

# Women and Health (C)

In the Beijing Declaration and Platform for Action (BPfA) 1995<sup>1</sup>, health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.

A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups. Women have different and unequal access to and use of basic health resources. Furthermore, women are subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction.

Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health.

Sexual and gender-based violence, including physical and psychological abuse, trafficking in women and girls and other forms of abuse and sexual exploitation place girls and women at high risk of physical and mental trauma, disease and unwanted pregnancy. HIV/AIDS and other sexually transmitted diseases, the transmission of which is sometimes a consequence of sexual violence, are having a devastating effect on women's health,

particularly the health of adolescent girls and young women.

With the increase in life expectancy and the growing number of older women, their health concerns require particular attention.

Statistical data on health are often not systematically collected, disaggregated and analysed by age, sex and socio-economic status and by established demographic criteria used to serve the interests and solve the problems of subgroups, with particular emphasis on the vulnerable and marginalised and other relevant variables. Relatively little is known about how social and economic factors affect the health of girls and women of all ages, about the provision of health services to girls and women and the patterns of their use of such services, and about the value of disease prevention and health promotion programmes for women.

In order to address these problems, the following strategic objectives were set and agreed to be implemented by the national governments.

## The strategic objectives

- C.1 Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services
- C.2 Strengthen preventive programmes that promote women's health
- C.3 Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues
- C.4 Promote research and disseminate information on women's health
- C.5 Increase resources and monitor follow-up for women's health



## Indicators

In 2006, the Austrian Presidency undertook to focus on indicators for measuring progress on women's health since gender-based data are the prerequisite for gender-related health policies and prepared a report<sup>2</sup> to propose indicators concerning women's health.

In developing the indicators for women's health, the Austrian Presidency considered the communication from the Commission 'A Roadmap for equality between women and men, 2006–2010'<sup>3</sup> which established that 'Women and men are confronted with specific health risks, diseases, issues and practices impacting their health. Medical research and many safety and health standards relate more to men and male-dominated work areas. Knowledge in this field should be improved and statistics and indicators further developed. Social, health and care services should be modernised with a view to improving their accessibility, quality and responsiveness to the new and specific needs of women and men.'

The number of indicators was restricted to three. The indicators on women's health proposed by the Austrian Presidency and outlined in the adopted conclusions<sup>4</sup> by the Council of the European Union in 2006 are: healthy life years; access to healthcare; and cardiovascular diseases.

### Indicator C1

**Name:** Healthy Life Years

**Concept:** This indicator, the Healthy Life Years (also called disability-free life expectancy) measures the number of remaining years that a person of a certain age is still expected to live without disability. Healthy Life Years (HLY) is a solid indicator to monitor health as a productivity/economic factor.

HLY introduces the concept of quality of life into life expectancy. It is used to distinguish between

years of life free of any activity limitation and years experienced with at least one activity limitation. The emphasis is not exclusively on the length of life, as is the case for life expectancy, but also on the quality of life. HLY is a functional health status measurement increasingly used to complement the conventional life expectancy measures. Chronic disease, frailty, and disability tend to become more prevalent at older ages, so that a population with a higher life expectancy may not be healthier.

Indeed, a major question within an ageing population is whether increases in life expectancy will be associated with a greater or lesser proportion of the future population spending their years living with disability. If HLY is increasing more rapidly than life expectancy in a population, then not only people are living longer, they are also living a greater portion of their lives free of disability.

The two components of the calculation of the HLY in the EU are the mortality tables and the self-perceived disability assessed by health surveys. Life tables which give mortality data for calculating life expectancy are fully available as a demographic long-term series based on the standard procedures of causes of death registration harmonised at EU level.

To provide an overview of the situation, the following two HLY indicators were used in the report by the Austrian Presidency:

- healthy life years in absolute value at birth
- percentage of life expectancy

**Data source:** The calculation of the indicator is based on two data sources<sup>5</sup>: Eurostat demographic data on mortality and the European Union Statistics on Income and Living Conditions (EU-SILC). The self-perceived disability is based on the EU-SILC survey, where an 'unhealthy' condition is defined by the limitation in the activities people usually do because of health problems at least for the last six months and this assessment is based on the question: 'For at least the past six

months, to what extent have you been limited because of a health problem in activities people usually do? Would you say you have been: strongly limited/limited/not limited at all?'

**Published:** Data are available in the Eurostat online database (hlth\_hlye: 'Structural indicators on health'<sup>6</sup>).

**Notes:** The data cover all EU Member States: the oldest data are available from 1995 and for all Member States since 2005. The data are updated annually.

