

HEALTH, FOOD AND ALCOHOL AND SAFETY

Fieldwork: January-February 2003

Publication: December 2003

This survey was requested by Directorate General Health and Consumer Protection and coordinated by Directorate General Press and Communication

This document does not represent the point of view of the European Commission.
The interpretations and opinions contained in it are solely those of the authors.

This opinion poll has been carried out at the request of the Directorate-General Health and Consumer Protection, managed and organised by the Directorate-General Press and Communication ('Public Opinion Analysis' Sector).

It was carried out between 15th January and 19th February 2003, in all European Union countries, on behalf of the European Opinion Research Group (EORG: a consortium of market research and public opinion agencies, made out of INRA in Belgium – I.C.O. and GfK Ad Hoc Worldwide).

The questionnaire, technical specifications and names of the agencies associated with this research are all shown in appendix.

This report is in no way binding upon the European Commission.

This report was originally written in English.

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Summary

- Nearly one-quarter of Europeans suffer some form of rheumatism or arthritis, while nearly one-fifth suffer from allergies, and just about 16% suffer from hypertension.
- Decreasing income is related to increasing incidence of rheumatism/arthritis, hypertension and diabetes. More women than men suffer chronic illness.
- Inhabitants of Luxembourg, former East Germans and Austrians have seen doctors the most in the previous year, and Portuguese, Greeks and Irish the least.
- About one-quarter of all Europeans are under long-term treatment; the major causes of treatment are rheumatism/arthritis (20.4%), hypertension (15.5%) or diabetes (13.1%). Diabetes is more common among those with less education, while depression most affects those with more education.
- Nearly one-third of Europeans are not missing any teeth, while just seven per cent are missing all of their teeth. The plurality of Europeans, 39 per cent, are missing 1 to 5 teeth, while just about ten per cent each are missing 6 to 10, more than 10 (but not all) and all. The Nordic countries have the best dental health.
- While all Europeans are 'fairly satisfied' with their teeth or dentures, the Danes, Irish and inhabitants of Luxembourg are the most so, and Italians, Spanish and Portuguese the least so. Satisfaction has risen slightly since 1996.
- The most common health check in the EU is a dental check, with nearly two-thirds of Europeans having had one in the previous year; southern Europeans have had dental check-ups least of all. Tests have increased slightly since 1996. Persons with the lowest income most often had tests which were ordered by a doctor, whereas higher income persons most often undertook the tests on their own initiative.
- Women overall feel more informed about Hormone Replacement Therapy than they did in 1996 (an increase from 2.13 to 2.30, on a scale where 2 is 'not very well informed' and 3 'well informed').

- The most common health test for women is the pap smear, or test for cervical cancer, which just under one-third of women have had in the previous year. Slightly over forty per cent of European women have had no tests. Except for an osteoporosis test, in all cases, higher income women had tests more often than did lower income women. Tests have decreased since 1996 and 1997.
- Just over sixty per cent (60.9%) of European women who had children breastfed all of them, with Irish women doing so at a rate of just 21.3%, but Finland at a rate of 92.2 per cent.
- In the European Union as a whole, between 1996 and 2002, average weight increased by nearly two per cent (1.68%), but overall height increased only by 0.05 per cent.
- Overall, Europeans assess their weight at slightly more than it should be, with a score of 2.35, on a scale of 2=about right and 3=too high. Self-assessment is linked to overall weight, and not to weight gain since 1996.
- Europeans believe their eating habits are 'fairly good', while one-third has changed their eating or drinking habits in the previous three years. The four most important changes were eating more fruits and vegetables, eating less fat, drinking more water and eating fewer calories. The Nordics changed their habits the most, and Austria, Spain and Portugal the least.
- One-third of Europeans who made changes did so to stay healthy, another third did so to lose weight and just under one-fifth did so because of a disease or health problem.
- Some 61.0% of Europeans had drunk alcohol in the previous month, with Denmark, Sweden and Luxembourg having done so the most, and Italy, Portugal and Spain the least. Of those who drank, Portuguese, Italians and Spaniards did so the most, measured by days on which alcohol was drunk. Finland, Sweden and Ireland drank on the fewest number of days. Ireland, Finland and Denmark rank at the top in terms of number of drinks consumed on one day, while Portugal, Austria and Italy rank at the bottom.
- Approximately even percentages of Europeans drink only when eating, mainly when eating, mainly when not eating and only when not eating. The younger drink more often without meals, the older do so with meals.

- Europeans, on average, drank at least one bottle of wine, five bottles/pints of beer or 5 measures of spirits 1.49 times in the past month, with Italians doing so the least and Finns doing so the most. Europeans on average believe they drank too much in the previous month on 0.43 times, with Italy at the bottom and Ireland at the top.
- Europeans began to drink at about 14 and a half. Those who are younger now started drinking earlier than those who are now older, indicating that the age of starting to drink has been decreasing.
- Europeans agree fairly strongly that manufacturers have to be responsible concerning children's safety and manufacturing. House persons most agree most strongly, and managers the least.
- Nearly all Europeans (89.9%) wear seatbelts in the car, but there are considerable national differences, with just 74.3% of Italians doing so, but 95.5% of the French and the Swedes doing so. Just 9.2% of Europeans wear a helmet when bicycling. Those with higher income and more education are more likely to take steps to protect their personal safety.
- About one-quarter of Europeans (24.2%) regularly look after children under the age of ten, with persons aged 25-39 doing so the most.
- There is a wide range in terms of children's safety, with 89.8% of Germans putting children in car seats, but just 47.8% of Greeks doing so. Greeks, on the other hand, most often remain with a child in the bath (81.6%), but just 56.3% of Finns do so.

1. Introduction

Illness, maintenance of health and steps taken to avoid injury and to protect children are the core issues addressed in this report. This set of questions from Eurobarometer 59.0 (Winter 2002/2003) addresses incidence of chronic illness, long-term treatment, dental health and, in more depth, health maintenance by discussing doctor's visits and various screening tests. Women's health – and medical tests relating specifically to women's health – are also addressed in some depth. Safety and children's safety are also examined in detail. While some aspects of health and safety are fairly uniform across Europe and across socio-demographic groups, others show notable differences and are described here.

2. Illness and Health Maintenance in the European Union

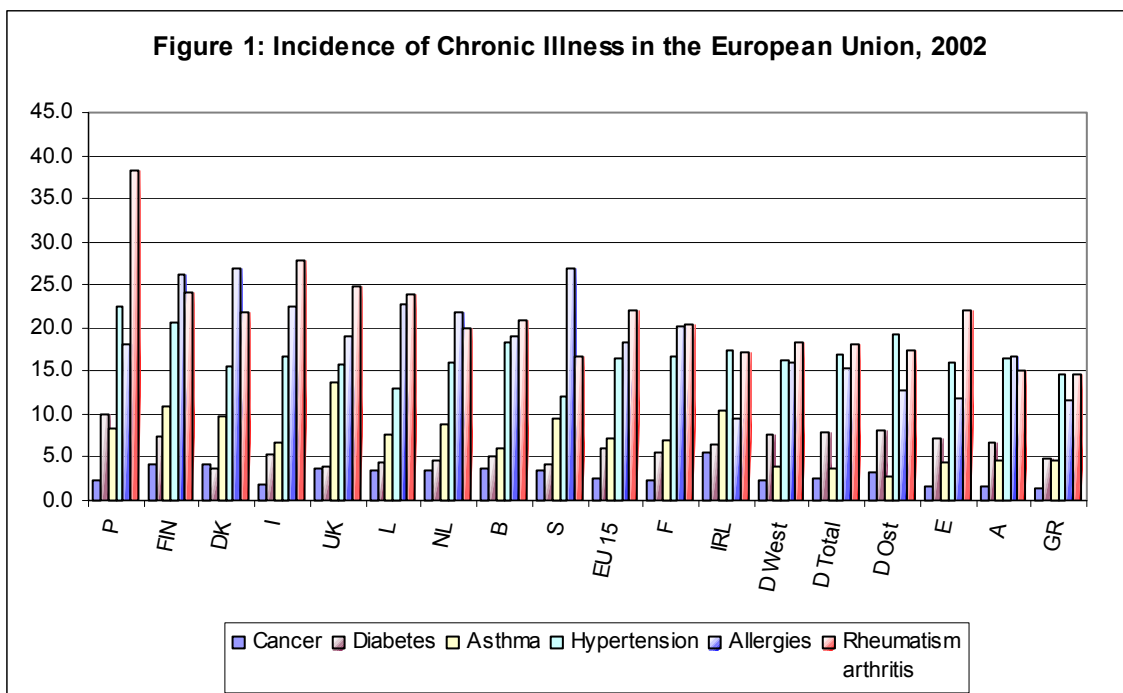
2.1. Chronic Illness

The data available here reflect the incidence of chronic illness of Europeans. The incidence of rheumatism/arthritis, allergies, high blood pressure (hypertension), asthma, diabetes and cancer is, overall in Europe, 22.1 per cent, 18.3 per cent, 16.5 per cent, 7.2 per cent, 6.0 per cent and 2.6 per cent, respectively (see Table 1, Figure 1). The incidence of these chronic illnesses varies strongly from one country to another, with, for instance, 38.2% of Portuguese having rheumatism or arthritis, but just 14.7% of Greeks having the same, illustrating that regional trends are not always present. Indeed, for the other chronic illnesses addressed here, there are likewise no regional trends. Some previous reports have suggested that cardiovascular disease may strike Southern Europeans less,¹ but a similar trend is not discernible with respect to the illnesses discussed here.

¹ With respect to Europeans under long-term treatment (25.8% of all Europeans), the Italians (9.9%), French (9.7%) and Portuguese (9.5%) are all below the EU average (11.7%) for treatment for cardiovascular disease, while the Spanish (13.6%) are above the EU average.

Table 1: Incidence of Chronic Illness in the European on, 2002

	Rheumatism, arthritis	Allergies	Hypertension	Asthma	Diabetes	Cancer
P	38.2	18.1	22.4	8.3	10.0	2.4
FIN	24.1	26.3	20.7	11.0	7.4	4.1
DK	21.8	26.9	15.5	9.8	3.7	4.2
I	27.9	22.6	16.7	6.7	5.4	1.9
UK	24.8	19.1	15.7	13.8	4.0	3.6
L	24.0	22.7	13.0	7.6	4.3	3.5
NL	19.9	21.7	15.9	8.7	4.6	3.4
B	20.9	19.1	18.3	6.1	5.1	3.6
S	16.6	26.9	12.1	9.6	4.1	3.4
EU 15	22.1	18.3	16.5	7.2	6.0	2.6
F	20.3	20.1	16.7	6.9	5.6	2.4
IRL	17.1	9.5	17.3	10.5	6.5	5.5
D West	18.3	16.1	16.2	4.0	7.7	2.3
D Total	18.1	15.4	16.9	3.7	7.8	2.5
D Ost	17.5	12.7	19.3	2.7	8.2	3.2
E	22.1	11.8	15.9	4.4	7.2	1.7
A	15.1	16.7	16.4	4.6	6.7	1.6
GR	14.7	11.7	14.6	4.7	4.9	1.4

Figure 1: Incidence of Chronic Illness in the European Union, 2002

The Portuguese, Finns and Danes have the highest incidence of chronic illness overall in Europe. In terms of individual illnesses, the Portuguese have the highest incidence of rheumatism and arthritis (38.2%), diabetes (10.0%) and hypertension (22.4%) in Europe, but are below the EU average for incidence of cancer and allergies. Finland is the only EU state which has a higher incidence of chronic illness than the EU average for all illnesses. Sweden has the highest incidence of allergies, with 26.9 per cent, while Ireland, with 5.5 per cent, has the highest incidence of cancer and the UK, at 13.8 per cent, the highest rate for asthma. The incidence of cancer (2.6 per cent overall, with a range from 1.4 per cent to 5.5 per cent) seems surprisingly low, although it must be noted that, in contrast to the other illnesses discussed here, cancer has the highest mortality rate, resulting in fewer survivors able to report that they have had cancer. Greece has the lowest incidence of cancer and rheumatism, while Germany has the lowest rate of asthma (there is quite a difference between the former East and the former West Germany, with East Germany having a 2.7 per cent incidence and West Germany a 4.0 per cent incidence).² Denmark has the lowest rate of diabetes with 3.7 per cent.

2.2. Long-Term Treatment

Denmark, Portugal and the United Kingdom have the highest percentage of people undergoing long-term treatment, with 31.5%, 31.3% and 31.0%, respectively, in comparison to the EU average of 25.8 per cent. Sweden (21.9%), Ireland (19.9%) and Austria (14.5%) have the lowest incidence of long-term treatment among Europeans (see Table 2). Rheumatism, hypertension and cardiovascular disease are the top three causes for long-term treatment in the European Union (although, strictly speaking, 'Other reason' is the second-most common reason for long-term treatment). There is some variation, however, with other illnesses being the top three for various countries. Leaving 'other' aside, the top three causes of long-term treatment are rheumatism/arthritis (except in Finland), hypertension (except the Netherlands, Germany and Austria) and either cardio-vascular disease (in 8 cases) or diabetes (in 8 cases). In Finland and Ireland, asthma is the third cause of long-term treatment, while in Denmark, depression and allergies are the second and third causes.

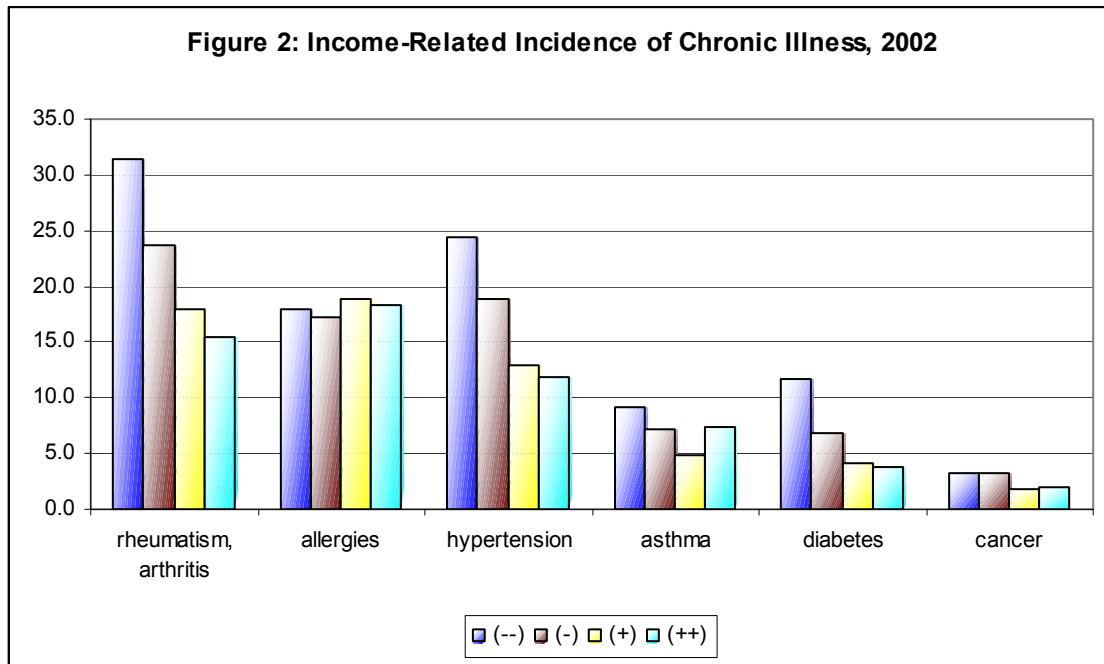
² The Eurobarometer data includes three data points for Germany: the former East Germany, the former West Germany and Germany overall. In a number of cases, there is a difference between the two, in which case the difference will be noted.

Table 2: Europeans Undergoing Long-Term Treatment, 2002

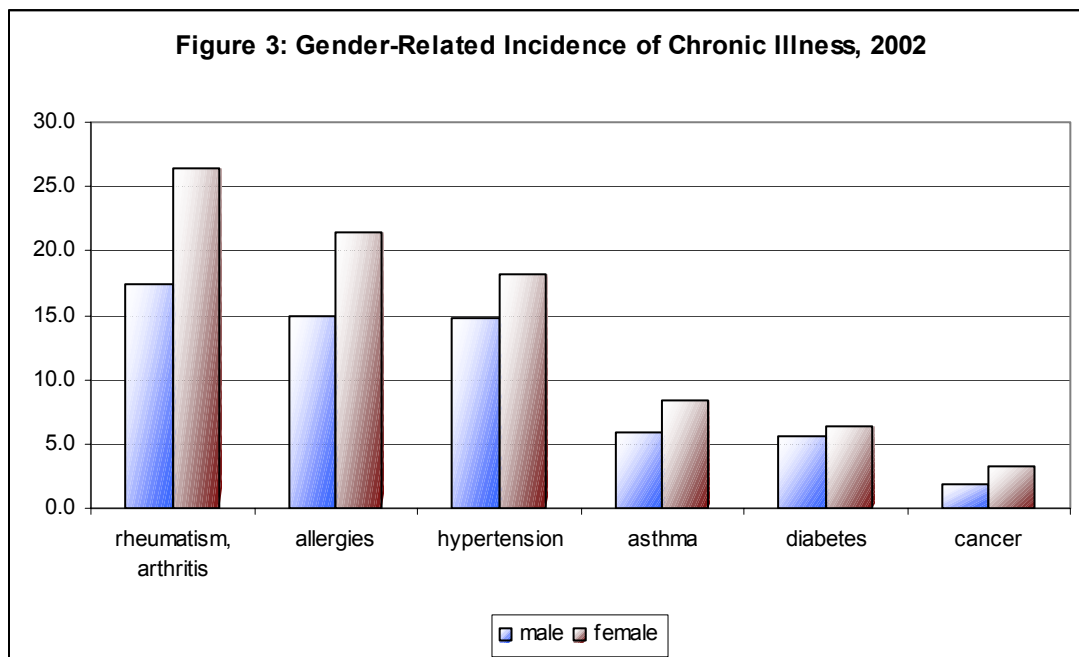
	% in long-term treatment	Rheumatism, arthritis	Other	Hypertension	Diabetes	Cardiovascular disease	Depression	Asthma	Allergy	Cancer	Physical Disability	Chronic Skin Disease	AIDS/HIV
DK	31.5	25.6	23.3	6.5	5.1	6.9	7.6	2.8	7.3	6.8	2.6	2.6	0.0
P	31.3	23.5	15.5	19.9	14.5	9.5	7.3	3.4	3.5	2.9	0.0	0.0	0.0
UK	31.0	27.3	16.9	14.6	9.1	8.6	6.1	9.0	1.6	2.9	1.8	0.0	0.0
FIN	29.0	8.6	10.9	22.3	8.0	11.1	7.0	9.5	2.6	1.5	0.4	0.9	0.0
NL	28.6	19.7	20.9	10.1	12.8	12.2	6.9	4.9	4.7	3.1	2.7	0.6	0.4
F	28.4	14.3	22.5	19.2	12.0	9.7	6.8	2.7	5.2	3.1	1.1	0.7	0.3
D Ost	27.5	19.8	8.7	13.7	15.7	17.9	3.1	1.3	6.4	6.8	1.4	0.9	0.0
EU 15	25.8	20.4	16.5	15.5	13.1	11.7	5.3	4.7	4.6	3.2	1.3	0.5	0.1
GR	25.6	13.1	21.3	23.5	11.7	16.3	2.3	2.7	3.1	3.1	0.0	0.5	0.0
E	25.4	22.9	11.4	15.5	16.5	13.6	7.7	4.3	4.9	1.5	0.4	0.6	0.0
L	24.8	20.9	28.6	9.3	5.8	18.6	1.3	4.4	4.5	2.9	1.4	1.5	0.0
D Total	23.2	20.8	6.4	9.3	17.7	16.5	3.9	3.2	7.1	4.9	2.3	0.6	0.0
B	23.0	17.2	20.5	16.1	12.8	13.4	3.4	4.8	4.4	4.3	0.9	0.7	0.0
I	23.0	16.9	25.8	21.0	12.8	9.9	2.2	2.8	4.8	2.2	0.0	0.5	0.0
D West	22.0	21.2	5.6	7.8	18.4	16.0	4.2	3.9	7.3	4.2	2.7	0.5	0.0
S	21.9	21.6	16.9	16.4	8.3	11.6	9.2	5.5	4.3	2.3	0.0	3.4	0.0
IRL	19.9	22.5	9.8	23.8	9.2	7.7	4.1	13.2	2.8	3.7	0.0	0.4	0.0
A	14.5	21.8	8.8	13.7	16.3	15.1	2.5	4.9	7.1	5.2	2.4	0.6	0.6

Socio-demographic profiles

Looking at the incidence of chronic illness from a socio-demographic, rather than a national, perspective, certain patterns emerge. Increasing number of years of education are linked to decreased incidence of illness in the case of rheumatism/arthritis (39% of those who studied up to 15 years of age suffer from rheumatism, compared to 18.3% of those who studied up to 16-19 years of age, 15.2% of those who left school at age of 20+ and 6.2% of those still studying), hypertension (29.6% of those who studied up to 15 years of age, 13.9% 16-19 years of age, 11.6% 20+ years of age and 1.7% of those still studying), to some extent diabetes (11.5% of those who studied up to 15 years of age, 4.4% 16-19 years of age, 4.7% 20+ and 0.7% of those still studying) and, somewhat less so, to cancer. The incidence of allergies and asthma do not appear to have any link to education level. Income level is a strong predictor for diabetes, hypertension, rheumatism/arthritis and a somewhat less strong predictor for cancer. Incidence of these illnesses clearly increases as income decreases (see Figure 2). Allergies and asthma seem to affect people relatively evenly, independent (particularly in the case of allergies) of income level.



Occupation likewise has a relation to incidence of the same illnesses, while it must be noted that age, income level and education all are included in occupation. In general, the higher level occupations have lower levels of illness. Age plays a role as well, with increasing incidence of all illnesses, except allergies and asthma, which are more or less even across age, occurring with increasing age. Finally, with respect to gender, in every case, women have a higher incidence of chronic illness than men (see Figure 3). Women likewise are more likely to undergo a long-term treatment, with nearly one-third (30.3%) answering positively, in contrast to just one-fifth of men (21.0%).



For those Europeans who are in long-term treatment, age, education and income are again, in addition to gender, strong predictors for being in long-term treatment. Just 10.1% of 15-24 year-olds are in long-term treatment, in comparison with 48.1% of those over 55 years. There is a steady upward progression through the age categories. Likewise, 40.2% of those who studied up to 15 years of age are in long-term treatment, as compared to 21.4% of those who studied 20 or more years of age. Some 36.9% of those in the lowest income category are in long-term treatment, as compared to 19.7% of those in the highest.

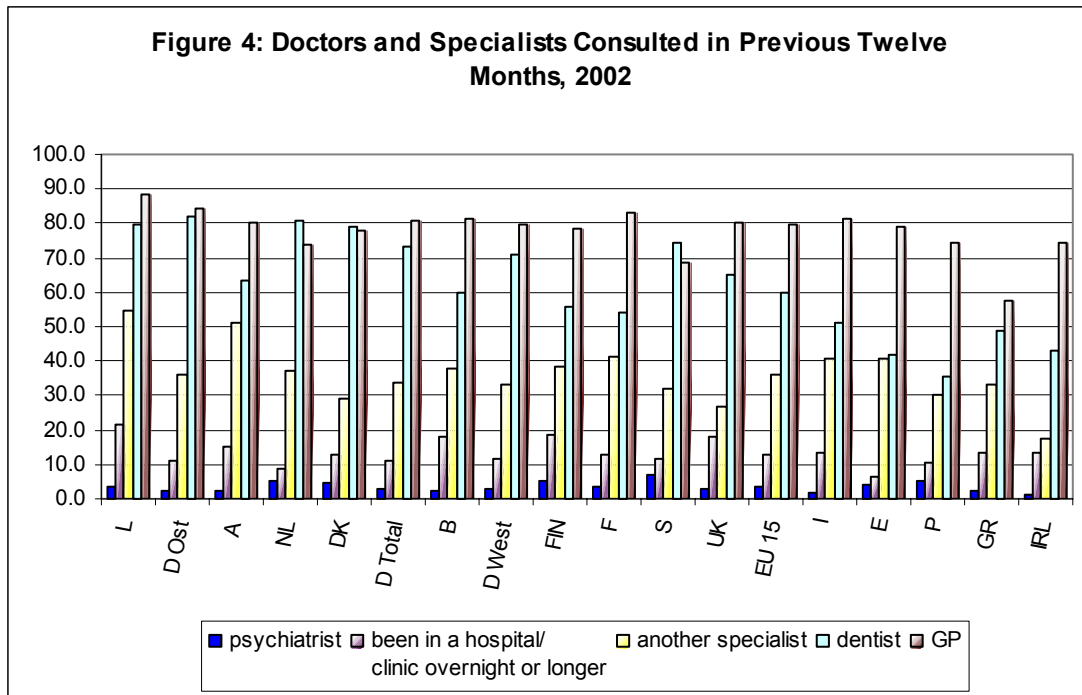
Age, education and income continue to play a role in some of the diseases in long-term treatment, with a positive correlation between age and cardiovascular disease, diabetes and hypertension, and a negative correlation between age and allergies and asthma. Cancer and depression are not age-related. Cardiovascular disease, diabetes, rheumatism/arthritis and hypertension strike those with less education more often, while depression most often affects those who have more education. Those with the lowest income are most often affected by cardiovascular disease and diabetes, while depression affects those with the highest income. Again, there is a steady progression through all categories.

