



# **Protecting Pro-Poor Health Services during Financial Crises Lessons from Experience<sup>1</sup>**

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## Executive Summary

The current global financial crisis is substantially affecting almost all countries at all levels of income. This paper addresses several key questions. What is the nature of this crisis and in what ways does it differ from previous experiences? What are the lessons from the past that can help us understand the potential health impacts of this crisis? How have governments responded previously – well and less well - to protect health? How can we improve the likelihood of positive action by all stakeholders today?

Today's crisis is clearly different, starting in the most developed countries and spreading to those of middle and lower income. It is more global in scope. The effects of the current crisis on developing countries are still emerging, but economic growth is already forecasted to dip significantly for many and the breadth and depth of today's difficulties may be greater than in the past.

We have better evidence on health impacts of previous crises in middle income countries, than in lower income countries. However, we can expect several health-related impacts in previous crises to emerge this time in both middle and low-income countries. Households will experience reductions in employment and income and this will affect nutrition and expenditures on health care. Many may be pushed into extreme poverty if catastrophic health events occur at the same time. The vulnerable will be more affected, including women, children, the poor, and informal sector workers, who constitute a large percentage of workers in developing countries - over 1 million excess infant deaths may have occurred in the developing world during 1980-2004 in countries experiencing economic contractions of 10% or higher. Real government spending on health care will likely decline due to reduced revenues, currency devaluation, and potential reductions in external aid flows. The lowest income countries with weaker fiscal positions will show the largest negative effects.

Past crises teach lessons about how to protect health outcomes and reduce financial risk. Broad-brush strategies to maintain overall levels of government health spending failed to protect access and quality of services for the poor. It is vital to ensure supplies of essential health commodities in the face of worsening exchange rates. Focused efforts to sustain the supply of lower level services, combined with targeted demand-side approaches like conditional cash transfers may be more effective than broader sectoral approaches. Lower income countries may need specific short-term measures to protect progress on the Millennium Development Goals (MDGs).

This paper is an initial contribution to work in this area by the World Bank and other partners. We expect to build on this work in the coming months.

## **Background**

The past few months have been extremely challenging for many countries across the world. For some of the poorer countries, the worst global economic contraction since the Great Depression comes on top of the earlier difficulties posed by higher food, fuel and commodity prices. The initial impacts were felt in the financial, credit, housing and export markets and are now reaching other economic sectors. Ministers of Finance and Central Bankers around the world, especially from developed countries, have reacted to the crisis with unprecedented rescue packages. The fiscal stimulus in G-20 countries in 2009 is projected to amount to 1.5% of GDP (IMF, 2009). Additional measures have been taken by developing countries. For example, China has announced a 4 trillion-Yuan (585 billion U.S. dollars) two-year economic stimulus package to boost growth and domestic demand (Hanson, 2009).

These support and stimulus packages are likely to have important fiscal implications which could have unintended adverse impacts on government sector priorities, including for the health sector. One key imperative is that the rescue and stimulus spending plans not come at the expense of resources for human development, especially programs targeted for the poor. It is equally important that the developed countries maintain the commitments that have made over the past few years to support efforts to reach the Millennium Development Goals (MDGs). These issues are especially critical, given that the evidence from prior crises suggests that government expenditures on health in developing countries are vulnerable during periods of fiscal stress and that donor funding can be very volatile, even in robust economic times. At the same time, economic downturns are often periods when household out-of-pocket health expenditures, especially on medicines, tend to decline. Potential reductions in health expenditures could therefore negatively impact progress towards meeting both the overall as well as the health-specific MDGs.

Given these concerns, the World Bank has recently encouraged developed country governments to donate 0.7% of their respective stimulus packages (analogous to the Monterey target for development assistance) to a Vulnerability Financing Framework which would support vulnerable populations affected by the global financial crisis.

## **Objective of this paper**

This paper reviews the impact of previous financial crises and the impact of the policy measures undertaken in response to these crises on health outcomes and health financing. The paper also reviews the effectiveness of health support provided by the World Bank to countries during previous financial crises. Learning from past experience should help us to make improved decisions during the present crisis.

The paper draws upon existing literature on the impact of financial crises on health as well as more generally on the economy. Financial crises have been the subject of extensive study at the World Bank and a recent review takes stock of the Bank's research

on past crises.<sup>2</sup> This review notes the impact of previous financial crises in Latin America and Asia over the 1980s and late 1990s on the real incomes of workers and households and their distribution and school enrolment. On the policy response side, the paper warns that social expenditures are pro-cyclical, and that during adjustments, the less pro-poor social expenditures are more likely to be protected. The paper also emphasizes that crises can have serious consequences for human development, including short-term nutritional deprivations that may increase child mortality, as well as long-lasting negative effects on cognitive ability and physical growth.

The Bank has supported countries undergoing financial crises, especially in Latin America, Asia, Eastern Europe, and the Former Soviet Union through different types of financial and other assistance programs. This support often included provisions to protect pro-poor expenditures, including expenditures on health, from declining. Were such provisions successful in protecting these expenditures and more importantly, were the protected expenditures actually pro-poor to begin with? If not, what actions could be taken during this crisis to better protect the poor?

It is not the purpose of this paper to make an exhaustive review of Bank operations to support health during financial crises. Rather, the aim is to draw some practical lessons from previous operations in order to gain some understanding about what to replicate and what to avoid in dealing with the current financial crisis. The paper draws on a review of existing research and on the analysis of household surveys and other data to track health outcomes and expenditure behavior during times of financial crisis.

Most of the analyses of past contractions have focused on middle-income countries. But today, much of our attention on health outcomes is on the lower income countries, especially those of Sub-Saharan Africa whose progress is critical for global achievement of the MDGs. There is little evidence on how previous crises affected these countries, which raises the question of the relevance of past experience to the current threats faced by the low-income countries. Despite this caveat, we believe the lessons learned on protecting pro-poor expenditures are probably highly relevant across a range of poor and middle income countries.

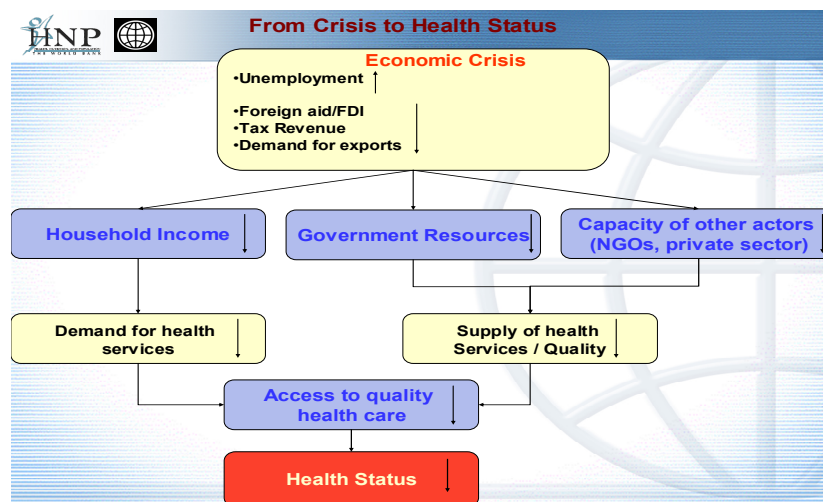
### **A Simple Conceptual Framework**

Financial crisis and economic contractions may potentially reduce demand for health services and the supply of quality health services. This could result in reduced access to quality health care for the poor, and ultimately a decline in their health status. *While no causality is being attributed in this paper, evidence suggests that there is a strong association between economic downturns, a decline in health utilization, and negative outcomes in some countries.* Box 1 illustrates one possible schematic of how a financial crisis can impact health status, especially for the poor.

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<sup>2</sup> Research Support Team. Development Research Group. Lessons From World Bank Research on Financial Crises. Policy Research Working Paper No. 4779. November 2008

### Box 1: From Crisis to Health



Economic crises can have significant negative consequences for health, especially for the poor. Large economic contractions could squeeze public and private resources, thereby impacting the availability of health funding and eventually health outcomes. In particular, the poor are especially susceptible to irreversible damage to their health status as a result of economic contractions. Thus, it is imperative that policymakers, governments and donors be ready with effective policy responses to the prevailing financial crisis.

**Increases in unemployment, declining foreign aid/FDI, declining tax revenues, and a lower demand for exports can be expected to result from the current crisis.** The current crisis has already resulted in a slow-down of growth in most developing countries. The current crisis is producing job losses across the developing and developed world. Remittances are beginning to decline. Governments in developing and developed countries alike are also likely to witness a fall in government revenues as tax collections dip. Economic uncertainty and domestic problems could force donors to scale back their aid commitments and for developing countries to reduce social spending. Exchange rate fluctuations may also reduce the purchasing power of aid flows.

**Household incomes, government resources, and the economic resource capacity of other actors also tend to decline during any crisis.** As economic activity slows down and unemployment rises, both labor and non-labor incomes tend to decline. Poorer households are likely to suffer the most as they have less room to re-adjust and cushion their expenditures, often forcing a decline in demand for health services. Crises can also significantly weaken the public sector and its ability to supply quality health services; delivery of certain services also may be stopped – budget cuts could force public hospitals to freeze hiring of nurses and doctors, for instance. Other actors, including NGOs, who typically attract fewer donors during a financial crisis, are also likely to face significant financial constraints.

**The aforementioned factors limit individual and household access to quality health care, with a likely impact on population health outcomes.** The poor, and other marginalized groups, such as girls and the elderly, are likely to suffer more during crises as they typically have less control over resources. The non-poor and other groups have in the past captured the public sector to the detriment of the poor. Even if outcomes do not change much in the aggregate, it is likely that the health status of the poor and other marginalized groups will regress if preemptive measures are not taken.

