Population ageing in the coming decades is likely to be a major challenge for the European Union’s (EU’s) health sector: indeed, the demand for healthcare will likely increase at a rapid pace, while an ageing population may result in staff shortages for certain medical specialisations or in specific geographic regions. According to a 2012 report by the Directorate-General for Health and Food Safety, more than 60 000 doctors (or 3.2% of the EU-28 workforce) were expected to retire/leave the profession each year during the period 2009-2020.

Health is an important priority for Europeans, who expect to be protected against illness or after an accident and to receive appropriate healthcare services. This chapter presents recent statistics on health across the regions of the EU, providing information concerning self-perceived health status. It also looks at healthcare services through an analysis of the number of hospital beds, the share of the population with unmet needs for medical examination(s), the number of (practising) dentists and the share of the population with unmet needs for dental examination(s). It concludes with information on the most common causes of death, focusing on female deaths from breast cancer, male deaths from prostate cancer and deaths from suicide.
Health status

Figure 1 provides an analysis by degree of urbanisation, detailing the proportion of the adult population (defined here as people aged ≥16 years) who perceived their health as good or very good.

A higher proportion of people living in cities perceived their own health as good or very good

In 2017, almost seven tenths (69.7 %) of the EU-28 adult population perceived their own health as good or very good. This share was higher for people living in cities (71.5 %) than it was for people living in towns and suburbs (70.1 %) or people living in rural areas (66.6 %). Note that self-perceived health status is quite strongly related to age, and so the analysis of health status by degree of urbanisation may reflect, at least to some degree, differences in age structures for each degree of urbanisation. A closer analysis among the EU Member States reveals that:

- a higher proportion of people living in cities (rather than towns and suburbs or rural areas) perceived their own health as good or very good in a majority (19) of the EU Member States; note that people living in major cities often tend to be comparatively young (in relation to the population as a whole);
- people living in towns and suburbs — often inhabited by a relatively high number of families — were most likely to perceive their own health as good or very good in the southern Member States of Cyprus, Italy, Spain and Portugal, as well as in Belgium and the Netherlands;
- people living in the rural areas of Ireland and the United Kingdom — which generally had a relatively high share of older persons among their inhabitants — were more likely to perceive their own health as good or very good.

![Figure 1: People who perceive their own health as good or very good, 2017](image)

Note: ranked on cities.
(*) Rural areas not available.
(†) 2016.
Source: Eurostat (online data code: hlth_silc_18)
**Healthcare**

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 hospitals and in speciality hospitals. There were 2.60 million hospital beds in the EU-28 in 2016, which meant that the total number of beds fell overall by 9.0 % during the most recent decade for which data are available. The average number of hospital beds in the EU-28, relative to population size, fell by 64 beds per 100 000 inhabitants between 2006 and 2016, such that there were, on average, 509 hospital beds per 100 000 inhabitants in the latest period. Falling numbers of hospital beds 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, at least in part, due to the introduction of new treatments and less-invasive forms of surgery.

The neighbouring regions of Mecklenburg-Vorpommern in north-east Germany and Zachodniopomorskie in north-west Poland recorded the highest density of hospital beds relative to population. Figure 2 reflects country-specific ways of organising health care and the types of service provided to patients. It confirms a very high density of hospital beds in Germany and Austria, as well as many eastern regions of the EU. There were only three regions that recorded ratios in excess of a thousand hospital beds per 100 000 inhabitants, they were:

- the northern German region of Mecklenburg-Vorpommern — a predominantly rural area with a low level of population density — which had the highest density of hospital beds in the EU, at slightly less than 1 300 hospital beds per 100 000 inhabitants;
- the northern Polish region of Zachodniopomorskie — which shares a border with Mecklenburg-Vorpommern — with just over 1 200 hospital beds per 100 000 inhabitants;
- the Romanian capital city region of Bucuresti - Ilfov, where there were 1 023 hospital beds per 100 000 inhabitants.

There were contrasting patterns in relation to the number of hospital beds relative to population size in capital city regions of the EU Member States:

- in many of the eastern Member States — Hungary (data only available for NUTS level 1), Czechia, Romania, Slovakia, Croatia and Slovenia — the capital city region had the highest ratio of hospital beds relative to population;
- in many western and northern Member States, it was more commonplace to find capital city regions recording relatively low ratios, while the highest ratios of hospital beds was 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).

