Technical Group Health and Health Interview Survey (HIS) Statistics

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Item 3.2 of the agenda

Background and rationale of the EHIS questions
EUROPEAN HEALTH INTERVIEW SURVEY (EHIS)

1ST ROUND 2007-2008

BACKGROUND AND RATIONALE
OF THE QUESTIONS

VERSION 30/05/2007
1. Introduction

At their meeting in Eurostat in September 2002 the Directors of Social Statistics (DSS) of the National Statistical Institutes of the EU Member States decided to implement a European Health Survey System (EHSS) including, in the framework of the European Statistical System, the development and implementation of the European Health Interview Survey (EHIS)\(^1\). The EHIS aims at measuring on a harmonised basis and with a high degree of comparability among EU Member States, the health status, life style (health determinants) and health care services use of the EU citizens.

Other statistical tools exist which also provide important information on health in the EU. In particular registers on diseases (e.g. cancer), contacts with health and other care institutions (e.g., hospital discharges by diagnostic) or causes of death, constitute sources both exhaustive over the whole EU population and based on medical information. However, registers don’t cover all aspects of health and, in the majority of the Member States, cannot easily be linked among themselves and together with basic socio-economic data. In addition, administrative sources are influenced by the organisation of the health care systems in Member States what involves comparability issues. Consequently, health interview surveys (HIS), though providing self-assessed information on a sample of persons, constitute for a large scope of health aspects the appropriate, and in a lot of cases the only relevant source.

A first attempt of collecting HIS data at EU level took place in 1999, 2002 and 2004 by post-harmonising data on “18 HIS items”\(^2\). However the quality and comparability of the data resulted to be poor so that the development of the EHIS was decided.

To complete the EHSS, which also includes health questions in the EU-SILC (see below) and the HIS/HES database, a European Health Examination Survey (EHES) is developed by DG SANCO. The EHES will provide useful additional information with medical measurements but will be performed with a lower frequency (related to its costs) than the every five years EHIS.

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\(^1\)http://forum.europa.eu.int/Public/irc/dsis/ssd/library?l=/dss_meetings/meetings_2002/meeting_2002_09/documents/doc_dss_5_en_doc_3_/EN_1.0_.&asd
\(^2\)http://forum.europa.eu.int/Public/irc/dsis/health/library?l=/methodologiessandsdatabase/healthsinterviewssurvey/collections_2_002-2004&vm=detailed&sb=Title
The EHIS questionnaire for its 1st round 2007-2008 was adopted by the Eurostat Working Group on Public Health Statistics at its meeting on 21-22/11/2006. The topics included in the questionnaire both answer policy driven needs, either in terms of indicators lists or not, and more scientific driven purposes. Within the framework of these needs, the EHIS concentrates on the main elements needed at EU level and do not intend to cover all detailed aspects which can better be carried out via specific surveys or survey modules at national level, or at EU level when necessary.

In particular, concerning the health status questions, the questionnaire does not enter too much in disability issues, which shall be covered by another instrument (EDSIM – European Disability and Social Integration Module - project) under development. In addition, with only few exceptions, the EHIS measures the capacity without aids in order to not mix health state with access to health care. The EHIS also avoids duplicating information provided in other EU surveys (e.g., for health care consumption / access, SILC questions on unmet need of medical / dental examination).

Concerning policy demands, the EHIS aims to answering requests for the EU indicators agreed by the Member States in the respective groups of the policy DGs:

- European Community Health Indicators (ECHI)
- Open Method of Coordination on health care and long term care (OMC)
- Structural (SI) and Sustainable Development (SDI) indicators.

In terms of methodology, structure and implementation of the EHIS, the DSS decided in 2002 that a high standardisation of the questionnaire (questions, answer categories, filters, etc.) shall be achieved, in particular via conceptual translation into all EU languages, but that flexibility shall be given to the countries for the implementation in particular concerning the vehicle survey that would host the EHIS. In addition, it was decided to structure the EHIS in 4 modules:

- European Health Status Module (EHSM),
- European Health Care Module (EHCM),
- European Health Determinants Module (life styles, EHDM), and
- European (demographic / socio-economic) Background Module (EBM).

In framework, Member States can either implement a new dedicated survey or use an existing national population survey, in particular a national HIS, in order to implement the EHIS. It was also agreed that Member States could implement the EHIS by module in various national population surveys. In such a case each vehicle survey shall contain the MEHM (see HS.01 to 3 below) and the socio-economic variables in order to link the sources. However, either for the whole EHIS or each module, depending on the vehicle survey(s) used, it is recommended to follow the order of the questions in the questionnaire adopted, as this order, in addition to each question and its related answer categories, has been an integral part of the decision of the Working group on Public Health Statistics in November 2006. In any case, all questions of the EHIS questionnaire shall be implemented.

1 http://forum.europa.eu.int/Public/irc/dsis/health/library?l=/working_group_2006/working_documents/indicators_06-2pdf_/EN_1.0_&a=a
2 http://ec.europa.eu/health/ph_information/dissemination/echi/echi_en.htm
3 http://ec.europa.eu/employment_social/social_inclusion/indicators_en.htm
4 http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1133,47800773,1133_47802558&_dad=portal&_schema=PORTAL
In this framework, the EHIS questionnaire was prepared on the basis of proposals made by two projects, one carried out by EuroReves on the EHSM and the other one carried out by the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office for the other modules (EHCM, EHDM, and EBM)\(^8\). Pre tests and/or filed tests were carried out in the Member States after the development of the EHSM; the remaining modules were duly tested in 5 languages within the development project. On this basis, the final version of the questionnaire for the first round of the EHIS in 2007/2008 was prepared together with the Member States in the framework of the Partnership for Public Health Statistics. It does not include all questions proposed by the two above projects and some other questions were modified or additional ones proposed for inclusion in the EHIS on the basis of the results of testing carried out and experience in the Member States as well as political requests (discussion at TG HIS 2-4/10/2006).

2. Detailed explanations

2.1. Background module (Questions IP.01 to .03 + HH.01 to .14 + IN.01 to .04)

The questions in the background module are used in order to breakdown results of the survey according to demographic and socio-economic characteristics of the respondents. They follow the Eurostat Core Social Variables standard as available at the time of the adoption of the questionnaire, i.e. according to the report of the Task Force on Core Social Variables presented at the meeting of the DSS on 18-19/09/2006, point 3 of the agenda\(^9\).