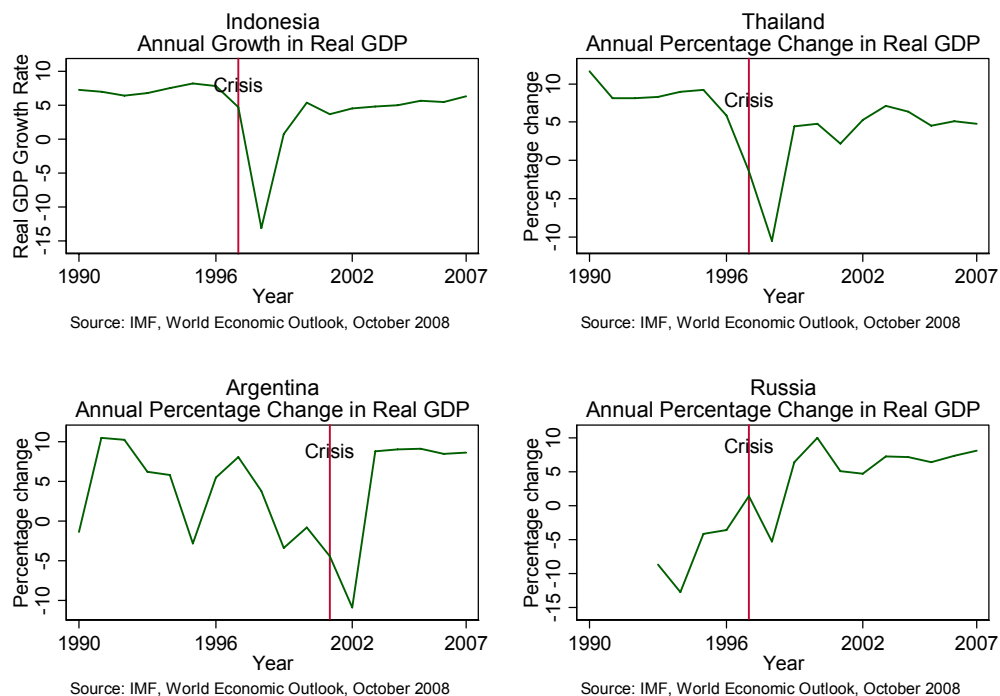
## How does the current crisis compare with previous crises?

We begin with a brief overview of how the current crisis differs from previous prominent examples. It is important to highlight some of the key differences in order to understand the implications for the current financial crisis. We focus here on the crisis in Argentina (2001), East Asia (1997-1998), Russia (1997-1998), Peru (1988-92), and Mexico (1980s and 1990s).

**One key difference is that previous crises primarily originated in developing countries.** The East Asian financial crisis started in April 1997 with the depreciation of the Thai baht, which then triggered a domino effect on the currencies of Indonesia, Korea, Malaysia, and the Philippines. **Additionally many countries at the time were plagued by large fiscal and external deficits that inhibited their ability to enact countercyclical government expenditure.** The Government of Argentina's foreign debt alone totaled approximately 50% of GDP in late 2001, with \$30 billion due in 2002 (Feldstein, 2002).

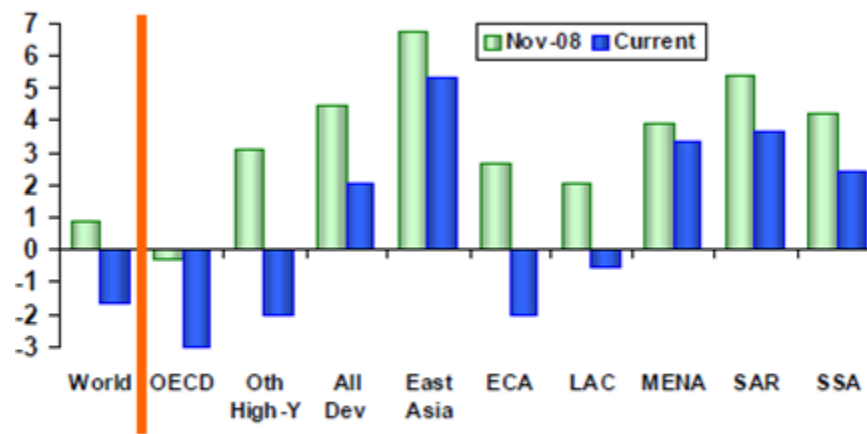
Graph 1 below shows the contractions in GDP from previous crises for Indonesia, Thailand, Argentina, and Mexico. In all four countries, economic growth not only decreased dramatically and became negative. The Argentinean economy, for instance, lost 20% of its GDP between 1999 and 2002 (Argentina Poverty Assessment, 2003). As a result of the 1997-98 financial crisis, GDP in Indonesia contracted by 13.1% and by 10% in Thailand in 1998 (ADB, 2001, Macfarlane Burnet Centre for Medical Research, 2000).

**Graph 1: GDP Growth in Indonesia, Thailand, Argentina, and Russia, 1990-2007**



**In contrast to the situation during previous crises, the current financial crisis has originated in developed economies.** High-income countries have been hit first and are in deep recession this year, with OECD economies likely to contract by 3% and other high-income countries by 2%<sup>3</sup> (World Bank, 2009f). GDP among developing economies are expected to decline from 5.8% (2008) to 2.1%<sup>4</sup> (contrasted with earlier projections of 4.4% growth from 2008 to 2009). Two developing regions, Europe and Central Asia, and Latin America and the Caribbean will experience a decline in GDP in 2009. Global GDP is expected to contract by 1.7% in 2009, which would be the first decline in world output on record<sup>5</sup> (World Bank, 2009f).

**Graph 2: GDP Growth in 2009<sup>6</sup>**



Source: World Bank, DEC Prospects Group.

**Some countries are in better fiscal positions now than during the early stages of previous crisis, but more countries are impacted.** As of 2008, emerging and developing countries on average had positive general government fiscal balances and were in a better fiscal position than advanced economies (Graph 3a). In reaction to the crisis, some governments have announced expansionary fiscal packages in order to boost their economies (IMF, 2009). These policy levers were not necessarily available during previous crises. But as the crisis expands, it affects more countries which are less able to mobilize significant domestic or international financing to produce much stimulus. These stimulus packages may also lead to further deterioration in fiscal positions in the coming years. Weaker revenues (resulting from reduced trade and collapse in manufacturing sectors) will also lead fiscal deficits to widen sharply in 2009 (Graph 3b) (World Bank, 2009f).

<sup>3</sup> As of April 2, 2009

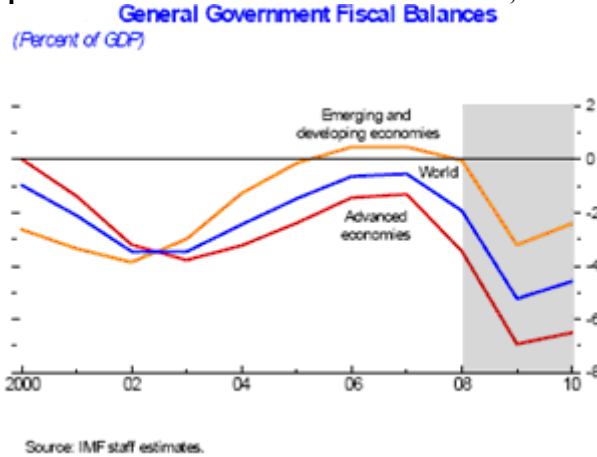
<sup>4</sup> As of April 2, 2009

<sup>5</sup> As of April 2, 2009

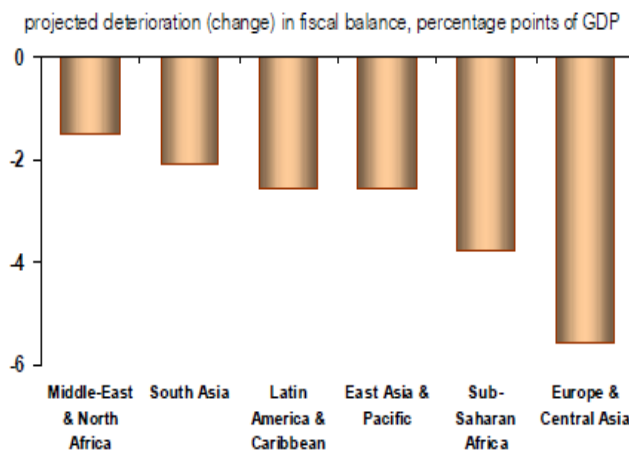
<sup>6</sup> As of April 2, 2009



**Graph 3a: General Government Fiscal Balances, 2000-2010**



**Graph 3b. Fiscal Deficits to Widen Sharply in 2009<sup>7</sup>**



Source: World Bank, DEC Prospects Group.

**Trade is slowing down and reduced demand for exports from developed country markets is hurting developing countries.** Volumes of world trade in goods and services are expected to drop to 6.1% in 2009<sup>8</sup>, with a significantly sharper contraction in trade volumes of manufactured products (World Bank, 2009f). There are fears that a prolonged crisis in developed countries may give way to increasing calls for protectionism (World Bank, 2009a). In November and October 2008, exports from low-income countries to the United States were down approximately 6% relative to the same time period in 2007, and approximately 3% from middle-income countries (World Bank,

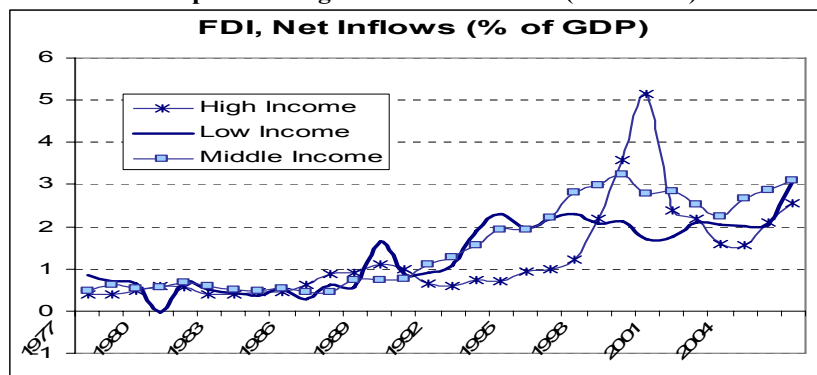
<sup>7</sup> As of April 2, 2009

<sup>8</sup> As of April 2, 2009

2009a). While some of these declines reflect a fall in commodity prices, low-income countries are likely to continue to face adverse market conditions for exports to high-income countries.

