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TO THE COUNCIL, THE EUROPEAN PARLIAMENT,  
THE ECONOMIC AND SOCIAL COMMITTEE  
AND THE COMMITTEE OF THE REGIONS

**on the state of women's health  
in the European Community**

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# PREAMBLE

The Treaty on the European Union created new responsibilities in public health for the European Community. Articles 3(o) and 129 of the Treaty lay down a general objective for the Community to contribute towards ensuring a high level of human health protection and make provisions for Community action that should be undertaken to meet this objective.

The Commission Communication on the framework for action in the field of public health (COM(93) 559 final of 24 November 1993) sets out how the Commission intends to implement this new Community competence. Among proposals made, it was envisaged that a health status report should be prepared for the European Community (EC) on a regular basis. The aim of these reports is to provide a source of information on particular health topics of interest and to promote discussion and initiate debate.

This is the second such report. The first report (COM(95) 357 final) provided an overview of health status in the EC in 1994. It included a description of the main demographic trends and patterns of mortality and morbidity, and a discussion of the major determinants of health. Because health trends and determinants only change slowly over time, there would be little new this year in a report of similar nature. This report, therefore, focuses on a particular topic - women's health issues - which is emerging as an important issue both of the general public and of health care providers and policy-makers in the EC.

The report contains an overview of major health trends, patterns of mortality and morbidity as well as relevant health determinants. In addition, it describes in greater detail a number of special health issues for women at various ages. This discussion includes information about determinants as well as relevant policies developed in the Member States.

This report is largely based upon work carried about by the University of Limerick, Ireland, using information from national sources, the World Health Organization's Health For All database, the Organization for Economic Co-operation and Development, the Statistical Office of the European Communities, and other readily available data. Where possible, the data obtained have been verified by national experts in each Member State.

# EXECUTIVE SUMMARY

## 1. Introduction

This report provides an overview of the health of women in the European Community (EC), highlighting both differences and similarities within and between the Member States. It examines the main causes of mortality and morbidity at different phases of women's lives as well as a number of individual and social determinants which influence women's health within the context of evolving demographic and social trends.

The main data sources include the World Health Organization's Health for All (HFA) database, various reports and data from the Statistical Office of the European Communities (Eurostat), and an EC-wide Eurobarometer survey, sponsored by DG V and carried out in early 1996. The latter survey contained a number of questions on women's health which are analysed in this report.

The data obtained from sources are, despite continuing improvements in quality, somewhat limited in their comprehensiveness and comparability. The choice of topics included in this report is to a large extent the result of these constraints. The report focuses on women aged 15 years and older, because most gender-specific health data at the EC level concentrate on this age-group.

The report consists of 8 sections. Section 1 introduces the report, Section 2 summarises the social and demographic trends affecting women, and Section 3 provides an overview of selected health indicators. Supplementing this information, Section 4 describes selected morbidity measures, while Section 5 concentrates on the main causes of death among women. Section 6 contains a discussion of various health determinants, while Section 7 describes a number of emerging health issues for women. Section 8 concludes the report.

## 2. Social and Demographic Trends

Women - totalling 191 million - constitute 51.2% of the population in the EC. This percentage is remarkably stable across the Member States, varying only from a low of 50.4% in Ireland to a high of 51.8% in Portugal. There is, however, considerable variation in the percentage of women across age-groups. In the group of women under 20 years of age, there are only 95 women for every 100 men, while among 80-year-olds, there are about 221 women for every 100 men. This so-called feminization ratio is particularly high in the older age-group because in the EC women on average live over 6 years longer than men.

Women's lives have changed significantly in the EC during the past three decades. The rate of marriage has declined (by almost one third) since 1960, while the rate of divorce has almost doubled (except in Ireland). At the same time, the average age of first marriage and the age at first birth have risen to 26.1 and 28.6 years, respectively.

At the same time, women's labour force participation has increased tremendously, although considerable variations exist in this area across the Member States. Concomitant with the increase in labour force participation has been an increase in women's unemployment rates, which tend to be higher than those of men.

When measuring women's position in society relative to men, women in the EC do well in comparison with women elsewhere. Within the EC, the Nordic Member States have the highest rates of gender equality, in part because of high levels of education and income relative to men.

### **3. Selected Health Indicators**

Women in the EC enjoy a high level of health as measured by a variety of health indicators. Life expectancy has been rising continuously for decades and has reached 80 years, which is well over 6 years higher than the corresponding average for EC men. This average, however, hides considerable variation across the Member States, ranging from a high of 81.9 years in France to a low of 77.8 years in Denmark.

Infant mortality has also been improving to the point that the most recent data (1992) indicate that only 6.9 (female) children out of 1000 live births die before the age of 1 year. This is a decline of 68% since 1970. Maternal mortality rates have also declined significantly (79% since 1970) to 7 deaths per 100,000 women.

According to ratings of self-perceived health status, women in the EC regard themselves as healthy (or very healthy). On average just over 62% report being in good or very good health. Rates vary across the Member States and across age-groups, with older women reporting lower levels of health, which is to be expected.

Height measurements indicate that women have been getting considerably taller during the past decades. Younger cohorts (18-29 year-olds) are almost 5 cm taller than older cohorts (60 years and older).

### **4. Morbidity**

Disease-specific morbidity measures are virtually non-existent at the EC level. Instead aggregate measures, such as short- and long-term disability and health care utilisation, are reported.

In spite of women's generally good health status, they report significant levels of disability due to long-term illness. On average, almost one out of four women report limitations in their daily activities to some extent (17.3%) or severely (6.3%) because of long-standing illness. This average varies from a high of 30% (in Finland and Portugal) to a low of 15% (in Luxembourg) and increases with age. More than half of all women aged 75 years and older report such activity limitations.

On a short-term basis, women also report considerable activity limitations. About 14% of women report having had to cut down on their activities in the past two weeks because of illness and injury, while 3% report having experienced such restrictions because of emotional or mental health problems. Among women aged 65 years and older, the corresponding figures are 25% and 5% respectively.

While not all chronic and short-term disability necessarily needs a doctor's attention, apparently a significant amount does. The results of the 1996 Eurobarometer survey indicate that on average one out of three women has consulted with a physician (in person or by telephone) in the past two weeks. Not surprisingly, older women report higher rates of consultation.

A small percentage of serious illnesses is likely to require hospitalisations. On average 10% of EC women report having had one or more (non-birth) hospitalisations in the past year, staying about 10 days in the hospital in total. Older women are about twice as likely as younger women to have been hospitalised, and they tend to stay longer as well.

## **5. Causes of Death and Trends in Female Mortality**

Across all ages, the most frequent causes of death among women are diseases of the circulatory system, accounting for 43% of all deaths, and cancer, which accounts for 26% of these. Diseases of the respiratory system are responsible for 6% of deaths among women, and suicide and accidents for 5%. The remaining 20% of deaths are due to other causes.

As might be expected, the major causes of death vary with age. Motor vehicle accidents are the main cause for women under 30 years, while suicide is for the 30-34 age-group. Cancer, specifically 'female cancers', such as breast and cervical cancer, is the main cause of death for women aged 35-64 years. For elderly women (65 years and older), diseases of the circulatory system account for most deaths, approximately half of all deaths in this age-group.

Average mortality (for all women) from motor vehicle accidents is 6.42 deaths per 100,000, while mortality from suicide and self-inflicted injury is 6.24 per 100,000. Mortality from cancer among women of all ages is about 150 deaths per 100,000, while mortality from diseases of the circulatory system (heart disease and stroke) is about 248 deaths per 100,000. Mortality due to ischaemic heart disease alone amounts to about 85 deaths per 100,000, while stroke mortality is almost 76 per 100,000.

Breast cancer accounts for 21% of all female cancer deaths in the EC, with a mortality rate of about 31 per 100,000. By contrast, cervical cancer is responsible for only about 2% of all cancer deaths in women, with a mortality rate of about 3 per 100,000.

Mortality from cancer of the respiratory system - predominantly lung cancer - has increased by almost 70% since 1970. It currently accounts for about 9% of all cancer deaths in women, with a mortality rate of 14 per 100,000.

## **6. Health Determinants and Health Promotion**

To a very large extent the two major causes of mortality (heart disease and cancer) are preventable through primary (healthier life styles) or secondary prevention (early detection through, for example, screening). The main risk factors associated with much premature mortality (death before aged 65 years) include smoking, (excessive) alcohol consumption, unhealthy diet, and physical inactivity.

About 28% of all women in the EC smoke, although the rate varies across the Member States. Denmark and Portugal stand out because of their respectively very high (42%) and low rates (12%) of smoking among women. There are no data on average alcohol consumption by women at the EC level, although it is known that women drink less than men.

While data on diet are scarce, data on the outcome of eating patterns (weight) are available from the 1996 Eurobarometer. Specifically, one out of every five women are overweight (or severely overweight) as measured by the body mass index (BMI), while

15% are underweight. Being overweight is a significant risk factor for a number of diseases, in particular heart disease and diabetes.

This survey also provided information about the extent to which, and what types of health check-ups EC women receive. These vary by age-group and by country. For example, 44% of EC women over the age of 65 years has had a heart check-up in the past year, about the same percentage as has had a cholesterol test. The rates for the entire population of women are, of course, lower.

Diabetes testing is less frequent, with around 22% having had a diabetes test in the past year, although among severely overweight women (aged 40 years and older) the rate is 44%. As obesity is a risk factor for non-insulin dependent diabetes, this is to be expected.

About 16% of EC women report having had an osteoporosis test in the past year. In contrast, cancer screening rates are much higher. About 40% of women report a cervical smear in the past year, the same percentage as reporting having had a breast examination by hand. About 18% of women report having had a mammography during the past year.

Because controversy surrounds the topic of mammography in many Member States, the Eurobarometer survey inquired about women's feelings on the subject. Overwhelmingly (more than 90%), and with little variation, women endorsed (free) mammography screening in the age-groups where it has the potential to reduce mortality.

## **7. Special Issues in Women's Health**

Several health issues have emerged during the past decades because of their particular relevance to or importance for women. These include eating disorders, which mostly afflict teenage and young women; HIV and AIDS, which traditionally has been considered a male disease, but to which women have been shown to be more vulnerable; heart disease, which also is largely seen as a man's disease in spite of the significant mortality it causes to women; and osteoporosis which is much more frequent among women than among men. In addition to these issues, family planning and abortion, as well as violence against women, should be added to this list of important women's health issues.

There is a notable lack of data on the incidence and prevalence of eating disorders (bulimia and anorexia nervosa), although the perception is that it has been increasing throughout the EC during the past two decades. Mortality in anorexia sufferers is estimated at 6%, double that for those with bulimia.

With the ageing of society, the incidence of osteoporosis is increasing. Because of the significant morbidity and mortality associated with this disease, osteoporosis is becoming a growing concern for many Member States. Hormone replacement therapy (HRT) contributes to preventing osteoporosis, but its use is still debated by health care providers. Furthermore, women seem to feel less than adequately informed about the costs and benefits of this type of therapy (according to results of the 1996 Eurobarometer survey).

## **8. Conclusions**

This report has sought to provide as comprehensive an overview of women's health issues as possible, given the available data. It is clear that while women live long lives and report feeling quite healthy, they also have significant disability due to chronic illness. Health, as



measured by a variety of indicators, typically varies across Member States as well as across age-groups. Not surprisingly, elderly women are in poorer health.

The report has also pointed to a number of policy initiatives which could help reduce the premature mortality among women in the EC.

# 1. INTRODUCTION

## 1.1 Background

This report provides an overview of the health of women in the European Community (EC), highlighting both differences and similarities within and between the Member States. It examines the main causes of mortality and morbidity as well as a number of individual and social determinants which influence women's health within the context of evolving demographic and social trends. This approach helps to highlight those health issues that are more prevalent among women (e.g., eating disorders, breast cancer, osteoporosis, sexual abuse, and consequences of domestic violence), those problems that are unique to women (e.g., reproductive health, cervical and ovarian cancer, and menopause), and those which appear to affect women differently from men (e.g., cardiovascular diseases and HIV/AIDS).

Women's health has improved significantly during this century, as evidenced by a considerable increase in life expectancy and a decrease in premature mortality, including maternal and child mortality. Women in the EC have a higher life expectancy than men, on average between 5 to 7 years. Yet the last two decades have seen a reappraisal of women's health and the health policies and services directed towards them, based on the growing recognition that women's health needs and concerns are different from those of men. A recent survey (Eurobarometer 44.3/1996)<sup>a</sup> asked women in the EC whether they thought that women's health issues received sufficient attention in their country. More than one out of three responded negatively (or were uncertain) (Figure 1.1). Not surprisingly, the distribution of responses (Figure 1.2) varied across the 15 Member States with almost 50% of Irish women indicating that *insufficient* attention was given to women's health issues (Table 1.1), compared to only about 12% of Danish women. These results are interesting considering that Danish and Irish women have among the lowest life expectancies in the EC (see Section 3.1). Apparently, other factors influence women's perceptions of this issue. It should be noted that the Irish government recently has issued a special health policy for women, the first of its kind in the EC<sup>1</sup>.

The stronger focus on women's health has taken place within a broader context of profound societal and demographic changes. These include the post-industrial development of Western Europe, women's increased participation in the labour force since the 1960s, and changing gender relations within both private and public life. Demographic trends highlight the ageing of society (including the feminization<sup>b</sup> of the older age-group), declining fertility rates, decreasing family sizes, older ages for first marriages, and increasing divorce rates. These features have dramatically changed the face of Western society and the position of women and men alike.

## 1.2 Women's Health

Although data on women's health are still incomplete, a clearer picture of their health in comparison to men's is emerging. Women experience higher rates of chronic illness and

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<sup>a</sup> See Section 1.4 for further details concerning the Eurobarometer survey.

<sup>b</sup> Feminisation of older age refers to the fact that due to differing mortality rates, the elderly population is predominantly made up of women. See Section 2.1 for further details.

disability than men, which cannot solely be ascribed to their longevity. They also have a more negative perception of their health than do men. Increasingly, evidence indicates that much biomedical knowledge of ill health - with the exception of biological health issues unique to women - is derived from research based on the male prototype. This has overlooked the influences of gender differences in diagnoses, treatments, and health outcomes. Women's patterns of disease and mortality are changing as well. Lung cancer, for example, is increasingly becoming a cause of female mortality, influenced by higher rates of smoking, especially among younger women.

Women make greater use of health services than do men (both on their own behalf and in their role as carers for children and elderly parents), and their participation in the labour force of the health sector greatly exceeds that of men. However, they are under-represented in the higher managerial and medical echelons which limits their influence on health policy development. Women are also more involved in and spend more time delivering unpaid care for the family, the elderly, and the community.

Despite their growing paid labour force participation, women continue to spend more time carrying out household tasks and have less leisure time than men. Furthermore, women's economic and social status is generally worse than that of men, and they experience poverty more often and are more frequently financially dependent on men and/or social welfare provisions. These conditions constrain their choices in life, including healthy lifestyles. The influence of these features on women's health and vice versa is, however, not adequately understood.

Awareness of these issues has contributed to a growing focus on women's health, characterised by many efforts to prioritise women's health on the political, social and biomedical agenda in the last two decades. The United Nation's (UN) Decade for Women (1976-1985) helped to highlight women's health. Similarly, the World Health Organization's (WHO) 1978 targets for Health for all by the Year 2000 included a specific health target for women. More recently, the UN's Fourth World Conference on Women, in Beijing in 1995, continued this emphasis, adopting an action programme which included an objective<sup>a</sup> to give priority to educational programmes aimed at, among other things, helping women make their own decisions and take responsibility for their health and fertility.

At the Community level a number of activities have been initiated recently related to the improvement and protection of women's health; for example adoption of the Council Directive on maternity leave<sup>2</sup>, the priority given to elderly women within the strategy on the elderly<sup>b</sup> <sup>3</sup>, and the network on breast cancer screening of the 'Europe Against Cancer' Programme<sup>4</sup>.

### **1.3 Indicators and Determinants of Women's Health**

Effective health policies and programmes (and their evaluation) increasingly rely on objective measures to describe the health status of populations and variations in health.

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<sup>a</sup> This objective is consistent with the major objectives of the European Union before, during, and after the Beijing conference.

<sup>b</sup> See, for example, European Year of the Older People, in 1993 and the forthcoming year of the United Nations International Year of Older People in 1999<sup>3</sup>.

Comparisons between (sub)populations and nations are also increasingly undertaken in order to assess the prevalence of various diseases, to understand the underlying causes, and to evaluate the impact of preventive health strategies.

While efforts towards standardising data to enable European and international comparisons have been initiated, truly comparable data are still scarce. This report, which utilises existing and new health data and indicators at the EC level, is therefore necessarily limited in its choice of topics. It is also limited to women aged 15 years and older because most gender-specific health data at the EC level focus on this age-group. Finally, in the interest of saving space, comparisons between men and women's health status are made only when they are of particular interest.

## 1.4 Information Sources

This report has drawn upon many existing health and health-related primary and secondary information sources. The level of aggregation varies, ranging from regional, national, to Community and international levels. Although the focus has been on quantifiable and comparable health indicators and determinants for women, qualitative information has also been used. References to the specific information sources are cited at the end of each section as well as in the bibliography at the end of the report.

The main data sources include the Health for All (HFA) Database (WHO, 1996)<sup>5</sup>, various reports and data published by the Statistical Office of the European Communities (Eurostat), as well as data from the first (1994) wave of Eurostat's European Community Household Panel (ECHP) survey, The World Women's 1970-1990 statistics<sup>6</sup> published by the UN, and data provided by different monitoring centres, such as the International Agency of Research on Cancer (IARC) in Lyon, and the European Centre for the Epidemiological Monitoring of AIDS in Paris. Finally, an important source of data for this report is an EC-wide Eurobarometer survey carried out in early 1996. This survey asked a representative sample of non-institutionalised persons (about 1000) in each Member State<sup>a</sup> a number of questions on health, including attitudinal questions, self-reported health status, and preventive health services received in the past year.

Despite continuing improvements in the availability and comparability of health indicators and determinants, many constraints remain. They include the lack of data on many issues of importance to women's health, for example, menopause and eating disorders (see Section 7), and/or specific groups, e.g., migrant women. There are also many gaps with regard to morbidity and survival statistics, and life style determinants both overall and gender-related. In addition, there are insufficient health-related data by gender, needed to study, for example, the relation between employment, stress, and health.

Where possible, information has been obtained for all the 15 Member States. In these cases results have generally been reported both for the Member States and the EC as a whole. Data for Germany before 1990 usually refer to the Federal Republic of Germany, and after 1990 to the Federal Republic, including the acceding territories, unless otherwise stated. There is, however, one important exception: the Eurobarometer results differentiate between the former German Democratic Republic and the pre-unification Federal Republic of Germany. This differentiation has been retained because the results

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<sup>a</sup> For the former German Democratic Republic and the pre-unification Federal Republic of Germany the sample size was 1000 persons each.

reflect important continuing differences in certain health and health-related indicators produced by the many years of separate statehood.

In all instances, the most recent data available have been used. In some cases, these data are several years old (e.g., the WHO mortality data are from 1992) while in others they are current (e.g., the 1996 Eurobarometer data).

## 1.5 Structure of the Report

This report is divided into 8 sections. Section 1 describes the aims, background, methods, and structure of the report, while Section 2 summarises the social and demographic trends of importance to women at different stages of their lives. Section 3 outlines a number of selected health indicators of relevance to women, including life expectancy, infant mortality, and self-perceived health status. Supplementing this information, Section 4 describes selected morbidity measures, including disability due to long-term illness, short-term restricted activity measures, and hospitalisations. Section 5 reviews causes of death for women of different ages. Section 6 contains a discussion of various health determinants, e.g., factors such as smoking and drinking as well as various screening programmes. Section 7 analyses a number of issues of particular concern for women at different stages of their life. Section 8 concludes the report. The Annexes contain a glossary of technical terms, a list of tables and figures, as well as the bibliography.

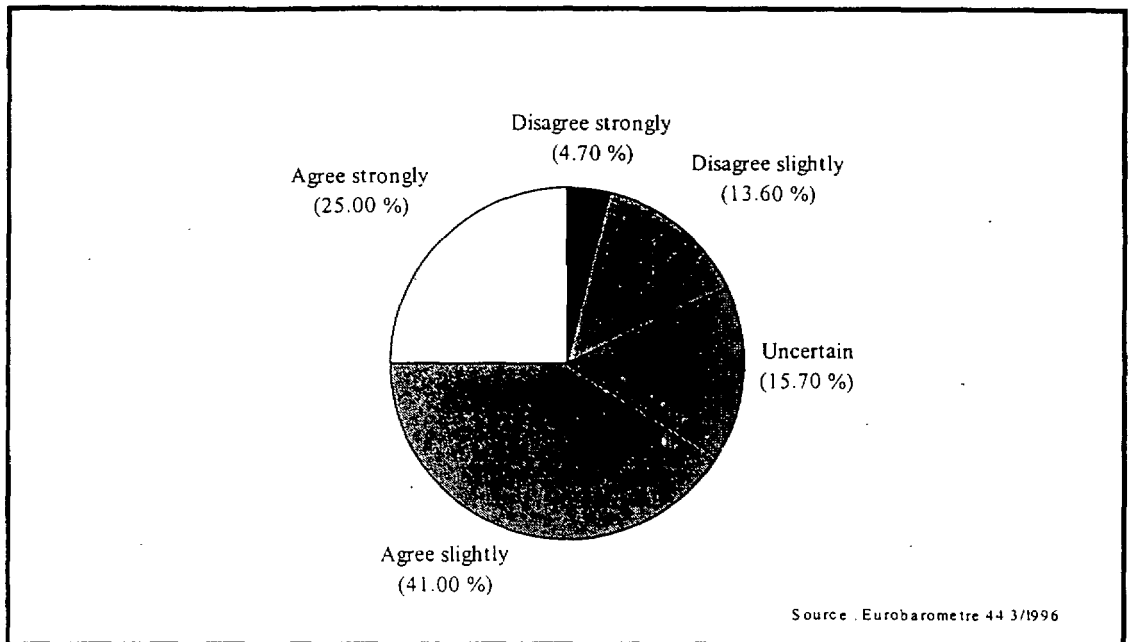
Throughout the report, numbered references are presented at the end of each section, while lettered footnotes appear at the bottom of each page. Figures and tables follow the references at the end of each section.

## References

- 1 Irish Department of Health (1995), *Developing a Policy for Women's Health: A Discussion Document*, Dublin: Stationary Office.
- 2 Commission of the European Communities (CEC), Directive 92/85/EEC, 10 Oct. 1992, Official Journal no. L 348 of 28 Nov. 1992.
- 3 Dooghe, G. and Appleton, N. (1995). *Elderly Women in Europe. Choices & Challenges*, Leuven: Centrum voor Bevolkings- en Gezinsstudies.
- 4 *European Journal of Cancer Prevention* (1994), Vol 3, Supplement 1.
- 5 See also for example: WHO (1994), *Health in Europe*, European Series, No. 56, Regional Publications, Copenhagen: WHO, Regional Office for Europe.
- 6 United Nations (1991), *The World's Women 1970-1990, Trends and Statistics*, New York: United Nations.

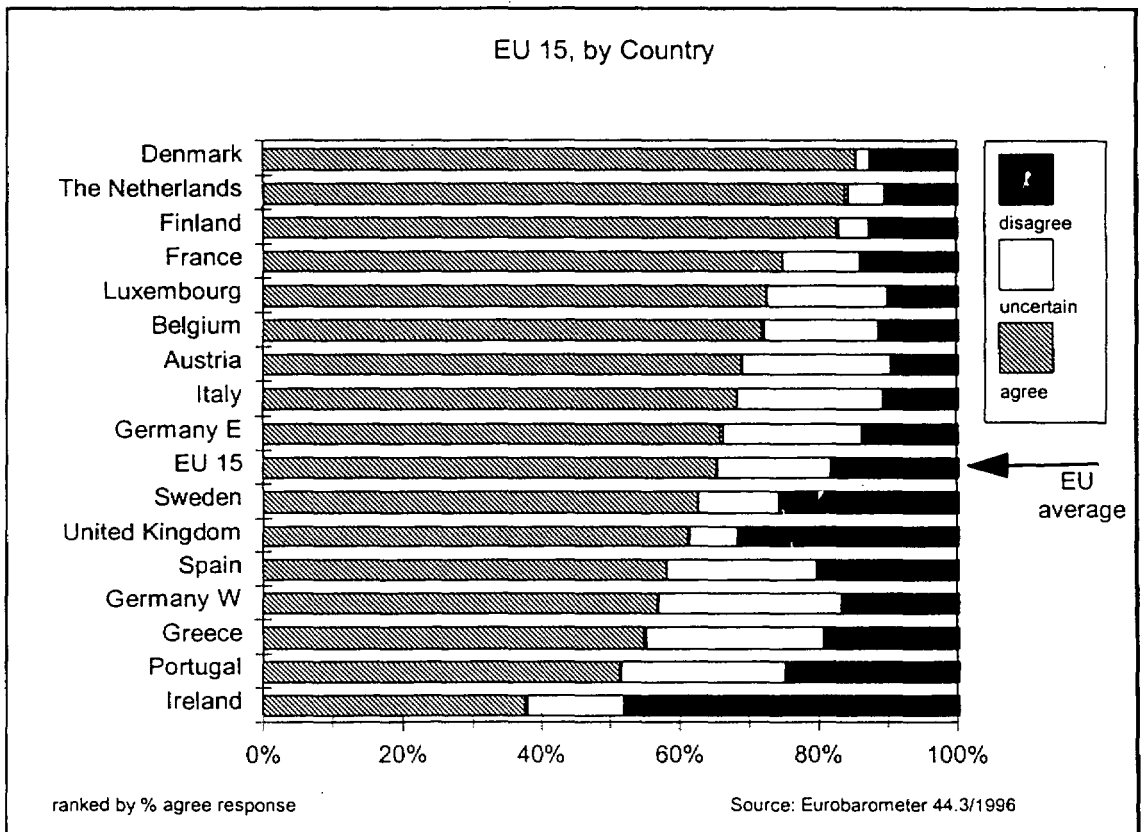
## [Figures and Tables ]

**Figure 1.1**  
**Sufficient Attention for Women's Health 1996 (\*)**  
**Women 15+ Years, EU 15**



(\*) : Distribution of responses of rating of the extent to which the respondent agreed/disagreed with the following statement : "In (country) sufficient attention is given to women's health issues, such as breast and cervical cancer"

**Figure 1.2**  
**Sufficient Attention Given To Women's Health, 1996 (\*)**  
**Women 15+ Years**



(\*) : Distribution of responses of rating of the extent to which the respondent agreed/disagreed with the following statement : "In (country) sufficient attention is given to women's health issues, such as breast and cervical cancer"

**Table 1.1**  
**Sufficient Attention Given To Women's Health, 1996(\*)**  
**Women 15+ Years**

	disagree strongly	disagree slightly	uncertain	agree slightly	agree strongly
	%	%	%	%	%
Denmark	3.8	8.7	2.0	33.3	52.2
The Netherlands	4.3	6.1	5.6	33.5	50.5
Finland	1.7	11.0	4.5	53.3	29.6
France	1.4	12.6	11.2	54.4	20.4
Luxembourg	1.6	8.4	17.4	48.7	23.9
Belgium	2.5	8.8	16.9	50.3	21.5
Austria	1.2	8.2	21.6	36.2	32.8
Italy	5.1	5.6	21.0	26.2	42.1
Germany E	2.6	11.1	20.3	49.5	16.5
<b>EU 15</b>	<b>4.6</b>	<b>13.6</b>	<b>16.4</b>	<b>42.9</b>	<b>22.5</b>
Sweden	4.8	20.9	11.6	42.6	20.1
United Kingdom	10.1	21.6	7.1	45.0	16.2
Spain	3.3	17.0	21.6	40.5	17.6
Germany W	1.7	14.9	26.5	41.2	15.6
Greece	4.6	14.7	25.8	31.5	23.4
Portugal	5.0	19.9	23.8	45.2	6.2
Ireland	20.7	27.4	14.4	27.2	10.4

(\*) : Respondents were asked to rate the extent to which they agreed (disagreed) with the following statement : "In (country), sufficient attention is given to women's health issues, such as breast and cervical cancer" (Eurobarometer 44.3/1996)



## 2. SOCIAL AND DEMOGRAPHIC TRENDS

This Section provides background information about demographic and social trends that concern women. Information about life expectancy and infant mortality, often defined as part of demographic statistics, is presented in Section 3 which focuses on selected health indicators.

### 2.1 Population Size and Structure

When the European Community admitted three new Member States, (Austria, Finland, and Sweden), on 1 January 1995, the overall population increased from approx. 350 to 372 million (6.3%). Women accounted for just over half (50.9%) of this increase, their number growing from 179 to 190 million. Thus, as before the expansion, women constitute 51.2% of the population in the EC. This percentage is remarkably stable across the Member States, varying slightly from a low of 50.4% in Ireland to a high of 51.8% in Portugal (see Table 2.1).

However, women make up varying proportions of the population at different ages. The under 20 age-group comprises 95 women for every 100 men. This over-representation of men in the population continues through age 39. In the 40 to 59 age-group, there are 100 women for every 100 men, but from there on the over-representation of women increases drastically to reach about 221 women for every 100 men among 80-year-olds. (see Figure 2.1).

This so-called feminization ratio is virtually identical for the under 20 year-olds across the Member States, but varies considerably in the 60 years and older age-group. Germany and Austria have the highest feminization ratio while Greece and Ireland have the lowest (see Figure 2.2).

The high feminization ratio in the older age-group is in part the result of the difference in life expectancy between men and women. On average, women in the EC live more than 6 years longer than men with the result that they are over-represented in the higher age-groups (for further details on life expectancy see Section 3).

This tendency for women to live longer than men is also apparent from the age distribution of the two sexes. As shown in Table 2.2, 23.6% of women are 60 years or older, while the corresponding percentage for men is only 17.8%. This relationship may change over time as the population ages, because as also shown in Table 2.2, the percentage of men over 60 years is increasing faster than the percentage of women over 60 years. From 1991 to 1996, the percentage of men over 60 years grew by 5.5%, while the corresponding increase for women was 2.7%.

### 2.2 Family Life

At the same time as the population is ageing, changes are also taking place in relation to family life. Most noteworthy is the significant decline in the marriage rate, which has declined by almost one third, between 1960 and 1995, from about 8 to 5.1 marriages per

1000 population. This decline has occurred fairly uniformly across all Member States, with Germany experiencing the greatest decline and Greece the smallest (see Table 2.3).

Concomitant with the decline in the marriage rate has been an increase in the age of first marriage from 24 to just over 26 years (see Table 2.3). Here Denmark and Sweden are notable in the EC for having the highest age at first marriage (28.1 and 28.5 years, respectively in 1994) as well as highest increase since 1960 in the age of first marriage.

Despite the decline in the marriage rate and the increase in the age of first marriage, the divorce rate has more than tripled since 1960, from 0.54 to 1.8 per 1000 population. As was the case with the marriage rate, the EC average obscures considerable differences across the Member States. Ireland stands out from the rest because divorce is illegal<sup>a</sup>. Southern Member States like Greece, Italy, and Spain have lower divorce rates, while the Nordic countries - Denmark, Finland, and Sweden, and the United Kingdom (UK) - top the list.

The results of these trends can be seen in Figure 2.3 which shows a large increase in single-person households as well as single-parent families between 1960 and 1995. Also shown in this figure is the large increase in the percentage of births occurring outside marriage, a trend that along with the increasing divorce rates; contributed to the increase in single-parent households.

The increase in bearing children out of wedlock was not the only change to occur during this period. Women's total fertility rate declined by 45%, from 2.59 to 1.43 children per woman. As a result, the total number of births fell by more than 1.7 million, or almost 31% to just under 4 million births per year (see Figure 2.3 and Table 2.4).

While there has been an overall decline in the total fertility rate in all Member States since 1960, the timing of this decline has varied greatly. As can be seen in Figure 2.4, Ireland in particular, has experienced this decline only in the 1990s, while most of the other Member States experienced the greatest declines in the 1960s or 1970s. It is also interesting that the Nordic countries which for a while had the lowest total fertility rates now have the highest. This is particularly curious because, as will be seen below, these countries have the highest labour force participation rates, something which traditionally has been associated with lower total fertility.

It is also not possible to attribute this increase in fertility rates in the Nordic countries to low levels of contraceptive use, which might have been one of the reason for Ireland's relatively recent fertility decline because, as Table 2.5 shows, a greater share of Nordic women report using contraception compared to women in the other Member States.

Table 2.5 also shows the age of first birth, which increased slightly (0.5 years) to 28.7 years between 1990 and 1994, probably as a result of the increase in the age of first marriage. Finally, the table shows the percentage of live births to teenage mothers, which varies considerably across the Member States, with the Netherlands reporting the lowest percentage (1.38%) and Portugal the highest (7.48%) (see also Section 7.3).

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<sup>a</sup> Legislation to allow divorce under certain circumstances has been introduced in the Irish legislature following a referendum in 1995.

## 2.3 Working Life

Changes have also been occurring in the working life of women, both those with children and those without. Some Member States, notably the Nordic countries, saw increased labour force participation rates as early as the 1960s, while others experienced such trends only in the 1970s and 1980s. As shown in **Table 2.6**, female employment has continued to grow into the 1990s, although two countries (Finland and Sweden) with very high rates of female labour force participation have actually experienced a decline since the mid-1980s. Women are also becoming increasingly active in starting up and running their own businesses: up to 30% of all enterprises across the Member States are managed by women and approximately a third of all new enterprises are started by women<sup>1</sup>.

In spite of the increases in employment (and labour force participation), large differences continue to exist between the Member States. The Nordic countries - Denmark, Finland, and Sweden - have by far the highest labour force participation rates, (more than 70% of women are in the labour force), while Greece, Ireland, Italy, Luxembourg, and Spain have the lowest rates (around 40-45%).

These differences are even greater for part-time employment. As shown in **Table 2.7**, the vast majority (70-90%) of part-time work is undertaken by women. When considered as a proportion of total employment, it is clear that the Netherlands far exceeds the rest of the EC, with more than 60% of employed women in part-time work. Other countries with a large proportion of women in part-time work include the UK (45.2%), Sweden (41.4%) and Denmark (36.7%). Greece, Finland, Italy, Portugal, and Spain have the lowest rates (less than 15%).

**Figure 2.5** shows the overall increase in part-time work for women (and men) between 1975 and 1991. During this period, women's part-time work increased from just over 20% to about 28%. This figure also shows the development in unemployment and temporary work, both of which roughly doubled between 1975-1991. With respect to unemployment, women have been much harder hit than men.

**Table 2.8** shows the development in unemployment rates between 1983 and 1993 in all the Member States. Only five countries report female unemployment rates in 1993 of less than 7% (Austria, Luxembourg, Portugal, Sweden and the UK). Others tend to hover around the 10-15% mark, with the notable exception of Spain, where the rate is almost 30%. In comparison to men, women have higher unemployment rates in all but three Member States (Finland, Ireland, and Sweden).

The situation of young women (under 25 years of age) is worse in the sense that the absolute level of unemployment is considerably higher than that for the overall female labour force. This is also clear from **Figure 2.6** which shows the distribution of activity across all the age-groups of the population in 1994.

## 2.4 Gender-Related Development Indices

Existing gender differences among Member States (except Germany) and their relative ranking world-wide, based on selected indices from the Human Development Report 1995<sup>2</sup>, are illustrated in **Table 2.9**.

The Human Development Index (HDI) is a way of assessing and ranking countries according to a number of selected social and economic indicators (health, income and education). Canada, the USA, and Japan are the three highest ranking countries, with two Member States, the Netherlands and Finland, in fourth and fifth place.

When the HDI is adjusted for gender using the Gender Development Index (GDI), however, a different picture emerges. The Nordic Member States, Sweden and Finland, top the list both within the Community and world-wide. The Netherlands drops dramatically on the GDI to ninth place within the Community, thus indicating a relatively high level of gender inequality.

The Gender Empowerment Measure (GEM), another gender-based index, indicates disparities related to economic and political decision-making. The Nordic Member States are again positioned at the top. However, the GEM does not mirror the GDI for all Member States. France, for example, ranking fourth on the GDI scale within the Community, occupies the lowest place on the GEM index. This represents the highest discrepancy within the Community between women and men with regard to women's parliamentary representation, their level of professionalisation, and their earning power.

Gender equality is highest in the Nordic Member States and is attributable to high female educational enrolment rates since the 1970s and relatively low disparity between women and men with regard to the percentage of shared earned income.

Although these indices are not flawless, they do indicate that gender inequality continues to exist both within and between the Member States, despite the progress made during the second half of this century. These inequalities appear less pronounced in relation to basic health and education, but are more strongly visible in the area of income distribution and economic and political representation. It should be noted that gender equality does not depend on income (GDP), because, as shown in **Table 2.9**, Luxembourg, which ranks highest with respect to basic purchasing power (real GDP per capita), ranks lowest in the Community with respect to GDI.

## **References**

- 1 European Observatory for SMEs, *Fourth Annual Report 1996*, p. 330.
- 2 United Nations Development Programme (1995), *Human Development Report 1995*, New York, Oxford University Press.

## [Figures and Tables]

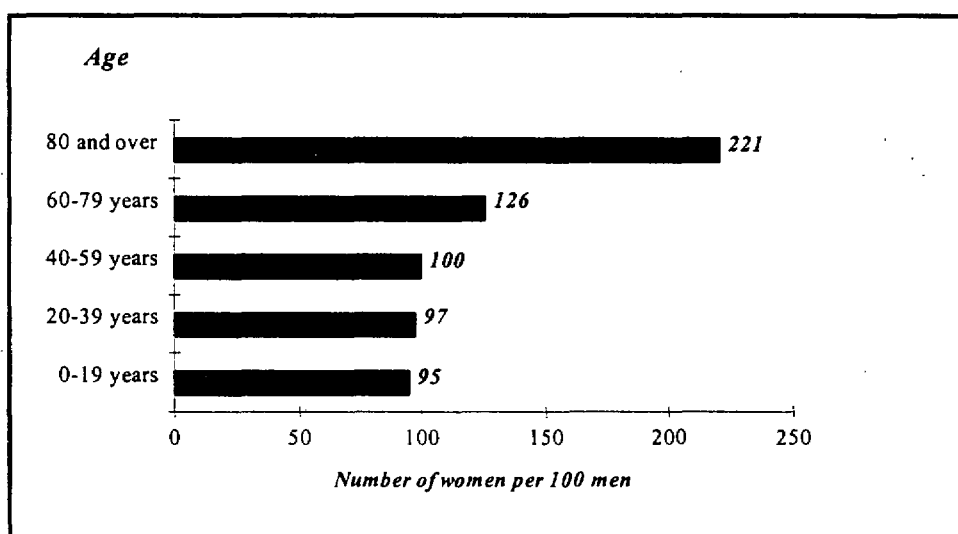
**Table 2.1**  
**Women in the Total Population**  
**of the European Union 1996 (EU 15)**

Country	Total Population	Number of Women	Women in %
<b>EU 15</b>	<b>372,653,590</b>	<b>190,739,240</b>	<b>51.18</b>
Portugal	9,920,760	5,143,280	51.84
Austria	8,054,800	4,147,630	51.49
Italy	57,333,000	29,515,580	51.48
Germany	81,817,500	41,992,680	51.32
France	58,255,880	29,891,710	51.31
Finland	5,116,830	2,625,130	51.30
Belgium	10,143,050	5,184,260	51.11
Spain	39,241,930	20,037,940	51.06
United Kingdom	58,693,970	29,908,290	50.96
Luxembourg	412,800	210,200	50.92
Greece	10,465,060	5,300,110	50.65
Denmark	5,251,030	2,658,800	50.63
Sweden	8,837,500	4,471,430	50.60
Netherlands	15,493,890	7,831,600	50.55
Ireland	3,615,600	1,820,600	50.35

Source : Eurostat 1997

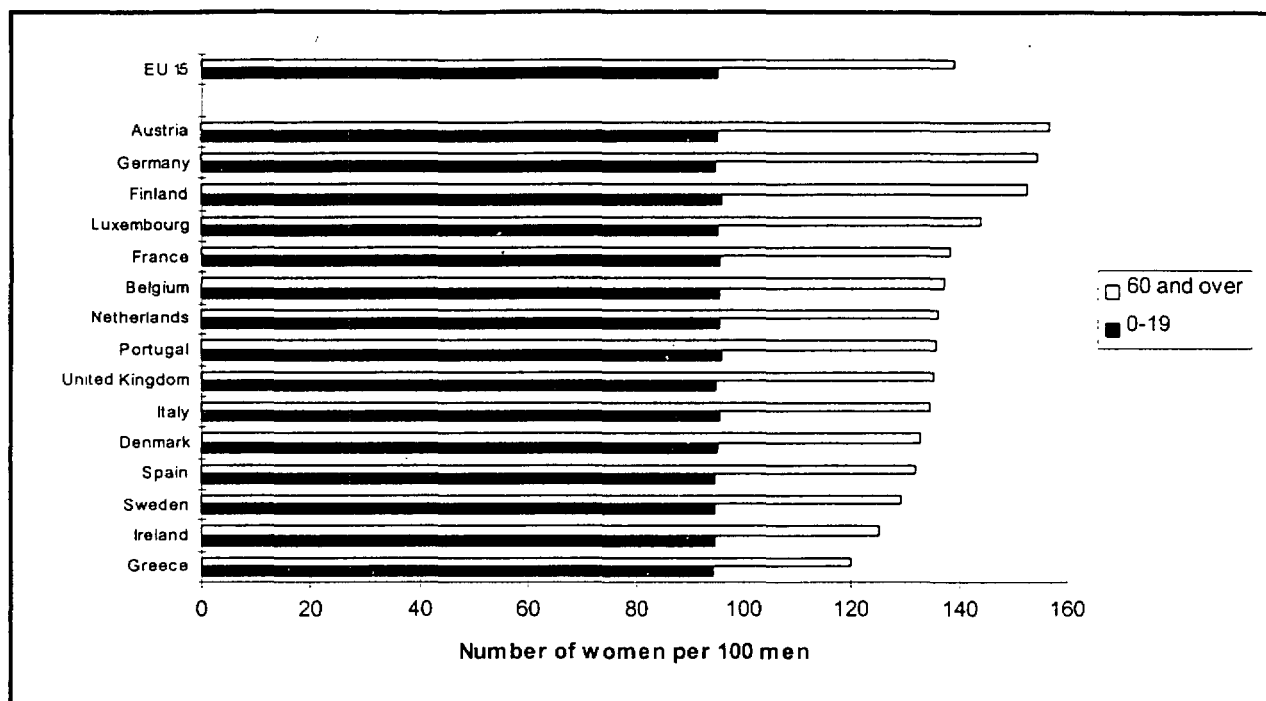
Note : The countries are in descending order of % women in the population.

