WORLD HEALTH ORGANIZATION
EUROPE

Highlights on health in Cyprus

2005

Highlights on health give an overview of a country's health status, describing recent data on mortality, morbidity and exposure to key risk factors along with trends over time. The reports link country findings to public health policy considerations developed by the WHO Regional Office for Europe and by other relevant agencies. *Highlights on health* are developed in collaboration with Member States and do not constitute a formal statistical publication.
Each report also compares a country, when possible, to a reference group. This report uses the 27 countries with very low child mortality and very low adult mortality, designated Eur-A by WHO, as the reference group. Eur-A comprises Andorra, Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Germany, Greece, Finland, France, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

To make the comparisons as valid as possible, data, as a rule, are taken from one source to ensure that they have been harmonized in a reasonably consistent way. Unless otherwise noted, the source of data in the reports is the European health for all database of the WHO Regional Office for Europe. Other data and information are referenced accordingly.

Keywords

HEALTH STATUS
BURDEN OF DISEASE
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Summary: findings and policy considerations

Life expectancy

WHO estimates that a person born in Cyprus in 2002 can expect to live 77.3 years on average: 79.1 years if female and 75.5 years if male. Life expectancy in Cyprus has been slightly higher than the Eur-A average for males, but below the Eur-A average for females. People in Cyprus spend 12.5% (9.7 years) of their lives on average with illness.

As the length of life increases, older people can respond with lifestyle changes that can increase healthy years of life. Correspondingly, health care systems need to shift towards more geriatric care, the prevention and management of chronic diseases and more formal long-term care. Since people are living longer, measures to improve health and prevent disease need to focus on people of working age.

Ageing and employment policies (OECD, 2004)

What are the main risk factors for disability in old age and how can disability be prevented? (Health Evidence Network, 2003a)

Infant mortality

Infant mortality in Cyprus in 2003 was below five deaths per 1000 live births, equals to the Eur-A average.

Antenatal care is one of the most important services in health care. Nevertheless, it can be expensive, and interventions may be excessive, unneeded and unproven. A simplified model of antenatal care, based on evidence of benefit, is available.

Managing newborn problems: a guide for doctors, nurses and midwives (WHO, 2003a)

What is the efficacy/effectiveness of antenatal care? (Health Evidence Network, 2003b)

The WHO reproductive health library, version 6 (WHO, 2003b)

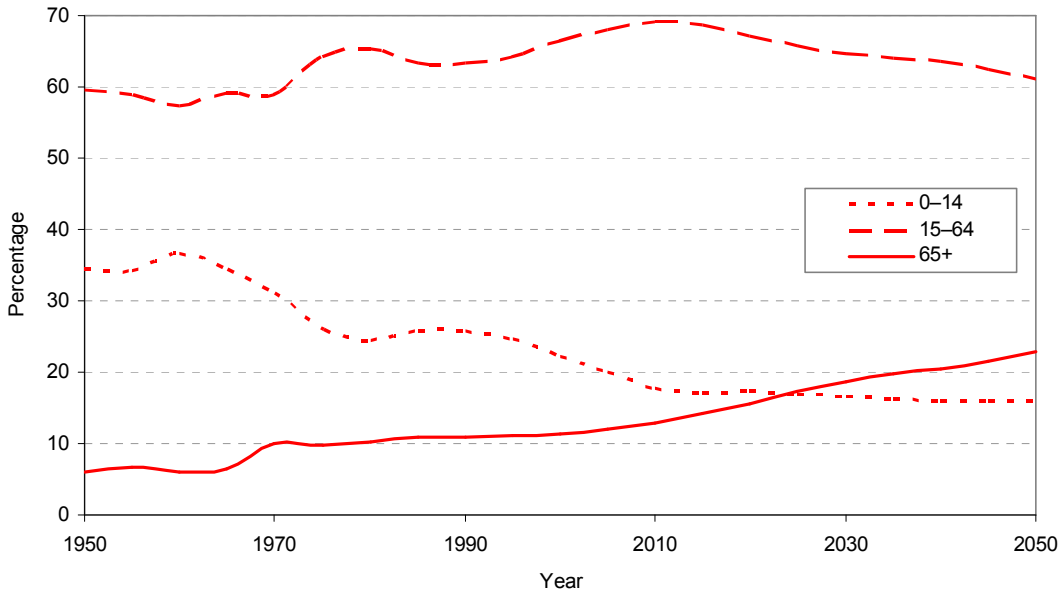
Selected demographic and socioeconomic information

Population profile

About 720 000 people lived in Cyprus in mid-2003. Compared to Eur-A averages, Cyprus has a higher proportion of 0–14 year olds and a lower proportion of people 65 and over.

The most striking demographic feature observed across most Eur-A countries is the increase in the proportion of elderly people in the population. As the large birth cohorts of the late 1940s approach retirement age, the number of people in Cyprus aged 65 and over is expected to grow by 50% – from about 12% of the population in 2003 (Council of Europe, 2005) to over 18% – by 2030 (Annex. Age pyramid; Figure. Population trends).

Percentage of the population aged 0–14, 15–64 and 65+ years, Cyprus, 1950 to 2050 (projected)



Source: United Nations (2005).

