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Health in times of global economic crisis: Implications for the WHO European Region

The WHO Regional Office for Europe, with its ongoing interest in documenting and highlighting the linkages between health systems, health and wealth, has been active in monitoring and assessing the impact of the ongoing financial and economic crisis on health systems and the health of populations in the WHO European Region. This paper consolidates and updates the work carried out over the last year with a review of the current situation, to help identify issues and options for further discussion at the fifty-ninth session of the WHO Regional Committee for Europe. It also builds on the outcome of the high-level conference on "Health in times of global economic crisis: Implications for the WHO European Region", organized jointly by the Regional Office and the Government of Norway and held in Oslo on 1–2 April 2009. The background document prepared for that conference, *Overview of the situation in the WHO European Region*, is included as an annex, as is a set of recommendations proposed for discussion on that occasion.

The essential thesis of this paper is that in times of crisis health systems can and should continue to provide essential care for all, adding value to human capital and wealth formation and behaving as a wise economic actor to contribute to the overall recovery. As such, it provides the evidence base for consideration by the Regional Committee of the key policy options set out in the attached draft resolution.

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Introduction

1. The world is in the midst of a severe financial and economic crisis that needs to be managed and recovered from, while facing daunting demographic (ageing, migration), social (growing inequalities between the “haves” and “have-nots”) and environmental (climate change) challenges.
2. The symptoms, magnitude and consequences of this crisis – the worst economic recession since the Second World War – vary greatly between regions and countries. The economic downturn is especially pronounced in advanced economies, with consequent spill-over effects to export-oriented emerging economies.
3. Thanks to actions taken by governments and central banks, a systemic financial meltdown has been prevented. However, despite increased public interventions to support economic activity (through both investment programmes and measures to stimulate consumption), the global economy remains weak and vulnerable to further shocks. In many developed or high-income export-oriented economies, unemployment has been rising sharply and rapidly. Looking ahead, the economic outlook is uncertain and the increasing public debt may significantly constrain public finances for years to come.
4. In such a context, the standards of living of millions of individuals and families in the WHO European Region are already affected or seriously threatened, as is the revenue base for health and social protection schemes. Evidence of the consequences of the crisis on health is scarce, and indeed it may take quite a while before they become apparent. However, the crisis is likely to trigger significant – both positive and negative – changes in social norms, lifestyles and health and healthcare-seeking behaviours, and as such to increase health inequities. There is a need to step up monitoring and analysis and better track these changes, especially for the poor and vulnerable segments of the European population.
5. Overcoming the crisis will require timely, well targeted, properly sequenced and fully coordinated efforts. Sound macroeconomic and fiscal policies are of course needed. However, health is wealth, and the erosion of human capital should be avoided at all costs, to prevent a social and health recession in the future. Investing in health and health systems is more than ever, a must in times of crisis and should be an essential component of the societal response to the crisis.
6. The Oslo Conference¹ in early April 2009 was one in a series of meetings organized and/or supported by WHO to anticipate and address the potential health and health systems impact of the economic crisis and to explore viable short- and longer-term policy options. It came after a high-level consultation on the health consequences of the financial crisis, held in Geneva on 19 January 2009, and provided a forum for a prelude to the debate on health and the economic crisis at the current session of the Regional Committee. Health leaders present in Oslo were unanimous in advocating the protection of health budgets, to be able to address public health threats effectively, widen access to essential health services, reduce inequalities in health and improve the performance and efficiency of health systems.
7. This paper consolidates and updates the work done in the WHO European Region over the past year with a rapid review of the situation to help identify issues and options for further discussion at the session. It should be read in conjunction with the background document prepared for the Oslo Conference, *Overview of the situation in the WHO European Region* (Annex 1).

¹ Health in times of global economic crisis: implications for the WHO European Region. Oslo, Norway, 1–2 April 2009

8. In addition to this introduction, this paper has three sections: the next section describes the current situation, followed by one that analyses the impact of the crisis on health and health systems. Building on recommendations from the Oslo Conference, the final section suggests a number of strategies and proposals for possible anti-crisis packages for health and health systems.

A multidimensional and severe crisis

9. Since 2008, the severe contraction of global demand for commodities, goods and services as a result of the liquidity crisis and the loss of trust in the financial/banking sector in the United States and Europe has considerably slowed down the global economy. According to the International Monetary Fund (IMF), world output is expected to contract by 1.4% in 2009, but it should gradually pick up in 2010 to reach a growth rate of 2.5%. The forecasts for the Euro zone, central and eastern Europe (CEE) and the Commonwealth of Independent States (CIS) are less optimistic, with output contracting by 4.8%, 5% and 5.8% in 2009, respectively, but again slowly picking up in 2010, albeit still negative in the Euro zone (-0.3%), modest in the CEE (1%), and slightly better in the CIS (2%).

10. While the global economy is slowly recovering thanks to public interventions the recovery will be sluggish overall and will vary greatly, depending on the health of the financial sector.

- The stabilization in the United States, Japan and other advanced economies is expected to be more pronounced than in the Euro zone and the rest of the WHO European Region. Output in both the United States and Japan is expected to start growing again in 2010.
- While growth in emerging and developing economies slowed down in 2008, growth projections in Asia for the rest of 2009 and 2010 have recently been revised upwards, to 5.5% in 2009 and 7.0% in 2010. They remain markedly lower, however, in Latin America, the Middle East and Africa.
- Despite the success of policy actions in preventing a further downturn, the European Union (EU) countries remain in deep recession. In 2009, gross domestic product (GDP) is expected to contract by 4.2% in the Euro zone and by 4.9% in emerging European economies, but by around 10% in the Baltic states. The recovery will take time. Further structural adjustments in the labour market may be needed in order to contain public expenditure related to ageing, but adjustment to a lower level of wealth will have to be made.

11. The financial and economic crises have resulted in the depreciation of a number of national currencies. Since November 2008 the United Kingdom's pound sterling, for instance, has depreciated by about 30% against the Euro in less than a year, as have the Polish zloty (32%), the Czech koruna (18%), the Romanian lei (17%) and the Hungarian forint (15%). Further adjustments in exchange rates are inevitable as countries revise their monetary policies. The new EU members in central and eastern Europe will have to continue to make structural adjustments in the public and banking sectors, as their ability to attract cheap funding has greatly diminished.

12. A relatively limited decrease in global demand has resulted in the collapse of certain commodity prices. Oil and wheat prices, for example, have decreased by over 60% since January 2008, although oil has since picked up in anticipation of a more positive growth outlook. Other prices have stagnated or have increased only moderately. According to the IMF, inflation in the advanced economies is expected to decrease to a record low of 0.1% in 2009 and 0.9% in 2010. The risk of deflation cannot be totally excluded in some EU countries.

13. The sharp reduction in investments and industrial production during this global economic downturn has resulted in a rapid increase in unemployment. Millions of jobs in both the industrial and services sectors have either been lost or are under threat. The International Labour Organization (ILO) estimates that the global unemployment rate could rise to 7.1% in 2009. In the EU, the unemployment rate is expected to reach 9.5% in 2010 (from 7.5% in 2007) and about 20 million jobs could be lost. The unemployment rate in the non-EU countries of central and southern Europe and the countries of former Soviet Union is also expected to rise in 2009 (it stood at 8.8% in 2008).

14. The rather prompt reactions and extraordinary efforts of central banks and governments have helped avoid a global collapse of the financial and banking sectors, and yet the global financial architecture remains vulnerable. Some banks are still at high risk of defaulting; in some cases, nationalization – at least partially – may become necessary. Insurance companies and pension funds have also been severely hit. Less affected at the beginning, many central and eastern European banks and insurance companies need to adjust to much reduced capital inflows from their parent banks elsewhere in Europe.

15. Governments (and through them taxpayers and societies) are also making remarkable efforts to extend financial support to all spheres of economic activity to stimulate consumption, protect employment and provide social assistance to the fast-growing ranks of the unemployed. In the richest European countries, a wave of economic recovery programmes has been designed and the first steps have been taken in implementing them. In other countries, governments have only limited scope to deal with the crisis through tax reductions and fiscal easing.

16. The economic downturn and the cost of these stimulus packages are rapidly leading to a deterioration of public finances, with public deficits and levels of public debt increasing significantly. This is already the case in nearly all advanced and emerging economies, and the situation may soon become even more critical in middle-income countries. For example, a significant deterioration of fiscal balances is expected in 2009 in the Baltic states and CEE countries. A further deterioration in the budgetary situation of most European countries (including those in the EU) is to be expected in 2010.

17. Evidence from past crises shows that the poor and the most vulnerable are likely to suffer the most in times of crisis. Indeed, a significant proportion of the population of the WHO European Region is already at risk of poverty. In the EU, for instance, 16% of the population is at risk of officially defined poverty, even after social transfers (the proportion ranges from 10% in Nordic countries to almost 25% in Italy or the Baltic states). It is also known that the living standards of poor people vary considerably across the Region, and that poverty tends to be more severe in countries where numbers in poverty are highest. Children and the elderly usually face a higher risk of poverty: from the information available, unemployment seems to affect more men than women and people below 24 and over 50 years, probably because the industrial sector is the hardest hit.

18. Fortunately, most governments in Europe appear to be continuing to pay significant attention to social cohesion and social protection. It seems clear that the crisis will not only affect living conditions and lifestyles but also accelerate changes and trigger shifts in social norms or economic policy. For example, the need for coordinated global regulation of the financial and banking sector is now more widely recognized, and the (previously taboo) increased public deficits and debt ratios are now seen as necessary evils.

