Sleep-related healthcare use prevalence among adults with insomnia symptoms in Hebei, China: a population-based cross-sectional study

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ABSTRACT
Objective This study investigated the prevalence of sleep-related healthcare use and the factors associated with it among adults with different insomnia symptoms.

Design and setting This was a population-based study with a cross-sectional design conducted in Hebei province, China.

Participants Participants were community residents aged 18 years and above; a total of 21 376 valid questionnaires were analysed.

Primary and secondary outcome measures The Athens Insomnia Scale (AIS) was used to evaluate participants’ insomnia symptoms. Variables such as sleep-related healthcare use, chronic disease, living alone and sociodemographics were assessed for all the participants.

Results Among adults with any insomnia symptoms, only 2.1% used sleep-related healthcare in the past year. Even for adults with insomnia, the prevalence of sleep-related healthcare use was only 6.2%. Furthermore, the prevalence rates of sleep-related healthcare use among adults with sleep induction, night awakenings, earlier awakening, sleep duration, sleep quality, daytime well-being, daytime functioning, and daytime sleepiness were 3.1%, 2.9%, 3.6%, 3.4%, 3.9%, 4.9%, 4.6% and 2.8%, respectively. The following factors were associated with sleep-related healthcare use among adults with insomnia: male (adjusted OR (aOR)=0.52, p<0.01), younger age (aOR=1.02, p<0.01), rural region (aOR=0.45, p<0.001) and AIS score (aOR=1.23, p<0.001). The same factors were also associated with sleep-related healthcare use among adults with insomnia symptoms.

Conclusions The prevalence of sleep-related healthcare use among adults with insomnia symptoms is very low. Young men from rural areas with insomnia symptoms tend not to use healthcare. As such, it is necessary to form policies and strategies to promote sleep-related healthcare use among rural young men with insomnia symptoms.

INTRODUCTION
Insomnia is one of the most prevalent sleep problems in the general population. Previous international epidemiological studies show that the prevalence of insomnia varied from 4.7% to 37.2% in different countries because of the varying criteria of insomnia.1 2 In China, a meta-analysis reported that insomnia was prevalent in approximately 15% of the general population.3 Additionally, the long-term negative impacts of insomnia comprise a multitude of emotional, social and physical problems such as depression,4 hypertension,5 suicidal behaviours6 and so on.7 8 As such, insomnia is an important public health problem in China and various other countries.9 10

Although it is hard for us to accurately evaluate the effect of professional sleep-related healthcare use on insomnia in the general population, professional sleep-related healthcare use is one of the best ways of dealing with insomnia problems. One of the reasons is that a variety of treatments are used for insomnia, including medicine, herbal, psychological interventions, behaviour therapy, and so on.11 However, healthcare use is the best and the most professional method to select an appropriate treatment. Moreover, it is crucial to grasp the prevalence of sleep-related healthcare use’s prevalence among adults with...
insomnia symptoms to understand the insomnia situation. Healthcare use is one of the most important public health aspects of insomnia. Finally, analysing the factors associated with sleep-related healthcare use can inform us of the target populations for intervention and help us manage insomnia problems.

In the past few decades, the impact of insomnia on healthcare use and health has been identified in several countries. However, the prevalence of sleep-related healthcare use among people with insomnia symptoms has been relatively less reported, especially in population-based studies. Previous telephone or postal surveys in Canada and Australia reported that approximately 13% of people with insomnia symptoms used medical care consultation. A secondary analysis of the primary care records or health insurance records in the UK and Chinese Taiwan reported that insomnia’s health-seeking prevalence rates were 4.2% and 19%, respectively. Although all these studies offer critical information on the prevalence of healthcare use among people with insomnia symptoms and the factors associated with it, a population-based face-to-face study is imminently required. This is in consideration of the varying findings, low response rate for telephone or postal surveys, and weakness of the secondary analysis in the previous studies, especially in the Chinese mainland.

Since the prevalence of sleep-related healthcare use among adults is a fundamental factor for insomnia prevention, grasping it is vital to understand the current insomnia situation. We conducted this population-based study to investigate the prevalence of sleep-related healthcare use among adults with different insomnia symptoms and to analyse the factors associated with it. The findings can help us understand the situation of sleep-related healthcare use among adults with different insomnia symptoms and provide valuable information to develop health policies to control and manage insomnia.

