Future of the European Health Interview Survey
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1. PURPOSE

With the *Wiesbaden memorandum of 2011* the General Directors of National Statistical Institutes (NSIs) agreed to modernise social statistics in order to be more flexible and responsive to new emerging needs while improving the standardisation of its various components. Eurostat has been working with the Directors of Social Statistics (DSS) of NSIs in order to design the main components of the future system.

At the time when the European Health Interview Survey (EHIS) is being conducted for the first time in all EU countries, the place of health surveys – and in particular the place of EHIS – has to be defined in this overall new legal framework. The present paper introduces for the first time the main elements to be taken into account when revising the legal basis which will apply to EHIS in the coming years.

2. EXPECTED OUTCOME

The members of the Public Health Working Group are expected to:

- take note of the issues at stake as regards the impact of health data collections (especially surveys and more specifically EHIS) of the modernisation of social statistics;
- express preliminary views during the meeting supplemented by written comments no later than 16 January 2015 on the provisions to be introduced in the IESS regulation: periodicity, precision requirements, data transmission delays;
- approve the terms of reference for the next EHIS Task-Force;
- take note that Eurostat will report to the DSS at its meeting end of February 2015 on the Working Group position as regards IESS provisions mentioned above.

3. MODERNISATION PROGRAMME FOR SOCIAL STATISTICS

The modernisation of social statistics has been discussed through a document submitted to the ESS Committee in November 2014 (see document provided for item 4 of the agenda of the Working Group). Its main characteristics are presented below. The strategy for modernising social statistics was generally supported by the ESSC.

3.1. Programme for the modernisation of social statistics

The modernisation programme for social statistics is part of the portfolio of actions which contribute to the overall objectives of the ESS Vision 2020. It covers at the same time social microdata collections (also referred to as "social surveys"), population statistics (including census) and mainly administratively-based statistics and accounts. Population projections are not covered by the modernisation programme. The issue of how to cover enterprises surveys most efficiently is still under discussion.

Three framework regulations are envisaged. Work has already started on the first framework regulation (IESS for Integrated European Social Statistics) which would provide a unified legal base for the existing social microdata collections\(^1\) (including

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The second framework regulation would cover population statistics including population and housing censuses, and the third framework regulation would cover the administratively-based statistics and accounts.

The programme includes actions pushing towards integration of data collections, with standardisation of variables and modules, wider use of innovative data sources, including administrative data and possibly Big Data, and improved statistical frames.

### 3.2. Integration of social statistics

The modernisation programme for social statistics is a step ahead in the harmonisation and integration of social statistics. For social microdata collections, increased harmonisation will be achieved through:

- common quality requirements and assessment,
- provision of minimum requirements for sampling frames,
- harmonisation of the definitions of variables common to several data collections, and of small modules, whenever possible,
- harmonisation of provisions for precision,
- unique planning procedure implemented for all data collections,
- similar structure of the data collections for example for the ad-hoc modules,
- common rules for the EU funding rules
- as well as of the harmonised data and metadata structure.

The different micro-data collections and the associated processes will be further integrated. In order to reach the target of a fully integrated system of social surveys, the micro-data collections will be streamlined with a central role given to SILC and LFS that will be reinforced with the inclusion of all the information required in the context of the Europe-2020 strategy.

Population and housing census has often been used as a sampling frame for social micro-data collections. Integration between census and micro-data collections will be reinforced as part of the strategy for the post-2020 population and housing census.

With these elements of harmonisation and integration, Eurostat intends to remove barriers to and facilitate the process of integration of social statistics. There are interesting examples of further integrations at national level. It is the intention to organise workshop on exchange of experiences and good practices aiming also at identifying the possible or needed future common work.

