Financial Wellbeing of Older Australians With Multiple Health Conditions

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Abstract

Objective: Given recent rises in out-of-pocket health expenses, we examined the financial wellbeing of older Australians with multiple health conditions and disabilities.

Methods: The 2014 General Social Survey was used to measure the (1) current financial position, (2) propensity to experience financial difficulties, and (3) types of behaviours older people with multiple health conditions engage in to improve financial resilience.

Results: Compared to older Australians with no health conditions, respondents with multiple health conditions had lower incomes and assets and a higher propensity to hold consumer debt (once controls were included). They were at a higher risk of cash flow difficulties, dissaving to meet day-to-day living expenses and exclusion from financial providers. However the majority of people with multiple health conditions engaged in financially resilient behaviours.

Conclusion: Many older Australians with multiple health conditions were in a financially precarious situation with implications for the ability to afford ongoing increases in out-of-pocket healthcare costs.

Keywords: Ageing, Comorbidity, Financial Wellbeing, Health Expenditures

Impact Statement

Many older Australians with multiple health conditions are in a financially precarious situation. Although they engage in financially resilient behaviours, their health conditions place constraints on re-entry to the labour market to improve financial wellbeing. The increased financial burden for people with multiple and/or long-term health conditions emphasises the benefits of preventative health interventions along the lifespan for the benefit of older Australians.

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Introduction

Recent cohorts of older Australians have experienced considerable improvements in their income and wealth relative to past generations of mature age people [1]. However, the older population is extremely heterogeneous with greater financial inequalities within the group existing now than in the past [2]. Indeed, one group of older Australians who may not have fared well financially in recent times are those with high health expenses in later life, particularly those with multiple health conditions.

Although Australia has heavily subsidised healthcare through Medicare and the Pharmaceutical Benefits Scheme, many older Australians with health conditions face significant out-of-pocket medical expenses. Over the past several years, a number of studies have noted the increasing financial burden brought about by health expenses for individuals with a range of conditions including chronic obstructive pulmonary disease, cancer, high blood pressure, diabetes and depression [3,4,5]. Healthcare expenses have been shown to be particularly unaffordable for older Australians with multiple health conditions, with one recent study showing that people with five or more health conditions spend five times as much on their health compared to those with no health condition [6,7]. Importantly, high out-of-pocket expenses spent on health conditions have been shown to contribute to these people skipping treatment and medications [8].

The high prevalence of multiple health conditions among older people points to consequences of burden on individual finances and health care systems. Many studies have indicated a bi-directional relationship between financial burden and multiple health conditions [9,10,11] but few have focused on interventions of financial self-management support, such as dissaving strategies, and its relationship to health and wellbeing for people with multiple health conditions in particular. Improving care for patients with multiple health conditions can be severely hampered by competing demands, such as financial issues [12].

With this considerable evidence base regarding the burden of out-of-pocket healthcare costs for those with multiple health conditions, we utilise new data to map the financial wellbeing of older Australians living with multiple disabilities and long-term health conditions. Firstly, we ask What is their current financial position relative to those with no underlying health condition? Secondly, what is their current propensity to experience financial difficulties? Finally, what types of behaviours do they engage in to improve financial self-reliance? This paper seeks to address these three questions.

Methods

Data for this study were from the 2014 General Social Survey (GSS) conducted by the Australian Bureau of Statistics between March and June 2014 [13]. These data and access to the remote access data laboratory are available to registered users of Australian Bureau of Statistics microdata. Data are available free of charge to participating universities in the Australian Bureau of Statistics/Universities Australia agreement. These data are available to other users on a fee for service basis.

The GSS included an initial sample of 18,574 private dwellings of which 16,145 dwellings were used due to issues of scope or uninhabited dwellings. In total, 80% fully responded, yielding a sample of 12,932 people aged 15 years and over. From this sample, we only included respondents aged 50 years and over, yielding a final sample size of 6,012 respondents.

