



Highlights on health in Croatia 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 25 countries with low child mortality and low or high adult mortality, designated Eur-B+C by WHO, as the reference group. 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.

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

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Contents

	<i>Page</i>
Summary: findings and policy considerations	1
Selected demographic and socioeconomic information	2
Population profile	2
Socioeconomic indicators	3
Life expectancy (LE) and healthy life expectancy (HALE)	5
Burden of disease	7
Main conditions	7
Main risk factors	7
Mortality	7
Infant, neonatal and child mortality	8
Maternal mortality	8
Excess mortality	9
Main causes of death	9
References	16
Annexes	18
Annex. Age Pyramid	18
Annex. Selected mortality	19
Annex. Mortality data	20
Technical notes	23
Glossary	25

Summary: findings and policy considerations

Life expectancy

According to WHO estimates, the average life expectancy (LE) of a Croatian born in 2003 is 74.7 years: 71.2 years for males - the lowest LE among Eur-A countries – and 78.2 years for females. In 2002, LE estimates for Croatia were lower than the Eur-A average by 4.7 years for males and 3.7 years for females. There was a large slump in male LE in 1991 as was also the case for both males and females between 1996 and 2000. WHO estimates that people in Croatia spend an average of 10.9% (8.2 years) of their lives in ill health.

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, 2004a)

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

Infant mortality

Between 1996 and 2001, the rates for infant and neonatal mortality in Croatia fell slightly. However, in 2002, these rates exceeded the Eur-A averages by more than 50% and are the highest among the Eur-A 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.

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

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

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

Main causes of death

Mortality rates for males and females in Croatia are the highest in the Eur-A group. These rates rose substantially between 1996 and 2000, followed by a drop in 2001 that did not continue into 2002 and 2003. In comparison to the countries of Eur-A, excess mortality in Croatia is greater in the middle-age and older populations than in the younger age groups.

In 2003, main noncommunicable diseases (NCD) were responsible for about 87% of all deaths in Croatia (cardiovascular diseases (CVD): 53%; cancer: 23%). External causes accounted for about 6% of all deaths and communicable diseases for less than 1%. Croatia's mortality rate for CVD is the highest among the Eur-A countries.

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

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

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

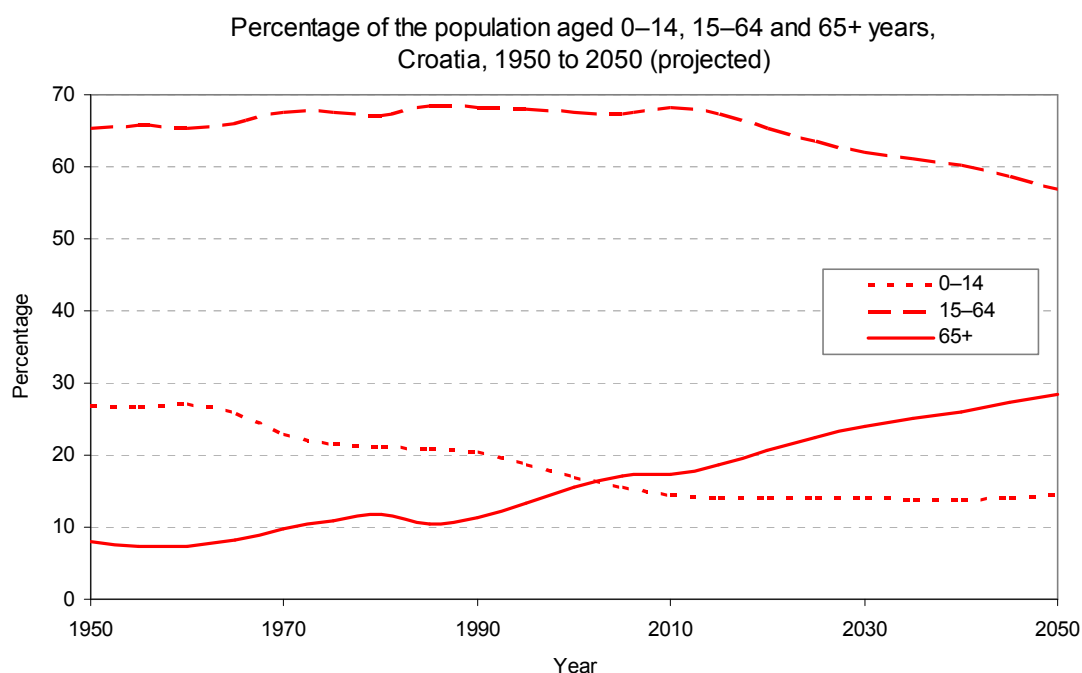
What are the advantages and disadvantages of restructuring a health care system to be more focused on primary health care services? (Health Evidence Network, 2004a)

Selected demographic and socioeconomic information

Population profile

In mid-2003, the population of Croatia was approximately 4.4 million. The proportion living in urban areas (about 59%) is at the low end of the scale for the Eur-A countries.