2.3. Visits to Doctors

With all visits to doctors taken together, the inhabitants of Luxembourg, East Germans and Austrians have seen doctors the most in the preceding twelve months. Below the EU average are Italians, Spaniards, Portuguese, Greeks and the Irish, who have seen doctors the least. There is a clear regional bias, with all southern European countries below the EU average – with the addition of Ireland at the very bottom. Ireland has the lowest rate (17.5%) of having seen another specialist, while the southern Europeans have the lowest rates across Europe of visiting dentists.

Over three-quarters (79.5%) of all Europeans have been to a family doctor/general practitioner in the last twelve months (see Figure 4), with a low of 57.6% of Greeks having done so, and a high of 88.5% Luxembourgers having done so. In terms of regional variation, Italians rank above the EU average, while Spaniards and Portuguese join the Greeks below the EU average. The Nordics (Finland, Denmark and Sweden) are all below the EU average with 78.5%, 77.9% and 68.5%, respectively. The Nordics are, however, all above the EU average of 3.2% with respect to psychiatrists; 6.8% of Swedes and 5.2% of Finns have visited a psychiatrist in the last twelve months, as have, in fifth place after the Netherlands and Portugal, 4.6% of Danes. The Greeks (2.2%), Italians (1.9%) and Irish (1.2%) have seen psychiatrists the least.

As noted above, southern Europeans have only rarely seen dentists (Italy 51.3%, Spain 41.7%, Portugal 35.5% and Greece 48.6%), while East Germany (82.2%, compared to West Germany's 70.9%), the Netherlands (81.0%) and Luxembourg (79.7%) have seen dentists the most.



In comparison to 1999, there has been very little change overall in the European Union terms of visits to doctors (see Table 3); while, in 1999, 78.3% of Europeans had visited a general practitioner, in 2002 the figure was 79.5%. For dentists' visits, some 57.0% of Europeans had visited dentists in the previous twelve months, while in 2002, 60.1% had done so. The percentage of Europeans visiting other specialists or spending the night in a clinic or hospital declined slightly, from 38.7% to 35.9% and from 13.5% to 12.8%, respectively. There have been, however, some notable changes on the national level. Some 79.2% of Spaniards, in contrast to 71.0% in 1999, had visited a GP, while the percentage of Swedes visiting a doctor rose from 59.8% to 68.5 per cent. Dentists' visits have decreased in France and Portugal, but have increased in Germany, Spain, Luxembourg, the Netherlands and Austria. Visits to specialists have decreased widely, although it must be noted that the 1999 data do not include visits to psychiatrists. The overall drop in visits to "other specialists" from 1999 to 2002 was 2.8%, and 3.2% of Europeans visited psychiatrists in 2002, indicating that approximately the same percentage may have visited psychiatrists in 1999 as in 2002. Visits overnight in clinics have gone up in some cases and down in others (see Table 3).

Table 3: Visits to Doctors 1999 and 2002

	GP 1999	dentist 1999	another specialist 1999	been in a hospital/ clinic overnight or longer 1999	GP 2002	dentist 2002	psychiatrist 2002	another specialist 2002	been in a hospital/ clinic overnight or longer 2002
L	83.4	73.9	54.0	19.7	88.5	79.7	3.6	54.9	21.3
D Ost	81.2	77.3	34.2	10.8	84.5	82.2	2.4	36.3	11.2
A	79.3	54.3	47.8	15.6	80.2	63.3	2.6	50.9	15.4
NL	71.0	75.6	39.2	8.6	74.0	81.0	5.1	37.3	8.6
DK	74.0	78.6	30.6	14.0	77.9	79.3	4.6	29.1	12.8
D Total	83.5	67.8	34.5	11.3	80.7	73.3	2.8	33.8	11.3
B	85.1	55.4	44.8	16.1	81.5	59.7	2.3	37.7	17.8
D West	84.1	65.3	34.6	11.5	79.7	70.9	2.9	33.1	11.4
FIN	75.9	52.5	36.7	18.3	78.5	55.7	5.2	38.6	18.4
F	85.4	60.1	46.0	17.3	83.2	54.0	3.7	41.1	13.0
S	59.8	69.3	28.0	13.3	68.5	74.7	6.8	32.1	11.8
UK	75.0	64.6	32.0	16.0	80.4	65.0	3.0	27.0	18.0
EU 15	78.3	57.0	38.7	13.5	79.5	60.1	3.2	35.9	12.8
I	81.7	46.5	42.3	13.0	81.4	51.3	1.9	40.6	13.4
E	71.0	33.0	44.1	10.0	79.2	41.7	3.9	40.9	6.6
P	74.8	38.8	39.7	14.2	74.7	35.5	5.0	30.3	10.4
GR	52.6	45.2	30.4	11.5	57.6	48.6	2.2	33.1	13.1
IRL	74.1	40.1	23.6	16.3	74.3	43.1	1.2	17.5	13.2

Socio-demographic profiles

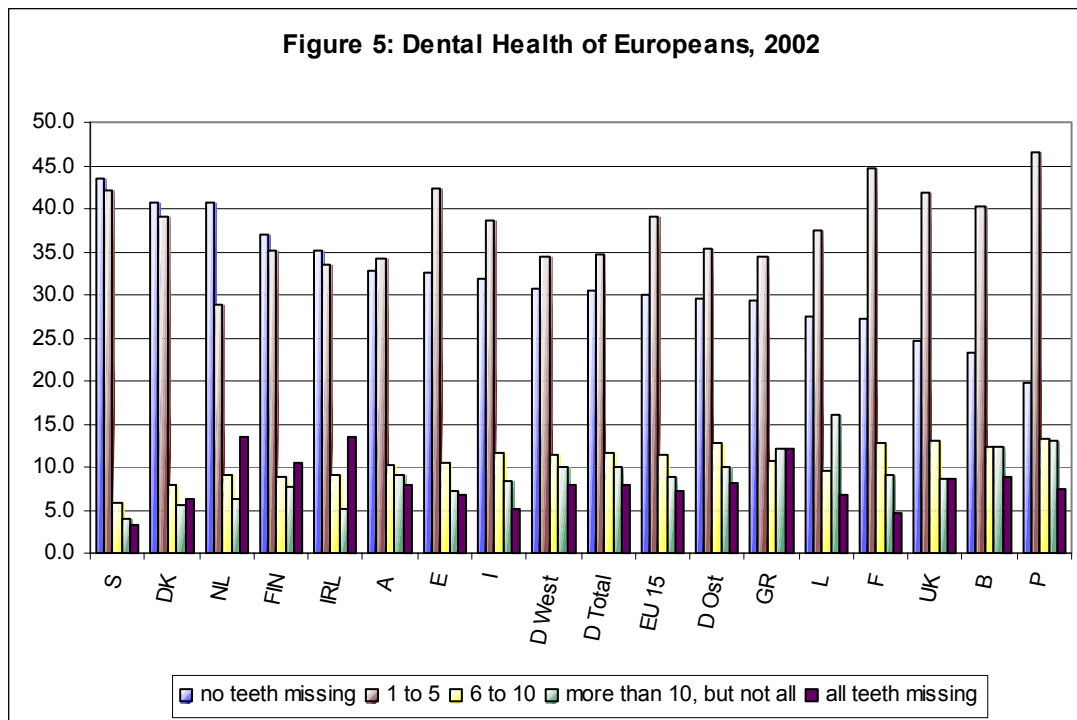
Income and education play a role in terms of doctors' visits (see Table 4). Those with less education and/or income were more likely to visit a general practitioner or to have been in a clinic or hospital at least overnight in the previous twelve months, but less likely to visit a dentist. Those with less education were less likely to visit a psychiatrist, whereas those with less income were more likely to do so. In every case, women again visited doctors more often than did men. Age likewise plays a role, with older people going to doctors more often – with the exception of psychiatrists, which were visited slightly more often by younger people (4.0% of those aged 15-24, 3.6% of those aged 25-29 and 40-54, but only 2.2% of those aged over 55), and of dentists, which were visited fairly evenly by all age groups (range 61.6% to 64.6%), except for those over 55 (53.6%).

Table 4: Doctors' Visits by Income and Education, 2002

	(--)	(-)	(+)	(++)	to	16-	20	still studying
GP	82.	82.	78.	76.	85.	78.	76.	73.
dentist	51.	58.	65.	69.	47.	63.	67.	64.
psychiatrist	4.0	3.3	2.4	3.1	2.5	3.2	3.7	4.2
another specialist	36.	35.	37.	37.	38.	34.	38.	29.

2.4. Dental Health

The Nordic countries have the best dental health in the European Union, with around forty per cent of Swedes, Danes and Finns (as well as Dutch) missing no teeth, in comparison to an EU average of thirty per cent missing no teeth (see Figure 5). While the Dutch have quite a high percentage of persons missing no teeth, they also are tied with Ireland for the highest rate (13.6%) in the EU of people missing all of their teeth.



When dental health, visits to dentists and dental check-ups are compared, there does not appear to be any connection between dental health and recent visits to the dentist; indeed, visits to the dentist could either be preventative or curative. In terms of satisfaction with their teeth, false teeth or dentures, the Danes, Irish and Luxembourgers are the most satisfied (with scores of 4.44, 4.32 and 4.21 respectively)³ and the Italians, Spanish and Portuguese are the least satisfied (with scores of 3.82, 3.75 and 3.65, respectively). The Greeks are fourth from the bottom, at 3.92, showing a clear regional bias. The EU average is 4.01, or just very slightly above "fairly satisfied". There does not appear to be a correspondence between number of missing teeth and satisfaction, indicating that false teeth or dentures inspire satisfaction in their wearers.

³ On a scale of 5=very satisfied, 4=fairly satisfied, 3=neither satisfied nor dissatisfied, 2=fairly dissatisfied and 1=very dissatisfied.

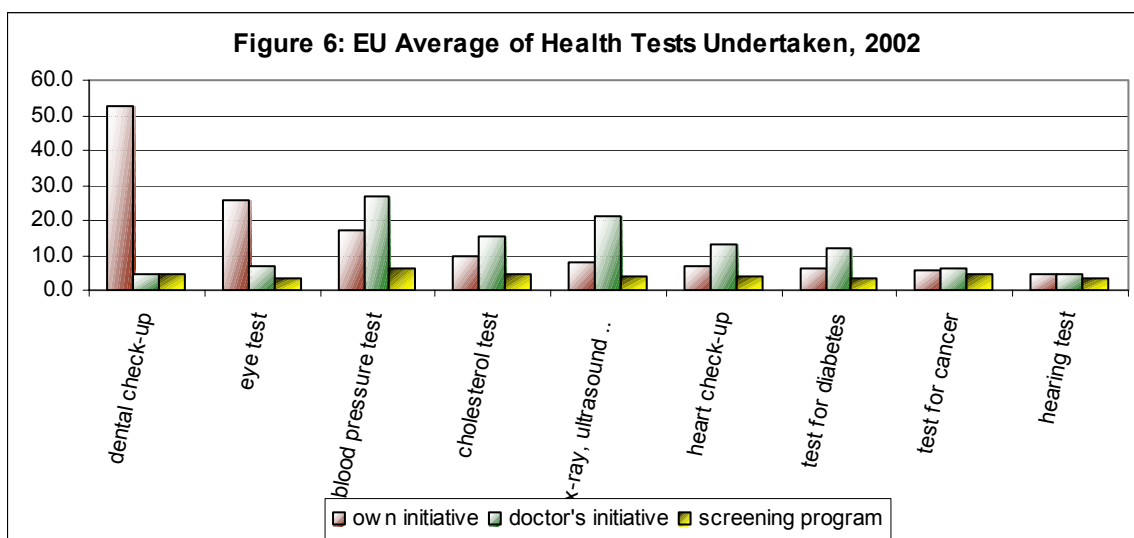
Overall, satisfaction in teeth or dentures has risen slightly since 1996, when the average satisfaction was 3.95, or just below "fairly satisfied". Dentists' visits have risen slightly since 1999, when 57.1% of the population had been to a dentist in the previous twelve months, as compared to 60.1% in 2002, indicating that there may be a connection between dentists' visits and satisfaction.

Socio-demographic profiles

There is clearly a correspondence between age and number of teeth missing; as age increases, the number of teeth missing increases. Education and income likewise play a role, with increasing education and increasing income corresponding to fewer missing teeth. Satisfaction with teeth or dentures, while not noticeably linked to dentist visits or check-ups, is, however, linked to age, education and income, with the younger (those aged 15-24 rank their satisfaction at 4.28, those over 55 at 3.83), better educated (education of up to 15 years of age 3.78; education of up to 20 years of age or more, 4.37) and those with higher income more satisfied with their teeth (lowest income 3.84, highest income 4.15).

2.5. Health Checks

The most common health check undertaken in the European Union is a dental check-up (61.4% in total), followed by a blood pressure test (49.9%) and then by an eye test (35.8%) (see Figure 6). The least common is a hearing test, with just 12.4% of EU citizens having had a hearing test in the previous twelve months. There are significant differences as to whether Europeans arranged the check-up themselves, whether a doctor ordered the test or whether it was part of a screening programme. Dental check-ups are, for the most part, undertaken by individuals on their own initiative – indicating that the habit of having a dental check-up once a year has been well accepted by the EU population. X-rays and other scans, cholesterol tests, heart check-ups and blood pressure tests are much more commonly undertaken on a doctor's initiative. Screening programmes do not appear to play, overall, as significant a role as one's own or a doctor's initiative although. The top three tests undertaken on one's own initiative are a dental check-up, eye test and blood pressure test. The top three undertaken on a doctor's initiative are blood pressure test, x-ray, ultrasound or other scan and cholesterol test. Blood pressure tests, tests for cancer and, once again, for dental health are the three most common tests through a screening programme.



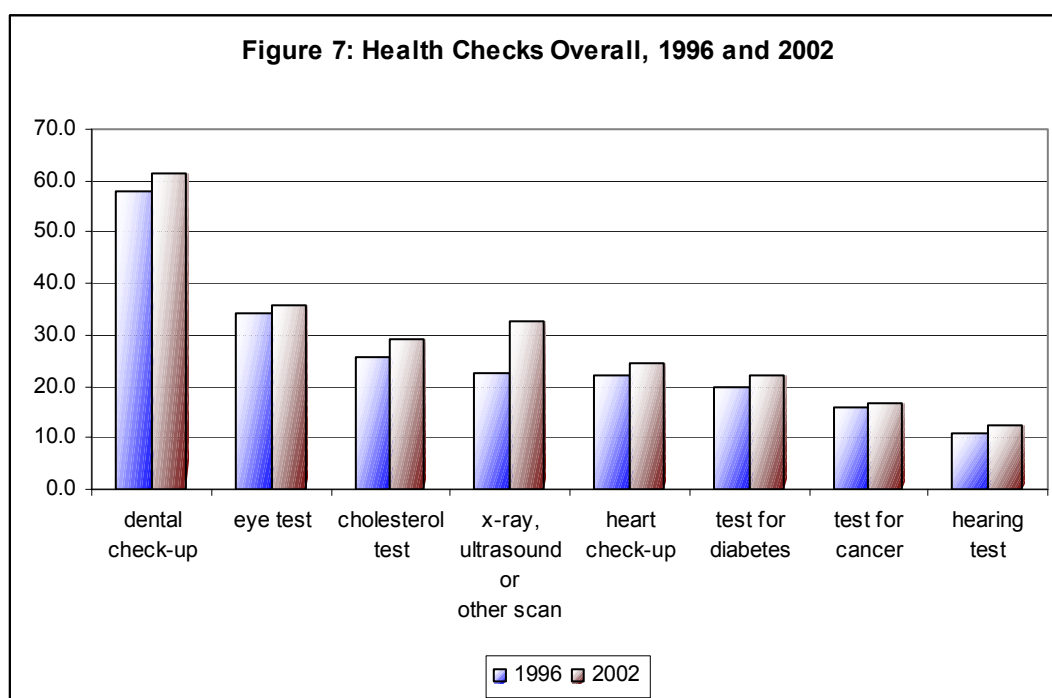
National differences do appear, with Greece and Luxembourg having the highest percentage of those going to check-ups on their own initiative, for nearly every test, with the Netherlands and the United Kingdom having consistently the lowest percentage (see Table 5). For Greece, the exception is the dental check-up, which, with 36.6% of Greeks going on their own initiative to a dental check-up, is the second-lowest in the EU after Portugal. Portugal and East Germany have the highest rates for check-ups undertaken upon a doctor's initiative, while Denmark and Sweden have the consistently lowest rates. Sweden and Austria have the highest rates for check-ups made as part of a screening programme, while Portugal and Ireland have the lowest. Thus, the low rates of doctor referrals in Sweden are counter-balanced by the higher rates of screening programmes and the reverse is true for Portugal.

Table 5: Health Checks in the European Union, 2002

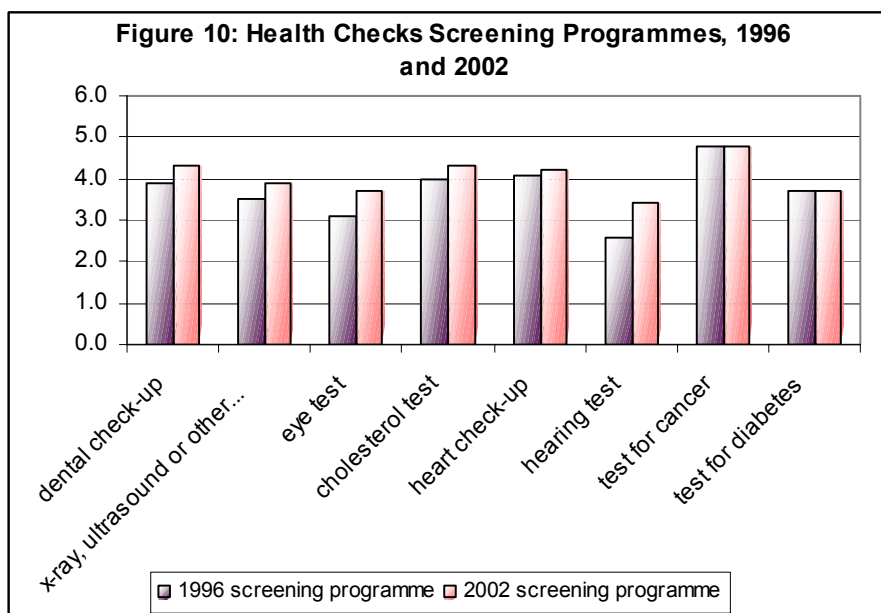
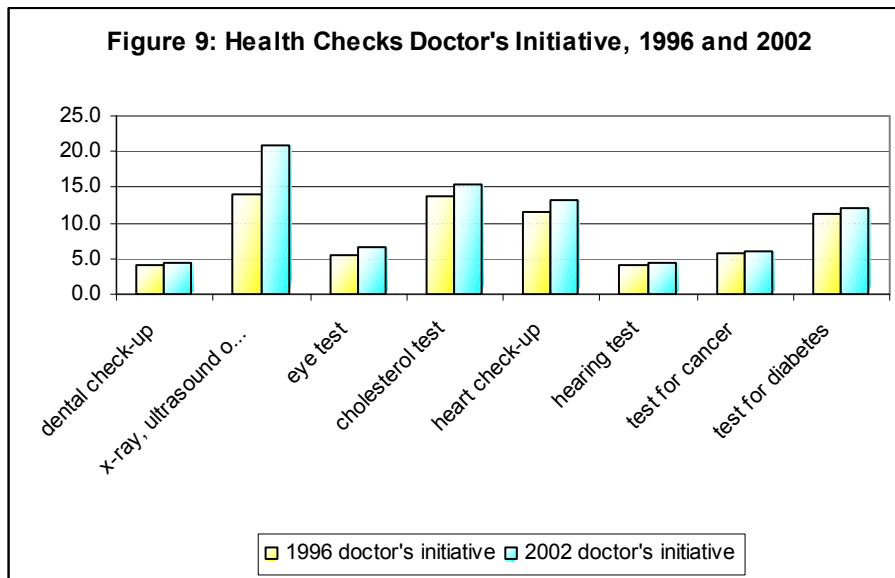
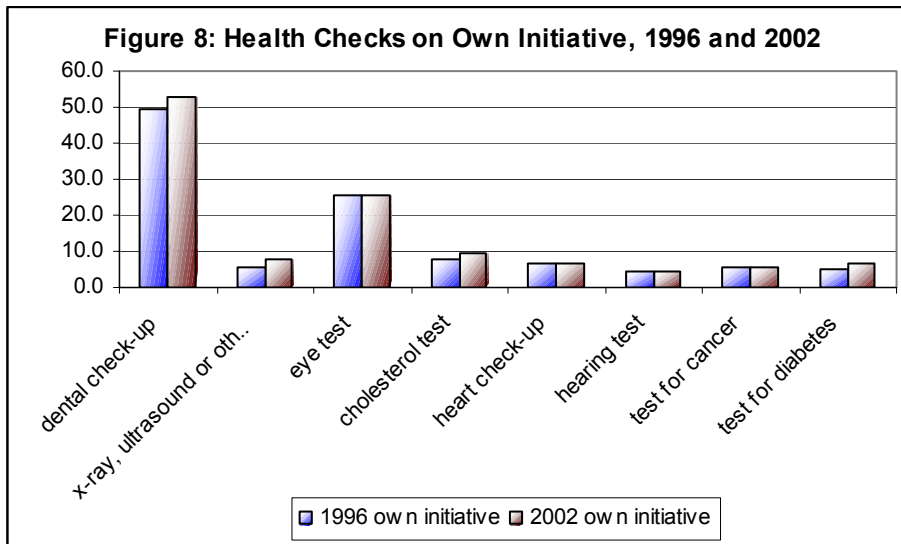
	B	DK	D West	D Total	D Ost	GR	E	F	IRL	I	L	NL	A	P	FIN	S	UK	EU 15	
Own initiative																			
dental check-up	53.1	60.8	92.9	65.1	73.2	36.6	39.2	49.5	42.9	46.7	76.7	59.5	60.7	27.3	45.6	36.9	59.4	52.8	
eye test	21.1	27.5	26.7	26.2	24.5	21.1	18.9	25.4	19.8	24.0	49.6	23.3	22.4	13.0	27.9	27.1	34.2	25.5	
blood pressure test	16.7	15.6	21.6	20.6	16.9	27.5	13.0	8.9	12.5	24.8	31.7	11.2	23.7	30.4	26.5	11.7	10.7	16.9	
cholesterol test	11.3	6.6	13.3	12.2	8.1	24.8	9.0	6.4	9.2	12.0	24.2	6.4	11.6	9.5	13.4	4.6	4.5	9.5	
x-ray, ultrasound or other scan	6.0	6.5	9.7	9.3	7.9	17.9	5.2	5.5	4.2	10.1	11.1	4.0	13.7	9.2	11.5	7.3	6.5	7.9	
heart check-up	6.3	3.5	13.9	12.4	6.9	15.2	4.4	4.3	8.5	7.3	14.4	2.1	7.8	6.1	7.3	4.0	3.1	6.9	
test for diabetes	5.2	5.2	12.2	11.4	8.6	11.7	4.5	3.8	2.3	7.6	11.9	3.1	8.6	7.6	7.8	2.5	2.4	6.5	
test for cancer	6.8	3.9	14.9	14.1	11.3	3.9	2.2	2.5	3.0	4.3	14.3	2.5	10.1	2.7	2.1	3.2	2.1	5.7	
hearing test	4.9	6.0	8.6	8.2	6.6	4.8	3.7	3.7	2.3	2.5	14.5	2.6	5.9	3.5	6.8	3.7	2.9	4.6	
doctor's initiative																			
blood pressure test	35.3	17.5	23.1	25.6	34.7	10.3	19.7	42.1	25.1	16.3	40.1	26.6	19.6	27.9	26.9	18.5	33.1	26.8	
x-ray, ultrasound or other scan	22.5	15.6	19.6	21.3	27.2	18.7	12.8	22.2	14.1	23.5	35.1	20.0	24.3	30.7	26.9	19.0	21.6	21.0	
cholesterol test	19.0	6.6	13.1	13.9	16.8	11.0	17.4	22.8	12.8	14.1	22.9	11.9	15.8	27.4	15.1	6.8	11.2	15.3	
heart check-up	15.1	6.9	12.4	13.7	18.7	10.8	11.8	15.0	15.6	13.1	13.7	9.3	13.1	24.6	15.5	10.5	12.3	13.3	
test for diabetes	11.4	6.4	12.2	13.2	16.9	5.8	9.2	20.8	7.4	10.5	13.5	7.7	11.9	19.7	11.9	5.0	8.9	12.1	
eye test	8.4	3.3	4.6	6.2	12.1	6.7	6.3	7.2	5.0	6.8	6.6	7.2	10.7	13.5	5.2	4.5	5.4	6.6	
test for cancer	9.5	5.0	8.2	8.7	10.3	2.5	3.8	6.9	5.7	3.0	12.5	4.6	10.7	10.2	6.1	5.4	5.4	6.1	
hearing test	6.9	1.9	4.1	4.7	6.6	2.5	4.9	6.1	4.8	2.7	6.7	3.5	7.5	6.7	7.9	3.1	3.5	4.4	
dental check-up	7.3	17.4	2.3	2.5	3.5	3.7	3.4	3.1	2.6	3.6	1.9	13.6	3.7	7.0	7.2	11.2	4.0	4.3	
screening programme																			
blood pressure test	3.7	6.2	8.8	8.7	8.3	2.1	8.4	2.8	1.7	6.9	3.6	4.1	15.8	1.5	10.6	16.3	3.4	6.2	
test for cancer	1.5	3.8	11.6	11.6	11.7	0.8	3.3	1.8	1.5	2.8	4.5	3.8	12.0	0.8	4.4	6.1	2.0	4.8	
dental check-up	0.9	0.8	9.1	8.7	7.0	0.5	2.9	0.4	0.9	3.9	3.7	5.2	4.7	0.8	2.4	26.1	1.8	4.3	
cholesterol test	1.0	3.4	6.9	6.7	5.6	1.9	8.4	1.3	1.3	4.5	2.9	1.5	14.2	1.7	5.6	8.4	1.4	4.3	
heart check-up	1.3	4.3	7.2	7.2	7.2	2.0	6.5	1.7	1.8	4.9	2.4	1.3	13.3	0.9	3.6	7.2	1.0	4.2	
x-ray, ultrasound or other scan	1.5	4.2	6.6	6.3	5.5	1.0	5.7	2.3	1.0	4.3	1.9	2.2	8.1	1.1	3.9	6.0	1.3	3.9	
eye test	3.3	1.4	4.3	4.3	4.2	1.0	7.6	2.0	1.5	5.1	3.1	1.1	6.2	1.2	2.4	5.8	2.0	3.7	
test for diabetes	1.2	3.2	6.4	6.5	6.9	1.9	5.3	1.9	1.0	4.1	2.1	1.0	11.3	0.6	3.9	6.3	0.8	3.7	
hearing test	2.8	2.6	4.3	4.6	5.5	1.4	6.7	2.8	1.0	2.4	2.5	1.4	6.9	1.1	6.3	9.1	1.2	3.4	

