



# Highlights on health in Slovenia 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  
COMPARATIVE STUDY  
SLOVENIA  
EUR/05/5046413H  
<http://www.euro.who.int/highlights>

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## Summary: findings and policy considerations

### Life expectancy

WHO estimates that a person born in Slovenia in 2003 can expect to live 77 years on average: 80 years if female and 73 years if male. Life expectancy in Slovenia is one of the lowest in Eur-A and is lower than the Eur-A average in 2002: by three years for males and two years for females. People in Slovenia spend on average seven years with illness and disability (9% of life expectancy).

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

The infant mortality rate in Slovenia and both its components, neonatal and post neonatal mortality, are lower than the corresponding Eur-A average rates. The post neonatal mortality rate is one of the lowest in European countries.

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)

*What is the effectiveness of antenatal care? (Supplement)* (Health Evidence Network, 2005)

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

### Main causes of death

In 2003, the main noncommunicable diseases accounted for about 80% of all deaths in Slovenia; external causes for 9%; and communicable diseases for less than 1%. In total, 37% of all deaths were caused by diseases of the circulatory system and 26% by cancer, which is similar to the Eur-A averages.

In general, mortality rates for Slovene males and females are among the highest in Eur-A. A decline in mortality rates was interrupted during the period 1991–1993, and then the rates resumed their decline, in parallel to the Eur-A average rates for males, but the decline was even faster for females. In 2003, however, the rates increased slightly for both sexes. The largest excess mortality among Slovene males, in comparison with the Eur-A average, is for stomach cancer (almost a twofold difference in mortality rates in 2002) and cancer of the lip, oral cavity and pharynx (60% excess in 2002). Among Slovene females, the largest excess mortality, in comparison with the Eur-A average, is for cancer of the uterine cervix (almost 50% excess), cancer of other parts of the uterus and stomach cancer.

Preventive care, delivered through a country's primary care system, can reduce all-cause mortality and premature mortality, particularly from CVD.

*A strategy to prevent chronic disease in Europe: a focus on public health action: the CINDI vision* (WHO Regional Office for Europe, 2004a)

*Towards a European strategy on noncommunicable diseases* (WHO Regional Office for Europe, 2004b)

*What are the advantages and disadvantages of restructuring a health care system to be more focused on primary health care services?* (Health Evidence Network, 2004)

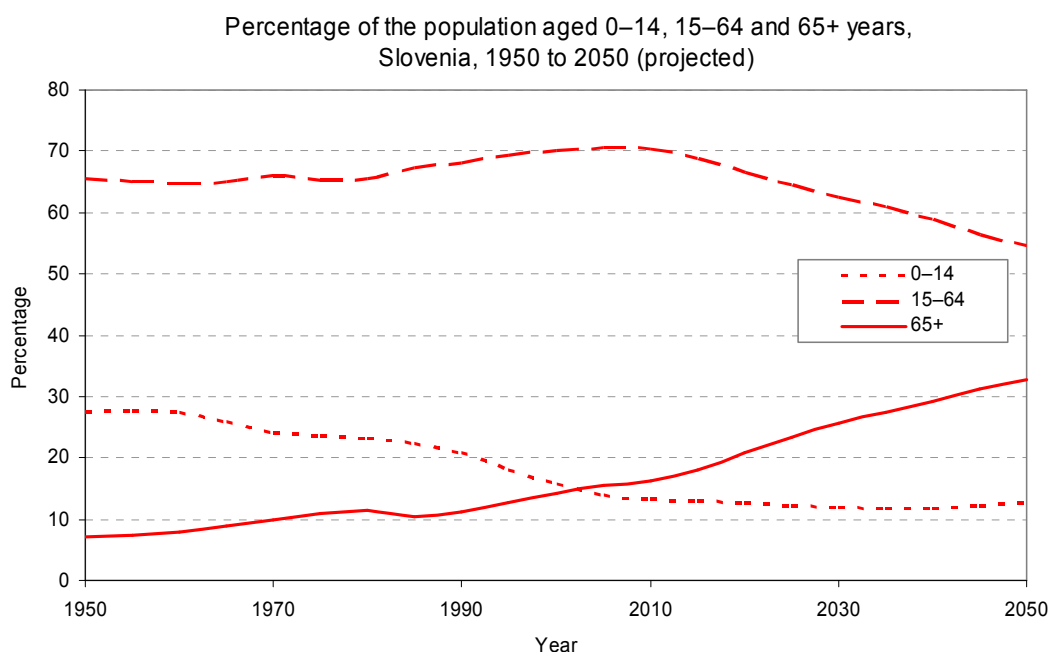
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## Selected demographic and socioeconomic information

### Population profile

In mid-2003, Slovenia had about 2 million people. About 50% of them lived in urban areas, which is the lowest percentage among Eur-A countries that year.

The percentage of the population 0–14 years old was relatively steady during the 1980s, but fell from about 21% in 1990 to 15% by 2003. The percentage is below the Eur-A average for this age group. Also, the percentage of Slovenia's population over 65 years old is below the Eur-A average. By 2030, an estimated 26% of Slovenia's population will be 65 years of age and older (Annex. Age pyramid)



The birth rate in Slovenia was the lowest in Eur-A in 2003. Also, natural population growth in Slovenia that year was negative and net migration positive, and both these indicators were below the corresponding Eur-A averages.

### Selected demographic indicators in the Slovenia and Eur-A, 2003 or latest available year

Indicators	Slovenia	Eur-A		
	Value	Average	Minimum	Maximum
Population (in 1000s)	1996.8	—	—	—
0–14 years (%)	14.8	—	—	—
15–64 years (%)	70.4	—	—	—
65+ years (%)	14.9	—	—	—
Urban population (%) <sup>a</sup>	50.8	78.5	50.8	100.0
Live births (per 1000)	8.6	10.7	8.6	21.7
Natural population growth (per 1000)	–1.2	1.1	–2.9	15.9
Net migration (per 1000) <sup>a</sup>	1.8	3.5	–0.5	8.8

<sup>a</sup> 2002.

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***

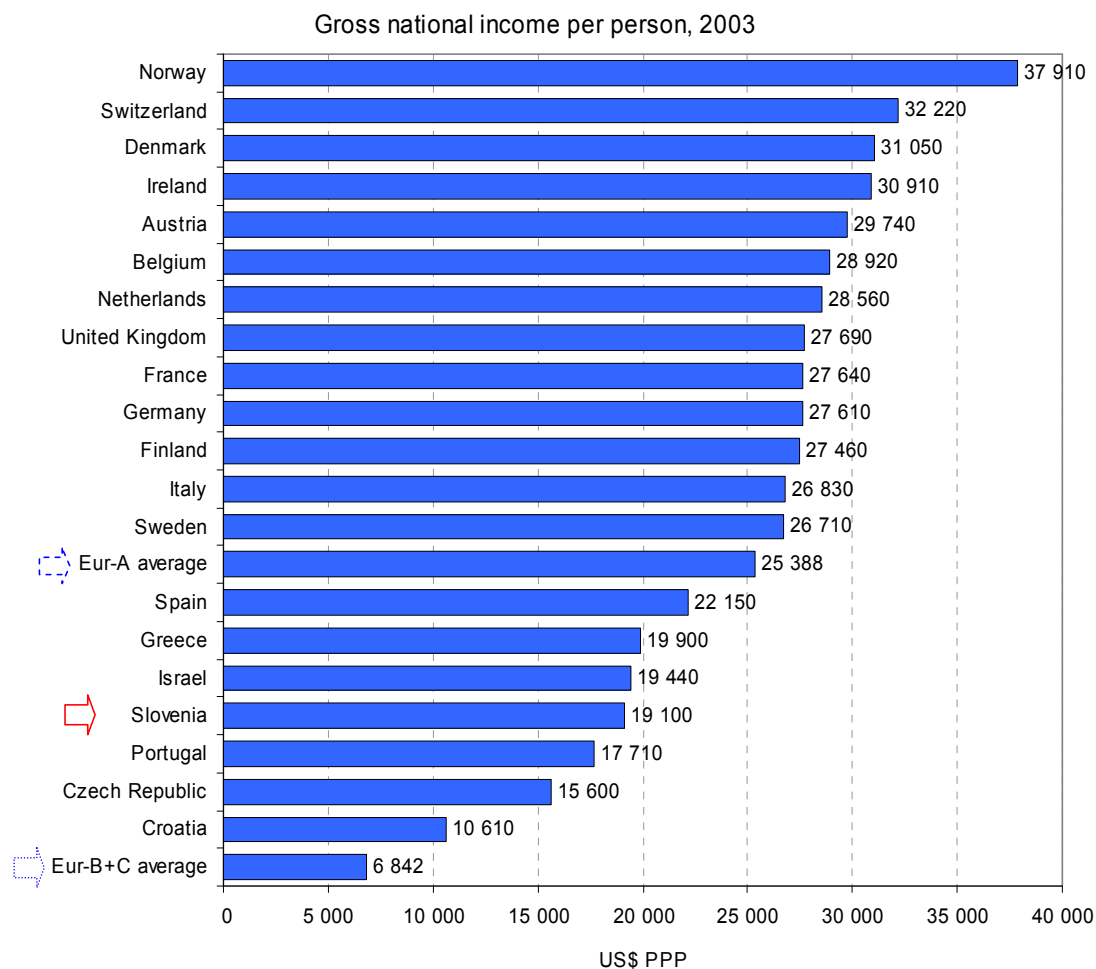
There is an income gradient affecting health: the poor generally suffer worse health and die younger than people with higher incomes. For instance, the latter are better able to afford the goods and services that contribute to health, for example, better food and living conditions.

People are considered to be in absolute poverty if their incomes are not sufficient to purchase very minimal goods and services. The World Bank currently uses an absolute poverty line of US\$ 2.15 and US\$ 4.30 income per capita per day to measure poverty in low- and middle-income countries of the WHO European Region (using 1993 international prices adjusted for purchasing power parity). While there is no certainty that the poverty lines measure the same degree of need across countries, the World Bank uses them as a constant to permit comparison. Many countries in the Region calculate their national poverty lines on the basis of a minimum consumption basket selected and priced according to the specific circumstances of the country.

Absolute poverty is rare in Slovenia. Using the World Bank benchmark of US\$ 4.30 income per person per day, less than 1% of the Slovene population lived in absolute poverty between 1987 (0.58%) and 1998 (0.62%) (World Bank, 2005).

Relative poverty is an indicator of income level below a given proportion (typically 50%) of the average national income. In high-income countries, there are far more pockets of relative poverty than of absolute poverty. In Slovenia, gross national income per person, adjusted for purchasing power parity (PPP), was US\$ 19 100 in 2003, the fourth lowest per person income in Eur-A. The Eur-A average that year was US\$ 25 388.

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In 2001, 11% of the population in Slovenia lived in relative poverty – that is, below the risk-of-poverty threshold set at 60% of the national median equivalent disposable income (after social redistribution). That same year, for the 17 Eur-A countries for which data are available, the average percentage of people living in relative poverty was 14% (Eurostat, 2005).

Another measure of relative poverty in terms of income is the Gini index. This presents the extent to which the distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution. A Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality.

