The health module in the EU Statistics on Income and Living Conditions survey (EU-SILC) allows respondents to report on their general health status, whether they have a chronic illness and whether they are limited in usual activities because of a health problem. Despite the subjective nature of these questions, indicators of perceived general health have been found to be a good predictor of people's future health care use and mortality (DeSalvo et al., 2005).

For the purpose of international comparisons, cross-country differences in perceived health status can be difficult to interpret because responses may be affected by social and cultural factors. Since they rely on the subjective views of respondents, self-reported health status may reflect cultural biases or other influences. Also, since older people report poor health more often than younger people, countries with a larger proportion of elderly people will have a lower proportion of people reporting good or very good health.

With these limitations in mind, adults in the European Union are generally rating their health quite positively: only about 10% on average reported to be in bad or very bad health in 2014 (Figure 3.22). Ireland and Sweden had the highest proportion of adults rating their health as good or very good, with 80% or more doing so. By contrast, less than 50% of adults in Lithuania, Latvia and Portugal reported to be in good or very good health.

In all European countries, men are more likely than women to rate their health as good. As expected, people's rating of their own health tends to decline with age. In many countries, there is a particularly marked decline in a positive rating of one's own health after age 45 and a further decline after age 65.

There are large disparities in self-reported health across different socio-economic groups, as measured by income or educational level. Figure 3.23 shows that, in all countries, the 20% of the population in the highest income group is much more likely to report being in good health than the 20% in the lowest income group. On average across European countries, nearly 80% of people in the highest income quintile report being in good health, compared with just over 60% for people in the lowest income quintile. The gap between the two income groups is highest in Estonia, Latvia and the Czech Republic. These disparities may be explained by differences in living and working conditions, as well as differences in lifestyles (e.g. smoking, harmful alcohol drinking, physical inactivity, and obesity problems). In addition, people in the lowest income group may have limited access to certain health services for financial or other reasons (see Chapter 7 on "Accessibility"). It is also possible that there is a reverse causal link, with poor health status leading to lower employment and lower income. Regardless of the causality link, greater emphasis on public health and disease prevention among disadvantaged groups and improving access to health services may contribute to further improvements in population health status in general and to reducing health inequalities.

EU-SILC also asks whether respondents had any long-standing limitations in daily activities because of a health problem, which is a common definition of disability. On average across EU member states, more than one-quarter of adults reported some limitations in daily activities in 2014, with most of them reporting that they were only "limited to some extent" (18.6%), but 8.6% of respondents reporting that they were "severely limited" (Figure 3.24). Adults most commonly reported some activity limitations in Latvia, Germany, Portugal and Estonia (more than one-third of respondents), and less so in Malta and Sweden (only about 10%).

Definition and comparability

The questions used in the EU-SILC survey to measure health and the prevalence of disability are: i) "How is your health in general? Is it very good, good, fair, bad, very bad", and ii) "For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do? Would you say you have been severely limited, limited but not severely, or not limited at all?". Persons in institutions are not surveyed.

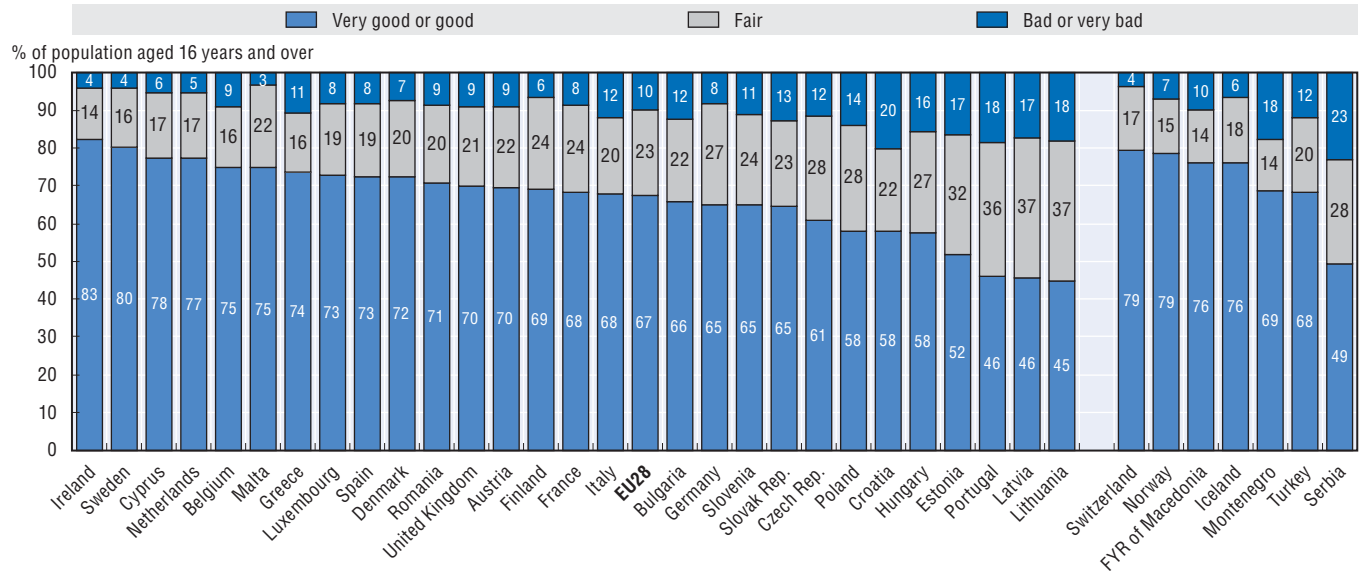
Self-reported health by income level is reported for the first quintile (lowest 20% of income group) and the fifth quintile (highest 20%). The income may relate either to the individual or the household (in which case the income is equivalised to take into account the number of persons in the household).

