

Original Article

Time trends in health inequalities due to care in the context of the Spanish Dependency Law

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ABSTRACT

Objective: In Spain, responsibility for care of old people and those in situations of dependency is assumed by families, and has an unequal social distribution according to gender and socioeconomic level. This responsibility has negative health effects on the carer. In 2006, the Dependency Law recognised the obligation of the State to provide support. This study analyses time trends in health inequalities attributable to caregiving under this new law.

Methods: Study of trends using two cross-sectional samples from the 2006 and 2012 editions of the Spanish National Health Survey (27,922 and 19,995 people, respectively). We compared fair/poor self-rated health, poor mental health (GHQ-12 >2), back pain, and the use of psychotropic drugs between non-carers, carers sharing care with other persons, and those providing care alone. We obtain prevalence ratios by fitting robust Poisson regression models.

Results: We observed no change in the social profile of carers according to gender or social class. Among women, the difference in all health indicators between carers and non-carers tended to decrease among those sharing care but not among lone carers. Inequalities tend to decrease slightly in both groups of men carers.

Conclusions: Between 2006 and 2012, trends in health inequalities attributable to informal care show different trends according to gender and share of responsibility. It is necessary to redesign and implement policies to reduce inequalities that take into account the most affected groups, such as women lone carers. Policies that strengthen the fair social distribution of care should also be adopted.

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Evolución de las desigualdades en salud debidas al cuidado en el contexto de la Ley de Dependencia española

RESUMEN

Objetivo: En España, el cuidado de las personas mayores o en situación de dependencia es desempeñado por las familias, con desigual distribución social según género y nivel socioeconómico. Esta responsabilidad afecta negativamente a la salud de quienes cuidan. En 2006, la Ley de Dependencia reconoció la obligación del Estado de atender esta situación. Este estudio analiza la evolución de las desigualdades en salud atribuibles al cuidado en el contexto de la ley.

Método: Estudio de tendencias basado en las ediciones de 2006 y 2012 de la Encuesta Nacional de Salud de España (27.922 y 19.995 personas, respectivamente). Se obtuvieron razones de prevalencia robusta mediante modelos de Poisson para comparar mala salud autopercibida, mala salud mental (GHQ-12 >2), lumbalgia crónica y uso de psicotrópicos entre quienes no cuidaban, quienes compartían con alguien el cuidado y quienes cuidaban en solitario.

Resultados: El perfil de las personas cuidadoras permaneció invariable según género y nivel socioeconómico. Entre las mujeres, las desigualdades en salud, respecto a las que no cuidaban, se redujeron para aquellas que compartían el cuidado, manteniéndose para las que cuidaban en solitario. En los hombres, las desigualdades disminuyeron para ambos grupos de cuidadores respecto a no cuidadores.

Palabras clave:

Cuidadores

Desigualdades en salud

Género

Políticas públicas

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Conclusiones: Entre 2006 y 2012, la evolución de las desigualdades en salud atribuibles al cuidado informal muestra diferentes tendencias según género y reparto de responsabilidad. Son necesarias políticas dirigidas a reducir estas desigualdades valorando los grupos más afectados, como las mujeres que cuidan solas. Además, deben adoptarse políticas que fortalezcan una distribución social más equitativa del cuidado.

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Introduction

The organisation of care for elderly people or individuals with functional diversity is one of the main challenges faced by western societies at the beginning of the 21st century. The “crisis of care” has intensified as women have progressively moved into the paid labour force and as fertility rates decrease and life expectancy increases in many countries. These ageing societies have resulted in heavy pressures on families and also on welfare state regimes.¹

The provision of care varies across Europe according to labour markets and welfare state regimes. Mediterranean countries form a distinctive cluster where the management of care is delegated almost entirely to the family, mostly to women in the private sphere.² Care is predominantly provided by women, based in traditional gender stereotype and the gendered division of work.

