Self-rated health and sustainable work ability in relation to long-term sickness absence in the Public sector

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Background
The sickness absence rate has increased rapidly in Sweden since 1997. Especially women in the public sector have a high long-term sickness absence.

Aim
The aim of this study is to analyse the association between the combination of self-rated health and work ability (health for working) and long-term sickness absence (>28 days) and to investigate if this relation is influenced by age and occupation.

Methods
6246 women, 18–65 years of age, employed by four county councils and six municipalities in Sweden participated in this ongoing longitudinal cohort study. A baseline questionnaire was administered in the year 2000 with a participation rate of 84 percent. Information about all new cases of sickness absence >28 days was continuously reported by the employers.

Results
Within 18 months from the baseline examination 8 percent of the women had had spells of sickness absence of 28 days or longer. An increased risk of long-term sickness absence was found among the 13 percent reporting poor health for working at the baseline (RR=1.7, 95% CI: 1.4–2.1). Poor health for working where most common among the youngest and the oldest age groups (about 20 percent). Among women 35 to 44 years of age poor health for working doubled the risk of long-term sickness absence (RR=2.3, 95% CI: 1.5–3.6). Based on occupation the highest prevalence of poor health for working was found in occupations with lower socio-economic gradient (about 24 percent) compared to registered nurses and secondary grade teachers with a prevalence of 8 percent. The association between poor health for working and long-term sickness absence varied by occupations.

Conclusions
These results indicate the importance of identifying specific physical and psychosocial work demands that may cause differences in prevalence of poor health for working in different occupations.

Parallel Session 12 – Health Indicators II: data

A standardized indicator set for the health reporting activities of 16 German states
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Issue/problem
A health indicator set for the German states has been introduced since 1991, but there was lacking correspondence with the health indicator sets at the federal level, deficient provision of data by many data holders and an increasing need for updating caused by the ICD-10 introduction, new health statistics and reforms in the health care system.

Description of the project
The indicator set of the German states consists of 10 thematic domains with 297 indicators containing socio-demographic, health, behaviour and environment-related data, moreover indicators on health care facilities, health services, manpower and on financing and cost. The indicator set was systematized following the criteria of WHO, EU and OECD; it was structured in a way allowing international comparisons as well as comparability from the municipal, state through to the federal level. The indicators are divided in time series, general tables and regional tables. Comparability is ensured by integrated statistical methodology and meta data description. About 50% of the indicators are included as core indicators in the binding part of the indicator set, the other indicators should be held as ‘state indicators’ depending on priority issues in health policy. It is intended that still in the year 2003 the health ministers of all German states will make the indicator set the basis of health reporting. Examples of various indicator categories will be shown.

Lessons learned
The indicator set was revised in close cooperation with the German states and together with the Federal Office for Statistics and the Robert Koch-Institute. The development of the indicators was coordinated by one institution. All data holders were included in good time into the shaping of the indicators and formulation of the meta data description. In this way it is to be ensured that in future the approval rate and completeness of the indicator set will be improved.

Conclusions
The state indicator set might be a module of the EU’s New Public Health Programme and supports the efforts of the European Union to develop comparable indicator sets in the Member States and candidate countries.

Health indicator profiles: an instrument for valid comparison of health data
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Issue / problem
Health indicators have been developed as part of the European Commission Health Monitoring Programme to contribute to the establishment of an European health monitoring system. Epidemiological information for this system will be derived from various information sources, one of which is primary care. However requirements for valid international comparison of this information still need to be established.

Description of project
To study the appropriateness and comparability of primary care data as a source of epidemiological information, health indicators will be structured into profiles. Primary care networks that monitor diseases on a continuous basis from Belgium, England & Wales, France, Germany, the Netherlands, Portugal and Spain delivered epidemiological data on diseases mainly managed in primary care. A total of 8 diseases was selected: acute diarrhoea/gastroenteritis, asthma, low back pain, chickenpox, depression, diabetes mellitus, herpes zoster and stroke/TIA. For each disease health indicator information from at least 3 countries was available. During a 2 year project, specific health indicator profiles (HIPs) are being developed for each disease.

Lessons learned
HIPs which are developed include the following categories: health indicator, information on case definition and contextual information per country. The latter category contained a.o. information on the position of primary care, notification status and availability of other information sources for validation in each country. HIPs for a selection of diseases will be presented here.

Conclusions
Primary care data can be used as a tool for public health monitoring. Background information and a description of the data source is necessary to make justified comparisons. Health indicator profiles are a useful instrument to ensure validity of these comparisons.

Health expectancies in the Netherlands
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Background
In the Dutch health policy document ‘Public Health Status and Forecasting 2002’, health expectancies are main indicators to assess the population health. In the document, the focus is on trends over time, differences according to socio-economic status and regional disparities. In this presentation, we would like to present in summary the results as published in this Dutch document.

Methods
Data on disabilities, chronic diseases, well being and perceived health is derived from the Dutch Health Interview Surveys. For the trend analyses, data is used over the years 1983 to 2000. For the socio-economic differences and the regional disparities, pooled data over the years 1995–1999 is used. Life expectancy without chronic diseases, disability free life expectancy, life expectancy in well being and life expectancy in good perceived health are calculated using Sullivan’s method. Socio-economic status is defined in terms of education, region by local health authority region’s.

Results
Trend analyses show a decrease in life expectancy without chronic diseases (for males 1 year, for females 5 years), but an increase in disability free life expectancy (for males and females around 3 years) and life expectancy in well being (males and females 1 year). Life expectancy in good perceived health has remained stable. Con-
sidering socio-economic classes, differences between the upper and the lower class range from 8 years (well being, males) to 16 years (perceived health, males). Differences among region are of the same magnitude as differences between socio-economic classes.

