Health Profile for the Brussels Region 2010

Summary

This third Health Profile for the Brussels Region provides an overview of the health of the population in Brussels, based on ten years of observation (1998–2007) and integrated into the region's demographic, social and multicultural situation.

This report is intended for all those who, in one way or another, are involved in the development and implementation of a coordinated health policy: policy-makers, health sector professionals and the stakeholders active in the numerous areas which determine the heath of the population.

I – General background

The Brussels region is a growing region, with a younger population that has grown continuously for more than 25 years: the region's birth rate (15.7‰) is constantly increasing and is the highest of the country's three regions. The average age of the population in Brussels is falling, as is the case in all large cities in the country.

The region's multicultural character continues to become more marked: 28% of declared inhabitants do not have Belgian nationality, including 62% who come from an EU27 country.

It is also a region marked by opposites: in terms of taxable income, it includes the poorest communes in the country as well as communes having a taxable income considerably above the national average.

One in four inhabitants of Brussels lives below the poverty line. Social inequalities are reflected, from birth throughout the life of inhabitants, in a considerable number of health and mortality indicators examined in this Health Profile.

II – State of health of the population

Perceived health

A quarter of inhabitants of Brussels consider themselves not to be in good health. This proportion is more or less unchanged since 1997. However, it is higher among women, especially girls and women aged over 75. Young inhabitants of Brussels are more likely than young people in large cities in Wallonia or Flanders to feel that their health is poor.

Mortality

Life expectancy at birth continues to rise, as in the rest of the country: in 2006, it was 76.9 years for males and 82.0 for females (compared with 73.6 and 80.5 respectively in 1995).

Standardised mortality rates in Brussels are among the ten countries in Europe having the lowest rates; they are however far higher than those of some European regions, such as Ile de France or Madrid. This positioning is the result of a combination of negative factors (significant proportion of poor people) and positive factors (high proportion of people having a healthy lifestyle (Mediterranean diet). The Health Profile reveals the effects of this balance between social gradients and cultural gradients on several occasions.

As in the majority of industrialised countries, the leading causes of death, all ages and genders taken together are, by order of importance, cardiovascular diseases, cancer and respiratory diseases. The weighting of the causes of mortality varies according to gender: death from cardiovascular diseases is higher among women, while the proportion of deaths linked to cancer and external causes (accidents, suicides and murders) is higher for men.

Premature mortality (before the age of 65) has fallen continuously since 1990, especially for men.

Premature mortality has declined for most of the leading causes. The five most significant causes of premature mortality are, for men, in decreasing order, lung cancer, ischemic heart disease, suicide, domestic accidents and alcohol-related diseases. For women, they are breast cancer, lung cancer, suicide, cerebrovascular diseases and ischemic heart diseases. Premature mortality rates for women are far lower than those of men, but the rate of premature mortality due to lung cancer increased sharply among women between 1998–2002 and 2003–2007.

The leading cause of years of potential life lost before the age of 75 among men is suicide. For women, it is breast cancer that is responsible for the largest number of years of potential life lost before the age of 75.

Chronic diseases and disability

In 2004, **a quarter of inhabitants of Brussels (and more than half of inhabitants of Brussels aged over 75) declared that they suffered from a chronic disease, a long-standing ailment or a disability**. This proportion is more or less unchanged over time. The most frequently mentioned chronic diseases include allergies, back problems, migraine headaches and high blood pressure.

In 2007, **22,404 inhabitants of Brussels were acknowledged as disabled.** Blue-collar workers are more affected than white-collar workers. Three pathologies alone account for two-thirds of disabilities: mental health disorders (by far the biggest cause and increasing), musculoskeletal disorders and circulatory system diseases.

Cardiovascular diseases

Cardiovascular diseases are responsible for a third of deaths among the population. In 2007 they killed 2,874 inhabitants of Brussels, i.e. almost 750 fewer than in 1998. The Brussels Region is among the regions with the lowest cardiovascular mortality rate in Europe, but the current increase in obesity, sedentary lifestyles and other psychosocial risk factors could change this trend.

Ischemic heart diseases and cerebrovascular diseases are still the first and second biggest causes of death by cardiovascular diseases, even if their weighting in total mortality is falling. In 2006, 1,057 cases of people hospitalised with a myocardial infarction were recorded.

