8. Current predictions for rates of growth in gross domestic product for **low-income countries as a group** remain relatively optimistic (6.9% for all developing countries, and 4.5% in sub-Saharan Africa). However, these figures disguise major variations *between* countries. Some major aid recipients may continue to grow, albeit less rapidly, whereas others, including so-called fragile states that already receive less donor support, may be more seriously affected.

Health spending

9. **Total health spending** in countries that have been affected by an economic downturn tends to fall, but not consistently. Some governments have protected health spending or even increased it, but others have done the reverse. Policy in this sphere is thus vitally important. In contrast to public spending, **private out-of-pocket expenditure** usually tends to decline in a recession, particularly if services are available at lower cost in the public sector.

10. **Informal surveys** suggest that very few health ministries have *yet* been given any indication from ministries of finance or development partners that health spending will be reduced. In many countries formal announcements await the next budget cycle. Some smaller countries look for economic signals coming from more powerful economies in their region.

11. Reductions in total expenditure will have an impact on the **composition of health spending**. Thus, where indications of impact have been reported, they suggest that salaries will be maintained, but that savings will be found in infrastructure and equipment.

12. Delaying **capital spending** is a common short-term response of governments faced with budget cuts. A logical response in the short term, it can, however, lead to longer-term problems if the downturn is sustained. Reductions in maintenance, medicines or other operating costs related to surveillance or supervision are likely to have a more damaging and immediate effect on service delivery.

Medicines and health-care commodities

13. Where recession is accompanied by inflation and **devaluation of domestic currencies** (e.g. 1997–1998 in East Asia and 2001–2002 in Latin America), the price of imported medicines, raw materials and medical equipment will increase. There is, however, evidence that the rise in cost of care to patients can be controlled, particularly through **generic substitution** or public subsidies.

14. If cost increases are not absorbed, the impact will be reflected in shortages or increased costs of care. With the growing burden of **noncommunicable diseases**, the demand for insulin, cardiovascular medicines and asthma inhalers, for example, is increasing rapidly. Although people can borrow to pay for treatment of *acute* illness episodes, those dependent on long-term treatment risk progressive impoverishment. Changes in the availability and cost of treatment are likely to happen relatively quickly and can be monitored relatively easily.

15. Some expenditures on medicines may be better protected than others. It is ethically difficult, for instance, to stop **treatment with antiretroviral agents**. If donors do not cut back on expenditure for medicines or on technical assistance yet reduce the overall volume of funds needed for service delivery, medicines may not get to those who need them. Such a situation risks exacerbating the tension between HIV/AIDS treatment and other forms of health spending.

Falling remittances

16. Income from remittances (which at about US\$ 240 000 million in 2007 is more than twice total official development assistance) has held up well through some past economic downturns. In current circumstances, where the initial impact of the recession has been in the industrialized economies, this may not be the case. There is already evidence that remittance income has started to fall.

17. How much is spent on health is uncertain, although one survey (from Mexico) reported that 57% of remitters said that covering health expenses was the primary purpose of the money sent home. Anecdotal evidence suggests, however, that these monies are often used to meet the cost of long-term or terminal illnesses or even funeral expenses. Thus a decline in remittance income may *not* be reflected in levels of population health. Nevertheless, these expenses still have to be met. Borrowing locally at high rates of interest can lead to impoverishment or increasing levels of debt.

Reduction in household income

18. The economies of many low-income and middle-income countries have benefited from the **rapid growth of export industries** in areas such as ready-made garments, food and flowers, and business processing. As demand declines in developed economies, job losses are likely with consequences for family income and the ability to pay for health care.

19. Many of the **human consequences of recession are often hidden**. For example, unemployment may erode women's growing economic independence, which will have its own health consequences. Similarly, coping strategies may exacerbate vulnerability (through, for example, increased exposure to HIV). Reduced spending has impacts on health and education, and ultimately on the well-being of families and the development of the community as a whole.

Utilization of health services

20. Decreasing health spending, increased costs of treatment, and reduced family income and/or insurance coverage will affect use of health services and their quality. The most common effect is to **lower demand for private care** with a consequent transfer of demand to the public sector. If public services are also compromised, they may not be adequately equipped to cope, and overall quality may decline. This problem will affect all countries in which publicly-funded services are under pressure. Changes in utilization rates – broadly following this pattern – were documented during the 1997–1998 Asian financial crisis. A decline in the use of services by the poor in these countries was particularly evident.