19. The intense political and technical debate that is being held also focuses on the ethical dimension of the financial and economic crisis. As individuals feel more vulnerable, the perception of social inequalities seems to be changing and becoming less abstract in many countries, going far beyond traders' bonuses or chief executives' "golden parachutes". Opinion

surveys and social barometers show widespread pessimism and a feeling of injustice; many people are demanding that the ethical dimension of the crisis must become a more important part both of the political debate and of the fiscal solutions. It is worth noting that concerns about how to increase social justice are moving up the political agenda at a time when the WHO Commission on Social Determinants of Health is underscoring existing health inequalities and calling for the gaps to be closed.

Box 1. Socioeconomic changes and health: the cases of Estonia (crisis in 1990) and Finland (crisis in 1986–1994)

There is no doubt that any rapid social and economic transition will have consequences on the health of populations. Yet, the extent, severity and distribution of these consequences are likely to vary greatly, depending upon how ready and well equipped the society and its institutions are to weather the crisis and cope with its impact. The existence and coverage of social safety nets, and the robustness of the health system's response (i.e. its resilience to threats to its underlying values, fiscal space and performance) appear to be essential. The cases of Estonia and Finland, two countries of similar sociocultural background yet with different recent histories in terms of political and social organization, offer a stark example of such variations.

Estonia

It is clear that the political and social transition that followed the dissolution of the Soviet Union was specific in many senses. It cannot be compared to any other economic crisis, in that it also encompassed general changes in the entire social realities. Also, in studying such a crisis there is the possibility of making wrong causal inferences: causative processes shaped decades before can manifest themselves later on and be incorrectly imputed to more recent periods – for example, life expectancy at birth in Estonia in 1980 (69.1 years) and 1990 (69.5 years) was in fact lower than in 1970 (70.0 years). Also the size of educational categories within the population has changed in most countries, which would affect any comparison.

With those caveats in mind, however, some studies have been carried out that might shed some light on the consequences of the economic turbulence that occurred after Estonia regained its political autonomy in 1991. Mortality changes by education from 1989 to 2000, for example, were analysed in order to assess the impact of the changes per se and the delayed effects of pre-transitional developments on high, middle, and low educational groups. During the first decade after Estonia regained its independence, overall life expectancy remained stable, albeit characterized by divergent mortality rates by socioeconomic status, measured mainly by educational attainment. All-cause mortality decreased across all age groups, particularly for those over 60 years of age, and among those of low and middle education, but it increased for those with higher-level education.

Importantly, an improved educational structure prevented an even greater decline in life expectancy –which means that the highly educated Estonians can potentially catalyse wider health progress (indeed, health indicators have since substantially improved: life expectancy at birth increased to 70.9 and 72.6 years in 2000 and 2005, respectively. Although cardiovascular and cancer mortality are still significant causes of premature death, reductions in infant mortality have been remarkable – from 12.4 per 1000 live births in 1990 to 8.4 in 2000 and 6.0 in 2005).

One important methodological lesson learnt is that analyses of trends in health inequalities in central and eastern Europe should capture the changing population composition. As indicated, no clear-cut conclusions can be reached about causal inferences since, in addition to social disruption and increasing inequalities in wealth (possible recent determinants) long-term trends from the past could have also contributed to the widening gap. It is worth mentioning as a hypothesis in the context of this paper that the worsening of life expectancy in selected groups

(a trend not reported in either Finland or Spain) could be related to the lack of social safety nets, which the country would have had no time to set up, and the very collapse of the health system. The absence of such worsening in the Czech Republic, however, would call for a different explanation. Further research is needed.

Finland

From the 1950s onwards the social structure in Finland underwent a substantial change, partly related to extremely rapid urbanization. The proportion of farmers diminished considerably and white-collar groups (with a large proportion of women) expanded over a longer period. Other simultaneous social structural changes included rising levels of education among both men and women.

Then economic recession struck in the early 1990s, making unemployment a major social problem for the first time in decades. Since the late 1970s unemployment had fluctuated between 3% and 8% but it jumped to 18% by 1994. Long-term unemployment in particular rose to 27% in 1994.

In spite of that, infant mortality in Finland declined from 1986 to 1994 from 6.3 to 4.0 per 1000 live births and overall health status remained stable or improved slightly among the adult population; that is, the Finnish population's health status remained relatively unaffected by the recession and the unemployment crisis.

Changes in social inequalities in health, as indicated by class and educational differences among Finnish men and women (measured using limiting long-standing illness and perceived health as below good), were mostly negligible. People in the Helsinki metropolitan region, the most modernized in the country with about one fifth of the population, continued to enjoy better health than people in the rest of the country, but the pattern and size of relative social inequalities in ill health remained generally stable during the eight-year study period. Men's and women's health inequalities at the end of the study period resembled each other more than eight years before. Differences between social classes, within both employed and non-employed people, showed only negligible changes.

Only tentative reasons can be advanced for the observed main trends in health status during a period of structural change in Finland. They could have two main explanations. First, adverse health consequences of the recession could take a longer time to show up – a plausible explanation for chronic conditions reflected by limiting long-standing illness, but less plausible for the strongly subjective component of self-assessed health – or simultaneous and contrasting processes (more education, less exposure to physical damage, etc.) could lie behind the development observed. Besides, adverse health trends may become apparent only in marginalized and vulnerable subgroups. Second, the findings could be due to the presence of welfare state institutions, the economic and political measures taken and the welfare outcomes achieved in the country, all of which remained surprisingly stable across some indicators during the period. From the welfare perspective, this suggests that the country performed well irrespective of the structural changes.

This would mean that, despite the socioeconomic turmoil and the subsequent structural adjustments, the values, principles and fundamentals of the welfare state (with a widely cast social safety net and a health system offering universal coverage with all essential services) remained intact and thus resilient to external threats.

Granted, such generalizations are prone to bias and alternative explanations, and as such causal attributions are perilous at best. Nonetheless, these and other country examples and lessons learned call for a better understanding of the cushioning role of strong social safety nets and health systems and an evidence-based policy response.

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Observed and potential impact on health and health systems

20. We know from past experience that in times of crisis, health outcomes and the risk of health-related financial hardship may be affected by changes in the resources available for health systems (financial and human resources, drugs and medical devices, running costs and infrastructure), by changes in living conditions, lifestyles and consumer behaviours, and by changes in social norms and values. Ideally the health system can and should do three things: (i) protect those most in need, (ii) concentrate on areas in which it is effective and adds value, and (iii) behave as an intelligent economic actor in terms of investment, expenditure and employment.

Box 2. Evidence for the impact of economic crises and recessions on health and health systems

Domestic health spending

- Private expenditure on health almost always falls as disposable household incomes fall.
- Government expenditure on health often but not always falls, partly because government revenues fall or the health budget is disproportionately cut. Some governments, however, have in the past increased health and social sector spending during a recession.
- Capital investments (infrastructure, equipment) are postponed, funds are either saved or switched to other more pressing expenditure categories.
- When the local currency is devalued, imported goods (e.g. medicines and consumables) become more expensive in local currency and thus less affordable.

Health service utilization

- Utilization at health facilities that charge for services falls – this is a consistent finding

across countries.

- There is a switch to utilization of government and subsidized or not-for-profit facilities.
- There is a greater mismatch between demand for health services in public settings and rationing of supply, and lower quality of care as a result of budgetary and other resource constraints.

Mortality and morbidity

- Negative impacts on health are frequently reported.
- In low-income countries, there is most commonly, an increase in infant and child mortality, and micronutrient deficiency and anaemia in women.
- In higher-income countries, there is an increase in mental illness, suicide rates and sometimes adult male mortality.
- A heavier burden of illness is imposed on the poor and vulnerable.
- In countries with a functioning social protection and assistance scheme in place, there is a modest or no negative impact on health, depending on how severe, long and entrenched the crisis is.

Source material

Based on: Evans D (2009). *The impact of the economic and financial crisis on global health* (Presentation at the high-level consultation on the financial and economic crisis and global health, Geneva, 19 January 2009).

21. For countries whose health system is financed through general tax revenues, decreases in GDP and economic outputs may result in significant reductions in public revenue for health. Alternatively, for countries that rely predominantly on wage-related contributions to health insurance funds, increases in unemployment are likely to constrain revenues earmarked for health. International prices for drugs and other consumables may increase owing to inflation and currency depreciation. These pressures on revenue generation and purchasing power may in turn persuade policy-makers to cut budgets, introduce or increase user fees, co-payments or other forms of private financing, reduce benefit packages or tolerate longer waiting times.

22. The truth, however, is that although both detailed and synthetic economic reviews and forecasts are published at least quarterly, the direct effects of this multidimensional crisis on health are still unclear. So far, the information and evidence available on the precise impact on individuals, vulnerable groups and the health system in general remain anecdotal and fragmented. Furthermore, this type of data is proving difficult to compile and analyse; existing health information and monitoring systems are proving rather unfit to serve the needs of policy-makers regarding these critical issues in many countries.

23. Few changes in health system expenditures have been observed. The European health sector² (which employs about 10% of the total workforce) seems not to have lost many jobs and in fact appears as a stabilizing sector. As is also the case in the United States, health is indeed one of the very few economic sectors that is still creating jobs. The “credit crunch” seems to

² Roughly speaking, the health sector includes the health system as defined in the Tallinn Conference on Health Systems, Health and Wealth (“Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health”), together with the industry and general services directly related to that system.

have mostly affected health-related private investors or medical insurance schemes and undermined some forms of public/private partnerships. Budget cuts or budgetary measures significantly affecting health or other social sectors have only been observed so far in a limited number of countries – although there are signs that they could become more frequent and drastic in the near future.

