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Introduction



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Statistical data at the regional level

The Structural Funds for the period 2007 to 2013 were decided in December 2005. This decision was based on the objective regional statistics compiled by Eurostat, thus highlighting the importance of our effort to produce a wide range of comparable regional information.

This yearbook shows many aspects of this regional data and suggests in the various chapters some of the analyses which can be made with them. But we also invite you the reader to yourself continue the analyses of the regional data supplied in each of the different themes presented here. We also hope that this publication will make you keen to further investigate Eurostat's statistical databases (available free of charge on the internet).

In keeping with the traditions of the Regional yearbook, we try to renew the publication a little each year, but also to keep its structure basically unchanged. In this way, many subjects reappear from year to year, but the theme or focus of the subject is always slightly different. This year we again have one theme that is totally new for the Regional Yearbook, namely "labour productivity", which combines statistics on GDP with labour market statistics in a very interesting way. This kind of cross-cutting of different statistical domains could of course also be conducted with other statistical themes, but we will for the moment leave that to a future edition of the yearbook.

Some highlights

We will not present here the content of all chapters of this Regional Yearbook. Here, however, are some hints to whet your appetite to read it carefully:

- The population chapter this year focuses on old and young dependency ratios in the coming decades, highlighting the drastic changes of society we will have to cope with.
- The chapter on regional GDP centres its attention on growth rates between 1999 and 2003, giving interesting insights into regional differences.
- The Urban Audit chapter concentrates on the competitiveness of cities, analysing various facets of benchmarking cities that compete against each other.
- The chapter on the Structural Business Survey focuses on specialised regions in different industrial and service activities. This highlights the heterogeneity of European regions in terms of the production process and skills.

Regional classification

All regional analysis in this yearbook is based on NUTS 2003. In the meantime, the ten new Member States have also been formally integrated into the new regional classification in the form of an amendment to the NUTS Regulation. The texts of the Regulation and the amendment are available on the CD-ROM – as is the annex, which lists the regions making up the nomenclature in each country.

Coverage

No distinction is made in the yearbook between the old Member States, the countries that became Member States in 2004 and those due to join in 2007 or 2008: wherever data are available for Bulgaria and Romania, these of course also feature in the maps and commentaries. In the case of Turkey and Croatia, there are still too few regional data to justify including them in the analyses.

Structure

In each chapter, regional distributions are highlighted by colour maps and graphs which are then evaluated by expert authors in text commentaries. In keeping with the traditions of the yearbook, an effort has been made to focus on aspects not recently covered.

In order to assist the understanding of the maps, the data series used for the maps in the yearbook are provided as Excel files on the CD-ROM.

In the maps, the statistics are presented at NUTS level 2. A map giving the code numbers of the regions can be found in the sleeve of this publication. At the end of the publication there is a list of all the NUTS-2 regions in the European Union, together with a list of the level 2 statistical regions in Bulgaria and Romania. Full details of these national regional breakdowns, including lists of level 2 and level 3 regions and the appropriate maps, may be consulted on the RAMON server.[1]

More regional information needed?

The public REGIO database on the Eurostat website contains more extensive time series (which may go back as far as 1970) and more detailed statistics than those given in this yearbook, such as population, death and birth by single years of age, detailed results of the Community labour-force survey, etc. Moreover, there is coverage in REGIO of a number of indicators at NUTS level 3 (such as area, population, births and deaths, gross domestic product, unemployment rates). This is important because there are no fewer than eight EU Member States (Cyprus, Denmark, Estonia, Latvia, Lithuania, Luxembourg, Malta and Slovenia) that do not have a level 2 breakdown.

For more detailed information on the contents of the REGIO database, please consult the Eurostat publication 'European regional and urban statistics — Reference Guide 2003', a copy of which is available in PDF format on the accompanying CD-ROM.

In addition, the reader is also invited to consult the web version of the "Portraits of the Regions", which give regional profiles of all individual regions across Europe.[2] These regional topical profiles describe the geography and history of the region, before going on to assess its strengths and weaknesses in terms of demographic, economic and cultural issues. Among the aspects examined are the labour market, education, infrastructure and resources.

Regional interest group on the web

Eurostat's regional statistics team maintains a publicly accessible interest group on the web ('CIRCA site') with many useful links and documents.[3]

Among other resources, you will find:

- a list of all regional coordination officers in the Member States, the candidate countries and the EFTA countries;
- the latest edition of the "Regional and Urban Reference Guide";
- PowerPoint presentations of Eurostat's work concerning regional and urban statistics;
- the regional classification NUTS for the Member States and the regional classification of the candidate countries.

Closure date for the yearbook data

The cut-off date for this issue was the 15th of May 2006.

[1] See http://europa.eu.int/comm/eurostat/ramon/index.cfm?TargetUrl=DSP_PUB_WELC

[2] See http://forum.europa.eu.int/irc/dsis/regportraits/info/data/en/index.htm

[3] See http://forum.europa.eu.int/Public/irc/dsis/regstat/information

Health

9.



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Introduction

Socio-health regions are defined in very different ways from one regional, provincial or local government to another, and from one Member State to another. As regional governments have become more important in Europe, the role of the regions as units for the political and administrative management of health issues has also developed. For example, in Spain, where regional governments have acquired a great deal of autonomy, one practical effect is that they manage the entire health budget. The situation is very similar in Belgium. Since 1996, France's healthcare reform – introduced to put healthcare planning on a regional footing – has allowed hospitals to be responsible for allocating the budget. Healthcare management is also being drastically reorganised in the United Kingdom, with NHS trusts having varying levels of responsibility. In other Member States such as the Netherlands and Sweden, the municipalities are responsible for healthcare.

Hence one difficulty with statistics on health and on medical/health/hospital services at regional level stems from the fact that local-government boundaries, and thus the regional breakdown which is of interest to health authorities in the Member States, do not always coincide with the NUTS, and cross-referencing problems may therefore arise when comparing regional statistics.

