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Quarterly of the
European Observatory on Health Systems and Policies
Eurostation (Office 07C020)
Place Victor Horta/Victor Hortaplein, 40/10
1060 Brussels, Belgium
T: +32 2 524 9240
F: +32 2 525 0936
Email: info@obs.euro.who.int
http://www.healthobservatory.eu

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List of Contributors

Karam Adel Ali • European Centre for Disease Prevention and Control, Stockholm, Sweden

Patrice Boyer • European Brain Council, Belgium and Paris 7 University, France

Frederic Destrebecq • European Brain Council, Belgium

Monica Di Luca • European Brain Council, Belgium and University of Milan, Italy

Giovanni Esposito • European Brain Council, Belgium

Gonçalo Figueiredo Augusto • Nova University of Lisbon, Portugal

Inês Fronteira • Nova University of Lisbon, Portugal

Maria M. Hofmarcher • HS&I HealthSystemIntelligence and Medical University of Vienna, Austria

Stefania Ilinca • European Centre for Social Welfare Policy and Research, Vienna, Austria

Sherry Merkur • European Observatory on Health Systems and Policies (London Hub), United Kingdom

David Nutt • European Brain Council, Belgium and Imperial College London, UK

Wolfgang Oertel • European Brain Council, Belgium and Philipps-Universität Marburg, Germany

Willy Palm • European Observatory on Health Systems and Policies (Secretariat), Belgium

Lucia Pastore Celentano • European Centre for Disease Prevention and Control, Stockholm, Sweden

Nataša Peri • Medical University of Vienna, Austria

Vinciane Quoidbach • European Brain Council, Belgium

Ricardo Rodrigues • European Centre for Social Welfare Policy and Research, Vienna, Austria

Andrea E. Schmidt • Austrian Public Health Institute, Vienna

Jorge Simões • Nova University of Lisbon, Portugal

Judit Simon • Medical University of Vienna, Austria

Ruth Waitzberg • Myers-JDC-Brookdale, Jerusalem, Israel

Daniel Weyermann • Federal Department of Economic Affairs, Education and Research – Civilian Service, Thun, Switzerland

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INEQUALITY AND INEQUITY IN THE USE OF LONG-TERM CARE SERVICES IN EUROPE: IS THERE REASON FOR CONCERN?

By: Ricardo Rodrigues, Stefania Ilinca and Andrea E. Schmidt

Summary: Possible inequalities and inequities in long-term care (LTC) use have thus far been overlooked in health policy. Two recent studies shed light on inequalities and inequities in the use of home care services and informal care, by socio-economic status, across Europe. Evidence suggests that use of home care services mostly reflects need and is therefore equitable. The picture is different for informal care, where use is concentrated among the poor, even after controlling for needs. This raises questions about possible unmet needs and the necessity to consider both informal and formal care when discussing equity in LTC.

Keywords: *Long-term Care, Inequality, Inequity, Informal Care, Home Care*

Introduction

Inequalities in the use of health care have consistently ranked as one of the most relevant issues in health care policy. In comparison, much less is known about possible inequalities in the use of long-term care (LTC) by older people. The policy relevance of this issue, however, is growing given the increasing share of the population in need of LTC and the significant out-of-pocket payments expected from people with LTC needs.[1] The European Commission has recently cautioned that failure to address LTC needs and the financial burden that it places on users and families may limit access to care to only those who have the means to pay for it.[2]

In addition, across Europe large differences exist in the availability and accessibility of home care. In recent years, many countries have sought to increase reliance on informal care provided by family members through the provision of cash-for-care benefits, often without a simultaneous extension of home care services (in-kind benefits). At the same time, eligibility criteria have also been tightened and mechanisms for increased provider competition have been introduced.[3] These differences in the financing and delivery of LTC across Europe beg the question of whether there are significant differences between countries in the use of LTC across different socio-economic groups.