### 3.3. Progress on the draft IESS Framework Regulation

The first draft IESS Framework Regulation was discussed by the DSS in September 2014. The various articles currently refer to:

- Scope of the Regulation (Articles 1-2);
- Multiannual rolling planning (Article 3);
- Technical elements (Articles 4-12) including periodicity (Article 9);
- Financing (Article 13);
- Overall management (Articles 14-19).
The domains covered by the IESS regulation are the following:

- labour market,
- income and living conditions,
- health,
- education and training,
- usage of the information and communication technologies,
- time use,
- consumption,
- tourism.

The modernisation programme for social statistics allows for a stepwise approach moving forward in parallel in several areas. The following key phases and milestones can be identified:

**Table 1: Timetable towards the adoption of the IESS Framework Regulation**

<table>
<thead>
<tr>
<th>Until IESS regulation is adopted</th>
<th>Transitional period: existing pieces of legislation are in force, work on various improvements regarding SILC and LFS (deprivation indicators, regional dimension of SILC, flows data for the labour market)</th>
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<tr>
<td>2014-2017</td>
<td>For social microdata collections: improvements to existing social microdata collections including joint planning, standardized definitions and variables and harmonised quality criteria; development of IESS framework regulation and implementing measures and methodological developments for streamlining of social surveys. In parallel:</td>
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<td></td>
<td>• Continuation of work on the use of administrative data including big data</td>
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<td></td>
<td>• Preparation for 2021 Census, including adoption of new implementing measures under Regulation 763/2008.</td>
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<tr>
<td></td>
<td>• Methodological developments for post-2021 censuses and harmonisation of population definitions.</td>
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</tbody>
</table>

| 12/2014                          | DSS Board  |
| 12/2014                          | Public Health Working Group  |
| 2 and 9/2015                     | DSS  |
| **11/2015**                      | **Consultation of ESSC on IESS**  |
| **Q4 2015 or Q1 2016**           | **Adoption of Commission proposal for IESS**  |
| **2017 or 2018**                 | **Adoption of IESS by European Parliament and Council, with adoption of implementing measures by Commission shortly afterwards.**  |
| **2020 onwards**                 | Adoption by European Parliament and Council of a second framework regulation to support a new approach to continuous collection of population and census data based on harmonised definitions; and of a third framework regulation to cover mainly administratively based aggregated data collections and accounts  |
4. **IMPACT OF THE MODERNISATION OF SOCIAL STATISTICS ON HEALTH STATISTICS (IN PARTICULAR FOR EHIS)**

4.1. **Issues related to the legal basis**

As of today, public health statistics are developed according to the framework regulation (EC) N° 1338/2008 adopted by the European Parliament and the Council covering both data collected from population surveys (such as EHIS) and other statistics compiled from administrative sources.

Within the modernisation of social statistics, and as regards future legal basis, health surveys data will be covered by the IESS regulation whereas health statistics compiled from administrative sources will be covered by the third regulation mentioned in section 3.1. As illustrated by the timetable for the IESS regulation, it is not planned to start now work on the third regulation.

As regards the framework regulation for the next EHIS, it is not realistic to envisage that the next EHIS will be implemented through the IESS regulation. More specifically, in order to be implemented in 2019, the implementing regulation for EHIS would need to be adopted in May 2017 (see timetable in Annex 1). In May 2017, it is very unlikely that the IESS regulation will have been adopted by the European Parliament and the Council (see timetable in Table 1 above). Therefore Eurostat is working under the assumption that the next EHIS wave 3 will not be implemented according to the specification of the IESS regulation currently being prepared. However the IESS regulation will definitely be the basis for the wave 4. Furthermore, in order to introduce the draft IESS regulation to the European Parliament and the Council in Q4/2015 or Q1/2016, it is urgent to discuss the elements related to EHIS wave 4 which will be included in it.

In this respect, it should be noted that some of the legal provisions which are currently described in the EHIS implementing regulation (Commission regulation N° 141/2013 of 19 February for EHIS2014) will have to be specified in the framework regulation IESS because they have an impact on costs at national level: it is in particular the case for precision requirements and deadlines for transmission of data and metadata. Periodicity of the survey is also an element of costs, which was already in the framework regulation 1338/2008 and will remain as a topic of the future IESS regulation.

