

Perceived health status

In almost all OECD countries, a majority of the adult population reports their health as good or better than good (Figure 6.4). Australia, Canada, New Zealand and the United States are the four leading countries, with almost nine out of ten people reporting to be in good health. However, the response categories offered to survey respondents in these three countries are different from those used in European countries and Asian OECD countries: they offer one more option on the positive side of the scale (“excellent”) and one less option on the negative side (very poor). This introduces an upward bias in the results. On the other hand, less than half of the adults in Japan, Korea and Portugal rate their health as good or very good. The proportion is also relatively low in Chile, Estonia, Hungary, Latvia and Poland, where less than 60% of adults consider themselves to be in good health. Such differences in self-assessed health status could in part stem from cultural biases.

In all OECD countries except in Australia and New Zealand, men are more likely than women to report being in good health. The gender gap is especially large in Chile, Portugal, the Slovak Republic and Turkey.

There are also large disparities in self-reported health across different socio-economic groups, as measured for instance by income or education level. Figure 6.5 (Panel A) shows that, in all countries, people with a lower level of income tend to report poorer health than people with a higher income, although the gap varies. **On average across OECD countries, nearly 80% of people in the highest income quintile reports being in good health, compared with just over 60% for people in the lowest income group.** These disparities may be explained by differences in living and working conditions, as well as differences in health-related lifestyles (e.g. smoking, harmful alcohol drinking, physical inactivity and obesity problems). In addition, people in low-income households may have more limited access to certain health services, for financial or non-financial reasons. It is also possible that the causal link goes the other way around, with poor health status in the first place leading to lower employment and lower income.

Self-reported health across different socio-economic groups is also available for the youth population aged 16-29 for European countries (Figure 6.5, Panel B). Unsurprisingly youth report higher levels of health status. Again **youth with a lower level of income tend to report poorer health than youth with a higher income but the gap tend to be smaller than the one measure than for the population as a whole.** However, the socio-economic gap is particularly important with 12 to 14 percentage points in Estonia, Germany and Portugal.

Definition and measurement

Perceived health status reflects people’s overall perception of their health, including both physical and psychological dimensions. Typically ascertained through health interview surveys, respondents are asked a question such as: “How is your health in general? Is it very good, good, fair, poor, very poor?”. OECD Health Statistics provides figures related to the proportion of people rating their health to be “good/very good” combined.

Caution is required in making cross-country comparisons of perceived health status, for at least two reasons. First, people’s assessment of their health is subjective and can be affected by factors such as cultural background and national traits. Second, there are variations in the question and answer categories used to measure perceived health across surveys and countries. In particular, the response scale used in Australia, Canada, New Zealand and the United States is asymmetric (skewed on the positive side), including the following response categories: “excellent, very good, good, fair, poor”. The data in OECD Health Statistics refer to respondents answering one of the three positive responses (“excellent, very good or good”). By contrast, in most other OECD countries, the response scale is symmetric, with response categories being: “very good, good, fair, poor, very poor”. The data reported from these countries refer only to the first two categories (“very good, good”). Such a difference in response categories biases upward the results from those countries that are using an asymmetric scale.

Self-reported health by income level is reported for the first quintile (lowest 20% of income group) and the fifth quintile (highest 20%). Depending on the surveys, the income may relate either to the individual or the household (in which case the income is equalised to take into account the number of people in the household).

Further reading

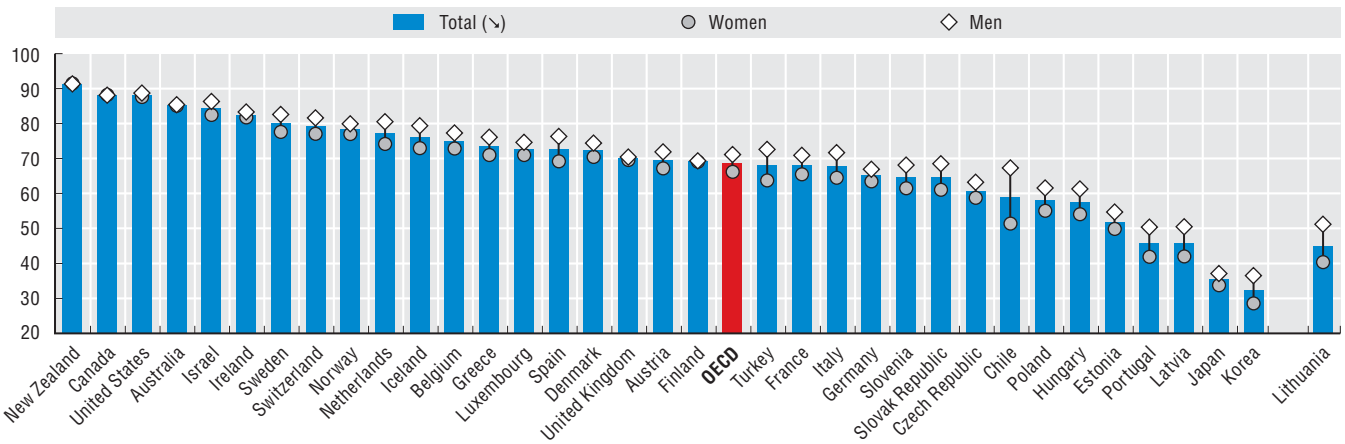
OECD (2015), *Health at a Glance 2015 – OECD Indicators*, OECD Publishing, Paris, http://dx.doi.org/10.1787/health_glance-2015-en.

