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HEALTH AND DEVELOPMENT: REPERCUSSION OF THE ECONOMIC CRISIS

The present document introduces research on the impact of the economic crisis of the 1980s on the health sector in five countries: Mexico, Honduras, Ecuador, Brazil, and Uruguay. The study discusses the effects of the crisis on the availability and use of health resources, the provision of services, and the health situation of the population from 1980 to 1986.

The study is in response to several resolutions of the Governing Bodies of PAHO on health and development. It encourages them to be continued and that further studies be made to determine the consequences of the economic crisis in the Region for the health sector. The final objective of such knowledge is to improve the response of the sector to the reduction of resources, regarding both defense of its programs and making more efficient and more equitable use of the resources it already possesses.

In presenting this study to the Executive Committee, it is urged that its repercussions on the health policies of the Member States be considered. In particular, the study suggests that the sensitivity of the health sector to economic fluctuations should be reduced and that relative protection should be provided in times of recession at the expense of less than proportional growth in times of economic prosperity. The desirability and feasibility of introducing this and other changes in the means of financing and organizing the health services, as well as the appropriate priorities for financial crisis periods, are topics that require analysis and debate. At the same time, the Executive Committee is requested to provide orientation with respect to PAHO technical cooperation and future research projects at the national and regional level.

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HEALTH AND DEVELOPMENT: REPERCUSSIONS OF THE ECONOMIC CRISIS

I. BACKGROUND: RESOLUTIONS AND PREVIOUS STUDIES

The question of how the economic crisis may have affected the health sector has been a natural and constant concern of PAHO since the crisis exploded in 1982. Since that year no fewer than four studies have been made on the topic, which has appeared on the agenda of the Executive Committee in 1984 and 1985 and of the Directing Council in 1979 (even before the crisis), and in 1984.

1.1 PAHO and WHO Resolutions on Health and Development

At its XXVI Meeting in September-October 1979, the Directing Council approved a resolution (CD26.R34) that, inter alia, requested the Director to organize activities to analyze the relationship between economic development and health and recommended that Member Governments carry out similar activities with the possible collaboration of PAHO. Five years later, the Executive Committee, at its 92nd Meeting in June 1984, resolved (CE92.R12) to assign to the Subcommittee on Planning and Programming, among other functions, that of analyzing economic and social factors and their repercussion on health conditions and the health sector. Another resolution was produced at the same meeting, which was approved by the Directing Council at its XXX Meeting in September-October 1984 (CD30.R2). This resolution manifested satisfaction with the study on the repercussions of the economic crisis on the health sector and requested the Director to continue to study the international economic area and the impact of the changes on the health sector, assist the Member Countries in analyzing their own situations, and report to the Governing Bodies on any important change in the situation. The study referred to was the first of those described below, and resolution CD30.R2 was the point of departure for the second and third of those studies.

Upon receiving the third study at its 6th Meeting in December 1985, the Subcommittee on Planning and Programming of the Executive Committee included in its Final Report a summary of its conclusions and an appraisal of its value for PAHO and the Member Countries. The discussion concludes with a series of recommendations, among which is that of continuing efforts to understand the crisis and its consequences, sharing such efforts and understanding with international agencies not specialized in health, and continuing collaboration with IDB and ILPES in this respect. The present and fourth study on the topic responds to that recommendation, in particular in regard to collaboration with the IDB.

1.2 Description of the Three Previous Studies

The first PAHO study on the economic crisis and health, undertaken in 1982 and concluded in 1984, analyzed five countries of the Región^{1/}; part of this information was later updated.^{2/} This research was

necessarily limited by the little time elapsed since the crisis began, and it dealt only with general financial information. In 1985 a study was made of five Central American countries^{3/} that was also limited to financial information but provided more detail on the composition of public spending on health, although the period analyzed was very short. Later in the same year, a broader study was made of public financing of health;^{4/} this project, in contrast to the previous one, was not based on data obtained in the countries but rather on IDB information on 25 of its Member Countries. This study also referred to information on the consequences of the crisis for the health of the population, obtained principally from several research projects promoted by UNICEF that were concentrated on the situation of the infant population. As in the previous studies, the intermediate level of financial resources and the long-term repercussions on the health situation were not investigated, that is, the use of the resources to provide health services to the population.