Aside from the outermost region of Mayotte (France) and the autonomous cities of Melilla and Ceuta (both Spain), the lowest ratios of hospital beds relative to population size were recorded in Calabria in Italy (223 beds).
Unmet needs for medical examination

There are a variety of reasons why an individual may claim that they have an unmet need for a medical examination, these include:

- cost, whereby medical examinations are considered too expensive;
- distance, if patients consider it too far to travel to a clinic/hospital for an examination or there are no means of transportation available;
- time, when patients are dissuaded from having a particular type of examination, for example, because of a lengthy waiting list or having to take time off work;
- cultural sensitivity/fear about certain types of medical examination.

Issues such as these have the potential to restrict an individual’s access to medical examinations and may subsequently have an impact on their overall quality of life, well-being and social participation, as well as influencing socioeconomic developments at a more aggregated level.

In 2017, the proportion of the EU-28 adult population (defined here as people aged ≥16 years) with unmet needs for medical examination — due to it being too expensive, too far to travel, and/or because of waiting lists — was 1.7 %. An analysis by degree of urbanisation (see Figure 3) reveals that this share was slightly higher in rural areas (2.0 %) than it was in either cities (1.6 %) or in towns and suburbs (1.5 %).

The overall proportion of the adult population with unmet needs for medical examination in 2017 was less than 0.5 % in Germany, Luxembourg, Malta, Austria, Spain and the Netherlands. By contrast, the share of adults with unmet needs for medical examination stood within the range of 3.0-5.0 % in Poland, the United Kingdom, Slovenia, Finland and Romania, rising to 6.2 % in Latvia and 10.0 % in Greece, while peaking at 11.8 % in Estonia.
In the cities, towns and suburbs of Estonia and the rural areas of Greece, more than 1 in 10 adults had unmet needs for medical examination.

An analysis by degree of urbanisation for 2017 shows that in 11 of the EU Member States the proportion of adults with unmet needs for medical examination was highest among people living in cities; this was most notably the case for people living in the cities of Estonia (14.4%). By contrast, people living in rural areas accounted for the highest proportion of adults with unmet needs for medical examination in seven EU Member States and this was particularly notable in Greece (11.7%) and Romania (6.0%). These differences may, at least in part, reflect differences in the distribution of poverty and social exclusion, which tends to be relatively high in the cities of northern and western Europe and in the rural areas of southern and eastern Europe.

Figure 3: People with unmet needs for medical examination, 2017 (% share of population aged ≥16 years, by degree of urbanisation)

Source: Eurostat (hlth_silc_21)

Numbers of dentists

Dentists diagnose, treat and prevent diseases, injuries and abnormalities of the teeth, mouth, jaws and associated tissues by applying the principles and procedures of modern dentistry. They use a broad range of specialised diagnostic, surgical and other techniques to promote and restore oral health. Eurostat gives preference to the concept of practising dentists, although data are only available for professionally active (the Netherlands, Slovakia, North Macedonia and Turkey) or licensed dentists (Ireland, Greece, Spain and Portugal) in some countries.

1Practising dentists provide services for patients. They include: practising dentists who have completed studies in dentistry/stomatology at university level and who are licensed to practice; interns (with an adequate diploma and providing services under supervision of other dentists or dental specialists during their postgraduate internship in a health care facility); salaried and self-employed dentists delivering services irrespectively of the place of service provision; foreign dentists licensed to practice and actively practising; stomatologists; dental surgeons; maxillofacial surgeons.
In 2016, there were an estimated 358 000 dentists across the EU-28, which equated to 70.0 dentists for every 100 000 inhabitants. A relatively short time-series exists, but this shows the total number of dentists in the EU-28 rising at a modest pace between 2009 and 2016, with an overall increase of 4.9%. Relative to the total number of inhabitants, the number of dentists in the EU-28 rose from 67.6 to 70.0 per 100 000 inhabitants during this period.

Attiki and Praha were the only regions to report more than twice as many dentists (relative to population size) as the EU-28 average.

Some of the highest ratios of dentists relative to population size (among NUTS level 2 regions) were recorded in capital city regions (see Map 1). Indeed, six of the seven highest ratios in 2015 were recorded in capital city regions, namely, those of Romania, Germany, Bulgaria, Spain, Czechia and particularly Greece (Attiki had the highest ratio in the EU, at 163.5 dentists per 100 000 inhabitants). The high number of dentists in capital city regions may be linked, at least in part, to the critical mass of (potential) clients provided by such large urban areas, as well as the high number of universities, research establishments, dental schools and specialist hospitals that are located in and around capital cities. In 2015, the only non-capital city region among the seven highest regional ratios was Yuzhen tsentralen in Bulgaria (129.8 dentists per 100 000 inhabitants).

