Health, Financial Well-being, and Financial Practices of Financially Distressed Consumers

This study examined relationships among the financial practices, financial well-being, and health of a sample of 3,121 financially distressed consumers who were new clients participating in the debt management program of a large national non-profit credit counseling organization. Respondents who reported having improved their health since participating in credit counseling were more likely than others to engage in positive financial behaviors. In addition, self-reported improved health was somewhat associated with self-reported improved finances. For six out of ten financial behaviors, respondents who reported improved health were more likely to report that their finances improved.

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This abstract describes a study of relationships among the health, financial well-being, and financial practices of a sample of financially distressed consumers who contacted a national non-profit credit counseling organization seeking assistance with heavy outstanding debt. Evidence exists that there are many parallels between personal behaviors that affect good health and foster financial success (Hollerith, 2004; O'Neill, 2004). Good health is a major factor in wealth creation because it is associated with increased workplace productivity, fewer wealth-eroding medical expenses, and longer life expectancies in which to earn compound interest on invested assets and collect Social Security and other retirement benefits (Lee & McKenzie, 1999).

Unfortunately, one in seven American families has problems paying health-care costs, which can lead to "juggling" of medical expenses with basic living costs and negative patient behaviors such as delaying necessary medical treatment and forgoing the use of prescription drugs (Kissel, 2004). Not surprisingly, unpaid medical bills are associated with a high number of personal bankruptcies. (Himmelstein, Warren, Thorne, & Woolhandler, 2005). When unexpected medical bills arrive, the collective impact of unexpected medical expenses, interruption of income, and/or consumer debt can trigger financial distress (Sullivan, Warren, & Westbrook, 2000). High household medical debt may also preclude recommended wealth creation strategies, such contributing to a 401(k) plan or Roth IRA, resulting in forgone savings opportunities (Kim, 2004).

For the most part, efforts to improve Americans' health and finances have operated on two separate, but parallel, tracks with separate literature and advocacy efforts. Often, health educators do not talk much about finances and financial educators do not concern themselves much with health care costs (Vitt, Siegenthaler, Siegenthaler, Lyter, & Kent, 2002). This study of relationships between financial practices, financial well-being, and health is an attempt to bridge this gap and look at these factors in combination with one another rather than in isolation.

The population for this study was a group of financially distressed consumers who telephoned a large national non-profit credit counseling organization, seeking assistance with outstanding debt and subsequently joined its debt management program (DMP). In mid-June 2003, a 32-item *Personal Finances Survey* questionnaire was mailed to a sample of 7,200 people who joined the program between February and April 2003. A total of 443 surveys were returned as undeliverable, typically because an address was incomplete, a person moved without providing a forwarding address, or the person was deceased. Thus, 6,757 questionnaires were mailed and 3,121 respondents returned useable questionnaires, a response rate of 46 percent (3,121/6,757).

Males comprised 29% of the clients and 71% were female. Approximately six in ten (63%) were either married (53%) or living with a partner (10%), and 37% were unmarried. Median annual family income was between $30,001 and $40,000. Four out of five (81%) were employed, with 69% working full-time, and 62% were age 45 or younger. Half (51%) reported moderate financial stress with 23% and 12% reporting severe and overwhelming financial stress, respectively.

Variables for this study included the following: financial behaviors, improved health, improved finances, perceived effect of financial problems on health, perceived health status, negative financial events, financial stress, financial satisfaction, family relationships, and work life. Ten hypotheses were developed indicating a positive relationship between health status and finances, work, and family relationships. Bivariate Chi-square tests were used as a measure of association between various categorical variables such as perceived health status ("Overall, would you say your health is…") and improved health status ("Since you joined [name of program] has your health improved?"), and indicators of financial status. For several variables measured in Likert scale, ANOVA was used to test if there were differences among four health

categories in terms of the scores of these variables. A 5% significance level was established to report the findings for both the Chi-square and ANOVA tests.

Respondents who reported having improved health since participating in the credit counseling program were more likely to engage in nine positive financial behaviors such as "cut down on living expenses" and "started or increased my savings. These findings provide support for a positive association between health status and recommended financial behaviors. Respondents who reported having improved health since joining credit counseling were more likely to report their overall personal finances had also improved. Thus, support for a positive association between self-reported improved health and improved personal finances was found.

In six out of the ten specific areas of financial improvement listed in the survey, respondents who reported having improved health were more likely to report their finances were improved. Respondents who reported poorer health were more likely to perceive their health is affected by financial problems than those in very good health. Similarly, a higher percentage of respondents who said their health was not affected by their finances reported they were in very good health vs. poor health. At higher levels of health status, there was an increase in the frequency of the perception that personal finances did not affect health.

The study explored the association between the perceived effect of personal finances upon health and 12 specific negative financial events (e.g., "took a cash advance on a credit card" and "bounced a check."). Respondents who experienced a negative financial event were more likely than those who did not to report that financial problems affected their health. This was true for all 12 specific financial events listed on the survey. These results lend support to a positive association of perceived effect of financial problems on health and negative financial events.

Self-reported health status, ranging from poor to very good, was positively associated with self-reported financial stress levels, which ranged from 1= none to 5= overwhelming with reverse-coding. Health status was also positively associated with perceived financial behavior, financial satisfaction, family relationships, and work life. Respondents perceiving poor and satisfactory health reported lower than average scores for these variables while those who perceived having good or very good health reported higher than average scores for these variables. These findings provide some evidence to support positive associations between health status and respondents' characterization of their financial behaviors, financial satisfaction, family relationships, and work life.

This study provides some evidence of positive associations between self-reported health status and health status improvements with indicators of financial well-being and positive financial behaviors. In addition, there was a positive association between perceived health status and level of financial stress. Respondents in poor health had the highest financial stress level and those in very good health the lowest level of financial stress. Since this study uses cross-sectional data, only associations, rather than causation, can be explored. Nevertheless, they present a case for integrating health and financial issues in financial counseling and education interventions and for continued research of health and personal finance linkages.

This study found positive associations between various aspects of heath and finances. Intuitively, it makes sense that poor health and financial distress are related. Without money, for example, it is difficult to eat right and afford adequate healthcare services, which can lead to new health problems and additional medical debt, a perfect "Catch-22." Poor finances are one of many life events that can cause people to experience the physical effects of stress that are associated with many health problems. Results from this study add to the growing body of literature that establishes relationships among financial stressor events, financial well-being, and health. They also make the case for possible health benefits, as well as financial benefits, associated with credit counseling debt management programs.

Employers have an important role to play in helping Americans improve their health and finances by offering targeted programs and incentives. Employers also stand to benefit tremendously from workers' improved financial well-being. Not only are there potential productivity benefits (Garman, Leech, & Grable, 1996) but it is also likely that health care costs associated with stress would be reduced, perhaps resulting in lower health care cost increases for employer-provided health plans. The relationship between poor health and serious financial distress suggests provocative clues that should be further investigated, particularly by the health care industry, employers, governments, and others involved in paying medical care costs.

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