2.2. Health Status Module

Questions HS.01 to .03 - Mini European Health Module - MEHM

These three questions constitute a general synthetic measure of the health state. The same set of questions is (MEHM) used in the SILC\(^10\) and adopted as the core health questions to be used in any EU health survey or survey module, in order to link results among surveys according to these 3 standard health characteristics of the population.

These 3 basic health status measures are: self-perceived health; chronic (long-standing) illness or condition; limitation in activities because of health problems (GALI) - based on EuroReves proposals\(^11\). Only the general health status is considered here, i.e. temporary problems are excluded.

The structural indicator Healthy Life Years is calculated on the basis of question HS.03 (also included as headline indicator in the SDI)\(^6,7\). More generally the 3 questions are used for the calculation of on prevalence of perceived health, self-reported longstanding illnesses or health problems and long-term activity limitation (also included in the OMC indicators\(^5\)).

\(^8\) http://forum.europa.eu.int/Members/irc/dsis/health/library?l=/reports/healthsinterviewssurvey&vm=detailed&sb=Title
\(^9\) http://forum.europa.eu.int/Public/irc/dsis/ssd/library?=dss_meetings/meeting_2006_18-19/working_documents&vm=detailed&sb=Title
and http://forum.europa.eu.int/Public/irc/dsis/eusilc/library?=/udb_user_database/publications_regulations/EN_1.0_a=d
\(^11\) http://www.hs.le.ac.uk/cgi-bin/reves/euroreves.cgi
Questions HS.04 to .06 – Chronic morbidity / physical conditions

These questions measure chronic diseases which represent one of the main public health concerns. The growing importance of chronic morbidity is due not only to the ageing of the population but also to therapeutic improvements. Surviving longer with chronic diseases is a challenge for the quality of life, especially for older people. At the individual level, the human organism’s capacity to defend and mechanism of recovery decrease as people age, therefore diseases become more and more likely. Many of these diseases are progressive and their impairments may be cumulated over time. Chronic diseases are, in fact, a major cause of use of health care services and their treatments are often very expensive. Measuring chronic morbidity, both the extent of the phenomenon and the types of diseases, is useful for overall evaluations in the domain of health status. It is also useful for the study of health care systems in terms of evaluation, policy formulation and assessment of need for health care. These questions are based on the proposal from Euroreves using the instrument for chronic physical conditions developed by EuroHIS12.

Question HS.04 is a general question in order to measure the self-reporting dimension of the respondent on the diseases or conditions proposed. For its part question HS.05 is aiming to check the medical assessment dimension of the diseases self-reported and HS.06 refers to the time and frequency dimension, i.e. whether or not the respondent suffers or suffered “recently” (last 12 months). The 3 dimensions together measure the burden of chronic diseases among the population. The list of diseases was selected on the basis of:

✓ the indicators needs3-5,
✓ the knowledge expected from the respondents about the diseases based on contacts with the health care system (disease usually underreported by lack of knowledge were not included) and
✓ a minimum prevalence level in the population (low prevalence diseases shall not be measured via a general population survey).

Questions HS.07 to .08 – Accidents and injuries

These questions aim to measure the frequency of all kind of accidents and injuries (excluding self-inflicted injuries) which represent also a high burden in term of consequences on health state, use of health care services and health and rehabilitation expenditures, in particular among young people (which on the opposite suffer less from chronic diseases). The need of measurement of the frequency of accidents and injury is also reinforced at EU level by the monitoring needs stated by the Community strategies on health and safety at work 2002-200613 and 2007-201214 as well as the Communication from the Commission and draft Council Recommendation on the prevention of injury and the promotion of safety15.

These different policy frameworks justify the breakdown according to the 4 main types of accidents (question HS.07). For its part question HS.08 measures 3 levels of severity (no use of health care due to the accident, visit to a doctor or a nurse and visit to an emergency department which is in principle referring to the most serious accidents), a better comparability being expected for the most serious cases.

12 http://www.euro.who.int/InformationSources/Publications/Catalogue/20030414_1
Question HS.07 is based on questions from the 2007 Labour Force Survey ad-hoc module on accidents at work and other work-related health problems\(^\text{16}\) when question HS.08 was proposed by the Core Group (CG) and Technical Group (TG) Health Interview Survey (HIS) of the Partnership on Public Health Statistics (PH). The measurement of the frequency of accidents and injury is also included in the ECHI indicators list\(^3,4\).

**Questions HS.09 – Work-related health problems**

This question measures the burden of work-related health problems among the population. These health problems may appear long time after the exposure and consequently affect not only current workers but also persons having worked in the past, including retired people. The impact of psychosocial diseases is also increasing. Finally, more and more occupational causes / exposures and non-occupational ones are merged in the sources of diseases, either physical (e.g., cancers, musculoskeletal problems) or psychosocial (stress and related mental disorders).

The impact on the health status of the population of all these health problems together, either fully or partly (made worse) caused by work, is consequently very important. In addition, usual measurement via administrative sources are strongly underestimating their burden as they are limited to cases recognised and compensated by occupational diseases insurance scheme which criteria are in general very restrictive (based on the principle of a full or very high causality between the professional exposure and the diseases).

As in the case of accidents at work above, the need for measurement of these diseases is stated by the Community strategy on health and safety at work 2002-2006\(^\text{10}\) and future strategy 2007-2012\(^\text{11}\). Question HS.09 is also based on questions from the 2007 Labour Force Survey ad-hoc module on accidents at work and other work-related health problems\(^\text{13}\).

**Questions HS.10 to .11 – Absenteeism due to health problems**

These questions measure the direct burden of health problems on the economic activity, i.e. in term of absenteeism during the last 12 months. They refer to all kind of health problems, i.e. the chronic diseases, injuries, occupational diseases measured in the previous questions, but also any other type of diseases and health problems including communicable diseases and temporary health problems.

This measurement is key information often required at EU level but which was never collected until now. Only some proxy information exist currently from harmonised EU sources, in the EU Labour Force Survey (only the absence of the job during the full reference week for "Own illness, injury or temporary disability")\(^\text{17}\) and, on small sample and then with limited possibilities for analysis, in the every five years European Working Condition Survey of the European Foundation for the Improvement of the Living and Working Conditions\(^\text{18}\). The incidence of sickness absence is also needed for ECHI\(^3,4\).