Currently, two different types of health statistics are available at regional level, mostly for NUTS level 2. Firstly there are data on **mortality** by underlying cause, where the illnesses or diseases in question are defined according to an international classification and where data are collected using comparable methods. This chapter focuses on patterns of premature mortality (i.e. on mortality of the population aged between 0 and 64 years) for selected causes. The second type of data available at regional level concerns **health care**; here the regional distribution of hospital discharges and of dentists is examined.

Mortality in EU regions

Mortality patterns differ significantly according to age and sex, and also vary considerably between regions. Many factors determine mortality patterns – intrinsic factors such as age and sex, extrinsic factors such as biological or social collective factors, living or working conditions, and individual factors such as lifestyle, smoking, alcohol consumption, driving behaviour, and sexual behaviour.

As a general rule, mortality is higher among men than women in all age groups. Although there are signs that the mortality gap is narrowing in some member states, the difference nevertheless warrants looking at women and men separately.

Looking at the overall mortality in EU-25 in 2003, diseases of the circulatory system account for 41% of all deaths and are thus the major cause (45% for women and 37% for men). These pathologies affect the population at advanced ages – over 80% of deaths due to cardiovascular diseases occur among people aged 70 years and older. Malignant neoplasms, i.e. cancers, follow as the second most frequent cause, accounting for 25% of all deaths in EU-25 (or 22% for women and 29% for men). Malignant neoplasms mostly affect elderly people, as almost 60% of all deaths due to cancer involve persons aged 70 years and older. At the same time, for premature deaths, i.e.

deaths under the age of 65, malignant neoplasms account for 36% and so represent the main cause (men under 65: 31%, women under 65: 45%). External causes also have a substantial impact on deaths below 65. For this age group, 15% of deaths are due to external causes (men: 18%, women: 10%) while for all ages it is only 5% (men: 6%, women: 4%).

Ischaemic heart diseases

Ischaemic heart diseases comprise Angina pectoris, acute myocardial infarction and other acute and chronic ischaemic heart diseases. For EU-25, ischaemic heart diseases account for 16% of all deaths and for 11% of deaths under the age of 65. This corresponds to nearly half of all deaths related to all diseases of the circulatory system occurring under 65. Substantial differences can be observed between men and women – only 6% of women die from ischaemic heart diseases before the age of 65 in contrast to 13% of men.

Male/female mortality ratios compare the differences in mortality between women and men. They are calculated by dividing the age-standardised death rate (SDR) for men in a given region and for a specific cause by the corresponding SDR for women (for SDR see also below in the methodological notes). Values higher than 1 indicate excess male mortality, while values lower than 1 mean excess female mortality.

Looking at all ages, the male/female mortality ratios for ischaemic heart diseases show a male excess mortality in all regions but the variation within EU-25 is relatively small, ranging from 1.2 in the French Guyane to 3.0 in Comunidad Foral de Navarra (Spain). However, for premature mortality, i.e. SDRs for the ages 0 to 64, considerably higher male excess mortality can be found throughout Europe. Even the regions with the lowest male excess mortality before the age of 65 report values of around 2.5, and values higher than 8.0 are reached in the following five European regions: Castilla y León and Comunidad Foral de Navarra (Spain), Bretagne and Poitou-Charentes (France) and Åland (Finland).

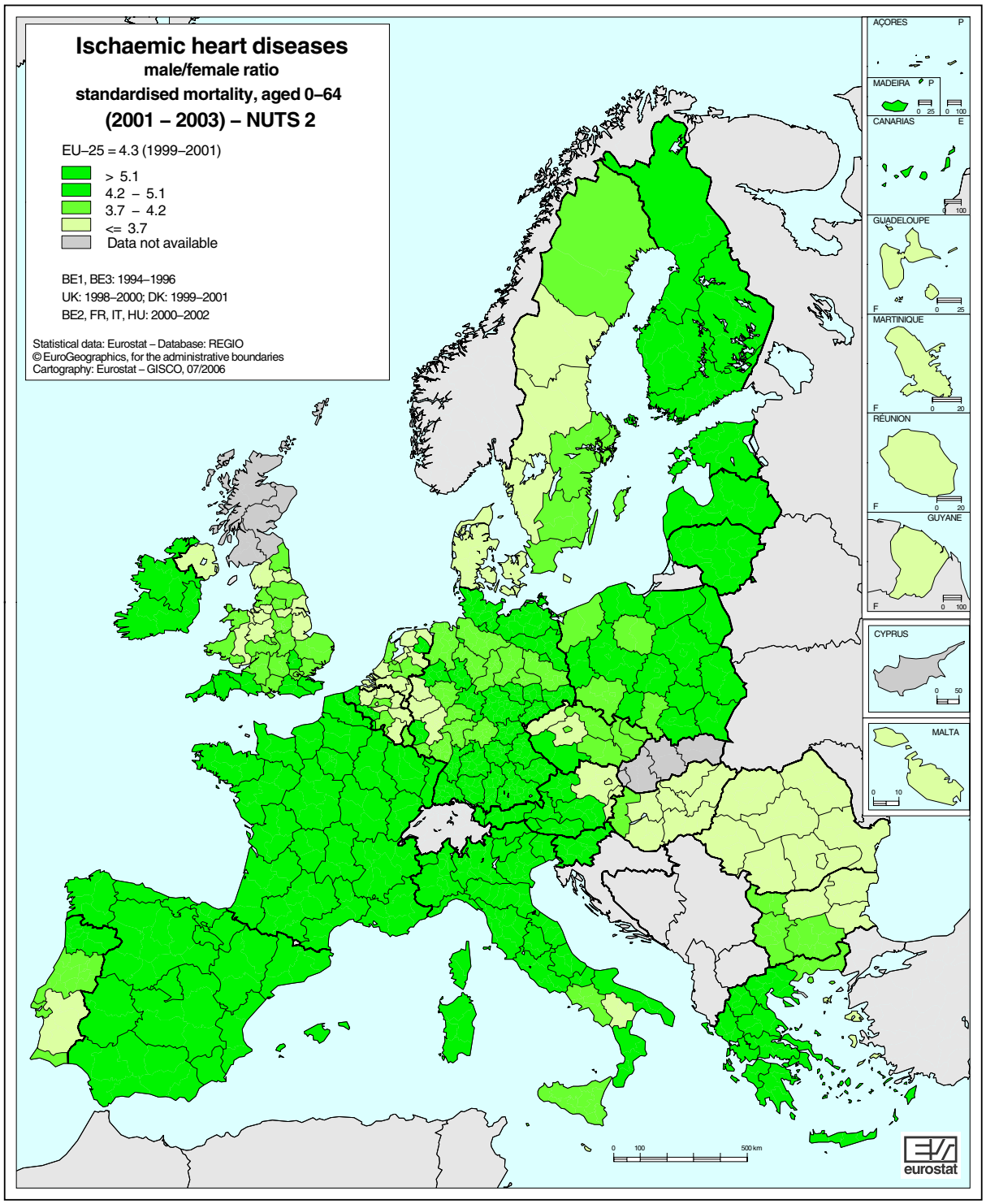
The regional pattern for this indicator is not very evident but some regional particularities can be observed. In the southern European regions as well as throughout France and the southern regions of Germany, a high male excess mortality can be observed, with few exceptions in Portugal (Alentejo, and also Algarve, Centro (P) and Lisboa) and in Italy (Basilicata, Campania and Sicilia). Regions with a low male excess mortality can be found in a diagonal across Europe – from United Kingdom through Belgium and the Netherlands and some of the neighbouring German regions (Düsseldorf, Köln and Koblenz) over to the Czech Republic and Austria. In the east, most Hungarian regions together with all Romanian and several Bulgarian regions present a joint area of relatively low male excess mortality. In the north, it is in Denmark and Sweden where smaller differences can be seen between men and women while Finland and the Baltic countries show a high male excess mortality for ischaemic heart diseases.

