



## Inequity in long-term care use and unmet need: Two sides of the same coin



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### ABSTRACT

We investigate the determinants of several LTC services and unmet need using data from a representative sample of the non-institutionalised disabled population in Spain in 2008. We measure the level of horizontal inequity and compare results using self-reported versus a more objective indicator of unmet needs. Evidence suggests that after controlling for a wide set of need variables, there is not an equitable distribution of use and unmet need of LTC services in Spain; formal services are concentrated among the better-off, while intensive informal care is concentrated among the worst-off. The distribution of unmet needs for LTC services depends on the service considered and on whether we focus on subjective or objective measures. In 2008, only individuals with the highest dependency level had universal coverage. Our results show that inequities in most LTC services and unmet needs among this group either remain or even increase for formal services.

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### 1. Introduction

A large body of literature describes the existence of inequity in health care use in most (if not all) developed countries (Van Doorslaer et al., 2004; Bago d'Uva and Jones, 2009; Devaux and de Looper, 2012). However, there is no evidence on the level of horizontal inequity in the access to long-term care (LTC) services, i.e., the range of services needed by persons who are dependent on help with basic activities of the daily living (OECD, 2005) or the level of unmet needs reported by potential users of these services.

It is well known that there are large differences in the current LTC organisation and spending among European countries. For example, while half of the EU-27 countries spent less than 1% of their GDP on LTC in 2007, Sweden and the Netherlands spent around 3.5% of their GDP (Economic Policy Committee, 2009).

Although the baseline is very different between countries and the evolution of the health status of their populations is uncertain, the demographic evolution of European countries in the forthcoming decades is expected to pose significant pressure on public budgets regarding pension benefits, health care and LTC costs (DG ECFIN, 2006; Economic Policy Committee, 2009). The evolution of LTC expenditures will be conditioned by several distinct factors: demographics (percentage of the population over 65), institutions (organisation of the LTC system, trade-off between formal and informal care and support for the latter type of care) and health (Spillman, 2004; European Commission, 2007; Lafortune et al., 2007; Manton et al., 2007; Manton, 2008; De Meijer et al., 2011; Jiménez-Martín and Vilaplana Prieto, 2012). Therefore, ageing of the population will not only challenge the organisation of health care systems but also imply a redefinition of LTC systems in the years to come. In this regard, identifying how access to LTC services is distributed across socioeconomic groups among the subsample of the population with a health impairment is crucial. Moreover, it is likely that barriers are not distributed equally among

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socioeconomic groups, so people with high levels of education and financial safety experience a lower level of entry barriers than those with low levels of education and income. This could be due, among other reasons, to an inequitable geographic distribution of LTC services, to differences in the treatment of patients on the basis of socioeconomic status, or to the existence of differences in the demand of health and social care services among patients with different levels of income and education (Hurley and Grignon, 2006).

We investigate inequity in the access of various LTC services using a rich Spanish dataset representative of the non-institutionalised disabled Spanish population. At the time of conducting the survey, Spain was characterised by very low LTC expenditures, with a strong component of private financing. We first analyse equity in the use of a series of LTC services. We find that individuals at the higher end of the income distribution utilise a relatively larger share of formal services (provided by a professional). In particular, high levels of pro-rich inequity are found for the use of community care services and some home care services of all disabled individuals, which may be related to the existence of barriers to access for poorer individuals in terms of both availability of the service (e.g., waiting lists) and costs associated to these services (Hernández-Quevedo and Jiménez Rubio, 2011). The use of intensive informal care services appears to be disproportionately concentrated within the worse-off, with families acting as safety nets.

However, inequity regarding LTC use may not be due only to an inequitable treatment of the rich/poor, but also to differences in preferences. If people with higher incomes and better education levels have a stronger preference for the use of certain LTC services, then similar LTC consumption patterns could result (Koolman, 2007). In addition, a given amount of use does not guarantee that all health needs are satisfied. Hence, we investigate unmet need for LTC services using two alternative definitions. Measuring whether needs for long-term care are met is difficult because it has multiple dimensions, both subjective and objective, and depends in part on individual preferences and perceptions (Kemper et al., 2008). In fact, we can distinguish between normative need (defined by experts or professionals using professional standards), a person's or group's felt need (based on their own belief of need) and technical need (when existing provision is made more effective or a new kind of provision is developed) (Vlachantoni et al., 2011).

