

THE ECONOMIC CRISIS AND ITS ETHICAL RELEVANCE FOR PUBLIC HEALTH IN EUROPE – AN ANALYSIS IN THE PERSPECTIVE OF THE CAPABILITY APPROACH

Caroline Brall, Peter Schröder-Bäck, Helmut Brand

Department of International Health, School CAPHRI, Maastricht University, Maastricht, Netherlands

SUMMARY

Policy responses to the economic crisis have manifest consequences to European population health and health systems. The aim of this article is to assess, by using the capability approach advanced by Sen, the ethical dimension of trade-offs made in health policy due to austerity measures. From a capability approach point of view, austerity measures such as reducing resources for health care, further deregulating the health care market or moving towards privatisation are ethically challenging since they limit opportunities and capabilities for individuals of a population. Public policies should thus aim to guarantee sufficient capabilities (options to access health care and possibilities to make healthy choices) for its populations. Prioritising those in need is a notion the capability approach particularly focuses on in its goal of supporting those with the least capabilities.

Key words: economic crisis, austerity, health, health care, capability approach, ethics

Address for correspondence: C. Brall, Department of International Health, School CAPHRI, Maastricht University, 6200 MD Maastricht, Netherlands. E-mail: caroline.brall@maastrichtuniversity.nl

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INTRODUCTION

Recent developments in several European countries have shown that the economic crisis has not only affected governmental budgets and private households but has also had an adverse impact on social arrangements, and in particular, on the health of citizens (1, 2). Yet only limited literature has been published concerning the consequences of the crisis on health or on health systems, whilst its ethical relevance has been neglected thus far. This article aims to provide a general overview of literature relating to this topic. It seeks to further explore the ethical dimension that the economic crisis and subsequent policy responses, in particular austerity measures, had on population health and health systems in Europe. For an ethical framework with at least heuristic value the capability approach (CA) developed by Amartya Sen is used (3). This approach will assess the ethical dimension of the trade-offs made in (health) policy due to the widespread ideology of austerity. An ancillary question of this article is whether the CA's criteria help in evaluating policy choices and health related outcomes during the current financial and economic crisis.

The Capability Approach

Sen's CA can be used as a normative framework to analyse how people's capabilities are affected by individual and population well-being and related social arrangements and policies (3, 4). Capabilities are all the potential options a person can choose from in order to lead a good life and therefore achieve good quality of life (4). Thus, capabilities can also be termed real

opportunities or (positive) freedoms. Whereas Rawls' theory of justice is focussed on the equal redistribution of so called primary goods (e.g. income), Sen amends it by arguing that it is also morally relevant to see what people can really do with these goods (considering their personal circumstances) (3, 5). Sen thus takes a broader perspective that also considers potential outcomes (i.e. what an individual can realise with the goods he or she receives): when a certain capability is realized, it is termed an achievement or 'functioning' (3). A person can thus attain a specific set of functionings chosen on the basis of their own personal values from real options (or capabilities). For Sen, it is essential that people have the choice of whether or not to make use of their capabilities. For example, a person fasting and a person starving might be in a similar physical state with respect to their health, however, one can eat but chooses not to whereas the other has no such freedom of choice. According to Sen's CA – and also Nussbaum's version (6) decisions should be fully informed, deliberate and consciously made. The real freedom (perceived as a real opportunity) to achieve a good life is thus the core value for Sen (7).

Besides the distinction between capabilities (freedoms and options to choose from) and functionings (achieved outcomes), Sen bases CA on another distinction, namely between means and ends. Whilst means are merely instrumental to attain certain ends, these are valuable in themselves, and as such are central to CA in assessing health related outcomes of the economic crisis. However, in some cases there is no strict demarcation between means and ends, as capabilities can also be ends as well as a means to other capabilities. For example, being healthy is an end as well as a means for being able to work (3). In our diverse societies means,

such as income, enable different people to reach either valuable capabilities (opportunities) or transform them into functionings (achievements). The ability to transform means into functioning, if valued, is described by the term ‘conversion factor’ (8). By placing a special focus on the ends and simultaneously assessing the means, it is possible to examine the extent to which people’s situations influence their ability to realise pursued ends (8).

