THE GENDER GAP IN LIFE EXPECTANCY

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KEY MESSAGES

Public health situation is best characterized by life expectancy and mortality indicators, which are largely affected by one of the health determinants — the gender.

In Latvia, life expectancy of men is 11 years shorter than in women. This gender gap in life expectancy is almost two times greater than in other European states.

The gender difference in life expectancy is determined by mortality from ischemic heart diseases, lung cancer, external causes of death (traffic accidents, falls, drowning, exposure to smoke, fire and flames, poisoning and exposure to hazardous substances, intentional self-harm, violence etc.). Mortality from these causes is much higher in men than in women, and occurs at earlier ages, for instance:

- mortality from ischemic heart disease is three times higher in men than in women;
- mortality from lung cancer is eight times higher in men than in women;
- mortality from external causes is four times higher in men than in women;
- mortality from suicides is almost five times higher in men than in women;
- the number of men killed in traffic accidents is three times higher than women.

Mortality is influenced by a number of risk factors, for instance, lifestyle habits (smoking, alcohol consumption) and socioeconomic factors (employment, education, income level).

Smoking is a risk factor for the prevalence of circulatory system and respiratory system diseases and cancer. In Latvia, smoking is widespread and the proportion of everyday smokers among men is higher than among women:

- in 2004, 18% of women and 47% of men (aged 15-64) were regular everyday smokers;
- in 2002, boys aged 15 more often were regular smokers than girls — 29% of boys and 21% of girls respectively.
Alcohol consumption is a risk factor for various diseases, including ischemic heart diseases, transport accidents, violence, and suicides. The proportion of regular alcohol consumers among men is higher than among women:

- in 2003, 17% of men and 4% of women drank 6 or more glasses of alcohol at a time each month;
- in 2003, 12% of men and 1% of women aged 25-34 drank 6 or more glasses of alcohol at a time each week;
- men were involved in traffic accidents under the influence of alcohol ten times more often than women.

As excessive alcohol consumption is more characteristic of men, health problems caused by alcohol (such as addiction, alcohol psychoses) are also more often occurring in men than in women (80% — men, 20% — women).

Problems related to alcohol consumption are also topical among young people. Among firstly registered children and young people with addiction diagnosis, intoxication or harmful excessive consumption in 2005, 74% were boys and 26% were girls.

Alcohol consumption and other lifestyle habits are related to socioeconomic problems, and, conversely, increasing isolation of several social groups facilitates the prevalence of alcohol and drug addiction.

Interaction of health and life conditions is reciprocal — poor life conditions often have a negative impact on health and, conversely, poor health may worsen life conditions. Main socioeconomic factors (education, income level, employment) are related to health and, consequently, affect the life expectancy. These factors also show gender differences: women have a higher education level, but men have a higher employment level and higher income.

Social and economic problems, inequality, poverty and social exclusion are preconditions for poor health. These factors are often related to higher rates of smoking, alcohol and drug consumption, depression, suicides, antisocial behaviour and violence, an increased risk for non-receiving of wholesome sustenance, numerous health problems and heavily decreased life expectancy in all age groups. These public health problems are more often occurring in men.
The above-mentioned risk factors affect mortality due to external causes, thus decreasing life expectancy, especially in men.
INTRODUCTION

The aim of the report is to prepare an analysis of the main factors determining gender differences in life expectancy and to provide recommendations for improvement of the situation.

The report includes the following five sections:
1. Introduction; evaluation of the problem;
2. Problem description;
3. The underlying causes and risk factors;
4. Policies in place;
5. Recommendations for improvement of the situation.

Main analyzed indicators:
- average life expectancy at birth;
- cancer mortality;
- mortality from diseases of the circulatory system;
- mortality due to external causes;
- potential years of life lost.

The average life expectancy at birth in Latvia in 2005 was 77 years for women and 66 years for men.

Firstly, life expectancy at birth in Latvia in comparison with other EU Member States is shorter by 8 years on average.

Secondly, life expectancy at birth has noticeable gender gaps. This difference is almost 11 years and it is twice higher than average in the EU where gender gap in life expectancy at birth is slightly less than 6 years.

The theme of the report “The Gender Gap in Life Expectancy” was chosen taking into account the topicality of the problem, noticeable differences between indicators in Latvia and the average EU indicators, as well as the aims stipulated by the Public Health Strategy approved by the Cabinet of Ministers on March 6, 2001 that should be reached by 2010. One of the tasks to reach the Millennium Development Goal 3 “To promote equality between women and men” is to decrease gender gaps in life expectancy and to reach the average EU indicator.

In order to increase life expectancy in Latvia, it should be taken into account that the noticeable gap in life expectancy of men and women is
among the most important issues to be solved. Therefore, this report pays greater attention to the problem related to gender gaps in life expectancy.

To formulate the necessary actions corresponding to situation, the following issues were taken into account in analyzing information:

- Life expectancy is the basic indicator reflecting the mortality level at different ages.
- Of the summarized mortality data on the main causes of death in different age groups data showing noticeable gender gaps were selected for further analysis.
- The connection between causes, risk factors, basic social factors and gender-specific causes of death, as well as gender gaps of these possible risk factors were investigated.

A noticeable gender gap in mortality indicators due to diseases of the circulatory system, lung cancer and external causes (accidents, injuries, suicides etc.) is seen in almost all age groups.
PROBLEM DESCRIPTION

Figure 1 shows trends of life expectancy at birth in Latvia and in the EU on average.

