

Guest editorial

Is the recession also wreaking chaos in health?

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In recent years, the pages of newspapers have been filled with alarming news about the effects of the recession, and this has been accompanied by news of political crises in many countries. There is said to be great disorder in property ownership, financial holdings are declaring insolvency and in Brussels there are marches protesting against the political crisis which is already several months old. People are justified in asking whether someone can be found who knows how to stop this disaster.

In these turbulent times, the health system is not an exception. Corruption in poor countries receiving funds from more developed ones to combat AIDS, tuberculosis and malaria is eating up a full two-thirds of the money collected. Economic and political chaos is also often cited as an excuse for resolving completely different matters while others are hidden as sacrificial lambs of the recession. The European Commissioner for Health, Androulla Vassiliou, has drawn attention to the catastrophic consequences people could experience as a result of the economic crisis if the European Union (EU) does not take the appropriate steps in a timely manner. At a ministerial summit meeting she stated that short-term pressures on national budgets in combination with the broader consequences of the economic crisis could have long-term negative consequences for people's health.

In healthcare, in addition to the economic issues to which we ascribe great importance, we encounter concrete human issues on an everyday basis. When visiting the doctor's office, people talk about their fear of losing their job. Construction workers no longer dare to voice discontent with their long work schedules or poor working conditions, and sometimes even work without safety equipment because they are glad to have a job at all. Older workers even calculate whether, or when, they will reach their eagerly awaited retirement. Many patients burdened by loans are in difficult straits when a doctor says that they should stay home from work to get well.

It is not known for certain to what extent the influence of these problems has increased the burden on primary, secondary and tertiary healthcare. Experts

speaking about the influences of the economic crisis on mortality and morbidity statistics. 'Health trends show a negative dynamic during a recession', 'unemployment is bad for people's health' and 'anyone that loses a job experiences a drop in health' are claims that, paradoxically, do not agree with the findings of certain studies. In Finland, a severe recession in the first half of the 1990s did not have a negative effect on the overall mortality in the middle-aged population. Quite the opposite: overall mortality fell more than during the economic boom in the late 1980s. The main factor that influenced the fall in mortality was the continuous fall in deaths due to ischaemic cardiovascular disease. Changes in the population's smoking rate, serum cholesterol levels and blood pressure explained the majority of the reduction in mortality. There was also a reduction in deaths due to diseases resulting from excessive alcohol consumption. Per capita alcohol consumption fell by 10% in the period from 1990 to 1994.¹ A study by Bezruchka also states that in wealthy and developed countries mortality falls faster during a recession than during an economic boom. According to the author, damaging lifestyles, especially smoking and excessive alcohol consumption, are less prevalent during a recession. In contrast, an excess of prosperity takes its toll on the body by overburdening it with food, drink and smoking, and of course severe stress due to competition for wealth. In a period of economic prosperity, more deaths are recorded due to traffic accidents, which primarily destroy young lives. A recession should therefore offer an opportunity for people to change their social priorities: more free time offers an excellent opportunity to spend time with family and friends or to engage in physical activity. In this way, a recession can have a favourable influence on illness and death rates.²

Although similar studies somewhat temper this conclusion, the fact cannot be overlooked that certain subgroups of the population experience burdens more rapidly and intensely. Here I am primarily thinking of immigrants, who are often engaged in construction and assembly work. When they lose their jobs, they are simply forced to return to their countries of origin.

When this happens they are 'lost' from both the morbidity and mortality statistics. Vulnerable groups of the population are also more affected in this situation. Those that are difficult to employ due to physical and mental illnesses can move into the part of the population living on the brink of poverty. These people also have different access to healthcare services compared to others. 'It's hard to even afford to take a bus to see a doctor or go to physiotherapy' was a recent complaint I heard from a woman with multiple diseases and little financial assistance. Such cases are hidden in the general trends of statistics.

A recession therefore 'encourages' us, alongside economic and social factors, to take stock of our consciences, especially how we care for the disabled, ethnic minorities and the elderly. This 'moral state' should also be checked in relation to those employed in healthcare. Alongside this, it would be worth re-checking whether the indicators by which we measure the population's health reflect true values, or whether it would perhaps make more sense to be measuring something else. One should also ask whether short-term calculations over a few years really show a true picture of what is happening in society, or whether the actual consequences will only be seen after some time. Newer indicators must measure the *quality* of healthcare in more depth, and therefore we could call them qualitative indicators. They could encompass three areas that are a gauge of healthcare quality: *structural indicators* must show the quality of the organisational structure of the healthcare system and its deficiencies, *process indicators* must be sensitive to how healthcare is carried out, and *outcomes indicators* must show the effects of healthcare and the effectiveness of using financial resources. After this brief description of indicators, the reader may assume that this is Donabedian's classic paradigm for assessing quality of care, which is based on a three-component approach: structure, process and outcomes.³ However, it involves more than this.

The development of new indicators demands professional cooperation and consistency and not simply following political expectations and pressures. To learn more about quality, particularly for the unemployed, or

those that are feeling the effects of the recession, we need to have insight into the problems these people experience in everyday life. There are personal barriers preventing patients from even seeking help, and transportation might be a problem. Poor people and people with disabilities are dependent on their neighbours, relatives and other members of the local community. Healthcare providers' attitudes can also act as either a barrier or a facilitator. People frequently mention self-management as an important factor in care. They always try to solve problems themselves first. The indicators should be more descriptive within these particular areas.

The recession draws our attention as specialists, researchers and scientists to assess not only our professional bearing, but our moral and ethical stance as well.

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