**The importance of foreign direct investment (FDI) has increased in most developing countries in recent years.** As shown in Graph 4 below, FDI is playing an increasingly important role in the economies of both low and middle income countries. Between 2005 and 2007, FDI totaled approximately 2.8 % of GDP in low and middle-income countries (World Bank, 2009). Declines in FDI and private international capital flows triggered by the financial crisis are already having a strong impact in developing countries. FDI in 2009 is expected to contract by over \$100 billion (World Bank, 2009).

**Graph 4: Foreign Direct Investment (1977-2007)**



**Remittances constitute an increasingly important source of foreign exchange and direct support to households in many developing countries.** In 2008 alone, remittances totaled \$283 billion (World Bank, 2009a). Between 2005 and 2007, the median value of remittances to low-income countries was 3.2% of GDP. In some countries, this number was above 20%.<sup>9</sup> Recession in developed countries and resulting rises in unemployment and decreased demand may decrease these remittances substantially. World Bank projections in November 2008 suggested that remittances to developing countries could decrease by between 1-6% in 2009.

**Increased reliance on Health ODA in recent years puts poor countries at greater risk of impact from what happens in developed countries.** In 1996 only 7 countries received development assistance for health (DAH) which comprised 30% or more of total health expenditure. By 2006, this number had grown to 23 (WHO, 2008). Currently, in Rwanda and Ethiopia, over 50% of total government budgeted health expenditure is financed by donors, and off-budget donor funding for health accounts for more than 100% of government health expenditures. While these large increases in external assistance for health have allowed governments to expand service provision, this has also made many countries dependent on these flows in order to sustain expenditure levels and service delivery to their populations, especially the poor and most vulnerable. **It is yet to be seen how the financial crisis will affect aid flows.** Research has shown

<sup>9</sup> Kyrgyzstan, Moldova, Tajikistan, Haiti, Honduras and a number of small island economies.

that there is an ambiguous relationship between economic growth in donor countries and subsequent aid flows to developing countries (Mold et al, 2008), and this is clearly an area of concern.

In addition to key differences from previous crises, there remain elements that tend to be common across all financial crises. **Unemployment, for instance, is projected to increase dramatically in both the developed and developing world.** The International Labor Organization's *Global Employment Trends 2009*, projects that global unemployment could increase by 18 to 30 million people in 2009. Additionally, in the worst case scenario approximately 200 million workers, particularly in developing countries, could be pushed into extreme poverty.

**Slower growth and shrinking trade will likely halt progress made by developing countries in reducing poverty.** Estimates suggest that slower growth in Indonesia will force some 1.6 million Indonesians, who otherwise would have escaped poverty, to remain below the national poverty line in 2009. In 2010, 2.7 million Indonesians will remain in poverty who would otherwise have escaped (Lin, 2008). This slowdown in poverty reduction is expected to be compounded by the already severe impacts of the food and fuel crisis. Current estimates suggest that between 130 and 155 million people were pushed into poverty in 2008 as a result of increased food and fuel prices (World Bank, 2009a). Coupled with these numbers are estimates that as a result of lower economic growth, 46 million people who would have otherwise exceeded this limit will remain below the \$1.25 per day poverty line (World Bank, 2009b).

As noted above, reduced trade flows and remittances along with downward pressures on FDI and donor assistance are channels through which the severe economic and financial difficulties in Europe, the US, and Japan are being transmitted to less developed countries in ways that were not so significant in past crises. Nevertheless, while previous financial crisis may have been different in nature, lessons can be derived with specific reference to health expenditures, utilization, and outcomes. These are discussed subsequently.

### **Impact of the Previous Crises on Health Expenditures**

The previous section looked at the general economic impact of financial crisis. In this section, we focus more specifically on the impact on government health expenditures. **Evidence from Latin America shows that public expenditure, particularly in the social sectors, tends to be pro-cyclical in countries with large fiscal deficits** (Ravallion, 2008; Braun and Gresia, 2003). Governments tend to expand social expenditures during times of economic expansion and decrease them during recession (Braun and Gresia, 2003). For instance, in Mexico the 4.9% fall in GDP per capita between 1994 and 1996 was mirrored by a 23.7% fall in targeted spending per poor person (Hicks and Wodon, 2000).<sup>10</sup> During times when the population is suffering due to

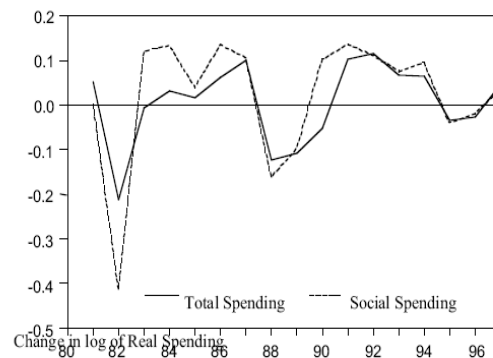
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<sup>10</sup> Targeted social spending includes government spending aimed at establishing or strengthening systems of social protection that mitigate the potential impact of crises before they occur and assist the poor cope with the shocks after they have happened (Hicks and Wodon, 2000).

stagnant or decreasing economic growth, social spending on health and education, including certain safety net programs, is at risk of being cut.

Data from Argentina during the 1980s and 1990s highlights this point. Graph 5 shows that the elasticity of social spending with respect to total government spending from 1980 to 1997 is 2.14 and statistically significant.<sup>11</sup> Therefore, a one percent decrease in total government spending is – on average – mirrored by a 2.14% decline in social spending. Conversely, Ravallion (2002b) finds that the elasticity of social spending to total spending during times of fiscal expansion was 0.14 and was not statistically significant. Thus, it is critical to look separately at the elasticity of social spending during recessions and expansions. During times of macroeconomic shocks and negative GDP growth, expansionary fiscal policy can help to compensate for declines in income through public spending, especially for vulnerable portions of the population (Braun and Gresia, 2003). However, between 1994 and 1996, targeted social spending in Mexico and Argentina actually contracted, concurrently with declines in GDP.

**Graph 5: Total Public Spending and Social Spending in Argentina 1980-97 (changes in logs)**



(Ravallion, 2002b)

There is evidence that Argentina was able to reverse some of its procyclical social spending trends during the 2001 financial crisis. While total government health spending per capita contracted in real terms and the total government budget contracted by 25% (Graph 6 and 7), national spending on public health programs actually expanded by 70% in real terms - from \$90 million pesos in 2001 to \$150 million pesos in 2002 (Braun and Gresia, 2003; World Bank, 2003). These increases were particularly focused on strengthening maternal and child health programs and programs targeted at specific diseases, including vaccinations. The Government of Argentina effectively prioritized this targeted health spending, despite overall fiscal and economic contractions.

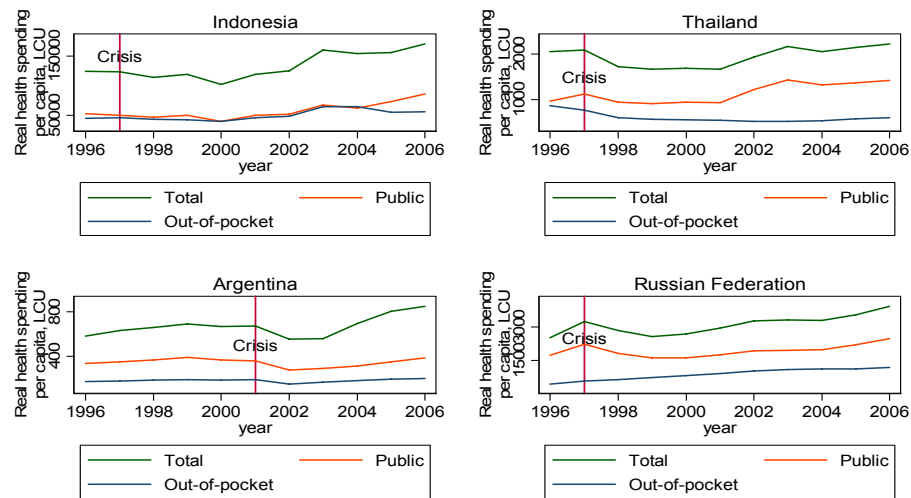
**Evidence from previous crises in Thailand, Indonesia, Argentina and Russia highlights the pro-cyclical declines in health spending** in both real local currency units (LCUs) and at the average US Dollar exchange rate (the latter highlights the impact of the sharp devaluations that take place during a crisis) (Graph 6 and 7). Total, out-of-pocket, and public health spending per capita fell in real LCUs, and fell at a much sharper

<sup>11</sup> Social spending includes education, health, water and sewage, housing and urban development, social assistance, and labor programs.

rate in US Dollar terms than in LCUs. In the case of Indonesia, Thailand, and Russia, it took many years for health spending to reach pre-crisis levels again. In the case of Argentina, total and public health spending per capita have yet to reach pre-crisis levels in US Dollar terms. Devaluations result in a rise in prices in local currencies of imported commodities, including drugs. Declines in government and out-of-pocket expenditure rates, combined with the increased utilization and demand for government services discussed later in this paper, emphasize the squeezing effect these crises can have on the financing of health service delivery. As a result, households may spend less of their income on health and other social services and look to publicly funded and provided sources. However, in the case of Argentina, Indonesia, Thailand, and Russia, the decreases in real public health spending per capita also inhibited the ability of governments to provide services.

