Disability statistics background - European health and social integration survey

Statistics Explained

Latest update of text: November 2015

This background article explains the data from the European Health and Social Integration Survey (EHSIS), a population survey that provides information relating to a biopsychosocial model of disability in the European Union (EU) . Starting from this model, people with disabilities are those who face barriers to participation associated with a long-standing health problem and/or a basic activity difficulty . The EHSIS not only presents information on barriers to participation that are related to disability, but also looks at a range of other barriers to participation, such as finance and convenience.

The article provides information on the main features of the disability data derived from the EHSIS, their historical development, some main methodological features and information concerning data quality.

This article is one of a set of background articles concerning the methodology for the production of disability statistics in the EU and accompanies a number of statistical articles which make up an online publication on disability statistics .

Main features

Statistical objectives

The EHSIS aims to provide statistical data — on a harmonised basis and with a high degree of comparability between the EU Member States — applying the concept of disability used by the World Health Organisation 's International classification of functioning, disability and health (ICF) , based on a biopsychosocial model.

Disabled people are those facing barriers to participation in any life area, owing to a long-standing health problem and/or a basic activity difficulty.

For more information on disability models, please refer to an introductory article on disability statistics .

Scope of the data

The EHSIS includes questions in three sections:

1. socio-economic background;
2. a health component to identify long-standing health problems and activity difficulties;
3. a list of 10 life areas that enable an individual to be a fully functional and integrated member of society, used to measure social integration in general and identify disability in particular.

The general coverage of the survey is the population aged 15 or over living in private households residing in the territory of the country.

Development and legal basis

Development and history

The European disability and social integration module (EDSIM) was initially conceived as a module for the European health interview survey (EHIS) . However, before being integrated into the EHIS it was decided to extend the planned module and to implement it as an independent disability survey, which then became known as the EHSIS.

The EHSIS was a one-off survey launched by Eurostat and conducted in 2012 or 2013 through calls for tenders. Only five national statistical authorities (Denmark, Spain, Latvia, Hungary and Slovenia) were partly or fully involved in the exercise; elsewhere it was implemented by private enterprises. As well as data for the EU Member States, data were also collected for Iceland and Norway. Data were not collected for Ireland (as the contract for the Irish survey was cancelled) nor for Croatia as it was not an EU Member State at the time of launching the call for tenders.

In November 2013, Eurostat and representatives of the national statistical authorities agreed to discontinue this survey and instead to consider including a disability module into the future waves of the European health interview survey (EHIS).

Legal basis

The EHSIS was conducted on the basis of calls for tenders and contracts, in other words, without a legal obligation.

Methodology

Main sources

The EHSIS was implemented in each participating EU Member State or non-member country based on a model questionnaire with instructions for interviewers. The contracting authorities were asked to translate it according to a standard translation protocol. No deviation was allowed except those resulting from cultural differences and the data collection method used: adaptations were needed in case of telephone or web-based interviews.

Geographical coverage

Data were collected for all of the EU Member States except for Ireland and Croatia, and also for Iceland and Norway.

Aggregates were calculated for the EU-27 as a whole and for the European economic area . Note that these aggregates exclude data for Ireland and the aggregate for the European economic area also excludes data for Liechtenstein; for these reasons these aggregates are disseminated as estimates.

Statistical units

The statistical unit is the individual.

Main concepts and definitions

A summary is given below of the topics surveyed in the EHSIS. Links to more detailed information are presented below under the heading further methodological information .

Socio-economic background

This section of the survey includes background classificatory questions, such as:

- where the person is living, country of birth, nationality;
- sex, age;
- marital status, household composition, income;
- education level;

- labour status, occupation.

