Chapter

Perspective Chapter: Reducing the Social Inequality Gaps in Older Ages in Low- and Middle-Income Countries

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Abstract

Social inequalities abound worldwide. However, those social inequalities that encompass the lack of access to resources, including primary healthcare, are more prevalent at older ages in low- and middle-income countries, which is the focus of this chapter. This challenge has become critical due to the increasing population of older age. The design and implementation of key policy measures, including primary healthcare in low- and middle-income countries, is essential in reducing such social disparities. Access to primary healthcare is perhaps the principal determinant of social equality and/or equity for older people, which in turn supports achieving Sustainable Development Goals and comprehensive healthcare access.

Keywords: low- and middle-income countries, older adults, population ageing, social inequality, sustainable development goals

1. Introduction

Social inequality refers to a situation in which individuals have unequal access to valuable resources, services, and societal positions [1]. It embodies the unequal opportunities and advantages that stem from various social positions or statuses within a particular community or group. It comprises recurring and organised patterns of inequitable allocations of resources, opportunities, rewards, and penalties. Social inequality is the result of a society structured according to age, gender, class, and race hierarchies that mediate entry to resources as well as privileges in a certain way that results in an unequal distribution of them. It may surface in various ways, such as disparities in financial status, inequitable educational and medical access, and discriminatory societal treatment. There are five primary categories of social inequalities, focusing on (1) wealth, (2) treatment and responsibility, (3) political activity, (4) life chances, and (5) membership [2]. The discussion in this chapter is more aligned with treatment and responsibility inequality and the differentials thereof, wherein most people can benefit more and access privileges than others.

Inequality of opportunities and conditions are the two primary modes of measuring social inequality. An imbalance in material items, income, or wealth constitutes an inequality of conditions. The Gini index, which measures the income distribution between the top and poorest 10%, reflects this type of inequality [3]. Disparity in the allocation of life chances among persons constitutes inequality of opportunity. Education attainment, health status, and interactions with the criminal justice system are indicators of this phenomenon.

As a social problem, inequality comprises the following components: structural circumstances, ideological backing, and social changes [1, 2]. Structural conditions comprise measurable factors that are influential in fostering social disparities. Power dynamics, occupations, educational achievement, income, and poverty all contribute to social inequality among individuals and communities. Ideological foundations consist of presumptions and concepts that uphold socioeconomic disparity within a given society. Studying how formal laws, public policies, and prevailing beliefs contribute to and maintain socioeconomic inequality. Social changes entail items of organised resistance, protest groups, and social movements. Understanding how such social reforms contribute to the formation or modification of societal inequality, in addition to their inception, consequences, and enduring repercussions, is necessary, to say the least.

In the opinion of classic functionalist theorists, inequality is unavoidable and desirable because it serves a vital societal purpose. Professions that are fundamental to society necessitate further education and should thus be compensated more. According to this view, social inequality and stratification lead to a meritocracy based on ability [4].

Older people are those who are approaching or have exceeded the average life expectancy. Seniors are also called as older people, elders, the elderly, senior citizens, or older adults. Old age is not a distinct biological phase. Old age, referred to as chronological age, varies depending on culture and historical context. According to Kent [5], old age is the final stage in an individual's life course. Typically, old age is characterised by a deterioration of both physical and mental faculties and a decline in social obligations. The exact initiation of old age exhibits cultural and historical variation. It is not a biological stage but rather a social construction.

Primary healthcare (PHC) is offered within the community to individuals who are seeking advice or treatment from a medical practitioner or clinic for the first time [6]. It is essential that PHC should be based on scientifically robust and socially acceptable methods and technologies. New solutions can make universal health coverage accessible to every family and community member. PHC initiatives enable community members to engage actively in the process of implementation and decision-making.

In the content of this chapter, low- and middle-income countries (LMICs) refer to developing countries, which, although sovereign states, possess underdeveloped industrial sectors and a less favourable position in the Human Development Index in comparison to other nations [7]. Precarious middle-income countries are not granted concessional funding or debt relief. Despite this, the Common Framework for Debt Treatment remains ineffective. In the realm of finance, they encounter interest rates that are as much as eight times more than those observed in wealthy nations. Official development assistance (ODA) inflows are significantly below the predetermined target of 0.7% of gross domestic product (GDP) [8].