In this context, two issues are addressed to the Working group:

1. Provisions to be introduced in the IESS regulation framework as regards periodicity, precision requirements and data transmission deadlines for EHIS wave 4. They should be later on discussed by the DSS in February and September 2015, and by the ESSC in November 2015 (see Section 5 below).

2. Preparation of the next EHIS wave 3 which will take place within the current framework regulation 1338/2008, with a view of vote by the ESSC in May 2017 (see Section 6 below). The future EHIS wave 3 implementing regulation will contain the technical elements already included into IESS (precision requirements and transmission deadlines).

It should also be noted that it is taken for granted by Eurostat that EHIS wave 3 will take place in 2019 (fieldwork). In the context where the Commission regulation implementing EHIS wave 2 mentioned 2013, 2014, or 2015 as reference years and where the 2008 framework regulation specified that statistics for EHIS shall be provided every 5 years, it could be argued whether 2018 or 2019 or 2020 should be introduced as the reference period. Eurostat is however of the opinion that given the fact that 24 EU countries ran the survey in 2014 and given the general interest to harmonise data across European
countries – including their reference year – the Working Group should agree upon the proposal to set 2019 as the reference year.

**Question 1:** The members of the Public Health Working Group are expected to express their opinion on the proposal to set 2019 as the reference period for EHIS wave 3.

### 4.2. First Eurostat proposals for the modernisation of health surveys

At the DSS meeting of November 2013 Eurostat made 5 proposals\(^2\) in relation to the modernisation of health surveys in an attempt to review the overall structure and the relevance of the produced statistical information for health and disability information. These proposals were the following:

- Proposal 1: a rolling module of 20 variables related to health in SILC every three years;
- Proposal 2: introduction of two health variables as core social variables, i.e. "Self-perceived health" (SPH) and "Global limitation in activities because of health problems" (GALI);
- Proposal 3: Harmonisation and improvement of some health variables (mainly GALI);
- Proposal 4: Discussion on the future periodicity of EHIS;
- Proposal 5: Discussion on the future of disability statistics and in particular of the European Health and Social Integration Survey (EHSIS).

The DSS broadly supported the proposals with the exception of the proposal to include two health variables as core variables, for which mixed views were expressed (a slight majority agreed). In particular, the DSS agreed to keep the current periodicity of EHIS data collection to five years in the future strategy, to discontinuing EHSIS and instead to consider the introduction of a limited disability module in EHIS.

However, as regards the periodicity of EHIS, the DSS reviewed its position later on in April 2014 in the context of the discussion on "Peaks and valleys". The minutes (items 3.3, 3.4 and 3.5) state that: "Eurostat will revise the "peaks and valleys" document in the light of suggestions made during the meeting. In addition, for EHIS and AES, their frequency in the future could still be re-discussed with policy users and Member States in order to fit to a general pattern of surveys at intervals of 2-4-6-10 years". This issue of periodicity is of utmost importance for this Working Group meeting and it is developed below under section 5.1.

As a follow-up of the discussion on disability statistics Eurostat investigated the current collection of relevant data across countries as well as the ability of EU Member States to respond to the requirements of the EU Disability Strategy. A document\(^3\) highlighting the outcomes of this consultation and introducing three proposals for the future was presented at the DSS meeting of April 2014. The three proposals consisted of:

- Proposal 1: to consider the possible introduction of SPH and GALI as core/common variables and take a final decision in 2015 (identical to Proposal 2 above);

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\(^2\) Doc. Eurostat/F/13/DSS/02/3.2/EN: "Issues paper for the DSS Board and DSS discussions"

\(^3\) Doc. Eurostat/F/14/DSS/03/3.6 EN: "The future of disability statistics within the European Statistical System"
– Proposal 2: to improve the current estimations of the number of disabled people, notably for the children;
– Proposal 3: develop a regular data collection concerning people living in institutions (particularly disabled people, including children).

