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Health Expectancy in Austria

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transition (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries. In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

What is in this report?

This report is produced by the European Health and Life Expectancy Information System (EHLEIS) as part of a country series. In each report we present:
- Life expectancies and Healthy Life Years (HLY) at age 65 for the country of interest and for the overall 28 European Union member states (EU28), using the SILC question on long term health related disability, known as the GALI (Global Activity Limitation Indicator), from 2004 to 2014. The wording of the question has been revised in 2008.
- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References

* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). The revision is being evaluated.
Key points:

Between 2004-2014 Austrian life expectancy (LE) at age 65 increased by 1.6 years for women and 1.7 years for men. This indicator value is above the EU28 average in 2014 for women and men (21.6 years for women and 18.1 for men).

The HLY series on the basis of SILC data shows this indicator value for Austrian women being 0.9 years below the EU28 average of 8.6 in 2014. Austrian men can expect 8.4 years HLYs which is also below the EU28 average of 8.6. Thus in 2014 women and men at age 65 can expect to spend 35% and 45% respectively of their remaining life without self-reported long-term activity limitations. Compared to earlier trends, the phrasing of the SILC question may explain the lower level of reported activity limitations as people report limitations of different severity. The wording of the GALI question was changed in Austria in 2008 to better reflect the EU standard, and another revision was implemented in 2014 to match the wording with the ATHIS (EHIS) survey.

Prevalence of activity limitation in Austria and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Austria tends to display slightly higher prevalence rates of activity limitation before age 65 and after age 80, but lower prevalence rates in between.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014 the sample size for Austria comprised 5655 women and 5083 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Austria (Health data from SILC 2014)

Key points:

In 2014, LE at age 65 in Austria was 21.8 years for women and 18.5 years for men.

Based on SILC 2014 data, women at age 65 spent 7.7 years (35% of their remaining life) without activity limitation (corresponding to Healthy Life Years [HLY]), 8.2 years (38%) with moderate activity limitation and 5.9 years (27%) with severe activity limitation.*

Men of the same age spent 8.3 years (45% of their remaining life) without activity limitation compared to 6.2 years (33%) with moderate activity limitation and 3.9 years (21%) with severe activity limitation.*

Although the total number of years lived by men were less than those for women, the relative number of HLY (with regard to all health measures, activity limitation, chronic morbidity and perceived health) were greater for men than women on all severity levels. Therefore compared to men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems. 

These results should be interpreted with caution as health states of people living in institutions or nursing home are not surveyed.

* These may not sum to Life Expectancy respective 100 % due to rounding

Publications and reports on health expectancies for Austria


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

The European Health and Life Expectancy Information System (EHLEIS) is part of BRIDGE-Health which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).
**Health Expectancy in Belgium**

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).


There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


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*Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:

Belgian life expectancy (LE) at age 65 has increased by 1.7 years for women and 1.9 years for men over the period 2004-2014. By 2014 LE was above the EU28 average for women (21.6) and above for men (18.1).

The new HLY series, initiated in 2004 with the SILC data, shows values for Belgium being in 2014 above the EU28 average (8.6 for women and men) by 2.4 years for women and men.

In 2014 women and men at age 65 can expect to spend 50% and 60% of their life without self-reported long-term activity limitations respectively. HLY increased slightly for women and men between 2013 and 2014.

Note that the wording of the GALI question was slightly changed in Belgium in 2005 to better reflect the EU standard.

Prevalence of activity limitation in Belgium and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age, observed in the European Union in the 3 years (2012-2014), Belgium tends to display same prevalence rates of activity limitation before the age of 50 years for men and 45 years for women and lower prevalence rates after this age for both sexes.

These results should be interpreted with caution as sample sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Belgium comprised 5913 women and 5512 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Belgium (Health data from SILC 2014)

Key points:

In 2014, LE at age 65 in Belgium was 21.9 years for women and 18.4 years for men.

Based on the SILC 2014, at age 65, women spent 11.0 years (50% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 6.0 years (28%) with moderate activity limitation and 4.9 years (22%) with severe activity limitation.*

Men of the same age spent 11.0 years (60% of their remaining life) without activity limitation compared to 4.5 years (24%) with moderate activity limitation and 2.9 years (16%) with severe activity limitation.*

The number of years lived without activity limitation is nearly identical for both sexes, the years lived without chronic morbidity, and the number of years in (very) good perceived health is higher for women than for men. Compared to men, women spent a larger proportion of their life in ill health, and spent more years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

* These may not sum to Life Expectancy due to rounding

Publications and reports on health expectancies for Belgium


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

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What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

The observed mortality and hypothetical morbidity and disability survival curves for females, USA, 1980

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

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Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on [www.eurohex.eu](http://www.eurohex.eu).

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
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References


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* Before the revision of 2008, the translations of the module used in some countries were not optimum (see Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:
Bulgarian life expectancy (LE) at age 65 has increased by 1.4 years for women and 0.9 year for men over the period 2004-2014. By 2014 LE for men and women was below the EU28 average (21.6 for women and 18.1 for men).
Because Bulgaria joined the European Union in 2007, health expectancy based on activity limitation (HLY) is not available before 2007.
The HLY series, initiated in 2008 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 55% and 62% of their life without self-reported long-term activity limitations respectively. The HLY value for Bulgaria is above the EU28 average (8.6 for women and men) by 1.0 years for women and by 0.1 year for men in 2014. These results should be interpreted with great caution as the wording of the SILC questions was clearly different in Bulgaria compared to other EU countries. Between 2008 and 2014 HLY remained almost stable for men and women.

Prevalence of activity limitation in Bulgaria and in the European Union (EU28) based on the GAIL question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Bulgaria tends to display lower prevalence rates of activity limitation at all ages for both sexes.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Bulgaria comprised 5641 women and 4967 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Bulgaria (Health data from SILC 2014)

Key points:

In 2014, LE at age 65 in Bulgaria was 17.6 years for women and 14.1 years for men.

Based on the SILC 2014 at age 65, women spent 9.6 years (55% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 6.0 years (34%) with moderate activity limitation and 2.1 years (12%) with severe activity limitation.*

Men of the same age spent 8.7 years (62% of their remaining life) without activity limitation compared to 3.9 years (28%) with moderate activity limitation and 1.5 years (10%) with severe activity limitation.*

Although the total years lived by men, the years lived without activity limitation and the years lived without chronic morbidity were less than those for women, the number of years lived in very good or good perceived health was greater for men than women.

Compared to men, women spent a much larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

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Publications and reports on health expectancies for Bulgaria


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The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).

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How do we compare health expectancies?

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Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

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This report is produced by the European Health and Life Expectancy Information System (EHLEIS) as part of a country series. In each report we present:

- Life expectancies and Healthy Life Years (HLY) at age 65 for the country of interest and for the overall 28 European Union member states (EU28), using the SILC question on long term health related disability, known as the GALI (Global Activity Limitation Indicator), from 2004 to 2014. The wording of the question has been revised in 2008;
- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). The revision is being evaluated.
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for Croatia and the European Union (EU28) based on SILC (2004-2014)

Key points:

Between 2004-2014 Croatian life expectancy (LE) at age 65 increased by 1.7 years for women and 1.8 years for men. This indicator value was below the EU28 average in 2014 (21.6 years for women and 18.1 for men).

The new HLY series on the basis of SILC data shows this indicator value for Croatian women being 2.8 year below the EU28 average of 8.6 in 2014, and Croatian men can expect 6.0 years HLYs which is also below the EU28 average of 8.6.

Thus in 2014 women and men at age 65 can expect to spend 30% and 39% respectively of their remaining life without self-reported long-term activity limitations. Between 2013 and 2014 HLY increased for men by 0.5 year and decreased for women by 0.1 year.

Prevalence of activity limitation in Croatia and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Croatia tends to display slightly lower prevalence rates of activity limitation before the age of 40 years for men and 50 years for women and slightly higher after these ages.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Croatia comprised 6471 women and 5828 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Croatia (Health data from SILC 2014)

Life Expectancy at age 65 and expected years
- Without activity limitation
- With moderate activity limitation
- With severe activity limitation

Life Expectancy at age 65 and expected years
- Without chronic morbidity
- With chronic morbidity

Life Expectancy at age 65 and expected years
- In very good or good perceived health
- In fair perceived health
- In bad or very bad perceived health

Key points:

In 2014, LE at age 65 in Croatia was 19.1 years for women and 15.5 years for men.

Based on SILC 2014 data, women at age 65 spent 5.8 years (30% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 8.7 years (45%) with moderate activity limitation and 4.7 years (25%) with severe activity limitation.*

Men of the same age spent 6.0 years (39% of their remaining life) without activity limitation compared to 6.3 years (41%) with moderate activity limitation and 3.1 years (20%) with severe activity limitation.*

Although the total number of years lived by men were less than those for women, the number of HLY (and with regard to chronic morbidity and perceived health) were similar for men and women. Therefore, compared to men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted with caution as health states of people living in institutions or nursing home are not surveyed.

* These may not sum to Life Expectancy due to rounding

Publications and reports on health expectancies for Croatia


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.