The birth rate in Cyprus was slightly above the Eur-A average in 2003, although it had dropped about 30% since 1995. Natural increase and net migration in Cyprus are both well above Eur-A averages, by four and two times, respectively (Table. Selected demographic indicators).

Selected demographic indicators in Cyprus and Eur-A
2003 or latest available year

Indicators	Cyprus	Eur-A		
	Value	Average	Minimum	Maximum
Population (in 1000s)	720.6	–	–	–
0–14 years (%)	20.0	–	–	–
15–64 years (%)	68.1	–	–	–
65+ years (%)	11.9	–	–	–
Urban population (%)	69.3	78.5	50.8	100.0
Live births (per 1000)	11.2	10.7	8.6	21.7
Natural population growth (per 1000)	4.0	1.1	–2.9	15.9
Net migration (per 1000)	17.1	3.5	–0.5	8.8

Sources: Council of Europe (2005), WHO Regional Office for Europe (2005).

Socioeconomic indicators

Health outcomes are influenced by various factors that operate at individual, household and community levels. Obvious factors are, for example, diet, health behaviour, access to clean water, sanitation and health services. However, underlying health determinants of a socioeconomic nature also play a role in causing vulnerability to health risks. Here, the key factors are income, education and employment. Though moderately correlated and interdependent, each of these three determinants captures distinctive aspects of the socioeconomic background of a population and they are not interchangeable. Various indicators represent the key socioeconomic determinants of health.

Income: absolute poverty, relative poverty and income distribution

There is an income gradient affecting health: the poor generally suffer worse health and die younger than people with higher incomes. For instance, the latter are better able to afford the goods and services that contribute to health, for example, better food and living conditions.

In Cyprus, per capita gross national income, adjusted for purchasing power parity, was US$ 12 692 in 2002 (WHO, 2005).

Education

Education tends to enhance an individual's job opportunities. In so doing, it can improve income, which in turn affects health positively. Education can also give more access to knowledge about healthy behaviour and increase the tendency to seek treatment when needed. A lower level of education – independent of individual income – is correlated with the inability to cope with stress, with depression and hostility and with adverse effects on health.

School enrolment is an indicator of access to education. The secondary school net enrolment represents the percentage of the total population of official school age (defined nationally) that is enrolled in secondary schools.

The proportion of school-age children who were enrolled in secondary schools in Cyprus in 2000 was 88.3% (93.2% in 2003), compared to the 88.5% Eur-A average. Among the Eur-A countries reporting these data in 2000, the lowest enrolment rate was in Luxembourg at 79.7% and the highest was in Slovenia at 96.0% (UNESCO, 2005).

Employment

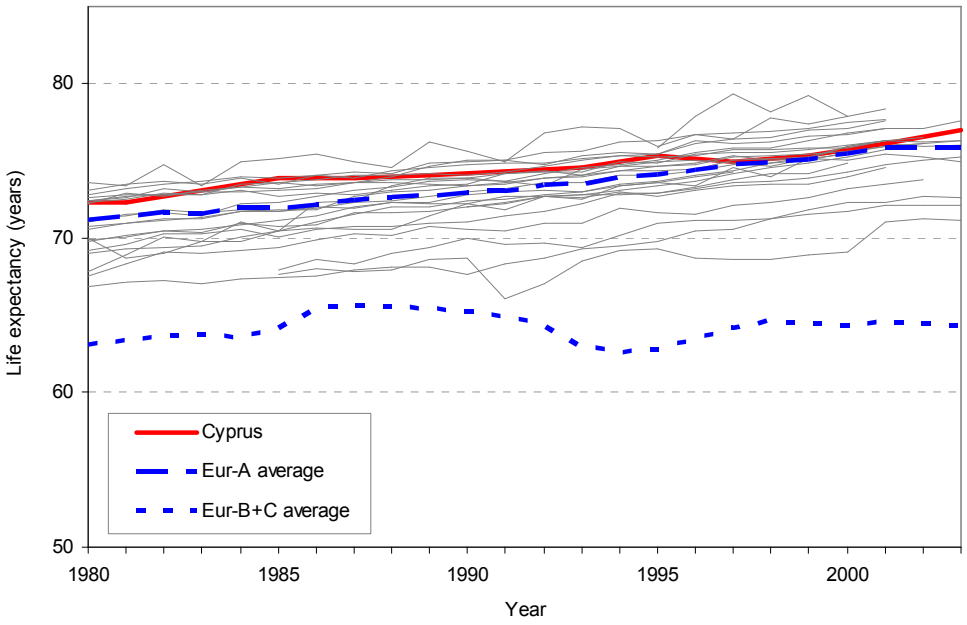
Being employed tends to be better for health than being unemployed, except in circumstances where employment exposes the individual to physical injury or psychological stress. National unemployment rates and rates for particular sub-populations are monitored to assess the extent to which people have or lack access to opportunities that would enable them to earn an income and feel secure. Vulnerability to health risk is increased by long-term unemployment, that is, continuous periods without work, usually for a year or longer; the socioeconomic status of an individual and of his/her dependents can slide as the period of unemployment increases.

