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Health profile in Brussels region, 2004,
Brussels Health and social observatory

PRESS RELEASE

Three years after the publication of the first edition the 2004 Health profile again spotlights the health situation in today's Brussels. Undertaken by the Health and social Observatory, this report provides us with a certain amount of food for thought in the light of data gathered and analysed since 1999. As in the previous edition, health has been studied in its demographic, social, environmental and multicultural context. A number of aspects have been expanded and a range of observations can now be made.

A number of positive remarks must he highlighted at the outset:

- The Brussels region is a **region of steady growth where the birth rate is the highest in the country (14.7%).** As a result of its social and multicultural structure, the region is characterised by its youth, as is evidenced by the increase in the proportion of young people under 20 and the fall in the proportion of persons over 65.
- **74% of the population of Brussels are in good health.**
- **The mortality rate continues to fall** (the rate has fallen from 10.7 per 1000 in 1999 to 10.1 in 2002), **foetal-infant death is also going down** (from 10.9 per 1000 births in 1998, it fell to 9.2 per 1000 births in 2002).
- **The rise in life-expectancy continues.** In 2001 it stood at 75.3 for men (as against 74.6 in 1998) and 81.4 for women (as against 81.1 in 1998).

Since the birth rate is the highest in the country, the 2004 Health profile has devoted a considerable proportion of it analyses to health around birth.

In this area several observations can be made:

1632 additional births were registered between 19987 and 2002. The number of births stood at 13,275 in 1998; and 14,907 in 2002.

Nearly 50% of newborn babies in Brussels had foreign mother (169 nationalities represented).

Being at-risk is a reality for a large number of young families: 25% of newborn babies in our regions are born in a family with neither parent is in work.

Perinatal mortality in Brussels (7.1 per 1,000 births from 1998 to 2002) **is at the European average, but affects babies from different social and nationality groups very unequally.** Babies with mothers from Turkey, Morocco or sub-Saharan Africa have a much greater risk of death than those with Belgian mothers (60 to 75% more).

Infant mortality (death between birth and one year of age) **in Brussels is,** however, **higher in comparison with other European data** (5.1 per 1000 births in 1998-2002). Inequalities between nationalities are here considerably less marked, while social inequalities remain significant.

The profile highlights two positive news regarding childbirth health: aside from the drop in perinatal and infant mortality, it also shows improved behaviour patterns as regards health, such as **less smoking** during pregnancy, and a **rise in breastfeeding.**

The report does, however, show an **increase in the number of mothers 35 years old or more (17.4%).** Babies with mothers in this age group have higher risk in terms of premature birth and perinatal mortality. The risk of having a premature baby or of losing the baby is even higher for women over forty. The report shows that their babies are twice as likely to die in the perinatal period as are those of younger women.

Other observations contained in the report:
The proportion of multiple births is rising, in the wake of increased recourse to medically-assisted pregnancy.
While the **proportion of premature babies** rose sharply between 1980 and 1998, the **figures stabilised** between 1998 and 2002 (7.1%). It is also interesting to be aware that babies who are very premature (1.1% of births) show a very high risk of learning difficulties and various handicaps.

And finally, **caesarean births are also on the increase** in the Brussels region (from 13% in 1998, they reached 17% in 2002). The caesarean section rate is still lower than that of a number of European countries and is comparable to the rate recorded for Flanders. The rate of **induced births** (27% in 2002) is, however, one of the highest in Europe , although still lower than the Flanders figure. In this respect the Scandinavian countries are taken as the model, in that they have a very low rate of intervention, and also record a very low rate of perinatal death.

Several significant health problems must be highlighted in the Brussels region.

In the matter of the main causes of premature death (before 65 years of age), one differential is sex.

For men, lung cancer and ischemic heart disease remain the main causes of premature death, even though mortality from these conditions has tended to fall over the past ten years. Also significant are deaths associated with alcohol and suicide (which rises with age).

In women the major cause of death is breast cancer (1 death out of 5 in the under-65 age group), although the mortality has stabilised in recent years. The Brussels region has had an effective screening programme in place for women between 50 and 69 since June 2002. **Lung cancer** comes second (but without falling mortality from this cause for women), followed by suicide (which rises with age), ischemic heart disease and alcoholic cirrhosis.

The health report stresses **the importance of implementing prevention policies**, particularly **as regards alcoholism and smoking.** Smoking is a significant factor in 28% of male deaths (the proportion of deaths due to smoking is falling) and 7% of female deaths (proportion of deaths due to tobacco is rising).

