3.
HEALTH



Causes of deaths
Potential widespread causes for health problems
Healthcare
Safety at work



3. HEALTH

Health issues cut across a range of topics in relation to the European social agenda and form an important item in the EU's strategy for sustainable development, both of which constitute important elements of the Lisbon strategy.

In May 2000, the European Commission proposed a new health strategy, which promoted an integrated approach to health-related initiatives at a Community level. On this basis, a new programme of Community action in the field of public health for the period 2003-08 was adopted in 2002. The programme is focused on three main strands of action specific to the requirements of the programme for Community action in the field of public health [23], namely:

- to enhance the capability of responding rapidly and in a coordinated fashion to threats to health, and;
- to improve health information and knowledge for the development of public health;
- to promote health and prevent disease through addressing health determinants across all policies and activities.

A Commission communication of 6 April 2005 [24] to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions entitled '*Healthier, safer, more confident citizens: a health and consumer protection strategy*' and together with a proposal for a decision of the European Parliament and of the Council establishing a programme of Community action in the field of health for 2007-13 [25], both state the need to expand European health monitoring.

[23] Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008) (OJ L 271, 9.10.2002, p. 1) (http://europa.eu/eur-lex/pri/en/oj/dat/2002/l_271/l_27120021009en00010011.pdf).

[24] COM(2005) 115 final (http://europa.eu/eur-lex/lex/LexUriServ/site/en/com/2005/com2005_0115en01.pdf).

[25] COM(2006) 234 final (http://europa.eu/eur-lex/lex/LexUriServ/site/en/com/2006/com2006_0234en01.pdf).

Eurostat has a wide range of data within this area, including:
- information on the causes of death;
- lifestyles and health behaviours (such as smoking, alcohol use, being overweight);
- population health status (such as self-perceived health, chronic conditions, disability);
- activity of the healthcare sector (such as the numbers of hospital beds, discharges, or expenditure on sickness/healthcare);
- healthcare personnel (such as the number of practising physicians);
- accidents at work;
- occupational diseases.

According to the Directorate-General for Health and Consumer Protection [26], the promotion of health and lifestyle choices can be of great potential for reducing disease and death. On average, EU citizens with better jobs, more education or higher incomes have better health and live longer. Differences in life expectancy of five years or more can be found between the most advantaged and least advantaged groups of society. Actions to reduce health inequalities aim:

- to improve everyone's level of health closer to that of the most advantaged;
- to ensure that the health needs of the most disadvantaged are fully addressed;
- to help the health of people in countries and regions with lower levels of health to improve faster.

Preventing the transmission of emerging pathogens and the resurgence of others, as well as enhancing a rapid and coordinated response capability to these threats, is a responsibility shared among national health authorities and the European Commission. The emergence of HIV and AIDS, the re-emergence of tuberculosis, the appearance of variant Creutzfeldt-Jakob Disease, or the avian influenza epidemic serve to illustrate the range of factors influencing the spread of disease.

The Community's public health programme endeavours to address these issues, as covered by a Commission decision of 19 March 2002 [27], through the exchange of information between Member States to provide early warnings of potential threats to public health.

Health incidence indicators provide a measure of the number of new cases arising in a given period. These indicators are often expressed as new cases of a disease (or disorder) per 100 000 inhabitants. In a similar vein, standard death rates refer to the number of deaths from a particular cause (using a similar ratio per 100 000 inhabitants).

[26] For more information, see http://ec.europa.eu/health/ph_determinants/healthdeterminants_en.htm

[27] Commission Decision 2002/253/EC laying down case definitions for reporting communicable diseases to the Community network (OJ L 86, 3.4.2002, p. 44) (http://europa.eu/eur-lex/pri/en/oj/dat/2002/l_086/l_08620020403en00440062.pdf).

CAUSES OF DEATH

The most important causes of death among men and women in the EU-25 in 2001 were cancer (malignant neoplasm) and ischaemic heart diseases. There were, however, large differences between the standard death rates for men and women, with the standard death rate among men from cancer (2001: 253 per 100 000 persons) higher than the rate for women (142). The standard death rate from ischaemic heart diseases was about twice as high for men (147) as it was for women (75).

Indeed, men reported higher standard death rates for all main causes of death, with rates as much as four or five times as high as those recorded for women in relation to drug dependence, alcoholic abuse, and AIDS (HIV), while deaths from suicide and transport accidents were 3.6 and 2.5 times as likely among men.

Deaths from cancer (malignant neoplasm) were relatively high in a number of the 10 Member States that joined the EU in 2004, with more than 300 male deaths per 100 000 male inhabitants in the Czech Republic, Hungary and Poland in 2004. The Baltic States reported the highest incidence of death from ischaemic heart disease among men, with rates above 400 per 100 000 male inhabitants. The Baltic States also reported the highest standardised death rates for men from suicide and transport accidents (except for a somewhat lower rate of deaths from transport accidents in Estonia). Among women, the highest standardised death rates for cancer (malignant neoplasm) were recorded in Denmark (197 deaths per 100 000), Hungary (188) and the Czech Republic (172).

Compared with the situation in 1994, the incidence of four of the main causes of death among men in the EU-15 declined through to 2001, with an overall reduction of 21.9 % for deaths caused by ischaemic heart diseases, 18.3 % for transport accidents, 14.6 % for suicide, and 9.2 % for cancer (malignant neoplasm). There was a similar pattern observed for women, with a 23.0 % reduction for transport accidents and 7.4 % for deaths caused by cancer (malignant neoplasm).

Table 3.1: Causes of death — standardised death rate, 2004

(per 100 000 inhabitants)

