

The 21st century epidemic: Inequality in health.

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Abstract:

The economic crisis has had a great impact on Spanish society, resulting in an increase in social inequality, including in the population's health.

Social and economic inequalities have relevant repercussions on health. In addition, the search for a balance between health and the social situation in Spain is fundamental to improving the quality of life within society.

Objective: To examine the problem of social inequalities in health in Spain since the start of the crisis to the present.

Methodology: A bibliographic review is carried out using different databases and other resources. A search strategy was defined in which 41 articles were selected following the PICOT model, taking into account different inclusion and exclusion criteria.

Conclusion: Although the improved economic situation in Spain is evident, there is still a long way to go before the country reaches the healthcare situation enjoyed before the crisis, which had a negative impact on Spain's National Health System and on the Spanish population, especially as regards inequality.

Key words: Inequality; Health; Wellbeing; Poverty; Nursing

1. Introduction

A decade has passed since Spain entered the economic, social and humanitarian crisis that has negatively affected the welfare state and the standard of living, and reciprocally the state of health of the Spanish population and the question of inequality.

Social inequalities in healthcare have increased since then, causing a greater social gap to appear in the population. This has resulted in a larger percentage of people with differences in the socioeconomic and political context, the socioeconomic situation and the mediating factors (work and living conditions, behavior and the health system). Other pertinent data concerning social inequality in healthcare are reflected in life expectancy and mortality rates, as well as in perceived health and mental health.

According to OXFAM [1], the crisis is taking its toll of the weakest members of Spanish society and the government's fiscal austerity measures are widening this inequality gap. Oxfam's studies calculate that, in 2022, almost 40% of the Spanish population will be at risk of poverty and social exclusion. The most vulnerable social groups are those from disadvantaged sectors of the population, women, or the immigrant population from poor countries, since they have worse living and working conditions, adopt unhealthy lifestyles and have

problems gaining access to some services. Besides individual characteristics, there are geographical variations concerning social, economic and healthcare resources between regions. Such social inequalities also occur in health, where the most disadvantaged groups have worse health and a shorter life expectancy.

On the other hand, according to the OECD [2], Spain is a country with a high life expectancy and a good welfare state. For the Spanish, the three most important issues are health, education and the balance between work and home life. Despite the economic development and social advances made over recent decades, according to the latest studies, Spain is still far from reaching the levels of wellbeing enjoyed in the EU.

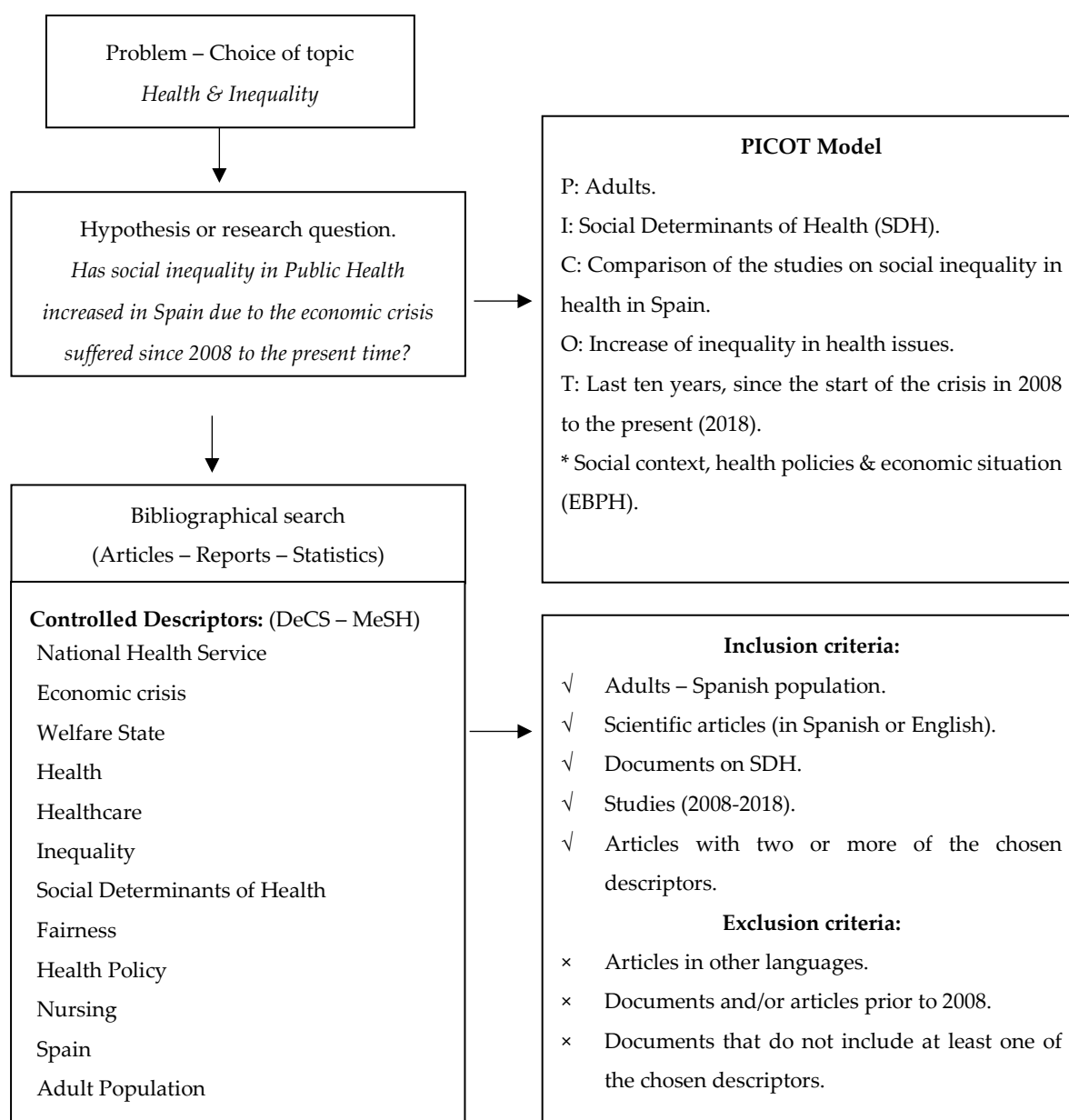
The situation concerning health in the Spanish population in recent years has not shown any great changes, even though the studies state that there has been a certain improvement. The preoccupation of the public authorities concerning this issue has been uneven and there is a particular absence of studies analyzing the results of the policies carried out by the different governments.