Although a significant portion of the Brussels immigrant population lives in at-risk social conditions, **non-Belgian adults have a lower rate of premature death** (for this sector the risk of death between 20 and 70 years of age is 50 to 70% of the risk for the Belgian population in the same age bracket). These differences in mortality rates, which vary according to the cause of death, are to a great extent explained by **healthier life habits** (not starting to smoke early, less alcohol, a "Mediterranean" diet). It is also noticeable that women over 50 from these immigrant groups have less risk of breast cancer (earlier and more numerous pregnancies, breast feeding more common).
On the basis of these considerations it is possible to state that a positive move would be to exchange the good eating habits of each culture.

Deaths due to infectious diseases are mainly caused by lung infections and septicaemia which affect the very old. The other significant infections are the various forms of hepatitis, AIDS, flue and tuberculosis, which are responsible for the largest proportion of deaths.

Domestic accidents should also be treated seriously as a **cause of death.** In numbers, **deaths arising from these kinds of accident exceed death from**

traffic accidents (306 per year compared with 86). Traffic accident deaths are actually relatively low in Brussels because of the slow speed of driving in the urban area. The ages at **both ends of life** (from 1 to 4 and over 80) are those most affected by domestic accident deaths. It is interesting to note that **old persons are often the victims of poor home organisation.** According to health professionals, a few simple re-arrangements of their homes would be enough to improve the safety of these elderly persons. Political programmes designed with this in mind would make it easier for them to be kept at home.

According to the National Health Survey carried out in 2001, **10% of the Brussels population suffered from depression.** This figure has not risen since 1997. In addition, 15% of the adult population stated that they had taken psychotropic drugs during the two weeks preceding the survey. This disturbing phenomenon is also observed among the young. 10% of young school students between 10 and 18 years of age in Brussels stated that they had taken this type of drug during the previous month.

And as has been observed in the other industrialised countries, as well as throughout the rest of Belgium, **obesity is a growing problem in Brussels.** 42.5% of people over 18 and 16% of adolescents are overweight; while 12% of adults and 5% of adolescents suffer from obesity. This type of problem is related to excessive rich food intake, but also to a reduction in physical activity (significantly lower in Brussels than in the other regions). Efforts must be made to **increase physical leisure activities** (particularly as regards women and female teenagers on technical and occupational education); but **"natural" physical activity must also be encouraged**, for example when moving about and in the work framework. The high unemployment rate in Brussels plays also a role in reducing physical activity, particularly as regards manual workers.

And **accommodation also affects health.** 11% of the population of Brussels live in housing which is too damp. This dampness helps to increase the frequency of respiratory infections as well as increasing the risk of developing asthma. And it aggravates chronic respiratory conditions.

Not all Brussels people are equal as regards health, as the Brussels-Capital Region Health Profile makes very clear.

As the previous edition of the Health Profile had already shown, social inequalities in respect of health persist in the Brussels region.

And in perinatal and infant health, these inequalities are repeated. Where there is no occupational income in a family, for example, perinatal and infant

mortality risks are doubled. Factors such as the mother's health, living standard, education and financial resources have a powerful effect on rates of premature birth, birth weight, and perinatal and infant mortality.

Another observation: **the residents of the poorest districts have a life expectancy 3 years less** than that of the residents of the wealthier districts. Death rate differences are more marked as regards ischemic heart disease, lung cancer, chronic respiratory conditions or conditions connected with alcohol. As has been stated above, these inequalities are nevertheless evened out somewhat by the fact that the poorest districts attract a higher proportion of non-Belgians who have a lower risk of premature death, despite their often at-risk living conditions.

Among persons with little education, depressions and diabetes are respectively 2, 3 and 5 times more common than in other groups of the population.

And the at-risk Brussels resident also has much more difficulty in adopting a healthy lifestyle than the others.

Having read these results, various patterns of analysis and action are clear for the health services.

Demographic factors and in particular the rising birth rate have focussed on the need to provide an adequate supply of services offering high quality perinatal monitoring and care; curative services and preventative health monitoring for infants as well as school-age children.

In Brussels, **chronic diseases** requiring long-term care **make up the largest part of health care needs.** On the one hand, the ageing nature of the population to be served and the increase in obesity are resulting in an increase in the incidence of chronic diseases. On the other hand, while improved treatment for some conditions has reduced mortality, it has not cut the number of patients requiring monitoring and care. This is the case which applies to ischemic heart disease, AIDS, cancer, etc. **The health services must therefore adapt themselves to these needs.** Efforts must be made to upgrade the status of general practice (the Brussels inhabitants are less numerous to have a regular general practitioner than inhabitants of other regions), and to think about coordination of ambulatory care.

The Brussels region must also incorporate specific needs arising from its status as a capital. It should be understood that 20% of deaths and 30% of births in the Brussels region concern persons who are not Brussels residents.

This is a result of the large number of care institutions present in the Brussels area.

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