The HLY indicator is calculated using the same method<sup>7</sup> (Sullivan's) for all countries. However, the comparability of the data across countries may be limited since the question on the existence of disabilities can be interpreted differently between countries. Moreover, breaks in series, caused by the change in the data source for calculating the prevalence of disability in 2004, limits comparability. From 1995 to 2001, the EU-ECHP (European Community Household Panel) results were used and since 2004 the EU-SILC (Statistics on Income and Living Conditions) results have been used. The way this question was implemented by the Member States, however, hampers cross-country comparisons for the data up to 2008. Therefore, before 2008, the results should be used with caution and only the evolution in time for each country should be considered.

The overall accuracy of HLY is considered good. However, the fact that institutional households are not covered by the EU-SILC raises a potential problem of representativeness especially because these persons are particularly exposed to health problems.

## Indicator C2

**Name:** Access to health care (unmet demand)

**Concept:** The access to healthcare indicator measures the share of women and men in the

total population aged 16 and over who needed medical examination or treatment during the last 12 months but did not receive it, and the reasons for this unmet need. Social protection systems must ensure that people who need medical or social care can get it regardless of their income or wealth and that the cost of such care does not cause poverty to the care recipients or their relatives.

Access to healthcare implies that ability to pay is not a precondition to receiving care and that the need for care does not lead to impoverishment. Consistent increases in expenditure, coupled with increasing population coverage over the years, have allowed Member States to generally ensure all residents have access to basic healthcare as well as ensuring that the need for healthcare is not a major cause of poverty and financial dependence of patients and their relatives. Despite that, there remain important access inequities to address.

Access barriers include lack of coverage of certain types of care, high individual financial costs of care, geographical disparities of supply, waiting times and lack of information. Limiting access can save costs but if too high can result in belated and more costly treatment. Moreover, countries identify different experiences of care use across socio-economic groups (e.g. richer households make more use of preventive and specialist care than poorer households who make more use of emergency hospital care).

During the preparation of the Austrian Presidency report in 2006, data were not available.

**Data source:** The calculation of the indicator is based on the European Union Statistics on Income and Living Conditions (EU-SILC) survey health module<sup>8</sup>. The questions on unmet needs of healthcare refer to the situation during the 12 months preceding the survey and are based on the respondent's own assessment of whether he or she needed a medical



examination or treatment, but did not have one and main reason for not having a medical examination or treatment, while needed.

The main reasons are the following:

1. Could not afford to (too expensive);
2. Waiting list;
3. Could not take time because of work, care for children or for others;
4. Too far to travel/no means of transportation;
5. Fear of doctor/hospitals/examination/treatment;
6. Wanted to wait and see if problem got better on its own;
7. Did not know any good doctor;
8. Other reasons.

**Published:** Data are available in the Eurostat online database (hlth\_silc\_08: 'People with unmet needs for medical examination by sex, age, reason and income quintile (%)').

**Notes:** The data cover all EU Member States: the oldest data are available from 2004 and for all Member States since 2007. The data are updated annually.

The indicator relies on self-assessment of the need for care and, therefore, has a subjective dimension. Until 2008, the implementation of health questions in EU-SILC was not fully harmonised and, thus, the comparability of the results is limited. New guidelines should improve comparability between countries from 2008.

### Indicator C3

**Name:** Cardio-vascular diseases

**Concept:** Cardiovascular diseases indicator measures the share of deaths of women and men caused by cardiovascular diseases (CVD) (coronary heart disease (CHD), stroke, and other CVD). According to the Austrian Presidency report, diseases of the heart and circulatory system

(cardiovascular disease or CVD) are the main cause of death in the European Union and the main forms of CVD are coronary heart disease (CHD) and stroke. Furthermore, the CVD is the main cause of death for women.

The incidence of coronary heart disease in women increases dramatically in middle age, which has led to the speculation that menopause marks the end of a protective effect of ovarian hormones on cardiovascular disease. CHD results in many premature deaths and since clinical care in CVDs is costly and prolonged, it is also a major economic burden in Europe.

Factors that have been identified as contributors to coronary heart disease for women include cholesterol, smoking, high blood pressure, obesity, physical inactivity, hormonal changes and diabetes mellitus. To these classical risk factors we can add others if we incorporate the gender perspective to analyse the risk factors, such as socio-economic condition, links with health services, subjective construction of the illness, insertion to the labour market or interconnection among the different areas of work, personal interests and family life.