The collaboration between PAHO and the IDB, initiated with the use of data provided by the IDB, was then extended to financial assistance from the IDB for the present study under an Agreement signed in 1987. The IDB also collaborated in defining the topic of the study and in selecting the countries to be studied; national studies of a limited number of countries were made. Preliminary versions of these studies were made between May and November 1987 and reviewed in the following year, when the comparative analysis that now makes up Part I of the complete study was also prepared. It should be noted that the beginning of the research coincided with the 40th World Health Assembly, during which Technical Discussions^{5/} were held on the topic of Economic Support for the Strategies of Health for All. These discussions, inter alia, referred to the impact of the world economic situation on the health sector.

II. OBJECTIVES OF THE PRESENT STUDY

Generally speaking, the reasons for carrying out this research are not different from those that prompted the previous research--to measure and analyze the impact of the economic crisis on the health sector in order to better understand how to defend the sector from the financial pressures to which it was being subjected and how to adjust expenditures and health services in order to minimize the harmful effects on the population served. However, the approach is something different from what it was in the previous studies, since, in principle, three levels were distinguished in which the analysis or its equivalent would be made, and three different kinds of possible impact were studied.

2.1 The Three Levels of Analysis

By definition, an economic crisis involves a reduction in the income of a nation or a population: the total product declines, whatever takes place with the composition of the product and its distribution

among different population groups. Almost automatically--exceptions would be rare and have not occurred in the Latin American case--public income, that is, the resources at the disposal of the various levels of government, are also reduced. It is therefore to be expected that there will be a reduction in public spending on health as well as in other types of expenditure.

The first impact needed to be studied, then, is the economic impact; this refers to the contracting of public resources for the health sector. (In parallel manner, there may be a contraction in private expenditure for medical care as a result of reduced private income. However, this change is less automatic, because if public health care declines, it is possible that the population may spend more than it has in an attempt to compensate for such deterioration.) This first level was the principal or sole approach of the previous studies.

Given a contraction of total public spending on health, the next question is, what occurs with the provision of health services? Here, in principle, there exist only three reasonable answers: A smaller quantity of services is provided, services of poorer quality are provided (spending less per unit of service), or services are provided more efficiently, utilizing fewer real resources per unit of care. Both the second and the third possibility mean a reduction in unit cost, but their consequences for the effectiveness of care and therefore for the health of the patient are very different. Given that a great variety of services is produced, it cannot be expected that the adjustment will be identical for everyone: There may be an essentially qualitative adjustment for some programs or actions and a basically qualitative adjustment for others in accordance with the capacity of adjustment of various institutions in the health system and in accordance with the political decisions to protect or sacrifice certain care. Moreover, the possibility exists of a perverse adjustment in which efficiency deteriorates and unit costs rise because of rigidities in expenditures and inefficient changes in the composition of resources. It is also necessary to take into account that the type of adjustment may be different in the short and long terms, since changes taking place at the beginning of the crisis will not necessarily be typical of the situation some years later. This second level of analysis constitutes the sphere of health care, in which changes in the total availability of resources are translated into changes in their composition and use in order to produce the health services.

An economic crisis may reduce the income of the people, which reduces their possibilities of being fed well and financing their own health care. On the other hand, it may reduce the resources with which the public sector satisfies the demands for care. There may be, therefore, direct effects on the health of the population--effects that are independent of the health services system--as there may also be indirect effects, mediated by what occurs within the system. The possible simultaneous presence of both types of effect generally makes it impossible to attribute any change in the health situation to one or the other factor. However, if the purpose of the health services is to

improve and protect the health of the population, it is essential to study a third level, the epidemiological level. And in order to have some idea of the relative importance of the direct and indirect effects of the crisis, it is essential to study the second level, as described above. This last level also has been the subject of previous study, notably as regards research on certain specific deterioration, such as infant mortality.

An attempt is being made in the present study to integrate these three levels of analysis. Ideally, the study sought to analyze how a total reduction of resources was translated into a reorientation of the expenditure by measuring quantitative, qualitative, and efficiency adjustments. Hence, an analysis was made of how these adjustments may have affected the health of the population--how the health of various population groups was protected or sacrificed in comparison with what the situation would have been in the absence of the indirect effects of the crisis. The extent to which it has been able to approximate this ideal is always incomplete and varies a great deal between one country studied and another and between one kind of information and another.

2.2 Analysis of the Health Services

As was mentioned previously, it is essential to study what occurs with health services during an economic crisis in order to determine whether reduced resources were translated into poorer health. There is also a second reason for focusing attention on this level of analysis, regardless of the visible effects on morbidity and mortality of the population: The production of health services absorbs substantial quantities of the real resources of the countries; therefore, changes in the efficiency or in the effectiveness of such resources are important in a purely economic sense, although they may not have any effect on health.

