Health is an important priority for Europeans, who expect to be protected against illness and accident and to receive appropriate healthcare services. In the coming decades, population ageing is likely to be a major challenge for the European Union’s (EU’s) health sector: indeed, the demand for healthcare will probably increase at a rapid pace, while the ageing population could result in staff shortages for certain medical specialisations or in specific geographic regions. According to the Directorate-General for Health and Food Safety, more than 60 thousand doctors (or 3.2 % of the EU-28 workforce) are expected to retire/leave the profession each year during the period up to 2020.

This article presents recent statistics on health for the regions of the EU, providing information concerning some of the most common causes of death. It also looks at healthcare services through an analysis of the number of hospital beds and healthcare professionals (physicians) and concludes with information on people with unmet healthcare needs and people's perceptions of their own health.

Health systems across the EU are organised, financed and managed in very different ways and the competence for the delivery of these services largely resides with the 28 individual EU Member States. Indeed, EU health policy is designed to complement national strategies by pooling resources and assisting Member States to tackle common challenges. The EU’s main policy objectives include: improving access to healthcare for all through effective, accessible and resilient health systems, fostering health coverage as a way of reducing inequalities and tackling social exclusion; promoting health information and education, healthier lifestyles and
individual well-being; investing in health through disease prevention, for example, through the creation of specialised centres of expertise for health experts, European reference networks (ERNs); preventing cross-border threats such as pandemics; improving safety standards for patients, pharmaceuticals/drugs and medical devices; guaranteeing/recognising prescriptions in other Member States.

The EU may adopt health legislation when this concerns the protection of public health, the approximation of laws, or social policy. Some areas where the EU has done so include: providing a legal framework for guaranteeing medicinal/pharmaceutical products; regulating tobacco products and creating smoke-free environments; or providing standards for the exchange of human organs between EU Member States. On a more practical level, the European health insurance card (EHIC) allows travellers from one EU Member State to obtain medical treatment if they fall ill whilst temporarily visiting another Member State or EFTA country. The EU has also introduced legislation on the application of patients’ rights in cross-border healthcare (Directive 2011/24/EU) which allows patients to go abroad for treatment when this is either necessary (specialist treatment is only available abroad) or easier (if the nearest hospital is just across a border). The European Centre for Disease Prevention and Control in Sweden is an EU agency that provides surveillance of emerging health threats so that the EU can respond rapidly. It pools knowledge on current and emerging threats, and works with national counterparts to develop disease monitoring across Europe, strengthening the EU’s defences against infectious diseases. The European Medicines Agency (EMA), which is in the process of relocating to Amsterdam (the Netherlands), helps national regulators by coordinating scientific assessments concerning the quality, safety and efficacy of medicines that are used across the EU. All medicines in the EU must be approved national or for the EU before being placed on the market. The safety of pharmaceuticals that are sold in the EU is monitored throughout a product’s life cycle and individual products may be banned, or their sales/marketing suspended.

Causes of death

Many factors determine mortality patterns, for example, age, sex, living/working conditions and the surrounding environment. Each individual may also influence their chances of leading a long and healthy life by adapting their lifestyle choices concerning, for example, exercise, diet, alcohol consumption, smoking or driving behaviour.

In 2016, there were 5.13 million deaths in the EU-28: this was somewhat lower than a year before, as the total number of deaths fell by approximately 92 thousand. This pattern was repeated in a majority (19) of the EU Member States, with the number of deaths falling at a particularly rapid pace in Cyprus (-6.6 %), Italy (-5.0 %) and Croatia (-4.9 %). By contrast, the total number of deaths rose by 1.0-2.0 % in Estonia, the Netherlands, Ireland and Portugal, while the highest increase was recorded in Finland (2.7 %).
Statistics on causes of death

The medical certification of death is an obligation in all EU Member States. Causes of death statistics are based on two pillars: medical information on death certificates, which may be used as a basis for ascertaining the cause of death; and the coding of causes of death following the International Statistical Classification of Diseases and Related Health Problems (ICD).

Statistics on causes of death provide information about diseases (and other eventualities, such as suicide or transport accidents) that lead directly to death; they can be used to help plan health services. These statistics refer to the underlying disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of an accident or an act of violence which produced a fatal injury, classified according to one of 86 different causes, as defined by the European shortlist for causes of death (2012).