Health outcomes

21. A significant reduction in spending on life-saving interventions will increase mortality, but data relating changes in mortality to periods of economic recession are scarce and sometimes contradictory. Some examples are, however, unequivocal. The Russian Federation, in the early 1990s, suffered a major increase in adult male mortality. Thailand also recorded an increase in adult mortality for the period 1996–1999. Peru recorded an increase in child mortality in 1989. Similarly, child mortality rose in Indonesia in between 1996 and 1999 but drought and fires were confounding factors. This last point emphasizes the fact that economic recession is but one influence among many affecting peoples' health.

22. The current food crisis in particular has been estimated as being responsible for pushing more than 100 million people back into poverty – with serious consequences for health outcomes and nutritional status. Shortages of food and consequent malnutrition predispose individuals to disease and thus act in vicious concert with the economic downturn.

23. Some counterintuitive findings come from the United States of America and Europe where recession has been accompanied by falling mortality rates – possibly because of reduction in alcohol use and smoking and more time available for child care. However, this has been observed only during recent, relatively short periods of recession and is unlikely to be found in a sustained downturn. More in line with expectations, a 500 000 person-year study in Sweden showed that men were at risk of increased mortality owing to business recessions (and this in a country with well-resourced welfare policies). Moreover, close associations have been shown between economic hardship and suicide in Japan, New Zealand, the Russian Federation, and the United States of America.

Official development assistance

24. **Official development assistance for health** tends to fall during periods of recession, but this is not always the case. Thus in 1990–1993, according to data from the OECD's Development Assistance Committee, total official development assistance *commitments* fell, but those for health continued to rise. In 1997–1999 both total and health assistance fell, but rose again within a year, only for health aid to fall again. In 2000–2001 total and health official development assistance both fell, with health assistance the more seriously affected. There is thus no clear pattern emerging from *aggregate* data.

25. There are however specific instances where official development assistance from **individual donors** has fallen massively (by more than 60%) during recession in a particular country. It is likely too that such assistance may be more seriously affected to some countries than to others.
26. A significant finding, particularly given the importance of maintaining the delivery of basic services, is in the **composition of aid spending**: levels of funding for technical assistance continue to increase during recession, in contrast to aid that is programmable by countries, which falls.
27. On a positive note, leaders in developed and developing countries as well as international financial institutions have made **strong public, political commitments to health and development**. It is widely accepted that health is both an intrinsic good and an investment to reduce poverty. This was not necessarily the case during earlier recessions.
28. OECD and European Union countries have made **pledges not to cut aid**. Groups in civil society will maintain pressure in order to try to hold donors to these commitments. At the same time, despite public statements to the contrary, some donors have already indicated that reductions in aid spending are likely. Furthermore, G8 countries' aid is already lagging well behind the targets they agreed at their summit in Gleneagles, Scotland, in 2005; even before the present crisis, projections suggested a shortfall of about \$34 000 million by 2010.
29. The crisis comes at a time when more **actors are involved in the health sector** and the range of financing mechanisms is wider. New global health initiatives, philanthropic foundations and a range of innovative financing initiatives that rely on income from investments are likely to be hard hit. Initiatives that tax consumption, such as the levy on airfares, will also be less able to provide counter-cyclical funding than traditional government financiers. On the provider side, more data are needed on the effect of the economic downturn on faith-based and community organizations and other non-state providers of health care.

MITIGATING THE HEALTH IMPACT OF THE FINANCIAL CRISIS

30. This section outlines some basic principles to guide the response to the health consequences of the economic crisis. It sets out areas for action, identifies some elements of best practice and practical advice, and highlights areas in which WHO will offer support.
31. In the face of declining revenues and income, **health should be made as visible as possible**. Health is an *entitlement* to which people have a basic right, as well as making a significant contribution to economic growth, poverty reduction, social development and human security.
32. Some countries will be more vulnerable to the impact of the crisis than others. It is equally important, however, to take into account the need of **vulnerable populations** – particularly the poorest of the poor – wherever they may live.
33. The financial crisis has provoked an examination of the values that underpin societies. The health response should also aim to be *transformative* and should be used to promote a greater focus on **social justice**.
34. A key characteristic of the current crisis is the *speed* with which it continues to evolve and, consequently, the *uncertainty* facing policy-makers. **Partnerships** will be critical. Rapid assessments, effective communications, exchange of experience, effective and flexible working arrangements will all be essential to success.

Monitoring the impact of the crisis

35. Given the rapid evolution of the crisis and the uncertainty surrounding its impact in different countries, monitoring its effects is a priority.

36. Monitoring should take place at several different levels: (a) changes in employment, housing and income – the most distal causes of ill-health; (b) changes in behaviour relevant to health, including changes in the use of health services (including mental health care) and changes in the behaviours of health workers themselves (including patterns of migration); and (c) changes within the health sector, including the cost and availability of key commodities and treatment.