In the same manner, a crisis may induce or accelerate structural changes in the organization and conduct of the health sector, as effectively occurred in several of the countries studied. Such changes perhaps do not produce effects on the health of the population (or produce them only after several years), but they may immediately affect the financial situation of the government, the demand for care, the balance between the public and the private sectors, and a number of other important variables. Finally, any adjustment of the composition or use of health resources may have repercussions in terms of equity, even while maintaining a constant picture in terms of overall morbidity and mortality. For all these reasons, the present study has placed particular emphasis on analyzing how the economic crisis has disturbed what takes place in the health sector and how it takes place.

III. METHODOLOGICAL ELEMENTS

In Chapter 2 the complete study describes a series of significant methodological matters that need not be discussed here. A brief reference to three considerations is sufficient: the information sources used for the national studies, the correct interpretation of the data on expenditures and costs, and the nature of the international comparisons made.

3.1 Information Sources

With few exceptions the information utilized in this study already existed, coming from the public sector. In no case was there time to create new data on the basis of surveys or deeper analyses of existing sources. Moreover, it was possible to supplement the available statistical information by means of interviews with staff members, estimates, and simplified calculations. All national researchers depended primarily on regular administrative and epidemiological data (normally available for every year of study), and secondarily on surveys and analyses that had been carried out in the country, which typically refer to a single year.

The lack of many kinds of information in the normally available national sources, together with the impossibility of undertaking new surveys on any topic, has several consequences that should be pointed out as regards the coverage and reliability of the information. In the first place, information on the private health sector is limited, which is not only a structural limitation in itself but also makes any analysis of how the population may have reacted to changes in the availability or in the quality of the public services very difficult. In the second place, in the countries studied, it was impossible to compare the general health situation and the use of medical services in two different years. Thus, in cases in which a detailed survey exists in this respect, it refers to one year only. In the third place--and because of the deficiencies indicated--it was frequently necessary to make estimates that suppose that some key variable has not varied, which is questionable in the circumstances of the crises analyzed. Perhaps the principal surprise deriving from this research was the lack of information on the operation of the sector itself, that is, of data referring to the second level of analysis discussed in section 2.1. This matter will be discussed again in section 5, below.

3.2 Deflation of Monetary Data

The specific information at the first level of analysis, the economic level, is monetary, while the specific information at the second level, that of health care, is measured by a variety of other units--beds and bed-days, outpatient consultations, number of professionals employed, and the like. At any given time, the relationship between a monetary expenditure and a physical input or product is the result of a constellation of input costs, which in turn determine the cost of a product created through the use of such inputs. Unfortunately, those prices vary over time, first by general inflation or a change in all the prices in the economy, and second by changes in the relative prices of the health sector--changes that reflect a series of factors, among which are technological changes specific to the sector.

General inflation may, in principle, be taken into account if expenditures and costs are deflated by a general index of prices. If the nominal expenditure on health rises because prices rise, the real or

deflated expenditure indicates the amount of goods and services that that expenditure would have been able to purchase at constant prices. But it does not indicate the amount of health services that corresponds to that expenditure if prices in the health sector behaved differently from prices in general. In order to make such a correction in the nominal expenditure an index of prices specific to the health sector would be required, which generally does not exist in the countries studied.

Therefore, the deflation used in the study does not take into account differential inflation in health; the deflated expenditures reflect, then, the "opportunity cost" of the resources used in health, that is, what those resources could have purchased if they were spent on a combination of goods and services typical of the entire economy. It is evident that this makes it difficult to estimate changes in the efficiency with which the resources are used, much as it does not permit a precise estimate of the real value of the health services from one year to another through purely monetary data. This limitation only increases the need for studying the physical indicators of production and utilization of resources and not limiting the study to monetary aspects, thereby strengthening the importance of the second level of analysis.

3.3 National Analysis and International Comparison

Any international comparison of the impact of the crisis is rendered difficult because of the various initial circumstances of the countries; the differences in the quantity, quality, and kind of information available; and the differences in prices levels in health, which could only be taken into account partially through adjustments to a common currency. In any case, the objective of the study has not been that of comparing the situation of one country with that of another, but to compare in them the changes taking place as a result of the crisis. For this reason, and in order to avoid errors of interpretation, all the international comparisons that appear in Part I of the study are based on index numbers for the various countries, all of which use the year 1982 as a basis. Thus, it is possible to see immediately if the crisis made a variable rise or fall by 10 percent in one country and 20 percent in another without revealing the absolute levels of the variables in either case. The effect is that trends or experiences between the countries studied are compared longitudinally and not by cross-section.

