



Full Length Article

Social capital and preventive care use among the elderly under Taiwan's National Health Insurance

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ABSTRACT

Objective: The National Health Insurance (NHI) system in Taiwan provides free annual preventive care services and other disease-specific preventive care services under low copayments to people aged 65 and older, yet their utilization rates remain low ever since implementation. This study investigates whether social capital is associated with preventive care use among people aged 65 and older.

Method: Using the 2009 National Health Interview Study, this study measures social capital by the elderly's social network and social participation, and employs the logistic regressions to estimate the association between social capital and the odds of using a variety of preventive care services.

Results: The results show that social capital in terms of social network and social participation is significantly associated with the use of NHI general preventive care services. For disease-specific preventive care, it is social participation, rather than social network, that is related to the utilization rate.

Conclusion: The associations between social capital and different types of preventive care use found in our study could be considered as an important factor when making policies to promote the utilization of preventive care.

1. Introduction

Containing medical costs through prevention programs has become even more important as many countries' health care expenditures are high and continually growing. Prevention programs include a range of services such as vaccination, public sanitation and public health programs, preventive and screening services, and disease awareness and education programs. The above preventive measures help reduce medical costs by means of promoting healthy lifestyles, reducing the odds of becoming sick, treating diseases at early stages, and preventing medical complications (Kenkel, 2000). Individuals invest in their own health by adopting good lifestyle and using preventive care services to achieve and maintain the proper health. It is therefore imperative to understand the determinants of preventive care utilization from a broader perspective.

Economic variables as well as social factors affect the utilization of preventive care services. Among social factors, social capital plays a crucial role in health status, health care service utilization, and health behavior (Lochner, Kawachi, & Keenedy, 1999; Deri, 2005; Hawe & Shiell, 2000; Kim & Konrath, 2016). Researchers have defined and measured social capital in a variety of ways (Coleman, 1988; Macinko & Starfield, 2001; Putnam, 1993). Generally, social capital consists of certain features of social organizations, such as trust, norms, and

networks. Some researchers focus on discussing community-level social capital, while others center on the exploration of individual-level social capital (Paldam, 2000).

There is a variety of channels through which social capital impacts individual health, health care service utilization, and lifestyle choices (Kawachi, Kennedy, & Glass, 1999). First, social capital facilitates access to health care services and health care delivery. Second, individuals obtain information via formal or informal networks, which may enhance people's ability to make healthy choices. Third, social capital improves individual health by enforcing or changing social norms.

1.1. Social capital and health

Many prior studies have empirically explored the relationship between social capital indicators and health-related variables such as health status, medical service utilization, and health behavior. Most found that social capital indicators are important determinants of physical health and psychological health. Using aggregate level data, Kawachi, Kennedy, Lochner, and Prothrow-Stith (1997) noted that lower investment in social capital is associated with higher mortality rates. Kawachi et al. (1999) showed that people living in areas with lower social capital are more likely to have self-reported poor health,

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after controlling for various socio-demographic variables. Rose (2000) used Russian data and presented that both social capital and human capital produce significant effects on physical health and emotional health. Using Taiwan data, Cheng and Chiang (2002) exhibited that a higher level of social capital is positively associated with health status and subjective happiness.

Using data of eight former Soviet republics, d'Hombres, Rocco, Suhrcke, and McKee (2006) supported the argument that social capital enhances individual health. Lindstrom and Mohseni (2009) examined political trust and psychological health in Sweden and reached the conclusion that a lower level of political trust is associated with worse mental health. Chang (2009) investigated the relationship between various forms of social capital and subjective happiness in Taiwan, finding that participating in civil groups, volunteering, participating in community activities, and the level of social trust all positively impact individual subjective happiness. Contrary to conclusions reached in most studies, Veenstra (2000) used Canadian individual-level data and found little evidence to support the argument that social capital enhances self-reported health.

Gray (2009) addressed the concept of social capital specifically for older people, defining social capital as “the array of social contacts that give access to social, emotional, and practical support”. The author pointed out that in recent years the declining support from family increases elders' dependence on communities in the U.K., and found that frequent interaction with other people through informal tie provides rich support for older people. Empirical gerontological studies have confirmed that social capital is positively related to older people's physical health, mental health, well-being, and lower mortality rate (Ichida et al., 1997; Litwin & Shiovitz-Ezra, 2011; Pollack & von dem Knesebeck, 2004; Zamora-Macorra et al., 2017; de Brito et al., 2017). For instance, Pollack and von dem Knesebeck (2004) provided evidence that lack of social capital in terms of civic trust is associated with poorer self-rated health, depression, and functional limitations among Americans aged 60 and older. Litwin and Shiovitz-Ezra (2011) showed that more diverse social network is related to better well-being among Americans aged 65 and older. Ichida et al. (1997) provided evidence from an East-Asian country, showing that a higher level of social capital and a lower level of income inequality relate to better self-rated health among community residents aged 65 and older in Japan.

