Chapter 7

A matter of disparities: risk groups for unhealthy lifestyle and poor health

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What it this chapter about?

This chapter addresses the results of the second Dutch National Survey of General Practice (DNSGP-2) with regard to differences in health and lifestyle according to age, socio-economic status, and working status in recent years. First, disparities in health and lifestyle will be presented, and secondly disparities according to age, socio-economic status and working status will be further elaborated upon. Sex, ethnic origin, and urbanisation level will be included in the description of the results where relevant. Also, comparisons with 1987 (based on the results of the DNSGP-1) are made, where possible. Besides presenting recent results on health and lifestyle disparities in the Netherlands, we explore how these results relate to previous Dutch studies.

How was it done?

The results described below are based on self-reported information, collected during interviews at the respondents' homes. From all 12 699 Dutch speaking patients who completed the health interview (*see* Chapter 2), a subsample of approximately 9000 respondents aged 25 years or older answered questions about health and lifestyle issues. Apart from age, the distribution of the respondents according to sex and place of residence is comparable with the original sample population. Additional interviews were held to collect information on lifestyle and health of 1151 migrants, i.e. people from Surinamese, Antillean, Moroccan and Turkish origin, aged 25 years and older. The statistics described here are based on univariate analyses; however, all described relations show statistical significance in the multivariate models when adjusted for the other variables.

What was found?

Disparities in health

Logically, elderly people are worse off healthwise than younger people. The health differences between the young and the old have, however, declined since 1987, due to the fact that elderly people now rate their health better than

in 1987 (67% versus 69.5% in good health), while the evaluation of their own health by youngsters has deteriorated slightly between 1987 and 2001. Other Dutch studies conclude that younger people live less healthy lives, but at the same time enjoy better health and use less healthcare than older people.[1]

Results from DNSGP-2 show also that people from a lower educational background rated their health lower (58.9% versus 86.8% in good health) and reported more acute conditions, chronic conditions and poorer mental health. Moreover, socio-economic differences in perceived health and mental health have increased between 1987 and 2001. In 1987, people with a lower educational attainment reported in 17.4% of cases a relatively high score on the General Health Questionnaire (GHQ) (2 or higher); this was 25.6% in 2001. People with a high educational background scored 19.4% in 1987 and 23.9% in 2001. The GLOBE study on the extent of and reasons for socio-economic health differences in the Netherlands concluded that people from a lower socio-economic background have more health problems and a higher mortality rate.[2] Another study confirms the increasing socio-economic health differences in the Netherlands in recent decades.[3]

Poor health is reported most often by occupationally disabled people, as well as Turks, lower educated persons and the unemployed.

Occupationally disabled people score the lowest on all health indicators included in the DNSGP-2, e.g. perceived health, acute complaints and diseases, chronic conditions, limitations and mental health. The poorer health of the occupationally disabled is confirmed in a number of other studies.[4,5]

Migrants report poorer health than the Dutch native population. People from ethnic minorities rate their health as poorer and report on average more health problems. Persons with an ethnic (non-western) background report in 37.3% of cases less than good health. Compared to the native Dutch population (21.9%), this is a large difference. Chronic conditions do not follow this rule. Some chronic conditions are more prevalent among migrant groups, whereas other are more prevalent among the indigenous population. The reporting of chronic conditions, and their order of prevalence rates vary among the different ethnic groups. Other studies confirm that migrants are generally less healthy than nationals.[6,7] Similar to the DNSGP-2 results, two studies report that migrants have a higher rate of diabetes mellitus.[8,9]

We found significant differences among the migrant groups themselves (*see* Table 7.1). In general, people of Turkish origin report a poorer health than those of Moroccan, Antillean or Surinamese origin. Turks report the poorest health; they are the least positive about their health and report more health complaints and chronic conditions than any of the other three migrant groups. Only mental health is not worse in Turkish people than in the other three groups.

In general, the health of women is poorer than that of men. Compared to 1987, health differences between men and women have increased slightly. Women rate their health lower than men (21.2% versus 17.6% report less than good health): they report more acute symptoms, more chronic conditions, more physical limitations and poorer mental health. These results corroborate the ruling view that women report more physical and mental problems than men

Table 7.1 Poor health by ethnic origin

	Dutch native	Moroccan	Antillean	Turkish	Surinamese
Perceived health less than good (%)	17.9	40.2	33.4	46.7	33.1
Number of chronic conditions (mean)	1.53	1.18	1.27	1.87	1.74
Anxious or worried (%)	33.2	25.5	39.7	25.2	33.9
Depressed or down (%)	27.5	24.7	37.0	31.9	34.9

and that the health situation of women has deteriorated in recent decades, whereas that of men has remained unchanged.[10,11]

