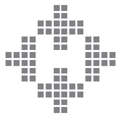
Studying Health and Health Care Use in At-Risk Groups



MANITOBA CENTRE FOR HEALTH POLICY AND EVALUATION

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Most people connect the idea of good health with the health care system—the care we receive from hospitals, doctors, nurses and other professionals. But there is plenty of evidence in recent years that many other factors are important for producing a healthy population—factors like education, social status, occupation and income.

The profound impact of these other factors on health suggests that to improve health, we need to look beyond the health care system. Many sectors must interact—housing, transportation, education, labour—if we are to make major improvements in the health of Manitobans. A recent study by MCHPE takes a big step in that direction—it involves cooperation between two Ministries: Health and Family Services.

One of the major determinants of health is income. Previous research at MCHPE has shown that people living in lower-income neighbourhoods die younger than people living in medium- or high-income neighbourhoods. They also have more chronic diseases, cancer and injuries, and they use hospitals and physicians more. Simply put, poverty is bad for your health. We know very little about how to address this problem. Nor do we know how well current programs reach the most vulnerable in our society: those who are both poor and sick.

To understand more about the relationship between poverty and health, and whether those Manitobans with some of the lowest incomes in the province have good access to the health care system, MCHPE was asked by the Ministries of Health and Family Services to undertake a research project relevant to both of their mandates. This project focussed on the feasibility of using anonymized data from both Ministries to understand the patterns of health and health care use of individuals receiving income assistance.

Such a study had the potential for answering important questions such as: Is income assistance supporting those who are particularly ill and disadvantaged? Do these vulnerable people make adequate use of the health care system?

This study signals a recognition that the responsibility for the health of Manitobans isn't confined to the Ministry of Health. People's living conditions and health are related: each affects the other. Poor living conditions can lead to poor health, but also, people who suffer ill health may not have the means to improve their circumstances. Government policies and services in these areas must work together if they are to be most effective.

Family Services provides income assistance to families and individuals who lack the resources to meet their basic needs. There are three income assistance categories: persons with a disability (further subdivided into mental health, mental retardation, physical disability and other), households with dependent children, and general assistance recipients. For this project, MCHPE focussed on the health status and health care used by the first two

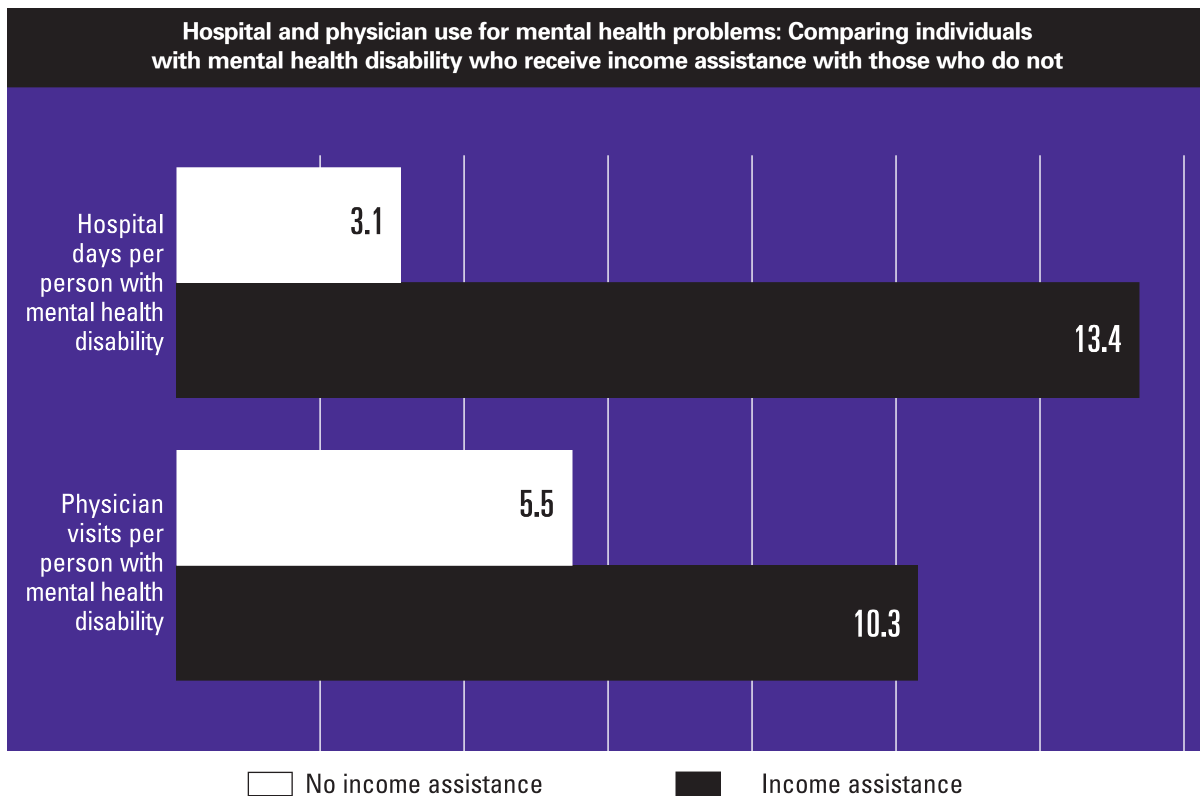
of these groups and wrote two reports: one about recipients of income assistance for mental health disability, the second about recipients with dependent children. The study included people in these two groups who received income assistance for at least one month between April 1994 and March 1995.