The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2005</th>
<th>2008</th>
<th>2011</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>23,0</td>
<td>23,1</td>
<td>23,0</td>
<td>23,9</td>
</tr>
<tr>
<td>(3-year gap)</td>
<td>(0,1)</td>
<td>(-0,1)</td>
<td>(0,8)</td>
<td></td>
</tr>
<tr>
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<td>27,8</td>
<td>28,2</td>
<td>28,6</td>
<td>29,3</td>
</tr>
<tr>
<td>(3-year gap)</td>
<td>(0,3)</td>
<td>(0,4)</td>
<td>(0,7)</td>
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</tr>
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</table>

The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.


The European Health and Life Expectancy Information System (EHLEIS) is part of BRIDGE-Health which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).

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Tel: +33 (0)4 67 14 33 85 /e-mail: christine.perrier@inserm.fr

Project leader : Jean-Marie Robine – Coordination of the Country reports : Isabelle Beluche
Health Expectancy in Cyprus

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

The general model of health transition (WHO, 1984): observed mortality and hypothetical morbidity and disability survival curves for females, USA, 1980

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

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Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
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References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:

Cypriot life expectancy (LE) at age 65 has increased by 2.0 year for women and 2.3 years for men over the period 2004-2014. From 2004 onwards LE for men and women has an increasing trend and by 2014 LE for men was above the EU28 average (21.6 for women and 18.1 for men) but below for women. For the first time LE slightly decreased for women.

The HLY series using the SILC data, initiated in 2006 in Cyprus, shows that in 2014 women and men at age 65 can expect to spend 41% and 55% of their life without self-reported long-term activity limitations respectively.

The HLY values for Cyprus are 0.2 year above the EU28 average of 8.6 for women in 2014 and 1.8 year above the EU28 average of 8.6 for men. Between 2013 and 2014 HLY strongly increased for men.

Prevalence of activity limitation in Cyprus and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Cyprus tends to display slightly lower prevalence rates of activity limitation for both sexes but slightly higher prevalence rates after the age of 65 years for women.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014 the sample size for Cyprus comprised 5281 women and 4694 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Cyprus (Health data from SILC 2014)

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th></th>
<th>Men</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Life Expectancy</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>at age 65 and</td>
<td></td>
<td></td>
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<tr>
<td>expected years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without activity</td>
<td>8.8</td>
<td>6.2</td>
<td>10.4</td>
<td>4.6</td>
</tr>
<tr>
<td>limitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With moderate</td>
<td>3.8</td>
<td>17.5</td>
<td>4.7</td>
<td>14.1</td>
</tr>
<tr>
<td>activity limitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With severe</td>
<td>5.6</td>
<td>10.2</td>
<td>7.7</td>
<td>7.9</td>
</tr>
<tr>
<td>activity limitation</td>
<td></td>
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</tbody>
</table>

**Key points:**

In 2014, LE at age 65 in Cyprus was 21.4 years for women and 18.9 years for men.

Based on the SILC 2014 at age 65, women spent 8.8 years (41% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 6.2 years (29%) with moderate activity limitation and 6.4 years (30%) with severe activity limitation. *

Men of the same age spent 10.4 years (55% of their remaining life) without activity limitation compared to 4.6 years (24%) with moderate activity limitation and 3.9 years (21%) with severe activity limitation.*

Although the total years lived by men were less than those for women, for all the health expectancies the years of life spent in positive health were significantly greater for men than women.

Compared to men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

* These may not sum to Life Expectancy due to rounding

**Publications and reports on health expectancies for Cyprus**


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.

The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).

The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

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Health Expectancy in Czech Republic

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

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There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

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References


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Key points:

Czech life expectancy (LE) at age 65 has increased by 2.2 years for women and 1.7 years for men over the period 2004-2014. LE was below the EU28 average (21.6 for women and 18.1 for men) in 2014 by 1.8 years for women and 2.2 years for men. The HLY series, initiated in 2005 with the SILC data, show that in 2014 women and men at age 65 can expect to spend 47% and 53% of their life without self-reported long-term activity limitations respectively. The HLY values for the Czech Republic in 2014 is 0.7 year above the EU28 average (8.6 for women and men) for women and slightly below to the EU28 average for men. The whole series should be interpreted with caution due to successive changes in the wording of the questions in the Czech Republic (in 2007 and then in 2008). Especially, the wording of the GALI question was changed to better reflect the EU standard. HLY remained stable for men between 2013 and 2014 and increased for women.

Prevalence of activity limitation in the Czech Republic and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), the Czech Republic tends to display slightly lower prevalence rates of activity limitation at all ages.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014 the sample size for the Czech Republic comprised 8274 women and 7272 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for the Czech Republic (Health data from SILC 2014)

Key points:

In 2014, LE at age 65 in the Czech Republic was 19.8 years for women and 15.9 years for men.

Based on the SILC 2014, at age 65, women spent 9.3 years (47% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 7.4 years (37%) with moderate activity limitation and 3.1 years (16%) with severe activity limitation.*

Men of the same age spent 8.5 years (53% of their remaining life) without activity limitation compared to 5.3 years (33%) with moderate activity limitation and 2.1 years (13%) with severe activity limitation.*

Although all health expectancies (but life expectancy in good perceived health) were greater for women than men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

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Publications and reports on health expectancies for the Czech Republic

- Daňková Š. Délka života ve zdraví a projekt EHLEIS v České republice [Healthy life expectancy and project EHLEIS in the Czech Republic]. In Langhamrová J., Šídlo L. (eds) Zdraví – výzvy a rizika, sborník z XLIII. konference České demografické společnosti, Praha, 2013

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References


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**Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for Denmark and the European Union (EU28) based on SILC (2004-2014)**

**Key points:**
Danish life expectancy (LE) at age 65 has increased by 1.8 years for women and 2.1 years for men over the period 2004-2014. In 2014 LE for women was below the EU28 (21.4 for women and 18.0 for men) and similar for men. Because the wording of the GALI question in the Danish survey was changed in 2008 to better reflect the EU standard, HLY estimates for Denmark are shown only from 2008. The Danish values were much higher than the EU28 average in 2014 (8.6 for women and men), 4.2 and 2.4 years higher for women and men respectively. Therefore, Danish women and men at age 65 can expect to spend 62% and 61%, respectively, of their remaining life without self-reported long-term activity limitations. HLY remained almost stable for women but decreased for men between 2013 and 2014 in Denmark. The results should be interpreted with caution as the samples sizes are small.

Prevalence of activity limitation in Denmark and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Denmark tends to display higher prevalence rates of activity limitation before the age of 60 years and much lower after this age.

Indeed prevalence of activity limitation reaches only 50% for men and 40% for women in Denmark at age 85 and over versus 70% and 78% respectively for men and women in the European Union on average.

These results should be interpreted with caution as the samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. Furthermore, the lack of institutionalized people in the Danish SILC surveys, such as people living in nursing homes, might contribute to an explanation of the results. In 2014 the sample size for Denmark comprised 2960 women and 2798 men aged 16 years and over.
Key points:

In 2014, LE at age 65 in Denmark was 20.8 years for women and 18.0 years for men.

Based on the SILC 2014, at age 65, women spent 12.8 years (62% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 6.5 years (31%) with moderate activity limitation and 1.5 years (7%) with severe activity limitation.

Men of the same age spent 10.9 years (61% of their remaining life) without activity limitation, 5.5 years (31%) with moderate activity limitation and 1.6 years (9%) with severe activity limitation.

Although for all the health expectancies the years of life spent in positive health were slightly greater for women than men, women spent a larger proportion of their life in ill health.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes, and the small sample size.

Publications and reports on health expectancies for Denmark


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.

The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).

The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

The European Health and Life Expectancy Information System (EHLEIS) is part of BRIDGE-Health which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).
Health Expectancy in Estonia

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

The general model of health transition (WHO, 1984): observed mortality and hypothetical morbidity and disability survival curves for females, USA, 1980

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

What is in this report?

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• Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
• Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:

Estonian life expectancy (LE) at age 65 has increased by 2.6 years for women and 2.3 years for men over the period 2004-2014. LE was below the EU28 average in 2014 (21.6 for women and 18.1 for men) although the gap with the EU28 average is reducing for women and men, women being much closer to the EU average than men.

HLY series, initiated in 2004 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 29% and 32% of their life without self-reported long-term activity limitations respectively. In 2014 the HLY values for Estonia are 2.6 years for women and 3.7 for men, below the EU28 average (8.6 for women and men).

The wording of the GALI question was changed in Estonia in 2008 to better reflect the EU standard. After a strong increase in 2009, HLY slightly increased for women and slightly decreased for men.

Prevalence of activity limitation in Estonia and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Estonia tends to display higher prevalence of activity limitation at all ages for men and at almost all ages except between 25 and 45 years for women.

Activity limitation in Estonia starts to increase already from age 45 for men and from age 50 for women. These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Estonia comprised 6710 women and 5772 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Estonia (Health data from SILC 2014)

Key points:

In 2014, LE at age 65 in Estonia was 20.4 years for women and 15.2 years for men.

