



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. The vast majority of policy areas covered within this chapter are under the remit of the Directorate-General for Health and Consumers.

However, the competence for the organisation and delivery of health services and healthcare is largely held by the Member States, while 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.

A first programme for Community action in the field of public health<sup>(1)</sup> for the period 2003 to 2008 focused 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.

(1) Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008) (OJ L 271, 9.10.2002, p. 1); [http://europa.eu/eur-lex/pri/en/oj/dat/2002/l\\_271/l\\_27120021009en00010011.pdf](http://europa.eu/eur-lex/pri/en/oj/dat/2002/l_271/l_27120021009en00010011.pdf).



On 23 October 2007 – the European Commission adopted a new strategy ‘Together for Health: A Strategic Approach for the EU 2008-2013’<sup>(2)</sup>. In order to bring about the changes sought within the sector and identified within the new strategy, the second programme of Community Action in the Field of Health<sup>(3)</sup> came into force from 1 January 2008. It puts in place an overarching, strategic framework for work on health at the EU level in the coming years and encompasses work not only in the health sector but across all policy areas. It has four main principles and three strategic themes for improving health in the EU. The principles include taking a value-driven approach, recognising the links between health and economic prosperity, integrating health in all policies, and strengthening the EU’s voice in global health issues. The strategic themes include fostering good health in an ageing Europe, protecting citizens from health threats, and dynamic health systems and new technologies. The programme is valued at EUR 321.5 million and will be implemented by means of annual work plans which will set out priority areas and funding criteria.

## 5.1 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.

Indicators on 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.

(2) [http://ec.europa.eu/health/ph\\_overview/Documents/strategy\\_wp\\_en.pdf](http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf).

(3) Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-2013) (OJ L 301/3, 20.11.2007); <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:301:0003:0013:EN:PDF>.



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. An increase in HLY is one of the main goals for European health policy, given that this would not only improve the situation of individuals (as good health and a long life are fundamental objectives of human activity) but would also result 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. Any loss in health will, nonetheless, have important effects. These will include an altered pattern of resource allocation within the healthcare system, as well as wider ranging effects on consumption and production throughout the economy.

### Definitions and data availability

The structural indicator on **healthy life years (HLY)** (also called **disability-free life expectancy (DFLE)**) 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. The indicator is calculated separately for males and females.

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 EU's survey of statistics on income and living conditions (EU-SILC). The way this question was implemented by the Member States in EU-SILC hampers cross-country comparisons for the data up to 2008. 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?

**Life expectancy at birth** is defined as the mean number of years still to be lived by a person at birth, if subjected throughout the rest of his or her life to the current mortality conditions.

### Main findings

While life expectancy rises, political attention has been re-focused on healthy life years (HLY). One measure that can be used to study the relative health of Europe's population is the relationship between healthy life years and total life expectancy, in other words, what percentage of each person's life is lived free from disability and disease. Men 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. Indeed, the male population consistently reported a higher proportion of healthy life years in total life expectancy when compared with rates for women, with differences of 8 percentage points or more in Portugal, Lithuania and Latvia.

The HLY indicator is calculated at two ages: birth and the age of 65. Healthy life years at age 65 is of particular interest in relation to the possible future demand for healthcare and social services, or the potential for older persons to remain within the workforce. For both men and women, Estonia, Latvia, Lithuania, Hungary and Slovakia were the countries where people could expect to spend the shortest period

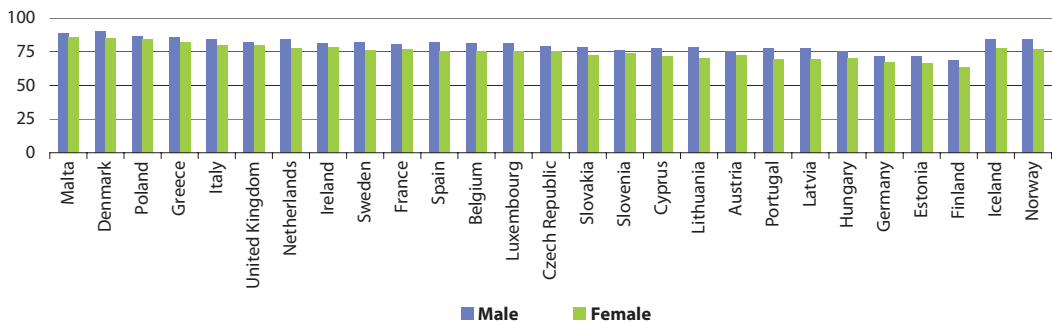


after the age of 65 without a disability. The data for Estonia, Luxembourg, Hungary, Austria and Iceland showed almost identical figures for men and women in terms of additional healthy life years they may expect to live at the age of 65. The highest differences between the sexes

were recorded in Poland and Cyprus. In Poland, women aged 65 were expected to have 1.8 years of healthy life more than men, while in Cyprus the opposite situation was found, as men could expect to have 1.9 additional years of healthy life than women.

**Figure 5.1:** Healthy life years at birth, 2005 (1)

(% of total life expectancy)

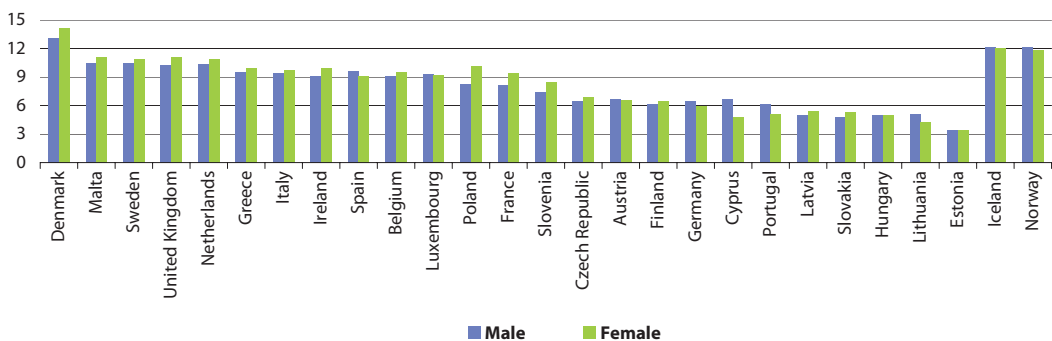


(1) Provisional data; Italy, life expectancy data is for 2004; Bulgaria and Romania, not available; the figure is ranked on the average of male and female.

Source: Eurostat (tsdph100 and tps00025)

**Figure 5.2:** Healthy life years at age 65, 2005 (1)

(years)



(1) Provisional data; Bulgaria and Romania, not available; the figure is ranked on the average of male and female.

Source: Eurostat (tsdph220)

## 5.2 Health problems

### Introduction

According to the Directorate-General for Health and Consumers<sup>(4)</sup>, 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.

Six out of the seven most important risk factors for premature death in the EU (blood pressure, cholesterol, body mass index, inadequate fruit and vegetable intake, physical inactivity, excessive alcohol consumption) relate to how people eat, drink and move (the only exception being tobacco). As such, a balanced diet and regular physical activity, along with restraining from smoking and drinking to excess, are important factors in the promotion and maintenance of good health.

Nevertheless, 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 Consumers 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.

Overweightness and obesity are increasing at an alarming rate in Europe, especially among children. Obesity is a serious public health problem, as it increases significantly the risk of chronic diseases such as cardiovascular disease, type 2 diabetes and certain cancers. Lifestyle factors, including diet, eating habits and levels of physical activity (and inactivity) are often adopted during the early years of life. As such, childhood obesity is strongly linked to adult obesity. However, maintaining a 'normal weight' can be a challenging exercise, given the abundance of energy-rich foods, and lifestyle pressures that decrease

(4) [http://ec.europa.eu/health/ph\\_determinants/healthdeterminants\\_en.htm](http://ec.europa.eu/health/ph_determinants/healthdeterminants_en.htm).



opportunities for physical activity both at work and during leisure time.

### 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.

Many health-related 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 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.