2.5.1 Trend Data from 1996

Data are available on the same issue from 1996 and reveal that, overall, taking own initiative, doctor's initiative and screening programmes together, the dental check-up was, also in 1996, the most common check-up, with 57.8%, indicating that a few percent more Europeans now have an annual dental check-up than did so six years ago (see Figure 7). The second most-common test in 2002, the blood pressure test, was not asked about in 1996, so no data are available. In 1996, the second most-common test was an eye test, with 34.2%, followed by a cholesterol test, with 25.5 per cent. The fourth most-common test in 2002 was a cholesterol test, with 29.1 per cent having had the test. On both eye tests and on cholesterol tests, the percentages are slightly higher in 2002 than in 1996. The test least commonly performed in 1996 was, as in 2002, the hearing test, with 11.0 per cent.



In 1996, health checks undertaken on one's own initiative also made up the majority of health checks, and have gone up very slightly since 1996 (see Figure 8). Checks undertaken on a doctor's initiative have gone up by several percent (see Figure 9), as have the checks undertaken through a screening programme (see Figure 10), so checks have increased by all three measurements.



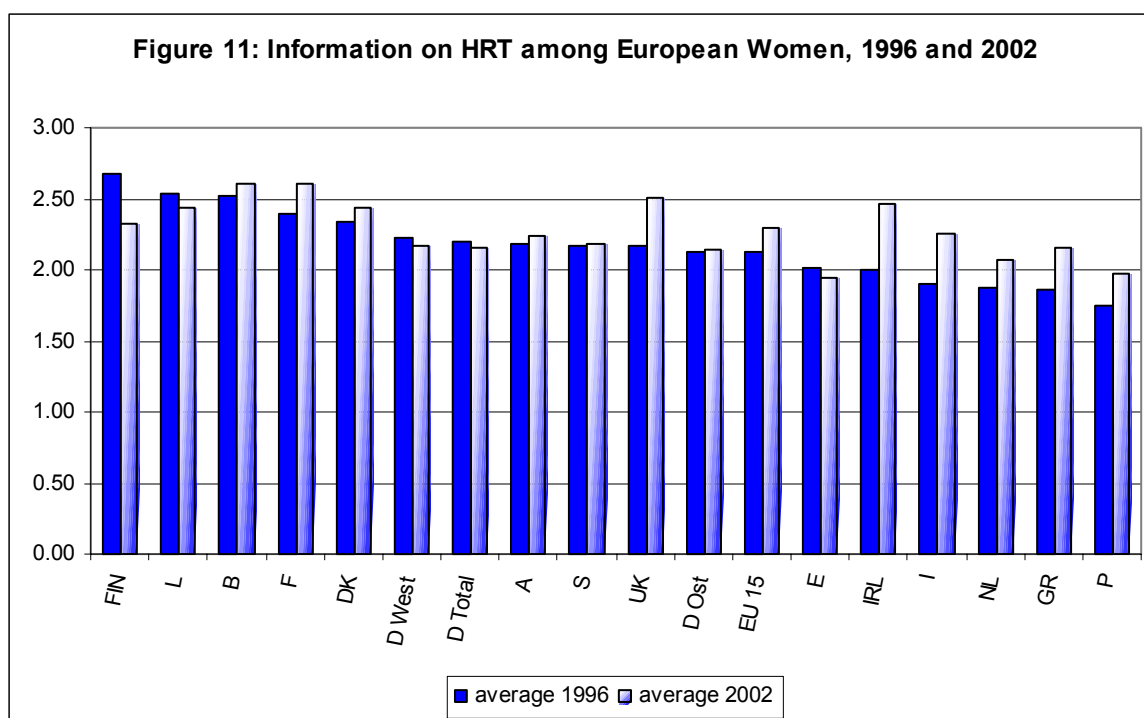
2.5.2 *Socio-demographic profiles*

Education and income once again play a significant role. Consistently, across most of the tests (with the exception of heart check-ups and hearing tests), the higher income groups go to doctors on their own initiative more often than the lower income groups (there is a clear progression across all four income groups discussed). For all tests, there is likewise a clear link between income and tests carried out on a doctor's initiative: the lower the income, the higher the percentage of those who had tests carried out on a doctor's initiative. Women have had tests more often carried out on their own initiative in almost every case, except for the heart test and the hearing test. For screening programmes, men and women undergo tests at approximately the same rate, with the exception of x-rays/ultrasounds/scans and cancer tests, which women undergo much more often, and the heart and hearing tests, which men undergo more often.

2.6. **Hormone Replacement Therapy**

Overall, women today feel slightly more informed about hormone replacement therapy than they did in 1996, with a score moving from 2.13 to 2.30⁴ (see Figure 11). While women in some countries feel that they are less well informed in 2002 than in 1996, primarily in Finland, it is worth noting that the figure for Finland for 2002, 2.32, is still slightly above the EU average of 2.30. Women in France, Belgium and the United Kingdom are the most well-informed at 2.61, 2.60 and 2.51, respectively. The Netherlands, Portugal and Spain have the lowest rate of being informed, with 2.07, 1.97 and 1.95, respectively.

⁴ 2 is equivalent to "not very well informed" and 3 to "well informed".



Socio-demographic profiles

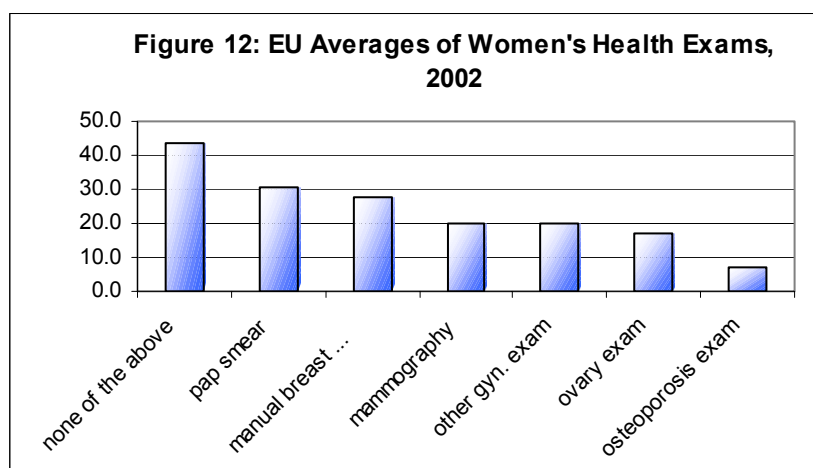
When age is taken into account, it becomes clear that older women are better informed than are younger women: 15-24 year-olds average 1.74, 25-39 year-olds 2.05, 40-54 year-olds 2.58 and those over 55 years 2.52. In other words, there is a slight decrease for those over 55, which corresponds to the percentage of women on hormone replacement therapy. There is also a link between income level and level of information, with those with the highest income averaging 2.45, the next income step 2.31, then 2.30 and those with the lowest income 2.16. Education plays somewhat of a role, with those having studied up to 15 years of age averaging 2.26, and those who studied up to 16-19 years of age, 2.34, and those who left school at the age of 20+, 2.50. The best informed of all socio-demographic categories are managers, who average at 2.63, and the lowest those aged 15-24 years old, at 1.74.

Women in higher income groups are considerably more likely to be on hormone replacement therapy,⁵ with 22.4% of those in the highest category on HRT, 14.6% of the next income step, 13.2% of the next-to-lowest and 8.3 % of those in the lowest income category on HRT. In terms of age, 23.2% of those aged 40-54 are on HRT, and 10.5% of those aged over 55 – these numbers correspond to the slight decrease in knowledge about HRT in those aged over 55.

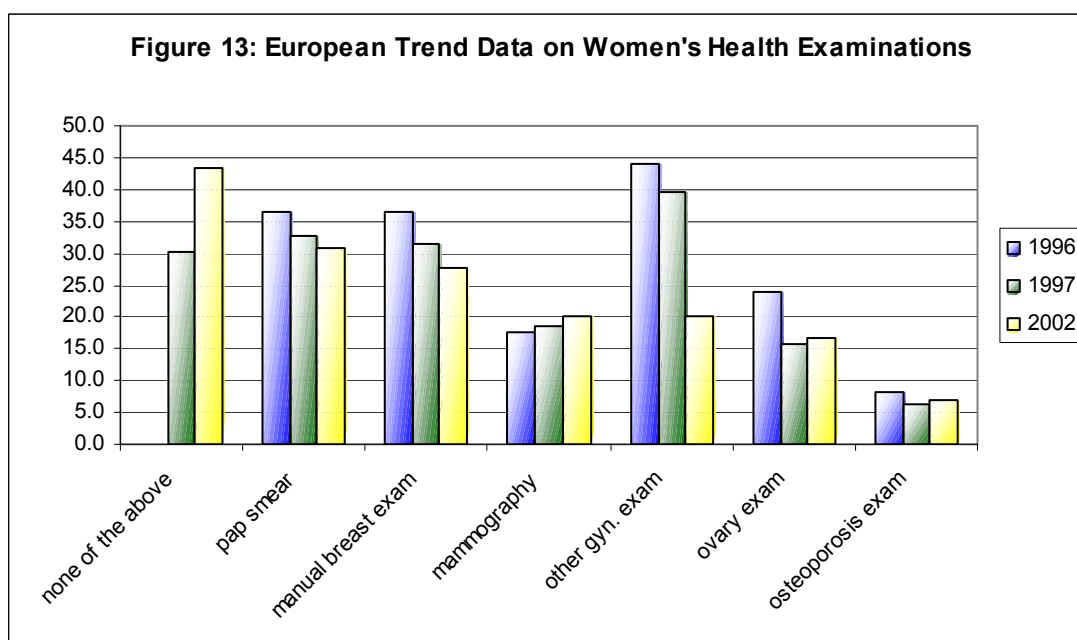
⁵ This information was not available broken down by nationality.

2.7. Women's Health Tests

There are a series of tests which are relevant for women only, primarily for detecting various forms of cancers, deterioration of bone (osteoporosis) and other disorders. Somewhat worryingly, a plurality of European women have had none of the tests mentioned (see Figure 12).



The most common test is the pap smear, or test for cervical cancer, which nearly a third of EU women had had in the previous twelve months. A manual breast exam, the most common test for breast cancer, was carried out for just over one-quarter of the women in 2002. Most disturbing is the trend since 1996 of decreasing examinations. While just 30.3% of women in 1997 had none of the tests discussed here, in 2002 the figure was 43.4 per cent. Only for mammography (breast examination by x-ray) has the percentage increased slightly from 1996; for other examinations, the percentage has dropped steadily (see Figure 13). Luxembourg and Austria have the highest percentage of women undergoing the most examinations while Ireland, the Netherlands and the United Kingdom have the lowest rates.



Greece (56.5%), the Netherlands (56.5%), Spain (55.8%) and Ireland (52.4%) have the highest rates of "none of the above" while Austria (25.1%), Luxembourg (24.6%) and East Germany (22.3%, as opposed to 37.1% in West Germany) have the lowest rates (see Table 6).

There is significant national variation on many of the tests, with 15.9% of Austrian women undergoing an osteoporosis exam, but just 2.9% of Dutch women and 3.1% of Spanish women doing so. Some 36.8% of Luxembourgish women and 31.8% of Austrian women have had ovary exams, in contrast to 2.2% of Dutch women and 2.4% of Irish women. Some 35.8% of Austrian women have had a mammogram in the previous twelve months, as have 31.3% of Luxembourgish women; just 9.4% of Irish women and 10.7% of Danish women had done so.

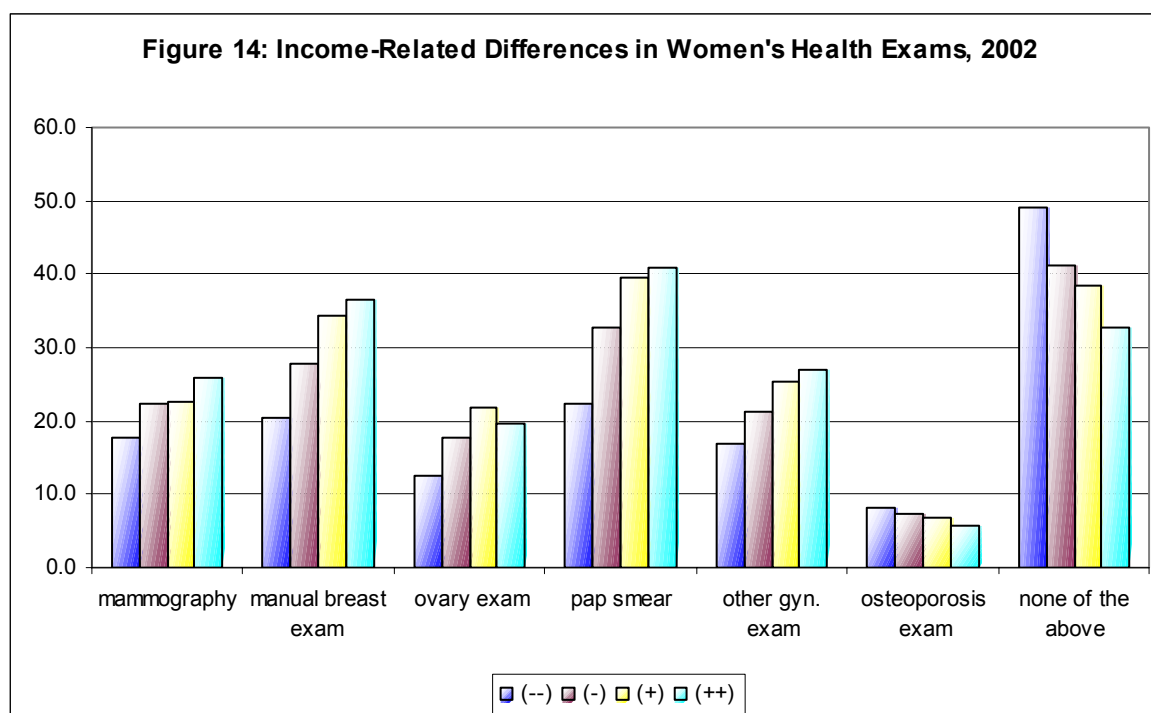
Table 6: Women's Health Tests, 1996, 1997 and 2002

1996	B	DK	D West	D Total	D Ost	GR	E	F	IRL	I	L	NL	A	P	FIN	S	UK	EU 15
mammography	16.8	30.6	20.2	20.3	20.6	11.9	19.4	16.5	4.4	14.6	26.0	21.6	29.0	18.1	17.2	28.0	13.8	17.7
manual breast exam	42.2	52.3	48.2	50.7	59.8	21.0	30.6	45.8	15.3	27.3	47.7	27.1	51.7	26.3	37.7	33.6	25.3	36.6
ovary exam	24.2	37.2	33.9	35.7	42.7	16.4	27.6	30.9	4.0	21.2	39.7	8.1	32.5	19.9	14.4	11.7	7.5	23.8
pap smear	41.3	61.9	39.4	41.8	50.5	31.3	27.7	50.6	14.7	28.2	38.9	23.0	48.6	25.0	43.3	27.5	33.1	36.4
other gyn. exam	49.9	77.6	54.8	58.5	72.6	33.6	39.5	62.7	10.6	38.0	60.8	19.1	56.6	29.5	53.0	43.0	21.6	44.1
osteoporosis exam	10.7	7.7	11.8	11.9	12.5	9.8	8.0	9.2	2.3	8.2	11.3	5.9	15.6	5.6	2.8	2.8	3.8	8.3
1997	B	DK	D West	D Total	D Ost	GR	E	F	IRL	I	L	NL	A	P	FIN	S	UK	EU 15
mammography	15.5	9.2	20.8	21.2	22.9	8.7	16.9	20.4	4.9	19.1	30.7	16.7	26	20.6	14.6	24.5	15.8	18.5
manual breast exam	29.9	24.1	49.3	51.8	61.2	20.8	24.6	40.2	16.9	24.7	51.7	14.6	47.7	19.6	28.5	25.2	15.5	31.6
ovary exam	13.4	10.5	21.1	23.8	33.9	10.6	19.3	20.5	4.0	14.5	39.5	2.4	29.1	16.1	12.7	10.5	4.1	15.8
pap smear	31.3	27.5	34.0	36.1	43.8	28.3	22.4	47.1	20.6	28.5	49.9	20.6	39.8	16.8	34.9	27.1	33.1	32.7
other gyn. exam	40.4	41.5	49.4	53.4	68.2	29.6	36.2	56.4	13.0	40.4	60.9	10.1	53.8	29.1	42.2	43.5	14.3	39.5
osteoporosis exam	6.4	2.4	7.1	7.5	9.0	8.3	4.1	6.6	2.7	11.1	13.7	1.2	13.6	7.5	2.5	3.3	2.8	6.4
none of the above	32.2	30.9	17.2	15.3	8.3	53.6	49.3	25.2	51.3	26.1	7.5	35.7	20.9	41.3	32.3	28.8	40.3	30.3
2002	B	DK	D West	D Total	D Ost	GR	E	F	IRL	I	L	NL	A	P	FIN	S	UK	EU 15
mammography	18.7	10.7	17.9	17.3	15.3	12.6	20.2	24.7	9.4	25.1	31.3	25.4	35.8	32.2	22.1	24.1	12.5	20.2
manual breast exam	32.3	14.5	45.6	47.2	53.1	16.1	18.6	25.6	22.7	24.9	51.4	11.3	43.8	27.2	26.2	11.5	16.5	27.6
ovary exam	17.4	9.0	26.2	27.3	31.5	10.9	15.5	15.6	2.4	19.6	36.8	2.2	31.8	17.1	16.4	11.2	5.9	16.8
pap smear	34.2	22.0	35.6	37.4	44.0	26.9	24.6	35.4	14.6	28.5	52.4	14.3	52.2	19.0	39.1	28.2	27.1	30.7
other gyn. exam	19.5	21.4	27.6	28.7	32.4	14.1	17.8	19.3	6.2	21.3	41.2	6.2	33.9	13.8	38.3	19.8	11.6	20.1
osteoporosis exam	7.2	5.2	8.7	8.8	9.3	9.5	3.1	4.9	6.3	11.0	11.0	2.9	15.9	10.6	4.9	2.9	4.5	6.9
none of the above	41.0	50.2	37.1	33.9	22.3	56.5	55.8	39.2	52.4	42.9	24.6	56.5	25.1	45.6	34.8	43.5	49.8	43.4

Socio-demographic profiles

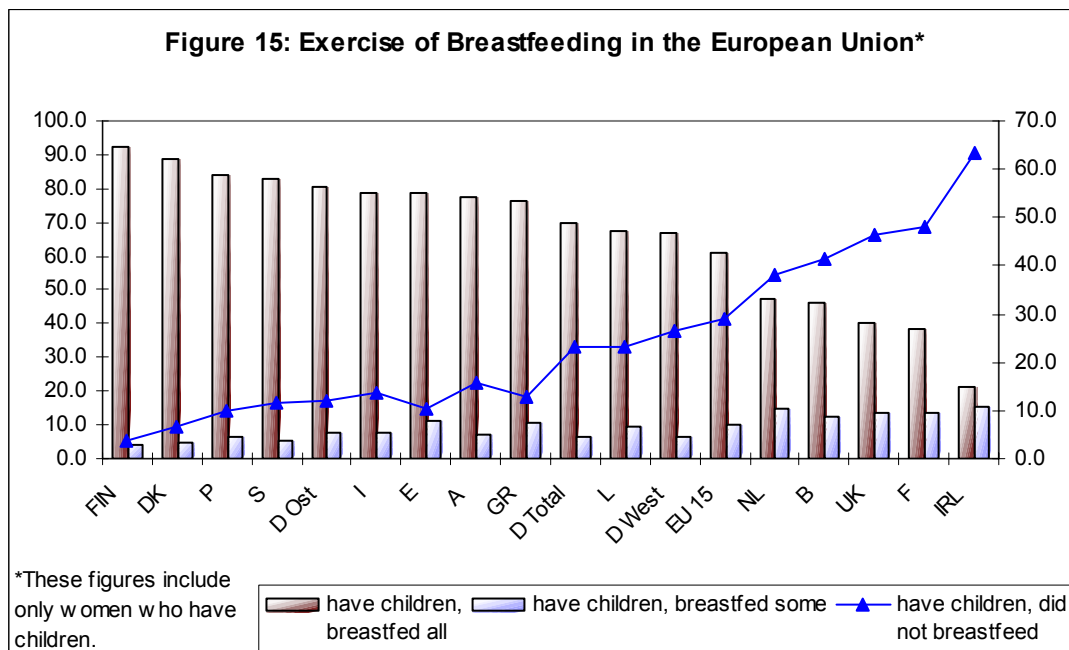
There is, in almost every case, a correlation between percentage of women having tests and age, education and income. In terms of age, it is clear that certain exams are only undertaken after a certain age. Mammography is recommended for women past the age of, for the most part, 35. However, just 30.9% of women aged 40-54 have had a mammogram in the previous twelve months, while 42.5% have had a pap smear, which is recommended for women of all ages. Education is also a predictor for undergoing tests, with those with higher education undergoing tests more often (just 34.0% of those who left school at the age of 20+ did not undergo any tests, while 50.7% of those who studied up to 15 years of age did not). Some 41.9% of those who studied up to 20 years of age or more had a pap smear in the previous twelve months, as compared to 36.3% of those who studied up to 16-19 years of age and 20.3% of those who studied up to 15 years of age.

