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AN EMPIRICAL EXAMINATION ON THE SELF-PERCEIVED HEALTH STATUS AND AFFECTING FACTORS IN TÜRKİYE

Doğancan ÇAVMAK*

Abstract

This study examines the self-perceived general health status and the related factors that can affect the status. The data were obtained from the Türkiye Health Survey 2022 Micro Data Set provided by the Turkish Statistical Institute. The dependent variable of the study is the self-perceived health status, while the independent variables are socio-demographic and economic variable, daily activity level, chronic disease condition, and indicators related to access to healthcare. The data were analyzed using descriptive statistics and multinomial logistic regression analysis. The results showed that low socio-economic indicators, low activity level, and having a chronic disease were associated with poor/bad perceived health status. It has been determined that experienced barriers in access to healthcare significantly increase the odds of individuals being reported in the bad health status category. It is recommended that healthcare policies, social services, and economic policies should prioritize those in the socio-economically weak group.

Keywords: *Health status, Access to healthcare, Health management.*

TÜRKİYE'DE ALGILANAN SAĞLIK STATÜSÜ VE ETKİLEYEN FAKTÖRLER ÜZERİNE AMPRİK BİR ARAŞTIRMA

Öz

Bu araştırmanın amacı, algılanan genel sağlık statüsünü ve bu değerlendirmeyi etkileyen faktörleri incelemektir. Bu amaç kapsamında analiz edilen veriler, Türkiye İstatistik Kurumu'ndan alınan, Türkiye Sağlık Araştırması 2022 Mikro Veri Seti'nden elde edilmiştir. Çalışmanın bağımlı değişkeni genel algılanan sağlık statüsü iken bağımsız değişkenler arasında sosyo-demografik ve ekonomik veriler, günlük aktivite düzeyi, kronik hastalık taşıma durumu ve sağlık hizmetlerine erişimle ilgili indikatörler yer almaktadır. Veriler, tanımlayıcı istatistikler ve multinominal lojistik regresyon analizi yöntemleri ile analiz edilmiştir. Analiz sonuçları, düşük sosyo-ekonomik göstergelerin, düşük aktivite düzeyinin ve kronik hastalık taşıyor olmanın algılanan sağlık statüsünde olumsuz değerlendirmeler ile ilişkili olduğunu göstermektedir. Sağlık hizmetlerine erişimle ilgili yaşanan engellerin, bireylerin kötü sağlık statüsü kategorisinde yer alma ihtimallerini anlamlı düzeyde arttırdığı tespit edilmiştir. Sağlık, sosyal hizmet ve ekonomi politikalarının, sosyo-ekonomik olarak zayıf grupta yer alanları hedeflemesi önerilmektedir.

Anahtar kelimeler: *Sağlık statüsü, Sağlık hizmetlerine erişim, Sağlık yönetimi.*

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1. INTRODUCTION

Health status has many determinants. The model of Dahlgren-Whitehead, also known as the "rainbow model", is the commonly used basic model that puts an emphasis on environmental conditions to examine the health status (Dahlgren and Whitehead, 1991). Following this, the study of Exworthy (2008) provided a useful framework which explained the social determinants of health as social, economic, behavioral, access to healthcare, genetics, and environmental factors. Self-perceived (also known as self-rated) health is one of the approaches to examine health status. It reflects a subjective evaluation of the current health conditions by individuals and is commonly measured by the question "How is your health in general?" which is rated using a five-point scale (Fayers and Sprangers, 2002). The common classification level goes from "poor or very bad" to "excellent or very good". When poor/very bad refers to the self-perceived conditions with significant existing health problems and low quality of life, very good indicates a strong positive perception towards existing health status. Although this approach seems quite simple, studies explored that numerous social, economic, cultural, health behavior and health systems-related factors are associated with the self-perceived health status, which poses it in a significantly important role. (Zadworna, 2022). Self-perceived health encompasses physical, mental, and social aspects of health based on individuals' perceptions (Jylhä, 2009). This approach has several advantages. It is easy to conduct, cost-effective, and provides a holistic view of health. Therefore, it is inclusive and a dynamic evaluation which is based on continuous monitoring of individuals' health. Self-perceived health status is also an important indicator for being able to influence health behavior (Benyamini, 2011). However, it also inherently has some limitations. Because when one asks people to rate their health status, it is expected to consider a more comprehensive set of factors by individuals than is possible to include in a single-item survey (Schnittker and Bacak, 2014). However, despite its limitations, the self-perceived health measurement is a valuable tool for identifying the populations under risk, identifying health disparities, and evaluating the effectiveness of public health policies. It is a complementary tool bringing objective health measures and individuals' perceptions of health and well-being together, which are critical for tailoring healthcare delivery and policy initiatives (DeSalvo et al., 2006).

