Health: Self-rated health

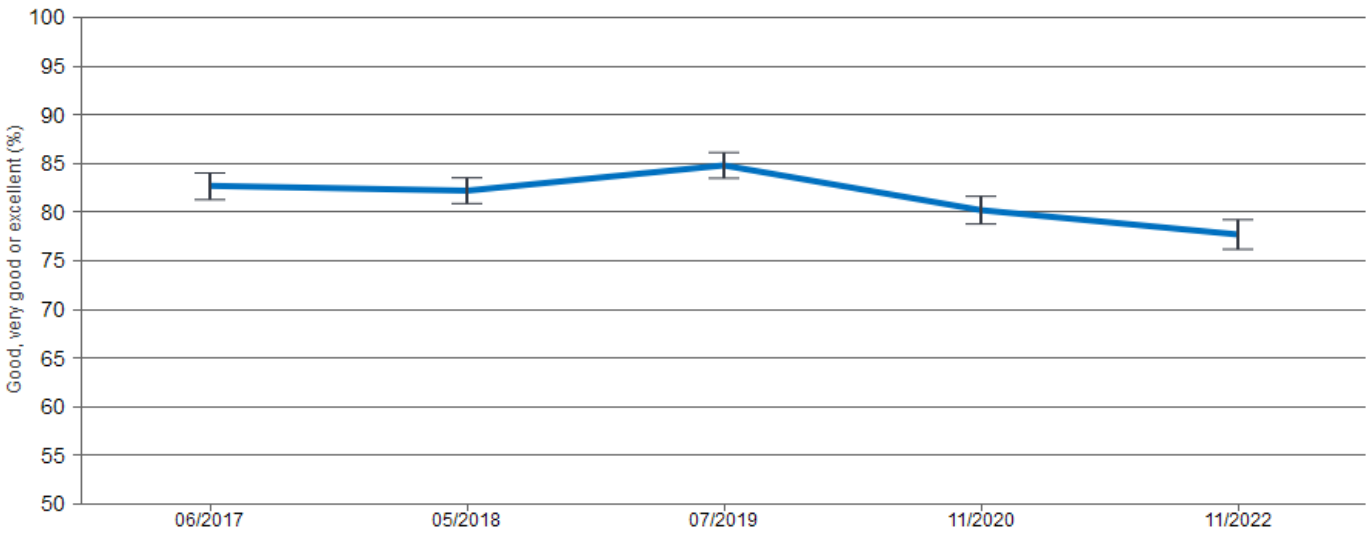
Downloaded from https://www.canterburywellbeing.org.nz/our-wellbeing/health/self-rated-health/ on 29/03/2024 7:50 AM

Self-rated health allows people to weigh together the different aspects of health that they consider most important [9]. In many health surveys, self-rated health is measured by a single question [9] and studies have found only very small differences in responses between different question wordings; suggesting that most single-question measures of health status tap into the same concept [10]. Self-rated health provides information in addition to standard clinical assessments of health status.

The Canterbury Wellbeing Survey has included the question, 'In general, how would you rate your health', since 2017 [11]. The question is scored using a five-category response format: poor–excellent.

