Self-perceived health statistics

This article presents an overview of the self-reported health status of the population of the European Union (EU). It focuses initially on two key indicators describing the levels and distribution of health status: self-perceived health gives an overall assessment by respondents of their health in general; chronic morbidity assesses the presence of a long-standing illness or health problem. Statistics on self-perceived health are supplemented by information concerning bodily pain.

This article is one of a set of statistical articles concerning health status in the EU which forms part of an online publication on health statistics.

Self-perceived health

More than two out of three people in the EU-28 perceived their health as very good or good in 2016

In the EU-28, 67.5% of the population aged 16 and over perceived their health as very good or good in 2016, while 23.7% perceived it as fair and 8.8% as bad or very bad. Across the EU Member States, the share of people who perceived their health as very good or good ranged from 58.5% in Poland to 78.7% in Cyprus, with Estonia (52.9%), Portugal (47.7%), Latvia (47.2%) and Lithuania (43.4%) below this range and Ireland (82.4% in 2015) and Cyprus (78.7%) above it; Switzerland (77.7%) and Norway (77.1%) also reported a high share (see Figure 1). Among the candidate countries included in Figure 1, the Former Yugoslav Republic of Macedonia recorded a relatively high share of persons perceiving their health as good or very good (77.1%).
Infographic: Self-perceived health

Self-perceived gender health gap: men tended to rate their health better than women
In 2016, men were more likely to rate their health as very good or good than women in all EU Member States (Table 1). By this measure, the largest gender health gaps were recorded in Romania, Latvia, Portugal and Lithuania. Across the EU-28 as a whole, the gender health gap was 5 percentage points, as 70.1% of men rated their health as very good or good compared with 65.1% of women.

Conversely, when focusing on the population that rated their health as bad or very bad, the shares for women were generally higher than those for men, with Ireland the only EU Member State that was an exception (a difference of 0.2 percentage points in 2015). In the EU-28 as a whole, 9.9% of women and 7.7% of men regarded their health as bad or very bad in 2016.
Negative perception of health increased with age as does the gender health gap

Self-perceived health also has a distinct age pattern as fewer people tended to rate their health as being very good or good in higher age groups than in lower age groups, while the share reporting bad or very bad health increased with age (see Figure 2). Similarly, the share of persons reporting that their health was fair increased up to the age group 85 and over where a decrease of 2.4 percentage points was recorded compared to the age group 75–84.

The gender health gap concerning the share of the population reporting very good or good health was evident across all age groups: the gap received the lowest value for the age group 16–24 (1.8 percentage points lower for women) and generally increased with age, peaking among people aged 75–84 (6.4 percentage points).
Higher educated people perceived their health as better

Clear differences appear when looking at the relationship between self-perceived health and educational attainment level. In the EU-28, 55.6 % of the population having completed at most lower secondary education, 69.3 % of the population having completed upper secondary or post-secondary non-tertiary education, and 79.8 % of the population having completed tertiary education perceived their health as very good or good in 2016. The health gap between educational attainment levels is apparent in nearly all EU Member States, generally with the same pattern as the one observed for the EU-28 as a whole. In Malta, the share of people reporting very good or good health was not substantially different among those having completed tertiary education and those with at most upper secondary or post-secondary non-tertiary education.

The largest gap in the share of the population reporting very good or good health between those with the highest and the lowest educational attainment levels was observed in Portugal (41 percentage points), followed by Croatia (39.5 percentage points) and Poland (38.2 percentage points). From the candidate countries for which data are available, Serbia recorded a high difference in the respective shares for high and low educated persons (38.4 percentage points). The smallest gap, less than 19 percentage points, was observed in Denmark, Germany and the Netherlands as well as Switzerland, Norway and Iceland (see Figure 3).
Figure 3: Share of persons aged 16 and over with very good or good self-perceived health, by educational attainment level, 2016 (%)Source: Eurostat (hlth_silc_02)

Health inequalities increased with income

In the EU-28, 60.1 % of the population in the first income quintile group (the 20 % of the population with the lowest income) and 60.7 % in the second quintile group perceived their health as very good or good in 2016, compared with 66 % in the third quintile group, 72.2 % in the fourth quintile group and 78.3 % in the fifth income quintile group (the 20 % of the population with the highest income).