With respect to income, there is a clear correspondence between income level and tests undertaken (see Figure 14). Interestingly, osteoporosis exams are undertaken more often for women of lower income groups, with 8.3% of the lowest income group having such an exam and 7.4%, 6.9% and 5.8% of the next three groups. For all other exams, however (with the exception of ovary exam, for which there is not a clear progression), women of higher income groups had tests at higher rates than the women of lower income. The differences can be quite startling, with 26.0% of those in the highest income group undergoing a mammogram, but just 17.6% of those in the lowest income group doing so. While mammography is age-related, a pap smear is not. Some 40.9% of those in the highest income group had a pap smear, while just 22.4% of those in the lowest did so. The differences continue to be remarkable (see Figure 14).

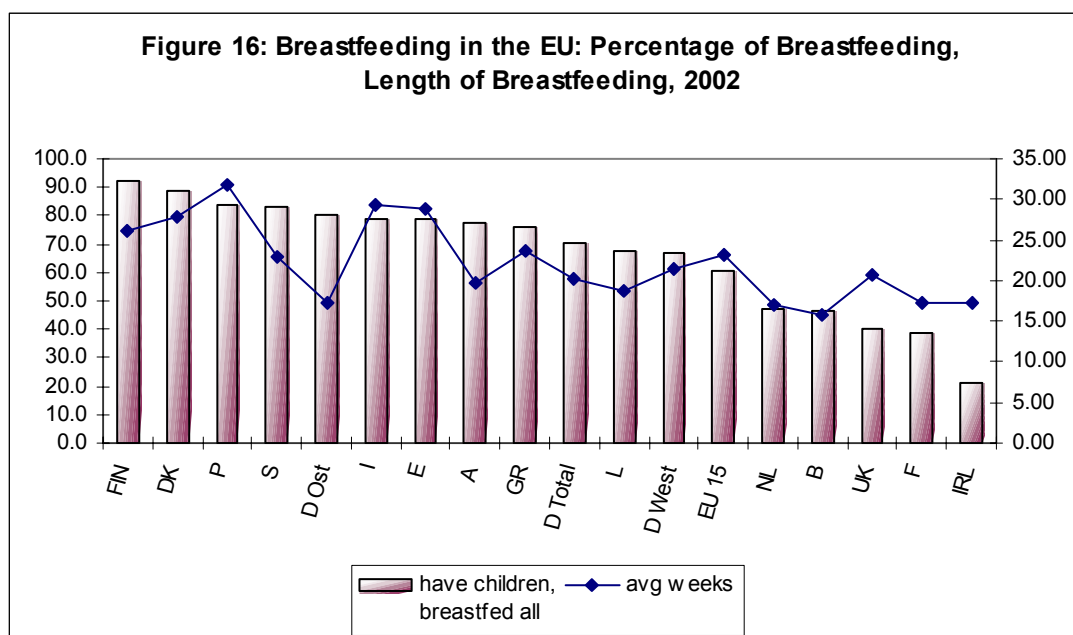


2.8. Breastfeeding in the European Union

There are some quite startling differences in breastfeeding habits across the European Union. Some 60.9% of all women who have children breastfed all of them. Finland (92.2%), Denmark (88.9%) and Portugal (84.0%) are the countries in which breastfeeding is the most common, while in the United Kingdom (40.0%), France (38.5%) and Ireland (21.3%), it is considerably less widespread (see Figure 15). The figures here reflect the decisions to breastfeed of just those women who do have children, and are not the figures for overall breastfeeding in the respective countries, which also includes women without children.



There does appear to be some correspondence between the percentage of mothers who breastfeed and the length of time for which children are breastfed (see Figure 16). With exceptions, the countries in which more mothers breastfeed also are the countries in which children are breastfed longer. Although this author does not have the information available, it is to be surmised that the length of breastfeeding is closely linked to the average length of maternity leave available. Recent introductions of certain benefits may, however, have been intended to encourage breastfeeding, and thus not be linked to percentage of mothers breastfeeding.



Socio-demographic profiles

Age and occupation are the strongest indicators of breastfeeding. Overall, 60.9% of women with children breastfed all of their children (see Figures 15 and 16). Some 42.7% of women overall (including those with no children) breastfed all of their children. Some 54.9% of women over the age of 55 breastfed all of their children (14.7% of those did not have children), while 52.3% of those aged 40-54 breastfed all of their children (12.5% did not have children). Just 6.9% of those aged 15-24 had breastfed all of their children (86.6% did not have children) and 38.5% of those aged 25-39 had done so (32.9% had not had children).

Those women who are retired or are "house persons" rank the highest in terms of having children and having breastfed all of them, with 55.2% and 55.5%, respectively. Those who are self-employed rank next, with 45.6%, while "other white collars" have the lowest percentage, with 33.6 per cent. Some 43.6% of managers had children and breastfed them. Other white collars also have the highest rate of not having any children, with 40.6%, followed by managers with 36.7 per cent. "House persons" have the lowest rate of not having children, with just 6.0% who did not have children.

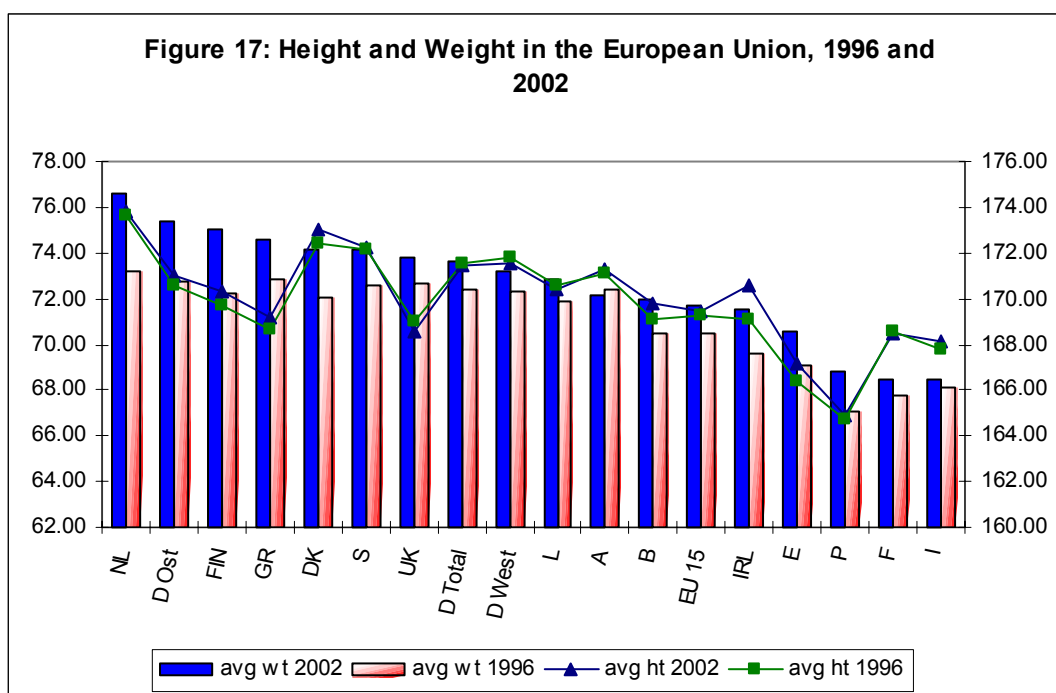
Those in rural areas have more children and breastfeed more often than those in small or middle-sized towns or in large towns. Some 45.7% of those in rural areas breastfed, compared to 42.8% in small or middle-sized towns and 39.6% in large towns. Income does not appear to play a significant role in the decision to breastfeed, although, in general, those in the two higher income brackets breastfeed more often (++ 48.2%, +49.3%) than those in the lower brackets (- -42.6%, - 44.6%).

Length of breastfeeding is also linked to socio-demographic variables, with occupation playing the most significant role; managers breastfed for 23.92 weeks, followed by 24.40 weeks for house persons and 24.84 weeks for retired. The unemployed (19.65), students (18.41 weeks) and the self-employed (18.23) breastfed for the shortest periods.

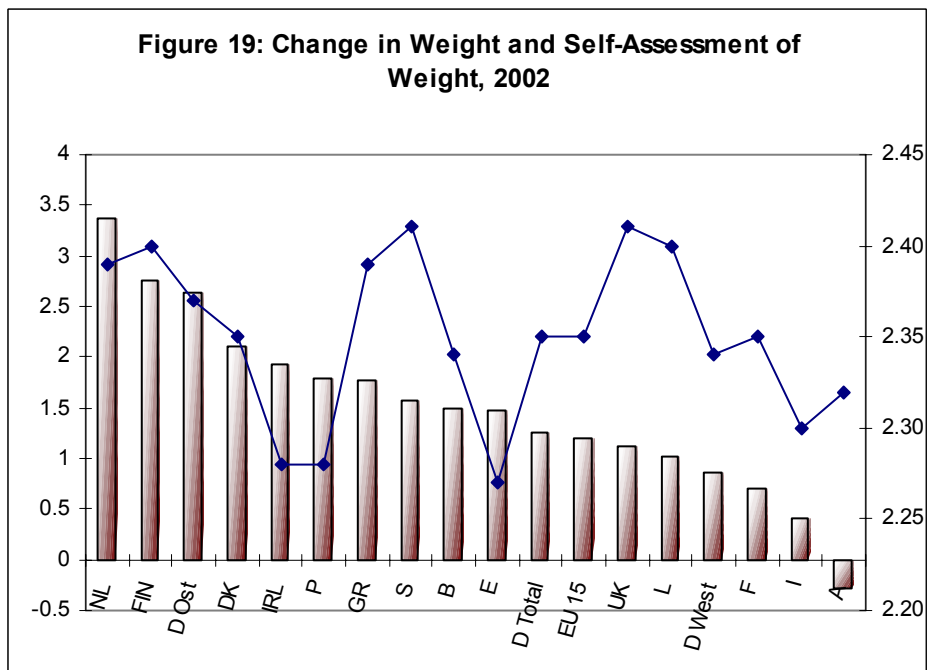
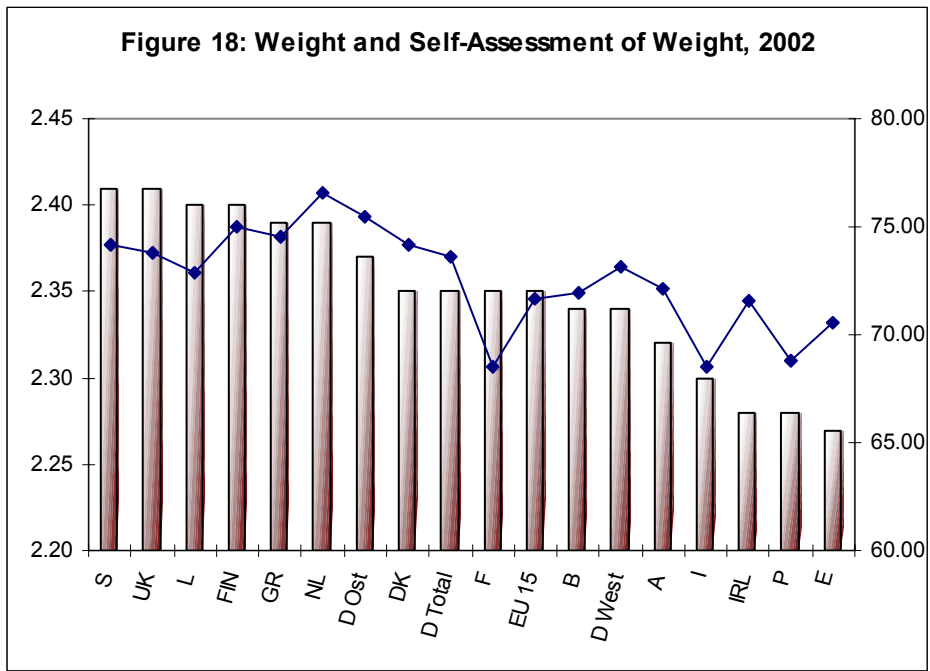
3. Health and Health Awareness in the European Union

3.1. Height and Weight in the EU

Overall in the European Union, between 1996 and 2002, average weight increased by nearly two per cent (1.68%, or 1.19 kg), but overall height increased only by 0.05 per cent (or 0.10 cm). Indeed, with the exception of Ireland, where the average height has increased by a full 1.5 cm, there have been no significant changes in height over the past six years (see Figure 17). In weight, however, the average weight in nearly every country has increased, with the exception of Austria, where average weight has decreased by 0.28 kilograms. The Netherlands has the largest increase, with an increase of over 3 kilograms (from 73.23 to 76.59), while East Germany and Finland have increases of just under 3 kilograms.



Interestingly, self-assessment of weight (2=about right, 3=too high, 1=too low) is more closely linked to overall weight than it is to change in weight (see Figures 18 and 19). Portugal, for instance, which has the third-lowest average weight in the EU, had an above-average weight gain since 1996, with 1.78 kilograms. The self-assessment of weight, however, is at 2.28, in contrast to Sweden, which has the sixth-heaviest average weight in the EU and an average weight gain of 1.58 and has a self-assessment of 2.41, somewhat above that of Portugal. The EU average self-assessment is 2.35.



Socio-demographic profiles

Men are, on average, 12 centimetres taller than women (175.68 cm compared to 163.54 cm). The youngest are the tallest (15-24 years 171.41 cm, 25-29 171.42 cm, 40-54 years 169.64, 55+ years 166.43 cm), as are those with the most education (those who studied up to 15 years of age 166.22 cm; those who left school at age of 20+ 171.81 cm), managers (173.40) and the self-employed (172.13). Income also plays a role, with the more well-to-do being four centimetres taller than the lowest income group (171.39 cm compared to 167.69 cm).

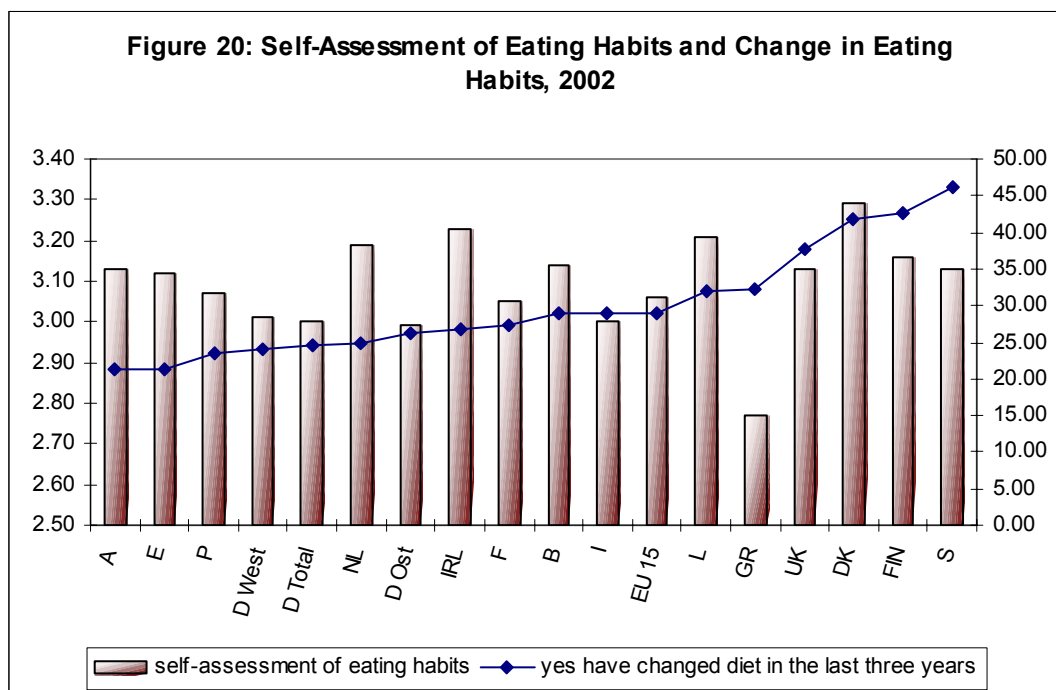
Women are a full thirteen kilograms lighter than men (65.36 kg compared to 78.31 kg), while age and education also play a role: those with less education weigh more (those who studied up to 15 years of age 72.68, 16-19 years 72.47 and those who left school at age of 20+ 72.08), as do those who are older (40-54 years 74.05, 25-39 years 71.48 kg, 15-24 years 65.80 years). Income does not appear to play a large role, with both the lower-middle and upper-middle categories about the same (73.13 and 73.14 kg) and the lowest income group at 70.68 kg, and the uppermost at 72.83 kilograms.

In terms of self-assessment of weight, women tend to believe that their weight is too high (ranking 2.41⁶) more often than do men (2.27), while those who are younger are more satisfied with their weight (15-24 ranks 2.14, 25-29 ranks 2.31, 40-54 ranks 2.41 and 55+ ranks 2.42). Those who are house persons (2.44) or retired (2.42) tend to believe their weight is too high, while students (2.13) and manual workers (2.31) and the unemployed (2.31) are more likely to believe their current weight is about right. When the weights of these groups are compared to EU averages, however, the self-assessments are perhaps not entirely wrong: house persons (most likely majority women), on average, weigh 67.74 kg, while the EU average is 71.69, the average for women is 65.36 and for men 78.31; the retired weigh, on average, 73.37, students 64.89, manual workers 73.27 and the unemployed 71.92 kilograms.

⁶ 2=about right, 3=too high

3.2. Eating Habits and Changes in Eating Habits

3.2.1 Self-Assessment of Eating Habits

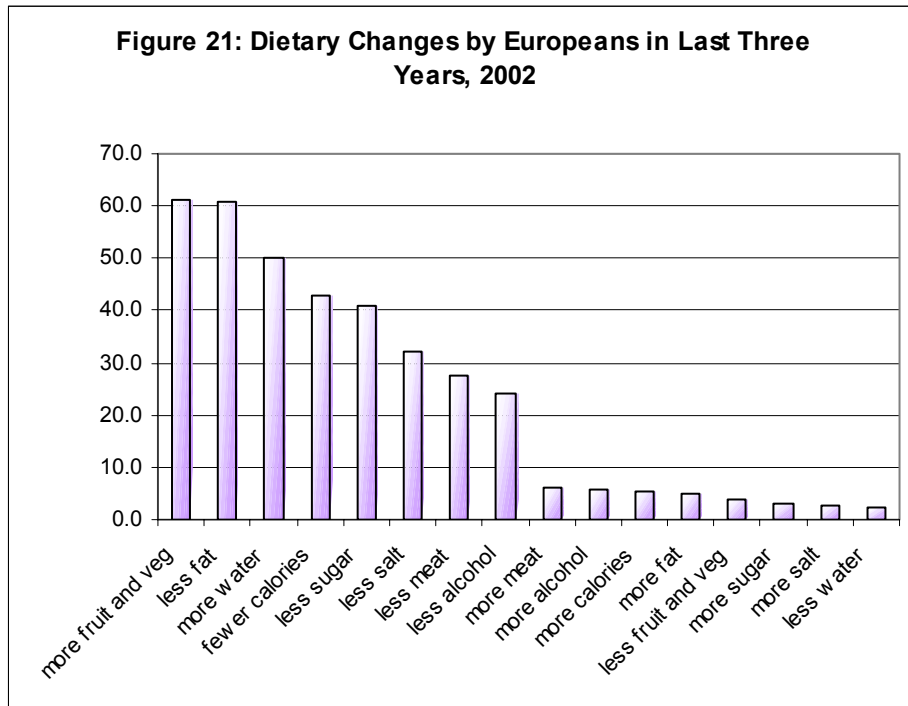


Overall, EU citizens believe that their eating habits are fairly good for them,⁷ with a ranking of 3.06, and just 13.2% of the population saying that their eating habits are 'not very good' and 1.9% saying they are 'not at all good'. There is some variation on the national level, with self-assessment rankings ranging from 2.77 to 3.29 (see Figure 20). The Greeks (2.77) and the Germans (3.00) and the Italians (3.00) have the lowest opinion of their eating habits, while the Danes (3.29), the Irish (3.23) and the Luxembourgers (3.21) think their eating habits are relatively good.

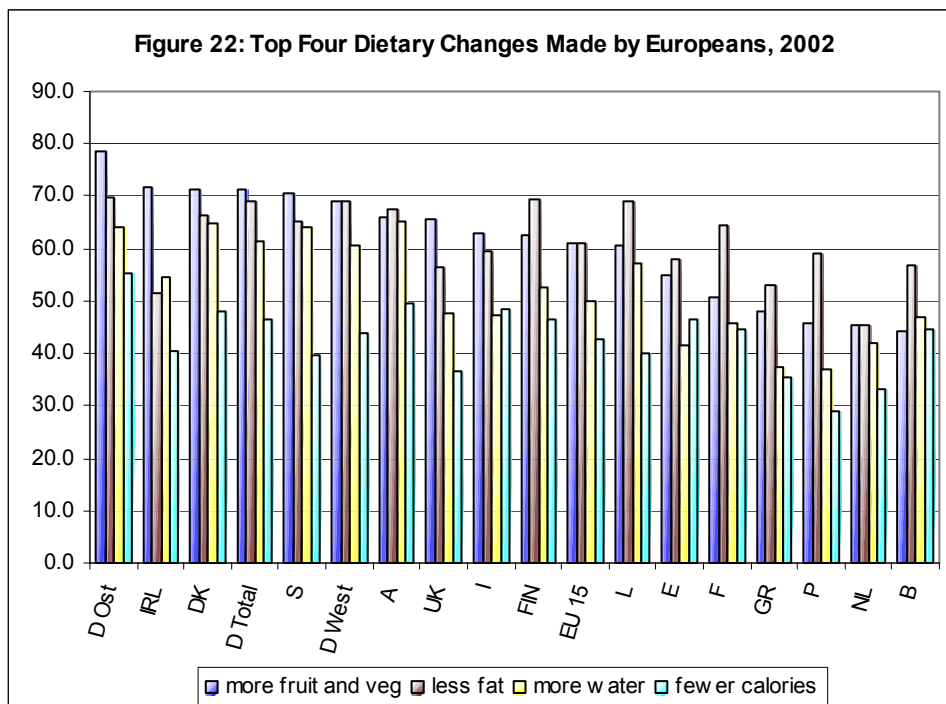
3.2.2 Change in Eating Habits

Nearly one-third (29.0%) of EU citizens have changed what they eat or drink in the past three years, with the Nordics (Denmark (41.9%), Finland (42.5%) and Sweden (46.1%) having changed their eating or drinking habits the most. Austria (21.2%), Spain (21.3%) and Portugal (23.6%) have changed their eating habits the least of all Europeans.