In Maps 1 and 2 and Figure 1, statistics on causes of death are presented as standardised death rates. Crude death rates are compiled by calculating a simple ratio of the number of deaths compared with the number of inhabitants; such rates are strongly influenced by differences in age structures between regions, as elderly persons are more likely to die (than younger persons) or catch/contract a specific illness/disease. Standardised death rates are regarded as being more comparable (for example, across countries/regions or over time) as age-specific mortality rates are adjusted to reflect the structure of a standard population (a hypothetical population for the EU and EFTA countries). The use of standardised rates allows statisticians to control for different age distributions across populations or over time and allows subgroups or regions with different age structures to be compared. Regional standardised death rates are provided in the form of three-year averages, in order to smooth out some of the relatively large fluctuations that might occur from one year to the next.

The most recent mortality statistics by cause of death are available for 2015 when there were 5.21 million deaths in the EU-28. The four leading causes of death were: diseases of the circulatory system (1.9 million deaths); cancer (1.3 million); diseases of the respiratory system (442 thousand); and external causes of morbidity and mortality (238 thousand), the latter includes, among others, intentional self-harm, falls and transport accidents.

During the three-year period covering 2013 to 2015, the EU-28 standardised death rate was 1 023 deaths per 100 000 inhabitants. Bulgaria, Romania and Latvia were the only EU Member States where the standardised death rate was above 1 500 deaths per 100 000 inhabitants, while Italy, Spain and France were the only Member States where this rate was below 900 deaths per 100 000 inhabitants.

During the period 2013 to 2015, the standardised death rates for the most common causes of death in the EU-28 were 380.9 per 100 000 inhabitants for diseases of the circulatory system, 261.7 per 100 000 inhabitants for cancer, 83.5 per 100 000 inhabitants for diseases of the respiratory system and 46.2 per 100 000 inhabitants for external causes of morbidity and mortality.

Chronic diseases

Chronic diseases are the leading cause of disability and death in the EU: for the purpose of this publication they are defined as cancers (more detailed information is provided below), diabetes mellitus, ischaemic heart diseases, cerebrovascular diseases, chronic lower respiratory diseases and chronic liver diseases. This broad range of medical conditions accounted for more than half of all deaths in the EU-28 during the period 2013 to 2015, with a combined death rate of 548.8 deaths per 100 000 inhabitants.

Deaths from chronic diseases were concentrated in eastern Europe and the Baltic Member States

Map 1 shows that the highest standardised death rates from chronic diseases were recorded in eastern Europe and the Baltic Member States, although both regions in Slovenia and all but two regions in Poland — Pomorskie and Ślaskie — had lower death rates. There were, in total, 44 NUTS level 2 regions in the EU where the standardised death rate from chronic diseases was greater than 650 deaths per 100 000 inhabitants (as shown by the darkest shade in Map 1), including also two German regions — Sachsen-Anhalt and Saarland — and a single region from the United Kingdom — South Western Scotland. A more detailed analysis reveals that there were 11 regions in the EU where the standardised death rate from chronic diseases was higher than 1 000 per 100 000 inhabitants (or 1.0 % of the population), including all but one of the regions in Hungary — the exception being the capital city region of Közép-Magyarország; three regions in Romania — Nord-Vest, Centru and Sud-Vest Oltenia; Latvia and Lithuania (both single regions at this level of detail).
The highest standardised death rate for chronic diseases among NUTS level 2 regions was recorded in the northern Hungarian region of Észak-Magyarország, at 1 168.6 per 100 000 inhabitants. By contrast, the lowest standardised death rate was recorded in the French outermost region of Guadeloupe, at 314.1 deaths per 100 000 inhabitants; as such a person living in Észak-Magyarország was 3.7 times as likely to die from a chronic disease as someone living in Guadeloupe.

