This article presents an overview of European Union (EU) statistics related to a selection of the most common types of cancer: colorectal cancer; trachea, bronchus and lung cancer (hereafter referred to simply as lung cancer); breast cancer; and prostate cancer. For each of these four types of cancer, an analysis is provided that focuses on cancer healthcare (in terms of the length of stay and the number of discharges) and deaths from cancer; there are also data on screenings for colorectal and breast cancer. An accompanying article provides an overview of statistics related to cancers in general.

This article is one of a set of statistical articles concerning health status in the EU which forms part of an online publication on health statistics.

**Lung cancer**

Within the EU, lung cancer accounted for one fifth of all deaths from cancer

In 2016, more than a quarter of a million (275 thousand) people died from lung cancer in the EU-28, one fifth (19.9%) of all deaths from cancer and 5.4% of the total number of deaths — see Table 1. The share of all deaths attributed to lung cancer was 7.2% among men, more than double the share (3.5%) recorded for women.
Among the EU Member States, the share of the total number of deaths from lung cancer peaked in the Netherlands (7.2 %), Hungary (7.0 %) and Denmark (6.9 %), in contrast to shares of less than 3.5 % in Latvia (3.3 %), Lithuania and Bulgaria (both 3.2 %). The high share of total deaths from lung cancer in the Netherlands reflected the fact that this country ranked third for men and for women (at 8.8 % of all male deaths and 5.7 % of all female deaths); the share of deaths from lung cancer among men was higher in Greece (9.4 %) and Hungary (8.9 %) and among women was higher in Denmark (6.7 %) and Ireland (5.8 %).

In 2016, the EU-28 standardised death rate for lung cancer was 53.6 per 100 000 inhabitants, higher than the rates for the three other types of cancer presented in this article. An analysis by gender and by age shows large differences in the standardised death rates for lung cancer: for men the rate was 82.2 per 100 000 inhabitants, some 2.6 times as high as for women (31.8 per 100 000 inhabitants), although there were signs of this gender gap narrowing in recent years. As is typical for cancers as a whole, the standardised death rate for lung cancer for persons aged 65 years and over (198.9 per 100 000 inhabitants) was many times higher than it was for younger persons: for persons aged less than 65 years the rate was 18.4 per 100 000 inhabitants.

Among the EU Member States, by far the highest standardised death rate for lung cancer in 2016 was recorded in Hungary (90.1 per 100 000 inhabitants), followed by Poland, Denmark, Croatia and the Netherlands with rates within the range of 66-69 deaths per 100 000 inhabitants. Finland, Sweden, Cyprus and Portugal were the only Member States to record standardised death rates for lung cancer that were below 40.0 per 100 000 inhabitants; this situation was also apparent in Liechtenstein. Sweden had by far the lowest standardised death rate among the Member States for males, at 41.4 deaths per 100 000 inhabitants in 2016, compared with the next lowest death rate which was 60.6 per 100 000 inhabitants in Finland. For females the lowest standardised death rates for lung cancer were recorded in Lithuania, Portugal and Latvia (all below 16.0 per 100 000 inhabitants).
More than 576 thousand in-patient discharges for lung cancer

Based on available data for the EU Member States (2017 data except: 2016 data for Denmark, Luxembourg and the United Kingdom; 2015 data for Portugal; no recent data for Estonia or Greece), there were 576 thousand discharges of lung cancer in-patients.

From Figure 1 it can be seen that the highest discharge rate for in-patients was in Hungary (2016 data), where 270 in-patients per 100,000 inhabitants were discharged after diagnosis or treatment for lung cancer. In Austria and Germany, this rate was closer to 250 discharges per 100,000 inhabitants in 2017. Elsewhere, the rate ranged from around 47 discharges per 100,000 inhabitants in Portugal (2015 data) to 176 discharges per 100,000 inhabitants in Latvia.

