

# The Financial Crisis and Global Health

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It's hard to see your way through a storm when you're in the middle of one. Such is the predicament of the global health community, as we sort out what the financial crisis will mean for the health of poor people in developing countries months – even years from now. While nothing is known for certain, most agree the impact will be substantial and negative. “After wars, plagues and natural disasters, financial crises kill the poor the most,” said Liliana Rojas-Suarez, senior fellow at Center for Global Development (CGD) and an expert in financial markets. There are some measures that can be taken to mitigate the damage (such as expanding and developing safety nets), but the main task is to get more health for every dollar.

Let's start with aid. Will politicians choose to offset a tiny fraction of the \$700 billion bailout by reducing official development assistance (ODA) in general, and funding for health (which has grown disproportionately in recent years)? The evidence suggests the answer is yes. Research from CGD fellow David Roodman shows that after each previous financial crisis in a donor country since 1970 (which includes Japan, Finland, Norway and Sweden), the country's aid declined. Foreign assistance tends to be pro-cyclical – that is, shortfalls in aid and domestic revenue tend to coincide. And as InterAmerican Development Bank health expert Amanda Glassman said, “Aid for health is no exception.” But don't expect governments to announce cuts in foreign assistance; the contraction will be invisible, with disbursements quietly dragged out and a contracting seeing a slowdown.

A shortfall in ODA could have big repercussions. Poor countries rely on donor assistance to supplement domestic resources for essential services such as primary education and immunization – in many sub-Saharan African countries, close to half of all basic health sector funding comes from development assistance, and donors buy the vast majority of vaccines for many poor countries. If ODA decreases – especially during a period of global economic contraction – these services may be disrupted with an immediate negative effect on those in greatest need.

What about other types of external support for health, such as the funding – some of it raised on the capital markets – for research and development and specific health programs? It may be more difficult to persuade private sector partners such as pharmaceutical companies that it's worth their time and resources to participate in public-private partnerships now, when firms are likely to be strapped for credit and have an even greater need to show near-term returns to shareholders. The United States is by far the biggest player in R&D, spending more than \$28 billion each year on biomedical research, and much of the private investment in R&D comes from U.S. sources. The financial crisis will mean increased competition for research dollars; funding for the National Institutes of Health is unlikely to increase. The financial crisis may also dampen enthusiasm for relying on capital markets more broadly, a model the International Finance Facility for Immunization follows, for example.

So can we turn to philanthropy to fill the gap? Possibly. Against the backdrop of the crisis, \$16 billion was pledged to fight poverty in late September at the United Nations summit of world leaders to review progress on achieving the Millennium Development Goals. But some foundations that depended on now-defunct hedge funds for contributions and/or which invested in the shakier parts of the stock market are likely to face a sharp decline in their assets. This makes it doubtful that they will embark on new initiatives that they otherwise might have considered. Grant making may also be reduced.

Individuals who give to charities involved in overseas relief and development – whose collective giving is significant (according to the Hudson Institute, in 2006, the United States gave \$34.8 billion in private philanthropy) – are also likely to have less to give away this year and next.

What health programs are at risk? It will be difficult for donors to pull back from certain commitments, such as funding for HIV/AIDS, because cutting funding would most certainly force people off life-extending treatment. Legislation passed in July 2008 authorizes approximately \$39 billion over the next five years for HIV/AIDS (as well as \$5 billion for malaria and \$4 billion for tuberculosis), but at least half of that must be spent on treatment and care. Resources for prevention have always been scarcer and it's unlikely they will increase given the enormous (and expanding) cost of treatment, given that it is harder to measure prevention successes, and given the complicated U.S. domestic politics that surround the issue.

There are other health priorities that will likely struggle for support in economic hard times (and for which little funding currently exists), such as building the capacity of health systems in developing countries, and preventing maternal mortality, which is the leading cause of mortality globally among adult women of reproductive age. And little can be expected in the area of chronic disease even though the toll of cardiovascular disease, hypertension, diabetes and cancer outweighs that of infectious disease in nearly every region of the world, according to CGD deputy director for global health, Rachel Nugent.