Question HS.10 is a filter question allowing remembering all absences from work while question HS.11 actually measures the number of days' absence. Both questions come from the European Working Condition Survey.

\(^{16}\) http://forum.europa.eu.int/Public/irc/dsis/hasaw/library?l=/lfs_2007_module&vm=detailed\&sbs=Title
\(^{18}\) http://www.europfound.europa.eu/ewco/surveys/index.htm
Questions PL.01 to .10 – Physical and sensory functional limitations

These questions measure the main physical and sensory functional limitations, i.e. according to the International Classification of Functioning, Disability and Health (ICF)\(^\text{19}\):

- PL.01 to .03: Seeing functions (ICF code B210)
- PL.04 to .05: Hearing functions (B230)
- PL.06: Walking (D450)
- PL.07: Climbing (D4551)
- PL.08: Squatting and kneeling (D4101, D4102)
- PL.09: Carrying in the hands or in the arms (D4301, D4302)
- PL.10: Fine hand use (D440)
- PL.11: Biting and chewing (B5101, B5102).

Measuring the prevalence of these limitations constitute the basic evaluation of the health state of the population, i.e. its situation in terms of functioning capacity whatever the reasons of the limitations (born with, disease, accident, ageing, etc.).

For these questions, the focus is on capacities without aids, i.e. the actual limitations in physical and sensory functional the people face due to their health state, without any support they can get (or not) by accessing (or not) the health care or social services in order to compensate these difficulties (devices, personal assistance, etc.). Only chronic limitations are considered and temporary problems are excluded. This means that in this part of the questionnaire it is aimed at measuring the general health state of the population from the body function point of view. The consecutive issues in terms of access and consumption of health care will be measured only in a second time in the part of the questionnaire related to the use of health care services.

However, as an exception, for questions PL.01 to .05, it is first checked whether the interviewee wear seeing (glasses, contact lenses) or hearing aids as, except in extreme cases of social exclusion, people can easily and systematically get these aids (i.e. it is assumed that there is no real issue related to access to health care in this case, though indeed these aids have an economic cost, and it is also easier to compensate for many seeing and hearing problems by using aids to the level of no problems). Consequently people tend to assess more easily their situation with aids for these functions. It is then considered that the health state is measured "with aids" for these two functions.

These questions are standard instruments used in numerous national and international health interview surveys. More specifically, they are based on the proposal from Euroreves\(^\text{8}\). However, concerning answer categories, the testing carried out and the experience of the Member States showed on the one hand that dichotomous answer categories (yes/no) were not sufficient to assess correctly the physical and sensory functional capacities measured, but on the other hand that:

- the most important was to assess into details the limitations side
- when for the positive side (absence or quasi absence of limitations) details were less necessary to assess and the difference between graduations was not so meaningful.

As a consequence 4 answer categories are used (“Can you …?": with no difficulty/some difficulty/a lot of difficulty/not at all).

\(^{19}\) [http://www.who.int/classifications/icf/en/](http://www.who.int/classifications/icf/en/)
The prevalence of the main physical and sensory functional limitations measured by the EHIS is included in the ECHI indicators list\textsuperscript{3,4}.

Finally it should be noted that in the framework of the Budapest Initiative (BI) of UNECE (United Nations Economic Commission for Europe)/WHO/Eurostat on the measurement of health state, questions PL.01 to .07 can be completed by the BI questions on the same domains\textsuperscript{20} (see also the end of the current document).

**Questions PC.01 to .04 – Activities of Daily Living (ADL) – "Personal Care Activities"**

These questions measure the performance and the help received or needed concerning the main Activities of Daily Living (ADL), i.e. according to the ICF\textsuperscript{16}:

- Feeding: Eating and drinking (D550, D560)
- Getting in and out of a bed or chair: Transferring oneself (D420)
- Dressing and undressing: Dressing (D540)
- Using toilets: Toileting (D530)
- Bathing or showering: Washing oneself (D510).

The measurement of the ADL constitute the first basic evaluation of disability prevalence in the population, in terms of performance for personal care activities, whatever the reasons of the disabilities (born with, disease, accident, ageing, etc.), and of related support provided to the disable persons.

As for PL questions, question PC.01 relates to the usual difficulties the interviewee has in carrying out by himself the ADL listed, without any help, i.e. support he/she can get (or not) by accessing (or not) the health care or social services in order to compensate these difficulties (devices, personal assistance, etc.). That means that again the measurement is without aids and ignoring temporary problems, aiming at measuring only the general health state of the population from the activities functions point of view.

On the opposite, questions PC.02 to .04 are focusing on help received or needed (either additional help or in case of no having help at all). They refer to ICF codes E310-E399 (Support and relationships) for family or other personal assistance, as well as E115 (Products and technology for personal use in daily living) for technical aids and housing adaptation. The help received or needed is measured for all ADL together ("for at least one activity") as it is considered sufficient for a first assessment of help related to ADL in the EHIS. More details shall be obtained in the EDSIM (see introduction above).

These questions are based on the proposal from Euroreves\textsuperscript{8}. As for the physical and sensory functional limitations and for the same reason, 4 answer categories are used for PC.01 (with no difficulty/some difficulty/a lot of difficulty/not at all). For PC.02 to .04 the focus is on the type of help. The measurement of the prevalence of the ADL is included in the ECHI indicators list\textsuperscript{3,4}.

\textsuperscript{20} http://forum.europa.eu.int/Members/irc/dsis/health/library/?l=/working_2006_limited/activities_05-3pdf/ EN 1.0 &a=l
Questions HA.01 to .05 – Instrumental Activities of Daily Living (IADL) – "Household Care Activities"

These questions measure the performance and the help received or needed concerning the main instrumental activities of daily living, i.e. according to the ICF\textsuperscript{16}:

- Preparing meals: Preparing meals (D630)
- Using the telephone: Using telecommunication devices (D3600)
- Shopping: Acquisition of goods and services (D620)
- Managing medication: Looking after one's health (D570)
- Light housework: Doing housework (D640)
- Occasional heavy housework: Doing housework (D640)
- Taking care of finances and everyday administrative tasks: Basic economic transactions and major life areas, other specified (D860, D898).

The measurement of the IADL constitute the second basic evaluation of disability prevalence in the population, in terms of performance for household care activities, whatever the reasons of the disabilities (born with, disease, accident, ageing, etc.), and of related support provided to the disable persons.

