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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 restraint. The case of the Spanish Health care System in Catalonia

What we have learnt from the 2017 Catalan Health System Observatory report on the population's health about the mechanisms needed to address socioeconomic inequalities and the precautions derived from it in order to build evidence-based, equity-related health policies and apply them in the near future.

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Abstract

Concern about inequalities in health has been a recurring theme since the 80s in European healthcare systems. On top of that, there is scarce knowledge about the 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 ideology, instead of evidence.

In Catalonia, in 2013, the Government 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. Since then, several reports have emerged. This year's recently published report analysed individual data of the entire population of Catalonia (7.5 million inhabitants), relating information regarding their income level and the financial benefits provided by the Social Security system with information about their health, their use of public healthcare services and drug consumption, focusing specifically on vulnerable groups.

Results show that there is a socioeconomic gradient in all indicators analysed, both in health and in the utilization of healthcare services and the consumption of drugs, and in most combinations of age and sex. This gradient is small in primary care 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.

Among the actions to be developed to meet the challenges of our health system, building robust, evidence-based policies requires effort: applying data in order to argue a case -that is typically a breeding ground to prejudice- in order to demonstrate the most successful intervention mechanisms required to restore the comprehensiveness of a health system of proportionate universalism.

Key Words: Inequalities, economic crisis, Catalonia, evidence-based 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. So where does the concern of so many analysts on the sustainability of our health system come from? Is the reason for this concern perhaps due to the fact that the system is very set in its ways and is not prepared for what is to come? That is, the need to direct universalism to a greater extent towards the most needy, fragile, among the population that have been left behind by the economic crisis and technological development, and absorb the impacts of an imminent clash in supply and demand, and which in the absence of a sturdy response criteria (prioritization), may spoil a good part of what has been achieved.

In fact, the driving forces behind this are diverse. In terms of equality, the gap in socioeconomic inequalities has been increased firstly by immigration, driven by the economic boom, followed by unemployment caused by the economic crisis, which has generated new vulnerable groups (children and elderly, as side effects), given that the terms of access to universal health services have changed. Meanwhile, these services suffer on one hand the demand of a significant push because of demographic change -causing both positive and forced adjustments- a certain tendency towards the over-utilization of services, linked to cultural values, lifestyle and life expectancy, as well as a tendency to disease mongering or medicalization caused by treatable health problems, which would have previously been considered as non-health issues.

And, in terms of supply, the pressure subjected by technological innovation -straddling on the border between cure and care- affecting all health systems is detected, ranging from more or less personalized treatments, or at the very least “classifiable”, to new biological or genetic repair drugs. These aspects overlap with problems related to the financial sustainability of the health system, emerging 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. In terms of equity, universalism must be understood as completely and potentially eligible for all citizens, but this should not exclude the filter of relative need and/or means testing which the Spanish health policy and management are little prepared for.

We cannot ignore 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) and are linked to socioeconomic factors. In this sense, universalism is not resilient to the economic crisis: the crisis distributes its consequences 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 lowest 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 causing the system to reduce its redistributive capacity because the former is associated with the high socioeconomic status.

Something similar occurs if 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, and also if the care quality of public healthcare services becomes high enough to cause private healthcare service users who previously consumed less public healthcare services, to go back to legitimately using the public healthcare system, and therefore also with greater frequency.

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 [3] of the Spanish population on the potentialities of our healthcare system. Confidence in terms of how the system's healthcare responds when faced with the havoc caused by the economic crisis in the sustainability of health financing, has been eroded and today this can be a factor that 'anchors' the levels of trust/a lack in trust observed.

However, how did the financing of the Spanish healthcare system during the crisis really change? With objectifiable data [4] we can say that little changed. Its growth has slowed down and only very few items that could affect the population have been reduced, given that the greatest impact has been perceived in wage and staff freezes and in drug expenditure. In any case, in the heat of the crisis, health sector cuts were a key cause for outrage among citizens and used as a political weapon against the government management of the crisis. The strong objection launched accusations of "austericide" while the victims of the crisis and government opposers were overwhelmed by indignation. The *ESADE Index* [3] shows that trust in the system has been damaged and continues that way, stagnated for some and still in regression for others in spite of economic recovery and expenditure¹.

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.

In this new context, what becomes relevant is how we adapt the Spanish system to the emerging challenges. In order to answer this question, we can take advantage of what we have learnt about the mechanisms related to socioeconomic inequalities on health and healthcare usage from a recent Catalan report. This new data helps us to apply certain precaution in building future evidence-based equity-related health policies.