37. The *purpose* of monitoring will be to identify the most vulnerable countries and populations – *before* people are exposed to risks that will affect their health. Many of the most rapidly changing indicators (such as employment and exchange rates) will be monitored by other agencies. Collaboration and rapid communication will therefore be essential. Specific efforts to monitor the impact of the crisis will complement existing, and longer-term efforts to monitor health outcomes.

38. Given the urgency of establishing effective systems and processes for monitoring the health impact of the crisis, **WHO will convene a meeting of relevant experts** as soon as possible following this consultation.

Saving lives and protecting incomes

39. The first priority in any country facing an economic downturn is to protect the lives and livelihoods of those most at risk. In terms of policy actions, **social safety nets** which support the poor will be a priority. The more serious the downturn, the greater the priority to be given in this area. Experience suggests that expanding established programmes for income support may be more effective and achieve more a rapid effect than creating new ones. There is a growing body of experience in the health sector with conditional cash transfers, which provide resources to families conditional upon certain health-related behaviours (e.g. attending clinics for child or antenatal care). In an acute situation, however, *unconditional* cash transfers can be made faster than conditional ones, and there is some evidence to show that these will be used in ways that promote health. Policies that help to stabilize prices, reduce the cost of buying food, allow the unemployed to maintain health insurance premiums and ensure that children can stay in education will be equally important.

40. **WHO** will work as part of the United Nations team at country level to support a range of initiatives to protect the livelihood and incomes of the poor. **WHO will make available its specific health financing expertise** to countries for advice on approaches to financial risk protection in the health sector.

Increasing the effectiveness of spending for health

41. Economic recession makes the task of defending health budgets more difficult. In countries affected by the financial crisis, recapitalizing banks and other financial institutions may be given priority. In countries affected by economic recession, sectors that generate employment or increase agricultural production will seek additional funding. Strategies need to take into account spending outside as well as within the health sector.

Increasing the health impact of public spending

42. Where resources for a significant fiscal stimulus are available, countercyclical public spending is seen as vital for reviving the economy. Although the primary aim of such programmes is to create or maintain employment, it is important to seek ways in which they can positively influence health. Rural roads, for example, are an essential component in reducing maternal mortality, and many clinics and rural hospitals would benefit from upgrading.

43. Many countries are dealing with several simultaneous threats to people's health – notably the food crisis, climate change and other environmental problems. Spending in all these areas can positively influence health, providing that health impact is carefully reviewed and understood. Health policy-makers should be assertive in seeking a seat at the table when public spending plans in these areas are being developed.

Increasing the effectiveness of health sector spending

44. Within the health sector ministers and their officials face tough choices. It is always easier, for instance, to cut **running costs** in order to safeguard **salaries**. However, past experience highlights the risks entailed: health spending becomes inefficient as health workers lack supplies; staff become disaffected; shortages of essential medicines lead to public mistrust; and existing infrastructure decays through lack of maintenance. Similar risks to health and the credibility of health services arise when **preventive services** are cut at the expense of **treatment**, or **rural clinics** disadvantaged in comparison to **urban hospitals**.

45. In line with popular wisdom, **every crisis is also an opportunity**. This has been borne out in countries such as Thailand. In 1997–1998 the outflow of physicians from government services to the private sector was reversed, providing an opportunity to introduce necessary reforms. Similarly, in the same region the price increases resulting from devaluation made it possible to introduce medicines policies based on generic substitution. The need for greater efficiency can also facilitate new ways of working, including task-shifting, seeking synergies between different programmes (e.g. tuberculosis and tobacco control) and increasing the use of communications technologies.

46. In many countries **recession has been accompanied by social unrest**. The reality or even the threat of social disruption may thus also act as a spur to social sector and health reform. However, pursuing this line uncritically has its risks. There are many examples where the assumption that acute reductions in public-sector budgets would act as stimulus for a rational or measured process of institutional reform has proven very wrong.

47. **Global public goods**. In times of crisis it is important not to forget the many other threats to health security. Preparing countries to cope with pandemics, food security, war and conflicts and the impact of adverse weather events requires effective **global and regional systems of surveillance, coordination and response**. It is important that these systems do not fall victim to the economic downturn.

