REPORT

Impact of the Asian Financial Crisis on Health

Indonesia
Thailand
The Philippines
Vietnam
Lao PDR

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This report was prepared by the staff of the International Health Unit of Macfarlane Burnet Centre for Medical Research, in particular:

Dr Mike Toole

Dr Alison Rodger

Ms Edelmira Peregrino-Go (research assistant)

Brad Otto (Indonesia)

Dr Niramonh Chanlivong (Laos PDR)

Dr David Hipgrave (Vietnam)

Nititta Prasopa-Plaisier (Thailand)

Dr Tony Stewart

Matt Leverett

with invaluable assistance by Dr Simon Barraclough (La Trobe University) and Claudio Schuftan (Hanoi).

Executive Summary

Objectives

The objectives of this study were to:

1. Report on the impact of the Asian economic crisis on the health sector in selected countries receiving Australian government assistance and to identify health sector priorities prior to and after the crisis

2. Investigate and report on the responses of recipient governments, the private sector, local communities, non-government organisations (NGO), UN and multilateral agencies (especially the World Bank and Asian Development Bank), and international donors to the challenges faced by the health sector as a result of the crisis, and to identify gaps in these responses

3. Identify how the Australian aid program, in keeping with the stated policy objectives and priority areas of AusAID, and other international donors can contribute to efforts to address the health impacts of the crisis.

Study Constraints

In seeking to understand the health impact of the crisis, three issues are particularly salient:

Causality: It is not always possible to attribute particular economic and social trends to the effects of the economic crisis. For example, some of the administrative difficulties experienced by the public health care sector in the Philippines and Indonesia since the crisis undoubtedly had their origins in devolution policies commenced prior to the crisis. Drought, fires, and/or flooding complicated the issues in Thailand, Indonesia, Vietnam, and the Philippines.

Intra- and international variations: Although most countries experienced a number of common consequences of the crisis, differences between countries were evident in the ways in which the crisis was experienced due to their differing levels of economic development, geography, ecology, and health systems. For example, The Philippines experienced three quarters of negative growth in its GDP compared to seven and five quarters in Thailand and Indonesia, respectively. Vietnam and the Lao PDR both retained positive economic growth during 1998. Some countries opted for IMF intervention, while others instituted their own economic reforms. ***Donor activity increased in all countries except the Lao PDR where foreign aid grants and loans declined in 1998.*** In both Indonesia and Thailand, the crisis contributed to changes of government, while in Vietnam, Lao PDR and The Philippines there was political continuity. Variations in the impact of the crisis were also evident between regions of the same country and between urban and rural areas.

Data reliability: In all countries, there were wide variations in reported economic and social indicators, especially unemployment, wages, inflation, and GDP growth. Data cited in this report are largely derived from the databases of the ADB, World Bank,

and IMF; however, contradictions between those sources and official government sources are highlighted in the body of the report. Insufficient time has elapsed since the onset of the crisis to allow for a more detailed investigation of the health consequences of the crisis. As a result, some studies and reports cited here are little more than a "snapshot" of conditions, taken at a time of rapid socio-economic change. Moreover, in some areas of concern, such as mental health and nutrition, there are few data available. Most reports on the social impact of the crisis in these countries were quite subjective in nature.

Summary of impact of economic crisis

The Asian Economic Crisis emerged from a complex set of factors that affected economic performance in Thailand and spread rapidly to Indonesia and later to the Lao PDR, the Philippines, and Vietnam. Countries were either directly affected through the effects of currency devaluation (Thailand and Indonesia) and to a lesser extent the Philippines, or indirectly affected through decreased regional trade and foreign investment, namely the Lao PDR and Vietnam. The Lao PDR experienced profound depreciation of its currency, both against the US dollar and the Thai baht, and rapidly escalating consumer price inflation to triple digits in 1999.

