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THE GLOBAL FINANCIAL CRISIS: IMPLICATIONS FOR THE HEALTH SECTOR IN THE AFRICAN REGION

Report of the Regional Director

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BACKGROUND

1. Since 2008, the severe reduction in global demand for commodities, goods and services as a result of the liquidity crisis and the loss of trust in the financial sector in the United States of America and Europe has considerably slowed down the global economy. According to the International Monetary Fund, world output was expected to contract by 1.4% in 2009 and to gradually pick up in 2010 to reach a growth rate of 2.5%.[1] Although Africa registered a real average gross domestic product (GDP) growth rate of above 5% between 2000 and 2008,[2] the growth rate declined to 2.8% in 2009.[3]

2. The GDP in the African Region shrank by US$ 94.48 billion between 2008 and 2009; 27 countries recorded a decrease in GDP, varying widely from US$ 0.007 billion to US$ 15 billion (Annex 1). Similarly, GDP per capita decreased by between US$ 6 and US$ 6183 in 31 countries[1] (Annex 2).

3. The contraction of GDP has been attributed to declines in private household expenditures, business enterprise purchases, government revenues, and exports of goods (e.g. crude oil, minerals, agricultural products) and services (e.g. tourism).[4,5] Other impacts of the crisis include falls in foreign exchange rates,[5] reduced foreign direct investment, decreased official development assistance (ODA) and other donor support, increased interest rates and risk premiums, and reduced remittances from abroad.[6]

4. There is lack of evidence on the impact of past economic crises on health in Africa. However, there is ample evidence in Asia and Latin America showing that similar crises resulted in cuts in expenditures on health, lower utilization of health services, and deterioration of child and maternal nutrition and health outcomes.[7] The ministries of health in the African Region are continuously monitoring the effects of global economic crisis on government and donor funding for health development, prices of medicines and basic foodstuffs, devaluation and unemployment.[8]

5. In 2008, 15 out of the 46 countries in the WHO African Region spent less than 5% of their GDP on health. Only five countries spent above 9% of their GDP on health.[9] Government expenditure on health as a percentage of total health expenditure in the Region varies widely from

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1 IMF. World economic outlook database. International Monetary Fund (last accessed 10/09).

2 AfDB, OECD and ECA. African economic outlook. Paris, African Development Bank, Organisation for Economic Cooperation and Development, and Economic Commission for Africa, 2009.

3 ECA. The global financial crisis: impact, responses and the way forward. Paper prepared for the Meeting of the Committee of Experts of the Second Joint Annual Meeting of the AU Conference of Ministers of Economics and Finance and ECA Conference of Ministers of Finance, Planning and Economic Development held in Cairo, Egypt 2–5 June 2009. Addis Abba, Economic Commission for Africa, 2009.

4 AfDB. Africa and the global economic crisis: strategies for preserving the foundations of long-term growth. Paper prepared for the Annual Meeting of the African Development Bank held in Dakar, Senegal, 13-14 May 2009.

5 ECA. The global financial crisis: impact, responses and the way forward. Paper prepared for the Meeting of the Committee of Experts of the Second Joint Annual Meeting of the AU Conference of Ministers of Economics and Finance and ECA Conference of Ministers of Finance, Planning and Economic Development held in Cairo, Egypt 2–5 June 2009. Addis Abba, Economic Commission for Africa, 2009.

6 WHO. The financial crisis and global health. Report of a high-level consultation. Information Note/2009/1. Geneva, World Health Organization, 2009.

7 World Bank. Health, population and nutrition: protecting pro-poor health services during financial crises: lessons from experience. Washington, DC, The World Bank, 2009.

8 WHO. Continuous monitoring of the effects of global financial crisis on funding for health development: a questionnaire for completion by directors of policy and planning at the Ministry of Health. Brazzaville, World Health Organization, Regional Office for Africa, 2009.

