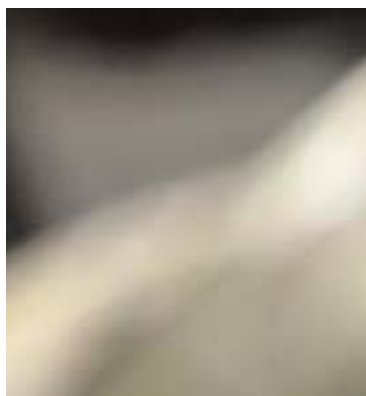


Health

3





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Health is an important priority for Europeans, who expect to be protected against illness and disease – at home, in the workplace and when travelling across the EU. Health issues cut across a range of topics – including consumer protection (food safety issues), workplace safety, environmental or social policies – and thus have a considerable impact on the EU's revised Lisbon strategy.

Competence for the organisation and delivery of health services and healthcare is largely held by the Member States, although the EU has the responsibility to give added value through launching actions such as those in relation to cross-border health threats and patient mobility, as well as reducing health inequalities and addressing key health determinants. Gathering and assessing accurate, detailed information on health issues is vital for the EU to effectively design policies and target future actions.

(41) 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); for more information: http://europa.eu/eur-lex/pri/en/oj/dat/2002/l_271/l_27120021009en00010011.pdf.

A programme for Community action in the field of public health⁽⁴¹⁾ for the period 2003 to 2008 focuses on three main areas, namely:

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

More recently – on 23 October 2007 – the European Commission adopted a new strategy 'Together for Health: A Strategic Approach for the EU 2008-2013' to set objectives that will guide future work on health at a European level; a discussion document⁽⁴²⁾ was made available for comment with more than 150 contributions received. Within the European Commission, the strategy is supported by the Second Programme of Community Action in the field of Health 2008-2013. This programme has been adopted with three broad objectives that align future health actions more closely to the objectives of prosperity, solidarity and security, namely through:

- improving citizens' health security;
- promoting health to improve prosperity and solidarity, and;
- generating and disseminating health knowledge.

(42) For more information: http://ec.europa.eu/health/ph_overview/Documents/strategy_discussion_en.pdf.

**EUROSTAT DATA IN THIS DOMAIN:****Population and social conditions****Population**

- Demography
- Demography – National data
- Mortality

Health

- Public health
- Health and safety at work

3.1 HEALTHY LIFE YEARS**INTRODUCTION**

Life expectancy at birth remains one of the most frequently quoted indicators of health status and economic development. While most people are aware that successive generations are living longer, less is known about the condition of health of Europe's ageing population. Life expectancy at birth has risen rapidly in the last century due to a number of important factors, including reductions in infant mortality, rising living standards, improved lifestyles and better education, as well as advances in healthcare and medicine.

The health status of a population is difficult to measure because it is hard to define among individuals, populations, cultures, or even across time periods. As a result, the demographic measure of life expectancy has often been used as a measure of a nation's health status because it is based on a simple and easy to understand characteristic – namely, that of death. However, the use of life expectancy is limited insofar as it does not provide any information on a population's health status.

Healthy life years (HLY) introduce the concept of the quality of life, by focusing on those years that may be enjoyed by individuals free from the limitations of illness or disability. Chronic disease, frailty, mental disorders and physical disability tend to become more prevalent in older age, and the burden of these conditions may impact on healthcare and pension provisions, while resulting in a low quality of life for those who suffer from such conditions.

HLY also monitor health as a productive or economic factor: these indicators form part of the structural indicators that are used to analyse progress being made in the EU with respect to the revised Lisbon criteria. Within this context, HLY can be used to help study issues such as the potential costs and benefits that may be associated with raising the retirement age.

An improvement in HLY is one of the main goals for European health policy, given that it not only improves the situation of individuals (as good health and a long life are fundamental objectives of human activity) but also results in lower levels of public healthcare expenditure. If HLY are increasing more rapidly than life expectancy, then not only are people living longer, but they are also living a greater proportion of their lives free from health problems.

DEFINITIONS AND DATA AVAILABILITY

The structural indicator, healthy life years, measures the number of remaining years that a person of a specific age is still expected to live without any severe or moderate health problems or acquired disabilities. The HLY indicator (also called disability-free life expectancy) measures the number of remaining years that a person of a certain age can be expected to live without disability; in other words, this is a health expectancy indicator.

There are two components to the calculation of HLY, namely, mortality statistics and data on self-perceived disability. Mortality data comes from Eurostat's demographic database, while self-perceived disability data has come from the European Union Statistics on Income and Living Conditions survey (EU-SILC).

The implementation of the EU-SILC question used for the calculation of the HLY indicator (see below) is not yet fully harmonised, which limits the comparability of the results. New guidelines for this question were provided by Eurostat in October 2007 to the Member States, in order to improve the data comparability for the coming years. The EU-SILC question is:

For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do? Would you say you have been:

- strongly limited?
- limited?
- not limited at all?

Examples of some of the problems raised at a national level during the implementation of this question include:

- the 6 months period is considered as a reference period and not as the minimum duration of the limitation;
- the reference is to the respondent's own daily activities and not to the ones that people usually do;
- the use of two answer categories instead of three (yes/no);
- only persons who answer with 'yes' to the previous question in the survey answer to this question instead of all persons.

MAIN FINDINGS

The values of healthy life years at birth in the EU-25 Member States varied in 2005 from 48.0 years to 68.5 years for men and from 52.2 years to 70.1 years for women, the lowest values being recorded in Estonia and the highest in Malta. Men in Denmark, Malta, Poland, Greece, Italy and the Netherlands were likely to spend the largest proportion of their lives free from disability.

Women could expect to live a slightly lower proportion of their lives free from disability; although their overall life expectancy at birth was higher than for men. The countries where women were likely to spend the largest proportion of their lives free from disability were broadly similar to those reported for men (except for the Czech Republic and Germany).

The HLY indicator is calculated at two ages: birth and the age of 65. Turning attention to those persons of retirement age, the highest figure for both men and women was recorded in Denmark where men were expected to have an additional 13.1 years of healthy life at the age of 65 and women an additional 14.1 years. Women aged 65 in Estonia recorded the lowest number of healthy life years among men and women across the Member States, at 3.4 years in both cases.

SOURCES

Statistical books

Work and health in the European Union – A statistical portrait

Pocketbooks

Health in Europe – Data 1998-2003

Methodologies and working papers

Methodology for the calculation of Eurostat's demographic indicators

Website data

Public health

Structural indicators on health

**Table 3.1: Healthy life years at birth**

(years)

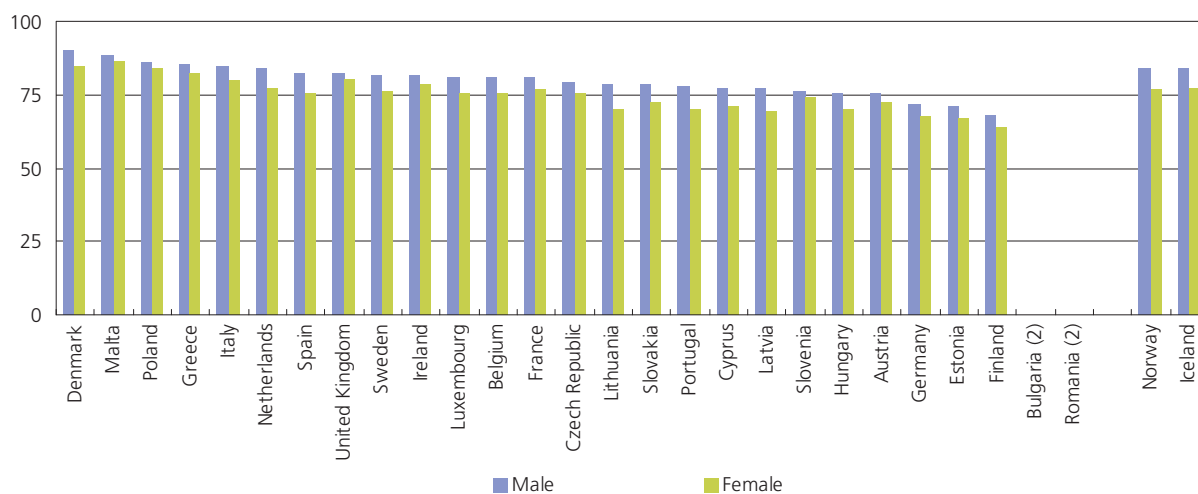
	Male		Female	
	2004	2005	2004	2005
Belgium	58.4	61.7	58.1	61.9
Bulgaria	:	:	:	:
Czech Republic	:	57.9	:	59.9
Denmark	68.3	68.4	68.8	68.2
Germany	:	55.0	:	55.1
Estonia	49.8	48.0	53.3	52.2
Ireland	62.5	62.9	64.3	64.1
Greece	63.7	65.7	65.2	67.2
Spain	62.5	63.2	62.5	63.1
France	61.2	62.0	64.1	64.3
Italy	67.9	65.8	70.2	67.0
Cyprus	:	59.5	:	57.9
Latvia	:	50.6	:	53.1
Lithuania	:	51.2	:	54.3
Luxembourg	59.1	62.2	60.2	62.1
Hungary	:	52.0	:	53.9
Malta	:	68.5	:	70.1
Netherlands	:	65.0	:	63.1
Austria	58.1	57.8	60.2	59.6
Poland	:	61.0	:	66.6
Portugal	55.1	58.4	52.0	56.7
Romania	:	:	:	:
Slovenia	:	56.3	:	59.9
Slovakia	:	54.9	:	56.4
Finland	53.1	51.7	52.9	52.4
Sweden	62.0	64.2	60.9	63.1
United Kingdom	:	63.2	:	65.0
Iceland	:	66.9	:	64.5
Norway	65.5	65.5	64.7	63.6

Source: Eurostat (tsien081 and tsien082)

Healthy life years (HLY) is a health expectancy indicator which combines information on mortality and morbidity. The data required are the age-specific prevalence (proportions) of the population in healthy and unhealthy conditions and age-specific mortality information. A healthy condition is defined by the absence of limitations in functioning/disability. The indicator is calculated separately for males and females. The indicator is also called disability-free life expectancy (DFLE).

Figure 3.1: Healthy life years at birth, 2005 (1)

(% of total life expectancy)



(1) Provisional data.

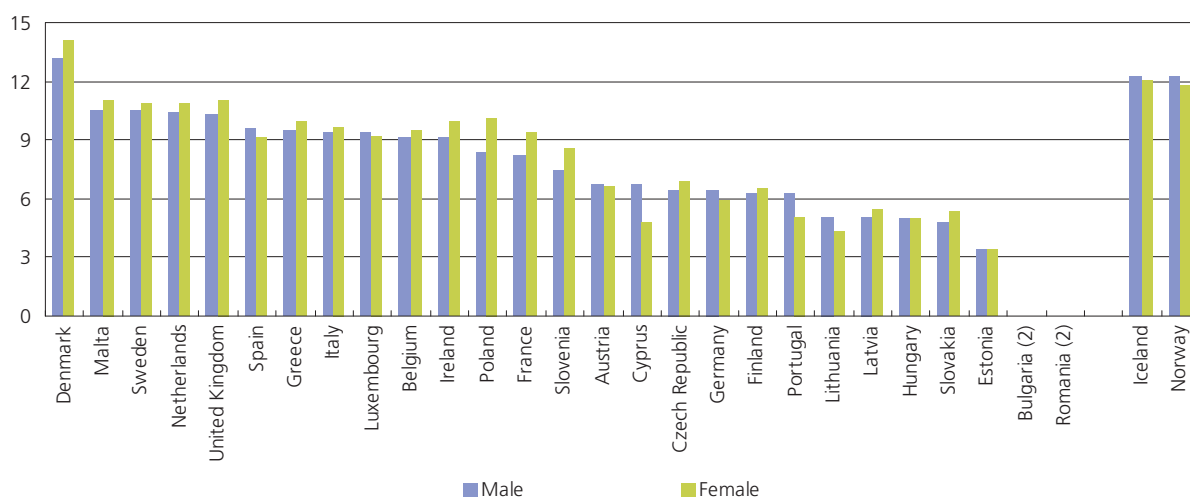
(2) Not available.

