



EUROSTAT QUALITY PROFILE

Indicator (definition)	Healthy Life Years (women, men) Healthy Life Years measures the number of years that a person at birth is still expected to live in a healthy condition (also called disability-free life expectancy).
Eurostat Unit	F5, Health and Food Safety
Other Commission DGs	DG SANCO
European Statistical System Working Group (WG)	Public Health Statistical Working Group
Date	22 May 2007

1. Overall assessment of accuracy and comparability (Description of quality grades under the following link: http://circa.europa.eu/Public/irc/dsis/structind/library?l=/general_information/quality_profiles/annex_enpdf/EN_1.0_&a=d)

A B C Indicator to be developed

Comparability across countries (between new Member States, Accessing/Candidate Countries and EU-15 Member States) is restricted as there are no common survey instruments and methodologies. Comparability over time will have to be re-assessed once data become available from EU-SILC.

2. Objective and relevance of the indicator:

The indicator Healthy Life Years (HLY) is a solid indicator to monitor health as a productivity/economic factor. HLY introduces the concept of the quality of life. One of the main advantages of the indicator is that it is easily readable by everybody.

At the Göteborg European Council (2001) public health was singled out as one of the four priority areas for the sustainable development strategy. The Council noted that the possibility of the creation of a European surveillance and early warning network on health issues be examined.

In the Report from the Commission to the Spring European Council (January 2004) the Commission took a commitment to examine the possibilities for integrating public health into the Lisbon strategy by 2005, as a contribution to growth and sustainable development.

In addition, the Commission presented health as a precondition for economic prosperity in its Financial Perspectives 2007-2013 Communication where it also stressed the economic impact of illnesses on productivity and work.

Restriction of the indicator's relevance and other characteristics which may lead to restrictions in using it in monitoring and reporting

The following assumption has been made:

The average prevalence of disability of 0-14 years old (not available in surveys) is supposed to be half of the prevalence of the next age group (16-19).

3. Data availability: details

(t ₁ : earliest reference year available; t ₂ : latest reference year available in May 2007)				
	EU Member States	ACC/CC	USA and Japan	EFTA ¹
t ₁	1995: BE, DK, DE, GR, ES, FR, IT, NL, PT, UK 1996: PL (1996 only), FI 1997: SE 1999: IE, 2000: AT 2002: CZ, MT, PL	-	-	-
t ₂	2003: BE, DK, DE, GR, ES, FR, IE, IT, CY, HU, NL, AT, PT, FI, SE, UK	-	-	2003: NO IS, CH: no data

Comments (including information on time series): The indicator is available for men and women only, while a global figure is not calculated given the high differences between men and women in terms of life expectancies.

Prevalence measurement of the proportion of population with and without disabilities

From 1995 to 2001, data from the European Community Household Panel (ECHP) have been used for the EU-15 Member States (for Finland from 1996 and for Sweden from 1997 from the Swedish survey on living conditions that provides comparable micro data). For Germany and UK, the values over the period 1997-2001 are estimated from the ECHP 1995-1996 values and relative evolutions over the period 1997-2001 in national sources. For Luxembourg, the ECHP data are available only for 1995 and 1996. The successor of ECHP, the EU-Statistics on Income and Living Conditions (EU-SILC) is being launched in the countries at different times:

2003 (interim version): BE, DK, GR, IE, LU, AT plus Norway

2004: ES, FR, IT, PT, FI, SE

2005: UK, NL, DE and the new Member States

During the transition between end-ECHP and start EU-SILC, for the EU15- calculation is based on extrapolated disability prevalence data from the ECHP 1995-2001 series; calculation from national data if the surveys and questions are comparable with ECHP, at least for CZ (2002), PL (2002), MT (2002) CY (2003), HU (2003)

As the disability is a phenomenon which changes slowly in time, in the calculations for 2002 and 2003 it was made the assumption that the evolution of the prevalence is linear.

The first set indicators from EU-SILC which covers all Member States will be available in Spring 2007.

Mortality data

Life tables which give mortality data for calculating the life expectancy are available from demographic statistics. For few countries and/or years where no data on mortality are available, the values from the previous year are used.

4. Overall accuracy

High



The indicator is calculated following the Sullivan method which is widely used by experts. It is based on prevalence measures of the age specific proportion of population with and without disabilities and on mortality data. Its interest lies in its simplicity, the availability of its basic data and its independence of the size and age structure of the population. Accuracy is good even if there exist some general restrictions:

- Institutional households are not included in the ECHP itself. However, it is assumed that the population living in the private households covered by ECHP is representative for the total population. Simulation carried out by Eurostat has shown that the effect of this assumption for the indicator HLY at birth is very limited and not significant.
- In some cases, because of a lack of information, the life expectancy at the last age was taken from another year.
- Revisions enable to update mortality data.

Regarding technical questions, regular consultation with the DG SANCO

¹ While being a member of the EFTA, Liechtenstein has complete or partial exemptions from several statistical requirements due to its size. Thus, Liechtenstein is excluded from this overview as most of the data for structural indicators are missing.

and its project European health expectancy monitoring unit (EHEMU – Euro-Reves network) have been held.

Restricted
(sources, errors,
methodology, etc.)

5. Comparability across countries

High
Restricted

Comparable data is available for EU-15 countries (except LU). Also, the breakdowns available (by sex) are the same. The ECHP uses standardised design and common technical and implementation procedures across countries. However, the main problem resides in the cultural differences from country to country. The questions on the existence of disabilities might be interpreted differently from a country to another one. It implies that the prevalence might differ between countries whereas there is no real difference in the health levels between those countries.

Another problem is the fact that data about prevalence of disability for Germany and the UK come from original surveys adapted to the ECHP format.

As there are no common survey instruments and methodology in the new Member States and Acceding/Candidate Countries, comparability among them as well as between them and the EU-15 Member States is restricted. However, efforts will be made to ensure maximal comparability with the ECHP.

The HLY indicator is calculated using the same method (Sullivan's) for all countries.

6. Comparability over time

High

Results for the period 1995-2001 are comparable and the extrapolation over 2002 and 2003 ensures a similar comparability for the estimated values for these two years. Actually, the restrictions on the comparability across countries apply on the "level" of the Healthy Life Years but not on its evolution.

Due to transition between end-ECHP and start-EU-SILC, there will be disruptions in series between 2003 and 2005, the extent to be examined once the data have become available.

Restricted

7. Development perspective for improving the quality of this indicator (including as far as possible an indication of the burden on Member States and respondents.)

Census based information on people living in institutions can be included in a second stage to take their specific characteristics into account in the calculation.

Possibility of crossing answers to several questions on health (self-perceived health with existence of disability) to obtain more accurate prevalence measures.

EU-wide implementation of EU-SILC as a data source will provide a high standard of harmonization.

8. Contribution to quality of the set/potential to qualify for an integrated policy analysis

Relevant European legislation:

Decision No 1786/2002 of the European Parliament and the Council of 23/09/2002 adopting a programme of Community action in the field of public health (2003 - 2008)

Decision No 2367/2002/EC of the European Parliament and of the Council of 16/12/2002 on the Community statistical programme 2003 to 2007

Commission Regulation (EC) No 1983/2003 of 7 November 2003 implementing Regulation (EC) 1177/2003 of the European Parliament and of the Council concerning Community statistics on income and living conditions (EU-SILC) as regards the list of target primary variables

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