9 WHO. National health accounts database. Geneva, World Health Organization, 2009. http://www.who.int/nha/country/en/index.html (last accessed 17/03/10)

less than 11% to over 83.8%. Only five countries[10] have met the Abuja target of allocating at least 15% of the government budget to health. Evidence from previous economic crises shows that governments tend to decrease social expenditures during times of economic recession.[11, 12]

6. In most countries, private expenditures on health constitute approximately 49.5% of total health expenditure, a large proportion of which consists of household out-of-pocket expenditures. In 32 countries, out-of-pocket expenditures account for more than 61% of private health expenditure. As economic activity slows down and unemployment rises, both labour and non-labour incomes tend to decline, resulting in reduced real per capita household spending on health and other social services.[12]

7. External funding for health as a percentage of total health expenditure accounts for a substantial proportion of health expenditures in some African countries. In 2008, 23 countries (50% of countries of the Region) received between 20.3% and 63.5% of their total health funding from external sources[11] (Annex 3).

8. The current economic crisis threatens to halt ongoing national efforts to realize the health-related Millennium Development Goals. The purpose of this document is to highlight the likely impacts of the crisis on the health sector in the African Region and to propose some actions that might mitigate the negative effects of the crisis.

ISSUES AND CHALLENGES

9. Owing to reductions in the size and growth of GDP, unless protected, the per capita spending on health and other social sectors is likely to decrease. The health budget tends to be especially vulnerable to reductions during times of financial and economic crisis.[13] The proportion of government health ministry budgets going to salaries (already high in many countries) tends to increase as capital spending and other operating expenditures declines. Reductions in maintenance, medicines or other operating expenditures related to disease surveillance or supervision are likely to have a more damaging and immediate effect on quality and quantity of health service delivery.[13]

10. Decreased real per capita household spending on health, coupled with increased costs of treatment and low coverage of prepaid health schemes will lower household demand for private sector health services, with demand switching to the public sector.[6] Because the public sector is already facing reduced funding, it may not be adequately equipped to absorb any surge in demand, and the result may be a worsening in quality of care. In most countries, publicly-funded health services were already overstretched long before the onset of the crisis.

11. During periods of economic crisis, poorer households are likely to suffer the most as they are unable to re-adjust and cushion their expenditures, often forcing a decline in demand for

[10] Burundi, Liberia, Rwanda, Tanzania and Zambia.
[11] Hicks N, Wodon Q. Economic shocks, safety nets, and fiscal constraints: social protection for the poor in Latin America. In: XII *Seminario Regional de Politica Fiscal: Compendio de Documentos*. Santiago, Chile, United Nations, CEPAL, 2000, pages 381-407.
[12] Ravallion M. Are the poor protected from budget cuts? Evidence from Argentina. *Journal of Applied Economics*, 1996, 5(1):95-121.
[13] Frankenberg E, Beegle K, Sikoki B. Health, family planning and well-being in Indonesia during an economic crisis: early results from the Indonesian family life survey. Rand Labor and Population Program Working Paper Series 99-06. Santa Monica, California, The Rand Corporation, 1998.

health services.[6,14] Without targeted pro-poor interventions or safety nets, the poor are disproportionately affected in terms of utilization of health services.[15]

12. Poor households are also forced to reduce food quantity (caloric intake) and quality (dietary diversity), resulting in weight loss and severe malnutrition.[16] Children who experience short-term nutritional deprivations can suffer long-lasting effects including retarded growth, lower cognitive and learning abilities, lower educational attainment, and, consequently, lower earnings in adulthood.[17, 18]

13. Although donor countries and international financial institutions have recently made strong commitments to help, past banking crises have led to sharp declines in ODA, including health development assistance. For example, the Global Fund to Fight AIDS, Tuberculosis and Malaria is facing a financing gap of US$ 4 billion which may lead to reduced funding for programmes.[19] However, reducing ODA for health at this time could be very costly, especially for low-income African countries which are striving to achieve health-related Millennium Development Goals.

14. There is growing evidence in the African Region of economic inefficiencies in the use of resources allocated to health facilities,[20] medicines procurement, distribution systems and prescribing practices.[21] Other inefficiencies include misallocation of resources by regions, levels of care (investment of most public resources in tertiary and secondary hospitals instead of first-level hospitals and health centres) and channelling most donor funds through vertical programmes instead of national health systems.[22] During the Asian and Latin American economic crises, some countries used donor funding to improve systems of public tax revenue collection and expenditures.