The average length of stay for lung cancer in-patients was typically up to 3.0 days longer than for all in-patients having been treated for neoplasms

Among the EU Member States for which data are available (see Figure 1), in 2017, the average length of stay for lung cancer in-patients ranged from less than 5.0 days in the Netherlands and Bulgaria (where the lowest average stay was recorded at 3.6 days) to peaks of 12.0 days in Portugal (2015 data) and 13.1 days in Malta. The average length of stay for lung cancer in-patients was typically longer than the average for all in-patients having been treated for neoplasms (whether malignant (cancer), in situ or benign): the difference reached 2.9 extra days in France and Malta, and 2.8 extra days in Belgium, Croatia, Italy and Finland. However, in Bulgaria, Germany, the Netherlands, Slovenia and Cyprus, the average length of stay for lung cancer in-patients was shorter than the average for all in-patients having been treated for neoplasms.

Figure 1: Health care activities — malignant neoplasm of trachea, bronchus and lung, 2017

Source: Eurostat (hlth_co_disch2 and hlth_co_inpst)
Colorectal cancer

Cyprus had the lowest share of deaths from colorectal cancer

In 2016, 157 000 people died from colorectal cancer in the EU-28, equivalent to 11.3 % of all deaths from cancer and 3.1 % of the total number of deaths from any cause — see Table 2. The share of deaths attributed to colorectal cancer was 3.4 % for men and 2.7 % for women, representing a much narrower range than observed for lung cancer.

Table 2: Causes of death — malignant neoplasms of colon, rectosigmoid junction, rectum, anus and anal canal, residents, 2016

Among the EU Member States, the share of the total number of deaths that were attributed to colorectal cancer peaked at 4.2 % in Croatia, whereas it was approximately half this share in Cyprus (2.1 %) with shares below 2.5 % also recorded in Lithuania, Bulgaria, Latvia, Finland and Greece; an even lower share was recorded in Turkey (1.7 % of all deaths).

Among the EU Member States, Cyprus recorded the lowest share of deaths attributed to colorectal cancer for females (1.7 %), while Lithuania recorded the lowest share for males (2.1 %). Croatia recorded the highest share for males, with 1 in 20 (5.0 %) of male deaths attributed to colorectal cancer in 2016, ahead of Slovakia, Hungary, Spain and Slovenia, where the share of male deaths attributed to colorectal cancer was between 4.5 % and 4.6 %. Malta (3.6 %) and Slovenia (3.5 %) recorded the highest shares of female deaths for colorectal cancer. For nearly all Member States the share of deaths for colorectal cancer was higher for males than for females: in Malta and Latvia there was almost no gender gap, while in Lithuania and Estonia, the share for females was higher than the share for men; this was also the case in Liechtenstein.

In 2016, the EU-28 standardised death rate for colorectal cancer was 30.4 per 100 000 inhabitants, which...
was just over half the rate recorded for lung cancer. An analysis by sex shows some gender differences in the standardised death rates for colorectal cancer: for men the EU-28 rate was 74% higher than for women; this difference was nevertheless considerably lower than that recorded for lung cancer.

As is typical for cancers as a whole, the standardised death rate for colorectal cancer for persons aged 65 years and over was many times higher than it was for younger persons. When expressed as a ratio, the standardised death rate for persons aged 65 years and over was 18 times as high as it was for younger persons, a higher ratio than for lung cancer (11 times as high) and also higher than the ratio for all cancers (14 times as high).

As with lung cancer, the highest standardised death rate for colorectal cancer among the EU Member States in 2016 was recorded in Hungary (54.0 per 100 000 inhabitants), followed by Croatia and Slovakia with rates within the range of 50-52 per 100 000 inhabitants. Luxembourg, Greece, Finland and Cyprus were the only Member States to record standardised death rates for colorectal cancer that were below 25.0 per 100 000 inhabitants; this situation was repeated in Switzerland and Turkey.

Hungary recorded the highest standardised death rates for colorectal cancer among men and women in 2016, while Cyprus recorded the lowest rates for men and women. In all EU Member States, standardised death rates for colorectal cancer were higher among men than among women. In percentage point terms, the closest rates were in Malta (where the rate for men was 4.2 points higher than that for women), while in Sweden the rate for men was 8.2 points higher. By contrast, in Slovakia, Croatia and Hungary, the rates for men were at least 40.0 points higher than those for women.