*Figure 1. Average life expectancy at birth (years) in Latvia and the EU by gender*  
*(WHO, European health for all database)*

It can be seen that difference between life expectancy of women and men in comparison with the average EU indicators is almost twice as high. This difference is rather stable during the given time period and even shows an increase in 2004 and 2005. Life expectancy at birth for women in 2005 was almost 77 years, but life expectancy at birth for men — only 66 years, the gap is 11 years. The average EU indicator shows a 6-year difference. Latvia and Lithuania both have the greatest gender gap in life expectancy in the entire EU.

Comparing the average life expectancy at birth for men in Latvia and the average life expectancy at birth for women in the EU, the difference is almost 15 years.

Public Health Strategy approved by the Cabinet of Ministers on March 6, 2001 stipulates that by 2010 the average life expectancy at birth in Latvia should reach at least 95% of the average indicators of the EU Member States.
Figure 2. **Average life expectancy at birth (percentage of the EU indicator) in Latvia compared to 95% of the EU**

(WHO, European health for all database)

![Graph of average life expectancy at birth](image)

Figure 2 reflects the percentage of average life expectancy at birth in Latvia in comparison with 95% of the average EU indicators. Average life expectancy at birth in Latvia approaches the average EU indicators and is on average 90% of the EU-27 indicator since 1996.

Figure 3. **Average life expectancy at birth (years) in 2004 by gender**

(WHO, European health for all database)

![Bar chart of average life expectancy by gender](image)

Figure 3 shows the distribution of average life expectancy at birth in several EU states by gender. Life expectancy of men in the Netherlands and Great Britain in 2004 was 77 years, whereas in Latvia and Lithuania — 66 years. In Finland and the Netherlands, the average life expectancy of...
women in 2004 was 82 years, but in Latvia, Bulgaria and Romania – 76 years.

Figure 4. Average life expectancy at birth (years) by gender in rural areas and towns
(CSB data)

Figure 4 shows that life expectancy indicators for men and women are lower in rural areas than in towns.

Life expectancy at birth for women born in 2005 and living in towns in Latvia is 79 years, and in rural areas — 75 years, i.e., by 4 years shorter.

Life expectancy at birth for men born in 2005 and living in towns in Latvia is 67 years, and in rural areas — 65 years, i.e., by 2 years shorter.

Figure 5. Standardized mortality indicators, all causes per 100 000 inhabitants by gender
(WHO, European health for all database)

By looking at the standardized mortality indicators due to all causes, Figure 5 shows that reflected trends are opposite to life expectancy trends
shown in Figure 1 — the higher the mortality, the lower the life expectancy.

Gender gaps of standardized mortality indicators in Latvia, compared to the EU, are also almost two times higher. In Latvia, mortality of men is two times higher than in women, in the EU this difference is 1.6 times. Data on the year 2005 show that mortality indicators increase for men and decrease for women, which may cause even greater gender gaps in life expectancy.

Figure 6 shows the indicator of potential years of life lost (PYLL) in distribution by gender. This indicator was calculated for inhabitants who are less than 65 years of age to emphasize premature death, i.e., mortality at an early age.

Figure 6. Potential years of life lost, all causes per 100 000 inhabitants by gender

(PHA data)

Men potentially lose three times more years of life than women. This trend is mainly related to high male mortality at an earlier age.

The Statistical Office of the European Communities (EUROSTAT) has performed calculations making a prognosis on the possible gender gaps in life expectancy in 2050. With the increase of life expectancy of women and men, the gender gap of this indicator will decrease reaching approximately 3 years in the Netherlands and Sweden, presently having a 4-year difference, and 8 years in Latvia and Lithuania\(^2\).
UNDERLYING CAUSES AND RISK FACTORS

Analysis of main causes of death

Main causes of death in Latvia are the following:
✓ circulatory system diseases;
✓ cancer;
✓ external causes of death (traffic accidents, falls, drowning, exposure to smoke, fire and flames, poisoning, intentional self-harm, violence etc.).

All three groups of main causes of death demonstrate gender gaps in mortality indicators.

Figure 7. Mortality in 2005 per 100 000 inhabitants by gender and age groups
(HSMTSA data were used in calculations)

Figure 7 shows mortality level at five basic age groups under 74 years of age. Gender gaps increase as age increases. In the age group 45-59, mortality indicators for men in 2005 were three times higher than for women.

According to HSMTSA data, the most substantial causes of death in men in Latvia in 2005 were: circulatory system diseases (59%), cancer (23%), injuries, poisoning and effects of external exposure (18%), in women — circulatory system diseases (74%), cancer (20%), injuries, poisoning and effects of external exposure (6%).
Diseases of the circulatory system

This section provides an overview of more detailed information on mortality due to circulatory system diseases. In Latvia, circulatory system diseases are the most significant cause of death.

Figure 8. Proportion of deaths (percentage) due to circulatory system diseases of all deaths by gender
(HSMTSA data were used in calculations)

Figure 8 shows that circulatory system diseases were the main cause of death for 62% of women and 48% of men of the total number of deaths. Even if the proportion of deaths due to circulatory system diseases is higher in women than in men, mortality due to these diseases is higher in men.

