

The Impact of the Global Financial Crisis on Public Health Expenditures in the Economies of the Former Soviet Union

By Roman Mogilevsky

The financial crisis strongly affected the countries of the former Soviet Union¹ (FSU) in 2008-2009. All of the countries experienced either a recession or a considerable slowdown in growth. The crisis also adversely affected government budget revenues, so governments had to adjust their expenditures to the falling revenues. Under such conditions, public expenditures on health were at risk of being cut. This brief explores whether or not this actually happened and why or why not.

All of the FSU countries inherited health systems that were fully government-owned and mostly government-funded. During the transition period, Belarus and Ukraine introduced minimal changes into their health systems, which were inherited from Soviet times, retaining state guarantees of universal and unlimited access to free healthcare. Kyrgyzstan, Moldova and Russia implemented major reforms of their health systems which are still incomplete. All three countries introduced mandatory health insurance, which includes a minimum guaranteed package of health services available to all of the insured population free of charge or with a minor co-payment. Georgia implemented the most radical reform, providing publicly funded health services only for the population

living below the poverty line. In the course of the post-Soviet transition, all of these republics had to reduce hospital facilities. In the three smaller countries of Georgia, Kyrgyzstan, and Moldova, these adjustments were dramatic – two or three-fold reductions, while in the three larger countries of Belarus, Russia, and Ukraine, the number of hospitals and beds fell by 20-40%. The number of primary health units increased in Belarus, Moldova and Ukraine, and fell in the three other countries. The number of health staff—physicians and nurses—mostly fell; however, in Belarus, the availability of both doctors and nurses increased for the same period of time. So, after twenty years of transition, the countries' health systems have diverged significantly due to differences in the size of their economies, the level of development, the reform path and the policies implemented.

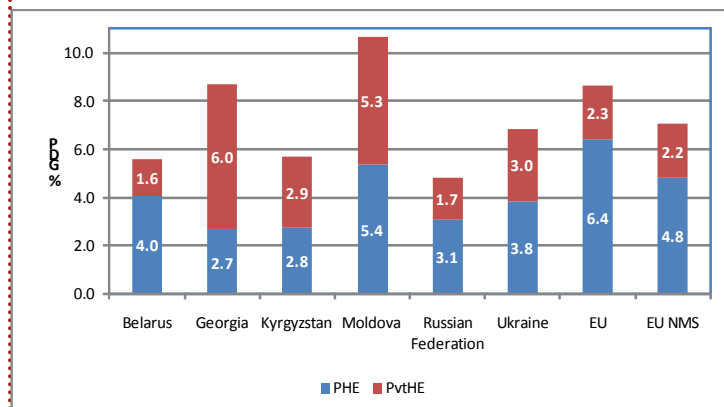
Public expenditures on health in the FSU countries

Public health expenditures before the crisis

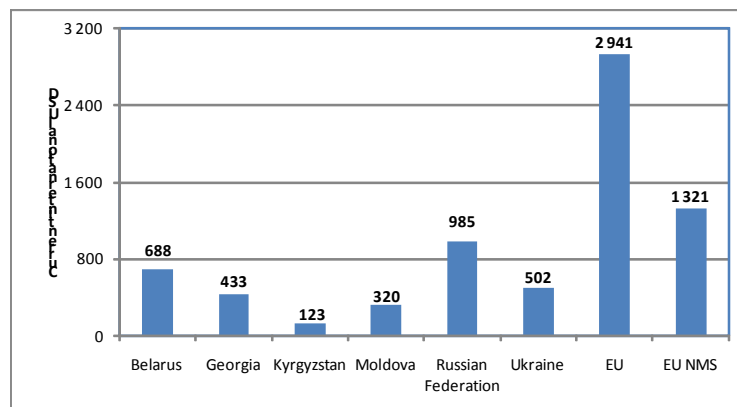
The share of total health expenditures in GDP in the FSU varied from 4.8% GDP in Russia to 10.7% GDP in

Figure 1. Total health expenditures, 2008

a) Public vs. private



b) Per capita, at purchasing power parity (PPP)



Sources: World Development Indicators, World Health Organization(WHO)

¹ Six countries are considered in this analysis: Belarus, Georgia, Kyrgyz Republic, Republic of Moldova, Russian Federation, and Ukraine.