Austria and Croatia reported the highest in-patient discharge rates for colorectal cancer

Based on available data for the EU Member States (2017 data except: 2016 data for Denmark, Luxembourg and the United Kingdom; 2015 data for Portugal; no recent data for Estonia or Greece), there were 626 thousand hospital discharges of colorectal cancer in-patients.

The highest discharge rates for colorectal cancer in-patients were in Austria and Croatia, where (respectively) 260 and 253 in-patients per 100 000 inhabitants were discharged in 2017 (see Figure 2). In Hungary, Lithuania, Bulgaria, Latvia, Germany and Romania, this rate was also in excess of 200 discharges per 100 000 inhabitants. The lowest discharge rates for colorectal cancer were reported for the United Kingdom (2016 data) and Ireland, at 68 and 59 discharges per 100 000 inhabitants respectively.
In a majority of EU Member States, the average length of stay for colorectal cancer in-patients was more than two days longer than the average for all in-patients having been treated for neoplasms.

In 2017, among the EU Member States for which data are available (see Figure 2), the average length of stay for colorectal cancer in-patients ranged from 5.8 days in Bulgaria to 13.6 days in Luxembourg (2016 data). In half of the Member States for which data are available (no recent data for Estonia or Greece), the average length of stay for colorectal cancer in-patients was two or more days longer than the average for all in-patients having been treated for neoplasms (whether malignant cancer, in situ or benign), with this difference rising to more than four days in France, Czechia, Luxembourg and Italy.

The indicator on colorectal screening presented in Figure 3 reflects a Council recommendation and refers to the population aged 50 to 74 years who reported having had a faecal occult blood test. The second wave of the European health interview survey (EHIS) was conducted between 2013 and 2015 and through this survey people were asked when they had most recently been screened for colorectal cancer. Germany and Austria had by far the highest proportion of their populations aged 50 to 74 years having been screened for colorectal cancer, both with shares of around four fifths. Apart from these two Member States, a majority of respondents in Slovenia, Czechia, France and Latvia also reported that they had been screened for colorectal cancer. However, in most EU Member States, as well as in Iceland, Norway and Turkey, only a minority of respondents aged 50 to 74 years had ever been screened, the lowest proportions being registered in Bulgaria, Cyprus and Romania (all below 10%).
In a majority of participating EU Member States, more than half of the subset of people who had at some stage been screened for colorectal cancer reported that this screening had occurred within the previous two years, this share peaking at 85 % in France. By contrast, in Estonia, Poland and Hungary, less than two fifths of those people who had been screened reported that this had been within the previous two years. By contrast, a gender analysis for those people who had never been screened shows the strongest differences in Lithuania and Luxembourg: more men than women had never been screened in Lithuania while the reverse situation was observed in Luxembourg.

Breast cancer

In Ireland, 5.0 % of deaths among women were from breast cancer

In 2016, 97.0 thousand people died from breast cancer in the EU-28, of which just over one thousand were men and the vast majority (95.8 thousand) were women. As such, deaths from breast cancer made up around 7.0 % of all deaths from cancer; among women, breast cancer accounted for 15.6 % of all deaths from cancer.
Compared with all causes of deaths (not just those from cancer), breast cancer was the main cause of death for 1.9 % of all deaths in the EU-28 in 2016 (see Table 3); among women, breast cancer accounted for 3.7 % of all deaths. Across the EU Member States, the share of deaths from breast cancer (among women) reached 4.7 % in Luxembourg and 5.0 % in Ireland, while this share was below 3.0 % in Estonia, Romania, Lithuania and Bulgaria.

In 2016, the EU-28 standardised death rate for breast cancer was 32.9 per 100 000 inhabitants for women and 0.5 per 100 000 inhabitants for men. As is typical for cancers as a whole, the standardised death rate for breast cancer for persons aged 65 years and over (67.5 per 100 000 inhabitants) was many times higher than it was for younger persons (7.1 per 100 000 inhabitants). Nevertheless, this age difference was somewhat narrower than for all malignant neoplasms in general: when expressed as a ratio, the standardised death rate for breast cancer among persons aged 65 years and over was almost 10 times as high as it was for younger persons, compared with 14 times as high for all cancers.