4. PRINCIPAL FINDINGS AND GENERALIZATIONS

The findings obtained by country are summarized in Chapters 4 to 8 of the complete study, while Chapter 3 presents several results common to at least three (and whenever possible, to all five) countries. Some more speculative generalizations are also provided as material for discussion. Some of the common conclusions are mentioned briefly below without detailing the specific findings for one country or another.

4.1 Heterogeneity of the Results

Perhaps the most notable finding of the research is the great heterogeneity revealed. Even considering it only as an economic phenomenon, the crisis of the years 1982-1986 was not uniform in the countries studied, and this variation is as much or more marked when the consequences for the health sector are analyzed. This does not mean that no generalizations may be made or common conclusions be drawn. Rather, it means that any effects of the crisis have to be studied in all the countries in order to see if they are equal or not, without depending on supposed logical or necessary relations between one or another variable. A logical scheme, which goes from the economic sphere up through the sphere of health care and hence up to the epidemiological sphere, serves to identify possible results of the crisis but not necessarily to ensure that they actually took place. The reason for this lies, first of all, in the heterogeneity of the countries themselves and of their situations when the crisis exploded. However, it also depends on the range of reactions to the crisis, as will be discussed below.

4.2 Some Common Findings

All the five national studies, or at least a majority of them, offer evidence of important findings that are pointed out below. (The statistical results, in the form of index numbers, are found in Chapter 3 of the complete study.)

- The resources available for the public health sector diminished in the same proportion as total public spending. Generally speaking, there was no discrimination against health nor any relative protection of expenditure in the sector. It does not appear that the governments sacrificed health for not being "productive," as was feared in the sector, nor that health was recognized as having a privileged position as a basic need of the population. Such an equally proportional correspondence is not seen in every year and in every country, however, since there are marked variations in the short term; it is, though, characteristic of the period as a whole.
- Contrary to what might be expected, the reduction of resources for health in the public budget did not bear any systematic relationship to the source (s) of their financing. It has not even been demonstrated that services financed by social security suffered any less than those of the Ministry of Health, with the (possible) exception of the beginning of the crisis.
- The restriction of resources, as was to be anticipated, fell more acutely on investment, giving some protection to current expenditures. However, available data do not make it possible to conclude if this response was efficient in terms of the provision of services because it is not known what portion of the current expenditure might have become ineffective for lack of capital expenditures.

- There is no systematic pattern of reduction of expenditure on programs, activities, or institutions in the public sector. As a result, there is no evidence of protection nor of relative discrimination between various kinds of service nor of care for particular population groups. This result largely derives from a deficiency in information. It may also reflect the absence of clear decisions as to how to respond to the crisis; this point is touched on again in section 5.2.
- Health workers typically paid a substantial part of the cost of adjustment in the crisis. That cost was not paid through the loss of employment, but by reduced real wages. Reduction in real income occurred in all public employment, and it does not appear that the work force in health suffered more or less than other state employees.
- In quantitative terms, public health services maintained their production. Generally speaking, the limited resources were not translated into a smaller number of consultations or hospitalizations. (When hospitalizations were reduced, it was more the result of a policy of cost containment than a simple consequence of the crisis; there was relative expansion of outpatient consultations.) It is not known, however, if the need for care rose, because the data record only what was provided to the population.
- Part of the restriction of resources was absorbed in hospital services through a small reduction in the average stay. This probably reduced hospitalization costs; it is not evident if the quality of care worsened or improved with this adjustment.
- The combination of reduced resources and approximately constant production raises the suspicion that part of the cost of adjustment was paid through a decline in the quality of care, even taking into account the reduction of real wages and the reduction in the bed-days per patient. There is no direct evidence of this possibility, however, and little can be inferred from the overall data. There is no detailed information on the composition of current expenditures ^{6/} or on the health of the patients after consultation or admission.
- For these reasons it is difficult or impossible to judge if the crisis induced improvement of efficiency in the use of resources or if rigidities in expenditure and internal obstacles to adjustment may have reduced the efficiency of the sector. However, two conclusions appear to be reliable. First, the possibilities of improving efficiency in response to financial pressure depend a great deal on the kind of inefficiency that characterized the sector before the crisis started--as phrased by one of the national investigations, whether there was "fat to trim in the first place." Second, taking advantage of any possibility of "trimming fat" and using the resources better depended on the policies adopted to face up to the crisis in the absence of an automatic reaction.

