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GLOBAL HEALTH PERSPECTIVES SERIES: HOW WILL THE GLOBAL ECONOMIC CRISIS IMPACT THE HEALTH OF THE WORLD'S POOR?

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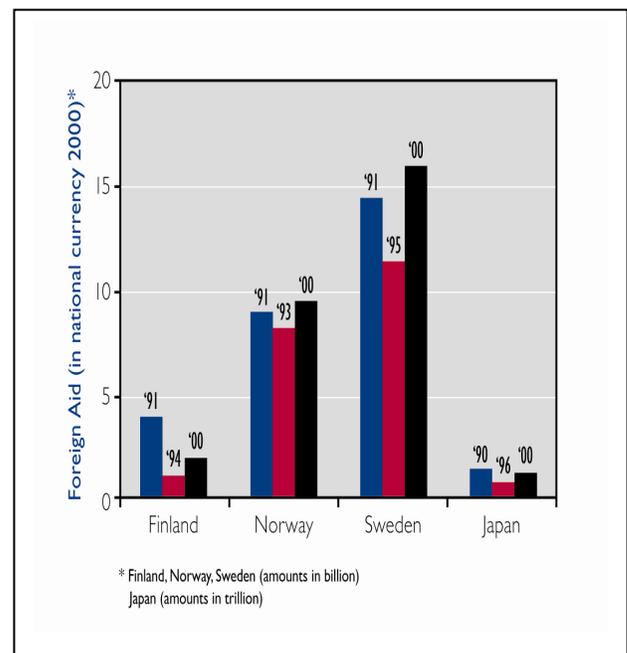
The effects of the economic crisis in the United States are being felt worldwide. While the downturn has largely occurred in wealthier nations, the poor in low-income countries will be the likely victims. Past economic downturns have been followed by substantial drops in foreign aid to developing countries.¹

Past economic crises have basically triggered two reactions from donor countries: cuts in government foreign aid and decreases in charitable contributions by large corporations and foundations (although decreases in the latter may be offset to some degree by contributions from private sources, who may be more likely to give, especially to charities, than in good economic times).² Even if charitable giving continues, government foreign aid has generally seen drastic cuts during past economic crises. Figure 1 illustrates the declines and recoveries that occurred in foreign assistance spending by Japan and Scandinavian donor countries after they experienced financial crises in the early 1990s.

In addition to decreased foreign assistance spending by governments, contributions from some major sources of private funding also fall as profit margins shrink in times of economic crises. Foundations, for example, whose endowments are often invested in the stock market, have fewer resources for making grants to health and social programs.³

While the decreases in foreign aid cited above do not tell us how much the funding of health programs

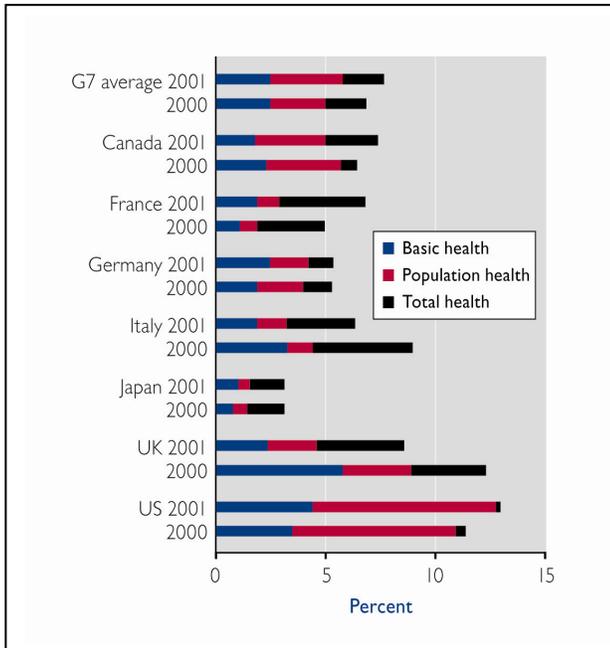
Figure 1: Post-Financial Crisis Foreign Assistance Funding, Scandinavian Donors and Japan, 1991–2000



declined, the following numbers suggest that health could suffer in a major way. Net overseas development assistance from member countries of the Organization for Economic Cooperation and Development (OECD) to developing countries amounted to almost US\$73 billion in 2007, according to the Organization's Development Assistance Committee.⁴ Any substantial drop in foreign aid to developing countries is likely to cut the funding of

As richer countries buy less from low-income countries, revenues decrease, which lowers worker incomes and raises unemployment. Health and social programs targeting the poor are often the first victims of budget cuts.

