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Research Paper

Disability and unmet health care needs in Canada: A longitudinal analysis

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Abstract

Background: The rate of unmet health care needs is quite high for the general population in Canada; however, the rate is even higher for the subset of people with disabilities. To date, there is a gap in the research utilizing longitudinal data to measure the unmet health care needs of Canadians.

Objective/hypothesis: The purpose of this research is to compare the rate of unmet health care needs of people with disabilities to people without disabilities over 15 years.

Methods: Longitudinal data from waves 1 to 8 (1994/95 to 2008/09) of the National Population Health Survey in Canada (NPHS) were analyzed using a growth curve modeling approach.

Results: Respondents with disabilities have two to three times the rate of unmet health care needs compared to respondents without disabilities. Unmet health care needs increase over time, and at a faster rate for all disability types except work-related disability. Personal reasons for unmet health care needs decrease over time and there is no significant difference between respondents with disabilities and respondents without disabilities. The opposite was found for structural reasons, which increase over time, and, people with disabilities have higher rates of structural-based unmet health care needs (45% higher) at baseline.

Conclusions: The incidence of disability in the population increases over time while at the same time the rate of unmet health care needs are higher for people with disabilities. The combination of these factors suggests that, in the absence of intervention, Canadians can expect more unmet health care needs in the future.

Keywords: Disability; Injured workers; Unmet health care needs; Longitudinal analysis

Unmet health care needs occur when health care is required for a particular health problem but the care is not received, does not adequately address the health problem, or is deemed unsuitable by the recipient. The increasing rate of unmet health care needs is becoming a worldwide problem.[1–4] The high rates of unmet health care needs reported in Canada are of particular concern as the health care system is publicly funded and the expectation is that health care is available and equally accessible to all Canadians.[5] Health care that does not meet the needs of individuals can negatively impact their independence, general health and wellbeing.[6]

There is a particular growing concern for those who are most vulnerable to unmet health care needs, including people with disability. Unmet health care needs for people with disabilities are generally much higher compared to people without disabilities.[4,7,8] Although this research focuses on unmet health care needs for people with disabilities in Canada, there is a need for more research on people with disabilities in developing countries as approximately 80% of the one million people with disabilities are affected by unmet health care needs.[4]

I am particularly interested in the experience of respondents with work-related disabilities. Qualitative researchers[9–13] have described the stigma that people with work-related disabilities face due to being an injured worker. I am interested in whether this stigma spills over into health care experiences. Goffman's[14(p3)] definition of stigma as "an attribute that is deeply discrediting," such that the person who is stigmatized "is thus reduced in our minds from a whole and usual person to a tainted, discounted one" is a good fit for people with work-related disabilities.

The Canadian National Population Health Survey (NPHS) and the Canadian Community Health Survey (CCHS) both include questions addressing unmet health care needs. Participants are asked whether they needed health care in the past 12 months but did not receive it. This subjective measure has been used in many research projects,[1–3,7,15–19] but most of these previous analyses

A variation of this study was presented by the author at the 2011 annual meeting of the Canadian Association on Gerontology.

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have not distinguished unmet health care needs by presence or type of disability. Rates of unmet health care needs have slowly increased between 1994/95 to 2000/01.[1,2] Rates of unmet health care needs for people with disabilities worldwide, in both developed and developing countries, is also much higher than people without disabilities.[4]

A life course perspective on disability and unmet health care needs

The definition of disability status in the NPHS is similar to that used by the World Health Organization (WHO), that is, disability occurs when a person experiences activity limitations and restrictions in participation.[20] Critical disability theorists argue that disability needs to be viewed as a continuum and not a dichotomy.[21] Therefore, people are neither disabled nor non-disabled, that is ability status falls somewhere between the two. The interplay of different identities and how they influence experience, is useful when studying disability.[22] For example, race, gender, age, and socioeconomic status can influence whether a person experiences disability or unmet health care needs. This includes, for example, the greater likelihood of reported disability[7] or unmet health care needs[1,3,7] by women as compared to men, or the experience of low income as a result of being unemployed due to ability.[23]

Priestley[24] advocates applying a life course perspective in disability research because impairment often affects people differently depending on their age. A life course perspective allows the process of aging to be viewed as interactive, flexible, and constantly changing to adapt to social change and social structures. The physical, psychological, and social aspects of aging can be studied using a life course perspective.[25]

As the Canadian population ages and the rates of disability for people at all ages increases, longitudinal research is needed to better understand the influence of time on unmet health care needs for people with disabilities. This present research uses a longitudinal perspective to examine whether people with disabilities report more unmet health care needs than people without disabilities, with particular focus on the reasons for unmet health care needs. The main questions guiding this research are:

(1) Do unmet health care needs increase over time? What is the effect of disability status?
(2) What is the impact of work-related disability on unmet health care needs?
(3) Do personal or structural unmet health care needs change over time? What is the effect of disability status?

Methods

The data for this research come from Cycles 1 to 8 (1994/95 to 2008/09) of the NPHS, a longitudinal survey administered by Statistics Canada. The target population of the NPHS includes people living in households in all provinces and territories, except those residents on Aboriginal reserves, Canadian Forces Bases, or in remote areas. One person from each household was selected to participate in the survey and followed through each cycle.[26]

Respondents in the 1994/95 survey were included if they were between 25 and 50 years of age at that cycle (n = 7249). These participants were interviewed every two years. The number of participants decreased over time due to attrition and in 2008/09 there were 4577 participants (63.1% of the original sample). People who missed an entire cycle were returned to the sample if they participated in subsequent cycles.

Missing data

Missed responses in longitudinal studies compound the problem of sample attrition. For example, in Cycle 1, 4.6% missed one response, 4.2% missed two or more responses, but no one missed the entire cycle. Participants in Cycle 8 had the most missing data: 7.3% had one missed response, 2.6% had two or more missed responses, and 36.9%[a] missed the entire cycle. The overall response rates across waves did not drop below 70%; however, this is similar to the response rate reported by Statistics Canada. Preliminary tests suggest that data across cycles were missing at random and Multiple Imputation (MI) was used to impute data for participants who were missing some responses in a cycle. Using STATA 11, missing values were imputed using the Multiple Imputation by Chained Equations (MICE) command to create five separate datasets. Only the variables that are included in the analyses were used to produce the estimated values. Analyses were conducted on all five datasets and the results were combined using Rubin's Rules for MI.[27]

Attrition was accessed to determine the characteristics of those missing from the analysis. The remaining sample is generally in better health, married, has higher household income, and is less likely to report an unmet health care need. There were 255 participants (0.04%) who died during the fifteen year time period. Those who died were more likely to be male, report poor health, and report a disability as a result of a disease or illness in Cycle 1.

Concepts and measures

Dependent variables

The first dependent variable used in this research was unmet health care need. Respondents who answered yes to the question "was there ever a time in the past 12 months when you felt that you needed health care but you didn't

[a] Attrition in the NPHS is common and Statistics Canada reports that 29.6% are missing from the 2008/09 NPHS which includes all respondents. This research focuses only on people between the ages of 25–50 in cycle 1 which could explain why the rate of attrition is a little higher.