More generally, the lowest standardised death rates from chronic diseases were almost exclusively recorded in French regions. Of the 17 regions in the EU-28 where this rate was less than 400 deaths per 100 000 inhabitants, the only region from outside France was the Spanish capital city region of Comunidad de Madrid. The second lowest standardised death rate for chronic diseases was in Île de France, the French capital city region. People living in capital city regions may benefit from rapid access to emergency care and the availability of a wide variety of specialists. By contrast, the regions in the EU with the highest death rates from chronic diseases were often characterised as traditional, industrial regions, where, among others, environmental concerns and a high share of manual work had the potential to impact on an individual’s health.
Standardised death rates from chronic diseases, by NUTS 2 regions, 2013-2015
(per 100 000 inhabitants)

Note: information shown for a three-year average. Chronic diseases are defined as cancer (malignant neoplasms), diabetes mellitus, ischaemic heart diseases, cerebrovascular diseases, chronic lower respiratory diseases and chronic liver diseases. Serbia: national data. Thessalia (EL61): 2011-2013. Liechtenstein: excludes diabetes mellitus.
Source: Eurostat (online data code: hlth_cd_yhdr2)

Map 1: Standardised death rates from chronic diseases, by NUTS 2 regions, 2013-2015 (per 100 000 inhabitants)
Source: Eurostat (hlth_cd_yhdr2)
Cancers

Although significant advances have been made in the fight against cancer, it remains a key public health concern and a considerable burden on society. In 2015, there were 1.32 million people in the EU-28 that died from cancer, which equated to just over one quarter (25.4%) of all deaths; this figure was higher than the number of deaths attributed to ischaemic heart diseases or cerebrovascular diseases.

All seven Hungarian regions featured among the top 10 regions in the EU with the highest standardised death rates from cancer

The EU-28 standardised death rate from cancer averaged 261.7 deaths per 100 000 inhabitants during the period 2013 to 2015. As for chronic diseases, Map 2 shows a relatively clear east-west split in terms of death rates from cancer across the different regions of the EU, although this was less pronounced. The highest standardised death rates from cancer — above 300 deaths per 100 000 inhabitants (as shown by the darkest shade) — were concentrated in Croatia (both regions), Hungary (all seven regions), Poland (half of its 16 regions), Slovenia (both regions), Slovakia (all four regions) and the United Kingdom (eight regions in northern England or Scotland). The remainder of the 36 regions with the highest death rates was composed of single regions from each of the Czech Republic, Denmark, the Netherlands, Portugal and Romania. The south-western Hungarian region of Dél-Dunántúl had the highest standardised death rate from cancer among NUTS level 2 regions, averaging 367.0 deaths per 100 000 inhabitants during the period 2013 to 2015. The six other Hungarian regions were also present among the ranking of the top 10 regions in the EU with the highest death rates, where they were joined by Kontinentálna Hrvatska (inland Croatia), South Western Scotland (the United Kingdom) and Západné Slovensko (western Slovakia).

The French outermost regions of Guyane and Guadeloupe (both 174 deaths per 100 000 inhabitants) were the only regions in the EU to report standardised death rates from cancer below 200.0 deaths per 100 000 inhabitants for the period covering 2013 to 2015. The next lowest death rates were recorded in: Cyprus (a single region at this level of detail); the southern Italian regions of Molise, Calabria, Abruzzo and Basilicata; another outermost French region, Martinique; Pohjois- ja Itä-Suomi (northern and eastern Finland); and the Spanish capital city region of Comunidad de Madrid.
Standardised death rates from cancer (malignant neoplasms), by NUTS 2 regions, 2013-2015 (per 100 000 inhabitants)

EU-28 = 261.7

- < 225
- 225 - < 250
- 250 - < 275
- 275 - < 300
- ≥ 300
- Data not available

Source: Eurostat (online data code: hlth_cd_ysd2)
Suicide

External causes of mortality were the fourth most common cause of death in the EU-28 during the period 2013 to 2015. This heading is composed of a number of different causes of death, including intentional self-harm — hereafter referred to as suicide — falls or (transport) accidents. Suicide is defined as a deliberate attempt to kill oneself: the statistics presented therefore relate only to the situations where the outcome was fatal, excluding failed attempts to commit suicide or other non-fatal forms of self-harm.