At the other end of the range, the lowest ratios of dentists relative to population size in 2015 were recorded in:

- six Polish regions — Pomorskie, Śląskie, Dolnośląskie, Warmińsko-mazurskie, Opolskie and Wielkopolskie;
- two regions from the Netherlands — Flevoland and Zeeland;
- two outermost regions of France (2016 data) — Guyane and Mayotte, the latter recording the lowest ratio in the EU, at 7.0 dentists per 100 000 inhabitants.

Professionally active dentists are practising dentists and other dentists for whom their education in dentistry/stomatology is a prerequisite for the execution of the job. They include: dentists who provide services for patients; dentists working in administration and management positions requiring education in dentistry; dentists conducting research into oral health and dental care; dentists who participate in public action to maintain or improve standards of oral health and dental care; dentists preparing scientific papers and reports.

Dentists licensed to practice include practising and other (non-practising) dentists, who are registered and entitled to practice as health care professionals in the field of dentistry. They include: dentists who provide services for patients; other dentists for whom their education in dentistry/stomatology is a prerequisite for the execution of the job; other dentists for whom their education in dentistry/stomatology is not a prerequisite for the execution of the job; dentists registered as health care professionals and licensed to practice but who are not economically active (for example, they are unemployed or retired); dentists working abroad.
Number of dentists, 2016
(per 100,000 inhabitants, by NUTS 2 regions)

Map 1: Number of dentists, 2016 (per 100,000 inhabitants, by NUTS 2 regions)
Source: Eurostat (hlth_rs_prsrg) and (hlth_rs_prs1)
Unmet needs for dental examination

In 2017, the proportion of the EU-28 adult population (defined here as people aged ≥16 years) with unmet needs for dental examination — due to it being too expensive, too far to travel, or because of waiting lists — was 2.9%; this could be compared with a share of 1.7% for unmet needs for medical examination. An analysis by degree of urbanisation (see Figure 4) reveals that the proportion of adults with unmet needs for dental examination was higher in rural areas (3.1%) of the EU-28 than it was in cities (3.0%) or in towns and suburbs (2.4%).

The share of the adult population with unmet needs for dental examination in 2017 was less than 1.0% in Austria, Germany, Luxembourg, Malta and the Netherlands (all five of these EU Member States also reported low shares, less than 0.5%, of their respective adult populations facing unmet needs for medical examination). By contrast, the share of adults with unmet needs for dental examination reached double figures in Greece (10.0%), Portugal (11.6%) and Latvia (13.9%). As such, both Greece and Latvia were present among the three Member States with the highest shares of people facing unmet needs for both medical and dental examination.

In the rural areas of Greece, Latvia and Portugal, more than 10% of all adults had unmet needs for dental examination

An analysis by degree of urbanisation shows that in 13 of the EU Member States the proportion of adults with unmet needs for dental examination in 2017 was highest for those people living in cities. The gap was particularly apparent in Slovenia, Austria and Finland, where the share of people living in cities with unmet needs for dental examination was at least 1.0 percentage point (pp) higher than the share in towns and suburbs or in rural areas. By contrast, people living in rural areas accounted for the highest proportion of adults with unmet needs for dental examination in nine EU Member States; this gap was particularly apparent in Portugal (a difference of 3.2 pp compared with the other degrees of urbanisation), Greece (1.1 pp), Romania (0.9 pp) and Bulgaria (0.8 pp).
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). These statistics 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. They refer specifically 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 one of 86 different causes, as defined by the European shortlist for causes of death (2012).

In 2017, there were 5.27 million deaths across the EU-28

During the last few years, there have been more deaths than births in the EU-28, although the total number of inhabitants has continued to rise due to net migration (for more information on these developments, see Chapter 2 on population). Eurostat’s demographic statistics reveal that there were 5.27 million deaths in the EU-28 in 2017: this was somewhat higher than a year before, with the total number of deaths increasing by 137,000. This pattern was repeated in a majority (24) of the EU Member States, with relatively high growth rates in Cyprus (where the number of deaths rose by 9.6 % between 2016 and 2017), Luxembourg (7.5 %), Malta (6.9 %), Italy (5.5 %) and Greece (4.8 %). Note that some of these are relatively small Member States and that the total number of deaths in one specific year may reflect the impact of a one off event, such as a particularly cold winter or the presence of an epidemic. More generally, the number of deaths increased at a relatively fast pace between 2016 and 2017 in most of the southern Member States, while Finland (-0.4 %), Ireland (-0.7 %), Portugal (-0.7 %) and Lithuania (-2.3 %) were the only Member States reporting a reduction in their total number of deaths.
A wide range of factors determine regional mortality patterns, for example: age structures, gender, living/working conditions and the surrounding environment. Each individual can also influence their own chances of leading a long and healthy life, through lifestyle choices they make concerning issues such as exercise, diet, the consumption of alcohol, whether or not they smoke, or their behaviour when driving.