The main objective of this work is to identify and highlight the most important inequalities in health by carrying out a constructive criticism of the situation and determining how the crucial social factors have contributed to the increased preoccupation of the public authorities in their efforts to tackle these inequalities. Secondary objectives are as follows: to demonstrate the need to improve and update the available sources of information, since the last report on this issue was published by the Ministry of Health, Social Services and Equality in 2015, but using much older data [3].

We therefore find ourselves faced with a relevant, current issue that concerns both the public authorities and the scientific community, with frequent debates on health policies carried out in the different countries of the European Union and the distribution of the economic resources and services, as well as the need to reduce material poverty and social inequality, all of which are principal determinants of inequalities in health. In order to develop the subject and address the different solutions put forward in Spain, we have used the model proposed by the WHO Commission on Social Determinants of Health, where social inequalities are grouped in the following way: the socioeconomic and political context, the socioeconomic situation, and the mediating factors [4].

2. Materials and Methods.

Putting into practice the principles of Evidence-based Public Health (EBPH), our work method consists of the following phases set out in Table 1:

Table 1: Flow Chart, EBPH. (Own creation)

When carrying out the bibliographical search in the CUIDEN, Scielo, DIALNET, PubMed and SCOPUS databases, we followed the specific regulations for use of each one, as well as the form of writing the descriptors and the operators. In addition, we have limited as far as possible the number of articles in each database, choosing those that contained the most relevant information for our purposes. Finally, 41 articles, 15 reports (MSSI, OMS, OECD, FOESSA, etc.) and 2 PhD theses were used.

Table 2: Results of the bibliographical search. Note. (Own creation)

Search strategy					
Inequality AND health AND Spain AND 2008	24	34	23	0	69
Determinants AND social AND health AND public AND Spain	35	14	342	18	39
Public health AND inequality AND Spain	114	24	66	0	240
Health AND economic crisis AND Spain	76	479	180	111	14
National health service OR health system AND economic crisis AND Spain	1445	3	41	31. 747	5
Economic crisis AND nursing AND Spain	51	812	3	6	5
Nursing AND healthcare AND health AND Spain	76	24	36	535	3
Total number of documents revised	36	26	8	33	56
Documents included in the bibliography	10	10	5	10	6
Total number of documents included in the review	41				

3. Results

There are different conceptual frameworks to explain and analyze the SDH, and to design the interventions to resolve the social inequalities concerning health. In this review, we have focused on the model created by Solar & Irwin, 2015 [3] and adapted by the WHO Commission on SDH, where the determinants are divided into two blocks: *the structural determinants of health inequalities and the mediating health determinants* [3].

