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Self-assessed health of individuals aged 55 and over in France and Québec: differences and similarities

Jocelyne Camirand*, Catherine Sermet**, Valeriu Dumitru*, Stéphanie Guillaume**

A comparison of the self-assessed health status of the French and Québécois population aged 55 and over living at home reveals both significant differences and similarities.

The Québécois aged 55 and over have a better subjective perception of their health than the French of the same age and express it with more enthusiasm. Cultural differences and the higher percentage of elderly Québécois living in institutions are the main contributing factors in these diverging perceptions.

In France as in Québec, the presence of chronic medical conditions and disabilities largely explains the increase with age in the percentage of the population self-reporting poor health. The majority of diseases retained for the study reveal a striking parallel between the presence of a disease and the self-reported health status. In Québec, cancer, high blood pressure and thyroid disease stand out as being more frequently associated with poor health reporting. Inversely, certain disabilities seem to have less impact on self-assessed health in Quebec than in France.

The measure of self-assessed health status is generally based on a question of the type used in this study: "Would you say in general your health is: excellent, very good, good, fair or poor?". Together with mortality and life-expectancy, self-assessed health is one of the most widely used health indicators. Recognized as reliable and valid, this measure is easily collected and interpreted, and is an excellent indicator of mortality and health services utilisation (Idler, Benyamini, 1997). For all these reasons, most health surveys carried out amongst the general population now include this type of question.

Self-assessed health status is most often used at a national level as a global health status indicator, or at an international level to analyse determinants of social inequality or to estimate inter-country differences in health inequality. Self-assessed health status and its determinants are, however, rarely used in comparative studies between countries (Desesquelles, Egidi, Salvatore, 2009).

A number of studies have nevertheless investigated factors determining individuals' responses to this question. These can be grouped into four categories: factors relating to disease and disability; demographic and socio-economic factors; health behaviours and factors relating to individuals' social and psychological resources. Among these factors, the influence of culture or ethnicity has often been discussed and invoked to underline the difficulty of making self-assessed health comparisons between countries (Jylha, Guralnik, Ferrucci, Jokela and Heikkinen, 1998). The variations in self-assessed health are indeed only partially explained by objective differences in health status. Such comparisons also reflect cultural differences (Jurges, 2007)

* Québec Institute for Statistics (ISQ).
** Institute for research and information in health economics (Irdes).

that manifest themselves in two distinct ways; a difference in health standards or a difference in ways of answering the questionnaire.

In this study, and without denying the cultural differences that effectively exist between France and Québec, we compare self-assessed health in the two populations and examine how health characteristics, and in particular disease and disability, influence this perception.

The study concerns non-institutionalized individuals aged 55 and over in France and Québec. The data were obtained from two national health surveys representative of the population residing at home: the 2002-2003 National Health Survey* (EDS*) in France and the 2003 Canadian Community Health Survey (CCHS) for Québec (*Cf.* inserts: Sources p. 4 and Methods p. 5). Both surveys include a virtually identical question on perceived health (*Cf.* Definitions insert p. 7).

Clear cultural differences

Responses obtained from the French and Québécois respondents aged 55 and over to the question on self-assessed health are different (*Cf.* graph 1). If in France we find a majority of individuals (64%) concentrated in the 'good' category to the quasi-exclusion of the 'excellent' category, in Québec, people with a positive opinion of their health can be divided into the three categories; 'excellent', 'very good' and 'good'. The reticence to use the term 'excellent' appears characteristic of Latin cultures and in opposition to English-speaking cultures where it is more widely and commonly used to express enthusiastic approval. The Québécois population sample, although in the majority French-speaking, does not share this cultural inclination with the French population sample.

In this study, we concentrate exclusively on individuals reporting poor health (passable/fair or poor). This grouping constitutes a commonly used indicator in literature on perceived health. Canadian studies, however, reveal that the factors associated with perceived health vary according to whether one is dealing with the positive or negative extreme of the self-assessed health scale.

The French aged 55 and over self-report poor health more frequently than the Québécois

In total, 26% of the French and 20% of the Québécois aged 55 and over living at home self-report poor health. The Québécois' more positive perception of health is in the majority expressed by individuals aged over 70 and women (*Cf.* graph 2). A higher percentage of women in France (29%) than in Québec (22%) self-report poor health but these differences are only significant among the most elderly women (over 70 years old), the age-specific trend not being significant among men. This disparity, concentrated amongst the most elderly, is probably due in part to the greater proportion of institutionalized individuals among the very elderly Québécois: individuals with a poorer health status live in institutions whereas those in better health live at home.