**Figure 2.1**  
**Feminisation Ratio, 1996 (EU 15)**



Source : Eurostat 1997

**Figure 2.2**  
**Feminisation Ratio in the 0-19 Years and 60+ Years**  
**Age-Groups, 1996 (EU15)**



Source : Eurostat 1997

**Table 2.2**  
**Female and Male Population in the EU (15)**

Age-Group	Women %		Men %	
	1991	1996	1991	1996
0-19 years	23.9	22.6	26.4	24.9
20-39 years	29.2	29.2	31.6	31.6
40-59 years	23.9	24.6	25.0	25.7
60 and over	23.0	23.6	16.9	17.8
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

Source : Eurostat 1997

**Table 2.3**  
**Marriages and Divorces in the EU (15), 1960-1995**

Country	Marriages				Average age at First Marriage (women)		Divorces			
	Number in 1995	Difference since 1960 (%)	Rate in 1995 (o/oo)	Difference since 1960 (%)	in 1994	Difference since 1960 (years)	Number in 1995	Difference since 1960 (%)	Rate in 1995 (o/oo)	Difference since 1960 (%)
EU 15	1,901,000 <sup>†</sup>	- 24.1	5.1 <sup>†</sup>	- 54.4	26.1 <sup>1</sup>	2.0	677,500 <sup>†</sup>	297.7	1.8 <sup>†</sup>	237.7
Austria	42,900	-26.6	5.3	-55.6	25.8	1.8	18,200	127.2	2.3	99.0
Belgium	51,500	-21.0	5.1	-40.7	25.2	2.4	35,000 <sup>2</sup>	662.3	3.5 <sup>2</sup>	586.0
Denmark	34,700	- 3.2	6.6	-18.0	28.9	6.1	13,000	94.2	2.5	70.0
Finland	23,700	-27.7	4.6	-59.5	26.7	2.9	14,000	283.7	2.7	232.8
France	254,000 <sup>†</sup>	-20.6	4.4 <sup>†</sup>	-60.3	26.7	3.7	117,000 <sup>†</sup>	287.6	2.0 <sup>†</sup>	204.1
Germany	430,500	-37.5	5.3	-79.8	26.3	2.9	169,400	130.8	2.1	105.9
Greece	64,000	10.0	6.1	-14.2	25.6	0.4	11,000	346.4	1.1	255.0
Ireland	15,600	1.0	4.4	-25.2	27.0 <sup>2</sup>	- 0.6	-	-	-	-
Italy	283,000 <sup>†</sup>	-27.0	4.9 <sup>†</sup>	-57.4	26.1 <sup>1</sup>	1.3	27,000	-	0.5	-
Luxembourg	2,100	- 7.2	5.1	-40.7	26.3	-	700	375.2	1.8	264.1
Netherlands	81,500	- 8.6	5.3	-47.2	27.0	2.8	34,200	502.4	2.2	345.4
Portugal	65,800	- 5.3	6.6	-18.2	24.6	- 0.2	12,300	1545.1	1.2	1369.5
Spain	196,900 <sup>†</sup>	-16.9	5.0 <sup>†</sup>	-53.9	26.2 <sup>1</sup>	0.1	33,100 <sup>†</sup>	-	0.8 <sup>†</sup>	-
Sweden	33,600	-32.9	3.8	-75.9	28.5	4.6	22,500	151.5	2.6	113.1
United Kingdom	321,000 <sup>†</sup>	-18.4	5.5 <sup>†</sup>	-37.1	25.8 <sup>1</sup>	-	170,100 <sup>†</sup>	559.0	2.9 <sup>†</sup>	489.0

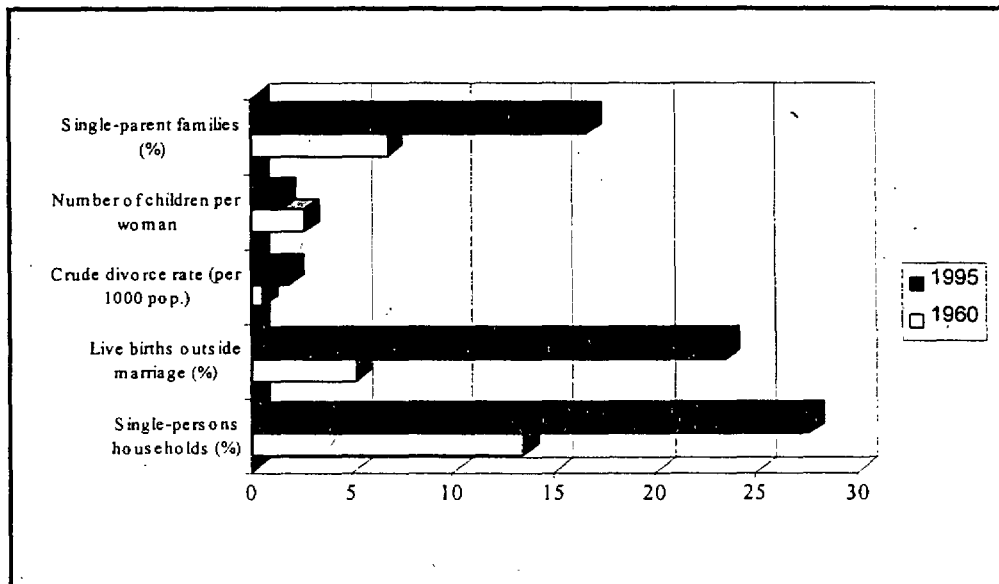
Source : Eurostat 1997

<sup>†</sup> provisional data  
1 1993

2 1992

\* estimate

**Figure 2.3**  
**Families Past and Present, EU 15**



Source : Eurostat 1997



***Table 2.4***  
**Births and Fertility in the EU (15), 1960-1995**

Country	Births		Percentage of births outside marriage		Fertility	
	Number in 1995	Difference since 1960 (%)	in 1995	Difference since 1960 (%)	Rate in 1995	Difference since 1960 (%)
<b>EU 15</b>	<b>3,999,000<sup>p</sup></b>	<b>-30.9</b>	<b>23.4<sup>*</sup></b>	<b>354.5</b>	<b>1.43<sup>*</sup></b>	<b>-44.9</b>
Austria	88,700	-29.6	27.4	110.2	1.40	-48.0
Belgium	114,700 <sup>p</sup>	-25.9	15.0 <sup>*</sup>	624.6	1.55 <sup>p</sup>	-39.5
Denmark	69,800	-8.3	46.5	494.2	1.80	-29.1
Finland	63,100	-23.2	33.1	719.8	1.81	-33.5
France	727,800 <sup>p</sup>	-10.8	36.1 <sup>1</sup>	491.8	1.70 <sup>p</sup>	-37.7
Germany	765,200	-39.3	16.1	112.4	1.25	-47.3
Greece	101,500	-35.5	3.0	145.2	1.32	-42.1
Ireland	48,500	-20.1	23.0	1347.2	1.87 <sup>p</sup>	-50.3
Italy	521,300 <sup>p</sup>	-42.7	8.1 <sup>p</sup>	233.1	1.17 <sup>*</sup>	-51.5
Luxembourg	5,400	8.0	13.1	314.2	1.69	-25.9
Netherlands	190,500	-20.3	15.5	1049.6	1.53	-51.0
Portugal	107,200	-49.9	18.7	97.6	1.40	-54.8
Spain	359,900 <sup>p</sup>	-45.5	10.8 <sup>1</sup>	365.8	1.18 <sup>*</sup>	-58.7
Sweden	103,400	1.2	53.0	369.5	1.73	-21.4
United Kingdom	732,000	-20.3	33.6	543.1	1.71 <sup>p</sup>	-37.3

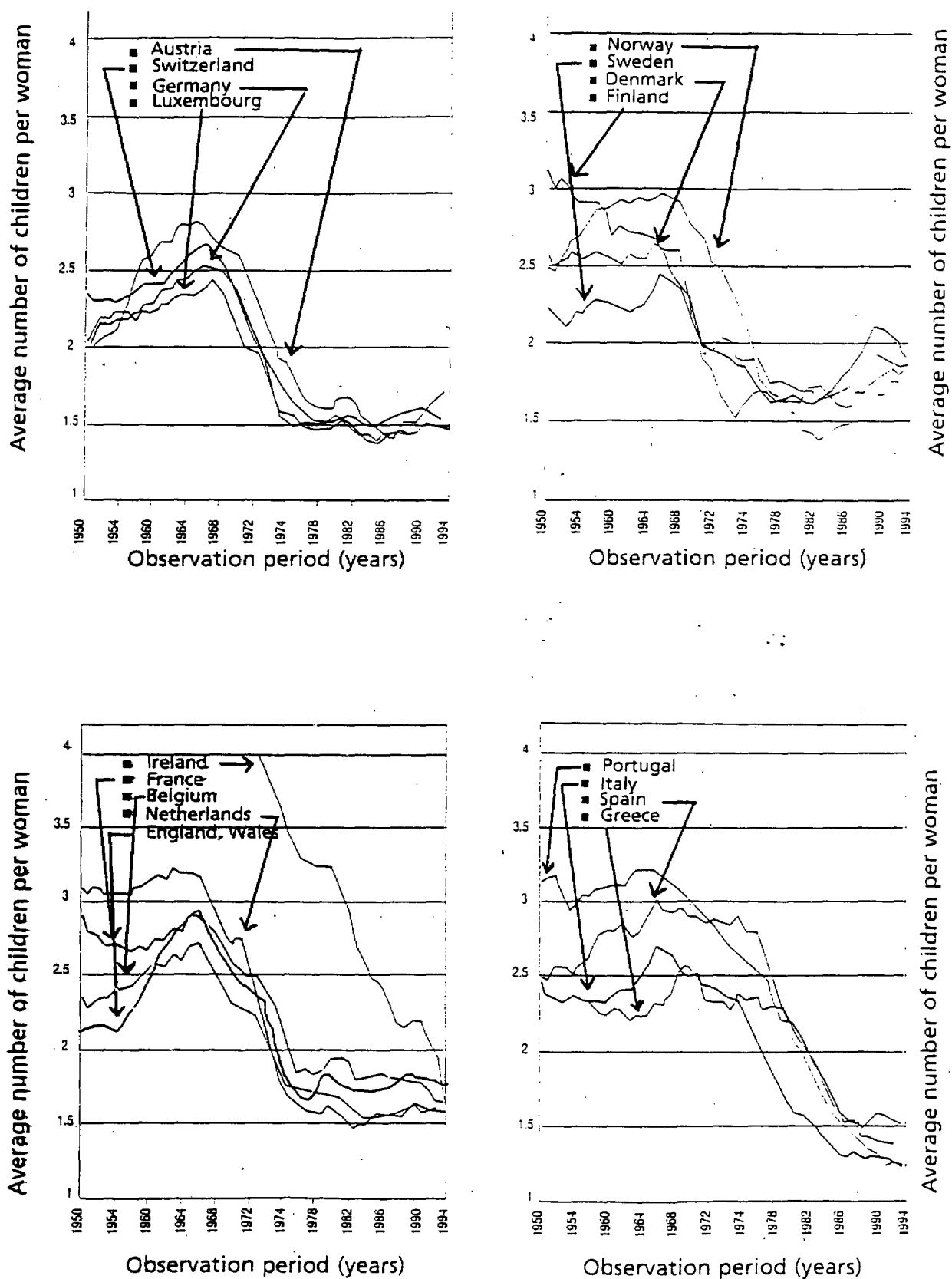
Source : Eurostat 1997

<sup>p</sup> provisional data

<sup>\*</sup> estimates

<sup>1</sup> 1994

**Figure 2.4**  
Trends in the economic indicator of fertility  
over the past 40 years



Source : The demographic situation in the European Union in 1995. European Communities. Luxembourg 1996

**Table 2.5**  
**Contraception Usage and Fertility (EU 15)**

Country	Women using contraception 1986-93 (%)	Average Age of Women at Childbirth		% Live Births to mothers under 20 1995
		1990	1994	
EU 15	-	28.2	28.7	3.84
Austria	71	26.7	27.5	4.39
Belgium	79	27.9	28.2*	2.40
Denmark	78	28.5	29.1	1.99
Finland	80	28.9	29.1	2.48
France	81	28.3	28.8 <sup>p</sup>	2.35*
Germany	75	27.6	28.2	3.48*
Greece	n/a	27.2	28.0	4.74
Ireland	n/a	30.1	30.3 <sup>p</sup>	5.11
Italy	78	29.0	29.6*	2.51 <sup>1</sup>
Luxembourg	n/a	27.9	28.8	2.12
Netherlands	76	29.3	29.9	1.38
Portugal	66	27.3	27.9	7.48
Spain	59	28.9	29.5*	3.55 <sup>1</sup>
Sweden	78	28.6	29.2	2.07
United Kingdom	81	27.7	28.1	6.38 <sup>1</sup>

Source : Human Development Report 1995; HFA 1996; and Eurostat 1997

<sup>p</sup> provisional data

\* estimate

<sup>1</sup> 1994

**Table 2.6**  
**Employment EU 15, (1993)**

**Women 15-64 years**

Country	Thousands	Change	Female participation rate*		
	1993	since 1983 %	1983 %	1993 %	% change
AUSTRIA <sup>1</sup>	3,724	13.1	49.7	58.0	16.70
BELGIUM <sup>1, 4</sup>	4,237	2.8	48.7	54.1	11.09
DENMARK	2,893	5.9	74.2	78.3	5.53
FINLAND	2,508	1.9	72.7	70.0	-3.71
FRANCE	25,213	6.3	54.3	59.0	8.66
GERMANY <sup>1, 3</sup>	38,682	8.1	52.5	61.3	16.76
GREECE	4,118	7.2	40.4	43.6	7.92
IRELAND <sup>2</sup>	1,334	4.9	37.8	39.9	5.56
ITALY <sup>1</sup>	22,787	1.2	40.3	46.5	15.38
LUXEMBOURG <sup>2</sup>	165	3.1	41.7	44.7	7.19
NETHERLANDS <sup>1</sup>	7,084	-	40.3	55.5	37.72
PORTUGAL	4,537	0.4	56.7	59.4	4.76
SPAIN	15,564	12.4	33.2	42.8	28.92
SWEDEN	4,320	1.3	76.6	75.8	-1.04
UNITED KINGDOM	28,179	5.9	57.2	64.8	13.29

<sup>1</sup> 1992

<sup>2</sup> 1991

<sup>3</sup> FRG to 1990

<sup>4</sup> 1992 1982

<sup>5</sup> 1991 1981

\* defined as female labour-force of all ages divided by female population aged 15-64 (in %)

**Table 2.7**  
**Part-Time Employment as % of Total Employment**  
**EU 15, (1993)**

Country	Both Sexes		Female		Male		Female part-time employment as a % of total part-time employment	
	1983	1993	1983	1993	1983	1993	1983	1993
AUSTRIA <sup>1</sup>	8.4	9.1	20.0	20.5	1.5	1.6	88.4	89.1
BELGIUM <sup>1</sup>	8.1	12.4	19.7	28.1	2.0	2.1	84.0	-
DENMARK <sup>1</sup>	23.8	22.5	44.7	36.7	6.6	10.1	84.7	75.8
FINLAND	8.3	8.6	12.5	11.2	4.5	6.2	71.7	63.1
FRANCE <sup>3</sup>	9.6	13.7	20.1	26.3	2.5	4.1	84.3	83.3
GERMANY <sup>1, 3</sup>	12.6	14.1	30.0	30.7	1.7	2.2	91.9	91.0
GREECE <sup>1</sup>	6.5	4.8	12.1	8.4	3.7	2.8	61.2	61.3
IRELAND <sup>2</sup>	6.6	8.4	15.5	17.8	2.7	3.6	71.6	71.6
ITALY <sup>1</sup>	4.6	5.9	9.4	11.5	2.4	2.9	64.8	68.5
LUXEMBOURG <sup>1</sup>	6.3	6.9	17.0	16.5	1.0	1.3	88.9	88.5
NETHERLANDS <sup>1</sup>	21.4	32.8	50.1	62.9	7.2	13.4	77.3	75.0
PORTUGAL <sup>4</sup>	6.0	7.3	10.0	11.2	3.4	4.3	65.9	67.3
SPAIN <sup>5</sup>	5.8	6.3	13.9	14.3	2.4	2.3	71.5	75.9
SWEDEN	24.8	24.9	45.9	41.4	6.3	9.1	86.6	81.3
UNITED KINGDOM <sup>1</sup>	19.4	24.0	42.4	45.2	3.3	6.5	89.8	85.1

<sup>1</sup> 1992

<sup>2</sup> 1991

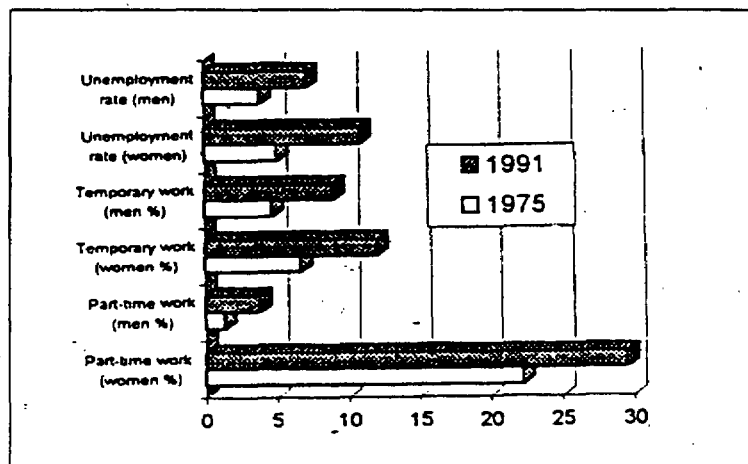
<sup>3</sup> FRG to 1990

<sup>4</sup> 1986

<sup>5</sup> 1987

Source - OECD 1994/ 1995

**Figure 2.5**  
**Changes in Employment (EU)**



Source - COM (96) 60 final

**Table 2.8**  
**Unemployment Rates**  
**EU 15, (1993)**

Country	Both sexes		Female		Male		Youth Unemployment rates			
	% of total labour force		% of total female labour force		% of total male labour force		(Under 25) % of youth labour force			
	1983	1993	1983	1993	1983	1993	Female		Male	
	1983	1993	1983	1993	1983	1993	1983	1993	1983	1993
AUSTRIA	4.1	4.2	5.1	4.5	3.5	4.0	-	-	-	-
BELGIUM <sup>1</sup>	13.2	10.3	18.3	14.2	10.0	-	28.5	19.7	19.1	17.4
DENMARK	11.4	10.7	12.3	11.1	10.7	10.3	19.3	14.6	17.8	14.3
FINLAND	5.4	17.7	5.2	15.6	5.6	19.5	10.8	11.3	10.3	15.4
FRANCE	8.3	11.6	11.2	13.7	6.3	9.8	25.5	28.4	15.0	21.5
GERMANY <sup>4</sup>	7.9	8.8	8.8	10.4	7.3	7.7	11.1	7.6	10.2	7.4
GREECE	7.9	9.7	11.8	15.3	5.8	6.4	30.0	38.6	17.1	20.1
IRELAND	14.0	15.7	11.1	<sup>3</sup> 12.1	15.3	<sup>3</sup> 17.3	16.6	20.9	22.9	24.9
ITALY	9.3	10.8	15.3	15.1	6.2	8.3	36.5	35.6	25.5	26.7
LUXEMBOURG <sup>1</sup>	16.0	1.2	1.7	2.0	1.0	1.1	7.4	3.8	6.2	4.2
NETHERLANDS <sup>2</sup>	11.8	6.7	14.0	8.8	10.6	5.3	18.8	6.8	22.6	6.8
PORTUGAL	7.8	5.5	12.2	6.5	4.7	4.6	24.6	14.9	13.2	9.8
SPAIN	17.0	22.4	20.3	28.9	15.6	18.6	43.7	47.4	33.7	39.9
SWEDEN	3.5	8.2	3.5	6.6	3.4	9.8	8.3	14.9	7.8	21.6
UNITED KINGDOM <sup>2</sup>	11.2	10.2	8.0	5.4	13.3	13.9	17.3	13.4	22.2	20.8

Source - OECD 1994/1995

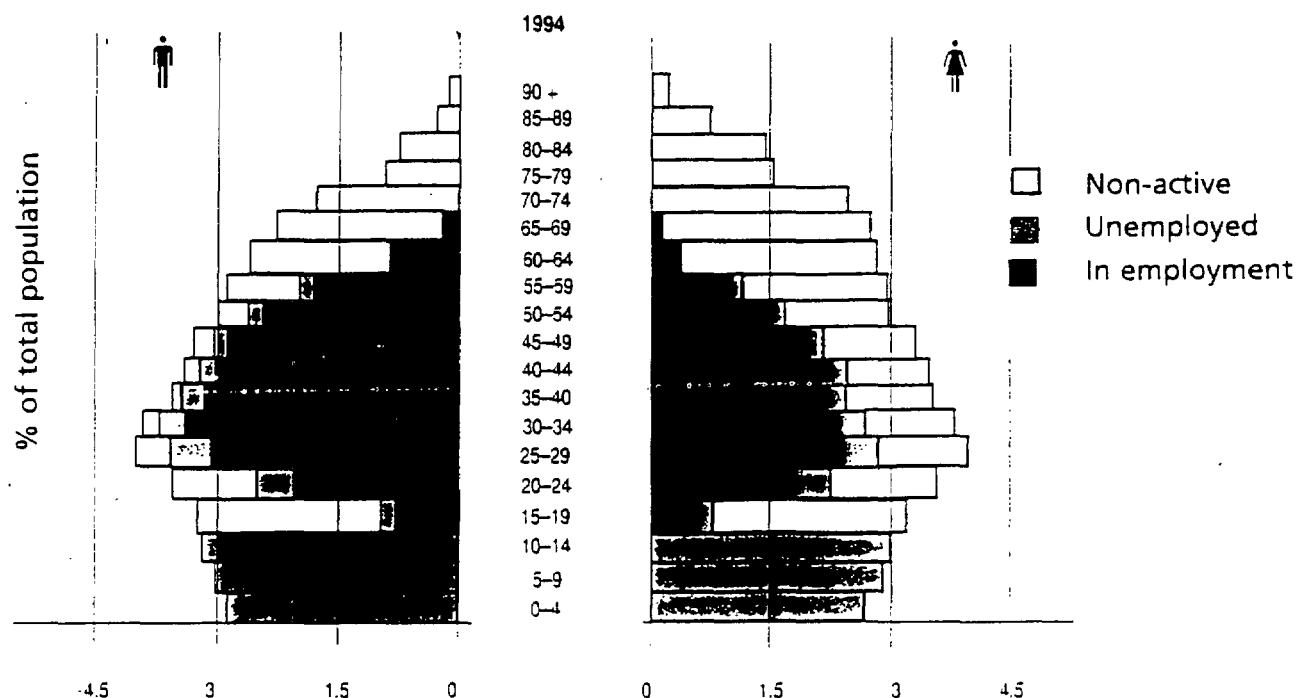
<sup>1</sup>National definition

<sup>2</sup>1992

<sup>3</sup>1991

<sup>4</sup>FRG to 1990

**Figure 2.6**  
**Present Demographic Structure and**  
**Structure of the Active Population**



Source : The demographic situation in the European Union in 1995, European Communities, Luxembourg 1996

**Table 2.9**  
**Gender Related Development Indices**

Country*	Gender-related development index (GDI) <sup>a</sup>	Real GDP per capita (PPPS) 1992	Share of earned income (%) <sup>b</sup>		Combined primary, secondary and tertiary education gross enrolment ratio (%) 1992		Gender empowerment measure (GEM) <sup>c</sup>	Human Development Index (HDI) <sup>d</sup>
			Female	Male	Female	Male		
Sweden	0.919 (1)	18,320	41.6	58.4	79.3	76.7	0.757 (1)	10
Finland	0.918 (2)	16,270	40.6	59.4	100.0	90.6	0.722 (3)	5
Denmark	0.904 (4)	19,080	39.8	60.2	85.6	82.3	0.683 (4)	16
France	0.898 (7)	19,510	35.7	64.3	87.5	83.5	0.433 (31)	8
Austria	0.882 (10)	18,710	33.6	66.4	82.0	85.9	0.610 (9)	14
United Kingdom	0.862 (13)	17,160	30.8	69.2	77.4	76.1	0.483 (19)	18
Italy	0.861 (14)	18,090	27.6	72.4	70.3	69.0	0.585 (10)	20
Belgium	0.852 (18)	18,630	27.3	72.7	84.3	84.1	0.479 (21)	12
Netherlands	0.851 (20)	17,780	25.2	74.8	86.5	89.4	0.625 (7)	4
Portugal	0.832 (25)	9,850	29.9	70.1	84.3	70.2	0.435 (30)	36
Greece	0.852 (27)	8,310	22.2	77.8	77.6	77.4	-	22
Ireland	0.813 (30)	12,830	22.2	77.8	84.6	80.6	0.469 (24)	19
Spain	0.795 (34)	13,400	18.6	81.4	88.7	83.0	0.452 (26)	9
Luxembourg	0.790 (35)	21,520	23.1	76.9	57.4	55.6	0.542 (13)	27

Source : Human Development Report, 1995

\*No data for Germany.

<sup>a</sup> The figure between brackets relates to the overall GDI ranking. GDI measures development but adjusts for gender.

<sup>b</sup> Latest available year.

<sup>c</sup> GEM measures gender disparity related to economic and political decision making.

<sup>d</sup> HDI measures national development according to social and economic indicators.

### 3. SELECTED HEALTH INDICATORS

The previous chapter provided an overview of social and demographic trends of importance to the situation of women within the EC. This section profiles selected health indicators, including life expectancy, infant mortality, maternal mortality, self-perceived health status, and height. These indicators are unfortunately the only ones currently available on a EC-wide basis. They do, however, indicate important differences across the Member States which are likely to reflect differences in underlying health status.

#### 3.1 Life Expectancy

Life expectancy (at birth) has increased significantly in recent decades in virtually all Member States. Between 1970 and 1995 the EC average life expectancy for women at birth increased by 5 1/2 years (for men the corresponding increase was almost 5 years). As a result, a girl born in 1995 may expect to live well over 80 years, while a boy may expect to live well over 73 1/2 years.

There has been considerable variation within the EC in the degree to which life expectancy (at birth) has increased as shown in **Figure 3.1**. Typically, the countries with the lowest life expectancy in 1970 experienced the greatest increase. This is particularly true for Portugal. Furthermore, the increase in some countries (e.g., Spain) was so great that they now rank towards the top of the distribution of life expectancy. Other countries experienced much smaller increases, in particular Denmark, where life expectancy went from being among the highest in 1970 to one of the lowest in the EC today due to a virtual stagnation in life expectancy since the mid-1970s. One reason for Denmark's low (and stagnating) life expectancy is its high premature mortality among women under 65 years of age<sup>a 1</sup>. As shown in **Figure 3.2**, Denmark had the highest reduction in life expectancy due to premature death, while Spain and Greece had the lowest.

In every Member State women live longer than men as **Figure 3.3** shows. On average, women live 6.4 years longer than men (see **Table 3.1**) but this ranges from 8.1 years in France to 5.1 years in Denmark. With a few exceptions, the gender gap has been relatively stable over time. Exceptions include Denmark, the Netherlands, and the UK where it has narrowed since the 1980s, and Spain where it has widened<sup>2</sup>.

Life expectancy is not limited to being measured at birth. **Tables 3.2-3.4** show life expectancy at ages 15, 45, and 65. The same patterns of variation across the Member States (and between men and women) persist across all age-groups, although the difference between average life expectancy of women and men decreases with age.

#### 3.2 Infant Mortality

Infant mortality (before the age of 1 year) is another widely reported health indicator. As shown in **Figure 3.4**, infant mortality has declined significantly in recent decades. In 1970, female infant mortality in the EC was 21.9 per 1000 live births, whereas in 1992 it was only 6.9, a decline of 68%. This decrease has been accompanied by a narrowing of the

---

a Explanations for the high rate of premature mortality in Denmark include excessive smoking and drinking, and high unemployment<sup>1</sup>.

range of rates. In 1971, Portugal, which had the highest infant mortality rate, reported almost 50 deaths per 1000 live births, while Sweden (in 1970) reported the lowest rate, (11 deaths per 1000 live births), a difference of almost 40 deaths per 1000 live births. In 1992, the highest (female) infant mortality rate, still that of Portugal, was 9.29 whereas the lowest rates were found in Sweden and Finland, just above 5 per 1000 live births. The difference was only 4.13 deaths per 1000 live births, a small fraction of the difference 22 years earlier.

The reasons for this important decline in infant mortality are related to improved health status of mothers, higher quality of ante- and neonatal care<sup>3</sup>, and general social and economic improvements over the last three decades.

### 3.3 Maternal Mortality

While there are many maternal deaths in developing countries, there are relatively few such deaths in developed countries because of their better health care delivery systems. Nevertheless even the EC has experienced a relatively large decline in maternal mortality during recent decades. As shown in **Figure 3.5**, maternal mortality has declined from approximately 35 per 100,000 live births in 1970 to just over 7 per 100,000 in 1992, a 79% decline during this period. In absolute terms, maternal deaths in the EC declined from 1,493 in 1970 to 178 in 1992.

As with infant mortality, the decline in maternal mortality rates has been accompanied by a large decline in both range and variation. In 1971 the highest maternal mortality, experienced by Luxembourg, was 67.5 per 100,000 while the lowest was found in Denmark, 8.47 per 100,000. In 1992, France had the highest maternal mortality with 12.91 per 100,000 whereas Sweden and Luxembourg had no maternal deaths.

As shown in **Figure 3.5** the greatest rates of decline were experienced by Sweden and Luxembourg (100%) while Denmark had the smallest decline (12.9%), one reason being that it had already an extremely low rate in 1970.

### 3.4 Self-Perceived Health Status

While life expectancy provides one measure of a population's health status, it says little about how its citizens rate their health. **Figure 3.6** shows how a random sample of women in the EC rated their own health at the beginning of 1996<sup>a</sup>. (See **Tables 3.5-3.7** for the distribution of responses for all women and elderly women). Generally, women in the EC perceive themselves as being in quite good health. About 62% report being in good or very good health during the past year. This percentage is naturally lower for elderly women. On average, only about 40% of women aged 65 to 74 years report being in good or very good health (**Table 3.6**). Not surprisingly, women aged 75 years and more typically report lower levels of self-perceived health status (see **Figure 3.7**), although in Austria, Luxembourg, Spain, and Portugal women aged 75 years and older report being in better health than women aged 65-74 years<sup>b</sup>.

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a Respondents were asked to rate their own health during the past 12 months on a 5-point scale: very good, good, fair, bad, very bad.

b The relatively small sample size may account for this somewhat anomalous result.



As with life expectancy, the EC average belies the large differences between Member States. As shown in **Table 3.5**, the percentage of women in each country reporting being in very good health varies from 45.9% in Ireland to 6.9% in Portugal (see also **Figure 3.6**). The combined percentage (of women in good and very good health) varies as much, ranging from 75.8% in Ireland to 34.7% in Portugal. It should be noted, however, that Portuguese women report a considerably lower percentage in good or very good health than do Finnish women who have the next lowest percentage (54.9%). Portugal's results are consistent with the relatively high level of disability due to long-term illness reported in Section 4.1.

### 3.5 Height

It is well known that the average height of the world's population has been increasing over the last century, but this has particularly been the case during the past few decades. Height in developed countries increasingly has come to be seen as a measure of the health status of the population. To capture this dimension of health status, a question about height has included in the 1996 Eurobarometer survey.

On average, European women are 163.5 cm tall but this average varies considerably across the Member States. As can be seen in **Figure 3.8** and **Table 3.8**, the Netherlands and Denmark have the tallest female population in the EC, with average heights of 167.9 and 166.3 cm, respectively, while Spain and Portugal have the shortest with average heights of 161.0 and 159.6 cm, respectively. Thus, the difference between the shortest and the tallest population in the EC is more than 8 cm.

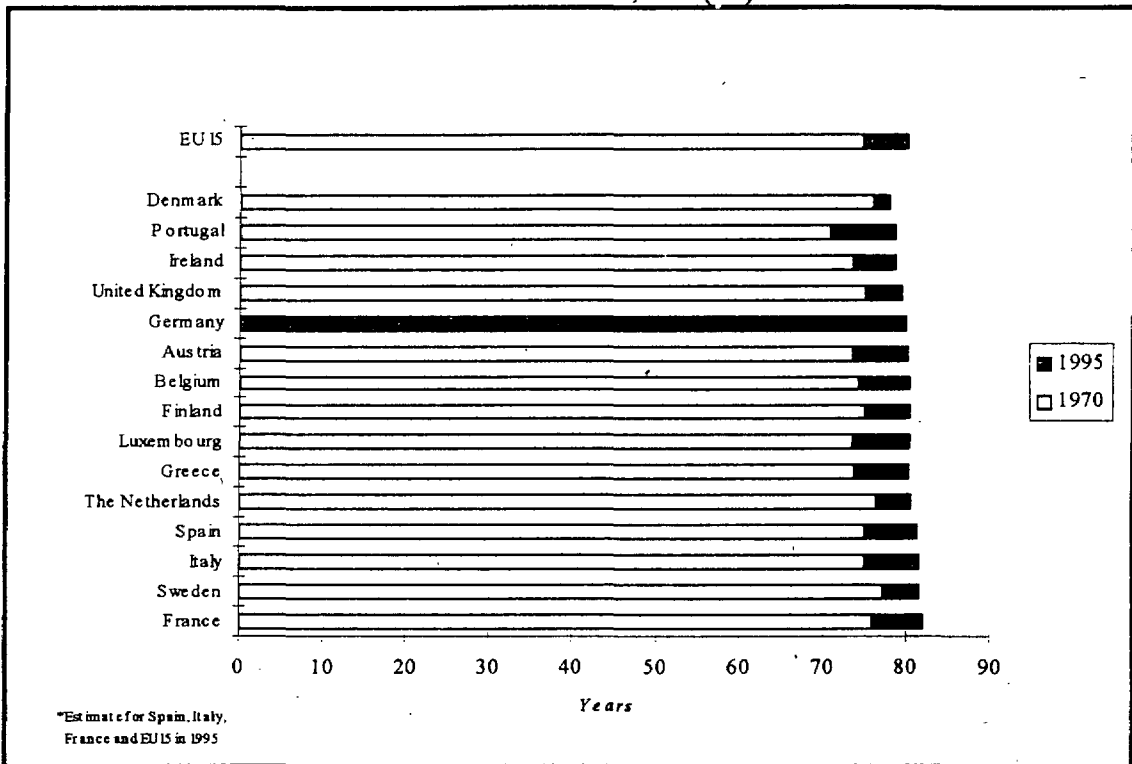
While average height differs considerably within the EC, all countries have experienced an increase in the height of the female population. As shown in **Figure 3.9** and **Table 3.8**, older cohorts (i.e., women 60 years and older) are considerably shorter than younger cohorts (i.e., women aged 18-29 years), which confirms the increasing height over time. This is even more apparent when looking at the distribution of the average height across the entire age-span, as depicted in **Figure 3.10**. Average height of EC women decreases uniformly from the youngest cohorts (aged 18-29 years) to the oldest cohort (aged 60 years and older), with the youngest age-group being almost 5 cm taller than the oldest age-group.

### References

- 1 Ministry of Health, Denmark (1994a), *Lifetime in Denmark*, Copenhagen, Denmark.
- 2 Eurostat (1995a), *Women and Men in the European Union, A Statistical Portrait*. Luxembourg: Office for Official Publications of the European Communities
- 3 Abel-Smith, B., Figueras, J., Holland, W., McKee, M., Mossialos, E. (1995), *Choices in Health Policy*. London: Dartmouth.

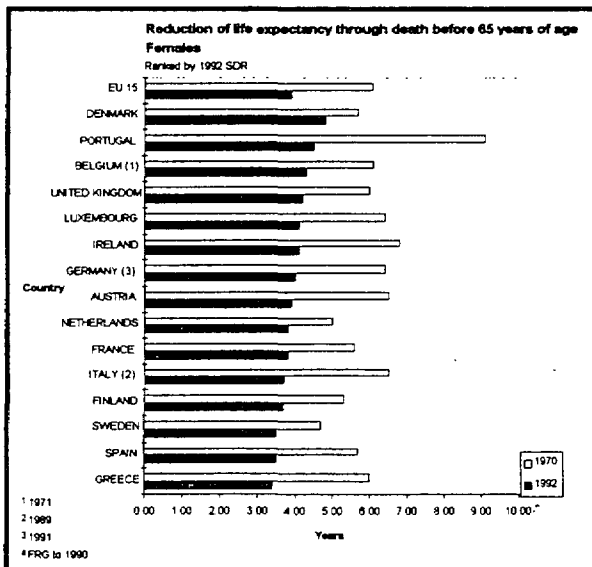
## [Figures and Tables]

**Figure 3.1**  
Life Expectancy at Birth, 1970-1995  
Women, EU (15)



Source : Eurostat 1997.

**Figure 3.2**  
Reduction in Life Expectancy Due to  
Premature Death



Source - HFA 1996.

Reduction of life expectancy through death before 65, Females		
Country	1992	% change since 1970
EU 15	3.89	-36.02
DENMARK	4.80	-15.79
PORTUGAL <sup>1</sup>	4.50	-50.55
BELGIUM <sup>2</sup>	4.30	-29.51
UNITED KINGDOM	4.20	-30.00
LUXEMBOURG <sup>1</sup>	4.10	-35.94
IRELAND	4.10	-39.71
GERMANY <sup>4</sup>	4.00	-37.50
AUSTRIA	3.90	-40.00
NETHERLANDS	3.80	-24.00
FRANCE	3.80	-32.14
ITALY <sup>3</sup>	3.70	-43.08
FINLAND	3.70	-30.19
SWEDEN	3.50	-25.53
SPAIN	3.50	-38.60
GREECE	3.40	-43.33

<sup>1</sup> 1971

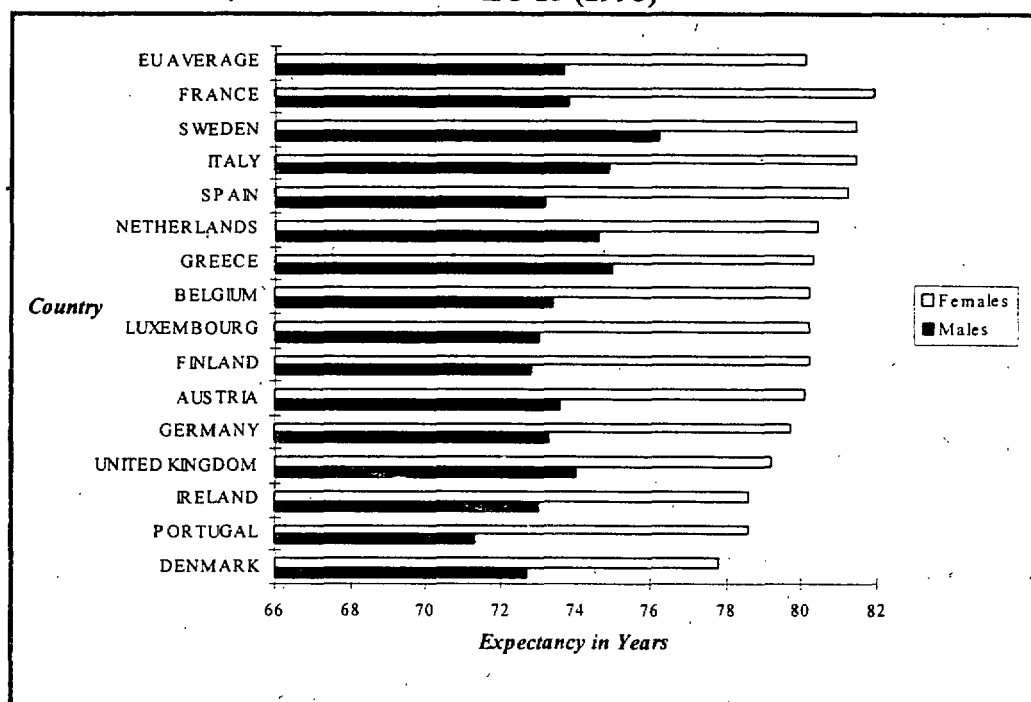
<sup>2</sup> 1989

<sup>3</sup> 1991

<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 3.3**  
**Life Expectancy at Birth (in Years)**  
**EU 15 (1995)**



Source: Eurostat 1997

**Table 3.1**  
**Life Expectancy at Birth (in Years)**  
**EU 15 (1995)**

Country	Males	Females	Difference <sup>a</sup>
EU AVERAGE	73.70*	80.10*	6.40
FRANCE	73.80*	81.90*	8.10
SPAIN	73.20*	81.20*	8.00
FINLAND	72.80	80.20	7.40
PORTUGAL	71.30	78.60	7.30
LUXEMBOURG	73.00	80.20	7.30
BELGIUM	73.40	80.20	6.80
ITALY	74.90*	81.40*	6.50
AUSTRIA	73.60	80.10	6.50
GERMANY	73.30	79.70	6.50
NETHERLANDS	74.60	80.40	5.80
IRELAND	73.00	78.60	5.60
SWEDEN	76.20	81.40	5.30
UNITED KINGDOM	74.00	79.20	5.20
GREECE	75.00	80.30	5.20
DENMARK	72.70	77.80	5.10

\*Estimate

<sup>a</sup> ranked by difference

Source : Eurostat 1997

**Table 3.2**  
**Life Expectancy at 15 Years (in Years)**  
**EU 15 (1995)**

Country	Males	Females	Difference <sup>a</sup>
EU AVERAGE	59.40	65.60	6.20
FRANCE	59.50	67.50	8.00
FINLAND	58.30	65.60	7.30
PORTUGAL	57.30	64.40	7.10
LUXEMBOURG	58.60	65.70	7.10
SPAIN	60.00	67.10	7.10
BELGIUM	59.20	65.80	6.60
GERMANY	58.90	65.30	6.40
AUSTRIA	59.20	65.60	6.40
ITALY	60.20	66.50	6.30
NETHERLANDS	60.30	65.90	5.60
IRELAND	58.70	64.20	5.50
SWEDEN	61.70	66.80	5.10
UNITED KINGDOM	59.70	64.80	5.10
GREECE	60.90	66.00	5.10
DENMARK	58.40	63.30	4.90

<sup>a</sup>ranked by difference  
Source - Eurostat 1997

**Table 3.3**  
**Life Expectancy at 45 Years (in Years)**  
**EU 15 (1995)**

Country	Males	Females	Difference <sup>a</sup>
EU AVERAGE	31.30	36.50	5.20
FRANCE	31.90	38.50	6.60
LUXEMBOURG	30.50	36.90	6.40
FINLAND	30.40	36.50	6.10
SPAIN	32.30	38.00	5.70
BELGIUM	31.10	36.80	5.70
GERMANY	30.70	36.20	5.50
ITALY	32.00	37.30	5.30
NETHERLANDS	31.60	36.80	5.20
AUSTRIA	31.20	36.40	5.20
PORTUGAL	30.30	35.50	5.20
IRELAND	30.30	35.00	4.70
SWEDEN	33.00	37.50	4.50
UNITED KINGDOM	31.20	35.60	4.40
DENMARK	30.20	34.30	4.10
GREECE	32.70	36.80	4.10

<sup>a</sup>ranked by difference  
Source - Eurostat 1997

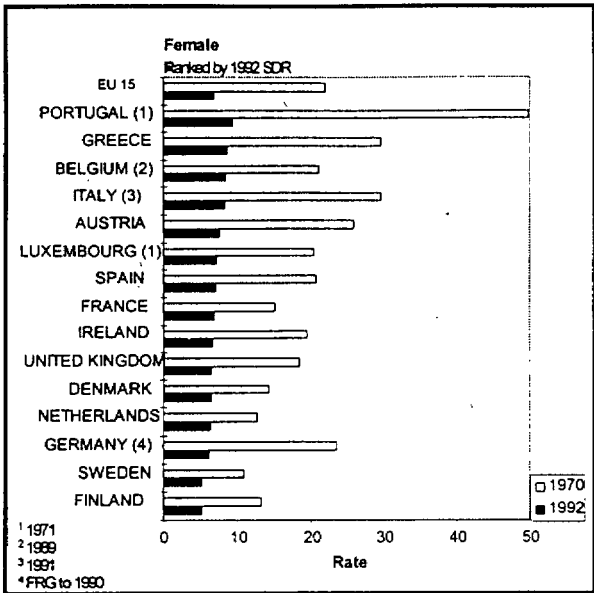
***Table 3.4***  
**Life Expectancy at 65 Years (in Years)**  
**EU 15 (1995)**

Country	Males	Females	Difference <sup>a</sup>
EU AVERAGE	15.00	18.80	3.80
LUXEMBOURG	14.70	19.20	4.50
NETHERLANDS	14.70	19.10	4.40
FRANCE	16.20	20.60	4.40
BELGIUM	14.80	19.10	4.30
FINLAND	14.50	18.60	4.10
GERMANY	14.70	18.50	3.80
ITALY	15.50	19.30	3.80
SPAIN	16.00	19.80	3.80
IRELAND	13.70	17.40	3.70
SWEDEN	16.00	19.70	3.70
AUSTRIA	15.20	18.70	3.50
UNITED KINGDOM	14.60	18.10	3.50
PORTUGAL	14.30	17.70	3.40
DENMARK	14.10	17.50	3.40
GREECE	16.10	18.40	2.30

<sup>a</sup>ranked by difference

Source - Eurostat 1997

**Figure 3.4**  
**Infant Mortality Rate \***



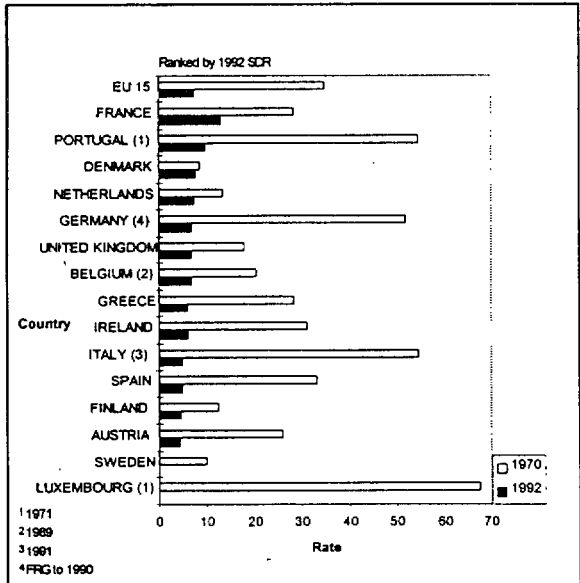
\*Number of Deaths under 1 Year of age per 1000 live births  
Source - HFA 1996

Country	Female	
	1992	% change since 1970
EU 15	6.93	-68.40
PORTUGAL <sup>1</sup>	9.29	-81.33
GREECE	8.56	-71.08
BELGIUM <sup>2</sup>	8.53	-59.55
ITALY <sup>3</sup>	8.22	-72.18
AUSTRIA	7.53	-70.92
LUXEMBOURG <sup>1</sup>	7.19	-64.89
SPAIN	7.05	-66.07
FRANCE	6.82	-54.95
IRELAND	6.67	-65.78
UNITED KINGDOM	6.58	-64.41
DENMARK	6.51	-54.12
NETHERLANDS	6.29	-50.67
GERMANY <sup>4</sup>	6.17	-73.90
SWEDEN	5.19	-52.82
FINLAND	5.16	-61.00

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 3.5**  
**Maternal Mortality \***



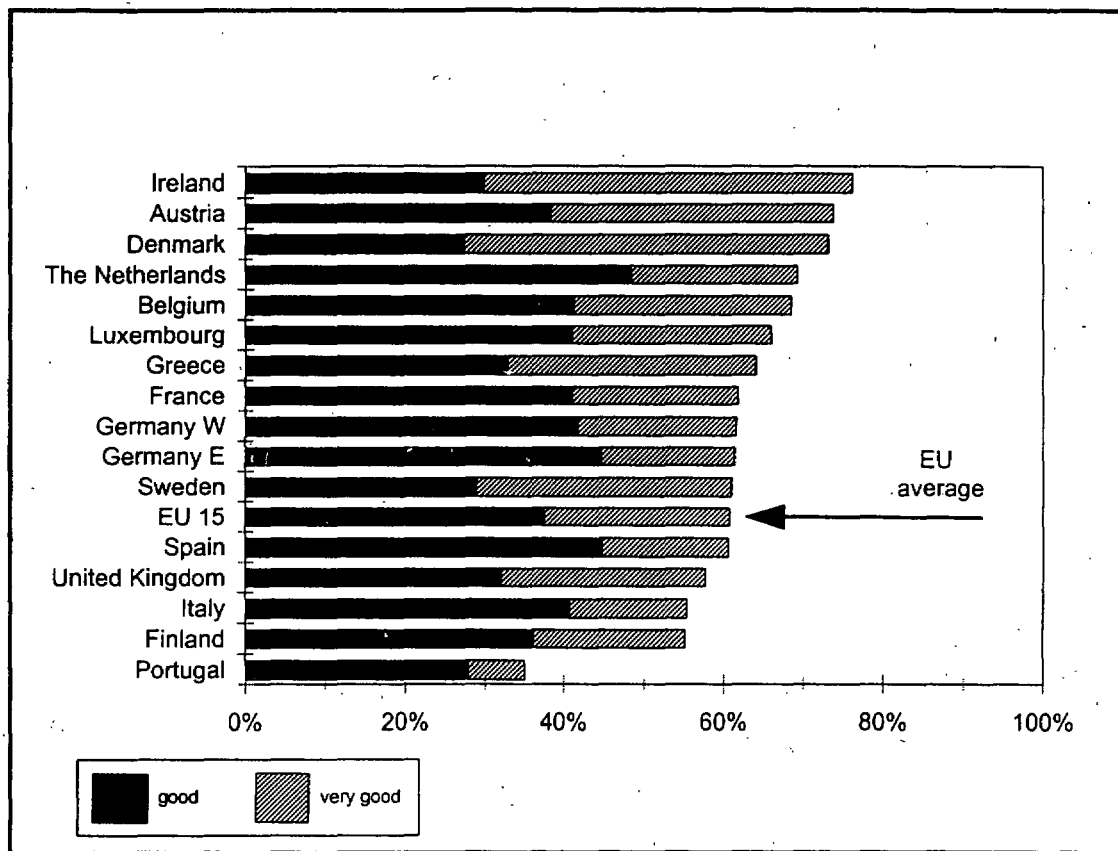
\* Maternal deaths (all causes) per 100000 live births  
Source - HFA 1996

Country	1992	% change since 1970
EU 15	7.14	-79.51
FRANCE	12.91	-54.20
PORTUGAL <sup>1</sup>	9.56	-82.46
DENMARK	7.38	-12.87
NETHERLANDS	7.12	-46.83
GERMANY <sup>4</sup>	6.67	-87.12
UNITED KINGDOM	6.66	-63.06
BELGIUM <sup>2</sup>	6.62	-67.55
GREECE	5.89	-79.18
IRELAND	5.82	-81.26
ITALY <sup>3</sup>	4.85	-91.10
SPAIN	4.79	-85.52
FINLAND	4.50	-63.68
AUSTRIA	4.20	-83.73
SWEDEN	0.00	-100.00
LUXEMBOURG <sup>1</sup>	0.00	-100.00

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 3.6**  
**Self-Perceived Health Status, 1996**  
**Women 15 + Years, EU 15**



Source : Eurobarometer 44.3/1996

**Table 3.5**  
**Self-Perceived Health Status, 1996**  
**Women 15+ Years, EU 15**

	Very Good	Good	Fair	Bad	Very Bad
	%	%	%	%	%
IRELAND	45.9	29.9	18.3	4.5	1.4
AUSTRIA	35.3	38.3	20.0	5.3	0.7
DENMARK	45.4	27.4	19.4	5.4	2.2
THE NETHERLANDS	20.7	48.4	22.7	5.8	2.4
BELGIUM	27.2	41.2	22.8	7.5	1.3
LUXEMBOURG	24.8	41.0	27.4	5.8	1.0
GREECE	30.8	32.9	19.8	14.3	2.2
FRANCE	20.6	41.0	25.0	10.6	2.8
GERMANY W	19.8	41.7	28.5	9.1	9.0
GERMANY E	16.5	44.7	29.6	7.0	2.0
SWEDEN	31.9	28.9	27.3	10.4	1.6
EU 15	23.1	37.5	27.0	8.0	2.7
SPAIN	15.6	44.8	27.8	10.2	1.5
UNITED KINGDOM	25.5	32.1	31.2	8.5	2.6
FINLAND	18.8	36.1	36.3	6.0	2.2
ITALY	14.4	40.7	37.9	5.6	1.4
PORTUGAL	6.9	27.8	37.6	20.7	6.9

Source : Eurobarometer 44.3/1996



**Table 3.6**  
**Health Assessment, 1996**  
**Women 65-74 Years, EU 15**

	Very Good	Good	Fair	Bad	Very Bad
	%	%	%	%	%
IRELAND	21.6	25.5	47.1	5.9	0.0
AUSTRIA	15.9	28.6	41.3	9.5	3.2
DENMARK	31.7	33.3	20.0	5.0	10.0
THE NETHERLANDS	25.0	40.0	30.0	0.0	5.0
BELGIUM	16.0	46.0	30.0	4.0	4.0
LUXEMBOURG	8.8	32.4	44.1	11.8	2.9
GREECE	9.0	29.9	22.4	37.3	1.5
FRANCE	6.4	27.7	36.2	19.1	10.6
GERMANY W	6.0	34.3	50.7	7.5	1.5
GERMANY E	4.7	34.4	51.6	4.7	4.7
SWEDEN	21.0	30.6	33.9	14.5	0.0
<b>EU 15</b>	<b>9.7</b>	<b>29.2</b>	<b>43.3</b>	<b>14.1</b>	<b>3.7</b>
SPAIN	6.9	25.0	37.5	25.0	5.6
UNITED KINGDOM	17.6	24.4	41.2	15.3	1.2
FINLAND	7.4	23.5	56.8	6.2	4.9
ITALY	4.2	28.4	54.7	12.6	0.0
PORTUGAL	0.0	4.3	52.9	34.3	8.6