Ricardo Rodrigues is Head of Health and Care Unit; **Stefania Ilinca** is Researcher, European Centre for Social Welfare Policy and Research; **Andrea E. Schmidt** is Researcher, Austrian Public Health Institute, Vienna, Austria. Email: rodrigues@euro.centre.org

Possible sources of inequalities in LTC

It is typically presumed that because people of lower socio-economic status (SES) have on average poorer health, they are more likely to use LTC services. If this is true, there could well be unequal use of LTC (i.e. inequalities), but without inequity. The distinction between inequality and inequity is an important one, particularly from a policy perspective. While inequality refers to differences in LTC use between groups (regardless of the reasons behind these differences), inequity refers to differences that are considered unfair (i.e. cannot be ascribed to legitimate differences in care needs). As a case in point, proportionally higher levels of use for those with more severe care needs would without doubt be deemed a justifiable ground for unequal use. Yet, if older people with similar needs have different possibilities to use LTC services depending on their income, this could be considered an inequitable (as well as an unequal) outcome.

> unequivocal signs of unequal use of LTC for older people

Beyond differences in need, what other factors could be considered sources of unfair inequalities in use of LTC and therefore lead to inequity? Firstly, and unlike in the case of health care, LTC services are seldom free at the point of delivery and higher out-of-pocket payments for LTC are common.[4] Lower-income people could thus find themselves in need of LTC but unable to afford it financially. In addition to income, education is another potential source of unfair inequalities in LTC use. Not only is higher education correlated with ability to pay, but it may allow individuals to better grasp complex eligibility criteria or make more credible claims for accessing services.

Household structure (e.g. marital status or number of children) may also affect use of LTC. The size and composition of the household may determine whether older people can access informal care and, given the substitutability of LTC services and informal care, this could in turn also impact on inequalities in service use. Close relatives may also act as 'advocates' for older people to receive LTC services. Finally, the structure of the household can become an explicit eligibility criterion, linking access to services to the (non-) existence of family members as potential informal carers. This is the case of the Netherlands, for example, where the existence of co-residing relatives is considered when determining eligibility for publicly funded LTC.

Lastly, regional variation in service availability is a potential source of unfair inequalities. Since LTC in Europe is usually a policy prerogative of regional or local governments, more affluent regions or municipalities may be able to provide or fund more LTC services or attract a greater number of providers. This could create a sort of 'postal code lottery' in access and use of services.

Inequities in the use of LTC, particularly if these negative aspects affect the more vulnerable groups in society (e.g. the poor), are of particular concern for public policies. However, both inequities and inequalities in use of LTC are relevant as the latter might underscore undesirable outcomes in health and LTC policies in a given context. For example, differences in use of LTC between less and more affluent individuals may simply mirror differences in need between these two groups, but from a policy standpoint it would still be relevant to know that poorer individuals systematically have poorer health (and thus need more LTC).

Inequalities in use of LTC across Europe

Two recent studies have sought to assess possible SES inequalities and inequities in the use of LTC among older people living in the community across several European countries.[5,6] They included two types of LTC: formal care services provided at home (both personal care and home help), and informal care provided by people living inside and outside the household (**see Box 1**). The countries considered include a wide and diverse mix of types of LTC systems according to breadth, depth and scope of coverage: Austria, Belgium, the Czech Republic, Denmark, Estonia, France, Germany, Italy, Luxembourg, the Netherlands, Slovenia, Spain, Sweden and Switzerland. Findings are based on a cross-country survey of older people carried out in 2013, the *Survey of Health, Ageing and Retirement in Europe* (SHARE). The dataset includes information on SES, health status, level of dependency and use of the aforementioned types of LTC. Inequalities were measured using the Concentration Index (CI), a standard method for assessing SES inequalities in health and health care use that allows for country-level comparison.[7] The CI can assume values between [-1, 1], with negative values signifying pro-poor inequality (i.e. use of LTC services is concentrated among poorer individuals) and positive values depicting pro-rich inequality. Throughout, SES is proxied by income.*

The findings show that the use of LTC is fundamentally unequal for both formal home care services (henceforth home care) and informal care across Europe (**see Figure 1**). For informal care there is pervasive evidence that poorer older people are more likely to use this type

