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Ethics and public health in times of crisis

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Ethics and public health in times of crisis

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INTRODUCTION

Five years after the crisis began, it seems that what we are facing is not so much the downturn in an economic cycle but rather a deeper and more dramatic social transformation, an unprecedented situation that will require us to adapt if we hope to survive it with dignity.

The development of the welfare state, which in Spain started much later than in most other western European countries, has come to a standstill, and it remains to be seen whether this actually heralds the start of the reversal of the expansionist trend of recent decades. The recession has led to a significant increase in income inequality, as measured by the Gini coefficient, which rose from 0.312 in 2006 to 0.340 in 2011, well above the average figure of 0.307 for the 27 states of the European Union as a whole. In Catalonia, the Gini coefficient has risen from 0.280 to 0.330, in large part due to the dramatic increase in unemployment, which affects a quarter of the active population, with youth unemployment rates of 55 per cent. As a result, 28 per cent of the population — and 32 per cent of children — are at high risk of social exclusion as a consequence of poverty.

This situation, which was initially mitigated by benefits and pensions (and also by the black economy, albeit with dire consequences for government finances) is made worse by the fact that in Spain around 2.3 million people have been unemployed for two years or more and no longer receive unemployment benefits, leaving over 700,000 Spanish homes with no income whatsoever.

These consequences are so dramatic that the indignation displayed by some sectors of society is more than justified. And the situation, at least at the micro-economic level, would appear to be worsening rather than improving, due to the policy of cutting public spending imposed by the European Union *troika*. However, the Keynesian public investment modeled on Roosevelt's New Deal for which some call would appear to be beyond the powers of our government, which has to find around 100 million euros every day simply to service the interest on its debt.

The result has been a reduction in public expenditure, including social programmes, due primarily to a shortage of economic resources. Although this policy is generally referred to by the term ‘austerity’ (which literally means doing away with superfluous spending) we believe it is more accurate to talk of cuts. This is not simply a question of rhetoric, as it can be argued that speculation and consumerism are among the causes of the economic crisis and that addressing these may indeed require ‘austerity’ in the strict sense of living more simply and doing without the superfluous as part of the process of establishing rational priorities in order to protect essential services.

It is thus extremely important to identify those populations that are most vulnerable to health problems, a vulnerability that is highly sensitive to public policy decisions, as can be seen from the divergent impact of recent economic crises in different countries. One example comes from a comparison of Russia and Finland, both of which experienced dramatic rises in unemployment in the 1990s. In the first case, this led to a significant fall in life expectancy, while in the latter it was actually associated with improvements in populational health. Another example is the reduction in mortality due to cardiovascular disease and diabetes experienced by the Cuban population during the ‘special period’, during which the average adult weight fell by 5kg due to food shortages and the lack of fuel for transport, leading to more journeys being completed on foot or by bicycle. It is therefore important to consider the relative impact not only of health policies but also of education, housing and social services. This is why we need to combine a public health perspective, with its focus on the impact of economic events on health and life expectancy, with an ethical perspective. Combining these two approaches was the topic of the first session of the day.

It is important to distinguish between short-term consequences, which are much more obvious, and consequences that may appear over the medium or long term. Indeed, it may be that we are not capable of detecting some of the most immediate reactions due to the limitations of surveillance and monitoring systems. One surprise finding of health surveys in Spain is an improvement in people’s perception of their own health, something that probably reflects a lowering of expectations. However, the risk of suffering from mental health problems is higher among those who have lost their jobs, and increases the longer people remain out of work. There has been a massive increase in the consumption of psychotropic drugs (both tranquilizers and anti-depressants) as recorded by health surveys and pharmacy sales alike. Material deprivation is compounded by dejection, uncertainty and even desperation: feelings that, at least in principle, do not have any pathological cause. While medical treatment may help to alleviate such problems, it is rarely possible to resolve them without addressing the causes, which in this case are clearly social and political in nature. However, it is also important to note that, because states of mind are influenced by expectations, pessimism may in itself lead to a subjective deterioration of the situation. It is therefore particularly important that we are very careful when evaluating some of the worst potential effects on mental health, such as suicide, as there is a danger that if we overstate the threat we may stimulate fear and inadvertently cause the very problem we seek to prevent. This was the focus of the second discussion session.

Finally, it is important to analyse the behaviour of health professionals and citizens when using public health services, as the inappropriate use of health services accounts for a significant proportion of the consumption of such services. Before the crisis we were already critical of the negative consequences of such misuse in terms of the basic ethical principles of justice (due to the impact on the fairness and efficiency with which health resources were used), non-maleficence (due to the frequency of health interventions offering little or no benefit but carrying the risk of harm arising from the medical treatment itself), and autonomy (by generating unrealistic expectations that make patients dependent on the health system). Now, several years into the crisis, the threat is even more acute.

Moreover, in so far as the crisis has caused an increase in social and economic inequality, it has also led to an increase in unjust health inequalities as a result of social factors. The current situation poses a particular threat to the most vulnerable populations, despite the fact that these are the very people who have least responsibility for causing it in the first place. This is why it is both right and necessary that public policy should seek to correct this situation.

That part of the population that suffers most from the economic crisis is also very likely to be the section that suffers the greatest impact on its health, unless beneficial effects such as those observed in Finland are produced, attributable in part to social welfare policies. We therefore need to measure both short- and long-term effects, so that policy can be based on more than guesswork and assumptions, while at the same time recognizing that the impact of the crisis on public health over the coming years is inherently unpredictable. Although it is impossible to make long-term predictions, the data that we already have, the experience of similar situations in the past, and general information about the influence of poverty, socioeconomic inequality and the gradual decline of social services on population health all show that we cannot afford to do nothing. Such a failure to act would, in effect, be to further amplify the impact of the crisis on people's health.

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METHODOLOGY

This monograph contains the proceedings of the workshop hosted by the Víctor Grífols i Lucas Foundation, in Barcelona, on 18 December 2013. The event was attended by specialists in the fields of ethics and public health, and the programme consisted of three sections, each providing a different perspective on the intersection between the economic crisis, ethics and public health. Each section was structured around a pair of presentations, designed to provide information, analysis and a starting point for the discussion session that followed.

The sections were: "Populations that are particularly vulnerable to the crisis," "The impact of the crisis on mental health. The case of suicide: Myth or reality?" and "For the morally correct use of public health services in times of crisis: the role of health professionals and the role of health service users."

Before the workshop, each of the speakers submitted a short document setting out the key points of their presentation. This text was then sent out to participants so that they would have the opportunity to prepare for the workshop by thinking about the issues under consideration.

Following the event, each of the speakers wrote a paper including their own thoughts on the discussion topic and incorporating contributions and observations from the group debate. The specialists who took part were also invited to write up their own ideas and conclusions from the day's proceedings. Both sets of documents are included in this publication.

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Populations that are particularly vulnerable to the crisis

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Introduction

The current economic crisis and the political response to it have been so long-lasting and dramatic that the social fabric itself is under threat, with the impact being most clearly felt by the most vulnerable members of society. The political response to the economic crisis in Spain has included cuts to education, health and benefits, affecting some of the key determinants of populational health. As the preamble to Spain's Public Health Act[1] states, "The provision of care is not the principal determinant of our level of health, which is something that is gained or lost in other arenas: both prior to birth and throughout the course of our lives we are exposed to a range of factors and we have positive and negative experiences that influence our health. The family setting, education, material goods, social and economic inequalities, access to work and the nature of this work, the design of urban environments, the quality of the air we breathe, the water we drink, the food we eat, the animals with whom we live, the physical exercise we perform, the social and environmental setting: all of these influence our health." The crisis and the political response to it involve almost all of the social factors listed above, and inflict more harm on those who were already vulnerable or whose circumstances have worsened as a result of the crisis.

In seeking to identify the most effective preventive interventions in vulnerable populations, we need to consider three perspectives on public health initiatives. Firstly, there is the perspective that focuses on the social determinants of health mentioned above, a perspective that stresses the role of all government policies in moulding the health of the population. This approach requires that health be included in the agenda of every government department in order to maximize positive populational health outcomes or, at least, to minimize harm without undermining the overarching policy objectives. Under current Spanish health legislation, those with responsibility for public health have the competency for promoting health across government policy by creating healthy environments and blocking policies that pose a threat to health. This is achieved through health impact assessments, a tool designed to evaluate the health gains and losses arising both from health policies and from policies in other spheres.

Secondly, there are specific public health provisions designed to monitor the health of the population and the factors that influence it, responding to threats to health and to health crises, taking measures to protect and promote health, and to prevent disease and injury. Traditionally, public health has received only limited resources, although this is no reason not to adapt what resources it has to difficult situations such as the one in which we currently find ourselves.

Finally, health services have the capacity to take some actions that go beyond the traditional tasks of curing, caring and rehabilitation. Health care can at least soften some of the most damaging effects of the crisis. There have long been calls for community health to play a more prominent role in primary care services, an approach that would help to provide a better response to social needs in times of crisis.

This brings us to the central question: do we forecast a significant negative impact on health as a result of the crisis such as would justify extraordinary preventive action? Although the answer might seem obvious[2], it is worth taking a moment to define the question more carefully. There has been a debate on the effects of the crisis so far on various European populations, with a particular focus on Greece[3–16]. The debate, primarily of an academic nature, has focused on effects that can be detected in the short term and that could be attributable to the economic crisis, such as suicide. Other studies have expanded the range of indicators, incorporating some specific and general mortality rates to track the impact of the crisis, although the years analysed so far do not allow any firm conclusions to be reached[17]. To draw relevant conclusions from this research, and other research looking at previous crises, we would need to conduct an exhaustive analysis, considering the general conceptual and contextual framework, and also considering the quality of the methodology used in each individual study.

I am not seeking to sidestep a discussion of the effects of the crisis on health, a debate that I believe is essential, and nor am I seeking to evade the question, but the complexity of this analysis surpasses what can be addressed here. For example, there are crises that, depending on the context and the policies applied, can have a positive impact on some health indicators, as occurred in Cuba with the reduction in the availability of food and motorized transport in the 1990s, which actually had a beneficial effect on health in comparison to the events in the Russian Federation at the same time[18], differences that motivated comparative analysis to identify the explanation[19]. In South Korea there was an increase in general mortality and morbidity — including occupational illnesses — and it was found that there was a need for a more in-depth study of the relationship between economic crisis and health over time[20–22]. In the countries of the former Soviet bloc, the impact of economic disintegration and mass privatization affected health differently depending on the level of social capital, the breakdown of institutions and the availability of social support networks, with the fall in life expectancy in Russia being particularly noticeable[19,23–27]. There are also local cases in which a fairly clear link has been established between the nature of the response to the economic crisis and the consequences in terms of tuberculosis epidemics, HIV infection and homicides[28]. As has been noted, political decisions can amplify the impact of the economic crisis and reduce social protection, thereby having a pronounced effect on population health[4]. We would therefore be interested in an in-depth study that sought to establish how the lessons of similar situations could be applied to the current, long-lasting crisis in Spain.

Dávila Quintana and González López-Valcárcel conducted a review that, while far from exhaustive, at least provides a basis for a tentative answer to this question[29]. There is no doubt that children, the elderly and some impoverished populations are particularly vulnerable, nor that the rapid fall in family incomes and resultant impoverishment, if a certain critical threshold is exceeded, begin to affect people's health. These effects, as models of lifetime health explain, bring irreversible effects that may be transmitted to future generations[30,31]. Some effects on children's health can already be detected in Spain[32]. If we accept a model of health as socially determined, we can already predict that the crisis will have permanent effects whose expression in the form of health problems will only be detected over the longer term and which will not be easy to link to the policies that are currently causing the impoverishment and loss of rights of vulnerable populations. I refer, for example, to the way that obstacles have been introduced to hinder access to the Spanish health system and other benefits and health provisions. The seriousness of the situation, as described in the FOESSA reports on inequality and social rights and the Cáritas report on impoverishment and social inequality, has led to warnings that, "we have seen record levels of unemployment and big increases in inequality, while the processes of impoverishment and economic insecurity in Spanish households have reached a point from which it will be difficult to recover. The mechanisms that underpin society have been weakened, and policies of austerity have increased the vulnerability of Spanish society."[33,34] The reduction of the social safety net will perpetuate marginalization and will undoubtedly have an impact on the health of the population. Furthermore, the level of suffering and anxiety already experienced by broad sectors of society is ethically unacceptable given the wealth available.

If we accept, then, that the crisis will have a harmful impact on the health of the population and that we must consider preventive actions to counteract or minimize this impact, let us consider from a public health perspective which interventions could be effective in the areas we have identified.

Preventive interventions in vulnerable populations

Public health surveillance

One question that has not aroused much attention but which goes to the very core of public health policy is the problem of the lack of information that would make it possible to monitor health-related events, evaluate them and recommend suitable interventions based on the scale of the events, and provide a basis for ensuring that interventions delivered the maximum impact on the health of the population. The problem is not a lack of public health surveillance capacity *per se*, but rather the mismatch between the scale of specific population health problems and the resources that the authorities allocate to monitoring each of these issues. This paradox can be clearly seen if we compare the resources and attention allocated by the authorities to the swine flu crisis of 2009 with the current silence about the enormous threat of the crisis to the health of the population. If numerous health administration activities were put on hold while the health policy and health surveillance agenda focused on the threat of swine flu, something that was arguably justified by uncertainty as to the scale of the problem during the first phase, then we should not accept the current indifference of the health authorities to the impact of the crisis on health.

Public health mechanisms are characterized by inertia and rigidity, capable of detecting the slightest problem caused by an infectious disease, for example, but incapable of showing any interest in monitoring the effects of the crisis on health or on the social determinants of health. Spain's Public Health Act, in article 12 on public health surveillance, provides for the monitoring of the social determinants and inequalities that affect health through measurement at both the individual and populational level[1]. This, like the majority of the provisions of this legislation, has been ignored by the authorities. As a result, the first thing that needs to be said with regard to preventive interventions aimed at vulnerable groups during the crisis relates to the question of adequate information and of the provision of health services that recognize and address problems of this sort. In 2008, inequalities had not been reduced despite years of economic growth, and the questions we are now asking about the need to intervene to protect vulnerable people were already relevant before the crisis began: in Spain, poverty is a long-standing problem. The Spanish Department of Health (which at the time was called the Department of Health and Social Policy) itself promoted the monitoring of the social determinants of health in the European Union during Spain's presidency of that organization, and had succeeded in obtaining the support of the Council of the European Union, in June 2010, for this monitoring and for health equity to be included in the European political agenda[35,36]. It is depressing to note the effort wasted simply because there has been a change of government, without the reasons for this waste even being discussed. And it is also depressing to contrast the urgency with which the European Commission implements measures that reduce the rights of citizens with its amnesia with regard to its own recommendations where these would bring social and economic benefits.

The health authorities should use all the information and data available to diagnose the current situation as accurately as possible, identifying those determinants of health that pose the greatest threat to public health and to the most vulnerable groups in society. At the same time, we need to establish monitoring systems that are stable over time and allow us to evaluate the development of the different determinants of health during the crisis and their effects in terms of morbidity, mortality and other indicators that reflect the populational health of the country. To do this, we need to build on the work of social policy departments and social organizations, establishing synergies to maximize their efficiency. This monitoring of the determinants of health and their impact on health should also include regular reports on the situation, and the evaluation of the impact on health of different policy initiatives. Much work has been done on the identification of combined indexes and indicators that reflect social health, bringing together sensitive health indicators with indicators of the social determinants of health with a predictive capacity that could be applied to situations such as the current one[35,37].

In addition to the actions taken by the authorities and civil society, such as scientific and professional associations in the health sector, we need to ensure that the impact of the crisis on health and proposed responses to it are included in the media and political agenda. That this is no simple task is demonstrated by the fact that some high-quality initiatives have not yet had the desired impact, but we already know that persistence is vital to public health advocacy[38,39].

Non-health interventions

Responsibility for the wide range of non-health policies that influence health lies with the departments that initiate these policies. However, the health authorities still need to help shape these policies so that they contribute to the basic goal of maximizing health outcomes. It is the job of the health authorities to identify the foreseeable effects of different policies and to suggest alternatives that would have a more positive impact on health (or at least a less negative one). The health authorities should conduct health impact assessments to evaluate proposed legislation, identifying as accurately as possible the likely impact on health. Health impact evaluation can also help quantify the negative effect of political inaction. It is beyond the scope of this text to review every individual policy that affects the health of vulnerable groups, and I will therefore only list the ones that I consider to be of particular importance.

Social policies, including those in the area of employment and education, which are key determinants of population health, are essential during economic crises. Education contributes to better health in a variety of ways[40]. As a result, during times of crisis it is more important than ever to dedicate maximum effort to increasing human capital, both by improving the quality of general education and through training for young unemployed people. This means constructing education policies around the principle of fairness, identifying those who are most vulnerable, and increasing investment where it is most needed. In the current situation, we need to identify extreme situations in which the family setting has been compromised, giving rise to a variety of threats to health, such as insufficient or poor quality nutrition, which not only increase the risk of disease but also undermine educational performance. The authorities must be capable of a swift, flexible response if we are to prevent effects from being cumulative or irreversible. For example, there have been some very positive initiatives to make up nutritional shortfalls by providing food in schools.

With regard to social policies, the minimum we can expect in a situation such as the present one is that every decision (or failure to act) should be accompanied by an explanation of the desired outcome, the predicted effect in social and economic terms, and the impact on fairness and on the most vulnerable members of society. For example, with the reform of Spanish legislation regarding personal autonomy and care for people in a situation of dependency, the State ceased to fund the contributions of non-professional carers to the social security system, as a result of which between June 2012 and June 2013 around 160,00 people were removed from the social security system and saw their benefits being cut. Ideally, there should be an explanation not only of the purpose of these changes (in theory, the reduction of the budget deficit) and of the actual net impact on the public deficit, but also of the social impact and, in particular, the impact on vulnerable groups. It is possible that the desired economic effects may not be achieved, while at the same time vulnerable people are penalized and the burden of implementing social policy falls upon carers.

There are other long-awaited policies that have a major impact on population health, such as policies to reduce environmental pollution, which combine initiatives to reduce emissions with those aimed at promoting physical mobility. Pollution in our cities causes serious health problems, and once again it is those at the bottom who are most affected. There is enough information on which to base action, and the potential benefits have been quantified in some detail[41]. The reduction in vehicle traffic as a result of the crisis may already be having a positive effect, but it is not enough: the current level of pollution in our cities causes illness on a daily basis and places unacceptable demands on our healthcare system. It makes no sense to continue with a transport model that is unsustainable from every point of view, one more reason to adopt decisive measures in this area.

Preventive interventions by the public health services

In addition to the public health surveillance described above, something that is the responsibility of the public health services, a number of other actions should also be considered. The use of legal instruments to protect the health of the population is an option that should not be ignored, so long as it is certain that the impact on equity will be a positive one. In the current situation, more use could be made of new regulations to protect health by reducing the exposure to health risks, while innovative strategies to use legal instruments to promote health could be explored. With regard to the former, Spain has made considerable progress in the last decade with regard to protection against passive exposure to cigarette smoke and other anti-smoking laws, but there is still plenty of potential for further public health legislation. In addition to smoking, where there is still room for more legislation, several other areas should be considered. Here, I will discuss nutrition and chemical contamination.

Nutrition policies should address the threat posed to public health by foods and drinks of poor nutritional quality and the resultant healthcare costs, in addition to other negative externalities. Actions that ought to be considered include regulating demand by taxing some items, subsidizing healthy foods and offering incentives to the poor. Although the scientific debate about the impact of such measures is ongoing, all the evidence would appear to indicate that this kind of regulation can have a positive impact on health and may even lead to greater equality[42–47]. We must recognize that such policies are complicated, and that their application has to be studied with great care, but it is precisely in situations such as the current one that there is the greatest need to devote our full intellectual capacity to a detailed, exhaustive analysis of the options. Public bodies tend to shield their own inaction behind the hope that a decision will be taken by a higher authority — whether at national or European level — although in this area healthy competition would be better. This was clearly illustrated by the delays in the introduction of anti-smoking legislation in Spain.

Another significant public health issue is chemical contamination. This is one of the principal causes of the increase in cancer, infertility, congenital diseases and many other health problems. Although the relationship is not linear and varies depending on the contaminant in question, the risk of exposure to toxic substances increases as we descend the social scale[48,49]. There has been progress in European regulatory policy, but the situation is far from ideal because the power of the chemical industries lobby continues to place obstacles in the path of public health. Not long ago, it transpired that 17 of the 18 editors of toxicology journals who wrote an editorial designed to persuade the European Commission not to adopt the precautionary principle with regard to certain contaminants — the so-called endocrine disruptors[50] — had worked with the chemical, cosmetic, tobacco, pesticide or biotechnology industries, both in an advisory capacity and through the receipt of funding. This fact indicates the degree to which science in Europe has become subordinated to the interests of large corporations, neglecting the interests of society as a whole[51]. Although this editorial has been rejected by numerous researchers not affected by conflicts of interest, and there is sufficient scientific evidence of the negative effects on health of endocrine disruptors, doubts remain as to the final decision the European Commission will reach[52,53]. Given this situation, it might seem wise to opt for preventive policies at the national level. It would be possible to introduce legislation to prevent exposure of the most vulnerable groups (workers who are pregnant or breastfeeding) to toxic substances such as endocrine disruptors by preventing their use in children's food packaging and eliminating their use in public contracts. Such measures should be accompanied by campaigns to inform the general public about toxic chemicals, taking into account the issue of equity, due to the greater risk posed to disadvantaged groups, and including specific interventions to reach those in settings such as casual employment.

Innovative strategies could be used to employ legal instruments in the defence of vulnerable groups, both to ensure that they achieve all of the support or benefits to which they are entitled (but which they do not necessarily receive, as a result of social exclusion) and to use legal advocacy to push for a healthier environment. While interventions to facilitate access to financial benefits or other support are reasonably common in Spain and clearly need to be strengthened in times of crisis, the use of legal advocacy to promote health is less common. It is not discussed in the scientific media, and in Spain it has generally been associated with the struggle for environmental conservation. In the United States, however, there is already extensive experience of legal advocacy, lobbying campaigns and other strategies to enforce the laws designed to create an atmosphere that reduces the risk of asthma[54]. This is relatively unexplored territory and although the effects would not be immediate, now would be a good time to consider it. There is, however, an underlying difficulty and this is the fact that the authorities are unable to promote such actions, as they could well be the targets of them: there is a need, therefore, for the development of a space in the heart of civic, professional or scientific organizations.

Finally, in the legal field it needs to be stressed that it is essential that the authorities implement the existing legislation. Spain's Public Health Act and public health laws in the regions of Andalucía, Extremadura and Valencia include provisions for the authorities to take specific actions to support population groups vulnerable to health risks, and to prioritize them in their interventions. Article 3 of the Public Health Act states that, "Policies, plans and programmes that have an impact on the health of the population shall promote a reduction in social health inequalities and will incorporate actions regarding their social determinants, including specific objectives in this regard. Equity will be considered in all public reports that have a significant impact on the health of the population. Likewise, actions with respect to public health shall incorporate a gender perspective and will pay specific regard to the needs of people with disabilities."[1] One need look no further than Royal Decree 16/2012, of 20 April, setting out urgent measures to guarantee the sustainability of the National Health System and to improve the quality and safety of services[55], which modifies the conditions of access to healthcare and excludes undocumented immigrants, to find a law that violates these principles.

