

SHARE, the Survey of Health, Ageing, and Retirement in Europe goes longitudinal

Data from wave 2 is now available

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The Survey of Health, Ageing, and Retirement in Europe (SHARE) is an international, multidisciplinary and longitudinal survey, developed to address research issues on ageing.

Wave 2 data, collected in 2006-07, provides panel data from respondents already interviewed in 2004-05. Since ageing should be seen as a process, rather than a state, longitudinal dimension is of foremost importance to put a stress on evolutions and transitions, as well as generation effects and causality.

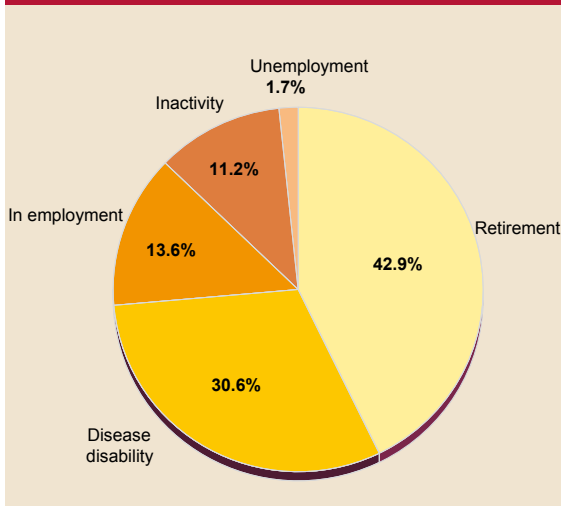
This issue presents some preliminary results from wave 2 of SHARE. These results deal with health and labour market dynamics. They show the influence of working conditions and institutional differences – especially concerning disability assurance enrolment, on early exits from the labour force and retirement decisions. Moreover, the new data confirms first wave analyses in terms of health disparities, and gives new insight about changes in health services utilization.

The ageing phenomenon particularly affects Europe where the proportion of elderly citizens is the highest. More than 20% of the population is already more than 60 and this figure could reach 35% in 2050. Since health deterioration often comes with ageing, health expenses should increase while economic viability of the system is questioned.

In order to face the challenges of an ageing population, economic, political, social, and public health mechanisms related to this trend should be taken into account. It is necessary to understand how the ageing process will affect all of us both individually and on a global scale. Nevertheless, this process affects the people in the European countries differently, because their culture, their historically developed societal structures and their public policy approaches differ.

SHARE is an invaluable tool to understand the relations between health, labour force participation and institutional context of old people support in Europe. The international, multidisciplinary, and longitudinal aspects (people are surveyed every two years since wave 2) are big advantages of SHARE. Panel data is very useful to emphasize transitions and generation effects, as well as causality. The data covers individuals and the husband or spouse, aged at least 50 years old – inter-

Statute of the surveyed people who had stated to perceive a disablement pension in 2004 and which does not perceive any more in 2006



Field. Predicted disability insurance enrolment if age, gender and health status were identical in all countries. Based on 8942 individuals of the relevant age range (50 to 64 years in Wave 1) with observations in both waves.

Note. This figure shows the distribution of those who left disability insurance. Only few individuals leaving disability insurance go back to the labour market: 13.6% are working and 1.7% actively seek work. The largest category consists of individuals who transit from disability insurance into old-age pensions (almost 43%). Another 31% remain sick or disabled and rely on family transfers. The remaining 11% are homemakers.

Source: Börsch-Supan *et al.* (2008).
Data: SHARE.

viewed for the first wave of SHARE in 2004-05 and surveyed again in 2006-07 (Cf. Box p 3 and table below).

Apart from the newcomer countries (Poland and Czech Republic), the main changes with the previous wave deal with additional households (refreshment sample) interviews of respondents in 2004 who moved to an institution, and an “end-of-life-interview” (also known as the “exit” interview) that gather information from a third person (proxy-respondents: relative, neighbour, or friends) about the circumstances of the death of the respondent surveyed in wave 1.

Generous public pension coverage combined with bad labour conditions, encourage early exists from the labour force

Disability insurance is a pathway to early retirement

The longitudinal feature of SHARE gives insights in the dynamics of disability insurance enrolment (insurance that covers employees to compensate a loss of income following a non work related illness) and helps to identify individual transitions. Among the 8 942 individuals aged from 50 to 64 in wave 1 who did not perceive such disability insurance in wave 2, 43% transit into old-age pensions and 15% went back to the labour market (13% found a job and 2% remained unemployed). Thus, disability insurance often works as a pathway to early retirement (Börsch-Supan *et al.*, 2008).