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 is not calculated for children. Note that data for Germany and for England relate to valid height and weight measurements, while for the other countries the data correspond to self-declared height and weight.

### 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, 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; 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 the corresponding average for women of all ages; this was particularly the case in the United Kingdom, Spain, Ireland and Germany.

Information from the EU's survey on income and living conditions (EU-SILC) provides data on difficulties faced by Europeans in their daily lives and their potential need for assistance; note that the data represents the perceived views of the population and does not specifically measure disability levels. Within the EU-25, some 6.9 % of men and 8.7 % of women (aged 15 or more) reported that they were severely hampered in activities people usually do because of health problems for at least the six months prior to the survey (conducted in 2006).

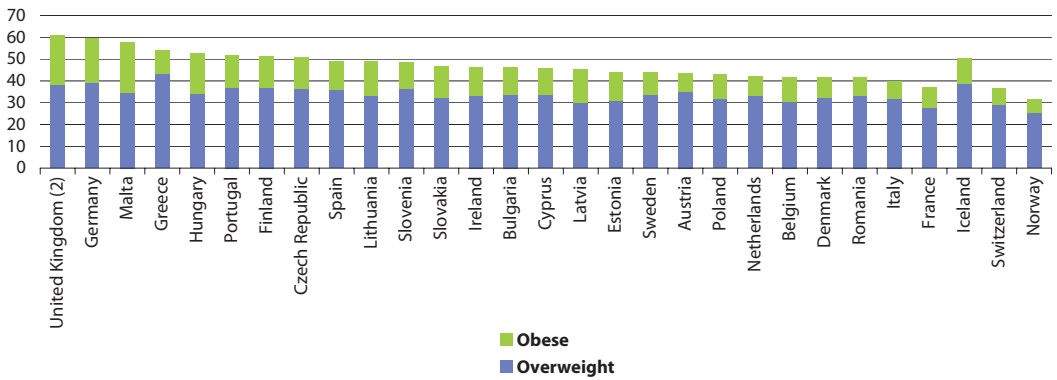
The proportion of women that were severely hampered in everyday activities due to health problems was higher across each of the Member States than the corresponding share for men (except in Ireland, where the share among men was 0.1 points higher than for women). The difference in rates between the sexes rose to almost 4 percentage points in Portugal, where 13.4 % of women were severely hampered, and was above 3 percentage points in Slovakia, Finland, Lithuania and Latvia; each of these countries reported that in excess of 10 % of their female population was severely hampered in everyday activities because of health problems.





**Figure 5.3: Overweight people, 2003 (1)**

(% of total population)



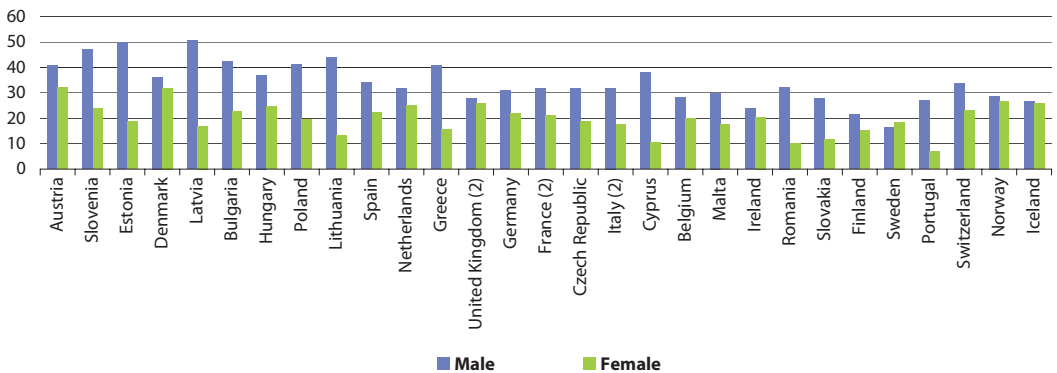
(1) National health interview survey (HIS) data, 1996-2003 depending on the country; note that data for Germany and for England relate to valid height and weight measurements, while for the other countries the data correspond to self-declared height and weight. Luxembourg, not available.

(2) Only England.

Source: Eurostat (hlth\_ls\_bmia)

**Figure 5.4: Daily smokers, 2003 (1)**

(% of male / female population)



(1) National health interview survey (HIS) data, 1996-2003 depending on the country; Luxembourg, not available; the figure is ranked on the average of male and female.

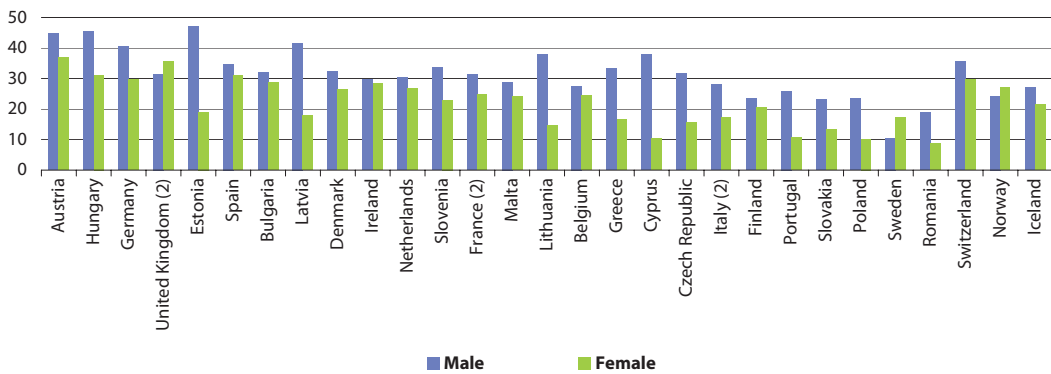
(2) No distinction between daily and occasional smoking.

Source: Eurostat (tps00169)



**Figure 5.5: Daily smokers among the population aged 15-24, 2003 (1)**

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



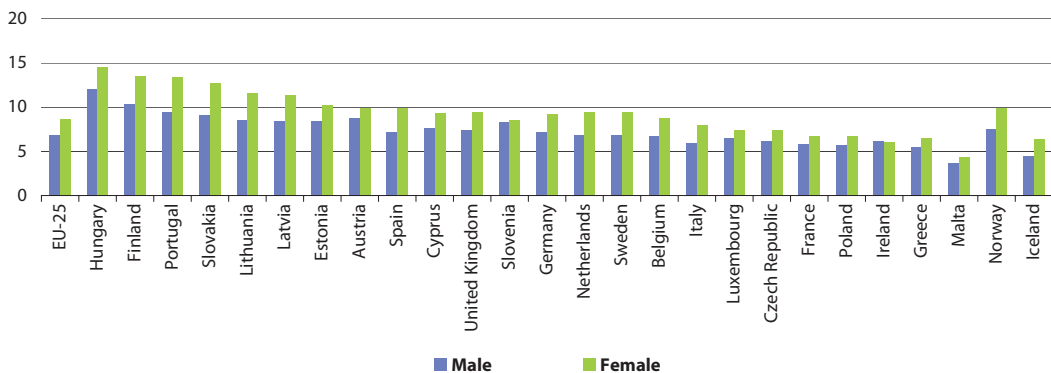
(1) National health interview survey (HIS) data, 1996-2003 depending on the country; Luxembourg, not available; the figure is ranked on the average of male and female.

(2) No distinction between daily and occasional smoking.

Source: Eurostat (tps00170)

**Figure 5.6: Persons severely hampered in activities people usually do because of health problems for at least the past 6 months, 2006 (1)**

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



(1) Bulgaria, Denmark and Romania, not available; the figure is ranked on the average of male and female.

Source: Eurostat (hlth\_silc\_06)



## 5.3 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 to 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. Indeed, healthcare systems and health policies across the EU are becoming more interconnected. This is not only a result of the movement of patients and professionals between countries, but may also be attributed to a set of common public expectations of health services across Europe, as well as more rapid dissemination of new medical technologies and techniques. On 2 July 2008, as part of a Renewed Social Agenda, the European Commission adopted a draft Directive on the application of patients' rights to cross-border healthcare<sup>(5)</sup>.