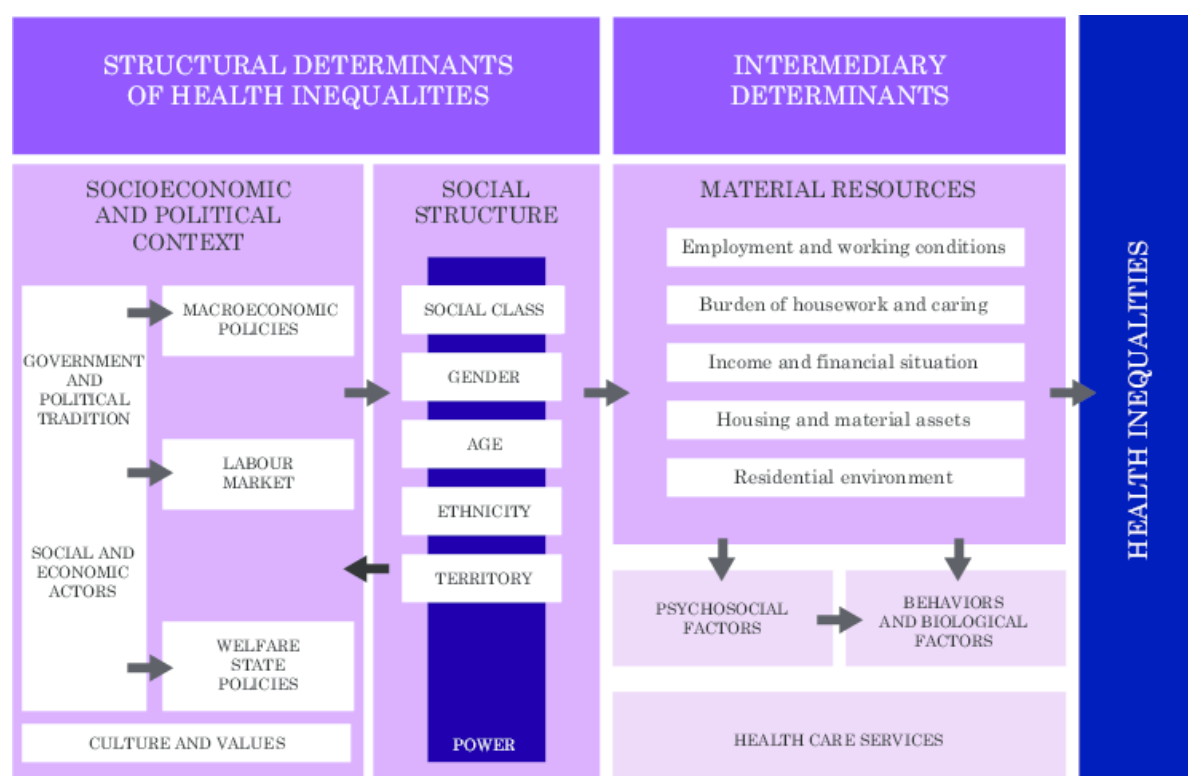


Figure 1: The determinants of social inequalities in health. Conceptual framework of the determinants of social inequalities in health. Commission for the reduction of Inequalities in Health in Spain, 2010. Adapted from Navarro (2004) and Solar & Irwin (2007)

Social inequality is a subject that is of concern worldwide, which is why the WHO in 2005 created “The Commission on Social Determinants of Health (CSDH)” to offer advice on how to attenuate the persisting inequalities. In 2008, the WHO published “Closing the Gap in a Generation”, which evaluates the impact of the SDH and the recommendations for resolving inequality [4].

In the 62nd edition of the World Health Assembly, held on May 2nd 2009, focused on *Reducing healthcare inequalities by acting upon the Social Determinants of Health* [5], the member states were asked to combat inequality in healthcare in order to improve people’s health. These SDH explain most of healthcare inequalities, i.e., the unfair, avoidable differences observed in the countries as far as the healthcare situation is concerned. In response to the growing concern of countries over such persistent and ever growing

inequalities, the WHO established the “Commission on Social Determinants of Health” in order to improve the conditions of everyday life, fight against the unequal distribution of the power, money and resources, and the measurement and analysis of the problem [5, 6].

Reducing health inequalities is an objective of the Health strategy of the WHO for the 21st century: “by the year 2020, the health differences between the socioeconomic groups of each country should be reduced by at least a quarter in all member states through the substantial improvement in the level of health of the most disadvantaged groups” [7].

In order to achieve equality of healthcare, the WHO has proposed the following interventions, according to their latest report on the SDH [7,8]:

- To improve the conditions of life.
- To fight against the unequal distribution of power, money and resources.
- To measure the magnitude of the problem, evaluate the interventions and increase the knowledge base.