The Department of Health has not applied the principle of equity, as established by the law, in almost any of its initiatives. In a situation of crisis, with hundreds of thousands of people suffering from poverty or social exclusion, it is imperative that laws that provide for special attention to be paid to the most disadvantaged be observed. If the principle of equity were applied as the law requires, this would in itself offer significant protection to the most vulnerable groups. The reduction of social inequality is applicable to all areas of health policy: however, the reality is that it is rarely applied either in the field of public health or in that of health care. There are sufficient ideas and proposals to enable us to apply the social determinants model of health to public health practice (as is shown by the example of the recent Public Health reports supplement on this issue[56]) which at times such as these should guide the public health authorities at the regional and national level. To start with, much of the Royal Decree cited above should be repealed so that we return to universal provision. The gradual exclusion of specific groups from healthcare provision is one of the government's most iniquitous actions, and to make it even worse this has gone so far as to apply to health intervention in situations where public health is at risk (or at least this appears to be the case, although the lack of transparency in the Department of Health makes it hard to know for sure). This means imposing health care on "others" in order to prevent a threat to those covered by the National Health System, with risk being defined primarily in terms of infectious disease but also including some mental illnesses. In other words, Royal Decree 16/2012 excludes some people from health care but provides for their compulsory treatment (applying Act 3/1986, of 14 April, on special measures in the area of public health) in those situations that could threaten the health of those who are covered by the system. To summarize: people who do not have health insurance (mainly undocumented immigrants) will only receive treatment in the event of contagious disease or mental illness, and this treatment may be applied against their wishes.

Interventions in the health services

Some recommendations on health and the healthcare services are provided in documents that have already been cited[38,39]. One recommendation for which there is broad support is to reduce the employment of useless or harmful health technologies and interventions, and to replace investment in such technologies with other more efficient approaches, or simply to cease such investment in order to ensure the sustainability of the public health system. In this regard, there is room for action to improve the health of vulnerable people. We know that there are low-tech health interventions that have been developed by practitioners (health professionals, community agents, physiotherapists etc.) that are much more efficient than pharmacological or surgical interventions and can easily be applied to small numbers of patients[57]. These interventions not only deliver more benefits in terms of health per cost unit but also help to maintain and increase employment in the health and social care sector, unlike the socially and economically less efficient technologies and products they could replace, for which we are heavily dependent on external suppliers. We need, then, to replace technology with people and to explore interventions aimed at vulnerable groups in which the opportunity cost is even greater (for example, the prevention of injury in poor, elderly people) and to focus on community health actions that address problems that may otherwise lead to medicalization, such as depression in the long-term unemployed. There are interventions that have achieved promising results by applying a community-based approach[58]. We can agree that the health system is too rigid in its biomedical focus, offering little space for other kinds of provision, despite the fact that many of these may have better health outcomes by avoiding the unnecessary medicalization of problems that are very frequent among vulnerable populations. This requires courage on the part of decision-makers to act in new ways, characterized by rigour rather than rigidity. And it requires academics and health professionals to seek the right answers, modifying a health research agenda that has been biased towards interventions that deliver industrial benefits[57] so that it includes the evaluation of interventions that do not generate profit for those who have designed them.

Finally, we need to stress that the daily work of health professionals should not be conducted on the basis of disregard for the law. All health actions should be characterized by a commitment to equity, and this means that in the doctor's office, in nursing care and in any other professional setting care must be focused where it is most needed and procedures established to ensure that this happens. There are plenty of recommendations available in this regard that can easily be adapted to the local context[59].

Conclusions

While we await a more thorough analysis of the effects of the political and economic crisis on the health of the population, it is vital that we take measures designed to prevent or mitigate such effects. The information we already have about the social effect of the crisis provides grounds for implementing actions, because we know that the damage to social health, of itself serious enough to merit a decisive intervention, also affects health and is having a permanent impact on the lifelong health of those affected. The knowledge available with regard to the social determinants of health provides some guidance as to which policies could be most effective, by identifying those determinants with the greatest impact on health and those that have been most severely affected by the crisis. In addition to focusing on the determinants, we also need to consider the feasibility of different measures and the factors that underpin their viability. There is a wide range of interventions available outside of the health framework, in the sphere of public health and social care services. The priority is to ensure that an understanding of the effects on the health of the population of our response to the crisis is pushed to the top of the public agenda. The current situation is a challenge to public health professionals, and their role is to evaluate the impact of the crisis on health and to monitor it over time, vigorously recommending the proposals that, in the light of current knowledge and social and economic opportunities, they believe to be most urgently required.

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Begoña Román Maestre

Introduction

I have divided this paper into three sections. In the first section, I will discuss vulnerable populations (those that are at risk of social exclusion or who are already excluded), why they are excluded, and how they arise. In the second section I will consider some of the new poor of the twenty-first century, people whom we may not think of as belonging to vulnerable groups (and who, indeed, may not consider themselves in these terms either). In the third section, I will propose some preventive interventions that could be taken by different agents.

Three key factors to combat risk and social exclusion

Three fundamental factors to prevent exclusion and to evaluate interventions are: the creation of stability, the creation of capacities, and the creation of stable, meaningful relationships.

Both individually and collectively, as rational, dependent, spiritual, mortal beings, we can lose our balance and lose our health (in the widest sense); we can lose our harmony and our ability to function; we can lose our stability. As ordinary beings, we need a degree of order that usually takes the form of habits (and this can be both a virtue and a vice). When the order of everyday life disintegrates, the individual becomes disoriented, and the first thing that has to be done before balance can be regained is to provide a degree of stability. If this loss of order is due to material causes, then our first concern must be to guarantee the provision of these material needs. This is particularly pressing when the intervention of the social services must meet basic needs for housing and food.

However, there is also a very real danger that such support, rather than promoting empowerment and autonomy, will simply generate greater dependency if we do not address the social causes that gave rise to the destabilization. The current crisis has indeed led to an increase in such assistance-induced dependency. While this may be an inevitable consequence of addressing people's basic needs, if we do not also question the status quo and address the causes of injustice (which deprives people of their fundamental rights) then it is all too easy for solidarity to shade into charity or ostentatious 'generosity', reducing it to just one more luxury consumer item for the wealthy. And when this happens, instead of fighting injustice, our actions may end up unwittingly fuelling the humiliation and resentment of the poor, generating social tension and division and, as a result, causing greater instability for all.

Moreover, we do not live by bread alone. We are social beings; in addition to our basic needs for food and shelter, we need to have plans and expectations for the future. However, many of the socially excluded are treated as "patients", and fall into a passive role in which they see themselves as victims, and in which the only dates in their diaries are with the "care" professionals who deal with them. If stabilization is not to generate chronic dependency, we need empowerment; we need, according to Nussbaum[1], to create capacities.

But creating capacities can also give rise to injustice. The lack of self-esteem, of hope, of creativity, of the resources — not just economic but also moral and social — with which to reinvent oneself constitutes the second risk of exclusion when one is deprived of access to work. The world of work is a world of relationships based on inclusion and recognition. Today's knowledge society converts the proletariat into a *cognitariat*, and this knowledge can only be acquired as a result of lifelong learning[2]. However, the acquisition of knowledge, the development of skills, gaining access to and remaining within the employment market are also the result of a social and biological lottery. While we are often told that we can do anything if we really want to, the reality is that before we get to the stage of wanting to do something we must first know what it is and what it involves.

This means having access to knowledge, which is precisely what vulnerable individuals and groups lack. Educational failure primarily affects the socially disadvantaged and those from unstructured family backgrounds. The same is true of unemployment, to which must be added the disappearance of skilled trades and the increasingly precarious nature of the jobs to which the poor can "reasonably" aspire in a world where the challenge is not simply to obtain a job but also for that job to be stable and not to be marked by the abuse of power and the control over knowledge that underpin the continuing supply of cheap labour in the service industries.

The worlds of school, of training and of work play a key role in relationships of recognition. The third risk of falling into social exclusion concerns the rupture or absence of such links, of emotions, of networks of family relationships, of contacts. Among those who receive support from the social services, their relationships with the outside world are often characterized by submission, victimhood or exploitation. Poverty creates the ideal conditions for violence and immorality.

If one of these three elements — stability, capacities and relationships — are missing, then sooner or later everything else will fail. And when all three elements are missing at once, then the excluded person is typically classified as a "social problem" or a "psychological problem". What is more, because social problems — which are always, in fact, people's problems — are tackled on a compartmentalized basis, whether social, mental, financial, clinical, educational or legal, the individual is transformed into a problem or "case" before embarking upon an odyssey through the different services, all of whom try to get rid of him or her because nobody really knows what is to be done. Until the problem case becomes an impossible case. Sometimes, it is even argued that the fault lies with those who are on the receiving end; that if a person or group need the support of social services then it must be because of something they have done wrong. Modern society, what Bauman terms "liquid society"[3], reacts by blaming: if he's ended up there, then there must be a reason for it, and that reason is individual; the fault is his and his alone.

In situations of crisis, the most basic of all bioethical principles — that of autonomy — is undermined by the vulnerability that such crises generate, and dignity, justice and non-maleficence take precedence over autonomy and beneficence. And the height of cynicism is to pass off this unacceptable situation as an unavoidable necessity.

To guarantee stability, capacities and relationships, we need not only to ensure certain minimum physical conditions but also certain moral conditions. And the mission of the social services is to work in both of these dimensions, committed not only to helping people meet their basic needs but also striving for the social inclusion that is essential if the individual is to become an agent. Ultimately, what people want is not charity but justice. The vulnerable are not in a position to establish contracts on conditions of equality and freedom. Their very vulnerability affects their supposedly autonomous decisions. For this reason, even Rawls[4] includes in his theory of justice, in the second principle of difference, a call to fraternity when he argues that those who increase their benefits can only do so if at the same time they reduce the disadvantages of those who are less well off. This requires an awareness of the general human condition, a sense and feeling of being a member of a human community in which everyone possesses an essential dignity.

New forms of exclusion

As our society changes, so the profiles of those who are attended by the social services must also change. This means that, if we are to deliver high-quality services that do not undermine the dignity and autonomy of their recipients, we must first understand who they are and base our programmes and our professional training on this knowledge. And we must also reject the market-based approach that argues that if somebody is not asking for help then it is because they do not need it.

Let us consider, then, these profiles of people who would not consider themselves as subjects of the social services, whom they see as providers of "charity" for the unfortunate poor. Although these people do not think of themselves as subjects of the social services, in light of the three risk factors set out above they are. They represent new forms of poverty and exclusion. The following are just a few examples: young people, those aged over 45, single-parent families and those with special needs that make them highly dependent.

Let us start by focusing on young people, a group that in Spain suffers from an unemployment rate of 50 per cent. Of course, this group contains all sorts of people. For some, life is a struggle to survive in the hostile jungle of precarious employment in which their efforts are rewarded scantily, if at all. Others, perhaps overly protected by their families, don't even bother to try, opting instead for a perennial dependency that does nothing to stimulate their initiative. For the huge majority, the model to which our society has taught them to aspire — of success, wealth and youth — is unattainable, and the lack of a coherent project, together with the postponement of any plans for independence, gradually undermines their stability.

These young people see themselves as losers, caught in a permanent present that must be filled with entertainment. And boredom — as Kierkegaard warned — is the root of all evil. They view themselves — and are viewed by adults — as having no future, because the future is seen as a tale of dependency foretold, a fateful destiny. To make matters worse, they have hardly been brought up to be stoical. Rather, these young people have grown up in a period of relative prosperity, they have been well provided for by their parents and by the welfare state, and this has not given them the moral resources to withstand whatever difficulties may come their way.

Secondly, there are those who are approaching (or have already reached) their dreaded fiftieth birthday. Rejected by the employment market because they are no longer young but are instead too expensive, it seems that nobody wants them or ever will, despite their knowledge and experience. This group is condemned to start again, to "reinvent itself", striving to face a future in which its employment prospects are worse, while remaining bound by a set of personal and financial commitments assumed when things were better. The new forms of social exclusion, in addition to those relating to "sex, race or religion", derive from age, nationality and even an excess of education and qualifications.

Another socially fragile group consists of those people, regardless of age, who struggle to maintain their family unit or to combine their family life with their work commitments.

Finally, there are dependent individuals, both elderly and otherwise, with mental or neurodegenerative illnesses, functional limitations due to disability etc. In many cases, this dependency arose in a society that trusted in the capacity of the State to support them, only for such hopes to be disappointed: the authorities did not provide the expected response, and they found themselves without the "cushion" of friends or family.

Society's decision to sustain social networks to provide protection against the inherently fragile situation of some individuals should not be based on Christian charity or on voluntary solidarity, nor should it be a courteous gesture of civilization; rather, it is a question of justice, rights and duties, of respect for dignity, and of solidarity and fraternity backed by the law. The breakneck pace of change in knowledge societies means that we must continuously review our social programmes if we wish our response to dependency to be one that promotes autonomy and empowerment.

In all of these groups, the three risk factors that lead to social exclusion and poverty tend to combine: a lack of stability as a result of circumstances beyond their control, the lack of capacities to deal with this situation and damaged daily relationships form a vicious cycle that can only be broken by achieving a more just redistribution of these risks. And this is something that must be done with them, from them, by them: not against them, about them or without them. In this situation, prepositions are not just words; they are important indicators that remind us to establish an attentive gaze (respect), with our focus on the person, and at a pace that reflects their needs.

Preventive actions: against the Matthew effect

According to the Gospel of Matthew, "Whoever has will be given more, and they will have an abundance. Whoever does not have, even what they have will be taken from them." (Matthew, 13:12). It would seem that something similar has occurred in some welfare policies. Because knowledge is power, whoever knows the system and has the capacity to make claims has more resources than the most vulnerable, who don't even know what their rights are. And if the latter have been lucky enough to encounter people willing to help remedy their situation, the result is only greater dependency. Rather than empowering people and generating capacities, the response to dependency only increases it further. Breaking this vicious cycle is one of the aims of the proposals we will discuss below.

I will list ten preventive measures involving different levels and participants (individual, professional, organizational and public policy) designed to ensure that we do not further dispossess the poor, and motivated by a desire to combat the risk of exclusion and the resultant injustice and social breakdown. Underlying all of these proposals is an attempt to reconsider the individualistic model of society that has reduced social policies to isolated actions of beneficence without any social commitment to combating the causes. This fight must always be twofold: ideological and executive; ethical and efficient; intelligent and powerfully transformative.

1. Shared responsibility for personal history

Any social, health or educational intervention must be based on hope and on the future; it should create both the strength and the desire to combat stigmatizing failures, whether these are generated by the individual (low self-esteem and self-confidence), by society or by professionals who are sometimes quick to label people. The capacity to believe in people, to help them become capable of succeeding is a fundamental element of any social or educational policy, and the health and legal systems are not exempt from this mission. However, if people are to tell their own story, then they need someone who is willing to listen, someone who is interested in their first-person narrative.

Support policies need not only the consent of those they are designed to help but also their shared responsibility. We need to think of health and social interventions not as isolated episodes in a history of vulnerability or illness but as part of a process of recognizing the life history of the individual as an ethical narrative in which the individual is a protagonist who shares responsibility for the intervention and for their life in general. In the social services, this creation of narratives, ordering thoughts, action and available resources, is already part of the "treatment". Receiving and recognizing the individual as a dignified human being and a full member of the community, somebody who can feel that they are "one of us", is a way of avoiding some of the side effects of dependency, humiliation or resentment that a paternalistic or charitable model may generate, effects that undermine its central objective of improving people's lives.

2. Creating capacities by encouraging realistic ambitions

As we have already said, the aim is not to foster the naive belief that the sky is the limit: establishing and accepting restrictions are also part of personal and institutional responsibility. Creating capacities and empowering people requires shared responsibility between individuals and the professionals and organizations that are supporting them, but both must accept their share of power and of duties. Both must believe that they can, but must also recognize their limits.

It is important not to forget that ambition is a positive value that can help people to overcome a difficult situation. Wishing to leave a place where nobody wants to be because of the suffering it entails; wanting more; wanting to be more. All of these are part of any educational and moral undertaking. Sometimes, of course, social services have to support families whose social and educational situation means that success is almost impossible. At other times, however, plans are developed to help improve a person's situation and these plans appear to be successful: the individual attends appointments with the psychologist, workshops, courses etc. but their situation does not improve, to the huge disappointment of all concerned.

Sometimes this failure and the resultant disappointment of those involved are because it is the agents who lack ambition, who lack confidence in themselves. And this lack of confidence is also seen in the rest of society, which questions the efficiency of these services (as recently, for example, the efficiency of schools has been questioned). However, it is also true that the initial social diagnosis is not always accurate: training programmes do not always reflect the reality of a changing labour market or benefit policies, and sometimes professionals fail to recognize the unique situation of the individuals with whom they are dealing.

The reality principle, for example, means that we should not ignore functional diversity, even as we strive to overcome its stigmatization. By the same token, we should not encourage people to attend workshops to learn how to become building workers while ignoring the radical changes in the construction industry over the last few years. The inertia and continuity of programmes and policies often contrasts with the rapid changes in society, in market demand, in moral values and in ways of viewing the world.

3. Avoiding chronic dependency

Some people will always require support, but long-term dependency can also be the result of negligence. When planning and evaluating programmes, it should be clear how long the intervention will last and what plans have been put in place to address possible failures. There is no such thing as zero risk: we always need a plan B, in case our efforts don’t succeed, or don’t succeed exactly as we had hoped.

For example, the fact that the great majority of minors who are brought up in care also end up failing educationally brings with it a whole set of consequences: poor self-esteem, failure to attend school, precarious employment, social exclusion. We need to accept that some people, because of their condition of dependency, will always need to be supported by the social services; but for other groups and individuals, such dependency is a sign that our interventions have failed. And this demoralizes both the recipients and the providers of such support.

4. Anticipating dependency and exclusion

As Jonas reminds us, “the prophecy of doom is made to avert its coming”[5]. Anticipating scenarios that none of us wish to see materialize can be a way of preventing them. We need to avoid a situation where those who come into contact with the social services become trapped in a system of “revolving doors”, a system that — in contrast with the one that allows politicians to pass seamlessly between the worlds of business and politics — only further heightens the misfortune of those it seeks to help.

Advance planning and establishing priorities with regard to the objectives being pursued and the resources required can help us to propose more effective interventions, generating reasonable expectations about the changes to be achieved, and helping people to accept the reality that is our starting point.

5. Links and support networks

We need to overcome an approach that is excessively individualistic, both in terms of the people who receive support and the professionals providing it. The tendency is for support work to be highly individual in nature, and while this may be necessary it is not sufficient, precisely because what we are talking about here is social work and social education, interventions that can only help people if they also recognize the circumstances and networks of support (or submission) that constitute people’s daily lives. If interventions are conducted only at the individual level, two problems arise: firstly, whenever there is a change of staff, any progress is undermined; and secondly, exclusion may be heightened because the individual’s relationship with their surroundings becomes strained.

We need to change the way we coordinate the work of professionals so that it cuts across the divisions between the different sectors of health, education, social and psychological services. Support networks are excessively sectorial, and some of their inefficiencies are the result of this compartmentalization, which leaves professionals in one sector unaware of what those in other sectors are doing. This is the case even within the social and health sphere, where social care may be provided both within the health system and at the local government level, for example. One symptom of this is seen in the handling of the issue of confidentiality, which means that none of the services ever have the whole story: each has access to a single chapter, but there is no over-arching narrative. Harm and inefficiency due to a lack of coordination are issues that need to be addressed, because they destabilize the individual and are an obstacle to the changes that professionals seek to effect.

6. The social factors that determine health

In a parallel to what occurs in the clinical setting, where patients who don't cooperate or play their part are discharged, in the social services too we frequently forget the social determinants that have contributed to their neglect for their health, their education, the absence of habits of care and self-care. The challenge is to avoid either inducing dependency or defending a radical "autonomism" that condemns people to neglect in the name of respecting their independence. As a result, the individual is classified as an "impossible case" who fails to cooperate and is abandoned because this is supposedly what he or she wishes. The voluntary discharge of patients and the penalization of service users because they have breached agreements generally results in a maleficence that derives from a failure to recognize the individual's position of vulnerability. And this problem is compounded by the effect of being bounced from pillar to post as people make their tortuous progress from one service to another.

While we must be careful to avoid paternalism, if vulnerable individuals are to achieve relational autonomy they need to be accompanied. The process of auditing and advising professionals and individuals should focus on strengthening alliances rather than enforcing contracts. For this reason, the ethic of care, the narrative ethic, the ethic of virtue remind us that attending to dependency in a way that is designed to promote autonomy must start by helping the subject to become powerful and competent, rather than leaving them to drown in the name of an autonomy that they never had due to a lack of education and information, a lack of understanding of this information, and ignorance of the likely outcome of whatever decisions are taken. Ultimately, the question we need to ask is what is the reasonable level of risk we can assume in the name of autonomy, without ignoring the question of vulnerability.

7. Subsidiarity and the voluntary sector: unfair competition with the public sector

The coordination between services cannot take place exclusively within the public sector. Sometimes, these are not sufficiently flexible to respond to the new situations that generate exclusion, and it is civil society organizations that have to fill this gap. However, the relationship between the voluntary sector and the public sector has often been characterized by competition rather than cooperation based on the responsible delegation of tasks. We need to take seriously the principle of subsidiarity. The crisis of the welfare state does not necessarily mean that the State should cease to do everything it has done until now and submit to the forces of the market. There are certain situations where the profit motive may be in conflict with social considerations such as, for example, the differences between how we approach the distribution of profits among shareholders and the distribution of benefits to service users.

Clarifying the role of each of the agents involved, so that responsibilities are assumed by those best placed to do so, cannot be left at the mercy of the ideology of whichever party happens to be in power. Programmes aimed at vulnerable populations should also encompass market dynamics, resisting the temptation (so common among politicians) to perpetually reinvent the wheel.

8. Public and private employment, lending and audit policies

Access to the job market and to credit are two key factors in the creation of capacities. However, in both of these areas vulnerable populations are at risk; they are excluded from the job market or only have access to the most precarious of employment, while at the same time they are exposed to lending that grants them full autonomy and considers them fully capable of managing the risks involved. Vulnerable populations fall into debt precisely because of this cycle of a lack of work, availability of loans and higher levels of debt.

Policy, both public and private, and social programmes should have a stronger evidence base. The question as to how long an intervention should last and which avoidable risks should be managed is an element of good reporting and accountability regarding the impact of services, not just the actions implemented or the budgets spent.

9. Programme evaluation

The evidence for education and social inclusion exists, but it has to be considered over the medium and long term. If we are to improve our diagnosis of social situations and the identification of "toxic" services, we must create centres for social studies where it is easy to access research data without constantly being told that this information is confidential.

Recovering the capacity to trust in others among people whose stories are full of betrayal and suspicion requires services that are accessible and free of bureaucracy, because impartial justice should not be the same as impersonal justice. A compassionate justice requires virtuous professionals, and this is something that we learn as part of a community, explaining the model of care and the kind of professional we need. The selection of professionals is not just a question of technical competence: ethical commitment is vital, and this can be measured, but in a different way. One of these methods involves measuring the satisfaction of those involved, of the professionals who work with them, and of the effectiveness of their actions.

Managing quality involves agencies operating independently of public policy in education, social affairs, health and the law. But the social services have often been the poor relation of the other authorities. It is not enough to provide them with financial resources: they also need knowledge, research and evaluation as part of a commitment to continuous improvement.