There is a considerable gender gap for suicide in the EU-28: during the period 2013 to 2015, the standardised death rate for men (18.5 deaths per 100 000 male inhabitants) was almost four times as high as that for women (4.9 deaths per 100 000 female inhabitants). Such differences may, at least in part, be attributed to the likelihood of success from the chosen suicide method with men often choosing more impulsive (and deadly) methods, such that, in keeping with other external causes of death, they are over-represented in terms of deaths from violent or criminal behaviour, drug use or extreme sports. This gender gap was repeated in each of the EU Member States and was most pronounced in eastern Europe, where standardised death rates from suicide for men in Romania, Slovakia and Poland were six or seven times as high as those for women; this was also the case in Malta.

Across EU regions, Lithuania recorded the highest standardised death rate from suicide for men and the fifth highest rate for women

Figure 1 identifies those NUTS level 2 regions with the highest and lowest standardised death rates from suicide. Lithuania (a single region at this level of detail) had the highest rate among men (60.5 deaths per 100 000 male inhabitants), more than three times as high as the EU-28 average. The next highest male death rates were recorded in: two neighbouring, rural Hungarian regions — Észak-Alföld and Dél-Alföld; Lubuskie (western Poland); Vzhodna Slovenija (eastern Slovenia); and two neighbouring, rural regions in France — Basse-Normandie and Bretagne. Lithuania also featured among the 10 regions with the highest female standardised death rates from suicide, in fifth position. Relatively high female death rates were recorded in: Dél-Alföld (also present in the ranking for men); and in three Belgian regions — Prov. West-Vlaanderen, Prov. Liège and Prov. Namur, where the highest female rate was recorded, at 14.6 deaths per 100 000 female inhabitants.
Healthcare

Maps 3 and 4 present indicators related to healthcare provision, the first concerning access to hospital beds and the second access to doctors/physicians. These two maps reflect country-specific ways of organising health care and the types of service provided to patients.

Hospital beds

For many years, the number of hospital beds available across the EU has decreased: this may be linked to changes in healthcare policies in a majority of the EU Member States, whereby the average length of hospital stays has been reduced by the introduction of new treatments and less-invasive forms of surgery, some of which may be delivered through ambulatory (out-patient) care.

Hospital beds are defined as those which are regularly maintained and staffed and immediately available for the care of patients admitted to hospitals; these statistics cover beds in general and speciality hospitals. There were 2.62 million hospital beds in the EU-28 in 2015, which meant that the total number of beds had fallen overall by 9.5% during the most recent 10-year period for which data are available.

Aside from Berlin, some of the highest numbers of hospital beds relative to population size were recorded in Germany

The average number of hospital beds in the EU-28, relative to population size, fell by 69 beds per 100 000 inhabitants between 2005 and 2015, such that there were on average 515 hospital beds per 100 000 inhabitants in 2015. Map 3 provides confirmation of the very high density of hospital beds in almost all German regions (as shown by the darkest shade in the map). Indeed, the capital city region of Berlin was the only one among the 16 NUTS level 1 regions in Germany to record less than 700 hospital beds per 100 000 inhabitants. The highest ratio was recorded in the northern German region of Mecklenburg-Vorpommern — a predominantly
rural area with a low level of population density — with just over 1 300 hospital beds per 100 000 inhabitants. There were only three other regions in the EU that recorded ratios in excess of one hospital bed per 1 000 inhabitants, they were: the eastern German (NUTS level 1) region of Thüringen; the Romanian capital city region of Bucuresti - Ilfov; and the northern Polish region of Zachodniopomorskie, which shares a border with Mecklenburg-Vorpommern.

There were 17 regions in the EU where there were fewer than 250 hospital beds per 100 000 inhabitants (as shown by the lightest shade in the map). These regions were distributed as follows: five regions from Spain; five regions from Sweden (including the capital city region of Stockholm); three regions from Denmark (including the capital city region of Hovedstaden); two regions from Portugal; and single regions from each of Ireland and Italy. Aside from the atypical Spanish regions of Ciudad Autónoma de Melilla and Ciudad Autónoma de Ceuta, the lowest ratios were recorded in the southern regions of Calabria in Italy (210.3 beds per 100 000 inhabitants), Alentejo in Portugal (217.2 beds per 100 000 inhabitants) and Andalucía in Spain (220.1 beds per 100 000 inhabitants).