1.2. Social capital and medical service utilization

As for the effect of social capital on the utilization of medical services, several researchers showed that social capital is an important factor influencing demand for healthcare services. Social networks are one form of social capital and could change utilization in many directions mainly through dissemination of information. Using the Canadian National Population Health Survey, Deri (2005) noted that strong social networks have an effect on healthcare service utilization. Laporte et al. (2008) explored the relationship between community- and individual-level social capital and healthcare service utilization, using the 2001 Canadian Community Health Survey and the Canadian Census. The authors exhibited that social capital impacts physician visits, but not hospitalization services.

For the elderly population, Kim and Konrath (2016) examined the relationship between volunteering and health care use among American adults aged above 51. The authors found that volunteers compared to non-volunteers have a higher probability to utilize preventive services. In addition, volunteers spent fewer nights in a hospital. For Taiwan, using the 2005 National Health Interview Survey, Lin and Tsai (2013) focused on the elderly population and presented that social capital is positively associated with self-reported health and mental health. In addition, social network positively impacts the use of outpatient care services, but negatively affects the use of inpatient care services. Chu and Chen (2012) provided evidence that the implementation of National Health Insurance in Taiwan reduces the financial barrier to

access health care and increases the role of informal social network in the utilization of health examinations among the elderly. They suggested that relatives and friends in the informal network improve the use of health examinations by providing related health information and enhancing the concept of health investment.

1.3. Social capital and health behavior

In the case of social capital and health-related behavior, Nollen, Catley, Davies, Hall, and Ahluwalia (2005) indicated that social support helps in the effort to quit smoking. Brown, Scheffler, Seo, and Reed (2006) contended that the proportion of community social capital attributable to religious groups is negatively and significantly related to consumers' tobacco consumption. Folland (2006) used Putnam's social capital index and state-level social capital to examine the relationship between social capital and risky health behaviors, such as smoking, binge drinking, and illicit drug consumption. Similar to findings in this line of research, the author found that social capital negatively impacts risky health behavior.

Using a sample of American aged 57–85, the study by Shiovitz-Ezra and Litwin (2012) indicated that older people with more resourceful social network are less likely to engage in risky health behavior such as alcohol abuse, more likely to participate in health-promoting activities such as walking and exercising, and more likely to seek alternative medicines such as acupuncture and massage therapies. Watt et al. (2014) presented similar results. Locher et al. (2005) found a positive relationship between social isolation and increased nutritional risk among all ethnic and gender groups of people aged 65 and older.

1.4. National Health Insurance (NHI) in Taiwan

Taiwan's NHI has been launched in 1995, providing comprehensive coverage in medical services for all people at low copayments. Before the implementation of NHI, 59% of the population was covered by various social insurance programs, such as labor insurance, government employee insurance, and farmers' insurance with different payment schemes and coverages. However, the remaining 41% of the population was uninsured, and most of the uninsured were the elderly, children, and people who lost jobs. Since 1995, NHI has integrated different social insurance programs and offered a uniform benefit package to all citizens and legal residents in Taiwan. It is a compulsory health insurance system with a single-payer design. NHI has a fairly comprehensive benefit package including outpatient care, inpatient care, prescription drugs, dental care, eye care, mental illness treatment, traditional Chinese medicine, and in-home care. The introduction of NHI has greatly alleviated people's financial burdens to access good quality of care with rather modest cost sharing. In Taiwan, most hospitals and clinics are private. Around 94% of health care providers are contracted with the government and obtain reimbursement when they provide medical services. In addition, people can easily access health care without referral and queuing. NHI is mainly financed by payroll based premiums. In order to contain growing medical expenditures, the government has also implemented a range of payment reforms in recent years (National Health Insurance Administration, 2016).

In 1996, NHI introduced the program of adult preventive care services, offering free general preventive care services to people aged 65 and older annually and people aged between 40 and 65 once every three years. The general adult preventive care services currently contain personal information inquiries, physical examinations, laboratory tests, and health consultation services. In addition to general preventive care, NHI offers a variety of disease-specific preventive care services to people aged 65 and older for free or at low copayments. Despite the utilization rate of preventive care services having increased over time since the inception of the adult preventive care program in 1996, general preventive care use remains around 35%.

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