For the two years 2000 and 2001, Gini indices based on World Bank estimates are available for seven Eur-A countries, ranging from 25.0 (Sweden, in 2000) to 36.0 (Italy, in 2000) (World Bank, 2005). The last available Gini index for Slovenia (28.4) is for 1998–1999.

### 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.



In 2000, 96.0% of Slovenia's school age children were enrolled in secondary schools, the highest percentage to be enrolled among the Eur-A countries with data for that year. The Eur-A average that year was 88.5% (UNESCO, 2005).

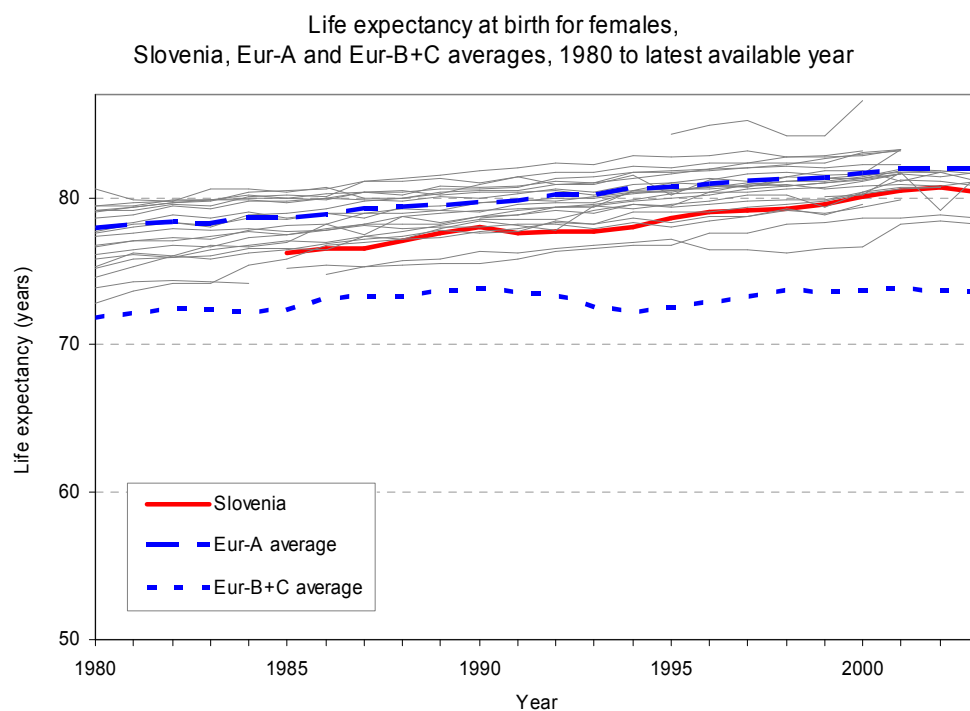
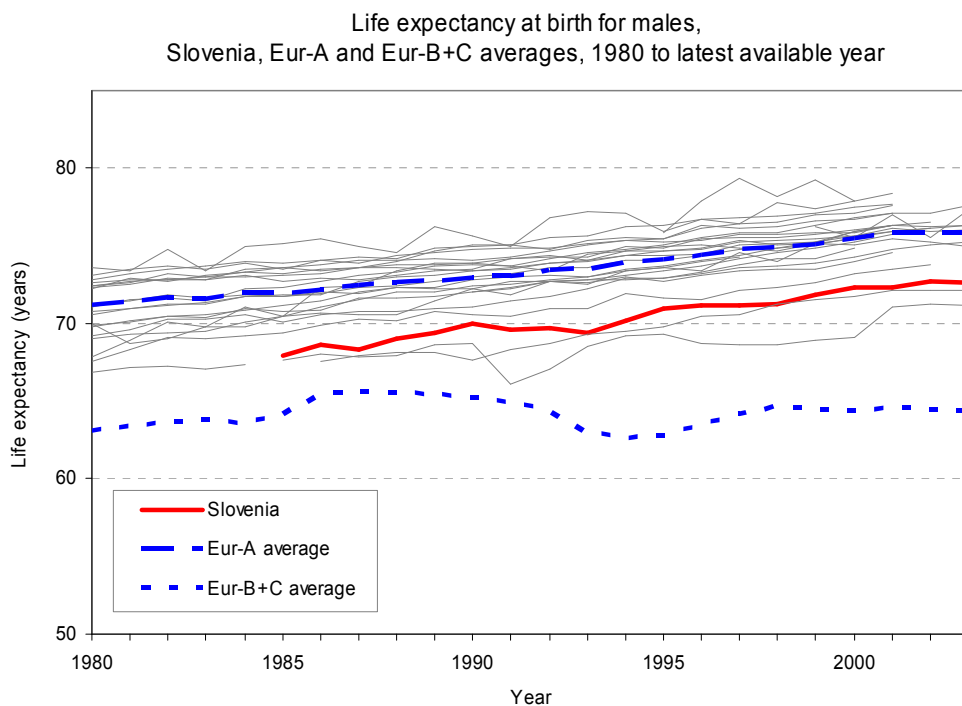
### **Employment**

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 total unemployment rate in Slovenia in 2001 was 5.9%, slightly lower than the Eur-A average of 6.2% that year, 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 (ILO, 2005). During the period 2000–2002, almost 60% of those unemployed had been so for a year or longer (World Bank, [2005](#)). In Slovenia, in 2001, unemployment among young people aged 15–24 years was higher than both the national average (16.2%) and the Eur-A average for young people (13.8%) (ILO, 2005).

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

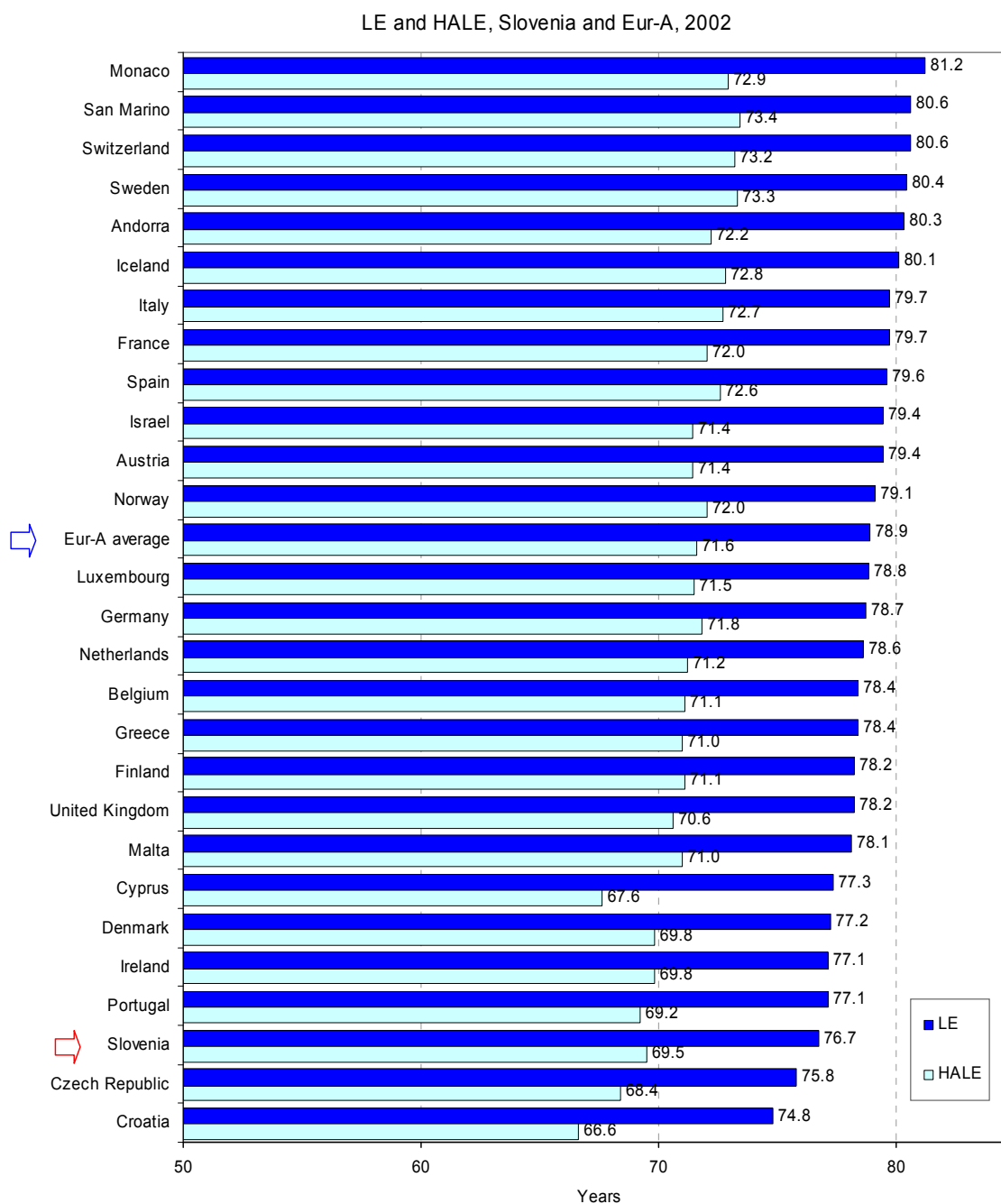
According to WHO (WHO, 2005) estimates, a person born in Slovenia in 2003 can expect to live 76.5 years on average: 80.4 years if female and 72.6 years if male. Life expectancy (LE) in Slovenia is one of the lowest in Eur-A countries and is lower than the Eur-A average in 2002: by 3.3 years for males and 1.5 years for females.



The increase in LE in Slovene males and females had a significant slump during the period 1991–1993. After 1995, the increase for Slovene males is similar to that of the Eur-A average, and for Slovene

females the gain is larger. As a consequence, the difference between LE in Slovenia and the Eur-A average LE declined from 2.0 years in 1995 to 1.3 years in 2002.

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 Slovenia, WHO (WHO, 2003c) estimates that people can expect to be healthy for about 91% of their lives. They lose an average of 7.2 years to illness – the difference between LE and HALE. This loss is similar to the Eur-A average (7.3 years) and the Eur-B+C average (7.6 years).



Since females generally live longer than males and since the possibility of deteriorating health increases with age, females lose more healthy years of life (8.2 years) than males (6.2 years). Nevertheless, the longer LE for females in Slovenia gives them 5.7 more years of healthy life than males.

At 60 years of age, this difference reduces to 3.8 years: woman can expect 18.1 years of healthy life and men can expect 14.3 years.

## 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 shows the top 10 conditions (disability groups), in descending order, that account for approximately 90% of the burden of disease among males and females in Slovenia. Neuropsychiatric conditions and cardiovascular diseases (CVD) account for the highest burden of disease 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.

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

Rank	Males		Females	
	Disability groups	Total DALYs (%)	Disability groups	Total DALYs (%)
1	Neuropsychiatric conditions	22.0	Neuropsychiatric conditions	29.3
2	Cardiovascular diseases	18.3	Cardiovascular diseases	17.4
3	Malignant neoplasms	16.4	Malignant neoplasms	16.2
4	Unintentional injuries	10.4	Digestive diseases	6.0
5	Digestive diseases	8.5	Musculoskeletal diseases	4.9
6	Intentional injuries	5.8	Sense organ diseases	4.9
7	Respiratory diseases	4.6	Respiratory diseases	4.8
8	Sense organ diseases	3.5	Unintentional injuries	4.4
9	Musculoskeletal diseases	2.7	Diabetes mellitus	2.1
10	Diabetes mellitus	1.7	Intentional injuries	1.9

Source: Background data from WHO (2003c).