Figure 2: Health Spending as Percentage of Foreign Aid, G7 Countries, 2000–2001



health programs, many of which target poor people. As figure 2 shows, health priorities, including population and reproductive health, nutrition, and water and sanitation, received about 7 percent of development assistance support from G7 countries in 2000–2001, although this percentage was considerably higher – closer to 12 percent – for the United States. At the 7 percent level of support for health programs, a 50 percent drop from the 2007 net assistance level would reduce health support for developing-country health programs by more than US\$2.5 billion.

The global economic crisis also reduces health spending by developing countries themselves.⁵ In addition, governments may raise taxes to offset revenue losses, which may drive families living barely above the poverty line into poverty or even lead to unemployment when higher taxes are levied against small businesses.

Anecdotal evidence of the current global economic crisis in the trade and labor sectors is well documented by the news media, but it is too early to quantify and evaluate its consequences for health and social services. Speculative accounts about its effects are reported every day. *Newsweek*, for example, wrote about the potential impact in India and China,⁶ and the *New York Times* warned that the crisis may affect Africa and other regions especially hard.⁷ The news of the likely effects of the crisis on the social sectors in developing countries is not all

bad, however, as some major donors, including the United States, Norway, and Denmark, have pledged to keep their commitments and increase their foreign assistance, as they did in 2008.⁸ This at least may alleviate the anticipated cuts in funding of social services by developing-country governments themselves. Nonetheless, it remains prudent to consider the health impacts of past crises, which have been studied to some extent and provide insights into what can be expected during the current crisis. Past experience and donor actions may provide useful guidance about approaches to reducing the impact of the current crisis on the world's poorest people.

Lessons from Past Economic Crises

Experience with past crises in East Asia and other regions shows that they may harm human development in four ways – by 1) increasing poverty, 2) worsening nutrition, 3) reducing the quality and supply of education and health services, and 4) wiping out the meager savings and wages of poor people. The Asian economic crisis that began in Thailand in 1997 had detrimental social impacts across five countries – Indonesia (see box next page), Thailand, Cambodia, Laos, and the Philippines – including the following documented threats to children and families in each country:

- Declines in family income as formal sector jobs disappeared and workers took lower-wage employment in the informal sector
- Erosion of real wages through inflation sparked by currency depreciation, with a particular impact on the price of food and medical supplies
- Declines in government revenue as the tax base – particularly imports and company profits – contracted, severely limiting government capacity to maintain social expenditures
- The devastating effects of high costs of food and lower family income on early childhood nutrition, including poorer health, lower cognitive abilities, less learning, and lower lifetime earnings (as children pulled out of school in times of hardship rarely return to the classroom)

Indonesia: Health Impacts of and Response to the 1997/98 Economic Crisis

The 1997/98 economic crisis in Indonesia had numerous adverse health impacts, including:

- 20 and 25 percent declines in, respectively, personal and government expenditures on primary care from 1996 to 2000. The use of health services for primary care also declined.
- 25 percent decline in purchases of medicines.
- Declines in DTP3 immunization rates from 92 to 64 percent and polio rates from 97 to 74 percent. Vitamin A supplementation also fell. The declines most likely occurred among the poorer populations.
- 18 percent decline in the lowest wealth quintile in child visits to health facilities (vs. 7 percent decline in highest wealth quintile).
- 15.4 percent decline in lowest wealth quintile in contacts with outreach workers (vs. 9.7 percent in highest wealth quintile).
- A halt in the 1990s downward trend in infant mortality.
- Mortality increases in 22 of 26 provinces between 1996 and 1999.

(Source: AusAid. Impact of the Asia crisis on children: issues for social safety nets. Canberra: Australian Agency for International Development, 1999.)

Research also found that while malnutrition did not widely increase among Indonesian children, the nutritional status of adults substantially worsened.

The Indonesian Government and its donor partners, mainly the Asian Development Bank, responded to the crisis with a set of measures known as JPS-BK. The objective of JPS-BK was to mitigate the effects of economic decline on the health of poor citizens by maintaining spending on primary health care and the quality of services provided to the poorest sectors of the community. The Government and nongovernmental organizations also distributed free food and food at subsidized prices to counteract shortages. However, these health and food support efforts did not prove very effective.

