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**EQUITY CONCERNS UNDER FISCAL RESTRAIN.
THE CASE OF THE SPANISH HEALTH CARE SYSTEM
IN CATALONIA**

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EQUITY CONCERNS UNDER FISCAL RESTRAIN. THE CASE OF THE SPANISH HEALTH CARE SYSTEM IN CATALONIA

What can we learn from the Catalan Health System Observatory 2017 report on the population's health in order to derive evidence based policies? Which insights do results offer about the mechanisms through that socioeconomic inequalities operate and need to be addressed? Which precautions are derived from it in order to build evidence-based, equity-related health policies to be applied in the near future?

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Key Words

Socioeconomic related health inequalities, economic crisis, Catalan Health System, evidence-based health policies

Introduction

Social protection systems are related to each country's culture. In fact, they are a part of it. The Spanish system is universal and meets objectives using public expenditure ratios both per capita and in terms of GDP figures, reasonably situated in the lower middle level out of the European countries. The main concern today on the sustainability of the situation comes from the fact that the system is very set in its ways and is not much prepared for what is to come in health care and the intervention therefore required to fight against the inequity that likely will result. That is, for example, the need today to direct universalism to a greater extent towards the most needy, fragile population that have been left behind by the economic crisis. The Spanish system is not prepared to prioritize services and set population targets and therefore is not resilient to the consequences of the technological and economic changes to come.

In Catalonia, a rather wealthy region in Spain, the driving forces behind these developments are a main concern. In terms of equality, the gap in socioeconomic inequalities has been increased during the last decades in Catalonia firstly by immigration, driven by the economic boom, followed by unemployment caused by the economic crisis. They have generated new vulnerable groups (unemployees, children and elderly, as side effects) and in addition some proposals from the Spanish conservative government to change the terms of access to universal health services to pursue fiscal deficit control (see Vall, Lopez-Casasnovas and Arnau mimeo, CRES, 2018) can make things worse.

These aspects overlap with problems related to technological innovation and financial pressures on utilization of the health system, emerging further issues on equity loss [1]. We know that in order to face them, the universalism of the welfare state, a free for all, is not an all-purpose solution (see Abasolo, Saez and Lopez-Casasnovas 2017). In terms of equity, universalism must be understood as completely and potentially eligible access for all citizens, but this should not exclude the filter to give priority to those in higher relative need and/or lack of means. For this the Spanish health policy and management are little prepared for.

We cannot ignore moreover the fact that equal access does not guarantee equality in consumption or in the result. The opportunity costs of access open up gaps (self-employed, illegal immigrants, unaware of how the system works, functional illiterates, those with handicaps and physical limitations) mainly linked to socioeconomic factors. In this sense, universalism is not a resilient to the effects of an economic crisis nor is free access to health innovations a guarantee in an age of personalized medicine: the consequences are distributed unevenly.

It is important to bear in mind that the social progression of a universal system occurs when, having made adjustments to their relative needs, the highest income groups consume proportionately less public services than what would correspond to them in terms of their adjusted demographic weight. The greater the awareness (through knowledge of how the system works or through contacts), the more utilization is made by high income groups causing the system to reduce its redistributive capacity because the former is associated with the high socioeconomic status. Something similar occurs in developed and much logrolled societies as the Catalan one where the costs of accessing the system for those in higher income brackets are lower, for example, because they know how to jump up the waiting lists, or benefit from private healthcare services

At the same time, a crisis that may indicate, or allow people to notice, a weakening of public services (perceived quality, waiting times), leading lower middle classes to begin considering paying for private services, while everything else remained the same, would almost certainly cause a loss of redistributive capacity of the public health benefits [2] because the allocation of public healthcare expenditure in favour of lower brackets would be reduced.

Many of the above uncertainties are detected by conducting confidence indexes of the Spanish population on the potentialities of our healthcare system. The *ESADE Index* [3] shows that trust in the system has been damaged in spite of economic recovery and increasing expenditure¹.