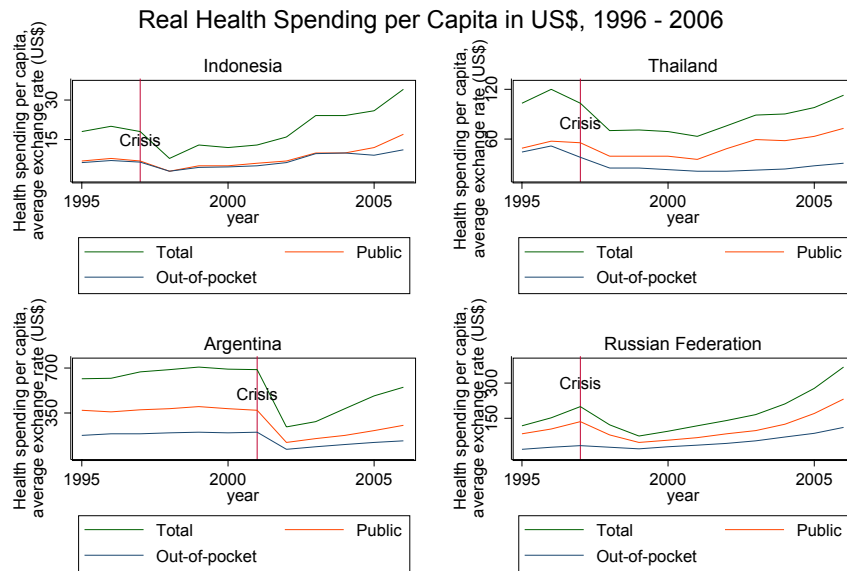
**Graph 6: Real Health Spending per Capita in Local Currency Units (LCUs)**

Real Health Spending per Capita in Local Currency Units (LCUs), 1996 - 2006



Source: World Health Organization and World Bank

**Graph 7: Real Health Spending per Capita in US\$**

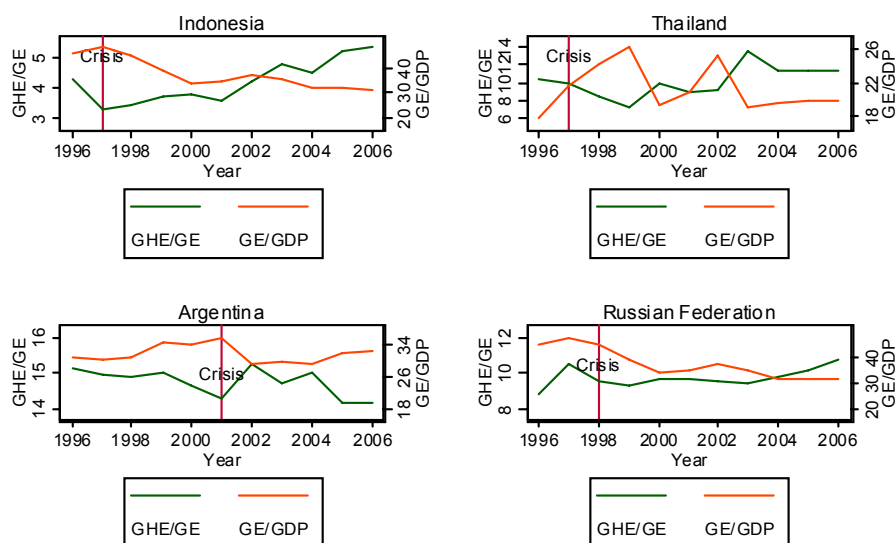


Source: World Health Organization and World Bank

One often considered policy response is to protect health spending as a share of GDP, or as a share of the budget. For instance, in response to the economic crisis in 1999, the Government of Georgia tried to maintain spending on health at 7.3% of the total government budget, as part of its lending agreement with the World Bank. Not only did government health spending decline in real terms that same year, it also did not meet the 7.3% target, according to WHO data. **Evidence suggests that efforts to protect government health expenditure as a proportion of GDP, or as a proportion of total government expenditure, may not be sufficient, as government expenditures per capita in real terms may still decline substantially.** In Argentina and Indonesia, despite increases in the share of health in government expenditure (Graph 8), government health spending per capita declined due to a fall in both GDP and overall government expenditure as a percentage of GDP. The decline in government health spending per capita in Thailand was driven by the decrease in health's share of government expenditure and an overall GDP decline. The situation in Russia was particularly severe, with government expenditure as a percent of GDP and government health expenditure as a percent of overall government expenditure both declining.

**Graph 8: Government Health Expenditure as Percent of Government Expenditure**

Government health expenditure as % of Government Expenditure (GHE/GE)  
Government Expenditure as % of GDP (GE/GDP)



Source: World Health Organization

**Non-salary expenditures may see the sharpest declines.** In many countries a large proportion of government health expenditure goes to pay salaries. Given the difficulty in downsizing the civil service, non-salary expenditures, used to pay for drugs and other variable inputs, as well as investments, may decline substantially and impact the quality of care. During the 1997 East Asian financial crisis, the percentage of the Thailand Ministry of Public Health budget going to salaries increased from approximately 39% in 1995, to 47% in 1999 (Wibulpolprasert, 1999). In the Thai case, the investment portion of the health budget fell from approximately 39 % of total health expenditure in 1995 to 11.5% in 1999. Even if health workers are protected, the quality of health care will decline in the absence of critical inputs such as equipment and medicines, due to reductions in variable budgets. Such a situation may be further exacerbated if the price of imported drugs and other supplies increase due to currency devaluation. Subsequent to the 1997/98 financial crisis in Indonesia, the decrease in utilization of health services was more pronounced for public facilities than for their private counterparts, primarily as a result of the severe shortage of drugs and other medical supplies in public facilities and the detrimental impact on quality of care (Frankenberg et al, 1998; Knowles et al. 1999).

**Governments need to put into place safeguards to protect health expenditures in real terms, particularly for those services and programs utilized by the poor and most vulnerable.** Ravallion (2002) shows that in Argentina, during 1980-1998, the targeting of social programs aimed at the poor weakened as the non-poor captured benefits. The Trabajar program was designed as a workfare program intended to help compensate poor unemployed workers from the impact of macroeconomic shock. Ravallion (2002a) found that when the health budget expanded, so did the presence of

Trabajar in poor areas<sup>12</sup>. However, during times of fiscal contraction, the program was cut from poor areas. As the budget was cut, the non-poor effectively captured the benefits of the program and targeting weakened. However, in reviewing social programs from Argentina, Bangladesh and India, Ravallion also found that targeting tends to improve as the program expands. This is certainly true of Argentina, where targeting improved significantly in later workfare programs. The workfare component of the Jefes de Hogar (Heads of Household) Program<sup>13</sup> addressed some of the weaknesses of earlier programs by expanding coverage and increasing spending on the social safety net<sup>14</sup> (World Bank, 2002). Argentina's response during the 2001-02 is also illustrative of how government protection of priority health programs can protect essential services used by the poor and the most vulnerable.

### Protection of priority health programs in Argentina during and after the 2001-02 crisis

The 2001-02 crisis in Argentina caused a drop in total health spending, but the national government protected spending on priority health programs. National spending on public health programs (including transfers to provinces) increased by 70 % in real terms - from 90 million pesos in 2001 to 150 million pesos in 2002. This increase is largely attributable to the strengthening of the maternal and child health program and the program for preventing and controlling specific diseases and risk factors (which include the purchase of vaccines). Health allocation in 2003 reflected a continued priority accorded to these programs.

**Total Health Sector Allocations (including National Public Spending and Budget Transfers)**  
(In millions of pesos, 2001)

	2001	2002*	2003*
<b>All Public Health Programs</b>	<b>89.19</b>	<b>150.84</b>	<b>121.92</b>
Fight against AIDS and Sexually Transmitted Infections	3.41	1.03	0.24
Prevention and Control of Diseases and Risk Factors (including immunizations, VIGI-A, etc.)	42.46	100.52	65.86
Maternal and Child Health Care	29.46	40.32	41.84
Coverage for Emergency Health Care	1.26	0.67	0.88
Other programs	12.61	8.31	13.09
Prevention and care of addictions, and the control and fight against drug addiction		7.41	11.39
Diagnosis and treatment of chronic diseases and risk behaviors		5.22	16.42

Source: National Office of Consolidated Public Spending – Ministry of Economy, 2003  
\*Preliminary estimates

Source: World Bank, 2003

<sup>12</sup> An evaluation of the Trabajar program, supported by the Bank, found that 80 % of benefits went to people in the bottom 20% of the income distribution, and over half of the benefits reached the lowest 10% (after factoring in foregone incomes).

<sup>13</sup> A social safety net launched by the Government of Argentina in April 2002 to alleviate the impact of rising unemployment due to the sharp worsening of the economic crisis. The Jefes de Hogar Program provides a stipend of 150 Argentine pesos/mo to an unemployed head of a household in exchange for participation in 4 hours of work in community services, small construction or maintenance activities, or training, including finishing basic education, or as a temporary employee of a private company.