Health status

The health component includes:

- the minimum European health module (MEHM) comprising questions about
  - a person's general health condition (self-perceived health)
  - the self-reported existence of long-standing illnesses or long-standing health problems (chronic morbidity) and
  - the severity of limitations in usual activities due to a health problem (activity limitation);
- questions about the existence of one or more long-standing health problems from a list of 18 groups;
- questions about basic activity difficulties (such as seeing, hearing, walking and communicating);
- questions about activities of daily living/personal care activities (such as bathing, dressing and feeding oneself);
- questions about instrumental activities of daily living/household activities (such as preparing meals, using the telephone, going shopping and doing housework).

A **long-standing health problem** is an illness, disease, injury or other health condition which has lasted or is likely to last for at least six months. The main characteristics of a long-standing health problem are that it is permanent and may be expected to require a long period of supervision, observation or care. Acute (temporary) health problems, such as a sprained ankle or a respiratory tract infection are not considered as being long-standing.

For the various types of activities — basic activities, personal care activities and household activities — respondents were asked to rate the **level of difficulty** between:

- no difficulty;
- some difficulty;
- a lot of difficulty;
- cannot do at all/unable to do.

Barriers to life areas

The final section of the survey concerns a list of 10 areas (also referred to as domains) concerning important aspects of life that relate to an individual's ability to be a fully functional and integrated member of society. These areas were identified as being the most relevant from the ICF. The areas are:

- mobility,
- transport,
- accessibility to buildings,
- education and training,
- employment,
- internet use,
- social contact and support,
- leisure pursuits,
- economic life,
- attitudes and behaviour.

For each of these areas respondents were asked whether:

- there were barriers restricting their participation in specified area and what those barriers were;

- a lack of aids or equipment prevented participation;
- a lack of personal help or assistance prevented participation.

Note that these questions concerning participation in life areas and restrictions to participation were asked to all respondents, not just those with a long-standing health problem or a basic activity difficulty.

People with disabilities and the severity of their disability

Based on the information participation in the 10 life areas and the re asons for barriers to participation, respondents were classified as disabled or not.

People with disabilities are those who face barriers to participation in any (in other words, at least one) of the 10 life areas, where the barrier is associated with a long-standing health problem and/or a basic activity limitation. A person identifying a long-standing health problem and/or basic activity limitation as barrier in any life domain was categorised as disabled.

Important note: not all people who have a long-standing health problem and/or basic activity limitation are disabled as it may be that these problems or limitations were not barriers to any of the 10 selected life areas.

The **severity of disability** was calculated by adding up the number of life areas where a respondent encounters a barrier associated with a long-standing health problem and/or a basic activity limitation. For the purposes of data presentation three levels of severity were compiled, for those facing disability barriers in: one life area, two or three life areas, and four or more life areas.

Reference period

The EHSIS data refer to the situation of the population at the time of the survey.

For long-standing health problems it concerns problems that had lasted or were likely to last for at least six months.

Main classifications

EHSIS makes use of the following international classifications:

- the international classification of functioning, disability and health (ICF);
- educational attainment is compiled according to the 1997 version of the international standard classification of education (ISCED 1997) ;
- occupation in employment uses the 2008 version of the international standard classification of occupations (ISCO-08) ;
- the economic sector in employment is collected according to an aggregation — into 10 headings — of the section level (one letter) of the 2008 version of the statistical classification of economic activities in the European Community (NACE Rev. 2) .

Further methodological information

A model questionnaire and detailed information on the questions asked are available in the EHSIS questionnaire interviewer instructions.

Metadata concerning the results of the EHSIS are available from European health and social integration survey (EHSIS) (ESMS metadata file — hlth_dsb_prve_esms).

Data quality

The data collection methods for this survey were prepared taking into account issues of comparability and harmonisation between EU Member States. As a basis for a high degree of comparability, a common questionnaire covering the three sections was prepared. No deviation was allowed except those resulting from cultural differences and the data collection method used (adaptations were needed in case of telephone or web-based interviews).

Eurostat checked the consistency and integrity of the microdata so that a minimum output quality standard was reached. In addition, data were accompanied by national quality reports stating the accuracy and reliability of the data.