⁷ 4=very good, 3=fairly good, 2=not very good, 1=not at all good



The major changes made by the one-third of the EU population who have changed what they eat or drink in the past three years were to add more fruit and vegetables into their diets (61.1%), to eat less fat (61.0%), to drink more water (50.0%) and to eat fewer calories (42.8%) (see Figure 21).



Other significant changes were eating less sugar (41.0%), less salt (32.2%), less meat (27.4%) and less alcohol (24.1%). Other changes, such as eating more meat, drinking more alcohol, eating more fat, etc. were made by Europeans in single digit percentages.

When countries' individual habits are discussed, it becomes clear that certain countries have made significant changes (see Figure 22). The former East Germany, for instance, tops the list for three of the four major changes, namely more fruit and vegetables, less fat and fewer calories, and is in fourth place for "more water" (see Table 7). Denmark, Germany, West Germany, Austria and Finland are also all above the EU average for all four of these categories. Greece, Portugal and the Netherlands are below the EU average for all four categories; indeed, Portugal is the lowest in the EU for drinking more water and eating fewer calories, with 37.1% and 29.1%, respectively.

Table 7: EU Countries Making the Most Dietary Changes, 2002

more fruit	less fat	more water	fewer calories
D Ost	D Ost	A	D Ost
IRL	FIN	DK	A
DK	D Total	S	I
D Total	D West	D Ost	DK
S	L	D Total	E
D West	A	D West	FIN
A	DK	L	D Total
UK	S	IRL	B
I	F	FIN	F
FIN	EU 15	EU 15	D West
EU 15	I	UK	EU 15
L	P	I	IRL
E	E	B	L
F	B	F	S
GR	UK	NL	UK
P	GR	E	GR
NL	IRL	GR	NL
B	NL	P	P

3.2.3 Socio-demographic profiles

On a socio-demographic level, there is very little variation as to self-assessment of eating habits. Women rank themselves at 3.06 and men do so at 3.07. The unemployed rank themselves the lowest, at 2.93, followed by the 15-24 year-olds, at 2.96. Those retired (3.16), over 55 years old (3.15), those in the highest income category (3.15) and those who left school at the age of 20 or more (3.12) rank themselves the highest. Income appears to play a role in eating habits: the lowest income group ranks themselves 3.04, the next 3.05, the upper-middle group ranks themselves 3.06 and, as noted, those in the uppermost rank themselves 3.15.

In terms of changing what they eat or drink, more women (33.6%) have changed their diet in the last three years than have men (24.1%). Within occupations, there is some variation, with 24.1% of manual workers and 25.2% of the self-employed having changed their diets, but 33.4% of "other white collars" and 32.2% of house persons having done so. Income-related variation is also noticeable; some 27.9% of the lowest income have changed their diets, as have 30.2% of the lower-middle group, 29.6% of the upper-middle group and 34.2% of the uppermost income group.

The four most significant changes, those of eating more fruit and vegetables, eating less fat, drinking more water and eating fewer calories, were made more often by women, often by those who are older (see Table 8), and often by persons with more education (see Table 9). Income appears to play a role to some extent: (lower 3.04; lower-middle 3.05; upper-middle 3.06; upper 3.15).

For all four major changes made, women made them more often than did men, with an average of 7.7% difference between the genders. Older persons (25-39, 40-54) more often made changes in eating more fruit and vegetables, less fat and fewer calories (see Table 8). It is only in eating less fat that those over 55 have made more changes than those younger. Younger persons are more likely to have begun to drink more water, with 54.6% of those 15-24 drinking more water and just 48.4% of those over 55 doing so.

Table 8: Gender and Age Differences for Changes in Eating Habits, 2002

	Male	Female	15-24	25-39	40-54	55+
more fruit and veg	57.4	63.5	57.9	62.6	62.4	60.2
less fat	57.4	63.3	46.2	55.7	66.0	69.1
more water	44.1	54.0	54.6	49.6	49.7	48.4
fewer calories	37.5	46.3	35.3	43.8	46.7	42.5

Those with more education made more changes in eating more fruit and vegetables and in eating fewer calories, while eating less fat and drinking more water show no particular trends, with both those with the least and with the most education more often eating less fat than those who left school between 16-19 years of age (see Table 9). Likewise, those with the least and most education more often increased water consumption than those who studied up to 16-19 years of age.

Table 9: Education-Related Dietary Changes, 2002

	<15	16-19	20+	still studying
more fruit and veg	58.0	60.5	64.9	62.1
less fat	63.8	61.6	62.4	47.9
more water	46.2	51.0	49.7	56.3
fewer calories	39.9	44.5	46.2	34.4

In terms of region of origin, whether rural or urban, and income level, there are some notable distinctions (see Table 10). Those in large towns are most likely to eat more fruits and vegetables, as well as to drink more water, while those from rural areas are least likely to do so. For eating less fat and consuming fewer calories, the findings are less clear-cut. Income-related dietary changes also play a role, with a clear progression of those with higher incomes eating more fruit and vegetables and those in the highest income category eating less fat. However, in terms of eating fewer calories and drinking more water, there is no such clear progression. As noted above, self-assessment of eating habits improves with each step upward in terms of income.

Table 10: Area of Origin and Income-Related Dietary Changes, 2002

	rural area	small or med town	large town	(--)	(-)	(+)	(++)
more fruit and veg	59.1	62.0	62.2	56.6	58.7	66.2	68.3
less fat	61.5	62.5	58.0	63.3	58.4	65.6	67.0
more water	47.7	49.9	52.6	50.3	50.0	52.8	51.2
fewer calories	39.7	44.6	43.3	35.4	41.7	47.9	43.8

3.2.4 Reasons for Changes⁸

Approximately one-third of the population (33.9%) made dietary changes to stay healthy, approximately another third (30.1%) did so to lose weight and just under one-fifth (18.4%) did so because of a disease or health problem (see Table 11). Finland, Ireland and Germany lead the EU for having made dietary changes with the intentions of staying healthy (45.1%, 43.1% and 40.5%, respectively). Finland had the second-highest percentage of respondents saying they had changed their eating habits, with 42.5% (after Sweden, with 46.1%), while Ireland was below the EU average (29.0%) with 26.7% and Germany was even lower at, 24.5 per cent.

France (39.2%), Belgium (37.6%) and Spain (34.8%) lead the EU in terms of having made dietary changes in order to lose weight, while Portugal (41.0%), East Germany (24.9%, as opposed to West Germany's 18.6%) and Spain (24.0%) did so because of a disease or health problem. As noted above (Chronic Illness), Portugal has the highest percentage in the Union of those with hypertension (22.7%) as well as diabetes (10.0%), while East Germany has the third-highest percentage of those with hypertension (19.3%) and the second-highest incidence of diabetes (8.2%). Interestingly, 3.4% of Belgians (compared to 1.6% EU average) made changes to gain weight, as did 2.4% of Spaniards. The low end of the scale is occupied by Finland, with 0.0% (and 0 respondents) and by Ireland with 0.3 per cent.

⁸ It must be noted that the percentages discussed here are percentages of the percentages of those nationalities or socio-demographic groups who stated that they had changed what they ate or drank in the previous three years.

Table 11: Reasons for Dietary Changes, 2002

	stay healthy	lose weight	because of a disease or health problem	other reason	keep weight steady	put on weight
P	28.3	20.8	41.0	5.7	2.9	0.9
D Ost	33.4	27.6	24.9	4.0	7.3	1.5
E	28.3	34.8	24.0	7.5	2.1	2.4
I	32.9	24.8	20.7	15.3	3.4	1.0
D Total	40.5	25.8	20.1	4.4	6.0	1.7
F	24.6	39.2	19.8	11.0	4.2	0.8
GR	36.4	22.6	18.7	14.8	2.4	2.2
D West	42.6	25.3	18.6	4.6	5.6	1.7
EU 15	33.9	30.1	18.4	10.4	4.4	1.6
A	38.6	33.2	17.5	5.3	4.8	0.5
L	39.3	27.1	16.4	11.0	4.3	0.8
FIN	45.1	21.5	15.6	9.7	4.6	0.0
UK	37.5	31.6	14.2	10.6	3.5	2.1
DK	30.7	32.3	13.6	13.9	4.3	2.9
B	23.0	37.6	13.3	5.9	16.7	3.4
IRL	43.1	31.3	13.2	3.5	7.1	0.3
NL	29.2	29.9	12.3	20.6	3.3	1.6
S	37.4	28.5	12.2	13.8	4.9	1.2

3.2.5 Socio-demographic profiles

Different socio-demographic groups have different reasons for altering their dietary habits. While the plurality of EU citizens (33.9%) wished to stay healthy, a plurality of women (35.7%) said they wanted to lose weight and, secondarily (32.0%), to stay healthy. A plurality of men (36.8%), on the other hand, wished to stay healthy and, secondarily, changed their diets because of a disease or health problem (20.8%, compared to 16.8% for women). Women rank third in terms of changing their diets in order to lose weight; the first place is held by "other white collars", of whom 37.3% wished to lose weight, and the second by the upper-middle income group, of whom 36.4% wished to lose weight. Retired persons are the group of which the lowest percentage wished to lose weight (20.6%), followed by 21.6% of men. More men than women (5.1% to 2.7%) wished to gain weight, as did the youngest group (aged 15-24: 5.1%), indicating that the small percentage of Europeans who changed their diet to include more fat, more meat, less fruits and vegetables, etc. was largely composed of young men who wished to gain weight.

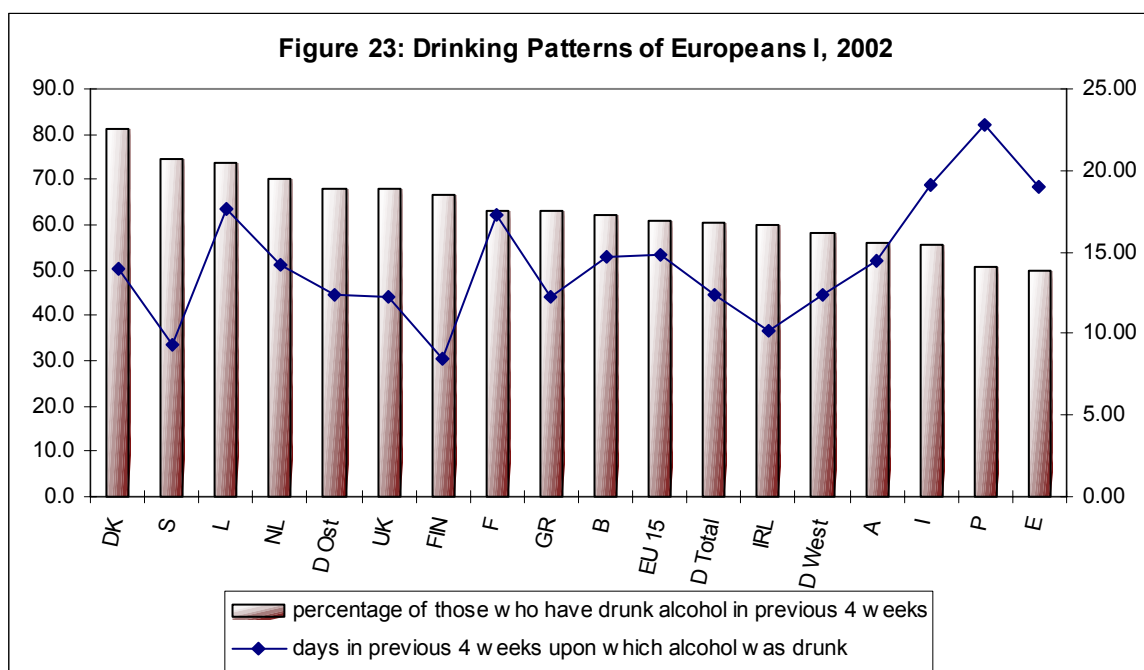
Managers were the most concerned with making dietary changes in order to remain healthy, with 43.6% doing so, followed by 38.8% of the unemployed as well as 38.8% of those in the highest income group, and 36.9% of those with more than 20 years of education. The groups least concerned with making dietary changes to remain healthy were those aged 15-24 (28.0%) and the retired (31.5%). There is a continuous progression across income, with 32.1% of the lowest income group having made changes to stay healthy, 34.1% of the lower-middle group having done so, as well as 35.1% of the upper-middle group and 38.8% of the upper income group.

Not surprisingly, disease or a health problem prompted more older persons to make dietary changes (34.7% of those over 55, 17.7% of those aged 40-54, 7.9% of those aged 25-29 and just 5.7% of those aged 15-24). The highest percentage is found among the retired, with 40.2 per cent, followed by 34.7% of those aged over 55 and 31.4% of those with up to 15 years of education. Having made dietary changes because of a disease or health problem is clearly linked to income and education; 25.1% of those in the lowest income group did so, as did 23.3% of those in the lower-middle group, 16.1% of those in the upper-middle group and 13.2% in the upper group. In terms of education, as noted, 31.4% of those who studied up to 15 years of age made changes for this reason, as did 15.7% of those who studied up to 16-19 years of age, and 15.2% of those who left school at age of 20 or later.

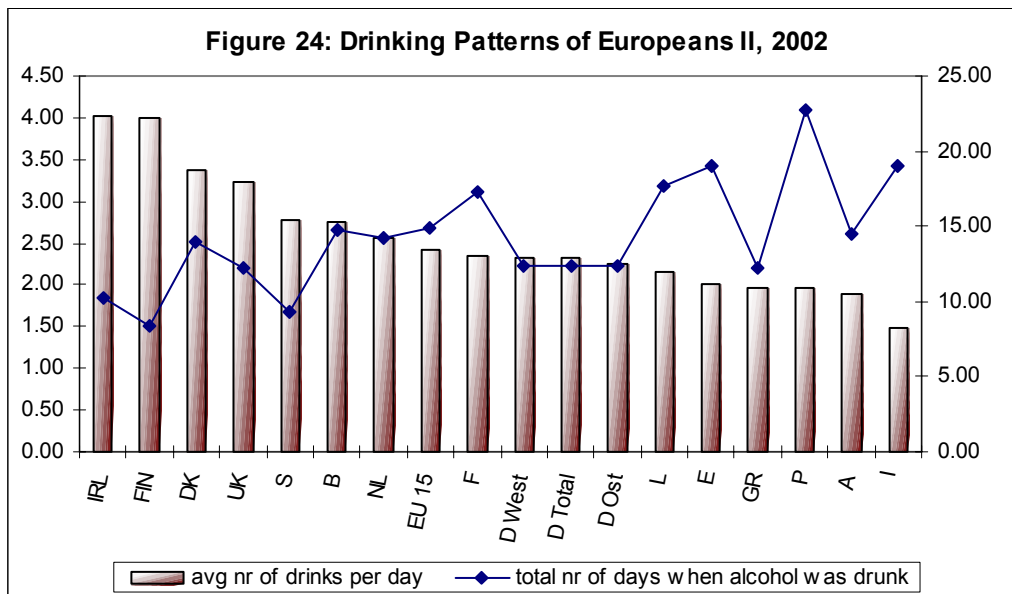
4. Alcohol Consumption in the European Union

4.1. Drinking Patterns: Frequency, Amount and Intensity

Denmark, Sweden and Luxembourg have the highest percentage of persons who have drunk alcohol (wine, beer, spirits, other alcoholic drinks) in the previous four weeks, with 81.2%, 74.6% and 73.8%, respectively. Italy, Portugal and Spain have the lowest, with 55.4%, 50.9% and 49.9%, respectively, of their populations having drunk alcohol in the previous four weeks (see Figure 23). The EU average is 61.0 per cent. Portugal leads the EU for the number of days in the previous four weeks upon which alcohol was drunk, with an average of 22.77 days, followed by Italy with 19.06 days and Spain with 19.01 days (see Figure 23). The countries with the lowest percentage of persons who have drunk alcohol in the previous four weeks have the highest average number of days upon which alcohol was drunk (see Figure 23). The countries with the lowest average number of days were Finland with 8.44 days, Sweden with 9.35 and Ireland with 10.22 days. In other words, countries with high percentages of persons who have drunk alcohol have low drinking frequency.



The intensity of drinking, that is to say, how many drinks are consumed at one sitting, also varies from country to country (see Figure 24). While Finland, Sweden and Ireland rank the lowest in terms of average number of days of drinking, Ireland and Finland rank first and second for number of drinks per day, with 4.03 and 3.99 drinks per days, respectively, and Sweden ranks fifth, with 2.77 drinks per day. Denmark (which ranks first for percentage of the population having drunk in the previous four weeks with 81.2%) ranks third for average number of drinks per day, with 3.38 drinks per day. Portugal, Austria and Italy rank last, at 1.96, 1.88 and 1.49 drinks per day.

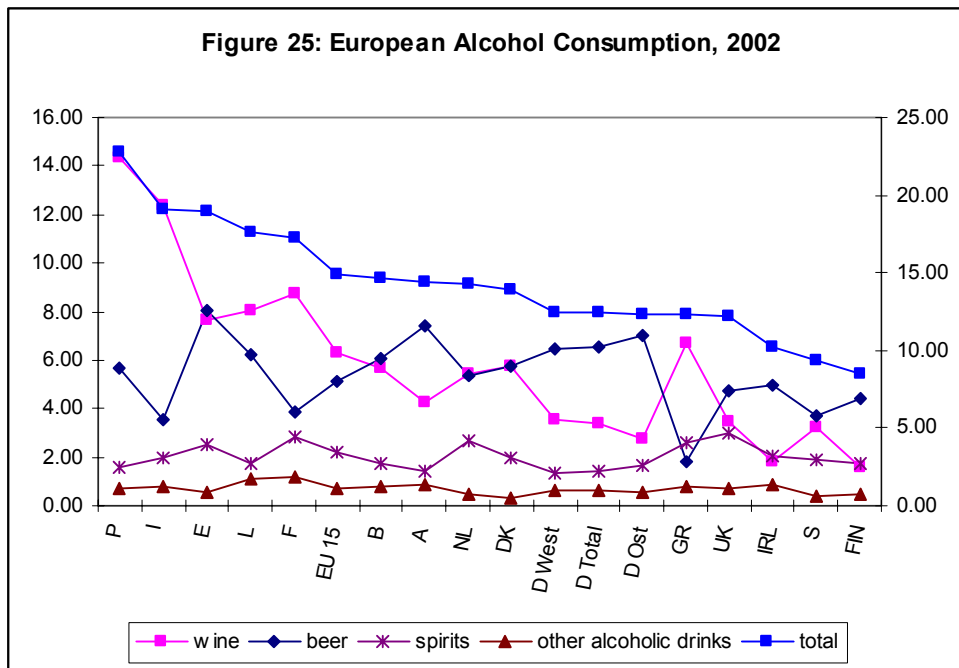


When all three measurements of alcohol consumption – percentage of population having drunk alcohol, number of days upon which alcohol was drunk and number of drinks drunk at one sitting – are placed together (see Table 12), some interesting patterns do emerge. Denmark has the highest percentage of those who have drunk alcohol in the previous four weeks, as well as a relatively high number of drinks per day on which alcohol was drunk. As noted above, Ireland has a low percentage of persons who have drunk alcohol in the previous four weeks, but the highest number of drinks consumed at one sitting.

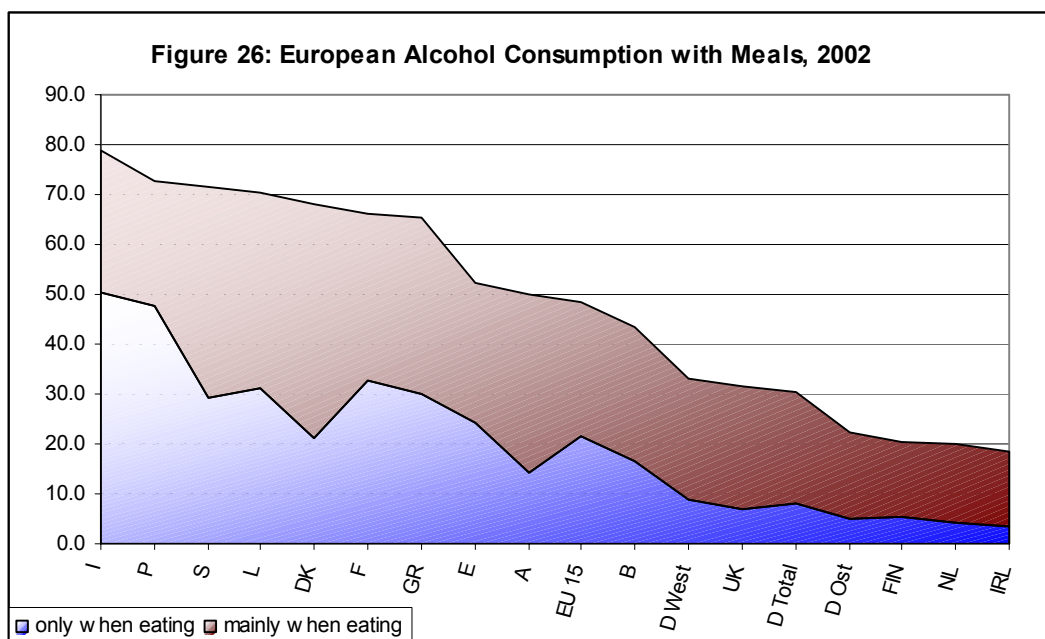
Table 12: Ranking of Measurement of Alcohol Consumption, 2002

% who have drunk alc. in prev. 4 weeks	Avg. no. of days alcohol was drunk	avg. no. of drinks per day
DK	P	IRL
S	I	FIN
L	E	DK
NL	L	UK
D Ost	F	S
UK	EU 15	B
FIN	B	NL
F	A	EU 15
GR	NL	F
B	DK	D West
EU 15	D West	D Total
D Total	D Total	D Ost
IRL	D Ost	L
D West	GR	E
A	UK	GR
I	IRL	P
P	S	A
E	FIN	I

The consumption of different types of alcohol – beer, wine or spirits – also differs from country to country (see Figure 25). Those countries which have the highest number of days upon which alcohol was drunk (Portugal, Italy, Spain, Luxembourg and France) also have the highest number of days upon which wine was drunk (Portugal 14.37, Italy 12.35, France 8.75, Luxembourg 8.04 and Spain 7.61), suggesting that drinking wine is a more social (see Figure 26) event and belongs to everyday life. The countries which drink the least wine are the former East Germany (2.78, as compared to 3.58 for West Germany and 3.38 for all of Germany), Ireland (1.83) and Finland (1.60). Beer is consumed upon the most days by Spaniards (8.03 days in the previous month), Austrians (7.38) and, in third place, Germans (6.58), and is consumed the least by Swedes (3.72), Italians (3.51) and Greeks (1.80). Beer is drunk much less often, both on average (6.34 EU average for wine, 5.14 EU average for beer) as well as by the top consumers, than is wine. With respect to spirits, there is less variation, with a high of 2.98 days upon which spirits were drunk, in the UK, followed by 2.86 in France and 2.66 in the Netherlands. The low end of the scale is occupied by Portugal (1.61), Germany (1.44) and Austria (1.43).



Overall, a plurality of the population (27.2%) drank alcohol mainly when eating, with 26.0% drinking alcohol mainly when not eating. Some 24.1% drank alcohol only when not eating and 21.4% drank alcohol only when eating, indicating that alcohol consumption is relatively evenly divided among the four groups. As far as national-level distinction among the four groups, a comparison of the percentage of Europeans who have drunk alcohol in the previous four weeks and of those who drank alcohol either ‘mainly when eating’ or ‘only when eating’ (see Figure 26) reveals that those countries in which the highest percentages drank alcohol did so, for the most part, with a meal. Many of the top countries for number of days on which alcohol was drunk (Portugal, Italy, Spain, Luxembourg and France) are also the top countries for drinking ‘mainly/only when eating’, and all are above the EU average.