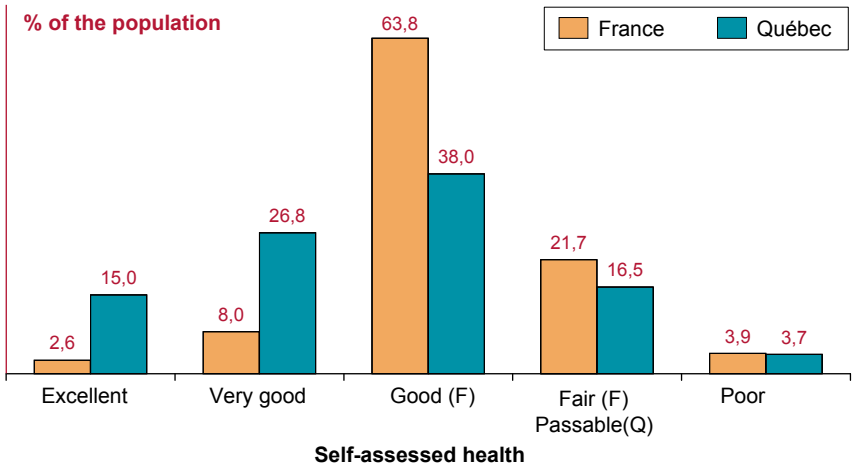
BACKGROUND

This analysis of self-assessed health in France and Québec situates itself in the continuity of research on health status and its determinants carried out in parallel, for many years, by the IRDES and Québec Institute for Statistics* (ISQ*). It was made possible by ISQ researcher Jocelyne Camirand's stay in France, and was financed by the ISQ and the Franco-Québec Observatory on Health and Solidarity* (OFQSS*)

In effect, among the population aged 75 and over, 17% of Québécois were institutionalized in 2001 whereas this was the case for only 10% of the French in 2003.

In France, women are proportionally more numerous to declare themselves in poor health than men and the gender gap is significant in all age groups over 60. This is not the case in Québec where the gender gap is not significant in any of the age groups studied.

G1 **Self-assessed health in the population aged 55 and over in France and Québec**



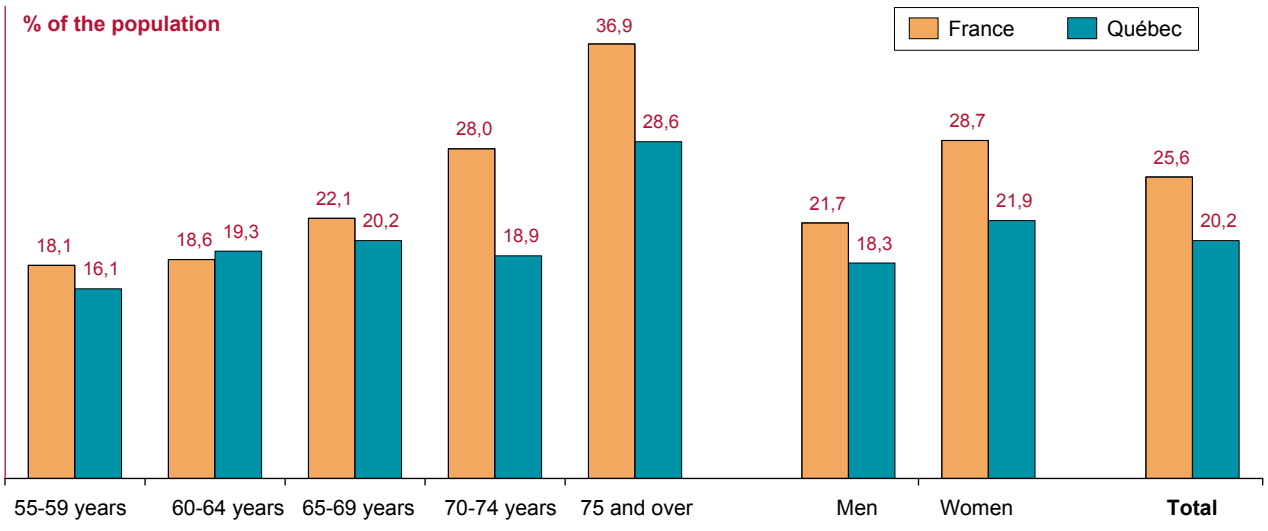
Reading guide: During the course of 2003, 21.7% of the French aged 55 and over reported their health being fair and 16.5% of Québécois aged 55 and over perceive their health as passable.

