Matic KAVČIČ

Health, social and spatial planning policies and accessibility of services in the ageing society

This short article outlines some of the important issues arising from the discussion on ageing in Slovenia and the related challenges of health, social and special planning policies in the Alpine area. This discussion raises many questions. What kind of policy approaches, measures or social organisation should be followed to improve the quality of life of the ageing society in times of austerity and uncertainty? Are health and social services equally accessible for all population groups regardless of the place of residence? Can special attention to questions of age and ageing result in positive discrimination towards the elderly? Are the policy efforts for older people's quality of life of marked by a zero-sum game and consequent loss of quality of life for the younger generation, which may cause intergenerational conflicts, or can a positive sum be achieved through intergenerational solidarity, intersectoral governance, inclusive policies and thus increased social cohesion and quality of life that lead towards inclusive growth and sustainable development despite demographic change? The following text is a short and tentative reflection on the current situation, which looks at many possible angles through a sociological perspective. The limited space of this article does not allow exhaustive discussion, and so the article mainly focuses on public policy principles and the accessibility of health services in particular as well as social services, including some examples of other services of general interest.

First, there are key principles that should provide a suitable guide when tackling the issues mentioned above. For health as an important element of quality of life, it is crucially important to understand this ubiquitous concept in a broader sense. This also means recognising social determinants of health among its biomedical dimensions; for example, the WHO definition of health (1948) also emphasises mental and social wellbeing among other dimensions. Therefore health policies should not focus solely on disease prevention and organisation of healthcare systems. Furthermore, WHO states several fundamental preconditions and resources for health: peace, shelter, education, food, income, a stable ecosystem and sustainable resources. It is therefore important to be aware that health is highly dependent on and derives from the physical and social environment. This means that taking care of health is strongly connected with governance across various sectors, including spatial planning. Many of the most pressing health issues are outside the healthcare sector. Since the First International Conference on Health Promotion in Ottawa, WHO (1986) has called for "healthy public policy". This means that health aspects should be implemented in all public policies and a whole-of-government approach should be taken. In addition to the "health-for-all" principle, the Alma-Ata declaration (WHO, 1978) also set user involvement as an important norm by stating that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care". Another guiding principle to be respected is "nothing about us without us" – a slogan often used by NGOs, especially pensioners' associations and patient organisations. At its core, spatial planning is bound to similar principles developed in the European Regional/Spatial Planning Charter (the "Torremolinos Charter"), which among other things include improving quality of life, coordinating different policy sectors, coordination and cooperation between various levels of decision-making, and promoting public participation (Council of Europe, 1983).

This brief overview of the current situation starts with population ageing. Slovenia has morphologically heterogeneous terrain, and demographic change has been particularly intense in remote mountainous areas (Statistical Office of the Republic of Slovenia, 2012). Lack of employment opportunities and remote services of general interest have accelerated out-migration of young people. Older people that are attached to the community and their place of residence do not out-migrate unless they are forced to move into a nursing institution, for example, due to ill health or infirmity. This breakup of family networks threatens intergenerational solidarity, which is an important source of wellbeing and welfare of all generations. A number of characteristics make older people one of the most vulnerable groups. With increasing age, the elder-

ly face a multitude of risks, including worsening of their physical and mental health, aggravation of their financial status, breakup of their social networks and consequently a reduction in their autonomy and quality of life. All policies including spatial planning should pay careful attention to these processes in order to tailor their interventions to the needs of an ageing population. Older people in remote areas face the risk of spatial and social isolation. A comparative quantitative study on social exclusion between EU countries has shown that older people in Slovenia are among the worst off with regard to low income and spatial exclusion (i.e., poor access to services in their local area), which is all the more worrying considering their limited mobility (Filipovič Hrast, 2011). A qualitative study (Hlebec et al., 2010; Kavčič, 2011) found numerous coping strategies that older people use to overcome problems of social isolation. The main disadvantages of older people living in remote rural areas were related to difficult access to various service infrastructure (from health services and administrative offices to disappearing local corner shops replaced by remote shopping centres), difficulties in transport (due to low availability and adaptation to their needs) and a shortage of cultural activities.

