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Title Page

Educational level and job status are the most important factors affecting compliance to oral antihistamine therapy for patients with chronic urticaria

Running head: Compliance to oral antihistamines in patients with chronic urticaria

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Abstract

Background: Management of chronic urticaria (CU) is often difficult with oral antihistamines (OAs) despite long-term use.

Objective: The aim of this study was to determine the extent of medication compliance (MC) and to assess the factors affecting the MC of CU patients toward OA therapy.

Methods: A 43-item questionnaire was administered to 201 adult patients. A compliance score (CS) of 6 points was chosen as a cut-off point. A CS of 0–6 correspond to poor compliance and scores of 6–9, to good compliance. Subsequently, associations with compliant and poorly compliant groups were made by univariate and multivariate analyses.

Results: The median age and disease duration of all patients was 47 years (range: 18–88) and 15 months (range: 1.5–480), respectively. Overall, the rate of compliant and poorly compliant patients was 53.2% and 46.8%, respectively. Educational level and job status were significantly associated with MC. To have graduated from university and high school increased MC by 9.1- (p=0.002, 95% confidence interval (CI): 2.26-36.37) and 3.6-fold (p=0.019, 95% CI: 1.26-13.47), respectively, compared with illiterates. Patients who had worked previously and were currently

looking for work were 4.8-fold ($p=0.032$, 95% CI: 1.14-19.97) more compliant than patients who had never worked.

Conclusion: Most CU patients had good compliance to OAs. Educational level and job status were significant predictors of MC to OAs in CU. The impact and long-term effects of education and job status should be evaluated in different patient groups.

Key words: chronic urticaria, compliance, oral antihistamines

Introduction

Chronic urticaria (CU) is a common skin disease characterized by itchy wheals and/or angioedema presenting for 6 weeks or more, continuously or intermittently. The prevalence of disease has been estimated at 0.5%–5% in the general population, and the incidence rate for new disease is 1.4 per year (1). The aetiology and pathogenic mechanism of CU is not fully understood. In most cases an identifiable cause has not been elucidated, although many disorders and conditions are associated with CU (1). Because CU is a long-standing and difficult disease to endure, it is often detrimental to patients' quality of life (QoL), well-being, sleep and mood. Studies showed that CU has a heavy impact on QoL by affecting sleep and leading to pruritus, fatigue, social isolation, loss of energy, emotional/sexual difficulties and restrictions in daily activities in terms of work and home (2-4). Oral antihistamines (OAs) are the mainstays of treatment. However, management of CU is often difficult with OA therapy, despite long-term use. Thus, medication compliance (MC) is a key factor in achieving successful outcomes for these patients. In practice, compliance is the patient's desire to follow medical advice regarding diagnosis and/or treatment (5). Compliance can be affected not only by patient-related factors but

also treatment-, doctor- and disease-related factors (5). The aim of this study was to determine the extent of MC and to assess the factors affecting the MC of CU patients toward OA therapy.

Materials and Methods

Study design and patients

The study took place in the Dermatology Department of Ankara Numune Training and Research Hospital between November 2016 and January 2018. The diagnosis of CU was based on a thorough history of spontaneous hives lasting for 6 weeks or longer and a physical examination. Two hundred one patients with CU fit the inclusion criteria and completed the questionnaire. Patients who were 18 years and older, had been diagnosed with CU, received only OA for the treatment of CU and agreed to join to the study were eligible to participate in this study. The exclusion criteria were acute urticaria, age younger than 18 years and previous or current treatment with any agents other than OA.

Data collection and measurements

A 43-item questionnaire possibly relevant to CU patients was administered by dermatologists. The survey took about 10-15 minutes to complete. The questionnaire was divided into 2 domains: items evaluating patient-, disease-, doctor- and treatment-related factors associated with MC (35 items, Table 1) and items measuring the degree of MC (8 items, Table 2). The patients' overall compliance score (CS) was calculated from the responses to the each of 8 items on a 9-point scale (Table 2). A CS of 6 points was chosen as a cut-off point, because median CS for the entire study population was 6 (range: 0-9). A CS of 0–6 correspond to poor compliance and scores of 6–9, to good compliance. Subsequently, associations with compliant and poorly compliant groups were made by univariate and multivariate analyses after classification.