- In regard to the health of the population, there is no evidence of general deterioration of appreciable magnitude. This finding should not be a surprise, given the general pattern of morbidity and mortality of the countries studied, a great part of which is independent of economic conditions, at least in the short term of a few years. This conclusion is strengthened by the evidence that there was no general abandonment of care for the public.
- When certain causes of disease and death in specific groups of the population are studied, however, some evidence of deterioration is found that may be attributed to the crisis. The most important of these, quantitatively, is an increase in child morbidity from diarrhea and an increase--or a deceleration in the decline--of infant mortality. The data that demonstrate these changes refer only to certain countries, but they appear to strengthen the concern, expressed and documented by UNICEF, for the possible detrimental impact of the crisis on this vulnerable group.^{7/}
- There is also evidence that the economic disorders in the early years of the crisis have increased the number of suicides (the evidence on homicides is less clear but may also be related to the crisis). In considering the total number of deaths from violence, including accidents, no trend is noted.

4.3 Reactions to the Crisis

As was already mentioned, the findings obtained in this study are the result not only of the crisis in itself, as a phenomenon exogenous to the health sector, but of the reactions--deliberate or improvised--of the governments that faced the crisis. These reactions begin with the decision to reduce expenditures on health when total public spending is cut and to continue with a series of decisions on wages, on expenditures for other inputs, on the relative priority of one or another program or activity, and the like. It is evident that the crisis took the governments by surprise; it also appears clear that there were all kinds of responses in reactions to financial restriction, from deliberate acceleration of reforms that sought greater efficiency and/or equity up to improvisations that sometimes lasted only a short time before being reversed or modified. With limited exceptions, the process of taking these decisions was not studied, and only information on its effects is available.

V. CHALLENGES FOR THE GOVERNMENTS AND PAHO

The findings obtained through this study, as well as the deficiencies they reveal, may be interpreted as the substance of several challenges being faced by the Member Governments of the countries studied and not studied, and by PAHO. Four general challenges that appear to arise from the analysis are discussed briefly below.

5.1 Information

It was possible to bring together in this research a body of information dealing with all three levels of analysis. However, gaps in data and the degree to which information is incomplete, irregular, or outdated are notorious. It is to be suspected that the lack of complete, detailed, and updated information is not simply a problem for research: Surely it also impedes understanding of what is occurring in a time of crisis so as to be able to take the best adjustment measures. This is particularly the case with respect to information referring to the use of resources and the provision of services. In the absence of such data, it is difficult if not impossible to know if any adjustment improves or worsens the effectiveness and efficiency of the services. Not knowing immediately the epidemiological consequences is not such a problem, because such results may take time to appear, but it is not possible to delay decisions on how and where to reduce or increase expenditures and on what activities priority should be given. It is at this second level of analysis that the scarcity of information necessary for the conduct of the sector is most harmful and also most surprising.

The challenge is posed, therefore, of creating a system (or improving the current system if it is already partially useful) that generates the required information with sufficient detail and relevance so as to permit its use in budgetary adjustment situations. Experience in the crisis only strengthens and makes still more urgent the emphasis that PAHO and the Member Countries are already giving this matter, because the costs of ignorance are probably greater in times of crisis than at normal times in the sector.

5.2 Adjustment Policies in the Face of Shortage of Resources

The crisis took the governments by surprise, nullifying in many cases programs for investment or expansion of coverage and even making it difficult to maintain basic services on the same quantitative scale. Although it was possible to maintain the number of consultations provided (perhaps with a certain sacrifice in quality), it does not appear that this was the result of a preexisting strategy for responding to a crisis. The study could not quantify it, but it is to be supposed that there was a substantial cost in the initial years of the recession owing to the need for improvising responses.

The challenge is proposed, thus, of creating and maintaining updated a policy for adjusting expenditures and actions for the sector to possible future restrictions of resources. In other words, planning in the sector cannot only presuppose a scenario of real growth or stability of resources; it will also have to envisage the possibility of real losses. It is clear that in order for such a strategy to exist and provide acceptable results, a system of adequate information as described above would be more than useful. It is also clear that this is not only a question of creating and applying a policy within the health sector in response to exogenous changes in the availability of funds. It is also a question of policy for the government as a whole in determining which sectors and types of expenditure to protect and which to sacrifice, in relative terms, when total resources are reduced by economic fluctuations. This matter will be dealt with later on.

