

What social determinants will cause ethical challenges in geriatric care? Comments from South Africa

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Abstract

Background. Social determinants are defined as those non-medical factors that influence health. Their influence is especially evident in vulnerable communities, such as the geriatric one. However, which social determinants will cause ethical challenges in geriatric healthcare in South Africa are not yet confirmed.

Objective. This study first identified which social determinants influence geriatric care. The study then established which of

these social determinants raises ethical challenges in geriatric care.

Methods. Twenty statements were identified from the literature review and were grouped into 3 indexes, focusing respectively on i) a general view on public health and social determinants; ii) social determinants influencing geriatric people's health; iii) the consequences of social determinants on geriatric people's health. The rating was based on presenting the statements employing a 5-point Likert scale.

Results. The rating of statements confirmed the generally accepted view that social determinants impact geriatric people's health. The responses to the statements were an additional confirmation that the quality and access to healthcare services influence geriatric care and lead to ethical challenges. Matters such as corruption, limited resources, and the COVID-19 pandemic contribute to the influence of social determinants and the expected but failed ethical behavior toward the geriatric community.

Conclusion. The geriatric community is vulnerable because of the ongoing social factors that have a negative impact on health, of which healthcare quality and provision are significant contributing factors. These factors contribute to ethical challenges in healthcare for the geriatric community.

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Introduction

The influence of social determinants on health is confirmed in the literature.¹⁻⁵ Social determinants in health are well defined by Braveman *et al.*,⁴ as *non-medical factors influencing health*. The World Health Organization (WHO) confirms in various reports that health is influenced by more factors than just physical illness.⁶⁻⁸ Aspects such as living conditions, food and water, social interface, and availability of healthcare influence general health. Wilkinson and Marmot confirm that health follows the social gradient.⁵

One of the negative consequences of social determinants is their impact on vulnerable communities. One such community is the geriatric one. Statistics from WHO suggest that the world population older than 60 years will nearly double by 2050.⁶

According to the South African Mid-year Population Estimates Report 2020,⁹ 9.1% of the population is over 60 years old. This group represents 5.43 million people out of an estimated population of 59.62 million people. Geriatric people are in general vulnerable because of their condition (for example, they may have less physical mobility), but they are also at risk due to the specific causes they are exposed to (for example, access to healthcare).⁸

A neglected aspect of social determinants that influence geriatric care is the difficulty of identifying which social determinants are open to ethical challenges, consequently leading to ethical dilemmas.

Objective

This study first identified which social determinants influence geriatric care. The study then ascertained which of these social determinants leads to ethical challenges in geriatric care.

Materials and Methods

This article is based on a completed study in community health. Multiple articles published from this study share a similar methodology and therefore report the methodology itself.

For the objective of this study, 20 statements were identified from the literature review and were grouped into 3 indexes. Statements 1-8 presented a general view on public health and social determinants, statements 9-14 focused on social determinants influencing geriatric people's health, and statements 15-20 looked at the consequences of social determinants on geriatric people's health.

A questionnaire was used to sample the data and statements were rated using a Likert-type scale. This article will discuss the results of the rating of the statements only. The rating was based on presenting the statements by means of a 5-point Likert scale questionnaire. The rating took place according to least important (1) to cannot do without this (5). The rating of statements can fit the 2 extremes of the Likert scale, namely either agree or disagree, with the moderate or neutral point being indecisive. From the rating of these statements, the following was achieved: i) confirmation of which social determinants influence the geriatric community; ii) confirmation of the possible ethical challenges that emerge from these social determinants.

Six geriatric institutions, 2 each in the Free State, Northern Cape, and North-West provinces, were identified. These provinces have the smallest populations compared to the other 6 provinces and represent 29.14% of the population over 60 years old.⁹ Economically these provinces fall outside the mainstream gross domestic product for provinces in South Africa.¹⁰ The geriatric institutions and the participants were identified based on Marshall's grouping of convenience sampling (most accessible environment).¹¹ Purposeful sampling was also used to identify and select geriatric institutions that are in marginalized provinces and often under-served regions may not always be part of data collection on a particular topic due to their locality.¹² The data was sampled from July to August 2020, analyzed from October to December 2020, and written up from January to July 2021.