PARTICIPANTS AND METHODS

Participants
This was a cross-sectional study conducted in Hebei province in northern China. Hebei is economically prosperous in both industry and agriculture. A multi-stage stratified cluster sampling was used to select the community residents of Hebei. First, five cities (Shijiazhuang, Baoding, Xingtai, Zhangjiakou and Qinhuan-gdao) were randomly selected from all 11 cities of Hebei. Second, three counties and one district were randomly chosen in each selected city. Third, one township or subdistrict was randomly selected from each county or district. Fourth, one village (community) was randomly chosen in each selected township (subdistrict). In total, 15 villages and 5 communities were chosen for the survey. All adult residents (aged 18 years and above) were interviewed, and a total of 21,376 valid questionnaires were collected.

Interviewing procedures
Interviews were conducted from June to August 2018. Before starting the survey, all interviewers received training to fully understand the research and questionnaire contents. A face-to-face interview was scheduled by one interviewer for all participants on obtaining their agreement through a written informed consent form. The interviews were scheduled at the participants’ homes. To ensure interview quality, all questionnaires were checked by different reviewers on each interview day. Participants who returned questionnaires with missing data were revisited or called on the next day.

Patient and public involvement
The public was not involved in the design, conducting, reporting or dissemination plans of the research.

Measures

Sleep-related healthcare use
Sleep-related healthcare use was evaluated using the question ‘Have you ever seen a doctor because of sleep problems in the past year?’ The participant was asked to respond either ‘yes’ or ‘no’. Those who answered yes were considered to use healthcare, while those who answered no were considered to not use healthcare.

Insomnia status

Insomnia status was evaluated using the Chinese version of the Athens Insomnia Scale (AIS), which is a valid instrument based on the International Classification of Diseases, 10th Revision, criteria. Higher scores indicate more severe insomnia symptoms. It contains eight symptoms: sleep induction, night awakenings, earlier awakening, sleep duration, sleep quality, daytime well-being, daytime functioning and daytime sleepiness. Each symptom should occur at least three times a week during the last month to receive a diagnosis of insomnia symptoms (total score ≥1). The Chinese version of the AIS has also been proven to be a reliable and valid instrument. Furthermore, for a diagnosis of insomnia disorder, the optimal cut-off point was a total score ≥7. In this study, we analysed the factors associated with healthcare use among adults with insomnia symptoms (total AIS score ≥1) and adults with insomnia disorder (total AIS score ≥7).

Living alone
Living alone was evaluated by the question ‘How many persons live with you (not including yourself)?’ The answer ‘0’ was considered as living alone (1). All other answers were analysed as not living alone (0).

Chronic disease
Chronic disease was assessed using 13 self-reported items regarding chronic diseases in the past year. Participants were asked whether they had been diagnosed with chronic diseases of the respiratory system, cardiovascular disease, immune system disease, skin complaint, hypertension, diabetes, thyropathy, gastritis, anaemia, anaphylactic rhinitis, cancer or other chronic diseases.
The answers were wither yes or no. Participants who responded ‘no’ to all the items were considered to have no chronic diseases.

**Socialdemographic variables**

Gender was assessed as ‘male’ (1) or ‘female’ (0). Age was calculated by the participants’ date of birth. Ethnicity was evaluated by ‘Han’ (1) or ‘others’ (0). Education level was assessed by academic degree with the following options: ‘elementary school’, ‘middle school’, ‘senior high school’ or ‘above.’ Marital status was evaluated by a question with the following response options: ‘never married’, ‘married’, ‘divorced’, ‘widowed’, ‘deuterogamist’ or ‘others’. Only a small percentage of participants chose the last four options; therefore, we coded marital status as ‘unmarried’ (1), ‘married’ (2) and ‘others’ (3). Monthly income was assessed by a question about participants’ monthly family income. The response options were: ‘no income’, ‘below ¥1000’ (¥7=$1), ‘¥1001–¥3000’, ‘¥3001–¥7000’, ‘¥7001–¥10000’, ‘¥10 001–¥20 000’ or ‘above ¥20 000’. A small percentage of responses were received for the last two categories, and income was recoded as ‘below ¥1000’ (1), ‘¥1001–¥7000’ (2) or ‘above ¥7000’ (3). Participants’ region of residence was classified into ‘urban region’ (0) or ‘rural region’ (1).