### Main risk factors

The table shows the top 10 risk factors with their relative contributions (percentage of total DALYs), in descending order, to the burden of disease in the male and female populations of Slovenia. According to the DALYs, tobacco and alcohol place the greatest burden of disease on the Slovene male population, and high blood pressure and tobacco place the greatest burden of disease on Slovene females.

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

Rank	Males		Females	
	Risk factors	Total DALYs (%)	Risk factors	Total DALYs (%)
1	Tobacco	19.0	High blood pressure	7.8
2	Alcohol	16.4	Tobacco	7.4
3	High blood pressure	8.5	High BMI	7.1
4	High cholesterol	7.2	High cholesterol	5.4
5	High BMI	6.6	Alcohol	5.3
6	Physical inactivity	3.0	Physical inactivity	2.6
7	Low fruit and vegetable intake	2.5	Unsafe sex	1.7
8	Illicit drugs	1.3	Low fruit and vegetable intake	1.5
9	Occupational airborne particulates	0.6	Illicit drugs	0.9
10	Occupational risk factors for injuries	0.6	Childhood sexual abuse	0.8

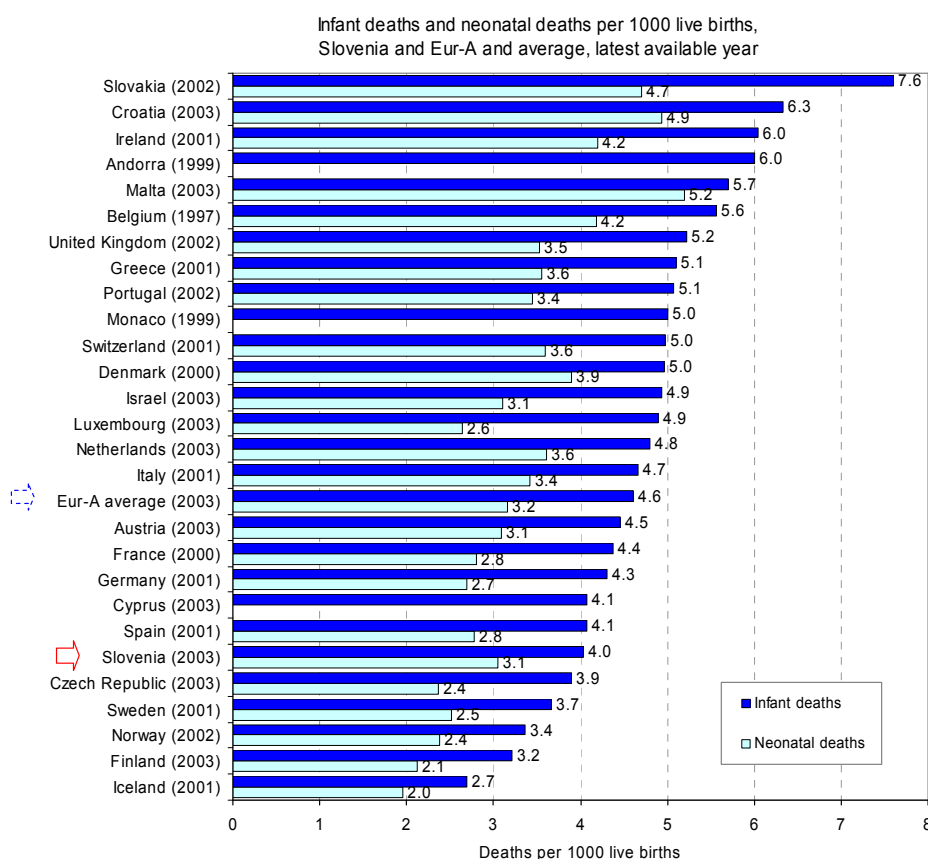
Source: Background data from WHO (2003c).

## Mortality

### Infant, neonatal and child mortality

The infant mortality rate and both its components, the neonatal and post neonatal mortality rates, are lower in Slovenia than the corresponding Eur-A average rates, and post neonatal mortality in Slovenia is one of the lowest in European countries. Progress in reducing the neonatal mortality rates after 1995 has been very slow.

National data and WHO estimates for 2002 show that out of every 1000 live births in Slovenia, there is a probability that between four and five children will die before the age of 5 years. The Eur-A average rate for 2002, based on nationally reported data, was between 5 and 6 deaths under-5 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.

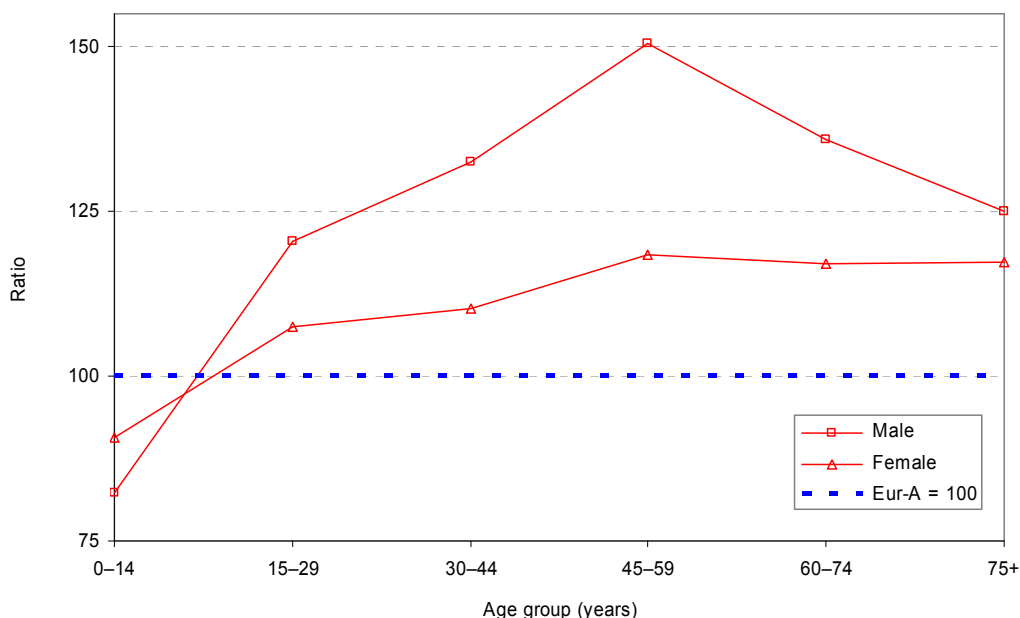
Slovenia's MMR show substantial variation over time; since 1995, however, it has been higher than the Eur-A average. During the period 1997–2001, there were 12 maternal deaths per 100 000 live births.

In 1990, Slovenia's rate was below the Eur-A average rate for that year. But from 1990 to 2000, the rate increased by a factor of 2.5 while the Eur-A average rate fell. For Slovenia to reach its MDG target, its 2000 rate would have to fall by 90% to a rate well below the latest Eur-A average. To reach the current Eur-A rate, Slovenia's MMR would have to decrease by about two thirds.

## Excess mortality

In general, mortality rates for Slovene males and females are among the highest in Eur-A. A period of decline in mortality was interrupted during the period 1991–1993, and then the rates again continued their decline – in parallel with the Eur-A average – for males, and even faster for females. In 2003, however, the rates increased slightly, both in males and females. The excess mortality in Slovenia, in comparison with the Eur-A average mortality rates, shows small changes across age groups among females, while in males excess mortality is highest in the group of 45–59 year olds (about 50%). Mortality in children 0-14 years old is lower than the Eur-A average level for this age group.

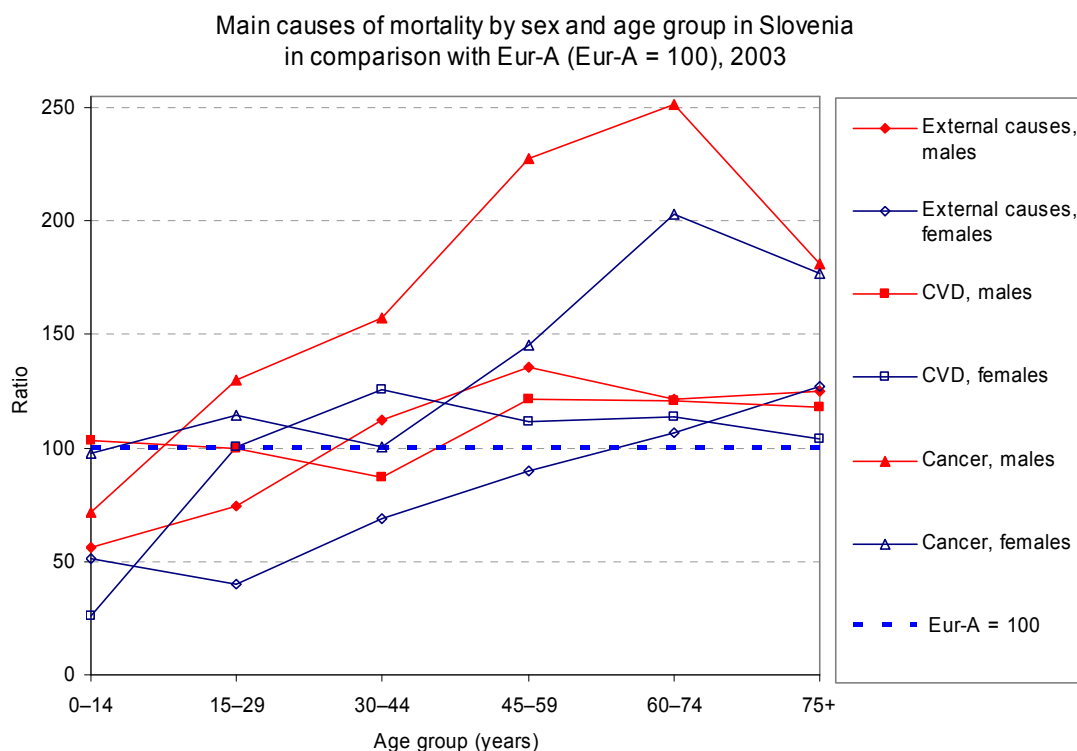
Total mortality by sex and age group in Slovenia  
in comparison with Eur-A (Eur-A = 100), 2003



## Main causes of death

In 2003, the main noncommunicable diseases accounted for about 80% of all deaths in Slovenia; external causes for almost 9%; and communicable diseases for less than 1%. In total, 37% of all deaths were caused by diseases of the circulatory system and 26% by cancer, which is similar to the average figures for Eur-A countries (Annex. Selected mortality; Annex. Mortality data).

