Evaluating the Uptake of the Healthy Life Years Indicator

Final report

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Executive summary

Objectives of this evaluation

The European Commission (EC) is interested in the uptake of the Healthy Life Years (HLY) indicator in the EC Services and Member States. In this respect, the EC (DG SANCO) asked RAND Europe to undertake an evaluation to help the EC better understand how to increase the uptake of the HLY indicator and how to raise the profile of health within non-health policies, particularly those addressing or shaped by demographic change. Uptake involves both awareness and use, which we defined as 'having knowledge of the indicator' (awareness) and use of the HLY indicator in practice (e.g. in policy making and/or impact assessment). The evaluation covers the period since the adoption of HLY as a Lisbon Structural Indicator in 2005.

This report charts the research and analysis conducted by RAND Europe. The purpose of this executive summary is to identify key and emerging findings given the evidence available.

Methods used

The evaluation is based upon desk research, a web-based survey and interviews with stakeholders. More specifically, we have reviewed 1) peer-reviewed (scientific) literature, 2) ministerial, OECD and WHO websites, health portals, and national policy documents, 3) Member States' submissions to the Commission and 4) wider information sources (newspaper, broadcast and on-line news websites and professional organisations at national and EU level). The survey was sent to 200 Commission Officials, 87 representatives of National or Regional Health Ministries and 91 representatives of National or Regional Non-Health Ministries. By November 20th, we had received 109 completed surveys (an overall 29% response rate): Commission Officials (N=59), representatives of National or Regional Health Ministries (N=27), representatives of National or Regional Non-Health Ministries (N=16) and anonymous respondents (N=7). In addition, we have conducted 16 telephone interviews comprising 4 Commission officials and 12 Representatives of National or Regional Health Ministries.

What we found

Awareness of the HLY indicator in the European Commission and Member States

Awareness about the concept of HLY is widespread in the scientific literature, but awareness of the HLY indicator differs by stakeholder group. The majority of the National or Regional Health Ministry respondents are aware of the indicator, while most of the Commission Officials responding are *not* aware of the HLY indicator. The picture is not (yet) clear for the surveyed National or Regional Non-Health Ministries. The HLY indicator is seen as a useful benchmarking instrument with regard to the health situation and health promotion between and within Member States, and can serve as relevant input for policies regarding labour market participation, pensions, health condition and lifestyles.

However, in the non-traditional literature, the HLY indicator is often mentioned in relation to the EC Services. There is a difficulty in reviewing the literature as some policy documents originate from the period prior to 2005. These documents are unlikely to contain any references to the HLY indicator, which was only implemented in 2005. However, this does not mean that these countries may not have adopted the indicator subsequently or that they did not use similar or even equivalent indicators. The policy documents do not provide good evidence about the uptake of the HLY indicator. In addition, references to the HLY indicator in Member State policy documents by and large refer to its actual use ('hard' evidence). Such policy documents provide little evidence relating to awareness of the indicator ('soft' evidence). In particular, they do not indicate whether the use of HLY or similar indicators was even considered.

Use of the HLY indicator in the European Commission and Member States

The use of the HLY indicator is *not* (yet) widespread, especially within Commission Services and by National and Regional Non-Health Ministries. Reasons for *not* using the indicator include limited awareness of the *concept*, stage of development of the HLY indicator, use of a similar health indicators prior to the adoption of the HLY indicator (e.g. healthy life expectancy), and the fact that differences between health expectancy indicators and the HLY indicator are not (yet) well understood.

A slight majority of responding National and Regional Health Ministries use the HLY indicator for policy making (e.g. health promotion and functional capacity of labour force), impact assessment (e.g. impact of healthy life style on health), and monitoring (e.g. trends in social protection). In addition, the evidence shows that the HLY indicator is seen as important to measure progress towards the Lisbon objectives, in particular because health is a precursor for economic growth and it is an instrument to put health higher on the European political agenda. However, Structural Indicators should be used alongside each other to measure progress and HLY might particularly be relevant for the added social component of the Lisbon Agenda because it provides information on health determinants of the population and access to, quality and structure of health information.

In the non-traditional literature we only found a small number of references to actual use of the HLY indicator, mainly referring to the UK.

Importance of measuring healthy ageing and the use of the HLY indicator

The review of national policy documents suggests that most Member States have policies to support healthy ageing (i.e. focus on health and quality of life). In fact, many take an even stronger stance, with policies to promote active ageing (i.e. increasing or extending the participation of senior citizens in social and economic life). Survey respondents were asked about their awareness of specific programmes or policies to promote healthy, active ageing. Almost half of the respondents were aware of such policies or programmes. A small number of respondents indicate that healthy ageing is being *monitored* and use the HLY indicator for this purpose. The review of national policy documents confirms that widespread monitoring of healthy ageing policies on the basis of the HLY indicator does not (yet) occur. In addition, only a minority of survey respondents mentioned that the HLY indicator is or would be used to actually *design* policies/programmes to promote healthy ageing.

From the interviews it appeared that the HLY indicator is or will be used for promoting and monitoring healthy ageing policies (e.g. organisation of health care and social care). Most interviewees were, however, hesitant about the usefulness of the HLY indicator to evaluate how well healthy ageing policies are being managed.

What it means

The evidence provided by the literature review, the survey and interviews show that the uptake of the HLY indicator within the EC Services and within National or Regional Non-Health Ministries is lagging behind use in National or Regional Health Ministries. This may be due to a number of factors, in particular, the National or Regional Health Ministries have more need for the HLY indicator; compared to Non-Health Ministries it is more directly relevant for policy making and both direct impact and the scope to incorporate such health expectancy considerations may be greater than at the EC level.

How to improve the uptake of the HLY indicator

Possible ways to increase the uptake of the HLY indicator were identified through the interviews undertaken and the synthesis of all evidence collected. The activities identified are:

- **Improve dissemination activities,** e.g. by providing easier access to information and increase visibility (e.g. through SANCO website); adopting and profiling of HLY by high level of EC Commissioners (e.g. High Commissioner for Health or Public Health Programme committee); and stimulating publication and dissemination of policy documents and scientific articles indicating the use of the HLY indicator both on a national and European level.
- **Improve measurement of the HLY indicator,** e.g. by standardizing definitions used; providing training to research staff and users of HLY; and improving research methodology by providing more financial resources to research groups.
- **Improve understanding of the HLY indicator,** e.g. by providing clear information about what the indictor really does mean, how it is calculated and what ways for harmonising national outputs exist; and organize conferences to increase awareness by presenting different methods to use the HLY indicator and its advantages/disadvantages.

In addition, it is important to raise the profile of the HLY indicator within non-health policies by ensuring that public health is strategically addressed in other EC policies and programmes at all levels ('health in all policies'). Health impact assessment is an effective means in both mainstreaming health and evaluating how other policies affect health. However, there is no sound and solid evidence on the systematic use of HIA across Community services. For HIA to become even more useful we recommend:

- **Supporting 'health in all policies' in the new Health Strategy (to be adopted in summer 2007)**;
- **Developing further coordinated action plans linking health with other policy areas** (e.g. health and safety at work, social affairs, environmental health) to exploit synergies and focus efforts where HLY is at stake; and
- **Providing training on HIA to EC Services** (e.g. DG SANCO developed a practical guide for screening of proposals for possible health impacts and background material useful for putting discussions on HIA in a broader perspective).

CHAPTER 1 Introduction

1.1 Scope of evaluation

In 2004, the European Council re-launched the Lisbon Goals, focusing its priorities on growth and employment. A set of Structural Indicators has been developed to support objective assessment of progress towards the Lisbon objectives. Additionally, integrating Public Health into the Lisbon strategy by 2005 was listed as a priority to contribute to growth and sustainable development. Suhrcke and colleagues describe that "it is a powerful argument for European governments to invest in the health of their populations, not only because better health is a desirable objective in its own right, but also because it is an important determinant of economic growth and competitiveness"[1]. Increasing the healthy life-span spent in work could help solve the age-related expenditure problem; average experience and productivity levels could rise and longer working life could head off retirement-driven increases in e.g. health care utilisation, the incidence of dementia, etc. Alternatively, a healthy retirement can stimulate demand, especially for services, which are an increasingly important sector of the European economy.

In order to guide investments in and monitor health as an economic and societal welfare factor, the European Commission (EC) developed the Healthy Life Years (HLY) indicator, which is part of the European Structural Indicators set. The HLY indicator measures the number of years that a person of a certain age can expect to live without ill-health. The HLY indicator is based on length of life (measured with mortality tables) weighted by quality of life (measured by self-perceived disability assessed by health surveys).

The Commission (DG SANCO) is interested in the uptake of the HLY indicator in the EC Services and Member States and asked RAND Europe to undertake an evaluation to help the Commission better to understand how to increase the uptake of the HLY indicator and how to raise the profile of health within non-health policies, particularly those addressing or shaped by demographic change. The HLY indicator can be used to monitor healthy/active ageing. Healthy ageing is an important policy issue for the societal well-being and economic prosperity of the European Union (EU) in the face of demographic challenges. If the population can remain healthy as they get older, they can also remain active, contributing to society and reducing strains on health and social systems. We would like to note that ageing policy is an example of use of the HLY indicator. In fact, HLY relates to health policy across the board, i.e. health policy is aimed to increase HLY and HLY can be used to measure the success of health policies.

The evaluation covers the period since the adoption of HLY as a Lisbon Structural Indicator in 2005.

[1] Suhrcke M, McKee M, Sauto Arce R, Tsolova S, Mortensen J. The contribution of health to the economy of the European Union. Luxembourg: Office for Official Publications of the European Communities, 2005, p. 5.

1.2 Objectives of evaluation

The evaluation aims to:

- Assess the uptake of the HLY indicator in the EC and Member States;
- Identify gaps in the uptake of the HLY indicator;
- Gain knowledge about the understanding about the importance of measuring healthy ageing at EU and national level;
- Provide evidence that will help the Commission better to understand how to increase the uptake of the HLY indicator; and
- Provide evidence on how to raise profile of health within non-health policies, particularly in the area of demographic change.

The Commission has set ***effectiveness*** as the evaluation criterion to be used for assessing the uptake of the HLY indicator in the EC and Member States. In terms of evaluation, in theory effectiveness means the extent to which the objectives have been achieved and this can be attributed to the policy output. Because uptake involves both **awareness** and **use**, measuring the uptake of the HLY indicator in the EU and the EC requires evidence of: discussion of HLY in relevant literature; practical application in policy making and implementation; and the views of different Commission Services and representatives of National/Regional administrations involved as to the indicator's uses, advantages, limitations and prospects. Please note that we defined awareness of the HLY indicator as 'having knowledge of the indicator' and that we used the term 'actual use' when the HLY indicator was used in practice (e.g. in policy making and/or impact assessment). Note also that awareness and use are not discrete (yes/no) but continuous (scored) variables - e.g. if a document refers to HLY, that shows a level of awareness of the concept (see also section 2.2).

1.3 Outline of report

In this report we detail the work of the evaluation. Chapter 2 describes the methodology and difficulties encountered. Results derived from desk research, the survey and interviews with stakeholders are presented in Chapter 3. The final chapter (Chapter 4) provides conclusions and recommendations.

CHAPTER 2 Methodology used

2.1 Evaluation questions

This Chapter provides a concise overview of the methodology used to assess the effectiveness of the uptake of the HLY indicator since its introduction in 2005. The objectives outlined in Section 1.2 above led to a set of specific evaluation questions.

- **Question 1:** To what extent has the HLY indicator been taken up by the European Commission (EC) Services and National and Regional Administrations since its adoption as a Lisbon indicator in 2005? Is it found in sectors other than the health sector?
- **Question 2:** To what extent is the HLY indicator understood to play an important role in preparing for demographic change and supporting healthy, active ageing?
- **Question 3:** What are the barriers and facilitators to further uptake of the HLY indicator?

These questions form the basis for evaluating the uptake of the HLY indicator in the EC Services and Member States. The data collection includes a literature review (including mass media), a survey and interviews. The following table provides an overview linking data collection methods to evaluation questions.

Table 1: Evaluation logic

	Question 1: Uptake	***Question 2: Healthy ageing***	***Question 3: Barriers and facilitators***
Literature-based assessment of status quo	Awareness, use	Awareness, use	Use and evaluations
Identify views of key stakeholders (survey, interviews)	How used	Scope, nature of use	Why not used, developments
Assessment of effectiveness	Extent of use, good practice	Use in policy, causal relation between ageing policy and HLY uptake	Drivers and requirements, awareness and understanding, data needs, alternatives

2.2 Awareness versus actual use

As described in Chapter 1, we differentiate between 'awareness' and 'actual use' when we refer to 'uptake' of the HLY indicator.

With regard to awareness it is useful to distinguish: awareness of stakeholders and co-ordination activities to build others' awareness.

With regard to actual use, we distinguish the use of the HLY indicator for policy formulation and/or impact assessment (i.e. what is for example direct suitability and utility of the HLY indicator as a measure for preparing demographic change and supporting healthy, active ageing?).

The assessment of uptake will include evidence on *what* indicator set (if any) is used, *how* HLY (or related indicators) are measured and used, how (if at all) the HLY indicator has been *adapted* for specific uses, and how HLY figures in co-ordination.

2.3 Data collection activities

2.3.1 Desk research

We used several documents and sources to assess awareness rather than to quantify or scale the media mentions. A secondary aim was to determine the extent to which such mentions are linked to specific policies of (further) interest. For this purpose, we reviewed relevant documentation at four levels:

- Peer-reviewed (scientific) literature through several databases: Cochrane, PubMed/Medline, CRD (DARE, NHS EED, HTA) PsycInfo and Web of Science.
  Using the search keys "health expectancy" and "healthy life expectancy", this search turned up a comprehensive body of literature.[2]
- Ministerial websites, health portals (such as the EU Health Portal), WHO and OECD websites (the primary level of HLY awareness and use) and key policy documents. The search strategy was based on applying an increasingly narrow (policy) focus, using the following search keys:
  - Lisbon (strategy)
  - Ageing, healthy ageing, active ageing; elderly, older, senior
  - Health expectancy, healthy life expectancy, healthy life years, HLY
- Member States' submissions to the Commission. The EC is launching public health reporting projects under the Health Information strand of the Community Action for Public Health (2003-2008); this activity will be continued intensively under the new Public Health Programme 2007-2013. We reviewed health reporting systems at national level.
  A list of the organisations involved in is presented at
  http://ec.europa.eu/health/ph_information/reporting/systems_en.htm.
- Internet-based review of wider information sources (newspaper, broadcast and on-line news websites and professional organisations at national and EU level). We used a Google search to find references to the HLY indicator in other web-sources (online newspapers and professional organizations). We used 'healthy life years' as our main search key.

2.3.2 Survey

We surveyed different stakeholder groups with regard to the uptake of the HLY indicator. Areas addressed include (1) usefulness of internationally comparable information, (2) usefulness of indicators in the core of the Lisbon Strategy, (3) awareness of the HLY indicator

[2] Health expectancy is a widely used measure for monitoring health trends of a population and assessing differences in health among population groups (Nusselder W, Looman J, Casper WN. (2004). Decomposition of Differences in Health Expectancy by Cause. *Demography* 41(2)).

and (4) use of the HLY indicator. These topics specifically address evaluation questions 1 (awareness and use) and 2 (healthy ageing).

Following internal testing an electronic survey was made available at www.hlysurvey.org. The survey, prepared by the project team, was authorized by the EC. To enhance cooperation, we prepared a 'mandate' letter in close collaboration with DG SANCO that was sent to the invitees.

The following stakeholder groups were invited to participate:

- ***Commission Officials*** from Directorate-General (DG) AGRI, COMP, DEV, EAC, ECFIN, EMPL, ENTR, INFSO, MARKT, REGIO, RTD and TREN (*sources*: Lisbon desk officer contacts, member list of the Inter-service Group on Health - provided by DG SANCO)
- ***Representatives of National or Regional Health Ministries*** (*sources:* DG SANCO Programme Committee, High Level Committee on Health, national health ministry websites and the Network of Competent Authorities on Health Information (provided by DG SANCO))
- ***Representatives of National or Regional Non-Health Ministries*** involved in demographic change and supporting healthy, active ageing (*sources*: European Foundation for the Improvement of Living and Working Conditions, Employment Committee for the European Employment Strategy, Economic Policy Committee Working Group on Ageing, Finnish National Programme on Ageing Workers 1998-2002 and national ministry websites).

Initially, email invitations (with two follow-ups for non-respondents) were sent to 422 stakeholders, divided among the following stakeholder groups: Commission Officials (52%), Representatives of National or Regional health ministries (23%) and representatives of other ministries (25%).

However, some of those invited to participate were no longer working in the relevant area, department or organisation, were on leave until after the survey deadline (November 20th) or declined participation without reason. These respondents have been excluded from our survey sample and where possible replaced with other relevant contact persons. As a result the final survey sample comprises 378 stakeholders: Commission Officials (53%), Representatives of National or Regional health ministries (23%) and representatives of other ministries (24%).

The sample and responses used for analysis are presented in Table 2.

Table 2: Survey sample

	Sample	Actual valid responses	Response rate
Commission Officials	200	59	30%
Representatives of National or Regional Health Ministries	87	27	31%
Representatives of National or Regional Non-Health Ministries	91	16	18%
Anonymous[3]	0	7	-
Total	378	109	29%

By November 20th, we had received 109 completed surveys (a 29% response rate). In general, response rates for online surveys range from 2%-30%[4].

The survey data has been quantitatively assessed (using SPSS) and is presented in Appendix 1. Chapter 3 synthesises the survey data in order to address the evaluation questions.

2.3.3 Interviews

Often, interviews allow for deeper interrogation of specific topics of interest. We designed an interview protocol to further investigate opinions on the importance of policy with regard to healthy ageing, the rationale of the HLY indicator, the (lack of) uptake of the HLY indicator and gain input for formulating recommendations to increase uptake (evaluation question 3).

The interview protocol is partly based on the survey questions, and divided into: one protocol for stakeholders who are *aware* of the HLY indicator and another for those who are *not (yet) aware* of the HLY indicator. The draft interview protocols were discussed with and approved by DG SANCO (see Appendix 2 and 3 for the interview protocols).