**Data source:** The calculation of this indicator is based on the Causes of death data<sup>10</sup> coordinated by Eurostat. Causes of death are classified by the 65 causes on the 'European shortlist'<sup>11</sup> of causes of death. This shortlist is based on the International Statistical Classification of Diseases and Related Health Problems (ICD)<sup>12</sup>. According to the Austrian Presidency report, the causes of death because of cardiovascular diseases should be defined as the following:

- coronary heart disease (CHD): ischaemic heart diseases according to European shortlist (indicator I20–I25 in the table);
- stroke: cerebrovascular diseases according to European shortlist (indicator I60–I69 in the table);

- other CVD such as rheumatic fever and rheumatic heart disease, diseases of the circulatory system, ischemic heart diseases, arterial hypertension: diseases of the circulatory system (indicator I in the table) minus CHD and stroke (indicator I20–I25 and indicator I60–I69 in the table).

**Published:** Data are available in the Eurostat online database ('hlth\_cd\_anr: Causes of death — Absolute number (Annual data)'<sup>13</sup>).

**Notes:** The data cover all EU Member States: the oldest data are available from 1994 (but not for all Member States). The data are updated annually.

Inaccuracies may be due to errors with the issue of the death certificate, errors in the medical diagnosis, in the selection of the main cause of death or in the coding of the cause of death. Sometimes there is ambiguity in the cause of death. Indeed, there is criticism that the coding of only one illness as a cause of death appears more and more unrealistic. For the majority of the deceased of 65 years and older, the selection of just one cause of death may be somewhat misleading as they often have had several chronic diseases that concurrently led to death. For this reason, some Member States have started to consider multiple-cause coding.

Although definitions are harmonised, the statistics may not be fully comparable as classifications may vary when the cause of death is multiple or difficult to evaluate and because of different notification procedures. The coverage of residents dying abroad can also affect the comparability among countries (national practices concerning the registration of residents dying abroad and domestic deaths of non-residents are far from harmonised across Member States).

## More information

### Policy documents

Beijing Declaration and Platform for Action 1995 (<http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf>).

Council of the European Union, Draft Council conclusions 'Review of the implementation by Member States and the EU institutions of the Beijing Platform for Action — Beijing + 15: A review of progress', Brussels, 10 November 2009 (<http://register.consilium.europa.eu/pdf/en/09/st15/st15487-ad01.en09.pdf>).

Council of the European Union, Draft Council conclusions on the review of the implementation by the Member States and the EU institutions of the Beijing Platform for Action, Brussels, 18 May 2006 (<http://register.consilium.europa.eu/pdf/en/06/st09/st09468.en06.pdf>).

Council of the European Union, Review of the implementation by the Member States and the EU institutions of the Beijing Platform for Action, Report by the Austrian Presidency — Indicators concerning women's health, Brussels, 18 May 2006 (<http://register.consilium.europa.eu/pdf/en/06/st09/st09468-ad01.en06.pdf>).

Council of the European Union, Press release, 2733rd Council meeting, Luxembourg, 1 and 2 June 2006 ([http://www.consilium.europa.eu/uedocs/cms\\_data/docs/pressdata/en/lisa/89830.pdf](http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lisa/89830.pdf)).

The European Commission's Strategy for equality between women and men 2010–2015 (COM(2010) 491 final of 21 September 2010) (<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52010DC0491:EN:PDF>).

European Commission, Communication from the Commission 'Europe 2020 — A strategy for smart, sustainable and inclusive growth', Brussels, 3 March 2010 (<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:2020:FIN:EN:PDF>).

European Commission, Communication from the Commission 'A Strengthened Commitment to



Equality between Women and Men — A Women's Charter', Brussels, 5 March 2010 (<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0078:FIN:EN:PDF>).

## Reports

Eurostat, The Social Situation in the European Union 2009, European Commission. Directorate-General for Employment, Social Affairs and Equal Opportunities — Unit E.1., Eurostat — Unit F.4. © European Union, 2010 ([http://epp.eurostat.ec.europa.eu/cache/ITY\\_OFFPUB/KE-AG-10-001/EN/KE-AG-10-001-EN.PDF](http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KE-AG-10-001/EN/KE-AG-10-001-EN.PDF)).

Eurostat Statistical books, Measuring progress towards a more sustainable Europe — 2007 monitoring report of the EU sustainable development strategy, © European Communities, 2007 ([http://ec.europa.eu/sustainable/docs/estat\\_2007\\_sds\\_en.pdf](http://ec.europa.eu/sustainable/docs/estat_2007_sds_en.pdf)).

OECD (2010), Health at a Glance — Europe 2010, OECD Publishing ([http://ec.europa.eu/health/reports/docs/health\\_glance\\_en.pdf](http://ec.europa.eu/health/reports/docs/health_glance_en.pdf)).

Baert, K., de Norre, B., 'Perception of health and access to health care in the EU-25 in 2007', Eurostat, Statistics in Focus, 24/2009 (<http://epp.eurostat>

[ec.europa.eu/cache/ITY\\_OFFPUB/KS-SF-09-024/EN/KS-SF-09-024-EN.PDF](http://ec.europa.eu/cache/ITY_OFFPUB/KS-SF-09-024/EN/KS-SF-09-024-EN.PDF)).