Sources: Irdes and ISQ.

Data: 2002-2003 National Health Survey* (Insee*) and 2003 Canadian Community Health Survey (Statistics Canada).

G2

Percentage of individuals aged 55 and over self-reporting poor health according to age and gender in France and Québec



Reading guide: In 2003, among the population aged 75 and over, 36.9% of the French and 28.6% of the Québécois self-reported poor health.

Sources: Irdes and ISQ.

Data: 2002-2003 National Health Survey* (Insee*) and 2003 Canadian Community Health Survey (Statistics Canada).

T1

Percentage of indivduals aged 55 and over self-reporting poor health in the presence of a chronic disease and prevalence of these diseases in France and Québec

♦ Data collection methods for diseases being different in France and Québec (*Cf.* Definitions insert p. 7), **the prevalence indicated below is not to be compared between the two geographic areas.** For information purposes only.

	FRANCE		QUÉBEC	
	Poor assessed health (%)	Prevalence (%)	**Poor assessed health (%)**	Prevalence (%)
Diseases				
Cancer	**42.3**	4.6	**51.4**	3.6
Thyroid disease	**33.1**	5.0	**28.8**	13.2
Diabetes	**43.1**	8.4	**37.6**	11.1
Mental disorders	**46.8**	6.1	**44.6**	6.5
Heart disease, cerebrovascular accident	**44.9**	15.6	**44.3**	15.7
High blood pressure	**29.2**	30.1	**28.9**	35.6
Chronic respiratory diseases	**45.8**	9.0	**41.0**	11.8
Intestinal disorders, stomach ulcers	**42.7**	5.6	**43.4**	6.1
Arthritis, rheumatism	**37.8**	27.4	**32.7**	34.5
Backache (outside arthritis and rheumatism)	**36.3**	10.4	**34.6**	19.0

Reading guide: In 2003, among the French population aged 55 and over having reported suffering from high blood pressure, 29.2% perceive their health as poor. This chronic disease has a 30.1% prevalence among the general population.

Sources: Irdes and ISQ.

Data: 2002-2003 National Health Survey* (Insee*) and 2003 Canadian Community Health Survey* (Statistics Canada).

A majority of persons perceive their health status as good despite chronic disease

The self-assessed health status was studied from the viewpoint of ten chronic diseases susceptible, because of their seriousness, of having an impact on health perception (*Cf.* table 1). Despite the presence of a chronic medical condition, the majority of individuals aged 55 and over, in Québec as in France, report being in good health. The percentage of persons considering themselves in poor health thus varies from 29 to 51% according to disease and geographic area, the majority being situated at approximately between 35 and 45%.

Noteworthy is the similarity, between France and Québec, in the percentage of individuals perceiving their health as poor in the presence of a given disease. For example, the percentage of individuals suffering from heart disease or cerebro-vascular accident reporting poor health is approximately 45% in both geographic areas. Certain diseases however distinguish themselves. In Québec, persons suffering from cancer

SOURCES

2002-2003 National health survey* (EDS*)

The National health survey* (EDS*), carried out every ten years by the National Institute for Statistics and Economic Studies* (Insee*), aims at measuring the population's health status and its health care consumption. It is based on a representative sample of individuals living in ordinary households in metropolitan France (excluding overseas territories).

Data were collected in face to face interviews divided into three visits (over two months) between October 2002 and September 2003 and using an age-specific self-administered questionnaire. The analyses are based on 6,779 persons aged 55 and over having responded to the health status question on the self-administered questionnaire (completed by individuals 18 years and over) and having participated in the three visits.

Canadian Community Health survey (CCHS)

The Canadian Community Health Survey (CCHS) consists of a series of general or thematic surveys carried out by Statistics Canada since 2000-2001. These surveys concern health status, its determinants and health services utilisation. It supplies data representative of the population living in private households in the Canadian provinces.