Predicted impacts included poverty, deteriorating public health services, food insecurity and malnutrition, and threats to public health and education. Gains of the past two decades were in danger of being reversed. In Indonesia and the Philippines the ongoing process of decentralisation and devolution of delivery of health and other services to local levels – as the effects of the crisis unfolded – amplified the impact of the crisis and made effective implementation of responses difficult.

Differences Between Countries: Pre-Crisis Health Systems

The health systems of the five countries targeted for this study were affected in various ways by the economic crisis. This was largely due to the state of the health systems pre-crisis. Utilisation of public health services was low in Indonesia and Lao PDR, moderate in the Philippines and Vietnam (declining) and high in Thailand. The total expenditure on health was high in Thailand (5.3% of GDP) and Vietnam (5.2%); and low in Lao PDR (2.6%), the Philippines (2.4%), and Indonesia (1.8%). The public sector expenditure as a percentage of GDP was similar in Thailand (1.4%), Lao PDR (1.3%), the Philippines (1.3%), Vietnam (1.1%), with Indonesia the lowest (0.6%). There was a strong private sector in Thailand, Indonesia and Vietnam.

Health consequences of the economic crisis

Food Security and Nutrition

Falling incomes and rising food and supplement prices were the main potential effects of the crisis on nutrition. Food prices increased significantly in Indonesia and Thailand early in the post-crisis period, stabilising (even decreasing) in 1999. In the Philippines, modest increases were experienced in 1998 and 1999. In the Lao PDR, food prices increased between five- and tenfold between 1996 and 1999, whereas in Vietnam, prices have been relatively stable.

Possible consequences were reduced micro-nutrient intake (particularly affecting children), reduced calorie intake and a reduction in breast feeding as mothers adopted less nutritious diets or were forced to increase their work. In each of the countries, the poor were most likely to suffer the greatest nutritional impact, especially urban dwellers that experienced under- or unemployment. However, regionally, a complex picture emerged of the effects of the crisis on nutrition, not all of which were negative.

In **Thailand**, no significant nutritional outcomes have been detected since the crisis except for a reported increase in the incidence of anaemia in pregnant women. The number of malnourished children reported during 1998 reflected a continuing long-term decline. In **Indonesia,** there is evidence of increased prevalence of micronutrient deficiencies (especially vitamin A) in children and women of reproductive age and of increased wasting (based on BMI) among poorer women. Malnutrition among children under 5 years of age has decreased overall from 34.9% in 1992 to 29.8% in 1998, but it is still a serious problem among vulnerable groups especially in urban areas. **Philippine** Health Department data appear to indicate a fall in malnutrition among children aged 6-59 months from 1996 to 1998. However, economic forecasting in the Philippines has warned of the likelihood of malnutrition among the poor with the risk of a decline in both protein and calorie availability greatest in the poorest quintile of the population. In **Vietnam**, the malnutrition rate (height/age deficit) in under five's declined from 46.9% in 1994 to 34.4% in 1998. **The Lao PDR** has a chronic nutrition problem predating the crisis. Inadequate food intake affects approximately one-third of households and both acute and chronic malnutrition prevalences are high by regional standards. There has been no detectable change in the situation since the economic crisis; however, there are few reliable data to adequately assess recent trends.

Morbidity and Mortality

Data on morbidity and mortality were adequate to assess trends up to and including 1998 in all countries except the Lao PDR. However, most data are derived from national health surveillance systems, which are inadequate in reliability and coverage in all but Thailand. There have been few focused studies on vulnerable population groups and geographic areas to enable detection of changing trends in these groups. From the data examined, there have been no significant changes in morbidity patterns. Increasing rates of tuberculosis in Indonesia, the Philippines, and Vietnam reflect long-term trends, and in the latter case possibly reflecting improved case-finding. A measles outbreak in Vietnam in 1998 cannot be linked directly or indirectly with the crisis or in any decline in immunisation coverage (which is very high).

