

Health and Ageing: a Comparative Assessment of the Situation of Men and Women in France and Europe

Muriel Moisy

With a female life expectancy of 85.3 years in 2016, France has one of the highest female life expectancies in Europe. The picture is somewhat different for men, with a six-year gap between the life expectancies at birth of men and women (79.3 years) in France, where the male disadvantage is greater than in other European countries. Twenty years earlier, the same indicator was 82.3 years for women and 74.2 years for men, representing an even greater gap between women and men. The persistent male disadvantage raises questions about the leading causes of premature male death, namely cancer, cardiovascular disease and accidents. These causes of death need to be examined in the light of risk behaviours and factors such as tobacco and alcohol consumption and, to a lesser extent in the case of France, the prevalence of overweight and obesity. The fact that people are living longer implies examining the development of the health status of people aged over 65, with ageing representing a cause of moderate or severe disability. In France in 2016, a 65-year-old woman could expect to live, on average, for 10.5 years without disability and for 12.8 years with mild to severe functional limitations, compared to 9.4 years and 9.9 years for men, respectively. France ranks in the middle of European countries. Having long been associated solely with women, the challenge of ageing with disabilities now also affects men.

In France in 2016, female life expectancy at birth was 85.3 years, while male life expectancy at birth was 79.3 years¹. According to the latest data published by Eurostat for 2016, life expectancy in Europe was 83.6 years for women and 78.2 years for men, with relatively significant country variations, particularly among men, ranging from 69.5 years in Lithuania to 81.0 years in Italy, representing a difference of nearly twelve years. However, the most striking finding relates to gender inequalities, primarily in France, where the gap between male and female life expectancies stands at six years. This is higher than the European average (5.4 years), but significantly lower than the gaps recorded in the Baltic states (10.7 years in Lithuania, 9.8 years in Latvia and 8.9 years in Estonia). On average, the life expectancy gaps between men and women are narrower (less than 5 years) in countries where life expectancy is high (United Kingdom, Denmark, Italy, Ireland, the Netherlands) and, conversely, wider in countries with a life expectancy at birth lower than the European average (Baltic states, Bulgaria, Poland, Hungary) (Figure 1). In this overview, France stands as something of an exception, combining life expectancies and gender gaps that are both higher than the European average.

Over the last twenty years, the trend has been towards longer life expectancy in all European countries, for both women and men, although life expectancy gains have been greater for men. For example, between 1996 and 2016, male life expectancy at birth increased by 9.1 years in Estonia, 7.1 years in Slovenia and 6.8 years in Ireland. Over the same period and in the

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1. According to the latest population estimates for 2017, life expectancy at birth in France is 85.3 years for women and 79.5 years for men, remaining stable for women but on the increase for men [Moisy, 2018].

1. Life Expectancy at Birth by Sex in 1996 and 2016

in years

	1996			2016		
	Women	Men	Differences W/M	Women	Men	Differences W/M
Austria	80.2	73.7	6.5	84.1	79.3	4.8
Belgium	80.7	73.9	6.8	84.0	79.0	5.0
Bulgaria	74.5	67.4	7.1	78.5	71.3	7.2
Croatia ¹	...	...	...	81.3	75.0	6.3
Cyprus	80.0	75.3	4.7	84.9	80.5	4.4
Czech Rep	77.5	70.4	7.1	82.1	76.1	6.0
Denmark	78.3	73.1	5.2	82.8	79.0	3.8
Estonia	75.6	64.2	11.4	82.2	73.3	8.9
United Kingdom	79.5	74.3	5.2	83.0	79.4	3.6
Finland	80.7	73.1	7.6	84.4	78.6	5.8
France	82.3	74.2	8.1	85.3	79.3	6.0
Germany	80.1	73.6	6.5	83.5	78.6	4.9
Greece	80.6	75.3	5.3	84.0	78.9	5.1
Hungary	75.0	66.3	8.7	79.7	72.6	7.1
Ireland	78.7	73.1	5.6	83.6	79.9	3.7
Italy	81.8	75.4	6.4	85.6	81.0	4.6
Latvia	...	...	...	79.6	69.8	9.8
Lithuania	75.9	64.6	11.3	80.1	69.5	10.7
Luxembourg	80.2	73.3	6.9	85.4	80.1	5.2
Malta	79.8	75.0	4.8	84.4	80.6	3.8
Netherlands	80.5	74.7	5.8	83.2	80.0	3.2
Poland	76.6	68.1	8.5	82.0	73.9	8.1
Portugal	79.0	71.6	7.4	84.3	78.1	6.2
Romania	72.8	65.1	7.7	79.1	71.7	7.4
Slovakia	77.0	68.8	8.2	80.7	73.8	6.9
Slovenia	79.0	71.1	7.9	84.3	78.2	6.1
Spain	82.0	74.5	7.5	86.3	80.5	5.8
Sweden	81.7	76.6	5.1	84.1	80.6	3.5
EU28	...	...	...	83.6	78.2	5.4

1. Data for Croatia in 2016 extracted in March 2019.

Sources: Eurostat, civil registration and vital statistics, data extracted in October 2018.

