PANORAMA OF THE EUROPEAN UNION

2002 EDITION

ISBN 92-894-3730-8
Cat. No. KS-08-02-002-EN-N

Health statistics

Key data on health 2002

Data 1970-2001

3

EUROPEAN COMMISSION

THEME 3
Population and social conditions

Europe Direct is a service to help you find answers to your questions about the European Union

New freephone number:

00 800 6 7 8 9 10 11

A great deal of additional information on the European Union is available on the Internet.
It can be accessed through the Europa server (http://europa.eu.int).

Luxembourg: Office for Official Publications of the European Communities, 2002

ISBN 92-894-3730-8

Preface

This second edition of ***Health statistics — Key data on health***, in the 'Panorama of the European Union' collection, contributes to the aims of the new **programme of Community action in the field of public health (2003-08),** adopted by the Decision 1786/2002/EC, of 23 September 2002, of the European Parliament and of the Council. The first strand of the new programme stresses the importance of development and dissemination to competent authorities in Member States, to health and other professionals and, where appropriate, to other stakeholders and the general public of **health information and knowledge**, including statistics, reports, reviews, analyses, and advice on issues of common interest to the Community and to Member States. In particular, there is a need to ensure, relying on competent and relevant expertise, appropriate sustainable coordination in the area of health information of activities in relation to the following: definition of information needs, development of indicators, collection of data and information, comparability issues, exchange of data and information with and between Member States, continuing development of databases, analyses, and wider dissemination of information. Such coordination should also be ensured regarding rapid reaction to health threats, and for activities in relation to epidemiological surveillance, development of surveillance methods, exchange of information on guidelines and on prevention and control actions, mechanisms and procedures.

The new programme follows the large number of projects completed or still ongoing under the EC Health Monitoring Programme (HMP) 1997–2001 and extended to 2002. The present publication provides a comprehensive, consistent and internationally comparable set of health data and indicators mentioning, where appropriate, the HMP activities useful for public health statistical purposes. A strong feature of this report is that Eurostat has brought together information on a wide range of health topics from the most relevant data sources available worldwide: the NewCronos database from Eurostat, 'Health data' database from the Organisation for Economic Cooperation and Development (OECD) and 'Health for All' database from the World Health Organisation (WHO), as well as data from the Food and Agriculture Organisation (FAO) of the United Nations, International Agency for Research in Cancer, European Centre for the Epidemiological Monitoring of AIDS (EuroHIV), specific epidemiological studies, and others.

Mortality is covered in detail in the volume ***Health statistics — Atlas of mortality*** of the collection 'Panorama of the European Union'. The present volume, ***Health statistics — Key data on health 2002***, brings together information on a wide range of health topics from over 40 of the most relevant sources available. Analysis is more detailed than in the first edition. New topics include human resources in the care and social sector, work-related health problems, stress, well-being and social isolation, childhood mortality, mental health, antimicrobial resistance, and certain communicable diseases.

The layout of ***Health statistics — Key data on health 2002*** has been improved for easier use: colour is used, the outputs are referenced within the text, a glossary is included, and full references are provided within each chapter or section, including web addresses to sources.

Where data are available, geographical coverage in ***Health statistics — Key data on health 2002*** includes the 15 Member States, as well as Iceland, Liechtenstein, Norway and Switzerland. Most analyses are at EU or country level, with some at NUTS 2 level (see 'Glossary'). Data for Germany include the former 'East' and 'West' for all years, unless otherwise stated.

Many of the databases are and have been updated retrospectively; therefore, some data in the outputs for previous years may differ from the previous volume. The latest extraction from NewCronos (Eurostat's database) was on 7 March 2003.

Metadata appear within boxes at the first appearance of a particular source within the volume. More detailed information is available about some of the sources from the references given within each chapter.

Please complete our questionnaire about this volume, as your feedback will enable us to further improve ***Health statistics — Key data on health***.

eurostat

FEEDBACK QUESTIONNAIRE

Please put **X** in all answer boxes that apply

1. Did you read the first edition of ***Health statistics — Key data on health***? Yes ☐ No ☐

2. Which chapter(s) or section(s) are the **most** useful to you? . . . . . .

. . . . . .

3. Which chapter(s) or section(s) are the **least** useful to you? . . . . . .

. . . . . .

4. Which of the following features are the **most** useful to you?

Outputs ☐ Analyses ☐ Metadata ☐ Web sites ☐

5. Which of the following features are the **least** useful to you?

Outputs ☐ Analyses ☐ Metadata ☐ Web sites ☐

6. What would you like to see in ***Health statistics — Key data on health*** that is not included?

. . . . . .

. . . . . .

7. Any comments about specific parts of the text? . . . . . .

. . . . . .

. . . . . .

. . . . . .

8. Any comments about specific outputs? . . . . . .

. . . . . .

. . . . . .

9. Any other comments? . . . . . .

. . . . . .

. . . . . .

10. Would you be interested in ***Health statistics — Key data on health*** as a web publication, with interactive features and links to sources? Yes ☐ No ☐

11. In which sector do you work? . . . . . .

. . . . . .

12. In which country do you live? . . . . . .

Please return to:

Antoni Montserrat Moliner
Eurostat
Bech Building
5, rue Alphonse Weicker
L-2721 Luxembourg

This publication has been prepared by
the Office for National Statistics (ONS), United Kingdom,
and
the sector 'Health and safety', of Unit E.3 (Education, health and culture) of Eurostat.

Text, tables, sources, references and glossary have been produced by
Antoni Montserrat Moliner (Eurostat)
and
Tim Devis and Susan Westlake (ONS, United Kingdom).

Support was also given by
Ehshan Sumun and Alan Hervé (ONS, United Kingdom) and other UK colleagues in the ONS, Department of Health and Department of Environment, Food and Rural Affairs,
and by
Gunter Brückner, Marleen De Smedt, Jaap van den Berg, Didier Dupré, Nassima Hamzaoui and Luca Locatelli (Eurostat, Unit E.3), other staff members of Eurostat, the Directorate-General for Health and Consumer Protection, and colleagues in other Commission services.

Readers' comments are most welcome and should be sent to:

antoni.montserrat@cec.eu.int
marleen.desmedt@cec.eu.int
Tel. (352) 43 01-33249/33673
Fax (352) 43 01-35399

eurostat

NewCronos is the macroeconomic and social database from **Eurostat** (Statistical Office of the European Communities) and has been created to help all those wanting high-quality statistical information for decision-making. It contains harmonised statistical data on the EU, the euro zone and their Member States as well as the candidate countries. These data — which may be daily, monthly, quarterly, half-yearly or annual, according to the statistical domain covered — are expressed in a whole range of different units. The data are available, depending on the variable or country selected, from 1960 to the present.

NewCronos is subdivided into nine themes (e.g. 'Population and social conditions'), each comprising several domains (e.g. 'Demography', 'Health and safety', 'Household budget surveys', 'Living and income conditions', etc.), each covering specific sectors. Each domain or sector consists of collections covering the economic and social indicators in question. These collections are themselves structured into multidimensional tables. Thus, the 'Health and safety' domain comprises two collections ('Public health' and 'Health and safety at work'), each including several groups (Causes of death, Health status, Health care, Lifestyles, Accidents at work, Work-related health problems, Occupational diseases, Commuting accidents, etc.).

All **NewCronos** data may be obtained by contacting your nearest Data Shop, the addresses of which are listed at the end of this publication.

Closure date for this volume
The cut-off date for this issue is 7 March 2003.

CONTENTS

eurostat

LIST OF TABLES, GRAPHS AND MAPS

2.2. Physical activity

2.2.1	table	Responses to 'Do you exercise at least twice a week?', 1999	Eurobarometer
2.2.2	table	Responses to 'Do you exercise at least twice a week?' by age, 1999	Eurobarometer
2.2.3	table	Smoking, diet and satisfaction with own health status, by regular exercise, EU-15, 1999	Eurobarometer
2.2.4	table	Responses to 'Is your lifestyle healthy?', 1999	Eurobarometer
2.2.5	table	Responses to 'Is your lifestyle healthy?' by age, 1999	Eurobarometer
2.2.6	table	Responses to 'Is your lifestyle healthy?' by professional status, 1999	Eurobarometer
2.2.7	table	Smoking, diet, drinking and physical exercise, by healthy lifestyle, EU-15, 1999	Eurobarometer
2.2.8	table	Participation in the four most popular physical activities in a typical week, by age, 1997	IEFS
2.2.9	table	Adults (15+) participating in various physical activities in a typical week, by time spent, 1997	IEFS
2.2.10	table	Perceived motivating factors for adult (15+) participation in physical activity/exercise, 1997	IEFS
2.2.11	table	Adults (15+) spending different numbers of hours at work per day being more physically active than standing or walking, 1997	IEFS
2.2.12	table	Amount of time spent sitting down by adults (15+) on a typical non-working day, 1997	IEFS
2.2.13	table	Children who report exercising for two or more hours a week, by age and sex, 1997/98	HBSC
2.2.14	table	Children who report watching television for four or more hours a day, by age and sex, 1997/98	HBSC

2.3. Smoking

2.3.1	table	Adults (15+) who are daily cigarette smokers, by age and sex, 1995	Eurobarometer
2.3.2	table	Smokers, by age and sex, 1999	Eurobarometer
2.3.3	table	Diet and stress, by smoking status, EU-15, 1999	Eurobarometer
2.3.4	table	Number of cigarettes per day for smokers, by sex, 1995	Eurobarometer
2.3.5	table	Trends in household expenditure on tobacco, 1988, 1994 and 1999	Eurostat
2.3.6	table	Structure of consumption expenditure on tobacco (Coicop level 2), 1999	Eurostat
2.3.7	table	Children who report smoking, 1997/98	HBSC
2.3.8	table	National controls on the sale and advertising of tobacco, 1994/2001	SANCO
2.3.9	table	Average number of cigarettes per person/year available on the market	WHO

2.4. Alcohol

2.4.1	table	Average number of litres of alcohol per person/year available on the market	WHO
2.4.2	table	Trends in household expenditure on alcohol	Eurostat
2.4.3	table	Structure of consumption expenditure on alcoholic beverages (Coicop level 2), 1999	Eurostat
2.4.4	table	Alcohol drinkers by age and sex, 1999	Eurobarometer
2.4.5	table	Exercise, stress and diet by alcohol consumption, EU-15, 1999	Eurobarometer
2.4.6	table	Children who report drinking beer, wine or spirits at least weekly, 1997/98	HBSC
2.4.7	table	National controls on the advertising of alcohol, 1994 and 1998	WHO

2.5. Drug use

2.5.1	table	Last 12 months prevalence of drug use in nationwide surveys, 1994–2000	EMCDDA
2.5.2	table	Lifetime prevalence of drug use in recent nationwide surveys among the general population, 1994–2000	EMCDDA
2.5.3	table	Lifetime prevalence of use of different illegal drugs among 15- to 16-year-old students in recent nationwide school surveys, 1993–2000	EMCDDA
2.5.4	table	National prevalence estimates of problem drug use in adults, 1996–98	EMCDDA
2.5.5	table	Some characteristics of persons treated for drug problems for the first time, 1998–2000	EMCDDA
2.5.6	table	Prevalence of antibodies against hepatitis C virus and HIV infection among injecting drug users, 1994–2000	EMCDDA

4. HEALTH STATUS

4.1. Self-reported health

4.1.1	table	Self-perceived health by sex	Eurostat
4.1.2	graph	Self-perceived health by education, EU-15, 1998	Eurostat
4.1.3	table	Self-perceived health by age	Eurostat
4.1.4	table	Self-perceived health by work status	Eurostat
4.1.5	table	Percentage of persons who suffer from chronic conditions by sex	Eurostat
4.1.6	table	Children who report a headache/stomach ache/backache at least once a week by age and sex, 1997/98	WHO

4.2. Anthropometric characteristics

4.2.1	table	Average height by age and sex, 1996	Eurobarometer
4.2.2	table	Average weight of Europeans by age and sex, 1996	Eurobarometer
4.2.3	table	Average body mass index by sex; distribution in population aged 15 and over, 1996	Eurobarometer
4.2.4	table	Children who report being on, or feeling that they should be on, a diet, 1997/98	WHO

4.3. Dental health

4.3.1	table	Dental caries: index DMFT (decayed, filled or missing teeth) and percentage affected, by age	WHO
4.3.2	table	Children who report brushing their teeth more than once a day, 1997/98	WHO

4.4. Disability and restrictions

4.4.1	table	Expectation of life at age 16, with and without disability, by sex, 1996	REVES
4.4.2	graph	Percentage of people aged 16–64 reporting severe or moderate disability, by sex, 1996	REVES
4.4.3	table	Hampered in daily activities by any physical or mental health problem, illness or disability, by sex, aged 16 and over	Eurostat
4.4.4	table	Hampered in daily activities by any physical or mental health problem, illness or disability, by age	Eurostat
4.4.5	table	Distribution of the population (16–64) with severe, moderate or no disability according to education levels (highest level completed), 1996	REVES
4.4.6	table	Hampered in daily activities by any physical or mental health problem, illness or disability, by education, aged 16 and over	Eurostat
4.4.7	table	People aged 16–64 with severe, moderate or no disability who are in work, by sex, 1996	REVES
4.4.8	table	Hampered in daily activities by any physical or mental health problem, illness or disability, by work status	Eurostat
4.4.9	table	Probability of having an income and earned income for those with severe, moderate or no disability of working age (16–64 years), 1996	REVES
4.4.10	table	Cutdown in activities over the past two weeks because of health problems, by sex	Eurostat
4.4.11	table	Cutdown in activities over the past two weeks because of health problems, by age	Eurostat
4.4.12	table	Cutdown in activities over the past two weeks because of health problems, by education	Eurostat
4.4.13	table	Cutdown in activities over the past two weeks because of health problems, by work status	Eurostat
4.4.14	graph	Attitudes of Europeans towards disability: knowledge of disabled persons, EU-15	Eurobarometer
4.4.15	graph	Attitudes of Europeans towards disability: access for people with disabilities to services, EU-15	Eurobarometer
4.4.16	graph	Attitudes of Europeans towards disability: awareness of Europeans regarding disabilities, EU-15	Eurobarometer

5.3. Special causes of death

6. HEALTH CARE

6.1. Human resources

6.2. Facilities and use of services

Symbols and country abbreviations used

0	a rate or percentage rounded to zero according to an agreed rounding procedure
:	data not available
-	nil
italics	provisional or estimated data
()	unreliable data due to small size of the sample
—	break in series
MS	Member States
EU-15	European Union (15 Member States)
euro zone	The 11 countries participating in the euro zone
EEA	European Economic Area
EFTA	European Free Trade Association
B	Belgium
DK	Denmark
D	Germany (including ex-GDR from 1991)
EL	Greece
E	Spain
F	France
IRL	Ireland
I	Italy
L	Luxembourg
NL	Netherlands
A	Austria
P	Portugal
FIN	Finland
S	Sweden
UK	United Kingdom
GB	Great Britain
CH	Switzerland
IS	Iceland
LI	Liechtenstein
NO	Norway

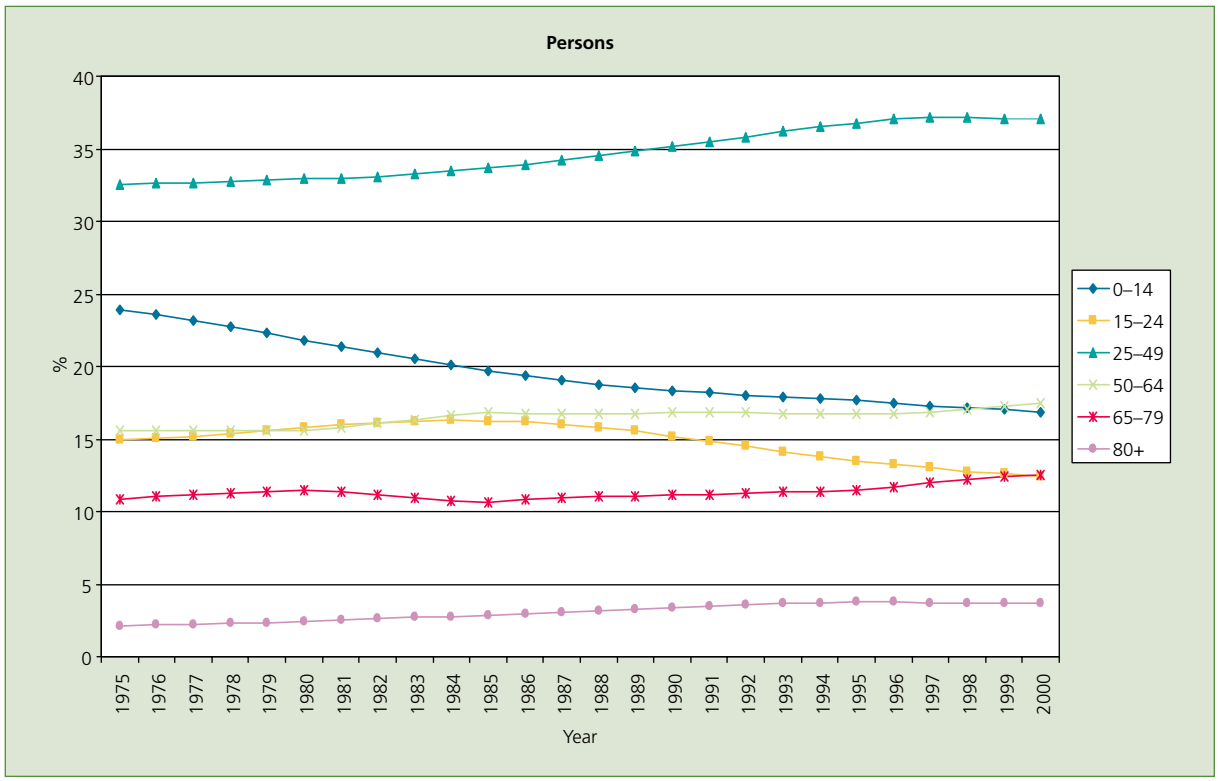
1. POPULATION AND SOCIOECONOMIC BACKGROUND

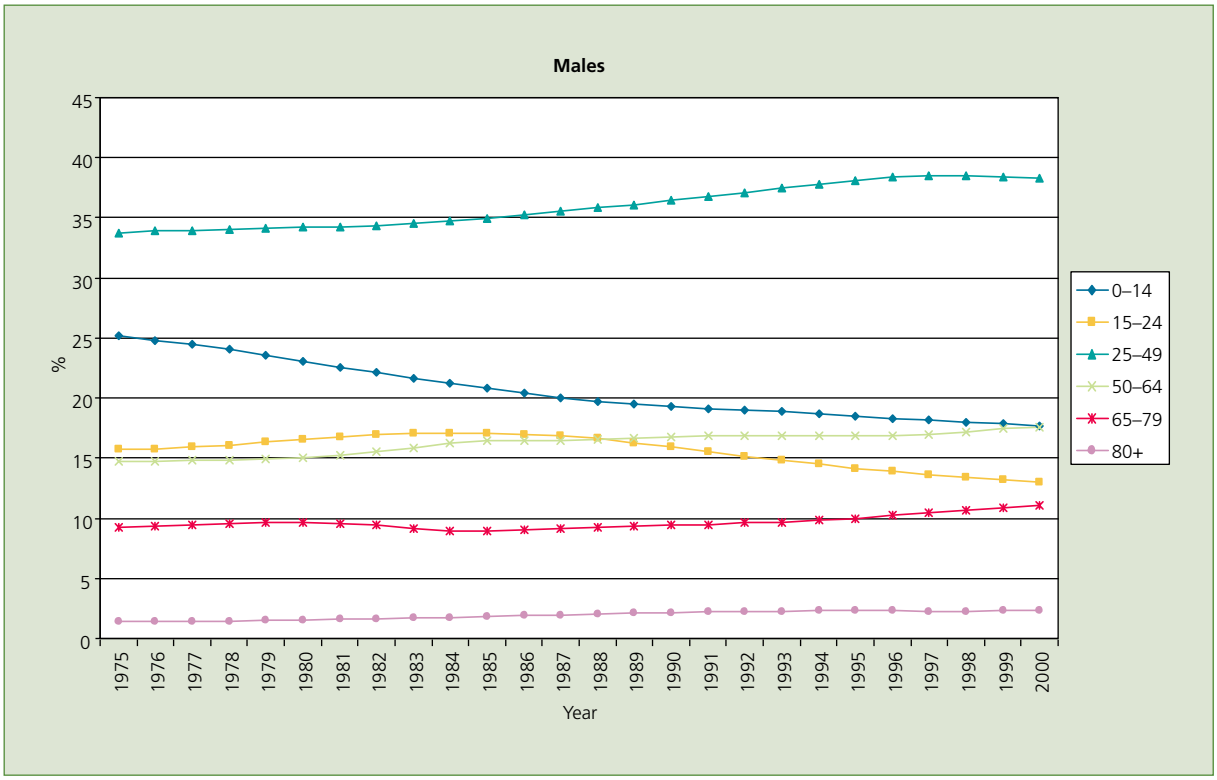
1.1. Population structure

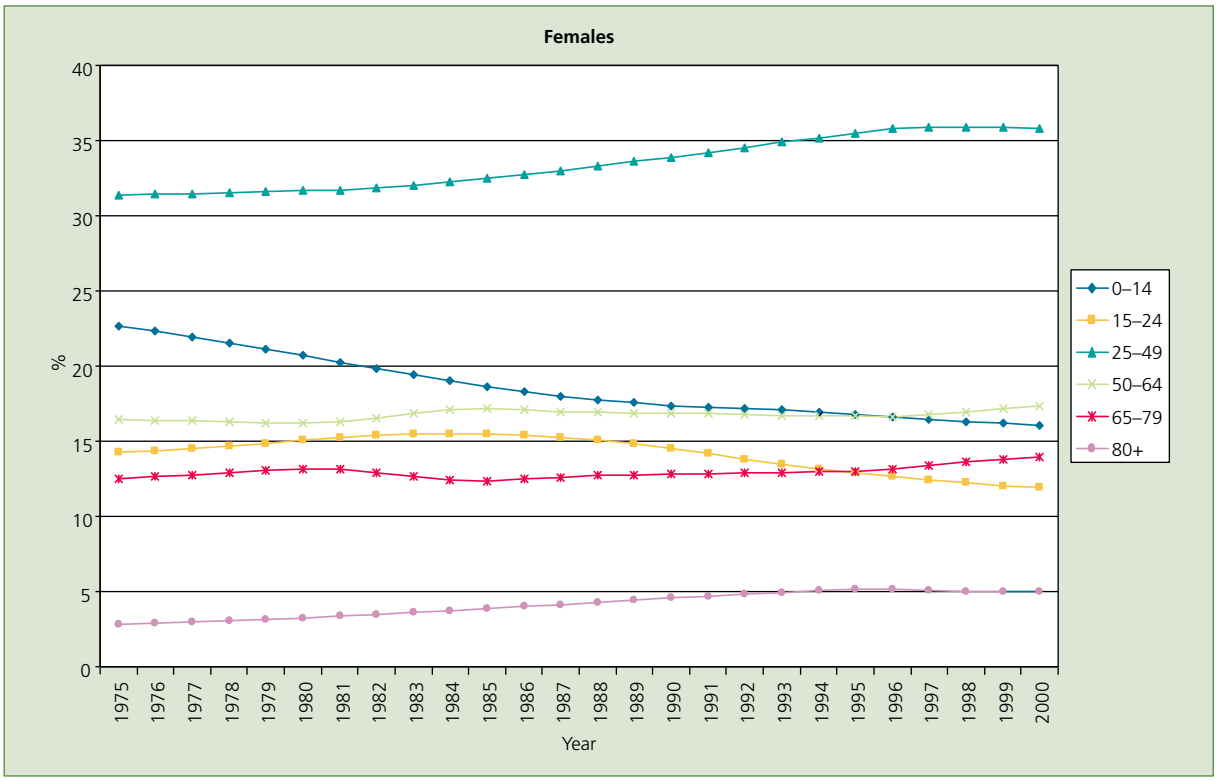
In 2001, the 15 Member States of the European Union were inhabited by 378.0 million people, with the most populous countries being Germany (82.3 million), the United Kingdom (59.9 million), France (59.0 million) and Italy (57.8 million) **(1.1.1)**. Luxembourg, by contrast, had a population of just under 0.5 million. In 1953, the EU's population was about 300 million (ref. Eurostat 2001). Thereafter, it took 10 years to grow by 25 million, then 13 years and 22 years. Thus, the rate of population growth slowed over the half-century, most noticeably in the past 20 years. In the 1990s, the annual rate of growth was 0.34 %, so with an estimated growth of 0.39 % (or almost 1.5 million people), 2001 fits fairly well in this recent general trend. Although lower levels of growth were recorded during the second half of the 1990s, the latest increase is much smaller than those observed during the 1960s (on average 2.5 million a year). Compared with the late 1990s, the 2001 level is slightly higher, but, from a longer-term perspective, it is a rather modest rise. The populations of both Luxembourg and Ireland will continue to grow at well over 1 % per year, whereas Germany will just exceed a rate of 0.1 %. These estimates confirm that international migration is still an important component of population change **(1.2.4)**. For example, without migration, Germany and Sweden would experience a population loss and Austria and Italy's populations would barely grow. Almost two thirds of the EU countries will have had an increase in their population in 2001. Notably, Spain is experiencing a relatively large increase in its population growth due to a substantial rise in live births and in the net inflow of migrants.

Analysed by **age (1.1.2** and **1.1.3)**, one in six (16.2 %) of the EU population was aged over 64 in 2000, a proportion similar for most countries, except Ireland (11.2 %). Over one in five (21.9 %) of the Irish population was aged under 15, a proportion much higher than elsewhere. Trends from 1975 show a high relative growth for those aged 25–49 (from 32 % to 37 % of the total population in 2000), while the proportion aged under 15 has declined, from 24 % to 17 % over the same period. Trends for these two age groups were similar for males and females. Increases for the oldest age group (80 and over) were also striking — from 1 % to 2 % for men, and from 3 % to 5 % for women.

1.1.2 Population proportions by age and by sex, 1975–2000, EU-15



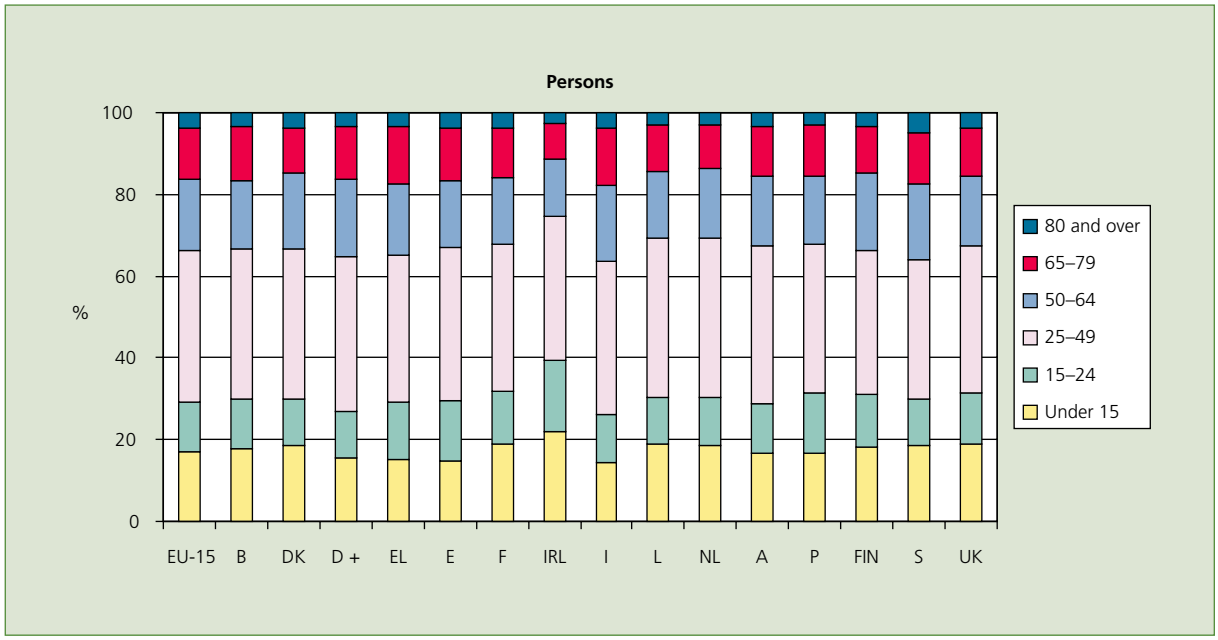


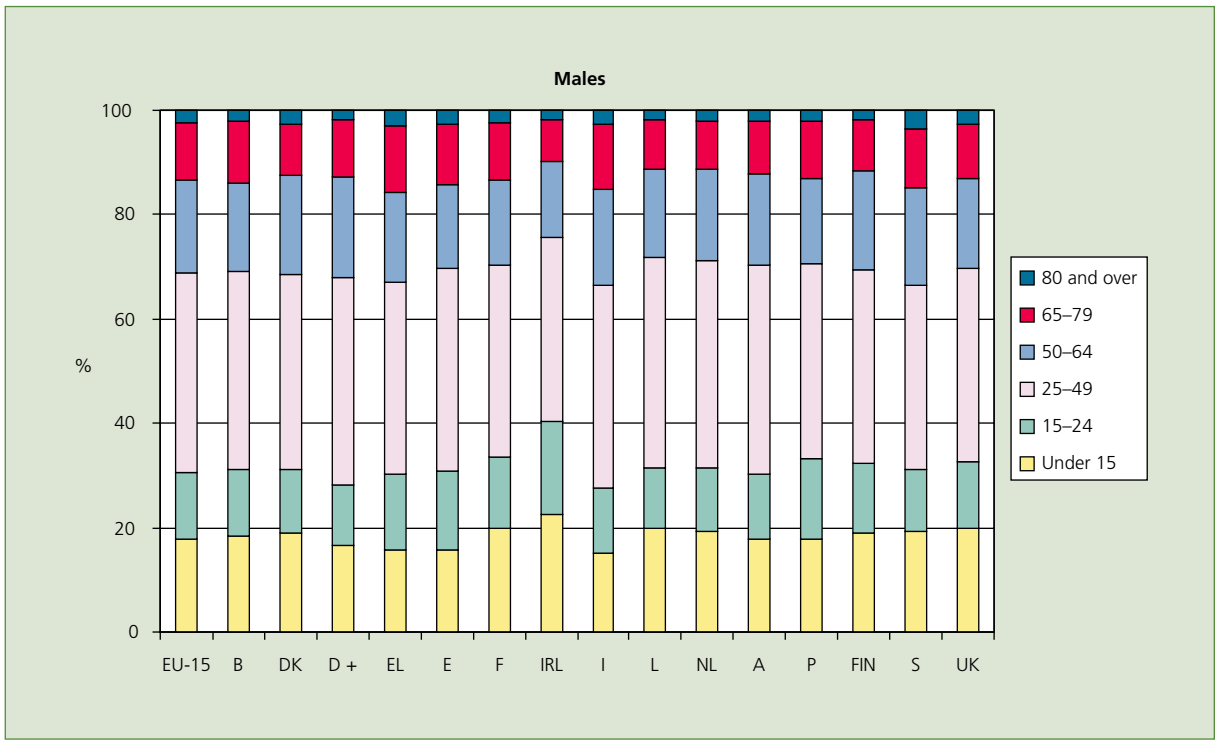


Source: Eurostat, NewCronos database (Demography).

The **age dependency ratio**, defined as the population aged under 15 and 65 and over to that aged 15–64, rose for the EU overall from 1960 to 1975, reaching 58 %, but then fell to 49 % by 1991, at which level it has subsequently remained **(1.1.4)**. High ratios indicate a greater dependence of the population not economically active, as found in Sweden, for instance, for 1998 (58 %). This situation may have

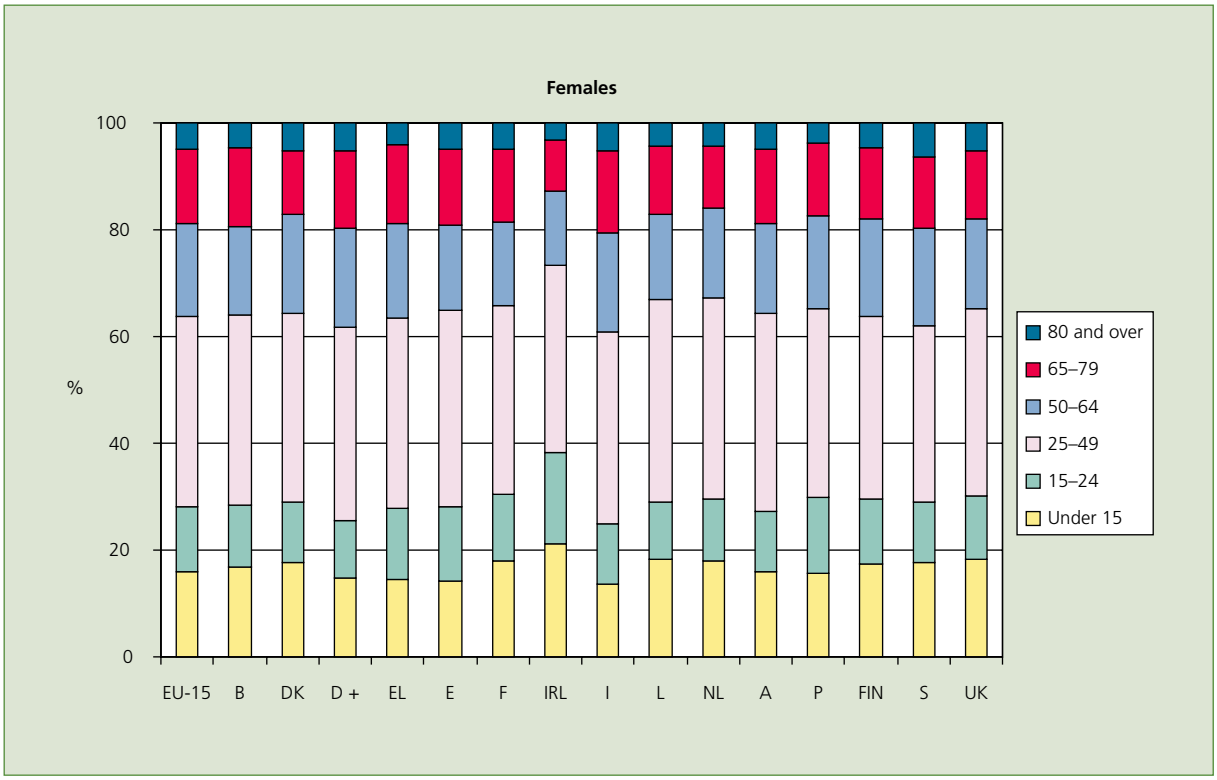
1.1.3 Population by age, 2000





considerable implications for health policy and also for social protection and labour market policies.

Projections for the EU indicate a population rising to 388.3 million by 2025 and then falling to 367.7 million by 2050 **(1.1.5)**. Over the 50-year period, substantial declines are forecast for the populations of Germany, Italy and Spain, but modest increases for some other countries such as France, the Netherlands and Sweden.



1.2. Births and deaths; net inward migration

Using the total fertility rate (TFR), **fertility** levels for the EU declined steadily from 2.72 children per woman in 1965 to 1.42 in 1995, and have changed little since then **(1.2.1)**. Consistent with the age structure noted above, the Irish TFR was the highest in the EU in 2000 (1.89), but had fallen sharply from a level of 4.03 in 1965. Spain (1.24 in 2000) and Italy (1.23 in the same year) reported the lowest fertility levels. Outside the EU, Iceland recorded a TFR of 2.08 in 2000 (ref. Eurostat 2002).

In 2001, the number of live births **(1.2.2)** is estimated to reach 4.03 million, about 0.5 % less than in 2000. In the mid-1960s, the annual number of live births was over 2 million higher, but, during the period 1965 to 1975, fertility levels dropped dramatically. Crude birth rates are forecast to remain highest in Ireland and lowest in Germany. Nine EU countries will probably see a fall in the number of live births, with Portugal facing the largest decrease (– 4 %). Greece, on the other hand, is expected to be the EU country with the largest rise in births (close to 6 %).

In 1976, the number of deaths in the EU reached a post-war high of almost 3.8 million. Thereafter, the annual number of deaths fluctuated and decreased somewhat to reach their recent level of around 3.6 million. The impact of a growing number of elderly people on the number of deaths was fully compensated for by decreasing crude death rates **(1.2.3)**. For 2001, it is also expected that the effects of population ageing will be counterbalanced by a further decrease in mortality rates. Due to an ageing population and a relatively less favourable mortality pattern, Germany and Denmark will continue to be the EU Member States with the highest **crude death rate (1.2.3)**. Ireland with its relatively young population is the Member State most likely to have the lowest level. About three quarters of the EU countries had a relatively 'good' year in 2001, with Ireland in the lead (7 % fewer deaths). Denmark is forecast to be confronted with a rise in the number of deaths of about 1 %.

The decade 1990–2000 saw a population increase of 12.7 million for the EU, most of this due to **net inward migration**. Natural increase, amounting to 658 000 in 1990, fell to only 261 000 by 1999. Total annual deaths remained at about 3.7 million in every year of the 1990s, but annual births fell from 4.4 million in 1990 to 4.0 million in 1999. These migration flows are shown in Table **1.2.4**, with substantial net inflows of over 1 million in each of the years 1990–92, continuing at a high level to 1994, with much of the net inflow to Germany. However, expressed as a rate per head of population, the largest net inflows were recorded for Luxembourg (10.2 per 1 000 in 1998) and Ireland (5.9 per 1 000 in 1998). By comparison, the net rate of inflow to Greece in 1991 was 14.9 per 1 000, which fell to 2.1 per 1 000 in 1998.

After a period of rather strong decline, the net inflow of (international) migrants to the EU increased

from 515 000 in 1998 to 897 000 in 1999. For 2000 and 2001, net migration is expected to have decreased very slightly to a level of around 1 million persons. Spain, Italy, the United Kingdom and Germany together will have received more than two thirds of this net inflow, although Luxembourg remains the EU country with the highest net in-migration rate per 1 000 inhabitants. France and Germany, on the other hand, seem to grow less due to net migration than one would expect considering their population size (**1.2.5**). Due mainly to a comprehensive programme of regularisation of its undocumented migrants, Spain continued to be the country that records the highest net in-migration levels within the EU.

The **natural population increase** is the difference between the number of live births and the number of deaths. The **age dependency ratio** is an indicator calculated by Eurostat as the ratio of the number of persons aged 0–14 and 65+ to those aged 15–64. It shows the extent to which the young (under 15) and the elderly (over 64) are dependent on what is considered to be the active population (aged 15–64). It is assumed that those in the 15–64 age group support their younger and older citizens. The ratio is expressed as a percentage.

The **total fertility rate** is the mean number of children that would be born alive to a woman during her lifetime if she were to pass through her childbearing years conforming to the fertility rates by age of a given year. It is therefore the completed fertility of a hypothetical generation, computed by adding the fertility rates by age for women in a given year (the number of women at each age is assumed to be the same). The total fertility rate is also used to indicate the replacement level fertility; in more developed countries, a rate of 2.1 is considered to be the replacement level. The **crude rate** (births or deaths) is the number of events (births or deaths) to the mean of the population in a given year.

Net migration is defined as the difference between immigration into and emigration from the area during the year; it is thus negative when the number of emigrants exceeds the number of immigrants. Since most countries either do not have accurate figures on immigration and emigration or have no figures at all, net migration is generally estimated on the basis of the difference between population change and natural increase between two dates. Statistics on net migration are therefore affected by all the statistical inaccuracies in the two components of this equation, especially population change.

1.3. Life expectancy

Over the EU, the expectation of life at birth, a measure summarising current levels of mortality, reached 74.6 years for males and 80.9 for females in 1997 **(1.3.1)**, with most Member States at about these levels. At the same time, comparable expectations of life at age 75 were 9.5 years for men and 11.8 for women **(1.3.2)**. The difference in the expectations for the two sexes is particularly marked in France, where the life expectancy of a female child at birth is 7.6 years more than that of a male child. In Sweden, the difference is only 5.1 years. Since 1960, life expectancy has increased in all EU countries. The clusters of male and female life expectancies observed are summarised in Table **1.3.5** (ref. Ferrinho and Pereira Miguel 2001). Countries in southern Europe have experienced increasing life expectancy at a faster rate than northern countries. Eurostat has used mortality projections to estimate future life expectancy. Using the high scenario, they expect men to reach 83 years of age in 2050, and women 87 years of age. Assumptions based on these values have been built into recent population forecasts **(1.3.6)**, so that, for example, life expectation at birth for France in 2025 is 78.8 years for males and 87.2 for females. In recent decades, life expectancy has increased significantly. For instance, male life expectancy for Spain rose from 59.8 years in 1950 to 69.2 in 1970, and 75.1 by 1999; comparable figures for females were 64.3, 74.8 and 82.1 years respectively.

Eurostat calculates **life expectancy** as the average further number of years that a person of a specified age can expect to live, assuming that the age-specific mortality levels remain constant (i.e. the rates observed for the period under review). Life expectancy tables are based on the probability of dying according to Farr's death rate method: $q_x = M_x/(B_x + (M_x/2))$ where M_x is the number of deaths at the age of x to under x + 1 years in the reported period; B_x is the average population aged x to under x + 1 in the base period and q_x is the death probability from age x to x + 1. Life expectancy is normally expressed as the number of years a person may expect to live, starting from age 0. Other ages can also be chosen as a starting point. Life expectancy is normally calculated for all age levels and for males, females and total population.

1.4. Socioeconomic background

The populations in Member States of the EU vary widely in their spread: rather thinly in Finland (15 persons per km^2) and Sweden (20), but much more densely in the Netherlands (380), Belgium (333), the United Kingdom (240) and Germany (230) **(1.4.1)**. Seven of the fifteen Member States have an urban population exceeding 80 % of the total, with Belgium being highest at 97 %, but in Ireland (59 %), Greece (60 %) and Portugal (63 %) urbanisation has advanced more slowly.

Measuring prosperity in terms of **gross domestic product (GDP)** at market prices in euro per inhabitant, there is considerable variation across the EU **(1.4.2)**. Thus, in 2001, GDP per capita for Greece was EUR 11 920, for Portugal EUR 12 200 and for Spain

EUR 16 150. Most of the remaining countries had a GDP per capita near the EU figure of EUR 23 170, but Luxembourg (EUR 47 470), Denmark (EUR 33 680) and Ireland (EUR 30 070) were well above this level.

Considering the level of **unemployment** as another indicator of a nation's well-being, rates for men over the EU were 6.4 % in 2001, a decline from 1994, and with the highest country levels in Germany (7.7 %), Spain (7.5 %) and Italy (7.3 %) **(1.4.3)**. The rate for women was higher, at 8.6 % for the EU, but has also fallen in recent years. In this case, the countries with the highest rates were Greece (15.6 %), Spain (15.5 %) and Italy (12.9 %). Interestingly, four countries — Sweden, Ireland, the United Kingdom and Norway — reported female rates lower than the male equivalent.

References

Eurostat (2001), *First demographic estimates for 2001,* 'Statistics in focus', 19/2001.

Eurostat (2002), *European social statistics — Demography*.

Ferrinho, P. and Pereira Miguel, J. (2001), *For better health in Europe*, European Commission, Directorate-General for Health and Consumer Protection.

1.1.1 Population by sex (on 1 January), 1950–2002

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1950 Persons	**295 833.4**	**8 639.0**	**4 251.5**	**68 376.0**	**7 566.0**	**28 009.0**	**41 647.3**	**2 969.0**	**47 101.0**	**294.7**
Male	:	4 253.0	2 109.0	31 493.0	3 687.0	13 526.0	20 004.7	1 511.0	22 935.0	:
Female	:	4 386.0	2 142.5	36 883.0	3 879.0	14 483.0	21 642.6	1 458.0	24 166.0	:
1960 Persons	**314 826.0**	**9 128.8**	**4 565.5**	**72 543.0**	**8 300.4**	**30 327.0**	**45 464.8**	**2 835.5**	**50 025.5**	**313.0**
Male	151 721.0	4 477.9	2 264.6	33 686.4	4 015.3	14 831.0	22 046.6	1 429.0	24 498.9	154.6
Female	163 105.0	4 650.9	2 300.9	38 856.6	4 285.1	15 496.0	23 418.2	1 406.5	25 526.6	158.4
1970 Persons	**339 974.9**	**9 660.2**	**4 906.9**	**78 269.1**	**8 780.4**	**33 587.6**	**50 528.2**	**2 943.3**	**53 685.3**	**338.5**
Male	164 762.1	4 729.6	2 432.5	37 031.5	4 283.2	16 414.3	24 655.5	1 478.9	26 260.0	166.2
Female	175 212.8	4 930.6	2 474.4	41 237.6	4 497.2	17 173.3	25 872.7	1 464.4	27 425.3	172.3
1980 Persons	**354 571.7**	**9 855.1**	**5 122.1**	**78 179.7**	**9 587.5**	**37 241.9**	**53 731.4**	**3 392.8**	**56 388.5**	**363.5**
Male	172 110.2	4 818.9	2 529.1	37 156.6	4 702.7	18 273.1	26 243.8	1 705.1	27 459.2	178.0
Female	182 461.5	5 036.2	2 593.0	41 023.1	4 884.8	18 968.8	27 487.6	1 687.7	28 929.3	185.5
1990 Persons	**363 763.4**	**9 947.8**	**5 135.4**	**79 112.8**	**10 120.9**	**38 826.3**	**56 577.0**	**3 507.0**	**56 694.4**	**379.3**
Male	177 012.0	4 860.1	2 530.6	38 109.7	4 982.0	19 024.6	27 544.0	1 743.2	27 527.8	185.4
Female	186 751.4	5 087.7	2 604.8	41 003.1	5 138.9	19 801.7	29 033.0	1 763.8	29 166.6	193.9
1995 Persons	**371 442.0**	**10 130.6**	**5 215.7**	**81 538.6**	**10 442.9**	**39 196.8**	**57 752.5**	**3 597.6**	**57 268.6**	**406.6**
Male	181 220.3	4 954.7	2 573.3	39 645.0	5 155.8	19 188.3	28 078.1	1 787.2	27 790.7	199.6
Female	190 221.7	5 175.9	2 642.4	41 893.6	5 287.0	20 008.5	29 674.5	1 810.4	29 477.9	207.0
1996 Persons	**372 475.6**	**10 143.0**	**5 251.0**	**81 817.5**	**10 465.1**	**39 249.1**	**57 936.0**	**3 620.1**	**57 333.0**	**412.8**
Male	181 923.7	4 958.8	2 592.2	39 824.8	5 164.9	19 204.0	28 365.3	1 797.4	27 817.4	202.6
Female	190 693.4	5 184.3	2 658.8	41 992.7	5 300.1	20 038.5	29 780.5	1 822.7	29 515.6	210.2
1997 Persons	**373 486.6**	**10 170.2**	**5 275.1**	**82 012.2**	**10 486.6**	**39 308.5**	**58 116.0**	**3 652.2**	**57 461.0**	**418.3**
Male	182 346.0	4 971.8	2 604.9	39 954.8	5 172.4	19 236.1	28 235.7	1 813.0	27 893.3	205.4
Female	191 140.6	5 198.4	2 670.2	42 057.3	5 314.2	20 072.4	29 880.3	1 839.1	29 567.6	212.9
1998 Persons	**374 144.5**	**10 192.3**	**5 294.9**	**82 057.4**	**10 511.0**	**39 387.5**	**58 299.0**	**3 694.0**	**57 563.4**	**423.7**
Male	182 803.7	4 982.7	2 615.7	39 992.3	5 181.2	19 271.2	28 316.2	1 833.7	27 950.6	208.2
Female	191 541.4	5 209.6	2 679.2	42 065.1	5 329.7	20 116.3	29 982.8	1 860.3	29 612.8	215.5
1999 Persons	**375 106.2**	**10 213.8**	**5 313.6**	**82 037.0**	**10 521.7**	**39 519.2**	**58 496.6**	**3 734.9**	**57 612.6**	**429.2**
Male	183 303.0	4 993.7	2 625.4	40 004.1	5 185.0	19 332.3	28 406.1	1 854.2	27 967.7	211.3
Female	191 973.8	5 220.0	2 688.2	42 032.9	5 336.7	20 186.9	30 090.5	1 880.7	29 644.9	218.0
2000 Persons	**376 481.8**	**10 239.1**	**5 330.0**	**82 163.5**	**10 554.4**	**39 733.0**	**58 748.7**	**3 776.6**	**57 679.9**	**435.7**
Male	183 967.8	5 006.0	2 634.1	40 090.8	5 199.8	19 435.8	28 533.4	1 875.3	28 003.3	214.7
Female	192 514.0	5 233.1	2 695.9	42 072.7	5 354.6	20 297.2	30 215.3	1 901.3	29 676.6	221.1
2001 Persons	**378 036.6**	**10 263.4**	**5 349.2**	**82 259.5**	***10 564.7***	**40 121.7**	**59 038.5**	**3 825.9**	**57 844.0**	***439.5***
Male	:	5 018.0	2 644.3	40 156.5	:	19 639.5	28 678.7	1 900.8	28 094.9	216.5
Female	:	5 245.4	2 704.9	42 103.0	:	20 482.2	30 360.3.	1 925.3	29 749.2	223.0
2002 Persons	**379 600.7**	**10 307.3**	**5 368.4**	**82 440.3**	**10 598.3**	**40 409.3**	**59 344.0**	**3 882.7**	**56 305.6**	**440.1**
Male	:	5 041.3	2 654.1	40 274.7	:	19 779.4	28 831.1	1 928.3	27 261.0	218.8
Female	:	5 266.6	2 714.2	42 165.6	:	20 630.0	30 512.9	1 954.4	29 044.6	225.2

Source: Eurostat, NewCronos database (Demography).

(1000)

NL	A	P	FIN	S	UK	IS	NO	CH	
10 026.8	**6 926.0**	**8 437.0**	**3 988.0**	**6 986.2**	**50 616.0**	**:**	**3 250.0**	**4 668.2**	**1950 Persons**
4 998.3	3 213.7	4 088.1	1 904.7	3 480.6	24 575.0	:	1 610.1	2 249.8	Male
5 028.5	3 712.3	4 349.0	2 083.3	3 505.6	26 041.0	:	1 639.8	2 418.4	Female
11 417.3	**7 030.4**	**8 826.0**	**4 413.0**	**7 471.3**	**52 164.4**	**175.7**	**3 567.7**	**5 295.6**	**1960 Persons**
5 686.2	3 273.2	4 222.8	2 124.7	3 727.8	25 282.1	87.5	1 777.8	2 565.1	Male
5 731.1	3 757.2	4 603.2	2 288.3	3 743.5	26 882.3	88.2	1 789.9	2 730.5	Female
12 957.6	**7 455.1**	**8 697.6**	**4 614.3**	**8 004.3**	**55 546.4**	**204.0**	**3 863.2**	**6 168.7**	**1970 Persons**
6 465.1	3 510.8	4 158.0	2 230.2	3 996.5	26 949.7	103.2	1 922.0	3 014.0	Male
6 492.5	3 944.3	4 539.6	2 384.1	4 007.8	28 596.7	100.8	1 941.2	3 154.7	Female
14 091.0	**7 545.5**	**9 713.6**	**4 771.3**	**8 303.0**	**56 285.0**	**226.9**	**4 078.9**	**6 303.6**	**1980 Persons**
6 994.3	3 564.2	4 670.7	2 306.8	4 115.5	27 392.4	114.4	2 021.9	3 066.2	Male
7 096.7	3 981.3	5 042.9	2 464.5	4 187.5	28 892.6	112.5	2 057.0	3 237.4	Female
14 892.6	**7 689.5**	**9 919.7**	**4 974.4**	**8 527.0**	**57 459.3**	**253.8**	**4 233.1**	**6 673.9**	**1990 Persons**
7 358.5	3 685.1	4 782.5	2 412.8	4 212.1	28 053.7	127.4	2 093.3	3 257.5	Male
7 534.1	4 004.4	5 137.2	2 561.6	4 314.9	29 405.6	126.4	2 139.8	3 416.4	Female
15 424.1	**8 039.9**	**10 012.8**	**5 098.8**	**8 816.4**	**58 500.2**	**267.0**	**4 348.4**	**7 019.0**	**1995 Persons**
7 627.5	3 898.4	4 824.3	2 481.6	4 356.3	28 659.6	133.9	2 150.3	3 428.4	Male
7 796.6	4 141.4	5 188.5	2 617.1	4 460.1	29 840.6	133.1	2 198.2	3 590.7	Female
15 493.9	**8 054.8**	**10 041.4**	**5 116.8**	**8 837.5**	**58 703.6**	**268.0**	**4 370.0**	**7 062.4**	**1996 Persons**
7 662.3	3 907.2	4 777.5	2 491.7	4 366.1	28 791.6	134.3	2 160.7	3 448.8	Male
7 831.6	4 147.6	5 202.2	2 625.1	4 471.4	29 912.1	133.6	2 209.2	3 613.5	Female
15 567.1	**8 067.8**	**10 069.8**	**5 132.3**	**8 844.5**	**58 905.1**	**269.9**	**4 392.7**	**7 081.3**	**1997 Persons**
7 696.8	3 915.0	4 853.7	2 500.6	4 369.7	28 922.6	135.2	2 172.1	3 457.6	Male
7 870.3	4 152.9	5 216.1	2 631.7	4 474.8	29 982.4	134.6	2 220.6	3 623.7	Female
15 654.2	**8 075.4**	**10 107.9**	**5 147.3**	**8 847.6**	**59 089.6**	**272.4**	**4 417.6**	**7 096.5**	**1998 Persons**
7 740.1	3 918.5	4 872.9	2 509.1	4 371.9	29 039.5	136.4	2 185.1	3 465.2	Male
7 914.1	4 157.0	5 235.0	2 638.3	4 475.7	30 050.1	135.9	2 232.5	3 631.2	Female
15 760.2	**8 082.8**	**10 150.1**	**5 159.6**	**8 854.3**	**59 391.1**	**275.7**	**4 445.3**	**7 123.5**	**1999 Persons**
7 793.3	3 922.5	4 894.5	2 516.1	4 375.6	29 221.1	138.1	2 199.6	3 478.7	Male
7 967.0	4 160.3	5 255.6	2 643.6	4 478.7	30 170.0	137.6	2 245.8	3 644.8	Female
15 864.0	**8 102.6**	**10 198.2**	**5 171.3**	**8 861.4**	**59 623.4**	**279.0**	**4 478.5**	**7 164.4**	**2000 Persons**
7 846.3	3 935.0	4 919.4	2 523.0	4 380.1	29 370.6	139.7	2 217.1	3 500.7	Male
8 017.6	4 167.5	5 278.8	2 648.3	4 481.3	30 252.8	139.4	2 261.4	3 663.7	Female
15 987.1	**8 121.3**	**10 262.9**	**5 181.1**	**8 882.8**	**59 894.2**	**283.4**	**4 503.4**	**7 204.1**	**2001 Persons**
7 909.9	3 947.8	4 953.3	2 529.3	4 392.8	29 511.8	141.9	2 231.3	3 519.7	Male
8 077.2	4 173.5	5 309.5	2 651.8	4 490.0	30 351.0	141.5	2 272.1	3 684.4	Female
16 105.3	**8 139.3**	**10 335.6**	**5 194.9**	**8 909.1**	**60 113.9**	**286.6**	**4 524.1**	**7 261.2**	**2002 Persons**
7 972.0	3 935.6	4 991.6	2 537.6	4 408.4	:	143.5	2 241.9	3 549.1	Male
8 133.3	4 179.7	5 344.0	2 657.3	4 500.7	:	143.1	2 282.1	3 712.1	Female

1.1.4 Age dependency ratio[1]

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1960	53.9	54.7	56.2	48.1	51.8	55.4	60.9	72.4	51.5	47.4
1965	55.7	57.2	54.1	54.3	52.2	56.7	60.6	73.6	51.9	52.1
1970	58.2	58.7	55.3	58.2	54.7	59.4	60.5	73.5	54.7	52.9
1975	58.4	57.0	56.1	57.5	56.6	60.0	59.9	72.0	56.9	49.7
1980	55.5	52.9	54.9	52.6	56.8	58.3	57.6	70.1	55.4	48.4
1985	49.7	48.4	50.6	44.1	52.5	54.9	51.9	67.0	48.2	44.0
1990	48.9	49.1	48.7	44.7	49.7	50.8	51.6	63.3	46.0	44.2
1991	49.0	49.6	48.3	45.3	49.2	49.9	51.9	61.9	45.7	44.7
1992	49.0	50.1	48.2	45.6	48.9	49.0	52.3	60.6	45.6	45.4
1993	49.1	50.5	48.2	45.8	48.6	48.2	52.6	59.2	45.6	46.1
1994	49.2	50.8	48.2	46.1	48.3	47.5	52.7	57.8	45.7	46.9
1995	49.2	51.0	48.3	46.4	48.1	47.0	52.9	56.2	45.9	47.6
1996	49.3	51.4	48.5	46.5	47.9	46.7	53.0	54.5	46.4	48.3
1997	49.3	51.7	48.8	46.5	47.7	46.4	53.2	53.0	46.9	48.8
1998	49.3	52.0	49.1	46.6	47.7	46.3	53.3	51.6	47.1	49.2
1999	49.4	52.2	49.4	46.5	47.8	46.2	53.4	50.4	47.5	49.5
2000	49.5	52.4	49.8	46.9	48.0	46.3	53.6	49.4	47.9	49.7
2001	:	52.5	50.1	47.4	:	46.2	53.7	48.5	48.4	50.0

([1]) The age dependency ratio is the number of persons aged 0–14 and 65+ to those aged 15–64.
Source: Eurostat, NewCronos database (Demography).

1.1.5 Population numbers: actual (1995–2000) and forecast (2005–50)

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1995	371 573.9	10 130.6	5 215.7	81 538.6	10 442.9	39 177.4	58 020.4	3 579.6	57 268.6	406.6
1996	372 635.4	10 157.4	5 250.9	81 849.5	10 480.6	39 238.5	58 243.3	3 588.6	57 292.5	412.7
1997	373 711.1	10 182.5	5 268.8	82 170.1	10 517.8	39 307.3	58 473.6	3 597.3	57 327.3	418.6
1998	374 800.4	10 205.7	5 286.1	82 493.2	10 557.6	39 382.4	58 707.6	3 606.2	57 368.5	424.2
1999	375 890.4	10 229.3	5 303.5	82 812.9	10 599.5	39 462.0	58 943.4	3 615.2	57 412.4	429.6
2000	376 960.7	10 252.3	5 320.5	83 123.5	10 642.8	39 544.5	59 178.8	3 624.6	57 454.9	434.5
2005	381 812.2	10 367.1	5 398.1	84 373.6	10 870.0	39 981.5	60 330.3	3 681.3	57 626.2	454.9
2010	385 382.2	10 484.0	5 452.3	84 853.6	11 079.3	40 372.4	61 386.8	3 760.1	57 632.9	471.2
2015	387 343.8	10 577.5	5 487.1	84 869.5	11 212.6	40 487.7	62 202.2	3 842.8	57 238.8	485.9
2020	388 232.6	10 657.9	5 525.7	84 670.0	11 269.4	40 307.4	62 830.7	3 908.7	56 543.5	500.8
2025	388 253.7	10 725.8	5 575.7	84 178.8	11 299.7	39 983.4	63 302.0	3 947.3	55 721.5	516.2
2030	387 236.1	10 763.8	5 617.5	83 344.9	11 343.2	39 640.5	63 615.9	3 958.6	54 828.1	530.6
2035	384 887.4	10 754.3	5 629.6	82 273.8	11 390.2	39 250.8	63 693.9	3 947.8	53 817.1	542.4
2040	380 776.5	10 682.7	5 610.8	80 939.2	11 400.1	38 684.5	63 401.4	3 919.8	52 576.4	551.1
2045	374 949.0	10 566.9	5 578.1	79 179.7	11 349.7	37 855.9	62 817.7	3 877.3	51 061.8	557.5
2050	367 729.2	10 427.8	5 541.6	77 089.2	11 242.4	36 736.4	62 063.0	3 818.0	49 286.9	562.6

Source: Eurostat, NewCronos database (Demography).

1.2.1 Total fertility rate

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1960	2.59	2.56	2.54	2.37	2.28	2.86	2.73	3.76	2.41	2.28
1965	2.72	2.62	2.61	2.50	2.30	2.94	2.84	4.03	2.66	2.42
1970	2.38	2.25	1.95	2.03	2.39	2.90	2.47	3.93	2.42	1.98
1975	1.96	1.74	1.92	1.48	2.38	2.80	1.93	3.40	2.20	1.55
1980	1.82	1.68	1.55	1.56	2.21	2.20	1.95	3.25	1.64	1.49
1985	1.60	1.51	1.45	1.37	1.68	1.64	1.81	2.50	1.42	1.38
1990	1.57	1.62	1.67	1.45	1.39	1.36	1.78	2.11	1.33	1.61
1991	1.53	1.66	1.68	1.33	1.38	1.33	1.77	2.08	1.31	1.60
1992	1.51	1.65	1.76	1.30	1.38	1.32	1.73	1.99	1.31	1.64
1993	1.47	1.61	1.75	1.28	1.34	1.27	1.65	1.90	1.25	1.70
1994	1.44	1.56	1.81	1.24	1.35	1.21	1.66	1.85	1.21	1.72
1995	*1.42*	1.55	1.80	1.25	1.32	1.18	1.70	1.84	1.18	1.69
1996	*1.44*	1.55	1.75	1.32	1.30	1.17	1.72	1.88	1.20	1.76
1997	*1.45*	1.55	*1.75*	1.37	1.31	*1.16*	*1.71*	*1.92*	1.22	1.71
1998	*1.45*	1.53	1.72	1.36	1.29	1.15	*1.75*	*1.93*	*1.19*	1.68
1999	*1.45*	*1.61*	1.73	1.36	*1.28*	*1.20*	*1.79*	*1.88*	*1.23*	1.73
2000	*1.48*	*1.66*	*1.77*	*1.36*	*1.29*	*1.24*	1.89	1.89	*1.23*	1.79
2001	*1.47*	*1.65*	*1.34*	*1.27*	*1.29*	*1.25*	*1.90*	*1.98*	*1.29*	*1.70*

Source: Eurostat, NewCronos database (Demography).

(%)

NL	A	P	FIN	S	UK	IS	NO	CH	
63.7	51.4	59.1	61.0	52.3	54.0	75.7	58.7	52.3	**1960**
61.0	57.0	59.5	54.7	50.5	55.1	75.5	57.9	52.7	**1965**
60.0	62.2	61.7	51.3	52.5	59.1	71.4	59.6	53.8	**1970**
57.1	61.8	60.7	48.5	55.5	59.9	65.2	60.0	54.0	**1975**
51.7	56.6	58.6	47.8	56.2	56.5	60.0	58.8	51.1	**1980**
46.4	48.3	55.4	46.7	54.6	52.3	57.3	55.7	46.6	**1985**
45.0	47.9	51.6	48.5	55.4	52.9	55.2	54.4	46.2	**1990**
45.2	47.8	50.6	48.7	55.7	53.3	55.3	54.5	46.5	**1991**
45.4	48.0	49.8	48.8	56.2	53.8	55.1	54.6	46.6	**1992**
45.7	48.1	49.0	49.1	56.6	54.1	55.6	54.8	47.1	**1993**
45.9	48.3	48.5	49.3	56.9	54.3	55.8	54.8	47.5	**1994**
46.2	48.5	48.0	49.7	57.1	54.2	55.6	54.8	47.8	**1995**
46.4	48.6	47.6	49.9	57.0	54.1	55.3	54.9	48.0	**1996**
46.6	48.5	47.7	50.0	56.8	53.9	55.0	54.9	48.3	**1997**
46.8	48.3	47.6	49.9	56.6	53.7	54.5	54.8	48.4	**1998**
47.1	48.1	47.5	49.6	56.2	53.4	53.9	54.6	48.5	**1999**
47.4	47.8	47.6	49.4	55.8	53.0	53.6	54.4	48.6	**2000**
47.5	47.4	47.9	49.4	55.3	:	53.4	54.1	48.6	**2001**

(1 000)

NL	A	P	FIN	S	UK	IS	NO	CH	
15 422.8	8 039.9	9 912.1	5 098.8	8 816.4	58 503.6	267.0	4 348.4	:	**1995**
15 498.3	8 058.7	9 921.0	5 115.1	8 835.7	58 692.6	268.2	4 369.2	:	**1996**
15 584.8	8 079.2	9 934.2	5 132.0	8 857.5	58 860.1	270.7	4 392.3	:	**1997**
15 676.9	8 100.6	9 951.2	5 147.9	8 881.3	59 011.0	273.1	4 415.6	:	**1998**
15 772.3	8 122.3	9 970.9	5 163.4	8 906.1	59 147.7	275.5	4 439.0	:	**1999**
15 868.2	8 144.0	9 993.0	5 178.4	8 931.6	59 269.2	277.9	4 462.0	:	**2000**
16 311.3	8 241.6	10 130.6	5 241.8	9 055.2	59 748.7	288.5	4 570.6	:	**2005**
16 659.1	8 325.5	10 292.7	5 290.1	9 175.9	60 146.1	297.3	4 662.8	:	**2010**
16 940.3	8 388.2	10 421.2	5 325.1	9 307.0	60 557.9	304.7	4 750.3	:	**2015**
17 204.5	8 442.7	10 512.6	5 350.3	9 470.2	61 038.3	311.1	4 850.6	:	**2020**
17 459.0	8 484.6	10 594.4	5 363.8	9 641.0	61 460.4	316.5	4 959.0	:	**2025**
17 665.9	8 497.8	10 677.8	5 351.8	9 772.3	61 627.5	320.3	5 053.2	:	**2030**
17 777.1	8 475.3	10 747.2	5 306.3	9 855.3	61 426.4	321.5	5 114.7	:	**2035**
17 770.5	8 425.2	10 776.3	5 232.7	9 914.3	60 891.6	319.8	5 142.4	:	**2040**
17 684.1	8 345.6	10 754.1	5 153.0	9 987.6	60 179.9	315.9	5 154.3	:	**2045**
17 563.9	8 240.7	10 681.1	5 078.3	10 082.3	59 315.1	310.6	5 160.8	:	**2050**

(number of births per woman)

NL	A	P	FIN	S	UK	IS	NO	CH	
3.12	2.69	3.10	2.72	2.20	2.72	4.17	2.91	2.44	**1960**
3.04	2.70	3.14	2.48	2.42	2.89	3.71	2.95	2.61	**1965**
2.57	2.29	2.83	1.83	1.92	2.43	2.81	2.50	2.10	**1970**
1.66	1.82	2.58	1.68	1.77	1.81	2.65	1.98	1.61	**1975**
1.60	1.62	2.18	1.63	1.68	1.90	2.48	1.72	1.55	**1980**
1.51	1.47	1.72	1.65	1.74	1.79	1.93	1.68	1.52	**1985**
1.62	1.45	1.57	1.78	2.13	1.83	2.30	1.93	1.59	**1990**
1.61	1.49	1.57	1.79	2.11	1.81	2.18	1.92	1.60	**1991**
1.59	1.49	1.54	1.85	2.09	1.79	2.21	1.88	1.58	**1992**
1.57	1.48	1.52	1.81	1.99	1.75	2.22	1.86	1.51	**1993**
1.57	1.44	1.44	1.85	1.88	1.74	2.14	1.86	1.49	**1994**
1.53	1.40	1.40	1.81	1.73	1.71	2.08	1.87	1.48	**1995**
1.53	1.42	1.43	1.76	1.60	1.72	2.12	1.89	1.50	**1996**
1.56	1.37	1.46	1.75	1.52	1.72	2.04	1.86	1.51	**1997**
1.63	1.34	1.46	1.70	1.50	1.71	2.05	1.81	1.46	**1998**
1.65	*1.32*	*1.49*	1.74	1.50	*1.68*	*1.99*	*1.84*	*1.48*	**1999**
1.72	*1.34*	*1.52*	1.73	1.54	*1.65*	*2.08*	*1.85*	*1.50*	**2000**
1.69	*1.29*	*1.42*	*1.73*	*1.57*	*1.63*	*1.95*	:	*1.41*	**2001**

1.2.2 Crude birth rate

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1960	18.3	17.0	16.6	17.3	18.9	21.5	17.9	21.4	18.1	16.0
1965	18.5	16.5	18.0	17.4	17.7	21.0	17.7	22.1	19.0	16.0
1970	16.2	14.8	14.4	13.5	16.5	19.6	16.7	21.8	16.7	13.0
1975	13.6	12.2	14.2	9.9	15.7	18.8	14.1	21.1	14.9	11.1
1980	13.0	12.6	11.2	11.1	15.4	15.3	14.9	21.8	11.3	11.4
1985	11.9	11.6	10.5	10.5	11.7	11.9	13.9	17.6	10.2	11.2
1990	12.0	12.4	12.3	11.4	10.1	10.3	13.4	15.1	10.0	12.9
1991	11.7	12.6	12.5	10.4	10.0	10.2	13.3	15.0	9.9	12.9
1992	11.5	12.4	13.1	10.0	10.1	10.2	13.0	14.4	10.0	13.1
1993	11.2	12.0	13.0	9.8	9.8	9.9	12.3	13.8	9.6	13.4
1994	10.9	11.5	13.4	9.5	10.0	9.5	12.3	13.5	9.3	13.5
1995	10.8	*11.4*	13.3	9.4	9.7	9.3	12.6	13.5	9.2	13.2
1996	10.8	*11.4*	12.9	9.7	9.6	9.2	12.7	14.0	9.2	13.7
1997	10.8	*11.4*	12.8	9.9	9.7	9.4	12.5	*14.3*	9.2	13.1
1998	10.7	*11.2*	12.5	9.6	9.6	9.2	*12.7*	*14.4*	9.0	12.6
1999	*10.6*	*11.1*	12.4	9.4	9.5	9.5	*12.7*	14.2	9.1	12.9
2000	*10.7*	*11.3*	*12.6*	*9.2*	*9.6*	*9.8*	*13.1*	*14.3*	9.4	13.1

Source: Eurostat, NewCronos database (Demography).

1.2.3 Crude death rate

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1960	10.7	12.5	9.5	12.0	7.3	8.6	11.4	11.5	9.6	11.8
1965	10.7	12.2	10.1	11.9	7.9	8.3	11.2	11.5	9.9	12.2
1970	10.8	12.3	9.8	12.6	8.4	8.3	10.7	11.4	9.7	12.2
1975	10.9	12.2	10.1	12.6	8.9	8.4	10.6	10.4	10.0	12.2
1980	10.5	11.5	10.9	12.2	9.1	7.7	10.2	9.8	9.8	11.3
1985	10.5	11.3	11.4	12.0	9.4	8.1	10.0	9.4	9.7	11.0
1990	10.2	10.4	11.9	11.6	9.3	8.6	9.3	8.9	9.6	9.9
1991	10.2	10.4	11.6	11.4	9.3	8.7	9.2	8.9	9.8	9.7
1992	10.0	10.4	11.8	11.0	9.5	8.5	9.1	8.7	9.6	10.2
1993	*10.2*	*10.7*	12.1	11.1	9.4	8.7	9.2	9.0	9.7	9.8
1994	*9.9*	*10.4*	11.7	10.9	9.4	8.6	9.0	8.6	9.7	9.4
1995	*10.0*	*10.5*	12.1	10.8	9.6	8.8	9.1	*8.8*	*9.7*	9.3
1996	*10.0*	*10.4*	11.6	10.8	9.6	*8.9*	*9.2*	*8.7*	*9.5*	9.4
1997	*9.9*	*10.2*	*11.3*	*10.5*	*9.6*	*9.1*	*9.1*	*8.6*	*9.6*	9.4
1998	*9.8*	*10.2*	*11.0*	*10.3*	*9.5*	*8.9*	*9.2*	*8.5*	*9.9*	*9.0*
1999	*9.9*	*10.3*	11.1	11.1	9.8	9.4	9.2	8.4	9.9	8.8
2000	*9.7*	*10.3*	*10.9*	*10.9*	*9.8*	*9.1*	*9.1*	8.2	9.7	8.6

Source: Eurostat, NewCronos database (Demography).

(live births per 1000 population)

NL	A	P	FIN	S	UK	IS	NO	CH	
20.8	17.9	24.1	18.5	13.7	17.5	28.0	17.3	17.7	**1960**
19.9	17.9	23.4	17.1	15.9	18.3	24.6	17.8	19.1	**1965**
18.3	15.0	20.8	14.0	13.7	16.2	19.7	16.7	16.1	**1970**
13.0	12.4	19.8	13.9	12.6	12.4	20.1	14.1	12.4	**1975**
12.8	12.0	16.2	13.2	11.7	13.4	19.8	12.5	11.7	**1980**
12.3	11.5	13.0	12.8	11.8	13.2	16.0	12.3	11.5	**1985**
13.2	11.7	11.8	13.1	14.5	13.9	18.7	14.4	12.5	**1990**
13.2	12.1	11.8	13.0	14.4	13.7	17.6	14.3	12.7	**1991**
13.0	12.0	11.7	13.2	14.2	13.5	17.7	14.0	12.6	**1992**
12.8	11.9	11.5	12.8	13.5	13.1	17.5	13.8	12.1	**1993**
12.7	11.5	11.0	12.8	12.8	12.9	16.7	13.9	11.9	**1994**
12.3	11.0	10.8	12.3	11.7	12.5	16.0	13.8	11.7	**1995**
12.2	11.0	11.1	11.8	10.8	12.5	16.1	13.9	11.7	**1996**
12.3	10.4	11.4	11.5	10.2	12.3	15.3	13.6	11.4	**1997**
12.7	10.1	11.4	11.1	10.1	*12.1*	15.2	13.2	*11.0*	**1998**
12.7	9.7	*11.5*	11.2	10.0	11.8	14.8	13.3	11.0	**1999**
13.0	9.6	*12.0*	11.0	10.2	*11.4*	15.3	13.2	*10.9*	**2000**

(deaths per 1000 population)

NL	A	P	FIN	S	UK	IS	NO	CH	
7.6	12.7	10.7	9.0	10.0	11.5	6.6	9.1	9.8	**1960**
8.0	13.0	10.6	9.7	10.1	11.6	6.7	9.4	9.5	**1965**
8.4	13.2	10.7	9.6	9.9	11.8	7.1	10.0	9.2	**1970**
8.3	12.7	10.8	9.3	10.8	11.8	6.5	10.0	8.8	**1975**
8.1	12.2	9.7	9.3	11.0	11.7	6.7	10.1	9.4	**1980**
8.5	11.8	9.7	9.8	11.3	11.8	6.8	10.7	9.2	**1985**
8.6	10.7	10.4	10.0	11.1	11.1	6.7	10.9	9.5	**1990**
8.6	10.7	10.6	9.8	11.0	11.2	7.0	10.5	9.2	**1991**
8.6	10.5	10.3	9.9	10.9	10.9	6.6	10.4	9.1	**1992**
9.0	10.3	10.8	10.1	11.1	11.3	6.6	10.8	9.0	**1993**
8.7	10.0	10.1	9.4	10.5	10.7	6.5	10.2	8.9	**1994**
8.8	10.1	10.5	9.6	10.6	11.0	7.2	10.4	9.0	**1995**
8.9	10.0	10.8	9.6	10.6	10.8	7.0	10.0	8.9	**1996**
8.7	9.8	10.6	9.6	10.5	*10.7*	6.8	10.1	8.9	**1997**
8.8	*9.7*	*10.8*	*9.7*	*10.5*	*10.4*	*6.7*	*9.9*	*8.9*	**1998**
8.9	9.7	*10.8*	9.6	10.7	10.6	*6.9*	*10.1*	*8.7*	**1999**
8.8	*9.5*	*10.6*	9.5	10.5	*10.2*	*6.5*	*9.8*	*8.7*	**2000**

1.2.4 Net migration

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					Net numbers					
1960	-117	4	3	174	-31	-142	140	-42	-94	1
1965	40	26	1	323	-40	-70	110	-22	-158	2
1970	:	4	12	560	-46	-28	180	-3	-47	1
1975	283	24	-9	-211	59	14	14	17	10	4
1980	575	-3	0	303	50	112	44	-1	-7	1
1985	299	0	10	56	6	-8	39	-26	82	1
1990	1 104	20	8	628	55	1	80	-23	133	4
1991	1 135	14	11	601	153	23	90	-2	33	4
1992	1 203	25	12	788	49	20	90	2	64	4
1993	900	19	11	471	56	25	70	-6	59	4
1994	726	18	10	330	27	27	50	-10	45	4
1995	:	13	29	431	30	:	45	:	51	5
1996	:	13	17	304	19	:	35	:	120	4
1997	:	6	12	95	21	:	40	20	:	4
1998	:	7	19	47	23	:	40	22	:	4
					Net migration rate					
1960	:	0.5	0.7	2.4	-3.7	-4.6	3.1	-14.8	-1.9	1.7
1965	:	2.8	0.1	4.2	-4.7	-2.2	2.3	-7.5	-3.0	5.3
1970	:	0.4	2.4	7.2	-5.3	-0.8	3.5	-1.2	-0.9	3.1
1975	:	2.4	-1.7	-2.7	6.5	0.4	0.3	5.4	0.2	9.7
1980	:	-0.3	0.1	3.9	5.2	3.0	0.8	-0.2	-0.1	3.7
1985	:	0.0	1.9	0.7	0.6	-0.2	0.7	-7.3	1.5	2.2
1990	:	2.0	1.6	7.9	5.4	0.0	1.4	-6.5	2.4	10.3
1991	:	1.4	2.1	7.5	14.9	0.6	1.6	-0.6	0.6	10.8
1992	:	2.5	2.2	9.8	4.7	0.5	1.6	0.6	1.1	10.8
1993	:	1.9	2.1	5.8	5.4	0.6	1.2	-1.7	1.0	10.7
1994	:	1.8	2.0	4.0	2.6	0.7	0.9	-2.8	0.8	9.9
1995	:	1.3	5.5	5.3	2.9	:	0.8	:	0.9	11.3
1996	:	1.3	3.3	3.7	1.8	:	0.6	:	2.1	8.8
1997	:	0.6	2.2	1.2	2.0	:	0.7	5.5	:	9.1
1998	:	0.7	3.5	0.6	2.1	:	0.7	5.9	:	10.2

Source: Eurostat, NewCronos database (Demography).

NL	A	P	FIN	S	UK	IS	NO	CH	
				1 000					
-13	-2	-226	-9	9	111	0	-5	22	**1960**
19	11	-129	-21	33	-44	0	-2	-2	**1965**
34	10	:	-36	49	-15	-2	-1	-18	**1970**
72	-25	347	-4	16	-45	0	5	-58	**1975**
53	9	42	-1	10	-37	-1	4	17	**1980**
24	7	23	3	11	72	-1	6	14	**1985**
60	123	-33	7	35	6	-1	2	57	**1990**
63	59	-25	13	25	73	1	8	69	**1991**
58	37	-10	9	20	36	0	10	41	**1992**
60	40	15	8	32	35	0	13	40	**1993**
37	13	10	3	51	111	-1	7	31	**1994**
33	:	5	3	12	109	-1	6	15	**1995**
43	:	10	3	6	93	-1	6	-1	**1996**
:	3	15	4	6	92	0	11	-7	**1997**
41	5	15	3	11	:	1	14	1	**1998**
				Per 1 000 population					
-1.1	-0.3	-25.5	-2.1	1.2	2.1	0.0	-1.4	4.2	**1960**
1.5	1.4	-14.3	-4.6	4.2	-0.8	-0.8	-0.5	-0.3	**1965**
2.6	1.4	:	-7.9	6.1	-0.3	-8.7	-0.3	-2.9	**1970**
5.3	-3.2	38.2	-0.8	2.0	-0.8	-1.9	1.2	-9.1	**1975**
3.7	1.2	4.3	-0.3	1.1	-0.7	-2.7	1.0	2.7	**1980**
1.7	1.0	2.3	0.6	1.3	1.3	-2.5	1.5	2.1	**1985**
4.0	15.9	-3.3	1.4	4.1	0.1	-3.9	0.4	8.4	**1990**
4.2	7.5	-2.5	2.6	2.9	1.3	3.9	1.9	10.1	**1991**
3.8	4.6	-1.0	1.7	2.3	0.6	-1.0	2.3	5.9	**1992**
3.9	5.0	1.5	1.7	3.7	0.6	-0.7	3.0	5.7	**1993**
2.4	1.6	1.0	0.6	5.8	1.9	-3.0	1.7	4.4	**1994**
2.1	:	0.5	0.6	1.3	1.9	-5.1	1.5	2.1	**1995**
2.8	:	1.0	0.5	0.7	1.6	-1.9	1.3	-0.2	**1996**
:	0.4	1.5	0.7	0.7	1.6	0.7	2.4	-1.0	**1997**
2.6	0.6	1.5	0.7	1.2	:	3.6	3.1	0.1	**1998**

1.2.5 Components of population change, 1990–2000

		EU-15	B	DK	D	EL	E	F	IRL	I	L
1990	**Population (1)**	**363 763.4**	**9 947.8**	**5 135.4**	**79 112.8**	**10 120.9**	**38 826.3**	**56 577.0**	**3 507.0**	**56 694.4**	**379.3**
	Live births	4 379.1	123.8	63.4	905.7	102.2	401.4	762.4	53.0	569.3	4.9
	Deaths	3 720.8	104.1	60.9	921.4	94.2	333.1	526.2	31.4	543.7	3.8
	Natural increase	658.3	19.6	2.5	-15.8	8.1	68.3	236.2	21.7	25.5	1.2
	Net migration (2)	1 012.8	19.5	8.6	656.2	71.1	-20.0	80.0	-7.7	24.2	3.9
	Total population increase	1 671.2	39.2	11.1	640.4	79.2	48.3	316.2	14.0	49.8	5.1
1991	**Population (1)**	**365 382.0**	**9 987.0**	**5 146.5**	**79 753.2**	**10 200.1**	**38 874.6**	**56 840.7**	**3 521.0**	**56 744.1**	**384.4**
	Live births	4 289.8	125.9	64.4	830.0	102.6	396.0	759.1	52.7	562.8	5.0
	Deaths	3 730.2	104.1	59.6	911.2	95.5	337.7	524.7	31.3	553.8	3.7
	Natural increase	559.6	21.8	4.8	-81.2	7.1	58.3	234.4	21.4	9.0	1.2
	Net migration (2)	1 023.9	13.2	10.9	602.6	87.2	32.2	35.5	5.1	4.2	4.2
	Total population increase	1 583.5	35.0	15.7	521.3	94.4	90.5	269.9	26.5	13.1	5.4
1992	**Population (1)**	**366 965.5**	**10 022.0**	**5 162.1**	**80 274.6**	**10 294.5**	**38 965.1**	**57 110.5**	**3 547.5**	**56 757.2**	**389.8**
	Live births	4 247.8	124.8	67.7	809.1	104.1	396.7	743.7	51.1	567.8	5.1
	Deaths	3 676.4	104.2	60.8	885.4	98.2	331.5	521.5	30.9	546.7	4.0
	Natural increase	571.4	20.6	6.9	-76.3	5.9	65.2	222.1	20.2	21.2	1.1
	Net migration (2)	1 302.7	25.7	11.6	776.4	48.9	26.3	36.5	1.7	181.9	4.3
	Total population increase	1 874.1	46.3	18.5	700.1	54.7	91.5	258.6	21.9	203.1	5.4
1993	**Population (1)**	**368 839.7**	**10 068.3**	**5 180.6**	**80 974.6**	**10 349.2**	**39 056.6**	**57 369.2**	**3 569.4**	**56 960.3**	**395.2**
	Live births	4 139.5	120.8	67.4	798.4	101.8	385.8	711.6	49.3	549.5	5.4
	Deaths	3 758.6	108.2	62.8	897.3	97.4	339.7	532.3	32.1	552.4	3.9
	Natural increase	381.0	12.7	4.6	-98.8	4.4	46.1	179.3	17.2	-2.9	1.4
	Net migration (2)	1 012.2	19.6	11.5	462.3	56.0	32.9	16.5	-3.4	181.1	4.3
	Total population increase	1 393.2	32.3	16.0	363.5	60.4	79.0	195.8	13.8	178.2	5.7
1994	**Population (1)**	**370 232.8**	**10 100.6**	**5 196.6**	**81 338.1**	**10 409.6**	**39 135.6**	**57 565.0**	**3 583.2**	**57 138.5**	**400.9**
	Live births	4 052.9	116.4	69.7	769.6	103.8	370.1	711.0	48.3	533.1	5.5
	Deaths	3 679.0	104.9	61.1	884.7	97.8	338.2	520.0	30.9	556.3	3.8
	Natural increase	373.9	11.6	8.6	-115.1	6.0	31.9	191.0	17.3	-23.3	1.7
	Net migration (2)	734.7	18.4	10.5	315.6	27.3	29.3	-3.5	-2.8	153.4	4.0
	Total population increase	1 108.5	29.9	19.1	200.5	33.3	61.2	187.5	14.5	130.1	5.7
1995	**Population (1)**	**371 442.0**	**10 130.6**	**5 215.7**	**81 538.6**	**10 442.9**	**39 196.8**	**57 752.5**	**3 597.6**	**57 268.6**	**406.6**
	Live births	4 009.9	115.6	69.8	765.2	101.5	363.5	729.6	48.8	525.6	5.4
	Deaths	3 733.9	105.9	63.1	884.6	100.2	346.2	531.6	32.3	556.7	3.8
	Natural increase	276.0	9.7	6.6	-119.4	1.3	17.2	198.0	16.5	-31.1	1.6
	Net migration (2)	737.6	2.8	28.7	398.3	20.9	35.1	-14.6	5.9	95.5	4.6
	Total population increase	1 013.6	12.5	35.3	278.9	22.2	52.3	183.4	22.4	64.4	6.2
1996	**Population (1)**	**372 475.6**	**10 143.0**	**5 251.0**	**81 817.5**	**10 465.1**	**39 249.1**	**57 936.0**	**3 620.1**	**57 333.0**	**412.8**
	Live births	4 040.1	116.2	67.6	796.0	100.7	362.6	734.3	50.7	528.1	5.7
	Deaths	3 732.3	105.3	61.0	882.8	100.7	351.4	535.8	31.7	554.6	3.9
	Natural increase	307.8	10.9	6.6	-86.8	0.0	11.2	198.6	18.9	-26.5	1.8
	Net migration (2)	688.2	16.3	17.5	281.5	21.6	48.2	-18.5	13.2	154.5	3.7
	Total population increase	996.0	27.2	24.1	194.7	21.5	59.4	180.1	32.1	128.0	5.5
1997	**Population (1)**	**373 486.6**	**10 170.2**	**5 275.1**	**82 012.2**	**10 486.6**	**39 308.5**	**58 116.0**	**3 652.2**	**57 461.0**	**418.3**
	Live births	4 046.4	115.9	67.6	812.2	102.0	369.0	726.8	52.3	528.9	5.5
	Deaths	3 684.9	103.9	59.9	860.4	99.7	349.5	530.3	31.6	553.1	3.9
	Natural increase	361.5	12.0	7.7	-48.2	2.3	19.5	196.4	20.7	-24.2 p	1.6
	Net migration (2)	482.0	10.0	12.0	93.4	22.1	59.5	-13.5 p	21.1	126.6	3.8
	Total population increase	843.5	22.0	19.7	45.2	24.4	79.0	182.9	41.8	102.4	5.4
1998	**Population (1)**	**374 345.1**	**10 192.3**	**5 294.9**	**82 057.4**	**10 511.0**	**39 387.5**	**58 299.0**	**3 694.0**	**57 563.4**	**423.7**
	Live births	4 000.2	114.3	66.2	785.0	100.9	361.9	740.3	53.6	515.4	5.4
	Deaths	3 715.2	104.6	58.4	852.4	102.7	357.9	540.4	31.4	569.4	3.9
	Natural increase	285.0	9.7	7.7	-67.3	-1.8	4.0	199.9	22.2	-54.0 p	1.5
	Net migration (2)	515.4	11.8	11.0	47.0	12.5	127.7	-2.2 p	18.7	103.2	4.0
	Total population increase	800.4	21.5	18.7	-20.4	10.7	131.7	197.7	40.9	49.3	5.5
1999	**Population (1)**	**375 276.8**	**10 213.8**	**5 313.6**	**82 037.0**	**10 521.7**	**39 519.2**	**58 496.6**	**3 734.9**	**57 612.6**	**429.2**
	Live births	3 996.6	113.5(*)	66.2(*)	770.7(*)	100.6(*)	377.8(*)	744.8(*)	53.4(*)	523.5(*)	5.6(*)
	Deaths	3 735.2	104.9(*)	59.2(*)	846.3(*)	103.3(*)	370.4(*)	541.6(*)	31.7(*)	570.9(*)	3.8(*)
	Natural increase	261.4	8.6(*)	7.1(*)	-75.6(*)	-2.7 (*)	7.4(*)	203.2(*)	21.7(*)	-47.5 e	1.8(*)
	Net migration (2)	897.4	16.8(*)	9.4(*)	202.1(*)	23.8(*)	206.4(*)	44.3(*)	20.0(*)	114.7(*)	4.7(*)
	Total population increase	1 158.7	25.3(*)	16.4(*)	126.5(*)	21.1(*)	213.8(*)	247.5(*)	41.7(*)	67.3(*)	6.5(*)
2000	**Population (1)**	***376 481.8***	**10 239.1**	**5 330.0**	**82 163.5**	**10 554.4**	**39 733.0**	**58 748.7**	***3 776.6***	**57 679.9**	**435.7**
	Live births	: e	: p	*67.1*	*754.1*	101.0(*)	395.8(*)	778.9	54.2(*)	543.0(*)	5.7(*)
	Deaths	3 6 62.6(*)	*104.9*	*58.0*	*830.3*	103.0(*)	359.1(*)	538.3	31.1(*)	560.2(*)	3.8(*)
	Natural increase	: e	: p	*9.1*	*-76.2 p*	-2.0 e	36.6(*)	240.6	23.1(*)	-17.2 e	2.0(*)
	Net migration (2)	: e	: ep	*10.1(*)*	*105.3(*)*	23.9(*)	352.1	55.0(*)	26.5(*)	181.3(*)	3.6(*)
	Total population increase	1 444.5(*)	*24.3(*)*	19.2(*)	*29.1(*)*	21.9(*)	388.7	295.6(*)	49.6(*)	164.1(*)	5.6(*)
2001	**Population (1)**	***377 987.8***	**10 263.4**	**5 349.2**	**82 259.5**	**10 564.7**	**40 121.7**	**59 037.2**	***3 826.2***	***57 844.0***	***441.3***

(1) As at 1 January.
(2) Including corrections.
(*) Estimated.
Pr*ovisional numbers in italics.*

Source: Eurostat, NewCronos database (Demography).

NL	A	P	FIN	S	UK	IS	NO	CH		
14 892.6	**7 689.5**	**9 919.7**	**4 974.4**	**8 527.0**	**57 459.3**	**253.8**	**4 233.1**	**6 673.9**	**1990**	**Population [1])**
198.0	90.5	116.4	65.5	123.9	798.6	4.8	60.9	83.9		Live births
128.8	83.0	103.1	50.1	95.2	641.8	1.7	46.0	63.7		Deaths
69.1	7.5	13.3	15.5	28.8	156.8	3.1	14.9	20.2		Natural increase
48.7	71.9	-55.5	8.6	34.8	68.4	-1.0	1.8	56.6		Net migration [2])
117.9	79.4	-42.2	24.1	63.6	225.2	2.1	16.7	76.8		Total population increase
15 010.4	**7 768.9**	**9 877.5**	**4 998.5**	**8 590.6**	**57 684.5**	**255.9**	**4 249.8**	**6 750.7**	**1991**	**Population [1])**
198.7	94.6	116.4	65.4	123.7	792.5	4.5	60.8	86.2		Live births
130.0	83.4	104.4	49.3	95.2	646.2	1.8	44.9	62.6		Deaths
68.7	11.2	12.1	16.1	28.5	146.3	2.7	15.9	23.6		Natural increase
50.0	87.7	-24.6	14.4	25.0	76.4	1.1	7.9	68.5		Net migration [2])
118.7	98.9	-12.6	30.5	53.5	222.7	3.9	23.8	92.1		Total population increase
15 129.2	**7 867.8**	**9 864.9**	**5 029.0**	**8 644.1**	**57 907.3**	**259.7**	**4 273.6**	**6 842.8**	**1992**	**Population [1])**
196.7	95.3	115.0	66.7	122.8	781.0	4.6	60.1	86.9		Live births
129.9	83.2	101.2	49.8	94.7	634.2	1.7	44.7	62.3		Deaths
66.8	12.1	13.9	16.9	28.1	146.8	2.9	15.4	24.6		Natural increase
43.2	82.1	-9.6	9.1	19.8	44.9	-0.2	10.2	40.6		Net migration [2])
110.0	94.2	4.3	26.0	47.9	191.7	2.7	25.5	65.2		Total population increase
15 239.2	**7 962.0**	**9 869.2**	**5 055.0**	**8 692.0**	**58 098.9**	**262.4**	**4 299.2**	**6 908.0**	**1993**	**Population [1])**
195.7	95.2	114.0	64.8	118.0	761.7	4.6	59.7	83.8		Live births
137.8	82.5	106.4	51.0	97.0	657.9	1.8	46.6	62.5		Deaths
58.0	12.7	7.6	13.8	21.0	103.9	2.9	13.1	21.3		Natural increase
44.4	40.3	15.3	9.1	32.1	90.1	-0.2	12.6	39.4		Net migration [2])
102.4	53.0	23.0	22.9	53.1	194.0	2.7	25.6	60.6		Total population increase
15 341.6	**8 015.0**	**9 892.2**	**5 077.9**	**8 745.1**	**58 292.9**	**265.1**	**4 324.8**	**6 968.6**	**1994**	**Population [1])**
195.6	92.4	109.3	65.2	112.3	750.7	4.4	60.1	83.0		Live births
133.5	80.7	99.6	48.0	91.8	627.6	1.7	44.1	62.0		Deaths
62.1	11.7	9.7	17.2	20.4	123.0	2.7	16.0	21.0		Natural increase
20.4	13.1	10.3	3.6	50.9	84.2	-0.8	7.6	29.5		Net migration [2])
82.6	24.8	20.0	20.8	71.3	207.3	1.9	23.6	50.4		Total population increase
15 424.1	**8 039.9**	**10 012.8**	**5 098.8**	**8 816.4**	**58 500.2**	**267.0**	**4 348.4**	**7 019.0**	**1995**	**Population [1])**
190.5	88.7	107.2	63.1	103.4	732.0	4.3	60.3	82.2		Live births
135.7	81.2	103.9	49.3	94.0	645.5	1.9	45.2	63.4		Deaths
54.8	7.5	3.2	13.8	9.5	86.6	2.4	15.1	18.8		Natural increase
14.9	7.4	5.4	4.3	11.6	116.9	-1.4	6.4	24.5		Net migration [2])
69.8	14.9	8.6	18.1	21.1	203.4	1.0	21.5	43.3		Total population increase
15 493.9	**8 054.8**	**10 041.4**	**5 116.8**	**8 837.5**	**58 703.6**	**268.0**	**4 370.0**	**7 062.4**	**1996**	**Population [1])**
189.5	88.8	110.4	60.7	95.3	733.4	4.3	60.9	83.0		Live births
137.6	80.8	107.3	49.2	94.1	636.0	1.9	43.9	62.6		Deaths
52.0	8.0	3.1	11.6	1.2	97.4	2.5	17.1	20.4		Natural increase
21.3	5.0	10.2	3.9	5.8	104.1	-0.5	5.7	-1.4		Net migration [2])
73.2	13.0	13.4	15.5	7.0	201.4	1.9	22.8	19.0		Total population increase
15 567.1	**8 067.8**	**10 069.8**	**5 132.3**	**8 844.5**	**58 905.1**	**269.9**	**4 392.7**	**7 081.3**	**1997**	**Population [1])**
192.4	84.0	113.0	59.3	90.5	726.8	4.2	59.8	80.6		Live births
135.8	79.4	105.2	49.1	93.3	629.7	1.8	44.6	62.8		Deaths
56.7	4.6	7.9	10.2	-2.8	97.1	2.3	15.2	17.7		Natural increase
30.4	3.0	15.3	4.8	6.0	87.5	0.2	9.7	-2.6		Net migration [2])
87.1	7.6	23.2	15.0	3.1	184.5	2.5	24.9	15.1		Total population increase
15 654.2	**8 075.4**	**10 107.9**	**5 147.3**	**8 847.6**	**59 089.6**	**272.4**	**4 417.6**	**7 096.5**	**1998**	**Population [1])**
199.4	81.2	113.5	57.1	89.0	716.9	4.2	58.4	78.4		Live births
137.5	78.3	106.6	49.3	93.3	629.2	1.8	44.0	62.6		Deaths
61.9	2.9	6.9	7.8	-4.2	87.7	2.4	14.4	15.8		Natural increase
44.1	4.5	15.2	4.5	10.9	102.5*	1.0	13.4	11.3		Net migration [2])
106.0	7.4	22.2	12.3	6.7	190.2*	3.3	27.7	27.1		Total population increase
15 760.2	**8 082.8**	**10 150.1**	**5 159.6**	**8 854.3**	**59 391.1**	**275.7**	**4 445.3**	**7 123.5**	**1999**	**Population [1])**
200.4(*)	78.1(*)	116.0(*)	57.6(*)	88.2(*)	700.2(*)	4.1(*)	59.3(*)	78.4(*)		Live births
140.5(*)	78.2(*)	108.3(*)	49.3(*)	94.7(*)	632.1(*)	1.9(*)	45.2(*)	62.5(*)		Deaths
60.0(*)	-0.1 e	7.8(*)	8.2(*)	-6.6(*)	68.1(*)	2.2(*)	14.1(*)	15.9(*)		Natural increase
43.8(*)	19.8(*)	10.4(*)	3.4(*)	13.7(*)	164.1(*)	1.1(*)	19.0(*)	25.0(*)		Net migration [2])
103.7(*)	19.7(*)	18.1(*)	11.7(*)	7.1(*)	232.3(*)	3.3(*)	33.2(*)	40.9(*)		Total population increase
15 864.0	**8 102.6**	**10 198.2**	**5 171.3**	**8 861.4**	**59 623.4**	**279.0**	**4 478.5**	**7 164.4**	**2000**	**Population [1])**
206.6	78.3(*)	*120.0*	56.7(*)	90.4(*)	*679.3(*)*	*4.3(*)*	59.2(*)	78.5(*)		Live births
140.5	76.8(*)	*105.4*	49.3(*)	93.5(*)	*608.4(*)*	*1.9(*)*	44.0(*)	*62.5(*)*		Deaths
66.1	1.5(*)	*14.6*	7.4(*)	-3.0(*)	*70.9(*)*	*2.4(*)*	15.2(*)	*15.9(*)*		Natural increase
57.0(*)	17.3(*)	50.0(*)	2.4(*)	24.4(*)	140.0(*)	1.9(*)	9.7(*)	*23.7(*)*		Net migration [2])
123.1(*)	18.8(*)	64.6(*)	9.8(*)	21.4(*)	208.7(*)	4.3(*)	24.9(*)	*39.6(*)*		Total population increase
15 987.1	**8 121.3**	***10 262.9***	**5 181.1**	**8 882.8**	***59 862.8***	**283.4**	**4 503.4**	**7 204.1**	**2001**	**Population [1])**

1.3.1 Life expectancy at birth, males and females

		EU-15	B	DK	D	EL	E	F	IRL	I	L
1950	**Male**	:	62.0	:	64.6	63.4	59.8	62.9	64.5	63.7	:
	Female	:	67.3	:	68.5	68.5	64.3	68.5	67.1	67.2	:
1960	**Male**	*67.4*	67.7	70.4	:	67.3	67.4	66.9	68.1	67.2	66.5
	Female	*72.9*	73.5	74.4	:	72.4	72.2	73.6	71.9	72.3	72.2
1970	**Male**	*68.4*	67.8	70.7	:	70.1	69.2	68.4	68.8	69.0	67.1
	Female	*74.7*	74.2	75.9	:	73.8	74.8	75.9	73.5	74.9	73.4
1980	**Male**	*70.5*	70.0	71.2	*69.6*	72.2	72.5	70.2	70.1	70.6	69.1
	Female	*77.2*	76.8	77.3	*76.1*	76.8	78.6	78.4	75.6	77.4	75.9
1990	**Male**	72.8	72.7	72.0	72.0	74.6	73.3	72.7	72.1	73.6	72.3
	Female	79.4	79.4	77.7	78.4	79.5	80.4	80.9	77.6	80.1	78.5
1995	**Male**	*73.9*	*73.4*	72.7	73.3	75.0	74.3	73.9	72.9	74.9	73.0
	Female	*80.4*	*80.2*	77.8	79.7	80.3	81.5	81.9	78.4	81.3	80.2
1996	**Male**	*74.2*	*73.8*	73.1	73.6	75.1	74.4	74.1	*73.1*	75.3	73.3
	Female	*80.6*	*80.5*	78.2	79.9	80.4	81.7	82.0	*78.7*	81.4	79.9
1997	**Male**	*74.6*	*74.1*	73.6	74.0	75.6	75.0	*74.6*	*73.4*	*74.9*	74.1
	Female	*80.9*	*80.6*	78.4	80.3	80.8	81.9	*82.2*	*78.6*	*81.3*	79.8
1998	**Male**	74.6	74.3	73.9	*74.5*	*75.5*	75.1	*74.8*	73.5	75.5	73.7
	Female	80.9	80.5	78.8	*80.6*	*80.6*	82.1	*82.4*	79.1	81.8	80.5
1999	**Male**	74.9	74.4	74.2	74.7	75.5	75.1	75.0	73.9	75.6	74.6
	Female	81.1	80.8	79.0	80.7	80.6	82.1	82.5	79.1	82.3	81.1
2000	**Male**	*75.3*	74.6	74.5	:	:	*75.5*	75.2	74.2	*76.3*	74.9
	Female	*81.4*	80.8	79.3	:	:	*82.7*	82.7	79.2	*82.4*	81.3

Source: Eurostat, NewCronos database (Demography).

1.3.2 Life expectancy at age 55, males and females

		EU-15	B	DK	D	EL	E	F	IRL	I	L
1960	**Male**	19.7	:	:	:	:	:	:	:	:	:
	Female	23.3	:	:	:	:	:	:	:	:	:
1970	**Male**	19.8	:	:	:	:	:	:	:	:	:
	Female	24.1	:	:	:	:	:	:	:	:	:
1980	**Male**	20.7	:	:	:	:	:	:	:	:	:
	Female	25.5	:	:	:	:	:	:	:	:	:
1990	**Male**	22.1	21.8	21.2	21.2	23.5	23.1	22.8	20.7	22.6	21.7
	Female	26.9	27.1	25.6	26.0	26.8	27.9	28.6	25.1	27.4	26.6
1995	**Male**	22.9	22.5	21.5	22.1	23.9	23.7	23.6	21.3	23.6	22.0
	Female	27.8	27.7	25.4	27.1	27.4	28.8	29.3	25.7	28.4	27.8
1996	**Male**	23.0	22.7	21.8	22.4	24.0	23.7	23.6	21.6	23.8	22.0
	Female	27.9	27.9	25.8	27.2	27.5	28.9	29.4	25.8	28.6	27.7
1997	**Male**	23.4	23.0	22.2	22.7	24.4	23.9	23.9	21.8	:	22.6
	Female	28.1	28.0	25.9	27.5	27.8	29.0	29.6	25.9	:	27.4
1998	**Male**	:	23.0	22.4	23.0	24.3	23.9	24.0	22.0	:	22.6
	Female	:	28.0	26.1	27.7	27.7	29.1	29.7	26.2	:	27.8
1999	**Male**	:	23.1	22.6	23.2	24.2	23.9	24.1	22.1	:	23.2
	Female	:	28.1	26.2	27.8	27.6	29.0	29.7	26.2	:	28.3
2000	**Male**	:	23.3	22.9	:	:	:	:	22.5	:	23.3
	Female	:	28.2	26.5	:	:	:	:	26.3	:	28.3

Source: Eurostat, NewCronos database (Demography).

NL	A	P	FIN	S	UK	IS	NO	CH		
:	:	56.4	:	:	66.2	:	:	:	**1950**	**Male**
:	:	61.6	:	:	71.2	:	:	:		**Female**
71.5	66.2	61.2	65.5	71.2	67.9	71.3	71.6	68.7	**1960**	**Male**
75.3	72.7	66.8	72.5	74.9	73.7	76.4	76.0	74.5		**Female**
70.7	66.5	64.2	66.5	72.2	68.7	71.2	71.2	70.7	**1970**	**Male**
76.5	73.4	70.8	75.0	77.1	75.0	77.3	77.5	76.9		**Female**
72.7	69.0	67.7	69.2	72.8	70.2	73.4	72.3	72.8	**1980**	**Male**
79.3	76.1	75.2	77.6	78.8	76.2	80.1	79.2	79.6		**Female**
73.8	72.4	70.4	70.9	74.8	72.9	75.4	73.4	74.0	**1990**	**Male**
80.9	78.9	77.4	78.9	80.4	78.5	80.5	79.8	80.7		**Female**
74.6	73.6	71.2	72.8	76.2	74.0	75.9	74.8	75.3	**1995**	**Male**
80.4	80.1	78.6	80.2	81.4	79.2	80.0	80.8	81.7		**Female**
74.7	73.9	71.1	73.0	76.5	74.3	76.5	75.4	75.9	**1996**	**Male**
80.3	80.2	78.6	80.5	81.5	79.5	81.2	81.0	82.0		**Female**
75.2	74.3	71.6	73.4	76.7	*74.7*	76.3	75.5	76.3	**1997**	**Male**
80.5	80.6	78.8	80.5	81.8	*79.6*	81.5	81.0	82.1		**Female**
75.2	*74.7*	71.7	73.5	76.9	*74.8*	*77.7*	75.6	*76.3*	**1998**	**Male**
80.6	*80.9*	78.9	80.8	81.9	*79.7*	*81.5*	81.3	*82.4*		**Female**
75.3	75.1	72.2	73.8	77.1	75.0	77.7	75.6	76.8	**1999**	**Male**
80.5	81.0	79.2	81.0	81.9	79.8	81.5	81.1	82.5		**Female**
75.5	75.4	72.7	74.2	77.4	75.4	78.0	76.0	76.9	**2000**	**Male**
80.5	81.2	79.7	81.0	82.0	80.2	81.4	81.4	82.6		**Female**

NL	A	P	FIN	S	UK	IS	NO	CH		
:	:	:	:	:	:	:	22.0	:	**1960**	**Male**
:	:	:	:	:	:	:	24.5	:		**Female**
:	18.6	:	:	:	:	:	21.1	:	**1970**	**Male**
:	23.0	:	:	:	:	:	25.3	:		**Female**
:	20.0	:	:	:	:	:	21.6	:	**1980**	**Male**
:	24.5	:	:	:	:	:	26.6	:		**Female**
22.1	21.7	21.3	20.9	23.1	21.5	24.1	22.2	23.0	**1990**	**Male**
27.5	26.5	25.6	26.4	27.6	26.0	27.8	27.1	28.2		**Female**
22.6	22.6	21.8	22.0	24.0	22.3	24.3	23.0	24.1	**1995**	**Male**
27.6	27.3	26.3	27.3	28.3	26.5	27.7	27.7	28.9		**Female**
22.6	22.8	21.6	22.2	24.2	22.6	24.1	23.5	24.4	**1996**	**Male**
27.6	27.4	26.4	27.6	28.4	26.7	28.0	28.0	29.1		**Female**
23.0	23.0	21.9	22.6	24.4	22.9	24.2	23.6	24.6	**1997**	**Male**
27.8	27.8	26.6	27.7	28.6	26.9	28.3	28.0	29.2		**Female**
23.0	23.3	22.0	22.5	24.5	23.0	24.8	23.7	24.6	**1998**	**Male**
27.8	28.0	26.6	27.9	28.6	26.9	28.4	28.3	29.4		**Female**
23.2	23.5	22.2	22.7	24.6	23.2	25.1	23.8	24.9	**1999**	**Male**
27.7	28.1	26.7	28.0	28.6	27.0	28.0	28.1	29.5		**Female**
23.3	24.0	22.5	23.2	24.9	23.6	26.5	24.2	25.1	**2000**	**Male**
27.8	28.3	27.1	28.1	28.7	27.4	28.0	28.3	29.4		**Female**

1.3.3 Life expectancy at age 65, males and females

		EU-15	B	DK	D	EL	E	F	IRL	I	L
1950	**Male**	:	12.3	:	:	13.0	11.8	12.3	12.1	12.6	:
	Female	:	13.9	:	:	13.7	13.5	14.6	13.3	13.7	:
1960	**Male**	*12.7*	12.4	13.7	:	13.4	13.1	12.5	12.6	13.4	12.5
	Female	*15.1*	14.8	15.3	:	14.6	15.3	15.6	14.4	15.3	14.5
1970	**Male**	*12.6*	12.1	13.7	:	13.9	13.3	13.0	12.4	13.3	12.1
	Female	*15.9*	15.3	16.7	:	15.2	16.0	16.8	15.0	16.2	14.9
1980	**Male**	*13.4*	13.0	13.6	:	14.6	14.8	14.0	12.6	13.3	12.3
	Female	*17.1*	16.9	17.6	:	16.8	17.9	18.2	15.7	17.1	16.0
1990	**Male**	14.6	14.3	14.0	14.0	15.7	15.4	15.6	13.3	15.1	14.2
	Female	18.4	18.5	17.8	17.6	18.0	19.1	19.9	16.9	18.8	18.2
1995	**Male**	15.3	14.8	14.1	14.7	16.1	16.0	16.1	13.6	15.8	14.7
	Female	19.1	19.1	17.5	18.5	18.4	19.8	20.6	17.3	19.6	19.2
1996	**Male**	15.4	15.0	14.4	14.9	16.1	16.0	16.1	13.9	16.0	14.8
	Female	19.2	19.2	17.8	18.6	18.6	19.9	20.6	17.3	19.8	19.2
1997	**Male**	15.6	15.2	14.6	15.2	16.5	16.1	16.3	14.1	:	14.8
	Female	19.4	19.4	17.9	18.9	18.9	20.0	20.8	17.5	:	19.0
1998	**Male**	:	15.2	14.8	15.3	16.4	16.1	16.4	14.2	:	15.1
	Female	:	19.3	18.1	19.0	18.7	20.1	20.9	17.7	:	19.2
1999	**Male**	:	15.4	14.9	15.5	16.3	16.1	16.5	14.2	:	15.3
	Female	:	19.4	18.1	19.2	18.7	20.1	20.9	17.7	:	19.5
2000	**Male**	:	15.5	15.2	:	:	:	:	14.6	:	15.6
	Female	:	19.5	18.3	:	:	:	:	17.7	:	19.8

Source: Eurostat, NewCronos database (Demography).

1.3.4 Life expectancy at age 75, males and females

		EU-15	B	DK	D	EL	E	F	IRL	I	L
1950	**Male**	:	7.1	:	:	7.8	6.8	7.0	6.9	7.0	:
	Female	:	8.0	:	:	7.7	7.6	8.4	7.6	7.6	:
1960	**Male**	:	7.3	7.9	:	7.7	7.6	7.2	7.1	7.8	7.4
	Female	:	8.4	8.7	:	8.2	8.8	8.9	8.1	8.8	8.3
1970	**Male**	:	7.3	8.3	:	7.9	7.9	7.8	7.3	7.9	7.4
	Female	:	8.8	9.9	:	8.6	9.2	9.8	8.5	9.3	8.5
1980	**Male**	:	7.6	8.2	:	8.8	8.8	8.2	7.3	7.8	7.2
	Female	:	9.8	10.6	:	9.7	10.5	10.7	9.1	9.9	8.8
1990	**Male**	8.7	8.4	8.4	8.2	9.3	9.2	9.3	7.7	9.1	8.7
	Female	11.0	11.0	11.0	10.3	10.4	11.2	12.0	10.0	11.1	11.1
1995	**Male**	9.2	8.7	8.4	8.8	9.7	9.6	9.9	7.9	9.6	8.8
	Female	11.5	11.5	10.8	11.1	10.7	11.8	12.6	10.3	11.9	11.7
1996	**Male**	9.3	8.8	8.6	8.9	9.8	9.6	9.8	8.0	9.7	8.6
	Female	11.6	11.6	11.1	11.1	10.8	11.9	12.6	10.2	12.0	11.6
1997	**Male**	9.5	9.0	8.8	9.2	10.1	9.6	10.0	8.2	:	8.9
	Female	11.8	11.7	11.2	11.4	11.1	12.0	12.7	10.4	:	11.6
1998	**Male**	:	9.0	8.9	9.2	9.9	9.6	10.0	8.2	:	8.8
	Female	:	11.6	11.4	11.4	10.9	12.0	12.9	10.5	:	11.7
1999	**Male**	:	9.0	8.9	9.3	9.8	9.6	10.1	8.1	:	9.1
	Female	:	11.6	11.4	11.5	10.8	11.9	12.8	10.4	:	11.8
2000	**Male**	:	9.1	9.1	:	:	:	:	8.4	:	9.1
	Female	:	11.7	11.6	:	:	:	:	10.4	:	12.0

Source: Eurostat, NewCronos database (Demography).

NL	A	P	FIN	S	UK	IS	NO	CH		
:	:	12.3	:	:	11.7	:	:	:	**1950**	**Male**
:	:	14.4	:	:	14.2	:	:	:		**Female**
14.2	:	13.0	:	13.7	11.9	:	14.5	:	**1960**	**Male**
15.7	:	15.3	:	15.3	15.1	:	16.1	:		**Female**
13.6	11.7	12.2	:	14.2	12.0	:	13.8	:	**1970**	**Male**
16.5	14.9	15.0	:	16.8	16.0	:	16.8	:		**Female**
14.0	12.9	12.9	12.5	14.3	12.6	15.6	14.3	:	**1980**	**Male**
18.5	16.3	16.5	16.5	17.9	16.6	19.0	18.0	:		**Female**
14.4	14.4	13.9	13.7	15.3	14.0	16.2	14.6	15.3	**1990**	**Male**
18.9	18.0	17.0	17.7	19.0	17.9	19.5	18.5	19.4		**Female**
14.7	15.1	14.3	14.5	16.0	14.6	16.2	15.1	16.1	**1995**	**Male**
19.0	18.7	17.7	18.6	19.6	18.2	19.0	19.1	20.2		**Female**
14.8	15.3	14.2	14.6	16.1	14.8	16.2	15.5	16.3	**1996**	**Male**
19.0	18.8	17.7	18.7	19.7	18.3	19.2	19.4	20.3		**Female**
15.0	15.4	14.4	15.0	16.2	15.1	16.3	15.5	16.5	**1997**	**Male**
19.2	19.1	17.9	18.9	19.9	18.4	19.9	19.4	20.4		**Female**
15.1	15.6	14.3	14.9	16.3	15.2	16.6	15.7	16.6	**1998**	**Male**
19.2	19.3	17.9	19.1	19.9	18.5	19.7	19.6	20.5		**Female**
15.1	15.8	14.5	15.1	16.4	15.3	16.9	15.6	16.8	**1999**	**Male**
19.1	19.4	18.0	19.2	19.9	18.5	19.2	19.5	20.6		**Female**
15.3	16.2	14.7	15.5	16.7	15.6	18.1	16.0	16.9	**2000**	**Male**
19.2	19.6	18.3	19.3	20.0	18.9	19.6	19.7	20.7		**Female**

NL	A	P	FIN	S	UK	IS	NO	CH		
:	:	:	:	:	6.7	:	:	:	**1950**	**Male**
:	:	:	:	:	8.0	:	:	:		**Female**
8.3	:	:	:	7.9	7.1	:	8.5	:	**1960**	**Male**
8.9	:	:	:	8.6	8.7	:	9.2	:		**Female**
8.2	7.0	:	:	8.4	7.2	:	8.1	:	**1970**	**Male**
9.5	8.5	:	:	9.6	9.4	:	9.6	:		**Female**
8.5	7.4	:	7.4	8.4	7.4	9.3	8.6	:	**1980**	**Male**
11.1	9.2	:	9.4	10.5	9.8	11.7	10.7	:		**Female**
8.5	8.5	8.0	8.2	8.9	8.4	10.1	8.7	9.0	**1990**	**Male**
11.4	10.5	9.7	10.4	11.4	11.1	12.1	11.1	11.6		**Female**
8.6	9.1	8.2	8.7	9.4	8.7	9.8	8.9	9.6	**1995**	**Male**
11.5	11.1	10.1	10.9	11.9	11.2	11.2	11.6	12.3		**Female**
8.6	9.2	8.1	8.7	9.5	8.9	9.3	9.1	9.8	**1996**	**Male**
11.5	11.2	10.0	11.0	12.0	11.3	11.8	11.8	12.3		**Female**
8.8	9.3	8.2	8.9	9.6	9.0	10.0	9.1	9.9	**1997**	**Male**
11.7	11.4	10.2	11.2	12.1	11.4	12.1	11.7	12.4		**Female**
8.9	9.4	8.1	8.8	9.6	9.1	9.7	9.2	9.8	**1998**	**Male**
11.6	11.5	10.2	11.3	12.1	11.4	11.9	11.8	12.4		**Female**
8.8	9.6	8.2	9.0	9.7	9.1	9.9	9.1	10.0	**1999**	**Male**
11.6	11.6	10.1	11.3	12.0	11.3	11.5	11.8	12.5		**Female**
8.9	9.9	8.3	9.1	9.8	9.3	11.1	9.3	10.1	**2000**	**Male**
11.6	11.7	10.5	11.4	12.2	11.6	12.0	11.9	12.6		**Female**

1.3.5 Country clusters for life expectancy at different ages

	Highest life expectancy cluster		Intermediate life expectancy cluster		Lowest life expectancy cluster	
	Males	Females	Males	Females	Males	Females
At birth to 15 years	S	F, I, E, S	A, F, D, EL, I, L, E, NL, UK	A, B, FIN, D, EL, L, NL, UK	B, DK, FIN, IRL, P	DK, IRL, P
At 45 years	F, EL, I, E, S	F	A, B, D, L, NL, DK	A, B, FIN, D, EL, I, L, E, NL, S	DK, FIN, IRL, P	DK, IRL, P, UK
At 65 years	F, EL, I, E, S	F	A, B, DK, FIN, D L, P, NL, UK	A, B, FIN, D, EL, I, L, E, NL, S, UK	IRL	DK, IRL, P

Source: For better health in Europe, Editors: Paulo Ferrinho and José Pereira Miguel, European Commission, Health and Consumer Protection DG, 2001.

1.3.6 Assumed life expectancies used in the most recent population forecasts

		EU-15	B	DK	D	EL	E	F	IRL	I	L
1990	**Male**	:	72.8	72.0	72.0	:	73.3	72.7	72.1	73.6	72.3
	Female	:	79.4	77.7	78.4	:	80.4	80.9	77.6	80.1	78.5
1991	**Male**	:	72.9	72.5	72.2	:	73.4	72.9	72.3	73.6	72.0
	Female	:	79.6	78.0	78.7	:	80.6	81.1	77.9	80.2	79.1
1992	**Male**	:	73.3	72.6	72.6	:	73.4	73.1	72.5	74.0	71.9
	Female	:	79.9	78.0	79.2	:	80.7	81.3	78.1	80.6	78.5
1993	**Male**	:	73.4	72.6	72.7	:	73.3	73.3	72.6	74.5	72.2
	Female	:	80.0	77.8	79.2	:	80.9	81.5	78.2	80.9	79.4
1994	**Male**	:	74.0	72.7	73.1	:	73.3	73.5	72.8	74.7	73.2
	Female	:	80.5	78.1	79.6	:	81.0	81.8	78.4	81.2	79.7
1995	**Male**	:	73.7	72.6	73.2	:	73.2	73.7	73.0	74.9	:
	Female	:	80.5	77.8	79.6	:	81.2	82.0	78.6	81.4	:
2000	**Male**	:	74.4	73.4	73.7	:	74.1	74.6	73.7	75.9	:
	Female	:	81.1	78.5	80.1	:	81.9	83.0	79.4	82.3	:
2005	**Male**	:	75.0	73.5	74.3	:	74.8	75.5	74.5	76.6	:
	Female	:	81.7	78.6	80.8	:	82.5	83.9	80.2	83.0	:
2010	**Male**	:	75.7	73.5	74.8	:	75.3	76.4	75.2	77.1	:
	Female	:	82.3	78.6	81.1	:	83.0	84.8	81.0	83.5	:
2015	**Male**	:	76.4	73.5	:	:	75.7	77.2	75.8	77.7	:
	Female	:	82.9	78.6	:	:	83.4	85.7	81.7	84.1	:
2020	**Male**	:	77.1	73.5	75.7	:	76.0	78.0	76.4	78.3	:
	Female	:	83.6	78.6	81.9	:	83.7	86.5	82.4	84.7	:
2025	**Male**	:	77.9	73.5	:	:	:	78.8	77.0	78.3	:
	Female	:	84.3	78.6	:	:	:	87.2	83.1	84.7	:

Source: Eurostat, NewCronos database (Demography).

(years)

NL	A	P	FIN	S	UK	IS	NO	CH		
73.8	72.4	:	70.9	74.8	72.9	75.4	73.4	74.0	**1990**	**Male**
80.1	78.9	:	78.9	80.4	78.5	80.5	79.8	80.7		**Female**
74.0	72.4	:	71.3	74.9	73.2	74.8	74.0	74.1	**1991**	**Male**
80.1	79.0	:	79.3	80.5	78.6	81.1	80.1	81.1		**Female**
74.3	72.7	:	71.7	75.4	73.6	76.7	74.2	74.5	**1992**	**Male**
80.3	79.2	:	79.4	80.8	79.0	80.7	80.3	81.3		**Female**
74.0	73.0	:	72.1	75.5	73.6	77.0	74.2	74.9	**1993**	**Male**
80.0	79.4	:	79.5	80.8	78.9	80.8	80.2	81.4		**Female**
74.6	73.4	:	72.8	76.1	74.2	77.1	74.9	75.2	**1994**	**Male**
80.3	79.7	:	80.1	81.4	79.4	81.2	80.6	81.7		**Female**
74.5	73.5	:	72.8	76.2	74.2	:	74.9	75.4	**1995**	**Male**
80.2	80.1	:	80.1	81.4	79.4	:	80.6	82.3		**Female**
75.3	74.4	:	73.6	77.2	75.1	77.3	75.4	76.1	**2000**	**Male**
80.6	80.8	:	80.6	82.0	80.1	81.9	81.5	83.0		**Female**
76.0	75.2	:	74.3	77.9	76.0	77.5	76.2	76.8	**2005**	**Male**
80.8	81.6	:	81.0	82.5	80.8	82.1	82.1	83.7		**Female**
76.6	76.1	:	75.1	78.5	76.6	77.5	76.9	77.5	**2010**	**Male**
81.1	82.3	:	81.5	83.0	81.5	82.1	82.7	84.4		**Female**
77.3	76.8	:	75.1	79.1	77.2	77.5	77.4	78.2	**2015**	**Male**
81.3	83.0	:	81.5	83.4	82.1	82.1	83.1	85.1		**Female**
77.8	77.6	:	75.1	79.6	77.6	77.5	77.9	78.8	**2020**	**Male**
81.6	83.7	:	81.5	83.8	82.6	82.1	83.5	85.6		**Female**
78.3	79.3	:	78.0	80.1	78.0	77.5	79.0	79.3	**2025**	**Male**
81.9	84.9	:	83.5	84.1	82.9	82.1	83.8	85.8		**Female**

1.4.1 Population density, urban population as proportion of total, and labour force as proportion of total, latest year

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Population density [1] (persons per km²)	:	333	123	230	81	78	107	54	192	169	380	97	109	15	20	240
Urban population as proportion of total (%) [2]	:	97	85	87	60	77	75	59	67	91	89	65	63	67	83	89
Labour force as proportion of total (%) [3]	:	43	54	49	43	42	45	45	41	43	49	48	50	50	48	50

[1] 2000.
[2] 1999.
[3] 1998, but B, FIN, D, IRL, L, E and UK are 1999.
Source: World Health Organisation/Europe: Health for All database.

1.4.2 GDP at market prices per capita

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1980	:	:	9 620	:	3 620	:	9 110	:	5 730	:
1985	:	11 110	15 460	:	5 380	:	12 700	:	9 930	:
1986	:	11 920	16 870	:	4 930	:	13 600	:	10 880	:
1987	:	12 610	17 830	:	4 880	:	14 000	:	11 640	:
1988	:	13 320	18 340	:	5 520	:	14 780	:	12 550	:
1989	:	14 410	19 090	:	*6 120*	:	15 820	:	13 980	*20 960*
1990	:	15 580	20 450	:	*6 510*	:	16 500	10 620	15 300	*22 780*
1991	*15 730*	16 340	21 060	17 910	*7 120*	*11 400*	16 930	10 960	16 560	*24 520*
1992	*16 310*	17 350	22 010	19 380	*7 460*	*11 870*	17 750	11 680	16 730	*26 310*
1993	*16 290*	18 290	22 860	20 580	*7 680*	*10 890*	18 500	11 950	14 880	*29 150*
1994	*17 020*	19 610	24 620	21 660	*8 090*	*10 850*	19 270	12 920	15 090	*32 010*
1995	17 650	20 880	26 390	23 020	8 600	11 390	20 030	14 130	14 640	33 510
1996	18 490	20 940	27 430	22 930	9 350	12 230	20 570	15 890	16 920	34 220
1997	19 420	21 260	28 250	22 710	10 200	12 600	20 780	19 290	17 910	36 710
1998	20 280	21 980	29 050	23 360	10 360	13 320	21 650	20 850	18 560	39 280
1999	21 280	23 040	30 670	24 050	11 200	14 270	22 530	23 770	19 230	42 200
2000	22 570	24 240	32 580	24 640	11 640	15 250	23 450	27 320	20 160	46 360
2001	*23 170*	24 960	33 680	25 060	11 920	16 150	*24 100*	*30 070*	21 000	*47 470*

Source: Eurostat, NewCronos database (Economy and finance).

(EUR)

NL	A	P	FIN	S	UK	IS	NO	CH	
:	7 580	:	7 900	11 160	6 840	:	11 170	12 240	**1980**
:	11 700	:	14 690	16 400	10 630	:	20 160	19 760	**1985**
:	12 830	:	14 750	16 700	9 990	:	18 440	21 710	**1986**
13 330	13 660	:	15 710	17 250	10 450	:	18 760	22 860	**1987**
13 770	14 260	:	18 180	18 920	12 330	:	19 730	23 950	**1988**
14 530	15 230	:	21 150	21 260	13 310	:	21 230	24 500	**1989**
15 510	16 470	:	21 610	21 910	13 560	19 530	21 440	26 830	**1990**
16 230	17 480	*6 640*	19 910	23 230	14 460	21 200	22 340	27 680	**1991**
17 030	18 570	7 650	16 630	22 740	14 280	20 560	22 770	27 380	**1992**
18 170	19 840	7 450	14 520	18 830	14 150	19 150	22 990	29 130	**1993**
19 110	20 940	7 710	16 580	19 840	15 040	19 850	23 890	31 540	**1994**
20 530	22 350	8 330	19 360	20 800	14 810	19 930	25 710	33 400	**1995**
20 900	22 630	8 900	19 610	23 330	15 930	21 260	28 310	33 000	**1996**
21 310	22 500	9 440	21 030	23 830	19 850	24 050	31 030	31 860	**1997**
22 390	23 350	10 060	22 370	24 140	21 450	26 550	29 720	32 950	**1998**
23 640	24 300	10 790	23 330	25 700	23 050	29 140	32 290	34 050	**1999**
25 190	25 260	11 490	25 340	28 010	26 100	32 990	39 080	36 190	**2000**
26 480	25 940	*12 200*	26 210	26 320	*26 510*	*29 800*	*40 570*	*38 260*	**2001**

1.4.3 Harmonised unemployment rate by sex

	EU-15	B	DK	D	EL	E	F	IRL	I
					Males				
1985	:	6.3	5.6	:	5.0	16.5	8.1	16.0	5.6
1990	:	4.0	6.8	:	3.9	9.6	6.6	12.8	6.2
1991	:	4.2	7.2	:	4.4	9.9	7.1	14.2	6.0
1992	:	5.1	8.0	5.1	5.0	11.7	8.1	15.1	6.3
1993	9.2	6.7	9.3	6.5	5.7	15.5	9.7	15.4	7.5
1994	9.4	7.7	7.1	7.0	6.0	16.2	10.2	14.2	8.5
1995	9.0	7.6	5.6	7.0	6.2	14.9	9.5	12.2	8.8
1996	9.1	7.4	5.3	8.1	6.1	14.4	10.2	11.5	8.9
1997	8.9	7.3	4.4	9.1	6.4	13.1	10.2	9.9	8.9
1998	8.2	7.7	3.9	8.6	7.1	11.2	9.7	7.7	9.0
1999	7.5	7.3	4.4	8.1	7.9	9.0	9.1	5.7	8.6
2000	6.7	5.6	4.1	7.5	7.3	7.9	7.6	4.2	8.0
2001	6.4	6.0	3.8	7.7	7.0	7.5	7.1	3.9	7.3
					Females				
1985	:	16.4	7.9	:	10.6	20.6	12.1	18.5	13.1
1990	:	10.4	7.6	:	10.8	19.8	11.3	14.6	13.5
1991	:	9.8	8.6	:	11.9	19.5	11.6	15.8	12.9
1992	:	10.0	9.2	8.2	12.9	21.0	12.4	16.0	13.0
1993	11.5	11.5	9.9	9.4	13.6	24.1	13.2	16.0	14.5
1994	11.9	12.7	8.5	9.8	13.7	26.1	13.8	14.6	15.4
1995	11.7	12.7	8.1	9.4	14.1	25.3	13.5	12.5	16.1
1996	11.7	12.5	7.5	9.5	15.2	24.4	13.9	11.8	15.9
1997	11.6	11.9	6.2	10.4	15.2	23.4	13.7	9.9	16.1
1998	11.1	11.6	6.0	9.7	16.7	21.8	13.4	7.3	16.1
1999	10.2	10.3	5.4	8.9	18.0	18.7	12.6	5.5	15.5
2000	9.2	8.5	4.8	8.1	16.8	16.7	11.2	4.2	14.3
2001	8.6	7.4	4.9	7.8	15.6	15.5	10.5	3.7	12.9

Source: Eurostat, NewCronos database (Unemployment).

L	NL	A	P	FIN	S	UK	NO	
				Males				
2.1	6.6	:	6.7	:	3.0	11.6	:	**1985**
1.2	4.1	:	3.3	3.6	1.7	7.2	:	**1990**
1.3	3.9	:	2.8	8.0	3.4	9.7	:	**1991**
1.7	4.1	:	3.6	13.6	6.6	11.6	:	**1992**
2.2	5.4	3.1	4.8	18.1	10.7	12.1	:	**1993**
2.6	6.0	3.0	6.1	18.1	10.7	11.0	:	**1994**
2.0	5.5	3.1	6.5	15.7	9.7	9.9	:	**1995**
2.2	4.7	3.7	6.5	14.3	10.1	9.3	4.7	**1996**
2.0	3.7	3.7	6.1	12.3	10.2	7.7	3.9	**1997**
1.9	3.0	3.8	4.1	10.9	8.6	6.8	3.1	**1998**
1.8	2.3	3.4	3.9	9.7	7.2	6.5	3.4	**1999**
1.8	2.1	3.1	3.3	9.0	6.0	5.9	3.6	**2000**
1.7	1.9	3.0	3.2	8.6	5.2	5.5	3.7	**2001**
				Females				
4.3	10.1	:	12.6	:	2.8	10.7	:	**1985**
2.5	8.5	:	6.7	2.7	1.7	6.4	:	**1990**
2.3	7.9	:	5.9	5.2	2.8	7.3	:	**1991**
2.8	7.2	:	5.1	9.6	4.4	7.5	:	**1992**
3.3	7.5	5.0	6.7	14.4	7.3	7.8	:	**1993**
4.1	7.9	4.9	7.9	14.9	7.8	7.2	:	**1994**
4.3	8.1	5.0	8.2	15.1	7.8	6.7	:	**1995**
4.2	7.7	5.2	8.2	14.9	9.0	6.3	4.8	**1996**
3.9	6.6	5.4	7.6	13.0	9.5	5.8	4.2	**1997**
4.0	5.0	5.4	6.4	12.0	8.1	5.3	3.3	**1998**
3.3	4.3	4.7	5.2	10.7	7.1	5.0	3.0	**1999**
3.1	3.6	4.3	5.0	10.6	5.8	4.7	3.2	**2000**
2.4	3.0	4.3	5.1	9.7	4.9	4.4	3.5	**2001**

2. LIFESTYLES

This volume can provide only a brief summary of the contribution of lifestyle to health, with only a small proportion of relevant data included. More detailed analyses of this topic may be found in the references provided. Data on nutrition, physical activity, smoking, alcohol, drugs, teenage pregnancy and social exclusion are included in this chapter.

2.1. Nutrition

According to the **Eurodiet** (ref. Eurodiet web site) project, initiated in October 1998, it is estimated that a third of all premature deaths are diet related, yet less than 1 % of the total health budget is spent on health promotion overall in the EU. In most of Europe since 1950, there has been a substantial increase in a number of major chronic diseases in adult life, which become worse with age. The principal factors in coronary heart disease, strokes, obesity, maturity onset diabetes mellitus, gallstones, iron and iodine deficiency disorders, dental caries, osteoporosis and several cancers are related to diet and inactivity. There is increasing evidence that the burden of ill health on the public and on European health services is steadily rising, especially for the expanding elderly populations who seem to be adding years of ill health rather than well-being to their extended lives.

2.1.1. Daily intakes

The **joint WHO/FAO expert consultation on diet, nutrition and the prevention of chronic diseases** suggests that population nutrient intake goals represent the population average intake that is judged to be consistent with maintenance of health in a population (ref. WHO/FAO web site). Seldom is there a single 'best value' for such a goal. Instead, consistent with the concept of a safe range of nutrient intakes for individuals, there is often a range of population averages that would be consistent with the maintenance of health. If existing population averages fall outside this range, or trends in intake suggest that the population average will move outside the range, health concerns are likely to arise. However, it would be of concern if a large proportion of values were outside the defined goals. Sometimes, there is no lower limit. This implies that there is no evidence that the nutrient is required in the diet and hence low intakes should not give rise to concern. The population nutrient intake goals for use in all parts of the world are presented in the following table. They are expressed in numerical terms, rather than as increases or decreases in intakes of specific nutrients, because the desirable change will depend upon existing intakes in the particular population, and could be in either direction. Attention is directed towards the energy-supplying macronutrients. This must not be taken to imply a lack of concern for the other nutrients. Rather, it is a recognition of the fact that previous FAO and WHO reports have provided limited guidance on the meaning of a 'balanced diet', described in terms of the proportions of the various energy sources, and that there is an apparent consensus on this aspect of diet in relation to effects on the chronic, non-deficiency diseases.

Ranges of population nutrient intake goals

Total fat	15–30 % energy
Saturated fatty acids (SFAs)	< 7 % energy
Polyunsaturated fatty acids (PUFAs)	6–10 % energy
n-6 Polyunsaturated fatty acids (PUFAs)	5–8 % energy
n-3 Polyunsaturated fatty acids (PUFAs)	1–2 % energy
Unsaturated fatty acids (trans FAs)	< 1 % energy
Monounsaturated fatty acids (MUFAs)	Remainder of total fat
Total carbohydrate	55–75 % energy
Free sugars	< 10 % energy
Protein	10–15 % energy
Cholesterol	< 300 mg/d
Sodium chloride (sodium)	< 5 g/d (< 2 g/d)
Fruit and vegetables	Ø400 g/d

Source: Joint WHO/FAO expert consultation on diet, nutrition and the prevention of chronic diseases.

Data from **WHO** (Health for All database — HFA) show that since 1970 there has been a gradual increase in the proportion of energy obtained from fat in food eaten by people in Europe **(2.1.1)**, except in Denmark (which had the highest proportion of 40.1 % in 1970), the Netherlands and Norway (ref. HFA (WHO) web site). In the Netherlands and Norway, the proportions fluctuated slightly and in Denmark they decreased. The largest increases between 1970 and 1999 were in Spain, Portugal and Italy, although Portugal consistently had the lowest proportion (followed by Ireland). In all countries (except Portugal before 1990), the proportion of energy obtained from fat exceeds the international recommendation of no more than 30 %. Eurodiet found that the percentage of energy from saturated fatty acids was always lower in people who consumed more fibre, fruit and vegetables.

Data from **Faostat** (the FAO database) show that more fat from animal products (83 g on average in the EU), rather than vegetable products (66.7 g), is eaten in all countries except Greece, Italy and Spain, where the reverse applies. These three countries consume the most vegetable oil per person, with Greece and Spain consuming the least animal fat. Denmark consumes the second highest amount of animal fat, after France. Denmark also consumes the most animal fat and the least vegetable oil per person. Comparing data from 1999 **(2.1.2)** and 1997, the consumption of fat increased recently in most countries. The greatest increase, of 16.2 g per person, from all animal products,

especially meat and animal fats, was in Iceland. However, people in Iceland consumed the least fat per day, in both years, along with those in Finland, Denmark, Portugal, Ireland and Sweden. The greatest consumers of fat in both years were found in France (> 164 g), with Austria, Belgium, Italy, Greece and Spain following (each > 150 g). However, the amount of fat consumed per person has decreased in Belgium, Denmark, Greece and Austria.

The average number of calories available per person per day has exceeded the recommended dietary allowances at least since 1970 **(2.1.3)**. Calorie consumption gradually increased from 1970 to 1999 in all countries except Switzerland. In 1970, the most calories per person were consumed in Switzerland (3 481 kcal), followed by Ireland, Italy and France, and the least in Spain (2 733 kcal) followed by Sweden and Portugal. In 1999, Portugal consumed the most (3 768 kcal), followed by Greece, Ireland, Italy and Belgium/Luxembourg, while Finland (3 143 kcal) and Sweden (3 141 kcal) consumed the least, followed by the Netherlands and Switzerland.

Cereals provided the greatest amounts of calories per person in all countries. The greatest amounts of calories from sweeteners were consumed in Iceland followed by Switzerland and Denmark **(2.1.4)**. Some analyses suggest that a sucrose intake of less than 18 kg per person per year is linked to lower rates of dental disease, and even clearer effects are seen with intakes below 10 kg per year. In all countries, more calories were provided from vegetable products than animal products, especially in Greece, Italy and Spain. People in Iceland and Norway obtain far more calories from fish than people in other countries. Comparing data from 1999 **(2.1.4)** and 1997, people in all countries except the Netherlands obtained more of their calories from vegetable products in 1999, while those in Austria, Belgium/Luxembourg, Denmark, Sweden and Switzerland obtained less of their calories from animal products in the same year. In both years, the numbers of calories obtained from vegetable products were highest in Greece (2 860 per person per day in 1999, 2 851 in 1997), and lowest in Iceland (1 966 in 1999, 1 893 in 1997) and Finland. The numbers of calories obtained from animal products were highest in France (1 353 in 1999, 1 334 in 1997), and lowest in Greece (829 in 1999, 798 in 1997) followed by Spain and Italy.

Between 1970 and 1999, the proportion of energy available per person from proteins gradually increased, with some fluctuation, in most countries according to **HFA** data. In Belgium and Luxembourg, there was an increase in the 1970s followed by a gradual decrease. The largest increase (2.5 %) was in Denmark **(2.1.5)**. According to **Faostat** data, animal products provide more proteins than vegetable products in all countries, though meat followed by cereals and then milk products provide the most protein overall in the EU **(2.1.6)**. The highest number of proteins per person is available in Portugal (120.7 g), and the lowest in Switzerland (88.6 g). In both 1997 and 1999, vegetable products provided the most proteins in Greece, Italy and Portugal, and the least in Switzerland, Sweden and the Netherlands. Also in both years, animal products provided the most proteins in Iceland and France, and the least in Switzerland, the United Kingdom and Germany.

Data for the **Health for All (HFA)** database are compiled by the World Health Organisation (WHO) Regional Office for Europe and cover the period from 1970. Data are submitted by member countries or collected from other international organisations or sources. Various sources are used for most indicators, dependent upon which data are available from a particular country in a particular year. The EU average is population weighted and is normally calculated when a minimum of half the countries have data for a given indicator for a selected time period. The number of countries included in the average calculations for different indicators will therefore vary. Also, when new data are received, more countries will meet the criteria for inclusion in the appropriate average calculation, with the result that averages for the same indicator and year may vary between different versions of the HFA database.

The **Food and Agriculture Organisation (FAO)** of the United Nations compiles food balance sheets for each country. Food balance sheets depend on agricultural production and trade statistics, and are based mainly on official data contained in national publications. Some countries release a complete food balance (e.g. Germany and Austria), while others make available only selected information on certain commodities (e.g. France and the United Kingdom). Data are available for the years 1961–99 and are collected annually. The food balance sheets adopt the calendar year time-reference period. The definition of a complete list of potentially edible commodities presents virtually insurmountable difficulties, both conceptual and statistical; therefore, a pragmatic list has been adopted by Faostat. Generally, food balance sheets are constructed for primary crops, and livestock and fish commodities — up to the first stage of processing in the case of crops and to the second (and sometimes the third) stage of processing in the case of livestock and fish commodities. The reason for this restriction on the higher stages of processing is the difficulty in obtaining data for all the varied forms of processed products, and, even more difficult, in tracing the components of the processed composite products. Commodity disaggregation software is used to convert many derived commodities back to the primary equivalent. The nutrition factors are added up separately and summed to the relevant aggregate groups. The

concept of supply has been defined differently over the years, but in recent years the following formula has been adopted when preparing and publishing food balance sheets: Supply for domestic utilisation = production + imports - exports + changes in stocks (decrease or increase).

For the purpose of calculating the calorific value and the protein and fat content of the per capita food supplies, the choice of the appropriate food consumption factors is very important. For example, the factors for wheat flour depend, among others, on the water content, variety, and degree of milling involved. The nutritive factors are obtained directly from national food composition tables. As the quantitative data of the food balance sheets are on an 'as purchased' basis, it is necessary that the nutritive composition in terms of edible portion be converted into this basis as well. The conversion is made by applying waste/refuse factors to the nutritive composition in terms of edible portion.

2.1.2. Food consumption

Per capita figures from **Faostat** represent only the average and do not necessarily indicate what is actually consumed by individuals. There could be considerable variation in consumption between individuals and in the degree of losses of edible food and nutrients in the household, for instance during storage, in preparation and cooking, as plate-waste or fed to animals and pets, or thrown away. Also, food balance sheets do not give any indication of the differences that may exist in the diet consumed by different population groups, for example different socioeconomic groups and geographical areas within a country; neither do they provide information on seasonal variations in the total food supply.

The **'Data food networking' (DAFNE)** project (ref. DAFNE web site)**,** coordinated by the **University of Athens**, under the EC Health Monitoring Programme, will provide more accurate data on food consumption, based on Household Budget Surveys (see Section 2.1.3). The data are not fully comparable because the period of data collection and other variables differed between countries and are only available for eight Member States. The current DAFNE IV project (see box below) will expand the following food availability (per person per day) to various levels of detail, ranging from 15 main to 57 disaggregated food groups. The available data show that there is a remarkable variation in food habits among European countries. For example **(2.1.7)**, meat availability exceeds 180 g per person per day in Hungary, Poland and Luxembourg; Spain is the highest for fish, and Greece for vegetables, at 229 g per person per day. Fruit availability follows a similar pattern to that of vegetables, with Mediterranean countries showing the highest availability figures and Spain having the highest of all at 308 g per person per day (roughly equal to a medium-sized pear plus a large orange). This contrasts sharply with only around 100 g per person per day in Poland and Ireland (roughly equal to one apple).

The **DAFNE** databank is based on information collected in the context of Household Budget Surveys (HBS, see Section 2.1.3). HBS are periodically conducted by the national statistical offices of most European countries in country-representative samples of households. The methodology followed is uniform enough to allow comparisons between countries following minimal adjustment only. HBS are not primarily designed to collect nutritional information. By recording data on the values and quantities of household food purchases, however, they can adequately depict the dietary patterns prevailing in representative population samples. Moreover, the concurrent recording of demographic and socioeconomic characteristics of the household members allows the evaluation of the effects of these characteristics on dietary choices. The DAFNE data are directly available in a software programme (the Dafne Soft v1.0) which can be freely downloaded from the project's web site (http://www.nut.uoa.gr). The current **DAFNE IV** project aims to expand the DAFNE databank and monitor trends in nutritional practices, based on comparable and harmonised information. The DAFNE databank will comprise surveys of 14 European countries covering the period of the last 20 years.

2.1.3. Expenditure on food

Data from the 1999 **Household Budget Surveys** show that Italy had the highest mean consumption expenditure on food (measured in purchasing power standards (PPS) per household, see box below), then Ireland followed by Luxembourg **(2.1.8)**. Finland, then the Netherlands followed by the United Kingdom had the lowest expenditure. Comparing the highest with the lowest expenditures, Italy spent twice as much on bread and nearly three times as much on meat as Finland, twice as much on dairy products as the United Kingdom and nearly three times as much on fruit as Denmark; Ireland spent twice as much on vegetables as Finland and four times as much on sweetened products as Portugal; Greece spent six times as much on oils and fats as the United Kingdom; Portugal spent eight times as much on fish and seafood as the Netherlands; and Austria spent nearly 22 times as much on 'other' products (not classified elsewhere) as Portugal. Ireland had the highest mean expenditure on non-alcoholic beverages (measured in PPS per household), especially soft drinks. Italy had the highest expenditure on coffee and other stimulants. Portugal had the lowest expenditure on all non-alcoholic drinks. Looking at trends over the last three sur-

veys, where data are available, there was an increase in mean consumption expenditure on food and non-alcoholic beverages in PPS per household between 1988 and 1994 in all Member States except Greece and Portugal, and an increase between 1994 and 1999 in all Member States except Germany, Luxembourg and Austria **(2.1.9)**.

Looking next at the 'percentage of household expenditure' spent on food and non-alcoholic beverages, a slightly different picture emerges **(2.1.8)**. Comparing the largest and smallest percentages: Portugal spent twice the proportion that Luxembourg and Austria did on vegetables, treble the proportion that the Netherlands did on meat, and 10 times the proportion that the Netherlands and Austria did on fish; Italy spent twice the proportion that Luxembourg did on bread, twice the proportion that Luxembourg and the United Kingdom did on dairy products, and nearly three times the proportion that Denmark, Ireland and the United Kingdom did on fruit; Denmark spent three times the proportion that Portugal did on sweetened products; Ireland spent three times the proportion that Portugal did on soft drinks; while Denmark and Italy spent twice the proportion that most other Member States did on coffee and other stimulants. Looking at trends over the last three surveys, where data are available, the 'percentage of total household expenditure' on food **(2.1.9)** decreased between 1988 and 1994 in all Member States, and also decreased between 1994 and 1999 in all Member States except Belgium.

The structure of consumption expenditure on food and non-alcoholic beverages was then analysed for different groups **(2.1.10)**. By socioeconomic category, the smallest proportions of total household expenditure were spent by 'non-manual' and 'self-employed' groups, and the largest by the 'unemployed', in most Member States. By income, those in the first quintile (on the lowest earnings) spent the largest proportion, and the proportions decreased as quintile increased in all Member States. By type of household, single people spent the smallest proportion. The largest proportions were spent by 'three or more adults with children' in six Member States and by 'single parents with children' in five Member States. By age, the largest proportions were spent by people aged 60 or more in all Member States except Denmark and Germany, and the least by people under the age of 30, except in Austria (30–44). By degree of urbanisation, the largest proportions were spent by people in rural areas, and the least by those in densely populated areas. In each of these groups, people in Luxembourg spent a lower proportion of their household budget on food and non-alcoholic beverages than people in other Member States, while people in Italy and Spain spent a higher proportion (twice the percentage spent by Luxembourg).

Eurostat's purpose in conducting **Household Budget Surveys (HBS)** is to give a precise picture of a private household's total consumption and expenditure broken down in sufficient detail as a function of household characteristics such as income, socioeconomic characteristics, size and composition, degree of urbanisation, region, etc. HBS also provide information on levels of living in terms of income and expenditure levels. The use of HBS for constructing consumer price indices is being reviewed in connection with establishing harmonised indices at the EU level. The surveys are also used as an input to building the national accounts for the purpose of measuring household final consumption (HFC) at an aggregate level. HFC forms part of the total production in a given economic territory at a given point in time and is thus part of the national accounts system for measuring gross national product (GNP). All HBS are confined to the population residing in **private households**. Collective or institutional households (elderly persons' homes, hospitals, prisons, military barracks, etc.) are excluded, as are generally persons without a fixed place of residence. In most cases, the population excluded in this way amounts to no more than 2 % of the total population, though the effect is more significant for particular groups such as old persons, and certainly the homeless. The final consumption expenditure of households corresponds to the expenditure effected by households in order to consume goods and services. This includes, in addition to purchases effected in monetary form, the estimated value of certain goods and services, for example the value of internal production, the benefits in kind and the imputed rents for certain categories of households.

PPPs (purchasing power parities) are currency conversion rates that convert economic indicators expressed in national currencies to some common currency at a rate that equalises the purchasing power of a unit of different national currencies. In other words, PPPs are both price deflators and currency converters; they eliminate the differences in price levels between countries in the process of conversion to a common currency. The reference currency could in principle be that of any member of the group, or another country such as the US dollar as is used by the OECD, the United Nations and other international organisations. For EU purposes, Eurostat has adopted an EU unit called PPS. A **PPS (purchasing power standard)** is the artificial common reference currency unit, determined in such a way that total EU gross domestic product expressed in PPS is equal to total EU GDP expressed in euro. Then economic volume aggregates are obtained after their original value in national currency units has been divided by the respective PPPs. One PPS represents the same given volume of goods and services in all countries. However, in the individual countries, different amounts of national currency are needed to buy this volume of goods and services, depending on the level of prices.

2.1.4. A good and balanced diet?

In 1999, the **Eurobarometer 52.1** survey conducted by the **European Commission** asked people if they ate a good, balanced diet **(2.1.11)**. Overall, three quarters said 'yes' — more than 50 % in each country except Italy (48.3 %). The greatest proportion saying 'yes' was in Ireland (85.7 %). More women than men said 'yes' in each country. Analysis by age shows that the overall proportion stating that they were eating a good diet increased with age — from 65.4 % between the ages of 15 and 24, to 83 % in the 55 and over group **(2.1.12)**. Italy had the smallest proportions in each age group. Looking at occupation and diet **(2.1.13)**, the largest overall proportions eating well were among the retired (84.1 %), then housepeople (81.4 %), and the smallest among the unemployed (64.6 %), then students (67.8 %).

Since autumn 1973, **Eurobarometer** (ref. Eurobarometer web site) surveys have been conducted twice a year on behalf of the European Commission, carried out through face-to-face interviews in participants' homes. The sample size, people aged 15 years and over, is about 1 000 in each country, except Luxembourg (600), the United Kingdom (1 000 in Great Britain and 300 in Northern Ireland) and Germany (2 000 — 1 000 in the former West Germany and 1 000 in the former East Germany). An identical set of questions is asked in each Member State, and back-translation control is applied. The small sample size results in large confidence intervals (CIs); in breakdowns for age and sex, the number of observations in a cell may not exceed 50, leading to a large CI. The basic sample design is a multistage, random (probability) one. In the first stage a random selection of sampling points is made within each NUTS 2 (Eurostat's nomenclature of territorial units for statistics, see Section 3.4) administrative region, which are proportional to the population size and density of each country, resulting in 1 350 sampling points. In the second stage, addresses are randomly selected. A participant is then randomly selected from each selected household. Up to two recalls are made to obtain an interview. Because quota sampling dominated, non-response figures are not available. However, the method of quota sampling is not completely random. People who are rarely at home are less represented in the sample but the interview sample can be considered representative of the category of average citizens who are accessible at home and who agree to be interviewed.

A comparison between the sample and the universe (derived from Eurostat population data) is carried out for each country. A national weighting procedure is then carried out, using marginal (RIM) and intercellular weighting (iterative proportional fitting), based on this universe. In all countries, a minimum number of variables (sex, age, NUTS 2 region) were introduced into the iteration procedure. A weight is used to bring together the former East Germany (20.8 %) and West Germany (79.2 %), and the United Kingdom from Northern Ireland (2.5 %) and Great Britain (97.5 %), where the other countries are 100 %. An EU-15 weight is calculated from the combined sample areas, using the population figures for each area.

2.1.5. Choosing the food

Data from the **Institute of European Food Studies (IEFS)** show (in order of popularity) the proportion of people selecting factors that they perceived to be among the 'three most important influences' in choosing food **(2.1.14)**. 'Quality and freshness' was the only factor chosen by more than half the participants in each country, except in Ireland where it was selected by 49 % of people. 'Convenience' in Denmark (25 %) and 'additives' in Luxembourg (21 %) were much more important than in other countries, whereas 'price' in Greece and Luxembourg (18 % in both) and 'habit' in Austria (10 %) were less important.

'Trying to eat healthily' as a factor was chosen by between a quarter and a half of the participants. Looking more closely at who selected this factor, in each Member State, the proportion of women trying to eat healthily **(2.1.15)** was greater in each age group than the proportion of men, except among those in Spain aged 55 and over. This proportion generally increased with age, although in Italy and Portugal the highest proportions were found for women aged 15–35. The proportions in Finland, France, the Netherlands and Spain were greater for women aged 36–54 than other age groups. Those in the Netherlands were greater for men aged 36–54 than in other age groups.

The **Institute of European Food Studies (IEFS)** (ref. IEFS web site) surveys are cross-sectional studies using interview face-to-face questionnaires. Interviews were carried out between (a) October 1995 and February 1996 for 'Influences on food choice and sources of information on healthy eating', and between (b) February and April 1997 for 'a pan-EU survey on consumer attitudes to food, nutrition and health' and 'a pan-EU survey on consumer attitudes to physical activity, body-weight and health' (ref. IEFS 1999). Approximately 1 000 people aged 15+ participated from each Member State, with a total sample size of approximately 15 000 for each survey. The exceptions were Luxembourg (500), Germany (1 250 — 1 000 from western Germany and 250 from eastern Germany), and the United Kingdom (1 000 from England, Wales and Scotland. Northern Ireland was not included in survey (a) and was represented by 250 people in survey (b). Subject selection was quota controlled to make the samples

nationally representative. These quotas were defined by various socio-demographic factors based on the most recent official statistics (census data) in each Member State. Results for individual Member States are weighted for sex, age and regional distribution where sample selection by quota controls did not quite meet the population. Results for the combined EU sample are weighted for population size and national profiles in terms of sex, age and regional distribution.

References

DAFNE, http://www.nut.uoa.gr/.

Eurobarometer, http://europa.eu.int/comm/dg10/epo/eb.html.

Eurodiet, http://Eurodiet.med.uoc.gr/.

Faostat, http://www.fao.org/.

HFA (WHO), www.who.dk.

IEFS, http://www.iefs.org/workinst.html.

IEFS (1999), *A pan-EU survey on consumer attitudes to food, nutrition and health* and *A pan-EU survey on consumer attitudes to food, nutrition and health,* Reports 1 and 2, Institute of European Food Studies, Dublin.

WHO/FAO, Joint WHO/FAO expert consultation on diet, nutrition and the prevention of chronic diseases (http://www.who.int/hpr/nutrition/26April-draftrev1.pdf).

2.2. Physical activity

According to **Eurodiet**, there are four different aspects of physical activity which benefit health: total amount regulates weight; short, intense activity induces fitness and influences well-being; moderate exercise reduces morbidity by 30–50 %; and weight-bearing activity limits bone loss and the chance of fracture. As little as one hour walking per day appears to be sufficient to slow down bone demineralisation (ref. Eurodiet web site). Rütten et al. (2001) explored self-reported physical activity in a sample of more than 3 000 adults in six Member States. They found that 'among both sexes, those reporting no activity reported lower income than those active; physical activity compares positively with income'. Controlling for age, sex, income and Member States, they also found that 'perceived opportunities' showed a 'significant main effect on self-rated health'.

In 1999, the **Eurobarometer 52.1** survey (see Section 2.1.4), conducted by the **European Commission**, asked people if they 'exercised at least twice a week' **(2.2.1)**. Less than half the respondents said that they did, although this ranged from 18.8 % in Greece to 77.8 % in Luxembourg. A higher proportion of men than women did so in most Member States. A larger proportion of people aged 15–24 exercised at least twice a week than in older groups. Differences between Member States increased with age, from between 45 and 88 % among the 15–24 group to between 8 and 85 % among the 55 and over group **(2.2.2)**. Of those who exercised, 81 % said that they had a good, balanced diet, compared with 70 % of those who did not exercise **(2.2.3)**. A smaller proportion of those who exercised (30 %) smoked, compared with those who did not exercise (36 %). Of those who exercised, 37 % were 'very' and 51 % 'fairly' satisfied with their own health, compared with 23 % who did not exercise being 'very' and 56 % 'fairly' satisfied.

In the same survey, people were asked if they considered their lifestyle to be healthy **(2.2.4)**. The proportions responding 'yes' ranged from 64 % in Greece to 89 % in Spain overall, with slightly more women than men doing so in each Member State except Portugal. Proportions saying 'yes' overall decreased slightly with age group until age 55 after which they increased significantly **(2.2.5)**. Variations between countries decreased with age. Greece had the lowest proportions saying 'yes' in each age group except the 55 and over group, where it was Portugal. However, Portugal had the highest proportion in the youngest age group. According to occupation, the 'retired' and 'houseperson' groups had the largest proportions saying 'yes' **(2.2.6)**. The 'managers' group had the smallest variations between Member States and 'other white collar' the largest. Again, Greece reported the least healthy lifestyles in all groups, except among the self-employed (the Netherlands) and the unemployed (Ireland). An analysis of this question with other variables **(2.2.7)** showed that, of those who considered their lifestyle to be healthy, 83 % said they had a good, balanced diet, 76 % did not drink alcohol regularly, 70 % did not smoke, and only 43 % exercised at least twice a week.

The 1997 data from the **Institute of European Food Studies (IEFS)** showed differences between countries in the amount of exercise/activity taken and the numbers of people participating. Walking, gardening, cycling, swimming and keep-fit were the five most popular recreational activities in the EU, enjoyed by people aged 15 and over (ref. IEFS 1999). As shown in Table **2.2.8**, a greater proportion of people participated in the first three activities, in total, in Austria and the Netherlands than in other Member States. On the other hand, swimming and cycling were less popular in Greece, Italy, Spain and Portugal than in other Member States, and gardening and walking were also less popular

in Portugal. Interestingly, a majority of people in Greece (68 %) and Portugal (63 %) agreed that local campaigns would be effective in encouraging them to do more physical activities (ref. IEFS 1999). This proportion was considerably higher than in other Member States. In the EU, a third of people aged 15 and over took no part in any of the suggested recreational activities. Of these, 41 % believed they did not need to be any more physically active than they were. Non-participants were more likely to be women over 55 years, with primary level education. As shown in Table **2.2.9**, the proportion of people who spent over five hours participating in various physical activities in a typical week ranged from over 40 % in Sweden, Austria and Finland to only 5 % in Portugal. The proportion of people that did not participate at all ranged from 8 % of people in Finland to 61 % in Portugal. The most active participants were likely to be young men with tertiary level education. Greater participation in activities other than gardening, cycling and walking was associated with higher educational levels. Table **2.2.10** shows that the proportions of people in each country choosing particular 'motivating factors' varied considerably. However, 'to maintain good health' was the top factor, out of 11 suggested, in all countries except Finland and the Netherlands. It seems that participation in physical exercise is not perceived as fun, with this factor being the least popular overall in the EU.

As the nature of work has changed greatly (ref. Rose and O'Reilly 1997) with the move from manufacturing to service industries and the growth of automation in the workplace, only 5 % of people in the EU were physically active (more than walking) at work for more than six hours per day. France had the smallest proportion of people in this category (1 %), followed by Luxembourg and Sweden (both 3 %), while Austria had the greatest (15 %). Other than walking, 42 % of workers in the EU were not physically active in their jobs. As shown in Table **2.2.11**, France had the highest number of people in this category (59 %), closely followed by Luxembourg and Spain, while Austria had the lowest (23 %). There was little difference in activity levels between men and women. People aged 15–34 were more likely to be sitting down for more than six hours per day than those of other ages, and more likely to mention work/study commitments as a barrier to exercise; this is likely to impact on their health. Countries differed in the amount of time that workers spent sitting down on a typical non-working day, as shown in Table **2.2.12**. The largest proportions of workers who sat down for more than four hours were in the Netherlands (51 %) and Germany (50 %), while the smallest were in Italy (21 %) and Belgium (24 %). There was little difference in the proportions that did not sit down at all in their leisure time, with Spain and Italy having the highest (5 %). Although, generally, activity at work was not associated with participation in the 17 suggested leisure activities, it is interesting that the people who were the most active at work spent less time sitting down in their leisure time, while those who sat down for more than six hours at work were the most likely to spend more of their leisure time sitting down.

In view of the trend for younger adults to become more sedentary than those aged 35 and over, mentioned above, the results of the 1997/98 **'Health behaviour of school-aged children' (HBSC)** study are included here. Boys were more likely to exercise for two hours or more per week than girls **(2.2.13)**. More children aged 11, 13 and 15 in Austria exercised for this period than in other countries, with the exception of 11-year-old boys in Switzerland. This is another indication of countries having different exercise/activity cultures across Europe. Excluding Portugal, because a different question was asked, a lower proportion of children aged 11, 13 and 15 in England exercised for two or more hours per week than in other countries (apart from girls aged 15 in Greece). Austria, Germany and Denmark had the largest proportion of girls in each age group exercising for this period of time. Proportions increased for both sexes between the ages of 11 and 13 in all countries, except in Switzerland and Northern Ireland where they remained the same. However, there is a gender difference in the change between the ages of 13 and 15. The proportions decreased for girls in all but two countries, but increased for boys in six countries and decreased in six. In a separate analysis by WHO (ref. Currie et al. 2000) using the same data and based on 11 countries, 7 of which are included in this volume, increased family affluence (as perceived by 11-, 13- and 15-year-olds) was found to be consistently associated with positive health behaviour such as taking more regular exercise and eating more fruit.

An indication of sedentary behaviour during leisure time is the proportion of children who reported watching television for four or more hours per day **(2.2.14)**. The proportions are broadly similar for all countries and categories, but there are some differences between countries and age groups. Wales had the largest proportion (ranging from 31–44 % across all age groups) while Switzerland (9–18 %) and France (12–17 %) had the smallest. According to WHO (ref. Currie et al. 2000), excessive television watching is associated with poor dietary habits for both sexes and all three ages, such as the consumption of sweets, crisps and sugared drinks.

The **'European physical activity surveillance system' (Eupass)** project, coordinated by the **Technische Universität Chemnitz** (Germany), under the EC Health Monitoring Programme has

The **'Health behaviour of school-aged children' (HBSC)** study was adopted by the World Health Organisation for Europe as a WHO collaborative study soon after it was initiated in 1982. Each participating member country carries out the survey, with questionnaires administered in the classroom by teachers or researchers. A special focus section of the questionnaire changes over time. The first survey was carried out in Finland, Norway, England and Austria in 1983/84, and the number of participating countries has since gradually increased to 32. Surveys have been carried out every four years since the second one in 1985/86. In Belgium only the Dutch-speaking part, in France only Nancy-Lorraine and Toulouse-Midi-Pyrénées, and in Germany only Nordrhein-Westfalen are covered in the 1997/98 study. The findings in each of these countries are therefore not representative of the whole country. Italy, Luxembourg and the Netherlands are not covered. It is anticipated that more countries will join in the next survey. The data collection period in each country should preferably be two weeks and not more than four. Fieldwork for 1997/98 was carried out between October 1997 and May 1998. The design is cross-sectional and three age groups are sampled to represent the onset of adolescence (11), the challenge of emotional and physical changes (13), and the middle years when very important life and career decisions are beginning to be made (15). It is recommended that all students in the age group, whether in private, public or special schools, be surveyed. Countries may choose to stratify their samples to ensure reasonable geographical coverage, and most do. It is recommended that 'cluster sampling' be used, where the cluster is the school class, but that these classes should be randomly sampled. The recommended minimum sample size for each of the three groups is 1 536 students. This assumes a 95 % confidence interval of +/– 3 % with a design-factor value of 1.2. Sample sizes for EU countries varied from just under 4 000 to over 6 000 (the three groups together).

been developing and testing a surveillance system for physical activity as a major behavioural determinant of health by providing core and optional indicators, testing selected indicators, and investigating implementation structures of health monitoring in the EU. Type, frequency, duration and intensity of activity have been identified as fundamental dimensions of activity for measurement. It has found that no single dimension was covered by any of the national surveys of eight Member States participating in the project. In addition, the focus of questions varied considerably between countries even when related to the same dimension, and different reference periods were used in most cases.

References

Currie, C. et al. (eds) (2000), 'Health and health behaviour among young people (International report from the "Health behaviour in school-aged children" — HBSC — 1997/98 survey)', *Health Policy for Children and Adolescents (HEPCA)*, Issue 1, World Health Organisation Policy Series, WHO Regional Office for Europe.

Eurodiet, http://Eurodiet.med.uoc.gr/.

IEFS (1999), *A pan-EU survey on consumer attitudes to physical activity, body-weight and health* and *A pan-EU survey on consumer attitudes to food, nutrition and health,* Reports 1 and 2, Institute of European Food Studies, Dublin.

Rose, D. and O'Reilly, K. (1997*), Constructing classes: Towards a new social classification for the UK*, ESRC/ONS, Swindon.

Rütten et al. (2001), 'Self-reported physical activity, public health, and perceived environment: Results from a comparative European study', *Journal of Epidemiology and Community Health* 55(2), 2001, pp. 139–146.

2.3. Smoking

Half a million people in the EU die from the effects of smoking each year, and half of these deaths occur in people aged between 35 and 69 — well below average life expectancy. Deaths from smoking will rise substantially over the coming decades as changes in the population structure and the delayed impact of smoking on health come fully into effect (ref. Harkin et al. 1997). Smoking-related morbidity ranges from acute respiratory infections such as coughs and colds to disablement from emphysema and — constituting the highest percentage of smoking-related deaths — cardiovascular disease. However, lung cancer is the disease most strongly linked to tobacco consumption and death rates resulting from it are the best indicator of long-term exposure. Many countries have information and education programmes about the harm caused by tobacco, as well as support for cessation of smoking. However, transnational television and press advertising, and enforcement of legislation banning sales to young people are problems for some countries, according to WHO (ref. Harkin et al. 1997). The Commission's proposal for a tobacco advertising Directive on rules for direct and indirect advertising and sponsorship of events was adopted in May 2001. The European Parliament and the Council adopted the Directive 2001/37/EC in June 2001 regarding the sale, marketing and manufacturing of tobacco products (ref. Europa web site).

2.3.1. People smoking

Data from the **Eurobarometer 43.0** (ref. Eurobarometer web site) survey, conducted by the **European Commission**, show that a third of men and a quarter of women in the EU smoked in

1995 **(2.3.1)**. More than a third of people aged 15 and over smoked in Greece, Denmark, Italy and France, while less than a quarter did so in Finland, Sweden and Portugal. The proportion of men who smoked increased between the 15–24 and 25–34 age groups, but then steadily decreased. The proportion of women who smoked decreased with age. There are differences between countries in the proportions of men and women of different ages who smoke, but these are not consistent. Generally, a larger proportion of men than women smoked in all age groups in each Member State, but there are a few exceptions, for example in Sweden in each age group and in Great Britain in two age groups. More Greek men and Danish women, and less Swedish men and Portuguese women smoked than in other Member States. The **IEFS** survey, carried out in 1997, found that 36 % of all people in the EU smoked, ranging from 46 % in France to 24 % in Sweden and Portugal (ref. IEFS 1999).

Data from the **Eurobarometer 52.1** survey, conducted by the **European Commission**, show a slightly different picture in that a third of people in most Member States smoked in 1999, while less than a quarter did so in Sweden only **(2.3.2)**. The context and wording of the questions are not strictly comparable between Eurobarometers 1995 and 1999. A new set of questions about smoking (identical to those from 1995) will be implemented in one of the forthcoming Eurobarometers (autumn 2002). A trend comparison for 1995–2002 will thus be possible in due course. According to Eurobarometer 52.1, men smoked more than women in each country except Denmark and Sweden, and overall differences between men and women increased with age. Within age groups, the largest proportions of male smokers were found in Belgium and France aged 15–24 (53 %), in Portugal aged 25–34 (66 %), in Greece aged 35–54 (with 74 and 83 %), in Spain aged 55–64 (52 %) and in Denmark aged 65 and over (39 %). The largest proportions of female smokers were found in France aged 15–24 (53 %), in Greece aged 25–34 (53 %) and in Denmark aged 35 and over (55, 48, 41 and 34 %). The smallest proportions of male smokers were found in Sweden in each age group from 15 to 64, and in Finland and then in Sweden aged 65 and over. The smallest proportions of female smokers were found in Portugal aged 15–24, and 35–54, in Italy aged 25–34, and in Spain aged 55 and over (along with France aged 65 and over). The data also show that 65 % of those who smoked ate a good, balanced diet, compared with 79 % of those who did not smoke **(2.3.3)**. Furthermore, 47 % of those who smoked 'regularly felt stressed', compared with 33 % of those who did not smoke.

In relation to heavy smoking, data **(2.3.4)** from **Eurobarometer 43.0** show that, among women living in the United Kingdom and men in Greece, Portugal and Austria only, a noticeable number smoked more than 40 cigarettes per day in 1995. The lowest level of smoking was found in Italy where practically all men smoked less than 25 cigarettes per day, and practically all women smoked less than 20. The most common level of smoking in the EU in 1995 was between 10 and 14 cigarettes per day. The large majority of smokers, in all countries of the EU, smoked less than 20 cigarettes per day, except Greek men, two thirds of whom smoked more than 20.

2.3.2. Expenditure on tobacco

Data from the **Household Budget Surveys (HBS)**, where available, show that between 1988 and 1994 expenditure on tobacco in 'PPS per household' increased in all Member States except Belgium (where it decreased), and increased between 1994 and 1999 in all Member States except Ireland (where it was the same), and Italy and Finland (where it decreased slightly). The percentage of total household expenditure on tobacco increased from 1988 to 1994 in all Member States except Belgium, Italy and the United Kingdom (where it decreased), and in Luxembourg (where it was the same). Between 1994 and 1999, it increased in five Member States and decreased in seven. Households in Greece spent the largest proportions in each year (2.9 % in 1999), three to four times the proportion spent by households in Luxembourg **(2.3.5)**. However, it is well known that surveyed people tend to underestimate, for cultural reasons, their expenditure on tobacco and alcohol when responding to the HBS.

Looking at the proportions spent on tobacco by various household groupings **(2.3.6)**, the HBS data for 1999, where available, show that: Ireland had the largest differences between socioeconomic categories and Italy the smallest, with the highest proportions in the EU spent by unemployed households; the United Kingdom, then Greece, had the largest differences between income quintiles and the Netherlands, followed by Italy, had the smallest — with proportions spent on tobacco in the EU decreasing as income increased; the largest proportions were spent by households with three adults, then by single-parent families, and the smallest by households with two adults plus children; by age, the largest proportions in most Member States were spent by households in which the reference person was under 30 years old, and the smallest where this person was 60 years or more — except in Denmark where it was between 30 and 44; there was no clear pattern by degree of urbanisation.

2.3.3. Very young smokers

Children who smoke daily are likely to be addicted to tobacco, whereas those who smoke 'at least weekly' may only smoke in social situations and could therefore be encouraged to stop. The **HBSC** (ref. Currie et al. 2000) survey data show that the proportion of 11-year-olds who smoked daily or 'at least weekly' in 1997/98 was very small, less than 3 % **(2.3.7)**. At this age, England and Northern Ireland had the highest rates of boys smoking weekly, while Scotland had the highest rates of girls smoking weekly and daily. The proportions increased for 13-year-olds with a wider variation between countries. For boys, these ranged from 2 % daily and 4 % weekly in Sweden to 9 % daily and 14 % weekly in Germany. For girls, these ranged from 2 % daily and 4 % weekly in Portugal to 12 % daily and 18 % weekly in Wales. At age 15, the proportions increased again. For boys, these ranged from 10 % daily and 18 % weekly in Sweden to 22 % daily in Germany and 30 % weekly in Austria. For girls, these ranged from 10 % daily and 14 % weekly in Portugal to 26 % daily and 36 % weekly in Austria. In each age group, boys smoked daily more than girls in Belgium and Ireland and vice versa in Scotland. However, while generally at age 11 more boys smoked than girls, this trend was reversed at ages 13 and 15 in most countries. The ratio of boys to girls smoking weekly was higher in eight countries at age 11, in six countries at age 13, and only in Portugal at age 15.

2.3.4. National controls on the sale and advertising of tobacco

Anti-smoking policies **(2.3.8)** were compared with children's smoking habits in each country. Four Member States had a minimum age of 18 for the purchase of cigarettes. Of these, and compared with other Member States: France had a much lower median number of cigarettes smoked by children aged 15, and the increase in the median with age was much smaller; Norway had the lowest rate for children aged 11 smoking weekly and one of the lowest median numbers of cigarettes smoked by boys of this age; and Sweden had one of the lowest median numbers of cigarettes smoked by boys aged 11 and 13, and the second lowest at age 15, the lowest rate for children aged 13 and 15 who were daily smokers, and the lowest rate for boys in each age group who were weekly smokers. Examining the three Member States with the least severe legislation concerning both smoking in public places and advertising compared with other Member States (leaving aside Spain which had no data for children) with regard to the smoking habits of children: Germany had the highest median number of cigarettes smoked by 11-year-old girls and the second highest by 13-year-old boys, and one of the highest rates of boys of each age who were daily smokers; Denmark had one of the highest proportions of children aged 15 smoking weekly and one of the highest median numbers of cigarettes smoked by children aged 15; and the United Kingdom had one of the highest proportions of children in each age group who smoked daily, one of the highest rates of children aged 11 and 13 and girls aged 15 smoking weekly, and one of the highest median numbers of cigarettes smoked by children aged 13. There is therefore some correlation between weak legislative controls and children's smoking habits. Looking at Member States with the most severe legislation concerning smoking in public places and advertising compared with other Member States with regard to children's smoking habits: Sweden had the lowest proportion of daily smokers and one of the lowest proportions of children aged 13 smoking weekly, the lowest median number of cigarettes smoked by boys aged 13 and almost the lowest for girls aged 13, the lowest for boys aged 15 smoking daily, the second lowest median number of cigarettes smoked by boys aged 15 and an average median for girls aged 15; and Norway had one of the lowest proportions for weekly and daily smoking, and one of the lowest median numbers of cigarettes smoked by children aged 13, an average proportion of children aged 15 smoking weekly, and around the average median number of cigarettes smoked by children aged 15. Although there appears to be an association between stronger controls and children's smoking habits in Sweden and Norway, there is no apparent link in Finland.

Comparing policies with adult smoking habits, Member States that had the most severe advertising policies tended to have lower proportions of people smoking more than 20 cigarettes per day. The main exception was Portugal, which had one of the highest rates. Portugal also had the highest proportion (69 %) of people who had never smoked followed by Austria (66 %), while France had by far the lowest proportion (35 %). France also had the highest proportion of people who had been ex-smokers for both more and less than a year. Germany, Austria and Portugal had the lowest rate of ex-smokers. France (46 %), Greece (44 %) and the Netherlands (42 %) had the highest rates of ex-smokers. For children aged 13 and 15, the HBSC survey found a strong association between tobacco experimentation, more frequent smoking and drinking, and being drunk more often. In an analysis carried out by WHO and based on 11 countries, 7 of which are included in this volume, increased family affluence (as perceived by 11-, 13- and 15-year-olds) was associated with smoking in Portugal, and with being drunk in Scotland, Wales and Portugal, but affluence had no relationship in other countries. In the **Eurobarometer 52.1**

survey, 41.5 % of people aged 15 and over who smoked also drank regularly, and 49.6 % of those who drank regularly also smoked.

2.3.5. Cigarettes available on the market

The official average number of cigarettes available on the market cannot reliably be compared in all countries in view of the widespread smuggling that takes place in many of them (ref. Harkin et al. 1997). Smuggling has been estimated to comprise 10–30 % of the consumption in Belgium and 25–30 % of the UK market in 2000 (ref. Rowell and Bates 2000). Spain and Italy have high rates of smuggling despite lower levels of taxation. In addition, some countries, for example Luxembourg (where prices are considerably lower than in neighbouring countries), have a small indigenous population and a large transient one. The number of cigarettes available in a country cannot be translated into an appropriate indicator per person to follow smoking trends. However, based on **WHO** data **(2.3.9)**, the average number of cigarettes per person/year available on the market has decreased considerably in the last 15 years, especially in Belgium, Italy, Finland, France, Sweden and the United Kingdom. In other countries such as Portugal, Ireland and Greece quantities per capita available on the market have increased at most by 20 %, remaining relatively stable in the rest of the Member States.

References

Currie, C. et al. (eds) (2000), 'Health and health behaviour among young people (International report from the "Health behaviour in school-aged children" — HBSC — 1997/98 survey)', *Health Policy for Children and Adolescents (HEPCA)*, Issue 1, World Health Organisation Policy Series, World Health Organisation, Regional Office for Europe.

Eurobarometer,
http://europa.eu.int/comm/dg10/epo/eb.html.

Europa,
http://www.europa.eu.int/comm/health/ph/programmes/tobacco/publication.htm.

Communication to the Council and the European Parliament on the present and proposed Community role in combating tobacco consumption.

(http://europa.eu.int/comm/health/ph/programmed/tobacco/comm-en8.htm).

Harkin, A.-M., Anderson, P. and Goos, C. (1997), *Smoking, drinking and drug-taking in Europe*, WHO, Copenhagen.

IEFS (1999), *A pan-EU survey on consumer attitudes to physical activity, body-weight and health*, Institute of European Food Studies, Dublin.

Rowell, A. and Bates, C. (2000), *Tobacco smuggling in the UK* (http://www.ash.org.uk/html/smuggling/html/uksmuggling.html).

2.4. Alcohol

Alcohol abuse is associated with various short-term adverse effects such as accidents, violence, poisoning and social problems, and with long-term risks of severe chronic diseases (ref. European Commission 2000). Alcohol-related harm frequently includes damage to the physical and mental health of the drinker's family, as well as to the drinker. As definitions of fatal injuries and the registration of injury accidents vary between countries, data for road traffic accidents (RTAs) involving alcohol are not comparable (ref. NTSB web site). However, in 1997/98 these varied between 4.3 per 100 000 in Italy and 52 per 100 000 in Luxembourg, according to WHO Europe (ref. Rehn et al. 2001). The **Directorate-General for Health and Consumer Protection's Working Group on Alcohol, Drugs and Medicines** is carrying out a project to describe the measurement and data collection methodology, and to maintain a database for all the Member States of the EU. The countries with the most severe driving restrictions regarding alcohol tended to have the lowest rates of RTAs, except Belgium. The 2001 report from the Swedish Presidency (ref. Report 2001) is based on results from the **European comparative alcohol study (ECAS)** which compared policies, consumption and harm between 1950 and 1995 in Member States as of 1998. This study showed increased convergence in beverage preferences, and diminished differences in consumption levels (also reflected in alcohol-related mortality, especially liver cirrhosis), between Member States over the years. The comments made about the sale of tobacco and smuggling in the previous section may also apply to alcohol. The ECAS survey found large differences between Member States in the quantities of privately imported alcohol, with the high-price countries (Finland, Sweden, Norway, Denmark and the United Kingdom) importing the most. It also found that other factors such as culture, living conditions and policies were more important than economic factors in explaining variations in consumption.

2.4.1. Alcohol available on the market

The highest availability on the market of pure alcohol per person, where data are available, occurred in Luxembourg in both 1998 (16.4 l) and 1999 (15 l), according to **WHO** (HFA) 1999 data **(2.4.1)**. The lowest availability of pure alcohol in 1998 occurred in Norway (5.4 l) and Sweden (6.0). Different drinking habits still seem to prevail in different parts of the EU. The highest annual availability of wine per person in 1999 was in Luxembourg (61 l), followed by

France (57.2), Portugal (51.7) and Italy (51.5). The lowest availability of wine was in Iceland (7.2 l), followed by Norway (9.5), the United Kingdom (14.5), Sweden (14.8), Finland (17.5) and the Netherlands (18.6). The highest annual availability of beer per person was in Ireland (154.7 l), followed by Germany (127.5) Luxembourg (109) and Austria (108.9). The lowest availability of beer was in Italy (27.1 l), followed by France (38.7), Greece (40.3) and Iceland (44.3). The highest availability of spirits was in Greece (2.7 l), followed by Spain and France (both 2.4) and Finland (2.3). The lowest availability of spirits was in Italy (0.5 l), followed by Norway (0.9).

2.4.2. Expenditure on alcohol

Looking at trends in data **(2.4.2)** from the **Household Budget Survey**, expenditure on alcohol (in PPS per household) increased from 1988 to 1994 in all Member States except Italy and Portugal. Between 1994 and 1999, it increased in half the Member States and decreased in the other half. Expenditure in Ireland in 1994 and 1999 was 10 times that of Greece, which had the lowest expenditure in each of the three years. Expenditure on spirits (in PPS per household) increased between 1988 and 1994 in all Member States except Belgium, with Portugal spending the least in both years. Between 1988 and 1994, expenditure on wine increased in all Member States except Portugal, while expenditure on beer increased in all Member States. In each of the three years, there were differences between Member States in the percentage of total expenditure spent by households on beer (0.2–3.9 % in 1999), wine (0.2–1.0 % in 1999) and spirits (0.1–0.8 % in 1999). Comparing the percentages of total household expenditure on alcohol by different households, the 1999 HBS data **(2.4.3)** show that: in each socioeconomic category and income quintile, households spent the highest proportions in Ireland and the lowest in Greece; the largest differences between socioeconomic categories were found in Ireland (4.1 %) and then Finland (1.4 %), and the smallest in Spain (0.2 %) and the United Kingdom (0.3 %); the largest differences between income quintiles were found in Ireland (1.6 %), and the smallest in Austria, the Netherlands, the United Kingdom and Greece (0.1 %); the types of household spending the largest proportion were those with three or more adults, and the least spending was by single-parent families; expenditure increased with the age of the reference person; and there was no consistent pattern in the proportion spent by degree of urbanisation in the EU.

2.4.3. Proportion of drinkers

The data **(2.4.4)** from **Eurobarometer 52.1** show that a quarter of people in the EU reported that they regularly drink alcohol, ranging from 6 % of women and 19 % of men in Italy to 40 % of women and 64 % of men in Ireland. More men than women drink regularly in each Member State and, in the EU as a whole, twice as many men as women drink regularly. There was little difference between age groups in the range 15–64 (26–28 %) but there was a considerable decrease to 17 % at age 65 and over. The data also show that 43 % of those who regularly drank alcohol also regularly felt stressed, compared with 36 % of those who did not drink regularly **(2.4.5)**.

2.4.4. Very young drinkers

Young people start tasting alcohol in their early teens, as in the past, but regular drinking begins at a younger age than before (ref. European Commission 2000). The **HBSC survey** looked at the proportions of young people consuming alcohol. Children aged 11, 13 and 15, drinking at least weekly in 1997/98, were more prominent in Greece, England, Wales and Denmark **(2.4.6)**, with a third more boys than girls drinking in these countries. The number of young people drinking roughly doubles between the ages of 11 and 15 for most of these countries. In an average week in England in 1998, 35 000 children under the age of 16 drank more than the recommended levels of alcohol for adults. Norway, Germany and Finland had the lowest proportions of young people drinking at age 11. At age 13, Norway had the lowest proportions for boys and girls (together with Switzerland and Portugal for girls), followed by Switzerland and Finland for boys. At age 15, Finland had the lowest proportions for boys and girls (followed by Portugal and Switzerland for girls, and Norway for boys).

A comparative risk analysis based on data from the WHO 'Global burden of disease study 2000' showed that one in four deaths in males aged 15–29 in the EU was attributable to alcohol (ref. Harkin et al. 1997). There seemed to be no association between the proportions of young people drinking and legislation governing the sale of alcohol. However, countries with the lowest proportions tended to have more restrictions on advertising **(2.4.7)**, while those with the highest prevalence tended to have less restrictions. Alcoholic drinks are among the most heavily advertised products, and many consider that alcohol advertisements on television undermine national initiatives (ref. IAS web site) for reducing alcohol consumption.

References

European Commission (2000), *Report on the state of young people's health in the European Union.*

Harkin, A.-M., Anderson, P. and Goos, C. (1997), *Smoking, drinking and drug-taking in Europe*, WHO, Copenhagen.

IAS (Institute of Alcohol Studies), http://www.ias.org.uk.

NTSB (National Transportation Safety Board), 'Reliability of road traffic accidents data' (http://www.ntsb.gov/ITSA/roaddata.htm).

Rehn, N., Room, R. and Edwards, G. (2001), *Alcohol in the European region — Consumption, harm and policies*, WHO, Regional Office for Europe.

Report (2001), *Report from the Swedish Presidency on alcohol*, June 2001.

2.5. Drug use

2.5.1. Prevalence of the use of drugs

Data collated (ref. EMCDDA web site) by the **European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)**, from surveys of last 12 months prevalence conducted between 1994 and 2000, show that cannabis was the most widely used drug in the Member States surveyed **(2.5.1)**. Use of cannabis among all adults (variable ages from 15–18 to 59–74) ranged from 1 % in Sweden to 9 % in the United Kingdom. Prevalence among younger adults (15–18 to 29–44) was roughly double the prevalence among all adults in most Member States, ranging from 1 % in Sweden to 23 % in the United Kingdom. Prevalence of use of other drugs among all adults was much lower in every Member State, from 0.0 % in Sweden for cocaine to 3 % in the United Kingdom for amphetamines, and among younger adults, from 0.0 % in Sweden for cocaine to 8 % in the United Kingdom for amphetamines, and their popularity varied between countries. Prevalence of use of drugs other than cannabis was less than or equal to 1 % among all adults in all Member States except Spain, the United Kingdom and Ireland, and less than 5 % among younger adults. In each country, a higher prevalence of use of one drug was usually associated with a higher prevalence of use of other drugs.