TPS00116 TPS00119 TPS00122 TPS00125 TPS00128 TPS00131 TPS00134 TPS00137 TPS00140 TPS00143 TPS00146 TPS00149

	Cancer (1)	Heart disease (2)	All accidents	Pneumonia	Chronic liver disease	Suicide (3)	Diseases of the nervous system	Diabetes mellitus	Alcohol abuse	AIDS (HIV)	Homicide, assault	Drug dependence
EU-25 (4)	187.7	106.1	28.5	16.0	14.3	11.5	16.2	13.9	2.8	1.2	1.2	0.7
EU-15 (4)	180.5	93.4	25.0	15.7	12.9	10.1	16.8	14.0	2.8	1.4	0.9	0.8
Euro area (4)	180.1	87.6	26.4	13.4	13.7	10.8	15.9	14.7	2.9	1.7	1.0	0.7
Belgium	:	:	:	:	:	:	:	:	:	:	:	:
Czech Republic	229.9	163.5	40.8	18.9	15.7	14.0	15.9	10.3	1.5	:	1.1	0.0
Denmark (4)	218.8	111.5	29.0	13.4	13.9	12.2	16.6	17.9	8.6	0.6	0.9	0.6
Germany	169.8	110.1	18.0	13.4	15.5	11.0	13.6	17.0	4.9	0.6	0.6	0.8
Estonia (5)	194.5	312.5	87.0	18.5	20.0	23.7	13.5	9.0	10.6	0.5	10.8	:
Greece	162.0	88.5	29.3	5.0	4.7	2.8	7.9	6.0	0.1	0.1	0.8	0.0
Spain	164.2	57.3	23.5	9.9	9.5	7.0	19.9	13.7	0.7	3.3	1.3	0.4
France (5)	181.0	45.3	34.6	11.4	12.6	16.4	26.2	12.8	4.9	1.7	0.8	0.2
Ireland	186.5	122.7	17.3	42.3	5.0	10.3	16.4	10.3	1.5	0.3	0.6	2.2
Italy (6)	175.3	72.4	26.1	8.3	12.7	6.0	14.3	17.0	0.3	1.5	0.9	0.7
Cyprus	122.9	76.9	35.9	11.7	6.0	0.7	12.7	41.6	0.4	0.1	1.5	:
Latvia (5)	193.9	291.6	88.5	16.2	14.0	24.1	14.5	9.2	2.5	0.5	10.3	:
Lithuania	194.9	330.2	85.7	13.6	21.1	38.9	11.3	7.2	0.8	0.2	8.3	0.3
Luxembourg	165.0	76.2	30.0	17.9	11.8	13.2	17.5	7.2	3.9	0.9	0.5	:
Hungary	260.8	233.6	48.9	6.7	51.0	24.3	13.9	17.0	4.1	0.1	2.0	:
Malta	151.8	131.9	20.7	16.6	5.5	5.4	14.0	23.3	0.5	0.5	1.4	:
Netherlands	191.2	64.0	16.0	21.4	4.4	8.7	15.8	16.9	1.0	0.5	1.2	0.1
Austria	170.7	115.2	24.2	10.4	17.5	15.2	15.3	29.6	4.0	0.6	0.7	2.3
Poland	213.8	117.5	39.0	18.3	14.1	15.1	10.0	11.6	4.0	0.3	1.5	0.1
Portugal	155.6	57.1	26.9	20.9	13.3	9.6	15.1	27.5	1.0	8.1	1.7	0.1
Slovenia	198.6	82.0	32.7	30.1	27.2	22.7	9.9	23.0	4.6	0.1	1.8	0.2
Slovakia (4)	225.6	290.0	37.3	29.7	25.7	12.7	10.9	14.2	:	0.0	2.1	0.0
Finland	143.8	145.4	47.5	19.8	16.0	19.3	30.9	7.4	4.0	0.2	2.4	0.6
Sweden (5)	155.5	113.2	22.2	13.8	5.7	11.4	15.2	11.9	3.8	0.3	0.9	0.3
United Kingdom (5)	185.6	122.7	16.8	36.4	11.0	6.4	19.5	7.9	1.4	0.4	0.5	1.7
Bulgaria	156.5	171.6	29.0	16.1	15.0	11.0	7.7	16.8	0.9	0.0	2.7	0.1
Croatia (6)	213.3	159.5	35.3	18.2	26.0	17.4	9.0	14.9	2.7	0.1	1.4	0.8
FYR of Macedonia	160.5	108.8	24.9	5.6	7.6	9.1	9.3	36.1	1.1	:	2.8	0.2
Romania (5)	178.0	228.4	45.1	28.9	46.6	12.8	8.2	8.3	4.4	1.2	3.8	:
Iceland	160.2	112.2	17.9	15.3	2.1	11.9	29.8	6.1	1.8	0.3	1.4	:
Norway	168.0	88.9	33.9	16.3	5.1	11.4	19.0	8.5	3.4	0.5	0.9	0.8
Switzerland	149.2	72.3	20.3	10.5	7.0	15.0	21.1	12.4	2.6	1.0	0.9	2.5

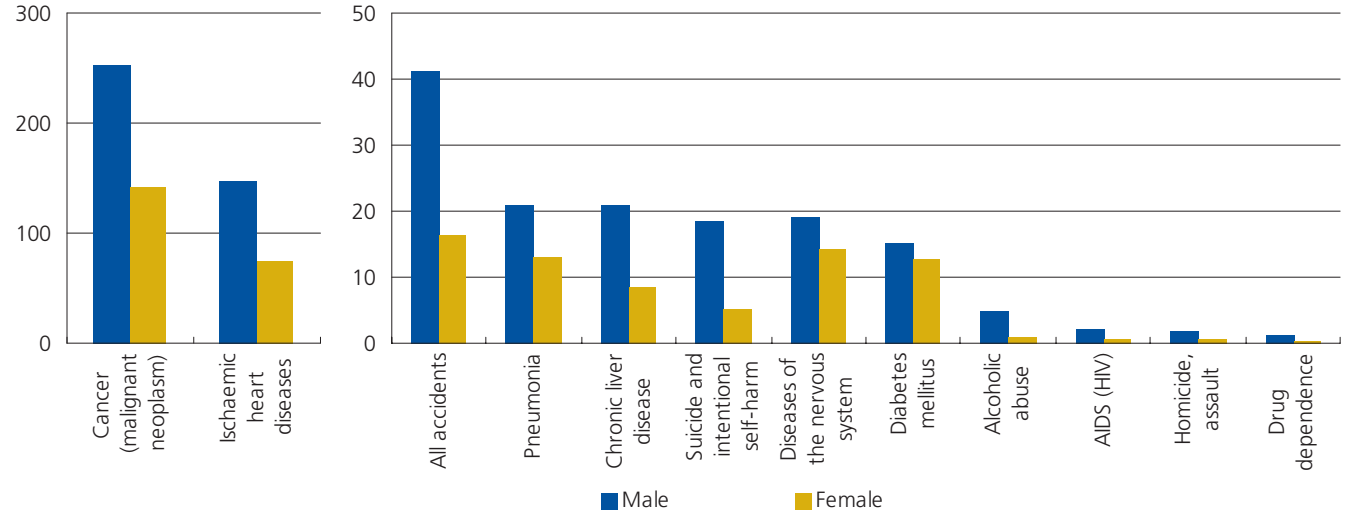
(1) Malignant neoplasm.
(2) Ischaemic heart diseases.
(3) Suicide and intentional self-harm
(4) 2001.
(5) 2003.
(6) 2002.

Death rate of a population of a standard age distribution; as most causes of death vary significantly with people's age and sex, the use of standard death rates improves comparability over time and between countries, as they aim at measuring death rates independently of different age structures of populations; the standard reference population used is the standard European population as defined by the World Health Organisation (WHO).

Figure 3.1: Causes of death — standardised death rate, EU-25, 2001 (1)

(per 100 000 inhabitants)

TPS00116 TPS00119 TPS00122 TPS00125 TPS00128 TPS00131
TPS00134 TPS00137 TPS00140 TPS00143 TPS00146 TPS00149



(1) Note the differences in the scales employed between the two parts of the graph.

Death rate of a population of a standard age distribution; as most causes of death vary significantly with people's age and sex, the use of standard death rates improves comparability over time and between countries, as they aim at measuring death rates independently of different age structures of populations; the standard reference population used is the standard European population as defined by the World Health Organisation (WHO).