15. Monitoring the effect the financial crisis on health-sector spending in countries in the Region is a challenge because 19 countries have not undertaken even a single round of national health accounts (NHA), and most countries have not institutionalized NHA. The lack of institutionalization of NHA makes it difficult to track changes in funding from all sources as well as flows to various health system inputs, service providers and beneficiaries.

16. The institutionalization of NHA in itself is not sufficient. An economic crisis can influence health outcomes and the social determinants of health, e.g. education, environment, food, housing, water and sanitation.[23] There is lack of evidence about how past economic crises in the African Region affected health system inputs, service outputs and outcomes;[24] as well as the

[14] World Bank. Averting a human crisis during the global downturn. Washington, DC, The World Bank, 2009.
[15] World Bank. The health sector in Argentina: current situation and options for improvement. Washington, DC, The World Bank, 2003.
[16] Ravillion M. Bailing out the world's poorest. Policy Research Working Paper 4763. Washington, DC, The World Bank, 2008.
[17] Baird S, Schady N, Friedman J. Infant mortality over the business cycle in the developing world. Policy Research Working Paper No. 4346. Washington, DC, The World Bank, 2007.
[18] Knowles J, Pernia E, Racelis M. Social consequences of the financial crisis in East Asia. Manila, Asian Development Bank, 1999.
[19] USAID. Impact of global economic crisis on health in Africa. Washington, DC, United States Agency for International Development, 2009.
[20] Kirigia JM, Diarra-Nama AJ. Can countries of the WHO African Region wean themselves off donor funding for health? *Bulletin of the World Health Organization*, 2008, 86(11):889–892.
[21] Transparency International. Global corruption report 2006: corruption and health. London, Pluto Press, 2006.
[22] Resolution AFR/RC56/R5, Health financing: a strategy for the African Region. In *Fifty-sixth of the WHO Regional Committee for Africa, Addis Ababa, Federal Democratic Republic of Ethiopia, 28 August–1 September 2006, Final Report,* pp 17–19, Brazzaville, World Health Organization, Regional Office for Africa, 2006.
[23] Levy BS, Sidel VW. The economic crisis and public health. *Social Medicine* 2009, 4(2):82-87; available at http://www.socialmedicine.info/index.php/socialmedicine/article/view/327/643.
[24] WHO. Monitoring health impacts and policy responses during the economic crisis. Geneva, World Health Organization, 2009.

social determinants of health that shape people's daily lives and their differential access to money, power and resources which significantly affect health inequities both within and between countries.[25]

17. There is thus a real danger that funding for health development in the African Region might be adversely affected by the ongoing global financial crisis and thereby compromise any ongoing national and international efforts in many countries to realize the Millennium Development Goals.[26] Therefore, there is need for concerted action from African governments and development partners to ensure that domestic and external funding for the health sector is not reduced.

ACTIONS PROPOSED

18. The following actions, in appropriate combination according to local context, may enable countries to mitigate the negative impact of the financial crisis on health sector funding in Africa. The proposed actions are consistent with those contained in the Framework for the implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa.

19. *Operational research to monitor health impacts and policy responses*: Establish a temporary multidisciplinary national commission on macroeconomics and health, or its equivalent, to generate national evidence on the relationship between health, development and wealth; and to monitor the effects of the economic crisis and policy responses on the social determinants of health (e.g. income level and distribution, unemployment, education, food, exchange rate fluctuations, volume of trade, tax revenues, government spending), health inputs (e.g. health workers, medicines, physical infrastructure, government and household expenditure on health, external health funding, financial policy linked to health), health system outputs (e.g. availability, prices, quality and efficiency of health services including prevention and promotion, utilization, risk behaviour), and health and health system outcomes.

20. *Intensify domestic and external advocacy*: Firstly, advocate nationally and through subregional economic communities for ministers of finance to sustain and increase domestic funding for the health sector in line with the Heads of State commitment to allocate at least 15% of national budgets to health. This will require strengthening of capacities of ministries of health to dialogue with ministries of finance. Secondly, advocate among development partners to fulfil their financial commitments to the health sector, including implementation of the Paris Declaration on Aid Effectiveness.