10. Solidarity, fraternity, compassion and forgiveness

Finally, there is the question of what kind of society we want. Knowledge societies, in the global village, with a post-conventional capacity to manage change and create worlds, must make the shift from the individual to the collective. Forging solid links, with deep and stable roots, requires communities of belonging and causes that are greater than the individual[6] to mobilize us to common action[7,8]. And all of this requires an applied, combative ethics with a capacity to make itself heard in the corridors of power. We need a new biopolitics, not of submission but of emancipation[9].

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The impact of the crisis on mental health
The case of suicide: myth or reality?

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The impact of the economic crisis and "austerity policies" on the mental health of people and communities

Maria José Fernández Sanmamed

> *"If the major determinants of health are social, so must be the remedies."*
>
> *Michael Marmot*

Introduction

How is the current economic crisis affecting the health of populations, and which populations is it affecting most? Is it affecting mental health? And, if so, how? In the current economic crisis we have lots of economic data and information about the changes to people's living conditions, but we know very little about the impact on their health.

There is plenty of literature about the effect of economic crises on health, and there is no shortage of debate[1]: from authors who deny the impact on health[2] or even argue that when we look at the bigger picture it could have some positive effects, to those who talk of a social catastrophe with major repercussions for health[3].

The impact of economic recessions on populations is different in each economic crisis and in each country. It depends on the type of recession, its duration and intensity, the economic changes it causes and the speed with which these occur. It also depends on the political, social and economic situation prior to the crisis, social inequalities and the distribution of wealth, family and collective support mechanisms, and the measures adopted by states to protect those most affected by the recession.

It is also important to note that, as Rico and Blakey explain[4], the effect is not always immediate, and attention must be paid to the medium- and long-term effects. While the economic impact may be very rapid, the effects on health can be far slower and may only become evident after several years. Moreover, the effects may be irreversible, particularly when their impact is felt during the first years of life.

The social determinants of health

To address this issue we will use the model of the social determinants of health proposed by the World Health Organization (WHO), which argues that socioeconomic status, social inequalities, the distribution of wealth and access to basic material goods are the most important determinants of people's health, both at the group and the individual level. Exposure to stressful situations — such as unemployment, precarious employment or unstable housing conditions — is associated with increased health problems and steeper social gradients in the health of populations.

The social determinants of health play a central role in influencing how economic crises affect health[7]. An increase in inequalities and social gradients is associated with poorer health outcomes over the short, medium and long term. Numerous cohort studies conducted during the twentieth century have demonstrated the importance of the social determinants of health (what social epidemiologists would describe as "the causes of the causes") in influencing health outcomes, academic performance and social integration throughout people's lifetimes[8].

In periods of crisis, rising unemployment and job insecurity are associated with an increase in poverty, the restriction of individual and family budgets for basic living requirements, and poor health. The deterioration in housing conditions is also associated with worse health outcomes. Rising energy and food costs restrict family budgets for food and have a disproportionate impact on those with fewer resources. It is universally accepted that the impact of the crisis disproportionately affects the most vulnerable populations, such as children, dependent adults, families with fewer economic resources and individuals with lower levels of educational attainment. The long-term unemployed, immigrants (especially irregular immigrants) and groups at risk of social exclusion (those in extreme poverty and the homeless) are the most vulnerable groups.

The current economic recession began in the United States in 2007 and hit Europe in 2008. Identifying a precise date when the crisis began in Spain is not easy, but most authors locate it in the second or third quarter of 2008. According to data from Spain's National Institute for Statistics (INE), unemployment rose from 8 per cent to 10 per cent in the second quarter, and then to 13 per cent in the third, while gross domestic product (GDP) stagnated in the second quarter and fell by 0.8 per cent in the third. The fourth quarter of 2008 saw GDP contracting for the second consecutive quarter, and repossessions as a result of mortgage defaults rose exponentially[9].

In the economic crisis of the 1990s that affected the countries of eastern Europe, there was a negative impact on mortality rates and life expectancy, and health inequities rose[10,11]. However, the impact varied widely between countries. It was much higher in Russia, far lower in other countries, such as Belarus, while in Finland mortality rates actually fell. In Finland and Sweden, although unemployment rose sharply during this period, there were no changes in health[12-14]. Authors who have studied these differences attribute them, among other factors, to differences between the social capital that existed in these countries, social protection policies and the stimulation of employment by some states to reduce the impact of the crisis.

In the current recession, the cuts in social provisions — so-called austerity measures — that are being implemented in the majority of countries in Europe not only do nothing to reduce the impact of the recession but are instead becoming part of the problem, as people's living conditions deteriorate and inequalities increase.

Spain is the European country where social inequalities have risen most sharply during the crisis, with the gap between better and worse off families growing by more than 20 per cent between 2005 and 2012. The unemployment rate in the active population was 8 per cent at the end of 2007 and 26 per cent at the end of 2013, while among those aged 16 to 24 it rose from 15 per cent in 2005 to 52 per cent in 2012 (INE). The proportion of children living in homes in which all the adults were unemployed rose from 3 per cent in 2003 to 11 per cent in 2011 and 16.6 per cent in 2012[15]. The risk of poverty and social exclusion has increased since the start of the crisis (fig. 1), and 1 in 4 children live in households that are below the poverty threshold (fig. 2), with the result that children have been identified as the group at greatest risk of social exclusion when compared with the rest of the population[16,17]. A report by Cáritas[18] shows that the number of requests for help rose from 900,000 in 2007 to 1.8 million in 2010. The most frequent requests from individuals and families were for food, accommodation, help with finding employment, legal advice and psychological support.

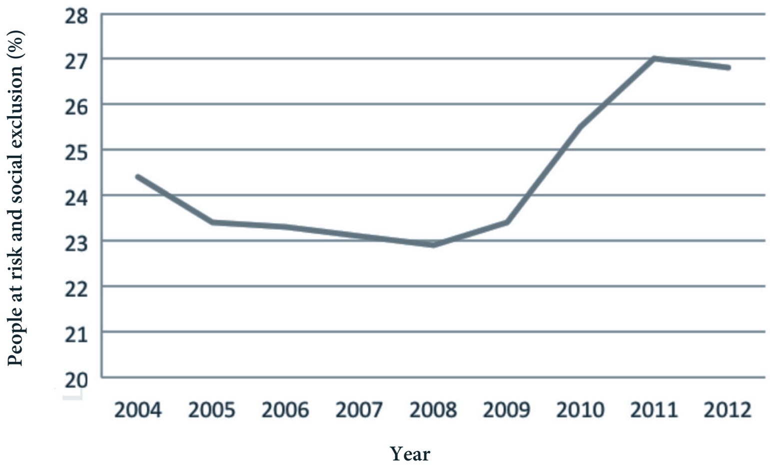

Figure 1. Percentage of people at risk of poverty and social exclusion in Spain. The population at risk of poverty is defined as people whose disposable income is 60 per cent of the median income of the reference population. Source: EUROSTAT.

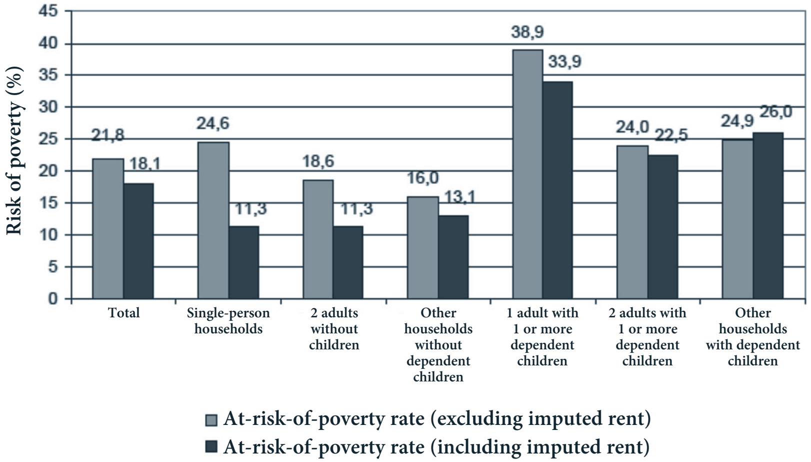

Figure 2. Rate of risk of poverty according to type of household in Spain in 2011. Source: Living conditions survey of the National Institute for Statistics (INE).

Effects of the economic recession and policy of cuts in social spending on mental health

What we know from previous crises

Despite the range of designs, diagnostic tools and indicators used, and the methodological defects of some of these studies, the literature is fairly consistent, and it is an accepted fact that mental suffering increases during economic recessions. This fact is closely linked to unemployment, job insecurity, debt and economic problems, and also housing instability[19].

According to a meta-analysis of more than 300 studies into the effects of unemployment on mental health conducted by Paul and Moser[20], the prevalence of mental disorders in the unemployed is twice that among those who work. Mental disorders are more prevalent among unemployed manual workers and the long-term unemployed, and in countries with greater inequalities.

In Spain, studies by Artazcoz, Borrell and Benach[21,22] also show that job insecurity is associated with poor mental health, with unemployed men being three times as likely to suffer from a mental disorder as those in work, and unemployed women being 1.5 times more likely.

There has also been an increase in the consumption of alcohol and other substances among the general population, an increase in diseases related to substance abuse in adolescents and young adults, and an increase in violence and homicides.

Some authors attribute the differences between countries regarding the impact of unemployment on mental health to the implementation of policies to promote employment and provide benefits, with those countries that have introduced such policies successfully reducing the impact on the mental health of their populations[23].

What information do we have about the current global crisis?

There is an abundance of studies in this area, with new publications on mental health and the crisis appearing almost daily. Again, the results tell of an increase in mental disorders that is closely linked to economic stress, unemployment and job insecurity, and financial and housing problems.

By way of illustration, we discuss three studies conducted in different countries and among different populations:

- Survey of a representative sample of the Greek population, conducted in 2008 and repeated in 2011[24]. This found that major depression increased significantly, rising from 2.4 per cent to 6.7 per cent among men and from 3.8 per cent to 9.9 per cent among women. It also found significant differences between people under high and low financial stress.

- Longitudinal study conducted in Detroit[25] of 1,547 people who completed two surveys, one in 2008 and the other in 2009. It found that foreclosure proceedings were predictive of symptoms of depression and anxiety disorder, using the data from the first survey as a control.
- Psychiatric telephone interview[26] conducted with 3,579 workers in Alberta, Canada, in January 2008 and repeated in October 2009. The prevalence of major depression rose from 5.1 per cent to 7.6 per cent, with chronic depression rising from 0.4 per cent to 1.5 per cent.

What information do we have about the current crisis in Spain?

In Spain, there have not been many studies of mental health and the economic recession. The most frequently quoted study is the one conducted by Gili[27], of the population attending primary care, which used the Primary Care Evaluation of Mental Disorders screening questionnaire for depressive symptoms (PRIME-MD, specificity, 81 per cent; sensitivity, 66 per cent), administered to 7,940 and 5,876 patients in 2006 and 2010, respectively. The study concluded that all mental disorders increased between 2006 and 2011 (fig. 3). In addition, the risk was greater in the unemployed, those struggling to keep up their mortgage payments, and people who had been evicted from their homes. Similarly, the risk of depression was greater among the unemployed (odds ratio 1.72) and in people with mortgage difficulties (odds ratio 2.12), and was almost three times greater in people who had been evicted (odds ratio 2.95).

It should be noted that the prevalences identified are very high, due to over-diagnosis that was probably the result of the measurement tools used. However, the study does have the advantage of having been repeated in 2006 and 2011 in the same population and using the same methodology, and undoubtedly describes the increase in symptoms and psychological suffering.

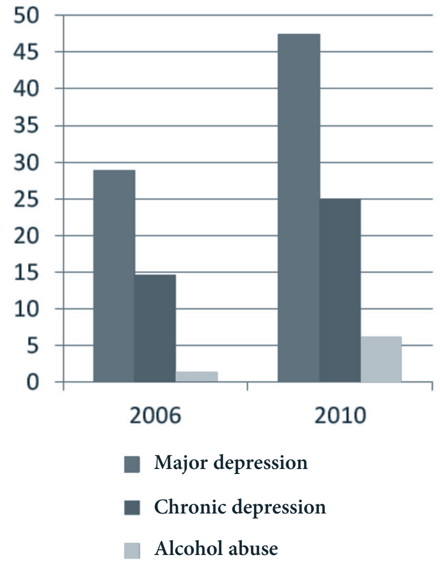

Figure 3. Prevalence of major depression, chronic depression and alcohol abuse in the population receiving primary care in 2006 and 2010[27].

The study by Bartoll et al.[28] also analyses the development in the risk of poor mental health in Spain in the population aged between 16 and 64 between 2006–2007 and 2011–2012, using the data obtained in the National Health Survey (ENSE). The data was collected using the General Health Questionnaire (GHQ-12). The results suggest an increase in the risk of poor mental health among men, while the risk was stable among women. The increase was greatest in the 35–44 and 45–54 age cohorts, in social class IV (where I is the most advantaged class and V the most disadvantaged), people with only primary or secondary school studies, and people who make the biggest contribution to the family budget, although these links are primarily attributable to employment status.

Effects of the economic recession and social spending cuts on suicide

Suicide can be seen as a proxy of poor mental health and, although it is not always attributable to a mental disorder, it is indicative of suffering and distress. Independently of whether it increases or not in times of economic crisis, each year over 3,000 people die from this cause in Spain (more than in traffic accidents) and it should therefore be considered an important public health problem.

It is also important to remember that statistics of suicide deaths do not include the many attempts that, fortunately, do not end in death, and also that there are hidden suicides and 'low-intensity' suicides, such as those relating to substance abuse, risky behaviour etc.

What we know from previous crises

The systematic reviews conducted by Falagas[29] and Milner[30] are both excellent syntheses of the knowledge obtained from previous economic recessions with regard to suicide. These studies indicate that mortality from suicide increases, and that it does so above all in men of working age.

In both reviews, unemployment — and long-term unemployment in particular — is associated with increased suicide mortality[30]. This risk is greater in the first 5 years of unemployment, but persists for 16 years after people have lost their job.

It is also known that suicide mortality in periods of crisis can be counteracted by social protection measures and employment policies. In Finland, during the 1990–1993 crisis, unemployment rose to 16.5 per cent (from 3.2 per cent) but suicides did not increase[12–14], in contrast with what occurred in Russia, where suicide mortality increased significantly[10].

A further example of this is provided by a comparison between Spain and Sweden with regard to the link between the unemployment rate and suicide rates between 1980 and 2005. While in Spain there is a clear link between unemployment and suicides, with suicide rates rising when unemployment increases, in Sweden this association was not observed[31] (fig. 4).

European Union data indicates that rising unemployment does not lead to increased suicide rates when more than 190 dollars per person per year are spent on social programmes[31]. The same hypothesis has also been explored from the opposite direction, with an association being found between increases in suicide rates and the reduction of spending on social policies[32].

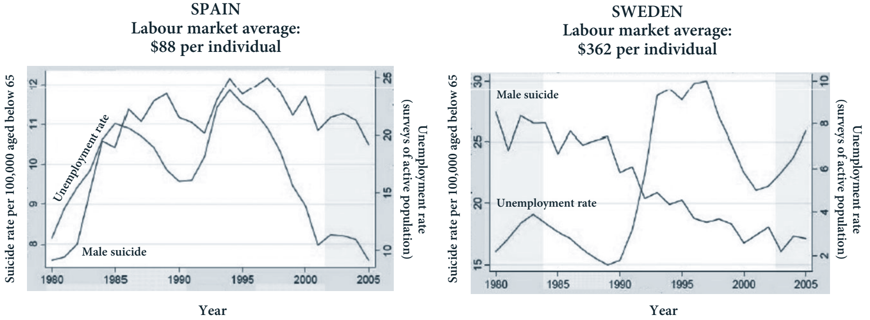

Figure 4. Unemployment and suicide rates per 100,000 men in Sweden and Spain between 1980 and 2005[31], showing the association (in Spain) or the lack of association (in Sweden) between unemployment and suicide.

What information do we have about suicide in the current global crisis?

Existing studies of mortality from suicide in the current crisis are, in general, studies of trends in time series. They calculate the excess deaths from suicide when comparing the figures with the expected deaths if the suicide mortality rate for the period prior to the crisis had continued. Despite the possible weaknesses of trend studies (difficulty of establishing causal relationships between the crisis and the increase in suicides, cyclical behaviour of suicides, short time periods to compare time series etc.), the great majority of these trend studies are in agreement and show rises in the number of suicides during the years of the crisis period: 4,750 additional deaths in United States from 2007 to 2010[33], 846 additional deaths from 2008 to 2010 in the United Kingdom[34], and increases in the number of suicides from 2008 to 2010 in all the countries of the European Union[3,35].

A recent study analysing suicide mortality in 54 countries in Europe, the Americas and Asia during 2009 in comparison to what would have been expected on the basis of the suicide mortality trend from 2000 to 2007, estimates that there were 4,884 additional deaths due to suicide. The increase was greater in men aged 15 to 24 in Europe and those aged 45 to 64 in the USA, and was associated with the length of time for which they had been unemployed. There was no increase among women in Europe, and in America the increase was far lower than in men[36].

A recent publication in Italy studied standardized suicide mortality rates for the period 2006–2007 in the population aged over 15, and compared them with the rates for the period 2008–2010. The study found an increase of 12 per cent in suicide mortality between 2008 and 2010 in men aged 25 to 64, while there was no significant increase in men aged below 25 and above 64, and it fell in women of all ages[37].

What information do we have about the current crisis in Spain?

Suicide rates in Spain are much higher in men than in women, and rose significantly between 1981 and 1990. They then stabilized, and in 1993 began to decline in all age groups, although more slowly among men aged 35 to 44 and 45 to 55[38,39]. There appears to have been an increase between 2008 and 2009, particularly among men aged 45 to 54, but this increase was not sustained in subsequent years and has not been properly studied. Both the study by Salmerón[38] and the study by Álvaro-Meca[39] reveal geographical differences in suicide rates, which are higher in rural areas and in communities with higher unemployment rates.

Although it has been heavily criticized from a methodological perspective (date of the start of the crisis, grouping of regions with different levels of unemployment etc.), we cannot ignore the study of suicide mortality trends for the period 2008–2010, comparing mortality with previous years, conducted by López Bernal[40]. This study concluded that during the three years of economic crisis that was an 8 per cent increase in suicides, representing 680 additional suicides. This increase was much higher in men of working age.

Conclusion

This survey of the evidence of mortality from suicide shows that the increased mortality from suicide of men of working age in previous crises is well documented, but that in the current crisis the majority of studies are time series trends in which the limitations mean it is not possible to reliably state that mortality from this cause has risen during the crisis. However, all the trend studies point in the same direction, as do the first studies containing standardized rates that are now being published. This, combined with news of suicides directly linked to evictions, mortgage defaults, redundancies and other situations of stress due to the recession, means that these deaths are attributable to the crisis and clearly avoidable.

In this respect, it is interesting to listen to the narratives of those affected and the qualitative study conducted by the Mental Health Observatory of Catalonia[41], which "collects the stories, complaints and suffering of people who attend primary care social services for reasons directly related to the economic crisis" and shows that dominant themes in these accounts are references to individuals losing control over their own lives, desperation, feelings of uselessness and thoughts of death. They talk about thoughts and experiences of desperation and the uselessness of their own efforts to resolve the problem.

This agrees with other studies of suicidal ideation, such as that conducted in Greece[42] by telephone survey between 2009 and 2011, in which the proportion of respondents reporting suicidal thoughts rose significantly, from 5.2 to 6.7 per cent, accompanied by a significant increase in the number reporting a recent suicide attempt, which rose from 1.1 to 1.5 per cent.

Summary of the evidence

- The recession and the political response in the form of austerity have led to a significant deterioration in the social determinants of health and have caused a rise in social inequalities.
- With the information available, it is difficult to establish causal associations between the recession and the health outcomes if we want to analyse the immediate impact.
- However, we know that a deterioration in the social determinants will cause effects over the short, medium and long term, and that some of these effects may be permanent.
- The lack of ad hoc indicators and improvements in some population groups may mask a deterioration in the most affected or most vulnerable groups.
- Despite the methodological shortcomings of the studies, the literature, both as it relates to previous crises and to the current one, indicates that there is a relationship between economic recession and increased emotional suffering linked to unemployment, financial instability and housing problems.
- The data we have about suicide is not conclusive, but there is a lot of evidence that something is happening. However, it is important to remember that suicide is only the tip of the iceberg, and it is likely that mental suffering and suicidal ideation have increased greatly, even if the number of cases in which people act on these thoughts is relatively low.

What can we do as public health professionals and as health care professionals?

We can show solidarity with those who are affected and highlight the effects of precariousness and the crisis on health[43], treating these effects as a public health problem. And this means constructing and studying specific ad hoc indicators, as exemplified by the Institute of Health and Equity, monitoring inequalities and studying the consequences for vulnerable groups[7], to gain insight into the more detailed picture that is sometimes obscured by statistical averages. Studies of what is happening to the unemployed, those in precarious employment, young people, people with housing problems or who have been evicted, immigrant communities and regional studies are more important than ever. In this respect, we note the work on perceived health and mental health conducted by CIBER and the Public Health Agency of Barcelona among people receiving help from Cáritas in the Diocese of Barcelona[44].

With regard to highlighting the consequences of the recession, the issue of suicide is a controversial one. Experts have called for a considered approach when discussing this issue, for fear of causing a “Werther effect”, named after Goethe’s novel, “The Sorrows of Young Werther”, published in 1774, in which the protagonist takes his own life. The novel, which was very popular among young people of the time, led a number of people to commit suicide in imitation of the protagonist. The term refers to the copycat effect that is observed when news of the suicide of artists or famous people is publicized. However, experts also talk of the Papageno effect[45], based on the Mozart opera, “The Magic Flute,” in which Papageno, facing the loss of his lover, considers suicide, but changes his mind when three boys offer him alternative ways of coping with his suffering. And this is also what civil associations and mutual support groups, such as the platform for those affected by mortgage problems, seek to do: to inform, but also to offer alternatives.

It is also important to study and analyse the epidemiology of resilience and of social cohesion and social capital, because an understanding of these protective factors will provide a basis for improving the policies that are implemented[46–48]. However, health surveillance and the study of the consequences of the crisis are not enough; we have to implement public health policies and interventions within the health services. But what should these interventions be? How should we address the emotional suffering that is a reaction to the insecurity caused by the recession? Suffering that, as Josep Moya, President of the Mental Health Observatory of Catalonia, has repeatedly stated, would cease if the individual obtained a job or the bank cancelled their debt, indicating that the problem is not a mental disorder.

The health system tends to transform social causes into personal ones and interprets psychological suffering in biological terms, and as a consequence it medicalizes the suffering caused by social stress. Medicalization means treating people as passive subjects, incapable of liberating themselves, an approach that has the effect of hiding social and individual problems. It replicates the dynamic of victimization and deprives people of their autonomy, rendering them dependent on drugs and on the health system.

We need to recover narratives that place the victims of this social catastrophe at the centre of their life stories, enabling them to recover their voice and the confidence that they will be heard and understood. This process means travelling in the opposite direct to that described above: moving from the invisible to the visible, from the individual to the collective, from victimization to empowerment in order to take effective action to enable people to recover their dignity. The challenge is to engender and promote interventions that create links and mutual support networks: actions that focus not on care but on empowerment.