Residents of highly urbanised areas report poorer health than those living in non-urban areas (22.1% versus 15% reported 'less than good health' in cities versus rural areas). This is true both for their own health evaluation and for the reported acute health problems, chronic illnesses, physical limitations and mental health. These differences between town and countryside have not increased between 1987 and 2001. The results show strong similarities with earlier research in the Netherlands concerning the differences between urban and rural areas.[12,13]

Disparities in lifestyle

Dutch people with lower socio-economic status smoke more often (29.4% smokers), are overweight more frequently, and take physical activity less frequently than people from higher socio-economic groups. This is in accordance with the results of the GLOBE study.[2,14,15]

Those who are unemployed or have been certified unfit to work report a comparatively less healthy lifestyle. They smoke more often (48.9% smokers), consume alcohol more often (19.3% heavy drinkers), are less physically active, and have poorer eating habits than people who are employed (36.3% smokers and 16% heavy drinkers). Additionally, the occupationally disabled are obese more often than the population on average (17.4% versus 10.8%). Other Dutch studies report that the occupationally disabled have a less healthy lifestyle than the working population, but that there is little or no difference between the employed and the unemployed in this respect.[4] However, results from the DNSGP-2 point out that it is often jobless people who report the least healthy lifestyles, certainly in terms of smoking, excessive alcohol consumption and drugs use.

Women generally report a healthier lifestyle than men. They smoke (25.7% versus 34.1%) and drink less (4% versus 19.5%), and have better eating habits than men. An exception to the healthier lifestyle of women is physical activity and weight. Women are less physically active and more overweight than men. Contrary to our finding of stable differences between men and women, Swinkels and Neve (1998) assert that the behaviour of women nowadays resembles more and more the lifestyle of men. They point out that in recent decades, fewer women than men have stopped smoking and that greater

numbers of women now drink alcohol, whereas the percentage among men has remained stable.[11]

DNSGP-2 shows that, although migrants generally report a less healthy lifestyle, there are also differences between the different migrant groups. Male migrants, especially Turks (46.9% smoking), smoke more often than Dutch males (28.4% smoking). With regard to women, only the Turkish women smoke more often than Dutch women, while almost no Moroccan women smoke. People from migrant communities take physical activity less frequently than their Dutch counterparts, in particular Turkish and Moroccan people. Almost all ethnic minorities are more often overweight or obese than the Dutch native population. However, they are less prone to excessive alcohol consumption. Exceptions are Surinamese men and Antillean men and women, who are more often heavy drinkers.

Other Dutch studies reported that people from ethnic minority communities smoke less frequently than those from the native population.[7,8] Other studies on alcohol consumption, physical activity patterns and body weight of migrants report findings in keeping with ours. People from migrant communities are less often heavy drinkers, but are physically active less frequently, and are more likely to be overweight than their Dutch counterparts.[1,6,7]

People living in cities generally report a less healthy lifestyle than residents of moderately urban or non-urban areas. City dwellers are more likely to smoke (32% versus 25.1%), use soft or hard drugs (3.6% versus 0.7%) and take insufficient physical activity (54% versus 48.9%) than people living in non-urban areas. Women living in cities are more prone to excessive alcohol consumption. On the other hand, those living in rural areas are more likely to be overweight (48.4% versus 44%).

Although healthy behaviour in terms of smoking and alcohol consumption has improved since 1987, the increasing prevalence of overweight and obesity is alarming (*see* Figure 7.1). The DNSGP-2 results indicate that an unhealthy lifestyle is reported mostly by men, youngsters, lower educated persons, immigrants, the unemployed or occupationally disabled, and urban dwellers.

Age disparities

Younger people live less healthily, but at the same time enjoy better health than older people.As mentioned above, older people generally live in a healthier way than younger people. After the age of 50 years, many smokers have apparently quit the habit (*see* Figure 7.2).

Excessive alcohol consumption is also less frequent after this age. Older people are more physically active and generally report a healthier diet than younger people. A stain on the healthy lifestyle of elderly is overweight and obesity that increase with age.

Although older people generally live in a healthier way than younger people, they suffer from more health problems than younger people due to ageing. An exception to this rule is, however, mental health. People aged under 45 years report poorer mental health than those over 45 years of age.