(5) [http://ec.europa.eu/health/ph\\_overview/co\\_operation/healthcare/docs/COM\\_en.pdf](http://ec.europa.eu/health/ph_overview/co_operation/healthcare/docs/COM_en.pdf).



### 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(s) they receive. Healthcare data are largely based on administrative data sources, and, to a large degree, they reflect country-specific ways of organising healthcare; as such, the information collected may not always be completely comparable.

**Hospitals** are defined according to the classification of healthcare providers of the System of Health Accounts (SHA); all public and private hospitals should be covered.

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 of '**practising professionals**', as this best describes the availability of healthcare resources. By way of example, physicians may be counted as licensed, economically active or practising. Data for two or more concepts are available in the majority of Member States. The preference, however, is for **practising**

**physicians** who are defined as those seeing patients either in a hospital, practice or elsewhere. Practising physicians' tasks include: conducting medical examination and making diagnosis, prescribing medication and giving treatment for diagnosed illnesses, disorders or injuries, giving specialised medical or surgical treatment for particular types of illnesses, disorders or injuries, giving advice on and applying preventive medicine methods and treatments.

**Hospital bed numbers** provide information on healthcare capacities, i.e. on the maximum number of patients who can be treated by hospitals. Hospital beds are those which are regularly maintained and staffed and immediately available for the care of admitted patients. These include: beds in all hospitals, including general hospitals, mental health and substance abuse hospitals, and other specialty hospitals: occupied and unoccupied beds. The statistics exclude surgical tables, recovery trolleys, emergency stretchers, beds for same-day care, cots for healthy infants, beds in wards which were closed for any reason, provisional and temporary beds, or beds in nursing and residential care facilities. They cover 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. **Curative care** (or acute care) beds in hospitals are beds that are available for curative care; these form a subgroup of total hospital beds.



Output-related indicators focus 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 defined as 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; transfers to another department within the same institution are excluded.

### Main findings

The highest number of physicians per 100 000 inhabitants was recorded in Greece (almost 500 professionally active physicians in 2005), followed by Belgium (405 practising physicians in 2007) and Austria (376 practising physicians in 2007); note the methodological differences between the various types of physicians reported in each country.

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 %); Austria was the only Member State to report an increase in hospital bed numbers, rising by 24.6 beds per 100 000 inhabitants over the period 1996 to 2005. A more detailed breakdown shows that reductions in bed numbers were spread across different categories, with an average of 406.3 curative care beds available per 100 000 inhabitants in the EU-27 in 2005, while there were 60.4 psychiatric beds in hospitals per 100 000 inhabitants; compared with 1997 these latest figures represented overall reductions of 16.6 % and 22.6 % respectively.

The general reduction in hospital bed numbers may result from a more efficient use of resources, with an increasing number of operations being dealt with in out-patient treatment, and shorter periods being spent in hospital following an operation. Nevertheless, the output of each National Health Service, as measured by the number of in-patient discharges, will usually (at least to some degree), reflect the number of physicians and hospital beds available. The highest number of hospital discharges in 2006 was recorded in Austria (more than 27 000 per 100 000 inhabitants), which was almost 25 % more than the next highest figure, 21 866 discharges in Lithuania. At the other end of the range, the number of hospital discharges of in-patients was relatively low in both Malta (2004) and Cyprus (below 7 000 per 100 000 inhabitants).



Diseases of the circulatory system accounted for the highest number of hospital discharges in 2006 in the vast majority of countries for which data are available, often with upwards of 3 000 discharges per 100 000 inhabitants. In Bulgaria and Romania (both 2005), higher numbers of discharges were recorded for diseases of the respiratory system. In Ireland, Spain (2005) and Malta (2005) there were more discharges from pregnancies, while in Cyprus the highest number of discharges resulted from injury or poisoning. Ireland, Spain, Cyprus and Malta were characterised by relatively low levels of hospital discharges, which may, at least in some cases, be due to patients travelling abroad in order to receive specialist treatment.

The average length of stay in hospital was generally longest for those patients suffering from cancer or from circulatory system problems. The average time spent in hospital is a function of hospital efficiency, as well as the type of treatments that are on offer; France, Cyprus, Malta and Poland reported the shortest average stays in hospital. At the other end of the range, some of the longest average stays were registered in Finland, the Czech Republic, Germany and Lithuania, with lengthy average stays for diseases of the circulatory system a common feature.

**Table 5.1:** Healthcare indicators

(per 100 000 inhabitants)

	Practising physicians (1)		Hospital beds		Hospital discharges of in-patients (excluding healthy new born babies)	
	1996	2006 (2)	1996 (3)	2006 (4)	2001	2006 (5)
<b>EU-27</b>	:	:	694.8	590.4	:	:
<b>Belgium</b>	360.3	404.7	798.3	672.3	16 162	16 084
<b>Bulgaria</b>	354.8	366.1	1 049.6	621.4	:	20 217
<b>Czech Republic</b>	298.6	355.7	886.9	817.0	:	20 799
<b>Denmark</b>	252.3	308.4	459.8	:	16 326	:
<b>Germany</b>	310.8	345.5	957.8	829.1	20 060	21 481
<b>Estonia</b>	317.0	328.9	795.5	565.3	:	:
<b>Ireland</b>	208.5	282.4	673.7	524.7	14 025	13 656
<b>Greece</b>	386.3	499.4	517.3	473.8	:	:
<b>Spain</b>	290.2	368.3	389.1	334.1	10 904	10 780
<b>France</b>	324.4	338.2	853.8	707.5	17 937	16 445
<b>Italy</b>	409.9	366.6	655.0	395.2	:	:
<b>Cyprus</b>	246.9	250.4	498.7	373.7	7 031	6 536
<b>Latvia</b>	282.1	286.1	1 038.3	755.4	:	19 970
<b>Lithuania</b>	373.2	364.8	1 092.0	801.0	23 454	21 866
<b>Luxembourg</b>	212.6	327.7	1 079.9	:	18 172	17 242
<b>Hungary</b>	304.3	303.7	903.0	792.1	:	:
<b>Malta</b>	:	332.8	576.8	237.8	:	6 871
<b>Netherlands</b>	189.9	:	522.2	438.2	:	10 135
<b>Austria</b>	280.6	375.7	746.3	770.9	:	27 119
<b>Poland</b>	235.1	218.0	766.3	647.5	:	17 955
<b>Portugal</b>	262.3	267.8	399.3	365.1	:	9 127
<b>Romania</b>	:	215.8	757.0	658.6	:	:
<b>Slovenia</b>	:	235.8	566.6	477.5	:	16 045
<b>Slovakia</b>	257.1	315.9	832.7	671.4	20 534	19 124
<b>Finland</b>	213.7	244.5	803.0	695.6	:	19 620
<b>Sweden</b>	289.0	356.6	559.8	287.7	14 997	:
<b>United Kingdom</b>	:	235.6	433.4	388.7	:	:
<b>Croatia</b>	219.9	:	618.5	545.0	12 268	13 307
<b>FYR of Macedonia</b>	226.4	245.2	523.0	470.2	:	:
<b>Turkey</b>	:	:	248.5	241.2	:	:
<b>Iceland</b>	310.9	364.0	:	:	16 789	16 084
<b>Norway</b>	283.1	377.7	400.6	402.7	15 999	17 424
<b>Switzerland</b>	180.0	:	665.9	555.6	:	15 656

(1) Greece, France, Italy and the former Yugoslav Republic of Macedonia, professionally active physicians; Ireland and Malta, licensed physicians.

(2) Belgium, Spain, Latvia, Malta and Austria, 2007; Denmark, Greece, Finland, the United Kingdom and the former Yugoslav Republic of Macedonia, 2005; Luxembourg and Portugal, 2004.