24. Currency depreciations are increasing the prices of imported medicines and medical devices in the countries concerned, causing initial problems to the less rich among the affected countries. Already facing threats in terms of expiry of patents on “blockbuster drugs” and rising research and development costs, the pharmaceutical industry has signalled difficulties in accessing credit and seems to expect additional downward pressures on drug prices.

25. Whether or not it is related to unemployment, the foreseeable reduction in household income could affect private expenditures on health and the ability of families to pay for health care. It is known that globally 150 million people are pushed into poverty yearly through the catastrophic household health costs that result from payments for access to health services but so far there are no reliable data – yet there is some anecdotal evidence – of any major deterioration of financial accessibility to health care in Europe (compared to the United States, where some red-light signals have already been observed). Reduced access to complementary medical insurance has in some cases been reported.

26. It is known that non-adherence to medical treatment could in the longer term result in wider prevalence of disease, complications of chronic conditions and increased drug resistance in the case of infectious diseases. However, only limited changes in effective health service utilization and consumption of medicines have been observed – an important fact since, in middle-income European countries, out-of-pocket payments for medicines for persons with chronic conditions seems to be the biggest “risk factor” for experiencing health care-related financial catastrophe.

27. Rising unemployment, the deterioration of millions of people’s living conditions, and the additional stress caused by the crisis may lead to less healthy lifestyle choices or riskier behaviour – such as increased use of drugs and alcohol. It is known that even small changes in behaviour today, compounded over time, could manifest themselves in health outcomes years later. Signs of individuals changing their behaviour have been reported in ways that could have both positive and negative impacts on health. For example, there have been reports of increasing consumption of cheap fast food, but people in several countries also seem to have cut back on driving, turning instead to public transport and/or increased physical activity.

28. While no clear statistics are available yet on the impact of the crisis on migration, the present situation is deemed likely to trigger shifts in migration and mobility patterns, with workers (and their families) moving to countries where job prospects are brightest or returning home from countries where job prospects have deteriorated. A related global decline in remittance flows is projected, but it could remain relatively limited (less than 6%), even if specific countries could be more severely affected. Very limited changes in mobility of health workers have been observed to date.

Navigating through particularly difficult times

29. The IMF, the World Bank, the Organisation for Economic Co-operation and Development (OECD), the European Commission (EC) and some other agencies are producing very similar economic forecasts. According to these, global growth rates could gradually recover in 2010, though only to lower levels than the ones observed in 2007 (up to 2%). However, in the current economic climate, all experts agree that the uncertainties attached to

any forecasts are very large – the risks are many, financial market conditions will take time to normalize, whatever the approach adopted, and it takes longer for industries to recruit than to fire. Not only is the outlook on the downside, but the risks of a long and deep recession or even a depression cannot be excluded.

30. As the crisis evolves, some issues are emerging regarding possible approaches and measures to help resolve it. Some revolve around the relative priority to be given to investment versus boosting consumption in economic recovery programmes, around how to minimize social damage and protect the most vulnerable groups, and even around what role the health sector could play as an economic area to help countries get out of the crisis. Member States are considering different approaches to perform better and doubt whether the crisis should be used as an opportunity to introduce drastic, often long-postponed changes in functions and in the overall architecture of their health systems.

31. The health impact of the rapid deterioration in public finances is likely to be fully felt only at the end of this year, when budgets for 2010 will be discussed. In view of the levels of public debt, it is more than likely that the fiscal “room to manoeuvre” will remain limited. The deterioration of public finances and a consequent shrinking of fiscal space could force governments to adopt drastic adjustment and austerity measures. Resources for health systems could be under severe pressure in the years ahead. Health authorities and related stakeholders will have to navigate through particularly difficult times in the foreseeable future, including focusing on what will happen after the crisis (for a start, debts will have to be paid).

Box 3. Hungary: mixed lessons from the health system response to the 1995 fiscal crisis

After the political transition in the early 1990s, Hungary’s government expenditure grew faster than its economy. Although GDP growth did not become negative, a serious fiscal crisis started by 1995. In an attempt to balance the public budget, the health sector underwent significant budget cuts; between 1994 and 1998, total public expenditure on health (excluding investments and public health) dropped in real terms by 26%. Cash benefits paid by the health insurance fund were reduced in real terms by more than 50% and dental care benefits by 30%. Expenditure on hospital inpatient care was reduced by 15% and the number of hospital beds by 20% (but without significantly reducing the number of facilities and fixed costs). The primary care and outpatient specialist care budget was also reduced by 24%. Despite the above, the number of doctor-patient contacts did not diminish in primary care and even increased in hospital care (that is, hospitals became more productive under the pressure of fiscal constraint).

The most accepted interpretation is that financial incentives in a new, sophisticated case-based scheme for payment of inpatient care were instrumental in producing this result; better management of the production process became the main source of the productivity increase. However, public capital investments dropped by almost 40%, delaying necessary investments and repairs. There were signs of problems with service quality (including occasionally the quality of clinical care). Satisfaction with the health system decreased.

Drug expenditure remained stable despite the plan to reduce it by 10%, possibly owing to lobbying pressure and marketing by the pharmaceutical industry. As a result, its share of total expenditure in the public sector increased (at the expense other health services). Patients’ cost-sharing also increased, mostly as a result of higher co-payments for medicines, which together with the above made overall sales of pharmaceutical products continue to increase during the fiscal crisis. The only area where expenditure continued to grow was dialysis services, almost exclusively provided by private providers (they managed to negotiate price increases when even emergency care was experiencing severe budget cuts).

No major setbacks in population health have been described, however, as a consequence of these cuts. Although average life expectancy at birth in Hungary was (and remains) distant from

the best in Europe, with high mortality due to cancer and liver diseases/cirrhosis among middle-aged men, male life expectancy at birth stagnated for more than two decades (from 66.3 years in 1970, down to 65.5 in 1980, to 65.0 in 1991 and 64.5 in 1993) and then started to climb rather slowly (to 65.3 in 1995, 66.4 in 1997, 66.3 in 1999 and 68.2 in 2001). Infant mortality also was (and remains) above the EU average (23.2 per 1000 live births in 1980 and 15.6 in 1991; it went down to 12.5 in 1993, to 10.7 in 1995, to 9.9 in 1997, to 8.4 in 1999 and to 8.1 in 2001).

Some other interesting lessons seem to emerge when analysing health expenditure during the crisis. First, the starting point matters: generous cash benefits and an oversized hospital sector offered relatively safe options for cuts without eroding not only health outcomes but even service utilization. Second, strong mechanisms for control of costs by the single payer through capped case-based payments for hospitals produced significant efficiency gains in hospital productivity (although in Hungary the service delivery system was not restructured afterwards). Third, relatively weak government control and regulation led to increased inefficiencies in the area of drug expenditure, as evidenced by rather high volumes and prices on top of already high figures in a western European context.

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32. So far, and while some recovery programmes occasionally include a “green investment” component with a potentially positive impact on health in the medium to long term, health-specific sub-packages can hardly be identified. In many countries the opportunities offered by the first wave of economic recovery programmes have been missed, as many have left health and environmental problems to be tackled at a later date. However, “health- and environment-smart” investments could help save energy, reduce pollution, reduce security risks attached to communicable diseases, respond more efficiently to the need of the elderly and the vulnerable, and significantly reduce certain costs for both households and society as a whole. In particular, the potential for energy-efficient investments in the health infrastructure can be explored, in order to reduce the running costs of hospitals and health systems in general. This would enable a greater share of available public resources to be allocated to variable inputs supporting patient treatment (e.g. medicines and supplies) rather than fixed costs (e.g. heat, electricity).

33. The effects of the crisis on health and health systems will vary significantly from country to country, depending on the structure of their economy, their dependency on exports and/or fluctuations in their domestic currency, as well as the policy actions developed by their government. There will certainly be no “one size fits all” or ready-made approach. In such a context, solutions will have to be customized to meet countries’ specific needs. Exchange of information and experience between countries and coordination of activities will certainly be needed, but supporting the preparation and implementation of country-specific programmes has to be the top priority.

34. Evidence from past crises indeed calls both for confidence in the future and for determination in action. The worst is never certain, and crises have also provided opportunities for governments to push through reforms that might have been politically unfeasible in normal times. In that and other senses, crises have the potential for both positive and negative impacts

on health outcomes and health systems. There is also evidence of people having developed very effective coping strategies, which have proven to remain effective long after the storm. In short, even if the word crisis resounds with the negative connotations of increased disease and suffering, there will certainly be chances and opportunities that should not be missed.

35. Moreover, unlike in previous crises, governments are now more sensitive to the vital importance of the health sector and to the role of health for the economy. Thanks to campaigns to introduce primary health care, Health for All and Health in All Policies, the work of the Commission on Social Determinants of Health and the Tallinn Charter on Health Systems for Health and Wealth, many policy-makers in the WHO European Region now recognize that making health services accessible is one of the most effective and efficient ways to reduce poverty and social inequalities, and that investing in health is good for social stability and for the economy. The experience in Finland in the crisis in the 1990s is being corroborated every day, indicating that in times of economic disaster robust health systems protect people and preclude many from having to face disease-related catastrophic expenses.

