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The financial crisis in Italy: Implications for the healthcare sector

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ABSTRACT

The global economic and financial crisis is having and impact on the Italian healthcare system which is undergoing a devolution process from the central government to regions and where about one third of the regional governments (mainly in the central and southern part of the country) are facing large financial deficits. The paper briefly describes the current macro scenario and the main responses taken to face the crisis and highlights the downside risks of introducing "linear" cuts in the allocation of resources. While justified by the risk of a national debt default, present fiscal policies might increase inequalities in access to care, deteriorate overall health indicators and population wellbeing, and sharpen existing difference in the quality of care between regions. Preliminary evidence shows that the crisis is affecting the quality of nutrition and the incidence of psychiatric disorders. During this difficult financial situation Italy is also facing the risk of a major reduction in investments for preventive medicine, Evidence Based Medicine infrastructures, health information systems and physical capital renewal. This cost-cutting strategy may have negative long term consequences Also, important achievement in terms of limiting waiting lists, improving continuity of care and patients' centeredness, and promoting integration between social and health care may be negatively affected by unprecedented resources' cuts. It is essential that in such a period of public funding constraints health authorities monitor incidence of diseases and access to care of the most vulnerable groups and specifically target interventions to those who may be disproportionally hit by the crisis.

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1. Background

Italy has a tax-funded National Health Service (*Servizio Sanitario Nazionale*, SSN) that guarantees the universal provision of comprehensive care throughout the country [1]. Responsibility for the organisation and delivery of services is attributed to the 21 regions. The definition of the essential level of care (*Livelli Essenziali di Assistenza*), resource allocation, and policy and planning frameworks are the responsibility of the national government through the Ministry of Health, with an increasingly important role played by the Government-Regions Committee (*Conferenza Stato-Regioni*) through agreements known as "Health Pacts" (*Patti per la Salute*), which are adopted every three years. The basic arrangements governing the functioning of the SSN indicate that the national tier maintains a guiding and strategic role in health policy and guarantees the financial sustainability of the system and the regions through its network of public and private providers, delivers essential levels of care and is liable for any deficit incurred [2]. However, these arrangements are not fully implemented; a detailed list of services guaranteed by the National Health

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Service has never been defined in important areas such as hospital care and regional health expenditures have not always been controlled. In the 2001–2010 period, regions generated over 38 billion Euros of cumulative deficit, approximately 4.2% of the total expenditure over the period. This deficit has been highly concentrated in the Lazio, Campania and Sicily regions, which together account for 69% of the total cumulative deficit.

The SSN is largely funded through national and regional taxes supplemented by co-payments for pharmaceuticals and outpatient care [2,3]. In 2010, 78.4% of healthcare funding derived from public sources, and the remainder was private, mainly in the form of out-of-pocket payments (especially for pharmaceuticals, outpatient care and dental services). Only about 3% of the total healthcare expenditure was funded by private insurance [4]. Italy has been affected by the current global recession more than other EU member states. In 2008 and 2009, the Italian Gross Domestic Product (GDP) decreased by 1.2% and 5.1%, whereas the 27 countries of the European Union had an average GDP increase of 0.5% and a decrease of 4.3%, respectively [4]. In 2010, Italy's recovery was more modest than that experienced by the other European Union countries (+1.5% vs. 1.8%) [5]. In 2011, the Italian GDP was projected to grow by 0.7%, compared to the average of 1.6% for the countries in the Euro area. This difference could persist for the next two years (0.7% in 2012 and 0.9% in 2013) [5,6].

Despite the recession, Italy has managed to maintain positive public primary deficits (that is, the difference between revenues and public spending, not including interest payments) while having one of the lowest stocks of private debt among the EU countries, at a time when most other European countries have high public deficits and have substantially increased their public debt. Nevertheless, due to the huge public debt (mainly accumulated in the 1980s), Italy has a high debt/GDP ratio, approximately 100–120%, which has been stable over the last decade but requires 3–4% of the GDP for interest repayment.