The overall reported unemployment rate in Cyprus in 2001 was 2.9% (3.5% in 2003) compared to the 6.2% Eur-A average, keeping in mind that national rates are based on estimates of people available and seeking employment, and that countries have different definitions of labour force and unemployment. Unemployment among 15 to 24 year-olds was 6.6% in 2001. The rate was higher than the overall national average but lower than the 13.8% Eur-A average (ILO, 2005).

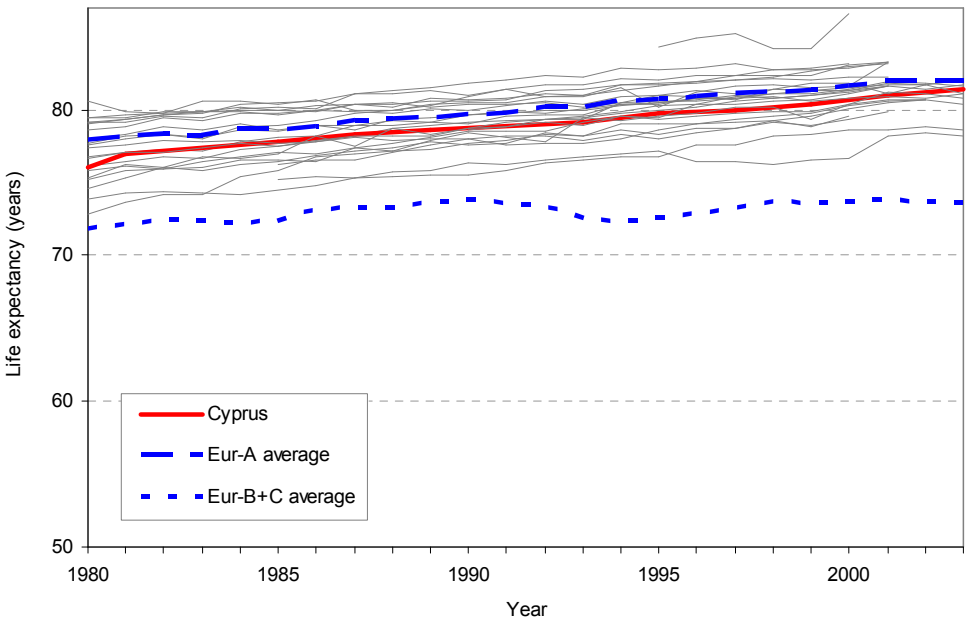
Life expectancy (LE) and healthy life expectancy (HALE)

According to WHO (2003c) estimates, a person born in Cyprus in 2002 can expect to live 77.3 years on average: 79.1 years if female and 75.5 years if male. For the same year, the Ministry of Health reported LE of 79.2 years for both sexes: 81.4 years for females and 77.0 for males. LE in Cyprus is slightly higher than the Eur-A average for males, but below the Eur-A average for females (Figure. Life expectancy for males; Figure. Life expectancy for females).

Life expectancy at birth for males, Cyprus, Eur-A and Eur-B+C averages, 1980 to latest available year

