Accessibility and health services use in old age—a comparison between Jews and Arabs in Israel

Abstract

This study examined whether there are differences in community health services use between disabled older Jews and Arabs. The study was based on Andersen’s Behavioral Model for the consumption of health services.1 300 participants from Northern Israel were interviewed—150 Jews and 150 Arabs. The findings revealed positive correlations between background variables of the participants and their health services use. A higher socio-economic status of elders and a higher level of knowledge were correlated with a higher level of health services used. A difference was found between level of health service usage, between Jewish and Arab elders. The findings may be related to better technological knowledge and use of health services by the Jewish population as opposed to Arab elders. Apparently, inequality in health service usage might stem not only from accessibility, but also from services adaptation to the specific culture and society in which they are provided. This, to encourage social inclusion of elders in later life and thus enhancing their quality of life.

Keywords: old age, health services, socio-economic population, older Jewish population

Introduction

Accessibility to high quality health services constitutes an important factor in the health of a person. Minority groups have more economic and technological barriers to accessible health services and accordingly are more restricted in their use.2 Over the years, data show that improved accessibility of low socio-economic population to health services has helped to reduce inequalities in health, and as a result, also to reduce death rates.3 Barriers to accessibility may be caused by factors within the health system (the supplier), such as gaps in population coverage or insurance coverage; insufficient coverage of the health basket; geographical barriers such as distance from services; organizational barriers that are liable to include waiting lists and working hours of the organization; the lack or absence of coordinated information; or the difference in cultural backgrounds between caregivers and patients. The barriers may also be due to factors associated with the patient (the consumer), such as type of treatment and its adaptation to the patient; income; age; ethnic and cultural background; and medical history.2

Literature indicates that among minority population groups it was possible to predict a low level of usage in formal professional services. The findings link this with data that cultural differences are frequently not taken into consideration by the organizations that provide services. The lack of sensitivity for minority needs, like for example older Arabs in Israel or immigrants to the US who should be the service consumers, is liable to cause a gap between potential customers and offered services.4,5 However, it is necessary to examine whether low-level usage of the offered services is due to factors associated purely with cultural perceptions, socio-economic status or to factors related to the services.

In a study conducted in Israel6 we compared older Jews and Arabs regarding their functional ability and their use of health services. The research was based on Andersen’s Behavioral Model which was relevant for examining consumption of health services.1 The model presents a link between three groups of variables and use of health services: Background and predisposing variables; Enabling variables and Health needs variables.

The research hypotheses were:

1. The degree of accessibility to community health services (clinics and hospitals) will be higher for older disabled Jews than for older disabled Arabs.

2. The higher the degree of such accessibility, the higher will be their usage. Older Jews will make greater use of health services in comparison with older Arabs.

300 participants from Haifa and Northern Israel were interviewed—150 Jews and 150 Arabs. The dependent variables were: degree of community health services usage—initial medical clinic services and acute hospitalization services. Usage degree of these services is usually a proxy for accessibility to services.7 The independent variables were: Predisposing variables—age, gender, family situation, number of children and grandchildren, place of residence, level of education. Enabling variables—level of income, number of medical insurances (supplementary), norms and information about the use of services. Healths need variables: Level of functioning in daily activities, number of illnesses, medications, and subjective estimation of health.

The findings revealed a positive correlation between elders’ background variables and their use of health services.8 Bronfenbrenner’s Ecological approach (1994) asserts that in order to understand patients and their behavior, we must first understand the environment in which they live and work. The research findings indicate that a link exists between elders’ various background variables, such as their socio-economic status, their level of knowledge (enabling variables) and between their level of services usage. Better socio-economic status and higher level of knowledge were correlated to higher level of health services usage. Such findings were also found in a Norwegian study.
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Conducted lately,9 however, we found a difference between level of health service usage, especially use of community clinics, between Jewish and Arab elders. Jews consumed less services, especially community clinics services, as compared with Arabs. Differences in consumption of health services is not only due to elders’ accessibility to the services but also to services’ adaptation to the culture and society in which they are provided. This is true not only to the Israeli case but to other countries.10

Also, the findings may be associated with socio-economic factors and with cultural aspects - the gaps in online consumption of health services. Data regarding adoption of technologies by various target communities show that elders adopt technologies in a slower pace in comparison with the younger population.11 Moreover, until recent years, most technological developments and technological innovations have been mainly directed at the young target community.12 In 2018, only 73% of US population aged 65+ declared that they use the Internet, compared with 100% of those aged 18-29.13 76.3% of Israeli population used the internet in 2017 (PMO, 2017).14 Internet usage gaps between Jews and Arab societies had been reduced in the last years (91% vs. 84%).15 Hence, it is probable that online health services are classified by elders in general and those in the Arab-traditional society as “modern services”. Accordingly, the older Arab population is likely to adopt them much later and in a more limited mode than the older Jewish population.

Conclusion

The findings are might make a significant social contribution as the Israeli arena provides a special perspective for tackling this important issue - cultural sensitivity. The findings suggest rethinking as to how inequality in health system usage can be reduced, as the services are targeted to treat patients from diverse population groups, in order to allow quality treatment to all population groups. It might be that programs for reducing degree of inequality in access to health services, if are only at the level of national planning, without means for disseminating them to the populations in need of these services, will not succeed.6,15 Based on such findings it is possible to develop a policy and a plan of intervention at various levels and improve services use in order to promote population health. In addition, in view of the impact of digital divides on services’ use among the two populations studied, especially among the Arab population, attention should be given to a better adaptation of online health websites and their accessibility to various population groups. This, not only at the language level of the site but also through the appropriate cultural lens.

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Conflict of interests

Authors declare that there is no conflict of interest.

References