Figure 9. Standardized mortality indicators, circulatory system diseases per 100,000 inhabitants by gender
(WHO, European health for all database)
Figure 9 shows the trends of male and female mortality indicators in Latvia. In comparison with the average EU indicators, a difference in indicators between genders is observed to be greater in Latvia. In Latvia, male mortality due to this cause is almost two times higher than female mortality. It should be mentioned that male mortality in Latvia has not decreased during the last year; there has been even a slight increase.

Mortality indicators due to circulatory system diseases in men and women in Latvia are almost two times higher than the average EU indicators.

Comparing standardized mortality indicators with the calculated potential years of life lost (see Figure 9 and 10), gender difference in indicators of potential years of life lost is seen to be greater indicating that men die at an earlier age than women. Similar differences are seen in mortality data related to all causes of death (see Figure 5 and 6).

**Figure 10. Potential years of life lost due to circulatory system diseases per 100,000 inhabitants by gender**

*(PHA data)*

Analyzing PYLL indicator by gender, it can be seen that PYLL due to circulatory system diseases, similarly to PYLL due to all causes in men, is almost three times higher in men than in women.

The most substantial gender difference in mortality indicators is related to ischemic heart disease. The greatest difference is observed in the 30-60 age group. Ischemic heart disease is more often detected among younger people.
An important place among all circulatory system diseases is taken by cerebrovascular diseases, including stroke. Mortality indicators due to cerebrovascular diseases have no substantial gender gaps.

*Cancer*

Cancer is the second leading cause of death in Latvia. Proportion of deaths in women due to this cause is by three percentage points lower than in men (Figure 12).

*Figure 11. Standardized mortality indicators, ischemic heart diseases per 100 000 inhabitants by gender (WHO, European health for all database)*

*Figure 12. Proportion of deaths (percentage) due to cancer of all deaths by gender (HSMTSA data were used in calculations)*
Analyzing information on mortality due to cancer, it can be seen that gender gap in cancer mortality indicators is smaller than gender gap in mortality indicators due to circulatory system diseases.

**Figure 13. Standardized mortality indicators, cancer per 100 000 inhabitants by gender**

*WHO, European health for all database*

Mortality caused by cancer is two times higher in men than in women. It should be noted that female mortality indicators in Latvia are almost at the same level as the average cancer mortality in the EU. There is a difference in male mortality indicators: in Latvia, male mortality is 20% higher than the EU average.

The greatest gender gaps in cancer mortality are related to tracheal, bronchial and lung cancer.

**Figure 14. Standardized mortality indicators, tracheal, bronchial and lung cancer per 100 000 inhabitants by gender**

*WHO, European health for all database*
In Latvia, standardized mortality indicators due to tracheal, bronchial and lung cancer in men are eight times higher than in women. In comparison with the EU, this gender gap is two times greater.

**Figure 15. Proportion of deaths (percentage) due to tracheal, bronchial and lung cancer of all deaths due to cancer by gender**  
*(HSMTSA data were used in calculations)*

Proportion of tracheal, bronchial and lung cancer in the overall structure of cancer mortality in men is almost 30%, and in women — 7%, which is four times lower than in men.

According to WHO data, mortality of men in Latvia due to lung cancer and other chronic upper airway diseases is five times higher than in women.

**External causes of death**

According to HSMTSA data, 10% of all deaths in 2005 were caused by external causes.

Proportion of deaths due to external causes in the overall structure of causes of death is 5% for women and 16% on average for men, which is three times higher than for women.
Figure 16. Proportion of deaths (percentage) due to external causes of all deaths by gender (HSMTSA data were used in calculations)

In comparison with the average EU indicators, mortality due to external causes is much higher in Latvia, especially in men. In Latvia, mortality due to external causes of death is five times higher than, for instance, in the Netherlands, and four times higher than in Germany (WHO data).

Figure 17. Standardized mortality indicators, external causes of death per 100 000 inhabitants by gender (WHO, European health for all database)

Male mortality due to external causes in Latvia is four times higher than female mortality due to external causes. In the EU this gender difference is three times.
Calculations performed by CSB show that if the number of deaths due to unnatural causes could be decreased for a half, the average life expectancy of men in Latvia would increase by 1.8 years (from 65.6 to 67.4), and in women — by 0.6 years (from 76.8 to 77.4).

Gender gaps in PYLL indicators due to external causes are greater than those of mortality indicators. This is indicative of the fact that men not only die in greater numbers than women but they also die at an earlier age.

**Figure 18. Potential years of life lost per 100 000 inhabitants by groups of external causes of death by gender in 2005**

*(PHA data)*

<table>
<thead>
<tr>
<th>Cause</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traffic accidents</td>
<td>905</td>
<td>296</td>
</tr>
<tr>
<td>Alcohol intoxication</td>
<td>283</td>
<td>111</td>
</tr>
<tr>
<td>Drowning, suffocation</td>
<td>593</td>
<td>145</td>
</tr>
<tr>
<td>Exposure to smoke, fire and flames</td>
<td>193</td>
<td>78</td>
</tr>
<tr>
<td>Suicide</td>
<td>933</td>
<td>121</td>
</tr>
<tr>
<td>Homicide</td>
<td>384</td>
<td>99</td>
</tr>
</tbody>
</table>

The highest PYLL in men is due to suicides, in women — due to traffic accidents; the second place in men is taken by traffic accidents, in women — drowning, suffocation.

