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 2013. 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 2013;
- Life expectancy and HLY at age 65 in the member states of European Union in 2008 and 2013, by gender.

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 2.5 years for women and 2.2 years for men over the period 2004-2013. LE was below the EU28 average in 2013 (21.3 for women and 17.9 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 2013 women and men at age 65 can expect to spend 28% and 34% of their life without self-reported long-term activity limitations respectively.

In 2013 the HLY values for Estonia are 2.9 years for women and 3.4 for men, below the EU28 average (8.6 for women and 8.5 for 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 remained stable for women and slightly decreased for men.

Prevalence of activity limitation in Estonia and in the European Union (EU27) based on the GALI question, by sex and age group (SILC, Mean 2011-2013)

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 (2011-2013), 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 2013 they ranged from 5429 in Denmark to 38039 in Italy. In 2013, the sample size for Estonia comprised 6716 women and 5835 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 2013)

**Key points:**

In 2013, LE at age 65 in Estonia was 20.3 years for women and 15.2 years for men.

Based on the SILC 2013, at age 65, women spent 5.7 years (28% of their remaining life) without activity limitation (corresponding to HLY)), 8.8 years (43%) with moderate activity limitation and 5.8 years (28%) with severe activity limitation.*

Men of the same age spent 5.1 years (34% of their remaining life) without activity limitation compared to 6.8 years (45%) with moderate activity limitation and 3.3 years (22%) 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. Haiguskoormuse tõttu kaotatud eluaastad Eestis [Health loss due to burden of disease in Estonia]: University of Tartu; 2005.
In 2013, LE at age 65 varies by 9.7 years in the EU from 13.9 years for men in Latvia to 23.6 years for women in France. In each MS, LE for women is always higher than for men – around 3.4 years on average. The proportion of LE free of activity limitation (corresponding to HLY) varies by country from 19.8% to 68.9%. Even ignoring potential outliers there still appears to be considerable cross-national variation. Men and women live about the same amount of time without activity limitations. Next to the 7 MS where the number of HLY was already slightly larger for men than for women in 2008, a slightly larger HLY in men is observed in an additional 5 MS in 2013.