The DSS was in favour of continuing methodological discussion for the possible introduction of SPH and GALI as core/common variables. A final decision will be taken in 2015, together with income variable in LFS. The DSS broadly agreed to develop measures of disability prevalence (including children). The DSS was also broadly in favour of developing in the future a regular data collection on people living in institutions, but not in the context of the framework regulation, and pending financial support. The DSS decided to set up a specific task force in charge of developing some concrete proposals that should meet for the first time in 2015.

5. PROVISIONS TO BE INTRODUCED IN THE IESS REGULATION AS REGARDS EHIS

The following section discusses the main elements regarding the future of EHIS to be included into the IESS Framework Regulation. The opinions of the Public Health Working Group will be reported by Eurostat to the next DSS meeting at the end of February

5.1. Periodicity of EHIS

A major issue regarding the future of EHIS is its periodicity.

The current legal basis under which EHIS operates stipulates that EHIS should be conducted every five years. The pros and cons of the various options regarding the future periodicity of EHIS relates in particular to the overall burden for the European Statistical System as well as with the timing for the health module in SILC. In general, it should be reminded that data requirements for policy monitoring at EU level – for instance in the context of the European Semester – are on an annual basis. Increasing the periodicity of EHIS to four years as well as combining EHIS data with the data from the 3-yearly module of SILC would improve the ESS response to policy needs and increase the use of these data at European level.

An essential element in this discussion is the nature of the link between EHIS and the new SILC module every three years. Conducting EHIS and SILC in the same year would allow pooling data and increase the availability and/or the precision of indicators based on common variables and/or variables strongly correlated. Initial experience in the field of data pooling showed the feasibility of such task despite the limitations of the exercise which was based on the 1st wave of EHIS and a wave of SILC which still contained a number of shortcomings (See item 6.3.4 of the agenda). Detailed information available from EHIS could also be used to calibrate some SILC indicators. On the other hand, a mismatch in the timing of EHIS and SILC would allow obtaining data for some indicators more frequently, despite the potential problems of coherence of results coming from different surveys. Having same variables in both EHIS and SILC should be seen as a major advantage as each survey is able to deliver different kinds of information and breakdowns: for instance, the presence of health variables in SILC will enable analysing in detail the links between health and income and living conditions.

Of course the periodicity cannot be discussed without having an idea about the burden of the survey. In this context, it must be stressed that the development of the 2nd wave of EHIS already took into account some drivers common to the modernisation such as the

relevance for European policy indicators, the harmonisation of variables, and the reduction of burden and cost. This process resulted in a substantial downsizing of the survey compared to the first wave of EHIS (from 207 to 115 variables). Therefore a further reduction in the set of variables does not seem possible and the options proposed below by Eurostat refer roughly to a stability of the number of variables.

Finally it should also be reminded that, beyond the European survey, a number of countries conduct a national health survey(s) more frequently than every 5 years. This element should be taken into account when reviewing the periodicity of EHIS as a better integration of the European and national health interview surveys is a condition for the good running of the system. As Eurostat is not aware of the current situation regarding the implementation of national HIS, the following Question 2 is asked to the delegates.

**Question 2:** The members of the Public Health Working Group are requested to inform Eurostat on the periodicity of the national health survey(s) (if any) as well as when the last/next survey was/will be organised.

The following options are proposed for consideration to the Public Health Working Group:

**Option 1: status quo – EHIS every five years**

Under this option EHIS would be confirmed every five years as stated in the framework regulation. It should be reminded that the DSS had a negative opinion about such continuation and asked the stakeholders to consider a periodicity of the survey with an even number of years in order to help with the spreading of surveys over time.