Figure notes

Figures 6.4 and 6.5: Results for Australia, Canada, Chile, Israel, New Zealand and the United States are not directly comparable with those for other countries, due to methodological differences in the survey questionnaire resulting in an upward bias. Data refer to 2009 for Chile and 2013 for Japan instead of 2014. No data for Mexico nor for youth aged 16-29 for non-European countries. Countries are ranked from left to right in decreasing order as in Figure 6.4.

6.4. A majority of the adult population reports their health as good

Percentage of adults aged 15 and over reporting to be in good or better than good health, by gender, 2014 (or nearest year)

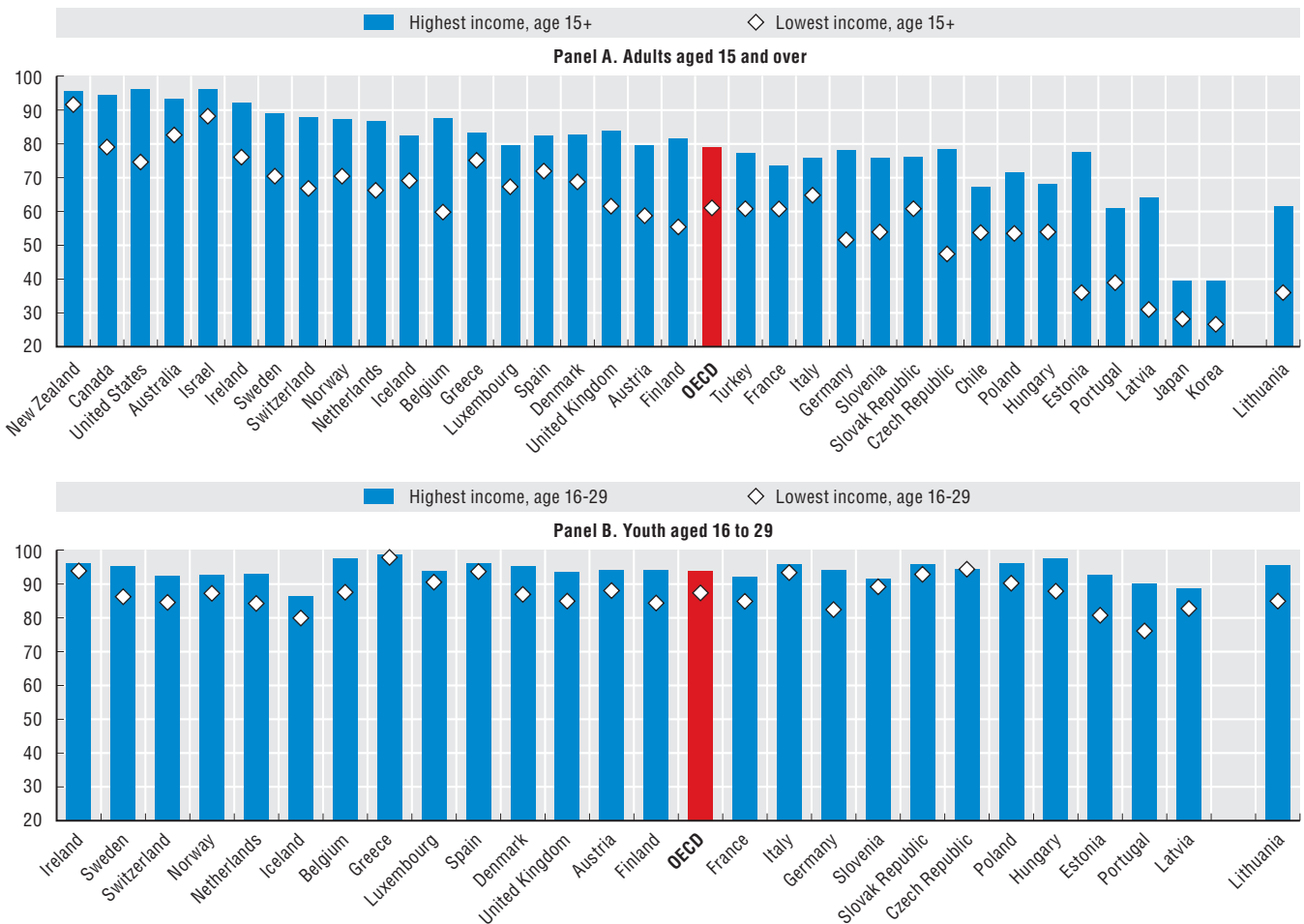


Source: OECD Health Statistics 2016, <http://dx.doi.org/10.1787/health-data-en>.

StatLink <http://dx.doi.org/10.1787/888933405577>

6.5. People in the highest income quintile report being in better health than people in the lowest income group

Percentage of people reporting to be in good or better than good health, by income level, in percentage, 2014 (or nearest year)



Source: OECD Health Statistics 2016, <http://dx.doi.org/10.1787/health-data-en> and EU-SILC for European countries.

StatLink <http://dx.doi.org/10.1787/888933405588>



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