Far more important than whether aid dollars rise or fall is the potential impact of the financial crisis on the fiscal positions of developing countries. The forecast is not encouraging. Slowed growth in emerging economies may dampen demand for imports, contributing to a drop in the prices of commodities. Leading indicators of global economic activity, such as shipping rates, are already declining at alarming rates. Taxable activities, such as trade, will be diminished and investment in low-income countries (LICs) may slow. Yet LICs have less ability to deal with the damage through counter-cyclical fiscal policies (such as issuing bonds). Private capital flows to emerging markets, which hit a record \$1 trillion in 2007, are also expected to drop to around \$800 billion by 2009, according a World Bank report. Developing countries are generally seen as risky borrowers, so when markets are jittery and lending is cut back, they lose more than most. Developing country budgets, therefore, are likely to be strained. And in times of austerity, health spending will be especially vulnerable.

Meanwhile, poor households will have to deal with inflation and high food prices. In poor countries, it is common for families to spend between 50-70 percent of their income on

food, according to the International Food Policy Research Institute. As domestic banks face pressures, families may find it difficult to obtain credit or access financial services. And a slowdown in the U.S. is likely to affect demand for labor and may lead to a decrease in the flow of remittances, which could have major effects on poor households, especially in Mexico and Central America. Money sent home by Mexicans living in the United States fell to \$1.9 billion for August 2008, according to the Bank of Mexico, a 12.2 percent drop from the same month last year.

Changes in both public and private expenditures could have a significant negative impact on the health of the poor in developing countries. The effects of economic shocks on health vary and can be ambiguous, but a new study analyzing the effects of economic shocks on child schooling and health from the World Bank shows that, “recessions, droughts and other economic downturns tend to have negative effects on both health and education outcomes for children in poor countries.”<sup>2</sup>

We have seen this happen before. A study<sup>3</sup> by Christina Paxson of Princeton University and Norbert Schady of the World Bank analyzed the impact of a crisis in Peru in the late 1980s on infant mortality. They show that there was an increase in the infant mortality rate of about 2.5 percentage points for children born during the crisis, implying that about 17,000 more children died than would have in the absence of the crisis. They suggest that the collapse in public and private expenditures on health played an important role.

A severe economic crisis in Argentina in 2001 led to drug shortages that prompted the government to import 21,000 doses of HIV drugs to be distributed in hospitals as an emergency measure, along with insulin from Brazil and over-the-counter drugs from Spain and Italy. At the same time, World Bank loans intended to support health sector reform were diverted to procure vaccines so that the country could maintain its immunization program. Health insurance and social security schemes faced severe financial difficulties while many bank accounts were frozen, leaving people with limited access to cash.

And the 1997 Asian currency crisis, which caused severe economic damage across much of East and Southeast Asia, had a negative impact on public health in Indonesia. Data from the World Health Organization show an almost 25 percent decline in immunization coverage rates between 1995 and 1999, the reduction being most striking in 1997-98. Expenditures by individuals on primary care from 1996/97 to 1999/2000 were reduced by 20 percent, and government spending was cut by 25 percent. Between 1997 and 1999, the use of health care services by poor children dropped by about 17 percent, compared with 8 percent in children from wealthier settings.<sup>4</sup>

So what is the global health community to do? In the short-term, we must consider the potential reorientation of aid dollars toward helping countries create viable safety nets in order to reach people who are made extremely vulnerable by shocks (e.g., populations who are most affected by high food prices, loss of remittances, and unemployment). According to the IMF, 56 countries reported targeted cash transfer programs for 2008, but only 39 had expanded their programs in response to fuel and food price increases.

Over the long-term, more emphasis should be placed on monitoring donors' financial contributions to global health and making it visible when they shirk earlier commitments. The field of global health is crowded with populist promises that often go unrealized, but good results depend on the predictability and reliability of resources. Strong advocacy for more sustained health assistance should also continue. The argument for investment in health is clear and compelling: good health improves labor productivity, facilitates learning, and contributes to economic growth and poverty reduction. And most fundamentally, donors must ensure that aid dollars reach the poorest, and that money translates into improved health.

“Like a hurricane, a financial crisis reminds us of how vulnerable we are, and how the most vulnerable are the least well protected,” said Ruth Levine, CGD vice president and senior fellow. It’s time to think about development assistance, not as a luxury to pursue when times are good, but as a powerful stabilizer when times are tough. The poorest need our help now more than ever.

## **References**

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