Data were collected by telephone interview (74%) or in face to face interviews lasting approximately 45 minutes . In this study we analyse data from the CCHS 2003 cycle 2.1 survey (shared file). The analyses concerns 9,207 respondents aged 55 and over having responded to the health status question.

(51%) more frequently perceive their health status as poor than in France. In France, as in Québec, persons suffering from high blood pressure or thyroid disease are relatively few to consider their health as being poor (approximately 30%).

Functional limitations and activity restrictions are associated with poor perceived health

The presence of functional limitations is studied here by means of four indicators relating to vision, hearing, mobility and dexterity (*Cf.* table 2). These limitations are often associated with poor health reporting from subjects aged 55 and over. For example, among people with a visual impairment uncorrected by glasses or contact lenses, 54% perceive their health as being poor in France, compared with

T2

Percentage of the population aged 55 and over self-reporting poor health in the presence of a functional limitation and prevalence of these limitations in France and Québec

♦ Data collection methods for disabilities being different in France and Québec (*Cf.* Definitions insert p. 7), **the prevalence indicated below is not to be compared between the two geographic areas.** For information purposes only.

FRANCE			QUÉBEC		
	Poor assessed health %)	Prevalence (%)		Poor assessed health (%)	Prevalence (%)
Vision			**Vision**		
No problem	**18.8**	13.2	No problem	**15.3**	14.7
Corrected problem	**23.3**	77.7	Corrected problem	**20.4**	82.3
Uncorrected problem	**53.9**	9.1	Uncorrected problem	**47.1**	2.1
Hearing			**Hearing**		
No problem	**22.9**	76.3	No problem	**20.0**	95.8
Corrected problem	**34.3**	20.6	Corrected problem	**20.3**	3.4
Uncorrected problem	**29.2**	3.1	Uncorrected problem	**34.4**[2]	0.8
Mobility			**Mobility**		
No difficulty without human or technical aid	**18.5**	83.6	No difficulty without technical aid	**17.5**	93.3
No difficulty with human or technical aid	**54.1**	3.4	Difficulty/in need of human or technical aid	**58.3**	6.7
Difficullty with human or technical aid	**63.6**	13.0	–	–	–
Dexterity			**Dexterity**		
No difficulty	**23.6**	94.6	No difficulty	**20.0**	99.4
Difficulty, uses technical aid	**59.3**	5.4	Difficulty/in need of human or technical aid	**39.9**[2]	0.6[2]

[1] This percentage having a coefficient of variation between 15 and 25% should be interpreted with caution..

[2] This percentage having a coefficient of variation superior to 25%, the imprecise estimation is provided for information purposes only..

Reading guide: In 2003, of the French population aged 55 and over having no difficulty walking when they have recourse to human or technical aid, 54.1% self-report poor health. The prevalence of this limitation is of 3.4% in the general population. For this indicator, the choice of responses is different in the two surveys-
Sources: Irdes and ISQ.

Data: 2002-2003 National Health Survey* (Insee*) and 2003 Canadian Community Health Survey* (Statistics Canada).

T3

Percentage of the population aged 55 and over self-reporting poor health in the presence of an activity restriction and prevalence of these restrictions in France and Québec

♦ Data collection methods for activity restriction being different in France and Québec (*Cf.* Definitions insert p. 7), **the prevalence indicated below is not to be compared between the two geographic areas.** For information purposes only.