The risk of dying from CVD, for both Slovene males and females, is higher than the average risk in Eur-A, by about a fifth, and the difference has been diminishing during recent years in females only. In 2003, the mortality rate for females below 65 years of age was below the Eur-A gender average. Among Slovene males, the excess mortality for cancer is of the same magnitude as that for CVD; among Slovene females, however, it is lower – below 10%. These gaps in mortality for cancer and CVD, when compared with Eur-A, show no tendency to decline. The risk of death from external causes for Slovene males and females is higher than the Eur-A average risk, and the difference between Slovenia and Eur-A is more than twofold among men aged 45–74 years and women aged 60–74 years.

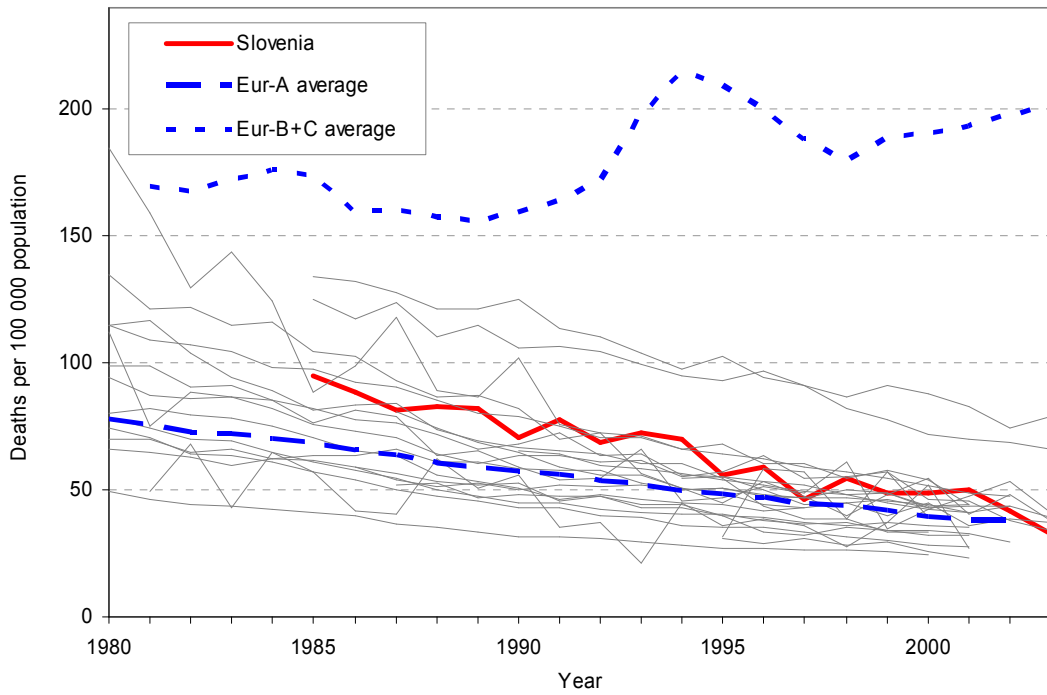


## CVD

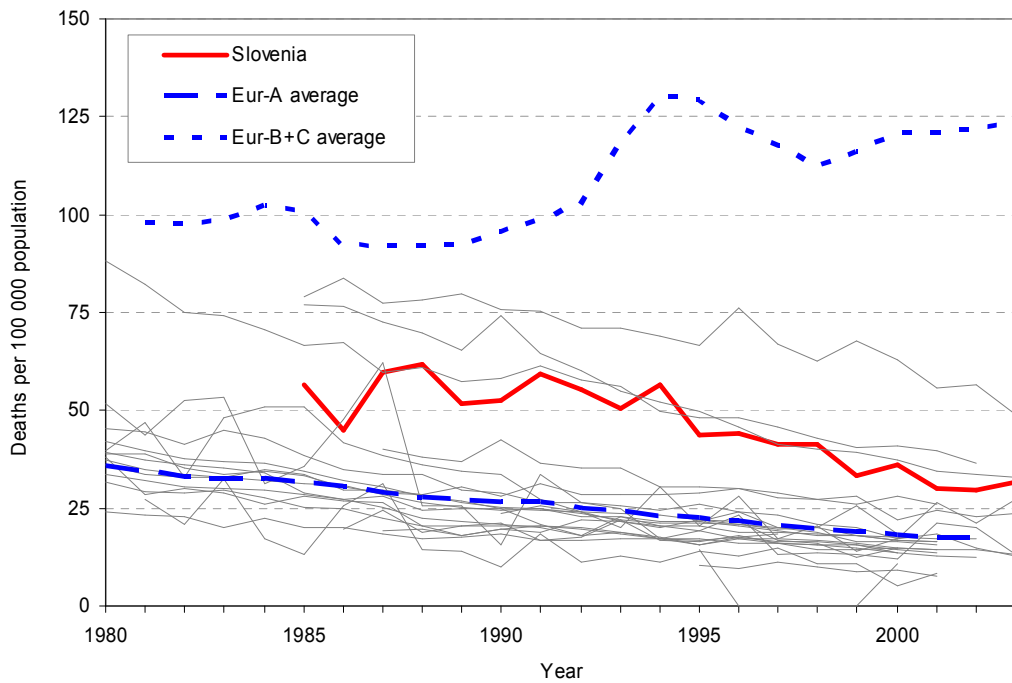
Mortality from CVD in Slovenia is among the highest in Eur-A: the third highest for males and the fifth highest for females. Except for a disruption at the beginning of 1990s, mortality rates show a rather steady decline. There was a noticeable decline (by 35%) in the mortality rate for women aged 25–64 years during the period 2001–2003, but a similar decline was not observed for men in this age group.

Ischaemic heart disease is the single biggest killer in Slovenia, being responsible for almost 12% of all deaths in 2003, which is somewhat less than the corresponding Eur-A average of 15%. The mortality rate for ischaemic heart disease in Slovenia has been close to the Eur-A average rate in the last few years. Also, in comparison with the Eur-A average mortality rate, the largest excess mortality in Slovenia is for diseases of the pulmonary circulation and other heart diseases (46%); in the middle-aged population, however, cerebrovascular diseases account for the highest excess (about 60%), especially in men (about 85% excess mortality). The mortality rates for these two groups of causes – diseases of the pulmonary circulation and other heart diseases, and cerebrovascular diseases – place Slovenia among the top six Eur-A countries for these causes. At the end of 1980s and the beginning of 1990s, the mortality trends for ischaemic heart disease and for diseases of the pulmonary circulation and other heart diseases diverged. The increase in mortality rates in the former group and their decrease in the latter group may be attributable to a change in the coding practice for the causes of death.

Standardized death rates (SDR) for CVD in females aged 25–64 years, Slovenia, Eur-A and Eur-B+C averages, 1980 to latest available year

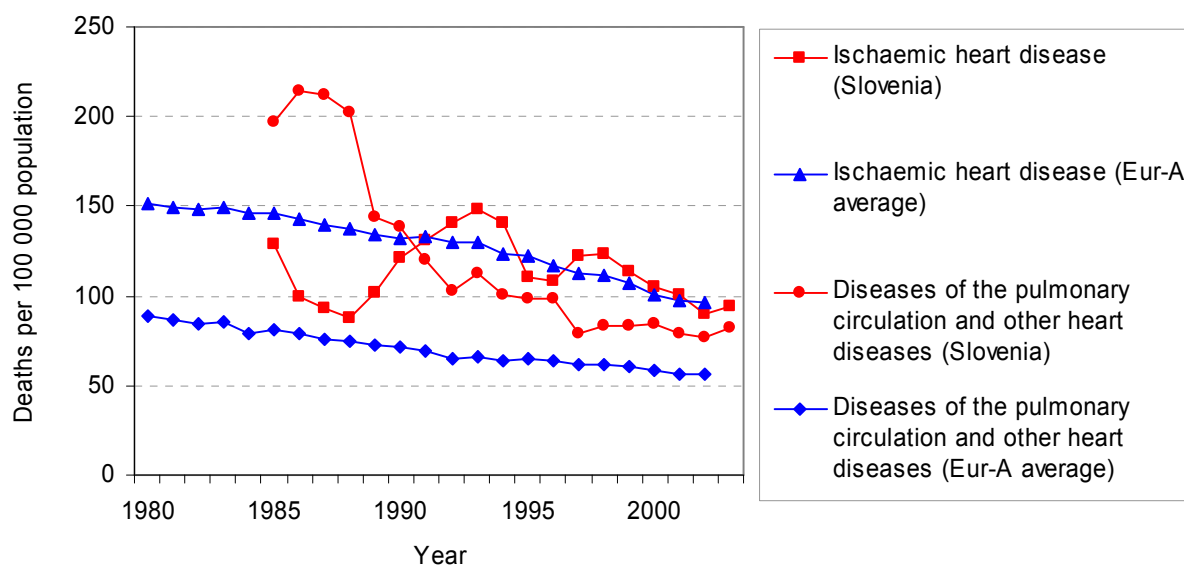


SDR for cerebrovascular diseases in males aged 25–64 years, Slovenia, Eur-A and Eur-B+C averages, 1980 to latest available year





SDR for ischaemic heart disease and diseases of the pulmonary circulation and other heart diseases, in people of all ages, Slovenia and Eur-A average