There are currently a whole range of initiatives, movements and social networks based on this approach, and these are the ones that are working most effectively to prevent mental illness in people affected by the crisis. Examples include initiatives such as that promoted by the *Comisiones Obreras* trade union federation in Catalonia, bringing together emotional support and mutual aid groups for the long-term unemployed, *El silencio roto de Fuenlabrada*, a support group for unemployed men aged between 40 and 60 in the town of Fuenlabrada (near Madrid) discussed in this workshop by Ildefonso Hernández, or the experiences of the Mental Health Observatory of Catalonia with people who attend the social services.

Final thoughts

The well-founded concern about the consequences of the global economic recession and cuts in social spending on health in general and on mental health in particular, especially among the most vulnerable populations, means that public health and healthcare professionals need to be vigilant about the short-, medium- and long-term effects, involving ourselves in research in this area, seeking to improve it, and above all promoting practical actions that empower the affected groups and collectives and help to mitigate the consequences. Both health systems and politicians need to consider the consequences of the recession for the mental health of their populations, including suicide, a public health problem of the first order, and to take action in this regard.

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Antonio Casado da Rocha

An ethical approach to suicide requires us to examine the changes in values that have occurred as a result of the crisis and how these values affect our concept of individual autonomy and the social care networks that support it. The Icelandic case shows what type of community is best able to resist crises and their negative impact on mental health. Its "moral core" or "living code" can throw light on the problem of suicide in other contemporary societies.

Introduction

Suicide is not just a public health issue of the first order (Pérez Jiménez, 2011); there are some, such as Albert Camus[1], who have termed it the "only really serious philosophical problem", one that forces us to ask what is the meaning of life. According to data for Spain, in 2010 suicide accounted for more deaths than road accidents or homicides, but as a phenomenon it remains both hidden and misunderstood. The enigma of suicidal behaviour and the stigma associated with it make scientific study of the phenomenon difficult, and this means we need the kind of multidisciplinary approach that is typical of applied ethics in general and of bioethics in particular.

We know that the current crisis is not just economic but also political and ideological; and we also know that, in general, mental disorders increase during times of crisis, particularly among the unemployed. However, there are significant differences between different societies, and there is also a wide variation in how different cultures define what constitutes a disorder or an illness. Bearing this in mind, what are the ethical factors related to greater resistance to mental illness in the context of economic and social upheaval? To evaluate the effects of the current crisis on the complex set of features that we call "mental health", and starting from an understanding of moral philosophy as "fieldwork in familiar places"[3], I will present some data drawn from recent research in Reykjavík[2].

Iceland is a particularly interesting society in which to consider this issue for a number of reasons, including its small size, the fact that it is home to innovative social experiments (such as the Sólheimar therapeutic community) and because it was the European country where the financial crisis of 2008 hit first and hit hardest. On the basis of some preliminary results from the fieldwork (primarily interviews with politicians and academics), I will seek to identify the moral core of the response of Icelandic society to the crisis. If, as appears to be the case, an increase in suicide can be prevented by welfare policies, social protection and measures to promote employment, then what ethical values or paradigms underpin this? In my research I have encountered stories that help to illustrate the social context and, while we need to be wary of the temptation to mythologize such factors, they appear to point to the importance of trust, a capacity to adapt and community feeling in coping with this situation. These results accord with other studies in which the crisis has been described as an opportunity that the preceding government exploited to improve the health indicators of the Icelandic population.

To distinguish between the myth and the reality that surround this topic, I will address the question from the perspective of empirical moral philosophy, understood as "fieldwork in familiar places"[3], drawing on a broad understanding of the concepts of suicide, crisis and mental health and their relationship to each other, to ask what the Icelandic experience can tell us about the "epidemiology of resilience". I will not discuss how these results apply to other situations, instead leaving this question for the general discussion.

An empirical approach

My starting point is similar to that of Victòria Camps, who has described bioethics as a "work in progress", something that is constructed between all of us through a process of self-regulation[4]. In this task, there can be no experts, not only because the decisions are the responsibility of every member of society but also because of the interdisciplinary nature of bioethics, which "is necessary precisely because the problems it considers are ethical, which means they cannot be reduced to medical, technical, legal or political problems. They are more than that; they affect everyone and are not the private concern of any single specialist sphere. (…) The fact that philosophers might, in principle, appear to be better placed than other specialists to address and pose moral questions does not mean that their moral authority to do so is greater than that of others."[4]

What, then, can a philosopher do? In my opinion, the broad perspective offered by moral philosophy provides a basis not for deciding upon moral questions but rather for integrating them with the interlinking discourse of other disciplines. This enables us to consider how suicide and economic crisis intersect, including the grey area occupied by unsuccessful suicides and other chronic problems (addiction, depression, etc.) without reducing the meaning of the crisis to the purely local or economic. The current philosophical debate about human nature[5] also points towards ways in which we might expand the concept of mental health, which is often approached in a reductive manner that defines unusual behaviours as disorders, which are then submitted to the dynamic of medicalization at the service of the pharmaceutical industry.

Mental health is a social construct, but it is no less real for that[6]. Mental disorders are often not accompanied by organic alterations, but this does not mean that they do not involve suffering, consisting as they do of patterns of thought, feelings and behaviour that may seem unintelligible. These patterns have more to do with the social than with the merely biological: when we define a syndrome as a mental disorder we are saying that it violates certain collective norms and expectations, and this explains the dramatic cultural variations in the prevalence of particular mental disorders and the symptoms they present.

Culture determines when something is pathological and also the form this illness takes, often including some degree of stigmatization, although in this area there are no linear relationships of cause and effect. Although the great majority of suicidal people have a diagnosable mental health problem, it is equally true that the great majority of people with a mental health problem do not commit suicide[7].

Returning to bioethics, an empirical approach to this subject can be traced back two decades, to when some authors — on the basis that "norms are contained within our actions" — began to argue for the role of anthropology and sociology as a source of live material with which to enrich our understanding of situations by offering a relational ethics of virtues and narratives to act as a counterweight to the rationalism of an analysis based solely on bioethical principles (López de la Vieja, 2013: 63–4; 71).

Let us turn, then, to the facts. We know that, as a consequence of the crisis, countries such as Greece, Spain and Portugal have adopted austerity policies that involved cutting spending on their health systems. And we also know that in these countries suicide and other public health problems are becoming more frequent. According to data from the National Institute for Statistics (INE), in Spain in 2010 there were more deaths from suicide (3,158) than from road accidents (2,478) or intentional homicide (390).

By contrast, Iceland rejected austerity through popular protest and at the polls, and the economic crisis would appear to have had fewer negative effects on health, despite the fact that unemployment affected both countries (in fact, unemployment rose by 386 per cent in Iceland between 2008 and 2009, something that was completely unheard of in its recent history; in Spain, the increase was of the order of 59 per cent). The current rate of unemployment in Spain is 25 per cent, compared to a rate of 6 per cent in Iceland.

Why was the economic crisis in Iceland not followed by a rise in the suicide rate?

Iceland was one of the first European countries to be hit by the economic crisis in 2008, and nowhere else were the effects so rapid and so dramatic. The ratio of debt to gross domestic product (GDP) rose from 28 per cent in 2007 to 130 per cent in 2011, and the value of its currency fell by 35 per cent in 2008[8]. The impact was dramatic, and became public on 6 October when the Prime Minister addressed the country to announce a national emergency in order to deal with the first consequences of the banking collapse (for example, Icelandic credit cards abroad had ceased to function, causing alarm among the general population).

According to data from the Mental Health Service of the National Hospital of Iceland[9], in the week following the economic collapse (mid-October 2008) there was a slight increase in the number of admissions due to attempted suicide, but this did not change the total number of suicide deaths, which has been stable at around 30 to 35 deaths per year for the last decade. Although some risk indicators have indeed risen, such as higher unemployment[10], this data represents a challenge to the manner in which the crisis, mental health and suicide mortality are conventionally linked.

What has happened in Iceland? What we do know is that the population voted in a referendum to reject orthodox proposals (communicated to its government by the International Monetary Fund) to repay debts incurred as a result of the crisis; this rejection has been validated by the Court of the European Free Trade Agreement (EFTA), which upheld the Icelandic decision against claims from the British and Dutch governments[11]. In contrast with other places, in Iceland there has been little impunity for those in charge of the banks (four bankers were recently given prison sentences)[12]. In addition to ignoring the advice of the International Monetary Fund, Iceland invested in its population: the current government has announced a plan to reduce every mortgage by 24,000 euros[13], and the previous one allocated a lot of resources to social protection and active measures to get people back to work, maintaining its restrictive policy on alcohol (high prices and a state monopoly); McDonald's has no restaurants on the island.

In addition to improving their diet, the Icelanders drew on their reserves of social capital, sticking together through the crisis. In summary, and "[a]lthough extrapolation to other countries should be undertaken with care, Iceland, by challenging the economic orthodoxy at every step of its response, has shown that an alternative to austerity exists,"[8] or at least that there are other ways of understanding it. There, the crisis was not experienced as an excuse to cut public services, but rather as an opportunity to recover certain fundamental ethical values, to slow down the pace of life and, at the same time, provide more opportunities for citizens' participation and social relations[14].

Indeed, the maintenance of policies of social protection, together with changes in people's lifestyles, have been indicated by several authors as causes of the improvement in the health indicators of the Icelandic population[15]. Some health indicators have improved thanks to the crisis, as a result of the reduction in certain behaviours that were dependent on people's purchasing power (tobacco, alcohol, sugary drinks, fast food and sun lamps), an increase in time-dependent behaviours (more hours of sleep) and, in general, an increase in prices (27 per cent between 2007 and 2009) that has had a significant influence on the impact of the crisis.

Before the crisis, in 2005 and 2006, Iceland occupied first position in the United Nations Human Development Index. Although the value of its currency has fallen, according to studies undertaken during this period people in Iceland continue to be fairly happy. This suggests that when basic needs are met and there are opportunities for social interaction people adapt better to change, however dramatic this may be. Since the crisis, the number of people in economic difficulty — and thus more vulnerable — has grown, but the happiest people continue to be the most resilient: people with stable, meaningful social relationships[16].

Iceland as a positive anomaly

Resilience is the capacity of a given system (natural or social) to overcome and absorb attacks or disasters in a way that allows it to maintain its identity over time[17]. Moving from the individual to the community level, we could say that Iceland has been an example of resilience throughout the 1,000 years of its history. Are there ethical factors at play? Some studies of the ethics of organizations argue that the "living code" — the identity by means of which an organization represents its ethos, in contrast with the "written code", which is sometimes merely cosmetic — provides protection against some of the negative effects of crises[18]. Does the living code or moral identity of a human group influence the factors related to greater resilience to mental illnesses in situations of economic and social upheaval?

The research, which is still in progress, includes a review of the scientific literature about the Icelandic case in the context of studies of social innovation and applied ethics, in addition to ten units of discourse analysis (basically, interviews with people from the worlds of politics and academia). The analysis and encoding of the interviews (allocation of more or less provisional categories to fragments of text) drew on the theoretical framework explained below, based on the work of Juan Carlos Siurana[19]. This professor at the University of Valencia has developed in various publications a description of moral life, which, in a simplified and modified form, I believe provides a useful basis for describing the moral identity of a community. The principal elements are:

- intersubjective values (the "level of self-understanding", to use Siurana's terminology)
- principles of public justification ("level of foundation")
- corresponding behaviour ("level of application").

With respect to the first level, that of values, the analysis of the interviews shows that the crisis affected the Icelandic identity, not just its economy or its politics. This identity is perceived as being increasingly vulnerable in a global context as, in the words of one informant, "small societies like ours are culturally vulnerable, especially now that we are exposed to so much information so quickly"; "we are inside the European market, but without its institutional protection", and "we feel defenceless against the banks". During the first months following the financial collapse, traditional values were revived, "going back to our roots: to our values of austerity and moderation, doing things like knitting jumpers". This identity and these origins are closely linked to a resilience based on the Icelandic culture and language: "our cultural roots enabled us to survive for five very difficult centuries"; "Iceland is above all a literary culture, in which language and literature play a role in its identity that are very different to that of other countries". This awareness of vulnerability and resilience is accompanied by the acceptance of certain limits of what it is proper to do, of the goals that can be proposed: "Iceland is a cohesive but also an inefficient society," "we are very aware that people are careless in almost everything".

With regard to the principles used to justify public decisions, the perception that there are no surplus citizens in Iceland is very noticeable: the education and participation of all is important for the survival of the community. As another informant told us, “there are too few of us and society is complex; to govern it well, you need to have a lot of people in different positions”. The political crisis has created a situation of “permanent social scrutiny”: although the project of the new constitution has been suspended, “it is the basis for a public discussion that will take place in some form over the coming years”. Their priority is to ensure that their needs are met (“Icelanders are very self-centred”) with the interests of others coming after. With respect to politics, this is experienced as something very personal and intimate: “political ideology doesn’t count” in a city-state like Reykjavík; “our politics have always been very personal and antagonistic”. Another major principle is that nothing is ever final: “you have to be adaptable, resilient and optimistic”, because in a changing and uncertain climate (both meteorologically and economically) “being an opportunist is crucial to survival”. They maintain the belief that “it will all work out” (a common phrase in Icelandic: *Þetta reddast*) because “for things to work, you have to believe and have trust”.

Finally, with regard to behaviour, Iceland is a paradoxical society, one that has responded to the crisis with a “mixture of social intervention and economic adjustment” to maintain an identity that is at once innovative and traditional, an economy based on tourism and fishing, and a political system that has scarcely changed in 70 years, with the recently proposed constitutional reform failing because “the lack of preparation prevented the debate from taking place”. It is a society that combines proximity and diversity, where “the best thing is to have different groups working together as well as possible”, and one that is extremely dependent on information; as one informant said, “we are a highly interconnected, nepotistic society”, with “the highest number of Facebook accounts per capita in the world”; “internet is essential to our politics”. A compact and hyperactive society, to the point of “attention deficit disorder”, where “it is better to do than to think” and social inclusion is “as difficult as being accepted into a small family”. A society where “permanent improvisation” causes a “lax responsibility”, that operates by fits and starts. Although there is relatively little impunity and social frustrations are aired without violence, there is no time for sustained deliberation: “Iceland does not have spaces for public debate, the media is dreadful and there is no real forum for serious public debate”; “here you can present your ideas and opinions, you don’t need a position to do that”, “but we lack the ability to debate”.

Conclusion: towards an epidemiology of resilience

In the light of this “living code”, it would appear that the key to the Icelandic anomaly, its “positive deviation”[18], lies in the return to a certain traditional austerity (not one of cuts, but rather of active welfare, protection and employment policies) combined with the protection of its resources, a positive vision of its capacity to resist in the face of adversity and intense social interaction. What relevance can these factors have when it comes to tackling suicide in other societies? As one of the participants at the seminar said: “Iceland, fine. And so what?” One response is that the Icelandic case provides evidence for progress towards an “epidemiology of resilience” (a new expression, borrowed from Karanikolosa[8], in which resilience is understood as the capacity for individual resilience).

In an analysis of cases of suicide in the contemporary literature and their relationship to concepts of autonomy in bioethics[20], I interpret the social significance of certain narratives of “rational suicide” as an indicator that the concept of autonomy that these narratives embody is unreal because it is excessively individualistic and seeks to portray as an expression of moral autonomy something that in reality is nothing other than loneliness, neglect and lack of communication. The notion of autonomy that is emerging in contemporary bioethical theory is relational, narrative and constructivist (Gracia, 2013) but in practice the hegemonic concept in our bioethical culture is one of the autonomy of producers and consumers within a context in which psychotropic drugs are the most widely used medicines (according to Guillermo Rendueles, in the work of Fernández-Savater)[21].

Irrespective of where they take place, crises are more than just a moment of collapse, “they are the conditions of possibility for a subjective, existential, vital mutation, whether in micro or macro contexts" (as Peter Pál Pelbart argues, in the work of Fernández-Savater)[21]. The Icelandic macromutation provides an example of effective, preventive interventions: stories of resilience that emphasize the role of trust, the capacity to adapt and mutual support in coping, on the basis of a sober communitarian foundation in which autonomy is understood in a relational context, as a network of people who share a cultural identity and provide mutual care.

The Icelandic case also shows that the only true remedy for post-crisis anxiety, the best alternative to psychotropic drugs, consists in creating safe, stable social networks that transmit trust. As Rendueles[22] notes, "technologically advanced measures to prevent suicide (drugs etc.) scarcely reduce the number of suicides. It is social networks, whether traditional or new, that improve mental health. But, instead of building on this insight, we ignore it. The only things we study are individual vulnerabilities."[21] In fact, it is obvious that in a country with 25 per cent unemployment there are social networks that protect the population, and maybe, instead of stressing technological and pharmacological interventions, we should promote social networks and tools for communication that help to recreate meaningful relationships on the ground, reconstruct the meaning of our damaged lives and thus preserve the communities in which our precarious autonomy finds expression.

Finally, the politics of resilience are exposed to two kinds of fallacious argument. The first is a version of the intellectualist fallacy (knowing how to do something is not the same as knowing how to do it well): let us not confuse practice with the doctrine that supports it, because crises cannot be overcome through moral catechism or occupational training. Let us not confuse empowerment with information, or social networks with religion. Although there are some studies that present religiosity as a protection against the risk of suicide in countries such as Spain, in the Protestant countries (which are not less religious but are rather religious in a more individualistic manner) quite the opposite is the case. This has led Rendueles to conclude that it is above all social networks, rather than religiosity, that truly protect[21]. Indeed, the fieldwork suggests that, in the Icelandic case, the "social cement" is not religion but rather Icelandic language and culture.

The second fallacy is "cyberfetishism": social networks are not the same as digital networks, which ultimately offer only an artificial community. Robust networks can make use of digital platforms, but cannot be reduced to them without succumbing to what César Rendueles[22] terms "cyberfetishism". As Pablo Simón mentioned in the discussion, the new social movements create social networks, but the experience of the *Occupy* movement in Spain also reveals their incapacity to carry out transformations over the short to medium term that go beyond the temporary mobilization of support. This coincides with the diagnosis of Rendueles[22] and with our own experience in Iceland, which revealed a country with a high level of technological development which, perhaps due to its geographic and historical peculiarities, has not lost its community feeling or an awareness of the determinants or anthropological limits to which César Rendueles refers[22].

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For the morally correct use of public health services in times of crisis: the role of health professionals and the role of health service users

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The use of health services in times of crisis[a]

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1. Introduction

What are the main changes in the patterns of health service usage that are occurring in the Spanish health system as a consequence of the crisis and the measures adopted in response to it?

In the first part of this text, I examine the impact of the introduction of co-payment for prescription medicines, which has seen a significant reduction in the number of prescriptions dispensed, although the effect on treatment adherence, access to necessary and effective treatments and overall health outcomes is still unknown. I also consider the lengthening of waiting times for medical appointments and of waiting lists for surgery during the most recent years of the crisis.

The economic situation has led to severe restraints being imposed on the budget of the Spanish health service. However, even before the crisis there were a number of sources of tension within the health system that required structural reform to ensure the ongoing solvency of the system. In the second part of this paper I start by analysing some of the most important sources of this tension with respect to the use of the health system's services.

I then go on to describe a route map intended to reduce this tension by making more efficient use of health resources through the application of two basic principles: the reduction of waste (under-use, over-use, the prevention of adverse effects) and a clear commitment to linking funding and usage of services with health outcomes (selective funding of medical services, drugs and technologies, and the integration of budgets by breaking down barriers between different parts of the system).

2. Some changes to service usage guidelines as a result of the crisis[b]

2.1 Paying for what seemed to be free

A key issue to consider within the framework of the changes in the Spanish health system is the role of contributions by users — referred to as "co-payment" — within the Spanish health system. If we do not wish this to become a tax on illness, then the revenue-raising role of co-payment must be limited. Co-payment based on criteria of effectiveness is preferable to a system in which it is linear and compulsory. If it is compulsory, as is the case at present, it is better if it is a reduced amount for all, in which there is a ceiling on the total amount paid by any patient for all types of co-payment (as in Sweden) or a maximum percentage of the patient's income (Germany), with patients with chronic illnesses either being excluded from the co-payment system or paying only a very reduced amount. To put an extreme example, the costs of not following effective treatment following a heart attack far outweigh any cost savings generated by dissuading patients from taking such treatment by imposing high co-payments.

Ideally, a well-designed co-payment system would not impose payment where treatment was more cost-effective than non-treatment, and the patient would make up the difference of the price of other more expensive treatments that deliver little health benefit. This is what happens in many European countries (for example, France) where co-payment depends on the degree of need and the efficacy of the treatment (the more necessary and

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[a] This text is based primarily on the author's recent work, cited here and written in collaboration with Beatriz González, Juan Oliva, Salvador Peiró, Santiago Rodríguez and Rosa Urbanos. The author would also like to acknowledge the comments and observations received at the seminar, *Ethics, the economic crisis and public health.*

[b] This section of the text is based on the work of Urbanos and Puig-Junoy[1] and Puig-Junoy, Rodríguez and González[2].

effective, the lower the level of co-payment). It should also be remembered that co-payment not only disciplines the patient but also the doctor, helping to promote a more rational use of resources. It is important to note that a good co-payment system should be based on the value of the care and not on its price; in other words, the cost should be minimal or zero the more effective and necessary the treatment, and it should be higher the less effective and necessary it is. Avoidable co-payment systems, such as those in Germany and the Netherlands, are intended to operate like this. The key element of targeted co-payment systems is that they must be based on value. And this value must be determined by scientific-clinical evidence[3].

Until July 2012, the Spanish health system provided generous pharmaceutical cover (free of charge) for all in-patients with the exception of civil servants, who were covered by separate arrangements, and pharmaceutical prescriptions to non-hospital patients, where 40 per cent of the retail price was payable from the start of the 1980s until mid-2012. In the case of medicines principally indicated for chronic illnesses, a co-payment percentage of 10 per cent has been applied, with a ceiling for each prescription. In the case of those in employment and their dependents, co-payment ranged from 40 per cent to below 10 per cent until 2012.

Pensioners and their dependents were exempt from this co-payment system until July 2012. As a result, co-payment only applied to those in work and their dependents, irrespective of their socioeconomic situation. There were no limits or ceilings on the maximum amount that any individual could be required to pay, and the retired or those on disability benefits, irrespective of their age, were automatically exempt from the co-payment system and were given free medical prescriptions, as were their dependents.

The nominal co-payment percentages (40 per cent and 10 per cent) remained unchanged for two decades, despite the fact that the average effective co-payment had fallen by more than half since the 1980s (from 15 per cent in 1980 to 7 per cent in 2009). This reduction in the level of effective co-payment was the result of the ageing of the population, a high number of medicines with a co-payment rate of 10 per cent, and excessive consumption associated with possible moral hazard[4]. As a result of this and other factors, the consumption of drugs per person in Spain was high by international standards[5].

In 2012 a fairly radical reform of the system of co-payment for drugs dispensed by pharmacies was introduced, leading to three parallel policies, which came into force more or less simultaneously between the end of June and the beginning of October 2012. These were: a) the temporary introduction of co-payment of one euro per prescription with an annual ceiling in Catalonia and Madrid, in the form of a regional fee, until it was suspended by the Constitutional Court; b) the state co-payment reform, that put an end to extensive free prescriptions for pensioners, requiring them to pay 10 per cent of the price of medicines, up to a maximum monthly limit, and also raising the charges for those in employment to 50 or 60 per cent, depending on their income level; and c) withdrawal of funding for over 400 drugs, including the majority of some therapeutic groups, primarily indicated for minor symptoms, and which is the equivalent for these medicines of a co-payment rate of 100 per cent.