To sum up, the dramatic scenario Italy faces has two main components. On the one hand, the slow economic growth restrains both public and private health sector expenditures, making it difficult to meet the health needs and expectations of the population. On the other hand, a significant national debt stock implies the need to improve public finances to avoid default. From this foundation, the article summarises some macro-economic figures, reports available evidence about the effects of the crises, analyses Italian health policy for the last two years and provides reflections on policy options.

2. Funding and healthcare expenditure

The recent history of healthcare expenditure in Italy is marked by the attempt to place stricter control over regions' health spending after a few regions incurred considerable deficits. To address this financial failure, the government introduced a special regime for overspending regions that requires the adoption and implementation of formal regional recovery plans (*Piani di Rientro*). Since 2007, ten[1] out of twenty-one regional health systems have adopted these plans, which include actions to address the structural determinants of costs.

All subsequent dynamics of public spending for healthcare in Italy must be seen in light of these provisions. It has been calculated that between 2006 and 2011, the regional health systems that were subject to recovery plans reduced their healthcare expenditure in real terms by 0.6%, compared to an increase of over 9.4% in the other regions [7]. The overall effects of this regime have a decrease in the yearly level of overspending. In 2010, the total deficit of the public healthcare sector was €2.33 billion, which is approximately one-third of the peak in 2004 (€6.42 billion) and is estimated to decline by €0.2 billion in 2011.

In 2010, €108.842 billion in public funding was available for healthcare, an average of €1.803 per capita. The overall public healthcare expenditure was €111.168 billion, with a modest growth rate of 0.9% compared to the previous year, confirming the marked deceleration since 2006 (Table 1). For the fourth time since 1995, the growth rate of public healthcare expenditure was lower than the GDP growth (0.9% vs. 1.9%) (Table 1 and Fig. 1). From 2007 to 2010, the average public healthcare expenditure growth rate was 2.3%, compared to 5.1% in the 2001–2006 period. Private healthcare expenditure shows a different trend; a clear change from 2008 onward is not observed, and, although volatile, private expenditure appears rather stable in the long run. Recent changes in private expenditure may reflect two contrasting forces. From one side, the crisis reduces disposable income and, thus, privately paid demand; on the other side, because of cost containment policies in the public sector, patients may be forced to pay higher co-payments or to go fully private. In this respect, it is interesting to note the emergence of low-cost initiatives in the private sector (e.g., for dental and eye care) [8].

The overall healthcare expenditure exceeded €141 billion in 2010 (9.2% of GDP), growing by 1.3% from 2009 and by an average of 3.8% from 2001 to 2010. In the last decade, the total healthcare expenditure has increased by 1.1 percentage points of the GDP (from 8.1% in 2001 to 9.2% in 2010), mainly because the public component has experienced rates of increase substantially higher than those of the GDP. Only in the last two years has the increase in public healthcare expenditure been radically contained; thus, the ratio of total healthcare expenditure to GDP has been stabilised [9].

3. Policy responses to the economic downturn

Italy initiated and implemented a range of policy responses to the global economic crisis that included plans and other interventions by the central government, actions jointly taken by the national and regional levels of government, and initiatives autonomously endorsed by regions. Nevertheless, when the crisis began, Italy had already been struggling for years to tighten control over regional spending, and restrictive policies of cost containment

[1] Piemonte, Liguria, Abruzzo, Molise, Lazio, Campania, Puglia, Calabria, Sicilia and Sardegna.

Table 1
Italian public and private healthcare expenditures, funding and deficit 2001–2010 (Million Euros).