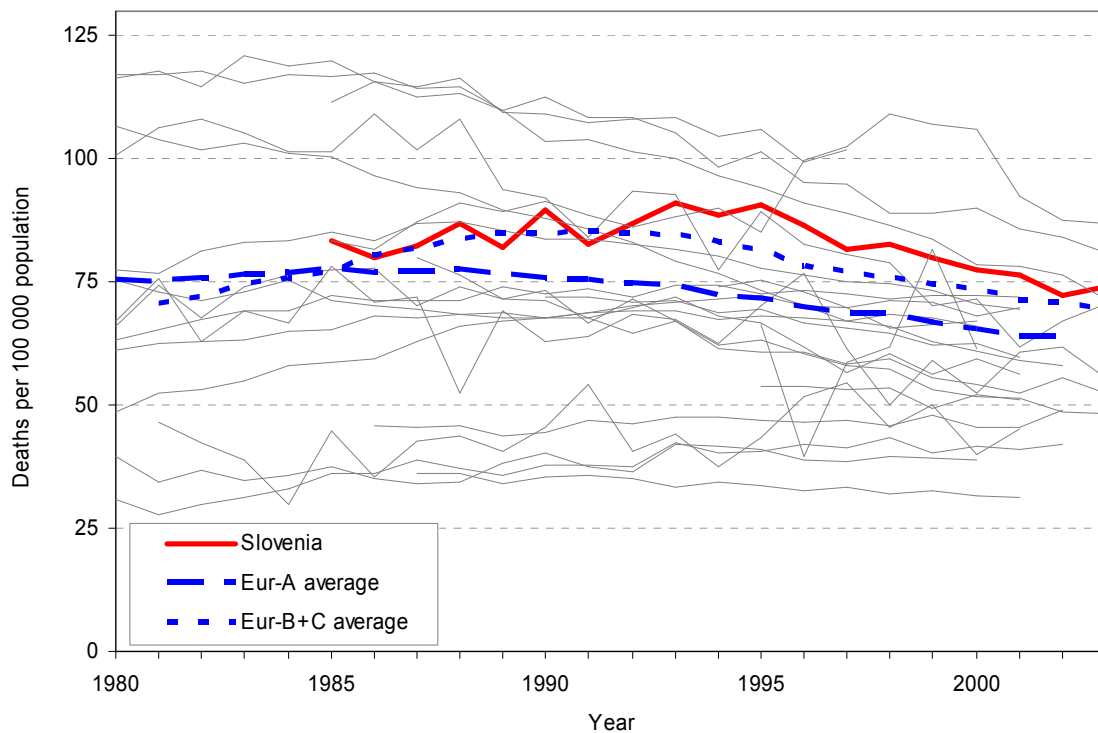


### Cancer

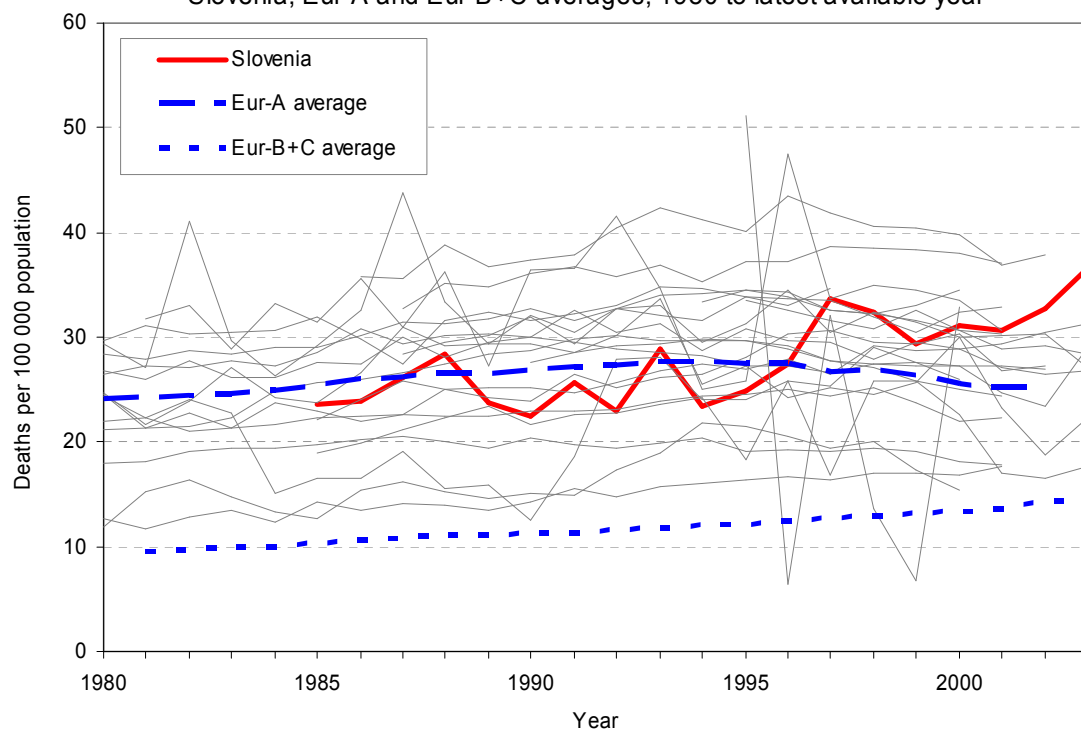
Cancer accounted for 26% of all deaths in Slovenia in 2003, which is similar to the Eur-A average (28%). For years, the risk of dying from cancer in Slovenia has been generally higher than the corresponding average risk in Eur-A, and in the second half of the 1980s the excess of deaths was smallest. However, mortality trends are different in the populations below and above 65 years of age. While in the younger population mortality rates have been clearly declining since 1995, faster than the Eur-A average, in the older population the rates increased until 1997, and only since then have they declined, though slower than the Eur-A average. The rates show higher excess mortality in Slovene males than in Slovene females when compared with both the Eur-A averages for younger (below 65 years of age) and older (65 years of age and more) populations.

Among Slovene males, mortality rates for cancer of the lip, oral cavity and pharynx, stomach cancer, cancer of the colon, rectum and anus, and prostate cancer are the third highest in Eur-A countries, and the mortality rate for cancer of the trachea, bronchus and lung (TBL) is the fourth highest. The rates for colon cancer and prostate cancer have been increasing, and the excess mortality, in comparison with the Eur-A average, has also increasing. On the other hand, mortality rates for lung cancer have been declining faster than the corresponding Eur-A average rate since 1995. The largest excess mortality in Slovene males, in comparison with the Eur-A average, is for stomach cancer (almost a twofold difference in mortality rates in 2002) and cancer of the lip, oral cavity and pharynx (60% excess in 2002).

SDR for trachea, bronchus and lung cancer in males, all ages,  
Slovenia, Eur-A and Eur-B+C averages, 1980 to latest available year

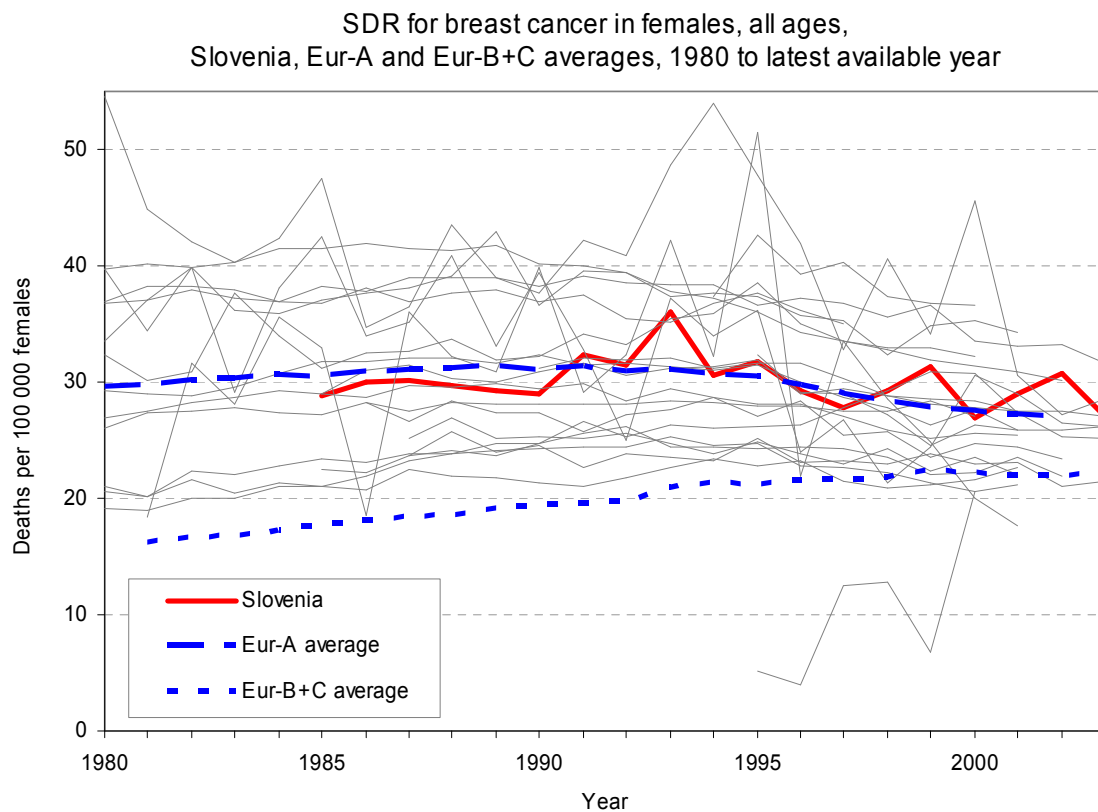
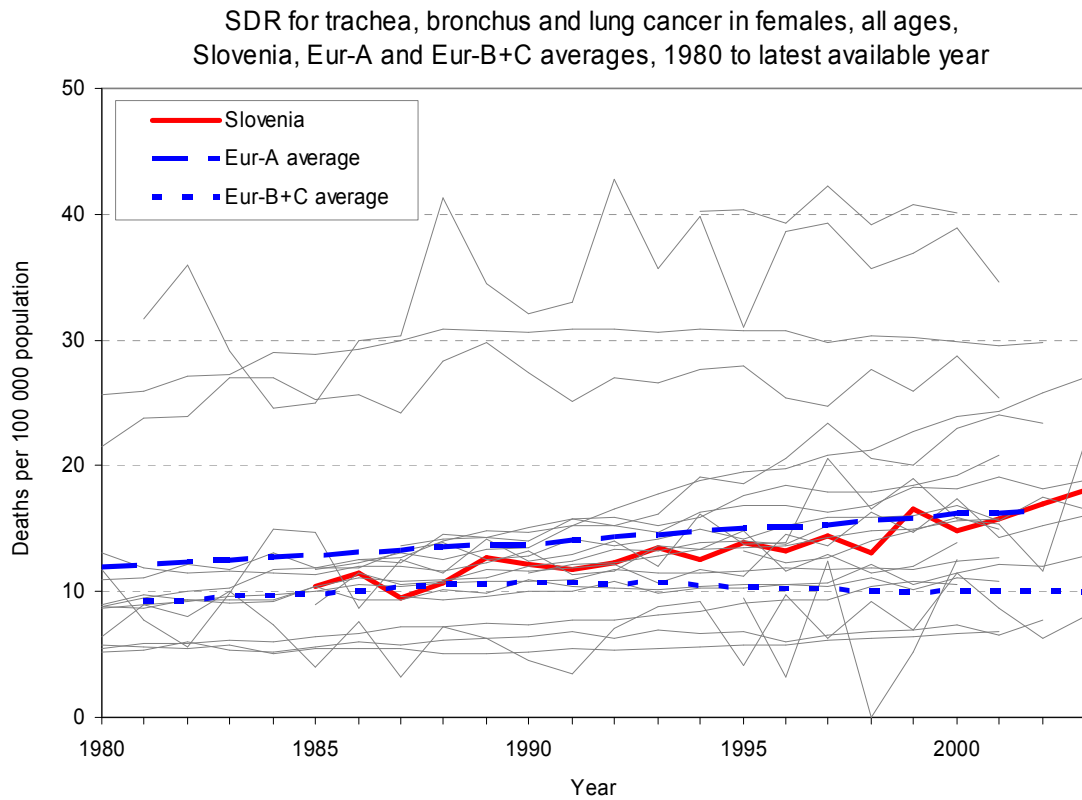


SDR for prostate cancer in males, all ages,  
Slovenia, Eur-A and Eur-B+C averages, 1980 to latest available year



For Slovene females, the recent mortality rates for the main sites of cancer are usually higher than the corresponding Eur-A average rates. The mortality rates for breast cancer, cancer of the uterine cervix and cancer of other parts of uterus are declining, though not continuously. The mortality rates for TBL