Within public health, CA can be used to assess people’s health in general and test whether the resources (or means) to reach good health and well-being exist. For instance, access to fresh water and adequate food supplies, access to medical care, basic understanding and knowledge of health-related matters and/or methods to prevent infectious diseases are all means to good health (4, 9). Factors influencing these capabilities range from economic and financial resources to social structures, institutions, norms, traditions, and political practices (3). Social and political structures can also have a key influence on inequalities between different social groups. In addition to personal differences in access to resources, institutional arrangements – such as gender disparities – can be a source of inequality (10). Nussbaum (6) adds in her version of CA that, from a moral standpoint, the question of how much resources one must have in order to consider these resources ‘sufficient’ to lead a dignified life depends on the resources and capabilities that exist in society. Thus, the CA’ conception of justice inherits a social-relativist perspective (8), which neither requests a total redistribution (as Rawls’ difference principle would), nor is it indifferent to ‘brute luck’. Rather, it requires a (social-relative) sufficient level of capabilities.

Notably, capabilities also entail a personal responsibility to act reasonably (11, 12). In terms of health, this personal responsibility denotes a person’s capability to influence his/her health status positively. Yet in order to act in a self-responsible manner, one has to be empowered or enabled to do so (e.g. by being offered health education, access to medical care etc.) (12). Thus CA pronounces clearly that social determinants of health demand ethical appraisal and evaluation. Here, Sen’s approach offers a wider perspective than many liberal theories of justice (such as theories inspired by Rawls) which consider only the access and distribution of goods instead of asking what people can do with these goods and to what extent they can really affect their capabilities. Along these lines, applying CA allows the identification of certain issues arising in the wake of the economic crisis, which endanger justice in health. In this respect, CA clarifies which goals should be prioritized for improving health-related functionings (13).

MATERIALS AND METHODS

In order to fully understand the impact of the economic crisis on population health and health systems and whether CA has already been used in this regard, a literature review was conducted. The online databases PubMed, SpringerLink, Oxford Journals, Embase, Elsevier, Informa Healthcare, JSTOR, SAGE, and Science Direct were searched. Keywords for the meta-search included the terms ‘austerity’, ‘austerity measures’, ‘economic crisis’, ‘financial crisis’, ‘health’, ‘health care’, ‘ethics’, ‘European Public Health’ and ‘capability approach’. These were used in combination and were searched for in the title and abstract of articles. The sampled literature was filtered by publication period

(January 2007 to March 2014) and for publications written in the English language. A title and abstract review was used to assess the relevance of each article to the recent economic crisis in Europe. Citation mapping was then applied to check for additional literature via snowball sampling.

The information collected on the consequences of the economic crisis on health and health systems was then reviewed, synthesized and presented according to an adaptation of the categories identified by Karanikolos et al. (14) and Quaglio et al. (15): existing policy approaches, consequences for health systems and effects on health. Lastly, the findings were analysed and discussed using CA (3). Applying Sen’s CA theory to the economic crisis facilitates the identification of morally challenging, critical issues for population health and health systems in Europe. Thus relevant issues can be conceptually constructed and discussed using ethical language derived from the CA normative concepts.

RESULTS

Twenty-six articles were identified as relevant to health and the economic crisis at a general policy level. None of them explicitly referred to CA in relation to the health crisis.

Policy Responses to the Economic Crisis and Their Impact on Healthcare Systems

From a macro-economic perspective, governments have mainly engaged in two policy options during the crisis: employing stimuli compatible with the Keynesian framework or implementing austerity measures so as to decrease their debts (framed more in the neoliberal ideology). While Keynesian economics stress the importance of government support during economic recession, neoliberal policies favour less government support and emphasize the role of free markets (16, 17).