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Public health care expenditure (Million Euros)	77,686	79,549	82,290	91,222	96,797	99,615	103,805	107,138	110,219	111,168
Over the previous year %	10.7	2.4	3.4	10.9	6.1	2.9	4.2	3.2	2.9	0.9
% on GDP	6.2	6.1	6.2	6.6	6.8	6.7	6.7	6.8	7.3	7.2
Funding (Million Euros)	73,908	76,658	79,967	84,800	91,062	95,131	100,095	103,669	106,967	108,842
Over the previous year %	10.4	3.7	4.3	6.0	7.4	4.5	5.2	3.6	3.2	1.8
Deficit (Million Euros)	−3778	−2891	−2323	−6422	−5735	−4483	−3709	−3469	−3252	−2326
Over the previous year %	17.0	−23.5	−19.6	176.5	−10.7	−21.8	−17.3	−6.5	−6.3	−28.5
% on funding	−5.1	−3.8	−2.9	−7.6	−6.3	−4.7	−3.7	−3.3	−3.0	−2.1
Private health care expenditure (Million Euros)	23,622	25,155	25,981	26,613	27,285	27,841	28,303	29,244	29,750	30,591
Over the previous year %	−3.1	6.5	3.3	2.4	2.5	2.0	1.7	3.3	1.7	2.8
% on GDP	1.9	1.9	1.9	1.9	1.9	1.9	1.8	1.9	2.0	2.0
Total healthcare expenditure (Million Euros)	101,308	104,704	108,271	117,835	124,081	127,455	132,107	136,381	139,969	141,759
Over the previous year %	7.2	3.4	3.4	8.8	5.3	2.7	3.6	3.2%	2.6	1.3

Source: Adapted from Relazione Generale della Situazione Economica del Paese (RGSEP) 2010 and Minister of Health and Finance and ISTAT (Italian Bureau of Statistics) 2011.

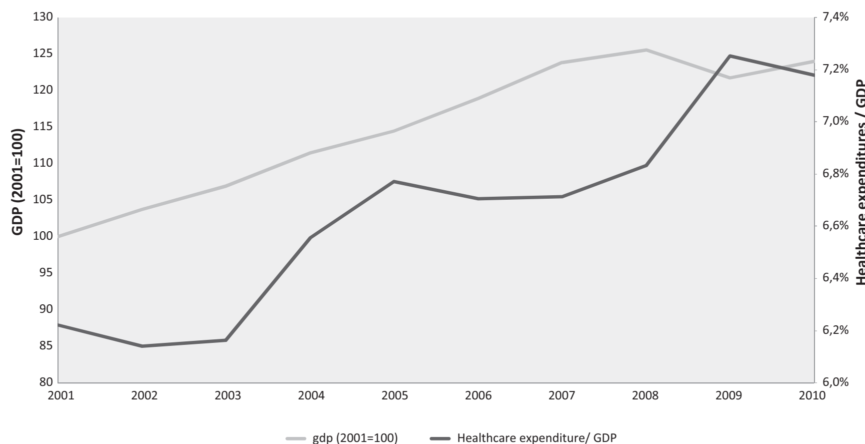

Fig. 1. GDP (2001 = 100) and public healthcare expenditure/GDP ratio (2001–2010).
Source: Adapted from Relazione Generale della Situazione Economica del Paese (RGSEP) 2010 and Minister of Health and Finance and ISTAT (Italian Bureau of Statistics) 2011.

were already in place.[2] Consequently, the main effects of the global financial crisis on Italian healthcare policy accelerated ongoing policy changes rather than triggering the introduction of radically new ones.