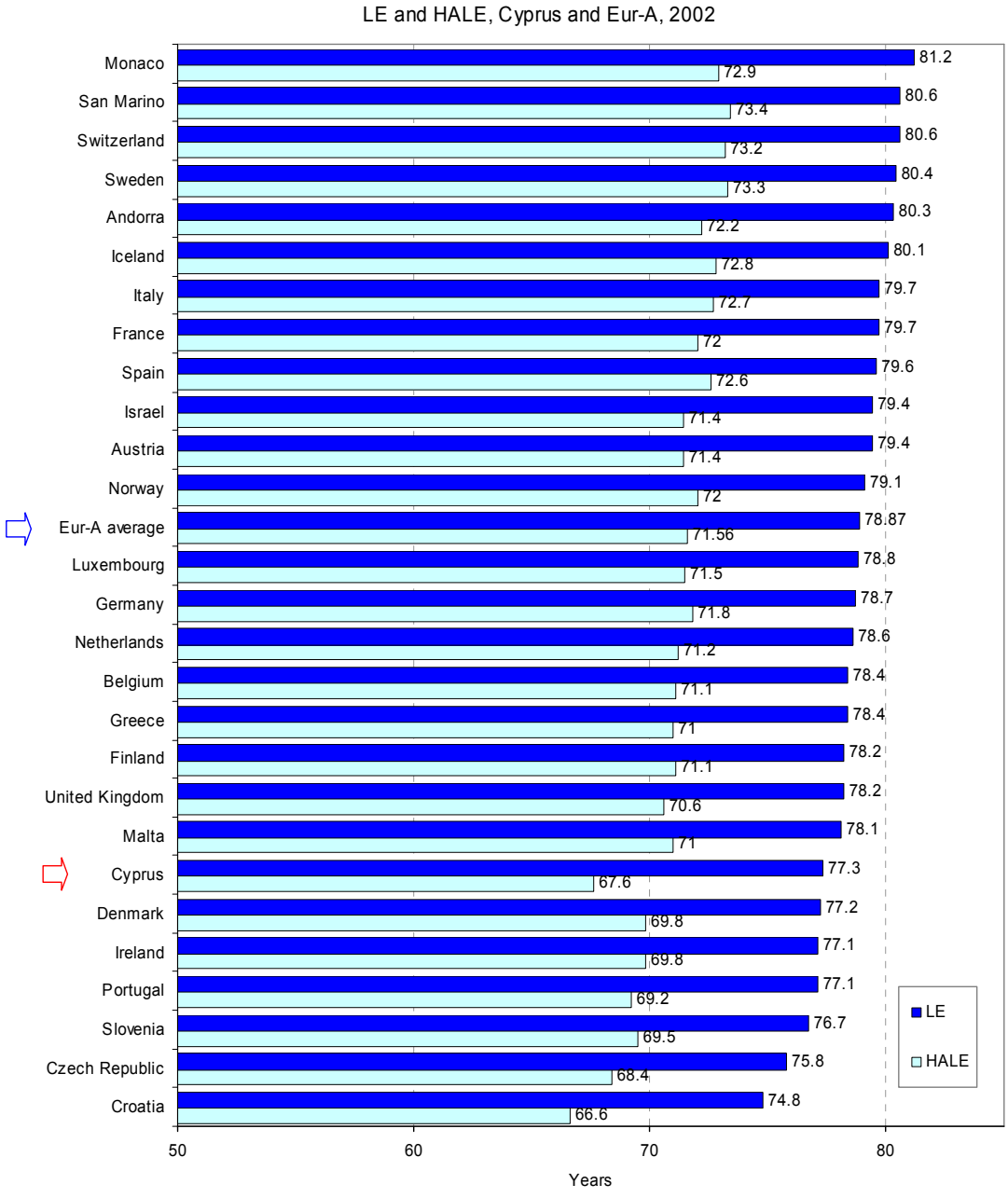


Life expectancy at birth for females, Cyprus, Eur-A and Eur-B+C averages, 1980 to latest available year



In addition to LE, it is increasingly important to know the expected length of life spent in good health. WHO uses a relatively new indicator for this purpose – healthy life expectancy (HALE),

subtracting estimated years of life spent with illness and disability from estimated LE. For Cyprus**,** WHO (2003c) estimates that people can expect to be healthy for about 87% of their lives. They lose an average of 9.7 years to illness – the difference between LE and HALE. This loss is more than two years more than the Eur-A average (7.3 years) and the Eur-B+C average (7.6 years); it is the largest loss in the WHO European Region (Figure. LE and HALE).



Source: WHO (2003c).

Since women live longer and since the possibility of deteriorating health increases with age, women lose more healthy years of life (10.6 years) than men (8.8 years). Nevertheless, the longer LE for women in Cyprus gives them 1.8 more years of healthy life. For 60 years olds, the gender difference is even smaller: females (15.0 years) live less than one year longer in good health compared to males (14.2 years) according to the WHO estimates (2003c).

Burden of disease

The burden of disease in a population can be viewed as the gap between current health status and an ideal situation in which everyone lives into old age, free of disease and disability. Causing the gap are premature mortality, disability and certain risk factors that contribute to illness. The analysis that follows elaborates on the burden of disease in the population. The disability-adjusted life-year (DALY) is a summary measure that combines the impact of illness, disability and mortality on population health.

Main conditions

The table below has the top 10 conditions, in descending order, that account for approximately 90% of the burden of disease among males and females in Cyprus. Cardiovascular diseases account for the most DALYs among males in the country and sense organ diseases the most among females. Neuropsychiatric disorders rank second highest among both males and females. Because mortality from neuropsychiatric conditions is minor, disability in daily living comprises the bulk of their burden on the population's health (Table. Ten leading disability groups).

Ten leading disability groups as percentages of total DALYs for both sexes in Cyprus (2002)

Rank	Males		Females	
	Disability groups	Total DALYs (%)	Disability groups	Total DALYs (%)
1	Cardiovascular diseases	21.1	Sense organ diseases	19.7
2	Neuropsychiatric conditions	15.8	Neuropsychiatric conditions	19.4
3	Sense organ diseases	15.6	Cardiovascular diseases	17.3
4	Unintentional injuries	13.3	Malignant neoplasms	8.2
5	Malignant neoplasms	7.0	Diabetes mellitus	5.5
6	Respiratory diseases	5.6	Respiratory diseases	4.3
7	Musculoskeletal diseases	2.9	Unintentional injuries	3.8
8	Respiratory infections	2.8	Musculoskeletal diseases	3.8
9	Digestive diseases	2.8	Infectious and parasitic diseases	3.0
10	Infectious and parasitic diseases	2.5	Respiratory infections	2.9

Source: Background data from WHO (2003c).

Main risk factors

The table below has the top 10 risk factors with their relative contributions, in descending order, to burden of disease in the male and female populations of Cyprus. According to DALYs, tobacco use and high blood pressure place the greatest burden of disease on the Cypriot male population and high blood pressure and high BMI on females (Table. Ten leading risk factors).