The concern for inequality

As mentioned above, the economic crisis of recent years has had a major impact on the social determinants of health, limiting the disposable income of citizens and affecting their living conditions, work and housing. In this context, social inequalities in health are still an unresolved issue in our health system. Concern about inequalities in health has been a recurring theme since the 80s in European healthcare systems. Existing studies focusing on this issue have used aggregate data, data regarding specific subgroups of the population, small sets of data, or information from individual surveys. Moreover, some authors have pointed out methodological shortcomings, and a substantial risk of bias [5].

On top of this, there is scarce knowledge about the 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 ideology, instead of evidence. The policies (and critics) that have been implemented (or not) during the recent economic crisis are an example of this, and their results should be analysed according to the characteristics of each specific context.

In Catalonia, in 2013, the Government 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. Since then, several reports have arisen, analysing the determinants of health, some population subgroups, and differences in territory. This year's recently published report, analysed individual data of the entire population of Catalonia (7.5 million inhabitants), relating information regarding their income level and financial benefits provided by the Social Security system with information about their health, their use of public healthcare services and drug consumption, focusing specifically on vulnerable groups [6].

The remaining section of the paper will make a short review of the recent literature on health-related socioeconomic inequalities, the impact of the recent economic crisis on the health status of populations (mainly from the European experience), the results found, as well as of the methodological shortcomings. The review will focus on the Marmot review. Following this, results from the Catalan report will be presented. Finally, a series of considerations will be shared in light of all the material reviewed, in order to present some arguments for evidence-based health policies.

What does the evidence tell us?

The review of literature on the impact of the economic crises -those 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 unemployment [7]. 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].

Both across Catalonia and Spain, some 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 evidence of the effect of the crisis on health factors, changes in certain lifestyles and access to health services [14].

In European health systems, socioeconomic inequalities in health have been an unresolved issue, since 1980, when the ‘Black Report’ [15] was published, revealing major inequalities in morbidity and mortality among the population of Great Britain, how they had increased since the creation of the National Health Service in 1948, and how they were a consequence of social inequalities unrelated to the health system (income level, education, housing, diet, employment, and labour conditions). Today, still in 15 OECD countries, vast social inequalities in health are still apparent, for example, important differences in life expectancy among people with higher and lower levels of education [16].

Regarding the use of services, faced with the same needs, which enables us to talk about inequity rather than just inequality, it is evident that in the majority of European countries, the groups with lower socioeconomic level have the same or more probability of seeking primary medical care than groups of higher socioeconomic level, while on the other hand, in all countries groups of higher socioeconomic levels systematically use specialized services [17].

Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. 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. We call this proportionate universalism. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits by reducing losses from illnesses associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs [18].

In accordance with the Marmott Report, reducing health inequalities will require action on six policy objectives:

- To give every child the best start in life
- To enable all children, young people and adults to maximize their capabilities and have control over their lives
- To create and develop healthy and sustainable places and communities
- To strengthen the role and impact of ill health prevention

National policies will not work however without effective local delivery systems focused on health equity in all policies. At the same time, in terms of healthcare priority decision-making on a population level, good medical ethics involves focusing on three main principles of health justice: cost-effectiveness, non-discrimination and priority to the worse off in terms of both current severity of illness and lifetime health [19].

In order to place sufficient emphasis on the question of justice, good medical ethics requires careful consideration of the opportunities provided in terms of the costs of healthcare decisions and who will bear them [19].

The Catalan Health System Observatory. What do data say on 7.5 million individuals?

The 2017 report by the Catalan Health System Observatory examines 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 were stratified by sex and age, focusing specifically on vulnerable groups. The potential of the current study is the analysis of individual data of the entire population of Catalonia, relating information regarding their income level and the financial benefits provided by the Social Security system, with information about their health, their use of public healthcare services and drug consumption.

Results show that there is a socioeconomic gradient in all indicators analysed, both in health and in the utilization of healthcare services and the consumption of drugs, and in most combinations of age and sex. We are unable to verify whether this gradient already existed given that individual information regarding Social Security benefits and co-payment levels since 2014 is only available systematically. This gradient is small in primary care 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. All of which has been concluded applies with respect to the standardization mentioned, and therefore requires greater care not only in interpreting the effects but also in applying their mechanisms for the future.

The mortality rate shows a remarkable gradient in people under the age of 65. The mortality rate of men and women of lower socioeconomic level is four times higher than those with incomes above €100,000. For people over 65, the gradient is lower. The mortality rate of women in the lowest socioeconomic level is 1.5 times higher than those in the highest level; in men it is twice as high. 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. For example, from 0.1 to 0.3 there is perhaps a less significant difference than interpreting the gradient as “three times greater”.