The potentially positive aspects of this reform — highlighting the fact that universal was not the same as free when we had one of the highest per capita rates of medicine consumption in the world — have been overshadowed by certain aspects that leave much to be desired. The first issue is that those in employment but with serious diseases are treated differently than others with the same income and needs, as the co-payment level is very high and there is no upper limit on payment. The second is that co-payment by those in employment, despite claims to the contrary, is not based on income: although the percentage paid per prescription varies, the lack of an upper limit means that 50 per cent of co-payment is accounted for by the 5 per cent of those in employment with the most serious health problems. And the third is the incapacity to manage the upper limit for pensioners at the point of dispensation, which not only generates additional costs related to the administration of repayment but also undermines the purpose of this limit, which is to reduce financial risk to the patient. However, these reforms — adopted in mid-2012 — produced a spectacular reduction in the number of prescriptions dispensed by pharmacies, for the first time in over three decades.

To date, only one (preliminary) quantitative evaluation has been conducted to study the overall impact on the number of prescriptions dispensed by pharmacies during the first ten months of application of the different co-payment methods (euro per prescription, changes to state co-payment and withdrawal of funding) applied in each of the 17 autonomous regions of Spain since June 2012[2].

The results of this study indicate that at 3, 6 and 10 months there has been a very significant reduction in the number of prescriptions dispensed in comparison with the projected trend (without reform) in all autonomous regions except for the Basque Country, where the only reform applied has been that of the withdrawal of funding from specified medicines. In Catalonia, with the adoption of the regional fee, there has been a reduction of 24.8 per cent in the number of prescriptions at ten months (-28.1, -21.4), a figure that is higher than in any other region; the scale of the difference between Catalonia and all the other regions was statistically significance (95 per cent confidence), with the exception of Galicia (-24.1 per cent) and Valencia (-20.8 per cent). The estimated impact in Catalonia was also higher after 3 months (-13.3 per cent) despite the fact that Catalonia had not applied the state reform during this initial period but only the regional fee, and also at the end of 6 months (-22.6 per cent).

The reform of the co-payment system, initiated with the measures adopted in July 2012, to which were added the withdrawal of funding from a list of medicines for minor symptoms and the attempts to apply regional fees to prescriptions, is in need both of a major overhaul and a detailed and urgent evaluation of its impact, given the significant reduction in the number of prescriptions. The redesign should take into account a number of different issues. Firstly, any co-payment should be cumulative, whether with regard to medicines or other services, with a maximum limit for each person, irrespective of whether they work or are a pensioner, as a co-payment system that does not include such limits or that does not allow them to be managed prior to prescription can be counterproductive. Secondly, the relationship of co-payment to income should be clarified, as the current system, despite claims to the contrary, is not income-related: what is related to income is the percentage of the price of each prescription, not the total amount payable by the patient during a given time period, bearing in mind that spending is only accumulated for a small number of patients. And thirdly, the emphasis should be on a co-payment system whose primary purpose is to discourage unnecessary medication rather than to maximize revenue, taking care to avoid compensatory effects in the form of higher spending on emergencies and the hospitalization of seriously ill patients as a result of non-compliance with treatment, through a system of minimum or zero payments for the most necessary and effective treatments and higher charges for less cost-effective treatments.

2.2 Cuts and changes to the insurance system

Difficulties accessing medical care as a result of the crisis have not been restricted to those who have been excluded from coverage by the Spanish health system. According to income and living conditions data (EU-SILC) for Spain[6], the percentage of the population stating that its basic medical needs were not covered rose by 0.7 per cent between 2008 and 2011. This means that the social gradient in access has tended to become steeper over recent years.

This situation has also been observed, more dramatically, in other European countries that have been hit hard by the crisis, such as Greece[7]. However, analysis of other data sources providing similar information offers contradictory results. For example, a comparison of the two most recent National Health Surveys for Spain (ENSE) corresponding to 2006 and 2011, show a slight reduction in the percentage of people stating they had needed medical assistance but not received it (from 3.63 per cent to 2.01 per cent of the total). However, it also found that there had been an increase in the proportion of cases most directly linked to the effects of the crisis: the direct cost of care, lack of coverage and waiting times. For the sample of adults, the percentage of people who identified the main causes of not receiving care as “too expensive/no money” and “not covered by insurance” rose from 4.6 per cent to 5.5 per cent between 2006 and 2011. For their part, the proportion of those stating they “had to wait too long” rose from 31.8 per cent to 36.8 per cent.

The indicators for waiting lists and waiting times released through the Spanish health system (which only provides aggregate data for the country as a whole) do not indicate major changes since the start of the crisis, at least with regard to appointments with specialists. However, there has been a slight deterioration, particularly since 2010, both in the number of patients waiting for elective surgery per 1,000 inhabitants (which rose from 9.38 in 2006 to 11.82 in 2012) and in the average waiting time for these operations (which rose from 70 to 76 days).

From the analysis of the data of the National Health Surveys in 2006 and 2011–2012, it can be concluded that, both in medical appointments within the Spanish health system and other services that are not included — in particular, dental appointments — the crisis is having the effect of dissuading the most disadvantaged sections of society from using health services.

3. From austerity to "establishing order"[c]

3.1 Reducing waste

The first point that has to be addressed in improving the efficiency of our use of the health services is the reduction of waste. Basically we need to limit those processes, products and services that do not add value (in terms of health and quality of life) for patients and populations, while safeguarding those that do add value.

A recent study estimated levels of waste in the United States health system (problems of quality, coordination, over-use, administrative complexity, fraud and others) at between 21 and 34 per cent of health spending[10].

In the Spanish health system we lack information of this sort, but there is extensive data indicating the waste of medicines (antibiotics, proton-pump inhibitors, statins, anti-osteoporotics, coxibs, psychoactive drugs etc.), adverse effects, overuse of diagnostic tests, lack of coordination in the care of chronic patients and other problems that suggest we are combining over-treatment of mild patients (spending without benefits) with under-treatment of high-risk patients (ultimately leading to higher spending further down the line to offset this under-treatment and the complications that sometimes arise as a result).

There is a problem of the under-use of health services in patients who do not receive the tests, treatments or interventions that their clinical situation would indicate. In the Spanish health system there is direct evidence of the under-use of drugs to prevent secondary heart attacks[11], the prevention of thrombosis in atrial fibrillation[12], heart failure[13], in the diagnosis and management of chronic obstructive pulmonary disease[14] and in high blood pressure, asthma and the management of so-called "minor symptoms".

This under-use massively increases therapeutic failure, understood as increases in morbidity and mortality that would be preventable with the appropriate diagnostic and therapeutic management of patients, which translates into waste as a result of spending on hospitalization and treatment of illness and compensatory therapy that could have been avoided. In this respect, in the Spanish health system there is evidence of significant failings in intermediate clinical outcomes and risk factors (blood pressure level, glycated haemoglobin etc.) which may be related to the high figures for "potentially avoidable hospitalizations" in the Spanish health system[15].

At the other extreme, over-use refers to the unnecessary performance of tests, treatments, surgery, medical appointments and other health care (without clinical benefits for patients). In the Spanish health system there is direct evidence of the over-use of antibiotics (between 6 and 55 per cent of those prescribed), lipid-lowering drugs (between 10 and 79 per cent), anti-ulcer drugs (between 13 and 54 per cent), anti-osteoporotics (between 43 and 92 per cent) and psychoactive drugs (with 25 per cent of patients receiving these drugs without presenting mental disorders[15]).

The over-use of diagnostic tests has been less widely researched, but some studies show excessive requests for some laboratory tests and dramatic variation in populational rates for the performance of the majority of laboratory tests, which would suggest a significant volume of inappropriate requests[16].

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c. This section is based on Oliva, Peiró and Puig-Junoy[8,9].

With respect to the over-use of imaging tests, a recent study in primary care estimated that a quarter of such tests were unnecessary[17].

It is also important to note some of the most common examples of over-use: visits to family doctors, preventive actions of questionable efficacy, referrals to specialist care[18] and the massive flow of "non-urgent" patients to hospital emergency services[19].

A third area where attention needs to be focused is on problems of safety and adverse effects. Here it is interesting to note research conducted in recent years in the area of hospitalization (ENEAS)[20], primary care (APEAS)[20], care homes (EARCAS)[21] and other more specific fields. The results, as the various reports show, do not differ widely from those found in other developed countries, but for precisely this reason they are very worrying. According to ENEAS, 9.3 per cent of hospitalized patients present some adverse effect. Of these, 16 per cent were serious and 42.8 per cent were preventable. If we apply these percentages to the 5.2 million hospital admissions in Spain in 2006, they represent 450,000 hospital adverse effects per year (of which 200,000 were preventable); of these, 90,000 were serious (of which 40,000 were preventable). The APEAS results are no more reassuring: there was one adverse effect for every 100 appointments (general medicine: 1.03; nursing: 1.15; paediatrics: 0.48), almost half of which were related to medicines. Of these, 64.3 per cent of the adverse effects were mild, 30.0 per cent were moderate and 5.7 per cent were serious, while 46 per cent were preventable.

If we apply these percentages to the almost 400 million annual appointments, we are talking about 3 million adverse effects per year, of which 300,000 would be serious and 1.4 million would be potentially preventable. These figures identify adverse effects as one of the principle (preventable) health problems of the Spanish population, together with cardiovascular disease and cancer.

3.2 Usage based on outcomes

The credibility of any reform of the health budget depends, above all, on our ability to make progress within a reasonable timeframe towards a selective funding of medical provision, drugs and technologies based on the best scientific knowledge available. Investing in the evaluation of the comparative incremental efficacy of new and existing treatments is the most effective way to ensure the future solvency of the public health system. One issue that requires urgent attention is the use of public resources to fund only those drugs, technologies and services that — in addition to being safe and effective — are also efficient. We need to clearly and explicitly include the issue of efficiency (the balance between additional cost and relative added value) when taking decisions related to public funding, pricing and the appropriate use of an innovation[22,23].

Despite the crisis and the cutbacks, the public health system remains wedded to the aim of doing "less" of the same: we end up publicly funding almost any new drug, regardless of whether the cost in terms of health outcomes is reasonable or exorbitant.

We pay high prices for drugs that other richer countries are not prepared to pay. In Spain, therapeutic value or level of innovation do not appear to be a key factor in determining the entrance price of new drugs, unlike the situation in the United States or Sweden. In reality, we don't even know the cost per quality-adjusted life year (QALY) of the drugs that are authorized each month on a central basis.

When we know that the principal factors driving health expenditure are the adoption of health innovations and the increase in use per person, it is essential for the sustainability of the system to have an independent procedure to evaluate incremental efficacy/effectiveness and the incremental cost-effectiveness ratio on which to base selective funding and pricing decisions.

Unlike the reform of the pension system, the sustainability of the health system is not automatically based on life expectancy but instead on the value of the treatments applied, a value that is measured through tools such as the evaluation of incremental efficacy or added therapeutic value, cost-effectiveness and payment ceilings per QALY. It can come as no surprise that Brussels has called upon us to increase the cost-effectiveness ratio of the health sector.

This means adding new requirements to the decision-making process and developing a framework that enables this in practice, both with regard to guidelines and at the level of clinical management. We need to create institutions that are capable of informing decisions about the prioritization of resources which include efficiency criteria. The European experience of the last decade is a rich source of inspiration in this area, as a growing number of countries, including Germany, the Netherlands, Portugal, Sweden and the United Kingdom, have adopted different models from which we could learn, borrowing those successful elements identified as being adaptable to the Spanish context.

Efficiency criteria should not only be used to evaluate which new technologies to include in the portfolio of services of the Spanish health system, but also to decide which technologies should be withdrawn. Disinvestment decisions should be guided by scientific evidence of the comparative effectiveness and relative efficiency of preventive measures, treatments and tests. To summarize, decisions to allocate and withdraw funding should be sufficiently transparent to enable those involved to understand (although not necessarily to agree with) the decisions taken, and the criteria on which these decisions are based should serve as a guide for innovation.

Another important issue is the need to overcome the compartmentalized approach that currently dominates the management and use of the health services. Resources are distributed between budgets that are separated between different levels of care (primary care, hospitals, social services) and between different types of product (medical prescriptions, hospital drugs, prosthesis) as if these were totally unrelated, instead of being distributed according to the justified cost of the integrated care required by the patient, regardless of where this care is actually provided. We need to focus budgets on funding the outcomes we want to achieve. We therefore need to start to pay for health outcomes: spending more on keeping patients healthy than on providing compensatory care for chronic patients, repeat admissions for complications following surgery or the excessive use of elective surgery; paying more for appointments that will actually resolve problems than for referring patients between health professionals without solving their health problems. This means integrating budgets that are currently compartmentalized between care levels (primary, specialist, social, pharmacy) through fixed, pre-established funding for all of a person's care depending on the characteristics (risk), making it possible to see the integrated cost of caring for a patient, overcoming the partial, fragmented vision that currently disperses resources and conceals the failure of clinical decision-making.

Against the current compartmentalization of care levels, the integration of budgets through forward planning based on per capita payments adjusted to reflect the characteristics of the population covered would help to promote integrated health care and to identify the total costs of care. At the macro level, this integration should include, among other things, an obligation to report on the performance of organizations within each health region, a move that would promote the introduction of methods of payment by results, consolidating the incentives to offer care aimed at solving people's problems and maintaining a population that is healthy and well cared for[24].

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Pablo Simón Lorda

Questioning assumptions

I want to start by questioning the title of this session. This title appears to take it for granted that:

1. A significant proportion of the general public use the public health services in an incorrect or “immoral” way.
2. This is particularly worrying “in times of crisis” for two possible reasons that establish causal links between “inappropriate use” and “crisis”.
    a) *A priori*: because this “immoral use” has been a significant contributor to the causes of “the crisis”.
    b) *A posteriori*: because in this crisis situation, “this immoral use becomes worse”, something which in turn “intensifies the crisis itself” through a circular feedback mechanism.

These assumptions are in reality part of a far larger argument about the origin of and possible solutions to the crisis. This broader framework includes both diagnostic and therapeutic arguments, such as the following:

1. There is a relationship between the economic crisis and health spending, such that the latter is one of the elements that have contributed to the former, as health spending accounts for a significant proportion of total public spending.
2. This spending is excessive because “we have spent more on health than we could afford”. Those responsible are the citizens and, to a lesser degree, the health professionals, who are nothing but irresponsible spendthrifts who have exposed themselves to moral hazard.

3. To balance the books and recover from the crisis, we therefore need to act on both supply and demand:
    - Restrict the right of access to the public health system, thereby destroying the idea of the right to health care as a universal human right.
    - Cut investment in the public health system, particularly in the most important area: spending on human resources or health professionals.
    - Cut back the portfolio of services as much as possible.
    - Expand payment for health services in order to:
        - Increase direct income.
        - Reduce the use of public health services, with a consequent reduction in expenditure.
        - Increase the attribution of responsibility to citizens and health professionals in order to combat "moral hazard".
        - Stimulate private insurance.
        - Privatize, under a variety of arrangements, whatever can be privatized, because it is obvious that private management is more efficient than public, which by definition is mediocre and wasteful.

All of these statements currently constitute the official dogma of governments and of many economists. What is more, it is enough to look at the actual policies of radical reform of the health system being implemented both by the Spanish state and by the great majority of autonomous regions to see that they reflect this programme fairly faithfully.

A very important feature of this programme is that it seeks to be presented as a "natural", "objective" and "morally neutral" law: "what has to be done because there is no other way of doing it", because that's Economics, a science that produces certainty. Therefore, any trace of criticism, of looking for alternatives or of a moral judgement that is contrary to these "laws" is automatically labelled utopian, radical or irresponsible.

There is no need to once again list the data, statistics and tables that reveal the fallacy of such supposedly "scientific" arguments on their own terms, or make clear the real impact of the policies that flow from such arguments on the daily lives of ordinary people. There are already scores of studies and reports that do just this[1].

It is more important to show that the framework that generates and seeks to justify these statements is pure ideology, in the original Marxist sense of the word. Not only are there strong technical reasons to contest this view and to question its accuracy; this ideological framework seeks to instil in the minds of citizens a false consciousness that hides the true causes of the current situation and legitimates a whole programme of social, political and economic transformation designed to ensure that the interests of the major financial powers prevail, using the hypocritical pretext that it is citizens' interests that are being protected.

This ideological programme is neoliberal capitalism, a programme that aims to do away with the Keynesian welfare policies introduced after the Second World War in Europe and, to a lesser degree, in North America[2]. The RAND Corporation was one of its leading think tanks during the 1960s and 1970s, but it was only in the wake of the oil crisis of 1973 that neoliberalism was able to go on the offensive during the 1980s, with the policies of Reagan and Thatcher, inspired by economists such as Frederick Hayek or Milton Friedman[3]. Its second assault took place during the 1990s with the dissemination of the ideological programme of the Washington Consensus[4], which was accepted to a greater or lesser degree by the governing parties of the western democracies, including, paradoxically, the social democratic parties. Neoliberalism is currently engaged in its third major offensive, using as its battering ram the crisis that began in 2008 as a result of financial speculation in the commodities and property markets. A crisis precipitated, therefore, by the very people who now seek to blame it on citizens and social welfare policies.

Obviously, however much it is disguised as objective science, this ideological programme is not morally neutral. It is based on assumptions that derive from a libertarian approach to moral philosophy that counts among its most prominent advocates Robert Nozick, in the philosophical sphere, and H.

Tristram Engelhardt Jr., in the field of bioethics. In the interstice between philosophy and economics, an important ideological mentor of neoliberalism has been James Buchanan and his theory of public choice, based on methodological individualism and the theory of rational decision-making.

Nozick is a Lockean contractarian, while John Rawls, the thinker who was responsible for updating the theory of the social contract in the political philosophy, his colleague and principal ideological opponent at Harvard, has been described both as a Lockean and as a Kantian contractarian. James Buchanan, by contrast, is a Hobbesian contractarian[5].

This point is important because, according to Boaventura de Sousa Santos, "the social contract is the metanarrative upon which modern political obligation is based (…); it is the founding metaphor of the social and political rationality of western modernity"[6]. For this reason, neoliberal capitalism has no choice but to be contractarian: not in the style of Rawls or Amartya Sen, but rather in the manner of Nozick or Buchanan. This means that the language of citizens' "rights" is always used to justify "reforms". And what rights? Well, according to Nozick in reality there is only one right that is in principle absolute and inviolable: the right to self-ownership, which affects oneself, one's body, one's talents and abilities, and the fruits or products that come from exercising these or that have been obtained in fair exchange. This right can only be limited in very exceptional circumstances, such as to impede the renunciation of this self-ownership: nobody is entitled to sell themselves into slavery.

The sole purpose of Nozick's social contract is to guarantee the complete protection of this absolute right, nothing more. Any collective action that could in any way limit the individual exercise of the right to self-ownership is morally illegitimate. Thus, in the preface to his 1974 book *Anarchy, State and Utopia* he argued:

> "Our main conclusions about the state are that a minimal state, limited to the narrow functions of protection against force, theft, fraud, enforcement of contracts, and so on, is justified, but any more extensive state will violate persons' rights not to be forced to do certain things, and is unjustified; and that the minimal state is inspiring as well as right. Two noteworthy implications are that the state may not use its coercive apparatus for the purpose of getting some citizens to aid others, or in order to prohibit activities to people for their own good or protection"[7].

The consequences of this position from the point of view of the right to health care are clearly set out by Engelhardt in his 1986 book, *The Foundations of Bioethics*:

> "The imposition of a single-tier, all-encompassing health care system is morally unjustifiable. It is a coercive act of totalitarian ideological zeal, which fails to recognize the diversity of moral visions that frame interests in health care, the secular moral limits of state authority, and the authority of individuals over themselves and their own property. A basic human secular right to health care does not exist — not even to a "decent minimum of health care"[8].

What is more:

> "The natural lottery creates inequalities and places individuals at disadvantage without creating a straightforward obligation on the part of others to aid those in need"[9].

The sole argument to help the disadvantaged is the existence of a duty of compassionate beneficence, one that does not derive from any "right" of the other, but rather from the need to seek one's own moral perfection. For Engelhardt, the origin of this duty is a religious mandate.

It is important to note that this argument excludes two of the classic foundations of the social contract and systems to redistribute wealth. One of these is based on human rights. For the libertarians of the Washington Consensus, article 25 of the Universal Declaration of Human Rights of 1948 is meaningless:

> "Article 25
>
> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing,

> housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
>
> Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."

And, of course, article 12 of the International Covenant on Economic, Social and Cultural Rights (1976/1996) is nothing less than an aberration:

> "Article 12
>
> The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.
>
> b) The improvement of all aspects of environmental and industrial hygiene.
>
> c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases.
>
> d) The creation of conditions that would assure to all medical service and medical attention in the event of sickness."

But what is surprising is that libertarian discourse is also an anti-utilitarian discourse. Throughout the twentieth century, utilitarianism has been the enemy of egalitarians. Indeed, it is widely recognized that Rawls constructed his *Theory of Justice* (1971) and resuscitated contractarianism precisely in order to oppose the hegemonic utilitarian discourse of the time, which contained not a trace of contractarianism. And there is no doubt that utilitarianism, blindly guided by the optimistic maxim of "achieving the greatest happiness for the greatest number of people" gives rise to no small number of disasters by maximizing utilities without attending to how these are distributed. But it must also be said that the concern with welfare that is encapsulated by utilitarianism at least assumes a degree of duty with respect to others, and that this gives rise to collective, mutual obligations.

Utilitarianism, despite its shortcomings, includes a concern for others that contrasts with the rigorous, selfish individualism of libertarianism. This is hardly surprising when one recalls that utilitarianism provided some of the strongest philosophical foundations of the welfare state and public health systems that the libertarian neoliberalism of the Washington Consensus is now seeking to destroy. It is well known, for example, that John Stuart Mill, in later years, expressed more sympathy for socialist ideals than for those of the untrammelled free market.

Modern contractarianism encapsulated a permanent, dialectical tension between competing aspects of modernity: social regulation against social emancipation; the state against civil society; coercion against consent; social justice against individual autonomy; the common good against private well-being. The different ways in which the political theory of the seventeenth and eighteenth centuries sought to articulate these conflicts gave rise to the very different — and sometimes contradictory — versions of contractarianism that we can find in Hobbes, Locke, Rousseau or Kant.

According to Boaventura De Sousa, it is this dialectical tension that has underpinned the enduring strength of the social contract, preventing it from disintegrating. However, this has also rested on three assumptions of a meta-contractual nature[10]. The first is a general system of values, a basic agreement regarding the need to defend the values of the common good and the general will, "as aggregating principles of sociability that make it possible to designate society as the expression of autonomous and contractual interactions between free and equal individuals". This system of principles or values defines the mutual expectations of citizens or, as Rawls would say, specifies "a system of cooperation designed to advance the good of those taking part in it"[11]. This system seeks, in a normal, constant and consistent manner, to generate four public goods: a) the legitimacy of the government; b) economic and social welfare; c) security; and d) collective identity.

The second necessary requirement is the existence of a shared system of measures, introducing consistent criteria by which to define the space and time that frame and give meaning to our reality.

The third requirement is that the state is identified as the best historical, social, political and economic stage on which the principal interactions of the contract should occur.

The current crisis, which is not just economic but also social, political, cultural and moral, is related to the collapse of these three assumptions and, in particular, the first of them. The result is the loss of legitimacy, well-being, security and identity that characterizes the current collective stage of mind and that facilitates the progress of the destructive work of libertarian neoliberalism.