The five most-often reported symptoms vary according to the different age groups. Children most often complain of a blocked nose and cough, followed by tiredness, headache and 'feeling aggressive'. The over 65 age group most

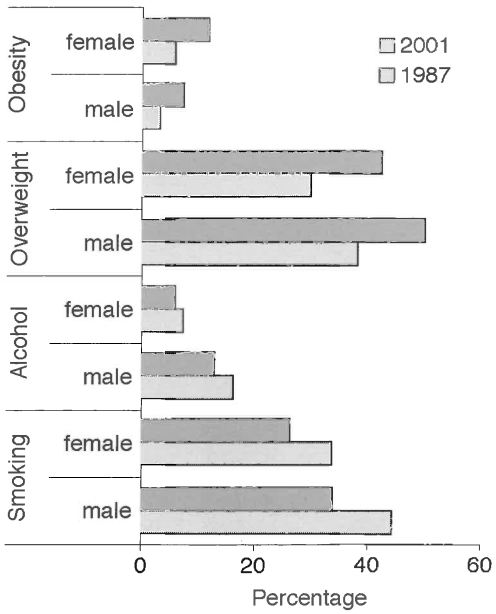

Figure 7.1 Changes in lifestyle between 1987 and 2001 (DNSGP); percentages of smokers, excessive alcohol consumers, people who are overweight (BMI > 25) and obese (BMI > 30) by sex.

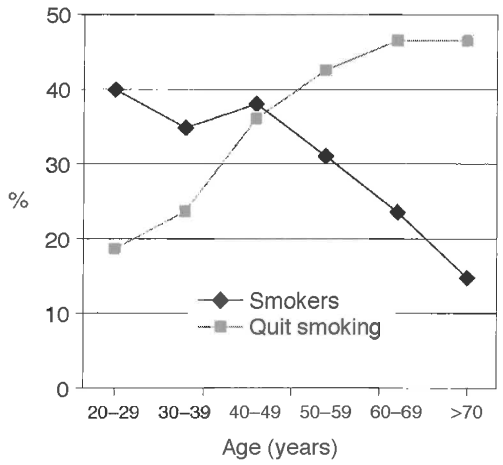

Figure 7.2 Percentage of respondents that report smoking and to have quit smoking by age group, 2001.

frequently report low back pain, tiredness, sleeplessness, neck or shoulder pain and impaired hearing. The majority of chronic conditions are also most prevalent among higher age groups. By contrast, the prevalence rates of migraine, serious headache and eczema seem to diminish with increasing age.

The good news is that since 1987 the differences in perceived health between younger and older people have decreased. Nowadays, older people report better

health than they did in 1987 (*see* Figure 7.3). This is particularly true for the 45–64 years age group. Younger people, on the other hand, report a somewhat poorer health than in 1987. Compared to 1987, the differences in mental health between older and younger age groups have, however, increased.

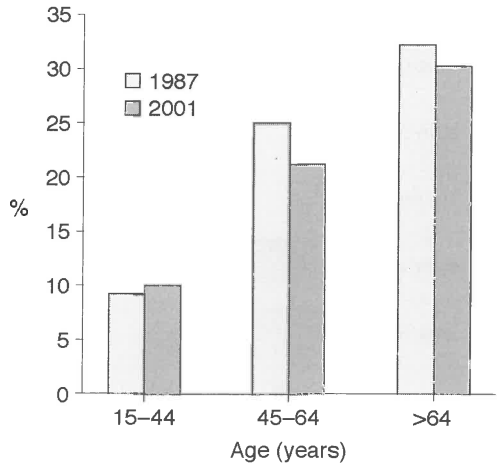

Figure 7.3 Poor self-rated health (% less than good) by age groups in 1987 and 2001.

Socio-economic differences

Lower socio-economic groups report comparatively poorer health and unhealthier behaviour than people from higher socio-economic backgrounds.

People with lower socio-economic status are more likely to smoke (29.4%) and have generally unhealthier eating habits than those with higher socio-economic status. People from a lower socio-economic background are more likely to be overweight or obese than others. There is, however, little difference between the two groups in terms of the national standard for adequate physical activity. The latter contradicts another Dutch study that reports that lower socio-economic groups take less physical activity.[14]

Finally, DNSGP-2 results show that between 1987 and 2001, socio-economic differences in smoking behaviour and excessive alcohol consumption have stabilised, while socio-economic differences in overweight and obesity have diminished since 1987.

We found that people from a lower socio-economic background rate their health lower and report more acute conditions, chronic conditions and poorer mental health. The GLOBE study reports similar socio-economic differences in health.[2] DNSGP-2 reports that socio-economic differences in perceived health and mental health have increased since 1987, as well as differences in the occurrence of diabetes mellitus. Socio-economic differences in the reported frequency of migraine or serious headache appear to have lessened. The increase of socio-economic health differences in recent decades in the Netherlands is corroborated by Dalstra *et al.* (2002).[3]

Differences related to working status

Those who are unemployed or have been certified unfit to work generally have a comparatively less healthy lifestyle. They smoke more frequently (48.9%, 43.3% and 36.3% respectively), consume alcohol more often, and take insufficient physical activity more often. They also skip breakfast or dinner more often. Additionally, the occupationally disabled are more often obese than the population average. The unhealthier lifestyle of the occupationally disabled compared with the employed is corroborated by van Deursen (1997),[4] but little or no difference between the employed and the unemployed was reported in this respect. By contrast, in our study population, it is often jobless people who report the least healthy lifestyles, certainly in terms of smoking, excessive alcohol consumption and drugs use.

