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Mental Health Status and Access to Health Care Services for Adults in Maine

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Mental Health Status and Access to Health Care Services for Adults in Maine

February 2017

INTRODUCTION

Access to health care services is critically important to individuals' health and well-being, yet Maine residents' ability to obtain needed health care or maintain an ongoing relationship with a personal doctor are not uniform across different population groups. In Maine, access to care may be affected by factors such as financial resources, education, age, race/ethnicity, and other characteristics.¹ Since many of these characteristics are also associated with chronic health problems or worse general health status, the inability to get needed care may increase the risk of poor health outcomes.

Individuals with mental health conditions or poorer mental health status may be at heightened risk of access barriers because of more limited financial resources or other challenges in obtaining needed services. Using the Maine Behavioral Risk Factor Surveillance System (BRFSS) for the years 2012-2014, this brief examines disparities in access to health care services for Maine adults based on self-reported mental health status. Specifically, it compares access for Maine adults with and without symptoms of depression, and also by the number mentally unhealthy days individuals say they've experienced in the past month. The relationship between mental health status and access to health care services is complex and may be related to other factors such as socioeconomic status. Thus, the brief also examines specific characteristics known to affect health care access (e.g., education, income and health insurance coverage) and how these differ for individuals at different levels of mental well-being.

The BRFSS is Maine's longest running and largest survey used to monitor population health statistics over time for a wide range of topics including health care access, health behaviors, and chronic disease prevalence. More detail about the BRFSS and the analyses used for this project, including specific information about the mental health status variables, is available in the Methods Note at the end of this brief.

FINDINGS

Among Maine adults 18 and older, about 9.5% have probable depression* at the time they receive the BRFSS survey. The survey also asks individuals to report number of bad days due to mental or emotional distress that they've experienced in the past month. Thirty-six percent report some mental health bad days in the past month, and 12% report 14 or more mental health bad days during that time. The findings in this brief generally show that individuals with poorer mental health also have poorer access to health care services; however, it is important to recognize that these relationships are complicated (see *Methods Note* on page 5 for more detail).

Adults at Risk for Depression Are Likely to Have Lower Income, Lower Educational Attainment, and Public or No Health Insurance

Maine adults with probable depression have high rates of socio-demographic vulnerabilities such as low income, low educational attainment, and public insurance or no insurance. These vulnerabilities may make it difficult for them to

* Depression or other mental health conditions can only be officially diagnosed by a clinician. However, as described in the Methods Note at the end of this brief, this BRFSS measure is based on two survey questions that research indicates are together a strong predictor of whether or not an individual is currently depressed. These questions generally ask how many days over the past two weeks an individual felt depressed or had little interest in normal activities.

Figure 1: Household Income, by Depression Status

| Percent in Each Income Group | | | | | |
|------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| | Less than \$15,000 | \$15,000-\$24,999 | \$25,000-\$34,999 | \$35,000-\$49,999 | \$50,000 or more |
| With probable depression | 31.2% (28.1-34.2) | 28.5% (25.6-31.5) | 12.4% (10.2-14.5) | 12.4% (10.5-14.4) | 15.5% (13.2-17.7) |
| Without probable depression | 9.4% (8.8-10.0) | 17.0% (16.2-17.7) | 11.6% (11.6-12.2) | 17.5% (16.8-18.3) | 44.5% (43.6-45.4) |

Source: 2012-2014 Maine BRFSS

*Statistically significant income group differences at $p < .05$. Numbers in parentheses are the 95% confidence intervals for the estimated percent in each group.

Figure 2: Insurance Status among Maine Adults, by Depression Status

| Percent with Each Insurance Type | | | | | |
|----------------------------------|----------------------|----------------------|----------------------|-------------------|----------------------|
| | Private | MaineCare (Medicaid) | Medicare | TriCare/IHS/Other | Uninsured |
| With probable depression | 26.7% (23.8-29.6) | 25.2% (22.1-28.4) | 24.3% (21.6-27.0) | 6.7% (5.3-8.1) | 17.1% (14.3-20.0) |
| Without probable depression | 53.7% (52.7-54.7) | 8.8% (8.2-9.5) | 19.0% (11.6-12.2) | 6.7% (6.3-7.2) | 11.8% (11.0-12.5) |

Source: 2012-2014 Maine BRFSS

*Statistically significant income group differences at $p < .05$. Numbers in parentheses are the 95% confidence intervals for the estimated percent in each group.

seek and secure adequate and affordable health care services. For example, among those with probable depression, 31% are part of households with income below \$15,000 per year compared to only 9% of those without probable depression (Figure 1).