Accidents

Before the age of 65, deaths due to external causes play a significant role (see above), and accidents account for almost 60% of deaths from external causes. This figure refers to all types of accidents, i.e. transport accidents, falls and other accidents such as drowning, fire, accidental poisoning – all types of circumstances that may well be preventable. The risk of men below the age of 65 falling victim to a fatal accident is twice as high as for women – in EU-25 in 2003, 10% of deaths among men younger than 65 were due to an accident, compared to only 5% among women in that age-group.

The regional distribution of premature mortality of men expressed in Standardised Death Rates (SDRs, see below – methodological notes) shows a very clear pattern for European risk areas. The highest SDRs for accidents are reported for a more or less coherent area in the east, stretching from Finland and the Baltic countries in the very north via Poland, the Czech Republic and regions in Austria and through Hungary, Romania, and Bulgaria all the way down to Greece. High mortality due to accidents is generally the result of transport accidents – for men in EU-25, just over half of all deaths due to accidents are caused by transport accidents.

In the west, almost all regions in France and Spain show high SDRs, though not at the same level as the regions in the east. The regions with lower mortality in these two countries are Alsace, Lorraine, Nord - Pas-de-Calais and Île-de-France (which comprises Paris) in France and Cantabria, País Vasco, Comunidad de Madrid and Canarias in Spain. The “safer” countries are the United Kingdom, Sweden, Denmark and the Netherlands, where all regions report SDRs below 30.6 (per 100 000 inhabitants). Most regions