Austerity Measures

In alignment with neoliberal policies, the implementation of austerity measures has been the most common policy response acted upon by countries such as Portugal, Spain, Greece and Ireland, among others (14). Due to budgetary pressures, several EU countries accepted the conditionalities proposed by the International Monetary Fund (IMF), European Commission (EC) and European Central Bank (ECB) (composing the so-called troika), so as to be eligible for financial rescue packages aimed at initiating economic growth (2, 14, 16). For instance, corresponding reforms in the health care sector implemented by the Greek government resulted in strict austerity measures; restricting access to health care services, introducing privatization schemes and deregulating private health services (2). On the other hand Belgium and Denmark, for example, preserved their health budgets and some countries such as the Czech Republic, Lithuania, Estonia, Slovakia, and Italy were able to refer to counter-cyclical policies, which were taken before the crisis with the goal to protect health, for instance, retaining financial funds specifically assigned to health (18). However, most of other EU countries reduced their health expenditure (14) by altering the contribution levels, volume, quality, and/or costs of care (18). Such health expenditure reduction is analysed below.

Contribution levels have already partially decreased due to the rise in unemployment, which has led to a loss of social insurance contributions (18, 19), yet countries with counter-cyclical policies implemented governmental contributions for unemployed people.

Alterations to the volume and quality of health care were not directly implemented, however, some countries introduced policies to lower the demand for health care through raising taxation on alcohol and tobacco (18). Nevertheless, countries neglected to promote healthy behaviours, e.g. diet, physical exercise and screening measures (18).

Primary targets for cutting costs of health care were found in the reduction or freezing of salaries for health professionals and rises in health service user charges (18–20). Uncompetitive salaries can lead to a migration of health professionals to other countries or to private health sectors further worsening an already ‘brain-drained’, publicly financed, health care system (14). Raising user charges for health care services decreases access to health services, especially for low-income and frequent users, who are also normally the ones most in need (14, 19). Thereby, health services may not be accessible in time, resulting in decreasing levels of health. This in turn may require emergency care, further reducing savings made in the first place (21). Additional cost-saving measures introduced by some countries included pay-for-performance systems, lower prices for health services paid to providers and reduced prices for pharmaceutical and medical devices through negotiations with pharmaceutical and medical technology companies (18, 20). Cuts in other areas, for instance those in higher education, are also seen critically, as they might have a negative impact on pharmaceutical innovation and thus on economic growth (22).

Moreover, cuts in health spending rapidly affect the primary care setting, with medical services increasingly shifting to this ‘low-priced’ primary care setting (23). In order to further reduce health care costs, the role of general practitioners should incorporate action to lower health illiteracy by providing health information, preventive behaviour and self-management techniques for patients. Such action represents ‘low hanging fruit’ for cost savings, with health illiterate patients generally being more frequent users of health services and with lower levels of health than literate ones. With regard to patient-centeredness, it is feared that the dehumanisation of care through the growing application of computerised techniques and increasingly market-focused view of health have been fortified by the economic crisis with patients being regarded as costs to the healthcare system instead of human beings (24). Indeed there have been criticisms stating that contemporary healthcare systems and their adherence to market values and consumerism neglect patient-centred approaches which respect patient dignity and individuality irrespective of his/her “social or economic situation, personal characteristics or the nature of the health problem” (24).

Stimuli

Another possible reaction towards the economic downturn, which was employed by countries such as Sweden, Germany and Iceland, was the implementation of stimuli to strengthen social safety nets. According to the Keynesian approach, stimulus is the opposite of austerity (14, 17). Unlike countries which were pressured to opt for austerity, countries enacting stimuli do not show

an increase in adverse health effects (18, 25, 26). A prominent example therein is Iceland, which, in relation to its economy, experienced the most severe banking crisis in history, nevertheless, health services quality remained stable. In two referenda, the population voted against austerity measures to favour a gradual pay off. The result was that the economy recovered without any decrease in health coverage or rise in suicides (14).