48. At global and regional levels WHO will continue to provide unequivocal and evidence-based support for maintaining, and where possible increasing, financing for health. WHO will also work

closely, at their request, with individual countries that are facing particular difficulties, supporting WHO country offices with missions from regional offices and headquarters.¹

Implementing primary health care reforms

49. There is no doubt that **primary health care**, and its central objective of moving towards *universal coverage*, remains compelling as an approach to health policy at a time of economic crisis. Indeed, as noted above, the advent of a crisis may provide the necessary stimulus to initiate reform.

50. First, primary health care requires a focus on **equity, solidarity and gender**. It reminds policy-makers, for example, that the high burden of maternal mortality is a result of many factors including poor access to care, failure to prevent unwanted pregnancy and women's low status in some societies. All these factors can be exacerbated in a recession.

51. Secondly, primary health care gives direction to work on health systems, reinforcing the idea of solidarity through progress towards the goal of **universal coverage**. This is particularly important given the increasing pressures on public services and the need for ways of reducing exclusion. Pooling risk and resources – central to the notion of universal coverage – not only protects people from catastrophic expenditure, it also facilitates greater allocative efficiency and thus more effective resource use.

52. Additionally, while offering a strong political signal of a country's intent to provide for its people, the concept of universal coverage is still context specific and **contingent on resource availability**. It allows for public debate on what should be included in a benefit package without resorting to the use of selective, or single-purpose, programmes.

53. Thirdly, in times of economic hardship a more “joined-up” approach to health and public policy is essential. Health is an outcome of actions across many sectors of society. Primary health care stresses the importance of the **social, economic and environmental determinants of health**, such as the impact of housing, education, employment and nutrition policy; import duties that affect access to essential medicines and technologies; the restriction on the movement of peoples or goods to prevent the spread of epidemics; laws that prevent discrimination against people living with HIV/AIDS; and the major role that clean water, clean air and access to proper sanitation play in protecting health and preventing disease.

54. Primary health care does not focus exclusively on the public sector, but acknowledges the role that **non-state providers** – private, voluntary, faith and community based – play in providing a significant proportion of services in many countries.

55. Lastly, **participation**, public involvement and transparency are central to the primary health care approach. If the public, civil society and parliaments are involved, decisions on how to make health spending more effective are more likely to be rational and accepted than if they are left to bureaucracies alone.

¹ The focus of this paper is WHO's provision of support to countries, but many of the issues affect WHO itself. The financial crisis has provoked an examination of how the Organization can increase its effectiveness. Work is in hand to seek efficiencies, to explore new and better ways of working, and to review priorities.

Protecting aid for health and ensuring it is effective

56. **WHO** will continue to make the case to all **donors – traditional and emerging** – that sustaining funding for health is crucial. Many new donors have favoured financing economic infrastructure over social-sector spending. Greater effort is needed to restate the case that a healthy workforce is not only going to be more productive, but that it is essential to achieving a return on donors' investment. In donor countries, sustaining vocal **public support for development aid** is more likely to influence politicians than technical argument alone.

57. Increasing efforts to implement the **Paris Declaration on Aid Effectiveness (2005)** and the **Accra Agenda for Action** (adopted at the third High-Level Forum on Aid Effectiveness – Accra, 2–4 September 2008) will be particularly important at times of economic uncertainty. In particular, aid recipients need *predictable* and *flexible* funding that is aligned to national priorities.¹ Mechanisms that increase uncertainty are not helpful. Many new sources of financing are inherently cyclical compared with traditional forms of official development assistance. Thus revenues from investments funds and taxes on travel will fall during a recession. However, mechanisms such as the international drug purchase facility UNITAID, the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria are significantly lowering prices for specific medicines and vaccines.

58. The focus needs to be maintained on achieving results, but it will be important to interpret the current vogue for **performance-linked funding** with some care. At times of crisis it may be the “poor performers” who need the most help.

59. **Global health funds and programmes** (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance) may become increasingly important as sources of finance if other forms of development assistance are reduced. Should this be the case it will be important, particularly for the Global Fund, to look at country grants in the light of the need to ensure adequate delivery systems – ones that benefit the health sector as a whole – as well as supplies of medicines for the three diseases. Achievement of the Millennium Development Goals depends on getting the spending balance right between commodities, people and delivery systems.

Working in partnership

60. As noted in the opening principles, all the policy actions recommended in this note require close collaboration between all the actors involved in global health. At a time of scarce resources, the world cannot afford a development system in which duplication and overlap of effort are common. The current circumstances will accelerate the process of **United Nations reform**, and encourage a more rational **division of labour**, based on national needs and aligned to national health-sector plans.

= = =

¹ These issues will be considered in detail by the **High Level Task Force on Innovative Financing for Health Systems**, whose objective is to explore new sources of funding for health in developing countries.