Source: Eurostat (tps00025)

The mean number of years that a newborn child can expect to live if subjected throughout his life to the current mortality conditions (age specific probabilities of dying).

Figure 3.2: Healthy life years at age 65, 2005 (1)

(years)



(1) Provisional data.

(2) Not available.

Source: Eurostat (tsdph220)

The indicator healthy life years (HLY) at age 65 measures the number of years that a person at age 65 is still expected to live in a healthy condition. HLY is a health expectancy indicator which combines information on mortality and morbidity. The data required are the age-specific prevalence (proportions) of the population in healthy and unhealthy conditions and age-specific mortality information. A healthy condition is defined by the absence of limitations in functioning/disability. The indicator is calculated separately for males and females. The indicator is also called disability-free life expectancy (DFLE).



3.2 HEALTH PROBLEMS

INTRODUCTION

According to the Directorate-General for Health and Consumer Protection (43), the promotion of health and lifestyle choices can play an important role in reducing disease and death. On average, Europeans with better jobs, more education or higher incomes have better health and longer life expectancy. 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.

Health problems linked to lifestyle related health determinants can be age specific (in childhood or in old age), as well as resulting from socio-economic factors. Health promotion in various settings, such as schools, workplaces, families or local communities has proven to be efficient in addressing health issues across communities, focusing on specific diseases or target groups.

Smoking is the single largest cause of avoidable death in the EU accounting for over half a million deaths each year. The Directorate-General for Health and Consumer Protection estimates that 25 % of all cancer deaths and 15 % of all deaths in the EU can be attributed to smoking. Smoking legislation has been adopted by an increasing number of Member States, restricting or forbidding smoking in public places and/or workplaces, as well as offering protection to passive smokers. The European Commission is developing a tobacco control policy, focused on:

- legislative measures;
- support for Europe-wide smoking prevention and cessation activities;
- mainstreaming tobacco control into a range of other Community policies (such as agricultural, taxation or development policy);
- making sure that the pioneering role played by the European Community in many tobacco control areas has an impact at a global level.

(43) For more information: http://ec.europa.eu/health/ph_determinants/healthdeterminants_en.htm.

Nutrition is another important health determinant, which together with smoking and physical inactivity, forms one of the main determinants for cardiovascular disease and cancer. Obesity is a known risk in relation to diseases such as diabetes, hypertension, cardiovascular disease, respiratory problems (asthma) and musculoskeletal disease (arthritis). Many different factors can lead to obesity, including excessive calorie consumption, a lack of physical activity, a genetic predisposition, or disorders of the endocrine system.

DEFINITIONS AND DATA AVAILABILITY

Health Interview Surveys (HIS) are the source of information for describing the health status and the health-related behaviours of the European population. The following topics are usually covered in a HIS:

- height and weight which form the basis for the calculation of the body mass index (BMI);
- self-perceived health;
- activities that have been reduced because of health problems;
- long-standing illnesses or health problems;
- smoking behaviour;
- alcohol consumption.

The indicators are expressed as percentages within different population cohorts on the basis of background variables covering gender, age, activity status, and educational level. Note that the information in this publication comes from non-harmonised national surveys and that the Member States were asked to post-harmonise the data according to a set of common guidelines. Member States have joined efforts on a harmonised EU survey (EHIS) which is, at the time of writing, being implemented (2007-2008).

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. The BMI is accepted as the most useful measure of obesity for adults when only weight and height data are available. It is calculated as the result of dividing body weight (in kilograms) by body height (in metres) squared. The following subdivisions are used to categorise the BMI into four categories:

- < 18.5: underweight;
- ≥ 18.5 and < 25: normal weight;
- ≥ 25 and < 30: overweight;
- ≥ 30 : obese.

Note that the BMI may not be suitable for children.

MAIN FINDINGS

Obesity is a serious public health problem that increases the risk of death and disability; it may be associated primarily with poor dietary habits and a lack of physical activity. Obesity rates have increased considerably in most Member States during the last decade. Approximately half of the EU's population was overweight or obese in 2003, a share that rose to as high as 61.0 % in England and 59.7 % in Germany, while Italy and France were the only Member States to report that less than 40 % of their population were either overweight or obese.

The proportion of daily smokers was close to 50 % of the male population in Latvia and Estonia in 2003; Sweden (16.5 %) and Finland (21.6 %) reported the lowest proportions of men smoking. Daily smoking rates were lower among women (compared with men) in each of the Member States, with the exception of Sweden where there was a slightly higher proportion of female daily smokers. Austria and Denmark recorded the highest incidence of daily smoking among women, at just over 30 % of the female population, while Portugal (6.8 %) was the

only Member State where the proportion of female daily smokers was in single figures. The largest absolute differences in smoking habits between the sexes were reported for the Baltic States, where the proportion of men smoking daily was upwards of 30 points more than the corresponding share for women. In relative terms, four times as many men (as women) smoked on a daily basis in Portugal, while between three and four times as many men smoked on daily basis in Cyprus, Lithuania, Romania and Latvia.

There would appear to be a shift in smoking patterns across Europe between the sexes. There was a much smaller difference between the proportion of men and women smoking when studying the population aged between 15 and 24. Young females in Sweden and the United Kingdom were more likely to smoke than young males. Furthermore, in the majority of Member States the proportion of young women smoking was often above that for all women; this was particularly the case in the United Kingdom, Spain, Ireland and Germany.

SOURCES

Statistical books

Work and health in the European Union – A statistical portrait

Pocketbooks

Health in Europe – Data 1998-2003

Methodologies and working papers

Health Interview Surveys – guidelines for the collection of data on 18 HIS items

Statistical analysis on health-related longitudinal data from the ECHP

Guidelines for the development and criteria for the adoption of health survey instruments

Website data

Public health

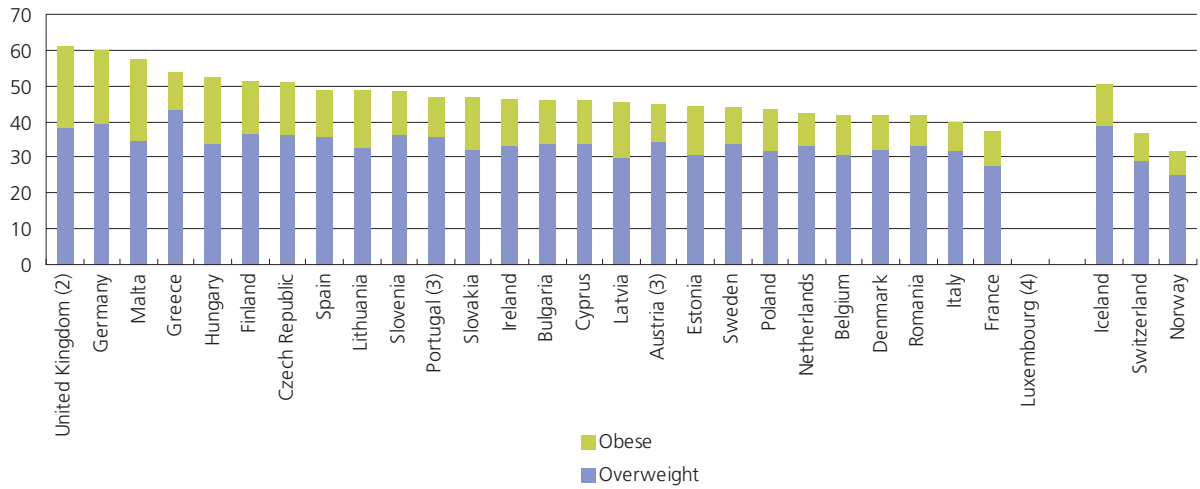
Health status: indicators from surveys (SILC, HIS, LFS)

Health status: indicators from the national Health Interview Surveys (HIS round 2004: period 1999-2003)



Figure 3.3: Overweight people, 2003 (1)

(% of total population)



(1) National health interview survey (HIS) data, 1996-2003 depending on the country.

(2) Only England.

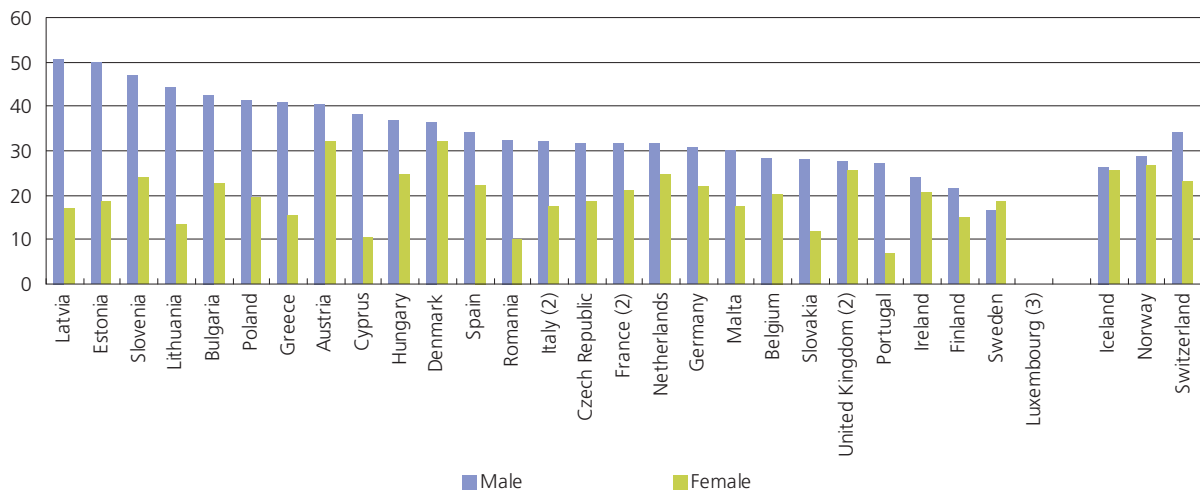
(3) European Community Household Panel data, 2001

(4) Not available.

Source: Eurostat (hlth_ls_bmia)

Figure 3.4: 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.