General Policy Responses

General health policy responses to the economic crisis have used arguments strongly advocating for health in order to prevent the healthcare system being adversely affected by cuts in spending or services (1). Policy responses should aim at controlling costs instead of simply shifting costs or narrowing health coverage (27). Schröder-Bäck et al. propose the use of ethical guidance in decision-making processes (28). Apart from basing trade-offs on values such as solidarity, equity and justice, which might not be of sufficient help for particular decision-making, procedural justice should be integrated and emphasized as a tool in policy-making. Indeed further tools and methods for analysing values and trade-offs ought to be framed and elaborated (29).

Consequences for Health of the Population

It remains difficult to assess health outcomes since research has been limited, and data is largely unavailable yet. In contrast to financial data, health and mortality records typically suffer a two-year time delay before effects are seen. This means that the full consequences of the (long-lasting) economic crisis are only likely to become measurable in the years to come (14, 15). Existing findings on health impacts however are described below and where possible linked to attributing factors.

So far, unemployment was found to be a major factor impacting health levels (26, 30). Even a 1% rise in the unemployment rate (of under the age of 65) correlates to a 0.79% increase in the number of suicides amongst the working age population (30). In Greece and Ireland suicide rates rose dramatically, showing a 17% and 13% increase, respectively, with the highest rate seen in Greece for 30 years after renewed austerity measures were introduced in 2011 (20, 31, 32). Moreover, sudden and vast increases in unemployment cause higher numbers of alcohol-related deaths (30). Among the unemployed, mental health issues are also twice as prevalent as in employed persons (34% vs. 16%) (14, 15, 20). Such declining health status due to unemployment can be directly linked to lower income levels or lack of health coverage, increasing difficulties faced in accessing health care services or affording a healthy and nutritious diet (2, 14, 30). Interestingly however, lower levels of income have reduced the use of private vehicles due to increased gas prices, which has led to a reduction of traffic-related deaths (14, 30, 31). Yet the crisis has seen the number of unmet medical and dental needs increase in tandem with poorer self-reported health levels (33). In a view of previous research it is expected that countries which suffered fast socio-economic changes will show a decrease in life expectancy in the years to come (14). Also, HIV infections increased substantially in many countries, e.g. in Greece from 15 to 484 between 2009 and 2012 (19). Besides HIV, incidence of other infectious diseases was observed, e.g. outbreaks of the West Nile Virus and malaria

in Greece during 2010 and 2011 (2). Portugal also saw mortality rates related to influenza increase; a product of low temperatures and lack of heating capacities (34). This rise in HIV infections can mainly be attributed to a rise of illicit drug users, spending cuts on street work programmes, and a reduced distribution of condoms and syringes to drug users (19, 20). Additionally, child health was affected seriously; stillbirths for instance increased by 21% and infant mortality by 43% (15, 19). This marks a reversal in otherwise stable or decreasing prevalence thereof.

When examining the impact of responses to the economic crisis on health, it was found that for each 100 USD increase in social welfare spending there was seven times greater mortality reduction compared to each 100 USD rise in GDP (1). This implies that economic growth is not the primary determining factor of positive health outcomes *per se*. Rather, such outcomes depend on whether resources are distributed equally across the population (26). Thus, investing in health by means of strengthening social safety nets may reduce the adverse effects of the economic crisis (1, 26, 35–37).

As regards taxation as an attributing factor for health outcomes, increased taxes on certain goods can lower the use of harmful substances, such as alcohol, tobacco, soft drinks, fast food chains, sweets etc. (15). Conversely, decreasing taxes on health-promoting resources, and thus increasing the affordability of healthy food, can positively affect health (14, 30).

It should be kept in mind that the crisis' effects on health may not be perceived to the same extent by all parts of the population due to differences in socioeconomic status (26, 35, 37). Especially vulnerable populations such as the poor, the destitute, children, the elderly, immigrants or those at risk of social exclusion will be affected most by the economic crisis and austerity policies. Such populations are particularly likely to suffer health deterioration when opportunities regarding employment, education, housing or health services are limited (22, 35, 38). This suggests that health inequalities, both between and within countries, may grow. The widening gap in health inequalities might thus hide existent health consequences of more vulnerable populations which then rather remain hidden in statistics also encompassing the ones which are better off (30). Also GDP, as the commonly used measurement for economic performance, does not take into account relevant factors for assessing economic instability e.g. inflation or unemployment (16). In order to enhance the measurement of well-being, it is therefore proposed to include elements such as living standards and life expectancy, following approaches such as the Human Development Index (16, 39).

