


Commentary: Self-rated health and mortality in low income settings

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Accepted 10 October 2012

Self-rated health is a widely used measure in population health surveys and clinical settings. The question to respondents commonly reads: ‘How in general would you describe your health?’ with 3–5 response alternatives ranging from poor to excellent.1 The first studies suggesting that poor self-rated health predicted increased mortality among elderly persons were published in the early 1980s.2,3 These were followed by numerous studies confirming that this simple self-reported measure can predict subsequent mortality, often more accurately than doctors.3

Why does self-rated health predict mortality? Self-rated health often retains an independent effect even when controlling for other health-related measures.1 Different explanations have been proposed, including (i) that self-rated health is more inclusive than the covariates used in many studies; (ii) self-rated health is a dynamic evaluation also judging the trajectory of health; (iii) self-rated health influences behaviours that subsequently influence health status; and that self-rated health reflects resources to cope with health threats.1,4

However, most previous studies have been conducted in high income settings, and there have been criticisms that the conclusions drawn from these studies cannot be applied to lower income settings. Amartya Sen, for instance, has claimed, based on data from different states in India, that self-reports of morbidity suggest poorer health among the population in Kerala than among the population in Bihar, whereas life expectancy in fact was considerably lower in Bihar,7 which would render self-rated health less useful in such settings. A more recent study6 also based on data from Kerala and Bihar, however, found that self-ratings of health were in line with observed prevalence levels of morbidity and life expectancy in the two states, and concluded that self-rated ill-health has construct validity.
as assessed via its relationship to socio-economic status.

In this issue of the journal, results from a study in rural Pune district, India, nested within a Health and Demographic Surveillance System under the Study on Global Aging and Adult Health, indicate that self-rated health is a strong predictor of mortality among rural Indian men aged ≥50 years, followed up for a 3-year period, independent of age, education, socio-economic status and self-rated disability. Disability was measured by the WHO Disability Assessment Schedule Index. There was an association between poor self-rated health and mortality also among women, but this association was more attenuated among women than among men when adjusting for disability. WHO Disability Assessment Schedule Index score and lack of spousal support were also associated with higher mortality both among men and women. The study used Cox proportional hazards regression and followed 5087 respondents aged ≥50 years for 3 years and recorded 410 deaths (232 men and 178 women). Nesting studies as this one within the context of a health and demographic surveillance system provides important opportunities for accurate estimation of survival time and mortality also in settings where other information on this is lacking.

Another team with some authors from the same group has also recently published similar results from a study within the Study on Global Aging and Adult Health framework in Indonesia among men and women aged ≥50 years, as also suggested in a previous study from Indonesia published in 2004. The predictive value of poor self-rated health for subsequent mortality has also recently been reported from Brazil, where poor self-rated health had the same predictive value for subsequent mortality as an inclusive objectively measured health score with biomedical measures and presence of disease. It seems, therefore, that evidence is mounting that self-rated health is a useful measure also outside high income settings.

What are the policy implications of the findings on self-rated health and mortality? The authors of the recent study from Indonesia suggest that monitoring of health among persons aged ≥50 years, who report poor health, should be done more intensively to detect possible treatable conditions. Similar conclusions are drawn from the Brazilian study.

Conflict of interest: None declared.

References