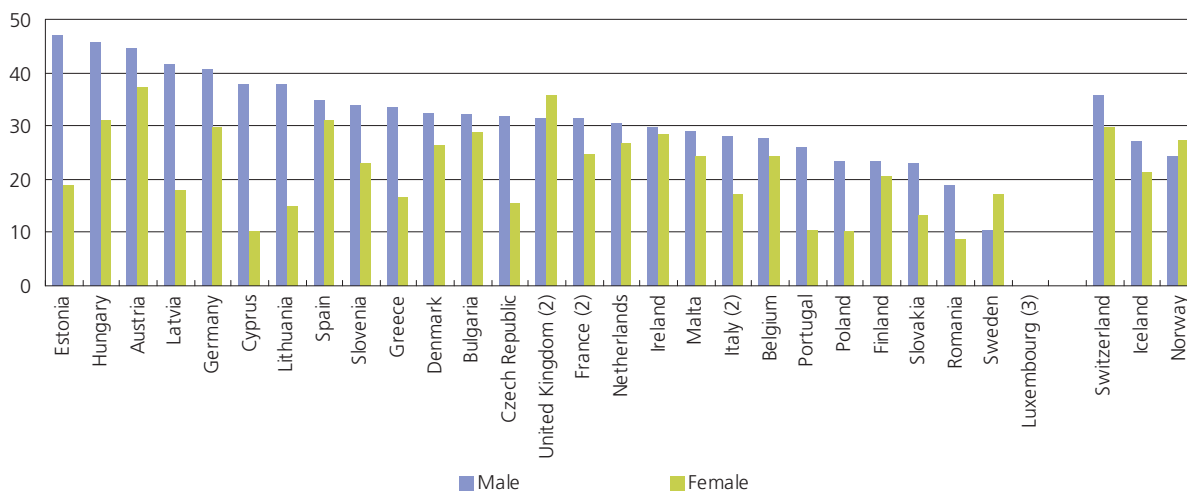
(3) Not available.

Source: Eurostat (tps00169)

Tobacco use remains the leading preventable cause of death and disease in our society. It is a major risk factor for diseases of the heart and blood vessels, chronic bronchitis and emphysema, cancers of the lung and other diseases. The indicator is defined as the number of current tobacco smokers among the population, expressed as a percentage of population. A person is a present smoker if he/she declares smoking tobacco daily or occasionally. The data come from non-harmonised national Health Interview Surveys (HIS) and the countries were asked to post-harmonise the data according to guidelines issued by Eurostat. The HIS data were collected in different years (between 1996 and 2003) depending on the country.

Figure 3.5: Daily smokers among the population aged 15-24, 2003 (1)

(% of male / female population aged 15-24)



(1) National health interview survey (HIS) data, 1996-2003 depending on the country.

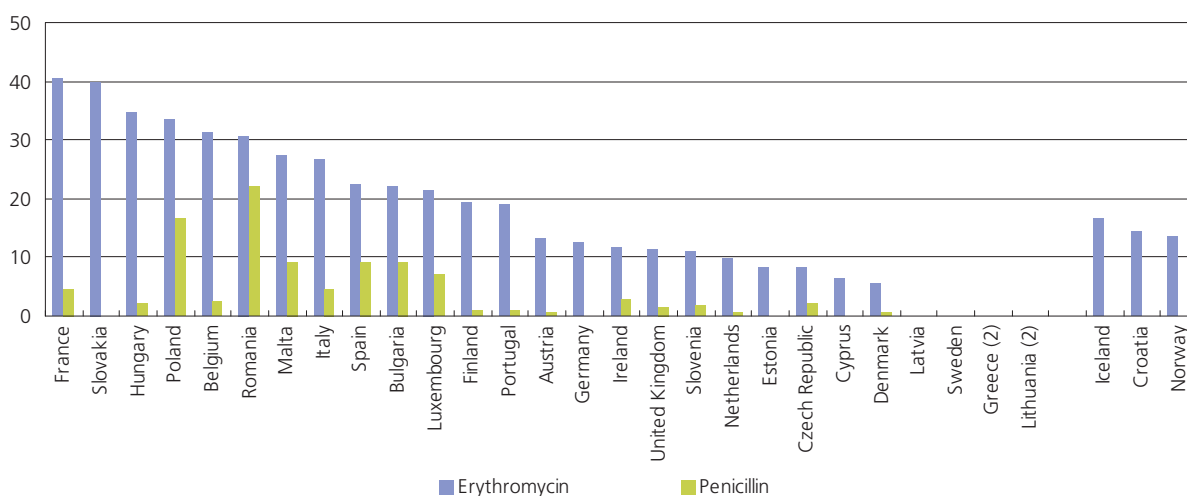
(2) No distinction between daily and occasional smoking.

(3) Not available.

Source: Eurostat (tps00170)

Figure 3.6: Resistance to antibiotics, 2005 (1)

(% of streptococcus pneumoniae isolates showing resistance either to erythromycin or penicillin)



(1) Bulgaria, the Czech Republic, Germany, Estonia, Latvia, Malta, Sweden, Croatia and Norway, provisional data for 2006.

(2) Not available.

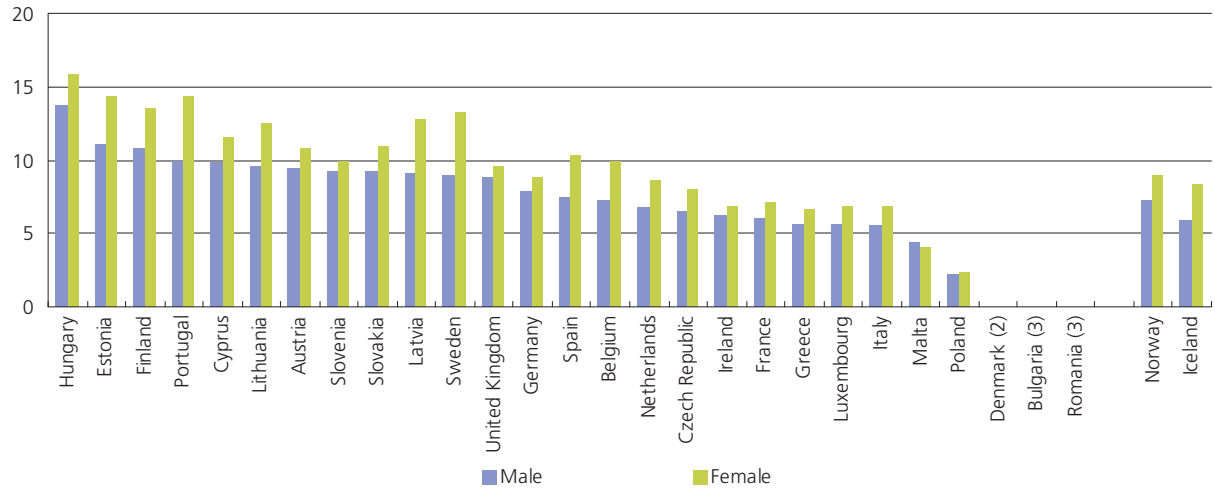
Source: Directorate-General for Health and Consumer Protection, EARSS (European Antimicrobial Resistance Surveillance System) project

The indicator shows the trends of erythromycin or penicillin resistance among invasive streptococcus pneumoniae, the single most important cause of infections of the lower respiratory tract (such as pneumonia) in adults and children. On average, around 62.4 % of the population of the countries covered by the indicator are considered for its calculation.



Figure 3.7: Persons strongly limited in activities people usually do because of health problems for at least the past 6 months, 2005 (1)

(% of male / female population aged 15 years and over)



(1) Provisional data.

(2) No distinction between strongly limited and limited.

(3) Not available.

Source: Eurostat (tps00030)

Statistics on Income and Living Conditions (SILC) contains several questions on health, including a general question on restrictions on everyday activities caused by a health problem. Therefore, while such a question is not exactly measuring disability levels in the population, it does allow for an overview of the situation regarding difficulties faced in daily life and the potential need for assistance as perceived by the population.

3.3 HEALTHCARE

INTRODUCTION

Most Europeans agree that there is a basic need for universal access to healthcare, as the cost of many modern-day health treatments can often be prohibitive to the average person. The provision of healthcare systems varies considerably between the Member States, although widespread use is made of public provision (national or regional health services) and comprehensive healthcare insurance. Healthcare schemes generally cover their entire resident population; nevertheless, an increasing proportion of individuals choose to adhere to private insurance schemes (usually on top of the national provision for care).

Public regulation of the healthcare sector is a complex task, as the healthcare market is characterised by numerous market imperfections. Member States generally aim to balance the efficient use of resources with ensuring that healthcare provisions are available to all. 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, while populations have different expectations of what services their national healthcare systems should offer. Indeed, the amount of money needed to fund a healthcare system is a function of a large number of variables, the most obvious being the burden of disease requiring treatment – 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.

The main consumers of healthcare are older people – a section of the European population that is growing rapidly, partly as a result of the baby-boom cohort reaching older age, but also because of continued increases in life expectancy. The likely increase in numbers of elderly persons will probably drive demand for more healthcare provision in the future, while medical advances are also likely to result in more and better treatments being available. Demand for healthcare is also likely to rise in the coming years in relation to long-term care provision (nursing and convalescence homes). In addition, more patients are travelling across borders to receive treatment, to avoid waiting lists or seek specialist treatment that may only be available abroad. The EU works towards ensuring that people who move across borders have access to healthcare anywhere within the Union.

DEFINITIONS AND DATA AVAILABILITY

Information on healthcare can be divided into two broad groups of data: resource-related healthcare data on human and technical resources and output-related data that focuses on hospital patients and the treatment they receive.

Healthcare data on resources and patients are largely based on administrative data sources. These may vary across countries, and to a large degree they reflect country-specific ways of organising healthcare; as such, the information collected may not always be completely comparable.

Data on healthcare staff, in the form of human resources available for providing healthcare services, is provided irrespective of the sector of employment (i.e. whether the personnel are independent, employed by a hospital, or any other healthcare provider). These statistics cover healthcare professionals such as physicians, dentists, nurses, pharmacists and physiotherapists. In the context of comparing healthcare services across Member States, Eurostat gives preference to the concept practising professionals, as this best describes the availability of healthcare resources.

Output-related data collection focuses on hospital patients and covers the interaction between patients and healthcare systems, namely in the form of the treatment received. Data in this domain are available for a range of indicators including hospital discharges of in-patients and day cases by age, sex, and selected (groups of) diseases; the average length of stay of in-patients; or the medical procedures performed in hospitals. The number of hospital discharges is the most commonly used measure of the utilisation of hospital services. Discharges, rather than admissions, are used because hospital abstracts for in-patient care are based on information gathered at the time of discharge. A hospital discharge is the formal release of a patient from a hospital after a procedure or course of treatment. A discharge occurs whenever a patient leaves because of finalisation of treatment, signs out against medical advice, transfers to another healthcare institution or on death; healthy newborn babies should be included.

Healthcare data presented in this section relate to absolute numbers and density rates that describe the availability of resources or the frequency of services rendered, as expressed by population-standardised rates per 100 000 inhabitants.



MAIN FINDINGS

Healthcare expenditure – defined here as expenditure on sickness/healthcare according to the European system of integrated social protection statistics (ESSPS) – was 7.4 % of GDP in the EU-25 in 2004. These expenditures cover: cash benefits that replace in whole or in part the loss of earnings during temporary inability to work due to sickness or injury; as well as medical care provided in the framework of social protection to maintain, restore or improve health. Across the Member States, healthcare expenditure reached more than 8 % of GDP in France, the Netherlands and Sweden, while it was less than 4 % in Latvia, Lithuania or Poland.

In 2005 there was an average of 590 hospital beds per 100 000 inhabitants within the EU-27, compared with 695 beds in 1997 (an overall reduction of 15 %). 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 (401) and Belgium (400) reported the highest numbers of physicians per 100 000 inhabitants in 2005; note that data for Lithuania refers to professionally active physicians and not to practising physicians and is therefore overestimated. At the other end of the range, there was an average of less than 250 practising physicians per 100 000 inhabitants in Poland, Romania, Slovenia, Finland, the United Kingdom and the former Yugoslav Republic of Macedonia.

