Impact of Economic Crises on Health Outcomes & Health Financing

Pablo Gottret
Lead HD Economist, SASHD
The World Bank
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Outline

- How bad is the current crisis
- How does the current crisis compare with previous ones
- Impact of previous crises on:
  - Health outcomes
  - Health utilization
  - Health expenditures
- Response to previous crises by:
  - Households
  - Policymakers & World Bank
- Conclusions & Recommendations
Conclusions & Recommendations

- Women and Children are the worst affected. Nutrition outcomes and IMR increase are decline at slower rates. The impact of outcomes tends to be more severe in the poorest quintiles of the population.

- Previous crises in Asia and LAC show the negative impact that crises can have on health and nutrition outcomes - may have been the result of sharp reductions of utilization of essential health services.

- Faced with reduced income, households may increase demand for publically financed (and in many countries provided) health services. However:

  - **Total public expenditures** in social sectors in many crises countries (those facing high external and internal imbalances) **tend to be pro-cyclical**.
  - **Government Health Expenditures (GHE) per capita in real terms declined** in all countries reviewed immediately **after a crisis**. This decline occurred even as many countries protected GHE as a proportion of total government expenditures
  - **Capture of government services by the non-poor** was known to have increased during crises in some cases.
Conclusions & Recommendations

During past crises the Bank has supported operations that attempted to protect public “pro-poor” expenditures through conditions in SALs, DPLs and other programmatic operations. The experience is mixed:

- **Conditions**
  - Some conditions aimed at protecting expenditures for the whole sector as a proportion of Government Expenditures.
  - Some conditions target budgetary commitments which may be quite different from actual government expenditures in health.
  - **Some conditions protected expenditures without evaluating whether the expenditures were pro-poor to start with.**

- **Good practices**
  - In the good practices, the project supported the financing of the initiation or expansion of a sustainable safety net that tied essential health services to identified financing on a per capita basis with an appropriate system of monitoring and evaluation
  - The good projects avoided conditions in short term instruments (DPL) that involved long term institutional reforms (which require an investment or technical assistance instrument).
Fundamental objective of public policy in health during a crisis must be to maintain/improve access to essential services by the population, especially the poor and vulnerable –

- This is not at odds with the reality of reduction in health expenditure (which tends to happen during financial crisis)

From this perspective, protecting government health expenditures is not an objective in itself, but maintaining/improving access to essential services is
How bad is the current crisis

Growth is expected to decline significantly across developed and developing countries in 2009

- **Growth in emerging and developing countries will fall** from 6.25% in 2008 to 3.25% in 2009 (World Bank, 2009)

- **GDP expected to decline by 4-6% in the euro area** in 2009 (World Bank, 2009)

- The US and Europe have been the hit first, with US GDP falling by 3.8% (annualized) in the fourth quarter of 2008 (World Bank, 2009)

- Many currencies have experienced large devaluations

Source: IMF staff estimates.
How does the current crisis compare with previous ones


### Previous Crisis
- Originated in developing countries
- Many countries had large fiscal & external deficits
- A large part of the effort to resume growth was to increase exports to developed countries.

### Current Crisis
- Originated in developed countries
- Many countries with better fiscal positions also likely to face a crisis.
- The importance of FDI has increased
- Large number of poor countries, especially in Africa are Aid dependent for financing government expenditure in general and health in particular.
- Remittances constitute an important source of foreign exchange and direct support to household in many developing countries.
From Crisis to Health Status

Economic

• Unemployment
• Foreign aid/FDI
• Tax Revenue
• Demand for exports

Household Income

Government Resources

Capacity of other actors (NGOs, private sector)

Demand for health services

Supply of health Services / Quality

Access to quality health care

Health Status
Typically, there is a strong link between economic growth, household incomes and poverty rates.

- A 1% percent decline in developing country growth rates could trap an additional 20 million people into poverty (World Bank, 2008).

Compounding effect of food, fuel and financial crisis on the poor

- Already 100 million people may have been driven into poverty as a result of high food and fuel prices (World Bank, 2008).
- The number of people suffering permanent cognitive and irreparable damage due to early malnutrition increased by 44 million in 2008 (World Bank, 2008).

Current crisis may last longer than previous ones as developed countries are likely to import less from export-dependent developing countries

- World trade volumes are projected to contract 2.1% in 2009 (World Bank, 2009).