In this new context, what becomes relevant is how we identify and adapt our health system to the emerging challenges and build on them evidence based responses. For this purpose we can now take advantage of what we have learnt about the mechanisms related to socioeconomic inequalities on health and healthcare usage recently in Catalonia (see A Garcia-Altés et al' paper in JECHE, 2018). So far existing studies in Spain had focused on aggregate data, disregarding specific subgroups of the population, or on information from individual surveys, with substantial methodological shortcomings and a risk of bias [5]. On top of this, there is scarce knowledge about the actual mechanisms that relate socioeconomic and health inequalities, and the existing mediating factors. Therefore, many public policy and health policy proposals tend to be based on intuitions or ideology, instead of evidence.

In 2013, the Government of Catalonia agreed to closely monitor the determinants of health as well as the health status of the population, in order to assess the impact of the economic crisis and to examine related issues. Since then, several reports have arisen, analysing the determinants of health, some population subgroups, and differences in territory. The 2017 report, referred above, analysing individual data of the entire population of Catalonia (7.5 million inhabitants) is a milestone. It refers information regarding their income level and financial benefits provided by the Social Security system to information about their health, their use of public healthcare services and drug consumption, focusing specifically on vulnerable groups [6]. The Catalan Health System

¹ The opinions on values expressed by men are decisive in this aspect given that they more than balance out the marginal improvement expressed by the women. Young people are equally decisive in the final rating and show a very negative opinion, which is surprising because they are the least likely group to make use of the services as a result of the crisis. Conversely, retired people recorded better ratings and a positive change: this is normal if, as frequent users, they consider that the worst has already passed.

Observatory may then examine inequalities in health, the utilization of public healthcare services and drug consumption among the population of Catalonia, according to socioeconomic levels that take both the employment status of the person as well as their income level into account. These are stratified by sex and age, identifying specifically those more vulnerable groups. The potential of the current study is the analysis of individual data of the entire population of Catalonia, relating economic and public protection information to individuals' health, their use of public healthcare services and drug consumption.

What does the Catalan evidence tell us?

The review of literature on the impact of the economic situation -that prior to the 2008 crisis- on health among the population, in some cases points to an increase in mortality all due to causes related to unemployment² [7]. Both across Catalonia and Spain, indicators such as life expectancy or general mortality do not appear to have been directly affected by the economic crisis [13,14], although there is some evidence of the effect of the crisis on health factors, changes in certain lifestyles and access to health services [14, 15, 16].

However, by focusing solely on average population rather than on the most disadvantaged one, the decrease of health inequalities is not sufficient. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage (this is *proportionate universalism* [17, 18]). In addition national policies do not work without effective local delivery systems working on three main principles of health justice: better cost-effectiveness, non-discrimination and priority to the worse off in terms of both current severity of illness and lifetime health [19].

Results show that there is a socioeconomic gradient in all indicators analysed in the Report, both in health and in the utilization of healthcare services, in the consumption of drugs and in most combinations of age and sex. This gradient is small in primary and emergency care, being greater in drug consumption (especially antipsychotics) and much higher in mental healthcare services and hospital care (especially psychiatric and avoidable hospitalizations). There is also a high gradient in mortality and complexity. The mortality rate shows a remarkable social gradient in people under the age of 65. All of which has been concluded applies with respect to the standardization mentioned in the Report, and therefore requires greater care not only in interpreting the effects but also in applying the intervention mechanisms for the future.

Undoubtedly, certain clarifications would be needed in order to avoid making exaggerated interpretations of the results because marking incremental values does not distinguish base values in absolute terms. Although the gap between social groups is reduced as age increases, a higher percentage of the population of pensioners with lower incomes are in situations of high complexity compared to higher income groups.

Children's health depends, as expected, on the socioeconomic level of their parents. We should note that this aspect is greater on an intergenerational level than an intragenerational one, in which the cross-section analysis often interprets the increased inequality in health of a specific population and leads to much more differentiated policies than those supposedly obtained with the end of "austericide" (austerity in public spending). Furthermore, despite extensive evidence on generational consequences, it does not seem that the dynastic element is well taken by the health authorities. In order to do so, we would need to focalize policies rather than simply demanding

² However, the more consistent effects of different economic crises are: the increase in suicide [8] -albeit with nuances [9]- and the impact on mental health with a higher probability among the unemployed of suffering from mental health problems [10] and those evicted or with difficulties to pay their mortgages [11].