Older adults who have low socioeconomic status (SES) have unfulfilled health needs, especially among individuals residing in areas with minimal health resources and yet are predisposed to the risk of not accessing healthcare. Studies from Europe

allude to socioeconomic inequalities and healthcare access in Central and Eastern European populations, as well as the Commonwealth of Independent States [9].

There has also been observation regarding the utilisation of healthcare services by older persons since it was global and also encompassed all health services, without much information on the utilisation of PHC in LMICs [10] such as Brazil, Chile, China, Estonia, Ethiopia, Ghana, Senegal, South Africa, and Thailand, among others. There is insufficient information regarding the fairness of PHC use among older individuals, particularly in LMICs. The impact of socioeconomic disparity on older individuals' usage of PHC is yet to be determined.

2. The social inequality challenge in the selected fields related to population ageing

Social inequality is on the rise globally and has been more disregarded. As Dworkin ([11], p. 11) describes, equality is becoming "the endangered species of political ideals". Economic disparities are significant, but social inequality encompasses broader issues. Significant social and economic disparities are seen in countries worldwide [12]. Unfortunately, spatial inequality remains. For example, food insecurity is especially prevalent among rural residents. Food insecurity of moderate to severe severity impacted 33% of individuals in rural regions and 26% of those in urban areas.

Identified major socioeconomic status (SES) indicators include income, education, employment, and health coverage status. Research findings consistently show that individuals with better income, higher educational attainment, and health insurance tend to use PHC services more frequently [13].

2.1 Education

A relationship between education and PHC utilisation was documented in several studies [14–23]. Observations and indications are that well-educated older persons had the likelihood of utilising PHC services compared to persons with lower levels of education in Brazil [18], Cuba [23], Estonia [21], Ethiopia [22], and Nigeria [23]. In addition, it has been indicated that seniors with limited education were inclined to utilise PHC services in Brazil [18] and China [14, 16]. Other studies found no association between the two variables. Furthermore, some studies have been conducted where scholars discovered no correlation in Chile [24], China [25, 26], Jordan [27], the Dominican Republic, Puerto Rico, Venezuela, Peru, Mexico, and India [23].

2.2 Employment

Notable correlations have been identified between present employment status or previous occupational roles and the utilisation of PHC services. Studies conducted by Martinez [17, 25] revealed the relationship between the current job status of seniors and PHC utilisation. Martnez [25] also found that unemployed or economically inactive senior women in Chile showed a higher tendency to utilise PHC services. Moreover, male individuals who were economically non-active appeared to be inclined to schedule preventative checkups. The same cannot, however, be said about unemployed older men. For instance, it has been observed in China [15] that an unfixed connection is present between different employment statuses and the use of local medical facilities.

The literature shows that in China [27], previous employment in formal sectors is linked to higher PHC usage. The results varied depending on the sorts of services. Older employees in the public sector or administration and firms were more inclined to utilise critical public health services, including medical checkups and everyday life advising, than workers in different sectors. However, the situation differs significantly when it comes to the utilisation of health records, health education services, and influenza vaccination services. There is no correlation between the use of PHC and occupation in China [28], mainly because occupation was not considered in the studied multivariable model. Similarly, no significant connections were found between the economic sector and the use of PHC in Brazil [17].

2.3 Health insurance

Some studies e.g. [15, 16, 26, 29] have analysed the correlation between enrolment in health insurance plans and PHC utilisation, indicating that older individuals with health insurance are more inclined to utilise PHC services. Specifically, it has been found that in LMICs, senior individuals with health coverage tended to utilise community health facilities within the last 3 months in Latin American and Asian nations, excluding rural Peru, rural China, and urban India [23]. Similarly, it has been documented that in China, India, Mexico, and South Africa [30], senior individuals with insurance were more prone to accessing fundamental chronic care services, except in South Africa. An investigation conducted in China examined the usage of PHC services among older adults with various health insurance kinds. The study revealed that self-financed people were less inclined to use PHC services [15]. Last but not least, Lu and the team [16] stated that older adults with prior exposure to paid insurance were more inclined to utilise a range of local medical facilities, such as chronic illness management and health examinations.