Importance of FDI in global economy

- Developing countries have become more dependent on FDI (which has already declined) in recent times.
Increased reliance on remittances could hurt countries

- Remittances to developing countries could decrease by 1-6% in 2009 (World Bank, 2009)

Foreign aid and ODA may be cut as a result of economic crisis

- Increased reliance on Health ODA puts poor countries at greater risk
- Rwanda and Ethiopia: Over 50% of budget total government expenditure is financed by donors and off-budget donor funding for health is more than 100% of government health expenditures.
- In 2006, 23 countries had more than 30% of total health expenditure funded from external sources. (based on preliminary WHO Data).
- However, there is an ambiguous relationship between economic growth in donor countries and subsequent aid flows (Mold et al, 2008).
Impact of Previous Crises on Health Outcomes

- **Children and women tend to bear the brunt** of crises as households economize on food consumption.

- **Over 1 million excess deaths (infants)** have occurred in the developing world during 1980-2004 in countries experiencing economic contractions of 10 percent or greater (Schady and Friedman, 2007).

- **Infant Mortality Rates (IMR) and Nutrition levels usually worsen during and after a crisis.**
  - Severe undernourishment increased from 24% from 1990-94 to 27.2% from 1997-98 in East Asia and the Pacific (UNICEF, 2009).
  - Elasticity of infant mortality with respect to per capita GDP is approximately -0.56 (Schady and Friedman, 2007).

- Rough estimates suggest that **mortality of girls is much more sensitive to changes in economic circumstances** than that of boys (Schady and Friedman, 2007).
Impact of Previous Crises on Health Outcomes
Evidence from East Asian & Latin American Crises

- **Indonesia**
  - *Increased prevalence of micro-nutrient deficiencies* (esp. vitamin A) in children and women of reproductive age. (Macfarlane Burnet Centre for Medical Research, 2000)

- **Thailand**
  - 22 percent *increase in anemia amongst pregnant women* (Knowles et al, 1999)

*Latin American crises* in the 80s *slowed down fall in average Infant Mortality Rates* (IMR) (Lustig, 1995)

- **Peru**
  - 2.5 percentage point increase in infant mortality for children born in 1989 and 1990. (*Paxson & Schady, 2005*)

- **Mexico**
  - Average of 7-10 percent increase in child mortality during crises years. (*Ferreira & Schady, 2008*)
Impact of Previous Crises on Health Utilization

- Deterioration of outcomes “may” be traced to reduced utilization of essential services
  
  Crisis → reduction of household income and insurance protection → decreased utilization of health services

  • Argentina
    
    • 63% of urban households experienced real income falls of 20% or more between October 2001 and October 2002.
    • 38% of households took their children less frequently to preventive medicine (World Bank Argentina Health Sector Report, 2003)
    • 57% of the poorest household took their children less frequently to preventive medicine.
Impact of previous crises on Health Utilization

- For some countries, utilization rates did not recover for a long time even after economic recovery
  - In Indonesia, between 1997-2005, utilization of professional healthcare decreased from about 53 percent to about 34 percent by those seeking care. (SUSENAS)
  - Health utilization rates have yet to return to their pre-crisis levels (World Bank Indonesia Health Public Expenditure Review 2008)

- Costs of drugs and medical services usually go up during a financial crisis which might make healthcare less affordable for the poor
  - Devaluation of local currencies results in an increase in the local currency price of drugs
  - Cost of drugs went up by almost 61 percent in Indonesia; Costs also went up in Thailand, Philippines and Vietnam (UNICEF, 2009)
Impact of Previous Crises on Health Expenditures

- Public Expenditures and Social Spending tend to be pro-cyclical in countries with internal imbalances.
- Government expenditures measured in real per capita terms tended to decline:
  - Government health spending per capita fell more than out-of-pocket spending per capita in all crisis countries reviewed.
  - In Argentina, Russia, Indonesia, and Thailand, government health spending per capita took time to reach pre-crisis levels.
  - In Argentina and Indonesia despite increases in the health’s share of government expenditure, government health spending per capita declined due to a fall in both GDP and government expenditure as a percentage of GDP.
  - In Thailand the decline in government health spending per capita was driven by the decrease in health’s share of government expenditure and an overall GDP decline.

Real Health Spending per Capita in Local Currency Units (LCUs), 1996 - 2006

Source: World Health Organization and World Bank
Real Health Spending per Capita in US$, 1996 - 2006

Source: World Health Organization and World Bank
Government health expenditure as % of Government Expenditure (GHE/GE) and Government Expenditure as % of GDP (GE/GDP) for Indonesia, Thailand, Argentina, and Russian Federation.

Source: World Health Organization
Impact of Previous Crises on Health Expenditures

- Post-crisis measures many times involve commitments to protect social expenditures such as health, specially for the poor and vulnerable.