Cancer

The total cancer mortality rate and the rate of premature mortality from cancer fell between 1998 and 2007. Cancer killed 2,224 inhabitants of Brussels in 2007 (1/4 of total deaths). For women in general the breast cancer mortality rate has fallen, but the lung cancer mortality rate has increased. For men, the lung cancer mortality rate has fallen constantly, as has, above all for men aged over 75, the prostrate cancer mortality rate.

The four most common types of cancer among men are prostrate cancer, lung cancer, colorectal cancer and leukaemia and lymphoma; among women, they are breast cancer, colorectal cancer, leukaemia and lymphoma, and lung cancer. These kinds of cancer are also, for both genders, the most deadly cancers.

As a result of the improvement in cure and remission rates, cancer is tending to evolve into a chronic disease, which results in the patients concerned having new needs.

Respiratory diseases

Mortality rates for chronic respiratory diseases have fallen, especially for men; mortality rates are however still higher for men than for women.
More than one in twenty inhabitants of Brussels reported suffering from pulmonary or chronic bronchial problems; this percentage is similar to that recorded in major cities in Wallonia and Flanders.

Alcohol-related diseases

Alcohol plays a major role in premature mortality: 13% of years of potential life lost before the age of 75 among men were caused by alcohol, 7% among women.
It is the fifth biggest cause of premature death for men and the sixth for women. Between 1998–2002 and 2003–2007, the alcohol-related mortality rate before the age of 65 fell, but it increased for men aged between 65 and 74.

Musculoskeletal disorders

In 2007, musculoskeletal disorders were responsible for one in five disabilities in Brussels. Between 2000 and 2007, the number of disabilities due to musculoskeletal disorders increased by 19%.
Between the ages of 25 and 44, 1 in 10 people declared that they suffer from chronic back pain.
The corresponding proportion for those aged 55 or over is 1 in 5 people.

Diabetes and obesity

The contribution of diabetes in total deaths has increased over the last 10 years. The proportion of men and women declaring that they suffer from diabetes is no different in Brussels to the proportion recorded in large cities in Wallonia and Flanders. The prevalence of diabetes increases with age and increased among women between 1997 and 2004.

Approximately 11% of the population suffers from obesity (BMI>30). The proportion of overweight men increased significantly between 1997 and 2004.

Infectious diseases

Almost 9% of deaths are due to infections, with pneumonia and septicaemia being the main causes of infection-related mortalities. **Infection-related mortality rates have increased between the two periods for elderly people**, in particular intestinal infections.

- *HIV and other Sexually Transmitted Diseases (STD)*

In 2007, 198 new HIV positive cases were reported in the Brussels Region; although the incidence of HIV positive cases seems to have stabilised, levels are still far higher than in 1997. In the same year, 45 cases of AIDS were recorded in the Brussels Region, which is the lowest number of annual cases since 1988.
The HIV infection-related mortality rate (1.6 per 100,000 inhabitants) has fallen sharply in comparison with the period 1998–2002 (2.4/100,000). The decrease in mortality is related to the introduction of antiretroviral therapy in 1995. However, the higher rates for non-Belgians probably indicate that the latter have not benefited from such therapy in the same way as Belgians.
The increase in homosexual transmission of the disease among Belgian males is a worrying sign of a deterioration in preventive behaviour, not only among middle-aged men but also among young men.

There has been a worrying rise in cases of syphilis, gonorrhea and chlamydia, also noted in other large Belgian cities; a comparison with various European countries seems to show similar trends. We have also seen the re-emergence of **lymphogranuloma venereum (LGV)**.

- *Tuberculosis*

Tuberculosis represents 1.6% of infection-related deaths; its incidence continues to decrease in Europe. Overall, in Brussels, its incidence (28.5/100,000 inhabitants) has been unchanged since 1987; in Brussels it is 3 to 4 times higher than in Wallonia and Flanders.

There are numerous reasons for this: the region's urban character, the presence of a significant number of inhabitants in a precarious social position and a high concentration of citizens who are natives of countries where tuberculosis is very prevalent.
In 2006, 66% of new tuberculosis patients in Brussels were foreign nationals.

- *Viral hepatitis*

Between 2005 and 2007, almost 8 times more cases of hepatitis C than hepatitis B were diagnosed. Although hepatitis B-related deaths have fallen slightly, hepatitis C-related deaths have increased slightly.