Twenty-two participants from the 6 geriatric institutions participated in the rating of the statements. The target population excluded geriatric people and focused on those who work with them in the domain of public health, namely doctors, registered nurses, nurses, healthcare workers, managers, and administrators. Geriatric people were excluded from the study as the focus was on gathering in-depth information on public health ethics as perceived by the identified target population, the healthcare providers, and managers.

Ethics approval was obtained and approval to conduct the study was received from the managers of the various institutions. Informed consent was obtained from all participants before the start of the data collection.

For this scale, Cronbach's α is 0.744, and Cronbach's α based on standardized items is 0.831. These results indicate a high level of internal consistency for the 20 items used in the scale.

Results and Discussion

Results and Discussion are combined because of the type and research that were conducted. The combination is more acceptable in qualitative research. A combination of the Results and Discussion sections was followed to make sure the reader has a result linked to an interpretation. The separation of Results and Discussion is more relevant in research based on experiments where the results are first presented followed by the discussion of the results.

The frequency information confirmed 2 cohorts: one with medical or healthcare experience (49.9% of respondents), and the other with management or administrative experience (45.4% of respondents). The information confirmed a high percentage of post-school training (72.7% of respondents), with 36.4 % of respondents having cumulatively 21 years and more of work experience.

These cohort profiles were used to analyze the feedback of respondents on statements around social determinants (Table 1), social determinants influencing geriatric people's health (Table 2), and the consequences of social determinants on geriatric people's health (Table 3).

All respondents agreed or strongly agreed with statement 3 that health is influenced by more than physical challenges or illness only. This is aligned with the accepted understanding of the influence of social determinants on people's health. The medical cohort

Table 1. Statements around social determinants.

Statements	Strongly disagree %	Disagree %	Neutral %	Agree %	Strongly agree %
S1. Public health is about prevention and not treatment.	14.3	19.0	0.0	61.9	4.8
S2. Public health is about collaboration between the government, healthcare facilities and communities.	0.0	0.0	4.5	68.2	27.3
S3. Health is influenced by more than physical challenges or illness only.	0.0	0.0	0.0	52.4	47.6
S4. Social factors such as low income, little and substandard education, limited employment options, high levels of unemployment and poor living and working conditions influence the health of all people.	0.0	0.0	0.0	36.4	63.6
S5. Lifestyle influences health.	0.0	4.5	0.0	50.0	45.5
S6. Poor service delivery influences healthcare.	0.0	0.0	0.0	36.4	63.6
S7. The poor management of healthcare influences health.	0.0	0.0	0.0	38.1	61.9
S8. Lack of finances influences access to and quality of healthcare.	0.0	4.5	0.0	40.9	54.5

and the management cohort agreed with this statement. The significance thereof is that this observation is accepted beyond the healthcare practitioners and workers' cohort and should positively influence the management of healthcare provision for the geriatric community.

The respondents were also 100% in agreement that social factors such as low income, little and substandard education, limited employment options, high levels of unemployment, and poor living and working conditions influence people's health. This is in line with the general understanding of social gradients influencing health.⁵ What is even more telling is that 63.6% strongly agreed with statement 3. Healthcare, management, and finances are all contributing factors confirming the influence of social determinants. This was confirmed by 100% of the respondents who agreed or strongly agreed with statements 6 and 7, and 95.5% who agreed or strongly agreed with statement 8. These responses are in line with the Statistics South Africa's Mid-year Population Estimates Report for 2020.⁹ The report identifies the apparent vulnerabilities in people over 60 years old caused by the need for social assistance programs, easy access to cash transfers, food programs, and healthcare. The situation is not improving due to the COVID-19 pandemic. In addition, in rating the statements, participants were equally represented from urban and rural geriatric institutions. The representation was a confirmation that social determinants in principle are not limited to a particular environment although the socio-economic status of an environment influences the impact of social determinants on people.