(3) EU-27, Denmark and the United Kingdom, 1997.

(4) France, Latvia and Malta, 2007; EU-27, Greece, Austria, the United Kingdom, Croatia, the former Yugoslav Republic of Macedonia and Switzerland, 2005; Portugal and Turkey, 2004.

(5) Belgium, Bulgaria, Spain, Latvia, Luxembourg, the Netherlands, Poland, Portugal, Slovakia, Croatia, Iceland, Norway and Switzerland, 2005; Malta, 2004.

Source: Eurostat (tps00044, hlth\_rs\_prs, tps00046 and hlth\_co\_disch2)

**Table 5.2: Hospital beds**

(per 100 000 inhabitants)

	Curative care beds in hospitals			Psychiatric care beds in hospitals		
	1996 (1)	2001 (2)	2006 (3)	1996 (1)	2001 (2)	2006 (4)
<b>EU-27</b>	487.2	450.7	406.3	78.0	66.0	60.4
<b>Belgium</b>	503.3	472.6	441.1	257.9	252.8	182.8
<b>Bulgaria</b>	:	583.1	469.0	88.0	71.1	67.1
<b>Czech Republic</b>	728.7	609.6	568.6	100.2	99.3	94.9
<b>Denmark</b>	380.2	349.5	327.8	79.6	75.1	:
<b>Germany</b>	744.5	680.3	634.9	:	:	:
<b>Estonia</b>	638.8	528.1	382.2	100.5	70.6	55.3
<b>Ireland</b>	306.3	281.1	279.8	168.8	126.9	90.3
<b>Greece</b>	389.7	387.3	:	107.1	93.5	86.9
<b>Spain</b>	303.9	287.2	259.9	58.5	51.0	46.2
<b>France</b>	460.8	416.0	372.1	123.6	104.5	91.2
<b>Italy</b>	552.6	407.0	331.7	54.9	14.4	13.1
<b>Cyprus</b>	366.4	370.4	349.1	87.8	38.1	26.9
<b>Latvia</b>	903.9	609.0	531.8	177.0	153.0	136.7
<b>Lithuania</b>	871.4	625.0	529.9	134.0	122.6	102.6
<b>Luxembourg</b>	618.8	572.2	549.4	128.0	83.8	:
<b>Hungary</b>	627.3	563.7	552.0	105.3	42.4	38.3
<b>Malta</b>	387.7	372.7	280.4	47.8	41.4	51.6
<b>Netherlands</b>	331.7	306.5	287.6	172.2	155.9	130.8
<b>Austria</b>	665.4	628.7	606.6	75.2	53.2	61.7
<b>Poland</b>	576.4	509.9	463.2	83.5	73.3	68.0
<b>Portugal</b>	:	:	:	:	:	:
<b>Romania</b>	569.2	551.5	456.3	88.8	83.9	79.7
<b>Slovenia</b>	475.4	446.1	388.2	80.3	75.2	71.4
<b>Slovakia</b>	620.5	566.5	501.1	90.6	93.0	83.8
<b>Finland</b>	295.8	241.2	223.7	120.5	101.1	92.1
<b>Sweden</b>	304.5	245.2	:	82.3	58.6	49.1
<b>United Kingdom</b>	321.0	315.0	309.7	103.0	85.9	73.7
<b>Croatia</b>	390.0	378.1	340.2	106.6	102.7	94.4
<b>FYR of Macedonia</b>	354.2	329.8	312.6	75.6	68.2	60.7
<b>Turkey</b>	190.6	218.0	231.1	12.8	12.5	12.1
<b>Iceland</b>	375.7	:	:	:	:	:
<b>Norway</b>	334.2	311.4	292.4	71.2	72.9	102.3
<b>Switzerland</b>	551.4	412.3	365.9	128.8	113.2	106.1

(1) EU-27, Denmark, Malta and the United Kingdom, 1997.

(2) Hungary and Sweden, break in series.

(3) France, Latvia and Malta, 2007; EU-27, Greece, Austria, the United Kingdom, Croatia, the former Yugoslav Republic of Macedonia and Switzerland, 2005; Luxembourg and Turkey, 2004.

(4) France, Latvia and Malta, 2007; EU-27, Greece, Austria, the United Kingdom, Croatia, the former Yugoslav Republic of Macedonia and Switzerland, 2005; Turkey, 2004.

Source: Eurostat (tps00168 and tps00047)





**Table 5.3:** Hospital discharges of in-patients by diagnosis (ISHMT - international shortlist for hospital morbidity tabulation), 2006

(per 100 000 inhabitants)

	Neoplasms (cancers)	Diseases of the circulatory system	Diseases of the respiratory system	Diseases of the digestive system	Pregnancy, childbirth & the puerperium	Injury, poisoning & certain other consequences of external causes
<b>Belgium (1)</b>	1 243.6	2 135.3	1 440.6	1 698.0	1 361.8	1 633.9
<b>Bulgaria (1)</b>	1 715.0	3 002.9	3 180.3	1 636.5	1 948.8	1 317.1
<b>Czech Republic</b>	1 760.7	3 225.3	1 367.5	1 837.7	1 520.3	1 730.8
<b>Denmark</b>	:	:	:	:	:	:
<b>Germany</b>	2 359.9	3 322.2	1 322.6	2 077.5	1 071.0	2 127.8
<b>Estonia (1)</b>	1 571.8	3 243.1	2 024.7	1 624.4	1 832.3	1 191.0
<b>Ireland</b>	860.6	1 234.3	1 399.1	1 238.8	2 482.7	1 347.2
<b>Greece</b>	:	:	:	:	:	:
<b>Spain (1)</b>	916.1	1 338.9	1 146.7	1 270.4	1 386.3	898.3
<b>France (1)</b>	1 277.0	1 972.7	1 005.3	1 696.7	1 566.6	1 460.7
<b>Italy (2)</b>	1 330.5	2 480.7	1 144.3	1 461.5	1 336.1	1 323.5
<b>Cyprus</b>	411.8	721.0	656.0	689.7	405.0	842.8
<b>Latvia (1)</b>	1 799.7	3 538.9	2 221.7	1 831.8	1 619.2	2 243.1
<b>Lithuania</b>	1 664.4	4 441.5	2 063.8	1 852.3	1 636.1	1 963.9
<b>Luxembourg (1)</b>	1 743.7	2 275.1	1 436.2	1 664.5	1 329.9	1 262.8
<b>Hungary</b>	:	:	:	:	:	:
<b>Malta (2)</b>	183.4	694.3	540.8	591.9	971.7	580.2
<b>Netherlands (1)</b>	997.4	1 527.5	731.2	915.8	857.5	848.3
<b>Austria</b>	2 809.2	3 720.3	1 685.7	2 502.8	1 331.9	2 909.3
<b>Poland (1)</b>	1 908.4	3 024.1	1 557.4	1 765.5	1 577.4	1 615.1
<b>Portugal (1)</b>	920.3	1 206.2	955.9	1 061.9	1 089.3	684.7
<b>Romania (1)</b>	1 274.6	2 588.1	2 785.3	2 070.8	1 697.3	1 279.2
<b>Slovenia</b>	1 836.4	1 971.8	1 221.7	1 419.5	1 248.7	1 529.9
<b>Slovakia (1)</b>	1 764.1	3 054.4	1 660.4	1 889.0	1 630.9	1 586.2
<b>Finland</b>	1 769.3	3 032.6	1 411.9	1 414.9	1 316.9	1 932.3
<b>Sweden</b>	:	:	:	:	:	:
<b>United Kingdom</b>	:	:	:	:	:	:
<b>Croatia (1)</b>	1 828.4	1 849.4	1 147.3	1 179.1	223.4	1 041.9
<b>FYR of Macedonia (1)</b>	1 164.0	1 553.7	1 424.1	1 038.9	753.5	579.2
<b>Iceland (1)</b>	1 393.8	1 824.9	980.3	1 346.7	2 113.7	1 020.4
<b>Norway (1)</b>	1 794.8	2 467.0	1 531.0	1 237.9	1 487.3	1 854.1
<b>Switzerland (1)</b>	1 123.6	1 735.1	869.4	1 353.3	1 181.9	1 846.2

(1) 2005.

