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Economic Crises, Inequity and Health Systems: The Importance of Mitigating the Impact on the Population

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Abstract

In this article the proposition that health systems are an essential tool in order to mitigate the impact which the economic crises have on the population will be analysed and explained. These play a relevant role in the increase of preventable deaths, years of potential life lost, cardiovascular diseases, neoplasias and suicides. In these hard times, the focus should be in the correction of unhealthy lifestyles, such as smoking, alcoholism or lack of physical activity, in the early detection of hypertension and tumours, and the treatment of diseases which were historically mortal, and have reappeared because of the socioeconomic changes. The state should be responsible for planning, regulating and acting needed in order to diminish health inequalities. At present, there are privileges, social and legal pressures, and no policy prioritisation. Therefore, we are not directing our efforts towards those actions which increase health equity.

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Development

A proper health system, by offering universal coverage [1] plays a key role in the social system. It is even more relevant than what Lalonde [2] imagined more than forty years ago, because it acts as a social justice device, which creates opportunities for the deprived and redistributes the wealth. Therefore, a health system is especially valuable during economic crises, when wealth's distribution inequities are enlarged noticeably. However, it should strategically shift from an episodic care delivery model to a transitional, continuous care delivery model [3,4] to reduce the unfair differences and the impact the catastrophic expenditures have on the families, and to widen the system's accessibility and intervention opportunities. Social determinants affect the population's health status, and health problems may impoverish families and be the cause of great economic losses [5,6]. Social inequity has a significant impact on healthcare quality and population's life expectancy [7]. This concept cannot be applied in societies which life's expectancy is affected by violence, war and or famine. However, it can be observed in societies which show varying levels of economic development indicators [8].

There are several ways to improve medical efficiency while using severe austerity measures. The NHS and Australia [9] are examples of how meticulous management and disinvestment policies have enhanced economic efficiency. A health system can contribute in the public expenditure's reduction without biasing patient safety or healthcare quality, by diminishing the effects economic crises have on the population's health status. The world built around the recent "sustainable development goals" (SDG) [10] is a clear example of the risk caused by the dissociation of the ideal global description from the real right to access an effective public health system, designed for the population's needs [11].

In the last decade, socioeconomic inequality levels have risen significantly in Latin America and Argentina. In consequence, we should include this topic in health policy's debate. Latin America is the most unequal continent in the world. A recent study has shown that in Argentina, and particularly in Ciudad Autónoma de Buenos Aires, premature mortality rates have remained unchanged from 2000 to 2010, even though there have been

improvements in socioeconomic levels during the same period. In Argentina, despite having a universal, free, public healthcare system, there are severe inequalities in equity and healthcare access between those who can pay for a private insurance and those who cannot. In the future, it would be wise to study if these inequalities are repeated in every region and city of the country.

Health inequities are huge, ancient, and growing. As a result, a hybrid demographic and epidemiologic transition, in which not only immuno-preventable, infectious, diseases affect vulnerable people, but also the disease burden is increased by chronic non-communicable diseases. In this context, lower social classes usually have higher levels of unhealthy habits, such as smoking, inappropriate nutrition, alcohol consumption, etc. [12]. They also live in poor home conditions and have restricted access to healthcare. Finally, there are more exposed to some of society's actual problems, such as child delinquency or drug addictions. These facts could support the theory that "the deprived will die before enjoying the economic spillover effect which liberal macroeconomists propose", and suggest that health policies for the impoverished ought to be a public health priority.

The health system should actively contribute in economic crises by diminishing the socioeconomic impact through the reduction of potentially preventable deaths. This phenomenon, known as levelling up, has been observed in Spain, Greece, Italy and Portugal, countries which have suffered socioeconomic crises, and which health indicators have not been seriously affected, as it was previously expected [13-15]. Even though the crises' consequences in health indicators are observed later than those which affect salaries and economic well-being, more than ten years have already passed since the crises started in the mentioned countries [16-19]. The SESPAS report 2014 [20] concluded that, even to date, the impact of Spain's economic crisis on mortality, morbidity due to infectious diseases, and sexual and reproductive health remains to be seen. In addition, the report concludes health is biased mainly by the unfavourable changes in the way of life (unemployment, poverty, social exclusion) rather than by modifications in health policies (limited coverage, financial cuts, restricted access, etc.). Due to these results, the mentioned response models can be studied as examples for societies which are currently undergoing socioeconomic crises.

During the last few years, there have been numerous health discoveries worldwide. At present, we possess the knowledge needed to increment life expectancy and build health equity. However, our health systems are not originally designed for this last purpose. The relationship between social determinants of health and unfair inequalities seems to be complex, and can be explained by ethical, social, economic, partisan and political arguments. Consequently, we should develop a strategic plan towards universal health coverage [21,22]. Gines González García, former Argentinean Minister of Health, said "reforms are made every day". This means we should be better prepared for the tasks we have been assigned with, assuming our responsibilities and committing to enhancing the health system, which must be patient centred. As González García also proposed: "we ought to focus in a person centred health system".

Finally, a number of measures which could be used to mitigate the impact of economic crises and unequal distribution of wealth have on the population's health are listed as follows:

1. Increased investment in public health. Application of a "health in all policies" programme and development of a universal health coverage scheme [25] based on transitional and continuous care strategies.
2. Integration of public and social security's healthcare and social services in a single structure.
3. Population nominalisation and georeferencing. Development of a unique, electronic, clinical history.
4. A professional healthcare network focused on the rapid diagnosis and treatment of high risk pathologies, which have a direct impact on the patients' vital capacity or negative externalities in the health system.
5. Local healthcare systems development, thoroughly associated, which allow an improved access to quality healthcare and medication.
6. Long stay institutions construction.
7. Perinatal care network creation, in order to reduce preventable new-born deaths.
8. Child malnutrition early detection, and appropriate child nutrition programmes application.
9. Obstetric care network creation. High risk pregnancy early detection and reduction of teenage pregnancy.
10. Immunisation and vaccination programmes, focused on the elder, paediatric patients, and pregnant women.
11. Clinical management programmes for non-communicable chronic diseases, designed specifically. Follow-up of diabetic patients with glomerular filtration rate.
12. Healthy habits promotion, focused on drug addiction prevention and treatment, smoking cessation and alcoholism.
13. HIV infection and other sexually transmitted diseases prevention.
14. Screening and early detection of cervical, uterus, breast, prostate, lung and colon cancers.
15. Diagnosis and treatment of psychopathology, especially depression caused by unemployment.
16. Gender, domestic and child violence programmes to detect its causes and prevent its consequences.
17. Industrial health, safety and ergonomic programmes.
18. High cost medication provision for rheumatic and oncologic diseases.
19. Quaternary prevention programmes for unnecessary medical practises.
20. Ophthalmologic [23] and dental [24] health improvement.

Conclusion

The state should be responsible for planning, regulating and acting needed in order to diminish health inequalities. This goal can be achieved by a mixed financial system (public-private), increased healthcare access, structured healthcare networks, excellent organisation's management, evidence based medicine, quality essential healthcare, and the professionals' commitment to education, promotion and prevention. At present, there are privileges, social and legal pressures, and no policy prioritisation. Therefore, we are not directing our efforts towards those actions which increase health equity, and most importantly, reduce preventable deaths.

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