The latest report of the WHO on “The determinants of health” in 2018 [9] demonstrates that there are many factors, either combined or alone, which can affect the health of people or communities. Whether people are healthy or not is conditioned, to a great extent, by the circumstances surrounding them, their place of residence, the state of the environment, their genetics, their level of income and education, relationships with family and friends, and access to healthcare services. Broadly speaking, such circumstances can be divided into the following determinants: the social and economic environment, the physical environment, and a person’s individual characteristics and behavior [9].

The member states of the EU have also taken measures to combat social inequality in healthcare. 2011 saw the publication of “Reducing health inequalities in the European Union”, a document which analyzes the factors that influence health inequalities and their indicators; it also explains the fundamental role played by determinants of health [10].

Following this document, the EU has undertaken the task to decrease the inequality in health by creating the project “Determine” to gather information concerning the strategies used by the member states to deal with inequalities in health and thus know the effects such strategies have had [11].

Few studies have been carried out in Spain on the SDH, one of the most important being “Innovation in Public Health: monitoring the social determinants of health and the reduction in health inequalities” by the Ministry of Health & Social Policy (2010). The repercussions were important as the study boosted both research and the creation of new policies aimed at achieving equality in healthcare [3].

The latest study carried out by the Ministry of Health, Social Services & Equality entitled “*Advancing towards equality. A proposal for policies and interventions to reduce social health inequalities in Spain*” (2015) and the Commission on Reducing Social Health Inequalities in Spain presented a total of 27 principal recommendations and 166 specific recommendations, ordered by priority and divided into the following 5 subsections for improving equality in healthcare [3, 12].

- I. The distribution of power, wealth and resources.

- II. Everyday living and work standards throughout the life cycle.
- III. An environment that favors health.
- IV. Healthcare services.
- V. Information, surveillance, research and teaching.

On the other hand, the Spanish Society of Public Health and Healthcare Administration (SESPAS), another agency that studies the social healthcare activities in Spain, sets out in their article “research into social determinants and inequalities in health: evidence for health in all policies” an overview of the social healthcare situation with respect to the SDH, broadening the vision of Public Healthcare and the healthcare services of Spanish society. [13, 32]

Worth a special mention is the European project SOPHIE, coordinated by the Public Agencies of Barcelona (ASPB), which have had the support of the Biomedical Research Center in the Public Health & Epidemiology Network (CIBERESP). The main objective was to build up proof of the influence of social and economic policies on the health of the population, and to what degree socioeconomic factors, gender and immigration influenced inequalities in healthcare. [14]

Finally, the Sustainability Observatory (SO) should also be mentioned. This observatory was set up in December 2014 to investigate and report on the sustainability analysis. That same year, a national sustainability report was compiled that applied contrasted, operative and representative indicators. The principal aim of the SO was to recount the real situation in Spain as concerns sustainability, on the basis of environmental, social and economic indicators, as well as an evaluation of the said sustainability, i.e., it gives an account of the situation, the tendencies and, in short, the context in which we find ourselves.

In this review, we have used the annual report on Sustainability in Spain of 2018 [15], the objective of which is to “be a reference in the analysis of sustainability in Spain and an effective vehicle for the transmission to society as a whole of relevant and true information, on the basis of collaborations with research institutions, the business world, non-governmental organizations and public administrations; information based on the best science available” [15].



Figure 2: The 17 Objectives of sustainable development (OSD). Sustainability observatory. Sustainability in Spain 2018 based on the evaluation of the objectives of sustainable development from the 2030 agenda of the UN. Page 2.

4. Discussion

It has been ten years (2008 - 2018) since the Spanish government reported on the country's situation. We had to face up to an economic crisis with global implications. As the years passed, it became clear how important sectors in the economy, such as agriculture, education or healthcare, were being affected by the economic situation and by the measures taken by the Spanish state and the EU.

As a result of all the above, the social divide has become wider, affecting the entire Spanish population. The divide was seen to be more pronounced in the most vulnerable people, thus increasing social exclusion and thereby inequality. This fact is directly related to the welfare state, social determinants and thus people's health. In addition, Spain's economic crisis saw an increase in the application of restrictive policies in the different regions that have had a different impact on health and social inequalities. Spanish society today has had to start living under the effects of a new economic and social situation, following a long period of recession. This improvement, however, is not sufficient to reduce the poverty, social exclusion and inequality [16].

The studies carried out by the 'FOESSA' Foundation show how poverty increased significantly during the crisis (2008 - 2014). Now, in 2018, poverty is not increasing, but neither can any decrease be appreciated [17].

The data from the latest *Survey on Living Standards (2016 -2017)* in Spain shows that those living in poverty has increased slightly, from 22.1% to 22.3%; while those households that have difficulties in reaching the end of the month rose from 33.7% to 33.9%, those at risk of poverty and exclusion in Europe fell from 28.6% to

27.9%, and severe material privation remained steady at 6.4% [18].