36. The coming weeks and months still offer a window of opportunity to prepare health systems better for the storm to come. As in any period of tight fiscal constraints, rationing decisions (postponement or revisions of investments, exclusion of certain services, increased co-payments or longer waiting times) may be unavoidable. Ministries of health need to identify and agree on core areas, services and activities to be fully protected, to build up both an understanding of the crisis and a consensus on solutions among key health stakeholders, and in many cases rapidly to enact long-needed but challenging essential reforms. This document includes some lines of thought about such possibilities.

Box 4. Kyrgyzstan: creating a universal health financing system to weather future crises

Kyrgyzstan's experience as an independent country has been characterized by successive economic crises, some followed by outbursts of social instability: the "tulip revolution" of March 2005, for instance, brought down the government in power at the time.

By 1995, fiscal contraction had made total public revenue only 15% of GDP (down from 41% in 1989); by 1998, the real level of government health spending was half its 1991 level; by the late 1990s, Kyrgyzstan was (and remains) classified by the World Bank as a low-income country. The situation became unsustainable; in 2000, over 21% of health expenditure under the state budget was spent on electricity, heating and other utilities, leaving little to pay for medicines and supplies.

Restructuring the infrastructure was impossible, owing to two important features of the inherited system: funding based on input-based norms and a fragmented structure (each level of government funded and managed its own health system). The combination of fiscal decline with a large infrastructure created a wide gap between the need for funding and available funds. As a consequence, although health care was formally free of charge, informal out-of-pocket payments became a substantial barrier to care and a great financial burden for households seeking care.

Starting in 1997, the country initiated a reform by creating the Mandatory Health Insurance Fund (MHIF) as an agency able to pool funds nationally and use new information systems as a basis for shifting from input- to output-based payment methods. A single hospital information system for all patients regardless of their insurance status was also created. This laid the basis for starting the transition to a universal system in 2001 with the introduction of the single payer reform: all local government general budget funds for health care were pooled in each "oblast" or regional department of the MHIF, which used these funds to provide universal coverage for the entire oblast population, using output-based payment methods and increased provider

autonomy, eliminating fragmentation and capacity-expanding incentives.

The single payer reform was implemented in every oblast by 2004. In 2006, a further reform centralized pooling to the national level. It combines Beveridge- and Bismarck- system features in a complementary way by providing universal coverage on the basis of citizenship/residence, while also offering a complementary benefit (reduced co-payments and an outpatient drug package) on a contributory basis for the “insured” population. This was an adaptation to the context of an economy with low levels of formal employment. In 2007 for example, 84% of public funds came from the government budget and 16% from a payroll tax. By organizing the pooling of these two sources in a complementary manner, however, Kyrgyzstan has made rapid progress towards establishing a universal system.

By reducing system fragmentation and addressing misaligned budgeting incentives, the reforms led to improvements. These took the form of gains in equity: following the centralization of pooling in 2006, the per capita public funding gap between the capital city and other oblasts reduced in all cases except one; financial barriers to care (according to analysis of 2001, 2004 and 2007 household surveys) also steadily reduced, with out-of-pocket costs declining especially for the two poorest quintiles; and the share of patients making informal payment significantly reduced for all categories of patient expenditures. There were also gains in efficiency: underused hospital buildings were reduced by over 30% in the first year, and the share of hospital revenues devoted to patient treatment inputs (drugs, supplies, food) doubled. Lastly gains in transparency were achieved: patients’ financial burden, particularly for medicines and medical supplies were reduced and informal payments were replaced by formal co-payments.

Clearly there is still a long way to go in Kyrgyzstan, however, as available public financing still leaves a substantial level of private cost-sharing. Further improvements in financial protection remain an ongoing challenge for health financing reforms.

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37. Since strong health systems are essential for weathering the storm, the commitment by Member States in the WHO European Region to strengthening their health systems based on the values and principles agreed in the Tallinn Charter is more relevant than ever (“to promote shared values of solidarity, equity and participation through health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and other vulnerable groups”). The particular social context will need to be carefully taken into account in determining the precise way to strive for equitable health gain, financial protection, responsiveness and efficiency improvement. Member States need to carefully review the way they provide services, generate the necessary inputs, finance their services and provide stewardship for the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health within the political and institutional framework of each country.

38. As stewards of their respective health systems, ministries of health have a duty to offer a deal to the other stakeholders and advocate for government policies that take a central position in terms of stewardship and health financing, as well as a pro-health and pro-poor approach across all sectors. This is certainly the case when it comes to discussions with ministries of finance, in the context of economic recovery plans, regarding the share of the budget to be allocated to health and other social sectors, which should not focus merely on growth or on the immediate protection of existing jobs.

39. Member States are asking WHO to play a central role in this environment by providing leadership, services tailored to country needs and up-to-date information/health intelligence and advice through innovative, value-adding policy dialogue with countries. Many are advocating for (i) voluntary benchmarking; (ii) networking among interested countries on specific topics; (iii) the sharing of information by all; and (iv) a minimum set of relevant common indicators for follow-up.

Box 5. Spain: the crisis in the 1990s in a context of decentralization after a political transition

In the past three decades Spain has undergone profound changes, including a transition to a parliamentary democracy and wide political decentralization. Seventeen autonomous communities (ACs) have been created, taking on wide responsibilities for the provision and management of public services, including health care.

Spain has also suffered economic turbulences during that period, with a severe economic crisis in the early 1990s on top of structural adjustment (“industrial reconversion”). After negative GDP annual growth of -0,4% in 1979, another negative figure (-1,1%) was registered in 1993. The official unemployment data from the “active population survey”, published quarterly by the National Institute of Statistics (INE), recorded double-digit unemployment (11.41%) for the first time in 1980, going up to 21.45% in 1985 and to a maximum of 24.11% in 1994. Official unemployment figures remained in double-digits afterwards and, despite robust economic growth, only came down to single figures in 2005 (9.13%).

Throughout that period, however, Spanish health indicators have improved. Infant mortality, for example, fell from 20.78 per 1000 live births in 1970 to 12.41 in 1980, 7.6 in 1990, 4.38 in 2000 and 3.46 in 2007. Life expectancy at birth rose accordingly, from 72.88 years in 1970 to 75.6 in 1980, 77 in 1990, 79.49 in 2000 and 80.34 in 2007.

Although the precision of Spanish official unemployment figures is often questioned, they probably reflect with some accuracy the effects of the crisis – nothing indicates that whatever bias there was, it would have been different in any particular period.

What then is the explanation for the discordance between economic and employment data on the one hand and health data on the other? Most likely, it is the effects of social protection mechanisms. Spain has offered health services free at the point of use to the whole population in spite of the evolving economic situation. Compulsory workers’ insurance (“social security”) started in 1943 and has expanded ever since, covering “people without financial means” in 1989 and reaching universal coverage around 1991.

The transfer of services to ACs as regional territories with elected governments legally guarantees access to health care to all and includes a commitment to correcting health inequalities. The precise effects of decentralization in terms of reducing health inequalities remain unclear. A study carried out between 1980 and 2001 using life expectancy at birth and infant mortality as indicators, reveals that the process of decentralization either did not affect convergence or led to divergence in health. Indeed, in the case of infant mortality, certain provinces with initially poor indicators have improved, overtaking those that were originally in

a better position. The final result, however, is one of greater dispersion than initially. The conclusions of the study – say the authors – “must be tested with other studies (...) using alternative indicators or different methodological specifications, but they constitute a first step towards understanding the complex relationships between health outcomes and territorial decentralization, at least in institutional contexts of universal coverage and tax-based health system financing”.

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40. In order to anticipate risks, it will be essential to make regular analyses at national and international levels of the economic and social situation and its effects on health and health systems. In many cases, the existing information systems in Member States may not be able to provide, in a timely manner, the health intelligence needed by decision-makers and other stakeholders. A WHO-supported virtual network and exchange platform and a “hot line” are being put in place at regional level, to help ministries and stakeholders access relevant information and advice. Ministries or other health-related authorities may also need to function in a “crisis management” mode, emphasizing the collection of information (including anecdotal), regularly analysing the situation, articulating strategic options and suggesting anti-crisis measures and interventions.

41. With the scarce information available, as indicated, it is hard to predict at this stage with any accuracy how people in Member States will be affected. However, the experience gained and lessons learned from previous crises helps to direct attention towards specific issues in order to anticipate difficulties, explore options and prepare anti-crisis measures. Annex 2 includes a set of rather general recommendations intended to trigger ideas that Member States could use in their own contexts in building proposals for possible anti-crisis packages for health and health systems. Those ideas were used to facilitate discussion prior to the meeting in Oslo in April.

Box 6. The United Kingdom: rationing experiences from the past crisis – “penny wise, pound foolish”?

Facing severe fiscal constraints or budgetary cuts, decision-makers at all levels are often tempted to resort to one of the following short-term solutions that should be avoided.

Let waiting lists grow – reducing the volume of services to decrease (variable) costs may, in the short run, result in some, often modest, savings but is unlikely to provide longer-term cost-containment since (i) it reduces efficiency, because less services are provided per unit fixed costs; (ii) delayed care may result in exacerbation of the underlying condition and thus increased costs for the whole episode of illness; (iii) patients may seek care elsewhere, either in the private sector or abroad, thus negating any savings in general; (iv) it seriously affects patient

satisfaction and thus increases transaction costs; (v) and it causes a political backlash, leading to an overhaul or major reform when one may not really be needed, as seen in the recent challenges to the value base and “building blocks” of the National Health Service in the United Kingdom.