Figure 4 shows the share of the population that reported very good or good health for three of the income quintile groups, specifically the highest, middle and lowest quintiles. Nearly all EU Member States showed a similar pattern, with the lowest shares of people who perceived their health as very good or good being recorded for the first income quintile group, the highest shares for the fifth income quintile group, and shares for the third income quintile group between these two. Only five EU Member States deviated from this pattern, Greece, Romania, Slovakia, Spain and Italy, where the population with middle income were less likely to report very good or good health compared with the population with lower income; this was also the case in Serbia.
By far the largest difference in the share of the population reporting very good or good health between the populations in the highest and lowest income quintiles was observed in Estonia, followed by Latvia (46 and 41 percentage points, respectively). By contrast, relatively little difference in very good and good self-perceived health between the highest and lowest income groups was observed in Romania.

**Bodily pain**

The second wave of the European health interview survey (EHIS) conducted between 2013 and 2015 surveyed persons aged 15 and over and included questions asking respondents about their health status; which among others, recorded the intensity of bodily (physical) pain that respondents experienced – on average – during the four weeks prior to the interview. In all countries, except for Germany, France, Luxembourg, the Netherlands, Slovenia, Finland as well as Iceland (see Table 2), more than two fifths of all respondents reported no bodily pain. This share was around three fifths of the reference population in just two Member States, namely, Greece and Italy, and peaked at 69.3 % in Cyprus. The share of the population reporting moderate, severe or very severe bodily pain was highest in Poland and Slovenia (between 31 % and 32 %), while it was lowest in Latvia and Malta (just over 13.5 % and 14 %, respectively). Focusing just on severe and very severe bodily pain, Portugal reported the highest share (15.3 %), followed by Poland, Estonia, the Netherlands and Belgium, as well as Iceland, with shares ranging from 10 % to 12 %. Turkey also recorded a relatively high share of severe or very severe bodily pain among the reference population (14.3 %). By far the lowest shares were reported in Latvia, the Czech Republic, Romania, Ireland and Bulgaria (around 5 %), with several Member States reporting shares between 7 % and 9 %.
Table 2: Distribution of persons aged 15 and over according to self-declared severity of bodily pain, 2014 or nearest year (%)

Source: Eurostat (hlth_ehis_pn1e)

Women were more likely than men to report experiencing bodily pain

An analysis by sex indicates that a higher proportion of men than women reported experiencing no bodily pain, with the differences between the sexes ranging between 7 and 15 percentage points, with Portugal (18.6 percentage points), Spain (16.7 percentage points) above this range and France and Ireland (both close to 5 percentage points) below it. Turkey also recorded a high difference in the respective proportions between the sexes (a difference of 19.3 percentage points).

Table 3 focuses on the share of the population aged 15 and over that reported at least moderate bodily pain, including therefore persons reporting moderate, severe or very severe bodily pain. For these levels of bodily pain, the range of the gender gap remained at the same levels, ranging from 4.5 percentage points in the Czech Republic to 13 percentage points in Lithuania and Spain, with Portugal again above this range (a difference of 17 percentage points). Similarly, in Turkey the respective gender gap exceeded 17 percentage points.
Table 3: Share of persons aged 15 and over declaring moderate, severe or very severe bodily pain, 2014 or nearest year (%)Source: Eurostat (hlth_ehis_pn1e)

Age is another important factor, with the proportion of older people reporting at least moderate bodily pain many times higher than the proportion of younger people (Table 3). For example, this was especially the case in Romania, where 1.6 % of those in the age group 15–24 reported at least moderate physical pain, compared with 66.8 % among the age group 75 and over.