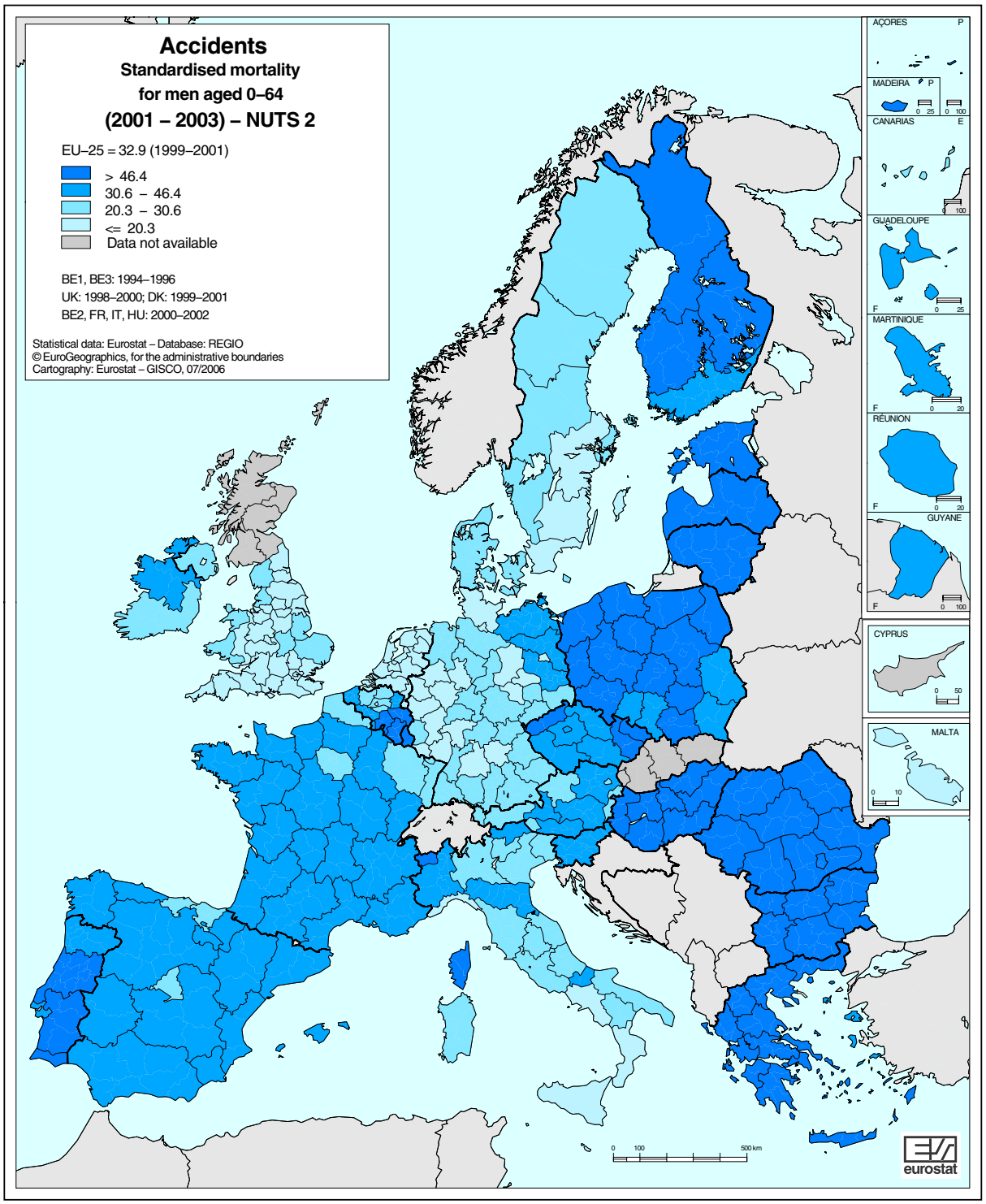


Map 9.1

in Germany and in Italy are also low-risk regions for accident mortality, with a few exceptions (SDRs higher than 35 in Brandenburg – Nordost, Brandenburg – Südwest and Mecklenburg-Vorpommern in Germany and higher than 30 in Piemonte, Valle d'Aosta/Vallée d'Aoste, Provincia Autonoma Bolzano/Bozen, Emilia-Romagna and Molise in Italy).

For women, premature mortality due to accidents is generally far lower, with SDRs ranging between less than 5 per 100 000 inhabitants in Malta and the Netherlands, and more than 30 in Estonia and Latvia. For men in the same age group the lowest rate reported is 14.1 (the Netherlands), and in the Baltic countries the rates are around 135 and above.

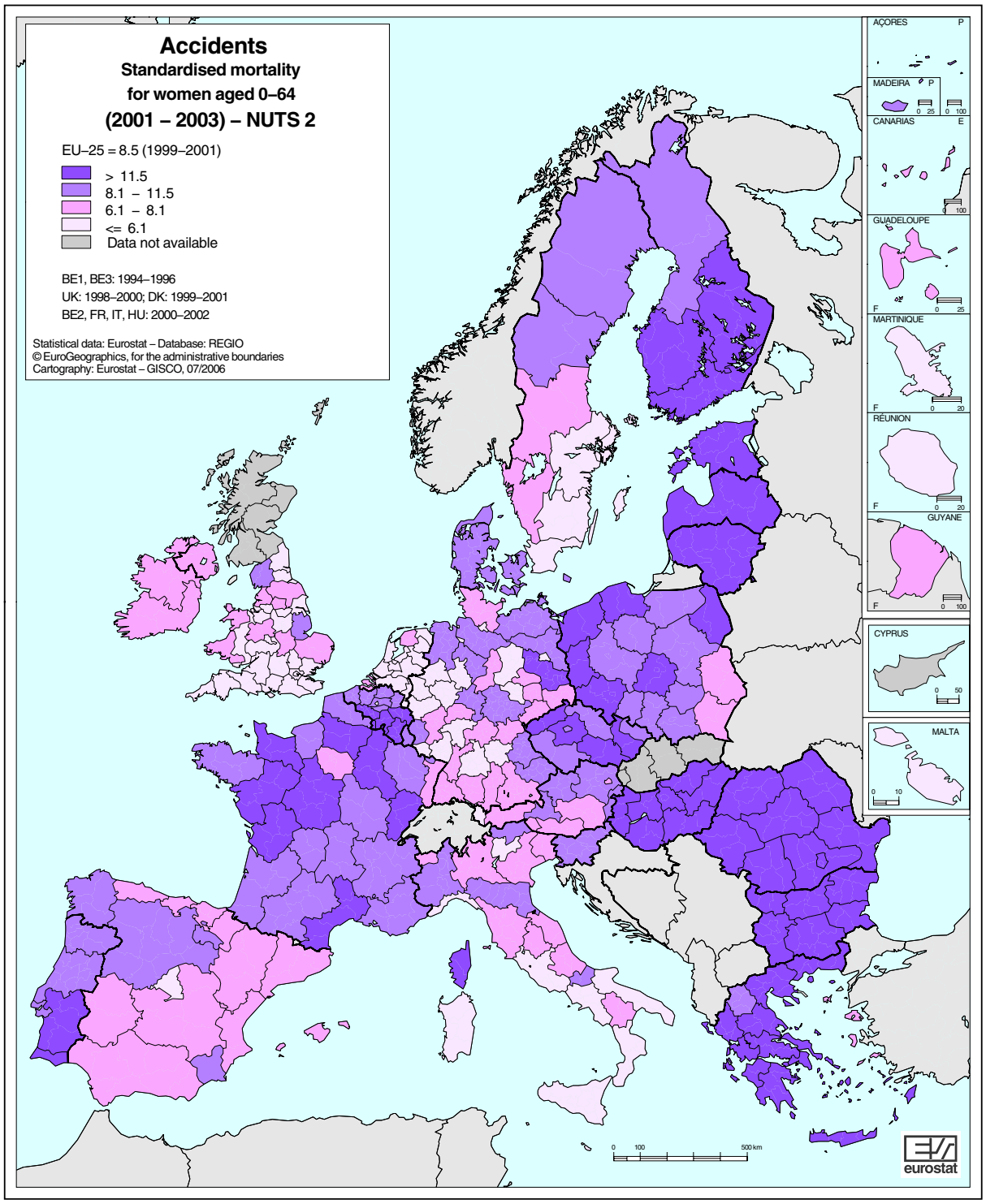
As for men, the standardised mortality for women due to accidents is relatively high in regions in the East of Europe, stretching from Finland to Greece. Low risk areas for women are mainly



Map 9.2

concentrated in the southern part of the United Kingdom, in the Netherlands, Germany and the south of Italy. But Malta, the Comunidad de Madrid, Vorarlberg (Austria), Åland (Finland) as well as 4 regions in the south-east of Sweden also have outstanding low accident related SDRs for women.