**Pros:**
- Satisfaction of some policy needs;
- Stability in the implementation and the organisation especially for the national authorities other than NSIs (issues of responsibility, planning, budget and embedding in the national vehicle surveys);
- No additional burden/cost.

**Cons:**
- No improved frequency of data for policy-monitoring (beyond the SILC proposal);
- Mismatch in years of execution between EHIS and the 3-yearly SILC-health module. Both surveys would be conducted the same year once in 15 years.
- Contrary to the general pattern of social surveys intervals (even periodicity) with possible unequal distribution of burden over time for NSIs which are in charge of EHIS.

**Option 2: EHIS is conducted every four years**

Under this option EHIS would be run more frequently in order to improve the availability of health data as a complement to the 3-yearly health module in SILC. This option would reflect a limited complementarity between SILC and EHIS and would result in an increased burden and cost for national authorities.

**Pros:**
- Higher frequency for health data and indicators;
Fitting better to a general pattern of social surveys intervals with equalizing the distribution of burden for NSIs which are in charge of EHIS.

**Cons:**
- Increase of costs (although a number of countries conduct a national health interview survey more frequently than 5 years);
- Increase of respondents’ burden;
- Relative mismatch in years of execution between EHIS and the 3-yearly SILC-health module. Both surveys would be conducted the same year once in 12 years.
- Potential instability in the implementation and the organisation especially for the national authorities other than NSIs (issues of responsibility, planning, budget and embedded in the national survey vehicles).

**Option 3:** EHIS is conducted every six years

Under this option EHIS would be conducted every 6 years and would be aligned with the 3-yearly frequency of the SILC-Health module. SILC and EHIS could be conducted in parallel every six years, years which would help to improve the periodicity of some variables and increase the possibility of pooling data, or in different years.

**Pros:**
- Some savings in terms of costs and burden;
- Possible integration between SILC and EHIS (common data every 6 years); Improved precision of indicators when combining EHIS and SILC samples every six years and possible calibration of SILC estimates using detailed information from EHIS.
- Fitting better to a general pattern of social surveys intervals with equalizing the distribution of burden for NSIs which are in charge of EHIS.

**Cons:**
- Lower frequency for health data and indicators from EHIS.
- Potential instability in the implementation and the organisation especially for the national authorities other than NSIs (issues of responsibility, planning, budget and embedding in the national vehicle surveys).

Given the high demand for more frequent health data characterised by a number of breakdowns Eurostat would favour Option 2 (every 4 years).

**Question 3:** The members of the Public Health Working Group are expected to comment the various options and express their preference.

### 5.2. Precision requirements for EHIS

As for EHIS wave 2, the precision requirements were defined in terms of minimum effective sample sizes (cf. Annex II of Commission Regulation (EU) N°141/2013). The minimum sample sizes were determined by defining a precision requirement of less than 1 percentage point error for the GALI question (i.e. the “percentage of people severely limited in daily activities”) taken as the most critical variable in the survey.\(^5\)

\(^5\) Cf. EHIS wave 2 Methodological manual, Section 12.7 ('Sample size')
However, in the future the minimum precision requirements should be incorporated in the framework regulation (IESS) in view of being harmonised and expressed for all surveys in terms of standard errors.

The following paragraphs introduce the currently proposed method for precision criteria to be applied for future EHIS. This method will be further discussed and possibly refined, taking into account for instance that the parameters used for estimating precision requirements are based on data currently available at Eurostat. Therefore the presented proposal should be considered as very provisional and reflecting the current state of play.

**Construction of precision requirements for future EHIS**

The construction of precision requirements consists of: a) a selection of critical variable(s)/indicator(s) and respective reference population(s), b) setting general conditions on precision criteria and c) setting parameters needed to calculate the sample size for each country.

