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Public health in times of austerity

Throughout the recent economic recession 2007–2009 and beyond the public's attention was directed principally to the worldwide impact on business and the way countries struggle with the financial aspects of the 'crisis'. But what about the influence of this recession on social and health aspects of life? These were discussed only later. Over the last 200 years, other important economic breakdowns have challenged the world. Below I review the consequences of today's crisis on individual health, population health (national and globally), look back at history, and then ask if there are possibilities for change.

Economic downturns are frequently accompanied by higher unemployment rates, decline of private consumption, job insecurity, and job migration. Indicators such as gross domestic product (GDP), investment spending, and household income decline during crises. Are there consequences for human health, and if so of what kind?

Health Consequences for the Individual

Among the common indicators of health, mortality rates are among the most accessible and most frequently used. Of all possible economic measures, unemployment is the most widely cited indicator of difficulty. Several studies in Europe as well as in the United States (US) have demonstrated that economic changes affect mortality rates.¹ High unemployment is associated

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with premature death from violence, such as suicides and homicides. Others have used indicators such as communicable diseases and mental health. These data vary greatly according to race, gender and country.

Example: Russia

Post-communist Russia² showed a transition of its own. Two significant economic crises hit Russia in the 1990s: the first in 1992, the second in 1998. The first coincided with Russia's transition to a market economy following the fall of communism. The second crisis involved the crash of the banking system (as explained by Gavrilova *et al*³).

The Russian Federation experienced a surge in death rates of almost 40 per cent from 1992 until today with numbers rising from 11 to 15.5 per thousand. At the same time, life expectancy fell; it is lower under the Russian Federation government than in the era of communist Russia. The decline in life expectancy has been attributed to a high level of mortality among working-class men as a result of alcoholism and smoking, among other manifestations of stress and 'lifestyle'. About half of all deaths of working-age men could be related to hazardous binge drinking.⁴ While overall alcohol consumption was steadily rising, most has taken the form of binge drinking⁵ – a phenomenon that increases alcohol-related deaths including accidents, violence, and alcohol poisoning.⁶

Alcohol played a key role in the 1990s' mortality crisis, especially the spike in alcohol-related deaths in working-age males.⁷ Alcoholism has a long tradition in Russia, as it is a socially acceptable behavior. Base-line alcohol-related mortality is already high without any financial crisis.⁸ However, even with such an elevated baseline, the rates rose even higher during the two crises of the 1990s. Other countries show evidence linking rapid and large rises in unemployment and short-term rises in suicides and homicides; all cause mortality is not affected. Not all countries of the former Eastern communist systems reacted similarly, countries with more cohesive elements of civil society, such as social organizations, sports clubs and the like, were less affected by the fall of the system as measured by mortality rates.

Example: Asia

On another continent, the Asian financial crisis of 1997–1998 also demonstrated that economic changes impact the health of individuals and of whole populations. Indonesia and Thailand suffered from outbreaks of tuberculosis and malaria – and other serious public health problems – whereas Malaysia suffered less. Thus, we can see that countries react differently to economic downturns. It may be useful to look at political decisions taken to alleviate

the consequences of the crisis. Hypothesis: economic policies of the respective countries may have had an influence. Thailand and Indonesia cut budgets to address the shortage of public funds. Among the consequences were deep cuts in HIV-prevention. Malaysia, in contrast, invested in preventive measures during the crisis. Through careful examination of operating expenditures Malaysia minimized adverse effects of budget constraints at the service interface. The Minister of Health reprioritised the development of health projects.⁹

Example: Iceland

Iceland's financial shutdown occurred as their three largest banks failed and debt soared to over 800 per cent of GDP. The International Monetary Fund formulated bailout plans for the country, intending to cut about 30 per cent of the health budget. The Icelandic people, however, voted against bailing out the banks, choosing instead to boost their universal health-care system. In Iceland, there ensued almost no rise in suicides or depression.^{10,11,12}

Mental health

Another indicator of interest that has been studied is mental health;¹³ most studies concern the working population. Research in the US shows job insecurity to be associated with worse mental and physical health population outcomes.¹⁴ Negative consequences of 'downsizing' of a company or single plant may be even more pronounced for remaining employees, aggravating stress by increasing workloads and deepening feelings of job insecurity. Thus, an economic crisis will likely adversely impact health – not only those who lose their jobs, but also for those who maintain employment. Researchers debate a causal link between suicide – as an indicator of mental health – and financial crisis. Several studies undertaken to look at the recent crisis in Europe come from South European countries, usually those known to have the lowest suicide rates in Europe. Greece reported a 17 per cent increase in suicides from 2007–2009.¹⁵ According to the Spanish National Institute of Statistics, overall suicide rates in Spain decreased between 2008 and 2011.¹⁶ However, Lopez-Bernal and colleagues noted an increase of suicide in working-age men.¹⁷