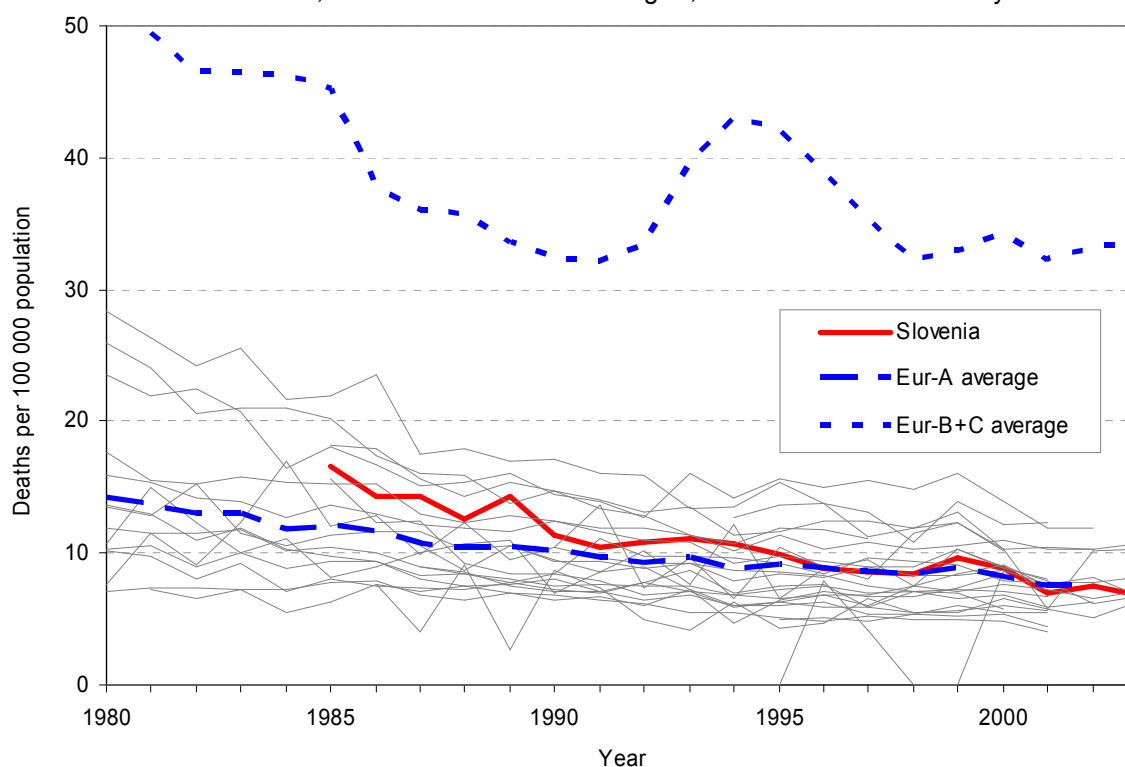
cancer are increasing faster than Eur-A average rates, and the mortality rates in 2002 and 2003 are higher in Slovene females than the average rates for their Eur-A counterparts. The largest excess mortality in Slovene females, in comparison with the Eur-A average rate, is for cancer of the uterine cervix (almost 50%) cancer of other parts of uterus and stomach cancer.



### Respiratory diseases

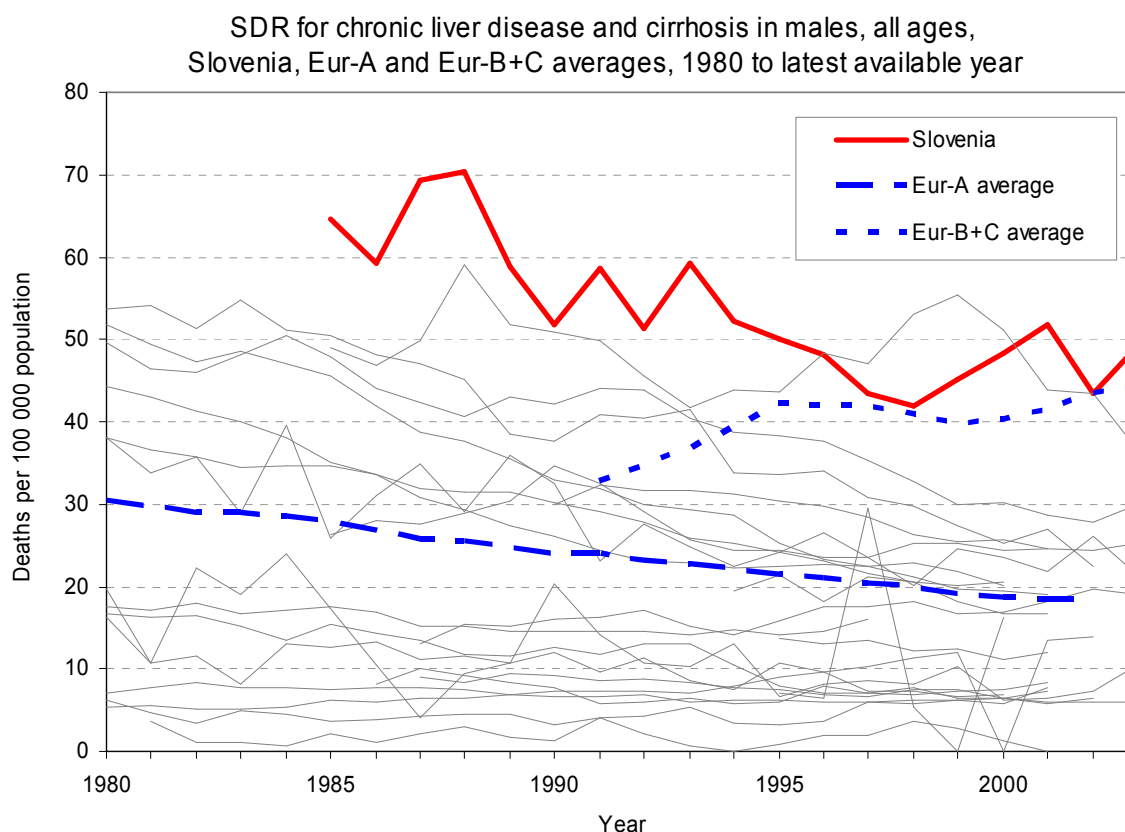
In 2003, respiratory diseases accounted for almost 8% of all deaths in Slovenia. Mortality rates show quite large variations over time and show no decline in the total population. Among Slovene males, the rates have been above Eur-A average rates since 1989 and, at present, are the fourth highest among Eur-A countries for all males. For years, mortality rates for Slovene males below 65 years of age have been higher than the average Eur-A rates, but they have been declining faster than the Eur-A averages, and the difference has almost disappeared. Mortality rates for all Slovene females are a little higher (less than 10% during the period 1999–2002) than the Eur-A average mortality rates; in the population below 65 years of age, however, the rates are below Eur-A average rates and show a decline over time. Among Slovene males, mortality from chronic lower respiratory diseases is higher than that from pneumonia, but the difference is diminishing due to opposing trends in the rates. Among females the order is reversed, with mortality rates for pneumonia being higher.

SDR for diseases of the respiratory system in people aged 0–64 years, Slovenia, Eur-A and Eur-B+C averages, 1980 to latest available year



### Digestive diseases

The mortality rates in Slovenia for diseases of the digestive system are the highest among Eur-A countries, for both males and females. The rates show some decline, however, but not among people 65 years and older. Since 1997, mortality rates for diseases of the digestive system in men 65 years and older have been increasing. Also, both males and females have the highest mortality rates among Eur-A countries for chronic liver disease and cirrhosis. The rates have declined, but the excess mortality has not changed much.

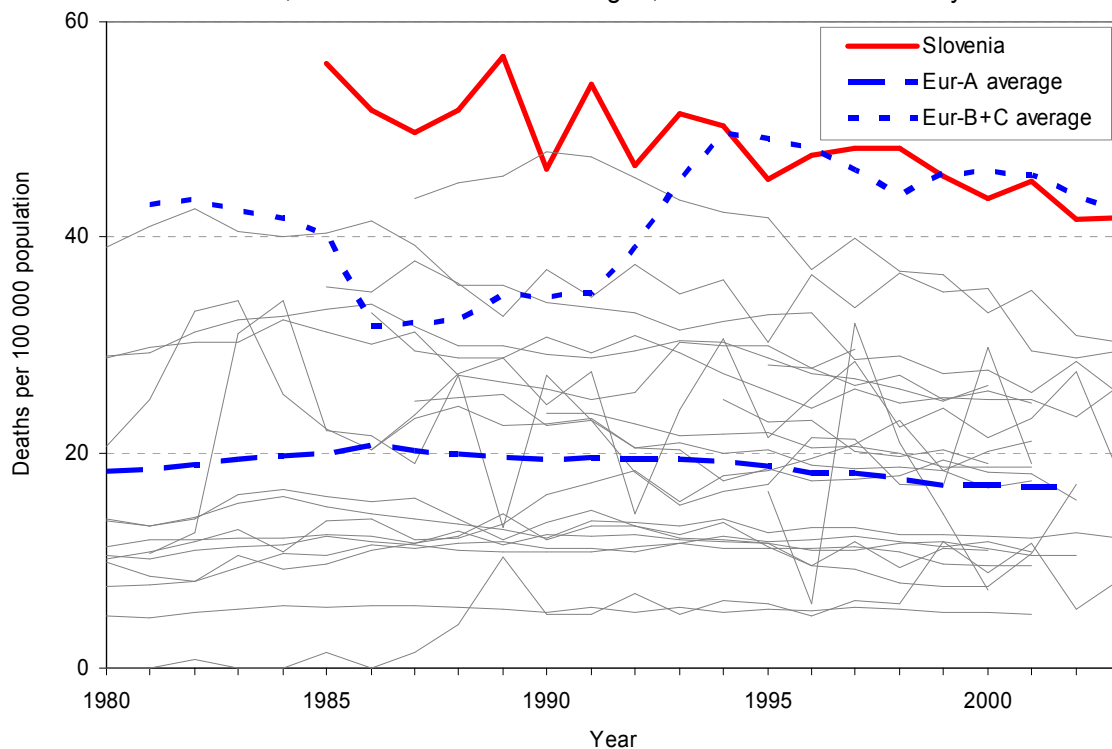


### **External causes**

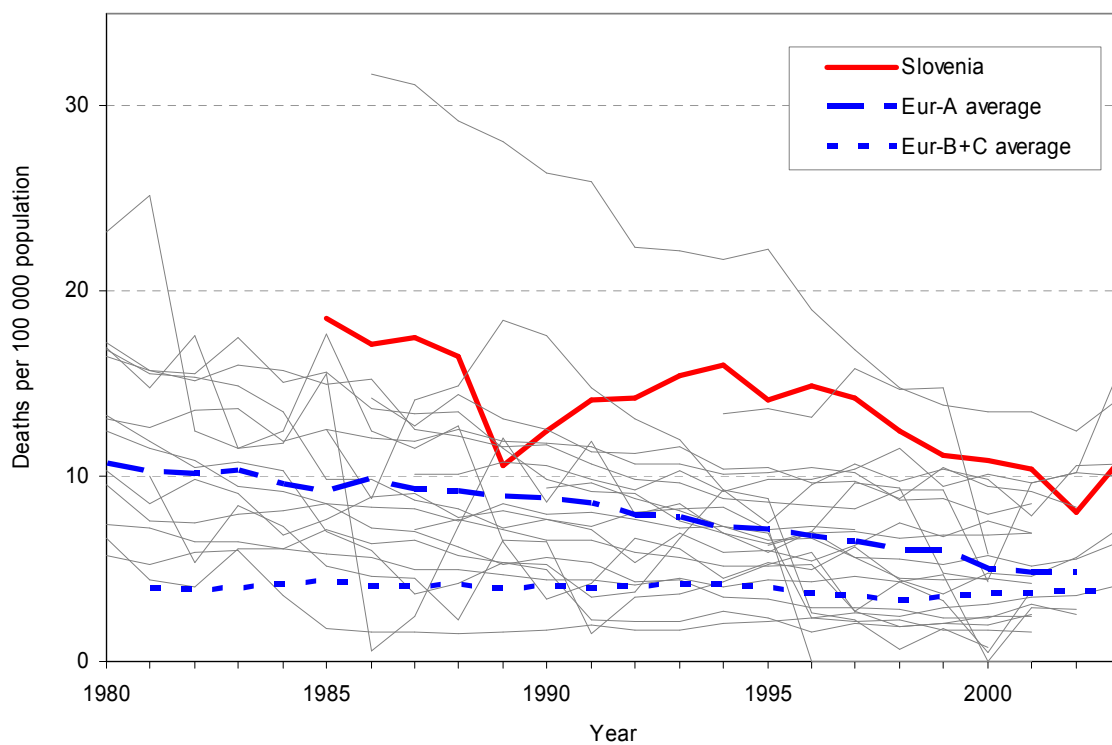
Mortality rates for external causes in Slovenia are the second highest among Eur-A countries for both males and females. However, the rates have been declining faster in Slovenia, so the excess mortality is slowly diminishing.