Statements 4 and 5 are very much person- and context-influenced, while statements 6 to 8 relate to healthcare quality and availability. The significance of statement 4 is influenced by heavy dependency on social or elderly grants in South Africa, social environment, and social circumstances.¹³ Responses to statements 6 to 8 also confirmed the significance of service delivery, quality, and the availability thereof. Within the context of geriatric healthcare service delivery, the quality, and availability of the service are essential. The COVID-19 pandemic and associated lockdown arrangements by the South African government have not eased the burden, due to a declined economy and reduced access to healthcare. An overarching concern is that the National Health Department's Strategic Plan for South Africa, 2020-2025 is not specific in its strategies or goals when addressing the social determinants impacting elderly people's health.¹⁴

Table 2 reflects on social determinants influencing geriatric people's health. Statements 9 to 11 rated access to healthcare, the influence of living conditions, and social factors. The responses to these 3 statements suggest that the existence of these conditions is outside the behavior control of geriatric people. Statement 12 refers to organized activities to secure healthy living for geriatric people. The agreement or strong agreement is 100% for statements 9 and 10, while the influence of family, peers, or isolation had a 95.5% rating of agreement or strong agreement. The influence of access to healthcare, living conditions, and social factors confirm the vulnerability of geriatric people as established by the literature. The vulnerability is further highlighted by factors such as lan-

Table 2. Statements around social determinants influencing geriatric people's health.

Statements	Strongly disagree %	Disagree %	Neutral %	Agree %	Strongly agree %
S9. Geriatric people's health is influenced by access to healthcare, whether financial, area (location of healthcare facility), language or mobility.	0.0	0.0	0.0	50.0	50.0
S10. Geriatric people's health is influenced by living conditions such as accommodation/housing, food, nutrition, electricity, water, sanitation, and the general environment.	0.0	0.0	0.0	40.9	59.1
S11. Geriatric people's health is influenced by social factors such as the role in the family (for example caring for grand children), isolation from peers and/or children.	0.0	0.0	4.5	63.6	31.8*
S12. Geriatric people's health is influenced by public health preparedness to prevent disease and create good living conditions.	0.0	0.0	4.5	77.3	18.2
S13. Geriatric people have the responsibility to care for themselves.	9.1	36.4	22.7	22.7	9.1
S14. Geriatric people need to be educated on how to care for themselves.	4.8	19.0	19.0	47.6	9.5*

*The percentages in the table above are rounded up to the first decimal place.

Table 3. Statements on consequences of social determinants on geriatric people's health.

Statements	Strongly disagree %	Disagree %	Neutral %	Agree %	Strongly agree %
S15. Government has only a financial responsibility to promote the health of geriatric people.	42.9*	52.4	0.0	0.0	4.8*
S16. Geriatric people have different needs from other population age groups.	0.0	9.1	9.1	50.0	31.8
S17. Geriatric people's interest is more important than the communities' interest.	13.6	36.4	36.4	9.1	4.5
S18. Differences in the availability of healthcare support systems is geriatric people's biggest challenge.	4.8	4.8	19.0	47.6	23.8
S19. There are enough healthcare support systems available to support geriatric people.	31.8	63.6	0.0	0.0	4.5*
S20. The healthcare of geriatric people is poorly managed.	0.0	9.1	13.6	63.6*	13.6

*The percentages in the table above are rounded up to the first decimal place.

guage. Without proper communication, the needs of geriatric people cannot be expressed or comprehended. The significance of these 3 categories of social determinants on geriatric people becomes more complex when challenged by socio-economic factors and the provision of basic healthcare. The National Department of Health's Strategic Plan of South Africa, 2020-2025 confirms the challenges in the health systems and the quality of healthcare.¹⁴ The South African Lancet National Commission's Report (2018) on healthcare in South Africa identifies effectiveness in guaranteeing the delivery of quality health service to all citizens as one of the characteristics of a quality health system.¹⁵

Statements 13 and 14 presented a mixed response to whether geriatric people have the responsibility to care for themselves and whether they should be educated on how to care for themselves. Almost half of the respondents, 45.5%, either strongly disagreed or disagreed that geriatric people have the responsibility to care for themselves. Although still significant, 31.8% of respondents agreed that elderly people have the responsibility to care for themselves. While not stated explicitly, the general assumption is that the health condition of the geriatric person plays a leading role in this statement. Geriatric people with mental health challenges or in palliative care will normally be excluded from this group. 22.7% of respondents were neutral, most probably considering the state of health of the geriatric person. The high percentage of respondents who disagreed that geriatric people should care for themselves strengthens the perception that geriatric people cannot make their own decisions. The isolation of the geriatric community during the COVID-19 pandemic may have contributed to this view. Through a factor analysis of .876, the relevance of this statement for the influence of social determinants is confirmed. Statement 14 had an opposite rating to statement 13. More than half (57.1%) of the respondents agreed with the statement that geriatric people need to be educated to care for themselves while 23.8% either disagreed or strongly disagreed. 19% of the respondents were neutral on this matter. Based on the concept of healthy aging, this statement, when read together with the previous one, presented the observation that through education on self-care, the opinion that geriatric people should care for themselves may change. The need for education is emphasized by Kececi and Baldock with their suggestion that healthy aging promotion strategies must be anchored in health education.¹⁶ Health education will assist people to make decisions about their health.¹⁷