21. *Institutionalize national and district health accounts to monitor domestic and external health expenditures*: Regularly undertake national and district health accounts to monitor the proportion of total government expenditure allocated to the health sector, household out-of-pocket spending on health as a percentage of total private health expenditure and trends of external (donor) expenditure on health.

22. *Reprioritize public expenditure*: Explore the possibility of creating resources for health development by shifting budgetary resources from low priority to high priority sectors, e.g. health. This can be done by proactively engaging national development planning commissions or similar government entities to prioritize health on the development agenda. The ministry of health can undertake a similar exercise regarding health sector activities. Policy-makers can use

[25] WHO. Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.
[26] Chan M. Statement from the WHO Director-General on the impact of the global financial and economic crisis on health. Geneva: World Health Organization, 2008.

available WHO cost-effectiveness evidence for choosing health interventions and programmes which maximize health from the available resources.

23. *Improve financial resource management by implementing legal and institutional frameworks*: Develop sound budget and expenditure systems, make budgetary information available for public scrutiny, institutionalize national health expenditure tracking, strengthen the effectiveness of audit institutions, and channel majority of aid flows for health development through general government budgets in line with the Paris Declaration on Aid Effectiveness. It will be necessary to strengthen capacities of planners in evidence-based planning and budgeting.

24. *Improve management of medical supplies by developing transparent policies, procedures and criteria for medicine licensing, accreditation and approvals*: Develop national medicines policies and plans within the context of overall national health policies and plans; promote appropriate prescribing and dispensing practices, and educate consumers on safe and optimal use of medicines; establish or strengthen national pharmacovigilance systems; develop national medicine formularies; build sustainable capacity in pharmaceuticals management as a fundamental component of functional and reliable health systems; establish a mechanism to determine national requirements and forecast needs for essential medicines; put in place, review or strengthen rules and guidelines for transparent, competitive and accountable procurement, supply management and distribution systems; and ban gifts and sponsorships in the marketing of medicines.

25. *Improve health worker-patient interaction via implementation of patient rights charters and improved access to information*: Promote contractual relationships between government and health workers; improve hierarchical accountability and human resource management; adopt codes of ethics regulating the medical profession; and increase community participation in health services management through local health boards or committees.

26. *Reduce economic inefficiencies*: Institutionalize economic efficiency monitoring within national health management information systems with a view to implementing appropriate policy interventions to reduce wastage of scarce health system inputs.

27. *Strengthen social safety nets*: Countries that still have health service user fees should develop and implement effective exemption mechanisms to assure financial access for vulnerable groups. In line with the Regional Committee resolution on health financing,[21] countries should strengthen national prepaid health financing systems including finance structures, processes and management systems. This is necessary to ensure sharing of financial risk among the population and avoiding catastrophic health-care expenditure and impoverishment of care-seeking individuals.

28. *Increase private sector involvement*: Improve private sector contributions by developing enabling policy and regulatory frameworks; developing and enforcing quality standards; expanding risk pooling arrangements; contracting to deliver specific services; and improving the ability of local financing institutions to support health service enterprises.

29. *Increase investments in national health systems*: In line with the Ouagadougou Declaration on Primary Health Care and health systems in Africa, existing and additional funding from both national and international sources for the health sector needs to focus on overall systems strengthening including service delivery; health workforce; information; medicines, vaccines and technologies; financing; and leadership and governance. This is the only way to optimize and sustain health gains, ensure responsiveness to client expectations and provide fairness in financial contributions to health service expenditures.