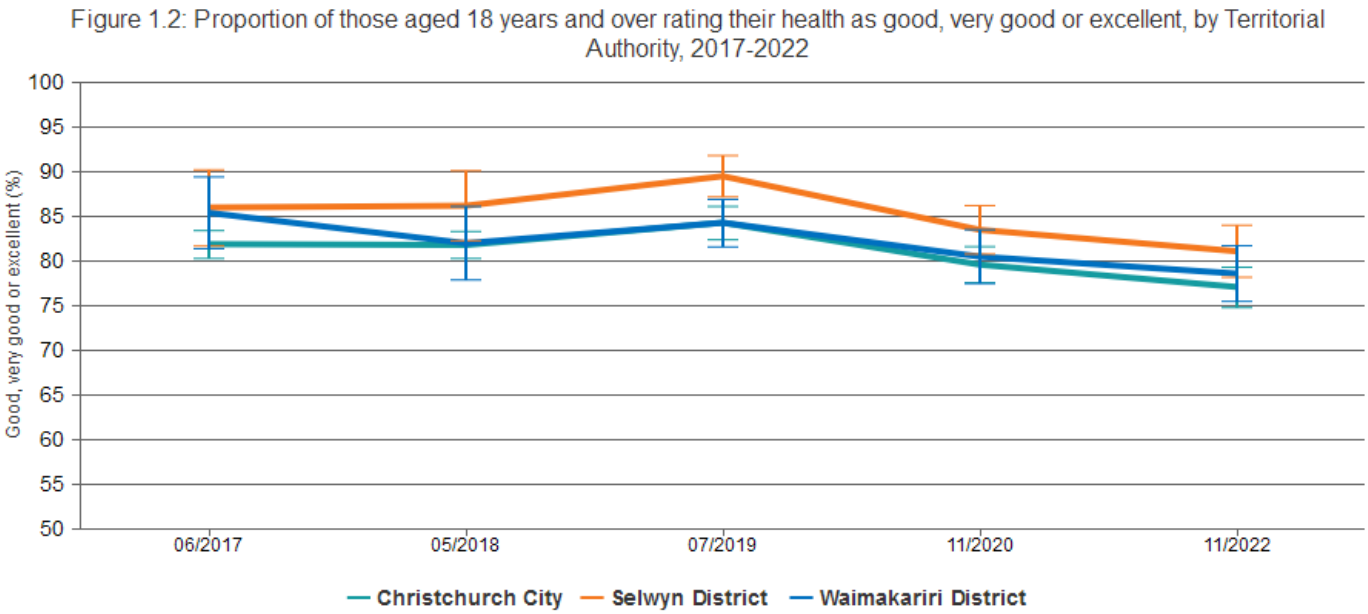
This indicator presents the proportion of those 18 years and over rating their health as good, very good, or excellent, in the 2017 to 2022 Canterbury Wellbeing Surveys.

Figure 1.1: Proportion of those aged 18 years and over rating their health as good, very good or excellent, in greater Christchurch, 2017-2022



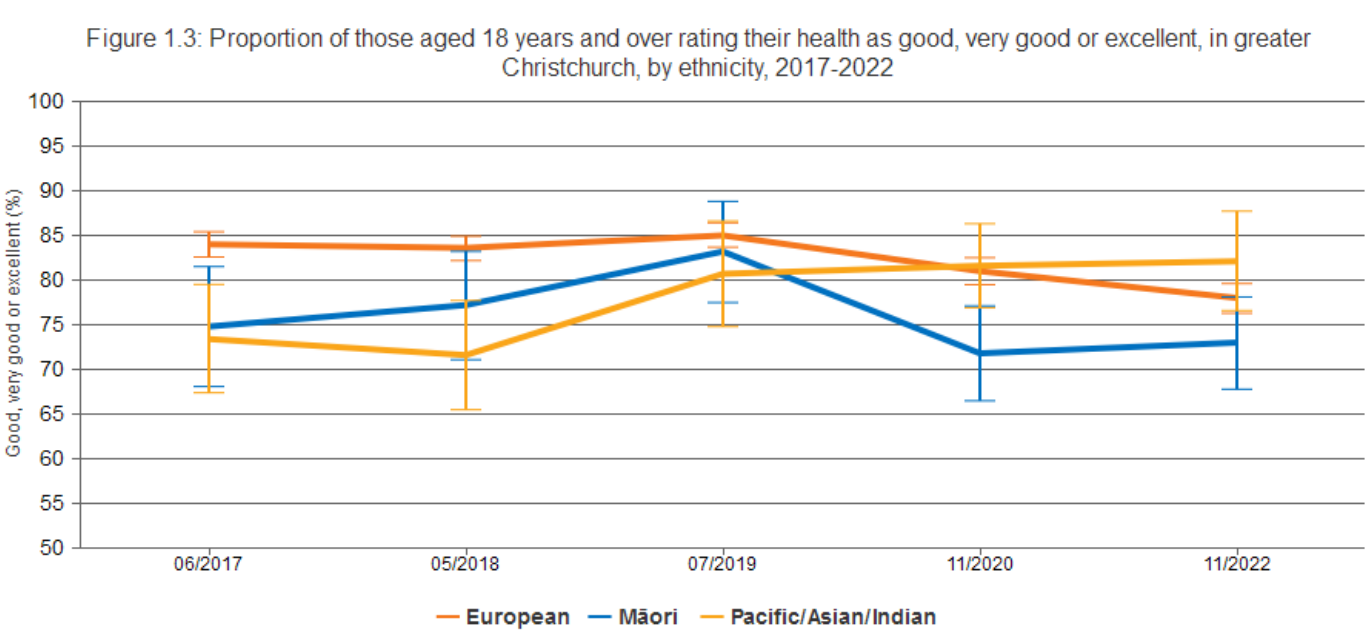
The figure shows that the proportion of respondents rating their health as good, very good or excellent in the 2022 Canterbury Wellbeing Survey was 77.7 percent. This proportion is statistically significantly lower than the 2019 high point (84.8%).