Based on the SILC 2014, at age 65, women spent 6.0 years (29% of their remaining life) without activity limitation (corresponding to HLY)), 8.8 years (43%) with moderate activity limitation and 5.6 years (28%) with severe activity limitation.*

Men of the same age spent 4.9 years (32% of their remaining life) without activity limitation compared to 6.8 years (45%) with moderate activity limitation and 3.5 years (23%) with severe activity limitation.*

Although the total years lived by women were 5.1 years higher than men, HLY is only slightly larger for women and other positive health expectancies are similar for both sexes. Compared to men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

* These may not sum to Life Expectancy due to rounding

Publications and reports on health expectancies for Estonia


Vals K. Haiguskoormus tõttu kaotatud eluaastad Eestis [Health loss due to burden of disease in Estonia]: University of Tartu; 2005.

Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

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**Health expectancy in Finland**

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries. In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on [www.eurohex.eu](http://www.eurohex.eu).

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Prevalence of activity limitation in Finland and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Finland tends to display a higher prevalence rate of activity limitation before the age of 65 years and a similar prevalence after this age.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Finland comprised 5511 women and 5519 men aged 16 years and over.

Key points:

Finnish life expectancy (LE) at age 65 has increased by 1.0 years for women and 1.7 years for men over the period 2004-2014. By 2014 LE was slightly above the EU28 average (21.6 for women and 18.1 for men) for women and similar for men.

The HLY series, initiated in 2004 with the SILC data, shows values in Finland being in 2014 0.7 year above the EU28 average (8.6 for women and men) for women and 0.2 year above for men.

In 2014 women and men at age 65 can expect to spend 43% and 48% of their life without self-reported long-term activity limitations respectively.

Between 2013 and 2014 HLY strongly increased for women and men in Finland. The whole series should be interpreted with caution due to successive changes in the wording of the question used especially in 2007.
Key points:

In 2014, LE at age 65 in Finland was 21.7 years for women and 18.2 years for men.

Based on the SILC 2014, at age 65, women spent 9.3 years (43% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY), 8.4 years (39%) with moderate activity limitation and 4.1 years (19%) with severe activity limitation.*

Men of the same age spent 8.8 years (48% of their remaining life) without activity limitation compared to 6.1 years (34%) with moderate activity limitation and 3.3 years (18%) with severe activity limitation.*

Although the total years lived by men were less than those for women, the number of years lived without chronic morbidity, without activity limitation, or in good perceived health was about the same. Compared to men, women spent a larger proportion of their life with chronic morbidity, disability and/or poor perceived health and these years of ill health were more likely to be years with severe health problems. These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

* These may not sum to Life Expectancy due to rounding

Publications and reports on health expectancies for Finland


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.

The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


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The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

### BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

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What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).


There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003). Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for France and the European Union (EU28) based on SILC (2004-2014)

Key points:

French life expectancy (LE) at age 65 has increased by 1.9 years for women and 2.0 years for men over the period 2004-2014. By 2014 LE for both sexes was the highest in the EU28, the EU28 average being 21.6 for women and 18.1 for men. The HLY series, initiated in 2004 with the SILC data continues the earlier stable trend for France and is above the EU28 average of 8.6 for women and men. In 2014 women and men at age 65 can expect to spend respectively 45% and 53% of their life without self-reported long-term activity limitations respectively. Between 2013 and 2014 HLY notably increased in France for men and remained stable for women. Note that the wording of the GALI question was marginally changed in France in 2008 to better reflect the EU standard. The small yearly variations observed since 2007 (decrease for men in 2008 or for women in 2009) are possibly due to random fluctuations. Between 2004 and 2014 the proportion HLY/LE (%), higher for men than women, remained stable for women and slightly increased for men. We can underline the strong contrast between the excellent rank of France in the EU28 for LE at age 65 and the middle rank for HLY.

Prevalence of activity limitation in France and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), France tends to display a similar prevalence rate of activity limitation before 55 years and a lower after this age for both sexes.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance, in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for France comprised 11047 women and 9936 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for France (Health data from SILC 2014)

Key points:

In 2014, LE at age 65 in France was 24.0 years for women and 19.7 years for men. Based on the SILC 2014, at age 65, women spent 10.7 years (45% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 7.3 years (30%) with moderate activity limitation and 5.9 years (25%) with severe activity limitation.*

Men of the same age spent 10.4 years (53% of their remaining life) without activity limitation compared to 5.4 years (27%) with moderate activity limitation and 3.8 years (19%) with severe activity limitation.*

Although all health expectancies were greater for women than men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems. These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing home.

*These may not sum to Life Expectancy due to rounding

Publications and reports on health expectancies for France


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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Health Expectancy in Germany

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

The general model of health transition (WHO, 1984); observed mortality and hypothetical morbidity and disability survival curves for females, USA, 1980

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries. In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

What is in this report?

This report is produced by the European Health and Life Expectancy Information System (EHLEIS) as part of a country series. In each report we present:

- Life expectancies and Healthy Life Years (HLY) at age 65 for the country of interest and for the overall 28 European Union member states (EU28), using the SILC question on long term health related disability, known as the GALI (Global Activity Limitation Indicator), from 2005 to 2014. The wording of the question has been revised in 2008;
- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for Germany and the European Union (EU28) based on SILC (2005-2014)

Key points:

German life expectancy (LE) at age 65 has increased by 1.3 years for women and 1.4 years for men over the period 2004-2014. LE was close to the EU28 average by 2014 (21.6 for women and 18.1 for men), similar for men and 0.2 year below for women.

The HLY series, initiated in 2005 with the SILC data, shows values for Germany being in 2014 below the EU28 average (8.6 for women and men) by 1.8 years for women and men. In 2014 women and men at age 65 can expect to spend 32% and 38% of their life without self-reported long-term activity limitations respectively. Note that the wording of the GALI question was changed in Germany in 2008 to better reflect the EU standard. This may explain the strong decrease in HLY observed between 2007 and 2008 in Germany, especially for men. Between 2013 and 2014 HLY slightly decreased for women and men. These results should be interpreted with caution as methodological issues were still under development in 2014.

Prevalence of activity limitation in Germany and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Germany tends to display a slightly higher prevalence rate of activity limitation at all ages and for both sexes.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Germany comprised 10111 women and 11827 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Germany (Health data from SILC 2014)

Key points:

In 2014, LE at age 65 in Germany was 21.4 years for women and 18.1 years for men.

Based on the SILC 2014 at age 65, women can expect to spend 6.8 years (32% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 9.2 years (43%) with moderate activity limitation and 5.5 years (26%) with severe activity limitation.*

Men of the same age spent 6.8 years (38% of their remaining life) without activity limitation compared to 7.7 years (43%) with moderate activity limitation and 3.6 years (20%) with severe activity limitation.**

Although for all the health expectancies the years of life spent in positive health were slightly greater or equal for women than men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population

* These may not sum to Life Expectancy due to rounding

Publications and reports on health expectancies for Germany


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


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The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

The European Health and Life Expectancy Information System (EHLEIS) is part of BRIDGE-Health which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).
Health Expectancy in Greece

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transition (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the 'mortality' curve), disability-free life expectancy (the area under the 'disability' curve) and life expectancy without chronic disease (the area under the 'mobidity' curve).

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

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- Life expectancies and Healthy Life Years (HLY) at age 65 for the country of interest and for the overall 28 European Union member states (EU28), using the SILC question on long term health related disability, known as the GALI (Global Activity Limitation Indicator), from 2004 to 2014. The wording of the question has been revised in 2008;
- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:

Greek life expectancy (LE) at age 65 has increased by 2.8 years for women and 1.9 years for men over the period 2004-2014. In 2014, LE was above the EU28 average (21.6 for women and 18.1 for men) by 0.1 year for women and 0.7 year for men. The HLY series, initiated in 2004 with the SILC data, shows values for Greece being in 2014 below the EU28 average (8.6 for women and men) for women and men. In 2014 women and men at age 65 can expect to spend 33% and 41.0% of their life without self-reported long-term activity limitations respectively.

Note that the wording of the GALI question was changed in Greece in 2007 and 2008. But it is not clear whether this better reflects the EU standard and can explain the strong decrease in HLY observed since 2007 in Greece. HLY decreased for men and remained almost stable for women between 2013 and 2014.