Data collected in the same period show that lifetime prevalence in most Member States was 2 to 3 times higher than last 12 months prevalence, except in Denmark where it was between 4 and 6 times higher and Sweden where it was between 8 and 13 times higher **(2.5.2)**. Among all adults, lifetime prevalence of cannabis was highest in the United Kingdom (25 %), Denmark (24.3 %) and Spain (22.2 %), and lowest in the former East Germany (3.6 %) and Finland (7.3 %). The picture is similar among younger adults but the proportions are larger — from 42 % in the United Kingdom down to 6.4 % in the former East Germany for cannabis. Amphetamines are the second most prevalent group of drugs used, although lifetime prevalence was less than 10 % in all Member States except the United Kingdom, where it reached up to 20 % for younger adults. Lifetime prevalence of use of cocaine and ecstasy was less than 5 % among all adults, and among younger adults except in Spain (5.2 %) and the United Kingdom (6.4 %) for cocaine, and in the United Kingdom for ecstasy (10 %). Where two years of surveys are shown, lifetime prevalence of use of all drugs in the table decreased in Spain and increased in the United Kingdom, but varied in other Member States.

Surveys of 15- and 16-year-olds from 1993 to 2000 **(2.5.3)** show that Wales had the highest lifetime prevalence of all illegal drug use (41.5 %), and solvents in particular (15.1 %). Prevalence of use of all drugs, especially cannabis, among 15- and 16-year-olds was also high in the United Kingdom as a whole, Ireland, Spain and the Netherlands. It was low in Austria, Portugal, Norway, Sweden, Finland and Greece, although Greece had the second highest prevalence of solvent use (13.7 %). Although the prevalence of use of LSD in Ireland was highest in 1995 at 13 %, a much larger sample in 1998 found it to be 3.4 %. Similarly, Luxembourg had a prevalence of 11.1 % in 1999 for cocaine use in a small sample, but a much larger sample found it to be only 1.5 %. Apart from the former figure, the prevalence of heroin and cocaine use among this age group was very low in all the countries in the table — less than 5 %. Prevalence of amphetamine and ecstasy use was less than 10 %, except in Scotland (12.0 %) and Wales (14.2 %) for amphetamines. Where there are two years of surveys, prevalence of all drugs increased in more countries than it decreased, except for ecstasy and amphetamines. However, the pattern of prevalence of use within particular countries varied. For example, the use of all drugs increased in Denmark, except for heroin which decreased, while the reverse is apparent in Italy.

For problem drug use, the estimates for national prevalence expressed per 1 000 people aged 15–64 in 1996–98 **(2.5.4)** were less than 10 in all Member States, and less than 5 in nine Member States. They ranged from 1.4 to 3 in Germany, and from 2.3 to 8.9 in the United Kingdom. EMCDDA data **(2.5.5)** show that the mean age of problem drug users in 1998 ranged from 23 years in Ireland and 23.5 in Finland, to 31.4 in the Netherlands and 33 in Sweden. The majority of drug users treated for problems were men in all Member States (68 % in Austria; 86 % in Italy). Where there are data, the proportion of injectors varies greatly, from 1.2 % in Spain to 100 % in Austria. Among this group of drug users treated for problems, opiates were the main drugs involved in 10 of 13 Member States, with their use being highest in Portugal (92.2 %). The lowest use of opiates

was found in Dutch-speaking Belgium, Finland and Sweden. Cocaine prevalence varied from 1 % in Sweden to 30.9 % in Spain, with the highest proportion of cocaine being injected in Portugal (78.4 %). The proportions of opiate, cocaine and amphetamine users who inject bear no relation to the prevalence of each drug in Member States. According to the EMCDDA, syringe-exchange programmes are now established in all Member States, although to varying degrees. Cannabis was the second main drug in problem drug use (3.4–40 %) in all but two Member States where use of cocaine was higher (the Netherlands and Spain), and one where the use of amphetamines was higher (Finland). Use of hallucinogens was less than 1 % in all Member States except Germany (2.2 %) and Sweden (2 %). Data from the EMCDDA 2000 annual report showed that there was a relatively higher proportion of 'other drug' use in Sweden (14 %) and Denmark (12 %) in 1998, and in Sweden (33 %) and Wallonia, Belgium (11.9 %) in 1997. However, as well as the figures for Denmark (2 %) and Belgium (5.5–6.5 %) being much lower, the data in Table **2.5.5** from the 2001 report show 47 % 'other drug' use but no figures for amphetamines or ecstasy in Sweden in 1998. The differences in Sweden's data are due to different sources being used — the DOK system, which covers different kinds of treatment units, was used for the 2000 report.

The national prevalence of hepatitis C antibodies among drug injectors tested between 1994 and 2000 ranged from 19 % in Sweden in 1998 to 83 % in Spain in 1996 **(2.5.6)**. Local data show prevalence ranging from 38 % in Lisbon, Portugal (1999) and Dutch-speaking Belgium (1999) to 92 % in Finland (1999–2000). The largest number of injecting drug users were tested in Italy, which had a hepatitis C prevalence of 67 % in 1999 compared with 68 % in 1998. Prevalence of HIV among injectors tested between 1996 and 2000 was less than 5 % in two thirds of Member States. The highest prevalence was found in Lisbon, Portugal, in 1998/99 (48 %), followed by 33.1 % in Spain (1999) and 25.9 % in a local study in the Netherlands between 1997 and 1999. Italy tested the most injectors and had a prevalence of 15.1 % in 1999 compared with 16.2 % in 1998. The incidence of AIDS cases related to injecting drug use between 1985 and 2000 was less than five per million in seven Member States (see Chapter 4). For all Member States, incidence peaked in the early 1990s, except in Portugal where it increased every year from 1985 (0.1) to 1999 (61.0), then slightly decreased to 60.4 in 2000. Incidences increased dramatically from 1985, peaked in 1993/94, and then decreased in three countries — Spain (2.4, 120.5, 33.5), Italy (1.7, 58.7, 11.5) and France (0.8, 25.2, 3.8).

Data are collected by the **European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)** from various bodies in each country, such as treatment centres and government departments. The European information network on drugs and drug addiction **(Reitox)** has a national focal point in each Member State that coordinates its national information centres in order to meet the EMCDDA's requirements for a set of core data. The sources are sample surveys, police data and treatment data. The **European school survey project (ESPAD)** (ref. IPDT web site) and **HBSC** data have been used for school children. The EMCDDA has been operational since 1995. Only Germany, Spain, Sweden and the United Kingdom have carried out series of comparable data collections. The EMCDDA states that the quality and comparability of the data produced by Member States has significantly improved, although there are differences in methods of data collection, sampling sizes and frames which could influence the precision and validity of the data. There are minor variations in the classification of drugs; for instance, surveys in some countries ask about 'cocaine' use, while others ask about 'cocaine or crack'. There are also variations in the age ranges of surveys. The years in which surveys were carried out vary between countries. All these variations affect comparability. Inhabitants of urban areas report higher rates of drug use than those of rural areas, and differences in national figures could be largely conditioned by the proportion of the urban population.

The sample sizes vary, both relatively and absolutely, between countries — from 562 to 47 657, but sizes refer to the complete national surveys. In some cases, national surveys cover a broader age range than that presented in a particular table, and, therefore, the estimates presented may be based on smaller samples. The most common sampling methods are simple random selection and multistage stratification with varying techniques at the different stages. The majority apply weighting, usually to adjust for age, gender and/or region. Some studies oversample, usually for age, gender and (in the United Kingdom) ethnicity. Results of surveys are affected by the cultural, political and economic climates in which they are undertaken. Survey data are not strictly comparable due to the methodological variations. The EMCDDA has produced guidelines for the standardised implementation of five key epidemiological indicators of drug use — drug use, problem drug use, demand for treatment, drug-related deaths and drug-related infectious diseases — to be fully implemented in all Member States at national level in the coming years.

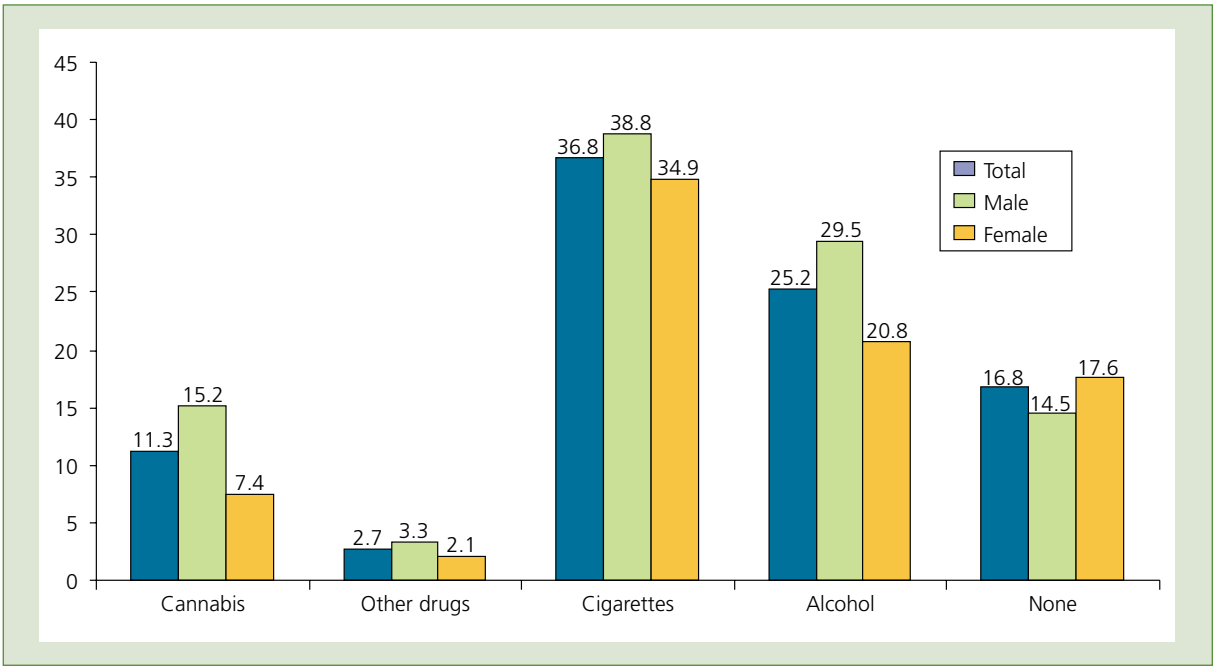
2.5.2. Attitudes and opinions of young people on drugs

Data from the 2002 **Eurobarometer 57.2** survey, conducted by the **European Commission**, analyse the attitudes and opinions of young citizens of the EU aged 15 to 24 regarding drugs (ref. Eurobarometer 57.2). More than 10 % of young people **(2.5.7)** say

they have used cannabis over the last month in France (19.8 %), Spain (15.0 %), the United Kingdom (13.4 %), Denmark (12.2 %) and the Netherlands (12.2 %). During the same period, use of another drug exceeds 3 % in Ireland (4.8 %), in the United Kingdom (4.4 %), in Spain (3.7 %), in the Netherlands (3.2 %) and in Finland (3.1 %). The United Kingdom, Spain and the Netherlands therefore find themselves in the lead group for the two types of use. France and Denmark are in the same group for cannabis but are within the European average for other drugs. The young Irish are the heaviest users of drugs other than cannabis but are, on average, less fond of the latter. In nearly all cases, there is a mathematical link between the rate of experimentation and the use of different drugs. The countries least affected by the phenomenon applying both to cannabis and other drugs are Greece (1.3 and 0.4 %), Sweden (3.9 and 1.6 %), Austria (4.6 and 1.3 %), Portugal (4.9 and 1.8 %) and, to a lesser extent, Italy (7.8 and 0.6 %) and Luxembourg (4.5 and 2.3 %). Although the southern countries, with the exception of Spain, seem less affected by drugs than the European average, there is no clear North–South divide on this issue. Finally, Belgium (9.5 and 1.9 %) and Germany (8.3 and 2.4 %) are well below the 11.3 % and 2.7 % for the whole of the European Union but less clearly so than the group mentioned above.

To check, as far as possible, any correlations which may exist between use of drugs and use of tobacco and/or alcohol, questions relating to the latter two substances were included in the analysis of each type of socio-demographic data **(2.5.8)**. It can be seen that the rate of penetration of cannabis is twice as high for boys as for girls and that of other drugs more than 50 % higher. Differences in behaviour regarding tobacco and alcohol are much less noticeable between the sexes. It therefore goes without saying that any link between these two substances and drugs will be less clear for girls than for boys.

2.5.8 Use of cannabis/other drugs, over the last month — Regular consumption of cigarettes and alcohol/EU-15, 2002



Source: Eurobarometer 57.2, European Commission.

The opinions on the potential consequences of drug use were also analysed in this Eurobarometer **(2.5.9)**. It should be noted that, in order to give the widest possible range of opinions the opportunity of being expressed, two 'positive' consequences were included in the questionnaire. One was 'relief from pain or stress' and the other 'enjoyment'. Dependence is in first place with less than two thirds (63 %) of the opinions expressed. The possibility of having problems with the law (38.3 %) is the second most frequently cited consequence. Consequences for mental or physical health occupy a more important place among the concerns than social problems (suicide, prostitution, poverty) that may be caused by drugs. Indeed mental problems (35.4 %), communicable diseases (33.7 %) and other health problems (23.1 %) are among the first six consequences mentioned. Relief from pain or stress (26.4 %) is in fifth position whilst enjoyment, in ninth place, manages to get 14 %. The 'beneficial' or 'fun' aspects of drugs do, therefore, persist among significant numbers of the segment of the population studied.

In order to establish a ranking of those substances judged most dangerous **(2.5.10)**, only the reply 'very dangerous' was taken into account. The results confirm the special position of cannabis among drugs. Aside from tobacco and alcohol, cannabis is judged the least dangerous substance on the list. 11.5 % of respondents even judged it 'not at all dangerous'. It should be noted however that, in spite of the fact that it is widely known about, 4.3 % said they had no opinion as to whether it was dangerous or not. Distrust of the other drugs exists to various degrees among nearly all those questioned. Less than 1 % of them consider that the six substances classified most dangerous are not at all dangerous. It can be seen also that the answers 'Don't know' are least frequent for heroin and cocaine, at the top of the table, and ecstasy in fifth position. They are slightly more frequent for morphine (6 %), crack (7.2 %), glue and solvents (8.1 %), LSD (8.6 %), doping substances (8.9 %) and amphetamines (11.4 %). It was felt to be of interest to measure the variations in national opinion taking as a reference three substances each occupying a different position in the scale of risks: heroin, considered the most dangerous, cannabis, seen as the least dangerous, and ecstasy, which occupies the fifth place on the list but which is possibly (apart from cannabis) the drug with most media coverage. Table **2.5.11** makes the comparison between the three substances. It can once again be seen that the item which garnered the most responses in the whole of the European Union is also the one for which the country-by-country answers show the highest level of homogeneity. For this item — heroin — opinions are close to the European Union average (88.8 %) in practically all the States. The Netherlands (79.2 %) and Portugal (75.4 %) are slightly lower and Greece (96.1 %) slightly higher than this average. Whatever the case, this substance is seen as very dangerous by a very large part of the population of each Member State. For ecstasy, the range of opinion is much broader. Italy (74.3 %) and Denmark (71.1 %) are the countries with the highest number of respondents who consider it very dangerous. Fewer Dutch (49.4 %), Finns (45.2 %) and Portuguese (44.1 %) than the European average (63.5 %) give it a very high danger rate. There are also marked differences from country to country as regards cannabis, the substance considered least dangerous by those covered by the study. The countries can be grouped by the rate of 'very dangerous' opinions as follows: the opinion that cannabis is a very dangerous substance is more widespread than the EU average (20.6 %) in Greece (47.8 %), Sweden (45.1 %) and Finland (35.3 %). It is found less frequently in the Netherlands (7.2 %) and in Denmark (8.7 %). It is possible that variations in tolerance and warnings about cannabis may play a role in the differences in people's assessment of how dangerous it is.

In the **Eurobarometer 57.2** (see Section 2.1.4 for details), in each Member State, the questions were submitted to a representative selection of the national population aged between 15 and 24. In total, 7 687 people were questioned, that is, on average, some 450 people per Member State, except in Germany (900 people questioned), Northern Ireland (200) and Luxembourg (200). It should be noted that the figures relating to the European Union are a weighted average of national figures. For each Member State, the weighting used is that State's share of the total Community population aged between 15 and 24.1.

References

EMCDDA, http://www.emcdda.org, *Annual report on the state of the drugs problem in the European Union 2002*, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Office for Official Publications of the European Communities, Luxembourg.

Eurobarometer 57.2, *Attitudes and opinions of young people in the European Union on drugs*, report by Marc Callemien for the Directorate-General for Justice and Home Affairs, 2002.

IPDT, http://www.ipdt.pt/investigacao/espad99/espadsumario99.pdf.

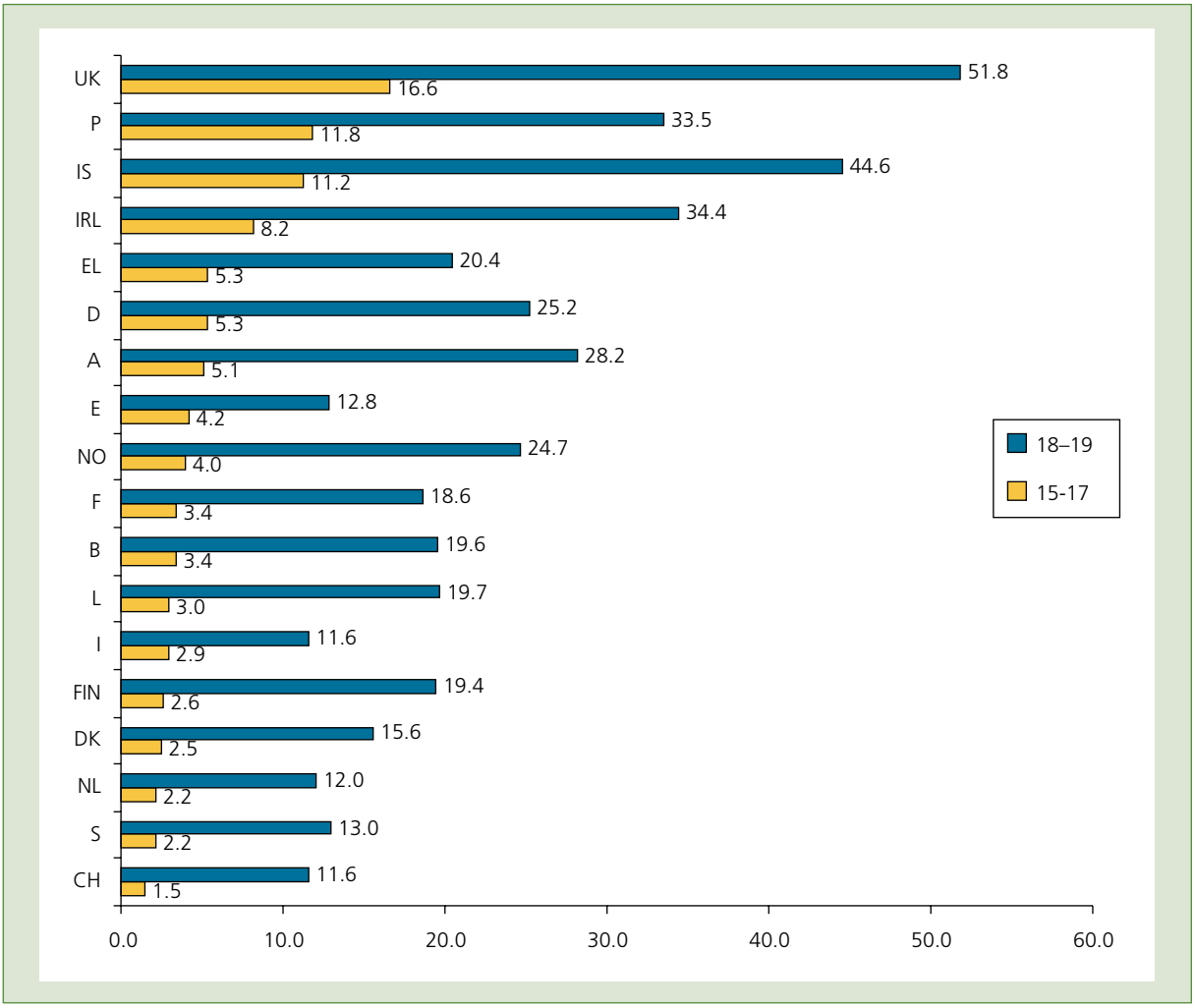
See also Harkin, A.-M., Anderson, P. and Goos, C. (1997), *Smoking, drinking and drug-taking in Europe*, WHO, Copenhagen.

2.6. Teenage pregnancy

Teenage pregnancy is associated with increased risk of adverse health and social outcomes for both mothers and their babies. For instance, data from the 1995 infant feeding survey in the United Kingdom (ref. Botting et al. 1999) showed that teenage mothers were more likely to smoke and less likely to breastfeed their babies. Mortality rates of babies born to teenage mothers were higher, and their birth weights lower. The babies were more likely to have congenital abnormalities and accidents. Most teenage mothers were unable to continue their education or work, and received State benefits. Lone mothers and their children were more likely to live in deprived conditions, and lack of education reduces their long-term potential to improve them. They may, therefore, face poverty and social exclusion. A study in Scotland concluded that the difference in rates of teenage pregnancy between the more affluent and more deprived areas widened between the early 1980s and the early 1990s,

increasing more rapidly in areas of greater socio-economic deprivation (ref. McLeod 2001). As data collection methods can vary between countries, comparisons between Member States must be made with caution. **Eurostat** has recalculated fertility rates by age, and mean age of women at childbearing, to the same definition — the age reached during the year of the event (ref. Calot 1984). Thus, these rates cannot be directly compared with the figures in *Health statistics — Key data on health 2000*, as they have been calculated in a different way. The United Kingdom had the highest fertility rate for girls aged 15–19 in 1980–2000 **(2.6.1)**, with 28.9 live births per 1 000 girls in 2000. Iceland, Portugal and Ireland also had high rates from 1980–2000. The lowest rates were found in the Netherlands, Italy and Sweden. According to **Unicef** (ref. Unicef), Graph **2.6.2** breaks the number of births for 1998 into younger and older teenagers, and it shows that, in the top half of the table, births to younger teenagers are a very small proportion of all teenage births. In the bottom half, however, births to 15–17-year-olds make up a considerably higher proportion of the overall teenage birth rate. The numbers of declared legal abortions for girls aged less than 15, and between 15 and 19, increased between 1995 and 1999, although they decreased slightly between 1998 and 1999 in the United Kingdom **(2.6.3)**.

2.6.2 Fertility rate, live births, for girls aged 15–17 and 18–19 in 1998



Source: Unicef (United Nations Children's Fund), Innocenti Research Centre, *A league table of teenage births in rich nations.*

There are no new data for **sexual behaviour** across the EU, but existing data can be found in *Health statistics — Key data on health 2000*. Data for **sexually transmitted diseases** can be found in Subsection 4.7.1.2.

A new project **Reprostat ('Reproductive health indicators in the European Union')** coordinated by the **Instituto de Medicina Preventiva** from the University of Lisbon (Portugal), under the EC Health Monitoring Programme,

started in 2001. The project focuses, among other things, on indicators on teenage birth rate, contraceptive prevalence rate, mean age at first childbirth, age and contraceptive used at first intercourse and condom use during last intercourse.

References

Botting, B. et al. (1999), 'Teenage mothers and the health of their children', *Population Trends,* No 97, National Statistics, The Stationery Office.

Calot, G. (1984), *INED Travaux et documents,* No 104.

McLeod, A. (2001), 'Changing patterns of teenage pregnancy: Population-based study of small areas', *British Medical Journal,* Vol. 323 (available at http://bmj.com/).

Unicef (United Nations Children's Fund), Innocenti Research Centre, *A league table of teenage births in rich nations*, July 2001.

2.7. Social exclusion

The term 'social exclusion' describes the process that prevents people from participating fully in society and from being socially integrated (ref. EACSI 1999). Poverty and social exclusion can lead to isolation and ill health. For instance, the poor are often highly stressed by a sense of stigmatisation and exclusion from society and the knowledge that they are unable to control their lives because of reduced opportunities. These conditions are now clearly linked to high levels of coronary heart disease. Poorer mothers are more likely to have children of low birth weight and this is also now clearly linked to an enhanced susceptibility to adult chronic diseases.

In the **European Community Household Panel (ECHP)**, people surveyed were asked about their ability to make ends meet or afford a car or a holiday. Of those in the EU living in **monetary poverty** (defined as less than 60 % of the median income) in 1995 and 1996, around half of the unemployed were socially excluded (as measured in Table **2.7.1**), compared with a third of 'inactives' and a fifth of employed people. The greatest differences between Member States were found among the unemployed, followed by the employed. In each employment group, the poor in Denmark were the least likely to be socially excluded, especially the unemployed. Member States with the greatest proportion of socially excluded poor people varied according to employment group. In the unemployed group, those in Italy, France, Germany and the United Kingdom were the most socially excluded. In the 'inactive' group, the poor in France and Luxembourg were amongst the most socially excluded in two of the criteria, along with those in Belgium and Portugal in one of the criteria. In the employed group, Luxembourg had the highest proportion of those who were socially excluded in all the criteria. Available sampling frames and administrative records tend to exclude the most marginal members of society, such as the homeless. In the same way, many survey samples also exclude the institutionalised population. Therefore, statistics based on existing sampling frames are bound to under-represent the potentially most socially excluded parts of the population.

Data from the 2001 **Eurobarometer 56.1** survey, conducted by the **European Commission,** measures the subjective poverty. With the exception of Denmark and Germany, the proportion of people who regard themselves as poor is distinctly greater than that of people facing an objectively measured risk of poverty. In certain countries, the difference is as much as threefold. In Portugal, for instance, 20 % of individuals are below the poverty line, while the proportion of individuals who consider themselves poor is 66 %. In Greece, there are 22 % according to the first indicator and 54 % according to the second. This difference **(2.7.2)** is mainly connected with the fact that these two indicators are not measuring the same thing. The first is relative, in the sense that it is calculated with reference to the national median income: it depends on the income distribution within the country in question, and can therefore be regarded as an indicator of national inequalities. The second measures individuals' degree of dissatisfaction with their standard of living; it depends on a personal perception of what is necessary for a decent life and of the possible gap between this subjective minimum and their declared net income (ref. Gallie and Paugam 2002).

Table **2.7.2** compares the 'risk of poverty' indicator based on the EU's objective money definition with that for subjective poverty as we have just defined it. According to the **European Community Household Panel (ECHP)**, the proportion of individuals at risk of poverty is distinctly greatest in Portugal, Greece and the United Kingdom (most often above 20 %). It is also high in Italy, Spain and Ireland (around 20 %). At the other end of the scale, the Scandinavian countries (Denmark, Sweden and Finland) appear least affected by the risk of poverty, for here the proportion of individuals living in poor households is most often less than 10 %. The Netherlands and Luxembourg also show a fairly low risk of poverty (between 11 and 12 %). France, Germany and Belgium are in the middle (between 15 and 20 %).

For a description of the **European Community Household Panel (ECHP)** survey, conducted in the EU Member States and coordinated by Eurostat, see Chapter 4.

While there is a great range of different indicators and methods for measuring poverty, statisticians generally adopt a strictly financial approach, setting an income threshold below which households or individuals are considered poor. The threshold varies: for many years, the most usual one was 50 % of national average (mean) income. Since 2001, **Eurostat** has used a reference threshold of 60 % of the national median, described as an indicator of the 'risk of poverty'. To take account of economies of scale applying to households depending on their composition, it is usual to give a value of 1 to the first adult in the household, 0.5 to all others aged 14 and over, and 0.3 to children under 14. Contrasting with this type of measurement, there are the approaches based on subjective poverty. Here, again, there is a customary definition: poor individuals are those whose total net income is less than they consider absolutely necessary for a proper standard of living.

References

EACSI (European Advisory Committee on Statistical Information) (1999), Statistics Users' Council's annual conference on social exclusion statistics, Imac Research.

Frey, L. (2001), 'Social exclusion and social cohesion: An introduction', CEIES decennial conference, *SIGMA,* 2/2001.

Gallie, D. and Paugam, S. (2002), *Social precarity and social integration*, report for the European Commission based on Eurobarometer 56.1.

2.1.1 Total energy available from fat in food for human consumption (1) per day

	EU-15	B (2)	DK	D	EL	E	F	IRL	I
1970	34.3	36.9	40.1	36.4	31.0	29.3	34.5	32.6	29.3
1975	34.9	36.8	38.7	36.2	32.7	30.8	36.2	33.0	30.7
1980	36.3	38.0	39.6	36.7	34.9	33.0	39.4	35.8	32.3
1985	37.2	39.6	37.1	36.6	35.4	35.5	39.8	35.4	36.2
1990	38.4	39.5	37.8	38.4	35.3	38.0	41.4	33.6	37.9
1991	38.5	39.9	36.6	38.4	35.9	39.0	41.6	33.5	37.7
1992	38.6	39.1	38.3	38.1	36.4	39.3	41.8	33.1	36.8
1993	38.7	39.7	37.1	38.5	35.8	39.5	41.7	33.0	37.5
1994	38.6	40.3	36.4	38.3	36.1	39.0	41.8	32.6	37.9
1995	38.8	40.5	36.8	37.8	37.1	39.3	41.8	32.6	37.6
1996	38.9	40.1	36.5	39.1	37.2	39.2	41.5	32.0	37.4
1997	39.2	39.6	34.8	40.2	37.7	39.6	42.0	33.8	37.6
1998	39.2	39.5	35.2	39.1	37.8	40.7	41.7	33.5	38.1
1999	39.0	:	35.4	38.8	36.9	40.5	41.4	33.6	37.8

(1) Recommendations from several food administrations imply that the fat intake should not exceed approximately 30–33 % of total energy intake.
(2) Includes Luxembourg.
Source: World Health Organisation/Europe, Health for All database.

2.1.2 Average daily fat consumption per person according to type of food, 1999

	EU-15	B (1)	DK	D	EL	E	F	IRL
Fat per day	149.8	159.1	130.4	146.9	151.3	150.7	164.6	136.3
Vegetable products	66.7	68.6	29.4	62.0	94.1	87.7	55.9	47.7
Cereals (excluding beer)	3.5	2.9	3.2	3.3	4.3	2.8	3.7	3.4
Starchy roots	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.3
Sweeteners	:	:	:	:	:	:	:	:
Pulses	0.2	0.1	0.0	0.1	0.2	0.4	0.1	0.1
Treenuts	2.6	3.1	2.7	3.2	4.7	3.7	2.1	0.5
Oilcrops	2.2	1.4	0.7	2.4	4.2	3.0	1.9	2.0
Vegetable oils	54.8	59.1	17.3	48.3	76.5	75.0	44.9	38.6
Vegetables	0.7	0.8	0.7	0.5	1.5	0.8	0.7	0.5
Fruit (excluding wine)	0.8	0.7	0.8	0.8	1.0	0.9	0.8	0.4
Stimulants (tea, coffee, etc.)	1.7	0.1	3.4	3.1	1.3	0.7	1.6	1.9
Spices	0.1	0.1	0.2	0.2	0.1	0.2	0.1	0.2
Alcoholic beverages	:	:	:	:	:	:	:	:
Animal products	83.0	90.5	101.0	85.0	57.1	63.1	108.6	88.5
Meat	33.3	21.3	31.6	27.9	23.3	33.8	45.1	33.9
Offals	0.4	0.8	0.1	0.4	0.4	0.4	0.8	1.6
Animal fats	25.0	46.4	49.2	36.9	4.5	7.0	32.7	25.7
Milk (excluding butter)	19.4	16.1	14.1	15.4	24.9	15.5	24.2	24.3
Eggs	3.4	3.9	4.2	3.3	2.8	3.8	4.3	1.9
Fish, seafood	1.5	1.9	1.9	1.1	1.2	2.5	1.5	1.2

(1) Includes Luxembourg.
Source: Faostat database, Food and Agriculture Organisation.

(%)

NL	A	P	FIN	S	UK	IS	NO	CH	
39.3	34.7	23.7	35.7	36.5	38.9	35.0	39.2	38.5	**1970**
38.6	36.8	25.8	38.3	36.3	38.2	38.8	42.5	41.9	**1978**
38.3	39.5	27.8	38.1	37.1	39.0	38.8	39.9	41.3	**1980**
38.5	41.1	28.7	37.6	37.0	38.5	38.2	38.2	41.3	**1985**
38.6	40.1	31.6	35.5	37.1	38.0	36.5	36.6	40.8	**1990**
37.3	40.3	32.1	36.2	37.1	38.1	34.3	37.0	41.2	**1991**
37.1	41.0	31.8	36.5	36.0	39.6	35.1	37.1	40.2	**1992**
38.6	40.9	31.8	37.1	36.6	38.9	34.6	37.0	40.5	**1993**
38.9	39.7	31.8	36.8	37.4	38.5	34.8	37.1	41.3	**1994**
41.0	39.7	31.7	37.9	38.2	39.2	34.2	37.3	40.8	**1995**
39.4	40.6	31.9	37.2	36.7	39.0	34.0	37.2	40.1	**1996**
39.1	40.5	32.2	36.9	37.9	38.7	36.1	36.4	39.8	**1997**
38.9	38.9	32.4	36.9	36.4	39.6	36.8	37.5	40.6	**1998**
39.0	37.8	32.4	36.5	37.3	39.5	37.3	36.8	40.2	**1999**

(grams per person)

I	NL	A	P	FIN	S	UK	IS	NO	CH	
152.4	140.4	152.8	135.6	127.6	130.1	145.7	137.2	140.2	145.7	**Fat per day**
82.7	53.9	59.4	58.8	37.0	57.4	63.6	39.2	52.9	57.3	***Vegetable products***
3.9	2.4	5.0	5.5	3.9	3.2	3.2	8.3	4.3	3.1	Cereals (excluding beer)
0.1	0.2	0.2	0.3	0.2	0.1	0.3	0.1	0.2	0.1	Starchy roots
:	:	:	:	:	:	:	:	:	:	Sweeteners
0.3	0.1	0	0.2	0	0.1	0.3	0	0	0.1	Pulses
3.5	2.2	3.4	1.5	0.7	1.7	0.8	0.5	2.2	5.8	Treenuts
1.3	1.6	2.7	1.1	1.2	1.8	3.2	1.8	0.9	1.4	Oilcrops
71.2	42.2	45.6	44.8	29.5	48.9	53.3	21.3	42.5	44.9	Vegetable oils
0.9	0.5	0.7	1.0	0.4	0.5	0.5	0.4	0.4	0.6	Vegetables
0.9	0.6	0.7	1.4	0.4	0.6	0.5	0.4	0.5	0.6	Fruit (excluding wine)
0.6	3.7	0.8	2.9	0.3	0.3	1.2	6.0	1.8	0.5	Stimulants (tea, coffee, etc.)
0	0.3	0.3	0.1	0.1	0.2	0.2	0.2	0.2	0.2	Spices
:	:	:	:	:	:	:	:	:	:	Alcoholic beverages
69.6	86.4	93.4	76.7	90.7	72.7	82.2	98	87.2	88.3	***Animal products***
30.1	32.6	30.9	30.4	44.3	22.9	37.3	42.1	29.6	40.3	Meat
0.3	0.1	0.1	0.6	0.1	0.1	0.2	0.9	0.2	0.4	Offals
16.7	19.9	36.9	24.6	14.8	22.4	19.9	26.5	26.7	22.2	Animal fats
17.6	28.2	21.0	16	26.4	21.9	21.1	23.3	22.3	21.5	Milk (excluding butter)
3.5	4.4	3.5	2.5	2.5	3.2	2.5	1.5	2.8	2.8	Eggs
1.5	1.2	0.9	2.6	2.5	2.2	1.2	3.6	5.8	1.2	Fish, seafood

2.1.3 Average daily number of calories

	EU-15	B (1)	DK	D	EL	E	F	IRL	I
1970	3 185	3 125	3 157	3 166	3 137	2 733	3 300	3 445	3 422
1975	3 177	3 167	2 988	3 161	3 335	2 990	3 246	3 496	3 364
1980	3 279	3 302	3 127	3 338	3 215	3 062	3 375	3 663	3 585
1985	3 333	3 439	3 165	3 464	3 507	3 120	3 498	3 604	3 411
1990	3 376	3 531	3 172	3 317	3 531	3 267	3 506	3 625	3 572
1991	3 423	3 571	3 251	3 430	3 571	3 338	3 538	3 616	3 628
1992	3 446	3 653	3 328	3 478	3 630	3 363	3 546	3 637	3 525
1993	3 380	3 589	3 308	3 329	3 523	3 304	3 535	3 613	3 457
1994	3 374	3 599	3 285	3 345	3 650	3 313	3 517	3 557	3 450
1995	3 378	3 584	3 333	3 397	3 608	3 249	3 536	3 552	3 493
1996	3 404	3 602	3 325	3 401	3 593	3 305	3 511	3 555	3 514
1997	3 413	3 619	3 407	3 382	3 649	3 310	3 518	3 565	3 507
1998	3 439	3 610	3 434	3 418	3 643	3 342	3 560	3 640	3 601
1999	3 461	3 625	3 317	3 411	3 689	3 353	3 575	3 649	3 629

The recommended dietary allowance (RDA) for most of the countries is about 2 900 kcal in certain maximal cases (males 25–50 years about 176 cm and 79 kg) or 2 200 kcal for women (25–50 about 163 cm and 63 kg) even if this RDA differs person by person according to certain characteristics.
(1) Includes Luxembourg.
Source: Faostat database, Food and Agriculture Organisation.

2.1.4 Average daily calories per person according to type of food supply: 1999

	EU-15	B-L	DK	D	EL	E	F	IRL	I
Calories per day	3 461	3 625	3 317	3 411	3 689	3 353	3 575	3 649	3 629
Vegetable products	2 380	2 483	2 089	2 344	2 860	2 425	2 221	2 454	2 692
Cereals (excluding beer)	849	758	770	778	1062	736	867	955	1152
Starchy roots	141	193	126	142	130	157	120	214	70
Sweeteners	374	472	499	414	308	300	385	456	302
Pulses	36	22	9	18	46	53	20	18	56
Treenuts	29	33	29	34	55	41	24	5	40
Oilcrops	26	16	8	31	43	32	21	22	13
Vegetable oils	485	523	153	427	677	664	397	342	630
Vegetables	83	133	78	54	165	106	86	61	105
Fruit (excluding wine)	126	121	119	137	203	136	81	77	163
Stimulants (tea etc.)	27	9	52	44	20	14	26	26	14
Spices	4	4	7	4	3	3	3	5	1
Alcoholic beverages	197	199	237	259	130	182	188	273	141
Animal products	1 082	1 141	1 229	1 067	829	929	1 353	1 195	937
Meat	429	308	432	368	330	461	552	447	407
Offals	15	25	3	13	13	13	30	59	12
Animal fats	226	420	446	334	41	63	294	234	151
Milk (excluding butter)	321	292	241	279	362	259	373	399	276
Eggs	49	56	59	47	40	54	62	27	50
Fish, seafood	42	40	47	27	44	78	42	29	41

Source: Faostat database, Food and Agriculture Organisation.

2.1.5 Total energy available from proteins in food for human consumption

	EU-15	B (1)	DK	D	EL	E	F	IRL	I
1970	11.6	11.8	9.9	11.2	12.8	12.2	12.7	12.3	11.4
1975	11.8	12.2	10.6	11.4	12.7	12.4	12.7	12.6	11.7
1980	12.1	12.3	11.2	11.6	12.8	12.7	13.3	12.6	12.0
1985	12.2	12.0	12.0	11.6	12.5	12.7	13.4	12.4	12.4
1990	12.3	11.7	12.5	11.9	12.7	12.8	13.2	12.6	12.3
1991	12.2	11.8	13.1	11.3	12.8	12.8	13.3	13.0	12.4
1992	12.0	11.7	12.3	11.1	12.5	12.7	13.0	12.4	12.5
1993	12.1	11.9	12.2	11.1	12.7	13.0	12.8	12.2	12.4
1994	12.2	11.6	12.3	11.4	12.7	13.3	12.9	12.0	12.4
1995	12.2	11.5	12.5	11.2	13.0	13.2	13.0	12.1	12.3
1996	12.2	11.3	12.8	11.3	13.0	13.0	13.0	12.4	12.5
1997	12.2	11.2	12.2	11.1	12.9	13.0	13.0	12.3	12.4
1998	12.3	11.4	12.3	11.4	12.9	13.2	13.0	12.3	12.4
1999	12.2	:	12.4	11.3	12.9	13.2	13.0	12.5	12.5

(1) Includes Luxembourg.
Source: World Health Organisation/Europe, Health for All database.

(kcal per person)

NL	A	P	FIN	S	UK	IS	NO	CH	
3 024	3 227	2 930	3 121	2 877	3 282	3 017	3 022	3 481	**1970**
3 047	3 145	3 109	3 198	2 922	3 128	2 975	2 979	3 230	**1975**
3 073	3 349	2 845	3 091	2 991	3 116	3 252	3 351	3 494	**1980**
3 105	3 373	3 060	2 963	2 981	3 191	3 161	3 195	3 348	**1985**
3 282	3 507	3 517	3 146	2 978	3 220	3 049	3 144	3 339	**1990**
3 344	3 543	3 546	3 120	2 954	3 188	3 120	3 211	3 253	**1991**
3 408	3 532	3 514	3 185	3 071	3 274	3 090	3 230	3 326	**1992**
3 327	3 512	3 570	3 040	3 148	3 233	3 074	3 269	3 283	**1993**
3 139	3 398	3 634	3 025	3 184	3 220	3 089	3 289	3 267	**1994**
3 186	3 550	3 630	3 107	3 120	3 136	3 086	3 276	3 260	**1995**
3 278	3 581	3 665	3 042	3 175	3 221	3 015	3 348	3 277	**1996**
3 284	3 536	3 667	3 100	3 194	3 276	3 117	3 357	3 223	**1997**
3 231	3 659	3 674	3 180	3 034	3 242	3 262	3 412	3 281	**1998**
3 243	3 639	3 768	3 143	3 141	3 318	3 313	3 425	3 258	**1999**

NL	A	P	FIN	S	UK	IS	NO	CH	
3 243	3 639	3 768	3 143	3 141	3 318	3 313	3 425	3 258	**Calories per day**
2 064	2 456	2 701	1 948	2 111	2 268	1 966	2 294	2 172	***Vegetable products***
572	910	1063	793	770	739	699	956	733	Cereals (excluding beer)
154	115	235	136	92	198	94	147	77	Starchy roots
455	452	330	391	436	370	611	459	504	Sweeteners
27	8	40	12	13	62	9	10	13	Pulses
25	37	22	8	19	9	5	23	63	Treenuts
18	34	11	14	20	37	22	10	18	Oilcrops
374	402	397	262	433	472	188	376	395	Vegetable oils
71	69	117	47	55	65	42	48	64	Vegetables
135	140	174	89	113	96	90	109	116	Fruit (excluding wine)
52	21	37	19	17	21	77	34	15	Stimulants (tea etc.)
11	6	1	3	4	5	4	4	5	Spices
170	257	264	168	133	187	102	112	170	Alcoholic beverages
1 178	1 183	1 067	1 195	1 030	1 050	1 347	1 132	1 086	***Animal products***
419	417	412	494	318	448	504	345	463	Meat
7	4	19	6	5	8	24	7	15	Offals
177	333	222	136	205	176	241	242	197	Animal fats
479	358	291	460	402	349	442	379	345	Milk (excluding butter)
62	50	36	36	45	35	22	39	40	Eggs
34	21	87	63	55	34	115	120	27	Fish, seafood

(%)

NL	A	P	FIN	S	UK	IS	NO	CH	
11.5	11.1	11.2	11.4	12.2	11.3	16.5	11.6	10.4	**1970**
11.8	11.5	11.0	11.8	12.6	11.4	16.9	12.4	10.9	**1975**
12.2	11.3	10.9	12.2	13.1	11.2	16.1	12.4	11.1	**1980**
12.5	11.4	11.6	12.5	12.9	11.6	16.1	12.6	11.5	**1985**
11.8	11.7	11.9	12.6	12.9	11.6	14.6	12.4	11.4	**1990**
11.8	11.6	11.9	12.5	12.8	11.5	14.7	12.2	11.7	**1991**
11.9	11.8	12.1	12.3	12.8	11.4	14.7	12.2	11.5	**1992**
12.5	11.7	12.2	12.2	12.8	11.4	15.0	12.3	11.3	**1993**
12.5	11.7	12.4	12.7	12.7	11.6	15.7	12.4	11.4	**1994**
12.9	11.8	12.3	12.9	12.6	11.7	15.3	12.5	11.2	**1995**
13.0	11.8	12.5	13.1	12.8	11.6	13.7	12.6	11.0	**1996**
13.2	11.7	12.6	12.9	12.7	11.7	14.2	12.5	11.0	**1997**
13.1	11.9	12.7	13.0	13.0	11.8	14.0	12.1	11.1	**1998**
12.8	11.7	12.8	12.9	12.9	11.7	13.9	12.2	10.9	**1999**

2.1.6 Average daily proteins per person according to type of food, 1999

	EU-15	B-L	D	DK	FIN	F	EL	IRL	I
Proteins per day	106	104.3	96.2	102.4	101.7	115.9	118.8	113.9	113.2
Vegetable products	42.0	39.8	38.5	37.8	35.8	39.8	54.6	41.9	51.4
Cereals (excluding beer)	26.1	23.6	23.6	23.5	24.2	26.4	33.4	27.9	35.5
Starchy roots	3.3	4.5	3.3	2.9	3.2	2.8	3.0	4.8	1.6
Sweeteners	0.1	0.1	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Pulses	2.4	1.4	1.2	0.6	0.8	1.3	2.9	1.2	3.7
Treenuts	0.8	0.8	0.9	0.8	0.2	0.6	1.5	0.1	1.0
Oilcrops	1.0	0.5	1.6	0.2	0.6	0.8	0.8	0.7	0.3
Vegetable oils	0.1	0.2	0.1	0.1	0.2	0	0	0.1	0.1
Vegetables	4.0	4.9	2.6	3.7	2.1	4.5	7.9	2.9	5.5
Fruit (excluding wine)	1.5	1.4	1.5	1.2	1.0	1.0	2.8	0.9	2.1
Stimulants (coffee etc.)	1.6	0.8	1.9	2.8	2.2	1.6	0.8	1.2	1.2
Spices	0.1	0.1	0.2	0.2	0.1	0.1	0.1	0.2	0.0
Alcoholic beverages	1.0	1.4	1.7	1.6	1.1	0.5	0.5	1.9	0.3
Animal products	64.1	64.5	57.7	64.5	65.9	76.1	64.2	72.0	61.7
Meat	30.2	27.0	27.1	34.2	22.4	34.2	28.1	33.1	31.8
Offals	2.3	4.0	2.1	0.5	0.9	4.9	1.9	9.5	1.9
Animal fats	0.4	0.7	0.7	0.7	0.6	0.6	0.2	0.7	0.3
Milk (excluding butter)	20.7	23.0	20.0	17.9	29.6	24.9	23.3	22.2	17.4
Eggs	3.9	4.5	3.8	4.8	2.9	5.0	3.2	2.2	4.0
Fish, seafood	6.5	5.3	4.0	6.4	9.4	6.4	7.5	4.2	6.3

Source: Faostat database, Food and Agriculture Organisation.

2.1.7 Average availability of some selected foods

(grams/person/day)

	B	D	EL	IRL	L	NO	E	UK
	1987/88	**1988**	**1993/94**	**1987**	**1993**	**1992/94**	**1990/91**	**1993**
Meat	168.0	140.0	151.0	138.0	185.0	128.0	178.0	138.0
Fruits	198.0	202.0	282.0	103.0	234.0	174.0	308.0	132.0
Fish	26.0	12.0	38.0	10.0	28.0	53.0	75.0	21.0
Vegetables	162.0	141.0	229.0	130.0	180.0	102.0	180.0	158.0
Pasta	7.3	8.6	24.0	3.5	25.0	4.9	10.0	8.9
Milk	153.0	207.0	190.0	484.0	154.0	338.0	349.0	288.0
Cereals	11.0	24.0	17.0	33.0	28.0	17.0	17.0	35.0

Source: DAFNE ('Data food networking'), Athens.

(grams)

NL	A	P	E	S	UK	NO	IS	CH	
104.0	106.0	120.7	110.7	101.3	96.8	104.1	114.7	88.6	**Proteins per day**
32.5	41.6	50.0	41.0	34.5	41.7	40.8	37.9	34.5	***Vegetable products***
17.8	27.1	30.7	22.9	23.2	23.5	28.7	27.4	22.5	Cereals (excluding beer)
3.6	2.6	5.5	3.7	2.1	4.7	3.5	2.1	1.8	Starchy roots
0.1	0.0	0.1	0.0	0.1	0.1	0.0	:	0.0	Sweeteners
1.8	0.5	2.5	3.3	0.9	4.1	0.6	0.6	0.9	Pulses
0.7	0.9	0.5	1.2	0.5	0.3	0.6	0.1	1.6	Treenuts
0.6	1.7	0.3	1.0	0.8	1.5	0.3	0.9	1.0	Oilcrops
0.2	0.1	0.1	0.1	0.2	0	0.2	:	0.1	Vegetable oils
3.1	3.3	5.9	4.9	2.5	3.1	2.1	1.9	3.2	Vegetables
1.4	1.5	2.0	1.8	1.3	1.1	1.3	1.0	1.4	Fruit (excluding wine)
1.9	2.0	1.2	1.2	2.0	1.7	2.3	2.5	1.2	Stimulants (coffee etc.)
0.3	0.2	0	0.1	0.1	0.2	0.1	0.1	0.2	Spices
1.1	1.6	0.9	0.9	0.8	1.4	0.8	0.6	0.7	Alcoholic beverages
71.5	64.5	70.7	69.6	66.8	55.1	63.4	76.8	54.1	***Animal products***
29.1	32.3	32.0	36.4	26.1	26.1	18.4	29.0	23.2	Meat
1.0	0.6	3.0	2.0	0.7	1.1	1.1	3.2	2.5	Offals
0.1	0.4	0.1	0.1	0.8	0.1	0.7	0.7	0.2	Animal fats
31.0	24.3	17.9	14.6	27.6	19.5	24.3	23.5	21.4	Milk (excluding butter)
5.0	4.0	2.9	4.4	3.6	2.8	3.2	1.8	3.2	Eggs
5.3	2.8	14.7	12.2	7.9	5.4	15.8	18.6	3.6	Fish, seafood

2.1.8 Food and non-alcoholic beverages — Mean consumption expenditure and structure of household expenditure, 1999

	B	DK	EL	E	F(1)	IRL(2)	I
MEAN CONSUMPTION EXPENDITURE (PPS PER HOUSEHOLD) (*)							
Food	3 303	2 725	3 680	3 508	3 399	4 014	4 748
Bread and cereals	647	511	459	572	631	723	891
Meat	981	666	939	1 043	1 005	1 122	1 268
Fish and seafood	209	129	304	496	218	110	438
Milk, cheese and eggs	442	434	591	509	495	603	753
Oils and fats	92	87	354	137	89	104	237
Fruit	233	174	320	290	250	216	477
Vegetables	339	296	455	291	400	503	457
Sugar, jam, chocolate, confectionery	248	355	223	121	173	396	184
Food products not elsewhere classified	113	74	35	49	138	237	44
Non-alcoholic beverages	354	348	212	202	223	485	431
Coffee, tea and cocoa	85	130	81	75	74	100	171
Mineral waters, soft drinks, juices	269	218	131	126	149	385	260
STRUCTURE OF EXPENDITURE (% OF TOTAL HOUSEHOLD EXPENDITURE)							
Food	12.1	11.6	15.7	17.3	15.2	13.6	17.4
Bread and cereals	2.4	2.2	2.0	2.8	2.8	2.4	3.3
Meat	3.6	2.8	4.0	5.1	4.5	3.8	4.7
Fish and seafood	0.8	0.6	1.3	2.4	1.0	0.4	1.6
Milk, cheese and eggs	1.6	1.9	2.5	2.5	2.2	2.0	2.8
Oils and fats	0.3	0.4	1.5	0.7	0.4	0.4	0.9
Fruit	0.8	0.7	1.4	1.4	1.1	0.7	1.8
Vegetables	1.2	1.3	1.9	1.4	1.8	1.7	1.7
Sugar, jam, chocolate, confectionery	0.9	1.5	1.0	0.6	0.8	1.3	0.7
Food products not elsewhere classified	0.4	0.3	0.1	0.2	0.6	0.8	0.2
Non-alcoholic beverages	1.3	1.5	0.9	1.0	1.0	1.6	1.6
Coffee, tea and cocoa	0.3	0.6	0.3	0.4	0.3	0.3	0.6
Mineral waters, soft drinks, juices	1.0	0.9	0.6	0.6	0.7	1.3	1.0

(*) PPS = purchasing power standards.
(1) 1994.
(2) Provisional.
Note: No data are available for Germany and Sweden.
Source: Eurostat, NewCronos database (Household Budget Survey).

2.1.9 Trends in household expenditure on food and non-alcoholic beverages, 1988, 1994 and 1999

MEAN CONSUMPTION EXPENDITURE (PPS PER HOUSEHOLD) (*)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1988	2 980	2 724	:	2 487	3 498	4 027	2 866	:	4 068	4 022	2 214	:	3 527	:	:	2 479
1994	3 375	2 735	2 592	2 786	3 153	4 469	3 622	4 121	4 818	4 764	2 454	3 754	3 461	2 525	3 198	2 724
1999	:	3 657	3 073	2 605	3 892	3 709	:	4 499	5 180	4 361	2 697	3 535	:	2 581	3 329	2 897

STRUCTURE OF EXPENDITURE (% OF TOTAL HOUSEHOLD EXPENDITURE)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1988	18.1	16.1	:	14.8	22.6	26.2	17.3	:	23.8	15.1	13.4	:	29.6	:	:	14.3
1994	16.1	12.0	13.5	13.5	17.8	22.8	16.2	18.5	21.1	12.3	12.1	15.4	21.2	15.8	17.8	13.3
1999	:	13.3	13.1	11.1	16.6	18.3	:	15.4	19.0	10.1	10.5	13.4	:	14.2	15.4	10.5

(*) PPS = purchasing power standards.
Source: Eurostat, NewCronos database (Household Budget Survey).

L	NL	A	P(1)	FIN	UK	
						MEAN CONSUMPTION EXPENDITURE (PPS PER HOUSEHOLD) (*)
3 911	2 437	3 181	3 348	2 351	2 638	**Food**
708	455	576	523	443	561	Bread and cereals
1 172	568	768	1 010	490	651	Meat
219	67	81	528	91	103	Fish and seafood
569	416	477	406	449	361	Milk, cheese and eggs
143	69	120	195	71	61	Oils and fats
338	207	264	254	175	187	Fruit
378	322	277	328	235	402	Vegetables
265	187	272	88	204	202	Sugar, jam, chocolate, confectionery
119	147	346	16	194	111	Food products not elsewhere classified
450	260	354	112	230	259	**Non-alcoholic beverages**
144	93	128	47	98	85	Coffee, tea and cocoa
306	168	226	66	132	174	Mineral waters, soft drinks, juices
						STRUCTURE OF EXPENDITURE (% OF TOTAL HOUSEHOLD EXPENDITURE)
9.1	9.5	12.0	20.5	12.9	9.5	**Food**
1.6	1.8	2.2	3.2	2.4	2.0	Bread and cereals
2.7	2.2	2.9	6.2	2.7	2.4	Meat
0.5	0.3	0.3	3.2	0.5	0.4	Fish and seafood
1.3	1.6	1.8	2.5	2.5	1.3	Milk, cheese and eggs
0.3	0.3	0.5	1.2	0.4	0.2	Oils and fats
0.8	0.8	1.0	1.6	1.0	0.7	Fruit
0.9	1.3	1.0	2.0	1.3	1.5	Vegetables
0.6	0.7	1.0	0.5	1.1	0.7	Sugar, jam, chocolate, confectionery
0.3	0.6	1.3	0.1	1.1	0.4	Food products not elsewhere classified
1.0	1.0	1.3	0.7	1.3	0.9	**Non-alcoholic beverages**
0.3	0.4	0.5	0.3	0.5	0.3	Coffee, tea and cocoa
0.7	0.7	0.9	0.4	0.7	0.6	Mineral waters, soft drinks, juices

2.1.10 Structure of consumption expenditure on food and non-alcoholic beverages (Coicop level 2), 1999

	B	DK	D	EL	E	IRL	I
By socioeconomic category							
Manual workers in industry and services	14.9	13.3	11.3	18.0	19.5	16.1	17.8
Non-manual workers in industry and services	12.7	12.6	:	13.2	14.6	13.5	:
Self-employed	12.7	12.4	10.0	16.8	19.0	16.3	16.9
Unemployed	14.2	15.4	13.5	18.2	20.7	21.0	22.1
Retired	13.9	13.8	:	19.6	21.6	16.3	21.0
Inactives — other	14.2	14.4	11.8	15.8	20.1	19.0	21.3
Unknown	:	:	:	:	:	19.6	:
By income quintile							
First quintile	16.9	15.5	15.5	24.0	24.9	18.1	25.1
Second quintile	14.9	14.8	13.5	20.6	21.6	16.8	22.4
Third quintile	14.0	13.7	12.1	18.4	19.6	15.9	20.1
Fourth quintile	12.9	12.8	10.8	15.8	17.4	14.2	18.0
Fifth quintile	10.6	11.2	8.2	12.1	13.3	13.1	14.0
By type of household							
Single person	11.0	12.2	9.5	13.1	15.7	12.7	18.9
Single parent with dependent children	13.4	14.4	12.8	13.9	15.6	18.0	19.0
Two adults	13.1	12.6	10.6	18.3	18.8	14.6	19.0
Two adults with dependent children	14.2	13.9	12.5	16.0	17.1	16.4	18.9
Three or more adults	15.7	13.6	11.4	17.2	19.6	13.5	19.2
Three or more adults with dependent children	14.3	14.5	12.3	18.1	19.9	16.6	19.7
By age of the reference person							
Less than 30 years	11.7	12.3	10.4	13.0	15.4	12.5	15.9
Between 30 and 44 years	13.2	13.7	11.7	15.1	16.6	15.6	17.1
Between 45 and 59 years	13.7	12.5	11.2	15.8	17.8	15.7	18.4
60 years and over	13.8	13.5	10.5	19.7	21.2	16.6	21.4
By degree of urbanisation							
Densely-populated area (at least 500 inhabitants/km^2)	13.2	13.1	:	:	16.9	:	18.4
Intermediate urbanised area (between 100 and 499 inhabitants/km^2)	13.5	12.5	:	:	18.3	:	19.5
Sparsely-populated area (less than 100 inhabitants/km^2)	14.2	14.1	:	:	21.0	:	20.4

No data are available for France and Portugal.
Coicop — Classification of individual consumption by purpose.
Source: Eurostat, NewCronos database (Household Budget Survey).

2.1.11 Responses to 'Do you eat a good, balanced diet?', 1999

		EU-15	B	DK	D	EL	E	F	IRL
Total	Yes	74.3	81.3	84.0	80.2	69.7	79.8	82.1	85.7
	No	23.5	17.5	14.5	16.3	28.7	18.3	17.0	12.7
	Don't know	2.2	1.2	1.5	3.5	1.5	1.9	0.9	1.6
Men	Yes	70.0	75.5	82.6	77.0	68.1	75.5	79.6	83.4
	No	27.7	22.6	15.7	19.9	31.1	22.0	19.7	15.2
	Don't know	2.4	1.9	1.7	3.2	0.9	2.5	0.7	1.5
Women	Yes	78.3	86.6	85.2	83.2	71.3	83.9	84.4	88.0
	No	19.5	12.8	13.4	12.9	26.5	14.8	14.5	10.4
	Don't know	2.1	0.6	1.3	3.9	2.2	1.3	1.1	1.7

Source: Eurobarometer 52.1, European Commission.

(%)

L	NL	A	FIN	S	UK	
						By socioeconomic category
11.9	10.2	14.8	14.9	16.7	11.5	Manual workers in industry and services
7.9	9.9	10.7	12.5	14.2	9.3	Non-manual workers in industry and services
9.4	10.7	13.7	14.3	14.0	9.6	Self-employed
10.8	13.3	15.3	16.7	16.6	12.9	Unemployed
11.9	11.2	15.3	16.6	16.4	12.0	Retired
10.7	12.0	14.1	12.2	16.2	12.8	Inactives — other
12.4	:	:	:	:	:	Unknown
						By income quintile
14.2	13.0	17.9	17.0	17.5	15.1	First quintile
12.5	12.8	15.5	17.0	16.5	12.9	Second quintile
10.5	10.8	13.9	14.9	16.8	11.3	Third quintile
9.3	9.8	13.4	13.8	15.0	10.2	Fourth quintile
7.5	8.4	9.7	11.5	12.8	7.6	Fifth quintile
						By type of household
8.0	9.0	10.7	13.0	14.3	9.0	Single person
9.5	11.8	13.6	16.1	15.4	13.2	Single parent with dependent children
9.4	10.1	12.8	13.6	14.7	10.1	Two adults
10.6	11.7	13.5	14.9	16.5	11.3	Two adults with dependent children
11.7	10.1	15.8	16.1	15.3	10.6	Three or more adults
12.1	11.4	17.0	15.4	19.3	11.1	Three or more adults with dependent children
						By age of the reference person
7.4	8.3	12.5	10.9	14.6	9.0	Less than 30 years
9.9	10.9	12.0	14.1	15.4	10.3	Between 30 and 44 years
9.9	10.5	13.8	14.0	15.2	10.2	Between 45 and 59 years
11.6	11.3	15.3	16.5	16.1	12.1	60 years and over
						By degree of urbanisation
9.6	:	11.5	13.3	14.0	10.3	Densely-populated area (at least 500 inhabitants/km²)
10.2	:	13.4	14.5	14.8	10.5	Intermediate urbanised area (between 100 and 499 inhabitants/km²)
10.5	:	15.6	16.5	16.2	10.9	Sparsely-populated area (less than 100 inhabitants/km²)

(%)

I	L	NL	A	P	FIN	S	UK		
48.3	77.0	77.2	82.8	58.6	80.1	79.8	78.3	**Total**	Yes
48.3	19.9	20.0	12.7	40.2	17.2	18.5	20.8		No
3.4	3.0	2.8	4.5	1.2	2.7	1.8	0.9		Don't know
40.9	71.4	72.5	81.8	52.6	76.7	75.6	72.7	**Men**	Yes
55.7	25.3	23.3	12.4	46.0	20.2	21.6	26.0		No
3.4	3.2	4.2	5.9	1.4	3.1	2.9	1.3		Don't know
55.2	82.2	81.7	83.7	64.0	83.2	83.8	83.6	**Women**	Yes
41.4	15.0	16.9	13.1	35.0	14.5	15.5	15.9		No
3.4	2.8	1.4	3.2	0.9	2.3	0.7	0.5		Don't know

2.1.12 Responses to 'Do you eat a good, balanced diet?', by age, 1999

		EU-15	B	DK	D	EL	E	F	IRL
15–24	Yes	65.4	71.0	62.9	68.6	54.8	78.2	77.2	79.3
	No	32.3	26.2	34.8	27.4	41.2	20.2	22.82	0.5
	Don't know	2.3	2.8	2.3	4.0	4.0	1.6	:	0.2
25–39	Yes	70.8	77.0	82.1	74.5	65.3	74.0	79.8	82.4
	No	26.7	21.6	16.5	21.5	33.3	21.8	19.5	15.2
	Don't know	2.6	1.5	1.4	3.9	1.4	4.1	0.7	2.3
40–54	Yes	72.5	80.4	89.0	80.0	73.9	78.9	80.5	85.5
	No	25.0	18.7	9.6	16.0	25.5	19.9	17.5	11.4
	Don't know	2.5	0.9	1.5	3.9	0.6	1.1	2.0	3.1
55+	Yes	83.0	90.4	91.8	89.7	78.4	87.1	88.2	93.4
	No	15.2	9.1	6.9	7.5	20.7	12.6	11.0	5.9
	Don't know	1.7	0.5	1.2	2.8	0.9	0.3	0.8	0.8

Source: Eurobarometer 52.1, European Commission.

2.1.13 Responses to 'Do you eat a good, balanced diet?', by professional status

		EU-15	B	DK	D	EL	E	F	IRL
Self-employed	Yes	70	71	89	84	71	78	85	88
	No	27	27	9	11	29	19	15	12
	Don't know	3	2	2	5	1	3	:	:
Managers	Yes	75	67	87	81	70	68	72	94
	No	23	33	11	16	30	28	28	4
	Don't know	2	:	2	3	:	4	:	2
Other white collar	Yes	69	80	73	76	60	71	80	80
	No	29	17	22	19	39	27	19	15
	Don't know	3	2	5	5	1	2	1	5
Manual workers	Yes	71	79	84	74	69	79	76	88
	No	27	21	14	22	31	19	22	11
	Don't know	2	0	2	4	:	2	2	2
Houseperson	Yes	81	91	100	90	75	91	93	91
	No	17	9	:	5	22	8	6	7
	Don't know	2	:	:	6	3	0	1	2
Unemployed	Yes	65	78	85	74	67	70	78	59
	No	33	20	15	24	33	25	20	38
	Don't know	3	2	:	3	:	5	2	3
Retired	Yes	84	90	91	90	78	85	92	95
	No	14	9	8	8	21	15	7	5
	Don't know	2	1	1	2	1	:	1	:
Students	Yes	68	74	73	67	57	81	78	78
	No	30	23	27	30	38	19	22	22
	Don't know	2	3	:	3	5	1	:	:

Source: Eurobarometer 52.1, European Commission.

2.1.14 Adults (15+) selecting factors perceived to be among the three most important influences on food choice, 1996

(%)

	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Quality/freshness	76	64	76	75	80	77	49	84	68	73	90	66	67	73	59
Price	34	39	40	18	52	57	30	29	18	36	54	38	62	59	43
Taste	46	29	31	47	22	42	45	40	49	41	25	40	41	37	49
Trying to eat healthily	37	48	31	32	32	25	35	25	24	28	50	34	40	30	40
Family preferences	29	22	29	38	25	21	36	36	18	36	32	24	17	31	30
Habit	19	18	26	28	20	20	29	19	18	21	10	21	20	21	20
Convenience	12	25	11	11	11	13	13	15	14	16	8	12	17	17	15
Content of additives	11	17	7	5	5	5	5	5	21	9	8	5	7	8	5

Source: Institute of European Food Studies (IEFS), 1996: 'A pan-EU survey on consumer attitudes to food', *Nutrition & Health* (2).

(%)

I	L	NL	A	P	FIN	S	UK		
40.7	50.7	69.5	76.8	58.1	69.7	52.5	64.5	**15–24**	Yes
56.4	47.3	29.0	17.9	39.8	28.1	45.0	33.4		No
2.9	2.0	1.6	5.4	2.1	2.2	2.5	2.1		Don't know
49.8	71.2	75.9	83.2	55.4	75.4	72.3	70.0	**25–39**	Yes
45.8	26.5	21.3	13.7	44.2	22.3	25.4	29.4		No
4.3	2.2	2.8	3.1	0.3	2.3	2.3	0.6		Don't know
39.5	81.2	72.8	80.9	54.2	77.3	85.6	80.9	**40–54**	Yes
58.1	14.9	22.8	11.5	44.8	17.3	12.9	17.9		No
2.4	3.9	4.4	7.6	1.1	5.4	1.4	1.2		Don't know
57.0	89.1	86.7	86.5	64.9	91.7	93.3	91.3	**55+**	Yes
39.4	7.4	11.3	10.2	33.7	7.5	5.5	8.3		No
3.6	3.4	2.0	3.3	1.4	0.8	1.2	0.4		Don't know

(%)

I	L	NL	A	P	FIN	S	UK		
40	80	66	76	56	85	85	85	**Self-employed**	Yes
55	20	28	20	43	13	14	15		No
5	:	6	4	1	2	1	:		Don't know
53	76	77	85	61	88	79	85	**Managers**	Yes
43	16	22	12	39	10	19	14		No
4	8	1	4	:	2	3	1		Don't know
46	63	73	79	47	74	81	66	**Other white collar**	Yes
51	34	24	19	50	23	19	32		No
3	3	3	3	4	3	:	1		Don't know
38	70	72	79	46	73	74	73	**Manual workers**	Yes
60	28	24	14	53	23	23	26		No
2	2	3	6	0	4	3	1		Don't know
55	95	87	89	68	89	83	81	**Houseperson**	Yes
42	4	11	8	32	11	8	19		No
3	2	1	3	:	:	9	0		Don't know
35	78	85	70	54	62	66	59	**Unemployed**	Yes
63	16	15	30	46	32	31	39		No
2	6	:	:	:	5	2	2		Don't know
59	87	84	89	70	92	94	91	**Retired**	Yes
37	11	13	6	28	8	4	9		No
4	3	3	4	2	1	1	0		Don't know
51	47	68	80	61	71	65	67	**Students**	Yes
47	51	29	12	37	25	34	30		No
2	2	4	8	2	4	1	3		Don't know

2.1.15 Adults (15+) selecting 'trying to eat healthily' as an important influence on food choice, by sex and age, 1996

(%)

	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Males															
15–35	26	26	25	29	28	17	23	17	14	16	35	30	25	18	32
36–54	37	43	29	25	21	21	28	23	22	23	48	30	36	19	34
55+	36	45	29	37	34	24	34	22	34	16	52	29	44	32	37
Females															
15–35	37	56	36	35	36	29	37	32	20	33	51	41	39	25	35
36–54	44	63	35	35	44	32	46	31	28	39	53	37	52	40	50
55+	45	63	33	38	28	30	53	26	34	33	57	36	46	52	53

Source: Institute of European Food Studies (IEFS) 1996: 'A pan-EU survey on consumer attitudes to food', *Nutrition & Health* (2).

2.2.1 Responses to 'Do you exercise at least twice a week?', 1999

		EU-15	B	DK	D	EL	E	F	IRL
Total	Yes	39.7	29.7	54.9	28.2	18.8	40.6	46.8	64.6
	No	59.6	69.8	44.7	70.6	80.3	59.0	52.6	34.4
	Don't know	0.7	0.5	0.4	1.2	0.9	0.3	0.6	1.0
Men	Yes	44.1	36.6	55.0	33.4	23.9	43.9	52.8	63.6
	No	55.4	62.5	44.4	65.8	75.5	56.1	47.0	36.0
	Don't know	0.5	1.0	0.6	0.8	0.6	:	0.2	0.3
Women	Yes	35.6	23.3	54.8	23.4	13.9	37.5	41.3	65.5
	No	63.5	76.7	45.0	75.1	84.9	61.8	57.7	32.9
	Don't know	0.8	-	0.2	1.5	1.3	0.6	1.0	1.6

Source: Eurobarometer 52.1, European Commission.

2.2.2 Responses to 'Do you exercise at least twice a week?' by age, 1999

		EU-15	B	DK	D	EL	E	F	IRL
15–24	Yes	58.5	46.8	51.0	55.4	45.1	59.7	48.6	69.9
	No	41.5	52.3	49.0	43.3	54.8	40.3	51.4	29.9
	Don't know	:	0.8	:	1.3	0.2	:	:	0.2
25–39	Yes	39.8	29.8	49.6	31.1	17.1	34.9	43.9	68.2
	No	59.3	69.9	49.5	66.9	81.8	64.0	55.5	31.0
	Don't know	0.9	0.4	1.0	2.0	1.1	1.1	0.6	0.8
40–54	Yes	36.9	28.2	51.0	27.6	12.1	37.7	41.9	64.8
	No	63.0	71.8	49.0	72.1	87.1	62.3	58.1	33.9
	Don't know	0.1	-	-	0.4	0.8	-	-	1.3
55+	Yes	34.4	22.7	65.2	15.7	10.7	36.4	52.2	57.5
	No	64.8	76.6	34.4	83.3	87.9	63.6	46.4	41.0
	Don't know	0.8	0.7	0.5	1.0	1.3	-	1.3	1.5

Source: Eurobarometer 52.1, European Commission.

2.2.3 Smoking, diet and satisfaction with own health status, by regular exercise, EU-15, 1999

Do you exercise at least twice a week?		Yes	No	Don't know
Do you eat a good, balanced diet?	Yes	81.2	69.9	51.5
	No	17.3	27.6	18.8
	Don't know	1.5	2.4	29.7
Do you smoke?	Yes	30.0	36.4	26.6
	No	69.6	63.5	58.0
	Don't know	0.4	0.1	15.4
Satisfaction with own health	Very satisfied	36.8	22.7	21.9
	Fairly satisfied	51.1	55.8	56.4
	Not very satisfied	9.8	17.6	14.2
	Not at all satisfied	1.9	3.7	2.6
	Don't know	0.3	0.2	4.9

Source: Eurobarometer 52.1, European Commission.

(%)

I	L	NL	A	P	FIN	S	UK		
26.7	77.8	55.8	40.6	23.6	76.0	57.7	57.1	**Total**	Yes
72.8	20.8	43.7	58.7	76.1	22.9	42.3	42.5		No
0.5	1.4	0.6	0.7	0.3	1.0	0.0	0.5		Don't know
32.0	80.0	53.9	45.3	32.9	72.4	57.0	60.7	**Men**	Yes
67.3	19.2	44.9	53.9	66.5	26.5	43.0	39.1		No
0.7	0.8	1.1	0.7	0.6	1.0	:	0.2		Don't know
21.7	75.8	57.5	36.2	15.3	79.4	58.5	53.7	**Women**	Yes
77.9	22.2	42.5	63.1	84.7	19.6	41.5	45.7		No
0.4	2.0	-	0.7	-	1.0	-	0.7		Don't know

(%)

I	L	NL	A	P	FIN	S	UK		
44.6	87.7	57.1	58.5	55.0	72.6	59.9	63.9	**15–24**	Yes
53.9	11.6	42.2	41.5	45.0	25.9	40.1	34.7		No
1.5	0.6	0.7	:	:	1.4	:	1.3		Don't know
35.1	73.4	47.9	44.1	26.5	67.0	49.3	54.5	**25–39**	Yes
64.6	25.6	50.7	55.2	72.5	31.9	50.7	45.5		No
0.4	0.9	1.4	0.7	1.0	1.2	:	0.0		Don't know
21.2	76.3	57.3	46.3	14.1	76.2	46.8	55.7	**40–54**	Yes
78.8	21.4	42.7	52.9	85.9	23.0	53.2	44.3		No
-	2.3	-	0.8	-	0.8	-	-		Don't know
16.0	78.7	62.6	24.6	8.1	85.1	71.6	57.1	**55+**	Yes
83.4	19.8	37.4	74.4	91.9	13.9	28.4	42.1		No
0.6	1.5	-	1.0	-	0.9	-	0.8		Don't know

2.2.4 Responses to 'Is your lifestyle healthy?', 1999

		EU-15	B	DK	D	EL	E	F	IRL
Total	Yes	80.8	84.1	79.3	81.2	64.4	89.1	88.2	86.4
	No	16.0	13.9	18.8	14.7	34.5	9.4	10.5	11.8
	Don't know	3.2	2.0	1.9	4.2	1.1	1.4	1.3	1.8
Men	Yes	78.1	82.3	78.8	79.0	60.7	87.7	85.7	83.5
	No	18.5	15.6	19.6	17.3	38.6	10.5	12.8	14.6
	Don't know	3.4	2.1	1.6	3.8	0.7	1.8	1.5	1.9
Women	Yes	83.4	85.8	79.7	83.2	68.0	90.5	90.5	89.1
	No	13.7	12.3	18.1	12.2	30.5	8.5	8.3	9.2
	Don't know	2.9	1.9	2.2	4.6	1.4	1.1	1.2	1.7

Source: Eurobarometer 52.1, European Commission.

2.2.5 Responses to 'Is your lifestyle healthy?' by age, 1999

		EU-15	B	DK	D	EL	E	F	IRL
15–24	Yes	79.8	78.1	59.5	79.9	58.2	87.8	85.5	86.1
	No	17.1	17.4	37.6	15.2	39.7	10.0	14.1	12.5
	Don't know	3.1	4.4	2.9	4.9	2.1	2.2	0.3	1.3
25–39	Yes	78.9	82.7	79.6	79.6	55.8	89.2	84.6	82.3
	No	17.9	15.5	18.7	16.2	43.9	9.6	14.0	15.8
	Don't know	3.3	1.9	1.8	4.1	0.3	1.3	1.4	2.0
40–54	Yes	76.8	84.3	80.4	76.4	63.4	87.5	85.8	84.4
	No	20.3	15.2	19.0	20.1	35.1	11.4	12.2	13.0
	Don't know	2.9	0.4	0.6	3.5	1.5	1.1	2.0	2.6
55+	Yes	85.9	88.0	88.1	86.1	75.2	91.0	94.8	91.7
	No	10.8	9.8	9.2	9.4	23.9	7.7	3.9	6.9
	Don't know	3.2	2.1	2.7	4.5	0.9	1.3	1.3	1.4

Source: Eurobarometer 52.1, European Commission.

2.2.6 Responses to 'Is your lifestyle healthy?' by professional status, 1999

		EU-15	B	DK	D	EL	E	F	IRL
Self-employed	Yes	76.2	80.4	78.9	78.4	65.8	89.6	85.2	88.8
	No	20.3	16.9	19.0	16.1	34.2	6.6	14.8	9.5
	Don't know	3.5	2.7	2.1	5.5	-	3.8	-	1.7
Managers	Yes	78.8	80.9	77.7	79.6	67.1	75.5	89.7	90.3
	No	17.4	19.1	20.1	14.3	32.9	22.9	9.4	9.0
	Don't know	3.8	-	2.2	6.2	-	1.6	0.9	0.8
Other white collar	Yes	78.3	87.9	78.0	82.3	51.4	85.1	85.5	80.8
	No	17.7	10.8	20.8	14.4	46.7	12.9	13.4	17.2
	Don't know	4.0	1.3	1.2	3.3	1.8	2.0	1.1	1.9
Manual workers	Yes	79.4	84.2	80.7	78.3	57.0	89.0	84.8	85.4
	No	17.1	14.2	17.2	16.8	43.0	9.4	13.2	12.7
	Don't know	3.4	1.6	2.1	4.9	-	1.7	2.0	2.0
Houseperson	Yes	86.3	89.1	100.0	84.7	69.6	93.3	95.7	91.2
	No	11.7	10.9	-	12.2	27.0	6.2	4.3	7.9
	Don't know	2.0	-	-	3.1	3.4	0.5	-	1.0
Unemployed	Yes	72.7	73.0	68.3	75.8	64.2	87.1	78.8	60.9
	No	25.7	23.6	31.7	22.5	35.8	12.9	19.6	32.4
	Don't know	1.6	3.3	-	1.6	-	-	1.6	6.7
Retired	Yes	85.9	88.9	88.2	87.2	70.6	94.8	95.1	88.0
	No	10.9	9.2	9.5	9.0	29.1	4.5	3.0	9.8
	Don't know	3.2	1.9	2.3	3.9	0.3	0.7	1.9	2.2
Students	Yes	80.2	76.4	67.0	78.4	62.7	88.3	84.4	89.0
	No	16.8	18.6	30.6	18.3	34.7	10.6	14.1	10.1
	Don't know	3.1	5.0	2.4	3.3	2.5	1.0	1.5	0.9

Source: Eurobarometer 52.1, European Commission.

(%)

I	L	NL	A	P	FIN	S	UK		
73.6	80.4	74.9	82.5	81.5	78.1	78.4	78.7	**Total**	Yes
19.2	16.6	22.1	11.8	17.0	19.0	19.7	19.8		No
7.2	3.0	2.9	5.8	1.5	2.8	1.8	1.5		Don't know
70.3	77.2	71.7	81.6	83.0	72.9	77.5	73.5	**Men**	Yes
20.7	20.6	25.5	11.7	16.2	24.0	20.9	24.8		No
9.1	2.1	2.8	6.7	0.7	3.1	1.6	1.7		Don't know
76.7	83.2	78.0	83.2	80.1	83.0	79.3	83.6	**Women**	Yes
17.9	13.0	18.9	11.9	17.7	14.4	18.6	15.1		No
5.5	3.8	3.0	4.9	2.2	2.6	2.0	1.3		Don't know

(%)

I	L	NL	A	P	FIN	S	UK		
74.4	69.1	72.3	82.3	93.1	73.4	72.3	78.7	**15–24**	Yes
19.4	29.2	26.4	9.7	6.2	22.2	26.6	19.3		No
6.2	1.7	1.4	8.0	0.7	4.5	1.0	2.1		Don't know
72.1	74.0	71.1	82.2	83.6	74.5	75.4	75.7	**25–39**	Yes
18.5	22.3	25.1	12.8	16.0	23.8	22.6	23.1		No
9.4	3.7	3.8	5.0	0.4	1.7	2.0	1.1		Don't know
68.0	79.9	72.6	83.5	78.3	70.3	74.2	72.8	**40–54**	Yes
25.9	17.6	25.4	13.5	21.7	25.2	23.1	25.1		No
6.1	2.5	2.1	3.0		4.5	2.7	2.1		Don't know
78.4	90.5	82.7	82.0	74.5	90.9	86.7	85.8	**55+**	Yes
14.9	6.4	13.7	10.4	21.5	7.7	11.9	13.2		No
6.7	3.2	3.6	7.5	4.0	1.4	1.4	1.0		Don't know

(%)

I	L	NL	A	P	FIN	S	UK		
60.8	79.2	55.2	81.5	85.8	84.9	81.4	81.3	**Self-employed**	Yes
31.3	19.3	41.2	14.2	13.0	13.3	16.8	18.6		No
7.9	1.5	3.7	4.3	1.2	1.9	1.8	0.1		Don't know
75.9	78.8	70.8	86.4	85.5	81.4	68.8	73.9	**Managers**	Yes
16.2	21.2	28.3	8.7	14.5	16.2	30.6	24.0		No
8.0	-	0.9	4.9	-	2.4	0.6	2.0		Don't know
70.5	68.9	74.1	82.6	78.3	63.1	79.6	72.0	**Other white collar**	Yes
16.3	27.8	23.3	14.4	20.9	29.9	18.4	26.7		No
13.2	3.2	2.6	3.1	0.8	6.9	2.0	1.3		Don't know
70.3	71.2	74.2	80.3	84.4	72.0	76.1	78.3	**Manual workers**	Yes
22.1	22.3	22.8	13.8	15.6	24.4	22.2	19.7		No
7.6	6.6	3.0	5.8	-	3.7	1.8	2.0		Don't know
82.1	93.1	82.5	80.4	80.3	87.2	90.9	85.6	**Houseperson**	Yes
15.0	4.6	14.0	14.1	16.9	12.8	-	12.8		No
2.9	2.3	3.5	5.5	2.8	-	9.1	1.6		Don't know
63.7	81.6	72.5	70.6	73.0	65.7	72.3	65.2	**Unemployed**	Yes
33.4	18.4	27.5	21.8	27.0	32.4	21.7	34.8		No
2.9	-	-	7.6	-	1.9	6.0	-		Don't know
80.4	88.8	78.0	86.1	72.2	88.9	86.3	81.6	**Retired**	Yes
12.5	8.3	18.0	7.5	25.2	9.8	12.3	17.1		No
7.1	2.9	4.0	6.4	2.7	1.3	1.4	1.3		Don't know
78.6	72.2	70.0	81.4	90.8	72.3	75.6	83.7	**Students**	Yes
15.5	26.6	27.5	8.6	6.5	22.8	23.3	14.4		No
5.8	1.2	2.5	10.0	2.7	4.9	1.0	1.8		Don't know

2.2.7 Smoking, diet, drinking and physical exercise, by healthy lifestyle, EU-15, 1999

Is your lifestyle healthy?		Yes	No	Don't know
Do you eat a good, balanced diet?	Yes	83.4	35.0	41.6
	No	15.2	63.0	35.9
	Don't know	1.5	2.0	22.5
Do you regularly drink alcohol?	Yes	23.3	35.3	21.3
	No	76.1	64.4	74.3
	Don't know	0.6	0.4	4.4
Do you smoke?	Yes	29.5	54.0	41.9
	No	70.3	45.8	54.9
	Don't know	0.3	0.3	3.2
Do you exercise twice a week?	Yes	43.3	25.1	22.5
	No	56.2	74.6	72.0
	Don't know	0.5	0.3	5.4

Source: Eurobarometer 52.1, European Commission.

2.2.8 Participation in the four most popular (*) physical activities in a typical week, by age, 1997

(%)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Walking																
Age 15–34	25	22	22	14	19	24	26	49	18	29	21	35	16	60	45	42
35–54	30	27	32	19	24	37	28	62	25	46	25	44	19	69	67	43
+55	40	32	35	35	33	50	43	56	34	57	26	43	24	76	74	41
Gardening																
15–34	8	9	17	12	2	1	8	15	5	13	19	17	4	3	9	9
35–54	21	19	43	25	11	4	20	32	14	32	37	41	2	11	29	26
+55	27	17	41	33	19	4	26	37	20	41	44	50	3	19	45	36
Cycling																
15–34	18	22	32	29	3	11	14	22	8	18	53	40	6	27	38	12
35–54	18	17	27	28	2	7	13	9	8	15	52	45	2	30	44	12
+55	14	18	24	26	1	3	11	12	5	18	54	29	<1	27	34	5
Swimming																
15–34	12	16	11	14	4	7	11	19	9	24	20	22	9	14	15	15
35–54	10	8	12	13	4	7	11	10	4	17	16	22	1	15	11	14
+55	7	4	7	10	5	4	9	5	2	12	13	14	<1	14	12	5

(*) From 17 suggested leisure activities in the EU. Continuously for 30 minutes.
Source: Institute of European Food Studies (IEFS), Dublin (supported by the European Commission).

2.2.9 Adults (15+) participating in various physical activities in a typical week, by time spent, 1997

(%)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
None	32	42	24	31	40	37	36	14	39	20	19	16	61	8	12	24
< 1 hour	7	7	6	6	4	11	7	5	7	8	6	4	7	5	4	7
1–3 hours	18	18	16	19	18	17	20	16	20	19	18	18	15	18	16	17
3–5 hours	21	15	22	19	22	21	20	28	19	21	18	20	11	26	23	25
> 5 hours	21	14	30	24	16	12	16	37	14	30	38	42	5	41	45	27

Source: Institute of European Food Studies (IEFS), Dublin (supported by the European Commission).

2.2.10 Perceived motivating factors (*) for adult (15+) participation in physical activity/exercise, 1997

(%)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
To maintain good health	42	45	44	49	49	55	28	38	47	39	34	44	21	41	44	37
To release tension	30	26	25	24	23	38	33	27	41	27	39	22	18	33	16	22
To get fit	30	33	22	34	24	32	29	27	27	29	26	21	8	32	36	34
To be out of doors	20	14	22	25	9	17	16	32	18	9	9	38	15	37	27	19
To socialise	14	14	35	13	6	13	12	17	12	16	22	22	12	9	15	16
To control weight	13	12	9	11	25	16	7	19	15	10	13	9	7	14	17	15
For fun	10	10	18	7	8	9	10	14	7	16	19	13	8	5	11	12
Do not participate	11	16	6	7	17	4	18	5	9	14	9	4	49	<1	5	8

(*) From 11 suggested factors.
Source: Institute of European Food Studies (IEFS), Dublin (supported by the European Commission).

2.2.11 Adults (15+) spending different numbers of hours at work per day being more physically active than standing or walking, 1997

(%)

	EU-15 (*)	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
None	42	39	37	38	49	56	59	34	38	58	28	23	51	34	51	31
Up to 2 hours	36	38	36	41	21	28	31	35	38	29	30	34	33	41	31	42
2 to 6 hours	17	16	19	15	21	12	9	24	20	10	27	28	10	17	15	21
Over 6 hours	5	7	7	6	9	4	1	7	4	3	7	15	6	8	3	6

(*) Weighted according to population size.
Source: Institute of European Food Studies (IEFS), Dublin (supported by the European Commission).

2.2.12 Amount of time spent sitting down by adults (15+) on a typical non-working day, 1997

(%)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
None	3	3	<1	<1	4	5	4	3	5	2	1	2	2	1	<1	2
Up to 2 hours	24	30	15	10	28	30	32	30	34	29	14	25	29	19	20	20
2 to 3 hours	39	42	40	40	35	39	39	37	40	39	33	41	38	45	38	38
Over 4 hours	34	24	45	50	33	26	26	30	21	30	51	32	31	35	40	40

Source: Institute of European Food Studies (IEFS), Dublin (supported by the European Commission).

2.2.13 Children who report exercising for two or more hours a week, by age and sex, 1997/98

	B (*)	DK	D (*)	EL	F (*)	IRL	A	P (**)
11-year-olds								
Boys	64	76	78	57	79	57	80	38
Girls	45	62	65	36	51	46	70	20
13-year-olds								
Boys	68	82	85	70	82	64	86	47
Girls	46	70	73	44	57	57	75	24
15-year-olds								
Boys	66	72	85	72	76	67	86	48
Girls	44	62	70	38	50	45	63	25

(*) In Belgium only the Dutch-speaking parts, in France only Nancy-Lorraine and Toulouse-Midi-Pyrénées, and in Germany only Nordrhein-Westfalen are covered. Spain, Italy, Luxembourg and the Netherlands are not covered.

(**) Students in Portugal were asked to state the duration of each occasion of activity, rather than total time spent per week; therefore the results cannot be compared to those of other countries.

Source: Currie, C. et al., 'Health and health behaviour among young people (International report from the "Health behaviour in school-aged children"— HBSC — 1997/98 survey)', World Health Organisation Policy Series: *Health Policy for Children and Adolescents (HEPCA)*, Issue 1 (2000), World Health Organisation Regional Office for Europe.

2.2.14 Children who report watching television for four or more hours a day, by age and sex, 1997/98

	B (*)	DK	D (*)	EL	F (*)	IRL	A	P
11-year-olds								
Boys	22	21	20	28	15	28	17	28
Girls	18	14	15	25	12	21	9	26
13-year-olds								
Boys	23	25	22	28	16	28	25	32
Girls	19	23	22	24	15	20	20	28
15-year-olds								
Boys	20	22	25	29	17	19	22	26
Girls	18	19	19	21	14	16	20	25

(*) In Belgium only the Dutch-speaking part, in France only Nancy-Lorraine and Toulouse-Midi-Pyrénées, and in Germany only Nordrhein-Westfalen are covered. Spain, Italy, Luxembourg and the Netherlands are not covered.

Source: See 2.2.13.

(%)

FIN	S	UK				NO	CH	
		England	Scotland	Northern Ireland	Wales			
								11-year-olds
70	57	45	69	67	67	58	81	Boys
56	44	37	53	48	45	53	54	Girls
								13-year-olds
76	67	57	72	67	75	73	81	Boys
60	53	43	54	55	51	65	60	Girls
								15-year-olds
72	68	61	72	71	75	70	79	Boys
59	53	40	52	49	48	63	56	Girls

(%)

FIN	S	UK				NO	CH	
		England	Scotland	Northern Ireland	Wales			
								11-year-olds
25	19	24	30	27	31	19	11	Boys
25	18	20	27	25	32	13	9	Girls
								13-year-olds
28	28	31	30	34	38	26	13	Boys
25	23	31	28	32	44	21	12	Girls
								15-year-olds
21	25	29	27	28	38	28	18	Boys
15	19	28	26	23	38	22	16	Girls

2.3.1 Adults (15+) who are daily cigarette smokers, by age and sex, 1995

(%)

	EU-15	B	DK	D (W)	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Total																
Males	33	34	39	30	49	39	39	31	33	28	37	35	37	22	18	29
Females	25	28	37	21	29	23	31	28	24	28	31	21	13	18	25	26
All	29	31	38	25	39	31	35	29	38	28	34	28	24	20	22	27
15–24																
Males	37	36	50	39	46	33	51	31	29	28	57	42	49	27	18	28
Females	33	28	45	35	36	26	58	31	22	34	40	33	27	13	25	30
All	35	32	47	37	41	30	54	31	25	31	48	38	37	19	22	29
25–34																
Males	44	43	55	33	56	49	57	37	28	37	44	53	58	35	14	32
Females	33	41	36	25	47	56	38	29	39	34	33	25	37	28	18	37
All	38	42	44	29	52	52	47	33	33	36	38	37	48	32	16	34
35–44																
Males	38	27	30	30	60	58	41	39	49	30	34	37	45	35	27	32
Females	29	41	47	22	39	33	37	31	34	20	36	20	11	25	33	26
All	33	34	38	26	50	45	39	35	41	25	35	28	27	29	30	29
45–54																
Males	34	44	34	31	65	32	37	26	35	29	34	37	32	35	20	33
Females	23	44	29	25	27	20	20	21	27	27	24	31	6	21	24	26
All	29	44	32	28	44	26	28	23	31	28	28	34	16	27	22	29
55–64																
Males	27	30	40	24	40	37	17	27	36	26	45	20	30	13	17	31
Females	16	12	37	15	11	3	15	29	21	36	33	10	-	10	24	23
All	21	20	39	20	25	19	16	28	28	31	38	15	12	12	20	27
65+																
Males	16	22	28	17	28	22	15	2	21	18	13	15	11	3	11	17
Females	11	9	26	5	7	-	10	22	7	21	18	9	-	-	33	15
All	13	14	27	10	17	8	12	21	13	19	16	12	5	2	21	16

Source: Eurobarometer 43.0, European Commission.

2.3.2 Smokers, by age and sex, 1999

(%)

Do you smoke?	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
TOTAL																
Males	40	47	32	41	58	47	43	38	35	39	37	47	44	40	19	37
Females	28	28	44	27	32	28	34	27	20	29	27	30	14	22	25	33
All	34	37	38	34	45	37	38	32	27	34	31	38	28	30	22	35
15–24																
Males	43	53	21	45	47	46	53	32	34	50	34	45	33	34	16	45
Females	40	38	49	45	43	45	53	27	23	39	29	39	16	29	26	41
All	41	46	35	45	45	46	53	30	29	45	32	42	25	31	21	43
25–34																
Males	46	55	33	49	64	49	56	34	38	43	39	50	66	49	20	35
Females	38	40	38	37	53	50	46	37	22	33	26	43	27	30	33	43
All	42	48	35	43	59	49	51	35	30	38	33	47	46	39	26	39
35–44																
Males	45	49	32	41	74	54	52	55	34	42	45	63	55	41	21	46
Females	38	40	55	34	42	38	49	41	33	25	34	50	24	28	34	37
All	41	44	43	37	58	46	50	48	33	34	39	57	39	34	27	41
45–54																
Males	46	48	40	45	83	65	41	38	45	36	36	51	55	62	23	34
Females	28	27	48	34	36	21	31	23	20	30	37	21	6	20	33	32
All	37	38	44	40	60	43	36	31	32	33	36	36	30	41	28	33
55–64																
Males	35	42	29	35	48	52	22	36	35	44	42	35	29	26	17	33
Females	20	23	41	17	16	8	28	27	14	35	23	18	11	12	24	29
All	27	32	35	26	31	29	25	31	24	38	32	26	20	19	21	31
65+																
Males	25	32	39	27	36	18	22	32	24	19	20	26	20	15	17	28
Females	10	8	34	8	7	5	5	13	10	7	11	11	:	12	8	19
All	16	17	36	15	20	11	12	21	15	14	15	17	8	13	12	23

Source: Eurobarometer 52.1, European Commission.

2.3.3 Diet and stress, by smoking status, EU-15, 1999

Do you smoke?		Yes	No	Don't know
Do you eat a good, balanced diet?	Yes	65.1	79.2	43.4
	No	32.4	18.9	24.2
	Don't know	2.5	1.9	32.4
Do you regularly feel stressed?	Yes	47.5	33.1	28.2
	No	49.5	64.1	27.0
	Don't know	3.0	2.8	44.8

Source: Eurobarometer 52.1, European Commission.

2.3.4 Number of cigarettes per day for smokers, by sex, 1995

(%)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Males																
<5	11	7	21	12	2	5	21	9	10	14	6	26	11	12	.	12
5–9	14	10	4	12	6	21	13	18	31	10	13	9	16	19	8	20
10–14	23	24	24	30	14	32	25	21	21	17	17	13	11	30	31	27
15–19	17	18	15	14	11	16	21	11	11	30	39	15	25	13	38	5
20–24	18	24	29	14	23	12	17	25	12	13	12	10	21	21	8	28
25–29	5	.	3	2	14	.	5	4	.	9	11	8	9	6	8	2
30–34	3	2	4	2	8	.	.	3	.	.	.	12	3	.	.	2
35–39	2	.	.	5	11	.	.	.	.	3	.	.	.	.	.	.
>40	2	.	.	.	12	.	.	.	.	.	.	4	4	.	.	.
Females																
<5	14	13	22	17	14	12	21	14	29	6	3	11	4	7	24	6
5–9	20	21	12	27	6	14	13	31	31	13	21	24	24	21	29	19
10–14	23	23	29	31	29	16	23	19	20	10	34	14	29	23	14	18
15–19	15	14	16	7	16	11	24	15	8	25	17	15	19	4	14	15
20–24	14	14	14	10	24	7	13	18	.	36	6	31	5	13	5	18
25–29	3	8	.	3	3	6	5	.	.	.	9	.	5	.	5	3
30–34	2	.	3	5	8	2	.	.	.	.	.	.	4	.	5	2
35–39	1	.	.	.	.	.	2	.	.	.	.	.	10	.	5	2
>40	1	.	.	.	.	.	.	.	.	.	.	2				
All																
<5	12	9	21	14	7	8	21	11	18	10	4	19	8	9	14	9
5-9	17	15	8	19	6	18	13	25	31	11	17	16	19	20	20	19
10-14	23	24	27	30	20	25	24	20	20	14	25	14	18	27	21	22
15-19	16	17	16	11	13	14	22	13	10	27	28	15	23	9	24	10
20-24	16	20	21	12	24	10	15	21	7	25	9	19	15	17	6	23
25-29	4	3	1	3	10	3	5	2	.	4	10	4	7	3	6	2
30-34	2	1	4	3	8	1	.	2	.	.	.	7	4	.	3	2
35-39	1	.	.	2	6	.	.	.	.	1	.	.	4	.	.	1
>40	1	.	.	.	7	.	1	.	.	.	.	2	2	.	3	1

Source: Eurobarometer 43.0, European Commission.

2.3.5 Trends in household expenditure on tobacco, 1988, 1994 and 1999

Mean consumption expenditure per household (in PPS) (*)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1988	168	153	:	:	354	201	136	:	224	192	142	:	170	:	:	365
1994	272	58	413	197	491	293	236	600	282	284	196	329	239	206	221	404
1999	:	233	456	:	668	389	:	600	267	348	206	400	:	201	224	428

Structure of expenditure (% of total household expenditure)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1988	1.0	0.9	:	:	2.3	1.3	0.8	:	1.3	0.7	0.9	:	1.4	:	:	2.1
1994	1.3	0.3	2.2	1.0	2.8	1.5	1.1	2.7	1.2	0.7	1.0	1.4	1.5	1.3	1.2	2.0
1999	:	0.8	1.9	:	2.9	1.9	:	2.1	1.0	0.8	0.8	1.5	:	1.1	1.0	1.5

(*) PPS = purchasing power standards.
Source: Eurostat, NewCronos database (Household Budget Survey).

2.3.6 Structure of consumption expenditure on tobacco (Coicop level 2), 1999

	B	DK	EL	E	IRL	
By socioeconomic category of the reference person						
Manual workers in industry and services	1.3	2.6	4.1	2.6	2.9	1.1
Non-manual workers in industry and services	0.8	1.5	2.3	1.6	1.7	:
Self-employed	0.8	1.3	3.3	2.0	1.5	1.0
Unemployed	2.4	3.7	4.8	2.7	5.2	1.8
Retired	0.6	2.2	2.2	1.6	2.0	0.8
Inactives — other	1.2	2.5	2.0	1.6	3.3	0.9
Unknown	:	:	:	:	5.5	:
By income quintile						
First quintile	1.5	2.6	4.4	2.8	2.4	1.4
Second quintile	1.0	2.7	3.7	2.3	2.5	1.1
Third quintile	0.8	2.2	3.1	2.1	2.4	1.0
Fourth quintile	0.8	1.8	2.8	1.8	2.1	0.9
Fifth quintile	0.6	1.3	1.8	1.3	1.4	0.7
By type of household						
Single person	0.9	2.5	1.9	0.8	1.8	0.9
Single parent with dependent children	1.2	1.9	1.9	1.7	2.8	1.2
Two adults	0.7	2.1	2.5	1.4	2.1	0.9
Two adults with dependent children	0.8	1.3	2.7	1.8	1.7	1.0
Three or more adults	0.9	2.3	3.6	2.4	2.5	1.0
Three or more adults with dependent children	1.3	3.1	3.8	2.5	3.1	1.1
By age of the reference person						
Less than 30 years	1.2	2.0	3.4	3.1	3.1	1.1
Between 30 and 44 years	0.9	1.8	3.0	2.0	2.0	1.1
Between 45 and 59 years	1.0	2.1	3.1	2.0	2.0	1.1
60 years and over	0.5	1.9	2.3	1.6	1.9	0.8
By degree of urbanisation						
Densely-populated area (at least 500 inhabitants/km^2)	0.9	2.0	:	1.9	:	1.0
Intermediate urbanised area (between 100 and 499 inhabitants/km^2)	0.8	1.6	:	2.0	:	1.0
Sparsely-populated area (less than 100 inhabitants/km^2)	0.9	2.3	:	2.0	:	0.9

Notes:
No data were available for Germany, France and Portugal.
Coicop, Classification of individual consumption by purpose.
Source: Eurostat, NewCronos database (Household Budget Survey).

(%)

L	NL	A	FIN	S	UK	
						By socioeconomic category of the reference person
1.3	0.9	2.3	1.8	1.4	2.4	Manual workers in industry and services
0.5	0.7	1.3	0.7	0.7	1.1	Non-manual workers in industry and services
0.5	0.9	1.3	0.9	1.0	1.5	Self-employed
2.3	1.9	3.7	2.5	2.0	3.9	Unemployed
0.8	0.6	1.1	0.9	0.6	1.0	Retired
1.3	1.3	1.5	1.2	1.6	3.1	Inactives — other
1.0	:	:	:	:	:	Unknown
						By income quintile
1.5	1.1	2.1	2.0	1.8	3.4	First quintile
1.2	1.0	1.8	1.3	1.0	2.5	Second quintile
0.7	0.9	1.6	1.1	1.1	1.5	Third quintile
0.7	0.7	1.4	1.1	1.0	1.3	Fourth quintile
0.4	0.5	1.1	0.7	0.6	0.7	Fifth quintile
						By type of household
0.8	1.0	1.6	1.3	1.4	1.6	Single person
0.9	1.1	1.8	1.3	1.3	2.3	Single parent with dependent children
0.7	0.8	1.4	1.1	0.9	1.3	Two adults
0.8	0.6	1.4	1.0	0.9	1.2	Two adults with dependent children
1.1	0.9	1.8	1.4	1.2	2.3	Three or more adults
0.9	1.1	1.4	1.1	1.1	2.4	Three or more adults with dependent children
						By age of the reference person
0.9	0.7	1.7	1.3	1.2	2.1	Less than 30 years
0.8	0.8	1.7	1.2	1.1	1.6	Between 30 and 44 years
0.9	1.0	1.8	1.2	1.1	1.5	Between 45 and 59 years
0.6	0.6	0.9	0.6	0.7	1.1	60 years and over
						By degree of urbanisation
0.9	:	1.7	1.0	1.1	1.6	Densely-populated area (at least 500 inhabitants/km^2)
0.8	:	1.5	1.1	1.1	1.4	Intermediate urbanised area (between 100 and 499 inhabitants/km^2)
0.7	:	1.3	1.3	1.0	1.4	Sparsely-populated area (less than 100 inhabitants/km^2)

2.3.7 Children who report smoking, 1997/98

	B (*)	DK	D (*)	EL	F (*)	IRL	A	P
				Smoke daily				
11-year-olds								
Boys	1	0.4	1	0.1	1	1	0.3	1
Girls	0	0.1	0.1	0.5	0.5	0.4	0.1	1
13-year-olds								
Boys	6	3	9	3	5	8	5	3
Girls	4	4	9	2	6	6	3	2
15-year-olds								
Boys	21	15	22	13	20	19	20	13
Girls	20	21	25	14	25	16	26	10
				Smoke weekly				
11-year-olds								
Boys	2	1	2	1	2	2	2	2
Girls	0.4	1	1	1	1	2	1	2
13-year-olds								
Boys	10	6	14	5	9	14	10	5
Girls	8	8	13	5	11	12	8	4
15-year-olds								
Boys	28	20	28	18	28	25	30	19
Girls	28	28	33	19	31	25	36	14
				Median number of cigarettes smoked weekly				
11-year-olds								
Boys	1	2	3	7	4.5	1	1	2
Girls	1	1	5	4.5	2.5	2	1	2.5
13-year-olds								
Boys	7	8	10	7	4.5	10	5	5
Girls	4	5	9	6	3	5	3	3
15-year-olds								
Boys	21	30	29.5	35	7	25	20	20
Girls	20	28	20	30	10	20	20	20

(*) In Belgium only the Dutch-speaking part, in France only Nancy-Lorraine and Toulouse-Midi-Pyrénées, and in Germany only Nordrhein-Westfalen, are covered. Spain, Italy, Luxembourg and the Netherlands are not covered.
Source: See 2.2.13.

2.3.8 National controls on the sale and advertising of tobacco, 1994/2001

	B (*)	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK	IS	NO
Minimum age to buy	:	:	:	:	16	18	:	16	:	:	:	:	18	18	16	16	18
1994 Public place ban ([1])	2	3	3	2	1	1	1	1	1	1	2	1	1	1	3	1	1
1994 Advertising ban ([2])	2	3	3	2	3	1	2	1	2	2	2	1	1	1	3	2	1
2001 Advertising legislation ([3])	C	C	L	L	L	B	C	B	L	C	L	B	B	L	C	:	:

(*) Dutch-speaking part only
The state of legislation concerning banning or restrictions, based on 1994 WHO tobacco profiles for the EU, has been classified as follows: *1* the most severe, *2* intermediate, *3* the least severe.
([1]) Public places are: schools and other premises where young people congregate; care centres and medical establishments; waiting rooms of railways, bus stations, harbours and airports; government buildings; public transport vehicles; railway stations; domestic and international flights; enclosed spaces available to the public; theatres, cinemas, exhibitions, art galleries, museums and libraries.
([2]) Advertising sites are: radio, TV; billboards, cinemas, health service premises, educational establishments, youth and sport centres.
([3]) L = limited restrictions, B = total ban, C = legislative change in progress.

Sources:
1. 'Tobacco consumption 1970–94 in the Member States of the European Union and in Norway and Iceland', Statistics Sweden, European Commission.
2. 'Proposal for a directive of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products' (30.5.2001), European Commission, Brussels.
3. *Smoking, drinking and drug-taking in Europe* (1997), Harkin, A.M., Anderson, P. and Goos, C., World Health Organisation, Denmark.

(%)

FIN	S	UK				NO	CH	
		England	Scotland	Northern Ireland	Wales			
Smoke daily								
								11-year-olds
0.2	0	1	1	1	1	1	0.5	Boys
0.4	0.3	1	2	1	1	0.1	0	Girls
								13-year-olds
7	2	7	5	7	6	4	3	Boys
8	2	8	8	10	12	5	4	Girls
								15-year-olds
19	10	21	19	16	18	18	17	Boys
20	16	24	24	24	23	21	17	Girls
Smoke weekly								
								11-year-olds
1	1	3	2	3	2	1	1	Boys
1	0.5	1	3	2	2	0.2	1	Girls
								13-year-olds
10	4	11	9	12	8	8	6	Boys
14	5	15	13	15	18	7	8	Girls
								15-year-olds
25	18	25	22	20	22	23	25	Boys
29	24	33	28	28	29	28	25	Girls
Median number of cigarettes smoked weekly								
								11-year-olds
2	1	2	2	3	4.5	1	1	Boys
2.5	2	1	2	3	2	2.5	1	Girls
								13-year-olds
10	4	10	5	10	11.5	5	4	Boys
9	4	5	8	10	12	5	4	Girls
								15-year-olds
26	10	30	30	30	30	25	20	Boys
20	20	20	30	30	30	20	20	Girls

2.3.9 Average number of cigarettes per person/year available on the market

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1985	1 852	1 989	1 717	:	2 866	2 023	1 744	1 759	1 984	1 967
1990	1 799	1 751	1 566	2 035	2 656	2 096	1 689	1 656	1 662	1 671
1995	1 616	1 585	1 702	1 654	2 937	1 989	1 519	1 680	1 531	:
1996	1 587	1 533	1 800	1 664	2 864	1 899	1 476	1 684	1 515	:
1997	1 598	1 199	1 717	1 678	2 848	2 057	1 416	1 713	1 621	:
1998	1 615	1 206	1 605	1 687	2 853	2 284	1 425	1 733	1 624	:
1999	1 653	1 212	1 636	1 909	2 861	2 271	1 416	1 834	1 613	

Source: Health for All database, 2002, WHO Europe.

2.4.1 Average number of litres of alcohol per person/year available on the market

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Wine 1999	33.6	24.9	29.9	22.9	35.2	33.7	57.2	28.7	51.5	61.0
Beer 1999	77.8	94.5	101.9	127.5	40.3	68.8	38.7	154.7	27.1	109.0
Spirits 1999	1.7	1.1	1.1	2.0	2.7	2.4	2.4	2.1	0.5	1.6
Pure alcohol (*) 1999	:	:	:	12.6	:	:	:	:	:	15.0
Pure alcohol (*) 1998			11.6	12.6	10.2	12.0	13.3	14.2	9.1	16.4

(*) Defined as ethanol consumed in country during the calendar year or calculated from official statistcs on local production, import and export, taking into account stocks and home production, whenever available. This amount is divided by the mid-year population.
Data published in 'World drink trends' was used as a source in some cases.
Source: Health for All database, 2002, WHO Europe.

2.4.2 Trends in household expenditure on alcohol

		EU-15	B	DK	D	EL	E	F	IRL
		Mean consumption expenditure per household (PPS (*))							
Spirits	**1988**	41	79	:	:	37	29	72	:
	1994	55	51	58	:	:	35	111	146
	1999	:	52	91	:	51	30	:	224
Wine	**1988**	95	98	:	:	40	92	165	:
	1994	125	230	176	:	82	97	257	131
	1999	:	256	243	:	53	84	:	218
Beer	**1988**	31	71	:	:	31	41	31	:
	1994	43	94	171	:	33	50	:	856
	1999	:	100	197	:	42	47	:	1 086
Alcohol	**1988**	166	249	:	:	109	162	267	:
	1994	313	376	405	321	115	182	367	1 132
	1999	:	408	531	:	146	161	:	1 528
		Structure of expenditure (% of total household expenditure)							
Spirits	**1988**	0.2	0.5	:	:	0.2	0.2	0.4	:
	1994	0.3	0.2	0.3	:	:	0.2	0.5	0.7
	1999	:	0.2	0.4	:	0.2	0.1	:	0.8
Wine	**1988**	0.6	0.6	:	:	0.3	0.6	1.0	:
	1994	0.6	1.0	0.9	:	0.5	0.5	1.1	0.6
	1999	:	0.9	1.0	:	0.2	0.4	:	0.8
Beer	**1988**	0.2	0.4	:	:	0.2	0.3	0.2	:
	1994	0.2	0.4	0.9	:	0.2	0.3	:	3.8
	1999	:	0.4	0.8	:	0.2	0.2	:	3.9

(*) PPS = purchasing power standards.
Source: Eurostat, NewCronos database (Household Budget Survey).

NL	A	P	FIN	S	UK	IS	NO	CH	
1 074	2 135	1 393	1 393	1 356	1 711	1 802	569	2 545	**1985**
1 222	1 789	1 565	1 436	1 254	1 710	1 621	695	2 488	**1990**
1 075	1 568	1 638	1 016	920	1 552	1 380	609	2 201	**1995**
991	1 605	1 627	885	936	1 518	1 376	621	2 185	**1996**
1 066	1 636	1 656	920	678	1 492	1 340	629	2 047	**1997**
1 058	1 919	1 653	934	644	1 400	1 272	581	2 012	**1998**
	1 928	1 649	931	711	1 336		608	2 009	**1999**

(litres)

NL	A	P	FIN	S	UK	IS	NO	CH	
18.6	30.9	51.7	17.5	14.8	14.5	7.2	9.5	43.6	**Wine 1999**
84.2	108.9	64.3	80.1	59.3	99.0	44.3	51.0	58.6	**Beer 1999**
1.7	1.4	1.5	2.3	1.0	1.5	1.1	0.9	1.4	**Spirits 1999**
10.1	11.2	13.2	8.7	:	10.0	:	:	:	**Pure alcohol (*) 1999**
9.9	11.2	13.6	8.6	6.0	9.8		5.4		**Pure alcohol (*) 1998**

I	L	NL	A	P	FIN	S	UK		
				Mean consumption expenditure per household (PPS (*))					
48	39	73	:	22	:	:	59	**Spirits**	**1988**
48	50	76	44	28	93	:	109		**1994**
19	75	74	35	:	93	:	87		**1999**
177	305	86	:	230	:	:	95	**Wine**	**1988**
210	375	117	125	166	77	:	135		**1994**
171	336	142	123	:	92	:	189		**1999**
35	94	77	:	23	:	:	50	**Beer**	**1988**
:	125	82	143	30	156	:	102		**1994**
49	100	109	119	:	150	:	121		**1999**
259	439	235	:	275	:	:	204	**Alcohol**	**1988**
258	550	274	312	223	325	354	346		**1994**
239	512	326	277	:	334	412	397		**1999**
				Structure of expenditure (% of total household expenditure)					
0.3	0.1	0.4	:	0.2	:	:	0.3	**Spirits**	**1988**
0.2	0.1	0.4	0.2	0.2	0.6	:	0.5		**1994**
0.1	0.2	0.3	0.1	:	0.5	:	0.3		**1999**
1.0	1.1	0.5	:	1.9	:	:	0.5	**Wine**	**1988**
0.9	1.0	0.6	0.5	1.0	0.5	:	0.7		**1994**
0.6	0.8	0.6	0.5	:	0.5	:	0.7		**1999**
0.2	0.4	0.5	:	0.2	:	:	0.3	**Beer**	**1988**
:	0.3	0.4	0.6	0.2	1.0	:	0.5		**1994**
0.2	0.2	0.4	0.5	:	0.8	:	0.4		**1999**

2.4.3 Structure of consumption expenditure on alcoholic beverages (Coicop level 2), 1999 *(%)*

	B	DK	EL	E	IRL	I	L	NL	A	FIN	S	UK
By socioeconomic category												
Manual workers in industry and services	1.2	2.0	0.7	0.8	7.0	0.8	1.2	1.2	1.0	2.1	1.7	1.5
Non-manual workers in industry and services	1.4	2.2	0.5	0.7	5.7	:	1.0	1.2	0.8	1.8	1.9	1.5
Self-employed	1.2	1.8	0.7	0.7	4.8	0.8	1.1	1.1	1.2	1.5	2.2	1.2
Unemployed	1.4	2.9	0.6	0.9	5.4	0.9	2.0	1.4	1.2	2.9	2.0	1.3
Retired	2.0	2.7	0.7	0.9	4.5	1.1	1.3	1.7	1.3	1.6	1.7	1.4
Inactives-other	1.6	1.8	0.3	0.7	4.7	0.7	1.3	1.2	1.1	1.9	1.9	1.3
Unknown	:	:	:	:	2.9	:	1.5	:	:	:	:	:
By income quintile												
First quintile	1.4	2.3	0.7	0.9	4.8	1.0	1.4	1.3	1.1	1.9	1.8	1.4
Second quintile	1.4	2.5	0.7	0.8	4.9	1.0	1.2	1.2	1.0	1.5	1.6	1.5
Third quintile	1.5	2.2	0.7	0.8	5.8	0.9	1.3	1.2	1.1	1.8	1.7	1.4
Fourth quintile	1.7	2.1	0.6	0.8	6.4	0.9	1.2	1.3	1.1	2.0	2.2	1.5
Fifth quintile	1.5	2.3	0.6	0.7	5.5	0.7	1.0	1.3	1.0	1.9	2.0	1.5
By type of household (Coicop level 2)												
Single person	1.5	2.5	0.5	0.5	4.1	0.9	1.4	1.2	1.0	1.8	2.1	1.4
Single parent with dependent children	1.1	1.7	0.4	0.4	3.5	0.6	1.3	0.7	0.7	1.5	1.1	1.0
Two adults	1.9	2.6	0.8	0.9	5.0	1.0	1.4	1.5	1.2	2.0	2.3	1.6
Two adults with dependent children	1.3	1.8	0.5	0.8	4.3	0.8	1.1	1.2	0.8	1.7	1.5	1.3
Three or more adults	2.3	2.8	0.7	0.9	8.6	1.0	1.0	1.5	1.3	2.2	1.4	1.6
Three or more adults with dependent children	1.3	2.4	0.7	0.8	7.5	0.9	0.8	1.2	1.3	1.7	1.7	1.4
By age of the reference person												
Less than 30 years	0.9	1.7	0.6	0.8	9.0	0.7	1.0	0.8	0.7	1.6	1.9	1.4
Between 30 and 44 years	1.2	1.9	0.6	0.8	4.9	0.7	1.1	1.0	0.9	1.8	1.6	1.4
Between 45 and 59 years	1.7	2.7	0.6	0.7	5.5	0.9	1.2	1.6	1.2	2.1	2.1	1.5
60 years and over	2.0	2.6	0.7	0.9	4.4	1.0	1.3	1.5	1.4	1.5	2.0	1.4
By degree of urbanisation												
Densely-populated area (at least 500 inhabitants/km^2)	1.6	2.4	:	0.7	:	0.9	1.3	:	0.9	1.9	2.4	1.4
Intermediate urbanised area (between 100 and 499 inhabitants/km^2)	1.3	1.9	:	0.8	:	0.9	1.2	:	1.2	1.8	2.0	1.5
Sparsely populated area (less than 100 inhabitants/km^2)	1.7	2.4	:	0.9	:	1.0	1.1	:	1.1	1.6	1.7	1.4

Notes: No data were available for Germany, France and Portugal.
Coicop - Classification of individual consumption by purpose.

Source: Eurostat, NewCronos database (Household Budget Survey).

2.4.4 Alcohol drinkers by age and sex, 1999

(%)

Do you regularly drink alcohol?	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
TOTAL																
Males	35.3	44.1	49.1	31.9	36.8	28.3	32.6	63.9	18.7	35.1	54.4	31.9	47.4	32	35.3	53.7
Females	16	18.7	38.5	11	7.7	9.3	13.4	39.9	6.3	13.9	31	9.7	12.9	14	20.9	34.6
All	25.3	30.9	43.6	21	22	18.5	22.6	51.5	12.3	24.1	42.5	20.3	29.2	22.6	27.9	43.9
15–24																
Males	33.3	48.6	46.6	30.4	40	31.3	23.2	53.1	14	29.5	56.2	22.6	24.7	32.1	50.8	56.7
Females	18.8	19.4	29.8	15.6	12.1	13.9	13.2	50.6	5.2	9.8	33.9	8.6	7	19.2	33.9	41.7
All	26.2	34.3	38.3	23.2	26.4	22.8	18.3	51.9	9.7	19.8	45.3	15.8	16	25.7	42.5	49.4
25–34																
Males	36.4	47.6	49.2	35.7	43.7	32	29	80	16.9	26.5	55.3	29.9	60.7	29.7	36.3	53.2
Females	18.9	24.5	29.6	16.7	18.3	17.3	18.6	51.2	2.8	15.2	21.2	10.5	19.4	15.5	17	37.5
All	27.8	36.1	39.7	26.4	31.2	24.8	23.8	65.6	9.9	20.9	38.5	20.2	39.9	22.6	26.8	45.5
35–44																
Males	37.3	46.5	37.7	33.1	39.6	24.2	31.2	70.5	19.8	39.6	58	39.7	55.3	39.5	37.1	63.5
Females	17.6	23.4	42	9.1	7.8	7.8	16.8	53	7.3	14.6	31.2	10.1	13	25.3	24.3	41
All	27.5	35.1	39.9	21.2	23.7	16	24	61.7	13.5	27.7	44.8	25.3	33.8	32.4	30.8	52.3
45–54																
Males	37.9	49.1	53.5	34.3	39.9	33.3	46.9	63.4	17.9	32.6	49.9	29.6	49.3	40.6	33.7	49.4
Females	18.3	21.1	46.7	14.6	5.6	9.9	15	39.2	4.5	18.5	37.9	8.5	9.9	10.8	25.5	42.4
All	28.1	35.2	50.1	24.5	23	21.5	30.8	51.3	11.1	25.9	44	19.1	28.8	26	29.7	45.9
55–64																
Males	38.9	34.9	58.1	33.3	35	36.5	36.3	51.1	26.3	30.6	55.9	35.7	52.9	30	37.4	57.7
Females	14.4	10.1	52.9	9.3	2.9	4.6	12.3	27.1	10.1	16.1	37.3	19.7	13.6	11.1	19	26.9
All	26.3	22.1	55.5	21.1	18.4	19.9	23.9	39	17.8	20.5	46.6	27.4	31.7	20.1	28.1	42.1
65+																
Males	28.4	35.2	51.7	22.1	22.5	13.5	32.2	62.6	19	49.4	50.4	33.3	46.2	14.3	20.4	42.1
Females	10	13.4	34	4.4	:	2	6	18.1	7.9	6.6	28.8	4.4	14.3	3.9	11.5	21.8
All	17.1	22.2	41.3	10.8	10	6.7	16.5	36.6	12.4	29.8	37.5	15	27.2	7.8	15.3	30.1

Source: Eurobarometer 52.1, European Commission.

2.4.5 Exercise, stress and diet by alcohol consumption, EU-15, 1999

Do you regularly drink alcohol?		Yes	No	Don't know
Do you exercise at least twice a week?	Yes	44.5	38.2	25.9
	No	55.0	61.3	49.9
	Don't know	0.6	0.5	24.2
Do you regularly feel stressed?	Yes	43.3	36.2	33.7
	No	54.0	61.0	30.0
	Don't know	2.7	2.8	36.3
Do you eat a good, balanced diet?	Yes	69.6	76.0	63.2
	No	28.3	21.9	18.4
	Don't know	2.2	2.1	18.5

Source: Eurobarometer 52.1, European Commission.

2.4.6 Children who report drinking beer, wine or spirits at least weekly, 1997/98

	B (*)	DK	D (*)	EL	F (*)	IRL	A	P
11-year-olds								
Boys	7	4	2	20	6	7	3	4
Girls	2	2	0.3	8	3	1	1	1
13-year-olds								
Boys	11	11	10	27	12	8	8	9
Girls	6	9	5	16	5	6	4	3
15-year-olds								
Boys	38	46	29	52	31	27	39	29
Girls	22	38	22	31	15	12	23	9

(*) In Belgium only the Dutch-speaking part, in France only Nancy-Lorraine and Toulouse-Midi-Pyrénées, and in Germany only Nordrhein-Westfalen are covered. Spain, Italy, Luxembourg and the Netherlands are not covered.

Source: See 2.2.13.

2.4.7 National controls on the advertising of alcohol, 1994 and 1998

	B		DK		D		EL		E		F		IRL		I		L	
	1994	1998	1994	1998	1994	1998	1994	1998	1994	1998	1994	1998	1994	1998	1994	1998	1994	1998
Spirits																		
TV	V	R	B	B	V	V	N	N	R	B	B	B	V	V	R	R	N	V
Radio	V	R	B	B	V	V	N	N	N	R	R	R	V	V	N	R	N	V
Print media	V	V	V	V	V	V	N	N	N	R	R	R	V	V	N	R	N	V
Billboards	V	V	V	V	V	V	N	N	N	N	R	R	V	V	N	V	N	V
Table wine																		
TV	N	R	B	B	V	V	N	N	N	R	B	B	V	V	R	R	N	V
Radio	N	R	B	B	V	V	N	N	N	R	R	R	V	V	N	R	N	V
Print media	N	V	V	V	V	V	N	N	N	R	R	R	V	V	N	R	N	V
Billboards	N	V	V	V	V	V	N	N	N	N	R	R	V	V	N	R	N	V
Beer																		
TV	V	R	B	B	V	V	N	N	N	R	B	B	V	V	R	R	N	V
Radio	V	R	B	B	V	V	N	N	N	R	R	R	V	V	N	V	N	V
Print media	V	V	V	V	V	V	N	N	N	R	R	R	V	V	N	R	N	V
Billboards	V	V	V	V	V	V	N	N	N	N	R	R	V	V	N	R	N	V

V Voluntary code **R** Restricted **B** Banned **N** No controls

Sources: 1. Harkin, A.M., Anderson, P. and Goos, C. (1997) *Smoking, drinking and drug-taking in Europe*, World Health Organisation, Copenhagen.
2. Rehn, N., Room, R. and Edwards, G. (2001) *Alcohol in the European region — Consumption, harm and policies*, World Health Organisation, Regional Office for Europe.

(%)

FIN	S	UK				NO	CH	
		England	Scotland	Northern Ireland	Wales			
								11-year-olds
2	3	14	8	5	12	1	4	Boys
0.3	1	9	4	1	5	0.2	0.5	Girls
								13-year-olds
5	6	22	17	14	24	4	5	Boys
4	4	16	11	6	16	3	3	Girls
								15-year-olds
11	17	47	37	33	53	16	19	Boys
8	11	36	33	20	36	12	9	Girls

NL		A		P		FIN		S		UK		IS		NO		CH		
1994	1998	1994	1998	1994	1998	1994	1998	1994	1998	1994	1998	1994	1998	1994	1998	1994	1998	
																		Spirits
V	V	V	R	R	R	B	B	B	B	V	V	B	B	B	B	B	B	TV
V	V	V	R	R	R	B	R	B	B	V	V	B	B	B	B	B	B	Radio
V	V	V	V	N	N	B	R	B	R	V	V	B	B	B	B	R	N	Print media
V	V	V	V	B	N	B	B	B	R	V	V	B	B	B	B	R	R	Billboards
																		Table wine
V	V	V	R	R	R	R	R	B	B	V	V	B	B	B	B	B	B	TV
V	V	V	R	R	R	R	R	B	B	V	V	B	B	B	B	B	B	Radio
V	V	V	V	N	N	R	R	B	R	V	V	B	B	B	B	N	N	Print media
V	V	V	V	V	N	R	R	B	R	V	V	B	B	B	B	B	N	Billboards
																		Beer
V	V	V	R	R	R	R	R	B	B	V	V	B	B	B	B	B	B	TV
V	V	V	R	R	R	R	R	B	B	V	V	B	B	B	B	B	B	Radio
V	V	V	V	N	N	R	R	B	R	V	V	B	B	B	B	N	N	Print media
V	V	V	V	B	N	R	R	B	R	V	V	B	B	B	B	R	N	Billboards

2.5.1 Last 12 months prevalence of drug use in nationwide surveys, 1994–2000

	Method			All adults (%)				
	Year	Data coll.	Sample	Age range	Cannabis	Cocaine	Amph (*)	Ecstasy
B (Dutch speaking)	**1994**	Phone	2 259	(18–65)	1.5	0.2	0.3	0.1
DK	**1994**	Interv.	2 521	:	:	:	:	:
	2000	Interv.	14 228	(16–64)	4.4	0.5	1.0	0.3
D (former West)	**1995**	Mail	6 292	(18–59)	5.0	0.9	0.8	0.9
(former East)	**1995**	Mail	1 541	(18–59)	1.9	0.2	0.2	0.6
D (former West)	**1997**	Mail	6 337	(18–59)	4.5	0.7	0.5	0.9
(former East)	**1997**	Mail	1 682	(18–59)	2.3	0.1	0.3	0.4
EL	**1998**	Interv.	3 752	(15–64)	4.4	0.5	0.1	0.1
	2000	Mail	8 139	(18–59)	6.0	0.9	0.6	0.7
E	**1997**	Interv.	12 445	(15–64)	7.6	(b) 1.6	0.9	(c) 0.9
	1999	Interv.	12 488	(15–64)	7.0	(b) 1.6	0.7	(c) 0.8
F	**1995**	Phone	1 993	(18–69)	4.7	0.2	(d) 0.3	:
	1999	Phone	1 999	(15–64)	7.4	0.2	0.1	0.2
IRL	**1998**	Mail	10 415	(15–64)	9.4	1.3	2.6	2.4
NL	**1997/98**	Interv.	22 000	(15–64)	5.5	0.7	0.4	0.8
P	**2001**	Interv.	15 000	(15–64)	3.3	0.3	0.1	0.4
FIN	**1996**	Mail	3 009	(16–74)	1.9	:	:	:
	1998	Mail $	2 568	(15–69)	2.5	(b) 0.2	0.2	0.2
S	**1998**	Interv.	1 500	(15–69)	1.0	:	:	:
	2000	Interv.	2 000	(15–64)	1.0	0.0	<0.5	<0.5
UK (England and Wales)	**1998**	Interv.	10 293	(16–59)	9.0	1.2	2.7	1.2
	2000	Interv.	1 330	(16–59)	8.6	0.0	1.7	1.7

(*) Amph = amphetamines; $ combined sample: mail (n=2 143) and phone (n=425); (a) hard drugs; (b) cocaine or crack; (c) ecstasy and other designer drugs; (d) amphetamine+ecstasy; (e) for 16–44 the figure is 7.0 %, same as in 1994 survey; (f) recalculated at national level for 16–34-year-olds.

Note: Prevalence figures presented in this table may be different, in some countries,from figures published at a national level due to use of different age ranges (see footnote 6).

Notes:
1. Data coll. means data collection method used in the survey, interv. (face-to-face interview), phone (telephone interview), mail (mailed questionnaire).
2. When several surveys are available for a country, the last two surveys are presented in the table. In Denmark there were two surveys in 1994, the one more comparable with the 2000 survey is presented.
3. Some city surveys reported by countries were not included as they tend to produce higher prevalence estimates, which are not comparable with estimates for whole countries.
4. Sample sizes refer to the complete national surveys. In some cases, national surveys cover a broader age range than that presented here, and therefore the estimates presented are based on somewhat smaller samples. Estimates for young adults are also based on smaller sub-samples.
5. In Belgium, Ireland and Luxembourg, the 1998 surveys did not produce estimates for last 12 months prevalence.
6. Countries were asked to report results using, as far as possible, EMCDDA standard age groups (all adults: 15–64, young adults: 15–34). In some countries where age ranges are more restrictive, prevalence estimates tend to be somewhat higher. Some countries have recalculated their prevalence figures using the EMCDDA standard age groups.

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Younger adults (%)					
Age range	Cannabis	Cocaine	Amph (*)	Ecstasy	
(18–35)	3.6	:	:	:	**B (Dutch speaking)**
(16–44)	7.0	:	(a) 0.5	:	**DK**
(16–34)	(e) 9.7	1.4	2.5	0.9	
(18–39)	8.8	1.6	1.5	1.6	**D (former West)**
(18–39)	3.5	0.3	0.4	1.2	**(former East)**
(18–39)	7.8	1.2	0.9	1.7	**D (former West)**
(18–39)	4.5	0.2	0.6	0.7	**(former East)**
(15–34)	8.8	1.0	0.1	0.3	**EL**
(18–34)	13.0	1.9	1.3	1.6	
(15–34)	14.2	(b) 2.7	1.7	(c) 1.7	**E**
(15–34)	12.7	(b) 2.7	1.4	(c) 1.7	
(18–39)	8.9	0.3	(d) 0.6	:	**F**
(15–34)	15.1	0.5	0.1	0.4	
(15–34)	17.7	2.6	5.4	4.9	**IRL**
(15–34)	9.8	1.4	0.8	1.8	**NL**
(15–34)	6.2	0.6	0.1	0.8	**P**
(16–34)	5.2	:	:	:	**FIN**
(15–34)	6.3	(b) 0.4	0.4	0.4	
(15–34)	2.0	:	:	:	**S**
(15–34)	1.0	0.0	0.0	<0.5	
(16–29)	23.0	3.0	8.0	4.0	**UK (England and Wales)**
(16–34) (f)	17.9	2.5	5.9	2.9	
(16–29)	22.0	5.0	5.0	5.0	

2.5.2 Lifetime prevalence of drug use in recent nationwide surveys among the general population, 1994–2001

	Method			All adults (%)				
	Year	Data coll.	Sample	Age range	Cannabis	Cocaine	Amph (*)	Ecstasy
B (Dutch speaking)	**1994**	Phone	2 259	(18–65)	5.8	0.5	0.9	0.5
B (French speaking)	**1996–97**	Phone	3 311#	(18–49)	12.8	:	:	:
B (French speaking)	**1998–99**	Phone	3 311#	(18–49)	20.8	:	:	:
DK	**1994**	Interv.	2 521	:	:	:	:	:
	2000	Interv.	14 228	(16–64)	24.3	1.7	4.5	0.8
D (former West)	**1995**	Mail	6 292	(18–59)	13.9	2.2	2.8	1.6
(former East)	**1995**	Mail	1 541	(18–59)	3.6	0.2	0.7	0.7
D (former West)	**1997**	Mail	6 337	(18–59)	13.4	1.5	1.8	1.7
(former East)	**1997**	Mail	1 682	(18–59)	4.2	0.2	0.5	0.7
EL	**1998**	Interv.	3 752	(15–64)	13.1	1.3	0.6	0.3
E	**1997**	Interv.	12 445	(15–64)	22.2	(c) 3.3	2.5	(e) 2.5
	1999	Interv.	12 488	(15–64)	19.8	(c) 3.2	2.2	(e) 2.4
F	**1999**	Phone	2 002	(15–64)	21.9	1.5	0.2	0.9
	2000	Phone	13 685	(15–64)	22.5	1.6	1.5	0.9
IRL	**1998**	Interv.	1 000	(18–64)	14.2	:	:	:
	1998	Mail	10 415	(15–64)	19.9	:	:	:
L	**1998**	Interv.	667	(15–64)	12.9	0.2	:	1.2
NL	**1997/98**	Interv.	22 000	(15–64)	19.1	2.6	2.2	2.3
P	**2001**	Interv.	15 000	(15–64)	16.2	0.9	0.5	0.7
FIN	**1998**	Mail	2 568	(15–69)	9.7	(c) 0.6	1.0	0.5
	2000	Interv.	2 500	(15–64)	9.9	0.6	1.0	0.6
S	**1998**	Interv.	1 500	(15–69)	13.0	1.0	2.0	0.0
	2000	Interv.	2 000	(15–64)	13.0	1.0	2.0	0.0
UK (England and Wales)	**1996**	Interv.	10 940	(16–59)	22.0	3.0	9.0	3.0
	1998	Interv.	10 293	(16–59)	25.0	3.0	10.0	4.0
NO	**1999**	Interv.	2 170	(15–64)	15.3	2.2	3.8	1.3

(*) Amph = amphetamines; # pooled sample for the 1996–99 period for the drug section 2 112; $ combined sample: mail (n=2 143) and phone (n=425); (a) hard drugs; (b) for 16–44-year-olds the figure for cannabis is 32.3 %; (c) cocaine or crack; (d) amphetamine+ecstasy; (e) ecstasy and other designer drugs; (f) recalculated at national level for 16–34-year-olds.

Note: Prevalence figures presented in this table may be different, in some countries, from figures published at a national level due to use of different age ranges (see footnote 6).

Notes:
1. Data coll. means data collection method used in the survey, interv. (face-to-face interview), phone (telephone interview), mail (mailed questionnaire).
2. When several surveys are available for a country, the last two surveys are presented in the table. In Denmark there were two surveys in 1994, the one more comparable with the 2000 survey is presented.
3. This table aims to present national surveys. Exceptionally some relevant regional surveys are presented. Some city surveys reported by countries were not included as they tend to produce higher prevalence estimates, which are not comparable with estimates for whole countries (or big regions with urban and rural areas).
4. Sample sizes refer to the complete national surveys. In some cases, national surveys cover a broader age range than that presented here, and therefore the estimates presented are based on somewhat smaller samples. Estimates for young adults are also based on smaller sub-samples.
5. In Luxembourg, the sample size of the 1998 survey is very small and results should be interpreted with caution.
6. Countries were asked to report results using, as far as possible, EMCDDA standard age groups (all adults: 15–64, young adults: 15–34). In some countries where age ranges are more restrictive, prevalence estimates tend to be somewhat higher. Some countries have recalculated their prevalence figures using the EMCDDA standard age groups.

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Younger adults (%)					
Age range	Cannabis	Cocaine	Amph (*)	Ecstasy	
(18–35)	9.2	1.2	2.0	1.3	**B (Dutch speaking)**
(18–34)	17.8	:	:	:	**B (French speaking)**
(18–34)	26.1	:	:	:	**B (French speaking)**
(16–44)	36.7	:	(a) 5.0	:	**DK**
(b) (16–34)	34.0	3.1	7.0	1.9	
(18–39)	21.0	3.7	4.1	2.8	**D (former West)**
(18–39)	6.4	0.3	1.3	1.3	**(former East)**
(18–39)	20.1	2.2	2.4	3.2	**D (former West)**
(18–39)	7.8	0.4	1.0	1.3	**(former East)**
(15–34)	19.7	2.2	0.7	0.6	**EL**
(15–34)	31.8	(c) 5.2	4.1	(e) 4.7	**E**
(15–34)	28.5	(c) 4.8	3.2	(e) 4.4	
(15–34)	32.9	1.9	0.1	1.7	**F**
(15–34)	35.7	1.9	1.4	1.8	
(18–34)	26.2	:	:	:	**IRL**
(15–34)	30.0	:	:	:	
(15–34)	15.8	0.3	:	1.9	**L**
(15–34)	27.3	3.7	3.0	4.4	**NL**
(15–34)	26.2	1.3	0.6	1.4	**P**
(15–34)	17.5	(c) 1.2	2.0	1.3	**FIN**
(15–34)	16.6	1.2	2.5	1.4	
(15–34)	16.0	1.0	3.0	1.0	**S**
(15–34)	14.0	1.0	2.0	1.0	
(16–29)	36.0	4.0	16.0	9.0	**UK (England and Wales)**
(16–29)	42.0	6.0	20.0	10.0	
(f) (16–34)	38.1	6.4	16.5	7.7	
(15–34)	20.9	3.3	5.4	2.5	**NO**

2.5.3 Lifetime prevalence of use of different illegal drugs among 15- to 16-year-old students in recent nationwide school surveys, 1993-2000

(%)

	Year	Project (*)	Sample	All illegal drugs	Cannabis	Sol-vents	Amph (**)	Ecstasy	LSD	Cocaine	Heroin
B (Dutch speaking)	**1998**	HBSC (WHO)	9 211	:	23.7	4.4	3.8	6.2	2.1	1.3	0.7
	1999		47 657	27.9	24.1	4.2	6.5	4.0	4.2	1.9	0.9
	2000	HBSC (WHO)	4 989		20.7	3.6	3.3	2.6	3	1.2	0.6
B (French speaking)	**1997–98**	HBSC (WHO)	12 987	:	27.9	5.8	7.0	6.3	7.1	3.5	3.4
DK	**1995**	ESPAD	2 571	:	18.0	6.0	1.9	0.5	0.4	0.5	2.0
	1999	ESPAD	1 557	25.4	24.8	7.5	4.0	3.1	1.0	1.5	1.3
EL	**1993**		10 543	4.5	3.0	6.3	4.0	:	1.1	0.9	0.6
	1998		8 557	11.4	10.2	13.7	3.6	1.8	2.6	1.6	0.8
E	**1996**		19 191	29.6	24.3	3.5	4.1	(c) 4.6	(e) 5.6	2.5	0.8
	1998		18 346	32.9	28.0	4.2	4.0	(c) 2.8	(e) 4.7	4.3	1.0
	2000		18 348	37.1	30.0	4.0	3.4	5.4	0.0	4.1	0.6
F	**1997**		9 919	27.5	23.0	5.5	1.9	(b) 2.5	:	1.5	1.4
	1999	ESPAD	12 113	:	28.8	11.0	2.3	2.4	1.0	1.5	1.2
IRL	**1995**	ESPAD	1 849	37.0	37.0	:	3.0	9.0	(e) 13.0	2.0	2.0
	1998		8 497	27.5	21.7	13.0	4.2	2.8	3.4	2.2	1.8
I	**1995**	ESPAD	1 641	21.0	19.0	8.0	3.0	4.0	(e) 5.0	3.0	2.0
	1999	ESPAD	20 215	:	16.8	4.7	1.4	1.3	(e) 2.1	1.6	3.7
	2000	ESPAD	22 358	30.2	28.4	4.9	1.3	2.9	2.5	2.7	0.3
L	**1999**		562	:	37.1	:	:	5.6	5.8	11.1	2.8
	1999		7 347	:	27.7	3.6	3.1	1.8	1.4	1.5	0.8
NL	**1996**		10 455	31.7	31.1	:	7.8	8.1	:	4.3	1.3
	1999		2 945	28.8	28.6	:	4.0	5.0	:	4.2	0.0
A	**1994**		2 250	9.9	9.5	:	:	:	:		(a) 2.0
P	**1995**	ESPAD	4 767	4.7	3.8	:	:	:	0.2	1.0	0.9
	1999	ESPAD	3 609	12.3	9.4	3.3	3.2	2.3	1.0	1.3	2.6
FIN	**1995**	ESPAD	2 300	5.5	5.2	4.4	0.5	0.2	0.3	0.2	0.1
	1999	ESPAD	3 109	10.1	9.9	5.4	0.6	0.6	:	0.6	1.0
S	**1998**		5 455	7.7	7.2	8.2	1.1	1.0	1.0	0.6	0.6
	1999		6 000	8.0	7.0	12.0	1.0	1.0	1.0	1.0	1.0
	2000		6 000	9.0	8.0	9.0	2.0	1.0	1.0	1.0	1.0
UK	**1997**		28 756	39.8	37.5	4.0	7.3	3.0	(d) 3.2	1.5	0.7
UK (England)	**1998**		4 752	31.4	29.6	5.7	7.6	2.5	3.2	2.8	1.0
UK (Scotland)	**1998**		3 538	39.0	38.0	9.0	12.0	4.0	7.0	1.0	0.0
UK (Scotland)	**2000**	15 years only	7 000	32.0							
UK (Wales)	**1998**	HBSC (WHO)	1 238	41.5	35.8	15.1	14.2	4.5	6.7	1.8	1.1
NO	**1999**	ESPAD	3 918	13.0	12.3	5.9	2.6	2.5	1.5	1.3	1.2

(*) Project = international projects in which framework the national surveys was conducted.
(**) Amph = amphetamines.
(a) 'hard drugs'; (b) LSD and ecstasy; (c) ecstasy and other synthetic drugs; (d) 'synthetic hallucinogens'; (e) LSD = 'LSD and other hallucinogens'.

Notes:
(1) This table aims to present national surveys. Exceptionally some relevant regional surveys are presented.
(2) In countries with information on more than two national surveys, only the last two are presented. In the case of Belgium and the United Kingdom more than two surveys are included because of different geographical coverages.
(3) Surveys that cover only cities or metropolitan areas are not included. Also surveys in which reporting age range diverge substantially from the requested range (15–16 years) are not presented.
(4) In all the surveys the method for data collection was written questionnaires.
(5) In ESPAD surveys cocaine does not include crack cocaine.
(6) The French survey of 1997 gives information on last year prevalence of drug use, instead of lifetime prevalence.
(7) In Germany a youth survey (12–25-year-olds) is conducted every 3 to 4 years since 1970 instead of the school survey. In the 1997 survey the total sample was 3 100 (12–25 years): lifetime prevalence for any illegal drug among 14–17-years olds was 11 % (former West Germany), and 10 % (former East Germany).
(8) In the Greek surveys (1993 and 1998), amphetamines are not included in the category All illegal drugs.
(9) In Luxembourg the sample size (562) of this survey is very small and results should be interpreted with caution.
(10) In UK (Scotland) only 15-year-old children are included.

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

2.5.4 National prevalence estimates of problem drug use in adults, 1996–98

	B	DK	D	E	F	IRL	I
Total population size (age 15–64) (*)	6 706.3	3 551.2	55 968.1	26 866.3	38 370.9	2 387.2	39 168.8
Extrapolation from police data	:	:	2.5–3.0	:	4.3	:	4.4
Extrapolation from treatment data	:	:	1.7–2.5	6.6 (b)	4.1–4.6	:	6.1–7.6
Mortality multiplier	:	4.0	1.4–2.0	3.1 (b)	:	1.9–3.2	
Capture-recapture	:	4.0	:	:	:	2.6–5.7 (c)	7.0
Multivariate indicator	:	:	:	:	:	:	6.3
Back calculation-HIV/AIDS multiplier	3.0 (a)	2.9	:	:	3.2–4.0	3.6	8.3
Overall range of estimates	3.0	2.9–4.0	1.4–3.0	3.1–6.6	3.2–4.6	1.9–5.7	4.4–8.3

(*) Thousands.

Notes:

(a) Estimate using HIV/AIDS register instead of back calculation, definition includes only IDUs and thus underestimates all problem drug use. (b) Opiate addicts. (c) Problematic opiate use. Police data include 7 % non-opiate users; 10 % were identified because of possession [not necessarily users] and 5 % were identified by other means. Three-sample capture — recapture: police data cover 1 September 1995 to 30 August 1996, other sources the 1996 calendar year. (d) Heroin addicts or hard drug users. (f) Problematic opiate and amphetamine users. The lower estimate refers mainly to drug users with medical problems while the higher also includes drug users with potential legal problems such as driving under influence. (g) 1 700 to 3 350 heroin addicts; 8 900 to 12 450 other addicts, mostly amphetamine injectors [excluding cannabis addicts]. (h) IDUs.

All estimates are based on a 12-month period between 1996 and 1998, except for Austria (1995), Ireland (1995–96) and Sweden (1992). Greece and Portugal were unable to provide estimates.

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) OCT 01 — project CT.99.RTX.05 (coordinated by the Institute for Therapy Research, Munich).

2.5.5 Some characteristics of persons treated for drug problems for the first time, 1998–2000

	Year	Mean age	Age distribution		Male/fem. distribution	% IV route main drug	% distribution of main drug (% IV route of administration)													
			<25	>35			Opiates		Cocaine		Amphetamines		Ecstasy		Hallucinogens		Cannabis		Others	
B	**1999**	24.5	63.0	13.0	76/24	8.0	21.0	(7.0)	5.0	(5.0)	14.0	3.0	3.0	0.0	1.0	(0.0)	44.0	(1.0)	4.0	(0.0)
DK (a)	**2000**	28.0	40.1	22.5	77/23	16.0	41.0	(33.0)	4.0	(7.0)	7.0	(5.0)	3.0	0.0		:	30.0	(0.0)	1.0	(0.0)
D (b)	**1999**	26.6	:	:	82/18	:	44.2	(37.1)	9.8	(21.7)		:		:	2.2	(:)	40.0	(:)		0.0
EL	**2000**	29.4	39.7	28.1	85/15	64.1	90.5	(70.6)	0.6	(16.7)		0.0	0.1	(0.0)	0.1	0.0	6.5	(0.0)	0.1	(0.0)
E	**2000**	28.8	36.2	21.6	85/15	9.2	48.6	(17.5)	32.1	(1.9)	1.4	(1.3)	1.1	(0.0)	0.3	(0.0)	14.5	(0.0)	0.4	(3.6)
F (c)	**1999**	28.9	31.6	20.7	80/20	:	58.8	(59.0)	5.0	(39.0)	0.2	(25.0)	1.3	(11.0)	0.4	(13.0)	25.3	(7.2)	1.1	(20.3)
IRL	**1999**	23.0	:	:	73/27	30.6	55.6	(55.0)	1.6	(8.0)	2.1	(6.0)	8.9	(0.0)	0.2	(0.0)	29.1	(0.0)	0.2	(0.0)
I (d)	**2000**	28.0	36.0	21.0	87/13	49.0	71.0	(100.0)	9.0	(8.0)	1.0	(0.0)	2.0	(0.0)		:	15.0	(1.0)	1.0	(0.0)
L	**2000**	24.2	63.0	26.0	50/50	75.0	88.0	(20.0)		:	:			:		:	13.0	(0.0)		:
NL	**2000**	30.1	35.0	28.0	79/21	3.0	28.0	(12.0)	34.1	(1.0)	3.0	(7.0)	2.0	(0.0)	0.0	(0.0)	6.0	(0.0)	1.0	(0.0)
A (e)	**2000**	29.2	33.9	26.2	70/30	100.0		100.0	:		:			:	:		:		:	
P (f)	**2000**	29.1	6.1	24.8	82/18	26.7	67.8	(28.0)	1.1	(1.3)	:			:	:		2.5	(0.0)		0.0
FIN	**1999**	23.5	:	:	75/25	43.7	23.2	(66.2)	:		39.0	(61.8)	1.6	(0.0)	:		32.7	(0.0)	:	
S (g)	**2000**	35.5	30.0	44.0	54/44	10.0	30.0	(14.0)	3.0	(0.0)	21.0	(23.0)	2.0	(0.0)		0.0	19.0	(0.0)	2.0	(0.0)

Notes:

(a) Data on opiates refer only to heroin.

(b) Information about IV route of admission of opiates refers to heroin and information about IV route of admission of cocaine refers to cocaine CIH.

(c) Data refer to the annual census on clients in treatment.

(d) Data refer to all clients in treatment during the reporting year, including clients continuing treatment from previous year.

(e) Data refer only to clients in substitution treatment only: data on opiates as main drug and IV route of administration are consequently 100 %.

(f) Data on all treatment demands refer to all interventions (not people); it is not possible to distinguish among drugs.

(g) Data came from 'national discharge register' from inpatient hospital units that used ICD-10 code 19, therefore no 'main' drug was discernible.

No data is available for the United Kingdom.

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

(per 1 000 inhabitants)

L	NL	A	FIN	S	UK	NO	
284.0	10 661.5	5 444.8	3 433.4	5 650.8	38 275.4	2 852.9	Total population size (age 15–64) (*)
6.7–7.7	:	:	:	:	:	:	Extrapolation from police data
6.7	2.3–2.7	:	0.5–0.7 (f)	:	6.9–8.9	:	Extrapolation from treatment data
:	:	:	1.2–2.5 (f)	:	2.3–4.6	3.2–4.6 (h)	Mortality multiplier
:	:	2.9–3.4	2.5–4.2 (f)	2.5–-3.5 (g)	:	:	Capture–recapture
:	2.5 (d)	:	:	:	7.2–7.5	:	Multivariate indicator
:	:	:	:	:	:	:	Back calculation — HIV/AIDS multiplier
6.7–7.7	2.3–2.7	2.9–3.4	0.5–4.2	2.5–3.5	2.3–8.9	3.2–4.6	Overall range of estimates

2.5.6 Prevalence of antibodies against hepatitis C virus and HIV infection among injecting drug users, 1994–2000

	Year	Data	Number tested	% infected
		Hepatitis C		
B (French speaking)	1998	Drug treatment, self-reports	237	52
B (Dutch speaking)	1999	Drug treatment, screening	195	(38)
DK	1996/97	(1) Funen: study prison/treatment, (2) Copenhagen: drug treatment, self-reports	602	(75–86)
D	1995	Lohr: survey drug treatment centre	120	(66)
EL	1999	(1) methadone treatment, (2) public health laboratory	567	41–82
E	1996	Survey drug treatment centres	1 000	83
F	1998/99	(1) drug treatment, self-report, (2) needle exchange, screening	8 744	50–63
IRL	1996/98	(1) survey prisons, (2) Dublin: drug treatment, screening	862	(52)–81
I	1999	Drug treatment	73 512	67
L	1998	Prison study, screening	116	37
NL	1996	Heerlen and Maastricht: study in drug treatment and on the street	288	(73)
A	1999	Vienna, screening: (1) inpatient treatment centre, (2) low threshold services and needle exchange	160	(63–72)
P	1997/00	(1) Lisbon and (2) Porto: drug treatment, screening	549	(45–88)
FIN	1999/00	Screening saliva test in prisons, and Helsinki: needle exchange, screening blood test	281	(38)–58
S	1994	Stockholm: study prison/treatment	905	(92)
UK (England)	1998	(1) prisons and community surveys, England outside London, (2) London: screening in drug treatment	1 169	19–(52)
		HIV infection		
B (French speaking)	1998	Drug treatment and low threshold services, self-reports	252	1.6
B (Dutch speaking)	1998/99	Drug treatment, low threshold services and hospitals, screening and self-reports	559	0.5–1.9
DK	1996/97	(1) Funen: study prison/drug treatment, (2) Copenhagen; drug treatment, self-reports	608	1.5
D	1999	Drug treatment, self-reports	1 795	3.8
EL	1999	Drug treatment reporting system, self-reports and screening	912	0–2.2
E	1999	Drug treatment reporting system, screening	8 750	33.1
F	1999	Drug treatment centres, self-reports	8 339	15.9
IRL	1997/99	(1) Dublin: drug treatment centre, screening, (2) prisons, screening	773	1.2–5.8
I	1999	Drug treatment in public services	69 474	15.1
L	1999	Drug treatment, low threshold services and hospitals, self-reports and screening	150	3.3
NL	1997/99	Screening, repeated surveys in and outside drug treatment: (1) Amsterdam, (2) Arnhem (3) Brabant, (4) Groningen, (5) Rotterdam	1 118	0.5–25.9
A	1999	Self-reports and screening, (1) opiate overdose deaths, (2) Vorarlberg: drug treatment, (3) Vienna: low threshold services, (4) Vienna: drug treatment	319	3.1
P	1998/00	Screening, (1) drug treatment 1999/00, (2) Lisbon: study in problematic area 1998/99	880	(0–48)
FIN	1999/00	Drug deaths, prisons, Helsinki and Tampere: syringe exchange	692	0–2.8
S	1997	Study nine prisons	196	2.6
UK (England)	1998	(1) Drug treatment, needle exchange, low threshold, screening saliva, (2) surveys	3 366	0.33–3.3
UK (Scotland)	1997	First positive named HIV tests	1 497	1.6

Notes:
(a) Data in brackets are local.
(b) Differences between countries have to be interpreted with caution due to different sources and in some cases local data.
(c) Data for Germany, Italy and Spain are limited to HCV prevalence among IDUs in treatment and may thus not be representative of HCV prevalence among IDUs who are not in treatment.
(d) In the column 'Data' the figures in brackets refer to sources (see http://www.emcdda.org/ for details).

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

2.5.7 Experimentation and recent use of drugs in young people (15–24 years of age), 2002

	Already tried		Used over last month	
	Cannabis	Other drugs	Cannabis	Other drugs
EU-15	28.9	8.8	11.3	2.7
B	24.7	6.8	9.5	1.9
DK	47.0	11.4	12.2	2.5
D (W)	27.2	8.4	8.8	2.4
D (E)	18.5	9.1	6.0	2.5
EL	4.8	1.2	1.3	0.4
I	17.2	2.7	7.8	0.6
E	29.4	12.2	15.0	3.7
F	44.9	9.0	19.8	2.9
IRL	24.2	8.9	8.7	4.8
L	27.3	6.6	4.5	2.3
NL	35.3	10.6	12.2	3.2
P	14.1	6.8	4.9	1.8
FIN	19.2	9.0	5.6	3.1
S	16.5	9.9	3.9	1.6
A	17.9	4.6	4.6	1.3
UK	37.0	13.7	13.4	4.4

Question: Which of the following applies to you?

Source: Eurobarometer 57.2, European Commission.

2.5.9 Self-perceived consequences of drug use, 2002

	Dependence	Problems with the law	Mental problems	Communicable diseases	Relief from pain or stress
EU-15	63.0	38.3	35.4	33.7	26.4
B	49.1	36.5	34.1	25.5	30.8
DK	69.3	43.4	69.8	15.0	24.6
D (W)	71.4	46.0	22.6	38.8	25.1
D (E)	69.2	36.2	24.3	29.2	23.3
EL	66.2	30.7	21.7	50.9	13.4
I	65.6	32.3	35.9	48.9	25.3
E	58.4	38.6	53.4	33.3	10.4
F	61.4	36.4	29.1	31.5	37.7
IRL	64.2	49.6	33.8	25.3	23.4
L	52.3	32.1	33.2	32.4	26.5
NL	61.2	20.5	45.5	13.2	40.8
P	56.1	26.7	26.2	54.7	13.0
FIN	67.4	47.0	43.1	37.5	14.6
S	65.8	31.2	57.6	25.3	22.4
A	64.5	43.6	50.7	35.4	19.9
UK	57.3	43.0	37.2	21.3	34.2

Question: Drug use may have certain consequences. Please choose the three that come closest to your own opinion.

Source: Eurobarometer 57.2, European Commission.

2.5.10 Assessment of the dangerousness of substances in EU-15, 2002

	Very dangerous	Fairly dangerous	Not very dangerous	Not at all dangerous	Don't know
Heroin	88.8	8.8	0.7	0.1	1.7
Cocaine	74.0	20.8	3.0	0.2	2.0
Crack	73.4	16.6	2.5	0.3	7.2
LSD	65.2	23.3	2.7	0.1	8.6
Ecstasy	63.5	28.7	4.7	0.1	3.1
Morphine	60.8	26.2	6.2	0.7	6.0
Glue or solvents	47.0	32.4	11.3	1.1	8.1
Amphetamines	40.9	37.5	9.3	1.0	11.4
Doping substances	32.8	40.1	16.6	1.6	8.9
Cannabis	20.6	27.0	36.6	11.5	4.3
Tobacco	12.4	35.7	41.3	9.6	1.1
Alcohol	12.9	34.9	43.4	7.4	1.1

Question: Here is a list. Tell me how dangerous or not you consider each of the following.

Source: Eurobarometer 57.2, European Commission.

2.5.11 Assessment of danger of three substances: % of 'very dangerous' responses

	Heroin	Ecstasy	Cannabis
EU-15	88.8	63.5	20.6
B	83.5	57.8	14.7
DK	84.2	71.1	8.7
D (W)	89.3	58.6	18.3
D (E)	84.6	48.9	22.5
EL	96.1	68.8	47.8
I	91.3	74.3	17.2
E	85.8	65.3	23.1
F	93.1	69.6	21.1
IRL	90.8	66.8	29.8
L	87.2	60.6	16.2
NL	79.2	49.4	7.2
P	75.4	44.1	24.9
FIN	91.2	45.2	35.3
S	90.0	68.2	45.1
A	86.2	52.0	20.2
UK	90.0	64.6	17.4

Question: Here is a list. Tell me how dangerous or not you consider each of the following.

Source: Eurobarometer 57.2, European Commission.

2.6.1 Fertility rate, live births, for girls aged 15–19

(per 1 000)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK	IS	NO	CH
1980	:	20.2	16.3	:	:	25.9	24.4	:	19.9	16.6	9.2	34.4	42.1	18.9	15.7	30.6	56.6	25.2	9.9
1985	:	12.5	9.8	:	36.0	18.3	15.9	:	12.2	10.6	6.8	24.4	32.8	18.5	11.0	29.4	34.7	17.8	6.6
1990	16.4	11.5	9.1	17.8	20.0	11.9	12.1	17.2	8.6	17.7	7.7	21.1	23.9	12.4	14.0	33.0	37.7	17.1	6.9
1996	:	:	8.2	12.9	12.1	7.3	9.7	16.6	6.6	9.9	5.6	15.6	20.7	9.8	7.7	29.5	21.5	13.6	5.6
1997	:	:	8.8	12.9	11.9	7.6	9.6	17.2	:	9.0	6.0	14.6	21.0	9.0	7.2	30.0	24.0	12.7	10.5
1998	:	:	8.1	:	11.6	7.7	9.6	18.6	:	9.7	6.2	14.0	20.9	9.2	6.5	30.6	24.7	12.4	5.5
1999	:	:	7.6	12.9	11.3	8.3	10.0	19.9	:	10.4	6.6	13.4	20.8	9.8	6.7	30.3	24.5	11.5	29.7
2000	:	:	7.7	:	:	:	:	19.0	:	12.7	7.2	13.5	22.0	10.3	7.0	28.9	22.5	11.6	30.0

Source: Eurostat, NewCronos database (Demography).

2.6.3 Total number of legal abortions in girls aged 15–19

	B	DK	D	EL	E	F	I	FIN	S	UK	IS	NO
1995	:	2 328	6 487	:	6 695	15 218	10 918	1 489	4 067	31 233	158	:
1996	:	2 339	11 131	468	:	:	:	1 514	4 225	35 557	207	:
1997	:	:	12 010	:	:	:	:	1 633	4 240	36 633	:	:
1998	1 781		:	:	7 657	:	10 941	1 786	:	40 371	:	:
1999	1 989	:	13 759	:	:	:	:	1 952	4 090	39 676	:	2 414
2000	:	:	:	:	:	:	11 160	2 264	5 001	40 235	:	:

Source: Eurostat, NewCronos database (Demography).

2.7.1 People living in poverty (1) who are socially excluded in one of three ways, by employment status

	EU-15		B		DK		D		EL		E		F	
	1995	1996	1995	1996	1995	1996	1995	1996	1995	1996	1995	1996	1995	1996
EMPLOYED														
Cannot afford to possess a car	19	22	14	20	7	11	18	17	22	28	20	21	18	26
Cannot afford a week's holiday	21	21	15	19	14	9	25	24	22	27	20	19	20	19
Having difficulty making ends meet	16	16	13	13	7	6	19	17	16	19	16	15	15	15
UNEMPLOYED														
Cannot afford to possess a car	59	6	66	52	12 (*)	16 (*)	54	58	44	49	55	50	67	75
Cannot afford a week's holiday	53	53	55	46	21	:	58	61	40	41	47	43	53	55
Having difficulty making ends meet	47	48	48	47	16	11 (*)	49	51	33	36	43	39	46	47
INACTIVES (**)														
Cannot afford to possess a car	34	34	40	36	25	30	29	26	40	37	29	27	40	45
Cannot afford a week's holiday	37	36	37	45	26	27	41	35	38	37	32	29	38	40
Having difficulty making ends meet	31	31	36	37	23	25	32	28	30	29	27	25	34	34

(*) Unreliable or uncertain data.
(**) Retired or unavailable for work.
(1) 60% of the median net equivalised income per person is the threshold for defining low-income households, and is more robust than 50 % in terms of data quality.
The median is less affected by extreme values or sample fluctuations than the mean.
No data are available for Finland or Sweden.

Source: Eurostat, NewCronos database (European Community Household Panel).

2.7.2 Comparison of objective and subjective poverty

	Risk of poverty indicator % living in households at risk of poverty (1)				Subjective poverty indicator % who consider themselves poor (2)
	1995	1996	1997	1998	2001
B	17	6	15	16	32
DK	12	10	8	9	9
D	17	15	15	16	14 (3)
EL	22	21	23	22	54
E	20	19	20	19	34
F	16	17	16	18	30
IRL	19	20	20	17	24
I	20	19	19	20	41
L	12	12	-	-	8
NL	11	12	11	12	18
A	13	14	13	13	16
P	23	22	24	20	66
FIN	-	8	8	-	30
S	-	-	9	10	20
UK	21	17	22	21	27

(1) European Community Household Panel threshold of poverty risk: 60 % of the national median income, modified OECD scale, in which the first adult of the household counts 1, others aged 14 years or more count 0.5, and children under 14 count 0.3.
(2) Eurobarometer 56.1, Poverty and social devaluation, 2001. These are the percentages of individuals whose total net income is below what they consider absolutely necessary for a proper standard of living.
(3) Western *Länder* of Germany: 11 %, eastern *Länder*: 24 %.

Source: Gallie, D. and Paugam, S. (2002), *Social precarity and social integration*, report for the European Commission based on Eurobarometer 56.1.

IRL		I		L		A		P		UK		
1995	1996	1995	1996	1995	1996	1995	1996	1995	1996	1995	1996	
												EMPLOYED
11	11	20	24 (*)	45	41	26	14	31	28	19	22	Cannot afford to possess a car
9	10	23	26	33	15	18	16	25	20	14	15	Cannot afford a week's holiday
8	8	18	21	30	18	14	10	20	17	13	11	Having difficulty making ends meet
												UNEMPLOYED
47	37	69	49		:	56	46	48	30	60	57	Cannot afford to possess a car
47	40	58	56		:	42	44	38	29	56	59	Cannot afford a week's holiday
42	38	53	54		:	38	34	34	27	53	58	Having difficulty making ends meet
												INACTIVES (**)
38	31	27	26	38	36	37	31	47	45	44	44	Cannot afford to possess a car
33	31	33	35	48	40	27	27	39	35	42	42	Cannot afford a week's holiday
28	27	28	31	43	39	22	19	33	30	37	36	Having difficulty making ends meet

3. RISKS ASSOCIATED WITH THE ENVIRONMENT, WORKING CONDITIONS, LEISURE AND TRAFFIC

3.1. Environment

3.1.1. Emissions of sulphur dioxide (SO_2)

Anthropogenic emissions (those introduced by humans to the environment from natural processes) of sulphur dioxide are partly responsible for acidification, and for the occurrence of winter smog episodes, leading to respiratory conditions (ref. European Commission 2001a). Sulphur dioxide has also been found to contribute towards the degradation of visibility, due to concentrations of aerosol sulphates in the atmosphere. Over the period 1980–98, emissions per head of population reduced by 68 % **(3.1.1)**. The highest emission rates in 1998 were for Greece (51 units per head) and Ireland (48); lowest levels were recorded for Sweden and for Austria (both 6). Austria also showed the greatest reduction over these years (89 %). The current proposed EU directive on national emission ceilings aims for a decrease of 77 % for EU-15 over the period 1990–2010. The table shows that, for the EU, a reduction of 53 % has already been reached, and that Denmark and Luxembourg have already achieved much of this targeted change. The majority of SO_2 emissions in 1998 were from the energy industry (65 %), with the transport sector being less important (5 %). One reason for the reduction in emissions since 1980 has been the decreasing use of lignite, especially in Germany. By contrast, an increased dependence on lignite for electricity generation has helped to make per capita emissions in Greece the highest in the EU. Other contributory factors in the EU decline have been an increase in the use of nuclear power, and European legislation reducing the sulphur content of fuels.

Data on sulphur dioxide emissions are collected by the **European Environment Agency (EEA)** as part of the annual UNECE Convention on Long-range Transboundary Air Pollution (CLRTAP) inventory. The main anthropogenic sources of these emissions are the combustion of coal, lignite and petroleum products. Total emissions of SO_2 are directly related to the amount of sulphur in fossil fuels and the desulphurisation techniques used. When details of the sulphur content or desulphurisation efficiency are not available, default emission factors are used to estimate SO_2 emissions.

3.1.2. Emissions of nitrogen oxides (NO_x)

Nitrogen oxides in the atmosphere can be transported over large distances and deposited many kilometres from their source (ref. European Commission 2001a). Emissions of nitrogen oxides are partly responsible for a variety of problems, including acidification, eutrophication, and increased concentration of photo-oxidants in the atmosphere, resulting in episodes of photochemical smog. Local emissions in urban areas with high traffic density are also associated with impacts on human health. The Sofia Protocol, signed in 1988, established targets for the stabilisation of NO_x emissions to the levels of 1987 to be reached by the year 1994. As Table **3.1.2** shows, by 1998 most Member States had emission rates well below those of 1987 and 1980. At present, the Member States with the highest emission rates are Finland (49 kg per capita) Denmark (44), and Luxembourg (40); as regards the EU, emissions are 28 kg per capita. Future targets for NO_x emissions were set by the 1999 Gothenburg Protocol, with a reduction of 49 % by 2010 compared with 1990. Some Member States are well on the way to achieving this target, in particular Germany and Sweden.

The main contributors to NO_x emissions in the EU are road transport, power stations generating electricity, other mobile sources and industry. Nearly half of all anthropogenic NO_x emissions result from the combustion of fossil fuels in vehicles. Although these emissions have decreased by 25 % since 1980, with considerable reductions from power plants and industry, the main obstacle to further decline is a continued increase in the use of petrol and diesel fuel for road transport. However, the gradual introduction of catalysts is achieving reductions, and this is expected to have a greater impact over the next few years.

Data on emissions of nitrogen oxides are collected by the **European Environment Agency (EEA)** as part of the annual UNECE Convention on Long-range Transboundary Air Pollution (CLRTAP) inventory. Nitrogen oxides (NO_x) include both nitrogen oxide (NO) and nitrogen dioxide (NO_2), but for comparability NO_x emissions are measured here in units of NO_2. Emissions of nitrogen oxides arise mainly from the reaction of nitrogen and oxygen during the combustion of fossil fuels and biomass, as well as from certain production processes. NO_x emissions from large point sources are reported individually, or, when this information is not available, they are estimated from activity data. Good estimates need detailed information on the characteristics of combustion conditions and processes, but these details are often of poor quality. Further work is required by the CLRTAP/EMEP to improve estimates (EMEP is the co-

operative programme for monitoring and evaluation of the long-range transmission of air pollution in Europe).

In 1988, the **protocol** concerning the control of emissions of nitrogen oxides or their transboundary fluxes was adopted in **Sofia** (Bulgaria). This protocol requires, as a first step, the freezing of emissions of nitrogen oxides or their transboundary fluxes. The general reference year is 1987 (with the exception of the United States of America that chose to relate its emission target to 1978).

A **protocol** to abate acidification, eutrophication and ground-level ozone was adopted in **Gothenburg** (Sweden) in 1999. The protocol sets emission ceilings for 2010 for four pollutants: sulphur, NO_x, volatile organic compounds (VOCs) and ammonia. These ceilings were negotiated on the basis of scientific assessments of pollution effects and abatement options. Parties whose emissions have a more severe environmental or health impact and whose emissions are relatively cheap to reduce will have to make the biggest cuts. Once the protocol is fully implemented, Europe's sulphur emissions should be cut by at least 63 %, its NO_x emissions by 41 %, its VOC emissions by 40 % and its ammonia emissions by 17 % compared with 1990. Eutrophication refers to the excessive enrichment of waters with nutrients and the associated adverse biological effects.

3.1.3. Emissions of carbon dioxide (CO_2)

Human activities, in particular the burning of fossil fuels, increase the concentration of greenhouse gases such as carbon dioxide and methane in the atmosphere, resulting in more heat being trapped and increasing global temperatures (ref. European Commission 2001a). In the 1997 Kyoto Protocol, the EU and its Member States committed themselves to an 8 % reduction from the 1990 levels in the emissions of a basket of six greenhouse gases by 2008–12. Carbon dioxide is the most important of these, and the most important source of anthropogenic emissions of this gas is the burning of fossil fuels, whether in power stations, industry or households, or for transport purposes. Although emissions per capita of carbon dioxide in the EU fell by 3 % over 1990–98 **(3.1.3)**, 11 of 15 countries showed a rise in this period, in particular Portugal (up 18 %) and Ireland (up 24 %). Only Germany (down 18 %), Luxembourg (down 55 %), and the United Kingdom (down 12 %) achieved marked reductions, for a variety of reasons. For instance, the UK reduction was the result of a move from coal towards gas for electricity generation. Four main sectors account for most CO_2 emissions in the EU. The energy sector is the most important (32 % of total emissions in 1998), and also the sector where most of the reductions have been made in recent years. Other relevant sectors are industry, transportation and others, mainly residential and commercial heating.

Data on CO_2 emissions are collected in the annual European Community greenhouse gas inventory by **the European Environment Agency (EEA)**. The international method of estimating emissions of greenhouse gases is based on guidelines from the Intergovernmental Panel on Climate Change (IPCC). These guidelines have been formally adopted by all parties to the UN Framework Convention on Climate Change (UNFCCC).

The most recent international effort to address the greenhouse gas effect was the **Kyoto Protocol**, an agreement among the industrialised nations of the world to reduce emissions of six greenhouse gases (primarily carbon dioxide (CO_2)) over a certain period of time. Each of the participating developed countries must decide on how to meet its respective reduction goal during a five-year period (2008–12), but specific ground rules remain to be worked out at future negotiating sessions.

3.1.4. Emissions of non-methane volatile organic compounds (NMVOCs)

Emissions of volatile organic compounds are usually separated into methane and non-methane (NMVOCs), due to their differing effects on the environment (ref. European Commission 2001a). Together with nitrogen oxides, NMVOCs contribute to the formation of photo-oxidants and are thus responsible for photochemical smog, particularly during summer months. NMVOC emissions are directly related to the use of organic solvents, and to various characteristics of fossil fuel use for energy purposes. The 1999 UNECE CLRTAP protocol set a target of a 57 % reduction in VOC emissions between 1990 and 2010. Over 1990–98, NMVOC emissions per capita in EU-15 decreased by 25 %, and certain Member States (the Netherlands, Austria, Luxembourg and Germany) had already achieved much of this reduction by 1998 **(3.1.4)**. In Greece and Portugal, however, the emission rate rose in these years.

In 1998, road transport was responsible for 34 % of NMVOC emissions, mainly from exhaust gases from motor vehicles and from fugitive emissions of gasoline, which occur during the filling of petrol tanks. The progressive fitting of catalytic converters to petrol engine vehicles has contributed to the falling emission rate in some countries. The increase for Portugal and Greece reflects the age of the vehicle fleet in these countries, as well as the level of road vehicle use. A further 38 % of NMVOC emissions are from the use of solvents and

products containing solvents, and VOCs released during their use. Countries which have implemented solvent control regulations (Belgium, Germany and Austria) show marked reductions in emissions from this source.

Data on NMVOC emissions are collected by the **European Environment Agency (EEA)** as part of the annual UNECE Convention on Long-range Transboundary Air Pollution (CLRTAP) inventory. The information collected includes: the amount of fuel consumed for energy purposes; the storage and handling of fuels during transportation and distribution; and the amount of solvents contained in particular products, such as paint, dry-cleaning agents, etc. Estimates of emissions are not very reliable, owing to poor data on the use of solvents. To overcome this, Member States use a 'solvent balance' method, with assumed emission factors, in producing their estimates.

3.1.5. Emissions of heavy metals in air

As they do not decay, all heavy metals emitted into the air will eventually be deposited on land or water and will subsequently accumulate in soil, water and sediments (ref. European Commission 2001a). An index of heavy metal emissions in air **(As-Teq)** has been developed, related to emissions of arsenic, cadmium, chromium, mercury, nickel and lead resulting from key processes, such as combustion. The index is based on human toxicity and the amounts of emitted material. It declined substantially between 1985 and 1996 **(3.1.5)**, with a reduction for the EU of 62 % over these years. Analysed by country, the greatest declines were in Germany and the Netherlands; the smallest in Luxembourg and Portugal. According to **Eurostat**, the most important reduction occurred in the transport sector, where weighted emissions were less than one fifth of the 1985 value. In 1985, road transport made up about one third of the index, but only 13 % in 1995 due to the phasing-out of leaded petrol. The reduction in emissions from the energy sector arose from a swing away from the use of lignite (brown coal) in the former East Germany, and from the increased use of filters in power stations to remove particles, including heavy metals, from flue gases.

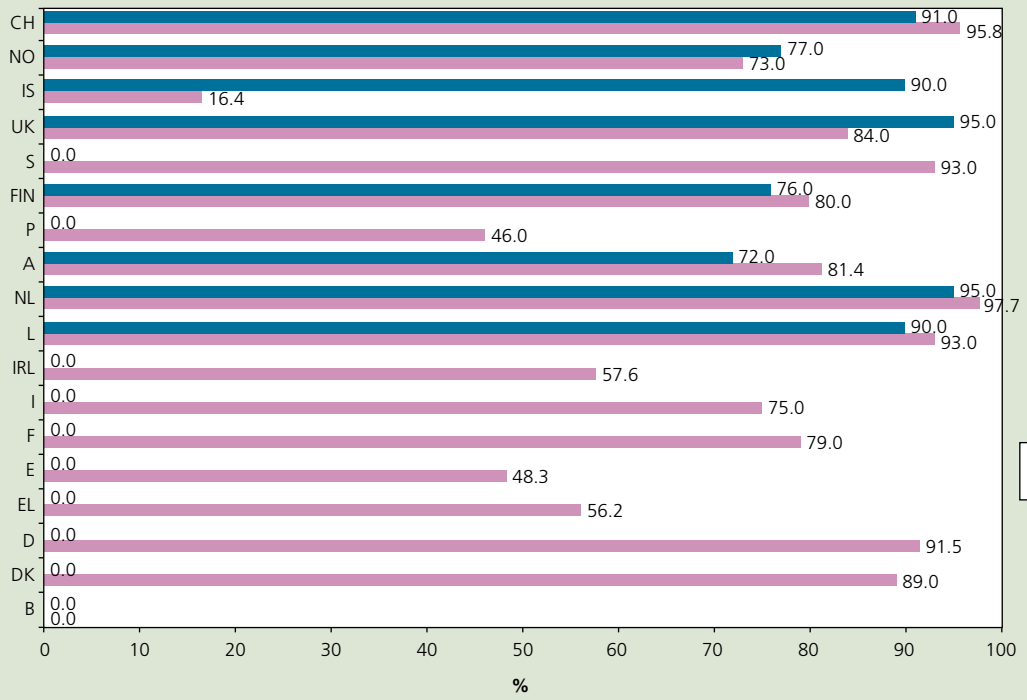
In the industry sector, heavy metal emissions result mainly from the combustion of fuels and from processes in iron and steel production. Within the latter, weighted emissions fell by 40 % between 1985 and 1995. For households, weighted heavy metal emissions fell by 29 % in the same period, a result of the move away from hard coal and lignite for residential heating. The 1998 CLRTAP protocol, on cadmium, lead and mercury, requires the countries to reduce emissions of these three metals to below their 1990 levels. Table **3.1.5** shows that in terms of As-Teq, which includes arsenic and nickel as well as the three metals above, this has been achieved for all Member States except Luxembourg.

The aim of the **As-Teq indicator** (developed by the **Öko-Institut** in Darmstadt and disseminated by **Eurostat)** is to provide a measure of the total amounts of heavy metal emitted to the air from the core sources in EU-15. In its construction, a distinction was drawn between substances with carcinogenic potential and those with long-term toxicity only. The former are weighted according to their unit risk values, while the latter are weighted according to their chronic toxicity. The heavy metal arsenic is used as a reference substance, so that 1 g As = 1 g As-TEQ. The processes included in calculating the index were: public power and heat generation from hard coal; lignite and fuel oil; industrial combustion of hard coal; road transport; the iron and steel industry; waste incineration; and solid fuel combustion in households. Emission data for heavy metals can vary widely for the same energy carrier and energy plant type, so the index should be used with caution in comparing countries or years. As data for 1985 are known to be suspect, the comparison shown here uses the 10-year period 1986–96.

3.1.6. Population connected to a sewerage system

The reduction of the organic loading in domestic (and industrial) sewage is due to treatment by oxidation, i.e. contact with air. To achieve this, the sewerage system collects and transports the untreated sewage. Since 1990, the proportion of the population connected to a sewerage system has increased substantially in some EU Member States, in particular Portugal (46 %) and Austria (from 72 % to 81 %). In all EU countries **(3.1.6)** for which data were available, at least 80 % of the population were connected to a sewerage system by 1998, and for some (the Netherlands and the United Kingdom) the proportion was much higher.

3.1.6 Percentage of population connected to a sewerage system (with treatment), 1990 and 1998 (*)



(*) D: 1995; EL: 1997; E: 1995; F: 1995; IRL: 1995; I: 1995; UK: 1997.

Source: Eurostat, NewCronos database (Environment and energy).

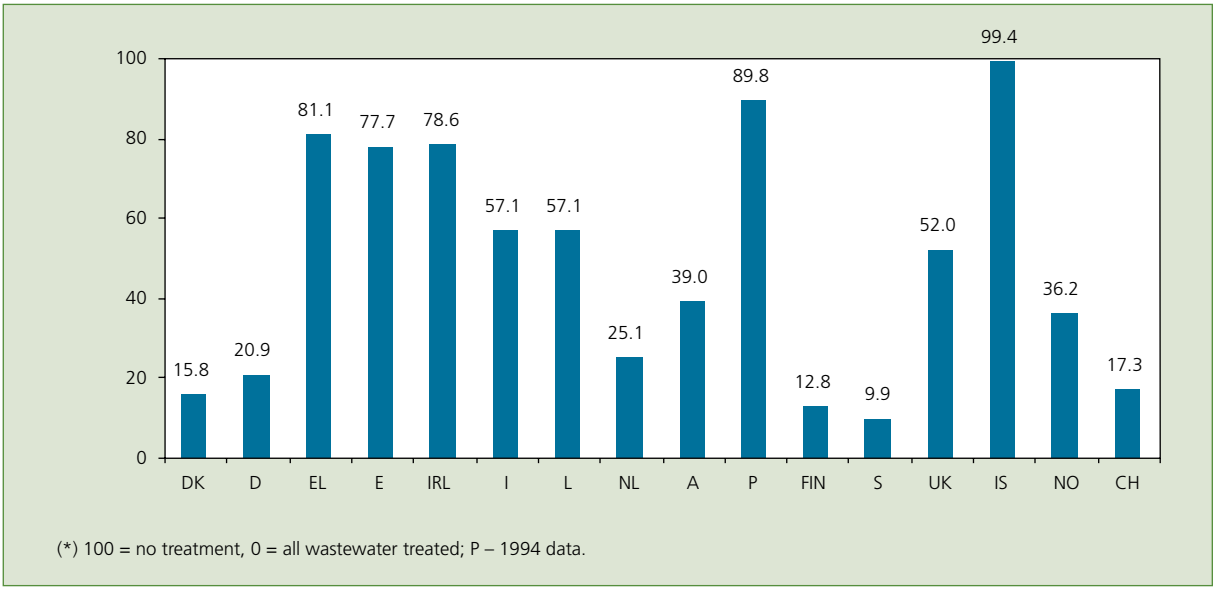
Data on the proportion of the population connected to a sewerage system are supplied by **Eurostat**, which collects information from Member States. As Graph **3.1.6** indicates, some countries have either not reported these details recently or not at all.

3.1.7. Treatment of urban wastewater

The discharge of non-treated urban wastewater is a major cause of pollution of surface water, leading to eutrophication problems, increased bacterial concentrations, oxygen deficiency and increased concentration of nutrients (ref. European Commission 2001a). In urban areas, severe contamination can occur due to sewer overflows or to direct rain run-off through separate sewer systems. To monitor the degree of treatment of urban wastewater, a simple measure is to use the percentage of the population connected to sewage treatment plants (see above). However, a more complex indicator, weighting the different types of treatment according to their ability to remove the most important pollutants, has been created by Eurostat (ref. European Commission 2001a, pp. 150–153). The indicator is based on weights for different types of wastewater treatment. It ranges from 0 (where all wastewater is subject to tertiary-level treatment) to 100 (where there is no treatment at all of wastewater).

In 1995, countries where most wastewater was treated to tertiary level included Sweden (index 10), Denmark (16) and Germany (21), contrasting with those where there was less treatment at this level — Ireland (index 79), Greece (81) and Portugal (90) **(3.1.7)**.

3.1.7 Index of municipal wastewater treatment, 1995 (*)

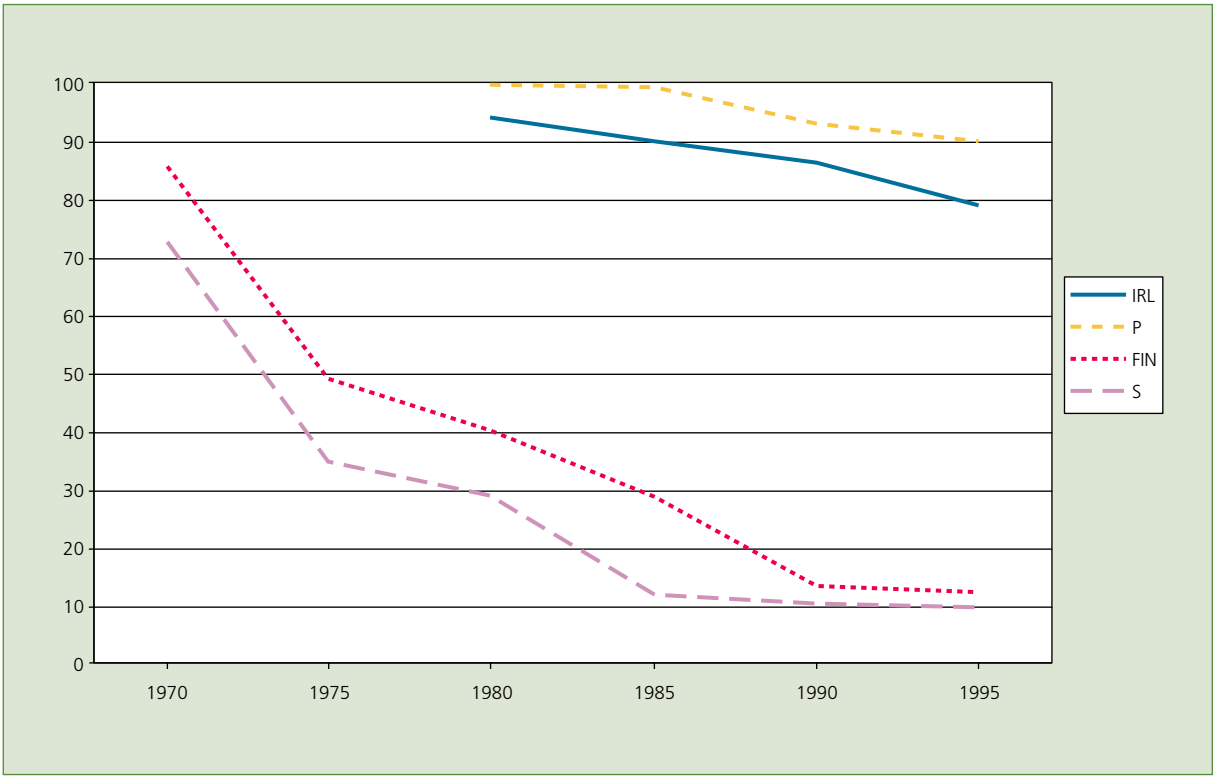


(*) 100 = no treatment, 0 = all wastewater treated; P – 1994 data.

Source: Eurostat, NewCronos database (Environment and energy).