It is interesting to contrast the ratio of hospital beds relative to population size for capital city regions with other regions, looking across the EU Member States. For example, in the eastern Member States of the Czech Republic, Hungary and Romania, the capital city region had (one of) the highest ratios, whereas in many western and northern Member States, it was more commonplace to find capital city regions recording relatively low ratios, whereas the highest numbers of beds per inhabitant were usually recorded in rural, sparsely populated regions (perhaps reflecting a higher level of availability in these regions to counteract the considerable distances that some people may need to travel in order to receive treatment) and the lack of economies of scale available in large, densely populated urban areas.
Number of hospital beds relative to population size, by NUTS 2 regions, 2015
(number per 100 000 inhabitants)

Source: Eurostat (online data codes: hlth_rs_bdsrg and hlth_rs_bds)

Map 3: Number of hospital beds relative to population size, by NUTS 2 regions, 2015(number per 100 000 inhabitants)Source: Eurostat (hlth_rs_bdsrg) and (hlth_rs_bds)
Numbers of physicians

Physicians or (medical) doctors have a degree in medicine and provide services directly to patients as consumers of healthcare. In the context of comparing health care services across EU Member States, Eurostat gives preference to the concept of practising physicians, although data are only available for professionally active (Greece, Slovakia and Finland, as well as the former Yugoslav Republic of Macedonia, Serbia and Turkey) or licensed physicians (Portugal) in some countries.

In 2015, there were 1.81 million physicians in the EU-28, which equated to 356 per 100,000 inhabitants. Map 4 shows that the highest ratios of physicians relative to population size were often recorded in capital city regions, where it is likely that specialist practitioners are concentrated. The four highest regional ratios were in the Greek, Czech, Austrian and Slovak capital city regions of Attiki, Praha (2013 data), Wien and Bratislavský kraj (2014 data), while Área Metropolitana de Lisboa (Portugal), Bucuresti - Ilfov (Romania) and Berlin (Germany; note that the information presented is for NUTS level 1) were also among the 17 regions in the EU where there were in excess of 500 (practising) physicians per 100,000 inhabitants.

1 A practising physician provides services directly to patients — these may include: conducting medical examinations and making diagnoses; prescribing medication and treating diagnosed illnesses, disorders or injuries; giving specialised medical or surgical treatment for particular illnesses, disorders or injuries; giving advice on and applying preventive medical methods and treatments. A professionally active physician is a practising physician or any other physician for whom medical education is a prerequisite for the execution of the job (for example, verifying medical absences from work, drug testing, medical research). A licensed physician is a physician licensed to practise; this category includes practising physicians, professionally active physicians, as well as any other registered physicians who are entitled to practise as healthcare professionals.
Map 4: Number of (practising) physicians relative to population size, by NUTS 2 regions, 2015 (number per 100 000 inhabitants)

Source: Eurostat (online data code: hlth_rs_prsrg)
Unmet needs for healthcare

There are a variety of reasons why an individual may claim that their need for medical care remains unmet. These include, among others: cost (services are considered too expensive); distance (too far to travel to a clinic or hospital); timeliness (waiting lists); or a lack of cultural sensitivity/discrimination. These issues have the potential to restrict an individual’s access to healthcare services and impinge upon their quality of life, well-being and social participation, as well as influencing socioeconomic developments at a more aggregated level.

In 2016, the proportion of the EU-28 adult population with unmet needs for healthcare — due to it being too expensive; too far to travel; or because of waiting lists — was 2.5 %. An analysis by degree of urbanisation (see Figure 2) reveals that this share was slightly higher in rural areas (3.0 %) than it was in either towns and suburbs (2.4 %) or cities (2.3 %).

The proportion of people aged 16 and over with unmet needs for healthcare was below the EU-28 average in a majority of the EU Member States and fell as low as 0.2 % in both the Netherlands and Austria. However, there was a considerable degree of variation among the remaining Member States, with the share of people having unmet needs for healthcare more than twice as high as the EU-28 average in Italy, Romania and Poland, more than three times as high in Latvia, more than five times as high in Greece, peaking at more than six times as high in Estonia.