The point of this offensive is the gradual replacement of a social contract founded on the ideal of the common good, general consent, cooperation and the social aggregation of interests, with a strictly individual and private contract based on the unilateral protection of self-ownership: "I only pay taxes if by doing so I obtain a direct, equivalent benefit; as regards the rest, everyone should pay for their own, entering into contracts if they can". The result, Boaventura de Sousa argues, is a "false contract: the misleading appearance of an agreement that is actually based on a set of conditions imposed without discussion on the weaker party, a set of conditions that are both onerous and unavoidable". He continues:

> "Under the guise of a contract, the new contractualization promotes the renewed emergence of status, that is, of the pre-modern principles of hierarchical ordering by which social relations are conditioned by the position of parties in the social hierarchy. This is not, however, a return to the past. Today, status is based on the huge inequality of economic power between the parties to the individual contract; it is born from the capacity that this inequality confers on the stronger party to impose without discussion the conditions that are most favourable to him. Post-modern status takes the form of a one-sided contract. (…) It finds expression in the structural dominance of processes of exclusion over those of inclusion"[12].

The excluded, due to their incapacity to enter into contracts, are excluded from civil society and returned to a state of nature. There, according to Locke, human rights continue to exist because they are inherent to the human condition and thus "natural", but in reality such rights are only theoretical and are empty of any content because it is only within civil society that they can be exercised effectively.

In this scenario of exclusion, the inverse care law formulated by Julian Tudor Hart in 1971 is applied to perfection: "The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where this exposure is reduced"[13]. The privatization of health care — that is, private, profit-motivated health care — is the most direct way of putting this into practice.

However, this reality is hidden from citizens through the creation of an Orwellian newspeak that is both pacifying and alienating, one that allows us to talk of one-sided contracts as though they were social contracts. Thus, words such as equity, rights and equality are emptied of real content, and inequality, privatization, cuts and deregulation are replaced by other words that are supposedly neutral, descriptive, objective and scientific[14]. The legitimating discourse of neoliberal ideology thus becomes a discourse that transforms reality, in a narrative about the success of the future that awaits us, once we are finally liberated from the restrictions of the state, taxes, the public sphere and our concern with the problems of others. A future that, however, is reserved for the few, for those who have the real capacity to pay for a pension plan, life insurance and, of course, private health insurance.

It is within the framework of this discourse that it makes sense to argue that public health services are being misused by citizens and that this is aggravating the crisis, so that we need to introduce corrective measures such as paying for services or restricting rights, in order to prevent absolute disaster. However, as a general narrative this is, as I have already argued, pure ideology.

A partial acceptance of some issues

Notwithstanding the above, and considering the question of the use of health services in a more detailed and isolated manner, I am prepared to partially accept the argument that underlies the title of this session.

I am prepared to accept that there might sometimes be a morally inappropriate use of the health services by some citizens that could limit the financial solvency of the public health system in times of crisis. I use the conditional because the first problem we face is the lack of data to demonstrate that this situation — which is perceived to exist by some people and is reported in some parts of the media — is a reality.

However, what we do know, with some certainty, is that the group of people who have been held up as an example and one of the key justifications for such arguments — immigrants — neither overuse nor misuse the public health system in Spain. This is demonstrated by a number of studies[15]. It is of course also true that they could not do so even if they wanted to, for the simple reason that they have been expelled from the system thanks to a piece of legislation described, in its preamble, as "a legislative instrument to provide an immediate response, without delay, to the internal demands to improve the equity that citizens demand"[16]. In reality, this group has been chosen, first, as a scapegoat to sacrifice on the altar of ultra-conservative voters of the governing party and secondly, and more worryingly, as a lever to undermine the concept of the right to health care as a universal right in Spain. Perhaps it will not be long before they are followed by other vulnerable groups who lack the capacity to hire services on a private basis.

A second important point is that it is not necessarily the case that any increase in use of the health system necessarily implies misuse of this system. There is no data at present of the direct over-use of the health services in Spain, an increase in demand that could, in any case, be causally linked to the crisis. What we do know is that the gradual deterioration in the public health system[17], evidenced by the decline in indicators such as waiting lists, appears to be related not so much to a direct increase in demand but rather to a reduction in supply, due to the cuts in health staff and thus in services.

However, it would be far from surprising if such an increase in demand were to occur in the near future. We already have plenty of evidence that the destruction of social welfare systems (pensions, unemployment benefits, social services and health insurance) damages people's health. Directly, because "austerity kills" (David Stuckler and Sanjay Basu), or indirectly, because it increases inequality (Richard Wilkinson) and amplifies the negative impact of the social determinants of health (Michael Marmot).

As Stuckler and Basu argue:

> "Had the austerity experiments been governed by the same rigorous standards as clinical trials, they would have been discontinued long ago by a board of medical ethics. The side effects of the austerity treatment have been severe and often deadly. The benefits of the treatment have failed to materialize. Instead of austerity, we should enact evidence-based policies to protect health during hard times. Social protection saves lives. If administered correctly, these programmes don't bust the budget, but (…) they boost economic growth and improve public health"[18].

Thus, in the event that such "over-use" existed, it would be perfectly reasonable and ethically fair. In this respect, any form of limiting access to health systems by referring to the "moral hazard" of a supposedly inappropriate use would not solve the problem but would rather, paradoxically, aggravate it both technically and morally.

Having listed these caveats, I can accept that, with or without the crisis, there may be citizens who misuse the public health services, and this is morally unjust.

In this case, the first thing we have to ask ourselves is why. What leads some citizens to repeatedly call the emergency services without clinical justification or to consult their family doctor with excessive frequency, to consume too many drugs or to demand inappropriate diagnostic tests or surgery?

A range of different answers to this question have been offered, and a variety of models proposed, of which perhaps the best known is that put forward by Andersen, which identifies predisposing characteristics, enabling resources and need as conditioning the decision to use health services[19].

I will focus on five possible reasons that are not necessarily exclusive and that may operate jointly (and indeed usually do so):

1. A lack of information about how to use public health services appropriately. However, this must go behind the personal responsibility of individuals to find information and must also include the responsibility of health professionals and the health authorities to actively provide such information. We should not forget, after all, that this is a right of all citizens, set out in article 12 of Spain's Patients' Autonomy Act (2002). The obligation to inform and educate citizens in the correct use of public health services should also be considered to be one of the responsibilities of the media and the education system. In this respect, the decision in Spain's most recent educational legislation (LOMCE) to no longer make education for citizenship a compulsory subject, which would have provided an ideal framework for educating future citizens about such matters, should be seen as one more strategy of libertarian neoliberal capitalism as part of its efforts to eliminate any form of critical civic education.

2. Vulnerability and social isolation, loneliness and fragility that, in the context of the weakening of other social support networks, leads people to seek help from the health services which, at least for the moment, continue to be easy to access. However, in this case the solution is not to implement measures to directly limit demand, such as through charging, but rather to redirect it by generating adequate social support systems. Moral blame and labelling vulnerable citizens as irresponsible, selfish and wasteful is, in this case, particularly reprehensible.

3. Anxiety derived from the desire for immortality and the difficulty in handling the uncertainty that is inherent in life and the inevitability of death. The search for certainty and for "zero risk" is inherent to the modern condition, as too is the discovery that they do not exist. But, in times of economic, social and political insecurity, this is exacerbated and, it must be said, health professionals and health authorities, with their technological imperative and their frequent authoritarianism, have made a significant contribution to this increased anxiety.

4. Hypermedicalization of the concept of health and its conversion into a consumer good: the creation of "diseases" and their corresponding "treatments" and "preventive vaccines", the obsession with technological diagnosis and therapy, and the simplistic reduction to health terms of any form of discomfort. All of this fills the consulting rooms of our health centres just as it filled those of Dr Knock[20]. But once again the responsibility of professionals, of pharmaceutical companies and of health authorities is central because, in the first instance, they all benefit from converting health into a consumer good and creating a health market, aware to a greater or lesser degree that supply creates demand. Until suddenly health professionals and public administrations become incapable of satisfying this demand and fall victim to their own success; this is not the case with pharmaceutical companies and private health providers, who are always able to keep abreast of demand because this is the object of their business, hence their interest in the privatization of the system and the liberalization of the health market, all of this in ideological concordance with the Washington Consensus.

5. Inflation of the concept of "right" to such a degree that it provokes "moral hazard". In this, the responsibility of the political class is central, although it is not exclusive. We have generated so many rights — with regard not only to health but also to almost any aspect of coexistence — that some citizens have come to view these as absolute or unlimited, so that they can exercise them whenever and however they wish, without attending to any criterion other than their own subjective wishes, their impulsive perception[21].

Let us now make a provisional assessment of these five reasons. While recognizing the dimension of personal responsibility that always exists in any inappropriate behaviour, in the first four reasons citizens are more sinned against than sinner. It is, rather, the health professionals, in the first instance, and also the health authorities, the pharmaceutical companies and the political class that appear as the main direct or indirect promoters of behaviours that lead to the poor use by citizens of public health services. It is grossly unfair to blame citizens for this and to punish them directly by restricting their access to services.

The fifth reason is more complex. Although we have pointed to the responsibility of the political class for the phenomenon of "rights inflation", the reality is that the political class is nothing more than a mirror of the citizenry. Here, there is a model of citizenship that views justice and rights through a strictly individualistic and selfish prism. This model has flourished in Spain as the crisis has continued and the state and its basic political institutions have been weakened. It is possible to observe a rapid decline in the collective beliefs and ethical values that, as John Rawls argues, sustain a society that "is fundamentally a system of social cooperation based on the recognition of certain rules that are obligatory for all, that enables us to live better than if everyone lived only by their own efforts". It is, therefore, not only an institutional problem: it is basically a personal one, and is related to selfish behaviour. The Rawlsian approach is insufficient because, as Gerald A. Cohen says:

> "If, as I now believe, how selfish people are affects the prospects for equality and justice, then that is partly because, as I now also believe, justice cannot be a matter only of the state-legislated structure in which people act but is also a matter of the acts they choose within that structure, the personal choices of their daily lives. I have come to think, in the words of a recently familiar slogan, that *the personal is political.*"[22]

It is necessary, therefore, to adequately integrate into the life of each citizen what Thomas Nagel calls personal and impersonal points of view[23]. The first has to do with one's own subjective moral position, and is related to the personal ideal of happiness. At the same time, the impersonal point of view is what allows us to put ourselves in another's place, to generate a "generalized other" and acquire political awareness, to have a sense of justice and of compassion, to oppose inequality and be citizens, not mere atomized, jealous and selfish individuals, taking refuge in our private life. The product of this integration is what the republican tradition has always defended as civic virtues[24]. A truly just society is only possible when, in addition to seeking to generate basic social structures that promote this justice, each of its members, the citizens, seeks to live and to act justly in every sphere of their lives: that is, when personal, private morality is accompanied by an impersonal, civic ethic. Otherwise, when civic virtues falter, moral hazard flourishes and "corruption" appears, leading us, for example and among other things, to misuse public health services because "they are mine, I pay for them with my taxes, with my money, and therefore I can use them as I see fit without heed to any consideration other than my own personal benefit".

When this destructive process began in Spanish society is an issue for debate. It may be that the institutional crisis unleashed by the economic crisis is in reality the expression of a political transition that, having been held up as a model for so many years, we are beginning to see as deeply flawed. And the principal flaw, as Teresa Vilarós has argued[25], stems from the process of the hollowing out of the public political conscience that began at the moment that the Franco regime began to die, with the assassination of Admiral Carrero Blanco. According to Vilarós, the "hyperideologization" — fundamentally from the left — of the transition was in reality a mirage that concealed the true desire at the heart of Spanish society as the Franco period was coming to an end. Behind the ideal of "freedom without anger" there was not a wish to "make a revolution" but rather a desire to join the consumerist society to be found in "liberal" western societies.

The crater left by the car bomb that killed Carrero Blanco in December 1973 soon filled with murky water. Over this hole, with its hidden desires and the remains of Francoism, an anaemic liberal democracy was built, one that encouraged a lack of political awareness and stimulated historical amnesia, individualism and selfishness. Today, this democracy resides in a rundown building in Lonely Street, on the outskirts of Dogville. And if we want to move into a better neighbourhood without once again missing the bus, we need a second political transition. The territorial model is one of the problems that must be resolved, although, in my opinion, it is neither the first nor the principal challenge to be addressed, not least because there is a real problem that, by seeking to address this issue, we will merely bring about further polarization that obscures the key issues.

Only through an approach that stresses the need to close the political divide of the unfinished transition will we be able to understand the fifth reason for the wasteful behaviour of some citizens in relation to the (mis)use of public health services. And only then will all of us be able to work together to reconstruct, in a healthier manner, the complex relationship that exists between needs, rights, wishes and preferences in the health sphere. These are the axes around which we must construct — or reconstruct — efficient and fair public health services.

And so, what should be done?

Implicit in the analysis set out in the preceding two points are various suggestions about what should be done. But there are no easy remedies or simple truths. We cannot be naive. It goes without saying that lots of different people need to act at many levels and over a long period of time to obtain meaningful results. Perhaps the ten most important and urgent tasks are:

1. To stimulate our capacity to be indignant, to rebel and to act peacefully but in an organized manner to resist the advance of public policies based on the ideology of libertarian neoliberalism. This is a time for rebels, not for those who prefer the comfort of the private sphere.
2. Reinvigorating public life and basic political and social institutions, introducing a clear republican corrective to our unhealthy liberal democracy; bringing about a second political transition.
3. Improving the ethical and political education of citizens, including health professionals, from the cradle to the grave: encouraging civic virtue in which citizens are austere in the private sphere and generous in and with the public sphere.

4. Struggle determinedly against the creation of an Orwellian newspeak in politics and health, to uncover the truths that are concealed by the false words of neoliberalism.
5. No cuts, repayment or privatization, but instead increasing public investment in health and optimizing its management, eliminating inefficiency in a decisive and, if necessary, ruthless manner. Central and regional health administrations bear the prime responsibility for implementing the appropriate reforms in this regard, but they will only do so if citizens and health professionals force them to.
6. Demedicalize, divert resources away from unnecessary activities, rationalize the portfolio of health services and increase preventive measures. Health professionals are essential agents in this task. It is a strict ethical obligation to commit to it in a decisive manner. However, the involvement of health administrations, the political class and associations of patients, consumers and service users is vital if it is to be carried through. And contact and cooperation with the pharmaceutical industries should be regulated and limited to what is strictly necessary, given that these form part of the financial lobby of global capitalism.
7. Reducing overall hospital health spending and, instead, increasing public spending on primary care, mental health, public health and the social care sector. Citizens and scientific and professional organizations should demand that political organizations make clear, explicit and measurable commitments to this effect.
8. Making significant progress towards the active, political participation of citizens in the management of the health system. At present, these levels of participation in Spain are generally minimal and of a “symbolic” nature according to Hart’s ladder[26]. The second political and health transition should take us to level 8 participation according to the Hart ladder: decisions initiated by citizens and coordinated with others — administration, health professionals — so that they are implemented effectively. But this requires a level of courage that almost no political party appears to possess at present.

9. Reinforce the ethical identity of public health professionals as against identities of a corporate, collegiate or merely personal nature. This requires a major change in health education at undergraduate, postgraduate and professional levels, a change that to date we have not witnessed in Spain. Despite the progress of recent decades, paternalism continues to be the dominant ideological framework of health professionals, and shows great resilience and a capacity to reproduce itself in each new generation. Many of these, unfortunately, would uncritically accept the assumptions that underlie the title of this session.
10. Resist.

Notes

1. A good compilation of this data can be found at: European Observatory on Health Systems and Policies and Andalusian School of Public Health. The health and financial crisis monitor (HFCM), 2013. Available at: http://www.hfcm.eu
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Contributions from participating health professionals

Macario Alemany

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Over recent decades, bioethics in Spain has, with the occasional exception, reflected two agendas: the bioethics agenda of the English-speaking world, and the set of issues raised by the doctrines of Spanish Catholicism. As an example of the first, I would point to the myriad of studies dedicated to patient autonomy and, in particular, the rule of informed consent. As an example of the second, one could mention the innumerable discussions of questions such as whether a frozen pre-embryo has the same moral significance and deserves the same legal protection as, for example, the reader of this document; whether a competent adult can freely decide to cease suffering when there are no prospects of recovery and whether, as a result, that individual has a right to euthanasia (I am thinking, for example, of cases such as that of Ramón Sampedro, whose situation was the subject of the film *The Sea Inside*); whether the power of guardianship includes the power to compel a sixteen-year-old daughter to take a pregnancy to term when she does not wish to do so, and so on. A first conclusion of the seminar, and one that is in my opinion extremely important, is that as a result of the crisis the shortcomings of our healthcare system have been exposed, and there is a clear need, one that is unanimously recognized, to completely reorganize our priorities. Pablo Simón Lorda's call to "action" should, I believe, be understood as a call to preserve what is most important: the right to health and the basis of an equal society.

The question that has been unduly ignored but is nevertheless fundamental is that of responsibility. Above all, there is the question of responsibility in the sense of causal responsibility: that is, whether a phenomenon can be properly explained as the result of the actions or omissions of a given agent. In this respect, there are two key questions: responsibility for the crisis in the funding of public health systems, and responsibility for the increase in the population living in poverty or at risk of falling into poverty. The first of these issues, the responsibility for the crisis in the funding of public health services, can be viewed from two perspectives: from the perspective of income, and from the perspective of expenditure. I believe there is almost universal agreement in recognizing that the crisis of 2008 has been, in the first place, a financial crisis, and that, in Spain in particular, the effects have been amplified by the completely irresponsible behaviour, at times even criminal, both of regulated economic agents (banks, savings banks, insurance firms etc.) and of the regulators in the widest sense (government agencies, ratings agencies, the financial media etc.). However, if we look at the issue from the perspective of spending, our view of the crisis changes: from this perspective, we must consider the actions of health professionals and those of the users of health services. The presentations by Jaume Puig and Pablo Simón both focused on the behaviour of service users.

Jaume Puig sought to rebut the fierce criticism that the introduction of pharmaceutical co-payment has aroused. Recognizing that we need far more information about the management and use of health services (a shortage of information noted by all the contributors), Puig put forward a defence of co-payment not as a funding measure ("repayment") but rather as a means of generating an appropriate structure of incentives (within a "behavioural economics" framework) to prevent the misuse of drugs by service users, one that has been tolerated for decades in Spain. However, the alarming current trend towards drug prescription levels similar to the situation before the introduction of co-payment suggests that we should look, in the first instance, to health professionals when investigating the responsibility for excessive spending.

Pablo Simón offered a very cautions investigation of the issue of the responsibility of the users of health services. His presentation set out the difficulties that this question poses if we wish to avoid using it as an argument in favour of reducing the welfare state (which, in the terms of the dominant ultra-liberal ideology, entails an unacceptable "moral hazard"). At the same time, he argued that the excessive emphasis on individual rights has completely overshadowed the question of the responsibility and social obligations of individuals. A very similar approach was implicit in the contribution of Antonio Casado in his description of Icelandic society, characterized by a strong community spirit that contrasts with liberal individualism.

The three other papers (by Ildefonso Hernández, Begoña Román and María José Fernández Sanmamed) considered the question of where responsibility for the growth of poverty lies. Ildefonso Hernández highlighted the need for more information on the impact of the crisis. The phenomenon of resilience, addressed in all three of these papers, makes it clear that the causes of poverty are extraordinarily complex. In particular, the issue of suicide appears to raise more doubts than certainties. María José Fernández, in addition to calling for more research in this area, argued for a more qualitative than quantitative approach to determine the scope of the phenomenon. Finally, the three agreed on the necessity of opening up more channels for communication between health service users and health professionals, and for an emphasis on human rather than technological solutions.

In conclusion, if bioethics arose as a pragmatic application of ethics, the seminar highlighted the need to renew this perspective, with greater attention to the most pressing problems of our society, among which the issue of responsibility is perhaps the most important of all.

Gracia Álvarez

President of the Clinical Ethics Committee, León Health Region

It is clear that economic crises have a negative impact on people's health. We can identify at least two consequences of the crisis to which this negative impact can be attributed: the lack of work and the reduction of the financial resources that the state allocates to the public health system. The question is how, as health professionals, we should address this situation.

Ortega defined ethics as the art of choosing the best behaviour. On this basis, if the issue is how to respond to the negative impact of the crisis on health, then the role of bioethics is to help professionals choose the best response from those available. And it is for this reason that the event included professionals active both in the field of health and in that of ethics.

What are the consequences of unemployment? The first is a reduction in the economic resources available to individuals and their families, leading in turn to shortages of the resources allocated to food, hygiene, housing etc. Secondly, there is a reduction in the resources allocated to education, bringing not only a lack of knowledge about health issues but also reducing people's capacity to access the education that would enable them to gain employment in the future. Those affected in this way are less able to adapt to the social changes that occur in a crisis.

Another consequence relates to the role of work as a source of social integration. Unemployment weakens social ties and undermines the social dimension of our lives, which in turn has a negative impact on health.

In this situation, health professionals ask ourselves what we can do to cushion the negative impact on health. Our responsibility as health professionals is to help people to deal with this new situation and its impact on their health; the challenge is how to do so.

I would argue that such help must be offered on the basis of respect for people's autonomy, understood as the development of a person's capacity to deal with this situation. The role of health professionals in the clinical relationship is therefore vitally important but by no means straightforward. The principal characteristic of a clinical relationship that promotes people's development and their capacity to respond to health problems is deliberation. We need, then, to abandon both the paternalistic model of the clinical relationship, in which users of the health system were excluded from decisions about their health, and an approach based on absolute tolerance, in which the decision is taken by patients without the support of the professionals who possess specialist knowledge in this area. If health professionals contribute to health decisions, these will be better precisely because they can help to narrow down the choices to help patients identify the best option.

This accords with the views put forward by Antonio Casado da Rocha. He referred to Professor Gracia when he argued that "the notion of autonomy that is emerging in contemporary bioethical theory is relational, narrative and constructivist". The way to recognize autonomy is through the process of deliberation. It is by deliberating with others — with patients or users of the health system — that we recognize the other as equal, and acknowledge the importance of their experience. This, in my view, is the principle that should govern our conduct as professionals and that should serve as a guide when we establish the clinical relationship.

What interventions can and should we implement, at the primary care level, to help the population to cope with the crisis in the best way possible? I would argue for the importance of health education, a sphere that has been undervalued and neglected in the recent past. It has been ignored in favour of activities that focus on short-term interventions designed to deliver a rapid response that requires little effort. It is easier to write a prescription than to make the effort to educate users of the health system in healthier ways of living and eating. Insisting on this issue, striving to reach agreements, helping people to change their habits and lifestyles, and doing so in an atmosphere of respect that does not involve "washing our hands of patients" requires effort and commitment, and not only more time (although health professionals tend to focus almost exclusively on this last requirement). The desire to change is the most important of all, because this is what enables us to seek out knowledge and develop the skills we need to achieve our objectives.

It is also easier for patients to take a pill than to modify unhealthy lifestyles; it is easier, but not as beneficial in the medium and long term. It is important that health education occurs both at the individual and the group level. Group education is important because of the social bonds that it creates between participants, the benefits people derive from sharing information, and the efficiency of providing information to several people at once.