An estimated 4.3 million people out of an estimated 5.3 million people in South Africa received an old age pension from the government in 2020.⁹ This group represents 81.13% of the elderly population and confirms the deprived socio-economic conditions of elderly people in South Africa. This observation further directs public health towards the focus of dealing with the geriatric community based on functional ability as part of healthy aging. These comments also direct toward the meaningful role that public health should play in the geriatric community's healthcare. This was further confirmed by the high number of respondents who agreed with statement 1, namely that public health is about prevention and not treatment. This observation was further strengthened through the 95.5% agreement rating of statement 2, that healthcare should be a partnership between the government, healthcare facilities, and communities.

The insufficient availability and poor quality of healthcare services for geriatric people were confirmed in statements 19 and 20. An overwhelming 94.5% disagreed or strongly disagreed that there are enough healthcare support systems available to geriatric people. This observation is in line with public commentaries that not enough is done to support the geriatric community,^{18,19} and was further confirmed through the 72.2% rating that healthcare is poor-

ly managed. An additional interpretation of statement 20 was that the absence of sufficient healthcare support systems is further challenged by the poor management of the services. The link to these statements was confirmed through an Inter-Item Correlation Matrix. Similar correlations existed with statements 12 and 15. Statements 12, 15, 19, and 20 emphasized the magnitude of public health in general and service delivery for geriatric healthcare in particular. The rating of these statements was a confirmation of the importance of good service delivery. The 9.1% disagreement with this statement can possibly relate to the experience within their own geriatric institution and not geriatric healthcare as a system in general.

It is evident that the government's responsibility goes beyond finance. The high percentage of respondents who agreed (52.4%) or strongly agreed (42.9%) with statement 15 were aligned with the general acceptance of such a view. The significance of this response is based on respondents who were representative of the medical, healthcare practitioners and workers, and management and administration cohorts. This rating aligned with general principles in both healthcare ethics and business ethics, namely to always act in the best interest of a person. Weber articulates the complexity of this responsibility well through the observation that compliance, cost, quality of care, patient, and healthcare worker should be considered in decisions in healthcare provision.²⁰

It is noteworthy that 4.7% of the respondents strongly agreed that government has financial responsibility only. This opinion can be linked to the agreement in statement 2 that there is a joint responsibility to care for the elderly. This percentage, although very small, can also be aligned with the view that sufficient finance will contribute to the required care. Such an observation is in line with the leading role that finance plays in healthcare, although it is at odds with an ethical view that financial means only are not enough to care for the geriatric community. The interpretation of these results should be read together with statement 16, where 81.8% of respondents agreed or strongly agreed that the geriatric community's needs are different from those of other population age groups. This statement confirmed the specific needs of this population group. Statement 17 was in line with a general healthcare ethics perspective, namely that no population age group should have preference over another group. 50% of the respondents disagreed or strongly disagreed that the geriatric community's interest is more important than that of the population. It is striking that 13.6% of the respondents fell in the 30-45 age group. The remaining respondents (86.4%) were all older than 45 years, which served as a confirmation that different age groups may have different needs, but there can be no preference for one group over the other.

Conclusions

From the results above, it was evident that the availability, access, and quality of healthcare are important factors influencing geriatric people's health. These activities can be grouped as healthcare services. The results further confirmed that living conditions and social factors play an equally important role in the geriatric community's health. The responses confirmed that social determinants' role in public health is equally important in both urban and rural contexts. This is in line with the general confirmation in the literature that socio-economic factors influence the reception of healthcare. Moreover, it is noteworthy that regardless of the geographic location, the role of the social determinants on health is not viewed differently.

Availability, access, and quality of service represent an unde-

niably constitutional right. According to the South African Constitution, healthcare is an economic right.²¹ The absence of services or their quality are confronted by high levels of government corruption, the collapse of services, and the COVID-19 pandemic. The challenges to vaccinating the geriatric community illustrate the lack of performance of the healthcare system.^{22,23} Availability and access to quality service contribute towards ethical challenges in geriatric care.

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