

The Impact of the Financial Crisis on Health

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I. Introduction

Poverty is directly linked to poor health through multiple routes. Thus, the global financial crisis has led to the concern that the economic crisis could bring a health crisis in its wake, which would undermine the important advances made in health care in Africa in the past decade.

The Crisis is not only financial

Understanding the routes of potential impact on health of the reduction of income for individuals and countries, globally and in Africa, as a consequence of the Crisis, provides the framework for action to mitigate against this threat becoming a reality. The pathways through which the recession in rich economies effects Africa are central to overall solutions, but, whatever route they take, the ultimate impact on health is similar, whether it is from a decline in export growth, commodity prices; foreign direct investment, exchange rates, capital or remittances.

- African government revenues decline, reducing expenditure in infrastructure that enhances health, such as improved water supply (to overcome diarrhoea) and electricity (offsets indoor air pollution, a major cause of pneumonia), reduction in informal settlements and support for agriculture;
- Emerging social nets for the poor are damaged leaving more people without the basic necessities, while the chances of the socially excluded and marginalised of moving out of their trap are blocked – indeed, their numbers are increased;
- More households dip below the poverty line from the impact of job losses leading to increases in malnutrition and vulnerability to other diseases, while food security declines;
- Household income declines due to job losses, reduced remittances etc. so that the health of those above the poverty line is also impacted on;
- Fewer health workers are employed and less is spent on health infrastructure, maintenance and running costs. Reducing running costs makes health spending inefficient as health workers lack supplies and other essentials and referrals become more difficult and workers become demoralised and frustrated and leave;

- As staff costs are often fixed by permanent public sector employment, staffing takes an increasing share of the budget, reducing funds for non-staff costs, such as medicines and supplies – yet, already half of Africans do not have regular access to essential medicines;
- Medicines and commodities become more expensive to import if local currencies are devalued;
- Funding pressure leads to a focus on financing for medicines, but as other aspects of the health system are impacted, health system performance is weakened, leading for example to reduced adherence to chronic disease care;
- Health service utilisation is reduced as governments reduce services and households are less able to buy care;
- People delay seeking care to avoid transport and health care costs, leading to more people presenting with more advanced disease, costing more to treat and increasing the need for hospitalisation;
- The contribution to care by non-state non-profit providers is reduced and use of private providers falls, putting pressure on the public system;
- Development assistance for health is reduced or delayed as tax revenues decline in developed countries and savings are sought to counter the effects of the crisis and to fund the counter measures;

The impact of all the various consequences of the crisis will not be felt equally by African countries, nor within countries, with the most vulnerable being hit the hardest. Also, the political economy of disease in Africa is such that the consequences tend to work together to reinforce each other in a vicious cycle of ill health, be it HIV/AIDS, Tuberculosis, Malaria, Malnutrition, Maternal and newborn deaths or locally endemic diseases. Poverty and weakened health services also have a compounding impact.

II. Have the Concerns about the Health Impact of the Financial Crisis Become a Reality?

Thus far there are concerns, but little in the way of strong evidence of health and health service impacts, but that certainly doesn't mean that there are none now, or that we should not be concerned about the future. One of the real difficulties is

that the kind of information needed to assess the effects of the financial crisis lags behind real time – health expenditure and disease and mortality data.

Increased poverty, reduced household income, job losses and reduced remittances have an effect on the social determinants of health and on access to health care and hence on health.

On the positive side we have seen global commitment to health reach unprecedented levels in the last decade, with more African countries starting to increase the proportion of their government expenditure on health and development assistance to health more than doubling and the emergence of The Global Fund and GAVI, the Bill and Melinda Gates Foundation and latterly the International Health Partnership. This has been matched by improvements in child health, AIDS and malaria interventions and care and commitments to universal access to AIDS care for all who need it by 2010.

However, maternal mortality, the best indicator of the performance of health systems and newborn mortality remain a concern. The urgent need for health systems strengthening and dealing with the Human Resources for Health crisis remains, while achievements are at risk and progress needed is jeopardized.

There is still a huge gap in financing to achieve the Health Millennium Development Goals – and this is an important issue: The aim in health and health care had not been to maintain the status quo – a huge burden of preventable disease and death, but to impact on disease burden through increased investments and commitment by both African countries and donors. Therefore, it is reasonable to reflect that staying the same actually constitutes a negative impact for which the financial crisis must be at least a fair share of the responsibility. Flattening of the slope of the trajectory of expenditure is something to watch out for. Absolute expenditures become important because the same per cent of a reduced national budget constitutes a reduction.

Past experience in health of structural adjustment and commitments being made when publicly expedient and then letting them slide still sits raw. But, this is offset by global recognition of investment in health as an investment in economic development. Also, development partners have become more aware of their responsibilities to keep to commitments and about the architecture of development aid. This has come with commitments not to allow the financial crisis to impact on promised development aid for health services and disease, but there have been indications that aid will be cut. Either way, G8 countries are still lagging behind funding their Gleneagles commitments, with the shortfall estimated at US\$ 34 billion globally before the crisis. Expenditure in many African countries remains below the critical minimum needed to fund essential basic health care. African countries are not in a position to bridge this gap – they simply do not have the fiscal space.