On average one fifth of external causes of death is intentional self-harm (suicides) taking the first place in the overall structure of external causes of death. Figure 19 reflects data on mortality trends due to intentional self-harm.

During the last 10 years, mortality due to suicides in Latvia is having a decreasing trend; nevertheless, Latvia still ranks among the first three states having the highest mortality due to suicides in the EU.

Mortality due to intentional self-harm in men in Latvia is five times higher than in women, in the EU the same difference is four times.
A suicide usually has several reasons; it results from various psychological, social, health and family problems.

Mortality due to traffic accidents occupies the second place in the overall structure of mortality due to external causes.

Male mortality due to traffic accidents in Latvia was three times higher than female mortality, and this trend is similar to the EU average. This is one of the few causes of death whose gender gaps in mortality indicators have no substantial difference between Latvia and the EU average.
Mortality indicators due to traffic accidents, especially in men, are two times higher in comparison with the average EU indicators.

The highest difference in mortality due to external causes between Latvia and the EU is due to exposure to smoke, fire and flames — ten times.

Figure 21. **Standardized mortality indicators, exposure to smoke, fire and flames per 100,000 inhabitants by gender**  
*(WHO, European health for all database)*

In Latvia, mortality caused by exposure to smoke, fire and flames in men is three times higher than in women; in distribution by gender in the EU this difference is two times.

In the structure of mortality due to external causes, violence constitutes 7%. In comparison with the average EU indicators, mortality due to violence is eight times higher in Latvia (Figure 22).
Figure 22. **Standardized mortality indicators, violence per 100 000 inhabitants by gender**  
*(WHO, European health for all database)*

Summary

In Latvia, gender gaps in life expectancy are mainly influenced by circulatory system diseases, cancer and external causes of death. Figure 23 and Table 1 contain summarized data about six age groups.

Figure 23. **Differences in mortality indicators (male/female), 2003**  
*(WHO data from Highlights on health in Latvia 2005 were used in calculations)*
Male mortality due to leading causes of death is higher in all age groups. The smallest gender gaps in mortality indicators are in the age group over 75, the greatest gaps are at workability age. These factors affect gender gaps in life expectancy.

The greatest gender gap in mortality indicators in the 0-14 age group is due to circulatory system diseases and cancer, in the 30-59 years age group — due to external causes of death.

The next section will look at the underlying risk factors of these death causes and the rate of the gender gaps of these risk factors.

**Analysis of main risk factors**

As already mentioned before, the leading causes of death in Latvia are circulatory system diseases, cancer and external causes of death.

Thus, noncommunicable diseases are one of the most frequent causes of death among Latvian inhabitants, which is closely linked to seven most important risk factors:

✓ **High blood pressure**

High blood pressure is dangerous, because it has no specific warning symptoms. A patient may feel well for years, so regular health check-ups are important.

High blood pressure may cause serious heart and brain disorders leading to death.

Risk factors for high blood pressure that may be corrected:

✓ obesity;
✓ smoking;
✓ low physical activity;
✓ excessive alcohol consumption;
✓ excessive salt consumption.

**Table 1. Mortality indicators (relation: male/female) 2003**

<table>
<thead>
<tr>
<th>Causes of death</th>
<th>Aged 0-14</th>
<th>Aged 15-29</th>
<th>Aged 30-44</th>
<th>Aged 45-59</th>
<th>Aged 60-74</th>
<th>Aged 75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>2.5</td>
<td>1.5</td>
<td>1.0</td>
<td>1.8</td>
<td>2.3</td>
<td>2.2</td>
</tr>
<tr>
<td>Circulatory system dis.</td>
<td>5.2</td>
<td>4.4</td>
<td>4.8</td>
<td>3.0</td>
<td>2.3</td>
<td>1.2</td>
</tr>
<tr>
<td>External causes</td>
<td>1.3</td>
<td>3.7</td>
<td>4.4</td>
<td>4.4</td>
<td>3.6</td>
<td>1.8</td>
</tr>
</tbody>
</table>
Risk factors for high blood pressure that may not be corrected:
✓ age — for men aged over 55 and women aged over 65,
✓ hereditary disposition for certain diseases in family such as hypertension, dyslipidemias, diabetes mellitus.³

The results of a study performed by the Central Statistical Bureau in 2003 “Health Survey of Latvian Inhabitants” demonstrate that “high blood pressure” is diagnosed in 7% of men and 12% of women.

✓ **High cholesterol level**

An increased level of cholesterol is often related to other risk factors: unhealthy sustenance, smoking etc.

The results of a study performed by the Central Statistical Bureau in 2003 “Health Survey of Latvian Inhabitants” demonstrate that 48% of men and 45% of women have never had their cholesterol level measured.

✓ **Smoking**

There are definite scientific evidences that exposure to tobacco fumes causes diseases (circulatory system diseases, lung cancer), disability and death⁴.

According to data of epidemiological studies, smoking is widespread among Latvian inhabitants. Data obtained from Health Promotion State Agency show that the proportion of smoking men exceeds the proportion of smoking women more than two times. In 2004, 18% of women and 47% of men (aged 15-64) were regular everyday smokers.