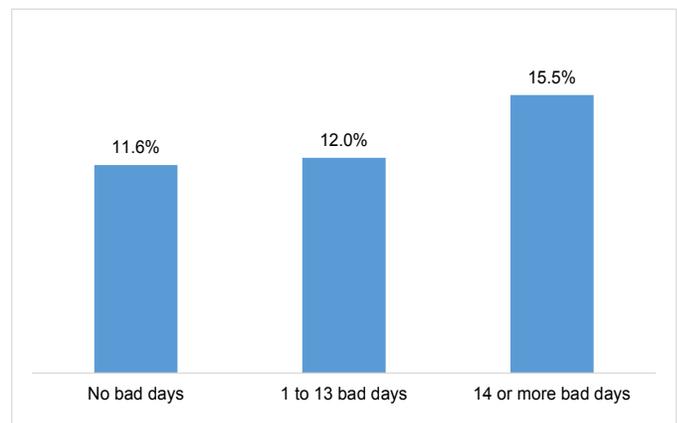
Following a similar pattern to income, adults with probable depression are more likely to have low educational attainment than those adults without depression. For example, among those with probable depression, 18% have less than a high school diploma compared with 9% of those without (data not shown). Adults with probable depression are less likely to have a college degree compared with adults who do appear to have depression (12% vs. 27%).

Maine adults with probable depression are more likely to have public sources of health insurance coverage—such as MaineCare or Medicare—or to be uninsured than adults without symptoms of depression (Figure 2). For example, among adults with probable depression, 25% have MaineCare, 17% are uninsured, and 26% have private coverage compared to 9%, 12%, and 54% respectively of adults not identified as having probable depression.

Adults with Poorer Mental Health Status Experience Access Barriers and Delays

Adults with more mental health bad days are less likely to have a regular health care provider, a hallmark of ongoing and appropriate care (Figure 3). The percent of Maine adults without a personal doctor or health care provider increases with an increase in the number of mental health bad days. Among those with no mental health bad days, 12% do not have a personal doctor, compared to 15.5% of those with 14 or more mental health bad days (there is no statistical

Figure 3: Percent of Adults without a Personal Doctor or Health Care Provider, by Mental Health Bad Days

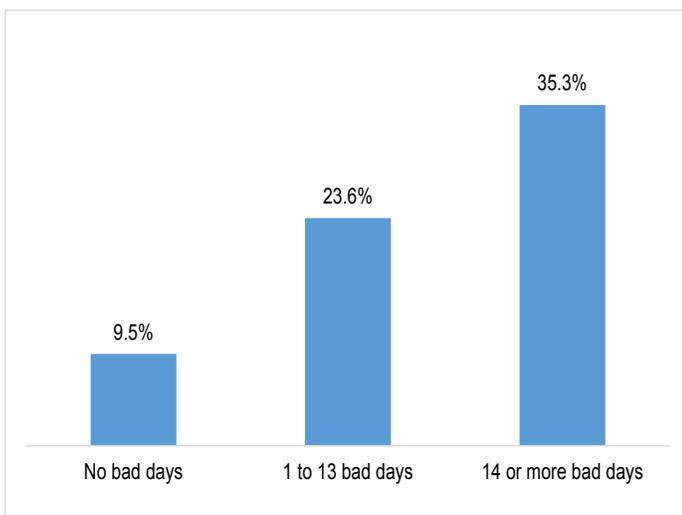


Source: 2012-2014 Maine BRFSS annual survey
Differences statistically significant at $p < .05$

difference between those without bad days and those with fewer than 13 bad days). A similar pattern is true for adults with probable depression, for whom 14% lack a regular provider compared to 11% of those without probable depression (data not shown).