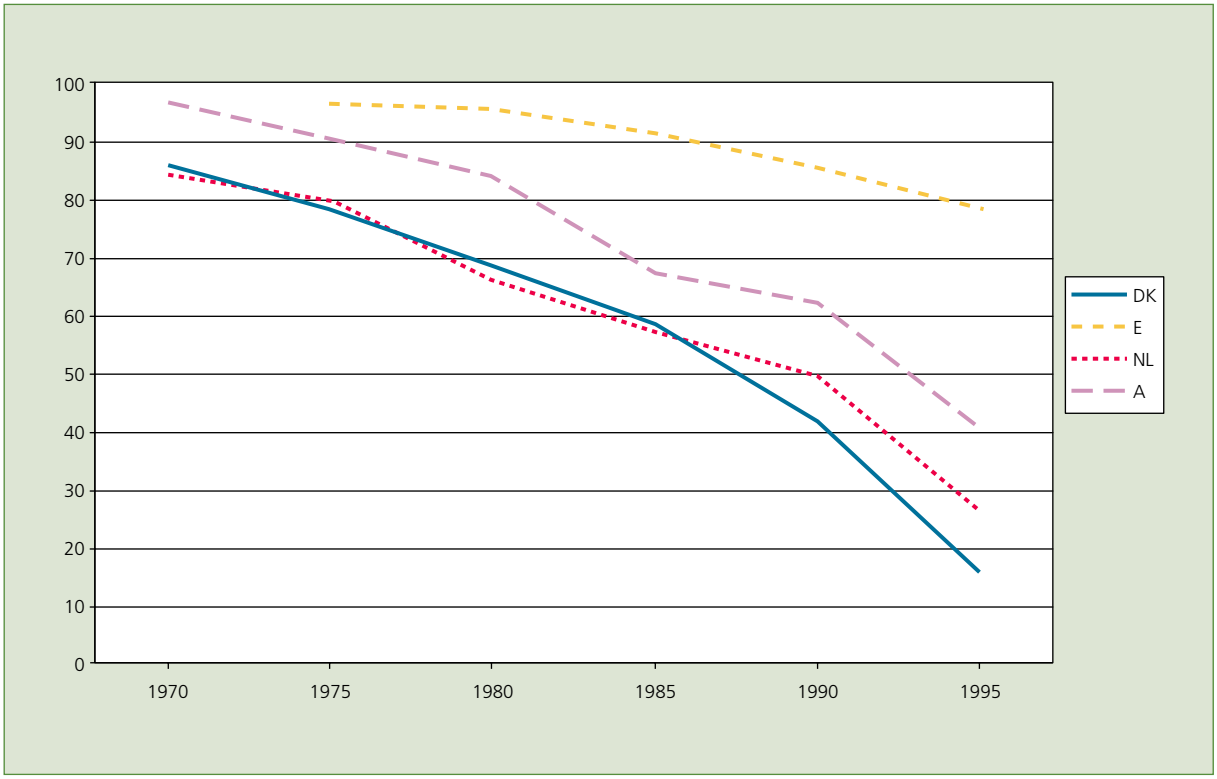
As the same weights were used in estimates for all Member States, the index for those with more efficient treatment systems should be lower. In reality, efficiencies differ from one country to another, so the index is better at illustrating trends for each Member State. As Graphs **3.1.8** and **3.1.9** show, the index has declined markedly in several countries since 1970, as more of the population have been connected to treatment plants and more efficient treatment technologies have been introduced. In general, there have been great improvements, especially in Finland, Sweden, Germany, the Netherlands and Denmark.

3.1.8 Index of municipal wastewater treatment, IRL, P, FIN, S, 1970–95



100 = no treatment is applied; 0 = all wastewater receives tertiary treatment.
Source: Eurostat, adapted by TAU.

3.1.9 Index of municipal wastewater treatment, DK, E, NL, A, 1970–95



100 = no treatment is applied; 0 = all wastewater receives tertiary treatment.
Source: Eurostat, adapted by TAU.

The index of wastewater treatment was developed for **Eurostat** by consultants, which include TAU (Madrid, Spain), EMAIL (Leiden, the Netherlands), Öko-Institut (Darmstadt, Germany) and DHI (Horsholm, Denmark). For each country/year, the index uses a set of weights, based on the theoretical removal efficiency for nitrogen, phosphorus and BOD (biochemical oxygen demand) for each type of treatment. The removal efficiencies are averages, and the same weights were used for all Member States. These weights were: 0 for tertiary treatment, which represents best available technology; 0.49 for secondary treatment; 0.86 for primary treatment; and 1 for no treatment. These weights were applied to the percentage of the population connected to each type of treatment plant and the percentage of the population without treatment.

3.1.8. Emissions of particles

Human health is at risk from high concentrations of particles in the atmosphere, particularly those smaller than 10 µm, which have been associated with heart and lung disease. Suspended particles, combined with high levels of sulphur dioxide, lead to episodes of winter smog in areas of low wind speeds and temperature inversion (ref. European Commission 2001a). When inhaled, they penetrate deep into the lungs and are considered to affect adversely health because they put an extra burden on people with COPD (chronic obstructive pulmonary disease) or CVDs (cardiovascular diseases). Particulate emissions also have a negative effect on visibility. Finer particles are mostly carbon and aerosols. The former is soot resulting from incomplete combustion of fuels, especially diesel and wood. Coarser particles result mainly from mechanical processes, such as mining and quarrying, and other industrial processes.

While emission rates have been estimated for the EU, there is a lack of data for many Member States. Differences in national definitions and methodologies, including differences in size thresholds, mean that the data in Table **3.1.10** are more suitable for following trends than for comparing countries. For most of the countries with continuous data, there was a reduction in particulate emissions over 1980–96, due mainly to a decline in the use of coal for heating and power generation. At the same time, emissions from road traffic, in particular from diesel engines, increased. These are of particular concern, although the trends for individual countries can be quite different.

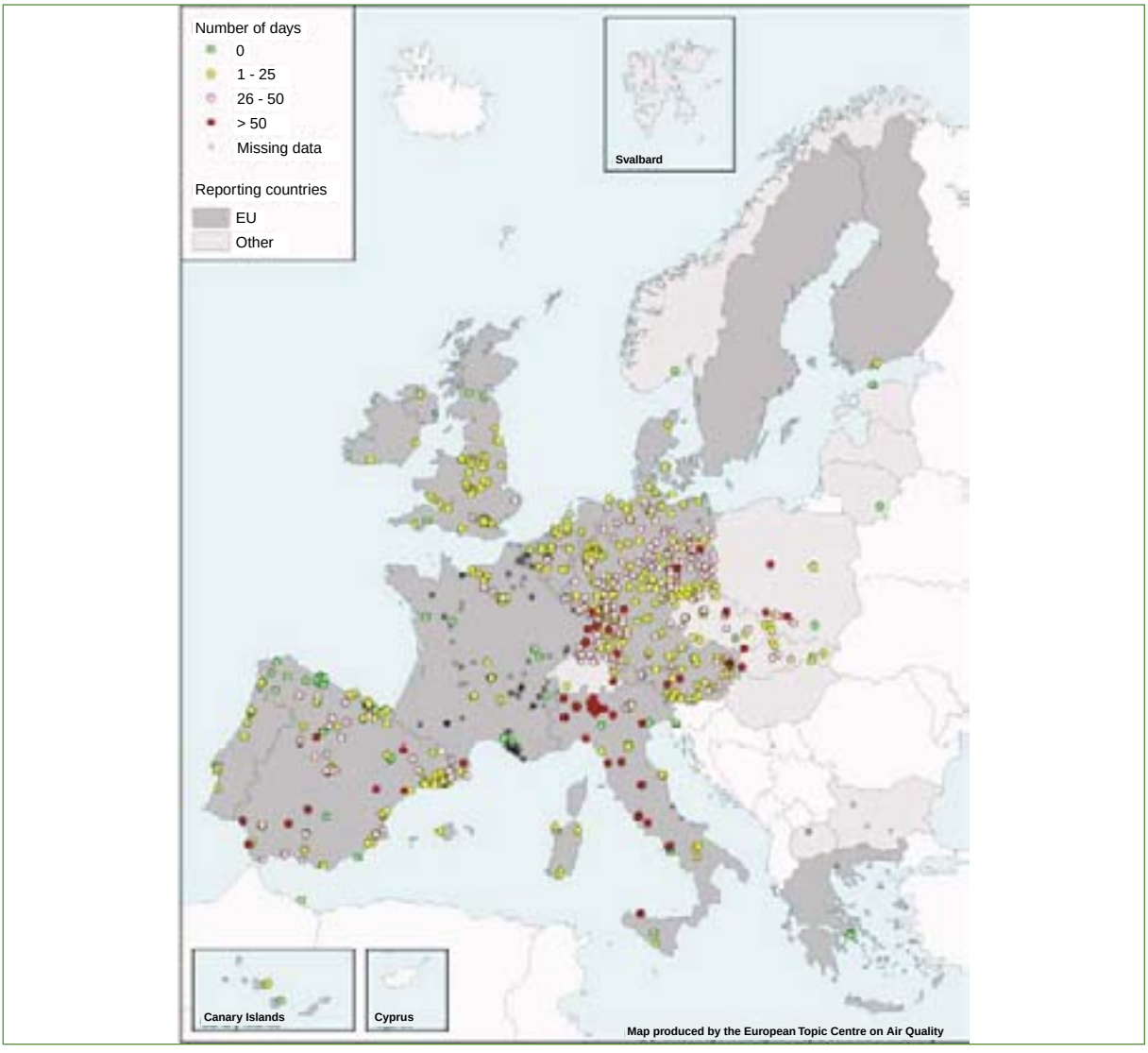
Data on particulate emissions are collected in a **Eurostat/OECD** joint questionnaire. Much of the current interest in these emissions is on very fine breathable particles, due to concern for their probable impact on human health. Particulate emissions are calculated from fuel use and emission factors, which vary with the combustion process.

3.1.9. Air pollution from ozone

Tropospheric ozone is a pollutant which is not directly emitted but formed by the reaction of precursors such as nitrogen oxides and VOCs under the influence of sunlight. It is thus a photochemical oxidant, giving rise to photochemical smog as a health hazard. Human exposure to elevated levels of ozone concentration can give rise to inflammatory responses and to decreases in lung functions. Symptoms observed are a cough, chest pain, difficulty in breathing, headache and eye irritation.

Under an EU Council directive of 1994, Member States are required to monitor ozone concentrations and to report details of episodes where concentrations exceed agreed threshold values (ref. EEA 2001). The threshold for human health protection is 110 µg/m^3, averaged over an eight-hour period. Ozone concentrations usually reach their maximum in the afternoon, when sunlight intensity is greatest, so the hours from noon to 8 p.m. are regarded as the most suitable for measuring maximum daily concentrations. Data for 1999 show that the threshold was most often reached in urban areas of Italy (especially the north) and certain parts of Germany and Spain **(3.1.11)**.

3.1.11 Number of days when the 100 µg/m^3 (12–20 h) ozone threshold was exceeded ([1]) — Urban, street and other stations, 1999

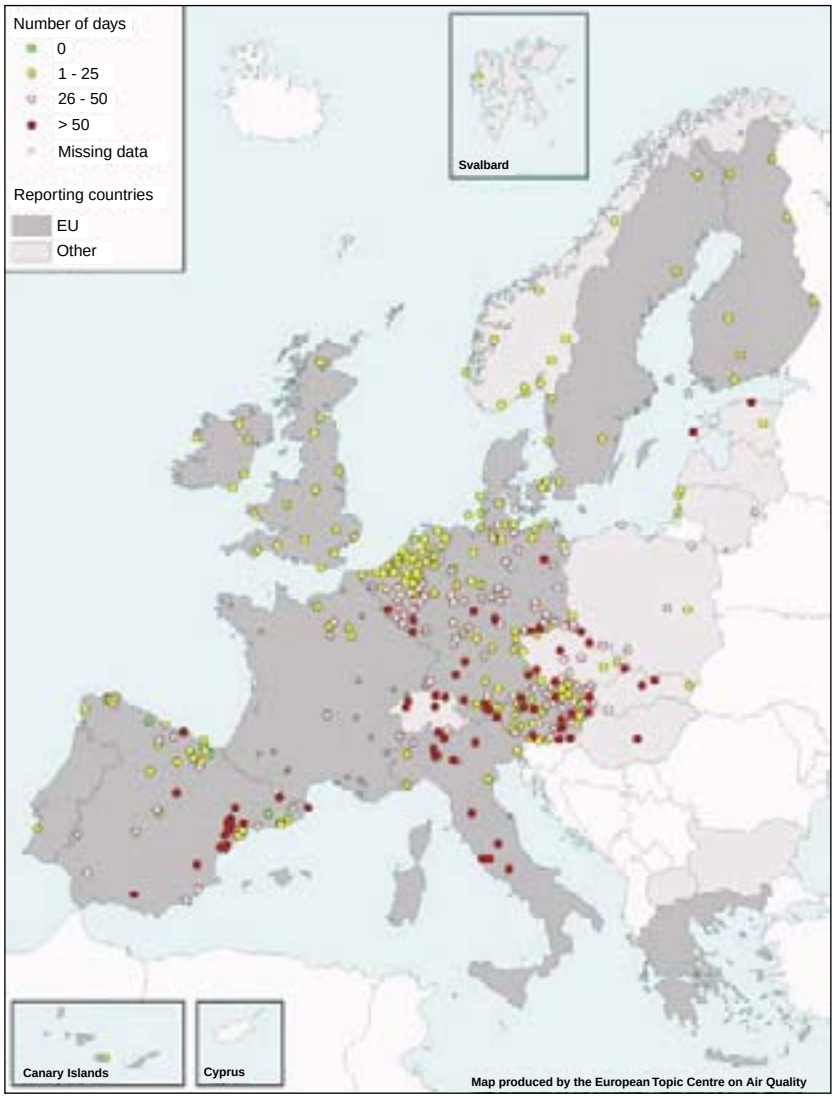


([1]) The threshold value of ozone for protection of human health is 100 µg/m3; the map shows, at measuring stations, the number of days in 1999 when this threshold was exceeded during the hours 12.00 to 20.00.

Source: European Environment Agency, Topic report No 1/2001.

In rural areas, the pattern was similar, but with parts of Austria also frequently reaching these levels **(3.1.12)**. The EEA considers that these higher measurements for Austria may be related to the altitude of the recording stations. It also reports that 42 % of the EU population was exposed to concentrations above 110 µg/m^3 for 1–25 days in 1999, and that 12 % experienced such an exposure for 50 days or more. The EU ozone Directive gave target values, but these were expressed in terms of a 120 µg/m^3 concentration being exceeded on not more than 20 days a year. Although it is not straightforward to compare 1999 data with the target, the EEA considers that the threshold for risk to human health was exceeded over the EU in that year.

3.1.12 Number of days when the 110 µg/m^3 (12–20 h) ozone threshold was exceeded ([1]) — Rural stations, 1999



([1]) The threshold value of ozone for protection of human health is 110 µg/m3; the map shows, at measuring stations, the number of days in 1999 when this threshold was exceeded during the hours 12.00 to 20.00.

Source: European Environment Agency, Topic report No 1/2001.

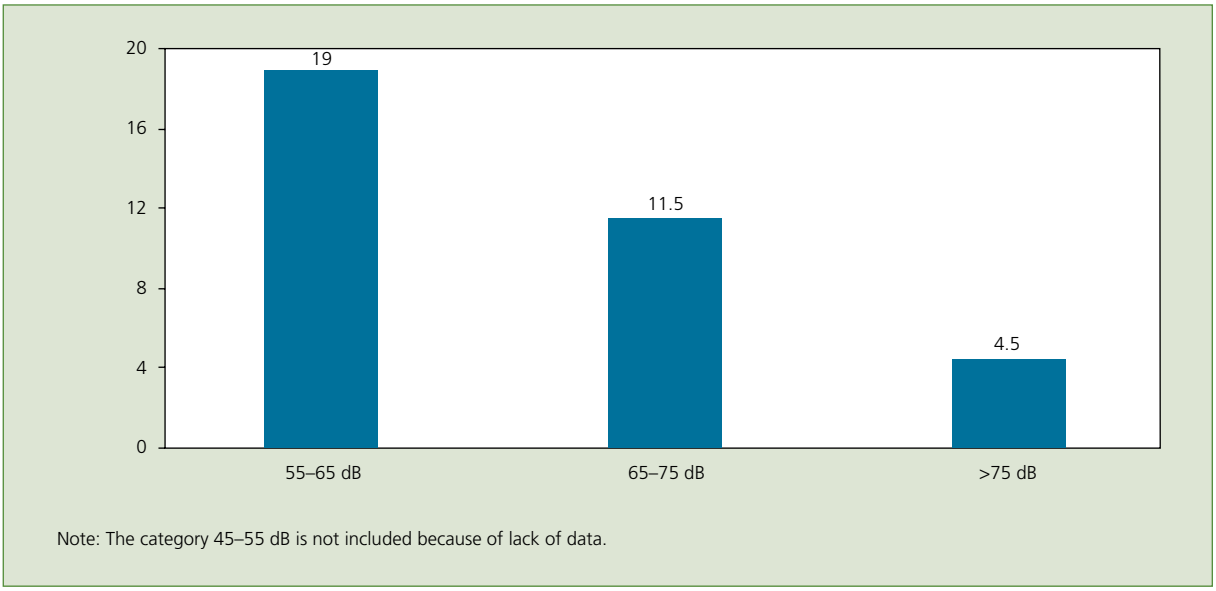
Information on air pollution from ozone is prepared by the European Topic Centre on Air Quality, under contract to the **European Environment Agency (EEA)**. In 1999, 1 451 monitoring stations reported information, of which 1 304 were located in EU Member States. Of the latter, 346 were in rural areas, 563 in urban background environments, 266 on a street, and 129 in either an industrial or unspecified environment.

3.1.10. Noise exposure

Traffic noise: exposure and annoyance

Noise is a serious issue — levels over 40 Ldn dB(A) affect our well-being, while there is evidence that levels over 60 Ldn dB(A) can affect our physical and psychological health (ref. EEA 2001). While the last two decades have seen significant reductions in the noise produced by all types of vehicles, the rapid growth in transport — particularly air and road — has resulted in well over 120 million people in the EU being exposed to noise levels above 55 Ldn dB(A) outside their homes. This represents over 30 % of the EU population **(3.1.13)**; more than 50 million people are exposed to noise levels above 65 Ldn dB(A). It is also estimated that 10 % of the EU population are exposed to rail noise above 55 dB LAeq. The data on noise nuisance by aircraft are the most uncertain, but studies indicate that 10 % of the total EU population may be extremely annoyed by air transport noise.

3.1.13 Share of population exposed to different road traffic noise levels (EU-15) (% of total EU population)



Note: The category 45–55 dB is not included because of lack of data.

Source: European Environment Agency, 1999.

Noise affects people physiologically and psychologically: noise levels above 40 dB LAeq can influence well-being, with most people being moderately annoyed at 50 dB LAeq and extremely annoyed at 55 dB LAeq. Levels above 65 dB LAeq are detrimental to health (ref. WHO 1999). EU noise emission limits have been tightened considerably since 1972 and EU legislation now sets maximum sound levels for motor vehicles, motorcycles and aircraft. However, methodological inconsistencies (non-harmonised indices and inadequate testing procedures for vehicles) have hampered progress on urban acoustic quality standards and severely limit the accuracy of noise assessments. The European Commission finally adopted Directive 2002/49/EC of the European Parliament and of the Council of 25 June 2002 relating to the assessment and management of environmental noise.

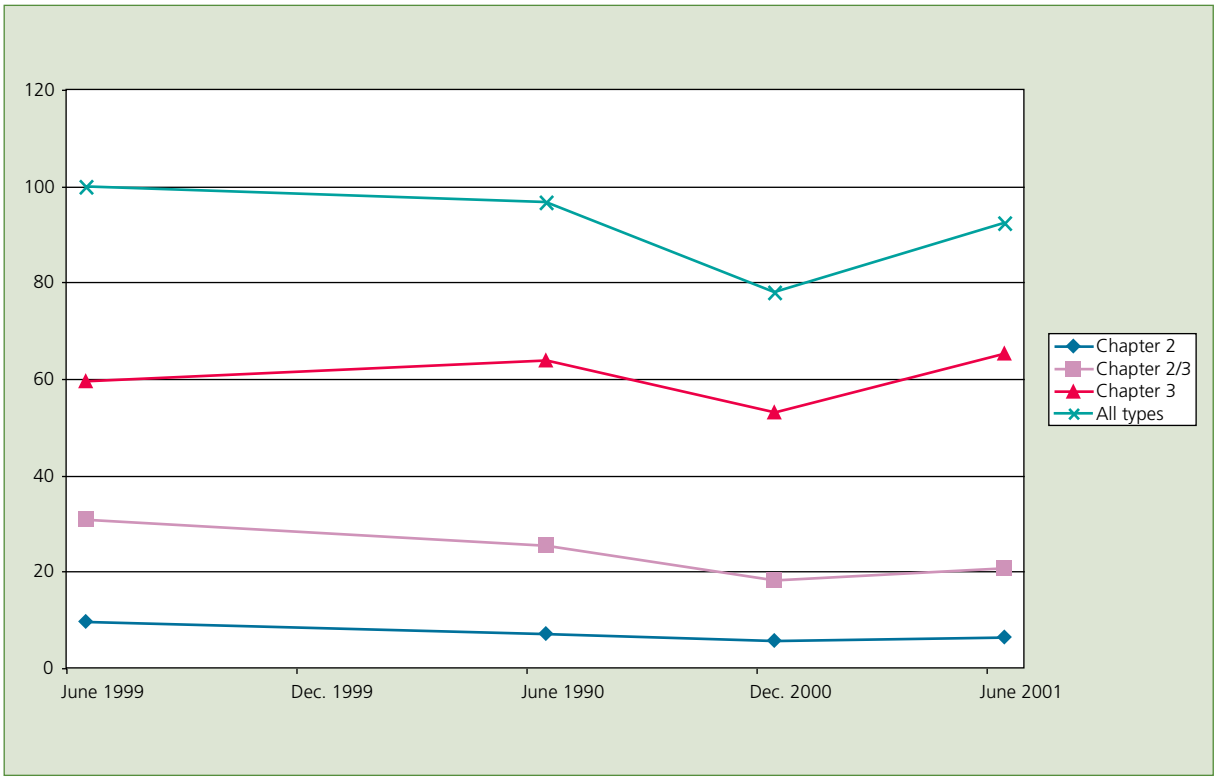
Air traffic exposure

Air traffic noise differs from the continuous fluctuating noise of road traffic in that it is associated principally with intense peaks as aircraft land and take off (ref. ECAC 1997). However, airport staff and those living close to airports are also subjected to high levels of noise from engine start-up, taxiing and other ground operations, such as auxiliary power units. Noise levels often exceed 60 dB and are dependent on the number of aircraft movements and type of aircraft. Population exposure is determined by the population pattern around the airport as well as the flight paths. Proven effects of aircraft noise include sleep disturbance, learning difficulties in children, hypertension, heart disease and a persistent feeling of malaise. International efforts to reduce noise from air transport have been aimed principally at reducing the noise of the aircraft themselves (see box below). However, setting standards for new aircraft has only a gradual impact on noise levels due to the long operating life and slow rate at which new aircraft enter the fleet. Other measures have also been necessary. Council Directive 83/206/EEC prevents non-noise-certificated aircraft registered outside the EU from landing in the EU. The **European Civil Aviation Conference (ECAC)** and the European Commu-

nity banned fleets from acquiring further Chapter 2 aircraft from November 1990. Council Directive 92/14/EEC has banned all Chapter 2 aircraft from 1 April 2002. Other measures to reduce aircraft and airport noise include restrictions on the noisiest aircraft especially at night, noise charges, land-use planning and mitigation measures, such as noise barriers.

ECAC has recently examined the situation regarding the phasing-out of Chapter 2 aircraft in Europe. Aircraft were classified into three categories: Chapter 2, Chapter 3 and Chapter 2/3, representing aircraft types which exist in different versions coming under different chapters, or possibly fitted with hushkits. ECAC used Eurocontrol estimates of noise energy by aircraft type for three recent periods: 1 June 1999, 1 June 2000, and 1 December 2000. Eurostat has added Eurocontrol estimates for 1 June 2001 for the purposes of this analysis. Total flights from ECAC countries rose by 14 % between 1 June 1999 and 1 June 2001, but this increase contained a decline of 56 % in flights by Chapter 2 and 43 % by Chapter 2/3 aircraft. The rise in flight numbers for Chapter 3 aircraft has resulted in a small increase in noise energy from this category **(3.1.14)**.

3.1.14 Total estimated noise energy (*), ECAC countries, 1999–2001



(*) Total noise energy in June 1999 = 100.
Source: Eurostat, NewCronos database (Environment and energy).

However, declining flight numbers for the other two categories have produced a marked fall in their corresponding overall noise emissions, and an overall decline in noise emissions for all aircraft types combined, indicating the effects on overall noise emissions of phasing out older aircraft. Figures for 1 December 2000 are included to show the effect of seasonal variation. On 1 June 2000, there were 448 695 departures from ECAC airports, of which 3 761 (0.8 %) were Chapter 2 aircraft. However, these flights produced 7.7 % of total sound energy from all flights. Similarly, Chapter 2/3 aircraft accounted for 8.4 % of all departures on that day, while producing 26.7 % of total sound energy. The effect of removing Chapter 2 aircraft will thus be disproportionately great in reducing noise levels (ref. ECAC 2001).

LAeq (hour equivalent continuous A-weighted sound pressure level in dB(A) referenced to 20 micropascals) means that steady noise level which would, in the course of a certain hour period, cause the same A-weighted sound energy as that due to

the actual noise over an actual working day. The **Ldn** (day–night noise level) is a measure of the 24-hour noise environment. It represents the constant A-weighted noise level that would be measured if all the sound energy received over the day was averaged. It also includes a 10 dB weighting for late night noise events.

The United Nations **International Civil Aviation Organisation (ICAO)** first established international noise certification standards in 1971. First-generation jet aircraft (e.g. Boeing 707 and Douglas DC-8) were not included in this certification and are hence known as non-noise certified. Aircraft designed before October 1977 were certified as Chapter 2 (e.g. BAe1-11, Boeing 727, Boeing 737-200 and Douglas DC-9). Since October 1997, new aircraft (e.g. 737-300/400, Boeing 767, Douglas DC-10 and Airbus A319) have been required to meet the stricter standards of Chapter 3. From 1 January 2006, new aircraft will have to conform to the even more stringent Chapter 4.

The **European Civil Aviation Conference (ECAC)** has 38 members, which include all EU Member States and nearly all European countries. ECAC is studying the traffic of carriers from developing nations, focusing on the current position and foreseeable developments in using noisy aircraft. This work was supported by **Eurocontrol** (European Organisation for the Safety of Air Navigation), the primary objective of which is the development of a seamless, pan-European air traffic management system. Data on noise emissions during overflight and approach for each type of aircraft were provided by the Association of European Airlines.

3.2. Working conditions

3.2.1. Safety at work

Safety at work may be measured by analysing the incidence of accidents at work. In 1999, there were an estimated 4 786 898 accidents at work in the EU which resulted in more than three days' absence, an increase of 2.3 % from the 4 678 586 similar accidents in 1998 **(3.2.1)**. These data were collected by **Eurostat** from the **European statistics on accidents at work (ESAW)** for 1994 onwards and complementary data from the **Labour Force Survey (LFS)** for 1999 (ref. Dupré 2001). Using these sources, the incidence rate (expressed per 100 000 persons in employment) for nine common branches of economic activity showed a steady downward trend from 4 539 in 1994 to 4 089 in 1998 and 4 088 in 1999. A similar comparison by branch of economic activity shows an increase for 1999 for those in agriculture, hunting and forestry (up 4.0 %), for workers in wholesale and retail trade and repairs (up 1.8 %), in hotels and restaurants (up 3.4 %) and for those in financial, real estate, renting and business activities (up 10.3 %). Analysed by age and sex, incidence rates in 1999 were markedly higher for men (5 253) than for women (1 909). They were also highest at the youngest ages of 18–24 years (5 804 in 1999), and fell with increasing age. The activities with the highest incidence rates tended to be those employing a large proportion of younger workers, particularly men, such as in construction.

ESAW data can also be used to analyse fatal accidents at work **(3.2.2)**. In 1999, there were 5 275 fatal accidents at work in the EU, of which 4 736 were of workers in the nine common branches of economic activity. The incidence of these accidents fell steadily from 1994 to 1999, and stood at 4.77 in 1999, a fall of 22 % from 1994. This downward trend was particularly evident for workers in financial intermediation (down 27 % from 1994 to 1999), in hotels and restaurants and in manufacturing (down 26 %). By contrast, the incidence rate for workers in the manufacturing of basic metals and fabricated metal products rose by 16 % from 1994 to 1998 (but was down again in 1999). Trend data in fatal accidents by age of worker show a greater fall in the incidence for younger workers (down 11.9 % from 1996 to 1999 for those aged 18–24 years) than for older workers (down 3.9 % for those aged 55–64 years).

The incidence of accidents at work in 1999 varied widely between countries **(3.2.3)**. Spain (standardised incidence rate of 7 027 per 100 000 employees in nine common branches), Portugal (5 048), and France, Luxembourg, Belgium and Germany (between 5 000 and 4 900) showed the highest levels, while Ireland (1 291), Sweden (1 425) and the United Kingdom (1 606) were the lowest. However, in general, the highest levels occurred for countries where an insurance system covers accidents at work, and the lowest for countries depending on declarations of accidents to the Labour Inspectorate, suggesting that the level depends on the source used. Fatal accidents at work are analysed by those in road traffic and transport (RTTA), and all others. For non-RTTA, the standardised incidence rate for EU-15 in 1999 was 2.9 deaths per 100 000 employees in the nine common branches. This rate ranged from 7.0 in Ireland, 6.3 in Greece and 6.1 in Portugal to 1.1 in Sweden and 1.4 in the United Kingdom.

The medical and economic consequences of accidents at work may be analysed by the part of the victim's body injured and by the type of injury suffered. In the EU and Norway in 1999, the majority of accidents affected the upper limbs (42 %) and lower limbs (27 %) **(3.2.4)**. Very few affected the whole body (3 %), but amongst these about one in eight (13 %) resulted in an absence of three

months or more, or permanent incapacity. Those suffering injuries to the limbs were much less likely to be absent for a long period (5 % for upper limbs, 7 % for lower limbs). The commonest injuries were wounds and superficial injuries (41 % of total injuries) and dislocations, sprains and strains (26 %); only 1.6 % were traumatic amputations, but nearly a third (31 %) of these amputations resulted in long-term absence or permanent incapacity. Bone fractures are an important group, comprising 11 % of all injuries, of which 9 in 10 result in an absence of two or more weeks.

The more recent LFS data (for 1999) identified specific groups of workers who were at a particularly high risk of accident at work **(3.2.5)**. Thus, the incidence of all accidents to workers in fisheries and aquaculture was 43 % greater than for all workers; this is based on an analysis of all accidents, with or without absence from work. In this same general group, accidents in short-term construction jobs were especially risky: where the job was temporary, the incidence was 132 % greater than the norm, and where the worker had been in post for less than two years it was 71 % greater. In addition, temporary workers in health and social work had an incidence rate 91 % greater, and workers of under two years seniority in hotels and restaurants showed a rate 72 % over the norm. The groups at high risk of accidents resulting in long-term absence (two weeks or more) were: workers in construction (70 % higher than the norm), in agriculture, hunting and forestry (44 % greater), and in mining and quarrying (39 % greater). Moreover, shift workers in general had a rate 34 % greater than the norm, and night workers 27 % greater.

European statistics on accidents at work (ESAW), collected by **Eurostat,** are based on Council Directive 89/391/EEC on measures to encourage improvements in the safety and health of workers at work. They cover both fatal accidents and accidents at work resulting in more than three days absence from work. The latter refers to accidents with a return to work not before the fifth day after the day of the accident, or at least four days absence from work. In nine Member States accidents must be reported in order to qualify for treatment under the social security or insurance scheme, so that virtually all accidents are included. In six others (Denmark, Greece, Ireland, the Netherlands, Sweden, and the United Kingdom, as well as in Norway) recording is incomplete and Eurostat estimates the overall number using an assumed reporting rate estimated by the Member States concerned. In the 1999 European Union **Labour Force Survey (LFS)**, a household survey on employment and the labour market, an ad hoc module covered accidents at work and occupational illnesses. Accidents at work were recorded retrospectively, by asking about their occurrence in a most recent 12-month period. The module was used by 11 Member States (the exceptions being Belgium, France and Austria, with the Netherlands using it at a later date).

3.2.2. Work environment

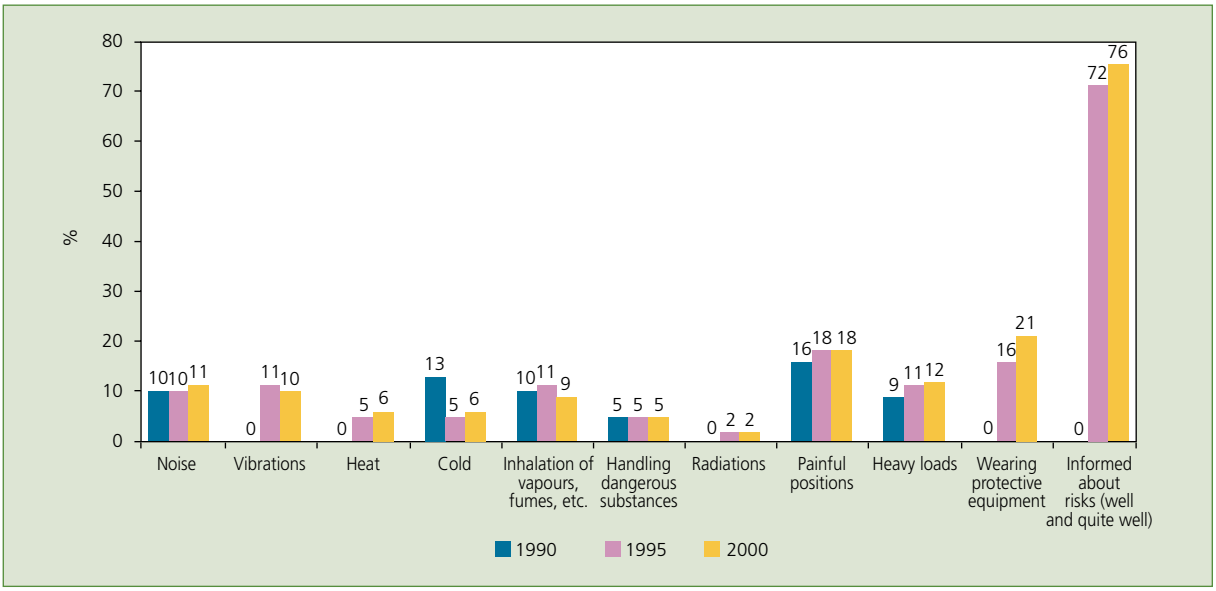
The Third **European Survey on Working Conditions** (ESWC), carried out in 2000 by the **Foundation for the Improvement of Living and Working Conditions,** showed that all workers in the EU continue to be exposed to physically stressful environments (29 % to intense noise, 47 % to painful and tiring positions, and 37 % to handling heavy loads) **(3.2.6)**.

3.2.6 Workers exposed to physical hazards

Source: Foundation for the Improvement of Living and Working Conditions, Dublin.

However, regarding other physical work factors **(3.2.7)**, improvements in some areas were observed since the 1995 survey — for example, exposure to cold (from 6 % to 5 %), inhalation of vapours/fumes (from 11 % to 9 %) and vibrations (from 11 % to 10 %). In addition, the use of protective equipment has increased, from 16 % to 21 %. The extent of exposure to physical risk varies according to gender, status, sector and occupation. In general, women are less exposed than men — although painful/tiring positions are experienced equally by both. A clear link emerged between temporary work and poor working conditions, which increase exposure to health risks: 62 % of employees with temporary agency contracts consider they are well informed about the risks in using materials, instruments or products, against 79 % of employees with indefinite contracts; 38 % of the former type of employee and 36 % of employees with fixed-term contracts make repetitive movements continuously against 29 % of those with indefinite contracts. Some 27 % of workers consider their health and safety to be at risk because of their work. This proportion declined slightly over the decade, from 30 % in 1990 to 28 % in 1995.

3.2.7 Physical work factors, EU-15 (%)



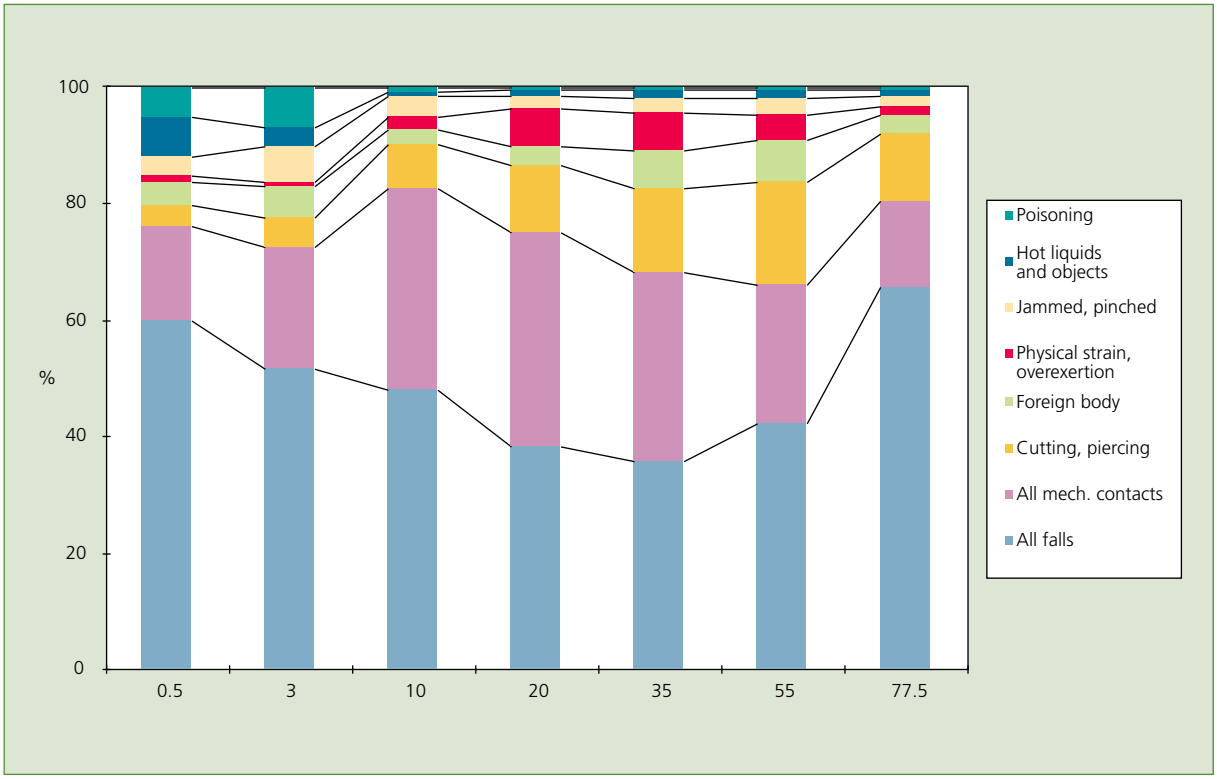
Source: Foundation for the Improvement of Living and Working Conditions, Dublin.

The **Foundation for the Improvement of Living and Working Conditions** carried out its third European Survey on Working Conditions in 2000 (ref. Paoli and Merllié 2001). This survey is carried out as a module of the **Eurobarometer** survey (see box in Section 2.1.4). The two previous surveys were carried out in 1990 and 1995. For the 2000 survey, a total of 21 703 workers were interviewed in face-to-face interviews conducted in their own homes. Around 1 500 workers were interviewed in each Member State, with the exception of Luxembourg where the number of persons interviewed totalled 502. This survey, in common with the 1990/91 and the 1995/96 surveys, was conducted by national institutes which carry out this type of survey at national level and in close cooperation with Eurostat.

3.3. Home and leisure accidents

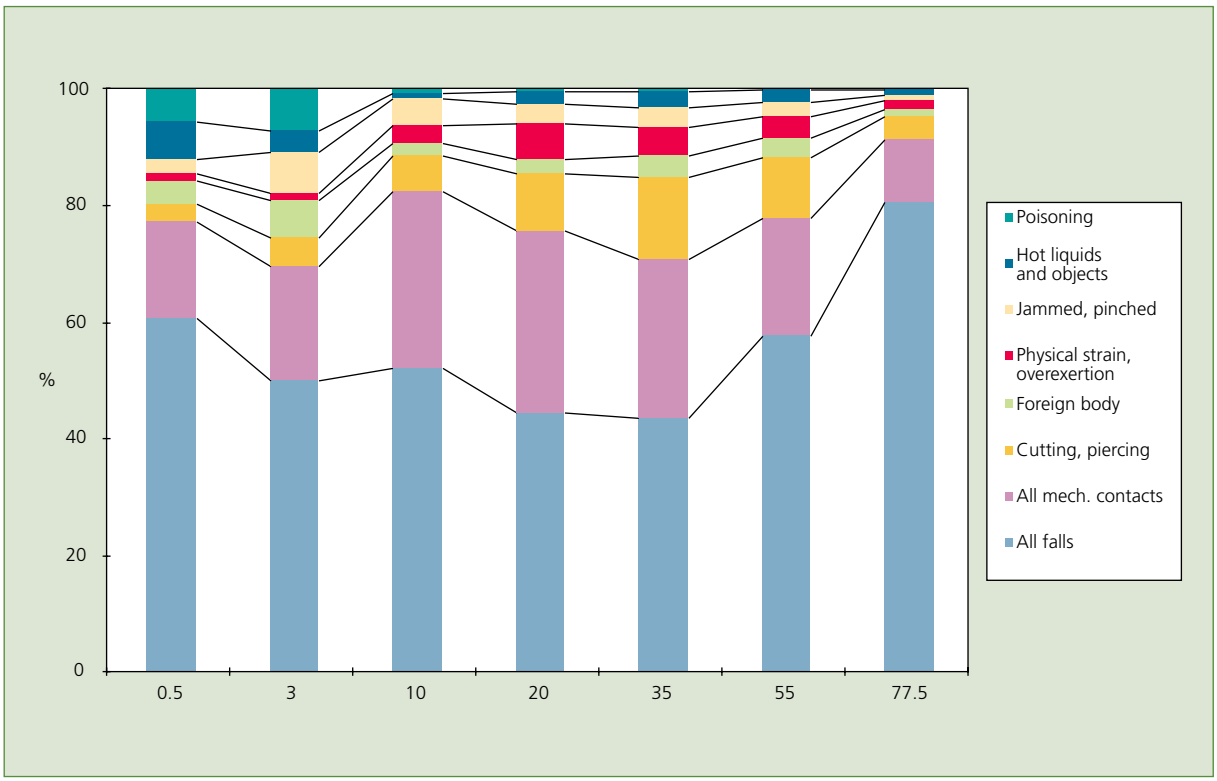
While the EU recognises the value and importance of data on accidents in the home and during leisure activities, there is a lack of up-to-date information on this subject. The most recent data relate to the period 1993–95 and are provided by the **European home and leisure accident surveillance system (Ehlass)**. Analyses presented here focus on the types of accidents in 1995, and the victim's sex and age **(3.3.1** and **3.3.2)**. For females, falls were the most common type in home and leisure accidents at all ages — in particular for infants under one year (60 % of all accidents) and for those aged 65 and over (80 %). Accidental poisonings were evident only at ages under five (6 %), while accidents involving cutting or piercing instruments become relatively more common with increasing age (3 % of infant accidents to 10 % of those at ages 55–64), and are then less common at ages 65 and over. Similar patterns were found for male accidents analysed in this way.

3.3.1 Home and leisure accidents by age and type of injury, EU, 1995 — Males



Source: European home and leisure accident surveillance system, Health and Consumer Protection DG.

3.3.2 Home and leisure accidents by age and type of injury, EU, 1995 — Females



Source: European home and leisure accident surveillance system, Health and Consumer Protection DG.

The **European home and leisure accident surveillance system (Ehlass)** originates from Council Decision 93/683/EEC of 29 October 1993, and has provided a network for the collection of information on home and leisure accidents. Data were collected by Member States and results submitted to the **Directorate-General for Health and Consumer Protection** (SANCO) of the European Commission. However, no results are available for later than 1995, and current plans are for a new injury surveillance system (ISS) to produce data on these accidents in the near future. The ISS is one of a number of applications to form part of the European Public Health Network (Euphin European Commission, 2001b).

3.4. Traffic accidents

Information allowing an analysis of road safety focuses on two measures: the incidence of injuries in road traffic accidents (RTAs) and the mortality from fatal RTAs. RTAs include accidents which involve one or more drivers, passengers, cyclists, motorcyclists and pedestrians. While there are agreed international classification standards for recording injuries and fatalities in RTAs, there are also variations in the way countries record and present the data. Changes in classification over time may also complicate the interpretation of trends. Taking these into account, the rate of injuries in road traffic accidents for the EU in 1999 was, according to **Eurostat**, 489 per 100 000 population, 17 % less than the rate in 1970 **(3.4.1)**. The decline since 1990 has been 6 %, but this minor change includes much variation between countries. Accident injury rates have risen sharply since 1990 in Italy (up 42 %), Ireland (up 17 %), and Greece (up 13 %). Over the same period rates have fallen for Finland (down 32 %), France (down 29 %), and Luxembourg (down 25 %).

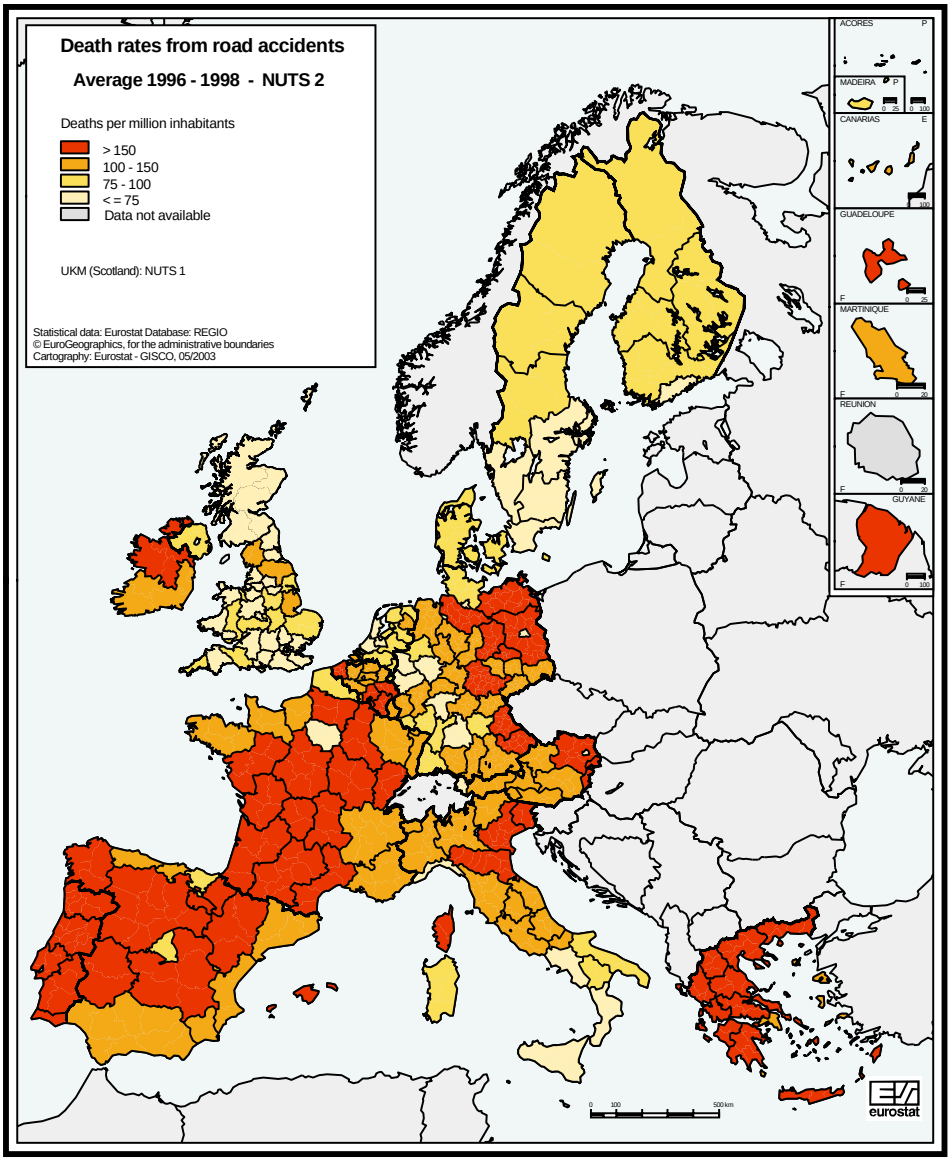
RTAs form the majority of all fatalities in transport accidents, and are the most common cause of death for persons aged under 40. Compared with normal life expectancy, a fatal RTA represents on average 40 years of life lost; corresponding losses are 10.5 years for cancer deaths and 9.7 years for deaths from cardiovascular disease (ref. Collin 2000). Mortality from RTAs in the EU has declined in recent years, from 140 deaths per million population in 1990 to 110 in 1998. This decline is evident in most Member States, but in Greece the rate rose, from 175 in 1991 to 212 in 1998.

Analysed by sub-national areas, mortality rates vary considerably over the EU **(3.4.2)**. In addition, these rates are not comparable with those in Chapter 5 of this volume because of differences in notification systems. Over the three-year period 1996–98, the highest rates were recorded for five Greek regions (Anatoliki Makedonia, Sterea Ellada, Thessalia, Kentriki Ellada and Peloponnisos), two Portuguese regions (Alentejo and Algarve), Namur (Belgium) and Luxembourg. However (ref. Loof and Finn 2001), when comparing regional rates, the population size and number of vehicles must be taken into account, together with other factors affecting road safety, such as quality of roads, size and quality of vehicles, attitude to safety belts and speed, and respect for traffic regulations. For instance, within the EU the permitted level of alcohol varies from 0.2 mg/ml in Sweden to 0.8 mg/ml in Ireland, Italy, Luxembourg and the United Kingdom. In Denmark and Sweden, the speed limit on motorways is 110 km/h but in France, Italy and Austria it is 130 km/h; moreover, Germany enforces no speed limit over much of its motorway network. Widespread social acceptance of limits on driver behaviour may explain the uniformity of mortality rates in RTAs over the regions of Sweden (ref. Loof and Finn 2001). The lowest mortality rates were found mainly in large urban areas: Brussels (Belgium), Hamburg (Germany), Berlin (Germany), Vienna (Austria), Uusimaa (Finland), Stockholm (Sweden), Vastsverige (Sweden), London (the United Kingdom) and West Midlands (the United Kingdom). These rates may possibly be explained by the relatively lower speeds encountered in urban areas, as well as the extensive use of public transport, even among car owners (ref. Loof and Finn 2001). An illustration of differences in methods and definitions is the contrast between high rates for RTA mortality and low rates for injuries in RTAs, as for instance in Greece, and the converse (low mortality rates, high accident rates) in, for example, the United Kingdom.

In 1997, nearly two thirds (64 %) of RTA fatalities were to vehicle drivers; younger drivers (under 34) were especially vulnerable, comprising 41 % of all RTA deaths (ref. Collin 2000). By contrast, 44 % of pedestrians killed in RTAs were aged 65 and over. Analysed by day of occurrence, nearly 50 % of all RTAs took place towards the end of the week, with 15 % on Fridays, and 17 % on Saturdays and Sundays respectively.

Deaths in road traffic accidents (RTAs) include those occurring either at the scene or within 30 days of the accident. Data are collected by **Eurostat**, and are presented here as standardised death rates, using a standard reference population. Although the reference period of 30 days has been agreed by the ECMT (European Conference of Ministers for Transport), there are wide variations in the period used by Member States. Data on persons injured in RTAs are obtained from the **UNECE** statistics on road traffic accidents in Europe.

3.4.2 Road safety: number of deaths per million inhabitants in the regions of the EU, 1996/98



Source: Eurostat, NewCronos database (Transport).

The **nomenclature of territorial units for statistics (NUTS)** (see web site reference) was established by Eurostat to provide a uniform and consistent breakdown of territorial units for the production of regional statistics for the European Union. Until now, the NUTS classification has had no legal base but, after extensive deliberations in the Council and European Parliament, it is hoped that the NUTS regulation will be adopted during 2002. The NUTS nomenclature is defined only for the 15 Member States of the European Union. NUTS subdivides each Member State into a whole number of NUTS 1 regions, each of which is in turn subdivided into a whole number of NUTS 2 regions and so on. It is thus a hierarchical classification. NUTS subdivides the economic territory of the Member States of the European Union into 78 regions at NUTS 1 level, 211 regions at NUTS 2 level and 1 093 regions at NUTS 3 level. Because of their relatively small area or population, some countries do not have all three regional levels. Ireland and Sweden have no level 1 regions; accordingly, the country level and level 1 are identical. Denmark has neither level 1 nor level 2 regions; thus, the country level and levels 1 and 2 are identical. Luxembourg, not having regions at levels 1, 2 or 3, is defined at all levels of NUTS as the whole country. In the maps in this publication, the statistics are presented at NUTS 2 level.

References

Collin, C. (2000), *Transport safety*, 'Statistics in focus', Theme 7 — 3/2000, European Commission.

Dupré, D. (2001), *Accidents at work in the EU 1998–99*, 'Statistics in focus', Theme 3 — 16/2001, European Commission.

ECAC (1997), *Report on standard method of computing noise contours around civil airports*, ECAC.CEAC Doc. 29.

ECAC (2001), 'Analysis of the June 2000 period for noisy aircraft', paper for meeting of Group of Experts on the Abatement of Nuisances caused by Air Transport, Madrid, June 2001.

EEA (European Environment Agency) (2001), *Air pollution by ozone in Europe in 1999 and the summer of 2000*, Topic report No 1/2001, Copenhagen.

Ehlass (European home and leisure accident surveillance system), http://europa.eu.int/comm/health/ph/programmes/injury/ehlass/default.htm.

European Commission (2001a), *Environmental pressure indicators for the EU,* Luxembourg.

European Commission (2001b), *Euphin Newsletter*, August 2001.

Loof, A. and Finn, N. (2001), *Road traffic deaths in the regions of Europe*, 'Statistics in focus', Theme 1 — 5/2001, European Commission.

NUTS, 'Regions — Nomenclature of territorial units for statistics — NUTS' (http://forum.europa.eu.int/Public/irc/dsis/regstat/ information).

Paoli, P. and Merllié, D. (2001), *Third European Survey on Working Conditions*, Foundation for the Improvement of Living and Working Conditions, Dublin.

WHO (1999), *Guidelines for Community noise* (http://www.who.int/peh/noise/guidelines2.html noise).

3.1.1 Emissions of sulphur dioxide (SO_2)

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1980	65	41	66	95	57	76	24	55	67	44
1985	54	41	66	95	55	62	23	52	34	44
1990	45	37	35	67	50	53	22	53	29	39
1991	40	33	47	50	54	53	24	51	27	38
1992	37	32	37	41	54	52	21	48	25	38
1993	33	29	30	36	53	49	18	45	23	38
1994	30	25	30	30	51	48	17	49	22	32
1995	28	24	29	26	53	44	16	45	23	21
1996	24	24	35	18	52	38	16	41	20	19
1997	21	22	21	17	50	38	13	45	18	13
1998	21	20	15	16	51	38	14	48	18	8
% change 1980–98 ([1])	*-68*	*-52*	*-78*	*-83*	*-10*	*-50*	*-40*	*-13*	*-73*	*-81*
1990–98 ([2])	*-53*	*-48*	*-59*	*-77*	*3*	*-28*	*-36*	*-10*	*-39*	*-78*

([1]) For IS and CH the change is over 1980–97.
([2]) For IS and CH the change is over 1990–97.
Source: Eurostat, NewCronos database (Environment and energy).

3.1.2 Emissions of nitrogen oxides (NO_x)

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1980	38	32	57	43	43	27	35	35	29	57
1985	37	32	57	43	42	24	34	33	29	57
1987	38	33	55	43	38	26	34	33	32	59
1990	37	34	52	34	32	30	33	34	34	61
1991	36	34	62	31	33	31	34	34	35	62
1992	35	34	53	29	32	32	33	37	35	63
1993	33	34	52	27	32	31	31	33	33	63
1994	32	34	53	25	33	31	30	32	31	57
1995	31	33	48	24	33	31	29	32	31	52
1996	30	31	55	23	34	30	29	33	31	54
1997	29	30	47	23	35	30	28	32	29	43
1998	28	29	44	22	36	30	28	33	29	40
% change 1980–98	*-25*	*-9*	*-24*	*-49*	*-15*	*11*	*-19*	*-5*	*1*	*-30*
1987–98	*-25*	*-11*	*-21*	*-50*	*-4*	*17*	*-17*	*0*	*-9*	*-32*

Source: Eurostat, NewCronos database (Environment and energy).

(kg SO_2 per capita)

NL	A	P	FIN	S	UK	IS	NO	CH	
19	51	35	54	16	87	38	34	18	**1980**
18	25	34	53	16	66	31	:	12	**1985**
14	12	35	52	15	65	32	12	6	**1990**
12	11	34	39	13	62	28	10	6	**1991**
11	8	40	28	12	60	31	9	6	**1992**
11	8	34	24	12	54	33	8	5	**1993**
10	7	32	22	11	46	30	8	4	**1994**
10	7	37	19	11	40	30	8	5	**1995**
9	7	34	21	9	34	32	8	5	**1996**
8	6	34	19	6	28	32	7	5	**1997**
7	6	34	17	6	27	:	7	:	**1998**
									% change
-61	*-89*	*-5*	*-68*	*-63*	*-68*	*-15*	*-80*	*-75*	***1980–98*** (1)
-47	*-52*	*-3*	*-67*	*-62*	*-58*			*-46*	***1990–98*** (2)

(kg per capita)

NL	A	P	FIN	S	UK	IS	NO	CH	
41	30	32	59	48	46	60	46	27	**1980**
40	29	31	58	48	45	85	:	28	**1985**
39	28	31	58	47	48	97	54	27	**1987**
39	25	31	57	47	49	103	52	25	**1990**
38	25	33	58	46	46	104	49	24	**1991**
37	24	35	56	45	45	109	49	22	**1992**
35	22	35	56	45	41	111	50	21	**1993**
33	23	36	55	43	39	110	49	19	**1994**
32	21	37	51	41	36	106	49	19	**1995**
32	21	38	52	34	35	110	51	19	**1996**
30	21	38	51	31	32	105	51	18	**1997**
29	21	38	49	29	30	:	51	:	**1998**
									% change
-28	*-30*	*19*	*-18*	*-40*	*-35*		*10*		***1980–98***
-25	*-25*	*21*	*-16*	*-39*	*-38*		*-6*		***1987–98***

3.1.3 Anthropogenic emissions of carbon dioxide (CO_2)

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1980	:	:	12.6	14.1	5.0	5.1	8.2	:	6.5	:
1985	:	:	12.5	13.9	5.9	4.8	6.0	:	6.1	30.0
1990	9.1	11.6	10.3	12.8	8.4	5.6	5.7	9.0	7.3	26.2
1991	:	12.0	12.3	12.2	8.3	5.8	6.1	9.1	7.1	:
1992	8.9	11.7	11.2	11.5	8.3	6.0	5.9	9.3	7.3	:
1993	8.7	10.8	11.5	11.3	8.4	5.7	5.4	9.1	7.1	27.6
1994	8.7	11.2	12.2	11.1	8.4	6.0	5.2	9.5	6.8	22.3
1995	8.7	12.4	11.5	11.1	8.6	6.2	5.4	9.6	7.3	17.1
1996	8.9	12.7	14.0	11.3	8.8	5.9	5.5	9.8	7.6	16.8
1997	8.7	12.4	12.1	10.9	9.1	:	5.4	10.4	7.7	14.3
1998	8.8	12.0	11.3	10.8	9.5	:	5.7	10.8	7.9	11.7
1999	:	11.9	10.7	10.5	:	:	5.6	11.2	7.9	11.9
% change 1990–99 [1]	-3	3	4	-18	13	5	-1	24	9	-55

([1]) 1990–98 for EU-15, EL, P, IS; 1990–96 for E.
Source: European Environment Agency.

3.1.4 Emissions of non-methane volatile organic compounds (NMVOCs)

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1980	44	67	39	42	65	45	47	32	38	42
1985	43	67	39	42	63	44	46	31	35	42
1990	42	34	32	41	33	48	45	31	39	50
1991	40	30	33	35	33	48	44	32	40	47
1992	39	30	32	32	33	47	43	32	41	44
1993	37	30	29	29	34	44	41	30	41	41
1994	36	29	31	27	34	46	39	30	41	44
1995	35	28	31	24	35	44	37	29	41	40
1996	33	26	26	23	36	43	36	30	37	40
1997	32	27	26	22	37	43	35	31	36	36
1998	31	26	24	21	38	43	33	31	36	31
% change 1990—98	*-25*	*-24*	*-24*	*-49*	*15*	*-10*	*-25*	*-1*	*-6*	*-37*

Source: Eurostat, NewCronos database (Environment and energy).

(tonnes per capita)

NL	A	P	FIN	S	UK	IS	NO	CH	LI	
11.8	8.5	:	11.3	9.9	10.7	7.9	7.9	:	6.0	**1980**
10.4	7.8	:	10.2	8.0	10.0	7.9	7.7	:	6.6	**1985**
11.0	8.0	5.7	11.8	6.4	10.3	8.2	8.3	6.0	7.2	**1990**
11.3	8.4	6.0	11.8	6.4	10.3	8.1	7.9	6.2	7.3	**1991**
11.1	7.6	6.4	11.3	6.5	10.0	8.4	8.0	6.0	7.5	**1992**
11.2	7.5	6.2	11.3	6.4	9.7	8.7	8.3	5.5	7.2	**1993**
11.3	7.7	6.2	12.4	6.6	9.6	8.6	8.7	5.3	7.2	**1994**
11.8	7.9	6.4	11.9	6.6	9.4	8.6	8.7	5.4	:	**1995**
12.2	8.1	6.3	13.1	7.1	9.7	8.9	9.3	5.4	:	**1996**
11.7	8.3	6.4	12.6	6.3	9.3	9.2	9.4	5.3	:	**1997**
11.5	8.1	6.7	12.4	6.4	9.6	9.1	9.3	5.4	:	**1998**
11.0	8.1	:	12.4	6.4	9.0	:	9.3	5.7	:	**1999**
0	1	18	5	0	-12	11	13	-5		***% change 1990–99*** **(1)**

(kg per capita)

NL	A	P	FIN	S	UK	IS	NO	CH	
38	47	32	44	64	40	24	44	51	**1980**
37	47	31	43	64	41	43	:	50	**1985**
34	45	32	42	63	43	50	71	44	**1990**
28	40	33	41	60	41	55	70	40	**1991**
29	36	35	40	58	39	54	77	37	**1992**
27	34	35	39	56	38	52	80	34	**1993**
25	32	37	37	53	37	53	82	32	**1994**
24	32	37	36	51	35	45	84	30	**1995**
23	31	38	34	50	33	45	84	29	**1996**
20	30	38	34	48	31	36	82	28	**1997**
19	29	38	34	48	30	:	78	:	**1998**
-43	*-34*	*19*	*-20*	*-23*	*-29*		*10*		***% change 1990–98***

3.1.5 As-Teq weighted emissions of heavy metals to the air

(1995 = 100)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1985	234	230	314	538	157	143	218	180	134	125	403	320	118	224	339	222
1990	165	143	148	331	113	153	159	132	108	84	192	207	117	131	153	152
1991	152	143	162	289	114	135	137	132	106	82	164	179	116	124	141	148
1992	138	136	135	237	110	118	123	122	110	75	143	167	123	113	138	136
1993	121	121	123	187	104	105	109	115	102	60	132	118	108	100	119	123
1994	109	117	115	141	99	104	98	107	101	75	112	100	97	98	104	111
1995	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
1996	88	81	104	84	93	82	99	102	88	97	77	99	81	78	91	86
% change 1985–96	*-62*	*-65*	*-67*	*-84*	*-41*	*-42*	*-54*	*-44*	*-34*	*-23*	*-81*	*-69*	*-31*	*-65*	*-73*	*-61*

Source: Öko-Institut (via Eurostat).

3.1.10 Emissions of particulates

(kg per capita)

	EU-15	B	D	F	IRL	I	L	NL	A	FIN	S	UK	NO	CH
1980	12.0	:	33.3	8.1	27.6	7.7	:	11.2	9.9	:	:	6.4	5.0	5.8
1985	11.6	:	34.2	5.4	33.1	7.9	8.4	6.1	7.7	16.7	:	6.0	5.4	4.3
1990	9.4	2.4	23.0	4.1	29.9	8.8	:	5.0	5.0	15.2	4.7	5.5	5.6	3.6
1991	6.9	:	12.0	4.1	:	:	:	4.0	4.9	14.4	:	5.4	5.2	3.4
1992	5.8	:	8.0	3.9	:	:	:	4.0	:	12.2	:	5.2	5.1	3.2
1993	5.3	:	6.0	3.7	:	:	:	4.0	:	11.2	:	5.0	5.7	3.0
1994	4.9	2.7	4.0	3.6	:	:	:	4.0	:	10.4	:	4.6	6.2	2.9
1995	4.8	:	4.0	:	:	:	:	3.0	:	9.5	:	3.7	5.9	2.8
1996	4.6	:	4.0	:	:	:	:	3.0	:	10.0	:	3.6	6.2	2.7
1997	:	:	4.0	:	:	:	:	3.0	:	10.1	:	:	5.0	2.6
% change 1980–96 (1)	*-61*	*:*	*-88*	*-55*	*:*	*:*	*:*	*-73*			*:*	*-44*	*23*	*-54*

(1) For 1980–96 or for latest comparable year.

Source: Eurostat, NewCronos database (Environment and energy).

3.2.1 Accidents at work in the EU by sex, age and type of activity, 1994–99

Type of economic activity ([1])	Persons in employment 1999 (thousands)	Accidents at work with more than 3 days absence from work ([7])								
		Estimated number 1999	Incidence rate ([6])						Change in incidence rate (%)		
			1994	1995	1996	1997	1998	1999	1994–98	1996–98	1998–99
Total — all branches of activity	**139 377**	**4 786 898**									
A, and D to K: total of 9 common branches	**99 269**	**4 058 272**	**4 539**	**4 266**	**4 229**	**4 106**	**4 089**	**4 088**	***-9.9***	***-3.3***	***0.0***
of which ([2]):											
men	61 896	3 251 269	5 960	5 534	5 458	5 291	5 268	**5 253**	***-11.6***	***-3.5***	***-0.3***
women	33 205	633 899	1 936	1 864	1 924	1 865	1 890	**1 909**	***-2.4***	***-1.8***	***1.0***
18-24 years	12 138	707 120	:	:	5 751	5 613	5 725	**5 804**		***-0.5***	***1.4***
25-34 years	28 883	1 215 247	:	:	4 390	4 210	4 179	**4 118**		***-4.8***	***-1.5***
35-44 years	26 171	945 924	:	:	3 766	3 696	3 678	**3 703**		***-2.3***	***0.7***
45-54 years	20 571	731 519	:	:	3 558	3 548	3 543	**3 521**		***-0.4***	***-0.6***
55-64 years	8 900	311 040	:	:	4 063	3 671	3 602	**3 577**		***-11.4***	***-0.7***
A: Agriculture, hunting and forestry	**5 124**	**361 736**	**6 496**	**6 123**	**6 771**	**6 647**	**6 790**	**7 060**	***4.5***	***0.3***	***4.0***
D: Manufacturing	**30 022**	**1 342 302**	**5 071**	**4 962**	**4 660**	**4 607**	**4 492**	**4 471**	***-11.4***	***-3.6***	***-0.5***
of which ([3]) :											
da Manufacture of food products, beverages and tobacco	3 397	275 012	7 360	6 920	6 557	6 550	6 323	**6 264**	***-14.1***	***-3.6***	***-0.9***
db Manufacture of textiles and textile products	2 266	52 469	:	2 765	2 639	2 589	2 653	**2 642**		***0.5***	***-0.4***
dc Manufacture of leather and leather products	506	10 132	:	2 505	2 394	2 308	2 292	**2 390**		***-4.3***	***4.3***
dd Manufacture of wood and wood products	910	87 661	:	10 238	10 793	12 020	10 677	**10 399**		***-1.1***	***-2.6***
de Manufacture of pulp, paper and paper products, publishing and printing	2 556	63 828	:	2 795	2 686	2 606	2 596	**2 548**		***-3.4***	***-1.8***
df Manufacture of coke, refined petroleum products and nuclear fuel	175	1 469	:	1 158	1 094	962	875	**859**		***- 20.0***	***-1.8***
dg Manufacture of chemicals, chemical products and man-made fibres	2 068	43 222	:	2 431	2 400	2 195	2 177	**2 126**		***- 9.3***	***-2.3***
dh Manufacture of rubber and plastic products	1 289	52 015	:	4 233	3 897	3 843	3 827	**4 102**		***- 1.8***	***7.2***
di Manufacture of other non-metallic mineral products ([4])	1 159	69 423	6 518	6 915	6 533	6 543	6 269	**6 352**	***-3.8***	***- 4.0***	***1.3***
dj Manufacture of basic metals and fabricated metal products	4 414	348 068	8 650	9 022	8 546	8 331	8 076	**8 080**	***-6.6***	***- 5.5***	***0.0***
dk Manufacture of machinery and equipment n.e.c.	3 277	110 661	:	3 708	3 308	3 523	3 615	**3 412**		***9.3***	***-5.6***
dl Manufacture of electrical and optical equipment	3 329	86 556	:	2 858	2 684	2 638	2 631	**2 637**		***- 2.0***	***0.2***
dm Manufacture of transport equipment	2 922	79 891	:	2 936	2 734	2 756	2 883	**2 782**		***5.5***	***-3.5***
dn Manufacturing n.e.c.	1 753	61 895	:	4 292	3 929	3 628	3 670	**3 686**		***- 6.6***	***0.4***
E: Electricity, gas and water supply	**1 156**	**16 459**	**:**	**1 545**	**1 619**	**1 662**	**1 625**	**1 423**		***0.4***	***-12.4***
of which ([3]) :											
e40 Electricity, gas, steam and hot water supply	918	11 418	:	1 368	1 383	1 461	1 410	**1 215**		***2.0***	***-13.8***
e41 Collection, purification and distribution of water	239	5 041	:	2 133	2 426	2 429	2 382	**2 182**		***- 1.8***	***-8.4***
F: Construction	**10 825**	**845 315**	**9 014**	**9 080**	**8 023**	**7 963**	**8 008**	**7 809**	***-11.2***	***- 0.2***	***-2.5***
G: Wholesale and retail trade; repair of motor vehicles, motorcycles, and personal and household goods	**21 037**	**525 071**	**2 552**	**2 523**	**2 431**	**2 394**	**2 451**	**2 496**	***- 4.0***	***0.8***	***1.8***
H: Hotels and restaurants ([5])	**5 425**	**201 328**	**4 121**	**3 645**	**3 532**	**3 365**	**3 590**	**3 711**	***-12.9***	***1.6***	***3.4***
I: Transport, storage and communication	**7 833**	**446 649**	**6 139**	**5 790**	**6 018**	**5 937**	**5 862**	**5 702**	***-4.5***	***- 2.6***	***-2.7***
of which ([3]) :											
i60 Land transport, transport via pipelines	3 141	188 319	5 732	5 139	6 000	6 006	5 987	**5 939**	***4.5***	***- 0.2***	***-0.8***
i61 Water transport	92	4 652	4 933	4 658	4 886	5 132	5 290	**5 347**	***7.2***	***8.3***	***1.1***
i62 Air transport	366	13 144	5 470	4 397	4 121	4 184	4 317	**3 682**	***-21.1***	***4.8***	***-14.7***
i63 Supporting and auxiliary transport activities; activities of travel agencies	1 953	185 812	11 580	11 829	10 526	10 415	9 755	**9 643**	***-15.8***	***- 7.3***	***-1.1***
J and K: Financial intermediation; real estate, renting and business activities	**17 848**	**319 412**	**1 638**	**1 627**	**1 582**	**1 602**	**1 623**	**1 790**	***-0.9***	***2.6***	***10.3***

Source: European statistics on accidents at work (ESAW). For Denmark and Ireland, 1998 = 1997; for France 1997 = 1998; for the Netherlands 1995–98 = 1994 accidents number, 1999 accidents numbers are revalued in proportion to the evolution 1999/94 of the employment; for Portugal 1996 = 1995, and 1998 = from 1999 data.

([1]) Classified by NACE Rev. 1 (economic activity), section (branch), and subsection or division (sector); branches cover the range A to K.

([2]) Gender or age are not always specified (particularly for the Netherlands); workers aged under 18 or over 64 are included in the total; incidence rates by age after age class correction for Portugal.

([3]) Incidence rates exclude Portugal; NACE Section I 'Transport, storage and communication' includes Division i64 'Post and telecommunications'.

([4]) Glass, ceramic goods, construction products.

([5]) Incidence rates exclude Portugal before 1996.

([6]) Incidence rates expressed as number of accidents at work per 1 000 persons in employment.

([7]) Excludes fatal accidents.

Source: Eurostat, NewCronos database (Health and safety).

3.2.2 Fatal accidents at work in the EU by sex, age and type of activity, 1994–98

Type of economic activity (1)	Persons in employment 1999 (thousands)	Fatal accidents at work (7)									
		Estimated number 1999	Incidence rate (6)						Change in incidence rate (%)		
			1994	1995	1996	1997	1998	1999	1994–98	1996–98	1998–99
Total — all branches of activity	**139 377**	**5 275**									
A, and D to K: total of 9 common branches	**99 269**	**4 736**	**6.09**	**5.90**	**5.18**	**5.22**	**5.03**	**4.77**	***- 17.5***	***- 3.0***	***-5.2***
of which (2):											
men	61 896	4 409	:	:	7.70	7.70	7.40	**7.12**	***.***	***- 3.8***	***-3.8***
women	33 205	239	:	:	0.76	0.82	0.84	**0.72**	***.***	***11.6***	***-14.3***
18–24 years	12 138	417	:	:	3.88	3.71	3.60	**3.42**	***.***	***- 7.3***	***-5.0***
25–34 years	28 883	1 055	:	:	4.10	3.94	3.85	**3.58**	***.***	***- 6.2***	***-7.0***
35–44 years	26 171	1 086	:	:	4.58	4.87	4.60	**4.25**	***.***	***0.5***	***-7.6***
45–54 years	20 571	1 218	:	:	6.28	6.00	6.12	**5.86**	***.***	***- 2.5***	***-4.2***
55–64 years	8 900	695	:	:	8.31	8.94	8.06	**7.99**	***.***	***- 3.0***	***-0.9***
A: Agriculture, hunting and forestry	**5 124**	**682**	**14.0**	**13.8**	**12.9**	**12.6**	**12.4**	**13.3**	***- 11.4***	***- 3.9***	***7.3***
D: Manufacturing	**30 022**	**1 009**	**4.6**	**4.2**	**3.9**	**4.0**	**3.7**	**3.4**	***- 19.6***	***- 5.1***	***-8.1***
of which (3) :											
da Manufacture of food products, beverages and tobacco	3 397	**171**	9.2	5.2	4.7	4.8	4.4	**3.6**	***- 52.2***	***- 6.4***	***-18.2***
db Manufacture of textiles and textile products	2 266	**28**		2.1	1.4	1.5	1.8	**1.4**	***.***	***28.6***	***-22.2***
dc Manufacture of leather and leather products	506	**10**		2.1	1.7	1.7	1.9	**2.4**	***.***	***.***	***.***
dd Manufacture of wood and wood products	910	**54**		9.5	8.5	9.1	8.9	**6.4**	***.***	***4.7***	***-28.1***
de Manufacture of pulp, paper and paper products, publishing and printing	2 556	**50**		2.7	1.7	1.7	1.9	**2.0**	***.***	***11.8***	***5.3***
df Manufacture of coke, refined petroleum products and nuclear fuel	175	**5**		1.1	0.8	4.0	2.9	**2.9**	***.***	***.***	***.***
dg Manufacture of chemicals, chemical products and man-made fibres	2 068	**57**		3.1	3.8	3.3	3.7	**2.8**	***.***	***- 2.6***	***-24.3***
dh Manufacture of rubber and plastic products	1 289	**47**		2.5	2.5	2.9	2.0	**3.7**	***.***	***- 20.0***	***85.0***
di Manufacture of other non-metallic mineral products (4)	1 159	**85**	9.1	7.3	8.1	10.4	8.2	**7.8**	***- 9.9***	***1.2***	***-4.9***
dj Manufacture of basic metals and fabricated metal products	4 414	**264**	6.2	7.7	7.7	8.1	7.2	**6.1**	***16.1***	***- 6.5***	***-15.3***
dk Manufacture of machinery and equipment n.e.c.	3 277	**85**		2.5	2.5	2.5	2.3	**2.6**	***.***	***- 8.0***	***13.0***
dl Manufacture of electrical and optical equipment	3 329	**73**		3.6	3.2	2.9	2.6	**2.2**	***.***	***- 18.8***	***-15.4***
dm Manufacture of transport equipment	2 922	**38**		2.6	2.0	2.0	1.5	**1.3**	***.***	***-25.0***	***-13.3***
dn Manufacturing n.e.c.	1 753	**42**		2.8	2.7	2.6	2.2	**2.5**	***.***	***- 18.5***	***13.6***
E: Electricity, gas and water supply	**1 156**	**37**		**4.4**	**5.7**	**3.6**	**3.2**	**3.2**	***.***	***- 43.9***	***0.0***
of which (3) :											
e40 Electricity, gas, steam and hot water supply	918	**33**		4.3	5.8	4.4	3.6	**3.7**	***.***	***- 37.9***	***2.8***
e41 Collection, purification and distribution of water	239	**4**		4.1	1.3	0.8	1.7	**1.7**	***.***	***.***	***.***
F: Construction	**10 825**	**1 266**	**14.7**	**14.8**	**13.3**	**13.1**	**12.8**	**11.7**	***- 12.9***	***- 3.8***	***-8.6***
G: Wholesale and retail trade; repair of motor vehicles, motorcycles, and personal and household goods	**21 037**	**491**	**2.8**	**2.9**	**2.5**	**2.4**	**2.5**	**2.3**	***- 10.7***	***0.0***	***-8.0***
H: Hotels and restaurants (5)	**5 425**	**75**	**1.9**	**1.8**	**1.1**	**1.2**	**1.3**	**1.4**	***- 31.6***	***18.2***	***7.7***
I: Transport, storage and communication	**7 833**	**892**	**13.7**	**13.7**	**12.0**	**12.1**	**11.8**	**11.4**	***- 13.9***	***- 1.7***	***-3.4***
of which (3) :											
i60 Land transport, transport via pipelines	3 141	**649**	21.7	22.8	20.4	20.8	20.3	**20.5**	***- 6.5***	***- 0.5***	***1.0***
i61 Water transport	92	**23**	38.4	30.8	26.4	20.7	15.7	**26.4**	***.***	***.***	***.***
i62 Air transport	366	**15**	7.9	6.0	5.7	4.3	5.3	**4.2**	***.***	***.***	***.***
i63 Supporting and auxiliary transport activities; activities of travel agencies	1 953	**175**	10.3	13.8	10.0	11.3	10.2	**9.1**	***- 1.0***	***2.0***	***-10.8***
J and K: Financial intermediation; real estate, renting and business activities	**17 848**	**284**	**2.2**	**1.8**	**1.6**	**1.8**	**1.7**	**1.6**	***- 22.7***	***6.3***	***-5.9***

Source: European statistics on accidents at work (ESAW). For Denmark and Ireland, 1998 = 1997; for France 1997 = 1998; for the Netherlands 1995–98 = 1994 accidents number, 1999 accidents numbers are revalued in proportion to the evolution 1999/94 of the employment; for Portugal 1996 = 1995, and 1998 = from 1999 data.

(1) Classified by NACE Rev. 1 (economic activity), section (branch), and subsection or division (sector); branches cover the range A to K.

(2) Gender or age are not always specified (particularly for the Netherlands); workers aged under 18 or over 64 are included in the total; incidence rates by age after age class correction for Portugal.

(3) Incidence rates exclude Portugal; NACE Section I 'Transport, storage and communication' includes Division i64 'Post and telecommunications'.

(4) Glass, ceramic goods, construction products.

(5) Incidence rates exclude Portugal before 1996.

(6) Incidence rates expressed as number of accidents at work per 1 000 persons in employment.

(7) Incidence rate expressed as fatal accidents per 100 000 persons in employment.

Source: Eurostat, NewCronos database (Health and safety).

3.2.3 Accidents at work, EU Member States, 1999

	Persons in employment (thousands)	Non-fatal accidents at work					Fatal accidents at work				
		With more than 3 days absence (1)				All (2)	Number of accidents			Standardised incidence rate	
		Estimated number	Standardised incidence rate 1994	Standardised incidence rate 1999	% of all non-fatal accidents (3)	Estimated number	Fatal RTTAs at work (8)	Other accidents	Total	Other accidents	Total
					All branches of economic activity						
EU-15	139 377	4 786 898			*63*	7 582 672	2 145	3 130	5 275		
EUR-12 (4)	105 581	4 283 010			*73*	5 836 452	2 088	2 853	4 941		
					9 common branches of economic activity						
EU-15	99 269	4 058 272	4 539	4 088	*64*	6 332 531	2 091	2 645	4 736	2.9	4.8
EUR-12	76 386	3 685 198	:	4 764	*73*	5 043 581	2 034	2 403	4 437	3.3	5.6
	National data from the insurance system covering accidents at work (5)										
B	1 926	90 385	4 415	4 924	*:*	:	48	57	105	3.3	:
D	24 185	1 214 329	5 583	4 908	*85*	:	487	529	1 016	2.4	:
EL	1 352	38 064	3 702	2 740	*:*	:	17	81	98	6.3	:
E	9 112	623 585	6 166	7 027	*71*	:	256	425	681	5.0	:
F	12 738	603 060	5 515	4 991	*:*	:	417	368	785	3.4	:
I	14 715	626 325	4 641	4 067	:	:	663	480	1 143	3.4	:
L	196	8 889	4 508	4 973	*59*	:	4	3	7		:
A (7)	2 713	96 807	3 554	3 301	:	:	63	146	209	5.1	:
P	2 788	151 471	7 361	5 048	:	:	53	170	223	6.1	:
FIN	1 570	48 775	3 914	3 137	:	:	5	26	31	1.8	:
	National data from declarations made to another competent authority (6)										
DK	1 748	52 816	2 653	3 031	*43*	:	23	35	58	2.2	:
IRL (7)	924	11 105	1 494	1 291	*51*	:	:	44	:	7.0	:
NL (7)	4 167	172 403	4 287	4 223	*:*	:	14	74	88	2.3	:
S	2 539	35 608	1 123	1 425	*23*	:	20	25	45	1.1	:
GB	18 596	284 650	1 915	1 606	*33*	:	:	182	:	1.4	:
NO	1 232	:	:	:	*:*	50 483	:	:	21	2.4	2.4

Sources: (1) European statistics on accidents at work (ESAW): accidents with more than 3 days absence from work.
(2) Ad hoc module in Labour Force Survey (LFS) 1999, including accidents without absence from work or with absence of less than 4 days.
(3) Percentages are for all branches of activity.
(4) Euro zone (EUR-12): Belgium, Germany, Greece, Spain, France, Ireland, Italy, Luxembourg, Netherlands, Austria, Portugal and Finland.
(5) Public insurance (e.g. social security) or private insurance, according to the Member State.
(6) Usually Labour Inspectorate.
(7) For Austria and Ireland, 1994 non-fatal rate = 1996; for the Netherlands, non-fatal based on 1994 data, except 1999 revalued in proportion to the evolution 1994/99 of the employment.
(8) Road traffic and transport accidents (RTTAs) at work = accidents in the transport branch and traffic accidents on all means of transport at work in all other branches of economic activity.

Source: Eurostat, NewCronos database (Health and safety).

3.2.4 Medical and economic consequences of accidents at work in the EU and Norway, 1998

	Total ([1, 2])	Up to 4 days absence from work ([1])	More than 3 days absence from work ([2]) by: Duration of absence from work (%)				Part of body injured/ type of injury (%)	Death ([2]) (%)
			Less than 2 weeks	2 weeks to less than 3 months	3 months or more permanent incapacity	Total		
Part of body injured (% by duration of absence)								
Total			***47.3***	***46.7***	***6.0***	***100***	**100.0**	**100.0**
Head			*64.9*	*30.8*	*4.3*	*100*	**9.2**	**28.2**
Neck (including vertebrae)			*36.6*	*57.8*	*5.6*	*100*	**2.1**	**2.0**
Back (including spine)			*50.1*	*43.7*	*6.2*	*100*	**7.7**	**3.2**
Torso (including organs)			*46.9*	*48.7*	*4.4*	*100*	**5.2**	**10.7**
Upper limbs (including hands			*48.0*	*46.5*	*5.4*	*100*	**41.2**	**1.6**
Lower limbs (including feet)			*42.0*	*51.2*	*6.8*	*100*	**26.5**	**2.2**
Whole body ([3])			*39.7*	*47.2*	*13.1*	*100*	**2.7**	**31.2**
Other ([3]) and unspecified			*46.9*	*41.8*	*11.3*	*100*	**5.4**	**20.8**
Type of injury ([4]) (% by duration of absence)								
Total			***47.3***	***46.7***	***6.0***	***100***	**100.0**	**100.0**
Wounds and superficial injuries			*56.5*	*40.0*	*3.5*	*100*	**37.6**	**-**
Bone fractures			*10.8*	*70.7*	*18.5*	*100*	**10.8**	**19.7**
Dislocations, sprains, strains			*45.6*	*49.5*	*4.7*	*100*	**24.4**	**-**
Traumatic amputations			*6.6*	*64.1*	*29.3*	*100*	**0.5**	**1.2**
Concussions and internal injuries ([4])			*50.0*	*42.8*	*7.2*	*100*	**11.3**	**6.5**
Burns and frostbite			*54.8*	*42.5*	*2.8*	*100*	**1.6**	**1.3**
Poisoning, infections ([4])			*60.8*	*35.9*	*3.3*	*100*	**1.0**	**0.7**
Drowning, asphyxiation			*60.4*	*36.2*	*3.5*	*100*	**0.2**	**1.9**
Noise, vibration, pressure effects ([4])			*57.7*	*40.3*	*2.0*	*100*	**0.0**	**0.1**
Temperature, light, radiation effects ([4])			*66.5*	*28.4*	*4.8*	*100*	**0.1**	**0.6**
Shocks ([4])			*36.7*	*51.9*	*11.4*	*100*	**0.0**	**0.5**
Multiple injuries ([4])			*30.9*	*57.2*	*11.9*	*100*	**0.2**	**10.0**
Other and unspecified			*45.6*	*44.3*	*10.2*	*100*	**12.3**	**57.6**
Severity ([5]) (% by duration of absence)	***100***	***36.8***	***29.8***	***29.5***	***3.8***	***63.1***		***0.1***
Number of days lost ([5])								
Estimated total (millions)	148.4	1.8	18.2	82.6	45.8	146.5		**-**
Per 100 000 persons in employment	108 798	1 164	13 334	60 676	33 624	107 634		**-**
Mean days lost per accident	20	1	8	38	162	31		**-**
Persons suffering from more than one accident per year (%) ([5])	**13.8**							

([3]) Whole body = including multiple sites; other = including deaths at work of strictly medical origin (in France).

([4]) Type of injury refers to 'most severe injury'. 'Multiple injuries' = injuries of the same severity; concussions, internal injuries = haemorrhages, injuries to internal organs, etc.; poisoning, infections, noise, vibration, pressure effects, extremes of temperature (including sunburn, hypothermia), light and radiation = acute effects; shocks = electric shock and shock following attack by a person, animal, etc.

([5]) Excluding Norway.

Sources: ([1,2]) Ad hoc module in the Labour Force Survey 1998: accidents over 12 months 1998–99, including non-absence and absence < 4 days Eurostat, NewCronos database (Health and safety).

3.2.5 Activities, persons and jobs at high risk of accident at work, Europe, 1998–99

	Relative incidence rate of accident at work [1]		
	All non-fatal accidents [2] (with or without absence from work)	Accidents with absence from work [2]	
		More than 3 days	2 weeks or more
All accidents [1]	**100**	**100**	**100**
Branch of activity			
Agriculture, hunting, forestry	132	166 [5]	144
Fisheries, aquaculture	243	:	:
Mining and quarrying	112	:	139
Manufacturing	112	110 [5]	127
Construction	141	196 [5]	170
Hotels and restaurants	117	88 [5]	63
Transport and communications	114	143 [5]	109
Health and social work	134	:	116
Men	**113**	**129 [5]**	**120**
of whom: aged 15–24	135 [4]	:	:
primary and lower secondary education [3]	179 [4]	:	:
Aged 15-24 (more than 3 days absence: 18–24)	**109 [4]**	**140 [5]**	**:**
Occupation			
Service workers, sales persons	113 [4]	:	:
Farmers/skilled agricultural and fishery workers	112 [4]	:	:
Craftspersons/workers in craft occupations	164 [4]	:	:
Plant and machine operators, assemblers	155 [4]	:	:
Elementary occupations, unskilled workers	134 [4]	:	:
Armed forces	108 [4]	:	:
Local unit with 1–9 employees	**:**	**100 [5]**	**:**
of which: Manufacturing	:	141 [5]	:
Construction	:	224 [5]	:
Transport and communication	:	174 [5]	:
Local unit with 10–49 employees	**:**	**126 [5]**	**:**
of which: Manufacturing	:	132 [5]	:
Construction	:	230 [5]	:
Transport and communication	:	205 [5]	
Permanent job, less than 2 years seniority [6]	**126**	**106**	**90**
of which: Manufacturing	138	:	121
Construction	171	:	140
Hotels and restaurants	172	:	59
Transport and communication	157	:	66
Health and social work	157	:	109
Temporary job	**115**	**101**	**104**
of which: Less than 2 years seniority [6]	121	106	104
of which: Construction	232	:	:
Wholesale and retail trade; repairs	131	:	:
Hotels and restaurants	137	:	:
Health and social work	191	:	:
Less than 20 hours of work per week	**144**	**101**	**106**
Shift work (often or sometimes) [7]	**146**	**137**	**134**
Night work (often or sometimes) [7]	**146**	**134**	**127**

([1]) Incidence or incidence rate = accidents during a year/persons in employment in the reference population; relative incidence rate = incidence in a particular group/incidence over all groups. The relative incidence rate is taken as 100 for all groups within each of three accident severity levels (all, > 3 days, >= 2 weeks). For instance, a relative incidence rate of 144 for accidents in agriculture resulting in 2 weeks or more absence means that the incidence of such accidents was 44 % higher than for all accidents in this severity group.

([2]) Accidents during past 6 months, employees responding directly (responses by another member of household excluded), in job which is still the main job at date of survey - except ([4]) and ([5]).

([3]) Level of education attained, except IRL, I, P, UK.

([4]) Accidents in past 12 months in job which is still the main job (employees or self-employed, direct or indirect responses).

([5]) European statistics on accidents at work (ESAW) 1998.

([6]) Seniority in firm or as self-employed person.

([7]) Shift and night work, except D, E, IRL, L, FIN (shift work), UK.

Source: Ad hoc module, Labour Force Survey 1999, except figures marked ([5]).

3.4.1 Persons injured in road accidents per 100 000 population

	EU-15	B	DK	D (1)	EL	E	F	IRL	I	L
1960	:	859	442	:	:	137	405	192	401	717
1970	590	1118	541	877	293	268	663	333	444	735
1975	539	862	414	740	258	278	681	249	429	801
1980	540	860	307	834	277	300	644	267	405	655
1985	489	774	286	705	324	342	510	232	391	567
1986	496	829	276	740	291	369	487	246	385	562
1987	492	850	248	708	280	411	445	250	391	472
1988	511	877	244	743	308	441	456	252	409	521
1989	512	892	240	737	303	454	439	264	387	507
1990	523	884	220	721	287	417	416	283	395	484
1991	494	825	211	646	300	398	378	293	434	445
1992	486	784	215	654	311	349	361	298	437	418
1993	463	770	202	635	306	316	344	287	390	432
1994	468	742	198	646	309	305	327	297	430	400
1995	474	708	202	639	318	324	326	364	464	422
1996	467	672	196	613	322	330	305	380	471	387
1997	473	697	191	621	332	333	303	371	482	370
1998	480	708	182	616	339	374	301	357	520	369
1999	489	715	186	644	324	375	294	331	561	362
% change										
1970-99 **(2)**	*-17*	*-36*	*-66*	*-27*	*11*	*40*	*-56*	*-1*	*26*	*-51*
1990-99 **(3)**	*-6*	*-19*	*-15*	*-11*	*13*	*-10*	*-29*	*17*	*42*	*-25*

(1) Figures relate to the Federal Republic of Germany prior to 1991.
(2) For NL: 1970–97.
(3) For NL: 1990–97.
Source: United Nations Economic Commission for Europe — Health for All (WHO, Europe), 2001.

(per 100 000 persons)

NL	A	P	FIN	S	UK	IS	NO	CH	
421	924	162	219	288	674	:	173	642	**1960**
552	983	352	371	293	652	465	318	609	**1970**
456	909	457	320	268	581	324	287	491	**1975**
414	858	439	188	242	600	312	260	531	**1980**
344	809	414	206	257	576	378	296	475	**1985**
354	788	430	231	268	583	326	299	482	**1986**
346	772	569	230	253	:	401	274	474	**1987**
334	779	623	254	280	593	371	269	471	**1988**
349	810	643	257	288	617	329	281	468	**1989**
357	803	663	269	272	615	346	288	450	**1990**
323	790	730	243	253	556	447	282	428	**1991**
327	744	744	208	248	555	516	274	429	**1992**
319	692	697	164	234	545	550	274	417	**1993**
328	687	647	168	247	561	558	266	428	**1994**
338	646	685	208	246	550	619	277	418	**1995**
318	629	692	189	241	567	580	280	384	**1996**
314	653	688	183	247	577	558	275	393	**1997**
:	644	687	184	247	572	518	281	399	**1998**
:	693	649	184	255	561	550	265	421	**1999**
									% change
-43	*-30*	*85*	*-50*	*-13*	*-14*	*18*	*-17*	*-31*	***1970–99*** **(2)**
-3	*-14*	*-2*	*-32*	*-6*	*-9*	*59*	*-8*	*-6*	***1990–99*** **(3)**

4. HEALTH STATUS

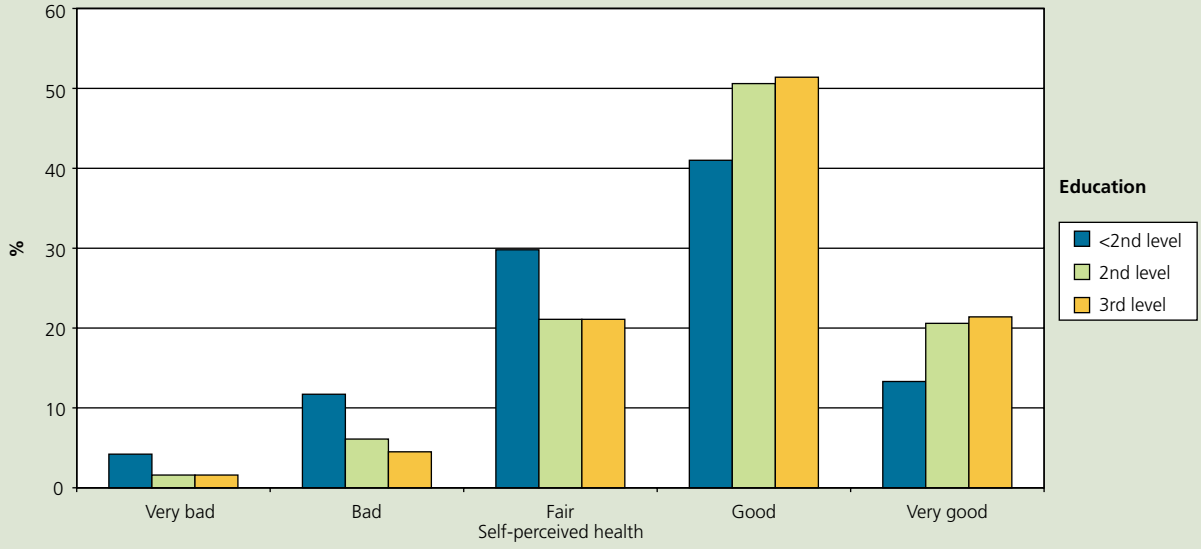
4.1. Self-reported health

4.1.1. Self-rated health

The general health status of populations, as measured by means of 'self-reports', by its very nature changes only slowly over time. Improvements in prevention, nutrition, physical activity and other lifestyle factors may be reflected in the population's health only years later. Moreover, health status is not evenly distributed; with each step up the socioeconomic ladder, groups are less vulnerable to disease, disability and premature death. Genetics, the physical environment and early childhood experiences all influence overall population health perception, in addition to the socioeconomic environment. Perceptions also can differ for each culture, thus making comparison more or less irrelevant. One of the ways used by governments to assess the positive aspects of health is through population survey measures of self-rated health status. Subjective or self-reported health status is not a substitute for more objective indicators, but rather complements these measures: self-reports of health introduce a consumer perspective into population health monitoring and reveal dimensions of health that may be inaccessible to the more traditional measures (ref. NZ MoH 1999). Indicators of self-perceived health have been found to be good predictors of future health care use and mortality (ref. Miilunpalo et al. 1997), and to have predictive value for decline of functional ability among the elderly and among the general population. The measurement of self-perceived health is, by its very nature, subjective. The EU comprises many different countries, each with its own languages and cultural traditions; even with agreement on the structure and wording of the self-rated health status question, it is likely that answers will at least partly reflect cultural differences in health perception (ref. Robine et al. 2002).

The **European Community Household Panel (ECHP)**, coordinated by **Eurostat**, asked people aged 16 and over to rate their own health (ref. ECHP web site). The majority of people in the EU perceived their health as being good or very good **(4.1.1)**. Women were slightly more likely than men to describe their health as fair, bad or very bad — 43.3 % compared with 36.1 %, in 1998. However, there were considerable differences between Member States. In 1998, a higher proportion of people rated their health as very good or good in Ireland (81 %), Denmark (75.6 %) and Greece (75.4 %) than in other Member States. Less than 50 % did so in Portugal and Germany, where 22.3 and 19.0 % respectively felt their health was bad or very bad. Generally in the EU, health ratings improved as educational levels increased **(4.1.2)**, and also the likelihood of self-perceived health as very good or good decreased as age increased. After a plateau of 85.3 % for those aged 16–24, a drop to 78.6 % was found in the 25–34 age group. With each successive age group after that, very good or good self-rated health declined, reaching a low of 23.7 % for the EU population aged 85 and over.

4.1.2 Self-perceived health by education, EU-15, 1998



Definition of educational classes:
3rd level: recognised 3rd level of education (ISCED 5–7).
2nd level: second stage of secondary education (ISCED 3).
<2nd level: less than second stage of secondary education (ISCED 0–2).
No data available for Sweden.

Source: European Community Household Panel, UBD, Eurostat, Version December 2001.

This pattern among successive age groups is remarkably similar to results from each of the previous ECHP waves **(4.1.3)**. The greatest proportions of those with very good perceptions of health were found in Greece, Ireland and Denmark between the ages of 16 and 54, in Ireland, the United Kingdom and Greece aged 55–64, and in the United Kingdom, Ireland and Denmark aged 65 and over. Perceptions of health as very bad were the greatest in France at all ages except 65–74, where they were the greatest in Finland, and 75–84 where they were the greatest in Germany.'Very bad' and 'bad' perceptions increased with age, the greatest proportions in these two categories being found in Portugal and Germany in most age groups. The ratio of very good and good health in the working population compared with the non-working population in the EU is about 2:1. The highest rates **(4.1.4)** of reporting fair or very bad and bad health status were in respondents who were inactive (unemployed, unable to work or retired).

The **European Community Household Panel (ECHP)** is a longitudinal, multi-subject survey covering many aspects of daily life, particularly employment and income, but also demographic characteristics, the environment, education and health. The ECHP is a unique source of information in the world due to its three main characteristics. These are: (i) its multidimensional coverage of a range of topics simultaneously; (ii) a standardised methodology and procedures yielding comparable information across countries; and (iii) a longitudinal or panel design. The ECHP was designed to complement the two main social surveys coordinated at EU level — the Labour Force Survey and the Household Budget Survey. In all, the sample covers some 60 000 households comprising 130 000 adults aged 16 or over at 31 December of the previous year. The first wave took place in 1994, when the EU had only 12 Member States, so Austria, Finland and Sweden were not included. The health section of the ECHP contains questions on perceived health, being hampered in daily activities because of chronic conditions, temporary reduction (last two weeks) of activity because of health problems and hospitalisation and medical consultations in the 12 months preceding the interview. The longitudinal, 'panel' design of the ECHP makes it possible to follow up and interview the same private households and persons over several consecutive years. In contrast to a cross-sectional survey, it supplies data on EU social dynamics; it provides information on relationships and transitions over time at the micro level. Three countries, namely Germany, Luxembourg and the United Kingdom, derive comparable data from other existing national panel surveys (German Socio-economic Panel — GSOEP, British Household Panel Survey — BHPS) which cover subjects similar to the ECHP. In 1997, Finland decided not to collect information on income from interviews, but to derive this information from registers. Furthermore, other countries have revised their data. With the availability of the ECHP to a wide range of users, and with the ECHP as a provider of important indicators, some countries became increasingly aware of data quality and undertook substantive revisions of data. These revisions are not yet completely finalised and the data will continue to be updated for 2000 and 2001 issues of the ECHP database, which contains from 1997 onwards comparable cross-sectional data for Sweden derived from the Swedish Survey of Living Conditions.

In health statistics, age is an important variable, since the occurrence of many health problems increases with age. However, it must be recognised that the ECHP suffers from several operational problems. The most important is the lack of timeliness of the data. Data collected nationally in 1999 will only be available at EU level at the beginning of 2003, i.e. with a time lag of 37 months. Some other problems relate mainly to initial response/attrition rates and the non-participation of one of the EU countries in the project, i.e. Sweden.

After a total duration of eight years (1994–2001), Eurostat, together with the Member States, decided to discontinue the European Community Household Panel (ECHP) project and replace it in 2003 with a new instrument, **EU-SILC (Statistics on Income and Living Conditions)**. There are several reasons for this change, the most important of which is the need to adapt the content and timeliness of the instrument to the new political needs, particularly after the Lisbon and Nice European Summits. During these summits, priority was given to the eradication of poverty, and a better understanding of social exclusion, based on commonly agreed indicators, was requested. As a consequence, there is an increasing need for comparable and timely data on income and social exclusion, particularly in the context of the programme of Community action to encourage cooperation between Member States to combat social exclusion, and for the structural indicators to be produced annually for the spring report to the European Council. The main output of this project is that, for the first time, comparable data on income distribution and on poverty/social exclusion have been produced for the EU.

4.1.2. Health interview surveys (HIS)

In EU Member States and EFTA/EEA countries, **health interview surveys (HIS), health examination surveys (HES)**, combinations of HIS/HES and other population surveys with a significant health component to provide insight into the coverage of areas that are relevant for health monitoring by national and international surveys can be used to collect information on the self-assessed health of the population (perceived health, chronic conditions, disabilities, mental health), on a number of health-related behaviours (health determinants such as smoking, use of alcohol, physical

activity, use of drugs, food consumption habits) and on the use of medical services (hospitalisation, consultation of doctors/dentists, use of medicines, preventive actions such as cancer screening tests). In addition, these surveys can collect comprehensive information on the personal characteristics of the interviewed persons, and, in a few countries, survey databases can be combined on the micro-level with data from registries.

For several years, **Eurostat** has worked in this field. Methodologies and instruments were developed and evaluated. Comprehensive information on existing national health surveys was collected and, with support of EC Health Monitoring Programme 1998–2002, stored in an electronic format (the **'HIS/HES database'**). Existing data from national HIS were collected in 1999 on 12 topics (see Section 4.1.3); a similar collection, but now on 18 topics, is currently under way. The 1999 collection indicated that there are already a number of topics for which existing national surveys can deliver sufficiently comparable data (self-perceived health, chronic conditions — global, smoking, body mass index); for a number of topics, relatively small adaptations to national approaches, for instance harmonisation of reference periods in questions on doctor/dentist consultations and use of medicines, could result in much better international comparability; and, for some other items, national approaches still differ significantly, but harmonisation seems possible. It is expected that the ongoing collection of existing data on 18 HIS topics will already show that, in at least some countries, significant improvements have been made in arriving at better international comparable data. In order to stimulate harmonisation, **Eurostat** is directly or indirectly involved with a number of projects aiming at the development of recommended instruments for health surveys, such as Eurohis (coordinated by WHO Europe), EuroREVES II and a number of other projects supported under the Community action programme on health monitoring). In addition to the development of single-topic instruments, recently efforts have begun to develop 'modules' containing several instruments in a specific domain (health status, health determinants, use of medical services).

Some form of future **European health interview survey (EHIS)** could be the **basic survey** of a European health survey system (EHSS) which is actually in development by Eurostat in collaboration with the Member States and the Directorate-General for Health and Consumer Protection. The first round of the EHIS could (possibly) take place in 2006 in all the EU Member States including the new members. The survey system could take various forms in the different Member States, but in all of them the common elements could be: the annual 'Mini European health module' (MEHM), which would be the annual component of the EHIS, providing the data needed annually for the European structural indicators in the field of health, such as disability-free life expectancy (DFLE), as well as other modules such as a 'European survey module on determinants of health' (ESMD) and a 'European survey module on care' (ESMC). From 2003 onwards, the MEHM module will be included annually in the EU-SILC survey (see box in Section 4.1.1).

The '**European Community health indicators' (ECHI)** is a project coordinated by the **National Institute of Public Health and the Environment (RIVM)** (the Netherlands), under the EC Health Monitoring Programme. Its objective is to propose a coherent set of European Community health indicators, meant to serve the purposes formulated for the programme of Community action in the field of public health, selected on the basis of explicit criteria, and supported by all Member States.

The **HIS/HES database** project, coordinated by **Statistics Netherlands**, **KTL** (Finland) and the **Scientific Institute of Public Health** (Belgium), started in 1998 under the EC health monitoring programme. This database contains information on the methods and content of HIS, HES and HIS/HES. Currently, the database covers information on 8 national HES, 70 national HIS and 2 international health surveys. In addition, recommended instruments from various sources (WHO Europe, health monitoring projects) are or will be included. The database covers more than 5 000 HIS questions, both in the original language and in English. Users of the database can search for specific information on particular surveys or on particular topics such as self-reported health, lifestyles and use of services. In order to facilitate the search on specific topics, a list of health topics has been developed. Currently, the list includes 93 topics, divided into seven areas: demographic and socioeconomic factors; health status; personal factors; lifestyle factors; living and working conditions; prevention, health protection and health promotion; and use of health and social services. As the database allows for permanent updating, it can serve as a timely reference guide for collecting data from Member States by the Commission. Other international organisations can use the results of the project whenever they need information on the availability of comparable data or an overview of (inter)national HIS/HES and similar surveys in the EU. National institutes can use the database as a mirror to evaluate their own surveys and to decide on adapting items in their surveys (towards international harmonisation).

The list of survey indicators is based on the list of health areas and health topics that was developed for a former inventory of HIS in 1996/97, and on the set of indicators recommended by the **European Community Health Indicators (ECHI)** project.

4.1.3. Self-reported chronic conditions

Insufficient comparable data on self-reported chronic conditions at EU level are available at present. Chronic disease represents one of the most relevant problems for health-related quality of life, especially for the elderly, and is one of the main causes of utilisation of health services. Chronic disease often affects the psychological or physical abilities of people for a long time or even indefinitely. Although it is important to monitor the distribution and trends of chronic disease in the general population, few countries collect such morbidity data on a regular basis. Data are usually only collected for selected diseases and for subgroups that are not necessarily representative of the whole population (for example, for the purposes of cancer registers). Many countries collect data on morbidity from chronic physical conditions through the use of HIS. This approach is particularly suitable for diseases of long duration and low mortality, and is also cheap, relatively quick to implement, and allows the simultaneous collection of data on a number of chronic conditions and other health-related information, such as use of medical services. HIS also have some disadvantages, however. The sample method is not suitable for measurement of conditions with a low prevalence, and the subjective reporting may not always correctly identify the condition; for example, people may have a disease but not be aware of it, or they may have incorrectly 'diagnosed' a condition themselves. Furthermore, there is considerable heterogeneity in the concepts and definitions that are adopted in different countries when surveying chronic conditions.

As mentioned above (see Section 4.1.2), existing data from national HIS were collected by **Eurostat** in 1999 on 12 topics in EU and EFTA/EEA Member States, from which a certain harmonisation seems quite possible in the near future. Variations are caused by differences in the year of data collection (ranging from 1991 to 1998), and by differences between the national health care systems. The previous results of a Eurostat study on some selected conditions show a large variation in percentage **(4.1.5)** of persons suffering from chronic conditions in Member States where data were available (only eight), ranging from 45.4 % in Sweden (1996/97), 40.0 % in the United Kingdom (1996) and 37.6 % in Denmark (1994) to 17.0 % in Switzerland (1997) and 27.7 % in Spain (1997). Several of these chronic conditions are significant because they are major causes of death, disability or hospitalisation (hypertension, diabetes, chronic heart disease or stroke).

4.1.4. Self-reported chronic conditions in children

According to the '**Health behaviour in school-aged children' (HBSC)** study (ref. HBSC web site) some data on self-perceived chronic conditions do exist for young people. Increases in symptoms that do not represent serious physical illness may reflect an imbalance in young people's psychosocial environment. Table **4.1.6** shows the proportions of young people who suffered from headaches, stomach aches or backaches 'at least once a week' in 1997/98. More young people aged 11, 13 and 15 reported headaches than either stomach aches or backaches. Looking at headaches first, more girls than boys suffered from headaches in all countries. For girls, the proportions increased from age 11 to 13 in all countries and from 13 to 15 in most countries. The proportions for boys increased with age in about half of the countries and decreased in the others. Looking next at stomach aches, these were reported by more girls than boys, aged 11, 13 and 15, in all countries. The proportions decreased between the ages of 11 and 13 and between 13 and 15 in most countries. Differences between countries increase slightly for boys between the ages of 11 and 13, and then decrease by a third at age 15. For girls, these differences decrease by a quarter between 11 and 13, then increase slightly. Considering backache, the proportion that suffered at age 13 was greater than at age 11, for boys in all countries and for girls in most countries. The proportion that suffered at age 15 was greater than at age 13, for girls in all countries and for boys in most countries. Again, there were differences between countries.

References

ECHP (see Chapter 4.1.1 for metadata), http://www-rcade.dur.ac.uk/echp/.

HBSC, A WHO collaborative study (http://www.ruhbc.ed.ac.uk/hbsc/).

Miilunpalo, S. et al. (1997), 'Self-rated health status as a health measure: The predictive value of self-reported health status on the use of physician services and on mortality in the working-age population', *Journal of Clinical Epidemiology*, Vol. 50, No 5, May 1997, pp. 517–528.

NZ MoH (New Zealand Ministry of Health) (1999), *Our health, our future: The health of New Zealanders*.

Robine, J. M., Jagger, C. and Romieu, I. (eds) (2002), *Selection of a coherent set of health indicators for the European Union*, Euro-REVES, Montpellier, France.

4.2. Anthropometric characteristics

Data from the 1996 **Eurobarometer** (ref. Eurobarometer web site) survey show there is an inverse relationship between age and height for both men and women, in the age groups shown in Table **4.2.1.** Each generation in the EU is therefore taller than the last. Generally, men continue to be taller

and heavier than women. Weight **(4.2.2)** increases with age for men up to age group 15–44 then decreases, whereas for women it increases to age group 55–64 before decreasing.

The **body mass index (BMI)** classifications used in 1996 by Eurobarometer in Table **4.2.3** were as follows: < 18 severely underweight; 18–19 underweight; 20–26 normal BMI; 27–30 overweight; > 30 severely overweight. Based on this, in all Member States, a larger proportion of women than men are severely underweight (especially in Belgium, France, Italy and Luxembourg) and underweight (especially in Denmark, Luxembourg, Italy and France). Larger proportions of men than women are overweight in all Member States (especially in Greece and Sweden) and severely overweight in nine Member States. The proportion of people who are of normal weight according to this classification ranges from 58 % in Spain to 74 % in the Netherlands for men, and from 51 % in Greece to 66 % in Ireland for women. Note that both BMI and a measure of fat distribution (waist circumference or waist/hip ratio, etc.) are important in calculating the risk of obesity co-morbidities. According to **Eurodiet**, obesity increases the risk of diabetes up to 100-fold (ref. Eurodiet web site). At least 80 % of the increasing number of diabetics can be attributed to excessive weight gain, particularly if fat accumulates within the abdomen. A BMI < 18.5 signifies an increased risk of developing other clinical problems. Many people have false perceptions of their own body image; for example, overweight people may not think that they are. On the other hand, there are also growing numbers of people, especially girls and young women, who are bulimic or anorexic (ref. Garrow and James 1993).

For young people aged 11, 13 and 15, data from the **'Health behaviour in school-aged children' (HBSC) 1997/98** survey **(4.2.4)** show differences between boys and girls, and between countries, in the proportions of young people who thought that they were overweight (ref. HBSC web site). A quarter of boys aged 11 and 13, and just under a quarter aged 15, were on a diet or thought that they should be. The proportion of girls was greater for each age and the increase between ages was also greater. For girls, nearly a third aged 11, nearly a half aged 13 and a half aged 15 were on a diet or thought that they should be. As the physical activity of young European women declines, they adapt by attempting to eat less food in order to limit their weight gain. This makes them susceptible to anaemia, according to Eurodiet (ref. Eurodiet web site). Children aged 11 were the least likely to diet in Sweden (18 % boys, 21 % girls) and Switzerland (19 % boys, 25 % girls). Young people aged 13 and 15 were the least likely to diet in Switzerland (age 13: 19 % boys, 34 % girls; age 15: 15 % boys, 42 % girls). Boys in Northern Ireland (28 %, 30 %, 26 %) and Greece (27 %, 30 %, 29 %) were the most likely to diet at all three ages, as were Austrian boys aged 11 (29 %) and 13 (30 %). Girls were more likely to diet in Greece (37 %), Wales (37 %) Belgium and Northern Ireland (36 % in both) at age 11, in Northern Ireland (53 %) and Wales (50 %) at age 13, and in Greece and Norway (56 % in both) age 15.

The **body mass index (BMI)** or **Quetelet's index** is a measure of a person's weight relative to his or her height that correlates fairly well with body fat content in adults. The BMI is accepted by experts as the most useful measure of obesity in adults when only weight and height data are available. The BMI is calculated for each respondent (of the **Eurobarometer** survey in this case) and is the result of dividing bodyweight (in kg) by body-height (in m) squared. If the result is between 18 and 20 the person is underweight, and is severely underweight when below 18. A person with a BMI between 27 and 30 is overweight and severely overweight with a BMI of 30 or more. There is no international consensus about the classification of moderate obesity and a range of 25–30 is sometimes used. The International Obesity Task Force of WHO has proposed reclassifying body mass index using a range 18.5–24.9 as the normal range, 25.0–29.9 as overweight, 30.0–34.9 as moderate obesity, 35.0–39.9 as severe obesity and > 40 as very severe obesity. This classification will be adopted by Eurostat in future surveys and analyses. Note that these values are age independent and correspond to the same degree of fatness across different populations.

References

Eurobarometer (see Chapter 2.1 for metadata), http://europa.eu.int/comm/dg10/epo/eb.html.

Eurodiet, http://eurodiet.med.uoc.gr.

Garrow, J. S. and James, W. P. T. (eds) (1993), *Human nutrition and dietetics,* Ninth edition, Churchill Livingstone, London.

HBSC, A WHO collaborative study (http://www.ruhbc.ed.ac.uk/hbsc/).

4.3. Dental health

Although dental health has improved over 20 years, attributed among other things to the use of fluoride in toothpaste, inequalities remain. A pan-European task force (ref. Dental web site) found that dental health is poorest in the lowest socioeconomic groups, and in some migrant groups. Periodontal disease, dental erosion and dental caries are all dental health problems, but dental caries comprises the single biggest cost (5–10 %) to the health budget and is the only well-documented major health problem of

dietary origin in Europe (ref. Eurodiet web site). Only a fraction of the money spent on treatment is spent on prevention. The frequent ingestion of sugar, particularly sucrose, in foods and drinks is the main cause of dental decay. Acids in food and drinks mainly cause dental erosion, which is increasing.

The data for dental caries have been compiled by the **WHO Collaborating Centre, Sweden** (ref. WHO web site), from a number of sources spanning several years, and are not, therefore, strictly comparable, but are the most up to date available **(4.3.1)**. Perhaps because of this, no countries emerged as consistently better nor worse than others. About half the EU population was affected by caries at age 5/6, rising to nearly 100 % by middle age. The mean number of teeth affected in all countries was 3.5 or less at age 5/6 and 2.3 or less at age 12, increasing to about half of all teeth by middle age and three quarters in the retired population. The global goal for oral health declared by the World Health Assembly of WHO in 1981 was that the number of decayed, missing and filled teeth (DMFT) for 12-year-olds should not exceed three by the year 2000. A detailed analysis of the caries situation in many countries shows that there is a skewed distribution of caries prevalence, such that some 12-year-olds have high DMFT values while others are caries free. Thus, a significant caries index (SiC) (ref. WHO web site) has been calculated for the third of the population with the highest caries scores — the mean DMFT for this group of 12-year-olds — for some countries, as follows: France 4.7, Germany 4.1, Sweden 2.8, United Kingdom (north-west England) 3.5, United Kingdom (Scotland) 4.3. The goal for the SiC is less than three DMFT by 2015.

In the 1997/98 study, **'Health behaviour in school-aged children' (HBSC)** (ref. HBSC web site), young people aged 11, 13 and 15 were asked if they brushed their teeth 'more than once a day'. In each country, more girls than boys did so **(4.3.2)**. The largest differences between boys and girls were found at age 15 in Finland (boys 31 %, girls 61 %), Greece (35 %, 61 %), Ireland (46 %, 74 %), and France (53 %, 79 %). In most countries, a greater proportion of girls and boys aged 15 brushed their teeth 'more than once a day' compared with those aged 13. A greater proportion of girls, but a smaller proportion of boys, did so at age 13 compared with age 11 in most countries. There are clear differences between countries at all three ages. Sweden had the largest proportions of young people (ranging from 81 to 92 %) who brushed their teeth 'more than once a day'. Denmark (78–88 %) and Switzerland (73–89 %) were also high. Finland had the smallest proportions of young people (ranging from 28 to 61 %) who brushed their teeth 'more than once a day'. Regular brushers in Belgium (33–62 %) and Greece (35–64 %) were also a low proportion.

References

Dental health in Europe: A problem for disadvantaged groups compiled by a pan-European task force established following a European Commission-funded conference on the promotion of dental health
(http://www.whocollab.od.mah.se/).

Eurodiet, http://eurodiet.med.uoc.gr/.

HBSC (see Chapter 2.2 for metadata), A WHO collaborative study
(http://www.ruhbc.ed.ac.uk/hbsc/).

WHO,
http://www.whocollab.od.mah.se/index.html.

4.4. Disability and restrictions

Definitions of disability (ref. Mayhew 2001) often vary according to the purpose of the data collection or to different classifications used. Because of this, and the potential to count people with multiple disabilities more than once, official and unofficial estimates vary. The International Classification of Impairments, Disabilities and Handicaps (ICIDH), developed by the World Health Organisation and first published in 1980, was revised and this has led to the new International Classification of Functioning, Disability and Health (ICF), adopted by WHO in 2001.

4.4.1. Disability-free life expectancy

Disability-free life expectancy (DFLE) at age 16 was calculated by **Inserm (REVES)** from Eurostat mortality statistics and data from the **European Community Household Panel (ECHP)**. It should be noted that national (cultural) differences in the reporting of disability may have a significant effect on the outcomes. There were clear differences found in life expectancies with either severe, moderate or no disability between Member States **(4.4.1)**. Men in Greece and women in France had the highest life expectancy at age 16, 60 and 66 years respectively. Also, men in Greece and women in Greece and Italy can expect to spend more of their lives free of disability than people in other Member States. On the other hand, men and women in Finland can expect to spend more of their lives with a moderate (men 10 years, women 13 years) or severe (men 7 years, women 8 years) disability. Men and women in Belgium can expect to spend the least number of years with a moderate disability, 5 and 6 years respectively. Men and women in Ireland can expect to spend the least number of years with a severe disability, 2 and 3 respectively. According to Eurodiet, recent analyses from the Institute of Public Health in Sweden, producing estimates in terms of disability adjusted life years (DALYs), suggest that dietary factors and a sedentary lifestyle impose costs on

health care which exceed those of tobacco use within the EU (ref. Eurodiet web site).

Disability-free life expectancy is calculated by **Inserm (REVES)** using Sullivan's method: the age-related prevalence of self-reported disability is used to subdivide the years lived from the current mortality table into years with and without disability (ref. Robine et al. 1992). The mortality tables come from Eurostat. Disability data are taken from the ECHP (1996 data). The ECHP contains various questions on health, including a general question on restrictions in daily activities caused by a health problem. Given the lack of comparable data for people living in institutions, REVES has assumed that, in each country, they have disability rates comparable to those of people living in households. This hypothesis is unlikely but is leading at least to a minimum estimate. Another assumption would be to consider that all people living in institutions have a disability, which would lead to a maximum estimate. However, the type of institution differs from country to country, and no sufficient data are available on severity of disability. Also, to be able to present calculations at birth, REVES has, for all countries and for both genders, applied a constant disability rate (of 1 %) between the ages of 0 and 16. This rate, which is compatible with the values observed over the age of 16, has virtually no impact on the value of disability-free life expectancies. Finally, REVES has calculated confidence intervals, for people over the age of 16, by the Mathers' method (1991), using Jagger's calculation table (1997).

4.4.2. Disability

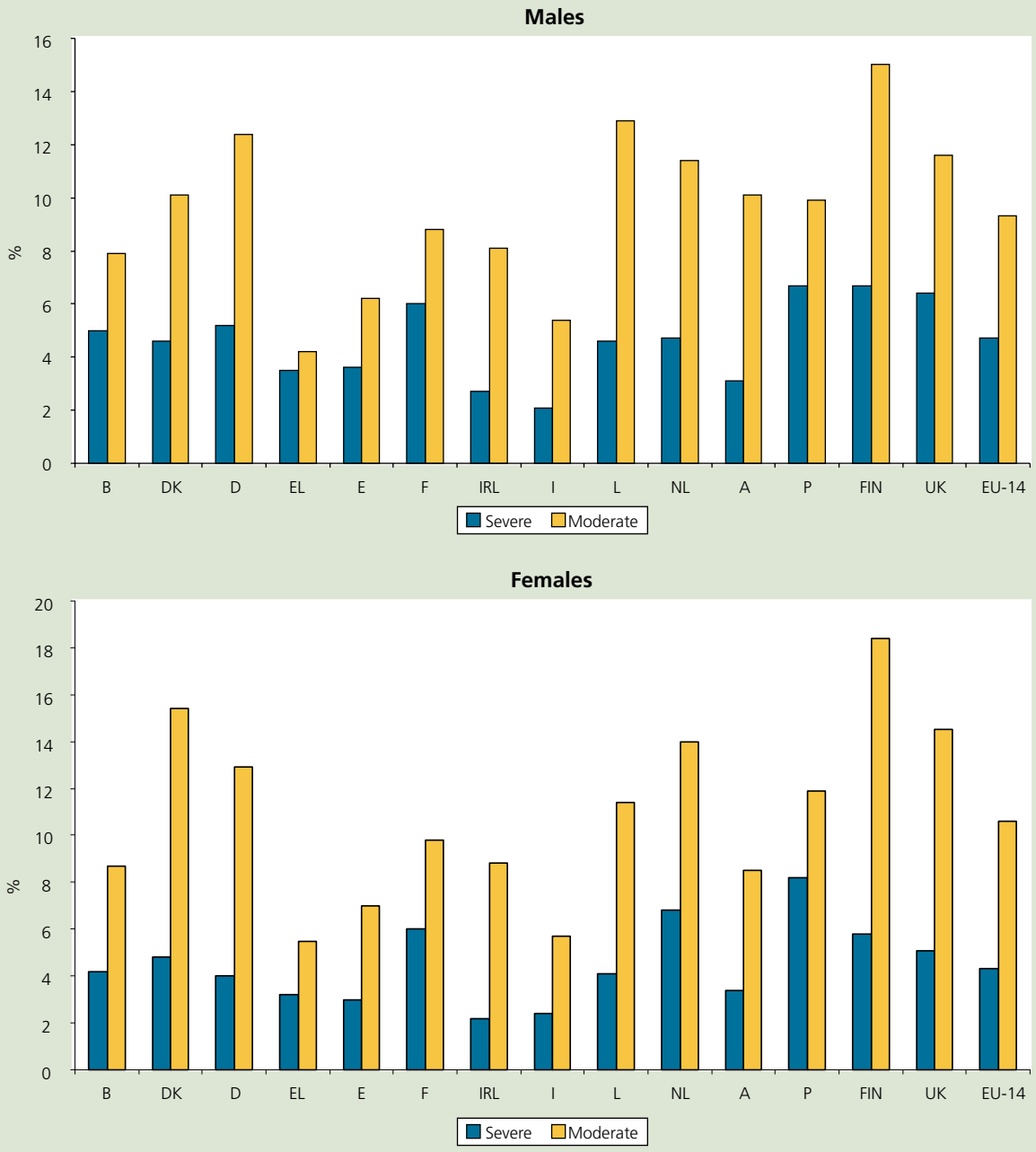
Data from the **European Community Household Panel (ECHP)** (ref. ECHP web site) show that overall in the EU there was little difference between the mean proportions of men and women reporting severe or moderate disability in 1996 **(4.4.2)**.

'Disability' is defined here by the ECHP question on 'being hampered in daily activities by any physical or mental health problem, illness or disability'. However, there were large differences between Member States, with the highest proportions of people reporting disability found in Finland and the lowest in Italy and Greece. Educational levels (ref. Educational levels web sites) were negatively correlated with disability in the EU. The proportion of people aged 16–64 with no disability who completed the highest level of education in 1996 (18 %) was twice that of those with a severe disability (9 %) **(4.4.5)**. Nearly 50 % more people with a severe disability (58 %) than with no disability (41 %) did not complete the second level of education. A greater proportion of people without a disability completed the highest level of education in Denmark (32 %), Finland (31 %), Belgium and the United Kingdom (both 25 %) than in other Member States. Also, greater proportions of people with a moderate disability in Belgium and Denmark (both 25 %), and with a severe disability in Belgium, Denmark and Germany (all 14 %), completed the highest level of education than in other Member States. A greater proportion of people in Austria, the Netherlands and Germany completed the second level of education in each disability category than in other Member States. Fewer people in Portugal completed the second level, regardless of disability status, than in other Member States.

Across the EU, 62 % of people aged 16–64 with no disability were in work in 1996, while 46 % of those with a moderate disability and only 24 % of those with a severe disability were in work **(4.4.7)**. Looking only at those aged 25–59, 72 % of people with no disability were in work compared with 56 % of those with a moderate disability and 29 % with a severe disability (ref. Disability 2001). As expected in view of traditional roles and childrearing, more men than women were in work in each category. There were differences between Member States in the proportions within each category that were in work. More men in the United Kingdom, Denmark, Germany and Portugal, and women in the United Kingdom and Denmark, without disabilities were in work than in other Member States. More men in Portugal and Denmark, and women in Finland, Denmark and Portugal, with a moderate disability were in work than in other Member States. Both men and women with a severe disability were more likely to be in work in France (followed by the Netherlands then Luxembourg for men, and Portugal then Austria for women) than in other Member States. Spain, Ireland and Italy had the smallest proportions of women working in each category. These countries also had amongst the smallest proportions for men, though Denmark had the smallest proportion of severely disabled men in work (15 %).

Disabled people in the EU were slightly more likely (severe 92 %, moderate 90 %) to have an income in 1996 than those who were not disabled (85 %) because of access to benefits **(4.4.9)**. However, there were some differences between Member States. People living in Denmark, the United Kingdom and Finland were much more likely (97–99 %) to have an income whether disabled or not than those in Italy, Spain and Greece. In the latter three Member States, the disabled were more likely to have an income than those with no disability (severe 77–82 %, moderate 74–79 %, no 66–71 %). However, the picture for earned income is very dif-

4.4.2 Percentage of people aged 16–64 reporting severe or moderate disability, by sex, 1996



Source: European Community Household Panel — Eurostat; with the cooperation of Réseau sur l'espérance de vie en santé (REVES).

ferent. People with a severe disability were much less likely to have an earned income than those with a moderate disability, who, in turn, were less likely to than those with no disability. The smallest proportions of people in each category, who earned an income through work, were found in Spain, Ireland and Italy: Spain 13 %, Ireland 17 % and Italy 18 % of the severely disabled; Spain 27 %, Italy 29 % and Ireland 31 % of the moderately disabled; Italy 49 % and Spain 52 % of those with no disability. The largest proportions of people who earned an income varied according to category: 38 % in Luxembourg and 36 % in France with severe disabilities; 58 % in Germany and 56 % in France with moderate disabilities; 79 % in Denmark and 76 % in the United Kingdom with no disabilities.

The proportion of people in the EU aged 16 and over that reported they were either severely or to some extent hampered in daily activities by any physical or mental health problem, illness or disability in 1998 ranged from 13.0 % in Italy to 40.1 % in Germany **(4.4.3)**. Germany had nearly

twice the proportion of people who were hampered to some extent in 1997 (29.6 %) and 1998 (29.3 %) than Denmark and the Netherlands where the next highest proportions were found. A greater proportion of men than women were affected in all Member States. Between 1996 and 1998, less than 5 % of people aged less than 45 were severely hampered, rising to nearly 30 % of those aged 75–84 and nearly 40 % aged 85 and over **(4.4.4)**. Table **4.4.6** compares the proportions of people in the EU aged 16 and over who were hampered in daily activities between 1996 and 1998, by level of education. Between 1996 and 1998, the proportion of people aged 16 and over who were working and not hampered in daily activities decreased slightly from 90 % to 85 % **(4.4.8)**. In 1998, proportions who were severely or to some extent hampered ranged from 5 % of working people in Italy to 28 % in Germany, and from 21 % of those not in work in Italy to 55 % in Germany.

4.4.3. Temporary cutdown in usual activities

The **European Community Household Panel (ECHP)** also asked people aged 16 and over whether they had cut down on their usual activities during the past two weeks because of health problems. A higher proportion of women (14.9 %) than men (11.7 %) in the EU had temporarily cut down their activities because of physical or mental reasons in 1996 **(4.4.10)**. The ratio of physical to mental reasons was nearly 6:1 for men and 4:1 for women. The proportions of people reporting cutdown of activity because of physical illness and injury in the years 1996–98 were greatest in Finland and Denmark, and smallest in Italy and Spain. The proportions restricted by emotional or mental problems were greatest in the Netherlands, and smallest in Italy.

Data from the ECHP from 1996 to 1998 show that cutdown in activities of people aged 16 and over in the EU generally increased with age, with some exceptions in some Member States — mainly in the two youngest and the oldest age groups **(4.4.11)**. There were wide variations between Member States. Looking at the 16–24 age group in 1998, the proportions cutting down due to illness or injury ranged from 1 % in Greece to 20 % in Denmark, and among those aged 85 and over from 13 % in Italy to 30 % in Denmark. Cutdown due to emotional or mental problems in 1998 among 16–24-year-olds ranged from 0.2 % in Italy to 3.9 % in Portugal, and among those aged 85 and over from 3 % in Ireland and the Netherlands to 25.5 % in Austria.

Generally in the EU, cutdown in activity slightly decreased as educational levels increased, although, in some Member States in some years, people with the highest educational levels cut down more than those with second-level **(4.4.12)**. In 1996 and 1997, Finland and Germany had the greatest proportions of people who had cut down, while Italy and Greece (along with Ireland for the first level due to illness or injury) had the least. In 1996, the ratio of inactive people compared to working people in the EU who cut down was more than 2:1 **(4.4.13)**. This ratio varied between Member States. The largest ratios in 1998 were: 10:1 in Ireland for cutdown due to emotional or mental problems — 0.4 % of working people compared with 4 % of inactive people; and 4:1 in Greece for cutdown due to illness or injury — 2 % of workers compared with 8 % of inactive people. Proportions within each category and Member State varied slightly between 1996 and 1998.

Disability data for Graph **4.4.2** and Tables **4.4.3** to **4.4.13** came from the ECHP; tables on education, work status, etc. by level of disability were based on a study by the Réseau sur l'espérance de vie en santé (REVES) on 1996 ECHP data. Questions asked in the ECHP were: 'Do you have any chronic physical or mental health problem, illness or disability?', and if 'yes' then 'Are you hampered in your daily activities by this chronic physical or mental health problem, illness or disability?' to which participants could answer 'yes, severely' or 'yes, to some extent' or 'no'. Variations in the outcomes between Member States are in part the result of real differences in the opportunities, or social integration, of population groups. Some of these variations may also be the result of differences in the interpretation of the question on disability (cultural differences) and differences in the social organisation and availability of services in the various Member States. In addition, differences in the systems of education, pensions, retirement and health care sometimes make it difficult to compare the categories of people under consideration.

4.4.4. Specific impairments

Data on the number of blind and partially sighted people in European countries are based on estimates provided by the national members of the **European Blind Union (EBU)** and are an approximation of a highly complex reality (ref. Euroblind web site). Lack of official statistics and varying legal definitions of blindness and partial sight make it particularly difficult to calculate accurate numbers. In particular, the number of visually impaired elderly people is on the increase. Many of them do not consider it useful to start rehabilitation courses and, as a consequence, are not in official registers. At European Union level, the figure generally used by those involved in campaigning to promote the interests of visually impaired people is 7 million (of a total population of about 385 million). Again, this figure should not be compared

with national data that are based on stricter definitions of visual impairment. In view of these problems with the data, and because little data have been updated, the figures do not appear in this volume.

At present, there are no data on the prevalence of deafness, hearing impairment or tinnitus in the EU. Surveys in a few countries are planned or progressing.

4.4.5. Employment of disabled people

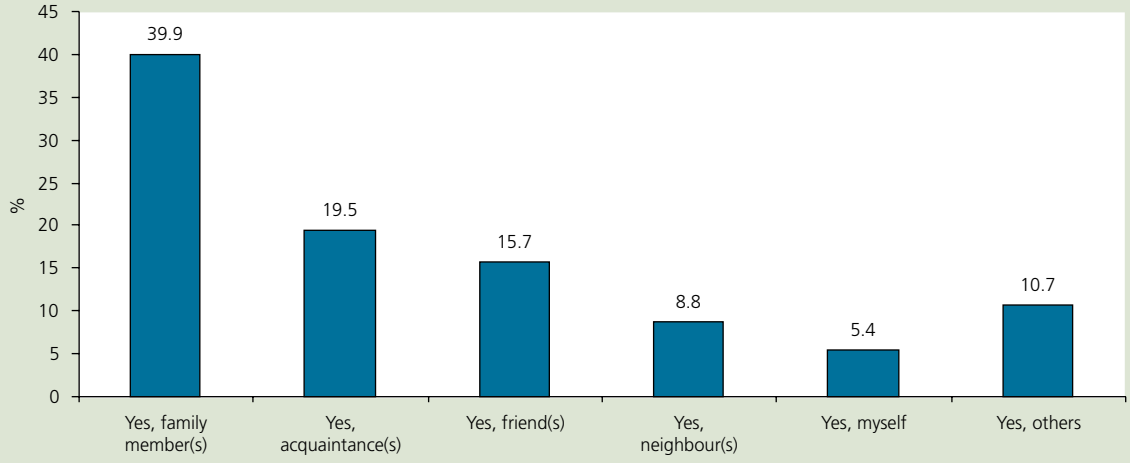
An ad hoc module in the **Labour Force Survey 2002** is collecting information on the employment of disabled people. It was developed by **Eurostat** together with ONS-UK (ref. Meltzer 2002), and accepted by the Member States for inclusion in the survey under the LFS regulation on ad hoc modules. It is expected to deliver, for the first time, detailed comparable information on the labour force participation of persons with disabilities as compared with the labour force participation of persons who have no disability. Also for the first time, the sample will be large enough for relevant breakdowns, for instance by nature of disability, and for information on the assistance provided to or needed by disabled persons in order to work. The content of the module has been influenced by theoretical, methodological and policy-driven perspectives.

The module focuses on restriction of activities rather than functional limitations. Disability is no longer seen as something which an individual has, but rather as the result of an interaction between the individual and the environment and, as such, is a dynamic rather than a static characteristic. One of the consequences of looking at disability as an interaction between the person and the environment is that its measurement and classification can no longer be described in terms of loss of structure or function. The choice of the LFS as a vehicle for a disability module permits the analysis of disability data with the whole range of employment data collected routinely in the LFS. The module is relevant for working and non-working disabled people in that it covers the tasks that they can do. The information to be collected refers to some long-standing causes of disability such as: problems with arms or hands (which include arthritis or rheumatism); problems with legs or feet (which include arthritis or rheumatism); problems with back or neck (which include arthritis or rheumatism); difficulty in seeing (with glasses or contact lenses, if worn); difficulties in hearing (with hearing aids or grommets, if used); speech impediment; skin conditions (which include severe disfigurement, allergies); chest or breathing problems (which include asthma and bronchitis); heart, blood pressure or circulation problems; stomach, liver, kidney or digestive problems; diabetes; epilepsy (including fits); mental, nervous or emotional problems; other progressive illnesses (which include cancers, multiple sclerosis, HIV or Parkinson's disease) and other long-standing health problems.

4.4.6. Attitudes of Europeans towards disability

The European Year of People with Disabilities in 2003 will promote awareness of disability. The **Eurobarometer 54.2 survey**, conducted by the **European Commission** in 2001, asked participants about their attitudes towards disability (ref. Eurobarometer 54.2). Note that the survey only focuses on the opinions expressed by Europeans, which do not necessarily reflect their daily behaviour. Europeans may show a diffuse knowledge about different forms of disabilities and their associated prob-

4.4.14 Attitudes of Europeans towards disability: knowledge of disabled persons, EU-15



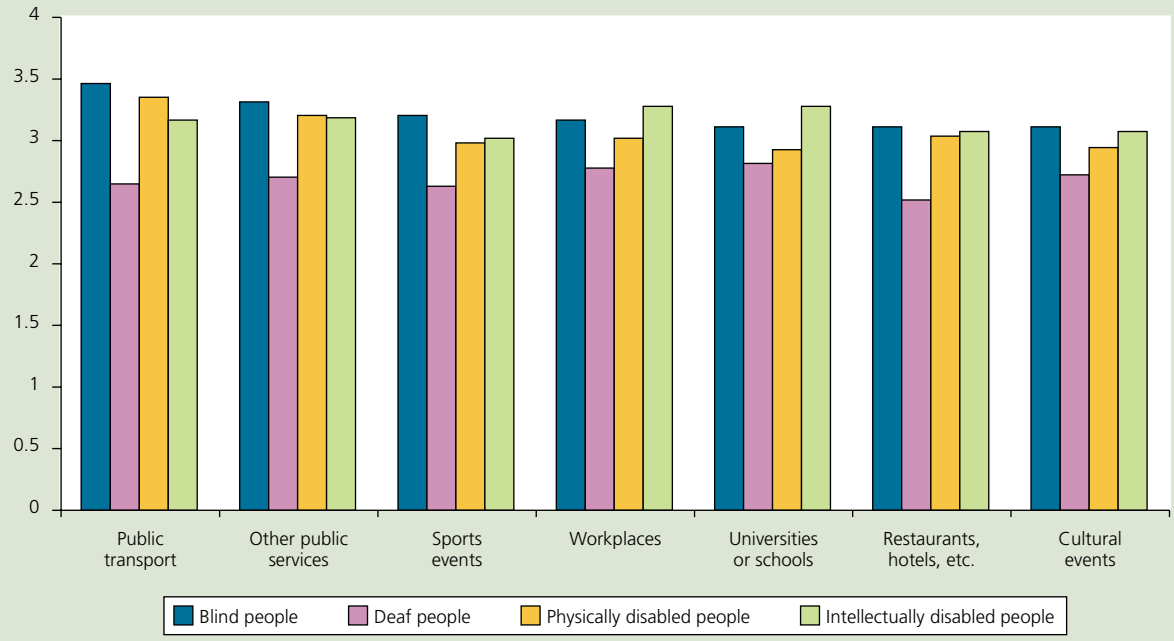
Question: Do you personally know anyone who has long-lasting illness, disability or infirmity that limits their activities in any way? Who are they?

Source: Eurobarometer 54,2, European Commission, 2001.

lems, but a lack of knowledge is not followed by indifference towards this issue. On the contrary, there is a tangible will to make things change. The survey **(4.4.14)** showed that a majority of EU citizens knew at least one person having a long-lasting illness, disability or invalidity, whether or not in their immediate surroundings. They also showed a high level of concern regarding the issue of disability, with 39.9 % having a member of their family affected by a disability, and 5.4 % considering themselves to be disabled. A large majority of Europeans (80 %) declared that they were very much at ease in the presence of people with disabilities, especially in Denmark, the United Kingdom, Sweden, the Netherlands, Spain and Ireland; the Greeks were the least at ease.

Overall, EU-15 citizens perceived access of disabled people to buildings, services and events as 'fairly difficult' to 'very difficult' **(4.4.15)**. From a list of seven typical types of these areas, 76 % perceived access for blind people as difficult. Perceptions for access for people with other disabilities were 73 % for intellectually disabled people and 71 % for the physically disabled, dropping to 54 % for deaf people. Averages were calculated by summing the results for 'very difficult' and 'fairly difficult' access. In all, 88 % of Europeans considered that access to public transport for the blind is difficult (54 % thought it was 'very difficult' and 34 % 'fairly difficult'). A total of 85 % pointed out the difficulties of access to public transport for physically disabled people. Nearly three in four thought that access to public services (transport included) was difficult for intellectually disabled people; 59 % of the participants thought that access to schools and universities was difficult for deaf people. When asked if access to public places had improved over the last 10 years, 57 % of Europeans thought it had with an average of 2.62 points, using a scale from 1 'not improved at all' to 4 'very much improved'. In four countries, only a few improvements had been noticed: Greece (1.85 points), Portugal (2.13), Italy (2.41) and France (2.49). Countries that express a much more positive appreciation of the changes are Luxembourg (2.84), the United Kingdom (2.91), Austria (2.95), Sweden (2.97), the Netherlands (2.99) and Finland (3.03).

4.4.15 Attitudes of Europeans towards disability: access for people with disabilities to services, EU-15



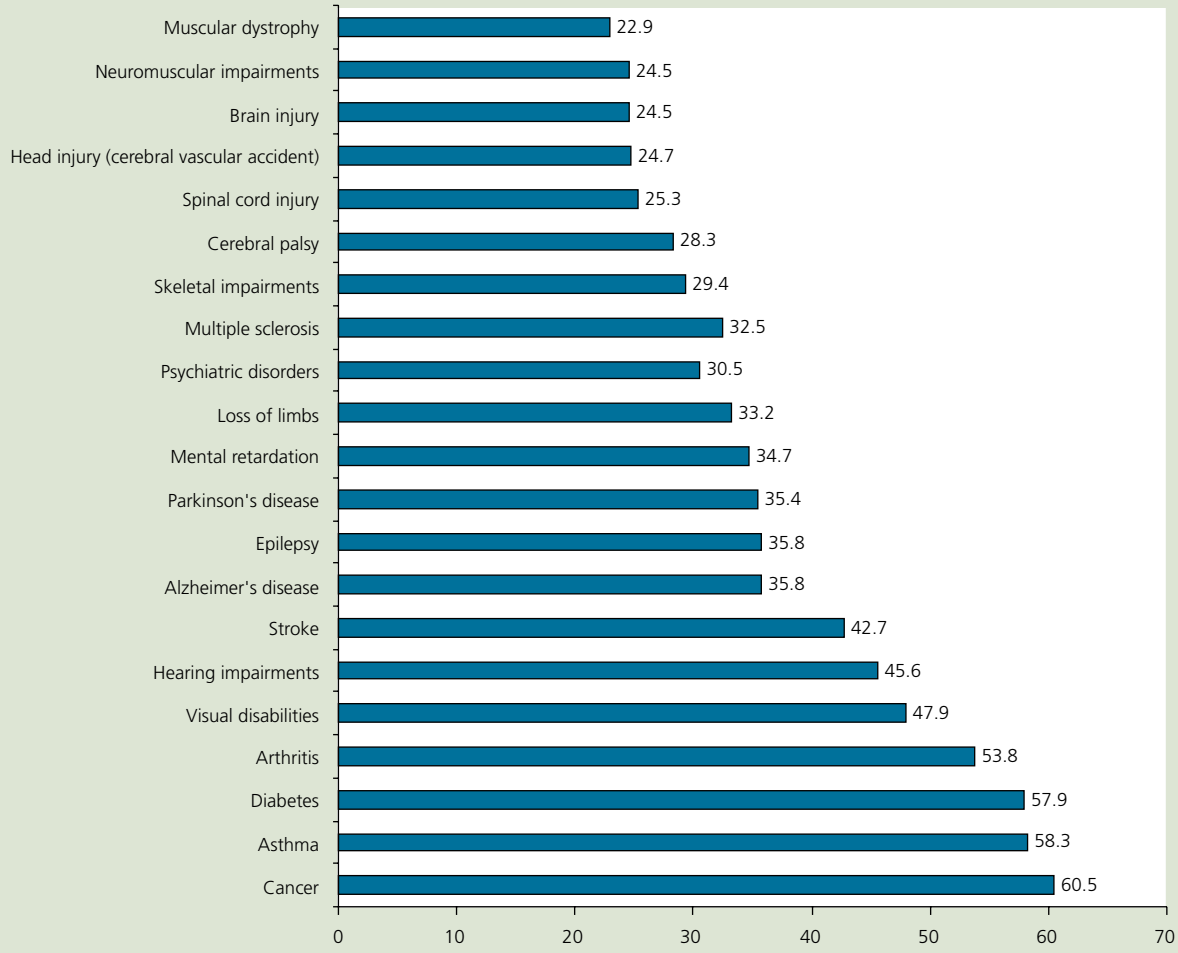
Average: (1 'not at all difficult', 2 'not very difficult', 3 'fairly difficult', 4 'very difficult').

Source: Eurobarometer 54.2, European Commission, 2001.

As 57 % of Europeans admitted having a lack of knowledge about the 21 types of disabilities named in the questionnaire (the average being based on results collected by each item), it is worth noting that the word 'disability' covers a series of deficiencies which generate different levels of information in the population. Knowledge was highest in four large groups **(4.4.16)**: (a) disabilities due to long-lasting illnesses such as cancer (61 %), asthma and diabetes (58 %), and arthritis (54 %) (which are not always considered a handicap); (b) disabilities that correspond to a more widespread perception of handicap such as physical and sensorial disabilities — for instance, 48 % of Europeans knew about visual disabilities, 46 % about hearing impairments, 43 % about cerebral stroke, and only

23 % about muscular dystrophy (which is the disability that obtains the lowest score out of the 21 selected types of disabilities); (c) mental and psychological disabilities are the least well known with only 36 % being fairly aware about Alzheimer's disease, 35 % about Parkinson's disease and 31 % about psychiatric disabilities; and (d) other types of disabilities with uneven levels of information — brain injury, head injury and spinal cord injury (25 %), multiple sclerosis (32 %) and skeletal impairments (30 %). Nearly a quarter of Europeans thought that 20 % or more of the population in their own country had a disability, and 19 % did not have any opinion about the actual number of people in their respective countries who were disabled.

4.4.16 Attitudes of Europeans towards disability: awareness of Europeans regarding disabilities, EU-15



Question: How aware are you of the various types of disabilities that exist? Would you say you are fairly aware?

Source: Eurobarometer 54.2, European Commission, 2001.

Virtually all participants in the survey were in favour of better integration of disabled people, and 97 % thought that something should be done to involve people with disabilities more in society (by, for instance, making it easier for them to access public places). More precisely, 93 % expressed a wish to spend more money on removing physical barriers, which complicate the life of physically disabled people; 72 % were in favour of the idea that children with disabilities should be taught in the same schools as other children. This positive attitude is reinforced by the fact that only a minority of 39 % asserted that disabled people are less productive at the workplace, and 76 % of Europeans rejected the idea of separating disabled people from the community.

References

Disability and social participation in Europe (2001), Office for Official Publications of the European Communities, Luxembourg.

ECHP, http://www-rcade.dur.ac.uk/echp/.

Educational levels, http://unescostat.unesco.org/en/act/act_p/isced.html and

http://www.fernunihagen.de/FTB/telemate/database/isced.htm.

Eurobarometer 54.2, *Attitudes of Europeans to disability*, European Commission, Directorate-General for Employment and Social Affairs, 2002.

Euroblind, http://www.euroblind.org/fichiersGB/STAT.htm.

Eurodiet, http://eurodiet.med.uoc.gr/ and *Determinants of the burden of disease in the EU* (1997), NIPH, Sweden.

Mayhew, L. (2001), 'Disability — Global trends and international perspectives', presented to the Staple Inn Actuarial Society, London.

Meltzer, H. (2002), *The 2002 LFS ad hoc module on disability*, Eurostat and the Office for National Statistics, United Kingdom.

Robine, J. M. et al. (OPCS) (1992), 'Health expectancy: First workshop of the International Healthy Life Expectancy Network (REVES)', *Studies on Medical and Population Subjects,* No 54, HMSO, London.

4.5. Stress

Stressful conditions are known to induce disadvantageous hormonal, metabolic and immunological changes which may contribute substantially to excessive morbidity and mortality from a number of mental illnesses, but also from cardiovascular disease and some cancers. Data from the **Eurobarometer 52.1** survey (1999) show that nearly 40 % of people aged 15 and over regularly felt stressed **(4.5.1)**. There were large variations between Member States, from 26 % in Finland to 72 % in Greece. A greater proportion of women than men were affected in most Member States, with the greatest differences being in France (13 %) and Portugal (12 %), and the smallest in Germany (0.2 %) and Finland (1 %). Variations between countries increased with age, and a larger proportion of people in each age group were stressed in Greece than in other Member States **(4.5.2)**. Finland had the smallest or second smallest proportions of stressed people in all age groups, except the '55 and over' where Germany then Denmark had the smallest. The largest proportions of stressed people were aged 25–39 in all Member States, except in the Netherlands and Germany where they were aged 15–24, and in France, Ireland and Italy where they were aged 40–54. The smallest proportions were aged 55 and over in all Member States, except Greece where they were aged 15–24.

Various aspects of life can affect mental and physical health. The **European Community Household Panel (ECHP)** asked people how satisfied they were with their work (or main activity), financial and housing situations and amount of leisure time. In 1997 **(4.5.3)**, nearly half of those asked in the EU were 'dissatisfied with their financial situation', and this aspect was associated with the widest variation between Member States at 50 %. 'Dissatisfaction with leisure hours' had the least variation between Member States at 27 %. There are clear differences between countries, with people in some Member States being most dissatisfied with every aspect investigated, and those in other Member States being least dissatisfied with every aspect. People in Greece, Italy and Portugal were the most 'dissatisfied with their work' (Greece 51 %, Italy 47 %, Portugal 37 %), 'financial situation' (Portugal 71 %, Greece 70 %, Italy 62 %), 'housing situation' (Greece 38 %, Portugal 31 %, Italy 29 %) and, together with those in Spain, 'leisure hours' (Greece 45 %, Italy 41 %, Spain 37 %, Portugal 33 %). People in Denmark, the Netherlands and Austria were the least 'dissatisfied with work' (11 % each), 'financial situation' (Denmark 21 %, the Netherlands 22 %, Austria 28 %), 'housing situation' (the Netherlands 8 %, Austria 9 %, Denmark 11 %, France 11 %) and, together with Finland, 'leisure hours' (Austria 18 %, Denmark 20 %, Finland 21 %, the Netherlands 22 %, Ireland 22 %).

4.6. Well-being and social isolation

In the **European Community Household Panel (ECHP)** individuals were asked about how often they met or spoke with friends **(4.6.1)**. In 1997, three quarters of people in the EU met friends at least once a week, with people in Ireland being the most sociable (95 %) in this respect, followed by those in Greece (93 %) and Spain (92 %). Germany had the lowest proportion of people by far (43 %) who met friends at least once a week, and the highest proportion by far (22 %) who met friends less than once a month. Among people who met friends less than once a month, Italy (33 %), Greece (30 %), Ireland (30 %) and then Spain (27 %) had the highest proportion of people who spoke to no one outside the household. There were no data for Germany in this respect. Thus, a small minority of people living in the most sociable countries, who see friends less than once a month, are likely to be lonelier than similar people in less sociable countries.

The World Health Organisation (WHO), in the **'Health behaviour in school-aged children' (HBSC)** study, asked young people in Europe aged 11, 13 and 15 whether they felt lonely in 1997/98 **(4.6.2)**. Those who replied 'yes, sometimes' are not included, but those who replied 'yes, rather often' or 'yes, very often' are combined in the table. The data show that the proportion of girls who were lonely ex-

ceeded the corresponding proportion of boys at each age and in each country (except for those aged 11 in Sweden). In countries other than Greece, the proportion of boys who reported feeling lonely decreased slightly between the ages of 11 and 15, whereas the proportion of girls who did so increased slightly. At age 11, the largest proportions of lonely young people were found in Wales (15 % boys, 22 % girls), and the smallest in Norway (4 % boys, 5 % girls). At age 15, the largest proportions were in Greece (20 % boys, 39 % girls), and the smallest in Denmark (3 % boys, 10 % girls).

References

HBSC (see Chapter 2.2 for metadata), (http://www.ruhbc.ed.ac.uk/hbsc/).

4.7. Diagnostic-related morbidity

The following two sections provide a brief overview of some disease groups. With the exception of cancer and some communicable diseases, there are currently very few disease-specific data representing the whole EU population. **Eurostat** has begun to investigate some of the methodological issues involved. Different methods are used to collect incidence and prevalence data across countries. The possible effects of actual differences on the data must be taken into account when making comparisons between countries.

There are two basic types of morbidity statistics, namely measures of incidence and of prevalence. **Incidence** is a measure of the number of new cases arising in a population in a given period. When expressed as an **incidence rate**, it is this number of cases as a proportion of the number of persons in the population at the beginning of the time period. Incidence thus measures risk in a defined time period. **Prevalence** is a measure of the number of cases existing at a certain time. The **prevalence rate** is the proportion of this number of cases in the total population. Prevalence is a measure frequently used in planning the allocation of health service resources. It is of less use in aetiological research, where incidence measures are of greater interest. For example, incidence might be expressed as the number of new cases of a disease (or disorder) per 100 000 population in a year, and prevalence as the proportion of a population with the disease at any time in a year. Incidence may refer either to the first onset of a disease (i.e. new cases) or to all episodes. For prevalence statistics from different studies to be comparable, the period considered must be the same. The main sources of disease-specific data for incidence and prevalence data across a range of EU countries are: health interview surveys, cross-sectional population surveys, panel/cohort surveys, medical statistics, hospital records, disease-specific registers, general practice (GP) records and administrative notifications.

Under the EC Health Monitoring Programme, a project '**Compiling a European Union wide inventory of morbidity data'**, coordinated by the **Office for National Statistics** (UK), was initiated to identify national sources for morbidity data in the EU. The project will result in the preparation of an electronic inventory of sources of disease-specific morbidity data, as well as meta-data, which can be updated annually by the Member States for the Commission, and be made widely available to the public. Also, the **Euro-Med-Data (EMD)** project, under the coordination of the **School of Public Health** of the Université Libre de Bruxelles (Belgium), was conceived to take part in this collective effort at EU level. Its object is to compile an inventory of medico-administrative data, routinely collected in 18 European countries at the primary and secondary health care level, as well as in the area of occupational medicine.

4.7.1 Communicable diseases

Surveillance is defined by WHO as the 'ongoing systematic collection, collation, analysis and interpretation of data; and the dissemination of information to those who need to know in order that action may be taken'. Under Commission Decision 2000/96/EC, of 22 December 1999, the EU agreed to set up a network at Community level to monitor the incidence of 39 specific communicable diseases, as well as nosocomial infections and antimicrobial resistance, which are covered in this section. In selecting diseases to be covered by epidemiological surveillance within an EU network, the criteria included:

- diseases that cause, or have the potential to cause, significant morbidity and/or mortality across the Community;
- diseases where the exchange of information may provide early warning of threats to public health;
- rare and serious diseases which would not be recognised at national level and where the pooling of data would allow hypothesis generation from a wider knowledge base;
- diseases for which effective preventive measures are available with protective health gain-records/administrative statistics, hospital records, disease-specific registers, general practice (GP) records and administrative notifications.

According to Commission Decision 2002/253/EC of 19 March 2002, which lays down case definitions for reporting communicable diseases to the Community network, Member States should communicate information on the epidemiological development and emergence of public health threats due to communicable diseases. They should use the Community network so as to allow comparisons to be made for preventive and control action to be

taken at Community and national level. For comparability of such information, the setting-up of common case definitions is a prerequisite, even where disease-specific surveillance networks have not yet been put in place. As soon as this decision comes into effect on 1 January 2003, these case definitions should be compulsory when reporting to the Community network, and should also comply with regulations on individual data protection.

A complete overview of all the sources of information on communicable diseases (statutory notification systems, non-statutory notification systems, outbreak alert systems, institutions and laboratories) may be found in **IRIDE ('Inventory of resources for infectious diseases in Europe')**, a project coordinated by the **Istituto Superiore di Sanità** (Italy) under the EC Health Monitoring Programme. This inventory (http://iride.cineca.org) provides a computerised source of information, facilitating the exchange of information among Member States within the European network for the control of communicable diseases. The purpose of IRIDE is also to provide descriptions and analyses of existing resources for the monitoring and control of communicable diseases in the Member States of the EU and candidate countries. Moreover, IRIDE provides an improvement in the exchange of information among the Member States relevant for the European network for the control of communicable diseases and an opportunity to standardise protocols for investigations of communicable disease outbreaks, of quality assurance for reference microbiological laboratories, and of other issues relevant to the control of communicable diseases across European countries.

The organisation of resources for the monitoring and control of communicable diseases varies between Member States (ref. Salmaso 1998). By contrast, the systems for notification of communicable diseases have been found to be similar. These are the **statutory notification systems (SNS)** from which the number of institutions involved at the national level in managing the notification system varies from one institution (Austria, Ireland, England and Wales, Finland, Scotland and Switzerland) to four institutions (the Netherlands). Ten countries have a peripheral and intermediate level between the notifier and the national level, and eight have more than one intermediate level. In the remaining two countries (Luxembourg and Norway), the notifier sends the report directly to the national-level institution. The systems in Germany, Italy, and Portugal have more complicated information flows, in that various intermediate-level institutions send information to various national-level institutions. The number of diseases and pathogens subject to statutory notification ranges from 22 in France to 80 in Finland, with a median of 39.5. In Italy and Spain, all communicable diseases are subject to mandatory notification. In six countries (Norway, Sweden, Finland, the Flemish Community and the French Community (Belgium), Denmark and Switzerland), laboratories also serve as notifiers, though their roles in the notification system vary by country. For example, in Sweden, all diseases included in the system are recorded by both clinics and laboratories, whereas, in Denmark, a clear distinction is made between the system that uses clinics as notifiers and that which uses laboratories.

Non-statutory surveillance systems (NSSS) are infrastructures designed to routinely analyse, interpret, and provide feedback on systematically collected data, not necessarily based on a specific legal act. An NSSS is often set up to respond rapidly to the need for information not otherwise available at the national level, and the primary sources of information may differ from those for statutory notification systems. Very often, NSSS are established for practical purposes, and, by definition, they are not established with specific legislation. Nonetheless, they represent an important source of information and may constitute important resources for the control of the event under surveillance. The number of NSSS in individual EU countries ranges from 1 to 20. Luxembourg and Norway are the only countries without NSSS (diseases and pathogens are reported through statutory systems only).

4.7.1.1. Diseases preventable by vaccination

Diseases included in this group are tetanus, the bacterial infections of diphtheria and pertussis, and of haemophilus influenzae type b, as well as the viral infections of influenza, measles, mumps, poliomyelitis and rubella. All are contagious, some highly so, but for most of these diseases vaccines are given routinely in childhood.

Poliomyelitis is caused by the polio virus, an enterovirus, which can affect the front part of the spinal cord, and thus nerve cells responsible for stimulating contraction of muscles. It may thus lead to permanent muscle weakness and paralysis. A routine vaccine is given in childhood, either by mouth (Sabin vaccine) or by injection (Salk vaccine). Within the EU, very few cases of poliomyelitis have been reported in the past decade **(4.7.1)**, save an outbreak in the Netherlands over 1992–93. The few cases reported since 1995 were all adverse reactions to the use of vaccine. In June 2002, WHO took the historic decision to certify the European region of the WHO as **poliomyelitis-free**. The last case of indigenous wild poliomyelitis occurred in eastern Turkey in 1998.

Diphtheria is caused by the bacterium *Corynebacterium diphtheriae*, and is sometimes fatal. Bacteria multiply in the mouth or throat, causing inflammation. Due to obligatory vaccination, the incidence of diphtheria is close to 0 in EU countries **(4.7.1)**, but epidemics have occurred in recent years in eastern Europe, for instance in Russia in 1997 (ref.

Editorial note 1997a). It is considered that some cases of diphtheria in EU countries could be linked to transmissions from some eastern countries. At a recent meeting of the **European Laboratory Working Group on Diphtheria**, it was noted that antibody levels decreased for diphtheria in populations over 21 years of age. This led to a recommendation that a routine booster dose of tetanus-diphtheria (Td) vaccine should be given every 10 years (ref. Lai and Efstratiou 2002).

The **haemophilus influenzae type b** (Hib) is the most likely of the *Haemophilus* bacteria to cause disease, in particular meningitis, but children are routinely immunised against it with a vaccine. The incidence of Hib in EU countries is generally low **(4.7.1)**, with the highest levels being in Belgium and moderate levels in France and Switzerland. In some countries, almost no cases have been reported in recent years.

Pertussis (or whooping cough) is caused by the bacterium *Bordetella pertussis*, resulting, among other symptoms, in characteristic fits of coughing. Possible complications may arise in the airways, where pneumonia can develop; pertussis can be a serious illness at ages under two. The history of pertussis in the EU shows that immunisation reduces the morbidity associated with the disease (ref. Therre and Baron 2000). While inactivated whole-cell pertussis vaccines have been used in some national vaccination programmes for over 30 years, adverse reactions, mainly among older recipients, have become a major concern. New acellular pertussis vaccines have been developed in recent years, and their use varies widely between European countries. Concerns about safety led some countries to stop vaccination with whole-cell vaccines, and later introduce acellular vaccines, whereas other countries have continued to use whole-cell vaccines. However, concerns about the safety and efficacy of pertussis vaccines are still debated.

Epidemics of pertussis occur about every three or four years, and European countries may be classified in three groups **(4.7.1)** with respect to pertussis incidence. First, those with a low incidence — Austria, Belgium, the United Kingdom, France, Italy, Greece, Luxembourg, Portugal and Spain. Second, those with a moderate level of incidence — Denmark, Iceland and Ireland. Third, those with high incidence — Switzerland, Finland, Germany, the Netherlands, Norway and Sweden. Note, however, the periodicity of outbreaks (Sweden over 1990–94, Finland 1995, Italy 1995–96, Norway 1997–98, the Netherlands 1999). Note also that in Sweden, although vaccination has been recommended since 1996 for all children and vaccine coverage is high, the current incidence remains high although declining. The recent development of acellular vaccines promised better control of pertussis, but major questions remain about the duration of immunity they provide. These vaccines also provide an opportunity to give late boosters so as to reduce the transmission of infection from the community to infants. Note, too, that the high price of acellular vaccines compared with whole-cell vaccines may also affect their wider use.

Rubella is a contagious viral infection, preventable by routine immunisation in childhood. It may be serious in pregnancy, as a woman infected during the first 16 weeks may miscarry, give birth to a stillborn baby, or have a baby with congenital anomalies. Rubella epidemics occur every six to nine years, usually during the spring. Reporting in 1998, most of the eight participating countries in the **European sero-epidemiology network (ESEN)** had introduced the rubella vaccine as a selective vaccination for pre-pubertal girls in the 1970s, in order to prevent rubella infection in pregnant women (ref. Levy-Bruhl et al. 1998). Some of these countries also included a programme to vaccinate older susceptible people. In the late 1980s, epidemiological data and results of mathematical modelling showed that the selective strategy alone could not eliminate congenital rubella. Rubella vaccination, therefore, now shares the same schedule and levels of coverage as measles vaccination. In Denmark, France, Germany and Italy, catch-up doses were still indicated in 1998 for unvaccinated or susceptible girls or women. From Table **4.7.1**, it is evident that rubella has been virtually eliminated in Finland and Sweden, as well as the Netherlands, but it persists in other countries, such as Switzerland, Italy, Ireland and the United Kingdom, for a variety of reasons.

Measles (or rubeola) is a viral infection producing various symptoms and a characteristic rash. Vaccination in childhood is routine, usually in combination with the mumps and rubella vaccines. Before the measles vaccine became widely available, epidemics occurred every two or three years. Measles can lead to complications, such as pneumonia (in infants) or a middle-ear infection. Within ESEN participating countries, most had achieved a high level of control over measles by 1998, due mainly to long-standing vaccination programmes and/or a two-dose MMR (measles/mumps/rubella) strategy. Finland and Sweden had achieved this high level, as had Denmark, the Netherlands and the United Kingdom. However, in Italy vaccination coverage (see Chapter 6) was low up to 1997, while coverage in France was higher but still well below 100 %. Both countries reported a relatively high measles incidence up to 1997, although more recently this has fallen sharply **(4.7.1)**. In the case of France, the reduction may have resulted from a second dose being recommended from 1996 (ref. Brachet et al. 2000).

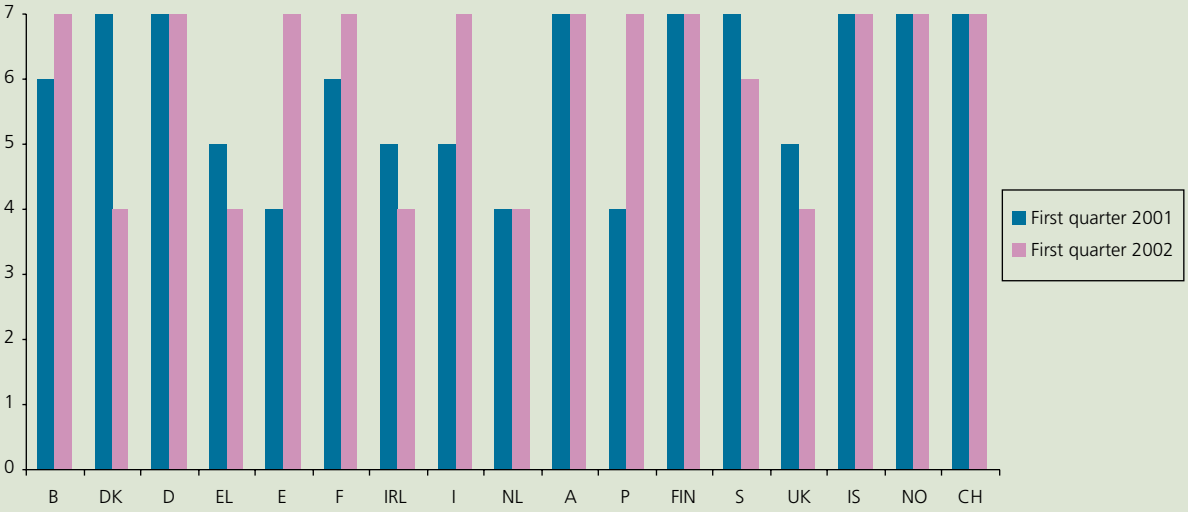
Mumps is a viral infection causing painful enlargement of the salivary glands, but it may also affect other organs, particularly in adults. These complications may result in orchitis (in men), encephalitis, or meningitis. Vaccination is routine in childhood. Within ESEN participating countries, routine vaccination was introduced during the 1980s, and the vaccine is now given as part of MMR (ref. Levy-Bruhl et al. 1998). Mumps has been virtually eliminated in Finland, Luxembourg, the Netherlands and Norway and is close to this objective in Denmark, Greece and Sweden. It is also under a high level of control in Ireland and the United Kingdom. Currently, the highest incidence rates for mumps are reported in Italy, Portugal, France, Belgium and Spain **(4.7.1)**. The immunisation schedule, vaccination coverage, and surveillance of mumps and measles are the same. As for measles, very high levels of coverage, with two doses of MMR, have resulted in Finland and Sweden achieving WHO targets of an incidence of under 1 per 100 000.

Tetanus is a serious, sometimes fatal, disease of the central nervous system that is caused by an infection of a wound with spores of the bacterium *Clostridium tetani*. The spores live in the soil. When spores enter the body through a wound, they can multiply and produce a toxin that affects the nerves which control muscle activity. Children who are less than seven years of age can receive the DTP vaccine — a combined vaccine against diphtheria, tetanus and pertussis. Tetanus remains an important public health problem in developing countries, but cases also occur, although rarely, in the EU. Over the last 50 years, large-scale use of tetanus vaccination and improved wound care have changed its epidemiology in industrialised countries: neonatal cases have disappeared and a huge reduction in the incidence of the disease has been observed in other age groups. However, although within the EU very few cases of tetanus have been reported in the past decade **(4.7.1)**, the disease has not disappeared.

Influenza is a viral infection which causes widespread outbreaks of respiratory illness, usually in late autumn and winter. It is normally found as the influenza A or influenza B virus. While the illness generally resolves in 7–10 days, there are possible complications for the very young, the very old, and persons with heart, lung or nervous system diseases. Annual vaccination is recommended against the virus strains most likely to cause influenza at that time. This is based on strains common in the previous year and current strains causing the illness elsewhere. Vaccination is usually targeted at those likely to suffer complications. An early-warning system for influenza in Europe, the **European influenza surveillance scheme (EISS)** has been in operation since 1996 (ref. Manguerra and Mosnier 2000). During the winter of 2000–01, most cases were of influenza A virus (H1N1), followed by influenza B virus, which is more common in some countries. In most countries covered by the EISS, the peaks in recorded morbidity rates were much lower than those for the previous season, showing a moderate level of influenza activity. In week 15/2002, most of the national networks participating in the EISS reported low or baseline levels of influenza activity. Five networks reported no influenza activity (Denmark, Ireland, Poland, Spain and Switzerland), eleven networks reported sporadic activity and two networks — Germany and Norway — reported local influenza activity. The dominant influenza virus in 2002 was influenza A in six networks, and influenza B in five networks. Seven networks reported no influenza viruses circulating in week 15/2002. No new cases of influenza A (H1N2) or influenza B/Victoria/2/87-like viruses were reported to the EISS in week 15/2002. Activity graphs are produced by the **national influenza centres to WHO — Flu Net (4.7.2)**. According to **Eurostat**, the number of deaths due to influenza in the EU has increased steadily in recent years (2 532 in 1994, 3 420 in 1995, 4 323 in 1996, 4 450 in 1997 and 5 613 in 1998).

In November 2001 the European Commission invited experts from all over Europe to express their views on ways to improve preparedness for an influenza pandemic at the European Community level. The conference was well attended and key actions to be addressed by public health authorities in cooperation with decision-makers and the pharmaceutical industry were identified. Based on the suggestions made at this conference, the Commission's public health service, assisted by a working group of Member States' experts, has drawn up a **Community influenza pandemic preparedness and response plan** (ref. Karcher 2002), which is now in its final stage. During the drafting phase, the plan was widely discussed within the Commission services, with experts from the European Agency for the Evaluation of Medicinal Products (EMEA), and vaccine and antiviral manufacturers under the auspices of the European Federation of Pharmaceutical Industries and Associations (EFPIA). Preparations to adopt the plan as a legal document are under way. The main purpose of the plan is to achieve a coordinated Community response in the event of an influenza pandemic. The plan addresses the key components of the response and seeks to identify all concerned parties at Community level and to clarify their roles. It also identifies those Commission and EMEA activities that could facilitate coordination of the activities of Member States, and sets the Community's response in the context of the wider international response. The most important task of surveillance is to provide early detection, and characterisation of pandemic strains from clinical or other specimens, and a

4.7.2. Monitored linked clinical-virological surveillance for influenza in Europe



1 = No Surveillance; 2 = No report; 3 = No Activity; 4 = Sporadic; 5 = Local outbreak; 6 = Regional outbreak; 7 = Widespread outbreak

Source: WHO Flu Net

reliable risk assessment as to its potential to cause widespread outbreaks among humans. Routine surveillance should include information on circulating and emerging influenza virus strains in humans and animals, the burden of disease in terms of severity, and, if possible, information on hospitalisation rates, attack rates, and costs. Making effective antivirals and vaccines available is the central pillar in prevention, mitigation and response strategies.

4.7.1.2. Sexually transmitted diseases

Because sexual activity provides an easy opportunity for organisms to find new hosts, a wide variety of infectious micro-organisms can be spread by sexual contact, and sexually transmitted diseases or infections (STIs) are among the most common infectious diseases. Those included here are chlamydia infections, gonococcal infections, HIV infection and syphilis.

Gonococcal infections (specifically gonorrhoea) are transmitted by the bacterium *Neisseria gonorrhoea*, and may spread through the bloodstream to other parts of the body, especially the skin and joints. This may result in pelvic and reproductive problems in women. Recent European trends **(4.7.3)** show an overall decline in incidence, especially in the years around 1990. However, rates remain high in the United Kingdom. A sudden increase in gonorrhoea was noted for France in 1998, based on the national laboratory surveillance network **(Renago)**, and recent data for England and Wales show diagnoses of gonorrhoea in 2000 to be at their highest since 1987, with an increase of 27 % in the latest year (ref. Hughes 2001). There is no linear link between the incidence of gonococcal infection and HIV infection, but the former is the most sensitive indicator of risk behaviours that could lead to a possible upsurge in HIV outbreaks in the near future. The French study noted the increasing importance of antibiotic-resistant strains, in particular to penicillin. This increases the likelihood of treatment failure and the risk of onward transmission.

Syphilis is a sexually transmitted infection (STI) caused by the bacterium *Treponema pallidum*, and is characterised by passing through three stages. The incidence of syphilis, which some years ago was a great threat, shows a gradually declining trend in EU countries over the past 15 years **(4.7.3)**. An exception to this is the increased incidence in Finland from 1993, peaking in 1995. Much of the increase has been linked to males who had become infected abroad, particularly in Russia (ref. HiltunenBack et al. 1996). More recently, outbreaks of infectious syphilis have been reported in Belgium, France, Ireland, Luxembourg and the United Kingdom. Young people, homosexual men and those with poor access to health care seem to be particularly affected, and these features are similar across EU States (ref. Fenton et al. 2001). However, STI control measures vary considerably across the EU, from closely regulated legal approaches in some countries to more relaxed attitudes in others.

The ***Chlamydia trachomatis*** bacterium causes about half of the urethral infections in men not caused by gonorrhoea, as well as cervical infections in women not caused by gonorrhoea. This STI ap-

pears to be as common now as syphilis or gonorrhoea were some years ago, but few data are available for EU Member States. In the United Kingdom, *Chlamydia trachomatis* infection is the most common bacterial STI, and the long-term consequences are especially detrimental for women, in whom it is a well-established cause of pelvic inflammatory disease, ectopic pregnancy and tubal infertility (ref. Pimenta and Fenton 2001). However, the condition is largely asymptomatic, so that a high proportion of diseases remain undiagnosed.

Data on diseases preventable by vaccination (except influenza) and sexually transmitted diseases (except AIDS) are collected by **Eurostat** directly from the statutory and non-statutory systems of surveillance existing in the Member States. Some data are obtained from the computerised information system for infectious diseases (CISID), from **WHO**.

4.7.1.3. HIV/AIDS

The **acquired immunodeficiency syndrome (AIDS)** was first recognised in 1981, but it was not until 1983 that the **human immunodeficiency virus (HIV)** was discovered, and it was recognised that AIDS was the result of an advanced HIV infection.

According to the **European Centre for the Epidemiological Monitoring of AIDS (EuroHIV)**, in 2001, 8 210 new AIDS cases (adjusted for reporting delays) were reported from the EU countries, bringing the cumulative total in the EU to 232 407 cases **(4.7.4)**; of this total, 18 were before 1981. For the seventh consecutive year since the start of the epidemic, the annual number of new reported cases decreased (by 11 % between 2000 and 2001). Annual AIDS incidence per million (adjusted for reporting delays) was estimated at 21.8 in 2001, having decreased by 11 % since 2000 in the EU **(4.7.5)**. At present, this corresponds to one new case per 40 000 Europeans compared with four such new cases some years ago. The year 1994 was the turning point in the annual incidence of AIDS in the EU when a total of 24 886 new cases was reached. The annual incidence of AIDS decreased by 66 % from 1994 to 2001. The most pronounced decrease (32 %) during those seven years occurred between 1996 and 1997, coinciding with the increased use of highly active antiretroviral treatment **(HAART)**. In the following years, this tendency continued, but the rate of decrease has slowed down, according to data adjusted for reporting delays. Since the introduction of HAART, a fall in the incidence of AIDS in all categories of transmission has been observed. HAART focuses on early initiation of aggressive combination antiretroviral regimens to suppress maximally viral replication, preserve immune function and reduce the development of resistance (ref. Montserrat and Hamzaoui 2002).

Similar patterns of levelling off of new cases are apparent in most Member States. Significant decreases were observed for the years 1995–2001 in Spain (– 69 %), the Member State with the highest incidence for 10 years, and in Italy (– 70 %) and France (– 72 %), which for a long time showed the second highest incidence in the EU. In 2001, Portugal experienced an annual increase of 13 % and, since 1998, has been the country with the highest adjusted incidence, due, in particular, to a relatively recent epidemic among injecting drug users (IDUs). Trends in AIDS incidence were affected by the progressive implementation of the 1993 revision of the European case definition, which resulted in an unusually large increase in 1994, followed by a relative decrease in 1995. However, trends since 1995 should have been little affected by this. The recent decline in AIDS incidence results from the increasing use of HAART since 1996, and the patterns of past HIV incidence which peaked in the mid-1980s.

Transmission categories

Analysed by transmission category, cumulative data to the end of 2001 **(4.7.6)** show that in the EU 39.4 % of AIDS cases resulted from injecting drug users, 32.6 % from homosexual or bisexual contacts, and 17.6 % from heterosexual contacts. These proportions vary widely between EU countries: thus, in Spain and Italy, the proportion of homo/bisexual contacts is around 15 %, and that of IDUs over 60 % or more. By contrast, homo/-bisexual contacts formed over 60 % in Denmark, the Netherlands, Finland and the United Kingdom, with small proportions of IDUs. For Belgium, another pattern is evident: homo/bisexual contacts 36 %, IDUs 6 %, but heterosexual contacts 45 %. For Germany, less than 9 % result from heterosexual contacts, but 64 % from homo/bisexual contacts and 14 % from IDUs.

Since the start of the epidemic, there has been an evolution in the characteristics of AIDS cases. In 1985, the highest incidence of AIDS was found in the homo/bisexual male transmission category, but, since 1990, a continuous decrease in the proportion of AIDS cases in this category has been observed. The homo/bisexual male category which exceeded 60 % in the first years of the epidemic fell to 19.6 % in 2001. Conversely, the proportion of AIDS cases due to heterosexual transmission has increased progressively, rising from 8.9 % in 1985 to 36.5 % in 2001. The percentage of cases of AIDS in the IDU transmission category has fallen in the last few years, from 43.7 % in 1996 to 33.2 % in 2001, although this remains the most important transmission category (39.4 % of total cumulative

cases) in the EU. Within these IDU cases of AIDS in the EU, there are three times more men than women. The proportion of AIDS cases caused by mother-to-child transmission has decreased considerably, by 80 % between 1985 and 2001, which is probably explained by the recommendation to treat pregnant women infected by HIV with zidovudine to prevent vertical transmission. However, the use of antiretroviral drugs in pregnancy requires consideration of potential adverse short- or long-term effects on the foetus and newborn. Since 1985, the number of cases for haemophiliac disorder and transfusion recipients has also fallen by 88 %. As soon as it was realised that the causative agent of AIDS could be transmitted through blood, members of the groups recognised to be at higher risk were asked not to donate. Since October 1985, when suitable tests became available, all donations should have been screened for HIV antibody. Finally, 4.6 % of the total cumulative cases represent a group with a few cases of nosocomial infection, some cases of occupational exposure in health care workers and cases with no or insufficient information to allow classification.

Incidence by sex and age

The **proportion of women** with AIDS increased between 1986 (11.0 %) and 2000 (22.9 %), due to the increasing weight of the heterosexual transmission category. In 2000, on average, in western Europe, 14 % of heterosexually infected women had a 'high-risk' partner (IDU, bisexual, etc.), while 36 % had a partner from a country with a generalised epidemic. Of AIDS cases within the EU, 19.1 % were recorded in the 25–29 age group, and 26.6 % within the 30–34 age group **(4.7.7)**. EU countries show a similar pattern when looking at the distribution by age, in that AIDS cases tend to be concentrated in the 30–34 and 40–49 age groups; the only exception is Portugal, where the highest concentration is at ages 25–29. In the 15–24 age group, Portugal (11.6 %) presents twice the EU average (5.5 %), and at ages 50–59 Luxembourg (15.4 %) and Germany (12.9 %) are also around twice the EU average (7.1 %). The average age of diagnosis of AIDS is higher in cases of homo/bisexual men than in those of heterosexual transmission, and the average age of diagnosis of both groups is higher than in the IDU group. The average age in the diagnosis of AIDS has increased over time, from less than 30 years until 1988 to 38.7 years in 2001. This increase has been particularly noticeable for the IDU group, rising from 26 years in the mid-1980s to 36 years in 2001. In the remaining categories, there is also a progressive shift in the age of diagnosis of AIDS towards older ages, but it is less pronounced. The figures show a lower incidence in new cohorts; the highest incidence in the older cohorts could be related to a difference in lifestyle.

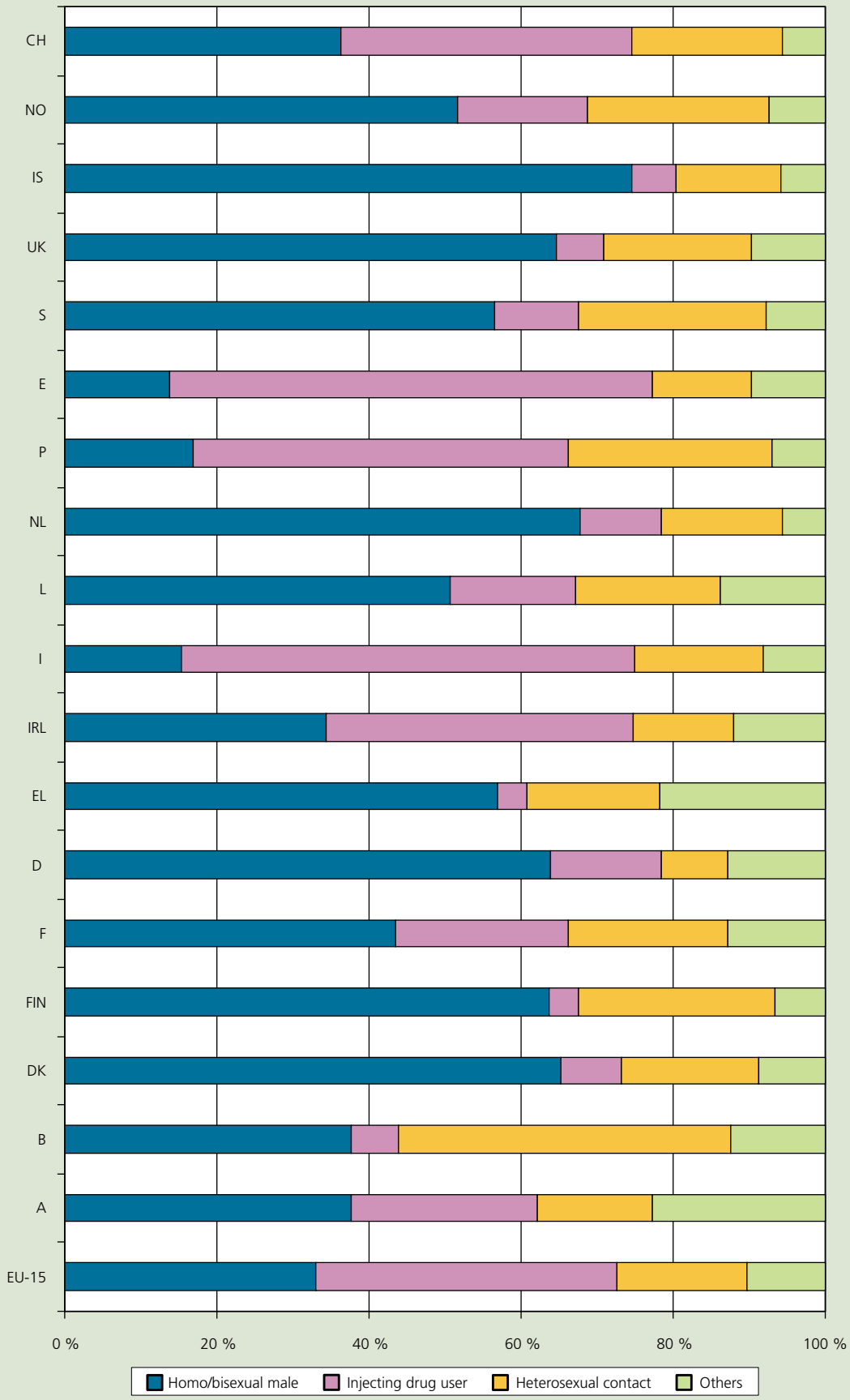
AIDS-indicative diseases

The diagnosis of AIDS requires the presence of at least one of the so-called opportunistic illnesses indicative of AIDS in a person infected by HIV. HAART has improved the immune situation of HIV-infected people and has contributed to reducing the frequency of all these illnesses. In 2001, pneumonia caused by *Pneumocystis carinii* was the most frequent opportunistic illness (and also the most life-threatening), being present in 22.2 % of men and 21.0 % of women diagnosed with AIDS in the EU **(4.7.8)**. Oesophageal candidiasis (caused by *Candida albicans,* the most common HIV-related fungal infection), was the second most frequent opportunistic illness in 2001 (13.0 % of men and 14.9 % of women). Tuberculosis (pulmonary and extrapulmonary together) occupies the second place for the two sexes combined; thus, in 41 % of the cases of AIDS diagnosed in 1994 tuberculosis was present. This percentage had decreased to 21.6 % by 2001. This fall was probably due to the increased use of prophylaxes and tuberculosis prevention for HIV-positive persons. Another well-known opportunistic illness is Kaposi's sarcoma (KS), traditionally the most noticeable external sign of AIDS because spots and lesions appear on the skin. The number of KS cases has also decreased significantly since HAART was introduced (from 21 % in the 1990s to 5.5 % in 2001).

