Health Policy 121 (2017) 307–314

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Poverty and private health expenditures in Italian households during the recent crisis

Simone Sarti [a], Marco Terraneo [b,*], Mara Tognetti Bordogna [b]

[a] Department of Social and Political Science, University of Milan, Italy
[b] Department of Sociology and Social Research, University of Milano-Bicocca, Italy

ARTICLE INFO

Article history:
Received 21 December 2015
Received in revised form 21 October 2016
Accepted 21 December 2016

Keywords:
Inequalities in health care expenditure
Crisis
Health expenditure: poverty
Italy

ABSTRACT

The global financial crisis that began in 2008 had an overall effect on the health behaviours of Italian households. Aggregate private health expenditures have decreased while the citizens have increasingly been asked to share health costs. The reduction of households' health expenditure could have serious consequences for health, especially if it concerns the most vulnerable people. The aim of this paper is to analyse the relation between poverty and household health expenditure, considering regional and social group variations. The data used stem from the "Family Expenditure Survey" collected by the Italian Statistical Institute (ISTAT) from 1997 to 2013.

Results of multivariate analysis controlling for potential socio-demographic confounders show that the propensity to spend for poor families is decreased in the last years compared to not poor households. Meanwhile, among the households who spend, the average expenditure in euro seems to have been more stable over time.

This is an alarming signal for the health of the most vulnerable households. These conditions could result in a gradual deterioration of health in poor families, which is likely to increase the burden on health systems in future. Hence, at this moment public intervention does not seem able to alleviate this situation.

1. Introduction

A substantial share of Italian household income is allocated to purchasing medical goods and services. In 2013 around 4.0% of overall monthly expenditure concerned health [1]. On the other hand, Italian households' spending on health decreased from 29.6 billion euro in 2011 to 27.6 billion euro in 2013, a reduction of 6.8% in two years [2].

This figure might indicate the difficulty that Italian families have had in safeguarding their health in these recent years of economic crisis, but it should also be evaluated from the standpoint of equity in access to care. Inequalities in health refer to objective and systematic differences with regard to the ownership of social, economic and cultural resources and the associated ability to use such resources in order to maximize the inclination towards full psycho-physical efficiency of the body [3–5]. Many studies have shown that considerable disparities persist in people's state of health according to individuals' demographic and socioeconomic characteristics (age, income, education, social class, or a combination of these and other factors, such as ethnic group or place of residence). However, health inequalities are also connected with individuals' ability to respond appropriately to events that threaten their health, such as disease or accident. In this context, socioeconomic

* Corresponding author at: University of Milano-Bicocca, Via Bicocca degli Arcimboldi, 8, 20126, Milano, Italy. Fax: +39 02 64487561.
E-mail address: marco.terraneo@unimib.it (M. Terraneo).