<sup>14</sup> For a more detailed discussion on the targeting component of the Jefes de Hogar (Heads of Household) Program, see World Bank, 2002



**Additional evidence from India and Bangladesh confirms that aggregate cuts in social programs tend to be associated with worse targeting and the deterioration of benefit incidence** (Ravallion, 2002a). In India, based upon the difference between the average and marginal odds of participation in three key poverty reduction programs – public works schemes, the Integrated Rural Development Program and a food rationing scheme<sup>15</sup> - higher aggregate outlays of various social programs are associated with more pro-poor benefit incidence and conversely, as budgets are cut, the targeting of the programs also deteriorates. The marginal odds of participation tended to fall more steeply than average odds of participation for richer income quintiles, pointing to a capture by the rich of the benefits and a greater vulnerability of the poor to lose out to budget cuts. Bangladesh's Food-for-Education Program, whose goal is to keep children of rural poor families in school through the distribution of food, provides a similar result. Ravallion (2002a) found that, as allocations were raised, the participation rate for the poor in the program increased faster than for the non-poor. This finding again suggests that targeting weakens with a contraction in the program. Other authors find similar results in Indonesia. *These results suggest that during a financial crisis, policy makers need to be particularly cognizant that the non-poor are likely to capture the benefits of social programs as budgets contract.*

**In many countries social spending is not specifically targeted and not inherently pro-poor** (Tandon et al, 2006). For instance, services such as pensions, unemployment compensation and higher education cannot necessarily be categorized as pro-poor and therefore the protection they offer during a financial crisis may not be effective at reaching those most vulnerable to falling below the poverty line or worse (Ravallion, 2002b).

### **Impact of Previous Crises on Health Utilization and Outcomes**

The next section summarizes evidence on the impact of financial crisis on health service utilization rates as well as on population health outcomes.

**Financial crises often disproportionately impact the ability of the poor to afford health services.** This can occur due to a variety of reasons. During financial crises, real wages tend to fall and unemployment tends to rise, driving down labor earnings. Non-labor incomes also fall because of declines in economic activity and changes in the relative prices of the goods and services produced by the poor. Thus, *demand for, and utilization of, health services may experience a decline during periods of economic distress.* Apart from being unable to afford treatment at health facilities and hospitals, the poor may be forced to forego consumption of essential drugs as local currency devaluation results in an unaffordable increase in the local currency price of drugs.

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<sup>15</sup> Ravallion (2002, 2002b) and Lanjouw et al. (2001) use the marginal odds-ratio of participation (MOP) to infer the incidence by quintile of an increase or decrease in public spending on a given program. The MOP is defined as the increment to the program participation of a given expenditure quintile associated with a change in the aggregate participation in the program. The average odds participation ratio is the quintile specific participation rate relative to the participation rate of the entire population and can vary from MOP in its results (Lanjouw, 2001).

During the East Asia crisis, prices of drugs rose significantly in Indonesia, and prices of some generic drugs, which were generally affordable to the poor, rose sharply during 1997- 98; some antibiotics doubling in price (Kashiwagi et al, 1999).

As mentioned earlier, the public sector also scales down its activities, including social programs, during crises. When government health expenditures decline, the quality of services in public facilities declines. Available services may be captured by the non-poor. Thus, without specific interventions, the poor are disproportionately affected in terms of utilization of health services. For example, in Argentina, from the end of 2001 to the middle of 2002, preventive health care for children dropped 38% in the general population, but 57% in the poorest households (World Bank, 2003).

**Financial crises have a significant adverse impact on nutrition.** Poor households are often forced to switch from more expensive to cheaper and often less nutritional foods, resulting in weight loss and severe malnutrition<sup>16</sup> (World Bank, 2008b). Even though the crisis itself may last for a few years, the impact on maternal and child health may be permanent. Children who experience short-term nutritional deprivations can suffer long-lasting effects including retarded child growth, lower cognitive and learning abilities, lower educational attainment, and lower earnings in adulthood (Ravallion, 2008). These problems may be more acute for developing countries, particularly Africa and low-income Asia, where health outcomes such as infant mortality and malnutrition rise as GDP growth declines during recessions (Ferreira and Schady, 2008).

Worsening nutritional outcomes were observed during the East Asia crisis. A survey of public health facilities in Thailand reported a 22% increase in anemia amongst pregnant women during the East Asia crisis, which is suggestive of a switch to less nutritious foods (Knowles et al, 1999). In Indonesia, prevalence of micro-nutrient deficiencies (especially vitamin A) in children and women (of reproductive age) increased during the crisis period (Macfarlane Burnet Centre for Medical Research, 2000). Also, the share of women whose body mass index is below the level at which risks of illness and death increase rose by a quarter, and the average weight of children under age three declined in Indonesia in 1998 (World Bank, 2001).

**Women and children often bear the brunt of the impact on health.** Most crises tend to affect these groups disproportionately because of their lack of control over resources and gender-based discrimination<sup>17</sup>. As mentioned earlier, there is some evidence that households have been forced to cut back on both food quantity (caloric intake) and quality (dietary diversity) during a crisis, and girls and women usually suffer more as they are unable to protect the nutrient intake that they particularly need (IFPRI, 2008). Mortality of girls may be much more sensitive to changes in economic circumstances than that of boys: one multi-country study reported that infant girls may experience almost three times higher increased mortality than boys for a given change in per capita

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<sup>16</sup> It is estimated that higher food prices in 2008 may have already increased the number of children suffering permanent cognitive and physical injury due to malnutrition by 44 million (World Bank, 2008b).

<sup>17</sup> Including extensive time burdens; threats or acts of violence; and limited legal benefits and protections, decision-making authority, and control of financial resources (IFPRI, 2008).

GDP, described by the authors as “a remarkable difference by any standard”<sup>18</sup> (Baird et al, 2007). This highlights the vulnerability of marginalized groups during crises.

*Over 1 million excess deaths (infants) may have occurred in the developing world during 1980-2004 in countries experiencing economic contractions of 10% or higher* (Baird et al, 2007). While the impact may vary across countries, it appears that crises either result in a worsening of health outcomes for infants and children, or a slowing down of health improvements.

In Latin America, the pace of decline in the infant mortality rates (IMR) decreased in some countries because of the financial crisis during the 1980s (Lustig, 1995). During these crisis years, child mortality increased by an average of 7-10% in Mexico<sup>19</sup> (Ferreira and Schady, 2008). However, children and women are not the only groups at risk; the young and elderly are also susceptible. For example, mortality rates for the very young and the elderly increased or declined less rapidly in Mexico during the crisis years as compared with non-crisis years (Cutler et al, 2002). Peru provides further evidence of the impact that crises can have on children. The economic crisis during 1998-02 resulted in a 2.5% point increase in infant mortality, with 18,000 more children dying than in the absence of the crisis (Ferreira and Schady, 2008). Though causality cannot be proved, the contraction of public health spending may have contributed to the increase in infant mortality<sup>20</sup>.

**There is limited evidence that child health outcomes suffer less in countries where expenditure on health is protected.** Past crises have resulted in cuts in expenditures on health, lower utilization of health services, and deterioration of child and maternal nutrition and health outcomes. However, it is difficult to establish whether these nutrition and health outcomes deteriorated less in countries that protected health expenditures from cuts, since the counterfactual is largely absent and establishing causality is difficult. Government health expenditures were cut in Indonesia following the 1998 crisis, but the effect of this was somewhat mitigated by increased donor assistance to the health sector. This may have contributed to Indonesia’s somewhat better performance in health outcomes, compared to other countries during crisis time. The contrast between Argentina’s policy actions after the 1993 crisis, which largely led to protecting non pro-poor expenditures, and the 2001 crisis, with strong protection of expenditures on nutrition, maternal and child services and essential drugs, may help explain some of the improved child and maternal outcomes seen in Argentina after 2002.

The next section discusses the response to previous crises by governments and policymakers to protect vulnerable populations from worsening health outcomes.

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<sup>18</sup> The data on births and deaths are based on 123 Demographic and Health Surveys (DHS) covering 59 countries. The surveys include countries in Africa (33 countries, 68 surveys), Latin America (12 countries, 31 surveys), and Asia (14 countries, 27 surveys).

<sup>19</sup> Cutler et al (2002) conclude that the three crisis periods resulted in increases in child mortality of 9.2 % (1982-84 crisis), 10.3 % (1985-89) and 6.9 % (1994-96).

<sup>20</sup> Paxson and Schady showed that public health expenditure fell from approximately 80 Peruvian soles per capita in 1988 to 30 soles in 1990 (Ferreira and Schady, 2008).

## Response to Previous Crises by Governments and Policymakers

**Social health insurance programs and social safety nets (SSNs) can serve as effective instruments in protecting health service utilization during crises.** In Indonesia, the *Health Care Subsidies (Health Card) program* was an important component of the social safety net, introduced by the government as a response to the economic crisis in 1997<sup>21</sup>. Under this program, a number of services were offered free to card holders, including: (1) outpatient and inpatient care, (2) contraception for women of child bearing age, (3) prenatal care, and (4) birth assistance. *While similar schemes already existed at the time, the coverage and scope of the program were changed and expanded as part of the SSN program.* The program was part of an overall effort to address the impact of the crisis, which included a rise in the price of items such as food and medicine. It was somewhat effective in increasing the utilization of health services, where direct subsidies were provided for basic health services for the poor (World Bank, 2008a). Evidence suggests that while targeting was pro-poor in the distribution of the health card, there was considerable leakage to the non-poor. Utilization of the health card for outpatient care was also pro-poor (Sparrow, 2008).

The Thai government also expanded existing social insurance programs as a response to the financial crisis. As part of this expansion, increased support was provided to the Public Assistance Scheme for low-income families. Government subsidy to the *Voluntary Health Card (VHC)* was also doubled from 500 baht to 1,000 baht per card<sup>22</sup>. Health centers and district hospitals reported a large increase in distribution of free health care cards between 1997 and 1998, and this may have contributed significantly to the increased use of public facilities<sup>23</sup>, thus mitigating the impact of the crisis on demand for health services by the poor (Pongsapich and Brimble, 1999).