“more resources for health;” a demand that is often embedded in the lobby on inequality in a very indiscriminate way.

Morbidity, the use of mental healthcare centres, hospitalization rates and the probability of consuming drugs in girls and boys of a lower socioeconomic level is 3 to 5 times higher than those with a higher socioeconomic status, and up to seven times in the case of psychiatric hospitalization. However, an additional clarification is required here because without intending to detract from the importance this subject deserves, the number of people affected is in fact very small, particularly psychiatric hospitalization

In addition to socioeconomic inequalities, consistently observed in all indicators, the 2017 Report shows also marked differences between women and men both in healthcare service utilization and consumption of drugs, as well as in health outcomes, and this seems to be the case for all age groups and almost all socioeconomic levels analysed. It is evident, therefore, how gender inequalities are perpetuated throughout people’s life cycle and affect those of all socioeconomic levels.

In brief, the study shows that despite the fact that the Catalan Health Care Service is a universal and well developed system, there exist significant socioeconomic inequalities in health and use of healthcare services in the population of Catalonia. But disparities in the utilization of public healthcare services are not necessarily considered bad if health inequalities exist, because these differences occur to some extent in response to the differences that exist in citizens’ states of health. In other words, it would be more worrying to see differences in mortality according to socioeconomic levels, than no differences in the use of healthcare services. However, since it is not possible to fully adjust to the degree of each person’s needs, we cannot ascertain whether the gradient observed in the use of services should be even greater than it is. In this case, the Report highlights the need to respond to this situation through more fine-tuned health policies and other tailor-made public policies such as education and labour.

Building evidence-based policies to tackle socioeconomic health-related inequalities

In order to define policies based on the maximum available evidence in order to tackle inequalities in health derived from the socioeconomic conditions of the population, we first need to better direct the focus of attention [20]. As pointed out above, evidence of the impact of the economic crisis on health results in Europe should alert us to a series of problems, which although show varying results depending on the country, the data and methodology of many studies are possible to compare. There is considerable consensus and evidence is in the fact that economic crises cause an increase in social inequalities in health, and disproportionately affect the most vulnerable among the population [5, 21].

Despite limitations to extracting common results, it would seem that the most affected area in the first instance to be prioritized is that of mental health, since suicides tend to increase with social fragility, facts that also come to light in the study on Catalonia. Another group of the population deserving of special attention is infancy. The infancy category also shows a structural representation of inequalities [22]. When parents are living in adverse socioeconomic conditions due to the economic crisis, these have a direct impact on the health and development of their children, and on top of this, these problems at such a young age will have a negative effect in the long term [23] both on their health and on their socioeconomic level [24], given that they tend to be influenced by their parents’ socioeconomic conditions [25] which become difficult to leave behind [26].

There is increasing scientific evidence both in biology and social sciences that points to the importance of the first years of life -including *in utero* exposure- in the formation of the capacities that promote well-being through the life cycle [27]. Inequality in early childhood is an important cause of inequalities in the skills provided by social development (educational achievements, health and risk behaviour, income levels, etc.). The risk of illness increases more rapidly with age among disadvantaged populations. If no measures are introduced to change the course of their lives, children who grow up disadvantaged are at risk on a socioeconomic and a biological level for the rest of their lives.

Another significant axis in health inequality, in addition to the socioeconomic axis, concerns gender. Women generally have worse states of health than men: they suffer from more illnesses or chronic health problems, as well as more anxiety problems and depression, disabilities or permanent limitations [28, 29]. Studies on health inequalities according to gender have traditionally been performed parallel to studies on socioeconomic levels, but it is very important to bear in mind that both of these axes of inequality act simultaneously [30]. For instance, in Spain there are significant gender inequalities in employment conditions and in work-related health issues that are influenced by people's socioeconomic level [31], meaning that women are also a particularly vulnerable group in the current socioeconomic context.