Statistical analyses

Statistical Package for the Social Sciences version 21.0 (IBM SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp.) was used for all statistical analyses. Descriptive statistics were used to define demographic characteristics of patients. Categorical variables were presented in percentage and frequency. A Shapiro-Wilk test was used to evaluate numeric variables (age, duration of disease, the number of people living at home) for the normal distribution. No numeric variables satisfied the normality assumption in this study. Data were expressed as median $\pm$ interquartile range (IQR), minimum and maximum for all numeric variables.

Differences in numeric variables between compliant and poorly compliant groups were analyzed by using the Mann-Whitney U test. The chi-square test (χ^2) was used to identify differences in categorical variables between compliant and poorly compliant groups. Multivariate logistic regression analysis was used to analyze variables with P-value cut-off point of 0.15. The strength of the association between variables and patient compliance was assessed by odds ratios (ORs) with the corresponding 95% confidence intervals (CIs). Statistical significance was defined as $p < 0.05$.

The study was approved by the Ankara Numune Training and Research Hospital Ethics Committee of Clinical Studies with the code of E-16-1026 on 19 October 2016. All procedures performed in the study were in accordance with the ethical principles of the 1964 Helsinki declaration.

Results

The study enrolled 201 patients (137 women, 64 men) with a median age of 47 years (range: 18–88) and median disease duration of 15 months (range: 1.5–480). Overall, the rate of compliant and poorly compliant patients was 53.2% and 46.8%, respectively. One patient scored the lowest possible total compliance score of 0, whereas 9 patients scored the highest possible total compliance score of 9 points. The differences between compliant and poorly compliant groups with respect to demographic characteristics and study variables obtained by univariate analyses are shown in Table 1. For compliant vs. poorly compliant patients, the median age and median disease duration were 43 vs. 51.5 years and 12 vs. 24 months, respectively ($p=0.001$ and $p=0.018$). Univariate analyses revealed an association with educational level, the presence of making an exploration of disease or medication, the presence of being currently under OA therapy during the study or the presence of underlying systemic diseases and MC ($p=0.017$, $p=0.016$, $p=0.003$ and $p=0.006$, respectively). Because therapy cessation due to complete recovery was the main reason for not obtaining active treatment during the study, it may not be appropriate to relate this factor to MC. The remaining parameters did not show any effects on MC in patients with CU (Table 2).

Multivariate logistic regression analyses were used to analyze variables with a P-value cut-off point of 0.15 via following elimination of confounding factors. This analysis showed that no factor was associated with MC, except educational level and job status ($p=0.012$ and $p=0.037$). To have graduated from university and high school increased patient compliance by 9.1- ($p=0.002$, 95% confidence interval (CI): 2.26–36.37) and 3.6-fold ($p=0.019$, 95% CI: 1.26–13.47), respectively, compared with illiterates. Furthermore, patients who had worked previously and were currently looking for work were 4.8-fold ($p=0.032$, 95% CI: 1.14–19.97)

more compliant than patients who had never worked. Therefore, educational level and job status were significant predictors of MC to OAs in CU in this study (Table 3).

Discussion

This study confirmed that most CU patients have good compliance to OAs and that educational level and job status have significant impacts on MC to OAs in CU. CU is a disease of high prevalence with a considerable impact on patients' lives. OAs are recommended as the first-line therapy for CU. Compliance with OAs, the most commonly used agents in the treatment of CU, is likely to be affected by the patients' educational level and job status according to the present study results.

MC is an important issue, particularly for chronic diseases (6). The World Health Organization published a report in 2003 indicating that adherence rates among patients with chronic illnesses are approximately 50% in developed countries (7). Medication adherence and QoL of patients with CU have been investigated in previous studies, revealing heterogeneous and variable results. Heng et al. conducted a study in Singapore with 103 CU patients, showing that most patients had low adherence to medical therapy. Moreover, the authors demonstrated that the patients' adherence to medications did not affect the QoL of patients with CU (4). Kaneko et al. investigated the adherence to oral and topical medications in urticaria by using the Morisky Medication Adherence Scale-8. This study was conducted on 751 patients with urticaria, suggesting that adherence to oral medication was significantly associated with the frequency of hospital visits (8). Another study on 98 patients with chronic spontaneous urticaria (CSU) demonstrated that education of primary care practitioners and guideline-dependent patient management improved patient outcome (9). A study from Spain evaluated patient adherence to published guidelines in the daily management of CU. The authors reported a high frequency of

prescription of sedating antihistamines, which could have negative impact on disease control and patient satisfaction (10). Another study from Italy investigating physician and patient attitudes toward CSU showed that 62% of patients confirmed that CSU had a negative impact on QoL. Management of patients based on urticaria guidelines and QoL-related needs are the main factors influencing treatment satisfaction (11).

