

The financial crisis and its impact on global health

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Previous recessions have shown that periods of economic decline can have calamitous effects on health, but they have also shown that this does not have to happen. While the current crisis has the potential to reverse some of the significant gains in global health made since the Millennium Declaration was signed, experience has shown that with the right policy choices it is possible to protect and promote health even during an economic crisis.

That being said, the current crisis differs in a number of important ways from recent global recessions. Most importantly, it is more severe, with the global economy as a whole expected to shrink in 2009 for the first time in more than 60 years. It also began with the near collapse of the financial systems of the rich countries; these donors and their economies are the most affected to date. According to the International Monetary Fund, negative growth or recession is expected in much of the industrialised world, parts of eastern Europe and selected countries whose growth relies heavily on trade, such as Singapore.¹ The developing world as a whole is still expected to grow in 2009, although at substantially lower rates than in the recent past.

What is the likely impact on health? In developed countries, the first health impact of economic downturns has often been an increased incidence of mental illness and suicide. Longer-term effects are possible, related to increases in unemployment and the resulting fall in household incomes. The poor and the unemployed tend to have poorer health than people with jobs, but a person who loses their job does not necessarily become less healthy overnight.² Whether we observe a noticeable reduction in population health linked to the current crisis will depend on the depth and duration of the recession, but also on how governments react to ensure continued access to needed health services, social networks and a liveable income.

The problem with this recession is that many of the richer countries have assumed vast debts to fund financial bailouts and economic stimulus packages. While the desire to stimulate growth through government spending is likely to protect health spending in most

developed countries for the moment, in the future governments will need to repay these debts by becoming more efficient, reducing expenditure and/or raising taxes. While this sounds ominous, it does not have to be bad for health. All these variables are choice variables – decisions on what and who is taxed and what areas of government spending are cut can be ‘health-friendly’ if populations and governments wish.

The increased indebtedness of richer countries is also a potential health hazard for poorer countries. In the typical low-income country in 2006, external development assistance contributed an additional 33% to the funds for health raised domestically by government, the private sector and households.³ In the three most recent global recessions, aggregate commitments to official development assistance (ODA) declined, although in the most recent (2001–02) ODA for health continued to increase. The need to repay the debts incurred in the industrialised world will put pressure on ODA in general, but the way governments react is another choice variable – they do not have to reduce overall ODA, nor do they have to reduce ODA for health. Indeed, if they are to meet their stated promises to the United Nations, they will not do so – only a few of the rich countries are anywhere near the 0.7% of gross national income they have continually committed to provide in ODA.⁴

On the domestic side, the economies of most developing countries are still growing. Average levels of income per capita are still rising, so more people than last year will escape from poverty and more will be able to improve their health. The downside is that they would have been much better off if the global downturn had not occurred and their economies had continued to grow as rapidly as they did in recent years. It has been estimated, for example, that if they had continued to grow at recent rates, an additional 200,000 to 400,000 infant lives would have been saved each year than will now be possible.⁵

Certainly, higher economic growth would have allowed countries to reduce infant mortality and improve health in general more rapidly, but lower growth rates in 2009 do not need to result in increases in mortality and

declines in health status.⁶ Increases in infant mortality and undernutrition have been observed in selected countries during previous downturns but this has not always happened. For example, Thailand showed during the 1997–98 Asian crisis that it was possible to expand social protection mechanisms, including access to health services, to ensure that the poor and vulnerable were protected.⁷

In theory, while their economies are still growing, governments should also be able to increase their health expenditures. The complicating factor now is that there has been a substantial reduction in global trade, the first since the 1980s, and many governments in developing countries rely heavily on levies on imports and exports rather than broad-based income taxes to raise revenue. Some governments are already reporting declines in revenues as a result of the decline in trade, so their capacities to maintain overall spending are lower than expected purely from their rates of overall economic growth. This is a concern because in previous recessions people in developing countries have switched from private-sector healthcare to the public sector, and a decline in government spending would make it even more difficult to maintain services in the face of increasing demand.

A final issue relates to increases in the price of medicines in countries whose currencies have been devalued and where medicines are imported. This has already been observed in a number of low- and middle-income countries. Rising prices mean that fewer medicines are available even if expenditure is maintained.

In these circumstances, it is even more important that governments make good choices. There are always ways to improve efficiency in health – a simple example is moving towards the purchase of generic medicines where this has not been done. Where countries need to reduce

government expenditures, they can protect health, education and social safety nets, even increasing them as Thailand did, and some have already made such commitments in this crisis. Where more revenue is needed, a health-friendly option is to levy additional taxes on harmful goods – taxes on cigarettes and alcohol remain relatively low in many low-income countries, and taxes on foods high in sugar and salt are rare even in rich countries.

A recent high-level consultation at the World Health Organization endorsed a five-point agenda for action, aimed at helping developing countries protect health during the crisis.⁸ The components are:

- Leadership, where domestic and international leaders speak out on the need to protect health;
- Monitoring and analysis, giving governments and the international community early warning signs of possible problems;
- Pro-poor and pro-health public spending to be given priority by governments and international partners;
- Appropriate domestic policy, based on the concept of universal health coverage; and
- New ways of doing business internationally to reduce overlaps and inefficiency in raising international funds for health and channelling them to countries.

The current crisis risks reversing many of the recent gains in population health in poor countries through declining levels of development assistance, declining household incomes, reduced government revenues and spending and increased prices of essential health inputs such as medicines. However, this does not have to happen if the appropriate policy choices are made. It is promising that many countries and the global community have recognised this, as suggested by the adoption of the WHO's five-point action agenda.

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