Compromise quality – not providing the full gamut of medically essential care services indicated by strong evidence of effectiveness (e.g. standard treatment and case management protocols) is bound to increase costs rather than containing them, because of the delayed health repercussions (e.g. medical errors) and health care consequences (e.g. increased readmission rates for the same episode), not to mention seriously compromising patient safety (e.g. iatrogenic infections) and public health (antibiotic resistance) and eroding public trust in the system.

“Slash and burn” and “salami slice” savings – indiscriminate expenditure cuts are ineffective and damaging because they focus on cost rather than value and may prove to be outright dangerous. Imagine cutting down on hospital renovation or maintenance across the board at the risk of increasing in post-surgical infections! They also are likely to penalize the efficient and leave the inefficient with untapped potential savings.

Pay cuts – while pay levels may need some adjustment, they should not be subject to severe cuts, lest the best and brightest leave and others will be demotivated, with the shorter-term consequences of longer working hours for those who remain, loss of productivity, demotivation, increased absenteeism and so on, and the longer-term consequences of recruiting and training new staff, rebuilding morale and increasing performance.

Cut training – previous experience shows that poorly thought-through cuts in training not only compromise quality and thus may increase overall cost, but also lead to avoidable shortages when times become better and demand for additional staff increase, thus resulting in pay inflation in the wage bill in the longer run.

Cut prevention – reducing public health expenditure to protect curative services is always a mistake and can potentially be disastrous.

Source material

Adapted from: NHS Confederation (2009). *Dealing with the downturn: The greatest ever leadership challenge for the NHS?* London (Future of leadership series, Paper 4).

42. The recommendations presented below are the outcome of the high-level Conference that took place in Oslo on 1–2 April 2009.

1. Distribute wealth based on solidarity and equity

Health authorities across Europe are concerned that the present economic system does not distribute wealth on the basis of the values of solidarity and equity, thus hindering improvement in health outcomes. Health leaders call for changes in the economic system that support health improvement.

2. Increase official development assistance (ODA) in order to protect the most vulnerable

The poorer countries are the most vulnerable when it comes to health loss in times of crisis. The current crisis is no time for decreasing ODA, but, rather, for increasing it.

3. Invest in health to improve wealth; protect health budgets

Investing in health is investing in human development, social well-being and wealth. Better health improves welfare. Health investments create wealth. Protect health budgets,

health insurance coverage and employment throughout the economic downturn. Include health- and environment-related investments in economic recovery plans.

4. “Every minister is a health minister”

Promote “Health in All Policies”. Consider the health and distributional effects of all political reforms.

5. Protect cost-effective public health and primary health care services

If spending on health is reduced:

- protect spending on public health programmes;
- protect spending on primary health care;
- reduce spending on the least cost-effective services. These will normally be found among the most high-technology, high-cost services in hospitals. Delay investment plans for high-cost facilities and promote the use of generic drugs.

6. Ensure “more money for health and more health for the money”

Make more money available for health and ensure more health for the money. Improve quality through transparent monitoring and performance assessment. Strengthen evidence-based medicine and make health services safer.

7. Strengthen universal access to social protection programmes

Use the opportunity of the crisis to strengthen universal access to social protection programmes in a more coordinated way.

8. Ensure universal access to health services

Use the opportunity of the crisis to ensure universal access to health services. Ensure social safety nets for the most vulnerable social groups.

9. Promote universal, compulsory and redistributive forms of revenue collection

Strive for equity in the financing of health services through universal, compulsory and redistributive forms of revenue collection.

10. Consider introducing or raising taxes on tobacco, alcohol, sugar and salt

Consider improving population health through public health reforms using structural measures. Examples are to raise taxes on tobacco, alcohol, and products containing high levels of sugar or salt. This could help to finance the social protection systems and at the same time have a positive impact on public health.

11. Step up the education of health professionals and ensure ethical recruitment

Even during this crisis, we must recognize the current shortages in the health workforce and the increasing need for health workforce in the future. Step up the education of health professionals and local health workers as appropriate. Use the crisis as an opportunity to attract new health workers. Continue supporting the development of a code for ethical recruitment across sectors and borders.

12. Encourage active public participation in the development of measures to mitigate the effects of the economic crisis on health

Health authorities call for more active public consultation and participation in defining, implementing and monitoring the execution of decisions regarding the crisis. Public participation may be direct (public debates, consultations) or indirect, through representative organizations, associations and unions.

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Annex 1

Overview of the situation in the WHO European Region

This annex provides a snapshot of developments related to the global financial and economic crisis in the WHO European Region since the situation worsened in 2008. It aims to portray the variety of developments and trends related to the sectors most relevant to health. It builds on selective examples from Member States and information publicly available in February 2009.

The document is divided into two parts. Part one, addressing the economic and social dimensions, looks at developments in economic growth, public debt, currencies, labour and social implications and presents a selective overview of government responses to date. The health sector dimension is addressed in part two, focusing on health finance, health system resources, and health care provision and utilization.

The most recent internationally available data were used in this document, with the following limitations: first, this paper is not intended to present an exhaustive review of the situation. Second, there are substantial differences between the economic and employment data presented by governments and those available from international sources. Third, the data presented in this document have not been validated by WHO Member States or by WHO. In view of the rapidly changing situation and the lack of statistical validation, all information and data contained in this document should therefore be used with caution.

Economic and social dimensions

Economic growth trends

Economic growth throughout the WHO European Region has slowed substantially and most countries moved into recession in the fourth quarter of 2008.

In many countries in the Region, industrial production is declining, a consequence of the contraction of both external and domestic demand. Some sectors are more affected than others. The automobile industry is troubled in numerous western and central European countries including the Czech Republic, France, Germany, Italy, Portugal, Slovakia and Sweden. The housing market has seen substantial deterioration in France, Denmark, Iceland, Spain, Sweden and the United Kingdom. The construction boom that has contributed to strong economic growth rates in the past decade has reversed in many central and eastern European countries, including in Armenia, the Czech Republic, Georgia, Hungary and Poland.

International forecasts for rates of growth in gross domestic product (GDP) in 2009 have been continuously revised downwards in the majority of countries in the Region in the past six months (Economist Intelligence Unit, 2009). GDP growth has been particularly hard-hit in Iceland and Lithuania with a contraction of 12%, and substantial negative growth rates are also anticipated in Estonia, Ireland and Latvia (Table 1).

Public debt and public deficits

The financial and economic crisis is having – and is likely to continue to have – major implications for the public finances of most European countries. First, government revenues are affected by the deceleration of growth and the declines in commodity prices. Second, governments are making extraordinary efforts to support the financial sector (through capital

injections, asset purchases, credit lines to financial institutions, and guarantees for financial sector liabilities). Third, governments have adopted fiscal stimulus packages. As a result, fiscal balances are deteriorating and government debts are increasing. This is true for both high- and middle-income countries. (International Monetary Fund, 2009a).

In the WHO European Region, Italy currently has the highest proportion of GDP accounted for by public debt (more than 100%), followed by Greece, France, Belgium, Israel, Norway and Hungary. At least 12 countries are expected to have levels of public debt above 60% of their GDP in 2009, some of which is related to their financial commitments in economic response packages. Public debt in Iceland is expected to increase to above 100% of GDP in 2009. Public debt developments will have longer-term implications for public spending, including on health, in numerous European countries.

The European Commission expects the public deficit in the European Union (EU) to more than double in 2009, up from 2% of GDP in 2008 to 4.5% in 2009. Several Member States are projected to stay over the reference value of 3% of GDP in 2009 (European Commission, 2009).

Currency dynamics

Substantial currency depreciation in central and eastern Europe is causing price increases in health-related commodities such as food, medical devices and pharmaceuticals. Depreciation is affecting Albania, Armenia, Hungary, Kazakhstan, Poland, the Russian Federation, Romania and Serbia. The Polish zloty and Ukrainian hryvna have lost about 30% of their value against the Euro and about 60% against the United States dollar, respectively, since 2008. A similar effect can be observed in Iceland and in the United Kingdom.

Labour market and social implications

Unemployment is on the increase in most countries of the WHO European Region.

Many companies are being closed or are significantly reducing their activities. Most of the decline in employment has been in the construction and manufacturing sectors, affecting more males than females. In Belgium, nearly 3000 bankruptcies were reported in the fourth quarter of 2008 alone. In Croatia, 30 000 people lost their jobs during the first two months of 2009. A growing number of lay-offs are reported in export-dependent branches of the economy in Serbia, such as those producing food, rubber and plastics, metals and chemicals.

According to Eurostat (2008), the Statistical Office of the European Communities, in October 2008 17.2 million people were unemployed in the EU (7.1% of the active population), over half a million more than in July 2008. Significant and rapid increases in unemployment rates have been observed in Estonia (from 4.1% to 7.5%) and Spain (from 8.5% to 12.8%). During the last quarter of 2008, more than 80 000 jobs were lost in France, not to mention the reduction of temporary jobs.

In 2009, the unemployment rate is expected to be above or close to 12% in Albania, Croatia, Georgia, Ireland, Latvia, Spain and Turkey, and above 9% in France, Germany, Poland and Portugal. In France alone, according to Unedic, the National Union for Employment in Industry and Commerce, about 450 000 jobs could be lost. In some countries such as Austria, Portugal and Sweden, unemployment is higher in younger and older age groups, and disproportionately higher among people with basic compulsory education.