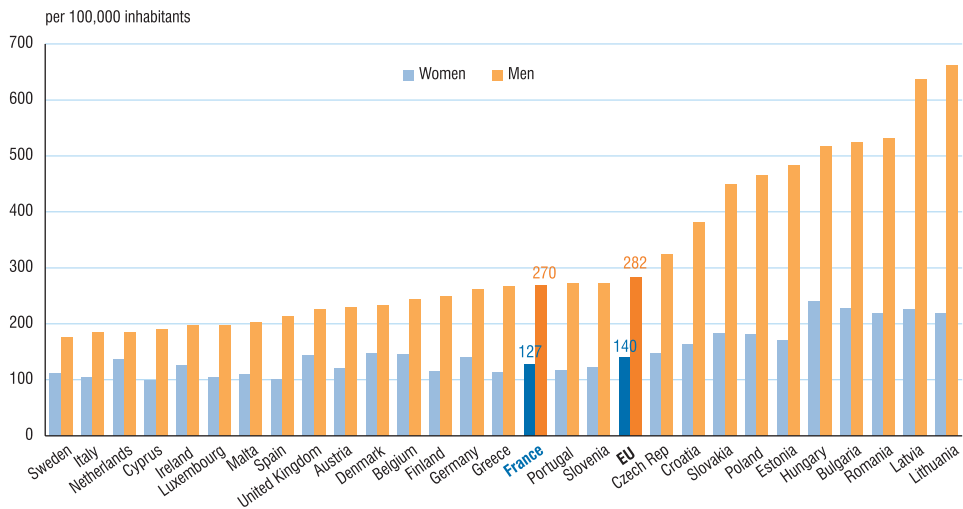
same three countries, the gains in female life expectancy totalled 6.6 years, 5.3 years and 4.9 years respectively. There has also been considerable progress in France, with male life expectancy increasing from 74.2 years in 1996 to 79.3 years in 2016 (+5.1 years) and female life expectancy increasing from 82.3 years to 85.3 years (+3.0 years). A directly related trend is that the gaps between women and men are narrowing across Europe, except in Bulgaria where they have remained stable. Despite this decrease, the male disadvantage remains a salient feature of the end of life.

France's Premature Mortality Rate Ranks among the Highest among Western European countries.

To better understand the male disadvantage, we need to examine premature mortality, i.e. deaths before the age of 65. In France in 2015, the **standardised premature death rate** was 127.0 per 100,000 for women and 27.0 per 100,000 for men (*Figure 2*). While

premature mortality among women is below the European average but comparable to that of countries with similar socioeconomic characteristics², the male rate, which is also slightly below the European average, is higher than in any of these countries. However, between 1990 and 2015, premature mortality trends were more favourable to men, with the rate dropping by nearly 40%, compared to 28% for women. In starting from a high level, they benefited from a higher margin of progress. Indeed, the greater decline in premature male mortality is not unique to France, but is observed in most European countries.

2. Standardised Premature Death Rates by Sex in 2015



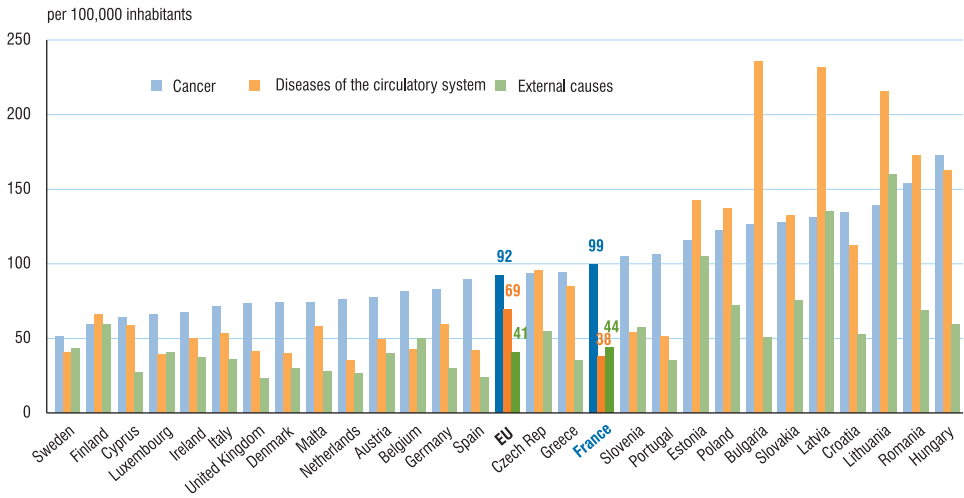
Sources: Eurostat, data extracted in October 2018.

Cancer and Cardiovascular Diseases are the Two Leading Causes of Premature Death among Men in Europe

In 2015, the leading causes of death among European men aged under 65 were cancer followed by diseases of the circulatory system (ischemic heart disease, other heart diseases, cerebro vascular disease) and external causes of death (accidents, suicides, falls, etc.) (Figure 3). This finding applies to most countries across Europe, with some exceptions. For example, in France, while cancer is the leading cause of death among men aged under 65, with cancer of the larynx, the bronchi and the lungs accounting for a third of all cancer deaths, premature mortality from circulatory diseases and, in particular, ischemic heart disease is low compared to other European countries. These diseases represent only the third leading cause of death behind external causes such as accidents and suicides. Other exceptions include the Baltic and Eastern European countries, where male deaths due to circulatory diseases play a leading

2. For the purposes of this dossier, countries with similar socioeconomic characteristics to France include the following: Austria, Belgium, Denmark, Finland, Germany, Italy, the Netherlands, Spain, Sweden and the United Kingdom.

3. Standardised Premature Male Death Rates by Leading Causes in 2015



Sources: Eurostat, data extracted in October 2018.

role. In six countries (Estonia, Poland, Bulgaria, Romania, Latvia and Lithuania), these diseases significantly outweigh cancer deaths, with particularly high rates of up to 236 per 100,000 in Bulgaria.

The Proportion of Cancer Deaths among Men before 65 is Particularly High in France

France is characterised by a particularly high standardised premature death rate due to cancer among men, close to 100 per 100,000 in 2015, which is significantly higher than the female rate (63.0 per 100,000), placing it in an unfavourable position compared to other European countries with similar socioeconomic characteristics (Figure 3). In Northern European countries, rates are generally lower, ranging between 50 and 80 per 100,000, while rates in the Baltic states and most Eastern European countries are high, between 110 and 170 per 100,000.