Among the EU Member States, the highest standardised death rates for breast cancer among women were recorded in Croatia (40.4 per 100 000 inhabitants) and Ireland (40.3 per 100 000 inhabitants), followed by Hungary and Slovakia, just under 40 per 100 000 inhabitants. Seven EU Member States recorded standardised death rates for breast cancer that were below 30 per 100 000 inhabitants: Estonia, Cyprus, Lithuania, Portugal, Finland and Sweden, with the lowest rate recorded in Spain (23.6 per 100 000 inhabitants).

In 19 out of the 28 EU Member States, the standardised death rate for women for breast cancer in 2016 was higher than that for lung cancer; the gap was particularly large in Latvia, Lithuania, Bulgaria, Slovakia, Portugal and Cyprus. The most notable exceptions — where there were, among women, 15-23 more deaths per 100 000 female inhabitants from lung cancer than from breast cancer — were Denmark, Hungary, the United Kingdom and the Netherlands.
Austria, Germany and Bulgaria recorded the highest in-patient discharge rates for breast cancer

Based on available data for the EU Member States (2017 data except: 2016 data for Denmark, Luxembourg and the United Kingdom; 2015 data for Portugal; no recent data for Estonia or Greece), there were 531 thousand discharges of breast cancer in-patients.

Figure 4 shows that the highest discharge rates for in-patients in 2017 were in Austria, Germany and Bulgaria, where more than 190 in-patients per 100 000 inhabitants were discharged after diagnosis or treatment for breast cancer. In the remaining EU Member States the in-patient discharge rate for breast cancer was less than 160 discharges per 100 000 inhabitants, falling to below 100 discharges per 100 000 inhabitants in 14 Member States. Malta, Ireland, Sweden, the United Kingdom (2016 data) and Denmark (2016 data) recorded the lowest rates, with under 60 discharges per 100 000 inhabitants.

The average length of stay for breast cancer in-patients was greatest in Germany and Lithuania

In 2017, among the 26 EU Member States for which data are available (see Figure 4), the average length of stay for breast cancer in-patients ranged from 2.2 days in the Netherlands to peaks of 10.1 and 10.0 days in Germany and Lithuania. A comparison with the average length of stay for all in-patients having been treated for neoplasms shows that in nearly all Member States the average length of stay for breast cancer in-patients was shorter. In Portugal, Italy, Malta, the United Kingdom, Ireland and Spain, breast cancer in-patients spent on average 4.2-5.0 days less as in-patients, while in a further three Member States —Belgium, Sweden and France — the average length of stay was 3.3-3.5 days shorter than for all in-patients having been treated for neoplasms.

Figure 4: Health care activities — malignant neoplasm of breast, 2017

Source: Eurostat (hlth_co_disch2) and (hlth_co_inpst)

The average length of stay for breast cancer in-patients was greatest in Germany and Lithuania
Only in four Member States was the average length of stay for breast cancer patients longer than the average stay for all in-patients having been treated for neoplasms; this was most notably the case in Lithuania (where the difference was 2.7 days), but was also apparent in Germany, Slovakia and Bulgaria.