“Crises have given birth to some of the worst social protection policies and some of the best”

Martin Ravallion, Director, Development Research at the World Bank

**Other examples of effective policy interventions include conditional cash transfer (CCT) programs.** Expanding the coverage and increasing the benefit levels on CCTs has been one of the many responses to economic crises, particularly in Latin America. Mexico was able to redress the adverse welfare impacts of the recent rise in food prices by implementing a one-time top up payment to Oportunidades<sup>24</sup> participants (Ravallion,

<sup>21</sup> A nationwide health program was introduced by the Indonesian government in August 1998, as part of the larger Indonesian Social Safety Net—Jaring Pengaman Sosial (JPS) (Sparrow, 2008) .

<sup>22</sup> Under this scheme, free health cards were distributed to the unemployed and low income families

<sup>23</sup> VHCs accounted for two-thirds of the outpatients visiting public health facilities

<sup>24</sup> During the Tequila financial crisis of 1994, the Government of Mexico realized that it lacked an effective safety net for the country’s poor. In 1997, it responded with a program called ‘PROGRESA’ (later called Oportunidades), which was oriented towards the poor and replaced simple cash transfers with subsidies to household investments in human capacity development. It worked more effectively because it relied on the active participation of women to improve their own and their families’ education, health, and nutrition status (Coady et al, 2005).

2008). Payment to the poorest families increased by 24.3% in 2008. While this additional payment did not fully compensate the poor for the increase in food prices, it did help avoid a detrimental effect on the poor<sup>25</sup> (Food and Agriculture Organization, 2008).

CCTs have been an extremely cost effective mechanism for financially constrained governments. On average, safety net expenditures in developing countries fall in the range of 1-2% of GDP, although there is significant variation across countries. Some of the more successful programs such as Mexico's Oportunidades or Brazil's Bolsa Familia, cost about 0.4% of GDP (World Bank, 2008b). However, CCTs are not always responsive to changes in the need for assistance, and can be prone to capture. Thus, it is critical that governments reassess eligibility when a crisis occurs. Finally, CCTs do not, in themselves, improve the supply or quality of services. If vaccines are not available at the health center, the baby will not be vaccinated, even if the CCT encourages the mother to bring the child to the clinic. Thus, demand-side incentives such as CCTs must be accompanied by adequate access and supply of services to be effective. This is even truer in times of crisis, when budget support for service delivery may be under stress.

#### **Brazil's Bolsa Familia Program**

In Brazil, the government spends 3.7% of GDP to cover the deficit in the main federal pension programs, which deliver more than 50% of their benefits to the richest 20% of the population. On the other hand, Brazil's Bolsa Familia, covering the poorest 20% of the population, cost about 0.4% of GDP in 2007, which is only one tenth of the federal pension programs.

Source: (Son, 2008)

**Financial crises have been used as an opportunity to improve the efficiency of public health systems.** In Thailand, for instance, the MoPH launched the "Good Health at Low Cost" strategy in the post-crisis period. This involved drug management reform (procuring a higher proportion of essential drugs, and support for greater use of generic drugs as currency devaluation increased the relative price of the more expensive patented formulations), and savings from a reduction of operating/capital costs and material costs<sup>26</sup> (Macfarlane Burnet Centre for Medical Research, 1999). As part of the reformulation of the MoPH budget, capital costs were reduced from 38.7% of the total budget in 1997 down to 11.5% in 2000<sup>27</sup> (Wibulpolprasert, 1999). At the same time, budgets were protected for essential services and programs such as HIV/AIDS.

<sup>25</sup> The number of beneficiaries increased by 1 million and the total number of Mexicans assisted by the program reached 5 million households (one out of four Mexican families) in 2008. Payment to the poorest families also increased to an average of 665 pesos per month (from an average of 535 pesos per month).

<sup>26</sup> This included measures such as reducing expenses on electricity, water and telephone in public hospitals and minimizing capital costs. No new capital investment projects were undertaken in 1998 and 1999 except to complete existing obligations (Macfarlane Burnet Centre for Medical Research, 1999).

<sup>27</sup> Capital costs were reduced from 38.7 % of the total budget in 1997 down to 27.3 % in 1998, 15.5 % in 1999, and 11.5 % in 2000 (Wibulpolprasert, 1999).

**In addition, public works programs have often been used by governments as a safety net.** Public spending on labor-intensive public works projects, such as building rural roads, can combine the benefits of an aggregate fiscal stimulus with those of income support for poor groups. Indonesia and Korea introduced such programs during the East Asian financial crisis; as did Mexico in the 1995 peso crisis; Peru during its recession of 1998-2001; and Argentina in the 2002 financial crisis. India has used public works programs to provide safety nets for many years. Research suggests that such programs do provide income gains for participants. Programs like Argentina's Trabajar provide effective household income support and also show that if correct incentives are in place for targeting work to poor areas, such programs may serve to compensate somewhat for what made those areas poor in the first place. It further demonstrates that protecting government spending in sectors other than health can complement essential health expenditures. *Preventing people from slipping into poverty could be critical in protecting health outcomes, as the ability of the poor to afford health services is the most at risk during crises.*

### **Response to Previous Crises by Households**

This section discusses how households are forced to change health utilization behavior in response to financial crisis, and how they might respond to such periods of economic distress. During a crisis, **households may no longer be able to afford health insurance or might become ineligible for it.** In most developing countries, pension, health, and unemployment insurance systems generally cover only formal sector workers. Thus, only a small proportion of the poor are insured. If unemployment increases, covered households may lose insurance as it is often tied to formal employment and layoffs during a crisis may result in a large pool of unemployed and uninsured individuals. The absence of health insurance, combined with the inability to finance health services through out-of-pocket payments, may result in reduced utilization of health services. For example, a survey from Argentina (World Bank Survey 2002) revealed that one negative consequence of the 2001-02 crisis was that by mid-2002, 13% of households reported that they had canceled their health insurance. *The reduction in insurance coverage was three times greater among poor households relative to non-poor households.* As a result, 57% of poor households reported a reduction in the utilization of preventative health services by their children (World Bank, 2003).

**Users may switch from the private health sector to the public health sector as their ability to pay for health services is impacted.** For example, In Thailand, the private sector faced significant demand reductions, and doctors from the private sector turned to the public sector for employment (WHO, 2009). Increased government support to the Public Assistance and Voluntary Health Card Schemes, and measures such as a reduction in private hospital entitlements in the Civil Service Medical Benefit Scheme, facilitated a transition to the public health sector. In Argentina, household incomes shrank during the 2001-02 crisis and households modified their demand for health services. The 2002 World Bank Survey referred to in the previous paragraph also revealed that, in comparison to end 2001, by mid-2002, 38% of households reported greater use of public health centers instead of private services.

**Households may have to bear additional costs and be forced to reduce their utilization of health services if public health systems are unable to respond because of reduced budgets and increased demand.** In Argentina, public hospitals in the Buenos Aires Province were unable to cope with a surge in demand as a result of the 2001-02 crisis (World Bank, 2003).

### **What should Donors do? Evidence from the World Bank's Response to Previous Crises**

**The evidence on the effectiveness of World Bank support to countries to protect pro-poor health expenditures and health service delivery for poor and vulnerable populations during financial crises is mixed.** World Bank programmatic lending operations in countries affected by financial crises in the 1990s and 2000s were reviewed in order to assess past experience and derive good practices to support quality health services for the poor during the current financial crisis. We reviewed these loans to see whether loan agreements included support for health expenditures, with an additional focus on whether pro-poor expenditures and services were identified as priorities. We then examined project completion reports to see whether countries met their commitments, and if this translated into actual protection of health services and expenditure levels. A complete list of these projects is included in Annex 1.

Our findings suggest that successful projects financed the initiation or expansion of sustainable safety nets that tied essential health services to identified funding on a per capita basis, along with an appropriate system of monitoring and evaluation. For instance, a primary objective of the 1999 Brazil Social Protection Special Sector Adjustment Loan (BSPSSAL) was to maintain expenditures on basic education, medical care, and nutritional services. Specifically, budget protection in health was included, based on floors set on per capita spending at the state and municipal level for a defined benefit package. Successful projects also avoided placing conditions on short term financial assistance that involved long term institutional reforms (which require an investment or capacity building instrument). Additionally, projects worked better when the Bank supported government efforts to expand the breadth and depth of coverage of an existing safety net, or to introduce a new, more sustainable safety net. This includes the Bolsa de Familia in Brazil and the 30-Baht/Universal Coverage insurance plan in Thailand referenced earlier.

**Despite some strong evidence of good practice, many of the projects reviewed suffer from insufficient evidence relating to baseline data and measurable indicators.** The project data tended to concentrate on the source of financing, rather than analyzing the potential effect of such financing on service delivery, or health outcomes. Likewise, the evaluations focused on indicators such as percentage of government expenditure allocated to health or other social programs which, as we have seen above, may not provide sufficient evidence about the beneficiaries. Few evaluations investigated whether the World Bank was supporting programs that were pro-poor to begin with. *As the World Bank and other donors respond to the current crisis, the focus should be to help finance a specific set of services for the poor/vulnerable, protect expenditures on a per capita basis*



*and in real terms, and where possible, the focus should be on expanding existing, well-targeted and sustainable safety nets. Baseline indicators are needed as the foundation for rigorous post-crisis evaluation.*

## **Conclusions and Recommendations**

**The global financial crisis is impacting almost all developed and developing countries.** Slower growth is forecasted for most emerging and developing economies. Developed country economies are contracting and this may impact foreign aid contributions, FDI, remittances, and global trade. Highly donor dependent countries are especially vulnerable to aid cuts. Currency devaluations in developing countries will result in higher domestic prices of imported goods, including drugs. These price increases in local currency units may decrease access to essential medicines, as well as increase the pressure on potentially shrinking government health budgets. The timing of the current crisis, on the heels of the food crisis, puts the poor at even greater risk.

