The Budapest Initiative (BI), a joint effort of WHO, UNECE, Eurostat and a number of interested countries, has developed a short form questionnaire intended to provide the basis for comparable standardized information on population health focusing on health state. The questionnaire, the Budapest Initiative – Mark 1 (BI-M1), can be used to produce internationally comparable estimates of the measurement of health state for the next 2 to 3 years. Developmental work and testing is currently underway to develop a more comprehensive module for future use.

Underlying this questionnaire is a conceptual foundation which defines health state in terms of functioning in a core set of health domains. Health state is only one of a large number of classes of indicators that would be necessary to provide a full statistical picture of population health. Health state does not include determinants of health. This exclusion is essential from an analytical point of view and allows the strength of association between a determinant of health and health state to be assessed empirically. Correspondingly, health state is clearly distinguished from overall well-being and quality of life. While there is no doubt that health state is a major factor determining well-being, it is not the only one. It is also important to distinguish health state from physiological markers like blood pressure and cholesterol levels, and from clinically or bio-medically defined disease. Health state is essentially a rigorously structured but vernacular or plain language description of an individual’s functional health status.

The BI-M1 addresses functional domains that met criteria related to relevance and feasibility as well as certain measurement characteristics. Relevance required each of the domains and their associated survey questions to be immediately seen as plausible and reasonable by ordinary individuals, to span the main aspects of health experienced by the population, to be seen as significant aspects of individuals’ health and to draw on selected key ideas of the International Classification of Functioning, Disability and Health (ICF). Feasibility refers to a question set that is suitable for use in health interview surveys, has a consistent meaning in different social contexts, manifests a reasonable degree of heterogeneity within the population, and minimizes the number of domains on which questions need to be asked.

The domains also had to meet several measurement requirements. Domains should exhibit statistical independence which means that in most populations of interest, the levels of health on one domain are unlikely to be correlated with levels of health on another. While achieving complete statistical independence is not a feasible goal, the goal remains to minimize dependence and to focus on a set of domains that provide the most information on the population’s health. Structural independence between domains is also important and is distinct from statistical independence; it applies when an individual’s level on one domain in no way predetermines his or her level on the other domain. Levels of functioning in each domain should also be graded in severity in an ordered fashion; and functioning should be measured within, on or near the skin. The latter criterion means that the domain refers to something that is intrinsic to
the individual (equivalent to “capacity” in the International Classification of Functioning, Disability and Health). In other words, it is independent (to the extent possible) of external factors such as the physical or social environment. While aids like eyeglasses or pain medication can be considered to be essentially “within the skin”, wheelchairs and wheelchair accessible public transport are not. This criterion generally implies two of the choices with regard to ICF concepts – specifically the focus on “functioning and disability” and not “contextual factors”, and the focus on more elemental “activity” and not the more complex and typically socially mediated “participation”. This criterion also greatly enhances the prospects for another criterion, cross-cultural comparability. Finally, functioning should be measured in a way that does not preclude preference measurement and the construction of summary measures of health.

Based on these criteria and the results of cognitive testing, the following functional domains have been included in the BI-M1 questionnaire: vision, hearing, mobility (walking), cognition (memory), affect (depression) and pain. Additional work is underway to develop questions in the areas of thinking in the domain of cognition, fatigue, and social relationships, and to improve on questions in all domains.

The BI recommends that the BI-M1 be included in the EHIS as a complete set or package. This would facilitate both international comparability on the individual domains and the computation of summary measures of health if there is interest in developing such a measure. The BI-M1 should be inserted in its entirety between the Self-Completion Form (pp. 41-44) and the European Background Variables Module (pp. 45-46). This would eliminate any "priming effects" of BI-M1 on the other health-related questions in the EHIS and not disrupt the question ordering. Since some of the BI-M1 items are similar to those already asked in the EHIS, it is recommended that the following preamble be used before asking the BI-M1:

"Now I am going to ask you some further questions about your general mental and physical health. These questions deal with your ability to do different daily activities, as well as with how you have been feeling. Although some of these questions may seem similar to ones you have already answered, it is important that we ask them all."