Affordability of Health Care

A decline in the ability to pay for health care will increase pressure on public health services where they are available. This picture is apparent in some countries, eg, **Thailand**, where utilisation of public health facilities increased by about 15% in 1998 due to an increase in government support to the Public Assistance and Voluntary Health Card Schemes; a reduction in private hospital entitlements in the Civil Service Medical Benefit Scheme; and a general shift from private health facilities to the public sector. In **Indonesia**, there is generally low utilisation of public health

services, and this has remained so since the crisis. Economic forecasting in the Philippines predicts that a decline in household incomes will lead to an increased demand for home-based care and upon charitable and public facilities. There has been an increase in the use of public hospitals in the **Lao PDR** since 1997 although average length of stay in hospital has decreased, possibly due to a reduction in purchasing power. Utilisation of health services in **Vietnam** declined in the years prior to 1997; however, there was an increase in 1998. Utilisation of both private and public health services by the poor continues a medium-term decline.

Costs of therapeutic goods

The health systems of the countries studied are heavily reliant upon imported medical goods, technologies, and pharmaceutical products or their ingredients. The **Philippines** faced an increase in the costs of drugs by approximately 40% by the end of 1997. In **Thailand**, increased costs of drugs and medical supplies resulted in substantial program reduction in 1998 compared with the previous year. However, a positive development resulting from the crisis has been an accelerated shift towards the use of essential drugs, including generic products. In **Indonesia**, Central Statistics Bureau figures on changes in the consumer price index between early 1996 and August 1998 show an overall price increase for services and drugs of 61%. This compares with rises of between 200-300% for various foodstuffs, over 200% for clothing and 36% for education. In **Vietnam**, no major changes in drug prices are reported in the market 1997/1998. The same is most probably true for contraceptives, vaccines, and the costs of the cold chain. In the **Lao PDR**, the cost of drugs for the MOPH increased by between 100% and 300% between 1996 and 1998.

Public Expenditure on Health

The situation varied between countries; however, there was generally a decrease in public expenditure on health following 1998. Most ministries of health focussed on ensuring access to health care by the poor, especially in **Indonesia** and **Thailand** where social safety nets are in a more advanced state than in the other three countries. The **Lao PDR** and **Vietnam** have virtually no mechanisms for ensuring access by the poor although Vietnam launched a free health card program in 1999, but coverage is so far minimal. Health financing must now move to the top of the policy agenda because of the steady erosion of the capacity of the family to support people. An over-reliance on bilateral and multilateral agencies to augment developing country government health budgets has been exposed as being insufficient for governments to respond appropriately to the full impact of the crisis. The crisis highlighted a need to better target health services towards the poor.

Utilisation rates in public and private health care facilities

In the **Philippines**, adequate data are not yet available, although a slight reduction in occupancy rates in Department of Health-retained hospitals was recorded between 1996 and 1997. Attendance at antenatal clinics did not change between 1996 and 1998. In **Thailand**, demand for private hospital care declined due to reduced household incomes, and the withdrawal of entitlements of civil servants to private care. Outpatients attending public health facilities increased by 15% in 1998. In **Indonesia**, it appears that use of both public and private sector facilities is falling

steadily across the board and being replaced by higher rates of self-treatment or non treatment. In **Vietnam**, from 1993 to 1997, there was a drop of 25% in inpatient admissions nationwide, but the total number of consultations, outpatient visits and inpatient admissions all increased in 1998 over 1997. The poor continue to show a decline in their utilisation of both private and public health facilities. In the **Lao PDR**, hospital admissions and outpatient visits increased substantially in four sentinel public hospitals in Vientiane, Luang Prabang, and Savannakhet. The reasons for this increase are not clear and do not necessarily reflect a shift from private health services because these are poorly developed in the country.