Delays in accessing care are common among adults with poorer mental health status in Maine. For example, Maine adults experiencing more mental health bad days are also more likely to report delays in getting needed health care services for a reason other than cost (Figure 4).

Figure 4: Percent of Adults with Care Delays, by Mental Health Bad Days

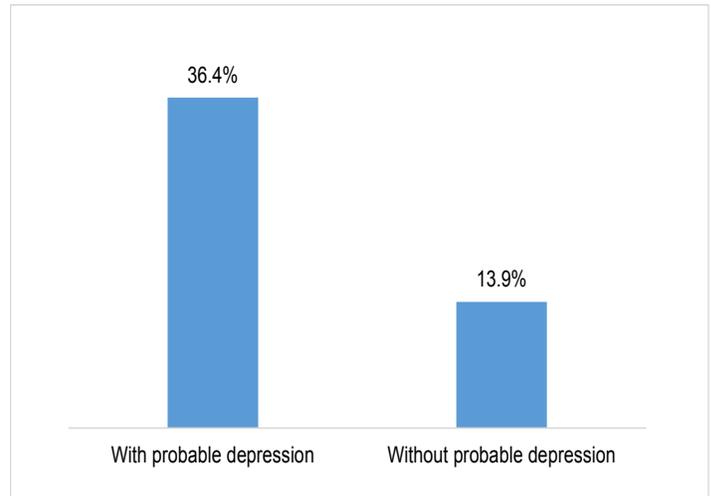


Source: 2012-2014 Maine BRFSS annual survey
Differences statistically significant at $p < .05$

Among adults with no mental health bad days, 9.5% delay care because of transportation, scheduling problems, or other non-cost reason (see *Methods Note*). However, among those with 14 or more mental health bad days, 35% experience a care delay. Similarly, 36% of individuals with probable depression report a delay in needed health care services compared with only 14% of those without (Figure 5).

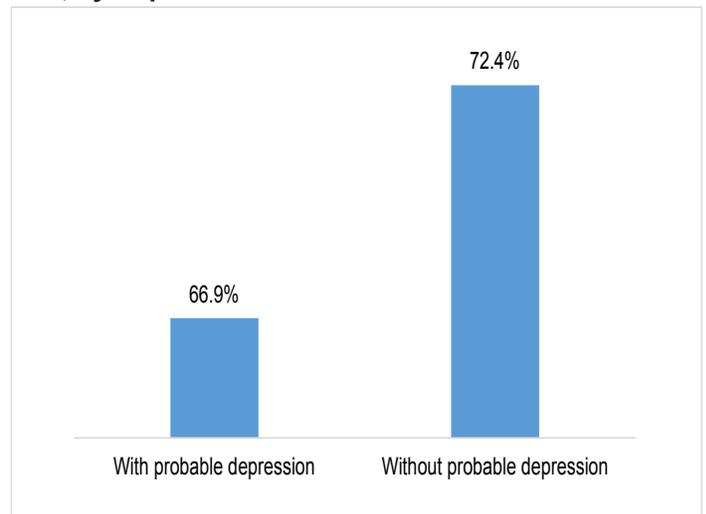
As shown in Figure 6, individuals with probable depression also are less likely to have had a routine check-up in the past year than those without symptoms of depression (67% compared with 72%).

Figure 5: Percent of Adults with Care Delays, by Depression Status



Source: 2012-2014 Maine BRFSS annual survey
Differences statistically significant at $p < .05$