In the 2008–2009 period, central government efforts to contain costs in the healthcare system were increased, especially through policies aimed at increasing the efficiency of public spending through improved accountability of the regions for the provision of essential services and respect for financial constraints. More recently, the 2010–2012 Health Pact reaffirmed the need to control public spending, reduce overcapacity (mainly in the hospital sector) and improve efficiency. A number of cost-containment measures were adopted, in line with the trends of previous years. These included the requirement

[2] Restrictive policies include the introduction of regional prescription charges; the adoption of extensive efficiency mechanisms on goods and health services procurement; the inclusion of more stringent quasi-market contracts with private health care providers; a partial block of personnel turnover and incentives for early retirement; the reclassification of drugs that are charged to the INHS; the introduction of extended forms of co-payment; the imposition to increase mark-ups to the regional tax rates (e.g., business tax IRAP; surtax on the national personal income tax IRPEF and vehicle tax); and the rationalization and reconfiguration of hospitals together with incentives to sell properties [10].

that regions reduce the number hospital beds (4 beds per 1000 population vs. 4.5 currently), hospital admissions (by increasing the use of appropriateness criteria to avoid unnecessary admissions) and the average length of stay. It is noteworthy that the regions with the highest debt were required to issue their implementation plans by mid-2010, earlier than the other regions (at the end of 2010). It is likely that this accelerated pace for overspending regions was intended to signal financial austerity and to differentiate regions according to their financial performance. Official data on the number of hospital beds in 2009 have recently been made available and show that the policy is effective: the number of hospital beds was reduced to 4.2 per 1000 in 2009, reaching a ratio that is well below the European average of 5.5 per 1000 inhabitants [11]. Data for 2010, 2011 and 2012 are expected to confirm this trend because the reduction of hospital capacity is proposed in the recovery plans currently being implemented.

In response to the financial crisis and the stricter public budget imperatives of the European Commission and the European Central Bank, the national government cut central transfers to regions and local governments for disability, childhood, migrants and other welfare policies. This reduction in central funding [3] was compensated primarily by higher co-payments and cost-saving measures to reduce pharmaceutical expenditures [12]. Beginning in October 2011, regions had to introduce a €10 co-payment for visits to public and private accredited specialists and a €25 charge for visits by patients aged 14 or older to hospital emergency departments that are deemed inappropriate. Exemptions defined by the Ministry of Health for low-income, disabled, aged and chronic patients remain in place; however, these copayments were added to existing tariffs, placing a significant burden on patients. Notwithstanding the centralised nature of these interventions, the national government allowed regions to decide whether to apply these copayments in full or to enact regional rules that allow for varying co-payments according to gross family income or service tariffs.[3]

New cost-saving measures to reduce pharmaceutical expenditure were also introduced. These measures include a mandatory 12.5% reduction in the prices of generic drugs, the adjustment of reimbursements for generic drugs to the average European level, the introduction of a system to monitor pharmaceuticals to compare regions and identify benchmarks, the tightening of controls over hospital budgets for pharmaceuticals through the centralisation of procurement procedures and changes in the distribution channels, and, for NHS-covered drugs, the reduction of prices and margins, the use of pay-for-performance schemes and the introduction of price revisions according to scientific evidence of efficacy.

Again, it is likely that these severe measures would have occurred irrespective of the global economic crisis, but they may have been hastened by the pressure to reduce public spending. To limit fiscal default and restore national financial credibility, the current government, widely supported by the Parliament and non-professional politicians, is pushing important structural reforms, including a fiscal overhaul, the promotion of competitiveness in traditionally regulated markets (e.g., distribution of pharmaceuticals), changes in labour regulation to make the labour market more flexible and an increase in the retirement age. In this context, interventions affecting healthcare include an increase in indirect business tax (IRAP) to finance healthcare spending, the introduction of a spending review on health services procurement and future changes in the content of essential levels of care to eliminate obsolete services.

4. The effects of the economic downturn

According to a report released by the Italian National Statistics Bureau (ISTAT) at the end of 2011, 18.2% of Italians are “at-risk of poverty” and 6.9% are in conditions of material deprivation according to EUROSTAT definitions [13]. Both of these rates have remained stable since 2009, when they were 18.6% and 6.9%, respectively. However, an international comparison reveals that the situation in Italy is worse than in European countries of comparable size, such as France (13.5%) and Germany (15.6%), and this difference is particularly marked for the age group younger than 18, for whom the rate is 24.7% in Italy, compared to 18.4% in France and 17.5% in Germany. Inequality, as measured by the Gini index, is stable at 0.31, the same value as in 2009 and 2008, and is substantially aligned with the European average of 0.30. However, interregional variability is significant, with Southern Italy scoring 0.32 and Central-Northern Italy scoring 0.29 above and below the European average, respectively [14].

