Dealing with inequalities in long-term care for older people in social health insurance systems

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Overview

1. Introduction: Social inequality and health inequality
2. Determinants of health inequalities
3. Inequalities in LTC and the impact of social status
4. Perspectives: Quality of LTC as area gaining relevance providing new opportunities for Health Promotion

Introduction

- Social inequality: Understood as
  - vertical – referring to a social hierarchy (mostly defined as referring to socio-economic status: education, income + property, professional status)
  - horizontal (age, gender, ethno-cultural background etc.)
- Impact of these factors on health?

Relationship between Social Class and Health 1

- Results of social epidemiological research
  - Huge social differences between wealthy and poor countries
  - But also inside countries, even cities
  - explicit correlation between mortality, morbidity and “social class”

Relationship between Social Class and Health 2

- Mortality: Impact of gender and income on average life expectancy – example Germany

Average life expectancy at birth	Women	Men
Income: Upper 25%	86	82
Income: Lower 25%	81	72

Reil-Held 2000, quoted by Mielck 2005, p.18

Relationship between Social Class and Health 3

- Morbidity: Odds of multimorbidity increases as social class decreases (Age controlled for)

Odds to become multimorbid	Women	Men
Class 1 (highest)	1	1
2	1,17	1,12
3	1,18	1,21
4	1,44	1,30
Class 4 (lowest)	1,44	1,70

Helmert/Shea 1994, quoted by Mielck 2005, p.46

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Factors identified as mechanisms creating impact of social class on health (Giddens 2006)

Ill-health

Long hours and stressful or dangerous working conditions

Lack of exercise

Stress

Low income and poverty

Poor education (particularly health education) and ignorance of healthcare and services available

Inadequate medical or social care and lack of access to health and social services

Lack of affordable leisure services or access to parks and gardens

Social isolation and social exclusion – being on the margins of society and having little control over your life

Smoking and drinking too much, taking illegal drugs, practising unsafe sex

Living in industrial areas, with risks of pollution, busy roads and poor air quality

Living in a high crime area

Lack of enforcement of health and safety at work

Eating 'junk food' and other unhealthy foods

Poor transport planning and poor access to public transport

Unemployment and poverty

Inadequate childcare and socialization

Not buying or preparing proper foods

Poor housing, with dampness, cold, and overcrowding

Figure 8.3 Cultural and material influences on health

Source: Browne (2005), p. 410

Focus on contribution of health care / LTC

Low income and poverty

Poor education (particularly health education) and ignorance of healthcare and services available

Inadequate medical or social care and lack of access to health and social services

Ill-health

The contribution of health care to health inequalities/ inequities

- A distinction offered by Bauer/Büscher 2008:
- Reproduction or production of health inequalities?
  - Reproduction: Inequalities produced by social status unchanged / not compensated by health care
  - Production: Contribution of health inequalities according to own functioning (e.g. because of preferences for specific diseases that are more likely to be effectively treated)
- Focus: Reproduction of social inequality

Mechanisms that produce health care’s contribution

- Unequal access
- Unequal utilization
- Unequal quality of care

What do we know about the relationship of social inequalities/ health inequalities in LTC in SHI/ German speaking countries?

- The impact of social inequalities on long-term care (LTC) so far has received little attention
  - in research
  - professional discussions
  - and political discussion
- Less attention than social inequality of health in general and in acute health care

(Bauer&Büscher 2008)

Why? Reasons for this imbalance

- Acute health care is understood as a basic citizen right in these systems – so inequalities are suspect of being inequities
- This is not the case for social care:
  - LTC basically is a complex mix of health and social care
  - Social care is understood as continuation of normal reproduction – where huge social differences are widely accepted
  - Social care is considered being part of welfare, closely related to management of poverty
  - Social care is a substitute for lacking private economic and social resources

What do we know about the impact of social inequality of health inequalities in the LTC field?

- Little systematic empirical research
- But plausible theoretical considerations and expert perspectives
  - that indicate a considerable impact of social status, at least in German speaking SHI countries!
- A correlation between social status on the one hand, mortality, morbidity and functional impairment on the other hand pertains also in old age
- Income and wealth, but also social and cultural capital seem to have a huge impact on which quality of LTC is available for individuals and their families

Assumptions on the impact of socio-economic status in different LTC settings

Impact concerning..	Access	Utilization	Quality
Dominantly informal care (AT: 50%)	Complex pattern	Complex pattern	Impact of health literacy of users and informal carers, economic, cultural and social capital (Bourdieu) very likely
Mix of informal and formal home care (AT: 30%)	Formally not restricted; but waiting times, quantitative restrictions of public services	Clear indication of dependency on social status	Impact of health (care) literacy, economic, cultural and social capital (Bourdieu) very likely
Residential care (AT: 20%)	Formally not restricted; but waiting times for public services	Inverse social gradient for nursing homes? Steep social gradient for privately financed options	Impact of health (care) literacy, economic, cultural and social capital (Bourdieu) very likely

Explanations for impact of inequalities in LTC

- A) Macro (societal) level
  - different conception of citizenship rights and other factors lead to a much lower level of public funding for LTC
  - A lower level of professional training and negative selection processes for (qualified) nursing staff
  - a much larger private sector where individual resources explicitly matter
  - (until recently) a much lower level of public and media attention
  - a much lower level of scientific research
- B) Meso (organisational) level
  - Resulting from A), a lower average level of resources
  - quality management/ development strategies much less developed in LTC organisations
  - Nevertheless, reforms of LTC organisations, aiming at changing size, architecture, local integration, organisational concepts etc. are beginning
- C) Micro level
  - Huge social differences in health (care) literacy of users and relatives
  - LTC systems in SHI countries seem even more complex and less transparent than acute care
  - Indications in access, utilization and quality of care indicate not only a steep social gradient on health of users, but also on health of their families as informal carers.

Quality of LTC: An area gaining relevance

- As a consequence of the ageing of European society, numbers of LTC users are growing quickly
- As well as numbers of families caring for an old person
- More voters directly affected
- The issue of LTC is gaining relevance
- Pressure for reforms on the political level for
  - more public money for LTC
  - better protective regulations
  - compulsory quality standards etc.
  - new public awareness for quality of care processes.

New Chances for Health Promotion

- New interest in quality of LTC offers a window of opportunity for developing health promotion also in LTC settings
- Seven year research program 2008 - 2014
- Program line of the Ludwig Boltzmann Institute Health Promotion Research in Vienna
- Developing concepts, tools, instruments and empirical knowledge on health promotion in organisational settings for LTC
- You can learn more about the HP in LTC approach tomorrow Friday at 14.00 in session 4.6!

Thank you for your attention!

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