Between 2002 and 2015, premature cancer mortality in France decreased, with a more significant decline among men (-25%) than among women (-8%). In a third of cases, this concerns tracheal, bronchial and lung cancer. The standardised death rate for these types of cancer has decreased significantly among men, from 40.2 per 100,000 in 2002 to 31.9 per 100,000 in 2015, while the rate has increased among women, from 8.2 per 100,000 to 13.4 per 100,000. Despite the decrease among men, France's standardised death rate is significantly higher than in Western and Northern European countries on account of public tobacco control policies introduced at an earlier stage. For example, in Sweden, the death rate from tracheal, bronchial and lung cancer is just 7.6 per 100,000 and was already below 20 per 100,000 in the mid-1990s. After declining dramatically in the 1990s and 2000s, the

rate in the United Kingdom now stands at 15.3 per 100,000. In Italy, but also in Germany, the Netherlands and Finland, the rates are below 23 per 100,000 and are continuing to follow a downward trend across the board.

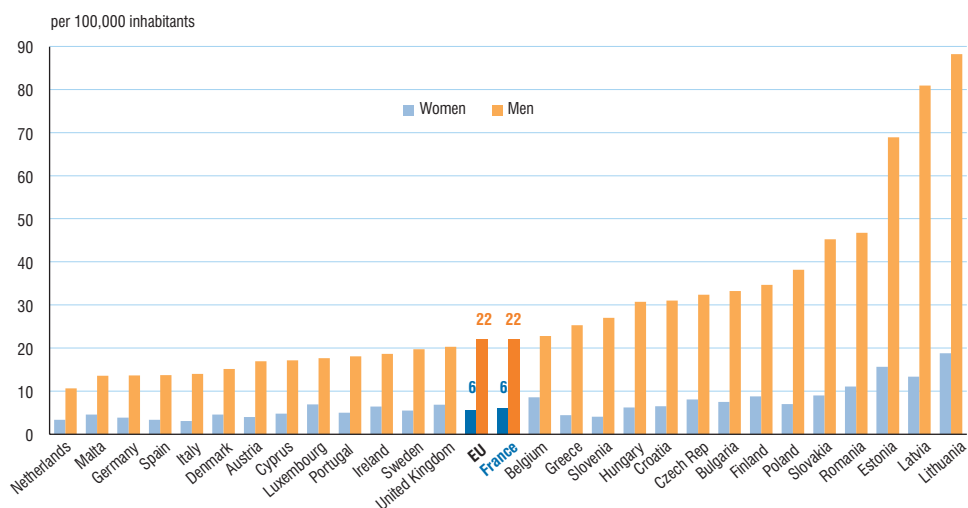
The second most common type of cancer in men is cancer of the lip, oral cavity and pharynx. The mortality rate in France was 5.6 per 100,000 in 2015, a rate close to that observed in Europe. The ratio of men to women is 3:1. Again, the main risk factors are tobacco and alcohol. As with lung cancer, albeit to a lesser extent, premature mortality among men for these types of cancer is on the decline in France (having stood at 8.7 per 100,000 in 2002), while the same rate among women has remained stable.

Accidents and Suicides: More Common Causes of Premature Death among Men in France than Across Europe on Average

External causes are the second leading cause of death among men before 65, with accidents and suicides accounting for the majority of such deaths. In 2015, one in six premature deaths among men was linked to violent death, compared to one in ten premature deaths among women. With a standardised rate of 44 per 100,000 for men, this is another specificity of France compared to neighbouring countries, where these rates are lower.

Among external causes, accidents account for more than half of male premature deaths, or 22 per 100,000, in line with the European average (Figure 4). There are significant differences between countries in Western and Southern Europe (Netherlands, Germany, Spain, Italy), where standardised rates are very low, and the Baltic states, where they are particularly high. In France, traffic accidents account for more than a third of accidental deaths among men aged under 65. The death rate from traffic accidents has been decreasing since 2000 for both men and women. This trend is observed in a majority of European countries, except in Eastern Europe where male premature mortality rates

4. Standardised Premature Death Rates by Accident and by Sex in 2015

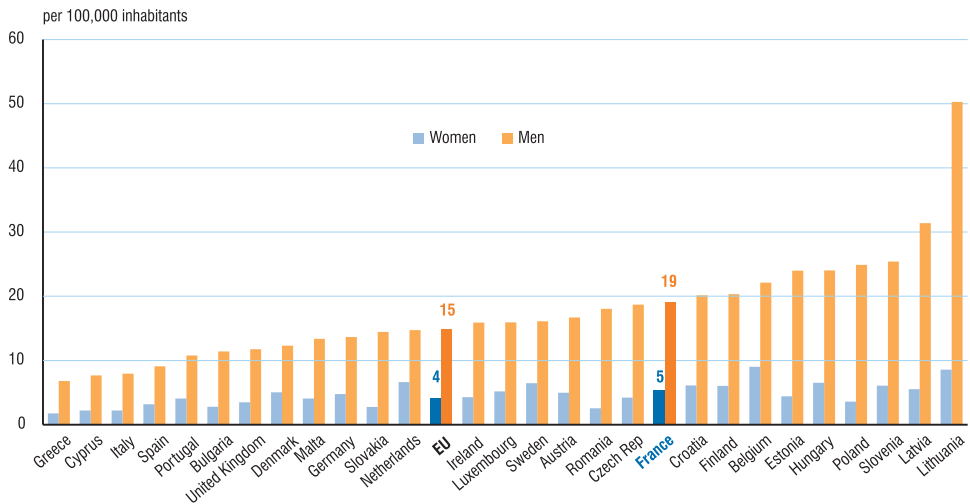


Sources: Eurostat, data extracted in October 2018.

have remained stable or even increased over the recent period, such as in Bulgaria, Hungary and Slovakia.

Another external cause of premature death among men is suicide. In 2015, nearly 5,000 suicide deaths of men under 65 were recorded in France, representing around 13 suicides per day. The standardised rate of premature death by suicide among men, which stands at 19 per 100,000, is four times higher than the female rate. It is also significantly higher than the European average (15 per 100,000) and, in particular, than the rates observed in Germany and the United Kingdom (Figure 5). These results reflect a slight downward trend seen in recent years, albeit a less marked decline than for traffic accidents. Nevertheless, caution should be exercised when counting deaths by suicide, both in terms of national trends and international comparisons. Suicide is a complex and eminently cultural event, the recording of which has yet to be standardised³.