As for PC.01, question HA.01 relates to the usual difficulties the interviewee has by carrying out by himself the IADL listed, without any support he/she can get (or not) by accessing (or not) the health care or social services in order to compensate these difficulties (devices, personal assistance, etc.). That means that again the measurement is without aids and ignoring temporary problems, aiming at measuring only the general health state of the population from the activities functions point of view.

In the case of the IADL difficulties may come either from health problems or similar reasons (disability, age) but also, by opposition to the ADL functions that everyone is normally able to perform, because the interviewee never carried out these activities and is consequently not able to do it by lack of knowledge or know-how (i.e. the activity was always done for him/her by another person). Question HA.02 allows filtering the persons the EHIS focuses on, i.e. the first category.

The questions HA.03 to.05, as PC.02 to .04 for the ADL, are focusing on help received or needed (either additional help or in case of no having help at all). They refer to ICF codes E310-E399 (Support and relationships) for family or other personal assistance, as well as E115 (Products and technology for personal use in daily living) for technical aids and housing adaptation. The help received or needed is measured for all ADL together ("for at least one activity") as it is considered sufficient for a first assessment of help related to ADL in the EHIS. More details shall be obtained in the EDSIM (see introduction above).

These questions are based on the proposal from Euroreves\textsuperscript{8}. As for the physical and sensory functional limitations and for the same reason, 4 answer categories are used for HA.01 (with no difficulty/some difficulty/a lot of difficulty/not at all). For HA.03 to HA.05 the focus is on the type of help. The measurement of the prevalence of the IADL is included in the ECHI indicators list\textsuperscript{3,4}.
Questions SF.01 to.10 – Pain, psychological distress and well-being

These questions cover some remaining items of the health state, in particular in terms of well-being, both from the physical aspects (pain) and the mental aspects, in order to get a complete general overview of the health state of the EU population. In addition, the domain of pain is a domain covered by the BI\textsuperscript{17}.

For this purpose, the following items from the SF-36v2 standard instrument\textsuperscript{21} were used:

- question SF.01 on pain has been proposed by the BI (as available on 31/03/2006) based on an adaptation from the related question in the 7th SF-36v2 questionnaire
- questions SF.02 to .10 on mental aspects come from question 9 of the SF-36v2 questionnaire.

The inclusion of pain, though not covered by any EU indicator needs, was strongly recommended for inclusion by the Member States as an important dimension of the health state not yet included in the Euroreves proposal. For its part, psychological distress and well being is included in the ECHI indicators list\textsuperscript{15}.

Concerning mental health, the general consensus was that this domain is very important and that a better instrument should consequently be developed for the following rounds of the EHIS. For the EHIS 1\textsuperscript{st} round, as such an instrument is not yet available, it was concluded that the best questions available were those of the SF-36v2.

2.3. Health consumption module

Questions HC.01 to .18 – Hospitalisation, consultations and visits of doctors, specialists, dentists and other health professionals as well as related care services

\textit{NB: for all questions HC and further questions of the EHCM, the operationalisation and translation into the different national languages should take account of the specificities of the national health care systems.}

Questions HC.01 to .18 aim to measure the use of curative medical services. They refer to the main types of these services: hospitalisation, consultations and visits of doctors, specialists, dentists and other health professionals (and some related care services). Actually, both hospitalisation (including the activity of the hospital medical, auxiliary and administrative personnel) and medical manpower caring for outpatient constitute the major source of health care expenditures. Consequently these questions measure, from the use by patients / interviewees, the health care services activities.

The focus is on hospitalisation, consultations, visits, examinations, “on your own behalf” i.e. of / by / to the interviewee himself / herself for his / her own health situation and not while only accompanying a member of the family, etc.

Finally, questions HC.06, .07, HC.014 and .015 refer to the issue of the unmet needs of health care in the framework of social inclusion, as tackled by the OMC on health care and long-term care\textsuperscript{5}.

\textsuperscript{21} \url{http://www.sf-36.org/tools/SF36.shtml#VERS2} and \url{http://www.qualitymetric.com/products/surveys/pdf/SF-36v2_Standard_Sample.pdf}
Questions HC.01 to .05 refer to the use of hospital care. Hospital services are the most expensive care services and are in particular related to the most severe health problems for which ill person are admitted either as inpatient of day-patient (out-patient services including emergency services are not included). The questions are based on the proposal from the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office\(^8\) and the instrument proposed by EuroHIS\(^{12}\). The reference period is one year as hospitalisation stays are not very frequent in average among the population.

For these questions (and questions HC.06 and .07) an “hospital” is defined according to the category HP.1 of the health care providers in the International Classification of Health Accounts (ICHA) used by Eurostat, OECD and WHO\(^{22}\), i.e. “a licensed establishments primarily engaged in providing medical, diagnostic, and treatment services that include physician, nursing, and other health services to in-patients and the specialised accommodation services required by in-patients.” They include general hospitals (HP.1.1), mental health and substance abuse hospitals (HP.1.2), and other speciality hospitals (HP.1.3). Nursing and residential care facilities (code HP.2 of ICHA), providing residential care combined with either nursing, supervisory or other types of care as required by the residents (mix of health and social services) are excluded.

Question HC.01 identifies persons having been hospitalised as an inpatient, i.e. staying at least one night in the hospital, during the last 12 months (prevalence). Among them, question HC.02 measures the number of stays in the hospital if the person was hospitalised more than one time during this period (frequency) and HC.03 the number of days they spent in the hospital during all these stays (HC.02 allowing to remember all stays). The information provided by these three questions complement the information available from administrative sources (hospital discharges\(^{23}\)), which provide more details on the causes of the hospitalisation (morbidity) but cannot link various stays for a same patient. Consequently HC.01 to .03 allow calculating indicators by patient and also link this analysis with all health state, health care and life style information provided by the EHIS.

Questions HC.04 to .05 provide similar information as HC.01 to .03 but for day patients, i.e. cases where the person is admitted in the morning and released before the evening. They also provide the same complementarily to administrative sources.