**Selection of critical variables and reference population**

As for the 2nd wave of EHIS, Eurostat proposes to keep the GALI variable as the critical variable when constructing sample sizes. Some modifications could be considered such as:

- Using the prevalence of any limitation (instead of moderate and severe, which are used for the calculation of Healthy Life Years);
- Focusing on middle-age or elderly population as severe limitation is not much prevalent in younger ages;
- or define separate precision criteria for men and women (disability data and Healthy Life Years are preferably computed and used separately for each gender).

Some other indicators could alternatively be considered as critical variables, e.g. the percentage of population suffering from diabetes (or any other important health condition), the percentage of daily smokers in the population, or the percentage of obese population.

The reference population for which the criteria would need to be fulfilled is the population aged 15 years and more but some subpopulations, e.g. men and women or population aged 65+, could also be considered.

**Setting general conditions on precision criteria and parameters**

In EHIS wave 2, the average sample size was set to ensure that the percentage of people “severely limited in daily activities” was estimated on average with less than 1 percentage point (p.p.) error that is obtaining the estimate within confidence interval +/- 0.5 p.p. This led to an estimation of an average sample size 7,000 under the assumption of an average prevalence of severe activity limitation equal to 8 %. In order to ensure consistency with EHIS wave 2, the minimum sample sizes should not substantially differ in the future.

The latest EU-SILC data gives an EU-28 prevalence of severe activity limitation equal to 9 %. In order to ensure a precision of the given prevalence of +0.5 pp (resp. +/- 1 pp), a sample size of at least 12,500 (resp. 3,200) would be needed.

A minimum sample size of 3,500 is proposed. This would ensure a precision of at least +/- 1 p.p. (standard error about 0.5) in each country, having in mind variations in the prevalence of severe activity limitation. The precision requirement is proposed to reflect to some extent the size of the country population to enable more detailed (including
regional) analysis of data and is therefore proposed to approximate 0.5 p.p. (standard error 0.25) in bigger Member States.

Based on defining general conditions on precision criteria, different parameters for calculation precision requirements for each country were tested and final parameters set-up.

**Provisional proposal for precision criteria for future EHIS**

Incorporating the assumption on precision requirements mentioned above and using 2013 population data and 2102 EU-28 prevalence of severe activity limitation, provisional estimates of country-specific standard errors, confidence intervals and effective sample sizes have been calculated.

The currently set parameters ensures that the precision is higher than +/- 1 p.p. in all EU 28 countries (it is between 0.49 and 0.95 p.p. under the assumption of 9 % prevalence) and that the precision in countries with highest population numbers approximates +/-0.5 p.p. (for Germany, Italy, France and the UK it is between 0.49 and 0.53).

In order to allow a comparison of precision requirements with EHIS wave 2, the provisional minimum effective sample sizes for the future EHIS were calculated (see Annex 2). The calculation brought an estimation of a minimum total sample size for EU 28 of about 187,000 (compared to about 200,000 for EHIS wave 2). The parameters currently used ensure that the minimum sample size is higher than 3,500 in each country. The proposal would bring a reduction of the sample size in most EU 28 Member States compared to EHIS wave 2 (except for Croatia, Ireland, Finland, Denmark and Slovakia where the increase is below 100).

It should be emphasised that, at this stage, the proposed method does not introduce any distinction between sub-populations (e.g. children, elderly, disabled), which could have an impact on the minimum sample size if over-sampling is to be considered.

**Question 4:** The members of the Public Health Working Group are expected to comment the proposed method.

### 5.3. Data transmission deadlines

The first reference year (field work) for EHIS wave 4 will be set within IESS regulation. The decision will be based on elements related to the future periodicity as well as the workload on the ESS.

As regards the 2nd wave of EHIS countries should deliver microdata by 30 September 2015 or at the latest 9 months after the end of the data collection period. Countries should also transmit reference metadata to Eurostat not later than two months after the transmission of the microdata.

Eurostat proposes that the deadline for the transmission of the microdata is set to 9 months after the end of the fieldwork period), while the deadline for the transmission of reference metadata would be set 11 months after the end of the fieldwork period.