*Figure 24. Proportion of everyday smokers (percentage)*

*(HPSA, FINBALT study data)*

![Percentage vs. Year Graph](chart.png)
The high proportion of everyday smokers among young people is especially alarming. Boys also smoke more than girls. At the age of 15, the proportion of smoking boys (29%) is one and a half times higher than that of girls (21%).

According to WHO information, Latvia in comparison with other EU countries has one of the highest gender gaps in numbers of everyday smokers (see Figure 1, 2 of the Annex).

Tobacco fumes are harmful not only for the smokers themselves, but also for people around who become passive smokers. A part of non-smokers who suffer from passive exposure to tobacco fumes develop diseases and disability in the course of time. Moreover, passive smoking can lead to death as well³.

Data of HPSA study show that every second inhabitant of Latvia aged 15-64 was exposed to passive smoking at home in 2004. The proportion of men among passive smokers is also higher than proportion of women. 46% of women and 54% of men are exposed to passive smoking at home, and 10% of women and 26% of men at least one hour a day are exposed to tobacco fumes at their workplace.

Almost 50% of smokers die prematurely due to diseases caused by regular smoking, and almost half of them die at middle age — in the economically active period of life⁶. Thus, considering the gender gaps in smoking indicators, it can be concluded that smoking is one of the most substantial risk factors causing a noticeable gender gap in mortality due to lung cancer.

✓ Overweight and obesity

Excess body weight and obesity are one of the health problems affecting development of various diseases and mortality. Unhealthy sustenance and insufficient physical activity are important risk factors in cases of obesity and overweight. Obesity is a risk factor for many serious diseases, including heart diseases, high blood pressure, heart attack, respiratory system diseases, arthritis and some types of cancer.

After evaluation of body mass index, the study of health-impacting habits of Latvian inhabitants performed by Health Promotion State Agency in 2004 ascertained that the proportion of men is higher both in the normal weight group (56% of men and 51% of women) and in the overweight group (30% of men and 24% of women); in the obesity group the
proportion of women is higher than the proportion of men (12% of men and 20% of women).

**Figure 25. Distribution of respondents by body mass index in 2004 by gender**

*(HPSA data)*

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
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<tbody>
<tr>
<td>Underweight</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Normal weight</td>
<td>56</td>
<td>51</td>
</tr>
<tr>
<td>Overweight</td>
<td>30</td>
<td>24</td>
</tr>
<tr>
<td>Obesity</td>
<td>12</td>
<td>20</td>
</tr>
</tbody>
</table>

After analyzing these indicators by age groups, it can be seen that at the age of 25-44 men are in a more unfavourable situation. In the normal body weight group the proportion of men is higher than the proportion of women and in the overweight group the proportion of men is higher than that of women (see Table 1 of the Annex).

✓ **Low consumption of vegetables and fruit**

Unhealthy sustenance is a precondition for many health problems, thus their prevention should include a timely correction of eating habits. The data of the study of health-impacting habits of Latvian inhabitants performed by HPSA in 2004 show that women consume fruits and berries more often than men do. Every fourth men and every fifth women have not consumed fruits and berries within the last week. Almost half of women (48%) and only 31% of men have consumed fruits or berries at least three days a week (see Figure 26).

The greatest gender gaps in consumption of fruits and berries are seen in the age group 25-34 (see Table 2 of the Annex).

52% of men and 47% of women have not consumed fresh vegetables during the last week. 60% of women and 54% of men have consumed them at least three days a week (see Figure 26). The greatest gender gaps in consumption of fresh vegetables are seen in the age group 35-44.
Figure 26. Consumption of fruit and vegetables for at least three days during the last week in 2004 by gender (HPSA data)

52% of men and 43% of women have not consumed boiled or stewed vegetables during the last week. 14% of men and 20% of women have consumed them for at least three days (see Figure 26). The greatest gender gaps in consumption of boiled or stewed vegetables are seen at the age of 35-54 (see Table 3 of the Annex).

✓ Sedentary life

During the study of health-impacting habits of Latvian inhabitants performed by Health Promotion State Agency in 2004 respondents were asked about their leisure time activities and the results show that the proportion of men is higher in the group responding “reading and watching TV” (53% of men and 47% of women) and in the group responding “heavy physical training” (5% of men and 1% of women).
The proportion of women is higher in the group of respondents who mentioned health-friendlier activities: 30% of men and 36% of women prefer walking or cycling in their leisure time; 12% of men and 16% of women choose jogging and other sports activities (see Figure 27).

✓ Alcohol and drug consumption

Excessive alcohol and drug consumption has a negative physical, psychic and social impact on the individual and his/her family and the society in general.

Indicators characterizing alcohol consumption (mortality, morbidity, amount and frequency of use) are higher in men than in women attesting that this problem is more characteristic of men as it is also in other EU countries.

The results of the study “Health Survey of Latvian Inhabitants” performed by CSB show that 17% of men and 4% of women drink 6 or more glasses of alcohol at a time each month. The greatest gender gap is seen at the age of 25-34 when 12% of men and 1% of women drink 6 or more glasses of alcohol at a time every week.

Data of the study of health-impacting habits of Latvian inhabitants performed by Health Promotion State Agency in 2004 show that the proportion of men who consumed 5 or more glasses of alcohol during the last week is four times higher than the proportion of women (20% of men and 5% of women).

Health problems caused by alcohol (e.g., addiction, alcohol psychoses) affect more men than women (20% — women, 80% — men).