Socio-demographic profiles

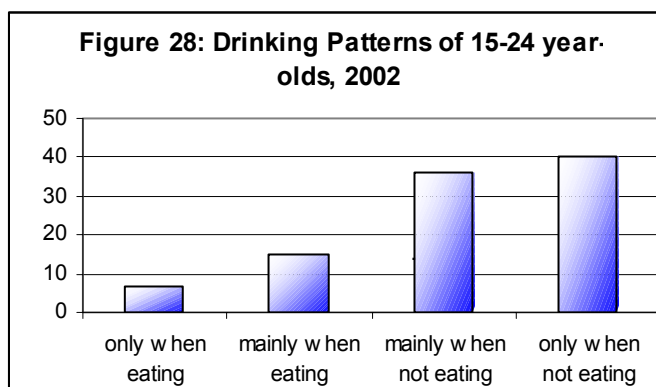
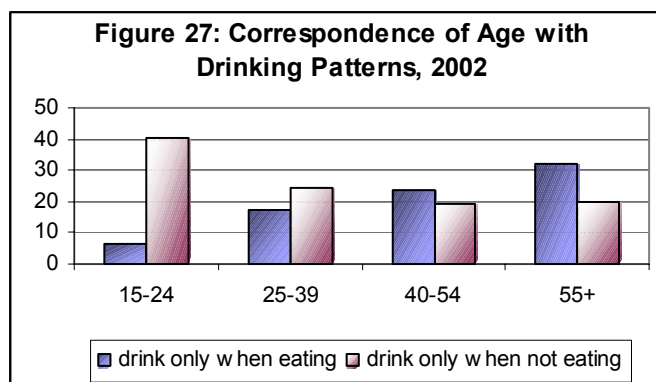
Considerably more men (72.9%) have drunk alcohol in the previous four weeks than women (49.9%). More of those who are older and have more education have also drunk alcohol in the previous four weeks (60.4% of those aged 15-24, 65.8% of those aged 25-29, 67.8% of those aged 40-54; 50.2% of those who studied up to 15 years of age, 64.7% of those who studied up to 16-19 years of age and 68.6% of those who left school at age of 20). Those with higher incomes have also more often drunk alcohol: highest income group: 73.1%, upper-middle: 64.0%, lower-middle: 60.3%, lower: 52.9 per cent. The group with the lowest percentage of those who have drunk alcohol in the previous four weeks are "house persons", with 46.6%, followed by women with 49.9% and those who studied up to 15 years of age with 50.2 per cent. Those groups with the highest percentages are the uppermost income group, with 73.1%, the self-employed, with 71.0% and managers, with 70.9 per cent.

With respect to the number of days upon which alcohol was drunk, the self-employed (19.49 days) and men (19.45 days) top the list, followed by the retired with 17.90 and those who studied up to 15 years of age, at 17.47 days. House persons, at 10.67, those still studying and students, at 10.47 and women, at 10.07, are those who drank on the fewest number of days in the previous four weeks. As age increases, so does the number of days upon which alcohol was drunk, with those aged 15-24 drinking on 10.92 days, 25-39 drinking on 13.75, those 40-54 drinking on 15.88 and those over 55 on 17.37 days. Education and income do not appear to play a significant role.

In terms of type of alcohol consumed, men (7.39), the unemployed (6.57) and manual workers (6.35) consumed the most beer, while students (3.93), house persons (2.61) and women (2.12) consumed the least. Age and education do not appear to play a role. For the consumption of wine, the retired (9.59), those over 55 (9.48), the self-employed (9.44) and those who left school at the age of 15 or younger (8.61) drank wine most often. The unemployed (3.72), those still studying (2.42), students (2.42) and those aged 15-24 (2.31) drank wine least often. As age increases, so do the number of days upon which persons drink wine: those aged 15-24 drink wine on 2.31 days, those aged 25-39 on 4.83 days, those aged 40-54 7.14 and those aged over 55 drank wine on 9.48 days. Men, the retired and those aged 15-24 most often drank spirits, at 2.80, 2.66 and 2.58 days, respectively. Managers, women and house persons drank spirits the least, at 1.07, 1.03 and 0.82 days, respectively. There do not appear to be any patterns of spirits consumption. For every category of alcohol, men drank more than did women.

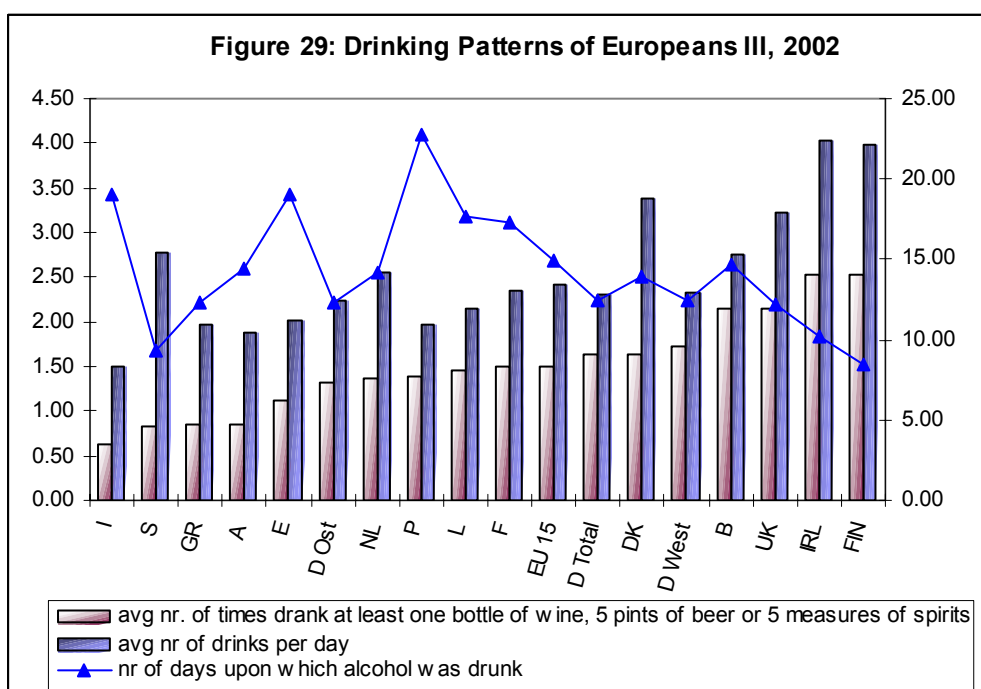
When total number of drinks (pints/bottles of beer, glasses of wine, measures of spirits) per day on which alcohol was drunk is counted, those who are aged 15-24 are clearly the socio-demographic group which drinks the most, with 3.10 drinks per day on which alcohol is consumed. Next are the unemployed, with 2.89 drinks per day, followed by students and those still studying with 2.84 and manual workers at 2.72. Those who drink the least are those aged over 55, with 1.98 drinks per day, those retired at 1.99 drinks per day, women at 2.04 drinks per day and house persons at 2.23 drinks per day. Men drink more than women, at 2.69 to 2.04, and the younger drink more than the older (15-24 years: 3.10 drinks, 25-39 years: 2.56 drinks, 40-54 years: 2.32, 55+ 1.98 drinks). Increase of education and of income correspond neither to an increase nor to a decrease in drinks per day.

There is a correlation of age to drinking patterns (with or without meals); the younger the person, the more likely he or she is to have drunk alcohol when not eating; the older are more likely to have drunk alcohol when eating (see Figure 27). The correspondence is particularly striking for the 15-24 year-olds (see Figure 28). Education does not appear to play a similar role. Those who left school at the age of 20 or older (35.1%), the self-employed (35.0%), other white collars (34.6%) and the uppermost income category (34.6%) rank the highest for drinking mainly when eating. In the same category, students, those aged 15-24 and those still studying all rank at just 15.1%, while 20.5% of the unemployed drink mainly when eating, as do 23.8% of the lowest income category.

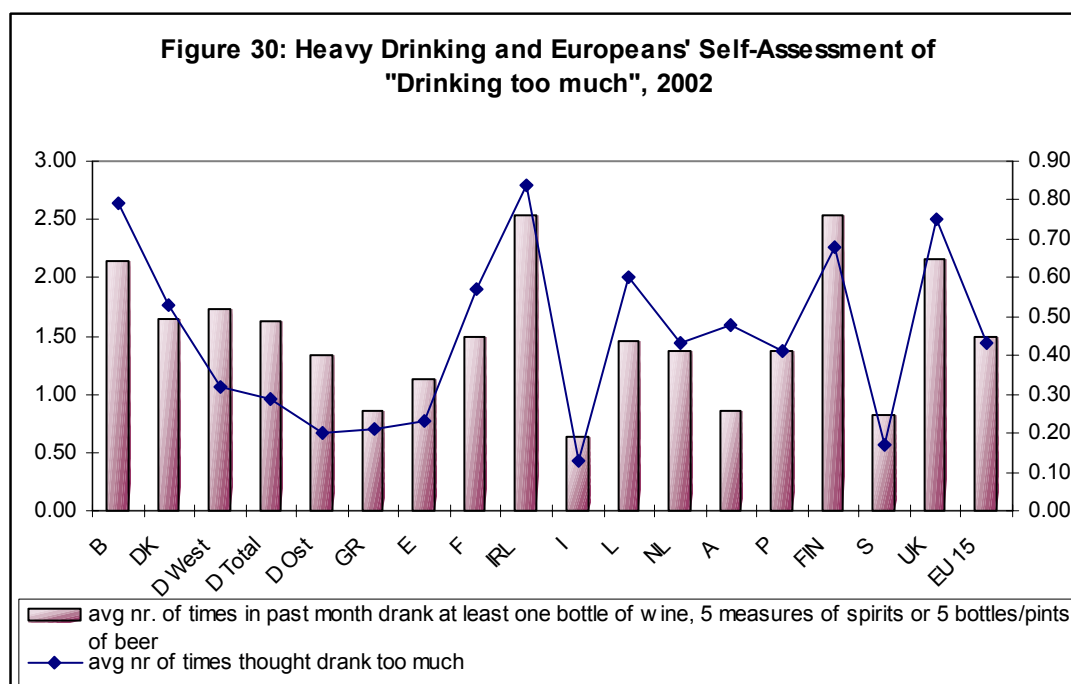


4.2. Excessive Alcohol Consumption

When asked as to how many times in the past month that they had consumed the equivalent of one bottle of wine, five pints/bottles of beer or five measures of spirits on one drinking occasion, the EU average was 1.49 times in the previous month, with a range from 0.63 (Italy) to 2.53 (Ireland and Finland). The second-highest was the UK, with 2.16, followed by Belgium, with 2.14. The second-lowest was Sweden with 0.83, and Austria and Greece, each with 0.86. While there does not appear to be any connection to the percentage of those who drank in the previous month in each country (the highest percentages were in Denmark, Sweden and Luxembourg and the lowest in Spain, Portugal and Italy), there are, however, connections to the amount of alcohol drunk on one day and, less so, to the number of days upon which alcohol was drunk (see Figure 29). As the number of drinks per day increases, so, too, does the number of times in which more than the aforementioned amount was drunk. With three exceptions (Sweden, Spain and Portugal), as the number of days upon which alcohol was consumed decreases, daily alcohol consumption increases.



When asked as to how many times in the previous month it had happened that they drank too much, the EU population responded with an average 0.43 times (this contrasts to the EU average of 1.49 times upon which Europeans drank at least the equivalent of one bottle of wine, five pints/bottles of beer or five measures of spirits on one drinking occasion), with a range from 0.13 times to 0.84 times. Ireland ranks highest, with 0.84, followed by Belgium with 0.79 and by the UK, with 0.75. At the bottom of the scale is Italy, with 0.13, followed by Sweden with 0.17, East Germany with 0.20 (West Germany compares at 0.32, all of Germany at 0.29) and Greece with 0.21. Despite the disparity between these figures and those above, as one score increases, so does, for the most part, the other (see Figure 30).

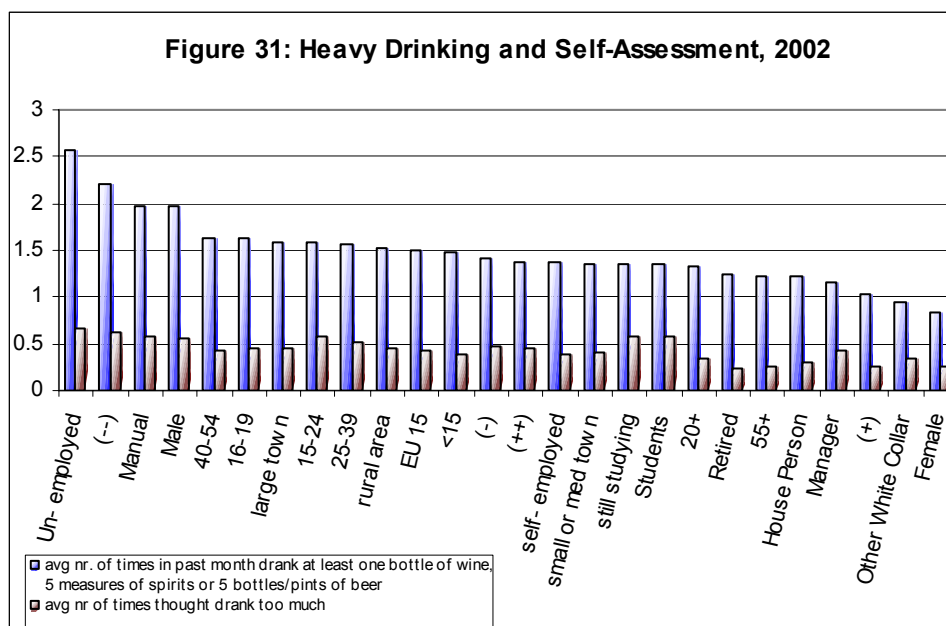


Socio-demographic profiles

With respect to socio-demographic groups and the number of times in the past month that EU citizens had consumed the equivalent of one bottle of wine, five pints/bottles of beer or five measures of spirits on one drinking occasion, the highest score was 2.58, for the unemployed, followed by 2.20, for the lowest income group and 1.98 times for manual workers. The groups with the least number of times on which this amount of alcohol was consumed were the upper-middle income group, with 1.03, other white collars, with 0.95 and women, with 0.84 (see Figure 31). There do not appear to be any patterns across various socio-demographic categories. When Europeans were asked as to how many times they felt they had drunk too much, the unemployed responded with 0.67, the lowest income group with 0.62 and the 15-24 year-olds with 0.58.

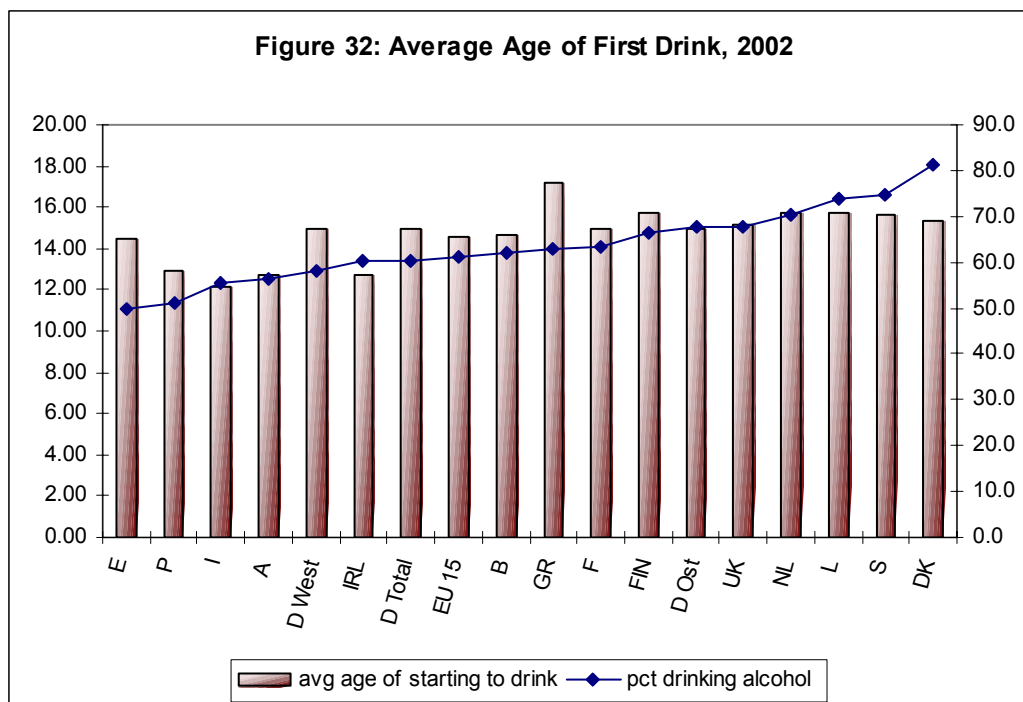
At the bottom of the scale were those over 55 with 0.26 and, once again, the upper-middle income group and women with 0.25 and the retired with 0.24.

The connection between drinking at least one bottle of wine, etc. and the self-assessment of having drunk too much remains with the socio-demographic groups: for the most part, those who drank more than one bottle of wine, etc. also assessed themselves as more often having drunk too much.



4.3. Average Age of First Drink

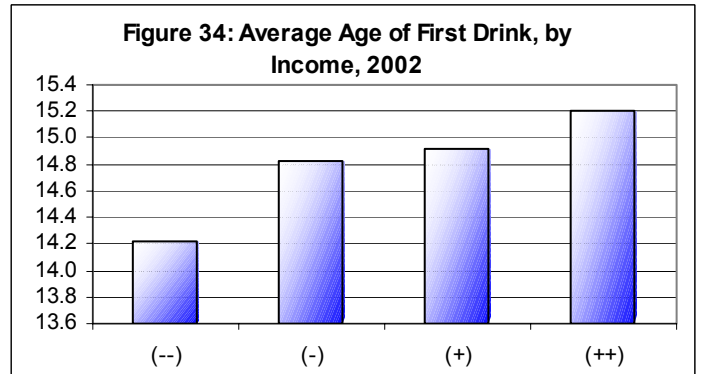
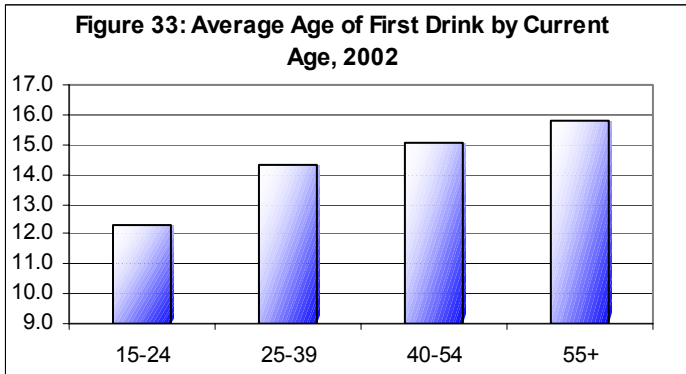
The average age at which Europeans began drinking is 14.57 years, with a range of 12.18, for Italy (followed by Ireland, at 12.70, and Austria, at 12.74) to 17.17, for Greece (followed by 15.76, for Luxembourg, and Finland at 15.74). When the average age of Europeans when they took their first drink is compared to the variety of drinking patterns discussed above, such as drinking more than a bottle of wine, etc., of average number of days per month on which alcohol was consumed, etc., there is no identifiable relationship between age of first drink and any of these. There is, however, a relationship between age of first drink and what percent of a country's nationals drank in the previous four weeks (see Figure 32). In general, looking at those countries in which a higher percentage have drunk alcohol in the previous four weeks, the age at which people began to drink is slightly lower.



Socio-demographic profiles

While men and women started drinking at approximately the same age (14.57 for men, 14.58 for women), there are some interesting differences to be noted in the age at which Europeans began drinking. The retired began drinking at 15.96, those over 55 at 15.81 and the uppermost income group at 15.21. Those who began drinking at the youngest age were house persons at 14.20, 15-24 year-olds, at 12.27, those still studying and students, both at 11.81. There is a clear correlation between current age and the age at which drinking was started: 15-24 year-olds started drinking at 12.27, 25-39 year-olds at 14.28, 40-54 year-olds at 15.02 and those over 55 at 15.81. In other words, the age of the first drink has been continuously decreasing (see Figure 33).

There is likewise a connection between income and age of first drink: the higher the income, the later the first drink. The lowest income group began drinking, on average, at 14.22, the lower-middle group at 14.82, the upper-middle group at 14.91 and the upper income group at 15.21 (see Figure 34). Education also plays a role, with those who studied up to 15 years of age starting to drink at 14.74, those who studied up to 16-19 years of age at 14.88 and those who left school at age of 20 or older at 15.13 (those still studying started at 11.81).



5. Safety in the European Union

5.1. Child Safety and Manufacturing

Overall, EU citizens agree fairly strongly (see Figure 35) on a range of statements concerning children's safety and manufacturing. They agree that manufacturers should bear the responsibility for the safety of their products and that they should take children's safety into account when designing play areas, child-related products and other products. Europeans agree slightly less strongly that the EU should enforce standards and regulations to help reduce accidental injury. At the bottom of the list, but still well above "tend to agree", are the statements that most accidental injuries concerning children can be avoided and that many products designed for child safety have unclear or complicated instructions. There is little variation on the national level on these statements, with scores below 4.00 only appearing for the two last statements in Figure 35 (see Table 13).

