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Financial crises and child health: reflections from Iceland

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In 2007, Iceland ranked first on the Human Development Index, reinforcing the pervasive idea at the time that Iceland was 'best'. The economic meltdown in October 2008 crushed this national illusion, and the social fabric of the country was severely shaken. The government sought help from and collaboration with the International Monetary Fund, and cut costs across the whole public sector complemented with tax hikes. The welfare system, its most costly component, was not spared despite efforts to alleviate the burdens of those most vulnerable.[1]

The socioeconomic situation of families is an important determinant for their health and well-being, and in times of economic crisis, they may gradually slide below the poverty line with risks for the health and well-being of their children.[2] This entails, but is not limited to, worse housing, low-quality nutrition, general stress and worse mental health. Furthermore, in times of crisis, the family's access to healthcare services is at risk to be curtailed if measures are not taken to effectively protect them.

Populations across Europe felt the impact of the crisis through decreased household income and less public expenditure on health, followed by reforms that, for example, entailed increased copayments.[3] Unemployment rates rose, affecting particularly young people, and the proportion of children at risk of poverty increased in countries such as Greece,[4] Italy,[5] Spain,[6] Portugal[7] and the UK.[8] Impact on infant mortality rates has not been observed, with the exception of Greece where it increased by 43% in 2011 compared with 2008, and there was substantial increase in the proportion of low-birth weight babies and stillbirths.[4] In Italy, fertility rates have fallen.[5] In Spain[6] and Portugal,[7] vulnerable groups of children were most affected, for example, evidenced through increased use of supplementary food services. In the UK, child homelessness and youth suicide rates increased, while subjective well-being of children stopped improving.[8]

In Iceland, little or no impact was seen on a myriad of commonly used child health indicators, including infant mortality, nine poverty-related morbidities, health and well-being of adolescents and access to preventive and curative maternal and child healthcare services that continued to be free of charge[9]; in 2007, the proportion of children less than 18 years at risk of poverty was 11.9% compared with 12.2% in 2013. Yet, a cause for concern was the increased prevalence rate of newborns given the International Classification of Diseases-10 diagnosis of small-for-gestational age (SGA), from on average 2.0% before the crisis (2003–2008) to 3.4% after the crisis (2009–2013). A recent analysis of delivery data for the period 2005–2012, with gestational age based on ultrasound determination, concludes that the rate of SGA did indeed increase following the crisis, in particular babies of parents with low socioeconomic status.[10] There was also evidence of increased incidence of low-birth weight babies, but not as sustained as that of SGA. This indicates the insidious impact chronic stress and economic difficulties may have on the growing fetus with potential negative consequences on later child health.

Another reason for concern was the decreased use of maternal/paternity leave following cuts in benefits after the crisis, in particular by fathers, and is an example of one misguided policy measure.[9] This trend is still continuing while recent raise in benefits aims to halt and reverse this development. Yet, of interest is that fertility rates in Iceland have abruptly fallen from 2.22 in 2009 to 1.75 children per woman in 2016 and has never been so low since its measurement began in 1853. This decrease may indicate a secular trend that Iceland is experiencing later than neighbouring countries, compounded by young couples' decision to delay having children as a consequence of fears of economic difficulties caused by recent sharp increase in rental and housing costs. Furthermore, the rapid economic recovery, driven by a booming tourist

service industry, may also be an influential factor for this historically low fertility rate.

A third reason for concern is increasing privatisation in the healthcare services following the crisis.[9] Since 2015, this trend has accelerated. For example, general practitioners (GPs) are now allowed to open and run their own primary healthcare services, based on a contract with the government, in direct competition with funds formerly earmarked for the state-run primary healthcare system. At the same time, user fees were raised in May 2017 for direct consultation with private specialists without a referral note from a GP, including for children, yet with thresholds for cost per month, year and family. Furthermore, there is continued divide between claimed political intentions to strengthen the university hospital and actual practice. There is a real risk that its services and teaching will suffer in quality as new for-profit clinics (and even hospitals) are established outside government control while still being reimbursed by public funds. In general, these clinics attend health problems of less severity or urgency, previously reserved for the university hospital.

The challenges facing the Icelandic population and its government were daunting in 2008/2009 to safeguard the favourable position of the healthcare services in general, but in particular that for children and their families. With the reservations given above, evidently, the policies were mostly successful. One additional evidence to its success is that Iceland ranked second (after Andorra) on the recently published Healthcare Access and Quality Index based on mortality to amenable diseases for the period 1990–2015.[11] Thus, there might be lessons to be drawn for other nations despite the country's particular geography and small population.

One potential contributory factor to the success of Iceland in its response to the crisis may be the robust welfare system that has been in the making for decades in line with other Nordic countries,[1] in contrast to some other European countries such as Greece,[4] Spain[6] and Portugal.[7] Before the economic crisis Iceland had publicly funded welfare services that reached all, irrespective of employment and socioeconomic status, and these were staffed with well-trained and resourceful professionals who stood up to the challenge to continue to deliver high-quality healthcare services despite cuts in costs. Another contributory factor might be that pregnant women and children continued to enjoy good access to primary healthcare and hospital services with diverse service provision for preventive and curative care without user charges. This did not change much during the crisis, and the services even improved in some aspects.[9] A third factor may have been the many labour market initiatives that were taken by the government after the crisis with the overall claimed aim 'inactivity is not an option'.[1] This benefited, in particular, young people, that is, those most likely to have children. Yet, despite evident success in many respects, overall the cuts in the welfare system were too deep from which it still suffers with consequences to be seen.

In conclusion, despite ongoing controversy on the direction of the welfare system and its organisation, it was the backbone of the response to the crisis. Amidst an economic collapse and popular protests, the Icelandic government aimed to protect those most vulnerable to the negative consequences of the crisis. Overall, it was mostly successful in doing so. In the end, protection of children and families is a conscious political decision.

Competing interests The author was the chief medical officer in Iceland in the period 2010–2014.

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