New HIV diagnosis

According to the **European Centre for the Epidemiological Monitoring of AIDS (EuroHIV)**, the current decline in AIDS incidence does not mean that HIV incidence is declining. In 1999, a **reporting system for HIV** was established in 12 of the 15 Member States of the EU at national or regional level. Nine countries began reporting before 1991, Germany in 1993, Greece, Spain and Luxembourg in 1999, and in France and Austria a system has yet to be implemented. In Spain, Italy and the Netherlands, the HIV reporting system has only just started in some regions and data are not considered here. Cases of HIV infection are reported by laboratories in four countries, by clinicians in two and by both in nine other countries **(4.7.9)**. A cumulative total of 119 710 HIV cases in the EU (for 10 Member States only) were reported by the end of 2001. For these 10 countries, a total of 10 632 HIV cases and 2 616 AIDS cases were reported in 2001. All countries reported more cases of HIV than AIDS with ratios ranging, in 2001, from 2.4 in Portugal and 2.5 in Germany to 10.0 in Luxembourg and 9.0 in Belgium. Reporting of HIV infection must be interpreted with caution, because

4.7.6 AIDS cases by transmission group, ages 13 and over, cumulative to end-2001



Source: European Centre for the Epidemiological Monitoring of AIDS (EuroHIV).

these reports do not provide an accurate measurement of its incidence and prevalence. The proportion of HIV-infected individuals who are diagnosed and reported varies according to the phase of the epidemic, HIV testing patterns and characteristics of surveillance systems. Annual numbers of persons with HIV infection reported in the 1990s were relatively stable in some countries and decreased in others. The comparison of HIV and AIDS reported data suggests that the level of HIV transmission has remained relatively stable in the EU in recent years and that the sudden decline in AIDS incidence has been due mainly to the effect of HAART.

In the last five years, there has been a remarkable reduction in the incidence of AIDS in the EU, but the incidence is still high. The current situation is characterised by a balance of factors that act in opposite directions. On the one hand, there are prevention campaigns and HAART, but, on the other hand, there are persistently high prevalences of HIV infection in some groups, a series of circumstances that limits the effectiveness of HAART, problems in access and continuity of treatment, and the late diagnosis of HIV infection. This last factor remains important because more than a third of the persons who develop AIDS do not know that they are HIV infected.

The **European Centre for the Epidemiological Monitoring of AIDS (EuroHIV)** provides a surveillance network covering the 51 countries of the WHO European region, in collaboration with WHO and Unaids. Since 2000, EuroHIV has been located in the Institut de veille sanitaire (InVS), in Saint-Maurice, France. EuroHIV is supported by the European Commission's Directorate-General for Health and Consumer Protection and its aim is to plan, develop and manage the European HIV/AIDS surveillance system. This includes the collection, analysis and dissemination of epidemiological data (http://www.eurohiv.org), with the objectives of describing and better understanding the HIV/AIDS epidemic and improving prevention and control. In each country, a single institution is responsible for the quality of data on reporting and for bringing together data from different sources and reporting to EuroHIV. Information on HIV and AIDS cases is reported to EuroHIV in a standard format. Figures disseminated by Eurostat are based on EuroHIV data. For surveillance purposes, cases attributable to more than one mode of transmission are counted once only. The definition for heterosexual transmission varies slightly between countries. The transmission category 'other/undetermined' includes a few cases of occupational exposure in health care workers and cases with no or insufficient information to allow classification. No adjustments are made for under-reporting or under-diagnosis, so the data presented do not take into account cases which will never be reported or diagnosed.

National estimates of under-reporting range from 0 to 25 % for AIDS cases, and are not available for HIV cases. Because of reporting delays (time between diagnosis of an AIDS case and reporting to national level), EuroHIV suggests that incidence trends are best assessed by examining data by year of diagnosis, with adjustment for reporting delay, rather than by year of report. Reporting delays vary widely between countries and transmission groups, and may be as long as several years in some cases. Overall, approximately one third of the cases are reported by the end of the quarter within which they were diagnosed, and between 10 and 15 % are reported more than one year after diagnosis. Different case definitions are used in different countries, depending on population factors (children, adults, relative occurrence of opportunistic infections) and on the laboratory infrastructure and training available, but the countries participating in the surveillance of AIDS in Europe use a uniform AIDS case definition which was definitively adopted in 1993. The European definition for AIDS differs from the definition used in the United States in that it does not include CD4+ T-lymphocyte count criteria. The WHO clinical case definition for AIDS is used in countries having limited diagnostic resources.

4.7.1.4. Viral hepatitis

Hepatitis, or inflammation of the liver, usually results from one of five viruses — hepatitis A, B, C, Delta or E. The first three are considered here **(4.7.10)**.

The **hepatitis A** virus is seldom fatal, but represents a significant cause of morbidity and socioeconomic loss. It is most likely in poor environmental hygienic conditions, so is at a low level of incidence in most European countries. A safe and effective vaccine is available, and hepatitis A is usually found in adults. In the EU, it is not very common, with an estimated incidence of 2.4 cases per 100 000 population in 2000, lower than in recent years. However, outbreaks occur from time to time, such as in Greece (1998), Ireland (1997), Italy (1996–97), Norway (1998–99) and Luxembourg (1997–2000), due generally to contaminated foodstuffs. An upsurge in hepatitis A infections in the Netherlands in early 1998 was possibly the result of secondary transmission from an earlier relatively high peak in autumn 1997 (ref. Termorshuizen and Van de Laar 1998).

In western Europe, the **hepatitis B** virus is less common than in the developing world, with under 1 % of the population chronically infected, where the virus is retained permanently and the patient later develops cirrhosis of the liver or liver cancer. Hepatitis B is the most serious type of viral hepatitis, and the only type causing chronic hepatitis for which a vaccine is available; this vaccine is both safe and effective. Within the EU, transmission is most likely through sexual activity at younger ages or injecting drug use; the hepatitis B virus is also a major infec-

tious occupational hazard of health workers. Incidence in the EU is currently low, at an estimated 3.9 cases per 100 000 population, and has declined over the past 10 years. But this trend conceals occasional outbreaks, such as in Portugal (1993), Luxembourg (1994), France (1997), Norway (1998) and Iceland (1999), as well as the relatively high incidence for Luxembourg, Iceland and Norway in recent years.

The **hepatitis C** virus is a major cause of acute hepatitis and chronic liver disease, and is spread primarily by contact with human blood — unscreened blood transfusions, and reuse of unsterilised needles and syringes (ref. WHO fact sheet 2000). No vaccine is presently available to prevent hepatitis C, with research on this subject complicated by the high mutability of the genome. As a result, the greatest impact on its incidence can be achieved by reducing the risk of transmission from nosocomial exposure, and high-risk behaviours. Hepatitis C incidence is low over much of the EU, but levels have been high in Finland, Iceland, Luxembourg, Sweden and Switzerland.

4.7.1.5. Food- and waterborne diseases and diseases of environmental origin

The figures here have to be interpreted carefully, since it is likely that many food- and waterborne infections go unrecorded because patients fail to report the illness, no laboratory diagnosis is made, or the diagnosis is not reported centrally. The cases reported may, in fact, only represent a low estimate of the disease's incidence. Despite this under-reporting, the magnitude of these human health problems is significant.

Campylobacteriosis arises from infections of the gastrointestinal tract or blood due to the *Campylobacter* bacterium. It commonly results in gastroenteritis, acquired by drinking contaminated water, eating undercooked meat, or by contact with infected animals. It is the leading cause of zoonotic enteric infections in both developed and developing countries. It is under-recognised because of inadequate surveillance, because few outbreaks occur and because the infections are rarely fatal (ref. WHO 2001d). In developed countries, its reported incidence has risen substantially during the past 20 years, especially since 1990. However, many unreported infections occur for every diagnosed case, with post-infectious sequelae being part of the burden. With respect to the latter, campylobacteriosis has been implicated in acute diarrhoeal disease and the paralytic disease Guillain-Barre syndrome. Furthermore, as with many infectious diseases, the resistance of campylobacteriosis to antibiotics is increasing. The disease is most common in young children and young adults, and more in men than women. Poultry is regarded as the most important vehicle for the infection in developed countries. In northern Europe an incidence of 60–90 per 100 000 is reported, but this is probably under-notified. Rates for Denmark showed a constant increase from 1990 to 2000; this was also seen for the United Kingdom and Switzerland. These rates, and others at a similar level in recent years, are shown in Table **4.7.11**. Many infections are acquired from international travel, a feature of many infectious diseases reported in EU countries (see box below), and these 'imports' account for some 10–15 % of cases in Denmark and the United Kingdom, and 50–65 % of cases in Norway and Sweden.

Salmonellosis is becoming more and more a significant health problem in the EU. The *Enterobacteriacae* are a group of bacteria that can cause infections of the gastrointestinal tract or other organs of the body. The group includes *Salmonella*, *Shigella* and *Escherichia*. Many types of *Salmonella* infections are known, besides those causing typhoid fever, and each produces gastrointestinal upset and enteric fever. Infected food products are often the sources of salmonellosis. In western Europe, the incidence of salmonellosis fell over 1993–95, but then rose to early-1997 (59.1 per 100 000), followed by a moderate decline in the following years. More recent trends show a relatively high incidence in many countries, in particular in Germany, Denmark (in 2000) and Luxembourg (1999–2000), contrasting with low levels in Greece and Portugal. Outbreaks in 2000 (England and Wales, Germany, Iceland, the Netherlands and Scotland) had lettuce as the implicated vehicle of infection, and those in 1999 (Denmark, England and Wales, Finland, Germany, Ireland, Norway, Sweden and Switzerland) had a Turkish resort as the origin (ref. Enter-net web site).

Botulism occurs most often from eating food contaminated with a toxin produced from the bacterium *Clostridium botulinum.* This toxin is the most potent known and can severely damage nerves and muscles. Nearly all cases reported in the EU are foodborne; infant botulism and wound botulism are rare (ref. Therre 1999). Foodborne botulism results from eating contaminated food. Home-canned foods are the most common source, as are also vegetables, fish, fruits and condiments, beef, milk products, pork and poultry. Although in most EU countries botulism is statutorily notifiable, there is variation among the Member States in their case definitions, so there may be some under-notification. Epidemiological features of botulism may also differ between countries because of varying dietary habits. During the period 1988–98, four countries — Germany, Spain, France and Italy — experienced frequent moderate outbreaks of botulism, while in four others — Belgium, Denmark, Sweden and the United Kingdom (England and Wales) — notified outbreaks were rare and small. In Greece, the Netherlands, Austria and Finland, no cases were

notified in the 10-year period before 2000. As Table **4.7.11** shows, these patterns continue to 2000, with the inclusion of a relatively high incidence in Portugal in the latest year.

Leptospirosis is an infection from *Leptospira* bacteria, which results in jaundice (and possibly fatal liver damage for the elderly) and Weil's syndrome. It is an occupational disease for farmers and workers in sewers and abattoirs. Human infection occurs through exposure to water and soil contaminated by infected animal urine. It has been associated with canoeing, wading and swimming in contaminated lakes and rivers. Its incidence is low in most EU countries, with the highest rates being in France (1996–99) and Portugal **(4.7.11)**. A study of leptospirosis in Portugal reported 552 cases over 1993–97, with the elderly having the highest incidence. However, the Portuguese figures were derived from two sources (notification and hospital discharges), and the actual incidence was probably higher than reported (ref. Falçao et al. 1999).

Listeriosis infection results from the bacterium *Listeria monocytogenes*, which can develop into meningitis. The bacteria are usually carried by contaminated dairy products or raw vegetables. Although throughout the EU incidence is generally low, the highest rates are reported in Denmark, France, Finland, Sweden and Switzerland **(4.7.11)**.

Shigellosis (or bacillary dysentery) is an intestinal infection caused by the *Shigella* bacterium, and results in severe diarrhoea. Epidemics are most likely in overcrowded populations with inadequate sanitation. Within the EU, the highest incidence rates are reported in Sweden, as well as Norway and Switzerland **(4.7.11)**. A report of an outbreak in Portugal in 1995 described the effect of the introduction of shigellosis into a childcare centre and the high risk of secondary spreading. This outbreak, most probably due to contaminated food, affected 123 persons, 99 of them children (ref. Suspiro and Menezes 1996).

Typhoid fever is an infectious feverish disease with severe symptoms in the digestive system in the second phase of the illness. Typhoid fever is caused by infection with the bacterium *Salmonella typhi*, found only in humans, and may lead to serious illness. **Paratyphoid fever** is caused by *Salmonella paratyphi*, a similar and generally milder disease. Classic typhoid fever is a serious disease. The disease is transmitted from human to human via food or drinking water, and it is therefore mainly hygiene and sanitary conditions that determine its spread. It is primarily for this reason that it is now less commonly seen in the EU **(4.7.11)**, except in Portugal, Austria and Italy (in 2000) and Sweden (2001).

Trichinosis (or **trichinellosis**) is an infection from the parasite *Trichinella spiralis*. It is usually acquired from raw pork or pork products, but sometimes from other animal meat. It is rare in the EU **(4.7.11)**, but two outbreaks detected in France and Italy in 1998 were linked with horse meat imported from Yugoslavia. These outbreaks pointed to some limitations of regulations controlling the testing of imported horse meat at the time (ref. Hemery 1999).

Yersiniosis is a type of gastroenteritis caused by *Yersinia* bacteria. *Yersinia* bacteria are often present in uncooked meat, particularly poultry and pork. They can grow at temperatures as low as 0 °C, and the increased use of refrigeration in the food chain may play a part in the increase in prevalence of this organism in food. Different serotypes of *Y. enterocolitica* are associated with human infections and have been observed in some Member States (Belgium, Denmark, Finland and Sweden).

Incidence data for other food- and waterborne diseases such as **enterohaemorrhagic *E. coli* (EHEC)**, **cryptosporidiosis, giardiasis** and **toxoplasmosis** are not available at present for the majority of EU Member States.

Events within one country, which previously might not have had implications outside its borders, may now potentially affect many other nations. Increasing international travel and current manufacturing and distribution practice play important roles in the occurrence of cases of infection due to foodborne pathogens. It is now possible to travel from almost any part of the globe to another within 24 hours, which is less time than the incubation period for the majority of enteric pathogens. Equally important is the fact that it is now common for a foodstuff to be manufactured or harvested at one place and then distributed. This distribution can be within a country, across economic regions (such as the European Union), continents or even worldwide. This presents an opportunity for outbreaks of infection to occur far from the source of contamination. The free movement of people and goods between countries can be effective ways of distributing disease internationally. The response has been to create surveillance networks such as **Enter-net (international surveillance network for the enteric infections)**, funded by the European Commission's Directorate-General for Health and Consumer Protection, that can react quickly to international outbreaks of foodborne infections.

4.7.1.6. Diseases transmitted by non-conventional agents

Creutzfeldt-Jakob disease (CJD), also known as subacute spongiform encephalopathy, is a progressive, inevitably fatal infection that produces muscle spasms and progressive loss of mental function. Although it occurs worldwide, little is known about how it is usually spread. It mainly affects adults, es-

pecially in their late 50s. A disease similar to CJD occurs in sheep (scrapie) and in cattle (bovine spongiform encephalopathy (BSE) — mad cow disease). The infection is transmitted to offspring, and it is speculated that it can be acquired by eating infected tissues. Diagnosis of CJD is usually not confirmed while the person is alive, as some brain tissue is required for testing. Consequently, reported figures for CJD cases include both definite and probable cases. As presented here **(4.7.12)**, they include sporadic, iatrogenic, familial, GSS and new variant aetiological subtypes (see box below). Within the EU, CJD has been reported in all countries, and while the actual incidence rate is low — no country reports over two cases per million population (except Switzerland and France in 2001) — the range is not great. In 2000/01, countries with the lowest incidence were Denmark (0.75 per million) and Greece (0.76); at the other end of the scale were Switzerland (2.65), France (2.20), Italy (1.61), Germany (1.46) and the United Kingdom (1.35). Sporadic aetiological cases constitute more than 85 % of cases in the majority of Member States while the new variant CJD (reported since 1996 and suspected as a human variant of BSE) has been observed in the United Kingdom (104 cases, of the 108 reported in the EU in 2001), France (3 cases) and Ireland (1 case).

Data collected by Eurostat are based initially on the collaborative study of CJD in the European Union, funded by the European Commission through the Biomed 1 programme in 1993. From 1993–95, data were compared from national registries for CJD in Spain, Germany, France, Italy, the Netherlands and the United Kingdom, as well as Slovakia. The main aim was to determine whether CJD incidence was similar within the EU, and whether there were any differences in putative risk factors in different countries. The project was extended in 1997, through the Biomed 2 programme, to include, *inter alia*, Austria and Switzerland, and is now known as the **European and Allied Countries Collaborative Study Group of CJD (EUROCJD)**. Further information may be found on the EUROCJD web site (http://www.eurocjd.ed.ac.uk/euroindex.htm).

Definite sporadic cases will have had the diagnosis pathologically confirmed; they have no identifiable cause, and account for 85 % of all cases. **Probable sporadic cases** have recognised symptoms and certain clinical features, but have not been confirmed pathologically. **Iatrogenic** cases are those where infection appears to have occurred accidentally as the result of a medical procedure. **Familial** cases occur in families associated with certain mutations or where there is probable CJD in a first-degree relative; they form 10–15 % of all cases. **GSS** refers to the rare Gerstmann-Straussler-Scheinker syndrome, while **nvCJD** is the new variant first reported in 1996.

4.7.1.7. Airborne diseases

Legionellosis (or legionnaires' disease) is caused by the bacterium *Legionella pneumophila*; it results in pneumonia, with death more likely to a person with lowered immunity levels. The bacteria live in water and are often found in air-conditioning plants in hospitals, hotels and other water systems that cause aerosols, for example whirlpool spas and fountains. By contrast, large outbreaks in the community are mostly associated with cooling towers. These are also called 'wet air-conditioning systems' because the process of cooling air involves extensive contact between water and air, thereby creating aerosols. When the *Legionella* bacteria are present in these systems, they can cause legionnaires' disease. The incidence has increased slowly in the EU **(4.7.13)**. Analysed by country, incidence in 2000 was highest in Spain (1.9 per 100 000), Denmark (1.7), the Netherlands (1.1), Switzerland (1.1) and France (1.0). Data from the **European Working Group for Legionella Infections (EWGLI)** suggest that, for 1999, 32 % of cases were community acquired, 9 % hospital acquired, and 21 % associated with travel, either in the victim's own country or abroad. The high rates for Denmark, the Netherlands and Spain were due to large community outbreaks, collectively giving rise to nearly 300 cases of legionellosis. Regarding travel-associated outbreaks, the number of clusters detected in 1999 had increased over the previous years although these were associated with a smaller number of cases. This may have been linked to a rapid response from local public health officials, and effective control and maintenance policies in many large hotels in European resorts.

Meningococcal disease is caused by the gram-negative coccal bacterium *Neisseria meningitides* (or meningococci), for which humans are the natural host. This contagious disease has two forms: the more common meningococcal meningitis (or cerebrospinal fever), which is the only form of bacterial meningitis to result in epidemics, and meningococcal septicaemia. Meningococcal meningitis occurs globally and is endemic in temperate climates, causing a steady number of sporadic cases or small clusters, with a seasonal increase in winter and spring. Apart from epidemics in sub-Saharan Africa, about 500 000 cases of meningococcal meningitis are estimated to occur every year, of which some 50 000 are fatal (ref. WHO fact sheet 1998). However, vaccination is available. Recent data for the EU show a low incidence, at 1.7 cases per 100 000 in 1999 **(4.7.13)**. The highest levels are reported in Ireland and Iceland. A report on bacterial meningitis in Europe for 1997–98 confirmed the relatively

high incidence in Ireland, and also noted an increased resistance to sulphonamide (found in 41 % of specimens in 1997–98, compared with 34 % in 1996) (ref. Handysides 1999).

Tuberculosis (TB) is a contagious, potentially fatal infection caused by the airborne bacteria *Mycobacterium tuberculosis, M. bovis* and *M. africanum*. Infection develops by inhaling indoor air containing *M. tuberculosis*; someone with tuberculosis needs to cough out the bacterium. As a result, it is easily spread in overcrowded and unsanitary conditions. From the 1940s, the development of antibiotics such as streptomycin, isoniazid, ethambutol and rifampicin (also known as rifampin) has reduced the prevalence of tuberculosis in many countries, but in the 1980s the advent of AIDS, together with new strains of the bacteria becoming resistant to antibiotics, produced an increase in levels of TB. However, in western Europe, incidence is now declining after the stabilisation or increases observed in many countries in the late 1980s and early 1990s. Trends in many EU countries are, however, affected by increasing numbers of notified cases of inpatients of foreign origin. Trends in notification rates among nationals have been consistently declining in recent years in countries with increasing numbers of cases reported among foreigners, suggesting that tuberculosis in the population of foreign origin may have had a limited effect on transmission among nationals (ref. EuroTB 2002). In the EU, 45 777 cases were notified in 2000, an incidence rate of 12.2 per 100 000 persons; rates were under 20 per 100 000 in all countries except Spain (21.3) and Portugal (45.2) **(4.7.14)**. Over 1995–2000, incidence fell by 15.9 %; annual decreases in rates ranged between – 4.0 % in 1995–98 and – 4.7 % in 1999–2000 **(4.7.16)**. Exceptions to the latter were Greece and Spain, where changes in notification were implemented recently. In Norway and Denmark rates rose in 1995–99, due to increasing numbers of cases of foreign origin (ref. EuroTB 2002). For 10 countries with available data, average annual decreases in the numbers of notified cases between 1995 and 1999 were more marked among nationals (– 7 %) than among cases of foreign origin (– 1.5 %). Analysed by age, the elderly formed the largest group, with 24 % of new cases aged 65 and over. In addition, 62 % of cases were men, who formed the majority of new cases in each EU country **(4.7.15)**.

Drug-resistant tuberculosis was recognised in the 1940s but it was not until 1994 that WHO launched its 'Global project on anti-tuberculosis drug resistance surveillance'. The global project has now confirmed the existence of multidrug-resistant tuberculosis (MDR-TB), defined as resistant to (at least) isoniazid and rifampicin. In western Europe over 1994–99, MDR-TB was not regarded as a public health problem; of the 13 areas studied, 11 had a prevalence of 1 % or less of MDR-TB (ref. WHO 2000). However, a recent report on Germany stated that while in 2000 the incidence of tuberculosis fell again, a sample of cases showed 5.5 % multi resistance, an increase over the preceding two years. While these data were not regarded as representative of Germany as a whole, it could be assumed that multiresistance is on the increase in the country (ref. Laude et al. 2001).

4.7.16. Average annual change* in TB notification rates, 1995-99

Source: WHO Collaborating Centre for the Surveillance of Tuberculosis in Europe (EuroTB)

The **WHO Collaborating Centre for the Surveillance of Tuberculosis in Europe (EuroTB)** was established in 1996, with the aim of improving epidemiological surveillance of tuberculosis control in Europe, and the standardisation of tuberculosis surveillance methods. It is funded mainly by the European Union (Directorate-General for Health and Consumer Protection), and is managed jointly by the French Institut de veille sanitaire (InVS) and the Royal Netherlands Tuberculosis Association (KNCV). All 51 countries of the WHO European region participate in the project through an official correspondent. The core activity is the annual collection, validation, analysis and publication of standardised data on tuberculosis notifications, and, since 1998, on anti-tuberculosis drug resistance.

4.7.1.8. Zoonoses (other than those in Subsection 4.7.1.5)

Anthrax is caused by the bacterium *Bacillus anthracis*, the spores of which may survive in the environment for some years. Most human cases are the cutaneous type, where a spore enters the skin through a cut or abrasion. Vaccines are available, but their use is usually confined to high-risk groups, such as those occupationally exposed. Within the EU, anthrax is most often reported from Spain, Greece and Portugal, although the incidence is very low — only 0.01 per 100 000 in the EU as a whole for the year 2000 **(4.7.17)**.

Brucellosis, caused by the *Brucella* bacteria, is usually transmitted through unpasteurised milk or dairy products. It is an occupational illness of veterinary workers and farmers. Recent incidence data for the EU **(4.7.17)** show a decreasing incidence (0.63 per 100 000 in 2000, a reduction of 56 % compared with 1996). In 2001, brucellosis was most likely in Greece (3.84), Portugal (3.71), Spain (2.30) and Italy (1.56).

Leishmaniasis — visceral and cutaneous — is transmitted by sandflies. In Europe, leishmaniasis is becoming also a frequent co-infection with HIV. In all countries bordering the Mediterranean, cutaneous and visceral leishmaniasis are transmitted to humans and dogs by *phebotomine* sandflies. The major incidences of visceral leishmaniasis are reported in regions of Italy, Greece, Portugal and Spain. Sandflies are very sensitive to temperature (ref. IPCC) and higher temperatures are likely to change the geographical distribution of the important sandfly vector species and accelerate maturation of the protozoal parasite, thereby increasing the risk of infection. Several imported cases of canine leishmaniasis are also reported every year.

Q fever (originally 'query fever') is a rickettsial infection caused by the organism *Coxiella burnetii*, and resembles viral pneumonia. It is usually transmitted by inhalation from contaminated material where sheep and livestock are bred. A review in 1997 showed that the reporting of Q fever varies considerably between EU countries (ref. Editorial note 1997b), but the latest figures show that the illness is uncommon **(4.7.17)**. In the review, four countries reported outbreaks at any time over 1990–2000, the largest of which were 995 cases (in Italy, 2000) and 276 cases (in Germany, 1999).

Rabies is a viral infection of the brain, leading to inflammation of the brain and spinal cord. The virus is present in the saliva of infected animals, and is usually transmitted to humans by the bite of an infected dog or cat. As above, vaccine is available for those working with animals, but booster doses are needed after two years. It is rare in the EU, with virtually no cases reported in the past decade **(4.7.17)**.

Tick-borne encephalitis (TBE) is a serious meningoencephalitis caused by a flavivirus that is transmitted to humans from the bite of an infected tick. Ingestion of unpasteurised milk from infected animals such as goats can also be a route of infection. The infection is endemic in many forested parts of Europe, especially Scandinavia. The distribution and abundance of ticks are sensitive to changes in climate, and also to habitat and the availability of hosts, particularly the larger species (commonly ungulates) upon which all three life stages of vector ticks feed. According to the **International Scientific Working Group on Tick-Borne Encephalitis (ISW-TBE)**, the incidence of TBE is underestimated, even in countries where the disease is known and is not yet diagnosed properly. The recorded incidence of TBE in Europe (ref. Randolph 2002) shows marked increases in Estonia, Germany, Slovakia and the Czech Republic in the 1990s. The number of TBE cases has increased steadily since the mid-1980s in Switzerland, Sweden and Finland. Since 1997, the first indigenous cases have appeared in Norway. In Austria, the only country with extensive systematic vaccination coverage, TBE incidence has decreased progressively since the early 1980s **(4.7.17)**.

4.7.1.9. Serious imported diseases

Malaria is an infection of the red blood cells caused by the organism *Plasmodium*, spread by the bite of the infected female *Anopheles* mosquito. A campaign launched at the end of the 1950s eradicated malaria in all countries in the WHO European region, including EU Member States. By the 1980s, it was an almost forgotten disease in Europe but in recent years it has re-emerged as a result of political and economic instability, massive population movements, and changes in land use (ref. Sabatinelli et al. 2001). For many EU countries, a substantial problem is cases of malaria imported from endemic tropical countries. The continual increase in international travel and

population movements have led to a massive import of communicable diseases into countries where they had been eradicated. The only autochthonous cases reported in the EU during the 1990s were in Greece and Italy, with very small numbers. However, imported malaria cases have increased eightfold **(4.7.18)**, most of which came to the EU (30 % of incidence increase between 1995 and 1999). A total of 13 986 cases were reported in 2000 (3.7 per 100 000) in the EU (8 843 in 1990, 2.4 per 100 000). The incidence in 2000/01 was particularly noticeable in France (13.6 per 100 000), the Netherlands (3.6), Denmark (2.9), the United Kingdom (3.4) and Belgium (3.2).

Cholera is an acute infection of the intestine caused by ingestion of food or water containing the bacterium *Vibrio cholerae*. Transmission may also be by person-to-person contact, but environmental sanitary conditions affect the occurrence of cholera, as the bacteria can spread rapidly in crowded living conditions and unprotected water resources (ref. WHO 2001b). Although this pandemic is still ongoing, only 34 cases (from three countries) were reported from EU countries in 2000, all of which were imported (ref. WHO 2001c). Data for EU countries **(4.7.18)** indicate that the few annual (imported) cases keep the incidence very low across Europe.

Plague has not been reported recently in Europe, and no EU data are presented here. It is usually spread by a flea bite in which the bacillus *Yersinia pestis* travels through the body to a lymph node, usually the groin. Vaccines are available, but recommended only for high-risk groups such as health workers.

4.7.1.10. Streptococcal diseases

Pneumococcal infections are caused by the gram-positive bacterium *Streptococcus pneumoniae*. The pneumococci usually inhabit upper respiratory tracts in winter or early spring, and worldwide are the leading cause of severe pneumonia in children under five years of age. Invasive pneumococcal infections include pneumonia, meningitis and febrile bacteraemia (ref. WHO 2002a). In the EU, elderly persons carry the major disease burden from pneumococcal disease, and conditions associated with it include HIV infection, sickle-cell anaemia and a variety of chronic organ failures. The currently available polyvalent pneumococcal vaccine has an average protective efficacy of about 60–70 %, but the duration of protection in affected groups is relatively short. Reported incidence for EU countries **(4.7.19)** shows the highest rates in Belgium (15.0 per 100 000 in 2000), Denmark (16.6 in 1999), and Sweden (15.0 in 2000). Rates are lowest in Spain (0.5 per 100 000 in 2000), but no data are available for five Member States.

***Streptococcus pyogenes* (Group A streptococcus, GAS)** is one of the most frequent pathogens in humans. It is estimated that between 5 and 15 % of normal individuals harbour the bacterium, usually in the respiratory tract, without signs of disease. When the bacteria are introduced or transmitted to vulnerable tissues, a variety of types of suppurative infections can occur. There has been a recent increase in variety, severity and sequelae of *Streptococcus pyogenes* infections, and a resurgence of severe invasive infections, prompting descriptions of 'killer bacteria' or 'flesh-eating bacteria' in the news media. A complete explanation for the decline and resurgence is unknown. This disease remains a major worldwide health concern, and effort is being directed towards clarifying the risk and mechanisms of sequelae, and identifying rheumatogenic and nephritogenic strains. **Strep-EURO**, a surveillance programme for severe Group A streptococcal disease, was launched on 1 September 2002, coordinated by **Lund University** (Sweden) with the aim of enhancing understanding of the epidemiology of GAS invasive disease in Europe. At present, surveillance **(4.7.19)** is based on passive reporting of cases from physicians throughout the EU and the number of cases notified may represent an underestimate, but Switzerland, Sweden, Norway and Belgium seem to present a noticeable incidence.

Group B streptococcus (GBS) is a type of bacterium that causes illness in newborn babies, pregnant women, the elderly and adults with other illnesses, such as diabetes or liver disease. GBS is the most common cause of sepsis, meningitis and pneumonia in newborns. Babies that survive, particularly those who have meningitis, may have long-term problems, such as hearing or vision loss or learning disabilities. In pregnant women, GBS can cause bladder infections, womb infections (amnionitis, endometritis), and stillbirth. Among men and among women who are not pregnant, the most common diseases caused by GBS are blood infections, skin or soft tissue infections, and pneumonia. Approximately 20% of men and non-pregnant women with GBS disease die from it. The EU data coverage for this disease is poor and very few data exist **(4.7.19)**.

Data on infectious diseases such as viral hepatitis, food- and waterborne diseases and diseases of environmental origin, airborne diseases (except tuberculosis), serious imported diseases and streptococcal diseases are collected by **Eurostat** directly from the statutory and non-statutory systems of surveillance existing in the Member States. Some data may be compiled from the computerised information system for infectious diseases (CISID) of **WHO**, and from the **Office international des épizooties (OIE)** for some zoonoses.

4.7.1.11. Nosocomial infections

At present, no complete data related to incidence of nosocomial or hospital-acquired infections (HAIs) have been published at EU level, but figures disseminated by some existing networks in France **(Raisin)** and Spain **(EPINE)** indicate the scale and implications of the problem **(4.7.20)**. In France, a HAI prevalence of 6.9 % for 2001 was observed (compared with 8.0 % in 1996). The most frequent HAIs were *E. coli* (22.6 % of total cases), *Staphylococcus aureus* (19.8 %), *Pseudomonas aeruginosa* (11.0 %) and *Enterococcus* (6.0 %). In Spain, the HAI prevalence decreased from 9.9 % in 1990 to 7.9 % in 1999. The most frequent HAIs were very similar to those in France but *Staphylococcus* coag neg (13.2 %) is much more prevalent in Spain than in France. Analysed by place of infection for Spain, infections of the urinary tract were most frequent (27.7 %), followed by superficial surgical infections (13.3 %), surgical deep infections (9.4 %), primary bacteraemias (7.6 %) and 'other respiratory infections' (7.1 %) (ref. Vaqué and Rossello). In fact, these data reflect the logical impact of the extrinsic factors of risk as a result of hospitalisation. For example, infections of the urinary tract are associated with frequency of intravenous infusion, surgical infections with surgery, respiratory infections with mechanical ventilation, and bacteriaemias with intravascular devices. HAIs are a worldwide problem, with prevalence studies in other countries showing that, at any time, between 6 and 12 % of hospital inpatients acquire an infection after admission.

The EU project **'Hospitals in Europe link for infection control through surveillance' (Helics**, http://helics.univ-lyon1.fr/index.htm) is an international partnership of national and regional networks coordinated by the **Université Claude Bernard Lyon 1** (France) under the EC Health Monitoring Programme; it commenced in 1998. In the current phase of this project (Helics III), two databases on HAIs for which a European consensus already exists are being used: surgical and intensive care unit infections; validating a scientific approach to comparative analysis in relation to previous pilot studies; making methods and data accessible for epidemiological evaluation; developing a consensus for prevalence surveys and for the surveillance of emerging infections in immuno-compromised patients. The differences between the regional and national protocols for the surveillance of nosocomial infections in intensive care units are too great to allow international comparison of infection rates. A European standardised protocol on infections acquired in intensive care units, including several levels of risk adjustments, is being set up and will be tested during 2002.

4.7.1.12 Antimicrobial resistance

The introduction of every antimicrobial agent into clinical practice has been followed by the detection of strains of micro-organisms that are resistant (ref. WHO 2001a). They are able to multiply in the presence of drug concentrations higher than the concentrations in humans receiving therapeutic doses. The prevalence of resistance varies by region and time, but sooner or later resistance emerges to every antimicrobial. On this subject, WHO's global strategy defines the appropriate use of antimicrobials as 'the cost-effective use of antimicrobials which maximises clinical therapeutic effect while minimising both drug-related toxicity and the development of antimicrobial resistance'.

WHO also regards surveillance of antimicrobial resistance as essential both in providing basic information and for monitoring the effect of interventions. In 2001, the **European Antimicrobial Resistance Surveillance System (EARSS)** monitored two pathogens: *Streptococcus pneumoniae* and *Staphylococcus aureus*, although in future other pathogens *(Escherichia coli* and *E. faecium/ E. faecalis*) will be included (ref. Buchholz et al. 2001). Resistance data from 1998 to 2000 on invasive strains of *S. pneumoniae* are summarised in Table **4.7.21**, and in this analysis penicillin non-susceptible *S. pneumoniae* (PNSP) is of primary importance. In this context, 'invasive' refers to isolates from blood and cerebrospinal fluid, although, of the 7 108 isolates from 16 countries, most appear to originate from blood. Analysis by age showed the highest relative incidence among the elderly, followed by children under five years of age. This youngest age group also showed the greatest risk for resistance. The proportion of PNSP among isolates was, in general, higher in south European countries (Spain, Portugal, Italy).

Staphylococcus aureus is a problem associated largely with length of hospital stay, so the surveillance of necessity included a wide range of hospitals in reporting countries. Antimicrobial resistance may result in prolonged hospital stay, higher costs, and higher morbidity or possibly mortality. Results, based on data from 1998 onwards, showed that patients from intensive care units were 2.3 times more likely to have *Staphylococcus aureus* resistant to methicillin (MRSA) than patients in other wards, such as internal medicine or obstetrics and gynaecology. Moreover, the risk of identifying an MRSA strain was found to rise with increasing age. However, for both pathogens, it is too soon to be able to identify any secular trends with less than three years' data available. As for PNSP, the proportion of MRSA among isolates was also generally higher in south European countries. Finally, it should be noted that *Staphylococcus aureus* is now increasingly reported as a community-acquired infection, and is not only a problem of hospitals.

The **European Antimicrobial Resistance Surveillance System (EARSS)**, funded by the European Commission, is a network of national surveillance systems that aim to collect comparable resistance data (ref. Bronzwaer et al. 1999). The EARSS recommends that national coordinators select sufficient laboratories in each country to cover at least 20 % of the total population. Information collected on isolates includes the test results, patient details, and the hospital served by the laboratory. The EARSS management team has set up quality control filters so as to maintain high standards of data collection and reporting. This helps to ensure the comparability of data between countries. The European Commission is also concerned with antimicrobial usage, and recently launched a call for proposals to provide information for each country on the quantities of antimicrobial agents used in human medicine, and on aspects of their use.

4.7.2. Non-communicable diseases

4.7.2.1. Cancer (malignant neoplasms)

A cell affected by cancer is one that has lost its normal control mechanisms and thus has unregulated growth. Cancer can develop from any tissue from within any organ of the body. As cancer cells grow and multiply, they form a mass of cancerous tissue that invades adjacent tissues and can spread (metastases) around the body. Many genetic and environmental factors can affect the risk of developing cancer. These include: family history, chromosomal abnormalities, smoking, extended exposure to ultraviolet radiation, diet, certain chemicals, and certain occupational exposures. The increasing incidence with age is probably a combination of increased and prolonged exposure to carcinogens and weakening of the body's immune system, all associated with a longer life span. Malignant neoplasms are a major cause of death, and their treatment is an important part of the use of health care resources.

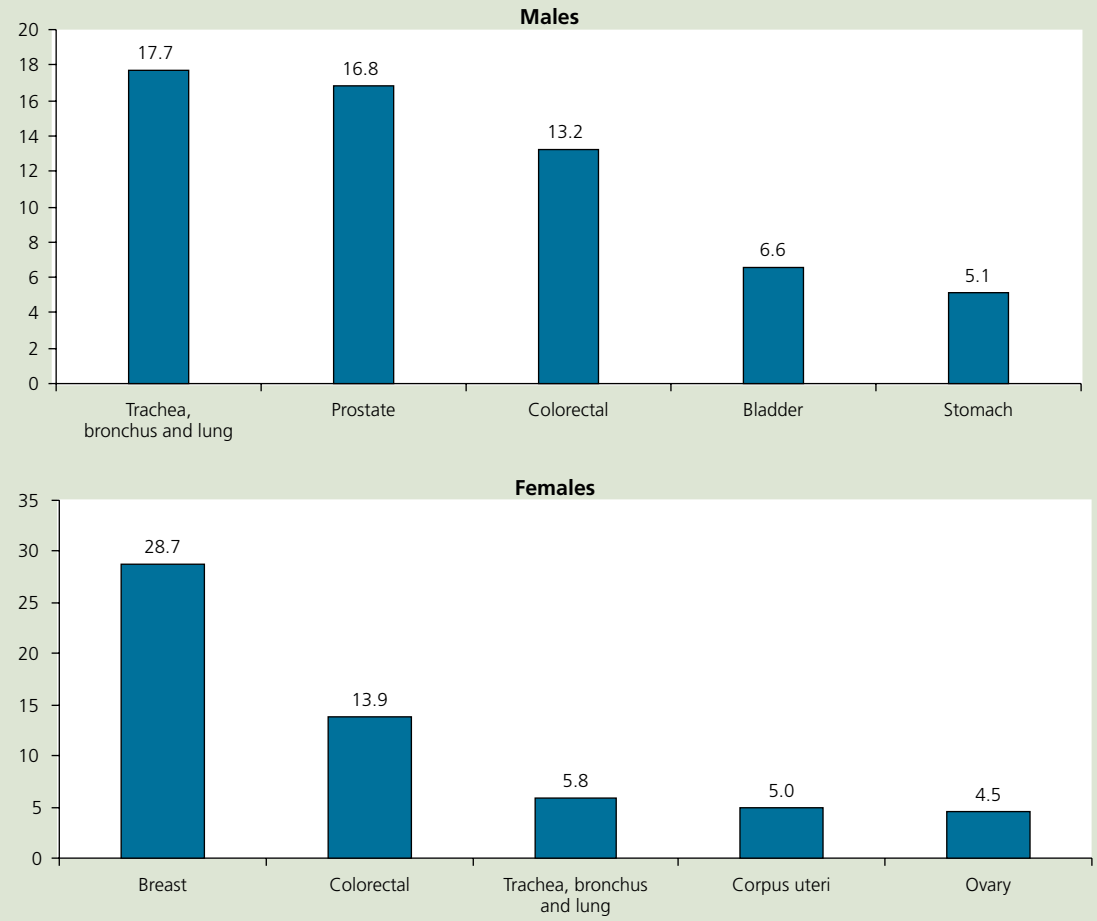
In this publication, the term 'cancer site' is used to represent cancers located in specific organs or tissues as well as systemic cancers such as leukaemia and lymphoma (ref. AIHW 1998). The data on incidence of new cancer cases refer to 1997 and are provided by the **International Agency for Research on Cancer (IARC)/WHO**. Data on mortality are provided by **Eurostat** (see Chapter 5 for details).

Excluding non-melanocytic skin cancers, there were 1 594 379 new cancer cases and 927 740 deaths due to cancer in the EU in 1997 (the last complete reference year for all the Member States). Cancer occurs more commonly in males than females. The age-standardised European population incidence rate in the EU in 1997 for all cancers combined (excluding non-melanocytic skin cancers) was 419.0 new cases per 100 000 for men and 296.8 per 100 000 for women, resulting in an age-adjusted sex ratio of 1.4 (an incidence of 345.1 per 100 000 for the two sexes together **(4.7.22)**. Men have a higher incidence rate for every cancer site, except breast (extremely rare in men) and thyroid gland. The highest incidence for men was found in the Netherlands (465.6), France (460.7) and Austria (460.3) and the lowest in Greece (338.1), Sweden (356.9) and Portugal (385.7). For women, the highest incidence occurred in Denmark (396.5), the United Kingdom (366.8) and Ireland (365.6) and the lowest in Greece (231.4), Spain (242.1) and Portugal (265.1).

At the incidence rates prevailing in 1997, it would be expected that one in three men and one in four women would be directly affected by cancer in the first 75 years of life. Cancer currently accounts for 28.5 % of male deaths and 22.0 % of female deaths. Among all persons in the EU, the combination of cancers of the colon and rectum (220 973 new cases) was the most common registrable cancer site in 1997 **(4.7.23)**. In males, the most common registrable cancer sites were trachea, bronchus and lung (17.7 % of total), prostate (16.8 %), colorectal (13.2 %), bladder (6.6 %) and stomach (5.1 %). These five cancers accounted for 59 % of all registrable cancers in males. In females, the breast (28.7 %) was the most common registrable cancer site, followed by colorectal (13.9 %), trachea, bronchus and lung (5.8 %), corpus uteri (5.0 %) and ovary (4.5 %), which in total accounted for 58 % of all registrable cancer sites in females.

Incidence of the most common cancers varies with age. In the EU in 1997, for persons aged less than 15, the most common cancers diagnosed were leukaemias (32.9 % of total cases for males and 32.1 % for females), cancers of the brain and central nervous system (16.1 and 17.2 % respectively) and non-Hodgkin's lymphoma (10.9 and 6.2 %). These three cancer sites thus accounted for 60 % of all cancers in this age group. In those aged 15–44, melanoma of the skin (8.2 %), testicular cancer (8.1 %) and non-Hodgkin's lymphoma (8.1 %) were the most frequent for men and breast cancer (39.7 %) and cervix uteri (9.9 %) for women. For the 45–64 age group, lip, oral cavity and pharynx (8.6 %), melanoma of the skin (8.2 %), testis cancer (8.1 %) and non-Hodgkin's lymphoma (8.1 %) appear as the most frequent for men, while breast (40.3 %), colorectal (9.6 %), stomach (9.2 %) and corpus uteri (6.3 %) were the top four for women. The pattern differs again for those aged 65 and over, for which prostate (21.8 %), trachea, bronchus and lung (17.8 %), colorectal (14.2 %) and bladder (7.2 %) for men, and breast (21.0 %), colorectal

4.7.23 Percentage of specific cancers over total number of cancers in the 15 EU countries, 1997



Source: EUCAN, International Agency for Research on Cancer, Lyons.

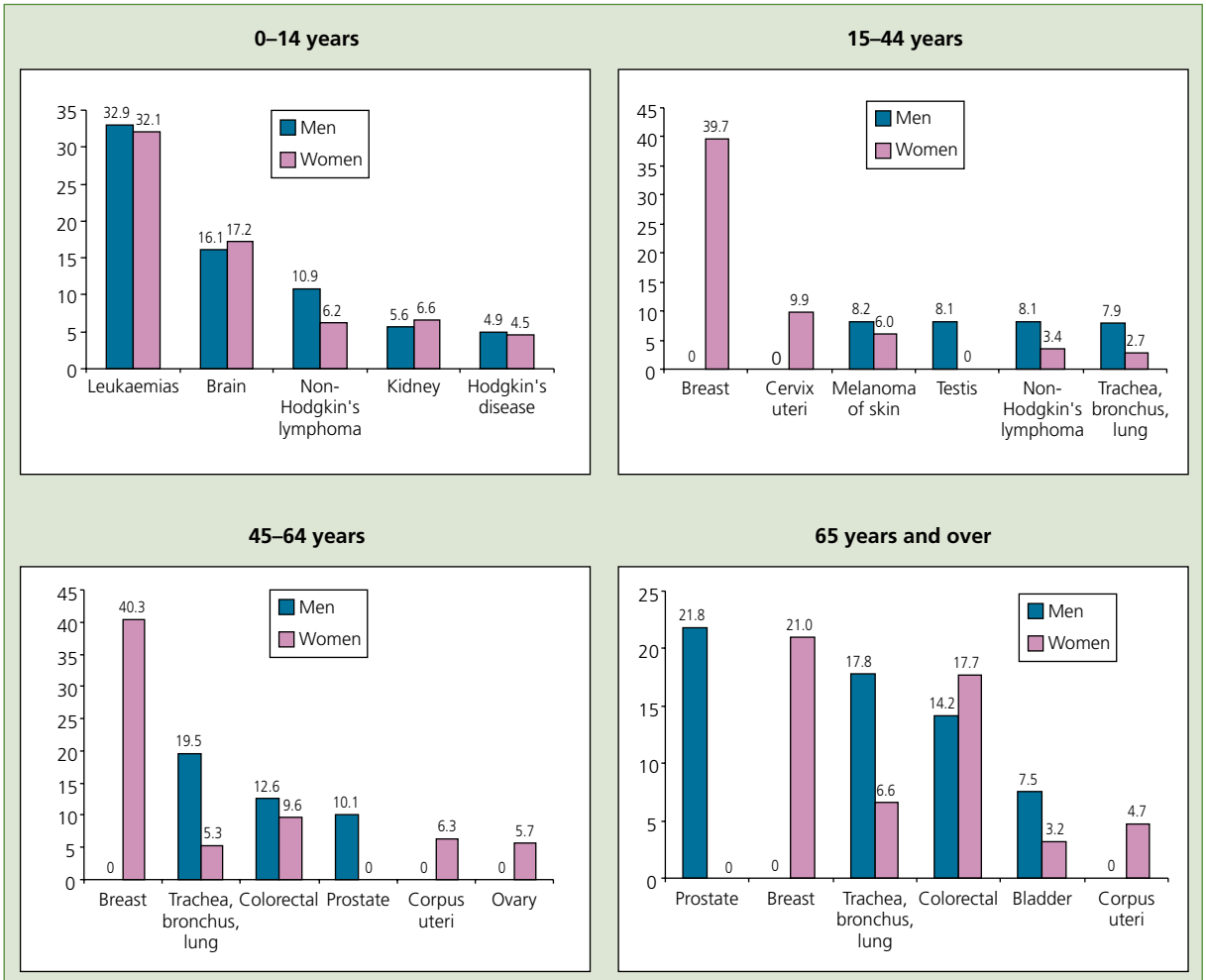
(17.7 %), trachea, bronchus and lung (6.6 %) and corpus uteri (4.7 %) for women were the most frequent. However, some cancer sites that would be ranked in the top five based on number of deaths are not presented in Graph **4.7.24**.

The main source of cancer prevalence data is cancer registries (CRs), which also collect information on incidence and survival. A recent report on the **Europreval** project (ref. Micheli et al. forthcoming) brings together comparable prevalence data for 17 European countries. The results, summarised in Table **4.7.25**, include nine EU Member States, although England and Scotland are shown individually. Among these Member States, CR populations in Austria (1 677 per 100 000) and Sweden (1 638) reported the highest age-standardised prevalence for all malignancies combined; Spain (1 175) reported the lowest. Analysing prevalence from the same source by site, the highest rates for **breast** cancer were found in Switzerland (637 per 100 000) and Iceland (667), with the lowest in Spain (386) and Germany (501). For **lung** cancer, populations in France (92) and the Netherlands (82) showed the highest levels, with Sweden (33) the lowest. **Prostate** cancer was most prevalent in Iceland (264), Austria (235) and Sweden (234), with the lowest levels in Spain (87) and Italy (93). For cancer of the **colon**, the Netherlands, Germany and Sweden had the highest prevalence, and Finland and Spain the lowest. More generally, the study found that in all populations cancer prevalence was higher in men than in women, and that in nearly all countries studied more than 50 % of cases were aged 65 and over. Female breast cancer showed the highest prevalence across all countries, and formed 34 % of total prevalence for women in Europe. Colorectal cancer (10 %) was the second most prevalent in women, but the most prevalent in men (15 %). For men, prostate cancer was the second most prevalent (15 %), followed by lung cancer (12 %).

In all countries participating in the **Europreval** project an age-adjusted five-year relative survival (%), for the 1988–92 incidence period, was calculated (based on the **Eurocare II** study). The age-standardised five-year relative survival by site for cancer patients of 15 years and over **(4.7.25)**

showed that the risk of dying was very high in the diagnosis of stomach, colorectal, lung cancer and leukaemias, and that the prognosis was much better for melanoma of the skin, Hodgkin's disease, breast, corpus uteri and cervix uteri cancers. Differences by country can also be significant. Switzerland (48.5 %), Austria (48.3 %) and France (45.2 %) have the best five-year relative survival rate.

4.7.24 Most frequently occurring cancers by sex and age group, EU-15, 1997



Source: EUCAN, International Agency for Research on Cancer, Lyons.

Recent data from the 1973–98 database of the 'Surveillance epidemiology and end results' (SEER) programme of the **US National Cancer Institute** were analysed by period analysis. Estimates of 5-year, 10-year, 15-year, and 20-year relative survival rates for all types of cancer were 63, 57, 53, and 51%, respectively, by period analysis. These estimates were 1, 7, 11, and 11% higher, respectively, than corresponding estimates by cohort-based survival analysis. By period analysis, 20-year relative survival rates were close to 90 % for thyroid and testis cancer, exceeded 80 % for melanomas and prostate cancer, were about 80 % for endometrial cancer, and almost 70 % for bladder cancer and Hodgkin's disease. A 20-year relative survival rate of 65 % was estimated for breast cancer, of 60 % for cervical cancer, and of about 50 % for colorectal, ovarian, and renal cancer (ref. Brenner 2002).

There is a project, **Eurochip** ('European cancer health indicator project'), under the coordination of the **Istituto Nazionale per lo Studio e la Cura e dei Tumori**, Italy, commenced in 2000 under the EC Health Monitoring Programme. The Eurochip project aims to develop a comprehensive list of health indicators useful for monitoring cancer in the countries of the EU. The list will include variables on the prevalence of risk factors, pre-clinicall activity, cancer occurrence, clinical follow-up, cancer recurrences, patient survival, diagnostic and therapeutic procedures, effectiveness of cancer care, outcome and care prevalence. The project aims also to indicate standardised methods for collecting, checking and validating data

and to propose methods, procedures and techniques to analyse the results and make them available.

EUCAN, which measures cancer incidence, mortality and prevalence, is a database collected by the **International Agency for Research in Cancer (IARC)**. These incidence data are provided by cancer registries, which also make available statistics on cancer survival. Cancer data are always collected and compiled some time after the events to which they relate, so that the most recent statistics are always 'late'. In the **Europreval** study, data for 2.98 million cancer patients were analysed. These patients were diagnosed from 1970 to 1992 in 38 population-based cancer registries in 17 European countries (ref. Micheli et al. forthcoming). National coverage for EU Member States varied widely, being complete in Denmark and Finland, about 50 % complete in the United Kingdom, from 6 to 18 % in Sweden, Austria, the Netherlands, Italy and Spain, and very low in Germany (1.7 %) and France (2.9 %). Rules for including cases in the analysis were those used by the **Eurocare** study on the survival of European cancer patients; the results are thus consistent with those from Eurocare.

4.7.2.2. Congenital anomalies

Congenital anomalies (birth defects) are a heterogeneous group of individual, often rare, conditions which collectively present an important public health burden in terms of their impact on the quality of life of affected individuals and their families, their contribution to potential years of life lost and years lived with significant disability, and health service cost. Factors affecting the risk of congenital anomalies include nutritional deficiencies, radiation, certain drugs, alcohol, certain types of infection and other illnesses in the mother and hereditary disorders.

Surveillance of congenital anomalies is carried out by the **Eurocat (European surveillance of congenital anomalies)** network of European congenital anomaly registers (see box below), which to date has covered a total population of 11 million births over a 20-year period and currently covers an annual population of over 700 000 births in 17 countries. European collaboration facilitates the pooling of data, the comparison of data between countries, the sharing of expertise and the adoption of a common approach to European public health questions.

Table **4.7.26** shows the number of cases for selected congenital anomalies by type of birth and total prevalence rates per 10 000 births in 28 full member Eurocat registries between 1980 and 1999. A total of 132 017 affected babies and foetuses were registered with congenital anomalies over this time period, giving a total prevalence rate of 217 per 10 000 births in the population. Table **4.7.27** shows the number of cases of congenital anomalies by type of birth and the associated prevalence rates (live birth, birth and total prevalence rates) for each of 28 full member registries and 4 associate member registries between 1980 and 1999. Graph **4.7.28** shows the percentage of cases in each of seven major anomaly groups in 28 full member registries by five-year time periods between 1980 and 1999.

Over all full member registries for 1980–99, the highest prevalence rates for anomaly groups were observed for congenital heart disease (53.8 per 10 000), followed by limb anomalies (40.2) and chromosomal abnormalities (27.1). Among specific anomalies, ventricular septal defects (22.9), Down's syndrome (16.8) and neural tube defects (10.9) were prominent. Note, however, that this information as collected refers to the number of specific anomalies reported, where an infant may present with more than one anomaly. Thus, the figures by anomaly are not counts of infants.

Over the last 20 years, there have been major trends in screening practice, leading to cases of congenital anomaly being diagnosed earlier and therefore coming within the reporting systems of the registers (a major factor leading to the increasing proportion of congenital heart disease shown in Graph **4.7.28**), and leading to more diagnoses being made prenatally often followed by termination of pregnancy for severe anomalies. In 1995–99, 15 % of all cases were induced abortions following prenatal diagnosis, with a maximum of 28 % in Paris. In addition, demographic trends, particularly the increasing average maternal age at birth, have led to a rise in the prevalence of pregnancies affected by age-related conditions such as Down's syndrome, as reflected in the increasing proportion of cases with chromosomal anomalies seen in Graph **4.7.28**.

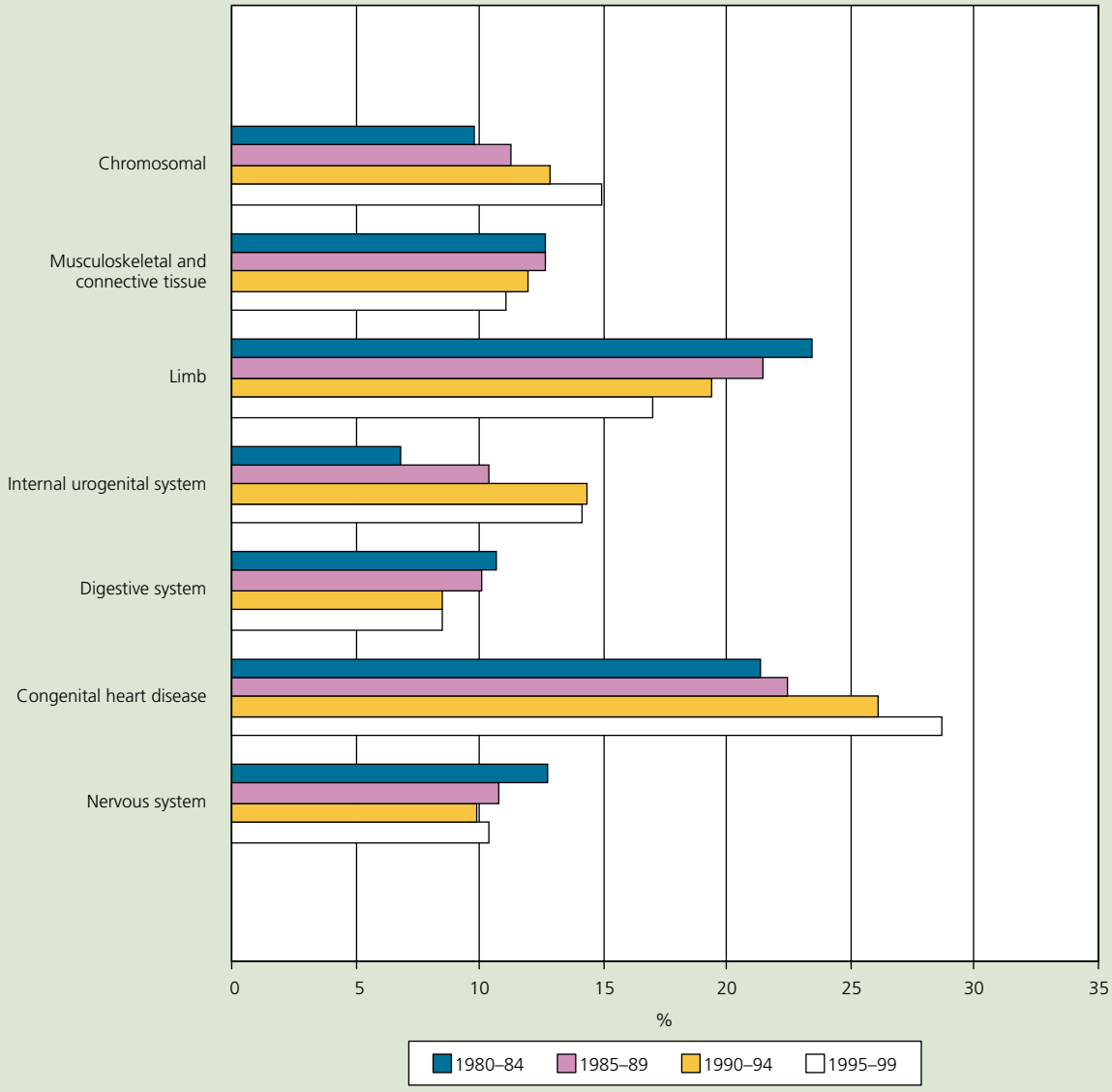
Eurocat (European surveillance of congenital anomalies) collects and publishes data on the prevalence of congenital anomalies and undertakes collaborative research. The project was established in 1979 and currently the central registry is based at the **University of Ulster**, and receives funding from the EC Rare Diseases Programme. In all, 39 registries in 17 European countries are members of Eurocat, all of which transmit data to the central registry on an annual basis **(4.7.26)**. Eurocat recommends a number of principles of registration, which include coverage of a geographically defined resident population (population-based), use of multiple sources of ascertainment, ascertainment of induced abortions following prenatal diagnosis, ascertainment of cases diagnosed after the neonatal period, and ascertainment of foetal deaths from 20 weeks' gestation. Nevertheless, it is important to note that the method of data collection differs in the different regions of Europe according to local characteristics

and constraints. Direct comparisons between registers must take these differences into account, as well as factors such as inclusion criteria, diagnostic practice in the region, and variations in age at diagnosis (prenatally and postnatally). Thus, differences in prevalence of all anomalies between regions shown in Table **4.7.27** cannot be simply interpreted as differences in risk. Further information on all aspects of Eurocat is available from its web site (http://www.eurocat.ulster.ac.uk).

4.7.2.3. Cardiovascular diseases

Diseases of the heart and circulatory system account for about half of all deaths in European countries, and within this group coronary (or ischaemic) heart disease (CHD) is a major cause of death. CHD results in many premature deaths and, since clinical care in cardiovascular diseases (CVDs) is costly and prolonged, it is also a major economic burden in Europe.

4.7.28 Congenital anomalies by major group, 28 full member registries, 1980–99



Source: Eurocat Report 8, *Surveillance of congenital anomalies in Europe 1980–99*. University of Ulster, 2002.

A recent WHO **Monica project** report summarises the conclusions of the project regarding the contribution of survival trends and coronary-event rates, showing that the incidence of coronary events was higher in populations studied in northern Europe than in the south **(4.7.29)**. In addition, the incidence of coronary events was falling rapidly in populations from northern Europe, but less quickly in the south

(ref. Rayner and Petersen 2000). The geographical pattern in incidence rates, and in trends in incidence rates, is similar to the geographical pattern in trends in death rates. Case fatality rates are affected by many factors, including the accuracy of diagnosis, the severity of the disease and the impact of treatment. Results from **Monica** show that case fatality tended to be higher in Belgium, Denmark, France and Germany, and lower in Finland and Iceland.

Over the study period, case fatality was falling in most populations, especially in France and Switzerland, but for some others — in Denmark and part of Finland — it was rising. Men living in North Karelia (Finland), Glasgow (United Kingdom), Kuopio (Finland) and Belfast (United Kingdom), and women living in Glasgow (United Kingdom), Belfast (United Kingdom) and Warsaw (Poland) had the highest average rates of heart disease among 170 000 persons studied over a 10-year period, from the mid-1980s to the mid-1990s. The lowest average heart attack rates in women over the 10 years occurred in Catalonia (Spain), Toulouse (France) and Brianza (Italy). Women's heart attack rates in Glasgow were eight times higher than those in Catalonia, for example. Among men, the lowest average heart attack rates over the 10 years occurred in Catalonia (Spain), Vaud-Fribourg (Switzerland) and Toulouse (France); rates in North Karelia were 10 times higher than those in Beijing, for example. The Monica project tracked heart attack rates, risk factors and coronary care in predefined populations in 37 countries from the mid-1980s to the mid-1990s. Where mortality rates were falling, the average change in survival contributed one third and change in heart attack rates two thirds to the total change in survival rates, indicating the importance of both the prevention of heart disease and improved care of acute events.

To improve understanding of the apparent decline in mortality from CHD in the late 1970s, the WHO **Monica project ('Monitoring trends and determinants in cardiovascular disease')** was set up to answer some key questions: (a) Were reported declines in CHD mortality genuine? (b) If so, how much of the declines are attributable to improved survival rather than to declining coronary event rates? It set out to measure, within defined populations over 10 years: trends in rates of events from coronary heart disease and their fatality; trends in risk factors; and trends in acute coronary care (ref. Tunstall-Pedoe et al. 1999). It covered 37 populations in 21 countries. Registrars identified non-fatal definite myocardial infarction and definite, possible, or unclassifiable coronary deaths in men and women aged 35–64 years, followed up for 28 days in or out of hospital. The project has a developed data collection methodology for standardised coronary and stroke event registration, including collection of data on diagnostic information and data on the medical care of patients before, during and after the attack. The methods have been developed taking into account the local characteristics of the health care system in each centre, and risk factor measurements through sample surveys of the study population.

A new project, **Eurociss** ('Cardiovascular indicators surveillance set'), under the coordination of the **Istituto Superiore di Sanità (ISS)**, Italy, commenced in 2000 under the EC Health Monitoring Programme. The project aims at identifying, among existing data sets, the essential information for an objective definition of morbidity indicators for cardiovascular diseases (CVDs) and at recommending standardised methods applicable in the European Union in the future, developing recommendations for the collection and harmonisation of the data that will be easily applicable within the different countries, in order to obtain reliable and significant data for the periodic monitoring of cardiovascular morbidity in the EU. Attack rates are not sufficient to describe the burden of CVDs in the population especially for ischaemic heart disease (IHD) given the high frequency of the chronic manifestations of this disease. Given demographic changes in Europe and the advances in the treatment of IHD, it is uncertain how this will affect the frequency of the chronic forms of the disease in the future, and therefore the need for monitoring the occurrence of the disease.

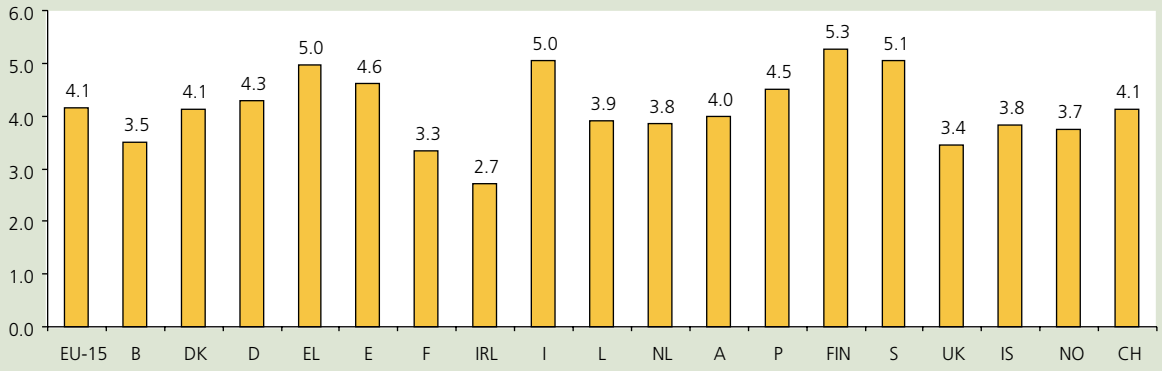
4.7.2.4. Diabetes

Diabetes mellitus is a chronic disease caused by inherited and/or acquired deficiency in production of insulin by the pancreas, or by the ineffectiveness of the insulin produced. Such a deficiency results in increased concentrations of glucose in the blood, which, in turn, damage many of the body systems, in particular the blood vessels and nerves (ref. WHO fact sheet 2002). There are two major types of diabetes: insulin-dependent (IDDM), where the pancreatic cells that produce insulin are destroyed by the body's immune system, and non-insulin-dependent (NIDDM), where the pancreas produces insulin but the body cannot use it effectively. Complications associated with diabetes include diabetic retinopathy (a leading cause of blindness and visual disability), kidney failure, heart disease, neuropathy and diabetic foot disease.

Worldwide estimates of the prevalence of diabetes are not accurate, and the latest available estimates for the EU are for 1995. Using mortality data gives an underestimate, since diabetes is frequently not mentioned on the death certificates of diabetics. EU estimates were produced by the **International Diabetes Institute (IDI)** in 1997, based on infor-

mation from surveys designed to measure the prevalence of IDDM and/or NIDDM in various populations (ref. Amos, McCarty and Zimmet 1997). The IDI also produced projections of diabetes prevalence for the years 2000 and 2010. For the EU, there were an estimated 12.7 million diabetics in 1995, predicted to rise to 15.6 million by 2000 (up 22.9 %) and to 19.6 million by 2010 (up a further 25.9 %) **(4.7.30)**. In 2000, an estimated 4.1 % of the EU population were diabetics, a proportion highest in Finland (5.3 %), Sweden (5.1 %), Italy (5.0 %) and Greece (5.0 %). Ireland (2.7 %) was the Member State with the lowest proportion of diabetics by far **(4.7.31)**.

4.7.31 Estimated prevalence of diabetes mellitus, 2000 *(% of population)*



Source: Amos, McCarty and Zimmet, International Diabetes Institute and WHO Collaborating Centre of the Epidemiology of Diabetes Mellitus (1997).

In their study for the **International Diabetes Institute (IDI)**, Amos, McCarty and Zimmet used the results of over 250 investigations worldwide to determine the prevalence of IDDM and/or NIDDM. While most of these studies were not specifically designed to measure national prevalence, the researchers generated these numbers by using age-specific prevalence rates. These rates were then applied to 1995 populations to produce estimates for each country. When prevalence data were not available for a country, rates from a nearby country with a similar ethnic composition were used as a substitute. To make projections, the researchers selected NIDDM prevalence rates available for each ethnic group, selected an appropriate rate, and applied this to the 2010 projected population. Because they considered NIDDM to be related to the degree of westernisation, the current and future levels of economic development were taken account of in the selection of rates. Projections for IDDM were made using the same methods as for the 1995 estimates. Projections for 2000 were based on an average of 1995 estimates and 2010 projections.

There is a project to establish diabetes indicators in Europe, the **'European diabetes indicator project' (EUDIP),** coordinated by the **Centre hospitalier de Luxembourg**, which commenced in 2001 under the EC Health Monitoring Programme, with the joint aims of proposing a set of diabetes indicators to be used in the EU and agreeing harmonised definitions on diabetes indicators. An inventory of available indicators and data sources in the different EU/EFTA countries will be established. Focusing on different aspects of diabetes mellitus requiring surveillance, further potential indicators and alternative data collection will be added to the inventory. From the list, a set of indicators will be selected, based on relevance, validity, sensitivity, reproducibility and responsiveness.

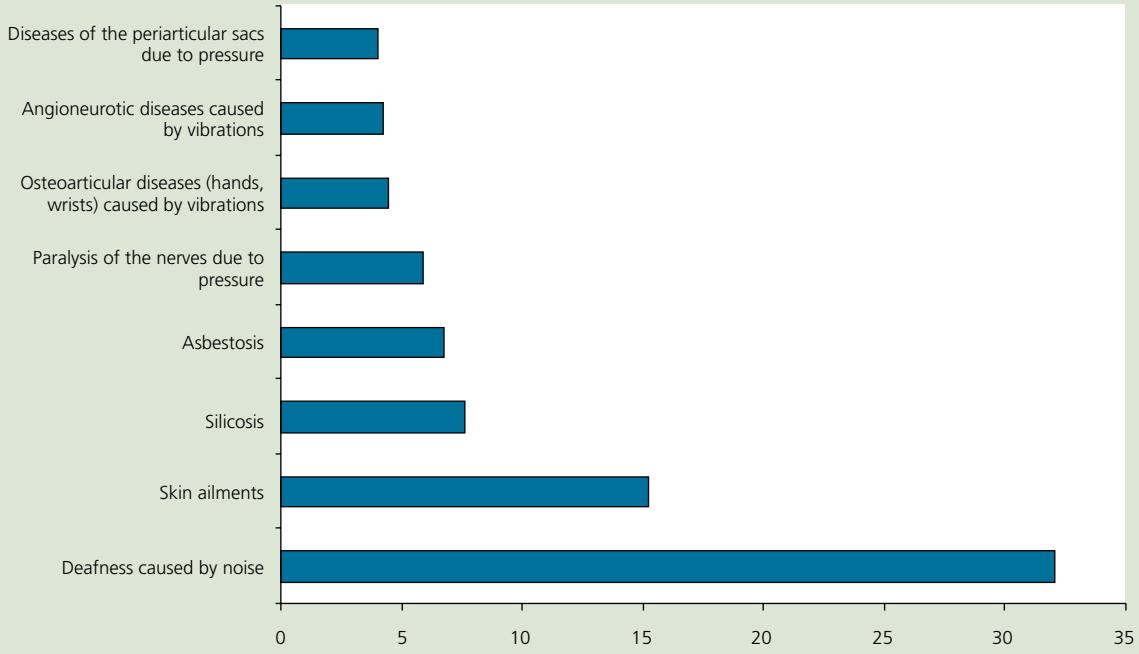
4.7.2.5. Occupational diseases

The results here constitute the initial findings of a **Eurostat** pilot project on **European statistics on occupational diseases (EODS project)**. In this project, Eurostat (at the request of the Directorate-General for Employment and Social Affairs of the European Commission) has compiled European statistics for 1995 with respect to 31 items selected from the European schedule of occupational diseases (Recommendation 90/326/EEC). Most of the occupational diseases corresponding to the 31 items selected were covered in all Member States. Eurostat has developed the European statistics on occupational diseases (EODS Phase I) implemented from the 2001 reference year onwards. The first data will be available in 2003.

Comparisons between Member States need much caution, whereas analyses of the data with respect to industry should be more reliable, taking into consideration the few exceptions to coverage mentioned above. In 1995, there were 57 414 recognised cases of occupational diseases, with respect to the 31

items **(4.7.32** and **4.7.33)** chosen from the European schedule of occupational diseases; this represents an incidence of 368.9 EODS cases per million for EU-15. The European statistics based on the 31 selected items thus cover about 70 % of all recognised cases of occupational diseases in Europe in 1995.

4.7.33 Recognised occupational diseases in EU-15 (% total cases), 1995



Source: Eurostat, EODS (European statistics on occupational diseases).

However, some national data exist for 1999. The total number of cases recognised by Germany, France and Spain shows different evolutions over the period from 1995 to 1999. In France there was a sharp increase from 8 534 cases in 1995 to 16 665 in 1999, mainly due to the modifications in the compensation of musculoskeletal diseases, involving a dramatic rise in recognised cases (from 4 704 cases in 1995 to 10 874 in 1999), as well as an increase in recognised cases of asbestos-related diseases (from 817 to 1 950 cases). There was a similar trend in Spain, from 6 005 cases in 1995 to 14 119 in 1999, also mainly due to musculoskeletal diseases. By contrast, there was a slight decrease in Germany, from 21 886 cases in 1995 to 17 046 in 1999. Numbers for the remaining countries with available data are stable or show a slight decrease in the number of cases. Only Italy and Sweden have shown a significant drop in the number of recognised occupational diseases from 1993, due to changes in legislation and social policies. Hearing disorders make up about one third of the subset of data covered by Eurostat. More than 95 % of cases of hearing disorders contracted at work are in men. Important factors here are that the participation rate of men in the labour market is higher than that of women, and men more often carry out tasks which involve, for example, noisy machinery and tools. Most cases of skin ailments are recorded in the manufacturing and social sector (hospitals). Most cases of infectious diseases are reported for the latter sector; these diseases are acknowledged as occupation related for persons working in hospitals and similar institutions in most of the recognition systems.

European statistics on occupational diseases (EODS), collected by **Eurostat**, include cases recognised by the Member States using their national criteria for the recognition of a disease as work related. The first publication includes only cases from the subset of 31 items selected from the European schedule of occupational diseases listed in Table **4.7.32**.

4.7.2.6. Work-related health problems

It has long been accepted that a trade or occupation can be the cause of a disease, or at least a contributory factor to it. This realisation has led to a wide range of measures, backed up by legislation, designed to regulate safety at work, although new hazards are always likely to arise. However, there is

also an interest in how a person's work affects their general state of health. **Eurostat** has recently analysed data from the **EU Labour Force Survey**, in which respondents gave a self-assessment of their work-related state of health (ref. Dupré 2001). In this study, the focus was on health problems, excluding accidental injuries (and irrespective of their severity), that respondents considered were caused or made worse by their current or past working conditions.

Over the period 1998–99, it was estimated that 7.7 million persons in the EU suffered from one or more work-related health problems (WRHPs) (excluding accidents), but including cases where the onset was earlier but continued to cause problems. By contrast, the comparable annual total for accidents at work was 7.4 million workers. These problems were more numerous among workers aged 45 and over (57 %), and among male workers (54 %). In addition, 12 % of victims had suffered from more than one WRHP over the year, but the characteristics of only the most serious problem were included **(4.7.34)**. Musculoskeletal disorders were by far the most common medical problem (53 % of all persons with a WRHP), followed by stress/depression/anxiety (18 %). Interestingly, within the group of non-active persons who had worked previously, only 8 % reported stress/depression/anxiety as a problem, though this does not mean that diseases such as depression disappear among this population but that they are much less related to their past work.

When persons with WRHPs resulting in an absence from work of more than three days are analysed separately, the distribution by diagnosis group is very much like that for all persons with WRHPs. The only marked difference is a higher proportion with a problem in the 'stress/depression/anxiety' group, suggesting that such problems tend to result in longer absences than others. If the group of three or more days' absentees is further analysed in terms of workers with an absence of two weeks or more, this differential for 'stress/depression/anxiety' is even more marked. A quarter of persons with WRHPs in 1998–99 did not have any time off for this reason **(4.7.35)**, and, if only the currently active are considered, over a third did not lose any working days; 49 % were either not absent or away for less than a week. In the reporting period, 348.7 million days were lost in the EU because of WRHPs, but most was attributable to workers with an absence of a week or more. Most of the overall number of days lost arose from persons expecting never to work again because of WRHPs (120.1 million days), and active persons absent for a month or more (148.3 million). Thus the major effect of WRHPs is not from the large proportion of workers with problems necessitating only a short absence from work, but from a smaller group of longer-term absentees.

Conceptual differences between the 1999 LFS ad hoc module and EODS data

	1999 LFS ad hoc module	EODS
Physical or psychological disease, illness, disability or health problem considered by the victim as due to his/her current or past work	Yes	No, except cases recognised as occupational disease
Physical or psychological disease, illness, disability or health problem considered by the victim as made worse by his/her current or past work	Yes	No
Physical or psychological disease, illness, disability or health problem reported to the authorities	Yes	Only if it is recognised as an occupational disease
Occupational disease recognised by the national insurance scheme	Yes	Yes
Characteristics (when more than one health problem for a person)	Most serious problem	All diseases
Reference period	Health problems suffered during the last 12 months ([1]), whatever the date of the onset and of the exposure to the harmful/aggravating agent or factor at work	Calendar year of recognition, whatever the date of the onset and of the exposure to the harmful agent or factor at work

([1]) At the date of interview.

For work-related health problems, the ad hoc module covers all diseases, disabilities and other physical or psychological health problems, apart from accidental injuries, suffered by persons during the past 12 months, caused or made worse by the work. This is a broad concept that covers much more than the occupational diseases recognised by the national insurance systems. However, as for the occupational diseases, it includes problems where the onset was one year prior to the survey (or reference year) and those due to earlier employment which, where appropriate, continue to affect persons currently non-active (such as a lung disease incurred by a miner perhaps many years before). The three main differences from the medico-legal concept of occupational disease are: (a) the concept of work-related health problem in the ad hoc module is based on a self-assessment by survey respondents of their work-related state of health; (b) it includes all complaints, irrespective of their severity; and (c) it also includes heath problems considered by the victim as only partly due to their current or past work activities ('made worse by the work'). Additionally, the ad hoc module refers to health problems suffered during the year while statistics on occupational diseases refer, in general, as EODS, to the year of recognition by the national insurance scheme.

4.7.2.7. Musculoskeletal diseases: osteoporosis

Disorders of the musculoskeletal system are a major cause of chronic pain and physical disability.

Within the 1999 **EU Labour Force Survey (LFS)**, a household survey on employment and the labour market, an ad hoc module investigated accidents at work and occupational illnesses. The module included questions on diseases, disabilities and other physical or psychological health problems, suffered by persons during the past 12 months, that had been caused or made worse by the work. The module was conducted by 11 Member States (exceptions were Belgium, France and Austria, with the Netherlands conducting it later) and Hungary. In total, 650 000 persons were interviewed in the survey regarding WRHPs. The active population is made up of people in employment and the unemployed during the reference week of the survey. However, for WRHPs only those unemployed who have already been in work are included, and absences from work over the past 12 months were counted only for those having been employed during the past 12 months.

While injuries to bones, muscles and joints are common, as are inflammations such as arthritis, metabolic or hormonal imbalances can also affect bones and joints. A notable example of the latter is osteoporosis, where an excessive loss of minerals such as calcium and phosphorus can weaken bone density and make fractures more likely. The two most common types are postmenopausal osteoporosis, caused by a lack of oestrogen, and mainly affecting women aged over 50, and senile osteoporosis, linked with age-related calcium deficiency and affecting those over 70, particularly women. Osteoporotic fractures typically occur at the hip, spine and forearm, and constitute a major public health problem. Both hip and vertebral fractures are associated with reduced survival as well as considerable morbidity.

Results from a recent study, supported by the EU, illustrate strikingly the increase in osteoporosis incidence and prevalence with age, as well as the sex differential noted above **(4.7.36** and **4.7.37)**. For reasons explained in the box below, comparisons between countries are difficult. Future projections (see box below) show that the annual number of hip fractures will be 414 000 in 2000, rising to 972 000 by the year 2050. Over the same period, the prevalence of vertebral fractures will increase from 23.7 million in 2000 to 37.3 million in 2050. These figures, influenced greatly by the increasing proportion of the old in EU populations, indicate a considerable demand for health resources in the coming years just from fractures caused by osteoporosis.

A new project, **'Indicators for monitoring musculoskeletal conditions'** coordinated by the **University of Oslo** (Norway), started in 2000 under the EC Health Monitoring Programme. The aim of the project is to identify and develop appropriate indicators to monitor musculoskeletal conditions in the population, focusing on public health aspects. The indicators should obtain necessary information on prevalence (overall and detailed for specific conditions), trends (time and regional), determinants (genetic, psychosocial and environmental), and consequences (quality of life, functional capacity, health care consumption and social security expenditures) on national and community level. The project will give priority to the so far poorly described conditions, lacking in the existing international classifications, and establish means to distinguish minor transient episodes occurring in any person's life from the more significant conditions.

In the mid-1990s, the European Commission's **Directorate-General for Health and Consumer Protection** set up a working party to study the epidemiology, pathogenesis and clinical management of osteoporosis in EU Member States, with emphasis on future prevention of the disease (ref. European Commission 1998). Incidence data came from a variety of sources. For five countries, results from the **Mediterranean osteoporosis study (MEDOS)** were used, while in others a variety of registers were drawn upon. In the tables shown here, data for certain countries are used

in others where no information was available; for example, incidence data for the Netherlands are also used for Luxembourg and Belgium. Also, incidence was considered to increase exponentially with age, so that all age-specific incidence data were transformed into natural logarithms at the mid-point of the age range. Linear regression could then be computed, and incidence figures estimated from a smoother distribution. The working party also made projections of future incidence and prevalence in the EU, based on current incidence and prevalence data for hip and vertebral fractures, with likely demographic changes and increasing life expectancy. For other countries, the **European vertebral osteoporosis study (EVOS)** was used. EVOS is the largest epidemiological study of osteoporosis in Europe, with over 17 000 subjects recruited, men and women aged 50–79 from 39 centres in 17 European countries. EVOS/EPOS have provided unique data on the descriptive epidemiology of both prevalent and incident vertebral deformity and of incident limb fracture in these countries. The studies have also assessed the role of several key lifestyle risk factors on the occurrence of fractures, the contribution of bone mineral density and, in addition, have evaluated the outcome following spinal fracture both in terms of morbidity and mortality.

4.7.2.8. Allergy and asthma

'Allergy and other hypersensitivity' is a generic term for symptoms caused by substances in our surroundings which people normally tolerate. The term 'allergy' should be reserved for reactions in which the body's immunological mechanisms are involved. 'Other hypersensitivity' means disorders resembling allergy without, as far as we know at present, being linked to the immune system (ref. NBHW 2001). Allergic diseases most commonly occur as rhinitis, asthma, atopic dermatitis and other skin complaints, but also as life-threatening anaphylactic shock. In developed countries, they are among the commonest chronic disorders, affecting up to 15–30 % of the population. Numerous studies, especially the **European Allergy White Paper** (UCB Institute of Allergy) and the **Spezialbericht Allergien** (Statistiches Bundesamt), show that allergic diseases are a real phenomenon. Various factors and complex environmental interactions are involved, including the quality of housing, different feeding habits and changed industrial and chemical environment.

Phase I results **(4.7.38)** from the **European Community Respiratory Health Survey (ECRHS)** confirm not only that the prevalence of asthma and allergy is still increasing, in general, but also that the countries in the survey are very differently affected, with variations in the ratio of up to 1:4 or 1:8, depending on the pathologies. This survey, which studied some 140 000 persons, aged 20–44 years, covered nearly all the EU countries. The prevalence of asthma can vary by a factor of 1 to 6 from one country to another. A marked pattern shows variations of 1 to 6 for asthma (from 2–12 % of individuals), of 1 to 4 for allergic rhinitis (from 10–40 %), and even of 1 to 8 (from 3.5–28 %) for bronchial hyperreactivity. The prevalence of asthmatic and allergic disorders is highest in the English-speaking regions and lowest in the Mediterranean countries and in Iceland. The sites with the highest prevalence of asthma were in Cambridge (the United Kingdom) and Umeå (Sweden). The lowest prevalence (about 2 %) was found in Erfurt (Germany) and Galdakao (Spain). The ECRHS has already begun Phase II, in which subjects who took part in Phase I will be re-examined 10 years after the first study. The aim of this new survey is to examine all the factors that explain not only the cause of asthma but also the means of securing protection against the disease.

Respiratory allergies are among the most common. They include allergic rhinitis, such as the familiar hay fever, the incidence of which seems to have increased from 1 % of the population at the beginning of the 20th century to between 15 and 20 % over recent years, affecting adolescents and young adults in particular. Chronic allergic rhinitis, usually caused by the allergens found in buildings, causes a level of discomfort equivalent to that of moderate asthma and can lead to asthma. The link is worrying, as asthma is another major allergy. It affects 10 % of children, continues in 5 % of adults and affects twice as many people as 20 years ago. Polluted air — with NO_x from vehicle emissions, for example — is increasingly being cited as the cause of the problem and some studies show that asthma is more common in urban than in rural areas. Skin allergies are another major category of allergy. Eczema and urticaria are also affecting a growing number of people, with experts predicting that between 40 and 60 % of this group are at risk of going on to develop respiratory problems. Diet is very often seen as being responsible for these disorders. Here, it is more a question of intolerance than of allergies, since the symptoms are not due to activation of the immune mechanism. Whatever the case, this hypersensitivity is also linked to a change in lifestyle.

The first phase of another very large international questionnaire-only survey of asthma symptoms, the **'International study of asthma and allergies in childhood' (ISAAC)**, carried out in 155 centres in 56 countries in children aged 6–9 years and 13–14 years, found very appreciable variations in asthma symptoms with up to fifteenfold variations between countries. From ISAAC **(4.7.39)**, the lowest prevalence for wheeze disturbing sleep in 13–14-year-olds was in eastern Europe (Russia, Uzbekistan, Albania, Romania) and Asia (China and South Korea). The highest prevalence was in developed, industrialised and affluent countries (the United States, the United Kingdom, New Zealand, Australia) and some developing coun-

tries, such as Nigeria and Brazil. Among 6–7-year olds, the variation in prevalence across countries did not show a clear pattern related to stage of development or affluence of the country. Lowest prevalences were observed in both developing countries (Hong Kong, South Korea, Malaysia, Indonesia, Estonia) and affluent western countries (Italy, France, Spain). The ECRHS and ISAAC have shown that there is marked regional variation in the prevalence of asthma and asthma symptoms, in childhood and up to the mid-adult years, both within and across countries, including both developed and developing countries. The reasons for this marked variation are still not clear. Understanding them will require more information about asthma prevalence from heterogeneous populations, especially from developing countries in which asthma prevalence appears to be very low. The expectation is that further study of these populations may offer clues to the reasons for the alarming increase in asthma prevalence that is occurring worldwide, especially in children.

The **European Community Respiratory Health Survey (ECRHS)** is the first study to assess the prevalence of asthma and allergic disease in many countries using a standardised protocol. The ECRHS is a longitudinal study of more than 10 000 young adults which began in 1990 and is a multi-centre study collecting data from mainly European countries. The study is coordinated by the Department of Public Health Sciences, **King's College London**, and funded by the 'Quality of life and management of living resources' programme under the EC Fifth Framework Programme for Research. Diagnosed current asthma was defined as a positive response to one or both of two questions: 'Have you had an attack of asthma in the last 12 months?'; 'Are you currently receiving medication for asthma?'. Results from ECRHS II are expected to be published in 2004. This survey, which studied some 140 000 persons, aged 20–44 years, covers nearly all the countries of the European Union in addition to information on Algeria, Australia, Estonia, Iceland, India, New Zealand and the United States. A total of 48 centres representing 22 countries took part in the initial phase of the ECRHS. Each centre processed data on 3 000 to 4 000 subjects, half of whom were men and half women. The ECRHS is the first study to assess the geographical variations of asthma and allergic diseases in a large number of countries, using the same technique and following two procedures. First, they used an identical, standardised protocol for all the different areas, so that one can be quite sure that the variations shown are genuine. Second, they combined subjective and objective measurements, with the benefit that both approaches indicate the same, quite marked pattern of geographical variations in asthma and allergic diseases. See the web site (http://www.ecrhs.org/).

The **'International study of asthma and allergies in childhood' (ISAAC)** project coordinated by the Faculty of Medicine and Health Sciences, **University of Auckland** (New Zealand), comprises three phases: the first comprises core written questionnaires for two age groups completed in 156 collaborating centres in 56 countries with a total of 721 601 children participating; the second enables internationally standardised comparisons of disease and relevant risk factors; the third will examine variations in time trends of asthma, allergic rhinoconjunctivitis and atopic eczema around the world, and assess the relationship between patterns found and environmental data. See the ISAAC web site (http://isaac.auckland.ac.nz/).

4.7.2.9. Dementia

Dementia is a decline in mental ability that usually progresses slowly, in which memory, thinking, and judgment are impaired, and personality may deteriorate. It usually develops slowly, and affects mainly those over 60. It is one of the most important causes of disability in the elderly; with the increasing proportion of the elderly in many populations, the number of dementia patients will also rise (ref. Huismann et al. 1998). The most common causes of dementia in the EU are Alzheimer's disease (about 50–70 % of cases), the successive strokes which lead to multi-infarct dementia (about 30 %); other causes are Pick's disease, Binswanger's disease, Lewy-Body dementia and others. Data on the prevalence of Alzheimer's disease and other dementias are available across the EU collected by **Alzheimer Europe**. However, these estimates **(4.7.40)** must be treated with caution, as the type of source varies considerably in scale and accuracy by Member State. An estimated 4.624 million Europeans between 30 and 99 years of age suffered from different types of dementias in 2000 (12.3 per 1 000 inhabitants). Within this group, more women (2.9 million) than men (1.7 million) were affected. Sweden (14.9) and Italy (13.9) showed the highest estimated prevalence, and Portugal (10.4) and Ireland (8.4) the lowest.

Age-specific rates for Alzheimer's disease (ref. Huismann et al. 1998) showed a steep rise with age, from about 1 % at 65–69, to 6 % at 75–79 and about 21 % by 85–89 years. Huismann et al. have also presented numbers of estimated cases for EU countries **(4.7.41)** in recent years, from which rates for the population 65 and over have been calculated. Thus, some figures may include only diagnosed cases where the disease is in an advanced stage. Since the disease may have a long duration and progress slowly, the number of cases may be much higher. Allowing for this, two countries show a dementia rate of 10 % (Denmark and Spain), with a rate of 14 % in Finland. For Alzheimer's disease, the rate is 7 % in Finland and only slightly lower in Sweden and Spain.

Although dementia does not only affect older people, the likelihood of developing dementia nevertheless increases with age. Thanks to the work of the European Community Concerted Action on the Epidemiology and Prevention of Dementia Group **(Eurodem)**, it is possible to estimate how many people in a given country are likely to have dementia provided that accurate population statistics are available. Eurodem pooled data on the prevalence of moderate to severe dementia in several European countries to produce a set of prevalence rates for men and women in nine different age groups (30–59, 60–64, 65–69, 70–74, 75–79, 80–84, 85–89, 90–94 and 95–99). The study included people with dementia who were living at home as well as those in institutions, nursing homes and residential care. For more details of this study, refer to Hofman et al. (1991).

Alzheimer Europe has calculated the likelihood of developing dementia using the Eurodem prevalence rates on the basis of population statistics obtained from Eurostat. A table was produced for each European country for which they had the relevant information, as well as one comparative table. For certain countries, the population statistics for the oldest age groups were not yet available so this should be borne in mind when consulting the tables. The results should also be treated with caution for the following reasons: the data were obtained from Germany, Finland, France, Italy, the Netherlands, Norway, Portugal, Spain, Sweden and the United Kingdom and might not therefore be accurate when used in connection with other countries not included in the study. The study was based solely on diagnosed cases. This poses a problem in accurately estimating the number of people with dementia, as many people with dementia never receive a diagnosis and so an estimate excludes those in the early stages of dementia who have not yet been diagnosed. For more information on Alzheimer Europe, consult its web site (http://www.alzheimer-europe.org/index.html).

4.7.2.10. Other neurological and neurodegenerative diseases

Parkinson's disease (PD) is a progressive degenerative disorder of the central nervous system that primarily affects voluntary, coordinated movement. The hallmark physical signs are tremor, rigidity and bradykinesia. Idiopathic parkinson's disease is caused by the progressive loss of dopaminergic neurons in the substantia nigra and nigrostriatal pathway of the midbrain. Secondary parkinsonism may be caused by certain drugs (e.g. metoclopramide and haloperidol) or by cerebrovascular disease (e.g. multiple lacunar strokes). It is a disease of late middle-age onset, usually affecting those over the age of 50. According to a recent WHO report, PD affects 3 765 000 individuals worldwide, and the condition is diagnosed in 305 000 people per year. In 1996, there were 2 635 000 people with PD who were chronically disabled and 58 000 deaths. In 1997, the **Europarkinson** study (ref. de Rijk), under the Biomed Programme, studied five community-based surveys, in Spain (two surveys), France, Italy and the Netherlands. The overall prevalence (per 100 population), age adjusted to a 1991 European standard population, was 2–3 for parkinsonism and 1–6 for Parkinson's disease. The overall prevalence of parkinsonism for the age groups 65–69, 70 –74, 75–79, 80–84, and 85–89 years was respectively, 0–9, 1–5, 3–7, 5–0, and 5–1. The corresponding age-specific figures for Parkinson's disease were 0–6, 1–0, 2–7, 3–6, and 3–5. After adjusting for age and sex, the prevalence figures did not differ significantly across studies, except for the French study in which prevalence was lower. Prevalence was similar in men and women. Overall, 24 % of the subjects with Parkinson's disease were newly detected through the surveys. Prevalence of both parkinsonism and Parkinson's disease increased with age, without significant differences between men and women. There was no convincing evidence for differences in prevalence across European countries. A substantial proportion of patients with Parkinson's disease went undetected in the general population. These estimates suggest that approximately 400 000 men and 540 000 women of 65 years of age and older and living in the EU, currently suffer from Parkinson's disease (ref. Erasmus). The *British Medical Journal* (1 July 2000) reported on a recent survey of the prevalence of Parkinson's disease in the London area. This was the first major survey of PD prevalence ever conducted in the south of England. It started with 121 000 names, being the entire patient registers of 15 GP practices. The accuracy of the overall result is some ± 15 %. The overall age-adjusted prevalence of idiopathic PD in London is 168 per 100 000 (i.e. about 0.17 %). This result is very similar to that of the EuroParkinson study, which found an overall age-adjusted prevalence figure of 160 per 100 000 or 0.16 %. The prevalence of PD in London was found to increase from 109 per 100 000 (0.11 %) in the age group 50–59, to 961 per 100 000 (0.96 %) in the age group 70–79, and 1 265 per 100 000 (1.27 %) in the over 80s. Prevalence has remained stable for 30 years despite decreasing mortality for patients aged under 75 years. Assuming that idiopathic Parkinson's disease remains undiagnosed in 10–20 % of all community patients, the true prevalence of idiopathic Parkinson's disease in London may be around 200 per 100 000.

Data on hospital discharges for PD have been studied in some EU countries, but over differing periods (ref. Gourbin and Wunsch). PD is not a pathology presenting a high level of hospitalisation, and the use of alternatives to hospitalisation may explain the differences between Member States (see Sub-

section 4.7.2.11). However, it seems that hospitals play an increasing role in the treatment of PD patients, with significant differences by age; thus, Sweden reported a hospitalisation rate of 11.9 per 100 000 for persons aged 45–49, and 235.4 for those aged 80–84 **(4.7.42)**.

Epilepsy is considered to be a recurrent seizure disorder caused by focal or generalised epileptogenic discharges from brain cells. It is characterised by abnormal electrical function of the neurons (nerves) in the cerebral cortex. It is not a distinct disease, but describes a group of disorders for which recurrent seizures are the main symptom. The different forms of epilepsy are either secondary to a particular abnormality or disorder, or are said to be 'idiopathic', without any clear cause. No data on prevalence or incidence in the EU have been collected (except some local or regional surveys or some data from patient registers, e.g. the UK). From many studies around the world, it has been estimated that the mean prevalence of active epilepsy (i.e. continuing seizures or the need for treatment) is approximately 8.2 per 1 000 of the general population, although this may be an underestimate. Studies in developed countries suggest an annual incidence of epilepsy of approximately 50 per 100 000 of the general population. In England and Wales between 1994 and 1998 using the 'General practice research' database, the age-standardised prevalence of epilepsy in 1998 was 7.4 per 1 000 in males and 7.2 per 1 000 in females, and increased by 7 % between 1994 and 1998. The prevalence of epilepsy was highest in deprived areas. The estimated number of patients with epilepsy in England and Wales in 1998 was 400 000 (ref. ONS). A European action **Eucare (European concerted action and research in epilepsy)** aims to raise the profile of epilepsy across Europe through a range of educational and political actions, and has published 'The European White Paper on epilepsy'**.**

Multiple sclerosis is a disorder of the central nervous system (brain and spinal cord) caused by lesions in the white matter of the central nervous system that degenerate the myelin sheath, marked by lack of muscle coordination, muscle weakness, speech problems, paraesthesia, and visual impairments. There is considerable variation in the occurrence of multiple sclerosis around the world. This has been ascribed to environmental factors, such as exposure to viruses or ionising radiation, or to genetic factors. Worldwide, multiple sclerosis occurs with much greater frequency in higher latitudes away from the equator than in lower latitudes closer to the equator. Estimates of the number of people affected by this disease throughout the world range between 1.1 and 2.5 million. No data on prevalence or incidence in the EU have been collected (except some local and regional surveys) and the number of persons affected is estimated at 350 000. The prevalence of multiple sclerosis (ref. RUG web site) varies from 20 to 40 per 100 000 for the Mediterranean to about 150 per 100 000 for the northern parts of the United Kingdom and Sicily. In the Netherlands, only data for the province of Groningen are available (61.1 per 100 000 in 1986) and a nationwide estimation in Austria found a prevalence of 98.5 per 100 000 (ref. Baumhackl, Eibl, and Ganzinger 2002). **Eurostat** data on mortality due to multiple sclerosis are available for six countries only: Denmark (288 deaths, 1996–99), Iceland (5, 1996–97), Luxembourg (9, 1998–99), the Netherlands (384, 1996–97), Norway (352, 1996–99) and Sweden (287, 1997–99).

It is difficult to measure incidence and prevalence rates for rare conditions (ref. Robbins and Ewbank 1998). For rare conditions such as Parkinson's disease or multiple sclerosis (or even epilepsy), the sample size required begins to approach the total population size. However, there is a class of diseases for which it is possible, but very expensive, to conduct large population-based surveys. Some diseases in this category have been studied in only a few population-based studies. Often, even the largest studies produce estimates with very wide confidence intervals. In some cases, we have only prevalence studies since they do not require longitudinal follow-up. These studies typically produce estimates of single parameters related to the disease of interest (e.g. incidence, prevalence, or associated mortality). The prevalence of a disease in a population is the proportion of that population with the disease at a specific point in time. It is, by definition, a product of the incidence of the disease (the rate at which new cases arise) and the mean duration of disease, which is determined by rates of recovery and mortality. Many chronic diseases are believed to have recovery rates of zero; once affected by the disease, patients' symptoms and progression may be more or less well controlled, but they never return to a disease-free state. For these diseases, prevalence is determined exclusively by incidence of disease and the mortality associated with it. Given the costs of estimating incidence and prevalence for many conditions, there are high returns to statistical analyses that improve estimates of incidence and prevalence. In particular, we can learn much if we can combine data from incidence and prevalence studies. From individual studies of incidence, we can combine the prevalence rates from the baseline survey with the longitudinal incidence rates.

4.7.2.11. Mental disorders

The burden of mental illness on health and productivity has long been underestimated. Data developed by the 'Global burden of disease study 2000', conducted by WHO, the World Bank and Harvard University, reveal that mental disorders, including suicide, account for over 15 % of the burden of disease in established market economies, such as the EU. *The World Health Report 2001 — Mental health:*

New understanding, new hope from **WHO** estimates the global burden of disease for mental illness at 12 %. Both studies developed a single measure to allow comparison of the burden of disease across many different disease conditions by including both death and disability. This measure was called disability adjusted life years (DALYs). Using the DALYs measure in the 'Global burden of disease study 2000', depression ranked second after ischaemic heart disease in magnitude of disease burden in established market economies. Schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder and post-traumatic stress disorder also contributed significantly to the total burden of illness attributable to mental disorders (ref. WHO 2002b).

The burden of disease is a measure of the health of a population. The approach offers a way to quantify the importance of different diseases. It is not just a measure of incidence or mortality, rather it calculates the total impact. The measure of disease burden is disability adjusted life years (DALYs), a measure using disease incidence, age of onset, and disability for each disease category to measure the burden of disease. The DALYs numbers give both the absolute and relative contributions of each disease category to the total disease burden of a population.

In the EU, the Council conclusions (ref. 2002/C6/01), of 15 November 2001, on combating stress and depression-related problems, recognise that stress and depression-related problems and their intergenerational transmission are of major importance to all age groups and are significant contributors to the burden of disease and the loss of quality of life within the European Union and invite the Commission in the context of the programmes of action in the field of public health to facilitate the collection of comparable data on the characteristics, determinants and causes of stress and depression, complement national policies and to develop strategies for the prevention of stress and depression-related problems.

A two-year action project to establish mental health indicators in the EU, coordinated by the **National Research and Development Centre for Welfare and Health (Stakes,** Finland), started at the beginning of 1999 under the EC Health Monitoring Programme with the objective of proposing a set of mental health indicators to be used in the EU. The project aimed to collect information on existing information systems and indicators and to agree on harmonised definitions of the mental health indicators. These mental health indicators are to be incorporated into a comprehensive European health monitoring system. Mental health (ref. Stakes 2002) has two dimensions: **(1) positive mental health** can be conceptualised either as a value in itself or as a resource including the ability to cope with adversity and avoid breakdown or diverse health problems when confronted with distressing experiences; **(2) negative mental health** is concerned with mental disorders, symptoms and problems. Mental health, as an indivisible part of general health, reflects the equilibrium between the individual and the environment. It is influenced by: (a) individual biological and psychological factors; (b) social interaction; (c) societal structures and resources; and (d) cultural values. In this context, mental health can be seen as a process that comprises predisposing, actual precipitating and supporting factors as well as various consequences and outcomes. The topic of mental health is, however, very complex as most mental disorders are multifactorial in their aetiology; a multitude of risk factors may influence the onset, course and restitution of one disorder and a risk factor may be common for many forms of ill-health, both somatic and mental illnesses.

A **mental health indicator** is a measure of the state of mental health; it is a variable that is related to mental health and indicates a priority or a problem. These may be items in health surveys, or statistical data gathered, and are repeated measures. Indicators are at their best only indirect or partial measures of a complex situation. The aim of the **Stakes** project has been to create a set of indicators to monitor mental health. Monitoring mental health is defined here as systematic, repeated measurement of factors related to the mental health of the population. In addition to collecting data, monitoring health implies the follow-up of these measures with the purpose of interpreting the evolution of the mental health situation, according to established policies and strategies, and to take relevant action if necessary.

Some of the indicators suggested in the **Stakes** project have been regularly collected by **Eurostat:** (a) resources (psychiatric beds, number of psychiatrists); (b) causes of death related to mental issues (suicide, alcohol, mental diseases); (c) stress; (d) cutdown in activities due to emotional problems; (e) well-being and social isolation; (f) consumption of psychotropic drugs; and (g) average length of stay in hospitals due to mental disorders. The indicators mentioned above are presented in other chapters or sections of this publication. Results from health surveys (chronic diseases) are not yet available (see Section 4.1), and other issues, such as mental well-being (according to the recommended **Euro-REVES Mental Health Group** suggested questions) and consultations to mental health professionals, will be implemented in a forthcoming Eurobarometer survey in 2002. Some sparse data from hospital discharges and from depression and anxiety problems related to work (also collected by Eurostat), and also some general preva-

lence data coming from various sources will be those used in this subsection.

Specific data on prevalence or incidence of the most significant mental diseases are rarely available on a continuous basis at national level in the EU. However, some local and regional studies and figures exist and have been used in this subsection.

Depression

Depression is, according to DSM-IV (see box below), characterised by sadness, loss of interest in activities, and decreased energy (ref. WHO 2001e). Other symptoms include loss of confidence and self-esteem, inappropriate guilt, thoughts of death and suicide, diminished concentration, and disturbance of sleep and appetite. A variety of somatic symptoms may also be present. Although depressive feelings are common, especially after experiencing setbacks in life, depressive disorder is diagnosed only when the symptoms reach a threshold and last at least two weeks. Depression is more common in women than in men. Depression can affect individuals at any stage of the lifespan, although the incidence is highest in middle age. There is, however, an increasing recognition of depression during adolescence and young adulthood (ref. Lewinsohn et al. 1993). Depression is essentially an episodic recurring disorder, each episode lasting usually from a few months to a few years, with a normal period in between. In about 20 % of cases, however, depression follows a chronic course with no remission (ref. Thornicroft and Sartorious 1993), especially when adequate treatment is not available. The recurrence rate for those who recover from the first episode is around 35 % within 2 years and about 60 % at 12 years. The recurrence rate is higher in those who are over 45 years of age. One of the particularly tragic outcomes of a depressive disorder is suicide. Around 15–20 % of depressive patients end their lives by committing suicide.

The study **'Outcome of depression in Europe' (ODIN)** is supported by the European Commission's **Directorate-General for Research**. ODIN formed part of a wider European study across several centres considering levels of depression in different areas including only four EU Member States and Norway. The aim was to assess the prevalence of depressive disorders in randomly selected samples of the general population in five European countries **(4.7.43)**. The study was designed as a cross-sectional two-phase community study using the 'Beck depression' inventory during Phase 1, and the 'Schedule for clinical assessment in neuropsychiatry' during Phase 2. An analysis of the combined sample (n = 8.764) gave an overall prevalence of depressive disorders of 8.2 %. The figures were 9.6 % for women and 6.2 % for men. The centres fall into three categories: high prevalence (urban Ireland and the United Kingdom: 12.8–17.1 % respectively), low prevalence (urban Spain: 2.6 %); and medium prevalence (Norway, Finland: 6.0–9.3 %). As a conclusion, ODIN shows that depressive disorder is a highly prevalent condition in Europe. The authors caution, however, that the study has limitations relating to a low response rate at some of the centres and possible bias derived from non-responders (ref. Ayuso-Mateos et al. 2001).

Another useful source (ref. Tafforeau and Bayingana 2002) is the **Depres ('Depression research in European society')** study. This was a survey in six Member States involving 78 463 adults aged 18 and over and using the MINI ('Mini-international neuropsychiatric interview'), in accordance with ICD-10. The results **(4.7.43)** found a six-month prevalence rate of 17.0 % for depressive disorders. The results show that France and the United Kingdom have the highest prevalence for different types of depression (more than 22 % for all types for the two sexes). The lowest prevalence is observed in Germany (11.3 %) and Belgium (12.2 %). In the **Depres** study, only 57 % of individuals identified as being depressed sought medical care. Of those who did, most consulted a primary care physician; two thirds of these were prescribed no medication and, when treatment was prescribed, an antidepressant was the drug of choice only 25 % of the time. Results are very similar to those of the **US National Comorbidity Survey** which found 17.3 % of the general population had experienced an episode of major depression and 24.5 % had suffered from an anxiety disorder at some time during their lives.

As mentioned earlier, the 1999 EU Labour Force Survey included an ad hoc module on work-related health problems (see Subsection 4.7.2.6). From this, the standardised prevalence rate of WRHPs by diagnosis group showed that 1 181 per 100 000 workers declared in the EU a problem of depression, anxiety or stress with or without any day's absence from work **(4.7.44)**; the coverage here was of only eight Member States. Results show a wide range of values with the highest prevalence in Nordic countries such as Finland (3 374) and Sweden (2 052), and the lowest in Italy (652) and Spain (326). For these eight Member States of the EU, the prevalence is highest in the education sector (2 306), and in the health and social work sector (2 188). These groups include teachers, nurses, social workers and medical practitioners. In the EU, 445 per 100 000 workers declared more than 14 days lost (i.e. two or more weeks' absence) for this reason. The highest prevalence was among the 45–54-year-olds for the two types (1 532 with or without absence, and 603 with more than 14 days lost). The prevalence rate resulting in an absence from work of two weeks or more (cumulated over one year) is highest in the health and social work sector (832), and in the education sector (828). Currently, information to assess the trends over time of these work-related conditions in the EU workforce is limited. Surveys of work-related illness suggest an in-

crease in the reported prevalence rate of work-related stress, although such an increase could be caused by factors other than, or as well as, a genuine rise in work stress. With respect to long-term restrictions, however, the **International Labour Organisation (ILO)** states that mental illness affects more human lives and gives rise to a greater waste of human resources than all other forms of disability, with mental disorders being one of the three leading causes of disability. In the EU, mental health disorders are a major reason for granting disability pensions (ref. ILO web site).

Schizophrenia

Schizophrenia is, according to DSM-IV (see box below), a severe disorder that typically begins in late adolescence or early adulthood (ref. WHO 2001e). It is characterised by fundamental distortions in thinking and perception, and by inappropriate emotions. The disturbance involves the most basic functions that give the normal person a feeling of individuality, uniqueness and self-direction. Behaviour may be seriously disturbed during some phases of the disorder, leading to adverse social consequences. Strong belief in ideas that are false and without any basis in reality (delusions) is another feature of this disorder. Schizophrenia follows a variable course, with complete symptomatic and social recovery in about one third of cases. It can, however, follow a chronic or recurrent course, with residual symptoms and incomplete social recovery. Individuals with chronic schizophrenia constituted a large proportion of all residents of mental institutions in the past, and still do where these institutions continue to exist.

Evidence from nearly a century of epidemiological research indicates that schizophrenia occurs in all populations with a prevalence in the range of 1.4 to 4.6 per 1 000, and incidence rates in the range of 0.16 to 0.42 per 1 000 population (ref. Jablensky 2000). According to US National Institute of Mental Health data, approximately 2.2 million American adults, or about 1.1 % of the population aged 18 and older in a given year, have schizophrenia (ref. Narrow 1998). In the EU, the scarce number of available studies show a range of prevalences between 2.4 and 6.7 per 1 000 of the population aged 18 and older. Schizophrenia is found approximately equally in men and women, though the onset tends to be later in women, who also tend to have a better course and outcome of this disorder. It has been repeatedly demonstrated that schizophrenia follows a less severe course in developing countries (ref. Kulhara and Wig 1978; Thara et al. 1994). For example, in one of the multi-site international studies, the proportion of patients showing full remission at two years was 63 % in developing countries, compared with 37 % in developed countries (ref. Jablensky et al. 1992).

Bipolar affective disorder

Bipolar affective disorder (ref. National Institute of Mental Health web site), also known as **manic-depressive illness**, is, according to DSM-IV (see box below), a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs that affect everyone, the symptoms of bipolar disorder are severe. They can result in damaged relationships, poor job or school performance, and even suicide. Bipolar disorder is a long-term illness that must be carefully managed throughout a person's life. It can be treated, and people with this illness can lead full and productive lives. Bipolar disorder typically develops in late adolescence or early adulthood. However, some people have their first symptoms during childhood, while others develop them late in life.

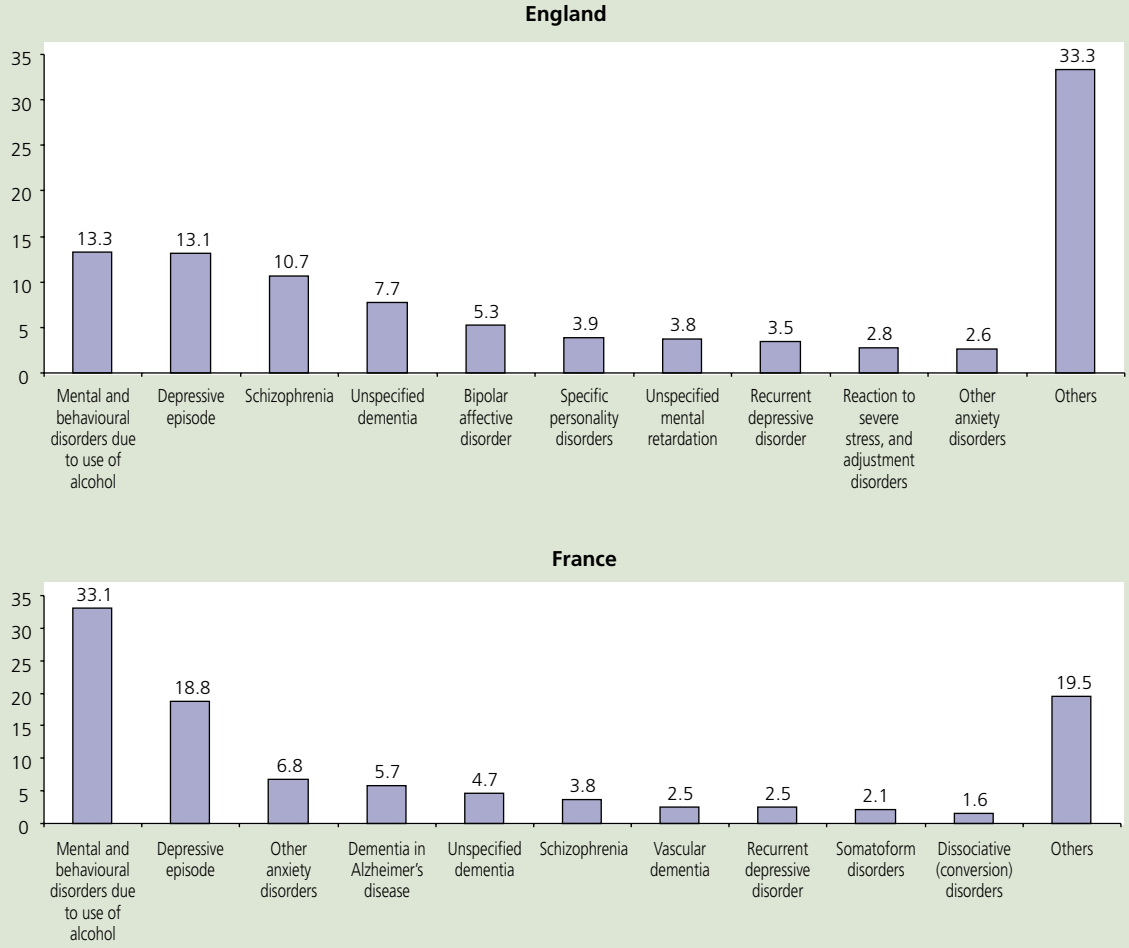
According to US National Institute of Mental Health data, using the DIS ('Diagnostic interview schedule') based on DSM-IV, bipolar disorder affects approximately 2.3 million adults, or about 1.2 % of the US population aged 18 and older in a given year (ref. Narrow 1998). In the EU, the majority of studies using the DIS **(4.7.43)** show a range of prevalences between 0.2 and 1.2 % of the population aged 18 and older in any given year. But certain manic or hypomanic situations are not reported as being part of a bipolar disorder and then this prevalence could be evaluated to a range of 1.6–6.5 % following some other studies (ref. Bourgeois and Verdoux 1995). Lifetime prevalence rates for bipolar I disorder in the Community range from 0 to 1.6 %, and for bipolar II disorder from 0.3 to 2.0 %. Studies which included other subgroups of the spectrum reported rates between 3.0 and 5.5 %. With the exception of the Zurich cohort study, which found a rate of 55 per 1 000, there are no prevalence data on DSM-IV hypomania, and there is none at all on DSM-IV cyclothymic disorder. A gender difference in prevalence for bipolar disorder is not proven.

Mental and behavioural disorders discharged from hospitals

The ICD-9-CM codes on hospital discharges represent only persons **hospitalised at least one night** for health problems and do not include patients treated in outpatient care by primary centres or doctors. Using this classification with the data collected by **Eurostat**, an estimated number of 2 141 000 Europeans (EU-15 without Belgium) were hospitalised in 1999 because of mental and behavioural disorders. A very similar figure was reported for the United States in the same year: 2 018 000 according to the US National Discharge Survey.

Detailed data on the main hospital diagnoses of mental and behavioural disorders are not available for the majority of Member States. Using the **Euro-**

4.7.46 Estimation of most frequently reported mental health disorders over total in hospital discharges, 1999 (%), England and France



Source: Eurostat (on the basis of national hospital discharges reports).

stat source **(4.7.46)**, the diagnoses of mental and behavioural disorders due to use of alcohol (13.3 %), and the depressive episode (13.1 %) are the most frequent diagnoses in England, followed by schizophrenia (10.7 %), unspecified dementia (7.7 %) and bipolar affective disorder (5.3 %). In France, the main causes are the same but percentages differ: the diagnoses of mental and behavioural disorders due to use of alcohol (33.1 %) and the depressive episode (18.8 %) are again the most frequent, followed by other anxiety disorders (6.8 %), dementia in Alzheimer's disease (5.7 %), unspecified dementia (4.7 %) and schizophrenia (3.8 %). Good data at EU level for readmission diagnoses are lacking, but it is estimated that schizophrenic disorders and affective psychoses are the most common cause of readmission. Discharge statistics (see Chapter 6) are based on counts of hospital discharges, which are counts of events, not patients. For example, a patient admitted and discharged three times during the reporting year would be counted, in these statistics, as three discharges.

In terms of discharges per 100 000 **(4.7.45)**, the highest national rates for the whole range of mental and behavioural disorders were in Finland (1 778.4), Austria (1 507.4) and Luxembourg (1 101.7 in 1998) and the lowest in Spain (261.9) and the Netherlands (137.6). Large differences in the rates of discharge among EU Member States may be attributable to the degree of availability and use of alternative types of care, such as outpatient clinics, community services and residential care facilities. Differences in rates between years could be attributable to changes in health care policies, such as the introduction of community-based treatment programmes to replace hospitalisation. For a correct reading of these figures, it is necessary to take account of the fact that hospital bed capacities have been reduced following different patterns in every Member State, which implies that the number of beds in psychiatric hospitals has decreased greatly everywhere, and it is

common that much mental health care today in EU Member States (in different proportions) is provided in ambulatory settings, in primary centres and private psychiatric hospitals (not necessarily covered by the official statistics). Today, health reform is accelerating these changes in public mental health systems. This deinstitutionalisation process resulted in a dispersion of patients into the community without sometimes the necessary services and supports to allow them to function successfully (see Chapter 6).

The ***Diagnostic and statistical manual of mental disorders (DSM)*** is published by the **American Psychiatric Association (APA)** and is the standard classification of mental disorders used originally by mental health professionals in the United States and nowadays used everywhere. It is intended to be applicable in a wide array of contexts (ref. APA web site) and used by clinicians and researchers of many different orientations (e.g. biological, psychodynamic, cognitive, behavioural, interpersonal, family/systems). DSM-IV has been designed for use across settings: inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care, and with community populations and by psychiatrists, psychologists, social workers, nurses, occupational and rehabilitation therapists, counsellors, and other health and mental health professionals. The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets and the descriptive text. The diagnostic classification is the list of the mental disorders that are officially part of the DSM system. 'Making a DSM diagnosis' consists of selecting those disorders from the classification that best reflect the signs and symptoms that are afflicting the individual being evaluated. Associated with each diagnostic label is a diagnostic code. These diagnostic codes are derived from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (see box in Chapter 5). ICD-9-CM is the official coding system used in the EU to track morbidity and mortality of diseases and produce subsequent statistics. For each disorder included in the DSM, there is a set of diagnostic criteria which indicate what symptoms must be present (and for how long) in order to qualify for a diagnosis (called inclusion criteria), as well as those symptoms that must not be present (called exclusion criteria) in order for an individual to qualify for a particular diagnosis.

DSM-IV is a diagnostic manual that uses ICD-9-CM codes to assist clinical medical record keeping. DSM-IV (*Diagnostic and statistical manual of mental disorders*, Fourth edition), published in 1994, was the last major revision of the DSM. In anticipation of the fact that the next major revision of the DSM (i.e. DSM-V) will not appear until 2010 or later, a text revision of DSM-IV called DSM-IV-TR was published in July 2000. Unlike DSM-III and DSM-III-R, all the diagnostic codes in DSM-IV and DSM-IV-TR were selected so as to be valid ICD-9-CM codes. In October 1995, the APA also published the *Diagnostic and statistical manual of mental disorders,* Fourth edition, 'Primary care' version (DSM-IV-PC). DSM-IV-PC was designed specifically for use by primary care clinicians. Because DSM-IV-TR is a diagnostic manual, there are a number of subtypes and specifiers not codable to ICD-9-CM. Currently, the **National Center for Health Statistics** (United States) is developing a modification of ICD-10 for use in the United States to be known as ICD-10-CM which will be field tested over the next few years. An international version of DSM-IV is available for psychiatrists in those countries that use ICD-10. The DSM-IV international version features the use of ICD-10 codes and additional text sections describing the relationship between the DSM-IV criteria sets and the ICD-10 diagnostic criteria for research.

A new action is currently ongoing, the **European study of the epidemiology of mental disorders** (**ESEMeD**/MHEDEA 2000), coordinated by the **Institut Municipal d'Investigació Mèdica** (Barcelona), a new cross-sectional study investigating the prevalence and the associated factors of mental disorders, as well as their effect on health-related quality of life and the use of services in six European countries. A total of 22 000 individuals representative of the non-institutionalised population aged 18 and over from Belgium, France, Germany, Italy, the Netherlands and Spain are being interviewed in their homes using the the most recent version of the 'Composite international diagnostic interview' (CIDI, 2000), a well-established epidemiological survey for assessing mental disorders. This is the first international study using the standardised up-to-date methodology for epidemiological assessment. Sizeable differences in prevalence, impact and level of need that is met by the health services are expected (ref. Alonso et al. 2000).

EU mental health systems

The **London School of Economics and Political Science**, LSE Health and Social Care, has examined (ref. Knapp 2002) the principal challenges facing Europe's mental health systems. Taking a resource perspective, there are several principal challenges facing Europe's mental health systems. One is the resource distribution: for example, there is a tendency for the best and widest range of services to be concentrated in large cities when mental health problems appear to be more prevalent among urban than rural populations. A related issue could be that some services are available only to higher income groups, even though many of the common mental health problems are associated with low income. More generally there is a need for European governments to tackle the age old problem, not only of social exclusion of people with severe and enduring mental illness, but also of substantial so-

cial disadvantage for people with common mental disorders. Another challenge is resource inappropriateness: a clear example of this is the continued dominant position of large psychiatric asylums in some countries. In cost terms, these hospitals account for high proportions of available mental health budgets whilst supporting small proportions of the total population in need.

The financing of mental health services is similar to the financing of general health services (ref. Dixon 2002). Many mental health problems tend to be chronic in nature, requiring access to services on an ongoing basis. However, the intensity of service use will vary over time due to the pattern of incidence of acute episodes, thus requiring flexibility in the delivery of care. In most countries and cultures, mental health problems carry a stigma and individuals may be slow to recognise or seek treatment for mental health problems and conversely it may be more difficult for the health care system to identify and treat individuals. More significant is the diversification that has taken place within most Member States as a result of the shift away from institutionalised psychiatric to community care.

Since the beginning of the deinstitutionalisation movement across many countries in the 1960s, a wide variety of models of community-based service have been developed to offer care to people with mental health problems outside the hospital environment (ref. Catty, Burns and Knapp 2002). While there is widespread consensus that treatment in the community is a valuable goal, there is far less consensus about the relative effectiveness of such service models or their resource implications. While mental health interventions are themselves by no means easy to evaluate, service models — structures for the delivery of a variety of interventions — are still less so. In response to the need to ascertain the effectiveness of 'home treatment' over other forms of care for people with mental health problems, the LSE has conducted a systematic review of 'home treatment' defined as any community-based non-residential service. Contextual factors such as methods of providing psychiatric and social care or differences in organisational and financing structures need to be fully understood and taken into consideration in interpreting the success or otherwise of an evaluated service and assessing its potential for adoption or translation into different contexts. For further information see http://www.lse.ac.uk/Depts/lsehsc/.

4.7.2.12. Rare diseases

A **Community action programme on rare diseases**, including genetic diseases, has been adopted by the European Parliament, and Council Decision No 1295/1999/EC of 29 April 1999 adopted a programme of Community action on rare diseases for the period 1 January 1999 to 31 December 2003. The aim of the programme is to contribute, in coordination with other Community measures, to ensuring a high level of health protection from rare diseases. For the purposes of this programme, rare diseases, including those of genetic origin, are life threatening or chronically debilitating diseases which are of such low prevalence that special combined efforts are needed to address them, in order to prevent significant morbidity or perinatal or early mortality or a considerable reduction in an individual's quality of life or socioeconomic potential. Low prevalence can be understood as being **less than 5 per 10 000** in the Community. Statistical information on these diseases is not often available, and in this volume only the results of the Eurocat programme on congenital anomalies are presented. A complete list of these rare diseases can be found in **Orphanet** (http://www.orpha.net), a database established with support from the Community action programme on rare diseases. Orphanet is a database dedicated to information on rare diseases and orphan drugs, and aims to improve management of such diseases whether they are genetic, autoimmune or infectious, of cancers or of diseases with no accurate diagnosis.

A project which commenced in 2002 to collect information on a few selected rare diseases is **Nephird ('Network of public health institutions on rare diseases')**, with support from the Community action programme on rare diseases, coordinated by the **Istituto Superiore di Sanità** (Italy). The main objectives of this project are: to develop a model for epidemiologic data collection at European level; to identify the ongoing national activities on rare diseases in the participating countries; and to design, build and run the Nephird web site. Recommendations on database standards, an institutional framework, and health policy action on data collection and service delivery are the expected outcomes of the study. This will simplify the production of valid and comprehensive epidemiological data (incidence, prevalence, and geographical distribution) which are important for planning or programming health service activities addressing rare diseases.

References

2002/C 6/01, Council conclusions of 15 November 2001 on combating stress and depression-related problems, *Official Journal of the European Communities* C 6/1 of 9 January 2002.

AIHW (Australian Institute of Health and Welfare) (1998), *Cancer in Australia 1998*.

Alonso, J. and Ferrer, M. et al. 2000, *The European study of the epidemiology of mental disorders (ESEMeD/MHEDEA 2000) project: rationale and*

methods, Institut Municipal d'Investigació Mèdica (IMIM-IMAS), Barcelona.

Amos, A., McCarty, D. and Zimmet, P. 'The rising global burden of diabetes and its complications: Estimates and projections to the year 2010', *Diabetic Medicine*, 1997.

APA (American Psychiatric Association), *Diagnostic and statistical manual of mental disorders (DSM*) (http://www.psych.org/clin_res/dsm/index.cfm).

Ayuso-Mateos, J. L. et al. (2001), 'Depressive disorders in Europe: Prevalence figures from the ODIN study', *British Journal of Psychiatry* 179, pp. 308–316.

Baumhackl, U., Eibl, G. and Ganzinger, U. et al. (2002), *Prevalence of multiple sclerosis in Austria. Results of a nationwide survey*, Austrian MS Study Committee.

Bourgeois, M. L. and Verdoux, H. (1995), *Les troubles bipolaires de l'humeur*, Paris.

Brachet, R. et al. (2000), 'Measles: Suboptimal situation in France', *Eurosurveillance* 5(2), pp. 21–22.

Brenner, H. (2002), 'Long-term survival rates of cancer achieved by the end of the 20th century: a period analysis', *The Lancet*, Vol. 360, pp. 1131–35.

Bronzwaer, S. L. A. M. et al. (1999), European Antimicrobial Resistance Surveillance System (EARSS): Objectives and organisation, *Eurosurveillance* 4(4), pp. 41–44.

Buchholz, U. et al. (2001), 'EARSS activities and results: Update', *Eurosurveillance* 6(1), pp. 2–5.

Catty, J., Burns, T. and Knapp, M. (2002), 'Evaluating innovative mental health services. Lessons from a systematic review of home treatment', *Eurohealth,* Vol. 8, No 1, winter 2001/02.

L. de Rijk, M.C., Tzourio, C. et al., 'Prevalence of parkinsonism and Parkinson's disease in Europe: the EuroParkinson collaborative study', *Journal of Neurology, Neurosurgery and Psychiatry,* 62, 1997, pp. 10–15.

Dixon, A. (2002), 'Dilemmas in financing mental health', *Eurohealth,* Vol. 8, No 1, winter 2001/02.

Dupré, D. (2001), *Work-related health problems in the EU 1998–99*, 'Statistics in focus', Theme 3 — 17/2001, European Commission.

Editorial note (1997a), 'Diphtheria cases notified in the European Union', *Eurosurveillance* 2(8/9).

Editorial note (1997b), 'Q fever in Europe', *Eurosurveillance* 2(2).

Enter-net (international surveillance network for the enteric infections), http://www.phls.co.uk/inter/enter-net/menu.htm.

Erasmus University Medical School, *Monitoring neurological diseases in Europe*, Report for DG V European Commission, 1996.

Eucare (European concerted action and research in epilepsy), http://www.eucare.be/index.htm.

Eurocat web site, http://www.eurocat.ulster.ac.uk, Eurocat Report 8*, Surveillance of congenital anomalies in Europe 1980–99*.

European Commission (1998), *Report on osteoporosis in the European Community — Action for prevention,* Luxembourg.

EuroTB (2002), *Surveillance of tuberculosis in Europe: Report on tuberculosis cases notified in 1999.*

Falçao, J. M. et al. (1999), 'Leptospirosis in Portugal: Epidemiology from 1991 to 1997', *Eurosurveillance* 4(4), pp. 44–47.

Fenton, K. et al. (2001), 'Europe-wide surveillance for sexually transmitted infections — A timely and appropriate intervention', *Eurosurveillance* 6(5), pp. 69–70.

Gourbin, C. and Wunsch, G. (no date), 'Les statistiques hospitalières: un instrument de la maladie d'Alzheimer et des autres maladies neurodégénératives', Institut de démographie, Université catholique de Louvain.

Handysides, S. (1999), 'Bacterial meningitis in Europe 1997–98', *Eurosurveillance Weekly*, issue 51.

Hemery, C. (1999), 'New outbreak of trichinellosis in the Midi-Pyrénées region of France, September-October 1998', *Eurosurveillance* 4(1), pp. 13–14.

HiltunenBack, E. et al. (1996), 'Increase of syphilis in Finland related to the Russian epidemic', *Eurosurveillance* 1(1).

Hofman, A. et al. (1991), 'The prevalence of dementia in Europe: A collaborative study of 1980–90 findings', *International Journal of Epidemiology*, Vol. 20, No 3, pp. 736–748.

Hughes, G. (2001), 'Diagnoses of gonorrhoea in England and Wales at their highest for 13 years', *Eurosurveillance Weekly*, issue 31.

Huismann, A. et al. (1998), 'Neurodegenerative diseases among migrants in EU States — Prevalence and care situation', compiled for WIAD on behalf of the European Commission (SOC 97 201321 05F03).

ILO (International Labour Organisation), http://www.wfmh.org/wmhday/sec1_pt2_reintegration.html.

Jablensky, A. et al. (1992), 'Schizophrenia: Manifestations, incidence and course in different cultures: A World Health Organisation ten-country

study', *Psychological Medicine Monograph* 20 (supplement).

Jablensky, A (2000), 'Epidemiology of schizophrenia: The global burden of disease and disability, *European Archives of Psychiatry and Clinical Neurosciences.*

IPCC (Intergovernmental Panel on Climate Change), *Climate change 2001: Impacts, adaptation and vulnerability*, 2001, (http://www.grida.no/climate/ipcc_tar/wg2/index.htm).

Karcher, F. and Buchow, H. (2002), 'Influenza pandemic preparedness and response planning at community level', *Eurosurveillance* 7(11), pp. 166–168.

Knapp, M. (2002), 'Mental health: Familiar challenges, unprecedented opportunities', *Eurohealth*, Vol. 8, No 1, winter 2001/02.

Kulhara, P. and Wig, N. N. (1978), 'The chronicity of schizophrenia in North-West India — Results of a follow-up study', *British Journal of Psychiatry* 132, pp. 186–190.

Lai, S. and Efstratiou, A. (2002), 'Report on the sixth international meeting of the European Laboratory Working Group on Diphtheria, Brussels, Belgium', *Eurosurveillance* 7(1), pp. 7–12.

Laude, G. et al. (2001), 'Tuberculosis in Germany, 2000', *Eurosurveillance Weekly*, issue 49.

Levy-Bruhl, D. et al. (1998), 'ESEN: A comparison of vaccination programmes — Part Three: Measles, mumps and rubella', *Eurosurveillance* 2(12), pp. 115–119.

Lewinsohn, P. M. et al. (1993), 'Adolescent psychopathology — Prevalence and incidence of depression and other DSM-III-R disorders in high school students', *Journal of Abnormal Psychology* 102, p. 517.

Manguerra, J. C. and Mosnier, A. (2000), 'Surveillance of influenza in Europe from October 1999 to February 2000', *Eurosurveillance* 5(6), pp. 63–68.

Merck manual of medical information, Berkow, R. (ed.), New York, 1997.

Micheli, A. et al. (forthcoming), 'Cancer prevalence in European registries areas', *Annals of Oncology.*

Montserrat, A. and Hamzaoui, N. (2002), *Trends of incidence and mortality of AIDS in the European Union 1981–2001*, 'Statistics in focus', Theme 3 — 17/2002, European Commission.

Narrow, W. E. (1998), 'One-year prevalence of depressive disorders among adults 18 and over in the US: NIMH ECA prospective data — Population estimates based on US census estimated residential population aged 18 and over on July 1 1998', unpublished (see http://www.nimh.nih.gov).

National Institute of Mental Health (United States), http://www.nimh.nih.gov.

NBHW (National Board of Health and Welfare) (2001), 'Health in Sweden', *Scandinavian Journal of Public Health*.

ONS, UK, 'Epilepsy prevalence and prescribing patterns in England and Wales', *Health Statistics Quarterly*, autumn 2002.

Pimenta, J. and Fenton, K. (2001), 'Recent trends in *Chlamydia trachomatis* in the United Kingdom and the potential for national screening', *Eurosurveillance* 6(5), pp. 81–84.

Raisin (Réseau d'alerte d'investigation et de surveillance des infections nosocomiales), *Enquête de prévalence nationale des infections nosocomiales 2001*, INVS, 2002.

Randolph, S. (2002), 'The changing incidence of tickborne encephalitis in Europe', *Eurosurveillance Weekly,* June 2002.

Rayner, M. and Petersen, S. (2000), *European cardiovascular disease statistics,* 2000 edition, British Heart Foundation.

Robbins, J. and Ewbank, D. (1998), *Dementia in Parkinson's disease: Demographic models and estimates*, Population Studies Center, University of Pennsylvania.

RUG (University of Groningen Northern Centre for Health Care Research), http://coo.med.rug.nl/nch/zwanikkensum.pdf.

Sabatinelli, G. et al. (2001), 'Malaria in the WHO European region (1971–99)', *Eurosurveillance* 6(4), pp. 61–65.

Salmaso, S. (1998), *Inventory of the means of controlling communicable diseases in the European Union, Norway, and Switzerland: Report on the analysis of the information collected*, Directorate-General for Health and Consumer Protection, 1998.

Stakes (2002), *Establishment of a set of mental health indicators for the European Union*, Helsinki.

Suspiro, A. and Menezes, J. (1996), 'An outbreak of shigellosis in a childcare institution in Queluz, Portugal — 1995', *Eurosurveillance* 1(1).

Tafforeau, J. and Bayingana, K. (2002), *La dépression — État des connaissances et données disponibles pour le développement d'une politique de santé en Belgique*, Institut scientifique de la santé publique.

Termorshuizen, F. and Van de Laar, M. (1998), 'Upsurge of hepatitis A in the Netherlands — Early 1998', *Eurosurveillance* 3(11), pp. 110–112.

Thara, R. et al. (1994), 'Ten-year course of schizophrenia: The Madras longitudinal study', *Acta Psychiatrica Scandinavica* 90, pp. 344–351.

Therre, H. (1999), 'Botulism in the European Union', *Eurosurveillance* 4(1), pp. 2–7.

Therre, H. and Baron, S. (2000), 'Pertussis immunisation in Europe — The situation in late 1999', *Eurosurveillance* 5(1), pp. 6–10.

Thornicroft, G. and Sartorious, N. (1993), 'The course and outcome of depression in different cultures: 10-year follow-up of the WHO collaborative study on the assessment of depressive disorders', *Psychological Medicine* 23, pp. 1023–1032.

Tunstall-Pedoe, H. et al. (1999), 'Contribution of trends in survival and coronary-event rates to changes in coronary heart disease mortality: 10-year results from 37 WHO Monica populations', *Lancet* 353, pp. 1547–1557.

Vaqué, J. and Rosselló, J. (eds), 'Evolución de la prevalencia de las infecciones nosocomiales en los hospitales españoles' (http://www.mpsp.org/mpsp/epine/).

WHO (2000), *Anti-tuberculosis drug resistance in the world — Report No 2: Prevalence and trends* (ref. WHO/CDS/TB/2000.278).

WHO consultation of experts, Copenhagen, Denmark, November 2000 (ref. WHO/CDS/CSR/APH/-2000.4).

WHO fact sheets: No 105 *Epidemic meningococcal disease* (1998); No 164 *Hepatitis C* (2000); No 138 *Diabetes mellitus* (2002).

WHO (2001a), *WHO global strategy for containment of antimicrobial resistance*.

WHO (2001b), *Report on global surveillance of epidemic-prone infectious diseases*, Chapter 4 — 'Cholera'.

WHO (2001c), 'Cholera 2000', *Weekly Epidemiological Record* 76, pp. 233–240.

WHO (2001d), *The increasing incidence of human campylobacteriosis*, Report and proceedings of a *WHO consultation of experts*, Copenhagen, Denmark, November 2000 (ref. WHO/CDS/CSR/APH/2000.4).

WHO (2001e), *The World Health Report 2001 — Mental health: New understanding, new hope*.

WHO (2002a), *Vaccines, immunisation and biologicals: Pneumococcus* (available on www.who.int/vaccines/).

WHO (2002b), *The global burden of disease* (http://www.who.int/msa/mnh/ems/dalys/intro.htm).

4.1.1 Self-perceived health by sex

			EU-15	B	DK	D	EL	E	F	IRL
Very good	**Total**	**1998**	16.1	22.3	43.5	8.2	53.7	17.0	9.7	45.7
		1997	17.4	24.4	44.2	8.1	49.6	18.8	12.8	46.0
		1996	20.0	23.7	44.8	12.5	52.5	20.4	13.9	45.5
	Males	**1998**	18.3	25.3	45.7	9.3	57.9	18.5	11.3	45.1
		1997	19.7	27.5	46.6	9.1	53.9	20.4	15.1	46.9
		1996	21.9	26.6	46.5	14.2	54.3	21.9	15.5	47.1
	Females	**1998**	14.0	19.6	41.3	7.2	49.9	15.5	8.2	46.2
		1997	15.2	21.7	41.8	7.2	45.6	17.3	10.6	45.1
		1996	18.2	21.0	43.1	11.0	50.7	19.1	12.4	43.9
Good	**Total**	**1998**	44.1	50.8	32.1	38.8	21.7	51.3	46.2	35.3
		1997	43.5	48.1	32.2	40.0	24.9	49.1	46.1	35.1
		1996	45.3	49.7	30.7	53.7	24.3	46.8	45.4	35.5
	Males	**1998**	45.6	52.3	31.5	41.3	20.9	52.4	48.3	37.7
		1997	45.1	49.2	32.0	42.8	24.8	51.6	48.1	36.7
		1996	47.0	50.7	32.2	55.0	22.7	48.6	47.7	36.4
	Females	**1998**	42.7	49.4	32.7	36.5	22.5	50.3	44.3	32.9
		1997	42.1	47.2	32.4	37.5	25.1	46.7	44.3	33.6
		1996	43.9	48.9	29.3	52.5	25.9	45.1	43.2	34.6
Fair	**Total**	**1998**	27.5	21.5	17.8	34.0	15.1	20.3	34.8	15.9
		1997	27.3	22.1	16.9	33.9	16.3	20.9	33.1	15.1
		1996	25.3	21.1	17.0	25.4	14.9	21.0	32.6	15.5
	Males	**1998**	25.6	18.1	17.0	32.8	13.0	19.8	32.5	14.4
		1997	25.2	19.0	16.4	32.8	13.1	19.0	29.7	13.7
		1996	23.0	18.4	15.6	23.2	14.4	19.5	29.6	13.6
	Females	**1998**	29.2	24.5	18.6	35.1	17.1	20.9	37.0	17.3
		1997	29.3	24.8	17.3	34.9	19.3	22.7	36.2	16.4
		1996	27.4	23.6	18.4	27.3	15.5	22.3	35.4	17.2
Bad	**Total**	**1998**	9.2	4.4	4.8	14.4	7.3	9.4	4.7	2.6
		1997	8.8	4.6	4.8	13.5	6.8	9.7	4.0	3.2
		1996	7.2	4.7	5.7	6.7	6.2	9.7	4.1	2.9
	Males	**1998**	7.9	3.4	4.2	12.6	6.5	7.6	3.9	2.4
		1997	7.4	3.5	3.6	11.3	5.9	8.0	3.5	2.1
		1996	6.2	3.7	4.6	6.1	6.2	8.7	3.4	2.1
	Females	**1998**	10.5	5.2	5.4	16.0	8.0	11.0	5.4	2.8
		1997	10.2	5.6	6.0	15.5	7.6	11.2	4.6	4.2
		1996	8.0	5.6	6.7	7.2	6.1	10.6	4.8	3.6
Very bad	**Total**	**1998**	3.1	1.1	1.8	4.6	2.1	2.0	4.6	0.6
		1997	2.9	0.8	2.0	4.5	2.4	1.6	4.0	0.7
		1996	2.2	0.8	1.8	1.7	2.1	2.1	4.0	0.7
	Males	**1998**	2.6	0.9	1.6	4.0	1.7	1.7	4.0	0.4
		1997	2.6	0.8	1.4	4.1	2.3	1.0	3.7	0.7
		1996	1.9	0.7	1.1	1.5	2.4	1.3	3.7	0.8
	Females	**1998**	3.6	1.3	2.0	5.2	2.5	2.2	5.1	0.7
		1997	3.3	0.8	2.6	4.9	2.5	2.1	4.3	0.8
		1996	2.5	0.9	2.5	2.0	1.8	2.9	4.2	0.7

Note: The surveys in Germany and the UK changed in 1997, therefore data from 1996 cannot be compared with later years.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

(%)

I	L	NL	A	P	FIN	S	UK			
15.7	:	17.9	31.7	3.3	:	(:)	21.2	**Very good**	**Total**	**1998**
17.4	:	18.7	31.6	3.3	(19.0)	(:)	23.5			**1997**
16.6	23.3	19.1	32.2	3.5	20.5	:	(31.5)			**1996**
19.1	:	21.4	34.9	4.0	:	(:)	24.5		**Males**	**1998**
20.7	:	22.5	34.8	4.3	(21.1)	(:)	26.7			**1997**
19.6	25.7	21.9	34.5	4.2	(21.7)	:	(33.2)			**1996**
12.5	:	14.5	28.8	2.7	:	(:)	18.4		**Females**	**1998**
14.3	:	15.2	28.7	2.4	17.2	(:)	20.6			**1997**
14.0	20.9	16.4	30.0	2.9	19.5	:	29.9			**1996**
43.6	:	55.4	40.9	43.3	:	(:)	47.5	**Good**	**Total**	**1998**
42.2	:	54.4	41.2	42.4	(43.3)	(:)	45.4			**1997**
42.5	44.3	54.7	39.9	44.4	39.4	:	(38.8)			**1996**
45.9	:	56.4	40.2	48.5	:	(:)	46.7		**Males**	**1998**
44.0	:	54.7	39.9	47.4	(41.8)	(:)	44.9			**1997**
44.8	45.3	55.3	40.3	50.4	(39.5)	:	(40.1)			**1996**
41.5	:	54.4	41.6	38.7	:	(:)	48.2		**Females**	**1998**
40.6	:	54.2	42.4	38.0	44.6	(:)	45.8			**1997**
40.4	43.3	54.2	39.5	39.0	39.4	:	37.6			**1996**
28.3	:	22.3	20.0	31.1	:	(:)	21.2	**Fair**	**Total**	**1998**
28.4	:	22.3	19.8	30.8	(29.2)	(:)	21.4			**1997**
28.6	25.5	21.7	19.9	29.3	31.1	:	(21.9)			**1996**
24.7	:	18.9	19.4	29.1	:	(:)	20.1		**Males**	**1998**
25.0	:	19.4	19.1	29.2	(30.0)	(:)	20.0			**1997**
25.4	22.5	19.4	18.0	27.3	(30.8)	:	(19.8)			**1996**
31.6	:	25.6	20.7	33.0	:	(:)	22.3		**Females**	**1998**
31.4	:	25.0	20.5	32.2	28.5	(:)	22.6			**1997**
31.6	28.5	23.9	21.6	31.1	31.4	:	23.7			**1996**
10.0	:	3.8	5.8	18.0	:	(:)	7.7	**Bad**	**Total**	**1998**
9.8	:	4.0	5.5	18.4	(7.2)	(:)	7.2			**1997**
9.9	5.9	3.9	6.2	18.1	7.9	:	(6.3)			**1996**
8.4	:	2.9	4.1	14.9	:	(:)	7.0		**Males**	**1998**
8.2	:	2.9	4.9	14.7	(6.1)	(:)	6.1			**1997**
8.3	5.8	2.9	5.7	14.1	(6.9)	:	(5.4)			**1996**
11.5	:	4.7	7.3	20.7	:	(:)	8.3		**Females**	**1998**
11.3	:	5.0	6.1	21.7	8.1	(:)	8.1			**1997**
11.4	6.0	4.8	6.6	21.8	8.7	:	7.1			**1996**
2.4	:	0.6	1.6	4.3	:	(:)	2.3	**Very bad**	**Total**	**1998**
2.2	:	0.6	1.8	5.0	(1.2)	(:)	2.6			**1997**
2.3	1.0	0.6	1.9	4.7	1.1	:	(1.5)			**1996**
1.9	:	0.5	1.4	3.6	:	(:)	1.7		**Males**	**1998**
2.0	:	0.5	1.2	4.3	(1.0)	(:)	2.2			**1997**
1.9	0.8	0.5	1.5	4.0	(1.2)	:	(1.5)			**1996**
2.9	:	0.8	1.7	4.9	:	(:)	2.8		**Females**	**1998**
2.4	:	0.6	2.3	5.7	1.5	(:)	2.9			**1997**
2.7	1.2	0.7	2.2	5.3	1.0	:	1.6			**1996**

4.1.3 Self-perceived health by age

			EU-15	B	DK	D	EL	E	F	IRL
16–24	**Very good**	**1998**	32.0	41.8	69.1	24.3	(89.4)	34.3	19.0	67.9
		1997	34.5	48.5	57.3	26.7	(90.2)	40.1	22.2	65.8
		1996	38.5	46.0	63.0	33.0	(94.1)	44.1	24.2	67.4
	Good	**1998**	53.3	49.6	26.6	58.1	(8.7)	58.7	60.2	26.5
		1997	50.3	43.5	32.5	54.1	(7.9)	50.4	60.7	27.8
		1996	50.7	44.5	29.9	57.3	(4.0)	49.2	56.6	25.7
	Fair	**1998**	12.3	8.0	3.2	15.1	(1.3)	4.8	18.2	5.0
		1997	12.6	7.2	8.8	15.5	(1.3)	7.3	15.2	5.3
		1996	9.4	9.1	6.4	8.9	(0.9)	5.0	17.3	6.4
	Bad	**1998**	2.0	0.5	0.3	2.3	(0.1)	2.0	1.4	0.2
		1997	1.9	0.8	0.7	2.6	(0.6)	1.9	1.0	0.6
		1996	1.1	0.3	0.1	0.7	(0.5)	1.6	1.0	0.4
	Very bad	**1998**	0.4	0.0	0.8	0.2	(0.4)	0.1	1.2	0.3
		1997	0.6	:	0.7	1.1	(0.0)	0.2	0.9	0.6
		1996	0.4	0.1	0.7	0.2	(0.4)	0.1	0.8	0.1
25–34	**Very good**	**1998**	24.8	36.2	61.5	13.0	82.2	24.3	17.3	58.3
		1997	26.3	38.0	63.9	11.9	80.0	27.6	21.6	56.5
		1996	30.4	35.5	61.6	22.7	83.2	28.2	22.5	53.9
	Good	**1998**	53.8	52.8	29.0	56.5	14.0	62.9	57.7	32.8
		1997	53.4	51.0	26.0	60.4	16.6	60.6	54.2	33.9
		1996	53.0	51.8	28.4	63.5	13.1	58.3	54.3	35.6
	Fair	**1998**	17.4	9.4	6.3	23.5	2.6	10.2	22.4	7.6
		1997	16.5	9.7	7.1	21.9	2.1	9.5	21.1	8.3
		1996	14.0	10.4	8.7	11.3	2.3	10.3	19.7	8.3
	Bad	**1998**	3.2	1.1	2.2	6.1	0.7	2.1	1.3	0.9
		1997	3.0	1.1	2.0	4.9	0.9	2.0	1.3	1.0
		1996	2.0	1.8	0.7	2.0	1.1	2.7	2.0	1.7
	Very bad	**1998**	0.8	0.6	1.0	0.9	0.5	0.4	1.3	0.4
		1997	0.9	0.1	0.9	1.0	0.3	0.3	1.8	0.2
		1996	0.6	0.5	0.6	0.4	0.4	0.4	1.5	0.5
35–44	**Very good**	**1998**	17.6	21.9	51.4	7.8	74.0	18.0	10.6	49.9
		1997	19.2	25.3	47.8	8.9	67.4	19.3	15.1	48.7
		1996	22.1	25.8	48.5	12.8	66.7	21.2	16.3	46.9
	Good	**1998**	51.8	57.9	33.3	47.5	19.1	62.4	54.3	35.9
		1997	51.3	52.2	37.7	49.5	26.1	60.7	51.6	35.7
		1996	53.2	54.8	32.4	65.5	26.1	59.3	50.2	39.2
	Fair	**1998**	24.3	17.0	12.4	34.5	5.0	15.3	30.3	12.8
		1997	23.2	19.1	12.0	30.4	4.5	15.8	28.5	12.6
		1996	20.0	16.0	14.0	18.8	5.6	14.9	28.3	11.2
	Bad	**1998**	4.9	2.6	2.3	8.5	1.5	3.7	2.0	1.4
		1997	5.0	3.1	2.2	10.4	0.9	3.6	2.7	2.7
		1996	3.7	3.0	4.3	2.6	1.0	4.1	2.6	2.3
	Very bad	**1998**	1.4	0.6	0.6	1.7	0.4	0.7	2.8	0.0
		1997	1.2	0.3	0.3	0.8	1.0	0.7	2.1	0.3
		1996	0.9	0.3	0.8	0.2	0.6	0.5	2.6	0.4
45–54	**Very good**	**1998**	12.5	17.4	41.4	5.2	52.7	11.3	7.1	38.8
		1997	13.5	20.6	42.4	4.6	45.9	12.4	8.6	42.0
		1996	15.5	18.6	43.8	8.6	49.0	14.4	10.2	42.1
	Good	**1998**	45.1	53.5	34.8	35.8	28.2	56.2	46.0	41.8
		1997	45.4	50.9	37.9	39.1	35.0	53.6	48.9	39.5
		1996	49.7	55.1	34.2	59.4	33.2	50.9	48.2	38.5
	Fair	**1998**	30.2	21.1	17.9	36.8	13.4	23.1	37.5	17.0
		1997	30.4	21.9	13.9	38.5	13.4	25.9	34.7	15.4
		1996	26.5	19.0	16.3	23.4	12.1	24.9	33.9	16.2
	Bad	**1998**	9.4	6.7	4.0	18.3	4.6	7.8	4.4	1.8
		1997	8.0	5.6	4.5	13.4	4.1	7.1	3.7	2.6
		1996	6.6	6.5	4.6	7.7	4.2	8.6	3.6	2.5
	Very bad	**1998**	2.9	1.3	1.9	4.0	1.2	1.7	5.1	0.7
		1997	2.7	1.1	1.4	4.4	1.6	1.0	4.1	0.5
		1996	1.7	0.8	1.1	0.9	1.5	1.3	4.1	0.6

(%)

I	L	NL	A	P	FIN	S	UK			
40.1	:	29.0	68.6	9.0	:	(52.2)	(24.5)	**16–24**	**Very good**	**1998**
42.8	:	29.6	64.1	8.7	(:)	(57.4)	(27.0)			**1997**
43.5	49.6	34.6	66.0	9.7	(:)	:	(:)			**1996**
49.8	:	58.7	28.3	75.8	:	(37.0)	52.7		**Good**	**1998**
47.0	:	58.2	29.9	75.6	(:)	(32.2)	48.9			**1997**
46.7	40.3	56.3	28.8	75.0	(:)	:	(:)			**1996**
8.8	:	10.9	2.3	12.9	:	(9.8)	17.2		**Fair**	**1998**
8.8	:	10.3	5.5	13.2	(:)	(9.9)	19.3			**1997**
8.2	8.0	7.1	4.7	11.5	(:)	:	(:)			**1996**
1.2	:	1.3	0.6	1.8	:	(0.5)	4.9		**Bad**	**1998**
1.2	:	1.7	0.2	1.8	(:)	(0.2)	4.0			**1997**
1.3	1.7	1.6	0.4	2.9	(:)	:	(:)			**1996**
0.1	:	0.1	0.2	0.6	:	(0.5)	0.8		**Very bad**	**1998**
0.2	:	0.3	0.2	0.7	:	(0.3)	0.8			**1997**
0.3	0.5	0.4	0.1	0.8	:	:	(:)			**1996**
28.6	:	26.9	49.4	4.5	:	(:)	27.7	**25–34**	**Very good**	**1998**
29.7	:	29.8	50.5	5.2	32.8	(:)	29.1			**1997**
26.3	36.7	27.7	52.8	4.7	37.9	:	(41.9)			**1996**
54.9	:	61.6	41.2	63.8	:	(:)	47.2		**Good**	**1998**
52.2	:	58.5	41.2	64.1	56.8	(:)	47.1			**1997**
54.6	51.7	60.2	37.4	65.0	52.0	:	(39.9)			**1996**
14.7	:	10.0	8.3	24.7	:	(:)	19.0		**Fair**	**1998**
16.2	:	9.6	5.9	22.2	9.5	(:)	17.2			**1997**
17.0	9.7	10.2	7.7	23.5	9.7	:	(15.7)			**1996**
1.3	:	1.3	0.9	5.4	:	(:)	5.2		**Bad**	**1998**
1.4	:	2.0	1.8	6.3	0.7	(:)	5.3			**1997**
1.6	1.6	1.7	1.5	5.6	0.3	:	(1.9)			**1996**
0.5	:	0.0	0.1	1.6	:	(:)	0.9		**Very bad**	**1998**
0.4	:	0.1	0.6	2.2	0.2	(:)	1.3			**1997**
0.5	0.3	0.2	0.6	1.2	0.2	:	(0.6)			**1996**
14.8	:	18.6	37.3	3.8	:	(:)	24.6	**35–44**	**Very good**	**1998**
16.1	:	17.6	36.7	3.8	23.0	(:)	28.2			**1997**
16.3	22.1	19.2	37.3	3.6	22.7	:	(37.9)			**1996**
54.9	:	60.7	48.6	51.2	:	(:)	50.7		**Good**	**1998**
54.9	:	60.8	48.6	50.3	55.3	(:)	47.5			**1997**
55.4	54.6	61.0	49.1	53.8	56.1	:	(36.5)			**1996**
26.0	:	16.9	11.7	34.0	:	(:)	16.4		**Fair**	**1998**
25.4	:	18.1	12.7	35.0	18.9	(:)	17.3			**1997**
24.9	18.9	16.7	11.9	31.2	18.6	:	(16.6)			**1996**
3.5	:	3.3	1.6	9.0	:	(:)	6.6		**Bad**	**1998**
2.6	:	3.0	1.4	7.4	2.6	(:)	5.2			**1997**
2.8	3.5	2.7	1.4	9.2	2.1	:	(7.8)			**1996**
0.7	:	0.5	0.8	2.0	:	(:)	1.7		**Very bad**	**1998**
1.0	:	0.5	0.6	3.5	0.3	(:)	1.8			**1997**
0.6	0.9	0.5	0.4	2.1	0.6	:	(1.2)			**1996**
7.5	:	15.5	19.3	1.4	:	(:)	22.2	**45–54**	**Very good**	**1998**
10.5	:	15.1	20.9	1.5	11.7	(:)	25.0			**1997**
9.5	18.1	14.1	20.2	1.4	12.7	:	(29.9)			**1996**
47.6	:	57.1	47.5	36.6	:	(:)	48.3		**Good**	**1998**
47.4	:	56.6	46.4	36.2	44.8	(:)	43.7			**1997**
47.8	45.1	58.2	46.9	40.0	42.1	:	(42.8)			**1996**
35.9	:	22.3	26.2	43.6	:	(:)	19.2		**Fair**	**1998**
34.2	:	23.3	25.0	41.3	36.3	(:)	20.7			**1997**
34.3	29.6	23.0	23.8	39.5	38.6	:	(19.8)			**1996**
7.5	:	4.4	5.9	16.3	:	(:)	7.2		**Bad**	**1998**
6.6	:	4.3	6.6	18.2	6.8	(:)	7.9			**1997**
7.1	5.4	4.2	6.9	15.9	6.0	:	(6.0)			**1996**
1.5	:	0.8	1.1	2.0	:	(:)	3.1		**Very bad**	**1998**
1.3	:	0.6	1.1	2.8	0.4	(:)	2.7			**1997**
1.4	1.8	0.5	2.2	3.2	0.7	:	(1.4)			**1996**

(cont.)

			EU-15	B	DK	D	EL	E	F	IRL
55–64	**Very good**	**1998**	8.5	14.1	27.8	2.7	32.5	7.0	4.0	28.3
		1997	8.9	14.1	35.4	1.9	22.9	5.3	7.2	29.3
		1996	10.7	11.3	32.5	5.4	25.9	7.5	6.6	31.8
	Good	**1998**	38.2	48.6	35.0	28.5	31.8	41.2	40.4	41.4
		1997	37.6	50.1	28.8	29.5	37.6	41.6	40.3	39.4
		1996	39.1	52.6	27.2	45.4	39.9	37.0	40.0	40.7
	Fair	**1998**	35.8	31.5	29.9	40.7	22.2	32.4	44.1	23.3
		1997	36.8	30.1	27.2	41.5	27.7	32.6	43.6	25.4
		1996	36.5	30.5	30.7	38.0	23.4	35.0	42.2	22.2
	Bad	**1998**	13.4	4.8	5.6	20.7	11.2	16.3	6.1	5.6
		1997	12.8	4.1	6.9	19.9	8.8	17.9	4.7	4.4
		1996	10.5	4.3	8.0	8.7	8.5	17.1	5.5	3.9
	Very bad	**1998**	4.0	1.0	1.7	7.4	2.4	3.2	5.3	1.3
		1997	3.9	1.5	1.8	7.2	3.1	2.5	4.1	1.5
		1996	3.2	1.2	1.5	2.6	2.2	3.4	5.7	1.4
65–74	**Very good**	**1998**	5.8	6.9	17.3	3.8	12.5	4.7	2.6	21.5
		1997	6.4	7.1	20.4	2.4	5.6	4.5	3.5	24.0
		1996	6.8	8.6	21.2	3.9	11.4	6.1	4.2	21.7
	Good	**1998**	29.3	44.5	35.0	18.8	28.7	28.9	27.1	37.7
		1997	28.3	43.2	31.7	17.3	30.8	30.3	28.3	39.1
		1996	32.5	42.0	32.0	40.8	31.8	28.0	29.2	37.7
	Fair	**1998**	41.5	37.3	34.7	47.1	33.5	39.6	51.0	34.4
		1997	43.1	38.8	35.9	52.1	38.7	38.3	52.8	29.2
		1996	41.7	38.9	28.5	41.3	35.9	38.4	51.4	34.8
	Bad	**1998**	17.9	8.4	9.3	23.4	19.6	22.1	11.0	5.5
		1997	16.9	9.1	8.7	20.3	20.4	23.5	7.7	7.2
		1996	14.5	8.2	14.3	10.4	16.1	22.7	8.4	5.2
	Very bad	**1998**	5.5	3.0	3.8	6.9	5.7	4.6	8.2	1.0
		1997	5.3	1.7	3.3	7.8	4.5	3.5	7.8	0.5
		1996	4.4	2.3	4.0	3.7	4.8	4.8	6.8	0.7
75–84	**Very good**	**1998**	4.3	6.1	14.5	1.5	6.7	3.3	1.5	12.1
		1997	4.3	6.9	17.4	2.4	2.6	2.2	3.3	16.4
		1996	4.8	6.5	14.4	1.6	2.9	3.1	2.8	14.3
	Good	**1998**	22.7	39.5	29.8	13.8	21.5	23.3	22.8	35.8
		1997	22.9	38.2	25.6	12.7	18.4	23.5	23.2	34.5
		1996	25.2	35.6	29.4	31.8	23.7	20.8	21.8	31.6
	Fair	**1998**	41.5	41.7	34.3	38.9	45.7	38.1	56.2	42.2
		1997	39.6	37.5	35.6	37.5	48.5	37.3	52.3	34.5
		1996	42.8	40.8	30.4	41.9	43.9	39.6	54.5	40.0
	Bad	**1998**	22.0	10.0	16.4	28.9	20.9	28.8	9.5	8.9
		1997	23.7	15.5	14.5	32.5	19.3	30.9	10.9	10.6
		1996	20.1	15.4	16.7	18.1	21.2	26.9	11.5	11.2
	Very bad	**1998**	9.6	2.7	5.0	16.8	5.3	6.5	10.0	1.0
		1997	9.5	1.9	6.9	14.9	11.2	6.2	10.2	4.0
		1996	7.1	1.6	9.1	6.6	8.4	9.5	9.4	2.9
85+	**Very good**	**1998**	4.2	8.1	12.6	2.8	1.0	1.8	2.2	8.9
		1997	4.3	5.3	13.6	2.6	0.5	3.7	3.0	10.3
		1996	3.7	5.5	11.5	0.8	0.2	4.2	3.2	5.6
	Good	**1998**	19.5	26.1	31.7	12.8	12.4	22.7	14.4	35.7
		1997	20.0	36.4	30.8	11.8	11.7	17.9	19.2	29.4
		1996	21.3	31.8	31.8	25.3	11.8	18.2	15.8	35.4
	Fair	**1998**	39.2	49.2	35.2	46.5	42.8	37.1	42.9	33.5
		1997	39.7	50.8	14.1	47.9	43.2	36.4	45.7	32.2
		1996	41.4	50.1	24.4	39.7	48.8	36.6	55.6	34.8
	Bad	**1998**	23.8	15.9	17.9	20.5	27.9	28.5	19.4	20.8
		1997	24.0	5.7	20.7	23.9	36.2	34.3	16.3	27.5
		1996	24.3	12.6	26.4	28.5	27.1	28.6	8.8	14.2
	Very bad	**1998**	14.0	0.7	2.6	17.4	15.9	10.0	21.0	1.1
		1997	12.1	1.8	20.8	13.8	8.4	7.7	15.8	0.6
		1996	9.7	:	5.9	5.7	12.1	12.4	16.5	10.0

Note: The surveys in Germany and the UK changed in 1997, therefore data from 1996 cannot be compared with later years.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

(cont.)

I	L	NL	A	P	FIN	S	UK			
5.5	:	11.5	10.9	0.6	:	(:)	18.0	**55–64**	**Very good**	**1998**
6.5	:	10.6	11.4	0.3	4.2	(:)	20.2			**1997**
4.8	12.2	10.7	9.1	0.9	6.1	:	27.7			**1996**
38.0	:	49.1	47.6	19.2	:	(:)	46.8		**Good**	**1998**
36.3	:	48.2	44.7	18.7	28.0	(:)	44.5			**1997**
35.4	39.5	47.3	42.7	19.4	25.7	:	34.5			**1996**
40.3	:	33.3	31.4	39.2	:	(:)	23.3		**Fair**	**1998**
41.1	:	35.5	33.8	43.3	51.5	(:)	23.7			**1997**
42.1	36.9	35.5	36.7	39.6	52.6	:	26.4			**1996**
14.0	:	4.8	8.7	35.8	:	(:)	9.4		**Bad**	**1998**
14.1	:	5.2	8.1	31.6	13.3	(:)	8.4			**1997**
14.3	10.4	5.5	9.0	33.1	13.6	:	9.2			**1996**
2.1	:	1.3	1.4	5.3	:	(:)	2.5		**Very bad**	**1998**
2.0	:	0.6	2.0	6.1	2.9	(:)	3.3			**1997**
3.4	1.1	1.0	2.6	7.0	2.0	:	2.2			**1996**
2.3	:	7.9	4.8	0.2	:	(:)	13.3	**65–74**	**Very good**	**1998**
4.5	:	8.5	4.6	0.1	5.7	(:)	17.0			**1997**
2.9	4.4	8.5	4.7	0.3	3.4	:	16.7			**1996**
26.4	:	47.1	36.7	8.8	:	(:)	45.0		**Good**	**1998**
22.9	:	46.0	42.1	10.3	21.6	(:)	42.3			**1997**
21.9	35.2	43.9	41.5	11.7	18.2	:	36.5			**1996**
41.9	:	39.2	43.7	38.4	:	(:)	28.5		**Fair**	**1998**
44.5	:	38.4	39.0	34.6	53.2	(:)	27.5			**1997**
44.4	49.4	39.8	36.9	35.9	60.0	:	35.8			**1996**
24.8	:	5.1	11.3	40.9	:	(:)	9.8		**Bad**	**1998**
23.7	:	5.8	11.3	44.8	15.3	(:)	10.2			**1997**
25.8	9.7	6.5	14.1	40.8	16.7	:	8.2			**1996**
4.7	:	0.8	3.4	11.8	:	(:)	3.4		**Very bad**	**1998**
4.4	:	1.2	3.1	10.4	4.1	(:)	3.0			**1997**
5.0	1.3	1.4	2.8	11.4	1.7	:	2.8			**1996**
1.9	:	4.2	3.1	:	:	(:)	12.5	**75–84**	**Very good**	**1998**
1.7	:	5.5	2.5	0.4	(0.5)	(:)	11.3			**1997**
2.7	4.7	4.0	2.6	0.0	(2.0)	:	15.2			**1996**
12.6	:	35.7	28.6	10.2	:	(:)	40.1		**Good**	**1998**
15.5	:	33.6	29.9	4.7	(14.0)	(:)	42.9			**1997**
14.1	16.0	33.9	26.1	5.4	(12.3)	:	33.2			**1996**
43.4	:	46.8	39.6	30.3	:	(:)	31.2		**Fair**	**1998**
39.4	:	47.4	38.1	31.0	(57.4)	(:)	29.0			**1997**
42.3	54.8	49.0	41.5	30.3	(52.0)	:	36.2			**1996**
31.6	:	11.5	22.1	43.9	:	(:)	12.2		**Bad**	**1998**
33.6	:	12.1	19.6	48.1	(23.9)	(:)	11.1			**1997**
32.7	22.3	11.2	21.9	49.9	(27.3)	:	11.6			**1996**
10.5	:	1.7	6.5	15.6	:	(:)	4.0		**Very bad**	**1998**
9.8	:	1.4	9.8	15.8	(4.2)	(:)	5.8			**1997**
8.2	2.2	2.0	8.0	14.4	(6.3)	:	3.8			**1996**
:	:	1.2	3.4	0.5	:	:	10.4	**85+**	**Very good**	**1998**
1.3	:	12.2	1.1	:	:	:	9.4			**1997**
2.6	:	4.1	2.3	:	:	:	(9.0)			**1996**
12.9	:	42.3	10.1	4.8	:	:	34.8		**Good**	**1998**
13.2	:	26.4	15.3	2.6	(:)	:	41.1			**1997**
11.1	: u	31.5	12.0	2.6	(:)	:	(33.6)			**1996**
33.9	:	45.1	36.8	32.4	:	:	29.9		**Fair**	**1998**
33.0	:	46.2	48.6	29.7	(:)	:	29.3			**1997**
38.3	: u	47.1	37.7	30.2	(:)	:	(36.2)			**1996**
35.7	:	10.1	35.3	41.8	:	:	17.5		**Bad**	**1998**
39.6	:	11.3	23.8	28.6	(:)	:	11.9			**1997**
34.7	: u	17.0	34.5	39.8	(:)	:	(19.2)			**1996**
17.5	:	1.3	14.5	20.4	:	:	7.4		**Very bad**	**1998**
12.8	:	4.0	11.2	39.2	(:)	:	8.3			**1997**
13.4	: u	0.4	13.5	27.4	(:)	:	(2.0)			**1996**

4.1.4 Self-perceived health by work status

			EU-15	B	DK	D	EL	E	F	IRL
Working	**Very good**	**1998**	19.9	26.2	51.7	9.5	71.9	20.1	11.9	53.9
		1997	21.4	30.0	53.0	9.7	67.6	22.6	15.5	53.7
		1996	24.6	28.9	53.0	15.3	69.5	25.0	16.7	53.3
	Good	**1998**	51.5	57.4	34.2	47.7	19.6	61.8	53.7	36.4
		1997	50.9	53.5	34.2	48.9	24.2	59.2	53.4	35.7
		1996	52.6	54.9	32.6	61.8	22.7	56.0	52.2	36.8
	Fair	**1998**	22.6	14.2	11.8	30.6	6.3	14.6	30.1	8.8
		1997	22.4	14.8	10.7	30.7	6.7	15.1	27.3	9.6
		1996	19.3	14.4	12.1	18.6	6.3	15.1	27.1	9.1
	Bad	**1998**	4.9	1.9	1.7	10.2	2.0	3.1	2.4	0.7
		1997	4.3	1.6	1.7	8.8	1.1	2.8	2.1	0.9
		1996	2.9	1.6	1.9	3.7	1.4	3.5	2.3	0.7
	Very bad	**1998**	1.1	0.2	0.6	2.0	0.2	0.5	1.9	0.3
		1997	1.0	0.1	0.4	2.0	0.3	0.3	1.7	0.1
		1996	0.7	0.3	0.4	0.6	0.2	0.4	1.7	0.1
Inactive	**Very good**	**1998**	11.7	18.0	28.9	6.3	32.8	13.8	6.9	35.0
		1997	12.8	18.4	27.7	6.2	30.9	15.0	8.8	36.2
		1996	14.4	18.0	30.0	8.9	34.4	15.8	10.1	35.7
	Good	**1998**	35.6	43.6	28.4	27.5	24.2	41.0	35.0	33.8
		1997	35.2	42.4	28.3	28.3	25.7	39.1	35.7	34.3
		1996	36.8	44.1	27.4	43.2	25.9	37.4	36.4	33.8
	Fair	**1998**	33.2	29.3	28.5	38.7	25.3	26.0	41.7	25.2
		1997	33.1	29.8	28.4	38.0	26.3	26.6	41.3	21.9
		1996	32.6	28.4	25.9	34.2	24.2	26.9	40.0	23.5
	Bad	**1998**	14.0	7.0	10.3	19.7	13.4	15.6	8.0	5.1
		1997	13.8	7.9	10.7	19.8	12.6	16.5	6.8	6.0
		1996	12.2	8.1	12.4	10.5	11.3	15.9	6.5	5.6
	Very bad	**1998**	5.4	2.1	3.9	7.8	4.3	3.5	8.5	0.9
		1997	5.1	1.6	4.9	7.7	4.5	2.8	7.3	1.5
		1996	4.1	1.5	4.3	3.2	4.2	3.9	6.9	1.5

Note: The surveys in Germany and the UK changed in 1997, therefore data from 1996 cannot be compared with later years.
No data for Sweden.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

4.1.5 Percentage of persons who suffer from chronic conditions by sex

	Year	Total	Men	Women
B	**1997**	27.5	26.8	28.2
DK	**1994**	37.6	35.5	39.6
NL	**1997/98**	34.6	32.1	37.1
E	**1997**	27.7	27.9	27.6
S	**1996/97**	45.4	42.3	48.4
UK	**1996**	40.0	39.8	40.2
NO	**1995**	47.2	47.6	46.9
CH	**1997**	17.0	15.8	18.2

Source: Eurostat (on the basis of national results of HIS for different periods and samples).

(%)

I	L	NL	A	P	FIN	UK			
20.8	:	21.4	40.5	3.9	:	26.2	**Working**	**Very good**	**1998**
21.7	:	22.2	40.8	3.8	21.8	29.0			**1997**
20.6	30.1	22.1	41.3	3.7	23.9	(38.9)			**1996**
53.3	:	61.6	43.9	53.2	:	51.5		**Good**	**1998**
52.3	:	59.6	43.4	53.9	52.6	48.8			**1997**
52.9	50.4	60.1	42.9	56.1	48.9	(43.2)			**1996**
22.5	:	14.4	13.4	32.1	:	17.4		**Fair**	**1998**
22.5	:	15.8	13.0	32.2	22.2	17.5			**1997**
23.0	15.9	15.5	13.1	30.2	24.0	(15.9)			**1996**
3.0	:	2.3	1.8	9.9	:	4.3		**Bad**	**1998**
3.1	:	2.0	2.2	9.1	3.2	3.9			**1997**
3.0	2.7	1.9	2.2	9.1	2.7	(1.8)			**1996**
0.4	:	0.3	0.3	0.9	:	0.6		**Very bad**	**1998**
0.3	:	0.3	0.5	1.0	0.2	0.9			**1997**
0.5	0.9	0.4	0.5	0.9	0.4	(0.2)			**1996**
11.2	:	12.9	19.5	2.5	:	15.9	**Inactive**	**Very good**	**1998**
13.5	:	14.3	18.9	2.6	(14.9)	17.7			**1997**
13.1	16.2	15.4	19.2	3.2	(14.9)	21.2			**1996**
34.9	:	47.2	36.7	27.3	:	45.2		**Good**	**1998**
33.3	:	47.2	38.2	24.8	(29.6)	44.0			**1997**
33.2	38.1	47.3	35.6	26.6	(24.0)	32.8			**1996**
33.4	:	32.9	29.3	29.4	:	26.0		**Fair**	**1998**
33.5	:	30.8	29.3	28.6	(39.5)	25.9			**1997**
33.6	35.4	29.7	29.5	28.0	(42.5)	30.1			**1996**
16.3	:	5.9	11.2	30.9	:	10.1		**Bad**	**1998**
15.8	:	6.8	10.0	32.8	(13.2)	9.0			**1997**
16.1	9.2	6.6	11.9	31.7	(16.4)	12.6			**1996**
4.3	:	1.1	3.3	9.8	:	2.9		**Very bad**	**1998**
3.9	:	1.0	3.6	11.2	(2.7)	3.4			**1997**
3.9	1.1	1.1	3.8	10.4	(2.2)	3.3			**1996**

4.1.6 Children who report a headache/stomach ache/backache at least once a week by age and sex, 1997/98

		B (*)	DK	D (*)	EL	F (*)	IRL	A	P
HEADACHE	**11-year-olds**								
	Boys	17	20	23	16	22	20	17	16
	Girls	25	26	27	23	35	22	23	27
	13-year-olds								
	Boys	16	19	21	21	20	22	19	17
	Girls	28	34	31	34	37	28	30	33
	15-year-olds								
	Boys	13	16	18	23	22	22	16	20
	Girls	27	34	30	44	42	38	36	46
STOMACH ACHE	**11-year-olds**								
	Boys	8	10	20	12	19	13	9	11
	Girls	15	20	25	17	38	19	17	12
	13-year-olds								
	Boys	6	9	12	12	17	13	10	8
	Girls	13	20	24	17	31	17	18	13
	15-year-olds								
	Boys	4	6	8	13	16	12	6	7
	Girls	10	12	19	21	32	14	18	16
BACKACHE	**11-year-olds**								
	Boys	8	14	13	10	15	11	7	19
	Girls	10	15	16	15	25	10	9	26
	13-year-olds								
	Boys	12	21	16	15	22	17	14	24
	Girls	16	21	20	15	32	16	17	29
	15-year-olds								
	Boys	17	26	19	23	26	21	19	23
	Girls	21	27	22	18	38	20	22	30

(*) In Belgium only the Dutch-speaking part, in France only Nancy-Lorraine and Toulouse-Midi-Pyrénées, and in Germany only Nordrhein-Westfalen are covered. Spain, Italy, Luxembourg, and the Netherlands are not covered.

Source: 'Health behaviour in school-aged children', World Health Organisation Europe.

4.2.1 Average height by age and sex, 1996

	EU-15	B	DK	D	EL	E	F	IRL
All ages								
Men	175.2	174.4	178.4	177.0	174.4	171.6	174.6	174.8
Women	164.0	164.0	166.4	165.6	162.8	161.2	163.2	163.4
15–24								
Men	177.6	175.6	181.4	180.2	176.4	173.4	176.4	176.2
Women	165.8	166.6	168.4	167.0	165.4	164.4	164.8	164.8
25–34								
Men	177.2	176.4	180.2	179.4	177.2	175.2	176.6	175.8
Women	165.4	165.4	168.0	167.4	164.4	162.8	164.6	163.0
35–44								
Men	176.6	176.6	180.0	178.4	175.6	172.0	174.8	175.6
Women	164.6	165.4	167.2	166.4	163.0	160.4	163.4	164.0
45–54								
Men	175.6	175.2	176.6	177.4	173.2	171.0	175.2	174.8
Women	163.8	163.0	165.8	166.0	162.2	159.8	162.0	163.2
55–64								
Men	173.2	172.2	177.2	174.2	170.6	168.2	171.8	173.0
Women	163.0	162.0	164.6	164.6	161.0	159.6	162.4	162.0
> 65								
Men	172.0	168.6	174.8	172.6	172.0	167.2	169.6	171.6
Women	161.4	160.6	163.8	162.0	160.2	158.0	160.2	162.2

Source: 1996 Eurobarometer 44.3, European Commission.

(%)

FIN	S	UK				NO	CH		
		England	Scotland	Northern Ireland	Wales				
								HEADACHE	**11-year-olds**
26	26	22	22	25	26	14	21		**Boys**
36	35	27	30	35	34	21	27		**Girls**
									13-year-olds
29	28	21	24	30	24	15	18		**Boys**
42	44	38	37	37	35	28	29		**Girls**
									15-year-olds
26	27	26	26	30	27	18	19		**Boys**
46	53	42	48	45	45	36	36		**Girls**
								STOMACH ACHE	**11-year-olds**
15	21	21	19	28	19	17	13		**Boys**
22	31	28	31	37	32	24	21		**Girls**
									13-year-olds
15	17	15	15	27	14	10	10		**Boys**
23	33	23	27	24	23	22	23		**Girls**
									15-year-olds
10	18	11	13	15	15	11	9		**Boys**
20	31	19	29	21	25	18	22		**Girls**
								BACKACHE	**11-year-olds**
11	11	11	11	12	15	10	8		**Boys**
10	12	11	11	12	16	9	12		**Girls**
									13-year-olds
13	13	13	12	17	17	14	13		**Boys**
14	20	13	16	19	15	19	19		**Girls**
									15-year-olds
18	25	17	17	17	23	17	19		**Boys**
21	25	17	19	25	22	25	23		**Girls**

(cm)

I	L	NL	A	P	FIN	S	UK	
								All ages
173.8	177.0	179.6	177.2	169.4	175.8	178.8	176.4	Men
162.2	165.2	168.0	165.6	160.0	163.4	165.6	162.4	Women
								15–24
176.2	179.0	182.4	178.2	173.8	178.2	179.6	178.2	Men
164.2	166.6	170.6	166.6	163.0	165.0	166.2	163.4	Women
								25–34
175.6	178.0	182.2	179.0	171.2	175.0	181.4	177.0	Men
164.4	166.0	168.6	166.8	161.0	165.4	166.8	162.8	Women
								35–44
174.4	178.8	181.2	179.0	169.4	175.8	179.0	176.6	Men
162.4	164.2	168.8	165.8	160.0	164.2	166.6	162.0	Women
								45–54
173.2	177.2	178.6	176.2	166.6	176.8	179.2	177.2	Men
161.2	166.0	167.2	165.8	157.8	164.2	165.2	162.4	Women
								55–64
171.4	173.6	176.8	175.8	166.4	174.8	176.8	175.0	Men
161.0	164.8	165.6	165.0	159.0	162.2	165.6	162.6	Women
								> 65
170.4	172.6	174.0	172.4	166.0	173.0	176.6	173.4	Men
160.6	163.0	164.0	162.8	157.4	160.6	163.8	161.0	Women

4.2.2 Average weight of Europeans by age and sex, 1996

	EU-15	B	DK	D	EL	E	F	IRL
All ages								
Men	78.8	75.8	79.6	80.0	78.4	75.2	74.8	75.8
Women	65.4	64.2	65.0	65.4	67.0	62.6	61.0	63.8
15–24								
Men	72.8	68.8	76.6	76.2	73.6	71.6	70.4	70.6
Women	60.2	59.2	64.0	61.0	59.4	57.0	56.4	59.4
25–34								
Men	78.6	75.6	80.0	79.8	79.2	78.0	75.4	75.8
Women	63.6	63.2	63.0	63.0	63.2	59.8	61.2	62.6
35–44								
Men	80.4	77.6	80.2	81.4	81.0	77.8	74.6	77.6
Women	64.8	62.8	64.0	65.8	67.2	60.8	61.0	62.8
45–54								
Men	81.6	79.8	81.0	83.2	80.8	76.2	77.6	78.0
Women	67.6	66.4	67.2	67.8	71.4	64.6	61.2	67.2
55–64								
Men	80.2	79.2	81.6	80.0	78.2	74.8	76.0	79.4
Women	69.2	68.6	66.8	70.2	70.8	70.2	65.4	68.6
65+								
Men	77.8	75.8	78.2	78.8	78.0	73.6	74.8	76.2
Women	67.0	66.8	66.0	64.8	71.0	66.6	62.2	66.8

Source: 1996 Eurobarometer 44.3, European Commission.

4.2.3 Average body mass index by sex; distribution in population aged 15 and over, 1996 (*)

	EU-15	B	DK	D	EL	E	F	IRL
BMI <18								
Men	0.8	1.8	0.4	0.4	0.6	0.8	0.6	0.4
Women	2.8	4.4	2.6	1.7	1.8	2.9	4.2	3.0
BMI 18–20								
Men	3.8	5.8	2.6	1.6	3.0	3.7	5.2	4.8
Women	10.6	10.0	14.3	7.8	9.5	10.4	18.8	10.8
BMI 20–27								
Men	65.9	64.0	73.0	62.2	60.2	58.3	69.7	71.4
Women	59.0	60.9	61.3	62.8	51.2	52.5	54.8	66.1
BMI 27–30								
Men	15.9	13.1	13.7	17.1	23.9	18.3	13.6	11.9
Women	10.8	7.9	8.1	11.2	14.7	12.2	9.0	7.9
BMI >30								
Men	8.4	7.8	8.1	8.7	11.0	11.4	6.6	7.3
Women	8.1	8.8	7.3	4.8	14.7	6.6	5.0	7.7
Unknown								
Men	5.1	7.6	2.2	10.0	1.4	7.5	4.4	4.2
Women	8.7	8.0	6.3	11.6	8.1	15.4	8.2	4.5

(*) <18 severely underweight, 18–20 underweight, 27–30 overweight, >30 severely overweight.

Source: 1996 Eurobarometer 44.3, European Commission.

(kg)

I	L	NL	A	P	FIN	S	UK	
								All ages
75.0	79.8	78.4	79.6	72.2	78.4	80.2	79.4	Men
61.2	64.0	68.0	65.6	62.8	65.6	65.2	65.6	Women
								15–24
70.8	73.2	73.4	73.4	69.4	75.0	73.4	74.2	Men
55.8	57.4	66.6	59.0	56.2	59.8	58.6	62.6	Women
								25–34
73.6	77.0	81.0	78.6	71.4	74.8	80.0	79.0	Men
57.0	64.2	66.6	63.4	60.8	63.4	63.4	64.4	Women
								35–44
77.0	79.4	79.6	81.0	75.4	78.6	80.2	81.4	Men
59.6	63.8	67.8	65.0	62.8	63.8	65.0	66.0	Women
								45–54
78.0	84.6	80.4	83.2	74.2	82.8	82.0	82.6	Men
63.6	68.6	68.8	72.4	66.0	68.2	67.8	67.0	Women
								55–64
78.0	84.2	79.6	83.0	72.0	83.8	81.0	80.4	Men
65.0	67.4	69.6	67.2	67.6	71.4	69.2	68.8	Women
								65+
74.6	81.6	76.4	77.8	72.0	78.6	82.8	79.4	Men
66.6	65.4	72.6	69.4	64.4	67.4	67.2	65.8	Women

(kg)

I	L	NL	A	P	FIN	S	UK	
								BMI <18
0.4	1.1	0.8	1.2	1.1	0.4	0.6	1.9	Men
4.2	4.8	2.6	2.5	2.1	3.2	2.2	2.0	Women
								BMI 18–20
4.3	4.9	6.8	2.5	3.2	4.3	4.2	2.6	Men
13.9	15.2	8.6	10.5	8.2	7.6	10.6	8.7	Women
								BMI 20–27
72.1	59.3	73.7	65.8	65.8	66.7	67.3	61.1	Men
56.7	53.2	65.4	60.5	54.6	59.4	65.5	55.3	Women
								BMI 27–30
13.0	17.2	12.8	16.8	13.8	15.9	20.1	16.9	Men
10.6	9.4	11.4	10.8	12.2	12.5	10.8	12.2	Women
								BMI >30
5.8	12.3	4.3	8.0	9.2	10.3	6.6	10.6	Men
6.3	7.7	8.0	7.4	11.3	10.1	6.4	10.9	Women
								Unknown
4.3	5.3	1.6	5.7	6.9	2.4	1.2	6.9	Men
8.3	9.7	4.1	8.3	11.5	7.3	4.6	10.8	Women

4.2.4 Children who report being on, or feeling that they should be on, a diet,1997/98

	B (*)	DK	D (*)	EL	F (*)	IRL	A	P
11-year-olds								
Boys	22	23	26	27	25	20	29	20
Girls	36	29	35	37	35	29	36	30
13-year-olds								
Boys	22	23	28	30	21	26	30	22
Girls	40	42	44	47	47	37	49	39
15-year-olds								
Boys	16	20	22	29	19	20	18	18
Girls	51	47	50	56	52	50	53	44

(*) In Belgium only the Dutch-speaking parts, in France only Nancy-Lorraine and Toulouse-Midi-Pyrénées, and in Germany only Nordrhein-Westfalen are covered. Spain, Italy, Luxembourg and the Netherlands are not covered.