FRANCE			QUÉBEC		
	Poor assessed health (%)	Prevalence (%)		Poor assessed health (%)	Prevalence (%)
PERSONAL CARE			**PERSONAL CARE**		
Total			**Total**		
Without difficulty	**22.1**	87.0	No need of aid	**19.4**	97.9
Difficulty, without aid	**41.4**	9.3	In need of aid	**60.2**	2.1
Difficulty, receives aid	**65.7**	3.7	–	–	–
ACTIVITIES OF DAILY LIVING			**ACTIVITIES OF DAILY LIVING**		
Preparing meals			**Preparing meals**		
Without difficulty	**23.6**	83.4	No need of aid	**18.4**	96.5
Difficulty, without aid	**76.1**	0.9	In need of aid	**69.3**	3.5
Difficulty, receives aid	**71.7**	1.8	–	–	–
Does not have to do it	**27.0**	13.9	–	–	–
Housekeeping			**Housekeeping**		
Without difficulty	**18.7**	72.9	No need of aid	**16.7**	91.1
Difficulty, without aid	**59.6**	3.2	In need of aid	**55.8**	8.9
Difficulty, receives aid	**62.3**	7.9	–	–	–
Does not have to do it	**31.5**	16.1	–	–	–
Shopping and transactions			**Shopping and transactions**		
Without difficulty	**19.9**	86.6	No need of aid	**16.0**	90.6
Difficulty, without aid	**66.1**	1.7	In need of aid	**60.6**	9.4
Difficulty, receives aid	**63.8**	9.2	–	–	–
Does not have to do it	**50.6**	2.5	–	–	–
Total[1]			**Total[1]**		
Without difficulty	**17.7**	67.0	No need of aid	**14.9**	87.1
Difficulty, without aid	**55.4**	3.1	In need of aid	**56.4**	12.9
Difficulty, receives aid	**61.0**	12.4	–	–	–
Does not have to do it	**25.3**	17.6	–	–	–

[1] The percentages of individuals in poor health in each of the 'Total' category responses are systematically inferior to the percentages observed in each separate category. This result can be explained by the method used to group together results in the 'Total' category (*Cf.* Definitions and methods insert p. 7).

Reading guide: In 2003, among the French aged 55 and over that experience difficulties and receive help to do their shopping, 63,8% perceive their health as poor. The prevalence of this restriction is of 9.2% in the general population. For this indicator, the choice of responses is different in the two surveys

Sources: Irdes and ISQ.

Data: 2002 -2003 National Health Survey* (Insee*) and 2003 Canadian Community Health Survey* (Statistics Canada).

47% in Québec. Furthermore, 64% of the French having difficulty walking despite recourse to technical or human aid, perceive their health status as poor. In Québec, the mobility question is different, identifying individuals having difficulty walking or in need of technical or human assistance. Of these, 58% perceive their health status as poor.

The presence of activity restrictions such as difficulties carrying out personal care or activities of daily living without aid often leads to poor health reporting (*Cf.* table 3). Indeed, in France, 66% of individuals receiving personal care assistance (washing, going to bed, personal hygiene, dressing, etc.) perceive their health as poor; the percentage is lower (41%) in individuals reporting difficulties with personal care but who are not receiving aid. As for the individuals experiencing difficulty accomplishing acts of daily living (ADL: preparing meals, housework, shopping or other transactions), they perceive their health as poor in 61 and 55% of cases respectively according to whether they receive assistance or not.

In Québec as in France, among individuals needing or receiving personal care or ADL assistance, approximately six out of ten report being in poor health (from 56 to 72%, depending on the activity).

Methods

Analysis

For both surveys, bivariate analyses (chi-square test and comparison of confidence intervals) and logistic regression models were performed using weighted data. The analyses of Québécois data take into account the survey plan effect. The significance threshold was fixed at 0.05. With the exception of age and gender, retained in all cases, only the significant variables were kept in the logistic regression models

T4 Probability model for self-reporting poor health in individuals aged 55 and over in France and Québec