The proportion of the population aged 0 to 14 years was relatively stable during the 1980s but fell from about 21% in 1990 to 16% in 2003, which was the Eur-A average for this age group. The percentage of the population aged 65 and over was also on the same level as the Eur-A average (Council of Europe, 2005). It is estimated that, by 2030, 24% of Croatia's population will be 65 and over (Annex. Age pyramid, Figure. Population trends)



The birth rate in Croatia was at the low end of the scale for the Eur-A countries in 2003. The natural population increase in Croatia was negative and the lowest among the Eur-A countries, while net migration was positive and only slightly below the Eur-A average (Table. Selected demographic indicators).

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

Indicators	Croatia	Eur-A		
	Value	Average	Minimum	Maximum
Population (in 1000s)	4441.8	–	–	–
0–14 years (%)	16.4	–	–	–
15–64 years (%)	67.2	–	–	–
65+ years (%)	16.4	–	–	–
Urban population (%) ^a	58.6	78.5	50.8	100.0
Live births (per 1000)	8.9	10.7	8.6	21.7
Natural population growth (per 1000)	–2.9	1.1	–2.9	15.9
Net migration (per 1000)	2.6	3.5	–0.5	8.8

^a 2002.

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

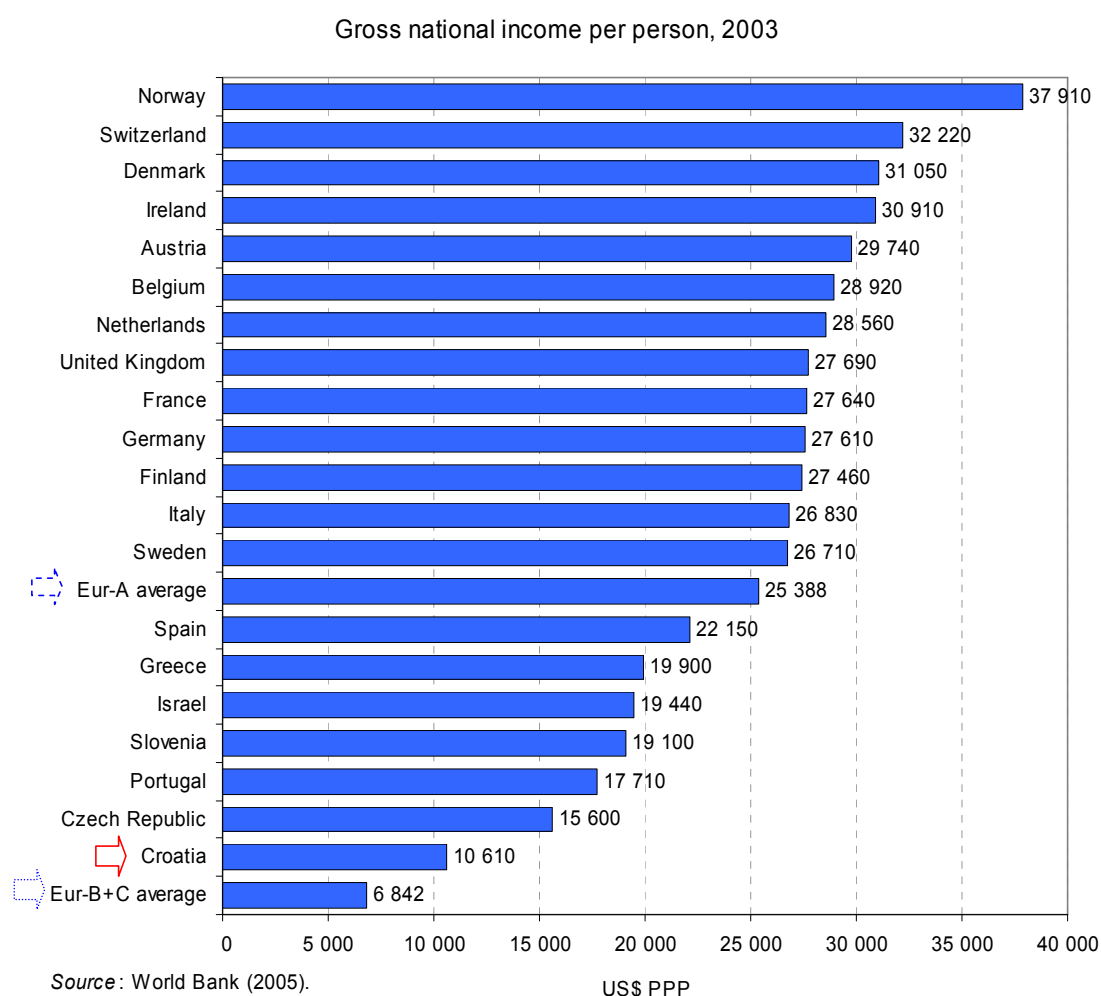
Socioeconomic indicators

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.

In Croatia, per capita gross national income, adjusted for purchasing power parity, was US\$ 10 610 in 2003, the lowest per capita income in the Eur-A group. The Eur-A average that year was US\$ 25 388 (Figure. Gross national income per person).



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.

Between 1988 and 2001, the proportion of Croatia's population living on US\$ 4.30 or less per day increased. Household surveys carried out in 2001 indicated that almost 10% of the population were living in absolute poverty, compared to 1.5% in 1988.