In contrast to other more technical interventions, education has the advantage of establishing relationships between people; it is beneficial in and of itself by virtue of the way that it contributes to maintaining social connections. The weakening or breaking of such connections, as Professor Román argued, is one of the determinants of the risk of social exclusion.

One consequence both of a deliberative clinical relationship and of educational activity is the better use of public services and a better appreciation, by users of the public health system, of the contribution of health professionals and the value of the system itself. I believe that this relationship would help many citizens to stop seeing us merely as issuers of prescriptions and to view us, instead, as agents who contribute to improving their health, accompanying them on their life's journey and helping them to cope with the many challenges they face along the way. A journey during which we reveal our vulnerability as human beings and our reliance on others to adapt to the different situations that arise. Serious dependency can affect us in at least two ways: when we ourselves become dependent or when we have to care for others. Both situations are difficult to cope with and we need the help of others if we are to do so successfully.

The deliberation that we propose as part of the clinical relationship could provide support to those seeking to manage the frustration that they feel when their health expectations are disappointed. Throughout people's lives, in different spheres, there are all sorts of expectations that are not met and that generate frustration, but those relating to health and illness are perhaps the most sensitive. Deliberation and dialogue enable people to construct more realistic expectations about what to expect from medicine, understanding its limitations as a science and the restrictions on its ability to restore people to full health or to extend people's lives to an unprecedented degree.

Another potentially interesting proposal concerns the development of qualitative research. This enables us to obtain a more accurate understanding of problems in their context. Rather than studying phenomena in isolation, the aim is to consider them in terms of the context in which they occur, and how they relate to this; it also means accepting that the search for knowledge can never be free of ideology, and that researchers therefore need to identify their own starting points. It is also important to consider the context, because we are discussing the impact on health of external factors or social determinants. Talking about the social determinants of health recognizes that the social context affects people's health, and this is why we cannot consider health issues in isolation.

The choice of research subject is also a reflection of what the researcher deems to be important, and this is inevitably a value judgement. Indeed, the ideology and values of individual researchers are an integral part of any research effort, which should start with an attempt to define and recognize what these values are.

There are a number of qualitative research procedures, of which we can highlight two. One is theory-based, in which the study of a specific problem allows us to see how a given group of people deal with this problem, and what resources they use to do so. An example can be found in the work of C. De la Cuesta-Benjumea, "La artesanía del cuidado: cuidar en la casa a un familiar con demencia avanzada" [The craft of care: caring in the house of a relative with advanced dementia] (*Enfermería Clínica*, 15, 2005, pp. 335–342). Another is the procedure of participative action-research, which seeks to make changes to the situation studied, and to do so in light of reflection upon what is happening. An example of this approach to research can be found in the work of P. Delgado Hito et al., "Modificación de la práctica enfermera a través de la reflexión: una investigación-acción participativa" [Modification of nursing practice through reflection: participatory action-research] (*Enfermería Intensiva*, 12, 2001, pp. 110–126). The intention is not to abandon quantitative research, but rather to provide another way of looking at the situation that enriches our understanding of it. We need to identify adequate tools to change this context and create a setting that is more favourable to our development as human beings.

At the start of this discussion, we identified the reduction of resources allocated to the public health system by the state. This means that we must evaluate it and make it more effective, focusing on the development of people's capacities as human beings; recognizing that illness, disability and ageing cannot be eradicated, and that we must be more modest in our aims, seeking to improve quality of life, "adding life to our years, not just adding years to our lives". Throughout the discussion there were a number of interventions along these lines. Health education is just one example of such an activity. We need to distribute resources better rather than cutting back on spending without regard for the consequences, as cutting in the wrong areas may have a greater negative impact on the health of the most disadvantaged and the most vulnerable.

Josep Maria Busquets

Member of the Bioethics Committee of Catalonia

Public health, like other social sciences, needs to be validated through the formulation and testing of hypotheses. Is there more malnutrition as a result of the economic crisis? Do more people commit suicide? Has general or specific mortality increased?

There is data to support some hypotheses, while others are less clear, and many are subject to differing interpretations that provide a basis both for defending and for criticizing the effectiveness or advisability of specific interventions. For this reason, without renouncing scientific or methodological rigour, we should also remember that the statistics handled by economists, sociologists and — to a degree — public health professionals, do not reflect the true nature of individual suffering. This is the reason for the deep scepticism towards purely statistical studies both in the political sphere and among specialists in these disciplines.

Since the middle of the nineteenth century, when Virchow attributed the state of people's health to social and economic causes, numerous studies have shown that ignorance and poverty are the main causes of disease. While these reports do not reveal anything that is not already obvious to all of us, we continue to remain obsessed with proving — through methodologically rigorous tests — the impact of policies that generate or fail to reverse inequalities. Even though the suffering of those who do not commit suicide and who do not appear in the statistics may be far greater than the suffering of those who choose to end their lives, this is not the object of such concern. And this leads us to a sad paradox: preventing the death of those who wish to die has a higher priority than preventing the suffering of those who wish to live.

Public health professionals should strive to remember the importance of this suffering, even if it is those working in other branches of medicine and the caring professions who are in contact with it on a daily basis. We need to seek to take greater account of the experiences and perceptions of the citizens to whom public health recommendations are addressed, with the result that some screening tests or preventive interventions would be given a different priority while others might be abandoned altogether. The challenge is not to adopt confrontational positions, but rather to encourage pluralistic, multidisciplinary deliberation as to the suitability of interventions. We also need to accept that the rejection by citizens of some tests, which they often see as an imposition, should be accepted more willingly and respectfully, especially when not performing these tests does not represent any risk to third parties and little risk to individuals themselves.

Public health should show a greater concern to respect people's wishes in a way that is already done, at least to some degree, in the medical care disciplines. While these, for their part, should be more aware of the need to ensure the fair and equitable distribution of the resources at their disposal.

As I said earlier, there are some situations of inequality that generate such clear health differences that there is no need for further analysis, and this is particularly so when we see that research findings do not lead to changes at the level of policy. We need to find new strategies that place solidarity and respect for our neighbours at the centre of our health systems. Greater citizens' participation at all levels will enable us to identify this strategy.

We should start from the premise that defending people's dignity, the fair distribution of resources and establishing equitable priorities are not just technical questions to be resolved exclusively by the specialists but are, rather, questions that, by virtue of their ethical content, require reflection and action of a truly collective nature.

Javier García León

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There are two issues that I would like to raise: the role of ethical deliberation in the political decision-making process, and the concept of the socioecological niche in our approach to social exclusion.

The reduction of spending on health and social policies has been part of the effort to reduce public spending in some countries, including Spain. These measures, required by European monetary authorities, have been implemented in Spain as the result of a decision-making process that is not viewed as just by the Spanish population.

This decision has been analysed from a number of perspectives, but there has been insufficient focus on the ethical aspect. A recently published study is helpful in this regard[1]. The values and principles applied by the European economic authorities may not agree with those of the citizens of the countries to which these decisions are applied, and nor are they consistent with the shared values and principles for health systems established by the European Union itself: equity, solidarity, universality and access to quality care[2].

When governments have to distribute scarce resources between different sectors of society, they are faced with a moral dilemma, and their decision should be based on ensuring the fair distribution of welfare within society. Powers and Faden[3], in their ethical theory of justice, argue that there are various dimensions of welfare for which certain minimum standards must be guaranteed for all: health, respect, security, self-determination, reasonableness and relevance. These are non-negotiable and, in the case of health, closely linked to the other dimensions, some of which are numbered among its determinants. This means that we need to focus on approaches that stress cooperation between different sectors, rather than competition for resources.

Daniels and Sabin[4] help to establish a minimum ethical analysis for the distribution of scarce resources in times of recession when it is not possible to cover everyone's needs: if it is not possible to guarantee justice, because we lack the means to guarantee well-being, then at the very least the decision-making procedure must be fair and there must be clear accountability. If the distribution of resources is to be fair and legitimate, then we need a decision-making process that is not only fair but also satisfies the following conditions:

1. The process must be transparent, including the reasoning behind whatever decisions are taken.
2. Decisions should be based on well-grounded, relevant arguments, and have the agreement of the parties involved.
3. Any decision can be modified if grounds for doing so arise.
4. Decisions should not be discriminatory or stigmatizing.

The decision-making process in Spain bears little relation to these criteria. The absence of a culture of accountability among politicians or of a culture of transparency in public bodies goes hand in hand with the insufficient use of evidence in decision-making and a lack of sensitivity to the impact that measures may have on social inequalities.

It is precisely these inequalities that we know have increased as a result of the crisis. The proportion of the population affected by social exclusion has risen from 23 per cent in 2007 to 28 per cent in 2012; over the same period, the percentage of households in extreme poverty has risen from 4 per cent to 8 per cent. Inequality has risen because it is the working class that has been most impoverished, with unskilled workers being particularly hard hit. The liberal professions, managers and businesspeople are the groups least affected by the crisis, both with regard to unemployment and in terms of loss of income[5].

Begoña Román's analysis threw a lot of light on this issue by setting out the risk factors for social exclusion and describing new types of social exclusion. She discussed the risk factor associated with the lack of material resources, to which the traditional response has been the provision of welfare, and talked about how in the current situation there has been a return to charity-based approaches (at the same time, we have also seen proposals to introduce basic income guarantees, although these have been criticized for taking a personal rather than collective approach)[6]. The second risk factor to which she referred was the lack of personal and social capacities, and the third was the lack of social connections; obviously, the loss of employment promotes (or may promote, depending on the support available) some or all of these risk factors. She also referred to the new profile of the excluded: young people, those aged over 50, single-parent families and large families, and how these risk factors may affect these groups differentially.

This struck me as an interesting basis for establishing intervention strategies because actions aimed at people at risk of exclusion cannot be based simply on the study of disease or on a strategy of offering support to those who are isolated. I recall a concept explained by Professor Enrique Nájera, based on what he calls "socioecological niches". Each of these niches is characterized by certain forms of production, relationships and values that shape how we live, how we become ill and how we die. Rather than focusing on how to measure the effect in terms of lifestyles, illness and death, our interventions should be focusing on factors that promote development or maintain social exclusion.

Such an approach would shift our interest toward people's living conditions and away from a narrow focus on the resources that support the care process or outcomes in terms of illness and heath. The risk factors and new forms of exclusion identified by Begoña Román provide a potential starting point for the identification of the socioecological niches in which those who are most affected by the crisis live.

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David Larios Risco

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I. Populations that are particularly vulnerable to the crisis and the most effective preventive interventions (health and non-health)

The implementation of measures to palliate the impact of the current political, financial and economic crisis on the health of the population is already supported by a clearly defined ethical and legal framework. The ethics of minimums represented by laws approved as part of the framework of social and democratic rights obliges public bodies to take action to mitigate the direct and indirect effects of lower quality of life.

The Spanish Constitution of 1978 charges public bodies with the task of organizing and protecting public health through preventive measures and the provision of the necessary services (art. 43.1); to promote the conditions for the free and effective participation of youth in political, social, economic and cultural development (art. 48); to implement policies for the provision, treatment, rehabilitation and inclusion of those with physical, sensory or mental handicaps, who will receive the specialist care they require (art. 49), and to promote the well-being of citizens of the third age through a system of social services to attend to their specific needs for health, housing, culture and leisure (art. 50).

These mandates constitute guiding principles of social and economic policy and are designed to inspire positive legislation and actions by public bodies. In developing these principles, numerous laws and regulations have been passed, which it would be tedious to list in detail but the ultimate purpose of which is — or should be — to guarantee dignified levels of protection for the country’s citizens.

The serious damaged being inflicted on these guiding principles as a result of the measures adopted in response to the financial crisis, in particular by means of urgent provisions that are inserted into the legal system, without the guarantees built into normal legislative procedures, through the abuse of the formula of Royal Decrees, rather than mitigating health and social problems, is instead aggravating them.

Pressure from citizens and the positions of professional organizations, trade unions, NGOs etc. appear not to be enough to force the authorities to reconsider their strategy of cutting social provisions, and as a result many of the rules and actions being implemented seriously compromise the constitutional requirement to protect health and promote social development, increasing the risk of health and social exclusion for the most vulnerable.

In this context, it is essential that citizens engage in ethical debate and demand their rights. Ethical and legal analysis with respect to the distributive justice of public resources has been a neglected subject in the past and is a challenge for the future.

II. The impact of the crisis on mental health. The case of suicide: myth or reality?

The data on deaths from suicide in Spain shows a clear worsening of the situation since the beginning of the crisis, to the point where the current situation can be defined without qualification as a serious public health problem, a silent epidemic in which the authorities, instead of addressing the problem and developing preventive actions and policies, cover it up both in their eagerness to hide one of the most shameful effects of the economic crisis and in their refusal to recognize that current suicide rates in Spain denote our failure as a society.

This passive and secretive approach by the authorities represents not only an attack on the ethical principles of responsibility, beneficence and justice, but also a clear disregard for their legal obligations. To give just a few examples, the authorities responsible for health and social services would be violating the obligations created, among other laws, by Act 33/2011, of 4 October, general legislation on public health, regarding the provision of information to the population with respect to the existence of threats to the health of the population (art. 10), on public health surveillance, requiring the existence of early warning and rapid response systems to detect and evaluate incidents, risks and other issues (art. 12), and the obligations relating to the promotion (art. 16) and encouragement of health (art. 17).

The outmoded belief that publishing suicide data would lead to a copycat effect among the population (the so-called Werther effect) cannot be used as an excuse for the authorities to continue to evade their responsibility with regard to this problem, nor for them to continue to neglect their duties in this area of public health and the serious harm that this neglect causes.

III. The morally correct use of public health services in times of crisis: the role of health professionals and the role of health service users

The way in which both the central government and the regions in Spain have regulated people's entitlements with respect to public health services by drawing up never-ending lists of "rights" leads us to consider whether these (largely rhetorical) rights need to be balanced by the obligation of citizens to use these services in an appropriate, reasonable and responsible manner.

With regard to health professionals, the legislation that regulates the health professions includes the duty to ensure that their use of the diagnostic and therapeutic resources administered in their role as public servants is both appropriate and reasonable.

The shortage of resources as a result of cuts to the health and social services budgets could also be an opportunity to modify patterns of the irresponsible consumption of resources by citizens and health professionals alike. In this, the role of health professionals is key, as health demand is determined primarily by health professionals as a result of the indication and prescription of treatment.

Ricard Meneu

Vice-President of the Health Services Research Institute Foundation in Valencia

In the first session, "Populations that are particularly vulnerable to the crisis", the approach was perhaps too general, identifying structural actions that should provide the framework for public health recommendations in response to the crisis: the need for an inter-departmental approach that involves placing particular emphasis on education as one of the best safeguards against inequality; the need for a more effective, transparent and responsible regulatory framework to limit the intrusion of private as opposed to social interests; employment policies with a particular focus on groups at risk of exclusion, and the consolidation of transport policies that reduce pollution and promote physical activity. All of these approaches, which are desirable both from a health and an ethical perspective, should be included in the primer for those producing manifestos, articles, commentaries and speeches in this area.

However, a crisis would appear to demand concrete, targeted actions that are easy to monitor and which, in addition to promoting the common good, limit the impact on the most vulnerable. We urgently need to debate which interventions actually fit this definition and who the target of these interventions should be, including a discussion of the degree to which they should focus on individuals or on selected groups. In any case, I believe it is essential that, in addition to insisting on broad guidelines for public health actions, we immediately develop a concrete definition of priority measures of proven efficacy that ensure a minimum level of protection from the impact of the crisis.

At the same time, there are efforts in the healthcare sector to develop specific, scientifically validated lists of procedures that should not be offered, because to do so when they contribute no value diverts scarce resources away from better alternatives. However, in light of what has already been said, it is worth noting two obstacles that stand in the path of such a development: firstly, the reluctance of our decision-makers to adopt fair and reasonable measures that are based on scientific knowledge; and secondly, the angry reaction of citizens to such proposals, interpreting any reduction of provision as a "cut" to their rights and an assault on equity, regardless of the fact that "waste is not subject to moral rules governing its distribution, but is instead immoral in and of itself"[1].

In the second session, "The impact of the crisis on mental health. The case of suicide: myth or reality?" two major objections arise. The first refers to the data and how it is used, while the second concerns an undue focus on suicide as an indicator.

With respect to the data and its rhetorical use, the methodological weakness of many of the studies and their tenuous relationship to the discourse they are supposed to support is frankly irritating. In particular, the study by López Bernal et al.[2] — which should not have passed a competent peer review process, as some of the responses to it have shown[3] — far from providing evidence of the biased arguments it is alleged to support, in fact contradicts them. Rather than providing evidence in Spain of a link between suicide and rising unemployment, the peak (an artefact?) it identifies actually occurred prior to the onset of the crisis. And since then, despite massive job losses, the suicide rate has remained below this level.

At the same time, and without wishing to deny the importance of mental health problems in many suicides, it strikes me as a crass error to seek to portray suicide as the supreme expression — in each and every case — of mental illness. It should not be so difficult to recognize that, faced with the irreparable failure of one's life project and the absence of any prospect of a solution, the decision to put an end to one's own life may, in such circumstances, have nothing to do with any psychiatric disorder.

In the third session, "For the morally correct use of public health services in times of crisis", there was broad agreement with the dissatisfaction expressed by Pablo Simón not so much with respect to specific actions as with "the map they draw". But it is not enough simply to replace this map with one depicting the land of Oz, greeted by shouts of approval that cannot help but remind one of Dorothy clicking her heels and crying, "Take me home to Aunt Em!"[4].

And this is because, after several decades of studying variation in the use and suitability of the services of the National Health System, seeking to measure quality and safety, recognizing achievements while remaining aware of the weaknesses, I do not believe it is desirable to simply try to roll back the years as if none of this had ever happened.

The surprise expressed by many health professionals in response to a rigorous description of the development of our co-payment system, such as the one presented by Jaume Puig, raises doubts as to what some of their beliefs are actually based on. If people are ignorant of the fact that co-payment has existed for decades and that it was already at quite high levels and applied in an extremely unfair manner, and then proclaim the immorality of its current design because it contradicts the principles of equality and free care (even when these never existed or were only applied in a completely haphazard manner) then it is hard to avoid drawing some fairly depressing conclusions. Principally, that certain "moral principles" or, more accurately, a particular interpretation of them can be applied in a wholly subjective manner, declaring a practice to be ethically unacceptable in Spain even when the same practice has been widely applied and accepted in countries that pay far greater attention to health inequalities. Or worse, that the analysis that underpins these principles is based on a clear — and unforgivable — lack of information. Wishing to return to a state that never existed simply because some people believe that it did neither validates this supposed Arcadia nor guarantees that the system inspired by it will be well-designed, built as it is on cognitive bias, ignorance and misinterpretation.

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The political meaning of words: insurance holder or citizen

The economic crisis has also ushered in a crisis of ideals. Although perhaps it would be more accurate to say that the crisis has been used as an opportunity to undermine those ideals that fail to conform to what appears to be the sole driver of today's economy: the enrichment of a small minority. It is in this context that we must understand attempts to impose the notion that the current public health system is unsustainable. This is the motto of the neoliberals who argue for private funding of basic services.

It is used to justify initiatives such as the 2012 legislation establishing a range of reforms to the public health system. These include the concept of insurance holder and beneficiary, designed to limit access to public healthcare. This is a return to the social security system prior to 1986, the date on which funding of the public health system through taxation was introduced.

The exclusion from public health care of groups who do not pay social security contributions and are at risk of being marginalized, such as undocumented immigrants or young unemployed people, whose only means of accessing the system is through emergency services, is in contradiction with the supposed purpose of the decree, which is to save resources.

Using the emergency services as the sole means of providing healthcare to people who do not have social security coverage actually leads to increased health spending. Patients only receive care when their illness is at a more advanced stage and with more serious complications that require more resources, including more hospital admissions. At the same time, it creates a trend towards using the emergency services to care for all sorts of patients, and this distorts the operation of these services and undermines their efficiency. We also undermine the public health goals of promoting and monitoring community health and preventing health problems if we fail to integrate and attend to vulnerable groups at risk of social exclusion.

It is, then, more vital than ever that we reaffirm the concept of the citizen, and that we restrict the concept of insurance holder and beneficiary to the sphere of private health insurance, because such notions are incompatible with the concept of a public health system. It is our condition as citizens that is the basis for our access to public services, on the grounds of the political conviction that equality between members of society, which is the foundation for peaceful coexistence, can only be exercised effectively if it is associated with a set of basic rights that are an inherent feature of the condition of citizenship itself.

We must strive to recover those shared ideals that have made of our health system an instrument of social cohesion and distributive justice. We must renew the civic commitment to attend to people's basic needs regardless of their contribution to the creation of wealth, ensuring that the poorest are cared for under the same conditions as the rich. And if there are to be inequalities, then these should be designed to mitigate the impact of poverty and marginalization on health.

This is a question not of charity but of justice; a reflection of our belief that citizens who are equal before the law should also be treated as equal in reality. This is the basis of social justice, inspired as it is by the principle of fraternity, one of the forgotten republican principles that underpin democratic coexistence. We need to recover and to rethink this principle, one that is often ignored, perhaps because it is misunderstood. One way of thinking about fraternity is as the exercise of solidarity between equals, as the principle that sustains one's convictions, and as a commitment to put into practice the notion of equality in the satisfaction of people's basic needs.

Statistical information as a motive for hope

The question as to whether the worrying suicide rate is related to the economic crisis raises all sorts of questions regarding the supposed scientific objectivity of field research. It is not easy to establish causal relationships that go beyond the co-occurrence of two phenomena. Or to prevent the researcher's aims and intellectual baggage from influencing both the choice of methodology and the interpretation of the results. However, although these are important issues, they should not divert us from the evidence of statistics that show that suicide has displaced traffic accidents as the main cause of death among young people in Spain.

Both of these causes of death are preventable, and this should spur the development of policies to address them. In this regard, it is impossible to ignore the reduction in road traffic deaths as a result of growing awareness among the general public, something that has been achieved, among other things, by regular information about the number of deaths, including monthly and annual comparisons.

We need to reflect upon the role of statistical information in maintaining and consolidating public health policies by stimulating the involvement of the general public. In his novel "The Plague", Camus describes the impact on the morale of the population of the daily mortality rate recorded by Grand, a humble local official. Everyone nervously follows the progress of the rising curve, and when it flattens out, the hope that it might be possible to defeat the epidemic bolsters the attitudes of ordinary people and their trust in the hygiene measures adopted by those responsible.

We should trust in the beneficent power of information when this information respects its victims, and we should hope that communicating the results of initial measures to protect people at risk of suicide will support the wider implementation of these measures by stimulating the involvement of those who are closest to them.

Renewing "activism" within and for the Spanish national health system

Little has been said and even less has been written about the role of health and education professionals in the transition to democracy in Spain in the 1970s. In those crucial years, the democratic principles of these groups took precedent over demands relating to employment issues. The conviction that consolidating democracy was the priority led to mobilization around other issues such as salaries to be postponed, in the fear that they might otherwise destabilize the fragile coexistence that was being forged in the post-Franco era.

The democratic commitment that was widely shared by health professionals found expression in the commitment to consolidate a high-quality public health system. Not only did we work within the public health system but we did so in the conviction that this was our contribution to consolidating the emerging democratic life of the country. As a result, it is no exaggeration to argue that we were "activists" within and for the public health system.