For their part, questions HC.06 and HC.07 measure the unmet needs of hospitalisation (also over the last 12 months). The topic of unmet needs of health care is covered partially by the EU Statistics on Income and Living Condition (SILC) survey, of which questions PH040 and PH050 tackle the unmet needs of medical examination and questions PH060 and PH070 tackle those of dental examination\(^{10}\). Consequently HC.06 and .07 complete the analysis of the unmet needs of health care by covering the unmet needs for hospital care. The structure of the questions and answer categories is the same as in SILC, with only minor adaptations in the case of hospitalisation:

- the need of hospitalisation shall come from a recommendation of a doctor and not just the point of view of the interviewee alone (in order to exclude cases where no real need existed);
- among the reasons, “not covered by the insurance fund” was added to “too expensive” as, e.g., some surgeries may not be covered by all insurance funds,

\(^{22}\) [http://forum.europa.eu.int/Public/irc/dsis/health/library?l=/methodologiessandsdashatascsystemsofhealthsaccount/haenglpdf/EN_1.0].

✓ “other reasons due to the hospital” was added to “waiting list”, e.g. in case of cancellation of the appointment for a surgery by the hospital, the fears were limited to surgery or treatment which are the most relevance in the case of hospitalisation, and
✓ the 2 categories “Waiting to find out if problem got better on its own” and “Didn’t know any good doctor or specialist” were suppressed because they were not considered important to know and probably not frequent in the case of hospitalisation (they are then included under “other reason”).

The indicators to be calculated from HC.01 to .07 belong to the ECHI4 list but mainly answer the indicators needs of the OMC on health care and long-term care3,5.

**Questions HC.08 to .11** refer to the use (consultations, visits) of dentists or orthodontists (HC.08 and .09, corresponding mainly to category HP.3.2 “Offices of dentists” of the health care providers in the ICHA classification19) or GPs and family doctors (HC.10 and .11, only a part of category HP.3.1 “Offices of physicians” in ICHA19, the other part not included here concerning specialists - see below). Dental services are not the most frequently used outpatient care services but they are often expensive. For their part, GPs and family doctors constitute in the majority of the EU Member States the primary access to health care. In addition in numerous countries, the GPs and family doctors shall be consulted in order to be oriented to a specialist when needed. Access to dental or primary medical examination is consequently a key element of equity in relation to health care. However, there are no questions on unmet needs of dental or medical examination as they are already included in the SILC (PH040 to PH070)23. Questions HC.08 to .11 are based on the proposal from the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office8 and use the instrument proposed by EuroHIS12.

Questions HC.08 and HC.10 respectively identify persons having visited a dentist / orthodontist or GP / family doctor during the last 12 months (prevalence). Among them, questions HC.09 and HC.11 respectively measure the number of visits during the last 4 weeks (frequency). As for hospitalisation, indicators to be calculated from HC.08 to .11 belong to the ECHI4 list but are mainly indicators needed for the OMC on health care and long-term care3,5.

**Questions HC.12 to .15** refer to the use (consultations, visits) of medical and surgical specialists (second part of category HP.3.1 “Offices of physicians” in ICHA19, see above). Specialists treat often more severe diseases and usually not directly accessible but only if referred by a GPs and family doctors. In some Member States this is generating waiting lists. In addition medical and surgical specialists rates may be high / free and consequently not fully compensated by insurance systems. For all these reasons the access to medical and surgical specialists is measuring an important aspect of equity in relation to health care. As there is no specific question on unmet needs of specialists’ medical and surgical examination in the SILC, this issue is covered by the EHIS. Questions HC.12 and HC.13 are based on the proposal from the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office8 and use the instrument proposed by EuroHIS12. For their part questions HC.14 and HC.15 are, as questions HC.06 and HC.07, similar to questions PH040 to PH070 on unmet needs of dental or medical examination in the EU SILC21.
Questions HC.12 (prevalence) and HC.13 (frequency) are the same as questions HC.08 to.11 but on medical and surgical specialists. For questions HC.14 to HC.15, as for HC.06 and HC.07, the structure of the questions and answer categories is the same as in SILC, with only minor adaptations:

- among the reasons, “not covered by the insurance fund” was added to “too expensive” as, e.g., some specialties or part of the rate may not be covered by the insurance fund,
- “don’t have the reference letter” was added to “waiting list” as the access to specialists is in general not direct.

The other changes made in the case of hospitalisation do not apply for specialists.

As for the previous health care use questions, the indicators to be calculated from HC.12 to.15 belong to the ECHI list but are mainly indicators needed for the OMC on health care and long-term care. This is particularly the case for questions HC.14 to HC.15 on unmet needs.

**Questions HC.16 to .18** refer to the use (visits) of other health professionals, and use of care services because of health-related limitations. These professionals/services are more and more visited or used at home, for example in our ageing societies (e.g., nurses, physiotherapists, occupational therapists, etc.) or for psychological problems (psychotherapists, speech therapist), or other reasons. In particular, the use of home care services and the corresponding expenditures are strongly increasing with the ageing of the society and are a key element of the future development of health care systems. It is then also necessary to assess the activity of these professionals and services from the answers of their patients/users, i.e. the interviewees. These questions are based on the proposal from the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office and use the instrument proposed by EuroHIS.

Questions HC.16 and HC.17 refer to the “other health professionals”, the breakdown in two questions corresponding to two subgroups, on the one hand (HC.16) the paramedics having in general a form of legal registration and licensing in the Member States, and on the other hand practitioners of “alternative” forms of medicine. They refer mainly to category HP.3.3 “Offices of other health practitioners” in ICHA.

Question HC.18 is referring to home care services to persons needing them because of health-related limitations. The related professionals correspond to category HP.3.6 “providers of home health care services” of ICHA. The increasing use (see above) and share in health expenditures of these services is the reason why a specific question is dedicated to their use services while they are mixed with paramedics use in EuroHIS.

The indicators to be calculated from HC.16 to 1.18 may belong in future to the lists of indicators of ECHI and the OMC on health care and long-term care.

**Questions MD.01 to .04 – Use of prescribed or recommended and non-prescribed nor recommended medicines**

These questions measure the use of prescribed or recommended and non-prescribed nor recommended medicines. Medicines are used either for curative or preventive purposes, either following the prescription of a physician or as self-medication. Their use has increased a lot during the last decades (it may also be an issue in an ageing society) and it indicates aspects of accessibility, up-to-date quality of care and costs. They shall consequently be also surveyed together with the other elements of the health care services consumption.
These questions on medicine use are based on the proposal from the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office⁸ and use the instrument proposed by EuroHIS¹². They are probably not optimal and a better instrument should be developed in future. A short reference period of 2 weeks is used for memory recall problems.