- *Meningitis*

Approximately 20 cases of meningitis and meningococcal septicemia are recorded every year in the Brussels Region, above all in winter and autumn; for the period 2003–2007, ten people, i.e. two a year on average, died from meningitis meningococcal (= 0.2% of infection-related deaths).

Mental Health

The 2004 Health Survey revealed a significantly higher level of psychological "ill-being" among inhabitants of Brussels aged over 15 in comparison with other large Belgian cities: 13% of men and 19% of women declared that they had psychological difficulties; 23% of men and 28% of women had suffered from at least one recent specific mental health episode. On an optimistic note, however, in the HBSC survey, 83% of teenage boys and 74% of teenage girls said that they were happy or very happy.

6.6% of male inhabitants of Brussels and 8.4% of female inhabitants of Brussels declared that they had suffered from depression during the previous year. According to a self-assessment questionnaire on depressive disorders, 7.0% of men and 11.8% of women suffer from such disorders. The frequency of depressive disorders increases with age but seems to reach a peak between the ages of 35 and 44 for men and between 45 and 54 for women.

Women are more likely than men to take psychotropic drugs: 13.4% of women reported taking sleeping pills during the last two weeks versus 6.9% of men. These proportions are respectively 9.6% and 6.3 % for sedatives and 8.7 and 5.1% for antidepressants.

In 2007, 154 deaths by suicide were recorded: 102 men and 52 women. **Suicide death rates have fallen regularly since the 1990s**. The suicide risk increases with age and remains more frequent among men than women, unlike suicide attempts. Among young adults, suicide is responsible for one in 4 deaths among men and one in 5 among women. The suicide death rate in the Brussels Region is above the European average and in particular is higher than those of urban regions such as the Ile de France, Berlin, London and Stockholm.

Accidents

According to the 2004 Health Survey, almost 7% of inhabitants of Brussels declared that they had been the victim of an accident, requiring them to consult a doctor or go to hospital.

Almost half of accidents at work (in total around 11,000 a year) involve inhabitants of Brussels aged under 35 and 55% of accident victims have worked for less than 5 years for the company. The number of fatal accidents has decreased since 2005, but the consequences of accidents in the workplace are far from being insignificant. For example, in 2007, 49% of accidents resulted in a temporary incapacity for work and 12% in a permanent incapacity for work.

During the period 2003–2007, 194 inhabitants of Brussels died in road accidents. Road accidents accounted for 12% of accidental deaths in 2003–2007. Between the periods 1998–2002 and 2003–2007, the road accident fatality rate fell by 36%. Fatalities are three times higher for men than for women. The proportion of road accidents among all accidental deaths is the highest for adolescents.

Fatal falls (approximately 100 deaths a year) represent 1/3 of accidental deaths and involve above all elderly people.

III – Determinants of health

The health of inhabitants of Brussels depends on numerous factors which come into play at various levels: at individual level, age, gender and lifestyle play an important role; the physical, cultural, social, etc. environment interacts with these individual factors; it in turn depends on the general socio-economic background. Social status, because of its connection with all the other determinants, is the most powerful determinant of health: the strong social diversity which characterises the regions is reflected in significant social inequalities in health.

Lifestyles

For several types of "health behaviour", the region's vast cultural diversity means that its position is relatively favourable in comparison with other large cities.

More and more inhabitants of Brussels are adopting healthy eating habits, such as having breakfast and regularly eating fruit and fish.

Many inhabitants of Brussels lead a sedentary lifestyle (23% of men and 30% of women).

Smoking continues to have a very important impact on the heath and mortality of inhabitants of Brussels, even if it is declining for men. However, at the current time, the proportion of male inhabitants of Brussels who smoke is stable and is not falling as it is in the rest of the country. For women, tobacco-related health problems are increasingly dramatically, due to the high level of tobacco consumption among women in Brussels in recent decades. At the current time, fortunately, the proportion of women in Brussels who

smoke is continuously declining and is lower than in the rest of the country. Among teenagers, there are perceptible differences depending on the type of education, and the situation of young girls in the technical education sector is particularly noteworthy.

Alcohol dependency remains a worrying problem in the Brussels Region despite the significant number of non-drinkers: one in 3 men and one in 5 women have "high-risk" drinking habits. Binge drinking is frequent among young people.