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.

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 2000 and 2001, GINI indices are available for seven Eur-A countries. These range from 25 (Sweden, 2000) to 36.0 (Italy, 2000). In 2001, the GINI index for Croatia was 29 (World Bank, 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 enrolled in secondary schools in Croatia has remained around 85% since 1998. In 2000, it was 85.5%; the Eur-A average that year was 88.5%. In 2001, the rate went up slightly to 86.3%. Among the Eur-A countries reporting these data in 2000, the lowest enrolment rate was seen in Luxembourg (79.7%) and the highest in Slovenia (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.

Total unemployment in Croatia has been relatively high compared to the other Eur-A countries, keeping in mind that national rates are based on estimated numbers of people available for and seeking employment, and that the definitions of "labour force" and "unemployment" differ from country to country. In 2001, 15.8% of the labour force in Croatia was without work, while in the Eur-A countries, the average rate that year was 6.2%. In 2002, Croatia's rate of unemployment was 15.2% compared to an average of 6.7% for the Eur-A group (ILO, 2005).

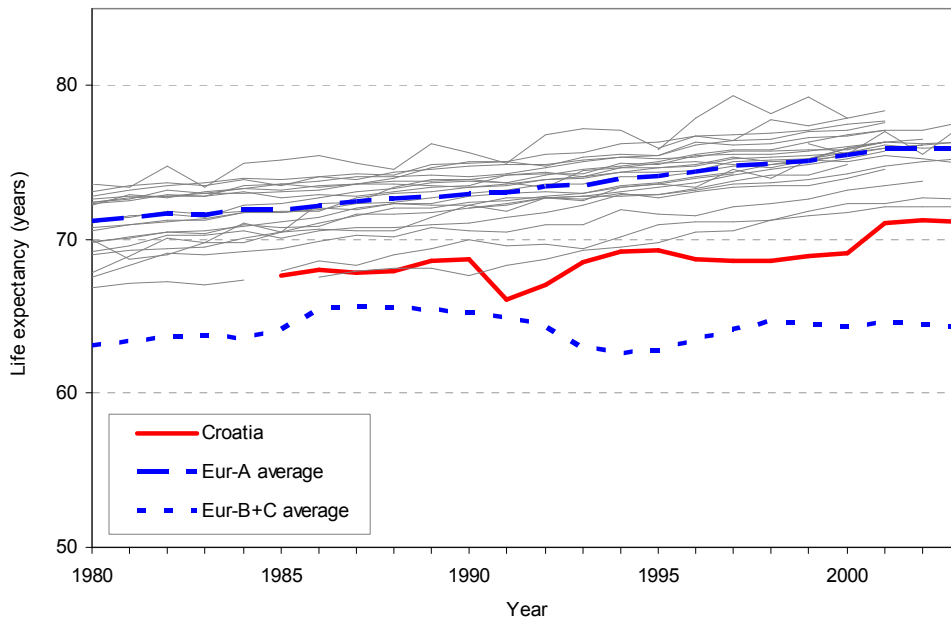
Unemployment in the 15–24 years age group has been very high, both in comparison to overall national unemployment rates and to the average rates for young people in Eur-A. In 2001, youth unemployment was 37.3% in Croatia compared to a Eur-A average of 13.8%. In 2002, the rate in Croatia was 36.9% while the Eur-A rate went up to 14.7% (ILO, 2005).