In Bosnia and Herzegovina unemployment is close to 30%, in the former Yugoslav Republic of Macedonia 33% and in Serbia above 17%. In the latter country, unemployment of young people

is also associated with higher educational status. About 50% of young women in Serbia are unemployed. The scale of unemployment in some eastern European countries is believed to be under-estimated, since many people do not register as unemployed or are sent on leave without pay. In Serbia, the number of self-employed people has increased markedly; they are considered to be more vulnerable to impoverishment than public sector employees.

Wages are falling on average in the WHO European Region. Real wages have decreased by 10% in Iceland. Estonia has cut salaries of state employees by 7%. Hungary has also cut civil servant wages and has taken back pension benefits. Romania is reporting wage decreases for the first time since 2000. Cut-backs in public wage bills have been resisted in Ireland, but may come. They are also likely to come in Albania, Belarus, Bosnia and Herzegovina, and Latvia. Migrant employment opportunities are expected to decline in countries such as the Russian Federation, which has hosted seasonal workers from Armenia, Azerbaijan, Belarus, the Republic of Moldova and central Asia.

Outward labour migration in Poland and many other central European countries has declined, and the return of migrants to regular employment in their home countries has been troubled by tight labour markets (World Bank, 2008a).

Numerous countries in the Region are finding it difficult to meet their poverty reduction targets owing to the financial crisis. The World Bank finds that Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan are among the 40 countries considered to be most vulnerable to increases in poverty related to the financial crisis (World Bank, 2009). There are concerns about the increasing number of impoverished people in Serbia and the large proportion of the population living in poverty. Serbia is currently also seeing a new phenomenon of an increase in urban poverty. The number of poor people in Slovenia (according to the national definition of people living on less than €21.70 per month) has increased by about 10% since November 2008, from 40 450 to 44 340 persons (over 2% of the population). Iceland has seen one of the most dramatic falls in wealth in the Region.

Rising unemployment, poorer working and living conditions and dissatisfaction with government initiatives to mitigate the crisis can be a trigger for unrest in Member States across the whole of the WHO European Region.

Table 1. Macroeconomic outlook¹

Country	GDP growth (% change)		Public debt (% GDP)		Unemployment (%)	
	2008	2009	2008	2009	2008	2009
Year	(b)	(c)	(a)	(b)	(a)	(b)
Reference ²	(b)	(c)	(a)	(b)	(a)	(b)
Albania	6	4	51.2		12.5	12.0
Andorra						
Armenia	6.8 (a.)	1.1			6.3	
Austria	1.6	-1.6	60.3	62.1	3.8	4.3
Azerbaijan	10.8	2.5	5.9	7.1	0.8	1.0
Belarus	8.1	10.3			1.6	
Belgium	1.2	-2.0	85.7	88.2	7.9	7.8
Bosnia and Herzegovina	5.0	1.5	40.0	43.0	29	
Bulgaria	5.4	-0.6	14.9	16.5	6.3	6.9
Croatia	2.2	0.4	48.9		13.7	14.9

¹ The most recent internationally available data were used in this table. There are substantial differences in economic and employment data from national and international sources. The data in Table 1 do not necessarily represent the position of WHO.

² Economist Intelligence Unit. Country Report February 2009 (or latest available); a – actual; b – estimates; c – forecasts.

Country	GDP growth (% change)		Public debt (% GDP)		Unemployment (%)	
	2008	2009	2008	2009	2008	2009
Year	(b)	(c)	(a)	(b)	(a)	(b)
Reference ²	(b)	(c)	(a)	(b)	(a)	(b)
Cyprus	3.5	1.0	49	48	3.8	4.1
Czech Republic	3.5	-2.0	27	30.2	5.4	7.3
Denmark	-0.9	-2.5	23.2	25.4	1.9	3.7
Estonia ³	-2.8	-5.0	4.3	5.8	5.3	7.3
Finland	1.6	-1.3	32.5	38.9	4.1	1.2
France	0.7	-2.5	65.4	71.0	7.4	9.0
Georgia	7.0	2.5	29 ³	27.4 ³	13.6	14.0 ³
Germany	1.3	-2.4	64.2	69.8	7.8	9.2
Greece	1.1	-1.8	93.4	96.5	7.8	8.6
Hungary	0.4	-3.0	68.6	69.3	7.8	8.5
Iceland	-3.5	-12.3	29	109	1.8	8.7
Ireland	-2.8	-4.8	31.8	48.2	6.9	11.9
Italy	-0.6	-2.5	105.4	110.3	6.7	8.5
Israel	4.1	0.4	79.7	83.9	6.1	7.6
Kazakhstan	3.2	0.3	9.0	15.7	6.6	7.6
Kyrgyzstan	8.5	7.6	52.2	47.2	18	
Latvia	-4.6	-12.0	14.0	36.0	5.3	13.0
Lithuania ³	3.2	-8.0	12.8	12.9	4.5	8.6
Luxembourg	0.6	-2.8	6.5		4.7	6.8
Malta	2.5				6.4	
Monaco						
Montenegro	6.5	2.0	26.8	32 ³	14.7	
Netherlands	2.0	-2.1	41.7	43.6	4.0	5.2
Norway	1.5	-1.0	67.6	88.8	2.6	4.0
Poland ³	4.8	0.7	44.8	45.8	9.8	10.4
Portugal	0.3	-2.0	64.5	69.1	8.9	9.1
Republic of Moldova	7.2	-1.0	21.9	28.8	1.5	2.6
Romania	7.7	-1.8	14.1	15.4	4.4	7.6
Russian Federation	5.6	-2.0	6.7	12.5	6.3	8.0
San Marino						
Serbia	5.4	0.0	38.0	35.0	17.6	20.3
Slovakia	6.8	2.0	35.3	37.9	7.7	9.0
Slovenia	4.0	0.5	23.0	28.5	6.7	8.1
Spain	1.1	-2.9	39.9	51.9	11.3	14.8
Sweden	0.5	-2.1	37.1	42.4	6.3	7.9
Switzerland	1.8	-1.8	44.0	44.8	2.6	4.1
Tajikistan	5.8	2.5			2.4	
The former Yugoslav Republic of Macedonia	4.9	1.0	29		33.5	35
Turkey	1.5	-1.5	39.6	40.3	10.2	11.0
Turkmenistan	3.0	2.0			33,5	35
Ukraine	2.1	-6.0	10.0	11.4	3.0	4.0
United Kingdom	0.7	-3.6	52.6	62.8	5.7	8.0
Uzbekistan ³	8.6	2.5	13.5	13.7	0.9	1.2

Government responses

At global level, all financial packages amount to an estimated total of US\$ 2.8 trillion. Many western European countries have provided immediate financial relief to their banking institutions, such as credit guarantees and stabilization measures to counter liquidity problems in Belgium, Germany and Sweden. Sweden looks back to the successful recovery of its financial institutions from a crisis in the early 1990s (Box 1).

³ Data from national sources.

Box 1: Drawing on experience from Sweden’s banking crisis in 1992

In 1992, Sweden faced a banking crisis that it successfully handled by shifting bad assets to an independent supervisory authority to provide solutions to debts and to liquidate assets. After the crisis, the Swedish state recovered its investments by selling assets that it had nationalized. The Swedish experience has been considered as a model for financial crisis plans in the United States (Dougherty, 2008).

Most western European countries and several central and eastern European ones have launched economic stimulus plans, amounting to 0.3% of GDP in Italy (with some more measures expected to follow), 1.3% of GDP up to 2010 in France, 3.4% of GDP up to 2010 in Germany and 1.5% of GDP in the United Kingdom (International Monetary Fund, 2009b). They amount to 1.5% of GDP in Azerbaijan, 2% of GDP in the Czech Republic and as much as 15% of GDP in Kyrgyzstan. The Kyrgyz plan includes short-term measures on food security, energy, social policy and health finance. Cyprus has pledged to spend 1% of its GDP on an economic stimulus package. Serbia has launched a €1.2 billion package (roughly 0.5% of its GDP).

The majority of stimulus plans have focused on boosting public investment, promoting employment, providing credit support and increasing private demand. It is hoped to enhance private consumption through cuts in tax rates, including payroll tax (social insurance) contributions. The EU10 countries⁴ have provided immediate support to ensure the liquidity of their financial institutions (World Bank, 2008a). Their financial capacity to invest in economic stimulus plans is more limited. Economic stimulus plans in the Czech Republic, Germany and Hungary provide for the reduction of social health insurance contributions by employers (Hungary) and employees (Germany, the Czech Republic). Finland has adopted general tax cuts to boost employment. France, Greece and Israel have launched or introduced tax cuts for their lower- and middle-income groups. Poland has decided to establish a solidarity fund, financed through increased excise taxes on alcohol and car imports. Benefits financed by the fund will likely focus on vulnerable population groups. Slovenia has decided to increase excise taxes on alcohol, tobacco and fuel.

The Italian plan is more modest in terms of expenditure, owing to concerns about its public deficit. It is an example of a plan that is targeted at vulnerable population groups (Box 2).

Box 2: An economic plan to support vulnerable and special population groups in Italy

The plan includes several measures directed at low-income families and individuals, such as the creation of a guarantee fund for couples with newborn children, a family bonus, and subsidies for purchasing milk and diapers for infants; rental subsidies and a halt to the increase in regional train tariffs, as well as a freeze on increases in motorways tolls. On employment, €1.2 billion have been earmarked to sustain social protection instruments, and incentives in terms of tax cuts have been decided for professors and researchers who have been working abroad and return to Italy.

