

Health Expectancy in Latvia

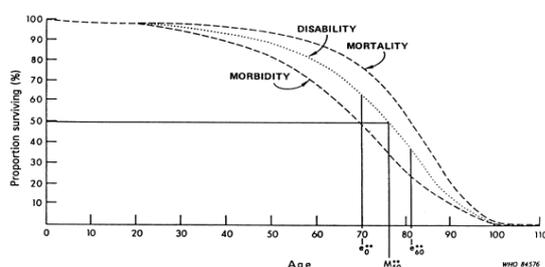
What is health expectancy?

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.



e_0^{**} and e_{60}^{**} are the number of years of autonomous life expected at birth and at age 60, respectively.
 M_{50}^{**} is the age to which 50% of females could expect to survive without loss of autonomy.

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 sub-groups: 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 Community 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 Joint Action European Health and Life Expectancy Information System (EHLEIS) as part of a country series. In each report we present:

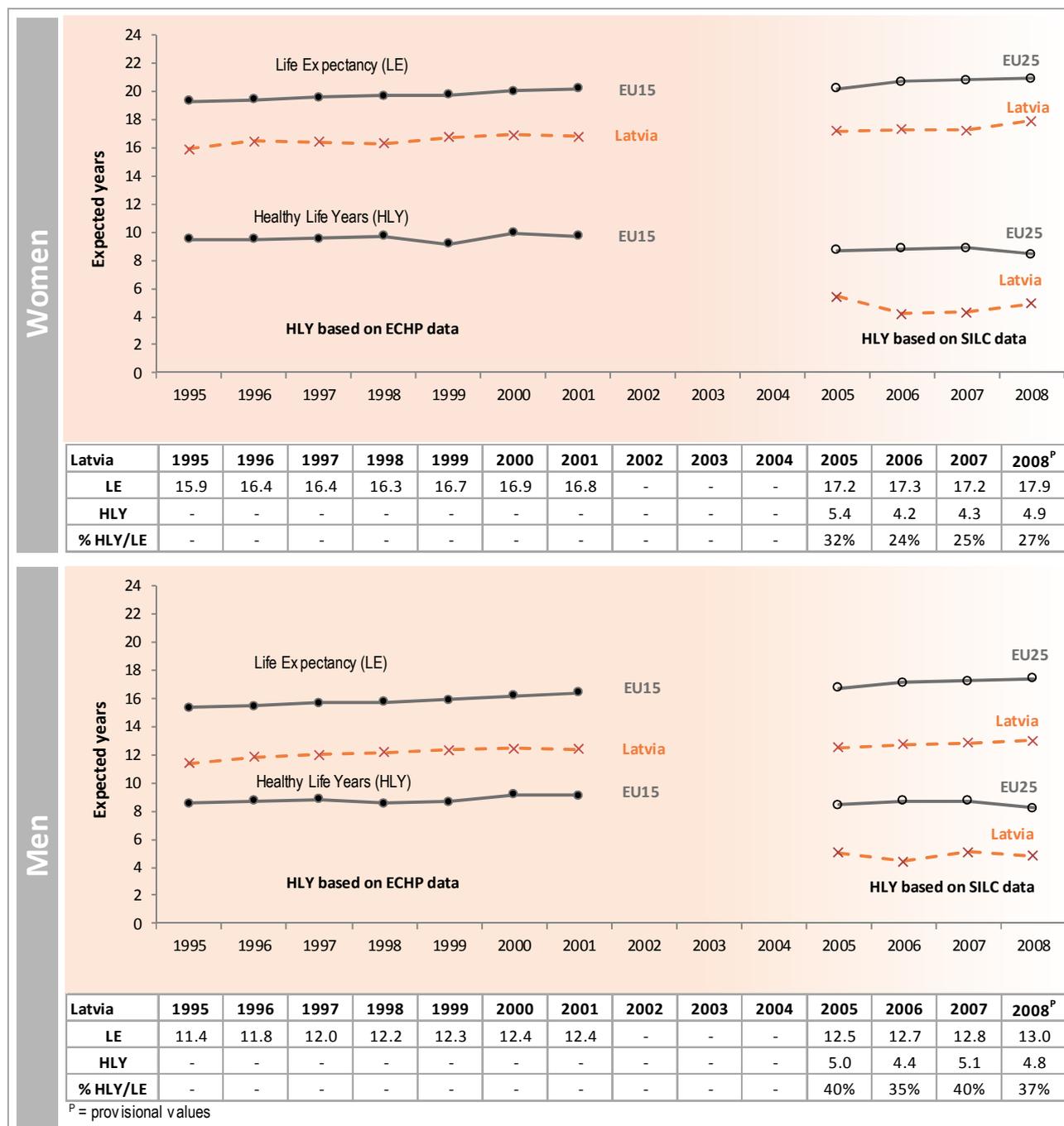
- life expectancies and Healthy Life Years (HLY) at age 65 for the country of interest and for the overall 25 (27 after 2007) European Union member states (EU25 then EU27), using the SILC question on long term health related disability, known as the GALI (Global Activity Limitation Indicator), from 2005. The wording of the question has been revised in 2008. When available, we provide previous HLY series based on the disability question of the 1995-2001 European Community Household Panel (ECHP);
- health expectancies based on the two additional dimensions of health (chronic morbidity and self-perceived health) for the country of interest, based on SILC 2008;
- a comparison of the prevalence of activity limitation in Europe before and after the revision of the GALI in 2008.

