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Original Research

Factors associated with self-rated health status in Southwestern Iran: a population-based study



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ABSTRACT

Objective: This study aimed to reveal the relationship between self-rated health (SRH) and objective health status in the general population in the Southwest of Iran.

Study design: A cross-sectional study.

Methods: Data were collected by face-to-face interview with 3554 residents, aged ≥ 18 years, who were selected by multistage sampling procedure. Collected data included sociodemographic, SRH status, and medical conditions; chronic diseases and mental symptoms. SRH was indicated by a single question in five scales of very good, good, fair, poor and very poor. An ordinal logistic regression analysis was used. Independent variables were organized into four blocks: block 1, age, gender, marital status, education level, employment status, size of household and monthly household income; block 2, chronic or long-term illness (coronary heart disease, hypertension and diabetes mellitus); block 3, psychological disorders (anxiety, impatience and sleep disorders); and block 4 (visual, skin, hearing and oral disorders).

Results: SRH status in most subjects reported to be positive, indicating 47.3% as very good, 30.8% good, 16.2% fair, 3.3% bad and 2.4% very bad. In studied subjects, poorer SRH was significantly related to older age (odds ratio [OR], 1.01), low-education level (OR, 1.09), single status (OR, 1.25), monthly household income (OR, 1.21), more chronic or long-term illness (OR, 1.61), greater psychological health disorders (OR, 1.69), more dermatologic disorders (OR, 1.30), and hearing problems (OR, 1.47).

Conclusion: Results of this study revealed that subjects with worse SRH were older with low-education level, lower household monthly income, more chronic illness, greater psychological health disorders, and more visual, skin, hearing and oral disorders. So, SRH, as indicated globally, can be used as a population screening tool to identify subjects who are most in need of public health services.

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Introduction

In 1948, a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, which has not been amended since, was approved as health definition by the World Health Organization.¹ In the public health research and practice, self-rated health (SRH) due to its simplicity to study, is among the most widely used measures of subjective health status and a strong predictive power for mortality.² Also, as an indicator of service need and intervention outcomes, SRH has been recognized as an appropriate and valid measurement.^{3,4} Furthermore, World Health Organization, European Union Commission and the Centers for Disease Control and Prevention suggested that SRH is a valid and reliable means of assessing and monitoring the health and quality of life of the population.^{5–7}

In previous studies, SRH was commonly used to compare health statuses between population groups. These studies showed that health-related risk factors such as strained lifestyle and work pressure, poor-mental status, were all associated with poorer SRH.⁸ A meta-analysis shows a higher mortality risk in persons with poor SRH than those with excellent SRH.⁷ Studies have also shown that SRH is a significant predictor of chronic conditions such as coronary heart disease, diabetes, stroke, lung disease, and arthritis in late midlife adults,⁹ but recent evidence has suggested that the strength of this association might vary across countries.¹⁰

Among Iranian population, an increase in life expectancy at all ages and a decrease in mortality rates was observed over the past decades. Also, currently, with the decrease in the prevalence and incidence of communicable diseases, the primary focus of medical care on infectious diseases has shifted to chronic non-communicable diseases.¹¹ Therefore, finding the details of the effect of health behaviours and chronic health conditions on health status can play a major role in developing tailored health promotion efforts.

In Iran, researches on the relationship between health factors and SRH status are limited and only a few studies have investigated this relationship between some partial factors in some special population. In a study on adolescents, physical health and high-risk behaviour were reported to be among the factors which significantly affected SRH.¹² One study indicated that poor-educational level was associated with poor SRH status.¹³ Another study reported significant association between age, marital status, level of education and household economic status with SRH in adult population.¹⁴ The study of Heshmat et al.¹⁵ also showed that in adolescents SRH was not related to BMI but had negative association with body weight perception.

The purpose of our study was to describe the health characteristics in relation to SRH status in a sample of Southwestern Iranian residents and also to explore the association between social and health-related factors and SRH.

Methods

This cross-sectional survey was done on a randomly selected sample from the general population of Shiraz, the capital city of Fars Province, Southwest of Iran.

Individuals, aged 18 years or above who had lived in Shiraz at least 6 months before the interview, were recruited from October 2014 to February 2015. Interviewees were selected randomly and proportionate to statistics released by Statistical Center of Iran on the distribution of Shiraz inhabitants' age, gender and the municipality district they lived.

Data collection was completed using face-to-face structured interviews undertaken by trained questioners and recorded in the checklists manually. The data collected included demographic variables (age, marital status, educational level, current job, and monthly household income), SRH status, medically diagnosed diseases, mental symptoms and chronic conditions.

In this study, SRH was the dependent variable and was indicated by the question 'In general, how would you rate your health?' using the Likert-scale of very good, good, fair, poor and very poor. To assess the clear differentiation among neutral, positive and negative responses, we combined the responses of very good and good into one category of 'good SRH status' and combined the responses of poor and very poor into a second category of 'poor SRH status'.

Independent variables for analysis in this study were demographic variables and medically diagnosed diseases which was measured using the question: 'Did a doctor ever tell you that you had ...?'. These ailments included: chronic or long-term illnesses (coronary heart disease, hypertension, diabetes mellitus, hyperlipidaemia, arthritis, migraine and anaemia); psychological health disorders (anxiety, impatience lack of motivation or enthusiasm, anhedonia and sleep disorders); and visual, skin, hearing and oral disorders.

All data were analysed using Stata version 11.0 (Stata Corp, College Station, TX, USA). Also, PASS version 11 was used for determining power of the variables shown in [Tables 2 and 3](#). Descriptive data were presented as mean \pm standard deviation, or number (percent) as appropriate. In the first step, tables of frequencies stratified by SRH status were used to analyse the collected data between subjects with good SRH or poor SRH status. Then, multivariate ordinal logistic regression analysis was done. We used four models in our analyses; first model included age, gender, marital status, education level, employment status, size of household and monthly household income. The second model comprised self-reported measures in the presence of chronic or long-term illness, each as a binary variable, including medical diagnosis for coronary heart disease, hypertension and diabetes mellitus. The third model presented psychological health disorders including self-reported measures of anxiety, impatience, and sleep disorders. Finally, the fourth model constituted visual, skin, hearing and oral disorders, as a binary variable, which assessed the association between good and poor SRH. Also, adjusted age was used in all models.

Results

Out of 3745, 3554 accepted to participate in our study, whereas the analyses conducted on 3523 responses. So, the response

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