According to the AROPE report (2017), a total of 12,989,405 people, or 27.9% of the population resident in Spain, is at risk of poverty and thus of social exclusion. To get back to the values prior to the crisis, there would have to be a further of two million in the number of people at risk and, on top of that, a further reduction of 800,000 (total 2,800,000 people) in order to fulfill the specific EU 2020 commitments. There exist different figures concerning poverty depending on the group under consideration: poverty has increased in all sectors of society, except for a reduction in the working population and those between 30 and 44 years of age [18].

Richard Wilkinson, a British social epidemiologist researching social health inequalities and their social determinants, has stated that “poverty is relative and arises out of social relations” [19]. This view is shared by other researchers in the matter. Wilkinson clearly stated in the 2017 congress on Poverty & Health [20], held in Berlin, that “the bigger the differences between the richest and poorest groups of a society, the longer the social scale, the more serious the social and individual consequences will be. The bigger the difference, the more effective will the limits of state and class become. The differences that have been identified lead to less social cohesion, less trust and greater fear of relegation, which in the long run is also reflected on the political level”. He also points out that “an alliance towards better health should always be an alliance representing greater justice and better opportunities for fulfillment” [20, 21].

For García & Guardiola in 2017, “the fracture in social cohesion is now wider than before the crisis, increasing by up to 45%” [22]. In relation to this highly significant figure and according to the latest reports from ENREFOESSA on economic poverty, the quality of employment, work opportunities, mental and physical health, or coexistence, it can be seen that the economic crisis has left very weak family budgets, reduced stability in life, worse health, greater unrest, and few opportunities to reach the lost levels of wellbeing [17,22].

Wilkinson & Pickett, in 2009, published the book *The Spirit Level: Why More Equal Societies Almost Always Do Better*, where they summarize how inequality negatively influences most of the health and social wellbeing variables. These authors state that “in developed countries, the greater the inequality, the lower life expectancy, reading comprehension and understanding of mathematics, society’s trust in their fellow citizens will be; while infant mortality, the percentage of recluse population, homicides, births in adolescent mothers, obesity, mental illness of all kinds and drug addictions will all be greater” [19]. It has also been shown that “a high general income level in countries does not mitigate its social and health problems” [23].

The 2018 report from Spain’s Sustainability observatory (SO) states that “social inequality in our country seems to be getting worse” [15]. Spain’s performance in the Social Justice Index has been getting worse since 2008 and the country remains among the worst of the EU. This index, compiled by the German foundation *BertelsmannStiftung*, is responsible for analyzing six indicators: poverty prevention, equality in education, access to the labor market, social cohesion and an absence of discrimination, health and, finally, intergenerational justice. Analyzing the last 17 SDOs (Sustainable development objectives), it can be seen that there is a certain improvement in four of them, so there is still much that needs to be done. The SDO 3 (Guaranteeing a healthy life and promoting wellbeing for all at all ages); SDO 5 (Gender equality and

empowerment of women and girls); SDO 12 (Guaranteeing sustainable production and consumption methods); and SDO 14 (Conserving and using, in a sustainable way, the oceans, seas and marine resources for sustainable development), show intermediate values of fulfillment (the evaluation is established in 5 stages: Very bad/1, Bad/2, Intermediate/3, Good/4 and Very good/5), while the other SDOs are still showing very low values [15].