Breakdown by Territorial Authority



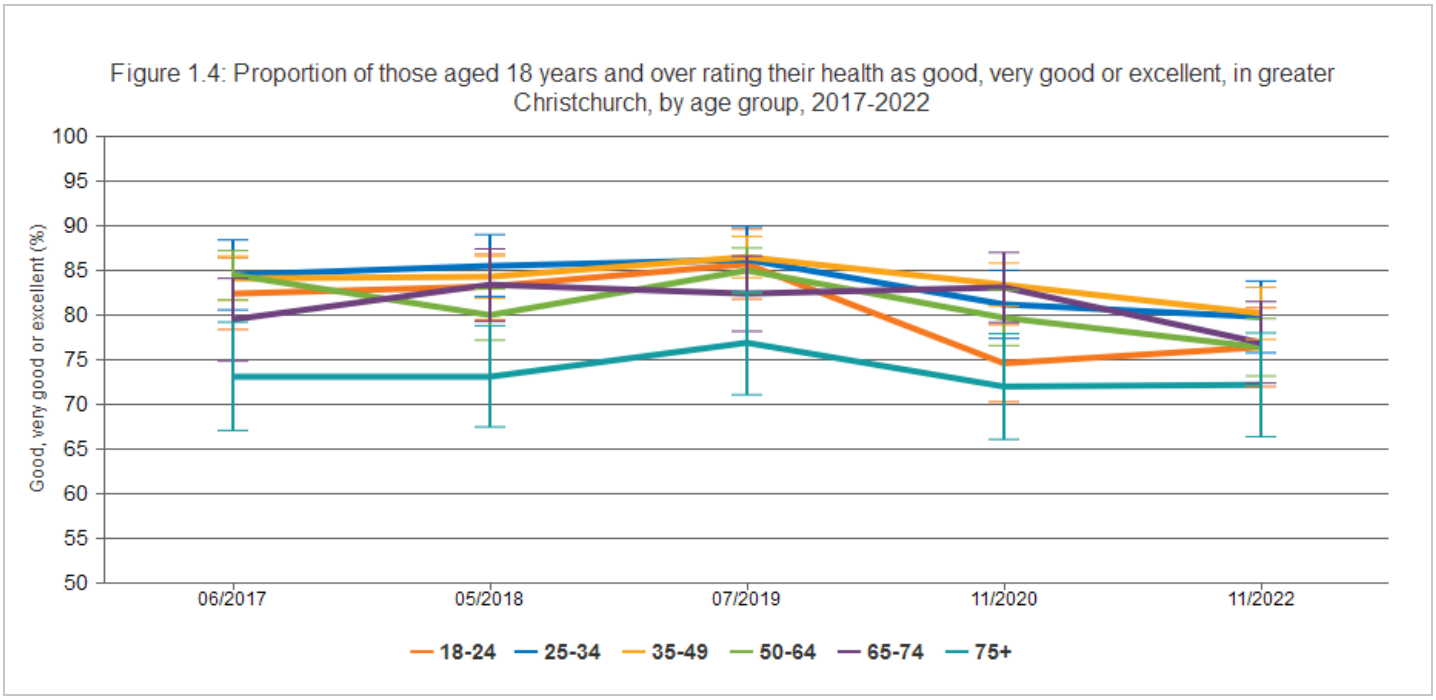
The figure shows no statistically significant differences in the proportion of respondents rating their health as good, very good or excellent in the 2017 to 2022 Canterbury Wellbeing Surveys, by Territorial Authority (Christchurch City, 77.1%; Selwyn District, 81.1%; and Waimakariri District, 78.6%, in 2022).