The interview focused on (1) usefulness of internationally comparable information, (2) usefulness of indicators in the core of the Lisbon Strategy, (3) awareness of the HLY indicator and (4) use of the HLY indicator.

We had planned to conduct 25 interviews comprising: 5 Commission officials, 12 representatives of National or Regional Health Ministries and 8 representatives of Non-Health Ministries. The interviewees were selected on the basis of surveys received until November 20th. The survey asks whether respondents are willing to participate in a follow-up telephone interview of about 30-45 minutes.

We encountered some problems getting enough interest in the interviews from survey respondents, especially among Health and Non-Health Ministries. In consultation with DG SANCO we decided to contact non survey respondents from Health and Non-Health Ministries to tell them that their participation would be useful even if they don't know much about the indicator, in which case they might learn something of interest from an interview that would not take very long. As a result we planned interviews with 12 representatives of Health Ministries, but no interviews with representatives of Non-Health Ministries. The few

[3] This group consists of respondents that have not specified any contact details. We have used them as a separate category of respondents in the analysis.

[4] http://en.wikipedia.org/wiki/Statistical_survey

responses we did receive from the Non-Health Ministries redirected us to contacts at national Health Ministries, which we gave follow-up.

All persons were interviewed by phone between November 22nd and December 12th following initial email contact to share the protocol and arrange a suitable time. One representative of a National or Regional Health Ministry provided a written response (see Appendix 4 for the interview respondents).

Table 3 provides an overview of the number of performed and declined interviews by stakeholder group.

Table 3: Planed, performed and declined interviews

Stakeholder group	**Interviews planned**	**Interviews performed**	**Aware of the HLY indicator (not aware)**	**Interviews declined**
Commission Officials	5	4	2 (2)	0
Representatives of National or Regional Health Ministries	12	12	10 (2)	0
Representatives of National or Regional Non-Health Ministries	8	0	N.A.	16[5]
Total number of interviews	25	16	12 (4)	16

Interview notes were summarised and analysed (qualitatively and quantitatively) by stakeholder group and question. Chapter 3 synthesises the interview data in order to address the evaluation questions.

2.4 Difficulties and solutions

We had to face a number of difficulties during the evaluation. Below we specify these and how they were addressed.

Literature review

Policy documents at the national policy level:

- Some policy documents originate from the period prior to 2005. These documents are unlikely to contain references to the HLY indicator, which was only implemented in 2005. However, this does not mean that these countries may not have adopted the indicator subsequently or that they did not use similar or even equivalent indicators. The policy documents do not provide good evidence about the uptake of the HLY indicator.
- References to the HLY indicator in Member State policy documents by and large refer to its actual use ('hard' evidence). Such policy documents provide little evidence relating to

[5] Based on declining responses from survey respondents

awareness of the indicator ('soft' evidence). In particular, they do not indicate whether the use of HLY or similar indicators was even considered. Here, the difference between 'actual use' and 'awareness' is at stake - see also section 2.2.

Survey

Contact details of survey invitees:

- Email addresses of survey invitees were obtained from (previous) address lists provided by DG SANCO and web-based searches. Some respondents were no longer working in the relevant area, department or organisation and were excluded from the survey and, where possible, replaced with other relevant contact persons.

Content of survey:

- Some respondents mentioned that they were probably not the 'right' person to answer (all) the questions or that, while they had heard about the HLY indicator, it was not directly related to their everyday work. Some of these persons encountered difficulties in answering the question about awareness of specific health indicators (question 4A, see Appendix 1).

Technical problems of survey:

- Seven respondents filled out the survey anonymously, and were pooled into a separate category of respondents.
- One respondent reported a technical problem, which was successfully resolved.

Interviews

Participation in interviews:

- We encountered some problems getting enough interest in the interviews from survey respondents, especially among Health and Non-Health Ministries. Potential interviewees are not obliged to participate in the evaluation. This is both an advantage and a drawback. The advantage is that non-serious or unwilling responses are avoided; the disadvantage is a potential selection effect towards those with greater interest or awareness. The small interest from Non-Health Ministries to participate in both the survey and interviews might be explained by the biased survey sample and low affinity of Non-Health Ministries with the HLY indicator, comparable health indicators and the concept of healthy ageing.
- We had scheduled 5 interviews with Commission Officials but one respondent had to decline due to illness. This appointment was already rescheduled until after the deadline of December 12th so we had no opportunity to schedule another interview.

The synthesised evidence from the literature review, survey and interviews are provided in the following Chapter.

CHAPTER 3 Results

3.1 Healthy life years and other health indicators

Definition of Healthy Life Years

In 2004, the European Council re-launched the Lisbon Agenda, focusing its priorities on growth and employment. A set of Structural Indicators, including Healthy Life Years (HLY), was developed to support objective assessment of progress towards the Lisbon objectives. Healthy Life Years is an indicator to monitor health as a productivity factor.

'Healthy life years' (also called disability-free life expectancy - DFLE) is one of the indicators used to measure health expectancy (HE). Health expectancy indicates the number of years that a person of a certain age can expect to live without ill-health (i.e. in a healthy condition)[6]. Indicators are based on length of life (measured with mortality tables) weighted by quality of life (measured by self-perceived disability assessed by health surveys).[7] Healthy Life Years as a Structural Indicator is measured at birth, but also at 15 - 90+ years at 5 years interval, and the data is available via Eurostat's website.

Differences between the HLY indicator and HE indicators

Other terms used to reflect health expectancy as a core indicator on health status encountered in the (peer-reviewed) literature include healthy life expectancy (HLE), Disability Adjusted Life Years (DALY) and Health Adjusted Life Expectancies (HALE). The differences between the HLY and HE indicators (especially DALY) have been described by Robine and Jagger (2005).[8] The differences focus on:

- viewing health positively (HLY - healthy condition defined by the absence of limitations in functioning/disability) or negatively (DALY - years of life lost);
- transparency of communication (HLY - remaining years lived from a certain age in good health) or implicit (DALY - years lived with disability being weighted as less than full years);

[6] European Health Expectancy Monitoring Unit. Disability free life expectancy (DFLE) in the European Union from 1995 to 2003 (presentation, 2005). Available at: http://www.ehemu.eu/ppt/Task%20forceon%20Health%20Expectancy%20Luxembourg25012005.pps#304,5,HLY-DFLE : definition & methodology

[7] Based on Sullivan's method. Sullivan DF (1971). A single index of mortality and morbidity. HSMA. *Health Reports* 86: 347-354.

[8] Robine JM and Jagger C. (2005). The rationale for Healthy Life Years as a Structural Indicator for the European Commission. Available at: http://ec.europa.eu/health/ph_information/implement/wp/indicators/docs/ev_20050125_rd01_en.pdf

- explicit use of different health domains (HLY - different levels of health are distinguished) or use of composite measure (DALY - different severity levels and health domains are weighted to be integrated into a single measure);
- measuring health inequalities between and within countries (HLY) or measuring health status of a certain population (DALY); and
- making use of observed data (HLY - standard life tables and prevalence of health status from national surveys) or using synthetic data (DALY - use of expert opinion to estimate total burden of disease).[9]

From this EC publication it appears that health expectancy is widely used for monitoring population health trends and assessing differences in health among population groups.[10] Health expectancy is being extensively measured in Europe. The indicator research has been a very active area and a range of weighted mortality indicators and morbidity indicators have been developed. E.g. the European Health Expectancy Monitoring Unit (EHEMU), financed by DG SANCO, provides 'a central facility for the co-ordinated analysis and synthesis of life and health expectancies to add the quality dimension to the quantity of life lived by the European populations, provide evidence of inequalities between Member States and highlight potential targets for public health strategies both nationally and at a pan-European level'.[11]

In addition to HE indicators several health indicators exist. For instance, the current EU Public Health Programme has drawn up a list of European Community Health Indicators (ECHI)[12], which includes such indicators as population by gender/age, crude birth rate, fertility rate and population projections. The applicability and comparability of health indicators depends sensitively on the policy issue under consideration.

What distinguishes the HLY indicator clearly from health indicators such as health expectancy, however, is the harmonization at the point of data collection (at present the European Community Household Panel and in the future the European Health Interview Survey).[13] In this manner, the HLY indicator allows for comparability across countries.

3.2 Importance of internationally comparable information

Desk research

One of the European Commission's aims is to produce comparable information on health and health-related behaviour of the population, and on diseases and health systems. This requires the development and use of indicators.

The European Union focuses on improving the quality and comparability of instruments to gather health information (health surveys, disease registers, hospital activity, health accounts, etc.) to make it easier for Member States and European networks to compare and analyse information for policy making and/or impact assessment. Without long-term and efficient

[9] Robine JM and Jagger C. (2005). The rationale for Healthy Life Years as a Structural Indicator for the European Commission. Available at: http://ec.europa.eu/health/ph_information/implement/wp/indicators/docs/ev_20050125_rd01_en.pdf

[10] Nusselder W, Looman J, Casper WN. (2004). Decomposition of Differences in Health Expectancy by Cause. *Demography* 41(2).

[11] http://www.ehemu.eu/aboutehemu.html

[12] http://ec.europa.eu/health/ph_information/indicators/indicators_en.htm

[13] http://www.hs.le.ac.uk/reves/ehemutest/index.html

actions in the field of qualitative information tools, no answers can be given to the basic health questions: How many? Who? and Why?[14]

Survey

All survey respondents (total valid responses N=108) believe that unified and standardised indicators for making country comparisons are moderately important (8%), important (31%) or very important (61%). The majority of those surveyed (85%, total valid responses N=108) consider international comparisons helpful for both policy making and impact assessment. This is followed by 10% of the respondents believing that international comparable information is only useful for policy making, 3% finding it not important and 2% considering it only useful for impact assessment. It is observed that 5 out of 16 (31%) Representatives of National or Regional Health Ministries believe that international comparable information is only useful for policy making, while 11 of them (69%) consider it being useful for both policy making and impact assessment.

Interviews

Importance of making international comparisons between countries

All interviewees (total respondents N=16) consider statistical benchmarking between countries important for the following reasons:

- getting an unbiased view of a country's status quo and development over time;
- statistical benchmarking provides relevant input for policy making and implementation;
- learn from good practices in other countries and adjust own policy objectives; and
- statistical benchmarking is a useful tool for measuring, monitoring and evaluating policy targets.

However, it was noted that international statistical comparisons should be treated with care and analysis should be nuanced for cultural and experiencing differences. Furthermore, comparisons should not have the objective to score countries ("naming and shaming") but rather be used for understanding the reasons behind differences.

Importance of having unified/standardised indicators for making comparisons between countries

All interviewees (total respondents N=16) agreed on the importance of unified/standardised indicators (i.e. indicators based on a unified common data source as opposed to harmonised treatment of national data) in making comparisons between countries. Besides the advantages respondents also reported obstacles and requirements. Reported advantages of standardized indicators include:

- criteria measures are based on common agreement and therefore likely to be more objective, valid and reliable in comparison to harmonised treatment of national data ("compare apples with apples"); and
- benchmarking standardized indicators is of use for policy development on a national (e.g. development of policies on labour market participation of elderly and healthcare investments based on the HLY indicator) and EU level (e.g. development of coherent, internal social policy).

Interviewees considered the following obstacles for unified indicators:

[14] http://ec.europa.eu/health/ph_information/indicators/indic_data_en.htm

- influence of cultural or country specific values and perceptions can make certain national indicators hard to standardize;
- protective behaviour from Member States if EU standardized indicators are imposed by legal mandate because they might be afraid of losing power; and
- implementation of unified indicators often implies considerable investments and redirection of resources (e.g. financial, human resources) and time, which often implies that resources are to be taken from other important areas.

Reported requirements for standardized indicators include:

- pragmatic use of unified indicators by assessing relevance and costs of standardizing indicators. Generating data from European surveys (e.g. European Community Household Panel) can be very costly and relevance of output can be questioned. In some cases it better to focus on quick wins and harmonisation of outputs instead of inputs;
- development of clear and commonly agreed definitions, methods and sample criteria; and
- training (potential) users of the HLY indicator with regard to collecting and analysing data and research coordination.

3.3 Awareness of indicators

3.3.1 Awareness of the HLY indicator

Desk research

The (development and measurement of the) concept of HLY (or disability-free life expectancy) has been published widely in the scientific literature (e.g. Breakwell and Bajekal, 2006; Jitapunkul et al, 2003; Murray and Lopez, 1997; and Robine and Ritchie, 1991).[15] Presentations of the HLY indicator in the media other than 'traditional literature' seem rather limited and are still closely related to the European Commission. For instance,

- Journal articles by European Health Commissioner Markos Kyprianou[16], and DG SANCO Director General Robert Madelin[17];
- A lecture by Robert Madelin[18] published on the website of the Royal College of Physicians (UK);
- A presentation of the results of the first year's work of the European Health Expectancy Monitoring Unit (EHEMU) in *Medical News Today*[19]; and

[15] Breakwell C, Bajekal M (2006). Health expectancies in the UK and its constituent countries. Health Statistics Quarterly. Office for National Statistics, 29: 18-25; Jitapunkul S, Kunanusont C, Phoolcharoen W, Suriyawongpaisal P, Ebrahim S (2003). Disability-free life expectancy of elderly people in a population undergoing demographic and epidemiologic transition. Age ageing; 32(4):401-405; Murray CJ, Lopez AD (1997). Regional patterns of disability-free life expectancy and disability-adjusted life expectancy: global Burden of Disease Study. Lancet; 10, 349(9062):1347-1352; Robine M, Ritchie K (1991). Healthy life expectancy: evaluation of global indicator of change in population health. British Medical Journal, 23; 302(6774): 457-460.

[16] http://www.gdsinternational.com/infocentre/artsum.asp?lang=en&mag=176&iss=144&art=25577

[17] http://www.ias.org.uk/resources/publications/theglobe/globe0503_0601/gl05030601_p8.html

[18] Director General for Health and Consumer Protection (DG SANCO)

[19] http://www.medicalnewstoday.com/medicalnews.php?newsid=46767

- A presentation by DG Joint Research Centre at a conference in Kalmar, 18-22 June 2006.[20]

Survey

Survey respondents were asked to indicate their awareness of the HLY indicator. Half of them (total valid responses N=105) were aware, while the other half was *not* aware of the indicator. It is important to note that most responding Commission Officials (65%, N=37) were *not* aware of the HLY indicator, while the clear majority of Representatives of National or Regional Health Ministries (23 out of 27) is aware of the HLY indicator. Representatives of National or Regional Non-Health Ministries are equally divided with regard to their awareness of the HLY indicator.

Interviews

Awareness of the HLY indicator

Of all the interviewees (N=16), two Commission Officials and 10 Representatives of National or Regional Health Ministries were already aware of the HLY indicator.

Commission Officials have reported awareness through:

- being a member of the Interservice Group on Health;
- a presentation from Eurostat on the HLY indicator; and
- being informed by their unit that was already using other Structural Indicators.

Representatives of National or Regional Health Ministries were informed on the HLY indicator by:

- participation in EC and Eurostat discussions as a Member State representative with regard to the development of the HLY indicator;
- participation in the Indicator Subgroup, which has as an objective to establish common indicators as a means of comparing best practice and measuring progress towards social protection and social inclusion in the EU. Establishing these common indicators is one of the five elements of the Open Method of Coordination (facilitated by DG Employment)[21];
- participation in the European Community Health Indicators project;
- being a project leader of national policy documents with regard to the future of the national health system, which include statistics based on the HLY indicator;
- being a member of the EC Task Force on health expectancy;
- being a member of the Social Protection Committee (DG Employment);
- being involved in the process of developing Structural Indicators when being employed at DG SANCO; and
- literature.

Commission Officials reported *no* further *increased* attention of the indicator since its adoption as an EC Structural Indicator, whereas from the Representatives of National or Regional Health Ministries (total respondent N=10) 8 reported an increased awareness for instance through being a member of specific EC committees, task forces or working groups,

[20] http://www.mai.liu.se/ties2006/cb/SaisanaTIES2006.ppt#1447,1,Slide 1

[21] http://ec.europa.eu/employment_social/social_inclusion/index_en.htm

the national use of similar indicators and being confronted with specific measurement problems.

3.3.2 Awareness of other health indicators

Survey

Respondents were asked to state their awareness of any other health indicators used for comparisons between countries. The majority of respondents (64%, total valid responses N=104) reported such awareness. Awareness seems highest among Representatives of National or Regional Health Ministries (96%, total valid responses N=26). Commission Officials were largely aware (61%, total valid responses N=57), while most of the Representatives of National or Regional Non-Health Ministries were *not* aware (73%, total valid responses N=15).

Respondents aware of other health indicators (N=67) were asked about relevant indicators from the European Community Health Indicators list[22] and indicators related to life expectancy and life years, such as healthy life expectancy and disability-adjusted life years (DALY). It should be noted that the *size* of respondent groups varies a lot. In particular, the small number of responses from Representatives of National or Regional Non-Health Ministries and Anonymous respondents makes it difficult to attach statistical significance to their responses.

Among the indicators listed, *life expectancy* is the most known indicator. The awareness of this indicator is high across all stakeholder categories. Other well known indicators are *infant mortality, expenditures on health* and *population by gender/age*. Our results indicate that awareness of health indicators differs across stakeholder groups. In general awareness is highest among Representatives of National or Regional Health Ministries, whilst relatively low among Anonymous Respondents.[23]

What is striking in Table 5 (Appendix 1) is that awareness of *health expectancy* (based on limitations of usual activities) is quite low across stakeholder groups, perhaps with the exception of representatives of National or Regional Health Ministries. The awareness of *health expectancy indicators* (healthy life expectancy (HALE), disability-free life expectancy (DFLE), quality-adjusted life years (QALY), and DALY) is around 50/50 overall. This may be important with respect to awareness and (future) use of the HLY indicator.

Interviews

Awareness of other health indicators

Interviewees that were *unaware* of the HLY indicator (N=4) were asked about their awareness of other health indicators such as health expectancy (HE), DFLE or the indicator used by WHO (HALE). One Commission Official reported to be unaware as they do not belong to the unit's domain of competence. The two representatives of National or Regional Health Ministries were aware of other health indicators.

[22] http://ec.europa.eu/health/ph_information/dissemination/echi/echi_en.htm

[23] With respect to the latter it should be pointed out that the number of respondents is very low.