Nevertheless, entry/exit trajectories of disability insurance and health declared trajectories do not appear to be related. This finding stays valid when looking at objective health indicators such as a test for depression symptoms or the measure of grip strength. It might reveal a “justification bias”: The individuals enrolled in disability insurance tend to report a worse subjective health status in order to satisfy health requirements for disability insurance eligibility.

Paradoxically, in the countries where a high rate of individuals receive disability insurance (Scandinavian countries and Holland), the declared average health status is better than in the South European countries, although characterised by a lower rate of disability insurance recipients.

Cross-national differences in disability insurance enrolment seem mostly explained by the systems’ generosity (health requirements for disability insurance eligibility, medical evaluation, etc.).

Job quality influences retirement behaviour

From SHARE data, a collective term for various working and employment conditions “job quality” can be associated with retirement decisions. This indicator puts data together concerning the physical work load, the imposed work pressure, the incentive structure and the perceived job stability.

Results from SHARE in 2004-05 have already pointed out a strong association

SHARE, as a European database about health and Ageing, relies on an international infrastructure acknowledged by the European Union. The Manheim Research Institute for the Economics of Ageing in Germany is in charge of the central coordination of the project. In each participant country across Europe, research centres or universities are in charge of research and management at the national level. In France, IRDES and INSEE are in charge of the survey. Notice that the three first waves of SHARE have been mainly funded by the European Union with additional support from national institutions. Following waves should be mostly funded by national contributors.

between poor job quality and poor health, and they have indicated that poor job quality – by reducing well-being – is positively related to the decision of retire. Poor job quality may have both a direct effect – by affecting the individual’s subjective overall job satisfaction - and an indirect effect – by affecting the health – on the decision to stop working.

Distribution of respondents in wave 1 and 2 of SHARE

	Wave sample 1 (2004)	Wave sample 2 (2006)	Panel (inquired having taken part in waves 1 and 2)	
			Effectif	Rate of retention
Austria	1,893	1,341	1,238	65.4%
Belgium	3,827	3,169	2,808	73.4%
Denmark	1,707	2,616	1,249	73.2%
France	3,193	2,968	1,998	62.6%
Germany	3,008	2,568	1,544	51.3%
Greece	2,898	3,243	2,280	78.7%
Italy	2,559	2,983	1,766	69.0%
Netherlands	2,979	2,661	1,777	59.7%
Spain	2,396	2,228	1,375	57.4%
Sweden	3,053	2,745	2,010	65.8%
Switzerland	1,004	1,462	696	69.3%
Total 11 countries	28,517	27,984	18,741	65.7%
Israel	2,598	<i>in progress</i>	-	-
Poland	-	2,467	-	-
Czechoslovakia	-	2,830	-	-
Ireland	-	<i>in progress</i>	-	-
Total 15 countries	31,115	33,281	-	-

Description. The table presents the number of respondents in SHARE surveyed in 2004 and 2006, and the number of those who have been reinterviewed in wave 2.

Note for the reader. In France, 3,193 people in 2004 and 2,968 people in 2006 took part in investigation SHARE. In 2006, 1 998 people had already been questioned in 2004; the share of this sample compared to that of 2004 is of 62.6%.

Source: SHARE



SHARE Survey on Health, Ageing and Retirement in Europe

Aims and field

SHARE survey aims to build a European panel focused on health and socio-economic issues related to ageing.

SHARE project started in 2002. First wave of data collection took place in 2004 in 11 European countries: Germany, Austria, Belgium, Denmark, Spain, Greece, Italy, the Netherlands, Sweden, Switzerland, France and Israel.

The scope of SHARE was extended to fifteen countries in 2006, now including the Czech Republic, Poland and Ireland. The survey provides panel data since then.

Topics

The SHARE data set covers following thematic areas:

- Health status (physical health, health behaviour, physical and cognitive functioning, mental health, healthcare facilities, grip strength);
- Work activity (employment and retirement);
- Living conditions (wealth, income, consumption, transfers of income and assets, housing);
- Demographic variables (marital status, children);

- Socio-economic status: (social support, assistance within families, social networks, volunteer activities).