Figure 3.2: Causes of death for males — standardised death rate, EU-15

(per 100 000 inhabitants)

TPS00117 TPS00120 TPS00123 TPS00165

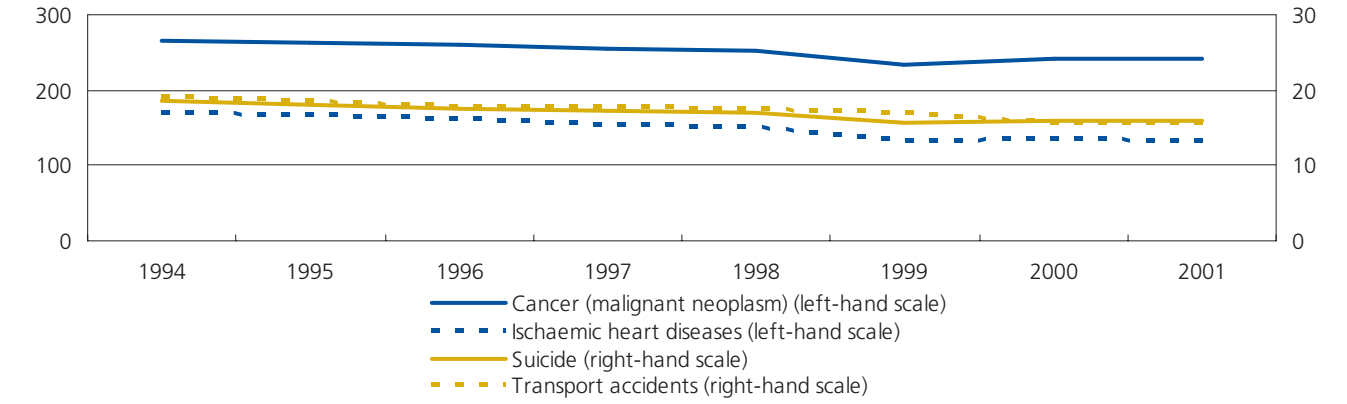


Figure 3.3: Causes of death for females — standardised death rate, EU-15

(per 100 000 inhabitants)

TPS00118 TPS00121 TPS00124 TPS00166

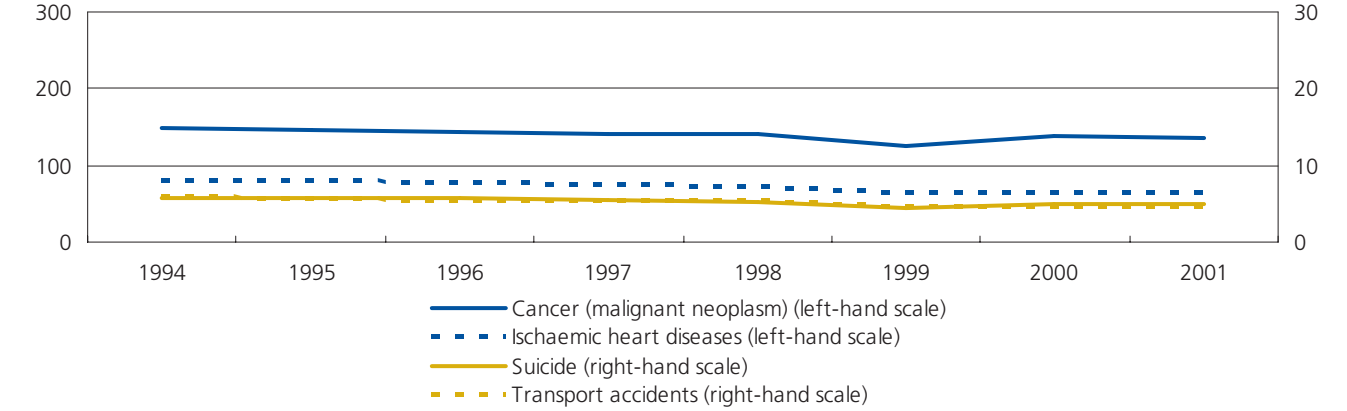
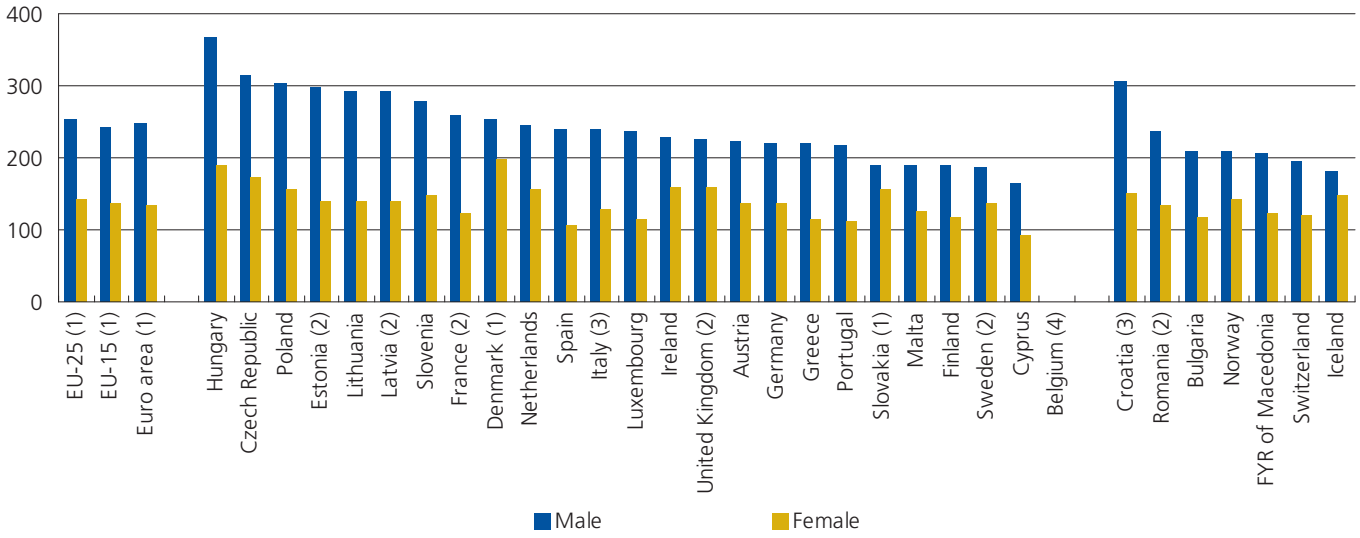


Figure 3.4: Deaths from cancer (malignant neoplasm) — standardised death rate, 2004