Using a face-to-face interview along with prompt cards, the Australian Bureau of Statistics collected information on a range of disabilities, long-term health conditions and financial wellbeing. Firstly, the GSS included a number of measures of the current level of household income, assets and consumer debts. The measure of household income available in these data is gross household income, adjusted or 'equivalised' using an equivalence scale to account for household size. The Australian Bureau of Statistics makes this adjustment in household income to allow for welfare and financial wellbeing comparisons between households of different sizes and compositions. The measure of consumer debts included debt accrued credit or store cards not paid off by the due date, car and personal loans, interest free purchases, hire purchase agreements and other forms of consumer debt. It is recorded as an ordinal variable in the GSS, ranging from $0 to over $50,000. Assets included holdings of over $1,000 in cash or deposited funds, own incorporated business, shares, stocks and bonds or investment properties. It is recorded as an ordinal variable in the GSS CURF, ranging from $0 to $100,000 or more.

The GSS also included a number of detailed items measuring cash flow problems and dissaving behaviors. Cash flow problems recorded in the GSS included difficulties paying (i) electricity, gas or telephone bills (ii) mortgage or rent payments, (iii) car registration or insurance, (iv) minimum credit card payments. It also included selling

belongings to pay for bills, going without meals, being unable to heat their home, and seeking financial support from friends, family or from welfare and community organisations.

In addition to cash flow problems, the GSS also recorded a number of measures of dissaving behaviors. They included, drawing down on assets or taking out liabilities to meet current living costs. Among the asset dissaving measures were drawing on accumulated savings or term deposits, selling household goods or jewelry, and selling shares, stocks or bonds or other assets. The liability dissaving measures included reducing home loan repayments, increasing the balance on credit cards by $1,000 or more, entering into a loan agreement with family or friends or taking out a personal loan. The GSS questionnaire was administered in a way to ensure that these measures were undertaken specifically to meet day-to-day living expenses.

A further measure of financial stress included in the GSS was financial exclusion. Respondents were asked whether in the previous 12 months they had been denied an application for financial products or services including savings/bank accounts, credit or store cards, home loans, hire purchase, insurance policies or 'other' loans.

Finally, the GSS also included a number of measures of financial resilience and planning. The first measure was whether households had taken any of the following actions in the previous 12 months: followed a budget, saved regularly, paid above the minimum payment on loans, paid more than the minimum on home loan repayments, made voluntary contributions to superannuation, or sought financial information or counselling from a professional. A further question sought to illicit the households' financial ability to deal with emergencies where respondents were asked whether they would be able to raise $2,000 within a week for 'something important'.

To model the association between health conditions and financial wellbeing, we utilised Stata via the Australian Bureau of Statistics Remote Access Data Laboratory. For ordinal variables (equivalent household income, assets and debt) we specified ordinal logistic regression models to measure the association between multiple disabilities and health conditions and measures of financial wellbeing. For binary

variables, we utilised logistic regression models. A range of control variables were included in these analyses, including labour force status, country of birth, education level, age, marital status and sex. Household income was also included in the non-income models.

To avoid duplication and to provide concise readable results, we present unadjusted odds ratios (not adjusted for control variables) and adjusted odds ratios (adjusted for control variables). Both were included to show the impact of demographic and economic factors on the financial wellbeing of older Australians with comorbidities. For example, with increasing age, comorbidities are more likely, and therefore need to be controlled in the analysis to avoid spurious statistical associations. Similarly, with increasing age, rates of labour force participation decreases, thereby increasing the likelihood of experiencing cash flow difficulties. The adjusted odds ratios control for the impact of these potentially confounding effects. The unadjusted odds ratios show the association of health conditions with financial wellbeing with no controls for these confoundingfactors.

Results

Current Income, Non-Housing Assets and Consumer Debt

Table 1 displays three measures of the current financial situation of older people classified by the number of disabilities, number of long-term health conditions and specific disabling conditions. As noted earlier, the measure of income available in the GSS was household gross weekly income adjusted using an equivalence scale (to adjust for differential household size) and placed in deciles to protect respondents' anonymity. Regardless of the measure used, older people with multiple health conditions had significantly lower levels of current income. For example, almost half of those with 4 or more disabling health conditions (45.7%) were in the lowest 20% of income earners, compared with 17.6% of respondents with no disability. This finding was inverse for the top 20% of income earners. About 16% of older people in this sample were in the top 20% income earners in Australia, compared with around 3% of those with 3 or 4 disabling health conditions. This result was broadly replicated for total long-term conditions and also for specific disabling conditions. For example, about half of those with a head injury, stroke or brain damage and those with an intellectual disability were in the bottom 20% of the income distribution relative to 17% of respondents with no disability.