Older persons' care should be integrated, localised, and well-aligned to their specific needs [31, 32]. This encompasses PHC. These demands pose challenges for authorities and families because PHC is mainly focused on addressing goals linked to maternity and child wellness as well as infectious diseases [33]. The world's population is ageing. Consequently, the percentage of individuals aged 60 and over is projected to rise from 12% in 2015 to 22% in 2050 [31]. This comes together with ceaseless and common noncommunicable diseases (NCDs), with co-morbidities increasing progressively with age [34, 35]. Moreover, still prevalent in the health systems of LMICs are infectious diseases, especially chronic infectious diseases, including human immunodeficiency virus and tuberculosis [36, 37]. This denotes a growing prevalence of chronic diseases that necessitates a robust PHC in communities [38], using chronic care models to address community health care requirements [39]. Many health systems globally face challenges in managing both infectious diseases and NCDs, with a particular struggle in addressing chronic illnesses due to inadequate resources [40]; thus, they are incapable of meeting the PHC requirements of seniors [41, 42].

Socioeconomic inequalities are disparities in wealth, social status, occupation, and educational history [43]. Inequalities are widespread and challenging to address by government action. For example, in Ghana, income disparities persist in the usage of health services by older individuals even after implementing the national health insurance scheme. The poorest senior individuals are the least

advantaged by this change in policy [44]. Socioeconomic disparities increase as individuals progress through life. They have a detrimental impact on medical conditions in the future [45]. However, high-quality PHC has been shown to provide chances to lessen the effects of socioeconomic disparities [29]. Hence, urgent action is needed to reduce inequalities.

3. The need and potential of universal health coverage in the context of sustainable development goals

The Sustainable Development Goal (SDG) 3 and the Alma-Ata Declaration promote "health for all", irrespective of economic position or age, among others [46]. In contemporary times, older adults are a vulnerable population that is disposed to impoverishment. However, governments worldwide are working toward universal health coverage (UHC) as a backdrop to the nemesis of such impoverishment from 2000 to 2015, targeting a 20% increase in coverage. This notwithstanding, much of the global population still lacks full coverage, whereas wealthy people maintain improved access to medical treatment and better health outcomes [47]. For example, more affluent people in China have documented increased utilisation of outpatient and inpatient healthcare services. This indicates a gap in health services utilisation between the rich and poor. Moreover, many global health objectives consistently prioritise younger age demographics, raising concerns that older individuals, especially those facing financial challenges, might be overlooked by health initiatives and reforms. Additionally, older individuals encounter more significant obstacles in accessing healthcare services, including socioeconomic disparities and limited incomes [13].

The 2023 SDGs Progress Report delivered by the UN Secretary-General outlined that SDG 10, which focuses on reducing inequality, was among the least-achieving SDGs. Urgent action is needed to address the increasing economic, wealth, and health disparities within and across countries during the COVID-19 pandemic and worldwide inflation crisis. Poorer countries did not have enough finances to support the poor or fight COVID-19, and for the first time in three decades, the gap between the rich world and the rest is increasing [8]. There is a significant and escalating disparity in wealth and resources, including economic and other forms of inequality that have reached intolerable proportions. Since 2020, about two-thirds of all new wealth has been amassed by the wealthiest 1%, which is equivalent to twice the amount of money held by the poorest 99% of the global population. This just presupposes that inequalities are at a record high and increasing. It depicts a situation in which 26 individuals own an equivalent amount of money to 50% of the global population.

The 2030 Agenda aims to promote justice, equality, fair and sustainable development, human rights, and dignity for all. Significant revisions in the organisation of the worldwide economy are necessary [48]. The SDGs are a means to overcome economic and geopolitical gaps, regain confidence, and strengthen unity. In this context, adaptation of Agenda 2030 by LMICs is imperative. The 2023 SDGs Progress Report also included other essential recommendations. It called for all Member States to recommit to national and international efforts to achieve the SDGs by 2030 by strengthening the social contract and reorientating their economies along low-carbon, resilient paths consistent with the Paris Agreement.