SOURCES

Pocketbooks

Health in Europe – Data 1998-2003

Website data

Public health

Health care: resources and patients (non-expenditure data)

Health care staff

Health care facilities

Hospital patients

Table 3.2: Healthcare indicators

(per 100 000 inhabitants)

	Practising physicians		Hospital beds		Hospital discharges of in-patients (excluding healthy new born babies)	
	1995	2005	1995	2005	2000	2005
EU-27 (1)	:	:	694.8	590.4	:	:
Belgium	344.6	399.5	741.8	744.8	16 252	16 084
Bulgaria (2, 3)	344.9	365.3	1 034.1	611.6	14 456	20 857
Czech Republic	299.8	354.9	938.7	850.3	:	23 030
Denmark (1, 4)	250.0	308.4	459.8	398.0	16 316	15 936
Germany	307.0	341.2	969.8	846.4	19 586	:
Estonia (5)	307.4	319.3	804.1	548.4	19 826	18 544
Ireland (6)	210.2	352.3	699.6	559.6	13 805	13 505
Greece	393.0	:	518.5	:	:	:
Spain	268.2	379.9	394.7	339.0	11 243	10 780
France (7, 8)	322.6	338.6	894.1	742.5	18 397	16 445
Italy (7, 9)	385.9	383.2	622.1	400.9	:	14 928
Cyprus	220.2	257.8	451.9	380.0	6 795	6 617
Latvia	277.8	291.5	1 099.3	766.4	:	:
Lithuania (7)	404.5	401.1	1 083.0	814.7	23 454	22 411
Luxembourg (10)	204.4	327.7	1 095.8	644.3	18 481	17 242
Hungary	302.8	278.4	909.1	786.2	:	:
Malta (6, 9, 11)	247.4	349.4	544.9	743.7	:	6 871
Netherlands	186.1	:	528.0	437.2	:	10 135
Austria (10)	265.7	346.7	755.1	770.9	:	26 809
Poland	231.8	213.6	768.7	652.2	:	17 955
Portugal (2, 10)	253.8	267.8	392.4	365.1	:	:
Romania	181.2	217.4	783.0	661.8	:	:
Slovenia (10)	:	229.9	573.6	483.9	:	15 358
Slovakia (5)	291.5	303.7	829.4	677.1	19 876	19 124
Finland (9)	207.3	244.5	801.0	704.2	:	20 514
Sweden (5)	288.2	348.1	609.0	:	15 272	14 751
United Kingdom (1, 5)	:	235.6	433.4	388.7	:	13 064
Croatia	203.6	:	407.3	545.0	12 710	13 307
FYR of Macedonia (3, 7)	230.7	245.2	543.9	470.2	9 444	9 881
Turkey (2)	:	:	246.5	241.2	:	:
Iceland	303.0	368.1	910.9	:	17 085	16 084
Norway	279.3	362.8	407.3	405.9	15 409	17 424
Switzerland	175.6	:	700.8	555.6	:	15 656

(1) 1997 instead of 1995 for hospital beds.

(2) 2004 instead of 2005 for hospital beds.

(3) Including healthy newborn babies for hospital discharges of in-patients.

(4) 2003 instead of 2005 for hospital beds.

(5) 2003 instead of 2005 for hospital discharges.

(6) Licensed physicians.

(7) Professionally active physicians.

(8) Metropolitan France for hospital beds.

(9) 2004 instead of 2005 for hospital discharges.

(10) 2004 instead of 2005 for practising physicians.

(11) 1997 instead of 1995 for practising physicians.

Source: Eurostat (tps00044, tps00046 and hlth_co_disch2)

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.

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 in-patient care. In-patient 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 in-patient care as a secondary activity.

Table 3.3: Hospital beds

(per 100 000 inhabitants)

	Curative care beds in hospitals			Psychiatric care beds in hospitals		
	1995	2000	2005	1995	2000	2005
EU-27 (1)	487.2	450.7	406.3	78.0	69.4	60.4
Belgium	503.3	472.6	441.1	195.3	259.5	250.8
Bulgaria (2)	:	583.1	469.0	88.7	63.8	64.4
Czech Republic	728.7	609.6	568.6	100.8	98.0	96.2
Denmark (1, 3)	380.2	349.5	327.8	79.6	75.6	70.2
Germany	744.5	680.3	634.9	:	:	:
Estonia	638.8	528.1	382.2	102.4	75.3	53.8
Ireland	306.3	281.1	279.8	185.4	142.1	96.7
Greece	389.7	387.3	:	110.4	100.7	:
Spain	303.9	287.2	259.9	60.3	52.6	44.5
France (4)	460.8	416.0	372.1	139.0	110.9	95.2
Italy	552.6	407.0	331.7	48.2	14.8	13.3
Cyprus	366.4	370.4	349.1	85.5	46.5	31.0
Latvia	903.9	609.0	531.8	195.4	165.1	136.7
Lithuania	871.4	625.0	529.9	130.6	120.9	103.7
Luxembourg (5)	618.8	572.2	549.4	129.9	84.9	:
Hungary	627.3	563.7	552.0	51.1	100.2	39.4
Malta (1)	387.7	372.7	280.4	178.1	171.5	170.4
Netherlands	331.7	306.5	287.6	171.3	163.8	131.0
Austria	665.4	628.7	606.6	81.7	62.1	61.7
Poland	576.4	509.9	463.2	84.3	73.4	67.4
Portugal (6)	:	:	:	71.8	66.2	63.4
Romania	569.2	551.5	456.3	90.7	83.6	79.7
Slovenia	475.4	446.1	388.2	80.1	76.7	73.7
Slovakia (7)	620.5	566.5	501.1	91.8	93.4	83.5
Finland	295.8	241.2	223.7	126.0	102.9	93.1
Sweden	304.5	245.2	:	95.0	62.8	:
United Kingdom (1)	321.0	315.0	309.7	103.0	90.9	73.7
Croatia	390.0	378.1	340.2	103.0	102.8	94.4
FYR of Macedonia	354.2	329.8	312.6	77.9	70.9	60.7
Turkey (2)	190.6	218.0	231.1	13.1	12.4	12.1
Iceland	375.7	:	:	118.0	:	:
Norway	334.2	311.4	292.4	73.0	69.4	100.2
Switzerland	551.4	412.3	365.9	138.0	119.9	106.1

(1) 1997 instead of 1995.

(2) 2004 instead of 2005.

(3) 2003 instead of 2005.

(4) Metropolitan France.

(5) 2004 instead of 2005 for curative care beds.

(6) 2003 instead of 2005 for psychiatric care beds.

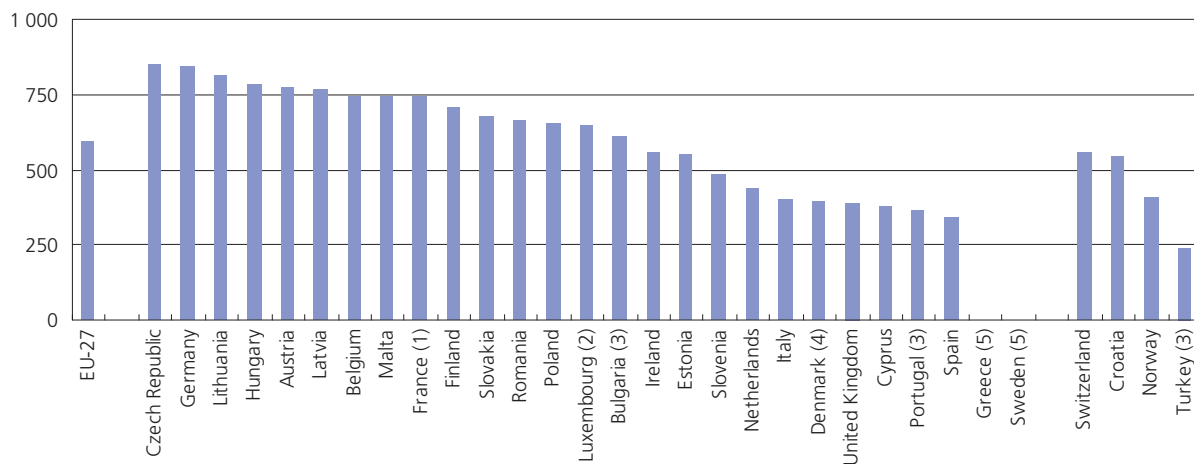
(7) 1996 instead of 1995.

Source: Eurostat (tps00168 and tps00047)

Hospital beds provide information on health care capacities, i.e. on the maximum number of patients who can be treated by hospitals. Curative care (or acute care) beds in hospitals are beds that are available for curative care. These beds are a subgroup of total hospital beds which are defined as all hospital beds which are regularly maintained and staffed and immediately available for the care of admitted patients; both occupied and unoccupied beds are covered. Hospitals are defined according to the classification of health care providers of the System of Health Accounts (SHA); all public and private hospitals should be covered.

Figure 3.8: Hospital beds, 2005

(per 100 000 inhabitants)



(1) Metropolitan France.

(2) 2002.

(3) 2004.

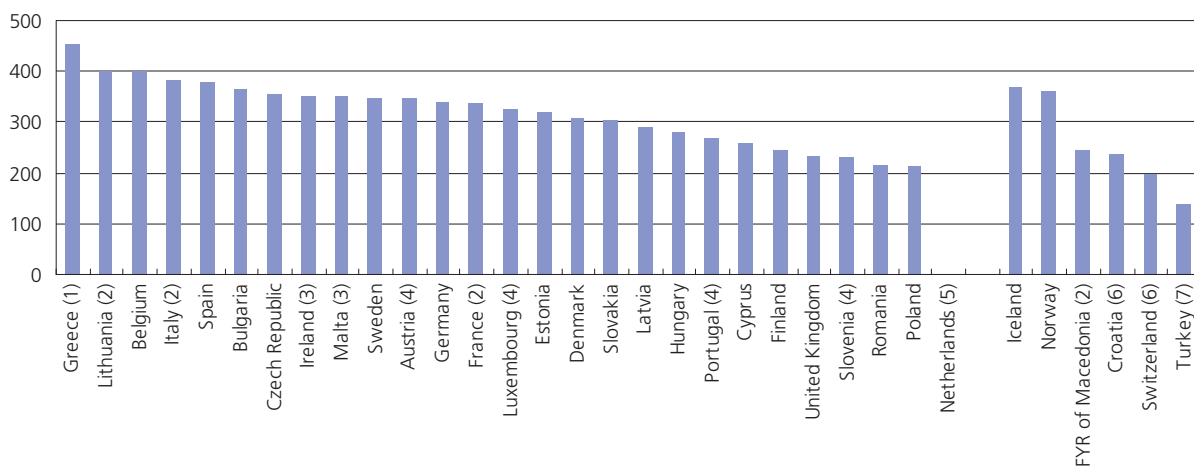
(4) 2003.

(5) Not available.

Source: Eurostat (tps00046)

Figure 3.9: Number of practising physicians, 2005

(per 100 000 inhabitants)



(1) 2001.

(2) Professionally active physicians

(3) Licensed physicians.

(4) 2004.

(5) Not available.

(6) 2002.

(7) 2003.