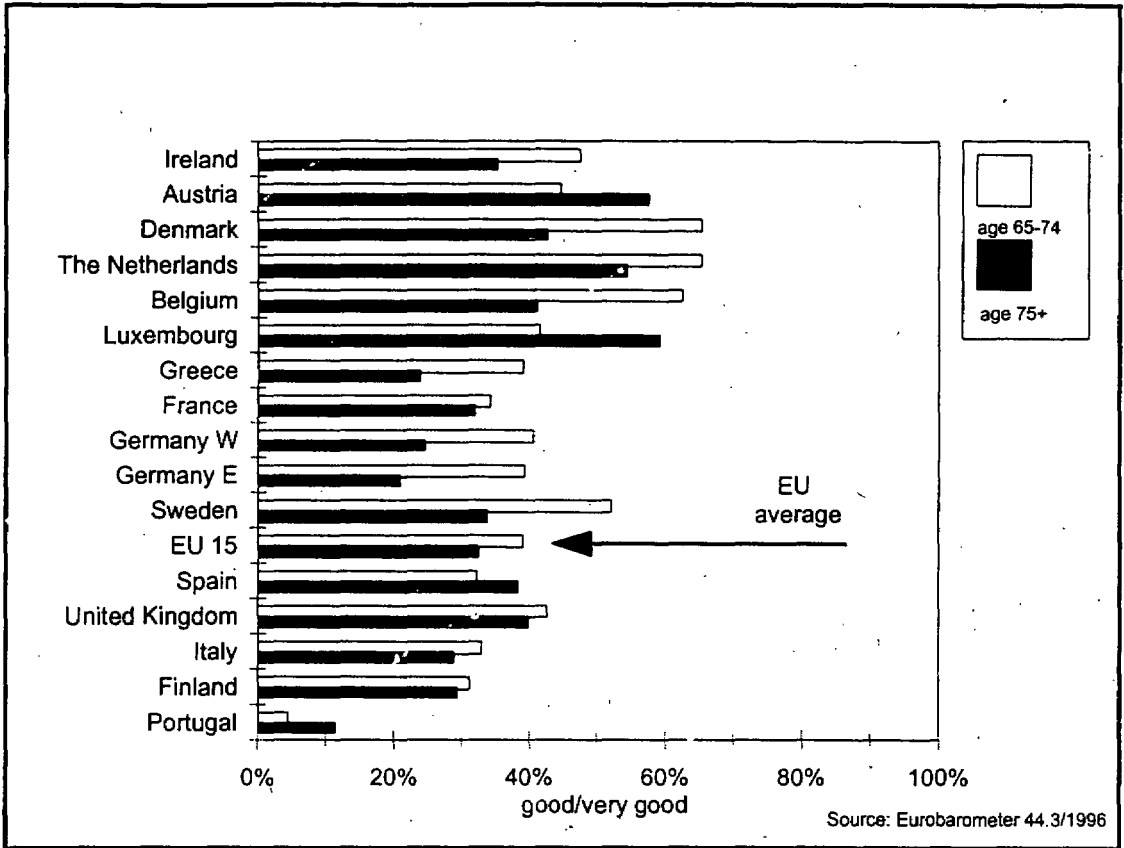
Source : Eurobarometer 44.3/1996

**Table 3.7**  
**Health Assessment, 1996**  
**Women 75+ Years, EU 15**

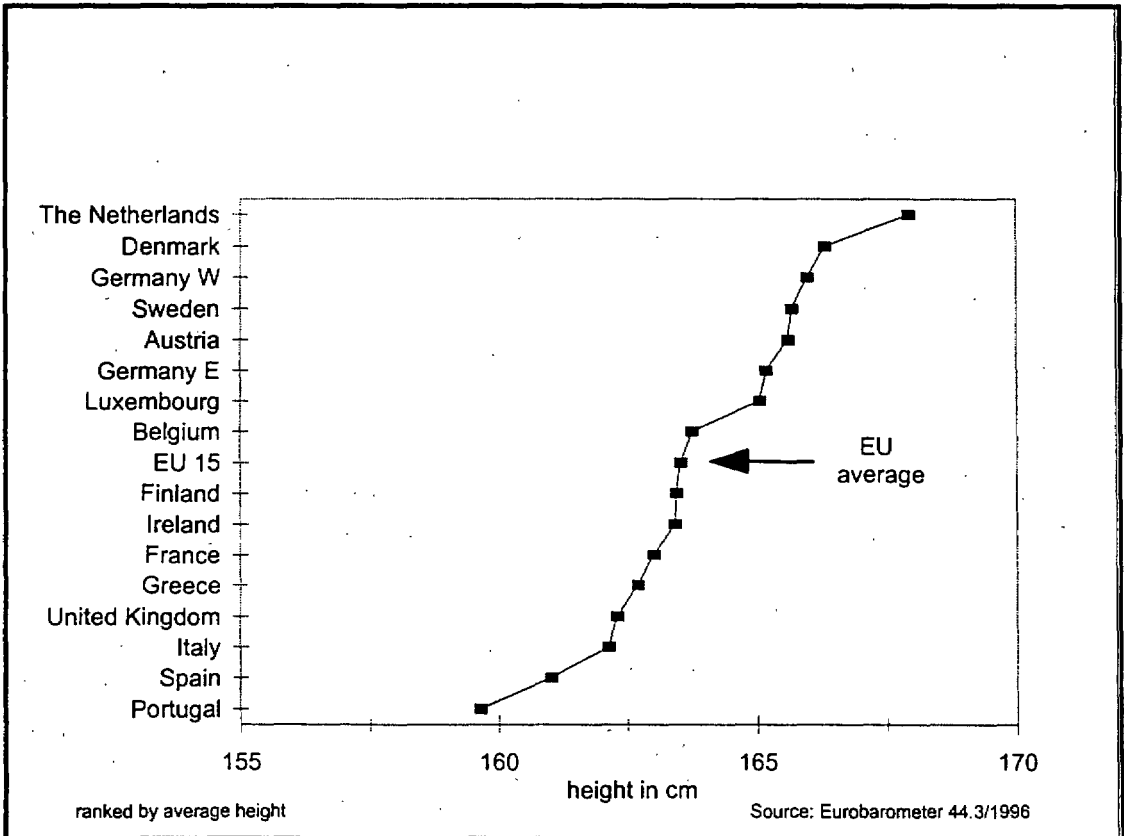
	Very Good	Good	Fair	Bad	Very Bad
	%	%	%	%	%
IRELAND	5.0	30.0	45.0	15.0	5.0
AUSTRIA	17.9	39.3	32.1	10.7	0.0
DENMARK	19.2	23.1	50.0	7.7	0.0
THE NETHERLANDS	30.8	23.1	23.1	23.1	0.0
BELGIUM	12.2	28.6	42.9	14.3	2.0
LUXEMBOURG	5.9	52.9	17.6	11.8	11.8
GREECE	0.0	23.5	11.8	58.8	5.9
FRANCE	5.3	26.3	47.4	15.8	5.3
GERMANY W	9.1	15.2	48.5	27.3	0.0
GERMANY E	0.0	20.8	62.5	16.7	0.0
SWEDEN	14.8	18.5	55.6	7.4	3.7
<b>EU 15</b>	<b>8.6</b>	<b>23.7</b>	<b>43.5</b>	<b>19.2</b>	<b>5.1</b>
SPAIN	9.5	28.6	38.1	19.0	4.8
UNITED KINGDOM	15.2	24.2	45.5	6.1	9.1
FINLAND	0.0	28.6	42.9	19.0	9.5
ITALY	7.9	21.1	44.7	21.1	5.3
PORTUGAL	3.7	7.4	18.5	51.9	18.5

Source : Eurobarometer 44.3/1996

**Figure 3.7**  
**Self-Perceived Health Status**  
**Elderly Women, EU 15 (1996)**



**Figure 3.8**  
**Average Height (in cm)**  
**Women 18+ Years, EU 15 (1996)**

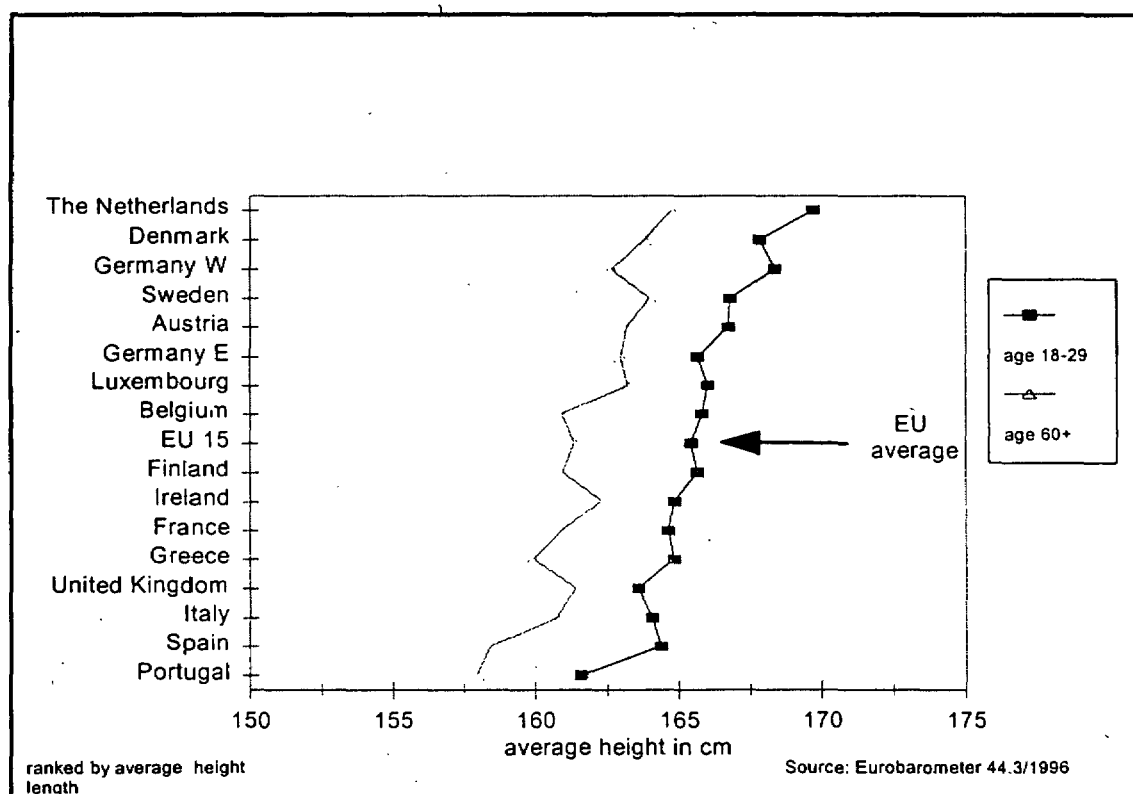


**Table 3.8**  
**Average Height (in cm)**  
**Women 18 + Years by Age-Group, EU 15 (1996)**

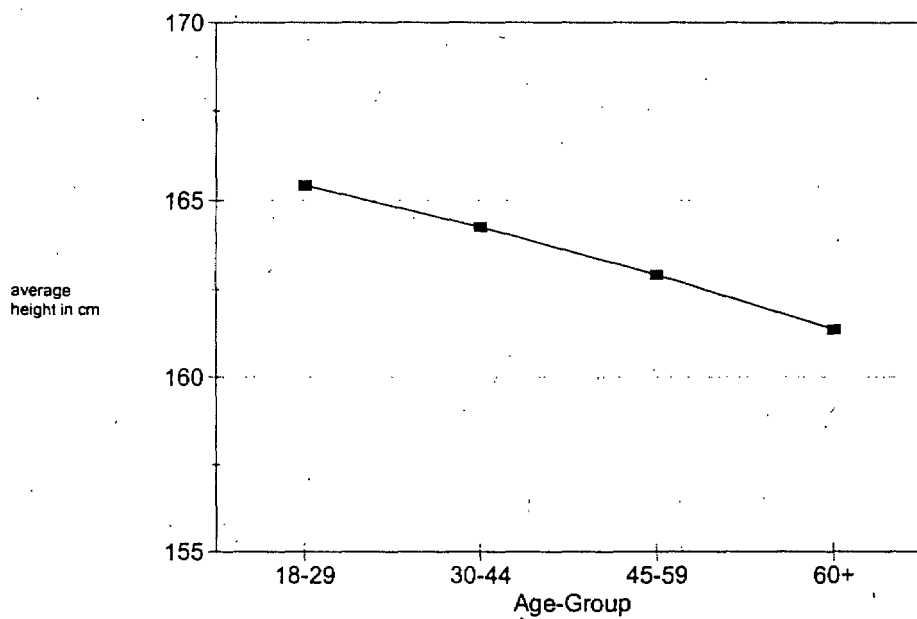
	AGE-GROUP				
	18-29 Years	30-44 Years	45-59 Years	60 + Years	Total 18+ Years
THE NETHERLANDS	169.7	168.6	167.0	164.8	167.9
DENMARK	167.8	167.8	165.6	163.8	166.3
GERMANY W	168.3	167.5	165.6	162.7	166.0
SWEDEN	166.8	166.4	165.6	164.0	165.7
AUSTRIA	166.7	166.2	165.8	163.2	165.6
GERMANY E	165.7	166.5	165.3	163.0	165.2
LUXEMBOURG	166.0	165.0	165.7	163.2	165.1
BELGIUM	165.8	165.3	162.8	160.9	163.7
EU 15	165.4	164.3	162.9	161.4	163.5
FINLAND	165.6	164.6	163.7	160.9	163.4
IRELAND	164.8	163.5	162.9	162.3	163.4
FRANCE	164.6	163.9	162.1	160.9	163.0
GREECE	164.8	163.3	162.4	159.9	162.7
UNITED KINGDOM	163.6	162.1	162.4	161.4	162.3
ITALY	164.1	162.9	161.0	160.7	162.1
SPAIN	164.4	160.9	159.7	158.4	161.0
PORTUGAL	161.6	160.7	158.4	157.9	159.6

Source : Eurobarometer 44.3/1996

**Figure 3.9**  
**Average Height (in cm)**  
**Women 18 + Years by Age-Group, EU 15 (1996)**



**Figure 3.10**  
**Average Height (in cm)**  
**Women by Age-Group, EU 15 (1996)**



Source: Eurobarometer 44.3/1996

## 4. MORBIDITY

The previous chapter described various health indicators such as life expectancy, infant mortality, and height. This chapter provides a brief overview of various morbidity measures. Because disease-specific morbidity indicators at the EC level do not exist, indirect measures, such as self-reported disability, both short-term and long-term, and use of health services, such as doctor consultations (in the past 2 weeks) and hospitalisations (in the past year) are used instead. The data for these measures come from the 1996 Eurobarometer survey and the 1994 European Community Household Panel survey (ECHP). Because the latter survey was undertaken when the EC had only 12 Member States, the ECHP data are limited to those countries.

### 4.1 Activity Limitations Due to Chronic Conditions

As shown in **Figure 4.1** and **Table 4.2**, almost one out of four women in the EC reports being limited in their daily activities to some extent (17.3%) or severely (6.3%) because of long-standing illness. This average ranges from a high of 30% in Finland and Portugal to a low of 15% in Luxembourg. While this measure may to some extent be influenced by each Member State's criteria for obtaining disability pensions, it is likely that it does reflect some underlying differences in the prevalence of disability in the female population. Certainly, the high percentage of Portuguese women reporting being hampered in their daily activities by long-standing illness corresponds well with the high percentage of them reporting being in poor health (see Section 3.4).

Not surprisingly, the incidence of disability due to long-term illness increases uniformly with age. As shown in **Figure 4.2**, the percentage of women reporting being disabled to some extent or severely rises from 10.2% among 15-29 year-old women to 54.3% among women aged 75 years or older. The percentage women under 30 years who report being severely disabled is 1.5% while it is just over 20% for women aged 75 years and older (**Table 4.2**).

When looking at older women only, i.e., those aged 65 years and older, it is noticeable that about half report being hampered to some extent (36.4%) or severely (12.3%) in their daily activities because of long-standing illness (see **Table 4.3**). Moreover, the ranking of disability among elderly women (aged 65 and over) differs from that among the entire population of women. This is shown in **Figure 4.3**, in which the Member States appear in the same order as in **Figure 4.1**, but that no longer corresponds to their relative ranking. For example, Greek women are ranked 10th on an overall population basis, just above the EC average, but Greece has the second highest percentage of elderly women with disability due to long-term illness. Thus, elderly Greek women are relatively more disabled than are younger Greek women. Similarly, Irish women have the third lowest percentage of disabled women overall, but the third highest among elderly women.

### 4.2 Short-Term Activity Limitations

Short-term activity limitations due to illness and injury are considerably less frequent than activity limitations due to chronic conditions. On average, 13.8% of EC women<sup>a</sup> report

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a Owing to data problems, only 11 of the then 12 Member States are included in this analysis.

having had to cut down on their *usual* activities in the past two weeks because of an illness or injury, but the range is considerable: only 5.6% of Italian women report having to cut down on their usual daily activities compared to almost 20% of Dutch women (Figure 4.4 and Table 4.4).

Not surprisingly, the percentage of women who report short-term activity limitations is much greater among elderly women, with an average of almost 25% reporting such activity limitation due to illness and injury, and a range from a low in Italy of 12.0% to a high in Germany of 31.5%. It is remarkable that Italian women (aged 65 years and older) report the lowest frequency of short-term disability when they report one of the highest prevalences of disability due to chronic conditions. Apparently, these two measures capture different dimensions of disability (Figure 4.5 and Table 4.5).

The last disability indicator to be reported here is short-term activity restrictions (in the past two weeks) because of emotional or mental health problems. As shown in Figure 4.6 and Table 4.6, only about 3% of women in the EC report having had to reduce their daily activities due to an emotional or mental health problem. This ranges from a low in Italy of approximately 1% to a high of almost 9% in the Netherlands.

When looking only at elderly women (aged 65 years and over), the pattern is the same but the level of activity restriction is higher. Thus, Italy reports the lowest incidence (2.8%) and the Netherlands reports the highest (11.2%), while the EU average is 5.0% (see Figure 4.7 and Table 4.7). Thus, the reported incidence of short-term restricted activity even among elderly women in the EC is quite low, both absolutely and relative to other types of activity restrictions.

### 4.3 Doctor Consultations

While restricted activity days are likely to result in a decline in quality of life, they do not necessarily give rise to medical consultations. In view of the cost implications, the 1996 Eurobarometer survey asked its respondents whether they had consulted a physician in the past two weeks (either in person or on the telephone). The results are given in Figure 4.8 and Table 4.8. On average, about one in three women had consulted a doctor in the past two weeks, with some variation between Member States. In Ireland and the Netherlands only 25% of women reported doing so, while 38% reported doing so in Spain.

Not surprisingly, the percentage of women consulting a doctor (during the previous 2 weeks) increases with age. While a sizeable proportion - almost one in four - seek medical help under the age of 30 years, this proportion increases uniformly with age until more than two out of five women seek medical help among the 75 and over group (Figure 4.9 and Table 4.9).

### 4.4 Hospitalisations

Hospital stays (in a one-year period) provide another measure of morbidity in a population. As periods in hospital are only necessary for the most severe illnesses, they are relatively infrequent, even on an annual basis. As shown in Figure 4.10 and Table 4.10, only about 10% of EC women report having been hospitalised. However, hospitalisations vary considerably within the EC, only 3.8% of the Danish women asked reported having

been hospitalised in the previous year compared to nearly 13% in France and Finland<sup>a</sup>. These differences may to some extent reflect differences in the availability of hospital beds, which also varies considerably within the EC<sup>1</sup>.

When looking at age-group differences, it is apparent that the increasing disability with older age also results in increasing hospitalisation. As shown in **Figure 4.11** only 6.3% of women aged 15-29 years report having been hospitalised in the previous year, compared to 18% of women aged 75 years or over (**Table 4.11**).

**Figure 4.12** shows the average number of nights spent in the hospital for those women who had at least one non-birth hospitalisation. On average, women spent about 10 nights in the hospital in a 12-month period. Again, there were considerable variations across the Member States, with the former German Democratic Republic and the pre-unification Federal Republic of Germany reporting the highest number of nights in the hospital (14.9 and 13.5, respectively) and Spain reporting the lowest (5.9) (see also **Table 4.12**). Care should be taken when interpreting these numbers, because of differences in the types of hospitals that exist in the various Member States and the relatively small number of hospitalisations that form the basis for these estimates.

## *References*

- 1 Eurostat (1995), *Social Portrait of Europe*, Luxembourg: Office for Official Publications of the European Communities.

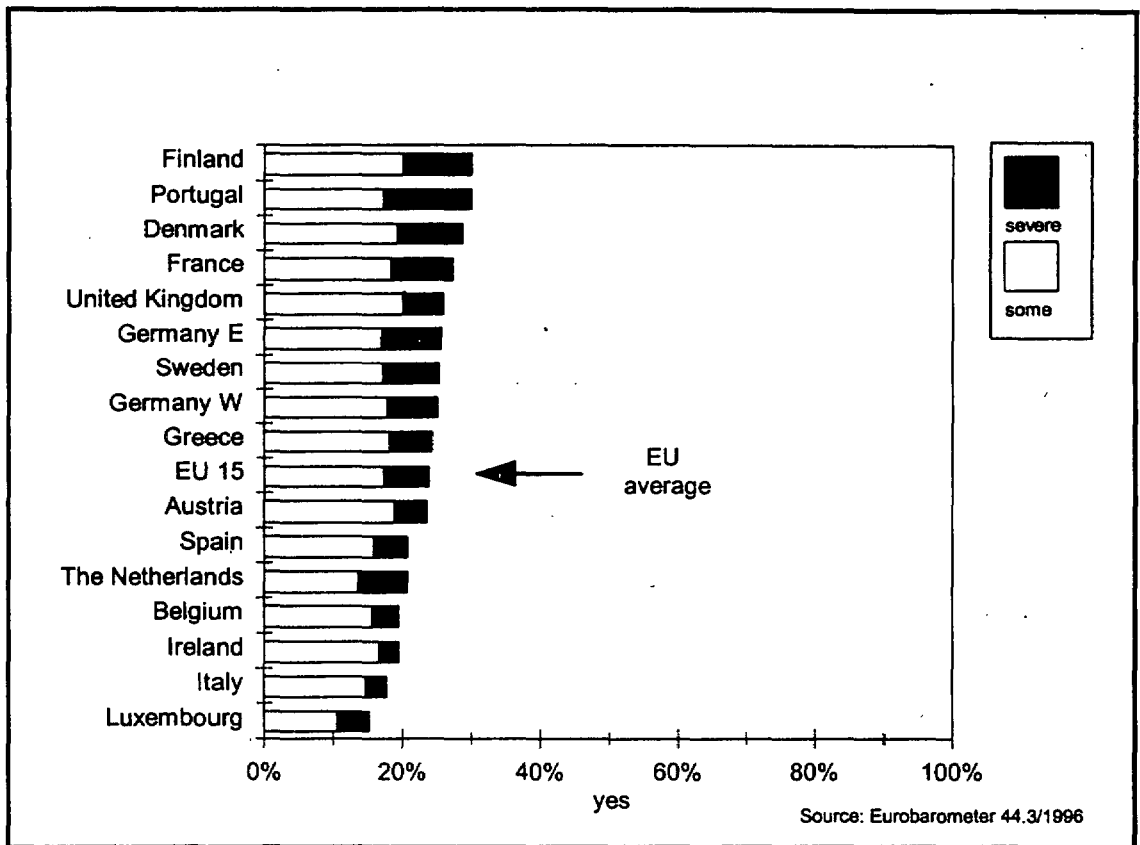
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<sup>a</sup> Corresponding data from the 1994 ECHP survey yield slightly different results, probably because of different sampling methods and sizes. In particular, 15% of women in Luxembourg and 12% of women in Denmark report a hospitalisation in the previous year.

## [Figures and Tables]



**Figure 4.1**  
**Percent with Disability Due to Long-Standing Illness**  
**Women 15 + Years, EU 15 (1996)**



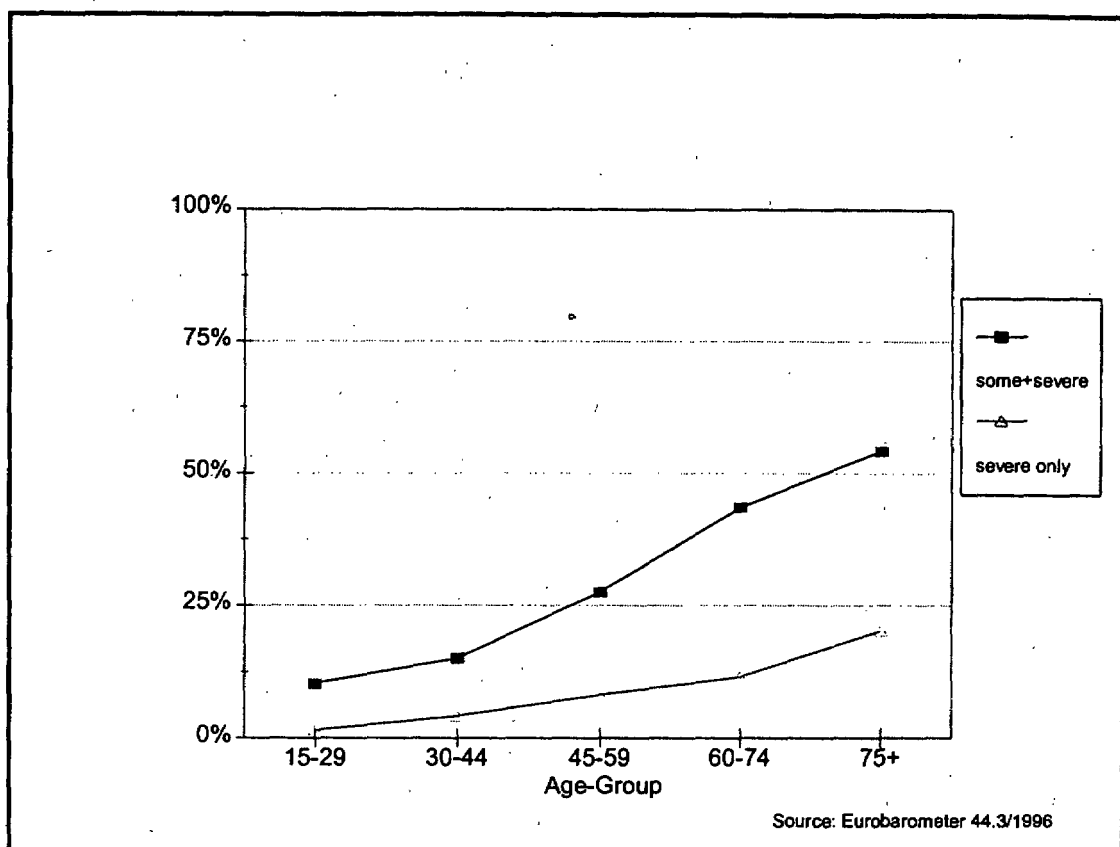
**Table 4.1**  
**Percent with Disability Due to Long-Standing Illness\***  
**Women 15+ Years, EU 15 (1996)**

	no %	yes,some %	yes,severe %	dk/refuse %
Finland	69.8	20.1	9.5	0.6
Portugal	69.9	17.2	12.4	0.5
Denmark	71.2	19.2	9.1	0.4
France	72.4	18.4	8.6	0.6
United Kingdom	74.0	20.1	5.6	0.3
Germany E	72.1	16.9	8.5	2.6
Sweden	74.9	17.1	8.0	0.0
Germany W	73.8	17.7	7.2	1.3
Greece	75.4	18.1	6.0	0.6
<b>EU 15</b>	<b>75.7</b>	<b>17.3</b>	<b>6.3</b>	<b>0.8</b>
Austria	75.0	18.8	4.4	1.8
Spain	78.4	15.8	4.8	1.0
The Netherlands	78.8	13.6	6.9	0.7
Belgium	80.5	15.6	3.5	0.4
Ireland	80.1	16.5	2.6	0.8
Italy	82.4	14.6	2.8	0.2
Luxembourg	83.9	10.6	4.2	1.3

Source: Eurobarometer 44.3/1996

\* Distribution of responses to the following question : "Do you have any long-standing illness, health problem or handicap that limits, to some extent or severely, your work or daily activities? This includes all types of health problems as well as those due to old age. If yes, to some extent or severely ?"

**Figure 4.2**  
**Percent with Disability Due to Long-Standing Illness**  
**by Age-Group and Severity, EU 15 (1996)**



**Table 4.2**  
**Percent with Disability Due to Long-Standing Illness\***  
**By Age-Group, EU 15 (1996)**

Age-group	some + severe	severe only
	%	%
15-29	10.2	1.5
30-44	15.0	4.1
45-59	27.4	8.1
60-74	43.5	11.6
75+	54.3	20.3

Source: Eurobarometer 44.3/1996

\* Distribution of responses to the following question : "Do you have any long-standing illness, health problem or handicap that limits, to some extent or severely, your work or daily activities? This includes all types of health problems as well as those due to old age. If yes, to some extent or severely ?"

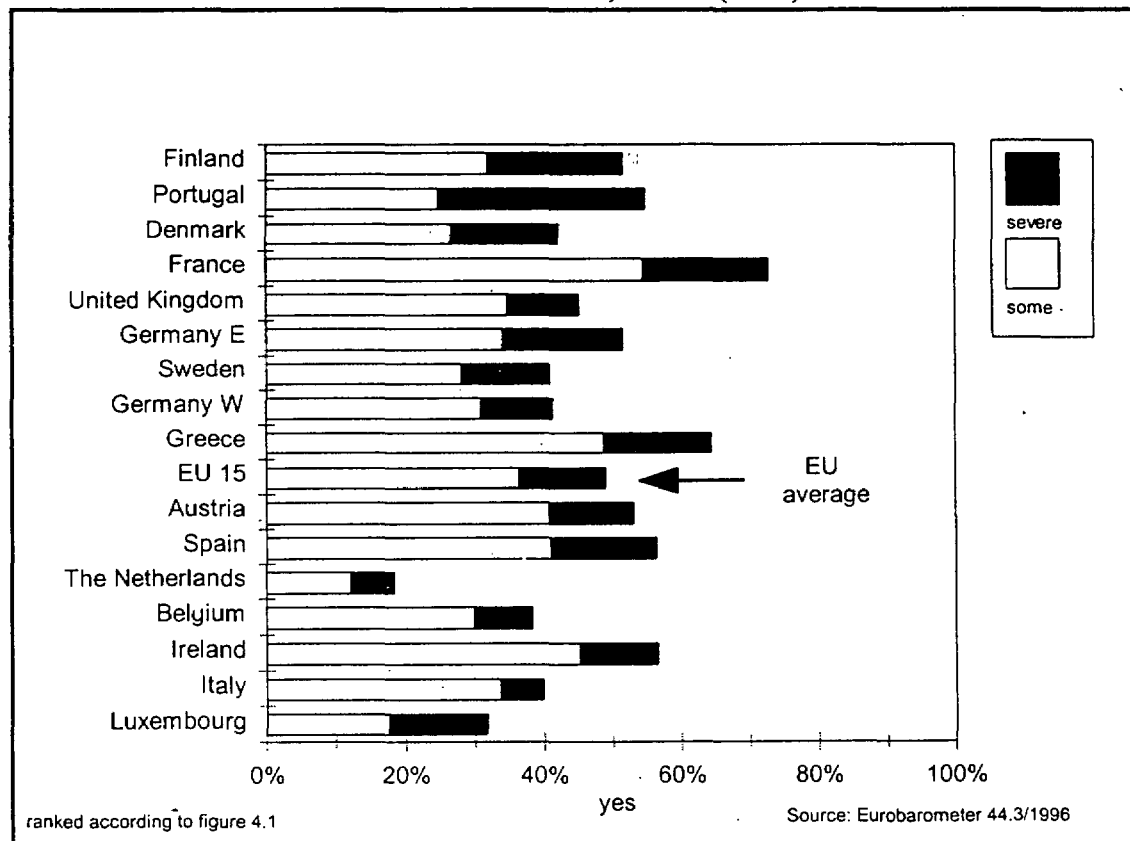
**Table 4.3**  
**Percent with Disability Due to Long-Standing Illness\***  
**Women 65+ Years, EU 15 (1996)**

	no %	yes, some %	yes, severe %	dk/refuse %
Finland	48.7	31.9	19.3	0.0
Portugal	44.3	24.7	29.9	1.0
Denmark	57.0	26.7	15.1	1.2
France	27.3	54.5	18.2	0.0
United Kingdom	55.1	34.7	10.2	0.0
Germany E	46.6	34.1	17.0	2.3
Sweden	59.6	28.1	12.4	0.0
Germany W	57.0	31.0	10.0	2.0
Greece	34.5	48.8	15.5	1.2
<b>EU 15</b>	<b>50.7</b>	<b>36.4</b>	<b>12.3</b>	<b>0.6</b>
Austria	45.1	40.7	12.1	2.2
Spain	44.1	40.9	15.1	0.0
The Netherlands	81.8	12.1	6.1	0.0
Belgium	61.9	29.9	8.2	0.0
Ireland	42.3	45.1	11.3	1.4
Italy	60.3	33.6	6.0	0.0
Luxembourg	68.6	17.6	13.7	0.0

Source: Eurobarometer 44.3/1996

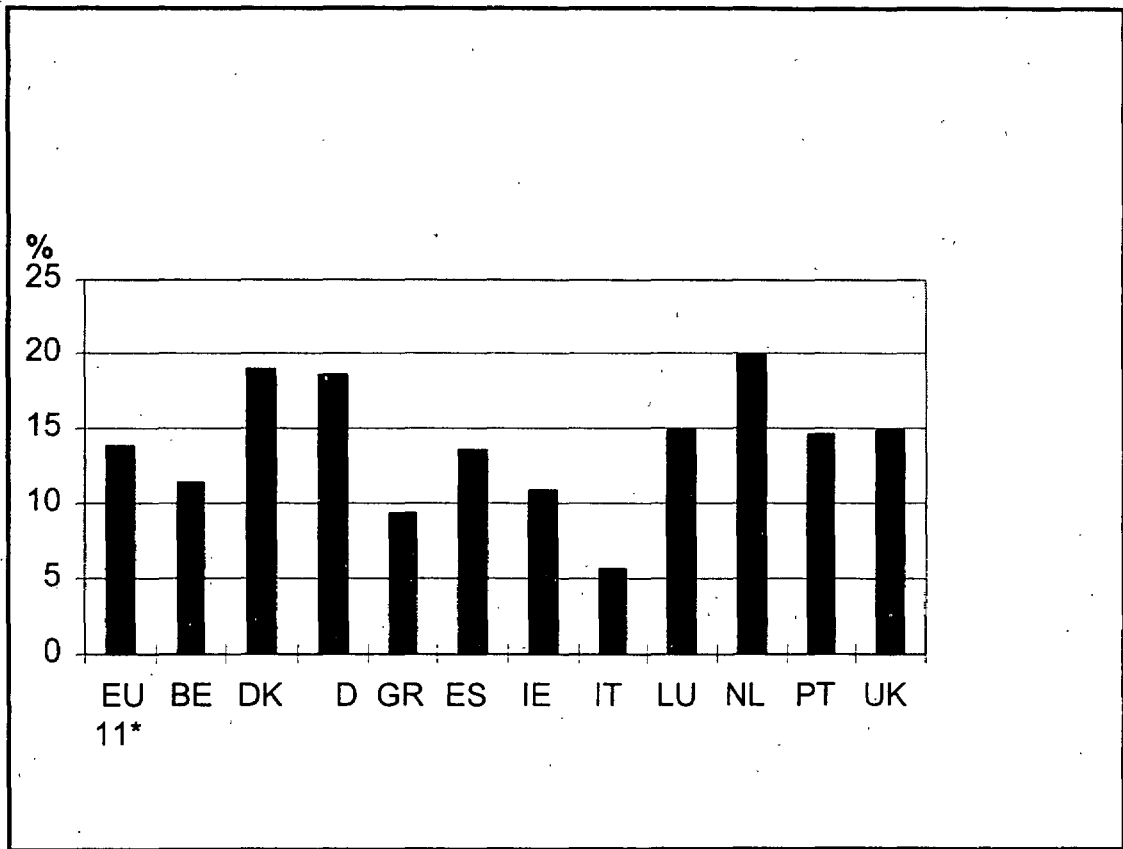
\* Distribution of reponses to the following question : "Do you have any long-standing illness, health problem or handicap that limits, to some extent or severely, your work or daily activities? This includes all types of health problems as well as those due to old age. If yes, to some extent or severely ?"

**Figure 4.3**  
**Percent with Disability Due to Long-Standing Illness\***  
**Women 65 + Years, EU 15 (1996)**



\* Distribution of reponses to the following question : "Do you have any long-standing illness, health problem or handicap that limits, to some extent or severely, your work or daily activities? This includes all types of health problems as well as those due to old age. If yes, to some extent or severely ?"

***Figure 4.4***  
**Percent with Restricted Activity in Past 2 Weeks**  
**Due to Illness or Injury**  
**Women 16+ Years, EU 11\* (1994)**



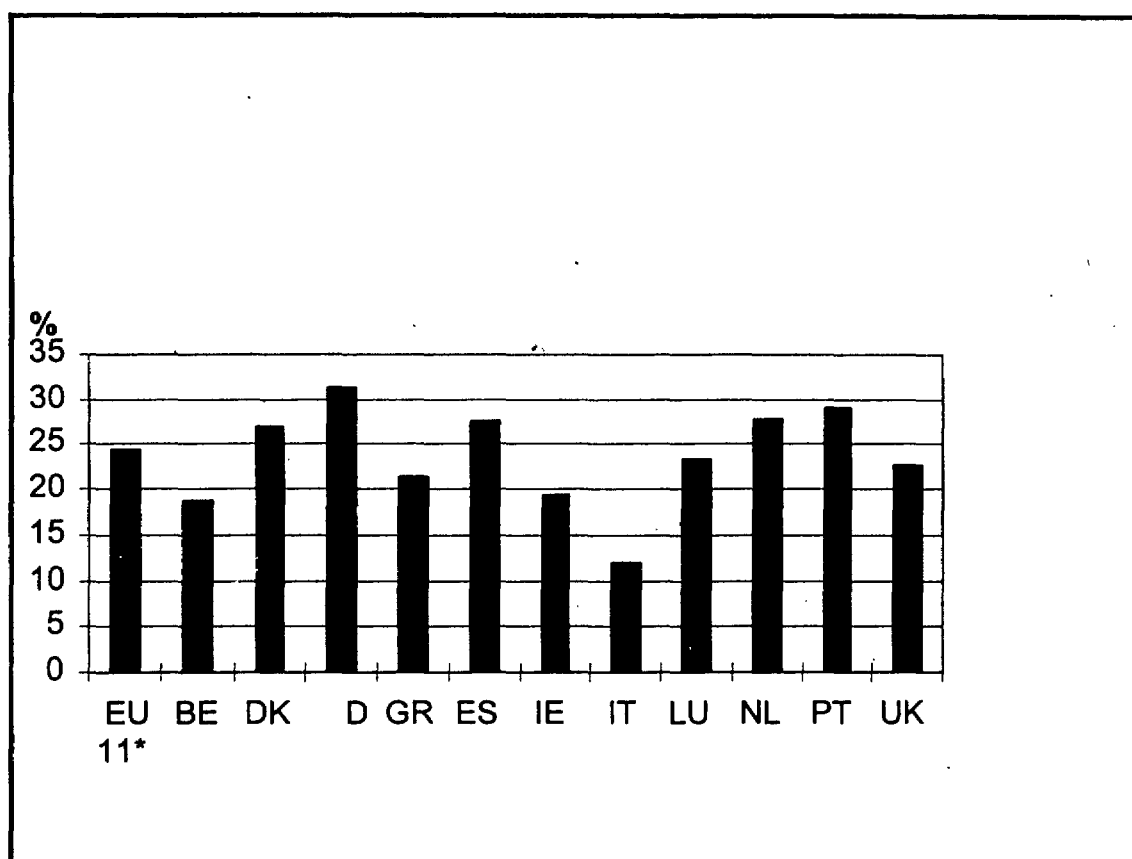
Source : European Community Household Panel 1994  
 \* Excluding France

***Table 4.4***  
**Percent with Restricted Activity in Past 2 Weeks**  
**Due to Illness or Injury**  
**Women 16+ Years, EU 11\* (1994)**

	Percent
EU 11*	13.8
Italy (IT)	5.6
Greece (GR)	9.4
Ireland (IE)	10.9
Belgium (BE)	11.4
Spain (ES)	13.6
Portugal (PT)	14.6
Luxembourg (LU)	14.9
United Kingdom (UK)	14.9
Germany (D)	18.6
Denmark (DK)	19.0
The Netherlands (NL)	19.9

Source : European Community Household Panel 1994  
 \* Excluding France

**Figure 4.5**  
**Percent with Restricted Activity in Past 2 Weeks**  
**Due to Illness or Injury**  
**Women 65+ Years, EU 11\* (1994)**



Source : European Community Household Panel 1994

\* Excluding France

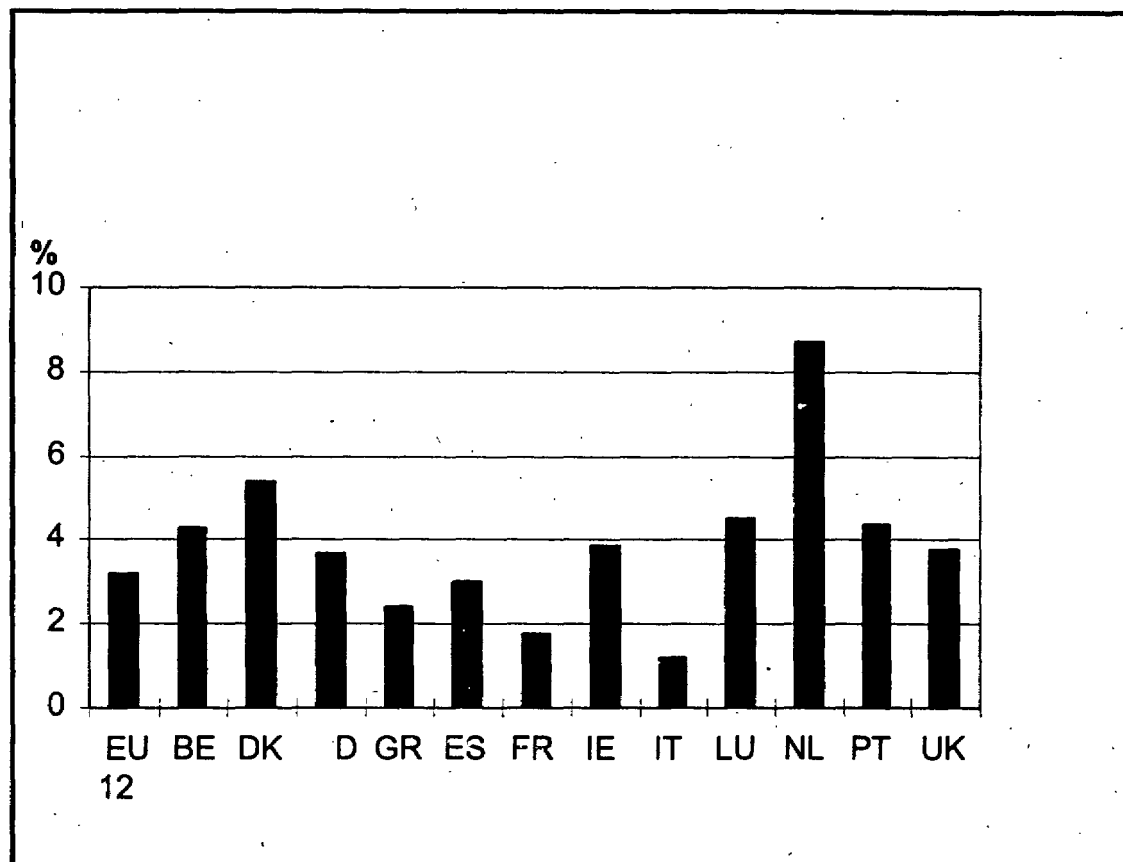
**Table 4.5**  
**Percent with Restricted Activity in Past 2 Weeks**  
**Due to Illness or Injury**  
**Women 65+ Years, EU 11\* (1994)**

	Percent
EU 11*	24.4
Italy (IT)	12.0
Greece (GR)	21.6
Ireland (IE)	19.4
Belgium (BE)	18.8
Spain (ES)	27.7
Portugal (PT)	29.0
Luxembourg (LU)	23.4
United Kingdom (UK)	22.7
Germany (D)	31.5
Denmark (DK)	27.0
The Netherlands (NL)	27.8

Source : European Community Household Panel 1994

\* Excluding France

***Figure 4.6***  
**Percent with Restricted Activity in Past 2 Weeks**  
**Due to Emotional or Mental Health Problem**  
**Women 16+ Years, EU 12 (1994)**



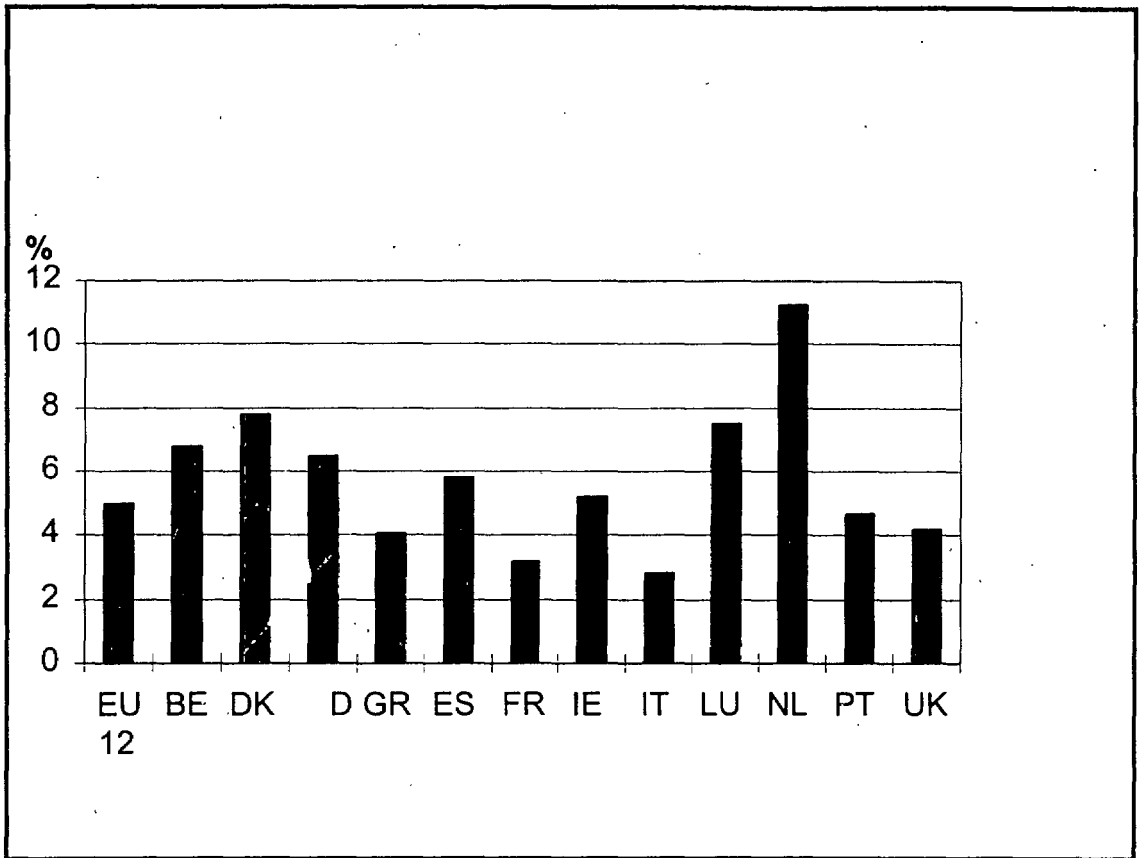
Source : European Community Household Panel 1994

***Table 4.6***  
**Percent with Restricted Activity in Past 2 Weeks**  
**Due to Emotional or Mental Health Problem**  
**Women 16+ Years, EU 12 (1994)**

	Percent
EU 12	3.2
Italy (IT)	1.2
Greece (GR)	2.4
Ireland (IE)	3.9
Belgium (BE)	4.3
Spain (ES)	3.0
Portugal (PT)	4.4
Luxembourg (LU)	4.5
France (FR)	1.8
Germany (D)	3.7
Denmark (DK)	5.4
The Netherlands (NL)	8.7
United Kingdom (UK)	3.8