An analysis by degree of urbanisation for 2016 reveals that the share of people with unmet needs for healthcare was particularly high for people living in the cities of Estonia; this was also the case in Luxembourg, Cyprus, the Netherlands and Sweden. By contrast, in Romania, Bulgaria and Croatia, a much higher share of the adult population living in rural areas had unmet needs for healthcare; this pattern was repeated in Portugal and Spain, where the share of people living in rural areas with unmet needs for healthcare was particularly high relative to the equivalent share for people living in cities.

Figure 2: Proportion of people with unmet needs for healthcare, by degree of urbanisation, 2016(% share of population aged 16 and over)Source: Eurostat (hlth_silc_21)

Note: ranked by cities. Unmet needs for healthcare due to it being too expensive, too far to travel, or because of waiting lists.

E.2016
Source: Eurostat (online data code: hlth_silc_21)
Self-perceived health status

Figure 3 provides an alternative analysis by degree of urbanisation, detailing the proportion of the adult population who declared their self-perceived health as good or very good. Across the EU-28, more than two thirds (67.5%) of the population aged 16 and over perceived their own health as good or very good in 2016. Looking in more detail, this share was higher across the EU-28 for people living in cities (69.3%) than it was for people living in towns and suburbs (67.7%) or rural areas (64.7%).

In a majority (18) of the EU Member States, a higher proportion of people living in cities (rather than people living in towns and suburbs or rural areas) perceived their own health as good or very good. By contrast, in Ireland, the Netherlands, Malta and the United Kingdom, people living in rural areas were more likely to perceive their own health as good or very good.

It should be noted that (self-perceived) health status is quite strongly related to age, and so the analysis of health status by degree of urbanisation may reflect differences in the age structure by degree of urbanisation.

Figure 3: Proportion of people who perceive their own health as good or very good, by degree of urbanisation, 2016 (% share of population aged 16 and over)

Source: Eurostat (hlth_silc_18)

Source data for figures and maps

- Health at regional level

Data sources

Since reference year 2011, data for causes of death have been provided under a specific legal basis, Regulation (EC) No 1338/2008 of the European Parliament and of the Council of 16 December 2008 on Community statistics on public health and health and safety at work and implementing Regulation (EU) No 328/2011 of 5 April 2011 on Community statistics on public health and health and safety at work, as regards statistics on causes of death. The information presented on causes of death relates to standardised death rates, averaged over the
three-year period of 2013-2015.

For more information:

Causes of death

Non-expenditure healthcare data, shown here for hospital beds and the number of physicians, are submitted to Eurostat on the basis of a gentlemen’s agreement, as there is currently no implementing legislation covering statistics on healthcare resources as specified within Regulation (EC) No 1338/2008. These data are mainly based on national administrative sources and therefore reflect country-specific ways of organising healthcare and may not always be completely comparable; a few countries compile their statistics from surveys.

For more information:

Non-expenditure healthcare data

The data presented for unmet needs for medical care and for the proportion of people who perceive their own health as good or very good are derived from EU statistics on income and living conditions (EU-SILC); this is an annual source which is the reference source for comparative statistics on income distribution and social inclusion in the EU. The information presented refers to the adult population (aged 16 years and over) who are living in private households.

For more information:

EU statistics on income and living conditions (EU-SILC) methodology - self-reported health

Context

As well as being a value in itself, health is a precondition for economic prosperity. Efficient and smart spending on health can promote economic growth through more sustainable health systems, health promotion programmes, or investments to break the cycle of poor health contributing to and resulting from inequalities, poverty and social exclusion. By doing so, Investing in health (SWD(2013) 43 final) may contribute towards the Europe 2020 objectives of ‘smart, sustainable and inclusive growth’.

The European Commission works with EU Member States using an open method of coordination for health issues, a voluntary process based on agreeing common objectives and helping national authorities cooperate. At an EU level, policy actions generally fall under the remit of the Directorate-General for Health and Food Safety and the Directorate-General for Employment, Social Affairs and Inclusion: they are focused on protecting people from health threats and disease (flu or other epidemics), consumer protection (food safety issues), promoting lifestyle choices (fitness and healthy eating), or workplace safety. The legal basis for the EU’s third health programme is provided by Regulation (EU) No 282/2014 on the establishment of a third Programme for the Union’s action in the field of health (2014-2020). It aims to:

- facilitate access to better and safer healthcare for EU citizens;
- contribute to innovative, efficient and sustainable healthcare systems;
- improve the health of EU citizens and reduce health inequalities;
- prevent disease and foster supportive environments for healthy lifestyles;
- protect citizens from cross-border health threats.