**Question 5:** The members of the Public Health Working Group are expected to express their opinion on the proposed deadlines for the transmission of microdata and metadata.
6. **PREPARATION OF THE NEXT EHIS WAVE 3**

As regards the future design and contents of EHIS, Eurostat intends to set up a new Task-Force which will meet for the first time in June 2015 with the objective to finalise its work at the beginning of 2017 in view of the adoption by the Commission of an Implementing regulation by the end of 2017. This Task-Force would be composed of a maximum of 20 participants, i.e. about 10 countries and representatives from policy stakeholders and the academia. Eurostat will keep regularly informed of the progress and will consult more formally the Public Health Working Group whenever need in order to validate the options selected by the Task-Force.

The choice to set up a new Task-Force instead of using the services of the Technical Group HIS is influenced by two main considerations:

- More interactive exchanges of opinions and ideas are expected in a smaller group
- A streamline of structures set up to discuss health statistics through Task Forces, Technical Groups and the Working Group has to be implemented from 2015 onwards: in this respect, Technical Groups will be progressively replaced by more frequent meetings of the Working Group Public Health statistics with a possible enlarged national participation. This is justified by some maturity now achieved by public health statistics and by budget limitation for meetings.

The draft terms of reference for the Task-Force are provided in Annex 1.

| **Question 6:** The members of the Public Health Working Group are expected to comment on the attached Terms of Reference and express their interest in being a member and contributing actively to the new Task-Force on EHIS. |
Annex 1: Terms of reference of the Task-Force on the review of EHIS (EHIS TF)

1. BACKGROUND

Important progress has been achieved in relation to the European Health Interview Survey (EHIS). This is the result of the coordinated work of the National Statistical Institutes (NSIs), the National Public Health Institutes or other relevant national bodies and Eurostat, together with the ‘Public Health’ Working Group and the HIS Technical Group.

EHIS aims at measuring on a harmonised basis and with a high degree of comparability among Member States the health status, lifestyle (health determinants) and health care services use of the EU citizens. The first wave of the survey was conducted between 2006 and 2009 under a gentlemen's agreement in nineteen countries:

2006: AT, EE
2007: SI, CH (no data received by Eurostat)
2008: BE, BG, CZ, CY, FR, LV, MT, RO, TR
2009: DE, EL, ES, HU, PL, SK.

The second wave of EHIS was made compulsory for EEA countries under Commission Regulation (EU) N° 141/2013. It is being conducted between 2013 and 2015 in 30 countries:

2013: BE, UK (2 countries)
2014: BG, CZ, EE, EL, ES, FR, HR, CY, LV, LT, LU, HU, MT, NL, AT, PL, PT, RO, SI, FI, SE, SK (23 countries)
2015: DE, DK, IE, IT, NO (5 countries)

Health statistics have gained in visibility and precise requests for further developments are stemming from the Europe 2020 European Semester (Joint Assessment Framework for Health) and the European Core Health Indicators (ECHI). It is now time to prepare the third wave of EHIS which should build on the experience gained from the previous waves while considering how to respond to new emerging needs.

2. MANDATE OF THE TASK-FORCE

The Task-Force on the ‘Review of EHIS’ will focus on the following areas:

- **Assessment of the implementation of the 2nd wave of EHIS**

The EHIS TF is launched when some countries are still running or have not yet started to implement EHIS. However it is necessary to begin the reflection on the third wave of EHIS in order to be ready on time for the 2019 operation. Based on national reports, the first task of the EHIS TF will be to assess the implementation of the second wave both at global level and for each variable. It will also discuss and prepare definition of EHIS wave 2 indicators.