Source : European Community Household Panel 1994

**Figure 4.7**  
**Percent with Restricted Activity in Past 2 Weeks**  
**Due to Emotional or Mental Health Problem**  
**Women 65+ Years, EU 12 (1994)**



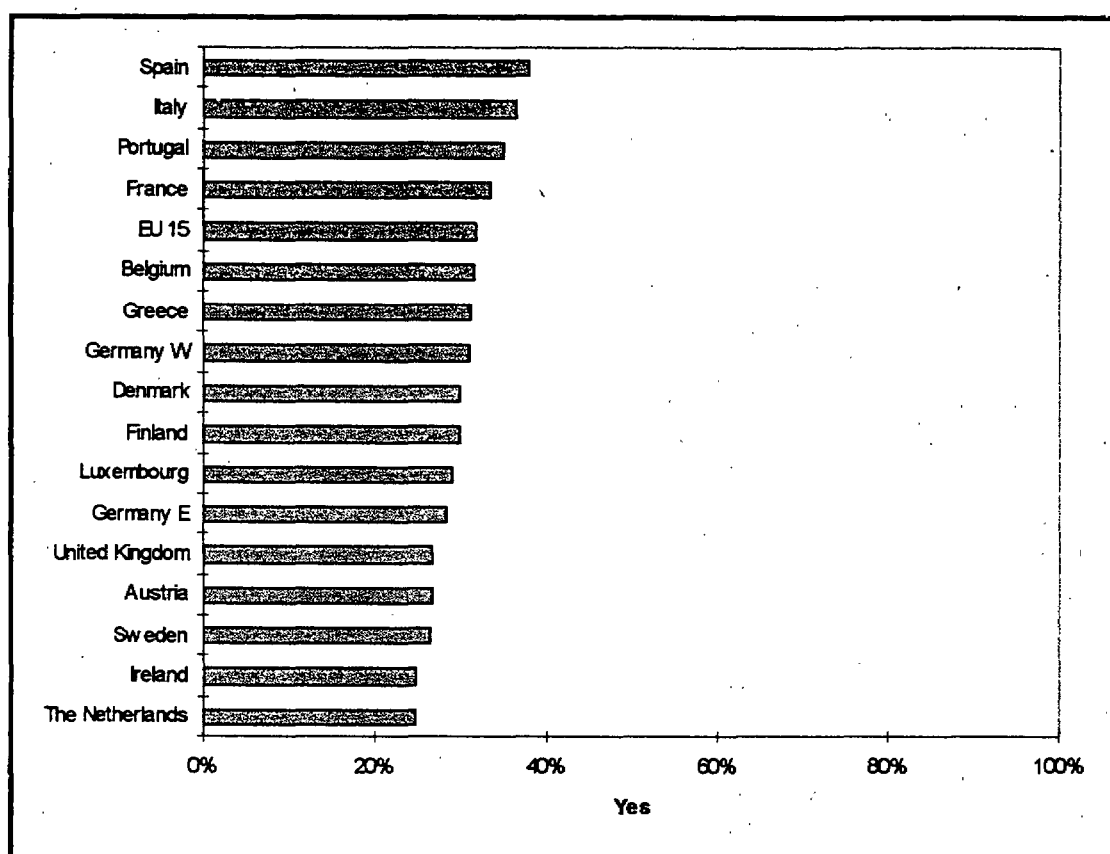
Source : European Community Household Panel 1994

**Table 4.7**  
**Percent with Restricted Activity in Past 2 Weeks**  
**Due to Emotional or Mental Health Problem**  
**Women 65+ Years, EU 12 (1994)**

	Percent
EU 12	5.0
Italy (IT)	2.8
Greece (GR)	4.1
Ireland (IE)	5.2
Belgium (BE)	6.8
Spain (ES)	5.8
Portugal (PT)	4.7
Luxembourg (LU)	7.5
France (FR)	3.2
Germany (D)	6.5
Denmark (DK)	7.8
The Netherlands (NL)	11.2
United Kingdom (UK)	4.2

Source : European Community Household Panel 1994

**Figure 4.8**  
**Percent Women with Doctor Consultation(s) in Past 2 Weeks**  
**Women 15+ Years, EU 15 (1996)**



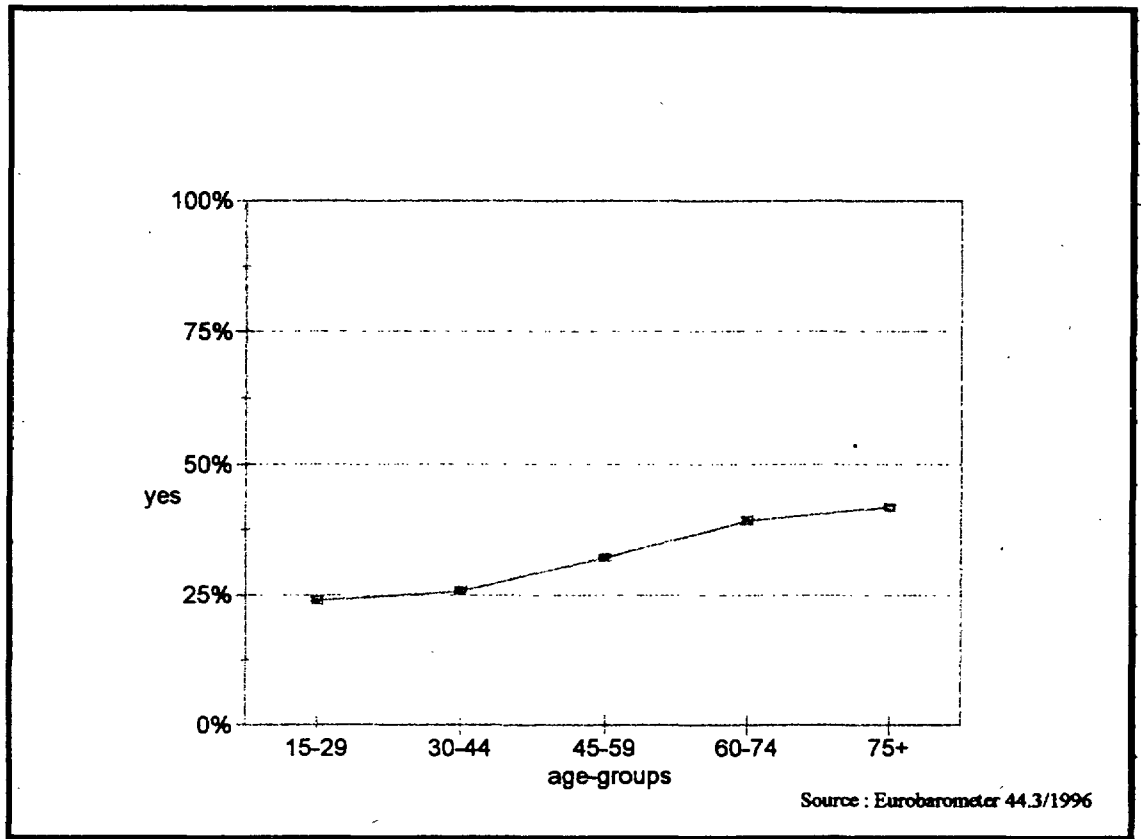
**Table 4.8**  
**Percent Women with Doctor Consultation(s) in Past 2 Weeks**  
**Women 15+ Years, EU 15 (1996)**

	Consultation	No Consultation
	%	%
Spain	37.8	62.2
Italy	36.4	63.6
Portugal	34.8	65.2
France	33.3	66.7
<b>UE 15</b>	<b>31.7</b>	<b>68.3</b>
Belgium	31.5	68.5
Greece	31.0	69.0
Germany W	30.9	69.1
Finland	29.7	70.3
Denmark	29.7	70.3
Luxembourg	28.9	71.1
Germany E	28.4	71.6
Austria	26.7	73.3
United Kingdom	26.7	73.3
Sweden	26.3	73.7
Ireland	24.6	75.4
The Netherlands	24.6	75.4

Source: Eurobarometer 44.3/1996



**Figure 4.9**  
**Percent Women with Doctor Consultation(s) in Past 2 Weeks**  
**By Age-Group, EU 15 (1996)**

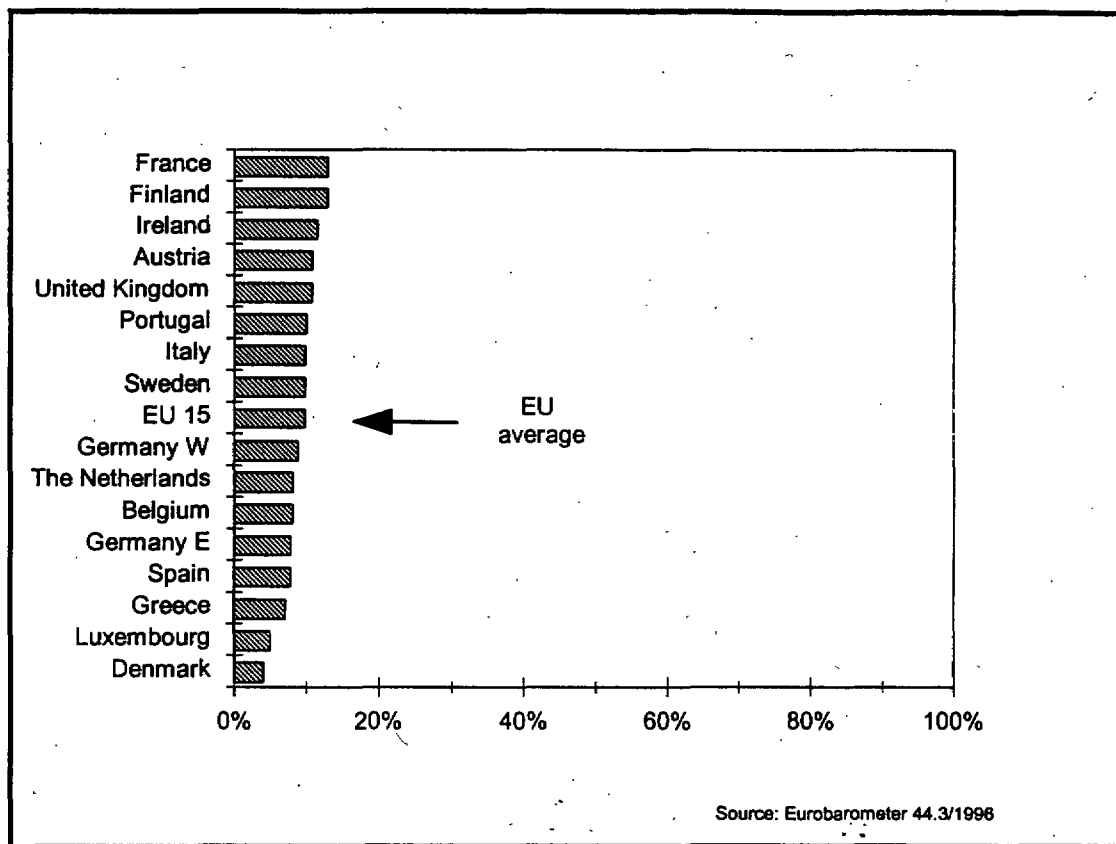


**Table 4.9**  
**Percent Women with Doctor Consultation(s) in Past 2 Weeks**  
**By Age-Group, EU 15 (1996)**

Age-Group	%
15-29	23.9
30-44	25.7
45-59	32.1
60-74	39.2
75+	41.8

Source: Eurobarometer 44.3/1996

***Figure 4.10***  
**Percentage with Non-Birth Hospitalisation(s) in Past Year**  
**Women 16+ Years, EU 15 (1996)**

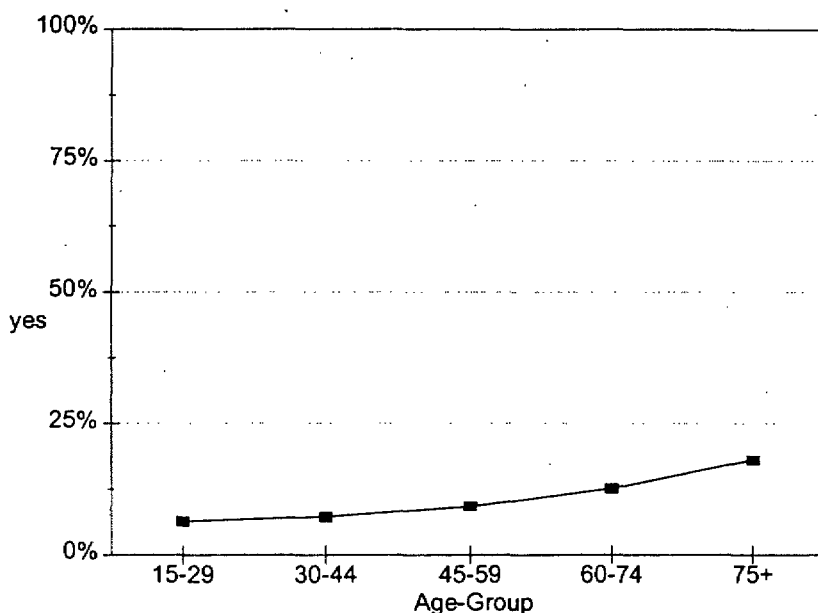


***Table 4.10***  
**Percentage with Non-Birth Hospitalisation(s) in Past Year**  
**Women 16+ Years, EU 15 (1996)**

	No Hospitalisation %	Hospitalisation %
France	87.3	12.7
Finland	87.3	12.7
Ireland	88.9	11.1
Austria	89.5	10.5
United Kingdom	89.6	10.4
Portugal	90.2	9.8
Italy	90.5	9.5
Sweden	90.5	9.5
<b>EU 15</b>	<b>90.5</b>	<b>9.5</b>
Germany W	91.5	8.5
The Netherlands	92.1	7.9
Belgium	92.2	7.8
Germany E	92.3	7.7
Spain	92.5	7.5
Greece	93.0	7.0
Luxembourg	95.4	4.6
Denmark	96.2	3.8

Source: Eurobarometer 44.3/1996

**Figure 4.11**  
**Percentage with Non-Birth Hospitalisation(s) in Past Year**  
**By Age-Group, EU 15 (1996)**



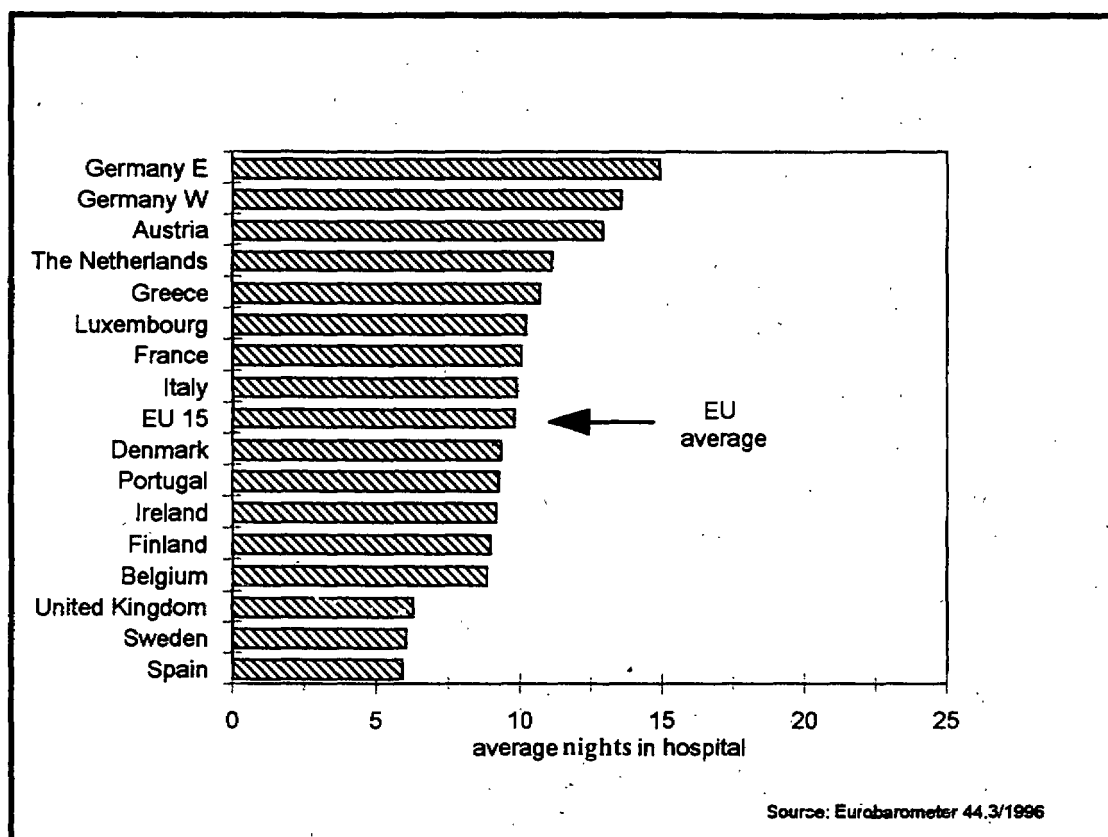
Source: Eurobarometer 44.3/1996

**Table 4.11**  
**Percentage with Non-Birth Hospitalisation(s) in Past Year**  
**By Age-Group, EU 15 (1996)**

Age-Group	No Hospitalisation %	Hospitalisation %
15-29	93.7	6.3
30-44	92.8	7.2
45-59	90.8	9.2
60-74	87.4	12.6
75+	82.0	18.0

Source: Eurobarometer 44.3/1996

**Figure 4.12**  
**Average Number of Nights in the Hospital\* in Past Year**  
**Women 15+ Years, EU 15 (1996)**



For those women with at least one (non-birth) hospitalisation in the past year.

**Table 4.12**  
**Average Number of Nights in the Hospital\* in Past Year**  
**Women 15+ Years, EU 15 (1996)**

	Number nights**
Germany E	14.9
Germany W	13.5
Austria	12.8
The Netherlands	11.1
Greece	10.7
Luxembourg	10.2
France	10.0
Italy	9.8
EU 15	9.8
Denmark	9.3
Portugal	9.2
Ireland	9.1
Finland	8.9
Belgium	8.8
United Kingdom	6.2
Sweden	6.0
Spain	5.9

Source : Eurobarometer 44.3/1996

\* For those women with at least one (non-birth) hospitalisation in the past year.

\*\* N= 729; 8 cases (outliers) are excluded (those above 60 days).

## 5. CAUSES OF DEATH AND TRENDS IN FEMALE MORTALITY

While the previous section focused on different measures of morbidity, this section concentrates on the main causes of death for women in the EC. It also describes the trends during the past two to three decades as well as the main risk factors associated with the diseases (and conditions) that are the main cause of female mortality in the EC (e.g., smoking and drinking). As will become apparent, much of the current premature mortality (i.e., deaths among women under 65 years) may be prevented through primary prevention (changes in life style) or secondary prevention (early detection of disease).

The main causes of female mortality (across all age-groups) are illustrated in Figure 5.1. The two largest causes of death among women are diseases of the circulatory system, which account for 43% of all deaths, and cancer which accounts for 26%. However, the major causes of death vary with age. Motor vehicle accidents are the main cause of mortality for women under 30 years, while suicide is the main cause for the 30-34 age-group. Cancer, specifically 'female cancers', such as breast and cervical cancer, is the main cause of death for women aged 35-64 years. For elderly women (65 years and older), it is diseases of the circulatory system that account for most deaths, approximately half of all deaths in this age-group<sup>1</sup>.

### 5.1 Motor Vehicle Accidents

Approximately 50,000 people are killed annually in the EU on the roads either as occupants of motor vehicles or pedestrians. Alcohol abuse is a significant cause of motor vehicle accidents. While such accidents are still an important cause of female mortality (see Figure 5.1), the rate of mortality has been declining. As can be seen in Figure 5.2, women's average mortality from motor vehicle accidents declined by nearly 40% from 1970 to 1992, to 6.42 deaths per 100,000. The rates range considerably, from a high in Luxembourg of 11.39 per 100,000 to a low of 4.14 per 100,000 in the UK. The rates of change since 1970 vary to an even greater extent, with all but three Member States reporting declining rates of between 25% (in Italy) to 64% (in the Netherlands<sup>a</sup> <sup>2</sup>). However, Greece reports an increase of almost 62%, while Luxembourg, Portugal, and Spain report smaller increases (4-14%).

### 5.2 Suicide and Self-Inflicted Injury

More than 40,000 people in the EU commit suicide each year<sup>3</sup>. While men are more likely than women to commit suicide, the so-called parasuicide (attempted suicide) rate is higher for women<sup>4</sup>, perhaps because women tend to use less violent methods than do men<sup>5</sup>. Overall female mortality from suicide has decreased by 24% since 1970, 6.24 deaths per 100,000 (see Figure 5.3). Suicide rates vary considerably within the EC, with a tendency toward higher rates in the North. Luxembourg has the highest suicide rate with 14.30 per

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a The educational programme implemented by the Traffic Safety Foundation in the Netherlands may have contributed to the decrease there<sup>2</sup>.

100,000, followed by Denmark with a rate of 13.67<sup>a</sup> 6. Both rates are over twice the EC average. Greece has the lowest rate with 1.21 deaths per 100,000.

Risk factors for suicide and parasuicide include alcoholism, depression, and socio-economic problems. Women with eating disorders, such as anorexia and bulimia, are also at higher risk of committing suicide and parasuicide<sup>7</sup>. Furthermore, women who have attempted suicide are much more likely to try again. Several studies estimates the risk of suicide within one to two years after a suicide attempt as several times higher than that for the average population<sup>8</sup>.

### 5.3 Cancer as a Cause of Female Mortality

Cancer is the second leading cause of death for women in the EC after diseases of the circulatory system, causing 26% of all female deaths in the Community in 1992 (see Figure 5.1). Furthermore, it is the primary cause of death for women 35-64 years of age. Figures 5.4 and 5.5 show women's mortality rates from cancer in the Member States. The EC average for women under 65 years was 69.74 per 100,000 in 1992, and 150.30 for women of all ages, indicating that most cancer mortality occurs among elderly women (over 65 years of age).

Cancer mortality for women under 65 years has declined by 13% since 1970, while it has declined by only 5% for all women combined. Among Member States there is a clear North-South division, with the Northern Member States generally reporting higher rates. However, both Sweden and Finland are below the EC average, with Finland having one of the lowest cancer rates in the EC. Conversely, Denmark has the highest rates in the EC (102.23 per 100,000 among women under 65 years, and 203.73 per 100,000 for all ages). Moreover, Denmark is the only Member State to report a (slight) increase (0.28%) since 1970 among women under 65 years, and one of only four Member States to see an increase in cancer mortality across all ages.

The so-called 'female' cancers (breast, cervix, and uterus) account for more than 23% of all cancer deaths. By comparison cancer of the digestive organs accounts for 32% and cancer of the respiratory system (trachea, bronchus, and lung) for 9% (see Figure 5.6). Importantly, the latter group of cancers have been rising among women but generally falling among men<sup>b</sup> 9, probably because smoking rates have been rising among women and falling among men (see Section 6.1). All these cancers are to a high degree related to life style and environment and therefore to a large extent preventable. They account for considerable premature mortality among women (under 65 years).

#### 5.3.1 Breast Cancer

Breast cancer is one of the most common types of cancer among women in the EC, as well as in other industrialised countries, such as the United States and Canada. Breast cancer was responsible for around 21% of all female cancer deaths in the EC in 1992 (see Figure 5.6). It is also the main cause of death for women aged 35-64 years<sup>10</sup>. It has been

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a A Danish study concluded that women there had a greater tendency to use violent methods, which may partly explain their relatively greater rates of 'success'<sup>6</sup>.

b Cancer of the trachea, bronchus, and lung has declined since 1970 by almost 20% among men, while it has increased by almost 70% among women in the EC<sup>9</sup>.

estimated that a woman in the EC has a 2-3% chance of developing breast cancer during her lifetime<sup>11</sup>.

The incidence of breast cancer is still rising in many Member States, though this may partly be due to the increased level of detection through screening programmes. Survival rates are improving because of earlier detection and more effective therapies, although survival rates are better for women under 50 years (60% survival after 5 years) than for older women (only 40% survival after 5 years)<sup>12</sup>. Survival rates also vary markedly according to whether the cancer is localised or has spread at the point of diagnosis. The rate of survival is over 90% when the cancer is localised within the breast, 75% when it has spread to adjoining areas, but below 20% when the cancer has reached other distant sites<sup>13</sup>.

**Figures 5.7 and 5.8** detail the EC breast cancer mortality rates in 1992. The average for women of all ages was 31.25 deaths per 100,000 (a 16% decline since 1970), while for women under 65 years, the mortality rate was 19.80 per 100,000 (a fall of 9.27%). These rates vary considerably across the Member States. For all ages Denmark has the highest rate (40.56 per 100,000) followed by the UK (39.23 per 100,000), while Greece has the lowest rate (21.32 per 100,000). The Greek rate, however, has risen by nearly 57% since 1970, a rise that is second only to the 73% increase of Spain.

Among women under 65 years Ireland has the highest rate (25.80 per 100,000), followed by Denmark (24.77 per 100,000). The Irish rate increased by 17% since 1970, while the Danish rate remained virtually unchanged. As was the case for the mortality rate for all ages, Greece has the lowest rate among women under 65 years (14.58 per 100,000), but has seen an increase of 45% over the rate in 1970. Spain also reports an increased rate (almost 62%). **Figure 5.9**, which shows how the rates in six EC countries changed between 1970 and 1992, clearly demonstrates the rising trend in Spain.

There is insufficient knowledge about the causes and relevant risk factors for breast cancer. Approximately 80% of women who develop it have none of the known risk factors<sup>14</sup>. The most important known parameters include age (the risk increases with age, and 2/3 of cases are in women over 50 years of age), and having a mother and/or a sister with breast cancer. Less important risk factors include early menarche (under 11), late menopause (over 54 years), being over 30 years at first full term pregnancy, and never having had any children. Other risk factors include having had certain breast diseases and a history of ovarian and/or endometrial cancer. It has been suggested that living in urbanised societies, the consumption of a diet high in animal fat and protein, and having high economic status may also be linked with breast cancer. Recent evidence suggests that alcohol consumption may also be a risk factor for breast cancer<sup>15</sup>.

Given the inadequate knowledge about the causes and associated risk factors of breast cancer, secondary prevention through early detection by self-examination, clinical examination and mammography is very important. Further research into the causes of breast cancer is needed to establish how far it might be preventable. International differences in incidence and studies on the development of breast cancer among different generations of immigrants support the idea that exposure to certain risk factors plays a key role<sup>16</sup>.

### 5.3.2 Cervical Cancer

Cancer of the cervix is the second most common of the 'female' cancers in the EC, responsible for around 2% of all cancer deaths (see **Figure 5.6**). Cervical cancer develops very slowly and, if the cancer is detected while still localised (pre-invasive), the 5-year relative survival rate is high, around 88%. However, if the cancer is detected in the later, invasive stages the survival rate falls to 13%<sup>17</sup>.

**Figures 5.10 and 5.11** show that mortality rates for cervical cancer have fallen in most Member States since 1970. The EC average mortality rate for women under 65 years has decreased to 2.28 per 100,000, corresponding to a decline of nearly 48% (**Figure 5.10**). For women of all ages mortality due to cervical cancer has declined by more than 40%, to 3.28 per 100,000 (**Figure 5.11**). Denmark has the highest mortality rate among women under 65 years of age (4.64 per 100,000) but has experienced a fall of more than 55% since 1970. Only in Spain<sup>a</sup> and Greece has the rate been rising, but it is still relatively low in these countries. Greece has the third lowest rate in the EC (1.31 per 100,000) while Spain has the fourth lowest (1.66 per 100,000). Italy has the lowest rate at 0.75 per 100,000.

The picture for all ages closely mirrors that of the under 65 age-group. Denmark has the highest rate, while Italy has the lowest rate, and Spain and Greece are the only Member States to report increases in mortality since 1970 (see **Figure 5.11**).

The general reduction in mortality may partly be attributable to effective screening programmes. It is now widely accepted that cervical cancer occurs after sexual transmission of a carcinogen. The principal known risk factor for cervical cancer is infection with the human papilloma virus (HPV16 and HPV18) and, to a lesser degree, with other sexually transmitted diseases (STDs), such as herpes, gonorrhoea, and chlamydia. Strong risk factors for this type of cancer are, therefore, 'unsafe' sex in general, early age at first intercourse (under 16 years), multiple sexual partners, and a past (or present) sexual partner infected with HPV or other STD(s). Other risk factors include active and/or passive smoking, infection with HIV, and poor nutrition<sup>19</sup>.

### 5.3.3 Cancer of the Respiratory System

As can be seen from **Figure 5.6**, 9% of deaths from cancer among women are attributable to lung cancer<sup>b</sup>. The EC average mortality rate for women of under 65 years has increased since 1970 by almost 45% to 66.3 per 100,000 (see **Figure 5.13**), while the corresponding rate for all women has increased by almost 70% since 1970, to 14.05 per 100,000 (see **Figure 5.14**). The rate of increase since 1970 has been most marked in the Netherlands and Denmark (for all ages as well as for the under 65 year-olds), while Spain has actually experienced a *decline* in lung cancer mortality among women (for all ages as well as for the under 65 year-olds). France has also seen a decline in lung cancer mortality but only among women less than 65 years old.

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a Research in Spain to determine causes for increased mortality from cervical cancer found a connection with increased sexual activity associated with increased tourism and a low level of education<sup>18</sup>.

b In this section we refer to lung cancer for the sake of brevity, but this includes other cancers of the respiratory system, such as cancer of the trachea and bronchus.



Within the EC, Denmark stands out as having by far the highest female mortality rates due to lung cancer, followed by the UK, Ireland, and the Netherlands. The Danish mortality rate is more than three times the EC average among women under 65 years, and more than twice the EC average for all ages. In contrast, the Mediterranean countries tend to have lower lung cancer mortality rates (see **Figures 5.13 and 5.14**). These results are consistent with the lower levels of smoking among women in the Mediterranean countries during the past decades and the high level of smoking among Danish women during the past forty years or more<sup>20</sup>.

Given the high increases in lung cancer mortality among women, it is not surprising that there is considerably uncertainty in the general population (of women) in the EC about which gender is more affected by lung cancer. As shown in **Figure 5.15** and **Table 5.1**, about half of all women asked in the 1996 Eurobarometer survey, thought that men were more affected by lung cancer than women, but more than one third did not know. Responses varied considerably within the EC. In particular, in Finland, 80% of those asked thought men had a higher incidence of lung cancer, whereas in Sweden 48% did not know. This striking difference between neighbouring countries may be partly explained by the higher female lung cancer mortality rates in Sweden (above the EC average) than in Finland which is below the EC average (see **Figures 5.13 and 5.14**).

Lung cancer is typically caused by inhalation of carcinogenic materials, such as tobacco smoke and asbestos, and by exposure to ionising radiation<sup>21</sup>. In particular, tobacco smoking is associated with greatly elevated risk of lung cancer. One study estimates that the risk of lung cancer is more than 12 times higher among women smokers than among non-smokers, and 25 times as great among male smokers as among non-smokers, corresponding to about 85 to 90% of all lung cancers being caused by smoking<sup>22</sup>. Passive smoking has also been shown to increase the risk of lung cancer although to a much lower degree<sup>23</sup>. Other risk factors include environmental pollution, poor nutrition, overcrowded housing, and low socio-economic status<sup>24</sup>.

## **5.4 Diseases of the Circulatory System (Cardiovascular Diseases)**

Diseases of the circulatory system (particularly ischaemic heart disease<sup>a</sup> and cerebrovascular diseases, or stroke) are disorders of the heart and blood vessels. They are the main cause of mortality (as well as morbidity and disability) among women generally in the EC (see **Figure 5.1**) and the second most important cause of premature death (under 65 years of age) after cancer.

These diseases are characteristic of developed Western societies and life style. They are also related to social class<sup>25</sup>. Thus, to a great extent these diseases are preventable through life style changes, such as not smoking and eating a diet low in saturated fats, sugar and salt<sup>26</sup>. Women appear to be differently affected by these diseases than men: They develop them more often, but at a later age, and particularly after the age of 65 years, when incidence and mortality increases rapidly. Another difference is that women have more strokes while men have more heart attacks.

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<sup>a</sup> Ischaemic heart disease is frequently used synonymously with coronary heart disease, however, the two are not strictly identical, because it is possible to have coronary heart disease without ischaemia (poor oxygen flow to the heart). Because death is caused by a lack of oxygen flow to the heart (i.e., by ischaemia), ischaemic heart disease is the term used in this report.

Death rates for circulatory diseases have decreased in all Member States since 1970 among women under 65 years of age. The EC average mortality rate for this age-group has dropped more than 50% since 1970, to 31.56 per 100,000 (Figure 5.1), with a range going from 64% decline in Finland to 32% decline in Denmark and Greece. The story is similar for women of all ages, except that in this case, the overall decline (since 1970) in mortality due to diseases of the circulatory system was only 37%. Furthermore, the overall mortality rate is much higher (248.44 per 100,000). Again, the Member States vary in the extent to which their mortality rates have declined. In particular, Greece stands out because it reports an overall increase (7.54%) in mortality since 1970 (Figure 5.17).

## 5.5 Ischaemic Heart Disease

Ischaemic heart disease is the largest single cause of female mortality in the EC. Despite this, it is often perceived by the public and media as a 'male' disease. As shown in **Figure 5.18** and **Table 5.2**, almost 60% of the women asked during the 1996 Eurobarometer survey, indicated that they thought that heart disease affected many more men than women. Over the last years some Member States have implemented prevention campaigns specifically addressed to women, for example, the campaign organised by the British Heart Foundation which referred to heart disease as 'Britain's no. 1 lady killer'<sup>27 28</sup>.

Heart disease follows a different pattern for women than for men. Typically men begin to develop ischaemic heart disease at an earlier age, often in their 40s and 50s, while women tend to be in their 60s, i.e., after menopause. This difference is assumed to be caused partly by the protective characteristics of the female oestrogen hormone, but may also be the result of lower iron stores in pre-menopausal women<sup>29</sup>. Data about coronary heart disease in women are generally insufficient, in part because many studies are carried out on men. Further investigation is required into claims that women more often have unrecognised symptoms, different symptoms, and different survival rates than do men<sup>30 31 32</sup>.

While there are significant variations in mortality from ischaemic heart disease, rates have generally been declining since 1970. Among women under 65 years of age, the mortality rate has declined by just over one third since 1970, to about 12 per 100,000 (**Figure 5.19**). The mortality rate varies from a high of 24.31 per 100,000 in Ireland to 4.51 per 100,000 in France. The rate of decline also varies, from a high of 60% in Finland to a low of about 2% in Greece.

As already noted, mortality rates are much higher among older women, accounting for the much higher rates when this group is included. As shown in **Figure 5.20**, the EC average mortality rate for ischaemic heart disease among women of all ages is 84.75 per 100,000. The range varies from a high of 149.75 per 100,000 in Finland to a low of 36.94 per 100,000 in France. All but three Member States (Greece, Spain, and Germany) report declines in overall mortality, ranging from 20% (in Portugal) to 46% (in Sweden).

The decrease in mortality rates is linked with changes in diet, notably a decrease in saturated fat intake, and declining smoking rates in certain groups and Member States. Notwithstanding its decline, ischaemic heart disease continues to be one of the main causes of premature and overall mortality for women in the EC. Moreover, decreases in mortality rates may hide increased rates of morbidity, specifically among elderly women. Furthermore, ischaemic heart disease is linked with chronic disability, high health care

expenditures and other economic costs, such as loss of working days, and often with a decline in quality of life.

There are many risk factors for heart disease. Some, such as ageing and genetic disposition, can not be altered, but the three most important risk factors - smoking, hypertension, and high levels of blood cholesterol - may be influenced either by life style changes or through medication.

Smoking is the single most important risk factor. The risk increases with the number of cigarettes smoked, in particular, for women over 35 years of age, who take oral contraceptives. Women are particularly vulnerable to developing hypertension after the age of 50 years. Furthermore, blood cholesterol levels also increase with age. Other risk factors for ischaemic heart disease include being overweight (see Section 6.3), diabetic, having a sedentary life style, and drinking excessively. Lower socio-economic status and occupational stress have also been associated with increased risk of ischaemic heart disease<sup>33</sup>.

Interestingly, stress is often perceived by the general public as a key risk factor for developing heart disease, even though medical evidence to support this notion is lacking, except as regards *occupational* stress. As shown in **Figure 5.21** and **Table 5.3**, almost 20% of the women asked during the 1996 Eurobarometer survey, rated stress as the *main* risk factor for heart disease. In Greece, Sweden, and the Netherlands over 30% regarded stress as a principal risk. In comparison with other (known) risk factors, stress was the second most frequently mentioned main risk factor, after smoking but ahead of an unhealthy diet, overweight, lack of exercise and excessive alcohol consumption (in that order). These results indicate that there is significant ignorance throughout the EC among women as to the main risk factors for heart disease. This points to an area where public health interventions might be targeted.

## 5.6 Cerebrovascular Disease (Stroke)

Another major disease of the circulatory system is cerebrovascular disease (stroke). The risk of this disease for women increases with age, especially after 65, in part because of increased rates of high blood pressure among older women. As with ischaemic heart disease, the mortality rates for stroke for women under 65 years have declined significantly since 1970, dropping almost 43% to an average of 8.73 deaths per 100,000. All Member States have experienced declines, ranging from a high of 69% in Ireland to a low of 2% in Luxembourg (see **Figure 5.22**). Among women under 65 years, Portugal has the highest mortality rate (18.42 per 100,000) while France has the lowest (5.80 per 100,000).

As already mentioned, the highest mortality from stroke occurs among elderly women. As a result, the mortality rates for all ages, which include this age-group, are much higher than those shown in **Figure 5.22**. As shown in **Figure 5.23**, the average mortality for women of all ages in the EC is 75.93 per 100,000. This rate varies from a high of 175.63 per 100,000 in Portugal to a low of 44.11 per 100,000 in France, which has the lowest rate in the EC of both ischaemic heart disease and cerebrovascular disease. As was the case for younger women, mortality rates for all age-groups combined have declined since 1970, by almost 43% at the EC level. However, rates have actually increased in

Luxembourg (10%) and in Greece (1%). In the other Member States, mortality rates have declined between 26% (in Portugal) and 60% (in France).

The main risk factor for cerebrovascular disease is high blood pressure. Other risk factors include previous heart disease and/or stroke, diabetes, and excessive alcohol consumption. Smoking has also been linked with cerebrovascular disease, although to a lesser extent than with ischaemic heart disease<sup>34</sup>. As with that disease, healthy life styles and appropriate health care can contribute to a reduction in female deaths, particularly among women under 65.

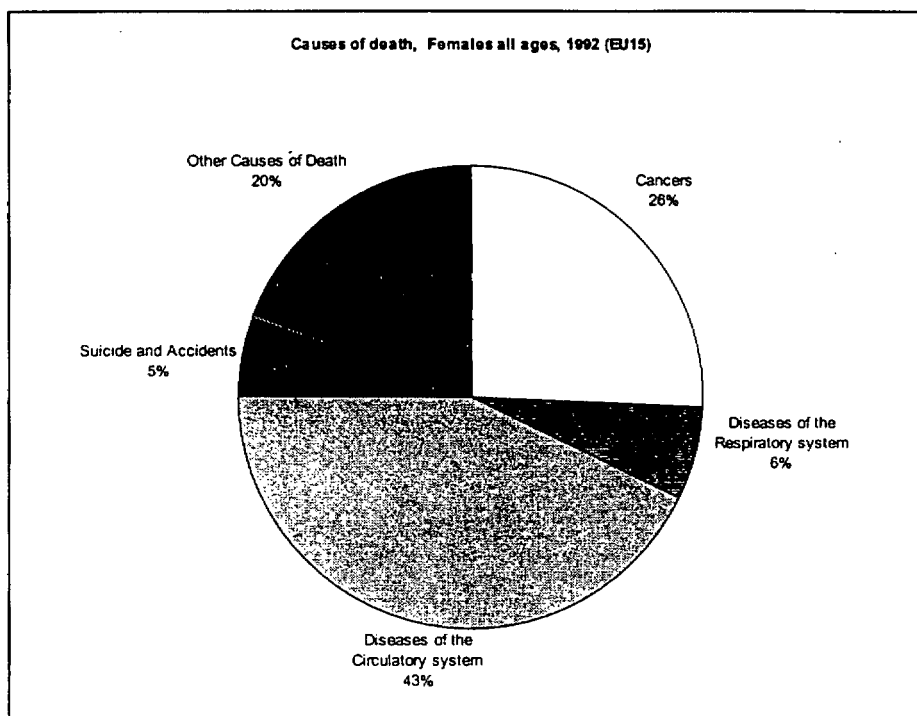
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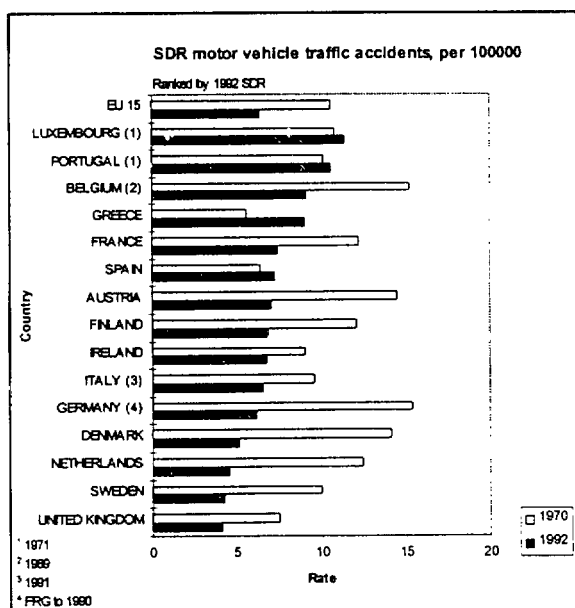
## [Figures and Tables]

**Figure 5.1**  
**Main Causes of Death (1992)**  
**All Women, EU (15)**



Source: HFA 1996

**Figure 5.2**  
**Motor Vehicle Traffic Accident Mortality (1992)**  
**All Women, EU 15**



Source - HFA 1996

SDR motor vehicle traffic accidents, per 100000		
Females		
Country	1992	% change since 1970
EU 15	6.42	-39.55
LUXEMBOURG <sup>1</sup>	11.39	5.37
PORTUGAL <sup>1</sup>	10.60	4.43
BELGIUM <sup>2</sup>	9.14	-39.87
GREECE	9.05	61.61
FRANCE	7.45	-38.88
SPAIN	7.30	13.88
AUSTRIA	7.04	-51.52
FINLAND	6.82	-43.59
IRELAND	6.79	-24.97
ITALY <sup>3</sup>	6.51	-31.97
GERMANY <sup>4</sup>	6.19	-59.65
DENMARK	5.12	-63.79
NETHERLANDS	4.57	-63.12
SWEDEN	4.28	-57.07
UNITED KINGDOM	4.14	-44.95

<sup>1</sup> 1971

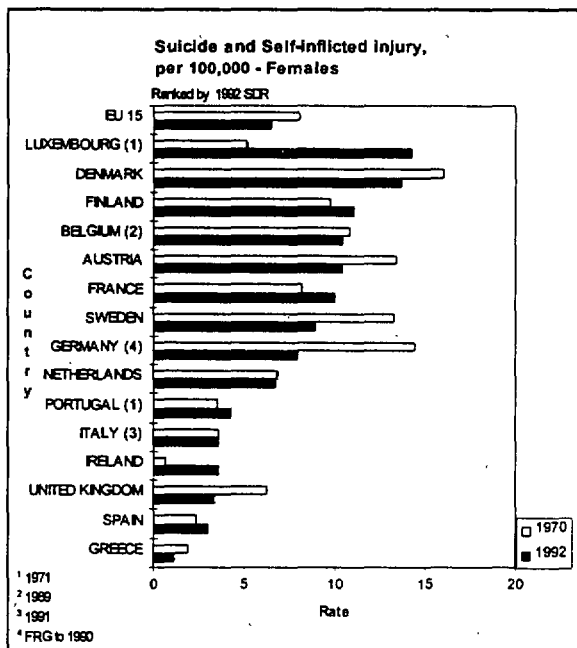
<sup>2</sup> 1989

<sup>3</sup> 1991

<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.3**  
**Suicide and Self-Inflicted Injury Mortality (1992)**  
**All Women, EU 15**



Source - HFA 1996

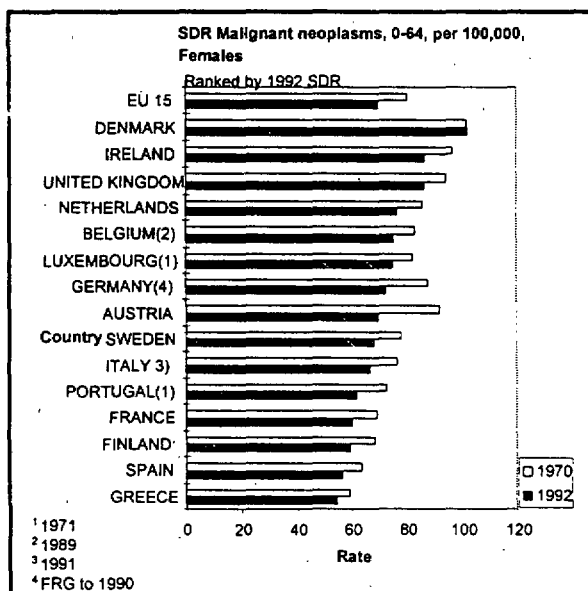
**Suicide and Self-inflicted injury, per 100,000 Females**

Country	1992	% change since 1970
EU 15	6.24	-24.27
LUXEMBOURG <sup>1</sup>	14.30	179.30
DENMARK	13.67	-14.62
FINLAND	11.00	-13.05
BELGIUM <sup>2</sup>	10.46	-3.33
AUSTRIA	10.39	-22.23
FRANCE	10.01	22.22
SWEDEN	8.90	-32.78
GERMANY <sup>4</sup>	7.96	-44.84
NETHERLANDS	6.72	-1.47
PORTUGAL <sup>1</sup>	4.23	20.17
ITALY <sup>3</sup>	3.63	1.68
IRELAND	3.61	464.06
UNITED KINGDOM	3.36	-46.41
SPAIN	2.99	26.69
GREECE	1.21	-36.32

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.4**  
**Cancer Mortality (1992)**  
**Women 0-64 Years, EU 15**



Source - HFA 1996

**SDR Malignant neoplasms, 0-64, per 100,000 Females**

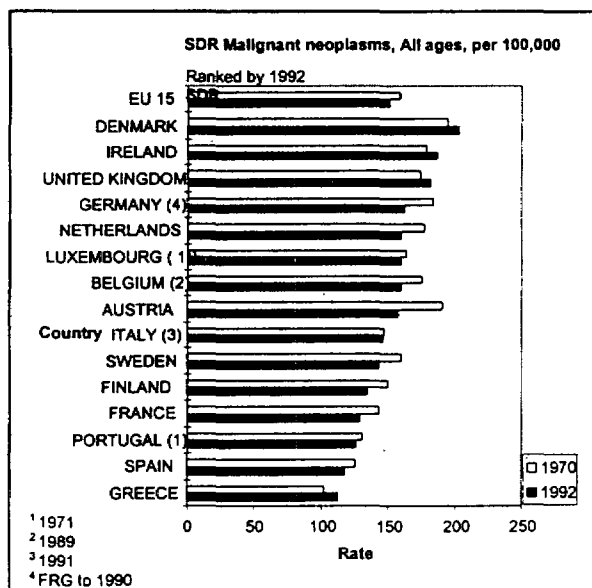
Country	1992	% change since 1970
EU 15	69.74	-13.02
DENMARK	102.23	0.28
IRELAND	86.98	-9.87
UNITED KINGDOM	86.23	-8.74
NETHERLANDS	76.50	-10.88
BELGIUM <sup>2</sup>	75.06	-9.64
LUXEMBOURG <sup>1</sup>	74.66	-9.19
GERMANY <sup>4</sup>	72.58	-17.34
AUSTRIA	69.52	-24.34
SWEDEN	68.27	-12.27
ITALY <sup>3</sup>	66.90	-12.63
PORTUGAL <sup>1</sup>	61.48	-15.01
FRANCE	60.04	-13.27
FINLAND	59.19	-13.46
SPAIN	56.36	-11.22
GREECE	54.77	-7.51

