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Thank you for submitting the above paper to Public Health.

After careful consideration, I believe that this paper is suitable for publication in Public Health and I am glad we are able to publish your work on this occasion. One of the editors of your paper has suggested that it would be valuable to include a comparison between unmet needs of immigrants with those of non-immigrants. This comparison will make it possible for you to draw relevant conclusions and make practical public health recommendations. I will make details of the editors' views and suggestions to you shortly to enable you effect changes appropriately.

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Perceiving Unmet Health Care Needs and Self-initiative in Improving Health

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Introduction

Unmet care needs represent perceived deficiencies in health care delivery,[1,2] and consist of three major components: perceived problems with availability, accessibility, and acceptability of health care services.[3] Long waiting time was the reason most frequently reported for unmet health care needs.[4] Relative to other developed countries, overall, unmet health care needs in Canada remain low (5%), although there has been a slight increase across all provinces.[5] The prevalence of unmet health care needs of all types was close to the national figure in most provinces.[6] There have been concerns that recent limits on health care budgets placed an unequal burden on disadvantaged groups. However, studies[1] have shown that the likelihood of reporting unmet needs due to a lack of services did not vary significantly based on factors such as household income, education, employment, Aboriginal status, or immigrant status.[1]

During the period covering 1998/99, about 1.5 million people in Canada, representing 6.6% of those 18 or older, reported having had health care needs in the previous 12 months that were not met.[7,8,9] This group felt that they needed, but did not receive, some form of health care.
During the same period under review, the “availability” factor predominantly accounted for the reported unmet care needs of Canadian citizens and residents. This factor included waiting too long for care (36% of cases of unmet need) and accessibility problems, specifically cost or lack of transportation (about 10%). Individuals’ responses to unmet care needs constitute crucial information for effective health care planning. In 49% of the cases of unmet need reported in 1998/99, the individuals chose to do without health care, either because of competing demands on their time or because of their attitude toward illness, health care providers, or the health care system. These situations, known as "acceptability" problems, were due to a variety of reasons including being too busy, deciding not to bother, believing care would be inadequate, or disliking or fearing doctors.[6]

It was observed that most people's unmet health care needs were attributable to only one category of reasons for non-acceptability.[6] Only in 5% of cases did the reported acceptability problems spread across more than one category. When people report or perceive unmet health care needs, they generally do something to improve their health. However, it is not in all cases that people who report unmet care needs do something to improve their health. Some people who

would ordinarily want to do something to improve their health are unable to do so owing to one or several barriers that they face. These might include language difficulties, transportation problems, poverty, and other social exclusion factors. Although immigrants and non-immigrants who do or desire to do something to improve their health may act differently, their actions might not be significantly different.[9] Among the strategies that individuals or groups adopt to improve their health are healthy eating, physical activity, and maintaining a healthy weight. As another way of ensuring good health among their citizens, many countries have developed national strategies for public health improvement that include immunization programs, disease screening, and other steps to reduce the population's risk of developing communicable and non-communicable diseases. Also, injury prevention and health protection and promotion measures have been put in place by many health jurisdictions.

This study, using the Canadian Community Health Survey (CCHS) Cycle 1.1 data, investigated Alberta immigrants' unmet health care needs. The study also determined whether or not the immigrants did something to improve their health. Immigrants were evaluated according to their socio-demographic groups. Finally, the CCHS data were analyzed to investigate the reasons for which immigrants did not receive health care.

Methods

Sources of data

The study utilized data from Cycle 1.1 of the Canadian Community Health Survey (CCHS). The CCHS is a cross-sectional survey conducted by Statistics Canada. It covers 136 health regions across the country and involves a total sample of 131,535 respondents aged 12 or older. There are 14,456 respondents from the province of Alberta included in the Cycle 1.1 CCHS survey. Of these, 1,815 were immigrants.

Survey questions

Survey questions were on "self-perceived unmet health care needs," whether respondents "did something to improve health," and "reasons for not receiving care." The first question had "yes," "no," "not applicable," "don't know," "refusal," and "not stated" as response options, but only the "yes" and "no" response options were considered for analyses. The second question had only "yes" and "no" as response options, while the third had "not available in area," "not available when required" "wait too long," "cost," "didn't know where," and "language problem" as response options.