Thailand was able to cope relatively effectively with the economic crisis and avert major declines in health status indicators. While the national budget declined 18.5 percent, social services and development programs were relatively protected from the budget revision.⁹ The budget for social services and development was reduced, but it increased as a percentage of government expenditures. The portion allocated to free medical care was increased in order to mitigate health care costs and impacts on the low-income population. Public sector hospitals did, however, experience insufficient supplies of drugs and commodities, negatively affecting the quality of care. Household expenditures on health services declined, while self-medication rose. Fortunately, there was no significant reduction in the supply of vaccines or in the percentage of children vaccinated; little effect on access to and use of health care and family planning services; and no major impact on health status.

Thailand's ability to generally withstand the potential health impacts of the crisis was perhaps due to its sound underlying infrastructure and social insurance policies, thanks to good use of donor and development funds. In 1997, the Thai Government launched a program to increase insurance and

expanded the program in response to the crisis – a critical step in ensuring a social safety net. Thailand's health sector reform was accelerated during the crisis with a US\$500 million Asian Development Bank (ADB) loan that strengthened the labor, social welfare, education, and public health sectors and was critical in expanding the health care safety net.

Cambodia and **Laos**, which are less developed than other Southeast Asian countries, responded to the crisis with budget and fiscal measures. Spending on health and education was reduced (although defense and security spending were maintained or increased). World Bank assessments in selected communities provided some insights into effects and coping strategies in the two countries. In Cambodia, drought and illegal rice exports led to severe food shortages in some areas. In addition, the economic downturn restricted opportunities to supplement incomes, and there were reports of growing numbers of women and children turning to prostitution, thus increasing the risk of rising HIV transmission and AIDS incidence rates. In Laos, high annual inflation and substantial price increases for commodities reduced incomes and purchasing power. People changed their diets or began to grow their own food. The costs of school supplies and medicines increased significantly, beyond the reach of many poor rural families.

Inequities increased, as more affluent farmers could sell at profits to neighboring countries, while poorer farmers saw declines in income and living conditions.

Several studies of the effects of the 1997/98 Asian crisis also note the impact on the health of the urban poor.¹⁰ The economic recession may have increased the rate of urbanization, thereby putting pressure on limited social and economic infrastructures and resources. In some countries, migrations from rural to urban areas of people, particularly women, seeking either employment or health care occurred.¹¹ In several countries, people shifted from private health care facilities back to public institutions, thereby increasing the pressure on already strained public facilities and weakening the public sector's ability to protect poor and vulnerable segments of the population. This situation was further compounded by rising prices for imported goods, including pharmaceuticals and food. Shortages and higher prices for these products resulted.

Protecting Health and Social Services during the Asian Crisis

In all the economies affected by the 1997/98 Asian economic crisis, macroeconomic policy responses and family and community coping mechanisms helped to shield families from the worst impacts. Although public health and family welfare did deteriorate, as seen in the above examples, the outcome could have been worse without the measures undertaken by the affected countries themselves and the international donor community. Programs funded by international development banks helped sustain social safety nets and other social programs that offset national budget cuts, thus cushioning the impact on the poor, especially women and children. Effective responses to the crisis occurred at several levels simultaneously:

- **Families and households:** Families used their resources to ensure adequate nutrition and education for their children. This included the reallocation of consumption to meet basic needs and a drawdown on savings. Households reduced expenses by shifting from private to public services in health and education.
- **National governments:** Several, but not all, governments protected operational expenditures on programs that provided services to children and women. This was in the face of substantial reductions in government revenue and was supported in part by loans for multilateral development banks' social sector programs. Governments,

together with donors, also put in place various mechanisms that counteracted the rising prices of medical supplies and costs of education to ensure access to primary care services and school enrollment.

- **International and bilateral donors:** Although not effective in all instances, restoration of confidence and access to international finance were seen as key to sustained recovery in all economies. The support from bilateral donors such as the United States, Canada, and Australia focused on the protection of the most vulnerable populations, especially women and children, and the provision of essential services and commodities. These included basic health services such as family planning and immunization, child welfare, basic education, reduction of child labor, and food security. The specific support provided by the development banks and international organizations is described below.

The World Bank and the ADB were the two largest international contributors to the financing of programs intended to mitigate the Asian financial crisis of 1997/98. Their assistance was in the form of long-term loans rather than grants. The Bank's loans provided mainly general government budget support, while ADB provided support specifically for the social and health/nutrition sectors. Both provided loans to fund specific social safety nets, social infrastructure development, or other social response projects.