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996



**Figure 5.5**  
**Cancer Mortality (1992)**  
**All Women, EU 15**



Source - HFA 1996

**SDR Malignant neoplasms, All ages, per 100,000**

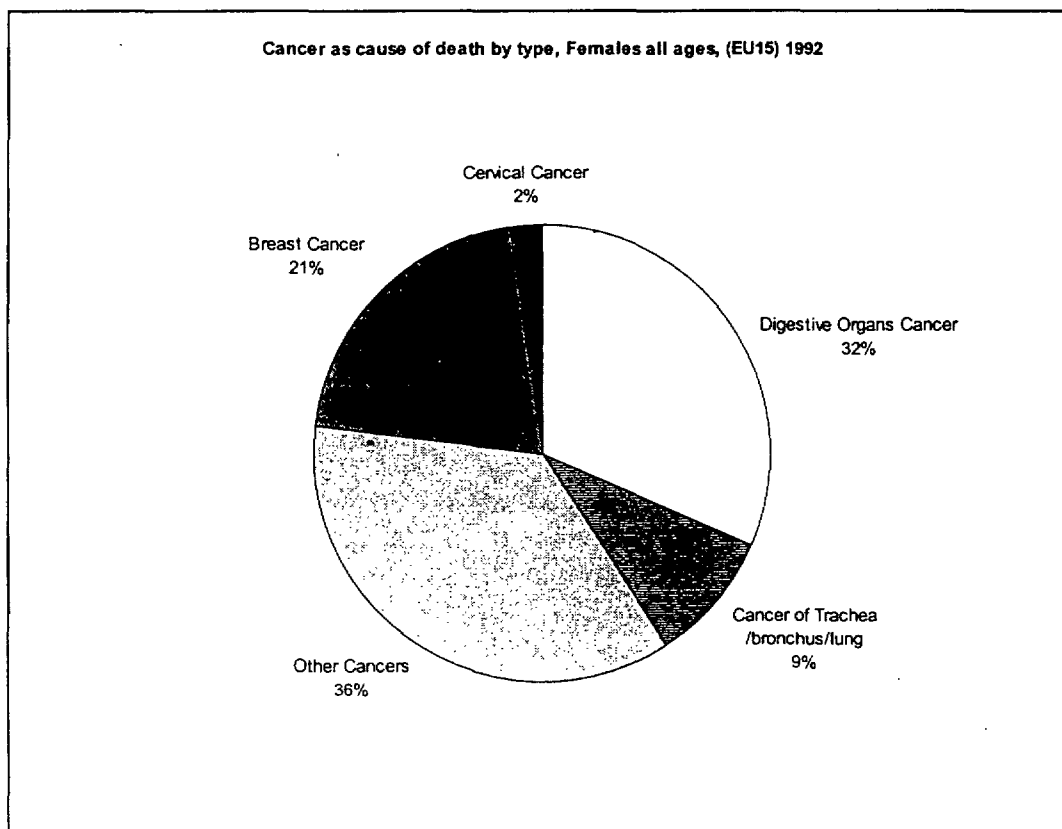
Ranked by 1992 SDR

Country	1992	% change since 1970
EU 15	150.30	-5.05
DENMARK	203.73	4.57
IRELAND	186.53	4.39
UNITED KINGDOM	182.37	4.66
GERMANY <sup>4</sup>	162.43	-11.87
NETHERLANDS	159.99	-9.69
LUXEMBOURG <sup>1</sup>	159.86	-1.93
BELGIUM <sup>2</sup>	159.80	-8.65
AUSTRIA	157.23	-17.36
ITALY <sup>3</sup>	145.93	-0.67
SWEDEN	143.04	-10.24
FINLAND	134.66	-9.95
FRANCE	128.78	-9.65
PORTUGAL <sup>1</sup>	125.57	-3.54
SPAIN	117.42	-6.76
GREECE	112.60	9.94

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

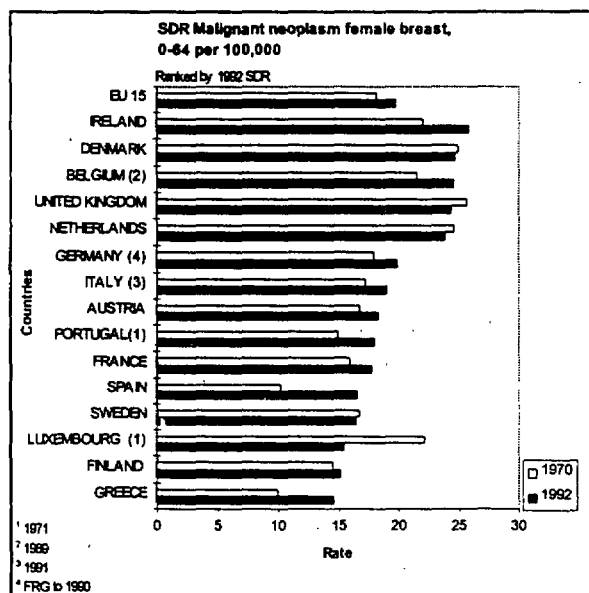
Source - HFA 1996

**Figure 5.6**  
**Cancer Mortality in Women (1992)**  
**All Women, EU 15**



Source - HFA 1996

**Figure 5.7**  
**Breast Cancer Mortality (1992)**  
**Women 0-64 Years, EU 15**



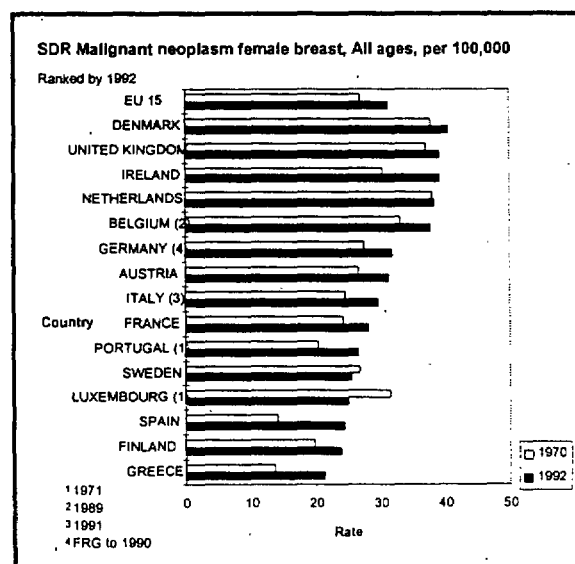
Source - HFA 1996

SDR Malignant neoplasm female breast, 0-64 per 100,000		
Country	1992	% change since 1970
EU 15	19.80	9.27
IRELAND	25.80	17.22
DENMARK	24.77	-0.84
BELGIUM <sup>1</sup>	24.63	14.77
UNITED KINGDOM	24.36	-5.18
NETHERLANDS	23.86	-3.28
GERMANY <sup>4</sup>	19.89	10.81
ITALY <sup>3</sup>	19.06	10.62
AUSTRIA	18.31	9.12
PORTUGAL <sup>1</sup>	17.96	20.05
FRANCE	17.75	11.57
SPAIN	16.60	62.11
SWEDEN	16.43	-1.56
LUXEMBOURG <sup>1</sup>	15.46	-30.30
FINLAND	15.12	4.49
GREECE	14.58	45.07

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.8**  
**Breast Cancer Mortality (1992)**  
**All Women, EU 15**



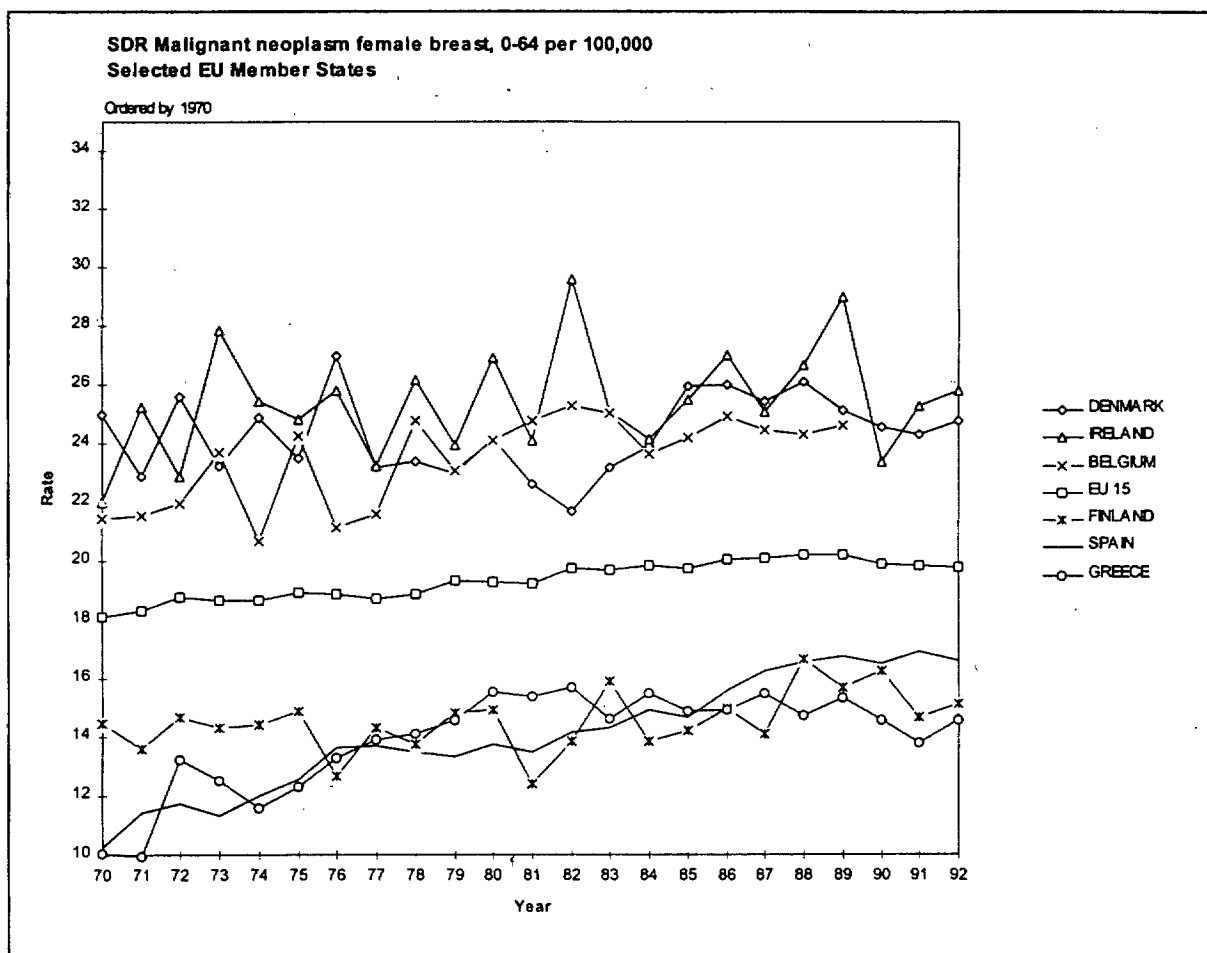
Source - HFA 1996

SDR Malignant neoplasm female breast, All ages, per 100,000		
Ranked by 1992 SDR		
Country	1992	% change since 1970
EU 15	31.25	16.26
DENMARK	40.56	6.79
UNITED KINGDOM	39.23	5.80
IRELAND	39.17	28.55
NETHERLANDS	38.47	1.16
BELGIUM <sup>1</sup>	37.93	14.80
GERMANY <sup>4</sup>	31.87	15.64
AUSTRIA	31.29	17.94
ITALY <sup>3</sup>	29.83	21.01
FRANCE	28.11	15.68
PORTUGAL <sup>1</sup>	26.57	29.80
SWEDEN	25.66	-4.07
LUXEMBOURG	24.99	-20.74
SPAIN	24.40	73.67
FINLAND	23.82	20.55
GREECE	21.32	56.88

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

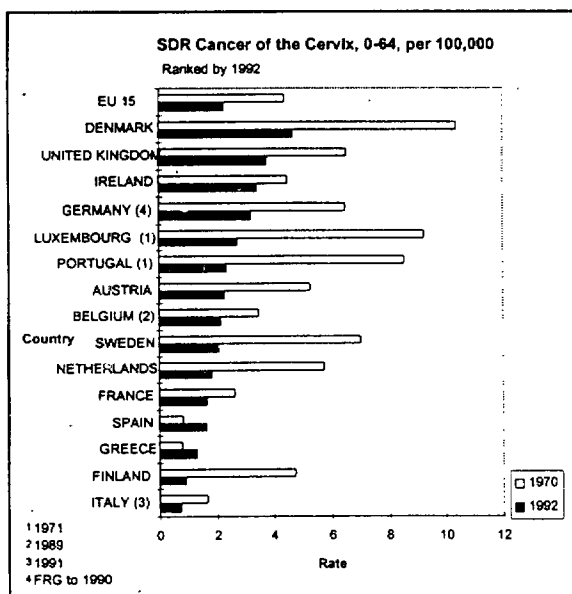
Source - HFA 1996

**Figure 5.9**  
**Breast Cancer Mortality (1992)**  
**All Women 1970-1992, EU 15**



Source- HFA 1996

**Figure 5.10**  
**Cervical Cancer Mortality (1992)**  
**Women 0-64 Years, EU 15**



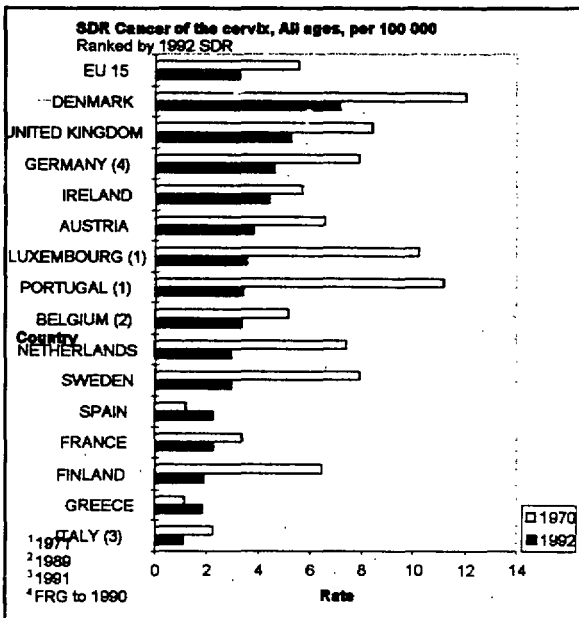
Source - HFA 1996

SDR Cancer of the cervix, 0-64, per 100,000		
Country	1992	% change since 1970
EU 15	2.28	-47.71
DENMARK	4.64	-55.34
UNITED KINGDOM	3.78	-42.02
IRELAND	3.41	-23.88
GERMANY <sup>4</sup>	3.20	-50.54
LUXEMBOURG <sup>1</sup>	2.71	-70.61
PORTUGAL <sup>1</sup>	2.30	-73.10
AUSTRIA	2.26	-56.87
BELGIUM <sup>2</sup>	2.14	-37.97
SWEDEN	2.05	-70.80
NETHERLANDS	1.84	-67.83
FRANCE	1.67	-36.26
SPAIN	1.66	95.29
GREECE	1.31	61.73
FINLAND	0.90	-81.05
ITALY <sup>3</sup>	0.75	-55.36

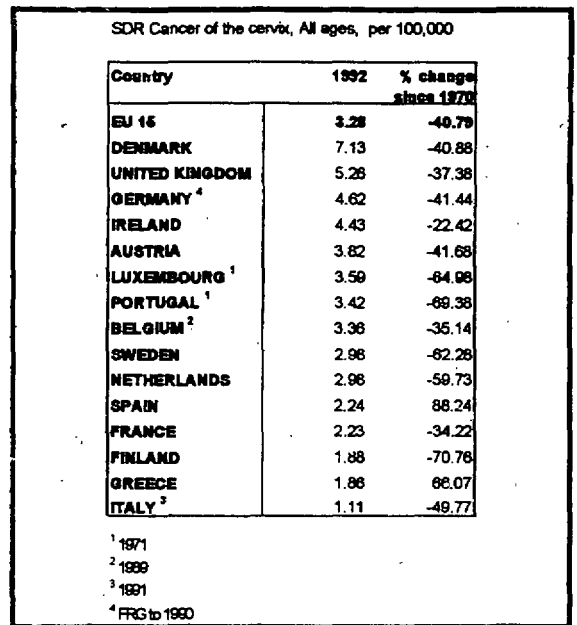
<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.11**  
**Cervical Cancer Mortality (1992)**  
**All Women, EU 15**

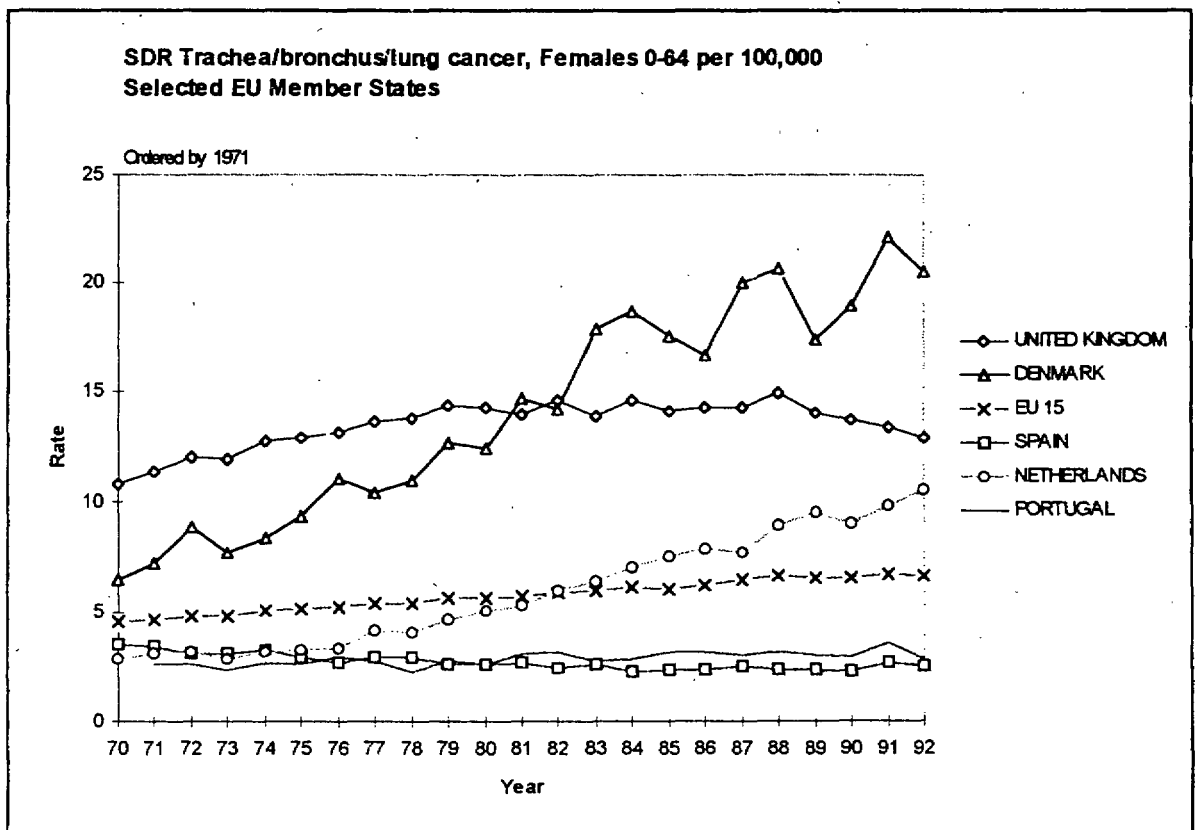


Source - HFA 1996



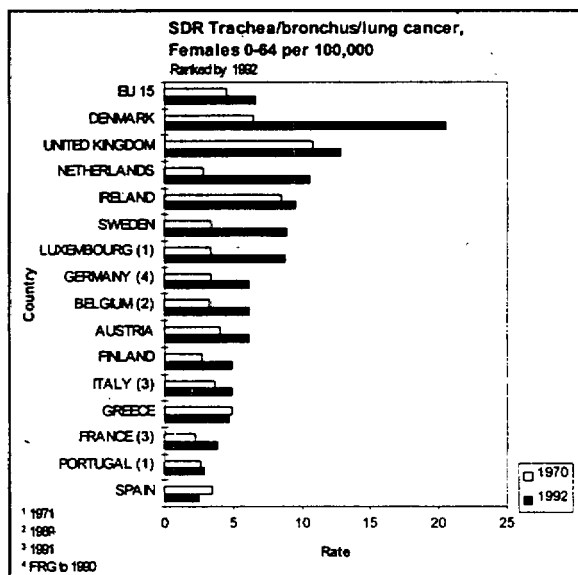
Source - HFA 1996

**Figure 5.12**  
**Respiratory System Cancer Mortality (1970-1992)**  
**Women 0-64 Years, EU 15**



Source - HFA 1996

**Figure 5.13**  
**Respiratory System Cancer Mortality (1992)**  
**Women 0-64 Years, EU 15**



Source - HFA 1996

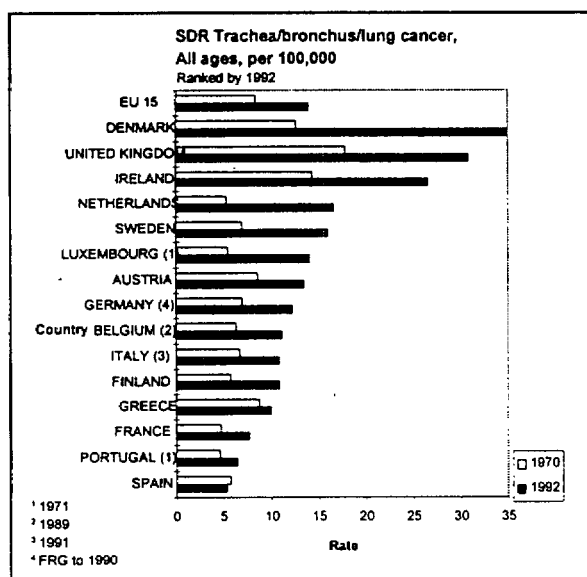
SDR Trachea/bronchus/lung cancer, 0-64 per 100,000 Females

Country	1992	% change since 1970
EU 15	6.83	44.76
DENMARK	20.52	218.63
UNITED KINGDOM	12.91	19.43
NETHERLANDS	10.56	269.23
IRELAND	9.55	12.49
SWEDEN	8.92	163.13
LUXEMBOURG <sup>1</sup>	8.78	155.98
GERMANY <sup>4</sup>	6.20	80.23
BELGIUM <sup>2</sup>	6.15	86.93
AUSTRIA	6.13	49.51
FINLAND	4.91	78.55
ITALY <sup>3</sup>	4.90	33.15
GREECE	4.69	-5.06
FRANCE	4.06	80.44
PORTUGAL <sup>1</sup>	2.89	10.31
SPAIN	2.52	-28.00

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.14**  
**Respiratory System Cancer Mortality (1992)**  
**All Women, EU 15**



Source - HFA 1996

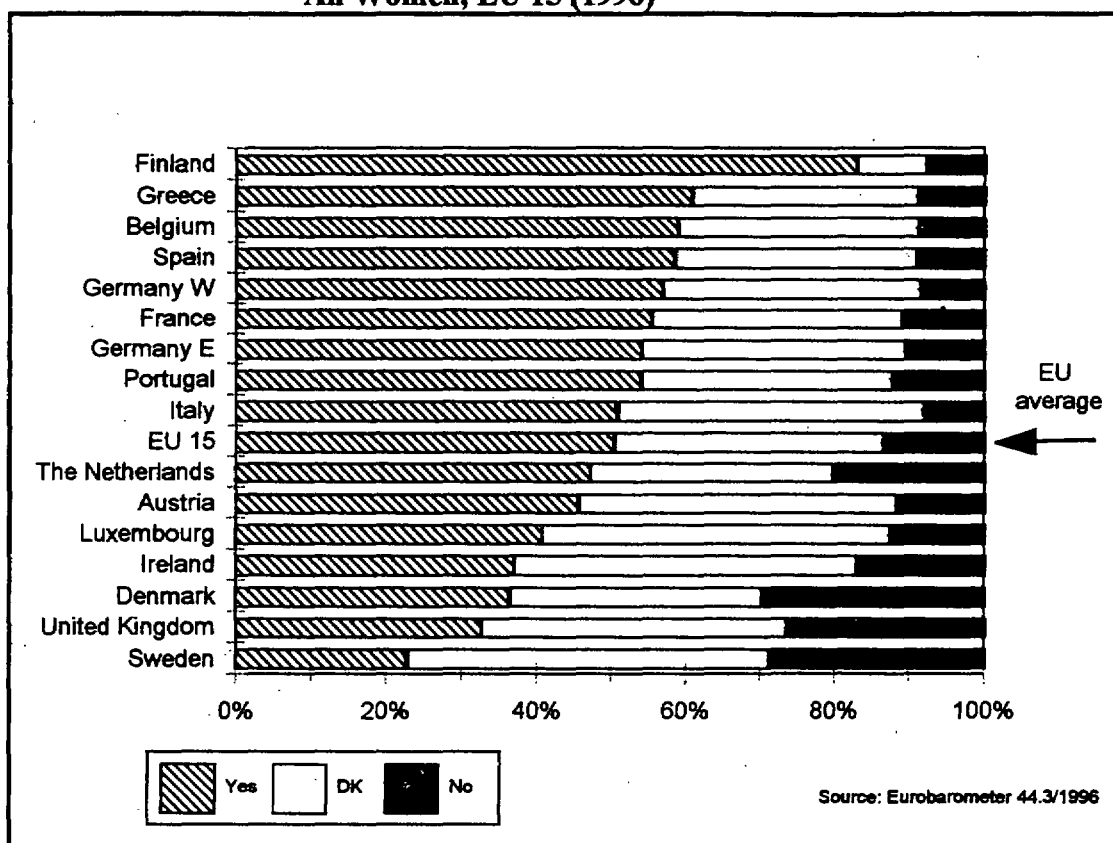
SDR Trachea/bronchus/lung cancer, All ages, per 100,000 Females

Country	1992	% change since 1970
EU 15	14.05	67.86
DENMARK	34.88	175.30
UNITED KINGDOM	30.89	73.15
IRELAND	26.60	85.24
NETHERLANDS	16.62	207.21
SWEDEN	15.94	126.74
LUXEMBOURG <sup>1</sup>	14.11	156.08
AUSTRIA	13.55	57.56
GERMANY <sup>4</sup>	12.28	74.43
BELGIUM <sup>2</sup>	11.15	73.68
ITALY <sup>3</sup>	10.89	61.57
FINLAND	10.88	90.54
GREECE	10.06	15.77
FRANCE	7.80	62.16
PORTUGAL <sup>1</sup>	6.44	39.09
SPAIN	5.40	-6.74

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.15**  
**Perceptions of which Gender Lung Cancer Affects More\***  
**All Women, EU 15 (1996)**



\* Respondents were asked to indicate the extent to which they agreed or disagreed with the following statement : "In (country) lung cancer affects many more men than women". Yes indicates that they agreed, no that they disagreed.

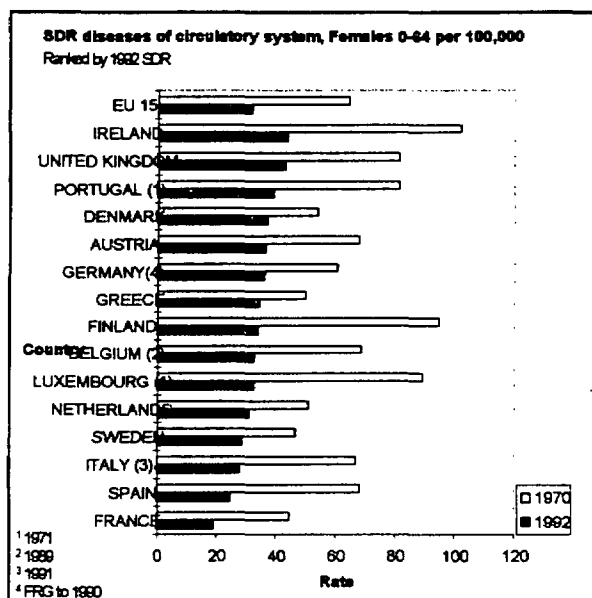
**Table 5.1**  
**Perceptions of which Gender Lung Cancer Affects More**  
**Women 15+ Years, EU 15 (1996)**

	Yes %	No %	DK %
Finland	82.9	7.8	9.3
Greece	60.7	8.9	30.4
Belgium	58.8	8.8	32.4
Spain	58.3	9.1	32.6
Germany W	56.8	8.6	34.7
France	55.4	11.0	33.6
Germany E	54.0	10.5	35.5
Portugal	53.9	12.2	33.9
Italy	50.7	8.1	41.2
EU 15	50.3	13.4	36.3
The Netherlands	47.1	20.3	32.6
Austria	45.4	11.7	42.9
Luxembourg	40.6	12.6	46.8
Ireland	36.8	17.1	46.1
Denmark	36.3	29.8	33.9
United Kingdom	32.5	26.6	40.8
Sweden	22.6	28.9	48.5

Source: Eurobarometer 44.3/1996

\* Respondents were asked to indicate the extent to which they agreed or disagreed with the following statement : "In (country) lung cancer affects many more men than women". Yes indicates that they agreed, no that they disagreed.

**Figure 5.16**  
**Mortality from Circulatory System Diseases (1992)**  
**Women 0-64 Years, EU 15**



Source - HFA 1996

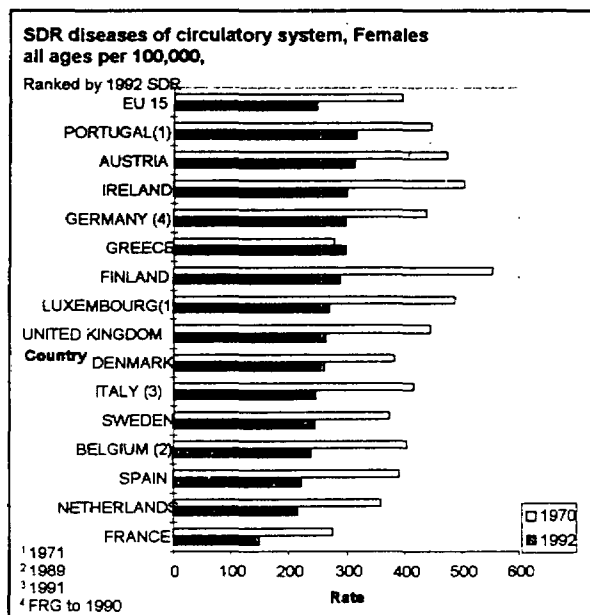
SDR diseases of circulatory system, Females 0-64 per 100,000

Country	1992	% change since 1970
EU 15	31.66	-61.01
IRELAND	43.81	-57.12
UNITED KINGDOM	42.98	-47.23
PORTUGAL <sup>1</sup>	39.30	-51.70
DENMARK	36.80	-31.62
AUSTRIA	36.65	-45.97
GERMANY <sup>4</sup>	36.06	-40.25
GREECE	34.16	-31.87
FINLAND	33.73	-64.47
BELGIUM <sup>2</sup>	32.71	-52.37
LUXEMBOURG <sup>1</sup>	32.43	-63.66
NETHERLANDS	30.89	-39.35
SWEDEN	28.85	-37.76
ITALY <sup>3</sup>	27.63	-58.76
SPAIN	24.76	-63.72
FRANCE	19.01	-57.71

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.17**  
**Mortality from Circulatory System Diseases (1992)**  
**All Women, EU 15**



Source - HFA 1996

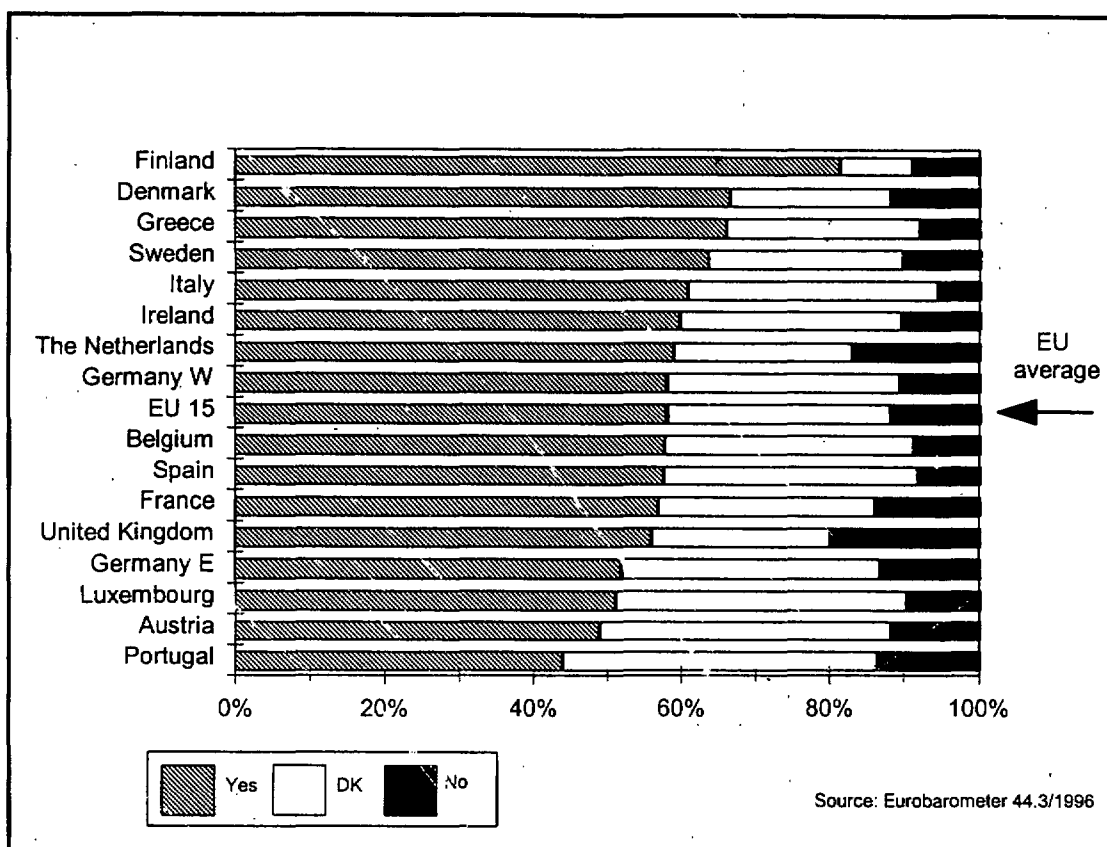
SDR diseases of circulatory system, Females all ages per 100,000

Country	1992	% change since 1970
EU 15	248.44	-37.35
PORTUGAL <sup>1</sup>	316.53	-29.56
AUSTRIA	315.53	-33.79
IRELAND	301.78	-40.35
GREECE	299.59	7.54
FINLAND	289.50	-47.79
GERMANY <sup>4</sup>	289.71	-31.60
LUXEMBOURG <sup>1</sup>	271.8	-44.52
UNITED KINGDOM	265.77	-40.52
DENMARK	263.09	-31.37
ITALY <sup>3</sup>	247.74	-40.56
SWEDEN	243.67	-34.91
BELGIUM <sup>2</sup>	239.31	-40.81
SPAIN	221.80	-43.28
NETHERLANDS	214.23	-40.42
FRANCE	150.55	-45.63

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.18**  
**Perceptions of which Gender is More Affected by Heart Disease\***  
**All Women, EU 15 (1996)**



\* Respondents were asked to indicate the extent to which they agreed or disagreed with the following statement : "In (country) heart disease affects many more men than women". Yes indicates that they agreed, no that they disagreed.

**Table 5.2**  
**Perceptions of which Gender is More Affected by Heart Disease\***  
**EU 15 All Women (1996)**

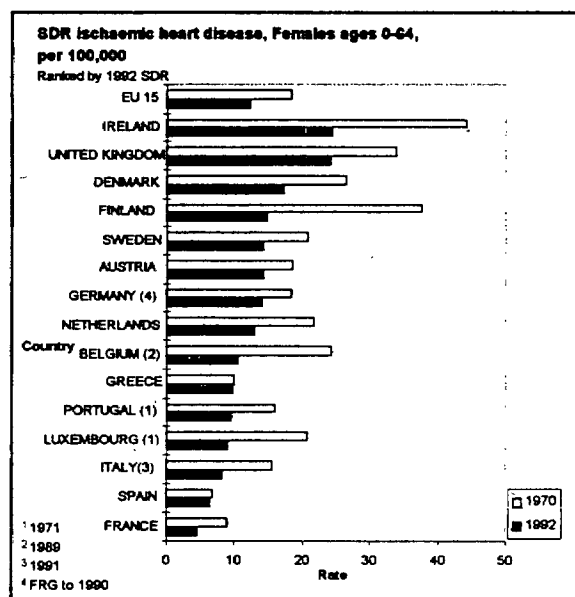
	Yes *	No*	DK
	%	%	%
Finland	81.2	9.1	9.7
Denmark	66.5	11.9	21.6
Greece	66.1	7.9	26.0
Sweden	63.5	10.2	26.3
Italy	60.7	5.6	33.6
Ireland	59.6	10.4	29.9
The Netherlands	58.8	17.1	24.0
Germany W	57.9	10.6	31.5
EU 15	57.8	11.9	30.2
Belgium	57.7	8.8	33.5
Spain	57.5	8.3	34.2
France	56.8	14.0	29.2
United Kingdom	55.8	20.0	24.2
Germany E	51.8	13.3	34.9
Luxembourg	51.0	9.7	39.4
Austria	48.8	11.9	39.4
Portugal	43.8	13.8	42.4

Source: Eurobarometer 44.3/1996

\* Respondents were asked to indicate the extent to which they agreed or disagreed with the following statement : "In (country) heart disease affects many more men than women". Yes indicates that they agreed, no that they disagreed.



**Figure 5.19**  
**Ischaemic Heart Disease Mortality (1992)**  
**Women 0-64 Years, EU 15**



Source - HFA 1996

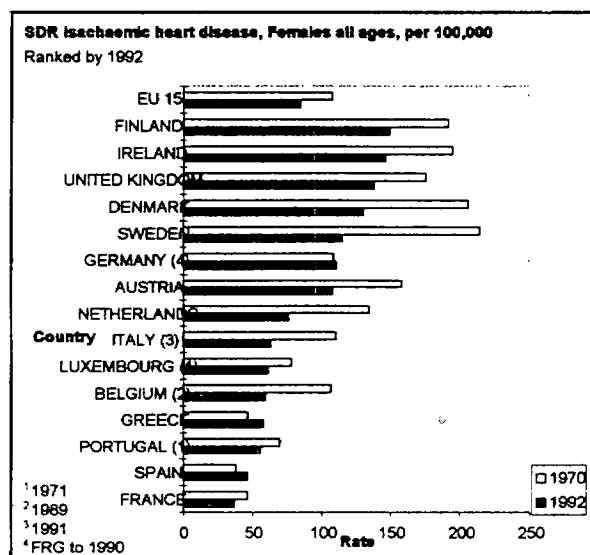
SDR ischaemic heart disease, Females ages 0-64, per 100,000

Country	1992	% change since 1970
EU 15	12.14	-34.06
IRELAND	24.31	-45.08
UNITED KINGDOM	24.12	-28.95
DENMARK	17.30	-34.44
FINLAND	14.77	-60.76
SWEDEN	14.20	-31.57
AUSTRIA	14.16	-23.34
GERMANY <sup>1</sup>	13.98	-25.39
NETHERLANDS	12.85	-40.67
BELGIUM <sup>2</sup>	10.50	-56.91
GREECE	9.71	-2.31
PORTUGAL <sup>3</sup>	9.56	-39.91
LUXEMBOURG	9.05	-56.47
ITALY <sup>3</sup>	8.21	-47.17
SPAIN	6.42	-5.87
FRANCE	4.51	-49.83

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.20**  
**Ischaemic Heart Disease Mortality (1992)**  
**All Women, EU 15**



Source - HFA 1996

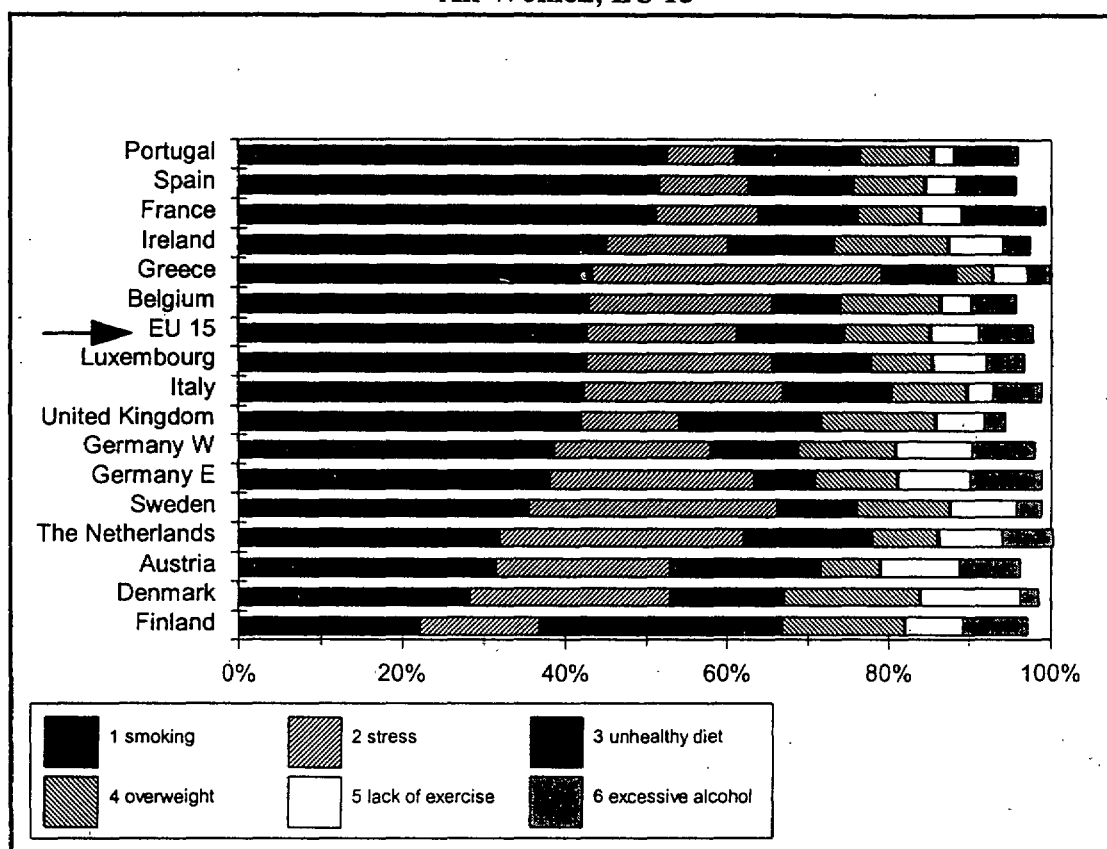
SDR ischaemic heart disease, Females all ages, per 100,000

Country	1992	% change since 1970
EU 15	84.76	-21.62
FINLAND	149.75	-22.34
IRELAND	147.19	-24.52
UNITED KINGDOM	138.76	-21.14
DENMARK	130.00	-37.00
SWEDEN	115.33	-46.34
GERMANY <sup>1</sup>	110.41	1.18
AUSTRIA	108.26	-31.62
NETHERLANDS	78.36	-43.36
ITALY <sup>2</sup>	62.79	-43.36
LUXEMBOURG	61.49	-21.52
BELGIUM	59.44	-44.26
GREECE	57.62	24.91
PORTUGAL <sup>3</sup>	56.08	-20.01
SPAIN	48.67	22.01
FRANCE	36.94	-20.73

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.21**  
**Perceived Main Risk Factors for Heart Disease (1996)\***  
**All Women, EU 15**



Source: Eurobarometer 44.3/1996

\* Respondents were asked to indicate the main and the second risk factors for heart disease.

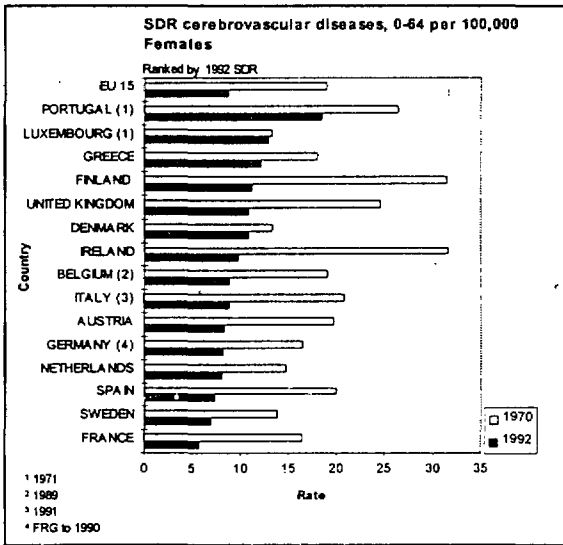
**Table 5.3**  
**Perceived Main Risk Factors for Heart Disease (1996)\***  
**All Women, EU 15**

	smoking %	unhealthy diet %	lack of exercise %	excessive alcohol %	stress %	overweight %	DK %
Portugal	52.5	15.6	3.0	7.6	8.3	8.7	4.3
Spain	51.5	13.1	4.1	7.1	11.0	8.7	4.4
France	51.2	12.4	5.2	10	12.6	7.6	1.0
Ireland	45.1	13.0	6.7	3.0	15.0	14.2	3.1
Greece	43.3	9.3	4.4	2.6	35.7	4.4	4.0
Belgium	42.9	8.4	4.0	5.2	22.6	12.3	4.6
EU 15	42.7	13.3	6.3	6.3	18.5	10.4	2.8
Luxembourg	42.6	12.3	6.8	4.5	22.9	7.4	3.5
Italy	42.3	13.4	3.3	5.6	24.6	9.3	1.4
United Kingdom	41.9	17.6	6.2	2.4	12.1	14.0	5.7
Germany W	38.7	10.9	9.6	7.4	19.2	11.9	2.3
Germany E	38.1	7.5	9.2	8.5	25.2	10.1	1.5
Sweden	35.5	9.8	8.2	2.8	30.7	11.6	1.6
The Netherlands	32.4	16.9	8.4	7.0	30.9	9.1	1.5
Austria	31.6	18.6	10.1	7.1	21.3	7.3	4.1
Denmark	28.4	14.1	12.5	2.0	24.6	16.7	1.8
Finland	22.3	30.0	7.4	7.6	14.5	15.1	3.0

Source: Eurobarometer 44.3/1996

\* Respondents were asked to indicate the main and the second risk factors for heart disease.

**Figure 5.22**  
**Cerebrovascular Disease Mortality (1992)**  
**Women 0-64 Years, EU 15**



Source - HFA 1996

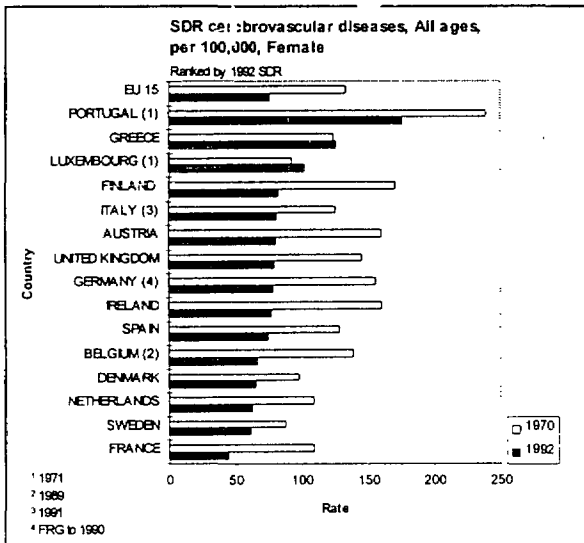
SDR cerebrovascular diseases, 0-64 per 100,000  
**Female**

Country	1992	% change since 1970
EU 15	8.73	-54.05
PORTUGAL <sup>1</sup>	18.42	-30.25
LUXEMBOURG <sup>1</sup>	12.98	-2.41
GREECE	12.12	-32.85
FINLAND	11.29	-64.11
UNITED KINGDOM	10.88	-55.70
DENMARK	10.82	-18.65
IRELAND	9.77	-69.08
BELGIUM <sup>2</sup>	8.92	-53.22
ITALY <sup>3</sup>	8.88	-57.14
AUSTRIA	8.41	-57.22
GERMANY <sup>4</sup>	8.17	-50.24
NETHERLANDS	8.08	-45.41
SPAIN	7.30	-63.37
SWEDEN	6.97	-49.82
FRANCE	5.80	-64.81

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 5.23**  
**Cerebrovascular Disease Mortality (1992)**  
**All Women, EU 15**



Source - HFA 1996

SDR cerebrovascular diseases, All ages, per 100,000  
**Female**

Country	1992	% change since 1970
EU 15	75.93	-42.94
PORTUGAL <sup>1</sup>	175.63	-26.34
GREECE	125.75	1.35
LUXEMBOURG <sup>1</sup>	101.82	9.85
FINLAND	82.71	-51.54
ITALY <sup>2</sup>	81.27	-35.24
AUSTRIA	80.33	-49.92
UNITED KINGDOM	79.53	-45.16
GERMANY <sup>4</sup>	78.80	-49.33
IRELAND	77.96	-51.26
SPAIN	75.25	-41.39
BELGIUM <sup>2</sup>	66.46	-52.30
DENMARK	65.41	-33.57
NETHERLANDS	62.75	-42.36
SWEDEN	61.34	-30.30
FRANCE	44.11	-59.68

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

## 6. HEALTH DETERMINANTS AND HEALTH PROMOTION

The major causes of mortality in women were outlined in the previous chapter. This chapter describes the major health determinants of the diseases that affect women, which include risk factors, such as smoking, drinking, diet and weight, and physical inactivity. It also discusses health promotion and disease prevention activities, such as cancer screening programmes.