Although access to Slovenian healthcare is insurance-based, the rights of entitlement to healthcare are universal. Nearly total coverage and healthcare facilities evenly spread across the country offer generally accessible services to all citizens. Nevertheless, in practice, there are limitations to universal access and choice due to waiting times and a shortage of providers in certain areas. For example, there is an insufficient number of dentists. Some providers (public or concessionaires) might reach full capacity for publicly funded programmes; hence, users are unable to choose their services. Less common and more complex pathologies can only be treated with certain specialists concentrated in main urban areas. Compared to other EU countries, accessibility of healthcare was found to be worse than in the old EU member states (Pahor et al., 2011). The main drawback of public services was found to be the waiting times (see Siciliani et al., 2013; Health Consumer Powerhouse, 2013). The rationale of concessions is to complement publicly operated services, deliver services in a more efficient and user-friendly manner, enhance patient choices and thus improve access to services, especially in remote and understaffed areas. However revisions by the Court of Audit (2008a; 2008b) have shown that in the process of granting concessions the key principle and condition of improving accessibility (in terms of distance and time) has often been disregarded. Furthermore medical doctors are less eager to choose a career path in a remote place, which leaves some distant places without suitable care. All of this results in less than optimal access to health services. Similar social services, in particular community care for the elderly, were found to be unequally accessible across municipalities. Municipalities where institutional care is not provided are predominantly rural and less developed. The majority of older people must leave their municipality of residence when moving into institutional care. Such a change of environment has various negative effects on the quality of life of older people. A similar situation can be observed if one takes social home care into account. A group of smaller rural municipalities with low availability and quality of services, a small number of users of home care and high costs turns out to be the most problematic (Filipovič Hrast et al., 2014; Hlebec et al., 2014).

Having named a few illustrative examples of health and social care accessibility issues, this article now outlines some of the policy recommendations that should be drawn into the discussion. An important and often overlooked issue in policymaking is the heterogeneity of older people (Nelson & Dannefer, 1992). Across the lifespan, diversity also increases due to cumulative advantage/disadvantage processes. It is therefore increasingly important for sectorial policies and spatial planning to also acknowledge the diversity of older people in order to avoid age-based generalisations in their policy measures that could render them ineffective. A few guiding policy principles have already been mentioned; for example, health in all policies (McQueen et al., 2012). Because health depends so much on the social and physical environment, it is absolutely necessary that it also be implemented in social and spatial policies. Spatial planning also recognises the need for coordination and cooperation with other policy sectors. In general, it is important to consider the broader impact of sectorial policies, which is becoming increasingly more difficult in complex postmodern societies. Public policies that tackle such complex issues should be coordinated and integrated as much as possible. Here further steps should be taken. Anecdotal evidence suggests that ministries often act decoupled from each other, like "silos" without proper and effective cooperation and integration to take advantage of desired synergies. The nature of cooperation rarely exceeds formal consultations; moreover, intensive joint work between different ministries towards common goals seems to be rather limited and is rarely translated into real policy integration – a point all too obvious in the case of the awaited act on insurance for long-term care. This anecdotal evidence of weak coordination is supported by the revision report of the Court of Audit (2012) on regulatory impact assessment. Impact assessment is often carried out insufficiently and is more or less regarded as a mere administrative obligation. The lack of monitoring of existing regulations in practice and the absence of a mechanism for monitor-

ing proposed regulations has also been identified. In addition, the Court of Audit has called for further improvements in public participation in the processes of adopting laws. In conclusion, it seems that in Slovenia public policies address issues of age-related quality of life separately. These fragmented policies cannot adequately manage diverse and complex social problems related to demographic change, and so it is increasingly important to follow new approaches. Without measures towards intersectoral governance of social problems and implementation of user involvement in all steps of policymaking and implementation, policymakers also run the risk of public opposition. Reorganisation and a new holistic approach focused around social problems to integrate intersectorial and interprofesional cooperation together with public involvement are needed. Only in this way can one hope for a positive sum of interventions for all generations leading to social cohesion, inclusive growth and sustainable development despite demographic change.

Matic Kavčič
University of Ljubljana, Faculty of Health Sciences, Ljubljana, Slovenia
E-mail: matic.kavcic@zf.uni-lj.si

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