3.4 Awareness and use of healthy ageing

Desk research

Investigation of the uptake of the HLY indicator at the national policy level is based on the following steps. We started the review at a broad/high level by looking for government policies on ageing. Second, we examined whether the HLY indicator is used to monitor progress in the respective policies.

Policy approaches on ageing can by and large be divided into three main categories:

- ***Healthy ageing***. The focus is on health and quality of life for older people. Examples include Denmark, Hungary and Spain.
- ***Active ageing***. These policies aim at increasing or extending the participation of senior citizens in social and economic life. Such policies go beyond improving health of older people to touch upon policy domains such as employment. We found this policy approach in quite a number of countries e.g. Belgium, Finland, France, Estonia, Germany, The Netherlands, Latvia, Czech Republic, and Portugal.
- No particular focus on elderly, just health in general.

The review of national policies suggests that Member States have policies to support healthy ageing. In fact, many Member States take an even stronger stance, with policies to promote active ageing as well. An overview of ageing policies in Europe that were found in the literature is presented in Appendix 5.

Survey

Respondents of the survey were asked about their awareness of specific programmes or policies to promote healthy ageing in their country or organisation. Almost half of the respondents (44%, total respondents N=108) were *not* aware of such policies or programmes, which can be largely attributed to responses from Commission Officials (53%, total respondents N=58). However, 43% of the respondents *were* aware, which can be attributed to Commission Officials (33%, total valid responses N=58), National or Regional Health Ministries (56%, total valid responses N=27), National or Regional Non-Health Ministries (56%, total valid responses N=16) and Anonymous Respondents (43%, total valid responses N=7).

The above mentioned respondents that were not aware of or do not have specific programmes or policies to promote healthy ageing (total respondents N=62), were asked whether healthy ageing or health status of the ageing population is a specific consideration in programmes or policies directed to *other objectives*. The majority (52%, total valid responses N=60) were *not* aware of such programmes or policies. This can be largely attributed to responses from Commission Officials; nearly half of them (49%, total valid responses N=39) were *not* aware. However, 30% indicated to be aware, whereas 18% reported there are no such policies or programmes.

Survey respondents were also asked whether healthy ageing is being *monitored or measured* in their country or organisation. A small number of respondents (31%, total valid responses N=108) indicate that healthy ageing is being monitored or measured. Almost half of the respondents (49%) report not to know, which can be largely attributed to Commission Officials from which 53% (total valid responses N=58) were not aware.

Respondents indicating that their country/organisation is not measuring or monitoring healthy ageing or are not aware of this (total valid responses N=75) were asked whether their country or organisation thinks it is important to measure or monitor healthy ageing. The majority (53%, total valid responses N=74) is not aware of this, which can be largely attributed to Commission Officials (65%, total valid responses N=43). This is followed by 37% of the total

valid respondents confirming that measuring or monitoring healthy ageing is seen as important by their country/organisation, which can be largely attributed to Representatives from National or Regional Health Ministries (87%, total valid responses N=15).

Those respondents confirming to measure or monitor healthy ageing (total valid responses N=33) and those who are not but consider it important (total valid responses N=29) were asked whether they would use the HLY indicator as an instrument to *actually design* policies/programmes to promote healthy ageing. The majority (66%, total valid responses N=54) confirmed that they would use the HLY indicator for this purpose. This can be largely attributed to positive responses from Commission Officials (71%, total valid responses N=21) and Representatives of National or Regional Health Ministries (71%, total valid responses N=24).

3.5 Use of indicators

3.5.1 Use of Structural Indicators

Survey

We asked survey respondents whether they use Structural Indicators to address the Lisbon Agenda objectives. Most respondents (72%, total valid responses N=107) use Structural Indicators. However, responses vary between stakeholder groups. Whereas the majority of Commission Officials (86%, total valid responses N=58) and Representatives of National or Regional Non-Health Ministries (69%, total valid responses N=16) use Structural Indicators, most of the Representatives of National or Regional Health Ministries (75%, total valid responses N=26) do *not* use them.

3.5.2 Use of the HLY indicator

Desk research

In the *non-traditional literature*, we only found a small number of references in which the HLY indicator was actually used:

- Two articles in Times Online about a lower health status in England compared to other Member States;[24] and
- Curriculum on public health assessment at the University of Cambridge.

As for references to the HLY indicator by the OECD and WHO, we found no literature in which the HLY indicator was mentioned. Both organisations use other health expectancy indicators (i.e. HALE and DALY).

The review of national policy documents resulted in one explicit reference to the HLY indicator. It is used to present healthy life expectancy (HLE) in the UK alongside an indicator of healthy life years based on *national* statistics. Monitoring HLE is important in the UK. "HLE is currently used to monitor progress towards achieving targets in a wide range of policies including:

- The Department of Health's National Service Framework for older people includes targets to increase HLE for older people;
- The Treasury's work on long term fiscal sustainability sees future HLE as an important demand driver; and

[24] http://www.timesonline.co.uk/article/0,,2091-2252666,00.html and http://www.timesonline.co.uk/article/0,,2087-2252638,00.html

- The Department for Work and Pensions' strategy for tackling poverty and social exclusion uses HLE as an indicator."[25]

From the review we cannot conclude whether the HLY indicator is (going to be) used to monitor HLE (i.e. replace the national indicator of HLE, which is practically the same as the HLY indicator - the difference lies in using national instead of European sources of data).

Survey

Of the respondents stating that healthy ageing is being monitored or measured (total respondents N=33), the majority (76%, total valid responses N=25) confirm to use the HLY indicator for this, which can be largely attributed to Commission Officials (80%, total valid responses N=10) and Representatives from National or Regional Health Ministries (91%, total valid responses N=11). The review of national policy documents also suggests that monitoring of healthy ageing policies on the basis of the HLY indicator does not (yet) occur, or at least not on an elaborate scale.

Interviews

Use of the HLY indicator

Both interviewed Commission Officials who are aware of the HLY indicator do *not* use the HLY indicator, because it is not relevant for the respective policy domains of the units they work.

Five representatives from National or Regional Health Ministries (N=10) are using the indicator, whilst the other 5 persons reported *not* to use the HLY indicator because they had limited awareness of the *concept* and/or the ministries have already been using a similar health indicator prior to the adoption of the HLY indicator (i.e. "année de vie en bonne santé" (France), "Healthy Life Expectancy" (UK) and "Healthy Life Years" (Sweden)). The HLY indicator therefore plays a subordinate role in national health programming.

The representatives of National or Regional Health Ministries using the HLY indicator (N=5) were asked *how* the HLY is being used. The interviewees mentioned to use the HLY for:

- planning and policy making (N=4) (e.g. health promotion and functional capacity of labour force);
- impact assessment (N=1) (e.g. impact of healthy life style on health); and
- monitoring (N=2) (e.g. trends in social protection).

However, one interviewee specified that despite the indicator's use for planning, it is as yet not very well organised and accepted in the unit. Another respondent mentioned that the HLY indicator is being used for the first time in a national health strategy. Increasing the population's HLY is one of the objectives of this new health strategy.

Future use of the HLY indicator

Those interviewees who are *not* using the HLY indicator at present (N=7) were asked whether the indicator could become an indicator for the organisation/department to measure/monitor healthy ageing. Overall, the interviewees believed that healthy ageing will become an increasingly important policy issue in the near future and that the indicator could/will be used for monitoring healthy ageing. In addition, some interviewees mentioned that the indicator could provide useful input for the discussion on pensions (retirement age), labour market participation and declining birth rates. However, it was also noted that the indicator is still under development and that more understanding and objective measurement is needed. One interviewee questioned the future use of the HLY indicator because policies are targeting

[25] http://www.parliament.uk/documents/upload/postpn257.pdf

developing countries and survival is of greater priority in those countries than the concept of HLY.

Use of the HLY indicator for policies or programmes to *promote* healthy ageing

Five representatives of National or Regional Health Ministries reported the use of the HLY indicator for promoting healthy ageing and preventive health policies. Examples mentioned are cancer control primarily targeted at the population between 45-65 years, social protection strategy (e.g. inclusion of elderly in labour market) and healthy ageing policies (organisation of health care and social care). It appeared that healthy ageing is seen as an inter-sectoral problem as it has an impact on different policy areas such as employment, health, finance, and pensions. One interviewee mentioned that the HLY indicator will be used for a national health strategy to promote healthy ageing, while another interviewee mentioned that the indicator is used on a decentralised level (i.e. regions). This is because specific health competence (e.g. health problems of the elderly) is available in regional governments.

One interviewee mentioned that Healthy Life Expectancy (HLE) is currently used for developing healthy ageing policies. However, the interviewee found it difficult to say whether the HLY indicator will be used in the future because of its similarity to the HLE indicator.

None of the interviewees was able to show an impact of these policies or programmes.

Use of the HLY indicator to *monitor* healthy ageing

Representatives of National or Regional Health Ministries that reported the use of the HLY indicator (N=5) were asked whether they also use it to monitor healthy ageing. Only one respondent confirmed that the indicator is useful for evaluating how well healthy ageing policies are being managed. Others were more hesitant and thought that other units dealing with healthy ageing policies were probably using the HLY indicator for monitoring and assessment. Finally, one interviewee reported no use of the indicator for monitoring healthy ageing because data is only available for one year. According to this interviewee, monitoring will become relevant when more data is generated for the consecutive years.

Use of the HLY indicator for other purposes

Just one respondent from a National Health Ministry reported that the HLY indicator is being used, yet being indirectly, for developing health priorities and policies (e.g. obesity). This indirect use can be explained by other factors such as lifestyle and living environment also playing an import role in developing such health policies (there are no simple linkages between causes and consequences). However, the interviewee was not in the position to answer whether these policies had a measurable impact yet.

Importance of the HLY indicator as a Structural Indicator to *measure* progress towards the Lisbon objectives

Respondents that are aware of the HLY indicator (N=12) were asked to what extent the HLY indicator measures progress toward the Lisbon objectives. The Commission Officials (N=2) had difficulties answering this question because the HLY indicator is not actively used within the respective DGs and because the respondent's units focus on other policy objectives of the Lisbon agenda (and indirectly with its health objectives).

From the representatives of National or Regional Health Ministries (N=10) the majority (N=7) believe that the HLY indicator is important for measuring progress towards the Lisbon objectives, in particular because health is a precursor for economic growth and it is an instrument to put health higher on the European political agenda. However, respondents specified that the following should be taken into account:

- the HLY indicator should be considered as an indicator in development;
- it is important to use Structural Indicators alongside each other to measure progress;

- HLY might particularly be relevant for the added social component of the Lisbon Agenda because it provides information on health determinants of the population and access to, quality and structure of health information; and
- the HLY indicator can only be useful if it takes into account the working population and sustainable development. If the focus is only on older people the HLY indicator will be less relevant to measure progress towards the Lisbon objectives.

One interviewee expressed doubts on the importance of the HLY indicator as a Structural Indicator. Since the objectives of the Lisbon agenda are primarily of economic nature and it is doubtful whether social problems will be really integrated.

3.5.3 Use of health indicators

Survey

Survey respondents were also asked whether they use other health indicators for policy making and/or impact assessment. The majority of respondents (57%, total valid responses N=109) do *not* use these indicators for policy making and/or impact assessment. This applies in particular to Commission Officials (68%, total valid responses N=59), Representatives of National or Regional Non-Health Ministries (69%, total valid responses N=16) and Anonymous respondents (71%, total valid responses N=7). However, most of the Representatives of National or Regional Health Ministries (78%, total valid responses N=27) do use health indicators for policy making and/or impact assessment.

Respondents using health indicators for policy making and/or impact assessment (N=47) were asked to specify which indicators they use. The first indicator included in the survey was the HLY indicator. Table 8 (Appendix 1) shows that two-thirds of the respondents (66%) report *not* to use the HLY indicator for policy making and/or impact assessment. Representatives of National and Regional Health Ministries are somewhat an exception here: approximately half of the respondents in this category report to use the HLY indicator for the above mentioned purposes.

All in all we can say that use of health indicators is relatively low, i.e. a minority of respondents uses them. Exceptions to this pattern are: *life expectancy, infant mortality, expenditures on health and population by gender/age*. These indicators correspond to the indicators that are also most known (section 3.2.2). Another indicator that is often used across all categories of stakeholders is *population projections*.

Our results indicate that use of health indicators differs across stakeholder groups. As was the case for awareness, use is highest among representatives of National or Regional Health Ministries.

Interviews

Use of health indicators

Interviewees that were *unaware* of the HLY indicator (N=4) were asked if they actually use other health indicators. Both Commission Officials reported that health indicators are *not* being used because the policy areas of the respective units are not health oriented. However, it was noted that health might become a more relevant issue in the future in terms of Europe's ageing population. One of the two representatives of National or Regional Health Ministries that were not aware of the HLY indicator reported that for the policy domain he focuses on more specific health indicators are being used. The other interviewee confirmed use of general health indicators particularly in the policy context of the ageing population and health prevention programmes. In addition, these indicators are used in cross-organisational policies or programmes (e.g. the Ministry of Labour and Social Insurance and the Ministry of Health

have a joint committee for policy areas and strategic plans with regard to the elderly and health services).

Use of health indicators for policies or programmes to promote healthy ageing

Only one interviewee (total respondents N=4), a representative from a National or Regional Health Ministry, confirmed that health indicators are being used for the design of policies to promote healthy ageing, in particular 'geriatrics' (i.e. medical services for the elderly). The indicators are in this specific context only used for *planning.* However, for the development and implementation of prevention programmes they are both used for *planning and monitoring*. The usefulness of health indicators were specified by this interviewee as to study the current situation and making international comparisons and to improve programmes and policies based on benchmark findings.

3.6 Barriers and facilitators in the uptake of the HLY indicator

Evidence for the barriers and facilitators in the uptake of the HLY indicator were identified through the interviews undertaken.

3.6.1 Strengths

Interviewees that are aware of the HLY indicator (N=12) were asked for its (potential) strengths as a Structural Indicator. The following strengths were put forward:

- the HLY indicator is an instrument that **puts health higher on the European political agenda** since health is a precursor for economic growth;
- the HLY indicator is a **useful benchmarking instrument** with regard to the health situation and health promotion between and within Member States. From these insights implications for regional, national (e.g. labour market participation of elderly, healthcare investments) and European policies (e.g. development of coherent social policies) can be derived;
- the HLY indicator **combines objective data (morbidity) and subjective data** (self perceived health); and
- the HLY indicator can be measured for the various stages of a person's life and a person's capacities in these stages (effectiveness) from which consequences for health system costs can be derived. This can serve as relevant **input for policies regarding labour market participation, pensions, health condition and lifestyles**.

3.6.2 Barriers

The same sample of interviewees (N=12) also expressed their views on the barriers to the uptake of the HLY indicator. The barriers can be divided into three issues:

- **the HLY indicator is still under development:**
  - definitions, measurement and valid questionnaires are not yet established; and
  - there is a lack of financial resources and research capacity (infrastructure) for data collection.
- **differences between the HLY indicator and other health indicators are not (yet) clear:**
  - policy makers may confuse the HLY indicator with other comparable health indicators (e.g. DALY, QALY, life expectancy, healthy life expectancy).
- **the interpretation of the HLY indicator is not (yet) clear:**

- policy makers that are not so familiar with the HLY indicator might interpret the indicator differently compared to more experienced policy makers;
- in order to measure progress towards the Lisbon objectives the HLY indicator should be analysed in conjunction with other Structural Indicators because there is risk that the usefulness of the indicator is being over interpreted; and
- self perception of health is determined by national and cultural values, norms, mental health and economic situation. These aspects influence the accuracy of the HLY indicator, which bears the risk of biased interpretation.

3.6.3 Facilitators

Commission Officials and representatives from National or Regional Health Ministries (N=16) were asked to express their suggestions for increasing the uptake of the HLY indicator. The facilitators mentioned can be distinguished into the following issues:

- **Improve dissemination activities:**
  - easier access to information and increase visibility (e.g. SANCO website);
  - adoption and profiling of HLY by high level of EC Commissioners (e.g. High Commissioner for Health or Public Health Programme committee) as an indicator that should be used by all Member States - i.e. EC should further raise awareness and communicate with Member States on HLY as useful indicator to measure effectiveness of national health system and useful steering instrument to adapt national policies, how HLY indicators fits within national health system, usefulness of international comparisons;
  - stimulate publication and dissemination of policy documents indicating the use of the HLY indicator both on a national and European level (e.g. DG EMPL is already active in this field);
  - stimulate scientific publications and other non-traditional publication to target wide audience including general public;
  - EC should strive to provide information in more concise matter (e.g. report resumes); and
  - Eurostat and DG SANCO (i.e. workgroup on health indicators) and engagement DG SANCO with other DGs are mentioned as relevant dissemination channels (European Global Report on Health), Health Interview Survey (resulting in document on health in the EU), PHP Portal.
- **Improve measurement of the HLY indicator**
  - standardize definitions used;
  - train potential users with regard to collecting and analysing data and coordinating research;
  - provide short term training for potential users of HLY;
  - collect more data (e.g. 5 years) to make relevant comparisons and to measure long term sustainability and impact on ageing;
  - set up rules for defining sample criteria, e.g. including and excluding people with regard to self perception of health to get more balanced views (issue of depression, economic conditions); and

- perform more research into factors influencing self perception of health, which results in a better and common agreed definition on health perception.

- **Improve understanding of the HLY indicator**
  - make sure that people understand what the indictor really does mean, how it is calculated and what ways for harmonising national outputs exists; and
  - EC should stimulate countries that are not or limitedly using the indicator to use HLY e.g. through conferences with the objective to increase awareness by presenting different methods to use the HLY indicator and its advantages/disadvantages.

CHAPTER 4 Conclusions and recommendations

Taking the methodological limitations, as described in Chapter 2, into account, we provide answers to the evaluation questions on the basis of the evidence available:

4.1 Awareness of the HLY indicator in the European Commission and Member States

Although awareness about the concept of HLY is widespread in the scientific literature, awareness about the HLY indicator is limited and differs by stakeholder group. The majority of the National or Regional Health Ministry survey respondents and interviewees are aware of the indicator, while most of the Commission Officials responding are *not* aware of the HLY indicator. The picture is not (yet) clear for the surveyed National or Regional Non-Health Ministries. Interviewees aware of the HLY indicator mentioned that the HLY indicator is a useful benchmarking instrument with regard to the health situation and health promotion between and within Member States, and can serve as relevant input for policies regarding labour market participation, pensions, health condition and lifestyles.