Considering this potential, self-perceived health status is currently an important and common indicator for health systems. Many countries regularly measure and evaluate the perception of the population on their health status (OECD, 2017). Therefore, there is a growing literature on this subject. Most research on self-perceived health focused on predicting mortality (Shimonovich et al., 2024; Dramé et al., 2023; Mutz and Lewis, 2022) and investigating the potential determinants (Caramenti and Castiglioni, 2022; Cai et al., 2017; Assari and Lankarani, 2017). There are many studies focused on the relationships between the social and economic level of the population and their health status. Generally, lower health status is associated with lower socioeconomical indicators such as educational level, income, and unemployment (Shaaban et al, 2022; Góngora-Salazar et al., 2022). Some studies investigated the effect of health literacy (Furuya et al., 2013), physical activity level (Olivares-Tirado and Zanga, 2014), unmet health needs (Tadiri et al., 2021) and satisfaction with healthcare services (Paul et al., 2016). Hence, this study included social, economic, and demographic factors as related factors with self-perceived health status and formulated the first hypothesis as;

Hypothesis 1: Socioeconomic and demographic factors significantly affect the self-perceived health status

Access to healthcare consists of two dimensions: physical accessibility and financial accessibility, based on the approach provided by Salkever (1976). Physical accessibility refers to transportation opportunities and time, while financial accessibility refers to the "ability to afford the monetary costs". Literature highlights that there is a positive relationship between the level of access to healthcare services and individuals' perceptions of their health status. Particularly individuals with chronic diseases have a tendency to consider their ability to access healthcare as a significant indicator of their overall health condition (Chávez Sosa et al., 2022; Tanner et al., 2020). There are also many studies which indicated better health outcomes were associated with access to health care (Tran et al., 2016; Moorin and Holman, 2006). The study of Shaaban et al, (2022) found that experiencing barriers in accessing healthcare was significantly related to reporting poor self-perceived health. However, to the

best of our knowledge, there is limited evidence from studies that primarily focused on self-perceived health. Therefore, this study considers that self-perceived health status may be linked to access to healthcare as well and formulates the second hypothesis as follows:

Hypothesis 2: Access to healthcare significantly affects the self-perceived health status.

2. METHODS

Data from the Türkiye Health Survey Micro Data Set- 2022 of the Turkish Statistical Institute was used. Required permissions were obtained from the Turkish Statistical Institute. The survey was carried out with 29,761 participants across Türkiye. However, for this study, only participants aged 15 and older were included, resulting in a final sample size of 22,742 individuals.

The dependent variable is "perceived general health status". Perceived general health status was measured by the question of "*how is your health in general*" and rated by a 5-point scale with 1=very bad, 2=bad, 3=fair, 4=good, 5= very good (the scale was in reverse in the original dataset. It was recoded reversely in the study as in the previous sentence). The independent variables were gender, age, education level, employment status, household income level, daily activity level, chronic disease status, and various barriers to accessing health services. Gender was coded as 1=female, 2=male, while age was in real values. Education level was classified into nine categories from illiterate to doctoral degree. Household income level was classified into three groups as low, moderate, and high. In the original dataset, there were twenty categories of monetary intervals for income level. In this study, the first seven intervals were aggregated in the low category, the second seven ones in moderate and the last six intervals in the high category. Daily activity level was classified into three categories: mostly inactive to mostly active. Having a chronic disease was reported as 1=yes and 2=no. In the dataset, the status of having a chronic disease was examined for twelve different situations/diseases. In line with this current study, those who said yes to at least one of these twelve situations/diseases were marked as having a chronic disease. Access to healthcare indicators was measured by the following questions: "Have you experienced a delay in getting healthcare in the past 12 months because the time needed to obtain an appointment was too long?", "Have you experienced a delay in getting healthcare in the past 12 months due to distance or transport problems?", "Was there any time in the past 12 months when you needed medical care but could not afford it?", "Was there any time in the past 12 months when you needed prescribed medicines but could not afford it?". These questions had three answers: "yes", "no", and "no need for health care". In this study, "no need for health care" was aggregated under "no" because the value for it was too low and could be considered as not facing the mentioned problem.