This paper uses country examples from previous crises to highlight the potential negative impacts on health expenditures, health utilization rates and health outcomes. It highlights mechanisms by which financial crises might impact the health sector, provides examples where impacts have been fairly severe, and identifies some effective policy responses. Because this crisis is different from previous crises and because much of the evidence available to us from earlier events relates more to middle income countries than to the poorest countries, there is a need for more and better evidence and sensitive prospective monitoring going forward<sup>28</sup>.

**The paper argues that a fundamental objective of health public policy during a crisis is to maintain/improve access to essential services by the population, and especially the poor and vulnerable.** This is not at odds with the potential reduction in health expenditures during a financial crisis as governments struggle with tightening budgets. Past experience shows that some countries took advantage of the crisis to improve the efficiency of their public health systems and were able to protect those services that are essential to the welfare of the poor. Thus, a combination of efficiency improvements, being selective in cutting of certain types of expenditures, and/or income-support mechanisms can allow governments to maintain services that are critical to the most poor and vulnerable.

**Previous crises in Asia and Latin America show the negative impact that crises can have on access to health and nutrition services and health outcomes.** Women and children are especially vulnerable. During crises, households may demand fewer health services and opt for lower quality and quantity of nutrition. Government capacity is also impacted. This may result in deteriorating health outcomes, especially marked in the poorest quintiles of the population.

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<sup>28</sup> Some new work to develop such monitoring and more in-depth country analysis is in the planning phase now in partnership with other development agencies.



**During past crises, the Bank has supported operations that attempted to protect public “pro-poor” expenditures through loan and credit agreements.** The experience has been mixed. *Good practices include* avoiding conditions in short term lending instruments that involve long term institutional reforms. *Projects worked better when they:* (i) were aimed at financing a specific set of services that are used by the poor/vulnerable, (ii) protected expenditures on a per capita basis and in real terms rather than only ratios such as percent of GDP, or government expenditure, (iii) financed expansion of existing safety nets, or facilitated introduction of a sustainable and well targeted safety net with clearly defined beneficiary populations, and (iv) supported appropriate monitoring and evaluation mechanisms. *Experience suggests that certain policies should not be supported:* (i) general input or commodity subsidies; (ii) general conditions that earmark expenditures for the whole sector; (iii) conditions that only protect expenditures without identifying the services, or the target population to be protected; and (iv) conditions that protect financing or services that are not pro-poor in the first place.

**While maintaining government health expenditures as a proportion of total government expenditure may be a worthwhile objective, it does not guarantee that pro-poor services will be protected.** Real government health expenditures per capita declined in all the reviewed countries immediately after the crisis. This decline occurred even as many countries tried to protect government health expenditures as a proportion of total government expenditures. *Development partners need therefore to focus on protecting pro-poor health expenditures, rather than overall expenditures.* Interventions that boost household income so as to enable the poor to maintain access to essential health services may also be an option if mechanisms are in place to manage such expenditures. Evidence suggests that if well designed, low cost social insurance programs and CCTs can be successful in reaching the poor with minimum leakage, and can also be extremely cost effective.

**Given that the fall in the quantity and quality of nutrition is one of the most serious human development consequences of an economic/financial crisis, pro-poor expenditures must focus specifically on ensuring adequate nutrition.** Pro-poor public spending on health, education and social protection will need to be protected to ensure that nutrition related outcomes, and others, do not deteriorate.

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## **Argentina**

The **1998 Special Structural Adjustment Loan** (US\$2.5b) had an explicit objective to “protect vulnerable groups during a period of high uncertainty”.<sup>29</sup> The project included the following indicators:

- Improved targeting and efficiency of poverty-reducing social programs. This was to be achieved by means of a new poverty line and methodology for measuring “unsatisfied basic needs”. At the time of the ICR, the definition of a new methodology for measuring poverty had been achieved.
- Expanded coverage of beneficiary identification systems. This would be measured by the application of improved information systems to more social programs. The extension to 14 more social programs was achieved at the time of the ICR.
- Improved efficiency of overlapping poorly targeted programs.
- Safeguarding the social programs critical to the poor from budget cuts. This target was met by obtaining commitments for 1999 spending on key programs. However the ICR does not give details of these commitments e.g. real or nominal expenditure levels or percentage of budget.
- Strengthened regulatory framework of health insurance

One of the main objectives of the **2003 Economic and Social Transition Structural Adjustment Loan** (US\$500m) was to “strengthen efforts to protect social programs, thereby helping to mitigate the adverse effects of the economic crisis on the poor in Argentina.” In addition, the loan aimed to ensure that “social protection programs responded adequately to the crisis”. In order to fulfill this objective, the 2003 budget included social spending of 8.6 % of total projected spending. However, the actual spending was 10.4% which reflected a 43.8% increase in social spending in real terms so this indicator/target was “more than fulfilled”.

The Program Document also contained an action to “ensure coverage of basic health services for the most vulnerable” and the 2003 approved national budget included emergency health spending of 1.4% of total projected spending (Arg \$0.8billion), representing an increase in real terms of 32% between 2002/03 intended for “the functioning of priority public health programs, including immunizations, infant and maternal health, HIV-AIDS, and control and prevention of infectious diseases”. This spending target was “substantially fulfilled” with health emergency spending in 2003 reaching 1.3% of total health spending which represented an increase in real terms of 44% between 2002/03. This increase in real expenditures surpassed the expected increase of 32%.

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<sup>29</sup> Implementation Completion Report on a Special Structural Loan to the Argentine Republic for a Special Structural Adjustment Loan (SSAL)

## **Brazil**

**Social Security Special Sector Adjustment Loan (\$758m).** One of the main objectives of the 1999 loan was “the protection of essential public expenditure on social assistance, education and health”. The protection of carefully selected public programs aimed at the poor – especially women and children – was a core condition of the Brazil Rescue Package, and supported with a separate single tranche for US\$252 million<sup>30</sup> known as the **Social Protection Special Sector Adjustment Loan.**

The main objective of the Social Protection support “was to minimize federal budget cuts to the social assistance, health, education and labor sectors during the 1998 fiscal adjustment and to provide budgetary protection for twenty two targeted programs for the poor administered in each of the separate sector ministries”.<sup>31</sup> More specific objectives were to: “(a) maintain expenditures for human capital investment in basic education, medical care and nutrition services; (b) provide support to maintain minimum consumption levels of the working poor; (c) lengthen eligibility for temporary income support through unemployment insurance for households with no other means of support”. According to the project ICR, achievement of the program objectives can be measured in terms of “the Government’s success in maintaining and increasing budget allocations to the protected programs” which “lies in sharp contrast with cuts across the board in other areas”. Budget protection, particularly in health, was implemented by setting floors on per-capita spending at the state and municipal levels, in order to ensure a more equal distribution of public resources between the relatively poor states in the North of the country and the wealthier South.

## **Georgia**

The **Third Structural Adjustment Credit (SAC III)** for US\$60 million was approved in 1999. One of the main objectives was to “strengthen fiscal performance while lessening the adverse impact of stabilization on the poor by ensuring budgetary provisions for basic health, education and social protection”<sup>32</sup>. In assessing the performance of the loan with regard to this objective, the ICR acknowledges that “SAC3 succeeded in enhancing execution of the social sector (health and education) budget and poverty benefits, giving greater credibility to the budget and yielding a positive social impact”<sup>33</sup>. The improvement in the execution of the budget along with the reversal of the accumulation of wages and pensions arrears had a “significant positive poverty reduction affect as about half of all the nation’s employment is in the public sector”.

A further objective of the loan was to “strengthen expenditure management and ensure provision of basic social services”. The main output here was to preserve spending levels on health and education at 7.3% and 13.0% of total budget in 1999. In terms of health expenditure, the government reached 5.3% in 2000 and 7.0% in 2001. Moreover, the

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<sup>30</sup> Implementation Completion Report Brazil Social Security Special Sector Adjustment Loan (SS SECAL)

<sup>31</sup> Implementation Completion Report Brazil Social Protection Special Sector Adjustment Loan (SP SECAL)

<sup>32</sup> Implementation Completion Report Georgia Third Structural Adjustment Credit

<sup>33</sup> Ibid.

Government was current for payments of poverty benefits in 2001 and 2002 and had cleared all arrears to the poverty benefits for 1999 and 2000.

## **Indonesia**

A main objective of the 1998 **Policy Reform Support Loan (PRSL)** was “to mitigate the effects of the economic crisis and drought on the poor” as well as “continue priority investments in basic education and health”<sup>34</sup>. In assessing whether the objectives of the loan were achieved the ICR acknowledges that the “Government made considerable efforts to protect the poor through expansion of public expenditures toward priority social safety net programs, including subsidies, grants, and public works” while the “PRSL also helped mitigate the effects on budgetary resources allocated to the social sector which would have been cut more deeply due to sharp decline in revenues, and thus helped protect the poor”. However, such actions could not prevent a rise in poverty as the incidence of poverty almost doubled at the height of the crisis<sup>35</sup>. In addition, no indicators were provided such as percent of budget allocated or real/nominal increases in expenditure.