However, in the non-traditional literature (i.e. mass media), the HLY indicator is often mentioned in relation to European Commission Services. There is a difficulty in reviewing the literature as some policy documents originate from the period prior to 2005. These documents are likely not to contain any references to the HLY indicator, as the latter was only implemented in 2005. However, this does not mean that these countries may not have adopted the indicator more recently. The policy documents do not provide good evidence about the uptake of the HLY indicator. In addition, references to the HLY indicator in Member State policy documents by and large refer to its actual use ('hard' evidence). Such policy documents provide little evidence relating to awareness of the indicator ('soft' evidence).

4.2 Use of the HLY indicator in the European Commission and Member States

The use of the HLY indicator is *not* (yet) widespread, especially within Commission Services and by National and Regional Non-Health Ministries. The main reasons for *not* using the HLY indicator include limited awareness of the *concept*, stage of development of the HLY indicator, use of a similar health indicators prior to the adoption of the HLY indicator (e.g. healthy life expectancy), and the fact that differences between health expectancy indicators and the HLY indicator are not (yet) well understood.

A slight majority of interviewed National and Regional Health Ministries use the HLY indicator for policy making (e.g. health promotion and functional capacity of labour force), impact assessment (e.g. impact of healthy life style on health), and monitoring (e.g. trends in social protection). In addition, the interviewees believe that the HLY indicator is important to

measure progress towards the Lisbon objectives, in particular because health is a precursor for economic growth and it is an instrument to put health higher on the European political agenda. The interviewees also mentioned that it is important to use Structural Indicators alongside each other to measure progress and that HLY might particularly be relevant for the added social component of the Lisbon Agenda because it provides information on health determinants of the population and access to, quality and structure of health information.

In the non-traditional literature we only found a small number of references to actual use of the HLY indicator, mainly referring to the UK.

4.3 Importance of measuring healthy ageing and the use of the HLY indicator

The review of national policy documents suggests that most Member States have policies to support healthy ageing (i.e. focus on health and quality of life). In fact, many take an even stronger stance, with policies to promote *active* ageing (i.e. increasing or extending the participation of senior citizens in social and economic life).

Survey respondents were asked about their awareness of specific programmes or policies to promote healthy, active ageing. Almost half of the respondents were aware of such policies or programmes. A small number of respondents indicate that healthy ageing is being monitored and use the HLY indicator for this purpose. The review of national policy documents confirms that widespread monitoring of healthy ageing policies on the basis of the HLY indicator does not (yet) occur. In addition, only a minority of survey respondents mentioned that the HLY indicator is or would be used to actually design policies/programmes to promote healthy ageing.

From the interviews it appeared that the HLY indicator is or will be used for promoting and monitoring healthy ageing policies (e.g. organisation of health care and social care). Most interviewees were, however, hesitant about the usefulness of the HLY indicator to evaluate how well healthy ageing policies are being managed.

4.4 Summary

The evidence provided by the literature review, the survey and the interviews show that the uptake of the HLY indicator within the European Commission Services and within National or Regional Non-Health Ministries is lagging behind use in National or Regional Health Ministries. This may be due to a number of factors, in particular, the National or Regional Health Ministries have more need for the HLY indicator; compared to Non-Health Ministries it is more directly relevant for policy making and both direct impact and the scope to incorporate such health expectancy considerations may be greater than at the European Commission level.

4.5 Recommendations

4.5.1 Ways to increase the uptake of the HLY indicator

Possible ways to increase the uptake of the HLY indicator were identified through the interviews undertaken and the synthesis of all evidence collected. The activities identified can be summarised as follows:

- **Improve dissemination activities,** e.g. by providing easier access to information and increase visibility (e.g. through SANCO website); adopting and profiling of HLY by high

level of EC Commissioners (e.g. High Commissioner for Health or Public Health Programme committee); and stimulating publication and dissemination of policy documents and scientific articles indicating the use of the HLY indicator both on a national and European level.

- **Improve measurement of the HLY indicator,** e.g. by standardizing definitions used; providing training to research staff and users of HLY; and improving research methodology by providing more financial resources to research groups.
- **Improve understanding of the HLY indicator,** e.g. by providing clear information about what the indictor really does mean, how it is calculated and what ways for harmonising national outputs exist; and organize conferences to increase awareness by presenting different methods to use the HLY indicator and its advantages/disadvantages.

4.5.2 How to raise the profile of HLY within non-health policies

Ways to raise the profile of the HLY indicator within non-health policies were mainly identified through desk research and the survey results as we were not able to plan interviews with Non-Health Regional and National Ministries. The synthesis of all evidence collected shows that it is important to ensure that public health is strategically addressed in other EC policies and programmes at all levels ('health in all policies' - HIAP). HIAP is part of the new Health Strategy (to be adopted in summer 2007), which aims to increase the number of HLY and increase cross-sectoral cooperation[26].

Health impact assessment (HIA) is an effective means in both mainstreaming health and evaluating how other policies affect health.[27] However, there is no sound and solid evidence on the systematic use of HIA across Community services. For HIA to become more useful there is a need to strengthen the logic used for predicting consequences of decisions, to improve estimates made of the magnitude of outcomes and to develop forms of participation that meet the needs of relevant actors. We recommend that EC policy makers become more acquainted with HIA and health impact assessors should develop better understanding of the policy making process.

In addition to the recommendations to improve the uptake of the HLY indicator, the profile of HLY within non-health policies can be improved by:

- **Supporting HIAP in the new Health Strategy**;
- **Developing further coordinated action plans linking health with other policy areas** (e.g. health and safety at work, social affairs, environmental health) to exploit synergies and focus efforts where HLY is at stake; and
- **Providing training on HIA to EC Services** (e.g. DG SANCO developed a practical guide for screening of proposals for possible health impacts and background material useful for putting discussions on HIA in a broader perspective)[28].

[26] http://ec.europa.eu/health/ph_overview/strategy/health_strategy_en.htm

[27] Byrne D (2004). Enabling Good Health for all – A reflection process for a new EU Health Strategy, 15.7.2004 (Available from http://europa.eu.int/comm/health/ph_overview/strategy/health_strategy_en.htm

[28] European Commission, Health & Consumer Protection Directorate-General, Ensuring a high level of health protection – A practical guide, Luxembourg, 17 December 2001

APPENDICES

Appendix 1: Survey results

In this appendix we set out the results of the electronic survey on the awareness and uptake of the Healthy Life Years (HLY) indicator. The survey targeted the following stakeholder groups: Commission Officials, Representatives of National or Regional Health Ministries and Representatives of National or Regional Non-Health Ministries. The key areas addressed by the survey include (1) usefulness of internationally comparable information, (2) usefulness of indicators in the core of the Lisbon Strategy, (3) awareness of the HLY indicator and (4) use of the HLY indicator.

The first section provides a summary of how the survey was carried out and the subsequent section discusses the results of each survey question.

Survey design and presentation of results

The survey was deployed on the web (http://www.hlysurvey.org) and respondents were invited to visit the website and fill in the survey online. In addition, the survey could be accessed via the news section of the EU Public Health Thematic Portal (http://ec.europa.eu/health-eu/index_en.htm) and the page on HLY, available via http://ec.europa.eu/health/ph_information/indicators/lifeyears_en.htm.

There was no option to download and complete a hardcopy of the questionnaire. Respondents were not forced to answer all the questions, the number of respondents (N) answering each question is shown below in each of the results tables.

The survey was open from November 3rd 2006 until November 2006 20th (a period of 18 days). On the initial deadline of November 10th we achieved a response rate of 14%. To increase the response rate we have sent reminder emails to non-respondents until November 15th. As some of the remaining respondents informed us about their willingness to participate but not being able to meet this deadline we decided to send a final reminder on November 15th requesting for survey completion on November 20th. Ultimately, we received a total of 109 valid responses from our sample of 378 stakeholders, which equals to a response rate of 29%.

Survey results

Part A. Usefulness of internationally comparable information

1. Do you consider international comparisons helpful for policy making and/or impact assessment in your area?

From the 108 valid survey respondents 92 (85%) consider international comparisons helpful for both policy making and impact assessment. This is followed by 10% of the respondents believing that international comparable information is only useful for policy making, 3% finding it not important and 2% considering it only useful for impact assessment. It is observed that 5 out of 16 (31%) Representatives of National or Regional Health Ministries believe that international comparable information is only useful for policy making, while 11 of the respondents (69%) consider it being useful for both policy making and impact assessment.

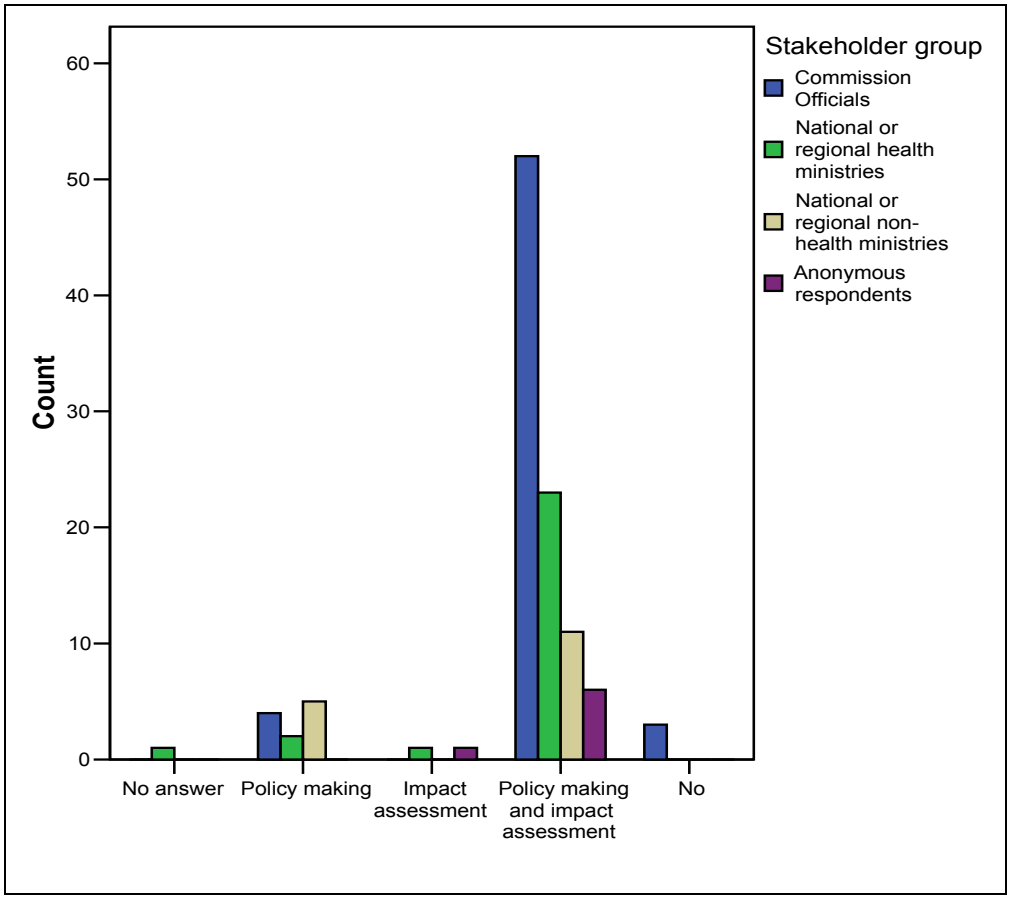

Figure 1. Usefulness of internationally comparable information

Table 1. Descriptive statistics

	Policy making	Impact assessment	Policy making and impact assessment	No	Not specified
Commission Officials	4	0	52	3	0

Representatives of National or Regional Health Ministries	2	1	23	0	1
Representatives of National or Regional Non-Health Ministries	5	0	11	0	0
Anonymous respondents	0	1	6	0	0
Total	11	2	92	3	1

(Total valid responses = 108)

2. In your opinion, how important are unified/standardised indicators in making comparisons between countries?

Respondents were asked to rate the importance of unified/standardised indicators in making country comparisons on a Likert scale from 1 (very important) to 5 (not important at all). All respondents believe that unified and standardised indicators for making country comparisons are moderately to very important with 66 out of 109 respondents (61%) rating these indicators as very important. This is followed by a minority rating unified/standardised indicators as important (31%) and moderately important (8%).

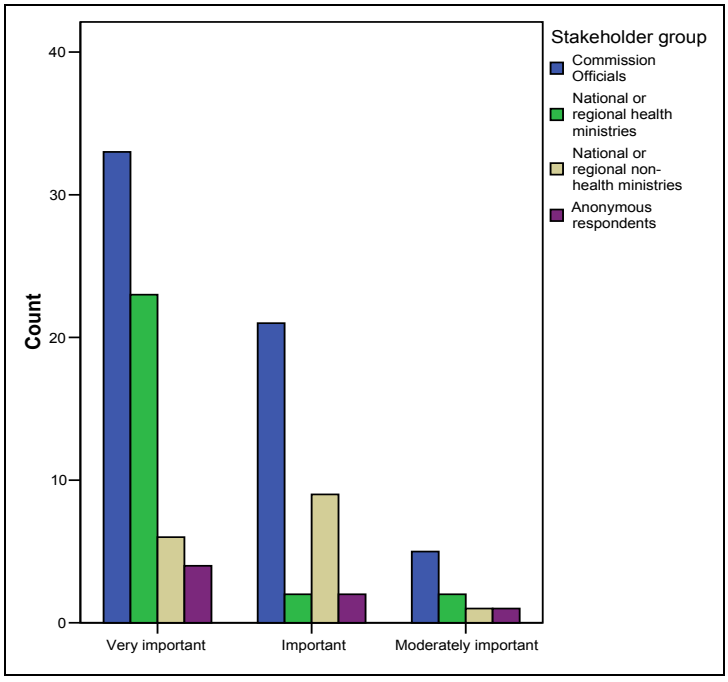

Figure 2. Importance of unified/standardised indicators in making comparisons between countries

Table 2. Descriptive statistics

	Very important	Important	Moderately important	Not very important	Not important at all
Commission Officials	33	21	5	0	0
Representatives of National or Regional Health Ministries	23	2	2	0	0
Representatives of	6	9	1	0	0

National or Regional Non-Health Ministries					
Anonymous respondents	4	2	1	0	0
Total	66	34	9	0	0

(Total valid responses = 109)

3. Where you aware of the HLY indicator as a Structural Indicator prior to this survey?

Respondents were asked to indicate their awareness of the HLY indicator. There is 50/50 percent distribution between respondents that are aware and those that are *not* aware of the indicator. However, analysing the results by stakeholder group shows that the majority of Commission Officials (37 out of 59) reported *not* to be aware of the HLY indicator, while the clear majority of Representatives of National or Regional Health Ministries (23 out of 27) is aware of the HLY indicator. Representatives of National or Regional Non-Health Ministries are equally divided with regard to their awareness of the HLY indicator.

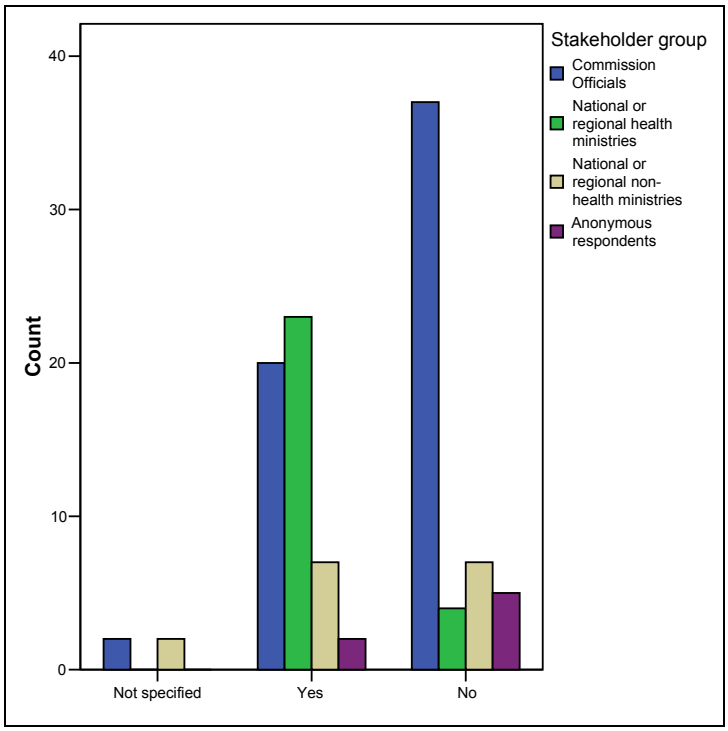

Figure 3. Awareness HLY indicator as a Structural Indicator

Table 3. Descriptive statistics

	Yes	No	Not specified
Commission Officials	20	37	2
Representatives of National or Regional Health Ministries	23	4	0
Representatives of National or Regional Non-Health Ministries	7	7	2
Anonymous respondents	2	5	0
Total	52	53	4

(Total valid responses = 105)

4. Are you aware of any other indicators that are used for comparisons in the area of health between countries?

Respondents were asked to state their awareness of any other health indicators that are used for comparisons between countries. The majority of respondents (64%, total valid responses=104) reported such awareness. Awareness seems highest among Representatives of National or Regional Health Ministries (96%, total valid responses N=26). Commission Officials were largely aware (61%, total valid responses N=57), while most of the Representatives of National or Regional Non-Health Ministries were *not* aware (73%, total valid responses N=15).