The analysis was conducted using multinomial logistic regression method to examine the relationships between self-perceived general health status and the various independent variables. This statistical method is particularly suited for situations where the dependent variable consists of several categories more than two. It has many advantages such as it is widely available and the outputs are easy to understand and evaluate. This analysis enables researchers to understand how different factors may influence individuals' perceptions of their health. (Kwak and Clayton-Matthews, 2002). The level of significance was determined as $p < 0.05$.

3. RESULTS

Because demographic profiles are important factors for understanding the general perceived health status, the demographic characteristics of the participants are summarized in Table 1.

Table 1: Demographic Characteristics

Mean Age	43.37 ± 17.52
Gender	**%**
Female	48.2
Male	51.8
Educational Status	
Illiterate	6.6
Literate	3.8
Primary school	35.1
Secondary school	11.9
High school	22.3
Associate degree	5.8
Bachelor's degree	12.4
Master's degree	1.7
Doctoral degree (Ph.D.)	0.3
Employment Status	
Not working (Disabled)	2.2
Retired	13.7
Housework	29.1
Job seeker	7.1
Student	9.3
Paid employee	32.6
Employer	6
Household Income Level (Relatively compared in the participants)	
Low	12.4
Middle	32.1
High	55.5

The average age of the population was 43 years, and 48.2% were women. Considering educational status, a significant portion of participants had completed primary education (35.1%), while 22.3% had attained high school diplomas. Higher education levels were less common, with only 12.4% holding a bachelor's degree, 5.8% having an associate degree, and 1.7% achieving a master's degree. A small fraction of participants (0.3%) possessed a doctoral degree, while 6.6% were illiterate and 3.8% were literate but had not completed any formal education. 32.6% of participants were paid employees, 6% were employers, and 29.1% were responsible with housework. 13.7% of the sample were retired ones, and 2.2% were not working due to disability. The proportion of people who were actively seeking employment was 7.1% of the participants, and 9.3% were students. In terms of household income level, the majority of the participants (55.5%) were classified as high, 32.1% as middle, followed by 12.4% as low income. Table 2. summarizes the health-related indicators.

Table 2: Health Status Related and Access to Healthcare Indicators

Perceived Health Status	**%**
Very bad	0.8
Bad	7.4
Fair	29.4
Good	54.5
Very good	7.9
Daily Activity Level	
Mostly inactive /Rarely active	49.7
Moderately active	45.3
Highly active / Hard work	5
Having a chronic disease	
Yes	54.3
No	45.7
Delaying in access to healthcare due to long appointment times	
Yes	36.3
No	63.7
Delaying in access to healthcare due to transportation problems	
Yes	10.7
No	89.3
Delaying in access to healthcare due to financial difficulty	
Yes	8.1
No	91.9
Delaying access to medicine due to having financial difficulty	
Yes	6
No	94

The majority of the participants (54.5%) rated their health status as good. The proportion of those with fair was 29.4%, with very good 7.9%, with bad 7.4%, and with very bad 0.8%. Regarding daily activity levels, nearly half of the participants (49.7%) identified themselves as mostly inactive, while 45.3% chose moderately active. Only a very small portion of the participants (5%) identified as highly active or engaged in hard work. 54.3% of participants reported having a chronic disease. 36.3% of participants indicated that they had experienced delays in accessing healthcare due to long appointment times, while 10.7% faced the same due to transportation problems. 8.1% reported delays in accessing healthcare, and 6% indicated delays in obtaining medications due to not being able to afford them.

