Self-reported health as a cultural health determinant in Arab and Jewish Israelis
MABAT—National Health and Nutrition Survey 1999–2001

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Abstract

Subjective health (SH) status serves as a measure of health in many studies of health-related issues as it is a good predictor of mortality, morbidity, and use of health services. The measure is used in many population groups. However, the degree to which it measures the same condition in different ethnic groups is not clear.

Within Israel's first National Health and Nutrition Survey (MABAT) conducted during 1999–2001, face-to-face interviews were held with 3222 Israeli interviewees, 2379 Jews and 843 Arabs, aged between 25–64 years. Respondents reported their SH, co-morbidity, and other socioeconomic characteristics.

Arabs reported higher levels of SH than Jews. In logistic regression analysis, co-morbidity was a much stronger correlate of poorer SH in the Arab than in the Jewish population. The association between socioeconomic variables depended on ethnic group and sex.

The findings indicate that SH in Jews and Arabs does not necessarily have the same meaning in relation to objective measures of health, and caution should be exercised in the use of this measure in different population groups with different cultures. Arabs tend to evaluate health better than Jews even though life expectancy is lower and morbidity and mortality are higher in the former population group. Yet diagnosis of a disease increases the frequency of reporting lower SH, more in Arabs than in Jews.
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Introduction

Subjective health (SH) is commonly used in epidemiological studies and in health-related questionnaires as a proxy measure of health and as a measure of self-evaluation of health. The term can be defined as

the individual's personal evaluation of his/her overall health. SH represents an overall summary of different aspects of one's health. It differs from other health measures in that the individual is asked to integrate all dimensions of health without specific reference to its different components, such as physical, mental, social or functional health, and without being prompted in one direction or another (Tissue, 1972; Brook et al., 1979; Liang, 1986; Jylha, 1994).

The process by which respondents construct their judgment is affected by the different dimensions of health and is processed in various ways depending on the individual's characteristics and his/her health (Krause & Jay, 1994; Borawski, Kinney, & Kahana, 1996; Manderbacka, 1998; Benyamini & Idler, 1999; Benyamini, Leventhal, & Leventhal, 2003; Tessler & Mechanic, 1978; Feinberg, Loftus, & Tanur, 1985). Personal characteristics may include age (SH decreases with age), socioeconomic factors such as income, occupation and education, where lower status corresponds to lower SH (Baron-Epel & Kaplan, 2001b; Borg & Kristensen, 2000). Social factors such as marital status influence SH too, for example, unmarried men have lower levels of SH (Bobak, Pikhart, Hertzman, Rose, & Marmot, 1998). Culture, values and beliefs may also play a role in the evaluation of SH (Wiseman, 1999). Knowledge, information, and perceptions of the individual has about many factors, such as physical illness or diseases, mental health, general feeling, pain, disabilities, tiredness, medications, medical treatments, social factors, health behaviors, and others, may play a role in the self-evaluation of health.

Generally, there seem to be three different issues influencing the evaluation of SH: the objective measures of health, the cultural surrounding in which the individual lives, and the comparisons the individual makes to judge SH.

Research interests in SH have grown considerably since follow-up studies found that SH predicts a number of future health outcomes. This contributed to the validity of the measure as representing health in general. The most important outcome is survival or mortality, and much research in the last few decades has been directed that way. Idler and Benyamini (1997) reviewed 27 studies looking at the predictive value of mortality by SH, and concluded that SH is an independent predictor of mortality after adjusting for various measures associated with survival. These studies were performed in many countries, mainly in the developed world. SH was found to predict survival in an older Jewish population in Israel too (Baron-Epel, Shemy, & Carmel, 2004). However, no information regarding the Arab population in Israel is available. SH has been found to predict other health-related variables less dramatically than mortality. In follow-up studies, poor SH predicted functional limitations, disability, receiving disability

pension, morbidity, hip fracture, recovery from illness, future physician rating of health, and institutionalization in the elderly (Kaplan, Strawbridge, Camacho, & Cohen, 1993; Idler & Kasl, 1995; Idler, Russell, & Davis, 2000; Guttman, Strark, Donald, & Beattie, 2001; Mansson & Merlo, 2001; Shadbolt, 1997; Ferraro, Farmer, & Wybraniec, 1997). SH was also a predictor of long-term use of health services, including visiting a general practitioner and community nurse, home help support, hospitalization, and increased medication use (Idler & Benyamini, 1997; Bath, 1999; Angel & Gronfein, 1988; Idler, 1993; Miilunpalo, Vuori, Oja, Pasanen & Urponen, 1997).

In follow-up studies, poor SH predicted high levels of distress (low mental health); together with the fact that distress adds to low SH, these findings point to a downward spiral reaction. Distress itself may cause poor SH, which over time leads to still poorer SH (Farmer & Ferraro, 1997).

This line of research led to the assumption that SH can serve as a useful tool for identifying individuals at risk for subsequent health problems that may be preventable. However, this should be taken in the context of the community's culture. Wiseman (1999) reported that while Aboriginal Australians suffer a clear health disadvantage relative to their non-indigenous counterparts, a similar proportion of indigenous and non-indigenous Australians reported fair or poor health. Therefore, SH may not provide an accurate picture of the level of morbidity and mortality in certain populations. Appels, Bosma, Grabauskas, Gostautas, and Sturmans (1996) compared Dutch and Lithuanian men and found that Dutch men reported higher levels of SH. In both cohorts, SH was associated with mortality; however, there was no discussion to the reasons for the differences in levels of SH in the two population.

In Israel, two distinct ethnic groups dwell, each with its own culture, language, and religion. The two ethnic groups have different levels of health knowledge and attitudes. They mostly live in separate communities. Most of the research on the measure of SH has been performed on the Jewish population (Baron-Epel & Kaplan, 2001a; Kaplan & Baron-Epel, 2003; Baron-Epel et al., 2004; Carmel, Lapidot, Mutran, & Shemy, 1996; Carmel, 2001). However, this measure is used also in studies of the minority Arab population, but its validity in that community is not clear.

Objective measures of health available in Israel present a picture of poorer health in the Arab population and also lower socioeconomic levels (Israel Center for Disease Control, 2004). Therefore, we expected to find lower levels of SH in the Arab population group compared to the Jewish population.

The aim of the study was to identify differences between Arabs and Jews regarding their subjective