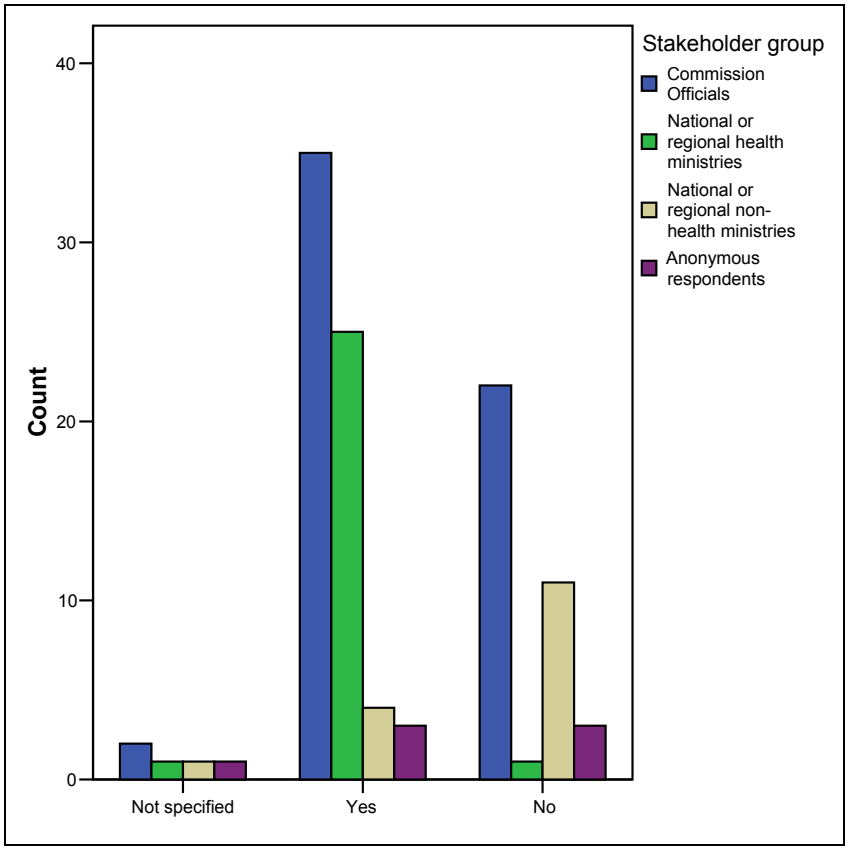

Figure 4. Awareness of any other health indicators for country comparisons

Table 4. Descriptive statistics

	Yes	No	Not specified
Commission Officials	35	22	2
Representatives of National or Regional Health Ministries	25	1	1
Representatives of National or Regional Non-Health Ministries	4	11	1
Anonymous respondents	3	3	1
Total	67	37	5

(Total valid responses = 104)

4A. If yes, please indicate any the following indicators that may apply[29]

The 67 respondents that are aware of other health indicators than the HLY indicator were asked to specify which indicators. It should be noted that the size of respondent groups varies a lot. In particular, the small number of responses from Representatives of National or Regional Non-Health Ministries and Anonymous respondents makes it difficult to attach statistical significance to their responses.

Among the indicators listed, life expectancy is the most known indicator. The awareness of this indicator is high across all stakeholder categories. Other well known indicators are infant mortality, expenditures on health and population by gender/age. Our results indicate that awareness of health indicators differs across stakeholder groups. In general awareness is highest among representatives of National or Regional Health Ministries, whilst relatively low among Anonymous respondents.[30]

What is striking in Table 5 (Appendix 1) is that awareness of *health expectancy* (based on limitations of usual activities) is quite low across stakeholder groups, perhaps with the exception of representatives of National or Regional Health Ministries. The awareness of *health expectancy indicators* (healthy life expectancy (HALE), disability-free life expectancy (DFLE), quality-adjusted life years (QALY), and DALY) is around 50/50 overall. This may be important with respect to awareness and (future) use of the HLY indicator.

[29] These are indicators from the European Community Health Indicators list, except for the category 'Other health indicators'. For further information please visit:
http://ec.europa.eu/health/ph_information/dissemination/echi/echi_en.htm

[30] With respect to the latter it should be pointed out that the number of respondents is very low.

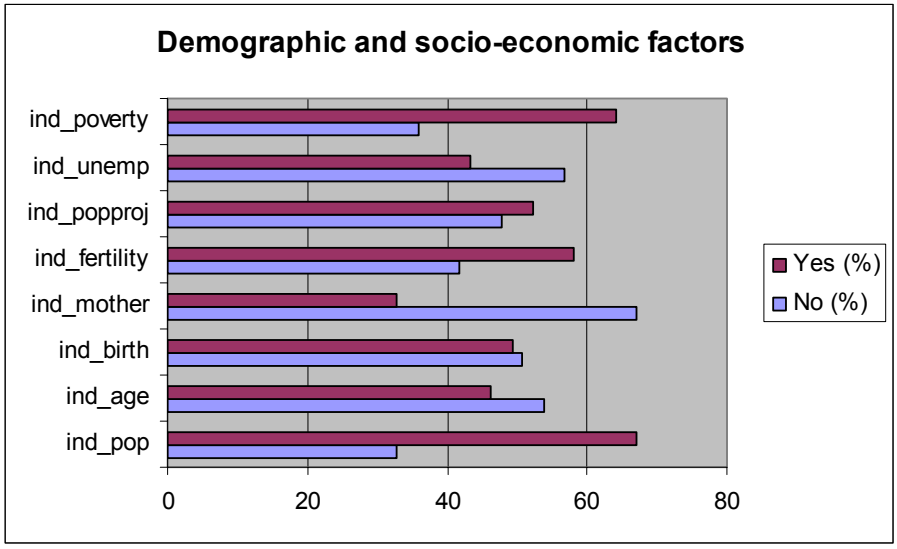

Figure 5 Awareness of demographic and socio-economic factor indicators

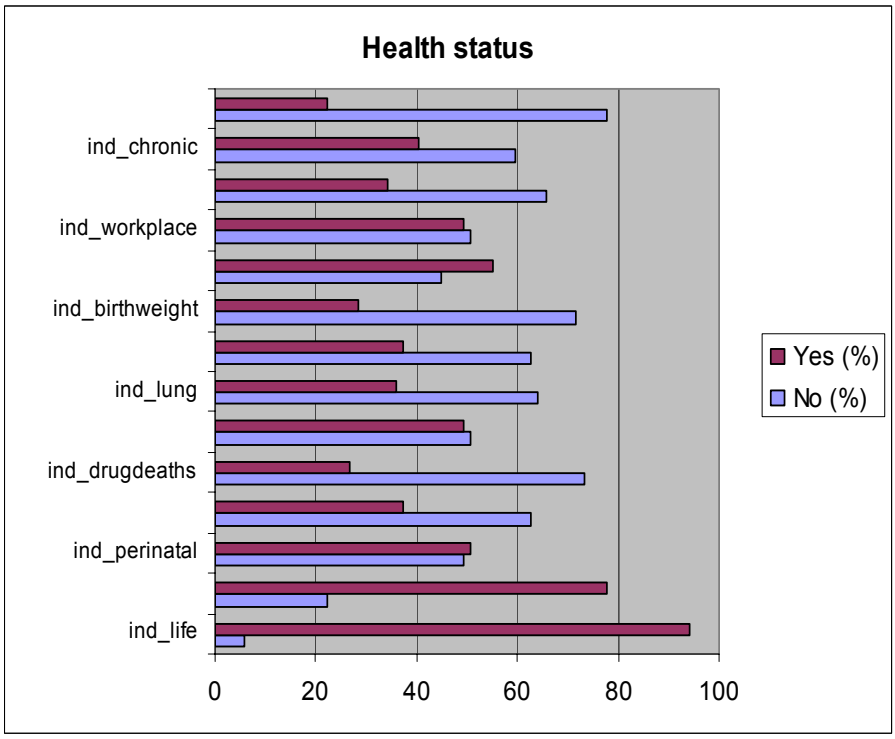

Figure 6. Awareness of health status indicators

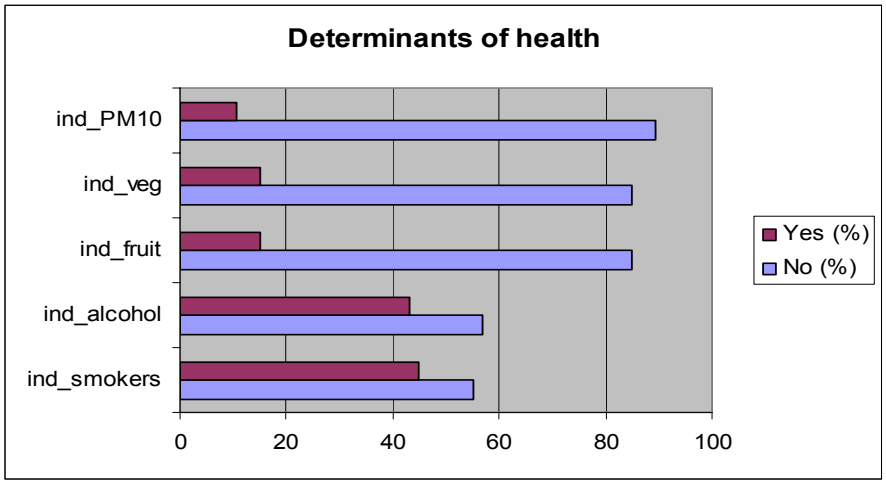

Figure 7. Awareness of determinants of health indicators

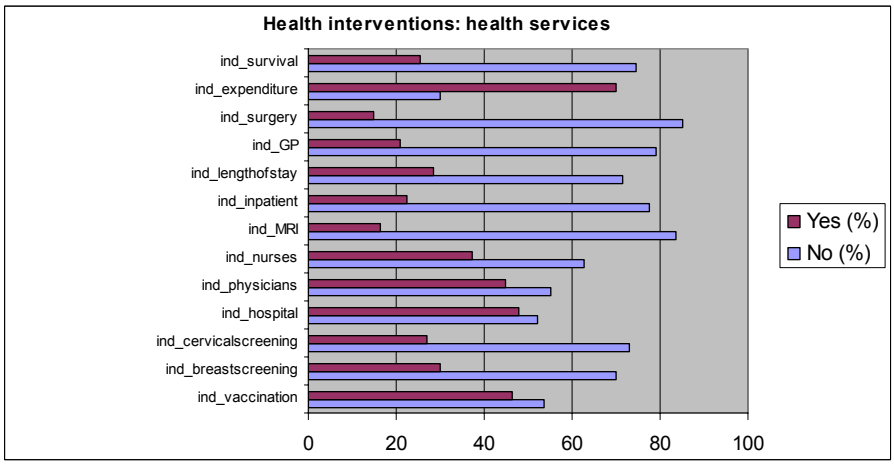

Figure 8. Awareness of health intervention and health services indicators

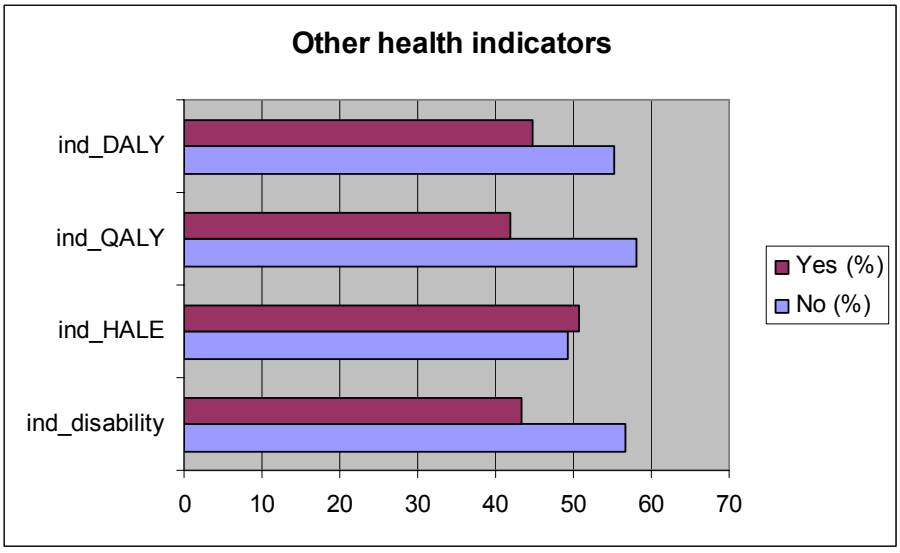

Figure 9. Awareness of health other health indicators

Table 5. Awareness of other indicators in the area of health for country comparisons (%)

	Commission Officials (n=35)		Representatives of National or Regional Health Ministries (n=25)		Representatives of National or Regional Non-Health Ministries (n=4)		Anonymous Respondents (n=3)		Total	
	No	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**
Demographic and socio-economic factors										
Population by gender/age	43	57	16	84	25	75	67	33	33	67
Age dependency ratio	57	43	44	56	75	25	67	33	54	46
Crude birth rate	63	37	28	72	50	50	100	0	51	49
Mother's age distribution (teenage pregnancies, aged mothers)	83	17	40	60	75	25	100	0	67	33
Fertility rate	46	54	32	68	50	50	67	33	42	58
Population projections	54	46	32	68	75	25	67	33	48	52
Total unemployment	63	37	48	52	50	50	67	33	57	43
Population below poverty line	37	63	32	68	25	75	67	33	36	64
Health status										
Life expectancy	11	89	0	100	0	100	0	100	6	94
Infant mortality	37	63	4	96	25	75	0	100	22	78
Perinatal mortality (foetal deaths plus early neonatal mortality)	69	31	24	76	50	50	33	67	49	51
Standardised death rates Eurostat 65 causes	86	14	28	72	75	25	67	33	63	37
Drug-related deaths	89	11	52	48	75	25	67	33	73	27
HIV/AIDS	69	31	24	76	50	50	67	33	51	49
Lung cancer	86	14	24	76	100	0	100	0	64	36
Breast cancer	86	14	24	76	75	25	100	0	63	37
(Low) birth weight	83	17	52	48	75	25	100	0	72	28
Injuries: road traffic	66	34	12	88	50	50	67	33	45	55
Injuries: work place	66	34	36	64	25	75	33	67	51	49
Perceived general health	83	17	44	56	75	25	33	67	66	34
Prevalence of any chronic illness	77	23	36	64	50	50	67	33	60	40
Health expectancy, based on limitation of usual activities	94	6	52	48	75	25	100	0	78	22
Determinants of health										
Regular smokers	74	26	28	72	50	50	67	33	55	45
Total alcohol consumption	69	31	32	68	75	25	100	0	57	43

Consumption/availability of fruit, excluding juice	100	0	60	40	100	0	100	0	85	15
Consumption/availability of vegetables, excluding potatoes and juice	100	0	64	36	75	25	100	0	85	15
PM10 (particular matter) exposure	100	0	72	28	100	0	100	0	90	10
Health interventions: health services										
Vaccination coverage in children	80	20	16	84	50	50	67	33	54	46
Breast cancer screening coverage	86	14	44	56	75	25	100	0	70	30
Cervical cancer screening coverage	91	9	48	52	75	25	67	33	73	27
Hospital beds	77	23	20	80	25	75	67	33	52	48
Physicians employed	77	23	24	76	25	75	100	0	55	45
Nurses employed	83	17	36	64	50	50	67	33	63	37
MRI units, CT scans	94	6	64	36	100	0	100	0	84	16
Hospital in-patient discharges, limited diagnoses	97	3	48	52	75	25	100	0	78	22
Average length of stay, limited diagnoses	91	9	40	60	100	0	67	33	72	28
GP utilisation	94	6	56	44	75	25	100	0	79	21
Surgeries; PTCA, hip, cataract	97	3	64	36	100	0	100	0	85	15
Expenditures on health	40	60	12	88	50	50	33	67	30	70
Survival rates breast, cervical cancer	94	6	44	56	100	0	67	33	75	25
Other health indicators										
Disability-free life expectancy	71	29	32	68	75	25	67	33	57	43
Healthy life expectancy (HALE)	66	34	24	76	50	50	67	33	49	51
Quality-adjusted life years (QALY)	80	20	32	68	50	50	33	67	58	42
Disability-adjusted life years (DALY)	71	29	28	72	75	25	67	33	55	45

(Total valid responses = 67)

Part B: Policy Context – Lisbon Strategy

5. Do you use Structural Indicators to address the objectives of the Lisbon Agenda?

Most of the survey respondents (72%, total valid responses N=107) use Structural Indicators to address the objectives of the Lisbon agenda. However, responses vary between stakeholder groups. Whereas the majority of Commission Officials (86%, total valid responses N=58) and Representatives of National or Regional Non-Health Ministries (69%, total valid responses

N=16) use Structural Indicators, most of the Representatives of National or Regional Health Ministries (75%, total valid responses N=26) do *not* use them.

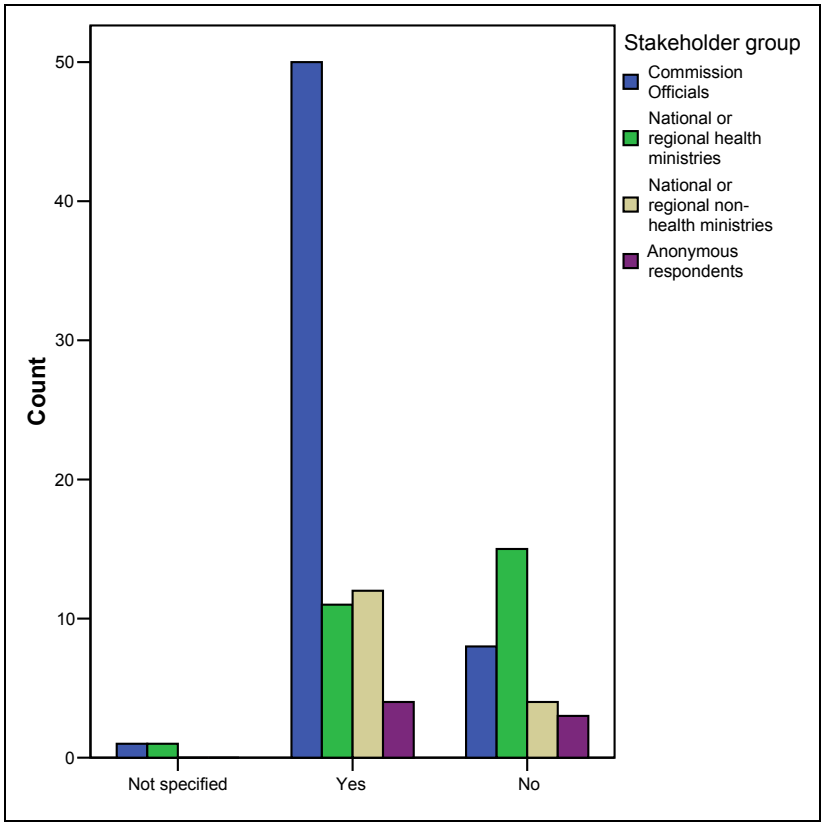

Figure 10. Use of Structural Indicators to address objectives Lisbon Agenda

Table 6. Descriptive statistics

	Yes	No	Not specified
Commission Officials	50	8	1
Representatives of National or Regional Health Ministries	11	15	1
Representatives of National or Regional Non-Health Ministries	12	4	0
Anonymous respondents	4	3	0
Total	77	30	2

(Total valid responses = 107)

6. Do you use health indicators for policy making and/or impact assessment?

Respondents were asked to whether they use health indicators for policy making and/or impact assessment. The majority of respondents (57%, total valid responses N=109) do *not* use these indicators for policy making and/or impact assessment. This applies in particular to Commission Officials (68%, total valid responses N=59), Representatives of National or Regional Non-Health Ministries (69%, total valid responses N=16) and Anonymous respondents (71%, total valid responses N=7). However, most of the Representatives of

National or Regional Health Ministries (78%, total valid responses N=27) do use health indicators for policy making and/or impact assessment.