References

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- Robine J.-M., Jagger C., Mathers C.D., Crimmins E.M., Suzman R.M., Eds. *Determining health expectancies*. Chichester UK: Wiley, 2003.
- Sullivan D.F. *A single index of mortality and morbidity*. HSMHA Health Reports 1971;86:347-354.
- World Health Organization. *The uses of epidemiology in the study of the elderly: Report of a WHO Scientific Group on the Epidemiology of Aging*. Geneva: WHO, 1984 (Technical Report Series 706).

* 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 Latvia and the European Union (EU15 and EU25) based on ECHP (1995-2001) and SILC (2005-2008)



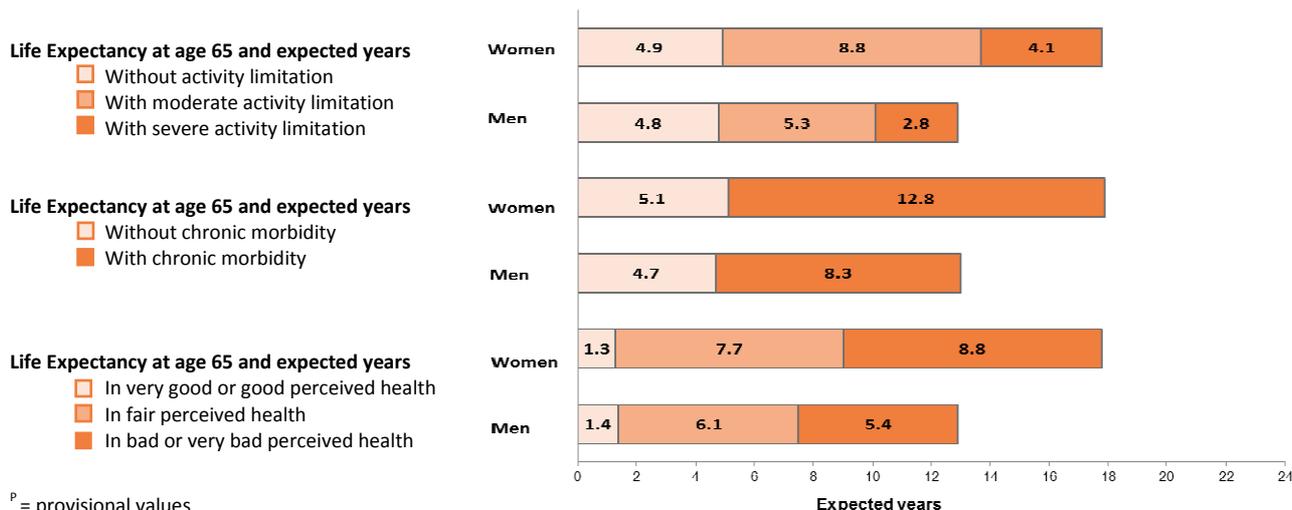
Key points:

Latvian life expectancy (LE) at age 65 has increased by 1.6 years for women and 0.8 year for men over the period 1998-2008: LE for both sexes between 1995 and 2001 was below the EU15 average and remained below the EU27 average (20.7 for women and 17.4 for men) in 2008, 4.8 years for men and 3.4 years for women.

Because Latvia joined the European Union in 2004, the first series of health expectancy based on activity limitation (HLY) over the 1995-2001 period is not available.

The new HLY series, initiated in 2005 with the SILC data, shows that in 2008 women and men at age 65 can expect to spend 27% and 37% of their life without *self-reported long-term activity limitations* respectively. In 2008 the HLY values for Latvia are 3.5 years and 3.4 years below the EU27 average (8.4 for women and 8.2 for men) for women and men respectively. Between 2007 and 2008 HLY increased for women and slightly decreased for men in Latvia. Note that the wording of the GALI question was not changed in 2008.

Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for Latvia (Health data from SILC 2008^P)



Key points:

In 2008 LE at age 65 in Latvia was 17.9 years for women and 13.0 years for men.

Based on the SILC 2008, at age 65, women spent 4.9 years (27% of remaining life) without activity limitation (corresponding to Healthy Life Years (HLY)), 8.8 years (49%) with moderate activity limitation and 4.1 years (24%) with severe activity limitation.*

Men of the same age spent 4.8 years (37% of remaining life) without activity limitation compared to 5.3 years (41%) with moderate activity limitation and 2.8 years (21%) with severe activity limitation.*

Although 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 similar.

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, and in some countries the small sample size. The sample size for Latvia comprised 1818 women and 893 men aged 65+ years in 2008.

* These may not sum to Life Expectancy due to rounding

Publications and reports on health expectancies for Latvia

- Krumins J. Health Policy and Recent Changes in Mortality and Life expectancy in Latvia. *Humanities and Social Sciences: Latvia*. 2008; 1 (54): 57-71.
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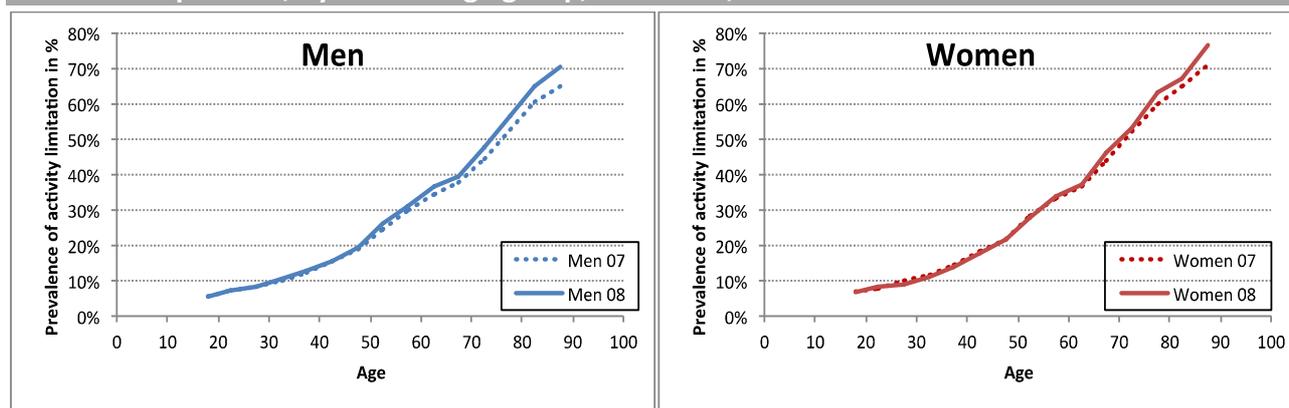
The prevalence of activity limitation in Europe before and after the revision of the GALI