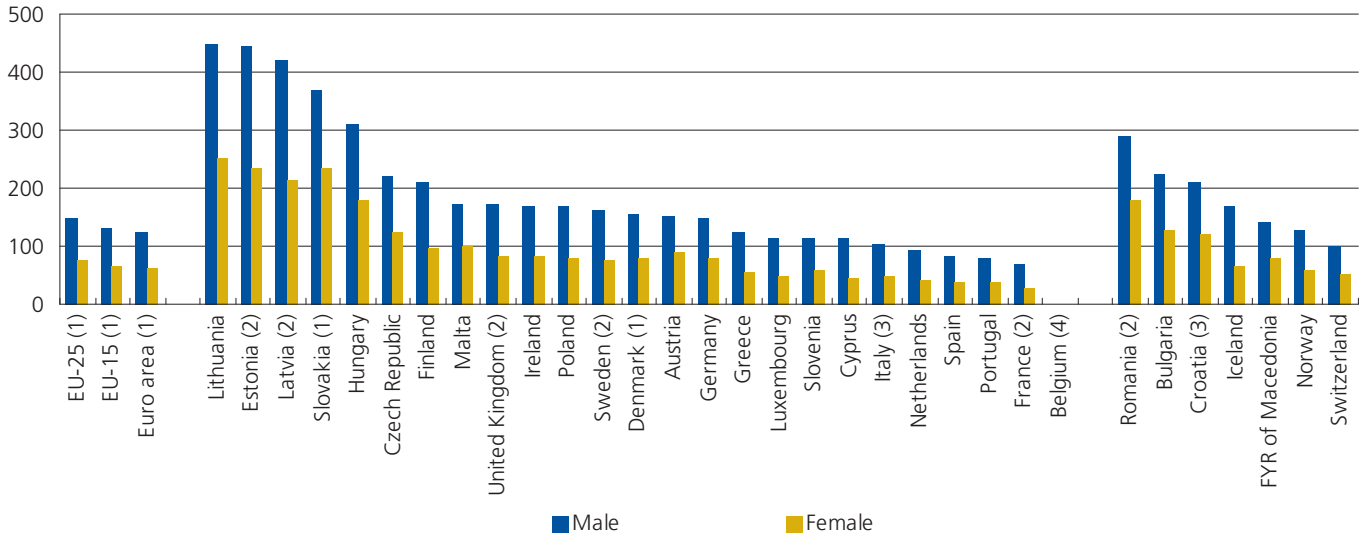
(per 100 000 inhabitants) TPS00117 TPS00118



(1) 2001.
(2) 2003.
(3) 2002.
(4) Not available.

Figure 3.5: Deaths from ischaemic heart diseases — standardised death rate, 2004

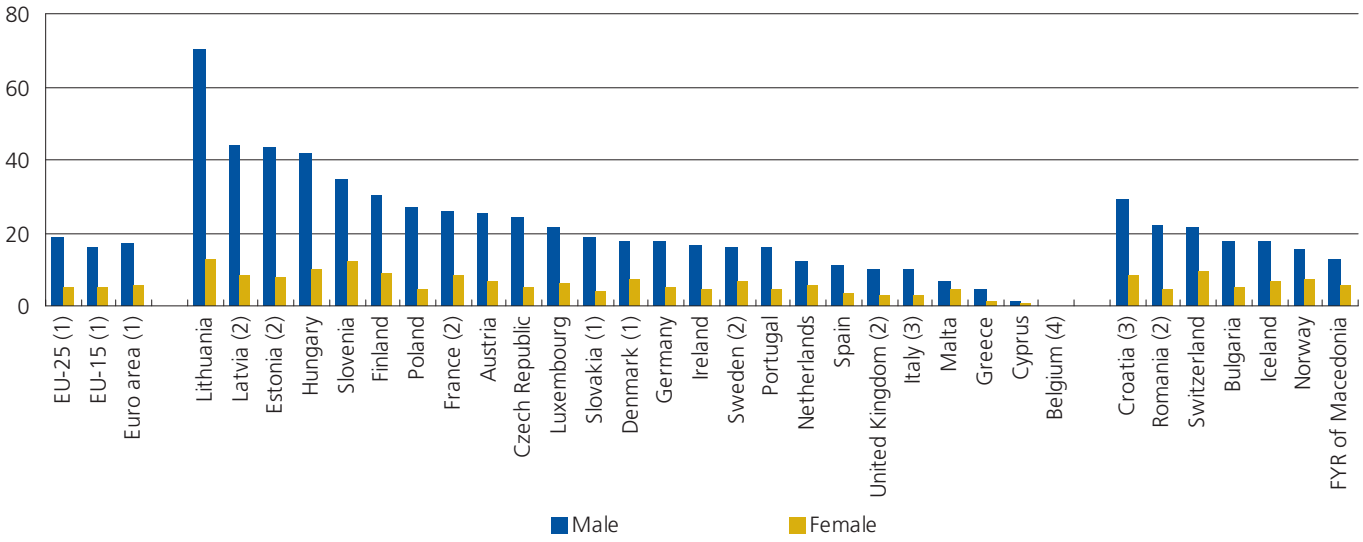
(per 100 000 inhabitants) TPS00120 TPS00121



(1) 2001.
(2) 2003.
(3) 2002.
(4) Not available.

Figure 3.6: Deaths from suicide — standardised death rate, 2004

(per 100 000 inhabitants) TPS00123 TPS00124

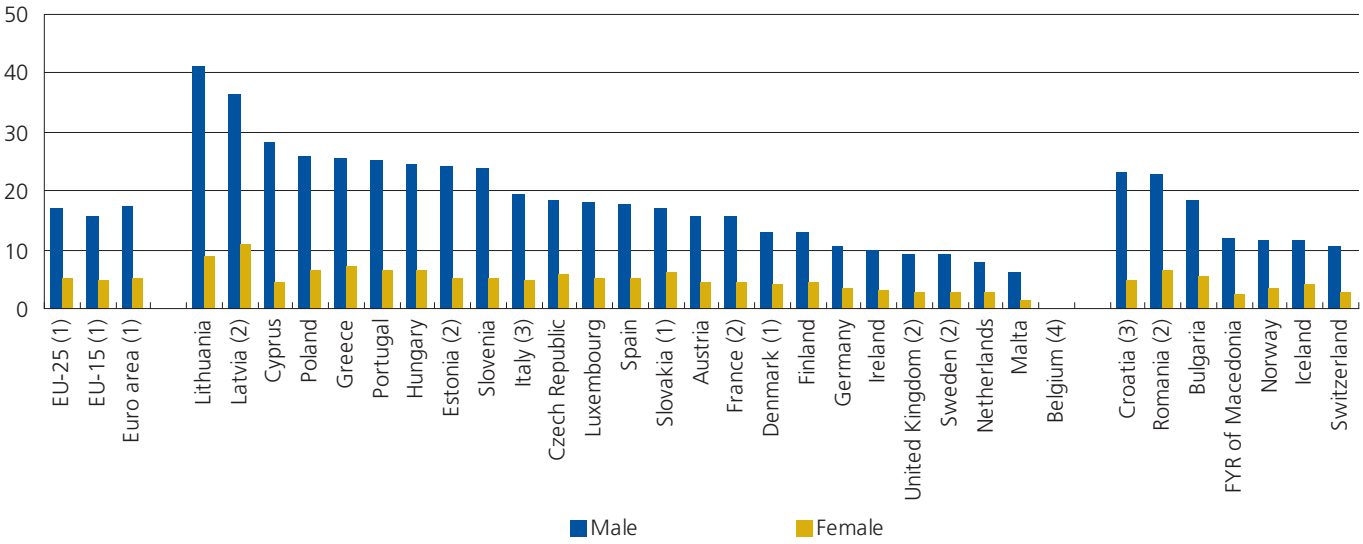


(1) 2001.
(2) 2003.
(3) 2002.
(4) Not available.