Mental Health Disability

During the study period, 133,000 Manitobans between the ages of 20 and 64 years were treated for a mental illness in the health care system; 10% of them suffered a major mental illness, like schizophrenia, paranoia or psychosis—illnesses which severely affect people's ability to work and to interact socially. Two questions addressed by this study were: what are the health characteristics of those receiving income assistance because of a mental disability, and are people receiving such assistance well served by the health care system?

In the year of our study, 17% of those with a major mental illness were on income assistance. In other words, most adults with mental illness, even those having severe mental health problems, do not receive income assistance. Two comparison groups not receiving income assistance were created for the study. Both comparison groups had the same gender, age and neighbourhood income level as the income-assisted mental health disability group. One of the comparison groups, the mental illness group, was also similar on the basis of mental illness, but this group did not receive income assistance. We focus on this comparison group primarily in this discussion.

First, we looked at hospitalizations for a mental health problem. The income-assistance group were hospitalized 2.5 times as often as the non-income-assistance group. Remember, we are comparing two groups matched for mental illness, one receiving income assistance, and one not. Also, once hospitalized, those receiving income assistance stayed longer, 32 days on average compared to 19 days for the group not on income assistance. Thus, those receiving income assistance spent four times as many days in hospital as persons with a mental illness who were not receiving income assistance (figure). The two groups



were similar in their use of hospitals for reasons not related to mental health.

We also reviewed the use of physicians by the two groups. Those receiving income assistance had high physician visit rates for mental health diagnoses: they saw physicians almost twice as often as the non-income-assistance mental health group (figure). However, both groups contacted physicians at a similar rate for non-mental health problems.

One fact uncovered by this study may be of use to those designing programs for this high-risk group. Only 8% of the income assistance group were married. In contrast, approximately half of those in both comparison groups were married. Hence, those receiving income assistance had very low levels of social support, a factor which may be related to their higher rates of hospitalization and longer stays. The group homes which are sometimes available to these individuals would seem to have potential for providing some of this missing support.

To sum up, people receiving income assistance for reasons of mental illness are severely disabled by their illness. They make high use of physicians for their mental health problems, and are still hospitalized frequently. Family Services and Health each provide a necessary component of care and support to this extremely high-need population.

Households with Dependent Children

This second study focussed on children living in households that received income assistance. One might expect that persons receiving income assistance because of a mental health disability would need a lot of health care. But why examine the health and health care of children living in income-assisted households? The reason is that poverty has a profound impact on children's health and future development.

The new report by the Canadian Council on Social Development on income and child well-being shows that the health of children declines progressively with decreasing levels of family income; children living in the lowest income households have the poorest health. For single-parent families, the duration of poverty can be especially long, and single-parent, income-assistance families have a greater depth of poverty than low income families not receiving income assistance.

