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Original Research

Subjective health of adolescents from families in receipt of social assistance

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ABSTRACT

Objective: To compare the subjective health of adolescents from families in receipt and not in receipt of social assistance.

Study design: Nationwide cross-sectional study of 1812 pupils aged 13–18 years in Poland in 2010–2011.

Methods: The analysis focused on two dimensions of the Child Health and Illness Profile – Adolescent Edition questionnaire: discomfort and satisfaction with health. Age, sex and seven socio-economic factors were considered as determinants.

Results: Overall, 10.8% of the respondents reported that their families were in receipt of social welfare benefits. Among the families of low socio-economic status and living in poor regions, the percentage in receipt of social welfare benefits increased to 22.1%; however, this figure was lower (4.4%) if both parents had a higher level of education. After adjustment for six sociodemographic variables, the standardized regression coefficient of the social welfare benefits variable amounted to 0.072 ($P = 0.004$) in the discomfort model and −0.044 ($P = 0.079$) in the satisfaction model. A significant three-level interaction was found ($P = 0.007$) between residential location, neighbourhood affluence and being in receipt of social welfare benefits as predicators of discomfort score (general linear model).

Conclusions: Being in receipt of social welfare benefits has a stronger impact on experiencing discomfort than diminishing satisfaction with one's health. It also has a stronger effect on physical problems than on emotional problems. The item 'on social assistance' is recommended as it helps to identify families particularly exposed to the health consequences of poverty.

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Introduction

In studies on health inequalities, data from large population surveys constitute an important source of information. Studies focus on health problems of the most disadvantaged social groups in contrast to the rest of the population (gap approach), or analyse how health problems increase consistently with lower social position (gradient approach).[1] Whichever approach is followed, more attention should be paid to the most vulnerable groups, such as children, adolescents and older people.[2] In health surveys of adolescents, it is difficult to choose appropriate measures of socio-economic status, and therefore to determine those living in extreme poverty. Children are not often able to describe the level of their parents' education and employment, or the family's income. High-quality methodology relevant for household surveys (such as relative poverty lines) is difficult to apply.[3,4] Investigators limit themselves to the subjective assessment of a family's wealth or introduce combined indices describing material resources.[5,6] New research tools to better reflect the full social structure and help in distinguishing extremely poor families are constantly required. Describing different forms of social assistance that only target the most economically disadvantaged could be a promising research tool, particularly when the gap approach is applied. To the best of the authors' knowledge, there is no history of using these types of questions in youth health surveys in European countries.

Van Lancker and Van Mechelen[7] undertook a classification of social assistance systems for families with children in 26 European countries. A system of universal allowances (typical of Scandinavian countries), the most commonly applied system of targeting within universalism, and a system of financial and in-kind support addressed to the poorest part of the population were distinguished in 2009 data. Poland belongs to the latter group, together with six other countries (Czech Republic, Italy, Lithuania, Portugal, Slovenia, and Spain). Van Lancker and Van Mechelen[7] concluded that the third of the above-mentioned systems is the most efficient for reducing poverty. In countries that use a selective system, information about the provision of social assistance is tantamount to classifying a family as belonging to the poorest part of society. Indirectly, this country-context-relevant information may be treated as an indicator of socio-economic status, and then correlated with health indicators.

The assumption that adolescents are aware of social assistance as it affects their family can be accepted. According to the law, some types of financial benefits and family allowances are granted in Poland. Benefits can be constant, periodical and intentional, or can consist of non-financial benefits such as caring services, shelter and meals. Beneficiaries of social care can be individuals or families considered to be impoverished on the basis of income criteria and at least one of the dysfunctions enumerated in the law. According to the Central Statistical Office's Report based on Ministry of Labour and Social Policy data,[8] over 538,000 households with children benefited from social care provision (through the municipal social welfare centres) in Poland in 2011. This constituted almost 12% of all households with children, 9% of household with children in cities and 16% of households with children in the countryside.

The aim of this study was to compare selected aspects of subjective health in adolescents living in families supported and not supported by social assistance.

The following research questions were asked:

- To what extent does the frequency of availing of social assistance correlate with other social indicators?
- Are there any differences in the health of adolescents from families supported and not supported by social care, and in what fields are the differences most visible?
- Can the item about social welfare benefits be recommended for other studies in this age group?

Methods

Data

The data used in this study came from a nationwide health survey conducted in Poland in the school year 2010–2011. The anonymous study was conducted on a sample of pupils attending lower secondary schools and different types of upper secondary schools (general and vocational). The responses of 1812 pupils (49% female, 45% urban residents) who answered the key question about social assistance were analysed (response rate 83%). The average age was 15 (standard deviation 1.46) years, and ranged from 13 to 18 years.

Measures

Socio-economic status

One general question was asked, 'Does your family benefit from social care?' Answer options were 'Yes', 'No' and 'I don't know'. Six additional socio-economic items were used. Irrespective of the three traditional questions about residential location and mother's/father's education, adolescents reported the subjective social status of their family and their status in their school class using the MacArthur visual scales, adapted by Goodman for the adolescent population.[9] Based on past experience, answers in the range from 0 to 5 were considered to indicate a low social position, answers from 6 to 8 were considered to indicate an average social position (50% of the population), and answers of 9 or 10 were considered to indicate a high social position. The three-item scale of neighbourhood affluence was also implemented. This has been tested previously in large-scale international surveys.[10]

Health measures

The analysis was limited to two domains of the Polish version of the Child Health and Illness Profile – Adolescent Edition (CHIP–AE)[11,12] questionnaire that refer directly to both physical and mental health: discomfort (negatively scored) and satisfaction (positively scored). The satisfaction scale (range 0–45 points) contains 14 questions connected with self-esteem, physical well-being, positive feelings and physical fitness. The discomfort scale (range 0–61) consists of 19 questions connected with various health-related conditions,

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