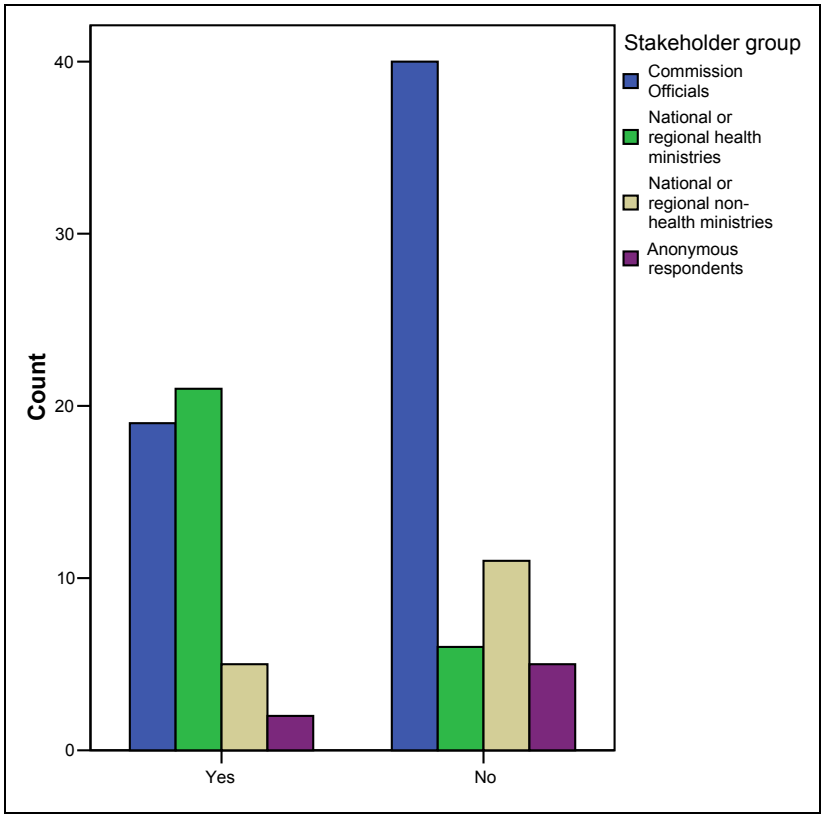

Figure 11. Use of health indicators for policy making and/or impact assessment

Table 7. Descriptive statistics

	Yes	No
Commission Officials	19	40
Representatives of National or Regional Health Ministries	21	6
Representatives of National or Regional Non-Health Ministries	5	11
Anonymous respondents	2	5
Total	47	62

(Total valid responses = 109)

6A. If answer to 6 yes, please indicate any of the following indicators that may apply.

Respondents using health indicators for policy making and/or impact assessment (N=47) were asked to specify which indicators they use. The first indicator included in the survey was the HLY indicator. Table 8 shows that two-thirds of the respondents (66%) report *not* to use the HLY indicator for policy making and/or impact assessment. Representatives of National and Regional Health Ministries are somewhat of an exception here: approximately half of the respondents in this category reports to use the HLY indicator for the above mentioned purposes.

All in all we can say that use of health indicators is relatively low, i.e. a minority of respondents uses them. Exceptions to this pattern are: *life expectancy, infant mortality, expenditures on health and population by gender/age*. These indicators correspond to the indicators that are also most known (Question 4a). Another indicator that is often used across all categories of stakeholders is *population projections*.

Our results indicate that use of health indicators differs across stakeholder groups. As was the case for awareness, use is highest among representatives of National or Regional Health Ministries.

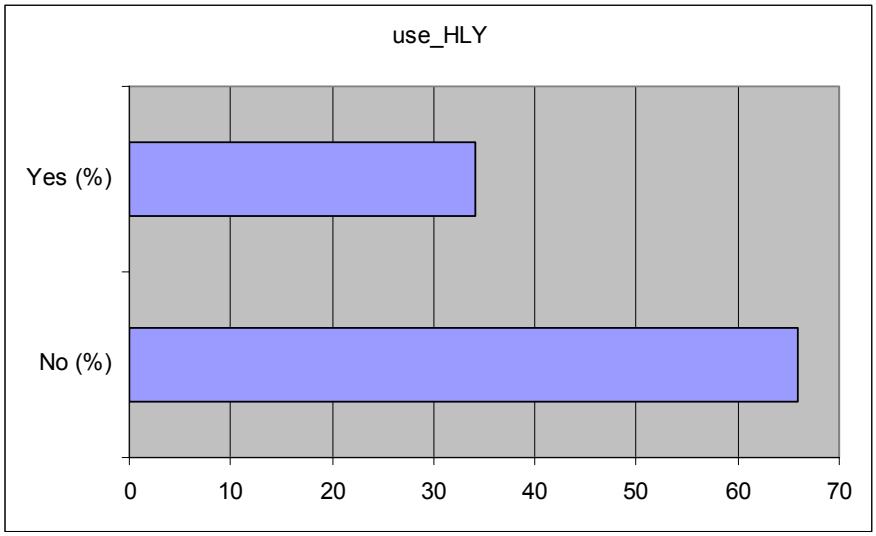

Figure 12. Use of HLY indicator

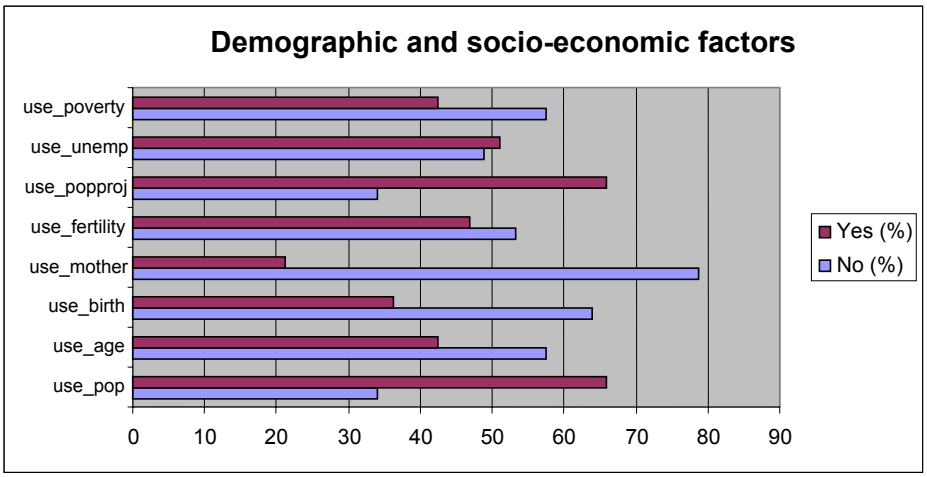

Figure 13. Use of demographic and socio-economic factor indicators

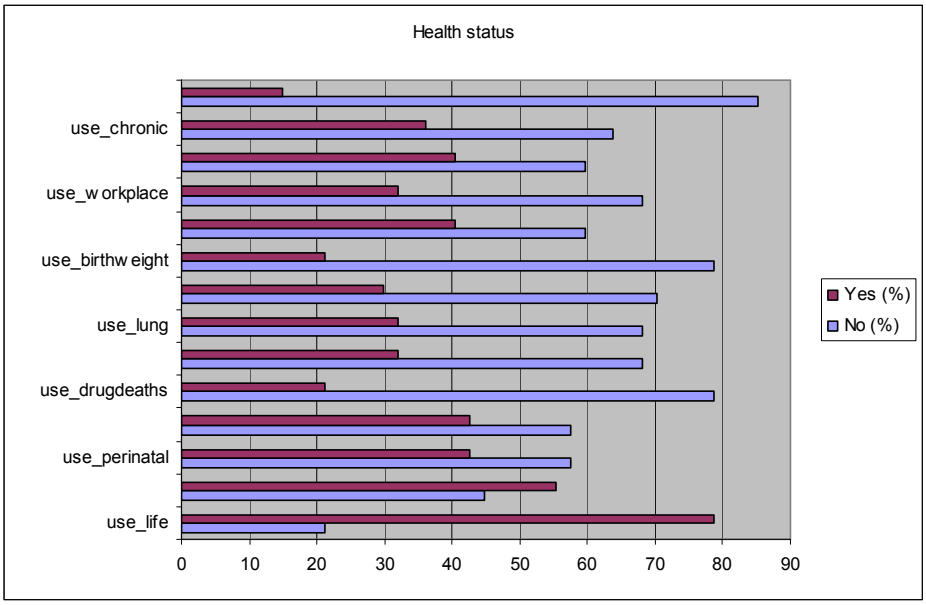

Figure 14. Use of health status indicators

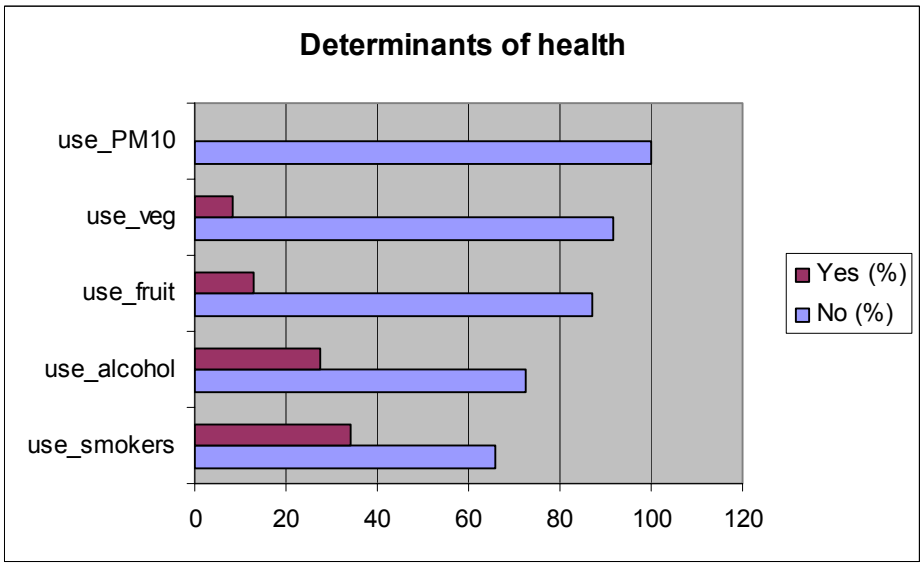

Figure 15. Use of determinants of health indicators

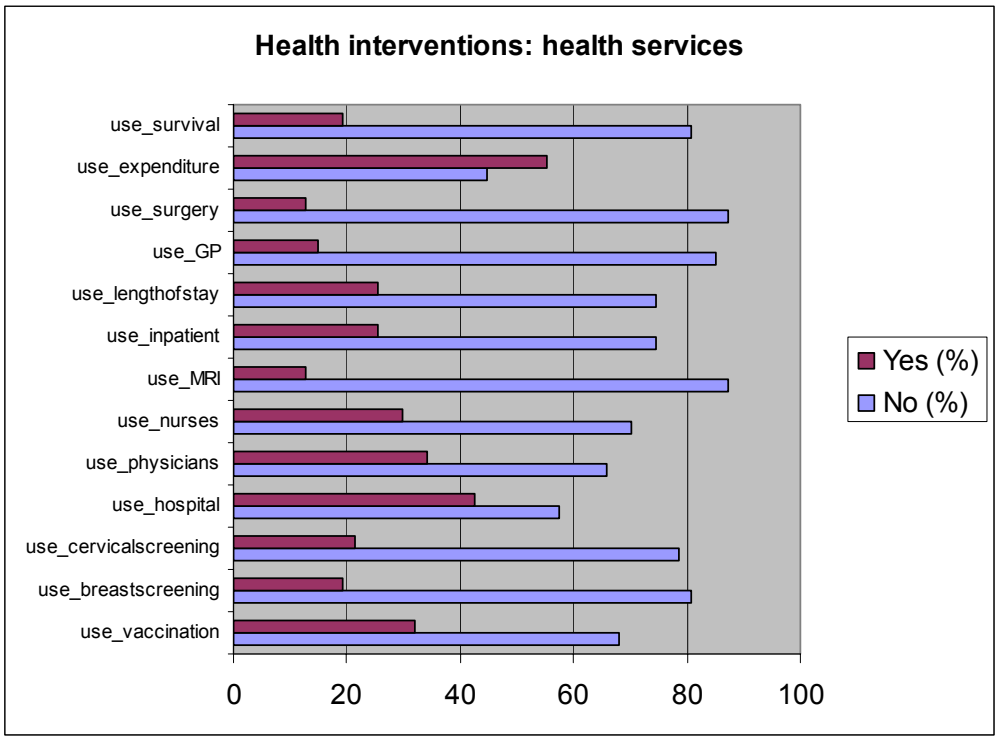

Figure 16. Use of health interventions and health services indicators

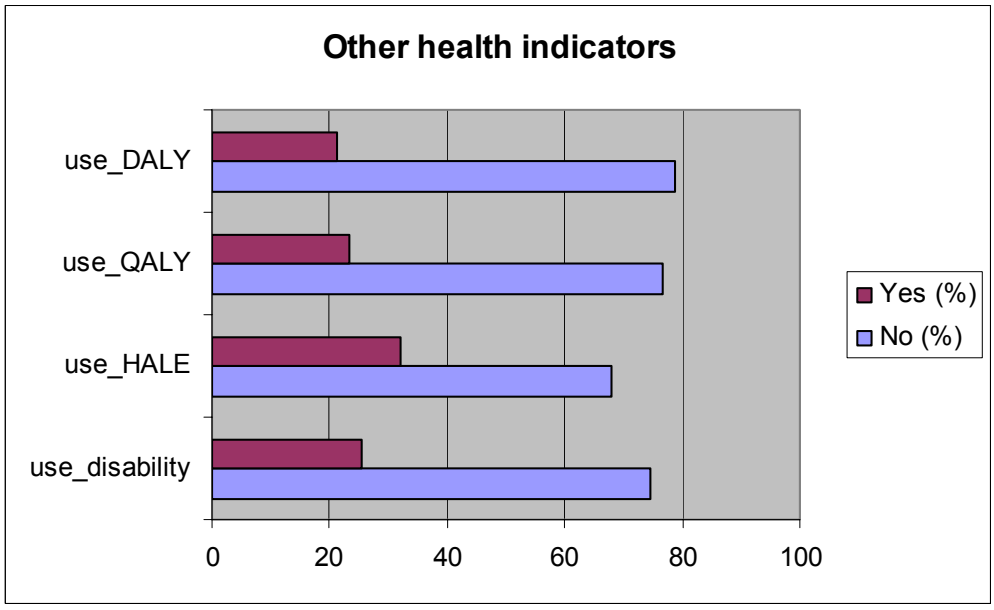

Figure 17. Use of other health indicators

Table 8. Use of health indicators for policy making and/or impact assessment (%)

	Commission Officials (n=19)		Representatives of National or Regional Health Ministries (n=21)		Representatives of National or Regional Non-Health Ministries (n=5)		Anonymous Respondents (n=2)		Total	
	No	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**
HLY indicator	79	21	48	52	80	20	100	0	66	34
Demographic and socio-economic factors										
Population by gender/age	42	58	29	71	20	80	50	50	34	66
Age dependency ratio	53	47	62	38	40	60	100	0	57	43
Crude birth rate	89	11	33	67	80	20	100	0	64	36
Mother's age distribution (teenage pregnancies, aged mothers)	100	0	52	48	100	0	100	0	79	21
Fertility rate	68	32	33	67	60	40	100	0	53	47
Population projections	32	68	38	62	20	80	50	50	34	66
Total unemployment	42	58	52	48	40	60	100	0	49	51
Population below poverty line	47	53	62	38	60	40	100	0	57	43
Health status										
Life expectancy	26	74	10	90	40	60	50	50	21	79
Infant mortality	74	26	14	86	60	40	50	50	45	55
Perinatal mortality (foetal deaths plus early neonatal mortality)	84	16	29	71	80	20	50	50	57	43
Standardised death rates Eurostat 65 causes	89	11	29	71	60	40	50	50	57	43
Drug-related deaths	100	0	62	38	60	40	100	0	79	21
HIV/AIDS	95	5	38	62	80	20	100	0	68	32
Lung cancer	100	0	33	67	80	20	100	0	68	32
Breast cancer	100	0	38	62	80	20	100	0	70	30
(Low) birth weight	100	0	52	48	100	0	100	0	79	21
Injuries: road traffic	79	21	33	67	80	20	100	0	60	40
Injuries: work place	84	16	62	38	40	60	50	50	68	32
Perceived general health	84	16	38	62	80	20	0	100	60	40
Prevalence of any chronic illness	84	16	43	57	60	40	100	0	64	36
Health expectancy, based on limitation of usual activities	95	5	81	19	80	20	50	50	85	15
Determinants of health										
Regular smokers	100	0	33	67	80	20	50	50	66	34

Total alcohol consumption	89	11	52	48	80	20	100	0	72	28
Consumption/availability of fruit, excluding juice	100	0	71	29	100	0	100	0	87	13
Consumption/availability of vegetables, excluding potatoes and juice	100	0	81	19	100	0	100	0	91	9
PM10 (particular matter) exposure	100	0	100	0	100	0	100	0	100	0
Health interventions: health services										
Vaccination coverage in children	100	0	38	62	80	20	50	50	68	32
Breast cancer screening coverage	100	0	67	33	80	20	50	50	81	19
Cervical cancer screening coverage	100	0	62	38	80	20	50	50	79	21
Hospital beds	79	21	38	62	60	40	50	50	57	43
Physicians employed	89	11	52	48	40	60	50	50	66	34
Nurses employed	89	11	52	48	60	40	100	0	70	30
MRI units, CT scans	100	0	76	24	100	0	50	50	87	13
Hospital in-patient discharges, limited diagnoses	95	5	48	52	100	0	100	0	74	26
Average length of stay, limited diagnoses	95	5	57	43	80	20	50	50	74	26
GP utilisation	95	5	76	24	100	0	50	50	85	15
Surgeries; PTCA, hip, cataract	100	0	71	29	100	0	100	0	87	13
Expenditures on health	47	53	38	62	80	20	0	100	45	55
Survival rates breast, cervical cancer	100	0	67	33	80	20	50	50	81	19
Other health indicators										
Disability-free life expectancy	79	21	67	33	100	0	50	50	74	26
Healthy life expectancy	84	16	52	48	60	40	100	0	68	32
Quality-adjusted life years (QALY)	89	11	67	33	80	20	50	50	77	23
Disability-adjusted life years (DALY)	79	21	71	29	100	0	100	0	79	21

(Total valid responses = 47)
[b] Total is unweigthed.