Suicides are by far the main external cause of death for Slovene males and the second major external cause for females. The mortality rate for suicide in Slovene males is the highest among Eur-A countries (2.5 times higher than the Eur-A average), and in Slovene females it is the second highest (almost twice as high as the Eur-A average). For males, but not females, the rates are declining faster than the Eur-A average suicide rates. Accidental falls are the second most important external cause of death in males (the mortality rate is the second highest among Eur-A countries), and they are the main cause in females (the mortality rate is the third highest among Eur-A countries). The excess mortality for accidental falls in the Slovene population, in comparison with the Eur-A average, is slowly declining. In females, the third major external cause of death is motor vehicle traffic accidents, with a rate close to that of the Eur-A average, while in males mortality from this cause is higher than the Eur-A average rate, but the rates are declining faster than the Eur-A average rates.

SDR for suicide and self-inflicted injury in males, all ages,  
Slovenia, Eur-A and Eur-B+C averages, 1980 to latest available year



SDR for accidental falls in females, all ages,  
Slovenia, Eur-A and Eur-B+C averages, 1980 to latest available year



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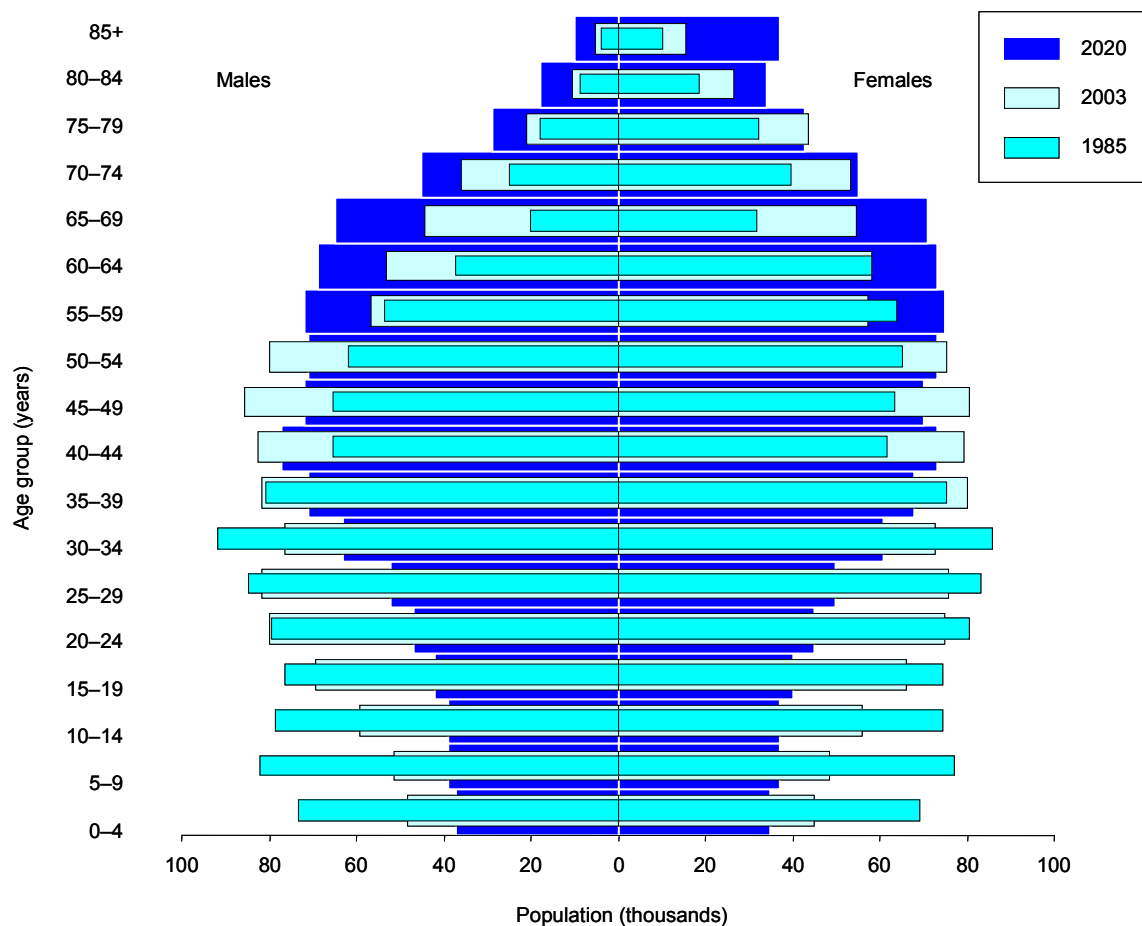
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## Annexes

### Annex. Age pyramid

#### Age pyramid for Slovenia



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

## Annex. Selected mortality

## Selected mortality in Slovenia compared with Eur-A average

Condition	SDR per 100 000		Excess mortality in Slovenia (%)	Total deaths in Slovenia (%)	Total deaths in Eur-A (%)
	Slovenia (2003)	Eur-A average (2002)			
<b>Selected non-communicable conditions</b>	634.3	533.8	18.8	79.7	82.4
<i>Cardiovascular diseases</i>	295.3	243.4	21.3	37.1	37.6
Ischaemic heart disease	94.4	95.9	-1.6	11.9	14.8
Cerebrovascular diseases	78.8	61.1	29.0	9.9	9.4
Diseases of pulmonary circulation and other heart disease	82.4	56.6	45.6	10.4	8.7
<i>Malignant neoplasms</i>	203.7	181.5	12.2	25.6	28.0
Trachea/bronchus/lung cancer	41.2	37.1	11.1	5.2	5.7
Female breast cancer	27.1	27.0	0.4	3.4	4.2
Colon/rectal/anal cancer	28.1	20.7	35.7	3.5	3.2
Prostate	36.5	25.1	45.4	4.6	3.9
<i>Respiratory diseases</i>	62.0	47.8	29.7	7.8	7.4
Chronic lower respiratory diseases	25.7	20.2	27.2	3.2	3.1
Pneumonia	30.1	16.2	85.8	3.8	2.5
<i>Digestive diseases</i>	53.3	30.8	73.1	6.7	4.8
Chronic liver disease and cirrhosis	31.3	12.6	148.4	3.9	1.9
<i>Neuropsychiatric disorders</i>	20.0	30.3	-34.0	2.5	4.7
<b>Communicable conditions</b>	4.3	8.4	-48.8	0.5	1.3
AIDS/HIV	0.0	1.1	-100.0	0.0	0.2
<b>External causes</b>	70.1	40.3	73.9	8.8	6.2
<i>Unintentional</i>	43.8	28.7	52.6	5.5	4.4
Road traffic injuries	11.9	9.9	20.2	1.5	1.5
Falls	15.2	6.1	149.2	1.9	0.9
<i>Intentional</i>	26.3	11.6	126.7	3.3	1.8
Self-inflicted (suicide)	25.0	10.6	135.8	3.1	1.6
Violence (homicide)	1.3	1.0	30.0	0.2	0.2
<b>Ill-defined conditions</b>	35.8	20.9	71.3	4.5	3.2
<b>All causes</b>	795.5	647.8	22.8	100.0	100.0

## Annex. Mortality data

Table 1. Selected mortality for the group 0–14 years by sex in Slovenia and Eur-A:  
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Slovenia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
<b>All causes</b>	Both	42.5	-4.1	49.4	-2.4	151.7	-3.8
	M	45.5	-4.6	55.3	-2.5	170.5	-3.9
	F	39.2	-3.2	43.3	-2.4	131.9	-3.8
<i>Infectious and parasitic diseases</i>	M	1.6	1.1	1.4	-1.1	10.9	-7.0
	F	0.0	-12.5	1.1	-3.0	9.5	-6.6
Intestinal infectious diseases	M	0.8		0.2	-0.7	5.1	-8.2
	F	0.0		0.1	-7.3	4.7	-7.9
<i>Malignant neoplasms</i>	M	3.4	-5.6	3.3	-1.8	5.1	-1.9
	F	0.7	-10.7	2.6	-1.8	4.2	-1.9
<i>Cardiovascular diseases</i>	M	0.8	-1.3	1.4	-3.1	3.3	1.1
	F	0.7	-1.8	1.3	-2.5	2.6	0.1
<i>Respiratory diseases</i>	M	0.6	-10.7	1.4	-4.3	35.9	-5.0
	F	1.7	14.7	1.0	-4.2	30.7	-5.0
Pneumonia	M	0.0	-12.5	0.5	-6.0	20.9	-4.9
	F	0.9	1.1	0.4	-5.1	17.9	-4.7
<i>Certain conditions originating in perinatal period</i>	M	210.3	0.2	255.3	-2.1	607.6	-2.7
	F	167.7	-1.9	202.3	-1.6	427.5	-2.7
Congenital malformations & chromosomal abnormalities	M	9.2	-6.1	11.6	-2.9	24.2	-2.8
	F	12.8	-0.3	10.0	-3.3	21.0	-2.6
<i>Ill-defined causes</i>	M	3.0	-3.3	5.0	-3.9	5.6	-0.6
	F	1.7	-7.5	3.4	-4.2	4.6	-1.0
<i>External causes of injury &amp; poisoning</i>	M	5.0	-8.1	7.0	-4.0	29.0	-3.4
	F	4.5	-5.2	4.6	-3.2	18.1	-3.1
Road traffic injuries	M	2.0	-7.8	2.5	-4.5	4.7	-2.6
	F	1.5	-8.2	1.7	-4.8	3.0	-1.6