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

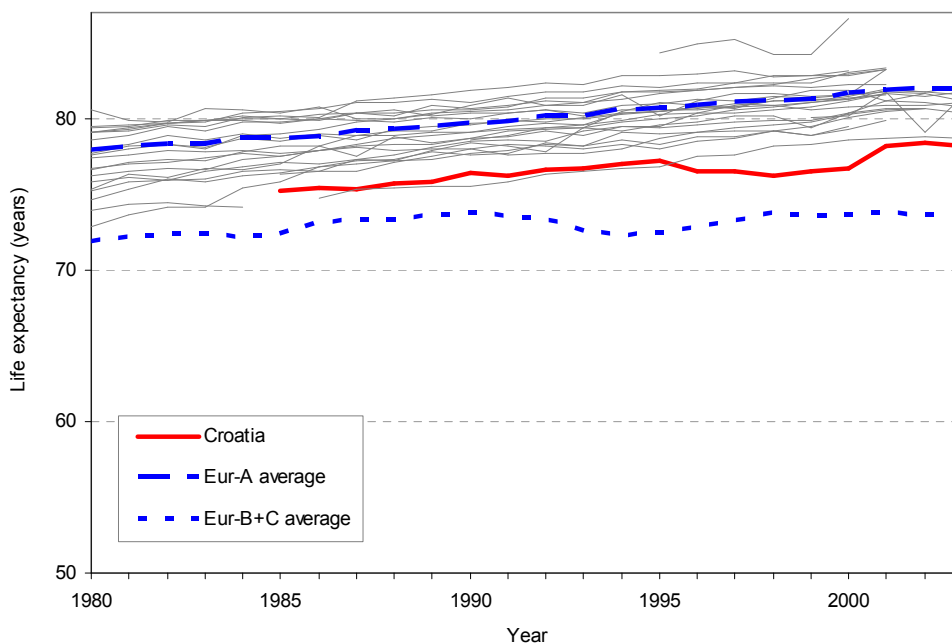
Life expectancy

According to WHO (2003c) estimates, a person born in Croatia in 2003 could expect to live 74.7 years on average: 78.2 years if female and 71.2 years if male. LE in Croatia is the lowest among the Eur-A countries and lower than the Eur-A average in 2002 by 4.7 years for men and 3.7 years for women (Figure. Life expectancy for males; Figure. Life expectancy for females).

