Health Status and Life Expectancy

A cross-country comparison based on the European Community Household Panel

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This study explores health profiles by marital status in eight European countries with regard to the theories of compression and expansion of morbidity. The Sullivan method is applied to age-specific death rates and age-specific prevalences of health states to statistically abstract the concept of health expectancy. Our analyses of self-perceived health cover the years 1995 through 1999 and base upon the question "Person is hampered in daily activities by any physical or mental health problem, illness or disability" of the European Community Household Panel.

Our research links national mortality to morbidity schedules in order to draw conclusions about the evolution of health at various stages of the individual life span along the observation period. Since health profiles may vary considerably across marital states, the married, divorced, widowed and never married population has been analyzed separately. The demand for institutional care largely depends on the marital status of the elderly. In view of the associated panel attrition, we assume the results of the married population to be the least biased and thus use it as reference category.

We find a longevity advantage of the married population over its unmarried counterparts. Yet with respect to health, there is no evidence that any marital status is advantaged. The reported health status varies largely across countries. With great consistency throughout our analyses, people in Italy indicate the highest prevalences of good health and the highest healthy life expectancies, while people in Germany show the least favorable health profiles and the lowest healthy life expectancies. Remarkably for Germany and Finland are also the very high prevalences of moderate disability.

Over the observation period, we find country-specific developments of health. For males and females in Germany and the United Kingdom, there is a tendency towards an expansion of morbidity. This also applies to females only in Portugal and partially to their counterparts in Belgium and the Netherlands. In the evolution of these divergent health trends in Europe, we attribute a decisive role to the variety of institutional designs and national policy regimes and discuss this assumption with the help of OECD data on national social expenditures.