Source: Eurostat (tps00044)



Table 3.4: Hospital discharges of in-patients by diagnosis (ISHMT – international shortlist for hospital morbidity tabulation), 2005

(per 100 000 inhabitants)

	Neoplasms (cancers)	Diseases of the circulatory system	Diseases of the digestive system	Diseases of the respiratory system	Injury, poisoning and certain other consequences of external causes	Pregnancy, childbirth and the puerperium
Belgium	1 244	2 135	1 698	1 441	1 634	1 362
Bulgaria	1 715	3 003	1 637	3 180	1 317	1 949
Czech Republic	2 061	3 703	2 079	1 598	1 956	1 512
Denmark (1)	1 563	2 228	1 378	1 424	1 552	1 281
Germany (2)	2 270	3 300	2 079	1 258	1 987	1 179
Estonia	1 572	3 243	1 624	2 025	1 191	1 832
Ireland	869	1 255	1 230	1 401	1 370	2 422
Greece	:	:	:	:	:	:
Spain	916	1 339	1 270	1 147	898	1 386
France	1 277	1 973	1 697	1 005	1 461	1 567
Italy (3)	1 331	2 481	1 462	1 144	1 324	1 336
Cyprus	428	780	684	657	861	435
Latvia	:	:	:	:	:	:
Lithuania	1 648	4 475	1 943	2 404	1 982	1 671
Luxembourg	1 744	2 275	1 665	1 436	1 263	1 330
Hungary	:	:	:	:	:	:
Malta	183	694	592	541	580	972
Netherlands	997	1 528	916	731	848	858
Austria	2 779	3 696	2 439	1 796	2 853	1 353
Poland	1 908	3 024	1 766	1 557	1 615	1 577
Portugal	:	:	:	:	:	:
Romania	1 275	2 588	2 071	2 785	1 279	1 697
Slovenia	1 791	1 863	1 377	1 265	1 515	1 242
Slovakia	1 764	3 054	1 889	1 660	1 586	1 631
Finland (3)	1 859	3 229	1 517	1 616	1 972	1 335
Sweden (1)	1 465	2 442	1 183	957	1 396	1 249
United Kingdom (1)	1 032	1 452	1 177	1 197	1 238	1 349
Croatia	1 828	1 849	1 179	1 147	1 042	223
FYR of Macedonia	1 164	1 554	1 039	1 424	579	754
Iceland	1 394	1 825	1 347	980	1 020	2 114
Norway	1 795	2 467	1 238	1 531	1 854	1 487
Switzerland	1 124	1 735	1 353	869	1 846	1 182

(1) 2003.

(2) 2002.

(3) 2004.

Source: Eurostat (hlth_co_disch2)

Table 3.5: Hospital discharges of in-patients by diagnosis (ISHMT – international shortlist for hospital morbidity tabulation), average length of stay, 2005

(days)

	Neoplasms (cancers)	Diseases of the circulatory system	Diseases of the digestive system	Diseases of the respiratory system	Injury, poisoning and certain other consequences of external causes	Pregnancy, childbirth and the puerperium
Belgium	9.4	8.4	6.1	8.4	8.5	5.0
Bulgaria	7.9	7.6	6.4	8.5	6.6	4.8
Czech Republic	9.4	12.6	7.1	9.1	9.2	5.6
Denmark (1)	7.1	6.6	5.3	5.6	5.9	3.8
Germany (2)	10.0	10.0	8.3	8.5	9.5	5.5
Estonia	8.0	10.6	5.2	5.0	8.8	3.1
Ireland	11.8	10.5	6.4	6.9	5.6	3.0
Greece	:	:	:	:	:	:
Spain	9.8	8.5	6.0	7.4	8.5	3.2
France	7.8	7.1	5.3	7.1	5.8	4.9
Italy (3)	9.7	8.7	6.8	8.1	7.8	4.0
Cyprus	9.1	6.0	5.3	5.0	5.3	5.3
Latvia	:	:	:	:	:	:
Lithuania	10.8	12.9	6.8	8.1	8.3	4.9
Luxembourg	8.9	7.9	5.9	6.0	7.7	4.8
Hungary	:	:	:	:	:	:
Malta	9.3	6.9	4.0	5.0	7.5	3.6
Netherlands	8.5	7.8	6.8	7.6	7.7	3.8
Austria	7.9	11.1	7.1	8.1	8.8	5.5
Poland	6.6	7.9	5.8	8.1	5.3	5.1
Portugal	:	:	:	:	:	:
Romania	7.7	8.5	6.9	7.5	6.5	5.4
Slovenia	8.0	8.8	6.4	7.5	7.2	4.7
Slovakia	9.1	9.0	6.5	8.2	7.1	5.8
Finland (3)	8.7	14.9	6.0	14.2	10.9	3.8
Sweden (1)	8.1	6.8	5.0	5.5	6.3	3.2
United Kingdom (1)	9.3	11.5	6.8	8.0	8.8	2.8
Croatia	10.4	10.9	9.0	9.6	9.1	8.3
FYR of Macedonia	8.5	10.9	6.3	8.2	9.1	4.4
Iceland	7.2	6.4	4.0	6.2	6.4	2.4
Norway	7.2	5.4	4.9	6.1	4.8	3.7
Switzerland	10.6	9.3	7.4	8.8	8.0	6.1

(1) 2003.

(2) 2002.

(3) 2004.

Source: Eurostat (hlth_co_inpst)



3.4 SAFETY AT WORK

INTRODUCTION

A high proportion of people spend 8 hours a day, 5 days a week at work. While there have been many studies concerning the benefits of work as a source of wealth (for both the individual and the enterprise) there has until recently been less interest in the negative effects that work can have on human and public health, in other words the costs and not just the benefits of work.

Health at work is not restricted to accidents or occupational illnesses, but also involves physical, moral and social well-being (issues such as intimidation and violence in the workplace), which are considered especially important determinants regarding the quality of work and the productivity of the workforce. A strategic health and safety policy is therefore not just crucial to ensuring the well-being of Europe's workers; it is also a key issue in competitiveness.

DEFINITIONS AND DATA AVAILABILITY

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, as well as the new strategy for the period 2007-2012 ⁽⁴⁴⁾. Harmonised data on accidents at work are collected in the framework of the European Statistics on Accidents at Work (ESAW). The ESAW methodology is in accordance with the International Labour Office (ILO) Resolution of 1998 concerning 'Statistics of Occupational Injuries: resulting from Occupational Accidents'.

National sources are typically declarations of accidents at work, either to the public (social security) or private insurance systems, or to other relevant national authorities. Data are typically presented in numbers or as incidence rates. Incidence rates are calculated as follows: (number of accidents (or fatal accidents) at work / number of persons in employment in the reference population) x 100 000.

(44) Council Resolution 2002/C 161/01 of 3 June 2002 on a new Community strategy on health and safety at work (2002-06) (OJ C 161, 5.7.2002, p. 1); for more information: http://eur-lex.europa.eu/LexUriServ/site/en/oj/2002/c_161/c_16120020705en00010004.pdf. Council Resolution 2007/C 145/01 of 25 June 2007 on a new Community strategy on health and safety at work (2007-2012) (OJ C 145, 30.6.2007, p.1); for more information: http://eur-lex.europa.eu/LexUriServ/site/en/oj/2007/c_145/c_14520070630en00010004.pdf.

The data on accidents at work refer to accidents that result in more than three days absence from work. An accident at work is a discrete occurrence during the course of work which leads to physical or mental harm. This includes accidents in the course of work outside the premises of his business, even if caused by a third party (on clients' premises, on another company's premises, in a public place or during transport, including road traffic accidents) and cases of acute poisoning. It excludes accidents on the way to or from work (commuting accidents), occurrences having only a medical origin (such as a heart attack at work) and occupational diseases.

A fatal accident at work is defined as an accident which leads to the death of a victim generally within one year of the accident. In practice the notification of an accident as fatal ranges from national registration procedures where the accident is registered as fatal when the victim died the same day (the Netherlands) to cases where no time limits are laid down (Belgium, Greece, France, Italy, Luxembourg, Austria, Sweden and Norway).

MAIN FINDINGS

According to the European Agency for Safety and Health at Work in Bilbao ⁽⁴⁵⁾, every three and a half minutes, somebody in the EU dies from work-related causes. Of the 150 000 deaths in a year, the vast majority are from occupational diseases (142 000), while the remainder are classified as work-related accidents.

In recent years the incidence rate of serious accidents at work has fallen, such that by 2004 it had decreased by 21 % in relation to 1998 for the EU-25. During the same period there was a 24 % reduction in fatal accidents at work in the EU-25. Note that these figures may in part reflect the structural shift of the European economy towards services, where the risks of accident and death at work are usually less than within agriculture, industry or construction.

There were only three Member States that reported a higher incidence of serious accidents at work in 2004 when compared with 1998: Estonia (24 % higher), Cyprus (3 % higher) and Romania (also 3 % higher). At the other end of the scale, the incidence of serious accidents in Bulgaria and Slovakia was almost halved between 1998 and 2004. The majority of the Member States also reported a reduction in the incidence of fatal accidents at work, although this was not the case in Lithuania (13 % increase), Austria (7 % increase), Romania (3 % increase), Finland (2 % increase) and Germany (no change). Italy, Denmark and Luxembourg all reduced their incidence of fatal accidents at work by at least half over the period considered.

(45) For more information: http://osha.europa.eu/index_html.

In absolute terms the highest incidence of serious and fatal accidents at work was recorded within the construction sector, with agriculture and transport also recording relatively high values. Men are considerably more likely to have an accident or to die at work. This is due, at least in part, to a higher proportion of men working in higher risk sectors and occupations, while men are also more likely to work on a full-time basis. These characteristics may also explain why the incidence of accidents has tended to fall at a more rapid pace for men than for women. Across different age groups, the incidence rate for accidents at work is considerably higher among those aged between 18 and 24 years, while fatal accidents at work are more common among those aged between 55 and 64 years.

SOURCES

Statistical books

Work and health in the European Union – A statistical portrait

Pocketbooks

Health in Europe – Data 1998-2003

Methodologies and working papers

Statistical analysis of socio-economic costs of accidents at work in the European Union