Table 2. Selected mortality for the group 15–29 years by sex in Slovenia and Eur-A:  
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Slovenia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
<b>All causes</b>	Both	66.2	-2.1	56.0	-2.3	161.0	-0.9
	M	98.7	-2.0	82.0	-2.3	241.7	-1.0
	F	31.5	-2.8	29.3	-2.2	79.0	-0.6
<i>Infectious and parasitic diseases</i>	M	0.5		1.2	1.5	12.3	3.0
	F	0.0		0.8	1.9	5.1	2.5
<i>Malignant neoplasms</i>	M	6.2	-4.0	6.2	-1.0	8.8	-1.9
	F	4.7	1.8	4.7	-1.4	7.7	-1.9
<i>Cardiovascular diseases</i>	M	3.1	4.6	4.1	-2.4	17.6	0.0
	F	0.9	-4.1	2.3	-2.0	7.3	-0.9
<i>Respiratory diseases</i>	M	0.9	-0.4	1.4	-3.6	6.9	0.2
	F	0.5		0.9	-2.7	3.8	-1.1
<i>Digestive diseases</i>	M	0.4	-0.9	0.9	-3.5	8.0	3.0
	F	0.5	-6.3	0.5	-3.8	3.7	3.1
<i>Ill-defined causes</i>	M	7.0	-0.5	4.0	-3.1	11.6	7.1
	F	3.4	-2.5	1.4	-1.3	3.3	5.8
<i>External causes</i>	M	75.8	-2.1	58.3	-1.4	162.4	-1.6
	F	16.5	-4.4	14.4	-1.6	36.9	-0.2
Road traffic injuries	M	31.7	-2.7	28.5	-1.3	27.8	-1.5
	F	6.3	-7.4	7.3	-1.4	8.0	0.3
Accidental drowning	M	2.7	-1.5	1.3	-2.2	10.8	-3.9
	F	0.5	-6.3	0.2	-2.1	1.9	-2.2
Accidental poisoning	M	2.1	7.5	2.8	0.0	19.1	3.3
	F	0.5	-0.4	0.7	0.8	4.4	2.5
Self-inflicted (suicide)	M	24.8	-3.0	12.7	-1.8	36.8	0.0
	F	6.3	6.6	3.1	-2.2	5.8	-1.3

Table 3. Selected mortality for the group 30–44 years by sex in Slovenia and Eur-A:  
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Slovenia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
<b>All causes</b>	Both	151.3	-2.4	120.3	-2.5	453.8	-0.7
	M	214.0	-2.4	161.6	-2.6	700.0	-0.8
	F	86.5	-2.5	78.5	-2.1	215.6	-0.2
<i>Malignant neoplasms</i>	M	24.0	-5.7	27.6	-2.3	40.2	-2.8
	F	39.3	0.4	31.3	-2.0	43.8	-1.4
Trachea/bronchus/lung cancer	M	4.7	-4.6	5.0	-3.4	7.3	-4.2
Female breast cancer	F	4.4	3.5	2.8	-0.6	2.2	-1.0
<i>Cardiovascular diseases</i>	F	10.2	1.6	10.0	-2.6	10.0	-2.3
	M	29.5	-1.1	26.1	-2.5	158.6	-0.4
Ischaemic heart disease	F	7.2	-3.4	10.4	-2.1	45.3	0.0
	M	11.0	-2.1	11.8	-3.1	73.7	-2.2
Cerebrovascular diseases	F	1.4	-5.9	2.4	-2.7	14.4	-1.3
	M	6.8	-2.7	4.4	-3.2	24.6	-0.4
<i>Respiratory diseases</i>	F	2.7	-6.5	3.6	-2.5	10.6	-1.3
	M	5.2	-3.8	3.9	-3.5	34.3	0.9
<i>Digestive diseases</i>	F	1.8	-3.8	2.2	-2.0	9.8	0.8
	M	26.1	-0.7	12.6	-2.4	50.2	1.4
<i>External causes</i>	F	6.7	-6.6	5.4	-1.7	19.4	4.1
	M	92.3	-2.8	58.8	-1.2	299.5	-1.9
Road traffic injuries	F	15.1	-5.7	15.1	-1.8	58.9	-1.0
Self-inflicted (suicide)	M	15.5	-5.9	16.0	-0.5	31.4	-1.7
	F	2.7	-6.1	3.9	-2.0	7.1	-0.5
	M	49.2	0.3	21.2	-1.5	54.9	-2.4
	F	5.8	-7.9	5.8	-2.2	7.9	-2.5

Table 4. Selected mortality for the group 45–59 years by sex in Slovenia and Eur-A:  
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Slovenia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
<b>All causes</b>	Both	613.7	-1.2	435.6	-1.3	1294.9	-0.6
	M	872.7	-1.2	580.1	-1.4	1981.7	-0.6
	F	347.5	-1.7	293.3	-1.0	698.9	-0.5
<i>Malignant neoplasms</i>	M	265.8	-2.5	218.2	-1.2	323.2	-1.9
	F	172.8	-1.8	155.0	-1.0	186.1	-0.5
Trachea/bronchus/lung cancer	M	78.2	-4.1	65.9	-1.5	101.4	-2.9
Female breast cancer	F	27.6	6.2	21.8	3.4	15.4	1.0
<i>Cardiovascular diseases</i>	F	45.3	-3.9	44.0	-2.2	45.3	0.1
	M	212.1	-1.2	156.4	-2.6	793.1	-0.1
Ischaemic heart disease	F	45.8	-3.6	50.9	-2.5	271.7	-0.6
	M	103.2	-0.1	86.2	-3.3	435.3	-0.7
Cerebrovascular diseases	F	8.7	-6.3	17.8	-3.4	111.1	-0.6
	M	47.9	-2.3	23.7	-2.6	168.6	-0.9
<i>Respiratory diseases</i>	F	17.7	-4.7	14.5	-2.1	88.4	-1.4
	M	21.4	-3.8	20.3	-1.7	108.7	-1.4
<i>Digestive diseases</i>	F	6.3	0.4	10.2	-1.3	24.5	-0.7
	M	112.8	-0.4	49.6	-0.8	129.7	0.7
<i>External causes</i>	F	42.3	-2.5	20.3	-0.7	57.3	1.9
	M	142.9	-0.9	62.8	-1.0	409.2	-0.9
Road traffic injuries	F	30.5	-2.3	20.9	-0.9	89.1	-1.1
Self-inflicted (suicide)	M	25.1	-0.3	13.0	-1.3	28.5	-1.8
	F	1.9	-9.8	4.1	-2.1	7.5	-1.4
	M	61.4	-2.2	23.1	-1.1	68.1	-2.4
	F	17.7	0.6	8.5	-1.2	10.2	-3.4

Table 5. Selected mortality for the group 60–74 years by sex in Slovenia and Eur-A:  
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Slovenia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
<b>All causes</b>	Both	1989.4	-1.8	1570.9	-1.9	3411.7	-0.1
	M	2933.9	-1.8	2156.9	-2.1	4996.4	0.1
	F	1251.6	-2.7	1069.2	-1.9	2339.0	-0.6
<i>Malignant neoplasms</i>	M	1031.5	-1.1	851.3	-1.4	1002.5	-0.8
	F	500.1	-0.8	439.8	-1.1	438.9	-0.7
Trachea/bronchus/lung cancer	M	320.7	-2.6	261.8	-1.9	321.7	-1.5
Female breast cancer	F	64.2	1.8	59.0	0.2	37.1	-1.4
<i>Cardiovascular diseases</i>	F	80.1	0.3	79.7	-1.6	68.7	1.3
	M	907.5	-3.5	744.9	-3.6	2903.0	0.6
Ischaemic heart disease	F	359.3	-5.4	335.7	-3.9	1507.8	-0.3
	M	378.5	-3.3	381.3	-4.2	1582.2	1.2
Cerebrovascular diseases	F	125.7	-4.7	133.5	-4.6	731.4	0.5
	M	221.5	-4.9	143.3	-3.7	833.7	0.2
<i>Respiratory diseases</i>	F	111.7	-5.9	86.7	-4.1	528.9	-0.8
	M	194.3	-3.7	144.0	-3.5	303.0	-2.4
<i>Digestive diseases</i>	F	56.9	-3.5	62.5	-2.4	68.6	-3.6
	M	241.8	-0.1	111.6	-1.6	193.0	0.1
<i>External causes</i>	F	98.2	-1.1	54.1	-1.7	94.2	0.2
	M	199.4	-1.3	79.3	-1.4	320.0	1.0
Road traffic injuries	F	65.1	-1.7	32.1	-2.1	88.7	-0.5
	M	27.7	-3.2	14.8	-3.0	24.3	-1.5
Self-inflicted (suicide)	F	10.4	-4.1	5.9	-3.4	9.5	-1.0
	M	77.2	0.2	24.5	-1.6	60.5	-0.8
	F	22.4	-0.1	8.7	-2.6	12.7	-3.1

Table 6. Selected mortality for the group 75+ years by sex in Slovenia and Eur-A:  
SDR per 100 000 population and percentage changes from 1995 to latest available year

Causes of death	Sex	Slovenia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
<b>All causes</b>	Both	9475.7	-0.6	8059.6	-1.0	12338.8	0.0
	M	12291.8	0.0	9832.0	-1.1	14838.0	0.1
	F	8348.8	-0.8	7112.5	-0.9	11421.7	0.0
<i>Malignant neoplasms</i>	M	2627.3	2.8	2231.1	-0.4	1489.3	1.2
	F	1182.2	0.2	1136.2	-0.4	721.7	0.8
Trachea/bronchus/lung cancer	M	469.3	1.1	457.1	-0.7	323.5	1.0
Female breast cancer	F	98.8	5.7	102.7	1.5	55.6	0.5
<i>Cardiovascular diseases</i>	F	155.2	-1.7	159.6	-0.4	92.0	3.1
	M	5448.0	-1.7	4356.2	-2.1	10221.2	0.4
Ischaemic heart disease	F	4549.1	-1.8	3577.9	-1.9	8805.6	0.4
	M	1789.2	0.5	1708.0	-2.2	4925.6	1.4
Cerebrovascular diseases	F	1145.1	-1.4	1150.0	-2.2	4028.6	1.2
	M	1457.4	-2.8	1119.8	-2.5	3004.4	0.7
<i>Respiratory diseases</i>	F	1224.9	-2.6	1026.9	-2.4	2967.6	0.5
	M	1815.6	0.2	1156.5	-2.4	824.1	-2.1
<i>Digestive diseases</i>	F	837.8	1.0	591.9	-2.1	302.3	-3.2
	M	486.4	1.3	340.3	-1.1	270.4	0.3
<i>External causes</i>	F	311.3	2.3	279.8	-0.4	175.0	1.1
	M	499.1	-0.9	275.0	-0.6	604.2	0.1
Road traffic injuries	F	331.8	-1.3	187.8	-1.2	172.4	-1.2
	M	33.0	-7.2	28.1	-2.2	34.6	-3.1
Self-inflicted (suicide)	F	9.9	-8.5	10.0	-3.1	14.7	-1.7
	M	117.0	1.9	49.5	-1.6	86.6	-1.1
	F	29.2	3.1	11.8	-3.2	22.4	-1.9

## 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*<sup>1</sup>.

### 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.

### 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

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<sup>1</sup> 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).

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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<sup>1</sup> 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, 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 end or average to be recognized more easily.

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

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## Glossary

### Causes of death

	<b>ICD-10 code</b>
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 <sup>1</sup> .
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.

<sup>1</sup> 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).