Data Analysis

Logistic regression was used to estimate the odds of the various segments of the immigrant population sample reporting the presence of "self-perceived health care needs," both unadjusted and adjusted for socio-demographic variables. The same procedure was carried out for "doing something to improve health." Similarly, weights were used to account for unequal probabilities of selection. Bootstrapping was not possible because the study did not use the original CCHS data file. Statistical significance of differences was set at $p < 0.05$. Regarding the reason(s) for not receiving care, the proportion of respondents who reported not receiving care out of the total number of respondents was obtained.

Results

Perceiving unmet health care needs

The first significant result in Table 1 indicates that females are 1.36 times more likely to report unmet health care needs than males. The second result shows that visible minority immigrants are 0.74 times as likely to report unmet health care needs as white immigrants. As for income adequacy, middle- or high-income immigrants are 0.74 times as likely to report unmet health care needs as immigrants in the low-income group. Similarly, widowed/separated/divorced immigrants are 1.20 times more likely to report unmet health care needs than married immigrants. The results in Table 2 indicate that wait time was the reason that Alberta immigrants cited the most for not receiving health care. It was followed, in decreasing order, by feeling/being inadequate, cost, and non-availability in area.

Doing something to improve health

Table 3 shows logistic regression results on whether Alberta immigrants did something to improve their health. Two significant results were obtained. The first is that female immigrants are 1.85 times more likely than their male counterparts to do something to improve their health. The second result indicates that immigrants without work are 0.71 times as likely to do something to improve health as immigrants who had a job throughout the previous year. Regarding marital status, widowed/separated/divorced immigrants are 0.68 times as likely to do something to improve health as their married counterparts.

Discussion

This study found that females are more likely than males to report unmet health care needs. Women were also found to be more likely to do something to improve their health than men were. This is in line with past literature and only shows that women derive health dividends from their increased utilization of health care services compared to men.[10] Visible minority immigrants were less likely to report unmet health care needs than white immigrants. Nevertheless, visible minority immigrants did not do anything significant to improve their health. The finding points to cultural differences that may shape the conception of health by minority immigrants and white immigrants. Moreover, differences in the economic and social experiences of visible minority immigrants and white immigrants might have affected the findings. In the same vein, social exclusion factors appear to be a plausible explanation for this result. Middle- or high-income immigrants are less likely to report unmet health care needs than those with low income. Indeed, they are also more likely to do something to improve their health than are low-income immigrants. It follows, therefore, that with their supposedly more beneficial incomes, middle- or high-income immigrants have an economic advantage over low-income immigrants in meeting their health care needs.

Immigrants without work are less likely to report unmet health care needs than immigrants who had a job throughout the previous year. Interestingly, the former are also

significantly less likely to do something to improve their health than the latter. As for marital status, widowed/separated/divorced immigrants are more likely to report unmet health care needs than married immigrants. Widowed/separated/divorced immigrants are also less likely than married immigrants to do something to improve their health.

Conclusion

The findings of this study generally revealed or confirmed a complex interplay of socio-cultural, economic, environmental, and personal factors that affect immigrants' experiences in Alberta, Canada. Sex, income level and employment, race and country of origin, length of residence in Canada, and immigrant status influenced the outcomes of this study in various ways. These findings have led to the conclusion that, in order to understand the issues that affect the health and welfare of immigrants, those issues need to be treated holistically rather than discretely. Moreover, positioning health and welfare efforts to succeed in Alberta presupposes that immigrants and residents for whom these projects are meant, and who know what they want more than anybody else, should, as a matter of necessity, always be included.

The twin problems of waiting time and wait-lists, which have become the bane of the Canadian health system, are featured again in the analysis of Alberta immigrants' health care needs. The conclusion, based on these findings, is that problems of unmet health care needs, reasons for not receiving care, and the issue of doing something to improve one's health need to be more proactively addressed by government and other relevant societal groups or agencies. Only then will the dream of evolving a more satisfactory, affordable, and accessible health care delivery system be fully actualized in Alberta and in Canada at large.

Acknowledgement

We would like to acknowledge the Alberta Ministry of Health & Wellness for its sponsorship of this research project.

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