Social inequalities in health

Because the population of Brussels includes all sections of society from the poorest to richest inhabitants, social inequalities in health within the region are very marked, from birth: a child is twice as likely to die before the age of one in a household with no working parent as in a two-income household.
These inequalities are lifelong: the lower inhabitants are in the social hierarchy, the more likely they are to suffer from chronic diseases, accidents or mental health problems. For example: the least educated citizens and unemployed people are less likely than other citizens to consider that they are in good health; the lower their level of education, the more likely citizens are to smoke and suffer from respiratory problems; people who left school early and unemployed people are more likely to suffer from depressive disorders; women having at most a primary school certificate are 4 times more likely than women who have a higher-education diploma to suffer from obesity, etc. There is also a social gradient for serious cardiac ailments and chronic back problems.
As regards screening, there are strong social inequalities as regards cervical cancer screening.
Given the social segregation of the Brussels Region, the social inequalities in health can be assessed by mortality inequalities between the municipalities. Inhabitants of the wealthy south-east municipalities have the lowest mortality and premature mortality rates in general and for virtually all the leading causes of death, except for breast cancer and suicide.
Inhabitants of the poorest municipalities die younger. For the period 2003–2007, inhabitants of the poorest municipalities have a life expectancy at birth which is 3.4 years lower than that of inhabitants of the richest municipalities, while for women it is 3.1 years lower. This gap has even increased among men in comparison with the period 1998–2002 (difference of 2.7 years).

Health inequalities between the poorest and richest citizens are increasing in Brussels. As part of a general improvement in health indicators, the increase in inequalities is more often than not linked to a more perceptibly favourable trend for the wealthiest inhabitants. This explains the increase in disparities as regards the infant mortality rate, deaths from lung cancer and ischemic heart disease as well as life expectancy disparities for men. But the increase in disparities can also be explained by a deterioration in the situation of the most disadvantaged citizens, as for obesity and diabetes among women and addiction to smoking among men.

The lower citizens are in the social hierarchy, the more likely they are to be vulnerable to health problems and accidents. However, for some health problems, social inequalities are mitigated in the Brussels Region owing to the not insignificant proportion among the less favoured sections of the population of migrants who have, or have had during their life, healthier lifestyles.

Multicultural Brussels

The health of migrants is shaped to a large extent by their social status but also has certain specific characteristics depending on the migrant's nationality.

The indicators in respect of inhabitants of Brussels from European Union countries are more favourable than those for other nationalities, including Belgians. Alongside a protective effect linked to a more favourable socio-economic status, we cannot exclude the possibility that mortality is underestimated (immigrants returning to their country of origin).

Inhabitants of Brussels from sub-Saharan Africa appear as a particularly vulnerable group from a health perspective, both for the perinatal period with a high rate of premature births and fetal and infantile deaths, and at adult age. This community has high mortality rates linked to infections acquired in the country of origin (AIDS, hepatitis) but also due to cerebrovascular accidents, diabetes and accidents.

Inhabitants of Brussels of Moroccan nationality have lower mortality rates than Belgian citizens, except in the perinatal period. This lower mortality rate can be explained to a large extent by generally healthier lifestyles (regular consumption of fruit, fish, low alcohol and tobacco use). Despite this lower mortality rate, the health of Moroccan and Turkish women has been adversely affected by a high frequency of obesity and diabetes, as a result of a lack of physical leisure activities and certain dietary habits.

The health indicators in respect of inhabitants of Brussels of **Turkish nationality** are similar to those of Moroccans. Men differ however by their high smoking rate which results in a high lung cancer mortality rate. Women are more likely to suffer from depressive disorders.

Access to healthcare and prevention

The Brussels Region has a wide, diversified range of healthcare services. In general, therefore, geographical accessibility to services is satisfactory. However, a not insignificant proportion of the inhabitants of Brussels lives in socially precarious situations and the financial access to healthcare is a problem for many inhabitants of Brussels. **In 2004, 17.5% of households in Brussels declared that they had had to postpone healthcare treatment for financial reasons**.

If we examine a specific area, such as flu vaccinations for the over-65s, a self-employed person is 2.6 times less likely to be vaccinated than a person insured under the general healthcare system and a person who has registered a Global Medical File (*Globaal Medisch Dossier, Dossier médical global*) with a general practitioner is 2.3 times more likely to be vaccinated than someone who has not registered a GMF.