Recapturing this spirit is more necessary than ever, although the current situation means that salary claims must also be included. Because democracy in Spain has already been consolidated, even if the quality of this democracy may leave much to be desired. And it is not acceptable that the only response to the economic crisis should take the form of cuts to the salaries of public servants. Such a reaction is no more than an administrative response from those who lack the will or the capacity to lead the political changes required to break up the power of oligopolies and to prevent speculation with toxic financial funds.

We must not only denounce unfair cuts but must also behave in a way that reflects the fact that we are the system's most valuable asset. We must help to maintain the trust of citizens by treating them with respect and providing accurate information, delivering the best care possible with the resources at our disposal. The viability of the system depends on the fair and appropriate use of the resources we administer. Now is the time to step up and demand greater participation in the management of health centres and hospitals. We need to emphasize the importance of a personal approach and of caring for people, promoting people's capacity to look after themselves, and being self-critical regarding the inappropriate use of medical technology, including multiple medication.

In summary, we need to recover the old spirit of activism within and for the national health system and to develop new ideas that place us, as always, at the service of our fellow citizens. No doubt there will be those who dismiss such an approach as mere voluntarism. And of course they are correct. Because it is precisely such volition that motivates people to defend that which they believe to be right.

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Crisis, what crisis? (Supertramp, 1975)

The title is not intended to minimize the reality of what has been both the worst financial and the worst economic crisis since the Crash of 1929. At the start, the talk was of a shortage of liquidity but it quickly became a lack of solvency. We should remember, however (and this is the point of the Supertramp reference) that the capitalist system, which has expanded following the disappearance of its political and economic rival and has a constant need for growth (measured in terms of gross domestic product, and technological rather than human progress) is a system that suffers regular crises, whether due to over-production, soaring prices (particularly problematic in the case of essential raw materials), the abuse of "toxic" financial products (or what many people would describe as fraud) or speculative bubbles (from tulips to property). Whatever the cause, the result is a general loss of confidence (not just among investors) and of expectations.

There is no doubt that this crisis is both serious and deep, and that the current level of globalization (notwithstanding the expansion of trade at the end of the nineteenth century), technological innovation (information and communication technologies and the knowledge economy) and our current stage of capitalist development may appear to indicate that we are entering a new stage in the dominant economic and social system. However, paradigm shifts can only be defined in retrospect. The social inequalities, which are now widening, were already present before the start of the current crisis. The capitalist system and the economic growth on which it is based necessarily generate social inequalities, whether in terms of income, opportunities or well-being. However, these began to increase towards the end of the 1970s, and now, in the current crisis, they have intensified dramatically.

These social differences — more clearly present within than between countries, given differences in levels of economic development — influence health or its determinants, although the degree of the influence (and whether it is positive or negative) may vary. In retrospect, the Wall Street Crash also had some positive health impacts. More recently, Cuba has been cited as an example of a natural experiment. During the so-called "special period", when Soviet subsidies were withdrawn, there was a significant improvement in indices of obesity, diabetes and other risk factors, although these deteriorated again when the economy began to recover. But the problem itself is just as important as the response. We should not forget that austerity, presented as the only solution to the crisis, has serious consequences and unquestionably has the greatest impact on the most disadvantaged and vulnerable[1]. But austerity is also a virtue, as are prudence and moderation, contrasting as they do with usury, greed, waste and ostentation.

The economic crisis, which is also a social crisis, affects health at both the individual and the collective level. Although it might seem surprising, the better off, as Wilkinson and Pickett have argued, also suffer from excessive inequality[2], although in their case this represents an incentive to philanthropy (individuals or charities, rather than the state, helping the most disadvantaged) to bring about the (necessary) redistribution of their surplus wealth according to their own preferences and tastes.

Although the crisis may lead to the modification of habits — more or less sedentary lifestyles, less road traffic and accidents or more risky behaviour, more home-cooked meals with fresh fruit and vegetables or more cheap, fast food, the reduction of costly "vices" or increased consumption of tobacco, alcohol or other substances — there appears to be no doubt that it is mental health that suffers most. There is talk of increased consumption of tranquilizers and antidepressants and a rise in the number of suicides. While it is difficult to record the suicide rate accurately, with respect to the consumption of medication it should be noted that this was already on the increase before the crisis, which would appear merely to have exacerbated an existing trend. Stress, excessive competitiveness, consumerism, the frustration that arises from the perception that others are better off than ourselves, the "social models" that are promoted and a whole range of other factors can hardly be said to contribute to a healthy society with a (minimum) degree of personal satisfaction[3].

Given that confidence and investment (putting savings to a productive use) depend on hope, I would like to add one final point: as one economist has recently noted, we are beginning to see signs of improvement, of growth (in gross domestic product) albeit small, of significant rises in exports and a positive balance of trade for the first time in many years, of the stabilization of unemployment and a decrease in seasonal fluctuations, the recovery of confidence and an increase in consumption, of the return of foreign investment etc., but there is little discussion of the economic model that will follow. One has the impression that, if this is really the case and we are beginning to glimpse light at the end of the tunnel, then we may finally emerge from the crisis to find ourselves with more of the same, without having reformed the institutional or social system, plagued as it is by corruption, without having reduced inequalities or done anything to remedy the disdain in which politicians and parties are held. What has been termed the "extractive elite" remains unaltered. Spain has experienced a particularly intense economic and financial crisis, combined with its own institutional and territorial crisis. But this crisis has also been one of values. As has been noted, we need profound changes at every level to improve transparency and participation and to regenerate the system, and that applies to health too[4]. Without good government, there is no hope of progress.

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For almost 40 years[1] we have had data showing that socioeconomic factors are the biggest determinants of populational health[2]. Their influence is clearly greater than that of the health system, for example[3]. It therefore seems reasonable to start with the hypothesis that a deterioration in the socioeconomic situation of the majority of the population will, sooner or later, have an impact on health indicators. However, we need to be able to measure this impact in order to confirm its existence. Here, we face a challenge: namely, that public health indicators are very general and react only slowly to real changes in people's health.

We also know that absolute income is not the only determinant of health inequalities. Uneven distribution and the strength or weakness of the social support network are also relevant factors. In other words, both isolation and an individual's perceived position in comparison to that of his or her fellow citizens can influence health problems. The link between the economy and health can be direct (restricted access to protective factors: food, housing, health services etc.; exposure to risk factors: pollution, infectious agents, toxins etc.) or indirect (educational limitations or the psychological impact of feelings of frustration or powerlessness).

However, in any ethical reflection we must be rigorous in our use of terms, and careful to keep our prejudices in check. It is always important to clarify the facts. The first thing we need to do is to define what we are talking about. Bioethics involves a dialogue between facts and values. If we only describe the facts, then we are merely summarizing, and if we talk only of values, then we are simply indulging in ideology. Therefore, the first moral issue when addressing "the crisis" arises within the framework of the ethics of communication. We enter a crisis because somebody says we have, and from that point on the downward flow of money ceases. At the very least, we need to clarify certain terms and phrases.

Crisis is not necessarily a negative term. Crisis can also mean change, continuous improvement, reflection, regret and hope. The crisis should be an opportunity, not an excuse. Ever since the emergence of organized society as a means of ensuring the survival of humanity, significant changes have always arisen in times of crisis. The origins of society itself lie in a moment of ecological stress, of crisis.

Austerity, likewise, is not necessarily a negative term. The practice of austerity in the public sphere should not depend on the fact that we are in a difficult macroeconomic situation. Austerity is at the heart of the honest, responsible management of public resources (which belong to and concern everyone). Like many other terms ("ethical", for example), "austerity" has been overused as a euphemism for "linear cuts that are exempt from any criteria of justice or prior analysis of their effectiveness". Both the efficient and the inefficient are cut in the name of the "common good" and "sustainability" (another word that has been put to a wide range of uses). As a result, the true meaning of austerity has been lost, and it has been reduced to nothing more than arithmetic.

The questionable versions of austerity we have witnessed in recent years have promoted a deterioration in living conditions and the frustration of the hopes of the middle and lower strata of society. Without wishing to encourage conspiracy theories, it is hard to rule out the suspicion that one of the aims of the crisis was to reverse the trend (which can be traced back to the legal abolition of slavery) which has seen workers gaining a degree of independence, developing life projects and ambitions. Could we be dealing with revisionists who are nostalgic for the textile mills of the United Kingdom or the cotton fields of the Deep South of the nineteenth century? Do we need to reread Dickens to know where we are headed?

Blaming the citizens ("we have been living beyond our means") has also been a recurrent message. It may indeed be part of the problem, not by generating it but rather by permitting, through consumption, the maintenance of obscene inequalities in salaries and benefits between those who hold the stick (or the carrot) and those who pull the cart towards an unknown destination.

On this point, it is vital that we reflect upon the nature of society itself. Organization into groups was a response of the first hominids to the absence of resources due to external conditions. Cooperation was the value that permitted many (but not all) to survive. One can argue as to whether this cooperation is based on genuine altruism (disinterested cooperation) or on reciprocal exchange. Indeed, social mechanisms have always been nothing more nor less than a means of regulating the rule of "today for you and tomorrow for me". The big question is whether what motivates us to organize ourselves into societies is solidarity or self-interest. Surely the answer is both, and we therefore need to strike a balance in which autonomy is ceded in degrees and on a temporary basis, rather than in its entirety and irrevocably. While society may, like many medical treatments, be necessary, this does not mean we should ignore its potentially toxic side effects.

The only way to ensure the highest degree of respect for the autonomy of each of us is for there to be true justice within the group. Therefore, particularly where public matters are concerned, we need to establish a hierarchy of moral principles, with an emphasis on non-maleficence and, above all, justice. To put this another way, society should not "squander" the principles of autonomy and beneficence.

Perhaps the main challenge for public health is to go beyond just measuring outcomes and instead to engage fully in studying and managing the determinants of health. This means adopting a far more proactive, more political and perhaps more difficult approach. I do not wish to reopen the old debate between theory and action, but it is nevertheless important to remember that action without analysis is mere agitation, and that this can be exploited by those who do not wish us to think.

Vulnerability and crisis

Protecting the vulnerable lies at the very roots of society and is the intuitive foundation of the principle of justice. If we start from the premise of the need for society, it is essential that we define the "us" (shared, responsible autonomy) that transcends the "I" (pure individualism).

However, both the definition of "vulnerable" and the support mechanisms we offer have important ethical implications. We need to talk more about vulnerability than about the "vulnerable". Society has a responsibility to define and address these situations. So too does each of its individuals when they use or misuse the different forms of protection that the group provides. Who should define situations of vulnerability and exclusion, and how? We need to be prepared, for example, to detect new forms of social exclusion that are not classically recognized (people on very low wages, single-parent families etc.). Sometimes we need to intervene to help those who are drowning, in order to prevent more people from being drowned.

Policies based solely on subsidies wrongly assume the existence of two completely separate worlds: the vulnerable and the rest. They promote passivity and do not address the central issue. As a result, they may actually have harmful effects by paradoxically increasing the very vulnerability we seek to reduce.

It is essential to emphasize both the capacities of the "vulnerable" — particularly when this fragility has social causes — and their responsibility with respect to the help they receive. The aim is not to blame people for their situation but to include them in dealing with their own vulnerability, helping them to rebuild beneficial social ties. As social animals we all need links with our fellow human beings. The risk to vulnerable people is that the ties they establish are damaging (manipulation, maltreatment, exploitation etc.) and that others devour their dignity and their autonomy in exchange for the promise of protection or security.

Fortunately, we have instruments that can reduce this vulnerability. The most important of all is a high-quality public education system, more important even than the existence of an efficient, universal public health system. At the same time, it is a distressing fact that we must consider the issue of child nutrition, as this is an essential precondition of fair access to knowledge and the more even distribution of income that is necessary if everyone is to be able to develop their individual life projects. Inequalities in education and opportunities paralyse society and undermine self-criticism and genuine political engagement.

While we may be impressed by the strength of the voluntary sector in coping with the difficult situations that are caused by socioeconomic vulnerability, society and politicians should be careful to avoid complacency in the face of the "spontaneous appearance" of popular initiatives to protect the vulnerable. A mature society cannot view this development as an excuse for abdicating its own responsibility in this regard. There is something very wrong with the social contract when individuals have to organize into small groups to cover people's basic needs.

Nobody should be exploited, and everyone has an inalienable dignity. We need to identify the limits that prevent the exploitation of individuals by the group, and we also need to ensure that society and its protective mechanisms are not manipulated dishonestly by private interests.

Mental health and the crisis. The case of suicide

The main argument put forward to explain the link between economic problems and damage to health is the stress and mental suffering they cause, particularly in a competitive society such as ours. However, it is not the crisis as such that causes mental suffering. In general, the origins of social stress lie in the frustration of people's socioeconomic expectations, in the mismatch between the actual situation and what the individual expects.

Suicide has been closely studied as a symbol of the impact of socioeconomic stress on mental health, but the methodologies have not always been the same, and this makes it difficult to reach reliable conclusions about the facts. Statistics from different countries should be evaluated with caution, as both cultural taboos and methodological shortcomings can generate official rates that are reassuring but false.

Suicide should not be seen as a discreet disorder to which a preventive model should be applied. Suicide is not an illness; it is a behaviour.

And it is a social rather than a medical symptom. Only those suicides linked to psychopathological disorders affecting people's perception of reality can be regarded as being similar to disease symptoms. While almost all people who commit suicide have mental disorders, suicide is rare among the mentally ill.

In the majority of cases, suicide is more a symptom of social frustration than of psychopathology. Although for obvious reasons it is difficult to obtain reliable statistics about the Third World, the prevalence of suicide does not appear to be greater among communities where people suffer from greater levels of deprivation.

We should therefore be reluctant to medicalize suicide. We need to reflect upon whether those who commit suicide have other alternatives, and ask ourselves, above all, what happens with those who do not commit suicide. Few things can be more shocking than somebody taking their own life, but for everyone who chooses this path, there are many more in difficult, nihilistic or self-destructive situations who carry on living. Suicide may be the tip of an iceberg, but if it is then the disease is social, rather than medical.

The morally correct use of public health services in times of crisis

The first point we need to make is to question the link between the correct and sustainable use of public resources and the existence of a difficult financial situation. The moral obligation to be efficient and the value of austerity should govern any public action, irrespective of the magnitude of the public deficit or the interest rate payable on public debt at any given time.

When we talk about the use of public resources, it is essential that we do not think solely in terms of those receiving assistance. The key element in the distribution of these resources are the professionals themselves. The problem is that, when economists want to solve problems in the short term, they see that the "human resources" bill is the largest single budget item, and cuts typically focus on jobs.

However, there is an apparent paradox that responsible investment in people could change the current techno-scientific and medicalizing paradigm that has arisen, at least in part, from the decision to treat social and health activities (consoling, caring, curing) as if they were an industrial production line with a single end product.

If society empowered both professionals and patients then we could change the dynamic of unthinking consumerism, and combine humanity with efficiency. Perhaps we need to start by apologizing for the mistakes of the past. Unless we do so, we will not be able to generate the climate of trust needed to correct false expectations and eliminate practices that lack any value.

Health professionals undoubtedly need to communicate better, to be more independent of external influences on the clinical relationship, and show greater scientific honesty. And society needs to wean itself off hypermedicalization, the ideal of immortality and invulnerability, and the inflation of the concept of rights. Without going through this cathartic process, it will be difficult to change dynamics that are deeply embedded in our society.

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One thing that emerges clearly from the contributions to this seminar is that we do not yet have the indicators that would enable us to evaluate the impact of the economic and social crisis on the health of the population, despite cuts to the health services both at the level of human resources and provision, and their undeniable effect on the public. It also seems clear that the years of deep economic crisis suffered by Spain have led to a significant increase in social inequalities and a decline in the social position of hundreds of thousands of people, many of whom belonged to the middle class, who find themselves in a precarious situation and at risk of exclusion.

The question is whether the crisis has had a more direct impact on people's health, leading to a poorer quality of life and higher levels of illness than would otherwise have been the case. And if this is the case, what ethical responsibility do we bear as a society with regard to this vulnerability, and what should the public health response be, both in terms of preventing and addressing these problems, on the basis of criteria of justice and equity, and respect for personal dignity and autonomy.

Apart from particularly vulnerable groups, which are on the increase, such as people with no income or economic resources, or undocumented migrants who are denied access to the public health system, most people whose social position has deteriorated remain covered by the public health system and have access to medicines and healthcare. In this respect, despite the difficult situation, their access has not been modified other than by the restrictions applied to the system as a whole, for the whole population (increased waiting lists, reduced health staff etc.).

Where, then, is the impact of the crisis on the health of the most vulnerable really being felt? It would appear that this impact is felt primarily in the form of deteriorating living conditions as a result of a more precarious economic situation, homelessness, nutritional deficits, more sedentary lifestyles etc., which traditionally affect health over the short or medium term, even if this is not easy to identify in figures. We will probably have more precise data about these issues over the next few years.

Another element to consider is which population groups have been most affected by the crisis and what the effect has been. While job losses, long-term unemployment with precarious benefits, youth unemployment and difficulties in entering the job market primarily affect the young and the middle-aged, who generally have fewer health problems and place less demands on the health system, the reality is that many of these situations and the needs that they generate fall upon elderly people, living on retirement pensions, who often have to support three generations. These elderly people, whose income was sufficient before the crisis, often suffer from chronic illnesses or dependency, and now find their situation made far worse because they have to provide resources for other members of their families whose situations have deteriorated. This affects the health of these elderly people over the medium term, and it seems likely that in the years to come we will see increased mortality and perhaps even falls in life expectancy among the Spanish population.

The other question addressed in the seminar, through the issue of suicide, was the impact of the social and economic crisis on the mental health of its victims. In this regard, the statistics show a direct correlation between the crisis and suicide, beyond any temporary impact that may be magnified by the media or specific groups, occasionally with demagogic intent (for example, suicides due to evictions). What is undoubtedly true is that the crisis has generated a lot of mental suffering in people who have been through great economic and social hardship, although many of these should not be seen as being "mentally ill" and in need of medical treatment. Suffering is an inevitable part of human experience, one in which we strive to overcome challenges, giving rise to resilience in some and resignation in others. However, the growing medicalization of our society leads, far too often, to the medicalization of all forms of suffering.

With respect to the last issue addressed in the seminar, linking the crisis to the appropriate use of health resources, I would agree with the idea that, once we have overcome the most serious difficulties and achieved a degree of balance in our finances, in the wake of the fairly drastic cuts we have endured, this situation should be treated as an opportunity to address many of the inefficiencies in our health system and to re-educate people in the responsible and limited use of resources that, with or without the crisis, are always scarce. The years of economic boom have led to a spiral in health expenditure that is hard to justify, and that should be redirected, safeguarding the model of universal, public access, but rationalizing investment and consumption, appealing to the responsibility of all, reviewing the portfolio of services, and implementing new models of co-payment or "repayment" (beyond payment through taxation) that are fair and just on the basis of wealth, permitting the system to survive to the benefit of the health of all.

Obviously, reversing the social and economic crisis would be the biggest contribution of all to the task of addressing inequalities and improving people's quality of life. However, some of the crisis' harmful effects on health are irreversible, and it is the duty of all to minimize these effects, to prevent them when possible, and to combat their spread.

List of participants

Coordinators

- Andreu Segura, Secretary of the Interdepartmental Commission on Public Health of the Government of Catalonia and Associate Professor of Public Health at Pompeu Fabra University.
- Angel Puyol, Professor of Moral and Political Philosophy at the Autonomous University of Barcelona.

  With the collaboration of:
- José Miguel Carrasco, Sociologist, specializing in Public Health, and Investigator at the Culture and Society Institute of the University of Navarre.

Speakers

- Antonio Casado da Rocha, Permanent Investigator at the Faculty of Philosophy and Education Sciences at the University of the Basque Country.
- Maria José Fernández Sanmamed, Specialist in Family and Community Medicine, Catalan Health Institute.
- Jaume Puig, Department of Economics and Business, Pompeu Fabra University, Centre for Research in Health Economics (CRES-UPF).
- Ildefonso Hernández, Professor of Preventive Medicine and Public Health at Miguel Hernández University.
- Begoña Román, Lecturer in Ethics at the University of Barcelona. Pablo Simón, Andalucian School of Public Health, Granada.

Chairperson

- Joan Pons, Scientific Advisor to the Health Quality and Evaluation Agency of Catalonia.

Invited specialists

- Macario Alemany García, Lecturer in Legal Philosophy at the University of Alicante.
- Gracia Álvarez, President of the Clinical Ethics Committee, León Health Region.
- Marc Antoni Broggi i Trias, Surgeon and President of the Bioethics Committee of Catalonia.
- Josep Maria Busquets Font, Member of the Bioethics Committee of Catalonia.
- Javier García León, Technical Advisor to the Agency for the Evaluation of Health Technologies of Andalucia.
- David Larios, Vice-President of the Association of Experts in Health Law.
- Isabel Marín, Head of the Public Health Service, Department of Equality, Health and Social Policy of the Regional Government of Andalucia.
- Ricard Meneu, Vice-president of the Health Services Research Institute Foundation in Valencia.
- Màrius Morlans, Nephrologist, Member of the Bioethics Committee of Catalonia.
- Josep Ramos, Psychiatrist and Director of Mental Health and Addictions Planning at the Parc Sanitari Sant Joan de Déu.
- Bernabé Robles, head of the Neurology Service, President of the Clinical Ethics Committee, Parc Sanitari Sant Joan de Déu.
- Miguel Ángel Royo, Head of the Student Area of the Escuela Nacional de Sanidad.
- Núria Terribas, Director of the Borja Institute for Bioethics.

Publications

Bioethics monographs:

33. *Alcance y límites de la solidaridad en tiempos de crisis* (The scope and limits of solidarity in times of crisis)

32. *Ethics and public health in times of crisis*

31. *Transparencia en el sistema sanitario público* (Transparency in the public health system)

30. *The ethic of care*

29. *Case studies in ethics and public health*

28. *Ethics in health institutions: the logic of care and the logic of management*

27. *Ethics and public health*

26. *The three ages of medicine and the doctor-patient relationship*

25. *Ethics: the essence of scientific and medical communication*

24. *Maleficence in prevention programmes*

23. *Ethics and clinical research*

22. *Consent by representation*

21. *Ethics in care services for people with severe mental disability*

20. *Ethical challenges of e-health*

19. *The person as the subject of medicine*

18. *Waiting lists: can we improve them?*

17. *Individual Good and Common Good in Bioethics*

16. *Autonomy and Dependency in Old Age*

15. *Informed consent and cultural diversity*

14. *Addressing the problem of patient competency*

13. *Health information and the active participation of users*

12. *The management of nursing care*

11. *Los fines de la medicina* (Spanish translation of *The goals of medicine*)

10. *Corporate responsibility in sustainable development*

9. *Ethics and sedation at the close of life*

8. *The rational use of medication. Ethical aspects*

7. *The management of medical errors*

6. *The ethics of medical communication*

5. *Practical problems of informed consent*

4. *Predictive medicine and discrimination*

3. *The pharmaceutical industry and medical progress*

2. *Ethical and scientific standards in research*

1. *Freedom and Health*

Reports:

5. *Ethics and Synthetic biology: four streams, three reports*

4. *Las prestaciones privadas en las organizaciones sanitarias públicas (Private services in public health organizations)*

3. Therapeutic Cloning: scientific, legal and ethical perspectives

2. An ethical framework for cooperation between companies and research centres

1. The Social Perception of Biotechnology

Ethical questions:

3. Surrogate pregnancy: an analysis of the current situation

2. Sexuality and the emotions: can they be taught?

1. What should we do with persistent sexual offenders?

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