5.3 Defending Equity and Promoting Efficiency

The findings of the study do not suggest that services or institutions that serve poor and vulnerable groups have been sacrificed, thereby making the sector less equitable. But neither do they indicate that it was possible to reorient the services in order to offset the increase in inequity that the crisis brought about as an economic phenomenon. And it was not possible to measure any change in the quality of the services except very indirectly, although such changes could have had an appreciable impact on the equity of care as a whole.

With respect to efficiency in the use of resources, again it is difficult to draw specific conclusions, and the available evidence is mixed. The crisis appears to have strengthened certain changes in the direction of greater efficiency, some of which were already under way. On the other hand, certain pre-existing types of inefficiency could only have been corrected by spending more--and the need for spending less obviously prevents such corrections from being made. This is particularly the case when past investment has been unproductive; it is less a problem when inefficiency is concentrated in current expenditures.

The need for defending equity and promoting efficiency as a constant structural policy is accepted by everyone. The crisis poses, however, the challenge of emphasizing these two objectives, precisely in circumstances in which the easiest solution may be to partially abandon equity and allow the resources to become still less productive than before. These should be crucial elements in the policy of adjustment to recession.

5.4 The Relationship of Health to Economic Circumstances

In accordance with the position of PAHO and the Ministries of Health of its Member Governments, health care is a basic need of the population. In economic terms that would mean the acceptance at the national level of a policy that dictates that when income rises, what is spent on health rises less than proportionally; and when income falls, what is spent on health is reduced less than proportionally, becoming a greater portion of total expenditure. The study demonstrates that that relation has not been characteristic of public spending in health recently. During intervals of economic prosperity the resources devoted to health have increased at the same rate as other components of public spending, or even more rapidly; and when the crisis arrived and that total was cut, what was spent on health suffered in the same proportion. This behavior, which also characterizes private, out-of-pocket expenditure on health, is consistent with luxury and not with need, and it limits the potential of the health sector to defend equity, to protect the most vulnerable, and to offset the fluctuations that occur in other elements of human well-being.

If this argument^{8/} is accepted, the challenge is posed of modifying not simply the level of expenditure on health, but also the relationship between that expenditure and variables such as the per capita income of a country and its total public expenditure. Any change

of this nature, in order to be real, would depend on a long-term political agreement: political, because ultimately the distribution of resources among different spheres of governmental action is a political decision and not merely the result of economic forces; and long term, because it would have to be adjusted to circumstantial fluctuations that may take several years and up to a decade. It would mean, then, a kind of social covenant in which the health sector would accept growing less than other sectors in times of prosperity, but would be protected and decrease less than the average in times of restriction. The question is is posed if a such change would offer net benefits for the efficiency and equity of the expenditure on health and if it would be feasible to introduce it.

In submitting this study for consideration by the Executive Committee, it is urged that its findings be analyzed and that the challenges it appears to present be debated. Orientations are sought with respect to policies recommendable at the national level, PAHO's technical cooperation, and future research projects at the national level and at the level of the Organization.

- 1/ Wilburg Jiménez-Castro, coordinator. The Economic Crisis in Latin America and the Caribbean and its Repercussions in the Health Sector. Document CD30/16, August 1984.
- 2/ Robert Landemann. Update of the Report on the Economic Crisis in Latin American and the Caribbean and its Repercussions in the Health Sector. Washington, D.C. PAHO, 1985.
- 3/ Rubén Suárez. Estudio sobre el Financiamiento del Sector Salud de los Países de Centroamérica y Panamá. Washington, D.C.: August 1985.
- 4/ Philip Musgrove. La Crisis Económica y su Impacto en la Salud y la Atención de Salud en América Latina y el Caribe. Document SPP6/4, November 1985.
- 5/ Apoyo Económico para las Estrategias de Salud para Todos. Document A40/Discusiones Técnicas/2. Geneva: WHO, May 1987.
- 6/ Evidence exists on this question in a country that was not included in the study: see Daisy Petrera, "Eficacia y eficiencia de la seguridad social en relación al cicly económico: el caso peruano." Boletín de la OPS 103(6), December 1987.
- 7/ UNICEF. "The Impact of World Recession on Children: a UNICEF Special Study." In The State of the World's Children. New York, 1984.
- 8/ Philip Musgrove. "Health Care and Economic Hardship". World Health, October 1984.