Prevalence of activity limitation in Greece and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years 2012-2014 Greece tends to display lower prevalence rate of activity limitation before the age of 75 years for men and 65 years for women and slightly higher after this age.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5,758 in Denmark to 40,274 in Italy. In 2014, the sample size for Greece comprised 9,250 women and 8,666 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Greece (Health data from SILC 2014)

Key points:
- In 2014, LE at age 65 in Greece was 21.7 years for women and 18.8 years for men.
- Based on the SILC 2014, at age 65, women spent 7.1 years (33.0% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 7.1 years (33.0%) with moderate activity limitation and 7.5 years (35%) with severe activity limitation.*
- Men of the same age spent 7.7 years (41.0% of their remaining life) without activity limitation compared to 5.7 years (30%) with moderate activity limitation and 5.3 years (28.0%) with severe activity limitation.*
- Although the total years lived by men were less than those for women, for all the health expectancies the years of life spent in positive health were greater for men than women.
- Compared to men, women spent a much larger proportion of their life in ill health.
- These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

* These may not sum to Life Expectancy due to rounding

Publications and reports on health expectancies for Greece
- Μπάγκαβος, Χ. 2014. «Η διάσταση του φύλου αναφορικά με το προοδόκιμο επιβίωσης και το προοδόκιμο υγείας στην Ελλάδα», στο Βανθοπούλου, Θ., Μπάγκαβος, Χ. και Στρατηγάκη, Μ. (επιμ.) Οικογένεια, φύλο και μετανάστευση στη σύγχρονη Ελλάδα. Αθήνα: Γκούτεμπεργκ, σελ. 227-245.
- Χρήστος Μπάγκαβος, Η κατάσταση υγείας του πληθυσμού στην ελλάδα, Προοδόκιμο επιβίωσης και προοδόκιμο υγείας, Ινστιτούτο Εργασίας ΕΕΕ, Παρατηρητήριο Οικονομικών και Κοινωνικών Εξελίξεων, Ερευνητική Μονάδα Κοινωνικής Πολιτικής Φτώχειας και Ανισοτήτων, Φεβρουάριος 2012, ISBN: 978-960-9571-21-0
- Μπάγκαβος C. Regional inequalities in health expectancy in Greece. Paper presented at the 17th European Colloquium on Quantitative and Theoretical Geography (ECQTG2011), Athens, 2-6 September 2011, Department of Geography, Harokopio University of Athens.

<table>
<thead>
<tr>
<th>Expected years</th>
<th>Women</th>
<th>Men</th>
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<tbody>
<tr>
<td>Without activity limitation</td>
<td>7.1</td>
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<tr>
<td>With moderate activity limitation</td>
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<td>5.7</td>
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<td>With severe activity limitation</td>
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<tr>
<th>Expected years</th>
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<th>Men</th>
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<tr>
<td>Without chronic morbidity</td>
<td>8.4</td>
<td>8.5</td>
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<tr>
<td>With chronic morbidity</td>
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<th>Expected years</th>
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<th>Men</th>
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<tbody>
<tr>
<td>In very good or good perceived health</td>
<td>6.4</td>
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<tr>
<td>In fair perceived health</td>
<td>8.0</td>
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Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

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What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transition (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

The general model of health transition (WHO, 1984): observed mortality and hypothetical morbidity and disability survival curves for females, USA, 1980

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

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References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for Hungary and the European Union (EU28) based SILC (2005-2014)

Key points:

Hungarian life expectancy (LE) at age 65 has increased by 1.3 years for women and 1.1 years for men over the period 2004-2014.

LE was below the EU28 average (21.6 for women and 18.1 for men) in 2014 by 3.6 years for men and 3.0 years for women. The HLY series, initiated in 2005 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 33% and 41% of their life without self-reported long-term activity limitations respectively.

In 2014 the HLY values for Hungary are 2.5 and 2.6 years below the EU28 average (8.6 for women and men) for women and men, respectively. Between 2013 and 2014 HLY remained almost stable in Hungary for men and women. Note that the wording of the GALI question was changed in 2008 to better reflect the EU standard.

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory observed in the European Union in the 3 years (2012-2014), Hungary tends to display lower prevalence rate of activity limitation before the age of 50 for women and men and slightly higher after this age.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Hungary comprised 10523 women and 8570 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Hungary (Health data from SILC 2014)

Life Expectancy at age 65 and expected years
- Without activity limitation
- With moderate activity limitation
- With severe activity limitation

Life Expectancy at age 65 and expected years
- Without chronic morbidity
- With chronic morbidity

Life Expectancy at age 65 and expected years
- In very good or good perceived health
- In fair perceived health
- In bad or very bad perceived health

Key points:

In 2014 LE at age 65 in Hungary was 18.6 years for women and 14.5 years for men.
Based on the SILC 2014, at age 65, women spent 6.1 years (33% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 8.0 years (43%) with moderate activity limitation and 4.5 years (24%) with severe activity limitation.*

Men of the same age spent 6.0 years (41% of their remaining life) without activity limitation compared to 5.8 years (40%) with moderate activity limitation and 2.7 years (19%) with severe activity limitation.*

Although for all the health expectancies the years of life spent in positive health were greater or equal for men than women, women spent a larger proportion of their life in ill health.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

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Publications and reports on health expectancies for Hungary

- See also Nők és férfiak Magyarországon, 2012 (in press) and the website: http://portal.ksh.hu/pls/ksh/docs/hun/thm/2/indi2_8_1.html
- The social development indices in Hungary (Health status 2000-2011) http://www.ksh.hu/thm/2/indi2_8_1.html

Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.

The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).

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**Health Expectancy in Ireland**

**What is health expectancy?**

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

**How is the effect of longer life measured?**

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

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Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

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**References**


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* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for Ireland and the European Union (EU28) based on SILC (2004-2014)

Key points:

Irish life expectancy (LE) at age 65 has increased by 1.5 years for women and 2.2 years for men over the period 2004-2014. LE by 2014 was below the EU28 average (21.6 for women and 18.1 for men) for women and slightly above for men.

The HLY series, initiated in 2004 with the SILC data, shows values for Ireland in 2014 notably above the EU28 average of 8.6 for women and 7.6 for men.

In 2014 women and men at age 65 can expect to spend 58% and 62% of their life without self-reported long-term activity limitations respectively.

Between 2009 and 2010 HLY strongly increased for men and women and in 2014 slightly increased for both sexes mostly for men.

Note that the wording of the GALI question did not need to be changed in Ireland in 2008.

Report of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age, observed in the European Union in the 3 years (2012-2014), Ireland tends to display lower prevalence rates of activity limitation after the age of 30 years for both sexes.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Ireland comprised 5546 women and 5082 men aged 16 years and over.
### Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Ireland (Health data from SILC 2014)

#### Key points:

In 2014, LE at age 65 in Ireland was 21.1 years for women and 18.4 years for men.

Based on the SILC 2014, at age 65, women spent 12.3 years (58% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 5.5 years (26%) with moderate activity limitation and 3.4 years (16%) with severe activity limitation.*

Men of the same age spent 11.4 years (62% of their remaining life) without activity limitation compared to 4.6 years (25%) with moderate activity limitation and 2.4 years (13%) with severe activity limitation.*

Although all health expectancies were greater for women than men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes (see: [http://www.cso.ie/releasespublications/nationaldisabilitysurvey06first.htm](http://www.cso.ie/releasespublications/nationaldisabilitysurvey06first.htm)).

*These may not sum to Life Expectancy due to rounding

### Publications and reports on health expectancies for Ireland


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


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<tr>
<td>Men</td>
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<tr>
<td>(3-year gap)</td>
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The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

The **European Health and Life Expectancy Information System (EHLEIS)** is part of **BRIDGE-Health** which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).

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**BRIDGE Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)**


Project leader: Jean-Marie Robine – Coordination of the Country reports: Isabelle Beluche

Contact: Christine Perrier - Université de Montpellier – U1198 MMDN - Place Eugène Bataillon - CC105 - 34095 Montpellier cedex 5 – France

Tel: +33 (0)4 67 14 33 85 /e-mail: christine.perrier@inserm.fr
Health Expectancy in Italy

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

What is in this report?

This report is produced by the European Health and Life Expectancy Information System (EHLEIS) as part of a country series. In each report we present:

- Life expectancies and Healthy Life Years (HLY) at age 65 for the country of interest and for the overall 28 European Union member states (EU28), using the SILC question on long term health related disability, known as the GALI (Global Activity Limitation Indicator), from 2004 to 2014. The wording of the question has been revised in 2008 for most countries. However it was made in 2007 in Italy;
- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality).
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for Italy and the European Union (EU28) based on SILC (2007-2014*)

Key points:

Italian life expectancy (LE) at age 65 has increased by 1.3 years for women and 1.7 years for men over the period 2004-2014. LE was above the EU28 average (21.6 for women and 18.1 for men) in 2014.

The HLY series shows values for Italy in 2014 being below the EU28 average which is 8.6 for women and men. In 2014 women and men at age 65 can respectively expect to spend 32% and 41% of their life without self-reported long-term activity limitations.

Between 2008 and 2011 HLY remained almost stable for women and men in Italy but all remained below the EU 28 average. From 2011 to 2012 HLY remained stable for women but decreased for men, while a slight increase is observed from 2013 to 2014.

*Data on activity limitation for 2010 have been estimated as the mean prevalence of 2009 and 2011.
Time series of LE may be different from previous report because they have been recalculated according to Eurostat estimated.

Prevalence of activity limitation in Italy and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the years 2012-2014, Italy tends to display similar or slightly lower prevalence rate of activity limitation before the age of 65 years for men and 60 for women and higher after this age.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40280 in Italy. In 2014, the sample size for Italy comprised 21165 women and 19115 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Italy (Health data from SILC 2014)

### Key points:

In 2014, LE at age 65 in Italy was 22.8 years for women and 19.2 years for men.

Based on the SILC 2014, at age 65, women spent 7.3 years (32% of remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 9.3 years (41%) with moderate activity limitation and 6.2 years (27%) with severe activity limitation.*

Men of the same age spent 7.8 years (41% of remaining life) without activity limitation compared to 7.1 years (37%) with moderate activity limitation and 4.3 years (22%) with severe activity limitation.*

Although total years lived by men were less than those for women, the numbers of years lived in very good or good perceived health and the years lived without activity limitation were slightly larger for men. However, the number of years lived without chronic morbidity was greater for women than men.