**Social Safety Net Adjustment Loan (SSNAL) (US\$600m).** One of the main objectives of the 1999 SSNAL was to “get a reasonable set of ‘safety net’ programs up and running fast to mitigate the social impact of the crisis and reach poor (subsidized rice) and “impacted” households (labor creation, community funds) and prevent deterioration in human capital (health, scholarships)”. The conditionality of the SSNAL was dependent on adequate performance and “safeguarding” of spending in six programs designated as the “key” SSN programs. In its assessment of whether the Loan achieved its objectives, the ICR states that poverty dropped from its August-October 1998 peaks, while utilization of health services increased and malnutrition did not rise above pre-crisis levels. While this may partly have been attributable to general economic recovery, the ICR maintains that the SSNAL could not be deemed a failure as conditions did not continue to deteriorate but instead improved substantially.

The program relevant to health was the “JPS-BK” (Health safety nets) which was an umbrella for many programs including health cards for entitlement to some free health services, subsidies to midwives and extra nutrition funding. Analysis suggests that health card coverage reached approximately 10% of the Indonesian population by February 1999. With regard to the targeting of the “health cards” with respect to poverty expenditure, or consumption expenditures (as an income proxy), the ICR states that this was “neither significantly better nor worse than other programs”. However, an evaluation by Pradhan, Sparrow and Saddah (2000) suggests that the health programs did increase health card usage among the poor.

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<sup>34</sup> Implementation Completion Report Republic of Indonesia Policy Reform Support Loan

<sup>35</sup> Ibid.



## **Thailand**

### **Economic and Financial Adjustment Loan and Second Economic and Financial Adjustment Loan (EFAL I and II)**

The First Economic and Financial Adjustment Loan of US\$400 million was approved in July 1998. The main objectives were “to support the Government of Thailand’s (GOT) program to restore growth by (a) deepening structural reform in the financial sector; and (b) facilitating corporate revival”.<sup>36</sup> The Loan contained a specific condition for “Protecting the Poor” whereby a commitment to “Increase public expenditures for protecting the poor” was made with the explicit objective that “Anti-poverty expenditures should be quick-disbursing and administratively simple to implement”. The government also made a commitment to “expand means-tested case and in-kind transfer programs”, with the objective of protecting the “well-being of vulnerable groups with adequate and assured income support”. The main condition relating to this stipulation was that the Government adopted “a policy of increased coverage for (i) cash transfer programs for needy families and poor elderly, and (ii) the in-kind transfer programs”.

EFAL I was followed by EFAL II which was approved in March 1999 for the amount of US\$600 million. Like its predecessor, this loan contained a commitment to increase public expenditures in order to provide protection to the poor. The ICR notes that such protection took the form of revision of workfare programs to ensure the inclusion of at least 30% unskilled workers, “geographic distribution of the workfare programs, a general increase in coverage for cash transfers for needy families and poor elderly (Bt200 to Bt300) and for in-kind transfer programs”<sup>37</sup>.

In terms of achieving its objectives, the ICR recognizes that the GOT followed through on budget allocations to social programs but the increased spending was achieved primarily by implementing projects that were already in the pipeline. In terms of the poverty impact of the loan, the report acknowledges that this had not been fully assessed but suggested that it was less than expected.

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<sup>36</sup> World Bank (1999) Implementation Completion Report The Kingdom of Thailand Economic and Financial Adjustment Loan

<sup>37</sup> World Bank (1999) Implementation Completion Report The Kingdom of Thailand Second Economic and Financial Adjustment Loan

<b>Project Name</b>	<b>Health Expenditure Objective</b>	<b>Indicator</b>	<b>Baseline</b>	<b>Ex-Post</b>	<b>Observations</b>
<b>Argentine Republic Special Structural Adjustment Loan (SSAL)</b>	“protect vulnerable groups during a period of high uncertainty”	<ol style="list-style-type: none"> <li>1. Improved targeting and efficiency of poverty-reducing social programs – proposal of a new poverty line and methodology for measuring “unsatisfied basic needs”</li> <li>2. Expanded coverage of beneficiary identification systems – application of improved information systems to more social programs</li> <li>3. Improved efficiency of overlapping poorly targeted social programs – design and implement proposals for integrating food and nutrition programs</li> <li>4. Safeguarding the social programs critical to the poor from budget cuts programs – obtain commitments for 1999 spending on key programs</li> </ol>	Not available in ICR	<ol style="list-style-type: none"> <li>1. Definition of new methodology for measuring poverty</li> <li>2. Extension of improved information systems to 14 more social programs</li> <li>3. Merger under the Social Development Secretariat of food and nutrition programs into an integrated activity</li> <li>4. Commitments obtained</li> <li>5. Satisfactory implementation of prudential and consumer protection norms</li> </ol>	ICR gives no baseline data or expenditure data for the indicators outlined. For example on the spending commitments obtained to safeguard the social programs deemed critical to the poor from budget cuts there is no information on increase in budget/spending and whether this is in real or nominal terms.

		5. Strengthened regulatory framework of health insurance – Implementation of prudential and consumer protection norms, and reporting on the union-run health program's performance			
<b>Argentine Republic Economic and Social Transition Structural Adjustment Loan (ESTSAL)</b>	“Ensure coverage of basic health services for the most vulnerable”	Emergency health spending of 1.4% of total projected spending (Arg \$0.8 billion) for 2003 for “the functioning of priority public health programs, including immunizations, infant and maternal health, HIV-AIDS, and control and prevention of infectious diseases”. This spending represents an increase of 32% in real terms for 2003/02	Not available in ICR	Health emergency spending in 2003 reached 1.3% of total health spending which is a 44% increase in real terms.	No information given in ICR on whether indicators of 1.4% of total projected spending and 1.3% of total health spending have the same denominator.
<b>Brazil Social Security Special Sector Adjustment Loan (SS SECAL)/Brazil Social Protection Special Sector Adjustment Loan (SP SECAL)</b>	“the protection of essential public expenditure on social assistance, education and health” and to “minimize federal budget cuts to the social assistance,	1. maintain expenditures for human capital investment in basic education, medical care and nutrition services 2. provide support to maintain minimum consumption levels of the working poor		Budget protection, particularly in health, was implemented by setting floors on per-capita spending at the state and municipal levels	No details given in ICR on monetary amount of spending floor

	<p>health, education and labor sectors during the 1998 fiscal adjustment and to provide budgetary protection for twenty two targeted programs for the poor administered in each of the separate sector ministries”</p>	<p>3. Lengthen eligibility for temporary income support through unemployment insurance for households with no other means of support” .</p>			
<p><b>Georgia Third Structural Adjustment Credit (SAC III)</b></p>	<p>“Strengthen expenditure management and ensure provision of basic social services”</p>	<p>1. The Government included in the 1999 budget 14.3 million GEL for the poverty benefit 2. Preserve spending levels on health at 7.3 % of total budget in 1999. 3. Adequate allocations to health, education and poverty in the 2000 budget 4. Adequate execution of the 2000 budget 5. Payment of all outstanding arrears to health education and poverty benefit</p>		<p>In terms of health expenditure, the government reached 5.3 % in 2000 and 7.0 % in 2001. Moreover, the Government was current for payments of poverty benefits in 2001 and 2002 and had cleared all arrears to the poverty benefits for 1999 and 2000.</p>	

<b>Indonesia Policy Reform Support Loan (PRSL)</b>	“to mitigate the effects of the economic crisis and drought on the poor” as well as “continue priority investments in basic education and health”				
<b>Indonesia Social Safety Net Adjustment Loan (SSNAL)</b>  Comprised of six programs  Health specific program was the JPS-BK (Health Safety Nets) Which was an umbrella for many programs: health cards entitling to some free health services, subsidies to midwives, extra nutrition funding	“get a reasonable set of “safety net” programs up and running fast to mitigate the social impact of the crisis and reach poor (subsidized rice) and “impacted” households (labor creation, community funds) and prevent deterioration in human capital (health, scholarships).	<b>Health Budget Allocation (billion rupiah):</b>  <b><u>1998/99: 2,270 billion rupiah</u></b>  SSN in Health Sector: 1043 Social Welfare: 92 Specific Block grant for Community Health Centers: 721 Supplementary Food for Primary School Students: 414  <b><u>1999/00: 1,682 billion rupiah</u></b>  SSN in Health Sector: 1030 Social Welfare: 102 Specific Block grant for Community Health Centers: 0 Supplementary Food		Fiscal year 1998/99 funds were disbursed up to December 1999 and the outputs were: 66% of targeted HHs received “health card”, 81.4% of “health card” holders received services, 61% of targeted delivering mothers received services from local health centers and village midwives, and 69% of targeted poor babies and children received supplementary food. Of 14.06 million targeted HHs, 13.0 million HHs had received “health card”, where 50.7% of the cardholders had been receiving free services.	

			<p>for Primary School Students: 550</p> <p><b><u>2000: 1,280 billion rupiah</u></b></p> <p>SSN in Health Sector: 867</p> <p>Social Welfare: 68</p> <p>Specific Block grant for Community Health Centers: 0</p> <p>Supplementary Food for Primary School Students: 345</p>			
<b>Thailand Economic and Financial Adjustment Loan and Second Economic and Financial Adjustment Loan (EFAL I and II)</b>	<b>Protecting the Poor:</b> <ol style="list-style-type: none"> <li>1. Increase public expenditures for protecting the poor</li> <li>2. Expand provision of public workfare programs</li> <li>3. Expand means-tested cash and in-kind transfer programs</li> </ol>				<p>1. No progress/status indicators</p> <p>2. Preliminary evaluations suggested that over 30% of resources concentrated on unskilled workers. However, the programs have been less successful in targeting the poor. In the case of decentralized programs the same amount of resources were allocated to each local community irrespective of population and poverty incidence. The effectiveness of</p>	

					<p>centralized programs' attempts to target the poor through alternative criteria based on social indicators was affected by data constraints.</p> <p>3. At time of ICR 400,000 poor elderly were receiving Bt300/month, compared to Bt200/month given earlier. However, the time required to process a transfer took up to six months.</p>	
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