The results of the multinomial logistic regression analysis, which were performed to examine the effect of the independent variables of general perceived health status, are summarized in Table 3.

Table 3: Results of the Multinomial Logistic Regression Analysis

Factors	Category	β	Std. Error	Sig	Exp(B) (OR)
Gender (1=female, 2= male)	Very bad	-0.046	0.172	0.788	0.955
	Bad	-0.044	0.067	0.512	0.957
	Fair	0.165	0.041	0.000	1.180
	Very good	-0.191	0.059	0.001	0.826
Age	Very bad	0.037	0.006	0.000	1.038
	Bad	0.038	0.002	0.000	1.038
	Fair	0.028	0.001	0.000	1.028
	Very good	-0.030	0.002	0.000	0.971
Education (from 1=illiterate to 9=doctoral degree)	Very bad	-0.476	0.067	0.000	0.621
	Bad	-0.366	0.024	0.000	0.694
	Fair	-0.144	0.013	0.000	0.866
	Very good	0.122	0.018	0.000	1.130
Employment Status (from 1= Not working to 7= employer)	Very bad	-0.382	0.075	0.000	0.683
	Bad	-0.209	0.024	0.000	0.811
	Fair	-0.031	0.013	0.019	0.969
	Very good	0.007	0.023	0.764	1.007
Household Income (from 1=low to 3=high)	Very bad	-0.110	0.107	0.302	0.895
	Bad	-0.217	0.045	0.000	0.805
	Fair	-0.058	0.029	0.050	0.944
	Very good	0.249	0.046	0.000	1.283
Daily Activity Level (from 1=mostly inactive to 3= highly active)	Very bad	-1.054	0.197	0.000	0.349
	Bad	-0.627	0.063	0.000	0.534
	Fair	-0.047	0.033	0.155	0.954
	Very good	0.159	0.046	0.001	1.172
Having a chronic disease (1= yes, 2=no)	Very bad	-4.174	0.714	0.000	0.015
	Bad	-4.598	0.262	0.000	0.010
	Fair	-2.616	0.049	0.000	0.073
	Very good	3.128	0.178	0.000	2.832
Delaying in access to healthcare due to long appointment times (1= yes, 2=no)	Very bad	-0.612	0.177	0.001	0.542
	Bad	-0.344	0.069	0.000	0.709
	Fair	-0.244	0.041	0.000	0.783
	Very good	0.225	0.066	0.001	1.252
Delaying in access to healthcare due to transportation problems (1= yes, 2=no)	Very bad	-0.877	0.198	0.000	0.416
	Bad	-0.496	0.093	0.000	0.609
	Fair	-0.150	0.066	0.022	0.861
	Very good	-0.090	0.127	0.481	0.914

Delaying in access to healthcare due to having financial difficulty (1= yes, 2=no)	Very bad	-0.980	0.229	0.000	0.375
	Bad	-0.613	0.111	0.000	0.542
	Fair	-0.256	0.079	0.001	0.774
	Very good	-0.123	0.166	0.457	0.884
Delaying in access to medicine due to having financial difficulty (1= yes, 2=no)	Very bad	-0.544	0.250	0.029	0.581
	Bad	-0.777	0.121	0.000	0.460
	Fair	-0.296	0.090	0.001	0.743
	Very good	0.152	0.190	0.423	1.165
Reference category: Good **N**=22742 **Final Model: -2Log Likelihood**: 26769.755 ; **Chi-Square**: 14249.924, **df**: 44, **p**<0.000 **Pseudo R^2**:0.279					

Considering the socio-demographic factors, there are significant associations. Gender is a significant factor for fair and good categories. Males are more likely to rate themselves as fair by %18 and %82,6 as very good ($p<0.001$). Age is associated with all categories. As age increases, the odds of poor and very poor health increase ($Exp(B) = 1.038$, $p < 0.001$) and the odds of very good decrease ($Exp(B) = 0.971$, $p < 0,001$). People with higher education levels are less likely to rate themselves as in poor, very poor, and fair health status. For very poor health status, the probability decreases by 37.9% as the level of education increases ($p < 0.001$), and one unit increase in educational level increase the odds of very good by 1,130 times. Working status is strongly associated with very bad health status. People who actively work are less likely by 31.7% to be in very bad health status. Income is also a significantly related factor. Increasing income has a positive impact on perceived health status, as people with higher levels of income are less likely to classify themselves as very bad category ($Exp(B) = 0.683$, $p < 0.001$).