Ten leading risk factors as causes of disease burden measured in DALYs in Cyprus (2002)

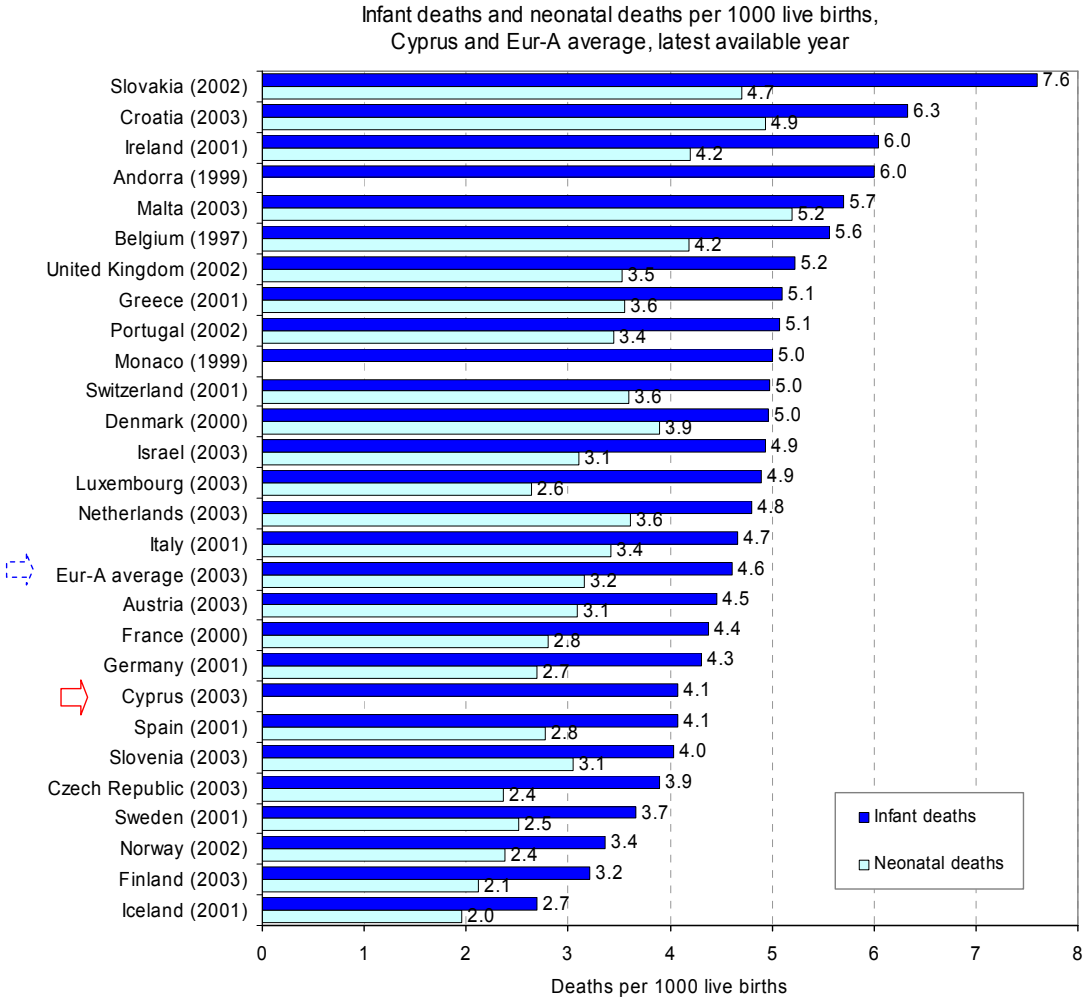
Rank	Males		Females	
	Risk factors	Total DALYs (%)	Risk factors	Total DALYs (%)
1	Tobacco	9.3	High blood pressure	7.0
2	High blood pressure	9.0	High BMI	6.4
3	High cholesterol	4.7	High cholesterol	3.1
4	High BMI	4.0	Physical inactivity	2.4
5	Low fruit and vegetable intake	2.7	Tobacco	1.9
6	Physical inactivity	2.5	Iron deficiency	1.7
7	Alcohol	1.6	Low fruit and vegetable intake	1.6
8	Occupational risk factors for injuries	1.6	Unsafe sex	1.5
9	Illicit drugs	1.6	Lead	1.0
10	Iron deficiency	1.4	Childhood sexual abuse	0.8

Source: Background data from WHO (2003c).

Mortality

Infant, neonatal and child mortality

Infant mortality in Cyprus was almost double the Eur-A average in 1980, but it has decreased significantly since then. The most recent rate, from 2003, is below five infant deaths per 1000 live births, equal to the Eur-A average. The WHO/UNICEF estimate for 2000 (7/1000) is slightly higher than the national figure (6/1000), but still low (WHO, 2004) (Figure: Infant deaths and neonatal deaths).



National data and WHO estimates for 2003 show that, out of every 1000 live births in Cyprus, there is a probability that about five children will die before the age of five. The estimated probability for 2003, based on national data, was the same, five deaths per 1000 live births. The Eur-A average rate for 2001–2003 varied between five and six per 1000 live births.