Caution is required in making cross-country comparisons of perceived general health, since people's assessment of their health is subjective and can be affected by their social and cultural backgrounds.

Reference

DeSalvo, K.B. et al. (2005), "Predicting Mortality and Healthcare Utilization with a Single Question", *Health Services Research*, Vol. 40, pp. 1234-1246.

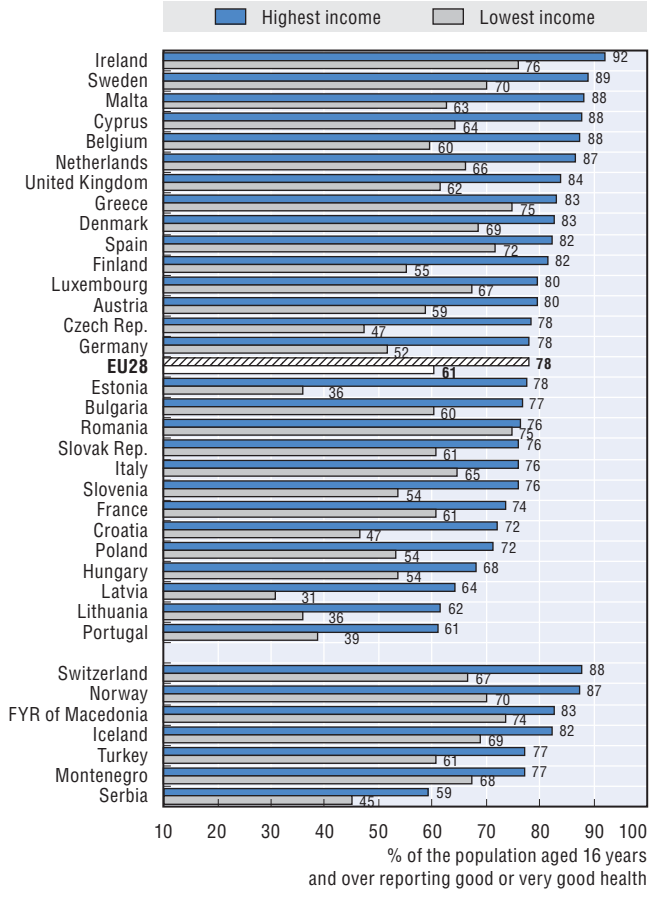
3.22. Self-reported health status, 2014



Source: EU Statistics on Income and Living Conditions survey.

StatLink http://dx.doi.org/10.1787/888933428725

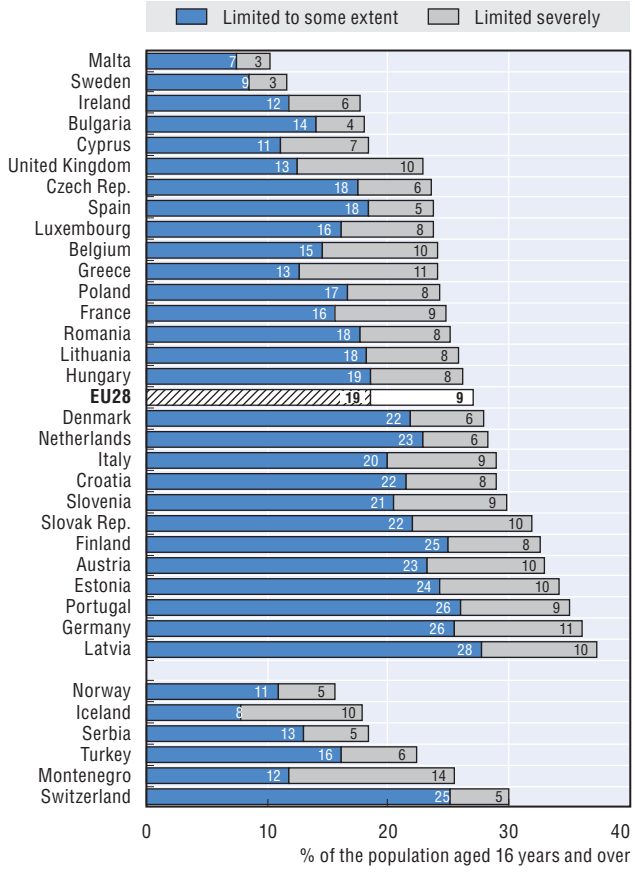
3.23. Self-reported health status by income level, 2014



Source: EU Statistics on Income and Living Conditions survey.

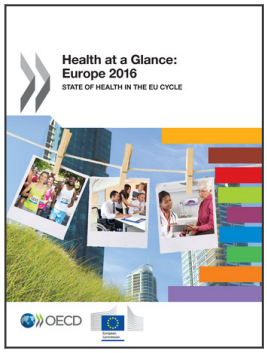
StatLink http://dx.doi.org/10.1787/888933428736

3.24. Self-reported disability, 2014



Source: EU Statistics on Income and Living Conditions survey.

StatLink http://dx.doi.org/10.1787/888933428745



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