(2) 2004.

Source: Eurostat (hlth\_co\_disch2)



**Table 5.4:** Hospital discharges of in-patients by diagnosis (ISHMT - international shortlist for hospital morbidity tabulation), average length of stay, 2006

(days)

	Neoplasms (cancers)	Diseases of the circulatory system	Diseases of the respiratory system	Diseases of the digestive system	Pregnancy, childbirth & the puerperium	Injury, poisoning & certain other consequences of external causes
<b>Belgium (1)</b>	9.4	8.4	8.4	6.1	5.0	8.5
<b>Bulgaria (1)</b>	7.9	7.6	8.5	6.4	4.8	6.6
<b>Czech Republic</b>	10.2	13.6	9.2	7.7	5.5	10.3
<b>Denmark</b>	:	:	:	:	:	:
<b>Germany</b>	10.4	10.5	8.9	7.6	4.9	9.3
<b>Estonia (1)</b>	8.0	10.6	5.0	5.2	3.1	8.8
<b>Ireland</b>	11.5	10.2	6.9	6.4	2.9	5.8
<b>Greece</b>	:	:	:	:	:	:
<b>Spain</b>	9.6	8.4	7.1	5.9	3.2	8.5
<b>France</b>	7.7	7.0	6.9	5.3	4.9	5.7
<b>Italy (2)</b>	9.7	8.7	8.1	6.8	4.0	7.8
<b>Cyprus</b>	8.5	5.9	5.0	4.8	5.5	4.9
<b>Latvia (1)</b>	9.1	9.2	7.9	6.2	5.6	7.5
<b>Lithuania</b>	10.5	13.0	7.9	6.7	4.7	8.5
<b>Luxembourg (1)</b>	8.9	7.9	6.0	5.9	4.8	7.7
<b>Hungary</b>	:	:	:	:	:	:
<b>Malta (3)</b>	7.5	6.5	4.9	3.9	3.5	5.9
<b>Netherlands (1)</b>	8.5	7.8	7.6	6.8	3.8	7.7
<b>Austria</b>	7.8	11.0	8.2	6.8	5.5	8.7
<b>Poland (1)</b>	6.6	7.9	8.1	5.8	5.1	5.3
<b>Portugal (1)</b>	8.7	7.9	8.2	5.9	3.3	9.3
<b>Romania (1)</b>	7.7	8.5	7.5	6.9	5.4	6.5
<b>Slovenia</b>	7.9	8.4	7.5	6.1	4.6	7.0
<b>Slovakia (1)</b>	9.1	9.0	8.2	6.5	5.8	7.1
<b>Finland</b>	9.0	16.3	13.4	6.0	3.7	11.1
<b>Sweden</b>	:	:	:	:	:	:
<b>United Kingdom</b>	:	:	:	:	:	:
<b>Croatia</b>	10.0	10.3	8.9	8.6	8.5	8.7
<b>FYR of Macedonia (1)</b>	8.5	10.9	8.2	6.3	4.4	9.1
<b>Iceland (1)</b>	7.2	6.4	6.2	4.0	2.4	6.4
<b>Norway (1)</b>	7.2	5.4	6.1	4.9	3.7	4.8
<b>Switzerland (1)</b>	10.6	9.3	8.8	7.4	6.1	8.0

(1) 2005.

(2) 2004.

(3) 2007.

Source: Eurostat (hlth\_co\_inpst)



## 5.4 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. Non-communicable diseases – a group of conditions that includes cardiovascular disease, cancer, mental health problems, diabetes mellitus, chronic respiratory disease, and musculoskeletal conditions – cause more than 85 % of deaths in Europe. These disorders are largely preventable and are linked by common risk factors, underlying determinants and opportunities for intervention. Among these, cancer and cardiovascular diseases are currently by far the most important causes of death in the EU for 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, 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). Although definitions are harmonised, the statistics may not be fully comparable as classifications may vary when the cause of death is multiple or difficult to evaluate and because of different notification procedures. Annual data are provided in absolute numbers, as crude death rates and as standardised death rates.

The **standardised death rate (SDR)** 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. Since most



causes of death vary significantly by age and sex, the use of standardised death rates improves comparability over time and between countries.

### Main findings

The progress made in medical health-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 fell from almost 28 deaths per 1 000 live births in 1965 to 4.7 deaths in 2006. Indeed, as a result of declining infant mortality rates, most of the Member States are now among a group of countries with the lowest infant mortality rates in the world, for example, 1.8 deaths per 1 000 live births in Luxembourg or less than 3 deaths per 1 000 live births in Slovenia, Finland or Sweden. 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.

By far the most important causes of death among men and women in the EU-27 in 2006 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 233 per 100 000, while the corresponding rate for women was 134. The difference in the incidence of death from cancer between the sexes was often particularly high among those Member States that joined the EU since 2004, although France and Spain also recorded considerable disparities.

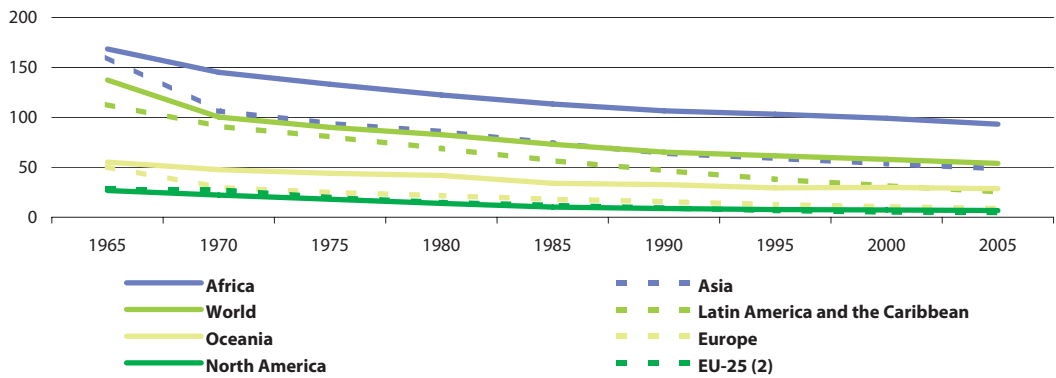
Standardised death rates for ischaemic heart diseases were about twice as high for men (at 132 per 100 000) as for women (68). Heart disease was particularly prevalent among men and women in the Baltic Member States, Slovakia, Hungary and Romania. Indeed, there was a higher incidence of death from heart disease than from cancer in each of these countries across both genders, other than for deaths from cancer among men in Hungary). Those countries reporting the lowest incidence of death from heart disease included France, Spain, Portugal and the Netherlands.

Men reported higher standardised death rates (than women) 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.



**Figure 5.7: Infant mortality (1)**

(per 1 000 live births)

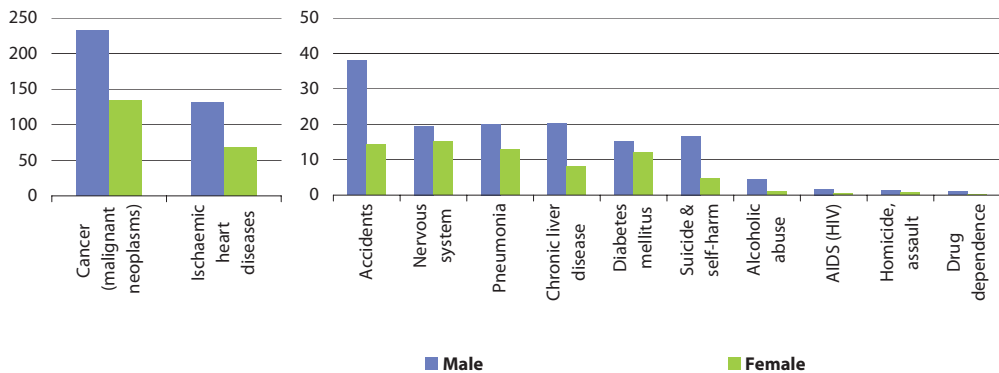


(1) All data (excluding EU-25) are averages of the five-year period up to and including the reference period referred to in the figure.  
 (2) EU-27 for latest period; 2007 instead of 2005.