**Breast cancer screening rates of 80 % or higher in Denmark, Finland, Portugal and Sweden**

Most of the data presented in Figure 5 for breast cancer screening are administrative data from screening programmes although some are from surveys. The data generally show the proportion of women aged 50-69 years who had received a mammography within the previous two years. Overall, the rates are much higher than those reported for colorectal screening. Data are available for 22 of the EU Member States from administrative data, either for 2017 or for an earlier year: among these, screening rates were below 50.0 % in eight, with a low of 0.2 % in Romania (2015 data). The lowest screening rates were generally recorded among those Member States that joined the EU in 2004 or more recently, although France, Germany (2016 data), Luxembourg and Italy also had relatively low screening rates (below 60.0 %). Denmark (2016 data), Finland and Spain (survey data) reported screening rates that were higher than 80 %, as did Sweden and Portugal (both older survey data), while at least three quarters of women aged 50-69 years were screened for breast cancer in the Netherlands (2015 data) and the United Kingdom.
A comparison of data for the two years shown in Figure 5 indicates that breast cancer screening rates increased in 10 of the 22 EU Member States for which data are available, with particularly large increases between 2012 and 2017 observed in Latvia, Lithuania and Czechia. In the 11 Member States where screening rates fell between the two years shown (note that the rate was unchanged in Croatia), the reductions were generally relatively small, with the exceptions of Luxembourg, where the rate fell from 64.7 % to 56.3 %, and Germany, where it fell from 56.3 % to 51.0 % (between 2012 and 2016).

Figure 6 indicates the availability of equipment solely intended for conducting mammographies. Relative to the size of population, this type of equipment was most widely available in Greece and Cyprus. Comparing the data presented in Figures 5 and 6, breast cancer screening rates in Czechia and Denmark appeared to be relatively high compared with the availability of mammography units, implying a higher average intensity of use or a greater use for screening of units other than ones solely for mammographies. By contrast, relatively low screening rates were observed in Cyprus and Bulgaria combined with a relatively high availability of mammography units.
Prostate cancer

In Sweden, the standardised death rate for prostate cancer for men was higher than the equivalent rate for lung cancer.

In 2016, 76.9 thousand men died from prostate cancer in the EU-28 (see Table 4), equivalent to 5.6 % of all deaths from cancer and 1.4 % of the total number of deaths from any cause. As all of these deaths occurred among men, the share of male deaths attributed to prostate cancer was 3.0 %, approximately double the share for the whole population.
Among the EU Member States, the share of all deaths among men that were attributed to prostate cancer was as low as 1.7 % in Bulgaria and Romania, but peaked at more than three times this share in Sweden (5.3 %); it was also relatively high in Iceland (5.4 %) and Norway (5.0 %), while it was particularly low in Turkey (1.6 %).

In 2016, the EU-28 standardised death rate for prostate cancer was 39.1 per 100 000 male inhabitants, slightly lower than the equivalent rate for men for colorectal cancer (40.4 per 100 000 inhabitants). As is typical for cancers as a whole, the standardised death rate for prostate cancer for men aged 65 years and over was many times higher than it was for younger men. When expressed as a ratio, the rate for men aged 65 years and over was 77 times as high as it was for younger men, a much higher ratio than for all cancers (14 times as high for both sexes together), underlining the fact that this is a form of cancer that particularly affects older rather than younger men.

Some of the highest standardised death rates for prostate cancer in 2016 were recorded across the Scandinavian and Baltic Member States, with rates above 50.0 per 100 000 male inhabitants recorded for all three Baltic Member States, Denmark and Sweden, as well as Slovenia, Croatia and Slovakia. A rate around half that level was reported by Italy (26.8 per 100 000 male inhabitants) — the lowest among the EU Member States.

As noted above, the standardised death rate for men for prostate cancer in the EU-28 as a whole was slightly lower than the equivalent rate for men for colorectal cancer. However, this was the case in a minority (13) of EU Member States: it was higher in the remaining 15 Member States. Sweden was the only EU Member State where the standardised death rate for men for prostate cancer was higher than the equivalent rate for men for lung cancer.

Based on available data for the EU Member States (2017 data except: 2016 data for Denmark, Luxembourg and the United Kingdom; no recent data for Estonia, Greece or Portugal), there were 295 thousand discharges...
of prostate cancer in-patients.

As with breast cancer, Austria and Germany reported the highest in-patient discharge rates for prostate cancer.

The highest discharge rates for prostate cancer in-patients were in Austria and Germany, where more than 250 in-patients per 100,000 men were discharged in 2017 (see Figure 7). In 11 of the EU Member States for which data are available, the discharge rate for prostate cancer was below 100 discharges per 100,000 men, dropping to less than 50 discharges per 100,000 men in Ireland, Cyprus and Malta (where the lowest rate was recorded, at 17.8 discharges per 100,000 men).