5. Standardised Premature Death Rates by Suicide and by Sex in 2015



Sources: Eurostat, data extracted in October 2018.

In France, 30% of men under 65 Years of Age Smoke Daily while 8% Smoke Occasionally, Representing Higher Proportions than the European average.

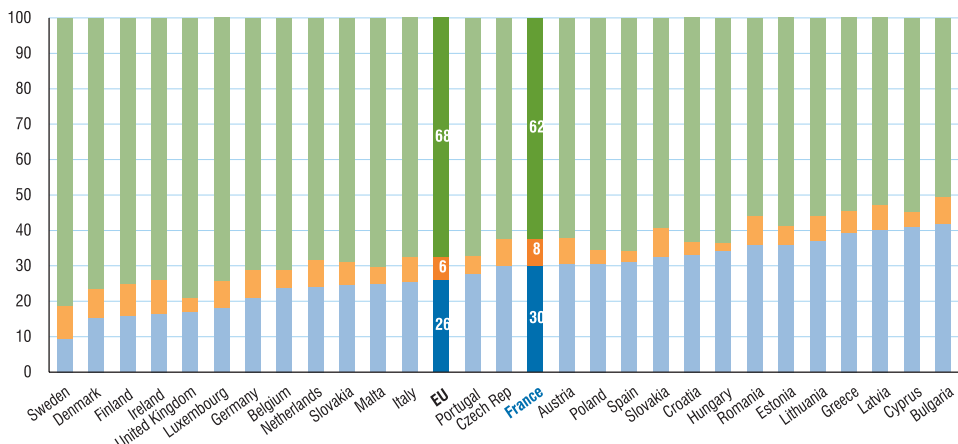
To shed light on these premature deaths, we need to look at how lifestyles are changing. Admittedly, the risk behaviours and practices observed over the recent period are not directly linked to deaths occurring before 65 on account of the delayed effect of the impact of these

3. This particular methodological difficulty is highlighted in a WHO report [2014]: “Suicide is stigmatized (or illegal) in many countries. As a result, obtaining high-quality actionable data about suicidal behaviour is difficult, particularly in countries that do not have good vital registration systems (that register suicide deaths) or good data-collection systems on the provision of hospital services (that register medically treated suicide attempts) [...] This problem of poor-quality mortality data is not unique to suicide, but given the sensitivity of suicide – and the illegality of suicidal behaviour in some countries – it is likely that under-reporting and misclassification are greater problems for suicide than for most other causes of death. Suicide registration is a complicated, multilevel procedure that includes medical and legal concerns and involves several responsible authorities that can vary from country to country

behaviours on health. However, they can help to shed some light, particularly in terms of the priorities of national public health policies.

The main determinants of premature deaths among men are smoking, excessive alcohol consumption, poor nutrition and physical inactivity. All of these factors expose individuals to an increased risk of cancer and chronic diseases in the more or less long term. Smoking, the leading cause of preventable death ahead of alcohol, is responsible, for example, for a significant number of cancer types, including tracheal, bronchial and lung cancer. The 2014 results of the European Health Interview Survey (EHIS) provide comparable data between countries on the prevalence of smoking according to daily consumption, occasional use or no consumption. In France, 30% of men aged 15 to 64 smoke every day and nearly 8% smoke occasionally (*Figure 6*). These rates are slightly below the European average (26% and 6%, respectively) and are significantly higher than those observed in the majority of countries with similar socioeconomic characteristics. The French Observatory for Drugs and Drug Addiction (in French, Observatoire français des drogues et toxicomanies, or OFDT) provides several explanations for the paradox observed in France between high tobacco prices and barely decreasing consumption. On the one hand, the lower cost of tobacco in neighbouring countries encourages cross-border shopping. On the other hand, anti-smoking policies lack consistency and firmness, as illustrated in particular by the overly timid or rare increases in the price of cigarette packs and the lack of commitment in the enforcement of measures relating to sale to minors [Lermenier-Jeannet, 2018].

6. Tobacco Consumption among Men aged 15-64 in 2014



Source : Eurostat, enquête santé European Health Interview survey (EHIS) 2014, extraction des données en octobre 2018.

Anti-smoking measures were introduced in France in the mid-1970s with the Veil Act (1976), which regulates tobacco advertising and requires a health message to be displayed on cigarette packages. Launched in 2003, the Cancer Plan marks a turning point, with several successive increases in tobacco prices and bans on sales to minors and at places of consumption. The immediate impact of these measures was a decrease in tobacco use among adult women and men, as well as among minors. However, the decrease observed between

2000 and 2005 was not a sustained trend, unlike in Northern European countries, where the proportion of daily smokers stands at less than 20%.

Public health policies in these countries have been more resolute in combining structural prevention measures and smoking cessation incentive and support measures. Structural prevention measures include increasing the price of tobacco, banning smoking in public places and workspaces and regulations on packaging and product composition. Incentive and support measures are illustrated by the implementation of public campaigns, with the Tobacco-Free Month known as “Stoptober” launched in 2012 in the United Kingdom and introduced in France from 2016, but also by the development of “Stop Smoking Centres”, smoking cessation centres for smokers who wish to quit their addiction and meet multidisciplinary professionals to help them in this process.

France Ranks 5th among European Countries with the Highest Weekly Alcohol Consumption Rates.

Alcohol is the second leading cause of premature death in France. Alcohol-related deaths mainly include cancer, cardiovascular diseases, digestive diseases (including cirrhosis), accidents and suicides. In 2015, according to data from the Standardised European Alcohol Survey (SEAS) of European adults aged 18 to 64, 85% of respondents in France had consumed alcohol in the last twelve months. The highest numbers of abstainers over the past year are found in Southern Europe: 30% in Italy, 28% in Portugal and 22% in Spain. Greece is an exception, with a very low abstinence rate (8%). By contrast, in Northern and Eastern European countries, alcohol consumption is more widespread among the adult population. Just 7% of Danes, 8% of Austrians and 9% of Bulgarians reported that they had not consumed alcohol in the last twelve months.