Breakdown by ethnicity



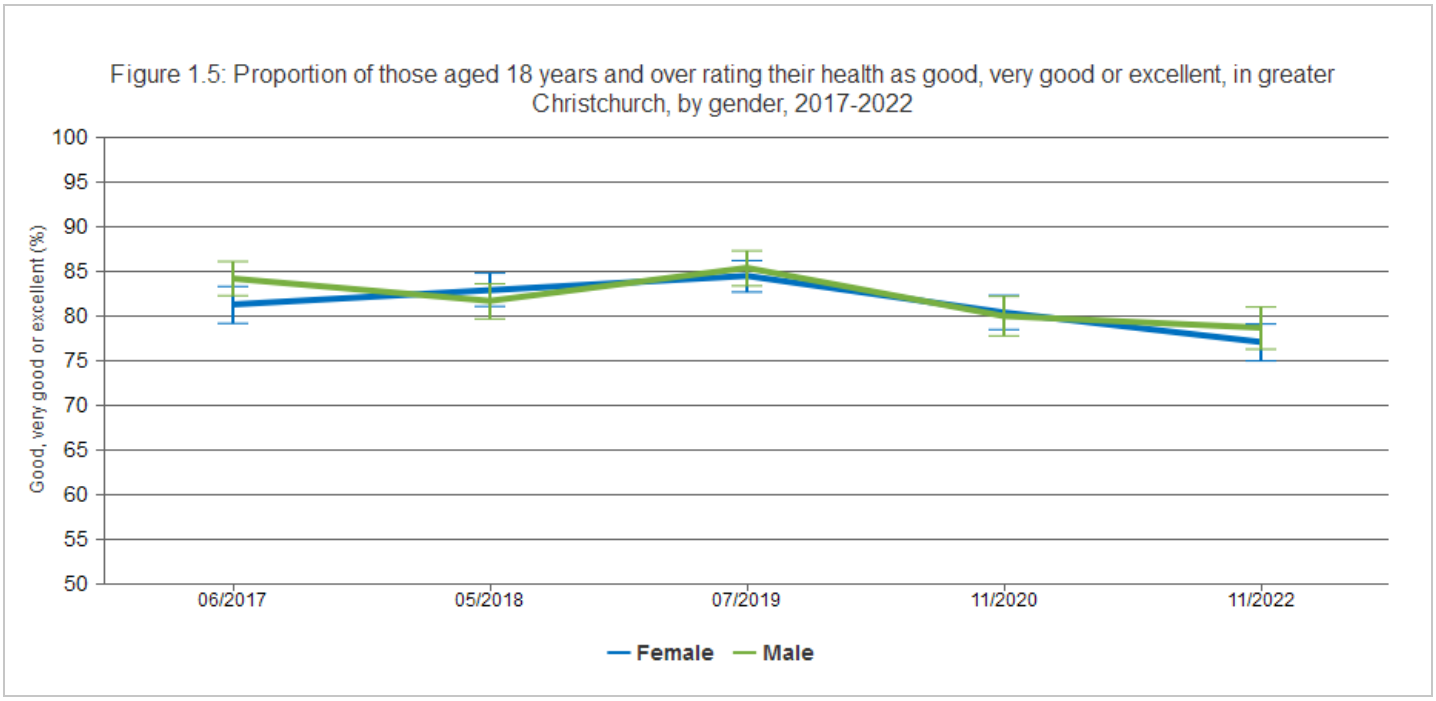
The figure shows the proportion of respondents rating their health as good, very good or excellent, for European respondents, Māori respondents, and for Pacific/Asian/Indian respondents (78.0%, 73%, and 82.1%, respectively, in 2022). European respondents had better self-rated health (a statistically significantly higher proportion rating their health as good, very good, or excellent) than Māori respondents in 2020, however, in 2022 there were no statistically significant differences between the groups.