Daily activity levels affect the perceived health status in favor of those who are mostly active or attain hard work. This group is 53,4% less likely to be in the bad category. Having a chronic condition is a major factor in all health conditions. In individuals with chronic diseases, the odds of very poor health status increase by 98.5%, the probability of poor health increases by 99%, and the probability of moderate health status decreases by 92.7%.

There are also significant relationships between access to healthcare indicators and general perceived health status. People who did not experience delays in access to healthcare due to financial difficulty are less likely to fall into the very bad (37.5%), bad (54.2%), and fair (77%) categories ($p<0.001$). The possibility is similar when delays in access to medicine due to having financial difficulty were examined. The odds were for very bad, bad, and fair, respectively, 58%, 46%, and 74%. Long appointment times and transportation problems are also significant in the possibility of very bad categories, respectively, by 54.2% and 41.6%.

4. DISCUSSION

This study aims to explore the relationship between socio-demographic factors, access to healthcare, and self-perceived health status, using multinomial logistic regression to examine the odds of individuals falling into different perceived health status categories: very poor, poor, fair, good, and very good. The analysis showed that each additional year in age is increasing the possibility of being in the very poor and poor health categories. Educational status showed a significant negative relationship with the likelihood of rating bad health status. People with higher educational attainment were less likely to fall into very bad health and bad health categories. The effects of income and work status were also found to be significant on the odds of falling into perceived health status categories. People with higher income levels were less likely to be in bad and very bad categories. Working individuals were less likely to rate themselves as having very bad and bad health compared to non-working individuals.

These findings are consistent with numerous similar studies that explored the effects of social, economic, and demographic factors on perceived or self-rated health status (Shaaban et al., 2022; Cialani and Mortazavi, 2020; Lamidi, 2020). A very similar study conducted in Türkiye found identical results on the relationship between age, educational level and income level, and self-perceived health status (Ürek et al., 2023). Another study conducted in Türkiye found that higher levels of income and education increase the possibility of good general health status

(Beyaz Sipahi, 2022). A study conducted in China used a population-based survey which is similar to the current study and found that high social and economic class and working population were more likely to rate their health status as good (Cai et al., 2017). Similar findings were found in a study conducted in Japan that highlighted the negative relationship of self-perceived health with age and the positive relationship with employment. (Furuya et al., 2013). The studies conducted by Kim et al. (2010) and Foraker et al. (2011) found that lower socio-economic groups rated lower self-rated health status. A study examining the associations between income inequality and self-rated health status indicated that reducing income disparities can improve health status (Góngora-Salazar et al., 2022).

There are also some more comprehensive studies using panel data or providing comparative results. A study examining OECD countries over a 15-year period includes variables similar to those in the current study as determinants of self-perceived health status. The study adopts a perspective that includes economic, social, environmental, healthcare resource-related, and behavioral factors as determinants. However, the study's distinguishing approach is its aim to explain variations in self-perceived health status across age groups and geographical distributions. The study emphasized that "the relation between selected socioeconomic determinants and the proportion of people who perceived their own health as good or very good is regionally divergent" (Antczak and Miszczyńska, 2020). Another study, which compares EU-17 countries, analyzes the differences in self-perceived health status based on income quintiles within its model. In this study, approaches that can be applied across all income groups to improve self-perceived health status are highlighted as "promoting higher education, increasing labor expenditure, and facilitating upward income transitions". It also emphasizes that improving access to healthcare services can be a significant approach only for the people with high incomes (Răileanu Szeles, 2018). These findings suggest that people with higher socio-economic levels may have better access to health and information or have the ability to obtain and assess health information which is contributing to improved perceived health status. Hence, when these studies' findings are handled together, the current study also highlights the significant influence of economic conditions, as well as factors such as education and employment status, which can shape future economic status, on self-perceived health status.