Consequences for public health programs

In the **Philippines,** there have been warnings of shortfalls between the budget appropriation and apportionment of funding or delays in allocating funding for a range of health programs and services, including STDs/AIDS control, drug procurement, and maternal and child services. In **Thailand**, there were substantial cuts to reproductive health programs of the Ministry of Public Health between 1997 and 1998. The HIV/AIDS budget was reduced by 24.7% in 1998. Despite these cuts, one study found that the crisis had no immediate adverse effect on access and utilisation of preventive health care and family planning services. In **Indonesia,** there has been no discernible effect on reproductive health programs. The HIV/AIDS budget was cut by 50% in 1999. There was an overall reduction in PHC funding of 6%. There was no evidence of declining rates of immunisation of children with standard EPI-recommended vaccines. In **Vietnam**, there has been a 10% drop in provincial government's per capita health budgets in 1998 but no substantial effects were detected on reproductive or child health programs. Immunisation coverage is stable and very high by regional standards. In the **Lao PDR**, there are few data on program coverage. Immunisation coverage rates, already low, declined slightly in 1998; however, the reasons are not clear and it is too soon to conclude that this was related to the economic crisis.

Responses to the Economic Crisis

As the economic crisis impacted differently on the health sector in each country, the responses have also differed.

In the **Philippines**, there have been no special policy responses to the health consequences of the crisis, with the exception of shielding the health, population, and nutrition sectors from certain budget cuts imposed on other areas of government expenditure. In **Thailand**, the government increased the budget for free medical care for the poor. Health budget cuts were designed to protect the most critical public health services. The FDA budget actually increased in 1998; however, HIV/AIDS and health promotion program budgets were reduced. The MOPH strengthened its essential drugs policies and drastically decreased the budget of the Civil Service Medical Benefits Scheme. The **Indonesian** Government response was not to expand capital investment on health but, with the support of international donors, to provide services for the poor and elderly, maintain MCH services, and ensure supply of essential drugs. Expansion of the Social Security Safety Net (SSN) formed a major component of the response. In **Vietnam**, one cannot really speak of 'responses' to the

Asian economic crisis in the health sector, because the crisis has not been recognised as having had a negative effect on health *yet*. This situation may change in the not too distant future if indicators begin showing significant downturns. In the **Lao PDR**, the government adopted a stronger budget for the 1998/99 fiscal year as well as raising customs valuation exchange rates and introducing a package of tax reforms. To improve the implementation of health programs, the MoH authorised the immunisation program to prepare a budget plan in US currency (the most stable currency).

The impact of the economic crisis has reinforced the decision by most donors to focus on primary health care. Many international donors, including the World Bank and AusAID, decided to target health interventions within a poverty focus. The crisis presents an excellent opportunity to take stock of such a move.

Monitoring

An indicator of governmental responses to the health aspects of the crisis is whether or not a special monitoring unit or committee has been established to gather and interpret data on the crisis and formulate appropriate policies. It appears that only **Indonesia** and **Thailand** have established such units.

The ADB has established the Asia Recovery Information Centre, accessible through the Internet, with the support of AusAID. While proving to be a valuable source of economic data, the quality and timeliness of social impact data, especially health indicators, is still not high. ARIC health indicators are mainly long-term indices such as life expectancy and infant mortality, which may not be particularly sensitive to the changes that have occurred due to the financial crisis. ARIC's section on Social Dimensions includes some valuable reference papers; however, they include very little information on the **Lao PDR** and **Vietnam**.

Recommendations

Recommendations differ between countries as the impact of the crisis, while similar in some sectors, varied greatly in others. See country chapters for more specific details.

Health monitoring systems

Recommendation: Provide additional support to strengthen and expand health-monitoring systems that would increase the capacity to assess the impact of the crisis on vulnerable groups.

This is particularly the case in the Philippines, the Lao PDR, and Vietnam where specific crisis impact monitoring systems are not in place. In these countries, extensive networks of development NGOs could assist in the collection of data. Data collection should focus on food security, household income and purchasing power, child and maternal nutritional status, health service utilisation and program coverage, prices of drugs and other essential medical supplies, and other key, non-health, social indicators, such as school dropouts.