Environmental experts have started to argue in favour of linking expenditures in stimulus plans with “green economy” action aimed at reducing carbon pollution through both short-term objectives (creating jobs, helping households to afford housing and cope with electricity price volatility) and longer-term ones (sustaining jobs, reducing greenhouse gas emissions, increasing energy efficiency, promoting the export of “green industries”). The extent of greenhouse gas emissions will have a longer-term impact on health. The EU in 2007 extended the commitments

⁴ Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia.

of the Kyoto Protocol to the United National Framework Convention on Climate Change (UNFCCC), agreeing to reduce the EU's greenhouse gas emissions by 20% below 1990 levels by 2020; to increase the use of renewable energy sources to 20% of the EU's overall energy mix by 2020; and to improve energy efficiency by 20% by 2020 (World Bank, 2009). So far, there is no information whether implementation of environmental plans will be postponed in view of the financial crisis.

The United Nations Environment Programme considers the Chinese and South Korean stimulus plans as leading in ecological terms (UNEP, 2009). About 13% and 7% of the volume of funding in the German and British stimulus packages, respectively, is devoted to environmental activity.

International measures supporting governments

Hungary has been provided with a rapid package worth €20 billion from the International Monetary Fund (IMF), the World Bank and the EU. It is also continuing to receive EU funding until 2013 for several public health programmes (cancer, cardiovascular diseases, child health), extension of health care provision (general practice, outpatient care) and information technology developments. Latvia has received €7.5 billion.

Assistance for Romania is currently being considered. In view of the financial crisis, international collaboration has also been intensified with Bosnia and Herzegovina: the EU plans to provide €40 million of support to infrastructure development and small- and medium-sized businesses. Implementation of ongoing projects funded by the World Bank will be accelerated, and negotiation of new projects and consultations with other international financial institutions will be intensified.

Armenia has been awarded a US\$ 35 million grant aimed at supporting employment in rural areas through road construction and investment in infrastructure (World Bank, 2009).

Ukraine has agreed with the IMF on a US\$ 16 billion loan to cover current funding gaps. Serbia will receive a US\$ 518 million loan from the IMF and will seek further international support to keep the growth of its budget deficit under control. Belarus will receive a 15-month loan of US\$ 2.46 billion. Iceland has obtained IMF support through a loan worth US\$ 2.1 billion. Georgia has approached several institutions for financial assistance.

Although some measures have been taken to support individual countries, it is also clear that general flows of international remittances to countries in need will decrease.

Health sector dimension

Health financing

State and health care budgets

Downward revisions of state budgets for 2009 and beyond can be expected in many countries, owing to a lower revenue base.

Belgium, the Czech Republic, Estonia, Latvia, Lithuania, Hungary, Portugal and Slovakia have already announced budget revisions to adjust for lower than expected revenues. Estonia, Latvia, Lithuania, Hungary and Romania have also announced health sector budget cuts or intend to make spending cuts to balance the budget deficit. The Ukrainian health budget remains at the level of 2008, despite 21% inflation and local currency depreciation in 2008. Montenegro has cut health insurance expenditures by about 3%, partly through a reduction of its basic benefit

package in primary care (mostly diminishing coverage for dental care) as a result of ongoing system reform. Budget adjustments are also expected in Belarus, Bulgaria and the Republic of Moldova, as well as in Azerbaijan, although it is hoped that the Azeri State Oil Fund will make up any deficits in revenues and that the health budget will remain a spending priority.

Initially, some countries had planned to expand their 2009 budgets. Increases had been announced in Armenia (about 20%), Albania (about 4.7%), Georgia (about 21%), Lithuania (13%) and the Republic of Moldova (30%), as well as in the former Yugoslav Republic of Macedonia, Kyrgyzstan and Turkey. However, most budgets were drawn up on the basis of previous revenue and spending projections, and these have since changed dramatically. It is uncertain whether these increases can be sustained. Some of these countries may have to deal with a situation where they obtain only 50% of the revenues that they had expected when developing their draft budgets.

Health system financing responses

Depending on the design of their health systems, western European countries currently seem to be considering different options for tackling declines in revenue and forecasted deficits, such as increasing state subsidies to social health insurance, introducing new distribution formulas for regional funding and containing the costs of health care provision. Decentralized health system funding, such as in Sweden and Italy, may require some adjustments in terms of transfers of central funds and redistributions between regions in view of the crisis (Box 3).

Box 3: Compensating for diminished health funding at regional levels in Sweden and Italy

In Sweden, municipal and county councils pay for the bulk of health system expenditure, with local taxes as the main source of revenue. Most county councils had already decided to raise taxes during 2008. Based on their approved budgets and taking account of reductions in current revenue projections, they can be expected to run into budget deficits during 2009, since revenue falls are greater than expected in 2008. Since deficits must be “clawed back” in the following year, developments in 2010 will be crucial when it comes to monitoring how counties and municipalities manage to bring their deficit into balance. It will also be important to monitor the spread of financial risks between the councils, and the varying options to tackle the risks.

In Italy, some regions have been assigned additional resources to fund their health sector budgets. New norms have also been established to ensure that regions align with national health targets.

The Czech Republic has cut health insurance contributions, and reductions are also considered in Hungary. In 2007, Montenegro decided to cut health insurance contribution rates from 12 to 10.5%. Germany and Austria have introduced state subsidies to tackle growing social health insurance deficits (Boxes 4 and 5).

Box 4: Measures to tackle the plunge in social health insurance revenue in Austria

Social health insurers in Austria reported an accumulated deficit of approximately €1.2 billion in 2008. Several of the health insurance funds expect additional budget deficits in 2009, owing to further growth in expenditure and declining revenues due to the current economic slowdown. Government plans indicate an increase of state subsidies from 2010 onwards, amounting to €450 million. In addition, a structural fund of €100 million per year is to be established. Subsidies from this fund to health insurers will be linked to efficiency performance.

Box 5: A new central fund in Germany introduces more government leverage on social health insurance

In Germany, the crisis has coincided with the establishment of a new central fund on 1 January 2009, which will pool all social health insurance contributions at federal level. A standard contribution rate (15.5% of gross income, up to an income ceiling) had been set initially, but the forecast revenue base – based on 2007 figures and calculated in October 2008 – has been corrected downwards to adjust for declines in total wages, wage averages and employment. The second stimulus plan contains a further tax-based injection of funding, to lower the contribution rate to 14.9%. The government loan subsidy to the social health insurance scheme will be gradually increased up to €14 billion in 2012 (Federal Ministry of Health, 2009). Establishment of the new central fund facilitates more centralized monitoring of social health insurance revenues and increases the opportunities to effect transfers from taxed sources. The financial crisis may prove to be an important test phase for its implementation.

Coverage of services and population groups will be significantly affected. Some countries have made plans to extend coverage and some to reduce it. For instance, Georgia has extended its Medical Assistance Programme (a fully subsidized voucher for health insurance covering a government-defined package of basic health care services) to an additional 200 000 people below the poverty line. Slovenia introduced state coverage of health insurance contributions for vulnerable population groups in January 2009. Serbia is at risk of losing public coverage of some of its vulnerable population groups owing to financial constraints. However, the health ministry is continuing to implement an action plan to protect the health of its Roma population, one of the most vulnerable groups. The Republic of Moldova is currently considering refining its existing state subsidy for health insurance contributions, to ensure a sharper focus on the most vulnerable groups.

A particular concern remains over the role of private funding in adjusting for public health funding deficits. In Portugal, a political initiative has suggested abolishing or decreasing user fees in emergency and hospital care, and Slovenia is considering lowering health service user charges in general, but in most central and eastern European countries private sources of funding will be increased. Estonia, for instance, is implementing a cost containment package which includes cuts in public administration costs and reductions in sick pay benefits. It has also introduced value added tax (VAT) on pharmaceuticals. Hungary is considering raising VAT and excise taxes. Croatia is planning increases in user charges for pharmaceuticals (Box 6). Latvia is increasing or introducing user charges for primary and secondary care and co-payments for pharmaceuticals. Georgia is launching a state-subsidized voluntary health insurance scheme (Box 7).

Box 6: Government plans in Croatia to increase health service user charges and prescription fees and promote complementary insurance coverage

In order to reduce the health insurance deficit, the government plans to increase co-payments for pharmaceuticals and service user charges by up to 20% and promote the uptake of supplementary health insurance. Certain population groups, particularly the vulnerable and socially deprived, will be exempt from co-payments and user charges. The increased charges apply to health insurance members without supplementary state health insurance cover. Supplementary state health insurance premiums will increase, dependent on incomes. The plans are opposed by some of the opposition parties and approximately half of all the general practitioners throughout the country, who fear that higher prescription fees and higher supplementary insurance premiums will deter patients from seeking needed care.

Box 7: Government-subsidized private health insurance scheme in Georgia

In March 2009, Georgia launched a voluntary state-subsidized health insurance scheme which covers emergency care and a variety of primary care services for Georgian citizens between 3 and 60 years of age. Two thirds of the insurance premium will be covered by the state. The insurance policy is provided by private health insurance companies.

Health care resources

Human resources

There is a mixed picture when it comes to human resources for health. In many western European countries, the health sector is one area that experienced a growth of professionals during 2008. For instance, the Austrian region of Tyrol reports a 10% increase in employment of health professionals during 2008. Germany reports an overall increase of employment of health professionals during 2008 (33 000 new employees, + 3.2%), although data from the Federal Agency for Employment show an upward trend in unemployed physicians, dentists and other health professionals since November 2008 (not seasonally adjusted).

