Subjective perceptions of financial strain by home care patients initiating palliative radiation for recurrent cancer: Do older adults accommodate more to objective family financial stress?

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Statement of the Research Problem

The efficacy of social work screening and treatment of patients and families at risk for financial burden, which may lead to negative biopsychosocial outcomes, is becoming increasingly important, especially as managed health care becomes entrenched. The literature reveals that financial burden is among the most prevalent indicators of other biopsychosocial needs within valid social work screening efforts (Becker & Becker, 1986; Kayser, Hansen, & Groves, 1995; Berkman, Shearer, Simmons, White, Robinson, Sampson et al., 1996; Cook, Freedman, Freedman, Arick, & Miller, 1996; McNeill, Nicholas, Szechy, & Lach, 1998).

Financial burden is often equated with the overall level of objective financial stress. However, objective financial stress and subjective financial strain may each tap unique aspects—and not the full range—of financial burden. When various subgroups of patients, caregivers, and families experiencing the same level of financial stress report different levels of financial strain, social workers should not neglect the reactionary, subjective perceptions of financial strain in the assessment of risk for negative biopsychosocial outcomes.

Research Background Questions/Hypotheses

Theory and Empirical Findings

An important dimension where financial strain perceptions may differ at the same level of objective family financial stress appears to be the subgroup distinction of younger versus older adult patients since hypotheses of increasing accommodation with age are supported by various empirical findings and theoretical perspectives. In a classic general population study, Campbell, Converse, & Rogers (1976) found that elders accommodate, compared to younger adults, with regard to satisfaction about the objective conditions of nine out of sixteen life domains, including finances (with minor differences for almost all of the remaining life domains).

Social stratification. Social structural characteristics (e.g., age, sex, race) and their interactions reflect different degrees of restrictions or barriers over access to economic resources and opportunities. Younger and middle-age adults tend to increase in economic status over time, unlike the elderly. Lower socioeconomic status over the life course
reflects cumulative disadvantages in the acquisition of power, prestige, and wealth that persist through old age.

Empirical evidence (Campbell et al., 1976; Henretta & Campbell, 1976; Carp & Carp, 1982) suggest that the elderly perceive greater equity in their fixed economic situations, often report high financial satisfaction even when they fail to reach their financial aspirations, and appear satisfied with maintenance of their economic position relative to others in their age cohorts. Younger adults may accommodate less due to their higher aspirations that may be fueled by a greater sense of recent achievements.

Fletcher and Lorenz (1985) provide support for the accommodation hypothesis that the linear relationship between objective economic well-being (total family annual income) and subjective economic well-being (financial satisfaction) is weakest among the oldest age group (54 and older) compared to the two younger age groups (p=.01) (i.e. interaction of “age * objective economic well-being”).

Relative deprivation. This perspective regards a person’s comparisons of his or her current circumstances with those of a peer group or previous circumstances as a means of self-evaluation. Universal entitlement by the elderly to Medicare and the income-redistribution aspects of Social Security may reduce elder perceptions of relative deprivation.

Adaptation-level theories. People are predicted to accommodate more to condition(s) the longer they are exposed to them. Thus, the elderly may be more satisfied with their life conditions because they have been exposed to them longer. Adaptation may also be a coping resource to fears that increase with age (e.g., chronic illness, widowhood, poverty).

An intracomparative adaptation-level theory of relative burden is limited to comparing the various components within one life domain, such as household finances. Studies reveal that out-of-pocket medical expenses and health insurance premiums account for a greater share of budgets in elderly households (Ruffin, 1989; Rasell, Bernstein, & Kainan, 1994). This implies that elders may adapt to considerably higher levels of objective financial stress due to medical care than younger adults. Further, elderly patients tend to have more illness diagnoses than younger patients. This might explain higher accommodation by elders to financial stressors compared to younger patients with similar levels of disability.