Part C: Policy Context – Healthy Ageing

7. Are there specific programmes or policies to promote healthy ageing in your country/organisation?

Respondents were asked for their awareness of specific programmes or policies to promote health ageing in their country or organisation. Almost half of the respondents (44%, total valid responses N=108) do not know of such policies or programmes, which can be largely attributed to responses from Commission Officials (53%, total valid responses N=58).

However, 43% of the respondents *were* aware, which can be attributed to Commission Officials (33%, total valid responses N=58), National or Regional Health Ministries (56%, total valid responses N=27), National or Regional Non-Health Ministries (56%, total valid responses N=16) and Anonymous Respondents (43%, total valid responses N=7).

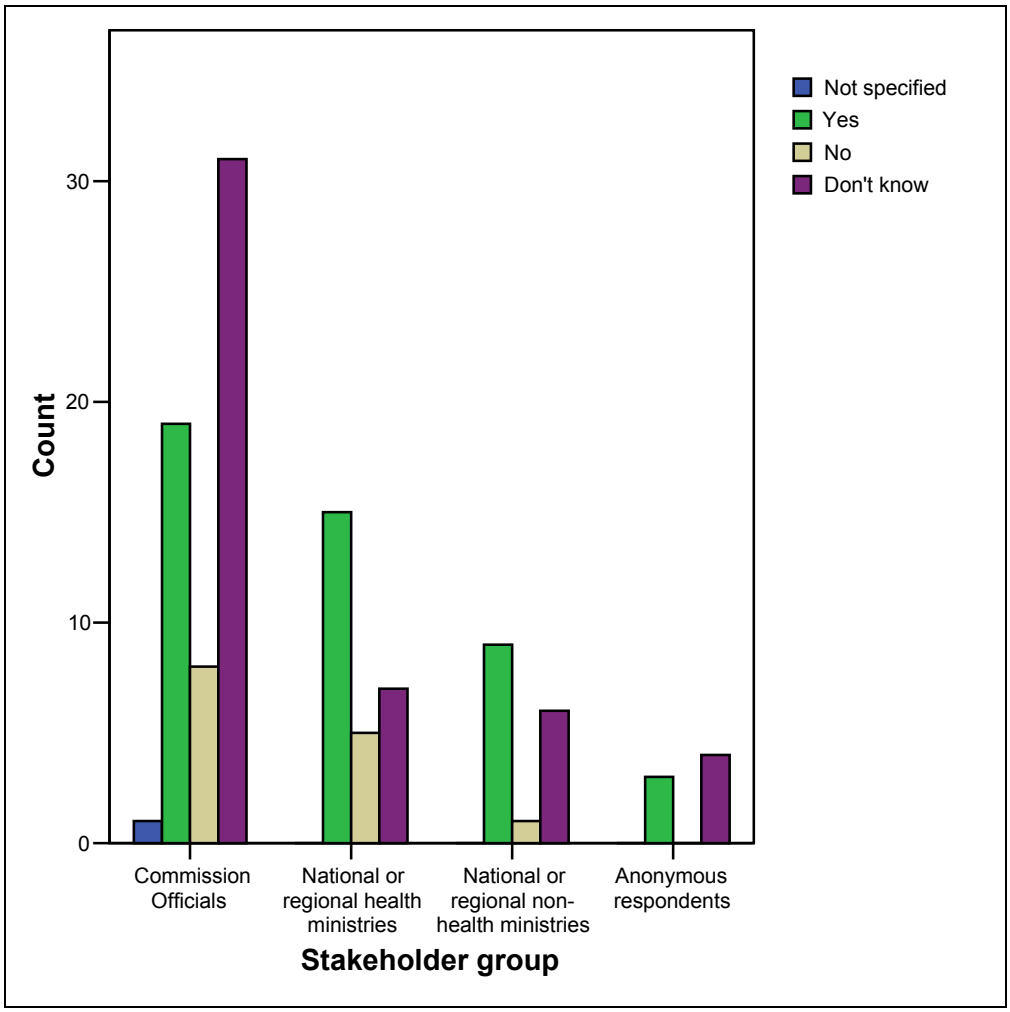

Figure 18. Prevalence of specific programmes or policies to promote healthy ageing

Table 9. Specific programmes or policies to promote healthy ageing in country/organisation

	Yes	No	Don't know	Not specified
Commission Officials	19	8	31	1
Representatives of National or Regional Health Ministries	15	5	7	0
Representatives of National or Regional Non-Health Ministries	9	1	6	0
Anonymous respondents	3	0	4	0
Total	46	14	48	1

(Total valid responses = 108)

7A. If answer to 7 yes: Could you please provide relevant references to policy or programme documentation?

The following references were provided by the different stakeholder groups:

Commission Officials

- "Forthcoming Communication to be published under the leadership of DG INFSO."
- "The e-Inclusion Ministerial declaration of the Riga Conference (June 2006) refers to the importance of Information and Communication technology for Inclusion and in particular for active ageing and healthy ageing. In the latest Framework Research Programme 7 several policy priorities reflect the importance of healthy ageing."
- "Not directly an issue to my Directorate General, but the Commission initiates policy coordination in the area of healthy ageing."
- "Community action programme for public health."
- "In the sense of good working conditions (preventing physically or psychologically harmful working situations)."
- "See DG SANCO. Not in our unit."
- "Active Labour Market Policies (ALMP)."
- "Lithuanian National Public Health Strategy 2006-2013 approved on 19 June 2006."
- "The Contribution of Health to the Economy in the European Union Community Programme for 2007-2013 (Health & Consumer Protection Strategy)"
- "European Social Fund documents from the European Commission"
- "http://ec.europa.eu/employment_social/social_protection/health_en.htm, and http://ec.europa.eu/employment_social/social_inclusion/naps_en.htm"

Representatives of National or Regional Health Ministries

- "http://www.stakes.fi/EN/Aiheet/olderpeople/index.htm"
- "Contact Ministère de la Famille et de l'Intégration in Luxembourg"
- "There is a specific programme concerning aging population included in the National Health Plan. It is available at http://www.dgs.pt."
- "In the Ministry's Strategy 'Strategies for Social Protection 2015 - towards a socially and economically sustainable development'. There are four strategic lines and two of them tackle health issues. These are: 1) promoting health and functional capacity and 2) making work more attractive. Under these strategic lines we have policy programs like "the Health 2015 public health programme."
- "Osteoporosis programme"
- "National strategy on bridging over the impact of ageing population (Resolution of the Government of the Republic of Lithuania of 14 June 2004 No 737; publication in the Official magazine "Valstybes zinios", 2004, No 95-3501) and its implementation action plan for 2005-2013 (Resolution of the Government of the Republic of Lithuania of 10 January 2005 No 5; publication in the Official magazine "Valstybes zinios", 2005, No 112)"

- "There is no policy or programme on a national level. The responsibility for promoting healthy ageing lies on the municipalities and county councils. They have a high level of autonomy."
- "National strategy on Healthy Ageing until 2010, solidarity among the generations"
- "Policy areas anti-smoking, fitness, screening and child-care and the national health aims"

Representatives of National or Regional Non-Health Ministries

- "National prevention programme 2002-2010, available at http://www.im.dk/publikationer/sund_hele_l/sund%20hele%20livet.pdf."
- "For instance, the National program of health protection for older Prenatal care female parent etc."
- "I am not able to specify. It would good to contact the website of the Ministry of Health."
- "The FPS Employment does not have the primary responsibility for health."
- "Initiative 50 Plus, Initiative New quality of Work."
- "http://www.healthpromotion.ie/, http://www.healthysteps.ie/."
- "Ministry of Health: http://www.mz.gov.si/en/, Institute of Public Health of the RS: http://www.ivz.si/, Ministry of Labour Family and Social Affairs: http://www.mddsz.gov.si/en/"

Anonymous respondents

- "Community Strategy for health and safety at work 2002-2006."
- "Health promotion programmes. In coordination with Social Services."

7B. If answer to 7 no or don't know: Is healthy ageing/health status of the ageing population a specific consideration in programmes or policies directed to other objectives?

The majority of survey respondents (52%, total valid responses N=60)) were *not* aware of programmes or policies to promote healthy ageing in their country/organisation. This can be largely attributed to the responses from Commission Officials; nearly half of them (49%, total valid responses N=39) were *not* aware. However, 30% indicates to be aware, whereas 18% reported there are no such policies or programmes.

	Yes	No	Don't know	Not specified
Commission Officials	11	9	19	0
Representatives of National or Regional Health Ministries	5	1	4	2
Representatives of National or Regional Non-Health Ministries	0	1	6	0
Anonymous respondents	2	0	2	0
Total	18	11	31	2

(Total valid responses = 60)

8. Does your country/organisation measure or monitor healthy ageing?

Respondents were asked whether healthy ageing is being monitored or measured in their country or organisation. Almost half of them (49%, total valid responses N=108) reported not

to know whether it is being monitored or measured, which can be largely attributed to Commission Officials from which 53% (total valid responses N=58) were not aware. However, healthy ageing is being monitored or measured by 31% of all respondents.

Table 10. Measuring and monitoring healthy ageing

	Yes	No	Don't know	Not specified
Commission Officials	15	12	31	1
Representatives of National or Regional Health Ministries	12	6	9	0
Representatives of National or Regional Non-Health Ministries	6	2	8	0
Anonymous respondents	0	2	5	0
Total	33	22	53	1

(Total valid responses = 108)

8A. If answer to 8 yes: Is the HLY indicator used to measure or monitor healthy ageing?

Table 11. Use of HLY indicator to measure or monitor healthy ageing

	Yes	No	Not specified
Commission Officials	8	2	5
Representatives of National or Regional Health Ministries	10	1	1
Representatives of National or Regional Non-Health Ministries	1	3	2
Anonymous respondents	0	0	0
Total	19	6	8

(Total valid responses = 25)

Of the respondents stating that healthy ageing is being monitored or measured, the majority (76%, total valid responses N=25) confirm to use the HLY indicator for this purpose, which can be largely attributed to Commission Officials (80%, total valid responses N=10) and Representatives from National or Regional Health Ministries (91%, total valid responses N=11).

8A.1. If answer to 8A no: Are other indicators used to measure or monitor healthy ageing, e.g. health expectancy (HE), disability-free life expectancy (DFLE) or the healthy life expectancy (HALE) indicator used by the WHO?

From the 6 respondents reporting that the HLY indicator is not being used to measure or monitor healthy ageing, 50% indicate that other indicators are being used for this purpose while the other half reported not to be aware.

Table 12. Use of other indicators to measure or monitor healthy ageing

	Yes	No	Don't know
Commission Officials	1	0	1
Representatives of National or Regional Health Ministries	1	0	0
Representatives of National or Regional Non-Health Ministries	1	0	2

Anonymous respondents	0	0	0
Total	3	0	3

(Total valid responses = 6)

8B. If answer to 8 no or don't know: Does your country/organisation think it is important to measure or monitor healthy ageing?

In response to question 8, 75 respondents indicated that their country/organisation is not measuring or monitoring healthy ageing or not to be aware of this. They were asked whether their country or organisation thinks it is important to measure or monitor healthy ageing. The majority (53%, total valid responses N=74) is not aware of this, which can be largely attributed to Commission Officials (65%, total valid responses N=43). This is followed by followed by 37% of the total valid respondents confirming that measuring or monitoring healthy ageing is seen as important by their country/organisation, which can be largely attributed to Representatives from National or Regional Health Ministries (87%, total valid responses N=15).

Table 13. Importance to measure or monitor healthy ageing

	Yes	No	Don't know	Not specified
Commission Officials	11	4	28	0
Representatives of National or Regional Health Ministries	13	0	2	0
Representatives of National or Regional Non-Health Ministries	2	1	6	1
Anonymous respondents	3	1	3	0
Total	29	6	39	1

(Total valid responses = 74)

9. Do/would you use the HLY indicator as an instrument to actually design policies/programmes to promote healthy ageing?

Respondents confirming to measure or monitor healthy ageing (question 8, total valid responses N=33) and those who are not but consider it important (question 8B, total valid responses N=29) were asked whether they would use the HLY indicator as an instrument to actually design policies/programmes to promote healthy ageing. The majority (66%, total valid responses N=54) confirmed that they would use the HLY indicator as an instrument to actually design policies/programmes to promote healthy ageing. This can be largely attributed to positive responses from Commission Officials (71%, total valid responses N=21) and Representatives of National or Regional Health Ministries (71%, total valid responses N=24).

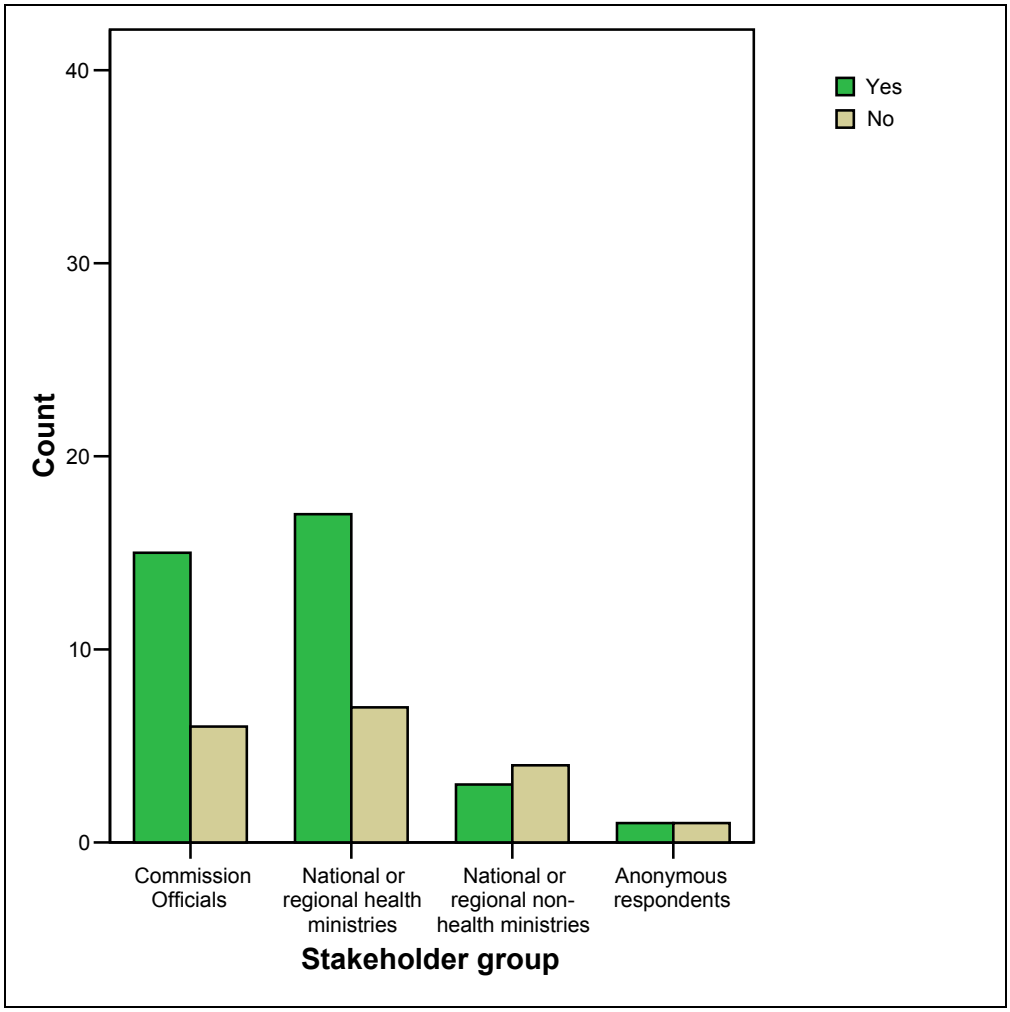

Figure 19. Use of HLY indicator as an instrument to actually design policies/programmes to promote healthy ageing

Table 14. Use of HLY indicator as instrument to design policies/programmes to promote healthy ageing

	Yes	No	Not specified
Commission Officials	15	6	5
Representatives of National or Regional Health Ministries	17	7	1
Representatives of National or Regional Non-Health Ministries	3	4	1
Anonymous respondents	1	1	1
Total	36	18	8

(Total valid responses = 54)

Appendix 2: Interview protocol for respondents *aware* of the HLY indicator

Introduction

In 2005, the Commission presented a new approach to the Lisbon strategy focusing on growth and employment. A set of Structural Indicators has been developed to provide an instrument for the objective assessment of progress made towards the Lisbon objectives. One of these indicators is the **Healthy Life Years** (HLY) indicator. The HLY indicator measures the number of years that a person of a certain age can expect to live without ill-health. It is based on length of life (measured with mortality tables) weighted by quality of life (measured by self-perceived disability assessed by health surveys). The HLY indicator is used in relation to **healthy ageing** (among other areas). Healthy ageing is an important policy issue in the face of demographic challenges to the societal well-being and economic prosperity of the EU. If the population can remain healthy as they get older, they can also remain active, contributing to society and reducing strains on health and social systems.