**Statistical methods**

Data analysis was conducted using IBM SPSS Statistics for Windows V.24.0 (web version). Descriptive statistics were reported as means and SD for continuous variables, and percentages for categorical variables. Student’s t-test or the χ² test was used to compare the means or proportions.
between those who used sleep-related healthcare use and those who did not. Binary logistic regression with enter method was performed to examine the factors associated with sleep-related healthcare use. Missing data were deleted from the analysis. All significance tests were two-tailed; a p value of 0.05 or lower was considered statistically significant.

**RESULTS**

We interviewed a total of 21,376 community residents in Hebei province, China. The participants’ descriptions are listed in the second column of table 1. The remaining parts of table 1 show the prevalence of healthcare use among the participants. There were 10,718 (50.1%) adults who reported insomnia symptoms, whereas 2,430 adults (11.4%) were categorised as having insomnia disorder. The prevalence of insomnia symptoms ranged from 10.5% to 28.9%. Single analyses revealed that self-reported healthcare use was associated with gender (p<0.001), age (p<0.001), education (p=0.007), marital status (p<0.001), monthly income (p<0.028), living alone (p<0.003), region (p<0.001), chronic disease (p<0.001) and all eight kinds of insomnia symptoms (all p<0.001). In table 1, we analysed the prevalence of sleep-related healthcare use among adults with insomnia symptoms and insomnia disorder.
healthcare use among adults with different insomnia symptoms. Only 2.1% of adults with any insomnia symptom used sleep-related healthcare in the past year. Even among those diagnosed with insomnia disorder, the prevalence of sleep-related healthcare use was 6.2%. Furthermore, among adults with sleep induction, night awakenings, earlier awakening, sleep duration, sleep quality, daytime well-being, daytime functioning and daytime sleepiness, the prevalence rates of sleep-related healthcare use were 3.1%, 2.9%, 3.6%, 3.4%, 3.9%, 4.9%, 4.6% and 2.8%, respectively.

Table 2 shows the results of the analysis between sociodemographic variables and sleep-related healthcare use among adults with insomnia symptoms and insomnia disorder. For adults with insomnia symptoms, gender ($\chi^2$=40.44, p<0.001), age ($t$=6.02, p<0.001), marital status ($\chi^2$=12.41, p=0.002), region ($\chi^2$=17.89, p<0.001), chronic disease ($\chi^2$=20.70, p<0.001), and AIS score ($t$=18.16, p<0.001) were associated with sleep-related healthcare use; for those with insomnia disorder, gender ($\chi^2$=8.25, p=0.004), age ($t$=2.39, p=0.017), region ($\chi^2$=21.01, p<0.001) and AIS score ($t$=4.76, p<0.001) were associated with sleep-related healthcare use.

Table 3 shows the results of the binary logistic regressions with enter method that analysed the factors associated with sleep-related healthcare use among adults with insomnia symptoms and insomnia disorder. Among adults with insomnia symptoms, these factors included male gender (aOR=0.44, p<0.001), age (aOR=1.02, p<0.001), rural region (aOR=0.45, p<0.001) and AIS score (aOR=1.23, p<0.001). Among adults with insomnia disorder, these factors were male gender (aOR=0.56, p<0.01), age (aOR=1.01, p<0.01), rural region (aOR=0.41, p<0.001) and AIS score (aOR=1.13, p<0.001).

**DISCUSSION**

We found that only 2.1% of adults with insomnia symptoms in this study used sleep-related healthcare. Furthermore, the prevalence of healthcare use was only 6.2% even among adults with insomnia disorder (AIS score ≥7).

Sleep-related healthcare use showed a decline in ranking for different insomnia symptoms from daytime wellbeing, daytime functioning, sleep quality, earlier awakening, sleep duration, sleep induction, night awakenings to daytime sleepiness. The results also indicated that participants who were male, of younger age and living in a rural region tended not to use healthcare services when they experienced insomnia symptoms. Considering the high rates of prevalence of insomnia symptoms and the importance of healthcare use for insomnia, these findings are noteworthy.