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

**Figure 5.8: Causes of death - standardised death rate, EU-27, 2006 (1)**

(per 100 000 inhabitants)



(1) Note the differences in the scales employed between the two parts of the figure; the figure is ranked on the average of male and female; EU-27 averages calculated on the basis of the latest year available for each Member State.

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

**Table 5.5: Infant mortality**

(per 1 000 live births)

	1965	1970	1975	1980	1985	1990	1995	2000	2005	2007
<b>EU-27 (1)</b>	28.6	25.5	20.8	15.8	12.8	10.3	7.5	5.9	4.9	4.7
<b>Euro area (1)</b>	28.5	23.8	18.9	12.8	9.7	7.6	5.6	4.6	3.9	3.7
<b>Belgium</b>	23.7	21.1	16.1	12.1	9.8	8.0	6.0	4.8	3.7	4.0
<b>Bulgaria</b>	30.8	27.3	23.1	20.2	15.4	14.8	14.8	13.3	10.4	9.2
<b>Czech Republic</b>	23.7	20.2	19.4	16.9	12.5	10.8	7.7	4.1	3.4	3.1
<b>Denmark</b>	18.7	14.2	10.4	8.4	7.9	7.5	5.1	5.3	4.4	4.0
<b>Germany</b>	24.1	22.5	18.9	12.4	9.1	7.0	5.3	4.4	3.9	3.9
<b>Estonia</b>	20.3	17.7	18.2	17.1	14.1	12.3	14.9	8.4	5.4	5.0
<b>Ireland</b>	25.2	19.5	17.5	11.1	8.8	8.2	6.4	6.2	4.0	3.1
<b>Greece</b>	34.3	29.6	24.0	17.9	14.1	9.7	8.1	5.9	3.8	3.5
<b>Spain</b>	29.4	20.7	18.9	12.3	8.9	7.6	5.5	4.4	3.8	3.7
<b>France (1)</b>	22.4	18.2	13.8	10.0	8.3	7.3	4.9	4.5	3.8	3.8
<b>Italy</b>	35.0	:	20.8	14.6	10.5	8.2	6.2	4.5	:	3.7
<b>Cyprus</b>	32.0	26.0	18.2	14.4	14.4	12.9	9.7	5.6	4.6	3.7
<b>Latvia</b>	18.9	17.7	20.3	15.3	13.0	13.7	18.8	:	7.8	8.7
<b>Lithuania</b>	24.7	19.3	19.6	14.5	14.2	10.2	12.5	8.6	6.8	5.9
<b>Luxembourg</b>	24.0	24.9	14.8	11.5	9.0	7.3	5.5	5.1	2.6	1.8
<b>Hungary</b>	38.8	35.9	32.8	23.2	20.4	14.8	10.7	9.2	6.2	5.9
<b>Malta</b>	34.8	27.9	18.3	15.2	14.5	9.1	8.9	5.9	6.0	6.5
<b>Netherlands</b>	14.4	12.7	10.6	8.6	8.0	7.1	5.5	:	4.9	4.1
<b>Austria</b>	28.3	25.9	20.5	14.3	11.2	7.8	5.4	4.8	4.2	3.7
<b>Poland</b>	41.6	36.4	24.8	25.4	22.1	19.4	13.6	8.1	6.4	6.0
<b>Portugal</b>	64.9	55.5	38.9	24.2	17.8	11.0	7.5	5.5	3.5	3.4
<b>Romania</b>	44.1	49.4	34.7	29.3	25.6	26.9	21.2	18.6	15.0	12.0
<b>Slovenia</b>	29.6	24.5	17.3	15.3	13.0	8.4	5.5	4.9	4.1	2.8
<b>Slovakia</b>	28.5	25.7	23.7	20.9	16.3	12.0	11.0	8.6	7.2	6.1
<b>Finland</b>	17.6	13.2	9.6	7.6	6.3	5.6	3.9	3.8	3.0	2.7
<b>Sweden</b>	13.3	11.0	8.6	6.9	6.8	6.0	4.1	3.4	2.4	2.5
<b>United Kingdom (2)</b>	19.6	18.5	18.9	13.9	11.1	7.9	6.2	5.6	5.1	4.9
<b>Croatia</b>	49.5	34.2	23.0	20.6	16.6	10.7	8.9	7.4	5.7	5.6
<b>FYR of Macedonia</b>	105.8	87.9	65.1	54.2	43.4	31.6	22.7	11.8	12.8	10.3
<b>Turkey</b>	:	:	:	:	:	:	:	28.9	23.6	21.7
<b>Iceland</b>	15.0	13.2	12.5	7.7	5.7	5.9	6.1	3.0	2.3	2.0
<b>Liechtenstein</b>	22.8	11.8	6.5	7.6	10.7	:	:	:	2.6	0.0
<b>Norway</b>	14.6	11.3	9.5	8.1	8.5	6.9	4.0	3.8	3.1	3.1
<b>Switzerland</b>	17.8	15.1	10.7	9.1	6.9	6.8	5.0	4.9	4.2	3.9

(1) 2006 instead of 2007. France: including overseas departments starting with 2000.

(2) 2006 instead of 2007.

Source: Eurostat (demo\_minfind)

**Table 5.6:** Causes of death - standardised death rate, 2006 (1)

(per 100 000 inhabitants)