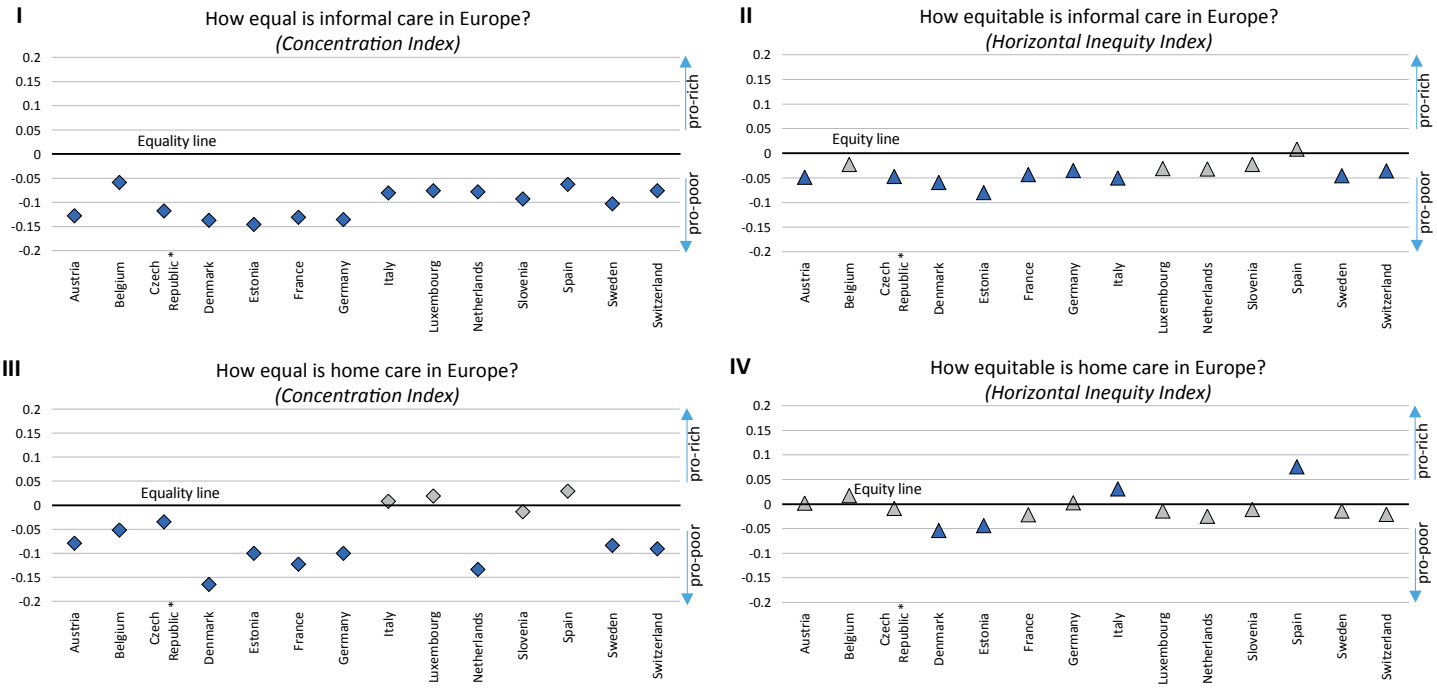
Box 1: Definitions of long-term care use

Home care refers to utilisation of professional or paid services in the home, including e.g. help with personal care, domestic tasks, other activities, and meals on wheels.

Informal care refers to receiving personal care or practical household help from a family member, friend or neighbour, inside or outside the care recipient's household.

* SES is a complex concept that refers to individuals' relative position in society, which may be determined by several factors (e.g. education, wealth, occupation). In these studies, income was considered as the main factor correlating with SES.

Figure 1: Inequalities and inequities in use of long-term care by income across Europe



Notes: Blue (darker) symbols represent statistically significant values ($p<0.05$). Grey (lighter) symbols mean that values are not statistically significant ($p\geq0.05$).
Based on weighted data. The results presented here are based on the authors' publication in the journal Health Economics [5]

of care for all the above-mentioned countries (quadrant I in **Figure 1**). The same is mostly true for home care, where use is also concentrated among poorer individuals for most countries (quadrant III in **Figure 1**). The exceptions are Italy, Luxembourg, Slovenia and Spain.