In the group of 15 to 64-year-olds, the proportion of people in situations of high complexity is eight times higher in the group of lower socioeconomic level compared with those in the highest socioeconomic group. Among children, this difference is more than double. 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 appear that the dynastic element attracts the attention of our health authorities. In order to do so, we would need to focalize policies rather than simply demanding "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

The utilization of the healthcare service by persons aged 65 and over is strongly related to the size of their pensions. In the absence of additional information on their income and assets, those with non-contributory pensions (PNC) systematically present worse health outcomes and higher healthcare service use, although a socioeconomic gradient is also observed among those with contributory pensions. This should not be surprising if we analyse who, thanks to their income bracket, is entitled to this type of pension, so it is not so much the amount of their pension but more a question of the fixed effect of who is eligible to this pension (without going into who is not eligible for any type of pension).

In general, both male and female pensioners aged between 55 to 64 have poorer health outcomes, make greater use of healthcare services, and have higher drug consumptions, with respect to employed people of the same age. At the same time, there are differences within both groups according to their socioeconomic level, the PNC being the most vulnerable group among pensioners, as well as people who have exhausted unemployment benefits or receive an MRI or RAI, the most vulnerable group being among the employed.

In addition to socioeconomic inequalities, consistently observed in all indicators, there are also marked differences between women and men both in healthcare service utilization and consumption of drugs, as well as in health outcomes, and this is true 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.

The study shows that there are significant socioeconomic inequalities in health and use of healthcare services in the population of Catalonia. However, 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 health policies and other 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 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 difficult to compare. Despite limitations to extracting common results, it would seem that the most affected area in the first instance is that of mental health, and that in general, suicides tend to increase with social fragility, facts that also come to light in the study on Catalonia. Where 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].

One 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]. In this sense, 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 study 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, gives no clear clues as to how elements arise and interact. Who could possibly have imagined that the main cause of inequalities in health is a consequence of the effects of cuts in health expenditure in order to balance the drop in tax revenue? Or that the increase inequality would be eliminated by simply restoring financial 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 about the resilience in levels of expenditure or about systems that have been able to respond better to the crisis by refocusing available resources in each case, having accepted that a higher expenditure in health is not always better and that now, more than ever, it has been necessary to prioritize?

Are we then 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 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 between price and income, in order to be able to identify an increase in health inequalities resulting from the economic crisis.

This might not occur, however, if the system lost universality, were more selective, and better prioritized the new and greater relative needs of certain social groups. Or if in the

case where elasticity of income existed, groups with medium/high incomes stopped using complementary insurances which would in turn affect their health.

We can see that these should not be unusual assumptions for some cases, because they would follow the same logic as that of many analysts that link health results to healthcare use (but not to appropriately standardized needs), attributing higher levels of health to those who use services that combine access to both public and private healthcare services.

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 fact, in general, a change in inequality in income due to an additional increase in unemployment (in the case of Spain) is not the same reaction mechanism as that of an increase in the incomes of the richest with respect to the poorest (as in the case of Nordic countries), or in contexts in which the loss of employment reduces stress and facilitates “jogging” as some American literature points out. And 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 the context of each situation, depending on lifestyles, and assessing wealth rather than income, (the composition of assets here is important considering the huge drop in the prices of assets, with greater effects in large estates), be it by individual, salary earner or head of family.

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.

Conclusion

Over and above the economic crisis suffered, and from a more structural macro-economic perspective, health systems face major challenges and more than likely see gaps in inequality in not only the use of new technology, but also access to it. Elements such as willingness to pay and economic capacity, together with scenarios of fiscal consolidation in public finances set off all the warning signs that we are faced with a new *equity chasm*. The path that the Spanish universal health systems needs to take in favour of targeting beneficiaries according to relative needs, and prioritizing in accordance with the cost-effectiveness of benefits, clashes with a culture that is hostile to change, a political fear that prioritization goes hand in hand with discrimination, health authorities set in their ways, and professionals who having put up with the consequences of the crisis in terms of salary and work load, are not up for the challenge. Therefore, faced with the pressure of

universalized demand and suppliers that push technology and cost with the argument that more is better, we fear that the concerns for equality are no more than that, just concerns.

Among the actions to be developed to meet the challenges of our health system, building robust, evidence-based policies requires effort: applying data in order to argue a case -that is typically a breeding ground to prejudice- in order to demonstrate the most successful intervention mechanisms required to restore the comprehensiveness of a health system of proportionate universalism. And this proves the importance of studies, such as that made here by the Catalan Health Inequalities Observatory.

Beyond the limitations that the data impose, *ceteris paribus*, in the future it is very important in order to monitor the different waves of analysis that the Observatory offers, so as to understand which vectors cause variations in the inequalities observed, and to what extent these are relevant in the political approach (as the pioneering work of John Roemer reminds us, not all inequalities are in fact precisely that), and then how to tackle them based on the understanding of how their fundamental mechanisms work.

This emphasizes the importance of how an analysis should generate more efforts from scholars and less of a supposed preoccupation of some groups who make political use of the subject of socioeconomic inequalities and health to set their own objectives which do not always correspond to general interests.

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