Figure 6: Percent of Adults with a Check-up in Past Year, by Depression Status

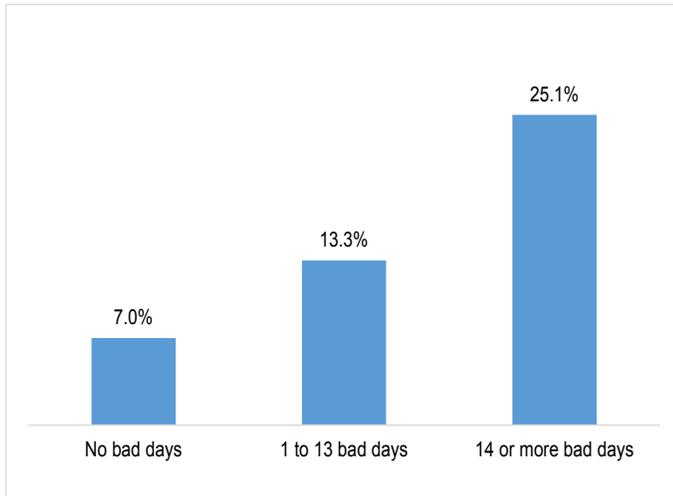


Source: 2012-2014 Maine BRFSS annual survey
Differences statistically significant at $p < .05$

Adults in Poorer Mental Health Experience Greater Affordability Barriers to Care

Maine adults' ability to afford health care services appears to be correlated with their mental health status. For example, poorer mental health status is associated with higher rates of foregoing needed medical care because of costs and of having medical bills that are being paid over time. Among adults with 14 or more mental health bad days, 25% report they are unable to access needed care from a doctor as a result of

Figure 7: Percent of Adults who Needed to See a Doctor but Could Not Due to Cost, by Mental Health Bad Days

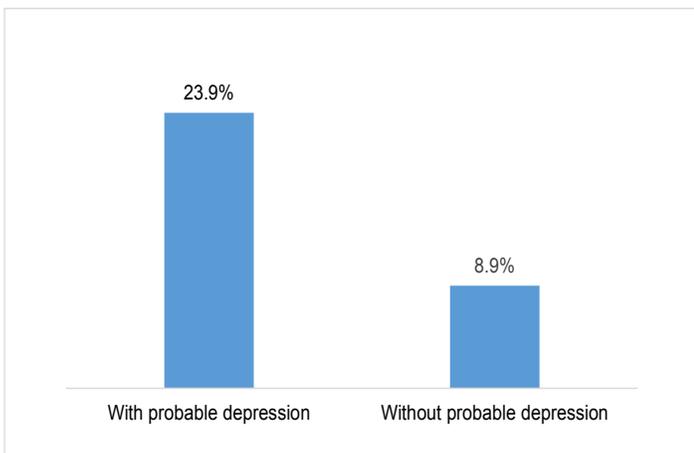


Source: 2012-2014 Maine BRFSS annual survey
Differences statistically significant at $p < .05$

cost, compared to 7% of adults with no mental health bad days (Figure 7).

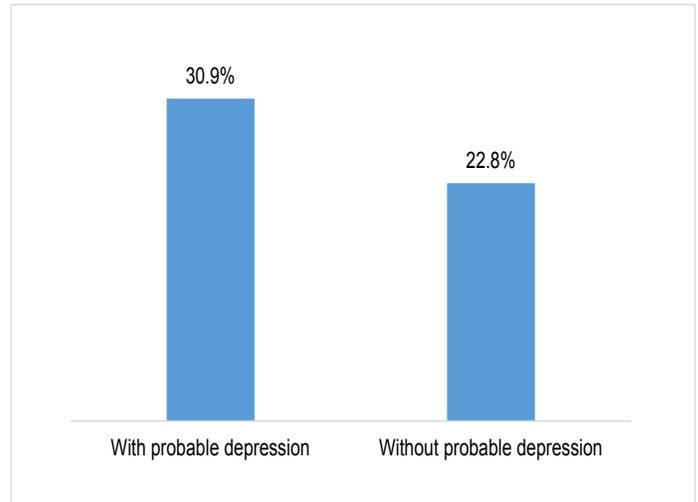
Maine adults who are likely to be suffering from depression have similar problems with paying their medical bills. Among those with probable depression, 24% report that they were unable to obtain needed care because of costs compared to only 9% of those without probable depression (Figure 8). Similarly, 31% of Maine adults with probable depression report that they had medical bills they were paying off over time, versus 23% of adults without

Figure 8: Percent of Adults who Needed to See a Doctor but Could Not Due to Cost, by Depression Status



Source: 2012-2014 Maine BRFSS annual survey
Differences statistically significant at $p < .05$

Figure 9: Percent of Adults Paying Medical Bills Over Time, by Depression Status



Source: 2012-2014 Maine BRFSS annual survey
Differences statistically significant at $p < .05$

depressive symptoms (Figure 9). In a similar pattern, adults with more mental health bad days are more likely to report paying medical bills over time. Only 19% of those with no mental health bad days are paying bills over time compared to 38% of those with 14 or more mental health bad days (data not shown).