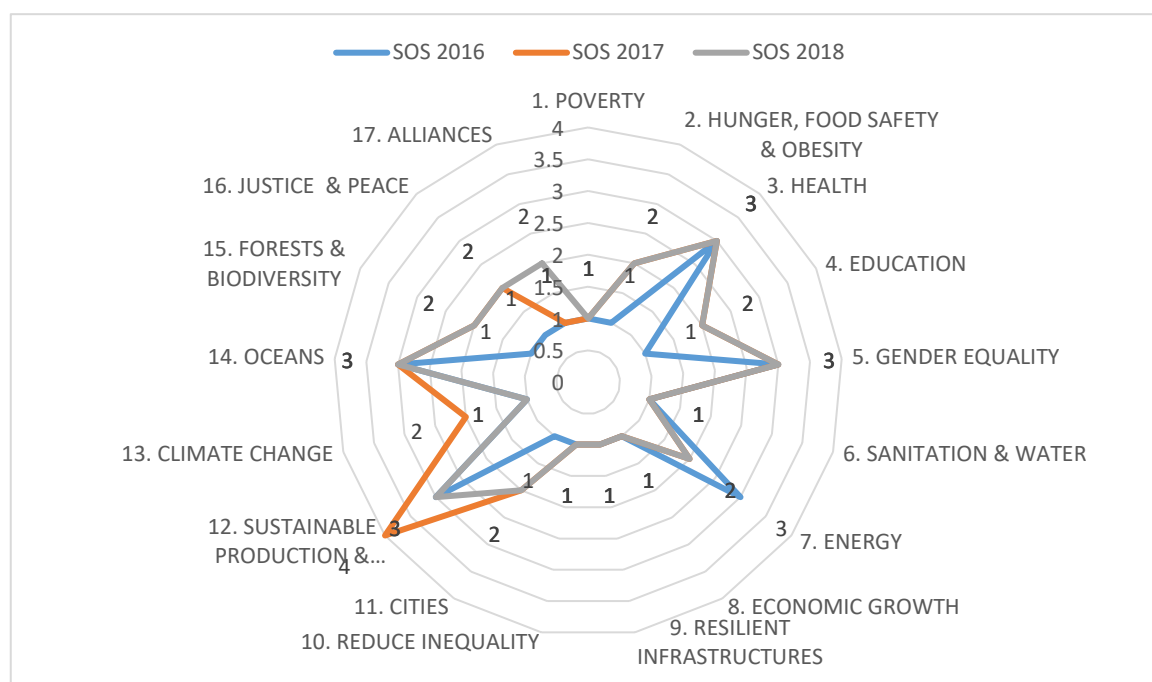


Figure 3: Star diagram evaluating Spain's SDO fulfillment from the UN 2030 Agenda in 2018. Prepared by the author, based on the SO, 2018 [15].

Despite what one could believe concerning the deterioration in the welfare state in Spain following the economic crisis and the inequalities, according to the OECD (Better Life Index) "Spain achieves good results in some measures of general wellbeing in comparison to the majority of countries included in the Better Life Index". In addition, the results situate Spain "above the average in the balance for life-work, housing, state of health, sense of community, and personal safety; but below average in income and patrimony, civic commitment, environmental quality, education and skills, employment and remuneration, and satisfaction" [25].

It can therefore be stated, according to the OECD in *Your Better Life Index* (2018), that Spain may have left behind the worst of the crisis and starting back on the road to recovery: "there is more growth and less unemployment, but this evolution has been insufficient to stop one of the greatest unresolved issues that the policies of the Spanish government have not been able to reverse: the great social and economic inequality" [25].

On the other hand, other authors state the opposite. Fernández García & Cabello stated in 2015 that "the so-called austerity measures taken in Europe since the start of the economic crisis have led western societies

towards a notable decrease in the Welfare State together with an increase in poverty and social exclusion” [26]. They point out that this decrease has been most notable in the countries of Southern Europe, accentuating social inequalities.

The future of the Welfare State in Europe will depend on political decisions, even if the diverse models that coexist do not intensify the policies of austerity and the cutbacks in the social and healthcare fields. The Welfare States in the Mediterranean countries, in particular, are in an especially complex situation. It is essential to redirect the current scenario towards one that favors social cohesion. Nevertheless, in Europe in general and in Spain in particular, several studies on public perceptions confirm that the majority of citizens supports the Welfare State and even express the opinion that it should, obligatorily, be a political priority [27].

For Spain to have a Welfare State reflected in the health indicators, it is necessary for the population to have good levels of health, so the SDH that influence them must be studied and controlled in order to improve people’s quality of life as much as possible. These health indicators are necessary to improve the health of individuals and the population as a whole, so governments and health authorities need to take decisions that will provide sufficient funding for the health services and programs as well as resources. In addition, it is also necessary to have consistent information on health differences between the various human and social collectives, on the prevalence or incidence of certain illnesses that vary over time and between social groups, as well as on their consequences, so as to be able to analyze the health risk factors with respect to social, economic and cultural characteristics, etc. [28].

One of the indicators of the Welfare State is the mean life expectancy and Spain has one of the highest life expectancies of the OECD, at 83 years, three years more than the Organization’s average of 80 years. This fact is related to a greater expenditure in healthcare per person, although there are other factors involved, such as lifestyle, education and the environment. Another important figure is that 72% of Spaniards consider that the quality of their health is good, which is higher than the average for the OECD, which stands at 69% [25].

As has already been mentioned, there are very large inequalities in Spain as regards the occurrence of health problems according to social class, gender and territory [12]. These inequalities mainly depend on the social determinants of health: the conditions in which people are born, grow up, live, work and grow old. These circumstances are set by the distribution of wealth, power and resources on worldwide, national and local levels, and they are strongly influenced by the economic and political powers [29].

