Inequality is one of the biggest predictors of poor health (Eibner & Evans 2005) and may have a greater effect on the health of older people, who are at risk of developing multiple chronic conditions (known as multimorbidity). In Scotland, those aged 65 are projected to increase in population (Scottish Government 2014) and most already have multimorbidity (Audit Scotland 2014). The aim of this study is to examine the role of inequality regarding the effect of provision of types of social care on the health outcomes of older people with multimorbidities in Scotland.

Following a literature review, it was found that it is likely that multimorbidities occur earlier and in greater number (Orueta et al 2014) in deprived areas, in part due to an inability to balance multiple prescriptions/appointments with a hectic personal life (O’Brien et al 2011). The likelihood of mental comorbidities was far higher than physical comorbidities in deprived areas (Barnett et al 2012). There was a lack of evidence regarding social care in deprived communities – and when it did occur multimorbidities were only briefly mentioned (Bierman & Clancy 2001) or focus was only on one condition (van den Bos et al 2002).

This study uses a linked dataset developed by the Scottish Government, consisting of health data (consisting of admissions to hospitals/mental health clinics) provided by the NHS and social care data provided by Scottish local authorities. The Scottish Index of Multiple Deprivation (SIMD) will be used to measure inequality for this study. Those whom are 65 or over, resident in Scotland and in receipt of some form of social care will be included in the dataset.

Analysis consists of logistic regression models using likelihood of emergency admissions as the dependent variable, with explanatory variables such as presence of multi-morbid conditions, level of deprivation and use of different types of social care. We will also examine likelihood of multimorbidity and likelihood of use of social care.
Inequalities in frailty in later life: an international comparison
Alan Marshall, University of St Andrews

This paper has two aims. First, to describe how frailty is changing across cohorts of older people, with stratification by wealth and country (focussing on the US, England and a selection of European countries). Second, to link evidence for widening or narrowing of inequalities in frailty according to wealth to plausible differences in national contextual factors.

Frailty has emerged as a key aspect in research on population ageing and geriatric clinical practice. While specific definitions and measures of frailty are contested, there is general agreement that frailty is a non-specific state reflecting age-related declines in multiple systems, which lead to a range of adverse outcomes such as falls, fractures, hospitalisation, institutionalisation and mortality.

Inequalities in levels of frailty in later life are stark and we present concerning evidence for increased levels of frailty in younger compared to older cohorts, particularly among the poorest older people and in England and the US. This trend carries the implication of a widening in health inequalities over time. Drivers for such cohort differences and their association with wealth are not entirely clear. Explanations focus on greater exposure of younger poorer cohorts to risk factors linked to poor health such as rising economic inequality, job insecurity, reduced pension provision or unhealthy lifestyle choices.

This paper exploits harmonised longitudinal data from the English Longitudinal Study of Ageing (ELSA), the US Health and Retirement Survey (HRS) and the Survey of Health and Ageing and Retirement in Europe (SHARE) to estimate cohort differences in levels and rates of change in trajectories of frailty, with stratification by wealth, within the US and a selection of European countries. Differences in frailty across cohorts and wealth are linked to plausible national contextual factors that vary across the countries examined (e.g. the extent/change in unhealthy lifestyle choices or the extent/change in economic inequality).

Impact of income inequality on utilisation of health care facilities among chronically ill older people of India
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Economic development can be a measure of the overall development of a country, but economic development does not benefit all people equally and can increase inequality within the country. According to a report from the Longitudinal Ageing Study in India (LASI) in 2010, less than 5% of the elderly have health insurance. Moreover, a large proportion of the elderly are not literate or have a low level of literacy, so are not aware of government programmes such as elder pensions schemes, free medical care, and the government initiated insurance programme.
Rediscovering Inequalities: Exploring the interconnections between crime, education and urban segregation
26-27th October 2016

This study focused on the socioeconomic inequality in health care utilization (including: overnight stays in health care facilities, emergency treatment, and outdoor health care) among the elderly in India. It uses data from the Study on Global Ageing and Adult Health 2007-08 (SAGE wave-0 and 1), with a sample size of the 12,198, which collected data on living arrangements, social cohesion, family support, working history, chronic health conditions and activities of daily living (ADL) of participants.
To analyse income inequality, we calculated two different wealth indices for rural and urban populations, then merged and adjusted them to form a composite wealth index. Descriptive statistics, concentration index, Gini coefficient, and Lorenz curve were used for analysis, and the regression analysis was also used to predict outcome variables with background characteristics.

The results suggest that people who have poor financial status are more likely to suffer from ill health, but they are significantly less likely to get health care than their rich counterparts. The highest levels of inequality were seen in utilisation of overnight health care facilities.