Measures vary when it comes to increases in levels of pay of health professionals. Bulgaria and Hungary have frozen salary levels of health professionals in state-owned hospitals and the ministry of health, and Hungary has introduced a marginal cut of health professionals' wages for those who earn above a certain threshold, whereas Finland and Greece have increased the levels of pay of health professional staff, following agreement with the trade unions. Salaries of health professionals in Romania are set to rise by 7% (Economist Intelligence Unit, 2009). Slovenia is implementing an increase of health professional salaries that was planned before the crisis and which is now expected to put pressure on the health insurance budget.

Health care providers

We have so far no evidence of trends in reducing health care provider capacity as an effect of the financial crisis. Reducing hospital capacity by closing rural hospitals is currently being considered in Latvia but there is considerable opposition to these plans.

In Portugal, the ongoing reforms affecting providers in primary, secondary and long-term care will likely be sustained in view of the crisis, as they are expected to yield budget savings (Portuguese Republic, Ministry of Finance and Public Administration, 2009). Most countries in the Region are currently expecting to continue implementing health system reform programmes in spite of the crisis.

Several economic stimulus packages in western Europe (e.g. Danish, French and German plans) focus on boosting public investment in infrastructure, which might open up opportunities for capital investments in health care facilities (Box 8). Greece is promoting private-public partnerships in its infrastructure investment initiative (which includes hospitals) but public funding for these initiatives is limited.

Box 8: Stimulus package 2: Opportunities for hospital investments in Germany

German hospitals have accumulated an investment halt of billions of Euros in recent years. The second stimulus package contains a €50 billion investment programme, for which €10 billion are earmarked for local investment programmes that can be used for hospitals regardless of form of ownership. The regions – which are responsible for capital financing of hospitals – are expected to share 25% of the investment costs (Federal Ministry of Health, 2009).

Pharmaceuticals

The pharmaceutical market is affected because the financial crisis is exerting upward pressure on drug prices. In Lithuania (Box 9), price rises are linked to VAT increases. Kazakhstan, the Republic of Moldova and Ukraine report pharmaceutical price increases of up to 30%. The general upward pressure on prices across the Region is exacerbated by country-specific currency depreciations, as in the case of Armenia (Box 10).

Box 9: VAT increases in Lithuania push pharmaceutical prices and health care expenditure upwards

In December 2008, Lithuania removed the VAT rate of 5% on pharmaceuticals. Drugs are now taxed at a standard rate of 19%, leading to a close to 14% increase in pharmaceutical prices and a 10% increase in health care expenditure in December 2008 as compared to December 2007.

Box 10: Inflationary pricing in Armenia

Consumer price inflation in 2008 stood at 9%, a relatively high level, but dropped to 5.3% at the end of the year. However, in early March 2009, Armenia abolished the fixed exchange rate for the Armenian dram and introduced a floating rate. This led to an immediate increase in prices of commodities such as oil and food of between 20 and 30%. There are concerns that this will affect the price of essential drugs, such as antibiotics and vaccines.

Health care provision and utilization

Concerns about the effect of the crisis on the utilization of care are only now emerging. In Italy, the risk of excluding patients from dental care that traditionally comes with high levels of user charges and correspondingly heavy financial burdens on household budgets has led to a regional initiative to protect dental care for vulnerable population groups (Box 11).

Box 11: Regional initiative to combat the risk of excluding patients from dental care in Italy

The Italian Society for Dental Care warns that the current crisis has already been affecting the number of patients asking for dental health treatments, enhancing fears of negative medium- and long-term effects on the people's health. In December 2008 the regional council of Lazio launched a "social dental care" programme, aimed at meeting the needs of those in economic difficulties.

In the eastern part of the European Region, there are substantial concerns about increases in the price of health services and pharmaceuticals. In Ukraine during first two months of 2009, for instance, health service prices increased by more than 30% compared with the same period in 2008. Price increases have a considerable effect on private health expenditures (in the form of official user charges and co-payments, payment for medicines, or informal payments) in numerous countries in the Region, and it is feared that this may deter patients from seeking the necessary care as it becomes unaffordable. Even before the crisis, in 2005 WHO recorded private health expenditure as accounting for more than 50% of total expenditure in Albania, Armenia, Azerbaijan, Cyprus, Georgia, Greece, Kyrgyzstan, Tajikistan, and Uzbekistan (WHO, 2008). Various consequences of the crisis, particularly the downward pressure on overall public spending and rising prices for key inputs such as medicines, are already creating the potential for forcing greater reliance on private financing sources throughout the Region.

Health-related lifestyles

One of the fears is that increases in prices of essential commodities will force consumers to adopt lifestyle changes that may affect their health. The World Bank reports the double threat of globally rising oil and food prices since 2006. Rising prices will threaten the health of households that spend between 50 and 90% of their income on food. The food situation is critical for the health of children and young people, and for pregnant and nursing women (World Bank, 2008b). Although oil prices have fallen between mid-2008 and early 2009, they are expected to increase substantially as the crisis unfolds further (UNEP, 2009). Oil price rises will further exacerbate those in food prices, owing to their effects on production, distribution and transport. The ongoing food crisis has increased price inflation by about 40% in Uzbekistan and 30% in Kyrgyzstan (Box 12).

Box 12: Rising food prices in the Republic of Moldova and Kyrgyzstan.

Following a drought in 2007, food prices in the Republic of Moldova increased by 60% from January 2007 to January 2008. In May 2008, food price inflation was estimated at 24%. For the poorest households, food constitutes 80% of total household income. The government extended a fixed one-time subsidy to all farmers to support agricultural activities in 2007.

Food price inflation in Kyrgyzstan amounted to about 32% in 2007, the highest value in the European Region. The government has introduced nutritional supplements and cash transfer programmes for the poor and vulnerable groups, including pregnant women and children under five years. The food crisis, seasonal fuel imports and agricultural modernization will require an estimated US\$ 400 to 475 million (World Bank, 2008b).

Policy concern in the WHO European Region over the burden of disease caused by alcohol and drug use and mental illness has been substantial and may be further triggered by the crisis: in Sweden, about 30% of the population is estimated to suffer from some form of mental health problem (Ministry of Health and Social Affairs, 2009).

Similar concerns relate to the abuse of illicit drugs. In Italy, for instance, a possible relation between increased heroin substance abuse and the financial crisis is being signalled (Box 13).

Box 13: Can the increase of heroin seizures in Italy be related to the economic crisis?

A causal relation between heroin consumption in Italy and the current crisis has been hypothesized, based on the argument that drug dealers seem to be pushing high-dependency drugs such as heroin onto the market to ensure a more reliable source of income. The hypothesis seems to be supported by an increase in heroin seizures by the police and an increase in demand for drug addiction-related services in health care facilities.

Overall, evidence of the impacts of the financial and economic crisis on health and health systems is currently sparse throughout the Region, suggesting a need for further continuous and systematic monitoring.

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⁵ All URLs accessed 24 March 2009

Annex 2

General recommendations for anti-crisis packages

- Establish an anti-crisis unit within the health ministry that can collect and analyse information in real time, rapidly explore strategic options and discuss (when needed) the technical feasibility and political economy of potential practical measures. Address the reorientation of activities and the reallocation of resources as much as possible, to ensure that core activities are protected and pro-poor measures are increased or extended.
- Processes are sometimes as important as content; keep stakeholders informed. Develop arguments to support advocacy efforts with other government departments, main stakeholders and partners even before you have drawn up a well delineated “anti-crisis package”. Maintain a permanent dialogue with trade unions, consumer associations and other bodies to help build consensus and in any case “feel the pulse” of society regarding the crisis.
- However good they may already be, improve direct lines of dialogue inside the government and maintain especially close links between the ministries of health and finance. Advocate for protecting health budgets and for the inclusion of health- and environment-related investments – especially cost-reducing investments – in economic recovery plans.
- Revise existing development plans and programmes to reduce investments in sophisticated equipment and infrastructure and increase support to more labour-intensive activities. Review the skill mix and update the competences of the workforce for them to perform better under crisis circumstances.
- Monitor carefully and, where appropriate, try to maintain employment in the health sector. If cost-beneficial, explore options to involve staff in preventive and primary care services. Negotiate with trade unions and staff representatives and develop initiatives to promote home-based care and other services for the elderly and the most vulnerable.
- Prepare for reallocation of resources to core health and health systems priorities. More specifically, reallocate funds in support of prevention of communicable diseases, including immunization and prevention of outbreaks.
- Get all stakeholders ready to rationalize and do better with less money. More specifically, explore options and implement measures to reduce the cost of medicines and medical devices. Develop “anti-waste” campaigns to promote all form of savings (energy, medicines, etc.) among health workers. Rationalize activities and organizational structures by avoiding duplications. Explore economies of scale and coordinated efforts.
- Encourage the establishment or improvement of facility management support teams to produce specific technical guidelines and directly help managers of hospitals, primary care centres and other health services to adjust to the new context by reducing costs while protecting quality and safety.
- Explore and identify options for maintaining and expanding access to necessary medical services. Whenever necessary, revise benefit packages to cut non-essential benefits should that be necessary, so that the most cost-effective services are available to all. Use research to further clarify contentious decisions if adequate.
- Remind everybody of the importance of addressing health inequities (as emphasized by the WHO Commission on Social Determinants of Health and in the Tallinn Charter), including analysing and monitoring their causes through robust health indicators, as well as of improving access to health care services in order to reduce the risk of poverty.

Social and economic policies have an impact on how fairly health is distributed across the social spectrum and on the degree of protection from the disadvantages associated with ill health.