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



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

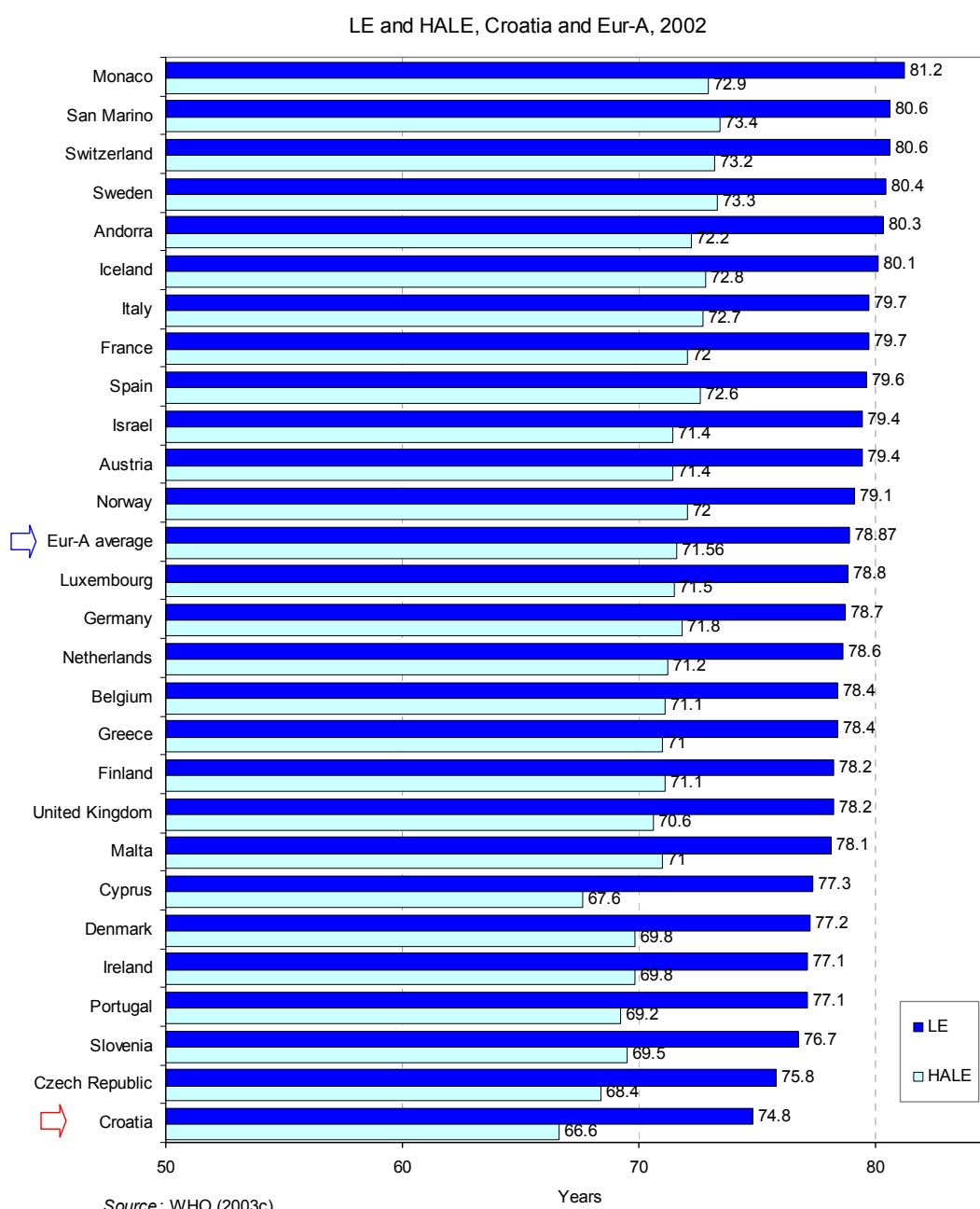


The long-term trend of increase in LE in Croatia parallels the Eur-A average. However, there were significant slumps in 1991 in men and during 1996-2000 in both men and women. The gain in LE

between 1985 and 2002 in Croatia was 3.2 years in women (the same as the average in the Eur-A countries) and 3.6 years in men (0.3 years less than the Eur-A average).

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 Croatia, WHO (2003c) estimates that people can expect to be healthy for about 89% of their lives. They lose an average of 8.2 years to illness – the difference between LE and HALE. This loss is almost one year more than the Eur-A average (7.3 years) and the Eur-B+C average (7.6 years).

Since women live longer and the possibility of deteriorating health increases with age, women lose more healthy years of life (9.3 years) than men (7.2 years). Nevertheless, the longer LE for women in Croatia gives them 5.5 years more HALE than men. Women of 60 years have 3.6 years longer HALE than men of the same age (16.1 years versus 12.5 years) (Figure. LE and HALE).



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 lists, in descending order, the top ten conditions responsible for approximately 90% of the burden of disease among males and females in Croatia. Cardiovascular diseases and neuropsychiatric conditions cause the highest burden of disease among both males and females. Because mortality from neuropsychiatric conditions is minor, it is the resulting disability in daily living that comprises the bulk of their burden on the health of the population (Table. Ten leading disability groups).

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

Rank	Males		Females	
	Disability groups	Total DALYs (%)	Disability groups	Total DALYs (%)
1	Cardiovascular diseases	26.9	Cardiovascular diseases	27.6
2	Neuropsychiatric conditions	20.7	Neuropsychiatric conditions	25.6
3	Malignant neoplasms	17.4	Malignant neoplasms	15.0
4	Unintentional injuries	8.0	Musculoskeletal diseases	4.5
5	Digestive diseases	6.2	Sense organ diseases	4.5
6	Respiratory diseases	3.9	Digestive diseases	4.0
7	Intentional injuries	3.5	Respiratory diseases	4.0
8	Sense organ diseases	3.1	Unintentional injuries	3.6
9	Musculoskeletal diseases	2.3	Diabetes mellitus	1.8
10	Infectious and parasitic diseases	1.3	Infectious and parasitic diseases	1.6

Source: Background data from WHO (2003c).