	FRANCE	QUÉBEC
	Model including, all things being equal, ...	
	... educational attainment, household income and type of household. The employment situation is not included as non-significant.	... educational attainment and household income. Type of household and employment situation are not included as non-significant.
Variables	***Odds ratios***	***Odds ratios***
Age		
55-59 years	*Ref.*	*Ref.*
60-64 years	N.S.	N.S.
65-69 years	N.S.	N.S.
70-74 years	N.S.	0.59
75 and over	N.S.	0.63
Gender		
Male	*Ref.*	*Ref.*
Female	1.25 **	0.70 **
Diseases		
Absence of the following diseases	*Réf.*	*Réf.*
Cancer	2.39 ***	4.95 ***
Thyroid disease	----	1.47 *
Diabetes	2.08 ***	2.24 ***
Mental disorders	2.23 ***	2.18 ***
Heart disease, cerebrovascular accident	2.23 ***	2.59 ***
High blood pressure	----	1.52 ***
Chronic respiratory disease	2.21 ***	2.31 ***
Intestinal disorders, stomach ulcers	1.92 ***	1.78 **
Arthritis, rheumatism	1.70 ***	1.87 ***
Backache (outside arthritis and rheumatism)	1.70 ***	1.77 ***
FUNCTIONAL LIMITATIONS, PERSONAL CARE, ACTIVITIES OF DAILY LIVING		
Vision		
No problems	*Ref.*	----
Corrected problem	1.24 *	----
Uncorrected problem	2.71 ***	----
Mobility		
France: *No difficulty*	*Ref.*	–
No difficulty with human and technical aid	2.46 ***	–
Difficulty with human and technical aid	3.13 ***	–
Québec: *No difficulty*	–	*Ref.*
Difficulty/In need of human or technical aid	–	1.82 **
Dexterity		
France: *No difficulty*	*Ref.*	–
Difficulty, with technical aid	1.78 ***	–
Québec: *No difficulty*	–	----
Difficulty/In need of human or technical aid	–	----
Personal care		
France: *No difficulty*	*Ref.*	–
Difficulty without aid	N.S.	–
Difficuly with aid	1.73 ***	–
Québec: *No need of aid*	–	----
In need of aid	–	----
Activities of daily living		
France: *No difficulty*	*Ref.*	–
Difficulty withoud aid	2.46 ***	–
Difficulty with aid	2.35 ***	–
Does not have to do it	1.23 *	–
Québec: *Does not need aid*	–	*Ref.*
In need of aid	–	3.39 ***

---- : Variable non-significant and not introduced in the final models presented here.

Sources: Irdes and ISQ.

Data: 2002-2003 National Health Survey* (Insee*) and 2003 Canadian Community Health Survey* (Statistics Canada).

Notes for table 4

Definition of *odds ratio*

An odds ratio (OR) expresses the effect of a variable on the probability of self-reporting poor health in comparison to a reference category (indicated in red italics in table 4). An OR superior to 1 indicates an increased probability of self-reporting poor health as compared to the reference category.

Significance of *odds ratios*:

N,S.: non significant, *: p<0.5, **: p<0.01, ***: p<0.001

Determinants of self-assessed health: differences and similarities

Logistic regression allows us to understand how disease and disability determine self-assessed health in the population aged 55 and over, all things being equal, by controlling for age, gender and individuals' social and economic characteristics (*Cf.* table 4).

The results obtained for France and Québec present both differences and similarities.

An age effect that differs according to geographic area...

In France, health deterioration due to age is entirely explained by the presence of chronic disease or disability as shown in the non-significant odds ratios. Inversely, in Québec there exists an age effect that tends to minimise poor health reporting among the most elderly once disease, disability and socio-economic factors have been taken into account. The probability of reporting poor health is thus significantly inferior among Québécois aged 70-74 and 75 and over, in comparison with those aged between 55 and 59.

... as does the gender effect

The gender effect is equally inversed in France and Québec. In France, all things being equal, women are more inclined than men to declare themselves in poor health. The contrary is true in Québec where the probability of reporting poor health is lower among women than in men, all other variables being taken into account.

Definitions and methods

Indicators

Assessed health

France (EDS[1]): assessed health is estimated from the following question: "Would you say in general your health is: excellent, very good, good, fair or poor?" .

Québec (CCHS2): the adjective 'passable' replaces the adjective 'fair'.

Chronic illnesses

France (EDS): a whole constituted of diseases declared (ICD-10 codification) and still present at the time of the third visit. Because of the methodological differences, prevalence is not comparable.

Québec (CCHS): ten long-term diseases (six months or longer) diagnosed by a health professional were retained.

Functional limitations

Vision: ability to see up close (for example reading a newspaper) or from afar (for example recognising a face at 4m distance) with or without correction (glasses or contact lenses).

Hearing: : ability to understand a conversation distinctly with or without correction (hearing aid).

Codification: the indicators relative to vision are fairly comparable between the EDS and CCHS. The same goes for those concerning hearing although these are more precise in the CCHS).

Mobility and dexterity

Mobility: ability to walk a distance of 500m without aid.

Dexterity: ability to manipulate small objects.

Codification: outside the presence of limitations, the EDS takes into consideration the effective use of technical aids (such as a walking stick, wheelchair) or human aid whereas the CCHS takes into consideration the need for aid (received or not).

Personal care and activities of daily living

Personal care: washing, dressing, taking medication...

