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Views and reviews

The census and health: commentaries about the 2001 Belgian Census

by

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In 2001, like many other countries, Belgium is carrying out its population census[5]. Such huge and wide scope statistical task may appear old-fashioned in an era when investigators and policy makers count with valid and competitive sources of information from numerous surveys and administrative databases. As this letter aims to show, this is not the case.

The census in in Belgium still the only comprehensive databank where demographic and administrative data are linked to crucial socio-economic indicators. It is also the only source of information for numerous data for small geographical units (municipalities and neighbourhoods).

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[5] The Census will be officially called Socio-economic Survey, mainly because it encompasses a wide range of socio-economic status indicators.

Moreover, the National Institute of Statistics had decided to give the census a new stance by including four self-rated health questions and three questions about non-professional caring. Such initiative is original but not unique, as the United Kingdom took a similar step with its 1991 census (1) and Canada in 1996. In this letter, we would like to present the wording of the health questions, to address their validity, and their potential usefulness for researchers and policy makers.

In the 2001 Belgian Census, four questions address the health of the respondents. They state:

- How is your health in general? (very good, good, fair, bad, very bad).
- Do you suffer from one or more longstanding illnesses, chronic conditions or handicaps? (yes, no).
- If yes, are you restricted in your daily activities due to this (these) illness(es), chronic condition(s) or handicaps? (continuously, every now and then, not or seldom).
- If yes, are you bedridden due to this (these) illness(es), chronic condition(s) or handicaps? (continuously, every now and then, not or seldom).

Such questions have been widely used in Health Interview Surveys in the UK, the Netherlands and in Belgium. They cover three general approaches to health, the subjective (question 1), the medical (question 2) and the functional model (question 3 & 4) (2). Are such questions a valid approach of health? In a recent review, Idler identified 27 studies using subjective health as a predictor of mortality, of which 23 evidenced a strong effect size on survival, even controlling for known risk factors (3). Subjective is also a valid and continuous measure of ill-health and risk factors (4). Qualitative studies suggest that the consistency of subjective may arise from the fact that it is a inclusive measure of health status, capturing a full array of illnesses, jointly with their severity, comorbidity, duration and restrictions posed by ill-health (3, 5).

Within the provided care one has to recognise that there is an unknown but probably increasing amount of unpaid personal help given to people with ill health. The objective of the 3 questions in the 2001 Belgian Census is to improve the understanding of variations in the need for care and the role the non-professional care has in current society. Similar questions are used in the 2001 UK Census. Their wording is as follow:

- Are you providing, at least once a week, non-professional help or care to one or more persons with a longstanding illness, condition or handicap? (Yes, No).

- If yes, is (are) this (these) person(s)? (a member of the household, a relative but not living in the household, neighbour, friend or acquaintance, etc).
- If yes, how much time do you usually spend on this help? (at least once a week (but not every day), daily, less then 30 min, daily, between 30 min and 2 hours, daily, between 2 and 4 hours, daily more than 4 hours).

The inclusion of the health related questions in the Census will serve various purposes of policy, planning and research both at local level, regional and Federal level. This is evidenced by the last revision of the Resource Allocation Working Party (RAWP) in the UK, which allocates hospital resources between the regional health authorities using the census. In such RAWP formula, self-rated longstanding illness had twofold the weight of standardised mortality ratio in the allocation of health care resources (6). This may be useful for the Belgian allocation scheme which, up to now, consider only mortality and legally entitled incapacity. Many other applications may interest policy makers regarding the provision and distribution of home care, health promotion or medical manpower planning.

Regarding research, the census data will allow a better analysis of individual in their ecologies, and thus to understand the contextual factor of subjective (7), functional and ill-health (8, 9). For example, such data may help to understand better why socio-economic inequalities in health are the product of individual features (such as income, education, occupation) and ecological features (population density, supply of health and social services, income inequality, etc.) (10).

Therefore, we think researchers and policy makers involved in public health matters should pay attention to the next Belgian Census.

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