Overall, the rates of compliant and poorly compliant patients were 53.2% and 46.8% in the present study, respectively. This study revealed that most patients were compliant with OA treatment regimens. For compliant vs. poorly compliant patients, the median age was 43 vs. 51.5 years. This may be explained by younger patients being more concerned about their health than older patients and older patients possibly having a low capacity to understand the medication. The impact of age on therapeutic compliance in several diseases remains controversial. Senior et al. (8) and Hertz et al. (9) found that older people might have higher compliance, whereas Balbay et al. (10) and Okuno et al. (11) observed that advancing age affects compliance adversely among older people. However, the present study showed that age had no significant impact on patient compliance after confounding factors are eliminated in multivariate analysis.

In this study, median disease duration in compliant vs. poorly compliant patients was 12 vs. 24 months, respectively. Chronicity of disease, frequent dosing, complex therapy regimens and asymptomatic periods may have adverse effects on compliance. Although there is no study in the literature evaluating the role of disease duration in patient compliance in CU, Poon et al. (2) demonstrated large variation within different urticarial subsets, suggesting that patients with chronic forms of urticaria display social and work restrictions. Some studies of chronic illnesses demonstrated that patient compliance increased with increasing disease duration, although no study compared acute and chronic forms of urticaria in terms of patient compliance. The

relationship between chronicity of disease and good compliance may be due to a reduction of disease denial in patients suffering for a long time from the same disease; this may improve therapeutic compliance in the form of treatment acceptance. However, the present study showed that disease duration had no significant impact on MC after confounding factors are eliminated in multivariate analysis.

The strongest association with MC in this study was educational level. To have graduated from university and high school increased patient compliance by 9.1 and 3.6 times, respectively, compared with illiterates. A review exploring factors affecting therapeutic compliance showed that the effect of educational level on compliance remains controversial (12). Several studies of different disease groups indicated that patients with higher educational levels might have higher compliance (13, 14), whereas some studies found no association between education and compliance (15, 16). Regarding the present study results, patients with high educational levels may have been more likely to understand the disease and the medication, and this may have enhanced MC.

The present study also confirmed that job status has a substantial impact on MC. Patients who had worked previously and were currently unemployed were 4.8 times more compliant than those who had never worked. This may be because having previously worked in a regular job may enhance compliance by affecting personal discipline and may facilitate access to health care services and medications. Moreover, patients may achieve good compliance by improving their health through therapeutic adherence to the search for a job.

The main limitations of the present study are its questionnaire format and the high proportion of women. Generalization of the study findings to the entire population might be a concern because the study was carried out at a single research centre. Because this study was

conducted in a tertiary hospital, it is possible that patients who were admitted to our department were more refractory to treatments. We could not make any comment on MC in children with CU due to the lack of patients younger than 18 years of age.

In conclusion, this study demonstrated that education level and job status were significant predictors of patient compliance to OAs in CU. Improving educational level and gaining regular work might influence compliance to OAs positively in patients with CU. Future studies should look at the long-term effects and the possible impact of educational level and job status on MC in patients with CU to OAs in different patient groups.

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Table 1. Comparison of demographic characteristics and study variables of compliant and poorly compliant patients according to univariate analysis.

Patient information	compliant patients n = 107 (%)	poorly compliant patients n = 94 (%)	p value
Sex			0.530
Male	32 (29.9%)	32 (34%)	
Female	75 (70.1%)	62 (66%)	
Age (median, minimum-maximum; years)	43.0 (18-88)	51.5 (21-88)	0.001
Disease duration (median, minimum-maximum; months)	12.0 (1.5-480)	24.0 (1.5-264)	0.018
Marital status			0.231
Married	81 (75.7%)	70 (74.5%)	
Single	16 (15.0%)	9 (9.6%)	
Divorced or widowed	10 (9.3%)	15 (16.0%)	
Job status			0.089
Full-time (≥ 32 h/week)	42 (39.3%)	33 (35.1%)	
Part-time (< 32 h/week)	5 (4.7%)	3 (3.2%)	
Retired	11 (10.3%)	16 (17%)	
Never worked before	36 (33.6%)	39 (41.5%)	
Unemployed and looking for work	13 (12.1%)	3 (3.2%)	
Educational level			0.017