In the study, a significant association between daily activity level and health status was also found. This finding is identical to similar studies. The study of Cai et al. (2017) found participants with high physical activity rated their health status higher than people with a lower level of physical activity. Olivares-Tirado and Zanga (2024) also found a significant positive association exists between physical activity and self-rated health status by conducting a similar study. Chan et al. (2015) also stated the association of physical inactivity to lower self-rated health status. These studies indicated that a physically active lifestyle improves perceived health status by enhancing social relationships and increasing life happiness. In the present study, findings supporting these conclusions were obtained.

As expected, having a chronic condition was the most significant determinant of perceived general health status. Participants with a chronic disease were found to have a significantly higher likelihood of rating very bad and bad status. The odds of being in fair decreased by 92.7%, indicating a strong negative impact of chronic conditions on perceived general health status. A population-based study also found that chronic diseases were strongly associated with lower perceived health status (Wu et al., 2013). Other studies also found that people with chronic diseases rated lower health status (Cialani and Mortazavi, 2020; Xu et al., 2019). The study of Chan et al. (2015) derived from a national health survey found that chronic diseases, including asthma, arthritis, hypertension, etc., were strongly associated with poor self-perceived health status. The present study also supports this inference in the literature by including a variable encompassing multiple chronic diseases. Hence, these outcomes highlighted the complex nature of health status determinants and emphasized the need to target socio-economically poor populations, especially those affected by chronic diseases.

Perceived general health status is also closely associated with access to healthcare services. People who have to postpone utilization of healthcare services due to not being able to make an appointment or transportation difficulties are significantly more likely to rate their health status as bad or very bad. A similar situation applies to conditions in which people cannot visit a doctor or cannot access medicines due to financial difficulties. Therefore, it can be stated that being able to access healthcare services positively affects individuals' perceptions of their

own health status. To the best of our knowledge, there are no studies that examine the topic using the barriers of access to healthcare variables included in this study. However, in the literature, there are many valuable studies that examined perceived health status with variables such as unmet health needs, satisfaction level with health services, and having health insurance, which may be similar to the variables of the current study. Shaaban et al. (2022) found that barriers to accessing healthcare services were associated with poor and very poor self-perceived health status. Tadiri et al. (2021) conducted a study in Canada and Austria and reported that in both countries perceived health was high and unmet healthcare needs were low. According to the study by Zhao et al. (2018), uninsured adults were about 30% more likely to report their health status as bad/fair health. Paul et al. (2016) reported an association between self-perceived health and satisfaction level with healthcare services.

5. CONCLUSIONS

This study provides insights into the significant role of socio-demographic factors, income, educational attainment, working status, chronic diseases, and access to healthcare in affecting individuals' self-perceived and rated general health status. Older age, lower educational levels, and lower income were associated with worse health status perceptions, while higher levels of physical activity and actively working positively affected perceived health status. Chronic conditions emerged as a key determinant, with affected individuals significantly more likely to report bad status. Additionally, barriers to accessing healthcare services, such as delayed appointments or financial difficulties, were strongly related to negative health status perceptions.

The findings of the current study revealed the complexity of the determinants of health status and provided data on which groups should be prioritized. Health policies should focus on the population within a socio-economically weak condition, supporting education through health literacy, and continuously monitoring perceptions about health status.

Having a health system perspective, it can be stated that ensuring equality and efficiency in access to health services are important factors. Policymakers can develop strategies to facilitate timely and continuous access to appropriate healthcare services. These strategies should encompass not only physical accessibility, such as transportation opportunities to healthcare facilities and adequate appointment systems, but also financial accessibility, including out-of-pocket payments and co-payments.

At this point, a strong communication and connection to be established between primary health services and the society can provide access to adequate health services and improve the perceptions of the health status of the society without increasing the burden on the health system. Moreover, ensuring easy and timely access for individuals with chronic conditions to these primary care services can contribute to improved health outcomes.

As a conclusion, the perceived health status of the population is significantly affected by socio-economic factors, health behaviors, and the level of access to health services. Policymakers should consider the association between these factors when making decisions to develop more effective policies.

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