Consequences for Health Systems

National health system reactions

Health systems, as discussed here, include the 'care and cure' clinical elements as well as population interventions to protect, prevent, and control

threats to health. Reactions from the political world to economic crises is frequently to cut budgets for health, education, and culture. Austerity 'measures' are meant to shrink debts. Thus the systems or parts of societies it seems 'best' to restrict with cutbacks are health, education, and culture. The political environment in a majority of countries favours these targets to reduce national debt. But these policy responses and cuts to health budgets create barriers to access to health care based on age, gender, ethnicity, and social status. The cuts also restrict the ability of governments to understand what problems threaten the health of populations through surveillance. Almost everywhere, health expenditures are among the largest nationally, after social security. Most health resources go into the acute care part of the health system. Public health, defined as the population-based, environment-related measures aiming to improve determinants of health rather than to repair the ravages of disease is typically the smallest portion of the expenditures. Public health is usually under pressure even before onset of an economic crisis; demographics, growing health expenditures, and the expanding health business command more attention. According to a report from the Organization of Economic Cooperation and Development (OECD), *Health at a Glance*,¹⁸ governments under pressure to protect acute care provision are cutting back elsewhere – primarily public health programmes including prevention. But the cuts do not stop at public health: Spain and Italy, for example, closed out services and reduced hospital beds. Introduction of co-payments for medicines or services is another 'tool', as is simply cutting salaries of health-care workers.

International reactions

All European countries have accepted overarching, common values: universality, equity, solidarity, and good quality care. They are enshrined in the Treaty of Lisbon and the European Charter of Fundamental Rights – to be maintained even in times of crisis. The Science and Technology Options Assessment (STOA) Unit at the European Parliament devoted a workshop to the question.¹⁹ International organizations concerned with health, including the World Health Organization (WHO) and the United Nations Development program (UNDP) have proposed ways to increase the resilience of health systems to economic crisis. There are well thought out plans and excellent research on ways how to avoid negative impacts of economy on health systems.²⁰ Unfortunately, national governments and financial do not always heed this wisdom. Even once evidence has been well worked out, political decision processes often lack transparency; sometimes they are completely detached from available evidence.

Health systems reforms

Health system reforms are necessary and useful – if they improve health outcomes. The processes of reform vary from country to country. Fiscal consolidation is not the only purpose of a health reform. If pressure comes only from the financial side, quality of care, access, and equity will be neglected.

Today's crisis could be as a catalyst for necessary reforms in inefficient health-care systems. But we must always keep in mind that health is a value in itself and a country's fiscal consolidation must not impair the overarching values that govern most of European countries.

Consequences at a Global Level

Health worker migration

Even by watching the European or North American situations, we can easily imagine consequences of what I have described above for countries elsewhere in the world. When countries worsen how they treat health professionals, by financial, and educational regulatory means detrimental to careers, health worker migration increases. Migration of health workers affects all countries. In some cases, health workers leave home countries altogether in search of better working conditions and career opportunities. In others, they leave rural areas for urban ones. The result: increasingly inequitable access to health care, within and between countries (See the WHO summary on Health workforce at: www.who.int/hrh/migration/en/, accessed 8 February 2014). Migration is frequently accompanied by cut backs in higher education, leading to a decrease in the 'supply' of newly graduated entrants into health professions. Effective correction must be addressed at the global level. Thus, WHO and its partners are developing strategies for countries to address the twin challenges of managing migration and improving the retention of health workers. This is only one example of global effects of today's financial crisis on health and health systems. As most corporate entities today act globally, their quest for financial wellbeing will have repercussions around the globe – the health of individuals and populations will be influenced.

Historical Perspective on Changes in Health Systems

Austerity has been proven to coincide with emergence of new concepts in health and/or social systems. In earlier times of austerity, what remedies surfaced at the political level? In 1929 in the US, an economic crisis known as

'the Great Depression' followed the famous 'Black Tuesday'. This great depression in the 1930s put millions of Americans out of work; business and industry were heavily affected. Hundreds of Americans found themselves homeless, and began congregating in shantytowns – called 'Hoovervilles' – that began to appear across the country. Citizens lived in difficult sanitary conditions. The total debt of the country was over 200 per cent of GDP and suicide rates increased markedly among the unemployed between 1929 and 1933. Newly elected President Roosevelt closed all the banks – to reopen them only after they were stabilized. The US Congress created the Federal Deposit Insurance Corporation to insure deposits up to US\$5000. President Roosevelt started programs that came to be known as the 'New Deal'. Major objectives included putting people back to work and re-housing those who had lost their homes.