Maps 2-5 show regional statistics on causes of death using standardised death rates: the standardisation aims to remove the influence of differences in age structures between regions (as elderly persons are more likely to die than younger persons, or are more likely to catch/contract a specific illness/disease). Standardised death rates are more comparable across space and/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). Statistics on causes of death are provided for NUTS level 2 regions in the form of three-year averages covering the period 2013-2015, thereby smoothing out some of the fluctuations that might occur from one year to the next for what may be relatively small subpopulations.

**Ischaemic heart diseases were the most common cause of death in the EU-28**

On the basis of the European shortlist for causes of death, the leading cause of death in the EU was ischaemic heart disease, with a standardised death rate of 129 deaths per 100 000 inhabitants during the period 2013-2015. The next most common causes of death included:

- other heart diseases (92 deaths per 100 000 inhabitants);
- cerebrovascular diseases (87 deaths);
- other diseases of the circulatory system (74 deaths);
- malignant neoplasm (cancer) of the trachea, bronchus and lung (54 deaths);
- dementia (35 deaths);
- chronic lower respiratory diseases (35 deaths);
- accidents (31 deaths);
- malignant neoplasm (cancer) of the colon, rectosigmoid junction, rectum, anus and anal canal (31 deaths);
- pneumonia (26 deaths).

Map 2 shows the most common causes of death for NUTS level 2 regions, based on standardised death rates for the period 2013-2015. Of the 271 regions in the EU for which data are available, a majority (154) reported that ischaemic heart disease was the most common cause of death. Across the EU Member States (composed of more than one NUTS level 2 region), ischaemic heart disease was the most common cause of death in each and every region of Czechia, Denmark, Croatia, Hungary, Austria, Slovakia, Finland, Sweden and the United Kingdom, while it was the most common cause of death in the vast majority of Italian regions.

Other heart diseases were the leading cause of death in 89 different regions, including every region of Belgium, the Netherlands and Slovenia, and the vast majority of regions in Spain, France and Poland. Cerebrovascular diseases were the most common cause of death in 17 different regions of the EU, including all of the mainland regions of Portugal. The other most common causes of death were less widespread — with a single-digit count of regions:

- other diseases of the circulatory system were the most common cause of death in seven eastern European regions;
- the residual grouping of ill-defined and unknown causes of mortality was the most common cause of death in three French regions — the capital city region of Ile-de-France, as well as the two outermost regions of Guadeloupe and Guyane;
- pneumonia was the most common cause of death in a single region, the outermost Portuguese Região Autónoma da Madeira.
Most common causes of death, 2013-2015
(standardised death rates per 100 000 inhabitants, by NUTS 2 regions)

Note: information shown for a three-year average, Kőzép-Magyarország (HU1), Makroregion Wojewódzwo Mazowieckie (PL9) and Scotland (UKM): NUTS level 1. Ireland, Lithuania and Serbia: national data.
Source: Eurostat (online data code: hlt_cd_ysdr2)
Across the EU, there were 32.8 deaths from breast cancer per 100,000 female inhabitants

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 95,400 people in the EU-28 that died from malignant neoplasm of the breast (hereafter referred to as breast cancer); this equated to 7.2 % of all deaths from cancer. Breast cancer predominantly affects women (although 957 men died from the disease in 2015): it accounted for around one sixth (16.2 %) of all female deaths related to cancer.

The EU-28 standardised death rate from all forms of cancer averaged 261.7 deaths per 100,000 inhabitants during the period 2013-2015. The rate for breast cancer among women averaged 32.8 deaths per 100,000 female inhabitants. Regional variations in deaths from breast cancer may, at least in part, reflect differences in national health care systems, for example the availability of mammography screenings (which reduce mortality rates) or the use made of hormone replacement therapy for menopause (which increases the risk of breast cancer).