### 6.1 Smoking

Tobacco smoking is one of the leading causes of morbidity and mortality in the European Community<sup>1</sup>. It is the major causative factor in an estimated 30% of cancers<sup>2</sup>, including lung cancer (85% of which is estimated to be caused by smoking), cancer of the oral cavity (lips, mouth, tongue, throat), cancer of the pharynx, larynx, oesophagus, bladder, and the kidneys. Respiratory diseases, such as chronic bronchitis, emphysema, and asthma, are also attributable to and/or exacerbated by smoking. Furthermore, smoking is a major contributor to cardiovascular disease, the risk of developing ischaemic heart disease being approximately twice as high among smokers as among non-smokers<sup>3</sup>. Passive smoking is also considered a risk factor for a number of diseases, in particular lung cancer.

Besides the generic risks associated with smoking, women smokers face a number of additional gender-specific health risks because smoking can influence their hormonal balance. Specifically, smoking may contribute to a reduction in fertility<sup>4 5</sup> and increase the risk of early menopause. Furthermore, it is a contributory factor to calcium loss and consequent osteoporosis in post-menopausal women. Smoking when combined with oral contraceptive use may also appreciably increase the risk of developing cardiovascular disease<sup>6</sup>. Smoking during pregnancy has been associated with increased risk of spontaneous abortion, complications of pregnancy (e.g., bleeding, placenta praevia) stillbirth, premature delivery, low birth-weight, and neonatal death. It also increases the risk of sudden infant death and is associated with a number of other long-term health consequences for the offspring (e.g., reduced lung capacity, increased infection rates)<sup>7</sup>.

Traditionally, a greater proportion of men than women smoke. The percentage of men who smoke (43%) in the EC has long been higher than the percentage of women who smoke (28%)<sup>8</sup>. However, significantly greater rates of smoking cessation and different patterns of smoking initiation among men have narrowed the gap between the two sexes in a number of Member States (e.g., Finland, the Netherlands, Spain, Germany, Portugal, Italy, and Denmark)<sup>9</sup> with the result that if current trends continue, female smokers could in a few years outnumber male smokers<sup>10</sup>.

As can be seen from **Figure 6.1** and **Table 6.1**, the percentage of women who smoke in most Member States is around 25%. Denmark and Portugal are exceptions to this pattern with Danish women reporting a much greater percentage of smokers (42%) and Portugal a much smaller percentage (12%)<sup>11</sup>.

Smoking typically is most frequent among women of lower socio-economic status (except in Portugal), among unemployed women, and those with lower educational attainment. Smoking among adolescents is a matter of particular concern because evidence suggests

that in this age-group the proportion of daily smokers amongst women is approaching that of men<sup>12</sup>. Indeed in Denmark, more women than men smoke in the younger age-groups.

Since tobacco-related diseases usually develop after smoking for 15-20 years or more, the results of increasing smoking rates among EC women are only just beginning to be seen. Evidence suggests that female mortality from smoking-related cancers during the past decade has increased in all Member States, except Portugal and Ireland, with the Netherlands having the highest increase (87%) and Belgium, Denmark, Germany and France showing increases of over 40%<sup>13</sup>. According to a calculation based on national vital statistics, the highest rate of female tobacco-related mortality is in Ireland and Denmark, where it was found that in 1990, 16.2 and 15.3%, respectively, of deaths in women aged 35 years and older were attributable to smoking (see **Figure 6.2** and **Table 6.2**). This is more than 3-1/2 times the average EU rate (5.1%), but at least in Denmark's case this rate is consistent with the high rates of smoking among Danish women during the past four or five decades<sup>14</sup>. On the other hand, the same calculations found that France had very few such deaths, and Luxembourg, Portugal and Spain had none. The latter result is, of course, rather unlikely but is probably an artefact of the extremely conservative methods used to calculate smoking attributable death rates<sup>15</sup>.

## 6.2 Alcohol Consumption

The relation between alcohol consumption and health is complicated. Evidence suggests that there is not a straightforward linear relation, but rather that low levels of alcohol consumption are associated with lower mortality while higher levels are associated with excess mortality. Alcohol abuse has been linked to a variety of diseases and conditions resulting in increased mortality. These include cirrhosis of the liver<sup>16</sup>, alcohol psychosis and alcohol poisoning<sup>17</sup>. It is also associated with raised blood pressure, stroke and heart disease<sup>18 19</sup>.

In addition, alcohol consumption is also a risk factor in a number of cancers, e.g., breast cancer<sup>20</sup>, cancer of the oral cavity, pharynx, larynx, oesophagus, and pancreas<sup>21</sup>. In several of these, there is a synergistic effect between alcohol consumption and tobacco smoking. Furthermore, alcohol abuse is associated with threatening behaviour, domestic violence, occupational and road accidents, as well as depression, suicide, and parasuicide<sup>22 23</sup>. Finally, excessive alcohol intake by pregnant women may lead to foetal alcohol syndrome which can result in physical and mental abnormalities in their children<sup>24</sup>.

Recent evidence suggests that the health risks associated with alcohol abuse may be greater for women than for men, partly because of differences in how they metabolise alcohol<sup>25</sup>. Despite the potential importance of alcohol consumption for women, there currently exist no gender-specific data on alcohol consumption at EC level. Various studies provide some information, but these are neither comprehensive nor comparable. Available evidence suggests that alcohol consumption among women has been rising in Finland, Sweden, Denmark, UK, and the Netherlands<sup>26</sup>. In Denmark and the UK this increase in alcohol consumption among women has been accompanied by an increase in death rate from liver diseases (see **Figure 6.3**).

Women still consume less alcohol than do men and they tend to drink less beer and spirits. However, some Member States, e.g., Sweden<sup>27</sup>, have noted an increase in consumption of spirits by women. In addition, alcohol consumption by young women (aged 12-24 years) is also of concern in some Member States. For example, in the Netherlands women in the

16-19 age-group constituted the highest percentage of heavy drinkers in 1993-1994<sup>28</sup>. Since the 1980s, Sweden has reported a significant increase in alcohol consumption by women in the 12-24 age group<sup>29</sup>; and the UK has set targets to reduce excessive alcohol consumption for those aged 15-16<sup>30</sup>.

Public health initiatives in the Member States involve education policies on the effects of alcohol, the setting of safe consumption levels in units per week (typically 21 units per week for men and 14 per week for women)<sup>a 31</sup>, and promotion of low-alcohol drinks. Recent EC legislation on alcohol relate to advertising and minimum rates of alcohol taxation<sup>32</sup>.

### 6.3 Diet and Weight

A nutritious diet is fundamental to good health. In industrialised countries diet-related health problems tend to be caused by over-eating or eating the wrong types of food. Over-eating can lead to obesity which in women is associated with increased risk of diabetes, hypertension, ischaemic heart disease, cardiovascular disease, as well as increased risk of certain cancers (including cancer of the colon and rectum, and, for women, breast<sup>33</sup>, cervical, and ovarian cancer)<sup>34</sup>.

Figure 6.4 and Table 6.3 show the distribution of underweight and overweight women in the EC according to body mass index (BMI)<sup>b</sup>. WHO defines women as being underweight when their BMI is between 18 and 20 and as being severely underweight when it is below 18. Women are defined as overweight with a BMI between 27 and 30 and as severely overweight with a BMI of 30 or more. Thus, women of normal weight have BMIs of between 20 and 27. Health risks increase considerably when the actual weight exceeds the desirable weight by more than 20% (or when BMI exceeds 27) and increase rapidly with a BMI of 30 and over<sup>35</sup>. The average BMI for women in the EC, which is 24, therefore falls within the normal range. However, a significant proportion of women (20%) are overweight. A smaller proportion (15%) are underweight.

Considerable differences exist within the EC. Greece and Portugal have the highest rates of obesity (33.2 and 28.5% respectively), while France, Denmark, the pre-unification Federal Republic of Germany, and Ireland have the lowest rates (15.5, 16.5, 16.5, and 16.9% respectively). The BMI of women from the former German Democratic Republic is higher than that of women from the pre-unification Federal Republic of Germany, as is the proportion of overweight women (20 and 16.5% respectively).

Eating the wrong types of food may result in a number of different health problems. A diet high in saturated fat is associated with increased cardiovascular disease<sup>36</sup>, while one low in fresh fruit and vegetables is associated with increased risk of a number of cancers, in particular cancer of the stomach, colon, rectum, and the intestines<sup>37 38</sup>.

Probably owing to different agricultural and cultural traditions, eating patterns in the EC are characterised by a north-south divide. The northern EC countries have traditionally consumed higher quantities of animal protein and fat, while southern (Mediterranean) EC countries have had a diet high(er) in natural fibres due to higher proportions of vegetables,

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a The UK recently increased its recommended limits to 21 for women and 28 for men<sup>31</sup>.

b BMI is calculated by dividing a person's weight (in kilograms) by her height (in meters) squared (thus,  $BMI = kg/m^2$ ), thereby creating a weight measure that controls for height.

fruits, cereals, and polyunsaturated fats. However, these eating patterns are becoming less delineated with the greater flow of food products within the EC resulting from the internal market. Sweden, for example, has adopted a more Mediterranean style diet on a national level, consuming higher proportions of fruit, vegetables, cereals, and low fat dairy products<sup>39</sup>.

Although there are no recent (post-1970) gender-specific data at the EC level on dietary habits, most Member States report that women eat more vegetables and fruits than do men.

Public health initiatives within the EC<sup>a</sup> include the highlighting of the connection between healthy diet and disease prevention, including the importance of screening tests for cholesterol and diabetes for identified risk groups. In this context, it is surprising that, on an EC level, only 17% of women recognised an unhealthy diet as the second main (life-style-related) risk factor linked to heart disease, while approximately 1 in 2 women recognised smoking as the main (life-style-related) risk factor.

## **6.4 Exercise**

Regular physical exercise is important for mental and physical well-being. Physical fitness reduces death rates from both heart disease and cancer<sup>40</sup> because of its ability to reduce the effect of stress, maintain an optimum body weight, strengthen the heart and lungs, and reduce the risk of heart disease<sup>41</sup>. Furthermore, load-bearing exercise (e.g., walking, running) is particularly important for pre-menopausal women in order to minimise the risk of osteoporosis in later life.

Although no gender-specific data on physical exercise exist at the EC level, it is generally accepted that women, in particular elderly women, exercise less than men and in insufficient amounts for optimal health benefits<sup>42</sup>.

## **6.5 Health Promotion and Disease Prevention**

As already noted, Article 129 of the Treaty specifies that the EC is to ensure a high level of health protection by means of health promotion and disease prevention. A number of questions were included in the 1996 Eurobarometer survey concerning the preventive and health promotion services that people receive. This survey also included some attitudinal questions to shed light on topics of frequent debate, such as mammography screening. The results show wide divergence between the Member States. As the data are self-reported, the results should be interpreted with care.

### **6.5.1 Heart Check-Up**

As discussed in Sections 5.7 and 5.8, heart disease is one of the major sources of morbidity and mortality in women, and early detection can play a major role in its prevention. The Eurobarometer survey included a question on heart check-ups. The results shown in **Figure 6.5** and **Table 6.4** indicate that about 22% of women in the EC had a heart check-up in the past year. Not surprisingly, the rate of heart check-ups is highly age-dependent, with older women reporting more check-ups; 44% of women aged

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<sup>a</sup> Programmes on cancer and health promotion.

65 and over had a heart check-up in the previous year, compared to only 10% of women under 35.

Considerable variation exists within the EC. The highest proportion of heart check-ups reported was in Germany (both the former German Democratic Republic and the pre-unification Federal Republic of Germany) and Portugal (35.3, 31.5, and 32.6% respectively) while the lowest rates were reported in the Netherlands and Sweden (9.7 and 12.8% respectively).

### *6.5.2 Cholesterol Testing*

Although controversy surrounds the issue of the desirability of mass screening for cholesterol, 1 in 4 women in the EC reports having had their cholesterol checked during the previous year. As in the case of heart check-ups, cholesterol testing is very age-dependent, with almost 43% of women aged 65 or over reporting having had a test in the previous year (see **Figure 6.6** and **Table 6.5**).

These results show large variation across the Member States, with Greece reporting the highest percentage (38.1%) of women having had a cholesterol test in the previous year, and Denmark reporting the lowest level (7.5%). The variation is even greater among women aged 65 and over where 67.9% of Greek women report having had such a test compared with only 12.8% of Danish women.

### *6.5.3 Diabetes Testing*

The incidence of non-insulin dependent diabetes mellitus (normally referred to as diabetes type II) has been increasing for the past several decades<sup>43</sup>. Women over age 40 are at particular risk of the disease, perhaps because of their higher rates of obesity following menopause. Evidence suggests that approximately half of all persons with diabetes type II are undiagnosed resulting in considerable preventable morbidity and mortality<sup>44</sup>.

**Figure 6.7** and **Table 6.6** show that just over 1 in 5 women in the EC had been tested for diabetes in the past year. While the rate is age-dependent, it is surprising that only 25% of women aged 40-64 years and 37% of women aged 65 years and older have been tested for diabetes. As obese women over the age of 40 years are particularly at risk of developing diabetes type II, the rate of diabetes testing in this group was calculated. The results indicate that about 39% of overweight women and 44% of severely overweight women underwent testing for diabetes in the previous year. These results suggest a need to increase diabetes testing in middle-age and older women, particularly among those who are overweight.

As was the case with cholesterol testing, significant variation exists across the Member States. The former German Democratic Republic and the pre-unification Federal Republic of Germany report the highest rates of testing overall (38.1 and 33.0% respectively), while Ireland and Sweden report the lowest overall rates (7.9 and 11.2% respectively) (**Table 6.6**).



#### 6.5.4 Osteoporosis Testing

Age-related osteoporosis occurs more frequently in women than in men and results in both significant morbidity and mortality. Data from the 1996 Eurobarometer survey indicate that 17% of women over the age of 50 years have had a test<sup>a</sup> for osteoporosis in the past year. This percentage varies from a high of 28% and 27%, respectively, in Austria and the pre-unification Federal Republic of Germany to a low of 5% and 4% in Ireland and Finland, respectively (see Figure 6.8 and Table 6.7).

#### 6.5.5 Cancer Screening

The third EC action plan against cancer (1996-2000) has assigned priority to early detection and screening of cancer. The objective is to help improve and increase the possibilities of early detection, in particular through the development and dissemination of effective screening programmes and appropriate practices<sup>45</sup>. For women, two specific cancer sites (breast and cervix) have been subject to screening practice for almost two decades and proven effective when adequately set up (see below).

Screening services are only as effective as the quality of the service itself. Misinterpretation of, for example, cervical smear tests has resulted in the need for recall of women for further assessment. Indeed, the fact that cancer screening results in some percentage of false positive and false negative results is for some people an important argument against such screening programmes.

In the screening programmes that do exist effectiveness is strongly influenced by the participation rate of the targeted population. A 60% participation rate is acceptable, but 75% (or greater) is desirable. Desirable rates are typically only achieved in countries with systematic screening programmes with personalised invitations. Reasons for non-participation include lack of access to screening facilities, either because of geographic isolation or because of (low) socio-economic status, lack of information, or lack of female physicians<sup>46 47</sup>. On this latter point, results from the 1996 Eurobarometer survey indicate that just over 36% of women in the EC prefer a doctor of the same sex. Rates vary considerably across the Member States, with Danish, Finnish, and Irish women expressing the most preference for a female doctor and Sweden, Luxembourg, and the Netherlands expressing the least preference for a female doctor (see Figure 6.9 and Table 6.8).

##### 6.5.5.1 Cervical Cancer Screening

Cervical cancer may be detected by a Papanicolaou smear test available to women through outlets such as GPs, family planning clinics, hospitals, and special women's clinics. Assessment of organised screening programmes shows a significant reduction in mortality from cervical cancer. For example, studies from Finland report possible mortality reductions of 50-80%<sup>48</sup>, while Sweden reports actual reductions of 34%<sup>49</sup>. Overall, the reduction in incidence of and mortality from cervical cancer is estimated to be sufficient to justify mass screening programmes<sup>50</sup>.

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a These data should be interpreted with care because "osteoporosis examination" was not specifically defined in the survey. As a result, there is no guarantee that respondents' replies are entirely accurate.

While facilities for smear testing exist in all Member States, not all of them have mass screening programmes<sup>51</sup>. Cervical cancer screening is organised on a national level in Denmark, Finland, Sweden, the Netherlands, and the UK, albeit with different recommended time intervals<sup>52</sup>. Denmark and Sweden, for example, call women for a test every three years, while Finland and the Netherlands use five-year intervals. In the UK women can opt for either three- or five-year intervals. The statutory age for screening also varies between Member States with the lower age limit ranging from 18-30 years and the upper limit from 59-75 years. Participation rates in these programmes range from 70 to 83% of the target population.

On an EC level about 40% of all women aged 15 and over report having had a cervical smear in the previous year (Eurobarometer, 1996). This varies from 16.5% among women aged 65 and over to about 46% among women aged 35-64 (see Figure 6.10 and Table 6.9). Considerable variation may be observed across the Member States as well, with Danish and German (both the former German Democratic Republic and the pre-unification Federal Republic of Germany) women reporting the highest overall rates of screening (63.5, 53.2, and 52.3% respectively). Ireland and Portugal report the lowest rates (15.8 and 22.3% respectively).

#### 6.5.5.2 Breast Cancer Screening

Breast cancer screening may be performed by physical examination of the breast or by a dedicated x-ray machine (mammography). For decades physical examination of the breasts, either by a doctor or other health worker (palpation) or by women themselves, has been promoted as a method of early detection. Palpation is carried out fairly often either as a separate examination or as part of a general medical examination. However, results have been disappointing with not many additional tumours being detected at an early stage. Furthermore, because many younger women have benign breast lumps, many women end up being unnecessarily referred for further tests or biopsies. Studies concerning the effectiveness of self-examination have been equivocal<sup>53</sup>. Nevertheless, almost 40% of all women in the EC report having performed a breast self-examination in the previous year (Eurobarometer, 1996). The rates vary slightly across the age-groups, ranging from 29.8% among women aged 60 and over to 48.4% among women aged 50-59 years (see Figure 6.11 and Table 6.10). Within the EC, the rates range from a high of 61.5% in the former German Democratic Republic to a low of 15.6% in Ireland.

Breast cancers detected through well organised screening among 50-69 year-old women are, on average, identified four years earlier than clinical appearance, resulting in (gradually) reduced death rates. Although screening programmes with full (100%) participation can almost cut in half the risk of dying from breast cancer, observed participation rates of around 70 percent reduce the risk of dying by one third<sup>54</sup>. As breast cancer is detected earlier in more women and life expectancy increases through early treatment, the number of follow-up checks for cancer will necessarily increase. Furthermore, as the breast cancer death rate drops there should be fewer patients with distant metastases to be treated.

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a Some of the autonomous communities in Spain have screening programmes and in Ireland a national programme is in preparation. In Germany women with health insurance are entitled to an annual check-up<sup>51</sup>.

While screening has been shown to be effective in reducing mortality from breast cancer in 50-69 year-old women, there is currently insufficient evidence to recommend mass screening of women aged 40-49 years<sup>55</sup>.

More and more countries are debating the desirability of breast cancer mass screening programmes. Those countries with a national screening programme justify their decision by arguing that the expense of the screening and the stress caused by false positive results or the knowledge that the disease is present are outweighed by the benefits of reduction in advanced treatment and mortality due to this disease.

Much of the debate about the so-called medicalisation of women has taken place without actual knowledge about women's feelings about mammography screening. In view of this, the 1996 Eurobarometer survey asked women to indicate the extent to which they agreed or disagreed with the following statement:

"Mammography screening, that is breast x-ray, should be offered free of charge to all women from a certain age because it may help reduce deaths from breast cancer."

The results, shown in **Figure 6.12** and **Table 6.11**, are unequivocally in favour of mass screening. Over 90% of women in the EC agree (slightly or strongly) with this statement. Furthermore, and contrary to all the other questions asked in the Eurobarometer survey, there is only very limited variation in the range of responses between Member States and age-groups.

Notwithstanding this consensus among women in favour of mammography screening, the situation in the Member States varies greatly. Currently, Finland, the Netherlands, Luxembourg (for women on social security), Sweden, and the UK have national mammography (mass) screening programmes. Denmark, France, and Spain have mammography screening programmes in some areas. In Germany, women with health insurance are offered an annual screening which, however, does not necessarily involve a mammogram.

Participation rates in national screening programmes vary. The Netherlands reports 79% participation, Finland 89%, Sweden 70-85%, and the UK 72%<sup>56</sup>.

Although many Member States do not have national screening programmes, this does not mean that women in those countries do not receive mammograms when needed. As shown in **Figure 6.13** and **Table 6.12**, 38% of all women aged 50-59 years and 28% of women aged 60-69 years report having had a mammogram in the previous 12 months. Given the variation in national screening programmes, it is not surprising that there are considerable differences between Member States in the percentage of women reporting having had a mammogram in the previous year. Sweden and Luxembourg - both countries with mass screening programmes - report 71% and 64%, respectively, while Greece and Ireland report the lowest rates of mammography screening with rates of 31% and 2%, respectively (for the 50-59 years old).

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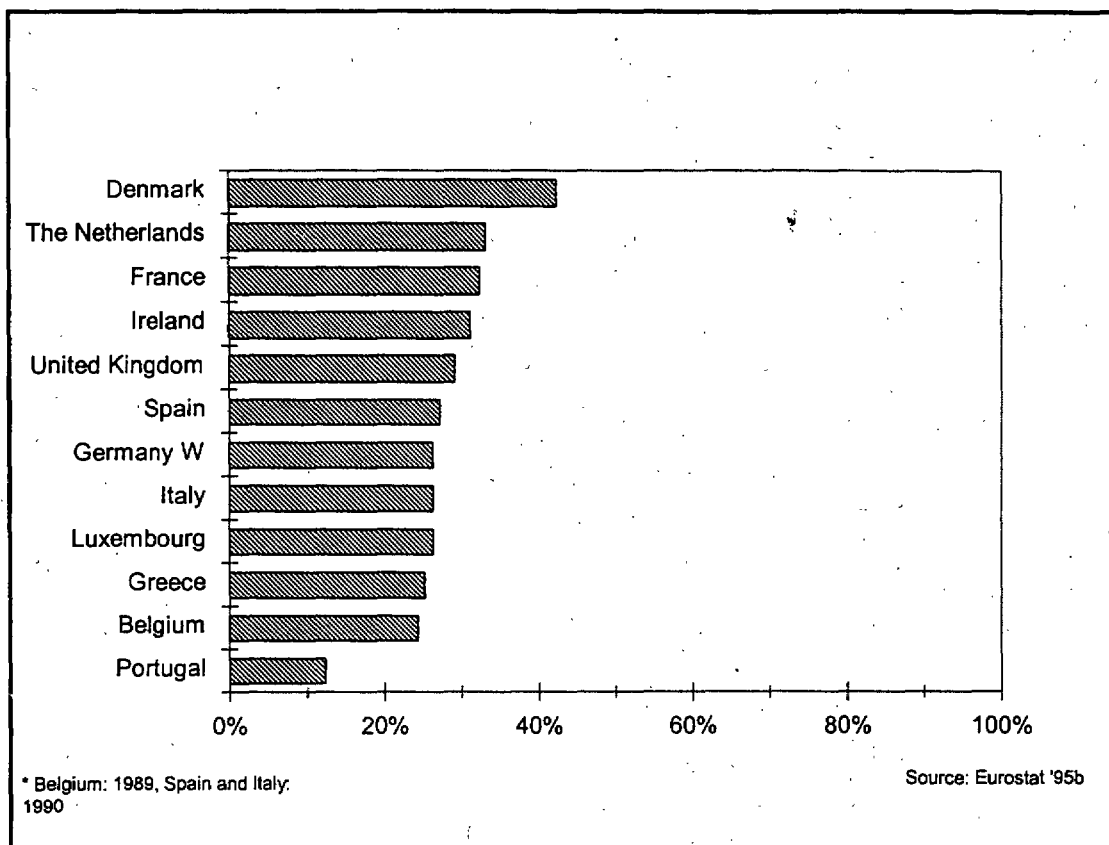
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## [Figures and Tables]

***Figure 6.1***  
**Percentage of smokers (1991)\***  
**Women 15+ Years, Selected EU Countries**



***Table 6.1***  
**Percentage of Smokers (1991)\***  
**Women 15+ Years, Selected EU Countries**

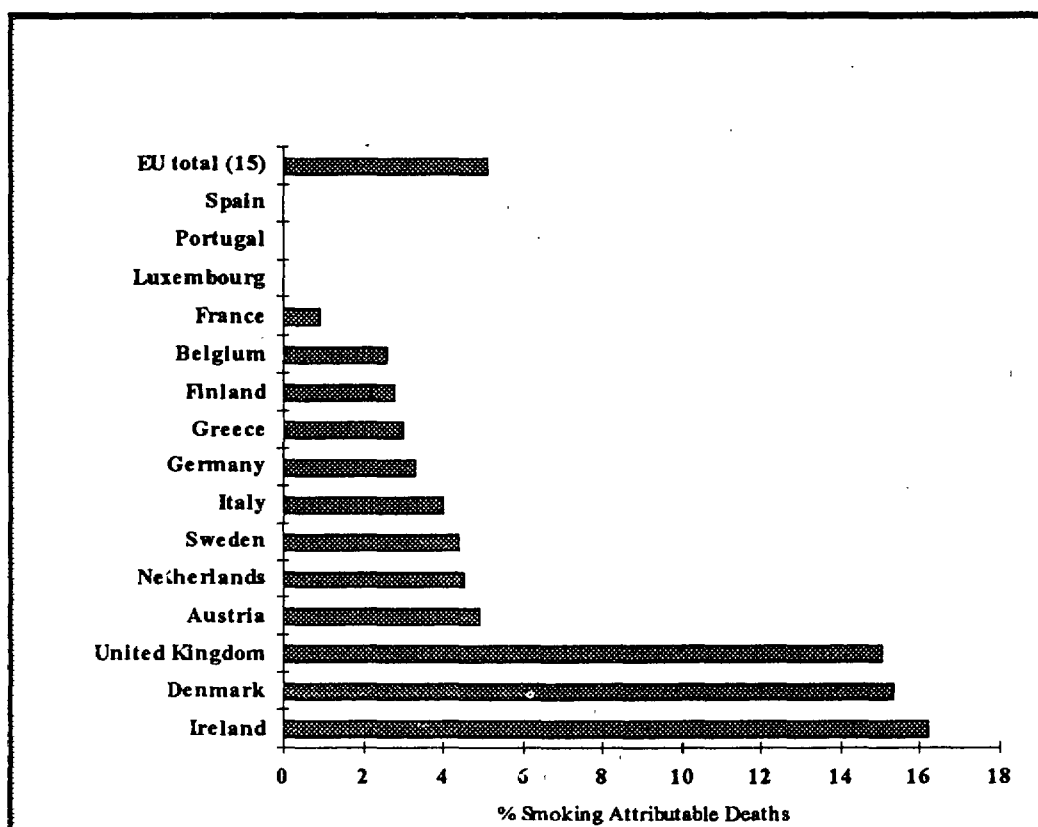
	Percent
Denmark	42
The Netherlands	33
France	32
Ireland	31
United Kingdom	29
Spain	27
West German	26
Italy	26
Luxembourg	26
Greece	25
Belgium	24
Portugal	12

\* Belgium 1989; Spain and Italy 1990

Source: Eurostat 1995b



**Figure 6.2**  
**Smoking Attributable Mortality (1990)**  
**Women 35+ Years, EU 15**



Source: Peto R, Lopez AD, Boreham J, Thun M, Heath C. *Mortality from smoking in developed countries. 1950-2000. Indirect estimates from vital statistics.* Oxford Medical Publications. Oxford, New York, Tokyo, 1994.

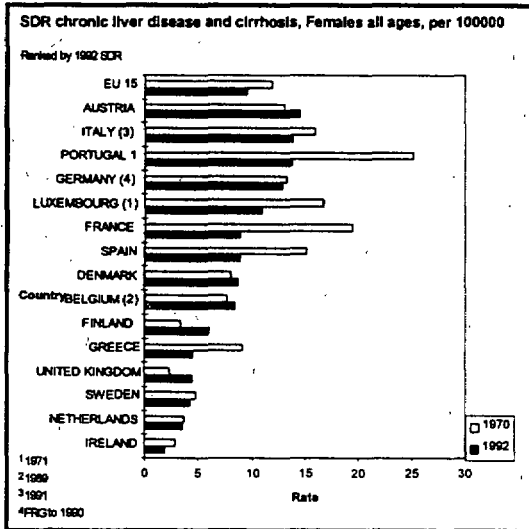
**Table 6.2**  
**Smoking Attributable Mortality \* (1990)**  
**Women 35+ Years, EU 15**

	Total Mortality*		Percent
Ireland	2.3 /	14.2	16.2
Denmark	4.4 /	28.8	15.3
United Kingdom	48.0 /	320.0	15.0
Austria	2.1 /	43.3	4.9
Netherlands	2.7 /	60.0	4.5
Sweden	2.0 /	45.5	4.4
Italy	10.1 /	256.0	4.0
Germany	16.2 /	487.0	3.3
Greece	1.3 /	43.2	3.0
Finland	0.7 /	24.9	2.8
Belgium	1.3 /	50.0	2.6
France	2.2 /	246.0	0.9
Luxembourg	0.0 /	1.8	0.0
Portugal	0.0 /	47.0	0.0
Spain	0.0 /	151.0	0.0
EU total (15)	9.3 /	1817.9	5.1

Source: Peto R, Lopez AD, Boreham J, Thun M, Heath C. *Mortality from smoking in developed countries. 1950-2000* Indirect estimates from vital statistics. Oxford Medical Publications. Oxford, New York, Tokyo, 1994.

\* Smoking related deaths over total deaths (in thousands) and in percentages; data were calculated (see source) for two age-groups: 35-69 and 70+ years of age and then added. (Estimates were computed for the year 1990).

**Figure 6.3**  
**Liver Disease Mortality (1992)**  
**All Women, EU 15**



Source - HFA 1996

SDR chronic liver disease and cirrhosis, all ages, per 100000

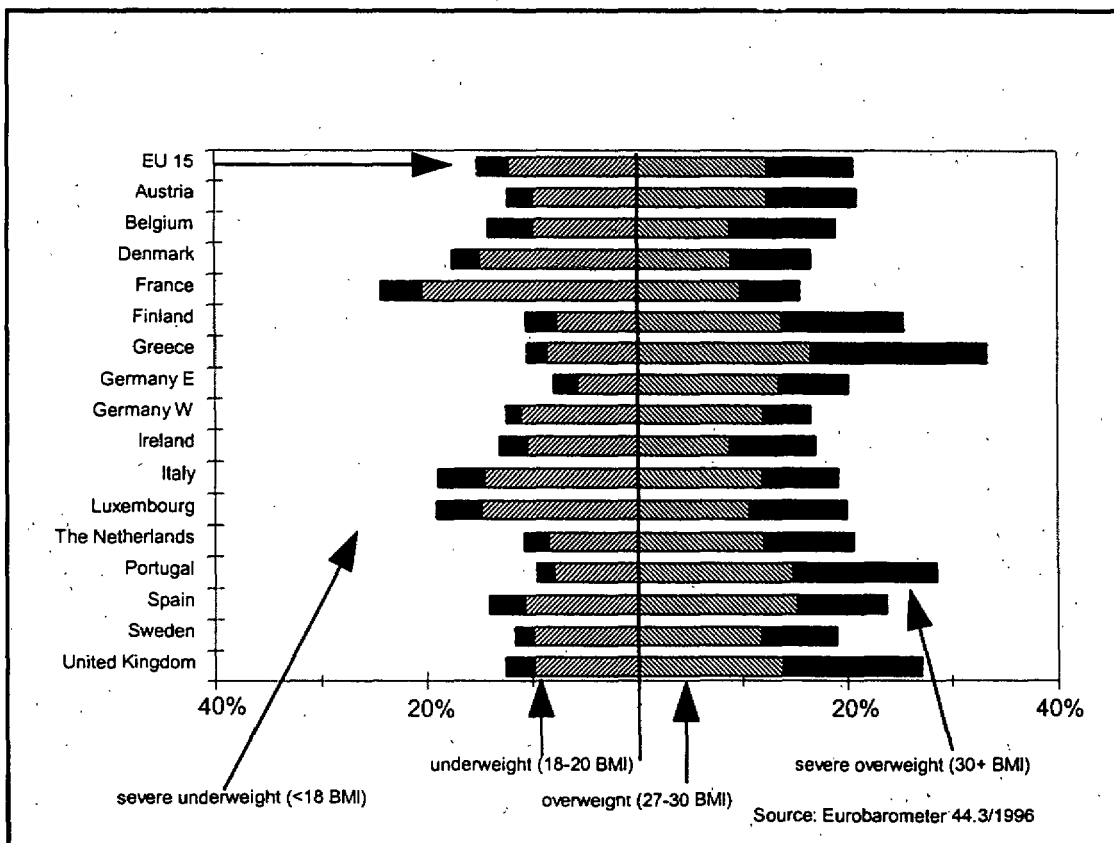
Females

Country	1992	% change since 1970
EU 15	9.51	-19.88
AUSTRIA	14.42	10.84
ITALY <sup>3</sup>	13.78	-13.11
PORTUGAL <sup>1</sup>	13.70	-45.57
GERMANY <sup>4</sup>	12.84	-3.31
LUXEMBOURG <sup>1</sup>	10.90	-34.69
FRANCE	8.98	-53.85
SPAIN	8.92	-40.97
DENMARK	8.77	8.54
BELGIUM <sup>2</sup>	8.46	10.59
FINLAND	6.01	80.48
GREECE	4.58	-50.22
UNITED KINGDOM	4.46	91.42
SWEDEN	4.19	-10.85
NETHERLANDS	3.58	-2.72
IRELAND	1.93	-33.45

<sup>1</sup> 1971  
<sup>2</sup> 1989  
<sup>3</sup> 1991  
<sup>4</sup> FRG to 1990

Source - HFA 1996

**Figure 6.4**  
**Percent Over- and Underweight, Women 18+ Years**  
**EU 15 (1996)**

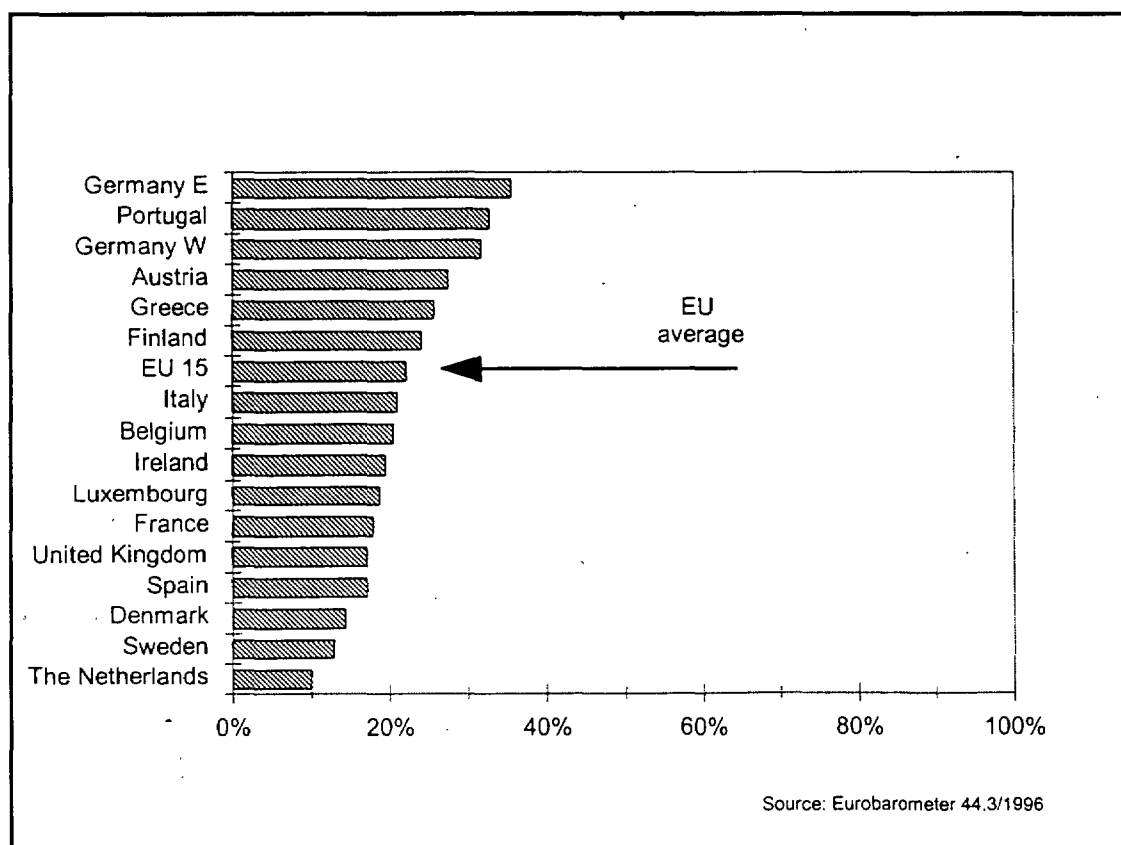


**Table 6.3**  
**Percent Over- and Underweight, Women 18+ Years,**  
**EU 15 (1996)**

	severe underweight (BMI<18) %	underweight 18≤BMI<20 %	normal weight (20≤BMI<27) %	overweight (27≤BMI<30) %	severe overweight (BMI≥30) %	mean BMI %
<b>EU 15</b>	<b>2.8</b>	<b>12.4</b>	<b>64.4</b>	<b>12.4</b>	<b>8.1</b>	<b>24.0</b>
Austria	2.2	10.1	66.7	12.4	8.5	24.1
Belgium	4.1	10.0	67.0	8.9	10.0	24.2
Denmark	2.4	15.2	65.9	9.0	7.5	23.5
France	3.8	20.5	60.1	9.9	5.6	23.0
Finland	2.8	7.8	64.1	13.8	11.4	24.7
Greece	1.8	8.7	56.3	16.6	16.6	25.5
Germany E	2.1	5.8	72.1	13.6	6.4	24.2
Germany W	1.4	11.1	71.0	12.0	4.5	23.6
Ireland	2.6	10.5	70.0	8.8	8.1	24.1
Italy	4.2	14.7	62.0	11.9	7.2	23.5
Luxembourg	4.2	14.9	61.1	10.7	9.2	23.7
The Netherlands	2.2	8.6	68.6	12.0	8.6	24.2
Portugal	1.5	8.1	61.9	14.8	13.7	24.9
Spain	3.2	10.9	62.3	15.3	8.3	24.3
Sweden	1.7	10.0	69.4	11.8	7.0	23.9
United Kingdom	2.5	10.1	60.6	13.8	13.1	25.2

Source: Eurobarometer 44.3/1996

**Figure 6.5**  
**Percent with Heart Check-Up in Past Year**  
**Women 15+ Years, EU 15 (1996)**

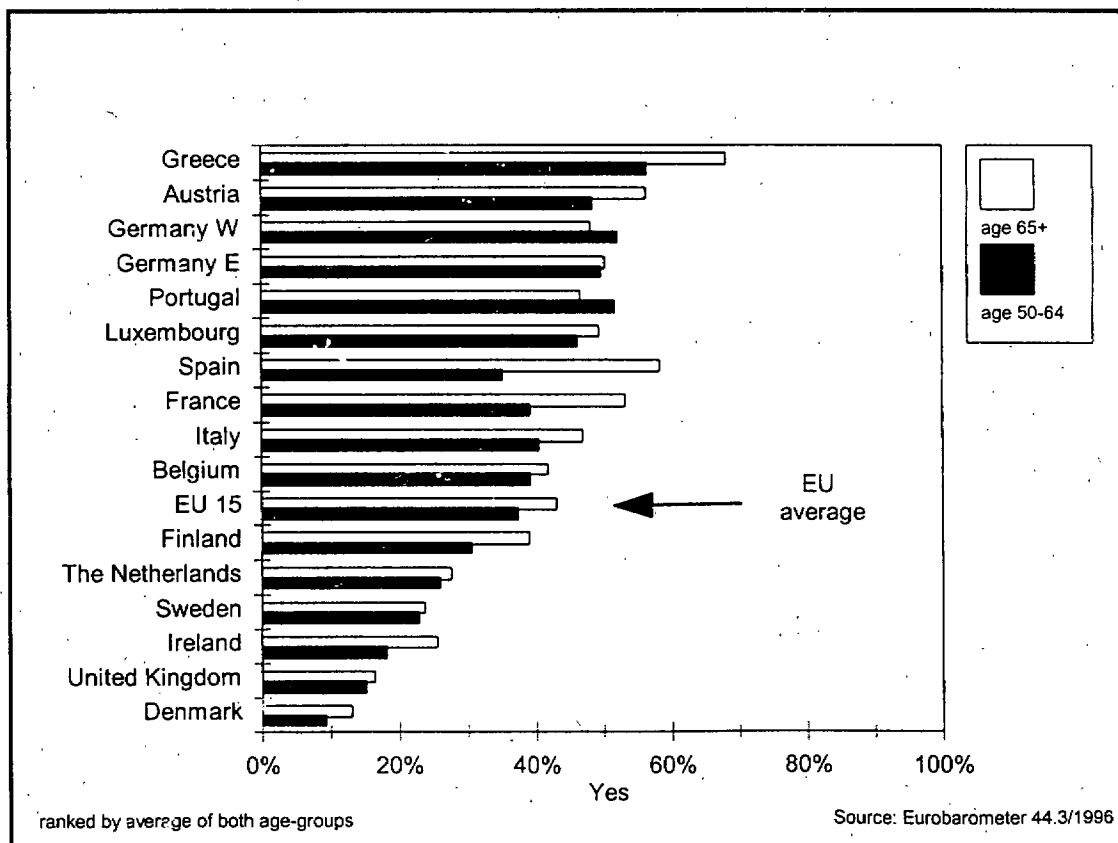


**Table 6.4**  
**Percent with Heart Check-Up in Past Year**  
**Women 15+ Years, EU 15 (1996)**

	15-34 years %	35-64 years %	65+ years %	Total %
Germany E	11.9	39.7	66.3	35.3
Portugal	15.1	38.6	54.2	32.6
Germany W	9.0	35.8	61.0	31.5
Austria	19.0	23.0	58.9	27.2
Greece	13.1	27.6	45.7	25.4
Finland	8.7	22.2	47.9	23.9
<b>EU 15</b>	<b>9.8</b>	<b>22.2</b>	<b>43.7</b>	<b>21.8</b>
Italy	9.9	18.6	43.5	20.7
Belgium	6.3	21.1	45.5	20.4
Ireland	7.5	19.7	50.7	19.1
Luxembourg	11.6	16.7	40.0	18.5
France	10.4	19.4	32.3	17.6
United Kingdom	8.3	15.1	36.2	17.0
Spain	13.3	12.8	35.2	16.9
Denmark	5.4	14.1	31.4	14.1
Sweden	4.0	12.1	32.2	12.8
The Netherlands	4.8	11.5	24.2	9.7

Source: Eurobarometer 44.3/1996

**Figure 6.6**  
**Percent Reporting a Cholesterol Test in Past Year**  
**Women 15+ Years, EU 15 (1996)**

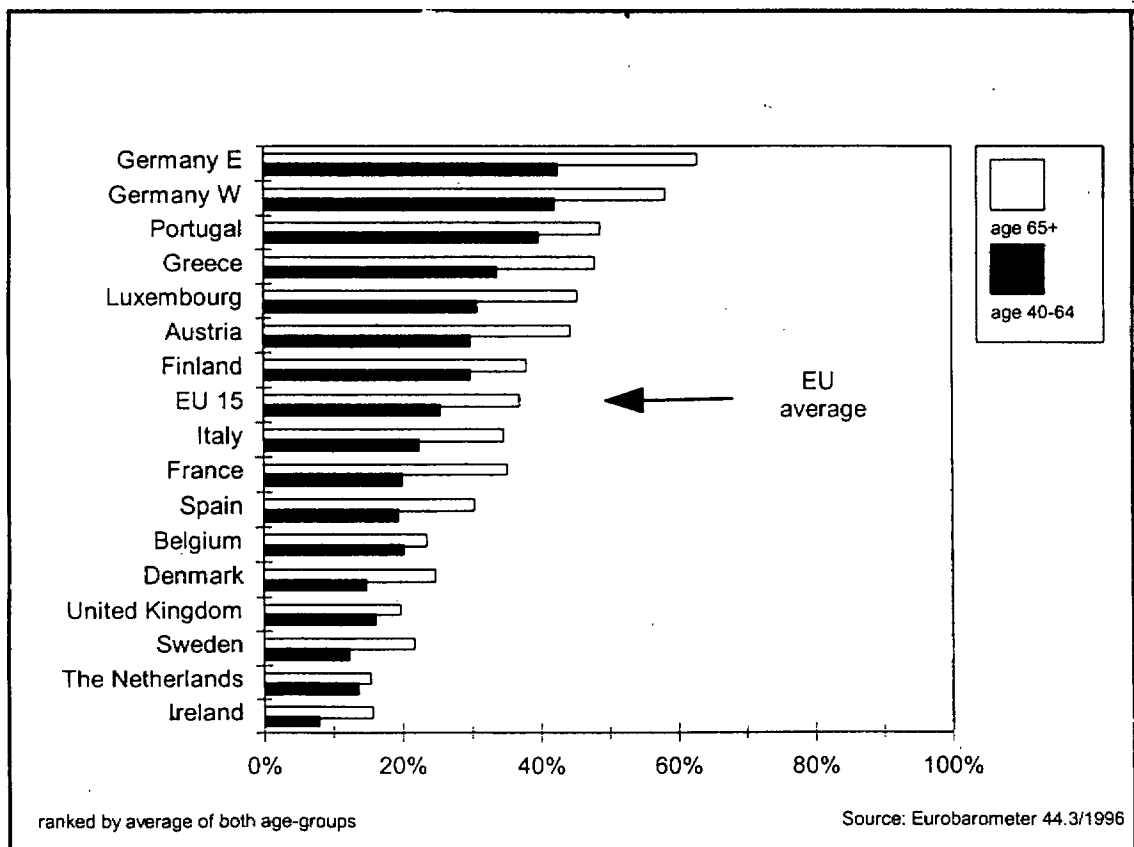


**Table 6.5**  
**Percent Reporting a Cholesterol Test in Past year**  
**Women 15+ Years, EU 15 (1996)**

	15-34 years	35-49 years	50-64 years	65+ years	Total
Greece	17.1	31.8	56.3	67.9	38.1
Austria	26.1	28.6	48.1	56.0	35.6
Germany W	11.7	22.8	52.0	48.0	30.6
Germany E	14.8	27.2	49.3	50.0	32.7
Portugal	14.5	34.2	51.4	46.4	33.3
Luxembourg	19.0	33.7	46.0	49.0	31.9
Spain	20.2	27.6	35.0	58.1	31.7
France	24.2	29.8	38.9	53.0	33.0
Italy	15.5	24.7	40.2	46.6	29.1
Belgium	11.1	22.6	39.0	41.4	25.1
<b>EU 15</b>	<b>13.8</b>	<b>22.8</b>	<b>37.2</b>	<b>42.8</b>	<b>26.2</b>
Finland	9.2	21.7	30.4	38.7	23.5
The Netherlands	5.7	10.6	25.8	27.3	12.5
Sweden	3.5	8.9	22.6	23.6	12.8
Ireland	4.5	12.3	18.0	25.4	12.0
United Kingdom	3.8	12.8	14.9	16.1	10.6
Denmark	3.6	8.0	8.9	12.8	7.5

Source: Eurbarometer 44.3/1996

**Figure 6.7**  
**Percent Reporting a Diabetes Test in Past Year**  
**Women 40 + Years, EU 15 (1996)**

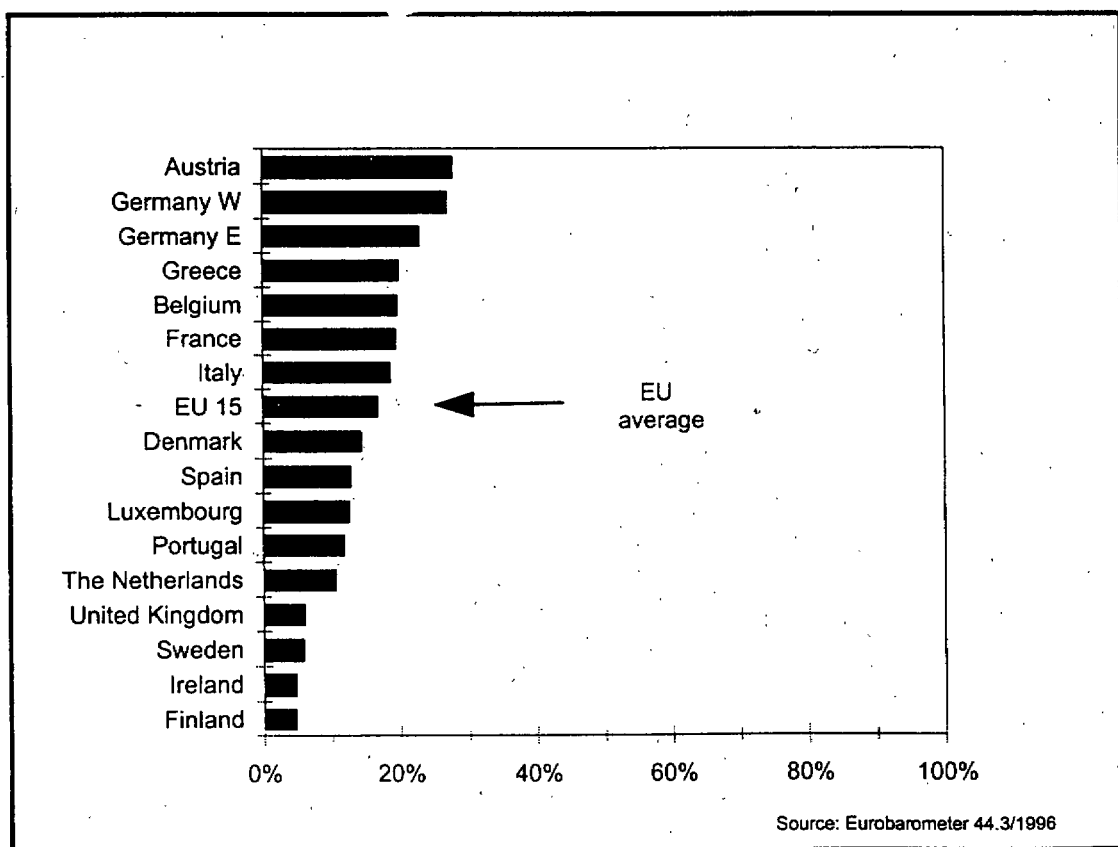


**Table 6.6**  
**Percent Reporting a Diabetes Test in Past Year**  
**Women 15+ Years, EU 15 (1996)**

	age <40 years	age 40-64 years	age 65+ years	Total
Germany E	23.7	42.2	62.5	38.1
Germany W	14.2	41.7	58.0	33.0
Portugal	17.2	39.5	48.5	31.4
Greece	12.8	33.3	47.6	26.8
Luxembourg	24.7	30.5	45.1	30.0
Austria	20.2	29.5	44.0	27.3
Finland	16.1	29.5	37.8	26.1
EU 15	12.5	25.1	36.6	21.6
Italy	7.5	22.2	34.5	18.5
France	15.2	19.8	34.9	19.6
Spain	7.3	19.2	30.1	15.4
Belgium	10.7	19.9	23.2	16.3
Denmark	10.4	14.6	24.4	14.5
United Kingdom	13.3	15.8	19.5	15.4
Sweden	5.8	12.1	21.4	11.2
The Netherlands	10.4	13.4	15.2	11.9
Ireland	5.8	7.8	15.5	7.9

Source: Eurobarometer 44.3/1996.