Death rate of a population of a standard age distribution; as most causes of death vary significantly with people's age and sex, the use of standard death rates improves comparability over time and between countries, as they aim at measuring death rates independently of different age structures of populations; the standard reference population used is the standard European population as defined by the World Health Organisation (WHO).

Figure 3.7: Deaths from transport accidents — standardised death rate, 2004

(per 100 000 inhabitants) TPS00165 TPS00166



(1) 2001.
(2) 2003.
(3) 2002.
(4) Not available.

POTENTIAL WIDESPREAD CAUSES OF HEALTH PROBLEMS

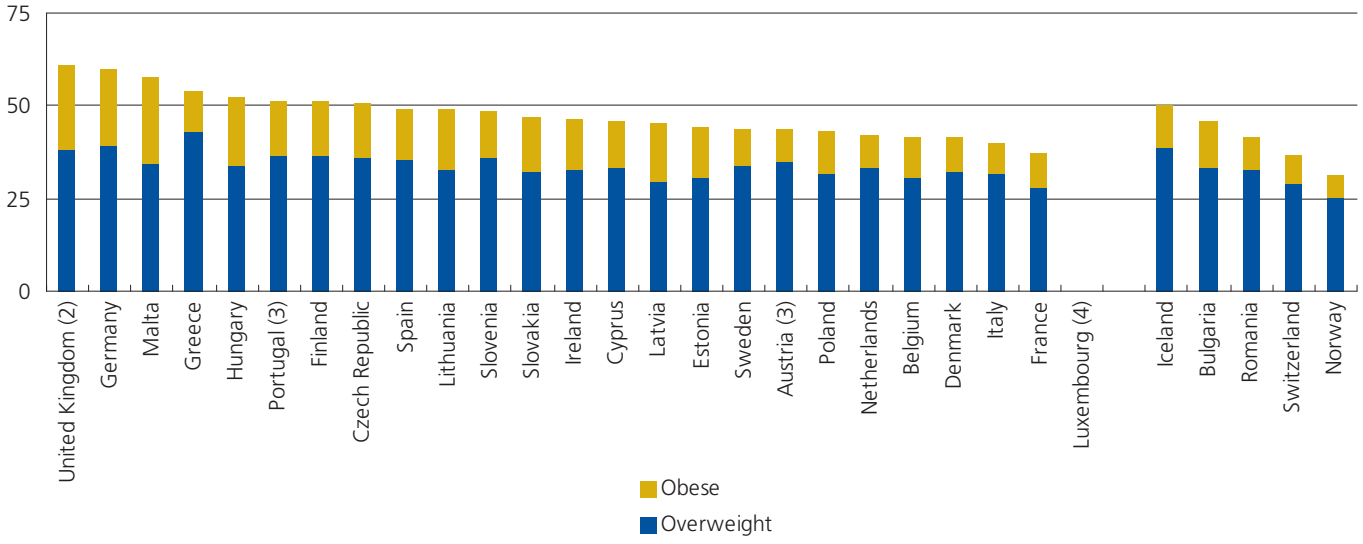
Potential widespread causes of health problems include being overweight, drinking too much and smoking. The latter of these causes has come in for particular attention in recent years in terms of legislation. Smoking legislation has been adopted by an increasing number of Member States, restricting or forbidding smoking in public places and/or workplaces, offering protection to passive smokers.

According to data from national health interview surveys (HIS), about 50 % of men smoked in Latvia, Estonia and Slovenia in 2003. For women, Austria and Denmark recorded the highest incidence, with just over 30 % of the female population classified as daily smokers. The lowest proportion of the population to smoke in 2003 was recorded in Sweden (16.5 %) and Finland (21.6 %) for men, and in Portugal (6.8 %) for women. The largest differences in smoking levels between the sexes were reported for the Baltic States. All countries reported higher levels of smoking for men than for women, with the exception of Sweden where there was a slightly higher proportion of female smokers.

Overweight and obesity are serious public health problems because they increase the risk of premature death and disability. They are associated with poor dietary habits and a lack of physical activity. The body mass index (BMI) is a measure of a person's weight relative to his or her height that correlates fairly well with body fat content in adults. BMI is accepted by experts as the most useful measure (when only weight and height data are available) for determining who is overweight or obese. The BMI is calculated by dividing body weight (in kilograms) by the square of the body height (in metres). A person with a BMI of 25 or more is considered to be overweight. At least 50 % of the population was overweight in 11 of the 25 Member States in 2003.

Figure 3.8: Overweight people, 2003 (1)

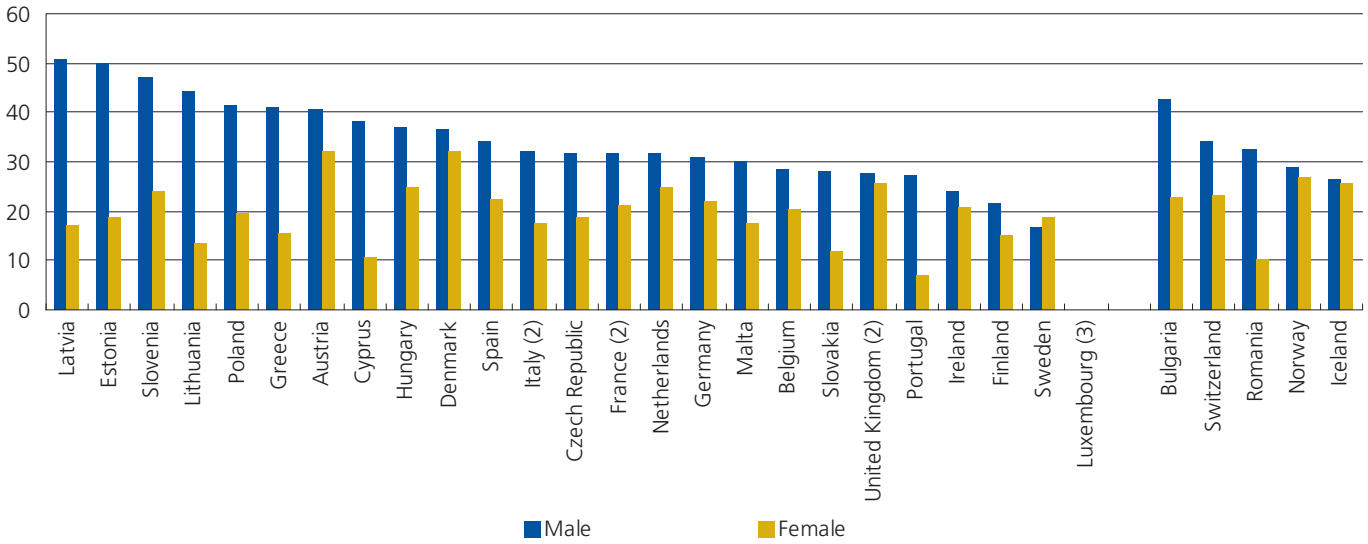
(% of total population)



(1) National health interview survey (HIS) data, 1996-2003 depending on the country.
(2) Only England.
(3) ECHP data, 2001.
(4) Not available.
Overweight people are those with a body mass index (BMI) greater than or equal to 25; this includes people who are severely overweight (obese), having a BMI greater than or equal to 30; the BMI is a measure of the body fat content of adults calculated as the ratio between the weight measured in kilograms, and the square of the height measured in metres.