Regarding the male/female mortality ratios for accidents, male excess mortality is particularly marked in Poland, Slovenia and Malta with values above 5. At the regional level, the largest divergence of accident-related mortality for women and men is reported for Guadeloupe and Martinique (France), Ciudad Autónoma de Ceuta (Spain), Valle d'Aosta/Vallée d'Aoste and Provincia Autonoma Trento (Italy), Região Autónoma da Madeira (Portugal), Åland (Finland) and Lubelskie (Poland) – in these regions values higher than 6 for male excess mortality are observed.



Map 9.3

Health care resources in EU regions

Hospital discharges

Hospitalisation statistics give a broad picture of the health care treatment of the population, and also of general health. Around 15 640 persons per 100 000 population were discharged from hospitals in EU-25 in 2003. However, even between countries, there is a wide range for this indicator, from less than 7 000 in Cyprus and Malta to over 26 000 in Finland and Austria. These differences may partly reflect the differences in the organisation of health care services.

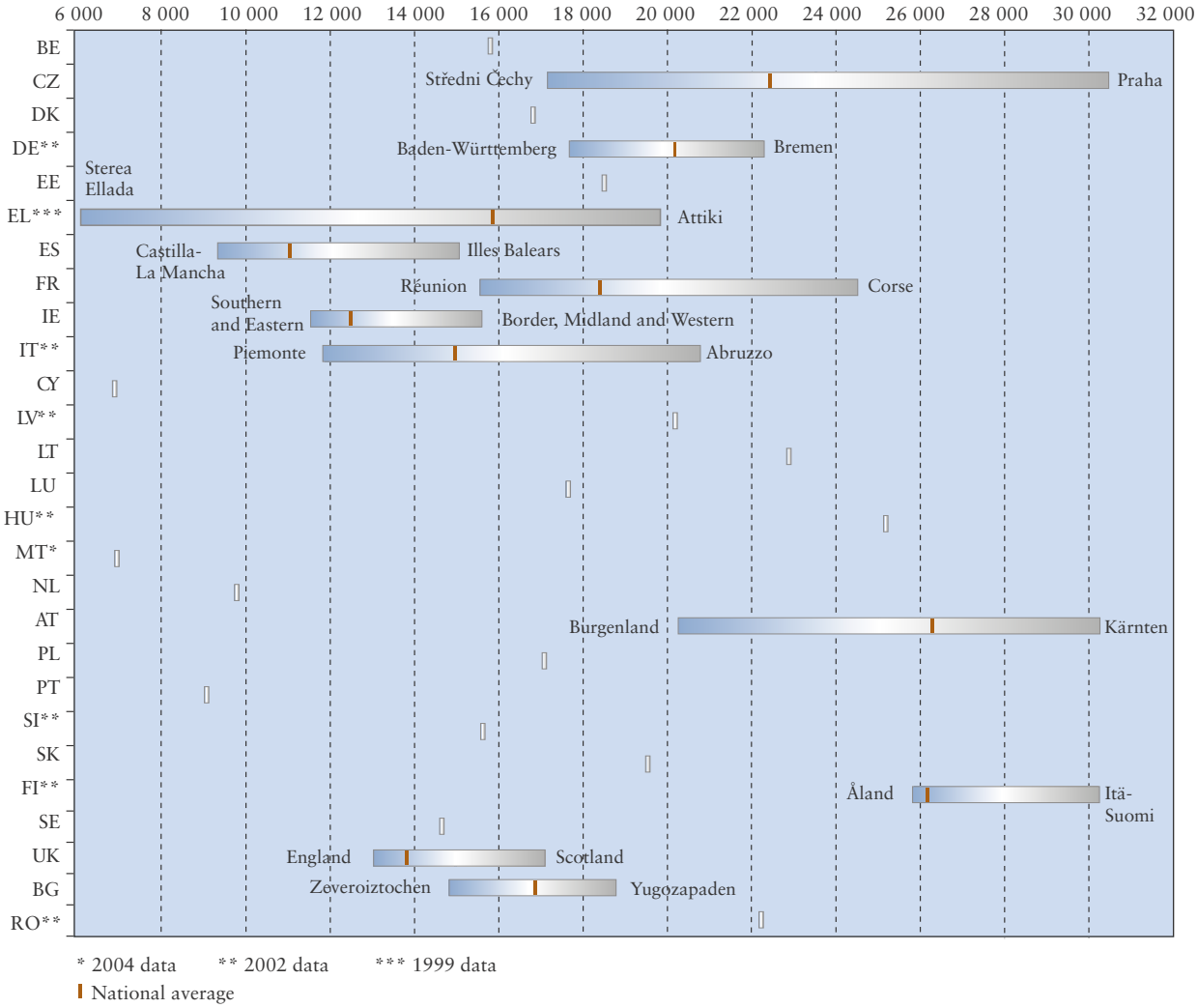
Regional data for hospital discharges of in-patients have only quite recently become available, and not all countries are yet in the position to

provide hospital discharges data at sub-national level. Amongst the countries with sub-national data, the Czech Republic, Greece and Italy show the greatest variation within the country for the number of hospital discharges per 100 000 inhabitants. In the Czech Republic, in the capital region comprising Prague, almost twice (1.8) as many persons are discharged from hospitals as in Střední Čechy, which geographically surrounds the region Praha. In Austria, hospital discharges within the country vary by a factor of 1.5, and between Wien and the surrounding Niederösterreich, it is only by a factor of 1.3. Within countries, it is often capital regions or relatively small regions including a big city which have high discharge rates: Praha (30 676), Bremen (28 284), and the Saarland (24 363) in Germany, Athens (19 799) in Greece. However, this is not very surprising since hospitals tend to be concentrated in cities and agglomerations. While the hospitals are located in the cities, their catchment area is much wider, and people living in the neighbouring regions may also use the health care facilities offered in the cities. However, relatively high hospital discharge rates can also be observed in some sparsely populated regions such as Mecklenburg-Vorpommern (Germany) and Limousin (France), (22 068 and 19 391 respectively) which may partly be explained by the effects of migration and ageing.