The coverage of the EHSIS limits its completeness in a number of ways, most notably in that it excludes children (under the age of 15) and people living in collective households and in institutions. As such it does not provide information on disabled children, and the data for persons aged 15 and over are biased in so far as the prevalence of disability in collective households and in institutions is different from that in private households.

Coverage errors

A failure to include all members from the target population in the sampling frame is likely to yield a coverage error. A variety of sampling frames were employed across countries. Population registers were used in 11 countries, random digit dialling (RDD) and list-assisted RDD was used in 10 countries, and area probability samples were drawn in the remaining seven countries. In 18 countries, the sampling frame was updated during the year of the survey data collection (2012); in seven countries (the Czech Republic, Estonia, Spain, Italy, Cyprus, Lithuania and Malta) the frame was a year older. Older frames were used in Greece and Portugal (both 2001), as well as in Romania (2004).

Use of proxy interviews

Since many of the questions in the EHSIS interview are subjective and rely on respondent's own assessment of their situation, proxy interviews — in other words, when someone else answers on behalf of the interviewee — were permissible only when the sampled person was severely impaired.

Unit response rates

Traditionally, face-to-face surveys yield the highest response rates, followed by telephone surveys, mail and web surveys. One caveat in the calculation of response rates for EHSIS is that they do not account for cases with unknown eligibility. As such, in telephone surveys for example, 'ring-no-answer' cases are probably included in the denominator (number of eligible units), even though it is unknown whether these are business lines, or numbers that not working for other reasons. This might explain the remarkably low response rates for telephone surveys, in particular when using the 'random digit dialling' method for selecting the sample (in such cases, the response rates were below 20 %).

In most countries, the main reason for non-response was refusal to take part in the interview. In only 10 Member States (Belgium, Denmark, Estonia, Latvia, Lithuania, Malta, Portugal, Romania, Finland and Sweden), the main reason for non-response was failure to contact the selected sampled person. The extent to which refusals and non-contacts are systematically different from those interviewed in the EHSIS on disability-related measures may introduce bias in the estimates reported by country. Most countries used post-stratification to adjust for non-response.

Data dissemination

Published data

Statistical data from the EHSIS are available in two formats. Statistics Explained articles provide data and analysis, while Eurobase provides a set of multi-dimensional databases .

Disseminated EHSIS data are normally analysed by age and/or sex and often by other dimensions, including: labour status, educational attainment level, income quintile and household type.

Most of the published EHSIS data are focused on disabled people. However, some of the data are concerned with people reporting a long-standing health problem or limitations in basic activities, personal care activities or household activities, regardless of whether they are disabled or not.

Time coverage

The data available from the EHSIS refer to 2012.

Units

All indicators are published in Eurostat's databases as the number of people, while the Statistics Explained articles concerning EHSIS data also present data as percentages, for example the percentage of disabled people in the population, or the percentage of disabled people with specific socio-demographic characteristics.

Timing of data release

The data from the EHSIS were disseminated in May 2015.

See also

Online publications

- Disability statistics
- Health in the European Union – facts and figures

Other background articles related to the methodology of disability statistics

- European health interview survey - methodology
- Health variables in SILC - methodology

Database

- Health (hlth) , see:

Disability (hlth_dsb)

Dedicated section

- Health

Methodology / Metadata

- European health and social integration survey (EHSIS) (ESMS metadata file — hlth_dsb_prve_esms)
- The EHSIS questionnaire interviewer instructions contain a model questionnaire
- List of data sources

External links

- European Commission — Directorate-General for Employment, Social Affairs and Inclusion — Social protection and social inclusion — EU social indicators
- European Commission — Directorate-General for Health and Food Safety — Public health — ECHI — European Core Health Indicators
- European Commission — Directorate-General for Health and Food Safety — Public health — Indicators — Policy
- International classification of functioning, disability and health (ICF)

View this article online at http://ec.europa.eu/eurostat/statistics-explained/index.php/Disability_statistics_background_-_European_health_and_social_integration_survey