Source: See 2.2.13.

4.3.1 Dental caries: index DMFT (decayed, filled or missing teeth) and percentage affected, by age

	Notes	Year of survey	% with DMFT					% affected by caries			
			5–6 years	12 years	18 years	35–44 years	65–74 years	5–6 years	12 years	18 years	35–44 years
B (Brussels)	**1**	**1998**	:	1.6	:	:	:	:	50.0	:	:
DK	**2**	**1985–2000**	1.3	1.0	4.6	22.9	:	37.0	:	85.0	99.0
D	**3**	**1997**	2.5	1.7	:	16.1	23.6	64.0	58.2	:	99.2
EL	**4**	**1994**	1.5	1.6	:	15.8	:	58.0	:	:	100.0
E	**5**	**1994**	1.0	2.3	:	10.9	25.2	30.0	68.0	:	99.0
F	**6**	**1993**	0.1	1.9	:	14.6	23.3	43.0	61.0	49.4	:
IRL	**7**	**1992**	2.1	2.1	:	19.0	:	58.0	56.0	:	:
I	**8**	**1996**	1.4	2.1	:	9.4	26.3	36.0	63.4	:	94.2
L		**1990**	3.0	:	:	:	:	:	:	:	:
NL	**9**	**1992–93**	1.7	0.9	:	17.4	22.3	45.0	40.0	:	:
A	**10**	**1996**	2.2	1.7	5.5	21.7	27.9	53.0	56.0	84.0	:
P	**11**	**1999**	2.1	1.5	:	10.9	:	47.0	53.0	:	:
FIN	**12**	**1997**	1.4	1.1	:	:	:	44.2	:	:	:
S	**13**	**1999**	:	0.9	3.6	:	:	28.0	39.0	41.1	:
UK	**14**	**1997–98**	1.7	1.1	:	16.6	20.3	42.6	44.0	:	:
IS	**15**	**1996**	3.5	1.5	:		26.2	:	:	:	:
NO	**16**	**1993**	1.4	2.1	6.9	20.5		36.0	64.0	90.0	:
CH		**1988**	2.2	2.0	:	18.8	27.4	53.0	62.0	:	:

Notes:
(1) For 5–7 years.
(2) For 5 years (1994); for 12 years (2000); for 18 years (1992); for 35–44 (1985).
(3) For 5–6 data from 1991–94 East Germany only.
(4) For 5–7 years (1994); for 12 years (Athens, 1993); for 35–44 (1985).
(5) For 6–7 years; for 35–44 (1993); for 65–74 (1989).
(6) For 6 years; for 12 years (1998); for 35–44 only Rhône-Alpes (1994); for 65–74 (1995).
(7) For 5 years; non-fluoridated.
(8) For 5–6 years (1994); for 12 years (1996); for 35–44 years (1995); 65–74 years (some regions, 1993).
(9) For 5 years; for 12 years (1996, only The Hague); for 35–44 and 65–74 years (1986).
(10) For 12 years (1997); 18 years (1998); 35–44 years (1974); 65–74 (1992).
(11) For 35–44 years (1984).
(12) % affected for 6 years (1997); DMFT for 5 years (1991); for 12 years (1997).
(13) For 6 years.
(14) For 5 years; for 35–44 and 65–74 years (1998); for 12 years (1996–97).
(15) For 5–6 years (1989); for 12 years (1996); 65–74 years (1992).
(16) For 5 years; for 35–44 years (1990).

Source: World Health Organisation Oral Health Country/Area Profile Programme (World Health Organisation Collaborating Centre, Malmö University, Sweden).

(%)

FIN	S	UK				NO	CH	
		England	Scotland	Northern Ireland	Wales			
								11-year-olds
26	18	25	23	28	26	20	19	Boys
31	21	31	34	36	37	26	25	Girls
								13-year-olds
24	19	25	26	30	22	22	19	Boys
41	39	39	47	53	50	43	34	Girls
								15-year-olds
16	19	20	22	26	20	21	15	Boys
42	51	49	51	55	53	56	42	Girls

4.3.2 Children who report brushing their teeth more than once a day, 1997/98

	B (*)	DK	D (*)	EL	F (*)	IRL	A	P
11-year-olds								
Boys	33	80	69	42	54	47	58	54
Girls	44	85	82	53	69	61	73	73
13-year-olds								
Boys	35	79	66	36	60	44	55	51
Girls	55	88	79	53	76	67	74	76
15-year-olds								
Boys	42	78	66	35	53	46	61	56
Girls	62	88	82	64	79	74	79	78

(*) In Belgium only the Dutch-speaking parts, in France only Nancy-Lorraine and Toulouse-Midi-Pyrénées, and in Germany only Nordrhein-Westfalen are covered. Spain, Italy, Luxembourg, and the Netherlands are not covered.

Source: 'Health behaviour in school-aged children', World Health Organisation Europe.

4.4.1 Expectation of life at age 16, with and without disability, by sex, 1996

		B	DK	D	EL	E	F	IRL
Expectation of life at age 16								
Total expected years	Men	58.5	57.7	:	60.0	59.1	58.8	57.9
of which:	Women	65.0	62.8	:	65.1	66.3	66.5	63.2
Years without any disability	Men	49.6	47.2	:	51.9	50.0	44.9	49.4
	Women	53.8	46.4	:	54.8	52.8	47.7	51.8
Years with a moderate disability	Men	5.1	7.1	:	4.4	5.5	7.6	6.4
	Women	5.8	11.2	:	5.8	8.7	10.6	8.2
Years with a severe disability	Men	3.8	3.4	:	3.7	3.5	6.4	2.1
	Women	5.4	5.2	:	4.5	4.8	8.3	3.2

Source: Eurostat — Mortality statistics and European Community Household Panel; calculated by Inserm (Euro-REVES).

4.4.3 Hampered in daily activities by any physical or mental health problem, illness or disability, by sex, aged 16 and over

			EU-15	B	DK	D	EL	E	F	IRL
Severely hampered	**Total**	**1998**	9.7	15.3	7.1	10.8	7.6	6.5	11.5	3.3
		1997	9.1	6.0	6.9	9.7	6.7	6.2	10.5	3.9
		1996	7.3	7.1	7.0	7.4	5.8	5.5	10.2	3.7
	Males	**1998**	8.8	12.8	5.5	10.1	7.0	6.1	10.8	3.4
		1997	7.9	4.4	5.3	8.2	6.7	5.9	9.7	3.6
		1996	6.8	6.8	6.0	7.1	6.2	5.1	9.7	3.3
	Females	**1998**	10.6	17.4	8.6	11.5	8.0	6.9	12.1	3.3
		1997	10.2	7.4	8.5	11.0	6.6	6.5	11.2	4.2
		1996	7.7	7.3	8.0	7.7	5.4	5.9	10.7	4.2
To some extent	**Total**	**1998**	16.0	7.1	15.8	29.3	8.7	9.7	13.4	12.7
		1997	15.9	9.1	16.6	29.6	9.3	9.6	12.8	11.8
		1996	12.9	9.9	14.4	15.4	8.0	9.8	13.2	10.9
	Males	**1998**	14.4	6.6	13.8	26.5	7.7	8.6	12.5	11.2
		1997	14.6	8.4	14.6	27.8	7.9	8.2	11.6	11.2
		1996	11.7	9.6	12.0	15.1	8.1	8.4	11.9	9.6
	Females	**1998**	17.4	7.5	17.9	31.9	9.6	10.7	14.3	14.2
		1997	17.1	9.8	18.7	31.3	10.5	10.9	13.8	12.3
		1996	13.9	10.2	16.7	15.8	7.9	11.1	14.4	12.1

Notes: The surveys in Germany and the UK changed in 1997, therefore data from 1996 cannot be compared with later years.
The survey in Belgium changed in 1998, therefore data from 1998 cannot be compared with earlier years.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

(%)

FIN	S	UK				NO	CH	
		England	Scotland	Northern Ireland	Wales			
								11-year-olds
28	82	62	57	55	56	65	78	**Boys**
42	88	76	66	75	71	72	84	**Girls**
								13-year-olds
28	81	60	56	50	56	62	77	**Boys**
50	90	82	73	76	76	74	84	**Girls**
								15-year-olds
31	82	64	56	56	60	64	73	**Boys**
61	92	84	78	84	82	82	89	**Girls**

I	L	NL	A	P	FIN	UK		
							Expectation of life at age 16	
59.6	57.9	59.4	58.6	56.1	57.6	59.0	Total expected years	Men
65.9	64.6	64.9	64.7	63.4	65.0	64.0	**of which:**	Women
51.5	45.4	47.5	46.3	43.9	40.8	45.5	Years without any disability	Men
54.8	48.5	47.6	50.4	46.4	43.7	46.9		Women
5.2	8.1	7.7	8.5	6.7	10.1	9.0	Years with a moderate disability	Men
6.5	11.3	11.0	9.4	9.7	12.8	11.6		Women
3.0	4.4	4.1	3.7	5.5	6.6	4.6	Years with a severe disability	Men
4.6	4.8	6.3	5.0	7.3	8.5	5.5		Women

(%)

I	L	NL	A	P	FIN	UK			
5.1	:	8.0	5.8	10.4	:	14.4	**Severely hampered**	**Total**	**1998**
5.1	:	7.8	6.1	10.9	9.1	15.1			**1997**
4.9	5.6	7.4	5.6	10.3	10.6	(7.6)			**1996**
4.3	:	6.5	4.7	9.2	:	12.9		**Males**	**1998**
4.2	:	6.4	5.2	9.2	8.6	12.9			**1997**
4.2	5.9	6.2	4.7	9.1	9.9	(7.7)			**1996**
5.9	:	9.3	6.9	11.4	:	15.7		**Females**	**1998**
5.9	:	9.1	7.0	12.3	9.5	17.1			**1997**
5.6	5.3	8.6	6.5	11.4	11.1	7.5			**1996**
7.9	:	15.0	11.5	13.5	:	:	**To some extent**	**Total**	**1998**
7.3	:	14.3	12.0	13.5	20.3	:			**1997**
7.9	15.0	14.1	12.3	13.8	19.1	(16.6)			**1996**
7.1	:	13.1	11.0	11.6	:	:		**Males**	**1998**
6.8	:	12.3	11.9	11.8	18.8	:			**1997**
7.2	14.9	12.3	11.9	12.5	17.5	(13.9)			**1996**
8.7	:	16.7	11.9	15.2	:	:		**Females**	**1998**
7.7	:	16.2	12.1	15.1	21.6	:			**1997**
8.6	15.1	15.9	12.7	15.1	20.5	18.9			**1996**

4.4.4 Hampered in daily activities by any physical or mental health problem, illness or disability, by age

			EU-15	B	DK	D	EL	E	F	IRL
Severely hampered	**All ages**	**1998**	9.7	15.3	7.1	10.8	7.6	6.5	11.5	3.3
		1997	9.1	6.0	6.9	9.7	6.7	6.2	10.5	3.9
		1996	7.3	7.1	7.0	7.4	5.8	5.5	10.2	3.7
	16–24	**1998**	1.8	4.3	1.2	1.5	(1.0)	2.2	2.5	1.1
		1997	1.5	0.5	0.6	1.1	(0.9)	2.0	2.1	2.0
		1996	1.6	1.1	1.0	1.8	(0.9)	1.4	1.9	1.0
	25–34	**1998**	2.7	6.5	1.4	2.3	1.2	1.7	2.7	2.2
		1997	2.6	1.3	2.5	2.3	1.1	1.0	2.7	1.0
		1996	2.0	2.0	1.2	1.9	1.1	1.4	3.6	2.0
	35–44	**1998**	4.7	10.7	3.7	4.4	1.7	3.6	4.9	2.1
		1997	4.2	3.1	2.7	3.3	1.9	3.1	5.4	2.8
		1996	3.0	4.3	3.9	1.8	2.1	2.3	5.3	2.6
	45–54	**1998**	8.1	16.5	4.3	8.5	5.1	5.0	9.9	2.8
		1997	8.0	6.2	4.3	8.4	4.7	4.6	9.0	3.3
		1996	5.6	7.1	5.1	5.6	4.6	3.5	8.0	3.2
	55–64	**1998**	13.9	20.1	9.6	17.2	10.7	10.6	16.0	4.9
		1997	13.0	7.7	9.8	15.1	10.3	12.2	13.0	5.3
		1996	10.9	8.4	10.9	11.3	8.1	9.7	13.3	4.5
	65–74	**1998**	17.8	26.6	17.0	16.7	18.2	11.8	25.7	6.6
		1997	16.9	12.7	18.2	16.6	13.4	11.7	22.3	8.6
		1996	13.9	15.4	17.6	12.4	12.5	11.1	22.5	7.7
	75–84	**1998**	(28.5)	35.8	23.2	37.0	20.6	20.9	29.4	9.2
		1997	27.3	16.3	18.7	32.7	22.7	19.5	30.6	13.5
		1996	22.6	21.1	21.2	21.9	17.9	18.9	28.9	14.1
	85+	**1998**	39.1	42.4	27.9	39.2	43.0	26.7	44.7	15.4
		1997	35.9	23.5	39.0	29.7	34.6	24.6	45.9	20.8
		1996	34.0	27.6	35.3	37.2	28.0	27.1	44.2	26.5
To some extent	**All ages**	**1998**	16.0	7.1	15.8	29.3	8.7	9.7	13.4	12.7
		1997	15.9	9.1	16.6	29.6	9.3	9.6	12.8	11.8
		1996	12.9	9.9	14.4	15.4	8.0	9.8	13.2	10.9
	16–24	**1998**	6.1	1.6	6.0	12.2	(0.8)	1.9	6.5	3.6
		1997	5.5	1.3	10.1	10.6	(0.4)	1.9	5.1	5.0
		1996	4.1	2.9	8.4	5.7	(0.5)	1.4	5.2	4.2
	25–34	**1998**	8.0	4.0	10.1	17.6	2.0	2.6	6.0	7.3
		1997	7.6	4.4	11.4	15.2	1.4	3.8	6.5	7.2
		1996	5.7	4.9	9.6	6.6	1.9	2.9	5.6	6.8
	35–44	**1998**	10.7	6.4	14.1	20.6	3.4	5.0	9.6	10.1
		1997	10.5	7.4	14.4	21.4	3.4	5.0	7.3	10.0
		1996	8.8	7.9	11.2	11.2	2.9	4.7	7.9	8.2
	45–54	**1998**	16.1	6.8	15.6	30.3	8.1	9.6	12.6	13.8
		1997	16.0	8.5	14.8	31.2	8.1	8.5	11.5	11.7
		1996	12.0	10.3	12.6	15.8	7.2	8.3	11.3	10.5
	55–64	**1998**	23.0	9.4	22.4	40.0	15.7	18.5	17.5	18.7
		1997	23.1	12.8	21.0	40.7	14.9	16.5	18.5	15.6
		1996	19.6	15.2	21.3	22.7	11.8	18.6	20.2	14.4
	65–74	**1998**	28.5	12.1	25.6	49.5	19.1	22.4	21.9	24.5
		1997	29.2	16.5	30.9	49.3	24.0	20.9	24.6	24.9
		1996	24.4	18.0	27.3	24.9	20.0	23.5	25.8	26.1
	75–84	**1998**	(29.0)	12.5	25.8	41.9	18.1	21.5	30.1	35.9
		1997	30.1	19.2	25.5	45.6	23.4	27.0	27.8	28.3
		1996	25.7	18.9	23.2	24.0	21.7	27.0	31.3	28.2
	85+	**1998**	28.8	19.7	18.5	42.2	13.9	23.8	34.2	24.1
		1997	32.3	19.1	17.3	58.1	21.9	23.4	26.7	22.3
		1996	24.3	9.8	15.1	25.4	23.6	16.2	32.4	16.5

Note: No data available for Sweden.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

(%)

I	L	NL	A	P	FIN	UK			
5.1	:	8.0	5.8	10.4	:	14.4	**Severely hampered**	**All ages**	**1998**
5.1	:	7.8	6.1	10.9	9.1	15.1			**1997**
4.9	5.6	7.4	5.6	10.3	10.6	(7.6)			**1996**
0.7	:	2.1	0.4	2.0	:	2.3		**16–24**	**1998**
0.7	:	2.6	0.4	2.1	1.7	2.3			**1997**
0.9	1.6	3.5	0.6	2.6	1.8	:			**1996**
1.3	:	2.3	1.5	4.8	:	5.3		**25–34**	**1998**
0.8	:	2.7	1.5	5.1	1.3	6.7			**1997**
1.0	1.6	2.7	1.7	4.5	1.3	(1.7)			**1996**
1.5	:	5.5	2.5	6.3	:	8.6		**35–44**	**1998**
1.4	:	5.6	2.2	7.4	2.2	8.4			**1997**
1.0	2.9	5.0	1.2	6.2	2.5	(4.5)			**1996**
2.5	:	8.0	6.0	7.4	:	14.0		**45–54**	**1998**
2.5	:	8.3	5.4	9.5	8.5	15.8			**1997**
2.7	5.5	7.9	5.6	7.9	8.1	(6.9)			**1996**
5.5	:	11.5	6.9	18.9	:	19.2		**55–64**	**1998**
5.7	:	11.8	8.1	14.8	16.9	20.6			**1997**
5.9	8.3	11.3	8.6	16.9	17.9	13.9			**1996**
10.7	:	14.7	10.8	20.0	:	23.8		**65–74**	**1998**
10.4	:	14.5	11.9	20.9	18.3	24.8			**1997**
10.9	10.5	12.9	11.7	19.1	22.4	11.8			**1996**
19.8	:	23.4	22.2	26.5	:	33.9		**75–84**	**1998**
20.9	:	22.3	25.9	28.7	38.7	32.8			**1997**
21.0	18.8	21.8	19.9	29.5	41.7	20.8			**1996**
32.1	:	27.7	42.4	43.9	:	52.4		**85+**	**1998**
32.2	:	18.4	37.5	47.8	(64.5)	50.1			**1997**
28.5	:	24.1	36.2	45.5	59.7	(29.8)			**1996**
7.9	:	15.0	11.5	13.5	:	:	**To some extent**	**All ages**	**1998**
7.3	:	14.3	12.0	13.5	20.3	:			**1997**
7.9	15.0	14.1	12.3	13.8	19.1	(16.6)			**1996**
1.8	:	9.0	1.5	3.9	:	:		**16–24**	**1998**
2.1	:	7.4	2.6	3.6	8.2	:			**1997**
1.5	8.3	7.8	2.4	4.9	9.9	:			**1996**
2.0	:	9.4	4.3	6.4	:	:		**25–34**	**1998**
2.0	:	7.9	4.2	6.2	10.6	:			**1997**
2.0	7.6	8.1	3.5	5.2	9.8	(9.9)			**1996**
4.2	:	12.6	6.5	6.7	:	:		**35–44**	**1998**
3.5	:	12.5	6.1	7.5	15.7	:			**1997**
3.7	9.9	12.5	8.0	9.3	13.7	(13.7)			**1996**
7.5	:	15.1	14.1	14.2	:	:		**45–54**	**1998**
6.9	:	15.6	15.2	14.9	20.7	:			**1997**
7.1	16.4	14.5	14.3	13.4	20.1	(13.9)			**1996**
12.3	:	21.0	18.8	23.4	:	:		**55–64**	**1998**
10.2	:	21.2	20.7	24.0	37.1	:			**1997**
13.1	21.7	21.4	21.8	24.3	32.2	21.3			**1996**
16.5	:	22.5	24.9	28.2	:	:		**65–74**	**1998**
16.0	:	22.4	24.6	26.5	35.5	:			**1997**
16.3	30.4	22.9	24.8	28.5	32.5	32.3			**1996**
20.6	:	24.7	24.9	30.9	:	:		**75–84**	**1998**
18.8	:	23.7	24.9	27.3	32.8	:			**1997**
22.5	24.7	24.7	26.8	27.7	26.1	26.7			**1996**
17.9	:	25.7	24.1	9.1	:	:		**85+**	**1998**
17.1	:	34.5	28.6	11.2	(23.8)	:			**1997**
19.9	:	21.9	28.0	15.0	23.6	(30.8)			**1996**

4.4.5 Distribution of the population (16–64) with severe, moderate and no disability according to education levels (highest level completed), 1996

	EU-14	B	DK	D	EL	E	F	IRL
Severe disability								
3rd level	9	14	14	14	8	5	8	3
2nd level	30	28	24	49	15	5	29	20
< 2nd level	58	56	60	36	75	90	58	76
At school or n/a	3	3	2	1	1	-	5	1
Moderate disability								
3rd level	14	25	25	18	9	5	14	6
2nd level	35	23	32	50	25	8	30	30
< 2nd level	48	44	41	31	66	87	49	62
At school or n/a	3	8	2	1	0	-	8	3
No disability								
3rd level	18	25	32	20	20	18	20	13
2nd level	38	27	39	50	31	24	34	34
< 2nd level	41	33	27	28	46	58	32	45
At school or n/a	4	14	3	2	3	-	13	8

Definition of the educational classes:
At school or n/a: at school or not applicable.
3rd level: recognised third level of education (ISCED 5–7).
2nd level: second stage of secondary education (ISCED 3).
< 2nd level: less than second stage of secondary education (ISCED–2).

Source: European Community Household Panel, Eurostat; with the cooperation of Réseau sur l'espérance de vie en santé (REVES).

4.4.6 Hampered in daily activities by any physical or mental health problem, illness or disability, by education, aged 16 and over

			EU	B	DK	D	EL	E	F	IRL
Severely hampered	**< 2nd level**	**1998**	12.5	23.0	15.4	12.3	11.8	9.7	10.7	5.0
		1997	12.3	9.1	11.7	11.3	9.7	8.5	17.2	5.5
		1996	10.6	10.9	11.7	11.1	8.5	7.6	16.4	5.8
	2nd level	**1998**	(6.3)	12.7	3.7	10.9	2.1	1.1	2.5	1.5
		1997	(6.7)	5.3	4.7	10.7	3.5	1.3	7.5	1.8
		1996	4.5	6.8	5.0	6.0	2.8	1.1	7.0	1.8
	3rd level	**1998**	(4.4)	9.2	2.7	8.0	1.3	1.0	2.7	1.0
		1997	(4.6)	2.7	4.3	6.6	1.6	1.6	3.9	1.7
		1996	3.3	3.5	4.0	5.1	1.9	1.4	3.9	0.7
To some extent	**< 2nd level**	**1998**	18.0	7.3	21.8	30.9	12.3	13.4	14.4	17.8
		1997	19.0	12.9	21.3	32.3	13.5	12.7	18.6	15.2
		1996	15.8	12.8	20.3	16.5	11.1	13.1	19.2	13.9
	2nd level	**1998**	(12.0)	6.9	15.2	29.2	3.3	4.1	6.3	7.2
		1997	(13.7)	8.2	15.5	30.6	4.6	3.5	10.2	9.2
		1996	9.9	9.2	11.6	15.3	5.0	2.7	10.0	8.9
	3rd level	**1998**	(11.6)	5.3	9.3	27.0	4.4	2.6	9.9	6.8
		1997	(11.7)	7.0	12.8	27.1	2.7	3.0	7.4	4.6
		1996	9.0	8.9	10.6	14.2	3.5	2.8	8.1	5.4

Definition of the educational classes:
3rd level: recognised third level of education (ISCED 5–7).
2nd level: second stage of secondary education (ISCED 3).
< 2nd level: less than second stage of secondary education (ISCED 0–2).

Notes: No data available for Sweden; the survey in Belgium changed in 1998, therefore data from 1998 cannot be compared with earlier years; the surveys in Germany and the UK changed in 1997, therefore data from 1996 cannot be compared with later years.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

(%)

I	L	NL	A	P	FIN	UK	
							Severe disability
2	11	10	2	1	7	11	3rd level
12	12	50	51	4	35	29	2nd level
69	73	40	46	96	57	60	< 2nd level
16	4	-	1	-	-	-	At school or n/a
							Moderate disability
3	10	13	6	2	22	18	3rd level
17	25	53	59	7	37	35	2nd level
71	61	32	35	91	41	47	< 2nd level
9	4	2	-	-	-	-	At school or n/a
							No disability
7	16	18	7	6	31	25	3rd level
35	28	54	65	15	41	37	2nd level
57	49	25	28	78	28	38	< 2nd level
2	7	3	1	1	-	0	At school or n/a

(%)

I	L	NL	A	P	FIN	UK			
7.6	:	8.1	9.8	12.5	:	21.9	**Severely hampered**	**< 2nd level**	**1998**
5.6	:	11.0	10.6	12.4	15.4	20.5			**1997**
5.3	7.7	11.1	9.4	12.1	18.4	(11.1)			**1996**
1.1	:	1.6	3.9	2.4	:	15.1		**2nd level**	**1998**
1.2	:	7.0	4.0	3.3	6.2	12.2			**1997**
1.2	2.7	6.4	3.7	2.7	7.4	(5.5)			**1996**
0.6	:	2.3	2.8	2.5	:	8.3		**3rd level**	**1998**
1.1	:	5.1	2.5	2.9	2.9	9.6			**1997**
2.1	3.0	4.7	2.5	1.5	2.8	(2.9)			**1996**
10.3	:	15.2	14.2	15.9	:	:	**To some extent**	**< 2nd level**	**1998**
7.6	:	17.1	14.9	15.5	25.5	:			**1997**
8.9	17.8	17.0	16.9	15.5	24.0	(20.1)			**1996**
4.3	:	5.8	10.5	4.2	:	:		**2nd level**	**1998**
4.1	:	14.1	10.9	5.2	17.6	:			**1997**
3.7	13.8	13.7	10.1	6.5	17.0	(13.4)			**1996**
3.0	:	9.0	6.7	4.7	:	:		**3rd level**	**1998**
4.4	:	10.3	7.1	3.3	16.3	:			**1997**
3.7	8.7	10.3	8.8	5.7	14.4	(12.9)			**1996**

4.4.7 People aged 16–64 with severe, moderate or no disability who are in work, by sex, 1996

(%)

	EU-14	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	UK
Severe															
Men	27.9	20.4	15.0	30.3	15.9	16.6	45.4	15.2	18.8	35.6	36.0	31.9	34.7	23.0	16.6
Women	20.5	15.9	19.2	21.5	17.5	9.0	28.5	11.8	12.2	20.8	19.5	25.3	27.7	19.9	18.2
Total	24.3	18.3	17.1	26.4	16.7	13.1	36.8	13.7	15.3	28.7	26.1	28.4	30.7	21.6	17.4
Moderate															
Men	57.6	54.2	62.3	67.3	54.2	40.2	59.0	38.7	40.5	49.5	57.1	54.5	64.1	50.8	57.7
Women	36.7	22.6	45.0	41.4	23.8	18.9	43.1	16.6	19.4	29.5	33.8	41.7	44.3	49.1	39.1
Total	46.2	36.9	52.0	53.8	36.3	28.7	50.5	27.1	29.6	40.2	44.0	48.6	52.9	49.8	46.6
No disability															
Men	75.1	69.2	81.7	81.4	77.6	66.6	73.2	72.2	65.4	78.6	78.8	81.5	80.0	65.5	84.3
Women	49.3	44.5	70.5	57.7	39.2	32.7	55.1	42.4	33.0	46.4	45.5	58.1	59.0	56.6	60.7
Total	61.9	56.3	76.3	69.3	57.8	49.5	64.0	57.2	49.0	62.4	62.4	69.6	69.2	61.1	71.6

Source: European Community Household Panel, Eurostat; with the cooperation of Réseau sur l'espérance de vie en santé (REVES).

4.4.8 Hampered in daily activities by any physical or mental health problem, illness or disability, by work status

			EU-15	B	DK	D	EL	E	F	IRL
Working	**Severely hampered**	**1998**	3.5	8.1	1.5	4.8	1.8	1.5	4.2	1.1
		1997	3.1	1.8	1.7	3.7	1.0	1.5	3.9	1.1
		1996	2.3	2.5	1.4	2.8	1.0	1.0	4.1	1.0
	To some extent	**1998**	11.2	4.4	12.4	23.6	4.0	4.6	9.1	6.8
		1997	11.0	5.0	11.7	23.3	4.1	3.9	8.7	6.4
		1996	8.1	6.6	10.1	11.7	3.4	4.2	8.3	5.5
Inactive	**Severely hampered**	**1998**	16.7	23.1	17.0	18.4	14.2	11.5	21.9	6.3
		1997	15.8	10.4	16.7	17.1	12.4	10.8	20.0	7.4
		1996	13.5	11.9	17.1	13.4	10.9	10.1	18.1	7.3
	To some extent	**1998**	21.7	10.0	22.1	36.9	14.1	14.7	19.5	20.5
		1997	21.9	13.5	26.0	38.0	14.7	15.2	18.5	18.6
		1996	18.8	13.6	22.0	20.3	13.0	15.4	19.7	17.7

Note: No data available for Sweden.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

4.4.9 Probability of having an income and earned income for those with severe, moderate or no disability of working age (16–64 years), 1996

(%)

	EU-14	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	UK
Having an income															
Severe	92	95	99	95	82	82	94	95	77	90	85	94	86	99	97
Moderate	90	90	98	93	79	74	92	95	78	88	85	95	82	97	98
No	85	88	99	94	71	67	93	91	66	85	84	90	76	97	98
Having an earned income															
Severe	26	20	21	29	22	13	36	17	18	38	29	34	28	22	22
Moderate	49	36	53	58	37	27	56	31	29	43	44	50	47	51	50
No	64	57	79	71	53	52	68	59	49	64	66	68	64	66	76

Source: European Community Household Panel, Eurostat; with the cooperation of Réseau sur l'espérance de vie en santé (REVES).

(%)

I	L	NL	A	P	FIN	UK			
1.0	:	4.0	1.9	4.2	:	4.8	**Working**	**Severely hampered**	**1998**
1.0	:	3.7	1.4	3.8	2.8	5.5			**1997**
1.0	2.3	3.9	1.6	3.8	3.0	(1.6)			**1996**
3.7	:	11.4	6.9	10.1	:	:		**To some extent**	**1998**
3.6	:	10.7	7.3	9.7	14.9	:			**1997**
3.5	9.8	11.0	7.4	9.9	15.2	(9.3)			**1996**
8.9	:	13.3	11.4	20.5	:	21.7	**Inactive**	**Severely hampered**	**1998**
8.6	:	13.1	12.6	21.6	17.9	22.4			**1997**
8.5	9.0	12.1	11.4	20.2	22.6	15.9			**1996**
11.8	:	19.6	17.9	18.7	:	:		**To some extent**	**1998**
10.5	:	19.1	18.4	19.4	27.9	:			**1997**
11.8	20.2	18.3	19.3	19.8	25.3	26.5			**1996**

4.4.10 Cutdown in activities over the past two weeks because of health problems, by sex

			EU-15	B	DK	D	EL	E	F	IRL
Illness or injury	**Total**	**1998**	:	11.8	20.7	:	4.6	9.8	:	7.6
		1997	:	9.0	17.7	:	6.6	10.4	6.9	8.6
		1996	11.1	10.1	18.2	15.0	5.8	9.3	7.8	8.7
	Males	**1998**	:	9.5	18.4	:	3.8	8.3	:	6.7
		1997	:	7.1	15.3	:	5.6	8.8	6.1	7.8
		1996	10.0	9.1	14.5	14.0	5.8	7.8	6.9	6.9
	Females	**1998**	:	13.8	23.0	:	5.2	11.2	:	8.5
		1997	:	10.6	20.1	:	7.4	11.8	7.8	9.3
		1996	12.1	11.0	21.8	15.8	5.7	10.8	8.5	10.5
Emotional or mental problem	**Total**	**1998**	:	3.7	3.8	:	1.3	2.3	:	2.0
		1997	:	3.1	4.0	:	1.1	1.7	1.3	2.0
		1996	2.3	3.3	3.8	3.0	0.8	1.8	1.5	2.0
	Males	**1998**	:	2.6	2.7	:	1.0	2.3	:	1.5
		1997	:	2.3	2.7	:	0.9	0.9	0.8	1.4
		1996	1.7	2.0	3.4	2.4	0.9	1.2	0.9	1.8
	Females	**1998**	:	4.8	4.9	:	1.5	2.4	:	2.6
		1997	:	3.8	5.3	:	1.3	2.4	1.8	2.5
		1996	2.8	4.5	4.2	3.5	0.7	2.4	2.0	2.2

Note: No data available for Sweden.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

(%)

I	L	NL	A	P	FIN	UK			
4.6	:	14.0	11.7	12.3	:	:	**Illness or injury**	**Total**	**1998**
3.9	:	14.5	12.5	12.2	22.1	:			**1997**
3.7	11.4	15.8	12.6	11.7	21.4	(15.8)			**1996**
4.2	:	11.4	10.2	11.0	:	:		**Males**	**1998**
3.3	:	11.4	10.8	10.6	20.0	:			**1997**
3.4	9.8	13.9	11.1	10.5	19.2	(14.1)			**1996**
4.9	:	16.5	13.0	13.5	:	:		**Females**	**1998**
4.5	:	17.5	14.0	13.6	24.1	:			**1997**
3.9	12.9	17.6	14.0	12.9	23.5	17.3			**1996**
0.8	:	5.0	2.9	4.2	:	:	**Emotional or mental problem**	**Total**	**1998**
0.9	:	5.1	2.7	3.5	2.3	:			**1997**
0.8	3.4	5.5	2.8	3.5	2.9	(2.7)			**1996**
0.5	:	3.5	2.4	4.0	:	:		**Males**	**1998**
0.7	:	3.0	2.3	3.1	1.9	:			**1997**
0.6	2.4	3.9	2.0	2.9	2.4	(1.8)			**1996**
1.2	:	6.4	3.4	4.4	:	:		**Females**	**1998**
1.1	:	7.1	3.1	3.8	2.8	:			**1997**
0.9	4.3	7.0	3.6	4.1	3.3	3.5			**1996**

4.4.11 Cutdown in activities over the past two weeks because of health problems, by age

			EU-15	B	DK	D	EL	E	F	IRL
Illness or injury	**16–24**	**1998**	:	8.4	20.3	:	(0.7)	6.5	:	4.8
		1997	:	4.5	20.6	:	(1.8)	6.7	2.9	5.0
		1996	5.5	6.1	16.0	8.8	(1.3)	3.8	3.5	5.1
	25–34	**1998**	:	8.2	19.1	:	1.7	6.7	:	4.8
		1997	:	6.6	13.2	:	1.4	5.9	4.4	7.9
		1996	7.2	6.1	17.9	9.9	1.2	6.1	4.5	8.1
	35–44	**1998**	:	9.8	19.8	:	1.9	7.5	:	5.9
		1997	:	6.6	14.4	:	1.9	7.4	4.2	8.3
		1996	7.8	7.9	13.7	9.9	2.0	7.1	4.7	7.4
	45–54	**1998**	:	12.7	16.3	:	2.7	9.2	:	6.8
		1997	:	9.7	13.7	:	4.2	10.3	5.0	8.2
		1996	9.6	9.8	14.4	12.3	4.8	6.5	6.7	7.8
	55–64	**1998**	:	13.7	17.0	:	5.9	11.0	:	10.4
		1997	:	8.0	19.4	:	8.8	15.6	8.2	8.5
		1996	14.1	12.5	19.2	18.3	6.5	13.5	9.2	10.5
	65–74	**1998**	:	15.3	28.6	:	9.7	14.6	:	13.9
		1997	(13.8)	15.6	24.8	:	14.3	16.3	13.0	12.5
		1996	16.7	15.7	26.4	22.7	13.2	17.0	13.4	12.4
	75–84	**1998**	:	17.2	32.6	:	11.8	19.5	:	18.1
		1997	(18.3)	16.5	26.3	:	23.5	18.7	17.4	17.8
		1996	22.7	20.3	32.0	28.0	19.0	21.1	20.7	20.3
	85+	**1998**	(23.3)	35.1	30.4	:	27.8	26.8	:	15.4
		1997	(21.7)	15.4	42.6	:	26.9	21.3	20.1	18.2
		1996	27.0	22.5	26.3	35.7	29.5	22.3	22.9	22.2
Emotional or mental problem	**16–24**	**1998**	:	1.3	1.9	:	(0.5)	2.0	:	1.4
		1997	:	2.2	3.7	:	(0.6)	0.5	0.2	0.9
		1996	0.9	1.4	1.6	1.2	(0.4)	0.6	0.5	0.7
	25–34	**1998**	:	2.4	1.3	:	0.7	2.1	:	1.2
		1997	:	1.7	2.4	:	0.9	0.6	1.0	1.6
		1996	1.7	1.8	3.0	2.4	0.5	0.9	0.9	1.6
	35–44	**1998**	:	3.4	3.0	:	1.1	2.0	:	1.3
		1997	:	3.0	3.6	:	1.0	1.7	0.8	1.2
		1996	1.7	3.0	2.6	1.6	0.4	1.3	1.2	1.7
	45–54	**1998**	:	6.1	3.4	:	0.9	2.5	:	2.6
		1997	:	3.0	3.3	:	0.8	1.9	1.2	2.5
		1996	2.5	4.5	4.4	3.3	0.6	2.0	1.8	2.5
	55–64	**1998**	:	5.2	5.4	:	1.8	2.0	:	3.3
		1997	:	4.0	3.8	:	1.4	2.1	1.4	3.1
		1996	2.7	3.5	5.5	3.0	1.0	2.5	1.8	3.6
	65–74	**1998**	:	3.6	7.1	:	2.2	2.4	:	3.1
		1997	(2.7)	4.8	7.0	:	1.7	2.7	2.1	2.4
		1996	2.9	5.0	6.8	3.8	1.2	2.1	2.6	2.1
	75–84	**1998**	:	4.9	7.9	:	1.5	3.2	:	4.0
		1997	(3.6)	3.7	7.1	:	2.1	3.4	3.0	5.4
		1996	4.7	6.3	5.5	6.4	2.3	5.4	3.1	4.5
	85+	**1998**	(7.3)	3.4	7.5	:	4.8	8.0	:	3.0
		1997	(6.1)	3.0	9.1	:	2.0	8.0	6.3	5.9
		1996	5.2	2.6	1.5	8.3	3.4	6.4	2.5	6.6

Note: No data available for Sweden.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

(%)

I	L	NL	A	P	FIN	UK			
2.8	:	10.3	4.2	1.4	:	:	**Illness or injury**	**16–24**	**1998**
1.6	:	11.0	6.3	2.6	16.2	:			**1997**
1.5	3.6	11.8	7.4	2.8	12.2	:			**1996**
3.2	:	11.3	6.7	4.5	:	:		**25–34**	**1998**
2.4	:	11.7	7.4	4.5	13.8	:			**1997**
2.3	5.1	13.2	6.6	4.4	13.6	(10.2)			**1996**
3.6	:	11.3	8.1	6.1	:	:		**35–44**	**1998**
2.4	:	13.2	8.2	7.1	16.0	:			**1997**
2.0	8.1	15.0	8.0	9.6	15.3	(12.0)			**1996**
4.6	:	14.3	11.5	11.4	:	:		**45–54**	**1998**
3.3	:	13.8	12.2	12.1	19.6	:			**1997**
3.1	10.7	16.3	14.6	10.7	17.8	(14.4)			**1996**
4.3	:	16.9	14.6	22.5	:	:		**55–64**	**1998**
4.6	:	17.9	15.5	20.7	31.0	:			**1997**
4.7	16.2	18.3	15.1	17.9	29.7	21.4			**1996**
5.9	:	17.6	21.5	26.0	:	:		**65–74**	**1998**
6.0	:	18.1	20.3	24.2	34.3	:			**1997**
5.7	22.4	18.7	21.1	23.1	33.8	18.9			**1996**
9.6	:	24.0	25.5	34.6	:	:		**75–84**	**1998**
9.7	:	24.9	33.0	28.3	50.0	:			**1997**
10.0	30.8	25.2	27.8	27.7	43.9	27.4			**1996**
13.1	:	25.1	39.3	36.5	:	:		**85+**	**1998**
13.1	:	23.8	31.9	41.7	(62.9)	:			**1997**
12.1	:	22.3	39.6	39.0	70.5	(31.6)			**1996**
0.2	:	2.8	0.5	3.9	:	:	**Emotional or mental problem**	**16–24**	**1998**
0.4	:	2.0	0.4	1.9	1.2	:			**1997**
0.1	1.1	3.4	0.9	2.6	1.5	:			**1996**
0.2	:	4.5	1.5	6.2	:	:		**25–34**	**1998**
0.5	:	4.6	1.4	4.2	1.1	:			**1997**
0.3	1.5	4.4	1.3	3.8	1.4	(2.8)			**1996**
1.1	:	4.5	1.2	3.4	:	:		**35–44**	**1998**
0.7	:	4.8	1.2	4.4	1.8	:			**1997**
0.5	2.0	5.0	1.1	2.8	3.1	(2.9)			**1996**
0.6	:	4.9	2.8	3.3	:	:		**45–54**	**1998**
0.6	:	4.8	2.9	2.6	3.4	:			**1997**
0.4	1.7	5.5	3.7	3.5	3.7	(3.2)			**1996**
0.3	:	6.2	3.5	3.4	:	:		**55–64**	**1998**
0.8	:	7.8	3.8	3.7	4.2	:			**1997**
0.8	3.4	7.3	3.8	4.3	4.1	3.5			**1996**
1.6	:	6.1	4.5	4.6	:	:		**65–74**	**1998**
1.3	:	6.0	4.5	4.0	2.9	:			**1997**
1.3	9.8	7.0	4.9	4.4	2.4	2.2			**1996**
1.3	:	8.4	7.8	3.8	:	:		**75–84**	**1998**
2.5	:	8.5	7.9	3.9	2.1	:			**1997**
3.4	11.4	9.3	8.3	4.0	5.1	3.0			**1996**
6.4	:	3.0	25.5	9.2	:	:		**85+**	**1998**
5.4	:	5.5	14.5	3.2	(2.7)	:			**1997**
4.4	:	6.1	10.4	1.8	1.6	(4.2)			**1996**

4.4.12 Cutdown in activities over the past two weeks because of health problems, by education

			EU-15	B	D	F	EL	E	F	IRL
< 2nd level	Illness or injury	1998	(10.3)	15.9	26.1	:	6.6	12.1	:	9.6
		1997	(10.3)	10.4	20.7	:	9.8	12.4	9.5	9.8
		1996	13.5	12.7	22.7	18.3	8.6	11.1	10.7	10.0
	Emotional or mental problem	1998	(2.8)	5.4	6.4	:	1.8	2.8	:	3.2
		1997	(2.4)	3.3	5.1	:	1.6	2.2	2.0	2.9
		1996	2.8	3.9	5.2	3.7	1.2	2.2	2.1	2.9
2nd level	Illness or injury	1998	:	9.7	18.7	:	1.5	5.1	:	5.5
		1997	:	9.6	15.2	:	2.4	6.6	6.1	7.3
		1996	9.3	9.4	16.9	14.2	2.3	5.1	6.2	8.1
	Emotional or mental problem	1998	:	2.7	2.7	:	0.6	1.9	:	1.0
		1997	:	3.4	3.3	:	0.7	0.6	0.9	0.9
		1996	1.9	3.7	3.5	2.6	0.4	1.0	1.4	1.2
3rd level	Illness or injury	1998	:	8.9	18.0	:	2.3	6.7	:	6.2
		1997	:	7.1	15.9	:	2.2	5.9	4.4	7.0
		1996	8.0	8.7	15.0	11.3	1.9	6.5	4.7	6.5
	Emotional or mental problem	1998	:	2.7	2.4	:	0.6	1.0	:	0.5
		1997	:	2.5	3.7	:	0.5	0.7	1.1	1.2
		1996	1.7	2.0	2.5	3.0	0.2	1.0	0.7	1.3

Definition of the educational classes:
3rd level: recognised third level of education (ISCED 5–7).
2nd level: second stage of secondary education (ISCED 3).
< 2nd level: less than second stage of secondary education (ISCED 0–2).

Note: No data available for Sweden.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

4.4.13 Cutdown in activities over the past two weeks because of health problems, by work status

			EU-15	B	DK	D	EL	E	F	IRL
Working	Illness or injury	1998	:	8.8	17.8	:	1.9	6.9	:	5.0
		1997	(5.5)	6.3	12.7	:	2.4	6.8	4.1	6.3
		1996	7.4	7.3	13.9	10.5	1.7	6.0	5.0	5.5
	Emotional or mental problem	1998	:	2.9	1.5	:	0.6	1.2	:	0.4
		1997	(1.0)	2.0	2.1	:	0.3	0.5	0.7	0.6
		1996	1.3	2.0	2.0	2.0	0.2	0.7	1.0	1.0
Inactive	Illness or injury	1998	:	15.1	25.9	:	7.6	12.6	:	11.1
		1997	(12.0)	11.9	27.0	:	10.9	13.9	11.1	11.4
		1996	15.9	13.2	26.0	20.7	10.1	12.7	11.4	12.8
	Emotional or mental problem	1998	:	4.7	8.0	:	2.1	3.4	:	4.2
		1997	(2.9)	4.2	7.6	:	1.9	2.8	2.2	3.7
		1996	3.5	4.7	7.1	4.2	1.4	2.8	2.2	3.4

Note: No data available for Sweden.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

(%)

I	L	NL	A	P	FIN	UK			
5.1	:	14.0	15.0	14.6	:	:	< 2nd level	Illness or injury	1998
4.2	:	17.6	15.6	14.1	28.6	:			1997
4.2	14.1	18.3	16.7	13.2	28.3	(18.2)			1996
1.2	:	5.0	4.0	4.7	:	:		Emotional or mental problem	1998
1.0	:	6.3	4.4	3.6	3.3	:			1997
0.7	4.1	7.1	4.0	3.9	4.2	(2.9)			1996
3.9	:	15.2	10.1	3.8	:	:	2nd level	Illness or injury	1998
2.4	:	14.1	11.0	3.4	19.6	:			1997
2.2	9.1	15.8	10.6	4.6	17.5	(14.6)			1996
0.2	:	5.5	2.4	3.0	:	:		Emotional or mental problem	1998
0.3	:	4.8	1.9	2.3	1.9	:			1997
0.3	2.0	5.2	2.2	1.5	1.9	(2.6)			1996
2.7	:	10.2	8.6	3.6	:	:	3rd level	Illness or injury	1998
2.7	:	10.9	10.2	3.3	16.0	:			1997
2.0	5.8	11.6	11.1	6.7	16.4	(12.3)			1996
0.0	:	4.5	1.7	2.2	:	:		Emotional or mental problem	1998
0.4	:	4.1	1.7	3.1	1.4	:			1997
0.3	1.3	3.3	2.5	1.5	2.2	(2.5)			1996

(%)

I	L	NL	A	P	FIN	UK			
3.8	:	11.4	7.4	6.6	:	:	Working	Illness or injury	1998
2.7	:	11.5	8.2	6.8	14.9	:			1997
2.6	6.1	13.4	8.4	7.1	14.9	(9.1)			1996
0.2	:	4.0	1.1	3.6	:	:		Emotional or mental problem	1998
0.3	:	3.9	1.2	2.5	1.6	:			1997
0.2	1.8	4.1	1.4	2.3	1.8	(1.3)			1996
5.2	:	17.7	17.6	21.5	:	:		Illness or injury	1998
4.9	:	18.9	18.4	20.4	32.4	:	Inactive		1997
4.6	16.8	19.3	18.6	18.7	31.9	25.1			1996
1.5	:	6.3	5.5	5.3	:	:		Emotional or mental problem	1998
1.4	:	7.0	4.8	5.0	3.4	:			1997
1.3	4.9	7.3	4.9	5.2	4.6	4.7			1996

4.5.1 Responses to 'Do you regularly feel stressed?', by sex, 1999

		EU-15	B	DK	D	EL	E	F	IRL
Male	Yes	35.3	41.1	27.7	32.0	68.6	31.3	37.6	38.3
	No	61.7	57.6	69.6	62.9	31.0	66.9	61.0	58.5
	Don't know	3.0	1.3	2.4	5.1	0.4	1.8	1.4	3.2
Female	Yes	40.5	51.9	35.2	31.8	74.4	37.5	50.2	32.2
	No	56.5	46.2	63.0	63.1	25.0	60.1	48.5	63.9
	Don't know	3.0	1.9	1.8	5.2	0.6	2.4	1.3	3.9
Total	Yes	38.0	46.7	31.5	31.9	71.6	34.5	44.2	35.2
	No	51.8	45.1	58.7	52.8	25.0	54.6	45.2	55.4
	Don't know	3.0	1.6	2.1	5.1	0.5	2.1	1.3	3.6

Source: Eurobarometer 52.1, European Commission.

4.5.2 Responses to 'Do you regularly feel stressed?', by age, 1999

		EU-15	B	DK	D	EL	E	F	IRL
16–24	Yes	40.7	49.5	36.1	47.1	67.2	29.0	39.8	30.3
	No	56.4	48.7	62.0	49.3	32.7	68.8	58.0	66.2
	Don't know	2.8	1.8	1.9	3.6	0.2	2.2	2.1	3.5
25–39	Yes	46.8	57.4	43.3	42.8	76.0	44.6	49.2	40.1
	No	50.7	39.9	55.9	52.1	23.3	53.6	50.2	56.3
	Don't know	2.5	2.6	0.8	5.1	0.7	1.8	0.6	3.7
40–54	Yes	44.2	54.2	37.8	39.9	74.4	42.8	52.5	41.3
	No	51.8	45.1	58.7	52.8	25.0	54.6	45.2	55.4
	Don't know	3.9	0.8	3.5	7.3	0.6	2.6	2.3	3.3
55+	Yes	24.4	30.7	13.0	11.2	68.6	22.7	35.7	29.7
	No	72.8	68.1	84.7	84.5	31.0	75.2	63.4	66.6
	Don't know	2.8	1.2	2.2	4.2	0.4	2.0	0.9	3.7

Source: Eurobarometer 52.1, European Commission.

4.5.3 Dissatisfaction with various aspects of life, 1997

(%)

	EU-15	B	DK	EL	E	F	IRL (*)	I	NL	A	P	FIN (*)	UK
Dissatisfaction with financial situation	47	32	21	70	58	45	45	62	22	28	71	39	33
Dissatisfaction with amount of leisure time	32	27	20	45	37	24	22	41	22	18	33	21	:
Dissatisfaction with work or main activity	28	20	11	51	33	19	22	47	11	11	37	19	:
Dissatisfaction with housing situation	20	12	11	38	22	11	14	29	8	9	31	15	:

(*) Low reliability (20–49 observations, or 10–20 % missing observations).
Note: No data available for Germany, Luxembourg and Sweden.

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

4.6.1 Frequency of meeting people at home/elsewhere in 1997

(%)

	EU-15	B	DK	D	EL	E	F	IRL	I	NL	A	P	FIN	UK
Meet friends														
(a) at least once a week	72	67	79	43	93	92	63	95	80	85	70	75	82	87
(b) once or twice a month	19	22	18	34	5	6	27	4	13	13	24	14	14	11
(c) less than once a month	9	11	3	22	2	3	10	1	7	2	7	11	4	3
% of those in category (c) who spoke to no-one	20	12	6	:	30	27	7	30 (*)	33	:	17	24	22	13

(*) = Low reliability (20–49 observations, or 10–20% missing observations).

Source: European Community Household Panel, UDB, Eurostat, Version December 2001.

(%)

I	L	NL	A	P	FIN	S	UK		
33.9	38.5	29.1	35.6	33.5	27.0	27.9	39.0	Yes	**Male**
61.0	60.7	69.8	58.4	63.5	68.2	70.9	60.0	No	
5.1	0.8	1.1	6.0	3.0	4.8	1.2	1.1	Don't know	
35.6	43.5	38.0	30.6	45.2	26.1	32.6	47.3	Yes	**Female**
60.2	52.2	58.6	65.0	51.1	70.0	66.8	51.6	No	
4.2	4.4	3.5	4.4	3.7	3.9	0.6	1.2	Don't know	
34.8	41.1	33.6	33.0	39.7	26.5	30.3	43.3	Yes	**Total**
6.6	56.2	64.1	61.9	57.0	69.2	68.8	55.6	No	
4.6	2.7	2.3	5.1	3.4	4.4	0.9	1.1	Don't know	

(%)

I	L	NL	A	P	FIN	S	UK		
31.2	49.9	42.7	31.1	32.9	26.4	38.5	52.1	Yes	**16–24**
63.1	47.7	56.4	63.4	63.6	71.0	60.0	46.7	No	
5.7	2.4	0.9	5.5	3.4	2.6	1.6	1.2	Don't know	
40.6	56.1	33.0	47.3	48.7	34.9	44.2	55.8	Yes	**25–39**
56.2	41.3	64.1	45.8	48.1	62.3	54.2	44.2	No	
3.2	2.6	2.9	6.9	3.2	2.8	1.6	–	Don't know	
42.2	39.4	36.7	40.8	44.4	32.5	31.8	45.3	Yes	**40–54**
53.7	57.4	61.4	53.6	53.3	59.2	67.7	51.5	No	
4.1	3.2	1.9	5.7	2.4	8.3	0.5	3.2	Don't know	
26.7	26.4	26.5	13.9	32.4	14.0	14.7	25.4	Yes	**55+**
67.7	71.2	70.8	83.3	63.4	83.2	84.9	73.9	No	
5.6	2.4	2.8	2.8	4.1	2.8	0.3	0.7	Don't know	

4.6.2 Children who report feeling lonely, by age and sex, 1997/98

(%)

	B (*)	DK	D (*)	EL	F (*)	IRL	S	UK				NO	CH
								England	Scotland	NI	Wales		
11-year-olds													
Boys	12	4	9	12	12	11	8	11	14	11	15	4	6
Girls	16	8	10	18	18	14	6	12	19	13	22	5	9
13-year-olds													
Boys	9	4	9	16	12	8	6	9	11	10	15	5	6
Girls	15	9	12	28	21	14	9	12	18	17	17	8	13
15-year-olds													
Boys	7	3	9	20	13	8	6	6	8	6	11	7	6
Girls	16	10	13	39	24	16	14	14	19	17	22	12	14

(*) In Belgium only the Dutch-speaking part, in France only Nancy-Lorraine and Toulouse-Midi-Pyrénées, and in Germany only Nordrhein-Westfalen are covered. Spain, Italy, Luxembourg, Austria, Portugal, Finland and the Netherlands are not covered.

Source: 'Health behaviour in school-aged children', World Health Organisation Europe.

4.7.1 Incidence of certain diseases preventable by vaccination

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Poliomyelitis										
1990	0	-	-	-	-	-	-	-	-	-
1995	0	-	-	0	-	-	-	-	-	-
1996	0	-	-	0	0	-	-	-	-	-
1997	-	-	-	-	-	-	-	-	-	-
1998	0	-	-	-	0	-	-	-	-	-
1999	0	-	-	-	-	0	-	-	-	-
2000	0	-	-	0	-	-	-	-	-	-
2001	0	-	-	-	-	0	-	-	-	-
Diphtheria										
1990	0	0	0	0	0	0	0	0	-	0
1995	0	0	0	0	0	0	0	0	0	0
1996	0	0	0	0	0	0	0	0	0	0
1997	0	0	0	0	0	0	-	0	0	0
1998	0	0	0	-	-	0	-	-	0	0
1999	0	-	-	0	-	-	-	-	-	-
2000	0	-	-	-	-	-	-	-	0	-
2001	0	-	-	-	-	-	:	-	0.1	-
Infections with haemophilus influenzae type B										
1990	:	1.9	:	:	:	0.2	:	:	:	:
1995	:	3.9	0.2	:	:	0.2	0.8	:	0.2	:
1996	:	4.0	0.1	:	:	0.2	0.8	:	0.2	:
1997	:	4.6	0.1	:	:	0.2	0.8	:	0.2	-
1998	:	6.2	0.1	:	:	0.2	0.7	:	0.2	-
1999	:	4.6	0.1	:	:	0.1	0.7	0.2	0.2	:
2000	:	0.1	0	:	0.1	0.1	:	0.2	:	-
2001	:	:	0	0.1	0.1	:	:	0.1	:	:
Measles										
1990	:	43.2	3.5	:	2.3	55.8	244.5	15.9	9.6	4.2
1995	:	105.1	0.4	:	1.7	22.6	93.5	6.5	65.9	0.2
1996	:	71.2	2.3	:	56.5	12.6	113.8	6.3	56.9	6.1
1997	:	38.0	1.2	:	1.3	4.7	137.4	5.1	71.8	0.2
1998	:	38.0	0.5	:	0.5	1.1	30.4	5.5	7.1	-
1999	:	16.0	0.1	:	0.4	0.6	31.1	3.9	5.0	-
2000	:	:	0.3	:	0.3	0.4	17.0	42.4	2.5	-
2001	:	:	0.2	7.3	0.5	0.2	14.3	6.3	1.0	1.6
Mumps										
1990	:	:	6.6	:	8.2	78.6	187.4	1.4	106.4	:
1995	:	85.1	0.3	:	2.2	25.6	84.6	0.8	114.4	-
1996	:	94.1	0.8	:	1.4	37.5	85.6	11.6	112.9	:
1997	:	58.0	0.6	:	1.4	17.8	68.4	8.0	51.6	0.5
1998	:	58.0	0.4	:	0.6	7.2	44.6	1.5	25.6	-
1999	:	30.0	0.4	:	0.7	10.5	35.3	0.4	70.2	-
2000	:	:	0.7	:	0.5	23.5	31.4	1.4	65.3	-
2001	:	:	0.3	:	0.1	19.4	19.5	1.0	20.3	1.4
Pertussis										
1990	:	0	11.1	:	7.0	25.9	2.1	22.9	26.9	0.8
1995	:	0	1.6	:	2.0	9.5	:	12.1	25.1	0.2
1996	:	0.1	1.7	:	0.9	9.1	0.8	7.2	6.8	0.2
1997	:	0.2	3.8	:	1.0	2.9	2.7	12.6	5.9	0
1998	:	0.5	2.4	:	0.8	0.8	1.3	6.8	12.1	0
1999	:	0.5	3.4	:	0.3	1.0	:	4.8	6.6	0
2000	:	0.8	3.1	:	0.1	2.3	:	4.0	4.4	-
2001	:	0.9	3.7	:	0.9	0.9	:	3.7	2.1	-
Rubella										
1990	:	:	8.8	:	7.8	60.2	0	7.4	61.4	:
1995	:	0	0.1	:	1.5	12.0	:	2.8	11.6	0.5
1996	:	:	0.2	:	1.4	43.3	:	16.6	38.2	:
1997	:	8.4	0	:	0.7	9.7	:	3.2	60.2	2.4
1998	:	:	0	:	0.7	2.2	:	2.2	5.8	-
1999	:	:	-	:	13.7	1.4	:	1.7	2.0	-
2000	:	:	-	:	0.1	0.9	:	2.6	4.5	-
2001	:	:	-	:	0.1	0.4	:	1.5	8.4	1.6
Tetanus										
1990	0.1	0	0	0	0	0.1	0.1	-	0.3	-
1995	0.1	0	0.1	0	0	0.1	0.1	-	0.2	-
1996	0.1	0	-	0	0.1	0.1	0.1	-	0.2	0.2
1997	0.1	0	0	0	0	0.1	0.1	-	0.2	-
1998	0.1	-	0	0	0	0.1	0	0	0.2	-
1999	0.1	0	0	0	0.1	0.1	0	0	0.2	-
2000	0.1	0	0.1	0	0	0.1	0.1	0	0.2	-
2001	:	0	0	0	0	0.1	0	0.1	0.1	-

Source: Eurostat, NewCronos database (Health and safety statistics).

(cases per 100 000 population)

NL	A	P	FIN	S	UK	IS	NO	CH	
									Poliomyelitis
-	-	-	-	-	-	-	-	-	**1990**
-	-	-	-	-	-	-	-	-	**1995**
-	-	-	-	-	-	-	-	-	**1996**
-	-	-	-	-	-	-	-	-	**1997**
-	-	-	-	-	-	-	-	-	**1998**
-	-	-	-	-	-	-	-	-	**1999**
-	-	-	-	-	-	-	0.1	-	**2000**
-	-	-	-	-	-	-	-	-	**2001**
									Diphtheria
0	0	0	0	0	0	0	0	0	**1990**
0	0	0	0	0	0	0	0	0	**1995**
0	0	0	0	0	0	0	0	0	**1996**
0	0	0	0	0	0	0	0	0	**1997**
0	:	0	0	0	0	0	0	-	**1998**
0	-	-	0	-	-	-	-	-	**1999**
-	-	0	0	-	-	-	0	-	**2000**
-	:	-	0	-	-	-	-	-	**2001**
									Infections with haemophilus influenzae type B
:	:	:	:	:	:	-	:	3.1	**1990**
:	:	:	0.1	:	:	-	0.3	0.7	**1995**
:	:	:	0.1	0.2	:	-	0.2	0.5	**1996**
0.1	:	:	0	0.5	:	-	0.2	0.7	**1997**
0.1	:	:	0.1	0.4	:	-	0.1	0.5	**1998**
0.1	:	0.2	0.1	0.2	:	-	0.1	0.8	**1999**
0.1	:	0.1	0	0.3	:	-	0.1	0.8	**2000**
0	:	0.1	0.1	0.2	0.3	-	0.0	0.7	**2001**
									Measles
0.1	3.0	4.1	0.1	0.3	27.2	:	2.2	43.5	**1990**
1.2	129.0	1.9	0.1	0.3	15.4	0.7	0.4	19.9	**1995**
0.4	85.0	1.1	-	0.5	11.7	0.4	0.5	28.3	**1996**
0.1	40.0	1.3	-	0.9	8.2	-	0.3	90.4	**1997**
0.1	8.5	1.0	0	0.1	7.7	-	0	28.2	**1998**
15.0	3.9	0.5	-	0.2	5.0	-	0.1	:	**1999**
6.4	4.1	0.5	0	0.7	4.8	-	1.6	:	**2000**
0.1	:	0.3	0	0.1	4.2	-	0.1	9.7	**2001**
									Mumps
0.1	:	12.8	0.1	0.2	9.2	30.2	13.8	62.6	**1990**
0.2	:	22.5	0.1	0.5	4.1	33.7	0.3	723.7	**1995**
0.2	:	113.6	0	0.1	3.7	13.4	0.4	181.2	**1996**
0.3	:	195.2	0	0.5	3.8	-	0.1	77.7	**1997**
0.2	:	28.4	0	0.4	3.2	4.4	0.2	112.7	**1998**
0	:	31.6	0	0.2	3.4	16.0	0.1	210.6	**1999**
:	:	64.9	-	0.4	5.6	-	0	:	**2000**
:	:	7.2	0	0.2	5.6	-	0.1	138.8	**2001**
									Pertussis
3.2	3.0	1.0	14.2	128.7	29.3	1.2	4.9	:	**1990**
2.1	1.1	0.2	9.9	120.9	4.1	10.1	1.6	284.9	**1995**
17.9	1.2	0.2	11.5	95.9	4.6	37.3	2.0	162.8	**1996**
22.5	1.5	0.1	11.8	52.5	6.2	2.2	41.8	183.6	**1997**
14.4	1.4	0.1	16.2	20.0	3.2	1.1	52.3	183.2	**1998**
39.8	1.3	0.1	17.8	27.4	2.5	8.0	27.2	154.4	**1999**
30.5	1.4	0.2	16.2	30.5	1.5	2.9	76.3	104.7	**2000**
43.7	3.1	0.0	6.1	11.0	1.7	1.1	57.2	83.3	**2001**
									Rubella
0.3	:	2.4	1.2	0.2	27.4	12.6	33.4	67.4	**1990**
0.1	:	1.3	0.1	0.0	13.1	77.1	0.2	25.6	**1995**
0.3	:	2.8	0	0.1	19.9	119.7	0.4	41.1	**1996**
0.1	:	2.7	0	0	7.1	-	0	50.8	**1997**
0.1	:	0.8	0	0	6.9	-	0.1	25.4	**1998**
0	:	0.6	-	0	4.3	-	0.1	19.7	**1999**
0.1	:	0.6	-	0	3.5	-	0.1	16.7	**2000**
0	:	0.4	-	0	2.8	-	0.0	16.7	**2001**
									Tetanus
0	:	0.3	0	0	0	-	0	0	**1990**
0	-	0.3	-	0	0	-	0.1	0	**1995**
0	-	0.2	0	0	0	-	0	0	**1996**
0	-	0.2	-	0	0	-	0.1	0	**1997**
-	-	0.2	0	0	:	-	0	0	**1998**
-	-	0.3	0.2	0	0	-	0	0	**1999**
:	-	0.2	:	-	0	-	-	0.1	**2000**
:	-	0.2	:	-	0	-	0	0	**2001**

4.7.3 Incidence of syphilis and of gonococcal infections

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Syphilis										
1985	:	2.1	6.5	:	:	10.3	:	:	4.4	8.2
1990	:	0.5	1.1	:	0.1	4.3	:	0.5	1.1	1.3
1995	:	0.3	0.8	1.4	:	2.6	:	0.3	0.8	0.7
1996	:	0.3	0.8	1.4	0.6	2.1	:	0.5	0.8	0.7
1997	:	0.2	1.1	1.4	:	1.9	:	0.4	0.8	1.0
1998	:	0.2	0.8	1.4	0.1	1.9	:	0.4	0.6	2.1
1999	:	0.3	0.6	1.4	0.0	1.7	:	0.2	0.6	0.9
2000	0.8	0.9	0.2	1.4	0.1	1.8	0.1	0.2	0.6	0.9
2001	:	:	0.3	2.0	0	1.7	0.3	:	0.4	3.6
Gonococcal infections										
1985	:	4.9	191.7	:	:	81.5	:	:	2.8	20.5
1990	:	3.7	38.8	:	0.3	35.2	:	2.6	0.9	0.8
1995	:	1.3	5.5	5.0	:	11.6	:	2.1	0.6	1.7
1996	:	1.0	3.4	4.2	:	10.1	:	2.3	0.6	0.5
1997	:	1.2	3.6	3.6	:	6.0	:	2.7	0.6	0.5
1998	:	1.6	4.0	2.9	0	5.5	:	3.4	0.6	0.2
1999	:	1.7	6.5	2.7	0.1	3.7	:	4.7	0.5	0.5
2000	:	1.4	6.6	3.1	0	2.6	:	7.1	0.5	0.5
2001	:	2.3	5.7	:	-	2.0	:	:	0.5	0.7

Source: Eurostat, NewCronos database (Health and safety statistics).

4.7.4 New AIDS cases by year of diagnosis (adjusted for reporting delays)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK	IS	NO	CH
1985	1 803	69	38	308	14	175	583	7	198	:	67	28	29	4	34	247	1	15	119
1990	15 752	205	197	1 539	143	3 909	4 319	68	3 134	9	419	165	254	15	132	1 244	3	59	613
1991	18 027	257	210	1 757	185	4 556	4 655	72	3 827	12	447	199	299	26	138	1 387	8	59	596
1992	19 972	250	209	1 883	190	5 060	5 193	72	4 261	12	512	193	411	21	127	1 578	3	50	715
1993	21 793	254	239	1 975	171	5 465	5 521	75	4 814	20	480	236	550	25	182	1 786	7	64	680
1994	24 886	258	236	2 044	213	7 354	5 763	75	5 524	13	488	167	670	43	187	1 851	6	74	685
1995	24 151	248	214	1 872	215	7 061	5 289	53	5 662	15	538	206	775	41	195	1 767	4	67	606
1996	20 952	205	158	1 565	233	6 548	4 008	56	5 051	13	458	139	932	24	134	1 428	3	56	509
1997	14 321	123	109	996	170	4 716	2 266	30	3 370	10	341	98	933	19	76	1 064	1	34	341
1998	11 057	114	74	821	120	3 466	1 918	18	2 418	9	241	97	918	15	58	770	2	36	248
1999	9 962	102	74	743	128	2 906	1 796	25	2 121	5	179	99	973	10	67	729	0	23	259
2000	9 197	118	58	685	125	2 565	1 735	13	1 907	10	105	84	922	16	55	793	1	38	190
2001	8 210	107	73	558	86	2 297	1 527	15	1 681	4	44	43	1 044	17	41	666	1	22	174
1981–2001	232 407	2 923	2 381	20 898	2 254	62 219	54 781	719	49 333	156	5 441	2 130	8 710	332	1 796	18 334	52	726	7 251

Source: European Centre for the Epidemiological Monitoring of AIDS (EuroHIV).

4.7.5 AIDS incidence rates per million population by year of diagnosis (adjusted for reporting delays)

(per million population)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK	IS	NO	CH
1985	5.0	7.0	7.4	4.0	1.4	4.6	10.6	2.0	3.5	5.5	4.6	3.7	2.9	0.8	4.1	4.4	4.2	3.6	18.4
1990	43.3	20.6	38.4	19.5	14.1	100.7	76.3	19.4	55.3	23.7	28.1	21.5	25.6	3.0	15.5	21.7	11.8	13.9	91.9
1991	49.3	25.7	40.8	22.0	18.1	117.2	81.8	20.4	67.4	31.2	29.8	25.6	30.3	5.2	16.1	24.0	31.3	13.9	88.3
1992	54.4	24.9	40.5	23.5	18.5	129.9	90.8	20.3	75.1	30.8	33.8	24.5	41.7	4.2	14.7	27.3	11.6	11.7	104.5
1993	59.1	25.2	46.1	24.4	16.5	139.9	96.0	21.0	84.5	50.6	31.5	29.6	55.7	4.9	20.9	30.7	26.7	14.9	98.4
1994	67.2	25.5	45.4	25.1	20.5	188.0	99.7	20.9	96.7	32.4	31.8	20.8	67.7	8.5	21.4	31.8	22.6	17.1	98.3
1995	65.0	24.5	41.0	23.0	20.6	180.2	91.2	14.7	98.9	36.9	34.9	25.6	78.2	8.0	22.1	30.2	15.0	15.4	86.3
1996	56.2	20.2	30.1	19.1	22.3	166.9	68.8	15.5	88.1	31.5	29.6	17.3	93.9	4.7	15.2	24.3	11.2	12.8	72.1
1997	38.3	12.1	20.7	12.1	16.2	120.0	38.7	8.2	58.6	23.9	21.9	12.1	93.9	3.7	8.6	18.1	3.7	7.7	48.7
1998	29.5	11.2	14.0	10.0	11.4	88.1	32.7	4.9	42.0	21.2	15.4	12.0	92.2	2.9	6.6	13.0	7.3	8.1	36.3
1999	26.5	10.0	14.1	9.1	12.2	73.8	30.5	6.7	36.8	11.6	11.4	12.3	97.5	1.9	7.6	12.3	-	5.2	36.5
2000	24.4	11.5	11.0	8.3	11.9	65.0	29.3	3.5	33.1	23.2	6.7	10.5	92.3	3.1	6.3	13.3	3.6	8.5	26.6
2001	21.8	10.5	13.9	6.8	8.1	58.0	25.0	4.2	29.4	9.5	2.8	5.3	105.8	3.3	4.7	11.3	3.5	4.9	23.6

Source: European Centre for the Epidemiological Monitoring of AIDS (EuroHIV).

(cases per 100 000 population)

NL	A	P	FIN	S	UK	IS	NO	CH	
									Syphilis
4.0	5.3	2.8	2.3	1.8	4.2	1.7	:	4.8	**1985**
3.4	2.6	1.8	0.6	1.7	2.4	2.8	0.2	4.9	**1990**
1.3	2.2	2.2	3.3	0.8	2.3	0.8	0.1	3.2	**1995**
1.4	2.6	2.1	4.3	0.6	2.0	0.0	0.2	2.4	**1996**
1.7	2.5	2.4	3.4	0.5	2.1	2.2	0.3	1.9	**1997**
0.8	2.5	1.8	3.6	0.5	2.2	1.8	0.3	2.4	**1998**
0.1	2.3	2.5	2.7	0.4	2.5	4.0	1.2	:	**1999**
0	2.9	1.8	3.9	1.1	3.0	5.4	0.9	:	**2000**
:	3.9	1.3	3.1	0.9	:	11.8	0.7	:	**2001**
									Gonococcal infections
86.1	64.9	2.5	127.4	64.6	92.6	114.3	141.7	15.1	**1985**
24.6	20.5	2.6	46.7	9.8	36.0	28.7	6.0	6.2	**1990**
9.1	11.1	0.7	7.4	2.8	22.2	0.4	4.0	3.8	**1995**
7.7	7.4	0.7	4.4	2.4	21.4	0.0	5.1	3.6	**1996**
7.6	5.5	0.7	4.2	2.8	22.2	1.9	4.4	3.8	**1997**
7.6	4.7	0.4	5.2	3.9	22.4	2.2	3.8	3.8	**1998**
0.5	5.4	0.6	4.9	4.8	27.7	0.7	4.3	4.6	**1999**
:	5.0	0.5	5.2	6.6	:	5.7	5.6	5.7	**2000**
:	6.6	0.4	4.7	6.0	:	1.1	7.3	6.6	**2001**

4.7.7 Cases (not adjusted) of AIDS by age group (% over cumulative total)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Less than 1	0.6	1.4	0.3	0.1	0.4	0.6	0.5	0.6	0.5	0.0	0.3	0.6	0.5	0.6	0.4	1.0
1–4	0.5	1.6	0.3	0.2	0.6	0.6	0.5	1.8	0.5	0.6	0.3	0.7	0.3	0.0	0.5	0.9
5–14	0.5	1.4	0.2	0.3	0.8	0.4	0.4	1.7	0.4	0.6	0.4	0.5	0.4	0.3	0.3	0.8
15–24	5.5	3.8	3.6	3.4	5.0	7.6	4.2	7.2	4.8	3.8	2.8	5.9	11.6	2.4	9.8	4.3
25–29	19.1	12.7	1.1	12.6	13.7	23.8	16.8	24.3	21.2	10.9	12.1	16.7	22.1	9.0	16.8	15.8
30–34	26.6	21.3	20.1	22.0	20.0	29.9	24.3	26.4	31.0	21.2	21.1	23.9	21.6	25.0	20.4	23.0
35–39	18.9	20.2	17.9	19.5	17.7	17.8	19.1	17.7	19.9	19.9	21.3	18.0	16.1	16.9	17.2	19.7
40–49	17.8	23.1	28.4	25.4	21.4	12.4	20.7	14.6	14.0	23.1	29.0	21.9	16.0	28.9	20.7	23.4
50–59	7.1	9.5	12.6	12.9	10.6	4.1	8.6	4.9	5.2	15.4	9.9	7.7	7.0	11.4	9.1	8.3
60 and over	3.4	4.9	4.6	3.6	8.3	2.5	4.8	0.6	2.4	4.5	2.8	4.1	4.4	5.4	4.7	2.9

Source: European Centre for the Epidemiological Monitoring of AIDS (EuroHIV).

4.7.8 AIDS-indicative diseases (non-adjusted cases) diagnosed in 2001 in adult/adolescent men and women (%), EU-15

	Men	Women	Total
Pneumocystis carinii	22.2	21.0	21.9
Oesophageal candidiasis	13.0	14.9	13.4
Pulmonary tuberculosis	11.9	12.1	11.9
Extrapulmonary tuberculosis	9.9	9.0	9.7
Toxoplasmosis	6.4	8.8	6.9
HIV wasting syndrome	5.8	4.8	5.6
Kaposi's sarcoma	6.5	2.3	5.5
CMV disease or retinitis	3.4	4.1	3.6
Recurrent pneumonia	2.7	3.5	2.9
Cryptococcosis	2.8	2.2	2.6
HIV encephalopathy	2.8	2.2	2.6
Progressive multifocal leukoencephalopathy	2.6	2.0	2.5
Lymphoma, not specified	2.2	1.6	2.1
Herpes simplex virus disease	1.0	1.7	1.1

Source: European Centre for the Epidemiological Monitoring of AIDS (EuroHIV).

4.7.9 HIV and AIDS comparative reporting data for 2001

	Cumulative HIV cases reported to end-2001		HIV cases in 2001		AIDS cases in 2001		HIV/AIDS Ratio
			Number	Rate per million	Number	Rate per million	2001
EU-15	**:**	119 710	10 632	54.4	2 616	:	4.1
B	**1986**	14 876	961	*94.5*	107	*10.5*	9.0
DK	**1990**	3 341	301	*56.8*	74	*13.9*	4.1
D	**1993**	18 251	1 377	*16.7*	558	*6.8*	2.5
EL	**1999**	5 859	427	*40.1*	87	*8.1*	4.9
E	**1999**	:	:	*:*	:	*:*	:
F	**:**	:	:	*:*	:	*:*	:
IRL	**1985**	2 645	299	*79.6*	16	*4.2*	:
I	**1985**	:	:	*:*	:	*:*	:
L	**1999**	511	40	*92.0*	4	*9.5*	10.0
NL	**1989**	:	:	*:*	:	*:*	:
A	**:**	:	:	*:*	:	*:*	:
P	**1983**	18 995	2 543	*257.5*	1 045	*105.8*	2.4
S	**1985**	5 645	277	*31.0*	42	*4.7*	6.6
FIN	**1986**	1 361	128	*24.7*	17	*3.3*	7.5
UK	**1984**	48 226	4 279	*72.6*	666	*11.3*	6.4

Source: European Centre for the Epidemiological Monitoring of AIDS (EuroHIV).

4.7.10 Incidence of viral hepatitis A, B and C

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Viral hepatitis A										
1990	:	2.9	1.8	:	1.7	:	:	15.3	3.6	:
1995	:	5.5	2.0	8.1	2.8	:	:	3.7	2.5	5.2
1996	:	5.6	2.0	6.0	1.0	:	15.4	8.6	15.1	2.4
1997	8.7	4.6	2.2	5.6	1.2	4.6	17.7	11.6	17.3	23.2
1998	6.4	5.1	1.6	4.7	2.3	5.1	17.5	6.0	5.1	28.6
1999	:	3.9	1.7	3.8	2.5	3.7	:	8.6	2.6	26.9
2000	:	4.3	1.5	3.4	1.4	2.5	:	8.2	1.6	20.7
2001	:	3.1	1.2	2.8	2.0	2.2	:	2.9	2.6	:
Viral hepatitis B										
1990	4.4	0.7	:	:	4.2	:	:	0.3	5.2	:
1995	4.3	0.7	2.1	7.5	2.1	:	:	0.3	4.5	19.8
1996	4.2	3.2	1.9	7.4	1.6	:	5.1	0.3	3.9	12.1
1997	5.0	3.0	1.9	7.4	1.6	3.0	10.3	0.8	3.5	19.4
1998	4.4	1.3	1.8	6.3	2.4	2.9	8.7	4.2	3.1	13.0
1999	:	1.2	1.1	5.5	2.4	2.4	:	4.3	2.9	14.4
2000	:	2.5	1.2	5.5	2.7	2.2	:	5.0	2.6	7.3
2001	:	5.2	0.8	3.0	2.2	1.9	:	9.0	1.8	18.6
Viral hepatitis C										
1990	:	:	:	:	0.1	:	:	:	:	:
1995	:	:	1.0	:	0.5	:	:	:	2.5	20.2
1996	:	1.7	0.3	:	0.3	:	:	:	2.0	11.6
1997	:	0.8	0.3	:	0.3	:	:	:	1.6	16.0
1998	:	:	0.5	4.7	1.1	:	9.9	:	1.5	13.5
1999	:	:	0.3	4.7	1.5	2.5	:	:	1.4	22.6
2000	:	4.2	0.2	4.3	1.4	2.1	:	:	0.4	12.9
2001	:	:	0.1	5.3	1.2	:	:	1.7	0.3	:

Source: Eurostat, NewCronos database (Health and safety statistics).

(cases per 100 000 population)

NL	A	P	FIN	S	UK	IS	NO	CH	
									Viral hepatitis A
5.1	4.2	8.1	1.4	3.1	12.7	2.0	2.8	13.2	**1990**
6.4	4.7	3.4	3.2	6.8	4.0	0.0	5.7	7.3	**1995**
4.7	3.2	4.7	3.6	5.5	2.5	1.1	11.9	3.7	**1996**
5.6	5.7	3.6	3.3	7.8	3.3	1.1	7.6	3.9	**1997**
7.9	3.2	2.7	2.3	2.9	2.8	0.7	11.5	5.1	**1998**
4.4	4.2	1.2	0.9	2.1	3.0	3.4	22.5	4.9	**1999**
4.1	2.7	0.9	0.9	1.7	1.8	-	7.2	4.0	**2000**
4.4	1.6	0.5	1.0	1.9	1.6	-	4.5	2.4	**2001**
									Viral hepatitis B
1.8	3.5	4.8	4.0	3.0	1.2	26.7	:	6.6	**1990**
1.5	2.6	10.0	2.2	3.3	1.3	3.0	2.3	5.0	**1995**
1.5	2.8	8.4	5.7	2.1	1.4	6.7	2.2	2.7	**1996**
1.6	2.6	6.8	6.2	1.7	1.6	7.8	4.2	3.7	**1997**
1.8	3.1	5.7	4.8	1.5	2.0	5.4	10.6	2.6	**1998**
4.3	4.0	4.1	4.9	2.4	2.1	16.3	10.6	2.8	**1999**
9.7	3.2	2.9	4.6	2.5	1.6	17.6	10.1	2.0	**2000**
10.2	2.6	2.0	2.5	2.4	1.5	21.9	4.5	1.8	**2001**
									Viral hepatitis C
:	:	:	:	5.4	:	5.9	:	:	**1990**
:	2.0	4.7	26.6	32.6	:	15.7	:	37.3	**1995**
:	2.1	4.1	34.7	29.6	:	18.7	0.4	35.6	**1996**
:	3.9	4.8	37.1	52.1	:	19.6	0.5	39.3	**1997**
:	4.7	7.0	35.0	45.0	:	24.2	0.5	39.9	**1998**
1.6	7.0	4.1	33.9	39.5	4.6	30.5	0.6	40.3	**1999**
3.2	5.1	2.0	33.6	38.8	5.0	31.2	0.5	33.7	**2000**
3.5	4.3	2.4	28.1	39.4	4.8	28.0	0.8	32.4	**2001**

4.7.11 Incidence of certain food- and waterborne diseases

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Botulism										
1990	:	0.01	0	0.02	-	0.03	0.02	:	0.08	:
1995	:	-	0.04	0.01	-	0.02	0	:	0.07	:
1996	:	-	0	0.01	-	0.02	0	:	0.10	:
1997	:	0.01	0	0.01	-	0.02	0	:	0.06	:
1998	:	0.03	0.02	0.03	-	0.03	0	:	0.06	:
1999	:	0.01	0	0.02	-	0.02	0.10	:	0.04	:
2000	:	0.02	-	0.01	:	0.02	0	:	:	:
2001	:	-	-	0.01	:	0	:	:	:	:
Campylobacteriosis										
1990	:	47.9	26.6	:	:	5.4	:	:	:	:
1995	:	47.2	49.9	8.1	:	8.4	:	17.9	2.8	:
1996	:	42.6	56.6	12.4	:	9.6	:	17.8	3.6	30.8
1997	:	49.6	50.5	16.0	:	9.7	:	25.8	4.1	25.0
1998	:	58.2	66.2	40.5	0.9	11.4	:	35.7	3.5	:
1999	:	57.7	45.6	35.2	2.4	13.5	:	55.8	3.1	:
2000	:	67.5	140.2	37.6	:	15.8	:	42.7	:	:
2001	:	67.7	86.7	66.4	:	15.5	:	:	:	:
Leptospirosis										
1990	:	:	:	:	0.01	0.03	:	0.14	0.22	:
1995	:	:	0.04	0.06	-	0.02	:	0.03	0.11	:
1996	:	-	0.08	0.03	-	0.03	1.73	0.17	0.13	:
1997	0.31	-	0.04	0.03	-	0.02	1.62	0.22	0.09	-
1998	0.26	-	0.04	0.05	0.11	0.02	1.16	0.32	0.12	-
1999	0.28	:	-	0.06	0.22	0.01	1.29	0.16	0.11	-
2000	:	-	0.13	0.05	0.12	0.02	0.08	0.20	0.08	-
2001	:	:	0.07	0.06	0.21	0.02	0.45	0.24	0.05	0.00
Listeriosis										
1990	:	:	0.72	:	:	0.05	:	:	:	:
1995	:	0.41	0.56	:	:	0.06	0.57	:	0.05	:
1996	:	0.49	0.74	:	-	0.05	0.42	:	0.07	:
1997	:	0.39	0.63	0.04	-	0.05	0.41	:	0.12	-
1998	0.18	0.59	0.76	0.05	-	0.04	0.37	0.11	0.08	-
1999	:	0.45	0.83	0.04	0.07	0.08	0.46	:	0.07	-
2000	0.17	:	0.46	0.04	0.06	0.09	0.44	0.19	0.06	-
2001	:	0.59	0.71	0.26	0.03	0.14	0.32	0.10	0.03	-
Salmonellosis										
1990	:	:	40.5	:	6.4	13.6	:	13.5	33.9	5.0
1995	58.8	102.9	70.1	141.8	12.3	10.7	30.5	15.9	25.8	11.3
1996	57.1	114.6	62.1	134.2	6.5	12.7	29.4	18.7	23.4	16.2
1997	59.1	134.8	95.1	129.6	2.9	13.1	32.8	26.2	27.9	13.4
1998	52.7	137.0	73.3	119.9	0.1	16.9	28.1	34.1	24.9	11.6
1999	47.5	154.4	43.6	104.0	2.9	17.6	23.2	25.8	24.5	68.5
2000	43.0	136.9	43.6	96.8	2.2	16.3	21.8	16.9	20.5	96.2
2001	40.6	104.3	54.6	93.8	2.9	19.4	21.8	11.2	12.0	82.9
Shigellosis										
1990	:	:	:	:	2.8	1.9	:	7.9	:	-
1995	:	:	1.1	2.3	0.2	0.3	:	2.7	2.8	-
1996	:	:	2.3	1.9	3.3	0.3	:	1.6	3.6	-
1997	2.6	2.0	1.5	2.4	0.2	0.5	1.7	1.1	4.1	-
1998	2.2	2.7	2.3	2.0	0.1	0.4	1.4	3.2	3.5	-
1999	2.1	2.9	1.0	2.0	0.5	0.2	1.6	3.1	3.1	-
2000	2.0	2.0	2.9	1.6	0.1	0.2	1.6	0.8	4.1	-
2001	:	4.5	2.8	2.0	0.1	0.2	:	0.7	3.2	-
Trichinosis										
1990	:	-	:	:	:	0.04	:	:	0.11	:
1995	:	:	:	:	:	0.10	:	0	-	:
1996	:	-	-	0	-	0.04	:	-	-	:
1997	:	-	-	0.01	-	0.03	:	:	-	-
1998	:	0.01	-	0.06	-	0.14	:	0.94	0.10	:
1999	:	-	-	0.03	-	0.04	:	:	-	:
2000	:	-	-	0	-	0.11	:	:	-	-
2001	:	-	-	0.01	-	0.11	-	:	-	-

(cases per 100 000 population)

NL	A	P	FIN	S	UK	IS	NO	CH	
									Botulism
-	-	:	0	0.01	-	:	-	0	**1990**
-	-	:	0	0.01	-	:	-	0	**1995**
-	-	:	0	0.01	-	:	-	0	**1996**
-	-	:	0	0	-	-	-	0.01	**1997**
-	-	:	0	0	0	0.37	0.18	0	**1998**
-	-	0.02	0	0	:	0.73	0.09	:	**1999**
0.02	0.01	0.31	0.02	-	:	1.08	0.04	:	**2000**
0.01	0.01	0	-	-	:	-	-	:	**2001**
									Campylobacteriosis
:	:	:	:	47.0	66.9	3.9	15.6	62.0	**1990**
18.4	:	:	43.1	63.3	83.4	7.1	24.1	71.9	**1995**
23.9	14.0	:	51.4	57.5	78.6	16.0	26.2	80.1	**1996**
23.5	20.7	:	46.8	77.8	89.0	34.5	26.8	84.1	**1997**
22.3	30.4	:	55.4	83.6	130.0	80.4	38.5	76.9	**1998**
20.1	40.2	:	64.0	86.6	130.6	158.1	51.9	94.2	**1999**
21.2	42.8	:	68.2	94.8	136.6	87.8	49.8	105.6	**2000**
23.0	48.2	:	76.6	96.6	:	76.7	66.5	93.7	**2001**
									Leptospirosis
0.26	0.01	0.25	:	:	0.07	:	:	0.06	**1990**
0.18	0.04	0.37	:	:	0.05	:	:	0.06	**1995**
0.06	0.01	0.39	0	-	0.04	-	-	0.03	**1996**
0.10	0.04	0.67	0	-	0.07	-	-	0.08	**1997**
0.15	0.04	0.92	0.02	-	0.06	-	-	0.06	**1998**
0.20	0.02	0.51	0.00	-	0.07	-	-	:	**1999**
0.18	0.05	0.45	0.02	-	0.10	-	-	:	**2000**
0.15	0.05	0.79	0.08	:	0.04	-	-	:	**2001**
									Listeriosis
:	:	:	:	0.15	:	:	:	:	**1990**
:	:	:	0.67	0.39	0.18	:	:	0.24	**1995**
-	:	:	0.57	0.26	0.22	1.12	0.34	0.38	**1996**
-	:	:	1.03	0.33	0.23	0.74	0.48	0.49	**1997**
0.19	-	-	0.89	0.47	0.21	-	0.20	0.61	**1998**
0.07	:	-	0.89	0.40	0.19	-	0.43	0.48	**1999**
0.11	-	-	0.35	0.60	0.18	-	0.07	0.73	**2000**
0.11	:	:	0.54	0.75	0.24	-	0.40	0.47	**2001**
									Salmonellosis
19.2	:	0.9	147.8	66.9	:	:	26.0	101.4	**1990**
16.6	89.7	2.0	67.8	40.4	56.9	:	23.8	64.4	**1995**
18.5	110.5	2.1	55.4	43.7	55.5	28.4	28.3	55.3	**1996**
16.4	92.8	1.8	57.6	53.1	61.8	33.0	31.7	51.2	**1997**
14.3	89.6	3.4	53.1	51.9	44.7	36.0	33.8	42.3	**1998**
13.5	87.3	4.1	54.3	58.1	33.8	62.7	32.2	39.1	**1999**
12.9	80.5	3.1	50.7	54.7	28.8	130.8	33.2	34.6	**2000**
13.1	81.4	5.2	52.7	53.0	29.0	59.5	42.4	37.4	**2001**
									Shigellosis
2.8	2.7	0.1	:	10.7	5.3	:	:	8.7	**1990**
2.5	1.9	1.4	1.4	6.4	9.4	:	3.4	7.6	**1995**
2.1	1.4	0.0	2.1	6.4	4.5	:	4.0	6.2	**1996**
2.6	2.5	0.1	2.0	7.1	4.1	2.2	3.7	8.8	**1997**
2.4	2.1	0.1	1.7	6.6	3.3	-	3.9	7.0	**1998**
2.1	3.0	0.2	1.4	5.3	2.7	0.7	4.3	7.7	**1999**
2.0	1.4	0.1	1.5	5.6	2.7	1.1	116.7	5.7	**2000**
2.2	2.5	0	4.3	6.1	2.4	-	4.2	6.6	**2001**
									Trichinosis
-	-	-	:	-	:	:	-	:	**1990**
-	0.01	-	-	-	:	:	-	:	**1995**
-	0	-	-	-	-	-	0.05	-	**1996**
-	0	-	-	-	-	-	-	-	**1997**
-	0.01	-	-	-	-	-	-	-	**1998**
0.01	0.04	-	-	-	:	-	-	:	**1999**
0.01	0.02	-	-	-	0.01	-	-	:	**2000**
0.01	:	:	-	-	:	-	-	:	**2001**

(cont.)

	EU	B	DK	D	EL	E	F	IRL	I	L
Typhoid and paratyphoid fever										
1990	:	:	:	:	1.1	4.8	0.3	-	2.1	0.3
1995	:	:	0.7	0.3	0.4	1.4	0.1	0.1	1.9	-
1996	:	:	0.5	0.3	0.4	1.4	0.2	0.1	1.9	1.0
1997	:	:	0.6	0.2	0.3	0.8	0.2	-	1.4	-
1998	0.5	-	0.4	0.2	0.3	0.8	0.1	0.1	1.2	-
1999	:	:	1.2	0.2	0.5	0.5	:	-	1.4	-
2000	:	:	0.6	0.2	0.3	0.5	:	0.0	1.1	-
2001	:	:	0.6	0.2	0	0.4	:	0.1	0.6	-
Yersiniosis										
1990	:	10.1	15.9	:	:	0.5	:	:	:	:
1995	:	9.9	14.9	:	:	0.7	:	:	:	:
1996	:	9.9	10.1	:	:	0.7	:	:	:	:
1997	:	9.9	8.2	:	:	0.9	:	:	:	:
1998	:	9.9	:	:	:	0.7	:	:	:	:
1999	:	9.8	6.3	6.5	0.5	1.1	:	:	:	:
2000	:	9.8	5.0	5.8	0.3	1.2	:	:	:	:
2001	:	9.8	5.3	8.7	0	1.4	:	:	:	:

Source: Eurostat, NewCronos database (Health and safety statistics).

4.7.12 Creutzfeldt-Jakob disease: sporadic, iatrogenic, familial, GSS and new variant — Definite and probable cases

	EU-15	B	DK	D	EL	E	F	IRL	I	L
						Total number of deaths				
1990	:	5	:	:	:	:	:	0	:	:
1991	:	7	:	:	:	:	:	2	:	:
1992	:	5	:	:	:	:	51	0	:	:
1993	:	6	:	21	:	26	55	0	36	:
1994	:	5	:	72	:	26	59	0	40	1
1995	:	6	:	87	:	21	74	1	35	1
1996	:	6	:	80	:	29	89	1	59	1
1997	466	11	11	107	6	44	91	2	62	0
1998	532	14	5	124	4	65	103	6	72	1
1999	515	13	5	106	7	52	105	2	86	1
2000	501	8	4	109	9	52	104	3	80	1
2001	585	15	4	120	8	58	130	5	93	0
						Rates per million of population				
1990	:	0.50	:	:	:	:	:	-	:	:
1991	:	0.70	:	:	:	:	:	0.60	:	:
1992	:	0.50	:	:	:	:	0.89	-	:	:
1993	:	0.60	:	0.26	:	0.67	0.96	-	0.63	:
1994	:	0.50	:	0.89	:	0.66	1.02	-	0.70	2.49
1995	:	0.59	:	1.07	:	0.67	1.28	0.30	0.61	2.46
1996	:	0.59	:	0.98	:	0.54	1.53	0.30	1.03	2.42
1997	1.25	1.08	2.09	1.30	0.57	0.74	1.56	0.55	1.08	-
1998	1.42	1.37	0.94	1.51	0.38	1.12	1.75	1.62	1.25	2.36
1999	1.37	1.27	0.94	1.29	0.67	1.65	1.78	0.54	1.49	2.33
2000	1.33	0.78	0.75	1.33	0.85	1.32	1.77	0.79	1.39	2.30
2001	1.55	1.46	0.75	1.46	0.76	1.46	2.20	1.31	1.61	-

Source: Eurostat, NewCronos database (Health and safety statistics).

(cont.)

NL	A	P	FIN	S	UK	IS	NO	CH	
									Typhoid and paratyphoid fever
0.5	0.8	4.2	:	0.9	0.5	:	:	1.0	**1990**
0.5	0.2	4.3	0.2	0.7	0.7	:	:	0.7	**1995**
0.4	0.2	3.4	0.3	0.5	0.5	:	:	0.5	**1996**
0.3	0.3	2.8	0.2	0.5	0.4	:	:	0.4	**1997**
0.2	0.1	3.1	0.1	0.6	0.4	:	0.9	0.5	**1998**
0.4	0.2	2.0	0.9	1.2	0.5	:	0.7	0.4	**1999**
0.4	1.4	1.4	0.1	0.5	0.3	:	0.7	:	**2000**
0.5	:	1.7	0.2	1.8	0.4	:	0.8	0.4	**2001**
									Yersiniosis
:	:	:	:	:	:	:	:	2.2	**1990**
:	:	:	18.1	:	:	:	3.4	1.2	**1995**
:	0.6	:	16.7	5.3	0.5	:	2.8	1.3	**1996**
:	0.9	:	13.7	8.5	0.4	:	2.5	1.0	**1997**
:	1.2	:	13.9	7.2	0.3	:	3.2	0.7	**1998**
:	1.1	:	12.3	6.2	:	:	2.8	:	**1999**
:	1.5	:	12.4	7.1	:	:	3.1	:	**2000**
:	:	:	14.1	6.5	:	:	2.8	:	**2001**

NL	A	P	FIN	S	UK	IS	NO	CH	
					Total number of deaths				
:	:	2	2	:	33	:	:	7	**1990**
:	:	1	3	:	36	:	:	9	**1991**
:	:	1	3	:	52	:	:	6	**1992**
12	6	1	0	:	46	:	:	10	**1993**
19	10	1	7	:	59	:	:	10	**1994**
8	10	2	:	:	47	:	:	9	**1995**
16	11	2	:	:	60	:	:	10	**1996**
19	7	4	10	13	80	1	7	10	**1997**
19	8	4	3	15	89	0	2	9	**1998**
20	8	6	7	13	84	0	2	8	**1999**
11	8	8	4	13	81	0	5	11	**2000**
16	11	15	8	11	81	0	5	19	**2001**
					Rates per million of population				
:	:	0.20	0.40	:	0.57	:	:	1.05	**1990**
:	:	0.10	0.60	:	0.62	:	:	1.33	**1991**
:	:	0.10	0.60	:	0.90	:	:	0.88	**1992**
0.79	0.75	0.10	-	:	0.79	:	:	1.45	**1993**
1.24	1.25	0.10	1.40	:	1.01	:	:	1.44	**1994**
0.52	1.24	0.20	:	:	0.80	:	:	1.28	**1995**
1.03	1.37	0.20	:	:	1.02	:	:	1.42	**1996**
1.22	0.87	0.40	1.95	1.47	1.36	3.71	1.59	1.41	**1997**
1.21	0.99	0.40	0.58	1.70	1.51	-	0.45	1.27	**1998**
1.27	0.99	0.53	1.36	1.47	1.42	-	0.45	1.12	**1999**
0.69	0.99	0.78	0.77	1.47	1.36	-	1.11	1.54	**2000**
1.01	1.35	1.46	1.54	1.24	1.35	-	1.12	2.65	**2001**

4.7.13 Incidence of some airborne diseases

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Legionellosis										
1990	:	:	:	:	:	:	0.1	0	0.1	:
1995	:	:	1.8	:	:	:	0.1	0	0.2	:
1996	:	:	1.3	0.2	:	1.1	0.1	0.1	0.2	:
1997	0.3	0.2	2.3	0.2	0	0.5	0.4	0.2	0.2	-
1998	0.4	0.6	1.7	0.0	-	0.9	0.6	0.1	0.2	-
1999	0.6	1.9	1.8	0.1	0	1.1	0.7	0.1	0.5	-
2000	0.6	0.6	1.7	0.1	0.0	1.9	1.0	0.2	0.4	0.2
2001	0.9	1.0	2.0	0.4	0.1	3.5	1.4	0.1	0.3	-
Meningococcal disease										
1990	1.6	0.5	3.9	1.1	1.3	3.2	0.6	3.7	0.7	0.5
1995	1.4	1.3	4.5	0.8	1.7	2.5	0.4	10.6	0.5	0.5
1996	1.7	2.0	4.3	0.8	2.2	3.9	0.5	11.3	0.4	0.7
1997	1.9	2.1	4.5	1.0	3.6	5.5	0.5	13.9	0.4	0.7
1998	1.6	2.4	3.1	0.9	2.1	2.8	0.7	13.3	0.3	1.9
1999	1.7	2.2	1.9	0.9	2.0	3.3	0.7	16.7	0.4	1.9
2000	1.8	2.9	3.0	0.9	2.5	3.5	0.8	15.5	0.3	1.6
2001	1.6	4.3	3.1	1.0	2.2	2.3	0.9	10.4	0.2	1.8

Source: Eurostat, NewCronos database (Health and safety statistics).

4.7.14 Incidence of tuberculosis, total per 100 000 persons

	EU	B	DK	D	EL (1)	E (2)	F	IRL	I	L
1975	33.9	43.9	12.3	:	87.9	8.9	47.5	36.9	7.3	28.9
1980	25.2	27.3	8.4	:	56.1	12.9	32.0	33.9	5.8	24.8
1985	19.5	19.8	6.1	25.8	15.7	28.0	20.5	22.7	7.3	15.0
1990	15.2	15.9	6.8	18.5	8.7	19.6	16.0	17.5	7.5	12.7
1991	14.8	14.6	6.5	16.9	7.5	23.2	15.0	18.2	6.6	12.5
1992	15.8	13.3	7.0	17.6	8.9	27.0	15.0	17.0	8.3	6.4
1993	15.5	14.9	7.9	17.5	9.6	24.3	16.6	16.8	8.3	9.6
1994	15.3	15.1	9.5	16.0	8.8	24.2	15.7	14.6	10.2	10.7
1995	14.5	13.6	8.6	15.0	9.0	21.3	15.0	12.7	9.1	7.9
1996	13.9	13.3	8.5	14.4	9.0	21.2	13.1	12.0	9.0	8.7
1997	13.6	12.4	10.5	13.6	7.3	23.8	11.7	11.4	9.0	9.1
1998	13.2	11.8	10.0	12.7	11.0	23.2	11.3	11.5	8.3	10.4
1999	12.8	12.4	10.1	12.2	9.0	21.3	11.3	12.6	7.7	9.8
2000	12.2	12.8	11.2	11.0	6.7	21.3	11.3	10.7	6.4	10.1

(1) Until 1996, new respiratory cases only; since 1997, new and recurrent respiratory and meningeal cases.
(2) New cases only.

Source: Eurostat, NewCronos database (Health and safety statistics) on the basis of data of WHO Collaborating Centre for the Surveillance of Tuberculosis in Europe (EuroTB).

4.7.15 Tuberculosis cases by age and sex (%), 1999

	EU	B	DK	D	EL	E (1)	F (2)	IRL	I	L
Age										
0–4	*2*	*3*	*4*	*2*	*2*	*4*	*2*	*4*	*2*	*2*
5–14	*3*	*2*	*5*	*2*	*2*	*3*	*3*	*4*	*2*	*5*
15–24	*11*	*10*	*13*	*9*	*9*	*13*	*10*	*12*	*9*	*12*
25–34	*18*	*16*	*31*	*15*	*12*	*22*	*15*	*16*	*17*	*29*
35–44	*17*	*14*	*19*	*16*	*15*	*17*	*18*	*12*	*14*	*10*
45–54	*13*	*15*	*12*	*13*	*11*	*11*	*14*	*12*	*11*	*12*
55–64	*11*	*11*	*7*	*15*	*13*	*8*	*10*	*13*	*12*	*10*
65–	*24*	*29*	*10*	*27*	*30*	*17*	*28*	*26*	*31*	*21*
Unknown	*1*	*0*	*0*	*0*	*7*	*4*	*0*	*0*	*3*	*0*
Sex										
Male	*62*	*66*	*56*	*62*	*70*	*65*	*59*	*61*	*63*	*86*
Female	*38*	*34*	*44*	*38*	*30*	*31*	*40*	*39*	*37*	*14*
Total cases	**47 981**	**1 270**	**536**	**9 974**	**952**	**8 393**	**6 674**	**469**	**4 429**	**42**

(1) Sex unknown for 1 % of cases.
(2) Sex unknown for 3 % of cases; includes respiratory and meningeal cases only.

Source: WHO Collaborating Centre for the Surveillance of Tuberculosis in Europe (EuroTB), Report on tuberculosis cases notified in 1999.

(cases per 100 000 population)

NL	A	P	FIN	S	UK	IS	NO	CH	
									Legionellosis
0.3	0.2	:	:	0.4	0.3	:	:	0.9	**1990**
0.3	0.2	:	0.1	0.5	0.3	:	:	0.5	**1995**
0.3	0.2	:	0.2	0.6	0.3	:	:	0.4	**1996**
0.3	0.2	0.1	0.2	1.3	0.4	-	0.0	1.0	**1997**
0.3	0.3	0.2	0.2	1.1	0.4	-	0.1	1.1	**1998**
1.7	0.5	0.1	0.2	1.0	0.4	0.7	0.2	1.1	**1999**
1.1	0.5	0.2	0.1	0.9	0.4	0.4	-	1.1	**2000**
1.1	0.1	0.1	0.3	0.9	0.3	0.4	1.0	1.9	**2001**
									Meningococcal disease
3.4	0.6	3.0	0.6	1.2	2.5	2.4	4.0	1.8	**1990**
3.0	0.6	1.8	1.5	0.9	2.4	8.2	3.6	1.5	**1995**
3.1	0.7	1.9	1.5	1.2	2.4	6.3	3.2	1.4	**1996**
3.2	1.3	1.9	0.9	0.9	2.6	7.4	2.6	1.5	**1997**
3.2	0.9	1.9	1.0	0.7	2.6	5.9	2.4	1.7	**1998**
3.4	1.1	2.4	1.1	0.7	2.7	7.6	1.8	2.3	**1999**
3.3	0.8	3.1	0.9	0.7	2.7	6.5	1.7	2.5	**2000**
4.8	1.2	1.9	0.9	0.8	2.3	6.4	1.9	2.3	**2001**

NL	A	P	FIN	S	UK	IS	NO	CH	
16.3	31.5	99.9	74.2	17.7	22.6	18.4	12.5	32.9	**1975**
12.0	29.2	69.5	47.0	11.1	18.8	11.0	12.2	18.3	**1980**
9.3	19.0	68.8	37.2	8.4	11.8	5.4	9.0	14.9	**1985**
9.4	19.8	62.6	15.5	6.5	10.3	7.1	6.7	19.1	**1990**
9.1	18.4	60.5	15.4	6.0	10.6	5.9	6.8	16.8	**1991**
11.3	17.2	60.1	13.9	7.1	11.1	6.2	6.7	14.4	**1992**
10.0	15.9	55.2	10.7	7.1	11.2	4.2	6.0	13.5	**1993**
11.8	15.8	56.8	10.9	6.0	10.6	6.8	5.6	13.3	**1994**
10.5	17.2	56.3	13.0	6.4	10.5	4.5	5.4	11.8	**1995**
10.8	17.9	52.9	12.6	5.6	10.6	4.1	5.0	10.8	**1996**
9.5	17.0	51.5	11.2	5.2	10.8	3.7	4.7	10.5	**1997**
8.6	16.2	52.8	12.2	5.0	10.5	6.2	5.5	10.6	**1998**
9.7	14.9	51.7	11.0	5.6	10.6	4.4	6.1	10.8	**1999**
8.9	15.0	45.2	10.4	5.1	11.3	4.7	5.3	8.8	**2000**

(percentages, and numbers of cases)

NL	A	P	FIN	S	UK	IS	NO	CH	
									Age
3	*2*	*1*	*0*	*0*	*2*	*0*	*3*	*1*	0–4
4	*2*	*2*	*0*	*2*	*4*	*0*	*6*	*2*	5–14
19	*7*	*11*	*3*	*13*	*14*	*17*	*15*	*14*	15–24
25	*15*	*22*	*5*	*24*	*20*	*17*	*21*	*21*	25–34
16	*18*	*21*	*6*	*14*	*16*	*25*	*15*	*18*	35–44
10	*17*	*14*	*12*	*8*	*11*	*8*	*10*	*10*	45–54
8	*12*	*11*	*12*	*6*	*11*	*8*	*6*	*8*	55–64
15	*26*	*18*	*61*	*33*	*22*	*25*	*25*	*26*	65–
0	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	Unknown
									Sex
58	*64*	*68*	*53*	*51*	*54*	*50*	*52*	*56*	Male
42	*36*	*32*	*47*	*49*	*46*	*50*	*48*	*44*	Female
1 535	**1 201**	**5 160**	**566**	**493**	**6 287**	**12**	**273**	**772**	**Total cases**

4.7.17 Incidence of certain zoonotic diseases

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Anthrax	-									
1990	:	:	:	:	0.04	0.32	:	:	0.02	:
1995	0	-	-	0	0.03	0.13	-	-	-	:
1996	0.02	-	-	0	0.04	0.13	-	-	-	:
1997	0.01	-	-	0	0.10	0.10	0.01	-	0	-
1998	0.01	-	-	-	0.01	0.09	-	-	-	-
1999	0.01	-	-	0.21	0.04	0.07	-	-	-	-
2000	0.01	-	-	-	-	0.09	-	-	-	-
2001	0.01	-	-	-	0	0.07	-	-	-	-
Brucellosis										
1990	:	:	:	0.04	1.84	7.83	0.15	0.43	2.20	0.26
1995	:	:	:	0.04	2.60	6.91	0.10	0.17	2.39	-
1996	1.41	-	-	0.03	2.68	5.30	0.10	0.28	3.31	-
1997	1.39	-	-	0.03	3.43	5.50	0.10	0.19	2.93	-
1998	1.15	-	-	0.02	3.99	3.93	0.10	0.41	2.54	-
1999	1.14	-	-	0.03	5.10	3.90	0.10	0.51	2.30	0.20
2000	0.89	-	-	0.03	5.19	2.83	0.10	0.40	1.85	-
2001	0.72	0	0.09	0.03	3.84	2.30	0.09	0.37	1.56	-
Leishmaniasis										
1990	:	:	:	:	0.23	0.31	:	:	0.20	:
1995	:	:	:	:	-	0.23	:	:	0.31	:
1996	:	-	-	:	0.06	0.19	:	:	0.31	:
1997	:	-	-	:	0.03	0.23	:	:	0.28	-
1998	:	-	-	:	0.24	0.22	:	:	0.23	-
1999	:	-	-	:	0.34	0.17	0.19	:	0.27	-
2000	:	-	-	:	0.49	0.20	:	:	0.37	-
2001	:	:	-	:	0.44	0.24	0.11	:	0.31	-
Q fever										
1990	:	:	:	:	:	:	:	:	0.04	:
1995	:	:	:	:	:	:	:	:	:	:
1996	:	-	-	0.09	-	:	0.08	-	-	:
1997	:	-	-	0.10	-	:	0.30	:	1.21	:
1998	:	-	-	0.18	-	0.48	0.40	:	0.26	-
1999	:	-	-	0.34	-	0.45	0.34	:	:	-
2000	:	-	-	0.24	0.01	0.20	0.40	:	1.73	-
2001	:	-	-	0.40	0.02	0.30	0.50	:	:	-
Rabies										
1990	0	-	-	0	-	-	-	-	-	-
1995	0	-	-	-	-	-	-	-	-	-
1996	0	-	-	0	-	-	0.01	-	0	-
1997	0	-	-	-	-	-	0	-	-	-
1998	-	-	-	-	-	-	-	-	-	-
1999	-	-	-	-	-	-	-	-	-	-
2000	0	-	-	-	-	-	-	-	-	-
2001	0	-	-	-	-	-	:	:	-	-
Tick-borne encephalitis										
1990	:	:	-	:	:	:	0	:	:	:
1995	:	:	-	0.30	:	:	0	:	0	:
1996	:	:	-	0.10	:	:	0	:	0	:
1997	:	:	-	0.30	:	:	0	:	0	:
1998	:	:	0	0.20	0.80	:	0	:	0	-
1999	:	:	0.10	0.10	:	-	0	:	0	:
2000	:	:	0.10	0.20	:	:	:	:	0	-
2001	:	:	:	0.30	:	:	:	:	:	:

Source: Eurostat, NewCronos database (Health and safety statistics).

(cases per 100 000 population)

NL	A	P	FIN	S	UK	IS	NO	CH	
									Anthrax
-	-	0.01	-	-	-	:	-	:	**1990**
-	-	0.06	-	-	0	:	-	-	**1995**
-	-	-	-	-	0	-	-	-	**1996**
-	-	-	-	-	0	-	-	-	**1997**
-	-	0.04	-	-	-	-	-	0.01	**1998**
-	-	0.04	-	-	0	-	0.12	-	**1999**
-	-	0.64	-	-	0	0	0.02	-	**2000**
-	-	-	-	-	0	-	-	-	**2001**
									Brucellosis
0.03	0.04	11.20	:	0.04	:	:	-	0.42	**1990**
0.02	0.01	9.23	0.02	0.03	:	:	-	0.20	**1995**
0.03	-	8.67	0	0.07	0.03	-	-	0.25	**1996**
0.02	0.05	8.72	0	0.03	0.01	-	-	0.20	**1997**
0.01	0.01	8.21	0.02	0.02	0.01	-	-	0.10	**1998**
0.01	0.02	0.02	0	-	0.14	-	0.02	0.10	**1999**
0.02	0.02	5.07	0	0.01	0.03	-	-	0.14	**2000**
0.01	0.02	3.71	0.02	0.02	0.04	-	0.04	0.15	**2001**
									Leishmaniasis
:	:	0.28	:	:	:	:	:	:	**1990**
:	:	0.18	0.06	:	:	:	:	:	**1995**
-	-	0.27	0.02	0.07	0.03	-	-	-	**1996**
-	-	0.15	-	0.01	0.02	-	-	-	**1997**
:	:	0.11	-	0.00	-	-	-	-	**1998**
:	:	0.19	-	0.03	-	-	-	:	**1999**
:	:	0.07	-	0.01	0.02	-	-	:	**2000**
:	:	0.13	-	-	0.04	-	0.02	:	**2001**
									Q fever
0.15	:	:	:	:	:	:	:	0.48	**1990**
0.18	:	:	-	:	:	:	:	0.20	**1995**
0.10	:	:	-	-	0.25	-	-	0.18	**1996**
0.10	:	:	-	-	0.21	-	:	0.18	**1997**
0.06	:	:	0.02	-	0.19	-	0.05	0.14	**1998**
0.04	:	0.12	-	-	0.19	-	0.04	:	**1999**
0.06	:	0.11	-	-	0.18	-	-	:	**2000**
0.09	:	0.19	0.00	:	0.10	-	-	:	**2001**
									Rabies
-	-	-	-	-	-	-	-	-	**1990**
-	-	-	-	-	0	-	-	-	**1995**
-	-	-	-	-	-	-	-	-	**1996**
0.01	-	-	-	-	-	-	-	-	**1997**
-	-	-	-	-	-	-	-	-	**1998**
-	-	-	-	-	-	-	-	-	**1999**
-	-	-	-	0	-	-	-	-	**2000**
-	:	-	-	0	0	-	-	:	**2001**
									Tick-borne encephalitis
:	1.20	:	0.20	0.60	:	:	-	0.40	**1990**
:	1.40	:	0.50	0.80	:	:	-	0.90	**1995**
:	1.60	:	0.20	0.50	:	:	-	0.90	**1996**
:	1.20	:	0.40	0.90	:	:	0	1.70	**1997**
:	0.80	:	0.30	0.70	-	:	-	1.00	**1998**
:	0.50	:	0.20	0.60	-	-	0	1.50	**1999**
:	0.70	:	0.80	2.20	-	-	0	1.30	**2000**
:	0.70	:	0.60	1.31	-	-	0	1.50	**2001**

4.7.18 Incidence of cholera and malaria

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Cholera										
1990	0	-	0	0	-	0	0	-	-	-
1995	0	-	0.1	0	-	0	0	-	0	-
1996	0	-	0	-	-	-	0	-	-	-
1997	0	-	-	0	-	-	0	-	-	-
1998	0	-	0	0	-	-	0	-	0	-
1999	0	-	-	0	-	-	-	-	0	:
2000	0	-	-	0	-	-	-	0	-	-
2001	0	0	-	0	-	0	-	0	-	-
Malaria										
1990	2.4	0.2	2.3	1.2	0.2	0.4	7.5	0.3	0.9	1.8
1995	2.3	0.1	3.3	1.2	0	0.7	6.3	0.3	1.3	1.5
1996	2.8	0.1	3.6	1.2	0	0.6	8.8	0.4	1.3	1.0
1997	2.9	0.1	4.0	1.2	0.1	0.7	9.2	0.2	1.4	1.9
1998	3.1	3.3	3.4	1.2	0.1	0.9	10.1	0.5	1.6	1.9
1999	3.4	3.6	3.9	1.1	0.2	1.0	12.1	0.5	1.7	4.2
2000	3.7	3.3	3.8	1.0	0.2	1.1	13.6	0.5	1.7	0.9
2001	3.5	3.2	2.9	1.3	0.2	1.2	12.2	0.3	1.7	0.9

Source: Eurostat, NewCronos database (Health and safety statistics).

4.7.19 Incidence of streptococcal diseases

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Streptococcus pneumoniae										
1990	:	6.8	12.5	:	:	:	:	:	:	:
1995	:	11.1	20.6	:	:	0.3	8.6	:	0.3	:
1996	:	15.0	27.0	:	:	0.4	9.0	:	0.3	:
1997	:	13.8	23.1	:	:	0.4	9.4	0.8	0.4	:
1998	:	13.9	17.9	:	:	0.3	8.9	0.5	0.4	:
1999	:	13.7	16.6	:	:	0.3	8.9	0.5	0.5	:
2000	:	13.3	:	1.3	:	0.5	:	0.7	:	:
Streptococcus pyogenes (Group A)										
1995	:	1.9	:	:	:	0.0	0.5	:	0.1	:
1996	:	2.7	:	:	:	0.0	1.0	:	0.1	:
1997	:	2.5	1.0	:	:	0.1	0.5	:	:	:
1998	:	2.9	0.7	:	:	0.1	0.9	:	:	:
1999	:	2.9	0.8	0.6	:	0.1	:	:	:	:
2000	:	3.8	1.5	:	:	:	:	:	:	:
2001	:	3.5	:	:	:	:	:	:	:	:
Streptococcus (Group B)										
1995	:	:	:	:	:	:	2.9	:	:	:
1996	:	:	:	:	:	:	3.0	:	:	:
1997	:	:	:	:	:	:	3.0	:	:	:
1998	:	:	:	:	:	:	3.4	:	:	:
1999	:	:	:	:	:	0	3.2	:	:	:
2000	:	0.8	:	0.1	:	0	:	:	:	:

Source: Eurostat, NewCronos database (Health and safety statistics).

(cases per 100 000 population)

NL	A	P	FIN	S	UK	IS	NO	CH	
									Cholera
0	-	-	-	-	0	-	-	-	**1990**
0.1	-	0	0	0	0.1	-	0	0	**1995**
0	-	-	-	-	0.1	-	-	-	**1996**
0	-	-	-	-	0.1	-	-	0	**1997**
0	0	-	0	-	0.1	-	0.1	0	**1998**
0	0	-	0	-	0.1	-	-	-	**1999**
-	-	-	-	-	0.1	-	-	-	**2000**
0	-	-	0	-	0	-	-	-	**2001**
									Malaria
1.7	1.5	1.3	:	2.4	3.6	0	1.4	4.4	**1990**
2.0	1.0	0.8	0.6	1.8	3.5	0	1.8	4.1	**1995**
2.0	1.1	0.9	0.9	2.1	4.3	0	2.3	4.1	**1996**
1.4	0.9	0.7	1.1	3.0	4.0	0	2.4	4.5	**1997**
1.6	1.0	0.8	0.8	2.4	3.5	0.7	2.0	4.8	**1998**
1.7	1.2	0.8	0.6	2.0	3.4	5.4	1.7	4.4	**1999**
4.4	0.8	0.8	0.7	1.8	3.5	:	0.7	4.4	**2000**
3.6	0.9	0.6	0.7	1.8	3.4	1.1	1.7	4.5	**2001**

(cases per 100 000 population)

NL	A	P	FIN	S	England	IS	NO	CH	
									Streptococcus pneumoniae
:	:	:	:	6.7	7.2	:	5.9	:	**1990**
:	:	:	9.7	13.7	8.0	:	16.2	:	**1995**
4.7	:	:	10.5	15.3	9.1	:	20.3	:	**1996**
4.5	:	:	11.5	13.2	9.9	:	18.6	:	**1997**
:	:	:	10.9	15.2	9.1	:	20.3	:	**1998**
:	:	:	11.0	13.0	9.0	:	19.7	3.6	**1999**
:	:	:	11.6	13.3	:	:	9.9	10.2	**2000**
									Streptococcus pyogenes (Group A)
:	:	:	1.1	3.3	:	:	2.5	:	**1995**
:	:	:	1.2	2.4	:	:	2.6	:	**1996**
1.9	:	:	1.6	3.4	:	:	3.7	:	**1997**
1.4	:	:	2.0	3.5	:	:	4.3	3.6	**1998**
0.9	:	:	2.2	3.4	1.3	:	5.9	10.3	**1999**
1.0	:	:	2.2	3.7	1.4	:	:	11.5	**2000**
1.2	:	:	1.9	3.6	1.4	:	4.6	:	**2001**
									Streptococcus (Group B)
:	:	:	2.2	:	:	:	2.0	:	**1995**
:	:	:	2.8	:	:	:	1.4	:	**1996**
:	:	:	2.7	:	:	:	2.0	:	**1997**
:	:	:	2.9	:	:	:	1.9	:	**1998**
:	0	:	3.0	:	:	:	3.0	:	**1999**
:	:	:	3.0	:	:	:	:	:	**2000**

4.7.20 Nosocomial infections in France and Spain (non-adjusted comparison)

	France				Spain			
	1996		2001		1990		1999	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Infected patients	18 885	8.0	21 010	6.9	3 720	9.7	4 170	7.8
from which:								
at the same hospital	15 798	6.7	18 042	5.9	-	-	-	-
in another hospital	3 087	1.3	2 939	1.0	-	-	-	-
Infections			23 024	7.5	-	-	-	-
from which:								
acquired in the hospital	-	-	19 640	6.4	-	-	-	-
acquired in another hospital	-	-	3 353	1.1	-	-	-	-

Most frequent infections								
	France				Spain			
	1996		2001		1990		1999	
Escherichia coli	-	-	4 452	23.6	447	16.3	545	16.7
Staphylococcus aureus	-	-	3 913	19.8	307	11.2	214	6.6
Pseudomonas aeruginosa	-	-	2 199	11.1	316	11.5	339	10.4
Enterococcus	-	-	1 178	6.0	212	7.7	290	8.9
Proteus mirabilis	-	-	1 048	5.3	101	3.7	122	3.7
Staphylococcus, coag neg	-	-	914	4.6	341	12.4	431	13.2
Candida albicans	-	-	704	3.6	91	3.3	135	4.1
Klebsiella pneumoniae	-	-	601	3.1	65	2.4	74	2.3
Streptoccocus other	-	-	514	2.6	93	3.4	82	2.5
Enterobacter spp	-	-	768	3.9	88	3.2	102	3.1
Candida non albicans	-	-	256	1.3	46	1.7	80	2.5
Klebsiella oxytoca	-	-	255	1.3	38	1.4	36	1.1
Morganella	-	-	233	1.2	18	0.7	43	1.3
Acinetobacter	-	-	230	1.2	25	1.9	117	3.6
Serratia	-	-	210	1.1	29	1.1	24	0.7

Source: Réseau d'alerte d'investigation et de surveillance des infections nosocomiales (Raisin), France and Estudio de la prevalencia de las infecciones nosocomiales en los hospitales españoles (EPINE), Spain.

4.7.21 Cumulative susceptibility test results of invasive *Streptococcus pneumoniae* and *Staphylococcus aureus*, 1998–2000

Pathogens	B	DK	D	EL	E	IRL	I	L	NL	A	P	FIN	S	UK	IS
Penicillin non-susceptible *S. pneumoniae* (PNSP):															
Intermediate resistant	143	:	0		316	28	13	1	11	0	20	8	18	16	2
Resistant	85	:	1		124	14	27	1	4	0	0	7	4	20	0
Total *S. pneumoniae*	1 531	:	210		1 344	265	338	27	1 106	33	119	246	1 214	544	77
PNSP (%)	*15*	:	*0*		*33*	*16*	*12*	*7*	*1*	*0*	*17*	*6*	*2*	*7*	*3*
Methicillin-resistant *S. aureus*	132	10	54	196	254	324	674	7	8	33	136	3	14	507	1
Total *S. aureus*	602	1 106	633	554	707	812	1 615	65	1 777	153	369	461	1 917	1 385	58
MRSA (%)	*22*	*1*	*9*	*35*	*36*	*40*	*42*	*11*	*0*	*22*	*37*	*1*	*1*	*37*	*2*

Source: Eurosurveillance Report, Vol. 6, No 1 (2001), from the European Antimicrobial Resistance Surveillance System (EARSS) .

4.7.22 Incidence of cancer, 1997: age-standardised rate per 100 000 (standard European population)

	EU-15	B	DK	D	EL	E	F	IRL
					Total			
All sites but skin (excluding non-melanocytic skin cancers)	345.1	380.2	364.1	341.1	278.4	322.1	359.5	361.8
Lip, oral cavity, pharynx	12.6	11.9	9.8	12.3	4.9	16.9	24.7	8.4
Oesophagus	5.4	4.9	5.9	4.6	1.4	4.3	7.8	8.8
Stomach	15.0	11.2	7.8	16.0	13.0	16.8	9.6	13.9
Colon, rectosigmoid junction, rectum and anus	45.2	46.1	52.2	50.8	24.5	42.2	43.3	52.8
Liver and the intrahepatic bile ducts	6.4	2.2	3.5	4.3	12.8	7.8	6.7	2.1
Pancreas	8.3	7.4	10.1	9.3	7.6	6.9	6.1	10.0
Larynx	5.6	7.6	4.4	4.3	5.0	8.8	7.0	3.0
Trachea, bronchus and lung	42.7	55.3	53.9	39.5	44.8	39.8	38.8	43.6
Melanoma of skin	8.5	7.2	14.5	8.6	3.2	6.6	8.4	12.0
Kidney and other urinary organs	10.3	9.7	10.0	12.4	7.8	8.7	10.1	8.8
Bladder	15.2	16.5	10.8	11.9	16.8	21.8	13.5	13.1
Brain	6.6	8.3	7.2	6.5	11.7	6.5	5.5	7.7
Thyroid gland	3.8	2.4	2.0	2.9	5.6	3.9	5.1	1.7
Non-Hodgkin's lymphoma	11.4	10.2	11.6	9.8	5.3	10.8	12.2	12.4
Hodgkin's disease	2.3	2.1	2.2	2.1	2.7	2.4	2.4	2.4
Multiple myeloma	4.3	4.4	4.4	4.1	2.9	3.6	4.8	5.3
Leukaemias	9.4	10.3	9.5	9.0	9.8	9.3	10.2	9.9
					Males			
All sites but skin (excluding non-melanocytic skin cancers)	419.0	473.1	373.4	413.6	338.1	426.7	460.7	405.9
Lip, oral cavity, pharynx	22.1	20.1	14.6	21.5	7.4	31.4	46.1	13.5
Oesophagus	9.3	8.6	9.4	8.2	2.3	8.4	14.7	13.0
Stomach	21.3	16.1	11.0	21.7	17.5	24.3	14.5	19.9
Colon, rectosigmoid junction, rectum and anus	56.1	55.1	57.7	62.4	27.6	53.3	55.4	65.9
Liver and the intrahepatic bile ducts	10.1	3.2	5.2	6.7	18.4	11.8	12.0	2.7
Pancreas	10.1	9.1	11.8	11.4	9.5	8.8	7.9	11.6
Larynx	11.3	14.2	7.8	8.6	9.9	18.5	13.9	5.4
Trachea, bronchus and lung	75.7	107.0	69.7	71.4	82.5	80.2	72.6	61.9
Melanoma of skin	9.3	8.0	13.6	10.5	3.4	7.9	9.5	10.5
Testis	4.9	4.9	10.5	5.7	3.2	2.3	5.3	4.6
Prostate	69.2	101.5	50.2	75.8	41.4	46.3	86.4	73.7
Kidney and other urinary organs	14.9	13.2	14.1	18.4	11.4	13.4	14.9	12.9
Bladder	27.7	29.1	18.8	21.2	30.3	42.7	24.7	21.5
Brain	8.0	9.9	9.3	7.8	14.3	8.2	6.6	9.5
Thyroid gland	2.0	1.6	1.3	1.7	2.9	1.7	2.4	1.4
Non-Hodgkin's lymphoma	14.0	12.5	13.5	12.2	6.1	13.4	15.5	14.4
Hodgkin's disease	2.7	2.4	2.9	2.5	3.2	2.9	2.9	2.4
Multiple myeloma	5.2	5.4	5.8	5.0	3.4	4.2	5.7	6.2
Leukaemias	11.9	12.8	12.1	11.4	12.5	11.8	12.8	12.5
					Females			
All sites but skin (excluding non-melanocytic skin cancers)	296.8	318.8	366.8	300.1	231.4	242.1	284.7	335.1
Lip, oral cavity, pharynx	4.2	4.4	5.3	4.2	2.7	4.1	5.3	4.0
Oesophagus	2.2	1.8	2.9	1.6	0.6	0.8	1.8	5.2
Stomach	10.3	7.5	5.2	12.1	9.2	10.8	5.8	9.0
Colon, rectosigmoid junction, rectum and anus	36.9	39.4	47.8	42.3	21.9	33.7	34.0	42.2
Liver and the intrahepatic bile ducts	3.6	1.5	2.2	2.6	8.0	4.4	2.4	1.5
Pancreas	6.8	6.0	8.5	7.6	6.0	5.2	4.5	8.7
Larynx	0.9	1.8	1.4	0.9	0.7	0.4	0.9	0.9
Trachea, bronchus and lung	17.0	14.9	42.1	16.2	12.2	6.9	10.3	28.5
Melanoma of skin	7.9	6.4	15.8	7.1	2.9	5.6	7.4	13.4
Breast	97.2	116.0	113.2	94.7	70.6	70.0	109.6	96.3
Cervix uteri	10.5	10.3	14.6	12.1	8.1	7.7	11.6	10.1
Corpus uteri	15.8	19.2	18.4	15.5	8.6	15.0	15.5	14.0
Ovary	14.5	16.8	18.2	15.2	10.0	13.5	12.6	19.8
Kidney and other urinary organs	6.5	6.9	6.5	7.9	4.7	4.9	6.0	5.3
Bladder	6.0	7.1	4.7	6.1	5.4	5.1	4.6	6.5
Brain	5.3	6.9	5.3	5.3	9.3	5.1	4.5	6.0
Thyroid gland	5.5	3.3	2.8	4.1	8.3	6.0	7.8	2.0
Non-Hodgkin's lymphoma	9.2	8.3	10.1	7.9	4.6	8.5	9.3	10.5
Hodgkin's disease	2.0	1.8	1.6	1.8	2.2	1.9	1.9	2.3
Multiple myeloma	3.6	3.7	3.2	3.4	2.5	3.2	4.0	4.5
Leukaemias	7.5	8.5	7.5	7.2	7.5	7.2	8.1	8.0

Source: EUCAN, International Agency for Research on Cancer, Lyons.

I	L	NL	A	P	FIN	S	UK	
				Total				
348.2	364.4	372.5	357.4	314.6	331.5	333.5	355.3	**All sites but skin (excluding non-melanocytic skin cancers)**
9.0	14.3	9.1	9.5	12.5	7.2	6.6	7.1	**Lip, oral cavity, pharynx**
2.9	6.0	5.8	3.6	4.6	3.3	2.7	9.2	**Oesophagus**
20.2	12.9	12.2	18.0	30.2	12.6	8.9	13.3	**Stomach**
44.2	48.7	50.0	49.6	46.5	33.4	39.8	45.0	**Colon, rectosigmoid junction, rectum and anus**
13.2	1.8	1.6	7.8	4.7	3.6	4.3	3.1	**Liver and the intrahepatic bile ducts**
9.2	6.6	7.7	12.0	6.8	11.7	7.8	8.7	**Pancreas**
7.4	4.7	4.4	3.6	9.1	2.1	1.6	3.4	**Larynx**
44.6	47.2	53.2	39.8	26.5	33.0	23.6	51.9	**Trachea, bronchus and lung**
7.4	8.5	13.4	10.8	4.5	9.8	16.4	9.2	**Melanoma of skin**
10.7	7.8	10.3	14.6	6.1	12.4	9.7	8.6	**Kidney and other urinary organs**
17.3	13.7	12.5	17.4	15.1	12.0	15.2	16.2	**Bladder**
5.9	7.3	6.2	5.9	7.3	6.8	7.0	6.9	**Brain**
5.8	2.2	2.1	4.5	5.7	6.3	3.1	1.8	**Thyroid gland**
14.2	9.7	12.0	9.7	13.0	14.4	11.6	11.6	**Non-Hodgkin's lymphoma**
2.9	0.6	2.0	1.9	2.7	2.6	1.9	2.1	**Hodgkin's disease**
4.6	3.6	4.8	3.3	3.9	4.0	4.4	4.4	**Multiple myeloma**
10.1	10.8	8.1	8.1	8.1	6.9	9.4	9.0	**Leukaemias**
				Males				
433.0	450.2	434.8	438.5	385.7	398.7	356.9	393.9	**All sites but skin (excluding non-melanocytic skin cancers)**
16.0	26.1	12.9	16.0	23.8	11.3	9.1	9.9	**Lip, oral cavity, pharynx**
5.3	10.4	9.3	7.0	8.5	4.5	4.4	13.3	**Oesophagus**
28.5	17.9	18.8	24.5	42.3	17.9	12.4	19.8	**Stomach**
55.6	58.9	60.8	64.2	60.5	38.8	47.1	56.2	**Colon, rectosigmoid junction, rectum and anus**
20.4	2.5	2.2	12.6	7.5	5.4	5.6	4.2	**Liver and the intrahepatic bile ducts**
11.3	7.9	8.2	13.5	8.7	14.0	8.3	10.2	**Pancreas**
15.3	9.9	8.1	7.2	18.8	4.3	3.0	6.1	**Larynx**
85.4	87.0	91.5	67.9	50.6	62.0	31.4	75.3	**Trachea, bronchus and lung**
8.9	9.0	11.8	11.9	3.9	10.3	16.9	8.4	**Melanoma of skin**
4.0	4.2	4.8	7.8	3.2	2.9	6.3	5.7	**Testis**
53.9	87.3	84.6	94.8	53.4	116.0	102.2	64.2	**Prostate**
16.4	10.9	13.9	19.6	9.0	17.4	12.2	11.9	**Kidney and other urinary organs**
33.2	24.3	23.0	31.7	25.8	23.6	25.4	27.0	**Bladder**
7.3	9.1	7.4	7.7	9.5	7.5	8.1	8.5	**Brain**
3.0	0.0	1.2	2.9	2.8	3.4	2.1	1.1	**Thyroid gland**
17.5	13.2	14.4	11.5	17.0	16.8	13.3	13.7	**Non-Hodgkin's lymphoma**
3.2	1.2	2.3	2.0	3.2	3.4	2.1	2.4	**Hodgkin's disease**
5.5	4.5	6.1	3.6	4.8	4.2	5.3	5.4	**Multiple myeloma**
12.9	16.3	10.8	10.3	10.0	8.7	11.5	11.2	**Leukaemias**
				Females				
291.4	307.6	338.4	307.3	265.1	302.1	326.0	336.6	**All sites but skin (excluding non-melanocytic skin cancers)**
3.1	3.5	5.8	3.8	2.9	4.0	4.3	4.6	**Lip, oral cavity, pharynx**
1.0	2.2	3.0	1.0	1.4	2.3	1.3	5.9	**Oesophagus**
13.9	9.3	7.1	13.9	20.8	9.5	6.2	8.2	**Stomach**
35.7	41.0	41.9	39.5	36.0	29.7	34.1	36.2	**Colon, rectosigmoid junction, rectum and anus**
7.5	1.2	1.1	4.2	2.5	2.4	3.3	2.1	**Liver and the intrahepatic bile ducts**
7.5	5.5	7.4	10.6	5.3	9.8	7.4	7.5	**Pancreas**
0.9	0.2	1.3	0.6	1.0	0.4	0.5	1.1	**Larynx**
13.1	16.1	24.5	19.4	7.6	13.4	17.3	34.6	**Trachea, bronchus and lung**
6.1	8.2	15.2	10.0	5.1	9.6	16.4	10.1	**Melanoma of skin**
93.4	99.7	120.0	90.1	73.8	102.3	107.3	108.3	**Breast**
9.1	4.2	8.2	11.2	17.3	5.1	10.8	10.2	**Cervix uteri**
16.9	32.0	16.6	18.1	17.8	20.6	22.1	14.3	**Corpus uteri**
11.1	15.4	15.8	16.7	9.9	16.1	20.4	18.9	**Ovary**
6.0	5.4	7.2	10.6	3.8	8.4	7.6	6.0	**Kidney and other urinary organs**
5.4	6.2	4.9	7.8	7.1	4.6	7.1	8.2	**Bladder**
4.7	5.6	5.2	4.4	5.4	6.2	6.0	5.5	**Brain**
8.4	4.2	2.9	5.9	8.3	9.2	4.1	2.5	**Thyroid gland**
11.3	6.8	10.0	8.3	9.6	12.4	10.1	9.7	**Non-Hodgkin's lymphoma**
2.6	0.0	1.7	1.7	2.3	2.0	1.7	1.8	**Hodgkin's disease**
4.0	3.0	3.8	3.1	3.2	3.8	3.6	3.6	**Multiple myeloma**
8.0	6.4	6.0	6.4	6.6	5.9	7.7	7.2	**Leukaemias**

4.7.25 Survival, and total prevalence for selected cancer sites, periods around 1990

Survival (1)

	Stomach	Colon	Rectum	Lung	Melanoma of skin	Breast	Cervix uteri	Corpus uteri	Prostate	Hodgkin's disease	Leu-kaemia	All malignant neo-plasms (*)
DK	13.3	41.2	39.7	5.7	78.5	70.6	64.2	75.6	41.0	69.6	27.6	38.6
FIN	19.7	49.0	47.7	10.2	80.6	78.4	60.4	75.9	61.6	73.8	33.6	44.1
IS	23.5	47.6	:	12.2	75.4	79.2	84.7	76.9	66.2	:	21.8	48.9
S registries	17.4	53.6	50.4	9.0	87.6	80.6	68.0	82.2	64.7	72.3	32.7	52.1
ENG registries	11.8	41.2	40.5	7.0	78.2	66.7	62.6	72.9	44.3	71.7	28.5	37.0
Scotland	10.7	41.1	37.4	6.2	82.5	65.0	59.0	70.2	47.2	65.8	26.1	33.7
A registry	26.9	48.5	50.6	11.0	89.3	63.2	68.7	80.7	54.4	:	42.0	48.3
D registry	25.5	49.8	43.5	9.4	76.1	71.7	64.1	73.0	67.6	72.0	39.0	44.7
NL registry	19.3	57.1	53.0	11.6	80.5	74.4	67.8	83.7	55.3	:	32.5	42.2
CH registries	22.8	50.8	52.1	10.3	88.6	79.6	67.2	76.6	71.4	75.9	40.3	48.5
F registries	24.8	52.9	48.4	11.9	77.4	80.3	64.1	74.7	61.7	75.9	47.2	45.2
I registries	23.2	47.0	43.5	8.8	67.7	76.7	64.0	72.9	47.4	70.6	26.6	41.0
E registries	26.4	49.5	43.2	:	78.8	70.4	61.8	73.0	54.5	:	39.4	43.4
European registries (**)	21.1	46.7	42.7	9.1	76.0	72.5	61.8	73.2	55.7	71.7	34.3	41.0

Prevalence (2)

	Stomach	Colon	Rectum	Lung	Melanoma of skin	Breast	Cervix uteri	Corpus uteri	Prostate	Hodgkin's disease	Leu-kaemia	All malignant neo-plasms (*)
DK	13.9	90.6	64.0	51.0	95.9	599.1	131.8	151.2	111.5	19.3	32.9	1 452.5
FIN	36.7	61.7	41.0	47.3	72.7	529.4	22.6	119.8	174.8	17.8	31.8	1 204.9
IS	57.4	90.4	30.3	52.3	58.3	666.8	95.6	141.5	263.9	18.2	25.4	1 593.3
S registries	22.1	98.4	59.6	33.4	140.8	620.0	85.9	129.2	233.9	16.9	33.9	1 638.4
ENG registries	17.7	76.3	50.8	50.8	50.4	554.4	93.7	87.9	106.0	20.5	27.6	1 202.2
Scotland	20.6	91.4	47.9	70.0	64.6	539.9	93.3	69.7	111.0	20.4	29.7	1 299.0
A registry	70.0	85.1	52.5	49.0	129.7	478.2	141.3	134.1	235.3	23.2	34.8	1 676.7
D registry	41.6	103.0	66.8	50.1	50.7	500.6	84.6	125.6	154.0	18.2	31.3	1 388.1
NL registry	35.5	112.2	67.4	81.8	59.6	612.6	47.1	110.9	151.8	15.3	25.9	1 331.8
CH registries	26.8	90.0	63.8	56.5	96.2	636.9	44.3	137.4	215.4	16.5	33.5	1 447.9
F registries	27.5	92.9	64.4	91.9	30.8	585.1	80.4	91.4	168.2	20.2	40.1	1 560.5
I registries	61.7	96.5	54.3	56.1	39.2	553.6	60.4	109.9	93.3	25.7	28.8	1 379.2
E registries	49.4	67.8	45.4	46.4	30.7	385.9	61.7	98.0	87.1	20.3	25.5	1 175.4
European registries (**)	30.5	78.1	52.4	54.4	55.0	503.9	88.2	108.3	113.6	19.8	28.4	1 252.8

(*) Excluding non-melanoma skin cancer.

(**) Including Estonia, Poland, Slovenia and Slovakia registers.

(1) *Source:* Eurocare 2 study. Eurocare age-adjusted five-year relative survival (%), 1988–92 incidence period.

(2) *Source:* Europreval study. Total prevalence at 31.12.1992; world standard age-adjusted proportion per 100 000.

4.7.26 Number of cases by type of birth, and total prevalence rates per 10 000 births, 28 full member Eurocat registries combined (*), 1980–99

	Live births LB N	Foetal deaths (1) FD N	Induced abortions (2) IA N	Total LB+FD+IA N	Total LB+FD+IA Rate (3)
Nervous system	**6 943**	**1 250**	**5 196**	**13 389**	**22.01**
Neural tube defects	2 613	759	3 244	6 616	10.88
Anencephalus and similar	368	463	1 661	2 492	4.10
Encephalocele	351	81	372	804	1.32
Spina bifida	1 894	215	1 211	3 320	5.46
Hydrocephaly	1 645	302	1 165	3 112	5.12
Microcephaly	1 123	70	122	1 315	2.55
Arhinencephaly/holoprosencephaly	205	56	303	564	1.09
Eye	**2 870**	**102**	**204**	**3 176**	**5.22**
Anophthalmos/microthalmos	619	50	120	789	1.30
Anophthalmos	117	20	37	174	0.29
Microthalmos	502	30	83	615	1.01
Cataract	558	4	18	580	0.95
Ear	**4 210**	**134**	**258**	**4 602**	**7.57**
Anotia/microtia	514	20	43	577	0.95
Anotia	119	6	18	143	0.24
Microtia	395	14	25	434	0.71
Congenital heart disease	**29 294**	**848**	**2 595**	**32 737**	**53.82**
Anomalies of cardiac chambers and connections	2 595	114	348	3 057	5.03
Common arterial truncus	341	37	68	446	0.86
Transposition of great vessels (complete)	1 167	21	82	1 270	2.45
Single ventrical	430	37	98	565	0.93
Malformations of cardiac septa	19 735	513	1 490	21 738	35.74
Ventricular septal defect	12 803	315	798	13 916	22.88
Atrial septal defect	6 119	131	291	6 541	10.75
Atrioventricular septal defect	1 516	73	400	1 989	3.27
Tetralogy of Fallot	1 358	36	118	1 512	2.49
Malformations of valves	4 908	152	575	5 635	9.26
Tricuspid atresia and stenosis	513	18	69	600	0.99
Ebstein's anomaly	158	12	14	184	0.30
Aortic valve atresia/stenosis	582	17	41	640	1.05
Hypoplastic left heart	898	40	325	1 263	2.08
Malformations of the great arteries and veins	6 447	176	417	7 040	11.57
Coarctation of aorta	1 652	47	100	1 799	2.96
Cleft lip with or without palate	**4 696**	**211**	**470**	**5 377**	**9.07**
Cleft palate	**3 080**	**119**	**227**	**3 426**	**5.78**
Digestive system	**10 027**	**435**	**1 011**	**11 473**	**18.86**
Tracheo-oesophagal fistula-Oesophageal atresia and stenosis	1 593	70	122	1 785	2.93
Congenital absence, atresia and/or stenosis of the small intestine	1 234	51	97	1 382	2.27
Congenital absence, atresia and/or stenosis of the duodenal	591	30	59	680	1.31
Congenital absence, atresia and/or stenosis of other specified parts of the small intestine	372	8	19	399	0.77
Ano-rectal atresia and stenosis	1 475	92	200	1 767	3.12
Internal urogenital system-ovaries uterus and renal system	**12 953**	**682**	**2 352**	**15 987**	**26.28**
Bilateral renal agenesis	527	168	520	1 215	2.05
Cystic kidney disease	1 823	107	625	2 555	4.92
Congenital hydronephrosis	4 054	83	304	4 441	7.30
Bladder extrophy	190	9	49	248	0.41
External genital system	**7 635**	**143**	**313**	**8 091**	**13.30**
Hypospadias	5 788	24	46	5 858	10.62
Indeterminate sex	291	49	68	408	0.79
Limb	**22 075**	**656**	**1 712**	**24 443**	**40.18**
Limb reduction	2 710	194	536	3 440	5.66
Upper limb reduction	1 739	139	377	2 255	3.71
Complete absence of upper limb	38	14	21	73	0.12
Absence of upper arm and forearm with hand present	40	5	9	54	0.09
Absence of both forearm and hand	139	7	25	171	0.28

(cont.)

	Live births LB N	Foetal deaths (1) FD N	Induced abortions (2) IA N	Total LB+FD+IA N	Rate (3)
Absence of hand and fingers	667	57	113	837	1.38
Longitudinal reduction defect/shortening of arm	580	52	172	804	1.32
Lower limb reduction	861	72	207	1 140	1.87
Complete absence of lower limb	31	5	22	58	0.10
Absence of thigh and lower leg with foot present	27	4	14	45	0.07
Absence of both lower leg and foot	18	3	8	29	0.05
Absence of foot and toe	244	23	40	307	0.50
Longitudinal reduction defect/shortening of leg	301	18	68	387	0.64
Polydactyly	4 658	117	289	5 064	8.95
Syndactyly	3 613	110	209	3 932	6.95
Musculoskeletal and connective tissue	**11 350**	**856**	**2 762**	**14 968**	**24.61**
Choanal atresia	444	4	17	465	0.76
Craniosynostosis	759	16	32	807	1.33
Pierre Robin syndrome	568	5	7	580	0.95
Mandibulofacial dystosis (Treacher-Collins and Franceschetti)	82	7	1	90	0.15
Oculomandibular dysostosis (Hallerman-Streiff)	6	0	0	6	0.01
Goldenhar's syndrome	133	2	4	139	0.23
Chondodystrophies and osteodystrophies	808	73	412	1 293	2.13
Diaphragmatic hernia	1 181	74	234	1 489	2.87
Omphalocele	826	164	594	1 584	2.60
Gastroschisis	605	64	172	841	1.38
Prune Belly syndrome	77	11	94	182	0.30
Chromosomal	**9 214**	**670**	**6 580**	**16 464**	**27.07**
Down's syndrome (Trisomy 21)	6 591	231	3 400	10 222	16.81
Patau syndrome (Trisomy 13)	259	60	356	675	1.30
Edward syndrome (Trisomy 18)	511	172	945	1 628	3.14
Other trisomies and partial trisomies of autosomes	464	61	540	1 065	1.75
Monosomies and deletions from the autosomes	368	16	149	533	0.88
Turner's syndrome	309	86	594	989	1.63
Klinefelters syndrome	188	9	225	422	0.69
Total cases (full member registries)	***112 550***	***3 893***	***15 574***	***132 017***	***217.04***

(*) Mainz: not including microcephaly.
North-east Italy do not register cases of: microcephaly, arhinencephaly/holoprosencephaly, cystic kidney disease, indeterminate sex, diaphragmatic hernia, Patau syndrome (Trisomy 13), Edward syndrome (Trisomy 18) and do not use standard coding for (not included) cases of: common arterial truncus, transposition of great vessels (complete), congenital absence, atresia and/or stenosis of the duodenum, congenital absence, atresia and/or stenosis of other specified parts of the small intestine.
South east Sicily do not use standard coding (not included) for cases of: cleft lip with or without palate, cleft palate, bilateral renal agenesis.
North Thames (West) (UK: *England)* do not register cases of: hypospadias, polydactyly, syndactyly.

(1) FD=foetal death from 20 weeks gestation.
(2) IA =induced abortion following prenatal diagnosis.
(3) Total prevalence rate=((LB(anomaly)+FD(anomaly)+IA(anomaly))/(LB(population)+still birth (SB)(population))*10 000.

Source: Eurocat Report 8, *Surveillance of congenital anomalies in Europe 1980–99*. University of Ulster, 2002.

4.7.27 Total number of cases of congenital anomalies by type of birth and prevalence rate per registry, 1980–99

Registry	Numbers of cases				Prevalence rates per 10 000 births (1)		
	Live births	Foetal deaths (2)	Induced abortions (3)	Total	Live births (4)	Live births and foetal deaths	Live births, foetal deaths and induced abortions
	LB	FD	IA	LB + FD + IA	LB	LB + FD	LB + FD + IA
Styria (Austria) 1985–99	4 902	109	371	5 382	255.7	260.5	279.8
Antwerp (Belgium) 1990–99	2 491	43	200	2 734	-	233.0	251.4
Hainaut (Belgium) 1980–99	4 888	179	476	5 543	229.4	236.4	258.6
Bulgaria 1980–99	665	40	40	745	175.2	184.3	190.4
Croatia 1983–99	1 697	22	15	1 734	165.3	166.5	167.9
Odense (Denmark) 1980–99	2 177	101	166	2 444	206.7	215.2	230.9
Paris (France) 1981–99	15 624	685	4 346	20 655	225.3	233.4	295.6
Strasbourg (France) 1982–98	6 310	182	811	7 303	280.9	287.3	323.2
Mainz (Germany) (5) 1990–99	1 337	59	105	1 501	356.8	367.7	395.3
Saxony–Anhalt (Germany) 1987–99	3 032	107	344	3 476	213.1	219.4	243.0
Dublin (Ireland) 1980–99	10 110	562		10 672	242.0	253.8	253.8
Galway (Ireland) 1981–99	870	40		910	160.7	166.9	166.9
Campania (Italy) 1996–99	2 927	20	569	3 516	149.8	150.3	179.3
Emilia Romagna (Italy) 1981–99	7 175	66	108	7 349	161.9	162.6	165.0
North–east Italy (6) 1981–99	8 835	137	1 477	10 449	99.2	100.3	116.8
South east Sicily (Italy) 1991–98	2 522	34		2 556	-	167.9	168.0
Tuscany (Italy) 1980–99	5 506	107	712	6 325	180.4	183.1	206.4
Malta 1986–99	1 618	60		1 678	228.3	235.2	235.2
Northern Netherlands 1981–99	6 646	218	389	7 253	232.0	238.3	251.8
Southern Portugal 1990–99	1 215	58	87	1 360	108.6	113.0	120.8
Asturias (Spain) 1990–99	1 431	33	247	1 711	208.9	212.5	248.3
Barcelona (Spain) 1992–99	1 309	57	428	1 794	132.6	137.6	180.8
Basque Country (Spain) 1990–98	2 291	47	502	2 840	159.5	162.0	196.8
Vaud (Switzerland) 1989–99	2 710	58	428	3 196	322.1	327.7	378.4
Glasgow (UK: Scotland) 1980–99	6 710	285	749	7 744	277.1	287.1	317.9
Mersey (UK: England) 1995–99	2 292	123	592	3 007	164.7	172.7	215.0
North Thames (West) (UK: England) (7) 1991–99	3 751	393	2 065	6 209	-	97.4	145.9
Wales (UK: Wales) 1998–99	1 509	75	347	1 931	230.2	240.5	293.1
Total (full member registries)	112 550	3 893	15 574	132 017	186.0	191.5	217.0
Associate member registries							
Finland 1993–99	11 750	316	1 471	13 537	274.6	280.9	315.1
Central East France 1980–99	24 160	520	3 966	28 646	128.2	130.2	151.1
Norway 1980–98	32 538	961	639	34 138	304.9	311.1	317.0
ECEMC (Spain) 1980–99	26 343	566		26 909	174.7	177.2	177.2
Total (associate member registries)	94 791	2 363	6 074	103 230	202.2	197.5	209.8
Total (all registries)	207 341	6 256	21 648	235 245	189.5	194.1	213.8

(1) For LB = (LB anomaly)/(LB population); for LB+FD = (LB anomaly+FD anomaly)/(LB+stillbirths (SB) population); for LB+FD+IA = (LB anomaly+FD anomaly+IA anomaly/(LB+ SB population).
(2) Foetal death from 20 weeks gestation.
(3) Induced abortion following prenatal diagnosis.
(4) Total for full member registries includes Antwerp (Belgium), south-east Sicily (Italy) and North Thames (West) (UK: England) with total birth population figure substituted for livebirth population.
(5) Not including microcephaly.
(6) Do not register cases of: microcephaly, arhinencephaly/holoprosencephaly, cystic kidney disease, indeterminate sex, diaphragmatic hernia, Patau syndrome (Trisomy 13), Edward syndrome (Trisomy 18) and do not use standard coding for (not included) cases of: common arterial truncs, transposition of great vessels (complete), congenital absence, atureia and/or stenosis of the duodenum, congenital absence, atureia /or stenosis of other specified parts of the small intestine.
(7) Do not register cases of: hypospadias, polydactyly, syndactyly.

Source: Eurocat Report 8, *Surveillance of congenital anomalies in Europe 1980–99*, University of Ulster, 2002.

4.7.29 Coronary event rates, coronary case fatalities, and annual changes; adults aged 35-64, by sex; years in 1980s and early 1990s

Population	Years of registration	Coronary event rate (1)		Coronary case fatality (2)		Annual change in coronary event rate (%)		Annual change in coronary case fatality (%)	
		M	F	M	F	M	F	M	F
B (Charleroi)	**1983–92**	487	118	50.1	59.3	0.3	1.1	-1.8	-1.8
B (Ghent)	**1983–92**	346	77	47.4	58.0	-3.2	-3.0	-1.6	-1.8
DK (Glostrup)	**1982–91**	517	140	52.5	58.0	-4.2	-2.5	1.5	2.5
FIN (Kuopio)	**1983–92**	718	124	45.7	38.7	-6.0	-4.5	1.0	1.0
FIN (North Karelia)	**1983–92**	835	145	48.1	41.3	-6.5	-5.1	-0.5	-0.2
FIN (Turku/Loimaa)	**1983–92**	549	94	48.5	48.9	-4.2	-4.5	-0.2	-1.9
F (Lille)	**1985–94**	298	64	58.7	69.5	-1.1	-1.6	-0.3	0.8
F (Strasbourg)	**1985–93**	292	64	49.0	57.1	-3.9	-6.6	-1.7	-2.3
F (Toulouse)	**1985–93**	233	36	40.0	59.8	-2.1	-1.7	-3.8	-3.6
D (Augsburg)	**1985–94**	286	63	55.1	64.6	-3.2	0.9	1.3	-2.9
D (Bremen)	**1985–92**	361	81	49.6	52.0	-3.4	0.7	-0.9	-2.2
D (East Germany)	**1985–93**	370	78	50.0	62.8	-0.5	2.5	1.7	-1.0
IS (Iceland)	**1981–94**	486	99	36.9	34.1	-4.7	-3.7	-2.1	-1.0
I (Brianza)	**1985–94**	279	42	40.7	52.5	-2.3	-3.5	-0.8	-4.8
I (Friuli)	**1984–93**	253	47	45.1	49.9	-0.9	-0.8	-2.0	-2.0
E (Catalonia)	**1985–94**	210	35	36.7	45.5	1.8	2.0	-1.7	1.5
S (Gothenburg)	**1984–94**	363	84	43.6	45.4	-4.2	-3.7	0.3	1.2
S (Northern Sweden)	**1985–95**	509	119	36.1	34.4	-5.1	-2.4	-2.9	0.4
CH (Ticino)	**1985–93**	290	:	33.5	:	-2.6	:	-4.2	:
CH (Vaud/Fribourg)	**1985–93**	231	:	38.4	:	-3.6	:	-3.0	:
UK (Belfast)	**1983–93**	695	188	41.0	41.5	-1.4	0.2	-1.3	-2.1
UK (Glasgow)	**1985–94**	777	265	48.2	46.4	0.4	2.8	-0.4	0.5

(1) Coronary events (non–fatal: myocardial infarction with survival to 28 days from onset; fatal: coronary heart disease deaths occurring within 28 days from onset) per 100 000 population; age standardised.
(2) (Fatal events/coronary events) as a percentage.

Source: Tunstall–Pedoe et al. (1999); from 'European cardiovascular disease statistics', 2000 edition.

4.7.30 Number of persons with diabetes mellitus: estimated total 1995, and projections for 2000 and 2010

(1000 and percentages)

	1995			2000			% increase 1995-00			2010			% increase 2000-10		
	Total	IDDM	NIDDM	Total	IDDM	NIDDM	Total	IDDM	NIDDM	Total	IDDM	NIDDM	Total	IDDM	NIDDM
EU-15	12 708.8	878.6	11 830.2	15 617.4	831.6	14 785.8	*22.9*	*-5.3*	*25.0*	19 663.8	803.8	18 860.0	*25.9*	*-3.3*	*27.6*
B	233.3	20.2	213.1	358.6	19.2	339.4	*53.7*	*-5.0*	*59.3*	517.0	18.7	498.3	*44.2*	*-2.6*	*46.8*
DK	194.8	23.0	171.8	220.1	25.0	195.1	*13.0*	*8.7*	*13.6*	267.4	26.0	241.4	*21.5*	*4.0*	*23.7*
D	2 900.1	184.6	2 715.5	3 527.5	174.0	3 353.5	*21.6*	*-5.7*	*23.5*	4 413.5	168.8	4 244.7	*25.1*	*-3.0*	*26.6*
EL	483.7	12.9	470.8	525.8	11.8	514.0	*8.7*	*-8.5*	*9.2*	579.6	11.3	568.3	*10.2*	*-4.2*	*10.6*
E	1 744.1	92.1	1 652.0	1 828.8	84.4	1 744.4	*4.9*	*-8.4*	*5.6*	1 939.1	79.7	1 859.4	*6.0*	*-5.6*	*6.6*
F	1 240.6	93.3	1 147.3	1 965.2	88.8	1 876.4	*58.4*	*-4.8*	*63.5*	2 869.7	85.4	2 784.3	*46.0*	*-3.8*	*48.4*
IRL	62.6	17.0	45.6	102.6	15.7	86.9	*63.9*	*-7.6*	*90.6*	161.8	14.8	147.0	*57.7*	*-5.7*	*69.2*
I	2 724.8	89.2	2 635.6	2 905.8	81.6	2 824.2	*6.6*	*-8.5*	*7.2*	3 249.3	76.7	3 172.6	*11.8*	*-6.0*	*12.3*
L	14.3	1.0	13.3	17.0	1.0	16.0	*18.9*	*0.0*	*20.3*	22.0	1.1	20.9	*29.4*	*10.0*	*30.6*
NL	486.2	37.8	448.4	610.4	36.2	574.2	*25.5*	*-4.2*	*28.1*	821.9	34.9	787.0	*34.6*	*-3.6*	*37.1*
A	269.1	13.2	255.9	322.8	12.7	310.1	*20.0*	*-3.8*	*21.2*	421.3	12.5	408.8	*30.5*	*-1.6*	*31.8*
P	444.2	12.6	431.6	458.3	13.7	444.6	*3.2*	*8.7*	*3.0*	477.8	14.4	463.4	*4.3*	*5.1*	*4.2*
FIN	280.4	37.4	243.0	272.8	35.4	237.4	*-2.7*	*-5.3*	*-2.3*	273.1	34.2	238.9	*0.1*	*-3.4*	*0.6*
S	353.8	44.0	309.8	448.6	42.4	406.2	*26.8*	*-3.6*	*31.1*	582.5	41.9	540.6	*29.8*	*-1.2*	*33.1*
UK	1 276.8	200.3	1 076.5	2 053.1	189.7	1 863.4	*60.8*	*-5.3*	*73.1*	3 067.8	183.4	2 884.4	*49.4*	*-3.3*	*54.8*
IS	7.7	0.7	7.0	10.7	0.7	10.0	*39.0*	*0.0*	*42.9*	15.8	0.7	15.1	*47.7*	*0.0*	*51.0*
NO	145.4	19.3	126.1	167.2	18.8	148.4	*15.0*	*-2.6*	*17.7*	213.3	18.5	194.8	*27.6*	*-1.6*	*31.3*
CH	241.1	10.5	230.6	295.4	10.2	285.2	*22.5*	*-2.9*	*23.7*	391.5	10.1	381.4	*32.5*	*-1.0*	*33.7*

IDDM = Insulin-dependent diabetes mellitus (Type I).
NIDDM = Non-insulin-dependent diabetes mellitus (Type II).

Sources: Amos, McCarty and Zimmet, International Diabetes Institute and WHO Collaborating Centre of the Epidemiology of Diabetes Mellitus (1997).

4.7.32 Recognised occupational diseases in the EU — Total cases and incidence per million, 1995

	Number of cases	Incidence per million
All cases of EODS	57 414	386.9
Diseases caused by isocyanates	301	2.0
Diseases caused by cadmium or compounds thereof	13	0.1
Diseases caused by chromium or compounds thereof	276	1.9
Diseases caused by mercury or compounds thereof	29	0.2
Diseases caused by manganese or compounds thereof	7	0.0
Diseases caused by nickel or compounds thereof	325	2.2
Diseases caused by lead or compounds thereof	200	1.3
Diseases caused by carbon disulphide	18	0.1
Diseases caused by benzene or counterparts thereof (the counterparts of benzene are defined by the formula: CnH2n-6)	259	1.7
Diseases caused by halogenated derivatives of the aromatic hydrocarbons	109	0.7
Skin diseases and skin cancers caused by by-products of the distillation of coal	30	0.2
Occupational skin ailments caused by scientifically recognised allergy-provoking or irritative substances not included under other headings	8 767	59.1
Silicosis	4 381	29.5
Asbestosis	3 894	26.2
Mesothelioma following the inhalation of asbestos dust	1 446	9.7
Pneumoconioses caused by dusts of silicates	488	3.3
Complication of asbestos in the form of bronchial cancer	987	6.7
Bronco-pulmonary ailments caused by dusts from sintered metals	57	0.4
Respiratory ailments of an allergic nature caused by the inhalation of substances consistently recognised as causing allergies and inherent to the type of work	4 543	30.6
Respiratory ailments caused by the inhalation of dust from cobalt, tin, barium and graphite	9	0.1
Infectious or parasitic diseases transmitted to man by animals or remains of animals	461	3.1
Brucellosis	242	1.6
Viral hepatitis	501	3.4
Tuberculosis	458	3.1
Cataracts caused by heat radiation	22	0.1
Hypoacousis or deafness caused by noise	18 419	124.1
Osteoarticular diseases of the hands and wrists caused by mechanical vibration	2 539	17.1
Angioneurotic diseases caused by mechanical vibration	2 454	16.5
Diseases of the periarticular sacs due to pressure	2 305	15.5
Paralysis of the nerves due to pressure	3 392	22.9
Diseases caused by ionising radiation	482	3.2
Diseases caused by certain chemical agents	1 567	10.6
Respiratory diseases	15 805	106.5
Infectious diseases	1 662	11.2
Diseases caused by physical agents	29 613	199.5

Source: Eurostat, EODS (European statistics on occupational diseases).

4.7.34 Persons with work-related health problems (1) other than accident injuries, Europe, 1998–99

Population group/diagnosis	Persons with work-related health problems							
	All (with or without absence from work)				With absence from work of more than 3 days		2 weeks or more	
	EU-11(2) and HU	EU-15 (estimated) (3)	% of total Population		EU-15 (estimate) (3,4)	%	EU-15 (estimate) (3,4)	%
	Number	Number	All	group	Number	of total	Number	of total
Total — all diagnoses and population groups	**6 012 672**	**7 711 906**	***100***		**2 953 543**	***100***	**2 063 482**	***100***
of which: men	3 280 617	4 174 268	*54*					
women	2 732 055	3 537 638	*46*					
persons with more than one health problem			*12*					
Diagnosis group								
Musculoskeletal disorders	3 192 147	4 094 276	*53*		1 472 563	*50*	1 015 146	*49*
Stress, depression, anxiety	1 091 389	1 399 825	*18*		669 328	*23*	533 066	*26*
Lung disorders	457 743	587 105	*8*		207 211	*7*	116 982	*6*
Cardiovascular disorders	249 050	319 434	*4*		101 528	*3*	83 796	*4*
Headaches, visual fatigue	204 631	262 462	*3*		74 932	*2*	33 739	*2*
Hearing disorders	161 412	207 028	*3*		50 257	*2*	38 512	*2*
Infectious diseases	152 964	196 193	*2*		127 656	*4*	60 270	*3*
Skin problems	152 238	195 262	*2*		56 183	*2*	34 024	*2*
Other	351 098	450 321	*6*		193 885	*7*	147 947	*7*
Active population (4)	**4 323 909**	**5 545 884**	***72***	***100***	**2 953 543**	***100***	**2 063 482**	***100***
of whom: musculoskeletal disorders	2 176 721	2 791 882	*36*	*50*	1 472 563	*50*	1 015 146	*49*
stress, depression, anxiety	949 620	1 217 991	*16*	*22*	669 328	*23*	553 066	*26*
lung disorders	288 616	370 181	*5*	*7*	207 211	*7*	116 982	*6*
aged under 45	2 389 606	3 064 930	*40*	*55*	1 608 207	*54*	1 054 503	*51*
aged 45–64	1 883 999	2 416 434	*31*	*44*	1 310 543	*44*	983 781	*48*
aged 65 and over	50 304	64 520	*1*	*1*	34 793	*1*	25 198	*1*
Non-active persons having worked previously	**1 688 763**	**2 166 022**	***28***	***100***				
of whom: musculoskeletal disorders	1 015 426	1 302 394	*17*	*60*				
stress, depression, anxiety	141 769	181 834	*2*	*8*				
lung disorders	169 127	216 924	*3*	*10*				
aged under 45	202 682	259 962	*3*	*12*				
aged 45–64	786 409	1 008 655	*13*	*47*				
aged 65 and over	699 672	897 405	*12*	*41*				

(1) Health problems suffered during all or part of the past 12 months, at date of interview; for persons with more. than one such problem, only the most severe (in medical terms and in terms of effect on activity) is counted.
(2) Except B, F, NL and A; no diagnosis available for D.
(3) Estimates for EU-15 have been drawn up on the basis of the data available for the Member States covered by the module.
(4) Absence from work in past 12 months.

Source: Ad hoc Labour Force Survey module, 1999, Eurostat.

4.7.35 Persons with work-related health problems (excluding accidents), by employment status of victim and duration of absence from work over past 12 months, EU, 1998–99

	Persons with work-related health problems			Number of days lost	
	All persons	Persons active or expecting never to work again through health problem ([1,2])		Total (million)	Average per work-related health problem
	% of total	% of total	Cumulative %		
Active persons ([1])					
No absence from work	*27*	*35*	*35*	0.0	0
1–3 days lost	*5*	*7*	*42*	0.8	2
4 days to less than 1 week lost	*5*	*7*	*49*	2.1	5
1 to less than 2 weeks lost	*6*	*8*	*57*	4.7	10
2 weeks to less than 1 month lost	*8*	*10*	*67*	13.2	22
1 to less than 3 months lost	*8*	*10*	*78*	37.3	60
3 months or more lost	*11*	*14*	*91*	111.0	137
Total	***70***	***91***		**169.1**	**31**
Persons expecting never to work again as result of work-related health problems ([2])	***7***	***9***	***100***	**120.1**	**274**
Total persons either active or expecting never to work again	***77***	***100***		**289.2**	**49**
Other non-active persons ([3])	***23***			**59.5**	**137**
All victims	***100***			**348.7**	**55**

([1]) Persons either in work or unemployed having worked in the past.
([2]) Persons either inactive through a health problem related to their work in the past, or expecting to become inactive, i.e will never do paid work again, as a result of a recent work-related health problem.
([3]) The work-related health problem is not specified as the cause of inactivity. Days lost are enumerated for non-retired persons, given that they would have been unable to work for 3 months or more because of this health problem (non-reported or partial reason for inactivity, factor preventing return to work, etc.). The average numbers of days lost in this group and the total are calculated by including only these cases.

Source: Ad hoc Labour Force Survey module, 1999, Eurostat.

4.7.36 Incidence (*) of hip fracture associated with osteoporosis, sex ratio (**) of incidence by age, and projected annual incident hip fractures, 2000, EU-15

(cases per 10 000 persons)

Age group		B [4]	DK [6]	D [4]	EL [3]	E [3]	F [3]	IRL [5]	I [3]	L [4]	NL [4]	A [4]	P [3]	FIN [4]	S [2]	UK [5]
50-54	**Men**	2	3	3	1	1	1	1	1	2	2	3	2	3	5	1
	Women	3	4	3	3	1	1	2	2	3	3	3	3	3	5	2
	Sex ratio	*142*	*146*	*106*	*179*	*120*	*120*	*138*	*145*	*142*	*142*	*94*	*113*	*93*	*104*	*138*
55–59	**Men**	4	6	6	3	1	1	3	2	4	4	6	5	6	9	3
	Women	6	9	7	5	2	2	4	4	6	6	7	5	6	10	4
	Sex ratio	*151*	*154*	*125*	*180*	*131*	*142*	*154*	*159*	*151*	*151*	*123*	*113*	*104*	*111*	*154*
60–64	**Men**	8	11	10	6	3	3	6	4	8	8	10	8	10	16	6
	Women	12	17	14	11	4	4	9	7	12	12	14	10	12	19	9
	Sex ratio	*157*	*162*	*147*	*183*	*142*	*156*	*163*	*176*	*157*	*157*	*146*	*128*	*116*	*119*	*163*
65–69	**Men**	14	19	16	11	7	6	11	7	14	14	16	12	18	28	11
	Women	23	32	27	20	11	10	19	14	23	23	47	17	23	36	19
	Sex ratio	*166*	*171*	*171*	*184*	*157*	*168*	*177*	*188*	*166*	*166*	*303*	*146*	*129*	*126*	*177*
70–74	**Men**	24	32	24	20	14	12	20	13	24	24	24	18	31	47	20
	Women	41	57	48	37	24	22	37	26	41	41	48	29	43	63	37
	Sex ratio	*173*	*179*	*197*	*185*	*172*	*184*	*190*	*202*	*173*	*173*	*197*	*164*	*141*	*133*	*190*
75–79	**Men**	40	53	37	35	27	24	34	21	40	40	37	26	49	77	34
	Women	72	98	82	64	50	47	70	45	72	72	82	48	76	107	70
	Sex ratio	*180*	*186*	*225*	*186*	*188*	*198*	*204*	*217*	*180*	*180*	*224*	*182*	*154*	*139*	*204*
80–84	**Men**	65	85	54	58	50	44	57	33	65	65	54	38	78	122	57
	Women	122	164	138	108	102	93	125	78	122	122	138	76	130	177	125
	Sex ratio	*187*	*194*	*256*	*186*	*204*	*213*	*219*	*232*	*187*	*187*	*256*	*201*	*168*	*145*	*219*
85+	**Men**	160	199	110	124	126	110	147	67	160	160	110	65	177	280	147
	Women	317	416	351	232	290	262	362	172	317	317	351	151	346	443	362
	Sex ratio	*198*	*209*	*319*	*187*	*230*	*238*	*246*	*257*	*198*	*198*	*319*	*234*	*195*	*158*	*246*
Projected number of cases [1]																
	Men	**3**	**2**	**21**	**3**	**8**	**10**	**1**	**9**	**0**	**4**	**2**	**2**	**2**	**6**	**15**
	Women	**10**	**7**	**94**	**8**	**28**	**41**	**2**	**34**	**0**	**13**	**9**	**5**	**4**	**14**	**59**

(*) Number of new cases of osteoporosis in the period specified.
(**) Sex ratio expressed as (female rate/male rate) x 100.
([1]) 2000: thousands of cases. ([2]) 1985. ([3]) 1994.
([4]) 1996. ([5]) 1997. ([6]) 1964–93.

Source: Report on osteoporosis in the European Community. Action for prevention. European Commission, Employment, Industrial Relations and Social Affairs DG, 1998.

4.7.37 Prevalence (*) of vertebral fractures associated with osteoporosis, sex ratio (**) of prevalence by age, and projected prevalent vertebral fractures, 2000, 15 Member States

(cases per 10 000 persons)

Age group		B (4)	DK (6)	D (4)	EL (3)	E (3)	F (3)	IRL (5)	I (3)	L (4)	NL (4)	A (4)	P (3)	FIN (4)	S (2)	UK (5)
50–54	**Men**	1 600	1 760	1 130	1 340	1 370	1 450	1 350	973	1 600	1 330	1 580	2 060	1 760	1 760	1 350
	Women	1 200	1 220	730	1 010	846	838	699	743	1 200	896	858	846	1 220	1 220	699
	Sex ratio	*75*	*69*	*65*	*75*	*62*	*58*	*52*	*76*	*75*	*67*	*54*	*41*	*69*	*69*	*52*
55–59	**Men**	1 790	1 960	1 260	1 490	1 520	1 620	1 500	1 080	1 790	1 480	1 760	2 300	1 960	1 960	1 500
	Women	1 620	1 630	980	1 360	1 130	1 120	938	996	1 620	1 200	1 150	1 130	1 630	1 630	938
	Sex ratio	*91*	*83*	*78*	*91*	*74*	*69*	*63*	*92*	*91*	*81*	*65*	*49*	*83*	*83*	*63*
60–64	**Men**	1 970	2 160	1 390	1 650	1 680	1 790	1 660	1 200	1 970	1 630	1 940	2 540	2 160	2 160	1 660
	Women	2 120	2 140	1 280	1 780	1 490	1 470	1 230	1 300	2 120	1 570	1 510	1 490	2 140	2 140	1 230
	Sex ratio	*108*	*99*	*92*	*108*	*89*	*82*	*74*	*108*	*108*	*96*	*78*	*59*	*99*	*99*	*74*
65–69	**Men**	2 160	2 370	1 520	1 810	1 840	1 960	1 810	1 310	2 160	1 790	2 120	2 780	2 370	2 370	1 810
	Women	2 710	2 740	1 640	2 280	1 900	1 890	1 570	1 670	2 710	2 020	1 930	1 900	2 740	2 740	1 570
	Sex ratio	*125*	*116*	*108*	*126*	*103*	*96*	*87*	*127*	*125*	*113*	*91*	*68*	*116*	*116*	*87*
70–74	**Men**	2 350	2 580	1 650	1 960	2 000	2 130	1 980	1 420	2 350	1 950	2 310	3 020	2 580	2 580	1 980
	Women	3 420	3 450	2 070	2 870	2 400	2 380	1 980	2 110	3 420	2 540	2 430	2 400	3 450	3 450	1 980
	Sex ratio	*146*	*134*	*125*	*146*	*120*	*112*	*100*	*149*	*146*	*130*	*105*	*79*	*134*	*134*	*100*
75–79	**Men**	2 540	2 790	1 790	2 130	3 160	2 310	2 140	1 540	2 540	2 110	2 500	3 270	2 790	2 790	2 140
	Women	4 230	4 280	2 570	3 550	2 970	2 950	2 460	2 610	4 230	3 150	3 020	2 970	4 280	4 280	2 460
	Sex ratio	*167*	*153*	*144*	*167*	*94*	*128*	*115*	*169*	*167*	*149*	*121*	*91*	*153*	*153*	*115*
80–84	**Men**	2 740	3 000	1 920	2 290	2 330	2 480	2 300	1 660	2 740	2 270	2 690	3 520	3 000	3 000	2 300
	Women	5 180	5 230	3 140	4 350	3 630	3 600	3 000	3 190	5 180	3 850	3 690	3 630	5 230	5 230	3 000
	Sex ratio	*189*	*174*	*164*	*190*	*156*	*145*	*130*	*192*	*189*	*170*	*137*	*103*	*174*	*174*	*130*
85+	**Men**	3 140	3 440	2 200	2 620	2 670	2 840	2 630	1 900	3 140	2 600	3 080	4 030	3 440	3 440	2 630
	Women	7 480	7 560	4 540	6 280	5 250	5 210	4 340	4 610	7 480	5 570	5 330	5 250	7 560	7 560	4 340
	Sex ratio	*238*	*220*	*206*	*240*	*197*	*183*	*165*	*243*	*238*	*214*	*173*	*130*	*220*	*220*	*165*
Projected number of cases (1)																
	Men	**324**	**187**	**1 880**	**300**	**1 040**	**1 620**	**74**	**1 170**	**13**	**384**	**234**	**373**	**172**	**338**	**1 520**
	Women	**570**	**293**	**2 930**	**492**	**1 490**	**2 210**	**80**	**2 100**	**22**	**563**	**318**	**362**	**260**	**521**	**1 830**

(*) Number of new cases of osteoporosis in the period specified.
(**) Sex ratio expressed as (female rate/male rate) x 100.
(1) 2000: thousands of cases. (2) 1985. (3) 1994.
(4) 1996. (5) 1997. (6) 1964–93.

Source: Report on osteoporosis in the European Community. Action for prevention. European Commission, Employment, Industrial Relations and Social Affairs DG, 1998.

4.7.38 Percentage of population presenting with positive reaction to allergens, and percentage suffering from asthma and rhinitis

		Allergies					
Country	**City**	**Cats**	**Pollen**	**Mould**	**Dust mites**	**Asthma**	**Rhinitis**
Belgium	**Antwerp South**	9.3	17.6	4.0	22.3	:	:
	Antwerp City	9.7	16.0	6.5	26.7	:	:
Germany	**Hamburg**	12.5	14.3	8.2	18.5	4.4	23.0
	Erfurt	8.2	20.2	3.9	15.7	2.1	13.4
Greece	**Athens**	3.9	15.8	1.7	13.6	:	:
Spain	**Albacete**	2.7	10.0	0.3	7.2	:	:
	Barcelona	14.4	15.0	13.6	29.1	:	:
	Galdakao	3.1	8.1	1.0	19.0	:	:
	Huelva	2.7	20.5	2.6	20.3	:	:
	Oviedo	4.2	9.5	1.1	18.5	:	:
	Seville	2.8	14.7	1.1	20.1	:	:
France	**Bordeaux**	10.5	19.3	4.6	32.6	5.5	30.2
	Montpellier	8.5	16.9	3.3	21.1	5.0	34.4
	Grenoble	7.3	18.7	1.5	18.8	3.5	28.1
	Paris	8.6	13.8	0.3	24.0	5.1	30.3
Ireland	**Dublin**	7.5	16.9	2.0	34.4	:	:
Italy	**Turin**	5.9	21.8	1.7	11.7	:	:
Netherlands	**Bergen-op-Zoom**	6.2	20.7	6.0	24.4	4.7	20.7
	Gelen	10.4	24.8	6.0	29.9	4.4	23.8
	Groningen	10.3	18.3	2.8	29.4	4.3	23.6
Sweden	**Gothenburg**	7.4	17.5	2.0	12.0	5.8	22.2
	Umeå	14.1	18.0	2.9	6.7	6.8	21.1
	Uppsala	14.8	18.5	2.4	8.5	6.0	22.3
United Kingdom	**Cambridge**	12.6	26.7	1.5	29.3	:	:
	Cardiff	8.5	16.2	1.7	29.4	:	:
	Ipswich	11.6	24.3	3.2	23.0	:	:
	Norwich	10.1	25.9	3.8	27.7	:	:
Iceland	**Reykjavik**	7.3	12.0	6.5	8.9	3.4	17.8
Norway	**Bergen**	7.4	15.0	1.6	14.2	4.3	19.5
Switzerland	**Basle**	14.4	33.1	6.7	18.8	:	:

Sources: Burney, P. et al., European Community Respiratory Health Survey, *European Respiratory Journal* 9, 1996, pp. 687–695.
'The distribution of total and specific IgE in the Community Respiratory Health Survey', *Journal of Allergy and Clinical Immunology* 99,1997, pp. 314–322.

4.7.39 Asthma and allergic symptoms in population of 13–14 years of age

	B	D		EL	E				F			I			
	Antwerp	Greifswald	Münster	Athens	Almería	Barcelona	Bilbao	Valladolid	Marseilles	Pessac	West Marne	Cremona	Milan	Rome	Viterbo
Wheeze ever	18.5	13.3	23.4	12.3	17.6	26.4	18.9	10.2	21.5	19.1	19.5	24.2	24.4	22.1	22.9
Wheeze in the last 12 months	12.0	3.0	14.1	3.7	7.4	14.3	11.9	6.1	14.9	12.8	13.3	9.2	10.6	9.8	6.7
Four or more attacks of wheeze in the last 12 months	3.5	1.1	3.7	0.7	2.2	3.4	4.2	1.5	4.0	3.9	4.2	1.7	2.3	2.0	1.5
Sleep disturbance from wheeze	1.5	5.1	1.3	0.7	0.9	1.4	1.5	0.5	1.2	1.0	1.4	0.6	0.7	0.4	0.2
Speech limited by wheeze in the last 12 months	2.6	4.2	6.1	0.7	1.9	2.7	3.0	1.4	2.8	1.8	2.9	1.6	2.5	2.6	1.0
Asthma ever	8.1	23.0	7.0	4.5	8.0	11.1	16.3	6.3	14.4	15.0	10.7	8.2	10.7	11.3	8.4
Wheeze during or after exercise in the last 12 months	13.1	21.5	21.2	3.6	11.4	18.3	19.8	13.1	22.8	19.3	20.1	13.2	18.0	14.4	1.5
Night cough in the last 12 months	21.2	38.0	20.2	6.7	15.9	20.5	25.6	22.9	26.9	24.3	25.4	19.7	27.3	23.0	16.0
Nose symptoms ever	44.8	38.0	36.5	17.2	38.3	35.4	48.5	45.2	54.1	53.6	47.9	36.6	45.2	39.5	16.1
Nose symptoms in the last 12 months	36.4	29.3	28.7	14.4	27.9	26.1	35.3	31.7	45.4	44.1	40.5	23.6	32.4	30.2	11.5
Nose and eye symptoms in the last 12 months	15.2	12.6	15.7	6.4	15.6	12.8	17.6	12.8	15.2	14.8	12.7	10.8	16.7	15.0	5.0
Nose symptoms affecting activities a lot in the last 12 months	1.7	0.5	0.7	0.2	0.3	0.3	0.4	0.1	1.1	0.7	0.9	0.2	0.5	0.5	0.2
Hayfever ever	17.0	11.7	21.1	12.7	10.5	8.5	11.0	7.7	11.0	15.4	16.8	15.7	21.0	16.4	4.7
Allergic rhinoconjunctivitis in the last 12 months	14.5	12.3	14.4	6.3	15.5	11.7	17.2	12.7	14.4	14.8	12.4	10.7	16.4	14.7	5.0
Rash ever	16.4	11.8	12.9	6.2	9.6	8.2	9.6	9.8	23.1	23.6	25.1	13.9	15.7	12.5	11.2
Rash in the last 12 months	11.4	8.2	9.1	4.0	6.5	5.8	6.4	6.4	16.1	16.2	16.4	9.0	10.4	8.2	5.5
Flexural rash	7.7	6.8	8.8	3.2	5.7	4.5	4.8	4.6	9.9	9.1	10.4	5.4	7.1	5.1	5.2
Complete clearance of rash in the last 12 months	7.8	4.7	7.8	2.7	5.0	5.4	5.1	5.3	11.6	11.9	12.3	7.8	9.3	7.2	5.9
Sleep disturbance from rash in the last 12 months	1.7	0.9	0.7	0.7	0.9	0.6	0.5	0.8	1.4	0.9	1.8	0.5	0.7	0.6	0.2
Eczema ever	21.5	5.8	10.0	3.9	9.8	12.6	8.3	10.1	22.8	23.2	23.7	9.8	11.8	5.1	12.7
Atopic eczema in the last 12 months	6.7	6.6	7.1	3.1	5.6	3.9	4.5	4.6	8.9	9.1	9.4	5.3	7.0	4.9	4.2

Source: ISAAC, 'International study of asthma and allergies in childhood'. New Zealand, 2001.

4.7.40 Estimated number of persons with Alzheimer's disease and other dementias (*) in 2000

	Age group	Number of cases			Prevalence rate
		Total	Men	Women	
EU-15	-	4 624 424	1 697 629	2 926 795	12.3
B	**30–99**	129 389	46 972	82 417	12.6
DK	**30–99**	65 959	24 720	41 239	12.4
D	**30–94**	1 032 969	353 744	679 225	12.6
EL	**30–99**	131 283	58 396	72 887	12.5
E	**30–99**	488 956	188 944	300 012	12.4
F	**30–99**	758 229	274 355	483 784	12.6
IRL	**30–94**	31 702	12 947	18 755	8.4
I	**30–99**	791 205	295 349	495 856	13.7
L	**30–94**	4 665	1 668	2 997	10.7
NL	**30–94**	164 910	61 508	103 402	10.4
A	**30–94**	97 137	33 417	63 720	12.0
P	**30–99**	103 690	40 992	62 968	10.4
FIN	**30–99**	58 797	20 241	38 556	11.4
S	**30–99**	131 643	49 987	81 656	14.9
UK	**30–94**	741 042	274 499	466 543	12.4
IS	**30–99**	2 510	1 069	1 441	9.0
NO	**30–99**	57 758	21 398	36 360	12.9
CH	**30–94**	88 304	32 860	55 444	12.3

(*) Other dementias include AIDS dementia complex, Binswanger's disease, Lewy-Body dementia, Pick's disease, multi-infarct dementia and other forms.