**Conclusion**

Although life expectancy without chronic diseases is decreasing, this does not result in more (severe) disabilities or less well-being. So, the Netherlands is not performing very badly in public health. However, differences between socio-economic classes and between regions are very high and these differences ask for an ongoing, perhaps even intensified effort to clarify the causes and diminish the differences.

The National Observatory on Health in the Italian Regions

**Issue**

Several occasional reports have described local variations in health status, services utilisation, clinical practice and quality of care in European countries but there is a lack of large and systematic analyses. Moreover present devolution from central to local powers is a further challenge for regional health systems whose performance needs a systematic monitoring.

**Description of the project**

The National Observatory on Health in the Italian Regions (Osservasalute) is a co-operation of public health professionals from all the twenty Italian regions. Osservasalute’s main objective is to monitor regional health system performances. To attain this objective Osservasalute collects and analyses data originated from different sources (Ministry of Health, Local Health Institutions, National Institute for Statistics and other non-health institutions). An output of this activity is the Annual Report on Health in the Regions aimed to benchmark variations in health and in resources utilisation. The Annual Report presents the following innovative criteria: operational definition of the used indicators with a clear description of their meaning, validity and sources (metadata); statistical methods to analyse variations among the regions; benchmark and regional rank for each used indicator; definition for the Regions with poorer performances of the target levels to achieve.

Our data confirm the wide variation between Italian Regions (i.e.: ageing index from 56.1 to 182.4; infant mortality rate from 2.0 to 7.6 per 1000 live births; caesarean section rate from 17% to 49%; antibiotic utilisation from 12.06 to 35.08 DDD/1000inh/day). Most of these differences persist after, when appropriate, data adjustment.

**Conclusions**

The Osservasalute Annual Report is an attempt to produce comparable regional data and to use them for monitoring and benchmarking regional health performances with the aim to narrow regional variations. This experience can be of value to other countries for both produced data and used methods.

The Health Determinants Surveillance System (HDSS) of Veneto Region

**Issue**

Health status is influenced by a wide array of determinants including genes and biological factors, the healthcare system, health behaviours, the physical and the socio-economic environment. Scientific evidence shows that health behaviours and socio-economic factors are key contributors of chronic disease and injury morbidity and mortality.

**Description of the project**

The Health Determinants Surveillance System (HDSS) is a computer assisted telephone interview (CATI) developed by the Reference Center of the Regional Epidemiologic System (CRS) of Veneto Region to collect prevalence data on two major categories of health determinants: behaviours and socio-economic factors. The HDSS instrument is composed by core questions asked every three years, and a set of optional questions. Fixed core questions cover topics such as: perceived health status, self-reported morbidity and disability, cigarette smoking, alcohol consumption, fruit and vegetable consumption, physical activity, seatbelt use, breast cancer screening utilization, self-reported hypertension, educational attainment, occupational status, housing tenure, car ownership, residential crowding and demographics. Optional questions for 2003 included job insecurity, work-load, turn-over, social support, stress, social capital, participation to community activities, attendance to religious services, and radon control. In 2003 a sample of 4002 non-institutionalized adults living in Veneto Region was interviewed. A two stage sampling strategy was employed: first a disproportionate stratified sampling was created to select households in the seven provinces of Veneto; then a quota sampling design was used to identify respondents within the household.

**Lessons learned**

The HDSS fills an important information gap regarding prevalence and trends of behavioural and social determinants of health in Veneto.

**Conclusions**

Information provided by the HDSS is of extreme relevance for public health action. When combined with mortality and morbidity and health services utilization statistics, these data enable policy makers and public health officials to establish priorities, formulate policies and strategies and assess progress toward regional health objectives.

**Parallel Session 13 – Risk Factors for Diseases**

**Trends in educational inequalities in smoking in different Italian regions**

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**Background**

Previous studies have shown increasing socioeconomic inequalities in smoking over the period between 1980 and 1994 in Italy.

**Aim**

The general objective of this study was to determine the extent of the inequality in smoking over the recent years and to assess whether regions are in different stages of the smoking epidemic.

**Methods**

We used data from four National Health Interview Surveys from 1986 to 2000. For each survey and level (national and macro-regional), we calculated age-adjusted prevalence rates of current smoking in different educational groups. Four macro-regions (north-west, north-east, Central; South) were considered. In order to obtain a relative measure of inequalities in tobacco use between high and low educated groups, we estimated odds ratios (with 95% confidence intervals) by means of logistic regression.

**Results**

In men aged 25–49, the Odds Ratio (OR) of current smoking of low-educated compared to high-educated was about 1.40 between 1987 and 1994, and increased to 1.71 (95% CI: 1.62–1.80) in 2000. A reversal of the positive association between education and tobacco use was found for women of the same age group: OR was 0.73 (95% CI: 0.68–0.80) in 1987 and 1.12 (95% CI: 1.06–1.19) in 2000. The ORs for older women (50–79) were nearly stable, slightly above one. The prevalence of smoking in older women was larger among the high-educated, with a decreasing gap over time. The trends in educational inequalities in smoking were similar between different macro-regions for men while a north-south gradient in the size of the inequality was apparent for both younger and older women with ORs being persistently larger in northern regions.

**Conclusions**

The gap between high and low-educated groups has widened, especially in the youngest generations. Southern regions lag behind central and northern Italy in the progression of the epidemic.

**The Dutch burden of disease and the contribution of risk factors**

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