Elementary school	20 (18.7%)	27 (28.7%)	
Middle school	19 (17.8%)	20 (21.3%)	
High school	36 (33.6%)	23 (24.5%)	
University	24 (22.4%)	9 (9.6%)	
No education	8 (7.5%)	15 (16.0%)	
Monthly income, ₺			0.105
< 1000	19 (17.8%)	25 (26.6%)	
1000-2000	26 (24.3%)	30 (31.9%)	
2000-3000	18 (16.8%)	15 (16.0%)	
≥ 3000	15 (14.0%)	5 (5.3%)	
No income	29 (27.1%)	19 (20.2%)	
Who are you living with?			0.552
single	12 (11.2%)	10 (10.6%)	
he/she and his/her wife/husband	19 (17.8%)	20 (21.3%)	
he/she, his/her wife/husband and children	53 (49.5%)	39 (41.5%)	
he/she and children	8 (7.5%)	13 (13.8%)	
he/she, mother/father and sibling/siblings/other	15 (14.0%)	12 (12.8%)	
How many people do you live at home?			0.345
1	12 (11.2%)	10 (10.6%)	
2	22 (20.6%)	27 (28.7%)	
3	19 (17.8%)	19 (20.2%)	
4	31 (29.0%)	20 (21.3%)	
5	19 (17.8%)	10 (10.6%)	

6	2 (1.9%)	6 (6.4%)	
7	2 (1.9%)	2 (2.1%)	
Do you have any systemic illnesses and are you taking any medicine for those?			0.006
None	61 (57.0%)	44 (46.8%)	
I have systemic disease but do not take any medication for it	8 (7.5%)	7 (7.4%)	
I have systemic disease and take one medication for it	24 (22.4%)	11 (11.7%)	
	5 (4.7%)	16 (17.0%)	
I have systemic disease and take two drugs for it	9 (8.4%)	16 (17.0%)	
I have systemic disease and taking three or more drugs for it			
Are you worried about the disease or about the medicine you are taking?			0.683
No worries about both of them	34 (31.8%)	36 (38.3%)	
Worried about the disease	38 (35.5%)	28 (29.8%)	
Worried about the medications	16 (15.0%)	16 (17.0%)	
Worried about both the disease and the medications	19 (17.8%)	14 (14.9%)	
Have you ever met an unfavorable condition related to the disease or the medication you are taking?			0.321
Never	45 (42.1%)	48 (51.1%)	
I have negative attitudes towards therapy and/or	19 (17.8%)	13 (13.8%)	

medications such as anxiety, fear or anger			
I can't participate in daily activities and it interferes my work	8 (7.5%)	3 (3.2%)	
The disease and/or the medication restrict daily activities but I keep doing my daily work	29 (27.1%)	28 (29.8%)	
I am embarrassed in going to public places due to the feeling of being stigmatized in society	6 (5.6%)	2 (2.1%)	
Have you ever made any exploration of disease or medication from journals, newspapers, internet or news?			0.016
Yes	67 (62.6%)	43 (45.7%)	
No	40 (37.4%)	51 (54.3%)	
Do you smoke cigarette?			0.713
Yes	46 (43.0%)	38 (40.4%)	
No	61 (57.0%)	56 (59.6%)	
Do you use alcohol?			0.157
Yes	23 (21.5%)	13 (13.8%)	
No	84 (78.5%)	81 (86.2%)	
How long does it take to reach to the physician? (minutes)			0.222
<10	40 (37.4%)	27 (28.7%)	
10-30	58 (54.2%)	53 (56.4%)	
30-60	9 (8.4%)	14 (14.9%)	
The continuity of the hives in the last one month			0.849

