The impact of the economic crisis on health care systems

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The current global economic crisis has given rise to concerns about its implications for health care sector and the ability of the health systems to provide adequate and qualitative services to the citizens. Experiences from the past are indicative of the impact that deep economic recessions have on health services. More specifically, four recessions of the twentieth century and their effects on health have been studied: the interwar Great Depression, the recession of the late 1970s and 1980s, the collapse of the former European socialist countries in early 1990s and the East Asian financial crisis in the second half of the 1990s (Levy and Sidel 2009, Stuckler et al. 2009).

The first of these recessions, the Great Depression, caused serious public health problems in the USA. Public health policies failed to address the impact of unemployment on child and maternal health during the 1930s. The welfare provision aimed at pregnant and nursing mothers was not effectively counteracting the adverse consequences of the economic depression, illustrated by the rise in maternal mortality (Webster 1985). Furthermore, curtailment of health budgets, reduction in health personnel, and limiting of projects, such as preventive campaigns against diphtheria, typhoid fever, etc. were reported (Dublin 1932, Editorial of American Journal of Public Health and the Nation’s Health 1934).

The recession of the late 1970s and 1980s had serious consequences for the Third World countries. The Structural Adjustment Programs (SAP) implemented by the heavily borrowing countries under the auspices of the IMF and the WB, had negative effects on health sector. Cuts in public expenditure, and the emphasis on cost recovery, made public health services inaccessible to the most vulnerable social groups, especially in rural areas. The problem was further aggravated by the increased dependence of adjusting countries’ health sectors on external support (Alubo 1990, Asthana 1994, Stewart 1989, Woodward 1992, Logie and Woodroffe 1993).

In early 1990s, during their transition from a command-and-control system to a free-market capital economy, many of the ex-socialist countries of the Central and Eastern Europe adopted a process of rapid economic reforms, known as “shock therapy” (Murrell 1993). The consequence of this strategy was the deterioration of health services and health conditions reflected in increasing mortality and morbidity (Field 1995). The Semashko type of national health system inherited at the beginning of the 1990s begun to change towards a Bismarckian social insurance model. The exaggerated emphasis placed on the efficient management of resources and expansion of financing sources, downgraded the important problem of equity in access and improvement of health status to a second priority. The transition to a social insurance system raised questions at a moment when the basic prerequisites, such as a strong economy with a high rate of employment and a sufficiently high wage level to allow for insurance contributions, did not exist. The introduction of market elements and the expansion of the role played by private payments, whether in the form of private insurance or in the form of additional insurance, deductibles, co-payments or direct payments, negated the criterion of equity (Figueras et al., eds 2004).

The last case study for exploring the impact of economic crisis on health sector is the East Asian crisis which occurred in 1997. At the time, some countries of Latin America, including Argentina and Mexico, were also plagued by fiscal deficits. Evidence from Indonesia (Hotchkiss and Jacobalis
1999, Simms and Rowson 2003, Waters et al. 2003) shows that between 1997 and 1999 there was a 20% reduction in per person spending and a 25% cut in government health spending. The devaluation of rupiah reduced even more real public health expenditure and household purchasing power. Between 1996 and 1997 there was a 25% fall in real spending on drugs that happened in parallel with price increases of about 170%, resulting from rupiah’s devaluation. The use of health care services by children from poor backgrounds dropped by about 17% compared with 8% in children from wealthier settings. Immunization coverage was declined almost 25% between 1995 and 1999. Rates of use of services by low-income households fell between 26% and 47%. From 1997 to 1998, outpatient contact rates declined by 25.4% for public health facilities and 9% for private facilities. In this context, the negative effects of the economic crisis on household purchasing power and government revenues undermined the viability of the government’s attempt to introduce managed care health reform. Similar trends in relation to cuts in health expenditures and lower utilization of health services were also observed in Korea (Yang et al. 2001).

In Latin America, the experience of Argentina highlights that the 2001 economic crisis exacerbated the problems of the health system. Provincial inequities in terms of health status, access to services and financing widened, and the health system became more fragmented and inefficient. Health insurance coverage decreased sharply and access to services was restricted, especially for the poorest, who suffered a decrease in health insurance coverage three times greater than that of the non-poor. The crisis also threatened the effectiveness of priority public health programs and services, and worsened the economic and financial situation of many insurers and service providers, thus increasing the debt prevailing in the health sector. In addition, total health expenditure per capita, decreased from US$669 in 1997 to US$242 in 2002 (Cavagnero and Bilger 2010, World Bank 2003). In Mexico, the 1995-6 crisis reduced income and resources for goods that improve or maintain health, such as out-of-pocket medical spending or nutrition. It also reduced public sector funds for health services, which affected groups dependent on those services. As a result, mortality rate increased by 5-6 percent among the population aged 60 and over, and by 7 percent among children aged 0-4, compared to the expected based on pre-crisis trends (Cutler et al. 2002).