Official statistics show that household expenditure for healthcare decreased significantly between 2008 and 2009. It recovered somewhat in 2010, but did not reach the 2008 level. This trend is consistent with global data on household expenditure and with the general interpretation that the immediate reaction to the changed economic scenario was an overall reduction of costs, followed by a careful reallocation of available income to essential goods and services [15].

In a survey commissioned by the regional branches of the Italian Association of GPs in October 2011, 21% of households declared that they had decreased their health-related expenditure for reasons connected to the financial crisis, and 10% had postponed surgical treatments for financial reasons. Twenty-six percent of households also reported that expenditure in cases of emergency had increased due to higher co-payments [16].

International comparison confirms that, although the trends we report also exist in other countries, these trends

[3] For example, the Toscana, Umbria and Emilia Romagna regions have jointly decided to apply the copayment to vary according to gross family income: €36,000, ticket exemption; €36,000 to €70,000, €5; €70,000 to €100,000, €10; higher than €100,000, €15. The Veneto region also adjusted the copayment by income level to impose the full charge for income above €29,000 and half of the charge for income below the threshold. In contrast, Lombardia and Piemonte regions adjusted the copayments uniformly based on the existing reimbursement levels associated with each service provided. This copayment equals 30% of the value of the service and ranges from €0 to €30. For example, the co-payment for a €10 service will be increased by €3, whereas no ticket will be applied to services worth less than €5, and the maximum level of €30 is applied to services worth more than €100 (e.g., Magnetic Resonance Imaging (MRI).

are made more serious in Italy by a situation of low economic growth that preceded the global crisis. In an international survey conducted in 10 countries between May and June 2011, 33% of Italians considered the NHS inefficient in ensuring equitable access to healthcare, compared to 41% in 2010 [17]. Italy was the only country with a significant decline in this respect. In contrast, the percentage of those interviewed that described themselves as willing to pay more taxes in return for better services plummeted from 57% in 2009 to 12% in 2011. Other countries show a similar trend but with lower percentages; in Germany, for example, those willing to pay more taxes fell from 80% to 38% in the same time frame. Of the countries surveyed, Italy is also the country with the greatest fear of a future lack of public funding for healthcare (85%) and the lowest belief that the healthcare system can contribute to the growth of the overall economy (from 77% in 2010 to 65% in 2011).

This survey confirms that the number of households that have given up or postponed some forms of medical care for financial reasons is on the rise, reaching 19% in 2011 (1% more than in 2010). In this measure of citizens reporting access to care, Italy performs slightly better than some other countries, such as Poland and France (36% and 29%, respectively), but much worse than Sweden and the UK (95% and 94%, respectively) [17].

Estimating the health effects of the financial crisis is neither simple nor immediate. Epidemiological data can only be collected with an intrinsic delay. Whereas financial data are available with a short delay, data related to morbidity and mortality have a latency period that varies from 2 to 5 years. This intrinsic limit of epidemiological research has been recently noted as additional data are necessary to tailor healthcare policies to rapid economic and demographic changes [18]. Therefore, it is too early for available systematic information about the incidence rates of diseases that can be co-determined by the economic crisis and by higher barriers to access to healthcare, especially for major categories of diseases, such as chronic and infectious diseases [19].