Question MD.01 and MD.02 refer to prescribed or recommended medicines (including dietary supplements, herbal medicines and vitamins). Question MD.01 is a filter (allowing to recall the medicines used) and MD.02 distinguish the different prescribed or recommended medicines used in two parts, the first one include medicines according to the diseases or health problems treated, while the second part include medicines according to both a general category of medicines – antibiotics – used against very different diseases due to bacteria, and specific medicines (for sleeping or contraceptive effect and hormones), plus an open category for other types of medicines.

For their part, questions MD.03 and MD.04 refer to neither non-prescribed nor recommended medicines (including dietary supplements, herbal medicines and vitamins). MD.03 is a filter while MD.04 distinguishes the different non-prescribed nor recommended medicines used, including also an open category for other types of medicines. Compared to the EuroHIS instrument, the category “pain” is divided in 3 categories in MD.04 complementing the question on pain added in the health status module.

The indicators to be calculated from MD.01 to .04 may belong in future to the lists of indicators of ECHI⁴ and the OMC on health care and long-term care³,⁵.

**Questions PA.01 to .17 – Use of preventive care**

These questions measure the use of preventing care services, such as vaccination, checking for important blood parameters related to risk of diseases of the circulatory system and diabetes, and screening of some cancers. In order to increase the health status of the population and decrease avoidable mortality, preventing actions are necessary. In EU Member States the majority of the population is covered from the first years of the life by the systematic vaccination against some of the most dangerous communicable diseases. In terms of vaccinations the new additional challenge, in particular again in an ageing society, is to protect persons at risk – elderly people and people suffering some chronic diseases – against influenza. In addition, the most important cause of deaths among people 44-65 is cancer, and among people 65+ is diseases of the circulatory system – this last type of diseases counting also for an important share of premature deaths (≤65). Finally, in relation with the important increase of obesity in EU Member States in the last 10-20 years, diabetes is one of the main concerns for health care – and also cause of death – in future. This is why the preventing actions related to these risks are now a strategic element for the quality and sustainability of health care systems and for the increase of health expectancy and healthy life years. The questions on the use of preventing care are based on the proposal from the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office⁸ and use:

- the instrument proposed by EuroHIS¹² for influenza vaccination, blood pressure, breast and cervical cancer screening (see also Council Recommendation on cancer screening²⁴),
- the instrument proposed by EHRM project²⁵ for blood cholesterol

²⁵ The European Health Risk Monitoring (EHRM), [http://www.ktl.fi/ehrm/](http://www.ktl.fi/ehrm/)
✓ the questions on blood sugar were added for the diabetes risk as indicated above and drafted on the model of the blood pressure and cholesterol questions
✓ the questions on faecal occult blood test was added as colon cancer is also an important cause of death and because this screening test is also recommended for this cancer by the Council\textsuperscript{24}, the question was drafted on the model of the other cancer screening questions.

**Questions PA.01 to .03** refer to the vaccination against flu, **PA.04 and PA.05** to the measurement of blood pressure, **PA.06 and PA.07** to measurement of blood cholesterol and **PA.08 and PA.09** to measurement of blood sugar. In each case the first question is a filter investigating if respectively the interviewee has ever been vaccinated or his blood pressure, cholesterol and sugar respectively have ever been measured (in case of blood pressure the terms “by a health professional” is added in order to exclude self-measurements). In case of positive answer, the second question is assessing whether the measurement was made within the delays medically recommended at EU or international level. In the case of influenza the second and third questions allow to know whether the person has been / is vaccinated for the latest / next winter, i.e. is correctly protected against influenza at the date of the interview.

**Questions PA.10 to .12** refer for their part to breast cancer screening (mammography), **PA.13 to .15** to cervical smear screening (test) and **PA.15 and PA.17** to colon cancer screening (faecal occult blood test). In each case the first question is a filter investigating if the interviewee (only women for PA.10 to PA.15) has ever had the corresponding test / screening; then, in case of positive answer, the second question is assessing whether the measurement was made within the delays medically recommended at EU or international level. Finally the third question (breast and cervical smear cancer only) investigate the reasons for having had the screening, in particular in order to assess the efficiency of official campaigns in the domain.

Indicators to be calculated from all questions **PA.01 to .17** belong to the ECHI\textsuperscript{4} and the OMC on health care and long-term care\textsuperscript{3,5} lists.

**Satisfaction with health care services (Question SA.01)**

This question deals with the issue of the user’s satisfaction with all health care services covered by the previous questions on use of health care services. Paramedics and medicine delivery were however excluded as these services are very different among them and not used (in the corresponding reference periods) by the majority of interviewees. On the other hand, home care is included as it is an important topic for long-term care. The question is also broken down on 5 sub-questions according to the health care services, as it was considered that the satisfaction of the citizens could differ from one service to another. This question measures the quality of health care delivered, according to the «consumers», and answers a demand from the OMC on health care and long-term care\textsuperscript{3,5}. The question is based on a proposal from DG EMPL and takes into account experiences in previous special Eurobarometers.
**OP.01 to .03 - Self-completion form – out-of-pocket expenses**

This subject is a key topic in terms of accessibility to health care services. It corresponds to the share of health care costs not covered by the national health insurance systems and consequently to be paid by the patients themselves. It is consequently a key subject for the OMC on health care and long-term care\(^3,5\). The system of health accounts allows identifying the out-of-pocket expenses at a macro level. However it does not allow breaking down out-of-pocket expenses by socio-economic status at the individual level. Out-of-pocket expenses should be also analysed together with all information of the EHIS on health status, health care use or life styles.

Consequently it has been decided to include questions on out-of-pocket expenses, which can be measured in the framework of a health interview survey. Draft questions were initially proposed by DG EMPL on the basis of the WHO world health survey and the SHARE survey (financed by DG RTD) and then were discussed and improved during CG and TG HIS meetings. The final questions are included in a self-completion form in order to allow interviewees to have the necessary time to answer these questions. For all questions **OP.01 to .03** the focus is on dental and medical examinations, as well as on medicines, “on your own behalf” / “prescribed to you” i.e. for the interviewee himself / herself for his /her own health situation and not for a member of the family, etc.