Breakdown by age



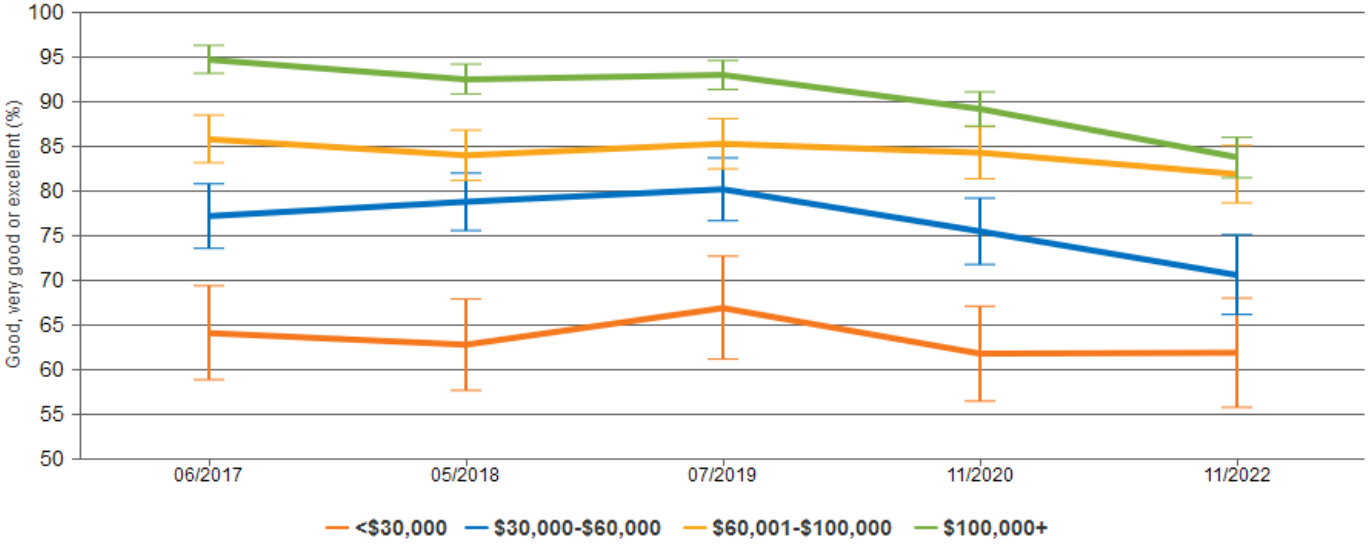
The figure shows a pattern of generally similar self-rated health (proportion rating their health as good, very good or excellent) for the age groups 18 to 24 years, 25 to 34 years, 35 to 49 years, 50 to 64 years, 65 to 74 years and 75+ years, for 2017 to 2022 (range 72.2% to 80.2%, in 2022). Of note, the proportion for the 75+ years age group was statistically significantly lower than for the 35 to 49 years age group and the 25 to 34 years age group, at all timepoints. There was a statistically significant decrease in self-rated health among 18- to 24-year-olds between 2019 and 2022 (85.7% rating their health as good, very good or excellent in 2019 compared with 76.4% in 2022).

Breakdown by gender



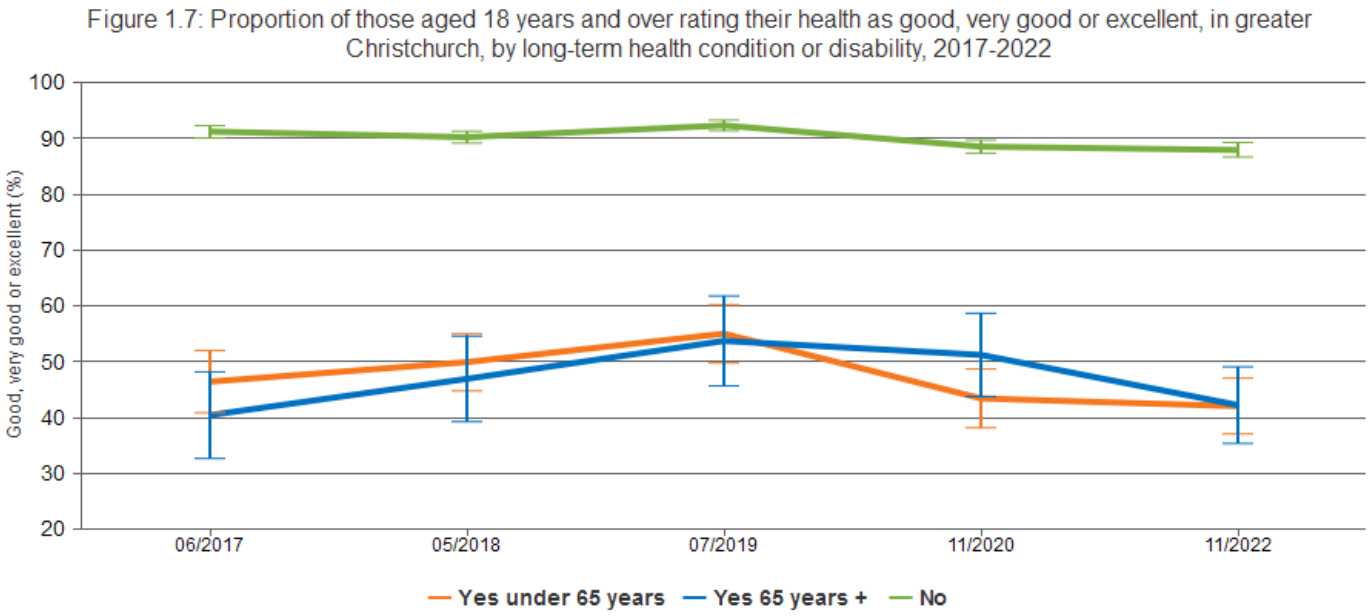
The figure shows a pattern of generally similar self-rated health (proportion rating their health as good, very good or excellent) for female and male respondents, between 2017 and 2022 (no statistically significant differences).