The statistical data show that alcohol-related problems are also topical among young people — in 2005, 430 minors were firstly registered.
with acute alcohol intoxication or excessive alcohol consumption, and the youngest patient was 9 years old. 74% of children and teenagers with firstly registered addiction diagnosis, intoxication or excessive consumption were boys, and 26% were girls.

Prevalence of men among drug consumers is also higher. In the EU Member States men not only use illegal drugs more often, they also more often have health problems, they seek medical aid more frequently and also die more often as a result of drug consumption.

In accordance with data obtained from State Narcology Agency, 79% of all death cases related to drug consumption in Latvia in 2004 were among men, and 21% — among women, and their average age was only 29 years. Thus, drug problems mainly affect young people this way not only increasing mortality, but also potential years of life lost and decreasing life expectancy.

In 2005, 71% of firstly registered patients with drug and psychotropic substance addiction were men and 29% — women (SNA data).

Another factor that may influence the health of population is prophylactic examinations and timely visits to doctor in case of health problems. The above-mentioned data show that measuring of cholesterol level and blood pressure is more widespread among women than among men.

Indicators characterizing visits to doctors during the last year show that proportion of men having attending a doctor (16%) is almost two times smaller than the proportion of women (29%). The attendance of a physician is also influenced by the availability of health care; however, claims on restricted availability are more often received from women than from men. The study on human capability in the regions (2005) has ascertained that 29% of men and 41% women had no sufficient financial resources to visit a doctor during the last year. It means that women care more about their health, visit doctors more often and face problems of health care availability.

Some of the above-mentioned factors affect not only the development of noncommunicable diseases, but are also related to mortality caused by other causes. Drug and alcohol consumption not only causes several chronic diseases (e.g., addiction, atrophic cirrhosis, psychoses) that are often a cause of mortality, but also causes part of traffic
accidents, drowning, freezing, suicides etc. Mortality due to these causes is more frequent among men. For instance, men ten times more often than women have been involved in traffic accidents under alcohol intoxication in 2005. Thus, alcohol is one of the substantial risk factors decreasing life expectancy by impacting the increase of male mortality.

With regard to mortality due to traffic accidents, the fact that men more often cause serious traffic accidents, including accidents under alcohol intoxication, and also use such safety means as seat belts less frequently should be mentioned as a risk factor. In accordance with the data of the study performed by HPSA, the proportion of women (72.2%) among the respondents who always use safety belts in cars when seated in the front seat is higher than the proportion of men (63.5%).

![Figure 28. Use of car safety belts on the front seat in 2004 by gender (HPSA data)](image)

Unfavourable socioeconomic conditions are related to several above-mentioned risk factors (smoking, eating habits, alcohol and drug consumption).

Place of residence

As life expectancy in Latvia differs in urban and rural areas, a place of residence may also be a substantial determinant. In Latvia, 68% of inhabitants live in towns, and 32% — in rural areas. The greatest concentration of inhabitants is in the capital — almost 30% of the total population and this is related to higher possibilities of employment and
higher wages. In Latvia, a specific problem is great differences in many socioeconomic aspects between towns (mainly Riga) and rural areas.

Place of residence is not only related with socioeconomic condition, but also with lifestyle habits, for instance, the proportion of smoking men in Riga is by 5 percentage points smaller than in rural areas\textsuperscript{10}.

\section*{Education}

Economically active women have a considerably higher level of education than men. In 2004, 26\% of women and only 17\% of men had a higher education, whereas, in 2004 men had a higher percentage indicator of primary school and lower level of education — 18\% (women — 10\%).

Lifestyle habits are often related to the level of education: inhabitants with a higher level of education have healthier lifestyle habits, for instance, the greatest proportion of non-smokers is among inhabitants with higher education. Men in the higher education group have two times smaller proportion of smokers than, for instance, in the secondary special education group. Also, the highest proportion of men regularly consuming fresh vegetables is in the higher education group\textsuperscript{11}.

\section*{Employment}

Comparing the employment level by gender, men are seen to have a higher employment level than women. In 2006, 66\% of men and only 55\% of women were employed.

\section*{Income}

The average income level of men is higher than that of women, because average wage of women for the equally performed work is lower than for men, for instance, in the field of financial brokerage services it is two times lower (see Table 2).
The amount of pension for women and men is different — men have higher both state and age pensions than women. State pension for men is by 13% higher than for women, and age pension — by 16% higher.

Women have a higher poverty risk index than men (17% and 15% respectively in 2003).

Previously analyzed risk factors influence not only the health status of the population of Latvia, but also their life expectancy.
POLICY INITIATIVES

Life expectancy as one of the main public health indicators was stressed in Public Health Strategy approved by the Cabinet of Ministers on March 6, 2001 with the aim to increase average life expectancy at birth in Latvia to at least 95% of the average indicators of the EU Member States (Goal 1). On March 9, 2004, Action Programme for the implementation of Public Health Strategy 2004-2010 was adopted. The basic objective of both documents is to achieve improvement of the health status of the population of Latvia by approaching the best indicators of the European states. The above mentioned Action Programme states only one activity aimed at reaching Goal 1 — “Development of Health Protection Law” by 2004. Unfortunately, the term was postponed and presently the public health field still has no basic law.