Maternal mortality

Maternal mortality rates (MMR) and the Millennium Development Goal (MDG)

Despite the difficulties in accurately measuring MMR, nationally reported figures are accepted at face value relative to the MDG to improve maternal health – to reduce the MMR by 75% between 1990 and 2015. In some countries, the 2015 target may be equal to or lower than the average current MMR for high income countries in the European Region (the Eur-A 2001 average of five maternal deaths per 100 000 live births). Countries with 2015 targets lower than the current Eur-A average can be judged as having achieved or being likely to achieve the MDG (World Bank, 2004).

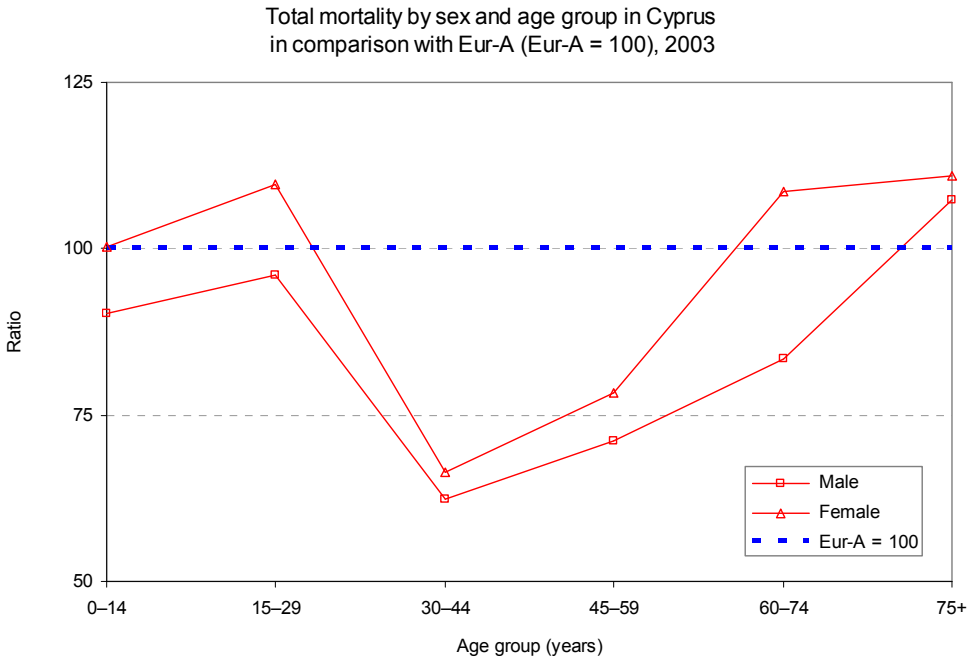
However, in some countries, MMR were higher in 2002 than they had been in 1990. Applying the 75% reduction to the 1990 baseline in these countries creates, in some cases, a 2015 MDG target that requires dramatic reductions in MMR before 2015. In these cases, more important than reaching maternal mortality targets is taking concrete action to provide women with access to adequate care during pregnancy and childbirth, initiatives that have proven to bring down MMR.

Three maternal deaths were reported in Cyprus from 1999 to 2001, an MMR of 12 per 100 000 live births, double the Eur-A average. However, changes in small countries like Cyprus over a short period of time should be assessed with special consideration. None of these maternal deaths was due to induced or spontaneous abortion (including ectopic pregnancies).

Excess mortality

In general, mortality rates for males in Cyprus are 8% lower than the Eur-A average, but the rates for females are 5% higher.

Cypriot women under 30 years old or over 60 have the same or up to 10% higher mortality than those in the Eur-A countries on average. Other age groups have low mortality rates, especially women 30–44 years old. Men under 75 years old have a lower total mortality rate than their Eur-A counterparts. Men 30–44 years old have the lowest mortality rate, even lower than Cypriot females (Annex. Mortality data; Figure. Total mortality by sex and age group).