more than thrice a week	58 (54.2%)	45 (47.9%)	
less than thrice a week but have an attack every week	32 (29.9%)	32 (34.0%)	
attack every month	8 (7.5%)	8 (8.5%)	
asymptomatic for the last month	9 (8.4%)	9 (9.6%)	
The frequency of hospital visits up till now			0.241
1-3 times	26 (24.3%)	21 (22.3%)	
3-5 times	45 (42.1%)	33 (35.1%)	
5-10 times	19 (17.8%)	14 (14.9%)	
>10 times	17 (15.9%)	26 (27.7%)	
Hospitalization due to CU			0.745
Yes	33 (30.8%)	31 (33.0%)	
No	74 (69.2%)	63 (67.0%)	
Cost of treatment			0.556
Nothing	28 (26.2%)	33 (35.1%)	
<20£/drug package	58 (54.2%)	43 (45.7%)	
20-50£/drug package	18 (16.8%)	15 (16.0%)	
50-100£/drug package	3 (2.8%)	3 (3.2%)	
CU diagnosis was confirmed by:			0.467
general practitioner	18 (16.8%)	21 (22.3%)	
family practitioner	17 (15.9%)	20 (21.3%)	
dermatologist	59 (55.1%)	43 (45.7%)	
allergist/other	13 (12.1%)	10 (10.6%)	

Did your doctor explain the detailed description of the medication to you?			0.094
Yes	87 (81.3%)	67 (71.3%)	
No	20 (18.7%)	27 (28.7%)	
Did your doctor make eye contact with you?			0.618
Yes	55 (51.4%)	45 (47.9%)	
No	52 (48.6%)	49 (52.1%)	
What was the recommended regimen for initial therapy of CU?			0.268
single OA once a day	40 (37.4%)	46 (48.9%)	
single OA two times a day	29 (27.1%)	14 (14.9%)	
single OA three or four times a day	6 (5.6%)	5 (5.3%)	
two OA once-once daily	23 (21.5%)	22 (23.4%)	
two OA twice-twice and more a day	9 (8.4%)	7 (7.4%)	
What is the last recommended treatment regimen you are using?			0.405
once daily single OA	19 (17.8%)	23 (24.5%)	
single OA two times a day	18 (16.8%)	17 (18.1%)	
single OA three times a day	10 (9.3%)	14 (14.9%)	
single OA four times a day	24 (22.4%)	12 (12.8%)	
two OA once-once daily	7 (6.5%)	9 (9.6%)	
two OA twice-once daily	9 (8.4%)	6 (6.4%)	
two OA twice-twice daily	12 (11.2%)	5 (5.3%)	

two OA more than twice-twice daily	6 (5.6%)	5 (5.3%)	
no treatment	2 (1.9%)	3 (3.2%)	
What is the recommended treatment regimen for you after applying to our clinic?			0.829
OA once a day	8 (7.5%)	10 (10.6%)	
OA two times a day	13 (12.1%)	14 (14.9%)	
OA three times a day	5 (4.7%)	9 (9.6%)	
OA more than three times a day	11 (10.3%)	9 (9.6%)	
OA every two days	4 (3.7%)	2 (2.1%)	
Systemic corticosteroids	17 (15.9%)	16 (17.0%)	
Cyclosporin	7 (6.5%)	4 (4.3%)	
Omalizumab	39 (36.4%)	28 (29.8%)	
Montelukast	3 (2.8%)	2 (2.1%)	
Are you troubled by drugs' side effects? If yes, please explain.	42 (39.3%)	45 (47.9%)	0.432
No drugs' side effect was notified.	22 (20.6%)	20 (21.3%)	
Drug side effect occurred, but passed in a short time, it was not persistent	36 (33.6%)	22 (23.4%)	
Drug side effect occurred and continued with intervals	7 (7.4%)	7 (7.4%)	
Drug side effect occurred and became persistent			
How do you deal with drugs' side effects?			0.676

The drug is discontinued due to side effects and a new medication was started.	18 (16.8%)	11 (11.7%)	
The drug is continued at the same dose despite side effects.	36 (33.6%)	30 (31.9%)	
The treatment was continued by reducing the dose of the drug due to side effects.	4 (3.7%)	4 (4.3%)	
A new medicine was initiated to treat side effects of responsible medicine.	7 (6.5%)	4 (4.3%)	
No drugs' side effect was notified.	42 (39.3%)	45 (47.9%)	
What is the treatment response to OA therapy?			0.178
complete recovery	1 (0.9%)	1 (1.1%)	
recurrence after complete recovery	14 (13.1%)	25 (26.6%)	
recurrence after partial recovery	18 (16.8%)	16 (17.0%)	
partial recovery	37 (34.6%)	27 (28.7%)	
no recovery	37 (34.6%)	25 (26.6%)	
Are you currently under medical treatment for CU?			0.003
Yes	101 (94.4%)	76 (80.9%)	
No	6 (5.6%)	18 (19.1%)	
Has the treatment been started in our clinic for patients who are currently under OA treatment?			0.361
Yes	57 (54.3%)	39 (47.6%)	
No	48 (45.7%)	43 (52.4%)	
When did you apply to our clinic?			0.486