Given the significantly lower levels of current household income, we would expect asset holdings, which do not include the primary residence, to be lower for those with multiple disabilities and health conditions. Results in Table 1 strongly support this hypothesis. Between 30% and 40% of respondents with 3 or more disabilities do not hold any assets in the asset classes measured in the GSS, compared to just 15% of people with no disabling condition. When older people with multiple disabilities or health conditions do hold assets, they are of lower value compared to assets held by people with no disability. E.g., about 40% of respondents with no disability had assets valued above $100,000, compared to 15.6% of those with 4 or more disabilities. Again, the results were replicated for the number of health conditions. Of specific disabling types, those with an intellectual, psychological or head injury condition were significantly less likely to own any assets at all.

Given lower levels of household income and lower levels of assets, do older Australians with multiple disabilities have a lower propensity to hold consumer debt? Results in Table 1 indicate the propensity to hold consumer debt is relatively similar throughout this sample by the number of long-term health conditions and long-term disabilities, ranging from about a 75% to 81% chance of not holding any debt. Those with multiple conditions were slightly more likely to hold lower levels of consumer debt, between $0 and $5,000.

[TABLE 1]

These descriptive results combined, show a significantly lower level of financial wellbeing amongst those with disabilities, and particularly those with multiple health conditions. However, could these results simply be due to the age/sex differential rates of differing health conditions, or differing levels of labour force participation, as discussed earlier? Results in Table 2 present odds ratios from ordinal logistic regression models, which control for the impact of differential labour force status, region of residence, education, age, sex, marital status and in the asset and debt models, household income. Even with these extensive controls, respondents with disabilities and long-term health conditions had lower levels of income and lower levels of assets. Importantly, once economic and demographic controls were included,

those with disabilities had similar or higher levels of consumer debt when compared to those with no disability. For example, once controls were included, those with 3, 4 or more disabilities were between 1.7 to 1.9 times more likely to hold consumer debt than people with no disability (OR = 1.7 $p<0.01$ and OR = 1.9 $p<0.01$).

[TABLE 2]

Of the specific disabling conditions, those with psychological and physical conditions were in a particularly deleterious position: with lower income, lower assets and a higher propensity to hold higher levels of consumer debt, once controls were included.

Cash Flow Problems and Dissaving Behaviours

These objective measures of financial wellbeing would indicate that older Australians with multiple health conditions and disabilities were at a heightened level of financial precariousness. Results in Table 3 display the prevalence and modelled odds ratios of the propensity to experience cash flow problems, employ dissaving strategies to meet the cost of day-to-day living expenses and the experience of being financially excluded. Across all measures, those with multiple and specific health condition types were more likely to experience cash flow problems, engage in dissaving strategies or be excluded by a financial provider. For example, about 30% of people with 4 or more disabilities experienced a cash flow problem in the last 12 months, compared with 8% of respondents with no disability. About one quarter of people with 3 or 4 or more disabilities dissaved, compared with about 14% of respondents with no or 1 disability. Although the proportions are small, about 8% of people with 4 or more disabilities had been excluded by a financial provider in the last 12 months compared with only 2% of those with no disability. Importantly, these differences remain highly statistically significant once controls for economic and demographic characteristics were included. For example, respondents with 4 or more disabilities or 4 or more long-term health conditions were between 3.9 and 7 times more likely to suffer a cash flow problem when compared to people with no health condition (OR = 3.9 $p<0.01$ and OR = 7 $p<0.01$).

Respondents with a psychological disability were again highlighted in these data. Older Australians with this disability type were between 2 to 3 times more likely to suffer a cash flow problem (OR =2.2 $p<0.01$), to dissave to meet day-to-day living expenses (OR = 1.8 $p<0.01$) and to be excluded by a financial provider (OR = 2.8 $p<0.01$) when compared to people with no psychological disability. This pattern was also reflected for people with a physical disability, but the effects were weaker.