United Nations agencies provided fewer funds but considerable expertise, especially in such areas as school dropout assessment, nutrient supplementation for infants, and generic pediatric pharmaceuticals (UNDP); back-to-school campaigns (UNESCO and UNICEF); integrated health and nutrition programs in primary schools (UNESCO); subsidized contraceptives and strengthened maternal blood supply management and obstetrics services (UNFPA); infant nutrition and educating mothers about feeding practices (UNICEF); and emergency food assistance programs (World Food Program).

The World Health Organization (WHO) sponsored a meeting in Thailand in March 1998 to discuss health implications of the economic crisis in the region and identified four major areas to be addressed: pharmaceutical production and management; health status and safety nets for the poor; financial risk protection; and management of human resources for health. The meeting also called for strengthening intercountry cooperation mechanisms, such as trade

of raw materials for local drug production, to address these issues.

The Current Crisis: Impact on Development and Health

The World Bank estimates that a 1 percent decline in developing-country growth rates traps an additional 20 million people in poverty and that 100 million people have already been driven into poverty by high food and fuel prices.¹² In September 2008, the U.N. Conference on Trade and Development reported that in many countries, concerns about inflation and the need for tighter monetary policies may not be well founded and may “lead to a further deceleration of growth.”¹³ Also, when government budgets come under pressure and household income drops, demand on public services will increase.

Association and the International Bank for Reconstruction and Development. The World Bank has initiated or strengthened a number of short- to medium-term programs, including the Global Food Crisis Response Program under the “New Deal for Global Food Policy.” The Bank is also undertaking a series of priority measures aimed at ensuring that basic food and health provisions are in place for poor households. A key action will be to help countries prioritize public expenditures in order to ensure that effective social protection programs are in place.¹⁶ The Bank has also approved loans and grants with fewer conditions than in the past.

In addition, the adoption in September 2008 of the Accra Agenda for Action by developed and developing countries should improve development assistance. The Agenda will make it easier for developing

Governments and donors should recognize the financial crisis as an opportunity to undertake financial and sectoral reforms. They should pursue a multisectoral response, with an emphasis in the health sector on primary care and prevention, which is far less expensive – both in the short and long terms – than curative care.

Source: WHO. The Financial Crisis and Global Health: Report of a High-Level Consultation. World Health Organization, Geneva 19 January 2009, p. 5. (http://www.who.int/mediacentre/events/meetings/2009_financial_crisis_report_en_.pdf)

Should donor funding decline, development partners such as nongovernmental organizations and charities may reduce hiring, which would reduce the ability to provide aid and reach those who need it. CARE International said several of its funders have seen their investments deteriorate. Oxfam noted that its aid spending dropped sharply during past global recessions and took years to recover. Oxfam also stated that it will be trimming its budget by between 10 and 15 percent for 2009, based on projections.¹⁴ The Millennium Development Goals may be affected as OECD countries direct their energies toward revamping their economies. Their pledges may still be met, however, as they only amount to about US\$100 billion, far less than the amounts spent for fixing the financial markets.

An additional effect of declines in aid from the United States and other Western countries is the potential response of receiving countries. African states, for example, are saying they are ready to turn elsewhere, and some are already working with other countries, such as China.¹⁵

Donor Responses

Commitments by the World Bank to developing countries have increased 11 percent, as has spending by the International Development

countries to plan policy responses to the economic effects of the crisis.¹⁷

Further donor response options, both those targeting vulnerable populations and those operating across a broader social scale, are listed on the following page.

USAID Actions

Existing USAID programs offer support on many levels for responding in the ways listed above to the global financial crisis. At the global level, for example, USAID is seeking to reinvigorate the international community’s commitment to good governance as a critical ingredient to economic growth. The Agency also supports specific countries in mitigating the threat of malnutrition from food insecurity, lack of access to food, or shortfalls in food production or supplies. U.S. food and related assistance worldwide increased to nearly US\$2.5 billion in 2008, from less than US\$1.7 billion in 2007, and internally USAID has formalized a Food Security Agency Policy Coordinating Committee from its former Food Security Task Force. Other new or intensified responses specific to the current economic crisis will depend on how exactly the crisis unfolds in specific countries and regions and affects the poorest and most vulnerable populations.