Please find below an overview of the questions for the (telephone) interview. The interview will last approximately 30-45 minutes.

The interview will address four main issues:

A. Awareness of HLY or other indicators

B. Use of HLY or other indicators

C. How to increase the uptake of the HLY indicator

D. Additional information

All answers will be treated in confidence and cannot be traced back to specific persons. However, we plan to include a list of interviewees in the final reporting of this project.

A. *Awareness* of the HLY indicator

1. How did you become ***aware*** of the HLY indicator?

2. Has the adoption of the HLY indicator as an EC structural indicator (from 2005 onwards) *increased* your awareness?

- Please specify

B. *Use* of the HLY indicator

3. Do you ***use*** the HLY indicator?

- Yes ---> continue with questions **a - d**
- No ---> continue with questions **e - f**

a) How do you use the HLY indicator?
   - Please specify

b) Does your organization/department have policies or programmes to promote healthy ageing?
   - Yes: Does your organization/department (intend to) **design/implement policies or programmes** to promote healthy ageing based on this/these indicator(s)?
     - In what policy areas (e.g. pensions, employment, finance, health)?
     - Have these policies/programmes had measurable impacts yet?
     - Could you provide us with references/copies of policy documents in which this/these indicator(s) is/are used?
   - No: Would you use the HLY indicator to actually design policies/programmes in order to promote healthy ageing in the future?
     - Yes, please explain how it would be used (e.g. to establish the case for policy, choose the instruments, monitor and adjust performance)
     - No, please explain why not

c) Do you use this/these indicator(s) to **monitor** healthy ageing?
   - Yes
   - No: Could the HLY indicator become an indicator to measure/monitor healthy ageing?
     - Yes, please explain how
     - No, please explain why not (e.g. there is a better indicator, a similar indicator using national data or other health status indicators, more data/understanding needed, it does not address key issues in healthy ageing)

d) Do you use the HLY indicator for other purposes (e.g. to analyse societal problems, raise awareness about healthy ageing or for benchmarking purposes)?
   - If yes, for which purposes?
     - Have these activities had measurable impacts yet? If yes, please specify
   - If not, why not? (e.g. because they use other indicators, or because they don't use quantitative indicators)

e) What are the reasons for ***not*** using the HLY indicator?

f) Could the HLY indicator become an indicator for your organization/department to **measure/monitor healthy ageing**?
   - Yes, please explain how
   - No, please explain why not (e.g. there is a better indicator, more data/understanding needed, it does not address key issues in healthy ageing, healthy ageing not identified as a separate policy area)

C. How to increase the uptake of the HLY indicator

4. Do you believe it is important to make comparisons between countries?

- Yes, please explain why
- No, please explain why not

5. Do you believe it is important to have unified/standardised indicators (i.e. indicators based on a unified common data source as opposed to harmonised treatment of national data) in making comparisons between countries?

- Yes, please explain why
- No, please explain why not

6. Do you believe it is important that the HLY indicator is included as a structural indicator to measure progress towards Lisbon objectives?

- Yes, please explain why
- No, please explain why not

7. What are the (potential) strengths of the HLY indicator in this context?

8. What are obstacles to uptake of the HLY indicator?

9. What should be done to increase the uptake of the HLY indicator (strategies for dissemination)?

D. Additional information

10. Are there any other organisations whose views should be sought because they use the HLY indicator, have healthy ageing policies and/or use other indicators for policy design, monitoring or comparisons?

- Please specify

11. Please could you recommend a person to interview about the use of indicators such as HLY in relation to healthy ageing?

- Please specify

12. Do you have any comments/remarks regarding this interview?

- Please specify

Appendix 3: Interview protocol for respondents *not aware* of the HLY indicator

Introduction

In 2005, the Commission presented a new approach to the Lisbon strategy focusing on growth and employment. A set of Structural Indicators has been developed to provide an instrument for the objective assessment of progress made towards the Lisbon objectives. One of these indicators is the **Healthy Life Years** (HLY) indicator. The HLY indicator measures the number of years that a person of a certain age can expect to live without ill-health. It is based on length of life (measured with mortality tables) weighted by quality of life (measured by self-perceived disability assessed by health surveys). The HLY indicator is used in relation to **healthy ageing** (among other areas). Healthy ageing is an important policy issue in the face of demographic challenges to the societal well-being and economic prosperity of the EU. If the population can remain healthy as they get older, they can also remain active, contributing to society and reducing strains on health and social systems.

Please find below an overview of the questions for the (telephone) interview. The interview will last approximately 30-45 minutes.

The interview will address four main issues:

A. Awareness of HLY or other indicators

B. Use of HLY or other indicators

C. How to increase the uptake of the HLY indicator

D. Additional information

All answers will be treated in confidence and cannot be traced back to specific persons. However, we plan to include a list of interviewees in the final reporting of this project.

A. *Awareness* of health indicators

1. Are you ***aware*** of indicators such as health expectancy (HE), disability-free life expectancy (DFLE) or the healthy life expectancy (HALE) indicator used by the WHO?

- Yes, please specify which indicator(s)
- No ---> continue with section C

B. *Use* of other health indicator(s)

2. Do you ***use*** this/these indicator(s)?

- Yes
  a) In what policy context?
  b) Do you use the indicator(s) in cross-organisational policies or programmes?
     - If yes, please specify
- No ---> continue with section C

3. Does your organization/department have policies or programmes to promote healthy ageing?

- Yes
  a) Does your organization/department (intend to) **design/implement policies or programmes** to promote healthy ageing based on this/these indicator(s)?
     - In what policy areas (e.g. pensions, employment, finance, health)?
     - Have these policies/programmes had measurable impacts yet?
     - Could you provide us with references/copies of policy documents in which this/these indicator(s) is/are used?
  b) Do you use this/these indicator(s) to **monitor** healthy ageing?

4. Do you use the indicator(s) to **monitor** other objectives?

- Yes, please specify which objectives

5. What is the usefulness of this/these indicator(s)?

C. How to increase the uptake of the HLY indicator

6. Do you believe it is important to make comparisons between countries?

- Yes, please explain why
- No, please explain why not

7. Do you believe it is important to have unified/standardised indicators (i.e. indicators based on a unified common data source as opposed to harmonised treatment of national data) in making comparisons between countries?

- Yes, please explain why
- No, please explain why not

8. What should be done to increase the uptake of the HLY indicator (strategies for dissemination)?

D. Additional information

9. Are there any other organisations whose views should be sought?

- Please specify

10. Please could you recommend a person to interview about the use of indicators such as the HLY indicator in relation to healthy ageing?

- Please specify

11. Do you have any comments/remarks regarding this interview?

- Please specify

Appendix 4: Interview respondents

Stakeholder category	Organisation	Country	Awareness of the HLY indicator
Commission Officials	DG Development and Relations with African, Caribbean and Pacific States	Belgium	Yes
Commission Officials	DG Enterprise and Industry	Belgium	Yes
Commission Officials	DG Regional Policy	Belgium	No
Commission Officials	DG Economic and Financial Affairs	Belgium	No
Representative National or Regional Health Ministry	Federal Ministry of Health and Woman	Austria	Yes
Representative National or Regional Health Ministry	Ministry of Health	Cyprus	No
Representative National or Regional Health Ministry	Ministry of Social Affairs	Estonia	Yes
Representative National or Regional Health Ministry	Ministry of Social Affairs and Health	Finland	Yes
Representative National or Regional Health Ministry	Ministry of Health and Solidarity	France	Yes
Representative National or Regional Health Ministry	Saxon Ministry of Social Affairs, Woman and Health	Germany	No
Representative National or Regional Health Ministry	Ministry of Health, Welfare and Sport	Netherlands	Yes
Representative National or Regional Health Ministry	Ministry of Health	Portugal	Yes
Representative National or Regional Health Ministry	Ministry of Health and Consumer Affairs	Spain	Yes
Representative National or Regional Health Ministry	Ministry of Health and Social Affairs	Sweden	Yes
Representative National or Regional Health Ministry	Ministry of Health	Turkey	Yes
Representative National or Regional Health Ministry	Department of Health	United Kingdom	Yes

Appendix 5: Ageing policies in Europe

	Name of policy/policy documents	Aim of policy/strategy	References
Belgium[1]	The National Lisbon Reform Programme 2005-2008	Macroeconomic stability: the challenge of the ageing population. More jobs for young and older workers.	http://www.belgium.be/eportal/ShowDoc/chancellery/imported_content/pdf/lisbon_strategy_EN.pdf?contentHome=entapp.BEA_personalization.eGovWebCacheDocumentManager.en
Bulgaria[2]	National Program to Control Osteoporosis in Bulgaria 2006-2010	The ultimate purpose is limitation of the disease, which causes tremendous financial costs for the healthcare as well as for the families of the patients and increase in the quality of life of the osteoporosis patients.	http://www.iofbonehealth.org/about-iof/member-societies/society.html?societyID=18&storyID=384
Czech Republic[1]	National Programme of Preparation for Ageing for 2003-2007	The aim of this National Programme is to create conditions to address the issue of ageing and to achieve a change in the attitudes and approaches at all levels, leading to a society for all generations. By creating conditions and opportunities for older employees to remain in work or to rejoin the labour market, the aim is to prolong the active stage of their lives and therefore gain substantial working and economic resources for society. The actual fulfilment of the programme and its objectives is broken down into measures where individual ministries are set responsibility for tasks.	http://www.mpsv.cz/files/clanky/1994/plan_2004-6.pdf
Denmark[1]	Danish ageing policy	The general objective of Danish ageing policy is to ease the discomfort of individual's everyday existence and improve his or her quality of life. Danish ageing policy is based on the general principles of:	http://eng.social.dk/netpublikationer/eng/dsp1dsp240902/9.htm

		▪ continuity in the individual's life ▪ use of personal resources ▪ autonomy and influence on own circumstances	
Estonia[1]	The policy for elderly in Estonia	The principal objective of the policy for the elderly in Estonia is to promote the internationally accepted principle of Society for All that is based on the consideration that society comprises people of different age groups who must have the possibility to participate in social life, irrespective of age. The policy for the elderly comprises the objectives, strategies and tasks related to the position and living conditions of the elderly. The policy for the elderly shall focus on the following issues: ▪ family and environment ▪ healthcare and social welfare ▪ employment and coping ▪ education, cultural activities and sports ▪ non-governmental organisations and self-help ▪ regional and international co-operation	http://www.sm.ee/eng/pages/index.html
Finland [1,2]	Government Resolution on the Health 2015 public health programme	1. Ageing people must be ensured opportunities for functioning actively in society, for: ▪ developing their knowledge and skills, and the ability to care for themselves, and for ▪ continuing to live an independent quality life with an adequate income for as long as possible. 2. Residential, local service and transport environments must be developed for ageing ▪ population groups that will safeguard the conditions for an independent life even when ▪ their capabilities deteriorate. Local authorities should work for these targets through an ▪ old age strategy incorporated into the municipal plan, as part of their welfare ▪ programmes, in traffic planning, and in developing and adding to housing areas. 3. A programme of services for old people should be worked out with the municipalities, ▪ aimed at developing care services needed in daily life and long-term care, incorporating ▪ informal care, voluntary work, commercial services and government action, and ▪ utilizing modern technology.	http://www.stm.fi/Resource.phx/publishing/store/2006/06/hm1157626104009/passthru.pdf
France[1]	1. 'The Elderly' (2002)	1. Aimed at improving the lives of the elderly. The initiative focuses on five main areas: ▪ a system aimed at tackling dependency: the Personal Autonomy Allowance ▪ home life ▪ institutions for the elderly ▪ hospital care ▪ service plan for the elderly	http://www.premierministre.gouv.fr/en/information/reports_98/day_of_solidarity_concerted_479/policies_for_the_elderly_53032.html?var_recherche=the+elderly

	2. National Concerted Action Plan for the Employment of Older Workers 2006-2010 (2006)	2.The purpose of the plan is to change the way older workers are perceived in French culture and society	
Germany[1,2]	1. Perspektive 50plus; 2.Erfahrung ist Zukunft	1. Increasing Older People's Employment in the Länder and Regions 2. The initiative „Erfahrung ist Zukunft" (Experience is Future) aims to raise awareness of the challenges of demographic change and to create a new image of ageing and elderly. It seeks to point out the perspectives of an ageing society in the areas employment, life long learning, health prevention and company start-ups to get the necessary changes going.	http://www.erfahrung-ist-zukunft.de/ http://www.perspektive50plus.de/content/e122/index_ger.html
Hungary[1]	The Programme of the Government of the Republic of Hungary for a Successful, Modern and Just Hungary 2006-2010	The government "wants to make sure that the physically and mentally healthy age of the people increases also in Hungary". A measure in this context: "recreation-oriented sport and leisure time activities of the population will be incited through indirect supports"	http://misc.meh.hu/binary/7866_new_hungary_program.pdf
Ireland[2]	National Health Promotion Strategy 2000-2005	Strategic aim: ▪ to enhance the quality of life and improve longevity for older people. Objectives: ▪ to consult older people in the planning and implementation of health promotion Programmes which promote positive mental health ▪ to work in partnership to implement community-based programmes such as Being Well and Go for Life ▪ to support the implementation of the Recommendations for a food and nutrition policy ▪ For older people and the recommendations in Building Healthier Hearts. ▪ to complete the implementation of the health promotion strategy for older people Adding Life to years and years to life.	http://www.healthpromotion.ie
Italy[1]	National Health Plan 1998-2000 – Health protection of weak people	Aim: give citizens the opportunity to live as healthy as possible. All the regions have adapted their regional plans to the national framework. Ministry of Public Health, regional health department. Linking ageing, social determinants of health and inter-sectoral cooperation.	-
Latvia[1]	National Lisbon Programme of Latvia	Employment of elderly	http://www.em.gov.lv/em/images/modules/items/item_file_11635_2.pd

	for 2005-2008		f
The Netherlands[1]	Policy for older persons in the perspective of an ageing population (2005)	The policy is aimed at increasing the participation of older people as a result of their increased healthy life expectancy.	http://www.minvws.nl/images/nota-ouderenbeleid_tcm19-98582.pdf
Poland[1]	Program of Cooperation between Government of Mazowieckie Voivodship with NGOs for 2005	The objectives of cooperation are: ▪ improvement in fitness and life activity of elderly persons ▪ helping them to integrate socially and maintain social contacts ▪ rise in availability and bettering quality of prophylactic, rehabilitative, therapeutic and nursing services ▪ development of diverse forms of long-term and hospice care and supporting care-takers for the chronically ill and/or disabled elderly persons ▪ reducing isolation, marginalization and social exclusion of seniors and combating use of violence against the eldest generation Planned activities include: ▪ organization of activities and rehabilitation for elderly people, particularly for the disabled; health prophylactics, physical exercises and therapy ▪ organization of meetings and integration events, excursions, package tours and other forms of spending time ▪ supporting individual and group assistance to the elderly ▪ help in creation and management of daily support centers 24h care for the elderly The expected results include: ▪ raising the standard of living of the elderly ▪ improvement in quality of the services ▪ enabling elderly people to solve some of their problems by means of self-organization and mutual aid ▪ improvement in life activities and development of the interests of the old generation	http://www.iccr-international.org/activage/docs/ActivAge-WP4-Poland.pdf
Portugal[1]	1. National Plan for the Health of the Elderly 2004-2010 2. Intervention Programme for active	1. Health policy, taking into account the problem of the system's sustainability, will have a key role by creating conditions that will permit an Active Ageing and preventing long term handicapping diseases. With development of new services and an integrated approach, for support and rehabilitation of persons in situations of dependence, there will be impacts in job creation, as well as in emergence of new professional profiles.' 2. An articulated set of measures aiming at fighting early drop-out from the labour market, valuing and promoting elder workers' knowledge and fighting their unemployment. The goal is to raise employment rate of elder workers, covering 90,000	http://www.planotecnologico.pt/InnerPage.aspx?idCat=581&idMasterCat=576&idLang=2&idContent=878&idLayout=4&site=lisbon-strategy

	ageing	(2005-2008).	
Slovakia[1]	The Manifesto of the Government of the Slovak Republic (2006)	The Government will enforce the orientation of health care on prevention and timely diagnostics of diseases, support the implementation of the most important society-wide preventive programmes, and enforce a comprehensive programme of care for children and the elderly.	http://www-8.vlada.gov.sk/data/files/1902.pdf
Spain[1]	Plan de Acción para las Personal Mayores 2003-2007 ("Action Plan for Grownups")	Active ageing (envejecimiento activo): Aim of the policy is to improve the living conditions of older people, putting a broad network of resources at their disposal. Age group 65+. Collaboration and advice of the Ministries of Health, Economy, Science and Technology, Education, Culture, Leisure and Sports, Home Office and Finance.	http://www.seg-social.es/imserso/normativas/planppmm20032007.pdf
Sweden[1]	The national health policy (2003)	The policy area for the elderly includes initiatives aimed at enabling elderly people to live independent lives of good quality. Many of these initiatives are undertaken in the context of general policies directed at more groups than elderly people, which means that several policy areas are involved, such as health and medical care policy, public health policy, housing policy and working life policy. The objective of welfare policy is to enable all people to enjoy a good life.	http://www.fhi.se/upload/PDF/2004/English/newpublic0401.pdf
United Kindom[1]	The National Service Framework for Older People (2001)	This National Service Framework addresses the needs of older people. It is founded on knowledge-based practice and partnership working between those who use and those who provide services; between different clinicians and practitioners; across different parts of the NHS; between the NHS and local government; between the public, voluntary and private sectors; and reaching out to individuals, groups and organisations within the community. The NSF focuses on: • rooting out age discrimination • providing person-centred care • promoting older people's health and independence • fitting services around people's needs	http://www.assoc-optometrists.org/uploaded_files/nsf-olderpersons.pdf

[1] Documents found through internet search and the three-year project entitled "Healthy Ageing" (http://www.healthyageing.nu) funded by the EU Public Health Programme in 2004

[2] References provided by policymakers in survey.