30. The Regional Committee is invited to examine and endorse the proposed actions.

ANNEX 1: Changes in gross domestic product in the African Region (US$ billions, current prices)

Country	GDP		
	Year 2008	Year 2009	Change
Algeria	159.669	134.797	-24.872
Angola	84.945	69.708	-15.237
Benin	6.712	6.401	-0.311
Botswana	13.461	10.808	-2.653
Burkina Faso	8.116	7.780	-0.336
Burundi	1.097	1.410	0.313
Cameroon	23.732	21.820	-1.912
Cape Verde	1.744	1.755	0.011
Central African Republic	1.997	1.983	-0.014
Chad	8.400	6.974	-1.426
Comoros	0.532	0.525	-0.007
Congo	10.774	8.632	-2.142
Côte d'Ivoire	23.508	22.909	-0.599
Democratic Republic of Congo	11.629	11.104	-0.525
Equatorial Guinea	18.525	11.175	-7.35
Eritrea	1.479	1.694	0.215
Ethiopia	26.393	33.920	7.527
Gabon	14.535	10.936	-3.599
Gambia	0.810	0.726	-0.084
Ghana	16.654	14.761	-1.893
Guinea	4.517	4.436	-0.081
Guinea-Bissau	0.461	0.438	-0.023
Kenya	29.564	30.212	0.648
Lesotho	1.618	1.624	0.006
Liberia	0.850	0.868	0.018
Madagascar	9.463	8.974	-0.489
Malawi	4.268	4.909	0.641
Mali	8.774	8.757	-0.017
Mauritania	3.161	3.241	0.08
Mauritius	8.738	9.156	0.418
Mozambique	9.897	9.654	-0.243
Namibia	8.835	9.039	0.204
Niger	5.382	5.323	-0.059
Nigeria	207.116	165.437	-41.679
Rwanda	4.459	5.011	0.552
Sao Tome and Principe	0.175	0.189	0.014
Senegal	13.350	12.610	-0.74
Seychelles	0.822	0.656	-0.166
Sierra Leone	1.953	2.064	0.111
South Africa	276.764	277.379	0.615
Swaziland	2.840	2.929	0.089
Tanzania	20.668	22.159	1.491
Togo	2.890	2.771	-0.119
Uganda	14.565	15.658	1.093
Zambia	14.654	12.293	-2.361
Zimbabwe	3.145	3.556	0.411
TOTAL	**1093.641**	**999.161**	**-94.480**

Source: IMF. World economic outlook database. International Monetary Fund.

ANNEX 2: Gross domestic product per capita in Member States of the WHO African Region (US$, current prices)

Country	Per capita GDP in 2008	Per capita GDP in 2009	Change
Algeria	4588	3816	-772
Angola	5054	4027	-1027
Benin	828	765	-63
Botswana	7554	5995	-1559
Burkina Faso	578	542	-36
Burundi	138	174	36
Cameroon	1224	1095	-129
Cape Verde	3464	3419	-45
Central African Republic	459	446	-12
Chad	863	699	-164
Comoros	816	788	-28
Congo	2952	2298	-654
Côte d'Ivoire	1132	1071	-61
Democratic Republic of Congo	185	171	-13
Equatorial Guinea	14 941	8759	-6183
Eritrea	295	328	33
Ethiopia	333	418	84
Gabon	9998	7414	-2583
Gambia	497	434	-62
Ghana	739	639	-100
Guinea	439	418	-21
Guinea-Bissau	264	244	-20
Kenya	838	842	4
Lesotho	660	651	-9
Liberia	216	210	-6
Madagascar	468	432	-36
Malawi	313	352	40
Mali	657	641	-16
Mauritania	1042	1044	1
Mauritius	6872	7146	274
Mozambique	477	456	-21
Namibia	4278	4341	63
Niger	391	375	-16
Nigeria	1401	1089	-312
Rwanda	465	512	47
São Tomé and Príncipe	1094	1160	66
Senegal	1066	984	-83
Seychelles	9640	7683	-1957
Sierra Leone	332	342	10
South Africa	5685	5635	-49
Swaziland	2778	2854	76
Tanzania	520	547	27
Togo	436	408	-28
Uganda	455	472	17
Zambia	1248	1027	-221
Zimbabwe	268	303	35

Source: IMF. World economic outlook database. International Monetary Fund.

ANNEX 3: External resources for health as a percentage of total expenditure on health in the WHO African Region in 2009

% of total expenditure on health	Number of countries	Percent
< 10	16	35
10-20	13	28
21-40	10	22
41-60	7	15
Total	46	100

Source: http://www.who.int/nha/country/en/index.html (accessed on 17/03/2010).