The participation rate in organised breast cancer screening varies from 5.9% in the municipality of Uccle to 17.9% in that of Jette; if we take into account individual screening, the total coverage of breast cancer screening can be estimated at 50%. The challenge therefore in Brussels is to encourage women who do not currently undergo any breast cancer screening to participate.

IV - The life cycle

Around birth

In 2007, almost half of babies in Brussels had a non-Belgian mother at the time of birth. 28% of babies were born in a household with no working parent and 17% to a single mother. 36% of babies were born into a two-income family.

Over the last ten years the age of mothers has increased: mothers aged under 20 are proportionally fewer (2.7%) while the proportions of mothers aged between 35 and 39 (17.5%) and aged over 40 (4.8%) have increased.

After a significant increase in the 1980s and 1990s, **the rate of premature births and babies born underweight has fallen since 2002**. The rate of very premature births (< 32 weeks) is more or less unchanged. However, linked to the increase in the number of births, the absolute number of babies born very prematurely or underweight has increased.
Caesarean birth rates continue to increase, especially among mothers aged over 35, but also for those aged 20 or over.

355 cases of infantile mortality were recorded during the period 2003–2007. The main causes of infant mortality are congenital abnormalities, various pathologies linked to the perinatal period, immaturity and Sudden Infant Death Syndrome.

When they leave the maternity clinic, nine out of ten mothers in the Brussels Region exclusively breastfeed their baby; this proportion is higher than in the other two regions in the country.
This rate is higher among mothers in underprivileged municipalities.

Children aged from one to nine years old

Children aged from one to nine years old are part of the age groups with the lowest mortality rates. The two main causes of death are accidents and tumours.
Immunisation coverage saw a sharp improvement in 2006, thanks in particular to the introduction of combined vaccines; social inequalities are less marked, probably as a result of free vaccination and the actions of preventive structures.

Adolescents between ten and nineteen years of age

Adolescents aged 10–19 are the age group with the lowest mortality rate after the 5–9 age group, with a specific death rate in 2007 of 13.7 per 100,000 among boys and 8.9 per 100,000 among girls.

A majority of adolescents "are in good health". Among young people aged 13–18 attending schools in Brussels, only 6% of boys and 9% of girls consider that their health is not good. Children from the most disadvantaged social category are more likely (12%) to report themselves to be in poor health.

Among young people aged 13–18 attending schools in Brussels, 10% of boys and 14% of girls declared that they smoke every day. There are significant differences according to the type of schooling: for boys, pupils in vocational education are the most likely to smoke, while for girls, pupils in technical education are the most likely to smoke (29%). Peer influence is a powerful factor in the tobacco- and alcohol-related behaviour of adolescents, whereas eating habits are above all influenced by family and cultural models. Social inequalities in nutrition emerge from childhood and persist through adolescence. Thus, for example, 3% of young people of the most advantaged tertile versus 7% of the most disadvantaged tertile declared that they eat chips at least once a day.

Adults

The young adult category (aged 25–34) is over-represented in Brussels, as is often the case in urban regions.

13.5% of young adults in Brussels consider that their health is not good. Among middle-aged adults (aged 45–54), this proportion is almost twice as high among men (26%) and almost three times as high among women (32%).

The leading cause of death among young adults in Brussels is suicide (approximately 25 deaths a year), followed by accidents and murders among men, and breast cancer and infections among women.

The mortality rate among middle-aged adults is higher than among young adults.
Among men, lung and larynx cancers are the leading cause of death, followed by suicides, ischemic heart diseases and alcohol-related diseases.
Among women, the main cause of death is breast cancer, followed by lung and larynx cancers, suicide and alcohol related diseases.

Among adults, mental health problems represent a sizeable proportion of chronic diseases and are the main cause of disabilities.

Young male adults are the least likely to adopt healthy eating habits (at least one piece of fruit and one vegetable a day, regularly eating breakfast). The prevalence of overweight people and obesity increases dramatically between the 25–34 and 45–54 age groups. This increase is due in part to changes in physical activity (occupational or leisure-related activities).