Some important area for out-of-pocket expenses, e.g. hospitalisation, was excluded as it was considered to be too much difficult to answer, in particular because of long delays between the hospitalisation and the date of receipt of the bill from the hospital. For dental and medical examinations as well as medicine use, the same reference periods are used as for the questions HC above on the use of these services. A definition of “out-of-pocket expenses” is provided in the questionnaire. Indicators to be calculated from questions OP.01 to .03 belong to the OMC on health care and long-term care\(^3,5\) list.

**2.4. Health determinant module**

**Introduction on questions of the EHIS health determinant module (EHDM)**

For the questions of the EHDM, the general focus was not on detailed measurements of exposures (or on the opposite healthy factors) "quantities" (relevant in an epidemiological/longitudinal approach), but on health behaviours as part of the individual actions with a health promotion aspect/intention, as well as on the current effect of health promotion campaigns and policies in terms of awareness in the population of what are the healthy lifestyles or aspects of them.

**BM.1 and BM.2 – Height and Weight**

The increase of obesity and overweight among the population becomes one of the most important public health issues in the developed countries, as overweight and obesity represent a high risk factor for diseases of the circulatory system, diabetes and other chronic diseases. The evolution of the way of life and food consumption in the EU Member States is characterised by low physical activity and energetic food intake which involve the increase of the body mass index. BM.01 and BM.02 collect the data needed to calculate this index. The prevalence of overweight/obesity is an indicator in ECHI\(^4\) and in the framework of the SDI\(^3,7\).
PE.01 to .06 – Physical activities

The need to monitor physical activity is linked with the previous topic on obesity and overweight but more generally on the effect of physical activity on the health states and risks of morbidity and mortality. In particular, increased physical activity has been related to reduction of mortality for all causes and in particular cardiovascular mortality, it decreases the risk of colorectal cancer, diabetes, depression, and is a factor in the prevention of osteoporosis. Questions PE.01 to .06 are based on the proposal from the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office\(^8\) and use the IPAQ instrument proposed by EuroHIS\(^{12}\).

However, some adaptations were done by the CG and TG HIS to this instrument (see EHDM introduction above):

- for questions PE.02, .04 and .06 on the time spent doing the activities, it is asked for the total time spent during the last 7 days and not for the time spent during an “usual” day the activity was performed
- the 7\(^{th}\) question of the IPAQ on sitting is not included (not necessary to calculate physical activities with the IPAQ instrument and no impact on responses to the other questions).

It should be noted that concerning physical activity, the general consensus was that a better instrument shall be developed for the following rounds of the EHIS but that as such an instrument is not yet available, the best questions available were those of the IPAQ. Within this framework, further indicators on physical activity will be needed and set up.

FV.01 to .03 –

This set of questions was not included in the framework of the proposal for an EHDM module developed for Eurostat. However, both Eurostat and the Member States though that, together with physical activity, healthy food intake is a key element for preventing numerous chronic diseases and that it was important to include a measure of this determinant in the EHIS. Questions were consequently proposed on the basis of existing questions in national HIS and the final set of questions and answer categories was decided by the Technical Group HIS.

The focus is not on the quantity (mainly linked with weight and exposure levels, see above) but on “quality”, as the type of food is considered as a (preventing) factor for cardiovascular problems, some cancers (e.g. colorectal) and other diseases. More specifically, the questions refer separately to the intake of fruits (excluding juice), vegetable or salad (excluding juice) or fruit or vegetable juice. These foods contain fibre and other constituents whose regular consumption has a high healthy preventing effect according to numerous studies (“Cretan diet”). The regularity of the intake is indeed a key element what explains the answer categories chosen. ECHI\(^{3,4}\) contains indicators on these 3 questions on consumption of fruit and vegetables.
EN.01 to .04 - Environment

As for the consumption of fruit and vegetables, this topic had not been initially included in the proposal for an EHDM module developed for Eurostat. However, in a similar way, it was also considered by Eurostat and the Member States that the link between environment and health, established in a lot of studies, could not be excluded from a European harmonised survey on health. In addition, there are also in this domain important policy developments.

First, concerning general environmental issues, the sixth Community Environment Action Programme includes an action on environment and health and quality of life as a key priority, calling for the definition and development of indicators of health and environment. In addition, the Environment and Health Action Plan 2004-2010 recognises the need to improve the quality, comparability and accessibility of data on health status for diseases and disorders linked to the environment, using the Community Statistical Programme (related question: EN.01).

In addition to the first concept of environment, the issue of environmental factors at work is also a political concern at EU level, under the Community strategies on health and safety at work 2002-2006 and 2007-2012 (related question: EN.03).

Two other elements are also tackled in a broad sense of the word “environment”, on the one hand in terms of exposure to criminality (related question: EN.02) and on the other hand on social support (related question: EN.04). Both are elements related to mental health determinants, the first one as a negative factor (exposure to crime increase fear and stress) and the second as a positive factor (social support and integration increase well being). Criminality is also a potential factor for physical health (injuries, etc.). In particular, mental health determinants are a political aim as stated by the Green paper "Promoting the mental health of the population. Towards a strategy on mental health for the EU" (COM(2005) 484 final).

The questions included on these 4 topics come respectively from:

- EN.01: SILC questions n° HS 170 and 180
- EN.02: SILC question n° HS 190
- EN.03: 2007 Labour Force Survey ad-hoc module on accidents at work and other work-related health problems and Fourth European Working Conditions Survey of the European Foundation for the Improvement of Living and Working Conditions
- EN.04: MINDFUL project of DG SANCO.

NB: SILC questions HS 170 to 190 on "Physical and social environment" are “repeated” in the EHIS but this was accepted as they can then be linked with all other EHIS health questions what is not possible in the SILC.

ECHI contains indicators on EN.01, EN.02 and EN.03 and the SDI on EN.04.

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SK.01 to .08, AL.01 to .03 and CN.01 to .04 – self completion part on smoking, alcohol and drugs

Due to the possible sensibility of these questions for the interviewee in relation to the other members of the household and the interviewer, it has been decided to include them in a self-completion form in order to allow the person to answer with the necessary confidentiality in order to increase the response rate and the accuracy of the answers.

**SK.01 to .08 - smoking**

Smoking is still nowadays an important factor for lung diseases and cancer, other cancers and diseases of the circulatory system. Lung, trachea and larynx cancer is the type of cancer with the higher standardised death rate among men in the EU. In addition, important policy activities are developed at EU level in order to limit tobacco consumption and a lot of Member States are in the process to forbid smoking in working and public areas. For these reasons it is a major determinant of health outcomes.

