Comparison between in HIS and HES

height, weight, BMI

	HES	*HIS*	*HES-HIS*
weight	70.9	69.2	1.7*
height	167.6	169.6	-2.0*
BMI	25.1	23.9	1.2*

***paired T-test, $p < 0.000$**

HIS: **“what is your weight?”**
“what is your height?”

HES: **weight, measured in kg**
height, measured in cm

S. Conti, G. Farchi et al, Italian National Institute of Health, 2002

Comparison between HIS and HES hypertension

HIS: "Are you affected by hypertension?"

HES: DBP $\geq$ 95 mmHg or SBP $\geq$ 160 mmHg or under medication

	HES (exam)	
HIS (self-reported)	**yes**	**no**
yes	13	15
no	47	268
	60	283

Sensitivity	**22**
Specificity	**96**
Positive predictive value	**46**
Negative predictive value	**85**

S. Conti, G. Farchi et al, Italian National Institute of Health, 2002

OECD – Ageing societies: data needed for research and policy

Comment on the SHARE Project
S Giampaoli, Istituto Superiore di Sanità, Rome, Italy
Paris, 20-21 June 2002

The OECD-Ageing Related Diseases is a project that has produced interesting comparisons between countries, pooling similar data, using similar definitions and codes for all the countries but retrospective data collection is a limitation of this project.

To investigate causal relationships longitudinal data are needed. When we know what causes diseases, we have a better chance to prevent them and to improve health care.

The proposal for a Longitudinal Survey of Health Ageing and Retirement in Europe should be encouraged because it is an opportunity to collect comparable data on 50-year and older persons using representative samples of European population.

Longitudinal data are needed at an individual level using standardised questionnaires and measurements. Standardised means validated procedures, methods, questionnaires, tools. This means all participating countries use the same questionnaires, procedures, methods. So we will have data that can be comparable, a common currency.

Examples of questionnaires are the MMSE for the evaluation of global cognitive function, or the ADL and IADL of WHO for physical performance, or the LSH questionnaire for cardiovascular diseases, all these instruments are translated in different languages and validated and allow us to collect data in a standardised procedure and to diagnose in a standardised way.

Data from interview surveys should be integrated with examination measurements. The figures are good examples of the kind of problems that we have.

In Italy during the years 1999-2000 the Italian Census Bureau conducted Health Interview Surveys (HIS) on a representative sample of Italian families; during the year 2000 the Istituto Superiore di Sanità in collaboration with a research group in Florence carried out a pilot Health Examination Survey (HES) on a sub-sample of the same population.

In the HIS the health status was investigated with a self-reported questionnaire.

In the HES the health status was investigated by professionals using questionnaires, clinical examination, and biochemical parameters.

Here are some results on people who had both surveys, on weight, height and body mass index. Weight is underreported in HIS, and people see themselves as taller; the result is that our population has higher body mass index than declared.

Similar results if we look at the prevalence of hypertensives.

Using the HES as the gold standard for the definition of hypertension, on 60 persons identified as hypertensives, only 13 reported having hypertension.

I would like to conclude with the suggestion to integrate the SHARE project with a few simple biological measurements, like blood pressure or weight, to adopt standardised and validated questionnaires and diagnostic criteria for the definition of diseases.