In response to the needs of single parent families, income assistance programs emphasize support to households with dependent children. In 1994/95, about 10% of all one-to-fifteen year-olds in Manitoba lived in households that received income assistance for at least one month. Here we highlight the findings for preschool children (1 to 5 years old) living in urban areas because children in this age group typically make high use of health care services, and because of the importance of this stage of life to future childhood development. The full report included children of all ages, and results were similar to those reported here.

This study presented an important opportunity to determine if income assistance was reaching particularly high need families, at least as measured from the perspective of their children's health. It was also an opportunity to learn if children in income assistance families are in regular contact with the health care system and receive services which seem to be in keeping with their needs.

We found that income assistance does indeed support families with high health care needs. Preschool children in families receiving income assistance were hospitalized 59% more often than other low-income children of the same age: 113 versus 71 hospitalizations per 1000 children. In contrast, children living in high-income neighbourhoods were hospitalized less often than both groups: 58 hospitalizations per 1000 children. However, not all children in income assistance families had high rates of hospitalization. Income assistance children with no recurrent or chronic health problems were hospitalized 41 times per 1000 children, that is, less than the hospitalization rate of children in high-income neighborhoods. On the other hand, income assistance children with multiple health problems were hospitalized very frequently, 543 times per 1000 children, compared to 362

times per 1000 non-assistance children with multiple health problems.

Were children in families receiving income assistance in regular touch with physicians at a rate which seems appropriate given their high health needs? Here the data suggest room for improvement. Although children of income assistance families saw a doctor somewhat more often than other Manitoba children—6.6 times a year versus 5.6 times—one might expect even higher visit rates given their high rates of hospitalization. We also found that income assistance children had somewhat fewer visits for preventive care, for example immunizations, than did children in higher-income neighborhoods: 0.58 versus 0.63 visits per year.

Implications

The primary purpose of this study was to test the technical feasibility of combining information from the Ministries of Family Services and Health to address important issues regarding the health of Manitobans. In this we were successful. That we were even asked to conduct such a study by two Ministries is significant; it embodies their recognition that the responsibility for health extends beyond the health care system.

A critical secondary objective of this pilot study was to assess whether there were insights which could be gained from working across the information provided by two Manitoba Ministries. This objective was also achieved. We confirmed that income assistance is reaching high need individuals and families. Learning how the health care system responds to the needs of this vulnerable population is also important. In the case of those receiving income assistance because of a mental health disability, the system is clearly providing individuals with a high level of medical care—from both physicians and hospitals. However, it is less clear that children in families receiving income assistance are obtaining as much preventive care or regular monitoring as they should, given their high rates of hospitalization. Lower visit rates may reflect physician practice patterns, but they may also indicate difficulties with the practical aspects of keeping doctors' appointments, for instance, lack of transportation or child care.

The study also raises other questions and suggests there are many things that we don't know. Is focussing on further initiatives via the medical care system the best way to improve health for these individuals or should alternative approaches be considered? For example, would investments in programs designed to provide social support better meet the needs of people with serious mental health problems? Might such programs even reduce the pressures on the health care system? Could programs focussed on early childhood development provide an alternative method for approaching the high needs of children in families receiving social assistance? Is there a way to ensure better uptake of preventive services, and more regular monitoring of these high-risk children's health problems? Further research can explore issues like these, offering evidence to assist in the development of social policy.

This study provides a first glimpse into some of the needs and service pattern use of two very high-risk groups. More importantly, the work suggests the promise of future research in helping us to learn more about what works and what doesn't to improve the circumstances of those most in need of assistance.

Summary based on the reports: A Description of the Use of Insured Health Care Services by Income Assistance Recipients in the Province of Manitoba, a Pilot Study: Recipients of Income Assistance for Mental Health Disability, *by Cam Mustard, Shelley Derksen and Anita Kozyrskyj; and* Considering the Health Care Needs of Children Living in Households Receiving Income Assistance in Manitoba: Family Services and Manitoba Health Pilot Project, *by Anita Kozyrskyj, Cam Mustard and Shelley Derksen*

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