Yet, data are beginning to emerge. Case reports and interviews with specialists and primary care doctors point to a deterioration of health indicators. Mental disorders [20], reduced access to dental care (even for children) and diseases associated with poverty (notably, edentulism) are increasing. Furthermore, there is recent evidence of a decrease in the intake of fruit, vegetables and fibres, a decrease in the time spent in sports/physical activity (especially in the Southern Regions) and an increase in unhealthy practices, such as the consumption of junk food and alcohol abuse, among youths and women [21].

As reported by McKee, the impact on population health of a financial and economic crisis, such as the current global crisis, may lead to an increase in suicides and deaths related to alcohol use [19]. Italy seems to confirm this hypothesis: the last available data show a sudden increase of 5.3% in suicides in 2008 (3.799, compared with 3.607 suicides in 2006, which represented the lowest value in a decreasing trend in the last 20 years) [22]. Although these numbers are less striking than data from other countries (in Greece, Latvia and Ireland, countries where the financial crisis severely affected the real economy, suicides increased by 17%, 17% and 13%, respectively [23]), this is a remarkable finding. Although Italy ranks among the lowest in Europe for suicide risk, an increase such as the one recorded requires that the situation be closely monitored at both the national and regional levels.

Although the economic downturn directly affects health and increases poverty, it also has indirect consequences for wellbeing through its effects on public policies. In particular, the public finance crisis of the last two years has forced the government to reduce public funding and to increase copayments (which, in turn, reduce disposable income) and to reduce the overall actual supply of SSN services. The enforcement of higher co-payments is a first major and visible consequence of the effects of the crises. Although exemption criteria protect the very poor, copayments severely affect low–middle class patients and make their access to SSN coverage more costly. This situation could exclude some segments of the population from care if there are no mechanisms to protect selected services targeted at lower-income groups [24]. An increasing body of evidence suggests that the exposure of households to health-related costs has reached alarming levels. Increased co-payments imposed on a population already affected by the labour market crisis combined with longer waiting lists and emergency departments suffering from a lack of personnel and staff have led families to delay important medical care.

If reducing public funding is not compensated by efficiency gains, providers may reduce their supply of services or their quality. For example, providers may decrease the number of outpatient consultations offered, thereby increasing waiting time, or they may terminate specific health programs (e.g., screenings and other outreach activities). There are clear signs that this may be the case. Investments in expensive medical technology and infrastructures have been postponed. In 2010, a €1 billion cut to investments in recovery of hospital buildings and technological turnover was mandated by the central government. In addition to its impact on the volume of care delivered by the NHS, this measure has been deemed highly risky for the safety of health workers and patients because most Italian hospitals are rather old (approximately 70 years old, on average). Recent data have also highlighted a major consequence of funding cuts: the SSN personnel decreased by 0.8% from 2009 to 2010 [9]. In the absence of efficiency gains, this means a significant reduction in the labour available to provide services.

Patients and citizens' perceptions of the quality of the healthcare system are also worsening. Between 2010 and 2011, Italians reported a marked increase in difficulties accessing healthcare. A 2011 annual report on Italian healthcare, conducted by a large consumers' association, revealed a strongly negative trend in the number of complaints concerning access to services, which grew from 5.5% of all complaints in 2009 to 9.5% in 2010. Of these complaints, 44.8% involved the cost of services, 32.1% involved increased waiting times compared to the past, and 23% involved the removal of a hospital or a ward following cost-saving policies. The number of people reporting excessive co-payments also increased to 73.5% from 62.5% in

2009. It is believed that the remarkable increase in complaints recorded for emergency services (from 29.8% to 41.4%) is related to cuts in secondary healthcare, particularly with regard to ambulance transport and waiting times in emergency rooms [25]. A number of consumer surveys conducted in 2010 found that the number people who believed that the healthcare systems in their regions had worsened in the previous two years was almost three times the number of those who believed that these systems had improved. Increasing numbers of citizens report concern with the future of the healthcare system. The most frequently reported concerns are the widening of the existing difference in quality between regions, the damage to the quality of healthcare due to political interference, and reduced supply of services due to financial difficulties [26,27].