> mostly no evidence of inequity in home care use

To understand what drives the observed inequalities in LTC use, the CI can be disaggregated into individual contributions of each of the main variables likely to impact use. The decomposition for home care showed that differences in use are mostly related to care needs (which includes health, as well as age and gender), particularly lower health status and higher dependency. Care needs are the main driving force in the use of home care and since higher need is concentrated among the poor, this accounts for a great deal of the pro-poor inequality in the use of home care that we find.

The second most important factor impacting on inequalities was household structures (in some countries this was even the most important factor), which included marital status, household size and number of children. Here too, we find that the household structure drives pro-poor inequalities in the use of home care (except for Spain). This is due to the fact that larger household size and co-residing with a spouse or partner mostly limit the use of home care – a sign of substitutability between informal and formal care – and more affluent older individuals tend to have a spouse or partner and live within larger households.[6] Finally, income and education are also relevant factors in explaining inequalities.

Inequity in use of LTC across Europe

Although the CIs show unequivocal signs of unequal use of LTC for older people living in the community in Europe, the more important question is whether these differences are unfair. The same studies[5,6] also analysed inequity for both home and informal care taking income as a measure of SES. Inequity was assessed using a well-established method that first estimates how much care a person would have received if treated in the same way as the average person with similar needs, and then goes on to compare this with the actual care received. Results are displayed as a Horizontal Inequity Index (HII)†, which can be read in much the same way as the CI above: negative values indicate pro-poor inequity in the use of LTC, while positive values indicate inequity favouring the rich.

† 'Horizontal' refers to the concept of 'horizontal equity', measuring whether there is equal use of care for equal care need levels.

Once differences in need are considered, there is mostly no evidence of inequity in home care use in the countries analysed (quadrant IV in **Figure 1**). The only countries for which there is evidence of inequity are Denmark, Estonia, Italy and Spain. Among these, the findings for Italy and Spain are particularly worrisome as inequity is found to disfavour the poor, while in Denmark and Estonia pro-poor inequity was found. The picture is somewhat different for informal care. There is evidence of pro-poor inequity for Austria, the Czech Republic, Denmark, Estonia, France, Germany, Italy, Sweden and Switzerland (quadrant II in **Figure 1**); while for the other countries there is no evidence of inequity.

> poorer individuals are found to make disproportional use of informal care

Confronted with these results, should policy-makers worry about inequity in LTC? At first glance, the different LTC systems across Europe seem to essentially target home care on the basis of need and therefore are fairly equitable in how use of home care is distributed across people with different incomes. This picture may, however, change in the near future as some countries have started to discuss making access to LTC services conditional on household situation (similarly to England or the Netherlands) in order to better target scarce resources. Findings from at least one of the studies included here[6] suggest that this could increase SES inequalities and inequities in the use of LTC services. Furthermore, the findings for informal care should also give policy-makers reason to pause. Poorer individuals are found to make disproportional use of informal care. While this could represent different preferences such as stronger filial norms among non-co-residing children of poorer older individuals,[8] it could also signal that some individuals may not be able to access LTC services and must be content with using informal care. At the same time, informal care may be less readily available to less affluent older individuals as they tend to live in smaller households and be single or widowed more frequently. Despite smaller (household) networks, poorer individuals disproportionately rely on informal care. Should this matter for European societies? This largely depends on who provides informal care and how. Several studies have linked high intensity informal care to adverse health and well-being among carers and limited ability to reconcile care with labour market attachment (for an overview see[9]). Furthermore, what is unquestionable is that women make up the majority of informal carers in Europe.

Conclusions

Despite the diversity of LTC systems in Europe, it seems that most countries are able to target LTC to those most in need regardless of their income. At the same time, however, there is strong evidence that informal care is mostly used by poorer older people. This may hint at the existence of unmet needs for LTC, either because individuals cannot afford services or because services provided only partially cover the needs of older people. As most informal carers are women, income differences in the use of informal care may also underscore gender inequalities in the provision of LTC. Informal care, besides LTC services, should thus be a key factor in the analysis and discussion of inequality and inequity in LTC.

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