Donor Response Options to Protect the Health of Poor and Vulnerable Populations

Options targeting poor and vulnerable populations:

- Join international aid agencies in mobilizing resources and technical assistance for actions to mitigate health impacts on poor and vulnerable populations
- Develop country and regional capacities for public campaigns targeting poor and vulnerable populations that mobilize family and community coping mechanisms and promote health and nutrition
- Promote public awareness about the impact of the crisis on poor and vulnerable populations
- Build capacity for generating data on health outcomes and health systems performance, especially those related to poor and vulnerable populations
- Assess/monitor the health and socioeconomic impacts of the crisis in donor-supported areas and identify the impacts on and needs of poor and vulnerable populations
- Monitor/improve the effectiveness of activities designed to protect poor and vulnerable populations

Options across broader social scale:

- Advocate for/strengthen basic health services and develop financing strategies as part of a broader support of social safety nets
- Enhance country capacity for health systems strengthening
- Promote cooperation among sectors and partners for supporting social safety nets and economic recovery at the country, regional, and global levels
- Identify/disseminate best practices for reducing socioeconomic disparities that cause health inequities
- Build technical and institutional capacities of community and civil society organizations to design and implement activities that strengthen health services targeting vulnerable and poor populations (e.g., food security and microcredit services; use of participatory approaches; public-private, cross-sectoral collaborations) within the broader context of support for social safety nets and economic recovery

¹ http://blogs.cgdev.org/globaldevelopment/2008/10/history_says_financial_crisis.php.

² Addison T., McGillivray M. and Odedokun M. Donor Funding of Multilateral Aid Agencies: Determining Factors and Revealed Burden Sharing. UNU/WIDER, Helsinki, 2004.

³ O'Connor D., Hatch D. Fundraising in a Cold Climate: An Analysis by Dublin, Ireland. Online at <http://www.2into3.com/news/Fundraising%20in%20a%20Cold%20Climate.pdf>.

⁴ OECD. Stat Extracts, Dataset: DAC Total Net ODA. http://stats.oecd.org/WBOS/Index.aspx?DataSetCode=REF_TOTALODA; accessed online March 18, 2009.

⁵ United Nations Economic and Social Commission for Asia and the Pacific. Policy issues for the ESCAP region: implications of recent economic and social developments. Report on the current economic situation in the region and policy issues. Note by the secretariat. Fifty-fifth session, Bangkok, 22-28 April 1999. <http://www.unescap.org/55/e1119e.htm>.

⁶ Bajoria J. Council On Foreign Relations. The Poverty Problem. The decline of the global economy has triggered concerns that millions will be sent into poverty in China and India. Newsweek, Nov 20, 2008. <http://www.newsweek.com/id/170022>.

⁷ Mark Landler. Financial Chill May Hit Developing Countries. New York Times, September 25, 2008.

⁸ Global: Financial crisis could cut official aid by 30%. <http://www.reliefweb.int/rw/rwb.nsf/db900SID/LSGZ-7L5D2K?OpenDocument>; accessed online March 18, 2009.

⁹ The Impact of the Asian Financial Crisis on the Health Sector in Thailand. Julian C. Managerial Finance. 26; 4:39-48, 2000.

¹⁰ Fiscal Vulnerabilities In Developing Countries And The Twin Oil-Food Shocks. Poverty Reduction and Economic Management (PREM) Network. The World Bank.

¹¹ Social Impact of the Asian Economic Crisis.

¹² Global Financial Crisis: Responding Today, Securing Tomorrow. Background paper prepared by the World Bank Group G20 Summit on Financial Markets and the World Economy. Washington, D.C., November 15, 2008.

¹³ United Nations Trade and Development Report 2008.

¹⁴ Higgins, A. "Aid Agencies: World's Poor Will Be Biggest Victim." October 14 2008.

¹⁵ News Daily <http://www.newsdaily.com/stories/tre48m0lr-us-un-assembly-africa/>.

¹⁶ Rising Food and Fuel Prices: Addressing the Risks to Future Generations. Human Development Network and Poverty Reduction and Economic Management (PREM) Network. The World Bank.

¹⁷ OECD, World Bank. Third High-Level Forum on Aid Effectiveness, September 2–4, 2008, Accra, Ghana (www.accraihf.net). Under the agreements of the Agenda, donors will provide three- to five-year advance information on their planned aid to partner countries. The agreement also largely removes donor conditions on how and when aid money is spent in favor of conditions based on the developing country's own development objectives and also removes restrictions on partner-country procurement of goods and services.