Figure 3.9: Daily smokers, 2003 (1)

(% of male/female population)



(1) National health interview survey (HIS) data, 1996-2003 depending on the country.
(2) No distinction between daily and occasional smoking.
(3) Not available.

HEALTHCARE

As a significant part of the economy, it is important to understand what factors determine a country's level of health expenditure. There is no simple answer to the question of how much a country should spend on healthcare, as each of the Member States faces a different burden of disease, its populations have differing expectations, and there are geographical constraints.

The amount of money needed to fund a healthcare system adequately is a function of a large number of variables. The most obvious is perhaps the burden of disease requiring treatment, as a sicker population will require more healthcare — although there is no simple linear relationship between the burden of disease and the need for resources, as some conditions can be treated simply and at low cost while others may require a complex and expensive care. A second factor is the extent to which care is provided by families and friends, which has generally been transferred to health and social care sectors. It is also necessary to take account of issues such as geographical dispersion, as it is more expensive to provide care to isolated areas, as well as providing mechanisms to enable inhabitants of these regions to obtain specialist care elsewhere [28].

A Commission communication [29] defined a common framework to support Member States in the reform and development of healthcare and long-term care. Healthcare expenditure — defined here as expenditure on sickness/healthcare according to the European system of integrated social protection statistics (ESSPROS) — as a share of GDP was 7.6 % in the EU-25 in 2003 (compared, for example, with 5.2 % for education). Shares of more than 8 % were recorded in Germany, France, the Netherlands and Sweden, while at the other end of the range less than 4 % of GDP was spent on healthcare in the Baltic States, Cyprus or Poland.

On the basis of data available for 18 Member States, the largest increases in health expenditure between 1995 and 2003 were recorded in Belgium, Greece, Italy, Sweden and the United Kingdom, where healthcare expenditure (as a share of GDP) rose by at least one percentage point.

In 2002 there was an average of 618 hospital beds per 100 000 inhabitants within the EU-25, compared with 715 beds in 1995 (an overall reduction of over 10 %). This fall in hospital bed numbers may result from a more efficient use of resources, with an increasing number of operations being dealt with in outpatient treatment, and shorter periods being spent in hospital following an operation.

Lithuania (395), Belgium (394) and the Czech Republic (389) reported the highest number of practising physicians per 100 000 inhabitants in 2003 (among those Member States for which data are available). At the other end of the range, there was an average of 216 practising physicians in the United Kingdom.

[28] For a more lengthy discussion of the issues refer to '*The contribution of health to the economy in the European Union*', European Commission, Directorate-General of the European Commission for Health and Consumer Protection (http://ec.europa.eu/health/ph_overview/Documents/health_economy_en.pdf).

[29] '*Modernising social protection for the development of high-quality, accessible and sustainable healthcare and long-term care: support for the national strategies using the "open method of coordination"*', COM(2004) 304 final of 20 April 2004 (http://ec.europa.eu/employment_social/soc-prot/healthcare/com_04_304_en.pdf).

Table 3.2: Healthcare indicators

TPS00044 TPS00046 TPS00048

	Hospital beds (per 100 000 inhabitants)		Physicians (per 100 000 inhabitants)		Discharges (per 100 000 inhabitants) (1)		Healthcare expenditure (% of GDP)	
	1995	2003	1995	2003	1995	2002	1995	2003
EU-25 (2)	719	618	:	:	:	:	:	7.6
EU-15 (2)	690	593	:	:	:	:	7.4	7.7
Euro area (2)	745	641	:	:	:	:	:	:
Belgium	744	686	345	394	7 158	:	6.3	7.6
Czech Republic (3)	939	868	346	389	9 070	9 838	6.4	7.1
Denmark	489	398	251	285	8 509	:	5.5	6.1
Germany	970	874	307	337	8 337	:	8.4	8.1
Estonia	804	591	307	315	:	9 438	:	4.2
Greece	500	:	393	:	5 971	:	5.6	6.7
Spain (2) (3)	395	358	268	329	4 249	5 057	6.1	5.9
France (4)	890	796	:	:	:	:	8.1	8.9
Ireland	1 015	1 007	:	:	:	5 954	6.5	6.6
Italy	622	418	:	:	:	7 032	5.5	6.5
Cyprus (5)	452	431	220	263	2 170	2 379	:	4.1
Latvia	1 099	779	278	278	9 526	9 522	:	3.0
Lithuania	1 083	866	405	395	9 955	11 009	:	3.9
Luxembourg (2)	1 096	644	204	245	:	8 610	5.7	5.8
Hungary	909	:	303	324	:	12 177	:	6.2
Malta	545	750	:	:	:	2 434	4.2	4.8
Netherlands (2)	533	463	186	:	4 800	4 369	8.3	8.2
Austria	755	836	266	338	11 247	13 835	7.1	7.1
Poland	769	668	232	243	5 552	:	:	4.3
Portugal (2)	392	365	255	269	:	4 213	7.0	6.5
Slovenia (2) (6)	574	509	:	228	:	6 465	:	7.8
Slovakia	:	724	292	328	8 481	8 237	6.0	5.8
Finland	801	724	:	:	11 595	11 672	6.4	6.5
Sweden	609	:	286	333	8 127	7 183	7.5	8.5
United Kingdom	:	397	173	216	7 579	8 925	6.5	7.7
Bulgaria	1 034	627	345	356	:	8 673	:	:
Croatia (2) (6)	588	568	204	239	3 583	4 763	:	:
Romania	763	656	:	200	7 984	10 370	:	:
Turkey	247	235	:	139	:	:	:	:
Iceland	911	:	303	363	:	7 067	7.2	8.5
Norway	406	428	279	329	7 568	:	7.4	9.4
Switzerland (6)	701	584	176	198	:	6 312	5.8	7.1
Japan	1 330	:	:	:	:	:	:	:
United States (3)	413	:	203	:	4 799	4 720	:	:

(1) Discharges relating to cancer (malignant neoplasms), diseases of the circulatory system, diseases of the respiratory system, diseases of the musculoskeletal system/connective tissue, and complications of pregnancy, childbirth and puerperium.
(2) 2002 instead of 2003 for hospital beds.
(3) 2001 instead of 2002 for discharges from hospital.
(4) France métropolitaine.
(5) 2002 instead of 2003 for healthcare expenditure.
(6) 2002 instead of 2003 for practising physicians.

Beds accommodating 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.