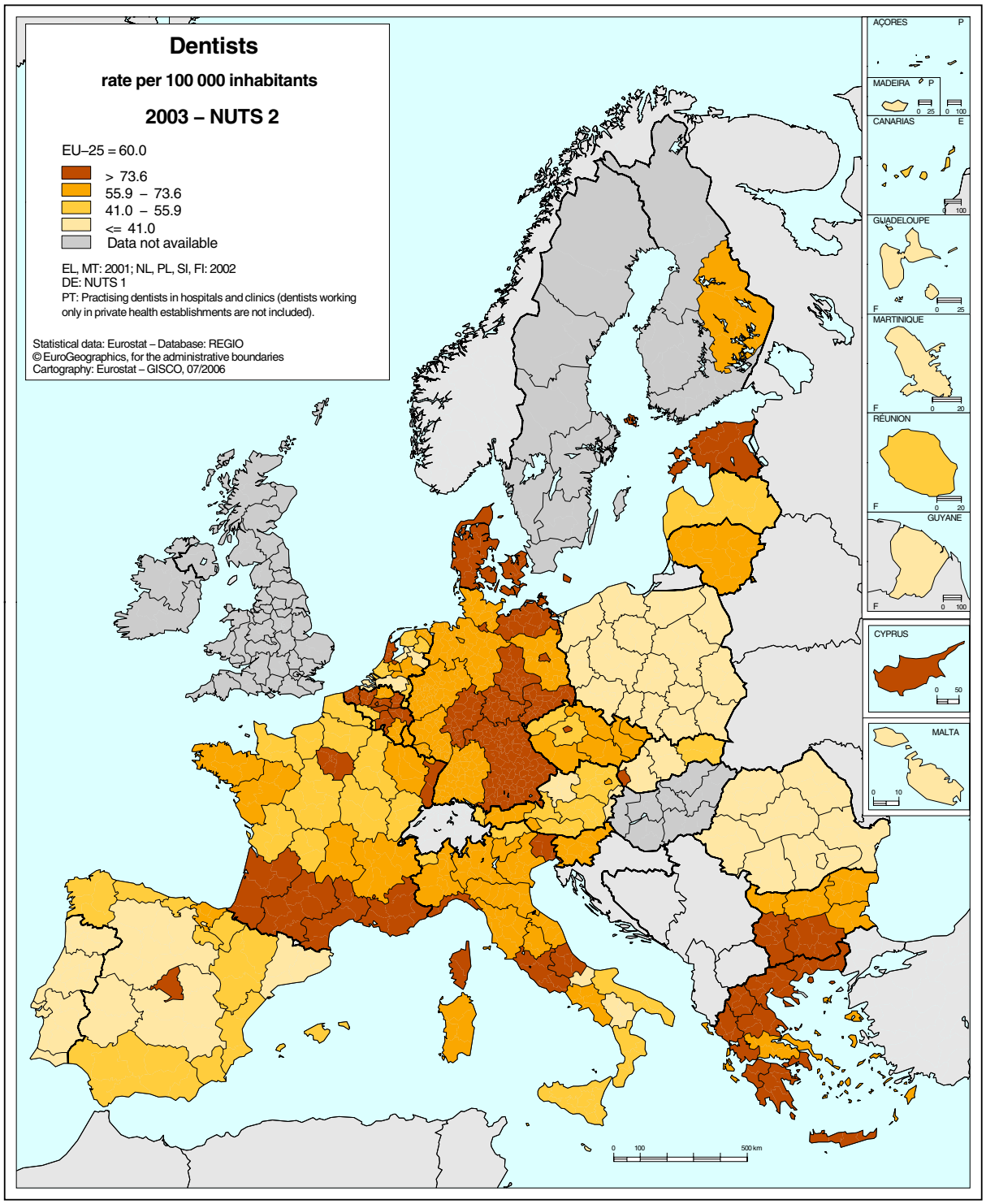
Dentists

For EU-25, the density rate of dentists, i.e. their average number per 100 000 inhabitants, is around 60. At the regional level, considerable variations in this indicator can be observed, and map 9.4 shows a clear picture of where the provision of dental services is concentrated. Across all regions, the density rates range from less than 20

Graph 9.1: Hospital discharges - Rate per 100 000 inhabitants, 2003 - NUTS 2



in a number of Polish, Romanian and Portuguese regions (however, data for the latter refer only to dentists practising in hospitals and clinics and therefore underreport the situation) up to rates higher than 100. Eight regions situated in Belgium, Bulgaria, the Czech Republic, Germany, and Greece report these highest density rates, and not very surprisingly, the capital regions of all five countries are in this group: Brussels, Sofia, Prague, Berlin and Athens. Similarly, in most other countries for which regional data are available it is again the capital region where the highest concentration of dentists within the country can be found.



Map 9.4

Conclusion

The currently available regional indicators for health already provide a first insight into similarities and particularities that exist throughout Europe. However, in analysing the data it has to be kept in mind that the differences observed are also influenced by the organisation of health care systems and by socio-cultural factors. Examples of the latter are the reporting of particular causes of death such as suicide or alcohol-related deaths and their link to culturally determined consumption patterns. Health care resources are influenced by the organisation of the systems at national and regional level, and in the medium term figures on health care capacities should be complemented by information on their effectiveness.