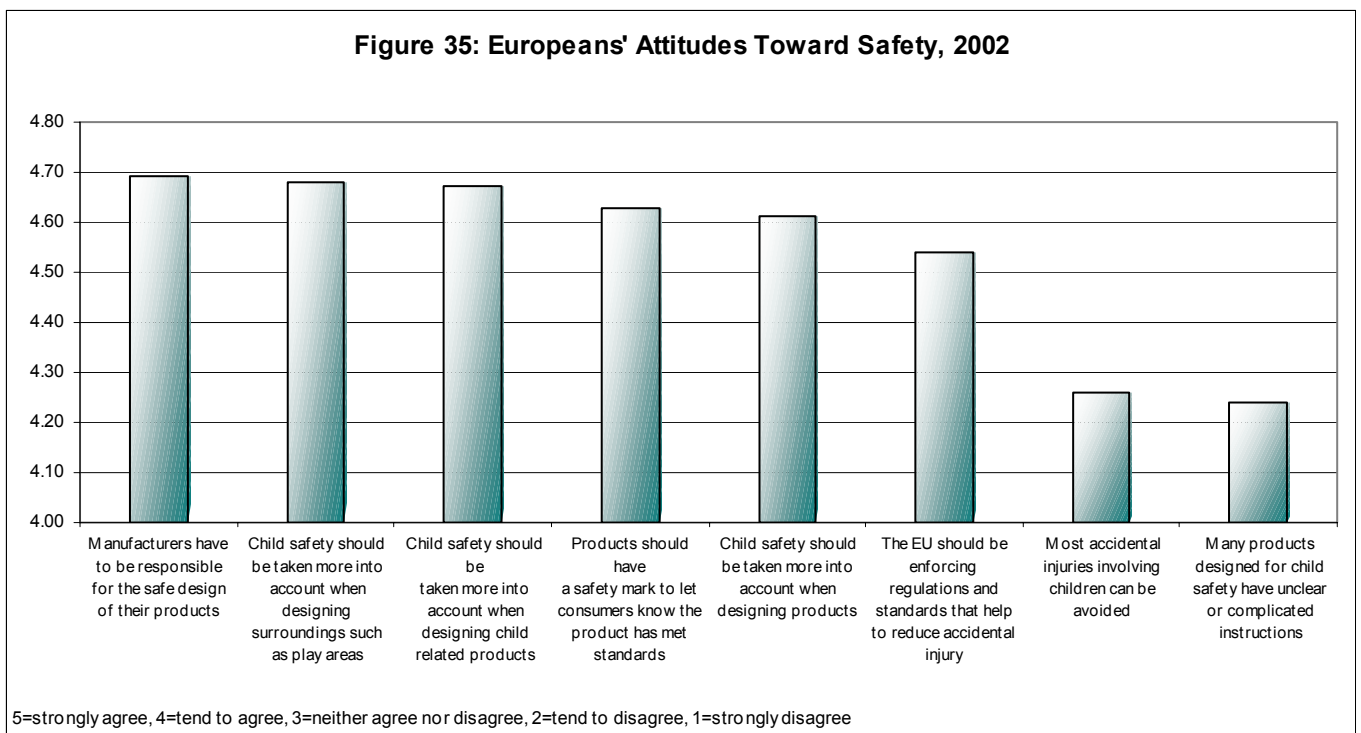


Table 13: Manufacturers and Safety, 2002*

	Child safety should be taken more into account when designing child related products	Child safety should be taken more into account when designing products	Child safety should be taken more into account when designing surroundings such as play areas	Many products designed for child safety have unclear or complicated instructions	Products should have a safety mark to let consumers know the product has met standards	Manufacturers have to be responsible for the safe design of their products	The EU should be enforcing regulations and standards that help to reduce accidental injury	Most accidental injuries involving children can be avoided
GR	4.92	4.89	4.91	4.64	4.88	4.86	4.87	4.67
E	4.81	4.76	4.76	4.58	4.76	4.77	4.72	4.53
I	4.84	4.73	4.80	4.29	4.70	4.78	4.68	4.46
P	4.70	4.66	4.71	4.48	4.64	4.65	4.68	4.55
IRL	4.72	4.67	4.72	4.38	4.65	4.72	4.68	4.42
S	4.84	4.79	4.85	4.18	4.70	4.89	4.52	4.19
L	4.68	4.67	4.68	4.16	4.76	4.77	4.64	4.12
UK	4.72	4.64	4.76	4.12	4.74	4.79	4.48	4.20
EU 15	4.67	4.61	4.68	4.24	4.63	4.69	4.54	4.26
D Ost	4.63	4.57	4.65	4.32	4.59	4.74	4.52	4.27
D Total	4.60	4.56	4.64	4.29	4.57	4.68	4.48	4.17
B	4.65	4.55	4.66	4.24	4.59	4.62	4.54	4.08
D West	4.59	4.56	4.63	4.29	4.56	4.67	4.47	4.15
FIN	4.72	4.66	4.73	3.97	4.67	4.82	4.19	3.96
A	4.58	4.55	4.59	4.26	4.52	4.55	4.45	4.14
DK	4.59	4.37	4.66	3.93	4.58	4.78	4.25	3.73
NL	4.30	4.26	4.34	3.76	4.29	4.41	4.17	3.66
F	4.48	4.47	4.52	4.08	4.52	4.51	4.47	4.22

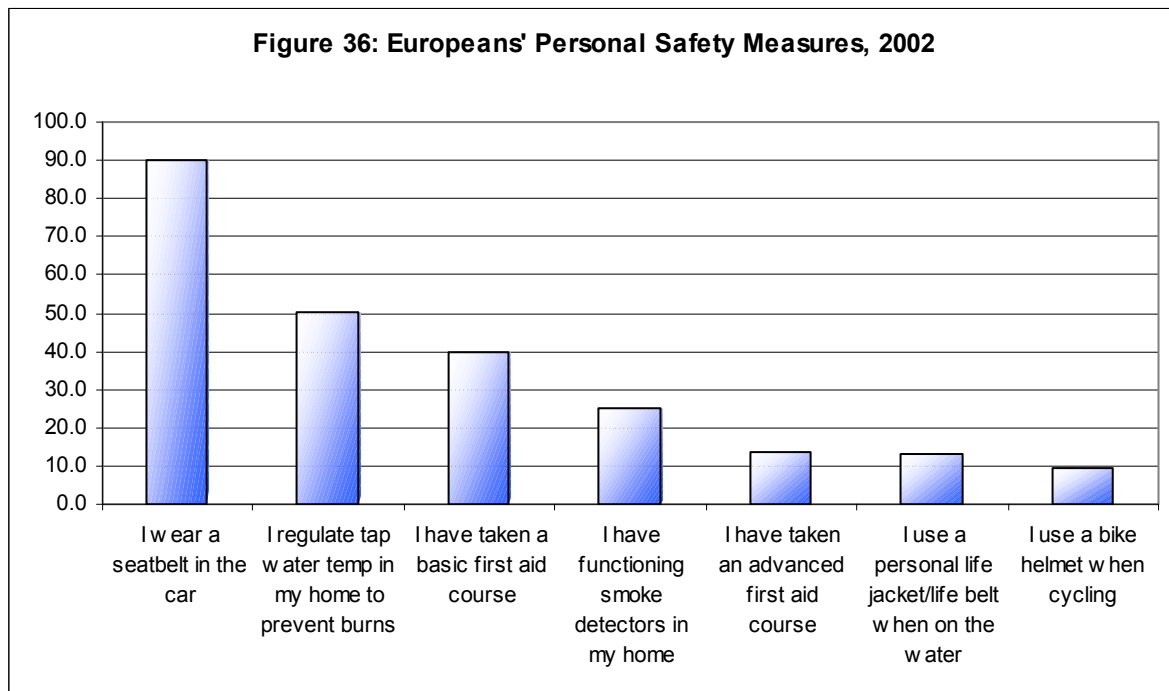
*(5=strongly agree, 4=tend to agree, 3=neither agree nor disagree, 2=tend to disagree, 1=strongly disagree)

Socio-demographic profiles

As in the case of the national differentiation, there is little variation on this question among different socio-demographic groups. There is a range of 4.75 (house persons and the upper-middle income group) to 4.64 for the self-employed on the issue of manufacturer responsibility. On taking child safety into account when designing surroundings, Europeans respond with a range of 4.74, for house persons, to 4.63, for the lowest income group. With respect to child safety being taken into account when designing child-related products, Europeans' responses range from 4.74 (house persons) to 4.57 (managers). House persons again are the high end of the range, with a score of 4.71 on whether products should have a safety mark, with managers again at the low end, with 4.58. The same groups are again high and low, with 4.69 and 4.52, on whether child safety should be taken into account when designing products, and again, with 4.67 and 4.44, on whether the EU should enforce regulations and standards to help reduce accidental injury. House persons represent the high end of the scale for the question of whether most accidental injuries can be avoided, with 4.38, and managers the low end, with 4.07. On the final point, as to whether many products designed for child safety have confusing instructions, the retired have the highest score, with 4.34 (house persons rank at 4.32) while students and those still studying rank at 4.05. While there is little variation, house persons agree most strongly with all but one of these statements, while managers rank lowest on a significant number.

5.2. Personal Safety

In terms of measures taken to protect personal safety, the wearing of a seatbelt is the measure most often taken, with nearly ninety percent (89.9%) of Europeans doing so. Just about half (50.5%) of all Europeans regulate the temperature of tap water in their homes to prevent burns, while just under forty percent (39.7%) have taken a basic first aid course. Under ten percent (9.2%) of Europeans use a bicycle helmet when cycling (see Figure 36).



There are also considerable national differences on many of these points, unlike in the previous question of agreement with various statements (see Table 14). Austrians, Finns and Swedes are the most safety-conscious, while Belgians and Italians and Greeks are the least. While 95.5% of the French and the Swedes wear seatbelts, as do 94.9% of West Germans (East Germans 90.3%), just 78.9% of Belgians, 78.5% of Greeks and 74.3% of Italians do so. The Spanish and the Portuguese are both above the EU average, so strict regional differences are not the case. Likewise, while 83.1% of Danes regulate the temperature of tap water, just 32.3% of the Irish do so. Some of the differences are dependent upon various national laws. Germany tops the list for having taken a basic first aid course (all of Germany 74.9%, former East Germany 79.1% and West Germany 73.7%), in part because this course is one of the requirements for the driver's license. The EU average is, as noted, just 39.7%, with Southern Europe bringing up the bottom of the list (Greece 19.9%, Spain 19.1%, Italy 12.3% and Portugal 8.0%).

With respect to functioning smoke detectors, Finland (91.7%) and Sweden (83.3%) top the list, followed by the UK with 79.1 per cent. Spain and France, with 4.9%, are toward the bottom, followed by Italy with 4.8%, Portugal with 3.4% and Greece with 1.8 per cent. Southern European countries are again at the bottom of the chart. Finland and Sweden are countries in which more houses are built in wood, indicating there may be a structural reason for the higher use of smoke detectors.

Table 14: Personal Safety, 2002

	I wear a seatbelt in the car	I regulate tap water temp in my home to prevent burns	I have taken a basic first aid course	I have functioning smoke detectors in my home	I have taken an advanced first aid course	I use a personal life jacket/life belt when on the water	I use a bike helmet when cycling
A	87.4	43.2	66.6	14.0	24.5	2.1	14.3
FIN	94.4	65.0	57.3	91.7	23.9	55.1	18.4
S	95.5	39.4	72.1	83.3	26.6	56.4	15.3
DK	90.3	83.1	61.2	49.7	31.2	44.1	6.2
L	93.2	64.8	43.2	18.2	48.8	18.3	16.1
UK	93.8	34.6	43.0	79.1	12.1	14.5	12.4
IRL	94.5	32.3	32.8	77.9	9.6	13.7	13.0
D West	94.9	40.3	73.7	14.3	25.0	8.1	14.9
D Total	93.9	39.8	74.9	13.9	24.3	7.5	13.3
D Ost	90.3	38.1	79.1	12.7	21.6	5.5	7.5
EU 15	89.9	50.5	39.7	25.0	13.7	12.9	9.2
NL	89.2	39.7	36.1	43.3	14.3	8.7	2.0
E	94.3	82.5	19.1	4.9	5.8	2.8	8.8
F	95.5	41.3	25.7	4.9	13.2	22.3	7.6
P	90.9	78.6	8.0	3.4	1.3	8.5	9.7
B	78.9	41.8	25.5	10.1	10.2	10.2	4.3
I	74.3	70.5	12.3	4.8	4.0	9.4	2.6
GR	78.5	47.5	19.9	1.8	5.6	2.2	4.6

Luxembourg (48.8%), Denmark (31.2%) and Sweden (26.6%) top the list of the countries where an advanced first aid course was most often taken. Southern Europeans took such a course least often, with Spain (5.8%), Greece (5.6%), Italy (4.0%) and Portugal (1.3%) ranking at the bottom. Nordic countries most often use life jackets when on the water (Sweden 56.4%; Finland 55.1% and Denmark 44.1%) while Spain (2.8%), Greece (2.2%) and Austria (2.1%) bring up the bottom. Finns, Luxembourgers and Swedes most often wear helmets when bicycling (18.4%, 16.1% and 15.3%, respectively) while Belgians (4.3%), Italians (2.6%) and the Dutch (2.0%) wear helmets the least.

Socio-demographic profiles

The higher the income, the more likely it is that individuals wear seatbelts; 85.0% of the lowest income group wear seatbelts, as do 91.4% of the lower-middle group, 92.0% of the upper-middle group and 94.2% of the upper income group. Those with more education do so as well (93.0% of those who left school at age of 20 do so, 91.0% of those who studied up to 16-19 years of age, and 86.1% of those who studied up to 15 years of age). The top of the range is 95.9% (managers) and the bottom 85.0% (the lowest income group). Some 58.7% of those in the highest income group, the highest percentage, regulate tap water temperature, while just 42.9% of 15-24 year-olds do so. Income again plays a role, with percentage of those regulating temperature increasing with income: ((- -) 44.9%, (-) 49.0%, (+) 53.4% and (++) 58.7%). Origin plays a role as well, with 54.1% of those in rural areas doing so, 51.0% of those in middle-sized towns and 46.2% of those in large towns. The group which has most often taken a first aid course are managers, with 60.0%, and the group which has done so the least are those who studied up to 15 years of age, at 25.4 per cent. Education plays somewhat of a role, with 45.8% of those who studied up to 16-19 years of age having taken such a course and 48.5% of those who left school at age of 20 or later having done so. There is a significant difference between men and women, with 43.6% to 36.1% having taken a course. Just 27.4% of house persons have done so. Income plays somewhat of a role, with the lowest income group ranking at 34.7%, the lower-middle ranking at 42.0%, the upper middle at 49.8% and the upper at 49.2 per cent. Origin again plays a role, with 41.3% of those from a rural area having taken a course, 39.8% of those in a medium-sized town having done so and 37.7% of those in a large town.

In terms of having functioning smoke detectors, income represents the greatest range, with the lowest percentage overall being the lowest income group (at 18.0%) and the highest percentage overall being the highest income group (31.9%). Some 25.4% of the lower-middle income group has smoke detectors, as does 24.8% of the upper-middle group. Those from rural areas have smoke detectors in 23.1% of the cases, from small or middle-sized towns in 25.5% of the cases and from large towns in 26.0 per cent of the time. Those who have taken an advanced first aid course are much the same as those who have taken a first aid course – managers rank top, with 28.2%, with the lowest percentage again being represented by those who studied up to 15 years of age. Those who studied up to 16-19 years of age are at 15.2%, and those who studied up to more than 20 years of age at 21.8 per cent. House persons again have a fairly low participation, with 7.5 per cent. The range between men and women remains, with 16.2% of men having done so, but just 11.5% of women. Income plays a role, with the lowest group having taken such a course in 10.3% of the cases, the lower-middle group having done so at a rate of 14.4%, the upper middle at 18.5% and the upper at 19.3 per cent.

Those from rural areas have again taken courses more often than those from larger towns: 15.5% compared to 13.1% for small/middle-sized towns and 13.0% for large towns, perhaps reflecting less access to immediate emergency care.

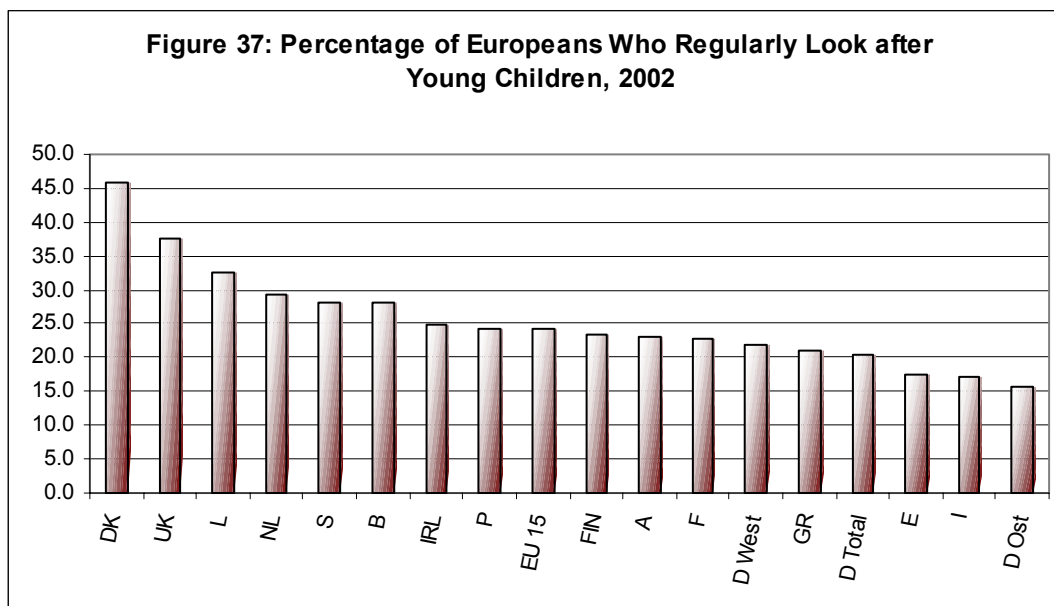
Managers most often wear a life jacket when on the water, at 23.0%, while those with education up to 15 years do so the least (7.0%). Education and income again play a role, with those who studied up to 16-19 years of age doing so 11.7% of the time and those who left school at age of 20 doing so 20.2% of the time. The lowest income group does so 10.4% of the time, while the lower-middle group does so in 11.8% of the cases, the upper middle group in 13.3% and the upper group in 19.7 per cent of the cases. The top and bottom of the range is again the same for using a bicycle helmet, with 16.7% of managers doing so, but just 4.0% of those who studied up to 15 years of age. Those who studied up to 16-19 years of age do so in 9.8% of the cases, and those who left school at age of 20 at a rate of 11.8 per cent. The lowest income group does so at a rate of 7.1%, the lower-middle group at 8.6%, the upper-middle group at 10.3% and the upper group at 12.4 per cent. It is clear that education level and income level both play a role in personal safety consciousness.

5.3. Child Safety in the Home

With generally available information indicating that the majority of accidents involving children occur in the home, child safety in the home is a vitally important issue. Europeans agree, overall, that most accidental injuries involving children can be avoided (EU average 4.26 on a scale of 4=tend to agree and 5=strongly agree). The results here, which refer only to those Europeans who affirmed that they take care of children under the age of 10, support this finding, with a significant number of these Europeans taking safety precautions (see EU average Table 15).

Overall, Ireland, the United Kingdom and Greece are the most safety-conscious countries in the European Union, while Sweden, Finland and Denmark are the least (see Table 15). It must be noted, however, that this statistic is arrived at by including such actions as "using a stair guard". For persons whose homes do not have stairs, clearly the answer will be in the negative, although the response does not necessarily indicate a lower awareness of security. Likewise, "remaining with a child near pets" is only relevant for households with pets. Finally, these questions refer to children below the age of ten, so that some questions, such as "using straps in the high chair" are irrelevant.

Before we discuss these results in more detail, it is worth indicating in which countries individuals regularly take care of children under the age of ten. The EU average is 24.2 per cent. Denmark (45.8%), the United Kingdom (37.5%) and Luxembourg (32.5%) top the list, while Spain (17.5%), Italy (17.1%) and East Germany (15.8%, as opposed to West Germany at 21.8%, for a total Germany of 20.5%) are at the bottom (see Figure 37).



Taking the above comments into account, as well as Figure 37, let us take a closer look at safety precautions taken in the home. Some 92.1% of Spaniards assist children crossing the road while walking, while just 68.6% of Finns do so. East Germans (91.4%, as compared to 80.9% West Germans, and 82.6% overall), Greeks (90.5%) and those in the United Kingdom (88.7%) rank the highest in terms of keeping household cleaners and vitamins out of reach. At the bottom are Finland, Sweden and Denmark, with 71.9%, 70.6% and 64.4%, respectively. In the United Kingdom, 89.4% keep an eye on the child while they are cooking, but just 61.6% of Finns do so.

Germany (89.8%), Austria (87.6%) and Luxembourg (85.8%) top the list in terms of putting children in car seats, while Belgium (57.7%), Italy (57.4%) and Greece (47.8%) are at the bottom, with Spain and Portugal (63.2% and 63.6%) also below the EU average (75.7%). Again, it must be noted that this statistic includes children up to the age of ten. The UK again ranks top for keeping an eye on the child while gardening or doing work around the home (DIY), with 84.3% doing so, as compared to just 59.6% of Spaniards who do so. The range for keeping matches and lighters out of reach is 88.5% (Ireland) to 50.5% (Denmark). Greeks are the top of the range, with 81.6% remaining with a child in the bath, compared to 56.3% of Finns who do so. The range for keeping knives and sharp objects out of reach is 84.5% (Ireland) to 46.8% (Denmark).

Some 71.8% of Greeks remain with a child on a changing table, as do 44.5% of West Germans (compared to 50.8% of East Germans, or 45.5% of all Germans). Some 74.6% of Greeks always stay with a child which is around pets, while just 26.4% of West Germans (49.3% of former East Germans, 30.2% of all Germans) do so. Spain, Portugal and Greece are at the top for accompanying children walking or biking to school, with 77.9%, 62.7% and 61.6%, respectively, with Germany (36.0%), Denmark (32.9%) and Finland (28.2%) at the bottom. Greece and East Germany (68.2%) are the top of the range for using electrical plug guards, and Denmark once again (26.0%) is the bottom of the range. For using straps in the high chair, the range goes from 55.4% (Ireland) to 19.0% (Denmark) while the range for using stair gates goes from 54.2% (United Kingdom) to 14.7% (Portugal). For using window guards, the range goes from 41.2% (Spain) to 3.8% (Denmark), again reflecting differing styles of homes and surroundings as well as of safety awareness.

2002

GR	E	D Ost	A	F	EU 15	L	B	P	NL	I	D Total	D West	S	FIN	DK
86.3	92.1	87.9	74.1	88.5	85.3	76.3	82.9	84.5	80.4	87.4	81.3	80.0	77.9	68.6	78.3
90.5	80.2	91.4	86.2	73.2	80.5	82.3	77.0	78.4	73.5	75.5	82.6	80.9	70.6	71.9	64.4
74.8	76.2	82.6	76.2	79.6	77.8	78.5	83.7	71.8	76.1	76.6	67.2	64.1	64.4	61.6	72.9
47.8	63.2	87.1	87.6	84.8	75.7	85.8	57.7	63.6	69.4	57.4	89.8	90.4	77.0	78.3	76.2
83.4	59.6	79.4	76.5	70.7	73.5	81.4	77.8	75.0	74.5	64.7	70.7	69.0	67.4	64.4	71.6
84.8	78.9	84.0	77.3	61.5	73.2	67.8	66.8	76.3	66.1	72.1	70.3	67.5	64.4	71.2	50.5
81.6	75.8	72.9	66.2	69.7	68.2	68.9	70.8	72.5	64.1	64.8	61.5	59.2	61.8	56.3	61.4
82.2	76.4	73.1	70.6	60.6	68.1	54.9	62.4	70.1	52.3	61.1	63.6	61.7	50.4	46.9	46.8
71.8	65.3	50.8	63.4	65.8	56.5	50.0	63.3	59.7	54.9	51.8	45.5	44.5	62.9	50.6	57.0
74.6	63.6	49.3	40.9	69.0	52.8	56.6	64.7	54.8	51.8	47.4	30.2	26.4	36.3	69.1	34.8
61.6	77.9	34.9	43.1	56.9	51.7	54.1	55.9	62.7	59.4	41.7	36.0	36.2	37.5	28.2	32.9
68.2	61.1	68.2	64.0	46.0	51.1	61.3	37.1	39.0	49.0	42.3	64.3	63.5	42.9	43.2	26.0
20.5	32.2	34.9	47.6	40.7	37.9	32.3	43.5	30.6	20.6	52.0	28.0	26.6	31.0	22.1	19.0
19.2	20.4	30.8	34.4	37.1	31.5	36.7	32.7	14.7	37.2	22.0	26.7	25.9	25.1	17.0	17.7
40.5	41.2	27.0	27.6	13.5	25.7	18.0	13.6	25.8	36.6	27.3	19.7	18.3	37.9	27.2	3.8

Socio-demographic profiles

Those aged 25-39 are the group which takes care of the most children under age 10, at 47.5%, with students doing so the least, at 8.5 per cent. Women take care of children, at 28.7%, more often than do men, at 19.3 per cent. Among occupations, house persons do so the most, at 45.5%, and students at 8.5% and the retired at 8.7% the least. With respect to income, there is a progression from the lowest to the upper-middle groups (15.8%, 26.0%, 31.3%) but the percentage then drops again at the highest group, to 29.6 per cent.

With respect to child safety in the home, there is fairly little variation on the socio-demographic level. Some 88.4% of the unemployed assist a child to cross the road on foot, while 74.6% of those aged 15-24 do so. Those aged 25-39, the group which most takes care of children, do so at 86.9 per cent. Neither education nor income appears to play a role in this question. Keeping household cleaners and vitamins out of reach, however, does appear to be linked to education, with those who studied up to 20 years of age or later doing so at 75.5%, those who studied up to 16-19 years of age doing so at 82.1% and those who studied up to 15 years of age doing so at 83.5 per cent. The range is from 73.3%, for the unemployed, to 86.6%, for house persons. Income does not play a role. When cooking, 90.0% of house persons also keep an eye on the child, while just 67.7% of men do so. Age appears to be significant, with 83.9% of 15-24 year-olds doing so, but just 79.4% of 25-39 year-olds and 69.4% of 40-54 year-olds doing so. Income again plays a role – but only for the three lower categories: the lowest group ranks at 80.5%, the lower-middle group at 77.3% and the upper-middle group at 75.4 per cent. The upper group ranks at 76.0 per cent.

Putting children into car seats does, as in the national-level data, have some variation: while 83.1% of managers put children into car seats, just 63.4% of the retired do so, along with 64.3% of those who studied up to 15 years of age. Education and income again play a role, with 78.8% of those who studied up to 16-19 years of age putting children in car seats and 79.1% of those who left school at age of 20 or later doing so. Some 77.5% of house persons and 82.3% of those aged 25-39 years (the main caregivers of children) do so as well. With respect to income, 71.2% of the lowest income group do so, as do 76.3% of those in the lower-middle income group, 77.2% of the upper-middle and 80.1% of the upper income group.