Website data

Health and safety at work

Structural indicators on health and safety at work

Accidents at work

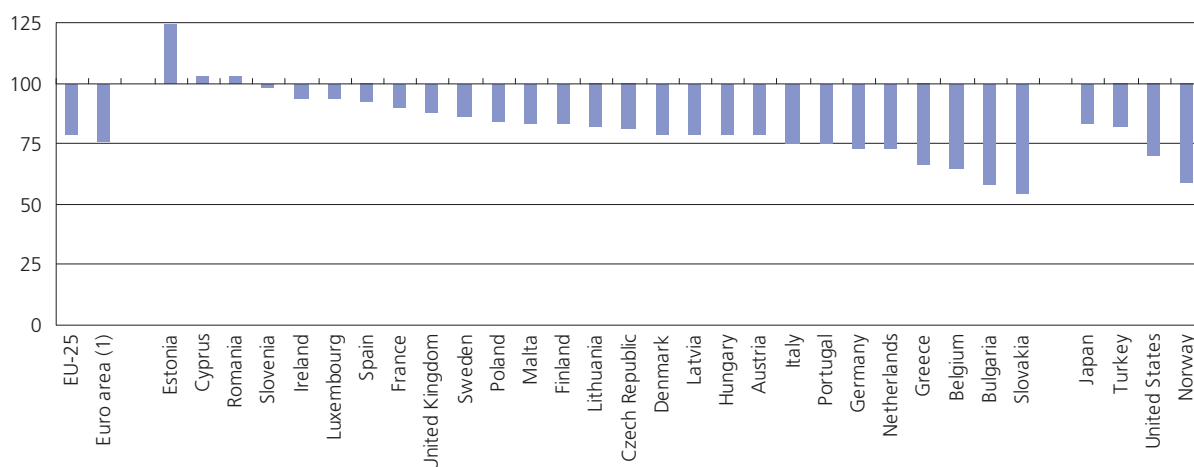
Commuting accidents

Occupational diseases

Work related health problems and accidental injuries

Figure 3.10: Incidence of serious accidents at work, 2004

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



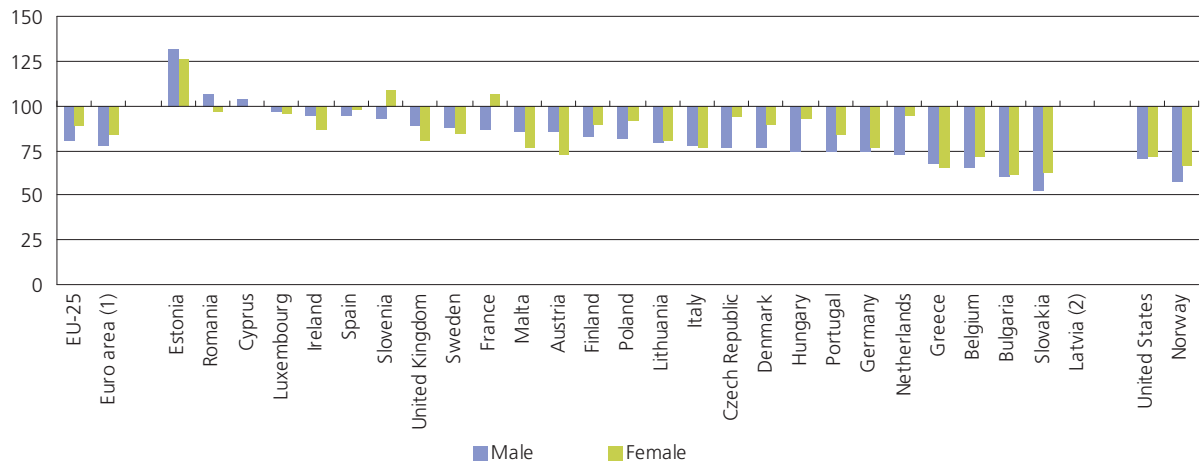
(1) EA-12, estimate.

Source: Eurostat (tsiem0611)

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 3 days' absence that occurred during the year/number of persons in employment in the reference population) x 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 3.11: Incidence of serious accidents at work, by gender, 2004

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



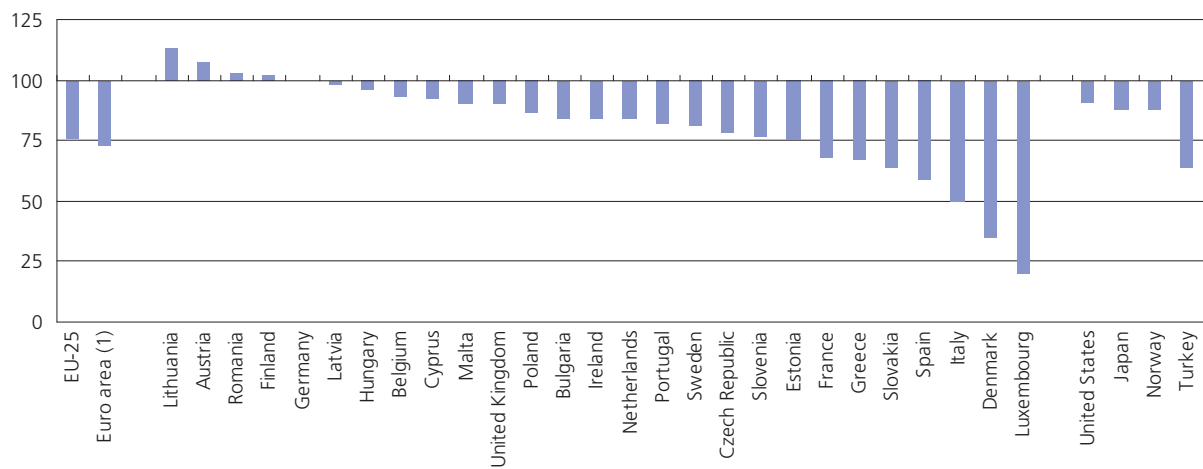
(1) EA-12, estimate.

(2) Not available.

Source: Eurostat (tsiem0613)

Figure 3.12: Incidence of fatal accidents at work, 2004

(1998=100, based on the number of fatal accidents per 100 000 persons employed)



(1) EA-12, estimate.

Source: Eurostat (tsiem0612)

3.5 CAUSES OF DEATH AND INFANT MORTALITY

INTRODUCTION

Broadly speaking, the EU has witnessed a very significant reduction in mortality during the last century or so – both in terms of reduced infant mortality and as a result of declines in infectious and degenerative diseases. Cancer and cardiovascular diseases are currently by far the most important causes of death in the EU among both men and women.

Mortality during the first year of life has decreased considerably in all Member States, such that current levels are among the lowest in the world. There however remain persistent differences in rates across different social groups or across geographical regions.

DEFINITIONS AND DATA AVAILABILITY

The infant mortality rate represents the ratio between deaths of children under one year and the number of live births in a given year; the value is expressed per 1 000 live births. Note that some countries use different definitions for spontaneous abortion, early foetal death and late foetal death (or stillbirth).

Eurostat began collecting and disseminating mortality data in 1994; data are currently available from 1994 to 2006 broken down by:

- a shortlist of 65 causes of death based on the International Statistical Classification of Diseases and Related Health Problems (ICD), that is developed and maintained by the World Health Organisation (WHO);
- gender;
- age;
- geographical region (NUTS level 2).

Causes of death (COD) statistics are based on information derived from medical certificates; the medical certification of death is an obligation in all Member States. They target the underlying cause of death, in other words, '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' (a definition adopted by the World Health Assembly).

Annual data are provided in absolute numbers, as crude death rates and as standardised death rate. 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, and therefore CDRs are influenced by the age structure of the population. The standardised death rate (SDR) is the death rate of a population of a standard age distribution. Since most causes of death vary significantly by age and sex, the use of standardised death rates improves comparability over time and between countries. These indicators aim at measuring death rates independently of different age structures across populations.

MAIN FINDINGS

The progress made in medical care services is reflected in a decreasing infant mortality rate. In the course of the last four decades the infant mortality rate in the EU-25 fell from almost 28 deaths per 1 000 live births in 1965 to 4.6 deaths in 2004. Among the Member States there were some considerable reductions in infant mortality rates: for example, in Greece, Italy (to 2003), Luxembourg and Portugal infant mortality rates were reduced by over 90 % between 1960 and 2005, resulting in some of the lowest infant mortality rates in the world. In contrast, infant mortality rates have levelled-off in some countries in recent years; this may in part be due to factors such as, an increasing number of women deferring childbirth, or a higher number of multiple births as a result of the more common use of fertility treatments.

The most important causes of death among men and women in the EU-27 in 2004 were cancer (malignant neoplasm) and ischaemic heart diseases; there were, however, large differences between standardised death rates for men and women.

Deaths from cancer among men had an incidence of 241 per 100 000, while the corresponding rate for women was 136. Standardised death rates for ischaemic heart diseases were about twice as high for men (at 138 per 100 000) as for women (71). Indeed, men reported higher standardised death rates for all of the main causes of death, with rates as much as four or five times as high as those recorded for women for drug dependence and alcohol abuse, and between three and four times as high for AIDS (HIV) and suicide and intentional self-harm.



SOURCES

Statistical books

Health statistics – Atlas on mortality in the European Union

Pocketbooks

Health in Europe – Data 1998-2003

Methodologies and working papers

Methodology for the calculation of Eurostat's demographic indicators

Website data

Public health

Causes of death

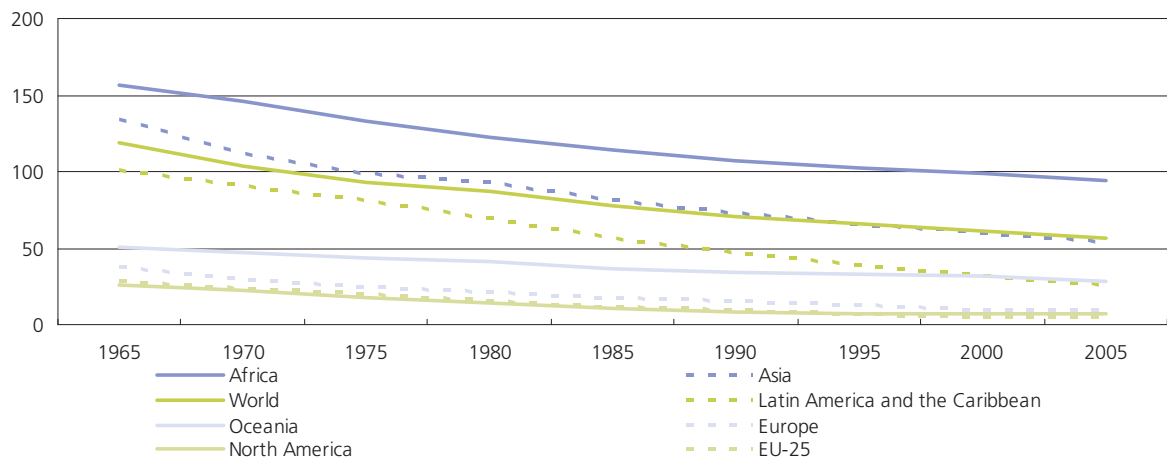
Mortality

Infant mortality

Infant mortality rates

Figure 3.13: Infant mortality (1)

(per 1 000 live births)



(1) All data (excluding EU-25) are averages of the five-year period up to and including the reference period referred to in the figure.

Source: Eurostat (tps00027), United Nations, Population Division of the Department of Economic and Social Affairs

The ratio of the number of deaths of children under one year of age during the year to the number of live births in that year. The value is expressed per 1 000 live births.