First, this study revealed the prevalence of insomnia symptoms among adults (age ≥18 years). Almost half of the participants (50.1%) reportedly experienced insomnia symptoms; furthermore, 11.4% of them were at a high risk of insomnia disorder (AIS score ≥7). This is higher than the rates of prevalence in the UK and Korea. However, the findings are similar to those in the USA. The possible reasons for the differences in results may be the different diagnostic criteria and number of insomnia symptoms evaluated in the studies. In two of the studies, only three main kinds of insomnia symptoms (ie, difficulty initiating sleep, difficult maintaining sleep and early morning awakening) were assessed. In other studies, the evaluation of insomnia symptoms did not meet the diagnostic criteria for insomnia (more than three nights a week). However, regarding the prevalence of insomnia disorder, our findings were similar to prior research.

One of the major findings of this study is the prevalence of sleep-related healthcare use among adults with insomnia symptoms in a year; the results showed a very low rate (2.1%) of prevalence. Moreover, even those with insomnia disorder reported a low prevalence rate (6.2%). The rate of prevalence for those with insomnia symptoms was similar to previous studies. One of the possible reasons may be that many people do not consider insomnia symptoms as medical problems. Furthermore, they lack awareness on healthcare use for insomnia symptoms. Another reason may be the high-level use of
complementary and complementary medicine, which was found in previous studies.\textsuperscript{32, 33}

We also analysed the prevalence of sleep-related healthcare use among adults with different insomnia symptoms. Adults with daytime functioning and well-being symptoms showed the highest sleep-related healthcare use. We found that healthcare use was lowest among adults with daytime sleepiness and night awakening; this is worrisome, given the higher prevalence, burden and negative influence of other insomnia symptoms.\textsuperscript{34, 35} These findings may be explained by the perceived seriousness of different insomnia symptoms; participants considered the symptoms of functioning and well-being as more serious than other insomnia symptoms.

This study found that young men in rural regions did not use sleep-related healthcare when they suffered from insomnia symptoms, after controlling the AIS scores. However, women tended to use sleep-related healthcare when they experienced insomnia symptoms. This was consistent with previous findings.\textsuperscript{36} One reason for this may be that the associations of inflammatory markers, cardiovascular diseases and insomnia are stronger in women than in men.\textsuperscript{37–39} We also found that young adults did not use sleep-related healthcare when they experienced insomnia symptoms. These findings were also similar to previous studies.\textsuperscript{15} Compared with older adults, young people may be more careless about their insomnia symptoms, leading to lower inclination to seek medical help. Rural adults with insomnia symptoms also showed a lower level of healthcare use. However, this may be explained by lack of access to healthcare.\textsuperscript{40} The association between AIS scores and healthcare use can also be easily explained; a higher AIS score means more severe insomnia symptoms, which may promote sleep-related healthcare use among adults.

This study also has some limitations that should be considered when interpreting the results. First, this was a cross-sectional study, and the data were collected at a certain time point. Thus, we cannot infer any causal relationships among the factors associated with sleep-related healthcare use. Second, all insomnia symptoms were evaluated based on participants’ self-report in 2018. Therefore, recall bias cannot be avoided; it is also possible that the symptoms changed over time, which may influence the results. Third, sleep-related healthcare use was evaluated by a single question regarding healthcare-seeking behaviour among people with sleep problems. Since there are a variety of sleep problems, the prevalence of sleep-related healthcare use may be over-rated in this study. Finally, the factors associated with sleep-related healthcare use analysed in this study are limited and there may be many more factors associated with healthcare use. However, we obtained a large sample size of 21,376 community residents through a population-based study. Moreover, our findings revealed the prevalence of sleep-related healthcare use and factors associated with it among people with insomnia symptoms. These results are significant in terms of the public health aspects of insomnia.

CONCLUSIONS

In conclusion, the prevalence of sleep-related healthcare use among adults with insomnia symptoms was very low. Considering the high prevalence and burden of insomnia in China, it is vital to control this condition. Policies and strategies should be developed to promote sleep-related healthcare use among adults with insomnia symptoms. Moreover, rural young men were found to not use healthcare services when they suffered from insomnia symptoms. Thus, policies for health education are urgently needed to deal with the situation of sleep-related healthcare use among adults with insomnia symptoms.

REFERENCES