- Evidence suggests that:
  - Protection of GHE as a proportion of GDP or as a proportion government expenditures may not be sufficient as government expenditures per capita in real terms may still decline substantially. **Question is: Is protection of public health expenditures necessary?**
  - Government programs and services have been captured by the non-poor (Ravallion, 2002)
    - Targeting of social programs weakens during crises as the non-poor try to capture them.
    - **Social Spending** in many countries is heterogeneous, incorporating services such as pensions, unemployment compensation and higher education and thus may be non pro-poor in the first place.
    - Evidence from India & Bangladesh (Food-for-Education Program) confirms that aggregate cuts in social programs tended to be associated with worse targeting and deterioration of benefit incidence (Ravallion 2002).
  - Protection of Government Expenditures in health protects mostly salaries with other variable expenditures decreasing and large detriments in quality of service
Response to Previous Crises by Households

- Users may switch from private sector to public sector
  - The public health system struggled to meet the increasing demand for services at Argentina’s public hospitals during the crisis (Iriart and Waitzkin, 2006)

- Public health service utilization may increase
  - Thailand experienced an increase in utilization of public health services as the government expanded the national coverage of public health insurance (World Bank, 1999)

*Argentina: Type of changes in health insurance coverage by income quintile*

<table>
<thead>
<tr>
<th>Quintile</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>Total</th>
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<tr>
<td>Lost all coverage</td>
<td>76.0</td>
<td>61.1</td>
<td>78.6</td>
<td>52.6</td>
<td>33.6</td>
<td>61.4</td>
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<tr>
<td>Changed coverage</td>
<td>24.0</td>
<td>38.9</td>
<td>21.4</td>
<td>47.4</td>
<td>66.4</td>
<td>38.7</td>
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Conditional Cash Transfers have been an effective instrument in protecting the poor

- Expanding the coverage and increasing the benefit levels on CCTs has been one response to crises, particularly in Latin America (Schady, N. & Fiszbein, A., 2008)
  - Mexico was able to help redress the adverse welfare impacts of the recent rise in food prices by implementing a one-time top up payment to Oportunidades participants.
- There is good evidence that **CCTs have improved the lives of poor people** (Schady, N. & Fiszbein, A., 2008).
  - CCT programs have also had a positive effect on the utilization of preventive health services, although the evidence is less clear-cut than with school enrollment.
- **The fiscal costs of CCTs need not be unduly high.**
  - Even such large and generous CCT programs as those in Mexico and Brazil are only around 0.5 percent of GDP (PREM Guidance Note on the Financial Crisis(WB), 2008).
Bank programs during past crises have worked better (according to reviews of ICR) when:

- **Aimed at financing a specific set of services** that are used by poor/vulnerable – Including immunization, primary health care, nutrition
- **Government policy and Bank support consisted in expanding breadth and depth of coverage of an existing safety net or introducing a sustainable safety net** (Bolsa de Familia in Brazil, 30-Baht/UC insurance in Thailand)
- **Targeting is simple and sustainable**
- **In absence of simple mechanisms for targeting vulnerable individuals or households, it possible to finance those services that are fundamental for the population** and likely to be under-consumed by the vulnerable groups (iron, zinc, vitamin A and micronutrient supplements for mother and child, maternal/child primary care, etc).
Examples of World Bank Project Conditionality

- **Effective (based on ICR)**
  - **Brazil Social Protection Special Sector Adjustment Loan**
    - **Objective**: Maintain expenditures for human capital investment in basic education, medical care and nutritional services.
    - **Indicator for health**: Budget protection in health based on floors set on per capita spending at the state and municipal level for a defined benefit package.
  - **Thailand Economic and Financial Adjustment Loan**
    - **Objective**: Increase public expenditures for protecting the poor.
    - **Indicator**: Based on the expansion of existing safety nets based on means testing.

- **Ineffective**
  - **Argentine Republic Special Structural Adjustment Loan**
    - Indicator = Safeguard social programs critical to the poor from budget cuts. Obtain commitments for 1999 spending on key programs.
  - **Georgia Third Structural Adjustment Credit**
    - **Objective**: Strengthen fiscal performance while lessening the adverse impact of stabilization on the poor by ensuring budgetary provisions for basic health, education and social protection
    - **Indicator**: Preserve spending levels at 7.3 percent of total budget in 1999.
Conclusions & Recommendations

- Previous crises in Asia and LAC show the **negative impact that crises can have on health and nutrition outcomes** - may have been the result of sharp reductions of utilization of essential health services.
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Better practices are those that:
- clearly define the health and nutrition services to be provided
- identify the financing for such services and specify it on a per capita basis and in real terms
- are affordable
- clearly identify the beneficiary population
- set appropriate monitoring and evaluation mechanisms.

Poor practices are many but the following must be avoided:
- general input or commodity subsidies
- general conditions that earmark expenditures for the whole sector
- conditions that only protect expenditures (for instance as proportion of budget or as proportion of GDP) without identifying the services to be produced and the target population.
- conditions that protect financing or services that are not pro-poor in the first place

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