Compared with the average for all neoplasms, the average length of stay for prostate cancer in-patients was particularly long in Malta.

In 2017, among the EU Member States for which data are available (see Figure 7 for availability), the average length of stay for male prostate cancer in-patients generally ranged from 5.7 days in the United Kingdom (2016 data) to 11.3 days in Ireland, although Sweden (4.6 days), Denmark (3.6 days, 2016 data) and the Netherlands (3.1 days) were below this range and Malta (14.6 days) above it. The average length of stay for prostate cancer in-patients was quite similar to the average for all male in-patients having been treated for neoplasms (whether malignant cancer, in situ or benign): in most Member States the average stay for prostate cancer was less than 2.5 days longer or shorter than the average for all neoplasms. However, in Spain and the United Kingdom the average length of stay for prostate cancer in-patients was nearer three days shorter, while in Lithuania the average length of stay was 3.2 days longer and in Malta it was 4.2 days longer.
**Source data for tables and graphs**

- *Cancer statistics — specific cancers: tables and figures*

**Data sources**

**Key concepts**

An in-patient is a patient who is formally admitted (or 'hospitalised') to an institution for treatment and/or care and stays for a minimum of one night or more than 24 hours in the hospital or other institution providing in-patient care. An in-patient or day care patient is discharged from hospital when formally released after a procedure or course of treatment (episode of care). A discharge may occur because of the finalisation of treatment, signing out against medical advice, transfer to another healthcare institution, or because of death.

The number of deaths from a particular cause of death can be expressed relative to the size of the population. A standardised (rather than crude) death rate can be compiled which is independent of the age and sex structure of a population: this is done as most causes of death vary significantly by age and according to sex and the standardisation facilitates comparisons of rates over time and between countries.

**Causes of death**

Statistics on causes of death provide information on mortality patterns, supplying information on developments over time in the underlying causes of death. This source is documented in more detail in this background article which provides information on the scope of the data, its legal basis, the methodology employed, as well as related concepts and definitions.

Causes of death are classified according to the *European shortlist* (86 causes), which is based on the *International Statistical Classification of Diseases and Related Health Problems (ICD)*. Chapter II of the ICD covers neoplasms, including (among others):

- C15-C26 Malignant neoplasms of digestive organs, including (among others):
  - C18 Malignant neoplasm of colon;
  - C19 Malignant neoplasm of rectosigmoid junction;
  - C20 Malignant neoplasm of rectum;
  - C21 Malignant neoplasm of anus and anal canal;
- C30-C39 Malignant neoplasms of respiratory and intrathoracic organs, including (among others):
  - C33–34 Malignant neoplasm of trachea, bronchus and lung;
  - C50 Malignant neoplasm of breast;
- C60–C63 Malignant neoplasms of male genital organs, including (among others):
  - C61 Malignant neoplasm of prostate.

For country specific notes on this data collection, please refer to this [background information document](#).

**Healthcare resources and activities**

Statistics on healthcare resources (such as personnel and medical equipment) and healthcare activities (such as information on surgical operations, procedures and hospital discharges) are documented in this background article which provides information on the scope of the data, its legal basis, the methodology employed, as well as related concepts and definitions.

For hospital discharges and the length of stay in hospitals, the *International Shortlist for Hospital Morbidity Tabulation (ISHMT)* is used to classify data from 2000 onwards; Chapter II covers neoplasms and includes the following headings (among others):
• Malignant neoplasm of colon, rectum and anus (0201);
• Malignant neoplasms of trachea, bronchus and lung (0202);
• Malignant neoplasm of breast (0204);
• Malignant neoplasm of prostate (0207).

For country specific notes on this data collection, please refer to this background information document.

Self-reported data on screening for colorectal cancer (referring to the population aged 50 to 74 years who reported having had a faecal occult blood test) come from the European health interview survey (EHIS) and are available for more than half of the EU Member States and for Turkey. This source is documented in more detail in this background article which provides information on the scope of the data, its legal basis, the methodology employed, as well as related concepts and definitions.