[TABLE 3]

Financial Resilience Measures

Given the lower income, lower asset holdings and higher likelihood of experiencing cash flow problems, dissaving behaviours and financial exclusions, do people with multiple health conditions have an ability to fund emergency events, such as an increase in the severity of their health condition, should they occur? Results in Table 4 indicate with increasing numbers of disabilities and health conditions, the ability to gain emergency funds declines significantly. For example, about 93% of respondents with no disability can access emergency funds, compared with 70% of people with 4 or more disabilities. When controls were included, respondents with 3 or 4 disabilities were about 60% less likely (OR = 0.4 $p<0.01$) to have access to emergency funds relative to people with no disability.

[TABLE 4]

Once more, respondents with psychological or physical disabilities were highlighted as experiencing financial difficulties. With controls included, older Australians with these condition types were between 30% and 50% less likely to have access to emergency funds (OR = 0.7 $p<0.01$ physical; OR = 0.5 $p<0.01$ psychological). This is particularly important as having a psychological disorder often negatively effects labour force attachment over the life course [14], which in turn effects income and the ability to afford out-of-pocket healthcare expenses.

Interestingly, the descriptive results showed no difference in the prevalence of financial resilience strategies by numbers of disabilities or health conditions. Between 73% and 78% of respondents had engaged in some kind of financial resilient behaviour such as setting a budget or seeking financial advice. However, when we

control for the available financial resources and background demographic factors, those with multiple health conditions were more likely to engage in such behaviours. Respondents with 4 or more long-term health conditions were about 1.6 times more likely to engage in financially resilient behaviours relative to people with no health condition (OR = 1.6 $p<0.01$).

Discussion

Privately met out-of-pocket expenses for primary healthcare has increased by 76% in Australia over recent years, rising from $9.7 billion in 2001–02 to $17.1 billion in 2011–12 [15]. A number of studies have documented the increasing out-of-pocket healthcare costs borne by Australians living with multiple health conditions. Some people with multiple health conditions are at risk of financial stress and are consequently skipping health treatment such as not consulting a General Practitioner or avoiding filling prescriptions because of cost constraints [16,6,8,17]. Motivated by these findings and the obvious concern this creates for clinicians, we set out to map the financial situation of older Australians with multiple disabilities, multiple health conditions and specific disability types. Using nationally representative data from the Australian Bureau of Statistics, we found that respondents with multiple disabilities, multiple health conditions and people with some specific disabilities are at heightened levels of financial precariousness due to higher risks of cash flow difficulties and being excluded from financial providers. We also showed an association between increasing disabilities and health conditions with increased consumer debt and a reduction in the ability to access emergency funds.

On a population health level, it is well established that rates of multiple health conditions are increasing in most developed countries, and are experienced more commonly by the cohort considered in this study [18]. With increasing multiple morbidities, resource utilisation also increases with longer hospital stays, higher hospital costs, greater financial risk, more procedures per patient and a higher mortality compared to patients with fewer health conditions [19]. This results in greater healthcare expenses – either public or privately funded. At the same time, those with multiple health conditions are more likely to experience treatment conflicts

and polypharmacy including high complex medication regimes. In Australia, almost 88% of people aged 65 years and over are prescribed at least one medication with 43–55% of older Australians being prescribed 4 or more regular medications [20,21]. Increasing rates of concurrent medications leads to a significantly higher risk of adverse drug effects [21]. This, in turn, leads to an increased reliance on the healthcare system, leading to more out-of-pocket expenses. Even with the assistance of Medicare and the Pharmaceutical Benefits Scheme, out-of-pocket healthcare expenses are accumulative and costly (relative to income) for Australians living with multiple health conditions.

However, the poor financial wellbeing of those with multiple conditions is not due to a lack of attempting to improve their financial situation. Older Australians with multiple health conditions are on average, as likely to engage in financial resilient behaviours, such as setting and maintaining a budget, as the broader community. Indeed, when controls for economic and demographic factors are included, older people with multiple health conditions are slightly more likely to engage in these behaviours. The ability for these older Australians to improve their financial position through labour force re-engagement, however, is severely limited because of their chronic health conditions [22].