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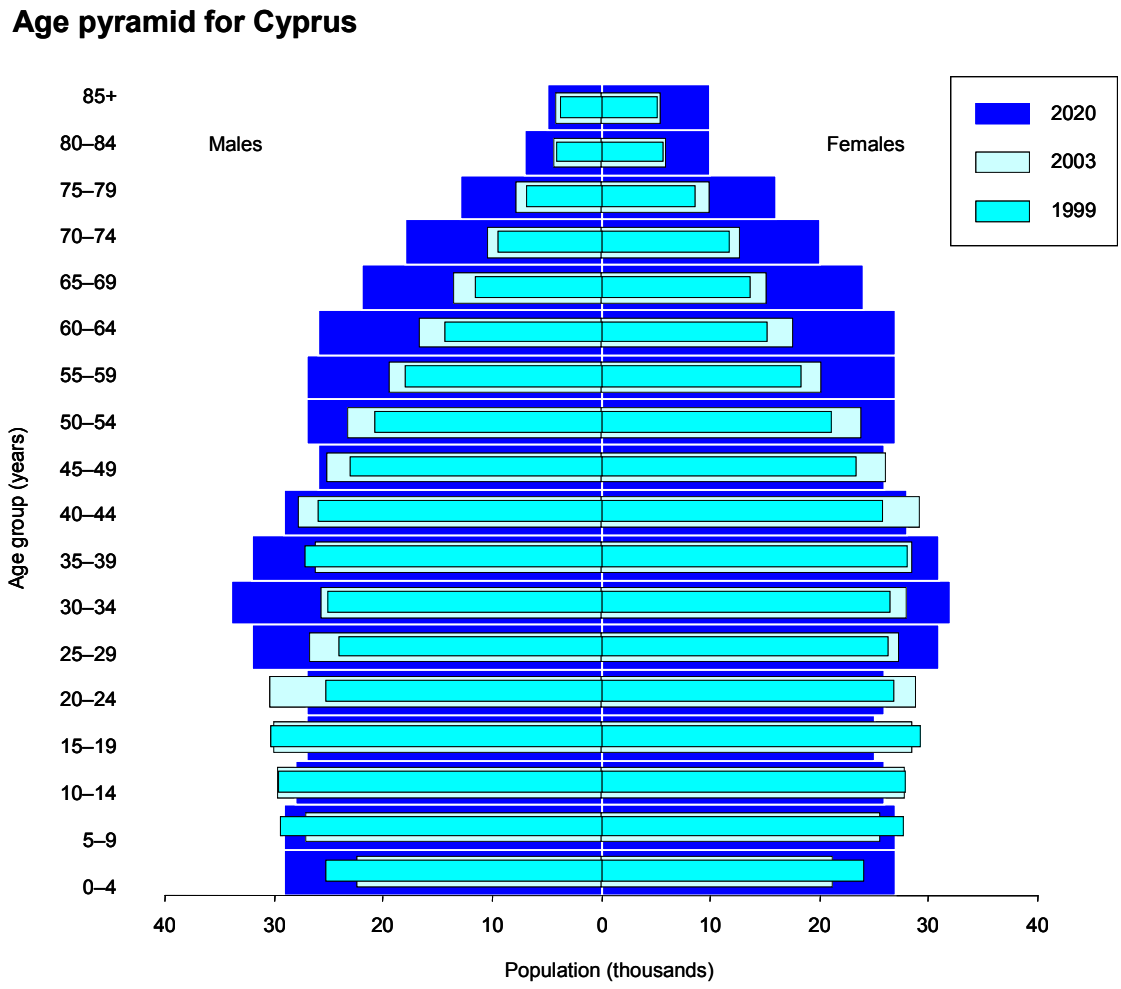
Annexes

Annex. Age pyramid



Sources: WHO Regional Office for Europe (2005) and United Nations (2005).

Annex. Mortality data

All causes of death,
SDR per 100 000 population and percentage changes from 1995 to 2003

	Sex	Rate	Eur-A country average	Eur-A average annual change (%)	Eur-B+C country average	Eur-B+C average annual change (%)
0–14 years	Both	46.8	49.4	–2.4	151.7	–3.8
	M	49.8	55.3	–2.5	170.5	–3.9
	F	43.5	43.3	–2.4	131.9	–3.8
15–29 years	Both	55.8	56.0	–2.3	161.0	–0.9
	M	78.7	82.0	–2.3	241.7	–1.0
	F	32.1	29.3	–2.2	79.0	–0.6
30–44 years	Both	75.5	120.3	–2.5	453.8	–0.7
	M	100.9	161.6	–2.6	700.0	–0.8
	F	52.1	78.5	–2.1	215.6	–0.2
45–59 years	Both	318.9	435.6	–1.3	1294.9	–0.6
	M	412.0	580.1	–1.4	1981.7	–0.6
	F	229.9	293.3	–1.0	698.9	–0.5
60–74 years	Both	1463.0	1570.9	–1.9	3411.7	–0.1
	M	1801.8	2156.9	–2.1	4996.4	0.1
	F	1161.1	1069.2	–1.9	2339.0	–0.6
75+	Both	9016.7	8059.6	–1.0	12338.8	0.0
	M	10541.3	9832.0	–1.1	14838.0	0.1
	F	7897.2	7112.5	–0.9	11421.7	–0.0

		Cyprus	Eur-A	Eur-B+C
Total all causes	Both sexes	637.9	648.1	1311.2

Technical notes

Calculation of averages

Averages for the reference group, when based on data in the European health for all database of the WHO Regional Office for Europe, are weighted by population. Some countries with insufficient data may be excluded from the calculation of averages. Otherwise, for data from other sources, simple averages have been calculated where required.

To smooth out fluctuations in annual rates caused by small numbers, three-year averages have been used, as appropriate. For example, maternal mortality, usually a small number, has three-year moving averages calculated for all countries. When extreme fluctuations are known to be due to population anomalies, data have been deleted, as appropriate.

Data sources

To make the comparisons as valid as possible, data for each indicator have, as a rule, been taken from one source to ensure that they have been harmonized in a reasonably consistent way. Unless otherwise noted, the source of data for figures and tables in this report is the January 2005 version of the European health for all database of the WHO Regional Office for Europe. The health for all database acknowledges the various primary sources of the data.

In cases where current census data for national population are unavailable, coupled with ongoing migrations of people in and out of countries, UN estimates or provisional figures supplied by the country are used to approximate national population. Such population figures create uncertainty in standardized death rates.

Disease coding

Case ascertainment, recording and classification practices (using the ninth and tenth revisions of the International Statistical Classification of Diseases and Related Health Problems: ICD-9 and ICD-10, respectively), along with culture and language, can influence data and therefore comparability across countries.