Main risk factors

The table below shows the top ten risk factors and, in descending order, the degree to which each contributed to the burden of disease in the male and female populations of Croatia in 2002. According to the DALY percentages, tobacco and alcohol place the greatest burden of disease on Croatian men, and high blood pressure and high cholesterol on women (Table. Ten leading risk factors).

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

Rank	Males		Females	
	Risk factors	Total DALYs (%)	Risk factors	Total DALYs (%)
1	Tobacco	23.6	High blood pressure	13.8
2	Alcohol	14.2	High cholesterol	10.1
3	High blood pressure	13.8	High BMI	9.6
4	High cholesterol	11.1	Tobacco	6.5
5	High BMI	8.8	Alcohol	4.3
6	Physical inactivity	4.2	Physical inactivity	4.0
7	Low fruit and vegetable intake	3.6	Low fruit and vegetable intake	2.7
8	Illicit drugs	2.0	Unsafe sex	1.6
9	Occupational airborne particulates	0.5	Illicit drugs	1.1
10	Occupational risk factors for injuries	0.5	Childhood sexual abuse	0.7

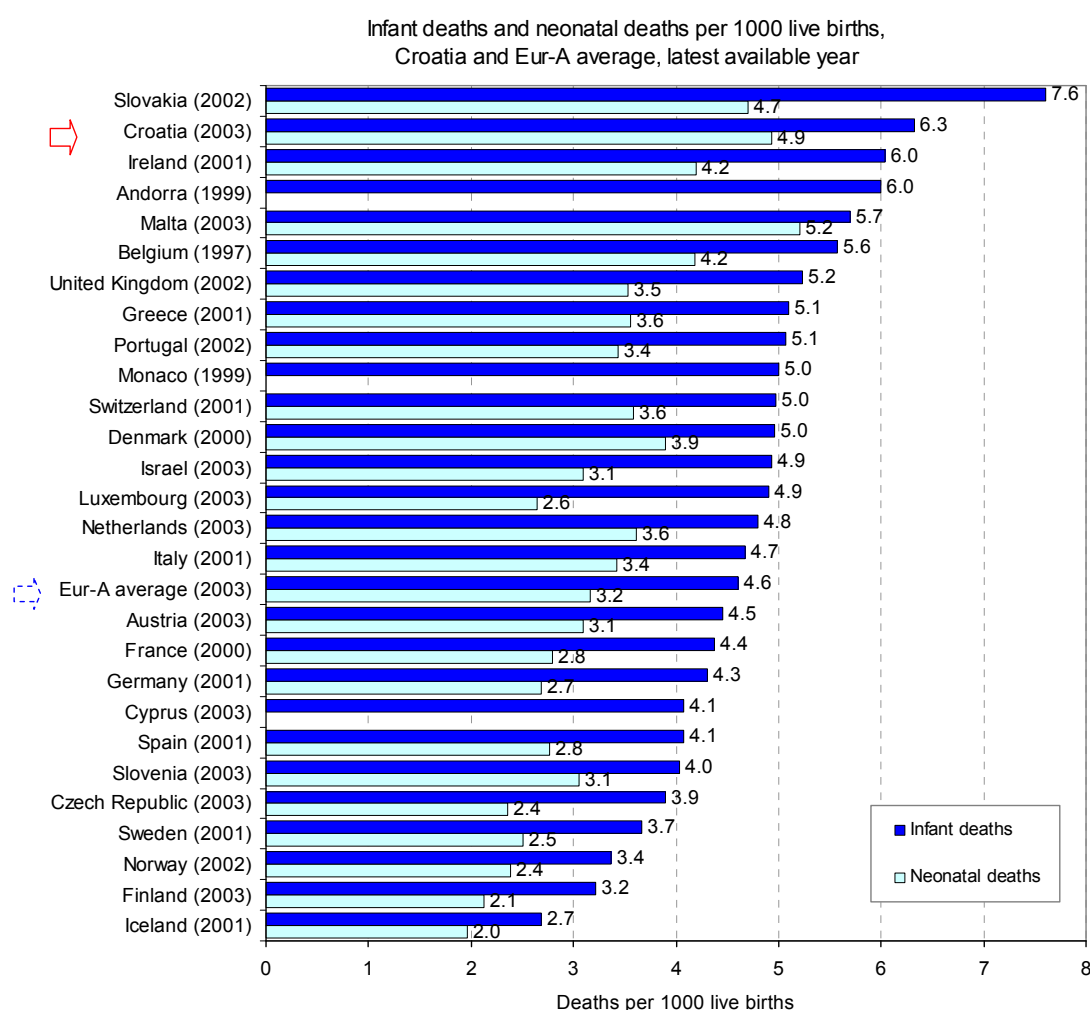
Source: Background data from WHO (2003c).