The EU’s cohesion policy provides a powerful instrument to help EU Member States and their regions to invest in sustainable, innovative and reformed health systems. Structural and investment funds for non-direct investments such as urban regeneration, transport, the environment, employment, social inclusion and housing
can also have a considerable impact on the health of individual people. During the period 2014-2020 the EU seeks to: invest in health infrastructure, in particular reinforcing the shift from a hospital-centred model to community-based care and integrated services; reduce health inequalities between regions and give disadvantaged groups and marginalised communities better access to healthcare; support the adaptation, up-skilling and lifelong learning of the health workforce; foster active, healthy ageing to promote employability and enable people to stay active for longer.

Other articles

- Health in the European Union – facts and figures — online publication
- Disability statistics — online publication
- Causes of death statistics
- Functional and activity limitations statistics
- Mortality and life expectancy statistics
- Self-perceived health statistics
- Unmet health care needs statistics

Publications

- Eurostat regional yearbook
- Atlas on mortality in the European Union, 2009
- 1 in every 4 persons aged 15 or over in the European Union is a smoker... — News release 245/2016
- 1 in 4 people in the EU reported long-standing limitations in usual activities in 2015 — News release 242/2016
- Almost 1 adult in 6 in the EU is considered obese — News release 203/2016

Main tables

- Causes of death (t_hlth_cdeath)
- Health care (t_hlth_care)
- Regional statistics (t_reg), see:

Regional health statistics (t_reg_hlth)

  All causes of death by NUTS 2 regions (tgs00057)
  Death due to cancer by NUTS 2 regions (tgs00058)
  Death due to ischaemic heart diseases by NUTS 2 regions (tgs00059)
  Death due to accidents by NUTS 2 regions (tgs00060)
  Death due to transport accidents by NUTS 2 regions (tgs00061)
  Physicians or doctors by NUTS 2 regions (tgs00062)
  Dentists by NUTS 2 regions (tgs00063)
  Available beds in hospitals by NUTS 2 regions (tgs00064)
Database

- **Causes of death** (hlth_cdeath)

- **Health status and determinants** (health_state), see:

  Health status (hlth_state)
  
  Self-perceived health and well-being (hlth_sph)
  Functional and activity limitations (hlth_fal)
  Self-reported chronic morbidity (hlth_srcm)

- **Health care** (hlth_care), see:

  Health care resources (hlth_res)
  
  Health care staff (hlth_staff)
  
  Health personnel by NUTS 2 regions (hlth_rs_prsrg)
  
  Health care facilities (hlth_facil)
  
  Hospital beds by NUTS 2 regions (hlth_rs_bdsrg)

  Unmet needs for health care (hlth_unm)

- **Regional statistics by NUTS classification** (reg), see:

  Regional health statistics (reg_hlth)
  
  Causes of death (reg_hlth_cdeath)
  
  Health care: resources and patients (non-expenditure data) (reg_hlth_care)

Dedicated section

- **Health**

- **Regions and cities**

Data visualisation

- **Eurostat statistical atlas (Chapter 3)**

- **Regional statistics illustrated**

Methodology

- **Causes of death** (ESMS metadata file — hlth_cdeath_esms)

- **Health care activities** (ESMS metadata file — hlth_act_esms)

- **Health care resources** (ESMS metadata file — hlth_res_esms)
External links

- Cohesion policy and health
- European Commission Directorate General for Health and Food Safety — Public health
- Health at a glance (OECD)
- World Health Organisation (WHO)

Maps can be explored interactively using Eurostat’s statistical atlas (see user manual).

This article forms part of Eurostat’s annual flagship publication, the Eurostat regional yearbook.

View this article online at http://ec.europa.eu/eurostat/statistics-explained/index.php/Health_statistics_at_regional_level