One key solution is the prevention of long-term health conditions in the first place, enabling continued labour force participation [23]. Indeed, recent research shows that over the last 15 years, the labour force participation of mature age Australians has increased considerably [24]. Nonetheless, there are many disabling conditions, such as acquired brain injury, that are not amenable to prevention or cure. Many older Australians with non-reversible and non-preventable disabilities have a higher propensity to experience financial burden and are a high vulnerable group who are in greater need of support and intervention.

In interpreting these results, it is important to recognise the limitations within this study. Firstly, the data are cross sectional. We cannot and do not draw causal inferences about health conditions and financial distress, but rather show a clear

association between the two. Secondly, our measures of health conditions and financial wellbeing are self-reported and therefore subject to recall bias.

Noting these limitations, results from this study show the considerable financial stress many older Australians with multiple disabilities are facing. Even with the safety nets of Medicare and the Pharmaceutical Benefits Scheme, costs for medical services and prescription medicines can be significant (particularly given lower levels of income and assets) and were associated with substantial financial burden for people with multiple health conditions. The policy solutions to this problem are complex and costly. Indeed, the health cost constraints faced by older people with multiple conditions may be associated with the oftentimes, fragmented, inefficient, ineffective and uncoordinated care that some receive. Some commentators have recommended new policy responses such as alternate payment structures that include bundled payments, block payments and pooled funding to fund complex condition management, while preserving fee-for-service arrangements for episodic care [25]. This may provide greater opportunity to match resources to needs and reduce service duplication and waste. Other commentators suggest the effective management of multiple health conditions should be incorporated into The National Health Care Reform Agenda and articulated in the National Health Priorities [26]. There is also scope for a widening of the safety net for people with multiple health conditions and to introduce targeted programs for lower income earners with multiple health conditions [27]. The detailed policy responses to improve the financial wellbeing of older Australians with comorbidities and multiple disabilities is a critical area for future research.

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Table 1: Income, Assets and Consumer Debt by Degrees of Disability and Long-term Health Conditions.

		Equivalent Income (Quintiles)1							Assets ($) 2					Debt ($) 3				
		<20%	20-40%	40-60%	60-80%	80-100%	Missing	Total	0	<$9999	<$49999	<$100000	$100000+	0	<$5,000	<$9999	<$49999	$50000+
Total Disabilities																		
	0	17.6	16.8	15.7	13.2	16.1	20.7	100	15.6	19.7	17.4	8.8	38.3	77.8	8.8	4.6	7.3	1.6
	1	24.5	22.3	13.5	10.7	9.5	19.4	100	20.8	20	17.6	9.8	31.8	80.3	8.8	4	5.2	1.7
	2	30.5	24	12.4	8.6	7.3	17.2	100	24.5	21.4	19.1	8	27.1	80.4	9.2	3.2	5.8	1.3
	3	34.6	28.4	8.8	6.1	3.2	19	100	32.5	21.4	18.4	6.4	21.3	77.8	10.9	4.7	5.2	1.5
	4+	45.7	21.5	8.2	4.4	2.7	17.4	100	44.3	20.4	12.5	7.3	15.6	74.8	14.1	5.2	4.8	1
Total Long Term Health Conditions																		
	0	15.7	15.9	15.6	14.1	17.3	21.4	100	15.7	20.3	15.5	9	39.6	77.5	9.9	4.6	6.1	2
	1	22.1	20.4	14.3	12	12.3	18.9	100	17.4	19.1	19.6	7.9	36.1	80.3	8	3.9	6.7	1.1
	2	24.2	22.7	13.6	9.7	10.6	19.2	100	19.6	20.7	17.7	9.4	32.6	81	6	3.6	7.8	1.6
	3	27.5	23.4	12.5	8.7	8.6	19.3	100	24.1	21.5	18.2	8.6	27.5	79.1	9.6	3.8	5.8	1.7
	4	36.8	23.1	10.6	6.9	4.7	17.9	100	34.2	20.8	17.7	7.2	20.2	75.4	13.1	5.1	5.2	1.3
Disability Type																		
No Disability		17.6	16.8	15.7	13.2	16.1	20.7	100	15.6	19.7	17.4	8.8	38.3	77.8	8.8	4.6	7.3	1.6
Sight, hearing, speech		31.2	26.5	11.1	7.7	5.7	17.8	100	25.8	20.6	18.6	7.9	27	80.8	9.5	3.6	4.8	1.4
Physical		33.1	24.4	10.6	7.5	5.8	18.6	100	29.5	21.1	17.7	7.8	23.9	78.2	10.5	4.1	5.8	1.4
Intellectual		45.1	24.6	7.1	5.4	2.7	15.2	100	49.1	16.4	14.6	4.1	15.9	77.8	13.1	4.5	4.1	0.5
Psychological		41	23.3	10	5.8	2.8	17.1	100	43.4	22.8	13.3	6.5	13.9	69.8	15.2	6.9	6.5	1.6
Head injury/stroke/brain damage		45.9	17.7	6.5	4.7	4.7	20.6	100	39.5	19.8	9.6	9.6	21.6	81.8	8.8	3.5	5.3	0.6
Other Disability		33	24.4	11.1	7.6	5.7	18.2	100	29.2	21.5	18	7.4	23.9	78.6	10.6	4.2	5.4	1.3