	Heart Cancer disease (2)	Nervous system (3)	Pneu- monia	Chronic liver disease	Diabetes mellitus	Sui- cide (4)	Homi- cide, Alc. abuse assault	AIDS (HIV)	Drug depen- dence			
<b>EU-27 (5)</b>	175.6	96.2	17.1	15.7	13.8	13.6	25.8	10.4	2.7	1.0	1.1	0.6
<b>Belgium</b>	:	:	:	:	:	:	:	:	:	:	:	:
<b>Bulgaria</b>	168.3	147.9	8.8	16.5	15.9	18.7	30.2	10.5	0.5	1.7	0.0	0.0
<b>Czech Republic</b>	212.5	168.8	15.7	22.7	15.9	10.7	32.5	12.2	1.8	1.0	0.0	0.0
<b>Denmark</b>	:	:	:	:	:	:	:	:	:	:	:	:
<b>Germany</b>	165.0	97.9	14.2	13.3	14.2	15.1	17.1	9.8	4.7	0.6	0.6	0.8
<b>Estonia</b>	198.9	253.3	17.4	10.7	22.0	12.8	75.5	16.2	9.9	7.1	3.6	0.1
<b>Ireland</b>	180.2	103.4	15.0	38.0	5.8	10.9	17.8	9.1	2.1	0.8	0.1	2.0
<b>Greece</b>	154.7	76.3	7.5	4.9	5.4	7.2	26.7	3.1	0.2	0.8	0.2	0.0
<b>Spain</b>	158.3	51.9	20.6	9.9	9.0	12.5	21.7	6.2	0.6	0.8	2.7	0.2
<b>France</b>	176.1	40.4	25.4	10.2	11.2	11.7	29.6	15.8	4.7	0.8	1.4	0.3
<b>Italy</b>	:	:	:	:	:	:	:	:	:	:	:	:
<b>Cyprus</b>	116.4	79.4	14.0	10.4	4.7	36.5	28.4	2.4	0.4	1.7	0.2	0.7
<b>Latvia</b>	199.7	279.4	13.5	20.4	17.8	8.9	94.9	19.3	3.4	9.1	1.3	0.0
<b>Lithuania</b>	195.4	347.2	14.9	17.3	35.1	8.0	99.4	28.9	0.9	7.3	0.2	0.5
<b>Luxembourg</b>	162.2	67.1	22.8	14.0	11.3	7.6	29.0	9.9	4.5	1.5	0.2	0.4
<b>Hungary</b>	239.9	240.7	12.5	5.1	44.7	21.9	39.9	21.8	4.5	1.9	0.0	0.0
<b>Malta</b>	145.3	149.5	18.1	14.7	6.4	22.1	19.9	4.2	0.4	0.5	0.3	:
<b>Netherlands</b>	186.5	54.3	16.8	22.1	4.2	15.0	15.2	8.7	1.1	0.8	0.3	0.1
<b>Austria</b>	161.9	107.7	15.5	9.3	14.7	26.9	23.4	13.4	3.6	0.8	0.5	2.5
<b>Poland</b>	210.1	111.2	10.9	19.6	15.4	13.1	38.1	14.3	4.6	1.4	0.3	0.0
<b>Portugal</b>	156.0	53.4	15.9	27.5	12.2	27.2	19.9	7.2	0.8	1.3	7.8	0.1
<b>Romania</b>	179.8	213.2	7.9	24.8	39.7	7.9	40.8	11.9	2.2	2.1	0.9	0.0
<b>Slovenia</b>	197.8	68.0	8.8	23.4	23.9	13.4	36.7	22.8	3.0	0.6	0.1	0.1
<b>Slovakia</b>	203.5	248.4	11.9	31.8	25.8	12.3	37.6	9.4	:	1.5	0.0	0.0
<b>Finland</b>	140.5	136.7	36.6	7.2	17.2	6.3	46.1	19.0	2.9	1.9	0.2	0.1
<b>Sweden</b>	152.3	98.4	17.8	10.1	5.6	11.9	20.7	12.0	2.8	0.9	0.2	0.2
<b>United Kingdom</b>	185.2	128.6	18.1	33.5	10.0	7.7	16.5	6.6	1.5	0.4	0.3	1.9
<b>Croatia</b>	209.8	159.6	11.2	18.8	21.7	17.2	35.2	15.5	3.9	1.7	0.2	0.4
<b>FYR of Macedonia</b>	169.5	107.0	7.1	4.5	7.5	36.3	22.3	8.3	0.6	2.5	0.1	0.1
<b>Iceland</b>	159.3	92.3	36.0	14.5	4.0	5.6	19.9	11.5	1.2	1.0	0.3	0.3
<b>Norway</b>	161.9	75.4	19.1	19.1	3.2	10.7	28.6	11.2	3.7	1.0	0.3	0.5
<b>Switzerland</b>	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) France, Luxembourg, Malta, Portugal, the United Kingdom and Switzerland, 2005; Iceland, 2005 except for AIDS (HIV), 2004; Slovenia, 2005 for AIDS (HIV); Estonia and Romania, 2005 for drug dependence; Slovakia, 2004 for drug dependence.

(2) Malignant neoplasms.

(3) Ischaemic heart diseases.

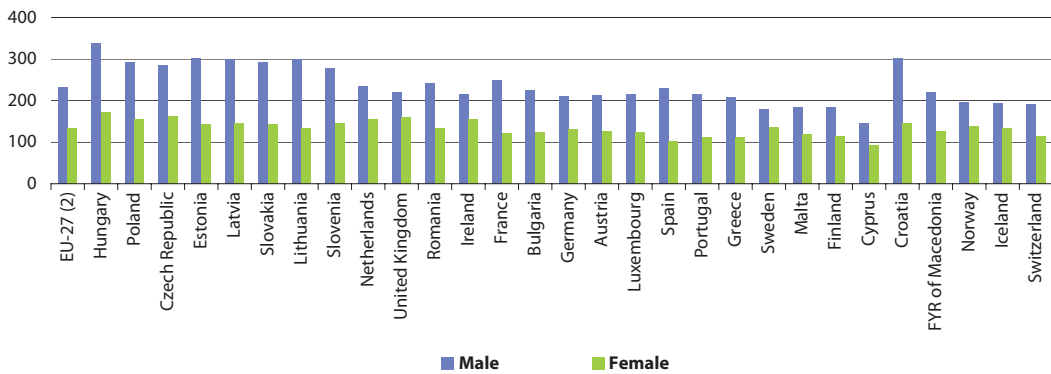
(4) Suicide and intentional self-harm.

(5) Average calculated on the basis of the latest year available for each Member State.

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



**Figure 5.9: Deaths from cancer (malignant neoplasms) - standardised death rate, 2006 (1)**  
(per 100 000 inhabitants)

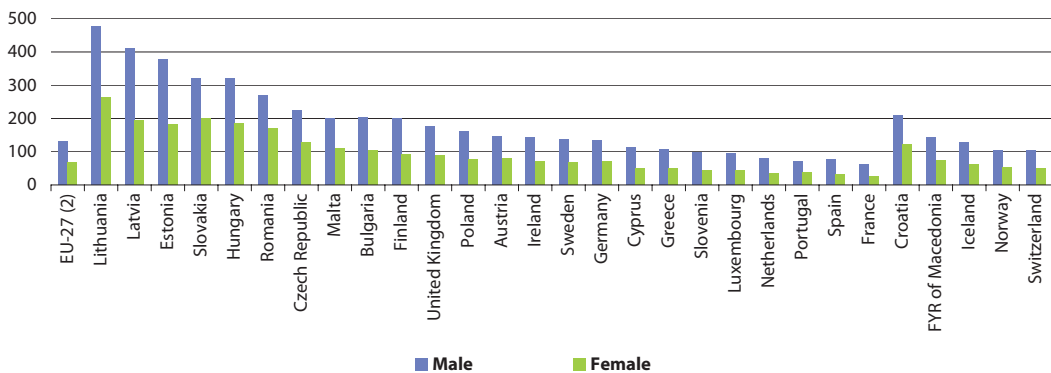


(1) France, Luxembourg, Malta, Portugal, the United Kingdom, Iceland and Switzerland, 2005; Belgium, Denmark and Italy, not available; the figure is ranked on the average of male and female.

(2) Average calculated on the basis of the latest year available for each Member State.

Source: Eurostat (tps00116)

**Figure 5.10: Deaths from ischaemic heart diseases - standardised death rate, 2006 (1)**  
(per 100 000 inhabitants)



(1) France, Luxembourg, Malta, Portugal, the United Kingdom, Iceland and Switzerland, 2005; Belgium, Denmark and Italy, not available; the figure is ranked on the average of male and female.

(2) Average calculated on the basis of the latest year available for each Member State.

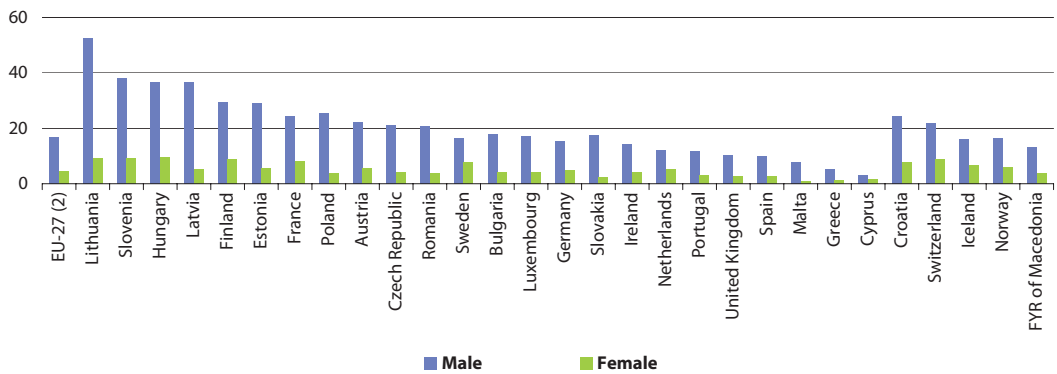
Source: Eurostat (tps00119)





**Figure 5.11: Deaths from suicide - standardised death rate, 2006 (1)**

(per 100 000 inhabitants)