The impact that the recent economic crisis of OECD countries has on health systems is well summarized in a report published by the WHO in 2009. In countries that have required emergency assistance from the International Monetary Fund, the spending restrictions imposed during loan repayment, negative GDP growth, substantial increases in unemployment and decreasing revenues impact on household income, government spending and the capacity of other actors in the private and voluntary sector to contribute to the health effort, despite the fact that all this is happening at a time of greater health need. Due to the drop in household income, patients turn from the private to the public sector, and as governments feel the financial need to cut back and public sector services are underfunded, quality of care deteriorates and access to services is restricted. Reductions in total expenditure have an impact on the composition of health spending, resulting in savings in salaries, infrastructure and equipment. In less developed countries, diminishing resources are accompanied by currency devaluations which increase costs in local currencies of all imported health expenditures including medicines and biomedical technology. In addition, in these countries, official development assistance from individual donors has fallen massively.

The above evidences indicate the negative effects of economic crisis on health care sector. This is especially true for countries where the crisis took the form of a fiscal and debt crisis. The fact that the development model of countries such as Greece is characterized by slow progress, weak
industrial base, the long existence of agricultural structures and institutional backwardness, make them vulnerable to international fluctuations and turmoil, especially in relation to the monetary exchange rate and fiscal sector, i.e. the sector which had financed their growth and where the signs of the international crisis were evident. In the context of the EU, the solution chosen to the problem is internal devaluation and cuts in social expenditure and more specifically cuts in pensions and health care (Sakellaropoulos 2012).

Nonetheless, it can be argued that under certain circumstances, economic shocks is possible to create windows of opportunity for significant policy change, by disrupting the self-refentiality of the health care system. Health system-specific deficits do not suffice in explaining health reforms. The paradigm of Greece and the health sector reform initiatives undertaken after the Memorandum show that the role of economic shocks is crucial in promoting changes, in the case that political actors, decision makers and stakeholders appear to disagree fundamentally over the values and the directions of health reforms and “party thinking” blocks the implementation of changes (Economou 2012). Yet, this is the one side of the coin. The other side concerns the question about the direction of the changes and their impact on the effective and efficient functioning of the health system, as well as on the equitable access to quality services. From this point of view, it can be argued that most of the reform measures adopted in the Greek health care sector are in the right direction. They put emphasis on the efficient functioning of the health system, and they try to remedy the shortcomings of public primary health care services, to rationalize hospital funding and professionalize its management, and to better control pharmaceutical expenditures. However, there are many other measures aiming at the privatization of selected public services and the increase or the introduction of new user charges and as a consequence they raise serious questions about the accessibility of health services, especially for low income citizens (Economou 2012). In addition, the fact that the government called for cuts in health services budgets while at the same time an increase in utilization of public health services is observed, puts the low income households and the vulnerable groups at risk (Kentikelenis and Papanicolas 2012).

The present volume reflects on the health care reforms introduced in European countries in the era of economic crisis. More specifically, Mourão et al., analyze the Portuguese health policies and health system, in the context of the present economic, financial and social crisis. Based on the speeches of policy-makers and experts about the processes of governance and contingency measures, they consider the criteria of efficiency and effectiveness. Verspohl examines the issue of the privatization of health services and the consequences of the introduction of market instruments in health systems. Her paper studies the power of ideas within the framework of structural reform pressure and institutional path-dependency in two countries representing the two ideal types: the Netherlands for Social Health Insurance and Sweden for the National Health Service. Geitona presents an overview of the rewarding innovation pharmaceutical regulatory systems in Greece, focusing on recent major pharmaceutical reforms. Liaropoulos et al., discuss the proposal for the reform of Greek Hospital Sector, also known as “hospital mergers”. They propose a new pattern of organizing hospitals in groups based on the reform of emergency care and the management of five main chronic diseases, namely AMI, Stroke, Cancer, Diabetes Mellitus and COPD. Minogiannis, in his paper argues for the necessity of a new managerial approach to be implemented in Greek public hospitals, which would sufficiently answer to the main four problematic conundrum of today: the perverse unaccountability of medical subjectivity, the obsolete management model, the lack of human resources management tools and the unhealthy financing of hospitals.
Bibliographical references
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