Compared to men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted with caution given the lack of the institutional population, such as people living in nursing homes, and the sample size. For Italy it comprises 6063 women and 4693 men aged 65+ years in 2014.

* These may not sum to Life Expectancy due to rounding

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**Publications and reports on health expectancies for Italy**

- Zauli S., Battisti A., Frova L., Lauriola P. “La speranza di vita per condizioni di salute (Healthy Life Years): un indice di grande interesse, ma da utilizzare con prudenza” (Healthy Life Years: a very promising indicator to be handled with caution) Epidemiologia & Prevenzione 2014; 38
- Istat Health for All – Italia Sistema informativo territoriale su sanità e salute – Up-date June 2016 [http://www.istat.it/it/archivio/14562](http://www.istat.it/it/archivio/14562)
- ISTAT. BES Il Benessere equo e sostenibile. 2015 [http://www.misuredelbenessere.it/](http://www.misuredelbenessere.it/)

Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
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References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for Latvia and the European Union (EU28) based on SILC (2005-2014)

Key points:

Latvian life expectancy (LE) at age 65 has increased by 1.9 years for women and 1.2 years for men over the period 2004-2014.

LE was below the EU28 average (21.6 for women and 18.1 for men) in 2014, 4.3 years for men and 2.6 years for women.

The HLY series, initiated in 2005 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 24% and 29% of their life without self-reported long-term activity limitations respectively.

In 2014 the HLY values for Latvia are 4.0 years and 4.6 years below the EU28 average (8.6 for women and men) for women and men respectively.

Since 2006 HLY tends to increase for women and men in Latvia and notably in 2012. But in 2013 HLY strongly decreased for both sexes, then remained stable in 2014. Note that the wording of the GALI question was not changed in 2008.

Prevalence of activity limitation in Latvia and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the years (2012-2014), Latvia tends to display similar prevalence rate of activity limitation before the age of 30 years for men and 35 years for women and slightly higher after these ages.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Latvia comprised 6899 women and 5027 men aged 16 years and over.
### Key points:

In 2014 LE at age 65 in Latvia was 19.0 years for women and 13.8 years for men.

Based on the SILC 2014, at age 65, women spent 4.6 years (24% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 9.1 years (48%) with moderate activity limitation and 5.4 years (28%) with severe activity limitation.*

Men of the same age spent 4.0 years (29% of their remaining life) without activity limitation compared to 6.5 years (47%) with moderate activity limitation and 3.2 years (23%) with severe activity limitation.*

Although women lived more years without chronic morbidity and/or without disability, compared to men, they spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

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### Publications and reports on health expectancies for Latvia


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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How is the effect of longer life measured?

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:

Lithuanian life expectancy (LE) at age 65 has increased by 1.6 year for women and by 0.9 year for men over the period 2004-2014. LE for both sexes was below the EU28 average (21.6 for women and 18.1 for men) in 2014, 3.8 years for men and 2.1 years for women. The HLY series, initiated in 2005 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 31% and 43% of their life without self-reported long-term activity limitations respectively. In 2014 the HLY values for Lithuania are 2.5 years below the EU28 average (8.6 for women and men) for women and men. HLY slightly increased for men in 2014 and slightly decreased for women. Note that the wording of the GALI question was changed in Lithuania in 2006 and again in 2007.

Prevalence of activity limitation in Lithuania and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years 2012-2014, Lithuania tends to display lower prevalence rate of activity limitation before the age of 55 years for men and 60 years for women, but higher prevalence after these ages for both sexes.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014 the sample size for Lithuania comprised 5756 women and 4808 men aged 16 years and over.
# Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Lithuania (Health data from SILC 2014)

<table>
<thead>
<tr>
<th>Life Expectancy at age 65 and expected years</th>
<th>Women</th>
<th>Men</th>
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<tr>
<td>Without activity limitation</td>
<td>6.1</td>
<td>6.1</td>
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<tr>
<td>With moderate activity limitation</td>
<td>9.0</td>
<td>5.3</td>
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<td>With severe activity limitation</td>
<td>4.4</td>
<td>2.9</td>
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<th>Life Expectancy at age 65 and expected years</th>
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<tbody>
<tr>
<td>Without chronic morbidity</td>
<td>5.0</td>
<td>4.9</td>
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<tr>
<td>With chronic morbidity</td>
<td>14.6</td>
<td>9.3</td>
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<tr>
<th>Life Expectancy at age 65 and expected years</th>
<th>Women</th>
<th>Men</th>
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<tbody>
<tr>
<td>In very good or good perceived health</td>
<td>0.6</td>
<td>0.9</td>
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<tr>
<td>In fair perceived health</td>
<td>8.7</td>
<td>7.5</td>
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<tr>
<td>In bad or very bad perceived health</td>
<td>10.2</td>
<td>5.9</td>
</tr>
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**Key points:**

In 2014, LE at age 65 in Lithuania was 19.5 years for women and 14.3 years for men.

Based on the SILC 2014 at age 65, women spent 6.1 years (31% of their remaining life) without activity limitation corresponding to Healthy Life Years (HLY), 9.0 years (46%) with moderate activity limitation and 4.4 years (23%) with severe activity limitation.*

Men of the same age spent 6.1 years (43% of their remaining life) without activity limitation compared to 5.3 years (37%) with moderate activity limitation and 2.9 years (20%) with severe activity limitation.*

Although the total years lived and the number of years lived without activity limitation was higher for women than men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

*These may not sum to Life Expectancy due to rounding

## Publications and reports on health expectancies for Lithuania


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.

<table>
<thead>
<tr>
<th>Age</th>
<th>Total limited</th>
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<tbody>
<tr>
<td>10</td>
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<td>90</td>
<td>0%</td>
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</table>

The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).

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<td>90</td>
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<td>0%</td>
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</table>

The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.


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The Europese Health and Life Expectancy Information System (EHLEIS) is part of BRIDGE-Health which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).
What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transition (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).


There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:

Luxembourg life expectancy (LE) at age 65 has increased by 2.2 years for women and 1.8 years for men over the period 2004-2014. By 2014 LE is 1.1 year above the EU28 average (21.6 for women and 18.1 for men) for women and 0.2 year above for men.

The HLY series, initiated in 2004 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 48% and 62% of their life without self-reported long-term activity limitations respectively.

In 2014, the HLY values for Luxembourg are above the EU28 average (8.6 for women and men) for women and men, by 2.2 years and 2.7 years respectively.

HLY increased for women and men between 2013 and 2014 in Luxembourg.

Prevalence of activity limitation in Luxembourg and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Luxembourg tends to display similar prevalence rate of activity limitation before the age of 55 years but very much lower after this age for both sexes.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Luxembourg comprised 4035 women and 3997 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Luxembourg (Health data from SILC 2014)

Key points:

In 2014 LE at age 65 in Luxembourg was 22.7 years for women and 18.3 years for men.

Based on the SILC 2014, at age 65, women spent 10.8 years (48% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 7.3 years (32%) with moderate activity limitation and 4.6 years (20%) with severe activity limitation.*

Men of the same age spent 11.3 years (62% of their remaining life) without activity limitation compared to 4.5 years (25%) with moderate activity limitation and 2.5 years (14%) with severe activity limitation.*

Although the total number of years lived by men were less than those for women, the relative number of HLY (and with regard to activity limitation and perceived health) were greater for men than women. Therefore compared to men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

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Publications and reports on health expectancies for Luxembourg

- Peltier F., Thill G., Schockmel M. 83 ans d’espérance de vie pour les femmes et 78 ans pour les hommes. STATEC, Statnews n°26-2008

Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.


<table>
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Men</td>
<td>23.0</td>
<td>23.1</td>
<td>23.0</td>
<td>23.9</td>
</tr>
<tr>
<td>(3-year gap)</td>
<td>(0.1)</td>
<td>(-0.1)</td>
<td>(0.8)</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>27.8</td>
<td>28.2</td>
<td>28.6</td>
<td>29.3</td>
</tr>
<tr>
<td>(3-year gap)</td>
<td>(0.3)</td>
<td>(0.4)</td>
<td>(0.7)</td>
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</tbody>
</table>

BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

The European Health and Life Expectancy Information System (EHLEIS) is part of BRIDGE-Health which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).
Health Expectancy in Malta

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

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References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for Malta and the European Union (EU28) based on SILC (2005-2014)

Key points:

Maltese life expectancy (LE) at age 65 has increased by 2.6 years for women and 2.3 years for men over the period 2004-2014. By 2014 LE for both men and women is slightly above the EU28 average (21.6 for women and 18.1 for men).

The HLY series, initiated in 2005 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 63% and 72% of their life without self-reported long-term activity limitations respectively. In 2014 the HLY values for Malta are notably above the EU28 average (8.6 for women and men) by 5.1 years for women and 4.7 years for men. A slow but consistent increase in HLY can be observed, except for a dip in 2006. Furthermore, from 2006 onwards, the gap between Malta and EU 28 has been increasing. Note that the wording of the GALI question in Malta was not changed in 2008 however was amended in 2012. Between 2013 and 2014 HLY strongly increased.