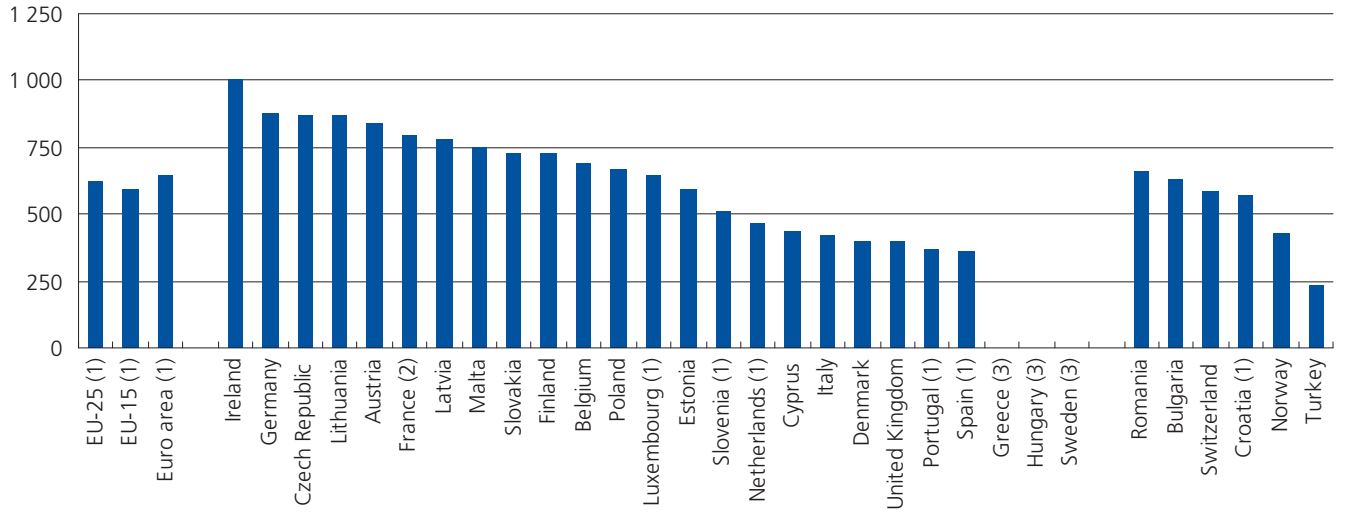
Physicians may be counted as licensed, economically active or practising; data for two or more concepts are available in the majority of Member States; practising physicians are those seeing patients either in a hospital, practice or elsewhere.

A discharge from a hospital or another healthcare facility 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.

Healthcare expenditure is defined as the share of sickness/healthcare expenditure in GDP; these expenditures cover — cash benefits that replace in whole or in part loss of earnings during temporary inability to work due to sickness or injury; medical care provided in the framework of social protection to maintain, restore or improve the health of the people protected.

Figure 3.10: Hospital beds, 2003

(per 100 000 inhabitants) TPS00046



(1) 2002 instead of 2003.
(2) France métropolitaine.
(3) Not available.

Beds accommodating 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.

Figure 3.11: Hospital beds, EU-25

(per 100 000 inhabitants) TPS00046

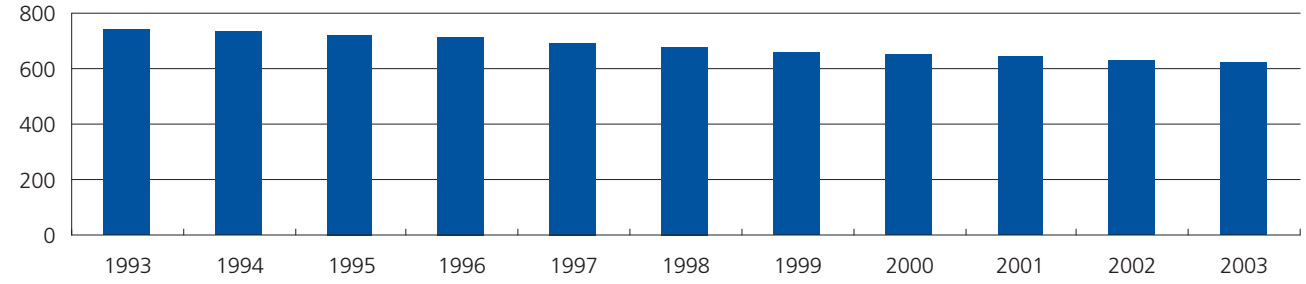
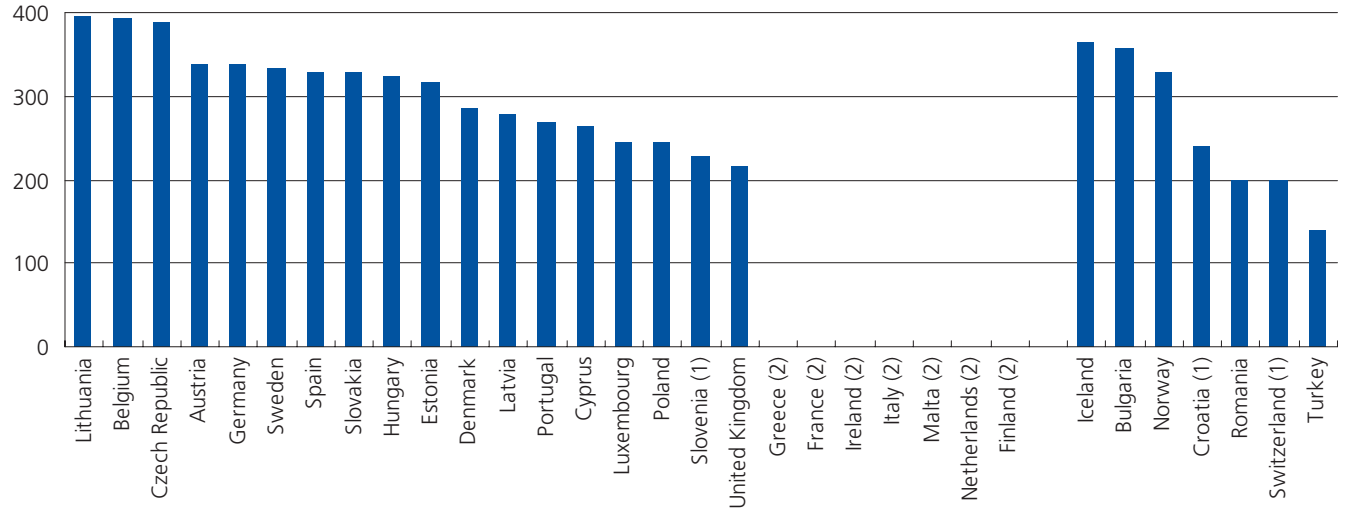


Figure 3.12: Number of practising physicians, 2003

(per 100 000 inhabitants) TPS00044



(1) 2002 instead of 2003.
(2) Not available.

Physicians may be counted as licensed, economically active or practising; data for two or more concepts are available in the majority of Member States; practising physicians are those seeing patients either in a hospital, practice or elsewhere.

SAFETY AT WORK

European statistics on accidents at work and occupational diseases respond to the requirements of the Community strategy on health and safety at work 2002–06 [30], which was developed to take account of changes in society and the workplace. It adopts a global approach to well-being at work, based on preventive measures and building partnerships between all players in the areas of employment, health and safety.