Elderly people

Unlike the rest of the country, the proportion of over-65s is falling in Brussels. On the other hand, the proportion of very old people (aged 85 and over) is rising. However, the average age of inhabitants of Brussels varies considerably from one municipality in Brussels to another: Ganshoren is still the “oldest” municipality, together with Watermael-Boitsfort, while Saint-Josse-Ten-Noode is the “youngest” municipality.
The proportion of people aged 60 or over from immigrant stock is increasing in Brussels.

38% of people aged 65–74 do not consider that they are in good health. For those aged over 75, this percentage is as high as 48% for men and 58% for women.

In the "top ten" of chronic diseases declared in the Health Survey for people aged 65 or over, high blood pressure comes in top place, closely followed by musculoskeletal disorders.

Almost one-quarter of female inhabitants of Brussels aged 75 or over declared that they suffer from depressive disorders, and more than a quarter of men declared that they suffer from sleeping disorders.

End of life

A breakdown of the places of death of inhabitants of Brussels shows that there have been few changes over the last ten years. 63% of people died in hospital, 22% in a retirement home and 15% in their own home. In Belgium, the Netherlands and the United Kingdom, the chances of dying "at home" are far lower for people living in large cities, but the large cities/outside large cities disparity is more marked in Belgium.
According to a survey conducted among family doctors, it is estimated that in two-thirds of expected deaths, death was preceded by one or more end-of-life decisions, including 15% with the explicit intention of ending the patient's life.

V Supply and consumption of healthcare

Healthcare is one health determinant among many others. Nevertheless, the supply and consumption of healthcare are an integral part of a health policy and are important determinants of access to healthcare.

In a recent survey, the INAMI noted that inhabitants of Brussels represent less healthcare spending than the average Belgian. In the Brussels Region, inhabitants use fewer home care services, are less likely to register a Global Medical File with a general practitioner, but are more likely to consult specialists, dentists and use retirement homes and hospitals compared with the rest of the country.

General practitioners

Although it is not easy to estimate the number of practising doctors, it is estimated, according to the INAMI's criteria, that there were 1,171 practising doctors in Brussels in 2007 (compared with 3,992 in Wallonia and 6,122 in Flanders). One-third of them are female. The density of doctors is higher in the south of the region and in Berchem-Sainte-Agathe. The average age of doctors in the Brussels Region is rising.

Maternal and infantile protection

In 2006, almost 51,000 children were registered for ONE and K&G consultations in the Brussels Region. The communes with the highest number of births (Molenbeek, Anderlecht, Brussels and Schaerbeek) are also those with the highest number of consultations.

Hospital care supply and consumption

Since 1996, in the Brussels Region, as in the rest of Belgium, **the number of hospitals and beds has decreased**. However, many factors can also influence hospitalisation, involving not only individual characteristics (demography, epidemiology and sociology) but also the organisation of medical care (attractiveness outside Brussels, changes in healthcare practices and its organisation).

Because of its capital region status and its supply of specialist healthcare services, Brussels attracts many patients from other regions: people from outside Brussels account for almost a quarter of hospital stays in Brussels.

According to minimal clinical data (RCM, *Résumés Cliniques Minimum*), from 1999 to 2006, although the number of traditional hospital stays was more or less unchanged, the number and rate of one-day hospital stays increased.

Help and accommodation for elderly people

Enabling elderly people to continue to live for as long as possible in their own home is one of the priorities as regards elderly people in Brussels. Despite a wide and evenly distributed range of services, some needs are inadequately covered and there are still access obstacles (language, financial obstacles and administrative concerns).

Semi-residential services are limited to ten day centres offering day care services for 170 people.
As regards **residential care**, at the end of 2008 the Brussels-Capital Region had 197 residential facilities for elderly people with a total capacity of 16,745 beds. The geographical distribution of retirement homes seems to mirror the proportional presence of people aged over 65 in the population. However, it is surprising to note the lack of retirement homes in the densely populated districts of the most disadvantaged area of the Brussels Region.
Over the past decade, the availability of residential homes has declined constantly, both in terms of the number of homes and the number of beds. In 2008, there were 76 fewer retirement homes for elderly people and 927 fewer beds than in 1997. The smallest homes have been the main victims.

The proportion of retirement homes costing less than 990 euro a month has fallen from 60% in 1997 to 25% in 2005. In comparison, the amount of the guaranteed income for elderly people was 670.59 euros for a single person on 01/08/2005.