Prevalence of activity limitation in Malta and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years 2012-2014, Malta tends to display strongly lower prevalence rate of activity limitation at all ages and for both sexes, women reaching almost the EU28 at age 85 years.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance, in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Malta comprised 5089 women and 4914 men aged 16 years and over.
### Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Malta (Health data from SILC 2014)

<table>
<thead>
<tr>
<th>Life Expectancy at age 65 and expected years</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without activity limitation</td>
<td>13.7</td>
<td>13.3</td>
</tr>
<tr>
<td>With moderate activity limitation</td>
<td>5.8</td>
<td>3.9</td>
</tr>
<tr>
<td>With severe activity limitation</td>
<td>2.1</td>
<td>1.4</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Life Expectancy at age 65 and expected years</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without chronic morbidity</td>
<td>6.5</td>
<td>6.6</td>
</tr>
<tr>
<td>With chronic morbidity</td>
<td>15.1</td>
<td>12.0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Life Expectancy at age 65 and expected years</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>In very good or good perceived health</td>
<td>6.5</td>
<td>6.7</td>
</tr>
<tr>
<td>In fair perceived health</td>
<td>12.4</td>
<td>9.7</td>
</tr>
<tr>
<td>In bad or very bad perceived health</td>
<td>2.8</td>
<td>2.1</td>
</tr>
</tbody>
</table>

### Key points:

In 2014, LE at age 65 in Malta was 21.7 years for women and 18.6 years for men. Based on the SILC 2014 at age 65, women spent 13.7 years (63% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 5.8 years (27%) with moderate activity limitation and 2.1 years (10%) with severe activity limitation.*

Men of the same age spent 13.3 years (72% of their remaining life) without activity limitation compared to 3.9 years (21%) with moderate activity limitation and 1.4 years (7%) with severe activity limitation.*

Although total years lived by men was less than those for women, years lived without chronic morbidity, years lived without activity limitation and years lived in very good or good perceived health were almost similar for women and men.

Compared to men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

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### Publications and reports on health expectancies for Malta


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<td>(3-year gap)</td>
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The general model of health transition (WHO, 1984): observed mortality and hypothetical morbidity and disability survival curves for females, USA, 1980

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

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Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for The Netherlands and the European Union (EU28) based on SILC (2005-2014)

Key points:

Dutch life expectancy (LE) at age 65 has increased by 1.5 years for women and 2.3 years for men over the period 2004-2014. By 2014 LE for Dutch men and women was very close to the EU28 average (21.6 for women and 18.1 for men).

The HLY series, initiated in 2005 with the SILC data, show values for the Netherlands being in 2014 above the EU28 average (8.6 for women and men) by 1.6 year for women and 2.1 year for men. In 2014 women and men at age 65 can expect to spend 48% and 58% of their remaining life without self-reported long-term activity limitations respectively. Note that the wording of the GALI question was changed in the Netherlands in 2008 to better reflect the EU standard. This led to a clear decrease in HLY for men and women between 2007 and 2008. After a decrease of HLY for women between 2009 and 2010, between 2010 and 2011 HLY increased, although for women only slightly. In 2012 HLY remained stable in women but decreased slightly for men. In 2013 HLY decreased notably for women and men but increased again in 2014 above the level of 2012.

Prevalence of activity limitation in the Netherlands and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), the Netherlands tends to display similar prevalence rate of activity limitation for men before the age of 55 years but lower after this age and for women higher prevalence rate before the age of 65 years but lower after this age.

These results should be interpreted with caution as samples sizes in the SILC survey for the Netherlands comprised 5327 women and 4690 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for The Netherlands (Health data from SILC 2014)

Key points:
In 2014 LE at age 65 in the Netherlands was 21.4 years for women and 18.6 years for men.
Based on the SILC 2014, at age 65 women spent 10.2 years (48% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 8.3 years (39%) with moderate activity limitation and 2.9 years (13%) with severe activity limitation.*
Men of the same age spent 10.7 years (58% of their remaining life) without activity limitation compared to 6.0 years (32%) with moderate activity limitation and 1.8 years (10%) with severe activity limitation.*
Although the total number of years lived by men were less than those for women, for all health expectancies, the years of life spent in positive health were similar for men and women. Therefore, compared to men, women spent a larger proportion of their life in ill health.
These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes

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Publications and reports on health expectancies for The Netherlands

- Essink-Bot ML, Deeg DJ, Nusselder WJ. [We are living longer, but are these additional years spent in good health?]. Ned Tijdschr Geneeskd. 2016;160(0)
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Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.

The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


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The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

### BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

The European Health and Life Expectancy Information System (EHLEIS) is part of BRIDGE-Health which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).
**Health Expectancy in The Netherlands**

**What is health expectancy?**

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

**How is the effect of longer life measured?**

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

![Graph of health expectancy](image)

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

**How do we compare health expectancies?**

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries. In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on [www.eurohex.eu](http://www.eurohex.eu).

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

**References**


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:

Dutch life expectancy (LE) at age 65 has increased by 1.5 years for women and 2.3 years for men over the period 2004-2014. By 2014 LE for Dutch men and women was very close to the EU28 average (21.6 for women and 18.1 for men).

The HLY series, initiated in 2005 with the SILC data, show values for the Netherlands being in 2014 above the EU28 average (8.6 for women and men) by 1.6 year for women and 2.1 year for men. In 2014 women and men at age 65 can expect to spend 48% and 58% of their remaining life without self-reported long-term activity limitations respectively. Note that the wording of the GALI question was changed in the Netherlands in 2008 to better reflect the EU standard. This led to a clear decrease in HLY for men and women between 2007 and 2008. After a decrease of HLY for women between 2009 and 2010, between 2010 and 2011 HLY increased, although for women only slightly. In 2012 HLY remained stable in women but decreased slightly for men. In 2013 HLY decreased notably for women and men but increased again in 2014 above the level of 2012.

Prevalence of activity limitation in the Netherlands and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), the Netherlands tends to display similar prevalence rate of activity limitation for men before the age of 55 years but lower after this age and for women higher prevalence rate before the age of 65 years but lower after this age.

These results should be interpreted with caution as samples sizes in the SILC survey for the Netherlands comprised 5327 women and 4690 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for The Netherlands (Health data from SILC 2014)

**Key points:**

In 2014 LE at age 65 in the Netherlands was 21.4 years for women and 18.6 years for men.

Based on the SILC 2014, at age 65 women spent 10.2 years (48% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 8.3 years (39%) with moderate activity limitation and 2.9 years (13%) with severe activity limitation.*

Men of the same age spent 10.7 years (58% of their remaining life) without activity limitation compared to 6.0 years (32%) with moderate activity limitation and 1.8 years (10%) with severe activity limitation.*

Although the total number of years lived by men were less than those for women, for all health expectancies, the years of life spent in positive health were similar for men and women. Therefore, compared to men, women spent a larger proportion of their life in ill health.

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for Poland and the European Union (EU28) based on SILC (2005-2014)

**Key points:**

Polish life expectancy (LE) at age 65 has increased by 2.1 years for women and 1.6 years for men over the period 2004-2014. By 2014 LE was lower than the EU28 average (21.6 for women and 18.1 for men) by 1.2 year for women and 2.5 years for men.

The HLY series, initiated in 2005 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 40% and 47% of their life without self-reported long-term activity limitations respectively.

In 2014 the HLY values for Poland are below the EU28 average (of 8.6 for women and men) by 0.5 year for women and 1.1 years for men. The HLY values remained stable in Poland since 2007, increased between 2010 and 2011 and slightly decreased in 2012 and 2013 for both sexes. In 2014 HLY increased notably for both sexes mostly for women.

Note that there are some differences in the wording of the GALI question the years 2005 and in 2006-2008 and 2009-2010 in Poland.

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Prevalence of activity limitation in Poland and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Poland tends to display almost similar prevalence rate of activity limitation at all ages for both sexes.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Poland comprised 15933 women and 14037 men aged 16 years and over.
### Key points:

In 2014, LE at age 65 in Poland was 20.4 years for women and 15.8 years for men.

Based on the SILC 2014, at age 65, women can expect to spend 8.1 years (40% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 7.6 years (37%) with moderate activity limitation and 4.7 years (23%) with severe activity limitation.*

Men of the same age can expect to spend 7.4 years (47% of their remaining life) without activity limitation compared to 5.1 years (32%) with moderate activity limitation and 3.3 years (21%) with severe activity limitation.*

Although the total years lived and the number of years lived without activity limitation was higher for women than men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

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### Publications and reports on health expectancies for Poland


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.

The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).

The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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Health Expectancy in Romania

What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transition (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ’mortality’ curve), disability-free life expectancy (the area under the ’disability’ curve) and life expectancy without chronic disease (the area under the ’morbidity’ curve).

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

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Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

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References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:

Romanian life expectancy (LE) at age 65 has increased by 2.4 years for women and 1.8 year for men over the period 2004-2014. By 2014 LE for men and women was largely below the EU28 average (21.4 for women and 18.0 for men).

The HLY series, initiated in 2007 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 32% and 40% of their life without self-reported long-term activity limitations respectively.