http://dx.doi.org/10.1016/j.healthpol.2016.12.008
0168-8510/

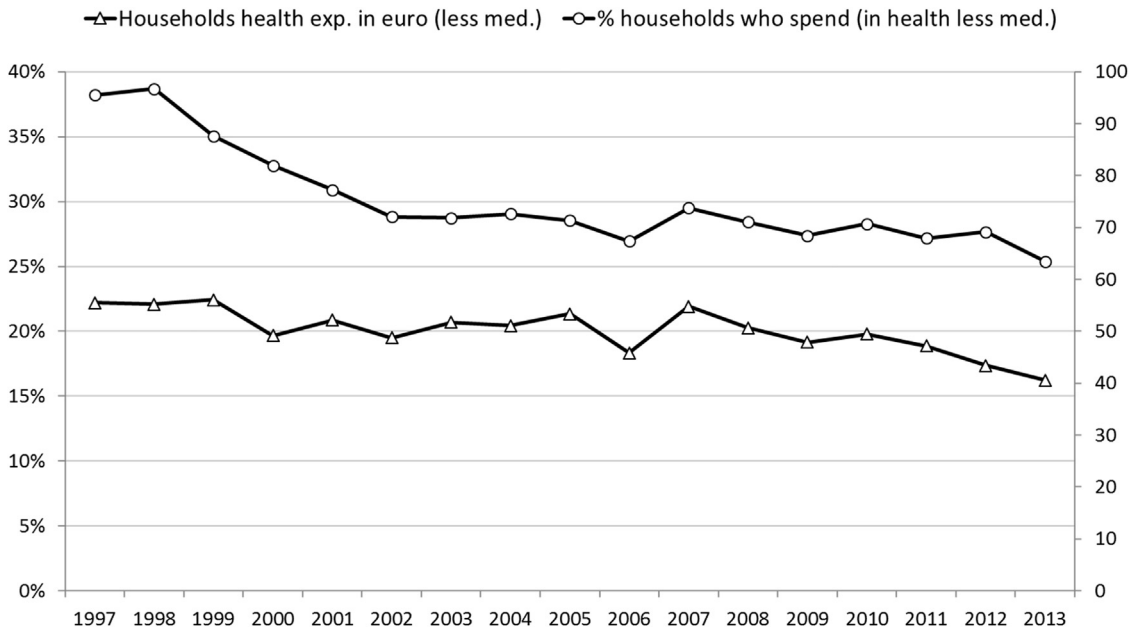

Fig. 1. Percentages of households who spend in health (less medicine), axis on the left, and average equivalent household health expenditures (less medicine) in euro PPP (constant 2013), axis on the right.

status (SES) is related to disease outcomes because individuals deploy resources (such as knowledge, money, power, etc.) to avoid risks and to adopt protective strategies [6,7]. Hence, it is not unreasonable to assume that people with greater resources are better able than people with lower SES to use health care services – in their various forms, private or public, medical or auxiliary – in order to improve their health [8]. Lesser utilization of certain health services may result in poorer health status for the population affected. In this perspective, we can talk about inequity in health care [9,10], as these differences are not only unnecessary and avoidable but are also considered unfair and unjust. Inequities in the use of health care services enhance the risk of disease and increase social disparities in health, as well as having serious effects in social and financial terms [11].

In Italy, as in most European countries, coverage of health care costs is universal for a core set of services, which usually include consultations with doctors and specialists, tests and examinations, and surgical and therapeutic procedures [12]. Nevertheless, although the aim is to offer a universal and equal healthcare system, that does not easily translate into equal utilization of care services [13–16].

When their health declines, people may purchase goods and services on the health market enabling them to overcome the problem or prevent it from becoming worse. For example, they will pay for urgent needs, such as diagnostic exams or specialist examinations, for periodic needs such as medicines for seasonal diseases or one-off morbidity or temporary limitations, as well as for routine or preventive medical tests. Some of these expenses, such as staying in a health spa, are not part of minimum levels of care covered by the Italian health system (Livelli Essenziali di Cura (LEA)—Essential Levels of Care), while in their turn waiting-list times may persuade households to turn to private care providers [17]. However, it should also be noted that literature about the public-private mix stresses that higher expenditure in the private health sector is not necessarily associated with low quality of public health services. Thus, dynamics in private expenditures, increasing or decreasing, may not depend on the functioning or effectiveness of the public health system [15].

Moreover, the share of household expenditure due to implementation of cost-sharing policies in recent years has grown steadily (e.g. the share of pharmaceutical out-of-pocket expense on total medicines expenditure per capita has increased from 6.6% in 2006 to 18.3% in 2013 [18]). In 2013, Italian households spent more than 2.9 billion by way of participation in the cost of health care (including drugs, diagnostic tests, specialist consultancies and access to Accident & Emergency) against 2.2 billion in 2010, that is an increase of over 30% [2].

Clearly, the amount of economic resources that a household devotes to health varies greatly from family to family, depending on the presence of sick members, elderly individuals or children. We know that these characteristics may represent risk factors for families' financial stability and hence affect their capacity to invest in health [19].

To complicate matters further, the worst financial crisis since the end of the Second World War, begun in 2008, has had a serious social impact, in particular on the most vulnerable individuals of society (the elderly, young, women), who have fewer resources to cope with the consequences of rising prices, erosion of savings and asset values, loss of jobs, and reduction in core public services, such as social welfare, health care, and education [13,20]. According to ISTAT [21], in 2012 11.1% of Italian citizens (13.3% in southern regions) gave up on seeking care (tests or specialists, surgery or purchase of drugs). Access to health care is more difficult for people with lim-