All goals set out in the Public Health Strategy, for instance, reduction of the harm caused by alcohol, drugs, psychotropic substances and tobacco, and tasks stipulated by the Action Programme are related to increase of life expectancy. Not only the Ministry of Health, but also many other ministries and subordinate institutions are responsible for the achievement of these goals and implementation of measures. Nevertheless, extra budgetary funds are assigned neither to this nor to many other programmes related to decrease of public health risks. Accordingly, activities may be implemented only partially within the framework of the existing budget.

The gender gaps in life expectancy are stressed in one of the tasks for reaching the Goal of the United Nations Millennium Declaration “To promote equality between women and men” in Latvia — to decrease gender gaps in life expectancy and to approach the average EU indicator.

The Cabinet of Ministers has adopted several policy planning documents in the field of public health defining more than 70 main public health problems, however, short-term and long-term state priorities in the field of public health are not clearly defined. Specific policy activity programmes, i.e., programmes related to improvement of the health status of men, are also missing.

In September 2006, the Ministry of Health established an intersectoral coordination committee with the aim to ensure coordination of the development and implementation of public health policy.
CONCLUSIONS AND RECOMMENDATIONS

Conclusions

✓ Life expectancy in men is shorter than in women. The gender gap in life expectancy in the EU countries is 6 years, but in Latvia it is 11 years.

✓ Life expectancy in Latvia is 8 years shorter than on average in the European Union.

✓ Male mortality due to main causes of death is considerably higher and occurs at an earlier age than in women:
  - mortality due to ischemic heart disease is three times higher in men than in women;
  - mortality due to lung cancer is eight times higher in men than in women;
  - mortality due to external causes is four times higher in men than in women;
  - mortality from suicide is almost five times higher in men than in women;
  - the number of deaths due to traffic accidents is three times higher in men than women.

✓ Men have more unhealthy lifestyle and behaviour habits than women:
  - proportion of men among tobacco, alcohol and drug addicts is higher than the proportion of women;
  - men have more unhealthy eating habits than women;
  - men care less about their health — they visit the doctor less frequently;
  - men have more risky behaviour as traffic participants than women (more frequent violation of rules, more often involved in traffic accidents, including accidents under alcohol intoxication).

✓ Men generally have a lower level of education than women. As unhealthy lifestyle habits are also related to education level, this may possibly increase a risk of health problems in men.
✓ Distribution of many indicators, especially those characterizing socioeconomic factors, by gender are missing.

Recommendations

✓ To facilitate the general public awareness and awareness of health care workers about gender as an important health determining factor.

✓ To implement health promotion and prevention measures with the aim to decrease male mortality, especially due to external causes.

✓ To decrease social inequality between men and women.

✓ To collect and register public health data in distribution by gender.

✓ To update the developed regulatory enactments in the field of public health, for instance, Health Protection Law, Patients’ Rights Law, Law on Psychiatric Aid.

✓ To carry out research to clarify the basic causes for high risk of premature death in Latvian men, for instance, by investigating causes of suicide among young men thus obtaining information for implementing corresponding prevention measures.
COMMENTS ON DATA

The report uses data obtained from the World Health Organization, databases of Central Statistical Bureau available over the Internet, various reports and results of studies as well as information provided by the Health Statistics and Medical Technologies State Agency and other institutions.

Standardized mortality indicators calculated by the World Health Organization were used for comparing mortality data of Latvia and the average EU indicators. Standardized mortality indicators reflect well the general trends by avoiding mistakes in comparisons among states that may be caused by age structure of different populations.

For the analysis of indicators relative indicators were mainly used — per 100,000 inhabitants of relevant age and gender.

In order to characterize gender gaps, in addition to mortality the proportion of deaths in men and women due to main death causes was calculated using data from the Health Statistics and Medical Technologies State Agency.

As life expectancy is influenced not only by high mortality (number of deaths), but also by age at death, premature mortality indicator — potential years of life lost before 65 years of age — was used.

Indicators characterizing lifestyle were mainly analyzed using results of the study of health-impacting habits of Latvian inhabitants (FINBALT) performed by HPSA providing information about adults aged 15-64.

During the analysis of data it was found that data on distribution of socioeconomic factors by gender are missing.
DEFINITIONS

Average life expectancy at birth — the average number of years children born in the relevant year can be expected to live if mortality at the time of birth were to stay the same at each age throughout the child’s life.

Qualitative data — information that may not be expressed in numeric form and is based upon a subjective evaluation of its components.

Quantitative data — information that may be expressed in numeric form and may be measured continuously or after a certain scale.

Body weight index — WHO indicator calculated according to the formula: BWI = Body weight (kg)/ height (m)². The result will be interpreted with the following evaluation:
- <18.5 – insufficient weight,
- 18.5-24.99 – normal weight,
- 25-29.99 – overweight,
- over 30 – obesity.

Poverty risk index — proportion of inhabitants living under relative poverty line.

Cause of death — a disease, pathologic condition or an injury causing or facilitating death, and an accident or act of violence resulting in death.

Noncommunicable diseases — diseases not associated with infectious disease-causing agents and injuries.

Suicide — a targeted action, self-harm with lethal outcome.

Potential years of life lost — years of life a person would have lived before a certain age (in this study — the age of 65) if he or she had not died in an accident, due to a disease or any other cause.

Percentage points — a difference resulting after subtracting one percentage from another percentage.