In order to set up the part of the EHIS questionnaire on smoking, the proposal from the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office analysed in particular the instruments developed by EuroHIS and EHRM. Nevertheless, the TG HIS revised the proposal and the final set of questions on smoking is not directly linked with any of the previous instruments though it constitutes an adaptation of some of their questions. For this final version, the focus was on 2 main points: the current smoking behaviour (not the past, see EHDM introduction above) – as proposed by the TG - and the exposure to tobacco smoke (“passive smoking”) – as required by policy needs.

Concerning current smoking, SK.01 filters from one hand daily smokers and for the other hand occasional or non-smokers. For current daily smokers, questions SK.02 and SK.03 analyse quantitatively the average daily consumption by type of tobacco product. For non-current daily smokers (either current occasional smokers or non-smokers at all), question SK.04 investigates whether the interviewee has been in the past a daily smoker. Finally, for both current or past daily smokers, SK.05 collects the total number of years (rounded and if necessary estimated) during which the interviewee has smoked daily.

Though the focus is on the situation of current smokers (see EHDM introduction above), questions SK.04 and SK.05 were introduced for public health purposes, in order to have a general assessment of current and past daily smokers which constitute a population at risk for the diseases above.

Concerning “passive smoking”, questions SK.06 to .08 assess it respectively at home, in public places and transport, and at the workplace. In addition to the “no exposure” and “full exposure” (more than 5 hours a day) answer categories, the TG HIS has suggested to make distinction between a light exposure (less than 1 hour per day) and a more important exposure (1 to 5 hours).

Various indicators on smoking have been set up, in particular for ECHI and the SDI.

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**AL.01 to .03 – drinking alcohol**

As in the case of smoking, alcohol is still nowadays an important factor for numerous chronic diseases (liver cirrhosis, diseases of the circulatory system, etc.). The pattern of alcohol consumption has changed in various Member States during the last decades, but in total alcohol consumption remains high and at individual level excessive drinking involves high health-related risks. There are two different types of such habits, which correlate only to a moderate extent:

- the first is consumption of large amounts of alcohol at each drinking spell (“binge drinking”). Potential health effects are intoxication, accidents, acute alcohol related deaths, cardiac arrhythmias, cerebrovascular accidents and acutely increased blood pressure levels
- the second type of habit is “chronic excessive use”, which might lead to raised blood pressure, neuropathies, liver cirrhosis and alcohol dependence.

In order to set up the part of the EHIS questionnaire on drinking alcohol, the proposal from the Belgium Scientific Institute of Public Health and the Hungarian Central Statistical Office analysed in particular the instruments developed by EuroHIS and EMCDDA (see references of the Agency below on drugs use). Nevertheless, the TG HIS revised the proposal and finally decided to use the AUDIT ("Alcohol Use Disorders Identification Test") -C (3 first questions of the Audit which are related to consumption) instrument from WHO. However, question 2 of Audit-C was replaced by the current question AL.02 that is more detailed but from which results to question 2 of the audit can be deduced. The selection of AL.02 was carried out together with MS at and after the TG HIS meeting in October 2006.

Question AL.01 allows to identify persons having frequent alcohol consumption and to filter the others. Question AL.02 allows identifying the usual weekly consumption of alcohol, breakdown by days of the week. Question 2 therefore identifies cases of “chronic excessive use” of alcohol. This questions also allows to identify patterns of consumption by day / part of the week (which may be linked to some part of the population, e.g. by age or socio-economic characteristics). For this purpose, each type of alcohol beverage used nationally is identified and the consumption is measured in terms of units of alcohol, a unit containing 10 g of pure alcohol (each Member States has to establish the equivalence in drinks of the alcoholic beverages used in the country). By adding the daily numbers of drinks and dividing the total by the numbers of days of the week when the interviewee usually drinks, it is possible to calculate the answer to the original second question of the Audit (“How many drinks containing alcohol do you have on a typical day when you are drinking”). Finally questions AL.03 identify cases of “binge drinking”.

ECHI includes indicators on consumption of alcohol.

**CN.01 to .04 – use of drugs**

Use of illicit drugs is a difficult topic in a health interview survey but shall be tackled as this behaviour has an important detrimental impact on a person’s health. The only instrument available in this area at the time of the preparation of the EHIS was the questions to measure prevalence of illicit drug use in the general population published by the EMCDDA.

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30 http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf
31 http://www.emcdda.europa.eu/?mmodeid=1380
From the EMCDDA proposal, only consumption of cannabis was selected to be explicitly asked for; for all the other drugs it was decided they would not be asked individually but under a common category “other drugs”. This is due to the difficulty to tackle the consumption of such dangerous drugs in a very broad and general health population survey. However, by at least asking about these “other drugs”, the full scope of illicit drug is tackled.

In both cases, cannabis and other drugs, the EMCDDA first and fourth questions were used. The first question “Do you personally know people who take cannabis” (CN.01 and CN.03 respectively) is at the same time a way to enter not to directly in the topic, in order to limit no responses, and a possible indirect assessment of self-consumption (it may be easier to report his own consumption as those of somebody known). The second question (CN.02 and CN.04) refers to the prevalence of the consumption during the last 12 months.

ECHI\(^4\) includes indicators on use of illicit drugs.

2.5. Background module (questions IN.01 to .04)

See “IP.01 to .03 + HH.01 to .14 + IN.01 to .04” at the beginning of this document.

3. Optional Questions

Questions developed for the EHIS by the 2 modules development projects, but which were not included in the EHIS, can be used on an optional way by the Member States. A document including the list of these questions will be provided separately.\(^32\)

4. Budapest Initiative (BI)

The time schedule of the BI development was not convenient (too late compared to the EHIS development and decision process) and the BI used different methods than those used for the agreement of the EHIS among 27 Member States. However, in order to promote international comparisons, it was accepted to give the EU Member States the possibility to use the BI in the framework of the EHIS. A specific document prepared by the Joint UNECE/WHO/Eurostat Task Force on Measuring Health Status is presenting the BI questions and the way proposed for its inclusion in the EHIS for countries that will want to do it.\(^33\)

\(^32\) In the Circa interest group Public Health statistics, together with the EHIS questionnaire, rationale and guidelines documents.