The main focus of Eurostat's work in the area of health statistics lies on the further improvement of the quality and comparability of the data, and on the further extension of the regional coverage.

Methodological notes

Causes of Death (COD) **statistics** are based on information derived from the medical death certificate. COD statistics record the **underlying cause of death**, i.e. "the disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury". This definition has been adopted by the World Health Assembly.

In addition to absolute numbers, crude death rates and standardised death rates for COD are provided at national and regional level. Regional level data are provided in the form of three-year averages. The **crude death rate** describes mortality in relation to the total population. It is expressed per 100 000 inhabitants, being calculated as the number of deaths recorded in the population for a given period divided by the population in the same period and then multiplied by 100 000. **Crude death rates** are calculated for 5-year age groups. At this level of detail, comparisons between countries and regions are meaningful. The crude death rate for the total population (all ages) by sex and age, however, is a weighted average of the age-specific mortality rates. The weighting factor is the age distribution of the population whose mortality is being observed. Thus, the population structure strongly influences this indicator for broad age classes. In a relatively 'old' population, there will be more deaths than in a 'young' one because mortality is higher in higher age groups. For comparisons, the age effect can be taken into account by using a standard population. The **standardised death rate (SDR)** is a weighted average of age-specific mortality rates. The weighting factor is the age distribution of a standard reference population. The standard reference population used is the 'standard European population' as defined by the World Health Organisation (WHO). Standardised death rates are expressed **per 100 000 inhabitants** and calculated for the age group 0-64 ('premature death') and for the total of ages. Causes of death are classified by the 65 causes on the **'European shortlist'** of causes of death. This shortlist is based on the International Statistical Classification of Diseases and Related Health Problems (ICD), a classification developed and maintained by the WHO.

Eurostat collects regional-level statistics on **health care staff** (numbers of doctors, dentist and of other health professions) and on **hospital beds** (the latter are not shown in this publication but available in Eurostat's statistical databases). Regional data on **hospital discharges of in-patients** have recently become available, though not yet for all countries. In addition to absolute numbers, density rates are provided for health care statistics. **Density rates** are used to describe the availability of these resources or the frequency of services rendered, expressed per 100 000 inhabitants. They are calculated by dividing the absolute number of health care resources available or services rendered in a given period by the respective population in the same period and then multiplied by 100 000.

Data on **dentists** should refer to those "immediately serving patients", i.e. dentists who have direct contact with patients as consumers of health care services. In the context of comparing health care services across Member States, Eurostat considers that this is the concept which best describes the availability of health care resources. However, Member States use different concepts when they report the number of health care professionals – both for national purposes and for international comparison. Therefore for some countries the data might refer to dentists 'licensed to practice' (i.e. successfully graduated dentists irrespective whether they see patients or not) or they might include dentists who work in their profession but do not see patients (i.e. they work in research, administration etc.).

A **discharge** from a hospital or another health care facility occurs at any time when a patient leaves because of medically authorised discharge, transfer, departure against medical advice, or death. The number of discharges is the most commonly used measure of the utilisation of hospital services, in preference to admissions. This is because it is at the time of discharge that information is gathered for hospital abstracts for in-patient care.

EUROPEAN UNION: NUTS 2 regions

BE10	Région de Bruxelles-Capitale/Brussels Hoofdstedelijk Gewest
BE21	Prov. Antwerpen
BE22	Prov. Limburg (BE)
BE23	Prov. Oost-Vlaanderen
BE24	Prov. Vlaams-Brabant
BE25	Prov. West-Vlaanderen
BE31	Prov. Brabant Wallon
BE32	Prov. Hainaut
BE33	Prov. Liège
BE34	Prov. Luxembourg (BE)
BE35	Prov. Namur
CZ01	Praha
CZ02	Střední Čechy
CZ03	Jihozápad
CZ04	Severozápad
CZ05	Severovýchod
CZ06	Jihovýchod
CZ07	Střední Morava
CZ08	Moravskoslezsko
DK00	Danmark
DE11	Stuttgart
DE12	Karlsruhe
DE13	Freiburg
DE14	Tübingen
DE21	Oberbayern
DE22	Niederbayern
DE23	Oberpfalz
DE24	Oberfranken
DE25	Mittelfranken
DE26	Unterfranken
DE27	Schwaben
DE30	Berlin
DE41	Brandenburg — Nordost
DE42	Brandenburg — Südwest
DE50	Bremen
DE60	Hamburg
DE71	Darmstadt
DE72	Gießen
DE73	Kassel
DE80	Mecklenburg-Vorpommern
DE91	Braunschweig
DE92	Hannover
DE93	Lüneburg
DE94	Weser-Ems
DEA1	Düsseldorf
DEA2	Köln
DEA3	Münster
DEA4	Detmold
DEA5	Arnsberg
DEB1	Koblenz
DEB2	Trier
DEB3	Rheinhessen-Pfalz
DEC0	Saarland
DED1	Chemnitz
DED2	Dresden
DED3	Leipzig
DEE1	Dessau
DEE2	Halle
DEE3	Magdeburg
DEF0	Schleswig-Holstein
DEG0	Thüringen
EE00	Eesti
GR11	Anatoliki Makedonia, Thraki
GR12	Kentriki Makedonia
GR13	Dytiki Makedonia
GR14	Thessalia
GR21	Ipeiros
GR22	Ionia Nisia
GR23	Dytiki Ellada
GR24	Sterea Ellada
GR25	Peloponnisos
GR30	Attiki
GR41	Voreio Aigaio
GR42	Notio Aigaio
GR43	Kriti
ES11	Galicia
ES12	Principado de Asturias
ES13	Cantabria
ES21	País Vasco
ES22	Comunidad Foral de Navarra
ES23	La Rioja
ES24	Aragón
ES30	Comunidad de Madrid
ES41	Castilla y León
ES42	Castilla-La Mancha
ES43	Extremadura
ES51	Cataluña
ES52	Comunidad Valenciana
ES53	Illes Balears
ES61	Andalucía
ES62	Región de Murcia
ES63	Ciudad Autónoma de Ceuta
ES64	Ciudad Autónoma de Melilla
ES70	Canarias
FR10	Île-de-France
FR21	Champagne-Ardenne
FR22	Picardie
FR23	Haute-Normandie
FR24	Centre
FR25	Basse-Normandie
FR26	Bourgogne
FR30	Nord - Pas-de-Calais
FR41	Lorraine
FR42	Alsace
FR43	Franche-Comté
FR51	Pays de la Loire
FR52	Bretagne
FR53	Poitou-Charentes
FR61	Aquitaine
FR62	Midi-Pyrénées
FR63	Limousin
FR71	Rhône-Alpes
FR72	Auvergne
FR81	Languedoc-Roussillon
FR82	Provence-Alpes-Côte d'Azur
FR83	Corse
FR91	Guadeloupe
FR92	Martinique
FR93	Guyane
FR94	Réunion
IE01	Border, Midland and Western
IE02	Southern and Eastern
ITC1	Piemonte
ITC2	Valle d'Aosta/Vallée d'Aoste
ITC3	Liguria
ITC4	Lombardia
ITD1	Provincia Autonoma Bolzano/Bozen
ITD2	Provincia Autonoma Trento
ITD3	Veneto
ITD4	Friuli-Venezia Giulia
ITD5	Emilia-Romagna
ITE1	Toscana
ITE2	Umbria
ITE3	Marche
ITE4	Lazio
ITF1	Abruzzo
ITF2	Molise
ITF3	Campania
ITF4	Puglia
ITF5	Basilicata
ITF6	Calabria
ITG1	Sicilia
ITG2	Sardegna
CY00	Kypros/Kıbrıs
LV00	Latvija
LT00	Lietuva
LU00	Luxembourg (Grand-Duché)
HU10	Közép-Magyarország
HU21	Közép-Dunántúl
HU22	Nyugat-Dunántúl
HU23	Dél-Dunántúl
HU31	Észak-Magyarország
HU32	Észak-Alföld
HU33	Dél-Alföld
MT00	Malta
NL11	Groningen