Notes: 1 Household income adjusted by an equivalence scale and ordered into quintiles. 2 Assets include holdings of over $1,000 in cash or deposited funds, own incorporated business, shares, stocks and bonds or investment properties. 3 Consumer debts include debt accrued credit or store cards not paid off consumer debt by the due date, car and personal loans, interest free purchases, hire purchase agreements and other forms of debt.

Table 2: Odds Ratios Derived from Ordinal Logistic Regression Models of Income, Assets and Debt.

		Equivalent Income				Assets				Consumer Debt			
		Odds Ratio				Odds Ratio				Odds Ratio			
		Unadjusted		Adjusted		Unadjusted		Adjusted		Unadjusted		Adjusted	
Total Disabilities													
	0	1	-	1	-	1	-	1	-	1	-	1	-
	1	0.6	***	0.8	**	0.8	***	0.8	**	0.9	*	1.1	
	2	0.4	***	0.7	***	0.6	***	0.7	***	0.8	**	1.3	***
	3	0.3	***	0.6	***	0.4	***	0.6	***	1		1.7	***
	4+	0.2	***	0.5	***	0.3	***	0.5	***	1.1		1.9	***
Total Long Term Health Conditions													
	0	1	-	1	-	1	-	1	-	1	-	1	-
	1	0.6	***	0.9		0.9	*	1		0.9	*	1.1	
	2	0.5	***	0.8	***	0.8	***	0.9	**	0.8	*	1.2	*
	3	0.4	***	0.8	***	0.6	***	0.7	***	0.9		1.4	***
	4	0.3	***	0.6	***	0.4	***	0.6	***	1.1		1.8	***
Disability Type1													
Sight, hearing, speech		0.7	***	0.9		1		1		0.8	***	1.1	*
Physical		0.6	***	0.8	**	0.7	***	0.8	***	1		1.3	***
Intellectual		0.7	***	0.7	***	0.5	***	0.7	***	0.9		0.9	
Psychological		0.7	***	0.7	***	0.5	***	0.7	***	1.7	***	1.5	***
Head injury/stroke/brain damage		0.7	***	0.7	**	0.9		1		0.8		0.8	
Other Disability		0.8	**	1		0.8	***	0.9	*	1		1.1	

Notes: Unadjusted Odds ratio with no adjustments for control variables; OR Odds ratio adjusted for control variables including labour force status, country of birth, education level, age, marital status and sex. Asset and debt models also include controls for household income; ***p<0.01 **p<0.05 *p<0.1; - reference category for regressions; 1 reference category for each disability type is persons without each disability.

Table 3: Odds Ratios Derived from Logistic Regression Models of Cash Flow Problems, Dissaving Strategies and Financial Exclusions.