Data on screening for breast cancer (referring to the population aged 50 to 69 years) come from survey or programme-based data. This source is documented in more detail in this background article which provides information on the scope of the data, its legal basis, the methodology employed, as well as related concepts and definitions.

Symbols

Note on tables:
• a colon ‘:’ is used to show where data are not available;
• a dash ‘–’ is used to show where data are not applicable/relevant.

Context

The most frequently occurring forms of cancer in the EU are colorectal, breast, prostate and lung cancers. Among men, lung cancer is the most frequent cause of death from cancer, with a standardised death rate in the EU-28 that in 2016 was approximately double that for colorectal cancer and prostate cancer. Among women, breast cancer and lung cancer are the most common causes of death.

Primary prevention offers the most cost-effective, long-term strategy for reducing the burden of diseases in the EU; it involves tackling major health determinants, such as smoking, unhealthy diets and physical inactivity. The European Commission has supported many projects related to health determinants and health promotion in general.

Secondary prevention aims to reduce mortality by early detection of cancer through screening. In December 2003, a Council Recommendation on cancer screening was adopted, setting out principles of best practice in the early detection of cancer. This invited EU Member States to take common action to implement national population-based screening programmes for breast, cervical and colorectal cancer, with appropriate quality assurance at all levels. In September 2014, the European Commission adopted its second report on the implementation of the Council Recommendation noting that the number of adults surviving for at least five years after diagnosis has risen steadily over time across the EU, reflecting major advances in cancer management such as organised cancer screening programmes and improved treatments. This was followed in February 2017 by a more detailed report Against cancer: cancer screening in the European Union (2017).

Other articles

Online publications
• Health in the European Union — facts and figures
• Disability statistics

Health status — selected diseases and related health problems

• Cancer

Causes of death

• Causes of death

• Causes of death of statistics — people over 65

Healthcare activities

• Hospital discharges and length of stay

• Preventive services

Methodology

• Healthcare non-expenditure statistics

• European health interview survey

• Causes of death statistics

General health statistics articles

• Health statistics introduced

• Health statistics at regional level

• The EU in the world — health

Publications

• More than 670 000 persons died in the EU from respiratory diseases — News release

• 1 in 4 deaths caused by cancer in the EU28 — Lung cancer main fatal cancer — News release

• Health statistics — Atlas on mortality in the European Union

Main tables

• Health (t_hlth), see:

Health care (t_hlth_care)

Causes of death (t_hlth_cdeath)

Database

• Health (hlth), see:

Health care (hlth_care)

Health care resources (hlth_res)

Health care staff (hlth_staff)

Health care facilities (hlth_facil)

Health care activities (hlth_act)

Hospital discharges and length of stay for inpatient and curative care (hlth_co_dischls)

Hospital discharges - national data (hlth_hosd)

Length of stay in hospital (hlth_hostay)

Operations, procedures and treatment (hlth_oper)

Causes of death (hlth_cdeath)

General mortality (hlth_cd_gmor)

Causes of death - deaths by country of residence and occurrence (hlth_cd_aro)

Causes of death - standardised death rate by residence (hlth_cd_asdr2)
Dedicated section

- Health

Methodology

- Causes of death statistics (ESMS metadata file — hlth_cdeath_esms)
- European health interview survey (ESMS metadata file — hlth_det_esms)
- Healthcare activities (ESMS metadata file — hlth_act)
- Healthcare resources (ESMS metadata file — hlth_res)

External links

- Cancer control Joint Action (CanCon)
- European Commission — Directorate-General for Health and Food Safety — Public health, see:
  - European Commission — Directorate-General for Health and Food Safety — Non-communicable diseases
    - European Commission — Directorate-General for Health and Food Safety — Non-communicable diseases — Cancer
    - European Commission — Directorate-General for Health and Food Safety — European core health indicators (ECHI)
    - Joint OECD / European Commission report 'Health at a Glance: Europe'

- OECD — Health policies and data
- WHO Global Health Observatory (GHO) — Mortality and global health estimates
- World Health Organisation (WHO) — Health systems