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Moldova in 2008 (Figure 1a). For comparison, in the EU, the median share of total health expenditures in terms of GDP was 8.7% in 2008; the median share for the EU new member states (NMS) was 7.0% of GDP.

As for the absolute size of expenditures, in 2008, Russia spent 985 current international USD per capita – the highest value among the analyzed countries (Figure 1b). Other countries spent considerably less. All of these countries, including Russia, spend less on health per capita, not only in comparison to the EU, but also in comparison to the EU NMS.

The countries also differ widely in terms of the role and absolute size of public health expenditures (PHE, Table 1). By international comparison, the more developed a country is, the greater the role of the public sector in financing health services. However, this is not quite true for the six analyzed FSU countries. In terms of the share of public expenditure in total health expenditure, Russia—the country with the highest GDP per capita—ranks lower than Belarus. On the other end, Georgia, whose GDP per capita is 1.5-2 times higher than Kyrgyzstan or Moldova's, has a much lower share of public expenditure in total health expenditures than those two countries. These deviations from the global trend originate in the various directions of healthcare reforms (or lack thereof) implemented in the post-Soviet period.

Among the countries under consideration, Moldova spends the highest share of public resources on health (13.0% in 2008); this is more than the 2008 median value of this indicator for the EU NMS (11.9%) and close to the EU median (13.6%). Georgia, with its relatively small government funding on healthcare, was at the bottom of the list, with PHE equal to 7.3% of total GG expenditure in 2008.

Regardless of their differences in absolute and relative levels of PHE, all of the countries demonstrated rapid growth in public health expenditures in real terms in 2006-2008. It seems that the governments tried to compensate for the chronic under-financing of the health sector in previous "poor" years; the lower the level of PHE in previous years, the higher was the compensatory effort.

Public health expenditures during the crisis

The fiscal situation in 2009 in all of these countries was

much tighter than in the previous years. This, of course, had implications for public health expenditures.

In 2009, the real growth rate of PHE per capita (Table 1) fell in comparison to 2008 in Georgia, Moldova and Ukraine, and increased in Kyrgyzstan, Belarus and Russia. In Ukraine, the 2009 PHE per capita decline

Table 1. Public expenditures on health before and during the crisis

	2006	2007	2008	2009
Belarus				
PHE, % of total health expenditure	74.7	74.8	72.2	70.6
PHE, % of total general government (GG) expenditure	9.9	9.5	8.2	8.8
PHE, % GDP	4.6	4.6	4.0	4.1
PHE per capita, PPP, current international USD	450	506	497	515
Real growth rate of PHE per capita, %	-1.2	10.4	-3.2	2.9
Georgia				
PHE, % of total health expenditure	26.8	27.6	30.9	28.7
PHE, % of total GG expenditure	7.0	6.3	7.3	7.5
PHE, % GDP	2.3	2.2	2.7	2.9
PHE per capita, PPP, current international USD	91	106	134	143
Real growth rate of PHE per capita, %	30.2	13.5	23.6	5.2
Kyrgyzstan				
PHE, % of total health expenditure	46.2	49.2	48.4	50.9
PHE, % of total GG expenditure	13.3	12.8	11.5	11.7
PHE, % GDP	3.0	3.2	2.8	3.5
PHE per capita, PPP, current international USD	53	64	60	77
Real growth rate of PHE per capita, %	27.2	17.4	-8.2	28.1
Moldova				
PHE, % of total health expenditure	48.4	49.1	50.6	53.7
PHE, % of total GG expenditure	11.7	11.7	13.0	14.1
PHE, % GDP	4.7	4.9	5.4	6.4
PHE per capita, PPP, current international USD	121	134	162	183
Real growth rate of PHE per capita, %	20.0	8.7	19.2	12.1
Russia				
PHE, % of total health expenditure	63.2	64.2	64.3	64.4
PHE, % of total GG expenditure	10.8	10.2	9.2	8.5
PHE, % GDP	3.3	3.5	3.1	3.5
PHE per capita, PPP, current international USD	504	581	633	669
Real growth rate of PHE per capita, %	13.0	12.4	-5.5	4.4
Ukraine				
PHE, % of total health expenditure	56.7	57.6	55.9	54.7
PHE, % of total GG expenditure	8.9	9.2	8.6	8.6
PHE, % GDP	3.9	3.9	3.8	3.8
PHE per capita, PPP, current international USD	243	275	280	244
Real growth rate of PHE per capita, %	10.1	9.8	-0.1	-14.6