This association between poorer mental health status and greater financial barriers to health care services may be related to the socioeconomic challenges that individuals with mental health conditions face. For example, Maine residents who report more mental health bad days or who screen positive for depression also tend to have lower incomes and higher uninsured rates than adults with better mental well-being (Figures 1 and 2, above). At the same time, individuals with mental health conditions also tend to have more physical health conditions than the average population. This may mean that individuals in poorer mental health have greater need for both mental health and health care services and, at the same time, have fewer financial resources to obtain this care. While fully understanding the complexity of the relationship between mental well-being and health care access is challenging, it is clear that Mainers with poorer mental health also face greater challenges in obtaining needed health care services.

METHODS NOTE

This brief is based on data from the 2012-2014 Behavioral Risk Factor Surveillance System (BRFSS). In 2012, 2013, and 2014, the full BRFSS samples for Maine were 9,876, 8,097, and 9,137 respectively for a total of 27,110 respondents that completed interviews over the combined three years. Because BRFSS questions may vary from year to year, some measures are presented for a single year or pair of years (for example, certain access questions were asked only in 2014). For other measures, particularly when comparing different socio-demographic groups, multiple years are pooled to ensure sufficient sample for these sub-analyses.

Questions regarding access to care used in these analyses appear in the BRFSS Core, which is standard across states and administered to all respondents. These access questions include:

1. Was there a time during the last 12 months when you needed to see a doctor, but could not because of the cost?
2. Do you have one person you think of as your personal doctor or health care provider?
3. About how long has it been since you last visited a doctor for a routine checkup?

The question on whether any care had been delayed was part of an optional module only asked in 2014 (have you delayed getting needed medical care for any of the following reasons in the past 12 months?). Response options for this question include being unable to reach the provider by phone, being unable to get an appointment soon enough, having to wait too long in the office, provider office hours, and transportation problems.

Individuals with probable depression are identified by the Patient Health Questionnaire depression two-question module (PHQ-2), designed to identify individuals who likely suffer from current depression.² These questions are:

1. Over the last two weeks, how many days have you felt down, depressed, or hopeless?
2. Over the last two weeks, how many days have you had little interest or pleasure in doing things?

Based on the number of days reported for each question, individuals are assigned a score that can be used to identify those who are likely suffering from depression. The measure of poor mental health days is based on the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Both the PHQ-2 and the self-reported poor mental health days measures have been tested extensively and they are widely accepted as accurate indicators of general mental health status.

As noted in the *Findings* section, the relationship between mental health status and access to care is complicated and the presented results should be interpreted with caution. For example, it is impossible to determine from the BRFSS data whether mental health status affects a persons' ability to obtain needed care, whether poor access reduces a person's mental well-being, or whether access and mental health status share a common set of other characteristics, such as lower socioeconomic status. Though the relationship is likely to be a combination of these three factors, the specific relationships are difficult to determine from a cross-sectional survey.

Because the BRFSS uses a complex sampling strategy, all analyses for the brief use sample weights to adjust for the ways in which the BRFSS sample is known to differ from the Maine population. The statistical testing and confidence intervals produced by these analyses take into account the complex design of the BRFSS.

All reported differences are statistically significant at the $p < .05$ level unless otherwise noted. Statistically significant results are indicated by p-values under the figures and 95% confidence intervals for some estimates are presented in parentheses ().

REFERENCES

1. Ziller E, Leonard B. *Access to Health Care Services for Adults in Maine*. Augusta, ME: Maine Health Access Foundation; October, 2016.
2. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. *Med Care*. Nov 2003;41(11):1284-1292.

For more information on this study, please contact Ericka Ziller, PhD at erika.ziller@maine.edu