Activities of daily living (ADL): preparing meals, daily household tasks (housework, washing), shopping and transactions (grocery shopping, payment of bills, making appointments…)…

Codification: personal care items were grouped into a single variable. According to the type of analysis, the ADL were either presented separately or grouped into a single category 'totality of ADL'. For this category, 'totality of ADL', we classified responses in the following manner for France: without difficulty = no difficulty in preparing meals, housework, shopping and transactions: difficulty without aid = at least one difficulty without aid in one of the three activities, but no 'difficulty with aid'; difficulty with aid = at least one difficulty with aid in one of the three activities; 'does not have to do it' = at least one response 'does not have to do it' in one of the three activities. The same classification principle was applied for Québec.

For each ADL, the National Health Survey explores the ability to carry out without difficulty the activity on one's own as well as the aid effectively received (or not received) for that activity whereas the CCHS asks questions on the need for aid (or not) as a result of a health problem.

Socio-demographic and economic characteristics in brief

Educational attainment: concerns the highest level of schooling attained

Employment situation: working, unemployed, retired or disabled.

Household income

France (EDS): household's total annual income by consumption unit in quartiles

Québec (CCHS): 5 levels classified according to income and the number of persons in the household.

Type of household: single person, couple with children, couple without children, single parent, other households.

[1] For further information on EDS: http://www.cmh.acsdm2.ens.fr/enquetes/XML/lil-0284.xml.

[2] For further information on CCHS: www.statcan.gc.ca/start-debut-fra.html.

On the other hand, disease impact is similar…

The relationship between health status and the ten diseases studied show numerous similarities: suffering from a disease considerably increases one's probability of declaring poor health. Even if the odds ratios cannot be compared directly, it should be noted that, for the majority of the diseases, the odds ratios are around 2 and are therefore of the same order in France and in Québec.

… with the exception of high blood pressure, thyroid disease and cancer

Among the differences observed, neither high blood pressure nor thyroid disease figure among the diseases associated with poor health in France, contrary to Québec where the *odds ratios* are significant. Are the Québécois better informed than the French concerning the risk factors associated with these diseases? In Québec, cancer equally differentiates itself; Québécois with cancer are much more inclined to report poor health than those that do not have cancer, all things being equal.

Certain functional limitations and activity restrictions only have an impact in France

Despite the slightly different ways of measuring functional limitations and activity restrictions in the two surveys studied, differences and similarities need to be highlighted.

Concerning functional limitations, uncorrected visual problems and difficulties with dexterity are only associated with poorer health in France. In both France and Québec, however, mobility problems more frequently result in poor health reporting. The results are also consistent for hearing difficulties that are not associated with poor health either in France or Québec.

Finally, concerning activity restrictions, difficulties relating to personal care are yet again only associated with poor health in France: the French experiencing difficulty with personal care despite receiving aid are more inclined to consider themselves in poor health. Furthermore, in France as in Québec, difficulties associated with housekeeping activities are important factors in self-assessed health status: in France the *odds ratios* are significant for persons having difficulties whether they receive aid or not, and in Québec, among those declaring they need aid. The differences found between the French and Québécois models with regard to personal care and dexterity are certainly linked to their very low prevalence in Québec and to dissimilar data collection methods.

* * *

This comparison of self-assessed health and its determinants in France and Québec opens up new research perspectives.

In general, it once again suggests the need for a deeper understanding of methods or instruments which would allow for a more objective comparison of perceived health.

These results also reveal a better perception of health status in the French population for conditions such as cancers, high blood pressure and thyroid diseases. What are the reasons for this? Would the differences have been similar had we compared France with other countries?

Finally, in France as in Québec, this study deserves to be taken further by introducing elements related to risk factors such as alcohol and tobacco consumption, weight or physical activity, and by broadening the comparison to include other diseases, for example. ♦

FURTHER INFORMATION

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GLOSSARY

- **National Health Survey (EDS):** Enquête décennale santé (EDS)
- **Canadian Community Health Survey (CCHS):** Enquête sur la santé dans les collectivités canadiennes (ESCC)
- **Québec Institute for Statistics (ISQ):** Institut de la statistique du Québec (ISQ)
- **Franco-Québec Observatory on Health and Solidarity (OFQSS):** Obervatoire franco-québécois de la santé et de la solidarité (OFQSS)
- **National Institute for Statistics and Economic Studies (INSEE):** Institut national de la statistique et des études économiques (Insee)

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