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6 The information should be considered as provisional. No information is available on Iceland. Switzerland was not bound by the EHIS regulation but conducted their national HIS using EHIS methodology in 2012.
Stocktaking of users' needs and quality concerns

From the outset of the revision process, the Task-Force should identify and prioritize users' needs to be accommodated as well as producers experience in implementing both the national and European Health Interview Surveys in order to make the purpose of the revision explicit. Some of these new or reinforced needs were already highlighted by the recent discussions at the DSS level (elderly, disability). As much as possible, the description of information needs should include the specification of the desired accuracy and frequency.

Design and contents of EHIS

Under this heading the Task-Force should in particular reflect on the following topics:

- Link with IESS: the EHIS TF will consider the implications of the IESS Framework regulation for the future design of EHIS regarding for instance the use of core/common variables. The Task-Force will explore if and when further harmonisation of variables and concepts, which could lead to an input harmonisation across countries, is needed.
- Modifications of the list of variables (+ / -): the Task-Force will have to analyse critically all current variables collected in EHIS (relevance, precision, comparability, codification) and whether they could be dropped or collected in other data collections. The Task-Force will also consider how to address information needs discussed under the previous objective (e.g. child health, elderly, disability).
- Preparation of the implementing regulation.
- Review the methodological manual for EHIS.

The Task-Force will report regularly to the Public Health Working Group in order to inform all countries and validate the options selected by the Task-Force. In view of this, the Task-Force should produce a draft synthetic report by June 2016 (after the third meeting of the TF) in view of consulting by written procedure the Working Group. This report will be finalised by the Task-Force in view of the 2016 meeting of the Working Group which will also discuss the draft implementing regulation for EHIS wave 3.

3. Composition of the Task-Force

The Task-Force should be composed of a relatively limited number of participants (maximum 20) including delegates from each strand of stakeholders:

- Eurostat staff: Eurostat will chair the meeting and provide the secretariat.
- Producers of statistical information: a maximum of 10 representatives from the statistical community;
- Users of statistical information: policy stakeholders, research community, and other Commission services.

The members will make a commitment to contribute in a substantial way to the statistical and reporting activities of the Task-Force. The members of the Task-Force are in particular expected to:

- Agree on the division of labour amongst them (e.g. presentation of national experience, contribution to papers and other materials for discussion);
- Work together, mainly via email and conference calls; and
– Participate, if and when necessary, in face-to-face meetings during the course of the project.

4. TIMETABLE OF THE TASK-FORCE

The EHIS TF is expected to work between 2015 and 2017. Five face-to-face meetings are foreseen so far but their final number will be adjusted depending on the needs and the progress of the Task-Force work.

Assuming that the third wave of EHIS will be prepared under the current legal framework and taking into account the regulatory procedure with scrutiny which implies that both the European Council and the European Parliament should be consulted formally on whether the Commission does not go beyond the rights given to it by the framework Regulation, in order to fulfil the deadline of 31 December 2017, the following tentative timetable can be set up starting from the end of the process:

Tentative timetable for the Task-Force on the review of EHIS (dates in italics are only tentative):

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<thead>
<tr>
<th>Action</th>
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<th>Main objective</th>
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<tr>
<td>1st meeting of EHIS TF</td>
<td>June 2015</td>
<td>Stocktaking of implementation of wave 2 and users' needs</td>
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<td>Information of the Public Health Working Group</td>
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<td>Link with IESS, Discussions on the modifications in the list of variables</td>
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<td>Discussions on the modifications in the list of variables, Draft progress report</td>
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<td>Draft Implementing Regulation, Draft report of the TF</td>
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<tr>
<td>Scrutiny procedure with European Council / European Parliament</td>
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<td>Implementing Regulation</td>
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<td>Adoption of EHIS Regulation by the European Commission</td>
<td>November 2017</td>
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Annex 2: Comparison of minimum effective sample sizes for EHIS wave 2 and indicative estimation for future EHIS (subject to endorsement of the whole methodology)

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<th>European Union (28 countries)</th>
<th>EHIS wave 2</th>
<th>future EHIS</th>
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