before control date	36 (33.6%)	22 (26.2%)	
on control date	36 (33.6%)	29 (34.5%)	
after control date	35 (32.7%)	33 (39.3%)	
What time have the treatment been stopped?			0.678
before the end of one box of drug	15 (14.0%)	12 (12.8%)	
when a box of drug is over	17 (15.9%)	20 (21.3%)	
after more than one box of drug used	28 (26.2%)	27 (28.7%)	
the treatment was not ceased ever	47 (43.9%)	35 (37.2%)	
What are the reason/reasons for cessation of the therapy in patients who experienced treatment disruption? ^a			0.660
The complexity and the long duration of the treatment	5 (4.7%)	5 (5.3%)	
	5 (4.7%)	3 (3.2%)	
Intolerance or side effects	2 (1.9%)	3 (3.2%)	
Difficulty in taking the drug according to timetable	23 (21.5%)	16 (17.0%)	
Inefficiency of the therapy	17 (15.9%)	22 (23.4%)	
Complete recovery	3 (2.8%)	5 (5.3%)	
Inadequate knowledge about the disease	6 (5.6%)	6 (6.4%)	
The perception of disease improvement			
Are you satisfied with the OA therapy?			0.521
Not satisfied at all	35 (32.7%)	23 (24.7%)	
Mildly satisfied	38 (35.5%)	34 (36.6%)	
Moderately satisfied	23 (21.5%)	27 (29.0%)	
Very satisfied	11 (10.3%)	9 (9.7%)	

n, number; IQR, interquartile range; CU, chronic urticaria; OA, oral antihistamine; $p < 0.05$ is defined statistically significant and shown in bold.

^a Patients who had never experienced therapy cessation were not included in this question.

Table 2. Questions evaluating the degree of MC and scores given according to the answers.

Question	n = 201	Score
Do you know the name of the treatment you are using for CU?		
Yes	116 (57.7%)	1
No	85 (42.3%)	0
Do you know the name of the disease you are suffering from?		
Yes	109 (54.2%)	1
No	92 (45.8%)	0
How do you manage of acute exacerbations in CU?		
I increase dosage of the drug by myself	25 (12.4%)	0
I stop using the drug	6 (3.0%)	0
I prefer alternative or holistic approaches	20 (10.0%)	0
I apply to the emergency service without stopping the drug	87 (43.3%)	1
I apply to my doctor without stopping the drug	63 (31.3%)	2
How did you use the drug?		
I used it as my physician told.	156 (77.6%)	1
I used it according to the description of the pharmacist.	16 (8.0%)	0

I used it according to the people around me such as neighbors, friends or familiars.	7 (3.5%)	0
I used it as the dosage I chose.	22 (10.9%)	0
Do you sometimes forget to take your drug?		
Yes	66 (32.8%)	0
No	135 (67.2%)	1
Do you take your drug on proposed time?		
Yes	119 (59.2%)	1
No	82 (40.8%)	0
Do you sometimes stop taking your drug when you feel like your symptoms are under control?		
Yes	62 (30.8%)	0
No	139 (69.2%)	1
Have you ever cut back or stopped taking your drug because you felt worse when you took it?		
Yes	60 (29.9%)	0
No	141 (70.1%)	1

n, number; MC, medication compliance; CU, chronic urticaria

Table 3. Multivariate logistic regression analysis for variables in compliant and poorly compliant groups.

Variable	p value	OR (95% CI)
Educational level	0.012	
No education		1 (ref)
High school	0.019	3.6 (1.26-13.47)
University	0.002	9.1 (2.26-36.37)
Job status	0.037	
Not worked before		1 (ref)
Unemployed and looking for work	0.032	4.8 (1.14-19.97)

OR, Odds ratio; CI, confidence interval. $p < 0.05$ is defined statistically significant.