Equally, education attainment levels play a role, with the lowest likelihood of reporting at least moderate bodily pain among people having completed tertiary education and the highest among those having completed at most lower secondary education (see Figure 5). Finland was the only EU Member State to display a slightly different pattern, as the proportion of people reporting at least moderate bodily pain was higher among those having completed upper secondary or post-secondary non-tertiary education than those having completed at most lower secondary education. Slovenia, Hungary, Croatia, Slovakia, Portugal and Romania reported relatively large differences in the share of people declaring at least moderate bodily pain according to their level of educational attainment.
Chronic morbidity

More than one out of three people in the EU aged 16 years or over reported having a long-standing illness or health problem in 2016

In 2016, 35.4 % of the EU-28 population aged 16 and over reported having a long-standing illness or health problem; this share has slightly increased over time. Among the EU Member States, the lowest prevalence of such problems was observed in Italy (15.2 %) and Romania (19.2 %), while most Member States reported shares ranging between 24 % and 40 %, although Bulgaria (21.2 %) and Luxembourg (23.2 %) were below this range, whereas Portugal (41.4 %), Germany (42.3 %), Estonia (44.1 %) and Finland (46.9 %) were above this range (see Table 4).
Men were less likely to have reported long-standing health problems than women

Similar to self-perceived health, men reported long-standing illnesses or health problems less often than women: in 2016, the EU-28 share for men was 33.4% while the respective share for women reached 37.4% (see Figure 6). Among the EU Member States, the largest gender gaps for this indicator were observed in Latvia, Finland, Portugal and Lithuania (8 percentage points or more); Iceland (2015), Norway as well as Serbia from the candidate countries also reported large gaps (9 percentage points or more). By contrast, the narrowest gaps were in Ireland (2015), Malta (both 0.9 percentage points) while in Cyprus the respective share of men was higher than that for women by 1.3 percentage points.
A major factor in the prevalence of long-standing illnesses or health problems was age: while 28.5% of the population in the EU-28 aged 16–24 reported a chronic health problem in 2016, the share rose to 66% for the age group 75–84 and to 72% among people aged 85 and over (see Figure 7).

Employed persons were less likely to have reported long-standing health problems than unemployed persons

Looking at the reference population (persons aged 16 and over), there is also a relationship between work-
ing status and the prevalence of long-standing illnesses and health problems (see Figure 8). Whereas 25.4% of employed persons in this age range in the EU-28 reported such problems in 2016, the share rose to 38.6% for unemployed persons. The differences in self-reported long-standing illnesses or health problems between employed and unemployed persons were higher among the older working-age population: for persons aged 16–44 the prevalence of long-standing illnesses and health problems among unemployed persons was 9 percentage points higher than for employed persons, while for persons aged 45–64 the difference was 18 percentage points.

Figure 8: Share of persons aged 16 and over with long-standing (chronic) health problems, by labour status, 2016 (%) Source: Eurostat (hlth_silc_04)

All of the Member States, reported the same broad pattern for the working-age population as described for the EU-28, with a lower share of persons reporting long-standing illnesses and health problems among employed persons than among unemployed persons. In percentage point terms, the largest difference was reported for the Netherlands, the shares of 60% for the unemployed and 24% for employed persons resulting in a difference of 36 percentage points. Other Member States where the difference exceeded 20 percentage points included Austria, the Czech Republic, Germany and Denmark (it should be noted that for the Czech Republic and Denmark data for the unemployed persons are unreliable). Iceland and Norway reported a relatively large difference (21 and 18 percentage points, respectively) in the shares of employed and unemployed persons reporting long-standing illnesses and health problems (although data are unreliable). The lowest differences (4 percentage points or less) in the prevalence of long-standing illnesses and health problems between employed and unemployed persons were reported in Cyprus, Malta, Bulgaria, Greece and Italy.

Source data for tables and graphs

- Self-perceived health: tables and figures

Data sources

Self-perceived health and chronic morbidity

The data used in the article concerning self-perceived health and chronic morbidity are derived from EU statistics on income and living conditions (EU-SILC). This source is documented in more detail in this background article which provides information on the scope of the data, its legal basis, the methodology employed, as well as related concepts and definitions.