There are studies to suggest that the association between inequalities in health and socioeconomic level is not linear, but follows a curve showing that inequalities are more pronounced up to the approximately €30,000 per year bracket, after which the effect smooths out [32]. These results indicate that those policies aimed at eradicating situations of poverty, which lead to a reduction in the number of people living in precarious conditions, result in major benefits in terms of health. In the case of the Catalan Report mentioned here, belonging to category corresponding to an income bracket of €18,000 or more leads to a significant improvement in health indicators.

Merely acknowledging the effects of the crisis on inequalities in income on one hand, and on health on the other, give no clear clues as to how elements arise and interact. Who may possibly imagine that the increase inequality will be eliminated by simply restoring financial expenditure levels to those of before the crisis?

It is true that some European health systems resisted the crisis better than others, and among the factors that could explain this better response is, according to some authors, public policies in health expenditure. Nevertheless, are we talking for the k-success about the resilience in levels of expenditure or about systems that have been able to respond better to the crisis by refocusing available resources to the new situations, having accepted that a higher expenditure in health is not always better and that in these cases, more than ever, it is necessary to prioritize? Are we in fact saying that it is inertia, or the incapacity to adapt to changing economic circumstances which is the decisive element? Is it perhaps not more likely that spending "a fixed amount" when facing a reduction in healthcare resources not only worsens the health of the population but makes it less equal? Are factors of demand decisive if higher unemployment rates, lower expectations of consumption, unpaid senseless commitments made in the past, and anxiety and loss of self-esteem the important vectors?

To prevent indeed more inequality, and not only a greater loss of health, we need to take some hypotheses on board concerning the patterns in demand, resulting from the elasticities of price and income, in order to be able to identify the causes of an increase in health inequalities and hence its correction.

The expected naïf effects of universalism may not occur, however, if the system is more proportionate, more selective and services are better prioritized according to the new and greater relative needs of certain social groups. Or if in the case where elasticity of income is important,

where groups with medium/high incomes do not stop using complementary insurances with not much impact in their health. We can see that these should not be unusual assumptions for some cases, because they would follow the mistaken logic of many analysts that link simply health results to healthcare use (even without an appropriate standardization of needs), or those that attribute higher levels of health to those who use services that combine access to both public and private healthcare services (having defined these last services as ineffective).

Other forms of social protection, such as those that would ensure adequate levels of public health expenditure, avoiding loopholes in health coverage, both legal ones and opportunity costs of access to free services, should be considered in a much more specific way. This can affect freelance and self-employed workers, illegal immigrants and regular employees who avoid absenteeism for fear of losing their jobs, as well as those citizens making lower levels of direct payment to cover the costs of alternative private healthcare services.

In general, a change in inequality in income due to an additional increase in unemployment (in the case of Spain) cannot follow the same reaction mechanism as that of an increase in the incomes of the richest with respect to the poorest individuals (as in the case of Nordic countries) given the respective unemployment protection levels, or in contexts in which can be shown that the loss of employment reduces stress and facilitates “jogging” (as some USA literature points out). It is clear that the crisis affects everybody in a totally different way according to the prior individual determinants of each person.

Admittedly, all this must be placed within each specific setting, depending on individuals’ lifestyles, after assessing wealth rather than just income as the conditioning factor and other related aspects. For instance, the composition of assets may be important having observed the huge drop in the prices of some of them, with greater effects in large estates, be it by individual, salary earner or head of family situations.

What is more, even if the mechanisms that interact in health inequalities of socioeconomic origin can be identified, caution obliges one to limit the conclusion to a specific country, time and place, without knowing for sure whether what is known of the past can guarantee the information regarding corrections required for the future.

Basic commented paper: *Socioeconomic inequalities in health and the use of healthcare services in Catalonia: analysis of the individual data of 7.5 million residents* Anna García-Altés, Dolores Ruiz-Muñoz, Cristina Colls, Montse Mias, Nicolau Martín Bassols
<https://jech.bmj.com/content/jech/72/10/871.full.pdf?ijkey=2kMaAyBKOTSz8GW&keytype=ref>

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