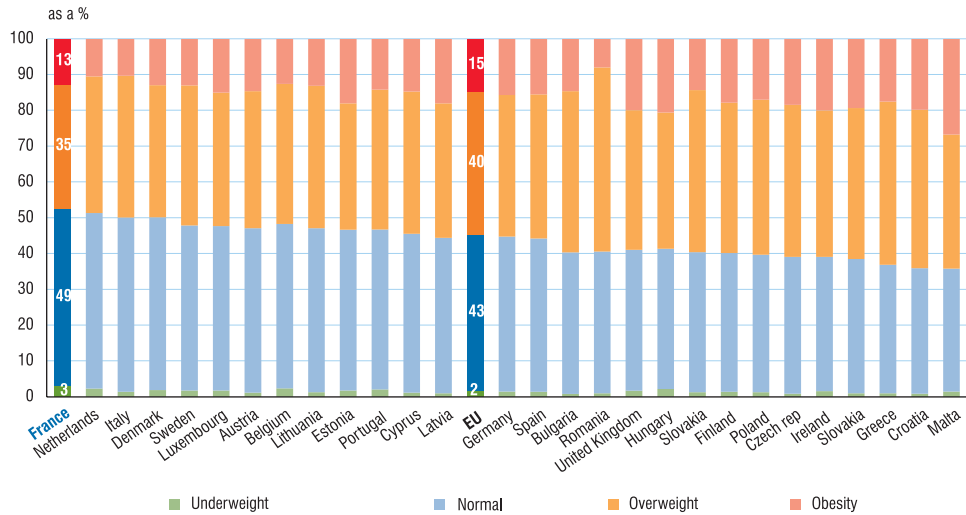
According to the survey data, 13% of French people under 65 years of age drink alcohol 6 to 7 times a week. France ranks 5th among the countries with the highest prevalence of weekly consumption. In addition, almost half of the respondents reported that they drink at least once a week. Although the abstinence rate is higher in Southern Europe, it is also here that the proportion of daily users is highest, above 20%, especially in Portugal and Spain. These rates appear to correlate with the type of alcohol consumed: a high daily consumption rate is more often associated with wine consumption. Moreover, France ranks 13th in terms of the proportion of individuals who engage in binge drinking, meaning six or more units on the same occasion in the case of men and four or more units for women. Only the proportion of individuals reporting at least one episode of drunkenness over the year, and even more so one episode of drunkenness within the last month, is low compared to other European countries.

In France, 47% of Men under 65 Years of Age are Overweight or Obese, the Lowest Rate in Europe

The EHIS asks individuals about their height and weight, providing comparative data on body mass index (BMI). In France in 2014, 47% of men had excess weight, meaning that they were either overweight (35%) or obese (13%) (*Figure 7*). Based on these data, France ranks well in Europe, where, on average, 55% of men aged 15 to 64 are either overweight or obese, with the rate exceeding 60% in seven countries (Poland, Czech Republic, Ireland, Slovenia, Greece, Croatia and Malta).

The rate of obesity ranges from 8% in Romania to 27% in Malta. Here too, France ranks among the countries least affected by this particular public health issue, representing the

7. BMI of Men Aged 15-64 in 2014



Sources: Eurostat, 2014 European Health Interview Survey (EHIS), data extracted in October 2018.

main risk factor for cardiovascular disease, diabetes and musculoskeletal disorders. The positive rates recorded among men under the age of 65 reflects a sustained trend as the prevalence of overweight and obesity in France has been stable since the early 2000s. This contributes to the fact that circulatory diseases are only the third leading cause of premature death among men, unlike in most other European countries.

In 2017, Women Aged 65 had a Life Expectancy of 23.2 Years Compared to 19.4 years for Men, Placing France in 1st and 2nd Position Respectively in Europe.

The first part of this dossier has served to highlight two key findings: first, life expectancy at birth in France is high compared to other European countries; second, there is a markedly higher rate of premature male mortality in France compared to European countries with similar socioeconomic characteristics. Excess mortality among men before 65 is mainly due to excessive alcohol consumption, which is predominantly occasional before 45 and chronic after 45, combined with a high prevalence of male smoking and a high frequency of traffic accidents and suicides.

While the challenge of reducing premature mortality among men has been driving public health policies in France for several decades, improving the knowledge and management of health problems after the age of 65 has also become the focus of intense interest.

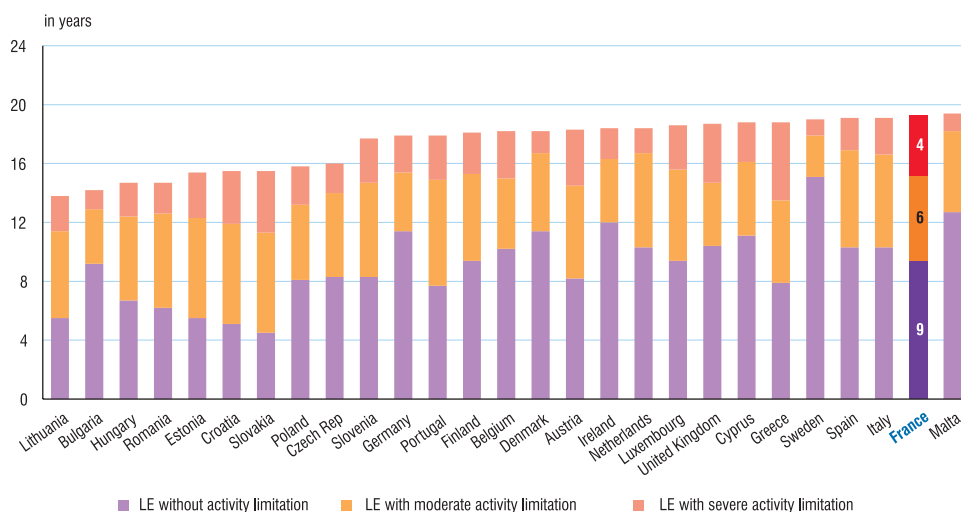
Several indicators can be used to better understand the conditions of population ageing. The first is **disability-free life expectancy**, which measures the number of years a person can expect to live without a disability in everyday life. The measure is based on responses to the following question included in the European Union Statistics on Income and Living Conditions survey (EU SILC): "For at least the past six months, to what extent have you been limited because of a