Sample

The SHARE sample includes households with at least one individual aged 50 and over. Wave 2 comprises more than 40 000 cross-sectional data in 15 European countries. Panel data covers more than 18 000 individuals aged 50 and over in the participating countries.

In France, following SHARE 2004, the survey that took place in 2006 included at least one member aged 50 and over. From 2 000 to 2 500 people aged 50 and over, as well as their spouse or husband have been interviewed again.

The 2006 sample includes in France:

- Individuals surveyed in 2004 in order to obtain panel data;
- A refresher sample composed of 1 500 households in which at least one individual is aged 50 and over in 2006. Within each household, an individual drawn among the eligible 50 and over has been surveyed again.

The respondents in 2004 who moved to an institution between the 2 waves have been surveyed again.

Methods

The method of the survey is based on:

- CAPI main questionnaire (data collected by face-to-face) divided into 22 modules;
- Cognitive and physical tests;
- Self-completion paper and pencil questionnaire;
- New end of life questionnaire entitled "exit interview".

The use of "proxy" is allowed: a designated financial, family or housing respondent can answer some parts of the questionnaire in case the respondent's health status has become too bad.

For more information...

Additional information is available on www.share-project.org where one can find a complete description of the data, preliminary findings from SHARE data, and a list of academic papers using SHARE data.

In particular, books edited by Börsch-Supan et al. (2005-2008) include interesting analysis on various topics: economic status, income and wealth, poverty and inequality, housing, quality of life, family and social networks, volunteering.

Data from wave 2 helps to go beyond the correlation observed at an international level. A first analysis at an individual level puts a stress on the influence of subjective job satisfaction in 2004 on the decision to stop working two years later. The fact that dissatisfied workers are twice as likely to retire within two years points toward the crucial importance of good subjective job satisfaction to keep the available labour force working.

SHARE allows a dynamic analysis of health disparities and changes in health services utilization

Socioeconomic disparities in health persist in European countries

First results from wave 2 confirm the findings from the previous one: low socioeconomic status is associated with

poor health. Europeans with low levels of education and wealth experience more cases of cardiovascular disease, lung disease, arthritis, or disability. For instance, 1.45% of the poorest Europeans in wave 1 have declared they had a stroke between wave 1 and 2, whereas only 0.85% of the richest did.

First results from the dynamic approach suggest a persistence of health disparities from one wave to another that reveals there is some determinism about individuals' health behaviour throughout life course. For instance, people with low education and wealth are less likely to quit smoking and to change toward a healthier lifestyle.

Life events modify health services utilization

First results from wave 2 give the opportunity to make the hypothesis that life events and changes in economic situation

Evolution of the sample between waves 1 and 2

All panels experience a decline in initial respondents due to moves out of or within the country, death, or refusals to be interviewed again. Much effort has been made by SHARE to adapt the survey design (e.g. length of the interview, topic of the survey, number of interviewer contacts, follow-up procedures, etc.) and to encourage respondents' participation. The average rate of retention (the share of people interviewed in wave 1 who are also interviewed in wave 2) is indeed 65.7%. Nevertheless, some countries – France for instance – with relatively mobile population and vast territory, and without regis-

ters of population, experience lower results than other countries (Cf. table 1). In order to increase the rate of retention, INSEE devoted special attention to locate respondents who moved to a different place in France (*l'Application de Suivi des Adresses – ASAR*). In addition, people interviewed in SHARE wave 3 (2009) will be asked to provide the name and address of at least one person (relative, friend, neighbour, etc.) who would be able to communicate the respondent's address in case of move. Notice that wave 4 of SHARE should see a major refreshment of the sample in every country.

between 2004-05 and 2006-07 predict a change in health services utilization.

In Wave 1, 2438 individuals (14 percent of the sample) reported no medical consultation in the past 12 months. 59 percent had one or more medical consultations in Wave 2. This ratio increased with age, between 53 percent at age 50-54 and 68 percent at age 75 and more. The probability to report at least 13 consultations per year also increases with age; it ranged between 5 percent at age 50-54 and 13 percent at age 75 and more.

Multivariate models suggested, (after controlling for age, gender, level of education, subjective health, etc.) that a reduction in household size, work cessation, and a change in health insurance for ambulatory medical care significantly increased the probability of transitioning

from no medical contact to at least one. By contrast, when taking into account the factors listed above, changes in income did not contribute to this evolution (Cf. graph p 1).