The HLY values for Romania are 2.9 years and 2.7 years below the EU28 average (8.6 for women and men) for women and men respectively in 2014. The HLY values decreased strongly between 2009 and 2010 for both sexes, continued a small decrease in 2011 but increased in 2012 and remained stable in 2013. In 2014 HLY slightly increased for women and men.

Note that the wording of the GALI question was changed in 2008 and change again in 2010.

Prevalence of activity limitation in Romania and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years (2012-2014), Romania tends to display lower prevalence rate of activity limitation before the age of 55 years for men and 45 years for women but higher prevalence after these ages.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Romania comprised 8202 women and 7400 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Romania (Health data from SILC 2014)

Key points:

In 2014, LE at age 65 in Romania was 18.1 years for women and 14.6 years for men.

Based on the SILC 2014 at age 65, women spent 5.7 years (32% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 7.6 years (42%) with moderate activity limitation and 4.8 years (26%) with severe activity limitation.*

Men of the same age spent 5.9 years (40% of their remaining life) without activity limitation compared to 5.8 years (40%) with moderate activity limitation and 2.9 years (20%) with severe activity limitation.*

Although the total years lived by men were less than those for women, for all the health expectancies the years of life spent in positive health were greater for men than women. Therefore compared to men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

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Publications and reports on health expectancies for Romania

- INS (2013), Evolution of mortality in Romania;
- INS (2014), Women and men, life and work partnership;
- INS (2016), Health expectancy in Romania.

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Acknowledgements

Marcela Postelnicu (National Institute of Statistics) has contributed to this report and its translation.
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Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries. In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

Further details on the MEHM, the European surveys and health expectancy calculation and interpretation can be found on www.eurohex.eu.

What is in this report?

This report is produced by the European Health and Life Expectancy Information System (EHLEIS) as part of a country series. In each report we present:
- Life expectancies and Healthy Life Years (HLY) at age 65 for the country of interest and for the overall 28 European Union member states (EU28), using the SILC question on long term health related disability, known as the GALI (Global Activity Limitation Indicator), from 2005 to 2014. The wording of the question has been revised in 2008;
- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References

* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Key points:

Slovak life expectancy (LE) at age 65 has increased by 2.0 years for women and 1.7 years for men over the period 2004-2014. LE was below the EU28 average (21.6 for women and 18.2 for men) by 3.2 years for men and 2.5 years for women in 2014.

The HLY series, initiated in 2005 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend respectively 19% and 28% of their life without self-reported long-term activity limitations. In 2014 the HLY values for Slovakia are below the EU28 average (8.6 for women and men) by 5.0 years and 4.4 years for women and men respectively. Note that the wording of the GALI question was changed in 2008 to better reflect the EU standard. This led to a clear decrease in HLY for men and women between 2007 and 2008.

Then from 2008 to 2010 HLY remained almost stable for women and men and slightly increased in 2011, continue to increase in 2012, and increased notably in 2013. In 2014 HLY remained stable.

Prevalence of activity limitation in Slovakia and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years 2012-2014, Slovakia tends to display higher prevalence rate of activity limitation after the age of 35 years for women and men, this prevalence reaching almost 100% at age 85 for men.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Slovakia comprised 7217 women and 6097 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Slovakia (Health data from SILC 2014)

### Key points:

In 2014 LE at age 65 in Slovakia was 19.1 years for women and 15.0 years for men.

Based on the SILC 2014, at age 65, women spent 3.6 years (19% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 8.4 years (44%) with moderate activity limitation and 7.0 years (37%) with severe activity limitation.*

Men of the same age spent 4.2 years (28% of their remaining life) without activity limitation compared to 6.3 years (42%) with moderate activity limitation and 4.4 years (29%) with severe activity limitation.*

Although total years lived by men were less than those for women, for all the health expectancies the number of years of life spent in positive health were greater for men than women. Therefore compared to men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

* These may not sum to Life Expectancy due to rounding

### Publications and reports on health expectancies for Slovakia

- Mészáros J. Stredná dĺžka života v zdraví podľa EHIS 2009. INFOSTAT Bratislava nov. 2010

Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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<tbody>
<tr>
<td>Men</td>
<td>23,0</td>
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<td>(3-year gap)</td>
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<td>(0,8)</td>
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<td>Women</td>
<td>27,8</td>
<td>28,2</td>
<td>28,6</td>
<td>29,3</td>
</tr>
<tr>
<td>(3-year gap)</td>
<td>(0,3)</td>
<td>(0,4)</td>
<td>(0,7)</td>
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BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

The European Health and Life Expectancy Information System (EHLEIS) is part of BRIDGE-Health which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).
What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

The general model of health transition (WHO, 1984): observed mortality and hypothetical morbidity and disability survival curves for females, USA, 1980

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries. In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). The revision is being evaluated.
Key points:

Slovenian life expectancy (LE) at age 65 has increased by 2.2 years for women and 2.7 years for men over the period 2004-2014. LE was similar to the EU28 average (21.6 for women and 18.1 for men) for women and below the EU28 average for men in 2014. However gaps are reducing.

The new HLY series, initiated in 2005 with the SILC data, shows that in 2014 women and men at age 65 can expect to spend 40% and 44% of their life without self-reported long-term activity limitations respectively. In 2014 the HLY values for Slovenia are similar to the EU28 average (8.6 for women and men) for women and below for men. Between 2005 and 2009 HLY increased for men in Slovenia. For women, HLY increased until 2007 then stabilized. Note that the wording of the GALI question changes in Slovenia in 2010. However, this slightly change hardly explains the strong decrease of HLY observed in 2010. In 2013 HLY strongly increased for women and remained stable for men. In 2014 HLY increased for women and men.

Prevalence of activity limitation in Slovenia and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years 2012-2014, Slovenia tends to display globally higher prevalence rate of activity limitation at all ages and for both sexes.

These results should be interpreted with caution, samples sizes in the SILC survey vary remarkably ranging between 5758 in Denmark to 40274 in Italy for instance in 2014. In 2014, the sample size for Slovenia comprised 4757 women and 4432 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Slovenia (Health data from SILC 2014)

### Key points:

In 2014, LE at age 65 in Slovenia was 21.6 years for women and 17.7 years for men.

Based on the SILC 2014, at age 65, women spent 8.6 years (40% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 7.5 years (35%) with moderate activity limitation and 5.5 years (25%) with severe activity limitation.*

Men of the same age spent 7.8 years (44% of their remaining life) without activity limitation compared to 6.1 years (35%) with moderate activity limitation and 3.8 years (22%) with severe activity limitation.*

Although for life expectancy without chronic morbidity and for life expectancy without activity limitation the years of life spent in positive health were greater for women than men, women spent a larger proportion of their life in ill health and these years of ill health were more likely to be years with severe health problems.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

* These may not sum to Life Expectancy due to rounding

### Publications and reports on health expectancies for Slovenia


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

How is the effect of longer life measured?

The general model of health transitions (WHO, 1984) shows the differences between life spent in different states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the 'mortality' curve), disability-free life expectancy (the area under the 'disability' curve) and life expectancy without chronic disease (the area under the 'morbidity' curve).

There are in fact as many health expectancies as concepts of health. The commonest health expectancies are those based on self-perceived health, activities of daily living and on chronic morbidity.

How do we compare health expectancies?

Health expectancies are independent of the size of populations and of their age structure and so they allow direct comparison of different population subgroups: e.g. sexes, socio-professional categories, as well as countries within Europe (Robine et al., 2003).

Health expectancies are most often calculated by the Sullivan method (Sullivan, 1971). However to make valid comparisons, the underlying health measure should be truly comparable.

To address this, the European Union has decided to include a small set of health expectancies among its European Core Health Indicators (ECHI) to provide summary measures of disability (i.e., activity limitation), chronic morbidity and perceived health. Therefore the Minimum European Health Module (MEHM), composed of 3 general questions covering these dimensions, has been introduced into the Statistics on Income and Living Conditions (SILC) to improve the comparability of health expectancies between countries.* In addition life expectancy without long term activity limitation, based on the disability question, was selected in 2004 to be one of the structural indicators for assessing the EU strategic goals (Lisbon strategy) under the name of “Healthy Life Years” (HLY).

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

References


* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). The revision is being evaluated.
Prevalence of activity limitation in Spain and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean 2012-2014)

Reports of limitation in usual activities strongly increase with age in the European Union and women systematically report slightly more activity limitation than men. Compared to the mean trajectory by age observed in the European Union in the 3 years 2012-2014, Spain tends to display lower prevalence rate of activity limitation at all ages except at age 85 and over where the prevalence become slightly higher than EU28 for women only.