Table 3.6: Infant mortality

(per 1 000 live births)

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005
EU-25 (1)	:	27.8	23.9	19.7	14.8	11.9	9.2	6.7	5.2	4.6
Euro area (1, 2)	35.9	28.4	23.7	18.8	12.7	9.6	7.6	5.6	4.5	4.1
Belgium	23.9	23.7	21.1	16.1	12.1	9.8	6.5	5.9	4.8	3.7
Bulgaria	45.1	30.8	27.3	23.0	20.2	15.4	14.8	14.8	13.3	10.4
Czech Republic	20.0	23.7	20.2	19.4	16.9	12.5	10.8	7.7	4.1	3.4
Denmark	21.5	18.7	14.2	10.3	8.4	8.0	7.5	5.1	5.3	4.4
Germany	35.0	24.1	22.5	18.9	12.4	9.1	7.0	5.3	4.4	3.9
Estonia	31.1	20.3	17.6	18.1	17.1	14.1	12.3	14.9	8.4	5.4
Ireland	29.3	25.3	19.5	17.5	11.1	8.8	8.2	6.4	6.2	4.0
Greece	40.1	34.3	29.6	24.0	17.9	14.1	9.7	8.1	5.9	3.8
Spain	35.4	29.3	20.7	18.9	12.3	8.9	7.6	5.5	4.4	3.8
France (1)	:	:	:	:	:	:	:	:	4.5	4.0
Italy (3)	43.3	35.0	29.0	20.8	14.6	10.5	8.2	6.2	4.5	3.9
Cyprus	:	32.0	26.0	18.3	14.4	14.3	12.9	9.7	5.6	4.0
Latvia	26.9	18.9	17.8	20.3	15.4	13.0	13.7	18.8	10.4	7.8
Lithuania	38.0	24.7	19.3	19.6	14.5	14.2	10.2	12.5	8.6	6.8
Luxembourg	31.6	24.0	25.0	14.8	11.4	9.0	7.3	5.5	5.1	2.6
Hungary	47.6	38.8	35.9	32.9	23.2	20.4	14.8	10.7	9.2	6.2
Malta	38.1	35.0	27.9	18.4	15.2	14.6	9.1	8.9	5.9	6.0
Netherlands	16.5	14.4	12.7	10.6	8.6	8.0	7.1	5.5	5.1	4.9
Austria	37.5	28.3	25.9	20.5	14.3	11.2	7.8	5.4	4.8	4.2
Poland	56.1	41.6	36.4	24.8	25.4	22.1	19.4	13.6	8.1	6.4
Portugal	77.5	64.9	55.5	38.9	24.2	17.8	11.0	7.5	5.5	3.5
Romania	75.8	44.1	49.4	34.7	29.3	25.6	26.9	21.2	18.6	15.0
Slovenia	35.1	29.6	24.6	17.2	15.3	13.1	8.3	5.5	4.9	4.1
Slovakia	28.6	28.5	25.7	23.7	20.9	16.3	12.0	11.0	8.6	7.2
Finland	21.0	17.6	13.2	9.6	7.6	6.3	5.6	3.9	3.8	3.0
Sweden	16.6	13.3	11.0	8.6	6.9	6.8	6.0	4.1	3.4	2.4
United Kingdom	22.5	19.6	18.5	18.9	13.9	11.1	7.9	6.2	5.6	5.1
Croatia	70.4	49.5	34.2	23.0	20.6	16.6	10.7	8.9	7.4	5.7
FYR of Macedonia	:	:	:	:	:	:	:	22.7	11.8	12.8
Turkey (1)	:	:	:	:	:	:	:	:	:	24.6
Iceland	13.1	15.1	13.3	12.5	7.8	5.6	5.8	6.1	3.0	2.3
Liechtenstein	20.0	22.5	12.5	6.7	7.5	10.0	0.0	:	:	2.6
Norway	15.9	14.6	11.3	9.5	8.1	8.5	6.9	4.0	3.8	3.1
Switzerland	21.1	17.9	15.1	10.7	9.1	6.9	6.8	5.0	4.9	4.2

(1) 2004 instead of 2005.

(2) EA-12.

(3) 2003 instead of 2005.

Source: Eurostat (tps00027)


Table 3.7: Causes of death – standardised death rate, 2005

(per 100 000 inhabitants)

	Diseases											
	Cancer (1)	Heart disease (2)	of the nervous system	Pneu- monia	Chronic liver disease	Diabetes mellitus	Acci- dents	Sui- cide (3)	Alcohol abuse	Homi- cide, assault	AIDS (HIV)	Drug depen- dence
EU-27 (4)	180.2	100.4	16.3	16.1	14.6	13.9	27.6	11.3	2.8	1.2	1.1	0.6
Belgium (5)	205.3	81.4	22.4	20.5	11.7	11.1	30.8	19.5	1.9	1.7	:	0.7
Bulgaria	171.0	163.1	8.4	18.0	17.4	16.5	29.5	10.7	0.6	2.2	0.0	0.0
Czech Republic (4)	229.9	163.5	15.9	18.9	15.7	10.3	40.8	14.0	1.5	1.1	:	0.0
Denmark (6)	218.8	111.5	16.6	13.4	13.9	17.9	29.0	12.2	8.6	0.9	0.6	0.6
Germany	168.0	104.2	13.9	14.7	15.0	17.0	17.9	10.4	5.1	0.5	0.5	0.9
Estonia	196.9	264.2	16.3	11.3	21.7	12.2	77.7	18.7	13.5	8.8	2.4	0.1
Ireland	179.7	112.3	16.3	39.6	5.3	10.1	18.5	9.5	2.0	0.3	0.2	2.5
Greece	160.3	77.8	7.4	4.4	5.0	6.1	27.7	3.1	0.2	0.9	0.2	0.0
Spain	159.7	56.3	21.3	12.1	9.4	13.8	23.2	6.6	0.6	0.8	3.1	0.3
France	176.0	40.4	25.4	10.2	11.2	11.7	29.6	15.8	4.7	0.8	1.4	0.3
Italy (7)	175.3	72.4	14.3	8.3	12.7	17.0	26.1	6.0	0.3	0.9	1.5	0.7
Cyprus	120.4	83.5	12.8	12.0	5.7	39.5	45.0	2.9	0.1	1.7	0.4	1.0
Latvia	193.8	287.0	14.5	19.9	15.3	7.2	90.4	22.6	3.2	10.0	1.1	:
Lithuania	194.7	355.0	11.3	17.2	26.0	8.1	98.1	37.0	0.6	8.8	0.1	0.2
Luxembourg	162.2	67.1	22.8	14.0	11.3	7.6	29.0	9.9	4.5	1.5	0.2	0.4
Hungary	237.4	261.3	13.4	6.6	44.5	25.5	41.8	23.2	4.9	1.8	0.1	0.0
Malta	145.3	149.5	18.1	14.7	6.4	22.1	19.9	4.2	0.4	0.5	0.3	:
Netherlands	189.5	59.5	15.9	23.1	4.4	16.6	15.8	9.0	1.2	1.1	0.5	0.1
Austria	165.8	111.6	14.6	10.8	16.7	27.9	25.7	14.7	3.5	0.8	0.8	2.4
Poland	211.3	114.2	11.2	20.3	15.0	12.2	38.9	15.0	4.0	1.4	0.3	0.0
Portugal	156.0	53.4	15.9	27.5	12.2	27.2	19.9	7.2	0.8	1.3	7.8	0.1
Romania (8)	177.7	229.0	8.2	29.0	46.5	8.2	45.1	12.8	4.4	3.8	1.2	:
Slovenia	196.8	79.9	8.7	26.8	21.9	18.6	32.0	22.0	3.7	1.1	0.1	0.0
Slovakia	210.1	272.3	12.2	32.9	24.9	12.4	37.7	12.0	:	1.6	:	:
Finland (4)	143.8	145.4	30.9	19.8	16.0	7.4	47.5	19.3	4.0	2.4	0.2	0.6
Sweden (4)	155.7	104.7	17.4	11.2	5.4	12.1	27.1	11.8	4.1	1.1	0.2	0.5
United Kingdom	181.5	107.3	18.9	33.0	10.9	7.0	16.8	6.4	1.6	0.4	0.4	1.8
Croatia	212.6	167.9	10.7	27.3	22.4	17.0	37.1	17.0	3.7	1.3	0.1	1.3
FYR of Macedonia	160.3	104.9	6.2	5.4	6.0	35.8	20.3	7.1	1.8	2.5	:	0.1
Iceland	159.3	92.3	36.0	14.5	4.0	5.6	19.9	11.5	1.2	1.0	:	0.3
Norway	166.6	79.1	18.5	21.2	3.3	10.7	29.3	11.3	3.3	0.6	0.5	0.6
Switzerland	146.1	72.4	21.8	11.3	7.0	11.3	19.2	15.0	2.4	0.9	0.9	3.0

(1) Malignant neoplasms.

(2) Ischaemic heart diseases.

(3) Suicide and intentional self-harm.

(4) 2004.

(5) 1997.

(6) 2001.

(7) 2002.

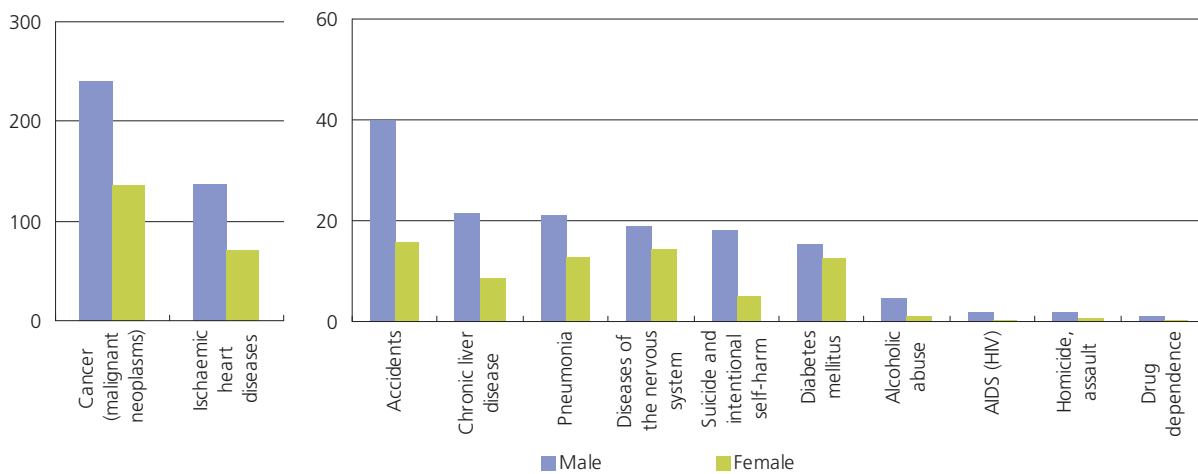
(8) 2003.

Source: Eurostat (tps00116, tps00119, tps00134, tps00128, tps00131, tps00137, tps00125, tps00122, tps00140, tps00146, tps00143 and tps00149)

Death rate of a population adjusted to 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 death rates used here are calculated on the basis of a standard European population (defined by the World Health Organization). Detailed data for 65 causes of death are available in the database.

Figure 3.14: Causes of death – standardised death rate, EU-27, 2004 (1)

(per 100 000 inhabitants)

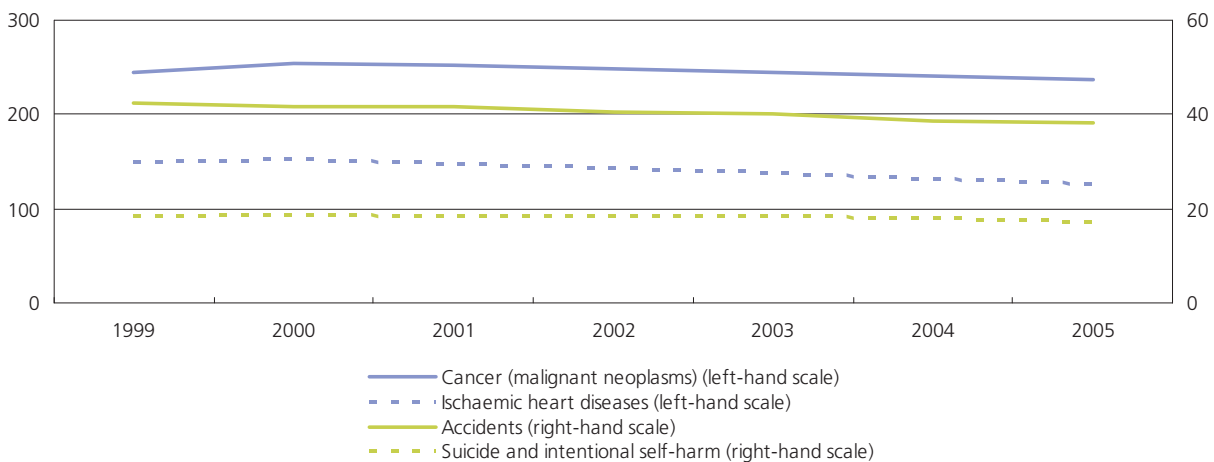


(1) Note the differences in the scales employed between the two parts of the graph.