DISCUSSION

The current literature available on the consequences of the economic crisis for European population health and health systems has shown that health outcomes are adversely affected. While it is a trivial statement to say that this is morally unfavourable, such a view is also supported by CA. Drawing on the theory of CA in assessing health related outcomes of the economic crisis confirms that health – and in particular the capability for health – is essential for well-being and leading a good life. Health should not be therefore neglected during times of economic crises, and it should constitute a key component of policy-making instead.

CA also highlights which social determinants of health are worsened by the economic crisis. In this context, CA concentrates on the 'conversion' of capabilities into functionings. Speaking in terms of CA, one can see that Keynesian economic stimuli generally open up opportunities which promote freedoms and capabilities to live a healthy life. Conversely, the implementation of austerity measures and cutbacks in health budgets limit opportunities and capabilities (for individuals of a population). From a CA point of view, there is a burden of proof (an obligation to provide verification) that reducing resources for health care, further deregulating the health care market and moving towards privatisation is actually ethically acceptable. Thus, it is not only crucial that sufficient capabilities should be guaranteed to everyone through the help of public policies, but also that the ability to make the right choices – choosing the option which benefits oneself – is ensured. CA asks if everyone really can make choices which promote health (e.g. by using health care) and whether these choices are available only to those who can afford it or are health literate enough. Thus, one could also state from a CA perspective that everything diminishing health literacy is *prima facie* morally unfavourable, which would also bear the burden of proof of being ethically acceptable. Since given 'choice' plays such an essential role in Sen's approach, the real opportunity for an informed choice is morally salient.

Austerity measures in the health and social sector affect especially vulnerable groups, depriving them of the opportunities they might have had if the austerity measures were not introduced. Fewer resources (i.e. means) reduce a person's conversion factor. Consequently, they are then less able to translate capabilities into real achievements (functionings). However, prioritising those in need is a notion CA highlights, demanding support for those with the least capabilities given that these groups overall have the worst chances to achieve valuable functionings.

In contrast to measures of well-being which are solely based on macroeconomic indicators (such as GDP), where inequalities between and within populations remain unknown, Sen's CA helps to identify these inequalities and their underlying factors. Unemployment as a key determinant of health reduces capabilities (e.g. the ability to reach high ages and full life expectancy) through raising the prevalence of suicides, alcohol-related deaths and other diseases. Yet, ill health may also lead to unemployment. Thus, it is essential to provide continued health care access to unemployed patients in order to protect them from diminished income and further financial burden when losing their job due to illness. Moreover, cuts in social welfare spending as a whole were identified as limiting the capabilities of people to live a healthy life.

The lack of health promotion measures is critical from an ethical point of view in terms of CA. Such lack most often detrimentally affects vulnerable groups of the population that would otherwise benefit from welfare and health programmes supporting healthy choices. However, it should be emphasized again that CA is not inherently paternalistic – wanting everyone to necessarily opt for 'the healthy choice', rather having a real choice is supported. When deciding against the healthy choice, however, one has to live with the consequences. CA purports that it is essential to be able to understand the consequences beforehand, not making the unhealthy choice simply due to a lack of knowledge or alternatives. In this respect, raising taxes on alcohol, tobacco and un-

healthy foods is an ambiguous policy response. On the one hand it limits the opportunity to consume these goods, constraining the freedom to do and be what one values, on the other health-risky behaviour is contained and health is generally promoted. Therefore, an increase in taxation of tobacco could even be criticised from a CA point of view, at least Breton and Sherlaw (11) do so, arguing that persons have less choice to live a good life according to their individual preferences.