Breakdown by income



The figure shows that the proportion of respondents rating their health as good, very good, or excellent increases with increasing annual household income. The differences between the four income groups were all statistically significant in 2017 and 2020 and all but two comparisons (<$30,000) vs. $30,000–$60,000 and $60,001–$100,000 vs. $100,000+) were statistically significant in 2022. In 2022, a statistically significantly smaller proportion of respondents from the $100,000+ income group (83.8%) rated their health as good, very good or excellent, compared with the 2020 result (89.2%), continuing the notable pattern of decline evident since 2019.

Breakdown by disability



The figure shows that respondents with a disability or long-term health condition (irrespective of age) indicated markedly poorer self-rated health (a statistically significantly smaller proportion rating their health as good, very good or excellent) compared with those without a disability or long-term health condition over the time period from 2017 to 2022. There is no statistically significant difference in self-rated health between those with a disability or long-term health condition who are aged under 65 years and those who are aged 65 years and over at any timepoint (42.0% and 42.2% in 2022, respectively). Between 2019 and 2022 there was a statistically significant decrease in the proportion of respondents with a disability or long-term health condition who are aged under 65 years rating their health as good, very good or excellent, however no significant change was observed among those without a disability or long-term health condition, or those with a disability or long-term health condition who are aged 65 years and over (while decreasing from 2019 to 2020, the difference is not statistically significant).

Data Sources

Source: Te Whatu Ora Waitaha Canterbury - formerly the Canterbury District Health Board.
Survey/data set: Canterbury Wellbeing Survey to 2022. Access publicly available data from Te Mana Ora | Community and Public Health website at www.cph.co.nz/your-health/wellbeing-survey/
Source data frequency: Annually.

Metadata for this indicator is available at https://www.canterburywellbeing.org.nz/our-wellbeing/index-data

REFERENCES

This is the full reference list for **Health**.

1 Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P (2012) WHO European review of social determinants of health and the health divide. *Lancet* 380: 1011-1029.

2 Keefe V, Reid P, Ormsby C, Robson B, Purdie G, et al. (2002) Serious health events following involuntary job loss in New Zealand meat processing workers. *International Journal of Epidemiology* 31: 1155-1161.

3 Howden-Chapman P, Matheson A, Crane J, Viggers H, Cunningham M, et al. (2007) Effect of insulating existing houses on health inequality: cluster randomised study in the community. *BMJ* 334: 460.

4 Ross CE, Wu C-l (1995) The Links Between Education and Health. *American Sociological Review* 60: 719-745.

5 McKee-Ryan F, Song Z, Wanberg CR, Kinicki AJ (2005) Psychological and physical well-being during unemployment: a meta-analytic study. *J Appl Psychol* 90: 53-76.

6 Cormack DM, Harris RB, Stanley J (2014) Investigating the Relationship between Socially-Assigned Ethnicity, Racial Discrimination and Health Advantage in New Zealand. *PLoS ONE* 8: e84039.

7 Robson B, Harris R (2007) *Hauora: Màori Standards of Health IV. A study of the years 2000–2005*; Robson B, Harris R, editors. Wellington: Te Ròpù Rangahau Hauora a Eru Pòmare.