More results about Health, Ageing and Retirement in Europe should come based on the already existing and the ongoing production of SHARE data. SHARELIFE, the third wave of SHARE will collect retrospective data about children, partners, housing, employment, financial assets, health status, health care, happiness and other well-being dimensions, along the respondent's life. The aim of this third wave of SHARE is to complement panel data from waves 1 and 2 with a deeper longitudinal approach, tracing back respondent's trajectories. It could be useful to test, for instance, the hypotheses suggesting that diseases in childhood influence mortality and life quality in the long run. It will also be possible to compile individual trajectories and economic, social, political, and institutional changes during last century.

SHARE aims to enlarge on most European countries, and to extend the sample inside the countries. As a "living" infrastructure, SHARE is adaptable to the most recent developments in research and public policy issues. New topics (e.g. nutrition, time spent, etc.) and new tools (e.g. biomarkers) are constantly being discussed in order to keep the survey up to date for researchers.

There is outside Europe a worldwide trend to develop infrastructures to gather individual data on ageing. In addition to prior surveys like HRS (Health and Retirement Study) in the USA and ELSA (English Longitudinal Survey on Ageing) in the UK – that have been very influential in the development of SHARE – one may note the presence of ongoing similar surveys in Mexico, Japan, Korea. Other countries (e.g. China, India, and Thailand) have already shown interest in SHARE and

may develop similar infrastructures in the near future. SHARE does not only appear as a successful partnership between researchers and national and supra-national institutions in Europe (agencies, governments, the European Commission), but also as a major part of a worldwide initiative devoted to research on ageing.



FURTHER INFORMATION

- Börsch-Supan A. et al. (2008). *Health, Ageing and Retirement in Europe (2004–2007). Starting the Longitudinal Dimension*. MEA, Université de Mannheim (Allemagne).
- Börsch-Supan A. et al. (2005). *Health, Ageing, and Retirement in Europe, First Results from the Survey of Health, Ageing, and Retirement in Europe*. MEA, U. de Mannheim (Allemagne).

See also:

- Sirven N., Santos-Eggimann B., Spagnoli J. (09/2008). *Comparability of Health Care Responsiveness in Europe. Using anchoring vignettes from SHARE*. Document de travail IRDES n° 15.
- Blanchet D., Debrand T. (2008). *The sooner, better? Analyzing preferences for early retirement in European countries*. Document de travail IRDES n° 13.
- Debrand T., Lengagne P. (2008). *Working Conditions and Health of European Older Workers*. Document de travail IRDES n° 8.
- Sirven N., Debrand T. (2008). *Promoting social participation for healthy ageing*. Document de travail IRDES n° 7.
- Lardjane S., Dourgnon P. (2007). *Les comparaisons internationales d'état de santé subjectif sont-elles pertinentes ? Une évaluation par la méthode des vignettes-étalons*. Document de travail IRDES n° 2.
- Blanchet D., Debrand T. (2007). *Aspiration à la retraite, santé et satisfaction au travail : une comparaison européenne*. Document de travail IRDES n° 1.

Enhancing International Comparability Using Anchoring Vignettes

International comparisons based on self-evaluations may suffer from differences in the way people understand and answer survey questions (e.g. due to differences in history, institutions, culture, living conditions, etc.).

This problem (A.K.A *Differential Item Functioning – DIF*) can be solved using anchoring vignettes which consist in short descriptions of a hypothetical person's situation (e.g. health status). Respondents are asked to evaluate the hypothetical persons on the same scale on which they assess their own health. They thus provide an anchor, which fixes their own health assessment to a pre-determined health status. These anchors can then be used to make subjective assessments comparable across countries and socio-economic groups. SHARE has made great efforts to deliver truly comparable data.

The vignette questionnaires in wave 2 were fielded in 11 countries on various topics such as health, satisfaction with work, etc. For an illustration of the anchoring vignettes method, one can refer to the work of Lardjane and Dourgnon (2007) on health status comparisons according to a non-parametric approach, and to the work of Sirven et al. (2008) on health care comparisons according to a parametric approach.



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Director of the publication: Chantal Cases

Technical senior editor: Nathalie Meunier

Translator: Nicolas Sirven, Violaine Eudier - Layout composer: Khadidja Ben Larbi

ISSN : 1283-4769 - Diffusion by subscription: €60 per annum - Price of number: €6 - 10 to 15 numbers per annum.