Sources: WHO, International Monetary Fund, author's calculations

took place while the share of PHE in total GG expenditure remained at the 2008 level. This means that health expenditures remained a high priority but fiscal constraints led to a reduction of health expenditures in real terms. Similarly, the PHE share increased in Georgia and Moldova against a slowdown in total GG expenditures growth. In Russia, the PHE share in total GG expenditures fell in 2009 in spite of the recorded increase in real per capita PHE growth rate. Due to these policies, the share of PHE in GDP in 2009 increased in comparison to 2008 in all countries except Ukraine, where it stayed at the 2008 level. Correspondingly, PHE per capita in USD PPP terms

increased in all countries but Ukraine.

Thus, as follows from the above analysis, PHE have been mostly protected in the FSU countries in 2009. In Belarus, Kyrgyzstan, Moldova, and Russia, PHE have grown in real per capita terms; in Ukraine, where total GG expenditures fell dramatically, PHE nevertheless recorded an increased share in GG. In Georgia, the PHE fell in 2009 in both absolute and relative terms, but this was compensated by private expenditures, which were the main source of healthcare financing in this country.

Health expenditure efficiency and medium-term expenditure outlook

To assess the sufficiency and efficiency of total and public health expenditures, it is worth comparing the resources spent with the health outcomes. Outcomes include life expectancy at birth as an integral measure of the health status of the population and various mortality and morbidity indicators.

All of the countries under consideration except for Georgia went through a substantial decline in life expectancy in the mid-1990s. In the 2000s, all of the analyzed countries except for Kyrgyzstan improved in terms of the life expectancy indicator; this points to a general improvement in overall health status. Still, in 2009, life expectancy in four out of six countries had

not returned to 1989 levels; only Georgia and Moldova have better longevity indicators now than they did at the end of the Soviet period. In all of these countries, life expectancy is now much lower than in the EU (10 years or more) and in the EU NMS. However, life expectancy in the analyzed countries has very little correlation with a country's income status or health expenditures. This lack of correlation indicates that there are important factors influencing the health status of the population, which are not directly related to the healthcare system such as environment, nutrition, lifestyle etc. Simultaneously, this also raises doubts about the efficiency of health spending in these countries.

Large differences between countries also exist in terms of the under-five mortality rate (U5MR). The values of this indicator are much higher in the FSU than in other European countries. It follows from the analysis that there is a strong positive statistical relationship between the U5MR and the fertility rate, i.e., the average number of children born per woman. After controlling for fertility, the U5MR appears to be strongly and negatively dependent on public health expenditure per capita, i.e., *ceteris paribus*, the higher the public health expenditures, the lower the child mortality.

Two main messages seem to emerge from this discussion.

First, health spending is not the only factor determining the health status of a population; the various socio-economic factors mentioned above are also important health determinants. From this perspective, in many cases it could be more efficient to implement policies promoting healthy lifestyles than to rely on narrowly-understood healthcare interventions.

Second, the absolute level of health spending is what matters for the effectiveness of healthcare. In order to improve a population's health, the analyzed countries need to significantly increase health spending. In many of these countries (especially in Russia), this would require increasing the share of total government resources allocated for healthcare. Most probably, this should also be accompanied by an increasing reliance on private sources of health financing, especially in those countries which currently rely heavily on public sources and where there is no fiscal space for further expansion of public health spending (Belarus, Moldova, Ukraine).

In the medium- to long-term, all analyzed countries except for Kyrgyzstan will have to increase their health spending due to rapid population ageing. Smaller countries will also have to think about the necessity of replacing external financing sources with domestic ones.

The required increase in health spending may create a heavy fiscal burden for these countries. In such a situation, a radical improvement in the efficiency of health spending should be a key priority. Targeting efficiency would require implementing politically difficult health reforms in those countries that have hesitated to initiate them so far (Belarus and Ukraine), and continuing them in other countries. This includes adjustments in the sector's physical infrastructure and staff, the introduction of minimally guaranteed packages of services, well-thought out reforms in financing mechanisms with a simultaneous strengthening of primary healthcare, increases in investments in modern health equipment, the retraining of health personnel, and other reforms.

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