**Figure 6.8**  
**Percent Reporting an Osteoporosis Examination in Past Year**  
**Women 50+ Years, EU 15 (1996)**

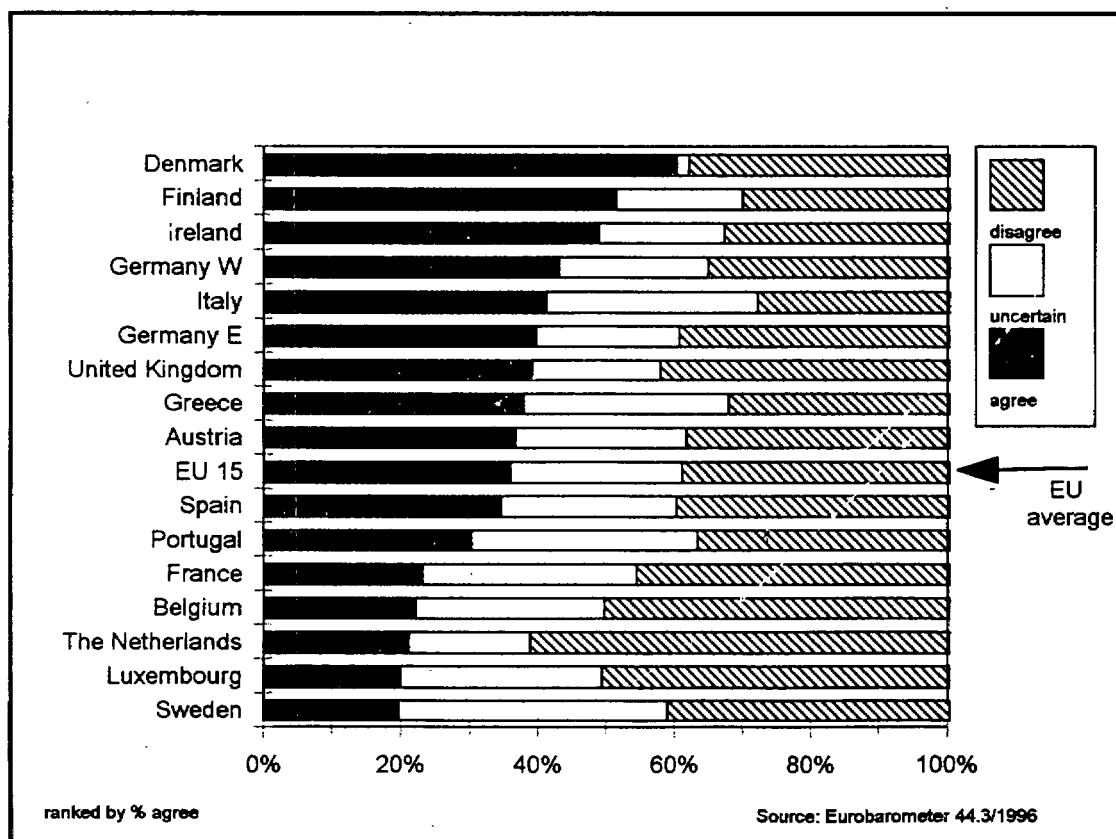


**Table 6.7**  
**Percent Reporting an Osteoporosis Test in Past Year**  
**Women 50+ Years, EU 15 (1996)**

	50+ years	50-64 years	65+ years	Total
Austria	27.5	28.9	25.9	15.7
Germany W	26.7	27.0	26.4	13.6
Germany E	22.8	18.8	29.5	14.1
Greece	19.7	18.2	21.7	9.0
Belgium	19.5	24.5	14.3	10.3
France	19.2	19.2	19.4	9.4
Italy	18.5	20.7	16.2	8.2
EU 15	16.8	16.7	17.2	8.7
Denmark	14.1	11.0	18.3	7.3
Spain	12.6	10.5	14.9	7.9
Luxembourg	12.3	19.4	7.1	14.3
Portugal	11.6	12.2	10.6	6.6
The Netherlands	10.3	8.5	15.6	4.7
United Kingdom	5.7	5.3	6.1	3.6
Sweden	5.5	3.5	8.0	2.4
Ireland	4.5	4.7	4.2	2.2
Finland	4.4	2.7	6.1	2.9

Source : Eurobarometer 44.3/1996

**Figure 6.9**  
**Percent Preferring Women Doctors\***  
**Women 15+ Years, EU 15 (1996)**



\* Respondents were asked to rate the extent to which they agreed/disagreed with the following statement: "I would prefer to consult a doctor of my own sex for my health problems". The table shows the distribution of responses to this statement.

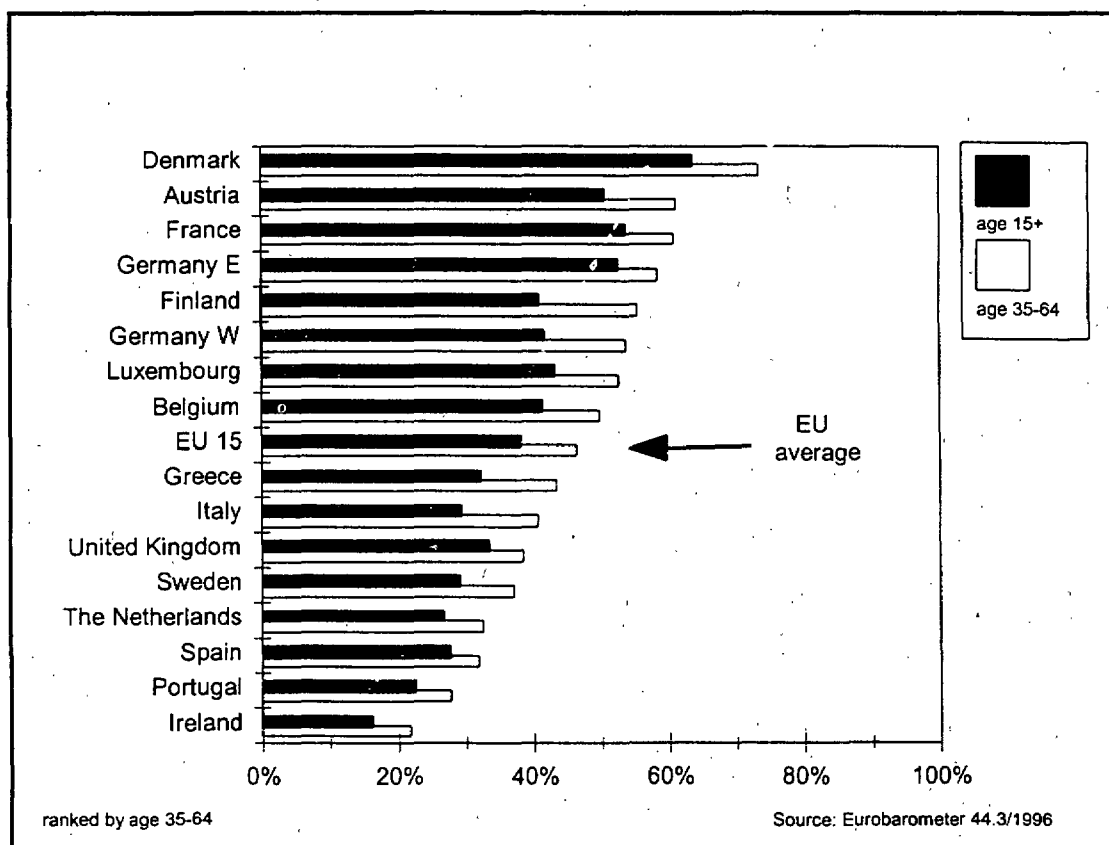
**Table 6.8**  
**Percent Preferring Women Doctors\***  
**Women 15+ Years, EU 15 (1996)**

	disagree strongly	disagree slightly	agree uncertain	agree slightly	agree strongly
Denmark	16.1	21.8	2.0	25.2	34.9
Finland	8.6	21.4	18.8	30.0	21.2
Ireland	10.0	22.8	18.7	21.7	26.8
Germany W	10.8	24.3	22.2	27.7	15.0
Italy	21.7	6.2	31.2	21.1	19.9
Germany E	12.6	26.8	21.1	23.1	16.5
United Kingdom	12.5	29.7	18.8	21.0	17.9
Greece	15.7	16.5	30.2	23.6	14.1
Austria	17.4	20.9	25.2	20.7	15.8
EU 15	16.7	22.3	25.4	21.0	14.6
Spain	9.7	30.1	25.7	23.9	10.6
Portugal	10.5	26.2	33.3	21.3	8.7
France	24.0	21.6	31.4	14.2	8.8
Belgium	15.9	34.4	27.6	15.0	7.1
The Netherlands	45.8	15.3	17.9	8.9	12.1
Luxembourg	19.7	31.0	29.7	13.2	6.5
Sweden	15.7	25.3	39.4	13.1	6.4

Source: Eurobarometer 44.3/1996

\* Respondents were asked to rate the extent to which they agreed/disagreed with the following statement: "I would prefer to consult a doctor of my own sex for my health problems". The tables shows the distribution of responses to this statement.

**Figure 6.10**  
**Percent Reporting a Cervical Smear Test in Past Year**  
**Women 15+ Years, EU 15 (1996)**



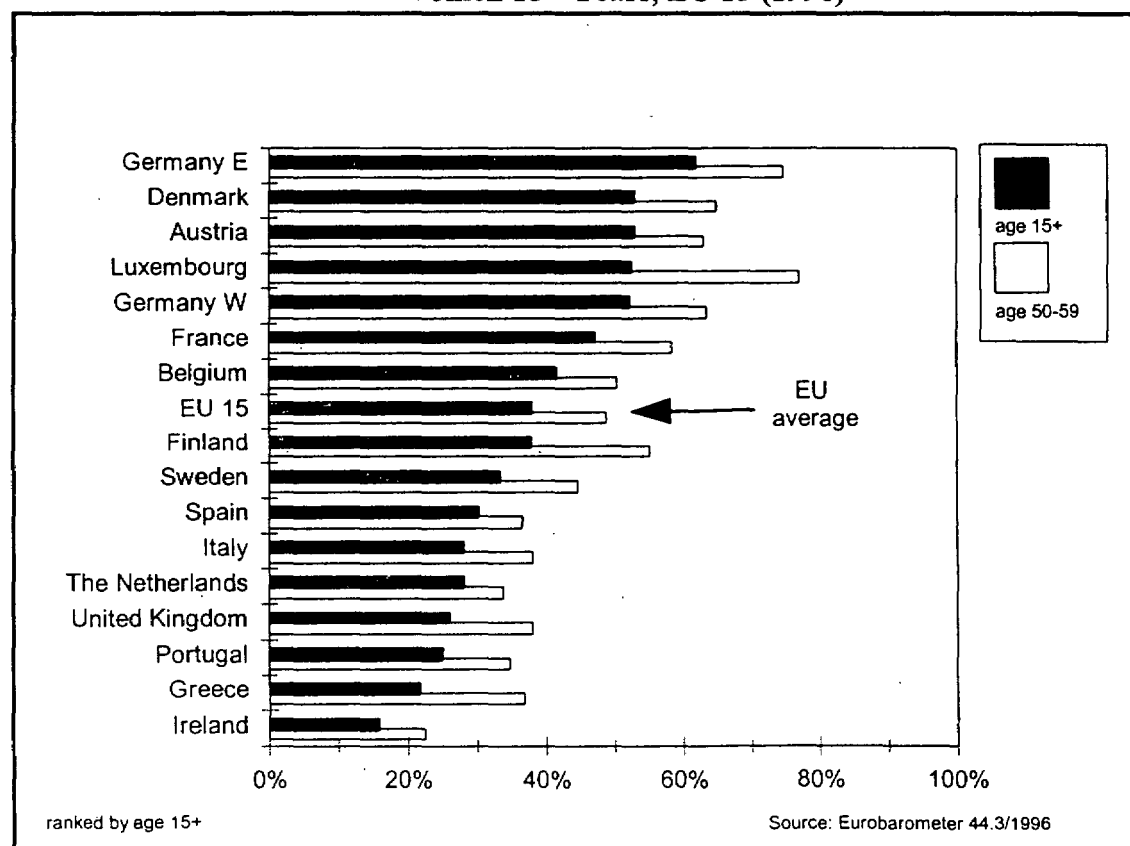


**Table 6.9**  
**Percent Reporting a Cervical Smear Test in Past Year**  
**Women 15+ Years, EU 15 (1996)**

	5-34 years	35-64 years	65+ years	Total
Denmark	51.8	73.2	58.1	63.5
Austria	49.3	60.9	22.0	50.2
France	55.2	60.4	21.2	53.2
Germany E	55.7	58.1	27.3	52.3
Finland	38.0	55.1	12.8	40.6
Germany W	38.0	53.2	18.0	41.4
Luxembourg	42.5	52.2	18.0	42.8
Belgium	41.6	49.4	20.2	41.0
<b>EU 15</b>	<b>37.3</b>	<b>45.9</b>	<b>16.5</b>	<b>37.7</b>
Greece	24.4	43.0	15.5	31.9
Italy	22.2	40.3	15.5	29.1
United Kingdom	41.6	38.0	8.6	33.3
Sweden	26.7	36.8	11.2	28.8
The Netherlands	20.1	32.2	15.2	26.4
Spain	29.3	31.3	12.9	27.2
Portugal	23.2	27.3	7.2	22.3
Ireland	14.4	21.5	1.4	15.8

Source: Eurobarometer 44.3/1996

**Figure 6.11**  
**Percent Reporting a Breast Examination by Hand in Past Year**  
**Women 15+ Years, EU 15 (1996)**

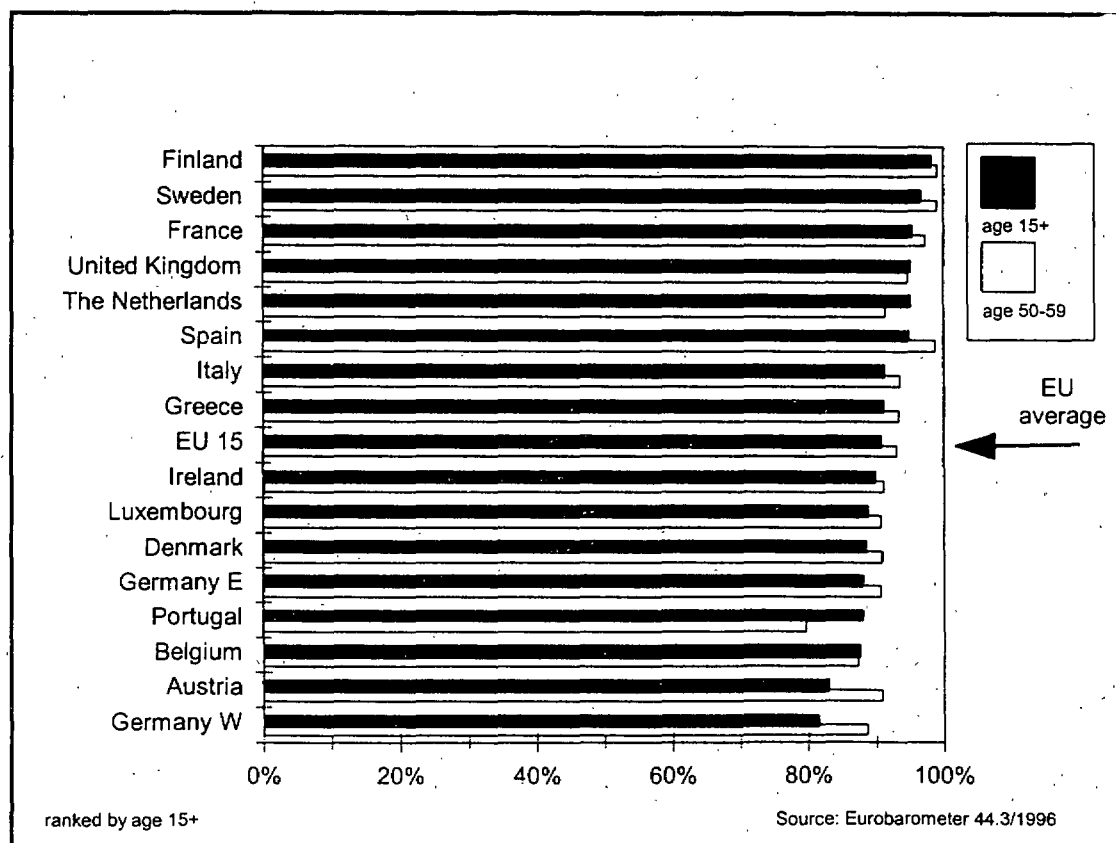


**Table 6.10**  
**Percent Reporting a Breast Examination by Hand in Past Year**  
**Women 15+ Years, EU 15 (1996)**

	15-34 years	35-49 years	50-59 years	60+ years	Total
Germany E	54.2	71.5	74.5	50.8	61.5
Denmark	41.1	51.5	64.7	62.8	52.8
Austria	55.4	59.7	62.7	32.5	52.7
Luxembourg	45.8	66.3	76.7	27.3	52.3
Germany W	48.6	64.3	63.1	38.4	52.0
France	42.3	50.9	58.2	39.4	46.8
Belgium	36.3	58.7	50.0	27.0	41.2
EU 15	32.4	47.0	48.4	29.8	37.9
Finland	24.1	48.6	54.8	33.6	37.6
Sweden	20.4	38.7	44.3	37.9	33.2
Spain	27.8	38.6	36.2	21.0	29.9
Italy	20.1	38.4	37.7	23.2	28.0
The Netherlands	16.3	39.4	33.3	26.0	27.9
United Kingdom	20.8	34.3	37.7	18.8	25.8
Portugal	19.3	35.8	34.5	18.0	24.8
Greece	15.9	29.6	36.5	11.5	21.4
Ireland	11.9	22.8	22.2	9.5	15.6

Source: Eurobarometer 44.3/1996

**Figure 6.12**  
**Percent Favouring Mammography Screening**  
**Women 15+ Years, EU 15 (1996)**

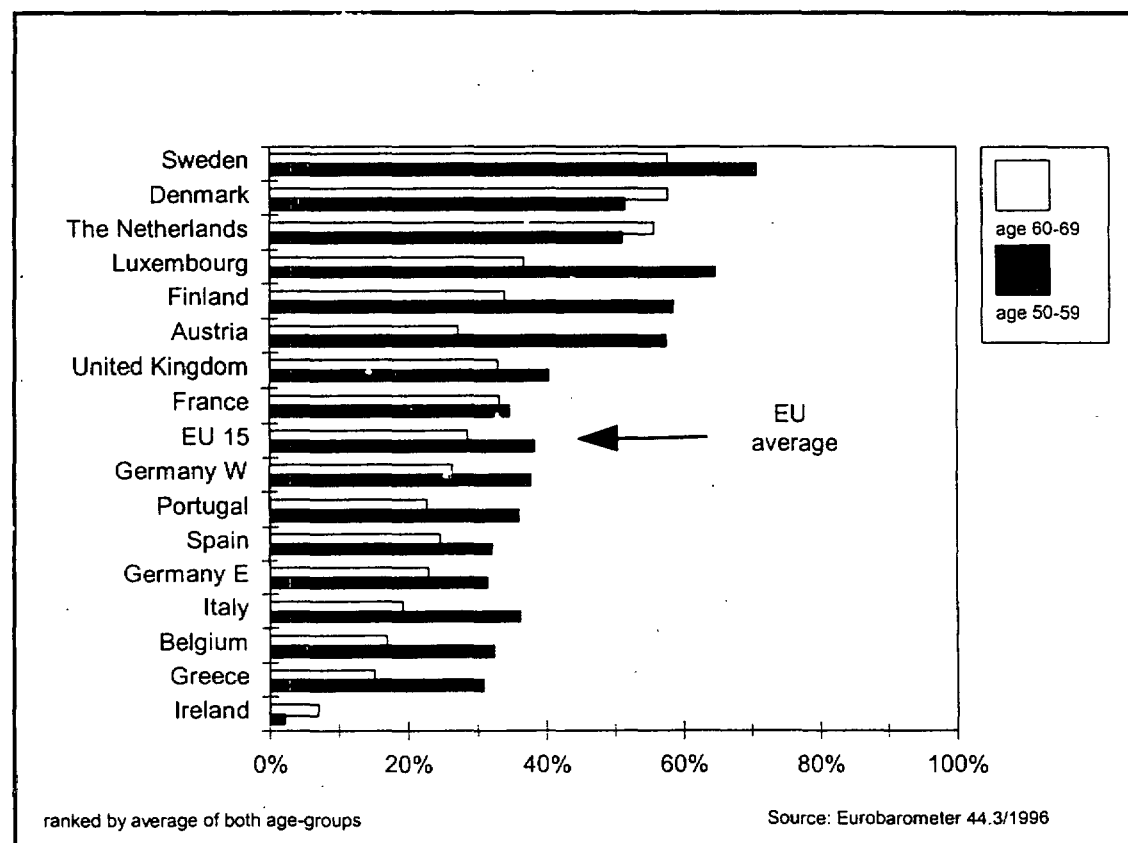


**Table 6.11**  
**Percent Favouring Mammography Screening**  
**Women 15+ Years, EU 15 (1996)**

	15-34 years	35-49 years	50-59 years	60+ years	Total
Finland	97.6	98.6	98.6	97.5	98.0
Sweden	97.1	96.8	98.9	93.1	96.4
France	95.4	93.0	96.9	95.7	95.2
The Netherlands	92.8	97.0	91.2	98.6	95.0
United Kingdom	94.8	96.6	94.3	94.0	95.0
Spain	96.5	96.1	98.6	88.7	94.8
Italy	93.8	91.1	93.5	86.8	91.2
Greece	92.1	96.2	93.2	82.0	90.9
EU 15	91.3	91.7	93.0	87.4	90.7
Ireland	91.6	89.7	90.9	84.8	89.6
Luxembourg	90.9	89.1	90.3	82.5	88.7
Denmark	88.1	89.1	90.6	85.8	88.3
Germany E	86.4	85.7	90.4	90.3	87.9
Portugal	91.3	90.0	79.3	86.0	87.8
Belgium	87.9	87.2	87.1	86.9	87.4
Austria	82.3	88.3	90.7	71.7	82.8
Germany W	81.1	85.0	88.2	73.2	81.1

Source: Eurobarometer 44.3/1996

**Figure 6.13**  
**Percent Reporting a Mammography in Past Year**  
**Women 50-69 Years, EU 15 (1996)**



**Table 6.12**  
**Percent Reporting a Mammography in the Past Year**  
**Women 15+ Years, EU 15 (1996)**

	<b>&lt;40 years</b>	<b>40-49 years</b>	<b>50-59 years</b>	<b>60-69 years</b>	<b>70+ years</b>	<b>Total</b>
Sweden	2.4	30.3	70.5	57.4	22.4	27.9
Denmark	11.0	34.4	51.2	57.4	45.5	31.1
The Netherlands	6.1	16.5	50.9	55.6	15.8	18.4
Luxembourg	13.9	47.0	64.3	36.4	20.0	28.3
Finland	2.4	11.8	58.3	33.7	9.1	17.8
Austria	19.1	41.1	57.3	27.1	19.3	28.9
United Kingdom	2.6	10.5	40.0	32.5	3.2	12.9
France	6.0	23.9	34.4	32.8	22.9	18.4
<b>EU 15</b>	<b>8.1</b>	<b>24.6</b>	<b>38.0</b>	<b>28.4</b>	<b>11.9</b>	<b>18.1</b>
Germany W	14.8	30.4	37.4	26.1	11.8	21.8
Portugal	10.7	21.7	35.6	22.5	10.2	18.0
Spain	12.6	32.5	31.9	24.3	3.9	18.8
Germany E	14.2	25.5	31.2	22.8	16.0	20.7
Italy	3.4	27.0	36.0	19.0	9.4	15.1
Belgium	11.0	31.2	32.2	16.7	10.5	17.2
Greece	3.2	19.3	30.6	14.8	5.1	12.0
Ireland	2.7	10.1	1.9	6.8	4.4	4.6

*Source : Eurobarometer 44.3/1996*

## 7. SPECIAL ISSUES IN WOMEN'S HEALTH

This chapter describes selected issues in women's health of importance to public health endeavours at both Community and Member State level. They have been chosen to reflect health concerns for women at different stages of their lives. Thus, for young women eating disorders and HIV/AIDS are discussed. For women of childbearing age the focus is on family planning and abortion issues, and for elderly women menopause and menopause-related health issues (e.g., osteoporosis and hormone replacement therapy (HRT)). In addition to these issues, violence against women is discussed because of its importance to women of all ages.

It should be pointed out that despite the importance of these issues, national statistics are scarce. Furthermore, existing data are of limited comparability because of differences in definitions and/or data collection methods. This chapter should therefore be seen as an attempt to highlight important, emerging health issues for women, rather than as a comparison of these aspects of the state of women's health in the EC.

### 7.1 Eating Disorders

The eating disorders bulimia and anorexia nervosa, which occur primarily in young women, are associated with considerable morbidity and even mortality. There is currently no national public health policy on these issues anywhere in the EC, and no national statistical data are available on their incidence and prevalence. Various estimates of the incidence of bulimia/anorexia nervosa indicate that they are increasing in the EC. However, with the greater media attention given to them, it is impossible to determine whether the apparent increase is real or only the result of greater awareness of the problem. An additional difficulty in obtaining reliable data on the incidence of eating disorders is that the victims often try to hide their disorder(s).

Estimated incidence rates for these eating disorders vary considerably. One source<sup>1</sup> estimates the incidence of anorexia nervosa in western countries to be nearly 1% among women aged 14-29. However, other studies have reported much lower rates, ranging from 0.45-per 100,000 in Sweden<sup>2</sup> to 8.1 per 100,000 in the Netherlands<sup>a 3</sup>, with the UK reporting rates of 0.66-3.77 per 100,000<sup>4</sup>. Needless to say it is impossible to determine which estimate is the most accurate. With respect to bulimia nervosa, estimates for Western countries put the incidence at 1-2% of women aged 14-45 years<sup>5</sup>. Estimates from individual studies vary considerably from a low of 11.4 per 100,000 in the Netherlands<sup>b 6</sup> to a high of 3-4% in Sweden and Germany<sup>7 8</sup>.

As already noted, anorexia and bulimia nervosa are associated with significant morbidity and mortality. In particular suicide and suicide attempts are frequent. Unfortunately, there is little information about the actual rates of morbidity and mortality from these disorders, because other conditions are often listed as the direct cause of death (or illness). For example, suicide from depression, or heart failure, both frequent sequelae of anorexia nervosa, are often given as the cause of death when anorexia nervosa would be equally (or more) correct. One study estimates a mortality rate of 6% for anorexia nervosa and 3.1%

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a In this study, 8.3% of the sample population were men.

b In this study, 3.5% of the sample population were men.

for bulimia nervosa<sup>9</sup>. In addition, many women suffer from partial anorexia/bulimia syndrome or other abnormal eating styles, which pose a health risk and put them at elevated risk for full eating disorders.

The causes of eating disorders are unclear, although some blame, at least in part, society's obsession with body weight and appearance. Research suggests that teenagers and young women are particularly concerned about their weight and this may be a reason for the higher incidence of eating disorders in these age-groups. For example, a Belgian study<sup>10</sup> found adolescent schoolgirls to be preoccupied with body weight, even when they had an ideal body mass index, causing them to adopt a restricted eating style which was considered a risk factor for developing eating disorders. Similarly, a Dutch study found that 41% of the sample's schoolgirls considered themselves too heavy, 33% were dieting, 11% were suffering from some form of eating disorder, and 1.5% were suffering from bulimia/anorexia nervosa<sup>11</sup>.

The findings from these and similar studies<sup>12</sup> are confirmed by the results of the 1996 Eurobarometer survey. As indicated in Figure 7.1 and Table 7.1, about 1/3 of EC women aged 15-24 report dissatisfaction with their body weight, and about 25% report having been on a diet in the previous year (see Figure 7.2 and Table 7.2). Considerable variation exists between the Member States, with Greek women reporting the highest level of dissatisfaction with their weight and Irish women reporting the lowest, perhaps reflecting, at least in part, differing body mass distributions (see Section 6.3). As shown in Figure 7.3, satisfaction with one's weight is highly correlated with body mass. Women considered severely overweight (i.e., those with BMI of 30 and over) are far more likely to report being unhappy with their weight than severely underweight women (i.e., those with a BMI of less than 18).

Treatment for eating disorders includes nutritional counselling, psychotherapy, family therapy (recommended for anorexia nervosa), and cognitive therapy (recommended for bulimia nervosa). Medical/psychiatric help is usually obtained through hospitals with specialist out-patient programmes; in-patient care being limited to instances where the disorder is life-threatening<sup>13</sup>. Specialist clinics have been established in some Member States (e.g., Sweden, Finland, Belgium, UK) but demand for treatment exceeds supply.

## **7.2 HIV/AIDS and Women's Health**

Infection with Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) is an important health issue for young women. Since the identification of the first AIDS cases in the EC in the early 1980s, the prevention of HIV has become an important public health concern. However, because AIDS first became wide-spread among gay and bi-sexual men, AIDS has only recently come to be seen as a problem for women as well. By 30 September 1996, 167,021 persons had contracted AIDS in the EC, of whom 27,355 (17%) were women (see Tables 7.3 and 7.4<sup>a</sup>)<sup>14</sup>. Among women, the majority (52%) were intravenous (IV) drug users. While the incidence of AIDS among gay and bi-sexual men appears to be stabilising, the rate of transmission in the heterosexual population (both male and female) is still increasing. Evidence suggests that

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a The total in the two tables are not identical although they come from the same source<sup>14</sup>. While no explanation is provided, the discrepancy is likely to be due to missing data on the sex of the reported case(s) in Table 7.3.

in the EC the majority of cases of heterosexually acquired HIV have resulted from unsafe sex with HIV-positive IV drug users<sup>15</sup>, and that the majority of babies born HIV-positive have acquired the virus through perinatal (vertical) transmission (i.e., from mother to child) from an IV drug-using mother or a mother with a partner at risk.

It should be noted, however, that the main transmission routes of HIV in women vary somewhat between Member States (see **Figure 7.4**). In Spain, Italy, Portugal, and Ireland, for example, IV drug users account for the largest share of AIDS cases, while in Belgium heterosexual transmission is the main route.

Owing to the higher prevalence of HIV/AIDS among men, knowledge about the natural history of HIV in women is relatively limited. It is clear, however, that they are more vulnerable to the virus (as well as to other sexually transmitted diseases) than are men. In other words, it is easier to transmit the HIV virus from men to women than vice versa. Furthermore, women are frequently diagnosed at a later stage, because of a general lack of recognition of their symptoms. Sexually-transmitted reproductive tract infections have also been identified as associated risk factors for the spread of HIV<sup>16</sup>.

In addition, women have other difficulties in safeguarding themselves from infection. They are in a weaker position to ensure safer sex, whether in stable, casual, or commercial sexual relationships, than are men. At the same time, it is often assumed that they should take the responsibility for using condoms. Trends show that women and men have changed their sexual behaviour; they use condoms more often and have reduced their number of partners. However, unsafe sex practices continue. Prostitutes face particular risks of infection, though contrary to public perception, prostitution does not appear to have played a significant role in the transmission of HIV in the EC<sup>17</sup>, indicating the use of safer sex practices in that group, encouraged by preventive interventions.

Notwithstanding the risks faced by women, preventive interventions aimed at women have in general been limited. Either women have been targeted indirectly as part of general campaigns for the whole population, or there have been particular actions targeted at certain groups, notably IV drug users and sex workers. More efforts are needed specifically tailored to women, and particularly young women who have, or are likely to become part of the group with, the highest HIV incidence.

### **7.3 Family Planning**

One of the most important questions for women during their reproductive years is family planning. Most women feel that in order to have control over their lives, they must be able to control their fertility with regard to the number and spacing of their children, and they must be able to express their sexuality without fear of unwanted pregnancy and sexually transmitted diseases (STDs). Availability of contraceptives and abortion are therefore important issues.

Widespread availability of effective contraceptives have contributed to rapidly falling fertility rates in the EC. Since 1970, fertility has declined in all Member States, except Finland and Sweden where fertility rates have increased slightly (see **Table 7.5**). Data on contraceptive use are not available in Greece, Ireland, and Luxembourg, however, the majority of Member States report contraceptive use rates between 71 and 81%. Portugal and Spain report rather lower rates, 66 and 59%, respectively.

There are no data on contraceptive use among teenagers, but it is known that teenagers are less likely than the adult population to use contraception for a variety of reasons. They may be inhibited by ignorance, by fear of parental discovery of their sexual activity, and by a lack of access to contraceptives, etc. These factors contribute to the relatively high teenage birth rates, which despite recent declines, continue in the EC (see Table 7.5).

The following methods of contraception are available in the EC: natural methods (e.g., the rhythm method, coitus interruptus/withdrawal), hormonal (e.g., birth control pills, injectable/transdermal absorption), barrier methods (e.g., male and female condoms, diaphragm, cervical cap, intra-uterine devices (IUDs)), surgical techniques (e.g., male and female sterilisation), and post-coital contraception (i.e., the morning-after pill). The most widely used contraceptives are birth control pills, followed by condoms. Use of condoms has increased as a result of efforts to prevent the spread of HIV<sup>18 19</sup>.

Choice of contraceptive method is likely to be influenced by availability, cost, and access, national policies, physical access, cultural and religious considerations, health status, partner preferences, and socio-economic status. Another factor influencing choice are the health risks and/or side-effects associated with a contraceptive method. For example, hypertension and increased thrombosis risk associated with some birth control pills, and increased risk of pelvic inflammatory diseases associated with IUDs, make these methods unacceptable to some women. Choice of method is also likely to change over a woman's fertile life. Younger women may favour the use of birth control pills or condoms, while IUDs and surgical sterilisation may be preferred by older women.

Family planning advice is readily available in all Member States from doctors, family planning centres, maternity clinics, and municipal health centres, however, cost varies considerably. In some Member States (e.g., Finland, Italy, and the UK) contraceptives are provided free of charge<sup>20 21</sup>, while in others (e.g., Ireland, Germany) certain groups, such as the poor<sup>22</sup> or the young<sup>23</sup> are targeted. Some Member States (e.g., Finland, the Netherlands, Sweden, and the UK) provide family planning centres especially for sexually active teenagers<sup>24</sup>.

## 7.4 Abortion

Improved family planning programmes have reduced the number of unwanted pregnancies but have not totally eliminated them. As a result, the demand for induced abortion persists, not least among teenagers<sup>25</sup>. Reasons for seeking abortions include failure of contraceptive method, completed family size, pregnancy as a result of rape, confirmed deformation of the foetus, health risk to the mother, and socio-economic circumstances.

Abortion is permitted, under varying criteria/conditions, in all Member States except Ireland and Northern Ireland<sup>a</sup>. Since 1995 health care professionals in Ireland may inform their clients about legal abortion services within the EC, but only within the context of full counselling on all available options and without advocating abortion. The right for Irish women to travel within the EC to procure an abortion was established in 1992.

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a Abortion is not available in Ireland. However, it should be noted that the Irish Supreme Court has ruled that an abortion would be permissible where there was a real and substantial threat to the life of the mother which could not be obviated by any other means. The Abortion Act of 1967 which applies to England, Scotland, and Wales was not extended to Northern Ireland where abortion is only permitted when the life of the mother is threatened.



The criteria for obtaining an abortion differ among the Member States that permit it. All include specific time limits which generally allow abortion to be performed within the first trimester, but only to a limited extent in the second trimester. Pre-abortion counselling with emphasis on alternative options and a period of reflection is mandatory in all Member States. Some Member States also specify that a health professional may refuse to perform an abortion because of moral objections. Recently, some Member States (Spain, Germany, and France) seem to have been liberalising their abortion policies, although not without controversy, while others (Italy and Belgium) have been trying to tighten theirs<sup>26</sup>.

Abortion rates per 1000 women vary across the EC (see Table 7.6). The highest rates are in Sweden (18.3 per 1000 women), Denmark (14.3 per 1000 women), and France (13.0 per 1000 women). Italy, the Netherlands, and Spain report substantially lower rates: 8.6, 6.0, and 5.4 per 1000 women, respectively. Another frequently reported abortion statistic is the ratio of abortion to 1000 live births. Not surprisingly, this ratio also varies within the EC, with the highest ratios reported in Sweden, Italy, Denmark, France, and the UK<sup>27</sup>, and the lowest in the Netherlands, Luxembourg, and Spain (see Table 7.6). The ratios in the latter countries are only one third of those in the former group.

Complications associated with abortions done under good medical conditions are very rare. One study estimates the mortality rate for legal abortions before 8 weeks to be 0.5 per 100,000<sup>28</sup>. This compares with a maternal mortality rate of 7 per 100,000 for childbirth (see Section 3.3).

Identification of trends in abortion over time is complicated by a dearth of data and lack of comparability. However, inspection of the data from the UK, the Netherlands, and Spain seems to indicate that there may be a typical pattern of development following legalisation of abortion in a Member State: first the abortion rate increases, often substantially, then as time passes the rate stabilises and may even decrease.

## **7.5 Menopause**

Menopause - literally the cessation of monthly menstruation - signifies the end of a woman's fertile period but usually refers to the extended period (20 or more years) in which a woman's body adjusts to a lower hormonal climate, before and after the end of menstruation. The average age at menopause is 50-52 years, thus women in the EC can expect to live at least one third of their lives after menopause.

The effect of menopause on women's health varies. Estimates indicate that 75% of menopausal women experience some problems or discomfort, but only 10-20% seek medical help<sup>29</sup>. Short-term effects of menopause include vasomotor symptoms (hot flushes and night sweats), genito-urinary symptoms, and mood swings. These symptoms may be attributed to the effect of declining hormone (oestrogen) levels associated with menopause.

The increasing longevity of women in the EC has intensified the debate about the possible long-term consequences of menopause. Although there is currently no proof of a causal relation between post-menopausal hormone levels and post-menopausal health, morbidity statistics reveal increased incidence of cardiovascular disease and osteoporosis in post-menopausal women.

### *7.5.1 Osteoporosis and Cardiovascular Disease*

Age-related osteoporosis occurs in both women and men, but is greater in women because of the accelerated bone loss that occurs in women during and after menopause. Post-menopausal osteoporosis is a cause of concern throughout the EC because of the high incidence of bone fracture, especially hip and vertebral fracture, which leads to considerable mortality, morbidity, reduced mobility, and decreased quality of life. Research suggests that osteoporosis is increasing. A Greek study estimated that 9% of women over 45 years have symptoms of osteoporosis<sup>30</sup>. A Finnish study calculated that women aged 50 and over have nearly 40% chance of sustaining an osteoporotic fracture during their life time<sup>31</sup>. Other studies show that hip fractures are associated with a 20% mortality during the first year and 40% during the three years after the fracture. Furthermore, more than half of those with hip fractures never regain full mobility<sup>32</sup>.

Preventive initiatives have focused on ways to maintain quality of life into old age and methods to reduce the costs associated with osteoporosis. There are currently no national osteoporosis screening programmes in the EC, although local screening facilities exist in most countries. Further research is needed to determine the cost-effectiveness of prevention methods, which include primary prevention involving increased exercise and greater calcium consumption among teenage and pre-menopausal women; secondary prevention emphasising early detection (and treatment) through screening; and tertiary prevention, which typically involves accident management and rehabilitation of osteoporotic women.

Cardiovascular disease has long been regarded as a disease of men primarily because of its low incidence in pre-menopausal women. Among women under 50 the incidence is only one quarter of that among similarly aged men. However, the risk of cardiovascular disease increases significant as women age. By the age of 60, the incidence has risen to half that of men<sup>33</sup>. When looking at women across their entire lives, cardiovascular disease emerges as the primary cause of death. Furthermore, with women's increased longevity, it is rapidly becoming an important source of morbidity throughout the EC.

### *7.5.2 Prevention and Symptom Control*

Research into the causes of and treatments for osteoporosis and cardiovascular disease in post-menopausal women continues in many Member States. Since the 1980s, many doctors have begun to recommend hormone replacement therapy (HRT) because of its potential for preventing both osteoporosis, cardiovascular disease, and, as documented recently, Alzheimer's disease<sup>34</sup>. However, the debate about the relative costs and benefits of HRT is far from settled. Precise rates of HRT usage in Member States are not available, but estimates range from 2% in Italy<sup>35</sup>, 4% in Spain<sup>36</sup>, 15% in the Netherlands<sup>37</sup>, 20% in Austria<sup>38</sup> and Sweden<sup>39</sup>, to 56% in Finland<sup>40</sup>.

Evidence suggests that HRT use is associated with higher socio-economic status and city residence<sup>41</sup>. More educated women are also more likely to use HRT, suggesting that information about the potential benefits (and side effects) of HRT may be insufficient among the general population. To address this issue, the 1996 Eurobarometer survey asked women whether they felt well (or poorly) informed about HRT. The results appear in **Figure 7.5** and **Table 7.7** which show that 61% feel insufficiently informed about HRT. When analysed by age-groups, this conclusion holds although on women aged 50-64 years appear slightly better informed than women of other ages. This is perhaps

understandable as this is the age-group for whom HRT is particularly relevant. Figure 7.5 also reveals considerable variation between Member States. Portugal, Ireland, Spain and Greece report the highest percentage of poorly informed women while Finland and Luxembourg report the lowest, to some extent mirroring the usage rates in these countries. Altogether these results clearly point to the need for more (or better) HRT information in the EC.

## 7.6 Violence against Women

Violence against women - defined by the UN General Assembly as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"<sup>42</sup> - is an issue of growing concern in the EC<sup>a</sup> <sup>43</sup>. Owing to the lack of national statistics on the subject, it is impossible to determine whether the perceived increase in violence against women reflects a true increase, or whether it is due to a higher level of reporting because of a greater awareness and acceptance of the problem.

Violence against women, which was initially seen as a human rights concern, has gradually been recognised as a public health issue. Indeed, the European Women's Health Network, established in Vienna in 1994, included violence against women as one of 6 major *health* concerns. Although violence against women is known to cut across socio-economic, cultural, religious, and racial boundaries, there is concern that some groups of women, such as the elderly, migrants and poor women, may be especially vulnerable.

The causes of violence against women are unclear, but alcohol and drug abuse, poverty, and overcrowded conditions are factors known to exacerbate violent attacks on women<sup>44</sup>. It has also been suggested that changes in society aimed at improving the status of women (relative to men) may have contributed to increased assaults and sexual violence against them<sup>45</sup>.

### 7.6.1 Domestic Violence

Although data are scarce, it is now recognised in all Member States that violence against women by a male partner is the most endemic form of violence<sup>46</sup> <sup>47</sup>. In general, available data differentiate between domestic and sexual violence, although there is considerable overlap since rape within an intimate relationship is also viewed as a form of domestic violence. Information on the long-term health consequences of domestic violence on women is very limited. The few studies that exist tend to focus on psychological rather than physical consequences. For example, it is estimated that battered women are four to five times more likely to require psychiatric treatment and five times more likely to attempt suicide than non-battered women<sup>48</sup>. A Danish study of women who attempted suicide found that they had been subjected to a high degree of psychological and physical violence<sup>49</sup>. More recently, in a number of Member States studies have been conducted to provide base-line data on the number of women exposed to domestic violence. Estimates differ and range from 1 in 5 women in Ireland<sup>50</sup>, 1 in 4 in the UK<sup>51</sup>, to 1 in 3 in Portugal<sup>52</sup> and Germany<sup>53</sup>.

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<sup>a</sup> The European Commission has recently proposed a Community action programme to fight the trafficking in women for the purposes of sexual exploitation<sup>44</sup>.

### 7.6.2 Rape and Sexual Assault

Rape and sexual assault may result in physical injury and profound emotional trauma. Furthermore, rape victims are also frequently exposed to a variety of health risks ranging from death/suicide to unwanted pregnancy, STDs, including HIV, long-term chronic conditions, as well as psychological symptoms, such as depression, anger, guilt, sleeping and eating disturbances, fear of sex, and inability to concentrate<sup>54</sup>.