Map 3 shows there were 15 regions across the EU where the standardised death rate from breast cancer was at least 40.0 deaths per 100,000 female inhabitants during the period 2013-2015 (these are shown in the darkest shade). They were widely distributed across the EU and included:

- three bordering regions from western Belgium and northern France — West-Vlaanderen and Prov. Hainaut in Belgium and Nord-Pas de Calais in France;
- four eastern European capital city regions, Kontinentalna Hrvatska (Croatia), Közép-Magyarország (Hungary; NUTS level 1), Bucureşti-Ilfov (Romania) and Bratislavský kraj (Slovakia).

At the other end of the range, there were only four regions in the EU where the standardised death rate from breast cancer was less than 20.0 deaths per 100,000 female inhabitants in 2013-2015, they were:

- La Rioja and its neighbouring region of Comunidad Foral de Navarra, located in northern Spain;
- Guyane, an outermost region of France;
- Åland, an autonomous archipelago in Finland, which recorded the lowest death rate at 15.7 deaths per 100,000 female inhabitants (note this region has a very small population which may strongly influence the results for a specific period).
Map 3: Standardised death rates from breast cancer, 2013-2015 (per 100 000 female inhabitants, by NUTS 2 regions)

Source: Eurostat (hlth_cd_ysdr2)
Prostate cancer was the main cause of death for a relatively high number of men in several Baltic and Nordic regions.

In 2015, there were 75 400 people in the EU-28 that died from malignant neoplasm of the prostate (hereafter referred to as prostate cancer); this equated to 5.7% of all deaths from cancer. Prostate cancer only affects men and accounted for just over one tenth (10.2%) of all male deaths that were related to cancer in 2015.

The number of men dying from prostate cancer has overtaken the number of women dying from breast cancer in several EU Member States; in 2015, this situation was observed in Sweden, the United Kingdom, Denmark, Finland, Estonia and Portugal. It may, at least in part, be related to demographic changes, with a higher number of men living much longer lives (prostate cancer tends to affect particularly elderly men), but may also reflect national health care systems (for example, the availability and take-up of screenings for both forms of cancer, as well as public information campaigns).

Standardised death rates are more reliable for comparing between diseases as they remove the impact of different age structures. The death rate from prostate cancer in the EU-28 averaged 39.5 deaths per 100 000 male inhabitants during the period 2013-2015, therefore somewhat higher than the standardised death rate from breast cancer, at 32.8 deaths per 100 000 female inhabitants.

Across NUTS level 2 regions, the highest standardised death rates from prostate cancer in 2013-2015 — at least 60.0 deaths per 100 000 male inhabitants (as shown by the darkest shade in Map 4) — were concentrated in:

- **Baltic** — Estonia, Latvia (both single regions at this level of detail) and Lithuania (only national data available) — and **Nordic** regions, including two regions in Denmark and five regions in Sweden;
- two outermost regions of France — Guadeloupe and Martinique — the latter recording the highest death rate, at 76.5 deaths per 100 000 male inhabitants;
- the outermost Portuguese Região Autónoma dos Açores;
- the eastern half of Slovenia, Vzhodna Slovenija.

By contrast, the lowest standardised death rates from prostate cancer were largely concentrated in southern Europe, as the death rate fell below 30.0 per 100 000 male inhabitants in 17 regions of Italy — including Molise, which recorded the lowest rate (23.6 deaths per 100 000 male inhabitants) in the EU — four regions in Greece, three regions in Spain and Malta (a single region at this level of detail).
Standardised death rates from prostate cancer, 2013-2015 (per 100 000 male inhabitants, by NUTS 2 regions)

Note: information shown for a three-year average. Közép-Magyarország (HU1), Makreregion Województwo Mazowieckie (PL9) and Scotland (UKM): NUTS level 1. Ireland, Lithuania and Serbia: national data.
Source: Eurostat (online data code: hlth_cd_ysd2)

Map 4: Standardised death rates from prostate cancer, 2013-2015 (per 100 000 male inhabitants, by NUTS 2 regions) Source: Eurostat (hlth_cd_ysd2)
Across the EU, there were 11.3 deaths from suicide per 100,000 inhabitants

Intentional self-harm — hereafter referred to as suicide — is one of the most common external causes of mortality, alongside falls and 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 and exclude failed attempts or other non-fatal forms of self-harm.