4. Emerging approaches toward reducing the social inequality gaps in older ages

The importance of economic growth and its diverse facets have continued to dominate national discussions over the past few years. This is not difficult to understand regarding concerns about economic well-being and attempts to evolve policies promoting inclusive growth, a precondition for economic development [49].

The World Economic Forum [50] documents that there are at least three distinct ways of "bridging" (reducing) the social inequality gap. First, there is the need to reduce income inequalities between top and bottom earners. In this case, countries need to agree to aim for a situation where the top 10% do not earn more than the bottom 40%. Second, inequality must be measured to monitor progress on SDGs. This calls for using concrete, proven inequality measures to monitor progress. This is situated in the framework of SDG 10, the tracker of which falls short of what is required in this context. It measures the bottom but not the top, which means it does not measure inequality. As a result, other proven measures, including the Gini coefficient and the Palma ratio, serve as the proxy. With these, inequality of incomes and wealth, which is far higher, can be measured. Third, it is imperative to invest in inequality data to inform decision-making, especially to enable high-level analysis by all governments.

Fourth, empirical evidence indicates that governmental protective measures, such as social pensions, can enhance the societal standing of older adults, leading to better health results and increased access to healthcare facilities [51]. Previous evidence indicates that disparities in enrolment in social safety systems occur for those with little resources in LMICs [52]. For example, older individuals with lower incomes in Senegal and Ghana are less inclined to participate in social health protection schemes, even when these initiatives are specifically designed to enhance access to healthcare services for this demographic category. Moreover, income influences the ability to pay the tiny charge for joining China's Cooperative Medical System in rural areas, with wealthier individuals benefiting more from this enrolment [53]. Such a scheme was replicated among older Ghanaian adults [42].

It is worth reiterating that policy interventions are crucial in this context, in the absence of which inequality may be said to destroy the hopes and goals of billions of the world's poorest individuals, without which privileges and disadvantages will continue for generations. Other ways of reducing the social inequalities older persons are predisposed to are worth mentioning in this context and serve as a continuation of the outline of the preceding measures.

Fifth, PHC is crucial in closing the gap to achieve universal healthcare. The idea of PHC introduced in the Alma-Ata Declaration continues to be frequently referenced in many situations [46] as a crucial part of a health system focused on equity and sustainability. According to the World Health Organisation, this approach to health is defined as a comprehensive strategy that strives to attain optimal health and well-being for all individuals, ensuring fairness in distribution. It focuses on addressing the needs and preferences of people at the individual, family, and community levels, within their immediate environments and as soon as possible in the spectrum from health promotion to palliative care [30].

PHC is well-positioned to provide efficient care in community contexts and/or settings. It is, in fact, a fundamental response to older persons' needs [30]. It can ensure the integration and coordination of care for older persons, including the support of collaborations across many industries and at different tiers of the healthcare system.

These are important for effective management of multimorbid chronic conditions. Older persons are more likely to face obstacles in obtaining health treatments due to socioeconomic disparities, particularly low income and the absence of health insurance, which are the main contributing factors restricting older adults' healthcare utilisation [54]. Contextually, regarding LMICs, access to PHC may probably appear to be a principal determinant of achieving SDGs and UHC [55].

Thus, it is crucial to increase the equity of PHC for seniors, irrespective of their socioeconomic positions. To achieve this, the United Nations Progress Report on SDGs urges nations to establish and meet ambitious national poverty and inequality reduction objectives by 2027 and 2030. This appeal was supported by an emphasis on critical domains that are pivotal for advancement: from increasing employment and social safety to addressing the education crisis; and from gender equality to digital inclusion [8].

5. Conclusion

We conclude that experiences of later life affect the usage of PHC services in older age. Older individuals with health insurance showed a greater propensity to use PHC services. Additionally, income levels during older age can influence the utilisation of PHC. Older individuals' health conditions and chronic care needs significantly determine their preferences for accessing PHC. Policies such as taxing wealth and high incomes, providing universal public services, including health and education, and ensuring social protection for all and fair wages for workers can drive progress in reducing the social inequality gap, particularly in older age. Health reforms have already enhanced the fairness of PHC systems and provided advantages to the impoverished in some developing countries.

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