Source: Alzheimer Europe.

A			P		FIN		S		UK				
Salzburg	Urfhar	Lisbon	Portimao	Oporto	Helsinki	Lapland	Linköping	Stockholm/Up.	Anglia/Oxford	North-East	Scotland	South Thames	
19.5	19.5	21.6	18.1	14.1	32.7	29.7	18.6	25.4	50.7	49.9	52.9	47.3	**Wheeze ever**
11.5	11.5	11.1	8.1	7.4	19.8	16.1	11.2	14.8	34.3	34.1	36.7	31.3	**Wheeze in the last 12 months**
2.3	3.0	2.8	2.0	1.7	5.1	3.3	3.5	4.5	10.2	9.3	11.6	9.7	**Four or more attacks of wheeze in the last 12 months**
0.8	0.9	1.3	1.4	1.0	0.8	0.2	0.7	0.9	2.9	4.3	4.7	3.4	**Sleep disturbance from wheeze**
3.0	5.0	2.4	1.9	1.6	5.1	2.7	1.7	2.3	9.0	8.7	10	8.8	**Speech limited by wheeze in the last 12 months**
6.3	5.3	12.3	10.3	11.3	7.4	6.6	10	10.8	22.8	20.3	21.4	20.6	**Asthma ever**
17.5	19.0	14.1	14.8	10.5	25.1	20.6	17.4	21.4	30.3	28.7	31.4	26.8	**Wheeze during or after exercise in the last 12 months**
13.3	13.3	17.5	18.1	13.1	19.5	15.6	10.2	14.0	43.3	47.1	42.3	45.5	**Night cough in the last 12 months**
28.5	25.3	31.4	28.5	29.8	55.1	43.9	25.4	35.1	46.0	49.1	48.5	46.9	**Nose symptoms ever**
22.1	21.0	20.4	19.7	22.7	45.5	33.3	19.2	26.7	37.1	39.6	40.1	37.2	**Nose symptoms in the last 12 months**
12.0	10.6	7.0	8.9	10.6	23.6	15.8	12	12.6	19.8	21.2	21.3	18.4	**Nose and eye symptoms in the last 12 months**
0.2	0.6	0.3	0.1	0.5	1.3	0.8	1.0	1.4	1.3	1.8	1.4	1.8	**Nose symptoms affecting activities a lot in the last 12 months**
20.0	14.1	5.1	3.1	4.2	30.9	23.2	23.4	24.8	38.6	33.1	33.2	38.4	**Hayfever ever**
11.5	9.2	6.5	8.8	6.2	22.9	14.9	11.3	12.0	18.2	19.4	20.3	16.6	**Allergic rhinoconjunctivitis in the last 12 months**
9.4	7.9	10.6	5.9	13.8	27.1	28.4	26.7	24.1	24.4	28.7	25.5	26.0	**Rash ever**
6.6	6.1	6.5	3.3	8.9	21.8	21.2	19.9	17.4	21.9	25.0	23	23.4	**Rash in the last 12 months**
5.5	6.5	4.5	2.0	5.1	18.6	18.6	17.8	15.0	16.7	19.9	17.6	18.0	**Flexural rash**
4.2	5.5	5.8	3.6	7.5	18.7	18.9	16.6	15.4	17.4	19.6	17.3	18.5	**Complete clearance of rash in the last 12 months**
0.5	0.7	1.2	1.1	1.5	1.3	0.7	1.3	1.2	1.9	3.5	3.3	2.4	**Sleep disturbance from rash in the last 12 months**
4.4	6.1	10.3	9.4	9.2	25.9	24.1	46.9	49.3	24.6	24.1	20.6	20.9	**Eczema ever**
5.1	5.3	4.0	1.8	4.4	17.3	17.1	15.6	13.3	15.6	18.7	16.7	16.6	**Atopic eczema in the last 12 months**

4.7.41 Estimated prevalence for dementia and Alzheimer's disease, selected years in 1990s

	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
Period	*1997*	*April 97*	*1997*	*April 97*	*April 97*	*March 97*	*April 97*	*1990/98*	*1992*	*1997*	*1996*	*1994*	*Feb. 96*	*1995*	*1996*
All dementia															
Estimated cases (1)	100	80	800	70	650	500	33	749	4	170	87	92	100	120–166	678
Rate (2)	60	101	62	41	104	55	79	76	71	81	71	65	136	78	73
Alzheimer's disease															
Estimated cases (1)	:	42	480	46	400	350	20	309–409	2	119	60	49	53	100	500
Rate (2)	:	53	37	27	64	38	48	41	37	57	49	34	72	65	54

(1) 1 000.

(2) Number of cases per 1 000 population aged 65 and over.

Source: Huismann, Raven and Geiger; from Alzheimer Europe (Luxembourg) and national Alzheimer associations.

4.7.42 Hospitalisation rate (1) for Parkinson's disease; selected countries and periods

	A	England	Wales	IRL	NL (2)	NL (3)	S
Men	*1993–96*	*1992–95*	*1992–95*	*1994–97*	*1994–96*	*1997*	*1994–96*
45–49	0.69	4.62		3.14	2.90	4.05	14.25
50–54	0.91	10.15	17.51	15.02	6.26	9.10	21.54
55–59	0.60	18.30	59.55	21.41	14.55	23.20	43.65
60–64	1.97	33.32	149.11	45.27	21.69	48.43	80.15
65–69	2.17	64.26	294.09	69.57	47.30	114.62	134.69
70–74	0.41	134.91	693.30	122.77	87.93	229.51	237.04
75–79	3.40	235.90	1 501.53	175.63	124.51	372.05	292.88
80–84	0.00	347.28	2 181.30	198.11	135.21	463.28	305.18
85 and over	3.14	400.79	3 229.39	75.46	101.03	384.47	214.32
Women							
45–49	1.50	2.35		2.29	2.57	4.38	9.40
50–54	0.87	4.80	17.10	4.90	4.21	6.19	9.39
55–59	0.93	10.58	25.82	11.69	11.47	19.22	24.93
60–64	1.65	18.98	76.66	33.02	21.47	38.67	51.76
65–69	1.88	39.87	154.95	48.03	36.60	67.56	118.00
70–74	2.33	73.46	395.06	68.00	77.01	151.12	171.09
75–79	0.77	116.52	745.63	94.39	92.28	262.20	197.12
80–84	1.40	156.78	1 113.75	125.37	88.65	275.34	192.44
85 and over	1.62	144.80	1 298.13	14.50	43.82	154.29	94.63
Persons							
45–49	1.09	3.49	:	2.72	2.74	1.12	11.86
50–54	0.89	7.47	17.30	10.05	5.26	2.93	15.58
55–59	0.77	14.42	42.53	16.58	13.02	4.07	34.30
60–64	1.80	25.96	111.74	39.08	21.57	13.24	65.54
65–69	2.01	51.28	220.18	58.18	41.55	39.37	125.84
70–74	1.63	100.29	524.96	92.40	81.70	122.71	200.94
75–79	1.65	163.57	1 041.29	128.31	104.76	301.14	237.69
80–84	0.97	222.01	1 471.43	153.36	104.14	643.09	235.42
85 and over	2.01	208.03	1 762.24	33.51	58.69	937.23	131.14

(1) Number in the sex/age group who were being treated in hospital for Parkinson's disease (PD), per 100 000 population.
(2) PD was the main diagnosis for all hospitals.
(3) PD was the main diagnosis or the associated diagnosis but only for general hospitals.

Source: Gourbin and Wunsch (Université catholique de Louvain).

4.7.43 Prevalence of major psychiatric disorders in primary health care according to some selected studies

ODIN (% weighted prevalence on DSM-IV criteria)

	Major depressive episode			Dysthimia			Adjustment disorder		
	Total	Males	Females	Total	Males	Females	Total	Males	Females
Finland, urban	4.7	2.7	6.6	0.3	0.3	0.4	0.2	0.8	1.3
Finland, rural	4.1	4.3	3.8	1.3	1.1	1.5	1.0	0.1	1.9
Ireland, urban	15.1	9.5	21.3	0.6	-	1.3	0.3	0.2	0.3
Ireland, rural	5.5	6.5	5.1	0.3	-	0.5	-	-	-
Norway, urban	7.0	4.6	9.4	1.5	0.4	2.6	0.2	-	0.5
Norway, rural	8.5	5.8	10.0	1.5	0.4	2.6	0.2	0.5	-
Spain, urban	1.8	2.0	1.8	0.5	-	0.7	0.2	2.3	0.4
United Kingdom, urban	7.8	2.7	14.8	2.3	2.2	2.6	1.1	0.7	1.5
United Kingdom, rural	6.1	6.5	5.9	1.1	3.3	-	0.6	1.0	-
Global sample	6.7	4.9	8.0	1.0	1.0	1.0	0.5	0.3	0.6

Depres ('Depression research in European society') (%)

	Year	Interviews	Total	Severe	Moderate	Symptoms
Belgium	**1994/95**	8 076	12.2	5.0	1.5	5.7
Germany	**1994/95**	16 184	11.3	3.8	1.9	5.6
Spain	**1994/95**	16 132	15.9	6.2	1.5	8.2
France	**1994/95**	14 517	22.4	9.1	1.7	11.6
Netherlands	**1994/95**	7 811	16.4	6.9	3.0	6.5
United Kingdom	**1994/95**	15 743	22.0	9.9	1.7	10.4
Total	**1994/95**	78 463	17.0	6.9	1.8	8.3

Schizophrenia (per 1 000 of population)

		Prevalence				
Thuringia, Germany	**1931**	37 561	2.4	-	-	-
Island population, Denmark	**1989**	50 000	3.3	-	-	-
Community in southern Sweden	**1956**	-	4.5 / 6.7	-	-	-
London Health District	**1997**	112 127	5.1	-	-	-
Croatia	**1971**	9 201	5.9	-	-	-
Australia, four urban areas	**2000**	980	3.9 / 6.9	-	-	-
		Incidence				
Norway	**1946**	14 231	0.24	-	-	-
Iceland	**1964**	2 338	0.27	-	-	-
Mannheim, Germany	**1970**	Case register	0.54	-	-	-
Moscow, Russia	**1974**	248 000	0.20	-	-	-
London (Camberwell), United Kingdom	**1991**	Case register	0.25	-	-	
Québec, Canada	**1992**	338 000	0.31	-	-	-
London Health District, United Kingdom	**1997**	112 127	0.21	-	-	
Nottingham, United Kingdom	**1997**	-	0.14 / 0.09	-	-	-
		Bipolar disorder (per 1 000 of population)				
Munich, Germany	**1992**	-	2.0	-	-	-
Basle, Switzerland	**1992**	-	4.0	-	-	-
Iceland	**1991**	-	7.0	-	-	-
Florence, Italy	**1985**	-	34.0	-	-	-
Zurich, Switzerland	**1994**	-	55.0	-	-	-
Mainz, Germany	**1993**	-	65.0	-	-	-

Sources: Depres, ODIN, WHO Health Report 2001, German Society for Biological Psychiatry and others.

4.7.44 Standardised prevalence rate of work–related health problems (stress, depression and anxiety) by diagnosis group and age

(per 100 000)

Age	Total	15–24	25–34	35–44	45–54	55–64	65 and over
				With or without days' absence from work			
EU–15 (estimated) (1)	1 181	542	890	1 356	1532	1 339	418
				More than 14 days lost (two weeks' absence or more)			
EU–15 (estimated) (1)	445	218	312	501	603	528	181
				With or without days' absence from work			
DK	842	529	635	770	1 296	918	:
E	326	:	:	460	389	422	:
I	652	310	493	849	814	479	411
L	843	:	672	905	1 059	1 569	:
P	847	312	971	1 049	724	705	608
FIN	3 374	914	2 215	4 163	4 302	4 765	1 878
S	2 052	624	1 541	2 573	2 494	2 489	:
UK	1 479	680	1 140	1 847	1 814	1 411	355

(1) Estimates for EU-15 have been drawn up on the basis of the data available for the Member States covered by the module.

Source: Ad hoc Labour Force Survey module, 1999, Eurostat.

4.7.45 Hospital discharges of inpatients by diagnosis per 100 000 of population: mental and behavioural disorders (F00-F99)

	EU-15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	England	IS	NO	CH
1993	:	:	:	806	333	234	:	:	482	:	145	959	:	1 499	1 296	:	:	147	:
1994	:	:	276	894	347	243	:	:	563	:	149	975	101	1 631	1 280	:	:	152	:
1995	:	:	255	938	341	249	:	110	:	:	148	1 009	96	1 639	1 217	:	:	151	:
1996	:	:	253	950	335	268	:	104	460	:	146	1 038	103	1 713	1 190	:	:	166	:
1997	:	:	261	981	344	268	465	102	472	:	149	1 450	110	1 740	1 117	:	:	164	:
1998	:	:	256	1 022	347	262	487	102	489	1 102	143	1 458	116	1 787	1 051	490	:	164	:
1999	:	:	257	1 037	:	:	509	100	463	:	138	1 507	112	1 778	:	467	:	194	:
2000	:	:	264	:	:	:	508	108	:	:	129	1 535	:	1 838	:	370	:	184	:

Source: Eurostat, NewCronos database (Health and safety statistics).

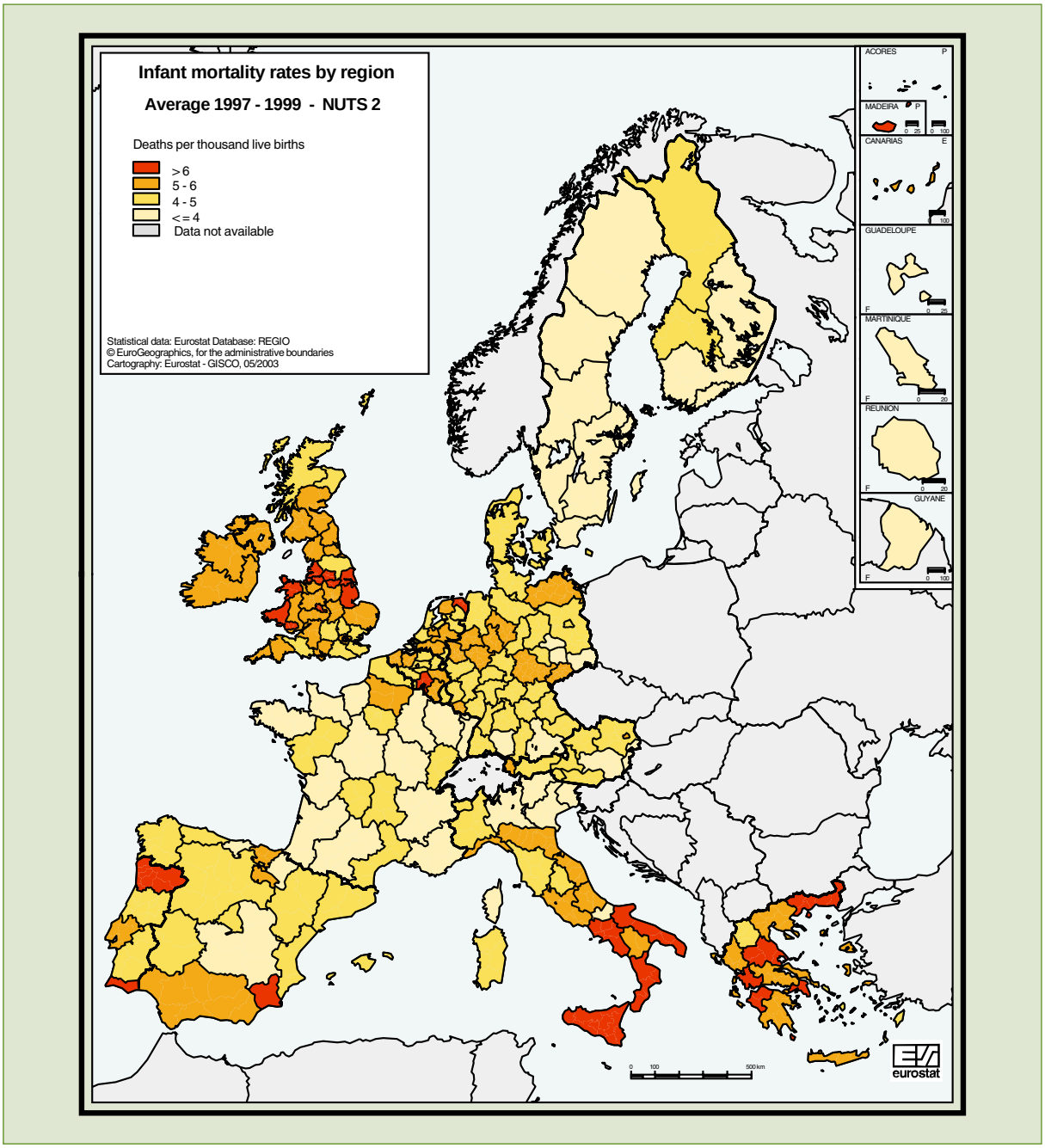
5. MORTALITY

The volume *Atlas of mortality* in the collection 'Panorama of the European Union' covers only **causes of death** (especially at NUTS 2 level). This chapter summarises key information on mortality patterns in the EU. For more detailed information, see the *Atlas of mortality*.

5.1. Infant and childhood mortality

The infant mortality rate (IMR) has been widely regarded as an important measure of public health for many years. According to **Eurostat** demographic data, in 2000, the EU rate was 4.9 deaths under one year per 1 000 live births **(5.1.1)**, a decline of more than a third from 1990. Particularly low rates were reported in 2000 for Iceland (3.0) and Sweden (3.4), but the IMR is generally low across all EU countries. This is evidenced by Map **5.1.3**, showing for 1997–99 relatively low rates in northern countries, much of France and Germany, and parts of Spain — but relatively higher rates in parts of the United Kingdom and Ireland, as well as in Belgium and the Netherlands, and the more southern parts of Spain and Italy.

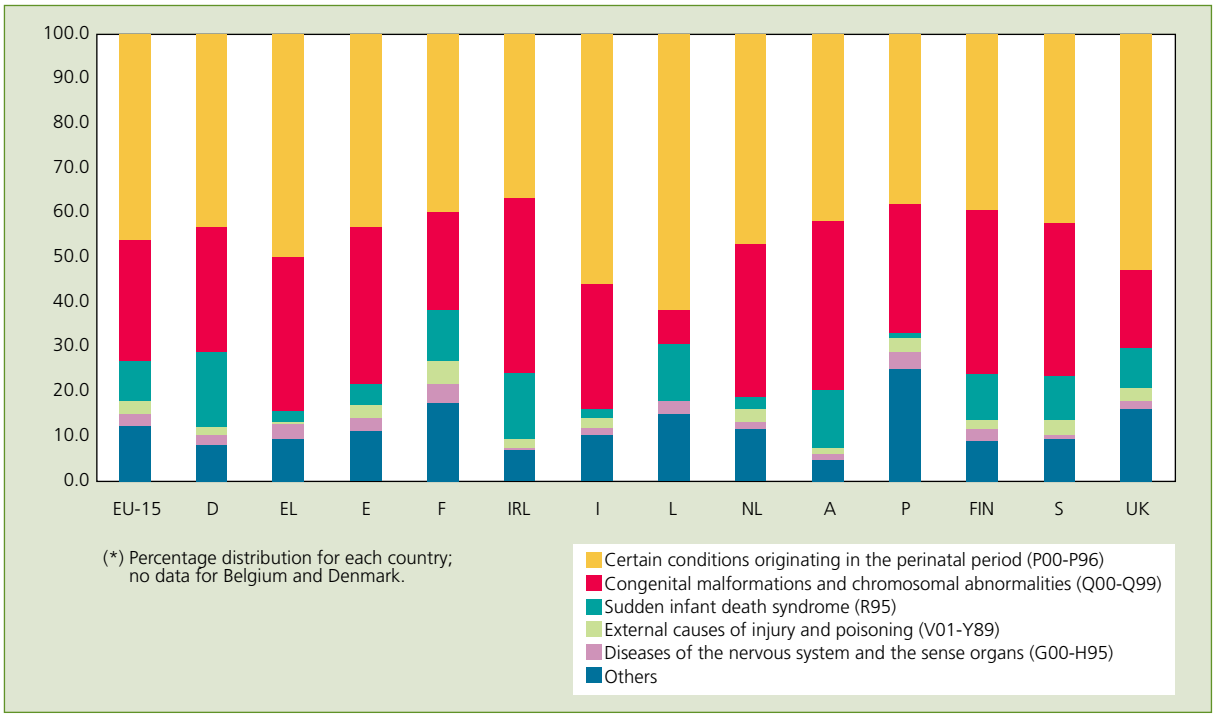
5.1.3 Infant mortality rates by region, 1997–99



Source: Eurostat, NewCronos database (Demography).

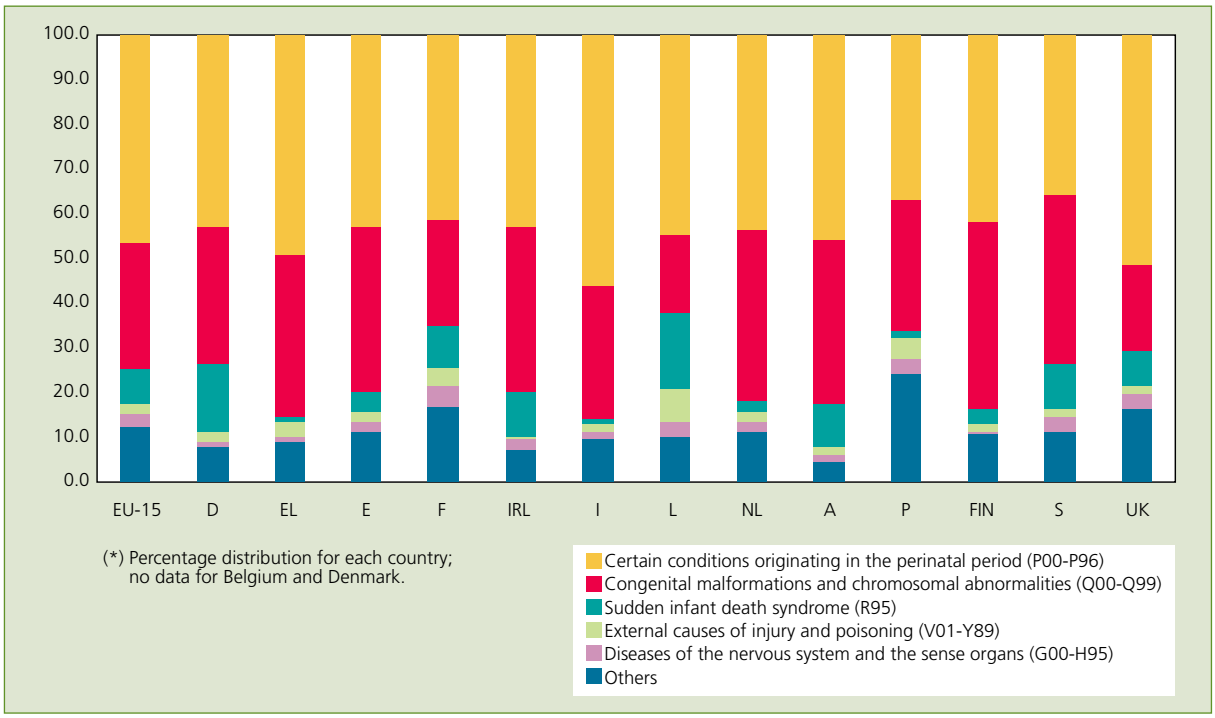
Analysing infant deaths by cause, using Eurostat demographic data, the group 'certain perinatal conditions' (which includes birth trauma, respiratory and cardiovascular disorders, infections specific to the perinatal period, etc.) is the most common cause of death for both boys and girls. This is especially so in Luxembourg (62 % of total causes for boys and 45 % for girls), Italy (56 % for both) and the United Kingdom (52 % for both) **(5.1.4** and **5.1.5).** Congenital malformations are another common cause, and are most likely in Ireland (39 % for boys and 37 % for girls,) Finland (37 and 42 %) and Austria (38 and 37 %), amounting to one third of all infant deaths. Also of interest is the small group of deaths from external causes, which is highest in France and Portugal.

5.1.4 Main causes of infant deaths, boys, 1997–99 (*)



Source: Eurostat, NewCronos database (Demography).

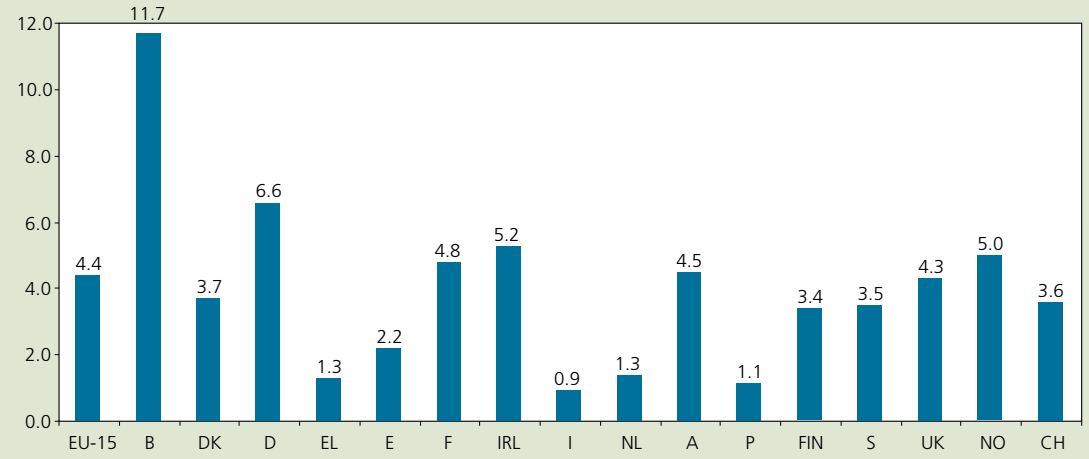
5.1.5 Main causes of infant deaths, girls, 1997–99 (*)



Source: Eurostat, NewCronos database (Demography).

Sudden infant death syndrome (SIDS) is an infant condition of much public interest, and the EU rate in 1998 was 4.4 deaths per 10 000 live births **(5.1.6)**. Cause of death data should be compared across countries with caution, owing to variations in notification and coding practices. This is particularly so for the assignment of deaths to SIDS.

5.1.6 Infant mortality rate for sudden infant death syndrome (SIDS), 1998



Notes: (1) D 1999, IRL 1999, NL 1999, A 1999. (2) P 1997, FIN 1997. (3) DK 1996, EL 1996. (4) B 1995. No data for Luxembourg.

Source: Eurostat, NewCronos database (Health and safety)

The decline in infant mortality may be considered in terms of its neonatal age and its perinatal age components. According to **Eurostat** demographic data for the EU, the IMR fell from 34.5 per 1 000 in 1960 to 18.1 in 1975, and 6.9 in 1992. Thus, over the period 1960–92, the decline was 80 %, and within this the decline from 1960–75 was 48 %. Comparable figures for the neonatal rate were a decline of 79 % for 1960–92 and of 38 % over 1960–75; and for the postneonatal rate 81 and 61 % respectively. Much of the IMR decline in the 1960s and 1970s was thus in postneonatal mortality, but in later years the decline was more pronounced for neonatal mortality.

Childhood mortality rates (covering ages 1–14) for EU countries are readily available from 1992 only, but show a slow though definite decline in recent years **(5.1.12)**. In 1998, the EU childhood mortality rate was 18.5 per 100 000, with a notably high figure for Portugal (36.8). In this age group, external causes of injury and poisoning are the most common cause of death (42 % for boys, 28 % for girls), followed by malignant neoplasms, and congenital malformations **(5.1.13** and **5.1.14)**.

A new project Peristat ('Indicators for monitoring and evaluating perinatal health'), coordinated by the Institut national de la santé et de la recherche médicale (Inserm, France), under the EC Health Monitoring Programme, commenced in 2000. The project's aim is to develop valid and reliable indicators to monitor and evaluate perinatal health in the European Union. Perinatal indicators include measures of maternal, foetal and infant health during pregnancy, delivery and the post-partum period and their determinants. This general aim of the project consists of four specific objectives: definition of relevant measures of perinatal health and the determinants of perinatal health; development of methods, definitions and guidelines for the construction and publication of reliable and comparable indicators; assessment of the extent to which existing data collection systems can be used to construct reliable perinatal health indicators; and creation of a database containing perinatal health indicators currently available for EU Member States.

Data on infant mortality are collected by **Eurostat**. **Infant mortality** is the mortality of live-born children who die in the first year of life. The infant mortality rate is computed as the ratio of deaths to children under one year of age per 1 000 live births in a given period. **Perinatal mortality** includes late foetal deaths and early neonatal deaths (i.e. live-born children who die within a period of one week after delivery). The perinatal mortality rate is calculated by dividing the total number of late foetal deaths and early neonatal deaths by the total number of births (i.e. stillbirths and live births), in a given period. Due to differences in the definition of late foetal deaths, perinatal mortality rates are not completely comparable. The **neonatal** and **early neonatal mortality rates** represent the rate of

deaths within 28 days, and within one week after birth respectively, per 1 000 live births in a given period. A number of countries are in the process of reviewing their definitions, which distinguish between spontaneous abortion, **early foetal death** and **late foetal death** (or stillbirth). The criteria used in Member States range from a minimum gestation period of 22 weeks (154 days) to 28 weeks (196 days). **Postneonatal** mortality covers the period from 28 days to under one year.

5.2. Mortality by cause

In presenting mortality data by cause, **Eurostat** uses a standard set of 65 conditions and groups of conditions, and these are given in age-standardised form for 1998 in Tables **5.2.1** and **5.2.2**. For the EU, the standardised male all causes of death rate is 923 per 100 000, and male mortality is the highest in Portugal (1 147 in 1998), Denmark (1 046) and Ireland (1 028). The lowest are found in Sweden (787) and Greece (811). The EU female rate is 525 per 100 000, and Denmark (682) and Portugal (667) show the highest rates, while France (461) and Spain (481) show the lowest.

The principal causes of death in the EU are circulatory diseases and malignant neoplasms; together they account for two thirds of all deaths, both male and female **(5.2.3)**. Within the group of circulatory diseases, ischaemic heart disease (IHD) accounts for one in six of all deaths, and cerebrovascular disease for about one in ten. IHD as a cause of death varies in its intensity across Europe: in Sweden and Finland, it causes nearly 25 % of all male deaths, but in France less than 10 %. Rates for pneumonia also vary between countries (8 % of male deaths in the United Kingdom, but only 1 % in Italy), but these are partly affected by differing coding and assignment procedures.

These features of the data are more prominent for female deaths. Thus, 60 % of female deaths in Austria are assigned to diseases of the circulatory system, and 20 % of all deaths to IHD, but in France the proportions are 32 and 8 %, respectively. Over the EU, the cancer sites with highest female mortality are breast, lung, colon, stomach, ovary, pancreas and uterus; for males, the highest rates are for lung, prostate, colon, lymphatic glands, stomach, pancreas and bladder.

The most likely causes of death at each age are shown in Graphs **5.2.4** and **5.2.5**, and indicate how death from diseases of the circulatory system becomes more likely with advancing years, while, as a cause of death, malignant neoplasms are most likely at ages 55–64. External causes are more likely at younger ages for males, especially 15–34, but decline with increasing age thereafter. More detailed figures are given in Table **5.2.6**.

Data on the actual number of deaths are collected by WHO (at national level) and by **Eurostat** (at national and regional NUTS 1 and NUTS 2 level). Data on deaths by cause are usually based on the underlying cause derived from the certifier's entries in Parts I and II of the death certificate. Acceptable causes of death are those listed in the WHO's International Classification of Diseases (ICD). All EU countries use either the ninth or the tenth revision of the classification.

The **International Classification of Diseases (ICD),** maintained by the World Health Organisation **(WHO)**, is designed to promote international comparability in the collection, processing, classification and presentation of mortality statistics. WHO provides rules and conventions for the user to apply, so as to ensure that consistent and comparable data can be obtained through statistical analyses locally, nationally and internationally. This includes providing a format for reporting causes of death on the death certificate. The reported conditions are then translated into medical codes through use of the classification structure and the selection and modification rules contained in the applicable revision of the ICD, published by WHO. These coding rules improve the usefulness of mortality statistics by giving preference to certain conditions, by consolidating conditions, and by systematically selecting a single cause of death from a reported sequence of conditions. The single selected cause for tabulation is called the underlying cause of death, and the other reported causes are the non-underlying causes of death. The combination of underlying and non-underlying causes are the multiple causes of death.

The ICD has been revised periodically to incorporate changes in the medical field. The tenth revision **(ICD-10)** differs from the ninth revision (ICD-9) in several respects, although the overall coverage is similar. ICD-10 has alphanumeric categories rather than numeric categories and some chapters have been rearranged, some titles changed, and certain conditions have been regrouped. ICD-10 has almost twice as many categories as ICD-9. Some fairly minor changes have been made in the coding rules for mortality. However, for coding of diagnoses and procedures associated with hospital utilisation in most EU countries, a version of ICD-9 (the International Classification of Diseases, Ninth revision, Clinical Modification (ICD-9-CM)) or the new ICD-10-CM is used (see Chapter 6).

The **crude death rate (CDR)** is a weighted average of the age-specific mortality rates. The weights are the age distribution of the population whose mortality experience is being observed. To compare the CDR from two or more populations (at the NUTS 2 level in this publication) is to compare a combination of different age-specific death rates and different population structures, not reflecting any 'real' mortality differences but including also the effect of the population structure on the total number of deaths and on the crude death rates.

The **standardised death rate (SDR)** is the death rate of a population of a standard age distribution. Since for most causes of death the rate varies significantly by age and sex, the use of standardised death rates improves comparability over time and between countries, since they aim at measuring death rates independently of different population age structures. For reasons of international comparability, SDRs used here are calculated by Eurostat using the standard European population, as defined by WHO.

Standardised death rates for specific conditions or groups of conditions and maps on mortality are not presented in this volume, as much of these data will be found in another volume of the Eurostat 'Panorama of the European Union', the *Atlas of mortality*. However, two groups of causes are included here which will not be found in that publication, namely 'all malignant neoplasms' **(5.2.8** and **5.2.9)**, and 'all respiratory diseases' **(5.2.10** and **5.2.11)**. The variation evident between countries for the latter group is a good illustration of the effects of changing rules for coding assignment. Thus, for the United Kingdom (England and Wales), reinterpreting WHO rules on the coding of pneumonia as a cause of death resulted in a sharp fall in this rate in 1984 (shown here for 1985), while a change in the opposite direction produced a sudden rise in 1993.

5.3. Special causes of death

In the EU, around 8 900 male and 2 500 female deaths were assigned to the condition of **alcohol abuse** in 1998. This condition (ICD-10 code F10) includes alcoholic psychosis and, as Table **5.3.1** shows, mortality associated with it is most common among the middle aged (40–69 years). That such a large proportion of deaths are reported from Germany is likely to be related to varying interpretations of coding assignment from death certificates.

The numbers of **drug-related deaths** are best assessed from details compiled by the **European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)**. Data from different countries **(5.3.2)** are not directly comparable because of varying definitions. Figures presented here show a steady rise in drug-related deaths from 1985–2000, and, according to the EMCDDA corrected index, the total number across all reporting countries rose by 142 % in the period, including a rise of 117 % over 1985–91. Since 1991, the index has stabilised, but this conceals varying trends for individual Member States. Thus, drug-related deaths in the United Kingdom rose by two thirds between 1991 and 2000, and trebled for Portugal over the same period, but numbers decreased in Italy, Germany, France and Spain. In absolute terms, the United Kingdom recorded the highest number of drug-related deaths in 2000 (3 495), with Germany reporting 2 030.

5.1.1 Infant mortality rate

	EU-15	B	DK	D (*)	EL	E	F	IRL	I	L
1960	34.5	31.2	21.5	35.0	40.1	43.7	27.5	29.3	43.9	31.5
1965	27.5	23.7	18.7	24.1	34.3	37.8	22.0	25.2	36.0	24.0
1970	23.4	21.1	14.2	22.5	29.6	28.1	18.2	19.5	29.6	24.9
1975	18.1	16.1	10.4	18.9	24.0	18.9	13.8	17.5	21.2	14.8
1980	12.4	12.1	8.4	12.4	17.9	12.3	10.0	11.1	14.6	11.5
1985	9.5	9.8	7.9	9.1	14.1	8.9	8.3	8.8	10.5	9.0
1990	7.6	8.0	7.5	7.0	9.7	7.6	7.3	8.2	8.2	7.3
1991	7.4	8.4	7.3	6.9	9.0	7.2	7.3	7.6	8.1	9.2
1992	6.9	9.6	6.6	6.2	8.4	7.1	6.8	6.5	7.9	8.5
1993	6.5	8.0	5.4	5.8	8.5	6.7	6.5	6.1	7.1	6.0
1994	6.1	7.6	5.5	5.6	7.9	6.0	5.9	5.7	6.6	5.3
1995	5.6	6.1	5.1	5.3	8.1	5.5	4.9	6.3	6.2	5.5
1996	5.5	5.6	5.6	5.0	7.2	5.5	4.8	6.0	6.2	4.9
1997	5.2	6.1	5.2	4.9	6.4	5.0	4.7	6.1	5.6	4.2
1998	**5.1**	5.6	4.7	4.7	**6.7**	4.9	4.6	6.2	5.4	5.0
1999	5.0	4.9	4.2	4.5	6.2	4.5	4.3	5.5	5.1	4.6
2000	**4.7**	4.8	5.3	**4.4**	6.1	**3.9**	**4.6**	5.9	**4.5**	5.1

(*) Federal Republic of Germany (including ex-GDR from 1991).
Source: Eurostat, NewCronos database (Demography).

5.1.2 Infant deaths (under one year)

	EU-15	B	DK	D (*)	EL	E	F	IRL	I	L
1960	199 773	4 824	1 636	44 105	6 300	28 826	22 484	1 777	39 950	158
1965	167 739	3 684	1 606	31 907	5 194	25 470	18 990	1 604	35 677	127
1970	128 623	2 999	1 005	23 547	4 290	18 595	15 437	1 255	26 639	110
1975	86 087	1 932	746	14 760	3 409	12 641	10 277	1 176	17 526	59
1980	57 642	1 510	484	10 779	2 658	7 048	8 010	821	9 320	48
1985	40 546	1 120	427	7 419	1 647	4 071	6 389	551	6 090	37
1990	33 373	985	473	6 385	993	3 050	5 599	434	4 654	36
1991	31 772	1 062	471	5 711	927	2 846	5 511	400	4 571	46
1992	29 401	1 194	444	4 992	871	2 798	5 075	331	4 489	44
1993	26 807	962	367	4 665	864	2 581	4 604	302	3 905	32
1994	24 663	887	380	4 309	823	2 239	4 193	277	3 507	29
1995	22 600	700	353	4 053	827	1 996	3 545	309	3 257	30
1996	22 190	652	376	3 962	730	2 008	3 501	303	3 250	28
1997	21 181	705	351	3 951	657	1 856	3 439	321	2 973	23
1998	20 376	642	309	3 666	**674**	1 774	3 399	330	2 803	27
1999	:	556	:	3 496	619	1 700	3 221	293	:	26
2000	:	554	358	3 362	:	1 535	:	322	2 461	29

(*) Federal Republic of Germany (including ex-GDR from 1991).
Source: Eurostat, NewCronos database (Demography).

NL	A	P	FIN	S	UK	IS	NO	CH	LI	
17.9	37.5	77.5	21.0	16.6	22.5	13.0	18.9	21.1	21.1	**1960**
14.4	28.3	64.9	17.6	13.3	19.7	15.0	16.8	17.8	22.8	**1965**
12.7	25.9	55.5	13.2	11.0	18.5	13.2	12.7	15.1	11.8	**1970**
10.6	20.5	38.9	10.0	8.6	16.1	12.5	11.1	10.7	6.5	**1975**
8.6	14.3	24.3	7.6	6.9	12.1	7.7	8.1	9.1	7.6	**1980**
8.0	11.2	17.8	6.3	6.8	9.3	5.7	8.5	6.9	10.7	**1985**
7.1	7.8	11.0	5.6	6.0	7.9	5.9	7.0	6.8	0.0	**1990**
6.5	7.5	10.8	5.9	6.2	7.4	5.5	6.4	6.2	0.0	**1991**
6.3	7.5	9.3	5.2	5.3	6.6	4.8	5.9	6.4	10.7	**1992**
6.3	6.5	8.7	4.4	4.8	6.3	4.8	5.1	5.6	0.0	**1993**
5.6	6.3	8.1	4.7	4.4	6.2	3.2	5.2	5.1	5.6	**1994**
5.5	5.4	7.5	3.9	4.1	6.2	6.1	4.0	5.0	0.0	**1995**
5.7	5.1	6.9	4.0	4.0	6.1	3.7	4.0	4.7	7.4	**1996**
5.0	4.7	6.4	3.9	3.6	5.9	5.5	4.1	4.8	:	**1997**
5.2	4.9	6.0	4.2	3.5	5.7	2.6	3.9	4.8	7.5	**1998**
5.2	4.4	5.6	3.6	3.4	5.8	2.4	3.9	4.6	:	**1999**
5.1	4.8	5.5	3.8	3.4	5.6	3.0	3.8	4.9	:	**2000**

NL	A	P	FIN	S	UK	IS	NO	CH	LI	
4 286	4 727	16 576	1 725	1 699	20 700	64	1 167	1 993	8	**1960**
3 541	3 673	13 656	1 371	1 639	19 600	71	1 113	1 996	9	**1965**
3 045	2 908	10 027	854	1 212	16 700	53	823	1 495	5	**1970**
1 894	1 926	6 991	656	894	11 200	55	625	843	2	**1975**
1 557	1 303	3 852	481	671	9 100	35	411	667	3	**1980**
1 430	977	2 327	395	666	7 000	22	434	515	4	**1985**
1 397	709	1 279	368	739	6 272	28	428	574	0	**1990**
1 291	708	1 259	383	761	5 825	25	387	537	0	**1991**
1 235	718	1 068	344	657	5 141	22	353	557	4	**1992**
1 227	618	996	287	571	4 826	22	305	465	0	**1993**
1 104	578	881	308	499	4 649	14	312	424	2	**1994**
1 041	481	805	248	429	4 526	26	244	415	0	**1995**
1 086	451	758	242	377	4 466	16	246	389	3	**1996**
968	398	727	232	328	4 252	23	247	387	:	**1997**
1 035	400	683	239	316	4 079	11	228	376	3	**1998**
1 048	341	651	208	297	4 045	10	232	361	:	**1999**
1 059	378	662	213	309	3 791	13	225	386	:	**2000**

5.1.7 Perinatal mortality rate (*)

	EU-15	B	DK	D (**)	EL	E	F	IRL	I	L
1960	**35.4**	31.9	26.2	34.9	26.4	**42.8**	31.4	37.7	41.9	32.2
1965	**30.3**	27.3	23.9	**27.9**	29.4	**37.1**	27.9	30.0	36.5	30.6
1970	**26.1**	23.3	17.9	25.3	27.4	**31.1**	23.3	24.3	31.2	24.7
1975	20.3	20.0	13.3	18.8	25.5	20.9	18.1	21.5	24.2	16.0
1980	14.1	14.1	8.9	12.1	20.3	14.4	12.9	14.8	17.8	9.8
1985	10.8	10.8	8.1	8.4	15.7	10.9	10.7	12.3	13.5	7.8
1990	8.3	8.9	8.3	6.3	11.9	7.6	8.3	10.1	10.5	6.9
1991	8.0	8.3	7.9	5.8	11.1	7.2	8.2	9.4	9.8	9.6
1992	7.6	8.4	8.1	5.8	10.0	7.3	7.7	9.3	8.8	7.7
1993	:	:	7.4	5.4	10.9	6.6	7.2	9.1	8.3	6.3
1994	:	:	7.8	6.4	9.7	6.5	7.4	9.3	:	6.2
1995	:	:	7.5	6.8	10.4	6.0	7.4	10.5	7.7	7.0
1996	:	:	8.0	6.8	9.5	6.4	8.2	:	7.6	:
1997	:	:	:	6.5	9.5	:	:	9.7	6.8	6.9
1998	:	:	:	:	8.9	5.9	7.0	:	6.1	:
1999	:	7.1	:	6.2	9.1	5.7	6.5	9.0	:	5.2
2000	:	:	:	6.1	:	:	:	:	:	7.3

(*) Late foetal deaths (plus deaths in first week) per 1 000 live births and stillbirths.
(**) Federal Republic of Germany (including ex-GDR from 1991).
Source: Eurostat, NewCronos database (Demography).

5.1.8 Neonatal mortality rate (*)

	EU-15	B	DK	D (**)	EL	E	F	IRL	I	L
1960	**20.3**	20.4	16.1	23.2	19.5	20.2	17.7	20.4	23.9	19.1
1965	**17.5**	16.0	14.7	**17.5**	19.8	20.0	15.3	17.2	22.5	16.3
1970	15.9	14.2	11.0	17.2	19.6	17.5	12.7	12.8	20.6	16.8
1975	12.6	11.7	8.0	13.4	18.0	12.6	9.1	12.0	16.1	9.5
1980	8.3	7.5	5.6	8.1	13.9	8.5	5.8	6.7	11.3	5.3
1985	6.0	5.8	4.7	5.3	10.6	5.9	4.6	5.3	8.2	2.9
1990	4.5	4.2	4.6	3.7	6.5	5.0	3.6	4.8	6.3	4.3
1991	4.4	4.3	4.2	3.5	6.1	4.6	3.5	5.0	6.3	5.0
1992	4.2	4.2	4.1	3.4	5.7	4.6	3.3	4.3	5.9	4.1
1993	:	:	3.5	3.1	6.1	4.1	3.1	4.0	5.3	3.4
1994	:	:	4.0	3.2	5.6	3.9	3.2	4.0	:	3.3
1995	:	:	3.7	3.2	5.8	3.5	2.9	4.7	4.6	3.5
1996	:	:	3.9	3.0	5.2	3.5	4.0	*4.1*	4.6	2.8
1997	:	:	:	2.9	4.9	3.2	3.0	3.6	4.3	2.2
1998	:	:	:	2.8	4.6	3.0	2.9	4.3	4.0	3.0
1999	:	3.1	:	2.9	4.4	2.8	2.7	3.9	:	3.2
2000	:	2.9	:	2.7	:	:	:	4.0	:	3.9

(*) Deaths under age 28 days per 1 000 live births.
(**) Federal Republic of Germany (including ex-GDR from 1991).
Source: Eurostat, NewCronos database (Demography).

NL	A	P	FIN	S	UK	IS	NO	CH	LI	
26.6	34.9	41.1	27.5	**25.4**	33.5	19.7	23.7	25.6	:	**1960**
23.1	29.5	38.6	24.5	**19.7**	27.7	24.0	21.4	22.8	:	**1965**
18.6	26.7	36.5	17.0	16.4	23.7	18.5	19.1	18.1	:	**1970**
13.9	21.2	31.3	12.4	11.3	19.8	15.6	14.1	13.4	:	**1975**
11.1	14.1	23.9	8.4	8.8	13.4	8.8	11.1	9.5	:	**1980**
9.8	10.1	21.5	7.3	7.4	9.9	5.2	9.1	8.3	:	**1985**
9.6	6.9	14.2	6.2	6.5	8.1	6.3	7.5	7.7	:	**1990**
9.1	6.5	13.7	6.8	6.6	8.1	4.6	7.4	7.1	:	**1991**
9.1	6.8	11.9	5.9	5.8	7.7	6.7	7.4	7.0	:	**1992**
9.1	6.1	10.2	5.1	5.9	9.1	4.1	6.9	6.8	:	**1993**
8.6	6.2	9.3	5.4	5.4	8.9	4.5	7.5	6.1	:	**1994**
8.0	6.8	9.1	4.9	5.5	:	6.3	6.1	7.0	:	**1995**
8.4	7.1	8.6	4.9	:	:	7.4	6.5	6.3	:	**1996**
7.9	6.4	7.2	5.9	5.4	:	:	:	6.9	:	**1997**
7.9	6.6	6.7	:	:	:	:	:	:	:	**1998**
7.9	6.0	6.4	4.3	5.6	8.2	5.8	6.1	:	:	**1999**
:	6.7	6.2	5.8	4.2	8.1	5.3	5.9	7.8	:	**2000**

NL	A	P	FIN	S	UK	IS	NO	CH	LI	
13.5	24.6	27.9	14.4	**13.4**	16.0	9.2	11.7	16.1	:	**1960**
11.4	20.1	25.4	13.6	**10.8**	13.4	10.6	11.9	13.8	:	**1965**
9.5	19.1	24.3	10.5	9.1	12.5	10.2	9.5	10.9	:	**1970**
7.6	15.5	22.1	7.8	6.4	10.9	8.9	7.3	7.4	:	**1975**
5.7	9.4	15.5	5.1	5.0	7.7	6.0	5.1	5.9	:	**1980**
5.0	7.1	12.2	4.3	4.2	5.3	3.6	4.7	4.5	:	**1985**
4.8	4.4	7.0	3.7	3.5	4.5	4.0	3.9	3.8	:	**1990**
4.6	4.4	6.9	4.2	3.6	4.4	2.9	3.7	3.6	:	**1991**
4.4	4.7	6.0	3.7	3.3	4.3	3.7	3.8	3.9	:	**1992**
4.5	3.7	5.6	3.0	3.1	4.2	2.8	3.5	3.5	:	**1993**
4.0	3.9	4.8	3.5	3.0	4.1	1.1	3.7	3.3	:	**1994**
3.8	3.4	4.7	2.6	2.9	4.2	4.4	2.7	3.4	:	**1995**
4.2	3.4	4.2	2.9	2.5	4.0	3.0	2.5	3.2	:	**1996**
3.7	3.2	4.1	2.8	2.4	3.9	3.1	:	3.4	:	**1997**
3.8	3.2	3.7	3.0	:	3.8	2.2	:	3.5	:	**1998**
4.0	2.8	3.6	2.6	2.2	3.9	1.5	2.7	3.4	:	**1999**
:	3.3	3.4	2.9	2.3	3.9	2.5	2.6	3.6	:	**2000**

5.1.9 Early neonatal mortality rate (*)

	EU-15	B	DK	D (**)	EL	E	F	IRL	I	L
1960	**16.2**	17.0	13.9	19.7	12.3	**15.9**	14.6	16.1	17.8	16.3
1965	**14.4**	13.9	13.2	**15.7**	14.2	**15.7**	12.8	13.6	17.1	13.8
1970	**13.0**	12.1	9.5	15.2	14.5	**13.7**	10.1	10.6	16.1	15.2
1975	10.3	10.0	6.7	11.2	13.8	9.8	7.3	10.3	13.2	8.8
1980	6.7	6.2	4.6	6.4	11.2	6.7	4.4	5.8	9.4	4.3
1985	4.7	4.6	3.6	4.0	7.6	4.6	3.4	4.2	6.8	2.4
1990	3.5	3.4	3.6	2.7	4.8	3.6	2.5	4.1	5.1	2.6
1991	3.4	3.4	3.4	2.5	4.3	3.3	2.5	3.8	5.0	4.2
1992	3.2	3.2	3.2	2.5	4.0	3.3	2.3	3.7	4.6	3.1
1993	:	:	2.9	2.4	4.3	2.9	2.2	3.2	4.2	2.2
1994	:	:	3.4	2.4	4.0	2.8	2.3	3.2	:	2.6
1995	:	:	3.0	2.4	4.1	2.6	2.2	3.8	3.4	2.6
1996	:	:	3.3	2.3	3.7	2.5	3.2	*3.5*	3.5	1.8
1997	:	:	:	2.2	3.4	2.2	2.1	2.7	3.1	1.8
1998	:	:	:	2.1	3.1	2.0	2.0	3.5	2.8	2.2
1999	:	2.4	:	2.2	3.0	1.9	2.0	3.2	:	2.7
2000	:	2.1	:	2.1	:	:	:	3.0	:	2.6

(*) Deaths at ages under seven days per 1 000 live births.
(**) Federal Republic of Germany (including ex-GDR from 1991).
Source: Eurostat, NewCronos Database (Demography).

5.1.10 Late foetal mortality rate (*)

	EU-15	B	DK	D (**)	EL	E	F	IRL	I	L
1960	19.5	15.1	12.4	15.5	14.3	27.3	17.0	21.9	24.5	16.1
1965	16.1	13.5	10.9	12.3	15.5	21.8	15.2	16.6	19.8	17.1
1970	13.4	11.2	8.5	10.3	13.1	17.6	13.3	13.8	15.4	9.7
1975	10.2	10.1	6.7	7.8	11.8	11.2	10.9	11.4	11.1	7.2
1980	7.5	7.9	4.4	5.7	9.2	7.8	8.6	9.1	8.4	5.5
1985	6.1	6.2	4.4	4.4	8.1	6.3	7.3	8.2	6.7	5.3
1990	4.8	5.5	4.7	3.5	7.1	4.0	5.9	6.0	5.4	4.2
1991	4.7	4.9	4.6	3.3	6.8	3.9	5.7	5.7	4.8	5.4
1992	4.4	5.2	5.0	3.3	6.0	4.0	5.4	5.5	4.3	4.6
1993	4.5	4.8	4.6	3.1	6.6	3.7	5.0	5.9	4.2	4.1
1994	4.6	4.0	4.4	4.0	5.7	3.7	5.1	6.1	3.9	3.7
1995	:	4.8	4.5	4.4	6.3	3.4	5.3	6.7	4.3	4.4
1996	:	:	4.8	4.5	5.8	3.9	5.0	:	4.2	:
1997	:	:	:	4.3	6.1	:	:	7.0	3.6	5.1
1998	:	:	:	:	5.9	3.9	5.0	:	3.2	:
1999	:	4.7	:	4.0	6.2	3.9	4.6	5.8	:	2.5
2000	:	:	:	4.0	:	3.6	4.5	:	:	4.7

(*) Stillbirths per 1 000 (live births and stillbirths).
(**) Federal Republic of Germany (including ex-GDR from 1991).
Source: Eurostat, NewCronos database (Demography).

NL	A	P	FIN	S	UK	IS	NO	CH	LI	
11.9	20.2	15.0	12.6	**11.8**	13.7	7.1	9.9	14.4	:	**1960**
10.1	17.8	15.7	12.3	**9.5**	11.7	9.3	10.6	12.5	:	**1965**
8.0	16.8	16.1	9.1	8.1	10.7	8.7	8.5	9.4	:	**1970**
6.3	12.9	16.3	6.8	5.5	9.3	8.2	6.1	6.3	:	**1975**
4.5	7.5	12.3	4.2	4.3	6.2	4.2	4.0	4.6	:	**1980**
4.0	5.5	10.2	3.5	3.4	4.4	2.9	3.9	3.7	:	**1985**
3.9	3.3	5.7	3.1	3.0	3.5	3.6	3.2	3.1	:	**1990**
3.8	3.1	5.5	3.5	2.8	3.4	1.8	2.7	3.0	:	**1991**
3.5	3.3	4.7	3.0	2.6	3.4	3.3	3.1	3.2	:	**1992**
3.7	2.8	4.1	2.5	2.6	3.4	2.2	2.7	2.7	:	**1993**
3.2	2.9	3.4	2.9	2.3	3.2	1.1	3.0	2.7	:	**1994**
3.1	2.5	3.6	2.0	2.2	3.3	4.4	2.2	2.9	:	**1995**
3.4	2.6	3.2	2.3	1.8	3.2	2.8	2.0	2.6	:	**1996**
2.8	2.2	2.8	2.2	2.0	3.0	2.6	:	2.8	:	**1997**
3.0	2.5	2.8	2.4	:	2.9	2.2	:	2.9	:	**1998**
3.2	2.0	2.7	2.1	1.7	3.0	1.2	2.1	2.9	:	**1999**
:	2.5	2.5	1.8	1.7	2.9	1.9	2.1	2.9	:	**2000**

NL	A	P	FIN	S	UK	IS	NO	CH	LI	
14.9	15.0	26.5	15.1	13.7	20.1	12.7	13.9	11.4	10.4	**1960**
13.1	11.9	23.2	12.4	10.2	16.1	14.8	10.9	10.4	5.0	**1965**
10.7	10.1	20.7	8.0	8.3	13.1	9.8	10.7	8.9	0.0	**1970**
7.7	8.4	15.2	5.7	5.8	10.5	7.5	8.1	7.2	0.0	**1975**
6.6	6.6	11.8	4.2	4.5	7.2	4.6	7.1	4.9	0.0	**1980**
5.9	4.6	11.4	3.9	3.9	5.5	2.3	5.2	4.6	0.0	**1985**
5.7	3.6	8.6	3.2	3.6	4.6	2.7	4.3	4.6	0.0	**1990**
5.3	3.4	8.2	3.3	3.7	4.7	2.9	4.6	4.1	:	**1991**
5.6	3.5	7.2	2.9	3.2	4.3	3.5	4.3	3.9	:	**1992**
5.4	3.3	6.1	2.7	3.4	5.7	1.9	4.2	4.1	:	**1993**
5.4	3.3	5.8	2.5	3.1	5.8	3.4	4.6	3.4	:	**1994**
4.9	4.4	5.4	3.0	3.4	:	1.9	3.9	4.1	:	**1995**
5.0	4.5	5.4	2.7	:	:	4.6	4.5	3.7	:	**1996**
5.1	4.3	4.5	3.7	3.5	:	:	:	4.2	:	**1997**
4.8	4.1	4.0	:	:	:	:	:	:	:	**1998**
4.7	4.0	3.7	2.2	3.8	5.3	4.6	4.0	:	:	**1999**
:	4.2	3.7	4.1	2.5	5.3	3.5	3.8	4.9	:	**2000**

5.1.11 Postneonatal mortality rate (*)

	EU-15	B	DK	D (**)	EL	E	F	IRL	I	L
1960	14.2	10.8	5.4	11.8	20.6	23.5	9.8	8.9	20.0	12.4
1965	10.0	7.7	4.0	6.6	14.5	17.8	6.7	8.0	13.5	7.7
1970	7.5	6.9	3.2	5.3	10.0	10.6	5.5	6.7	9.0	8.1
1975	5.5	4.4	2.4	5.5	6.0	6.3	4.7	5.5	5.1	5.3
1980	4.1	4.6	2.8	4.3	4.0	3.8	4.2	4.4	3.3	6.2
1985	3.5	4.0	3.2	3.8	3.5	3.0	3.7	3.5	2.3	6.1
1990	3.1	3.8	2.9	3.3	3.2	2.6	3.7	3.4	1.9	3.0
1991	3.0	4.1	3.1	3.4	2.9	2.6	3.8	2.6	1.8	4.2
1992	2.7	5.4	2.5	2.8	2.7	2.5	3.5	2.2	2.0	4.4
1993	:	:	1.9	2.7	2.4	2.6	3.4	2.1	1.8	2.6
1994	:	:	1.5	2.4	2.3	2.1	2.7	1.7	:	2.0
1995	:	:	1.4	2.1	2.3	2.0	2.0	1.6	1.6	2.0
1996	:	:	1.7	2.0	2.0	2.0	0.8	1.9	1.6	2.1
1997	:	:	:	2.0	1.5	1.8	1.7	2.5	1.3	2.0
1998	:	:	:	1.9	2.1	1.9	1.7	1.9	1.4	2.0
1999	:	1.8	:	1.6	1.8	1.7	1.6	1.6	:	1.4
2000	:	:	:	:	:	:	:	1.9	:	1.3

(*) Stillbirths per 1 000 (live births and stillbirths).
(**) Federal Republic of Germany (including ex-GDR from 1991).
Source: Eurostat, NewCronos database (Demography).

5.1.12 Childhood mortality rates (*)

	EU-15	B	DK	D	EL	E	F	IRL	I
1992	:	24.8	:	22.6	:	:	:	:	:
1993	:	21.8	:	21.9	:	:	:	:	:
1994	21.4	21.3	21.9	20.7	20.5	23.5	20.5	18.9	21.0
1995	20.2	23.0	21.4	19.4	18.6	22.3	19.7	20.7	21.1
1996	19.5	:	21.8	17.3	21.6	23.1	18.4	19.7	20.1
1997	19.0	:	:	17.1	21.5	20.9	18.0	18.9	19.6
1998	18.5	:	:	16.4	:	20.4	17.3	20.0	16.5
1999	:	:	:	16.5	:	:	:	21.2	:

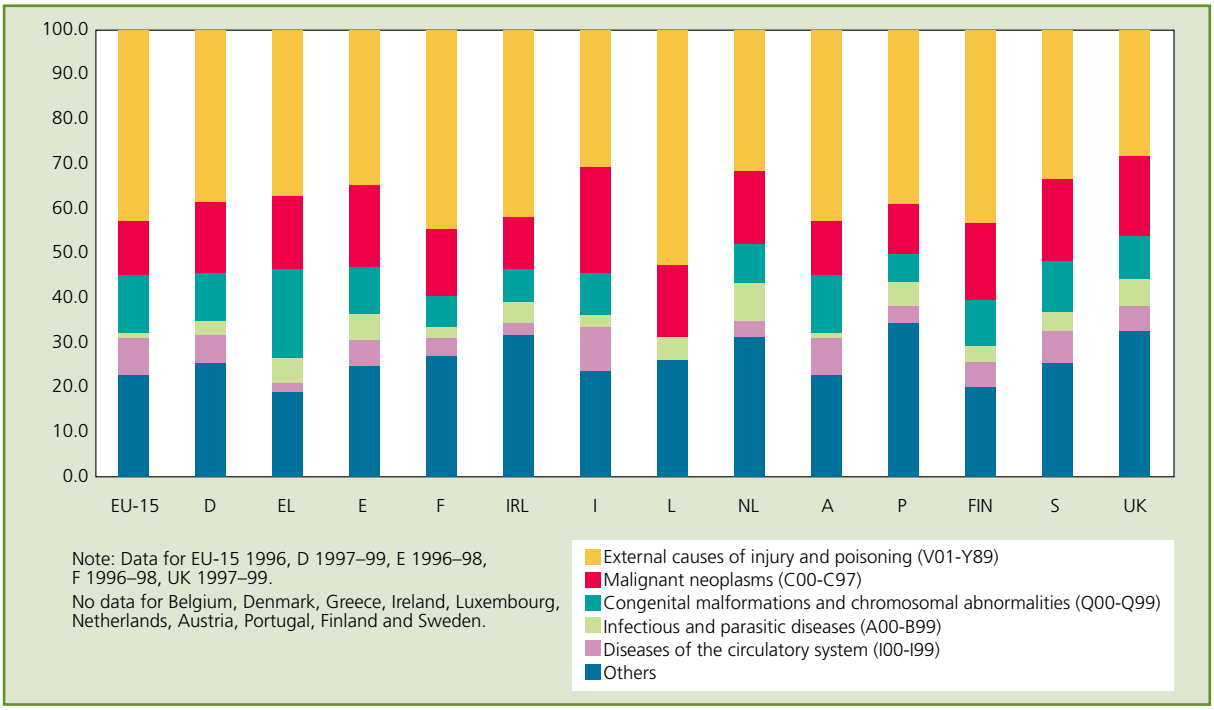
(*) Deaths at ages 1–14 per 1 000 population at these ages.
Source: Eurostat, NewCronos database (Demography).

NL	A	P	FIN	S	UK	IS	NO	CH	
4.4	12.9	49.6	6.6	3.2	6.5	3.8	7.2	5.0	**1960**
3.0	8.2	39.5	4.0	2.5	6.3	4.4	4.9	4.0	**1965**
3.2	6.8	31.2	2.7	1.9	6.0	3.0	3.2	4.2	**1970**
3.0	5.0	16.8	2.2	2.2	5.2	3.6	3.8	3.3	**1975**
2.9	4.9	8.8	2.5	1.9	4.4	1.7	3.0	3.2	**1980**
3.0	4.1	5.6	2.0	2.6	4.0	2.1	3.8	2.4	**1985**
2.3	3.4	4.0	1.9	2.5	3.4	1.9	3.1	3.0	**1990**
1.9	3.1	3.9	1.7	2.6	3.0	2.6	2.7	2.6	**1991**
1.9	2.8	3.3	1.5	2.0	2.3	1.1	2.1	2.5	**1992**
1.8	2.8	3.1	1.4	1.7	2.1	2.0	1.6	2.1	**1993**
1.6	2.4	3.3	1.2	1.4	2.1	2.1	1.5	1.8	**1994**
1.7	2.0	2.8	1.3	1.2	2.0	1.7	1.3	1.6	**1995**
1.5	1.7	2.7	1.1	1.5	2.1	0.7	1.5	1.5	**1996**
1.3	1.5	2.3	1.1	1.2	2.0	2.4	:	1.4	**1997**
1.4	1.7	2.3	1.2	:	1.9	0.4	:	1.3	**1998**
1.2	1.6	2.0	1.0	1.2	1.9	0.9	1.2	1.2	**1999**
:	1.5	2.1	:	1.1	1.7	0.5	1.2	1.3	**2000**

(per 100 000)

NL	A	P	FIN	S	UK	NO	CH	
:	:	:	:	:	:	:	:	**1992**
:	:	:	:	:	:	:	:	**1993**
20.5	22.8	40.5	17.1	14.6	21.0	20.0	24.1	**1994**
21.7	19.5	37.6	18.5	13.1	17.8	18.5	19.6	**1995**
19.8	19.3	38.1	18.4	13.5	17.5	17.6	19.1	**1996**
18.7	18.2	36.5	19.9	:	17.9	20.7	18.7	**1997**
17.2	17.0	36.8	14.2	14.6	17.5	15.9	16.9	**1998**
18.7	17.1	30.3	17.8	:	16.8	:	:	**1999**

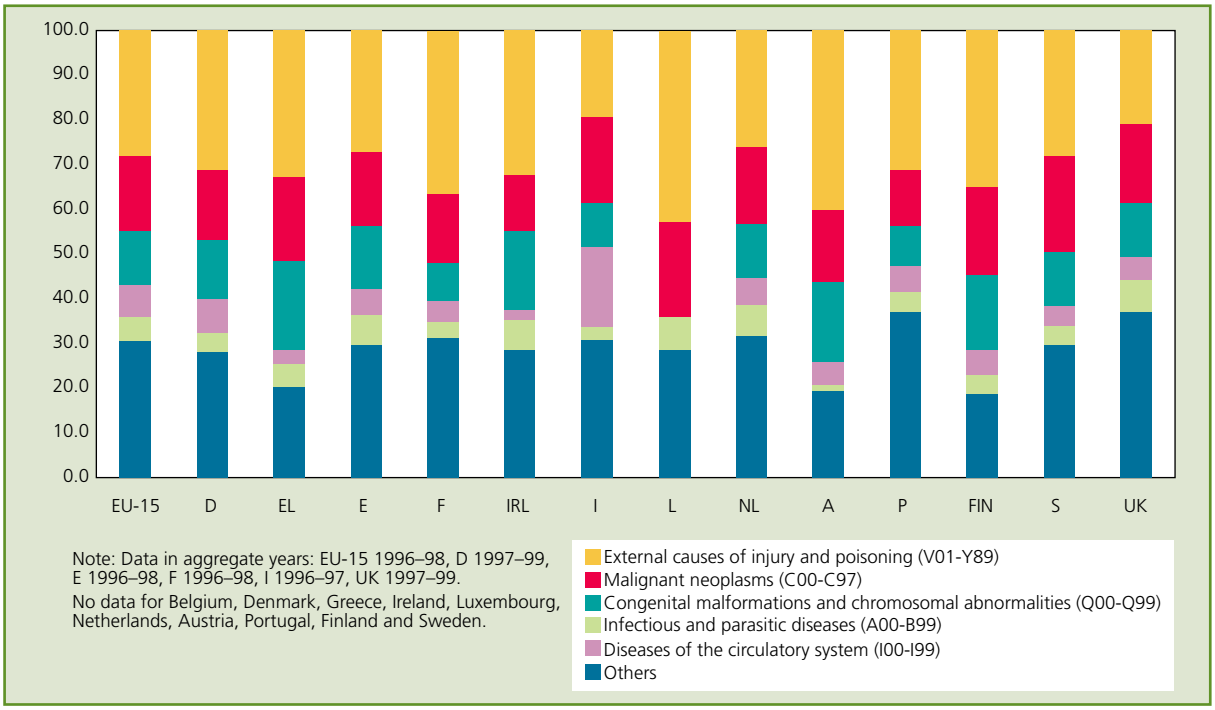
5.1.13 Childhood mortality by selected cause of death, boys, late 1990s



Note: Data for EU-15 1996, D 1997–99, E 1996–98, F 1996–98, UK 1997–99.
No data for Belgium, Denmark, Greece, Ireland, Luxembourg, Netherlands, Austria, Portugal, Finland and Sweden.

Source: Eurostat, NewCronos database (Demography).

5.1.14 Childhood mortality by selected cause of death, girls, late 1990s (*)



(*) Deaths at ages 1 to 14.

Source: Eurostat, NewCronos database (Demography).

5.2.1 Age-standardised death rate for 65 causes of death, males, 1998

	EU-15	B (*)	DK (**)	D	EL (***)	E	F	IRL	I
All causes of death	923.3	995.3	1046.5	926.9	811.2	872.3	862.9	1027.9	835.0
Infectious and parasitic diseases	11.2	16.1	11.6	9.2	6.2	17.7	12.8	6.8	5.3
Tuberculosis	1.5	1.5	1.2	1.1	0.8	1.9	2.1	2.0	1.1
Meningococcal infection	0.2	0.3	0.1	0.1	0.3	0.2	0.0	0.4	0.0
AIDS (HIV disease)	2.9	:	5.1	1.1	0.5	7.1	2.7	0.5	:
Viral hepatitis	1.0	1.0	0.5	1.0	0.4	1.9	0.4	0.5	2.1
Neoplasms	264.6	302.4	274.5	255.9	217.3	265.2	286.2	252.9	266.1
Malignant neoplasms	258.4	301.1	268.3	249.9	217.2	258.7	279.4	250.6	255.9
lip, oral cavity, pharynx	8.2	8.3	6.7	8.8	2.9	9.3	14.8	5.8	7.0
oesophagus	8.5	8.0	9.2	6.9	2.6	7.7	12.4	11.9	4.8
stomach	15.5	12.9	10.7	16.2	12.4	17.1	10.6	12.7	19.5
colon	19.2	22.1	22.1	21.2	11.2	20.2	19.2	22.8	17.4
rectum and anus	8.5	7.8	12.7	10.3	1.6	7.1	7.1	9.2	7.8
liver and the intrahepatic bile ducts	11.0	6.7	5.1	7.3	18.2	12.7	16.7	4.3	18.9
pancreas	11.1	11.0	11.0	12.3	9.4	9.2	11.6	12.1	11.1
larynx and trachea/bronchus/lung	73.9	112.0	76.6	67.9	77.3	79.5	75.8	63.9	80.2
skin	2.4	1.6	3.9	2.3	0.7	2.0	2.1	1.6	2.4
breast	0.4	0.4	0.4	0.5	0.1	0.3	0.4	0.4	0.3
prostate	27.6	33.9	33.9	27.2	16.3	25.2	27.4	31.6	19.4
kidney	5.9	5.8	5.9	7.0	4.1	4.3	6.2	5.8	5.5
bladder	10.7	12.3	14.8	8.7	10.0	13.6	10.9	6.4	11.1
lymph/haematopoietic tissue	18.8	20.0	19.9	18.5	14.6	16.0	19.2	23.4	19.5
Diseases of the blood (-forming organs), immunological disorders	3.0	4.7	2.1	1.5	1.4	4.0	4.3	3.1	6.2
Endocrine, nutritional and metabolic diseases	18.7	15.4	14.8	19.4	6.8	19.3	19.3	16.9	22.8
Diabetes mellitus	14.9	11.1	10.8	16.9	5.2	16.0	11.8	13.7	19.6
Mental and behavioural disorders	15.6	15.4	15.2	14.6	1.1	18.6	18.4	15.6	10.7
Alcohol abuse (including alcoholic psychosis)	4.7	2.7	8.4	10.3	0.5	1.2	6.9	4.5	0.6
Drug dependence, toxicomania	1.7	0.6	0.4	2.0	:	0.3	1.0	4.3	2.8
Diseases of the nervous system and the sense organs	17.4	22.9	13.2	17.3	8.8	16.5	21.1	18.5	16.3
Meningitis (other than meningococcal infection)	0.3	0.3	1.0	0.3	0.4	0.4	0.3	0.3	0.2
Diseases of the circulatory system	349.2	328.2	373.6	401.4	367.6	277.4	233.8	430.4	321.0
Ischaemic heart diseases	157.1	127.2	200.0	197.2	128.5	103.9	78.2	261.6	118.2
Other heart diseases	64.0	92.3	54.5	71.0	100.8	60.3	59.7	59.5	71.6
Cerebrovascular diseases	78.9	68.7	76.8	78.3	111.5	70.5	50.5	66.8	81.0
Diseases of the respiratory system	86.9	113.8	90.0	61.6	43.6	102.7	66.3	153.2	60.4
Influenza	1.0	1.2	2.0	0.2	0.0	1.0	1.9	0.4	1.3
Pneumonia	30.2	26.3	30.5	18.2	6.6	18.9	22.4	64.9	12.4
Chronic lower respiratory diseases	41.9	65.0	50.2	36.4	10.4	56.5	30.4	68.7	35.1
of which asthma	2.6	3.6	3.4	4.7	0.6	1.5	2.5	3.0	1.7
Diseases of the digestive system	42.9	38.6	43.1	48.0	22.0	48.1	45.2	29.7	40.3
Ulcer of stomach, duodenum and jejunum	3.7	3.3	8.2	3.5	2.0	2.6	2.3	5.0	3.1
Chronic liver diseases	20.2	14.0	18.1	26.4	7.0	20.6	22.9	5.9	21.3
Diseases of the skin and subcutaneous tissue	1.2	2.5	0.4	0.3	0.2	1.3	2.2	1.5	0.6
Diseases of the musculosketal system/connective tissue	2.5	3.2	2.7	1.3	0.9	4.1	2.8	3.9	1.5
Rheumatoid arthritis and osteoarthrosis	0.5	0.5	1.0	0.3	0.0	0.4	0.3	2.2	0.5
Diseases of the genitourinary system	12.5	13.2	10.3	11.0	12.3	17.1	10.5	16.7	11.8
Diseases of kidney and ureter	9.4	10.6	7.1	8.8	11.7	13.1	7.8	12.5	10.2
Certain conditions originating in the perinatal period	4.1	4.3	4.6	3.6	5.3	3.5	3.0	4.7	4.9
Congenital malformations and chromosomal abnormalities	3.8	4.0	5.9	3.3	5.1	4.2	2.9	6.2	4.0
Congenital malformations of the nervous system	0.4	0.5	0.7	0.3	0.6	0.4	0.4	0.8	0.6
Congenital malformations of the circulatory system	1.7	1.6	2.5	1.5	2.8	2.0	1.5	1.9	1.8
Symptoms, signs, abnormal findings, ill-defined causes	29.3	28.9	112.7	25.8	52.7	14.1	47.2	5.4	9.2
Sudden infant death syndrome	0.8	2.3	0.7	1.4	0.3	0.4	0.9	1.5	0.1
Unknown and unspecified causes	18.9	19.9	98.9	19.0	36.0	3.7	33.8	1.4	4.4
External causes of injury and poisoning	60.5	81.6	71.9	52.7	59.7	58.3	86.6	61.9	53.8
Accidents	37.9	46.0	43.4	27.4	51.5	44.5	53.7	36.5	39.0
Transport accidents	17.5	23.9	15.3	14.2	33.0	23.7	20.6	18.4	20.9
Accidental falls	8.9	10.3	17.0	7.4	3.9	4.7	11.8	9.1	10.5
Accidental poisoning	1.9	2.4	4.2	0.4	4.5	3.9	1.1	1.3	0.6
Suicide and intentional self-harm	17.1	29.8	22.9	20.0	5.7	11.8	25.9	22.8	10.8
Homicide, assault	1.3	1.9	1.3	1.1	2.5	1.2	0.9	1.6	1.9
Events of undetermined intent	3.6	3.4	3.8	3.4	:	0.5	4.8	1.2	2.1

(*) 1994. (**) 1996. (***) 1997.

Source: Eurostat, NewCronos database (Health and safety).

(per 100 000 inhabitants)

L	NL	A	P	FIN	S	UK	NO	CH	
956.3	910.2	901.9	1 146.6	992.8	787.2	907.7	863.3	759.6	**All causes of death**
11.9	10.0	4.8	30.5	7.2	7.7	6.5	8.5	10.1	**Infectious and parasitic diseases**
1.8	1.0	1.5	6.4	2.0	0.6	1.0	1.0	0.7	Tuberculosis
:	0.5	0.1	0.1	0.1	0.1	0.4	0.1	0.3	Meningococcal infection
1.7	1.2	1.2	14.0	0.2	0.5	0.5	0.9	3.4	AIDS (HIV disease)
0.9	0.4	0.5	1.9	0.1	0.4	0.4	0.4	0.4	Viral hepatitis
272.9	276.7	241.5	247.4	215.9	199.5	247.1	226.9	216.0	**Neoplasms**
271.2	270.4	237.6	242.9	211.9	192.5	243.8	223.2	211.1	**Malignant neoplasms**
10.5	4.0	8.9	9.7	2.9	3.6	4.2	4.7	7.3	lip, oral cavity, pharynx
11.5	9.3	5.5	7.8	3.9	4.4	13.3	4.4	7.4	oesophagus
10.6	13.7	17.7	30.3	13.1	9.7	13.4	12.2	9.4	stomach
25.7	21.4	19.7	21.0	10.0	14.2	17.1	18.6	14.5	colon
9.9	7.0	10.8	9.5	7.4	7.5	9.8	11.7	7.2	rectum and anus
9.0	3.3	10.1	7.0	7.7	5.9	4.0	2.3	8.4	liver and the intrahepatic bile ducts
12.8	10.6	13.3	8.8	14.0	11.1	9.8	10.4	10.3	pancreas
83.7	89.4	63.3	53.5	58.4	32.9	68.2	47.1	53.8	larynx and trachea/bronchus/lung
3.1	3.4	3.4	1.6	3.3	4.1	2.5	4.8	3.7	skin
1.0	0.4	0.4	0.4	0.1	0.2	0.3	0.1	0.2	breast
24.5	32.3	27.9	33.5	32.4	38.6	27.3	40.5	29.2	prostate
4.1	6.7	5.6	3.3	7.2	7.3	5.7	6.8	4.3	kidney
7.9	10.8	8.7	8.9	6.2	6.6	9.8	9.2	7.6	bladder
23.2	20.5	17.2	16.7	18.4	18.7	18.3	20.4	17.1	lymph/haematopoietic tissue
3.1	2.2	0.9	3.0	0.8	1.4	3.1	1.1	1.7	**Diseases of the blood (-forming organs), immunological disorders**
10.2	20.6	13.5	30.9	11.2	15.4	11.9	16.4	19.4	**Endocrine, nutritional and metabolic diseases**
6.8	16.8	12.6	27.2	9.8	12.6	9.3	12.5	17.1	Diabetes mellitus
17.1	17.8	7.4	3.9	42.5	24.9	13.5	22.7	22.5	**Mental and behavioural disorders**
8.6	2.3	5.9	1.2	9.5	8.7	1.5	6.8	4.6	Alcohol abuse (including alcoholic psychosis)
0.4	0.1	1.3	0.1	0.6	1.7	3.1	9.0	4.5	Drug dependence, toxicomania
29.6	16.3	13.4	12.3	24.1	13.2	16.0	18.3	22.1	**Diseases of the nervous system and the sense organs**
:	0.3	0.3	0.7	0.5	0.3	0.4	0.5	0.4	Meningitis (other than meningococcal infection)
347.6	323.9	434.6	403.1	418.6	357.7	367.0	357.4	274.4	**Diseases of the circulatory system**
137.7	142.8	205.6	104.5	266.8	195.9	225.3	191.2	137.6	Ischaemic heart diseases
80.1	73.8	94.0	61.0	31.1	44.0	22.9	52.9	51.4	Other heart diseases
85.8	63.4	85.6	195.6	83.3	69.7	72.3	75.2	45.2	Cerebrovascular diseases
91.3	102.0	45.2	113.1	92.0	51.3	134.2	67.4	55.9	**Diseases of the respiratory system**
:	1.1	0.5	1.1	2.1	2.1	0.2	1.5	2.3	Influenza
22.7	35.1	12.6	49.2	47.4	20.7	71.1	27.9	15.2	Pneumonia
37.2	59.5	28.5	34.9	36.7	21.9	49.2	33.2	30.9	Chronic lower respiratory diseases
2.5	0.6	2.9	2.4	1.7	1.5	1.8	4.6	2.6	of which asthma
44.8	29.1	47.1	56.8	41.1	24.7	33.9	25.7	26.7	**Diseases of the digestive system**
2.3	2.1	2.9	4.5	4.3	3.9	6.0	4.3	1.7	Ulcer of stomach, duodenum and jejunum
20.1	6.2	32.7	31.1	18.3	7.4	11.4	7.7	12.0	Chronic liver diseases
1.8	1.9	0.1	1.8	0.5	0.7	1.0	0.7	0.7	**Diseases of the skin and subcutaneous tissue**
0.9	3.1	0.9	1.2	3.5	2.5	3.0	3.4	3.4	**Diseases of the musculosketal system/connective tissue**
:	0.6	0.3	0.2	1.7	0.7	0.7	1.6	1.2	Rheumatoid arthritis and osteoarthrosis
10.0	14.7	7.2	16.3	7.9	11.2	10.4	10.8	7.2	**Diseases of the genitourinary system**
9.4	8.2	6.5	14.7	5.4	6.4	6.2	7.5	4.2	Diseases of kidney and ureter
5.4	4.8	3.6	3.4	2.6	2.6	5.3	3.7	4.2	**Certain conditions originating in the perinatal period**
1.7	5.4	4.0	4.9	4.2	3.6	3.7	4.5	5.3	**Congenital malformations and chromosomal abnormalities**
:	0.6	0.6	0.6	0.3	0.3	0.3	0.6	0.3	Congenital malformations of the nervous system
1.7	1.5	1.4	2.3	2.0	1.1	1.7	1.7	2.5	Congenital malformations of the circulatory system
29.7	44.7	6.7	142.0	4.6	15.4	10.9	35.1	28.7	**Symptoms, signs, abnormal findings, ill-defined causes**
1.1	0.3	1.0	0.1	0.9	0.6	0.7	1.0	0.8	Sudden infant death syndrome
15.7	33.7	0.6	101.1	3.3	8.4	2.3	27.5	22.2	Unknown and unspecified causes
78.2	37.0	71.0	76.0	116.1	55.5	40.2	60.7	61.2	**External causes of injury and poisoning**
51.1	21.7	39.8	47.1	71.8	29.1	22.7	40.2	31.5	Accidents
21.8	9.9	16.4	30.8	16.0	9.2	8.9	15.3	12.3	Transport accidents
11.4	3.7	12.4	6.9	25.4	5.0	5.7	13.9	10.9	Accidental falls
6.7	0.7	1.7	1.5	15.8	2.1	2.6	2.3	0.5	Accidental poisoning
22.3	12.4	28.9	8.3	36.8	18.7	11.3	17.9	27.0	Suicide and intentional self-harm
0.9	1.6	1.3	2.0	3.4	1.5	1.0	1.3	1.0	Homicide, assault
2.4	0.9	0.9	18.4	2.3	4.6	5.2	0.5	1.1	Events of undetermined intent

5.2.2 Age-standardised death rate for 65 causes of death, females, 1998

	EU-15	B (*)	DK (**)	D	EL (***)	E	F	IRL	I
All causes of death	525.1	564.4	681.5	556.3	542.7	480.7	461.0	645.7	484.6
Infectious and parasitic diseases	5.7	8.4	5.0	5.2	4.3	7.9	7.0	3.9	3.4
Tuberculosis	0.6	0.5	0.3	0.3	0.4	0.6	0.9	0.9	0.4
Meningococcal infection	0.2	0.2	0.4	0.1	0.1	0.2	0.0	0.3	0.0
AIDS (HIV disease)	0.7	:	0.8	0.2	0.1	1.4	0.7	0.2	:
Viral hepatitis	0.6	0.7	0.0	0.7	0.3	1.3	0.2	0.1	1.4
Neoplasms	145.1	155.6	206.6	154.5	115.1	116.9	130.3	175.5	137.3
Malignant neoplasms	141.2	154.6	200.9	150.6	115.0	112.9	125.9	173.6	131.7
lip, oral cavity, pharynx	1.6	2.0	2.5	1.8	0.8	1.3	1.8	2.0	1.4
oesophagus	1.9	1.8	2.6	1.4	0.5	0.8	1.6	4.5	1.0
stomach	7.2	5.5	4.6	9.0	6.6	7.3	4.0	6.5	9.2
colon	12.5	14.6	17.5	14.9	8.4	12.0	11.7	14.2	11.4
rectum and anus	4.5	3.6	7.2	5.9	1.2	3.6	3.7	3.8	4.0
liver and the intrahepatic bile ducts	3.8	3.1	3.3	2.7	8.1	4.6	3.2	2.8	6.8
pancreas	7.3	7.4	9.1	8.5	5.6	5.2	6.5	8.9	7.5
larynx and trachea/bronchus/lung	15.9	14.6	39.9	15.2	10.7	6.5	10.8	28.2	12.2
skin	1.6	1.5	2.2	1.6	0.7	1.2	1.5	2.5	1.4
breast	28.4	37.7	39.3	28.8	21.5	22.2	27.5	32.6	25.9
prostate	2.7	3.1	5.0	3.5	1.4	2.4	2.2	4.3	1.1
kidney	4.3	4.5	4.5	4.0	3.2	4.1	5.1	2.9	5.0
bladder	8.6	10.7	14.4	9.4	5.4	6.1	8.1	12.7	6.5
lymph/haematopoietic tissue	2.6	3.0	3.7	3.2	1.6	1.6	2.6	2.3	2.1
Diseases of the blood (-forming organs), immunological disorders	2.3	3.1	4.4	2.5	1.8	1.7	1.9	2.1	1.7
Endocrine, nutritional and metabolic diseases	11.8	12.4	11.9	12.1	9.3	10.7	11.7	14.7	12.3
Diabetes mellitus	2.0	3.2	1.9	1.2	1.3	2.7	2.8	2.3	3.2
Mental and behavioural disorders	15.8	15.5	10.6	17.3	7.1	18.8	15.5	11.8	20.7
Alcohol abuse (including alcoholic psychosis)	12.6	11.0	7.0	15.1	5.8	15.5	8.7	8.0	17.8
Drug dependence, toxicomania	10.1	11.6	7.9	5.0	0.7	18.5	13.0	10.0	8.1
Diseases of the nervous system and the sense organs	1.2	1.0	2.2	2.6	0.0	0.2	1.7	2.2	0.1
Meningitis (other than meningococcal infection)	0.4	0.3	0.2	0.5	:	0.0	0.2	1.3	0.4
Diseases of the circulatory system	12.4	18.5	10.3	11.0	6.0	12.4	15.8	13.0	12.6
Ischaemic heart diseases	0.2	0.2	0.6	0.2	0.2	0.2	0.2	0.4	0.2
Other heart diseases	210.1	207.3	220.4	258.1	285.1	187.8	136.3	257.0	208.4
Cerebrovascular diseases	73.4	56.1	99.1	102.5	56.2	45.5	32.2	125.8	56.2
Diseases of the respiratory system	43.4	69.0	31.7	52.0	97.3	52.0	38.1	40.5	50.8
Influenza	59.3	55.1	60.2	60.8	112.8	56.7	36.5	60.0	62.6
Pneumonia	39.6	40.3	64.8	26.1	28.5	38.6	32.0	94.4	23.4
Chronic lower respiratory diseases	0.8	1.0	2.1	0.2	0.0	1.0	1.8	0.4	1.0
of which asthma	17.6	12.9	21.7	9.9	4.5	9.5	12.2	47.7	6.8
Diseases of the digestive system	14.6	17.9	37.2	12.9	3.5	12.4	12.3	34.5	10.5
Ulcer of stomach, duodenum and jejunum	2.1	3.4	4.5	2.8	0.3	2.1	2.4	2.6	1.1
Chronic liver diseases	23.8	25.4	27.6	26.4	11.8	24.4	23.3	22.0	22.4
Diseases of the skin and subcutaneous tissue	2.1	2.2	6.5	2.2	1.3	1.1	1.2	3.3	1.4
Diseases of the musculosketal system/connective tissue	8.3	7.6	7.6	10.6	2.1	6.9	8.6	3.5	10.1
Rheumatoid arthritis and osteoarthrosis	1.2	3.1	0.7	0.4	0.5	1.5	2.4	2.5	0.8
Diseases of the genitourinary system	3.2	5.0	3.1	1.6	1.0	5.2	3.2	5.2	2.6
Diseases of kidney and ureter	1.0	0.9	0.9	0.6	0.0	0.7	0.8	2.9	1.0
Certain conditions originating in the perinatal period	7.3	9.1	6.2	6.9	8.9	10.7	6.0	11.6	6.4
Congenital malformations and chromosomal abnormalities	5.6	7.6	4.6	5.6	8.5	8.2	4.5	8.5	6.0
Congenital malformations of the nervous system	0.1	0.2	0.2	0.1	:	0.0	0.2	0.2	0.1
Congenital malformations of the circulatory system	3.3	2.6	3.2	2.9	5.0	3.0	2.6	3.6	4.4
Symptoms, signs, abnormal findings, ill-defined causes	3.3	3.1	5.1	3.1	4.4	3.8	2.7	5.8	3.6
Sudden infant death syndrome	0.4	0.6	0.7	0.3	0.5	0.5	0.3	0.8	0.4
Unknown and unspecified causes	1.4	1.2	2.3	1.1	2.5	1.6	1.2	2.0	1.6
External causes of injury and poisoning	18.8	21.7	73.6	16.1	45.3	10.4	30.3	5.3	6.1
Accidents	0.6	1.3	0.5	1.0	0.1	0.3	0.6	1.0	0.2
Transport accidents	9.2	13.3	56.7	9.1	28.9	1.9	17.8	1.3	1.8
Accidental falls	23.3	33.6	34.3	20.3	17.7	18.0	37.6	21.2	21.1
Accidental poisoning	15.8	20.5	22.2	11.7	16.2	14.0	26.1	15.7	16.9
Suicide and intentional self-harm	5.5	7.6	5.0	5.0	9.8	6.9	7.3	5.0	5.7
Homicide, assault	5.9	7.1	13.2	4.5	2.0	2.3	9.2	7.1	8.7
Events of undetermined intent	0.6	1.3	1.6	0.2	0.9	0.7	0.8	0.5	0.3
Suicide and intentional self-harm	5.2	10.5	8.7	6.0	0.9	3.2	8.3	4.5	2.9
Homicide, assault	0.6	1.2	0.8	0.7	0.6	0.4	0.5	0.7	0.5
Events of undetermined intent	1.4	1.3	2.4	1.6	:	0.2	1.9	0.5	0.7

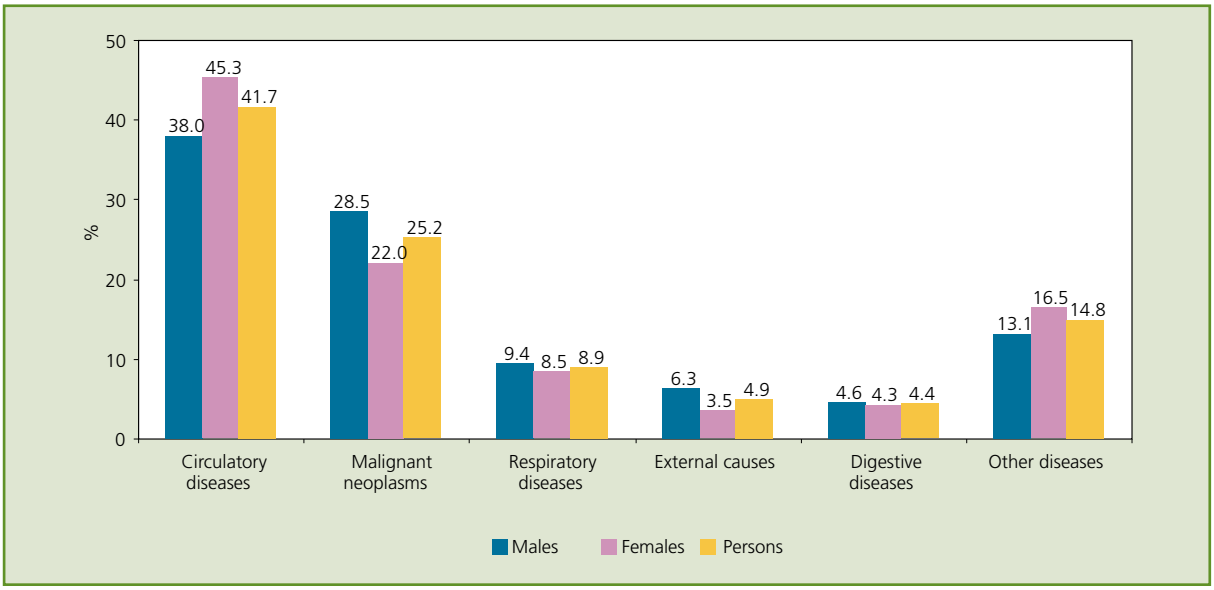
(*) 1994. (**) 1996. (***) 1997.

Source: Eurostat, NewCronos database (Health and safety).

(per 100 000 inhabitants)

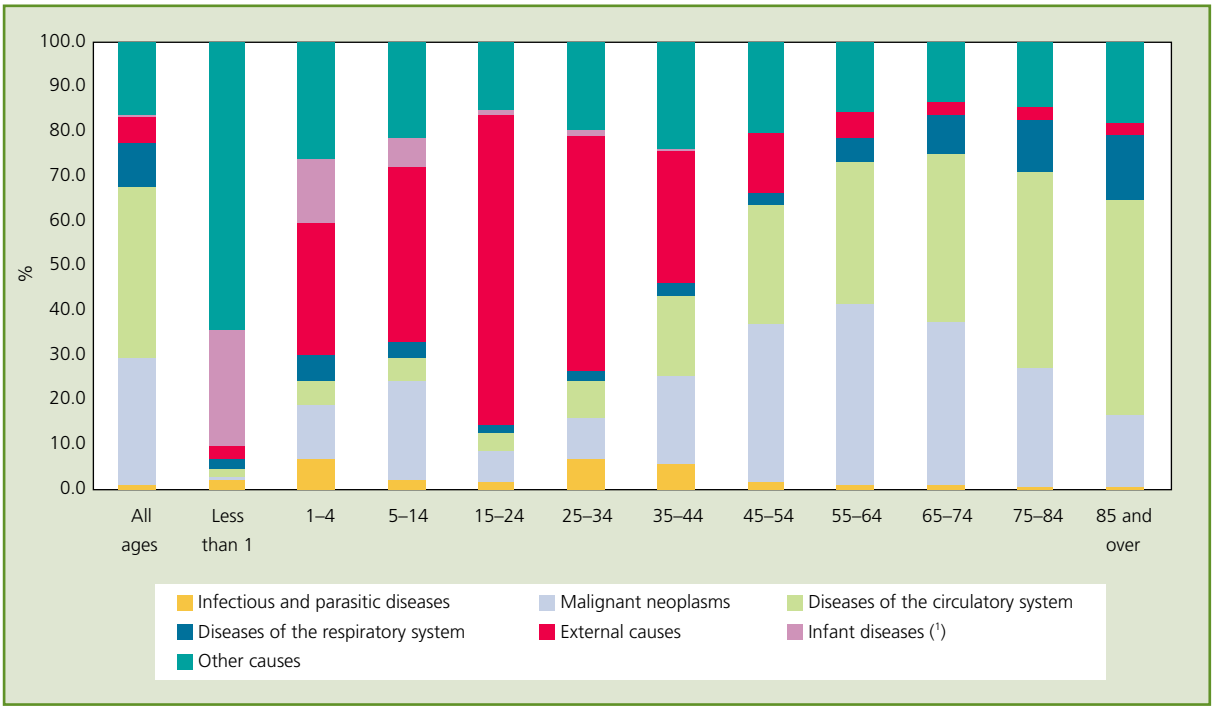
L	NL	A	P	FIN	S	UK	NO	CH	
528.5	552.6	539.3	667.2	540.1	493.0	596.3	523.9	444.2	**All causes of death**
5.2	6.3	2.4	10.4	4.3	5.0	4.3	6.7	5.0	**Infectious and parasitic diseases**
0.5	0.4	0.4	1.7	1.1	0.7	0.4	0.7	0.4	Tuberculosis
:	0.3	0.2	0.1	0.1	0.1	0.5	0.1	0.1	Meningococcal infection
0.5	0.3	0.2	3.2	:	0.1	0.1	0.3	1.2	AIDS (HIV disease)
0.7	0.2	0.3	0.6	0.0	0.1	0.2	0.2	0.2	Viral hepatitis
144.1	162.6	143.7	126.6	129.6	142.7	169.2	148.4	124.0	**Neoplasms**
143.4	158.5	140.3	123.1	126.0	138.0	166.8	145.7	120.4	**Malignant neoplasms**
5.0	1.8	1.6	1.1	1.2	1.1	1.6	1.5	1.4	lip, oral cavity, pharynx
1.4	2.9	1.0	1.5	1.6	1.4	5.0	1.2	1.8	oesophagus
6.3	5.2	8.9	14.1	6.4	4.3	5.6	5.7	4.2	stomach
15.2	15.2	12.1	11.8	8.2	10.9	11.7	14.4	8.4	colon
3.6	4.0	6.0	4.4	4.4	4.2	4.9	6.0	4.1	rectum and anus
3.1	1.7	3.2	2.9	3.5	3.6	2.0	0.9	2.4	liver and the intrahepatic bile ducts
8.0	8.2	8.8	5.5	9.7	10.0	7.1	8.2	7.4	pancreas
17.6	21.6	16.3	7.6	12.3	18.0	30.8	20.8	14.0	larynx and trachea/bronchus/lung
2.1	2.2	2.2	1.1	1.8	2.2	2.1	2.5	1.8	skin
21.4	35.6	27.7	24.4	23.0	24.3	32.7	25.7	26.8	breast
2.3	2.8	3.0	3.5	1.7	2.4	3.6	4.8	2.2	prostate
4.7	3.5	5.0	6.1	3.4	4.2	3.2	3.4	3.0	kidney
9.0	9.7	9.2	5.6	8.4	8.9	11.5	10.6	7.5	bladder
1.8	3.1	3.1	1.4	3.5	3.9	2.7	3.3	2.3	lymph/haematopoietic tissue
0.9	2.4	2.1	1.9	1.3	1.9	3.2	2.7	2.2	**Diseases of the blood (-forming organs), immunological disorders**
13.4	12.9	10.7	10.6	13.9	12.6	11.7	12.3	11.6	**Endocrine, nutritional and metabolic diseases**
1.7	1.6	0.7	1.7	0.8	1.2	2.2	1.5	1.4	Diabetes mellitus
8.3	19.1	11.3	28.1	7.8	10.6	8.7	11.0	15.3	**Mental and behavioural disorders**
6.1	14.7	10.8	24.8	6.8	8.7	6.4	8.1	12.8	Alcohol abuse (including alcoholic psychosis)
9.6	20.8	1.4	2.7	37.3	18.1	11.5	13.0	17.0	Drug dependence, toxicomania
2.2	0.6	1.1	0.1	2.2	1.8	0.7	1.2	1.1	**Diseases of the nervous system and the sense organs**
:	:	0.2	0.0	0.2	0.3	0.8	2.1	1.6	Meningitis (other than meningococcal infection)
15.9	13.6	8.7	7.9	19.5	10.7	12.0	13.6	17.6	**Diseases of the circulatory system**
:	0.3	0.2	0.4	0.0	0.3	0.3	0.3	0.1	Ischaemic heart diseases
222.0	188.0	284.2	284.4	225.7	206.9	222.9	202.2	165.2	Other heart diseases
55.3	63.4	106.0	52.1	124.6	90.1	107.1	82.0	66.2	Cerebrovascular diseases
60.2	46.7	68.5	46.7	15.9	30.6	18.8	36.8	35.3	**Diseases of the respiratory system**
69.2	53.2	70.2	152.1	60.2	54.6	65.2	59.5	34.6	Influenza
35.1	46.9	20.2	51.0	38.1	30.2	87.8	44.9	26.6	Pneumonia
1.8	1.1	0.5	0.7	1.7	1.9	0.1	2.0	2.7	Chronic lower respiratory diseases
8.7	23.3	8.5	23.7	25.0	12.4	53.0	21.4	10.5	of which asthma
11.3	19.6	9.4	11.3	8.8	12.5	26.3	18.4	9.9	**Diseases of the digestive system**
2.6	0.6	1.2	1.7	2.1	1.5	2.2	3.8	1.5	Ulcer of stomach, duodenum and jejunum
28.5	22.0	23.9	23.9	20.9	15.9	25.6	16.9	17.0	Chronic liver diseases
1.6	1.5	2.1	2.1	2.6	2.1	4.0	2.5	1.5	**Diseases of the skin and subcutaneous tissue**
11.3	3.2	11.2	9.0	5.1	3.4	6.2	3.5	5.1	**Diseases of the musculosketal system/connective tissue**
1.3	2.3	0.3	1.9	0.2	0.8	1.3	0.7	0.7	Rheumatoid arthritis and osteoarthrosis
3.1	4.5	1.3	1.7	4.9	4.1	4.9	5.0	4.3	**Diseases of the genitourinary system**
1.0	1.5	0.7	0.5	3.2	1.7	1.7	2.4	1.7	Diseases of kidney and ureter
7.5	10.4	5.4	9.5	6.3	5.6	7.4	6.3	4.3	**Certain conditions originating in the perinatal period**
6.8	5.7	5.0	8.5	5.1	3.6	4.3	4.0	3.1	**Congenital malformations and chromosomal abnormalities**
0.4	0.3	0.1	0.2	0.1	0.2	0.2	0.2	0.1	Congenital malformations of the nervous system
2.9	3.4	2.9	3.1	2.5	1.6	4.0	2.2	2.9	Congenital malformations of the circulatory system
0.6	4.1	3.7	4.0	4.3	3.1	3.1	3.8	4.2	**Symptoms, signs, abnormal findings, ill-defined causes**
0.6	0.6	0.7	0.5	0.5	0.4	0.4	0.3	0.7	Sudden infant death syndrome
:	1.0	1.2	1.8	2.2	1.0	1.4	1.7	1.3	Unknown and unspecified causes
14.7	28.1	5.9	86.7	2.1	13.1	14.9	22.2	15.5	**External causes of injury and poisoning**
1.7	0.1	0.7	0.1	0.1	0.4	0.6	0.6	0.5	Accidents
3.5	17.0	0.2	44.9	1.4	4.8	1.2	14.3	11.3	Transport accidents
27.8	18.7	23.3	23.4	35.9	23.2	16.3	25.2	23.1	Accidental falls
18.0	11.6	14.0	14.7	24.1	12.2	10.7	17.3	13.2	Accidental poisoning
3.4	3.6	5.4	7.8	4.7	3.0	3.0	4.3	4.1	Suicide and intentional self-harm
4.4	2.4	5.5	3.1	11.5	1.9	4.3	8.8	6.3	Homicide, assault
1.7	0.1	0.5	0.5	4.8	0.6	1.1	0.8	0.1	Events of undetermined intent
6.4	6.0	7.9	2.2	9.6	7.0	3.1	6.6	8.6	Suicide and intentional self-harm
1.0	0.5	0.9	0.7	1.3	0.8	0.4	0.6	0.7	Homicide, assault
1.4	0.3	0.5	5.8	0.5	2.3	2.0	0.1	0.3	Events of undetermined intent

5.2.3 Deaths by selected cause and by sex, 1998 (*), EU-15



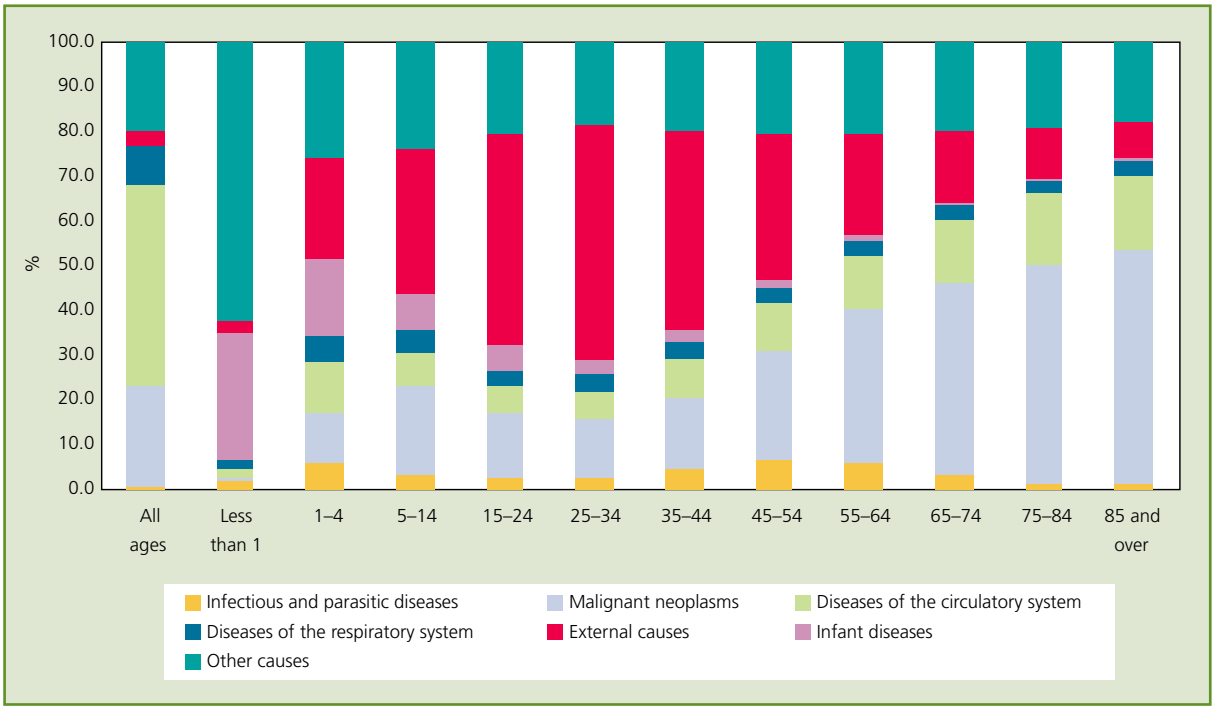
Source: Eurostat, NewCronos database (Health and safety).

5.2.4 Deaths by selected cause and age, males, 1998



(1) Includes deaths due to congenital malformations and chromosomal abnormalities.
Source: Eurostat, NewCronos database (Health and safety).

5.2.5 Deaths by selected cause and age, females, 1998



Source: Eurostat, NewCronos database (Health and safety).

5.2.6 Deaths from selected causes, by sex and age, 1998, percentages for each sex/age group

	Total			1–4			5–14			15–24		
	Total	Men	Women	Total	Men (1)	Women	Total	Men (2)	Women (2)	Total	Men	Women
Infectious and parasitic diseases	1.1	1.2	1.0	3.0	3.1	2.8	2.9	2.6	3.4	1.9	1.5	2.8
from which: AIDS (HIV disease)	0.2	0.3	0.1	0.1	0.1	0.2	0.6	0.5	0.6	0.7	0.6	0.8
Malignant neoplasms	25.2	28.5	22.0	2.6	2.6	2.6	21.0	21.7	20.1	8.5	7.0	12.9
Endocrine, nutritional and metabolic diseases	2.6	2.0	3.1	1.5	1.5	1.6	3.2	3.0	3.5	1.3	0.8	2.4
Diabetes mellitus	2.1	1.7	2.5	0.1	0.1	0.1	0.3	0.4	0.2	0.2	0.2	0.4
Mental and behavioural disorders	2.0	1.6	2.3	:	:	:	0.2	0.2	0.3	3.1	3.2	2.6
Diseases of the circulatory system	41.7	38.0	45.3	3.0	2.5	3.7	6.0	5.1	7.3	4.8	4.2	6.5
from which: ischaemic heart diseases	16.3	17.3	15.3	0.2	0.1	0.3	0.3	0.2	0.4	0.6	0.5	0.6
from which: cerebrovascular diseases	10.8	8.6	12.9	0.7	0.6	0.8	1.7	1.5	2.0	1.2	1.0	1.8
Diseases of the respiratory system	8.9	9.4	8.5	2.8	2.8	2.8	4.2	3.7	5.0	2.3	1.8	3.8
Diseases of the digestive system	4.4	4.6	4.3	0.9	1.0	0.8	1.3	1.4	1.2	0.8	0.7	1.3
Diseases of the genitourinary system	1.4	1.3	1.5	0.3	0.3	0.4	0.4	0.4	0.5	0.3	0.2	0.5
Congenital malformations	0.3	0.3	0.3	24.8	23.9	26.0	7.2	6.5	8.1	1.9	1.4	3.2
Accidents	3.3	4.0	2.6	5.8	6.2	5.3	30.7	33.3	26.8	46.5	49.6	37.5
Suicide and intentional self-harm	1.2	1.8	0.6	:	:	:	2.1	2.2	1.9	12.8	13.9	9.7
Other causes of death	7.9	7.1	8.7	55.1	56.1	53.9	20.8	20.0	21.8	16.0	15.6	17.0

(1) Missing data for mental and behavioural disorders.
(2) Missing data for mental and behavioural disorders and suicide.
(3) Missing data for diabetes mellitus and mental and behavioural disorders.
Source: Eurostat, NewCronos database (Health and safety).

5.2.7 Maternal death rate

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	34.9	20.4	8.5	:	28.3	33.1	28.2	31.1	54.5	:
1975	22.0	12.6	5.6	:	19.0	21.7	19.9	7.4	25.4	50.2
1980	13.1	5.6	1.8	:	17.6	11.1	12.9	6.8	12.8	0.0
1985	8.6	6.1	1.9	:	6.9	4.4	12.0	6.4	8.0	0.0
1986	7.6	3.4	3.6	:	8.0	5.5	10.9	4.9	5.5	0.0
1987	7.2	3.4	8.9	:	4.7	4.9	9.6	3.4	4.5	23.6
1988	7.7	3.3	3.4	:	5.6	5.0	9.3	1.8	7.6	0.0
1989	6.4	6.6	8.2	:	3.9	2.9	8.5	3.8	4.6	0.0
1990	7.8	3.2	1.6	9.1	1.0	5.5	10.4	3.8	8.6	20.3
1991	7.3	4.0	3.1	8.7	2.9	3.3	11.9	7.6	4.9	0.0
1992	7.4	5.6	7.4	6.7	5.8	4.8	12.9	3.9	7.2	0.0
1993	5.8	5.0	7.4	5.5	1.0	4.7	9.3	0.0	4.3	0.0
1994	6.6	6.0	4.3	5.2	1.9	3.5	11.7	2.1	3.5	18.4
1995	6.1	9.5	10.0	5.4	0.0	4.4	9.6	0.0	3.2	18.5
1996	7.3	:	5.9	6.4	5.0	3.9	13.2	5.9	3.8	0.0
1997	5.9	:	7.4	6.0	0.0	2.2	9.6	5.7	4.4	0.0
1998	6.6	:	3.0	5.6	6.9	2.7	10.2	3.7	3.4	18.6
1999	5.7	:	:	4.8	6.0	:	:	1.9	:	:
2000	:	:	:	:	:	:	:	1.8	:	17.5

Source: Health for All database, WHO, 2002.

25–34			35–44			45–64			65+			
Total	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	
7.0	7.1	6.8	4.7	5.5	3.0	1.2	1.3	1.0	0.8	0.8	0.8	**Infectious and parasitic diseases**
5.6	5.8	5.0	3.4	4.1	1.8	0.3	0.3	0.1	:	:	:	**from which: AIDS (HIV disease)**
13.2	8.9	24.4	27.5	19.7	43.2	42.9	39.0	50.6	22.6	27.3	18.7	**Malignant neoplasms**
1.2	1.0	1.8	1.5	1.4	1.5	2.0	1.9	2.3	2.8	2.2	3.2	**Endocrine, nutritional and metabolic diseases**
0.6	0.5	0.8	0.9	0.9	0.8	1.5	1.5	1.7	2.3	1.8	2.7	**Diabetes mellitus**
4.6	5.4	2.6	3.6	4.2	2.3	1.5	1.7	1.0	2.0	1.4	2.4	**Mental and behavioural disorders**
9.0	8.3	10.8	17.0	18.4	14.2	27.1	30.0	21.3	46.2	42.6	49.1	**Diseases of the circulatory system**
2.1	2.3	1.6	7.3	9.2	3.4	14.2	17.1	8.4	17.4	18.5	16.6	**from which: ischaemic heart diseases**
2.2	1.7	3.5	3.7	3.0	5.3	4.9	4.6	5.4	12.3	10.2	14.1	**from which: cerebrovascular diseases**
2.5	2.1	3.3	2.7	2.6	3.0	4.3	4.4	4.2	10.1	11.4	9.1	**Diseases of the respiratory system**
3.2	3.0	3.6	8.4	9.1	7.0	7.0	7.4	6.3	4.0	3.8	4.0	**Diseases of the digestive system**
0.4	0.3	0.8	0.5	0.4	0.7	0.8	0.7	0.9	1.6	1.6	1.6	**Diseases of the genitourinary system**
1.1	0.9	1.8	0.5	0.5	0.7	0.2	0.2	0.3	:	:	:	**Congenital malformations**
27.1	30.8	17.2	12.5	15.1	7.1	3.8	4.3	2.8	2.1	1.9	2.2	**Accidents**
15.1	16.7	10.7	9.5	11.0	6.5	2.6	2.9	2.1	0.4	0.6	0.2	**Suicide and intentional self-harm**
15.6	15.4	16.2	11.7	12.1	10.7	6.6	6.3	7.0	7.5	6.3	8.4	**Other causes of death**

(per 100 000 live births)

NL	A	P	FIN	S	UK	IS	NO	CH	
13.4	25.8	:	12.4	10.0	18.0	:	10.8	25.2	**1970**
10.7	17.1	42.9	10.7	1.9	12.0	22.8	7.1	12.7	**1975**
8.8	7.7	19.6	1.6	8.2	10.9	0.0	11.8	5.4	**1980**
4.5	6.9	10.0	6.4	5.1	7.3	0.0	2.0	5.4	**1985**
8.1	6.9	8.7	6.6	2.9	6.9	0.0	3.8	3.9	**1986**
7.5	4.6	12.2	5.0	4.8	6.3	23.9	5.6	6.5	**1987**
9.6	5.7	6.6	11.1	8.9	6.4	0.0	3.5	10.0	**1988**
5.3	7.9	10.1	3.2	5.2	7.7	0.0	8.4	3.7	**1989**
7.6	6.6	10.3	6.1	3.2	7.6	21.0	3.3	6.0	**1990**
6.0	7.4	12.0	4.6	4.0	6.9	0.0	8.2	1.2	**1991**
7.1	4.2	9.6	4.5	0.0	6.7	0.0	6.7	4.6	**1992**
8.2	4.2	6.1	3.1	5.1	5.7	0.0	3.4	6.0	**1993**
6.1	8.7	9.2	10.7	0.9	7.9	0.0	0.0	3.6	**1994**
7.4	1.1	8.4	1.6	3.9	7.0	0.0	6.6	8.5	**1995**
12.1	4.5	5.4	3.3	5.3	6.6	0.0	1.6	3.6	**1996**
7.8	2.4	5.3	5.1	3.3	5.4	0.0	1.7	3.7	**1997**
11.5	4.9	7.9	5.3	7.9	6.8	0.0	6.9	:	**1998**
9.5	1.3	5.2	3.5	1.1	5.3	48.8	:	:	**1999**
:	2.6	2.5	:	:	:	0.0	:	:	**2000**

5.2.8 Standardised death rate (SDR) from malignant neoplasms, all ages, males

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	252.4	286.8	239.2	:	177.7	197.6	264.8	228.9	243.6	:
1975	263.8	303.8	248.0	:	200.5	222.9	285.8	247.7	252.6	311.1
1980	269.8	323.2	277.4	:	204.6	221.6	297.7	247.4	270.6	297.3
1985	275.4	323.9	278.8	:	216.0	236.0	304.4	262.9	287.4	323.8
1990	272.9	307.0	278.7	269.2	215.0	253.0	298.1	267.8	285.4	300.6
1991	272.8	303.2	265.3	272.3	217.1	254.6	296.7	266.0	284.4	284.6
1992	272.1	302.9	271.8	272.9	216.8	257.7	295.4	272.0	278.2	302.7
1993	270.4	306.9	277.7	271.6	218.7	258.0	293.2	274.0	276.4	304.2
1994	266.1	301.3	280.3	265.7	219.4	261.1	284.5	262.5	275.5	267.6
1995	262.3	:	274.9	263.2	221.2	262.2	281.7	267.3	260.9	302.4
1996	259.6	:	268.2	258.9	218.2	257.4	279.7	257.1	258.2	281.2
1997	:	:	262.5	251.7	217.2	258.2	273.1	253.8	254.9	249.8
1998	:	:	260.3	249.9	211.8	258.7	279.3	251.1	256.2	271.1
1999	:	:	:	243.4	:	:	:	:	:	237.4
2000	:	:	:	:	:	:	:	:	:	259.3

Source: Health for All database, WHO, 2002.

5.2.9 Standardised death rate (SDR) from malignant neoplasms, all ages, females

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	158.3	174.9	194.8	:	102.4	125.9	142.5	178.7	146.9	:
1975	157.4	171.4	190.9	:	111.7	130.1	143.1	190.4	145.0	183.5
1980	153.6	168.9	200.9	:	116.8	119.6	136.8	180.8	143.5	194.0
1985	152.5	162.2	200.8	:	116.8	115.6	132.7	177.1	147.5	181.1
1990	150.4	154.9	201.4	160.4	113.1	118.4	129.2	181.8	144.8	170.0
1991	150.9	155.4	206.4	163.6	112.6	119.5	128.9	185.4	145.9	158.6
1992	150.1	156.3	203.7	162.4	115.1	117.4	128.8	187.7	144.2	159.9
1993	149.6	153.3	204.1	162.0	116.2	118.2	129.3	180.8	143.8	158.4
1994	147.7	154.3	206.8	158.9	116.3	118.9	126.5	182.5	142.8	154.0
1995	145.5	:	209.4	156.4	114.7	117.8	126.2	178.2	135.9	146.8
1996	143.9	:	200.9	154.6	116.6	114.7	125.5	173.0	135.9	140.8
1997	142.0	:	204.4	150.6	115.0	114.3	123.4	177.7	135.8	160.6
1998	141.1	:	196.8	150.6	112.4	112.9	125.9	171.8	133.3	143.3
1999	:	:	:	147.4	:	:	:	:	131.6	134.8
2000	:	:	:	:	:	:	:	:	:	141.5

Source: Health for All database, WHO, 2002.

(per 100 000 males)

NL	A	P	FIN	S	UK	IS	NO	CH	
277.7	290.8	:	287.1	200.5	284.4	:	204.3	261.1	**1970**
299.5	282.3	187.3	271.6	229.5	282.8	212.1	209.9	270.2	**1975**
307.6	284.4	210.6	273.5	220.4	284.0	189.4	214.8	262.0	**1980**
305.6	269.1	214.9	258.3	202.6	285.7	216.0	229.4	280.7	**1985**
296.4	267.8	219.1	237.7	199.5	276.0	227.0	222.6	263.4	**1990**
295.3	269.0	214.9	228.9	199.8	275.7	234.1	225.1	263.0	**1991**
294.6	263.2	222.2	231.8	196.8	274.6	203.8	224.8	259.3	**1992**
292.2	265.2	228.8	230.1	194.5	267.0	182.1	229.7	253.6	**1993**
285.6	250.9	229.5	221.5	191.8	261.7	189.7	229.4	248.0	**1994**
281.9	249.7	234.8	220.6	190.9	257.6	201.6	227.2	227.5	**1995**
279.8	245.3	239.5	224.3	190.5	251.6	240	227.8	223.5	**1996**
272.9	241.7	240.6	210.4	195.7	243.8	241.6	228.8	218.9	**1997**
270.4	237.6	243.0	211.9	192.5	243.2	:	223.2	:	**1998**
270.2	232.5	243.1	208.3	:	235.6	:	:	:	**1999**
:	225.6	:	:	:	:	:	:	:	**2000**

(per 100 000 males)

NL	A	P	FIN	S	UK	IS	NO	CH	
177.2	190.3	:	149.5	159.4	174.3	:	146.9	165.1	**1970**
170.2	178.4	119.2	144.8	166.1	176.8	166.0	146.4	155.3	**1975**
159.6	172.6	127.3	140.8	159.6	181.5	148.8	146.0	151.3	**1980**
162.8	165.6	123.0	137.9	147.3	188.0	157.7	151.2	153.3	**1985**
162.4	160.7	126.9	136.9	144.2	185.5	176.9	150.4	146.8	**1990**
162.3	158.1	126.5	132.0	143.7	183.3	156.9	145.5	145.8	**1991**
160.0	159.1	125.7	134.7	143.0	182.4	162.5	144.1	144.6	**1992**
162.2	158.3	127.7	135.0	143.9	178.7	185.5	149.7	142.3	**1993**
162.4	155.2	122.7	125.9	138.0	176.8	171.0	154.1	138.8	**1994**
158.8	152.9	125.6	130.2	142.3	174.1	173.2	151.6	132.5	**1995**
161.1	146.7	124.3	123.0	140.6	171.6	178.9	158.4	127.1	**1996**
161.5	145.2	123.6	129.8	140.4	168.8	168.8	156.4	127.8	**1997**
158.5	140.3	123.2	126.0	138.0	167.0	:	145.7	:	**1998**
161.6	140.4	122.3	121.6	:	164.7	:	:	:	**1999**
:	141.0		:	:	:	:	:	:	**2000**

5.2.10 Standardised death rate (SDR) from all respiratory diseases, all ages, males

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	144.9	138.9	79.5	:	110.4	129.3	91.2	228.0	137.2	:
1975	131.5	119.7	86.1	:	105.8	150.8	88.5	179.7	124.3	90.8
1980	110.2	109.9	93.0	:	75.7	109.7	77.6	187.5	97.4	70.6
1985	100.5	115.4	93.0	:	59.0	106.0	74.0	195.0	90.5	86.9
1990	88.5	110.3	86.1	84.1	49.0	107.0	66.3	175.5	75.2	85.8
1991	84.7	105.9	78.3	78.4	48.4	103.0	62.9	159.5	69.8	81.7
1992	80.6	106.5	81.5	73.8	55.6	95.4	63.8	148.7	63.7	87.5
1993	89.1	119.5	87.1	75.0	49.4	98.5	65.5	158.7	61.6	82.4
1994	82.7	108.1	85.4	73.1	47.6	93.0	60.1	157.7	62.4	86.2
1995	85.9	:	94.1	72.5	47.8	98.1	62.9	170.3	61.2	81.3
1996	84.4	:	89.9	70.3	47.0	99.3	65.3	155.4	55.9	78.8
1997	83.2	:	90.0	65.2	43.6	97.1	64.0	157.6	59.1	76.7
1998	83.2	:	84.2	61.6	53.2	102.7	66.2	152.8	60.7	91.4
1999	:	:	:	62.0	:	:	:	:	:	91.1
2000	:	:	:	:	:	:	:	:	:	76.6

Source: Health for All database, WHO, 2002.

5.2.11 Standardised death rate (SDR) from all respiratory diseases, all ages, females

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	73.1	54.6	41.1	:	78.7	81.2	44.9	141.4	75.4	:
1975	61.5	46.8	45.4	:	74.1	84.4	39.5	109.8	58.2	32.4
1980	49.8	35.4	48.4	:	51.0	53.5	30.9	111.6	40.8	26.3
1985	42.9	34.6	50.0	:	37.7	45.7	31.2	107.1	34.2	37.5
1990	39.3	35.3	49.8	33.2	31.7	42.8	30.1	97.4	28.0	32.0
1991	37.4	33.4	47.5	30.2	31.7	39.4	27.7	101.0	25.4	33.6
1992	35.6	35.3	50.1	27.6	35.2	35.4	28.9	88.4	24.1	32.2
1993	42.0	40.2	55.7	29.3	31.3	36.7	30.5	95.3	22.7	39.2
1994	38.5	36.7	54.1	29.1	28.9	34.2	27.0	91.8	23.8	34.5
1995	40.6	:	61.8	29.0	30.5	35.7	28.4	102.8	22.4	31.5
1996	40.5	:	64.8	28.7	29.3	36.3	29.9	99.6	20.8	31.3
1997	40.8	:	58.3	26.6	28.5	36.2	30.4	98.8	22.7	33.4
1998	41.1	:	60.1	26.1	33.9	38.6	32.0	96.4	23.4	35.0
1999	:	:	:	27.6	:	:	:	:	:	41.9
2000	:	:	:	:	:	:	:	:	:	32.8

Source: Health for All database, WHO, 2002.

(per 100 000 males)

NL	A	P	FIN	S	UK	IS	NO	CH	
98.6	142.8	:	153.3	66.4	240.1	:	102.1	94.7	**1970**
90.4	108.9	155.0	142.4	57.3	208.3	115.7	101.3	77.9	**1975**
76.8	74.7	119.2	142.5	61.5	195.0	90.7	88.3	69.3	**1980**
91.1	79.6	109.8	124.9	82.8	144.9	81.1	94.7	61.8	**1985**
95.5	60.7	98.6	102.3	67.8	117.7	78.4	92.4	79.6	**1990**
94.2	57.4	96.4	91.1	63.7	117.9	76.1	83.3	65.2	**1991**
85.4	56.6	87.7	91.8	64.5	111.0	82.2	86.4	63.7	**1992**
109.2	54.4	98.8	102.9	70.4	150.1	80.5	100.3	67.6	**1993**
92.3	46.8	91.2	87.4	58.9	132.7	73.7	82.5	64.3	**1994**
99.7	48.3	98.3	90.9	60.2	143.5	81.0	91.9	56.9	**1995**
101.1	46.4	102.9	97.1	63.9	137.2	91.8	71.9	53.6	**1996**
98.6	45.6	110.5	92.1	55.0	138.3	69.5	71.8	60.2	**1997**
102.0	45.2	113.1	92.0	51.3	133.6	:	67.3	:	**1998**
100.0	48.5	132.8	89.7	:	142.1	:	:	:	**1999**
:	47.5	:	:	:	:	:	:	:	**2000**

(per 100 000 females)

NL	A	P	FIN	S	UK	IS	NO	CH	
47.2	72.4	:	75.4	43.7	112.1	:	74.3	45.0	**1970**
33.7	59.2	78.2	62.0	28.8	99.0	68.3	73.9	34.8	**1975**
29.8	37.1	57.5	58.6	34.1	101.0	65.0	53.9	29.5	**1980**
34.4	32.9	48.2	48.9	44.4	71.4	83.7	59.0	24.9	**1985**
36.7	26.7	45.0	42.4	36.4	65.0	69.3	55.6	37.2	**1990**
36.5	24.4	40.5	38.8	36.2	65.8	63.9	53.2	27.7	**1991**
33.0	23.7	38.5	39.8	35.3	62.0	81.0	55.4	29.3	**1992**
45.9	23.4	44.7	48.7	41.6	91.7	79.0	65.6	31.7	**1993**
38.2	21.9	39.1	38.8	34.4	80.5	72.6	51.5	28.8	**1994**
42.6	20.0	44.3	37.7	35.7	89.6	86.0	56.0	22.6	**1995**
43.4	20.5	46.6	41.4	37.2	86.8	73.4	44.7	23.0	**1996**
44.0	20.7	48.8	38.8	33.5	90.5	52.5	44.6	27.7	**1997**
46.9	20.2	51.0	38.1	30.2	87.9	:	44.9	:	**1998**
49.2	23.2	61.3	39.6	:	96.2	:	:	:	**1999**
:	23.9	:		:	:	:	:	:	**2000**

5.3.1 Deaths from alcohol abuse (including alcoholic psychosis), by sex and age, 1998

	EU-15	B	DK	D	EL	E	F	IRL	I	L
Males										
Total	8 939	:	225	4 498	32	231	1 992	73	180	18
Under 15	2	:	:	2	:	:	:	:	:	:
20–24	19	:	:	10	:	:	3	:	:	:
25–29	54	:	:	23	:	:	9	2	3	:
30–34	244	:	3	145	:	4	43	5	9	:
35–39	517	:	6	287	:	7	108	6	10	1
40–44	945	:	28	494	4	21	207	11	14	3
45–49	1 155	:	27	579	1	21	264	13	15	:
50–54	1 257	:	40	569	2	29	280	10	19	5
55–59	1 386	:	39	783	4	27	236	10	26	2
60–64	1 189	:	25	667	5	32	237	5	23	3
65–69	925	:	25	446	5	44	216	4	26	2
70–74	601	:	16	259	7	24	175	4	17	1
75–79	381	:	8	137	3	14	130	3	6	:
80–84	146	:	7	49	1	3	49	:	8	1
85 and over	118	:	1	48	:	5	35	:	4	:
Females										
Total	2 511	:	62	1 267	2	39	549	36	31	5
Under 15	0	:	:	:	:	:	:	:	:	:
20–24	5	:	:	3	:	:	:	:	:	:
25–29	11	:	:	8	:	:	2	:	:	:
30–34	52	:	:	25	:	2	9	:	1	:
35–39	153	:	2	74	:	:	35	3	2	:
40–44	258	:	5	126	:	3	64	4	0	1
45–49	310	:	11	141	1	3	77	8	5	1
50–54	310	:	11	138	:	6	58	8	3	1
55–59	313	:	9	168	:	5	57	2	2	:
60–64	318	:	8	188	:	4	48	4	3	1
65–69	252	:	3	125	:	2	69	2	6	:
70–74	197	:	6	96	1	3	54	2	3	:
75–79	153	:	4	76	:	5	34	1	1	1
80–84	81	:	2	37	:	2	20	2	1	:
85 and over	98	:	1	62	:	4	22	:	4	:

Source: Eurostat, NewCronos database (Health and safety).

NL	A	P	FIN	S	UK	IS	NO	CH	
									Males
178	237	57	253	405	426	:	148	173	**Total**
:	:	:	:	:	:	:	:	:	**Under 15**
:	1	:	2	:	:	:	1	:	**20–24**
1	4	:	2	1	6	:	:	2	**25–29**
2	8	4	9	3	9	:	:	3	**30–34**
7	14	2	23	14	25	:	6	12	**35–39**
15	16	8	32	22	59	:	6	10	**40–44**
24	24	6	48	47	66	:	15	11	**45–49**
25	40	10	40	96	66	:	22	21	**50–54**
36	41	5	33	66	69	:	18	19	**55–59**
23	20	8	22	60	45	:	21	21	**60–64**
17	33	3	17	35	38	:	23	21	**65–69**
7	21	4	12	25	16	:	14	20	**70–74**
9	8	4	10	23	15	:	12	15	**75–79**
9	2	1	1	5	9	:	6	9	**80–84**
3	5	2	2	8	3	:	4	9	**85 and over**
									Females
51	51	9	62	86	207	:	28	46	**Total**
:	:	:	:	:	:	:	:	:	**Under 15**
:	:	:	:	:	1	:	:	:	**20–24**
:	:	:	:	:	1	:	:	:	**25–29**
1	1	1	3	1	8	:	:	2	**30–34**
2	5	:	6	2	17	:	:	:	**35–39**
3	3	:	12	11	19	:	3	:	**40–44**
5	6	1	10	12	26	:	5	6	**45–49**
10	10	:	5	18	36	:	6	11	**50–54**
6	8	1	8	11	26	:	1	6	**55–59**
7	3	:	9	11	23	:	4	1	**60–64**
7	2	1	3	8	20	:	1	2	**65–69**
3	5	2	5	4	12	:	4	8	**70–74**
4	2	:	1	5	12	:	4	6	**75–79**
2	4	2	:	2	5	:	:	1	**80–84**
1	2	1	:	1	1	:	:	3	**85 and over**

5.3.2 Acute drug-related deaths ([1])

	EU-15	B	DK	D	EL	E	F	IRL	I
1985	:	:	150	324	10	140	172	19	242
1986	:	:	109	348	28	151	185	6	292
1987	:	:	140	442	56	226	228	4	543
1988	:	:	135	670	62	327	236	7	809
1989	:	:	123	991	72	426	318	5	974
1990	:	:	115	1 491	66	444	350	7	1 161
1991	6 406	314	188	2 125	79	553	411	8	1 383
1992	6 827	325	208	2 099	79	536	499	14	1 217
1993	7 239	346	210	1 738	78	421	454	18	888
1994	7 610	376	271	1 624	146	367	564	19	867
1995	6 820	346	274	1 565	176	371	465	43	1 195
1996	:	:	268	1 712	222	381	393	53	1 566
1997	:	:	275	1 501	232	321	228	81	1 160
1998	:	:	251	1 674	245	271	143	97	1 080
1999	:	:	239	1 812	255	258	118	85	1 002
2000	:	:	247	2 030	303	254	120	89	1 016

Note: The numbers presented here are those recorded in EU countries according to national definitions; see footnote 1.

([1]) Data from different countries are not directly comparable, as there are differences in the ways cases are defined. In some countries traditional definitions of 'drug-related deaths' used at national level are different from those presented here, and may include also some deaths only indirectly related to drug use e.g. AIDS related; accidents.

([2]) Corrected index: 1985 = 100 %. For technical details see EMCDDA publication under Project CT.99.RTX.04.

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Annual report 2002.

L	NL	A	P	FIN	S	UK	Corrected index (2)	
1	40	:	:	:	:	2 260	100	**1985**
3	42	:	18	:	:	2 341	104	**1986**
5	23	:	22	:	:	2 316	119	**1987**
4	33	:	33	11	:	2 343	138	**1988**
8	30	40	52	23	:	2 238	155	**1989**
11	43	43	82	41	64	2 356	182	**1990**
17	49	71	121	34	62	2 374	217	**1991**
17	43	129	156	27	67	2 628	224	**1992**
15	38	156	115	26	82	2 654	202	**1993**
29	50	173	143	35	85	2 861	212	**1994**
22	33	170	198	51	71	3 035	223	**1995**
17	63	191	232	43	124	3 221	247	**1996**
10	70	136	235	43	99	3 344	225	**1997**
16	61	109	337	52	81	3 411	228	**1998**
18	76	128	369	65	99	3 485	233	**1999**
26	:	167	318	:	:	3 495	242	**2000**

6. HEALTH CARE

6.1. Human resources

6.1.1. Human resources in the health and social work sector

According to data from the **Eurostat Labour Force Survey (LFS)**, the number of people employed in the area of health and social work in the EU grew steadily from 13 to 15 million in total between 1995 and 2000 **(6.1.1)**. The collection of data on the LFS is implemented following the statistical classification of economic activities in the European Union, NACE Rev. 1. This classification includes Section N: 'Health and social work' (see box below). Expressed as a proportion of total employment, it grew from 9.0 % to 9.5 % over the same period **(6.1.2)**. The employment data from the LFS refer to both employees and the self-employed, and include all professions. They describe all the manpower engaged in providing health and social care and supplement the more detailed data on selected groups of health care professionals **(6.1.3** to **6.1.27)**. The LFS can only describe the employment situation for a compound of health and social care. As such, existing LFS data are likely to overestimate employment in the health sector, because of the unknown share to be attributed to social care. At the same time, LFS data are also likely to underestimate employment in the health care sector, as some providers of health care services (particularly in the area of production, gross and retail sales of medical goods) are allocated to other business sectors of the LFS.

Some deeper insight may be gained by monitoring, in particular, occupational and professional groups associated with health care **(6.1.1** and **6.1.2)**. This refers both to breaking down employment in the health and social work sector by professional category and to providing the number of health professionals employed in other business sectors. Still, the results obtained will not be completely satisfactory. In 10 Member States and EEA countries, employment in health and social care increased from 1999 to 2000. In four Member States and EEA countries (Denmark, Greece, Italy and Sweden), the respective figures decreased, while, in the remaining four (Ireland, Austria, Finland and the United Kingdom), the numbers remained unchanged. In 2000, Sweden (18.5 %) and Denmark (17.4 %) had the largest proportions of people employed in health and social work, more than three times those of the Member States with the smallest proportions — Greece (4.7 %), Portugal (5.1 %) and Spain (5.3 %). These percentage shares of employment in health and social work in Sweden and Denmark are to a large extent influenced by one professional group: personal care and related services. In EU-15, this group represents 24.6 % of total employment in health and social care; in Denmark and Sweden the respective shares are 41.2 and 51.0 %, however. As personal care and related services relate more to social care than to health care at first glance, the variations of employment in health care are likely to be less prominent than indicated by overall LFS data.

LFS data on employment by professional category also indicate that the individual professional groups are likely to differ across countries as far as the respective roles in the national processes of health and social care provision are concerned. The percentages of 'professionals' on one side and 'technicians and associate professionals' on the other differ substantially. The highest share of 'professionals' in overall employment can be observed in Belgium, Ireland and Spain with 52.7, 50.0 and 44.2 %, and the lowest in Denmark with 10.1 %. In Austria, Germany and Italy, the role of 'technicians and associate professionals' is predominant with 55.1, 49.0 and 46.4 %, whereas in Spain this group represents only 11.2 % of all employees. The percentage of health professionals working outside the health and social work sector varies similarly. In Spain, Ireland and Belgium, the respective numbers make up more than 34 % of overall employment in the sector, whereas the rate in Denmark is only 7.6 %.

It may be concluded from these observations that the analysis of detailed numbers provided for health and social care professionals in Tables **6.1.3** to **6.1.6**, Map **6.1.7**, Graphs **6.1.8** and **6.1.9**, and Tables **6.1.10** to **6.1.27** has to take into consideration that these professionals play substantially different roles in the respective national health systems. A direct comparison of density rates (professionals per 100 000 inhabitants) between countries implies a similarity of functions performed, which may not always be realised.

The **Labour Force Survey (LFS)** was established under Council Regulation (EEC) No 3711/91 of 16 December 1991. The concepts and definitions used remained essentially those adopted by the 13th International Conference of Labour Statisticians of 1982 and used in the Community surveys from 1983 to 1991, so that a high degree of comparability could be assured between the results from the two series. In 1998, Council Regulation (EC) No 577/98 was adopted and replaced the previous one to take into account new statistical requirements. Data were collected every two years from 1960 to 1983, then annually from 1984 to 1992 and quarterly thereafter. Since 1995, it has covered 15 Member States and 700 000 private households. The concepts and definitions have been internationally

agreed. The degree of comparability among Member States is considerably higher than that of any other set of statistics on unemployment/employment.

The LFS is an annual survey carried out on the basis of a revised set of concepts designed to guarantee an improved degree of comparability between the Member States and also, as far as possible, with other countries. The methodological basis and the content of the survey are described in the Eurostat publication *Labour Force Survey — Methods and definitions — 1998 series*. In the LFS, all persons who are not classified as employed or unemployed are defined as inactive. A labour force survey is an inquiry directed to households, designed to obtain information on the labour market and related issues by means of personal interviews. As it would clearly involve considerable expense to include all households (as in population censuses), labour force surveys are usually confined to a sample of households, the actual size of which depends primarily on the level of detail required in the survey estimates.

Data on human resources by profession are coded according to the **ISCO-88 (COM)**, which is based upon ISCO-88 **(International Standard Classification of Occupations)** adopted by the ILO (International Labour Organisation). ISCO classifies jobs past, present or future. It classifies persons through their actual and potential relation with jobs. Jobs are classified with respect to the type of work performed or to be performed. The basic criteria used to define the system of major, sub-major, minor and unit groups are the 'skill' level and 'skill specialisation' required to carry out the tasks and duties of the occupations. In collecting and processing statistics classified by occupation (e.g. for use in fields such as labour market analysis, education planning, manpower planning, occupational health analysis, wages analysis, etc.), each country should ensure the possibility of conversion to the ISCO-88 system to facilitate international use of occupational information.

NACE Rev. 1 is the statistical classification of economic activities in the European Union. It came into force in 1990 through Council Regulation (EEC) No 3037/90 of 9 October 1990. The acronym 'NACE' derives from the French title: *nomenclature générale des activités économiques dans les Communautés européennes*. The collection of data on the LFS is implemented following NACE Rev. 1. This classification includes Section N: 'Health and social work'.

Eurostat has launched a project aiming at a comprehensive and detailed compilation of **health care human resources**, coordinated by the **BASYS Institute** (ref. Augsburg 2001). It will use different data sources (including LFS) to provide a complete picture of the manpower engaged in the provision of health care and of the work sharing established between the various professionals and occupational groups. This project follows a first inventory of BASYS on **human resources of European health systems**, concerning the broad availability of data in many of the countries which delivered meta information. The inventory also shows the problem of limited availability of data in some areas (actors according to the ICHA-HP classification (see Section 6.4.4) and the various levels (age, gender, head counts, etc.) to which data are broken down. This, as well as the differing level of the quality of reporting, causes difficulties in submitting comparable statistics on human resources at the European level (ref. Augsburg 2001). The new project will use the methodological framework of the **System of Health Accounts** (see Subsection 6.4.4*)* and, therefore, the resulting data will be fully compatible with health expenditure data compiled elsewhere.

6.1.2. Physicians

The opportunity to study medicine is subject to restrictions in all EU Member States, with the exception of Austria. In France, although there are no restrictions on access to medical studies, students must pass a *concours* before they are allowed to continue to the second year. Council Directive 93/16/EEC states that basic medical training in the EU must be at least six years or 5 500 hours in or under the supervision of a university. The majority of Member States meet this requirement. However, there are two countries where the minimum duration is shorter — Great Britain (4 or 5 years) and Sweden (5.5 years), and two where this minimum duration is longer — Finland (6.5 years) and Belgium (7 years). In some EU Member States, doctors are conferred their licence to independent medical practice immediately after the completion of medical studies. This is the case in Belgium, Greece, Spain, Italy and the Netherlands. In other Member States, doctors, having graduated from the medical university, take up a probationary period of practical postgraduate training which, if successfully completed, allows them to carry out independent medical practice as a doctor. The duration of this training period varies: in Great Britain and Ireland, it is 12 months (which allows these countries to meet the basic requirement of the directive); in Germany, Portugal and Sweden, it is 18 months. In Luxembourg, the Ministry of Health grants an authorisation to practise in the medical profession on the grounds of diplomas issued in another EU Member State (postgraduate training may not be undertaken in Luxembourg). The conferral of the licence alone does not mean that the doctor is admitted into the respective system of social security. The prerequisite in the public health care systems as well as in the social insurance systems is additional specific training in general medical practice or in a

speciality. In France, Austria and Finland, the licence to independently practise in the medical profession is conferred only after the completion of specific training in general medical practice or specialist training. Therefore, there are no doctors in those countries which have only an 'approbation'; that is, doctors are only entitled to practise in the medical profession independently after completion of their training as general medical practitioners or as specialists.

Council Directive 93/16/EEC states that general practitioners intending to exercise their profession within the social security system must furnish proof of postgraduate practical training. At the moment, the minimum duration of two years for this training is required in Belgium, Italy and Finland, and two and a half years in France for training in general medical practice. General practitioners in Sweden generally undergo free specialist training for a minimum period of five years in family medicine/GP. A training period of three years in general medical practice is required in Greece, Spain, Portugal, the Netherlands, Ireland and Austria. In Denmark, the duration of training in general medical practice is three and a half years. In Germany, the requirement is four-year 'specialist' training in general medical practice that includes the 18-month period of 'approbation' (ref. OA web site).

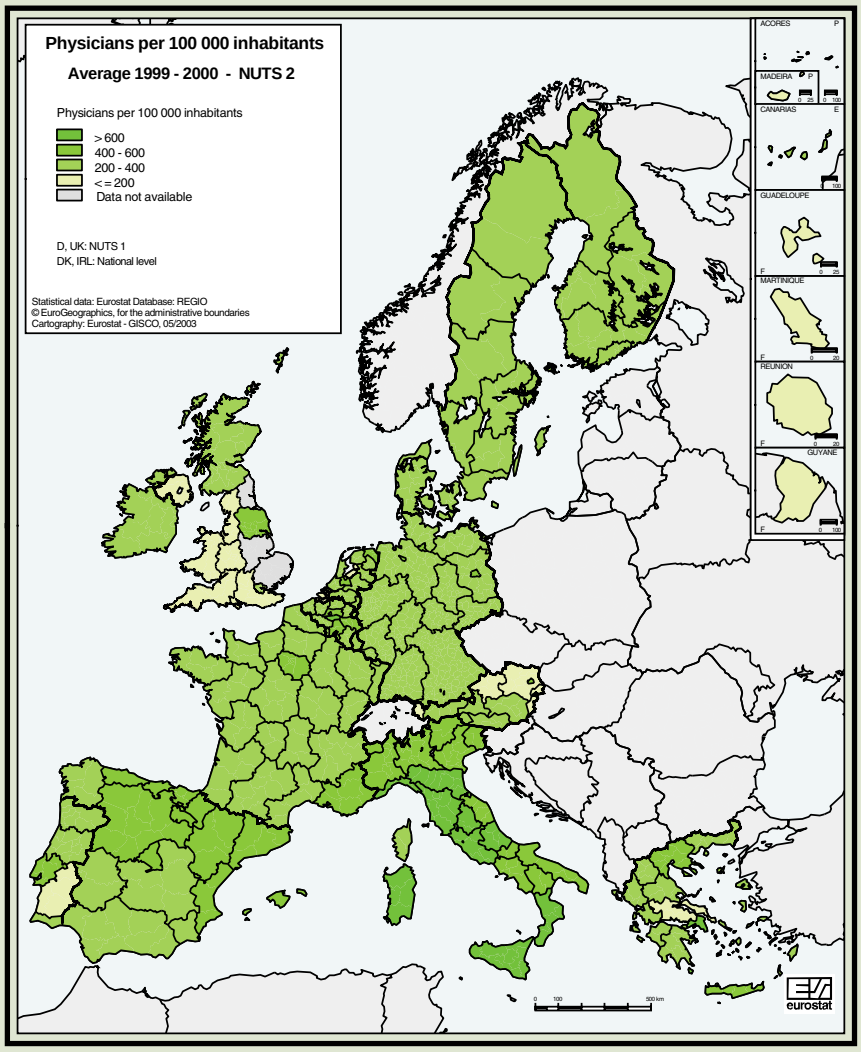
Data on doctors and dentists suffer from the different concepts used in Member States for the respective data sets. Doctors and dentists may be counted as 'entitled to practise', 'economically active' or 'practising'; often, data for two or more methodological concepts are available. It is obvious that there are few valid conclusions to be drawn about doctor density, even if data based on different concepts are presented next to one another in one table, with differences identified by footnotes only. The data presented here correspond to physicians/doctors licensed to practise and practising physicians/doctors.

According to **Eurostat**, the total number of practising physicians has steadily increased in most Member States over the last 20 years **(6.1.3)**; in Luxembourg, it has more than doubled. The number of licensed physicians exceeds the number of practising physicians in all countries **(6.1.3** to **6.1.5)**, although the ratio observed in 2000 varies between countries. In Luxembourg, the differences are comparatively small; in Spain and Switzerland, they are substantial. The density rates for practising physicians (physicians per 100 000 inhabitants) have increased in all Member States and EEA countries over the last 20 years **(6.1.4)**. In 1999, Greece reported rates of over 400. In five Member States (Belgium, Germany, France, Luxembourg and Austria) and three EEA countries, there were over 300 practising physicians per 100 000 inhabitants. In two Member States (the Netherlands and the United Kingdom) and in Switzerland, the rates were below 200, but UK and Irish figures refer only to physicians working in the National Health Service, and are therefore not comparable. However, this huge range of doctor densities can also be explained by differences in the health care systems. Some studies suggest that the number of doctors will possibly increase in some Member States (e.g. some specialities, increasing needs in the long-term care sector, etc.) and in others (e.g. the United Kingdom) there is a discussion on supplementary needs from GPs and specialists due to a lack of assistant doctors in hospitals (ref. HBS 2002).

The density rates for licensed physicians vary between 250 per 100 000 inhabitants in Ireland and 599 per 100 000 in Italy **(6.1.6)**, the range substantially exceeding that for practising physicians **(6.1.4)**.

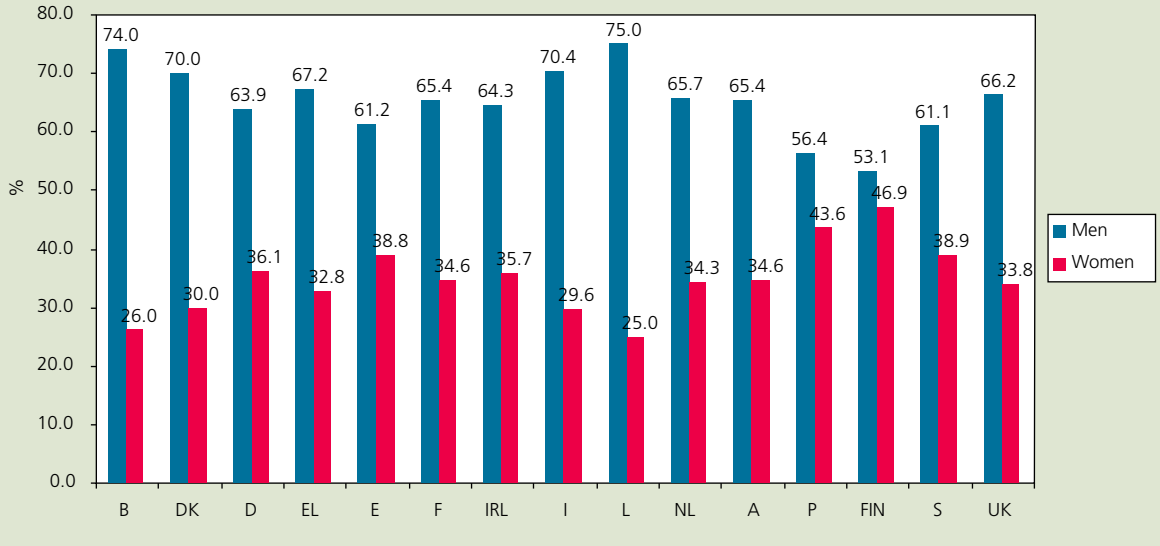
Map **6.1.7** shows the average regional density of physicians per 100 000 people using NUTS 2 level data for a 1999-2000 average. In some Member States, this rate is rather uniform across regions, but varies between regions in others. Highest density rates refer to metropolitan areas, for example Lazio (Italy), Brussels (Belgium), Attiki (Greece), Vienna (Austria), Madrid (Spain) and Hamburg (Germany). Compared with 1986, the figures have been rising in virtually all regions of the Member States. Low numbers are observed in areas with low population density. In the majority of Italian and northern Spanish regions, there is a high density of medical staff and these regions are net 'exporters' of doctors to other regions, particularly to the United Kingdom. This phenomenon is even more apparent with nurses. The high density of doctors in the Greek regions of Attiki and Kentriki Makedonia (including the cities of Athens and Thessaloniki respectively) may be explained by less strict legislation on recognition of medical qualifications from the candidate countries. All regions of the EU seem to have a sufficiently high density of doctors, with the exception of a few parts of Greece and Portugal.

6.1.7 Physicians per 100 000 inhabitants, 1999–2000



Source: Eurostat, NewCronos database (Health and Safety).

6.1.8 Physicians by sex, latest available year

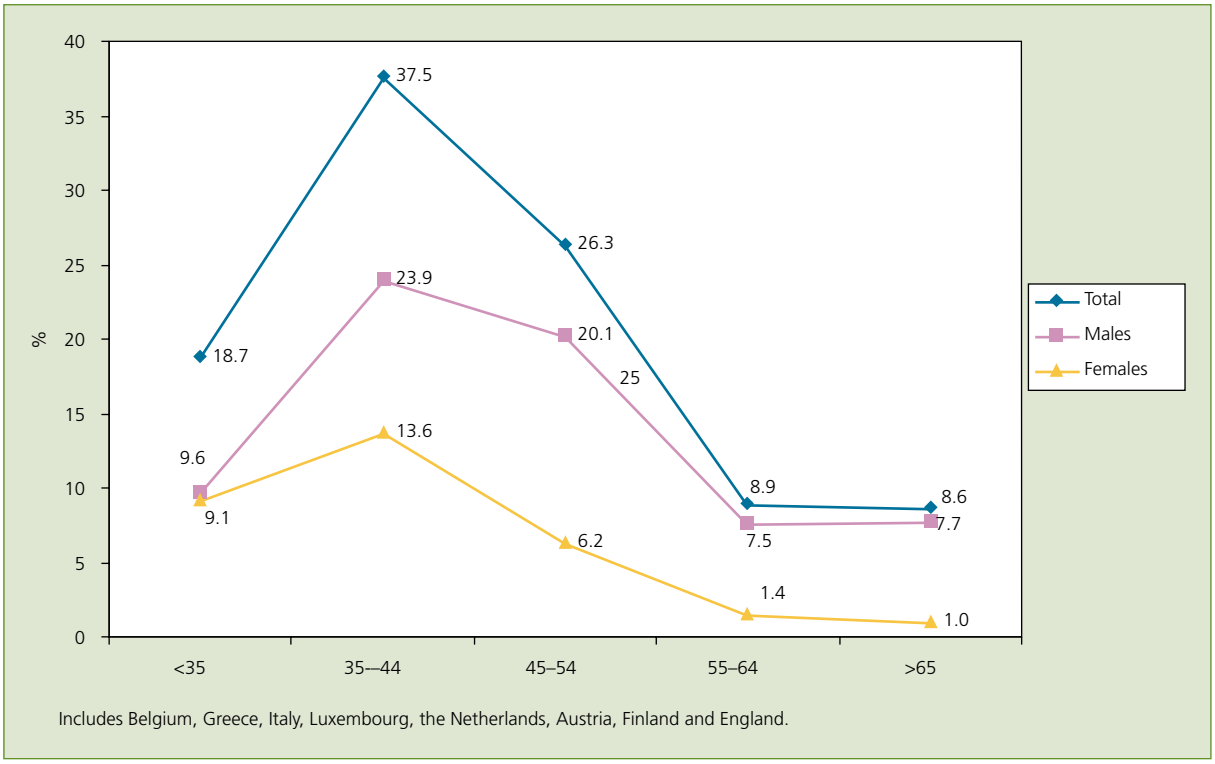


Note: B (1995); DK (1994)s.
Source: Eurostat, NewCronos database (Health and safety).

Data from **Eurostat** show that male physicians outnumbered female ones in each Member State in 1997 **(6.1.8)**. The proportion of female physicians varied from 25 % in Luxembourg to 44 % in Portugal and 47 % in Finland.

Graph **6.1.9** shows the age and sex distribution of physicians in eight Member States in 1998. The proportion of males to females is very similar under age 35, but increases with age thereafter. Compared with the distribution for 1996 in the last volume, for both sexes combined, the proportion of physicians under age 35 increased from 17.6 % to 18.7 %. For ages 45–54 and ages 55–64 the proportions increased from 21.5 % to 26.3 %, and 8.3 % to 8.9 % respectively. For ages 35–44, and 65 and over, the proportions decreased from 43 % to 37.5 % and from 9.6 % to 8.6 % respectively.

6.1.9 Percentage of physicians by age groups according to sex, 1998



Includes Belgium, Greece, Italy, Luxembourg, the Netherlands, Austria, Finland and England.

Source: Eurostat, NewCronos database (Health and safety).

6.1.3. Medical specialists

The definition of activities, content and required training for medical specialities in EU Member States is based on Council Directive 93/16/EEC of 5 April 1993, to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications. In 2001, an update of Directive 2001/19/EC (doctors' directive) was published. This directive will have to be implemented by the Member States before 1 January 2003. The major changes are: (a) the minimum training duration for general practitioners is extended from two to three years (Article 31b); (b) in the case of migration within the EU, certificates of medical specialists have to be recognised by the host country even if the particular speciality is not recognised as an independent speciality in the host country (Article 42b); (c) in the case of migration within the EU, training obtained in countries outside the European Union will have to be examined and considered by the host country. The host country has to decide about recognition within three months. Appeal to the national court of justice is possible (Article 42c); (d) an already effective administrative change is the transfer of the lists of specialities to an annex to the directive. This means that changes do not have to be approved by the Council of Ministers but by the Committee of Senior Officials on Public Health (CSOPH).

In Annex VI/C to Directive 2001/19/EC, 52 recognised specialities are listed. Some of these are recognised in all EU Member States and some in two or more EU Member States. Other bodies such as the European Union of Medical Specialists (EUMS) recognises 74 specialities. Of these 74 specialities, 23 are recognised in all EU Member States and the remaining 51 are recognised in two or more Member States. The problem of complementary specialisations (280 in total according to the

CSOPH5 (ref. Doc. XV/D/8536/98) has been discussed in the Comité consultatif pour la formation des médecins (CCFM). Four EU studies (1979, 1983, 1986 and 1996) have been made about the subject. A large number of these complementary specialisations present only minor differences with recognised specialities. The last study (Rapport Salvatore) proposes 20 common core specialities with an *ex post* orientation to other complementary specialisations. Discussions are still ongoing.

The number of medical specialists is shown in Table **6.1.10**, the data from **Eurostat** being for the latest year available. There are large variations between countries, for both total numbers and per 100 000 inhabitants in Table **6.1.11**. These are especially apparent in specialities such as oncology, infant surgery, occupational medicine and urology, where the range of density number exceeds the ratio 10:1. They also hold for the 'large' groups such as internal medicine with 12:0, and psychiatry and (to a lesser extent) general practitioners with a ratio of 6:1. In certain fields, there are a lack of specialists and an unbalanced distribution of specialists across countries.

6.1.4. Dentists

Dentists diagnose, prevent and treat teeth and tissue problems and also perform corrective surgery using a variety of equipment. Problems related to training and data collection concepts are similar to those explained in the case of physicians/doctors.

According to **Eurostat**, the number of practising dentists in the EU has increased over the last 20 years, apart from Sweden where they have decreased since 1990 **(6.1.12)**. The number per 100 000 people has also increased **(6.1.13)** with the growth rates showing across countries. The same can be said for the number of licensed dentists and the respective density rate per 100 000 inhabitants **(6.1.14** and **6.1.15)**. The most recent density rates still show wide variations between countries, both for practising (46 in Austria versus 91 in Denmark) and for licensed dentists (44 in Spain and Portugal versus 93 in Finland).

6.1.5. Pharmacists

Practising pharmacists now provide a much broader range of services than before. There seems to be an increasing lack of pharmacists in the United States, which is even greater than the lack of pharmacists in the EU (ref. DHHS 2000).

According to **Eurostat**, there has been a steady increase in the number of practising pharmacists in the EU over the last 20 years **(6.1.16)** with the highest growth rates in Greece and a decrease in Finland. We can see a similar picture in the density rate per 100 000 inhabitants, except that numbers fluctuated in France, decreased in Luxembourg from 1992 and in Finland until 1993 **(6.1.17)**. This table also shows wide variations between Member States and EEA countries — from 19 pharmacists per 100 000 in the Netherlands in 1999 to 148 in Finland in 2000. The number of pharmacists working in pharmacies is currently only available for selected Member States **(6.1.18)**. The available data indicate that in France and Sweden only 56 % of all practising pharmacists actually work in pharmacies, whereas in the Netherlands the density rate for pharmacists working in pharmacies does not differ substantially from the rate for practising pharmacists **(6.1.19)**.

6.1.6. Nurses and midwives

The EU has agreed upon a set of acceptable minimum standards for the training of nursing professionals in order to allow free movement of nurses in the Member States. It concerns NRGC (called general nurses (EC) or nurses responsible for general care) having completed a basic general training of at least three years (Directives 77/452/EEC, 77/453/EEC and amendments of 10 October 1989 and 30 October 1989). Midwives are those with training in accordance with Directives 80/154/EEC and 80/155/EEC (EC midwives directives).

According to **Eurostat**, separate data for nurses and midwives are not available from all Member States, and data are not available for all years, but their combined number has steadily increased over the last 20 years **(6.1.20)**. The number per 100 000 inhabitants shows some fluctuations in the trend, especially in Sweden, and to a lesser extent in Germany, Greece and the United Kingdom **(6.1.21)**. Density varies widely between Member States, from 391 per 100 000 in Greece to 2 174 in Finland in 1999. The differences in the density of doctors and nurses are sometimes significant within Member States. The influence of these different densities on the effectiveness and the efficiency of health care systems (e.g. substitution of doctors by other medical professions) is now being discussed by the OECD and by Eurostat.

Data for the numbers of qualified nurses **(6.1.22)** and midwives **(6.1.24)** increase in a similar way. The respective density rates **(6.1.23** and **6.1.25)** fluctuate to a somewhat lesser degree. The range between the countries with the lowest and highest density rates (Greece and Finland) is even wider for qualified nurses than it was with the total of practising nurses and midwives mentioned above.

Recent estimates of unfilled nursing positions reveal a large number of open nursing positions in hospitals. Physician practices report having greater difficulty in hiring nurses to supervise clinical staff and perform higher-level duties, waiting longer to

hire nursing staff and not being able to offer higher salaries to attract qualified candidates. Enrolment in nursing studies has been steadily declining recently and the level of migration and mobility is high in this profession.

Whether a nurse is counted in the figures depends on the definition of the health and social care sector (e.g. inclusion of maternity hospitals and specialist hospitals in the general hospital sector). Some Member States classify geriatric hospitals under general hospitals, while others classify them under residential services for the elderly. For some Member States, the issue is not clear and, for others, figures refer to acute general hospitals only (ref. Versieck and Bouten 1995). Sector-based information continues to be difficult to compare and interpret. There are also some problems related to the categories of nurses in statistics. In the different Member States, nursing and caring tasks may be carried out by different types of health care personnel: NRGC (nurses responsible for general care), second-level nurses and specialists nurses — but also other categories of caring personnel. In Denmark and Portugal, for instance, there is only one category of 'nurse'. There are neither second-level nurses nor specialists nurses. However, in Denmark, other categories of health personnel perform important nursing and caring tasks. In Member States in which second-level nurses are trained, housekeeping, guiding and caring tasks are frequently the responsibility of these nurses. In one Member State, different categories of nurses perform nursing and caring tasks while in another Member State nursing and caring staff share these tasks. This creates a problem when comparing quantitative information (e.g. staffing norms and number of nurses per 100 000 inhabitants), since nursing staff are included in the scope of the research while caring staff are not. For information to be comparable, both nursing staff and relevant categories of caring personnel should be considered. Data on nurses and midwives for Italy, Ireland and United Kingdom are referred only to those employed in the National Health System.

According to **Eurostat**, for midwives the variations are less pronounced. In the majority of Member States, midwives are considered a completely separate group of health professionals, including those who trained before the adoption of the midwifery directives and decisions already mentioned. In the United Kingdom, for instance, there are separate entry requirements, separate training programmes, separate career pathways and entirely different fields of practice for nurses and midwives.

6.1.7. Physiotherapists

Although the practice of physiotherapy may be very similar across the countries of the EU, the philosophy underlying the legislation may lead to different approaches to the way in which the profession is regulated. In countries where an exhaustive list of authorised activities exists, the law may also recognise that the practice of some of these activities is shared with other professions or reserved exclusively to physiotherapists. The regulations may state that the practice of certain procedures is forbidden to physiotherapists (e.g. spinal manipulations in Belgium, Germany, France and Luxembourg, and manipulations under anaesthesia or surgery in the United Kingdom) and the role of physiotherapists in the overall provision of health care may not be directly comparable.

According to **Eurostat**, data for physiotherapists are not available for some of the years covered in Table **6.1.26**. Existing data show a gradual increase in the number of physiotherapists in most Member States. Density rates in Table **6.1.27** show that Spain had the lowest number (4) per 100 000 inhabitants in 2000, and that this number had decreased from 8 in 1988. Belgium (264), Finland (195) and the Netherlands (191) had the largest numbers in 2000.

Eurostat collects statistics on health care human resources. The Member States of the EU base their statistics in this field on different concepts and registers. **Physicians** may be counted as 'licensed' 'economically active' or 'practising'. Data for two or more concepts are available in the majority of Member States. **Physicians** entitled to practise are those **licensed**, irrespective of whether they are active, retired, unemployed or abroad and **practising** physicians are those seeing patients either in a hospital, a practice or elsewhere. The situation for **dentists** is similar to that for physicians.

Doctors who have completed their specialist training are entitled to be recognised as **specialists** in other Member States. However, not all specialities are recognised as independent disciplines in all Member States. Each European country will have a system of medical training and a range of specialities which have evolved to meet the needs of its own health care system. Each Member State can only recognise the medical specialities admitted in its own legislation, described in Annex VI/C to Directive 2001/19/EC. As mentioned before, a title of 'specialist' present in a Member State but not found in the State to which a person wishes to transfer will not **automatically** be valid in the host State, but the decision is made on a case-by-case basis by the competent authority of the host State. The legislation further sets out some basic minimum criteria for the structure of specialist training, and also specifies minimum training periods for all the specialities which it lists. Member States are free to exceed these minimum training periods, but must not fall below them. Although the EU legislation was not the only incentive (as medical education is in a pro-

cess of upheaval worldwide), the directives resulted in a reform of the specialist training system in some countries. For instance, specialities ceased to be recognised as independent specialities or new specialities came into effect. The impact of EU legislation was most notable in the United Kingdom, where previously speciality training had no fixed duration, and the term 'specialist' had no legal significance.

The Committee of Senior Officials on Public Health (CSOPH) was created by Council Decision 75/365/EEC of 16 June 1975 setting up a Committee of Senior Officials on Public Health. The main functions of the CSOPH are to collect all relevant information on the conditions under which general and specialist medical care are given in the Member States and to deliver opinions which could guide the Commission's work with a view to amendment of the medical profession directives. Whereas Article 43 of Directive 93/16/EEC provides that where a Member State encounters major difficulties in certain fields when applying that directive, the Commission shall examine these difficulties in conjunction with that country and shall request the opinion of the CSOPH.

Practising pharmacists include those working in a pharmacy and those working in the pharmaceutical industry, administration, research, etc. Data should exclude pharmacists working abroad, but include foreign pharmacists licensed to practise. For some countries (e.g. the United Kingdom), the figures received by **Eurostat** cover only the subcategory of pharmacists working in a pharmacy. For others, figures refer to those who are entitled to practise this profession. Others include certain pharmacists in activity and some who are not in activity (e.g. unemployed pharmacists).

In the case of **nurses**, there is the problem with different concepts (practising versus licensed) as already described above. The comparability of data is further limited, some Member States mixing health care personnel performing nursing and caring tasks. Nurses refer to qualified nurses (NRGC), second-level nurses and specialised nurses as well as to other categories of caring personnel. With the high fluctuation rates observed with nurses in many countries, the usability of data based on the 'licensed nurses' concept seems to be particularly limited.

For **physiotherapists**, the comparability is hampered by the fact that the types of tasks performed might differ between Member States; density rates should therefore be compared with caution.

References

Augsburg, D. (2001), *Human resources of European health systems*, Final report, December 2001, BASYS.

DHSS (Department of Health and Human Services) (2000), *The pharmacist workforce: A study of the supply and demand for pharmacists,* Bureau of Health Professions, United States.

Doc. XV/D/8536/98 of the EU Committee of Senior Officials on Public Health.

HBS (2002), BASYS, *Beschäftigungsunterschiede in ausgewählten Gesundheitssystemen der EU*, Gefördert von der Hans-Böckler-Stiftung, 2002.

Health at a glance, OECD, 2001.

OA (Österreichische Ärztekammer), http://www.aek.or.at.

Versieck, K. and Bouten, R. (1995), *Manpower problems in the nursing/midwifery profession in the EC,* Hooger Instituut voor de Arbeid, KU Leiven.

6.2. Facilities and use of services

The supply of hospital services at national and regional levels is closely linked to total health care expenditure. Between 1980 and 1999, health care increased its share in GDP in most Member States (see Section 6.4). The level of expenditure depends partly on the price of goods and services and partly on the quantities supplied. In this sector, the general problem is associated with the output of 'health' that is not directly measurable. Whereas figures for goods and prices are readily available in most sectors of the economy, it is impossible to record items such as outpatient or hospital services directly. However, it should be stressed again that differences in the way in which health care is organised and delimited at national or regional levels make it difficult to interpret comparisons between countries, whether these are of figures on given dates or of trends (e.g. where should the dividing line be drawn between health services and social services?).

The EU health care systems depend on a design of gatekeeping and referral systems that ensure their integrated functioning and continuity of care. Structures for public health differ markedly across countries, and overall public health activities are highly fragmented among different authorities. Secondary care is mainly provided in general hospitals. Day care hospitals and day surgery are emerging as significant alternatives to inpatient care in countries such as Belgium, Denmark, France, Ireland, Italy, the Netherlands and the United Kingdom. Day surgery is growing in importance in Germany, Luxembourg and Portugal, but there is little in Greece and Spain. There is also an increasing tendency to integrate specialist mental health care into general hospitals, to coordinate provision with community care and to close down large segregated mental institutions (ref. Ferrinho and Pereira 2001).

With regional governments becoming more important, the regions are also increasingly important as units for the political and administrative management of health issues. In Spain, for example, the regional communities have acquired a great deal of autonomy, one practical effect of which is that they manage the health budget as a whole. The situation is very similar in Belgium. Since 1996, the French health care reforms have put health care planning on a regional footing and allowed hospitals to be responsible for allocating their budget. Health care management is also being drastically reorganised in the United Kingdom and there are differences in the level of responsibility of the health care authorities (NHS trusts). In other Member States — the Netherlands and Sweden, for example — municipalities have responsibilities for health care. The difficulty with statistics on health/hospital services on a regional scale stems from the fact that regional, provincial or local governments define their socio-health regions very differently from one Member State to another. Sometimes, the regional breakdown which is of interest to health authorities in the Member States does not coincide with the NUTS 2 classification and some problems in cross comparing regional statistics can appear.

For a good and very detailed understanding of differences in the regional organisation of hospital services as well as the management of the national health care systems, see the web site of the **European Observatory on Health Care Systems**, http://www.euro.who.int/observatory. The European Observatory on Health Care Systems (EOHCS) is a partnership between the WHO Regional Office for Europe, the governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science (LSE) and the London School of Hygiene and Tropical Medicine. The country profiles (HiTs) elaborated by the EOHCS provide an analytical description of each health care system and of the reform initiatives in progress or under development. In this context, decentralisation is defined by the EOHCS as the changing relations within and between a variety of organisational structures/ bodies, resulting in the transfer of the authority to plan, make decisions or manage public functions from the national level to any organisation or agency at the subnational level. Health care reform is inherently a normative as well as an economic and organisational activity (ref. Figueras 1999).

6.2.1. Hospital beds and stay

According to the **System of Health Accounts (SHA)** definition, a hospital comprises licensed establishments primarily engaged in providing medical, diagnostic, and treatment services that include physician, nursing, and other health services to inpatients and the specialised accommodation services required by inpatients. Hospitals may also provide outpatient services as a secondary activity. Hospitals provide inpatient health services, many of which can only be provided using the specialised facilities and equipment that form a significant and integral part of the production process. In some countries, health facilities also need a minimum size (such as number of beds) in order to be registered as a hospital.

One issue to be clarified is what the precise meaning of the term 'hospital' is. This word covers many types of institutions, even within a single country. Given the many interpretations and the changing roles of a modern hospital, discussion should focus on the spectrum of services that are provided for a designated population wherever they are delivered, inside or outside the hospital. The technical advances in surgical care allow more treatment in free-standing ambulatory surgeries. Another main issue for hospitals is that older people will have multiple disorders that require coordinated programmes of care by multidisciplinary teams of professionals with a range of specialist skills. Population ageing is only one factor behind changing disease patterns. Changing risk factors, such as smoking and diet, will also influence the diseases that hospitals have to deal with. Furthermore, hospitals must also respond to changing public expectations and more demanding consumers. Elements of health care provided outside hospitals should also be taken into account. The individual hospital has the primary responsibility for providing quality care. The first step is to provide appropriate facilities. These should be sufficiently flexible to adapt to inevitably changing circumstances. Increasing ambulatory surgery requires fewer beds but more operating theatres, and advances in anaesthesia enable some routine surgery to be removed from the hospital altogether into free-standing ambulatory care facilities (ref. Mckee and Healy 2002).

Eurostat data show that the total number of hospital beds has decreased substantially in most Member States since 1980. For EU-15, the number of hospital beds decreased by more than 30 % between 1980 and 2000 **(6.2.1)**. A considerable share of this reduction is likely to have been caused by the drop in the length of hospital stay. It decreased in EU-15 from 17.4 days in 1980 to less than 11 days in 1997 **(6.2.3)**. In many countries, the length of stay has dropped considerably over the last 30 years. At the same time, the variation across countries has also decreased. In 1980, Luxembourg and Sweden recorded the highest value with 23.2 days, which was 2.4 times the lowest value recorded for Ireland with 9.8 days. In 1996, the

highest value was 15.3 (Luxembourg), the lowest 7.2 (Denmark). The data for the Netherlands seem to reflect a special situation. The length of stay is longer than in all other countries, but the data from different sources differ (see, for example, Table **6.2.8** and Graph **6.2.11**).

Translated into hospital beds per 100 000 inhabitants, Table **6.2.2** shows that the total number in the EU has decreased by roughly one third in less than 20 years. Sweden, the United Kingdom and Spain have the lowest number of beds per 100 000 in all Member States — 359, 408 and 409 in 1999/2000, respectively — and France has the highest with 820. All these figures refer to both public and private hospitals, but they differ with respect to the inclusion of nursing homes and day care beds. The variation in bed density is substantial, despite the obvious definitional differences. EEA countries vary in a similar fashion — Norway records small values and Switzerland and Iceland comparatively high ones. Resources available, expressed as the number of hospital beds per capita, vary substantially from one Member State to another.

Between 1990 and 1996, the total number of psychiatric beds in the EU decreased by more than 20 % from 490 000 to 387 000 **(6.2.5)**. In some countries, the number dropped by 50–80 % between 1980 and 2000 (e.g. France and Italy), which indicates a substantial reorganisation of the psychiatric care in these countries. The overall number of beds per 100 000 people fell from 140 to 104 between 1990 and 1996 **(6.2.6)**. The size of the decrease over the last 30 years has varied across the EU, with Luxembourg, Italy, and Finland having the largest proportional decrease and Germany, then the Netherlands, having the smallest. The highest number of psychiatric beds in 1999 was found in the Netherlands (154 per 100 000) and the smallest in Italy (16 per 100 000). As mentioned in Chapter 4 (see 'Mental disorders'), differences between countries could be attributed to changes in health care mental policies, such as the introduction of community-based treatment programmes to replace hospitalisation. Also, much mental health care today in EU Member States is provided in ambulatory settings, in primary centres and private psychiatric hospitals (not necessarily covered by the official statistics).

Trends for acute care beds very closely follow those for total inpatient beds. For the EU, there was a decrease from 516 per 100 000 in 1985 to 442 per 100 000 in 1997. Austria (663 per 100 000 in 1994) and Germany (645 per 100 000 in 1999) appear to be the Member States with the highest stock of acute care beds, and Spain (201 per 100 000 in 1997) and the United Kingdom (239 per 100 000 in 1998) the lowest **(6.2.7** and **6.2.8)**.

6.2.2. Long-term care beds

According to the **System of Health Accounts (SHA)** definition, nursing and residential care facilities comprise establishments primarily engaged in providing residential care combined with either nursing, supervisory or other types of care as required by the residents. In these establishments, a significant part of the production process and the care provided is a mix of health and social services with the health services being largely at the level of nursing services. The increased demand for health care for elderly people, many of whom suffer from chronic disability and diseases, has, in most cases, been met by transferring beds for acute or psychiatric care to long-term care. Due to the significant comparability problems for the figures on long-term care beds from Member States (inclusion or not of nursing homes, beds in the social or health sector, etc.), the data are difficult to analyse statistically (e.g. Sweden transfers beds to municipalities and these beds 'disappear' from the health sector). However, in some countries (Germany, France, Luxembourg, the United Kingdom, etc.), trends seem to be reliable **(6.2.9** and **6.2.10)**.

A communication from the Commission (ref. COM(2001) 723 final) gives some indication of future EU initiatives on long-term health care for the elderly as a result of the increase in the numbers of elderly people which will increase the pressure on the public sector for long-term care. Age-related illnesses, which may be serious enough to make sufferers completely dependent on others, require long-term care (outpatient care, in long-stay units or in psychiatric units). Such care is not a matter for the 'conventional' health system, but for the medical-social sector. The increase in the number of smaller and more unstable family structures could undermine the family networks of solidarity and make the provision of health care within families more difficult to continue. Consequently, if the number of people requiring long-term care increases, and given the rise in the employment rate for women (the primary informal care providers), specific measures will have to be taken. The factors related to how provision is organised are thus crucially important in this context.

Data on the number of beds reported to **Eurostat** are normally given as an annual average of beds in use during the year of reporting or according to concepts of registration or budgetary or planned approval. Comparability is weak and must be treated with caution due to the different concepts of 'hospital' and 'hospital bed' in the EU countries. In general, differences in the number of beds are influenced by different systems of accounting (average per year, years to either 31 March or 31 December, 'legal', 'budgetary' or 'planned' beds). Bed-counts include only beds used for full inpatient accommo-

dation. The figures for 'total inpatient care beds' refer to all beds in general (except cots for healthy infants), university and specialised hospitals, mental hospitals, institutions for the psychologically impaired, nursing homes and others. Beds in hospitals available for nursing day care, medical children's homes, nurseries for toddlers under medical supervision and institutions for the sensorially handicapped are not necessarily included. The following definitions are those used in the **OECD 'Health data 2002'** database and in the EU project ENS-Care.

Inpatient care beds accommodate patients who are formally admitted (or 'hospitalised') to an institution for treatment and/or care and who stay for a minimum of one night in the hospital or other institution providing inpatient care. Inpatient care is delivered in hospitals, other nursing and residential care facilities, or in establishments which are classified according to their focus of care under the ambulatory care industry but perform inpatient care as a secondary activity. **Acute care** beds accommodate patients where the principal clinical intent is to do one or more of the following: manage labour (obstetric), cure illness (obstetric); cure illness; provide definitive treatment of injury; perform surgery; relieve symptoms of illness or injury (excluding palliative care); reduce severity of illness or injury; protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions; perform diagnostic or therapeutic procedures. **Psychiatric care** beds accommodate inpatients for mental health problems (including substance abuse therapy), but beds for patients who are mentally handicapped if the principal clinical intent is not of a medical nature are excluded. **Long-term care** beds are for inpatients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living. These beds are provided in institutions or community facilities.

6.2.3. Hospital beds: the regional dimension

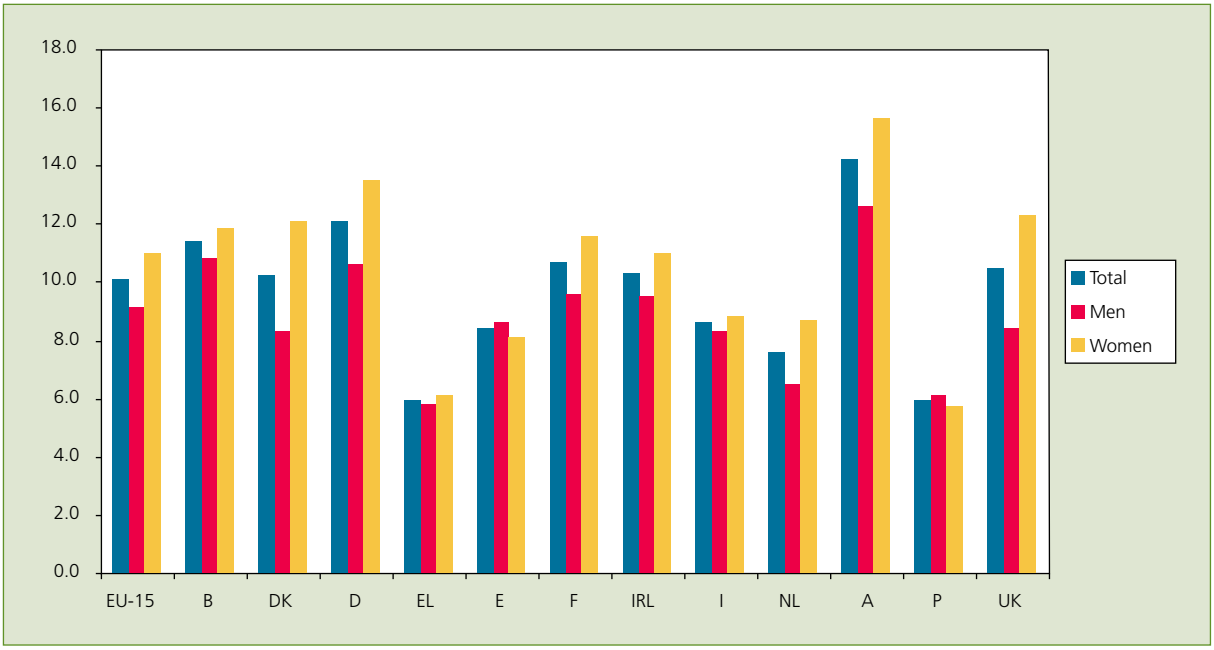
Map **6.2.4** shows the density of beds per 100 000 inhabitants using NUTS II level data for a 1999-2000 average. Spain was the most uniform with between 300 and 500 and Austria the most variable with between 600 and 1 200. Austria, France and Germany had the greatest number of beds per 100 000 while Spain, Portugal and regions of Greece had the least. Numbers of hospital beds per capita show a quite different trend. Over the period 1986–99, the number of beds declined sharply in the EU as a whole, from 830 beds per 100 000 inhabitants to 630. This fall may be due to changes in medical technology, which have cut the average stay in hospital for any given disorder. A further reason is the financial constraints which arose during the 1990s and which have led to a rationalisation of health care services everywhere. The North–South divide applies to hospital beds. The German, French, Austrian and Finnish regions (headed by Mecklenburg-Vorpommern, Itä-Suomi and Limousin) have a high density of beds, in marked contrast to the Italian, Spanish, Portuguese and Greek regions (Algarve and Sicily, in particular), the United Kingdom and Ireland. Certain regions which border on candidate countries or Russia also have a higher density than other regions due, possibly, to inflows of patients from these neighbouring countries.

6.2.4. Nights spent in hospital

Data from the **European Community Household Panel (ECHP)** (see Chapter 4 for methodological details) provide information on the percentage of hospitalised persons in the EU and on the average number of nights spent in hospital per capita. Data based on surveys such as the ECHP generally contain no information on the causes of hospitalisation but are based on single person-related data. The data collected from information on discharges from hospitals are based on cases, which can include readmissions of the same person in most of the countries.

According to 1998 results **(6.2.11)** of the **ECHP**, 10.1 % of Europeans have experienced hospitalisation during the last 12 months (9.1 % of men and 11.0 % of women).

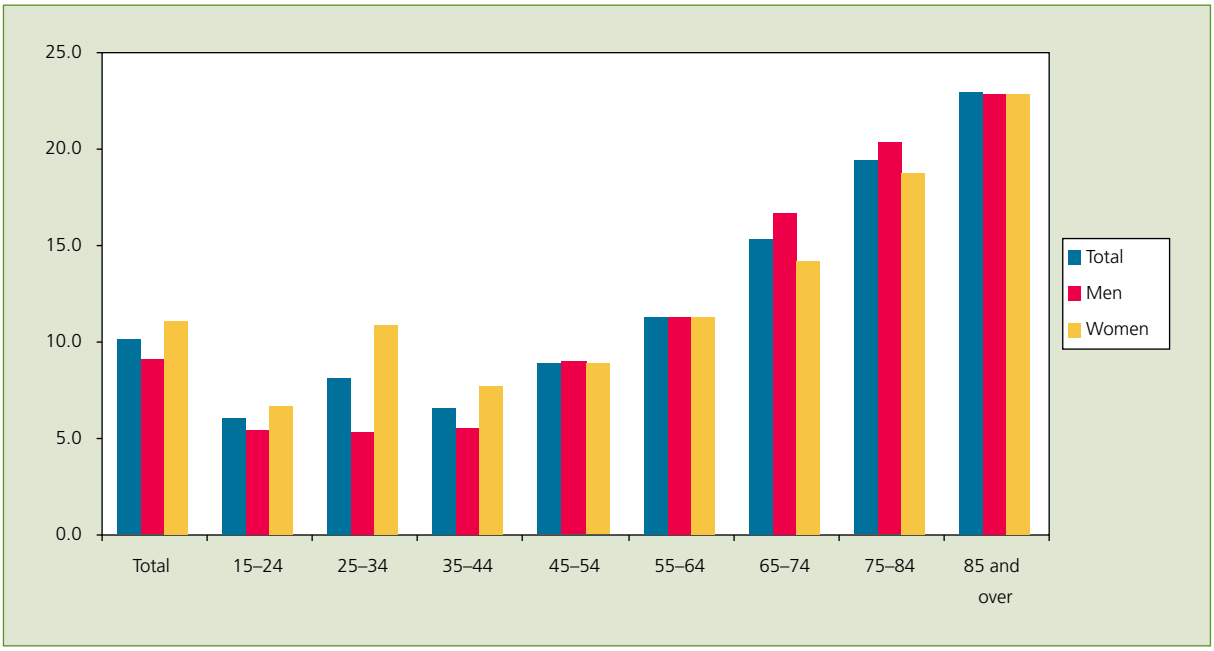
6.2.11 Percentage of population hospitalised during the last 12 months (16+ years) (1)



(1) Excluding hospitalisation for childbirth.
Source: European Community Household Panel, Version December 2001.

The proportion ranges from 5.9 % in Portugal and in Greece to 14.2 % in Austria and 12.1 % in Germany. These differences may partly reflect the differences in organisation of health care services. Therefore, with caution, it could be said that the figures are lower in the southern Member States of the EU and in the Netherlands than in the other Member States. Up to and including the age group 45–54 years, women have higher hospitalisation rates than men; after that, men tend to have higher rates, especially in the age group 65–74 **(6.2.12)**.

6.2.12 Percentage of population hospitalised during the last 12 months by age, EU-15 (1)



(1) Excluding hospitalisation for childbirth.
Source: European Community Household Panel, Version December 2001.

Also according to the **ECHP**, the average number of nights for EU-15 decreased from 1.5 in 1996 to 1.3 in 1998, with women spending 0.2 nights more than men overall among the EU population **(6.2.13)**. However, men spent slightly more nights in hospital than women in Portugal, Greece and Luxembourg. The variation across Member States is much more prominent than that between the sexes. The highest values were recorded in Germany and Austria (2.0 days in 1998), the lowest in the Netherlands and Portugal (0.8 days) and Greece (0.7).