There is evidence that family care negatively affects the caregiver's quality of life, with an impact on both physical and psychological health.³ The stress produced by caregiving can lead to physical and emotional problems, and even death.⁴ The responsibility of care is also linked to a deterioration in self-perceived health, pain, depression.⁵ Caring for others also affects other aspects of life, undermining personal development and opportunities to enjoy leisure time and a social life.⁶ These health effects are due to the conditions under which care is given, rather the care itself, and are likely modulated by the amount of time devoted to caregiving,^{7,8} the type of activities carried out,⁹ social support,¹⁰ and formal and informal networks to complement care activities.^{7,11} In addition, cultural norms and motivation to provide care could also influence the burden.¹² Family care is assumed according to a social hierarchy that is related to gender and socio-economic level. Informal care is distributed in families according to gender, age, relationship, and cohabitation status. Thus, caregivers are usually women aged ≥ 50 years who are the mother, daughter or wife of the care-receiver, who live in the same home as the care-receiver, and who are not in paid employment.^{13,14} Due to its unequal social distribution, caregiving is a determinant of health inequalities.⁸

Spain has one of the highest proportions of elderly people of all OECD countries, with 17.6% of the population aged >65 years. In 2008, there were 3,850,000 people with functional diversity (8.5% of the population), of which more than half were in a situation of dependence, i.e. needing personal assistance to carry out activities of daily living.¹⁵ The Dependency Law passed in 2006 (Ley 39/2006 2006; LAPAD, from its acronym in Spanish) was an important turning point because it introduced the notion that all citizens have a right to be cared, and that the State is obliged to provide care for people in situations of dependence. LAPAD contemplates social benefits in the form of services and economic compensation when a person is cared by family members. Reports and studies of LAPAD have highlighted budget difficulties since its implementation,¹⁶ with the most important reductions in July 2012 due to budget cuts in the context of government austerity policies.¹⁷ Some authors have argued that LAPAD does not sufficiently integrate all the perspectives of the various actors involved, and that this could reinforce care-related social inequalities.^{1,12,18} To date, studies analysing the impact of LAPAD have mainly focused on the

economic aspects, and on satisfaction among people in situations of dependence.¹⁶ To our knowledge, no population-level studies have examined the influence of LAPAD on caregivers' health and health inequalities with respect to non-caregivers.

The aim of this paper is to analyse time trends in health inequities due to caregiving for elderly people or those in situations of dependence in the context of LAPAD, taking gender and caregiver status into account.

Methods

Design, information source and study population

We performed a study of time trends using two cross-sectional samples based on data from the 2006 and 2012 editions of the Spanish National Health Survey (acronym in Spanish: ENS), which were conducted before and after introduction of LAPAD, respectively. The study population consisted of all non-institutionalised persons aged ≥ 16 years who were living in Spain in the year of the survey.

Study sample

A stratified multistage sampling was applied for both surveys, the first, second and third-stage units being census tracts, main family dwellings, and individuals, respectively. Individuals who declared severe chronic limitation to their activity due to a health problem in the previous 6 months (5.3% of samples in 2006 and 4.3% in 2012) were excluded from the analyses to avoid reverse causality due to their inability to be caregiver. The final sample obtained consisted of 27,922 persons in 2006 and 19,995 in 2012.¹⁹

Variables

1) Health outcomes

The following health indicators were used as the main dependent variables:

- Self-rated general health status: using the question “Within the last 12 months, would you say your health was very good, good, fair, bad or very bad?”, we created a dichotomous outcome variable expressed as good (“very good” or “good”) or poor (“fair”, “bad” or “very bad”) health.²⁰
- Mental health: assessed using the 12-item version of the General Health Questionnaire (GHQ-12) with questions referring to the previous weeks and categorizing three or more points as indicating poor mental health.²¹
- Lower back pain: assessed using the question “During the last 12 months, have you suffered from lower back pain?” (yes/no).
- Use of psychotropic drugs: assessed using the question “during the past two weeks, have you used tranquilizers, anxiolytics, sleeping pills, antidepressants and/or stimulants?” (yes/no).

2) Main independent variable

To identify caregivers, ENS 2006 used the following questions: “Is there anyone in your home older than 74 who needs care? If yes, who mainly takes care of this person?”; and “Is there anyone in your home who is disabled or has limitations, and who

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