Stress/strain relationships. Several studies reveal declining numbers of stressful life events and chronic life strains as people age (e.g., Chiriboga, 1989), and this might explain the higher satisfaction of the elderly across life domains, including finances. In contrast to elderly patients, younger patients are more apt to rely on less secure wage income (which may not include sick pay); risk losing their jobs and, consequently, private health insurance coverage; support children and other dependents; rely upon spouse caregivers who work full-time to support the family; and face outstanding major debts and mortgages.
Hypotheses

It is hypothesized that at any given level of overall family financial stress, older patients tend to perceive less financial strain (i.e. "worry about finances," "difficulty paying bills," "inadequacy of insurance/financial resources for future health needs") and that this occurs increasingly as patients age (i.e. the curvilinear term, "age\(^2\)," is statistically significant) or when the overall level of family financial stress is high (i.e. the interaction term, "age * objective family financial stress," is statistically significant). That is, older patients tend to accommodate in their financial strain responses to overall family financial stress, and at higher financial stress levels or with increasing age, the extent of accommodation increases. (Note that “objective family financial stress” is based upon indices reflecting out-of-pocket medical expenses, medical bills management, wage loss, tapped financial resources, ended employment, and overall finances trend).

Methodology

The Sample

This secondary data analysis is based upon the first wave of a large comprehensive survey during 1990-91 regarding the biopsychosocial and home care needs of recurrent cancer patients receiving palliative radiation to reduce pain (see Schulz, Williamson, Knapp, Bookwala, Lave, & Fello, 1995). Eligible patients lived at home and recently initiated outpatient palliative care, however they were not deemed terminally ill. Patients were interviewed at home, and 268 out of 575 eligible patients participated (47% response rate). Each sex comprises about half the sample.

The Statistical Model

The data are analyzed using an extension of ordinal probit regression, which includes three ordinal, dependent (\(y\)) variables that serve as observed indicators of a unidimensional latent factor or construct (i.e. subjective patient financial strain). This combined regression and factor analysis constitutes a Multiple Indicators-Multiple Causes (MIMIC) structural equation model that is estimated using LISCOMP software. All factor loadings are greater than 0.60, and model fit indices reveal good fit. All other independent (\(x\)) variables: 1) account for effects that otherwise would wrongly be attributed to age; and 2) serve as controls for sampling error.

As an initial step in testing the explanatory hypotheses, "age\(^2\)" and/or "age * objective family financial stress" should be statistically significant. The subsequent simple slopes plots, specified at low, average, and high levels of objective family financial stress, are based upon these higher-order terms and their lower-order component terms. These plots should reveal that the relationship between advancing age with each measure of financial strain is negative (i.e. an “accommodation” or “buffering” effect, the opposite of an “exacerbation” effect revealed by a positive plot).
Of the three financial strain measures, accommodation with advancing age is detected for “difficulty paying bills.” Considered alone, it appears that this financial strain measure might be used to detect at-risk younger adult patients within high-risk screenings. Even so, indirect evidence from the literature suggests that the lower-income disabled elderly may consume fewer health services, compared to other disabled elderly, because they are unable to afford additional out-of-pocket costs (Coughlin, Liu, & McBride, 1992). Disabled older adults who incur especially low levels of overall financial stress may do so because they are already experiencing high financial strain.

Indeed, post-hoc analyses within the current study reveal that as patients with low to moderate “objective family financial stress” and high “disability days” (exceeding the mean) grow older, their perceptions about the “inadequacy of their insurance/financial resources to meet future health needs” appear increasingly exacerbated (i.e. the interaction term, “age * disability status dummy * objective family financial stress,” is significant with a positive plot).

When disability status is replaced with a dummy variable representing all patients except eleven percent who are unemployed or on-leave from work, the results are similar at low “objective family financial stress.” However, at high levels, patients tend to accommodate with advancing age, implying that the younger patients may be at enhanced risk for coping difficulties.

In conjunction with the explanatory findings of increasing accommodation with advancing age to the financial strain from “difficulty paying bills,” these results imply that in order to continue meeting bills and expenses, older adult patients incurring low levels of financial stress—or others acting on their behalf—may curb or forego financial stress judged to be unaffordable, and consequently, needed care. This implication was speculated by Mentnech, Ross, Park, and Benner (1995) who warned that cost-containment pressures within government health insurance programs could escalate this tendency.

Accommodation to present circumstances may stem from exacerbated perceptions about future conditions. Dysfunctional coping responses may be associated with chronic strains, family sacrifice, lack of access to care, unrelieved pain or symptoms, or medical noncompliance. Cognitive-behavioral interventions are discussed. Social policies with implications for patients and families include issues regarding Medicare/Medigap, Medicaid and state programs, and options for underinsured patients to afford private insurance.
References