NL12 Friesland
NL13 Drenthe
NL21 Overijssel
NL22 Gelderland
NL23 Flevoland
NL31 Utrecht
NL32 Noord-Holland
NL33 Zuid-Holland
NL34 Zeeland
NL41 Noord-Brabant
NL42 Limburg (NL)
AT11 Burgenland
AT12 Niederösterreich
AT13 Wien
AT21 Kärnten
AT22 Steiermark
AT31 Oberösterreich
AT32 Salzburg
AT33 Tirol
AT34 Vorarlberg
PL11 Łódzkie
PL12 Mazowieckie
PL21 Małopolskie
PL22 Śląskie
PL31 Lubelskie
PL32 Podkarpackie
PL33 Świętokrzyskie
PL34 Podlaskie
PL41 Wielkopolskie
PL42 Zachodniopomorskie
PL43 Lubuskie
PL51 Dolnośląskie
PL52 Opolskie
PL61 Kujawsko-Pomorskie
PL62 Warmińsko-Mazurskie
PL63 Pomorskie
PT11 Norte
PT15 Algarve
PT16 Centro (PT)
PT17 Lisboa
PT18 Alentejo
PT20 Região Autónoma dos Açores
PT30 Região Autónoma da Madeira
SI00 Slovenija
SK01 Bratislavský kraj
SK02 Západné Slovensko
SK03 Stredné Slovensko
SK04 Východné Slovensko
FI13 Itä-Suomi
FI18 Etelä-Suomi
FI19 Länsi-Suomi
FI1A Pohjois-Suomi
FI20 Åland
SE01 Stockholm
SE02 Östra Mellansverige
SE04 Sydsverige
SE06 Norra Mellansverige
SE07 Mellersta Norrland
SE08 Övre Norrland
SE09 Småland med öarna
SE0A Västsverige
UKC1 Tees Valley and Durham
UKC2 Northumberland and Tyne and Wear
UKD1 Cumbria
UKD2 Cheshire
UKD3 Greater Manchester
UKD4 Lancashire
UKD5 Merseyside
UKE1 East Riding and North Lincolnshire
UKE2 North Yorkshire
UKE3 South Yorkshire
UKE4 West Yorkshire
UKF1 Derbyshire and Nottinghamshire
UKF2 Leicestershire, Rutland and Northamptonshire
UKF3 Lincolnshire
UKG1 Herefordshire, Worcestershire and Warwickshire
UKG2 Shropshire and Staffordshire
UKG3 West Midlands
UKH1 East Anglia
UKH2 Bedfordshire and Hertfordshire
UKH3 Essex
UKI1 Inner London
UKI2 Outer London
UKJ1 Berkshire, Buckinghamshire and Oxfordshire
UKJ2 Surrey, East and West Sussex
UKJ3 Hampshire and Isle of Wight
UKJ4 Kent
UKK1 Gloucestershire, Wiltshire and North Somerset
UKK2 Dorset and Somerset
UKK3 Cornwall and Isles of Scilly
UKK4 Devon
UKL1 West Wales and the Valleys
UKL2 East Wales
UKM1 North Eastern Scotland
UKM2 Eastern Scotland
UKM3 South Western Scotland
UKM4 Highlands and Islands
UKN0 Northern Ireland

CANDIDATE COUNTRIES: Statistical regions at level 2

BG11 Severozapaden
BG12 Severen tsentralen
BG13 Severoiztochen
BG21 Yugozapaden
BG22 Yuzhen tsentralen
BG23 Yugoiztochen
RO01 Nord-Est
RO02 Sud-Est
RO03 Sud
RO04 Sud-Vest
RO05 Vest
RO06 Nord-Vest
RO07 Centru
RO08 Bucureşti