health problem in activities people usually do?”. In other words, the indicator is a means of determining whether the years gained due to the extension of life expectancy are lived in good health or with functional limitations. The evidence suggests that in 2017, women in France could expect to live 64.9 years in good health, i.e. without experiencing moderate or severe functional limitations that are likely to create discomfort in everyday life. Among men, the indicator stands at 62.6 years. The gap in disability-free life expectancy between women and men is relatively small, in the order of two years, while six years separate their life expectancy at birth. To overcome the differences between women and men in premature mortality and infant mortality, it is worth examining the situation at 65 years of age. In 2017, a 65-year-old man could expect to live 19.4 years, which breaks down into 9.2 years without disability, 6.1 years with moderate disabilities and finally 4.2 years with severe disabilities. For their part, women could expect to live 23.2 years, including 10.8 years without disability, 6.9 years with moderate disabilities and 5.6 years with severe disabilities. Thus, women live longer than men, whether disability-free or with mild to moderate disabilities.

Large Disparities in Disability-Free Life Expectancy at 65 in Europe

In Europe, there are significant disparities in life expectancy at 65 years. In 2016, the indicator for men ranged from less than 14 years in Lithuania to 19 years or more in Sweden, Spain, Italy, France and Malta (Figure 8a). In addition to these differences, there

8a. Life Expectancy (LE) of Men aged 65 by Degree of Activity Limitation in 2016



Coverage: EU Data not available for Latvia.

Sources: Eurostat, EU-SILC data and vital statistics, data extracted in October 2018.

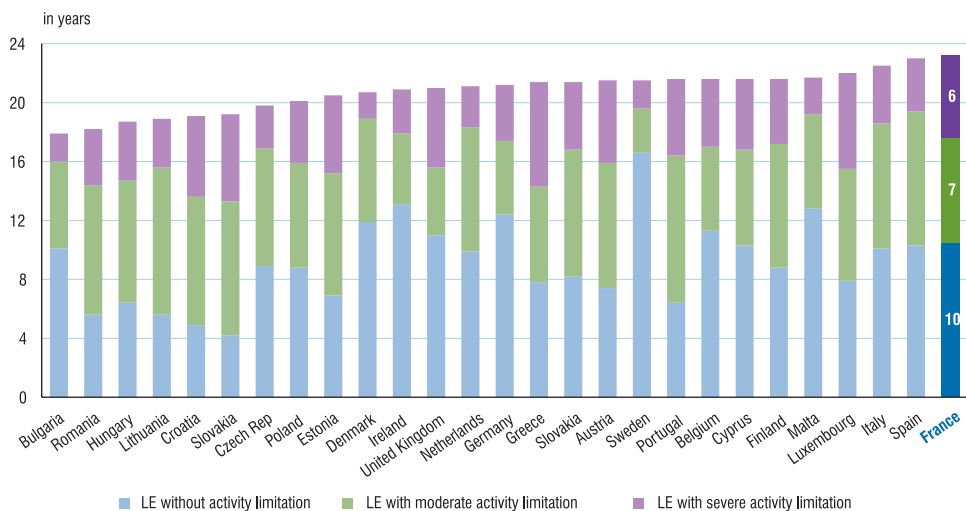
4. The disability-free life expectancy indicator, based on a synthetic question on self-reported limitations in everyday activities, covers a broader spectrum than the functional limitations for which comparative data are available in Europe. In addition to sensory (vision, hearing) and physical (locomotion) limitations, there are also cognitive limitations such as “having memory difficulties”. These limitations sometimes prefigure activity restrictions with a risk of dependency.

are also variations in the quality of life years, as measured by the difference between the two following indicators: life expectancy at 65 and life expectancy at 65 without disability. However, caution should be exercised in interpreting this measure. The disability-free life expectancy indicator is based on respondents' self-assessment of how they feel about more or less severe limitations in their daily activities. Some of the differences observed are due to both nuances in the translations of the GALI (Global Activity Limitation Indicator) question in different European languages and to the understanding and interpretation of the response modalities from one country to another linked to cultural differences.

In France, where the life expectancy of men at 65 ranks among the highest, men at this age live on average for nearly ten years with functional limitations. Other countries with high male life expectancy at 65, such as Italy, Spain, Greece, the United Kingdom and Luxembourg, are in a similar situation to France, with more than eight years spent with activity limitations. However, the situation in these countries is not directly comparable in terms of the severity of self-reported functional limitations, with more years lived with severe limitations in France (4.1 years), Greece (5.3 years) or the United Kingdom (4.0 years) than in Italy (2.5 years), Spain (2.2 years) and, to an even greater extent, Malta (1.2 years). For their part, Eastern European countries are characterised by a relatively low male life expectancy at 65 and disability-free life expectancy at 65, ranging from 4.5 years in Slovakia to 8.3 years in Slovenia and the Czech Republic, corresponding to an end of life lived most often with limitations in daily activities.

Life expectancy at 65 for women ranges from 18 years in Bulgaria to more than 23 years in Spain and France, a difference of roughly five years comparable to that observed among men (Figure 8b). Disparities in the life expectancy indicator at 65 without disability are greater between countries although, as noted above, these differences are no doubt partly related to reporting bias. It should be noted that French women are among the women with the highest life expectancy with severe disabilities (nearly 6 years).