Activity limitation, a key component of the Healthy Life Years (HLY), has been monitored at the EU25 level since 2005 (and 2007 for the EU27) by the Global Activity Limitation Indicator (GALI) from the Statistics on Income and Living Conditions (SILC) survey.

In 2008 translations of the GALI in the national SILC

questionnaires were revised based on scientific translations made for the European Health Interview Survey (EHIS). The resulting improvement of the wording of the GALI for a number of countries coincided with a small increase in the prevalence of activity limitation in Europe particularly at older ages (Figure and Table below).

Prevalence of activity limitation in Europe (EU25) before and after the revision of the translation of the GALI question, by sex and age group, SILC EU25, 2007 and 2008



In 2008, as in 2007, reported limitation in usual activities strongly increased with age and women systematically reported more activity limitation than men. However the prevalence of activity limitation in the EU25 appears to have increased between 2007 and 2008. This increase is greatest at older ages, amounting to around 4% for the standardized prevalence rate at age 65 and over (see Table).

This increase in the prevalence of limitation in usual activities, as reported in SILC between 2007 and 2008, may be due to the revision of the wording of the questions in SILC in 2008. Only future values will tell us whether activity limitation is really increasing in Europe or whether it is merely a methodological issue.

When interpreting national series of Healthy Life Years (HLY) from 2005 or 2004 (for the first countries running

SILC), it is important therefore to consider whether the wording of the GALI question has changed between 2007 and 2008 and whether the new national wording better reflects the EU GALI standard. Because of this overall increase in the prevalence of activity limitation at the EU level, HLY estimates will decrease for the first time since the implementation of SILC.

Standardized prevalence of activity limitation at age 65 and over (in %), SILC EU25, 2005-2008 ^a				
	2005	2006	2007	2008
Men	45%	44%	44%	47%
Women	50%	50%	50%	52%

^aStandardized to the 2007 EU25 Population

About the Joint Action EHLEIS

The current Joint Action EHLEIS (European Health and Life Expectancy Information System) and Eurohex (www.eurohex.eu) are funded by the European Public Health Programme (2008-2013) and is a collaboration between: Belgium (Scientific Institute of Public Health - ISP-WIV), the Czech Republic (Institute of Health Information and Statistics of the Czech Republic - UZIS CR), Denmark (Danish National Board of Health - SST; Economic Council of the Labour Movement - AE; University of Southern Denmark - IPH; National Institute of Public Health - NIPH), France (National Institute of Health and Medical Research - INSERM; National Institute of Demography - INED; Regional Oncology Research Centre - CRLC; University of Montpellier - UM2), Germany (Robert Koch Institute - RKI; Rostock Center for Demographic Change - UROS), Greece (Hellenic Statistical Authority - HSA), Italy (University La Sapienza - DSSEAD), The Netherlands (Erasmus Medical center - EMC; National Institute for Public Health and the Environment - RIVM; Statistical Office - CBS), Sweden (National Board of Health and Welfare - SoS/NBHW) and the United Kingdom (Office for National Statistics - ONS; Newcastle University - UNEW). The JA:EHLEIS and Eurohex aim to provide a central facility for the coordinated analysis, interpretation and dissemination of life and health expectancies to add the quality dimension to the quantity of life lived by the European populations. Further details about the Joint Action can be found on the websites: www.eurohex.eu and www.healthy-life-years.eu.