Faculty of Medicine Carl Gustav Carus Research Association, Public Health Saxony and Saxony-Anhalt, Data and information on women's health in the European Union, Directorate-General for Health & Consumers, Technische Universität Dresden, Dresden, Germany, © European Communities, 2009 ([http://ec.europa.eu/health/population\\_groups/docs/women\\_report\\_en.pdf](http://ec.europa.eu/health/population_groups/docs/women_report_en.pdf)).

Eurostat Statistical books, Health statistics — Atlas on mortality in the European Union, © European Communities, 2009 ([http://epp.eurostat.ec.europa.eu/cache/ITY\\_OFFPUB/KS-30-08-357/EN/KS-30-08-357-EN.PDF](http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-30-08-357/EN/KS-30-08-357-EN.PDF)).

The State of Men's Health in Europe 2011, European Commission, Directorate-General for Health & Consumers ([http://ec.europa.eu/health/population\\_groups/docs/men\\_health\\_extended\\_en.pdf](http://ec.europa.eu/health/population_groups/docs/men_health_extended_en.pdf)).

Engender, Improving gender equality in health (<http://engender.eurohealth.ie>).

Access to healthcare and long-term care — Equal for Women and Men?, European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities (<http://ec.europa.eu/social/BlobServlet?docId=5590&langId=en>).

## Notes

1. Beijing Declaration and Platform for Action 1995, p. 34 (<http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf>).
2. The report prepared by Austrian EU Presidency is available online (<http://register.consilium.europa.eu/pdf/en/06/st09/st09468-ad01.en06.pdf>).
3. Communication from the Commission 'A Roadmap for equality between women and men 2006–2010' (COM (2006) 92 final) (<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2006:0092:FIN:EN:PDF>).
4. Council of the European Union, Press release, 2733rd Council Meeting, Luxembourg, 1 and 2 June 2006 ([http://www.consilium.europa.eu/uedocs/cms\\_data/docs/pressdata/en/lsa/89830.pdf](http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/89830.pdf)).
5. Structural indicators on health, Eurostat metadata ([http://epp.eurostat.ec.europa.eu/cache/ITY\\_SDDS/EN/hlth\\_hlye\\_esms.htm](http://epp.eurostat.ec.europa.eu/cache/ITY_SDDS/EN/hlth_hlye_esms.htm)).
6. Table 'hlth\_hlye: Structural indicators on health' is available online ([http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth\\_hlye&lang=en](http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_hlye&lang=en)).
7. Healthy Life Years Expectancy disability-free life expectancy — DFLE Method ([http://epp.eurostat.ec.europa.eu/cache/ITY\\_SDDS/Annexes/hlth\\_hlye\\_esms\\_an1.pdf](http://epp.eurostat.ec.europa.eu/cache/ITY_SDDS/Annexes/hlth_hlye_esms_an1.pdf)).
8. SILC variables on healthcare ([http://epp.eurostat.ec.europa.eu/cache/ITY\\_SDDS/Annexes/hlth\\_care\\_silc\\_esms\\_an1.pdf](http://epp.eurostat.ec.europa.eu/cache/ITY_SDDS/Annexes/hlth_care_silc_esms_an1.pdf)).
9. Table 'hlth\_silc\_08: People with unmet needs for medical examination by sex, age, reason

and income quintile (%)’ is available online ([http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth\\_silc\\_08&lang=en](http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_silc_08&lang=en)).

10. Causes of death, Eurostat metadata ([http://epp.eurostat.ec.europa.eu/cache/ITY\\_SDDS/EN/hlth\\_cdeath\\_esms.htm](http://epp.eurostat.ec.europa.eu/cache/ITY_SDDS/EN/hlth_cdeath_esms.htm)).
11. Metadata, European Shortlist for Causes of Death, 1998 ([http://ec.europa.eu/eurostat/ramon/nomenclatures/index](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST_NOM_DTL&StrNom=COD_1998&StrLanguageCode=EN&IntPcKey=&StrLayoutCode=HIERARCHIC)

[c](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST_NOM_DTL&StrNom=COD_1998&StrLanguageCode=EN&IntPcKey=&StrLayoutCode=HIERARCHIC)

12. International Classification of Diseases (ICD) (<http://www.who.int/classifications/icd/en/>).
13. Table ‘hlth\_cd\_anr: Causes of death — Absolute number (Annual data)’ is available online ([http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth\\_cd\\_anr&lang=en](http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_cd_anr&lang=en)).