Therefore, the definition of unmet need depends on the concept of need considered. Together with self-reported measures of unmet needs for the use of several LTC services included in the survey, we consider an alternative indicator, which captures whether an individual who has at least one daily living activity (ADL) affected does not receive any care. While both self-reported and ADL-related unmet need variables have been used in several studies (Allin et al., 2010; Kemper et al., 2008; Shea et al., 2003; Tennstedt et al., 1994), this is the first study to our knowledge that compares results for both types of unmet needs measures. The empirical analysis indicates significant differences depending on the type of care considered and between the two types of indicators of unmet needs. This suggests the importance of considering complementary indicators of unmet needs whenever possible for enriching the analysis and not unduly limiting the nature and dimensions considered in this complex concept. Our results show that the more objective measure considered in the analysis has a larger level of pro-poor inequity compared to self-reported measures, suggesting some level of self-reporting bias on the basis of the socioeconomic position.

Spain provides an interesting context to study inequity in LTC. In 2006, a new Dependency Act was approved in Spain, which recognised the universal right of the dependent population to receive services. The implementation of the new system was designed to

be progressive, and at the time of our analysis, only the population with the highest level of dependency were included. We investigate if inequity in access and unmet need is reduced once we look at the subgroup of the population with universal coverage. Our results are not very encouraging as they show that beneficiaries of LTC services (major dependents) seem to experience (relatively higher) pro-rich inequity in the use of formal services.

Our findings will be particularly useful to countries such as Italy, Poland or Hungary, which, like Spain, have not yet implemented fully comprehensive national LTC programmes and which rely heavily on informal care (Saltman et al., 2006). To our knowledge, this is the first attempt to evaluate the level of income related inequity in the access to LTC (rather than health care), that is, whether disabled individuals with the same level of need that require these services experience a difference in the level of utilisation or unmet needs related to their socioeconomic status.

In the next section we describe the Spanish LTC system. Section 3 describes the data and method used. In Section 4, we discuss the results on the determinants of use and unmet need in LTC and the inequity in the use of several LTC services and unmet need. The last section discusses the main policy implications and concludes.

## 2. Institutional background

The Spanish National Health Service is universal in coverage, funded from taxes and predominantly operates within the public sector, with health competences totally devolved to regions since 2002 (García-Armeño et al., 2010). Health expenditure in Spain reached US\$ 3027 purchasing power parity (PPP) per capita and 9.54% of gross domestic product (GDP) in 2010. Most health expenditure (73.6%) is derived from public sources (mainly from taxation) (OECD Health Data, 2012).

By contrast, at the turn of the century, Spanish levels of social protection expenditure associated with LTC were extremely low compared to other European countries (Comas-Herrera et al., 2006; DG ECFIN, 2006). Coverage was not universal; a significant share of LTC expenditure was funded directly by households (dependent person and his/her family), with a high level of co-payments and a greater weight on informal care. Formal remuneration for informal caregivers was very low (almost nonexistent), and social protection was weak. The family played a dominant role as the main safety net to cover the needs of people in situations of dependency, while public sector support was secondary. Only when the family did not exist, or collapsed due to the large burden accumulated by caregivers, and when the economic capacity was not sufficient to pay for formal professional care, public social services were provided. However, demographic projections, coupled with social changes that occurred in recent decades (e.g. reduction of family size, increasing incorporation of women into the labour market) seriously threatened the future sustainability of this system (Gutiérrez et al., 2010).

In this context, at the end of 2006, the Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency Act (Act 39/2006 of 14th December) was approved in Spain, establishing a new National System for Autonomy and Assistance for Situations of Dependency (SAAD). The Act recognises the universal nature of social benefits and the entitlement to access them under equal conditions for all elderly or disabled people who need help carrying out basic daily living activities. Regions are responsible for the provision of benefits and services established by the Dependency Act. These responsibilities include both provision of services to dependent people and the provision of certain benefits. The Ministry of Health, Social Policies and Equality sets a threshold of minimum services and benefits that should be allocated to eligible

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