In addition, there is a place for focused studies that assess the impact of the crisis in particular disadvantaged groups, such as the urban and rural poor, unemployed, female-headed households, homeless children, and – in some countries, such as the Lao PDR – certain ethnic groups. The Asia Recovery Information Centre, funded by AusAID, should revise its health indicators to include indices that are more sensitive to acute changes in the health environment. Information on social impact in Vietnam, Lao PDR, and – possibly – Cambodia should be included on the site.

Protect government health programs from general budget cuts

Recommendation: Provide support to supplement activities and funding requirements where the government is unable to maintain program coverage.

Potential areas where a budget shortfall could occur include HIV/AIDS and STDs, child immunisation, maternal and child health, family planning services, and tuberculosis treatment and control. The Lao PDR and certain provinces in the Philippines require significant support for EPI. Both these countries have included routine ***Hepatitis B vaccination*** in their current five-year health plans; however, neither is able to implement these programs.

Provision of basic health services

Recommendation: Continue to provide and expand commitment to primary health care projects at the community level.

Emphasis needs to be on provision of health promotion and disease prevention services, in particular to poor urban areas in Thailand and Indonesia, and the rural poor in the Philippines, Vietnam, and Lao PDR. NGO-based health projects targeted at vulnerable groups should be supported.

Nutrition

Recommendation: Provide support for micronutrient supplementation programs.

While there is disparate and often contradictory evidence of adverse nutritional effects of the crisis in the countries studied, the potential impact on vulnerable groups should not be underestimated. The effects on nutrition may not be immediately apparent; however, children and pregnant and lactating women are at greatest risk. Rather than increased acute malnutrition prevalence, it is more likely that rates of chronic malnutrition (stunting) and micronutrient deficiency disorders will increase in the medium-term.

Health promotion

Recommendation: Provide support to expanding health promotion programs, especially those aimed at preventing non-communicable diseases and injuries.

The leading causes of morbidity and mortality in the countries reviewed in this study (with the probable exception of the Lao PDR) are shifting rapidly to what WHO and the World Bank refer to as Group 2 and 3 conditions. These diseases are related to changes in nutrition, lifestyle, drug, alcohol and tobacco use, environmental and occupational factors, and rapid urbanisation.

As a result of stagnating government revenue, public investment in programs that address these issues is unlikely to increase in the short-to-medium term. This support should initially be in the form of applied health research, especially intervention research studies that develop appropriate strategies to promote good health in the context of the national health profile, culture, risk behaviours, and available resources.

Rational Drug Policy

Recommendation: Provide financial support to assist with the procurement of essential drugs, vaccines, and other medical supplies.

Policy reviews should be undertaken (and supported by donors) with a view to promoting the rational use of drugs, increasing the use of generic drugs, and standardising prescribing practices. Logistics systems also need to be strengthened in some countries.

Health Sector Reform

Recommendation: Provide support to strengthen planning and management skills at both the local and national levels to ensure that appropriate and high quality health services are provided.

Assistance should be given with training (including needs analysis, monitoring and evaluation) to address some of the complications brought about by devolution, which have been intensified by the economic crisis. Low quality of health care and inequity of provision of health care have also aggravated problems in the health sector and such issues need to be addressed at a national level. There is a danger that future reform efforts may lead to budget cuts at a national level that will disadvantage certain vulnerable groups.

Health Insurance Schemes

Recommendation: Support should be extended to the development of appropriate health care financing initiatives, including cost recovery; more effective targeting of government subsidies; pilot projects of other risk sharing mechanisms; and the development of a stronger planning and policy capacity in the field of health insurance in order to improve the long term sustainability of health systems.

Indonesia and Thailand have demonstrated a commitment to ensuring equity of access to health services since the onset of the crisis by concentrating resources on social

safety net schemes. The Philippines has had mixed success with SSN programs while Vietnam and the Lao PDR basically have no such systems. Indonesia and Thailand have required substantial donor contributions to maintain and expand their SSN schemes, a situation that is not sustainable in the long-term. Support in this area is probably relevant in all five countries in the study, although each is at a different stage in developing national health insurance schemes.