The ethical relevance of what has been termed ‘dehumanisation of care’ becomes clear when we focus again on the special role which self-respect plays within CA. One may assume that fewer human encounters in the care setting will result from a shift away from (more costly) human interaction. Of course, there are many advantages of more ‘automatized care’, besides saving costs. However, when ‘dehumanisation of care’ is introduced to save costs, the burden of proof for showing that this is not undermining people’s self-respect and dignity is on those proposing this way of care.

However, it is also possible to identify factors within policy responses which promote opportunities to gain good health and thereby foster freedom. These include investing in social welfare and particularly labour market programmes, for instance, the capability to have a job as a means to improved health may be facilitated with such investment. Furthermore, government contributions for the unemployed in order to support them are crucial, since they help retain the capabilities or functionings which are only achievable with monetary resources. The reduction of pharmaceutical prices is another policy response to the economic crisis which promotes capabilities by reducing the threshold to attain pharmaceuticals.

With regards to the choice of whether to enact austerity measures or not, Iceland can be drawn on as a capability-promoting example. During the crisis Iceland allowed its citizens to vote on austerity measures in two referenda. This political participation, which was exercised by many citizens and translated into a functioning, enabled them to choose a life according to their values. Austerity and deep cuts to the healthcare system were avoided, thus political participation can be identified as a distinct social determinant of health in this regard.

Taking the ‘moral point of view’ according to CA reveals inconsistencies in action which are subject to a burden of proof of being morally justifiable. Germany, for example, followed a different policy approach imposed by the troika on other countries. Whilst other countries were forced into less healthy/ethically favourable austerity measures, Germany itself adhered, at least in some aspects, to a more Keynesian approach stimulating its own economy. Against the perspective of persons having equal worth in the European Union, this policy is at the very least ethically challenging, if not questionable. From an ethical point of view, there is, again, a burden of proof on such rationale which constitutes a seemingly inconsistent behaviour preferring (within a supra-national community) one’s own population over others.

As already demanded by others, further research is indispensable. The knowledge gap has to be closed with regard to both strengthening resilience to health threats (resulting from economic downturns), and to which policy responses can result in a reduction of risks (14, 16, 29, 31, 37). The findings of this article are dependent on the contingent data available. However, it is obvious that action is necessary even if complete data is not

available yet. Thus, it is suggested to act tutoristically instead of not acting at all.

Given the fact that austerity measures cannot be avoided in all cases, research is needed to ensure that austerity measures in Europe are based on ethical foundations enabling values and norms to guide action and minimizing any negative impact on capabilities (and functionings) (40). Apart from the identified elements mitigating the effects of the economic crisis on health and health systems, other criteria should be taken into account for ethical guidance in dealing with shrinking health resources. As Stuckler and Basu (41) argue, the leading principle should be to ‘do no harm’. Regarding the clear ethical normative imperative that harm is to be avoided, CA offers a perspective to specify the broad notion of ‘harm’ according to more concrete criteria – namely the lack of capabilities spelled out by Sen. These criteria include dimensions of self-esteem and recognition which are rarely considered in debates about the economic crisis and its impact on health.

CONCLUSION

Existing literature about the effects of the economic crisis suggest that consequences for health and health systems are severe and that there are a myriad of associated problems. Concluding that a decrease in overall population health and health equity is morally unacceptable does not require extensive consideration of ethical theory, as it is a normative judgement widely shared, at least within the public health community. However, CA, a theory at the interface of normative economic theories and ethics, offers a framework to highlight morally salient aspects in policy responses aiding ethical evaluation of policy options. CA thus establishes areas for further ethical discussion aiming to increase awareness rather than offering an algorithm for solving health related consequences of the economic crisis. It demonstrates several cases where there is a shift in the burden of proof for justifying policy actions mandating public health and health science experts to go beyond considering the success of policies just in terms of the level and distribution of life expectancy, incidence and mortality rates. Instead CA draws our attention to several normatively relevant aspects of health and the determinants of health which otherwise would not have been considered. Among these aspects is the major claim that the success of economic, political and health systems cannot be expressed solely in cumulative figures such as GDP. Instead, ethical judgements need to incorporate other information about the well-being of human beings at both the population and individual level.

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Conflict of Interests

None declared

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