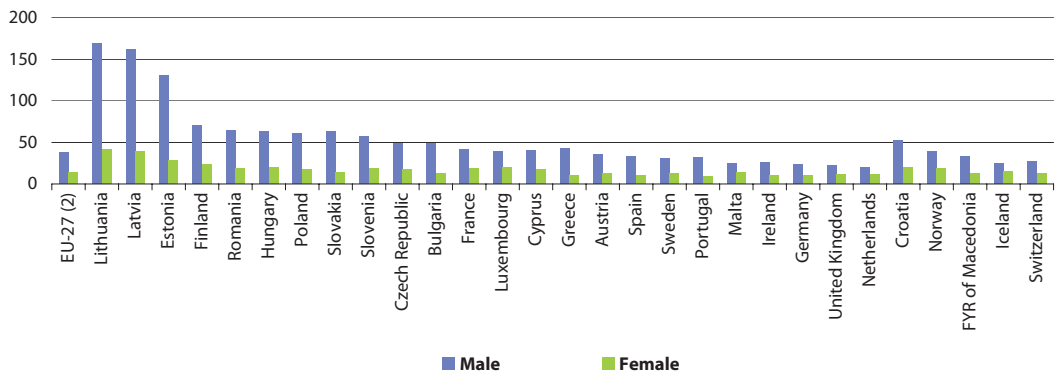
(1) France, Luxembourg, Malta, Portugal, the United Kingdom, Iceland and Switzerland, 2005; Belgium, Denmark and Italy, not available; the figure is ranked on the average of male and female.

(2) Average calculated on the basis of the latest year available for each Member State.

Source: Eurostat (tps00122)

**Figure 5.12: Deaths from accidents - standardised death rate, 2006 (1)**

(per 100 000 inhabitants)



(1) France, Luxembourg, Malta, Portugal, the United Kingdom, Iceland and Switzerland, 2005; Belgium, Denmark and Italy, not available; the figure is ranked on the average of male and female.

(2) Average calculated on the basis of the latest year available for each Member State.

Source: Eurostat (tps00125)



## 5.5 Safety at work

### Introduction

Working conditions change over time. 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. Many aspects of work have the potential to bring about illness (or death) and these are not restricted to safety issues and accidents. Rather, health and safety in the workplace has been redefined in order to take account of the move from traditional, industrial, heavy industries, to focus on the modern-day world of work, which is characterised more by issues such as stress and psychological risks, musculoskeletal disorders, noise, or the abuse of tobacco, alcohol, or dangerous substances related to work.

Health at work 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<sup>(6)</sup>. The adoption and application in recent decades of a large body of Community laws has improved working conditions in the Member States and reduced the incidence of work-related accidents and illnesses. The new strategy for 2007-2012 aims for a 25 % reduction in the total incidence rate of accidents at work by 2012 in the EU-27, which as well as having direct effects on employees, will also play a role in contributing towards the success of the Growth and Jobs Strategy.

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 presented in numbers or as incidence rates. **Incidence rates** are calculated as follows: (number of persons involved in (fatal) accidents at work / number of persons in employment in the reference population) x 100 000.

(6) 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); [http://eur-lex.europa.eu/LexUriServ/site/en/oj/2002/c\\_161/c\\_16120020705en00010004.pdf](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); [http://eur-lex.europa.eu/LexUriServ/site/en/oj/2007/c\\_145/c\\_14520070630en00010004.pdf](http://eur-lex.europa.eu/LexUriServ/site/en/oj/2007/c_145/c_14520070630en00010004.pdf).



The data on **serious 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. The information presented 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

The European Agency for Safety and Health at Work<sup>(7)</sup> is located in Bilbao, Spain. It claims that every three and a half minutes, somebody in the EU dies from work-related causes, which equates to more than 150 000 deaths a year.

In recent years the incidence rate of serious accidents at work has fallen, such that by 2005 it had decreased by 22 % in relation to 1998 for the EU-27. During the same period there was a 24 % reduction in fatal accidents at work in the EU-27.

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 2005 when compared with 1998: Estonia (26 % higher), Lithuania (4 % higher) and Ireland (1 % higher). At the other end of the scale, the incidence of serious accidents in Bulgaria, Greece and Romania 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 (33 % increase), Sweden (31 % increase), Slovenia (28 % increase) and Ireland (17 % increase). Greece, Malta and France each reduced their incidence of fatal accidents at work by at least half over the period considered.

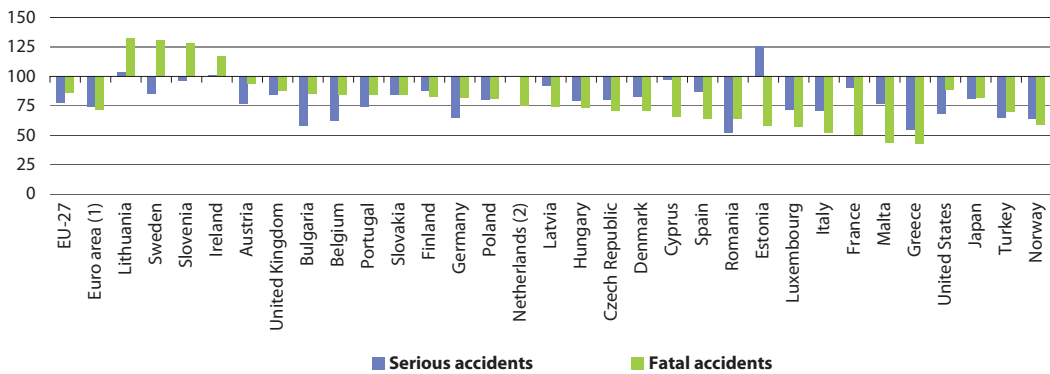
In absolute terms the highest incidence of serious and fatal accidents at work was recorded within the construction sector, with agriculture and transport also recording relatively high values. Men are considerably more likely to have an accident or to die at work. This is due, at least in part, to a 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. For example, the incidence of serious accidents for men fell by 19 % between 1998 and 2005, while the corresponding reduction for women was 15 %.

(7) <http://osha.europa.eu/en>.



**Figure 5.13: Incidence of accidents at work, 2005**

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



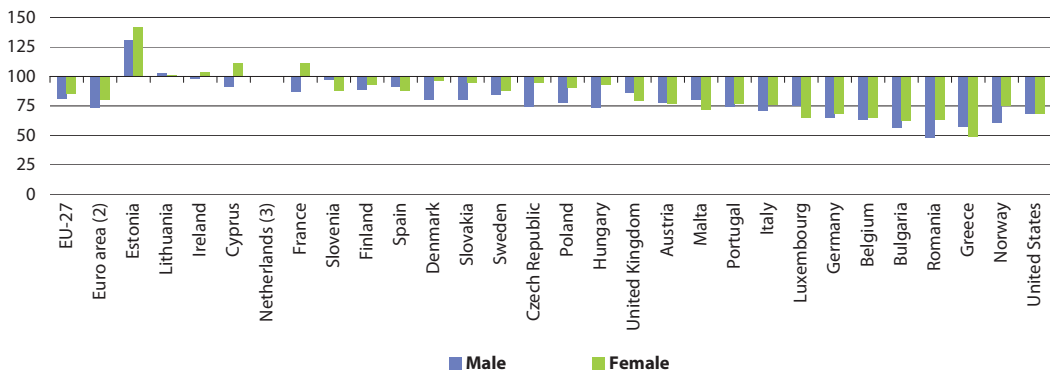
(1) EA-12 instead of EA-15.

(2) Break in series for serious accidents (re-based, 2005=100).

Source: Eurostat (tsiem090 and tsiem100)

**Figure 5.14: Incidence of serious accidents at work, by gender, 2005 (1)**

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



(1) Latvia, not available; the figure is ranked on the average of male and female.

(2) EA-12 instead of EA-15, estimates.

(3) Break in series for serious accidents (re-based, 2005=100).

Source: Eurostat (tsiem090)