In the Commission on Health Determinants’ report for the WHO on reaching equality in healthcare by taking action on the said social determinants of health, it says that “the bad health of the poor, the social health gradient within countries and the large healthcare inequalities between countries are caused by an unequal distribution, on both international and national levels, of power, income, goods and services, and the consequent injustices that affect the living conditions of the population in an immediate and visible way (access to healthcare, schooling, education, work conditions and free time, housing, communities, villages or cities) and the possibility of leading a prosperous life. Such an unequal distribution of prejudicial health experiences is not a «natural» phenomenon in any way whatsoever.” [30].

The level of health and/or illness of a population depend largely on the economic development, on the medical advances, and on the healthcare services. Never before has such a rich world existed, with so much

scientific/healthcare knowledge, and neither have there ever been so many healthcare resources. However, the inequalities between individuals in questions of health and healthcare services have gradually been increasing. Such an increase has not happened by chance, it has mainly been due to important social determinants that lead to bad health: the type of work, the environment, social exclusion, the economic situation, etc. [31].

One aspect to keep in mind is that “those people on the lowest incomes visit their general practitioner six times a year, while those with the greatest resources only do so twice”, according to a report by the Center for Studies of Andalusia in 2017. This also influences the perception of illness, “one out three of the poorest people in Andalusia claims to suffer bad health, a figure that does not reach one in ten among those with the highest incomes. It is even noticeable in the ‘feeling of sadness’ that affects 18.8% of the most disadvantaged, but only 1.4% of the well-off” [32].

Numerous scientific studies show that health inequalities are enormous and that they are responsible for a higher rate of mortality and morbidity than most known factors indicating risk of suffering from diseases. In addition, in those spheres where they have been studied, these inequalities almost always increase, since health improves faster in the better-off classes.

Those with the least incomes visit their doctor four times more; have a greater risk of suffering certain illnesses, from mental disorders to cardiovascular diseases; or a higher rate of suicide. They even have a lower life expectancy. This health inequality has always existed, but the gap has widened since the economic crisis, and according to some scientists, is becoming the main “disease” of the 21st century.

In the case of Spain, it is not a question of access to healthcare, but rather that “the social problems turn into medical problems”, as explained by Ildefonso Hernández, a member of the Spanish Society for Public Health (SESPAS). A lower income means a worse quality of life: more deficient diet, physical inactivity, difficulties to gain access to certain treatments (especially dentists or physiotherapists), and above all problems of depression and anxiety [33, 34].

SOPHIE (acronym for Structural Policies for Health Inequalities Evaluation) (2016), a project coordinated by the Public Health Agency of Barcelona (ASPB), and the Biomedical Research Center in the Public Health and Epidemiology Network (CIBERESP) have a common goal: the evaluation of the impact of structural policies on inequalities in healthcare and their social determinants and measures for change. The project has shown that the public policies focused on equality, in such diverse spheres as city planning and housing, social protection, dependence, or the integration of immigrants, can have repercussions on the health of citizens and reduce inequalities in health that arise due to the socioeconomic level, gender or place of birth [14]. As opposed to other studies about the effects of the crisis on the health of the European population, they have observed a global reduction in mortality, but the suicide rate has risen. It is also clear that the policies of austerity have made the figures for all the causes of mortality worse.

April 4th 2018 was World Health Day and “Médecines du Monde” Spain, in a conference celebrated to analyze the challenges, stated that “it is necessary to combat health inequality and leave anyone outside the national health system”. They also stressed that “although Spain was seeing above average growth for the EU countries, it had reduced its investment in healthcare in the PGE 2018, recently presented by the government,

dedicating only 5.8% of the Gross National Product (GNP). More than 800 million people (almost 12% of the world's population) spend at least 10% of their family budget on paying for healthcare services".

Spain has become the European country in which inequality has increased the most over the last ten years, according to a recent warning by the European Commission. The implementation of the health reform act in 2012 resulted in the exclusion of particularly vulnerable collectives, marginalizing immigrants in an irregular administrative situation (including women and minors), young people or pensioners, among others. José Félix Hoyo, president of Médecins du Monde in Spain, pointed out that "something as important, individually and collectively, as health is no longer a right but an arguable, and occasionally arbitrary, depending on the particular administrative situation" [35].

Inequality is initially a neutral state of difference, while injustice implies a call to change, since it breaks the standard ideals. For instance, the consequences of inequality may affect life and fulfillment opportunities, which make the inequalities unjust. Within a few years, according to Andreas Mielck (Helmholtz Center, Munich), so many inequalities have been identified that the politics of science will need help to prioritize the inequalities. Thus, it makes sense to focus on the qualitative differences in health inequalities.