8b. Life Expectancy (LE) of Women Aged 65 by Degree of Activity Limitation in 2016



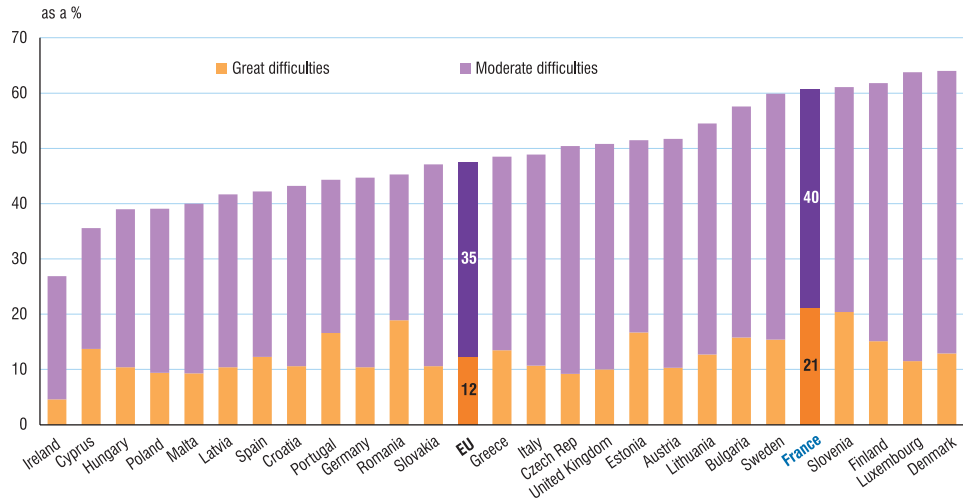
Coverage: EU Data not available for Latvia.

Sources: Eurostat, EU-SILC data and vital statistics, data extracted in October 2018.

More Pronounced Vision and Hearing Impairments among the Over-65s in France Compared to the European Average

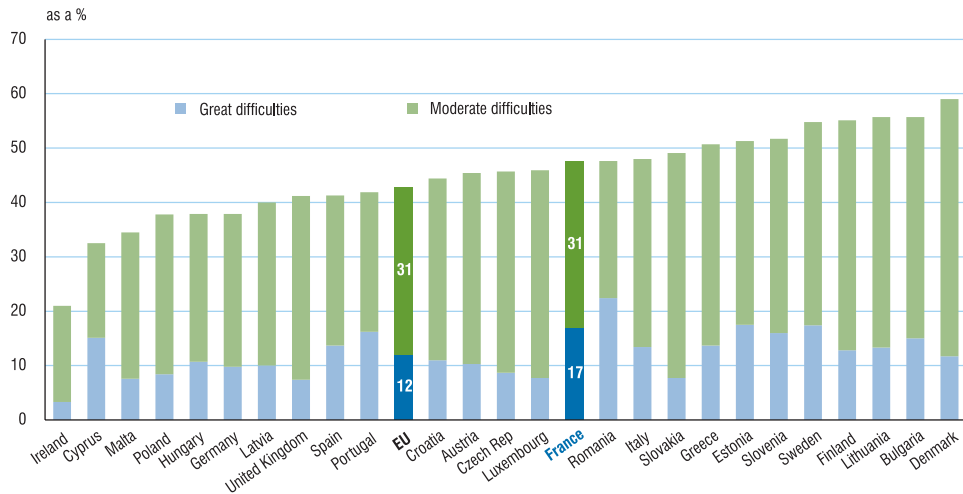
The 2014 EHIS data illustrate, in part, the functional limitations experienced by individuals aged 65 or older. In particular, respondents are asked about the difficulties they may encounter in everyday life. Targeted difficulties include hearing, vision and walking. It should be noted that the responses collected also include difficulties with aid devices⁵ (hearing aids, glasses, lenses, etc.). In Europe, 49 % of men aged 65 or over report having hearing difficulties, including 12% who refer to significant difficulties (*Figure 9a*). France is in a very unfavourable position in Europe for this type of difficulty, with more than six out of ten men aged 65 or more reporting hearing problems, including 21% with significant difficulties. Only Slovenia, Finland, Luxembourg and Denmark have higher proportions of reported hearing problems, but in these four countries the proportion of severe difficulties is lower than in France. The French disadvantage is equally pronounced as regards problems with vision, with one third of men aged 65 or over reporting having difficulty seeing, including with their glasses. This proportion is higher than the European average (27%) and, above all, higher than the difficulties reported in some countries with socioeconomic characteristics similar to France, with just 12% of Britons, 22% of Germans and 23% of Spaniards having the same vision problems. Similarly unfavourable results are found among French women in terms of vision and hearing difficulties (*Figure 9b*). Only the difficulties in walking 500 metres on level ground without assistance are less pronounced in France, with percentages lower than the European average for both men and women. Just 27% of men aged 65 or over report having difficulties, including 12% who report having major difficulties, while the European average stands at 36% and 16% respectively and the proportions observed in neighbouring countries such as the United Kingdom, Spain and Italy are significantly higher than in France (*Figure 10a*). The proportions are higher for French women aged 65 or over, but still below the European average: 40% report having difficulty walking and, of these, 23% report having significant difficulties, compared to 50% and 25% respectively of European women (*Figure 10b*). ■

9a. Proportion of Men Aged 65 or Over Reporting Hearing Difficulties in 2014



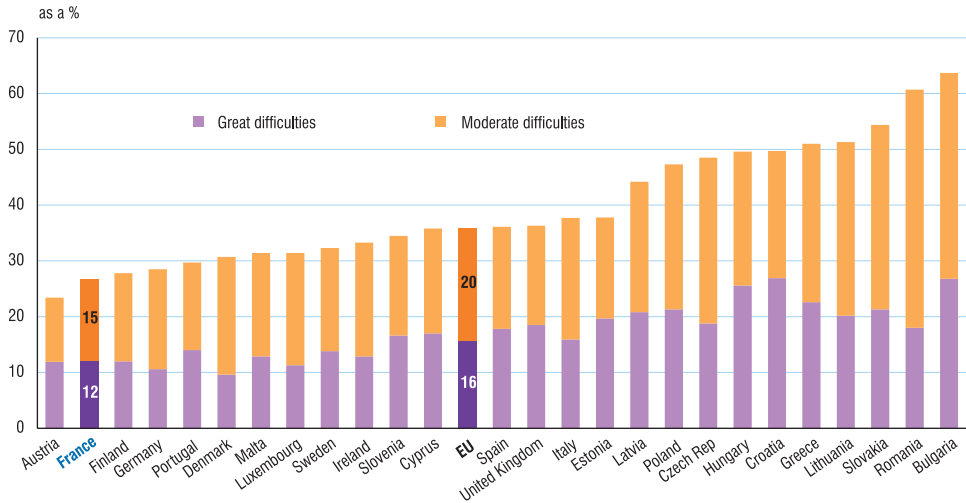
Coverage: EU Data not available for Belgium and the Netherlands.
 Sources: Eurostat, 2014 European Health Interview Survey (EHIS), data extracted in October 2018.