The general coverage of EU-SILC is all private households and their members (who are residents at the time of data collection); this therefore excludes people living in collective households. Data refer to the population
Bodily pain

The data concerning bodily pain come from the European health interview survey (EHIS). This source is documented in more detail in this background article which provides information on the scope of the data, its legal basis, the methodology employed, as well as related concepts and definitions.

The general coverage of the EHIS is the population aged 15 and over living in private households. The second wave of the EHIS was conducted in all EU Member States during 2013–2015 according to European Commission Regulation 141/2013 and its subsequent amendment to take account of the accession of Croatia to the EU (European Commission Regulation 68/2014). The data presented here are the results for individual EU Member States from this second wave of the survey.

Limitations of the data

All of the indicators presented in this article are derived from self-reported data so they are, to a certain extent, affected by respondents’ subjective perception as well as by their social and cultural background. Despite their subjective nature, the statistics that are presented are considered to be relevant and reliable estimators of the health status of populations as well as good predictors of health care needs; they are useful for trend analysis and for measuring socioeconomic disparities.

EU-SILC and the EHIS do not cover the institutionalised population, for example, people living in health and social care institutions whose health status is likely to be worse than that of the population living in private households. It is therefore likely that, to some degree, both of these data sources under-estimate health problems. Another factor that may influence the results shown is the different organisation of health care services, be that nationally or locally. Furthermore, the indicators presented are not age-standardised and thus reflect the current national age structures. Finally, the implementation of EU-SILC and the EHIS was organised nationally, which may impact on the results presented, for example, due to differences in the formulation of questions or their precise coverage.

Context

The World Health Organisation defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’, which alludes to its multidimensional nature and a range of different indicators for measuring it.

Good health is an asset in itself. It is not only of value to the individual as a major determinant of quality of life, well-being and social participation, but it also contributes to general social and economic growth. Many factors influence the health status of a population and these can be addressed by health and other policies regionally, nationally or across the EU.

Indicators on health status are given high importance in EU health policies. The monitoring of health status of populations was included in the overarching EU strategy ‘Together for Health: A Strategic Approach for the EU 2008-2013’ (COM(2007) 630 final) and in the more recent ‘Investing in health’ working document. Health status monitoring is also important for more topical policies such as active and healthy ageing, health inequalities and social protection and social inclusion.

Three general health questions on self-perceived health, chronic morbidity and long-term activity limitation (see the article on functional and activity limitations) constitute the Minimum European Health Module (MEHM). Indicators based on the three questions are included in the health status chapter of the European core health indicators (ECHI).

The health status of individuals and of the population in general is determined by a complex set of factors: genetic dispositions, individual behaviour, environmental, cultural and socioeconomic conditions, as well as by the functioning of healthcare services. Eurostat provides data on different health determinants that can help to explain the different levels and distribution of health status among the population, such as:

• health care;
• accidents at work and work-related health problems;
• living conditions and welfare;
• the labour market, in particular unemployment;
• education and training.

Other articles
Online publications
• Health in the European Union — facts and figures
• Disability statistics

Health status
• Healthy life years
• Functional and activity limitations
• Mortality and life expectancy

Methodology
• European health interview survey
• Health variables in SILC

General health statistics articles
• Health statistics introduced
• Health statistics at regional level
• The EU in the world — health

Database
• Health status and determinants, see:

  Health status (hlth_state)
  Self-perceived health and well-being (hlth_sph)
  Self-reported chronic morbidity (hlth_srcm)

Dedicated section
• Health
• Health status and determinants
• Income and living conditions

Publications
• Health statistics — Atlas on mortality in the European Union

Methodology
• European health interview survey (ESMS metadata file — hlth_det_esms)
• European Health Interview Survey (EHIS wave 2) — Methodological manual — 2013 edition
• Health variables of EU-SILC (ESMS metadata file — hlth_silc_01_esms)
External links

- European Commission — Directorate-General for Employment, Social Affairs & Inclusion — Indicators of the health and long-term care strand developed under the open method of coordination on social protection and social inclusion

- European Commission — Directorate-General for Health and Public Safety — European Core Health Indicators (ECHI)

- European Commission — Directorate-General for Health and Public Safety — Public Health — Social determinants and health inequalities


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