The healthcare personnel are vital for the attenuation of social health inequalities, as pointed out in the report by the Ministry of Health & Social Policy of 2010 *Towards equality in health: monitoring the social determinants of health and the reduction of health inequalities*; it is necessary to "promote community plans to reduce health inequalities by means of the participation of the citizens, the professionals of the health and social services, and other possible agents involved in healthcare" [3]. Thus, the community nurse in Spain is fundamental to the promotion of healthcare, the prevention of possible illnesses, and the education of the population as a whole. Some of the systematic strategies proposed by the Spanish government focus on the structural aspects in order to achieve healthy lifestyles, encouraging access and reducing costs for the population with fewer resources to preventive and curative services not included in the social security.

On the other hand, it is very important to ensure and guarantee full, universal healthcare for all those resident in Spain, with 100% cover, independently of age, gender, ethnicity or nationality. In addition, specific objectives should be included in all the Health Plans and State, Autonomic and Local Directory Plans for the decrease of inequalities in the welfare state and in the quality, effectiveness and access to healthcare services.

Finally, and to conclude this section, we set out how the measures carried out by the Spanish state to recuperate from the crisis have affected health, decreasing the material resources and cutting back on healthcare personnel, thus affecting the quality of the service.

The nursing union (SATSE) claim it is necessary to increase nursing staff in Spain, considering that the political cutbacks in spending on health over the last few years have been especially aggressive with the activities dedicated to prevention and health promotion. In addition, the situation has left some professionals saturated by overwork, thus affecting the quality and effectiveness of the attention provided in the healthcare sector. The consequences arising from this situation can be seen in increased costs, in hospital admittance figures and in the average time spent by patients when in hospital, in an increase in the waiting lists for operations and in a worsening of patients' chronic diseases [36, 38].

In 2017, the website 'Mundosanitario' (Healthworld), created by the SATSE union, stated that "Spain is

now the sixth country with the lowest number of nurses in the world". Spain has 5.2 nurses for every 1,000 inhabitants, according to "Health at a Glance", leaving Spain at the bottom of the list in Europe, which has an average of 8.4 [37].

According to the OECD, the evolution of Spain's Welfare State will become negative if measures are not taken to solve the lack of nurses [3, 24].

5. Conclusions

The economic crisis is something that should serve to provide evidence of the consequences and the improvements made by society, as well as demonstrating the available means for analyzing the impact, both positive and negative, that can be derived and which can affect the National Health System and the inequalities in health.

The question we asked at the beginning: *Has social inequality in public healthcare increased (SDH) in Spain as a consequence of the economic crisis suffered from 2008 to the present day?* From the reviewed studies, it is clear that the answer is yes. There are more social health inequalities in Spain now than before the crisis, and even though we have today signs of a slight improvement, we are still far from the levels being handled before the said crisis.

The institutions and authorities that are responsible for managing wealth and the Welfare State should reflect on the adopted measures and on the results obtained.

The need to create quality and effective health systems is of great importance in order to be able to foresee and face the possible negative consequences that the social determinants produce on health and equality in the population, and in particular on the health system itself in the short and medium and long term.

Finally, the work of healthcare professionals must be stressed, especially that of the nursing staff who, despite the changes made following the crisis, with less resources, worse conditions, fewer staff, etc., continue to work at the same level as before and with the same professionalism. So the need for a change in the model for managing and distributing resources is clearly needed. Such changes are essential if we wish to identify and improve the health needs of the population.

Abbreviations:

AROE: At Risk of Poverty and/or Exclusion.

ASPB: Public Health Agency of Barcelona.

BIREME: Latin American & Caribbean Center on Health Sciences Information.

BVS: Virtual Health Library.

CC.AA: Autonomous Communities (Regions).

CIBERESP: Biomedical Research Center in Public Health & Epidemiology Network.

CSDH: Closing the gap in a generation.

DeCS: Health Science Descriptors.

SD: Social Determinants.

SDH: Social Determinants of Health.

FOESSA: Promotion of Social Studies & Applied Sociology.

GINI: Measure of inequality.

INE: National Statistics Institute.

MeSH: Medical Subject Head.

UN: United Nations.

OECD: Organization for Economic Cooperation and Development.

WHO: World Health Organization.

PAHO: Pan American Health Organization.

SO: Sustainability Observatory.

PICOT: Problem, Intervention, Comparison, Results & Time.

RAE: Royal Academy of the Spanish Language.

REBIUN: University Library Network.

SR: Systematic Review.

SASTE: Nursing Union.

EBPH: Evidence-based Public Health.

SOPHIE: Structural Policies for Health Inequalities Evaluation.

[WHO: Commission on Social Determinants of Health.](#)

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