8 Hider P (1998) *Acute medical admissions: a critical appraisal of the literature*. New Zealand Health Technology Assessment Clearing House.

9 Peter M. Fayers, Hays RD, editors (2005) Assessing Quality of Life in Clinical Trials: Methods and Practice. 2 ed. Oxford: UK: Oxford University Press. 467 p.

10 Idler EL, Benyamini Y (1997) Self-rated health and mortality: a review of twenty-seven community studies. *J Health Soc Behav* 38: 21-37.

11 CDHB (2017) *Canterbury Wellbeing Survey, June 2017: Report prepared by Nielsen for the Canterbury District Health Board and partnering agencies.* Christchurch: Canterbury District Health Board.

12 Health Promotion Agency (2020) Smokefree facts and figures. Retrieved from https://www.smokefree.org.nz/smoking-its-effects/facts-figures.

13 Ministry of Health (2019) *Annual Data Explorer 2018/19: New Zealand Health Survey* [Data File]. Retrieved from https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/.

14 National Center for Chronic Disease Prevention and Health Promotion (US) (2014) *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Patterns of Tobacco Use Among U.S. Youth, Young Adults, and Adults.* Atlanta (GA): Office on Smoking and Health, Centers for Disease Control and Prevention (US).

15 U.S. Department of Health and Human Services (USDHHS) (1994) *A report of the Surgeon General: Preventing tobacco use among young people*. Atlanta, GA: Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

16 U.S. Department of Health and Human Services (USDHHS) (2012) *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General*. Atlanta (GA): Centers for Disease Control and Prevention (US).

17 Ministry of Health (2013) *Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016*. Wellington: Ministry of Health.

18 Banks E, Joshy G, Weber MF, Liu B, Grenfell R, et al. (2015) Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence. *BMC Medicine* 13: 38.

19 World Health Organization (2015) *WHO report on the global tobacco epidemic, 2015: Raising taxes on tobacco*. Geneva: WHO. ISBN 978 92 4 069460 6.

20 Ministry of Health (2018) Regional Data Explorer 2014–17: New Zealand Health Survey [Data File].

21 Ministry of Health (2017) *Methodology Report 2016/17: New Zealand Health Survey*. Wellington: Ministry of Health.

22 WHO (2007) *Global Database on Body Mass Index.* Geneva: World Health Organization.

23 Ministry of Health (2017) *Clinical Guidelines for Weight Management in New Zealand Adults*. Wellington: Ministry of Health, Clinical Trials

Research Unit.

24 Ministry of Health (2018) Obesity. Retrieved from www.health.govt.nz/our-work/diseases-and-conditions/obesity

25 Ministry of Health (2016) *Annual Update of Key Results 2015/16: New Zealand Health Survey*. Wellington: Ministry of Health.

26 Swinburn BA, Sacks G, Hall KD, McPherson K, Finegood DT, et al. (2011) The global obesity pandemic: shaped by global drivers and local environments. *Lancet* 378: 804-814.

27 Drewnowski A (2009) Obesity, diets, and social inequalities. *Nutr Rev* 67 Suppl 1: S36-39.

28 Physical Activity Guidelines Advisory Committee (2018) *2018 Physical Activity Guidelines Advisory Committee Scientific Report*. Washington, DC: U.S. Department of Health and Human Services.

29 McLean G, Tobias M (2004) *The New Zealand Physical Activity Questionnaire: Report on the validation of the NZPAQ-long and NZPAQ-short form physical activity questionnaires*. Wellington: Sport and Recreation New Zealand.

30 Craig CL, Marshall AL, Sjostrom M, Bauman AE, Booth ML, et al. (2003) International physical activity questionnaire: 12-country reliability and validity. *Med Sci Sports Exerc* 35: 1381-1395.

31 Ministry of Health (2018) Annual Data Explorer 2017/18: New Zealand Health Survey [Data File].

32 Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG, World Health Organization (2001) *AUDIT: the alcohol use disorders identification test: guidelines for use in primary health care*. Geneva: World Health Organization.

33 Ministry of Health (2013) Hazardous drinking in 2011/12: Findings from the New Zealand Health Survey. Retrieved from www.moh.govt.nz/NoteBook/nbbooks.nsf/0/81BF301BDCF63B94CC257B6C006ED8EC/$file/12-findings-from-the-new-zealand-health-survey.pdf

34 Braillon A, Dubois G (2005) Alcohol and public health. *Lancet* 365: 1387.

35 Health Promotion Agency (2016) *Alcohol – the Body and Health Effects: A brief overview*. Wellington: Health Promotion Agency.

