DETERMINANTS OF POOR SELF-RATED HEALTH IN RECENTLY DIAGNOSED RHEUMATOID ARTHRITIS PATIENTS

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BACKGROUND
Self-rated health is a strong predictor variable for a number of important health outcomes such as mortality, morbidity or utilisation of healthcare services [1 – 3]. In spite of that, there still remain questions concerning the mechanisms underlying the process of evaluation of health. The aim of this study was to shed more light on possible determinants of this powerful construct.

METHODS
Sample
150 patients with early rheumatoid arthritis (disease duration ≤ 4 years) 64.4% female
mean age 48.7±12 years
mean disease duration 22.2±15.9 months

Statistics
Multiple regression analyses
Dependent variable: self-rated health
Independent variables:
sociodemographic, medical and psychological

Variables / Measures
Socio-demographic: age, gender, education
Clinical variables: ESR – erythrocyte sedimentation rate, CRP – C-reactive protein, disease duration
Pain: NHP – Nottingham Health Profile, RAI – Ritchie Articular Index
Disability: GARS – Groningen Activity Restriction Scale
Psychological well-being: GHQ-28 – General Health Questionnaire-28
Adjustment to disease: GARA – General Adjustment to disease
Self-rated health: OEH – Overall Evaluation of Health (100mm VAS)

RESULTS
The first regression model consisting of basic socio-demographic variables (older age, female gender, lower education) explained 19% of the variance of poor self-rated health. In the next steps, entering relevant clinical variables (higher erythrocyte sedimentation rate and C-reactive protein as well as longer disease duration) explained additional 5%, more pain 4%, more disability 4%, and worse adjustment to disease another 6%. The total explained variance after entering all variables into the equation was 51% (adjusted).

In the final model only age (-0.33), education (-0.31), pain as measured by the RAI (-0.34) and adjustment to disease (-0.33) remained significant (all p<0.01).

CONCLUSION
The outcomes provide support for the hypothesised relationships between the variables under the study, even though the non-significant association of psychological distress is to a certain extent surprising. The findings also reveal interesting implications for adjustment to disease (viewed as a result of a coping process) as being one of the most important determinants of self-rated health.

References

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Objective
To evaluate in a life course approach the role of depressive symptoms on being involved in physical fighting at 17 years old.

Methods
The EPITeen project was designed to study a population-based cohort of urban adolescents. We included in the analysis, 1596 adolescents evaluated when they were 13 years old and 17 years old. Depressive symptoms were evaluated using Beck Depressive Inventory II (BDI), and adolescents were categorized as (i) score ≤13 in both assessments; (ii) >13 only at baseline, (iii) >13 at the age of 17 years. Physical fighting was defined as being involved in physical fights in the previous year and it was measured at 17 years old.

We used logistic regression odds ratio (OR) and 95% confidence intervals (CI) to estimate the magnitude of the associations, adjusted to parents’ education and family history of depression.

Results
During the past year, 29.5% of girls and 62.5% of boys who had scored BDI-13 at 17 year old were involved in physical fights. For those who scored >13 only at baseline the values were 20.2 and 45.8%, respectively. After adjustment, the association between a BDI score >13 at 13 years old and being involved in physical fights were OR = 1.10 95% CI (0.51–2.36) in girls and OR = 1.32 95% CI (0.48–3.62) in boys. Considering the same BDI scores at 17 years old the association was OR = 1.87 95% CI (1.04–3.37) among girls and OR = 2.43 95% CI (0.92–6.38) among boys.

Conclusions
There is a positive association between depressive symptoms and being involved in physical fighting.
Background
Self-rated health is a strong predictor variable for a number of important health outcomes such as mortality, morbidity or utilization of health-care services. In spite of that, there still remain questions concerning the mechanisms underlying the process of evaluation of health. The aim of this study was to shed more light on possible determinants of this powerful construct.

Methods
A total of 160 patients with recently diagnosed rheumatoid arthritis were followed up over a 4-year period (mean age 48.7 ± 12.0 years, mean disease duration 22.2 ± 15.9 months). Patients filled in questionnaires on pain (NHP, RA1), disability (GARS), psychological distress (GHQ-28), adjustment to disease (GARA) and self-rated health (OEH). Multiple linear regressions, controlling for relevant socio-demographic and clinical variables, were used to analyse data.

Results
The first regression model consisting of basic socio-demographic variables (older age, female gender, lower education) explained 19% of the variance of poor self-rated health. In the next steps, entering relevant clinical variables (higher erythrocyte sedimentation rate and C-reactive protein as well as longer disease duration) explained additional 5%, more pain 24%, more disability 4%, and worse adjustment to disease another 6%. The total explained variance after entering all variables into the equation was 51% (adjusted). In the final model only age, education, pain and adjustment to disease remained significant.

Conclusions
The outcomes provide support for the hypothesized relationships between the variables under study, even though the non-significant association of psychological distress is to a certain extent surprising. The findings also reveal interesting implications for adjustment to disease (viewed as a result of a coping process) as being one of the most important determinants of self-rated health.

Approaches to chronic care and disease management in Denmark in 2009
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Background
Developing and validating disease management evaluation methods for European health care systems (DISMEVAL) project aims to review approaches to chronic care and disease management in Europe as well as test and validate possible chronic care and disease management evaluation methods. The current study is a part of the DISMEVAL work package two and provides the overview of approaches to chronic care and disease management in Denmark in 2009.

Methods
The study is a review of scientific literature and political documents. In addition, face-to-face interviews as well as e-mail correspondence with the experts in the field (national and regional level politicians working with chronic disease management in Denmark; physicians, nurses and physiotherapists involved in the programmes described) were carried out. A template for data collection was elaborated by RAND Europe.

Results
Three principal approaches to chronic care in Denmark were described. (i) The National Board of Health developed integrated clinical pathways for 34 cancers and four heart diseases in the period 2005–09. The aim of the pathways is to provide integrated clinical pathways for 34 cancers and four heart diseases in the period 2005–09. The aim of the pathways is to describe the disease management programmes (DMP) in general concepts and terms. The focus of the DMP is integrated care assured by cooperation between general practice, hospital and municipality. In 2009 two regions in Denmark developed and approved DMPs for diabetes and chronic obstructive pulmonary disease (COPD). (iii) Rehabilitation programmes in municipalities and hospitals.

Conclusions
The only one long-term approach to chronic care in Denmark that has been implemented and evaluated in 2009 was a rehabilitation programme for people with COPD, diabetes type 2, chronic heart diseases and balance problems in elderly carried out in collaboration between the Municipality of Copenhagen, Bispebjerg hospital and general practitioners in the local area.