Inequality in good health: evidences from SHARE survey

Active aging profiles in healthy older adults by class and context

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Not Just a Matter of Numbers

Although health inequalities studies are dominated by the ‘epidemiological paradigm’ focused on the different odds of some social categories for good or ill health (Williams, 2003), health inequality it’s not just a matter of numbers. It can also be expressed in the way how certain social groups relate to dominant discourses, such as Healthy Living or Active Aging.

There are relevant differences between contexts and social groups in the adoption of the active profile among healthy older adults. ‘Active Aging’ is shown to be an exclusionary practice, not equally available to all.

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Introduction

The ‘self to health’

Since the end of the twenty century, western European countries have entered a period of great social change where individualization, materialization and consumption become increasingly shared cultural traits. These ‘new’ values contained all dimensions of daily living having an important role in shaping body and health concerns. Discourses aimed at enhancing the government of the ‘invisible self’ have been expanding since that time. Health is commonly understood as an individual and linked to individual choices (the so-called health behaviour), that is sometimes combined with health ‘self help’ (Higgs et al. 2009).

But individual behavior is still social behavior

‘Will to health’ discourses disregard the importance of a wide range of socio-determinants not connected with individual agency. Also, individual behavior is still ‘a social behavior’, that is, it is deeply shaped by the social context where it is located. In other words, disorders demonstrated has the personal interests, dispositions or traits are determined by social class; so that the social structure is redistributed even at the level of individual subjectivity (Beaumont, 2001). The inter-relationship between social position, ‘behaviours’ and ‘state’ produces relative stable health categories and behaviors which intervene on health (Williams, 1995).

‘Will to health’ in later life

‘Will to health’ discourses are dominating the conceptions of later life. One the scope in which the ‘will to health’ dominated later life is through the construction of normality of aging. It is defined as: “habitual and ‘same’ produce relative stable health categories and behaviors which intervene on health” (Williams, 1995).

Active aging: a right or a duty?

With the compliance of such conceptions about aging, many of the policy responses have increasingly focused the responsibility upon the older adults by promoting ‘always in lifestyle (focus on individuals responsibility) that feature social cohesion (healthy老ing), social productivity (productive aging) and health’ (healthy living). Active aging appear to be longer and duty, a ‘compulsory and as a result to promote the population’s aging’ (Walker, 2008).

How the ‘active aging’ concept transpires from behavioural profiles of healthy European older adults from different classes and contexts?

Method

Sample

Data from the fourth waves of the Survey of Health, Aging and Retirement in Europe (SHARE – 2004 – 2010). For this study it was selected a sample of older adults with (50 – 65 years old) a self-reported good health (‘good’, ‘very good’ or excellent’ self-rated health), living in four different European countries was selected. The sample intends to represent the cultural, institutional, and geographic diversity of European countries. The sample comprises a country from the north (Denmark, DK), the south (Portugal, PT), the east (Hungary, HU), and the western (Germany, DE) regions of Europe.

A confrontation of behavior patterns in each country sample based on multivariate analysis.

In each country sample: (1) Multiple correspondence analysis (MCA) or 12 indicators of individuals’ health behaviors and social integration practices; (2) Cluster analysis of the object scores calculated by the MCA to identify groups of individuals with similar behavioral patterns (the procedure combined a hierarchical method – Ward’s method – and a non-hierarchical method – K-means – the number of clusters retained was based on the point at which the additional of more clusters introduce no significant changes in the aggregation coefficient).

Association tests (χ2) between the identified behavioral profiles and individuals social class indicators (education, income, perceived economical difficulties).

Results

Different active aging profiles

Different behavioral profiles were found in each sample.

Healthy profile (composed by physically inactive individuals with low participation in social activities).

Moderated profile (composed by physically active individuals with moderated participation in social activities).

Active profile (composed with by physically active individuals with relative higher participation in social activities).

WHAT DOES THIS MEAN?

The active profile is the most frequent and the moderated profile the most common one in all countries, but it is possible to identify important context differences.

Income

Not good

Lower

What does this mean?

Healthy older adults with more education, lower incomes and higher economical difficulties have less probabilities of present an active aging profile.

Economical difficulties

Not good

Not good

Not good

Notes

Not good

Not good

Not good

Not good

Socio-scientific discussions around the adoption of the active profile among healthy older adults relates to dominant discourses, such as Healthy Living or Active Aging.

References