In 2015, there were 56,200 people in the EU-28 that died from suicide, which was slightly higher than the number of people that died from falls (55,200) and considerably more than the number that died from transport accidents (30,100). Given the sensitivity of suicide, it should be noted that for some EU Member States data on suicide are potentially under-reported.

There is a considerable gender gap for suicide: in 2015, men accounted for more than three quarters (76.7%) of all suicides in the EU-28. This may, at least in part, be attributed to the likelihood of success from the chosen method of suicide, as men tend to select more impulsive (and deadly) methods. The EU-28 standardised death rate from suicide during the period 2013-2015 averaged 11.3 deaths per 100,000 inhabitants, with the rate for men (18.5 deaths per 100,000 male inhabitants) some 3.75 times as high as that for women.

Map 5 presents standardised death rates from suicide for the period 2013-2015. The highest death rates in the EU (20.0 or more deaths per 100,000 inhabitants) are shown in the darkest shade. Lithuania (only national data available) had, by far, the highest death rate, among NUTS level 2 regions, at 32.6 deaths per 100,000 inhabitants, followed by two neighbouring regions from south-east of Hungary (Észak-Alföld and Dél-Alföld) and two neighbouring regions in north-west France (Bretagne and Basse Normandie).

At the other end of the range, the lowest death rates from suicide (below 5.0 deaths per 100,000 inhabitants) are shown in the lightest shade; they included six regions each from Greece and Italy (including Molise, which had the lowest rate in the EU, at 3.6 deaths per 100,000 inhabitants).

As noted above, there are considerable differences between the sexes for suicide. The highest standardised death rate for men during the period 2013-2015 was recorded in Lithuania (only national data available), at 60.5 deaths per 100,000 male inhabitants, followed by two Hungarian regions — Észak-Alföld (48.1 per 100,000 male inhabitants) and Dél-Alföld (44.1 per 100,000 male inhabitants). By contrast, the three highest death rates from suicide for women were all recorded in Belgium: Prov. Namur (14.6 per 100,000 female inhabitants), Prov. Liège (12.9 per 100,000 female inhabitants) and Prov. West-Vlaanderen (12.4 per 100,000 female inhabitants).

There was a gender gap for suicide in each of the NUTS level 2 regions of the EU (subject to data availability), with higher death rates for men than women. This pattern was particularly apparent in eastern Europe, as standardised death rates for men from suicide were at least six times as high as those for women in:

- all but one region of Poland, the exception being Zachodniopomorskie;
- all but one region of Slovakia, the exception being the capital city region of Bratislavske kjraj;
- a majority of the regions in Romania;
- the easternmost region of Czechia, Moravskoslezsko.

Standardised death rates from suicide were also at least six times as high for men as they were for women in six regions located across southern Europe:

- three from Greece — Dyrtiki Ellada, Dyrtiki Makedonia and Kriti;
- the two autonomous, outermost regions of Portugal — Açores and Madeira;
- Malta (a single region at this level of detail).
Map 5: Standardised death rates from suicide, 2013-2015 (per 100 000 inhabitants, by NUTS 2 regions)

Source: Eurostat (hlth_cd_ysdr2)
Data sources

Data presented for self-perceived health, as well as self-reported unmet needs for medical and dental examination are derived from EU statistics on income and living conditions (EU-SILC) ; this is an annual source which is the reference for comparative statistics on income distribution and social inclusion in the EU. EU-SILC was launched in 2003 on the basis of a gentlemen’s agreement: it now operates under a framework Regulation of the Council and the Parliament ( Regulation (EC) No 1177/2003 ) and a series of Commission implementing Regulations, including Regulation (EC) No 1983/2003 which provides a list of target primary variables including some on health (the module for health is composed of three variables on health status and four variables on unmet needs for health care). Data from EU-SILC refer 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

Non-expenditure healthcare data, shown here for hospital beds and the number of dentists, 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


For more information:

Causes of death

Context

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 individual EU Member States. Health policy in the EU is designed to complement national strategies by pooling resources and assisting Member States to tackle common challenges. The European Commission works with 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 within the health domain 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 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.

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 EU’s cohesion policy also 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 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.

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 recently relocated 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 at a national level or by 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.

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
• More than 95% of children in the EU considered to be in good or very good health — News release 25/2019
• 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
• Health, see:
  Health status (t_hlth_state)
  Health care (t_hlth_care)
  Causes of death (t_hlth_cdeath)
• 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

- **Health**, 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)

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)

Causes of death (hlth_cdeath)

- **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

- European Commission Directorate General for Health and Food Safety — Public health
- 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.