Source: Eurostat (tps00116, tps00119, tps00125, tps00131, tps00128, tps00134, tps00122, tps00137, tps00140, tps00143, tps00146 and tps00149)

Figure 3.15: Causes of death for males – standardised death rate, EU-25

(per 100 000 inhabitants)

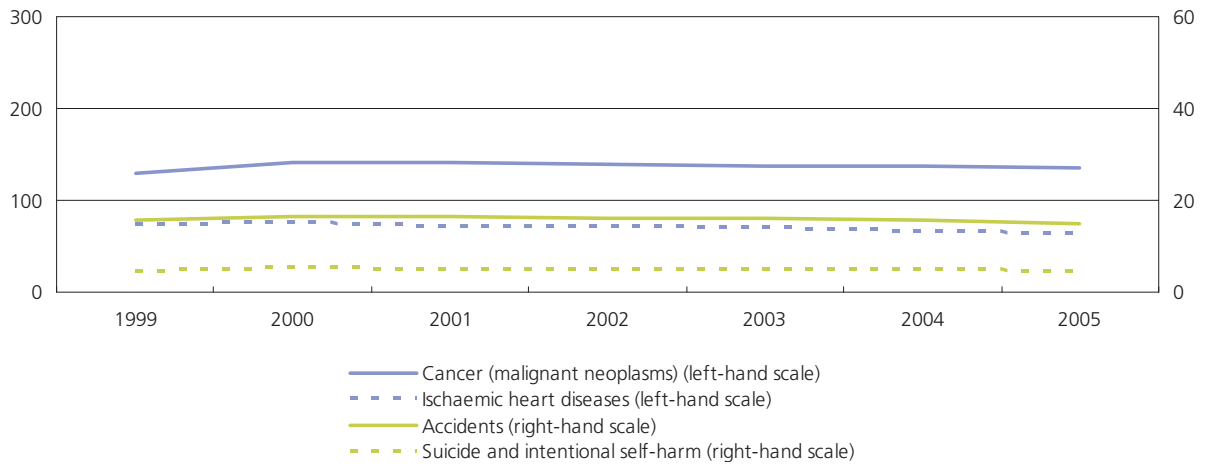


Source: Eurostat (tps00116, tps00119, tps00122 and tps00125)



Figure 3.16: Causes of death for females – standardised death rate, EU-25

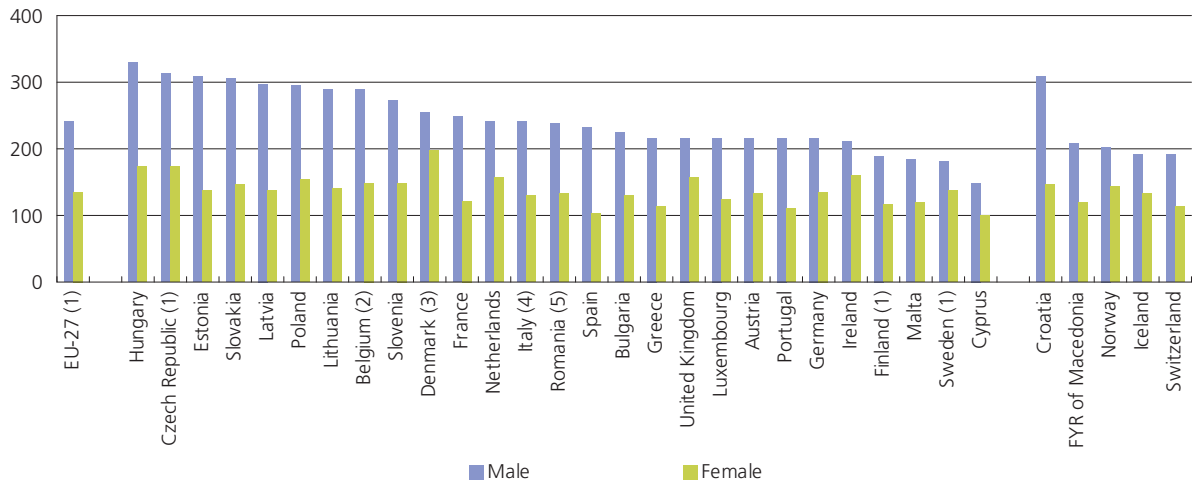
(per 100 000 inhabitants)



Source: Eurostat (tps00116, tps00119, tps00122 and tps00125)

Figure 3.17: Deaths from cancer (malignant neoplasms) – standardised death rate, 2005

(per 100 000 inhabitants)

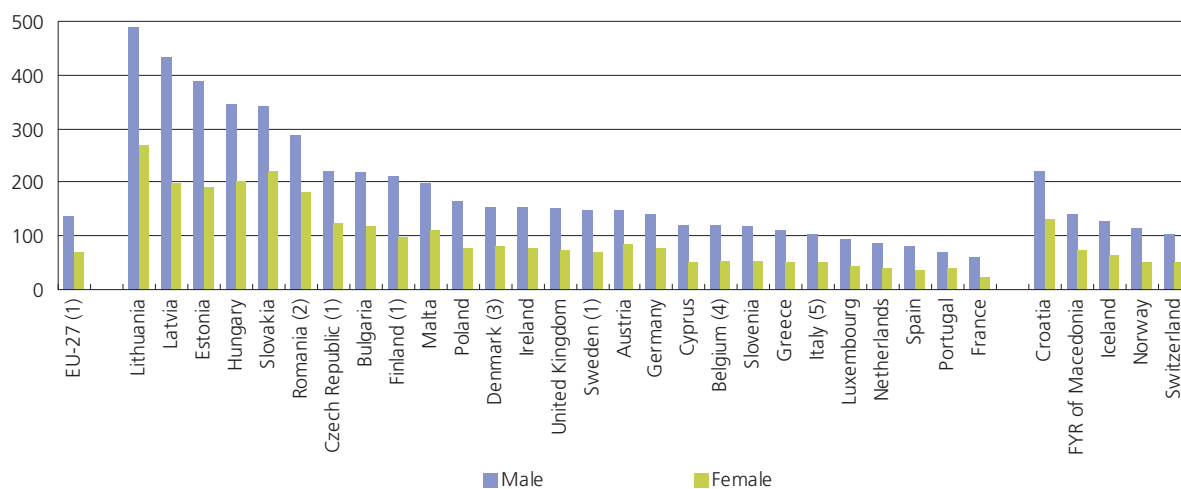


- (1) 2004.
 (2) 1997.
 (3) 2001.
 (4) 2002.
 (5) 2003.

Source: Eurostat (tps00116)

Figure 3.18: Deaths from ischaemic heart diseases – standardised death rate, 2005

(per 100 000 inhabitants)

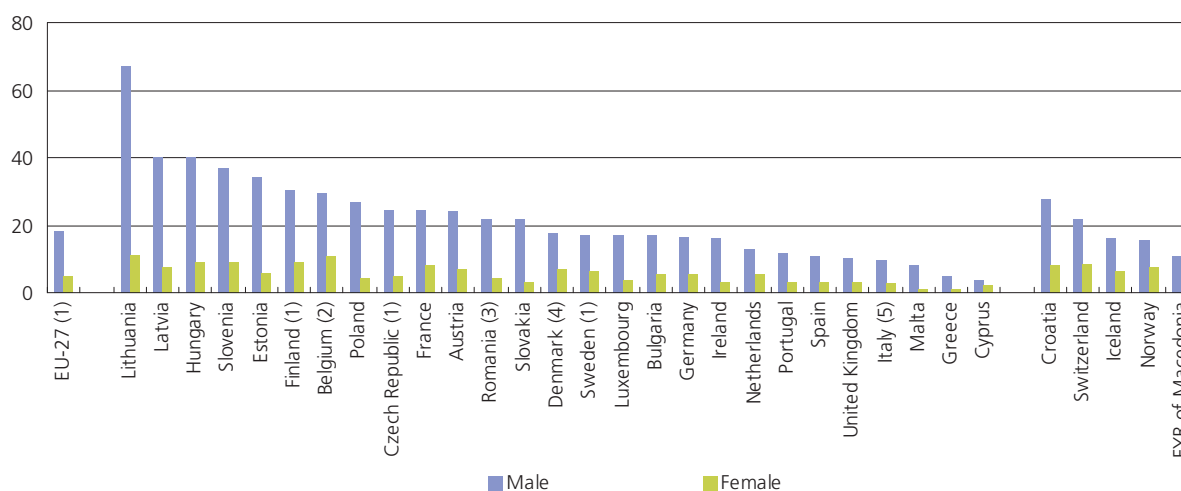


- (1) 2004.
- (2) 2003.
- (3) 2001.
- (4) 1997.
- (5) 2002.

Source: Eurostat (tps00119)

Figure 3.19: Deaths from suicide – standardised death rate, 2005

(per 100 000 inhabitants)



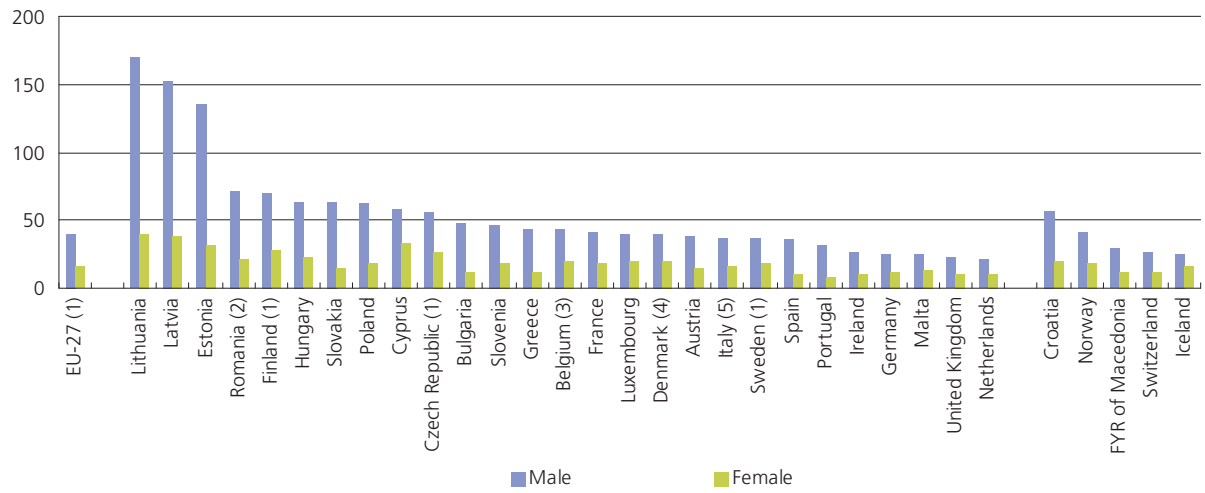
- (1) 2004.
- (2) 1997.
- (3) 2003.
- (4) 2001.
- (5) 2002.

Source: Eurostat (tps00122)



Figure 3.20: Deaths from accidents – standardised death rate, 2005

(per 100 000 inhabitants)



- (1) 2004.
- (2) 2003.
- (3) 1997.
- (4) 2001.
- (5) 2002.

Source: Eurostat (tps00125)