The High-level Taskforce on Innovative International Financing for Health Systems has highlighted the critical need to raise up to an additional US\$10 billion per year to spend on health in poor countries, much of it in Africa. It points out that the cost of not raising this additional funding is dire – 4 million children dying each year, who otherwise would have been saved, and 780,000 avoidable deaths of adults, including 322,000 women dying as a result of giving birth. Experience has shown that the often blamed “lack of absorption capacity” is not the key impediment to use of funds, the architecture of donor funding not uncommonly being an impediment.

It is still early to judge whether public health services and access to health care is being maintained. If medicines purchasing is used as an indicator, then services are being maintained, at least in the short term. But this does not offer room for complacency. We have still not seen if country expenditure on health services will be maintained and grown, likewise for development aid. Similarly, we have not seen whether the shortfalls in the commitment to provide Anti retroviral

treatment for all those who need it by 2010 will be bridged. Nor do we know if support for primary health care system strengthening to achieve adherence with care will be sufficient.

It is important to recognise that continental or regional economic community aggregates may belie stress on individual countries, especially those that have suffered the most as a result of the crisis and potentially those who have a heavy dependence on donor funding.

In sum, we need to recognise the commitments made to protect health in the face of the economic crisis, but not allow any lack of immediate evidence to delay action needed to ensure that impact is offset. Certainly 2010 will be a critical “litmus test” year for government budgets as financial planning for this year will have been done after the crisis and health allocations need to be thoroughly analysed.

III. Actions Needed to Protect Health and Health Care - *Key Action Points*

A wide range of actions need to be taken or reinforced by national, continental and global stakeholders. It is imperative that these are pro-actively implemented, rather than wait and create realities for negative historic analysis.

1. Determinants of Health

- As ongoing global and continental action is taken to address the fallout of the financial crisis, priority should be given to measures that are pro-poor and that create jobs;
- Food security and support for agriculture, especially high health yield foods, must be a priority;
- Infrastructure decisions should give a high priority rating to those developments with the greatest health benefit;
- In all measures – jobs, infrastructure, social nets and health care access – implement measures in a manner to that avoids “the inverse care law” – that those who would benefit most are the least likely to receive it;

2. Health services

- Countries should prepare costed health service plans, including Human Resources plans that clarify the mix and numbers of professional, mid and community health workers. Development partners should prioritise filling the gaps in agreed national health strategies;
- Efforts achieve to strengthen rural services should not be reduced in response to more organised and vocal urban challenges to reductions;
- Health systems should move towards universal coverage and away from payment at the time of needing services and offset the possibility of the poor being faced with catastrophic health expenditure;
- Countries should introduce revolving contract employment in the public service to match cycles of funding – this to overcome the concern of making commitments that may not be able to be sustained;

3. Pharmaceuticals

- Commit to making the concept of Global Public goods a reality;
- Implement financing commitments to encourage the pharmaceutical industry to develop medicines needed by Africa and at an affordable price;
- The African Union Pharmaceutical Manufacturing Plan for Africa should be supported;

4. Financing

- Maintain and grow development aid for health and improve its architecture in line with the Paris Declaration on Aid Effectiveness – reducing the transaction costs and providing long term, predictable aid;
- Implement innovative health financing systems of the kind recommended by the High Level Task Force on Health Financing;
- Partners should fund public health services, but when doing so should seek a commitment from countries that they will not reduce their own funding for health as development aid increases;
- Countries should submit more ambitious proposals to the Global Fund to Fight AIDS, TB and malaria in line with their need and the HS windows of this and other Funds should be expanded and made easier to obtain;

- Balancing rewarding good governance and stewardship and nurturing others forward is a difficult balance, but routes to supporting fragile states and closing national variations between needs and funding are important;
- Greater use should be made of needs based indicative funding for health versus competitive funding;

5. Monitoring and evaluation

- Develop real time monitoring systems on key indicators of potential impact of the global financial crisis on health and health systems;
- Countries should commit to being forthcoming with timely information needed to track the impact of the financial crisis on health;
- Commission research targeted at achieving a better understanding of the Impact of the global financial crisis on Health;
- Early warning systems should be in place, especially for impact on individual countries;
- Countries should share their experience – both positives and problems - on dealing with the health and health service implications of the crisis;

6. Leadership

- Global advocacy by world leaders and organisations to stress the importance of health to development and its need as an intrinsic good and basic right, to sustain global momentum and citizen support;
- The African Union Health Strategy should be supported;
- Strong leadership is needed from Ministries of Finance and of Planning to give effect to the value of health as a productive investment and human right and for pro-health policies;
- Strengthening of Ministries should not be impeded by the crisis, nor should measures to strengthening national and local institutional management capacity;
- Domestic policy formulation and ownership should not be overridden by international technocracy;

- International agreements to create a viable response to the bleeding of Africa's health professionals need to be reached and implemented and there should be a commitment to having no unemployed health professionals;
- All stakeholders, including the private for-profit and not-for profit sectors and global and local civil society should be integral part to the response to the crisis;

IV. Conclusion

African countries and development partners should reaffirm their commitment to or, as they see fit, support / endorse the actions proposed to protect health and health care from the effects of the global financial crisis and the measures taken to address it.

The African side and Development partners, under the auspices of the Africa Partnership Forum (APF), should continue to investigate further the impact that the global financial crisis is having on their efforts to support attainment of the Millennium Development Goals (MDGs) and other globally agreed health and health care goals and the measures being taken to overcome these and African partners should do likewise for the continent.

*NEPAD Secretariat
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