In the EU, the total length of stay for hospitalised people, over the total of hospitalised persons, measured by the **ECHP** fell from 14.1 nights in 1996 to 13.0 nights in 1998, with men spending slightly more nights than women overall. As these data refer to the total number of nights a person has spent in hospitals in a year, they may exceed the length of stay recorded per case in other sources (discharges). The total number of nights was the greatest in Germany — at 16.8 in 1998 this was nearly twice that spent in the United Kingdom (9.2). Looking at the breakdown by age and sex for this hospitalised group, on average men spent more nights than women between the ages of 16 and 44, and between the ages of 65 and 74 **(6.2.14)**. The number of nights decreases between the ages of 16 and 34 for both sexes and then steadily increases.

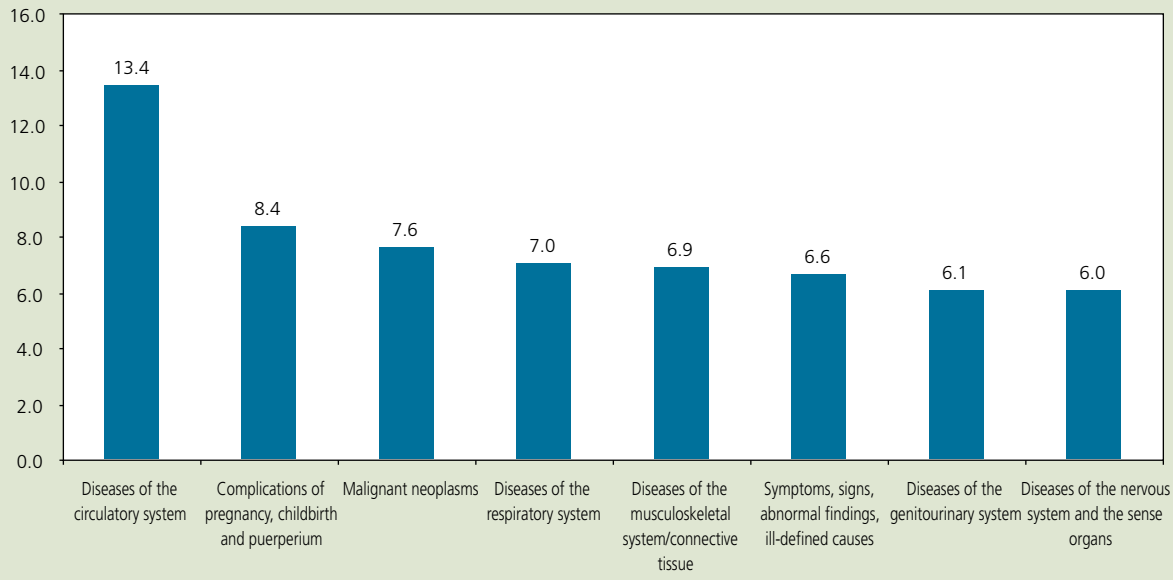
6.2.5. Hospital discharges and average length of stay

Hospitalisation statistics give a broad picture of the general health and health care treatment of the population. As health care is moving more towards managed care, prevention, and cost control, patient care is also moving more to outpatient, home care and alternative care settings. While the proportion of care provided in inpatient settings has declined, it still provides a picture of health at the extreme end of care and shows how care is shifting from a fee-for-service to a managed care environment. The data on hospital discharges of inpatients by diagnosis and average length of stay (ALOS) are regularly collected and used for different purposes, such as monitoring disease-specific health status and health care delivery.

The breakdown by diagnosis applied by **Eurostat** is based on the various different national diagnosis classifications (relating to ICD-9-CM or ICD-10) in use. The number of hospital discharges is the most commonly used measure of the utilisation of hospital services. Hospital discharges, rather than admissions, are used because hospital abstracts for inpatient care are based on information gathered at the time of discharge. Good data at EU level for readmission diagnoses are lacking. Discharge statistics are based on counts of hospital discharges, which are counts of events, not patients. For example, a patient admitted and discharged three times during the reporting year would be counted as three discharges. Other problems in hospital discharge statistics are studied (ref. Smedby 2002) in the context of the **HDP project** (see below). Most European countries use ICD but, due to the long implementation period of the 10th revision of the ICD (ICD-10), there was — and still is — a simultaneous use of ICD-9-CM and ICD-10 during the 1990s. Accounting remains a problem in the sense that if a patient is transferred from a department of internal medicine to the surgery department of the same hospital, the main diagnosis for the patient may be the same for both department spells or it may change. If it changes, some rules for the reporting of the main diagnosis for the whole hospital spell have to be followed. It is difficult to assess the impact of this reporting difference for specific diagnoses without more detailed studies. Most hospital inpatient statistics are based on the application of the 'main condition' concept. This means that, for each discharged patient, a main condition is chosen to represent the patient in statistical tables, even if there were other diagnoses registered as well. In addition to discrepancies in the registration of main and secondary diagnoses referred to above, there are other problems with an impact on the comparability of discharge statistics. These are simple errors in the assignment of diagnoses as well as coding errors of correct diagnoses. The HDP project and Eurostat are oriented to the proposal of a shortlist for hospital morbidity primarily based on ICD-10, given the intention to use it for many years ahead. The European countries presently using ICD-9-CM will probably change to ICD-10 in the near future.

For EU-15 as a whole, **Eurostat** data show that diseases of the circulatory system were the main cause of hospitalisation in 1999 (as well as in previous years) accounting for 8.4 million hospitalisations (13.4 % of the total) **(6.2.15)**. Other leading causes of hospitalisation were: diseases of the digestive system (6.2 million, 9.8 % of the total), complications of pregnancy, childbirth and puerperium (5.3 million and 8.4 % of the total), malignant neoplasms (4.8 million, 7.6 % of the total) and diseases of the respiratory system (4.4 million, 7.0 % of the total). In 1999, these leading causes of hospitalisation accounted for 46.4 % of all resident discharges. There are many serious and expensive causes of hospitalisation that are not included in the leading causes.

6.2.15 Most frequent hospital discharges per ICD-10 diagnosis, EU-15, 1999



Source: Eurostat, NewCronos database (Health and safety).

Looking at diagnoses by Member State, **Eurostat** data show that the main causes of discharge from hospitals in 1999 were the following: diseases of the circulatory system in Denmark, Germany, Italy, the Netherlands, Austria and Finland; diseases of the digestive system in France and Ireland; complications of pregnancy, childbirth and puerperium in Portugal; and all categories not elsewhere classified in England **(6.2.16)**. Austria (28 093), Finland (26 755), France (25 699) and England (24 594) had the most discharges per 100 000 people, while Portugal had the least by far (8 728) along with the Netherlands (9 618).

Looking at average length of stay by main diagnosis, the highest number of days were spent in hospital for mental and behavioural disorders in all Member States except: Belgium, where it was for diseases of the blood(-forming organs) and immunological disorders; Denmark, England, France and Norway, where it was for certain conditions originating in the perinatal period **(6.2.17)**. The longest stay for a particular disease in one Member State tended to be two to three times that of the shortest stay for the same disease in another Member State. However, for mental and behavioural disorders it was fifteenfold, for diseases of the skin and subcutaneous tissue it was sixfold, and for congenital malformations and chromosomal abnormalities it was fourfold.

One-day cases are defined as patients admitted to and discharged from inpatient treatment the same calendar day, i.e. they are never an element of a 'midnight' patient set. The future improvement of the hospital data collections will give major relevance to the percentage and weight of one-day cases over the total number of hospital days. **Eurostat** data are only available for four Member States. In the Netherlands, one-day cases represented 6.4 % of the total number of hospital days in 1999. Values are very different in other countries: Finland (3.8 %), Italy (1.8 %) and Germany (0.8 %).

For **Eurostat** hospital discharge statistics, diagnoses and procedures associated with hospitalisations are classified in accordance with the ninth revision of the **International Classification of Diseases (ICD-9)**. Its original use was to classify causes of mortality (see Chapter 5). Later, it was extended to include diagnoses in morbidity. The **Clinical Modification** of the ICD is used in categorising hospital diagnoses. Diagnostic chapters (using principal diagnosis) have been defined according to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). In practice, the ICD has become the international standard diagnostic classification for all general epidemiological, as well as health management, purposes. The diagnostic categories used are based on the principal diagnosis, which is submitted as the first of several possible diagnoses coded on the discharge record. The principal diagnosis represents the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. Discharge is the formal release of an inpatient, by an inpatient or acute care institution.

The discharge rates are expressed by the number per 100 000 population. Most Member States will adopt or are adopting the tenth ICD classification.

Average length of stay is computed by dividing the number of days stayed (from the date of admission in an inpatient institution) by the number of separations (discharges plus deaths) during the year. **A bed-day** is a day during which a person is confined to a bed and in which the patient stays overnight in a hospital. Day cases (patients admitted for a medical procedure or surgery in the morning and released before the evening) are excluded.

The **'Hospital data project' (HDP)** under the coordination of the **Department of Health and Children** (Ireland), started in 2000 under the EC Health Monitoring Programme, with the primary aim of developing a common data set (CDS) for hospital patients, based on an examination of the contents of hospital data currently collected in each EU Member State. The initial focus of the project is to achieve comparability for a limited number of core data items, but it is hoped that the data set will be improved, refined and possibly expanded over time. A key issue is the coverage of the data set (i.e. types of patients and hospitals), in order to ensure comparability between Member States in terms of the area of activity included. Some draft proposals on coverage have been developed, using the function and provider dimensions of the OECD **System of Health Accounts (SHA)** framework and maintaining consistency with OECD and Eurostat health accounts and related work such as the Eucomp project.

Other projects for health care data are being developed by the **Standing Committee of the Hospitals of the European Union**. Its acronym is **HOPE** (Hospitals for EurOPE). The committee includes national hospital associations or representatives of the national health systems of the 15 Member States of the European Union, plus Bulgaria, Cyprus, Hungary, Malta, Romania, Slovakia and Switzerland as observer members. One of the projects on quality care (ref. HOPE web site) aims to provide information on the general principles of quality, quality management and quality challenges in health care. The challenge of quality is founded on the basic principle of reducing the number of errors. Latest research demonstrates that almost every 10th patient suffers from preventable harm and adverse effects related to their care and that variation among health care providers is large and cannot be explained by patient characteristics.

6.2.6. High-tech medical facilities

The introduction of a technological component into medical practice is one of the most important elements in the process of capitalisation of the health sector, and has reinforced the creation of large hospital complexes. The introduction of high-tech medical facilities has resulted in the predominance of hospitals in the health systems and has increased the number of high-tech specialised personnel. In accordance with their purpose, high-tech medical facilities are classified into five groups: diagnosis, prevention, therapy or rehabilitation, organisation and administration, and support (ref. Puig 1993).

According to **OECD 'Health data 2002'**, Table **6.2.18** shows the number of high-tech facilities per million inhabitants between 1980 and 2000. Although the number of these facilities has gradually increased, there are wide variations between Member States. Where data were comparable, Austria had the greatest number of computed tomography (CT) scanners and magnetic resonance imaging (MRI) units in 2000 for all Member States with 25.8 and 10.8. Finland had the most radiotherapy equipment among Member States, and Iceland had the most among EEA countries, with 14.3 and 14.4 in 1999, respectively. Germany had the most lithotriptors among Member States and Iceland had the most among EEA countries (3.0 and 3.7, respectively, in 1998), while Italy had the most haemodialysis stations in 1999 with 194.1. Mammographs have only been added recently, and the data are too incomplete for a meaningful comparison.

The database created by the Organisation for Economic Cooperation and Development, **OECD 'Health data 2002'**, is a comprehensive source of statistics on health and health systems across OECD countries. It covers over 1 200 indicators and offers some sophisticated query modules. The OECD health files are classified into nine parts: health status, health care resources, health care utilisation, expenditure on health, financing and remuneration, social protection, pharmaceutical market, non-medical determinants of health, demographic references, economic references. The statistics contained in OECD 'Health data 2002' reflect the situation at the time of release; they have been refined and improved year after year. For further information, see the OECD web site (http://www.oecd.org).

6.2.7. Ambulatory care: consultations with health professionals

Primary care involves consultation with health professionals, especially general practitioners (GPs). The GP is gaining in status as the gatekeeper of the overall health care systems. About half of the countries give their GP gatekeeper status (see Annex III).

The method of paying primary care doctors in the public sector is also indicated in Annex III. Doctors can be faced with changing incentives by altering the method of payment. In six countries, they are paid on a capitation basis. This is a fixed payment for each listed or registered person served for a period of time. Payments will vary according to the number of patients registered, but not to the number of services supplied per patient. In five countries, mainly those with a national health service, GPs are paid salaries. This payment does not vary either with the number of individuals served or with the number of services rendered. In eight countries, a fee is paid for each service rendered.

The 1998 **European Community Household Panel (ECHP)** asked participants how often they visited general practitioners, medical specialists and dentists, subsequently referred to as health professionals **(6.2.19)**. According to the 1998 results of the **ECHP**, the percentage of persons having consulted a doctor, a dentist or an optician during the past 12 months was 92.9 % on average for EU-15, 89.6 % of men and 95.8 % of women. Women made more visits than men in each Member State. The average number of visits to general practitioners in the previous 12 months ranged from two in Greece, to four by men and six by women in Belgium. The average number of visits to dentists was less than two in each Member State, with less than one made in Greece, Ireland, Portugal and Spain. The average number of visits made to medical specialists was less than three in each Member State, with people in Ireland making the least and those in Austria making the most. Looking at the proportion who consulted any of these health professionals, we can see in Table **6.2.20** that more women than men made 'three or more visits', and more men than women made 'no visits', 'one visit' or 'two visits'. The widest variations between Member States are for 'no visits' (from 6 % in the Netherlands and Austria to 33 % in Greece), and for 'three or more' (from 46 % in Greece to 78 % in Austria).

6.2.8. Home care

All EU countries are faced with an increase in demand for home care; the main reasons are the ageing population, smaller family size and increased female participation in the labour market. Another reason for substitution of hospital care by home care is an attempt to control health care expenditures. There are differences among the countries in the definition of home care. According to **NIVEL (Netherlands Institute of Primary Health Care)** whose data (see Annex II) are used in this publication, home care is restricted to the care provided at home by professional home-nursing organisations and home-help services. Services included in home help and home nursing are described in the annex. There are large differences between EU countries in the development of home-care services. In countries such as Belgium, Denmark, Ireland, the Netherlands, Finland, Sweden and the United Kingdom, home-nursing and home-help services are fairly developed compared with Greece, Spain, Italy and Austria. There are also large differences among the countries regarding the level of coordination of home-nursing and home-help services. A major problem in many countries is the separation between health and social services. Whereas home-nursing services are mostly financed by general taxation or social insurance, home-help services are usually administrated and financed by local government or by voluntary organisations. In general, there are also large differences between the countries on the financing of home care.

6.2.9. Consumption of pharmaceuticals

Member States have implemented a series of measures, both controls and incentives, to influence the supply of, and demand for, pharmaceuticals. Some countries have given greater emphasis to supply, and others to demand. The supply-side controls are aimed at limiting the cost of reimbursed medicines to the authorities, by controlling their price and/or reimbursement and by limiting their availability through the use of positive and negative lists (see Annex III). Authorities are aware of the possibility that if the range of reimbursed treatments is too narrow, or the cost to the patient is too high, there will be public health repercussions and cost implications as more patients seek admission to hospitals. Physicians are encouraged in several ways to prescribe effective and (cost-) efficient medicinal products (e.g. the Netherlands and the United Kingdom). Prescribing guidelines and treatment protocols, with a focus on indications, are published by competent authorities and medical associations/royal colleges of physicians. The aims of prescribing guidelines are to encourage doctors to prescribe rationally and consistently, according to the medicine's indications and the therapeutic needs of their patients. The main outcomes should be greater consistency in the drugs and length of treatment prescribed for each condition, and a reduction in the volume of drugs prescribed as redundant or duplicate ones are eliminated. Rational prescribing also means that the cheapest drugs are favoured from among those that are medically interchangeable for a given condition. When guidelines are first applied, savings may be noticed. Thereafter, sales volumes will depend on the changing morbidity of the population and variations in the guidelines (ref. Kanavos).

According to the 'Drug Monitor' of **IMS Health**, the equivalent of USD 54.0 billion was spent on

drugs in retail pharmacies in the top five European markets during the year ending 31 January 2002 **(6.2.21)**. Germany, spending more than other Member States in most of the drug categories, had the largest share overall (USD 15.3 billion) — nearly three times that of Spain which spent less than other Member States in most of the categories. Italy had the largest overall growth rate at 13 %, while France had the smallest at 7 %. The greatest amount spent within the five Member States was on cardiovascular drugs, and the amount had grown by 9 % over the year, while the least was on parasitology, which had fallen by 2 %. The blood agents product group had the highest growth rate among the drugs at 21 %.

IMS Health (Intercontinental Marketing Services) provides data on the sales of medicinal products by retail pharmacy outlets (ref. IMS Health web site). These figures are taken from the monthly pharmaceutical audit conducted by IMS Health, and cover the 12-month period from January 2001 to January 2002. All sales values are shown in millions of US dollars at prevailing exchange rates. In order to remove the effects of fluctuating exchange rates, growth rates are calculated net of exchange; in other words, growth figures are shown at local currency level or constant exchange. DDD is used to track sales activity for every major distribution channel, including hospitals, clinics, mail service, major retail food stores and chains, mass merchandisers and independent pharmacies. DDD supports pharmaceutical compensation and sales force deployment activities.

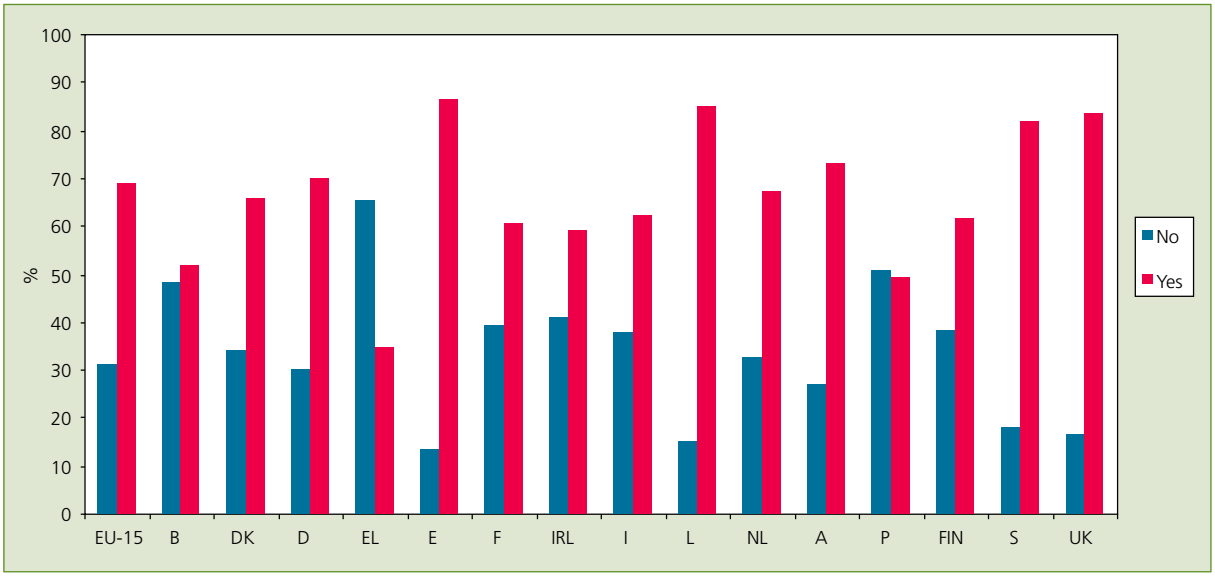
Medicines are classified according to the **ATC (anatomical therapeutic chemical classification system)** established by the WHO Collaborating Centre for Drug Statistics Methodology. The ATC system divides medicinal substances for human use into 14 anatomical main groups. **DDD (defined daily dose)** is an international unit based on an average daily dose of the pharmaceutical substance when used by an adult for its main indication. Thus, it does not indicate the dose size most commonly prescribed or used. DDD is based on drug wholesale volumes or the amount of drugs in units of weight or volume and the internationally agreed theoretical daily dose for each drug.

The use of medicines without a doctor's prescription is increasing. According to the **Eurobarometer survey 1996**, 13.0 % of Europeans declared that they had consumed medicines without a doctor's prescription during the two weeks prior to the survey. This percentage is greater for women (15.2 %) than for men (10.7 %). The Spanish (19.0 %) are the highest self-consumers of medicines, especially in the case of women (22.7 %). The lowest consumption of unprescribed medicines is in Ireland (6.3 %) and in the Netherlands (6.5 %). In all, 6.7 % of Europeans declare that they consume vitamins without a doctor's prescription (women 7.9 %; men 5.4 %).

6.2.10. Easy access to some health services

Eurobarometer 52.1 (1999) asked people in the EU if they could walk to their general practitioner (GP) or health centre, how long it took them to get there, and how long it took to reach their nearest hospital. Although overall 75 % could walk to their GP, there were considerable variations between Member States, ranging from 35 % in Greece to 85 % in Luxembourg and 87 % in Spain **(6.2.22)**.

6.2.22 Easy access to general practitioner or health centre: Can walk, 1999



Source: Eurobarometer 52.1, European Commission.

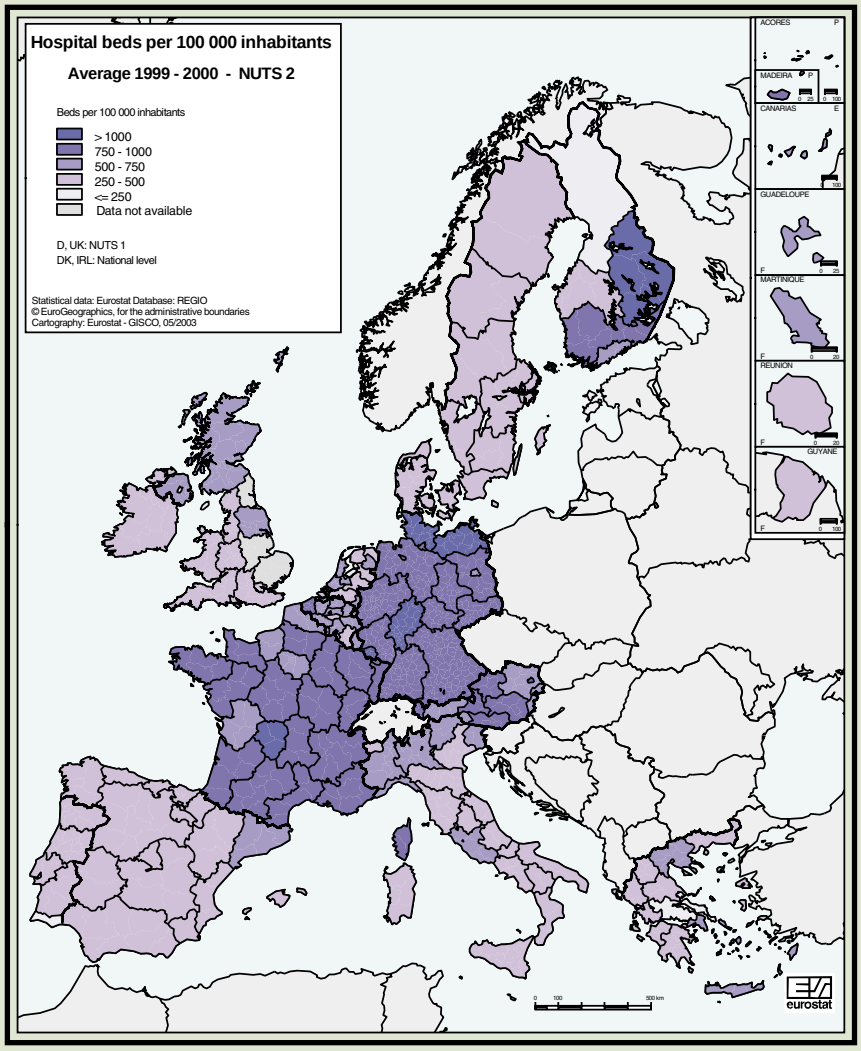
Travelling time to the GP or health centre was less than 20 minutes for 83 % of people in the EU, ranging from 55 % in Greece and 61 % in Portugal to 90 % in the Netherlands and Denmark **(6.2.23)**. Travelling time to the nearest hospital was less than 20 minutes for just over 50 % of people in the EU, ranging from 37 % in Portugal and Greece to 70 % in the Netherlands; 4 % took over an hour.

6.2.11. Satisfaction with health systems

The **Eurobarometer** survey establishes an anchor point in the EU Member States and despite a number of methodological problems and limitations can provide useful information on citizens' views on health care. Changes in citizens' views in the future could be taken into account to measure the popularity of specific measures or reforms. More research focusing on citizens' views is necessary, since the Eurobarometer survey provides only a general review of the public's views on health care (ref. Mossialos). A new Eurobarometer survey (spring 2002) on citizens' views on health care has been realised and results will be available at the end of 2002.

Eurobarometer 52.1 (1999) asked people in the EU how satisfied they were with the health care system at the time, and compared with two years earlier. The results of the Eurobarometer survey illustrate a general evaluation of the national health system without specific reference to issues such as equity, efficiency and satisfaction with different levels of care. Just over half were 'very' or 'fairly' satisfied with the health system but there were large differences between Member States **(6.2.24)**.

6.2.4 Hospital beds per 100 000 inhabitants



Source: Eurostat, NewCronos database (Health and safety).

The largest proportions of satisfied people were found in Austria (81 % of men, 75 % of women), France and Belgium, while the smallest were found in Greece (17 % of men, 20 % of women), Portugal and Italy. Satisfaction increased with the age at which full-time education was completed **(6.2.25)**. Greater proportions of people in each educational category were the 'least' satisfied in Greece, Portugal and Italy, and were 'very' satisfied in Denmark, Austria and Luxembourg. As expected, there were greater differences in satisfaction between Member States than between occupational category **(6.2.26)**. The greatest proportions of people who were satisfied were students (59.3 %), while the smallest were the unemployed (46.3 %). A high proportion of students in Ireland (18 %), Luxembourg (17 %) and Belgium (9 %), as well as 15 % of unemployed people in Luxembourg and nearly 10 % of managers in Belgium, 'didn't know'.

Looking at satisfaction with the health system compared with two years earlier, 60 % of people in the EU said there had been 'no change', ranging from 45 % in the Netherlands to 76 % in Spain **(6.2.27)**. Just over a quarter were 'less satisfied', from 10 % in Ireland and Austria to 36 % in Sweden and Germany. More than 10 % of people in the EU were 'more satisfied', ranging from 6 % in Italy to 21 % in Ireland. The largest differences between occupational groups were found among those who said they were 'less satisfied', ranging from 20 % of students to 30 % of both managers and the retired **(6.2.28)**. Ireland had the highest proportions of people in most occupational categories who were 'more satisfied', while Luxembourg had the highest proportion of 'don't knows'. Sweden had a very high proportion (74 %) of housepeople who were 'less satisfied' compared with other Member States.

References

COM(2001) 723 final, 'The future of health care for the elderly: Guaranteeing accessibility, quality and financial viability', communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions.

Ferrinho, P. and Pereira, J. M. (eds) (2001), *For better health in Europe,* European Commission, Directorate-General for Health and Consumer Protection.

Figueras, J., Saltman, R. and Sakellarides, C. (eds) (1999), *Critical challenges for health care reform in Europe*, European Observatory on Health Care Systems, WHO.

HOPE, http://www.hope.be/07publi/leaflet/quality/frames.htm.

IMS Health, http://www.imshealth.com/.

Kanavos, P., *Overview of pharmaceutical pricing and reimbursement regulation in Europe*, LSE Health and Social Care.

Mckee, M. and Healy, H. (eds) (2002), *Hospitals in a changing Europe*, European Observatory on Health Care Systems, WHO.

Mossialos, E., *Citizens and health systems: Main results from a Eurobarometer survey* (http://europa.eu.int/comm/health/ph/general/first.htm).

Puig, J. J. (1993), *Crecimiento, empleo y tecnología en el sector hospitalario español*, Departament de Sanitat i Seguretat Social, Generalitat de Catalunya.

Smedby, B. (2002), *Comparing diagnostic information on hospital inpatients*, WHO Collaborating Centre for the Classification of Diseases in the Nordic Countries.

6.3. Some treatments and medical procedures

6.3.1. Immunisation coverage as a result of vaccination

Many serious childhood diseases are preventable by using vaccines routinely recommended for children. Since the introduction of these vaccines, rates of diseases such as poliomyelitis, measles, mumps, rubella, diphtheria, pertussis (whooping cough) and meningitis caused by haemophilus influenzae type B have declined by between 95 and 100 %. By contrast, and according to WHO, in under-immunised populations of the world, 600 000 children die each year from pertussis.

Table **6.3.1** uses data from **WHO** to show the most recent levels of immunisation among infants against diphtheria, pertussis and poliomyelitis, and also measles, mumps, tetanus and tuberculosis. Iceland, Sweden, Finland and the Netherlands have the largest coverage (96–99.9 %) against all of these diseases except tuberculosis, while Ireland and Germany (50–85 %) have the smallest. The EU target is 95 %, which was also met in Belgium, Denmark, Spain, France, the Netherlands and Portugal for DTP.

Eradication is a feasible long-term objective. For example, WHO has adopted a resolution calling for global eradication of poliomyelitis by the end of 2005. Three WHO regions have not identified a single case caused by wild poliovirus for over two years. Prevention and control of measles, mumps and rubella are important elements of the routine childhood immunisation programme in most of the developed world. An inventory of immunisation

programmes in 17 European countries (the 15 EU Member States plus Norway and Switzerland) has been developed by the **EUVAX** project report, according to a questionnaire survey carried out by the **EUVAC-NET** in 2000. All countries in the EU have implemented a schedule of two doses of measles, mumps and rubella vaccine. The success of immunisation against measles, mumps and rubella has led to a decline in the EU in the incidence of these diseases (see Chapter 4).

The 'Communicable disease surveillance and response' programme and the Information Support Unit of the **WHO** Regional Office for Europe are working closely together for the development of the computerised information system for infectious diseases **(CISID)**. Data received by CISID from member countries reflect varied national data collection criteria and methods. CISID aims firstly to improve the standardisation, timeliness and completeness of the data, and secondly to identify risk by age, sex and sub-national geographic area.

Immunisation coverage has been defined as the proportion of a population (or sub-population, however defined) that has been vaccinated. In countries where public health data are computerised and actively managed, the results cover the entire child population precisely, for example in Denmark, the Netherlands, and the United Kingdom. In countries where computerised public health records are confidential, indirect methods have to be used. This is why it is essential to validate coverage data either systematically or periodically. Systematic measures are taken in Denmark, France, Ireland, Italy (compulsory vaccines), the Netherlands, Portugal, Finland, Sweden and the United Kingdom. In Belgium, Germany, Greece, Spain and Austria, where many vaccinations are given by the private sector, coverage is mainly assessed by estimating the number of imported or distributed vaccines. In Italy, the same method is used to assess the coverage of MMR vaccination. Finally, in Belgium, Greece, France, Italy and Finland, estimates of coverage are validated by performing ad hoc surveys of representative samples. The age of complete immunisation differs across countries due to different immunisation schedules. Childhood immunisation refers to two measures: the percentage of one-year-old children vaccinated against diphtheria, tetanus and pertussis combined (DTP) and the proportion of one-year-old children vaccinated against measles.

6.3.2. Surgical procedures

A procedure is defined as a clinical intervention that is surgical in nature, or carries a procedural or anaesthesic risk, or requires specialised training and/or requires special facilities or equipment only available in an acute setting. Procedures therefore encompass surgical procedures and also non-surgical investigative and therapeutic procedures, such as X-rays and chemotherapy (ref. Australian Institute of Health and Welfare 2001). There are important differences between the classifications used in Member States for coding surgical procedures and the ICD-9-CM and ICD-10 classifications. It is not always possible to define a direct conversion, in which the original meaning of the procedure rubric is preserved. ICD-9-CM includes a series of additions which are not present in the most structured Member States' classifications (Nomesco (ref. Nomesco 2001), OPCS4-UK, CDAM-France, etc.). Experience shows that it is impossible to design a system of code conversions without ambiguities and potential sources of misclassification.

However, **OECD 'Health data 2002'** and other national sources provide some data on some surgical procedures, for some Member States. Per 100 000 inhabitants, operations on the digestive system, musculoskeletal system and cardiovascular system appear to be relatively frequent **(6.3.2)**.

6.3.3. Caesarean sections

Data from the **Health for All** (WHO) database show that there has been a gradual increase in caesarean sections over the last 30 years, with some fluctuations in certain Member States **(6.3.3)**. Many reasons contribute to this rise: caesarean sections are safer operations than in the past and are an accepted part of modern obstetric care; with improved neonatal intensive care units, caesarean sections are used in multiple pregnancy; the use of electronic intra-partum foetal monitoring alerts staff to possible complications; two thirds of women who have had a caesarean section also have one for their next baby; three quarters of elective caesareans are timed to suit staff and mothers (ref. Thomas and Paranjothy 2001).

Nearly one fifth of all live births in the EU were by caesarean section in 1999. Italy had the highest rate, nearly a third of births in 1999, then Portugal with more than a quarter in 1998, although Greece had the highest rate in 1991 — the latest year with data for Greece. Luxembourg had the lowest rate by far, 18.1 in 1998. The number fell in Spain, from 193 per 1 000 live births in 1996 to 141 in 1998. Ireland's rates fell between 1993 and 1996, then quickly increased.

6.3.4. Organ transplants

Transplantation is the transfer of cells, tissues or organs from one area of the body to another or from one organism to another. For many patients, transplantation offers the only hope for a healthy, productive life. Numerous organs and tissues can be transplanted, including kidney, cornea, lung, heart, liver, bone marrow, skin, bowel and pancreas.

According to **Eurostat**, the greatest number of transplants carried out in the EU were kidney (living and cadaveric donors) — 11 747 in 2000 — followed by liver (4 275) then heart (1 975) **(6.3.4)**. The total number of kidney, lung, pancreas and (except in 2000) liver transplants carried out has increased over the last 10 years, whereas the number of combined heart and lung transplants has decreased. Heart transplants fluctuated between 1995 and 2000, with an overall decrease in the period. The number of bone marrow transplants has increased, except in Denmark and the Netherlands where the numbers have fluctuated. There have been very few intestine transplants, only 11 in the year 2000.

Transplants are most frequent in Spain, Austria and Belgium/Luxembourg — 49, 49 and 44 kidney transplants per million people respectively in 2000 **(6.3.5)**. They are least frequent in Greece — 10 kidney transplants per million in 2000.

The European practices on organ donation and transplantation are based on Recommendation No R(97)16 of the Committee of Ministers of the Council of Europe to the Member States on liver transplantation from living related donors. **Eurostat** collects these data on the basis of results disseminated from different specialised national and international organisations (Eurotransplant, Scandiatransplant and the Spanish National Organisation for Transplants (ref. ONT web site)). The Council of Europe in the past has developed ethical principles governing organ transplantation. At the third Conference of Ministers for Health on organ transplantation, the ministers reconfirmed the principle of non-commercialisation of human organs and the need for organisational measures to increase the availability of organs. The Member States continue to cooperate in this area and particular attention is now being paid to quality control of organ transplantation.

6.3.5. Dialysis

Dialysis is a method of removing toxic substances (impurities or wastes) from the blood when the kidneys are unable to do so. Dialysis is most frequently used for patients who have kidney failure, but may also be used to quickly remove drugs or poisons in acute situations. This technique can be life saving in people with acute or chronic kidney failure (ref. MedlinePlus web site). According to **OECD 'Health data 2002'**, the number of patients undergoing dialysis has increased in each Member State over the last 30 years **(6.3.6)**. Germany had the highest number per 100 000 people, 64 in 2000. In 1994, the latest year for which data were available for all Member States, Greece had the second highest rate (42), while Ireland had the least (10) then the United Kingdom (15) and Finland (17).

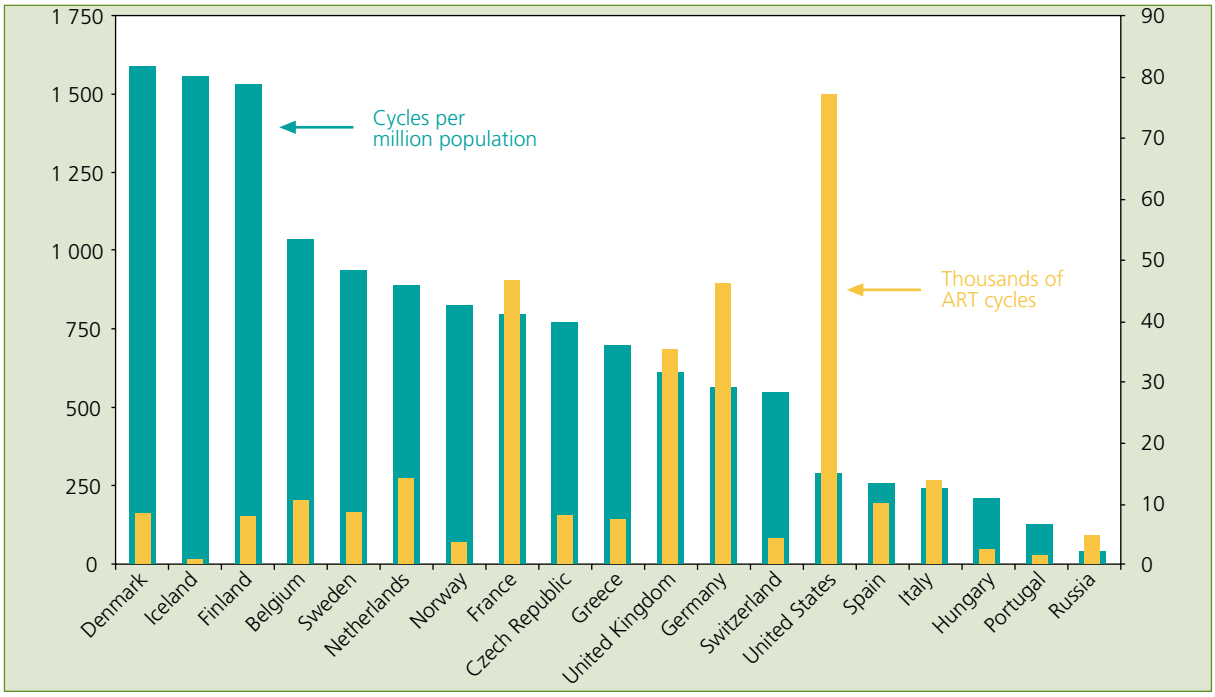
In **OECD 'Health data 2002',** figures correspond to the number of patients undergoing dialysis treatment including hospital/centre and home haemodialysis/haemoinfiltration, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis (CAPD), and continuous cyclical peritoneal dialysis (CCPD) on 31 December of each year.

6.3.6 Assisted reproductive technology

Assisted reproduction technologies (ART) is a common name for the set of various existing methods to join sperms and eggs in order to help infertile couples to conceive children. The most common method to date has been *in vitro* fertilisation (IVF), but other methods exist such as the gamete intrafallopian transfer (GIFT) and the zygote intrafallopian transfer (ZIFT). Until recently, IVF was applied almost exclusively to the reproductive problems of women, yet the introduction of ICSI (intracytoplasmic sperm injection) has made IVF available for the treatment of even severe male infertility.

The results of the third European report on ART in Europe (ref. ART), conducted by the **ESRHE (European Society for Human Reproduction and Embryology)**, contains data from 1999 to 2000 and cover all west European countries, with the exception of Austria (which is due to join soon) and Luxembourg (which has no ART clinics for the moment). In the three years since 1997, the numbers of treatment cycles have increased by 24 %, from 203 225 to 249 624. Three countries, Germany, France and UK, account for nearly half of all those cycles. Denmark still tops the league table for availability of ART treatment; there were 1 659 treatment cycles per million inhabitants in 1999, 1 407 in Finland, 1 383 in Iceland (where there is only one clinic), 973 in Sweden, 915 in the Netherlands, and 882 in France. By comparison, in the United States there are approximately 250 cycles per million **(6.3.7)**. IVF (with and without ICSI) accounts for approximately 96 % of these procedures. The success rate across Europe was fairly constant, with an average of 22 % of treatment cycles resulting in a live birth. The proportion of all children born who were conceived by assisted reproduction varied from 3.45 % of total births in Iceland to 0.35 % in Portugal.

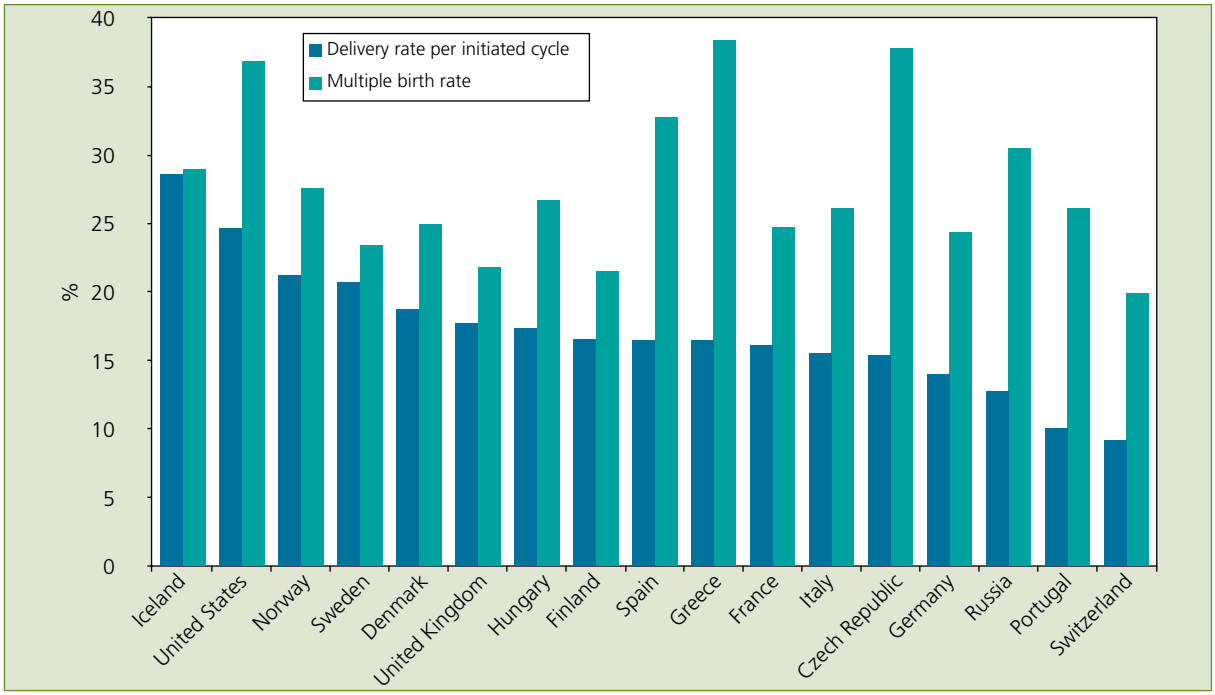
6.3.7 Assisted reproduction technologies (ART) per million population



Source: Kat, P. (2002), 'The economic impact of the assisted reproductive technologies', *Nature Medicine* 8 (S1), S29-S32.

Multiple births may occur after IVF treatment, when more than one embryo is transferred to increase the likelihood of pregnancy. Three or more embryos were transferred in 51 % of European cycles, and four or more were transferred in only 9 % of cycles, although in practice there is wide variation. In 1998, the percentage of IVF births that were multiples was higher in the United States than in Europe **(6.3.8)**: 26 % of the IVF births in Europe were multiples (24 % twins, 2 % triplets or more). Multiple births generate higher costs than singleton births, as a result of the higher incidence of antenatal, obstetrical and neonatal complications associated with the pre-term labour and delivery of low birth-weight premature infants.

6.3.8 ART delivery rate and multiple birth rate (% of total births)



Source: Kat, P. (2002), 'The economic impact of the assisted reproductive technologies', *Nature Medicine* 8 (S1), S29-S32.

The results of the European ART monitoring programme initiated by the **ESRHE (European Society for Human Reproduction and Embryology)** are generated from national registries and individual collections of data encompassing 494 clinics in 18 countries. Because ART consists of several steps over an interval of approximately two weeks, an ART procedure is more appropriately considered a **cycle** of treatment rather than a procedure at a single point in time. The start of an ART cycle is considered to be when a woman begins taking drugs to stimulate egg production or starts ovarian monitoring with the intent of having embryos transferred.

References:

Australian Institute of Health and Welfare (2001), *Australian hospital statistics 1999–2000*.

MedlinePlus, http://www.nlm.nih.gov/medlineplus/ency/article/003421.htm.

Nomesco (Nordic Medico-Statistical Committee) (2001), *Nomesco classification of surgical procedures*.

ONT (Organización Nacional de Transplantes), Ministerio de Sanidad y Consumo, Spain, http://www.msc.es/ont/esp/estadisticas/f_estadisticas.htm.

Thomas, J. and Paranjothy, S. (2001), *The National Sentinel caesarean section audit report*, Royal College of Obstetricians and Gynaecologists' Clinical Effectiveness Support Unit, London, RCOG press.

ART in Europe, 1999 — Third ESHRE report, by Dr Karl Nygren and Dr Anders Nyboe Andersen, European Society for Human Reproduction and Embryology, 2002.

6.4. Economic dimensions of health care — Production value, health expenditure, costs and financing

From an economic point of view, a health care system can be defined as a subset of the economic system that includes all economic units involved in the production, consumption and distribution of health care. However, in most countries health care production, consumption and distribution are not organised in a single way or according to the same sets of resource allocation principles and mechanisms for the whole population. While part of the population consumes health care according to free-market criteria, some groups may have access to care under a given set of governmental regulations which include a mix of insurance, subsidiarity, monopsony and other market interventions. A general characteristic of health care consumption is the presence of financial intermediates or third-party payers. Health care is sometimes the object of voluntary insurance, but in most countries a large proportion of the population is covered by a so-called social or mandatory insurance, where membership or entitlement is not the result of consumer decision but legally enforced. In any event, the consumer seldom pays for health care directly to the provider.

Most countries have more than one organisational structure for delivery of health care and for its remuneration. Hence, one has to consider the sum of a country's health care systems and its subsystems, each of them following its own resource allocation criteria and working independently of each other (ref. Rovira et al. 1998). To help interpret the basic empirical information on health systems, Eurostat proposes an understanding of the underlying structures considered necessary, such as reimbursements, benefits, cost sharing, planning, public versus private insurance, financing methods, legal systems, etc. A few aspects are highlighted here. Health systems may be categorised according to one of three basic models: (a) national health service (Beveridge) model, characterised by universal cover, tax financing, and public providers; (b) social insurance (Bismarck) model, characterised by compulsory universal coverage (generally within the framework of social security), financed by employer and individual contributions through non-profit insurance funds and public and/or private providers; and (c) private insurance model, characterised by employer-based or individual purchase of private health insurance coverage financed by individual and/or employer contributions, and private providers.

The prototype example of the third model is the United States. In all Member States of the EU, however, people are covered by public institutions against (most of) the costs of their treatment in case of illness. Nine Member States (Denmark, Greece, Spain, Ireland, Italy, Portugal, Finland, Sweden, the United Kingdom) cover their entire population by means of a national health service. The south European countries (Greece, Spain, Italy, Portugal) have adopted this type of universal cover over the last 20 years. National health systems involve the direct provision of services by the State, and access to the majority of health services is generally free for the whole population. Health care is financed mainly out of taxation, which can include both direct taxes (such as income tax) and indirect taxes (such as VAT). In Greece, Spain and Italy, however, financing is mixed — in other words, based on both taxation and sickness insurance contributions. In Ireland, the main source of finance is taxation, but, in contrast to the United

Kingdom, many hospitals are in private hands. Only persons with low incomes are covered for primary care in Ireland; those not covered have to pay for care received privately and a modest amount per day for hospital care received publicly.

In Greece, the universal right to health care consists of access to public hospitals, including their outpatient departments. In the six other Member States (Belgium, Denmark, France, Luxembourg, the Netherlands, Austria), medical cover is through social insurance. Social insurance covers almost the entire population, except in the Netherlands and Germany. In the Netherlands, almost the entire population is insured against the risk of serious or long-term illness. At present, around 70 % of the population have compulsory coverage against the risks of acute illnesses, while the remaining 30 % — persons with income over a certain level and self-employed persons — have (voluntary) private insurance. In Germany, 92.5 % of the population are covered by social insurance against the risk of sickness (85 % of these on a compulsory basis and 15 % on a voluntary basis), and the remainder (mainly civil servants, self-employed persons and the high-income group) are covered by private sickness insurance schemes. In Belgium, the self-employed and employers are covered only for heavy risks — inpatient care — and for certain diseases, such as cancer and tuberculosis.

In all Member States, private insurance also plays a role, albeit a varied one. In some countries (e.g. the Netherlands), voluntary private insurance fills most of the gaps left by statutory insurance. In others (e.g. Austria), private insurance also provides supplementary cover to persons who already have comprehensive public cover. In yet other countries (e.g. France), private insurance provides cover against public sector co-payments *(ticket modérateur)* levied on prescription medicines, consultations with a doctor, etc. In Ireland, private insurance serves all three functions. Hospital beds are over 90 % publicly owned in Denmark, Finland, Sweden and the United Kingdom, between 80 and 90 % publicly owned in Italy and Portugal, and the majority are publicly owned in Greece, Spain, France and Italy. About half are publicly owned in Germany and Austria. In Belgium, Luxembourg and the Netherlands, most acute-care hospitals are private. In Belgium, Germany, France and Luxembourg, patients can go directly to a specialist. In the other Member States, access is normally by referral from a general practitioner (gatekeeper mechanism).

Funding mechanisms include taxation, social insurance contributions, private insurance premiums, savings, out-of-pocket payments and loans, grants and donations. These can be direct (on individuals or businesses) or indirect (on transactions or commodities). Social health insurance contributions are usually related to income, and shared between employees and employers. Contributions on behalf of elderly, unemployed or disabled people may be collected from pension or sickness funds. Private health insurance premiums are paid by an individual, shared between employees and employers, or paid wholly by the employer. They may also be subsidised by government, using tax credits or tax relief (ref. Mossialos and Dixon 2001).

6.4.1. Health care production value in the System of National Accounts

Health care is an important economic sector. Its share in gross domestic product is substantial and can be expected to grow further in the near future. It is not simple to provide meaningful economic data on this sector, because of its special characteristics — a substantial share of the demand is steered by government and often prices are administered.

The subsequent tables present all the information available with respect to the economic dimensions of health care. The information on gross value ,health and social work sector. It can be linked to the employment data provided in Table **6.1.1**, which refer to the same economic sector. The data are taken from the **System of National Accounts** and have to be understood in their proper context. Unfortunately, the sector refers not only to health but also to social care. The collection of data using the System of National Accounts has been implemented following the statistical classification of economic activities in the European Union, namely NACE Rev. 1. This classification includes Section N: 'Health and social work'.

Gross value added per capita in the health and social care sector increased substantially over the last 30 years, in the United Kingdom by a factor of 24, and in Denmark, Italy and Germany by factors of 14, 14 and 11, respectively. From 1980 to 2000, gross value added in all countries (where data are available) increased between 320 and 450 %.

National accounts in the EU are based on the **European system of integrated economic accounts (ESA)**. The ESA framework consists of two main sets of tables: (a) the sector accounts; and (b)

the input–output framework and the accounts by industry. The sector accounts provide, by institutional sector, a systematic description of the different stages of the economic process: production, generation of income, distribution of income, use of income and financial and non-financial accumulation. The sector accounts also include balance sheets to describe the stocks of assets, liabilities and net worth at the beginning and at the end of the accounting period. **Eurostat** produces figures for the final consumption of households, representing the value of goods and services used for the direct satisfaction of individual human needs. The flow contains the final consumption of resident households and non-resident households on the economic territory. It is valued at purchasers' prices for products bought on the market and at basic prices for own consumption and for products received by employees from their employers as remuneration in kind. This does not apply to social transfers in kind, such as expenditure initially incurred by households but subsequently reimbursed by social security (e.g. some medical expenses).

NACE Rev. 1 is the statistical classification of economic activities in the European Union. Section N covers: hospital services (inpatient treatments (including surgical services, medical services, gynaecological and obstetric services, rehabilitation services, etc.); medical practice services (outpatient treatments (including services by general practitioners and by medical and surgical services)); dental practice services; other human health services (including services provided by midwives, nurses, physiotherapists, etc., ambulance services and medical laboratories); social work services with accommodation (including welfare services to old and disabled persons delivered through institutions etc.); and social work services without accommodation.

6.4.2. Health expenditure: the OECD approach

Information on health expenditure has been collected separately to overcome some of the known shortcomings associated with health in the framework of national accounts. In the last 30 years, the **OECD** has acted as the main institution providing data for different countries. The data presented in Tables **6.4.2** to **6.4.11** are still based on a traditional OECD data collection approach, and thus do not yet take account of the new methodological framework of the **System of Health Accounts** (see Section 6.4.4). Substantial resources and time will be required in all Member States before time series data are available, based on the new concept.

According to **OECD 'Health data 2002'**, from 1970 to 2000 total health expenditure (THE) in all Member States and EEA countries increased substantially. From 1980 to 2000, a period for which most countries are able to provide data, per capita expenditures increased by a factor ranging from 2.5 (the Netherlands) to 22 (Portugal and Spain). The economic importance of THE can also be deduced from the percentage share of THE in GDP; this indicates the proportion of total economic resources in the society directed towards health. In 1998, the last year for which all countries provided data, this proportion ranged from 5.8 to 10.2 % of GDP. Public health expenditure has increased in a similar way to total health expenditure. Its percentage share of GDP is only slightly lower than the corresponding share of THE in GDP; in 1998, proportions of the former ranged from 4.7 to 7.8 %.

All forms of health expenditure presented in Tables **6.4.4** to **6.4.9** show a substantial increase over recent decades. There is substantial variation between countries in the various subcategories, however. Expenditure on medical goods dispensed to outpatients per capita varied between EUR 240 and EUR 450 in 1998, equivalent to 1.0 and 2.0 % of GDP.

According to **OECD 'Health data 2002',** total health expenditure is the most comprehensive concept used for describing the final demand of health care goods and services. Total health expenditure encompasses expenditure on personal and collective health care (i.e. expenditure which can and cannot be attributed to individual patients) and expenditure on preventive care, as well as on health administration and some other health-related functions. Public health expenditure refers to that part of total health expenditure which is financed through public bodies — the government budget or social security payments. Public health expenditure refers to all categories of total health expenditure, to a varying degree. Expenditure on personal and collective health care (i.e. expenditure which can and cannot be attributed to individual patients) is more often the subject of private (co-)financing than expenditure on preventive care or on health administration and some other health-related functions. Personal health expenditure refers to health expenditure which can be directly attributed to patients — irrespective of whether financed by government, social security institutions or private payments. Personal health expenditure can be broken down further by the type of care provided, for example inpatient care, outpatient care, home care or medical goods dispersed to outpatients. Personal health expenditure may be financed either by public funds or by private co-payments; the determination of the respective shares is subject to political debate in many countries.

6.4.3. Pharmaceutical expenditure

In spite of price differentials, pharmaceutical expenditure tends to be a relatively heavier burden for health care systems in countries with lower GDP

per capita. Hence, its share of GDP is highest in countries such as Portugal or Greece. On the other hand, the share is relatively lower in countries such as Denmark, Norway, Luxembourg, Switzerland and the Netherlands. Ireland is a special case due to rapid economic development. Italy is the only major country where strong fiscal consolidation during the 1990s had an impact on the share of pharmaceuticals in GDP. France, Japan, Spain and Belgium tend to spend relatively more. The increase in consumption has also been extremely rapid in Portugal. Even in countries with relatively moderate health expenditure growth, such as the United Kingdom or the Netherlands, the growth of the share of pharmaceuticals in GDP has been significant (ref. Jacobzone 2000).

Based on **OECD 'Health data 2002'**, figures in Table **6.4.10** show the rising economic importance of pharmaceutical expenditure in all countries. Data on therapeutical appliances **(6.4.11)** are not yet available for many countries, and the existing data may lack good comparability (Belgium and France show the extremes). Highest pharmaceutical expenditures per capita are recorded in France, Italy and Germany; lowest values occur in Spain and Ireland (all data from 1998). Pharmaceuticals represent roughly 15 % of total health expenditure in OECD countries. This percentage declined slightly between 1970 and 1980, but rose significantly between 1990 and 1996. As for GDP, this share is higher in countries with relatively smaller levels of GDP per capita. The share of pharmaceuticals is lowest in Switzerland and highest in Greece and Portugal. Norway, Denmark and Ireland are also notable for relatively low levels. This share has decreased significantly in a number of countries since 1970 (Belgium, France, Greece, Ireland, Luxembourg). It has also declined in Germany. In terms of the share of public health expenditure, pharmaceutical spending only represents a tenth of the total. Compared with the share of pharmaceuticals in general health expenditure, the lower share of public expenditure in total public expenditure on health reflects the fact that co-payment levels are usually higher for pharmaceuticals than for hospitals.

According to **OECD 'Health data 2002'**, total expenditure on medical goods is broken down further into pharmaceuticals and other medical non-durables, and therapeutic appliances and other medical durables. The first category includes medical preparations, branded and generic medicines, drugs, patent medicines, serums and vaccines, vitamins, minerals and contraceptives, while the second takes in glasses, hearing aids, and also orthopaedic appliances and other prosthetics, and medico-technical devices, including wheelchairs.

6.4.4. The System of Health Accounts

The demand for these data has increased substantially over recent years; at the same time, there has also been a growing concern about the lack of comparability embedded in the data collection. This has led to a joint effort of the OECD and Eurostat, together with Member States, to improve the comparability of data by agreeing on common borderlines and breakdown categories: the result is the OECD manual **'A System of Health Accounts (SHA)'**. Most Member States have already begun to implement the SHA concept in their national health expenditure surveys.

National health accounts usually take the form of two-dimensional tables cross-classifying expenditure by health care providers/programmes, and by sources of funding. Country-specific mixtures of institutional and functional criteria are currently used to classify health care providers. The resulting items (such as 'general hospital', 'maternity clinic' and 'family doctor') have different contexts across countries, and result in overall boundaries of health spending which differ between countries and change over time. Over two decades of experience with international comparisons and health policy analysis on a national level suggest that a separation of institutional and functional aspects of health care services into two separate dimensions of reporting is essential to health accounting for international comparisons. This separation is also an indispensable tool to improve comparisons over time within national health accounts. This principle, only recently introduced into health accounting, has long been observed and applied in other data collection exercises for functionally defined fields of specific interest for public policy such as education, research and development, and social protection in general. The provision of health care and its funding is a complex, multidimensional process. The set of core tables in the **System of Health Accounts (SHA)** addresses three basic questions: (a) where does the money come from? (source of funding); (b) where does the money go to? (providers of health care services and goods); and (c) what kind of (functionally defined) services are performed and what types of goods are purchased?

Consequently, the SHA is organised around a triaxial system for the recording of health expenditure using a newly proposed International Classification for Health Accounts (ICHA), which defines: health care **by function** (ICHA-HC), health care **service provider industries** (ICHA-HP) and sources of **funding** health care (ICHA-HF). These proposed classifications provide basic links with non-monetary data such as employment and other resource statistics. Existing national and international classifications served as a starting point for the proposed classifications. The ICHA classification of health

care industries, for example, presents a refinement of the International Standard Industrial Classification (ISIC, Rev. 3) from the United Nations. Recently designed or revised classifications such as the Central Product Classification from the United Nations, and the 1998 revision of the SNA 93 functional classifications are referred to in the SHA manual to assist statisticians who move their national systems to these revised classifications so as to establish links with the ICHA. The choice of categories in the three dimensions of the ICHA was guided by their relevance for health policy and reform issues, in particular for monitoring structural changes, such as shifts from inpatient to outpatient care and the emergence and spread of multifunctional providers in national health care systems (ref. OECD 2000).

Eurostat currently sponsors various projects to support the efforts of Member States in implementing the SHA. **'Health account guidelines'**, a project coordinated by the **Office for National Statistics** (United Kingdom), is targeted at providing Member States with practical help and support when confronted with the implementation task. Analysis of the **'Health accounts prototype'**, a project coordinated by the **BASYS Institute**, will help Member States to overcome known difficulties of data compilation. **'Health accounts by age and gender'**, coordinated by the **Inspection générale de la securité sociale** (Luxembourg), will study the breakdowns used in the system. It is expected that good quality SHA data may be available for the majority of Member States by the end of 2005.

6.4.5. The boundaries of the health systems: Eucomp

To understand better the organisation of health care systems and differences in health care resources in Member States, the **Eucomp ('Towards comparable health care data in the European Union')** project was launched in 1999, within the framework of the EU Health Monitoring Programme. It was coordinated by the **North-Eastern Health Board** (Ireland) with the support of Eurostat and all Member States. The intention was to produce results capable of application in all Member States, with a template for data collection and a toolkit for comparisons. The design of the questionnaire was characterised first by the integration of the list of functions of health care from the Dutch CCP project and second by the functional classification established by the OECD within the framework of the development of a system of health accounts. Eucomp succeeded in providing such a functional breakdown of health care systems for most countries of the European Union, and for Iceland and Norway. Metadata have also been gathered as an interpretative framework for health care statistics in the future. The functional breakdown of health care systems makes it possible to show differences between them. A good knowledge of these differences is indispensable in order to be able to judge whether comparison is possible and, if so, to what degree. The starting point for the functional breakdown was the assumption: 'the package of functions (activities) in health care is stable, while the providers are different'. From this, a questionnaire was developed, based on a list of functions/activities and grouped according to the OECD classification of health care functions. Respondents were requested to indicate the functions of the actors known in their health care systems and to provide information on the modes of production in the terminology of the OECD, as far as applicable. A **Eucomp-2** project will complete some of the information, and will also incorporate EU candidate countries. It is expected that the results of the Eucomp-project will be provided on a public web site in the future.

6.4.6. Health care expenditure in the social protection schemes

Social protection encompasses all interventions from public or private bodies intended to relieve households and individuals of the burden of a defined set of risks or needs, provided that there is neither a simultaneous reciprocal nor an individual arrangement involved (ref. Esspros 2002a). The risks or needs that may require social protection are classified by convention under eight social protection functions (such as the sickness/health care function). For the EU in 1999, 41.0 % of social protection expenditure was used on old age. The share of sickness/health care was 26.7 %. Family policy, disability, survivors', social exclusion, and housing benefits accounted for 25 % on average. Of these functions, the proportion for unemployment expenditure varied most by Member State, due to the unemployment situation differing in each country. In recent years, the shares for old age and sickness/health care have increased in all Member States, while the expenditure on unemployment has decreased. The distribution of social protection expenditure is similar across the EU Member States.

The data on social protection expenditure and receipts for Member States of the EU are presented by **Eurostat** according to the **European system of integrated social protection statistics (Esspros)**. This harmonised system provides a means of analysing and comparing the relevant financial flows (ref. Esspros 2002b). Expenditure on social protection schemes is broken down into social benefits, administration costs, transfers to other schemes and other expenditure. Social benefits consist of transfers, in cash or in kind, by social protection schemes, to households or individuals to

relieve them of the burden of risks or needs. Social benefits are classified by function (such as the sickness/health care function), by whether or not they are subject to means testing (i.e. whether the beneficiary's income and/or wealth falls below a specified level), by type: cash benefits (periodic and lump sum), benefits in kind and re-routed social contributions (payments made by one social protection scheme to another in order to maintain or accrue the rights of persons covered by social protection under the latter scheme). Eurostat has undertaken many efforts to harmonise information on social expenditure in Europe. This includes all forms of social security, and the data on health care do not always receive the interest they deserve. This may be partly due to the 'abstract' categories used in data presentation.

The data in Table **6.4.12** show the amount of social protection expenditure for sickness/health care from 1990 to 1999. Values vary between EUR 677 per capita in Greece and EUR 2 240 per capita in Luxembourg, with an EU-15 average of slightly below EUR 1 500 (all data refer to 1999). From 1990 to 1999, expenditure more than doubled in some countries (Portugal, Ireland), while in others the amounts actually decreased — with some fluctuations (Italy, Finland). The percentage share of social protection expenditure in GDP differs from the percentage share of public health expenditure **(6.4.5)** due to the differing definitions applied. In most countries which provide data for both concepts, Esspros expenditure is higher than public health expenditure, both expressed as a percentage of GDP. The exceptions are Denmark and Germany (all data for 1998).

Data in Tables **6.4.13** and **6.4.14** show the relative importance of cash benefits and benefits in kind. For all countries, benefits in kind make up more of the social protection expenditure than cash benefits. In 1999, the relation was roughly 6:1 for EU-15. There seems to be no obvious trend of an increase or decrease in either type of expenditure, but percentages of GDP fluctuate for both concepts in the majority of countries. The more detailed structure of expenditure **(6.4.15)** replicates the variation across countries described above. The types of expenditure do not differ greatly across countries; the amount per capita and the percentage share of total expenditure vary substantially, however.

The sickness/health care function in **Esspros (European system of integrated social protection Statistics)** collected by Eurostat includes: **cash benefits** (limited because most are included in other social protection functions) that replace the whole or part loss of earnings during temporary inability to work due to sickness or injury, and **medical care** provided in the framework of social protection to maintain, restore or improve the health of persons protected. Medical care covers services (medical and paramedical services provided by general practitioners, specialists and other personnel; laboratory tests and other examinations; dental care; physiotherapy; thermal cures; transport of sick people; preventive treatment such as vaccinations; accommodation in the case of a stay in hospital or other institution) and goods (pharmaceutical products; medical prostheses; dressings and medical supplies). Data from Esspros describe the health sector from a different, but harmonised, perspective. Social protection expenditure is classified with respect to the type of remuneration (cash benefits or benefits in kind), and with respect to eligibility (means-tested and non-means-tested expenditure). Table **6.4.12** provides total Esspros expenditure for sickness/health care, while Tables **6.4.13** and **6.4.14** refer to cash benefits and benefits in kind, respectively. The former type of payment describes cash payments to the household, whereas the latter refers to the provision of goods and services, rather than cash. Table **6.4.15** gives an overview for all categories of Esspros social protection payments in a systematic manner. Data given here refer to 1999.

6.4.7. Final consumption expenditure of private households on health in the System of National Accounts

Table **6.4.16** presents **System of National Accounts (SNA)** data for the final demand of private households for goods and services associated with health. All values are in euro per capita; the amounts increase at different rates over time, but the variation across countries is less prominent than in other categories of health expenditure.

In recent years, there has been growing political debate in many countries concerning privately financed health expenditure. Such expenditure may occur as co-payments or as out-of-pocket purchases, covered either by some form of private insurance or left at the risk of the individual household. Statistical institutions have increased their efforts to shed more light on this particular subject. Two different methods have been used: (1) in the framework of national accounts, private demand is broken down by types of goods and services paid for by households; and (2) in household budget surveys, individual households specify the amount of their budget spent on well-defined categories of goods and services. Although the SNA data from (1) often use household budget data from (2), the results differ.

6.4.8. Final consumption expenditure of private households on health in Household Budget Surveys

The **Household Budget Survey (HBS)** data in Table **6.4.17** refer to three years only and are not directly comparable to SNA data in Table **6.4.16** because they are expressed in PPS rather than euro. Nonetheless, they support the observation that private expenditure on health has increased dramatically in some countries (Italy and Belgium on health overall, Greece on outpatient services). There is no general trend, however. The amounts spent under different headings have developed differently over time and across countries.

The level of health expenditure for a particular country in the HBS depends heavily on the way the health care system is organised in that country, thereby affecting good comparability. HBS health expenditure is higher in countries with a reimbursement system, where recording is on the basis of **gross** expenditure (Belgium (partially) and France). If the HBS records high expenditure in 'direct provision' countries, this is most probably due to significant private expenditure in these countries. This is particularly true for Greece, Portugal and Italy. Specific features worth noting for these countries are: for **Greece**, the extensive involvement of the private sector dominated by a large shadow economy, in which people pay private or hospital doctors directly without being insured; for **Portugal**, the fairly extensive co-payment system; and for **Italy**, the high private pharmaceutical expenditure, due to the large number of medicines not covered by the public health scheme. Although less significant than for Portugal and Italy, private household expenditure in the HBS for Germany and Luxembourg is important considering the extensive cost-sharing arrangements (Germany) or the high non-reimbursable out-of-pocket payments (Luxembourg). Low household expenditures are reported in the United Kingdom, Sweden and Denmark, with health care systems based on direct provision and very small private sectors (ref. Bierings and Haponiuk 2001).

In each country, the health insurance system has a statutory part (the 'public' scheme) and a voluntary part (the 'private' scheme), each with its own peculiarities. The statutory health insurance scheme is financed almost entirely through taxation and social contributions, and the greater part of the population in each country is covered by it. With some small deviations between countries, almost 80 % of total expenditure on health may be attributed to the 'public' part or government units. Note that taxes and (social) insurance premiums are not considered as consumption. The main source of **incomparability of HBS health expenditures** between countries occurs because financing in one country may be through social insurance contributions and in another country through taxation. Under one regime, based on reimbursements, people pay social insurance premiums, and when, for instance, they go to a hospital or physician, they normally pay the medical bill and are then reimbursed by government units. Under another regime, based on direct provision, people pay indirectly through taxes, and health care goods and services are in general provided directly in the form of social transfers in kind.

6.4.9. Research and development on human health

Research and development (R & D) health programmes include R & D on food hygiene and nutrition, radiation used for medical purposes, biochemical engineering, and pharmacology, as well as research into epidemiology, prevention of occupational diseases, and drug addiction. According to Eurostat data, the increase in human health R & D appropriations varies significantly between Member States **(6.4.18)**. Research and development into the protection and improvement of human health, expressed as a proportion of all government spending on R & D, has increased in the EU since the 1980s. By 1997, the EU figure was 5.9 % **(6.4.18)**, but cross-country comparisons are difficult.

According to **Eurostat**, government budget appropriations or outlays on research and development mean all appropriations by central government allocated to R & D in central government budgets. Data on government R & D appropriations, therefore, refer to budget **provisions**, not to **actual expenditure**. The figures for actual expenditure, which are not available in their final form until some time after the end of the budget year concerned, may well differ from the original budget provisions. Government R & D appropriations are broken down by socioeconomic objectives derived from the nomenclature for the analysis and comparison of scientific programmes and budgets (NABS), developed by the European Commission.

References

Bierings, H. and Haponiuk, M. (2001), *Improving the comparability of health and education expenditures in the household budget surveys of the EU for some selected household types*, Eurostat.

Espross (2002a), *The social situation in the European Union 2002*, Directorate-General for Employment and Social Affairs and Eurostat.

Espross (2002b), *European social statistics: Social protection — Expenditure and receipts 1980–99*, Eurostat.

Jacobzone, S. (2000), *Pharmaceutical policies in OECD countries: Reconciling social and industrial goals*, OECD.

Mossialos, E. and Dixon, A. (2001), 'Funding health care: An introduction', *Funding health care: Options for Europe,* WHO.

OECD (2000), *A system of health accounts*, OECD, Paris.

Rovira, J. and Schneider, M. et al. (1998), 'Comparing cost-sharing in European Union Member States: A system-oriented framework*', Health care and its financing in the single European market*, Amsterdam.

6.1.1 People employed in health and social work

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1993	:	377	427	2 224	155	570	2 071	88	1 115	10
1994	:	389	396	2 284	161	582	2 156	99	1 140	10
1995	13 338	381	433	3 070	163	607	2 237	101	1 122	11
1996	13 785	400	440	3 277	171	669	2 279	109	1 122	12
1997	14 063	416	446	3 280	170	708	2 324	117	1 153	12
1998	14 411	417	456	3 389	185	716	2 355	114	1 291	12
1999	14 842	451	473	3 543	186	731	2 392	120	1 299	14
2000	15 089	490	472	3 606	184	815	2 414	132	1 277	15
Thereof										
200 Professionals	3 251	202	38	586	57	329	260	53	303	2
222 Health professionals	1 458	44	20	363	51	143	205	11	248	2
223 Nursing/midwifery professionals	963	112	8		1	140		38		0
244 Social science and related professionals	504	37	3	173	1	26	22	2	5	0
299 Other	327	10	7	50	4	21	32	2	50	0
300 Technicians and associate professionals	4 740	84	160	1 588	52	85	757	16	576	5
322 Health associate professionals	837	37	20	187	7	47	93	6	125	1
323 Nursing/midwifery associate professionals	2 088	5	48	762	34		375	2	331	3
346 Social work associate professionals	706		5	312	2	7	69	4	36	0
399 Other	1 110	41	87	327	9	31	220	5	84	2
400 Clerks	1 195	39	24	183	20	61	250	13	114	1
411 Secretaries	398	16	13	52	8	15	96	4	50	1
419 Office clerks	302	18	4	84	10	32	19	4	11	0
499 Other	495	5	6	46	2	14	135	4	53	0
500 Service workers	4 164	84	200	848	32	244	906	31	194	3
512 Housekeeping and restaurant service	389	14	5	148	6	23	51	4		1
513 Personal care and related service	3 716	70	195	679	25	219	850	26	180	2
599 Other	59	0	0	21	1	1	5	1	14	0
Notably: Health professionals outside sector N										
000 Altogether	893	35	12	204	15	88	212	5	60	2
222 Health professionals	348	14	5	84	12	43	84	2	32	1
223 Nursing/midwifery professionals	58	7	0			13		1		
322 Health associate professionals	417	15	7	107	2	33	96	2	22	1
323 Nursing/midwifery associate professionals	70	0	0	13	1		32		6	0

Source: Eurostat, NewCronos database (Labour Force Survey).

(1 000)

NL	A	P	FIN	S	UK	IS	NO	CH	
884	:	198	:	:	2 607	:	:	:	**1993**
906	:	199	:	:	2 662	:	:	:	**1994**
916	270	196	291	813	2 729	21	356		**1995**
917	277	201	287	802	2 824	20	376	375	**1996**
968	282	207	308	768	2 904	21	381	399	**1997**
987	291	198	305	756	2 938	21	383	410	**1998**
1 009	293	226	327	786	2 989	21	396	428	**1999**
1 064	293	248	327	763	2 989	21	402	445	**2000**
									Thereof
219	38	62	126	105	869	4	37	76	200 Professionals
53	32	53	23	32	176	2	11	37	222 Health professionals
58			67	39	501	2	19	-	223 Nursing/midwifery professionals
73	3	5	22	21	109	0	2	23	244 Social science and related professionals
35	3	4	14	13	83	1	5	18	299 Other
407	142	31	95	176	566	5	107	194	300 Technicians and associate professionals
86	24	8	11	21	165	0	13	65	322 Health associate professionals
196	84	0	72	56	121	2	54	95	323 Nursing/midwifery associate professionals
46	22		5	17	180	0	16	3	346 Social work associate professionals
79	12	23	7	82	100	3	24	32	399 Other
68	12	29	18	30	334	1	14	26	400 Clerks
17	8	4	7	16	91	0	11	11	411 Secretaries
15	3	0	3	6	94	0	-	8	419 Office clerks
36	2	25	8	8	149	0	3	7	499 Other
221	55	84	62	404	796	9	200	97	500 Service workers
24	9	11	5	12	74	1	4	24	512 Housekeeping and restaurant service
195	46	70	57	389	714	8	191	69	513 Personal care and related service
2	0	3	1	3	8	0	4	4	599 Other
									Notably: Health professionals outside sector N
48	14	9	23	30	136	:	:	:	000 Altogether
9	7	5	9	6	36	:	:	:	222 Health professionals
2			3	5	28	:	:	:	223 Nursing/midwifery professionals
32	6	4	9	15	67	:	:	:	322 Health associate professionals
5	1		1	4	6	:	:	:	323 Nursing/midwifery associate professionals

6.1.2 Percentage of employment in the health and social work sector over total employment

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1993	:	10.1	16.6	6.2	4.2	4.8	9.5	7.6	5.5	6.0
1994	:	10.4	15.6	6.4	4.3	5.0	9.9	8.2	5.7	6.1
1995	9.0	10.0	16.6	8.6	4.3	5.0	10.1	8.0	5.6	6.6
1996	9.2	10.5	16.8	9.2	4.4	5.4	10.3	8.3	5.6	7.2
1997	9.4	10.8	16.7	9.3	4.4	5.6	10.5	8.6	5.8	7.3
1998	9.5	10.8	17.0	9.5	4.7	5.4	10.5	7.6	6.3	7.2
1999	9.5	11.3	17.5	9.8	4.7	5.3	10.5	7.5	6.3	8.1
2000	9.5	11.9	17.4	9.9	4.7	5.3	10.4	8.0	6.1	8.1
Thereof employment by profession in % of total employment in the health and social work sector										
200 Professionals	***24.7***	***52.7***	***10.1***	***18.7***	***36.2***	***44.2***	***13.4***	***50.0***	***27.9***	***23.8***
222 Health professionals	*11.6*	*12.8*	*5.9*	*11.7*	*33.1*	*18.6*	*10.9*	*8.6*	*22.7*	*19.1*
223 Nursing/midwifery professionals	*7.2*	*28.7*	*2.1*	*0.0*	*0.4*	*20.0*	*0.0*	*35.5*	*0.0*	*0.8*
244 Social science and related professionals	*3.5*	*8.7*	*1.1*	*5.2*	*0.9*	*3.2*	*1.0*	*2.4*	*0.4*	*2.0*
299 Other	*2.4*	*2.5*	*1.0*	*1.8*	*1.8*	*2.4*	*1.5*	*3.5*	*4.8*	*1.9*
300 Technicians and associate professionals	***34.9***	***16.9***	***37.5***	***49.0***	***29.3***	***11.2***	***34.6***	***13.3***	***46.4***	***43.9***
322 Health associate professionals	*5.8*	*8.5*	*5.9*	*5.5*	*5.2*	*5.9*	*4.3*	*4.3*	*8.1*	*5.1*
323 Nursing/midwifery associate professionals	*16.1*	*1.0*	*11.2*	*24.5*	*18.2*	*0.0*	*17.6*	*1.5*	*29.0*	*24.4*
346 Social work associate professionals	*5.0*	*0.0*	*1.1*	*9.0*	*0.7*	*1.0*	*2.5*	*3.4*	*2.7*	*1.1*
399 Other	*8.1*	*7.5*	*19.3*	*10.0*	*5.1*	*4.3*	*10.2*	*4.1*	*6.6*	*13.3*
400 Clerks	***9.2***	***11.1***	***5.8***	***5.9***	***11.5***	***8.1***	***11.0***	***11.8***	***9.9***	***14.9***
411 Secretaries	*3.2*	*3.8*	*3.6*	*1.8*	*5.1*	*2.2*	*4.1*	*4.3*	*4.9*	*6.0*
419 Office clerks	*6.1*	*7.3*	*2.2*	*4.1*	*6.5*	*6.0*	*6.9*	*7.4*	*5.0*	*8.8*
499 Other	***31.2***	***19.3***	***46.6***	***26.4***	***23.0***	***36.4***	***41.1***	***24.9***	***15.9***	***17.4***
500 Service workers	*3.0*	*4.7*	*2.4*	*4.8*	*5.5*	*4.0*	*2.1*	*3.9*	*0.0*	*6.5*
512 Housekeeping and restaurant service	*27.8*	*14.3*	*44.1*	*21.0*	*17.3*	*32.2*	*38.8*	*20.6*	*15.2*	*10.4*
513 Personal care and related service	*0.4*	*0.3*	*0.1*	*0.6*	*0.1*	*0.2*	*0.1*	*0.4*	*0.7*	*0.6*
599 Other										
Notably: Health professionals outside sector N	***19.3***	***34.8***	***7.6***	***13.4***	***29.9***	***38.7***	***13.8***	***38.2***	***21.7***	***19.6***
000 Altogether	*9.7*	*9.0*	*4.3*	*10.1*	*27.9*	*17.5*	*8.5*	*8.1*	*19.4*	*13.6*
222 Health professionals	*6.4*	*22.8*	*1.7*		*0.5*	*17.2*		*28.7*		*0.9*
223 Nursing/midwifery professionals	*2.8*	*3.0*	*1.5*	*3.0*	*0.9*	*4.0*	*4.0*	*1.4*	*1.8*	*4.1*
322 Health associate professionals	*0.5*	*0.1*	*0.1*	*0.4*	*0.6*		*1.3*		*0.5*	*1.0*
323 Nursing/midwifery associate professionals										

Source: Eurostat, NewCronos database (Labour Force Survey).

(%)

NL	A	P	FIN	S	UK	IS	NO	CH	
13.3	:	4.4	:	:	10.2	:	:	:	**1993**
13.5	:	4.5	:	:	10.4	:	:	:	**1994**
13.5	7.3	4.4	14.4	20.1	10.5	15.4	17.4	:	**1995**
13.2	7.7	4.5	13.9	20.1	10.8	14.5	17.8	9.9	**1996**
13.5	7.8	4.6	14.5	19.6	10.9	15.2	17.5	10.6	**1997**
13.3	8.0	4.2	14.0	19.2	10.9	14.2	17.1	10.7	**1998**
13.3	8.0	4.7	14.0	19.4	10.9	13.9	17.6	11.1	**1999**
14.4	8.0	5.1	13.9	18.5	10.8	13.4	17.7	11.5	**2000**
									Thereof employment by profession in % of total employment in the health and social work sector
25.0	***17.0***	***28.7***	***41.4***	***14.4***	***33.2***	:	:	:	200 Professionals
6.8	*15.3*	*25.4*	*6.9*	*5.3*	*7.3*	:	:	:	222 Health professionals
7.6	*0.0*	*0.0*	*21.7*	*4.9*	*19.2*	:	:	:	223 Nursing/midwifery professionals
6.8	*0.7*	*2.1*	*7.3*	*2.5*	*4.0*	:	:	:	244 Social science and related professionals
3.8	*1.0*	*1.2*	*5.5*	*1.7*	*2.7*	:	:	:	299 Other
44.0	***55.1***	***15.1***	***31.6***	***22.8***	***21.9***	:	:	:	300 Technicians and associate professionals
9.2	*9.7*	*4.5*	*3.3*	*3.3*	*5.4*	:	:	:	322 Health associate professionals
21.0	*33.4*	*0.0*	*24.6*	*6.8*	*5.5*	:	:	:	323 Nursing/midwifery associate professionals
4.8	*8.1*	*0.0*	*1.4*	*2.1*	*7.3*	:	:	:	346 Social work associate professionals
9.0	*3.8*	*10.6*	*2.3*	*10.6*	*3.8*	:	:	:	399 Other
7.5	***5.3***	***15.1***	***5.5***	***4.4***	***14.2***	:	:	:	400 Clerks
2.1	*3.0*	*2.6*	*1.9*	*2.4*	*3.9*	:	:	:	411 Secretaries
5.4	*2.3*	*12.5*	*3.6*	*2.0*	*10.3*	:	:	:	419 Office clerks
23.5	***22.7***	***41.0***	***21.5***	***58.4***	***30.7***	:	:	:	499 Other
2.4	*3.0*	*6.2*	*2.0*	*1.5*	*2.6*	:	:	:	500 Service workers
20.6	*19.6*	*31.8*	*19.2*	*56.6*	*27.8*	:	:	:	512 Housekeeping and restaurant service
0.5	*0.0*	*3.1*	*0.3*	*0.2*	*0.3*	:	:	:	513 Personal care and related service
						:	:	:	599 Other
13.9	***13.5***	***22.8***	***30.7***	***11.8***	***25.1***	:	:	:	*Notably: Health professionals outside sector N*
5.0	*11.0*	*21.3*	*7.2*	*4.2*	*5.9*	:	:	:	000 Altogether
5.5			*20.4*	*5.1*	*16.8*	:	:	:	222 Health professionals
3.0	*2.2*	*1.5*	*2.8*	*1.9*	*2.2*	:	:	:	223 Nursing/midwifery professionals
0.5	*0.2*		*0.4*	*0.5*	*0.2*	:	:	:	322 Health associate professionals
									323 Nursing/midwifery associate professionals

6.1.3 Number of practising physicians

	B	DK	D	EL	E	F	L	NL
1970	:	6 925	126 909	14 263	:	62 400	384	:
1980	22 759	11 143	173 325	23 469	:	104 073	621	:
1985	27 989	13 848	198 854	29 103	:	120 929	663	:
1990	32 547	15 104	237 750	34 336	:	148 089	766	:
1991	33 271	15 284	244 238	37 238	:	152 096	780	:
1992	34 069	15 667	251 877	38 738	:	155 896	814	:
1993	34 736	15 876	259 981	40 116	:	158 897	848	:
1994	35 486	15 886	267 186	40 487	:	160 235	870	:
1995	35 870	16 110	273 880	41 039	92 000	169 447	1 137	28 709
1996	36 644	16 253	279 335	41 511	106 400	171 758	1 189	29 568
1997	37 451	16 306	282 737	43 030	107 900	174 560	1 253	29 721
1998	38 109	16 603	287 032	44 753	106 300	175 431	1 299	29 520
1999	38 769	16 844	291 171	46 124	110 700	177 138	1 342	30 316
2000	39 519	:	294 676	47 521	119 400	:	1 373	:

Note: No data for IRL, I and FIN. Data for UK only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

6.1.4 Practising physicians per 100 000 inhabitants

	B	DK	D	EL	E	F	L	NL
1970	:	135	162	162	:	123	113	:
1980	231	218	222	245	:	194	171	:
1985	284	270	256	293	:	219	181	:
1990	327	293	301	339	:	262	202	:
1991	333	296	306	365	:	267	203	:
1992	340	302	314	376	:	272	209	:
1993	345	306	321	388	:	276	215	:
1994	351	305	328	389	:	277	217	:
1995	354	307	336	393	235	292	280	186
1996	361	308	341	397	271	295	288	191
1997	368	308	345	410	275	298	300	191
1998	374	312	350	426	270	299	307	189
1999	380	316	355	438	281	300	313	192
2000	386	:	359	:	303	:	315	:

Note: No data for IRL, I and FIN. Data for UK only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

A	P	S	UK	IS	LI	NO	CH	
10 153	:	10 560	51 098	291	15	5 361	5 508	**1970**
12 374	:	18 300	72 198	488	19	8 050	7 473	**1980**
14 215	24 674	:	78 550	626	22	9 176	9 299	**1985**
17 189	24 169	22 182	80 954	726	28	13 234	10 398	**1990**
17 889	24 280	23 154	81 306	734	29	10 955	10 781	**1991**
18 737	24 667	23 655	84 886	771	31	10 996	11 120	**1992**
19 491	24 499	23 861	87 721	779	32	11 302	11 563	**1993**
20 528	25 211	24 545	88 726	797	32	11 754	11 814	**1994**
21 363	25 491	24 587	92 299	809	32	12 146	12 327	**1995**
22 364	26 418	24 765	95 191	839	33	12 434	12 711	**1996**
23 318	26 384	24 600	98 827	884	41	11 121	13 038	**1997**
24 368	26 193	24 957	101 732	909	44	12 102	13 357	**1998**
24 223	:	25 428	104 417	938	:	12 464	13 622	**1999**
25 001	27 031	26 400	106 996	:	:	:	13 935	**2000**

A	P	S	UK	IS	LI	NO	CH	
136	:	132	92	143	72	139	89	**1970**
164	:	220	128	215	74	197	119	**1980**
188	247	:	139	260	82	221	144	**1985**
224	244	260	141	286	98	313	156	**1990**
230	246	270	141	287	100	258	160	**1991**
238	250	274	147	297	105	257	163	**1992**
245	248	275	151	297	107	263	167	**1993**
256	255	281	152	301	106	272	170	**1994**
266	257	279	158	303	104	279	176	**1995**
278	266	280	162	313	107	285	180	**1996**
289	266	278	168	328	132	253	184	**1997**
302	263	282	172	334	140	274	188	**1998**
300	:	287	176	340	:	280	191	**1999**
309	265	298	179	:	:	:	195	**2000**

6.1.5 Number of licensed physicians

	B	DK	D	E	IRL	I	L
1970	14 991	:	:	45 335	:	58 297	:
1980	24 536	:	:	86 253	:	148 101	:
1985	29 993	15 736	199 146	127 195	5 750	215 206	:
1990	34 275	17 285	287 170	148 717	5 450	266 447	:
1991	35 199	17 625	297 803	153 306	5 995	276 810	:
1992	36 178	17 962	307 994	156 100	7 096	285 111	:
1993	36 821	18 217	317 737	159 291	7 212	313 337	:
1994	37 792	18 491	326 760	162 089	7 129	319 502	:
1995	38 369	18 760	335 348	162 650	7 563	324 348	1 158
1996	38 690	19 061	343 556	165 560	7 622	327 254	1 210
1997	39 240	19 333	350 854	168 240	7 801	332 124	1 275
1998	40 291	19 647	357 727	171 494	8 102	335 786	1 321
1999	41 331	19 980	363 396	174 916	8 469	339 264	1 364
2000	42 036	:	369 319	179 033	9 439	345 718	1 394

Note: No data for EL, F and the UK.
Source: Eurostat, NewCronos database (Health and safety).

6.1.6 Licensed physicians per 100 000 inhabitants

	B	DK	D	E	IRL	I	L
1970	155	:	:	135	:	109	:
1980	249	:	:	232	:	263	:
1985	304	308	326	332	162	380	:
1990	345	337	363	383	155	470	:
1991	352	342	373	394	170	488	:
1992	361	348	384	401	200	502	:
1993	366	352	392	408	202	550	:
1994	374	356	402	414	199	559	:
1995	379	360	411	415	210	566	285
1996	381	363	420	422	211	571	293
1997	386	366	428	428	214	578	305
1998	395	371	436	436	219	583	312
1999	405	376	443	444	227	589	318
2000	411	:	449	454	250	599	320

Note: No data for EL, F and the UK.
Source: Eurostat, NewCronos database (Health and safety).

NL	A	P	FIN	S	NO	CH	
16 292	12 287	8 156	4 798	:	:	8 890	**1970**
26 987	16 938	19 332	9 004	:	:	15 865	**1980**
32 193	19 451	24 390	10 193	:	:	17 667	**1985**
37 461	23 238	28 016	12 091	:	:	20 030	**1990**
39 069	24 049	28 326	12 357	:	11 089	20 594	**1991**
:	25 268	28 604	12 929	:	11 383	20 706	**1992**
:	26 121	28 769	13 344	:	11 652	21 238	**1993**
:	27 170	29 031	13 700	:	12 076	21 788	**1994**
:	27 889	29 353	14 141	:	12 871	22 275	**1995**
:	28 530	29 902	14 579	:	13 351	22 718	**1996**
:	29 226	30 431	15 192	:	13 547	23 144	**1997**
46 101	30 110	31 087	15 436	34 458	:	23 679	**1998**
48 987	30 115	31 758	15 794	:	:	24 026	**1999**
50 856	31 059	32 498	15 905	:	:	25 216	**2000**

NL	A	P	FIN	S	NO	CH	
126	165	94	104	:	:	144	**1970**
192	224	199	189	:	:	252	**1980**
223	257	244	208	:	:	274	**1985**
252	302	282	243	:	:	300	**1990**
260	310	287	247	:	261	305	**1991**
:	321	290	257	:	266	303	**1992**
:	328	292	264	:	271	307	**1993**
:	339	293	270	:	279	313	**1994**
:	347	296	277	:	296	317	**1995**
:	354	301	285	:	306	322	**1996**
:	362	306	296	:	308	327	**1997**
294	373	312	300	389	:	334	**1998**
311	373	318	306	:	:	337	**1999**
321	:	325	308	:	:	352	**2000**

6.1.10 Number of medical specialists by speciality, most recent year

	B	DK	D	EL	E	F	L	NL
	2001	1999	2001	2001	1996	2001	2000	1999
Anaesthesiology and intensive care	1 609	735	17 533	1 420	2 805	10 099	60	1 089
General surgery	1 536	631	14 046	1 898	4 716	4 757	59	1 023
Infant surgery	:	:	140	155	278	74	0	:
Neurological surgery	133	:	1 160	241	398	343	4	109
Plastic surgery	168	:	210	223	468	238	4	176
Dermatology	631	164	6 029	770	1 124	3 855	20	396
Gynaecology and obstetrics	1 303	500	18 686	2 301	4 351	5 006	57	817
General practice	19 493	3 916	109 937	:	:	96 246	371	7 217
Internal medicine	2 190	1 054	45 497	:	4 242	2 423	102	1 707
Cardiology	797	188	2 787	2 274	1 904	5 609	33	662
Endocrinology	:	:	335	355	840	1 279	3	:
Gastroenterology	387	:	1 761	450	1 616	3 164	15	145
Respiratory medicine	313	89	1 175	922	873	2 522	16	388
Oncology	:	88	1 015	42	426	487	0	:
Rheumatology	246	181	672	219	548	2 582	13	163
Neurology	176	188	2 738	486	1 002	1 620	17	651
Psychiatry/Neuropsychiatry	1 924	733	9 356	1 224	2 603	13 291	51	2 246
Occupational medicine	768	:	3 592	28	1 017	4 736	8	1 102
Ophthalmology	1 001	312	8 108	1 512	2 349	5 280	45	627
Otorhinolaryngology	590	358	6 742	947	1 662	2 884	30	453
Paediatrics	1 413	316	15 141	2 736	7 019	6 263	52	996
Radiotherapy/Radiology	1 734	406	7 729	1 692	2 316	7 801	46	1 055
Urology	348	111	5 303	677	1 373	436	21	315

Note: No data for IRL and I. England: only those working in the NHS.
Source: Eurostat, NewCronos database (Health and safety).

A 2001	P 2000	FIN 2001	S 1998	ENGLAND 2001	IS 2000	NO 1998	CH 1999	
1 639	1 144	555	1 156	7 515	57	444	769	Anaesthesiology and intensive care
1 176	1 288	995	1 631	5 036	73	864	912	General surgery
16	96	50	:	285	3	:	49	Infant surgery
123	143	39	86	427	6	:	62	Neurological surgery
85	170	45	107	578	11	:	104	Plastic surgery
524	254	172	339	1 093	15	110	286	Dermatology
1 280	1 336	550	1 203	4 152	45	414	885	Gynaecology and obstetrics
11 081	4 530	2 013	5 230	30 685	171	2 352	2 740	General practice
2 692	1 454	1 095	2 621	:	137	1 067	4 004	Internal medicine
:	700	96	532	1 412	24	189	358	Cardiology
:	158	22	130	987	3	:	109	Endocrinology
:	376	62	169	1 154	19	145	234	Gastroenterology
319	463	214	269	1 019	18	130	198	Respiratory medicine
:	171	108	268	776	20	87	180	Oncology
:	83	99	218	904	16	407	246	Rheumatology
582	319	252	284	751	20	190	250	Neurology
:	869	913	1 444	7 437	69	770	1 598	Psychiatry/Neuropsychiatry
72	457	30	734	208	2	:	61	Occupational medicine
651	735	357	590	2 067	30	264	531	Ophthalmology
496	486	283	587	1 339	21	245	329	Otorhinolaryngology
955	1 307	519	1 202	4 943	74	367	856	Paediatrics
780	823	498	931	2 507	37	342	414	Radiotherapy/Radiology
399	286	95	303	1 115	16	109	151	Urology

6.1.11 Medical specialists by speciality per 100 000 inhabitants, most recent year

	B	DK	D	EL	E	F	L	NL
	2001	1999	2001	2001	1996	2001	2000	1999
Anaesthesiology and intensive care	16	14	21	13	7	17	14	7
General surgery	15	12	17	18	12	8	14	6
Infant surgery	:	:	0	1	1	0	:	:
Neurological surgery	1	:	1	2	1	1	1	1
Plastic surgery	2	:	0	2	1	0	1	1
Dermatology	6	3	7	7	3	7	5	3
Gynaecology and obstetrics	12	9	23	22	11	9	13	5
General practice	:	73	13	:	:	16	85	46
Internal medicine	21	20	55	22	11	4	23	11
Cardiology	7	4	3	3	5	10	8	4
Endocrinology	:	:	0	4	2	2	1	:
Gastroenterology	3	:	2	9	4	5	3	1
Respiratory medicine	3	2	1	0	2	4	4	2
Oncology	:	2	1	2	1	1	:	:
Rheumatology	2	3	1	5	1	4	3	1
Neurology	1	4	3	12	3	3	4	4
Psychiatry/Neuropsychiatry	18	14	11	18	7	23	12	14
Occupational medicine	4	:	4	3	3	8	2	7
Ophthalmology	10	6	10	14	6	9	10	4
Otorhinolaringology	6	7	8	9	4	5	7	3
Paediatrics	13	6	18	26	18	11	12	6
Radiotherapy/Radiology	17	8	9	16	6	13	11	7
Urology	3	2	6	6	3	1	5	2

Note: No data for IRL and I. England: only those working in the NHS.
Source: Eurostat, NewCronos database (Health and safety).

A 2001	P 2000	FIN 2001	S 1998	ENGLAND 2001	IS 2000	NO 1998	CH 1999	
19	11	11	13	15	20	10	11	Anaesthesiology and intensive care
14	13	19	18	10	26	20	13	General surgery
0	1	1	:	1	1	:	1	Infant surgery
1	1	8	1	1	2	:	1	Neurological surgery
1	2	9	1	1	4	:	1	Plastic surgery
6	3	3	4	2	5	2	4	Dermatology
15	13	11	14	8	16	9	12	Gynaecology and obstetrics
:	45	39	59	62	61	53	38	General practice
32	15	21	30	:	49	24	56	Internal medicine
:	7	19	6	3	9	4	5	Cardiology
:	2	4	1	2	1	:	2	Endocrinology
:	4	1	2	2	7	3	3	Gastroenterology
4	5	4	3	2	6	3	3	Respiratory medicine
:	2	2	3	2	7	2	3	Oncology
:	1	2	2	2	6	9	3	Rheumatology
7	3	5	3	2	7	4	4	Neurology
10	9	18	16	15	25	17	22	Psychiatry/Neuropsychiatry
1	5	6	8	0	1	:	1	Occupational medicine
8	7	7	7	4	11	6	7	Ophthalmology
6	5	5	7	3	8	6	5	Otorhinolaringology
11	13	10	14	10	27	8	12	Paediatrics
9	8	10	11	5	13	8	6	Radiotherapy/Radiology
5	3	2	3	2	6	2	2	Urology

6.1.12 Number of practising dentists

	B	DK	D	EL	F	IRL	L	NL
1970	1 758	3 125	38 524	4 395	:	:	106	3 364
1980	4 353	5 108	34 981	7 646	30 321	1 033	131	5 688
1985	6 214	5 152	36 853	8 737	34 744	1 168	168	7 116
1990	7 135	5 242	43 167	10 038	37 931	1 313	198	:
1991	7 045	5 240	54 972	10 258	38 146	1 348	198	:
1992	6 978	5 244	56 342	10 403	38 451	1 400	205	:
1993	6 971	5 262	58 194	10 731	38 868	1 433	203	:
1994	7 070	5 175	59 211	10 865	39 284	1 494	210	:
1995	7 085	5 191	60 616	10 663	39 714	1 568	223	6 344
1996	7 152	5 202	61 404	11 419	39 565	1 609	231	:
1997	7 360	5 156	62 024	11 638	39 471	1 671	245	:
1998	7 106	5 166	62 277	11 947	39 457	1 713	257	:
1999	:	5 142	62 564	12 152	40 088	1 794	264	:
2000	:	:	63 120	12 362	40 539	2 013	282	:

Note: No data for E, I, P and FIN. Data for UK: only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

6.1.13 Practising dentists per 100 000 inhabitants

	B	DK	D	EL	F	IRL	L	NL
1970	18	36	49	50	:	:	31	26
1980	44	53	45	80	56	30	36	40
1985	63	52	47	88	63	33	46	49
1990	72	53	55	99	67	37	52	:
1991	71	53	69	101	67	38	52	:
1992	70	53	70	101	67	39	53	:
1993	69	53	72	104	68	40	51	:
1994	70	52	73	104	68	42	52	:
1995	70	52	74	102	68	44	55	41
1996	71	52	75	109	68	44	56	:
1997	72	51	76	111	67	46	59	:
1998	70	51	76	114	67	46	61	:
1999	:	51	76	115	68	48	62	:
2000	:	:	77	:	:	53	65	:

Note: No data for E, I, P and FIN. Data for UK: only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

A	S	UK	IS	LI	NO	CH	
3 217	6 720	12 786	101	6	3 355	1 982	**1970**
3 095	8 263	17 604	168	8	:	2 841	**1980**
3 078	:	19 854	197	7	3 414	3 117	**1985**
3 317	8 629	21 083	230	12	3 484	3 268	**1990**
3 354	8 923	20 991	241	12	3 479	3 252	**1991**
3 422	8 923	20 990	257	12	3 519	3 368	**1992**
3 517	8 459	21 440	264	12	3 515	3 309	**1993**
3 607	8 338	21 547	273	11	3 540	3 479	**1994**
3 395	:	21 806	270	12	3 566	3 474	**1995**
3 524	7 643	22 274	277	15	3 627	3 460	**1996**
3 623	7 514	22 676	284	18	3 692	3 549	**1997**
3 619	7 667	23 409	271	20	3 642	3 470	**1998**
3 666	7 837	23 897	278	:	:	3 449	**1999**
3 722	7 722	24 423	283	:	:	3 468	**2000**

A	S	UK	IS	LI	NO	CH	
43	84	23	49	29	87	32	**1970**
41	100	31	74	31	:	45	**1980**
41	:	35	82	26	82	48	**1985**
43	101	37	91	42	82	49	**1990**
43	104	36	94	41	82	48	**1991**
43	103	36	99	41	82	49	**1992**
44	97	37	101	40	82	48	**1993**
45	95	37	103	36	82	50	**1994**
42	:	37	101	39	82	49	**1995**
44	86	38	103	49	83	49	**1996**
45	85	38	105	58	84	50	**1997**
45	87	40	99	64	82	49	**1998**
45	89	40	101	:	:	48	**1999**
46	87	41	101	:	:	48	**2000**

6.1.14 Number of licensed dentists

	B	DK	D	E	I	L	NL	A
1970	2 718	:	:	3 361	:	:	:	3 217
1980	4 291	:	44 084	3 946	:	:	:	3 095
1985	6 214	5 702	47 043	5 137	71	:	7 118	3 078
1990	7 135	6 148	56 672	10 347	13 430	:	7 900	3 317
1991	7 033	6 199	56 942	11 249	19 651	:	:	3 354
1992	6 978	6 292	71 528	11 808	22 868	:	:	3 422
1993	6 855	6 365	73 477	12 247	24 777	:	:	3 517
1994	6 961	6 412	74 644	13 242	26 561	:	:	3 607
1995	6 983	6 457	75 998	14 012	28 257	227	7 668	3 687
1996	7 200	6 499	76 390	14 877	29 602	235	:	3 793
1997	7 490	6 506	77 349	15 291	30 464	250	8 614	3 848
1998	7 586	6 549	77 895	16 133	31 437	262	8 172	3 813
1999	:	6 566	78 689	16 891	32 135	269	8 501	3 835
2000	:	:	78 759	17 538	33 124	287	8 819	3 874

Note: No data for EL, F and IRL.
Source: Eurostat, NewCronos database (Health and safety).

6.1.15 Licensed dentists per 100 000 inhabitants

	B	DK	D	E	I	L	NL	A
1970	28	:	:	10	:	:	:	43
1980	44	:	56	11	:	:	:	41
1985	63	111	61	13	0	:	49	41
1990	72	119	72	27	24	:	53	43
1991	70	120	71	29	35	:	:	43
1992	70	121	89	30	40	:	:	43
1993	68	122	91	31	43	:	:	44
1994	69	123	92	34	46	:	:	45
1995	69	123	93	36	49	56	50	46
1996	71	123	93	38	52	57	:	47
1997	74	123	94	39	53	60	55	48
1998	74	123	95	41	55	62	52	47
1999	:	123	95	43	56	63	54	47
2000	:	:	96	44	57	66	56	48

Note: No data for EL, F and IRL
Source: Eurostat, NewCronos database (Health and safety).

P	FIN	S	UK	IS	NO	CH	
471	2 695	:	14 973	:	:	:	**1970**
1 083	3 941	10 338	17 949	:	3 710	:	**1980**
1 265	3 916	11 790	21 082	:	3 702	:	**1985**
1 687	4 486	12 412	22 344	251	4 949	:	**1990**
1 691	4 562	12 591	22 088	263	5 084	:	**1991**
1 772	4 614	12 760	22 154	270	:	:	**1992**
2 064	4 602	12 972	22 782	275	:	:	**1993**
2 307	4 685	13 178	23 735	278	5 600	:	**1994**
2 529	4 761	13 441	23 988	284	5 154	:	**1995**
2 780	4 796	:	24 485	295	:	:	**1996**
3 025	4 839	:	25 118	:	:	:	**1997**
3 322	4 833	13 457	25 801	:	5 160	:	**1998**
3 769	4 826	:	26 424	:	:	:	**1999**
4 370	4 794	:	:	:	:	:	**2000**

P	FIN	S	UK	IS	NO	CH	
5	58	:	27	:	:	:	**1970**
11	83	125	32	:	91	:	**1980**
13	80	141	37	:	89	:	**1985**
17	90	146	39	99	117	:	**1990**
17	91	147	38	103	120	:	**1991**
18	92	148	38	104	:	:	**1992**
21	91	149	39	105	:	:	**1993**
23	92	151	41	105	129	:	**1994**
26	93	152	41	106	119	:	**1995**
28	94	:	42	110	:	:	**1996**
30	94	:	43	:	:	:	**1997**
33	94	152	44	:	117	:	**1998**
38	94	:	44	:	:	:	**1999**
44	93	:	:	:	:	:	**2000**

6.1.16 Total number of practising pharmacists

	B	DK	D	EL	E	F	L	NL
1970	:	:	:	2 120	:	23 324	181	1 057
1980	:	:	:	5 170	:	39 747	223	1 529
1985	:	:	:	5 994	:	46 192	254	1 900
1990	:	:	:	7 463	23 000	53 481	307	2 247
1991	:	:	:	7 670	23 000	54 080	316	2 287
1992	:	2 451	46 772	7 834	19 000	54 284	336	2 393
1993	:	2 449	47 363	7 948	16 000	52 673	255	2 464
1994	9 499	2 412	48 392	8 147	24 300	53 085	263	2 484
1995	9 692	2 446	49 429	8 348	23 800	53 810	269	2 556
1996	9 879	2 459	50 372	8 646	28 000	55 153	286	2 622
1997	10 087	2 553	52 076	8 770	23 900	55 137	284	2 717
1998	10 437	2 404	52 221	8 767	26 600	58 839	292	2 922
1999	10 724	2 643	53 001	8 928	25 800	56 195	:	2 965
2000	:	2 666	53 223	8 977	31 200	58 407	:	:

Note: No data for I, IRL and UK.
Source: Eurostat, NewCronos database (Health and safety).

6.1.17 Practising pharmacists per 100 000 inhabitants

	B	DK	D	EL	E	F	L	NL
1970	:	:	30	24	:	46	53	8
1980	:	:	41	54	:	74	61	11
1985	:	:	46	60	:	84	69	13
1990	:	:	:	74	:	95	81	15
1991	:	:	52	75	:	95	82	15
1992	:	47	53	76	:	95	86	16
1993	:	47	53	77	:	92	65	16
1994	94	46	54	78	62	92	66	16
1995	96	47	55	80	61	93	66	17
1996	97	47	56	83	71	95	69	17
1997	99	48	57	84	61	94	68	17
1998	102	45	58	83	68	100	69	19
1999	105	50	58	:	65	95	:	19
2000	:	50	58	:	79	:	:	:

Note: No data for I, IRL and UK.
Source: Eurostat, NewCronos database (Health and safety).

A	P	FIN	S	IS	LI	NO	CH	
2 627	:	:	3 230	93	1	:	1 140	**1970**
2 972	:	7 788	3 972	151	2	:	1 217	**1980**
3 136	:	7 085	4 107	178	2	:	1 366	**1985**
3 486	:	6 877	5 080	223	2	1 909	1 536	**1990**
3 582	:	6 924	5 285	222	2	:	1 537	**1991**
3 745	:	6 954	5 416	236	2	:	1 562	**1992**
3 871	:	6 985	5 603	240	2	:	1 543	**1993**
4 009	:	7 113	5 786	261	2	:	1 591	**1994**
4 071	:	7 204	5 945	293	2	:	1 585	**1995**
4 180	:	7 250	6 035	313	2	1 854	1 579	**1996**
4 264	:	7 367	6 040	329	2	:	1 651	**1997**
4 337	:	7 462	5 967	334	2	:	1 651	**1998**
4 439	7 114	7 569	:	338	:	:	1 640	**1999**
4 532	7 293	7 660	:	:	:	:	1 658	**2000**

A	P	FIN	S	IS	LI	NO	CH	
35	:	:	40	46	5	:	18	**1970**
39	:	163	48	67	8	:	19	**1980**
41	:	145	49	74	7	:	21	**1985**
45	:	138	60	88	7	45	23	**1990**
46	:	139	62	87	7	:	23	**1991**
48	:	138	63	91	7	:	23	**1992**
49	:	138	64	91	7	:	22	**1993**
50	:	140	66	98	7	:	23	**1994**
51	:	141	67	110	7	:	23	**1995**
52	:	142	68	117	6	42	22	**1996**
53	:	144	68	122	6	:	23	**1997**
54	:	145	67	123	6	:	23	**1998**
55	71	147	:	123	:	:	23	**1999**
56	73	148	:	:	:	:	23	**2000**

6.1.18 Number of pharmacists working in pharmacies

	D	F	L	NL	UK	IS	LI
1970	23 751	16 872	:	:	:	:	1
1980	32 223	20 594	:	:	:	:	2
1985	36 017	22 745	:	1 673	19 285	84	2
1990	:	24 878	:	1 979	21 208	134	2
1991	41 607	25 179	:	:	21 049	139	2
1992	42 369	25 646	:	2 100	21 401	148	2
1993	42 887	26 028	223	2 170	21 248	153	2
1994	43 822	26 184	231	2 181	:	176	2
1995	44 696	26 564	235	2 229	:	207	2
1996	45 534	26 668	252	2 292	:	213	2
1997	47 139	26 848	248	2 083	:	225	2
1998	47 322	27 220	:	2 166	:	232	2
1999	47 920	32 354	:	2 573	:	234	:
2000	47 907	32 837	:	2 667	:	:	:

Note: No data for B, DK, EL, E, IRL, I, A, P and FIN.
Source: Eurostat, NewCronos database (Health and safety).

6.1.20 Practising nurses and midwives

	B	DK	D	EL	E	F	IRL	I ([1])	L
1970	:	:	:	12 416	:	:	:	:	:
1980	83 833	26 753	382 000	18 654	118 702	254 976	:	:	:
1985	75 474	45 875	452 000	24 499	143 508	259 311	:	:	:
1990	:	50 458	:	34 582	158 497	315 815	39 595	:	:
1991	:	51 342	708 000	35 715	161 285	319 013	42 705	:	:
1992	:	52 251	698 000	36 505	164 891	324 679	44 130	:	:
1993	:	53 319	704 000	37 211	167 894	331 984	46 509	227 651	:
1994	107 558	48 756	740 000	37 476	167 957	344 000	48 945	244 957	:
1995	110 957	50 231	735 000	38 195	172 132	353 303	51 200	246 597	2 913
1996	109 195	51 243	782 000	38 808	177 034	356 316	53 641	251 538	3 047
1997	:	52 703	777 000	40 211	181 877	361 064	56 155	255 273	3 152
1998	:	53 720	785 000	40 932	192 598	373 938	59 010	262 002	3 164
1999	:	54 367	781 000	41 151	197 340	381 047	61 629	256 860	3 240
2000	:	:	765 000	:	204 485	397 279	64 439	:	3 317

([1]) Data on nurses and midwives refer only to those employed in the national health system.
Source: Eurostat, NewCronos database (Health and safety).

6.1.19 Pharmacists working in pharmacies per 100 000 inhabitants

	F	L	NL	UK	IS	LI
1970	33	:	:	:	:	5
1980	38	:	:	:	:	8
1985	41	:	12	34	35	7
1990	44	:	13	37	53	7
1991	44	:	:	36	54	7
1992	45	:	14	37	57	7
1993	45	56	14	37	58	7
1994	45	58	14	:	66	7
1995	46	58	14	:	78	7
1996	46	61	15	:	79	6
1997	46	59	13	:	83	6
1998	46	:	14	:	85	6
1999	55	:	16	:	85	:
2000	:	:	:	:	:	:

Note: No data for B, DK, D, EL, E, IRL, I, A, P and FIN.
Source: Eurostat, NewCronos database (Health and safety).

NL	A	P	FIN	S	UK (1)	IS	NO	CH	
:	25 743	:	:	40 850	:	856	:	37 092	**1970**
:	40 755	22 144	69 737	73 230	:	1 314	:	64 877	**1980**
:	47 665	23 991	79 433	64 437	:	1 754	:	:	**1985**
:	55 802	27 652	92 396	75 340	:	1 995	:	94 641	**1990**
:	59 361	29 418	93 922	77 626	:	2 013	30 436	:	**1991**
:	62 236	29 626	97 288	75 283	:	2 059	31 733	:	**1992**
:	64 249	30 975	101 434	74 763	:	2 108	31 852	:	**1993**
:	67 479	31 991	105 470	76 301	:	2 146	33 905	:	**1994**
:	68 859	35 549	107 698	74 627	524 944	:	36 601	:	**1995**
:	70 059	34 509	108 981	74 236	529 871	:	38 460	:	**1996**
:	70 970	36 586	110 375	72 617	529 063	2 277	40 296	:	**1997**
197 183	71 849	37 747	111 447	73 562	534 206	2 412	42 004	:	**1998**
202 714	73 084	:	112 186	74 567	:	2 425	:	:	**1999**
208 875	74 601	:	112 771	75 382	:	:	:	:	**2000**

6.1.21 Practising nurses and midwives per 100 000 inhabitants

	B	DK	D	EL	E	F	IRL	I (1)	L
1970	:	:	:	183	:	:	:	:	:
1980	851	522	620	196	319	475	:	:	:
1985	766	898	741	247	374	470	:	:	:
1990	:	983	:	342	408	558	1 129	:	:
1991	:	998	888	350	415	561	1 213	:	:
1992	:	1 012	870	355	423	567	1 244	:	:
1993	:	1 029	869	360	430	577	1 303	400	:
1994	1 065	938	910	360	429	595	1 366	429	:
1995	1 095	963	901	366	439	609	1 423	431	716
1996	1 077	976	956	371	451	612	1 482	439	738
1997	:	999	947	363	463	617	1 538	444	754
1998	:	1 015	957	369	489	637	1 597	455	747
1999	:	1 023	952	391	501	646	1 650	446	755
2000	:	:	931	:	518	:	1 706	:	761

(1) Data on nurses and midwives refer only to those employed in the national health system.
Source: Eurostat, NewCronos database (Health and safety).

6.1.22 Number of qualified nurses

	DK	D	EL	E	F	I (1)	L	NL
1970	:	:	:	:	:	:	:	:
1980	26 002	:	5 048	114 510	245 594	:	:	:
1985	29 892	:	6 613	137 301	286 162	:	:	:
1990	35 001	:	8 523	152 176	304 480	:	:	:
1991	36 202	333 523	9 332	155 035	308 141	:	:	:
1992	36 960	343 944	10 034	158 646	313 474	:	:	:
1993	37 310	353 568	10 630	161 684	320 505	219 911	:	:
1994	37 252	366 639	10 802	161 852	332 043	236 535	:	:
1995	36 881	378 399	11 188	166 060	341 085	238 213	2 272	:
1996	37 962	382 239	11 653	170 720	343 654	243 302	2 382	:
1997	38 110	381 170	12 457	175 782	347 918	246 996	2 484	:
1998	38 351	383 891	13 198	185 899	360 067	253 878	2 503	195 142
1999	38 601	384 149	13 216	190 996	367 126	249 948	2 563	200 532
2000	:	:	:	198 046	382 296	:	2 625	206 525

Note: No data for B and IRL.
(1) Data on nurses and midwives refer only to those employed in the national health system. Data for UK: only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

NL	A	P	FIN	S	UK (1)	IS	NO	CH	
:	345	:	:	510	:	420	:	601	**1970**
:	540	228	1 462	882	:	579	:	1 029	**1980**
:	629	240	1 623	772	:	729	:	:	**1985**
:	726	279	1 857	884	:	786	:	1 418	**1990**
:	764	298	1 879	904	:	787	716	:	**1991**
:	791	300	1 935	871	:	793	743	:	**1992**
:	807	314	2 007	860	:	803	741	:	**1993**
:	842	323	2 077	872	:	810	784	:	**1994**
:	856	359	2 112	846	897	:	842	:	**1995**
:	870	348	2 130	840	903	:	880	:	**1996**
:	880	368	2 151	821	898	844	917	:	**1997**
1 260	890	379	2 165	831	904	886	951	:	**1998**
1 286	904	:	2 174	843	:	880	:	:	**1999**
1 317	921	:	2 181	851	:	:	:	:	**2000**

A	P	FIN	S	UK (1)	IS	NO	CH	
:	:	:	40 850	217 369	699	:	18 405	**1970**
22 186	:	68 850	73 230	240 642	1 160	:	34 253	**1980**
27 377	:	76 194	64 437	284 116	1 565	:	:	**1985**
31 643	:	88 731	75 340	297 320	1 793	:	51 803	**1990**
32 745	:	90 258	77 626	298 299	1 816	:	:	**1991**
34 641	:	93 407	75 283	300 698	1 859	:	:	**1992**
37 069	:	97 654	74 763	295 245	1 913	:	:	**1993**
39 970	:	101 398	76 301	291 070	1 952	:	:	**1994**
41 786	:	103 861	74 627	292 248	2 035	:	:	**1995**
42 829	:	105 086	74 236	267 744	2 052	:	:	**1996**
44 032	:	106 462	72 617	267 732	2 075	:	:	**1997**
44 849	:	107 427	:	299 010	2 216	39 961	:	**1998**
:	34 691	108 161	:	267 575	2 237	:	:	**1999**
:	37 487	108 722	:	309 642	:	:	:	**2000**

6.1.23 Qualified nurses per 100 000 inhabitants

	DK	D	EL	E	F	I (1)	L	NL
1970	:	:	:	:	:	:	:	:
1980	508	:	53	307	457	:	:	:
1985	585	:	67	358	519	:	:	:
1990	682	:	84	392	538	:	:	:
1991	703	418	:	399	542	:	:	:
1992	716	428	:	407	548	:	:	:
1993	720	437	:	414	557	386	:	:
1994	717	451	:	414	575	414	:	:
1995	707	464	107	424	588	416	559	:
1996	723	467	111	435	590	424	577	:
1997	722	465	119	447	595	430	594	:
1998	724	468	126	472	613	441	591	1 247
1999	726	468	126	485	622	434	597	1 272
2000	:	:	:	502	:	:	602	1 302

Note: No data for B and IRL.
(1) Data on nurses and midwives refer only to those employed in the national health system. Data for UK: only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

6.1.24 Number of midwives

	B	DK	D	EL	E	F	I	L
1970	:	560	:	:	:	:	:	:
1980	:	751	:	1 704	4 192	9 382	5 727	:
1985	:	1 039	:	1 910	6 207	9 149	6 411	102
1990	:	1 170	:	1 860	6 321	10 705	6 800	124
1991	:	1 198	8 826	1 866	6 250	10 872	:	:
1992	:	1 233	8 812	1 895	6 245	11 205	:	:
1993	:	1 274	8 917	1 916	6 210	11 479	7 740	:
1994	:	1 308	8 938	1 837	6 105	11 957	8 422	72
1995	4 026	1 351	9 105	1 945	6 072	12 218	8 384	75
1996	:	1 399	9 187	2 046	6 314	12 662	8 236	80
1997	4 311	1 480	9 245	2 099	6 095	13 146	8 277	82
1998	4 376	1 548	9 259	2 154	6 699	13 871	8 124	85
1999	4 351	1 611	9 282	2 199	6 344	13 921	6 912	93
2000	4 508	:	:	:	6 439	14 353	:	97

Note: No data for IRL and UK.
Source: Eurostat, NewCronos database (Health and safety).

A	P	FIN	S	UK (1)	IS	NO	CH	
:	:	:	510	391	343	:	298	**1970**
294	:	1 443	882	428	511	:	543	**1980**
361	:	1 557	772	502	650	:	:	**1985**
412	:	1 784	884	517	707	:	776	**1990**
421	:	1 806	904	517	710	:	:	**1991**
440	:	1 857	871	519	716	:	:	**1992**
466	:	1 932	860	508	729	:	:	**1993**
499	:	1 997	872	499	736	:	:	**1994**
520	:	2 037	846	500	762	:	:	**1995**
532	:	2 054	840	456	766	:	:	**1996**
546	:	2 074	821	455	769	:	:	**1997**
555	:	2 087	:	506	814	905	:	**1998**
:	348	2 096	:	451	811	:	:	**1999**
:	375	2 102	:	519	:	:	:	**2000**

NL	A	P	FIN	S	IS	NO	CH	
:	1 322	:	:	:	157	:	:	**1970**
898	1 100	1 067	887	:	154	:	1 410	**1980**
971	1 059	907	3 239	:	189	:	:	**1985**
1 122	1 090	:	3 665	:	202	:	1 779	**1990**
1 167	1 154	:	3 664	6 180	197	:	:	**1991**
1 203	1 204	:	3 881	6 364	200	:	:	**1992**
1 234	1 309	:	3 780	:	195	:	:	**1993**
1 276	1 340	:	3 772	6 676	194	1 097	:	**1994**
1 332	1 441	:	3 837	:	:	:	:	**1995**
1 357	1 457	:	3 895	6 842	:	1 283	:	**1996**
1 422	1 498	:	3 913	:	202	1 301	:	**1997**
1 515	1 534	:	4 020	:	207	1 355	:	**1998**
1 576	1 555	:	4 025	7 314	209	:	:	**1999**
1 627	1 522	:	4 049	:	:	:	:	**2000**

6.1.25 Midwives per 100 000 inhabitants

	B	DK	D	EL	E	F	I	L
1970	:	11	:	:	:	:	:	:
1980	:	15	:	18	11	17	10	:
1985	:	20	:	19	16	17	11	28
1990	:	23	:	18	16	19	12	33
1991	:	23	11	18	16	19	:	:
1992	:	24	11	18	16	20	:	:
1993	:	25	11	19	16	20	14	:
1994	:	25	11	:	16	21	15	18
1995	40	26	11	19	15	21	15	18
1996	:	27	11	20	16	22	14	19
1997	42	28	11	20	16	22	14	20
1998	43	29	11	20	17	24	14	20
1999	43	30	11	21	16	24	12	22
2000	44	:	:	:	16	:	:	22

Note : No data for IRL and UK.
Source: Eurostat, NewCronos database (Health and safety).

6.1.26 Number of physiotherapists

	B	DK	D	E	F	IRL	I	L
1970	:	:	:	:	:	:	:	:
1980	:	:	:	:	34 572	:	:	:
1985	:	4 046	:	:	34 589	:	:	:
1990	:	5 035	:	2 905	38 257	844	:	:
1991	:	5 245	16 287	2 720	39 323	:	:	:
1992	:	5 455	17 087	2 661	40 254	:	:	:
1993	:	5 702	17 835	2 426	41 858	:	:	:
1994	:	5 923	19 047	2 331	43 968	:	:	:
1995	23 347	6 252	20 112	2 409	45 783	1 099	:	255
1996	24 331	6 540	21 098	1 883	48 819	1 123	10 874	271
1997	24 286	6 891	21 624	2 099	49 476	1 185	9 361	278
1998	25 009	7 247	22 558	2 336	49 341	1 294	:	278
1999	26 050	7 649	23 519	1 824	50 474	1 356	:	273
2000	27 053	:	:	1 721	52 056	:	:	273

Note: No data for EL and P.
Source: Eurostat, NewCronos database (Health and safety).

NL	A	P	FIN	S	IS	NO	CH	
:	18	:	:	:	77	:	:	**1970**
6	15	11	19	:	68	:	22	**1980**
7	14	9	66	:	79	:	:	**1985**
8	14	:	74	:	80	:	27	**1990**
8	15	:	73	72	77	:	:	**1991**
8	15	:	77	74	77	:	:	**1992**
8	16	:	75	:	74	:	:	**1993**
8	17	:	74	76	73	25	:	**1994**
9	18	:	75	:	:	:	:	**1995**
9	18	:	76	77	:	29	:	**1996**
9	19	:	76	:	75	30	:	**1997**
10	19	:	78	:	76	31	:	**1998**
10	19	:	78	83	76	:	:	**1999**
10	19	:	78	:	:	:	:	**2000**

NL	A	FIN	S	UK	IS	NO	CH	
:	:	:	:	:	:	:	3 261	**1970**
:	:	:	:	:	75	:	7 292	**1980**
:	:	4 557	:	:	133	:	:	**1985**
:	:	6 232	:	:	206	:	11 327	**1990**
:	:	6 605	:	:	210	4 000	:	**1991**
:	:	6 908	:	:	233	:	:	**1992**
:	:	7 339	6 740	:	247	4 290	:	**1993**
:	:	7 781	7 028	12 872	252	4 255	:	**1994**
29 438	:	8 135	7 318	:	270	4 626	:	**1995**
31 803	1 905	8 531	7 563	14 332	288	4 566	:	**1996**
32 267	1 992	9 048	:	14 779	321	4 656	:	**1997**
27 823	:	9 484	7 858	15 206	333	4 840	:	**1998**
29 188	:	9 784	8 125	:	375	:	:	**1999**
30 337	:	10 088	:	:	405	5 201	:	**2000**

6.1.27 Physiotherapists per 100 000 inhabitants

	B	DK	D	E	F	IRL	I	L
1970	:	:	:	:	:	:	:	:
1980	:	:	:	:	64	:	:	:
1985	:	79	:	:	63	:	:	:
1990	:	98	:	7	68	24	:	:
1991	:	102	20	7	69	:	:	:
1992	:	106	21	7	70	:	:	:
1993	:	110	22	6	73	:	:	:
1994	:	114	23	6	76	:	:	:
1995	230	120	25	6	79	31	:	63
1996	240	125	26	5	84	31	19	66
1997	239	131	26	5	85	32	16	66
1998	245	137	27	6	84	35	:	66
1999	255	144	29	5	86	36	:	64
2000	264	:	:	4	:	:	:	63

Note: No data for EL and P.
Source: Eurostat, NewCronos database (Health and safety).

NL	A	FIN	S	UK	IS	NO	CH	
:	:	:	:	:	:	:	53	**1970**
:	:	:	:	:	33	:	116	**1980**
:	:	93	:	:	55	:	:	**1985**
:	:	125	:	:	81	:	170	**1990**
:	:	132	:	:	82	94	:	**1991**
:	:	137	:	:	90	:	:	**1992**
:	:	145	78	:	94	100	:	**1993**
:	:	153	80	22	95	98	:	**1994**
191	:	160	83	:	101	106	:	**1995**
205	24	167	86	24	107	104	:	**1996**
207	25	176	:	25	119	106	:	**1997**
178	:	184	89	26	122	110	:	**1998**
185	:	190	92	:	136	:	:	**1999**
191	:	195	:	:	145	116	:	**2000**

6.2.1 Total number of hospital beds (including psychiatric beds)

	EU-15	B	DK	D (1)	EL (3)	E (2)	F	IRL (1,4)	I (3)	L
1970	:	80 392	40 100	873 279	54 633	157 598	:	:	564 397	4 289
1980	3 345 845	92 436	41 621	879 605	60 067	201 035	597 800	31 106	548 428	4 667
1985	:	91 790	:	843 854	54 438	175 410	579 750	29 320	470 579	4 587
1990	2 833 495	80 551	29 104	817 692	51 329	165 897	552 755	21 701	410 026	4 483
1991	2 764 783	79 346	28 072	809 737	51 297	164 451	546 423	21 444	385 691	4 438
1992	2 696 347	77 869	26 764	796 905	51 477	161 537	540 074	20 914	389 457	4 429
1993	2 635 004	77 723	26 463	784 289	52 144	158 944	533 070	20 101	380 420	4 560
1994	2 605 022	77 181	26 170	790 851	51 788	157 433	523 242	19 577	373 408	3 672
1995	2 558 907	75 360	25 767	790 756	52 227	154 644	516 361	19 374	356 242	3 405
1996	:	74 480	:	783 631	52 586	153 433	508 075	18 989	372 352	:
1997	:	74 116	24 538	769 294	52 474	166 276	498 982	18 525	334 613	:
1998	:	73 606	24 082	762 596	52 495	164 097	498 929	18 268	315 848	:
1999	2 363 909	73 143	23 352	754 865	51 404	162 608	492 031	18 114	280 438	2 413
2000	:	72 863	:	749 473	:	161 217	485 803	:	268 524	:

(1) Nursing homes and day care beds not included.
(2) Nursing homes and day care beds partially included.
(3) Beds in military hospitals not included.
(4) Only beds in public hospitals are included.
Source: Eurostat, NewCronos database (Health and safety).

6.2.2 Hospital beds (including psychiatric beds) per 100 000 inhabitants

	EU-15	B	DK	D (1)	EL (3)	E (2)	F	IRL (1,4)	I (3)	L
1970	:	:	:	1 116	622	469	:	:	1 059	1 267
1980	:	:	:	1 125	627	540	1 113	917	962	1 284
1985	:	931	:	1 086	549	457	1 051	827	832	1 253
1990	779	810	567	1 034	507	427	977	619	723	1 182
1991	757	795	546	1 015	503	423	960	609	680	1 155
1992	733	777	519	993	500	415	944	590	686	1 136
1993	713	772	511	969	497	407	927	563	668	1 154
1994	702	764	504	972	498	402	906	546	654	1 108
1995	:	744	494	970	500	395	890	539	622	:
1996	:	734	:	958	503	391	872	525	650	:
1997	:	729	465	938	500	423	853	507	582	:
1998	:	722	455	929	499	417	850	495	549	:
1999	630	716	440	920	489	413	834	485	489	562
2000	:	712	:	:	:	409	820	:	466	:

(1) Nursing homes and day care beds not included.
(2) Nursing homes and day care beds partially included.
(3) Beds in military hospitals not included.
(4) Only beds in public hospitals are included.
Source: Eurostat, NewCronos database (Health and safety).

NL (1)	A	P (1)	FIN	S (4)	UK (4)	IS	NO	CH	
97 900	80 549	54 514	69 376	123 224	536 000	2 643	:	:	**1970**
95 200	84 382	51 254	74 381	125 863	458 000	3 386	:	56 408	**1980**
90 600	82 397	44 115	62 000	121 917	421 000	:	:	54 762	**1985**
86 852	77 970	42 920	45 731	106 484	340 000	2 671	19 667	53 865	**1990**
86 033	77 643	44 536	44 289	102 152	325 000	2 587	18 785	53 699	**1991**
85 507	77 059	44 343	42 967	66 045	311 000	2 549	18 361	52 970	**1992**
84 626	75 563	43 544	41 807	61 258	294 000	2 554	18 061	51 848	**1993**
82 072	75 203	43 072	41 186	57 167	283 000	2 483	17 590	48 928	**1994**
80 687	74 863	40 548	40 984	53 689	274 000	2 432	17 646	49 192	**1995**
80 131	74 061	41 114	41 089	49 468	265 000	:	17 501	47 029	**1996**
79 998	73 128	40 736	40 586	46 177	257 000	:	17 492	47 000	**1997**
78 944	72 078	39 936	40 055	33 660	251 000	:	17 585	45 189	**1998**
78 340	70 999	38 821	39 285	33 096	245 000	:	17 344	44 848	**1999**
75 409	69 851	39 152	39 007	31 765	243 000	:	17 052	:	**2000**

NL (1)	A	P (1)	FIN	S (4)	UK (4)	IS	NO	CH	
756	1 080	:	:	1 540	965	:	:	:	**1970**
676	1 118	:	:	1 516	814	:	:	895	**1980**
627	823	582	1267	1 461	744	:	:	848	**1985**
583	786	558	919	1 249	592	1 053	465	807	**1990**
573	776	542	886	1 189	563	1 011	442	796	**1991**
565	770	532	854	764	537	981	430	774	**1992**
555	756	515	827	705	506	973	420	751	**1993**
535	761	507	811	654	486	937	407	702	**1994**
523	755	504	804	609	468	911	406	701	**1995**
517	746	510	803	560	451	:	401	666	**1996**
514	737	481	791	522	436	:	398	664	**1997**
504	724	495	778	380	425	:	398	637	**1998**
497	712	480	761	374	413	:	390	630	**1999**
475	699	:	754	359	408	:	381	:	**2000**

6.2.3 Average length of stay in hospitals

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	:	:	18.1	23.7	15.0	:	18.3	:	19.1	27.0
1980	17.4	19.5	12.7	19.0	13.3	14.8	16.7	9.8	13.5	23.2
1985	15.7	16.9	11.0	17.4	11.6	13.4	15.5	8.4	12.2	20.4
1990	14.6	13.8	8.2	17.2	9.9	12.2	13.3	7.9	11.7	17.6
1991	13.8	13.0	8.0	16.2	9.9	11.9	11.9	7.8	11.6	17.6
1992	13.1	12.3	7.8	15.6	9.2	11.5	11.7	8.0	11.2	16.5
1993	12.5	12.0	7.6	15.0	8.8	11.5	11.7	7.9	11.1	15.7
1994	12.3	11.7	7.5	14.7	8.5	11.3	11.7	7.7	10.8	15.5
1995	11.8	11.4	7.3	14.2	8.2	10.0	11.2	7.6	10.1	15.3
1996	11.5	11.1	7.2	13.5	8.2	10.0	11.2	7.5	9.4	15.3
1997	10.9	11.1	7.1	12.5	8.6	9.7	10.7	7.6	8.1	:
1998	:	:	6.9	12.3	8.3	:	10.7	7.6	8.0	:
1999	:	:	:	12.0	:	:	10.6	7.6	:	:
2000	:	:	:	11.9	:	:	:	7.5	:	:

Source: OECD, Health data 2002.

(days)

NL	A	P	FIN	S	UK	IS	NO	CH	
38.2	22.2	23.8	24.4	27.2	25.7	28.3	21.0	26.0	**1970**
34.7	17.9	14.4	21.6	23.2	19.1	23.0	14.3	24.7	**1980**
34.3	15.2	13.9	19.9	21.2	15.8	21.4	11.6	24.4	**1985**
34.1	12.8	10.8	18.2	18.0	15.6	18.3	:	:	**1990**
33.8	12.3	10.5	18.8	16.8	14.1	17.8	:	:	**1991**
33.5	11.8	10.1	16.6	10.1	12.4	16.8	:	:	**1992**
33.3	11.4	9.9	14.8	9.4	10.2	20.1	:	:	**1993**
32.7	11.3	9.5	13.1	8.1	10.0	20.3	10.1	:	**1994**
32.8	10.9	9.8	11.8	7.8	9.9	20.0	10.0	:	**1995**
32.5	10.5	9.8	11.6	7.5	9.8	:	9.9	:	**1996**
31.7	9.7	9.3	11.1	6.6	:	:	9.3	14.7	**1997**
33.7	9.3	9.0	10.9	6.6	:	:	9.0	13.7	**1998**
33.3	8.9	:	10.6	6.7	:	:	8.7	13.2	**1999**
33.4	8.6	:	10.3	6.4	:	:	8.9	12.8	**2000**

6.2.5 Number of psychiatric hospital beds

	EU-15	B	DK	D (3)	EL (1)	E	F	IRL	I (1)	L
1970	:	26 553	:	123 773	:	:	:	:	119 351	1 343
1980	:	24 182	:	121 164	:	42 694	:	13 441	82 187	:
1985	:	21 870	:	114 850	13 231	35 342	111 657	12 097	63 188	:
1990	492 120	19 371	4 934	103 916	11 889	27 352	99 780	7 992	47 786	852
1991	489 337	19 146	4 776	123 033	11 675	26 400	96 100	7 638	42 431	797
1992	461 606	17 939	4 375	115 197	11 480	25 050	92 632	6 912	41 168	797
1993	436 810	17 883	4 292	107 507	11 489	24 390	87 979	6 457	39 668	734
1994	422 550	17 209	4 300	108 343	10 654	24 165	83 350	6 110	39 115	524
1995	400 014	17 077	4 246	107 497	11 530	23 639	80 303	5 812	27 584	414
1996	:	16 683	4 262	104 780	11 205	23 071	77 925	5 407	31 198	:
1997	:	16 683	4 214	104 166	11 236	22 278	70 062	4 999	22 568	:
1998	:	16 665	4 177	104 231	11 323	:	70 060	4 807	18 825	:
1999	:	16 590	4 198	104 274	10 552	16 871	67 458	4 614	9 217	:
2000	:	16 548	:	104 935	:	16 247	65 418	4 651	7 843	:

(1) Beds in military hospitals not included.
(2) Only beds in public hospitals are included.
(3) From 1970–90 hospital beds in West Germany only.
(4) Only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

6.2.6 Psychiatric hospital beds per 100 000 inhabitants

	EU-15	B	DK	D (3)	EL (1)	E	F	IRL	I (1)	L
1970	:	275	:	158	:	:	:	:	222	397
1980	:	245	:	155	:	115	242	396	146	357
1985	:	222	:	148	133	92	92	341	112	300
1990	135	195	96	131	118	70	170	228	84	225
1991	134	192	93	154	115	68	163	217	75	207
1992	126	179	85	144	112	64	154	195	73	205
1993	118	178	83	133	111	63	145	181	70	186
1994	114	170	83	133	102	62	139	171	69	131
1995	108	169	81	132	110	60	134	162	48	102
1996	:	165	81	128	107	59	129	149	54	:
1997	:	164	80	127	107	38	120	137	39	:
1998	:	164	79	127	108	:	119	130	33	:
1999	:	162	79	127	:	43	114	124	16	:
2000	:	162	:	:	:	41	111	123	:	:

(1) Beds in military hospitals not included.
(2) Only beds in public hospitals are included.
(3) From 1970–90 hospital beds in West Germany only.
(4) Only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

NL	A	P	FIN	S (2)	UK (4)	IS	NO	CH	
:	:	:	19 628	:	:	:	9 730	18 491	**1970**
:	:	:	18 972	26 962	:	:	7 640	14 012	**1980**
:	9 414	8 478	16 470	20 906	137 950	:	5 087	12 898	**1985**
24 532	7 607	8 799	9 977	14 533	103 200	383	3 627	11 036	**1990**
24 660	7 478	8 481	8 962	12 960	94 800	367	3 467	10 941	**1991**
24 476	7 128	7 263	8 093	11 846	87 250	375	3 310	10 479	**1992**
24 642	6 976	7 100	7 278	10 865	79 550	346	3 338	9 793	**1993**
24 967	6 774	7 154	6 788	9 797	73 300	346	3 175	9 370	**1994**
24 308	6 493	7 191	6 448	8 372	69 100	315	3 112	9 686	**1995**
24 569	5 978	7 320	6 167	7 276	64 150	:	3 013	9 096	**1996**
24 541	5 775	7 117	5 850	6 267	60 250	:	3 037	8 042	**1997**
24 054	5 414	6 958	5 613	5 872	57 600	:	3 190	8 501	**1998**
24 104	5 078	:	5 479	5 786	:	:	3 151	8 581	**1999**
23 989	4 969	6 754	5 355	5 565	:	:	3 108	8 589	**2000**

NL	A	P	FIN	S (2)	UK (4)	IS	NO	CH	
:	:	:	425	:	:	:	252	300	**1970**
:	:	:	398	325	:	:	187	222	**1980**
:	124	112	337	251	250	:	123	200	**1985**
165	99	114	201	170	184	151	86	165	**1990**
164	96	109	179	151	169	143	82	162	**1991**
162	91	92	161	137	155	144	78	153	**1992**
162	88	89	144	125	141	132	78	142	**1993**
163	85	89	134	112	129	131	73	134	**1994**
158	81	89	127	95	121	118	72	138	**1995**
159	74	91	121	82	112	:	71	129	**1996**
158	72	88	114	71	105	:	71	114	**1997**
154	67	86	109	66	100	:	72	120	**1998**
153	63	:	106	65	:	:	71	120	**1999**
151	61	66	104	63	:	:	69	120	**2000**

6.2.7 Number of acute hospital beds

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	:	45 828	:	457 004	:	:	:	:	:	:
1980	:	53 889	27 126	476 652	45 651	:	334 796	14 459	444 143	2 710
1985	:	57 693	24 137	462 124	41 373	135 120	312 548	14 533	393 447	2 765
1990	:	48 975	21 333	474 083	40 675	129 903	292 852	11 254	349 398	2 671
1991	:	48 597	20 494	598 073	40 114	127 080	288 746	11 373	330 764	2 671
1992	:	48 304	19 591	591 830	40 360	123 865	284 718	11 215	335 592	2 671
1993	:	48 281	19 583	578 621	40 655	122 131	279 624	10 948	328 320	2 737
1994	1 738 833	48 465	19 188	569 638	41 134	121 743	270 972	10 960	321 266	2 629
1995	1 709 511	47 241	18 984	564 624	40 697	119 065	266 141	11 093	316 451	2 342
1996	1 700 499	46 793	18 769	552 149	41 381	118 152	260 276	11 107	328 083	2 342
1997	1 648 945	46 477	18 347	540 914	41 238	116 507	253 759	10 934	299 805	2 342
1998	:	46 000	18 067	533 770	41 172	:	253 706	10 858	285 488	2 342
1999	:	45 163	17 758	528 946	40 852	:	248 972	10 775	260 737	:
2000	:	44 827	:	523 114	:	:	244 707	10 852	:	:

Note: Data for UK only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

6.2.8 Acute hospital beds per 100 000 inhabitants

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	:	474	:	584	:	:	:	:	:	:
1980	:	547	530	610	476	:	623	426	788	746
1985	:	585	472	595	417	352	567	410	695	755
1990	:	492	415	599	402	335	518	321	616	704
1991	:	487	398	750	393	327	508	323	583	695
1992	:	482	380	737	392	318	498	316	591	685
1993	:	480	378	715	400	313	486	307	576	693
1994	470	480	369	700	395	311	469	306	562	656
1995	460	466	364	693	396	304	459	308	553	576
1996	457	461	357	675	401	301	447	307	572	567
1997	441	457	348	660	401	201	434	299	522	560
1998	:	451	341	651	399	:	432	294	496	553
1999	:	442	334	645	396	:	422	289	453	:
2000	:	438	:	:	:	:	413	287	:	:

Note: Data for UK only England and Wales.
Source: Eurostat, NewCronos database (Health and safety).

NL	A	P	FIN	S	UK	IS	NO	CH	
:	:	36 157	22 300	:	:	:	21 099	44 072	**1970**
:	:	40 564	23 456	42 285	194 350	:	19 515	44 912	**1980**
:	56 361	36 650	23 502	38 689	182 000	:	19 359	43 850	**1985**
:	54 437	35 922	17 401	35 403	157 050	1 034	15 318	43 851	**1990**
:	53 556	35 707	16 791	33 943	154 100	1 068	15 051	43 531	**1991**
:	53 211	36 708	16 154	31 737	150 700	1 058	14 723	43 301	**1992**
:	52 884	36 074	15 777	29 659	146 800	1 057	14 415	42 175	**1993**
54 139	53 143	35 608	18 527	28 171	143 300	1 086	14 534	40 409	**1994**
53 267	52 856	33 117	15 135	26 848	141 650	1 091	14 396	40 383	**1995**
52 603	52 515	33 794	15 162	24 973	142 400	:	14 377	:	**1996**
52 773	52 024	33 619	14 155	23 801	142 250	:	14 346	:	**1997**
52 672	51 311	32 978	13 412	22 751	141 300	:	14 161	33 510	**1998**
52 148	50 796	:	12 920	22 485	:	:	14 193	33 540	**1999**
52 050	50 313	:	12 576	21 966	:	:	13 944	:	**2000**

NL	A	P	FIN	S	UK	IS	NO	CH	
:	:	416	483	:	:	:	546	714	**1970**
:	:	418	492	509	345	:	478	713	**1980**
:	744	484	480	464	322	:	467	679	**1985**
:	708	467	350	415	273	407	362	657	**1990**
:	689	460	336	395	267	417	354	645	**1991**
:	676	467	321	367	260	407	345	633	**1992**
:	664	453	312	341	253	403	335	611	**1993**
353	663	444	365	322	246	410	336	580	**1994**
345	657	412	297	305	242	409	331	575	**1995**
340	652	420	296	283	243	:	329	:	**1996**
339	645	417	276	269	242	:	327	:	**1997**
337	635	408	261	257	239	:	321	472	**1998**
331	628	:	250	254	:	:	319	471	**1999**
328	621	:	243	248	:	:	311	:	**2000**

6.2.9 Number of long-term care beds

	B	DK	D	EL	E	F	IRL	I
1970	:	:	:	:	:	:	:	:
1980	:	49 126	102 982	1 400	:	38 550	16 360	15 930
1985	:	49 736	135 854	2 500	4 948	55 080	17 469	13 944
1990	12 203	44 847	219 531	3 045	8 462	68 531	17 652	12 842
1991	11 603	42 285	269 593	3 045	10 971	70 835	:	12 496
1992	11 625	40 449	278 461	:	12 622	73 772	:	12 697
1993	11 559	39 190	300 208	2 710	12 423	76 414	:	12 432
1994	11 507	37 683	308 554	2 710	11 525	77 871	19 572	13 027
1995	11 042	36 468	301 961	2 710	11 940	78 500	19 621	12 207
1996	10 902	36 444	344 732	2 630	12 210	79 000	20 061	13 071
1997	10 956	35 423	363 878	2 580	12 518	80 817	21 447	12 240
1998	10 941	34 786	:	:	:	81 573	20 250	11 535
1999	11 390	31 244	645 456	:	11 898	82 187	:	10 527
2000	11 488	29 685	:	:	11 005	83 531	:	:

Note: No data for P and FIN.
Source: Eurostat, NewCronos database (Health and safety).

6.2.10 Long-term care beds per 100 000 inhabitants

	B	DK	D	EL	E	F	IRL	I
1970	:	:	:	:	:	:	:	:
1980	:	959	132	15	:	72	482	28
1985	:	973	175	25	13	100	493	25
1990	123	873	278	30	22	121	503	23
1991	116	822	338	30	28	125	:	22
1992	116	784	347	:	32	129	:	22
1993	115	757	371	26	32	133	:	22
1994	114	725	379	26	30	135	546	23
1995	:	699	370	26	31	135	545	21
1996	:	694	421	25	31	136	554	23
1997	:	:	444	25	22	138	587	21
1998	107	:	:	:	:	139	548	20
1999	112	:	787	:	30	139	:	18
2000	112	557	:	:	28	141	:	:

Note: No data for P and FIN.
Source: Eurostat, NewCronos database (Health and safety).

L	NL	A	S	UK	IS	NO	CH	
:	:	:	:	:	628	27 602	:	**1970**
:	:	:	44 859	26 900	646	30 380	:	**1980**
654	49 252	16 622	51 529	38 000	758	45 607	:	**1985**
786	51 674	15 926	45 965	199 800	1 042	45 628	:	**1990**
786	52 059	15 653	45 091	218 600	1 082	45 946	:	**1991**
919	52 662	15 601	12 600	232 500	1 126	45 890	:	**1992**
1 392	53 702	14 739	10 691	250 200	:	45 767	:	**1993**
1 512	54 423	15 403	6 284	258 500	:	44 941	:	**1994**
1 633	55 464	15 500	5 581	264 700	:	43 928	:	**1995**
1 777	56 434	15 544	4 699	268 500	:	43 735	:	**1996**
:	56 942	15 379	3 740	268 800	:	43 377	89 404	**1997**
:	57 506	15 353	3 627	260 500	:	43 196	86 591	**1998**
:	57 445	15 125	3 502	251 900	:	43 240	83 296	**1999**
:	58 179	14 569	3 189	:	:	42 876	84 031	**2000**

L	NL	A	S	UK	IS	NO	CH	
:	:	:	:	:	308	715	:	**1970**
:	:	:	540	48	285	745	:	**1980**
179	341	220	618	67	315	1 100	:	**1985**
207	347	207	539	348	411	1 078	:	**1990**
205	347	202	525	379	423	1 081	:	**1991**
236	348	198	146	402	434	1 074	:	**1992**
352	352	185	123	431	:	1 065	:	**1993**
:	355	192	72	444	:	1 039	:	**1994**
:	360	193	63	453	:	1 010	:	**1995**
:	364	193	53	457	:	1 001	:	**1996**
:	366	191	42	:	:	988	1 263	**1997**
:	367	190	41	:	:	978	1 220	**1998**
:	365	187	40	:	:	973	1 169	**1999**
:	367	180	36	:	:	957	1 173	**2000**

6.2.13 Average number of nights spent in hospitals per capita by sex

		EU-15	B	DK	D	EL	E	F	IRL
Total	**1996**	1.5	1.5	1.1	2.9	0.8	0.9	1.3	1.0
	1997	1.4	1.8	1.5	2.1	0.9	1.0	1.2	1.3
	1998	1.3	1.6	1.6	2.0	0.7	1.0	1.4	1.2
Males	**1996**	1.5	1.4	1.1	2.9	1.0	1.0	1.2	0.8
	1997	1.3	1.4	1.4	1.9	1.0	1.0	1.2	1.0
	1998	1.2	1.5	1.1	1.9	0.8	1.0	1.2	1.1
Females	**1996**	1.6	1.7	1.2	2.8	0.7	0.8	1.4	1.2
	1997	1.5	2.1	1.5	2.3	0.8	1.0	1.3	1.7
	1998	1.4	1.7	2.0	2.2	0.6	1.0	1.5	1.3

Note: No data available for Sweden.
Source: European Community Household Panel, Version December 2001.

6.2.14 Total length of stay of hospitalised people by sex

		EU-15	B	DK	D	EL	E	F	IRL
Total	**1996**	14.1	13.4	11.9	21.3	14.4	12.5	12.7	10.0
	1997	13.4	14.6	13.6	17.0	12.3	12.4	12.0	12.4
	1998	13.0	14.4	15.3	16.8	11.5	12.1	12.7	11.6
Males	**1996**	14.2	12.7	11.8	22.2	15.5	13.2	12.3	9.2
	1997	13.8	13.8	13.9	17.2	12.4	13.4	11.6	10.1
	1998	13.2	14.0	13.8	18.0	13.0	11.8	12.4	11.2
Females	**1996**	13.9	14.0	12.0	20.6	13.0	11.8	13.1	10.7
	1997	13.0	15.1	13.3	16.8	12.1	11.6	12.3	14.1
	1998	13.0	14.7	16.2	15.9	10.2	12.5	13.0	11.9

Note: No data available for Sweden.
Source: European Community Household Panel, Version December 2001.

I	L	NL	A	P	FIN	UK		
1.2	1.7	0.9	2.1	0.8	1.7	(0.8)	**1996**	**Total**
1.2	:	0.9	2.4	0.8	1.3	1.1	**1997**	
1.1	:	0.8	2.0	0.8	:	1.0	**1998**	
1.2	1.8	0.9	1.8	1.0	1.7	(0.6)	**1996**	**Males**
1.3	:	0.6	2.1	0.9	1.3	1.0	**1997**	
1.0	:	0.7	1.7	0.8	:	0.8	**1998**	
1.3	1.7	1.0	2.5	0.6	1.7	1.0	**1996**	**Females**
1.2	:	1.1	2.7	0.7	1.4	1.1	**1997**	
1.2	:	0.9	2.3	0.7	:	1.1	**1998**	

(nights)

I	L	NL	A	P	FIN	UK		
13.5	13.5	12.0	15.7	12.9	11.9	*(7.7)*	**1996**	**Total**
13.5	:	11.3	17.1	14.2	10.1	10.2	**1997**	
12.7	:	10.5	13.9	12.6	:	9.2	**1998**	
13.4	14.6	12.9	15.0	14.8	12.7	(6.9)	**1996**	**Males**
14.2	:	10.2	17.0	18.4	10.4	11.6	**1997**	
11.9	:	10.5	13.1	12.4	:	9.8	**1998**	
13.7	12.6	11.3	16.2	11.0	11.2	8.2	**1996**	**Females**
13.0	:	11.9	17.1	11.1	9.8	9.3	**1997**	
13.4	:	10.5	14.6	12.8	:	8.8	**1998**	

6.2.16 Discharges from hospitals per 100 000 inhabitants by ICD-10 diagnosis, 1999

	B (*)	DK	D	EL (*)	E (*)	F	IRL	I
Total hospital discharges by main ICD diagnosis	15 584	17 611	19 529	13 507	11 276	25 699	12 491	16 106
Infectious and parasitic diseases	389	478	365	374	186	425	376	311
Neoplasms	:	2 054	2 317	:	861	1 960	:	1 422
Malignant neoplasms	976	1 611	1 815	1 229	625	1 147	657	1 043
Diseases of the blood(-forming organs), immunological disorders	115	214	125	334	79	183	121	133
Endocrine, nutritional and metabolic diseases	410	468	567	240	196	610	196	350
Mental and behavioural disorders	:	257	1 037	330	262	509	100	463
Neurotic disorders and other non-psychotic mental disorders	:	190	617	:	39	273	:	226
Diseases of the nervous system and the sense organs	852	764	1 209	796	594	1 993	538	1 176
Disorders of the central and peripheral nervous system	:	457	487	:	146	769	:	341
Disorders of the eye and adnexa	:	177	513	:	372	913	:	669
Diseases of the ear and mastoid process	:	131	209	:	77	312	:	166
Diseases of the circulatory system	2 351	2 590	3 369	1 952	1 292	2 244	1 413	2 592
Hypertensive disease	:	91	228	:	46	86	:	193
Ischaemic heart diseases	:	808	1 036	:	104	480	460	588
Diseases of the respiratory system	1 440	1 622	1 266	1 073	1 036	1 393	1 497	1 239
Influenza and pneumonia	:	449	633	:	202	205	277	244
Acute respiratory infections and other diseases	:	366	311	:	344	566	:	526
Diseases of the digestive system	1 728	1 640	1 912	1 480	1 281	2 835	1 278	1 809
Appendicitis	:	446	227	:	117	230	147	165
Hernia of abdominal cavity	:	237	332	:	335	406	:	359
Diseases of the skin and subcutaneous tissue	172	266	292	1 162	137	398	245	253
Diseases of the musculoskeletal system/connective tissue	1 349	1 025	1 450	1 214	630	1 507	521	942
Arthropathies and related disorders	:	454	725	:	284	741	:	390
Dorsopathies	:	320	396	:	98	351	:	261
Rheumatism, excluding the back	:	174	171	:	90	280	:	149
Diseases of the genitourinary system	1 045	1 021	1 283	231	732	1 416	799	1 112
Nephritis and other diseases of urinary system	:	438	517	:	53	564	:	488
Diseases of male genital organs	:	179	178	:	156	317	:	200
Diseases of breast and female organs	:	394	588	:	283	526	:	424
Complications of pregnancy, childbirth and puerperium	1 349	1 747	1 290	571	1 248	2 062	2 145	1 378
Certain conditions originating in the perinatal period	60	172	132	117	135	246	146	267
Congenital malformations and chromosomal abnormalities	115	189	136	165	87	200	120	156
Symptoms, signs, abnormal findings, ill-defined causes	629	1 214	784	967	707	1 496	1 373	883
Injury, poisoning and certain other consequences of external causes	:	1 878	1 995	:	850	2 108	:	1 624
Fractures	:	778	879	:	398	752	:	685
External causes of injury and poisoning	1 678	1 874	1 995	1 273	849	:	1 130	1 622

(*) Belgium, Greece, Spain, Luxembourg, Sweden: 1998; Greece: 1997.
(**) England: Final consultant episodes.
Source: Eurostat, NewCronos database (Health and safety).

L (*)	NL	A	P	FIN	S (*)	ENGLAND (**)	NO	
20 845	9 618	28 093	8 728	26 755	16 650	24 594	15 677	Total hospital discharges by main ICD diagnosis
347	118	359	200	741	458	290	378	Infectious and parasitic diseases
:	900	3 482	:	2 393	:	2 719	:	Neoplasms
1 485	791	2 871	507	1 838	1 441	2 147	1 449	Malignant neoplasms
19	89	206	58	202	125	297	104	Diseases of the blood(-forming organs), immunological disorders
313	179	1 007	173	554	372	327	224	Endocrine, nutritional and metabolic diseases
1 102	138	1 507	112	1 778	1 051	467	194	Mental and behavioural disorders
:	:	773	:	496	:	147	:	Neurotic disorders and other non-psychotic mental disorders
753	404	2 032	392	2 191	740	1 389	477	Diseases of the nervous system and the sense organs
:	146	744	:	959	:	465	:	Disorders of the central and peripheral nervous system
:	193	921	:	907	:	734	:	Disorders of the eye and adnexa
:	66	367	:	325	:	185	:	Diseases of the ear and mastoid process
2 447	1 474	3 970	1 046	3 983	2 983	2 138	2 396	Diseases of the circulatory system
:	:	331	:	132	:	44	:	Hypertensive disease
:	552	899	:	1 136	:	736	898	Ischaemic heart diseases
2 135	673	2 099	718	2 430	1 193	1 500	1 380	Diseases of the respiratory system
:	299	432	:	559	:	218	:	Influenza and pneumonia
:	125	989	:	1 177	:	455	:	Acute respiratory infections and other diseases
1 905	839	2 294	924	1 837	1 330	2 623	1 166	Diseases of the digestive system
:	96	229	:	143	:	77	:	Appendicitis
:	172	376	:	336	:	317	:	Hernia of abdominal cavity
216	96	430	133	336	125	438	160	Diseases of the skin and subcutaneous tissue
527	681	2 739	259	2 270	895	2 144	1 004	Diseases of the musculoskeletal system/connective tissue
:	306	1 040	:	1 155	:	654	:	Arthropathies and related disorders
:	171	982	:	495	:	297	:	Dorsopathies
:	98	354	:	394	:	248	:	Rheumatism, excluding the back
:	489	1 753	487	1 422	833	1 349	793	Diseases of the genitourinary system
:	184	666	:	643	:	669	:	Nephritis and other diseases of urinary system
:	88	301	:	217	:	239	:	Diseases of male genital organs
:	217	786	:	562	:	699	:	Diseases of breast and female organs
31	848	1 505	1 216	1 693	1 279	1 985	1 607	Complications of pregnancy, childbirth and puerperium
134	415	153	26	152	151	315	205	Certain conditions originating in the perinatal period
107	86	195	77	230	145	167	225	Congenital malformations and chromosomal abnormalities
671	689	886	121	1 722	1 598	2 786	1 088	Symptoms, signs, abnormal findings, ill-defined causes
:	762	2 960	:	2 156	:	:	:	Injury, poisoning and certain other consequences of external causes
:	336	724	:	933	:	562	:	Fractures
1 752	762	:	696	2 139	1 631	1 534	1 680	External causes of injury and poisoning

6.2.17 Average length of stay by main ICD-10 diagnosis, 1999

		B	DK	D	EL (*)	E (*)	F	IRL	I
I	Infectious and parasitic diseases	8.3	5.3	9.3	7.0	9.5	6.7	4.4	8.0
II	Neoplasms	:	:	10.4	:	10.8	:	:	10.3
III	Malignant neoplasms	12.5	7.4	:	9.8	13.0	10.2	7.6	11.7
IV	Diseases of the blood(-forming organs), immunological disorders	15.1	5.5	9.7	8.8	9.1	7.1	4.4	9.0
V	Endocrine, nutritional and metabolic diseases	9.5	6.8	10.8	3.4	10.7	7.5	4.9	7.8
VI	Mental and behavioural disorders	7.5	6.1	26.9	95.7	62.1	6.8	8.5	12.9
VII	Diseases of the nervous system and the sense organs	7.4	5.5	8.0	10.2	5.9	4.3	4.1	4.8
VIII	Diseases of the circulatory system	9.9	7.4	11.3	9.7	10.2	7.7	8.2	8.3
IX	Diseases of the respiratory system	9.2	5.5	9.0	6.1	8.1	6.8	6.0	7.5
X	Diseases of the digestive system	7.0	5.0	6.5	8.0	7.2	5.8	3.7	7.1
XI	Diseases of the skin and subcutaneous tissue	12.0	6.2	12.1	6.7	7.8	6.3	3.4	6.8
XII	Diseases of the musculoskeletal system/connective tissue	12.0	7.6	12.4	4.8	8.0	7.2	5.6	7.0
XIII	Diseases of the genitourinary system	6.1	4.1	8.2	7.7	6.2	5.2	3.6	5.8
XIV	Complications of pregnancy, childbirth and puerperium	5.6	3.4	12.2	11.5	3.9	5.5	3.6	4.4
XV	Certain conditions originating in the perinatal period	10.9	10.8	14.7	9.2	9.8	10.0	9.9	7.8
XVI	Congenital malformations and chromosomal abnormalities	6.0	4.2	14.7	8.3	7.1	5.5	4.1	5.9
XVII	Symptoms, signs, abnormal findings, ill-defined causes	5.4	3.5	10.1	5.3	7.1	5.0	3.1	5.8
XVIII	Injury, poisoning and other consequences of external causes	:	:	13.4	:	17.5	:	:	5.9
XIX	External causes of injury and poisoning	9.4	6.1	:	7.2	:	6.0	4.7	5.9
	Special admissions (including live births in hospitals)	:	:	10.8	:	:	:	:	4.7
	All categories not elsewhere classified	:	:	:	:	:	4.7	:	:
	No diagnosis	:	:	10.8	:	:	:	:	8.2
	Total	8.6	5.4	10.5	9.8	9.1	6.2	4.8	7.1

(*) Belgium, Greece, Spain, Luxembourg, Sweden: 1998; Greece: 1997.
Source: Eurostat, NewCronos database (Health and safety).

L (*)	NL	A	P	FIN	S (*)	ENGLAND (**)	NO		
4.9	11.1	9.6	11.4	6.9	5.2	:	6.2	I	Infectious and parasitic diseases
:	10.8	6.9	:	7.0	:	:	:	II	Neoplasms
8.7	11.2	7.1	13.3	7.7	8.1	8.1	8.8	III	Malignant neoplasms
4.4	8.4	6.7	8.6	6.2	5.6	8.4	5.6	IV	Diseases of the blood(-forming organs), immunological disorders
8.9	11.7	10.4	9.4	10.1	6.9	8.6	6.2	V	Endocrine, nutritional and metabolic diseases
12.7	29.5	17.1	16.6	39.5	21.6	6.2	5.1	VI	Mental and behavioural disorders
8.3	7.1	7.1	4.9	9.0	5.6	:	5.1	VII	Diseases of the nervous system and the sense organs
8.4	10.5	14.1	8.5	15.6	7.0	14.8	6.6	VIII	Diseases of the circulatory system
5.0	9.1	8.9	8.4	11.3	5.4	10.6	6.2	IX	Diseases of the respiratory system
5.9	8.2	7.9	6.8	5.2	4.9	8.1	5.6	X	Diseases of the digestive system
6.7	11.0	7.6	6.8	6.7	7.3	1.9	7.7	XI	Diseases of the skin and subcutaneous tissue
6.0	9.2	11.2	8.8	6.0	7.1	7.6	7.2	XII	Diseases of the musculoskeletal system/connective tissue
:	7.0	6.0	6.0	5.0	4.5	6.5	4.8	XIII	Diseases of the genitourinary system
5.6	4.5	5.6	3.6	3.6	3.4	5.1	4.4	XIV	Complications of pregnancy, childbirth and puerperium
9.5	7.5	10.9	7.9	9.4	10.4	15.4	11.5	XV	Certain conditions originating in the perinatal period
3.5	7.7	7.0	6.0	5.1	4.8	7.2	5.6	XVI	Congenital malformations and chromosomal abnormalities
4.5	6.9	7.3	5.3	5.1	2.9	5.1	2.9	XVII	Symptoms, signs, abnormal findings, ill-defined causes
:	10.6	8.0	:	9.6	:	:	:	XVIII	Injury, poisoning and other consequences of external causes
7.0	:	:	9.5	9.7	6.3	8.4	5.4	XIX	External causes of injury and poisoning
:	4.6	5.3	:	4.8	:	:	:		Special admissions (including live births in hospitals)
:	:	:	4.2	:	7.0	6.9	:		All categories not elsewhere classified
:	:	:	:	14.6	:	:	:		No diagnosis
6.4	8.7	9.3	7.0	10.6	6.7	8.4	6.1		**Total**

6.2.18 High-tech medical facilities per million population

	B	DK	D	EL	E	F	IRL	I	L
Computed tomography scanners									
1980	0.2	:	:	:	:	:	:	:	:
1990	16.1	4.3	10.1	2.3	:	6.7	4.3	6.0	15.6
1995	:	7.3	15.6	4.4	8.3	9.2	:	:	24.2
1996	:	7.6	16.4	4.9	9.0	9.4	:	12.7	24.1
1997	:	9.1	17.1	5.7	9.3	9.7	:	14.6	23.8
1998	:	9.1	:	6.6	10.2	9.7	:	17.8	23.4
1999	:	10.2	:	7.8	11.6	9.6	:	19.6	25.4
2000	:	10.9	:	:	12.2	:	:	:	25.1
Magnetic resonance imaging units									
1980	:	:	:	:	:	:	:	:	:
1990	2.0	2.5	1.9	0.3	:	0.8	0.3	1.3	2.6
1995	3.2	:	4.8	1.1	2.7	2.1	:	:	2.4
1996	3.2	:	5.7	1.7	3.2	2.3	:	3.4	2.4
1997	3.2	:	6.2	1.5	3.3	2.5	:	4.1	2.4
1998	:	:	:	1.3	3.8	2.6	:	6.3	2.3
1999	:	5.5	:	1.5	4.6	2.8	:	6.7	2.3
2000	:	6.6	:	:	4.9	:	:	:	4.6
Radiotherapy equipment									
1980	:	:	:	:	:	:	:	:	:
1990	:	:	5.1	5.4	:	:	:	1.3	:
1995	6.1	:	4.5	5.8	3.3	7.5	:	:	:
1996	6.4	:	4.7	5.4	3.3	7.6	:	2.3	:
1997	6.4	:	4.6	4.3	3.3	7.8	:	2.4	:
1998	:	:	:	3.6	3.5	7.9	:	3.1	:
1999	:	:	:	4.2	3.6	7.2	:	3.7	:
2000	:	5.2	:	:	3.8	:	:	:	2.3
Lithotriptors									
1980	:	:	:	:	:	:	:	:	:
1990	:	:	1.2	2.4	:	0.7	:	1.7	:
1995	:	:	1.6	3.1	1.7	0.8	:	2.4	2.4
1996	:	:	1.7	3.2	1.8	0.8	:	2.9	2.4
1997	:	:	1.7	3.1	1.8	0.8	:	:	2.4
1998	:	:	:	3.0	1.9	0.8	:	:	2.3
1999	:	:	:	:	1.8	0.9	:	:	2.3
2000	:	:	:	:	1.8	:	:	:	2.3
Haemodialysis stations									
1980	:	:	:	:	:	:	:	:	:
1990	:	:	:	78.7	:	:	:	:	:
1995	5.8	:	:	115.4	59.7	156.3	:	:	12.1
1996	5.5	:	:	:	63.2	164.0	:	:	12.0
1997	5.6	:	:	:	63.6	169.7	:	156.3	11.9
1998	:	:	:	136.2	:	172.4	:	186.7	11.7
1999	:	:	:	153.4	:	178.6	:	194.1	11.6
2000	:	:	:	166.0	:	:	:	:	11.4
Mammographs									
1980	:	:	:	:	:	:	:	:	:
1990	:	:	:	:	:	:	:	:	:
1995	:	:	:	:	:	:	:	:	24.2
1996	:	:	:	:	:	:	:	:	24.1
1997	:	:	:	:	:	:	:	:	23.8
1998	:	:	:	:	:	:	:	:	23.4
1999	:	:	:	:	:	:	:	:	23.1
2000	:	:	:	:	:	:	:	:	22.8

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
									Computed tomography scanners
:	:	1.5	1.9	:	0.0	:	2.3	:	**1980**
7.3	11.7	4.5	9.8	10.5	4.3	11.8	11.6	12.5	**1990**
:	:	:	11.7	:	:	18.7	:	:	**1995**
:	23.9	:	12.5	:	:	14.9	:	:	**1996**
:	24.9	12.3	12.5	:	:	14.8	:	18.3	**1997**
:	25.7	:	12.2	:	5.8	18.3	:	19.0	**1998**
:	25.7	:	12.8	14.2	6.1	21.6	:	18.5	**1999**
:	25.8	:	13.5	:	3.6	21.3	:	:	**2000**
									Magnetic resonance imaging units
:	:	:	:	:	:	:	:	:	**1980**
0.9	:	0.8	1.8	1.5	1.0	3.9	0.7	3.9	**1990**
3.9	:	:	4.3	6.8	3.4	7.5	:	:	**1995**
:	7.4	:	5.7	:	:	7.4	:	:	**1996**
:	8.4	2.8	7.2	:	:	7.4	:	12.4	**1997**
:	8.4	:	8.3	:	:	7.3	:	13.2	**1998**
:	10.9	:	9.9	7.9	4.5	7.2	:	13.0	**1999**
:	10.8	:	11.0	:	3.9	10.7	:	:	**2000**
									Radiotherapy equipment
:	:	:	:	:	:	17.5	:	:	**1980**
:	:	:	16.4	:	:	23.5	:	:	**1990**
7.1	:	:	14.7	:	:	15.0	:	:	**1995**
7.1	3.2	:	15.0	:	:	14.9	:	:	**1996**
7.2	3.7	2.9	14.2	:	3.3	14.8	:	11.1	**1997**
:	4.1	:	14.4	:	:	14.6	:	11.7	**1998**
:	4.2	:	14.3	:	:	14.4	:	11.2	**1999**
:	4.2	:	:	:	4.8	14.2	:	:	**2000**
									Lithotriptors
:	:	:	:	:	:	:	:	:	**1980**
0.8	:	:	0.2	1.2	:	:	:	:	**1990**
:	:	:	0.2	:	:	:	:	:	**1995**
:	1.6	:	0.2	:	:	3.7	:	:	**1996**
:	1.6	1.2	0.4	:	:	3.7	:	3.5	**1997**
:	1.6	:	0.4	:	:	3.7	:	3.0	**1998**
:	1.7	:	0.4	:	:	3.6	:	3.9	**1999**
:	1.7	:	:	:	:	3.6	:	:	**2000**
									Haemodialysis stations
:	:	:	:	:	:	:	:	:	**1980**
:	:	:	:	:	:	:	:	:	**1990**
48.6	78.4	:	:	:	24.3	:	:	:	**1995**
49.6	79.0	:	:	:	:	:	:	:	**1996**
52.0	84.7	:	:	:	:	:	:	8.2	**1997**
	86.0	:	:	:	39.5	73.0	:	9.6	**1998**
	86.1	:	:	:	:	:	:	9.2	**1999**
	85.4	:	:	:	:	:	:	:	**2000**
									Mammographs
:	:			:	:	4.4	:	:	**1980**
:	:		29.3	:	:	15.7	:	:	**1990**
:	:		37.6	:	:	18.7	:	:	**1995**
:	:		37.9	:	:	18.6	:	:	**1996**
:	:	3.6	38.1	:	:	18.5	:	:	**1997**
:	:		38.8	:	:	18.3	:	:	**1998**
:	:		36.4	:	5.6	18.0	:	:	**1999**
:	:			:	:	:	:	:	**2000**

6.2.19 Number of consultations with health professionals in the past 12 months, 1998

(mean number)

	B	DK	EL	E	IRL	I	NL	A	P	UK
General practitioners										
Total	5.2	3.1	2.0	3.7	3.6	4.7	2.9	4.8	3.4	3.2
Males	4.3	2.4	1.7	3.0	2.9	3.9	2.2	3.8	2.6	2.6
Females	6.0	3.7	2.2	4.3	4.3	5.5	3.5	5.7	4.1	3.7
Dentists										
Total	1.3	1.8	0.7	0.8	0.7	1.1	1.6	1.5	0.8	1.4
Males	1.3	1.7	0.6	0.7	0.6	1.0	1.6	1.4	0.7	1.4
Females	1.3	1.9	0.8	0.9	0.8	1.3	1.7	1.6	0.8	1.4
Medical specialists										
Total	2.1	1.1	1.6	1.7	0.6	1.4	1.7	2.1	1.3	1.3
Males	1.5	0.8	1.3	1.3	0.5	1.1	1.3	1.6	1.0	1.4
Females	2.5	1.3	1.8	2.0	0.7	1.6	2.1	2.6	1.5	1.3
Total consultations of health professionals										
Total	8.5	5.9	4.2	6.2	4.9	7.2	6.2	8.4	5.4	5.9
Males	7.1	4.8	3.6	5.1	4.0	5.9	5.0	6.8	4.3	5.4
Females	9.8	6.9	4.8	7.3	5.7	8.5	7.3	9.9	6.4	6.3

Note: No data for Germany, France, Luxembourg, Finland and Sweden.
Source: European Community Household Panel, Version December 2001.

6.2.20 Frequency of consultations with health professionals in the past 12 months, 1998

(% of population)

		B	DK	EL	E	IRL	I	NL	A	P
Total	**0**	7.1	7.7	33.1	19.0	19.5	16.1	5.7	5.9	20.9
	1	6.3	9.0	8.4	10.9	13.1	7.7	7.8	6.6	8.5
	2	10.4	18.3	12.9	12.8	14.0	10.6	17.9	9.7	11.2
	3 or more	76.2	64.9	45.6	57.4	53.5	65.6	68.7	77.9	59.3
Males	**0**	10.3	10.2	39.2	24.0	25.5	20.8	7.8	8.1	28.2
	1	8.8	11.5	9.1	12.9	14.8	9.9	9.7	9.2	11.2
	2	12.4	20.5	13.3	13.8	14.6	13.1	21.6	12.6	11.5
	3 or more	68.4	57.8	38.5	49.3	45.1	56.2	61.0	70.1	49.1
Females	**0**	4.1	5.3	27.7	14.3	13.8	11.7	3.7	3.9	14.5
	1	4.0	6.6	7.8	9.0	11.4	5.7	5.9	4.2	6.1
	2	8.6	16.2	12.5	11.9	13.3	8.3	14.4	7.0	11.0
	3 or more	83.2	71.9	52.0	64.9	61.4	74.3	76.0	84.9	68.4

Note: No data for Germany, France, Luxembourg, Finland, Sweden and the UK.
Source: European Community Household Panel, Version December 2001.

6.2.21 Drugs purchased in retail pharmacies by type of drug — 12 months to 31 January 2002

(in million USD and % change over previous year)

	EU-15		D		E		F		I		UK	
	Million USD	%	Million USD	%	Million USD	%	Million USD	%	Million USD	%	Million USD	%
Total	54 022	:	15 336	*10*	5 724	*11*	13 780	*7*	9 662	*13*	9 523	*11*
Cardiovascular	12 770	*9*	3 551	*8*	1 310	*10*	3 361	*5*	2 321	*11*	2 227	*13*
Central nervous system	8 282	*14*	2 053	*14*	1 055	*16*	2 146	*8*	1 188	*19*	1 840	*17*
Alimentary/metabolism	8 120	*7*	2 443	*8*	798	*4*	2 004	*4*	1 381	*11*	1 494	*8*
Anti-infectives	4 389	*3*	1 208	*2*	394	*1*	1 363	*5*	1 025	*5*	399	*0*
Respiratory	5 161	*8*	1 259	*4*	601	*11*	1 227	*5*	856	*19*	1 218	*8*
Musculoskeletal	2 935	*17*	750	*15*	326	*16*	785	*26*	592	*17*	483	*8*
Genitourinary	3 229	*10*	919	*8*	325	*24*	841	*7*	584	*12*	561	*10*
Cytostatics	2 216	*15*	886	*23*	234	*7*	391	*13*	416	*7*	288	*11*
Dermatologicals	1 865	*5*	537	*4*	206	*9*	446	*2*	306	*9*	371	*5*
Blood agents	1 673	*21*	503	*22*	190	*24*	401	*17*	431	*22*	147	*26*
Sensory organs	1 022	*12*	243	*14*	127	*19*	270	*9*	212	*13*	171	*11*
Diagnostic agents	843	*14*	382	*20*	2	*(8)*	190	*(2)*	132	*20*	137	*18*
Hormones	988	*6*	320	*8*	148	*5*	244	*9*	166	*7*	109	*(3)*
Miscellaneous	351	*10*	212	*12*	4	*124*	73	*3*	30	*7*	33	*8*
Hospital solutions	91	*9*	50	*9*	2	*3*	13	*16*	16	*9*	10	*5*
Parasitology	87	*(2)*	20	*(3)*	2	*11*	25	*(11)*	6	*3*	35	*4*

Note: In order to remove the effects of fluctuating exchange rates, growth rates are calculated net of exchange; in other words, growth figures are shown at local currency level or constant exchange. Data in (brackets) indicate negative growth.

Source: Intercontinental Marketing Services (IMS) Health, IMS Drug Monitor.

6.2.23 Easy access to general practitioner or health centre, 1999

	EU-15	B	DK	D	EL	E	F	IRL
Travelling time to nearest GP								
Less than 20 mins	83.4	84.6	90.2	80.8	55.1	85.5	86.7	74.0
20–59 minutes	14.0	11.2	8.6	17.4	40.3	9.3	9.7	21.7
1 hour plus	0.8	0.6	0.3	1.1	3.1	0.6	0.8	1.5
Don't know	1.8	3.6	0.8	0.7	1.5	4.7	2.7	2.8
Travelling time to nearest hospital								
Less than 20 mins	51.5	64.5	62.2	50.7	37.5	40.8	52.1	37.8
20–59 minutes	43.1	30.8	36.4	44.1	55.1	51.1	42.5	49.6
1 hour plus	4.3	2.6	1.2	4.2	6.7	6.6	3.5	10.9
Don't know/NA	1.0	2.1	0.3	1.0	0.7	1.5	2.0	1.7

Source: Eurobarometer 52.1, European Commission.

6.2.24 Satisfaction with health care system, by sex, 1999

		EU-15	B	DK	D	EL	E	F	IRL
Male	Very satisfied	11.3	18.3	34.8	7.9	3.4	10.0	18.6	11.3
	Fairly satisfied	43.0	59.9	43.0	47.9	13.2	35.7	61.0	38.9
	Not very satisfied	31.4	16.6	18.1	31.2	46.4	43.0	15.8	26.1
	Not at all satisfied	12.4	2.8	3.8	11.2	34.9	8.0	3.9	19.3
	Don't know	1.9	2.4	0.3	1.8	2.1	3.2	0.7	4.5
Female	Very satisfied	10.1	13.5	26.7	7.1	2.3	9.2	13.7	11.6
	Fairly satisfied	41.6	62.6	47.2	38.0	18.1	40.1	63.3	33.8
	Not very satisfied	33.6	17.2	21.9	39.6	45.1	38.4	17.5	27.7
	Not at all satisfied	13.1	5.2	3.8	12.9	33.4	10.5	4.9	21.3
	Don't know	1.7	1.5	0.4	2.5	1.1	1.8	0.6	5.6

Source: Eurobarometer 52.1, European Commission.

(%)

I	L	NL	A	P	FIN	S	UK	
								Travelling time to nearest GP
87.5	80.6	90.4	78.9	60.9	73.9	87.5	85.9	Less than 20 mins
10.9	12.6	7.3	18.9	36.0	24.5	11.6	12.5	20—59 minutes
0.3	0.7	2.0	0.9	2.2	0.9	0.1	0.4	1 hour plus
1.4	6.1	0.4	1.3	0.9	0.7	0.8	1.2	Don't know
								Travelling time to nearest hospital
65.5	67.3	69.7	39.7	37.4	49.6	52.2	44.4	Less than 20 mins
31.3	27.7	29.4	51.5	52.0	45.8	39.3	50.6	20–59 minutes
2.9	1.0	0.5	7.9	10.1	3.1	7.4	4.3	1 hour plus
0.3	4.0	0.5	0.9	0.5	1.5	1.1	0.7	Don't know/NA

(%)

I	L	NL	A	P	FIN	S	UK		
2.2	25.6	21.1	32.2	3.3	17.7	15.3	11.7	Very satisfied	**Male**
24.0	47.6	54.2	49.2	20.3	57.0	43.4	44.6	Fairly satisfied	
45.0	16.7	20.3	13.2	43.0	21.4	29.7	30.9	Not very satisfied	
26.9	5.5	3.9	3.2	30.8	2.7	8.1	10.3	Not at all satisfied	
1.9	4.5	0.5	2.2	2.5	1.2	3.5	2.5	Don't know	
2.0	26.4	17.0	30.6	3.0	18.3	11.8	14.3	Very satisfied	**Female**
24.3	43.7	54.3	54.5	21.7	55.7	47.0	40.9	Fairly satisfied	
46.2	16.9	23.5	10.8	41.9	22.7	29.5	32.7	Not very satisfied	
25.5	4.7	4.4	1.3	32.6	2.6	10.4	10.6	Not at all satisfied	
1.9	8.4	0.8	2.8	0.8	0.6	1.3	1.5	Don't know	

6.2.25 Satisfaction with health care system, by age at end of full-time education, 1999

		EU-15	B	DK	D	EL	E	F	IRL
Up to 15 years	Very satisfied	10.7	12.6	37.3	7.0	2.8	11.9	16.3	11.4
	Fairly satisfied	37.2	62.4	44.6	36.8	19.6	36.0	57.9	32.3
	Not very satisfied	34.9	19.8	14.0	39.0	44.2	40.0	19.8	28.2
	Not at all satisfied	15.7	4.7	4.2	16.0	32.6	9.2	4.8	26.9
	Don't know	1.5	0.5	:	1.3	0.8	2.9	1.3	1.2
16–19 years	Very satisfied	10.3	18.5	31.0	8.1	2.9	7.8	14.6	9.9
	Fairly satisfied	43.3	59.9	42.0	42.3	12.8	41.9	61.5	38.2
	Not very satisfied	32.8	17.6	22.3	35.5	44.5	40.2	19.2	28.2
	Not at all satisfied	11.7	3.6	4.8	12.0	38.8	8.5	4.2	19.7
	Don't know	1.9	0.4	:	2.2	1.0	1.6	0.6	4.0
20+ years	Very satisfied	10.7	14.8	31.6	7.1	3.1	6.2	14.5	7.5
	Fairly satisfied	46.1	60.9	43.5	52.2	10.4	34.2	66.5	36.0
	Not very satisfied	30.5	16.7	20.8	30.9	49.4	47.3	14.0	34.6
	Not at all satisfied	11.7	4.7	3.5	7.8	34.6	11.7	4.7	20.2
	Don't know	1.0	2.9	0.6	2.0	2.5	0.5	0.2	1.6
Still studying	Very satisfied	12.1	13.9	22.6	6.2	2.6	10.7	25.1	19.8
	Fairly satisfied	47.2	65.9	56.0	49.8	17.9	42.7	63.5	36.4
	Not very satisfied	26.9	8.5	18.1	32.5	50.4	31.4	7.1	14.0
	Not at all satisfied	9.4	2.6	3.2	5.7	23.1	7.2	3.7	11.7
	Don't know	4.3	9.0	:	5.7	6.0	7.9	0.6	18.0

Source: Eurobarometer 52.1, European Commission.

(%)

I	L	NL	A	P	FIN	S	UK		
3.6	23.3	17.5	30.9	2.8	18.6	16.4	17.5	Very satisfied	**Up to 15 years**
22.8	50.3	46.3	54.6	21.6	60.5	50.0	41.8	Fairly satisfied	
44.8	14.1	27.0	9.7	43.1	17.7	25.0	27.9	Not very satisfied	
26.4	7.3	8.5	2.2	31.6	3.2	7.4	12.3	Not at all satisfied	
2.3	5.0	0.6	2.6	0.9	:	1.2	0.5	Don't know	
1.6	26.6	15.4	32.1	5.1	18.0	14.2	11.1	Very satisfied	**16–19 years**
24.9	43.4	56.2	51.1	20.1	51.3	44.0	41.4	Fairly satisfied	
45.7	19.6	23.4	12.4	39.4	26.8	27.2	35.3	Not very satisfied	
25.5	4.8	4.9	2.2	32.6	2.6	10.2	9.5	Not at all satisfied	
2.3	5.6	0.1	2.1	2.8	1.3	4.4	2.7	Don't know	
1.3	27.8	22.7	30.4	0.8	15.8	13.6	9.6	Very satisfied	**20+ years**
22.6	40.5	53.3	53.7	13.4	58.8	43.7	47.9	Fairly satisfied	
47.6	21.0	21.3	12.8	44.9	22.6	33.3	29.4	Not very satisfied	
28.1	5.3	1.7	2.3	40.1	2.6	8.5	11.4	Not at all satisfied	
0.4	5.4	1.0	0.9	0.8	0.3	0.9	1.7	Don't know	
:	26.3	25.5	30.1	4.6	23.1	7.3	10.9	Very satisfied	**Still studying**
30.6	53.2	60.4	44.9	28.0	55.8	46.3	48.9	Fairly satisfied	
44.1	4.2	10.6	15.6	40.8	16.2	29.9	29.0	Not very satisfied	
22.9	:	1.4	2.2	21.3	2.1	12.3	5.8	Not at all satisfied	
2.4	16.3	2.0	7.2	5.3	2.8	4.2	5.4	Don't know	

6.2.26 Satisfaction with health care system, by occupation, 1999

		EU-15	B	DK	D	EL	E	F	IRL
Self-employed	Very satisfied	8.5	15.2	31.2	8.8	2.0	6.6	13.5	13.9
	Fairly satisfied	39.4	59.7	43.8	59.5	14.9	46.1	61.3	38.4
	Not very satisfied	35.6	24.0	19.8	23.7	44.2	40.4	16.4	33.4
	Not at all satisfied	15.3	1.0	5.3	7.9	38.0	4.2	7.5	12.0
	Don't know	1.2	:	:	:	0.8	2.7	1.3	2.4
Managers	Very satisfied	11.8	19.4	33.4	8.1	:	7.7	20.7	10.0
	Fairly satisfied	44.1	59.9	40.8	47.9	25.2	33.1	62.4	37.0
	Not very satisfied	32.4	11.2	23.2	31.5	42.1	47.5	15.2	33.1
	Not at all satisfied	10.7	:	2.1	11.1	27.3	11.7	1.0	19.9
	Don't know	1.0	9.6	0.5	1.3	5.4	:	0.8	:
Other white collar	Very satisfied	7.9	15.8	21.5	7.4	4.2	4.1	10.1	9.9
	Fairly satisfied	47.5	58.8	57.5	40.3	10.3	45.0	69.7	40.4
	Not very satisfied	32.0	20.9	19.6	38.6	47.2	38.8	17.0	29.0
	Not at all satisfied	11.2	2.0	1.3	11.8	38.3	10.7	3.2	17.9
	Don't know	1.5	2.5	:	2.0	:	1.4	:	2.7
Manual workers	Very satisfied	11.2	18.5	33.4	8.1	1.6	10.2	18.2	8.5
	Fairly satisfied	41.3	64.8	40.3	43.8	11.4	30.3	55.5	32.4
	Not very satisfied	32.2	13.3	20.9	33.6	41.8	43.0	22.1	31.5
	Not at all satisfied	13.3	3.4	4.6	12.2	42.4	12.3	4.1	20.5
	Don't know	1.9	:	0.8	2.4	2.8	4.2	:	7.1
Houseperson	Very satisfied	8.4	12.9	28.5	5.7	3.9	8.1	7.8	10.3
	Fairly satisfied	40.1	59.6	49.9	36.1	21.4	37.9	63.2	33.0
	Not very satisfied	38.4	21.9	21.6	46.5	45.5	46.1	21.0	29.1
	Not at all satisfied	12.4	5.6	:	11.2	28.0	7.4	8.0	25.4
	Don't know	0.7	:	:	0.5	1.2	0.5	:	2.2
Unemployed	Very satisfied	9.6	7.4	18.3	9.7	:	12.9	18.3	6.3
	Fairly satisfied	36.7	62.8	57.4	29.1	11.8	35.9	53.6	40.9
	Not very satisfied	34.3	17.9	17.8	39.7	39.9	37.3	18.2	13.7
	Not at all satisfied	16.8	8.3	6.5	19.5	48.3	12.0	7.5	36.1
	Don't know	2.6	3.5	:	2.0	:	1.9	2.3	3.0
Retired	Very satisfied	12.9	18.4	38.2	6.5	4.1	15.7	15.1	9.3
	Fairly satisfied	41.8	59.1	37.7	40.8	15.6	39.2	66.0	42.0
	Not very satisfied	30.3	16.4	19.8	36.9	48.8	35.6	13.8	28.4
	Not at all satisfied	13.2	5.8	4.0	13.2	30.5	8.2	3.7	20.4
	Don't know	1.8	0.4	0.3	2.6	1.0	1.3	1.3	:
Students	Very satisfied	12.1	13.9	22.8	6.2	2.6	10.7	25.1	19.8
	Fairly satisfied	47.2	65.9	55.7	49.8	17.9	42.7	63.5	36.4
	Not very satisfied	26.9	8.5	18.3	32.5	50.4	31.4	7.1	14.0
	Not at all satisfied	9.4	2.6	3.3	5.7	23.1	7.2	3.7	11.7
	Don't know	4.3	9.0	:	5.7	6.0	7.9	0.6	18.0

Source: Eurobarometer 52.1, European Commission.