The unemployed and occupationally disabled report poorer health than those in paid employment. They report more health complaints, chronic conditions and poorer mental health. The disabled also have more physical limitations. The poorer health of the occupationally disabled is confirmed in a number of studies.[4,5] Studies on the health of the unemployed report poorer physical health among the unemployed as compared to the employed,[5,16] as well as similar health for unemployed and employed people.[4] The DNSGP-2 results concur with the first.

Since 1987, this health gap between these groups and employed people has increased, due to the deterioration of the health situation of the occupationally disabled and unemployed. For instance, the percentage of unemployed people who rate their health as 'poor' or 'bad' has increased, whereas this is not true of those with a job (*see* Figure 7.4). Also acute health problems, migraine and poor mental health have increased more sharply among the unemployed than among other groups.

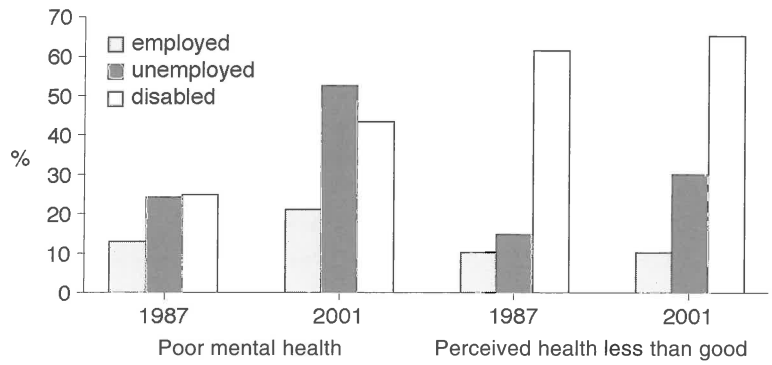

Figure 7.4 Poor perceived mental health and health by working status, 1987 and 2001.

What to think about it

This chapter presents an updated profile of the existing disparities in health and lifestyle in the population of the Netherlands. Where possible, comparisons are made over time. The results show that differences in health have not disappeared. The groups with poorer lifestyle and health tend to be the unemployed, the occupationally disabled, the less well educated, ethnic minorities and the elderly. Indeed, the health gap appears to have widened in some cases. Also striking is the deterioration of mental health among the unemployed, the occupationally disabled and the less well educated.

Need for caution

It is not always the less healthy groups who have a less healthy lifestyle. For instance, excessive alcohol consumption is higher among the Dutch native population than among migrant groups, while migrants report generally a poorer health status. Also, young people and men tend to behave more unhealthily, while older people and women are the ones who report poorer health.

Compared to 1987, the lifestyle of the Dutch population has deteriorated in a number of areas; at the same time it has improved in other areas. For instance, the number of overweight people has increased, but smoking has declined, as has excessive alcohol consumption.

Public health policy issues

In the government report *Langer Gezond Leven* (A longer healthy life) of the Health Ministry (2003), smoking, obesity and diabetes mellitus were appointed spearheads in the area of prevention.[17] According to the DNSGP-2 results highlighted in this chapter, this choice of topics simultaneously addresses the issue of disparities, since these problems show clear sociodemographic differences. For example, smoking, obesity and diabetes mellitus are more prevalent among lower socio-economic groups and ethnic minorities, with the exception of smoking among immigrant women.

The government report also prioritises a number of chronic diseases: cardiovascular diseases, cancer, asthma/chronic obstructive pulmonary disease (COPD), diabetes mellitus, mental conditions and mobility problems. Our results reported above show that chronic conditions are not evenly distributed among sociodemographic groups. In particular, the high prevalence of mobility problems, especially osteoarthritis, among those with a lower educational level is striking. Another notable result from DNSGP-2 in this respect is the poor mental health of the unemployed and occupationally disabled and lower-educated people.

Additionally to the above-mentioned prioritising of specific illnesses and prevention spearheads, public health should pay special attention to the situation of the unemployed and occupationally disabled. The results of DNSGP-2 show that these groups appear to be worse off on all fronts. Public health policy should especially focus on the deteriorating health of the unemployed and the occupationally disabled. These people are at a marked disadvantage and are increasingly becoming a vulnerable group in Dutch society.

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