	Cash Flow Problems							Dissaving Strategies							Financial Exclusions						
	n	%		Odds Ratio				n	%		Odds Ratio				n	%		Odds Ratio			
				Unadjusted		Adjusted					Unadjusted		Adjusted					Unadjusted		Adjusted	
Total Disabilities																					
0	2944	8.2		1	-	1	-	2905	14.4		1	-	1	-	2333	2.1		1	-	1	-
1	829	9.1		1.1		1.26		811	14.9		1.1		1.2		649	3.4	*	1.7	**	1.9	**
2	1276	13.7	***	1.8	***	2.1	***	1268	20.7	***	1.6	***	1.9	***	999	3.3	*	1.6	**	1.9	***
3	691	17.8	***	2.4	***	2.7	***	688	23.8	***	1.9	***	2.2	***	542	4.6	***	2.3	***	2.6	***
4+	293	29.4	***	4.6	***	3.9	***	287	25.8	***	2.1	***	2.1	***	213	8	***	4.1	***	3.7	***
Total Long Term Health Conditions																					
0	1507	7.1		1	-	1	-	1491	12.1		1	-	1	-	1206	2.6		1	-	1	-
1	1424	8		1.1		1.3	**	1398	14.8	**	1.3	**	1.4	***	1127	2.2		0.9		1	
2	1103	10.3	***	1.5	***	1.9	***	1090	16.4	***	1.4	***	1.7	***	864	2.9		1.1		1.4	
3	768	11.7	***	1.7	***	2	***	759	20.7	***	1.9	***	2.3	***	598	3		1.2		1.4	
4	1231	22.4	***	3.8	***	7	***	1221	25.8	***	2.5	***	2.9	***	941	4.9	***	1.9	***	2	***
Disability Type1																					
Sight, hearing, speech				0.9		1.3	**				0.9		1.1					0.9		1.1	
Physical				1.4	***	1.4	***				1.1		1.2	**				1.6	***	1.7	**
Intellectual				1.4	*	1.1					0.9		0.8					1		0.8	
Psychological				3.5	***	2.2	***				2.4	***	1.8	***				3.9	***	2.8	***
Head injury/stroke/brain damage				1.4	*	1.1					1		0.9					1.5		1.2	
Other Disability				1.2		1.3	*				1.4	***	1.4	***				0.9		0.9	

Notes: n cell count; % percentage reporting in the affirmative; Unadjusted Odds ratio with no adjustments for control variables; OR Odds ratio adjusted for control variables including labour force status, country of birth, education level, age, marital status, sex and household income. - reference category for regressions; 1 reference category for each disability type is persons without each disability. ***p<0.01 **p<0.05 *p<0.1

Table 4: Odds Ratios Derived from Logistic Regression Models of Financial Resilience and Availability of Emergency Money

	Financial Resilience					Emergency Money				
		Odds Ratio					Odds Ratio			
	%		Unadjusted		Adjusted	%		Unadjusted		Adjusted	
Total Disabilities											
0	78.5		1	-	1	-	92.7	-	1	-	1	-
1	78.9		1		1.3	***	91.1		0.8		0.9	
2	77.4		0.9		1.3	***	86	***	0.5	***	0.6	***
3	73.2	***	0.7	***	1.2		79.1	***	0.3	***	0.4	***
4+	75.5		0.8		1.5	**	69.3	***	0.2	***	0.4	***
Total Long Term Health Conditions												
0	77.7		1	-	1	-	93.4	-	1	-	1	-
1	78		1		1.2	**	91.6	*	0.8	*	0.8	
2	78		1		1.3	***	89.5	***	0.6	***	0.7	***
3	75.8		0.9		1.3	**	88.3	***	0.5	***	0.6	**
4	77.7		1		1.6	***	77.4	***	0.2	***	0.4	***
Disability Type1												
Sight, hearing, speech			0.8	**	1				1		0.9	
Physical			0.9	*	1				0.5	***	0.7	***
Intellectual			0.7	**	0.8				0.6	***	0.8	
Psychological			1		1				0.3	***	0.5	***
Head injury/stroke/brain damage			0.8		0.9				0.8		1.1	

Other Disability	1.2	**	1.3	***	0.9	0.9	

Notes: n cell count; % percentage reporting in the affirmative; Unadjusted Odds ratio with no adjustments for control variables; OR Odds ratio adjusted for control variables including labour force status, country of birth, education level, age, marital status, sex and household income. - reference category for regressions; 1 reference category for each disability type is persons without each disability; ***p<0.01 **p<0.05 *p<0.1

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