Health at work is not restricted to the absence of accidents or occupational illnesses, but also involves physical, moral and social well-being, which are considered especially important for the quality of work and productivity of the workforce.

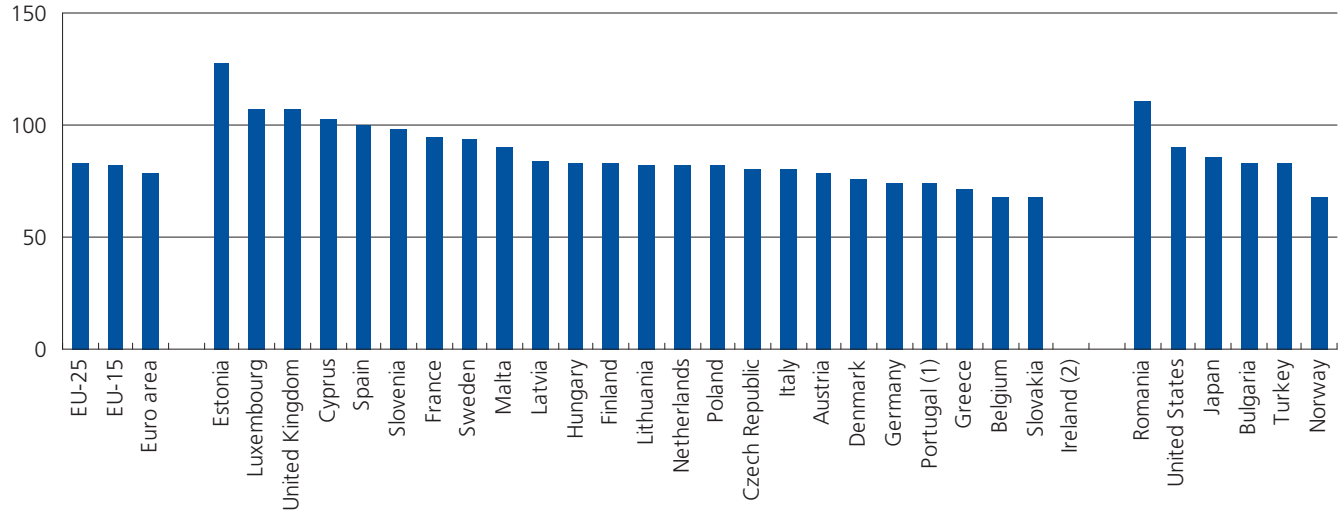
An accident at work is a discrete occurrence that leads to physical or mental harm; it excludes accidents on the way to or from work. Between 1998 and 2003, the incidence rate of serious accidents at work decreased by 17 % in the EU-25, and also fell in the majority of Member States (for which data are available), with the exception of Estonia, Luxembourg and the United Kingdom.

The incidence rate of fatal accidents at work fell by 23 % in the EU-25 between 1998 and 2003. Note that these figures may in part be affected by the structural shift in the economy towards services, where the risks of death at work are usually less than within agriculture, industry or construction.

[30] Council Resolution 2002/C 161/01 of 3 June 2002 on a new Community strategy on health and safety at work (2002–2006) (OJ C 161, 5.7.2002, p. 1) (http://eur-lex.europa.eu/LexUriServ/site/en/oj/2002/c_161/c_16120020705en00010004.pdf).

Figure 3.13: Serious accidents at work, 2003

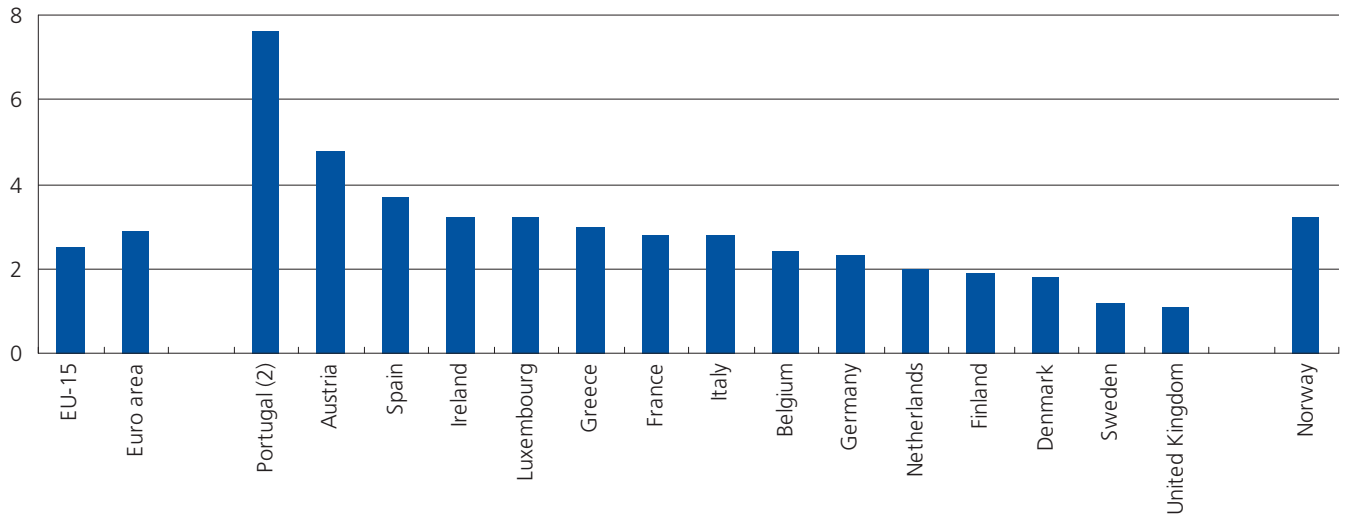
(1998 = 100, based on the number of serious accidents per 100 000 persons in employment)



(1) 2002.
(2) Not available.
The index shows the evolution of the incidence rate of serious accidents at work in comparison to 1998 (= 100); the incidence rate = number of accidents at work with more than three days' absence that occurred during the year/number of persons in employment in the reference population × 100 000; an accident at work is a discrete occurrence in the course of work that leads to physical or mental harm; this includes accidents in the course of work outside the premises of his/her business, even if caused by a third party, and cases of acute poisoning; it excludes accidents on the way to or from work, occurrences having only a medical origin, and occupational diseases.

Figure 3.14: Fatal accident at work, 2003 (1)

(per 100 000 persons employed) TPS00043



3

(1) Excludes road traffic accidents during work; no information available for the 10 Member States that joined the EU in 2004.
(2) 2002.
The incidence rate = number of fatal accidents at work that occurred during the year/number of persons in employment in the reference population × 100 000; a fatal accident at work is a discrete occurrence in the course of work with physical or mental harm, leading to death within one year of the accident; it excludes accidents on the way to or from work, occurrences having only a medical origin, and occupational diseases; to adjust for differences between the Member States in the distribution of workforce across the risk branches, a standardisation is made giving each branch the same weight at national level as in the European Union total.