These results should be interpreted with caution as samples sizes in the SILC survey vary remarkably; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for Spain comprised 13840 women and 12673 men aged 16 years and over.
Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Spain (Health data from SILC 2014)

<table>
<thead>
<tr>
<th>Life Expectancy at age 65 and expected years</th>
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<tr>
<td>Without activity limitation</td>
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<tr>
<td>With moderate activity limitation</td>
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<tr>
<td>With severe activity limitation</td>
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<table>
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<tr>
<th>Women</th>
<th>Men</th>
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<tbody>
<tr>
<td>9.5</td>
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<td>9.1</td>
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<td>7.7</td>
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<th>Life Expectancy at age 65 and expected years</th>
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<tr>
<td>Without chronic morbidity</td>
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<tr>
<td>9.5</td>
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<td>14.4</td>
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<td>9.3</td>
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<table>
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<th>Life Expectancy at age 65 and expected years</th>
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<tr>
<td>In very good or good perceived health</td>
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<tr>
<td>In fair perceived health</td>
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<td>In bad or very bad perceived health</td>
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<th>Women</th>
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<tbody>
<tr>
<td>4.5</td>
<td>2.4</td>
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<tr>
<td>6.5</td>
<td>3.6</td>
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</table>

Key points:

In 2014, LE at age 65 in Spain was 23.5 years for women and 19.3 years for men.

Based on the SILC 2014, at age 65, women spent 9.5 years (40% of their remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 9.5 years (40%) with moderate activity limitation and 4.5 years (19%) with severe activity limitation.*

Men of the same age spent 10.1 years (52% of their remaining life) without activity limitation compared to 6.8 years (35%) with moderate activity limitation and 2.4 years (12%) with severe activity limitation.*

Although total years lived by men were less than those for women, for life expectancy in very good or good perceived health and for life expectancy without activity limitation the years of life spent in ill health and these years of ill health were more likely to be years with severe health problems. Therefore compared to men, women spent a larger number of years and a larger proportion in ill health and these years of ill health were more likely to be years with severe health problems. These results should be interpreted cautiously given the lack of the institutional population, such as people living in nursing homes.

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Publications and reports on health expectancies for Spain


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The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).

The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

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**Health Expectancy in**

**United Kingdom**

### What is health expectancy?

Health expectancies were first developed to address whether or not longer life is being accompanied by an increase in the time lived in good health (the compression of morbidity scenario) or in bad health (expansion of morbidity). So health expectancies divide life expectancy into life spent in different states of health, from say good to bad health. In this way they add a dimension of quality to the quantity of life lived.

### How is the effect of longer life measured?

The general model of health transition (WHO, 1984) shows the differences between life spent indifferent states: total survival, disability-free survival and survival without chronic disease. This leads naturally to life expectancy (the area under the ‘mortality’ curve), disability-free life expectancy (the area under the ‘disability’ curve) and life expectancy without chronic disease (the area under the ‘morbidity’ curve).

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- Prevalence of activity limitation in the country of interest and in the European Union based on the GALI question by sex and age group;
- Health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2014;

### References


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* Before the revision of 2008, the translations of the module used in some countries were not optimum (See Eurostat-EU Task Force on Health Expectancies common statement about the SILC data quality). This revision is being evaluated.
Life expectancy (LE) and Healthy Life Years (HLY) at age 65 for United Kingdom and the European Union (EU28) based on SILC (2005-2014)

Key points:
UK life expectancy (LE) at age 65 has increased by 1.7 years for women and 2.0 years for men over the period 2004-2014. In 2014 LE was above the EU28 average of 18.1 for men and slightly below the EU28 average of 21.6 for women.

The new HLY series, initiated in 2005 with the SILC data, shows values for the UK being in 2014 above the EU28 average (8.6 for women and men) by 2.0 years for women and 1.2 years for men. Women and men at age 65 can expect to spend 50% and 52% of their life without self-reported long-term activity limitations respectively. HLY for men in the UK grew by 0.6 years between 2005 reaching 11.0 years in 2011 before falling back to 10.6 years in 2014. For women HLY was highest in 2011 at 11.9 years, but the pattern was irregular, fluctuating between 11.1 and 11.8 years. HLY declined markedly by 1.4 years in 2012, remained stable in 2013 and declined again in 2014. The wording of the GALI question was not revised in UK in 2008, but the data source and questions did change in 2012; the survey source changed from the General Lifestyle Survey to the Family Resources Survey from April 2012. The EU-SILC data for 2012 was based only on data collected between April 2012 and September 2012 and therefore the available sample for the UK was reduced compared with previous years. The revised data items for activity limitation measurement changed from April 2012, using different responses categories, time periods and terminology. These differences in combination are likely reasons for the abrupt reduction in HLY observed in 2012 and 2013.

FRS collects data on benefits, likely to affect reporting of activity limitation. Question changes can be seen at: http://www.eurohex.eu/pdf/Reports_2014/2014_TR4%20SILC%20questions_Backtranslation.pdf

Prevalence of activity limitation in United Kingdom and in the European Union (EU28) based on the GALI question, by sex and age group (SILC, Mean2012-2014)

These results should be interpreted with caution as samples sizes in the SILC survey vary markedly; for instance in 2014 they ranged from 5758 in Denmark to 40274 in Italy. In 2014, the sample size for United Kingdom comprised 9469 women and 8436 men aged 16 years and over.
Key points:

In 2014, LE at age 65 in United Kingdom was 21.3 years for women and 18.8 years for men.

Based on the SILC 2014 at age 65, women spent 10.6 years (50% of their remaining life) without activity limitation (corresponding to Healthy Life Years, HLY), 5.3 years (25%) with moderate and 5.3 years (25%) with severe activity limitation.*

Men of the same age spent 9.8 years (52% of their remaining life) without activity limitation, 4.6 years (25%) with moderate and 4.4 years (23%) with severe activity limitation.*

For all health expectancies the years of life spent in positive health were greater for women than men; however, because women have longer life expectancies than men, they experience a slightly higher proportion of their lives in unfavourable health states than men.

These results should be interpreted cautiously given the lack of the institutional population, such as people living in residential and nursing homes, which constitute a higher proportion of those aged 65+ years.

*These may not sum to Life Expectancy due to rounding

Publications and reports on health expectancies for United Kingdom


<table>
<thead>
<tr>
<th>Life Expectancy at age 65 and expected years</th>
<th>Women</th>
<th>10.6</th>
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<th>5.3</th>
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<tr>
<td>Without activity limitation</td>
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<tr>
<td>With moderate activity limitation</td>
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<td>With severe activity limitation</td>
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<td>Men</td>
<td></td>
<td>9.8</td>
<td>4.6</td>
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<tr>
<td>Without chronic morbidity</td>
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<td>Life Expectancy at age 65 and expected years</td>
<td>Women</td>
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<td>13.8</td>
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<tr>
<td>Without chronic morbidity</td>
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<tr>
<td>With chronic morbidity</td>
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<tr>
<td>Men</td>
<td></td>
<td>6.4</td>
<td>12.4</td>
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<td>In very good or good perceived health</td>
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<td>In fair perceived health</td>
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<tr>
<td>In bad or very bad perceived health</td>
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<tr>
<td>Men</td>
<td></td>
<td>9.2</td>
<td>6.6</td>
<td>3.0</td>
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Expected years

0 2 4 6 8 10 12 14 16 18 20 22 24

Women

Men

Life Expectancy at age 65 and expected years

- Without activity limitation
- With moderate activity limitation
- With severe activity limitation

Life Expectancy at age 65 and expected years

- Without chronic morbidity
- With chronic morbidity

Life Expectancy at age 65 and expected years

- In very good or good perceived health
- In fair perceived health
- In bad or very bad perceived health

Publications


Thanks to the EU-SILC survey, we now have 10 years of experience in measuring disability within the European Union. The survey really started in 2005 with 25 Member States (MS). In 2008, a coordinated revision of the translation of the GALI was made by some countries to better reflect the original standard. An evaluation made by Eurostat shows that in 2012 the translation of the GALI fully follows the English standard in 18 MS, partially in 8 others and still not in 5 MS. Progressively EU-SILC involved 27 then 28 MS but all the estimations provided below have been estimated for the EU28. The prevalence of disability among women and men is displayed by age and level of severity of the reported disability, from the age group 16-19 to 85+, for the calendar years 2005, 2008, 2011 and 2014.


The revision of the translation of the GALI in 2008 significantly changed the age trajectory of the prevalence of disability, increasing the report of disability among the oldest participants in the EU-SILC survey, especially for those reporting being not severely limited in usual activities. Beyond this change between 2005 and 2008, the general pattern of the age trajectory remains almost unchanged over time. In particular, and especially for the severe limitation, we observed less rapid increase of the prevalence around the retirement age. Among men and women, the age standardized prevalence of reported disability increases over time (Table).


The standardized rate of disability varies little over the years, even between 2005 and 2008 (period of changes in the instrument in some MS). Overall, these rates disclose a small increase over time in the prevalence of reported disability across the European Union.

<table>
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<td>23.0</td>
<td>23.1</td>
<td>23.0</td>
<td>23.9</td>
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<td>(3-year gap)</td>
<td>(0.1)</td>
<td>(-0.1)</td>
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<td>Women</td>
<td>27.8</td>
<td>28.2</td>
<td>28.6</td>
<td>29.3</td>
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<td>(3-year gap)</td>
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</table>

BRIDGE-Health (Bridging Information and Data Generation for Evidence-based Health Policy and Research)

The European Health and Life Expectancy Information System (EHLEIS) is part of BRIDGE-Health which aims to prepare the transition towards a sustainable and integrated EU health information system within the third EU Health Program, 2014-2020 (www.bridge-health.eu).
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