Furthermore, additional and more severe policies aimed at the most indebted Regions (those that have overrun the budget in the past) may contribute to increasing the existing regional health inequalities across the country [28], which were by-products of recovery plans.

5. Current policy options

Throughout 2012, the number of Italians deemed absolutely or relatively poor will increase significantly due to lower average disposable incomes, higher unemployment and increased healthcare-related private costs. According to the 2011 estimates based on government projections, the amount of additional private expenditure due to the higher copayment for services provided by the SSN could reach €4.5 billion by 2012 (about € 140 per Italian) [29]. It is likely that the observed situation of access to healthcare hindered by financial barriers will worsen. Designing interventions specifically targeted to support the poorest households should be the first priority of Italian health and social policy.

Decisive actions by social protection and welfare agencies are needed to protect households from unemployment, debt and loss of purchase power. In particular, the government could consider reorienting budgets to protect the population from unemployment, both by curbing its direct negative effects on households and by enabling unemployed people to obtain work as quickly as possible. The present economic downturn strengthens these arguments. A lack of social protection at this time would lead to effects on individual health that are worse than normal [30].

In the field of healthcare, the increase in copayments could also be better organised. Because of the risk of creating excessive disincentives to demand medical care, to adjust co-payments to family income seems more equitable than adjusting them uniformly based on the prices of services – an across-the-board cut.

A second issue Italy faces in the present crisis is the risk of a general decrease in health status, potentially coupled with an increase in regional heterogeneity. During an economic crisis, the overall determinants of health become more relevant, and the synergy between unhealthy behaviours and barriers to prevention programs may cause health losses that are more significant than usual. The national government, regions and healthcare organisations should prioritise actions that can counter the reduced demand for health services and prevention programs. Priority should be given to financial coverage of existing programs for the promotion of healthy lifestyles and preventive medicine (such as programs to increase vaccine coverage) that rely on general practices, and additional effort should be devoted to their timely implementation.

As reported, the crisis may even result in higher mortality due to suicide. The European Commission put “depression and suicide prevention” among the five priorities identified by the European Pact for Mental Health and Well-being. The Italian “National Plan for Prevention 2010–2012” also included suicide prevention among its main intervention areas [22]. The provisions included in the plan must be implemented rapidly.

A risk specific to the distinctive features of the Italian healthcare system is the enhancement of geographical inequalities in the quality of care, which contributes to large flows of patients, typically from the south to the centre-north. An effect of the crisis could be to further widen regional differences. To avoid such risks, it is important to design active policies to improve institutional, managerial and professional capabilities.

In all regions (and based on a stronger central role in this respect), the financial crisis can serve to hasten the Health Technology Assessment agenda, which lags in comparison with the initiatives of a number of EU member states. Expenditure cuts should not be linear; rather, they should focus on activities with lower priority and value, introducing more limitations to expensive services that may be ineffective or not cost effective and ensuring that a minimum of resources are maintained to sustain innovation.

As we hope that this is a transitory period, we strongly argue that investments to make the system more efficient, effective, appropriate and patient-centred should not be interrupted. Urgent innovations include pilot examinations of the adoption of appropriateness measures, investments in information systems, and organisational arrangements that integrate primary, secondary and social care. A vicious cycle, especially a complex one in which economic, social and health-related factors are intertwined, can only be broken by ensuring that equally significant positive cycles are initiated.

The financial and economic crisis raises serious equity concerns. People losing their job or being unable to enter the job market are particularly at risk, as unemployment is a risk factor of malnutrition, mental disorders or simply lower self-protection of health. Other individuals particularly at risk of the health effects of the crisis are elderly people living alone, migrants and single mothers with dependent children. It is thus essential that in such a period of public funding constraints health authorities monitor incidence of diseases and access to care of the most vulnerable groups and specifically target interventions to those who may be disproportionally affected by the crisis.

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