When Europeans are gardening or working in the house (DIY), 73.5% keep an eye on any child as well. The range for socio-demographic groups is from 55.1%, for students, to 78.3%, for the upper income group. Both income and origin play a role, with the lowest income group keeping an eye on children 70.7% of the time, the lower-middle group doing so in 73.9% of the cases and the upper-middle group in 76.5% of the cases. Those of rural origin keep an eye on children 76.3% of the time, as compared to 74.0% for those from small or middle-sized towns and 70.1% for those from large towns.

Those with less education keep lighters and matches locked away more often than do those with more education (up to 15 years of age: 78.4%; 16-19 years of age: 73.1%; 20 years of age or older 69.8%). The retired are most careful with matches and lighters (82.0%) and other white collars (65.2%) are the least careful. Those in large towns (76.6%) are more careful than those in rural areas or small towns (both 72.0%). Those with less education are also more careful with a child in the bath: 71.0% of those who studied up to 15 years of age always remain with a child in the bath, as compared to 67.6% of those who studied up to 16-19 years of age and 67.5% of those who left school at age of 20 or later. The group that most often remains with a child in the bath is those aged 15-24 (82.4%), and the group that does so the least is men, at 61.9 per cent.

Knives and other sharp objects are again treated by those with less education with more respect: 76.5% of those with education up to 15 years keep knives and other sharp objects out of reach of children, while just 68.2% of those who studied up to 16-19 years of age and 60.7% of those who left school at age of 20 or later do so. The highest percentage is found with the 15-24 year-olds at 85.6% and the lowest is 60.2%, for those in the upper income category. Income also plays a role, with increasing income resulting in decreasing care with sharp objects: the lowest income group keeps knives locked away 72.5% of the time, the lower-middle group does so 70.2% of the time and the upper-middle group does so 65.1% of the time.

Some 65.1% of 15-24 year-olds always remain with a child on the changing table, compared to 46.5% of 40-54 year-olds. There are no particular trends within the socio-demographic profiles. Some 45.3% of the self-employed always remain with children around pets, as do 58.5% of house persons. Education and income do not play a role, but origin once again does so: persons of rural origin always remain with children around pets 49.9% of the time, compared to 53.1% of those from small or medium-sized towns and 56.4% of those from large towns.

House persons accompany children travelling to school on foot or on bicycle in 59.9% of the cases, while those aged 15-24 do so 40.1% of the time. The retired use electrical plug guards 42.4% of the time, while those aged 15-24 do so 57.2% of the time. Age appears to be a factor, with 54.5% of those aged 25-39 doing so, and 44.2% of those aged 40-54 doing so. Those aged 40-54 and the unemployed both use straps in the high chair only at 29.5%, while house persons do so 44.0% of the time. The lowest income groups use a stair gate/guard 27.4% of the time, although it should be noted that the lowest income groups are least likely to have a home with stairs and are more likely to live in an apartment on one level. Those aged 15-24 use a stair gate most often, at 39.5 per cent. The self-employed use window guards the least at 21.3%, while manual workers use them the most, at 29.2 per cent.

Overall, while those of higher income and higher education take great care with personal safety, such as wearing bicycle helmets, they take less care with keeping certain objects out of children's reach.

2002

GR	E	D Ost	A	F	EU 15	L	B	P	NL	I	D Total	D West	S	FIN	DK
86.3	92.1	87.9	74.1	88.5	85.3	76.3	82.9	84.5	80.4	87.4	81.3	80.0	77.9	68.6	78.3
90.5	80.2	91.4	86.2	73.2	80.5	82.3	77.0	78.4	73.5	75.5	82.6	80.9	70.6	71.9	64.4
74.8	76.2	82.6	76.2	79.6	77.8	78.5	83.7	71.8	76.1	76.6	67.2	64.1	64.4	61.6	72.9
47.8	63.2	87.1	87.6	84.8	75.7	85.8	57.7	63.6	69.4	57.4	89.8	90.4	77.0	78.3	76.2
83.4	59.6	79.4	76.5	70.7	73.5	81.4	77.8	75.0	74.5	64.7	70.7	69.0	67.4	64.4	71.6
84.8	78.9	84.0	77.3	61.5	73.2	67.8	66.8	76.3	66.1	72.1	70.3	67.5	64.4	71.2	50.5
81.6	75.8	72.9	66.2	69.7	68.2	68.9	70.8	72.5	64.1	64.8	61.5	59.2	61.8	56.3	61.4
82.2	76.4	73.1	70.6	60.6	68.1	54.9	62.4	70.1	52.3	61.1	63.6	61.7	50.4	46.9	46.8
71.8	65.3	50.8	63.4	65.8	56.5	50.0	63.3	59.7	54.9	51.8	45.5	44.5	62.9	50.6	57.0
74.6	63.6	49.3	40.9	69.0	52.8	56.6	64.7	54.8	51.8	47.4	30.2	26.4	36.3	69.1	34.8
61.6	77.9	34.9	43.1	56.9	51.7	54.1	55.9	62.7	59.4	41.7	36.0	36.2	37.5	28.2	32.9
68.2	61.1	68.2	64.0	46.0	51.1	61.3	37.1	39.0	49.0	42.3	64.3	63.5	42.9	43.2	26.0
20.5	32.2	34.9	47.6	40.7	37.9	32.3	43.5	30.6	20.6	52.0	28.0	26.6	31.0	22.1	19.0
19.2	20.4	30.8	34.4	37.1	31.5	36.7	32.7	14.7	37.2	22.0	26.7	25.9	25.1	17.0	17.7
40.5	41.2	27.0	27.6	13.5	25.7	18.0	13.6	25.8	36.6	27.3	19.7	18.3	37.9	27.2	3.8

APPENDICES

ENGLISH QUESTIONNAIRE

Let's move to another topic, health problems.

Q.19. Do you have or have you ever had any of the following illnesses?

	READ OUT	YES	NO	DK
1	Diabetes	1	2	3 (345)
2	An allergy	1	2	3 (346)
3	Asthma	1	2	3 (347)
4	Hypertension (high blood pressure)	1	2	3 (348)
5	Long-standing troubles with your muscles, bones and joints (rheumatism, arthritis)	1	2	3 (349)
6	Cancer	1	2	3 (350)

EB59.0 – NEW

Q.20. In the last twelve months, have you...?

	READ OUT	YES	NO	DK
1	been to a family doctor or a general practitioner	1	2	3 (351)
2	been to a dentist	1	2	3 (352)
3	been to a psychiatrist (N)	1	2	3 (353)
4	been to another specialist (M)	1	2	3 (354)
5	been in a hospital or clinic as a patient overnight or longer	1	2	3 (355)

EB52.1 – Q.22. – TREND MODIFIED

Q.21. a) Are you undergoing a long-term treatment?

Yes..... 1 (356)
 No 2
 DK/refusal..... 3

EB59.0 – NEW

IF "YES", CODE 1 IN Q.21.a.

Q.21. b) For what reason? (SHOW CARD – READ OUT – ONE ANSWER ONLY)

Cardio-vascular disease.....	1 (357 – 358)
Diabetes	2
An allergy	3
Asthma	4
Cancer	5
AIDS/HIV	6
Depression	7
Troubles with your muscles, bones and joints (rheumatism, arthritis).....	8
Physical disability	9
Hypertension (high blood pressure)	10
Chronic skin disease	11
Others (SPONTANEOUS).....	12
DK/refusal	13

EB59.0 – NEW

ASK ALLQ.22. How many of your own natural teeth are missing?
(READ OUT – ONE ANSWER ONLY)

None	1 (359)
1-5 teeth	2
6-10 teeth	3
More than 10 teeth, but not all.....	4
All teeth missing	5
DK/refusal	6

EB59.0 – NEW

Q.23. Over the last twelve months, on the whole, how satisfied have you been with your teeth, the dentures or false teeth you may have or your mouth in general?
Would you say you have been...? (SHOW CARD – READ OUT – ONE ANSWER ONLY)

very satisfied	1 (360)
fairly satisfied	2
neither satisfied nor dissatisfied	3
fairly dissatisfied.....	4
very dissatisfied.....	5
DK/refusal (M).....	6

EB44.3 – Q.115. – TREND MODIFIED

- Q.24. I am going to read out a series of possible tests or health check-ups.
For each of them, please tell me if you had one in the last twelve months, whether or not as part of any treatment.
And if yes, whether it was on your own initiative, at a doctor's initiative or as part of a screening programme?

	READ OUT	YES, OWN INITIATIVE	YES, DOCTOR'S INITIATIVE	YES, SCREENING PROGRAMME	NO	DK
1	Dental check-up	1	2	3	4	5 (361)
2	X-ray, ultrasound or other scan (M)	1	2	3	4	5 (362)
3	Eye test by an optician or an eye doctor (M)	1	2	3	4	5 (363)
4	Cholesterol test	1	2	3	4	5 (364)
5	Heart check-up	1	2	3	4	5 (365)
6	Hearing test	1	2	3	4	5 (366)
7	Blood pressure test (N)	1	2	3	4	5 (367)
8	Test for cancer (M)	1	2	3	4	5 (368)
9	Test for diabetes	1	2	3	4	5 (369)

EB44.3 – Q.120. – TREND MODIFIED

D.10. Gender

Male 1 (370) **GO TO Q.29.**
Female..... 2 **GO TO Q.25.**

EB58.2 – D.10. – DEMO TREND

ASK WOMEN ONLY, IF CODE 2 IN D.10.

- Q.25. Do you feel very well informed, fairly well informed, not very well informed or not at all well informed about hormone replacement therapy (HRT) for women going through the menopause?

Very well informed 1 (371)
Fairly well informed 2
Not very well informed 3
Not at all well informed..... 4
DK..... 5

EB44.3 – Q.131. – TREND MODIFIED

D.11. How old are you?

(INT.: IF REFUSE, ESTIMATE)

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(372 – 373)

EB58.2 – D.11. – DEMO TREND

ASK WOMEN > 50 YEARS OLD ONLY

Q.26. Are you on hormone replacement therapy?

- Yes..... 1 (374)
- No..... 2
- DK/refusal..... 3

EB59.0 – NEW

ASK WOMEN ONLYQ.27. Over the last twelve months, which, if any, of the following tests have you had?
(SHOW CARD – READ OUT – MULTIPLE ANSWERS POSSIBLE)

- Breast examination by X-ray, that is mammography..... 1, (375 – 382)
- Breast examination by hand 2,
- Ovary examination..... 3,
- Cervical smear test, that is pap smear..... 4,
- Other gynaecological examination (M)..... 5,
- Osteoporosis examination 6,
- None of them (SPONTANEOUS)..... 7,
- DK/don't remember..... 8,

EB47.2 – Q.37.b. – TREND MODIFIED

ASK WOMEN ONLY

Q.28. a) Do you have children? If yes, did you breastfeed any of them?

- Yes, I have children and I have breastfed all of them 1 (383) **GO TO Q.28.b.**
- Yes, I have children and I have breastfed some of them 2 **GO TO Q.28.b.**
- Yes, I have children but I did not breastfeed them 3 **GO TO Q.29.**
- No, I don't have children 4 **GO TO Q.29.**

EB59.0 – NEW

IF "HAVE BREASTFED", CODE 1 OR 2 IN Q.28.a.

Q.28. b) Thinking about the last child that you breastfed, for how long have you breastfed him/her?

(INT.: IF "DK", CODE '99')

MONTHS (384 – 385) WEEKS (386 – 387)

EB59.0 – NEW

ASK ALL

Q.29. How tall are you (in cm) without shoes?

(INT.: IF "REFUSAL", CODE '998' – IF "DK", CODE '999')

CM (388 – 390)

EB44.3 – Q.111. – TREND

Q.30. What is your weight (in kg) without shoes and clothes?

(INT.: IF "REFUSAL", CODE '998' – IF "DK", CODE '999')

KG (391 – 393)

EB44.3 – Q.112. – TREND

Q.31. Would you say that your current weight is...? (SHOW CARD – READ OUT – ONE ANSWER ONLY)

too high 1 (394)
 too low 2
 about right 3
 DK/refusal 4

EB59.0 – NEW

Q.32. Would you say that what you normally eat is good for your health?

(SHOW CARD – READ OUT – ONE ANSWER ONLY)

Yes, very good 1 (395)
 Yes, fairly good 2
 No, not very good 3
 No, not at all good 4
 DK 5

EB59.0 – NEW

Q.33. Have you changed what you eat or drink in the past three years, or not?

Yes.....	1 (396)
No.....	2
DK.....	3

EB59.0 - NEW

IF “YES”, CODE 1 IN Q.33.

Q.34. What kind of changes did you make? (SHOW CARD – READ OUT – MULTIPLE ANSWERS POSSIBLE)

Fewer calories	1, (397 – 414)
More calories	2,
More fruit and vegetables	3,
Less fruit and vegetables	4,
Less fat	5,
More fat.....	6,
Less meat	7,
More meat.....	8,
Less salt.....	9,
More salt	10,
Eat less sugar	11,
Eat more sugar	12,
Less alcohol.....	13,
More alcohol	14,
Drinking more water.....	15,
Drinking less water.....	16,
Other change (SPONTANEOUS)	17,
DK.....	18,

EB59.0 – NEW

IF “YES”, CODE 1 IN Q.33.

Q.35. What was the main reason for these changes? Was it...?
(SHOW CARD – READ OUT – ONE ANSWER ONLY)

to lose weight.....	1 (415)
to put on weight	2
to keep my weight steady	3
to stay healthy.....	4
because of a disease or health problem	5
Other reason (SPONTANEOUS).....	6
DK.....	7

EB59.0 – NEW

ASK ALL

Q.36. Did you drink any alcohol (beer, wine, spirits, other alcoholic drinks) in the past four weeks?

- Yes..... 1 (416) **GO TO Q.37.**
 No 2 **GO TO Q.42.**
 DK/don't remember..... 3 **GO TO Q.42.**

EB59.0 – NEW

IF “YES”, CODE 1 IN Q.36.

Q. 37. In the past four weeks, on how many days did you drink...?
 (INT.: IF “NONE”, CODE ‘00’ – IF “DK”, CODE ‘99’ – MAX. ‘28’)

a) ...beer?

DAYS (417 – 418)

EB59.0 – NEW

b) ...wine?

DAYS (419 – 420)

EB59.0 – NEW

c) ...spirits (vodka, whisky, etc.)?

DAYS (421 – 422)

EB59.0 – NEW

d) ...other alcoholic drinks?

DAYS (423 – 424)

EB59.0 – NEW

IF “YES”, CODE 1 IN Q.36.

Q.38. In the past four weeks, did you drink alcohol...? (READ OUT – ONE ANSWER ONLY)

- only when eating..... 1 (425)
 mainly when eating..... 2
 mainly when not eating..... 3
 only when not eating..... 4
 DK/refusal..... 5

EB59.0 – NEW

IF “YES”, CODE 1 IN Q.36.

- Q.39. On a day when you drink alcohol, how many glasses do you usually drink in total? By a glass, I mean a bottle or a pint of beer, a glass of wine, a measure of spirits, etc. (INT.: PLEASE NOTE THE AVERAGE TOTAL NUMBER OF GLASSES PER DAY)

Less than 1	1 (426)
1-2.....	2
3-4.....	3
5-6.....	4
7-9.....	5
10 or more	6
It depends (SPONTANEOUS)	7
DK.....	8

EB59.0 – NEW

IF “YES”, CODE 1 IN Q.36.

- Q.40. In the past four weeks, how many times did you drink at least one bottle of wine or 5 measures of spirits or 5 bottles or pints of beer on one drinking occasion? (INT.: IF “NONE”, CODE ‘00’ – IF “DK”, CODE ‘99’ – MAX. ‘28’)

<input type="text"/>	<input type="text"/>	NUMBER OF TIMES	(427 – 428)
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EB59.0 – NEW

IF “YES”, CODE 1 IN Q.36.

- Q.41. In the past four weeks, how many times did it happen that you thought you drank too much? (INT.: IF “NONE”, CODE ‘00’ – IF “DK”, CODE ‘99’ – MAX. ‘28’)

<input type="text"/>	<input type="text"/>	NUMBER OF TIMES	(429 – 430)
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EB59.0 – NEW

ASK ALL

- Q.42. How old were you when drank alcohol for the first time? (INT.: COULD NOT BE > D.11. – IF “DON’T DRINK ALCOHOLIC DRINKS AT ALL”, CODE ‘00’ – IF “DK/DON’T REMEMBER”, CODE ‘99’)

<input type="text"/>	<input type="text"/>	YEARS OLD	(431 – 432)
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EB37.0 – Q.91. – TREND MODIFIED

Q.43. Do you agree or disagree with each of the following statements?
(SHOW CARD WITH SCALE)

	READ OUT	STRONGLY AGREE	TEND TO AGREE	NEITHER AGREE NOR DISAGREE	TEND TO DISAGREE	STRONGLY DISAGREE	DK
1	Child safety should be taken more into account when designing child related products	1	2	3	4	5	6 (433)
2	Child safety should be taken more into account when designing products	1	2	3	4	5	6 (434)
3	Child safety should be taken more into account when designing surroundings such as play areas	1	2	3	4	5	6 (435)
4	Many products designed for child safety have unclear or complicated instructions	1	2	3	4	5	6 (436)
5	Products should have a safety mark (sticker/label) to let consumers know the product has met safety standards	1	2	3	4	5	6 (437)
6	Manufacturers have to be responsible for the safe design of their products	1	2	3	4	5	6 (438)
7	The European Union should be enforcing regulations and standards that help to reduce accidental injury	1	2	3	4	5	6 (439)
8	Most accidental injuries involving children can be avoided	1	2	3	4	5	6 (440)

EB59.0 – NEW

Q.44. Which of the following do you do?

	READ OUT	YES	NO	NOT APPLICABLE
1	I wear a seat belt when in the car	1	2	3 (441)
2	I have functioning smoke detectors in my home	1	2	3 (442)
3	I use a bike helmet when cycling	1	2	3 (443)
4	I use a personal life jacket/life belt on water	1	2	3 (444)
5	I regulate tap water temperature in my home to prevent burns	1	2	3 (445)
6	Have taken a basic first aid course	1	2	3 (446)
7	Have taken an advance first aid course	1	2	3 (447)

EB59.0 – NEW

Q.45. Do you have or do you regularly look after small children? By small children, I mean from when they are born until they are 10 years old.

Yes.....1 (448) **GO TO Q.46.**

No.....2 **GO TO Q.47.**

EB59.0 – NEW

IF “YES”, CODE 1 IN Q.45.

Q.46. For each of the following, do you do it, or not?

	READ OUT	YES	NO	NOT APPLICABLE
1	I put the children in car seats when they are travelling in the car	1	2	3 (449)
2	I accompany a child while travelling to school on foot or by bicycle	1	2	3 (450)
3	I keep household cleaners, medicines and vitamins locked away or out of reach	1	2	3 (451)
4	I keep lighters and matches locked away or out of reach	1	2	3 (452)
5	I keep all knives and sharp objects locked away or out of reach	1	2	3 (453)
6	I use window guards	1	2	3 (454)
7	I use straps in the high chair	1	2	3 (455)
8	I use electrical plug points guards	1	2	3 (456)
9	I use a stair gate/guard	1	2	3 (457)
10	I help my/the child/ren cross the road when walking	1	2	3 (458)
11	I always stay with a child which is on a changing table	1	2	3 (459)
12	I always stay with a child which is in the bath	1	2	3 (460)
13	I always stay with a child which is around pets	1	2	3 (461)
14	When I am cooking I always keep an eye on the child	1	2	3 (462)
15	When I am using gardening or DIY tools, I always a keep an eye on the child	1	2	3 (463)

EB59.0 – NEW

STANDARD EUROBAROMETER 59.0 TECHNICAL SPECIFICATIONS

Between 15th January 2003 and 19th February 2003, the European Opinion Research Group, a consortium of Market and Public Opinion Research agencies, made out of INRA in Belgium – I.C.O. and GfK Worldwide, carried out wave 59.0 of the standard Eurobarometer, on request of the EUROPEAN COMMISSION, Directorate-General Press and Communication, Opinion Polls.

The Standard EUROBAROMETER 59.0 covers the population of the respective nationalities of the European Union Member States, aged 15 years and over, resident in each of the Member States. The basic sample design applied in all Member States is a multi-stage, random (probability) one. In each EU country, a number of sampling points was drawn with probability proportional to population size (for a total coverage of the country) and to population density.

For doing so, the points were drawn systematically from each of the "administrative regional units", after stratification by individual unit and type of area. They thus represent the whole territory of the Member States according to the EUROSTAT NUTS 2 (or equivalent) and according to the distribution of the resident population of the respective EU-nationalities in terms of metropolitan, urban and rural areas. In each of the selected sampling points, a starting address was drawn, at random. Further addresses were selected as every Nth address by standard random route procedures, from the initial address. In each household, the respondent was drawn, at random. All interviews were face-to-face in people's home and in the appropriate national language.

<u>COUNTRIES</u>	<u>INSTITUTES</u>	<u>N° INTERVIEWS</u>	<u>FIELDWORK DATES</u>	<u>POPULATION 15+ (x 000)</u>
Belgium	INRA BELGIUM	1,073	15/01 – 19/02	8,326
Denmark	GfK DENMARK	1,000	19/01 – 19/02	4,338
Germany (East)	INRA DEUTSCHLAND	1,109	21/01 – 8/02	13,028
Germany (West)	INRA DEUTSCHLAND	1,062	21/01 – 7/02	55,782
Greece	MARKET ANALYSIS	1,001	21/01 – 18/02	8,793
Spain	INRA ESPAÑA	1,000	28/01 – 17/02	33,024
France	CSA-TMO	1,039	18/01 – 17/02	46,945
Ireland	LANSLOWNE Market Research	1,007	22/01 – 14/02	2,980
Italy	INRA Demoskopoea	1,006	27/01 – 17/02	49,017
Luxembourg	ILRes	615	18/01 – 18/02	364
The Netherlands	INTOMART	1,002	21/01 – 19/02	12,705
Austria	SPECTRA	1,022	21/01 – 06/02	6,668
Portugal	METRIS	1,000	24/01 – 13/02	8,217
Finland	MDC MARKETING RESEARCH	1,018	20/01 – 18/02	4,165
Sweden	GfK SVERIGE	1,000	22/01 – 19/02	7,183
Great Britain	MARTIN HAMBLIN LTD	1,109	16/01 – 19/02	46,077
Northern Ireland	ULSTER MARKETING SURVEYS	307	22/01 – 11/02	1,273
	TOTAL NUMBER OF INTERVIEWS	16,370		

For each country a comparison between the sample and the universe was carried out. The Universe description was derived from Eurostat population data or from national statistics. For all EU member-countries a national weighting procedure, using marginal and intercellular weighting, was carried out based on this Universe description. As such in all countries, minimum gender, age, region NUTS 2 were introduced in the iteration procedure. For international weighting (i.e. EU averages), INRA (EUROPE) applies the official population figures as provided by EUROSTAT in the Regional Statistics Yearbook (data for 1997). The total population figures for input in this post-weighting procedure are listed above.

The results of the Eurobarometer studies are reported in the form of tables, datafiles and analyses. Per question a table of results is given with the full question text in English, French and German. The results are expressed as a percentage of the total. The results of the Eurobarometer surveys are analysed and made available through the Directorate-General Press and Communication, Opinion Polls of the European Commission, rue de la Loi 200, B-1049 Brussels. The results are published on the Internet server of the European Commission: <http://europa.eu.int/comm/dg10/epo>. All Eurobarometer datafiles are stored at the Zentral Archiv (Universität Köln, Bachemer Strasse, 40, D-50869 Köln-Lindenthal), available through the CESSDA Database <http://www.nsd.uib.no/cessda/europe.html>. They are at the disposal of all institutes members of the European Consortium for Political Research (Essex), of the Inter-University Consortium for Political and Social Research (Michigan) and of all those interested in social science research.

Readers are reminded that survey results are estimations, the accuracy of which, everything being equal, rests upon the sample size and upon the observed percentage. With samples of about 1,000 interviews, the real percentages vary within the following confidence limits:

Observed percentages	10% or 90%	20% or 80%	30% or 70%	40% or 60%	50%
Confidence limits	± 1.9%	± 2.5%	± 2.7%	± 3.0%	± 3.1%

**STANDARD EUROBAROMETER 59.0
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