Relative poverty line — proportion of inhabitants (percentage) whose equivalent income is below the poverty line (i.e., 60% of the equivalent income median or 60% of the average income).

Risk analysis — identification, evaluation and prioritization of risks by dividing them into high, medium and low level risks at the same time providing also their controlling measures.

State pensions — age pension, disability pension, survivor's pension.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSB</td>
<td>Central Statistical Bureau</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>LV</td>
<td>Latvia</td>
</tr>
<tr>
<td>CM</td>
<td>Cabinet of Ministers</td>
</tr>
<tr>
<td>NSA</td>
<td>Narcology State Agency</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>PYLL</td>
<td>potential years of life lost</td>
</tr>
<tr>
<td>PHA</td>
<td>Public Health Agency</td>
</tr>
<tr>
<td>HSMTSA</td>
<td>Health Statistics and Medical Technologies State Agency</td>
</tr>
<tr>
<td>HPSA</td>
<td>Health Promotion State Agency</td>
</tr>
</tbody>
</table>
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**Annexes**

*Figure 1.* Regular female smokers in the European countries in 2004

**Regular daily smokers, 2004**

percentages, ages 15+, females

Source: WHO-IHA

Legend:
- 10.3 - 10.5
- 10.5 - 17.8
- 17.8 - 21.0
- 21.0 - 26.7
- 26.7 - 33.9
- No data
Figure 2. Regular male smokers in the European countries in 2004 (WHO data)

Regular daily smokers, 2004
percentages, ages 15+, males

Table 1. Body weight after evaluation of body mass index in 2004 by gender and age groups (percentage) (HPSA data)

<table>
<thead>
<tr>
<th>Body mass index</th>
<th>Males age groups</th>
<th>Females age groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-24</td>
<td>25-34</td>
</tr>
<tr>
<td>Underweight</td>
<td>8.8</td>
<td>0</td>
</tr>
<tr>
<td>Normal weight</td>
<td>80.8</td>
<td>59.3</td>
</tr>
<tr>
<td>Overweight</td>
<td>8.8</td>
<td>34.1</td>
</tr>
<tr>
<td>Obesity</td>
<td>1.6</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Source: WHO-HFA
### Table 2. Consumption of fruits or berries during the last week in 2004 by gender and age groups (percentage)

(HPSA data)

<table>
<thead>
<tr>
<th>Have you consumed fruits or berries during the last week?</th>
<th>Males age groups</th>
<th>Females age groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-24</td>
<td>25-34</td>
</tr>
<tr>
<td>None</td>
<td>23.2</td>
<td>31.4</td>
</tr>
<tr>
<td>1-2 days</td>
<td>43.5</td>
<td>47.1</td>
</tr>
<tr>
<td>3-5 days</td>
<td>23.7</td>
<td>17.4</td>
</tr>
<tr>
<td>6-7 days</td>
<td>9.6</td>
<td>4.1</td>
</tr>
</tbody>
</table>

### Table 3. Consumption of boiled or stewed vegetables during the last week in 2004 by gender and age groups (percentage)

(HPSA data)

<table>
<thead>
<tr>
<th>Have you consumed boiled or stewed vegetables during the last week?</th>
<th>Males age groups</th>
<th>Females age groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-24</td>
<td>25-34</td>
</tr>
<tr>
<td>None</td>
<td>62.9</td>
<td>52.5</td>
</tr>
<tr>
<td>1-2 days</td>
<td>26.4</td>
<td>33.9</td>
</tr>
<tr>
<td>3-5 days</td>
<td>8.4</td>
<td>10.2</td>
</tr>
<tr>
<td>6-7 days</td>
<td>2.2</td>
<td>3.4</td>
</tr>
</tbody>
</table>
Table 4. Types of leisure time activities in 2004 by gender and age groups (percentage)

(HPSA data)

<table>
<thead>
<tr>
<th>Which of the following activities describes best your leisure time activities?</th>
<th>Males age groups</th>
<th>Females age groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-24</td>
<td>25-34</td>
</tr>
<tr>
<td>Reading, watching TV</td>
<td>34.7</td>
<td>55.1</td>
</tr>
<tr>
<td>Walking, riding a bicycle</td>
<td>42.6</td>
<td>30.9</td>
</tr>
<tr>
<td>Jogging and other types of physical training</td>
<td>10.5</td>
<td>8.8</td>
</tr>
<tr>
<td>Hard physical training</td>
<td>12.1</td>
<td>5.1</td>
</tr>
</tbody>
</table>

Table 5. Alcohol consumption in 2004 by gender and age groups (percentage)

(HPSA data)

<table>
<thead>
<tr>
<th>How often do you drink 6 or more glasses of alcohol at a time?</th>
<th>Males age groups</th>
<th>Females age groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-24</td>
<td>25-34</td>
</tr>
<tr>
<td>Every day or almost every day</td>
<td>0.4</td>
<td>0.6</td>
</tr>
<tr>
<td>Every week</td>
<td>6.7</td>
<td>11.7</td>
</tr>
<tr>
<td>Every month</td>
<td>14.7</td>
<td>21.5</td>
</tr>
<tr>
<td>Less than once a month</td>
<td>30.7</td>
<td>40.6</td>
</tr>
<tr>
<td>Never</td>
<td>47.5</td>
<td>25.6</td>
</tr>
</tbody>
</table>