Most important for our comparison was the Social Security Act: It established a system of old-age pensions for workers, survivor benefits for victims of industrial accidents, unemployment insurance, and aid for dependent mothers and children, the blind and the physically disabled (www.ourdocuments.gov/doc.php?flash=true&doc=68). The money expended in New Deal programs was well invested, as every additional \$100 per capita reduced suicides by 4 per 100 000 and reduced infant deaths too. Not all States of the US implemented the New Deal with equal rigor. Thus, differences can be observed: States that fully implemented the programs had better health outcomes. After the recovery from the Recession of 1937–1938, American conservatives were able to form a bipartisan conservative coalition to stop expansion of the New Deal and, when unemployment dropped to 2 per cent in the early 1940s, they abolished all relief programs. Social security remained in place. The great depression had similar effects worldwide; the link between economic crises and public health consequences became well established. Policies were aimed at alleviating both social and health consequences of the economic downturn. The new policies and programs emerged under the pressure of the imminent harm for an entire population. The Great Depression was a major factor in the implementation of social democracy and planned economies in a large number of countries.

A second historical example appeared after World War II. The United Kingdom (UK) mounted an ambitious plan to bring good health care to everyone – it created a National Health Service (NHS) – in 1948. For the first time, hospitals, doctors, nurses, pharmacists, opticians and dentists were brought together under one umbrella organization to provide services free for all at the point of delivery. The central principles are clear: the health service will be available to all and financed entirely from taxation; people pay into it according to their means (www.nhshistory.net/shorthistory.htm). When the UK created the NHS, it was still struggling with effects of World War II.

Its economy had yet to recover, having lost huge amounts of absolute wealth. The winter of 1946–1947 proved to be very harsh; it curtailed production and led to shortages of coal, that again damaged the economy. At the time, the currency (British pound) was over valued – and subsequently devalued. The US initiated Marshall Plan grants (mostly grants, also a few loans) thereby pumping \$3.3 billion into the European economies. The health conditions for British people were as difficult as in all other European post-war countries.

Thus, the NHS amounted to an ambitious, new, egalitarian and comprehensive approach – created in times of severe austerity. The concept of a NHS which already existed, having been under discussion since the 1930s, but go from an idea to policy and program proved difficult. One of the stakeholders most resistant was the British Medical Association (BMA). The members even voted not to join the new service in May 1948. However, by the time the NHS was launched in July 1948, the BMA agreed to participate.

One final historical case here is creation of the Germany social insurance program – the first in the world. In 1873, Germany and much of Europe and America entered an economic slump – the so called ‘Long Depression’ or *Gründerkrise*. This downturn was the first to hit the German economy since industrial development began to surge in the 1850s. The states of the German Reich had waves of emigration of their population – primarily for economic reasons and primarily to the US. In 1870, German-born farmers outnumber native born in the state of Pennsylvania who were born native to the US.

In this setting that a socialist movement developed in Germany – and the founding of Germany’s Social Democratic Party. As a result of a major depression’ that swept Europe and the US in the mid-1870s, Bismarck initiated economic policy change in 1878–1879. He tried to constrain the rise of social democrats by any means. While undergoing economic, social and political unrest, Germany (Prussia) became the first country in Europe to offer compulsory social health insurance (1883), accident insurance bill (1884) and an old-age and disability bill (1889). It was chancellor Bismarck who introduced them, usually after serious debates in the Reichstag and much opposition from the liberals (www.historyhome.co.uk/europe/bisdom.htm). Despite his impeccable right-wing credentials, Bismarck would be called a socialist for introducing these programs, as would President Roosevelt 70 years later (see New Deal above).

Conclusion

There are ‘economic’ determinants of health, and they often become apparent during times of financial crisis. Impacts of economic changes on health are well documented. Austerity affects individuals, populations, systems. It is exactly these times when public health can and should lead,

showing the way to overcome adverse health impacts of a crisis, thus helping our countries and continents to move beyond crisis. However, health systems under pressure too often respond by cutting back public health first. Then comes reduction of health care spending – for example – by shrinking services, limiting those eligible for service and usually by shifting from government to private sector health-care delivery.

Austerity today often seems a pretext for making cuts. Surely some of our systems are long overdue for reform. When needed changes (to improve efficiency, maybe even quality) have not been made, without leadership to do them well, even a financial crisis cannot produce good results. Instead, the 'easy' way of across-the-board cuts avoids strategic decision and usually results in widening gaps in equity, access and universality.

History shows that austerity has sometimes been important for change in health and social systems. Implementation of change, usually the most difficult part in a change process, can be possible just when nothing seems to work. The policies that led to important changes and the leadership came from all parts of the political spectrum. Thus, austerity can be a catalyst for change. Reforms can open an opportunity to tackle health inequalities. Political decisions about reform processes can address underlying problems. Public health-minded persons should know about economic determinants of health and be able to argue with economic-minded individuals. Reductions in social and health budgets create new inefficiencies, and may increase costs and inequalities. Health is wealth and only healthy populations will be engines for dynamic economies and creators of employment.

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