36 GBD 2016 Alcohol Collaborators (2018) Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet* 392: 1015-1035.

37 Connor, J., Kydd, R., Shield, K., & Rehm, J. (2015). The burden of disease and injury attributable to alcohol in New Zealanders under 80 years of age: marked disparities by ethnicity and sex. *N Z Med J, 128*(1409), 15-28.

38 Hall JJ, Taylor R (2003) Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries. *Med J Aust* 178: 17-20.

39 Winnard D, Crampton P, Cumming J, Sheridan N, Neuwelt P, et al. (2008) *Population Health – Meaning in Aotearoa New Zealand? A discussion paper to support implementation of the Primary Health Care Strategy*. Auckland: Auckland Regional Public Health Service.

40 Neuwelt P, Matheson D, Arroll B, Dowell A, Winnard D, et al. (2009) Putting population health into practice through primary health care. *NZ Med J* 122: 98-104.

41 Schluter PJ, Hamilton GJ, Deely JM, Ardagh MW (2016) Impact of integrated health system changes, accelerated due to an earthquake, on emergency department attendances and acute admissions: a Bayesian change-point analysis. *BMJ Open* 6: e010709.

42 Galenkamp H, Deeg DJH, de Jongh RT, Kardaun JWPF, Huisman M (2016) Trend study on the association between hospital admissions and the health of Dutch older adults (1995–2009). *BMJ Open* 6: e011967.

43 Mordal J, Bramness JG, Holm B, Mørland J. (2008) Drugs of abuse among acute psychiatric and medical admissions: laboratory based identification of prevalence and drug influence. Gen Hosp Psychiatry 30(1):55-60.

44 Kessler RC, Angermeyer M, Anthony JC, R DEG, Demyttenaere K, et al. (2007) Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry* 6: 168-176.

45 Ministry of Health (2017) *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health.

46 Ministry of Health (2018) PRIMHD: Mental health data. Retrieved from www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data

47 Oakley Browne MA (2006) Lifetime prevalence and lifetime risk of DSM-IV disorders. In: Oakley Browne MA, Wells JE, Scott KM, editors. Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health.

48 Kessler RC, Foster CL, Saunders WB, Stang PE (1995) Social consequences of psychiatric disorders, I: Educational attainment. *American Journal of Psychiatry* 152: 1026–1032.

49 The Mental Health Commission (1998) *Blueprint for Mental Health services in New Zealand. How things need to be*. Wellington: The Mental Health Commission.

50 The Mental Health Commission (2012) *Blueprint II Improving mental health and wellbeing for all New Zealanders. How things need to be*. Wellington: The Mental Health Commission.

51 Cerdá M, Tracy M, Galea S (2011) A prospective population based study of changes in alcohol use and binge drinking after a mass traumatic event. *Drug & Alcohol Dependence* 115: 1-8.

52 Fergusson DM, Horwood J, Boden JM, Mulder RT (2014) Impact of a Major Disaster on the Mental Health of a Well-Studied Cohort. *JAMA Psychiatry* 71: 1025-1031.

53 Galea S, Nandi A, Vlahov D (2005) The epidemiology of post-traumatic stress disorder after disasters. *Epidemiol Rev* 27: 78-91.

54 Gluckman P (2011) *The psychological consequences of the Canterbury earthquakes*. Wellington: Office of the Prime Minister's Science Advisory Committee.

55 Kessler RC, McLaughlin KA, Koenen KC, Petukhova M, Hill ED, et al. (2012) The importance of secondary trauma exposure for post-disaster mental disorder. *Epidemiology and Psychiatric Sciences* 21: 35-45.

56 Lock S, Rubin GJ, Murray V, Rogers MB, Amlot R, et al. (2012) Secondary stressors and extreme events and disasters: a systematic review of primary research from 2010-2011. *PLoS Curr* 4.

57 Kerdemelidis M, Reid MC. (2019) *Wellbeing recovery after mass shootings: information for the response to the Christchurch mosque attacks 2019. Rapid literature review.* Christchurch, New Zealand: Planning and Funding, Canterbury District Health Board.

© Crown copyright 2024 Printed on: 29/03/2024