It is acknowledged throughout the EC that rape is a very under-reported crime. In Finland, for example, the average number of reported rape cases per year in the 1980s was 345, although the police estimates that the actual number was between 6000 and 10,000 per year<sup>55</sup>. Other reports of the number of rapes per year vary from 125 in Portugal (1992), 1381 in Sweden (1995), 1599 in Spain (1992), to 5082 in UK (1994). In the Netherlands, which reports rape on a population basis, the rate increased from 7 to 10 per 100,000 women between 1980 and 1988<sup>56</sup>.

### 7.6.3 Sexual Harassment and Stalking

Awareness of sexual harassment - undesired sexual advances - as well as stalking - persistent annoyance of someone - has been increasing throughout the Member States during recent years. Although national statistics are unavailable, a number of studies suggest that the prevalence of sexual harassment of women is substantial. In Finland, for example, one study estimated that among 18-to-24-year-olds, 26% of women (compared with 4% of men) experience sexual harassment<sup>57</sup>. In the Netherlands reports indicate that 1 in 3 girls under the age of 16 years experienced some form of unsolicited sexual advance, ranging from sexual harassment to rape<sup>58</sup>.

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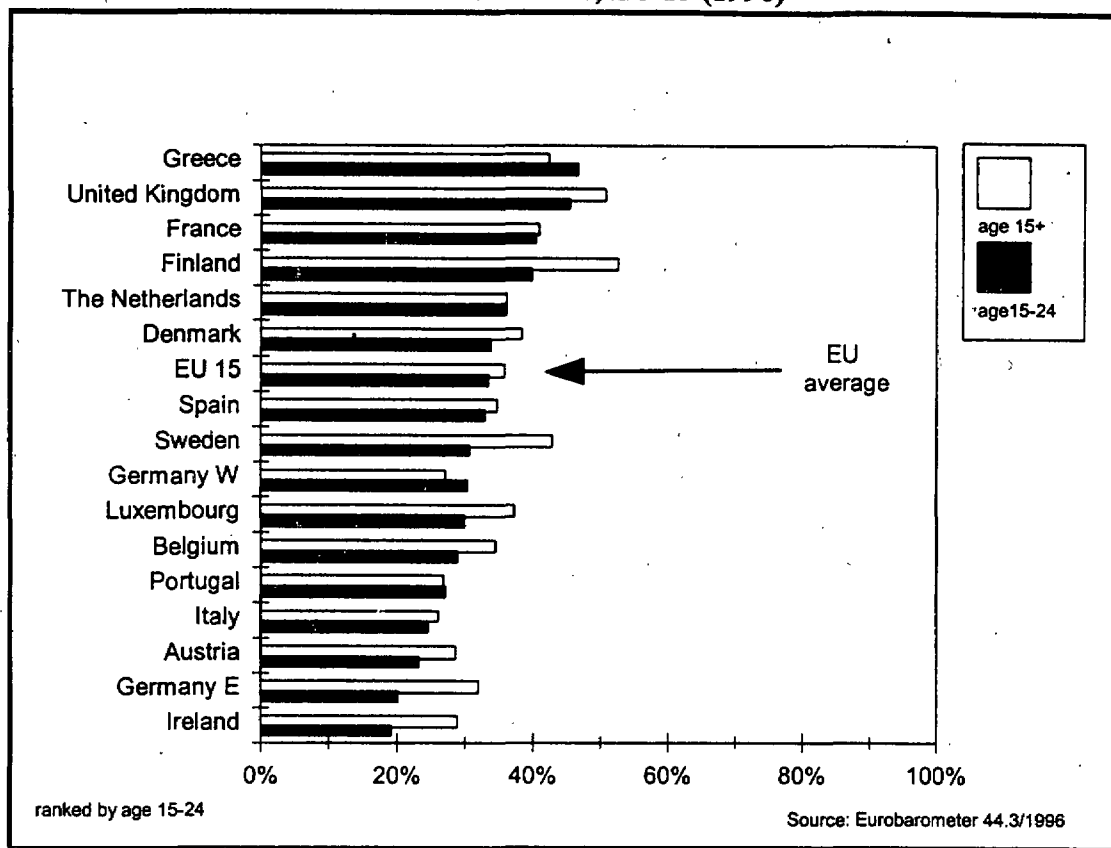
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## [Figures and Tables]

**Figure 7.1**  
**Percent Dissatisfied with Body Weight\***  
**Women 15+ Years, EU 15 (1996)**



\* Respondents were asked to rate the extent to which they agreed/disagreed with the following statement: "I am very satisfied with my body weight." The figure shows the percentage of respondents who disagreed (either slightly or strongly) with this statement.

**Table 7.1**  
**Percent Dissatisfied with Body Weight\***  
**Women 15+ Years, EU 15 (1996)**

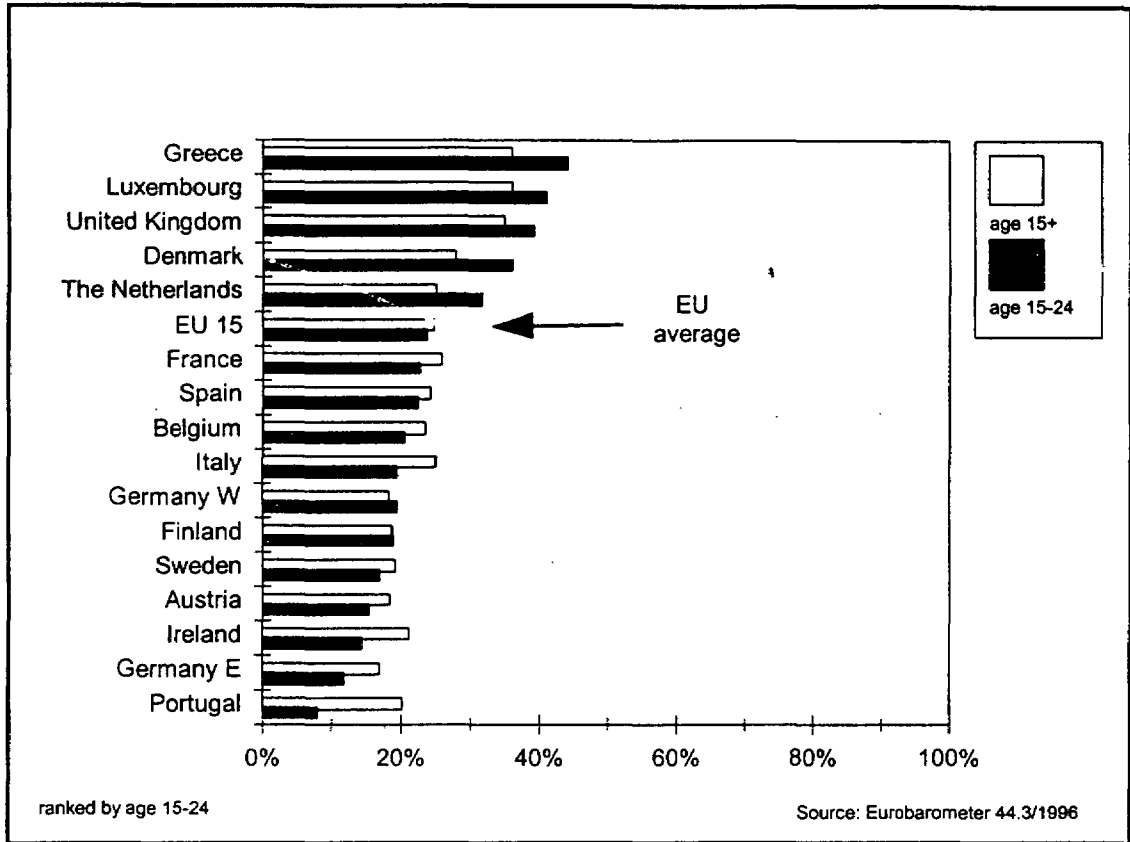
	15-24 years	25-34 years	35-64 years	65+ years	Total
Greece	46.5	35.3	45.9	33.7	42.1
United Kingdom	45.0	43.6	56.9	47.9	50.4
France	40.0	41.2	43.7	28.8	40.6
Finland	39.5	52.3	60.0	45.4	52.2
The Netherlands	35.7	28.7	38.0	42.4	35.6
Denmark	33.4	32.7	43.8	31.4	38.0
EU 15	33.3	30.6	40.1	30.7	35.4
Spain	32.7	31.2	37.8	31.5	34.4
Sweden	30.5	38.2	49.3	39.3	42.6
Germany W	30.2	18.1	33.3	19.4	26.9
Luxembourg	29.7	38.8	42.3	26.5	36.9
Belgium	28.5	40.5	35.8	28.5	34.3
Portugal	26.9	27.4	31.0	12.6	26.5
Italy	24.3	19.1	28.3	26.8	25.8
Austria	23.0	28.0	33.1	40.7	28.3
Germany E	20.0	23.9	41.2	22.1	31.7
Ireland	18.9	27.1	34.2	26.8	28.6

Source : Eurobarometer 44.3/1996

\* Respondents were asked to rate the extent to which they agreed/disagreed with the following statement: "I am very satisfied with my body weight." The table shows the percentage of respondents who disagreed (either slightly or strongly) with this statement



**Figure 7.2**  
**Percent Dieting during the Past Year**  
**Women 15+ Years, EU 15 (1996)**

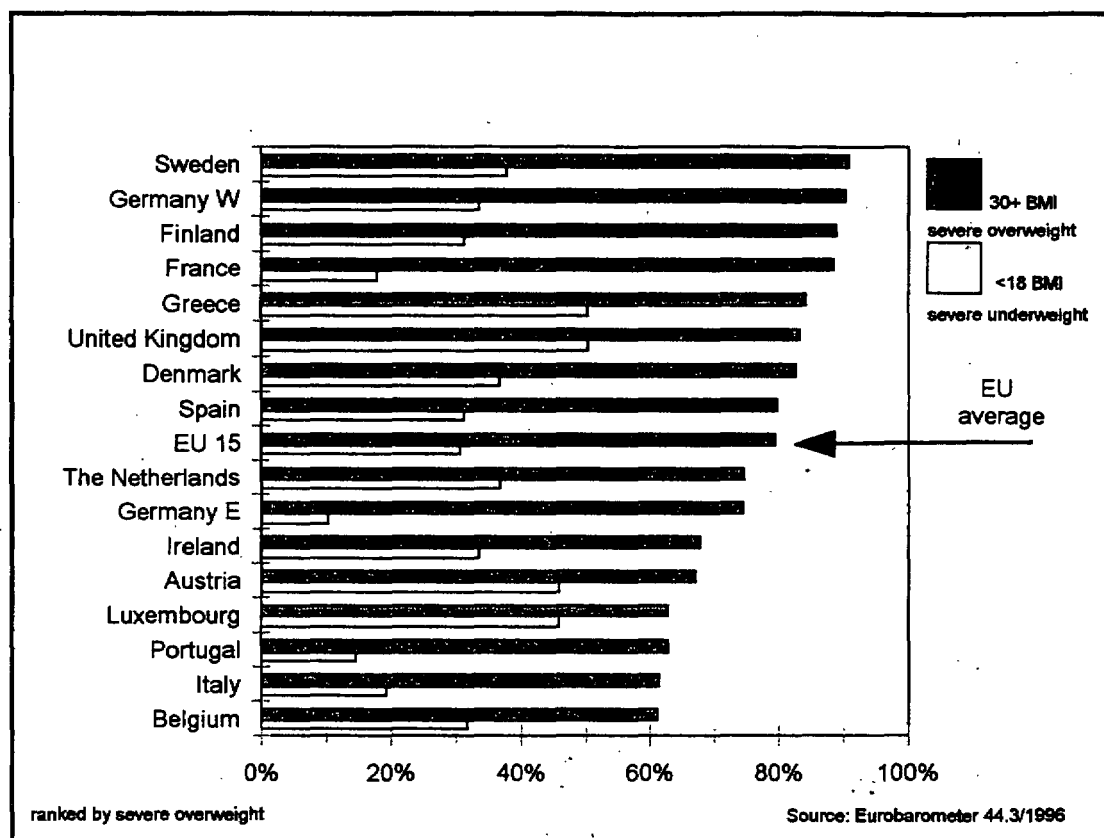


**Table 7.2**  
**Percent Dieting during the Past Year**  
**Women 15+ Years, EU 15 (1996)**

	15-24 years	25+ years	Total
Greece	43.7	34.1	35.7
Luxembourg	40.7	34.8	35.8
United Kingdom	39.0	33.7	34.6
Denmark	35.8	26.4	27.7
The Netherlands	31.4	23.8	24.8
EU 15	23.6	24.7	24.5
France	22.5	26.0	25.4
Spain	22.1	24.6	24.1
Belgium	20.2	23.7	23.1
Italy	19.2	26.1	24.8
Germany W	19.1	17.8	17.9
Finland	18.6	18.5	18.5
Sweden	16.7	19.4	19.0
Austria	15.2	18.6	18.1
Ireland	14.2	22.7	20.9
Germany E	11.7	17.4	16.7
Portugal	7.7	22.8	20.0

Source: Eurobarometer 44.3/1996

**Figure 7.3**  
**Percent Dissatisfied with Body Weight by Weight Category\***  
**Women 18+ Years, EU 15 (1996)**



\* See note to Figure 7.1.

**Table 7.3**  
**Cumulative Number of AIDS Cases\***  
**by Transmission Group, EU 15 (1996)**

Transmission Group	Females		Males	
	Cumulative Total** N	Cumulative Total** %	Cumulative Total** N	Cumulative Total** %
Homo/bisexual male	-	-	59 260	43.3
Injecting drug user (IDU)	14 049	51.4	51 535	37.6
Homo/bisexual IDU	-	-	2 535	1.9
Haemophiliac/Coagulation disorder	71	0.3	2 806	2.0
Transfusion recipient ***	1 439	5.3	1 635	1.2
Heterosexual contact	10 199	37.3	12 869	9.4
Other ****/Undetermined	1 597	5.8	6 344	4.6
<b>TOTAL</b>	<b>27 355</b>	<b>100</b>	<b>136 984</b>	<b>100</b>

\* Aged 13 years and older

\*\* From the beginning of the epidemic to 30 September 1996, unadjusted for reporting delays.

\*\*\* Includes recipients of blood components or tissue

\*\*\*\* Includes transsexual subjects

Source : European Centre for the Epidemiological Monitoring of AIDS, Quarterly Report No. 36, 30 September 1996.

**Figure 7.4**

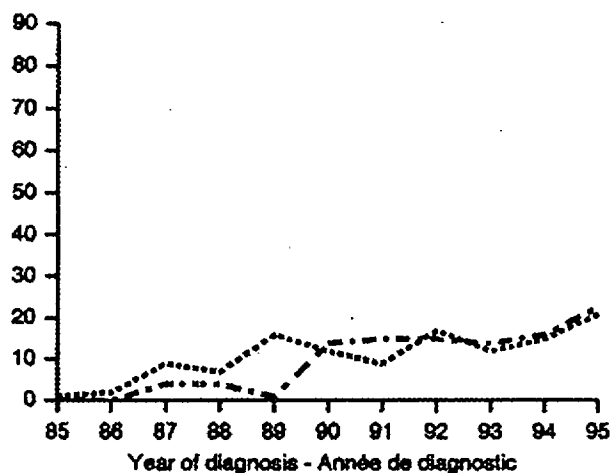
**Adult/Adolescent\* AIDS Cases in the Two Main Transmission Groups  
1985-1995**

**Austria**

Number of cases\*\* by year of diagnosis

Women - Femmes

Cases - Cas

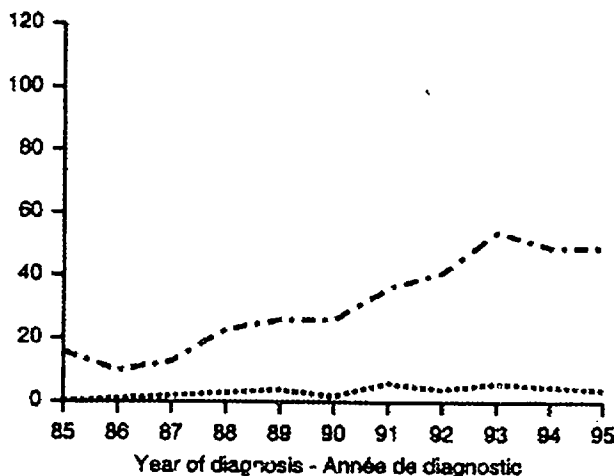


**Belgium**

Number of cases\*\* by year of diagnosis

Women - Femmes

Cases - Cas



..... IDU-UDI      - - - Heterosex.

\*13 years or over

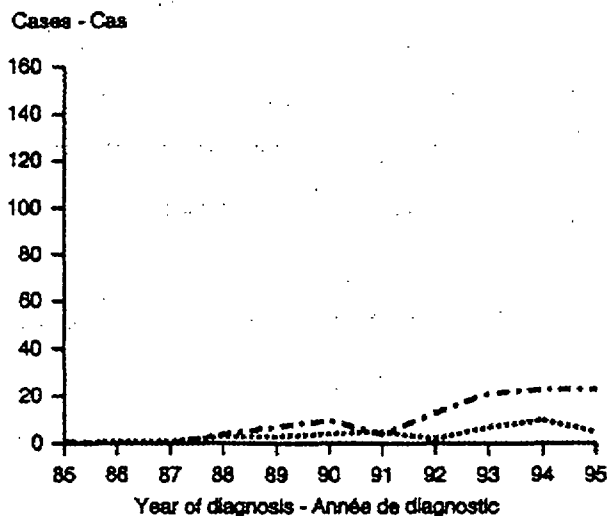
\*\*Adjusted for reporting delays (1993-1995)

# **Adult/Adolescent\* AIDS Cases in the Two Main Transmission Groups, 1985-1995**

## **Denmark**

Number of cases\*\* by year of diagnosis

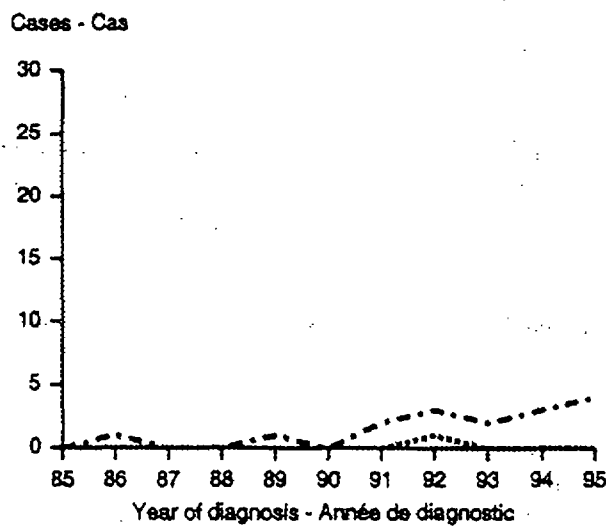
**Women - Femmes**



## **Finland**

Number of cases\*\* by year of diagnosis

**Women - Femmes**



..... IDU-UDI      - - - Heterosex.

\*13 years or over

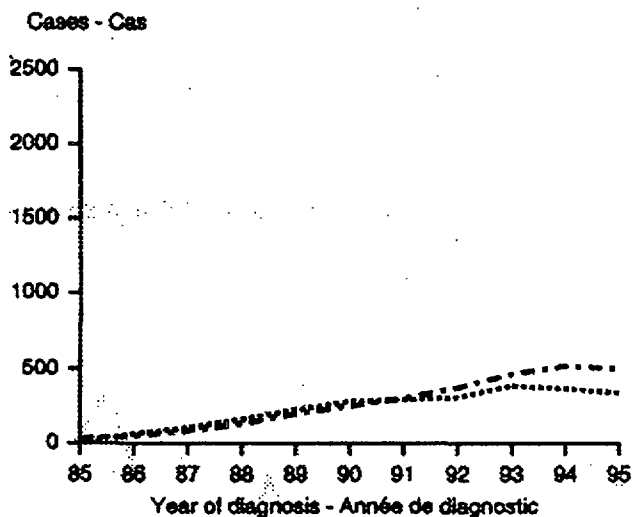
\*\*Adjusted for reporting delays (1993-1995)

# **Adult/Adolescent\* AIDS Cases in the Two Main Transmission Groups, 1985-1995**

## **France**

Number of cases\*\* by year of diagnosis

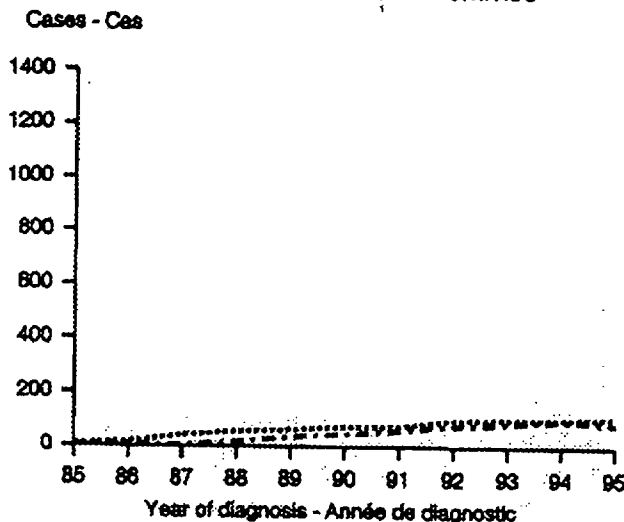
**Women - Femmes**



## **Germany**

Number of cases\*\* by year of diagnosis

**Women - Femmes**



..... IDU-UDI      - - - Heterosex.

\*13 years or over

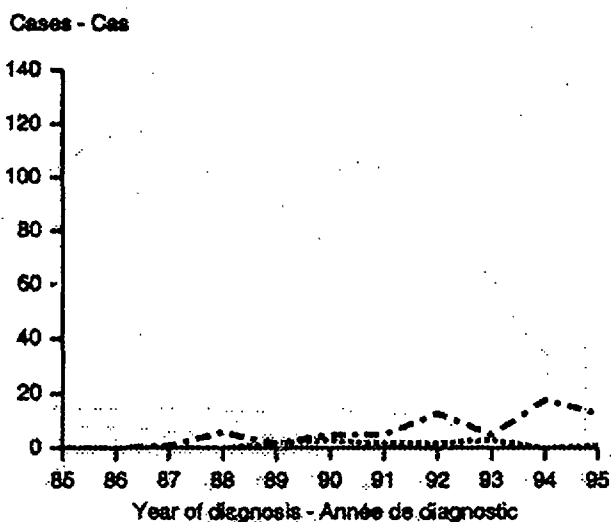
\*\*Adjusted for reporting delays (1993-1995)

# **Adult/Adolescent\* AIDS Cases in the Two Main Transmission Groups, 1985-1995**

## **Greece**

Number of cases\*\* by year of diagnosis

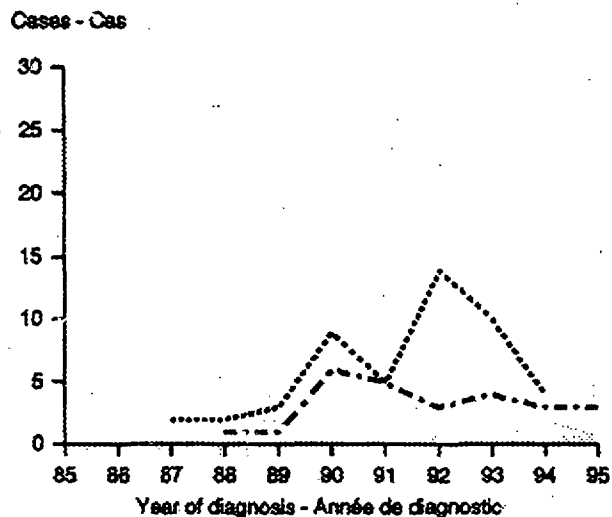
**Women - Femmes**



## **Ireland**

Number of cases\*\* by year of diagnosis

**Women - Femmes**



..... IDU-UDI      - - - Heterosex.

\*13 years or over

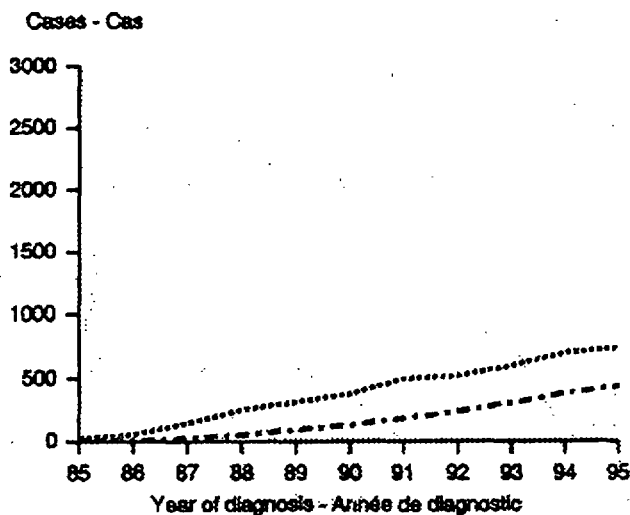
\*\*Adjusted for reporting delays (1993-1995)

## Adult/Adolescent\* AIDS Cases in the Two Main Transmission Groups, 1985-1995

### Italy

Number of cases\*\* by year of diagnosis

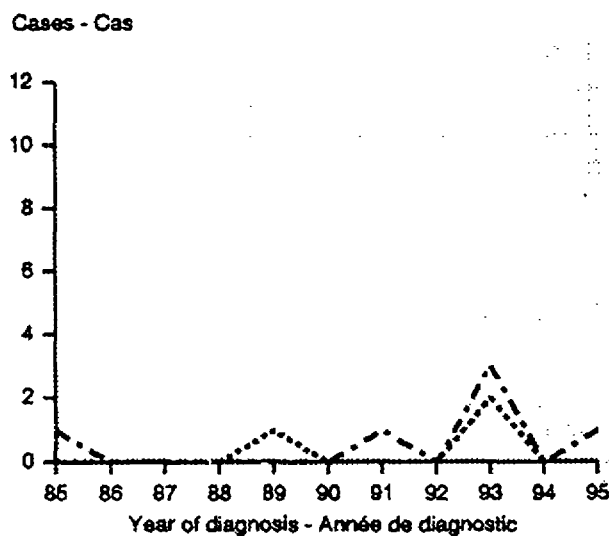
Women - Femmes



### Luxembourg

Number of cases\*\* by year of diagnosis

Women - Femmes



..... IDU-UDI	- - - Heterosex.
---------------	------------------

\*13 years or over

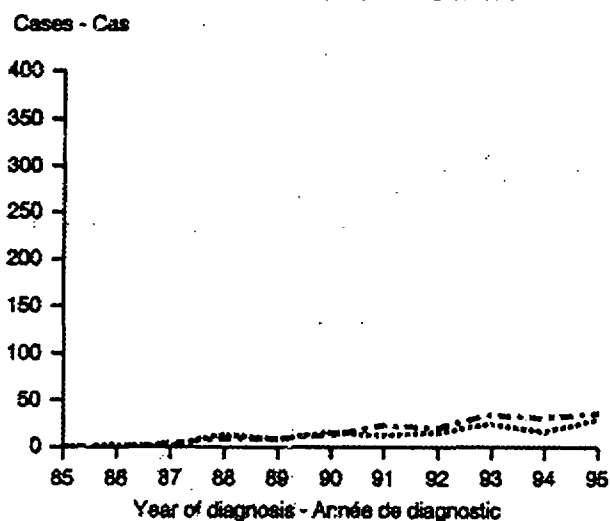
\*\*Adjusted for reporting delays (1993-1995)

# **Adult/Adolescent\* AIDS Cases in the Two Main Transmission Groups, 1985-1995**

## **Netherlands**

Number of cases\*\* by year of diagnosis

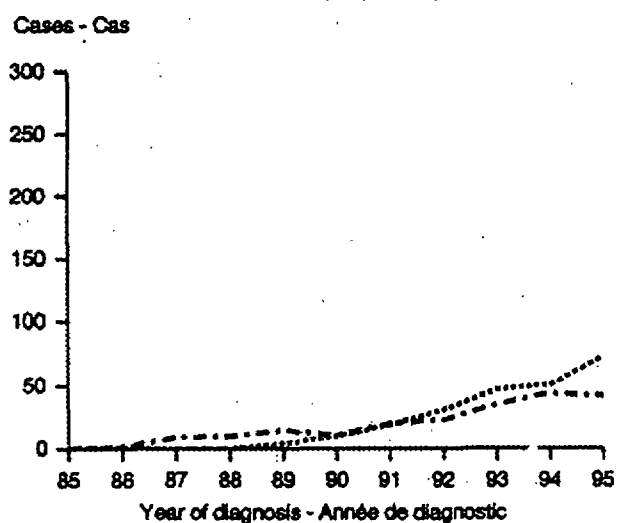
**Women - Femmes**



## **Portugal**

Number of cases\*\* by year of diagnosis

**Women - Femmes**



..... IDU-UDI	- - - Heterosex.
---------------	------------------

\*13 years or over

\*\*Adjusted for reporting delays (1993-1995)

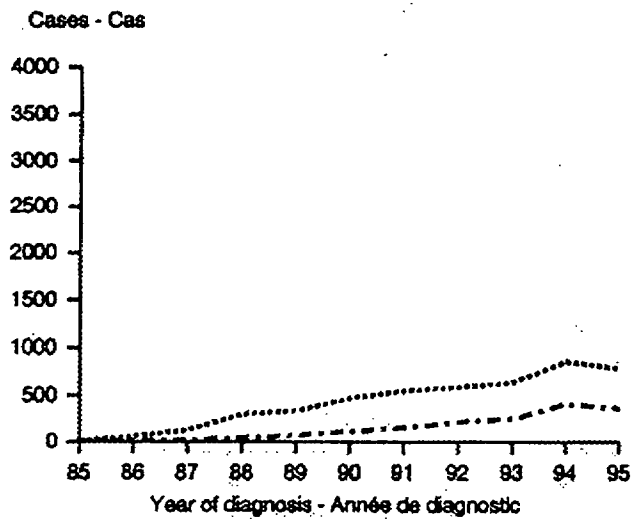


# **Adult/Adolescent\* AIDS Cases in the Two Main Transmission Groups, 1985-1995**

## **Spain**

Number of cases\*\* by year of diagnosis

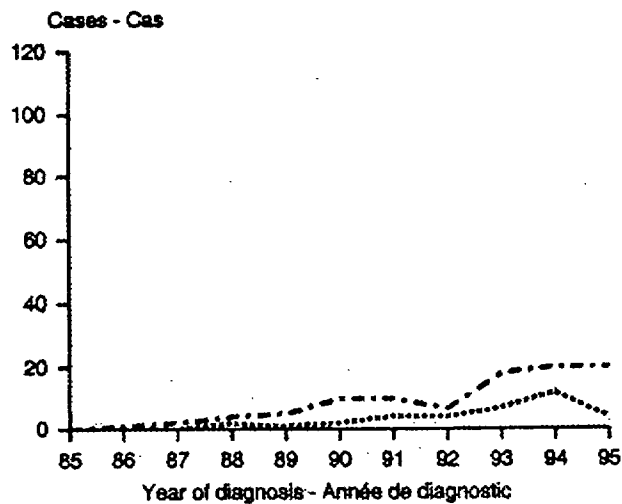
**Women - Femmes**



## **Sweden**

Number of cases\*\* by year of diagnosis

**Women - Femmes**



..... IDU-UDI	- - - Heterosex.
---------------	------------------

\*13 years or over

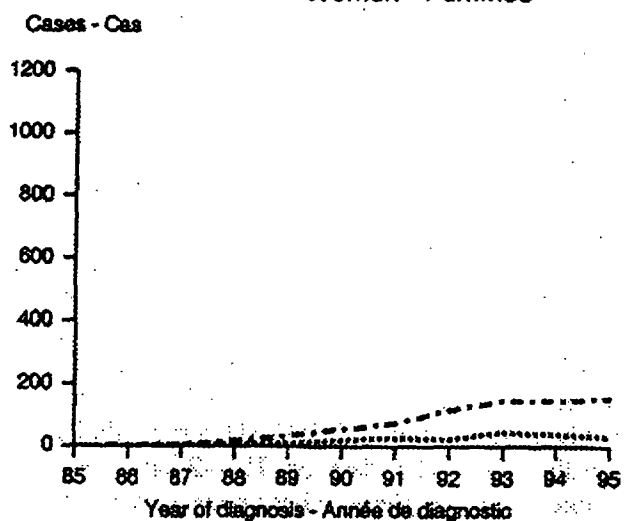
\*\*Adjusted for reporting delays (1993-1995)

# **Adult/Adolescent\* AIDS Cases in the Two Main Transmission Groups, 1985-1995**

## **United Kingdom**

Number of cases\*\* by year of diagnosis

**Women - Femmes**



..... IDU-UDI      - - - - Heterosex.

\*13 years or over

\*\*Adjusted for reporting delays (1993-1995)

**Table 7.4**  
**Cumulative Number of AIDS**  
**Cases for both Sexes\*, EU 15 (1996)**

Country	Cumulative Total* 30.9.1996
Austria	1 609
Belgium	2 203
Denmark	1 957
Finland	248
France	43 451
Germany	15 308
Greece	1 422
Ireland	549
Italy	35 949
Luxembourg	114
Netherlands	4 199
Portugal	3 575
Spain	41 598
Sweden	1 445
United Kingdom	13 394
<b>TOTAL EC</b>	<b>167 021</b>

\* Since the beginning of the epidemic until 30 September 1996, unadjusted for reporting delays.

Source : European Centre for the Epidemiological Monitoring of AIDS, Quarterly Report No. 36, 30 September 1996.

**Table 7.5**  
**Contraceptive Use and Fertility Rates among**  
**Women, EU 15**

Country	Women using contraception (%) 1986-93	Total fertility rate		% Live births to mothers under 20 latest available year	Fertility rate per 1000 women 15-19 years	
		1970	1993		1970	1990
Austria	71	2.30	1.50	5.76 (1992)	61.4	21.3
Belgium	79	2.20	1.70	3.69 (1986)	31.1	12.2
Denmark	78	1.90	1.70	2.73 (1988)	32.4	9.1
Finland	80	1.80	1.90	2.70 (1992)	32.2	12.1
France	81	2.50	1.70	2.40 (1991)	26.4	9.0
Germany	75	2.10	1.30	3.36 (1991)	n/a	n/a
Greece	n/a	2.30	1.40	5.82 (1992)	36.5	26.3
Ireland	n/a	3.90	2.10	4.35 (1987)	16.9	16.0
Italy	78	2.40	1.30	3.00 (1994)	42.8	10.0
Luxembourg	n/a	n/a	1.70	2.62 (1989)	28.0	11.6
Netherlands	76	2.60	1.60	1.87 (1992)	22.6	8.3
Portugal	66	2.80	1.60	10.35 (1985)	29.4	26.3
Spain	59	2.80	1.20	5.20 (1989)	14.1	16.7
Sweden	78	1.90	2.10	3.11 (1986)	34.0	12.7
United Kingdom	81	2.40	1.80	8.13 (1989)	49.7	33.0

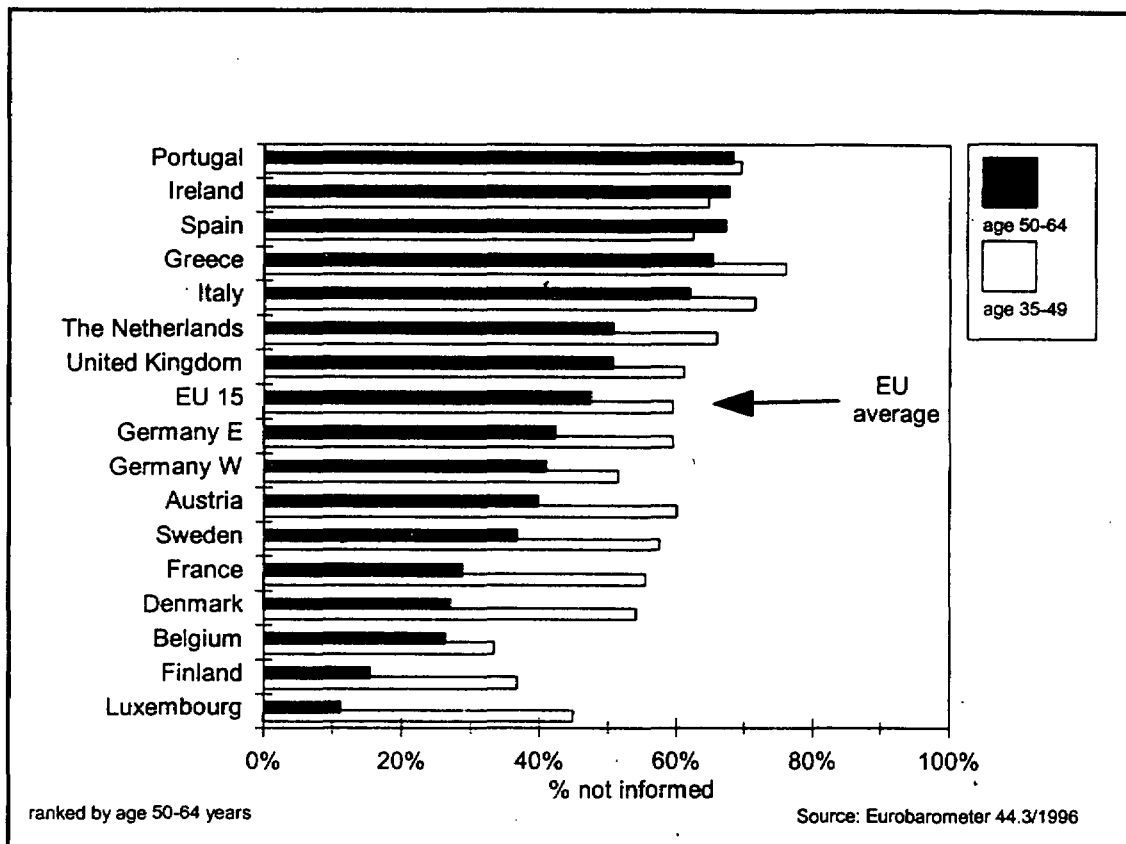
Source : Human Development Report 1995/HFA, 1996.

***Table 7.6***  
**Abortion, EU (15)**

Country	Abortion Legislation Year	Abortion Rate per 1000 women	Ratio of abortions to 1000 live births all ages	Ratio of abortions to 1000 live births under 20
Austria	1975	n/a	n/a	n/a
Belgium	1990	n/a	n/a	n/a
Denmark	-	14.3 (1993)	278.00 (1992)	1856.07 (1988)
Finland	1970	7.9 (1994)	157.34 (1993)	961.22 (1991)
France	1975	13.0 (1990)	254.00 (1990)	1058.00 (1990)
Germany	1992/1996	n/a	146.60 (1992)	n/a
Greece	1986	n/a	108.25 (1991)	86.47 (1992)
Ireland	Illegal	n/a	n/a	n/a
Italy	1978	8.6 (1994)	287.30 (1991)	n/a
Luxembourg	1979	n/a	99.00 (1992)	n/a
Netherlands	1984	6.0 (1994)	98.70 (1992)	558.50 (1988)
Portugal	1984	n/a	200.00 (1994)	n/a
Spain	1985	5.38 (1994)	92.70 (1990)	n/a
Sweden	1938	18.3 (1994)	290.00 (1993)	1701.40 (1993)
United Kingdom	1968	12.18 (1994)*	227.48 (1988)	663.52 (1988)

Source : Human Development Report 1995/HFA, 1996.

**Figure 7.5**  
**Percent Not Well Informed about HRT**  
**Women 35+ Years, EU 15 (1996)**



**Table 7.7**  
**Percent Not Well Informed about HRT**  
**Women 15+ Years, EU 15 (1996)**

	<35 years	35-49 years	50-64 years	65+ years	Total
Portugal	77.3	69.2	67.9	67.0	71.5
Ireland	69.8	64.4	67.4	74.7	68.5
Spain	72.7	62.2	67.0	71.0	68.7
Greece	76.7	75.8	65.2	81.0	74.6
Italy	89.7	71.2	61.6	69.0	75.2
The Netherlands	67.9	65.7	50.5	51.5	62.9
United Kingdom	70.1	60.8	50.5	62.7	62.8
EU 15	71.7	59.3	47.1	58.5	60.9
Germany E	64.5	59.2	42.1	65.9	57.5
Germany W	67.2	51.2	40.7	54.0	54.7
Austria	64.7	59.7	39.4	58.2	57.6
Sweden	77.0	57.3	36.5	46.1	57.4
France	66.0	55.3	28.6	45.5	51.4
Denmark	71.4	53.6	26.8	41.9	51.6
Belgium	55.8	33.1	26.0	32.3	39.9
Finland	54.6	36.4	15.2	32.8	36.7
Luxembourg	53.7	44.6	10.8	21.6	40.3

Source: Eurobarometer 44.3/1996

## 8. CONCLUSION

This report was prepared in order to provide an overview of issues related to women's health and women's health status. Its aim is to help clarify women's health issues using the most recent Community-wide data available to promote discussion. The report is not intended to form the basis for a new Community action programme on women's health, however, its findings will be incorporated into existing programmes where relevant. Although the available data are far from ideal, it has nonetheless still been possible to gather enough data to provide a picture of (some of) the many different dimensions of women's health. In particular, it is clear that women in the EC are quite healthy, both in terms of life expectancy, which currently equals 80 years, and in terms of self-perceived health status. On average, more than 60% of women in the EC report being in good or very good health.

This situation is the result of several decades of improvements in women's health, in part as a result of general improvements in living conditions throughout the EC, in part as a result of improvements in the status of women in society. Needless to say, the health of women varies across the Member States, in part because of different starting points, in part because of different rates of progress. What is clear is that some of the Member States with the poorest health status twenty years ago have achieved the greatest improvements, while other Member States with historically good levels of health have had more modest results.

In spite of the improvements seen, there is still cause for concern about women's health. Almost one out of every four women in the EC reports some degree of disability due to a long-term illness. Furthermore, a large number (and percentage) of women report unhealthy life styles (e.g., smoking, drinking, sedentary life styles, and unhealthy diets). Combined, these factors contribute to (much of) the disability, morbidity, and premature mortality among women in the EC.

The main causes of death for women are cardiovascular disease and cancer. Both of these diseases also result in significant amounts of premature mortality, which to a considerable extent may be prevented either through primary prevention, improved life styles, or secondary prevention (early detection of disease through, for example, screening). Unfortunately, there seems to be considerable misconception among women about the extent to which they are at risk for heart disease and what are the main risk factors for the disease.

Data on health promotion and disease prevention activities indicate large variations across the Member States in the extent to which women receive needed services. In particular, it is noteworthy that less than half of obese women over 40, who are at elevated risk for diabetes type II, have been screened in the previous year for a disease that is rapidly rising and that causes significant mortality and morbidity. It is also notable that most women, regardless of age feel insufficiently informed about the potential advantages and disadvantages of hormone-replacement therapy. These and other findings make it clear that there are a number of important health concerns for women which have yet to be addressed.

The final part of the report has attempted to highlight aspects of emerging health issues of importance to women at different stages of their life cycle. In particular, it is apparent that

HIV and AIDS are no longer health concerns specific to (homosexual) men. In fact, women are more vulnerable to contracting the disease than are men, even if they still represent a minority of AIDS victims. Efforts to prevent the spread of this disease should therefore also target women. Eating disorders among young women appears to be an increasing health problem with potentially serious consequences.

Among elderly women, one of the chief concerns is the rising incidence of osteoporosis which is due in part to the ageing of society, in part to insufficient attention to prevention and treatment opportunities.

In closing, it is important to emphasise that this report on women's health is not intended to imply that greater emphasis should be placed on women's health compared to men's health but rather, that for biological, social, and other reasons, their health concerns are *different* from those of men, and that deserves recognition. Women may live longer than men today, but they do so with significant illness and disability. Recognition of women's unique health problems is a first step towards improving their situation.

# **Annex I**

## **Glossary**

### **Anorexia nervosa:**

An eating and psychological disorder which affects mostly women. It involves extreme dieting, weight loss, and starvation, and is accompanied by a disturbed body image and loss of control and can lead to mortality<sup>1</sup>.

### **Bulimia nervosa:**

An eating and psychological disorder which affects mostly women. It involves consuming large quantities of food in a short period of time (bingeing), accompanied by a sense of lack of control and recurrent compensatory behaviour in order to prevent weight gain, e.g., by vomiting<sup>2</sup>.

### **Diseases of the circulatory system:**

These include acute myocardial infarctions and other ischaemic cardiopathies. Ischaemia is the localised stoppage of the blood supply<sup>3</sup>.

### **Incidence:**

the number of new cases of a disease recorded over a given period (usually a year)<sup>4</sup>.

### **Infant mortality rate:**

The yearly number of deaths of children aged less than one year per 1000 live births<sup>5</sup>.

### **Life expectancy:**

The mean number of years which a person of a given age can expected to live, assuming the current age-specific mortality rates remain constant. Life expectancy at 65 years for instance, indicates the mean number of years for which a person reaching the age of 65 can expect to live<sup>6</sup>.

### **Maternal mortality:**

Deaths related to childbirth; usually reported per 100,000.

### **Menopause:**

The cessation of monthly menstruation which signifies the end of a woman's fertile period. The average age at the menopause in the EC is 50-52 years.

### **Prevalence:**

The number of existing cases of a disease in a population at a give time or period<sup>7</sup>.



## **Reduction of life expectancy (in years) through death before age 65 years:**

The hypothetical increase in life expectancy if mortality in age-group 0-64 years were completely eliminated<sup>8</sup>.

## **Standardised death rate (SDR):**

The number of deaths per 100,000 adjusted to the age structure of a standard European population. Standardised death rates allow comparability between countries over time as they measure death rates independently of different age structures of populations. The death rates applied in this report are calculated by the WHO<sup>9</sup>.

## **Total fertility rate:**

The average number of children that would be born alive to a woman during her lifetime, if she were to bear children at each age in accordance with prevailing age-specific rates<sup>10</sup>.

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- 10 CEC (1995a), *Report from the Commission on the Status of Health in the European Community, 1995*, COM(95) 357 final, Brussels: CEC.

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# **ANNEX V**

## **Member State Coordinators**

**The Member State Coordinators prepared unpublished national reports on women's health which were used as input in the preparation of this report.**

### **Austria**

Ms. Andrea Birbaumer  
Technische Universität Wien  
Inst.f. Gestaltungs- und Wirkungsforschung  
Abteilung für CSCW  
Vienna

### **Belgium**

Mrs. Katrien Bruggeman  
Prof. Mieke van Haegendoren  
Nederlandstalige Nationale Vrouwenraad  
De Amazone  
Brussel

### **Denmark**

Dr. Birgit Petersson  
Department of Social Medicine  
Medical Female Research Unit  
University of Copenhagen  
Panum Institute  
Copenhagen

### **Finland**

Prof. Sirkka Sinkkonen  
Prof. Katri Vehviläinen-Julkunen  
Department for Health Policy and Management  
University of Kuopio  
Kuopio

### **France**

(Collaboration based on: Saurel-Cubizolles, M.J., Blondel, B. (1996), La Santé des Femmes. Paris: Flammarion Médecine-Sciences, see bibliographical reference, this publication is not initiated by the European Women's Health Project).

Dr. Beatrice Blondel  
INSERM  
Unité de Recherches Épidémiologiques sur la Santé des Femmes et des Enfants-U 149  
Villejuif Cedex  
France

## **Germany**

Dr. Caren Weilandt  
Ms. Adrienne Zeir  
Wissenschaftliches Institut der Ärzte Deutschlands (WIAD)  
**Bonn**

## **Greece**

Dr. George Kallinikos  
Prof. Anastasia Roumeliotou  
National School of Public Health  
**Athens**

## **Ireland**

Drs. H. Riper  
Mrs. H. Cowley  
University of Limerick  
Limerick

## **Italy**

Prof. Francesco Grigoletto  
Dr. Anna Chiara Frigo  
Universita' degli Studi di Padova  
Istituto di Igiene  
**Padova**

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Comissao Para a Igualdade e Para os Direitos das Mulheres  
(Commission for Equality and Women's Rights)  
Ministry of Employment and Social Security  
Porto

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Mrs. Carmen Sanchis  
Institute of Public Health of Valencia  
Generalitat Valenciana (Conselleria de Sanitat i Consum)  
Institut Valencia d'Estudis en Salut Publica (IVESP)  
Valencia

## **Sweden**

Ms. Mona Sundh  
Ms. Barbro Renck  
Centrum for Folkhalsoforskning  
Centre for Public Health Research  
Karlstad

## **United Kingdom**

Dr. Carol Thomas  
University of Lancaster  
Dept. of Applied Social Science  
Lancaster

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