(%)

I	L	NL	A	P	FIN	S	UK		
3.6	22.9	23.2	35.5	1.2	10.3	2.8	10.6	Very satisfied	**Self-employed**
15.6	42.7	55.5	49.0	18.4	55.8	44.0	42.7	Fairly satisfied	
55.4	20.6	18.3	9.2	40.0	29.8	33.0	33.7	Not very satisfied	
24.3	10.4	3.0	5.4	39.1	4.0	12.8	11.4	Not at all satisfied	
1.0	3.5	:	0.9	1.3		7.5	1.6	Don't know	
1.6	22.6	21.0	30.1	:	21.4	15.1	13.5	Very satisfied	**Managers**
22.4	39.1	54.0	60.8	12.6	61.2	40.8	42.5	Fairly satisfied	
49.6	29.3	25.1	7.5	45.2	15.4	35.0	34.8	Not very satisfied	
25.4	4.9	:	:	42.2	1.0	8.4	8.4	Not at all satisfied	
1.0	4.1	:	1.6	:	0.9	0.6	0.9	Don't know	
0.6	31.8	19.1	36.4	4.5	14.9	14.5	4.9	Very satisfied	**Other white collar**
36.2	42.2	53.9	45.4	19.5	59.0	43.1	49.3	Fairly satisfied	
39.9	13.9	20.6	16.1	37.4	24.7	33.5	35.8	Not very satisfied	
20.1	8.0	5.5	:	36.0	:	7.1	9.1	Not at all satisfied	
3.2	4.1	1.0	2.2	2.6	1.4	1.8	1.0	Don't know	
1.0	26.7	18.6	28.2	5.8	20.1	11.7	11.1	Very satisfied	**Manual workers**
16.7	46.3	53.5	53.5	19.6	55.2	51.0	43.9	Fairly satisfied	
45.8	16.7	23.6	11.5	46.4	20.3	25.8	30.7	Not very satisfied	
35.2	5.2	3.8	3.1	26.6	3.0	8.5	12.4	Not at all satisfied	
1.4	5.1	0.5	3.8	1.5	1.4	3.1	1.9	Don't know	
0.7	23.5	16.3	32.5	3.7	10.2	:	13.6	Very satisfied	**Houseperson**
26.0	46.6	51.5	54.8	27.4	64.7	61.7	42.9	Fairly satisfied	
50.4	18.1	27.0	9.3	39.4	25.1	29.6	33.7	Not very satisfied	
21.8	4.5	4.2	0.9	29.5	:	8.7	8.9	Not at all satisfied	
1.1	7.3	1.0	2.4	:	:	:	0.9	Don't know	
1.7	20.3	7.9	29.6	:	12.2	10.2	8.3	Very satisfied	**Unemployed**
17.5	51.3	53.9	51.9	5.9	60.8	41.6	46.4	Fairly satisfied	
49.3	7.9	33.3	5.6	50.7	22.3	32.9	29.5	Not very satisfied	
29.6	5.4	4.9	9.9	41.4	4.8	13.2	9.9	Not at all satisfied	
1.9	15.2	:	3.0	2.0	:	2.2	5.8	Don't know	
5.0	28.7	17.5	31.7	0.8	19.6	21.4	20.2	Very satisfied	**Retired**
26.7	46.4	54.4	50.4	20.6	50.4	42.3	36.2	Fairly satisfied	
38.4	16.0	21.3	15.6	43.4	26.7	27.4	30.1	Not very satisfied	
27.3	4.0	6.7	1.6	33.3	3.3	8.0	11.5	Not at all satisfied	
2.6	4.9	:	0.7	1.9	:	0.9	1.9	Don't know	
:	24.4	25.5	30.1	4.6	23.8	7.3	10.9	Very satisfied	**Students**
30.6	54.1	60.4	44.9	28.0	55.2	46.3	48.9	Fairly satisfied	
44.1	4.4	10.6	15.6	40.8	16.0	29.9	29.0	Not very satisfied	
22.9	:	1.4	2.2	21.3	2.1	12.3	5.8	Not at all satisfied	
2.4	17.1	2.0	7.2	5.3	2.9	4.2	5.4	Don't know	

6.2.27 Satisfaction with health care system compared with two years ago, 1999

	EU-15	B	DK	D	EL	E	F	IRL
More satisfied	10.2	12.5	17.5	9.3	9.6	10.9	13.5	21.2
Less satisfied	26.8	16.0	15.2	35.6	32.2	11.3	14.5	10.1
No change	60.4	70.3	67.3	51.4	55.4	76.1	70.8	67.4
Don't know	2.6	1.1	:	3.7	2.8	1.7	1.2	1.2

Source: Eurobarometer 52.1, European Commission.

6.2.28 Satisfaction with health care system compared with two years ago, by occupation, 1999

		EU-15	B	DK	D	EL	E	F	IRL
Self-employed	More satisfied	10.0	11.5	21.7	5.4	8.9	16.2	10.4	18.5
	Less satisfied	28.5	10.3	8.2	32.5	36.5	13.0	16.7	12.1
	No change	58.4	75.6	70.0	58.8	51.3	68.4	71.8	68.5
	Don't know	3.0	2.6	:	3.2	3.3	2.3	1.2	0.9
Managers	More satisfied	11.0	14.1	19.4	9.0	13.1	9.3	14.4	25.2
	Less satisfied	29.8	18.3	12.1	40.5	36.5	18.9	12.3	6.4
	No change	56.3	65.1	68.6	48.0	50.4	71.9	70.2	67.2
	Don't know	2.8	2.5	:	2.5	:	:	3.0	1.1
Other white collar	More satisfied	10.9	14.5	20.4	13.7	11.4	11.9	11.7	26.8
	Less satisfied	24.9	15.3	11.8	40.0	25.6	11.3	14.7	6.2
	No change	62.7	69.5	67.9	44.3	62.2	75.9	72.8	65.3
	Don't know	1.4	0.7	:	2.1	0.8	0.9	0.7	1.7
Manual workers	More satisfied	10.5	11.6	16.3	11.9	5.2	9.9	13.2	24.9
	Less satisfied	27.3	13.2	12.1	34.4	32.4	11.3	18.1	3.9
	No change	59.6	74.0	71.6	50.2	55.1	78.3	66.9	69.9
	Don't know	2.6	1.2	:	3.5	7.3	0.5	1.8	1.3
Houseperson	More satisfied	10.0	11.0	17.0	6.7	11.6	10.5	20.2	21.8
	Less satisfied	24.5	20.3	42.6	30.2	31.0	11.5	12.7	10.9
	No change	63.7	67.5	40.4	61.3	55.6	76.9	67.1	65.9
	Don't know	1.9	1.2	:	1.8	1.8	1.2	:	1.4
Unemployed	More satisfied	8.6	14.9	29.7	6.3	17.7	5.2	7.0	10.5
	Less satisfied	25.9	10.3	12.0	34.0	38.3	6.3	18.0	15.4
	No change	62.5	73.9	58.3	53.1	44.0	84.2	75.0	70.7
	Don't know	2.9	1.0	:	6.6	:	4.2	:	3.3
Retired	More satisfied	9.2	10.1	11.6	6.6	7.9	12.4	14.3	15.4
	Less satisfied	29.7	22.8	22.4	38.6	31.3	9.8	14.7	27.4
	No change	59.2	66.3	66.0	51.9	60.6	77.3	71.0	56.2
	Don't know	1.9	0.8	:	2.9	0.1	0.5	:	1.1
Students	More satisfied	11.5	17.8	18.9	11.3	9.3	8.6	14.4	22.8
	Less satisfied	19.5	11.3	14.1	28.4	27.9	8.9	5.5	3.5
	No change	62.6	70.9	67.0	49.2	55.0	74.1	77.0	73.7
	Don't know	6.4	:	:	11.1	7.8	8.5	3.1	:

Source: Eurobarometer 52.1, European Commission.

(%)

I	L	NL	A	P	FIN	S	UK	
5.8	11.5	10.5	12.8	11.6	12.2	7.4	10.0	More satisfied
32.0	14.4	41.5	10.2	23.6	23.7	36.4	32.4	Less satisfied
58.1	66.4	45.1	74.6	62.7	62.6	53.9	55.2	No change
4.1	7.7	2.9	2.5	2.1	1.5	2.4	2.4	Don't know

(%)

I	L	NL	A	P	FIN	S	UK		
10.4	8.6	3.3	13.1	14.8	11.2	3.6	5.3	More satisfied	**Self-employed**
35.1	4.7	52.1	10.2	26.6	27.3	51.8	43.5	Less satisfied	
47.9	73.8	44.6	75.8	58.1	59.0	41.5	51.1	No change	
6.5	12.9	:	0.9	0.5	2.5	3.0	0.1	Don't know	
5.4	6.9	9.8	14.9	13.5	15.4	7.0	15.0	More satisfied	**Managers**
37.0	16.7	40.7	6.5	18.0	20.7	36.5	30.8	Less satisfied	
51.3	70.0	47.9	76.1	68.5	63.0	56.5	50.5	No change	
6.3	6.5	1.6	2.4	:	0.9	:	3.7	Don't know	
6.6	12.2	8.0	19.0	12.2	12.0	5.8	8.9	More satisfied	**Other white collar**
23.0	25.4	45.7	6.2	19.3	20.5	43.7	26.0	Less satisfied	
69.8	57.9	43.5	74.1	67.3	66.0	46.9	62.5	No change	
0.7	4.5	2.7	0.7	1.2	1.5	3.5	2.6	Don't know	
3.4	17.0	10.8	12.5	9.5	12.2	9.9	9.6	More satisfied	**Manual workers**
36.2	14.6	43.3	13.8	21.3	25.1	32.3	31.6	Less satisfied	
56.5	63.8	43.1	70.2	65.6	60.4	55.2	56.7	No change	
3.9	4.6	2.8	3.5	3.5	2.3	2.6	2.0	Don't know	
4.9	9.6	8.4	8.6	14.6	9.8	:	8.8	More satisfied	**Houseperson**
20.9	10.3	43.2	10.0	23.3	13.5	74.2	36.2	Less satisfied	
69.6	74.3	46.3	80.1	61.2	74.4	25.8	53.1	No change	
4.5	5.8	2.1	1.4	1.0	2.2	:	1.9	Don't know	
10.2	20.4	5.2	9.7	5.2	17.0	7.7	9.4	More satisfied	**Unemployed**
36.2	13.3	41.9	9.9	33.2	31.0	44.2	22.0	Less satisfied	
52.9	58.6	46.4	73.4	54.0	52.0	44.2	67.7	No change	
0.7	7.6	6.4	7.0	7.7	:	3.9	0.9	Don't know	
3.2	10.9	13.0	12.4	5.6	10.8	8.2	11.0	More satisfied	**Retired**
37.1	13.6	41.2	8.8	30.4	24.5	30.9	36.2	Less satisfied	
56.8	68.1	44.0	76.8	61.8	64.3	58.5	50.2	No change	
2.9	7.4	1.8	2.0	2.2	0.4	2.4	2.6	Don't know	
7.0	11.9	17.0	11.1	17.3	11.7	5.6	10.2	More satisfied	**Students**
28.5	13.0	25.7	13.6	16.9	22.8	32.7	22.2	Less satisfied	
56.7	54.6	49.3	70.4	62.1	63.4	59.6	60.7	No change	
7.8	20.5	8.0	4.9	3.8	2.1	2.1	6.8	Don't know	

6.3.1 Immunisation of infants; coverage by disease

	EU-15	B	DK	D	EL	E	F	IRL	I	L
	1996–99	1996	1998	1997	1997	1999	1998	1997	1999	1997
Measles ([1])	:	73	84	75	90	95	83	:	70	91
Mumps ([2])	:	85	84	75	80	95	84	:	69	91
Tetanus	93	95	99	85	90	95	98	76	95	98
Diphtheria	93	95	99	85	90	95	98	76	95	98
Pertussis ([3])	82	95	99	50	85	95	97	76	80	94
Poliomyelitis	92	94	99	80	95	95	97	76	97	98
Tuberculosis ([4])	:	:	:	:	70	:	84	:	95	59

Note: ([1]) DK 1997, CH 1991; ([2]) B 1995, DK 1997, F 1997, I 1997, S 1995, IS 1995, CH 1991; ([3]) S 1999; ([4]) I 1994, UK 1997.
Source: World Health Organisation Immunisation coverage.

6.3.2 Number of some surgical procedures per 100 000 inhabitants

	B	DK	EL	IRL	I	NL	P	FIN	S	ENGLAND	NO
Nervous system	227	:	562	582	173	91	244	279	:	400	:
Endocrine system	64	:	55	21	74	21	34	47	:	183	:
Operations on the eye	666	:	512	385	604	201	370	886	:	782	:
Operations on the ear	145	:	23	91	46	62	77	510	:	193	:
Operations on nose, mouth, pharynx	508	:	117	433	405	:	173	625	:	161	:
Respiratory system	133	:	280	218	195	:	194	91	:	410	:
Cardiovascular system	1 017	:	24	772	617	301	812	:	:	731	:
Coronary angioplasty	201	83	:	81	67	:	39	:	:	87	:
Coronary bypass	157	64	:	25	46	:	31	65	59	44	76
Digestive system	1 584	:	840	1 637	1 391	701	1 197	1 298	:	2 096	:
Appendectomy	160	54	150	160	145	96	115	163	117	82	36
Inguinal and femoral hernia	237	230	247	97	265	:	147	243	:	233	162
Operations male genital organs	298	:	165	144	243	122	130	256	:	199	:
Prostatectomy	161	:	90	57	86	:	38	86	85	129	113
Operations on female genital organs	778	:	312	649	671	245	578	1 173	:	1 079	:
Operations on musculoskeletal system	2 357	:	228	962	1 223	:	703	2 393	:	1 226	170
Total hip replacement	183	141	61	85	113	:	63	92	123	94	:

Source: OECD, Health data 2002.

(%)

NL	A	P	FIN	S	UK	IS	NO	CH	
1998	1997	1998	1999	1997	1999	1998	1999	1998	
96	90	96	98	96	88	100	88	83	**Measles (1)**
96	90	96	98	96	88	99	88	80	**Mumps (2)**
97	90	97	99	99	92	100	89	94	**Tetanus**
97	90	97	99	99	92	100	89	94	**Diphtheria**
97	90	97	99	99	92	100	89	94	**Pertussis (3)**
97	95	96	98	99	92	100	89	92	**Poliomyelitis**
:	:	87	99	13	11	:	90	:	**Tuberculosis (1)**

6.3.3 Caesarean sections per 1 000 live births

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	:	:	57.0	:	130.0	:	:	:	:	:
1980	90.4	74.0	104.0	:	180.0	:	:	:	112.0	13.2
1985	114.5	94.2	130.0	:	180.0	104.5	:	77.1	158.0	16.7
1990	144.8	104.4	125.8	157.0	240.0	142.2	139.4	105.4	207.9	16.5
1991	154.4	116.1	123.0	152.2	240.0	150.3	127.5	115.6	226.0	17.0
1992	160.9	119.7	122.3	159.4	:	162.0	145.1	120.4	232.4	17.4
1993	168.5	129.4	127.4	165.7	:	173.3	154.9	128.7	241.3	:
1994	173.4	129.4	126.3	170.7	:	177.8	151.1		247.6	16.8
1995	180.8	134.5	125.5	172.4	:	188.0	149.8		260.7	16.4
1996	171.7	136.7	128.8	176.1	:	192.9	153.7	49.1	223.1	16.4
1997	182.6	137.7	129.8	181.4	:	:	159.7	92.2	271.2	16.9
1998	184.5	144.1	137.8	190.7	:	140.5	157.2	101.1	290.9	18.1
1999	192.7	159.2	142.9	198.0	:	:	:	179.1	311.1	:
2000	:	:	152.6	:	:	:	:	187.4	:	:

Source: Health for All database, WHO/Europe.

NL	A	P	FIN	S	UK	IS	NO	CH	
21.4	:	23.3	60.0	:	:	31.0	:	:	**1970**
46.8	:	70.6	:	118.4	82.0	74.0	83.8	:	**1980**
64.1	:	101.3	148.0	120.6	93.9	112.3	119.7	198.0	**1985**
74.1	:	186.1	135.2	107.9	112.8	118.1	127.5	186.0	**1990**
77.4	:	200.1	143.1	112.3	:	114.3	124.8	177.0	**1991**
79.5	:	217.9	144.9	112.0	:	134.3	125.6	:	**1992**
84.4	:	225.2	145.8	116.0	:	129.8	124.8	:	**1993**
91.8	:	238.7	153.0	117.3	:	137.6	126.0	:	**1994**
96.5	123.9	241.7	155.9	120.0	141.5	141.1	126.4	:	**1995**
100.6	130.9	246.3	156.3	117.3	:	151.5	127.3	:	**1996**
103.9	139.5	274.1	155.2	131.6	:	162.6	128.8	:	**1997**
110.6	145.8	275.3	153.2	137.6	:	159.2	136.7	:	**1998**
113.4	164.2	:	157.5	144.0	:	173.2	:	:	**1999**
:	172.0	:	156.5	:	:	176.8	:	:	**2000**

6.3.4 Organ transplants (absolute figures)

	EU-15	B/L	DK	D	EL	E	F	I	NL
Kidney (1)									
1990	:	:	:	2 015	:	1 240	:	:	:
1995	10 796	350	304	2 128	131	1 800	1 638	1 149	491
1996	10 758	443	168	2 015	106	1 707	1 638	1 237	505
1997	11 325	429	160	2 249	134	1 861	1 688	1 309	510
1998	11 697	387	202	2 340	169	1 996	1 885	1 241	484
1999	11 700	459	168	2 275	154	2 023	1 837	1 357	478
2000	11 747	465	154	2 219	104	1 938	1 924	1 396	540
2001	12 096	371	162	2 346	163	1 924	2 023	1 546	500
Heart									
1990	:	:	:	:	:	164	:	:	:
1995	2 237	101	30	475	10	278	397	390	48
1996	2 162	107	32	489	7	282	397	372	60
1997	2 390	96	33	584	8	317	419	372	53
1998	2 188	96	27	528	13	342	369	336	41
1999	2 139	91	94	500	7	336	349	332	45
2000	1 975	90	28	418	2	353	353	298	41
2001	1 895	84	31	409	5	341	342	316	37
Liver									
1990	:	:	:	:	:	313	:	:	40
1995	3 607	138	36	595	7	698	654	404	98
1996	3 739	147	41	699	10	700	651	426	76
1997	4 020	139	39	762	18	790	623	473	89
1998	4 232	139	34	699	18	899	693	549	100
1999	4 527	169	145	757	12	960	699	680	95
2000	4 275	136	24	783	10	954	806	728	126
2001	4 844	201	32	757	18	972	803	792	107
Lung									
1990	:	:	:	:	:	2	:	:	:
1995	440	16	18	60	1	45	81	41	20
1996	540	19	28	86	3	76	69	55	20
1997	554	26	22	89	1	108	62	74	10
1998	661	32	36	116	–	128	88	65	17
1999	777	28	46	146	:	135	99	98	19
2000	727	37	31	158	0	138	96	60	16
2001	757	46	29	149	0	143	117	62	27
Pancreas									
1990	:	:	:	:	:	19	:	:	:
1995	:	19	:	75	–	24	:	:	11
1996	:	16	:	113	–	24	:	:	17
1997	:	19	–	162	–	27	:	29	–
1998	402	29	16	175	–	28	47	52	16
1999	463	37	33	218	0	25	50	35	19
2000	521	32	0	244	0	48	52	43	18
2001	514	21	0	200	0	56	53	61	23
Heart and lung									
1990	:	:	:	:	:	4	:	:	:
1995	:	19	–	23	–	–	:	:	1
1996	:	10	–	22	–	–	:	–	1
1997	189	9	1	31	–	1	26	–	–
1998	118	1	5	14	–	7	26	2	–
1999	108	5	–	20	:	4	28	3	2
2000	92	6	0	11	0	5	25	4	1
2001	87	4	0	13	0	4	26	0	2
Intestine									
1990	:	:	:	:	:	:	:	:	:
1995	–	–	–	–	–	–	–	–	–
1996	–	–	–	–	–	–	–	–	–
1997	–	–	–	–	–	–	–	–	–
1998	10	–	–	–	–	–	9	–	–
1999	16	–	–	1	–	1	7	1	–
2000	11	0	0	0	0	0	4	1	0
2001	14	0	0	3	0	0	2	5	1
Bone marrow									
1990	:	235	38	:	:	477	:	:	:
1995	:	365	43	:	:	1 797	:	:	368
1996	:	518	52	:	:	2 094	:	2 537	266
1997	:	519	35	:	:	2 270	:	3 129	258
1998	:	761	:	:	:	2 287	:	3 339	256
1999	:	598	:	:	:	2 288	556	3 894	:
2000	:	:	:	:	:	:	:	:	:
2001	:	:	:	:	:	:	:	:	:

(1) From dead and living donors.

Source: Eurostat, NewCronos database (Health and safety).

A	P	FIN	S	UK/IRL	IS	NO	CH	
								Kidney (1)
:	256	:	:	:	5	203	214	**1990**
304	361	166	276	1 908	6	189	199	**1995**
365	402	178	308	1 689	7	186	209	**1996**
334	385	144	334	1 785	4	180	236	**1997**
373	309	187	357	1 767	6	203	261	**1998**
417	367	163	301	1 701	2	204	246	**1999**
394	356	194	283	1 780	:	206	252	**2000**
414	365	169	307	1 806	:	211	235	**2001**
								Heart
77	15	23	:	:	0	:	40	**1990**
108	8	26	21	337	1	22	43	**1995**
103	9	29	22	280	2	22	41	**1996**
94	6	20	40	321	1	24	35	**1997**
94	8	18	36	281	0	33	44	**1998**
95	12	15	34	289	0	32	47	**1999**
87	15	17	22	251	0	27	38	**2000**
66	17	13	25	209	:	29	38	**2001**
								Liver
80	0	21	48	:	0	:	21	**1990**
110	67	31	87	688	1	19	47	**1995**
132	127	29	75	638	0	20	67	**1996**
131	144	28	92	693	0	18	55	**1997**
133	133	39	105	690	1	25	77	**1998**
139	159	30	93	589	:	29	75	**1999**
151	162	31	104	710	:	30	77	**2000**
128	184	38	102	710	:	37	88	**2001**
								Lung
17	:	:	:	:	0	:	–	**1990**
29	–	4	16	109	4	14	18	**1995**
29	–	5	23	117	0	7	31	**1996**
30	1	3	17	112	0	13	16	**1997**
61	–	1	33	84	0	9	30	**1998**
70	:	–	26	110	0	11	32	**1999**
59	0	8	27	97	:	15	24	**2000**
57	1	13	21	92	:	27	25	**2001**
								Pancreas
:	:	:	:	:	0	:	5	**1990**
8	–	–	:	:	1	–	9	**1995**
7	–	:	:	:	1	–	7	**1996**
25	–	–	9	34	3	1	5	**1997**
29	–	–	10	29	:	6	4	**1998**
32	0	–	7	40	:	:	4	**1999**
30	3	0	10	41	:	8	4	**2000**
19	4	22	5	50	:	12	12	**2001**
								Heart and lung
:	:	:	:	:	:	:	:	**1990**
–	–	:	:	:	:	:	:	**1995**
9	–	–	:	:	:	–	:	**1996**
3	1	3	4	44	:	–	–	**1997**
1	–	1	–	62	:	3	–	**1998**
1	:	2	3	40	:	0	–	**1999**
2	:	3	2	:	:	2	:	**2000**
2	:	3	1	32	:	2	1	**2001**
								Intestine
:	:	:	:	:	:	:	:	**1990**
–	–	–	–	–	:	–	–	**1995**
–	–	–	–	–	:	–	2	**1996**
–	–	–	–	–	:	–	1	**1997**
–	1	–	–	–	:	–	3	**1998**
6	:	–	–	:	:	–	3	**1999**
6	0	0	0	0	:	0	0	**2000**
1	0	0	0	2	:	0	0	**2001**
								Bone marrow
:	:	34	64	:	:	:	:	**1990**
227	135	74	128	:	4	:	54	**1995**
305	180	96	108	:	8	:	69	**1996**
358	208	105	133	:	6	:	72	**1997**
376	243	112	167	:	5	:	73	**1998**
379	230	115	159	:	7	:	85	**1999**
:	:	123	:	:	7	:	:	**2000**
:	:	191	:	:	7	:	:	**2001**

6.3.5 Organ transplants (per million population)

	EU-15	B/L	DK	D	EL	E	F	I	NL
Kidney (1)									
1990	:	:	:	25.5	:	31.9	:	:	:
1995	29.1	33.2	58.3	26.1	12.5	45.9	28.4	20.1	31.8
1996	28.9	42.0	32.0	24.6	10.1	43.5	28.3	21.6	32.6
1997	30.3	40.5	30.3	27.4	12.8	47.3	29.0	22.8	32.8
1998	31.2	36.5	38.2	28.5	16.1	50.7	32.3	21.6	30.9
1999	31.2	43.1	31.6	27.7	14.6	51.2	31.4	23.6	30.3
2000	31.2	43.6	28.9	27.0	9.9	48.8	32.7	24.2	34.0
2001	32.0	34.7	30.3	28.5	15.4	48.0	34.3	26.7	31.3
Heart									
1990	:	:	:	:	:	4.2	:	:	:
1995	6.0	9.6	5.8	5.8	1.0	7.1	6.9	6.8	3.1
1996	5.8	10.1	6.1	6.0	0.7	7.2	6.9	6.5	3.9
1997	6.4	9.1	6.3	7.1	0.8	8.1	7.2	6.5	3.4
1998	5.8	9.0	5.1	6.4	1.2	8.7	6.3	5.8	2.6
1999	5.7	8.6	17.7	6.1	0.7	8.5	6.0	5.8	2.9
2000	5.2	8.4	5.3	5.1	0.2	8.9	6.0	5.2	2.6
2001	5.0	7.8	5.8	5.0	0.5	8.5	5.8	5.5	2.3
Liver									
1990	:	:	:	:	:	8.1	:	:	2.7
1995	9.7	13.1	6.9	7.3	0.7	17.8	11.3	7.1	6.4
1996	10.0	13.9	7.8	8.5	1.0	17.8	11.2	7.4	4.9
1997	10.8	13.1	7.4	9.3	1.7	20.1	10.7	8.2	5.7
1998	11.3	13.1	6.4	8.5	1.7	22.8	11.9	9.5	6.4
1999	12.1	15.9	27.3	9.2	1.1	24.3	11.9	11.8	6.0
2000	11.4	12.7	4.5	9.5	0.9	24.0	13.7	12.6	7.9
2001	12.8	18.8	6.0	9.2	1.7	24.2	13.6	13.7	6.7
Lung									
1990	:	:	:	:	:	0.1	:	:	:
1995	1.2	1.5	3.5	0.7	0.1	1.1	1.4	0.7	1.3
1996	1.4	1.8	5.3	1.1	0.3	1.9	1.2	1.0	1.3
1997	1.5	2.5	4.2	1.1	0.1	2.7	1.1	1.3	0.6
1998	1.8	3.0	6.8	1.4	–	3.2	1.5	1.1	1.1
1999	2.1	2.6	8.7	1.8	:	3.4	1.7	1.7	1.2
2000	1.9	3.5	5.8	1.9	0.0	3.5	1.6	1.0	1.0
2001	2.0	4.3	5.4	1.8	0.0	3.6	2.0	1.1	1.7
Pancreas									
1990	:	:	:	:	:	0.5	:	:	:
1995	:	1.8	:	0.9	–	0.6	:	:	0.7
1996	:	1.5	:	1.4	–	0.6	:	:	1.1
1997	:	1.8	–	2.0	–	0.7	:	0.5	–
1998	1.1	2.7	3.0	2.1	–	0.7	0.8	0.9	1.0
1999	1.2	3.5	6.2	2.7	0.0	0.6	0.9	0.6	1.2
2000	1.4	3.0	0.0	3.0	0.0	1.2	0.9	0.7	1.1
2001	1.4	2.0	0.0	2.4	0.0	1.4	0.9	1.1	1.4
Heart and lung									
1990	:	:	:	:	:	0.1	:	:	:
1995	:	1.8	–	0.3	–	–	:	:	0.1
1996	:	0.9	–	0.3	–	–	:	–	0.1
1997	0.5	0.8	0.2	0.4	–	0.0	0.4	–	–
1998	0.3	0.1	0.9	0.2	–	0.2	0.4	0.0	–
1999	0.3	0.5	–	0.2	:	0.1	0.5	0.1	0.1
2000	0.2	0.6	0.0	0.1	0.0	0.1	0.4	0.1	0.1
2001	0.2	0.4	0.0	0.2	0.0	0.1	0.4	0.0	0.1
Intestine									
1990	:	:	:	:	:	:	:	:	:
1995	–	–	–	–	–	–	–	–	–
1996	–	–	–	–	–	–	–	–	–
1997	–	–	–	–	–	–	–	–	–
1998	0.0	–	–	–	–	–	0.2	–	–
1999	0.0	–	–	0.0	–	0.0	0.1	0.0	–
2000	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
2001	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Bone marrow									
1990	:	22.8	7.4	:	:	12.3	:	:	:
1995	:	34.6	8.2	:	:	45.8	:	:	23.9
1996	:	49.1	9.9	:	:	53.4	:	44.3	17.2
1997	:	49.0	6.6	:	:	57.7	:	54.5	16.6
1998	:	71.7	:	:	:	58.1	:	58.0	16.4
1999	:	56.2	:	:	:	57.9	9.5	67.6	:
2000	:	:	:	:	:	:	:	:	:
2001	:	:	:	:	:	:	:	:	:

(1) From dead and living donors.

Source: Eurostat, NewCronos database (Health and safety).

A	P	FIN	S	UK/IRL	IS	NO	CH	
								Kidney (1)
:	25.8	:	:	:	19.7	48.0	32.1	**1990**
37.8	36.1	32.6	31.3	30.7	22.5	43.5	28.4	**1995**
45.3	40.0	34.8	34.9	27.1	26.1	42.6	29.6	**1996**
41.4	38.2	28.1	37.8	28.5	14.8	41.0	33.3	**1997**
46.2	30.6	36.3	40.3	28.1	22.0	46.0	36.8	**1998**
51.6	36.2	31.6	34.0	26.9	7.3	45.9	34.5	**1999**
48.6	34.9	37.5	31.9	28.1	:	46.0	35.2	**2000**
51.0	35.6	32.6	34.6	28.4	:	46.9	32.6	**2001**
								Heart
10.0	1.5	4.6	:	:	0.0	:	6.0	**1990**
13.4	0.8	5.1	2.4	5.4	3.7	5.1	6.1	**1995**
12.8	0.9	5.7	2.5	4.5	7.5	5.0	5.8	**1996**
11.7	0.6	3.9	4.5	5.1	3.7	5.5	4.9	**1997**
11.6	0.8	3.5	4.1	4.5	0.0	7.5	6.2	**1998**
11.8	1.2	2.9	3.8	4.6	0.0	7.2	6.6	**1999**
10.7	1.5	3.3	2.5	4.0	0.0	6.0	5.3	**2000**
8.1	1.7	2.5	2.8	3.3	:	6.4	5.3	**2001**
								Liver
10.4	0.0	4.2	5.6	:	0.0	:	3.1	**1990**
13.7	6.7	6.1	9.9	11.1	3.7	4.4	6.7	**1995**
16.4	12.6	5.7	8.5	10.2	0.0	4.6	9.5	**1996**
16.2	14.3	5.5	10.4	11.1	0.0	4.1	7.8	**1997**
16.5	13.2	7.6	11.9	11.0	3.7	5.7	10.9	**1998**
17.2	15.7	5.8	10.5	9.3	:	6.5	10.5	**1999**
18.6	15.9	6.0	11.7	11.2	:	6.7	10.7	**2000**
15.8	17.9	7.3	11.5	11.1	:	8.2	12.2	**2001**
								Lung
2.2	:	:	:	:	0.0	:	–	**1990**
3.6	–	0.8	1.8	1.8	15.0	3.2	2.6	**1995**
3.6	–	1.0	2.6	1.9	0.0	1.6	4.4	**1996**
3.7	0.1	0.6	1.9	1.8	0.0	3.0	2.3	**1997**
7.6	–	0.2	3.7	1.3	0.0	2.0	4.2	**1998**
8.7	:	–	2.9	1.7	0.0	2.5	4.5	**1999**
7.3	0.0	1.5	3.0	1.5	:	3.3	3.3	**2000**
7.0	0.1	2.5	2.4	1.4	:	6.0	3.5	**2001**
								Pancreas
:	:	:	:	:	0.0	:	0.7	**1990**
1.0	–	–	:	:	3.7	–	1.3	**1995**
0.9	–	:	:	:	3.7	–	1.0	**1996**
3.1	–	–	1.0	0.5	11.1	0.2	0.7	**1997**
3.6	–	–	1.1	0.5	:	1.4	0.6	**1998**
4.0	0.0	–	0.8	0.6	:	:	0.6	**1999**
3.7	0.3	0.0	1.1	0.6	:	1.8	0.6	**2000**
2.3	0.4	4.2	0.6	0.8	:	2.7	1.7	**2001**
								Heart and lung
:	:	:	:	:	:	:	:	**1990**
–	–	:	:	:	:	:	:	**1995**
1.1	–	–	:	:	:	–	:	**1996**
0.4	0.1	0.6	0.5	0.7	:	–	–	**1997**
0.1	–	0.2	–	1.0	:	0.7	–	**1998**
0.1	:	0.4	0.3	0.6	:	0.0	–	**1999**
0.2	:	0.6	0.2	:	:	0.4	:	**2000**
0.2	:	0.6	0.1	0.5	:	0.4	0.1	**2001**
								Intestine
:	:	:	:	:	:	:	:	**1990**
–	–	–	–	–	:	–	–	**1995**
–	–	–	–	–	:	–	0.3	**1996**
–	–	–	–	–	:	–	0.1	**1997**
–	0.1	–	–	–	:	–	0.4	**1998**
0.7	:	–	–	:	:	–	0.4	**1999**
0.7	0.0	0.0	0.0	0.0	:	0.0	0.0	**2000**
0.1	0.0	0.0	0.0	0.0	:	0.0	0.0	**2001**
								Bone marrow
:	:	6.8	7.5	:	:	:	:	**1990**
28.2	13.5	14.5	14.5	:	15.0	:	7.7	**1995**
37.9	17.9	18.8	12.2	:	29.9	:	9.8	**1996**
44.4	20.7	20.5	15.0	:	22.2	:	10.2	**1997**
46.6	24.0	21.8	18.9	:	18.4	:	10.3	**1998**
46.9	22.7	22.3	18.0	:	25.4	:	11.9	**1999**
:	:	23.8	:	:	25.1	:	:	**2000**
:	:	36.9	:	:	24.7	:	:	**2001**

6.3.6 Patients undergoing dialysis

	EU-15	B	DK	D	EL	E	F	IRL	I	L
1970	1.4	2.0	2.1	1.6	0.3	0.3	2.2	1.6	0.6	0.6
1980	13.4	15.7	10.1	17.6	7.5	12.6	18.4	5.1	16.8	18.6
1985	20.3	25.4	14.7	25.6	13.9	21.5	23.7	8.5	24.4	24.0
1990	23.7	26.1	19.4	29.7	30.7	26.5	23.6	9.0	25.6	25.0
1991	26.1	29.0	19.2	26.5	33.5	35.2	30.0	8.9	28.4	45.1
1992	25.1	29.9	20.1	22.2	36.9	35.9	28.9	6.9	26.2	35.9
1993	27.2	32.4	22.4	23.0	39.0	36.5	31.5	7.4	34.1	34.4
1994	33.7	32.9	24.5	48.9	42.1	38.4	37.2	9.8	31.6	32.9
1995	:	:	26.9	50.6	45.6	39.3	26.2	5.5	34.1	41.2
1996	:	:	28.7	52.4	48.7	39.7	:	:	:	57.2
1997	:	:	30.5	54.9	52.4	42.7	:	:	:	49.4
1998	:	:	32.5	58.5	56.4	44.5	:	:	:	53.2
1999	:	:	36.2	54.6	60.7	46.0	:	:	:	60.5
2000	:	:	:	64.0	66.4	:	:	:	:	:
2001	:	:	:	:	:	:	:	:	:	:

Source: OECD, Health data 2002.

(per 100 000)

NL	A	P	FIN	S	UK	IS	NO	CH	
2.9	1.0	0.2	1.5	2.7	1.7	1.0	0.4	3.3	**1970**
11.3	10.4	2.7	4.4	9.0	6.8	3.1	3.9	16.1	**1980**
17.0	18.5	18.2	9.3	13.8	11.3	5.8	5.6	22.4	**1985**
21.0	25.1	27.4	12.4	14.1	15.4	9.8	5.8	24.4	**1990**
24.1	26.0	26.1	14.1	21.0	15.7	11.6	6.6	26.6	**1991**
24.7	27.3	23.7	14.5	21.5	17.2	9.6	7.1	23.3	**1992**
25.9	28.3	24.7	16.3	25.6	15.9	11.7	6.4	27.5	**1993**
26.6	29.8	30.4	16.8	25.5	14.7	13.2	6.1	26.4	**1994**
26.6	31.9	35.5	17.3	25.5	17.7	13.1	9.1	20.8	**1995**
28.2	32.4	:	17.8	:	19.0	7.8	:	:	**1996**
:	34.6	:	18.3	:	:	9.6	:	:	**1997**
:	35.4	:	19.9	:	:	13.1	:	:	**1998**
:	36.1	:	21.4	:	26.9	12.6	:	:	**1999**
:	36.8	:	22.9	:	:	13.9	:	:	**2000**
:	:	:	:	:	:	17.5	:	:	**2001**

6.4.1 Gross value added — Health sector and social care

	EU-15	B	DK	D	EL	E	F	IRL	I
					in million EUR				
1970	:	:	1 005	10 070	:	:	:	:	3 375
1980	:	:	4 319	33 460	:	:	:	:	11 855
1985	:	:	6 778	44 680	:	:	:	:	21 187
1990	:	:	9 581	59 240	2 813	:	53 064	:	36 255
1995	:	12 293	12 027	107 074	4 336	23 181	72 431	:	33 801
1996	:	12 486	12 635	108 429	4 587	25 034	75 110	:	39 923
1997	:	12 414	13 191	106 996	5 154	25 209	76 012	:	44 246
1998	:	12 695	14 072	109 876	5 410	:	78 109	:	44 954
1999	:	13 604	14 659	112 448	5 869	:	80 200	:	46 939
2000	:	14 320	15 149	112 540	5 632	:	:	:	49 440
2001	:	:	15 793	:	:	:	:	:	:
					in EUR per capita				
1970	:	:	205	129	:	:	:	:	63
1980	:	:	843	428	:	:	:	:	210
1985	:	:	1 326	575	:	:	:	:	374
1990	:	:	1 866	749	278	:	938	:	639
1995	:	1 213	2 306	1 313	415	591	1 254	:	590
1996	:	1 231	2 406	1 325	438	638	1 296	:	696
1997	:	1 221	2 501	1 305	491	641	1 308	:	770
1998	:	1 246	2 658	1 339	515	:	1 340	:	781
1999	:	1 332	2 759	1 371	558	:	1 371	:	815
2000	:	1 399	2 842	1 370	534	:	:	:	857
2001	:	:	2 952	:	:	:	:	:	:

Source: Eurostat, NewCronos database (Economy and finance statistics).

L	NL	A	P	FIN	S	UK	NO	
				in million EUR				
:	:	:	:	:	:	3 623	463	**1970**
:	:	2 350	:	2 063	:	19 426	2 611	**1980**
:	:	3 874	:	4 831	:	27 439	4 757	**1985**
:	:	5 988	0	7 817	:	40 961	6 280	**1990**
553	21 560	9 916	3 905	7 405	17 445	50 738	8 470	**1995**
620	21 659	10 129	4 196	7 671	20 412	54 764	9 338	**1996**
653	22 001	8 175	4 435	7 765	19 357	67 733	10 189	**1997**
654	22 946	8 507	4 903	7 917	19 691	73 281	:	**1998**
697	24 858	8 414	5 682	8 302	21 252	80 128	:	**1999**
706	:	8 918	:	8 823	:	92 696	:	**2000**
:	:	:	:	9 426	:	98 750	:	**2001**
				in EUR per capita				
:	:	:	:	:	:	65	120	**1970**
:	:	311	:	432	:	345	640	**1980**
:	:	511	:	987	:	485	1 147	**1985**
:	:	779	0	1 571	:	713	1 484	**1990**
1 360	1 398	1 233	390	1 452	1 979	867	1 948	**1995**
1 502	1 398	1 258	418	1 499	2 310	933	2 137	**1996**
1 561	1 413	1 013	440	1 513	2 189	1 150	2 320	**1997**
1 544	1 466	1 053	485	1 538	2 226	1 240	:	**1998**
1 624	1 577	1 041	560	1 609	2 400	1 349	:	**1999**
1 620	:	1 101	:	1 706	:	1 555	:	**2000**
:	:	:	:	1 819	:	1 650	:	**2001**

6.4.2 Total health expenditures

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	1 277	:	21 656	60	587	:	114	1 786	56
1980	:	5 683	4 724	66 417	402	5 163	:	1 081	:	225
1985	:	8 740	7 394	86 405	:	9 624	:	1 861	:	345
1990	396 951	12 157	9 425	108 292	2 947	20 842	86 863	2 395	54 683	562
1995	578 508	17 524	11 131	183 692	7 095	33 880	113 399	3 791	68 104	841
1996	610 161	18 325	11 800	194 484	7 779	35 975	115 885	4 063	73 696	893
1997	627 154	18 447	12 328	196 894	8 482	37 664	117 894	4 636	79 415	919
1998	650 860	19 256	13 028	199 061	9 208	40 310	121 922	5 255	82 751	987
1999	:	20 387	13 887	:	9 851	43 423	126 601	6 038	86 795	1 108
2000	:	21 627	14 508	:	10 032	46 681	132 808	6 952	93 910	:
					in EUR per capita					
1970	:	132	:	357	7	17	:	39	33	165
1980	:	577	922	1 079	42	138	:	318	:	616
1985	:	887	1 446	1 416	:	250	:	526	:	940
1990	1 140	1 220	1 833	1 712	292	536	1 532	684	964	1 464
1995	1 556	1 725	2 129	2 249	679	864	1 960	1 053	1 189	2 036
1996	1 637	1 804	2 243	2 375	743	916	1 997	1 121	1 284	2 147
1997	1 678	1 812	2 333	2 400	808	958	2 025	1 266	1 381	2 183
1998	1 738	1 887	2 458	2 427	876	1 024	2 088	1 418	1 437	2 311
1999	:	1 994	2 611	:	935	1 102	2 160	1 612	1 506	2 559
2000	:	2 110	2 718	:	952	1 183	2 255	1 836	1 626	:
					in % of gross domestic product (GDP)					
1970	:	4.0	:	6.3	6.0	3.6	:	5.1	5.1	3.6
1980	:	6.4	9.1	8.8	6.6	5.4	:	8.4	:	5.9
1985	:	7.2	8.7	9.3	:	5.4	:	7.6	:	5.9
1990	7.9	7.4	8.5	8.7	7.5	6.6	8.6	6.6	8.0	6.1
1995	8.7	8.7	8.2	10.2	8.9	7.7	9.6	7.2	7.4	6.4
1996	8.8	8.8	8.3	10.6	8.9	7.7	9.6	7.0	7.5	6.4
1997	8.7	8.5	8.2	10.5	8.7	7.6	9.4	6.9	7.7	5.9
1998	8.6	8.5	8.4	10.3	8.7	7.6	9.3	6.8	7.7	5.8
1999	:	8.7	8.5	:	8.7	7.7	9.4	6.8	7.8	6.0
2000	:	8.7	8.3	:	8.3	7.7	9.5	6.7	8.1	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
					in million EUR				
:	1 488	28	439	1 312	3 262	0	453	3 320	**1970**
12 103	5 697	414	2 094	5 259	18 279	13	2 480	8 440	**1980**
14 670	6 653	1 265	4 067	8 236	29 286	113	4 108	11 753	**1985**
19 525	9 491	3 142	6 911	12 600	47 116	374	6 372	16 801	**1990**
25 420	14 731	6 707	7 155	14 716	70 321	478	8 412	22 408	**1995**
26 257	15 475	7 332	7 545	15 512	75 140	510	9 234	23 491	**1996**
27 205	14 513	7 981	7 806	15 659	77 310	539	9 994	23 963	**1997**
28 833	15 263	8 444	8 037	15 948	82 557	624	10 782	24 968	**1998**
30 568	15 845	9 042	8 300	:	90 467	701	11 469	25 770	**1999**
32 547	16 487	9 415	8 710	:	96 165	:	:	:	**2000**
					in EUR per capita				
	199	3	95	163	59	1	117	530	**1970**
855	755	42	438	633	324	57	607	1 322	**1980**
1 012	880	126	830	986	517	470	989	1 799	**1985**
1 306	1 230	318	1 386	1 472	819	1 467	1 502	2 503	**1990**
1 644	1 831	676	1 401	1 667	1 200	1 790	1 930	3 183	**1995**
1 691	1 920	739	1 472	1 755	1 278	1 895	2 108	3 322	**1996**
1 743	1 798	802	1 519	1 770	1 310	1 990	2 269	3 380	**1997**
1 836	1 889	847	1 560	1 802	1 394	2 276	2 433	3 512	**1998**
1 933	1 958	897	1 605	:	1 520	2 529	2 570	3 607	**1999**
2 044	2 032	922	1 681	:	1 609	:	:	:	**2000**
					in % of gross domestic product (GDP)				
:	5.3	2.7	5.6	6.9	4.5	4.9	4.4	5.6	**1970**
7.5	7.6	5.6	6.4	9.1	5.6	6.1	7.0	7.6	**1980**
7.3	6.6	6.0	7.2	8.7	5.9	7.2	6.7	8.0	**1985**
8.0	7.1	6.2	7.9	8.5	6.0	7.9	7.8	8.5	**1990**
8.4	8.6	8.3	7.5	8.1	7.0	8.2	8.0	10.0	**1995**
8.3	8.7	8.5	7.7	8.4	7.0	8.2	8.0	10.4	**1996**
8.2	8.0	8.6	7.3	8.1	6.8	8.0	8.0	10.4	**1997**
8.1	8.0	8.3	6.9	7.9	6.8	8.3	8.5	10.6	**1998**
8.2	8.1	8.4	6.9	:	7.1	8.7	8.5	10.7	**1999**
8.1	8.0	8.2	6.6	:	7.3	:	:	:	**2000**

6.4.3 Public health expenditures

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	:	:	15 768	26	384	:	93	1 552	50
1980	:	:	4 147	52 266	224	4 126	:	881	:	209
1985	:	:	6 330	66 854	:	7 803	:	1 409	:	308
1990	:	:	7 797	82 521	1 848	16 413	66 558	1 751	43 337	523
1995	441 497	12 197	9 186	143 463	3 865	24 031	86 321	2 797	49 173	777
1996	464 198	13 163	9 725	152 274	4 294	25 590	88 203	2 979	52 932	829
1997	471 674	13 011	10 143	150 749	4 678	26 781	89 811	3 521	57 307	849
1998	487 359	13 601	10 670	150 867	5 009	28 419	92 695	4 005	59 575	912
1999	:	14 499	11 418	:	5 347	30 493	96 336	4 605	62 767	1 029
2000	:	15 408	11 905	:	5 572	32 634	100 920	5 269	69 195	:
					in EUR per capita					
1970	:	:	:	260	3	11	:	32	29	147
1980	:	:	809	849	23	110	:	259	:	573
1985	:	:	1 238	1 096	:	203	:	398	:	839
1990	:	:	1 517	1 305	183	422	1 174	500	764	1 362
1995	1 187	1 201	1 757	1 757	370	613	1 492	777	858	1 881
1996	1 245	1 296	1 848	1 859	410	652	1 520	822	922	1 993
1997	1 262	1 278	1 920	1 837	446	681	1 543	962	996	2 017
1998	1 301	1 333	2 013	1 839	476	722	1 587	1 081	1 035	2 136
1999	:	1 418	2 147	:	507	774	1 643	1 230	1 089	2 376
2000	:	1 503	2 231	:	529	827	1 714	1 391	1 198	:
					in % of gross domestic product (GDP)					
1980	:	:	8.0	6.9	3.7	4.3	:	6.8	:	5.5
1985	:	:	7.4	7.2	:	4.4	:	5.8	:	5.3
1990	:	:	7.0	6.7	4.7	5.2	6.6	4.8	6.4	5.7
1995	6.6	6.0	6.8	8.0	4.8	5.5	7.3	5.3	5.3	5.9
1996	6.7	6.4	6.8	8.3	4.9	5.5	7.3	5.1	5.4	5.9
1997	6.5	6.0	6.8	8.1	4.8	5.4	7.2	5.3	5.6	5.4
1998	6.4	6.0	6.9	7.8	4.7	5.4	7.1	5.2	5.6	5.4
1999	:	6.2	7.0	:	4.7	5.4	7.1	5.2	5.7	5.6
2000	:	6.2	6.8	:	4.6	5.4	7.2	5.1	5.9	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in million EUR					
:	937	16	324	1 128	2 836	0	415	1 990	**1970**
8 394	3 921	267	1 654	4 866	16 333	11	2 111	5 329	**1980**
10 412	5 061	690	3 198	7 443	25 116	99	3 523	7 535	**1985**
13 094	6 978	2 059	5 592	11 323	39 367	324	5 276	11 159	**1990**
18 059	10 579	4 137	5 405	12 535	58 973	404	7 002	12 049	**1995**
17 376	10 922	4 741	5 718	13 146	62 306	428	7 645	12 845	**1996**
18 450	10 296	5 169	5 938	13 193	61 778	451	8 291	13 218	**1997**
19 540	10 903	5 700	6 128	13 364	65 970	523	8 930	13 699	**1998**
20 334	11 099	6 395	6 254	:	72 510	594	9 506	14 261	**1999**
21 985	11 493	6 700	6 538	:	77 911	:	:	:	**2000**
				in EUR per capita					
:	125	2	70	140	51	1	107	317	**1970**
593	519	27	346	586	290	50	517	835	**1980**
719	670	69	652	891	443	409	848	1 153	**1985**
876	904	208	1 122	1 323	684	1 271	1 244	1 662	**1990**
1 168	1 315	417	1 058	1 420	1 006	1 512	1 606	1 711	**1995**
1 119	1 355	478	1 116	1 487	1 059	1 590	1 745	1 816	**1996**
1 182	1 276	520	1 155	1 491	1 047	1 666	1 882	1 865	**1997**
1 244	1 350	572	1 189	1 510	1 114	1 910	2 015	1 927	**1998**
1 286	1 372	634	1 209	:	1 219	2 145	2 130	1 996	**1999**
1 380	1 417	656	1 262	:	1 304	:	:	:	**2000**
				in % of gross domestic product (GDP)					
5.2	5.2	3.6	5.0	8.4	5.0	5.4	5.9	4.8	**1980**
5.2	5.0	3.3	5.6	7.9	5.0	6.2	5.7	5.1	**1985**
5.4	5.2	4.1	6.4	7.6	5.0	6.8	6.4	5.7	**1990**
6.0	6.1	5.1	5.7	6.9	5.8	6.9	6.7	5.4	**1995**
5.5	6.1	5.5	5.8	7.1	5.8	6.8	6.6	5.7	**1996**
5.5	5.6	5.5	5.6	6.8	5.4	6.7	6.7	5.7	**1997**
5.5	5.7	5.6	5.3	6.6	5.5	7.0	7.1	5.8	**1998**
5.4	5.6	5.9	5.2	:	5.7	7.4	7.0	5.9	**1999**
5.5	5.6	5.8	5.0	:	5.9	:	:	:	**2000**

6.4.4 Total expenditures for personal health care

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	:	:	17 649	:	:	:	:	1 798	:
1980	:	:	4 489	56 723	:	4 001	:	:	:	231
1985	:	:	7 023	73 830	:	8 803	:	:	:	271
1990	:	:	9 139	92 711	:	15 687	81 282	763	50 364	445
1995	:	:	10 683	157 162	:	31 762	105 919	1 147	64 763	712
1996	:	:	11 310	167 411	:	33 835	108 061	:	69 746	763
1997	:	:	11 803	170 537	:	35 490	110 069	:	75 204	812
1998	:	:	12 470	173 098	:	37 906	113 812	:	78 122	813
1999	:	:	13 318	:	:	40 844	117 772	:	81 791	:
2000	:	:	13 919	:	:	:	123 704	:	88 741	:
					in EUR per capita					
1970	:	:	:	291	:	:	:	:	33	:
1980	:	:	876	921	:	107	:	:	:	633
1985	:	:	1 373	1 210	:	229	:	:	:	738
1990	:	:	1 778	1 466	:	404	1 433	218	888	1 159
1995	:	:	2 043	1 925	:	810	1 831	319	1 130	1 724
1996	:	:	2 149	2 044	:	862	1 862	:	1 215	1 834
1997	:	:	2 234	2 078	:	903	1 891	:	1 308	1 929
1998	:	:	2 352	2 110	:	963	1 949	:	1 357	1 904
1999	:	:	2 504	:	:	1 036	2 009	:	1 419	:
2000	:	:	2 608	:	:	:	2 101	:	1 536	:
					in % of gross domestic product (GDP)					
1970	:	:	:	5.1	:	:	:	:	5.2	:
1980	:	:	8.7	7.5	:	4.2	:	:	:	6.1
1985	:	:	8.2	7.9	:	5.0	:	:	:	4.6
1990	:	:	8.2	7.5	:	5.0	8.1	2.1	7.4	4.9
1995	:	:	7.9	8.7	:	7.3	9.0	2.2	7.0	5.4
1996	:	:	7.9	9.1	:	7.3	8.9	:	7.1	5.5
1997	:	:	7.9	9.1	:	7.2	8.8	:	7.3	5.2
1998	:	:	8.0	9.0	:	7.2	8.7	:	7.3	4.8
1999	:	:	8.2	:	:	7.2	8.7	:	7.4	:
2000	:	:	8.0	:	:	:	8.8	:	7.6	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in million EUR					
:	:	:	384	:	:	:	:	3 147	**1970**
10 553	:	:	1 866	:	:	12	2 283	7 890	**1980**
12 997	:	:	3 626	:	:	108	3 943	10 879	**1985**
16 889	:	:	6 149	:	:	360	5 884	15 399	**1990**
21 906	13 292	:	6 489	:	:	461	7 796	19 903	**1995**
22 661	13 780	:	6 839	:	:	494	8 525	20 934	**1996**
23 660	12 928	:	7 041	:	:	524	9 174	21 433	**1997**
25 156	13 625	:	7 254	:	:	602	:	22 309	**1998**
26 593	14 038	:	7 504	:	:	676	:	23 052	**1999**
28 363	14 619	:	7 862	:	:	:	:	:	**2000**
				in EUR per capita					
:	:	:	83	:	:	:	:	502	**1970**
746	:	:	390	:	:	54	559	1 236	**1980**
897	:	:	740	:	:	448	950	1 665	**1985**
1 130	:	:	1 233	:	:	1 413	1 387	2 294	**1990**
1 417	1 652	:	1 270	:	:	1 725	1 788	2 827	**1995**
1 459	1 710	:	1 334	:	:	1 836	1 946	2 960	**1996**
1 516	1 602	:	1 370	:	:	1 933	2 083	3 023	**1997**
1 602	1 687	:	1 408	:	:	2 197	:	3 138	**1998**
1 682	1 735	:	1 451	:	:	2 441	:	3 227	**1999**
1 781	1 802	:	1 517	:	:	:	:	:	**2000**
				in % of gross domestic product (GDP)					
:	:	:	4.9	:	:	:	:	5.3	**1970**
6.6	:	:	5.7	:	:	5.8	6.4	7.1	**1980**
6.5	:	:	6.4	:	:	6.8	6.4	7.4	**1985**
6.9	:	:	7.0	:	:	7.6	7.2	7.8	**1990**
7.2	7.7	:	6.8	:	:	7.9	7.4	8.8	**1995**
7.2	7.7	:	6.9	:	:	7.9	7.4	9.2	**1996**
7.1	7.1	:	6.6	:	:	7.7	7.4	9.3	**1997**
7.1	7.2	:	6.3	:	:	8.0	:	9.5	**1998**
7.1	7.1	:	6.2	:	:	8.4	:	9.6	**1999**
7.1	7.1	:	6.0	:	:	:	:	:	**2000**

6.4.5 Public expenditures for personal health care

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	:	:	12 660	:	330	:	:	:	:
1980	:	:	3 912	44 176	:	3 854	:	:	:	192
1985	:	:	5 959	56 787	:	7 226	:	:	:	300
1990	:	:	7 512	69 883	:	14 860	62 947	:	41 657	:
1995	:	:	8 738	120 702	:	22 405	81 433	:	47 464	:
1996	:	:	9 235	128 890	:	23 936	83 100	2 702	51 174	:
1997	:	:	9 618	128 372	:	25 120	84 820	3 139	55 247	:
1998	:	:	10 113	129 111	:	26 552	87 553	3 591	57 067	:
1999	:	:	10 849	:	:	28 464	90 615	4 113	60 112	:
2000	:	:	11 316	:	:	:	95 081	4 617	66 356	:
					in EUR per capita					
1970	:	:	:	209	:	10	:	:	:	:
1980	:	:	764	718	:	103	:	:	:	526
1985	:	:	1 165	931	:	188	:	:	:	817
1990	:	:	1 461	1 105	:	382	1 110	:	734	:
1995	:	:	1 671	1 478	:	571	1 408	:	828	:
1996	:	:	1 755	1 574	:	610	1 432	745	892	:
1997	:	:	1 820	1 565	:	639	1 457	857	961	:
1998	:	:	1 908	1 574	:	674	1 499	969	991	:
1999	:	:	2 040	:	:	722	1 546	1 098	1 043	:
2000	:	:	2 120	:	:	:	1 614	1 219	1 149	:
					in % of gross domestic product (GDP)					
1970	:	:		3.7	:	2.0	:	:	:	:
1980	:	:	7.5	5.9	:	4.0	:	:	:	5.1
1985	:	:	7.0	6.1	:	4.1	:	:	:	5.1
1990	:	:	6.8	5.6	:	4.7	6.2	:	6.1	:
1995	:	:	6.4	6.7	:	5.1	6.9	:	5.1	:
1996	:	:	6.5	7.0	:	5.2	6.9	4.7	5.2	:
1997	:	:	6.4	6.9	:	5.1	6.8	4.7	5.4	:
1998	:	:	6.5	6.7	:	5.0	6.7	4.7	5.3	:
1999	:	:	6.7	:	:	5.0	6.7	4.6	5.4	:
2000	:	:	6.5	:	:	:	6.8	4.5	5.7	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in million EUR					
:	:	:	273	:	:	:	:	:	**1970**
7 845	:	:	1 453	:	:	11	:	:	**1980**
9 632	:	:	2 809	:	:	93	3 126	6 819	**1985**
12 155	:	:	4 927	:	:	310	4 851	10 045	**1990**
16 959	9 673	:	4 845	:	:	386	6 457	10 080	**1995**
16 272	9 930	:	5 127	:	:	412	7 014	10 880	**1996**
17 312	9 644	:	5 294	:	:	436	7 554	11 335	**1997**
18 391	10 196	:	5 478	:	:	502	:	11 768	**1998**
19 145	10 397	:	5 600	:	:	570	:	12 282	**1999**
20 762	10 815	:	5 844	:	:	:	:	:	**2000**
				in EUR per capita					
:	:	:	59	:	:	:	:	:	**1970**
554	:	:	304	:	:	47	:	:	**1980**
665	:	:	573	:	:	387	753	1 044	**1985**
813	:	:	988	:	:	1 216	1 144	1 497	**1990**
1 097	1 202	:	949	:	:	1 447	1 481	1 432	**1995**
1 048	1 232	:	1 000	:	:	1 531	1 601	1 539	**1996**
1 109	1 195	:	1 030	:	:	1 608	1 715	1 599	**1997**
1 171	1 262	:	1 063	:	:	1 832	:	1 655	**1998**
1 211	1 285	:	1 083	:	:	2 057	:	1 719	**1999**
1 304	1 333	:	1 128	:	:	:	:	:	**2000**
				in % of gross domestic product (GDP)					
:	:	:	3.5	:	:	:	:	:	**1970**
4.9	:	:	4.4	:	:	5.1	:	:	**1980**
4.8	:	:	4.9	:	:	5.9	5.1	4.6	**1985**
5.0	:	:	5.6	:	:	6.5	5.9	5.1	**1990**
5.6	5.6	:	5.1	:	:	6.6	6.1	4.5	**1995**
5.2	5.6	:	5.2	:	:	6.6	6.1	4.8	**1996**
5.2	5.3	:	5.0	:	:	6.4	6.1	4.9	**1997**
5.2	5.4	:	4.7	:	:	6.7	:	5.0	**1998**
5.1	5.3	:	4.6	:	:	7.1	:	5.1	**1999**
5.2	5.3	:	4.5	:	:	:	:	:	**2000**

6.4.6 Total expenditures for inpatient care

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	328	:	6 670	:	:	:	:	853	:
1980	:	1 880	2 909	22 067	:	2 791	:	635	:	70
1985	:	2 971	4 466	29 460	:	5 357	:	:	:	94
1990	:	3 990	5 344	37 628	:	9 194	39 949	:	23 376	148
1995	:	5 874	6 121	63 697	:	14 757	51 615	:	30 493	263
1996	:	6 386	6 523	66 362	:	15 692	52 764	:	30 712	289
1997	:	6 450	6 745	66 236	:	16 296	53 495	:	33 754	331
1998	:	:	7 071	67 748	:	17 254	54 373	:	34 363	303
1999	:	:	7 481	:	:	18 352	55 211	:	36 204	330
2000	:	:	7 757	:	:	:	56 821	:	39 725	:
					in EUR per capita					
1970	:	34	:	110	:	:	:	:	16	:
1980	:	191	568	358	:	74	:	187	:	192
1985	:	301	873	483	:	139	:	:	:	256
1990	:	400	1 040	595	:	237	704	:	412	385
1995	:	578	1 171	780	:	376	892	:	532	637
1996	:	629	1 240	810	:	400	909	:	535	695
1997	:	634	1 277	807	:	414	919	:	587	786
1998	:	:	1 334	826	:	438	931	:	597	710
1999	:	:	1 406	:	:	466	942	:	628	762
2000	:	:	1 453	:	:	:	965	:	688	:
					in % of gross domestic product (GDP)					
1970	:	1.0	:	1.9	:	:	:	:	2.5	:
1980	:	2.1	5.6	2.9	:	2.9	:	4.9	:	1.8
1985	:	2.4	5.2	3.2	:	3.0	:	:	:	1.6
1990	:	2.4	4.8	3.0	:	2.9	4.0	:	3.4	1.6
1995	:	2.9	4.5	3.5	:	3.4	4.4	:	3.3	2.0
1996	:	3.1	4.6	3.6	:	3.4	4.4	:	3.1	2.1
1997	:	3.0	4.5	3.5	:	3.3	4.3	:	3.3	2.1
1998	:	:	4.6	3.5	:	3.3	4.2	:	3.2	1.8
1999	:	:	4.6	:	:	3.2	4.1	:	3.3	1.8
2000	:	:	4.5	:	:	:	4.0	:	3.4	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in million EUR					
:	:	:	204	:	:	0	309	1 461	**1970**
6 612	:	119	968	:	:	8	1 584	3 999	**1980**
7 943	:	333	1 871	:	:	64	2 663	5 485	**1985**
9 601	:	1 015	3 090	:	:	205	3 932	8 047	**1990**
12 477	7 130	2 240	3 007	:	:	264	3 141	9 940	**1995**
13 033	7 276	:	3 154	:	:	281	3 450	10 559	**1996**
13 581	6 345	:	3 232	:	:	296	3 776	10 781	**1997**
14 383	6 549	:	3 303	:	:	343	4 168	11 065	**1998**
15 126	6 621	:	3 359	:	:	390	4 527	11 309	**1999**
16 013	6 834	:	3 471	:	:				**2000**
				in EUR per capita					
:	:	:	44	:	:	1	80	233	**1970**
467	:	12	203	:	:	34	388	626	**1980**
548	:	33	382	:	:	266	641	840	**1985**
642	:	103	620	:	:	805	927	1 199	**1990**
807	886	226	589	:	:	988	721	1 412	**1995**
839	903	:	615	:	:	1 044	787	1 493	**1996**
870	786	:	629	:	:	1 094	857	1 521	**1997**
916	811	:	641	:	:	1 254	941	1 556	**1998**
957	818	:	650	:	:	1 408	1 015	1 583	**1999**
1 005	842	:	670	:	:	:	:	:	**2000**
				in % of gross domestic product (GDP)					
:	:	:	2.6	:	:	2.4	3.0	2.5	**1970**
4.1	:	1.6	2.9	:	:	3.6	4.5	3.6	**1980**
4.0	:	1.6	3.3	:	:	4.1	4.3	3.7	**1985**
3.9	:	2.0	3.5	:	:	4.3	4.8	4.1	**1990**
4.1	4.1	2.8	3.2	:	:	4.5	3.0	4.4	**1995**
4.1	4.1	:	3.2	:	:	4.5	3.0	4.7	**1996**
4.1	3.5	:	3.0	:	:	4.4	3.0	4.7	**1997**
4.1	3.4	:	2.8	:	:	4.6	3.3	4.7	**1998**
4.0	3.4	:	2.8	:	:	4.8	3.3	4.7	**1999**
4.0	3.3	:	2.6	:	:	:	:	:	**2000**

6.4.7 Total expenditures for outpatient care

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	543	:	6 912	:	:	:	:	647	13
1980	:	2 227	1 053	22 151	:	:	:	:	:	111
1985	:	3 500	1 522	27 444	:	:	:	:	:	178
1990	:	4 832	2 088	32 967	:	:	20 488	:	15 392	277
1995	:	6 033	2 603	53 111	:	9 275	26 145	:	20 016	436
1996	:	6 330	2 717	56 027	:	9 711	26 619	:	23 480	447
1997	:	6 334	2 874	58 322	:	10 012	27 037	:	24 524	463
1998	:	:	3 103	57 556	:	10 685	27 982	:	25 682	492
1999	:	:	3 468	:	:	11 568	28 817	:	26 293	:
2000	:	:	3 652	:	:	:	29 852	:	27 822	:
					in EUR per capita					
1970	:	56	:	114	:	:	:	:	12	38
1980	:	226	206	360	:	:	:	:	:	304
1985	:	355	298	450	:	:	:	:	:	485
1990	:	485	406	521	:	:	361	:	271	721
1995	:	594	498	650	:	237	452	:	349	1 056
1996	:	623	516	684	:	247	459	:	409	1 075
1997	:	622	544	711	:	255	464	:	426	1 100
1998	:	:	585	702	:	271	479	:	446	1 152
1999	:	:	652	:	:	293	492	:	456	:
2000	:	:	684	:	:	:	507	:	482	:
					in % of gross domestic product (GDP)					
1970	:	1.7	:	2.0	:	:	:	:	1.9	0.8
1980	:	2.5	2.0	2.9	:	:	:	:	:	2.9
1985	:	2.9	1.8	2.9	:	:	:	:	:	3.0
1990	:	2.9	1.9	2.7	:	:	2.0	:	2.3	3.0
1995	:	3.0	1.9	2.9	:	2.1	2.2	:	2.2	3.3
1996	:	3.1	1.9	3.1	:	2.1	2.2	:	2.4	3.2
1997	:	2.9	1.9	3.1	:	2.0	2.2	:	2.4	3.0
1998	:	:	2.0	3.0	:	2.0	2.1	:	2.4	2.9
1999	:	:	2.1	:	:	2.0	2.1	:	2.4	:
2000	:	:	2.1	:	:	:	2.1	:	2.4	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in million EUR					
:	356	:	92	:	:	:	:	1 078	**1970**
2 367	1 097	:	524	:	:	2	457	2 672	**1980**
2 827	1 496	:	1 205	:	:	22	866	3 823	**1985**
3 376	2 281	:	2 169	:	:	86	1 329	5 306	**1990**
3 866	4 207	:	2 203	:	:	112	:	6 058	**1995**
3 886	4 437	:	2 313	:	:	119	:	6 296	**1996**
4 070	4 339	:	2 355	:	:	123	:	6 447	**1997**
4 253	4 598	:	2 458	:	:	143	:	6 854	**1998**
4 513	4 751	:	2 528	:	:	156	:	7 132	**1999**
4 791	4 939	:	2 650	:	:	:	:	:	**2000**
				in EUR per capita					
:	48	:	20	:	:	:	:	172	**1970**
167	145	:	110	:	:	10	112	418	**1980**
195	198	:	246	:	:	91	209	585	**1985**
226	296	:	435	:	:	336	313	791	**1990**
250	523	:	431	:	:	420	:	860	**1995**
250	551	:	451	:	:	441	:	890	**1996**
261	538	:	458	:	:	454	:	909	**1997**
271	569	:	477	:	:	520	:	964	**1998**
285	587	:	489	:	:	565	:	998	**1999**
301	609	:	511	:	:	:	:	:	**2000**
				in % of gross domestic product (GDP)					
:	1.3	:	1.2	:	:	:	:	1.8	**1970**
1.5	1.5	:	1.6	:	:	1.0	1.3	2.4	**1980**
1.4	1.5	:	2.1	:	:	1.4	1.4	2.6	**1985**
1.4	1.7	:	2.5	:	:	1.8	1.6	2.7	**1990**
1.3	2.4	:	2.3	:	:	1.9	:	2.7	**1995**
1.2	2.5	:	2.3	:	:	1.9	:	2.8	**1996**
1.2	2.4	:	2.2	:	:	1.8	:	2.8	**1997**
1.2	2.4	:	2.1	:	:	1.9	:	2.9	**1998**
1.2	2.4	:	2.1	:	:	1.9	:	3.0	**1999**
1.2	2.4	:	2.0	:	:	:	:	:	**2000**

6.4.8 Total expenditures for home care

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	:	:	2	:	:	:	:	:	:
1980	:	:	89	67	:	:	:	:	:	:
1985	:	:	229	210	:	:	:	:	:	:
1990	:	:	431	276	:	:	234	:	:	:
1995	:	5 327	455	5 423	:	:	412	:	:	:
1996	:	5 162	502	7 628	:	:	436	:	:	:
1997	:	5 436	520	7 994	:	:	449	:	:	:
1998	:	5 655	518	8 059	:	:	477	:	:	:
1999	:	5 888	494	:	:	:	504	:	:	:
2000	:	6 219	534	:	:	:	538	:	:	:
					in EUR per capita					
1970	:	:	:	0	:	:	:	:	:	:
1980	:	:	17	1	:	:	:	:	:	:
1985	:	:	45	3	:	:	:	:	:	:
1990	:	:	84	4	:	:	4	:	:	:
1995	:	524	87	66	:	:	7	:	:	:
1996	:	508	95	93	:	:	8	:	:	:
1997	:	534	98	97	:	:	8	:	:	:
1998	:	554	98	98	:	:	8	:	:	:
1999	:	576	93	:	:	:	9	:	:	:
2000	:	607	100	:	:	:	9	:	:	:
					in % of gross domestic product (GDP)					
1970	:	:	:	0.0	:	:	:	:	:	:
1980	:	:	0.2	0.0	:	:	:	:	:	:
1985	:	:	0.3	0.0	:	:	:	:	:	:
1990	:	:	0.4	0.0	:	:	0.0	:	:	:
1995	:	2.6	0.3	0.3	:	:	0.0	:	:	:
1996	:	2.5	0.4	0.4	:	:	0.0	:	:	:
1997	:	2.5	0.3	0.4	:	:	0.0	:	:	:
1998	:	2.5	0.3	0.4	:	:	0.0	:	:	:
1999	:	2.5	0.3	:	:	:	0.0	:	:	:
2000	:	2.5	0.3	:	:	:	0.0	:	:	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in million EUR					
:	:	:	18	:	:	:	:	:	**1970**
321	:	:	61	:	362	:	:	:	**1980**
454	:	:	:	:	658	:	:	:	**1985**
1 366	:	:	:	:	1 616	:	:	:	**1990**
1 726	:	:	:	:	:	:	:	435	**1995**
1 761	:	:	:	:	:	:	:	479	**1996**
1 857	:	:	:	:	:	:	:	476	**1997**
1 953	:	:	:	:	:	:	:	505	**1998**
2 062	:	:	:	:	:	:	:	525	**1999**
2 342	:	:	:	:	:	:	:		**2000**
				in EUR per capita					
:	:	:	4	:	:	:	:	:	**1970**
23	:	:	13	:	6	:	:	:	**1980**
31	:	:	:	:	12	:	:	:	**1985**
91	:	:	:	:	28	:	:	:	**1990**
112	:	:	:	:	:	:	:	62	**1995**
113	:	:	:	:	:	:	:	68	**1996**
119	:	:	:	:	:	:	:	67	**1997**
124	:	:	:	:	:	:	:	71	**1998**
130	:	:	:	:	:	:	:	74	**1999**
147	:	:	:	:	:	:	:	:	**2000**
				in % of gross domestic product (GDP)					
:	:	:	0.2	:	:	:	:	:	**1970**
0.2	:	:	0.2	:	0.1	:	:	:	**1980**
0.2	:	:	:	:	0.1	:	:	:	**1985**
0.6	:	:	:	:	0.2	:	:	:	**1990**
0.6	:	:	:	:	:	:	:	0.2	**1995**
0.6	:	:	:	:	:	:	:	0.2	**1996**
0.6	:	:	:	:	:	:	:	0.2	**1997**
0.6	:	:	:	:	:	:	:	0.2	**1998**
0.6	:	:	:	:	:	:	:	0.2	**1999**
0.6	:	:	:	:	:	:	:	:	**2000**

6.4.9 Total expenditures for medical goods dispersed to outpatients

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	403	:	3 970	:	:	:	:	:	:
1980	:	1 113	387	11 875	:	:	:	:	:	:
1985	:	1 541	657	15 981	:	:	:	:	:	:
1990	:	2 125	959	21 053	:	:	17 362	:	11 596	:
1995	:	3 247	1 297	32 966	:	7 478	23 817	:	14 254	:
1996	:	3 241	1 340	35 329	:	8 155	24 333	:	15 554	:
1997	:	:	1 417	35 886	:	8 892	25 106	:	16 926	:
1998	:	:	1 525	37 530	:	9 637	26 724	:	18 078	:
1999	:	:	1 593	:	:	10 572	28 733	:	19 294	:
2000	:	:	1 685	:	:	:	31 642	:	21 194	:
					in EUR per capita					
1970	:	42	:	65	:	:	:	:	:	:
1980	:	113	76	193	:	:	:	:	:	:
1985	:	156	128	262	:	:	:	:	:	:
1990	:	213	187	333	:	:	306	:	204	:
1995	:	320	248	404	:	191	412	:	249	:
1996	:	319	255	431	:	208	419	:	271	:
1997	:	:	268	437	:	226	431	:	294	:
1998	:	:	288	458	:	245	458	:	314	:
1999	:	:	300	:	:	268	490	:	335	:
2000	:	:	316	:	:	:	537	:	367	:
					in % of gross domestic product (GDP)					
1970	:	1.3	:	1.1	:	:	:	:	:	:
1980	:	1.3	0.7	1.6	:	:	:	:	:	:
1985	:	1.3	0.8	1.7	:	:	:	:	:	:
1990	:	1.3	0.9	1.7	:	:	1.7	:	1.7	:
1995	:	1.6	1.0	1.8	:	1.7	2.0	:	1.5	:
1996	:	1.6	0.9	1.9	:	1.8	2.0	:	1.6	:
1997	:	:	0.9	1.9	:	1.8	2.0	:	1.6	:
1998	:	:	1.0	1.9	:	1.8	2.0	:	1.7	:
1999	:	:	1.0	:	:	1.9	2.1	:	1.7	:
2000	:	:	1.0	:	:	:	2.3	:	1.8	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in million EUR					
:	:	:	64	:	:	:	:	609	**1970**
1 114	:	:	283	:	:	:	:	1 220	**1980**
1 602	:	:	500	:	:	:	:	1 570	**1985**
2 339	:	:	820	:	:	:	701	2 046	**1990**
3 546	1 955	:	1 186	:	:	:	1 047	2 667	**1995**
3 667	2 067	:	1 268	:	:	:	1 178	2 813	**1996**
3 815	2 244	:	1 346	:	:	:	1 294	2 961	**1997**
4 210	2 478	:	1 381	:	:	:	:	3 045	**1998**
4 525	2 667	:	1 502	:	:	:	:	3 222	**1999**
4 829	2 846	:	1 617	:	:	:	:	:	**2000**
				in EUR per capita					
:	:	:	14	:	:	:	:	97	**1970**
79	:	:	59	:	:	:	:	191	**1980**
111	:	:	102	:	:	:	:	240	**1985**
156	:	:	164	:	:	:	165	305	**1990**
229	243	:	232	:	:	:	240	379	**1995**
236	256	:	247	:	:	:	269	398	**1996**
244	278	:	262	:	:	:	294	418	**1997**
268	307	:	268	:	:	:	:	428	**1998**
286	330	:	290	:	:	:	:	451	**1999**
303	351	:	312	:	:	:	:	:	**2000**
				in % of gross domestic product (GDP)					
:	:	:	0.8	:	:	:	:	1.0	**1970**
0.7	:	:	0.9	:	:	:	:	1.1	**1980**
0.8	:	:	0.9	:	:	:	:	1.1	**1985**
1.0	:	:	0.9	:	:	:	0.9	1.0	**1990**
1.2	1.1	:	1.2	:	:	:	1.0	1.2	**1995**
1.2	1.2	:	1.3	:	:	:	1.0	1.2	**1996**
1.1	1.2	:	1.3	:	:	:	1.0	1.3	**1997**
1.2	1.3	:	1.2	:	:	:	:	1.3	**1998**
1.2	1.4	:	1.2	:	:	:	:	1.3	**1999**
1.2	1.4	:	1.2	:	:	:	:	:	**2000**

6.4.10 Total expenditures for pharmaceuticals dispersed to outpatients

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	359	:	3 502	15	:	:	25	258	11
1980	:	987	286	8 872	76	1 084	:	118	:	33
1985	:	1 371	487	11 941	190	1 955	:	184	:	51
1990	:	1 887	704	15 434	428	3 711	14 560	272	11 596	84
1995	:	2 859	1 010	22 620	1 226	6 009	19 809	368	14 254	101
1996	:	2 866	1 050	24 181	1 390	6 561	20 246	391	15 554	103
1997	:	3 009	1 109	24 027	1 453	7 151	21 108	432	16 926	116
1998	:	:	1 203	25 320	1 291	:	22 588	512	18 078	121
1999	:	:	1 249	:	1 561	:	24 369	596	19 294	130
2000	:	:	1 337	:	1 846	:	26 735	664	21 194	:
					in EUR per capita					
1970	:	37	:	58	2	:	:	8	5	32
1980	:	100	56	144	8	29	:	35	:	90
1985	:	139	95	196	19	51	:	52	:	139
1990	:	189	137	244	42	96	257	78	204	219
1995	:	281	193	277	117	153	342	102	249	245
1996	:	282	200	295	133	167	349	108	271	248
1997	:	296	210	293	138	182	363	118	294	276
1998	:	:	227	309	123	:	387	138	314	283
1999	:	:	235	:	148	:	416	159	335	300
2000	:	:	250	:	175	:	454	175	367	:
					in % of gross domestic product (GDP)					
1970	:	1.1	:	1.0	1.5	:	:	1.1	0.7	0.7
1980	:	1.1	0.6	1.2	1.2	1.1	:	0.9	:	0.9
1985	:	1.1	0.6	1.3	1.1	1.1	:	0.8	:	0.9
1995	:	1.4	0.7	1.3	1.5	1.4	1.7	0.7	1.5	0.8
1996	:	1.4	0.7	1.3	1.6	1.4	1.7	0.7	1.6	0.7
1997	:	1.4	0.7	1.3	1.5	1.4	1.7	0.6	1.6	0.7
1998	:	:	0.8	1.3	1.2	:	1.7	0.7	1.7	0.7
1999	:	:	0.8	:	1.4	:	1.8	0.7	1.7	0.7
2000	:	:	0.8	:	1.5	:	1.9	0.6	1.8	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in million EUR					
:	:	4	55	87	480	0	35		**1970**
965	:	83	223	342	2 338	2	215		**1980**
1 361	:	321	395	577	4 129	19	372	1 316	**1985**
1 870	:	781	651	1 010	6 373	59	460	1 715	**1990**
2 791	:	1 556	1 005	1 836	10 728	74	755	2 238	**1995**
2 890	:	1 731	1 085	2 005	11 725	85	829	2 360	**1996**
2 981	:	1 876	1 156	2 011	12 323	88	909	2 475	**1997**
3 279	:	1 985	1 174	:	:	97	:	2 554	**1998**
3 559	:	:	1 250	:	:	108	:	2 706	**1999**
3 826	:	:	1 353	:	:	:	:	:	**2000**
				in EUR per capita					
:	:	0	12	11	9	0	9	:	**1970**
68	:	8	47	41	41	9	53	:	**1980**
94	:	32	81	69	73	78	90	201	**1985**
125	:	79	131	118	111	230	109	256	**1990**
181	:	157	197	208	183	279	173	318	**1995**
186	:	174	212	227	199	314	189	334	**1996**
191	:	189	225	227	209	324	206	349	**1997**
209	:	199	228	:	:	352	:	359	**1998**
225	:	:	242	:	:	389	:	379	**1999**
240	:	:	261	:	:	:	:	:	**2000**
				in % of gross domestic product (GDP)					
:	:	0.4	0.7	0.5	0.7	0.9	0.3	:	**1970**
0.6	:	1.1	0.7	0.6	0.7	1.0	0.6	:	**1980**
0.7	:	1.5	0.7	0.6	0.8	1.2	0.6	0.9	**1985**
0.9	:	1.9	1.1	1.0	1.1	1.3	0.7	1.0	**1995**
0.9	:	2.0	1.1	1.1	1.1	1.4	0.7	1.0	**1996**
0.9	:	2.0	1.1	1.0	1.1	1.3	0.7	1.1	**1997**
0.9	:	2.0	1.0	:	:	1.3	:	1.1	**1998**
1.0	:	:	1.0	:	:	1.3	:	1.1	**1999**
1.0	:	:	1.0	:	:	:	:	:	**2000**

6.4.11 Total expenditures for therapeutical appliances dispersed to outpatients

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in million EUR					
1970	:	:	:	2	:	:	:	:	:	:
1980	:	:	89	67	:	:	:	:	:	:
1985	:	:	229	210	:	:	:	:	:	:
1990	:	:	431	276	:	:	234	:	:	:
1995	:	5 327	455	5 423	:	:	412	:	:	:
1996	:	5 162	502	7 628	:	:	436	:	:	:
1997	:	5 436	520	7 994	:	:	449	:	:	:
1998	:	5 655	518	8 059	:	:	477	:	:	:
1999	:	5 888	494	:	:	:	504	:	:	:
2000	:	6 219	534	:	:	:	538	:	:	:
					in EUR per capita					
1970	:	:	:	0	:	:	:	:	:	:
1980	:	:	17	1	:	:	:	:	:	:
1985	:	:	45	3	:	:	:	:	:	:
1990	:	:	84	4	:	:	4	:	:	:
1995	:	524	87	66	:	:	7	:	:	:
1996	:	508	95	93	:	:	8	:	:	:
1997	:	534	98	97	:	:	8	:	:	:
1998	:	554	98	98	:	:	8	:	:	:
1999	:	576	93	:	:	:	9	:	:	:
2000	:	607	100	:	:	:	9	:	:	:
					in % of gross domestic product (GDP)					
1970	:	:	:	0.0	:	:	:	:	:	:
1980	:	:	0.2	0.0	:	:	:	:	:	:
1985	:	:	0.3	0.0	:	:	:	:	:	:
1990	:	:	0.4	0.0	:	:	0.0	:	:	:
1995	:	2.6	0.3	0.3	:	:	0.0	:	:	:
1996	:	2.5	0.4	0.4	:	:	0.0	:	:	:
1997	:	2.5	0.3	0.4	:	:	0.0	:	:	:
1998	:	2.5	0.3	0.4	:	:	0.0	:	:	:
1999	:	2.5	0.3	:	:	:	0.0	:	:	:
2000	:	2.5	0.3	:	:	:	0.0	:	:	:

Source: OECD, Health data 2002.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in million EUR					
	:	:	18	:	:	:	:	:	**1970**
321	:	:	61	:	362	:	:	:	**1980**
454	:	:		:	658	:	:	:	**1985**
1 366	:	:	:	:	1 616	:	:	:	**1990**
1 726	:	:	:	:	:	:	:	435	**1995**
1 761	:	:	:	:	:	:	:	479	**1996**
1 857	:	:	:	:	:	:	:	476	**1997**
1 953	:	:	:	:	:	:	:	505	**1998**
2 062	:	:	:	:	:	:	:	525	**1999**
2 342	:	:	:	:	:	:	:	:	**2000**
				in EUR per capita					
:	:	:	4	:	:	:	:	:	**1970**
23	:	:	13	:	6	:	:	:	**1980**
31	:	:	:	:	12	:	:	:	**1985**
91	:	:	:	:	28	:	:	:	**1990**
112	:	:	:	:	:	:	:	62	**1995**
113	:	:	:	:	:	:	:	68	**1996**
119	:	:	:	:	:	:	:	67	**1997**
124	:	:	:	:	:	:	:	71	**1998**
130	:	:	:	:	:	:	:	74	**1999**
147	:	:	:	:	:	:	:	:	**2000**
				in % of gross domestic product (GDP)					
:	:	:	0.2	:	:	:	:	:	**1970**
0.2	:	:	0.2	:	0.1	:	:	:	**1980**
0.2	:	:	:	:	0.1	:	:	:	**1985**
0.6	:	:	:	:	0.2	:	:	:	**1990**
0.6	:	:	:	:	:	:	:	0.2	**1995**
0.6	:	:	:	:	:	:	:	0.2	**1996**
0.6	:	:	:	:	:	:	:	0.2	**1997**
0.6	:	:	:	:	:	:	:	0.2	**1998**
0.6	:	:	:	:	:	:	:	0.2	**1999**
0.6	:	:	:	:	:	:	:	:	**2000**

6.4.12 Social protection expenditures for sickness/health care

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in EUR per capita					
1990	:	1 024	1 147	1 452	347	574	1 238	635	1 008	1 202
1991	:	1 118	1 224	1 425	356	677	1 294	694	1 110	1 325
1992	:	1 279	1 278	1 639	396	757	1 403	772	1 105	1 484
1993	1 221	1 260	1 364	1 703	425	710	1 518	800	948	1 685
1994	1 256	1 310	1 384	1 815	453	681	1 571	847	905	1 752
1995	1 298	1 312	1 474	1 983	482	697	1 644	928	810	1 922
1996	1 346	1 394	1 488	1 962	518	752	1 707	955	941	2 076
1997	1 368	1 334	1 513	1 837	578	737	1 699	1 125	1 024	2 051
1998	1 429	1 390	1 649	1 862	587	773	1 767	1 167	1 055	2 083
1999	1 497	1 472	1 742	1 936	677	810	1 819	1 345	1 111	2 240
					in % of gross domestic product (GDP)					
1990	:	6.6	5.6	7.8	5.3	5.6	7.5	6.0	6.6	5.4
1991	7.1	6.8	5.8	8.0	5.0	6.0	7.6	6.3	6.7	5.6
1992	7.5	7.3	5.8	8.5	5.3	6.4	7.9	6.6	6.6	5.8
1993	7.5	6.9	6.0	8.3	5.5	6.6	8.2	6.7	6.4	5.9
1994	7.4	6.7	5.6	8.4	5.6	6.4	8.2	6.6	6.0	5.6
1995	7.4	6.3	5.6	8.6	5.6	6.1	8.2	6.6	5.5	5.6
1996	7.3	6.7	5.4	8.6	5.5	6.1	8.3	6.0	5.6	6.0
1997	7.1	6.3	5.4	8.1	5.7	5.9	8.2	5.8	5.7	5.6
1998	7.1	6.3	5.6	8.0	5.7	5.8	8.2	5.6	5.7	5.4
1999	7.1	6.4	5.6	8.0	6.1	5.7	8.1	5.7	5.8	5.3

Source: Esspros (European system of integrated social protection statistics), Eurostat.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in EUR per capita					
1 301	1 095	232	1 492	:	719	1 391	1 671	1 289	**1990**
1 376	1 170	306	1 541	:	893	1 564	1 782	1 428	**1991**
1 511	1 279	416	1 271	:	940	1 485	1 817	1 483	**1992**
1 639	1 411	450	1 043	1 633	952	1 422	1 770	1 564	**1993**
1 610	1 504	493	1 107	1 564	999	1 368	1 779	1 729	**1994**
1 707	1 614	497	1 253	1 589	961	1 409	1 915	1 838	**1995**
1 639	1 605	551	1 286	1 749	1 026	1 470	2 181	1 898	**1996**
1 611	1 610	595	1 313	1 789	1 256	1 647	2 449	1 881	**1997**
1 682	1 687	649	1 339	1 893	1 401	1 838	2 609	2 003	**1998**
1 808	1 813	716	1 393	2 090	1 455	2 179	2 890	2 095	**1999**
				in % of gross domestic product (GDP)					
8.7	6.7	4.1	6.9	:	5.3	7.1	7.8	4.8	**1990**
8.8	6.8	4.6	7.7	7.7	6.2	7.4	8.0	5.2	**1991**
9.3	7.0	5.4	7.6	8.3	6.6	7.2	8.0	5.4	**1992**
9.4	7.2	6.0	7.2	8.7	6.8	7.2	7.7	5.4	**1993**
8.4	7.3	6.4	6.7	7.9	6.7	6.9	7.4	5.5	**1994**
8.3	7.4	6.0	6.5	7.6	6.5	7.1	7.4	5.5	**1995**
7.8	7.2	6.2	6.6	7.5	6.5	6.9	7.7	5.8	**1996**
7.6	7.1	6.3	6.2	7.5	6.4	6.8	7.9	5.9	**1997**
7.5	7.2	6.5	6.0	7.8	6.6	6.9	8.8	6.1	**1998**
7.6	7.4	6.7	6.0	8.2	6.4	7.5	8.9	6.2	**1999**

6.4.13 Social protection cash benefits for sickness/health care

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in EUR per capita					
1990	:	231	244	372	61	104	109	106	142	160
1991	:	248	224	352	62	125	115	110	143	177
1992	:	302	228	398	61	146	124	117	146	198
1993	220	307	249	407	62	133	130	114	125	211
1994	218	315	235	409	64	126	130	112	119	218
1995	226	247	298	461	65	129	136	155	109	231
1996	218	246	303	415	67	139	142	126	120	239
1997	205	263	294	345	71	130	139	135	124	236
1998	215	252	283	341	81	126	145	142	130	248
1999	227	257	294	367	87	138	153	147	133	277
					in % of gross domestic product (GDP)					
1990	:	1.5	1.2	2.0	0.9	1.0	0.7	1.0	0.9	0.7
1991	:	1.5	1.1	2.0	0.9	1.1	0.7	1.0	0.9	0.7
1992	:	1.7	1.0	2.1	0.8	1.2	0.7	1.0	0.9	0.8
1993	1.4	1.7	1.1	2.0	0.8	1.2	0.7	1.0	0.8	0.7
1994	1.3	1.6	1.0	1.9	0.8	1.2	0.7	0.9	0.8	0.7
1995	1.3	1.2	1.1	2.0	0.8	1.1	0.7	1.1	0.7	0.7
1996	1.2	1.2	1.1	1.8	0.7	1.1	0.7	0.8	0.7	0.7
1997	1.1	1.2	1.0	1.5	0.7	1.0	0.7	0.7	0.7	0.6
1998	1.1	1.2	1.0	1.5	0.8	0.9	0.7	0.7	0.7	0.6
1999	1.1	1.1	0.9	1.5	0.8	1.0	0.7	0.6	0.7	0.7

Source: Esspros (European system of integrated social protection statistics), Eurostat.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in EUR per capita					
451	197	31	328	:	94	297	564	223	**1990**
448	213	39	329	:	132	341	612	248	**1991**
460	230	46	262	:	151	329	577	249	**1992**
484	243	40	205	429	147	308	528	265	**1993**
487	253	42	216	362	146	278	494	280	**1994**
507	261	49	245	342	127	278	545	294	**1995**
500	245	49	243	334	122	273	696	296	**1996**
487	228	51	248	346	141	329	752	290	**1997**
532	236	49	258	439	171	351	802	310	**1998**
568	269	47	274	537	158	403	923	308	**1999**
				in % of gross domestic product (GDP)					
3.0	1.2	0.5	1.5	:	0.7	1.5	2.6	0.8	**1990**
2.9	1.2	0.6	1.7	:	0.9	1.6	2.7	0.9	**1991**
2.8	1.3	0.6	1.6	:	1.1	1.6	2.5	0.9	**1992**
2.8	1.2	0.5	1.4	2.3	1.0	1.6	2.3	0.9	**1993**
2.6	1.2	0.5	1.3	1.8	1.0	1.4	2.1	0.9	**1994**
2.5	1.2	0.6	1.3	1.6	0.9	1.4	2.1	0.9	**1995**
2.4	1.1	0.6	1.2	1.4	0.8	1.3	2.5	0.9	**1996**
2.3	1.0	0.5	1.2	1.5	0.7	1.4	2.4	0.9	**1997**
2.4	1.0	0.5	1.2	1.8	0.8	1.3	2.7	0.9	**1998**
2.4	1.1	0.4	1.2	2.1	0.7	1.4	2.9	0.9	**1999**

6.4.14 Social protection benefits in kind for sickness/health care

	EU-15	B	DK	D	EL	E	F	IRL	I	L
					in EUR per capita					
1990	:	793	903	1 080	287	470	1 129	528	866	1 043
1991	:	871	1 000	1 073	294	552	1 179	584	967	1 147
1992	:	977	1 050	1 242	335	612	1 279	655	958	1 286
1993	1 001	953	1 115	1 296	363	577	1 388	686	823	1 473
1994	1 038	995	1 148	1 406	389	554	1 440	735	786	1 534
1995	1 071	1 065	1 176	1 522	416	569	1 508	773	701	1 691
1996	1 128	1 148	1 185	1 547	451	613	1 565	829	820	1 837
1997	1 163	1 071	1 218	1 492	507	607	1 560	990	900	1 815
1998	1 214	1 138	1 366	1 521	506	647	1 622	1 025	925	1 835
1999	1 271	1 215	1 448	1 569	590	672	1 665	1 198	978	1 963
					in % of gross domestic product (GDP)					
1990	:	5.1	4.4	5.8	4.4	4.6	6.8	5.0	5.7	4.7
1991	:	5.3	4.8	6.0	4.1	4.9	7.0	5.3	5.8	4.8
1992	:	5.6	4.8	6.4	4.5	5.2	7.2	5.6	5.7	5.0
1993	6.2	5.2	4.9	6.3	4.7	5.4	7.5	5.8	5.5	5.2
1994	6.1	5.1	4.7	6.5	4.8	5.2	7.5	5.7	5.2	4.9
1995	6.1	5.1	4.5	6.6	4.8	5.0	7.5	5.5	4.8	5.0
1996	6.1	5.5	4.3	6.7	4.8	5.0	7.6	5.2	4.8	5.3
1997	6.0	5.1	4.3	6.6	5.0	4.8	7.5	5.1	5.0	5.0
1998	6.0	5.2	4.6	6.5	4.9	4.9	7.5	4.9	5.0	4.8
1999	6.0	5.3	4.7	6.5	5.3	4.7	7.4	5.0	5.1	4.7

Source: Esspros (European system of integrated social protection statistics), Eurostat.

NL	A	P	FIN	S	UK	IS	NO	CH	
				in EUR per capita					
850	898	201	1 164	:	625	1 094	1 107	1 066	**1990**
928	956	267	1 212	:	761	1 224	1 170	1 180	**1991**
1 051	1 049	370	1 009	:	789	1 156	1 240	1 235	**1992**
1 155	1 168	410	838	1 205	804	1 114	1 242	1 299	**1993**
1 122	1 250	451	891	1 202	854	1 090	1 285	1 449	**1994**
1 200	1 354	448	1 008	1 247	834	1 131	1 370	1 544	**1995**
1 139	1 360	502	1 043	1 415	904	1 197	1 485	1 603	**1996**
1 124	1 382	544	1 065	1 443	1 115	1 318	1 698	1 591	**1997**
1 150	1 451	599	1 081	1 454	1 230	1 487	1 807	1 693	**1998**
1 240	1 544	669	1 119	1 553	1 297	1 776	1 966	1 787	**1999**
				in % of gross domestic product (GDP)					
5.7	5.5	3.5	5.4	:	4.6	5.6	5.2	4.0	**1990**
6.0	5.5	4.0	6.1	:	5.3	5.8	5.2	4.3	**1991**
6.4	5.7	4.8	6.1	:	5.6	5.6	5.4	4.5	**1992**
6.6	6.0	5.5	5.8	6.4	5.7	5.7	5.4	4.5	**1993**
5.9	6.1	5.9	5.4	6.1	5.7	5.5	5.4	4.6	**1994**
5.8	6.2	5.4	5.2	6.0	5.7	5.7	5.3	4.6	**1995**
5.5	6.1	5.6	5.3	6.1	5.7	5.6	5.2	4.9	**1996**
5.3	6.1	5.8	5.1	6.1	5.7	5.5	5.5	5.0	**1997**
5.1	6.2	6.0	4.8	6.0	5.8	5.6	6.1	5.1	**1998**
5.2	6.3	6.2	4.8	6.1	5.7	6.1	6.1	5.3	**1999**

6.4.15 Social benefits by functions: sickness/health care (all schemes), 1999

	EU-15	B	DK	D	EL	E	F	IRL	I	L
						in million EUR				
Social protection benefits	1 497	1 472	1 742	1 936	677	810	1 819	1 345	1 111	2 240
Cash benefits	227	257	294	367	87	138	153	147	133	277
Benefits in kind	1 271	1 215	1 448	1 569	590	672	1 665	1 198	978	1 963
Means-tested benefits	:	18	:	23	2	24	19	169	2	12
Cash benefits	:	:	:	:	:	:	5	0	2	:
Periodic cash benefits	:	:	:	:	:	:	:	0	2	:
Paid sick leave benefit	:	:	:	:	:	:	:	:	:	:
Other periodic cash benefits	:	:	:	:	:	:	:	0	2	:
Lump sum cash benefits	:	:	:	:	:	:	5	:	:	:
Other lump sum cash benefits	:	:	:	:	:	:	5	:	:	:
Benefits in kind	:	18	:	23	2	24	14	168	:	12
Inpatient care	:	17	:	6	:	17	:	:	:	:
Inpatient care: direct provision	:	17	:	6	:	17	:	:	:	:
Inpatient care: reimbursement	:	:	:	:	:	:	:	:	:	:
Outpatient care	:	1	:	17		7	10	168	:	12
Outpatient care: direct provision of pharmaceutical products	:	:	:	3	:	:	:	62	:	2
Outpatient care: other direct provision	:	1	:	14		7	:	107	:	10
Outpatient care: other reimbursement	:	:	:	:	:	:	10	:	:	:
Other benefits in kind	:	:	:		2	:	4	:	:	:
Non-means-tested benefits	1 482	1 454	1 742	1 913	675	786	1 800	1 176	1 109	2 228
Cash benefits	224	257	294	367	87	138	149	147	132	277
Periodic cash benefits	220	176	288	367	73	138	149	147	132	277
Paid sick leave benefit	215	176	284	367	73	138	149	82	132	277
Other periodic cash benefits	:	:	4	:		:	:	65	:	:
Lump sum cash benefits	:	81	6		14	:		:	:	:
Other lump sum cash benefits	:	81	6		14	:		:	:	:
Benefits in kind	1 259	1 197	1 448	1 546	588	648	1 651	1 029	978	1 951
Inpatient care	693	1 177	972	643	292	392	870	866	552	982
Inpatient care: direct provision	618	1	972	601	265	390	661	866	552	982
Inpatient care: reimbursement	:	1 176	:	42	28	2	209	:	:	:
Outpatient care	548	18	477	867	262	255	753	164	426	969
Outpatient care: direct provision of pharmaceutical products	:	:	117	238	3	161	:	:	128	210
Outpatient care: other direct provision	:	17	360	543	115	92	:	100	298	373
Outpatient care: reimbursement of pharmaceutical products	:	1	:	17	119	:	291	51	:	:
Outpatient care: other reimbursement	:	:	:	68	25	2	462	12	:	385
Other benefits in kind	:	1	:	37	33		28	:	:	:

Source: Esspros (European system of integrated social protection statistics), Eurostat.

(EUR per inhabitant)

NL	A	P	FIN	S	UK	IS	NO	CH	
			in million EUR						
1 808	1 813	716	1 393	2 090	1 455	2 179	2 890	2 095	**Social protection benefits**
568	269	47	274	537	158	403	923	308	**Cash benefits**
1 240	1 544	669	1 119	1 553	1 297	1 776	1 966	1 787	**Benefits in kind**
1	:	1	:	:	12	:	:	62	**Means-tested benefits**
1	:		:	:	12	:	:	:	*Cash benefits*
1	:	:	:	:	11	:	:	:	Periodic cash benefits
1	:	:	:	:	:	:	:	:	Paid sick leave benefit
:	:	:	:	:	11	:	:	:	Other periodic cash benefits
:	:		:	:		:	:	:	Lump sum cash benefits
:	:		:	:		:	:	:	Other lump sum cash benefits
:	:	1	:	:	:	:	:	62	*Benefits in kind*
:	:		:	:	:	:	:	12	Inpatient care
:	:		:	:	:	:	:	:	Inpatient care: direct provision
:	:	:	:	:	:	:	:	12	Inpatient care: reimbursement
:	:		:	:	:	:	:	12	Outpatient care
:	:		:	:	:	:	:	:	Outpatient care: direct provision of pharmaceutical products
:	:		:	:	:	:	:	12	Outpatient care: other direct provision
:	:	:	:	:	:	:	:	:	Outpatient care: other reimbursement
:	:	1	:	:	:	:	:	38	Other benefits in kind
1 808	1 813	715	1 393	2 090	1 444	2 179	2 890	2 034	**Non-means-tested benefits**
567	269	47	274	537	146	403	923	308	*Cash benefits*
566	269	47	274	537	141	403	921	308	Periodic cash benefits
452	269	46	274	536	140	403	921	308	Paid sick leave benefit
115	0		:	1	1	:	:	:	Other periodic cash benefits
1	:	:	:	:	6	:	2		Lump sum cash benefits
1	:	:	:	:	6	:	2		Other lump sum cash benefits
1 240	1 544	668	1 119	1 553	1 297	1 776	1 966	1 726	*Benefits in kind*
876	801	337	522	780	870	1 065	1 066	844	Inpatient care
876	801	334	512	780	870	1 065	:	844	Inpatient care: direct provision
:	:	3	9	:	:	:	:		Inpatient care: reimbursement
348	704	322	587	737	424	649	822	766	Outpatient care
145	237	115	:	211	68	226	:	243	Outpatient care: direct provision of pharmaceutical products
203	467	184	374	526	356	423	:	523	Outpatient care: other direct provision
:	:	5	118	:	:	:	:	:	Outpatient care: reimbursement of pharmaceutical products
:	:	20	95	:	:	:	:		Outpatient care: other reimbursement
16	39	9	10	35	3	62	79	115	Other benefits in kind

6.4.16 Final consumption expenditure of private households

	EU-15	B	DK	D	EL	E	F	IRL	I
					For health altogether				
1970	:	:	36	:	:	:	:	:	13
1980	:	:	90	188	:	:	:	:	53
1985	:	:	164	273	:	:	:	:	113
1990	:	:	258	346	:	:	305	173	195
1995	:	409	316	503	375	236	414	221	274
1996	:	410	327	489	395	252	428	237	320
1997	:	415	337	504	426	256	420	267	348
1998	:	429	359	515	433	277	425	266	364
1999	:	448	374	525	469	302	442	285	376
2000	:	472	393	544	434	327	454	316	388
2001	:	:	418	:	:	:	473	:	371
					For hospital services				
1970	:	:	4	:	:	:	:	:	2
1980	:	:	14	:	:	:	:	:	6
1985	:	:	25	:	:	:	:	:	16
1990	:	:	17	:	:	:	70	91	19
1995	:	120	26	156	:	34	93	131	31
1996	:	122	31	140	:	36	99	141	34
1997	:	119	34	143	:	36	98	162	34
1998	:	126	40	148	:	39	93	163	37
1999	:	134	42	150	:	43	93	170	38
2000	:	142	44	153	:	:	93	183	41
2001	:	:	46	:	:	:	96	:	40
					For outpatient services				
1970	:	:	19	:	:	:	:	:	5
1980	:	:	31	129	:	:	:	:	20
1985	:	:	60	186	:	:	:	:	41
1990	:	:	108	218	:	:	122	40	79
1995	:	133	133	186	332	130	157	60	104
1996	:	136	135	189	351	138	162	66	121
1997	:	138	137	195	380	139	158	74	133
1998	:	148	146	187	386	151	163	74	139
1999	:	153	151	190	420	164	170	81	142
2000	:	158	157	194	386	:	170	92	142
2001	:	:	169	:	:	:	174	:	145
					For medical products, appliances and equipment				
1970	:	:	13	:	:	:	:	:	6
1980	:	:	45	60	:	:	:	:	27
1985	:	:	79	87	:	:	:	:	56
1990	:	:	132	128	:	:	113	42	97
1995	:	156	157	161	42	72	164	30	139
1996	:	152	161	160	44	78	167	29	165
1997	:	158	167	167	46	80	163	31	182
1998	:	154	172	180	47	87	169	28	189
1999	:	161	181	184	49	95	179	35	197
2000	:	173	192	197	49	:	190	41	204
2001	:	:	203	:	:	:	203	:	186

Source: Eurostat, NewCronos database (Economy and finance statistics).

(EUR per capita)

NL	A	P	FIN	S	UK	IS	NO	
				For health altogether				
:	:	:	:	:	12	:	:	**1970**
:	94	:	88	:	37	:	92	**1980**
:	152	:	200	:	74	:	156	**1985**
:	254	237	314	:	108	206	243	**1990**
346	403	273	337	216	141	264	309	**1995**
418	423	281	350	249	151	293	349	**1996**
409	404	296	364	267	185	326	378	**1997**
413	420	302	371	280	202	402	:	**1998**
462	449	322	404	300	217	442	:	**1999**
:	468	344	449	:	244	525	:	**2000**
:	:	:	480	:	254	:	:	**2001**
				For hospital services				
:	:	:	:	:	1	:	:	**1970**
:	34	:	15	:	5	:	2	**1980**
:	57	:	41	:	12	:	3	**1985**
:	89	0	56	:	20	:	3	**1990**
149	126	:	53	:	23	:	4	**1995**
162	125	:	55	:	26	:	4	**1996**
153	120	:	58	:	32	:	5	**1997**
153	121	0	58	:	35	:	:	**1998**
171	131	:	63	:	37	:	:	**1999**
:	133	:	78	:	42	:	:	**2000**
:	:	:	83	:	41	:	:	**2001**
				For outpatient services				
:	:	:	:	:	3	:	:	**1970**
:	37	:	22	:	11	:	49	**1980**
:	57	:	67	:	22	:	81	**1985**
:	106	186	118	:	33	135	144	**1990**
127	186	201	115	:	37	178	187	**1995**
129	203	208	115	:	38	195	208	**1996**
128	192	219	124	:	46	209	219	**1997**
123	205	221	125	:	50	244	:	**1998**
138	219	:	138	:	53	266	:	**1999**
:	230	:	151	:	58	297	:	**2000**
:	:	:	162	:	67	:	:	**2001**
				For medical products, appliances and equipment				
:	:	:	:	:	8	:	:	**1970**
:	23	:	51	:	21	:	42	**1980**
:	39	:	91	:	41	:	72	**1985**
:	59	51	139	:	55	71	95	**1990**
70	92	72	169	:	81	86	118	**1995**
127	94	73	179	:	88	97	137	**1996**
127	91	77	182	:	107	117	154	**1997**
137	94	81	188	:	117	159	:	**1998**
153	99	:	203	:	127	176	:	**1999**
:	105	:	219	:	143	228	:	**2000**
:	:	:	235	:	146	:	:	**2001**

6.4.17 Mean expenditure on health by households

		EU-15	B	DK	D	EL	E	F	IRL
Health	**1999**	:	1 281	560	850	1 468	497	:	539
	1994	639	947	422	638	920	548	1 161	399
	1988	546	604	0	696	693	338	1 007	0
Medical products, appliances and equipment	**1999**	:	514	309	430	272	289	:	288
	1994	263	376	240	214	37	204	536	162
	1988	158	258	0	0	119	140	446	0
Pharmaceutical products	**1999**	:	335	197	209	215	184	:	288
	1994	117	277	148	163	11	94	21	124
	1988	111	175	0	0	89	64	358	0
Other medical products	**1999**	:	10	6	37	15	8	:	0
	1994	55	8	5	1	0	47	286	39
	1988	4	6	0	0	10	32	2	0
Therapeutic appliances and equipment	**1999**	:	169	105	184	42	97	:	0
	1994	90	91	87	50	26	63	229	0
	1988	43	78	0	0	20	44	87	0
Outpatient services	**1999**	:	630	240	341	1 010	192	:	219
	1994	329	458	171	332	767	339	591	236
	1988	190	314	0	0	522	195	546	0
Medical services	**1999**	:	336	10	176	348	54	:	119
	1994	180	330	6	116	416	54	357	155
	1988	118	212	0	0	244	83	314	0
Dental services	**1999**	:	142	165	120	497	109	:	73
	1994	97	98	124	166	318	162	124	66
	1988	54	59	0	0	254	108	172	0
Paramedical services	**1999**	:	152	66	45	165	30	:	27
	1988	48	30	41	49	33	122	110	16
	1988	18	43	0	0	24	3	59	0
Hospital services	**1999**	:	137	11	78	185	16	:	32
	1994	43	113	10	92	116	5	34	0
	1988	8	32	0	0	52	4	15	0

Source: Eurostat, NewCronos database (Household Budget Survey).

(pps)

I	L	NL	A	P	FIN	S	UK		
1 204	1 027	288	641	:	679	641	309	**1999**	**Health**
674	542	303	513	753	636	367	237	**1994**	
370	1 135	363	0	355	0	0	178	**1988**	
662	469	194	323	:	331	244	204	**1999**	Medical products, appliances and equipment
310	270	166	0	344	291	177	148	**1994**	
152	222	155	0	200	0	0	124	**1988**	
533	254	79	209	:	232	170	111	**1999**	Pharmaceutical products
228	146	80	0	291	203	83	44	**1994**	
86	183	85	0	158	0	0	84	**1988**	
33	9	7	11	:	10	10	0	**1999**	Other medical products
0	0	6	0	6	7	0	31	**1994**	
0	36	5	0	5	0	0	0	**1988**	
95	206	108	103	:	89	64	94	**1999**	Therapeutic appliances and equipment
82	124	80	0	47	82	94	72	**1994**	
66	4	66	0	37	0	0	40	**1988**	
523	499	124	288	:	0	393	104	**1999**	Outpatient services
344	205	132	213	385	282	101	90	**1994**	
207	739	200	0	134	0	0	54	**1988**	
152	141	34	74	:	0	49	52	**1999**	Medical services
327	80	43	0	223	106	0	90	**1994**	
188	434	95	0	80	0	0	43	**1988**	
237	285	61	153	:	123	317	52	**1999**	Dental services
0	102	61	0	97	107	101	0	**1994**	
0	217	75	0	19	0	0	11	**1988**	
135	73	28	61	:	73	27	0	**1999**	Paramedical services
18	23	27	0	65	69	0	0	**1988**	
19	88	30	0	35	0	0	0	**1988**	
19	59	1	30	:	0	4	0	**1999**	Hospital services
20	67	5	38	24	63	89	0	**1994**	
11	173	8	0	20	0	0	0	**1988**	

6.4.18 Protection and improvement of human health as a proportion of total R & D government appropriations (final budget)

	EU-15	B	DK	D	EL	E	F	IRL	I
1980	:	:	:	:	:	:	:	:	:
1985	:	1.9	3.4	3.1	6.3	2.7	4.0	4.4	7.1
1990	:	2.9	1.7	3.3	8.0	6.8	3.3	4.2	4.8
1995	4.6	1.9	1.6	3.1	5.1	5.4	4.8	3.4	8.5
1996	5.5	1.5	1.6	*3.3*	5.7	5.6	5.2	3.1	7.6
1997	*6.0*	1.4	1.6	3.4	5.7	5.0	5.5	3.6	8.5
1998	5.7	1.3	1.8	3.2	4.9	4.6	5.6	4.1	5.6
1999	6.3	1.3	1.8	3.3	4.9	4.8	5.5	2.9	9.4
2000	*6.2*	1.6	2.0	3.4	5.8	4.8	5.6	:	6.8
2001	:	:	:	3.9	:	:	:	:	:

Source: Eurostat, NewCronos database (Research and development statistics).

(%)

NL	A	P	FIN	S	UK	EEA	IS	NO	
:	:	:	:	:	:	:	:	:	**1980**
2.4	:	:	:	:	3.5	:	:	6.7	**1985**
2.5	:	2.5	:	:	5.2	:	:	5.5	**1990**
2.5	3.1	7.9	3.5	*1.5*	7.7	*4.6*	:	6.2	**1995**
2.1	2.4	4.6	3.4	*1.5*	14.2	5.5	3.6	6.1	**1996**
2.0	2.2	5.9	7.9	:	14.5	*6.0*	5.7	6.8	**1997**
2.3	2.6	6.1	7.6	0.9	14.5	5.8	3.9	6.8	**1998**
3.7	2.6	5.3	7.0	1.8	14.7	6.3	4.2	7.0	**1999**
3.6	2.5	5.4	6.9	1.3	15.2	*6.3*	:	7.0	**2000**
3.1	1.7	7.2	6.4	:	14.2	:	:	7.0	**2001**

I. Organisation of health systems

	Main type of coverage	Share (%) in financing health system (1999)				Methods of providing services under the public scheme (2002)		Main type of providers	Type of payment to primary care doctors
		Social contributions (*)	*State*	*Persons*	*Private insurance*	*Integrated*	*Contracted*		
B+	Social insurance + government subsidies	50.8	31.0	12.5	4.7	-	All services	Ambulatory private; hospitals partly public	Fee-for-service
DK	National Health Service	0.0	83.4	14.6	2.0	Hospitals	GPs, specialists outside hospitals, pharmacies	Mainly public	Capitation, fee-for-service (R) (2)
D+	Social insurance	69.5	11.0	11.0	8.5	-	All services	Ambulatory private; hospitals partly public	Fee-for-service, case payment, budget based on capitation
EL	Mixed system: National Health Service + contributions	46.7	37.5	11.6	4.2	Doctors, dentists, hospitals	Private hospitals and pharmacies	Mainly public	Salary (R)
E	National Health Service	6.4	63.8	26.4	3.4	Specialists, hospitals, GPs	Pharmacies, dentists and private hospitals	Mainly public	Salary, capitation
F	Social insurance	72.9	6.0	9.8	10.4	-	All services	Ambulatory private; hospitals mainly public	Fee-for-service
IRL	Publicly financed health system	4.2	76.6	11.1	7.8	Public hospitals, specialists	Private non-profit hospitals, GPs, pharmacies	Mainly private	Fee-for-service, capitation (R)
I	National Health Service	1.6	66.0	27.2	4.1	Public hospitals and specialists	Private hospitals, GPs and private specialists	Mainly public	Salary, capitation (R)
L	Social insurance	56.0	24.8	17.3	2.0	-	All services	Mainly private	Fee-for-service
NL+	Social insurance	74.5	5.1	6.8	14.9	-	All services	Mainly private	Fee-for-service, capitation (R)
A	Social insurance	54.6	29.1	10.3	6.0	-	All services	Ambulatory mainly private; hospitals mainly public	Fee-for-service (R), case payment (1)
P	National Health Service	11.9	54.1	31.1	2.5	GPs, some specialists, public hospitals	Private hospitals, some doctors in rural areas, pharmacies, labs for X-rays and pathology	Mainly public	Salary, fee-for-service (R)
FIN	National Health Service	12.2	64.2	23.2	0.5	Hospitals, health centres	Private hospitals, pharmacies, private outpatient care services	Mainly public	Salary, capitation (R)
S	National Health Service	11.0	68.3	16.4	4.3	Hospitals, health centres, pharmacies	Private doctors, private hospitals (1 % of beds)	Mainly public	Salary (R), private doctors on fee-for-service
UK	National Health Service	7.1	74.2	12.7	6.0	-	Almost all services	GPs and dentists mainly private; hospitals mainly public	Capitation (R) (3)
CH+	Social insurance + government subsidies	43.7	15.4	30.5	10.4	-	All services	Ambulatory private; hospitals partly public, managed care organisations	Fee-for-service

(*) Including employers.

+ Social insurance with free choice of funds.

(R) Access to a specialist is normally by referral from a general practitioner.

(1) This may be reduced if the doctor has many patients.

(2) Also, private doctors on fee-for-service with rights to extra-bill.

(3) There are also components of salary, some fees-for-services and bonuses for achieving certain preventive targets.

Source: BASYS (Beratungsgesellschaft für angewandte Systemforschung), Augsburg, 2002.

II. Overview of home-care systems (home-nursing and home-help services)

	Main providers	Provision of services	Medical referral required (for home nursing)
B	*Home nursing:* One nationwide private non-profit organisation (White/Yellow Cross), some smaller organisations and a large number of independent nurses *Home help:* Social services of municipality and some private organisations	*Home nursing:* Hygiene and other personal care, routine technical nursing procedures, more complicated nursing activities, patient education and encouragement of informal care. *Home help:* Housework, hygienic and other personal care, moral support, general and family support; 11 hours' help per week per family (average) spread over two days	Yes, for technical nursing care such as injections
DK	*Home care:* Department of Municipalities	*Home nursing:* Not available *Home care:* Housework, hygienic and other personal care, shopping and outdoor walks	No
D	*Home nursing:* Mainly private non-profit organisations; in some regions, mainly for-profit organisations *Home help:* Mainly private non-profit organisations. Different organisations for services in addition to home nursing *(Sozialstationen)* and for home help for the elderly (MSDs)	*Home nursing: Grundpflege* (helping the patient with basic needs including ADL activities), *Behandlungspflege* (technical nursing procedures) *Home help:* Temporary care for families or individuals at home including basic nursing care, pedagogical and psychological care and homemaking services	Yes
EL	*Home nursing:* NHS organisations, private organisations (both for- and non-profit) *Home help:* Private organisations (both for- and non-profit)	*Home nursing:* Needs assessment, routine technical nursing procedures, more complicated nursing activities, patient education, psychosocial activities and evaluation of care *Home help:* Housework, hygienic and other personal care, routine technical nursing procedures, moral support	No
E	*Home nursing:* NHS health care centres *Home help:* Social services of municipalities	*Home nursing:* Needs assessment, hygienic and other personal care, routine technical nursing procedures, more complicated nursing activities, patient education, psychosocial activities, encouraging help and evaluation of care *Home help:* Housework, hygienic and other personal care, family support	No
F	Mainly private non-profit organisations, some services by municipalities and large number of independent nurses	*Home nursing:* Hygienic and other personal care, psychosocial activities and encouraging help from family members and other carers *Home help:* Housework, hygienic care (in certain cases)	Yes
IRL	*Home nursing:* Only statutory health boards *Home help:* Health boards and some voluntary organisations	*Home nursing:* Hygienic and other personal care, needs assessment, routine technical nursing procedures, more complicated nursing activities, patient education, psychosocial activities and stimulating informal care *Home help:* Basic personal care, moral support, administrative duties and monitoring home-help standards	No
I	*Home nursing:* Different organisations: NHS, social services of municipalities, private organisations (for- and non-profit) *Home help:* Social services of municipalities and private organisations (for- and non-profit)	*Home nursing:* Minimal amount of care per year is determined by law (140 hours of homemaking activities and personal care, 100 hours of nursing care, 50 house calls by the GP, 50 hours of rehabilitation care and 8 medical controls) *Home help:* Housework, hygienic and personal care, moral support, general and family support	No

Assessment of needs	Funding of organisation	Co-payments by patients	
By home nurse, social worker or social nurse using a national standardised form *(Katzschaal)*	*Home nursing:* Fee-for-service: per diem, or per activity determined by level of dependency of patient *Home help:* Subsidised by central government based on number of persons and clients	*Home nursing:* Yes, mainly membership fee *Home help:* Yes, depending on income and household composition Average % of total costs: 20 %	**B**
By social counsellor or nurse No standardised assessment forms	Fixed budget funded by national and local taxes	No, except in some very specified cases in home nursing Average % of total costs: 0 %	**DK**
Home nursing: By physician in cooperation with head nurse, using standardised forms *Home help:* Mostly by a nurse or social worker, using standardised forms	*Home nursing:* Fee-for-service *Home help:* Fee-for-service (by patient or insurance). For MSDs a global budget from municipalities is added, based on number of personnel and output	*Home nursing:* No *Home help:* Yes, except for home help in addition to home nursing Average % of total costs:10 % *(Sozialstationen)*, 20 % (other)	**D**
Home nursing: By physician, health visitor visiting nurse No standardised form *Home help:* By visiting nurse or social worker No standardised form	*Home nursing:* NHS and Red Cross organisation: fixed budget; others: fee-for-service *Home help:* Fee-for-service No funding by authorities or insurances	*Home nursing:* Yes, for all services *Home help:* Yes, in private for-profit organisations only Average % of total costs: 20 %	**EL**
Home nursing: By nurse or physician using a standardised form *Home help:* By social worker In some parts of the country a standardised form is used	*Home nursing:* Fixed budget *Home help:* Fixed budget from municipalities and central government	*Home nursing:* No *Home help:* Yes, income-related Average % of total costs: 10 %	**E**
Home nursing: By nurse using standardised forms *Home help:* By social worker	*Home nursing:* Fee-for-service (payment for activity) and budget for a fixed number of patients *Home help:* Funding by municipality (low-income group) or private insurance	*Home nursing:* Yes, but mostly paid by additional insurance *Home help:* Not below a certain income; otherwise dependent on old-age insurance Average % of total costs: 0 %	**F**
By public health nurse or home-help organiser No national standardised forms	Fixed budget	*Home nursing:* No *Home help:* Yes, but different regulations in health boards Average % of total costs: 10 %	**IRL**
Home nursing: Nurse, physician or special team No national standardised forms *Home help:* Large differences between organisations No national standardised forms	Public organisations: Budgets Private organisations: Fee-for-service	*Home nursing:* Yes, in social services and private organisations Not in NHS *Home help:* Yes, but large differences between organisations Average % of total costs: 50 %	**I**

	Main providers	Provision of services	Medical referral required (for home nursing)
L	*Home nursing:* Two large private non-profit organisations and four smaller ones (two non-profit) *Home help:* Mainly private non-profit organisations	*Home nursing:* The majority are prescribed services (hygienic and other personal care, needs assessment, routine technical nursing procedures, more complicated nursing activities, patient education, psychosocial activities) *Home help:* Housework, hygienic and personal care, moral support, administrative duties	Yes, for technical nursing activities only
NL	The National Association of Home Care which consists of regional cross associations or home-care organisations (all are private non-profit)	*Home nursing:* Needs assessment, hygienic and other personal care, routine technical nursing procedures, more complicated nursing activities, patient education, psychosocial activities, encouraging help and evaluation of care *Home help:* Housework, hygienic and personal care, moral support, psychosocial support	No
A	Different organisation, varying between provinces Mainly private non-profit organisations	*Home nursing:* Grundpflege (helping the patient with basic needs including ADL activities), Medizinischer Hauskrakenpflege (technical nursing procedures) and basic care like washing and dressing *Home help:* Temporary care for families or individuals at home	Yes, for technical home-nursing care only
P	*Home nursing:* Mainly NHS health care centres and some private non-profit organisations *Home help:* Social services of municipalities and some private non-profit social solidarity organisations	*Home nursing:* Routine technical nursing procedures, patient education, psychosocial care and stimulating informal care *Home help:* Housework, hygienic and other personal care, family support	No
FIN	*Home nursing:* Local health (and social) care centres (NHS) *Home help:* Local health (and social) care centres (NHS), social welfare board of municipality and private non-profit organisations	*Home nursing:* Medical and nursing care at the patient's own home, assist with all activities of daily living and coordinate the care of patient with home-help services to keep the patient living at home as long as possible *Home help:* Housework, hygienic and other personal care, moral support	Yes
S	NHS health care centres or social services of municipalities	*Home nursing:* Needs assessment, hygienic and other personal care, routine technical nursing procedures, more complicated nursing activities, patient education, psychosocial activities, encouraging help and evaluation of care *Home help:* Housework, hygienic and other personal care, routine technical nursing procedures	No, only in a few regions
UK	*Home nursing:* Part of NHS: community unit of DHAs or independent community trusts (after reform of NHS) *Home help:* Social services of municipalities and private organisations (both for- and non-profit)	*Home nursing:* Needs assessment, hygienic and other personal care, routine technical nursing procedures, more complicated nursing activities, patient education, psychosocial activities, encouraging help and evaluation of care *Home help:* Housework, hygienic and other personal care, general and family support	No

Source: NIVEL, Utrecht, 1999.

Assessment of needs	Funding of organisation	Co-payments by patients	
Home nursing: Physician or specialised nurse A special form can be used *Home help:* By head of regional service: social worker or specialised nurse	*Home nursing:* Mainly fee-for-service; the four smaller ones also receive an additional State budget *Home help:* Mainly budgets financed by the Ministry of Health and municipalities	*Home nursing:* Yes, for general basic nursing care *Home help:* Yes, income-related Average % of total costs: 30 %	**L**
Home-care nurse (in regional cross associations); nurse, home-help manager or special team (in home-care organisations) No national standardised forms	*Home nursing:* Fixed budget based on the number of personnel *Home help:* Fixed budget from central government based on number of inhabitants and age distribution in catchment area	*Home nursing:* No *Home help:* Yes, dependent on income and household composition Average % of total costs: 10 %	**NL**
Home nursing: By qualified nurse using a standardised form *Home help:* By qualified nurse of a special government agency, with standardised form	*Home nursing:* Fee-for-service: payment for nursing activity *Home help:* Subsidised by province and municipalities and payment per hour	*Home nursing:* Yes, for general basic nursing care *Home help:* Yes, depending on income Average % of total costs: 13 %	**A**
Home nursing: By nurse or physician No standardised forms *Home help:* By social worker No standardised forms	*Home nursing:* Fixed budget based on historical costs with adjustments for inflation *Home help:* Fixed budget from central government based on number of clients and types of services	*Home nursing:* No *Home help:* Yes, income-related	**P**
Home nursing: By physician, health visitor or registered nurse Standardised forms are used *Home help:* By leading homemaker or social worker (social welfare) or health visitor or registered nurse (health and social centres) Standardised forms are used	Budget determined by local authorities	Yes, income and household-related Average % of total costs: 11–35 %	**FIN**
Home nursing: By registered nurse (in health care centres) By home-help administrator (in social services) No standardised forms *Home help:* Fixed budget from municipalities and central government	*Home nursing:* Fixed budget *Home help:* Fixed budget from municipalities and central government	*Home nursing:* Yes *Home help:* Yes, dependent on income and number of hours of care	**S**
Home nursing: By the team leader (a qualified nurse) No national standardised forms *Home help:* By care manager (social worker) No national standardised forms	*Home nursing:* Old system: fixed budget based on number of inhabitants and demography of population New system: fee-for-service *Home help:* Social service: budgets Private organisations: fee-for-service	*Home nursing:* No *Home help:* Yes, different regulations exist Average % of total costs: 20 %	**UK**

III. Description of out-of-pocket payments: (i) Main cost-sharing measures for medical treatment and hospital stays, 2001

	Approval of medical treatment	Professional fees
DK	All doctors qualified to practise (numbers limited by district according to number of inhabitants). *Category 1:* Free choice of doctor (once in a period of six months) registered with the district. No fees payable for care given by the chosen doctor. *Category 2:* Free choice, but the insured person has to pay part of the costs.	Fees are fixed by agreement between the doctors' organisation and the public health insurance. Fees are calculated according to the number of patients registered and the medical services performed. Specialists are paid a flat-rate sum for each medical action. *Category 1:* Free choice of doctor (once in a period of six months) registered with the district. No fees payable for care given by the chosen doctor. *Category 2:* Free choice, but the insured person has to pay part of the costs.
D	Contract doctors are formed into associations of sickness fund doctors *(Kassenärztliche Vereinigungen)* at regional and national level. In certain cases, hospital doctors who have completed a course of further training, doctors in hospitals and rehabilitation institutions, and, in special cases, doctor-run institutions.	System based in principle on benefits in kind. No fees paid by the insured; fees are paid by the association of sickness fund doctors *(Kassenärztliche Vereinigung)*. The remuneration can be a fixed amount or can be calculated based on the criteria of either individual services provided or of a flat rate per head, or according to a system resulting from a combination of these or further methods of calculation. The association of sickness fund doctors *(Kassenärztliche Vereinigung)* distributes the remuneration package among the contract doctors on the basis of a certain scale (payment distribution scale). Free choice among contracted sickness insurance fund doctors. Voluntary insured patients can choose cost repayment instead of benefits in kind.
EL	Doctors employed by the insurance institute (IKA).	Doctors are paid by the insurance institute. There is no choice of doctor. The insured person goes to the local insurance institute doctor. No fees.
E	Public health services *(servicios públicos de salud)* appoint doctors to vacancies on the basis of competitive examinations.	General practitioners and specialists working outside hospitals are, in general, paid on a lump-sum basis determined by the number of insured persons entered on their list, thereby guaranteeing a minimum level of earnings. Hospital doctors are, in general, paid on a monthly salary basis plus certain supplementary payments. Free choice of general practitioner, paediatrician and obstetrician within area, provided choice would not bring number on doctor's list above maximum permitted. No fees are due.
F	All doctors qualified to practise	Scales of fees fixed by a national agreement or by interministerial decree. These scales may be exceeded: for agreed physicians working in the so-called 'free-fee' sector, or having acquired a special qualification before 1980. Free choice of doctor. Advance on fees by insured person. Refund based upon agreed or official rate.

Patient's participation	Hospital stays	
Category 1: No charges. (Treatment by the chosen GP or a specialist to whom he or she refers the patient.) *Category 2:* The part of expenses which exceeds the amount fixed by the public scheme for Category 1.	Free choice of regional public hospitals. *Public hospitals and approved private establishments:* No charge. *Non-approved private establishments:* Patients pay all costs. *In the case where a public hospital refers a patient to a private establishment:* No charge.	**DK**
No participation in the case of treatment by contracted doctors, except in the case of treatment (e.g. massages, baths or physiotherapy) which is also part of the prescribed cure, where 15 % has to be paid by the patient, except for children or hardship cases.	Free hospitalisation in a shared room with the exception of participation of DEM 17 (EUR 8.69) (old *Länder*) or DEM 14 (EUR 7.16) (new *Länder*) per calendar day during a maximum of 14 days. *Duration of benefit:* Unlimited, in principle.	**D**
No participation.	The insured has the right to hospitalisation in a public hospital or in a registered clinic designated by the insurance institute or in an IKA hospital. No charge, in case of hospitalisation, for the insured.	**EL**
No participation.	*Surgery:* Entirely free of charge. *For other reasons:* Authorised by administering body either automatically or on medical application where necessitated by diagnosis or patient suffering from a communicable disease or conduct or behaviour of the patient is such as to require constant attention.	**E**
Share borne by insured person (statutory): 30 % for doctors' fees; 25 % for consultations given in hospitals; 20 % for hospital treatment. Not required for certain complaints and for those complaints only.	Free choice among public and private (approved) hospitals. *Participation of the insured:* 20 %, in general. No participation from 31st day of hospitalisation for treatment or series of treatments above K 50 (scale of sicknesses). *Participation for hospitalisation:* FRF 70 (EUR 11) per day, including the day of discharge. *Duration of coverage:* Unlimited, subject to sickness fund's prior approval.	**F**

	Approval of medical treatment	Professional fees
IRL	Doctors participate in the general medical services on the basis of a contract agreed by the Department of Health with the Irish Medical Organisation.	Doctors are paid an annual capitation fee per eligible patient in accordance with a scale of fees agreed with the Irish Medical Organisation. Persons with full eligibility may choose from a list of local doctors. Doctors' fees are paid by the local health board. Persons with limited eligibility choose their own doctor and pay fees directly to the doctor.
I	Doctors employed either by the regional health administrations or by the hospitals. General practitioners and specialists approved under special contracts.	*Employed doctors:* Variable monthly wages, determined by the government according to professional categories. *Approved doctors:* Flat-rate amount per capita. Free choice of general practitioner among those approved for the region. The choice is confirmed unless the insured person decides otherwise. There is no payment made by the insured person for treatment but the doctor receives from the region a flat-rate lump sum per insured person. For specialists, a prescription made out by a general practitioner is needed and only specialists who work at the health centres (USL) are covered.
L	All doctors qualified to practise.	Fees according to collective agreements. Scales of fees are linked to the trend of reasonable compensation of employees. Payment for treatment. Free choice of doctor for each complaint; treatment abroad subject to approval of sickness fund. Fees first paid by the insured person who is in turn refunded by sickness funds.
NL	All doctors qualified to practise who have entered into a contract with a health insurance fund.	Direct payment of fees by the sickness fund: Flat rate per insured person according to the system of lists (family doctor principle). Free choice of doctor (twice a year) by registering with a doctor who has entered into a contract with a health insurance fund.
A	The relationship between medical doctors and insurance funds is governed by individual contracts, the content of which is determined to a far-reaching extent by overall contracts with the regional chambers of medical doctors *(Ärztekammer)*.	Fees are laid down in the overall contracts between the regional chambers of medical doctors and the insurance funds (flat rate per person, per sick case or per medical treatment or a combination of all). Free choice of doctors who have concluded an individual contract *(Vertragsärzte)*. No fees paid by the insured person; the payment is made by the insurance fund.

Patient's participation	Hospital stays	
Persons with full eligibility: These enjoy a full range of general practitioner services, including related prescribed drugs, at no cost. There is also a range of schemes, particularly with respect to prescribed drugs, intended to assist persons not eligible for a medical card. *Persons with limited eligibility:* These can avail themselves of specialist services in public hospitals free of charge.	*Persons with full eligibility:* No charge. *Persons with limited eligibility:* Charge of IEP 25 (EUR 32) per night in a public ward up to a maximum of IEP 250 (EUR 317) in any 12-month consecutive period. *Persons who attend the Accident and Emergency Department directly without having a letter of referral from their general practitioner:* These are liable for a charge of IEP 20 (EUR 25) which applies to the first visit for any episode of care only. No charge applies to attendances at outpatient clinics. *Private hospitals and homes:* Patient is liable for all costs except that in some nursing homes financial aid is given towards the cost of maintenance. *Infectious diseases treatment:* Free of charge to all persons. Unlimited duration.	**IRL**
Tests, visits to a specialist and medication of group B are free of charge for: children up to six years, persons aged over 65 if they come from a family whose income is below ITL 70 000 000 (EUR 36 152); recipients of minimal pensions aged over 60 and unemployed persons with an annual family income of less than ITL 16 000 000 (EUR 8 263): this limit amounts to ITL 22 000 000 (EUR 11 362) for a couple and is increased by ITL 1 000 000 (EUR 516) for each dependent child; recipients of social pensions; those with serious complaints or for patients waiting for a transplantation. Other insured persons pay up to ITL 70 000 (EUR 36) for each prescription. In the case of pregnancy, all tests are free of charge if carried out within the framework of the public health service. For each test carried out or each visit to a specialist, the insured person is expected to contribute ITL 6 000 (EUR 3.10). If more than one service is rendered in the same specialised field, the insured person contributes 50 % of the costs, with a ceiling of ITL 70 000 (EUR 36).	Free choice of public or private hospital among those registered under the scheme. Direct assistance free (sharing a room).	**I**
Share borne by insured person: 20 % of the ordinary tariff for visits for the first medical visit in any 28-day period; 5 % for other visits or consultations. No charge in cases of hospitalisation. No restriction on seeing a specialist.	Free choice of hospital (hospital abroad subject to approval of sickness fund). *Participation in maintenance costs:* LUF 219 (EUR 5.43) per day of hospitalisation.	**L**
Health Insurance Act (ZFW): The system of a general share borne by the insured person with a maximum of NLG 200 (EUR 91) per year, which was introduced in 1997, was abolished as of 1 January 1999. *Exceptional Medical Expenses Act (AWBZ):* A share must be borne by insured persons over 18, for nursing home care with a maximum of NLG 3 520 (EUR 1 597) per month.	Free choice among hospitals or institutions approved by the Ministry of Health. No share borne by the beneficiary in the lower class of accommodation. Admission must be authorised by the health insurance fund. *Duration of benefit:* As long as indicated (after a year taken over by cover under the Exceptional Medical Expenses Act — AWBZ).	**NL**
As of 1 January 1997, patients have paid a contribution amounting to ATS 50 (EUR 3.63) on each certificate for treatment by a doctor or a dentist (except in the case of children, pensioners and the needy).	Full coverage of expenses in the general scale of fees of a public or private hospital (which has concluded a contract), with the exception of a minor participation of a maximum amount of ATS 72 (EUR 5.23) per day which can only be claimed for a maximum of 28 days per calendar year. For the hospitalisation of a dependant, a 10 % contribution for a period of four weeks. *Duration of benefit:* As long as required.	**A**

	Approval of medical treatment	Professional fees
P	Doctors employed either by regional health authorities or by hospitals. Specialists approved under agreement between the Order of Medical Practitioners and the Ministry of Health for the purpose of consultations for persons unable to reach an official clinic within a specified time.	*Employed doctors:* Monthly salary set by government, varying according to professional category. *Approved doctors:* Payment per item of service. Free choice of general practitioner/specialist working either in health centres or under agreement. No fees to be paid (National Health Service).
FIN	All doctors must be approved by the National Board of Medicolegal Affairs.	Doctors working at public hospitals or health centres are paid on a salary basis by municipalities. Private doctors are paid on a fee-for-service basis. *Public hospital and health centre:* Only limited choice. Doctors are employed by the municipality. *Private doctor:* Free choice and the patient pays the doctor directly in full.
S	All doctors qualified to practise are able to be affiliated to the sickness insurance fund *(sjuk- och föräldraförsäkring).*	Doctors employed by the public health authorities are paid an income. Private practitioners affiliated to a county council paid according to a tax, which is fixed after negotiations between the government and the doctors' organisations. Free choice of doctors from the public health and private practitioners affiliated to a county council. The patient pays a part of the cost. The doctor, if a private practitioner, will be paid the rest from the regional health authorities.
UK	Doctors licensed to practise by the General Medical Council (the statutory licensing body) contract with local health authorities, subject to approval of the Medical Practices Committee (which regulates the numbers of doctors in each locality).	Fees, allowances and reimbursements set nationally by government, in the light of recommendations by an independent pay review body and after consultation with doctors' representatives (National Health Service). From April 1998, alternative arrangements based on direct negotiations between individual doctors and health authorities are being piloted. Free choice by patient (or parent/guardian), subject to acceptance by doctor. If a patient cannot find a doctor willing to accept him or her, the health authority will assign a patient to a doctor's list. No fees for services provided by the National Health Service.

Source: Missoc (mutual information system on social protection in the EU), European Commission, Directorate-General for Employment and Social Affairs, 2001.

Patient's participation	Hospital stays	
Variable insured person's share set by government. Exemption for some specific groups, for example pregnant women, children under 12 years, pensioners with income below the national minimum wage, persons responsible for certain disabled young people, the socially and economically disadvantaged.	Free choice among public hospitals and, if there is a waiting list, institutions approved by the Ministry of Health. No participation in charges in a public ward (or in a private room if recommended by the doctor). If in a private room freely chosen by beneficiaries, charges are payable in full by the beneficiaries, as well as private hospital and clinic charges.	**P**
Health centre: Physician services of maximum FIM 50 (EUR 8.41) for the first three visits in a calendar year or an annual maximum fee of FIM 100 (EUR 17) for 12 months depending on the municipality; most other services are free of charge. Children under the age of 15 are exempt from the fee. *Hospital:* The fee for an outpatient visit is FIM 100 (EUR 17) and for day surgery FIM 250 (EUR 42). The fee for inpatient care is FIM 125 (EUR 21) per day. The fee for inpatient care in psychiatric units is FIM 70 (EUR 12) per day. *Private doctor:* The patient pays the doctor's basic fee which, as far as it does not exceed a fixed tariff, is refunded by 60 % from the sickness insurance. For treatment costs on prescription by certain other medical staff, the patient's own liability is FIM 70 (EUR 12) and 25 % of the excess amount within a fixed tariff.	*Public hospital:* Hospital fee of FIM 125 (EUR 21) per day. Patients under the age of 18 may be charged only for the first seven treatment days in a calendar year. Patients receiving long-term care (over three months) are charged a fee in accordance with their means. Such a fee, however, may be no more than 80 % of the patient's net monthly income. *Private hospital:* Part of the doctor's fee and costs for examination and care are refunded by the sickness insurance.	**FIN**
The insured person pays between SEK 100 (EUR 11) and SEK 140 (EUR 15) per visit to a doctor. For specialist care, the patient pays between SEK 120 (EUR 13) and SEK 250 (EUR 26). Emergency cases: between SEK 120 (EUR 13) and SEK 300 (EUR 32). Below the age of 20, no charge.	Free choice of regional public hospitals and approved private establishments. The patient will be charged a maximum of SEK 80 (EUR 8.45) per 24 hours.	**S**
No charge.	No charge, except where the patient asks for special amenities or for extra treatment which is not clinically necessary.	**UK**

Description of out-of-pocket payments: (ii) Main cost-sharing measures for other provisions on health care, 2001

	Pharmaceutical products	Prostheses, spectacles and hearing aids
D	*Insured person's contribution:* A charge of DEM 8 (EUR 4.09), DEM 9 (EUR 4.60), or DEM 10 (EUR 5.11), depending on the packet size of the pharmaceutical product prescribed, except for children and hardship cases. If there is a fixed price for a group of products *(Festbetragsarzneimittel)*, the amount of contribution payable depends on this fixed price. In such cases, the patient must pay the difference between the fixed price and the prescribed product, in addition to the set prescription charge. Insured persons must pay for comfort drugs *(Bagatellarzneimittel)*. Certain uneconomical drugs are not paid by the insurance. *Members of family:* As for insured persons.	As long as no fixed amounts are established, the sickness funds will cover the entire costs, when fixed amounts have been established, the costs will be covered up to these amounts. *For bandages, insoles and aids for compression therapy:* 20 % of the amount will be covered by the sickness funds, with the exception of children and hardship cases. Payment of costs for a spectacle frame by the insured.

Dental services	Transport of patients	Courses of treatment	Others	
A system encompassing all age groups of prophylactic measures designed to prevent dental disease. Full compensation of conservative dental treatment, including dental prophylactics. For dentures, the insured person contributes 50 % of the costs of the required medical treatment. When the insured person takes measures to maintain healthy teeth, the benefit is increased by a bonus of 10 or 15 %.	In certain cases, the costs of rescue and transport back to the hospital or to the doctor are covered; DEM 25 (EUR 13) participation per journey.	Payment of medical services for ambulatory preventive or rehabilitative courses; contribution to the other costs (accommodation, nursing, transportation) up to DEM 15 (EUR 7.67) per day. Full compensation with DEM 25 (EUR 13) (old *Länder*) and DEM 20 (EUR 10) (new *Länder*) paid by the insured patient per (calendar) day or contribution of sickness funds for preventive and curative courses for mothers. Full compensation for institutional preventive or rehabilitative courses, except for co-payment of insured person of DEM 25 (EUR 13) (old *Länder*) and DEM 20 (EUR 10) (new *Länder*) per day.	*Home care:* Basic nursing and treatment as well as household assistance. *Household aid:* i.e. replacement in the household or payment of cost of household assistant. Examination of children for early discovery of diseases. Medical examination of insured persons after the age of 35 for early discovery of heart, circulation or kidney diseases and of diabetes. Examinations for early discovery of cancer. *Prescribed items other than medicines:* Insured person pays 15 %, except for children and hardship cases. *Long-term care insurance:* Benefits for persons permanently and to a large extent in need of help because of a physical illness or mental disease or due to any other disability. *Domiciliary care:* Basic nursing and household assistance by non-residential care institutions up to the amount of DEM 750 (EUR 383), DEM 1 800 (EUR 920) or DEM 2 800 (EUR 1 432) per month, depending on the nursing level; in special 'hardship cases' up to DEM 3 750 (EUR 1 917) per month. *Care allowance:* Instead of availing him/herself of the help of professional care services, the person in need of care may apply for a nursing allowance if he/she personally ensures that the necessary basic care and assistance are provided by a carer; depending on the care level, the rate of the allowance is equal to DEM 400 (EUR 205), DEM 800 (EUR 409) or DEM 1 300 (EUR 665) per month. *Combined benefit:* If the insured person does not claim the full benefit in kind to which he/she is entitled, a proportionate nursing allowance is paid at the same time. *Carer's substitute:* If the carer is temporarily unable to ensure the care because of a holiday, sickness or other reasons, the costs of providing a substitute are taken over for a maximum of four weeks and up to the amount of DEM 2 800 (EUR 1 432) per year. *Partially residential care:* As a supplement to domiciliary care, the care in institutions providing care during the day and night is paid up to the value of DEM 750 (EUR 383), DEM 1 500 (EUR 767) or DEM 2 100 (EUR 1 074) per month. If the insured person does not claim the full amount of the benefit in kind, he/she is entitled to a proportionate nursing allowance. *Short-term care:* Provided that there is no other possibility to ensure domiciliary care, the costs of accommodation in a residential institution are taken over for a maximum of four weeks and up to DEM 2 800 (EUR 1 432) per year during the transitional period following inpatient treatment or if the carer is unavailable. *Inpatient care:* From 1 January 1998, the costs for care, for medical treatment and also for social assistance have been covered depending on the care level at DEM 2 000 (EUR 1 023), DEM 2 500 (EUR 1 278), or DEM 2 800 (EUR 1 432); in extreme cases the sum has increased to DEM 3 300 (EUR 1 687).	**D**

	Pharmaceutical products	Prostheses, spectacles and hearing aids
DK	Cost to insured according to lists of products: *Very important products:* 25 % of cost; *Less important products:* 50 % of cost; *Insulin:* No charge to the insured person. For each category, the proportion of the cost payable by the insurance schemes is calculated with reference to two similar medicines on the market at the lowest end of the price scale.	Partial reimbursement.
EL	Charge of 25 % for medicines prescribed by a doctor. 10 % contribution towards cost of medication prescribed for certain illnesses (Parkinson's disease, Paget's disease, Crohn's disease, etc.). 10 % contribution towards cost of medication for retired persons receiving the minimum pension. No charges payable in the event of an employment accident, for medication during pregnancy and for chronic illnesses (cancer, diabetes, etc.).	Charge limited to 25 % maximum.
E	Beneficiaries pay 40 % of the price of medicaments. There is a 10 % reduction of the price for certain special medicaments, with a maximum limit of ESP 439 (EUR 2.64). No charge whatsoever for pensioners, patients undergoing residential hospital care and residents over 65 years of age with insufficient means of existence, as well as conscientious objectors performing social work.	Provision and normal replacement of prosthesis, orthopaedic apparatus and wheelchairs are free of charge. Grants may be made towards spectacles, hearing aids and other special types of prosthesis.
F	Insured person's share: 35 %, or 65 % for drugs mainly meant for troubles or affections normally without gravity. 100 % for ease drugs. No share required from long-term patient, only for the illness concerned.	*Subject to sickness fund's prior approval:* Refund of established fees (65 %) and for major fittings (100 %).
IRL	No charge for persons with full eligibility. For those with limited eligibility, a refund of expenses over IEP 90 (EUR 114) per quarter. Persons suffering from a long-term condition are obliged to pay only IEP 32 (EUR 41) per month. No charge for persons suffering from a mental handicap and mental illness (for persons under 16 years only) and from specified long-term illnesses in respect of drugs prescribed for treatment. A new drug payment scheme has been introduced from 1 March 1999, whereby no individual or family has to pay more than IEP 42.00 (EUR 53) per month for prescribed medicines.	No charge for persons with full eligibility and for children under six years of age and national school pupils. Limited charges only levied on insured persons who satisfy certain contribution conditions.

Dental services	Transport of patients	Courses of treatment	Others	
Cost to insured person in both categories: From 35 to 60 % of cost of treatments on list. 100 % for treatment not included on the list. Treatment is free for children and partially covered for handicapped persons.	Free transport to doctor or hospital for pensioners who are insured in Category 1, and in certain other cases and circumstances.	Same as for hospitalisation.	For both categories of insured persons, share of cost met for treatment by chiropractor, physiotherapist or psychologist to whom the general practitioner has referred the insured. Free assistance and treatment given by nurse at home if recommended by a doctor.	**DK**
As for health care, but charge of 25 % for dental prosthesis.	Cost of travelling for the sick living in distant regions, subject to certain conditions.	Partial contribution by the insured.	-	**EL**
Comprising extractions and certain types of treatment. Certain financial aids for dental prosthesis. In the event of an employment injury or in the case of an occupational disease, oral and facial surgery are also covered.	Transport to hospital for sick people, in emergencies and under other special circumstances.	Precautionary measures. Thermal baths possible under certain conditions.	Home help for retired people, invalids, the mentally handicapped, etc.	**E**
Comprising preventive and conservative treatment, extractions and (subject to approval) dental prosthesis, orthodontic treatment. Refund: According to fixed rate as for medical care. Share borne by the insured person: 30 %.	Transportation in case of hospitalisation.	*Subject to sickness fund's prior approval:* Refund of medical fees and cost of treatment in a thermal centre. No daily allowances in principle (except for social and medical treatment provided by the sickness fund).	Supplementary benefits and aid benefits which may be granted by the sickness insurance fund for social and medical treatment.	**F**
No charge for persons with full eligibility, children under six years of age and persons who attend national school up to the age of 14 years. No charge for insured persons who satisfy certain contribution conditions for scaling, examinations, and polishing. Limited charge for fillings, extractions and other services.	Free transport to hospital, subject to certain conditions.	Health examination service for pre-school children and pupils of national schools. All necessary follow-up services for defects discovered at such examinations. A national screening service for scoliosis. Immunisation, diagnostic and hospital services for infectious diseases available without charge to all.	Hospital inpatient and outpatient services are provided free of charge for children suffering from certain long-term diseases and disabilities, women receiving maternity services, children up to six weeks of age and children referred from child health clinics and school health examinations. Free home-help service, subject to certain conditions.	**IRL**

	Pharmaceutical products	Prostheses, spectacles and hearing aids
I	Classification of medication into three groups: *Group A:* Medication termed 'essential' for the treatment of more serious complaints: Free for all insured persons. *Group B:* Medication for the treatment of serious complaints but less serious than those referred to in group A: Free of charge for some categories of persons as mentioned under item 'Patient's participation in medical expenses' and for the disabled. The rest of the population pays half price. *Group C:* Other medication and medication for which a prescription is not required: The cost is borne fully by the insured person. Each prescription may not include more than two items. The patient is expected to contribute ITL 4 000 (EUR 2.07) for the prescription of one item and ITL 6 000 (EUR 3.10) for the prescription of two items; only the 100 % disabled are exempt from making a contribution and also all medication essential for the treatment of very serious illnesses.	No benefits.
L	Reimbursement according to classification of drugs: *Normal reimbursement:* 80 %; *Preferential reimbursement:*100 %; *Reduced reimbursement:* 40 %. Non-refundable products and drugs.	*Subject to sickness fund's prior approval:* Refunds at the tariff rates fixed by agreements.
NL	Registration of insured person with a chemist who entered into contract with the health insurance fund. Insured person is entitled to a qualitatively good package of medicines without it being necessary to make additional payment. Besides this medical package, medicines can be supplied and charged to the health insurance funds up to the average price per standard dosage of medicines which belong to a certain classified medical package, with an additional payment to be paid by the insured himself.	Subject to prior approval of health insurer. No cost sharing except for the following. *Artificial breasts:* Payment of cost in excess of maximum NLG 397.50 (EUR 180). *Orthopaedic shoes:* Share in cost of NLG 112 (EUR 51) per year up to age 16; NLG 224 per year (EUR 102) for those aged 16 and over. *Spectacles and contact lenses:* After first purchase, entitlement without cost sharing only on specific medical indication. *Hearing appliances:* Payment of cost in excess of NLG 1 273.50 (EUR 578). *Wigs:* Payment of cost in excess of NLG 556 (EUR 252).

Dental services	Transport of patients	Courses of treatment	Others	
Free treatment in the centres of the National Health Service and from registered doctors.	No benefits.	*Thermal cures:* Subject to prior approval of the local health unit. *Participation:* ITL 6 000 (EUR 3.10) for the prescription, plus 50 % of fixed rates, with a maximum of ITL 70 000 (EUR 36) for each course of treatment.	-	**I**
Comprising preventive and conservative treatment, extractions, orthodontic treatment, and prostheses. Refund of tariffs as established in the collective agreements. Reimbursement of 80 % in excess of an annual sum of LUF 1 335 (EUR 33) which is fully covered. Prostheses are 100 % covered, unless the insured person did not regularly consult a dentist, in which case the patient's participation is 80 %. Supplements for prostheses and benefits are for necessary treatment only; any extra treatment is not covered.	Transportation cost reimbursable under certain conditions.	Subject to approval.	-	**L**
Comprising dental care for children including preventive maintenance work, fluoride applications up to twice a year from the age of six, sealing, periodontal care and surgical treatment. Comprising for adults preventive dental care (check up at least once a year), dentures and specialist surgical treatment. *Dentures:* Patient's participation of 25 %.	*By ambulance, taxi or private car:* Share in the cost of EUR 66 per 12 months.	No benefits.	*Physiotherapy:* Entitlement of nine treatments per indication per year.	**NL**

	Pharmaceutical products	Prostheses, spectacles and hearing aids
A	Coverage of expenses for medically prescribed registered pharmaceutical products included in the list of pharmaceutical products (others: approved by medical superintendent or supervisory medical doctor). The charge amounts to ATS 44 (EUR 3.20) per item prescribed (free of charge for notifiable infectious diseases or in case of need).	Insured person's contribution 10 %; minimum ATS 281 (EUR 20) (free of charge in case of need). The maximum amount to be covered by the insurance funds amount to ATS 14 049 (EUR 1 021) for prostheses costing up to ATS 35 121 (EUR 2 552) according to the statutes of the insurance funds.
P	Depending on the type of illness, the State contributes 70 or 40 % of the cost of medicines on the official list drawn up by the health services. These percentages are increased by 15 % for pensioners whose pensions are less than the minimum wage.	80 % charge for a prosthesis on the official list. *Spectacles under health service prescription:* 75 % charge for spectacles (contact lenses if certified necessary by doctor). *Spectacles prescribed by specialists in private practice:* Paid for by patient subject to 75 % reimbursement on prices according to official scale.

Dental services	Transport of patients	Courses of treatment	Others	
Dental treatment and (indisposable) dental prostheses are granted according to the statutes. Medical treatment includes conservative, surgical and orthodontic treatments. The patient's or family member's contribution towards orthodontic treatment and a removable dental prosthesis, such as braces, is between 25 and 50 %. As of 1 January 1997, a contribution amounting to ATS 50 (EUR 3.63) has to be paid for each dental treatment certificate, except in the case of children, pensioners and the needy. For extra treatment and services (e.g. inlays and crowns), the insurance fund's subsidy is between ATS 325 (EUR 24) and ATS 2 960 (EUR 215) per unit.	Expenses for transport, refund of travel expenses.	May be granted if necessary (in institutions of the insurance funds, contract institutions or in the form of supplements). Contribution amounts to between ATS 76 (EUR 5.52) and ATS 194 (EUR 14) per day and lasts for a maximum of 28 days per calendar year. The needy are exempt from participation.	Examinations of young persons, preventive examinations, mother-and-child examinations, medical care at home (medical benefits following the doctor's orders, provided by qualified staff, for a maximum of four weeks), psychotherapy.	**A**
Medical treatment in health centres. Reimbursement by health service in line with scale laid down by government, in the event of recourse to private health services. *Dental prosthesis prescribed by health service:* Benefit of 75 % of the price of the dental prosthesis according to scale. *Dental prosthesis prescribed by private specialist:* Fees paid by patient. Refund of 75 % of the fee according to official scale.	Payment of travel costs for patients living in remote areas, subject to certain conditions.	Reimbursement of cost of treatment in thermal centres in line with prevailing official scale, after receiving permission.	-	**P**

	Pharmaceutical products	Prostheses, spectacles and hearing aids
FIN	*Public hospitals:* Costs included in fee. *Sickness insurance:* Patient's own liability is FIM 50 (EUR 8.41) + 50 % of excess amount for products prescribed by a doctor. In serious and chronic diseases, a number of listed pharmaceutical products qualify for refunds of 75 or 100 % of the costs exceeding FIM 25 (EUR 4.20). If patient's own costs for pharmaceutical products during one calendar year exceed FIM 3 283 (EUR 552), the excess amount is fully reimbursed.	*Health centre:* In certain cases free of charge. *Sickness insurance:* Not refundable.
S	The patient pays the whole cost up to and including SEK 400 (EUR 42). Costs between SEK 401 (EUR 42) and SEK 1 200 (EUR 127) are subsidised by 50 %. Costs between SEK 1 201 (EUR 127) and SEK 2 800 (EUR 296) are subsidised by 75 %. Costs between SEK 2 801 (EUR 296) and SEK 3 800 (EUR 401) are subsidised by 90 %. Costs above SEK 3 800 (EUR 401) are subsidised totally.	The county councils provide appliances on certain conditions.

Dental services	Transport of patients	Courses of treatment	Others	
Health centre: The patient normally pays a fee according to a basic fee and a fixed tariff for each intervention. Health centres are allowed to fix their tariff within certain limits. They are all lower than those by private dentists. Persons under the age of 19 and war veterans receive dental treatment free of charge. *Sickness insurance:* Dental expenses are partly refunded to persons born in 1956 or thereafter. For examination and preventive treatment, the rate of refund is 75 % and for other treatment 60 % of the fee up to a specified limit. No refund is provided in respect of orthodontic and prosthodontic treatment. Other persons' costs for dental treatment are partly refunded only if the care was needed for the treatment of a disease other than the dental one. In addition, costs for examination and preventive treatment are refunded to persons born in 1955 or before once in every three calendar years.	Travel and transport costs are fully compensated from the sickness insurance after deduction of the patient's own liability of FIM 45 (EUR 7.57). If the patient's share of travel costs during the same calendar year is more than FIM 900 (EUR 151), the excess amount is fully refunded. Accommodation is refunded up to a maximum of FIM 120 (EUR 20) per night.	See 'Patient's participation'.	-	**FIN**
For children up to 20 years of age, dental care is free of charge in the public dental-care sector. A new system of dental care subsidies was introduced on 1 January 1999. Free pricing was introduced for dentists and dental hygienists. For basic treatment, the insurance pays a fixed amount to the dentist, and the individual the remaining costs. The amount from insurance corresponds to 30 % of the tariff valid for 1998. For prosthetic treatment and orthodontic treatment, there is a limit for high costs, where the insurance pays double the fixed amount for basic care reduced by SEK 3 500 (EUR 370) and the individual pays the rest.	Reimbursement for transportation costs, subject to certain conditions.	See 'Hospital stays'.	Limitations for high costs. When a person within a 12-month period has costs for public health and medical care, the limit is a maximum of SEK 900 (EUR 95). For pharmaceutical products, the limit is SEK 1 300 (EUR 137) for a period of 12 months.	**S**

	Pharmaceutical products	Prostheses, spectacles and hearing aids
UK	Charge of GBP 5.80 (EUR 8.16) per prescribed item except for children under 16, people aged 16–18 and still in full-time education, people aged 60 and over, pregnant women and women who have had a baby within the last 12 months, war pensioners (for their accepted disability), persons receiving income support, income-based job-seeker's allowance, family credit or disability working allowance and their partners, some other people on low incomes, and people suffering from specified conditions. An annual (or four-month) season ticket can be bought entitling the holder to an unlimited number of prescribed items without charge in the period of its validity. The cost of the ticket is GBP 30.10 (EUR 42) for four months and GBP 82.70 (EUR 116) for a year.	*Spectacles:* No spectacles supplied free. *Vouchers available to help with purchase of spectacles for certain groups:* For children under 16 or under 19 and still in full-time education, or people receiving income-based job-seeker's allowance, income support, family credit or disability working allowance and their partners. Also for those on low incomes or requiring complex lenses; also for war pensioners (for their accepted disability) and hospital eye service patients. No charge for sight tests for the above categories, plus registered blind or partially sighted, diagnosed diabetic or glaucoma patient, or aged 40 or over and the brother, sister, parent or child of a diagnosed glaucoma patient. Others pay privately. *Prostheses and hearing aids:* No charge for provision and fitting of National Health Service appliances.

Source: Missoc (mutual information system on social protection in the EU), European Commission, Directorate-General for Employment and Social Affairs, 2001.

Dental services	Transport of patients	Courses of treatment	Others	
Proportional charges for NHS dental treatment in the general dental service, including examination; 80 % of cost of a course of treatment up to a maximum of GBP 340 (EUR 478). No charge for women who are pregnant, or who have had a baby in the preceding 12 months, when the course of treatment starts; people under 18; those under 19 in full-time education; people receiving income support, or income-related job-seeker's allowance, family credit or disability working allowance and their partners. People on a low income may be able to get help with the cost of treatment. Dental treatment in the hospital and community dental services, however, is free except for dentures and bridges.	Various additional benefits provided under the National Health Service and by local authorities, for example free transport to hospital, or in the case of medical need, reimbursement of hospital travelling costs in certain cases.	No charge, except where the patient asks for special amenities or for extra treatment which is not clinically necessary.	-	**UK**

GLOSSARY

The reference in parentheses, for example (3.1), indicates at least one part of the volume where the term has been used.

Acellular (4.7.1): Not containing cells.

Activity (Chapter 1): Economic activity is that engaged in by those producing economic goods and services, whether employed or unemployed and seeking work. Examples of branches of activity (3.2), as used in this volume, are: manufacturing; construction; agriculture, hunting and forestry.

Aetiology (4.7.2): The medical study of the cause of disease.

Age dependency ratio (Chapter 1): The ratio of the combined child population and aged population to the population at other ages. The numerator is commonly expressed as the population aged under 15, and that aged 65 and over, and the denominator as the population aged 15–64.

Ambulatory care (Chapter 6): Any contact with a physician which occurs while the patient is not a hospital inpatient, such as office visits, as well as visits to emergency rooms, outpatient clinics or house calls.

Anatomical therapeutic chemical (ATC) classification system (Chapter 6): A drug classification system widely used in the EU and derived from the WHO's Collaborating Centre for Drug Statistics Methodology. Drugs are divided into different groups at five levels according to the organ or system on which they act and/or therapeutic and chemical characteristics: (1) anatomical group; (2) therapeutic main group; (3) therapeutic/pharmacological subgroup; (4) chemical/therapeutic/pharmacological subgroup; and (5) subgroup for chemical substances.

Anthropogenic (3.1): This denotes a thing of human origin.

Antimicrobial resistance (4.7.1): The introduction of every antimicrobial agent into clinical practice has been followed by the detection of strains of micro-organisms that are resistant. They are able to multiply in the presence of drug concentrations higher than the concentrations in humans receiving therapeutic doses. The prevalence of resistance varies by region and time, but sooner or later resistance emerges to every antimicrobial.

Aquaculture (3.2): This is the use of the sea, lakes and rivers for activities such as fish farming, shellfish cultivation and the growing of plants.

ART (assisted reproductive technologies) (6.3.6): All treatments or procedures that involve surgically removing eggs from a woman's ovaries and combining the eggs with sperm to help a woman become pregnant. The types of ART are *in vitro* fertilisation, gamete intrafallopian transfer, and zygote intrafallopian transfer.

ART cycle (6.3.6): A process in which (1) an ART procedure is carried out, (2) a woman has undergone ovarian stimulation or monitoring with the intent of having an ART procedure, or (3) frozen embryos have been thawed with the intent of transferring them to a woman. A cycle begins when a woman begins taking fertility drugs or having her ovaries monitored for follicle production.

As-Teq (3.1): An index of heavy metal emissions to air; the heavy metal arsenic is used as a reference substance, so that 1 g As = 1 g As-Teq.

Bacteria (4.7.1): These are a class of organisms which do not possess chlorophyll; they occur virtually everywhere and (amongst other activities) can cause and transmit disease.

Balanced diet (2.1.4): Intake of appropriate types and adequate amounts of food and drink to supply nutrition and energy for maintenance of body cells, tissues, and organs, and to support normal growth and development.

Benefits in kind (6.4.6): These are benefits granted in the form of goods and services.

Biomass (3.1): This is the mass of living organisms forming a prescribed population on a given area.

BOD (biochemical oxygen demand) (3.1): This is a standard water-treatment test for the presence of organic pollutants; it depends on the activities of bacteria and other microscopic organisms which in the presence of oxygen feed upon organic matter.

Burden of disease (Chapter 4): This is a measure of the health of a population. The approach offers a way to quantify the importance of different diseases. It is not just a measure of incidence or mortality; rather, it calculates the total impact. The measure of disease burden is disability adjusted life years (DALYs).

Capitation (Chapter 6): A per capita method of compensation for physicians. The amount of revenue a practice receives is based on an amount paid per patient (capitation fee) times the number of patients the practice treats (practice population) regardless of the number of visits.

Central Product Classification (6.4.4): This was developed by the United Nations as a standard central product classification to serve as an instrument for assembling and tabulating all kinds of statistics requiring product detail. Such statistics may cover production, intermediate and final consumption, capital formation, foreign trade or prices. They may refer to commodity flows, to stocks or to balances and may be compiled in the context of input-

output tables, balance-of-payments and other analytical presentations.

Certain perinatal conditions (5.1): These medical conditions include, *inter alia,* the following: respiratory distress syndrome, chronic respiratory disease, intrauterine hypoxia and birth asphyxia, and slow foetal growth and foetal malnutrition. They include conditions with an origin in the perinatal period even though death or morbidity occurs later.

Chromosomal anomalies (4.7.2): A person normally has 23 pairs of chromosomes. A chromosomal anomaly can affect the number of chromosomes, the size or appearance of certain chromosomes, or the arrangement of parts of chromosomes.

Chronic condition (Chapter 4): A condition that is continuous or persistent over an extended period of time. The opposite of acute.

CI (confidence interval) (Chapter 4): The confidence intervals for specific statistics give a range of values around the statistic where the 'true' (population) statistic can be expected to be located (with a given level of certainty).

Coicop (Chapter 2): Classification of individual consumption by purpose, adapted to the needs of household budget surveys.

Combustion (3.1): This is a chemical reaction in which a fuel combines with oxygen with the evolution of heat.

Co-morbidity (4.2): Two or more coexisting medical conditions or unrelated disease processes.

Computed tomography scanners (6.2.6): Computed tomography (CT) scanners, also known as 'CAT' scans for computed axial tomography. CT scanners image anatomical information from a cross-sectional plane of the body. Each image is generated by a computer synthesis of X-ray transmission data obtained in many different directions in a given plane.

Co-payment (Chapter 6 and Annexes I and III): The portion of a claim or medical expense that a member must pay out of his/her own pocket to a provider of a facility for each service. It is usually a fixed amount that is paid at the time the service is rendered.

DALYs (disability adjusted life years) (4.7.2): This is a measure using disease incidence, age of onset, and disability for each disease category to measure the burden of disease. The DALYs numbers give both the absolute and relative contributions of each disease category to the total disease burden of a population.

Defined daily dose (Chapter 6): The average dose per day for a drug product when used for its major indication in everyday practice. It standardises the measurement of drug utilisation within and between drug entities and can be used to describe drug utilisation across a population.

Desulphurisation (3.1): A technology that employs a sorbent, usually lime or limestone, to remove sulphur dioxide from the gases produced by burning fossil fuels. Flue gas desulphurisation is current state-of-the art technology for major SO_2 emitters such as power plants.

Diagnosis (Chapters 4 and 6): Identification of a patient's illness or disease, often coded using either ICD-9-CM, ICD-10 or DSM-IV (for mental health disorders). For each patient discharged from hospital, several diagnoses can be reported, including the main diagnosis and any secondary diagnoses/conditions present.

DSM-IV (4.7.2.11): The *Diagnostic and statistical manual of mental disorders (DSM)* is the standard classification of mental disorders used originally by mental health professionals in the United States and nowadays used everywhere. The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets and the descriptive text. The diagnostic classification is the list of the mental disorders that are officially part of the DSM system.

Encephalitis (Chapter 4): This is an inflammation of the brain.

Endemic (Chapter 4): A term that refers to a disease that occurs continuously and with predictable regularity in a specific area or population.

Eutrophication (3.1): This is the natural ageing of a lake or landlocked body of water which results in organic material being produced in abundance due to a ready supply of nutrients.

Expectation of life at birth (Chapter 1): The life table is a statistical technique for summarising mortality rates, calculated over one year, from which may be derived a measure of life expectation. When expectation of life is calculated at all ages (from birth), it denotes the number of years a person would live, on average, if he/she experienced current mortality rates.

External causes (5.2): A shortened form of the ICD classification chapter 'External causes of injury and poisoning'. This chapter includes all deaths and injuries from accidental and violent causes. The ICD is able to classify such deaths and injuries according to both the nature of injury suffered and the external cause.

Fatal accident at work (3.2): This is an accident which leads to the death of a victim within one year of its occurrence.

Fats (Chapter 2): These are organic compounds made up of carbon, hydrogen and oxygen. They are the most concentrated source of energy in foods. All fats are combinations of saturated and unsaturated fatty acids. Saturated fats are found in foods from both animal and vegetable sources. Unsaturated fat is a type that is usually liquid at refrigerator temperature. Monounsaturated and polyunsaturated fat are two kinds of unsaturated fat.

Fee-for-service (Chapter 6, Annexes I and III): A financial method in which health care providers set their own fees for services rendered. Under this method, patients pay fees for each and every service at the time it is provided.

General practitioner (Chapter 6): This is a medical practitioner who provides personal medical services. It may be abbreviated to GP.

Gram (4.7.1): This refers to a test (the Gram's stain) used in laboratory testing of bacteria. Bacteria that stain blue are gram-positive, while those which stain pink are gram-negative. This classification corresponds to characteristics of the bacteria, such as the infection that may be produced and antibiotics for treatment.

Greenhouse gas (3.1): A gas that contributes to the natural greenhouse effect. The Kyoto Protocol covers a basket of six greenhouse gases (GHGs) produced by human activities: carbon dioxide, methane, nitrous oxide, hydrofluorocarbons, perfluorocarbons and sulphur hexafluoride.

Gross domestic product (GDP) (Chapter 1): This is the total output of goods and services for final use produced by an economy, by both residents and non-residents, regardless of the allocation to domestic or foreign claims.

Gross national product (GNP) (Chapter 2): This is the total value of all goods and services produced in a specified period (usually annual) within a country, plus the income from property held in foreign countries and income of domestic residents from abroad, but less similar payments made to residents of other countries.

HAIs (4.7.1): Hospital-acquired infections.

Health interview survey (Chapter 4): A research method in which questionnaires are used to gather information regarding health status and other related issues from many participants. They are often administered in person, over the phone or via mail. The resulting data are useful in describing, comparing, and sometimes explaining different phenomena.

Hib (4.7.1): Haemophilus influenza type b, a bacterium causing serious diseases, mainly in children, such as meningitis and pneumonia.

HIV infection (4.7.1.3): A viral infection caused by the human immunodeficiency virus (HIV) that gradually destroys the immune system, resulting in infections that are difficult for the body to fight.

Home care (6.2.8): Health services provided to residents within their own homes.

Hospital discharge (6.2.5): A discharge from a hospital or another health care facility which occurs any time a patient (or resident) leaves because of death, discharge, sign out against medical advice or transfer. The number of discharges is the most commonly used measure of the utilisation of hospital services. Discharges, rather than admissions, are used because hospital abstracts for inpatient care are based on information gathered at the time of discharge.

Iatrogenic (4.7.1): This refers to a disease induced by medical treatment.

ICSI (intracytoplasmic sperm injection) (6.3.6): A procedure in which a single sperm is injected directly into an egg; this procedure is most commonly used to overcome male infertility problems.

ICD (Chapters 4, 5 and 6): This is the international statistical classification of diseases, injuries and causes of death (ninth or tenth revision). This is a classification of diseases, health conditions and procedures developed by the World Health Organisation (WHO), which represents the international standard for the labelling and numeric coding of disease. Within this system, all diseases are assigned numbers in hierarchical order. There are several applications of the ICD coding system, including ICD-8, ICD-9, ICD-9-CM (Clinical Modification), ICD-O (Oncology), and ICD-10.

ICD-9-CM (Chapter 6): The Clinical Modification of the ICD is used in categorising hospital diagnoses defined according to ICD-9. The diagnostic categories used are based on the diagnosis principle, which is submitted as the first of several possible diagnoses coded on the discharge record. The principal diagnosis represents the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.

IDDM (4.7.2): Insulin-dependent diabetes mellitus.

Incidence (3.2): Incident cases of a disease are those which first occur in a defined period of time, and incidence (or the incidence rate) is this number of cases as a proportion of the population at the beginning of the period.

Infant mortality rate (5.1): The number of infant deaths during a year per 1 000 live births during the year; the infant mortality rate is actually a ratio.

IPCC (Intergovernmental Panel on Climate Change) (Chapter 3): Recognising the problem of

potential global climate change, the World Meteorological Organisation (WMO) and the United Nations Environment Programme (UNEP) established the Intergovernmental Panel on Climate Change (IPCC) in 1988. The role of the IPCC is to assess the scientific, technical and socioeconomic information relevant for the understanding of the risk of human-induced climate change.

ISIC (Rev. 3) (6.4.4): International Standard Industrial Classification of all Economic Activities, Revision 3 (United Nations). The ISIC is a standard classification of productive economic activities. Its main purpose is to provide a set of activity categories that can be used when analysing statistics according to such activities.

Lignite (3.1): This is a low grade coal, often brown in colour, with a relatively low heat value.

Lithotriptors (6.2.6): Lithotripsy is a procedure used to break up kidney stones. This makes it easier to pass them in the urine. In one type of lithotripsy, the lithotriptor machine breaks up stones in the kidney or upper ureters. It uses shock waves to pulverise the kidney stones, breaking them into smaller fragments.

Longitudinal surveys (Chapter 4): The essential feature of a longitudinal survey is that it provides repeated observations over time on a set of variables for the set of persons belonging to the survey. Different ways of deriving these repeated observations on the same people distinguish the three main types of longitudinal surveys: retrospective surveys, panel surveys, and record linkages.

Magnetic resonance imaging units (6.2.6): These refer to a diagnostic procedure in which the magnetic nuclei (especially protons) of a patient are aligned in a strong, uniform magnetic field, absorb energy from tuned radio frequency pulses, and emit radio frequency signals as their excitation decays. These signals, which vary in intensity according to nuclear abundance and molecular chemical environment, are converted into sets of tomographic images by using field gradients in the magnetic field, which permit 3D localisation of the point sources of the signals. Unlike conventional radiography or CT, MRI does not expose patients to ionising radiation.

Mammography (6.2.6): Mammography is the procedure used to generate a mammogram, an X-ray image of the breast.

Metastasis (4.7.1): A secondary tumour distant from the original site of disease.

Migrant (Chapter 1): A person who moves permanently from one address to another.

MINI ('Mini-international neuropsychiatric interview') (4.7.2): This is a semi-structured, clinician-rated interview tool based on DSM-IV. It is used to help establish the diagnosis of depression.

Morbidity (Chapter 4): A diseased condition or state.

Neonatal (5.1): The period from birth to under 28 days of age; the neonatal mortality rate is the number of deaths of infants under 28 days of age during a year per 1 000 live births in the year.

Neoplasm (4.7.1): A morbid new growth of tissue.

Net migration (Chapter 1): The balance of migration into an area, and migration from the same area.

NMVOCs (3.1): Non-methane volatile organic compounds.

Non-contributory schemes (Chapter 6): These are social protection schemes in which eligibility to benefits is not conditional on the payment of contributions by the protected persons or by other parties on their behalf. Many non-contributory schemes give benefits only after a means test. Non-contributory schemes which do not require a means test include national health services and family allowance schemes instituted in several Member States.

Nosocomial (4.7.1.11): Relating to a hospital.

NUTS (3.4): The nomenclature of territorial units for statistics was established by Eurostat to provide a uniform and consistent breakdown of territorial units for the production of regional statistics for the EU. The 1999 version of NUTS divides the EU into 78 regions at NUTS 1 level, 211 at NUTS 2 level and 1 093 at NUTS 3 level. Because of their relatively small area or population, some countries do not have all three regional levels: Ireland and Sweden have no level 1 regions; Denmark has no level 1 or 2 regions; Luxembourg has no levels 1, 2 or 3.

Occupational disease (4.7.2.5): This is an illness or disease which was brought on or caused by exposure in the workplace to a physical, chemical or biological agent, to the extent that the health of a staff member is impaired.

Other benefits in kind (6.4.6): Help provided to sick or injured people, other than medical care, to assist them with daily tasks, such as home-help or transport facilities.

Out-of-pocket payments (Chapter 6 and Annex III): Payments borne directly by a patient without the benefit of insurance. They include cost-sharing and informal payments to health care providers

Ozone (3.1): This is an allotropic form of oxygen present in the atmosphere; it contains three atoms of oxygen (O_3), whereas atmospheric oxygen molecules contain two atoms (O_2).

Particulates (3.1): Fine solids or liquid droplets suspended in the air.

Pathogen (4.7.1): An organism or substance that causes disease.

Perinatal (5.1): The period around birth; thus, the perinatal mortality rate includes stillbirths and deaths at ages under seven days.

Periodontal (4.3): This relates to the tissues surrounding the teeth, such as gums.

Photochemical (3.1): Denotes chemical change brought about by light.

Population forecasts (Chapter 1): These imply more certainty in predicting future numbers.

Population projections (Chapter 1): Population projections involve making estimates of future population numbers or producing the most plausible figures for the years to come. Estimates are made by Eurostat using the latest available figures for the population on 1 January. In general, key assumptions are made with respect to mortality, fertility and migration by sex and by age, and ageing techniques are applied to the population pyramid from year to year.

Postneonatal (5.1): The period from 28 days to under one year of age; the postneonatal mortality rate is the number of deaths of infants at ages from 28 days to 364 days during a year per 1 000 live births in the year.

PPPs (purchasing power parities) (Chapters 2 and 6): These are currency conversion rates that convert economic indicators expressed in national currencies to some common currency at a rate that equalises the purchasing power of a unit of different national currencies. In other words, PPPs are both price deflators and currency converters; they eliminate differences in price levels between countries in the process of conversion to a common currency. The reference currency could in principle be that of any member of the group, or another country such as the US dollar; the latter is used by the OECD, the UN and other international organisations.

PPS (purchasing power standard) (Chapters 2 and 6): This is the artificial common reference currency unit, determined in such a way that total EU gross domestic product expressed in PPS is equal to total EU GDP expressed in euro. Then economic volume aggregates are obtained after their original value in national currency units has been divided by the respective PPPs. One PPS represents the same given volume of goods and services in all countries. However, in individual countries, different amounts of national currency are needed to buy this volume of goods and services, depending on the level of prices.

Prevalence (4.7.1): Measures the burden of disease in a population; the prevalence rate is the number of cases of a disease in a population at one point in time expressed as a proportion of the total population.

Psychosocial (4.1): This pertains to a combination of psychological and social factors.

Pure alcohol (2.4): This is defined as ethanol (consumed in a country during the calendar year or calculated from official statistics on local production, import and export, taking into account stocks and home production, whenever available) being the intoxicating agent in fermented and distilled liquors.

Quintile (2.1.3): One of five segments of a distribution that has been divided into fifths. For example, the second-from-the-bottom quintile of an income distribution comprises those whose income exceeds the incomes of from 20 to 40 % of the population.

Quota sampling (Chapters 2 and 4): Usually refers to the process whereby a researcher attempts to match in a sample the exact make-up of the population with regard to certain demographic characteristics deemed important (such as gender, age, race, income, etc.). The purpose of this practice usually is to achieve some kind of representative sample of the underlying population.

Radiotherapy equipment (6.2.6): Equipment for treatment with X-rays or radionuclides. This includes: linear accelerators, cobalt-60 units, caesium-137 telepathy units, low to orthovoltage X-ray units, high dose rate brachytherapy units, low dose rate brachytherapy units and conventional brachytherapy.

Rare diseases (4.7.2.12): Rare diseases, including those of genetic origin, are life threatening or chronically debilitating diseases which are of very low prevalence, that is less than 5 per 10 000.

Relative incidence rate (3.2): This is used in an analysis of data on accidents at work (3.2.2). While the incidence (or incidence rate) is given by the number of accidents during a year per 1 000 persons in employment in the reference population, the relative incidence rate is the ratio of the incidence in a particular group to the incidence over all groups. It is conventionally expressed as 100 over all groups.

Rickettsial infections (4.7.1): These are caused by *Rickettsiae* micro-organisms which show features of both bacteria and viruses.

RTAs (3.4): Road traffic accidents.

RTTAs (3.2): Road traffic and travel accidents.

Serum (4.7.1): Fluid separated from clotted blood or blood plasma, and allowed to stand.

Sewage and sewerage (3.1): Sewage is the liquid waste from a community, while sewerage is the system of pipes or channels for the transport of domestic and industrial sewage.

Standardised incidence rate (3.2): In the analysis of data on accidents at work, the incidence rate (see above) gives the risk of such accidents. But since the structure of a country's economically active population can influence this rate, the standardised incidence rate may be used. It gives each branch of activity the same weight at national level as at EU level.

Standardised mortality rates (5.2): When comparing levels of mortality between different populations it is helpful to take account of differences in age structure. Standardisation is a way of doing this, either indirectly, where a set of standard rates is applied to each population, and the expected number of deaths is compared with the number actually recorded, or directly, where observed rates for each population are applied to each population, and a similar comparison made.

STIs (4.7.1.2): Sexually transmitted infections.

Stroke (4.7.2.3): When the blood supply to any part of the brain is interrupted, resulting in tissue death and loss of brain function.

Temperature inversion (3.1): Air temperature normally decreases with increasing height. Under certain meteorological conditions, this trend can be reversed, with a warmer layer of air over a cooler layer. The cooler air cannot rise because it is heavier, thus trapping any air pollutants below.

Tinnitus (4.4.4): This is a symptom of an ear disorder, distinguished by ringing, buzzing, humming or other noises in the ears.

Total fertility rate (TFR) (Chapter 1): The average number of children a woman will have during her reproductive period, if the current age-specific fertility rates are applied.

Troposphere (3.1): This is the lowest layer of the atmosphere, in which temperature falls as height increases.

Unemployed (Chapters 1 and 2): Those who, during the reference week of the Labour Force Survey: (a) had no employment, and (b) were available to start work within the next two weeks, and (c) had actively sought employment at some time during the previous four weeks. In addition, unemployed persons include those who had no employment and had already found a job to start later.

Virus (4.7.1): A small infectious organism that needs a living cell in order to reproduce.

VOCs (volatile organic compounds) (3.1): Compounds which evaporate readily and contribute to air pollution; examples are benzene, acetone and ethylene.

WRHPs (4.7.2): Work-related health problems.

Zoonotic (4.7.1): Relating to an infectious disease of animals that can be transmitted to man.

Main sources used

CODED, Eurostat's 'Concepts and definitions' database.

MedlinePlus database, 'Health information'.

Manitoba Centre for Health Policy, Thesaurus database.

OECD 'Health data 2002'.

Merck manual of medical information.

Porteous, A., *Dictionary of environmental science and technology*, Wiley, 1991, and Eurostat 'Health and safety' publications.