Healthy life expectancy (HALE) and disability-adjusted-life-years (DALYs)

HALE and DALYs are summary measures of population health that combine information on mortality and non-fatal health outcomes to represent population health in a single number. They complement mortality indicators by estimating the relative contributions of different causes to overall loss of health in populations.

DALYs are based on cause-of-death information for each WHO region and on regional assessments of the epidemiology of major disabling conditions. The regional estimates have been disaggregated to Member State level for the highlights reports.

National estimates of HALE are based on the life tables for each Member State, population representative sample surveys assessing physical and cognitive disability and general health status, and on detailed information on the epidemiology of major disabling conditions in each country.

More explanation is provided in the statistical annex and explanatory notes of *The world health report 2003*[1].

Limitations of national-level data

National-level averages, particularly when they indicate relatively good positions or trends in health status, as is the case in most developed countries, hide pockets of problems. Unless the health status of a small population is so dramatically different from the norm that it influences a national indicator, health risks and poorer health outcomes for small groups will only become evident through subnational data.

[1] WHO (2003). *The world health report 2003 – Shaping the future.* Geneva, World Health Organization (http://www.who.int/whr/2003/en, accessed 10 June 2005).

Reference groups for comparison

When possible, international comparisons are used as one means of assessing a country's comparative strengths and weaknesses and to provide a summary assessment of what has been achieved so far and what could be improved in the future. Differences between countries and average values allow the formulation of hypotheses of causation or imply links or remedies that encourage further investigation.

The country groups[1] used for comparison are called reference groups and comprise:

- countries with similar health and socioeconomic trends or development; and/or
- geopolitical groups.

The 27 countries with very low child mortality and very low adult mortality are designated Eur-A by WHO. Eur-A comprises Andorra, Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland and the United Kingdom. However, data for most indicators are unavailable for two of the 27 countries: Andorra and Monaco. Therefore, unless otherwise indicated, Eur-A and averages for Eur-A refer to the 25 countries for which data are available.

The 25 countries with low child mortality and low or high adult mortality are designated Eur-B+C by WHO. Eur-B+C comprises Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Russian Federation, Serbia and Montenegro, Slovakia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, and Uzbekistan. Unless otherwise indicated, Eur-B+C and averages for Eur-B+C refer to these countries.

Comparisons should preferably refer to the same point in time, but the countries' latest available data are not all for the same year. This should be kept in mind as a country's position may change when more up-to-date data become available.

Graphs have usually been used to show time trends from 1980 onwards. These graphs present the trends for all the reference countries as appropriate. Only the country in focus and the group average are highlighted and identified in the legend. This enables the country's trends to be followed in relation to those of all the reference countries, and performance in relation to observable clusters and/or the main trend or average to be recognized more easily.

[1] WHO (2004). *The world health report 2004 – Changing history.* Geneva, World Health Organization (http://www.who.int/whr/2004/en, accessed 26 August 2004.

Glossary

Causes of death	*ICD-10 code*
Cerebrovascular diseases	I60–I69
Chronic liver disease and cirrhosis	K70, K73, K74, K76
Chronic obstructive pulmonary disease	J40–J47
Colon/rectal/anal cancer	C18–C21
Diseases of pulmonary circulation and other heart disease	I26–I51
Falls	W00–W19
Female breast cancer	C50
Ischaemic heart disease	I20–I25
Pneumonia	J12–J18
Prostate cancer	C61
Neuropsychiatric disorders	F00–99, G00–99, H00–95
Road traffic injuries	V02–V04, V09, V12–V14, V19–V79, V82–V87, V89
Self-inflicted (suicide)	X60–X84
Trachea/bronchus/lung cancer	C33–C34
Violence	X85–Y09

Technical terminology

Disability-adjusted life-year (DALY)	The DALY combines in one measure the time lived with disability and the time lost owing to premature mortality. One DALY can be thought of as one lost year of healthy life.
GINI index	The GINI index measures inequality over the entire distribution of income or consumption. A value of 0 represents perfect equality; a value of 100, perfect inequality. Low levels in the WHO European Region range from 23 to 25; high levels range from 35 to 36[1].
Healthy life expectancy (HALE)	HALE summarizes total life expectancy into equivalent years of full health by taking account of years lived in less than full health due to diseases and injuries.
Income poverty line (50% of median income)	The percentage of the population living below a specified poverty line: in this case, with less than 50% of median income.
Life expectancy at birth	The average number of years a newborn infant would live if prevailing patterns of mortality at the time of birth were to continue throughout the child's life.
Natural population growth	The birth rate less the death rate.
Neuropsychiatric conditions	Mental, neurological and substance-use disorders.
Population growth	(The birth rate less the death rate) + (immigration less emigration).
Standardized death rate (SDR)	The age-standardized death rate calculated using the direct method: that is, it represents what the crude rate would have been if the population had the same age distribution as the standard European population.

[1] WHO Regional Office for Europe (2002). *The European health report 2002*. Copenhagen, WHO Regional Office for Europe:156 (http://www.euro.who.int/europeanhealthreport, accessed 28 May 2004).