9b. Proportion of Women Aged 65 or Over Reporting Hearing Difficulties in 2014



Coverage: EU Data not available for Belgium and the Netherlands.
 Sources: Eurostat, 2014 European Health Interview Survey (EHIS), data extracted in October 2018.

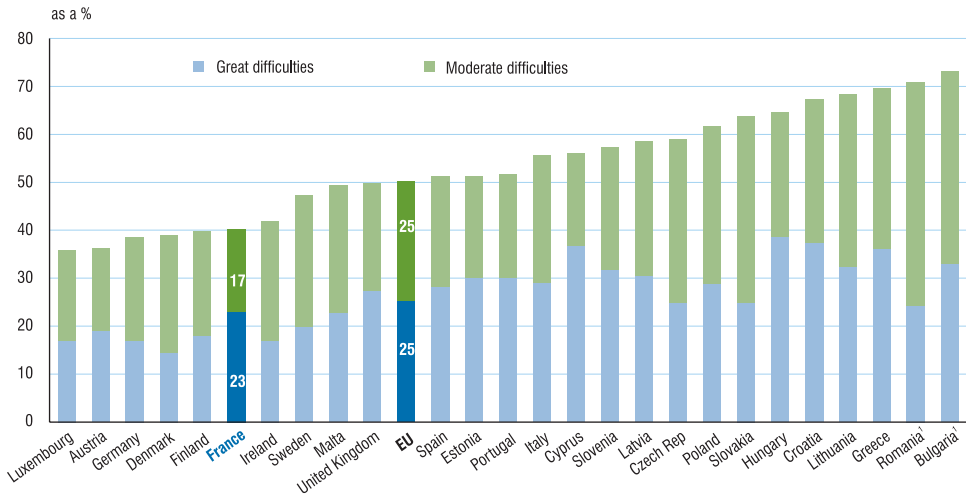
10a. Proportion of Men Aged 65 or Over Reporting Walking Difficulties in 2014



Coverage: EU. Data not available for Belgium and the Netherlands.

Sources: Eurostat, 2014 European Health Interview Survey (EHIS), data extracted in October 2018.

10b. Proportion of Women Aged 65 or Over Reporting Walking Difficulties in 2014



1. Data for Bulgaria and Romania extracted in March 2019.

Coverage: EU. Data not available for Belgium and the Netherlands.

Sources: Eurostat, 2014 European Health Interview Survey (EHIS), data extracted in October 2018.

Définitions

Life expectancy “without disability” or “in good health” measures the number of years that a notional generation can expect to live without disability by being subjected, at each age, to the mortality and morbidity conditions by age in the year of observation.

The so-called **“GALI”** (Global Activity Limitation Indicator) question measures the proportion of people who report having been “for at least the past six months [...] limited because of a health problem in activities people usually do”. The prevalence of disability and life expectancy with and without disability are calculated on the basis of this question.

The **premature death rate** is the number of deaths during the year of individuals aged under 65, compared to the total population aged under 65, in the same year.

The **standardised death rate** (SDR) is the death rate of a population adjusted to a standard age distribution. It is calculated as a weighted average of the age-specific death rates of a given population, with the weighting coefficients corresponding to the age distribution of the population in question. Standardised death rates are calculated on the basis of the European standard population, revised by Eurostat in 2012 and published in 2013.

For further information

Cambois E., Robine J.-M., « Vieillesse et restriction d'activité : l'enjeu de la compensation des problèmes fonctionnels », *Études et Résultats* n° 261, Drees, septembre 2003.

Drees, *L'État de santé de la population en France*, Rapport 2017.

Haut Conseil de la santé publique, *Prévention de la maladie d'Alzheimer et des maladies apparentées*, Collection Avis et Rapports, La Documentation Française, décembre 2017.

Haut Conseil de la santé publique, *La santé en France et en Europe : convergences et contrastes*, Collection Avis et Rapports, La Documentation Française, mars 2012.

Helmer C., Grasset L., Pérès K., Dartigues J.-F., « Évolution temporelle des démences : État des lieux en France et à l'international », *Bulletin épidémiologique hebdomadaire* n° 28-29, Institut de veille sanitaire, septembre 2016.

Lermenier-Jeannet A., « Consommations, ventes et prix du tabac : une perspective européenne », *Tendances* n° 126, Observatoire français des drogues et des toxicomanies, juillet 2018.

Moisy M., « Les femmes vivent neuf mois de plus en bonne santé en 2017 », *Études et Résultats* n° 1083, Drees, octobre 2018.

Moisy M., « Les Français vivent plus longtemps, mais leur espérance de vie en bonne santé reste stable », *Études et Résultats* n° 1046, Drees, janvier 2018.

OECD, *State of Health in the EU. France, Profils de santé par pays*, 2017.

OMS, *2 Prévention du Suicide. L'État d'urgence mondiale*, 2014.

OMS, *Santé 2020. Cadre politique et stratégie*, 2013.

Palle C., Beck F., Richard J.-B., « Usages d'alcool et dommages subis : une perspective européenne », *Tendances* n° 118, Observatoire français des drogues et toxicomanies, juin 2017.

Robine J.-M., Cambois E., « Les espérances de vie en bonne santé des Européens », *Population et Sociétés* n° 499, Ined, avril 2013.