Mortality

Infant, neonatal and child mortality

Infant and neonatal mortality rates in Croatia are the highest in the Eur-A group, exceeding the EUR-A average by more than 50% in 2002. There was very small reduction in the rates between 1996 and 2001.

National data and WHO estimates for 2002 indicate the probability that, out of every 1000 live births in Croatia, about eight children will die before the age of five. Based on national data, the estimated probability for 2003 was about 7 deaths per 1000 live births. The Eur-A average rate for 2002, based on nationally reported data, was between 5 and 6 deaths per 1000 live births in the age group under five years (Figure. Infant deaths and neonatal deaths).



Maternal mortality

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

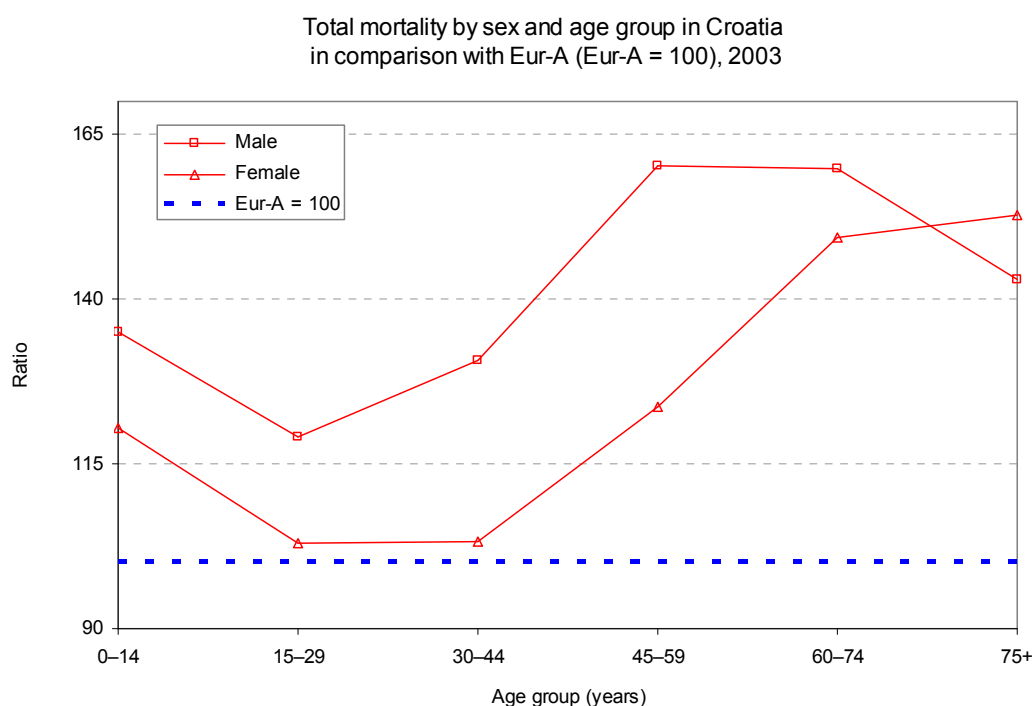
Despite the difficulties in accurately measuring MMR, nationally reported figures are accepted at face value relative to the MDG to improve maternal health – to reduce the MMR by 75% between 1990 and 2015. In some countries, the 2015 target may be equal to or lower than the average current MMR for high income countries in the European Region (the Eur-A 2001 average of 5 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 2015MDG 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.

The MMR for Croatia show substantial variation over time; in some years they were above the Eur-A average and in some they were below. Sixteen maternal deaths occurred between 1999 and 2003.

Excess mortality

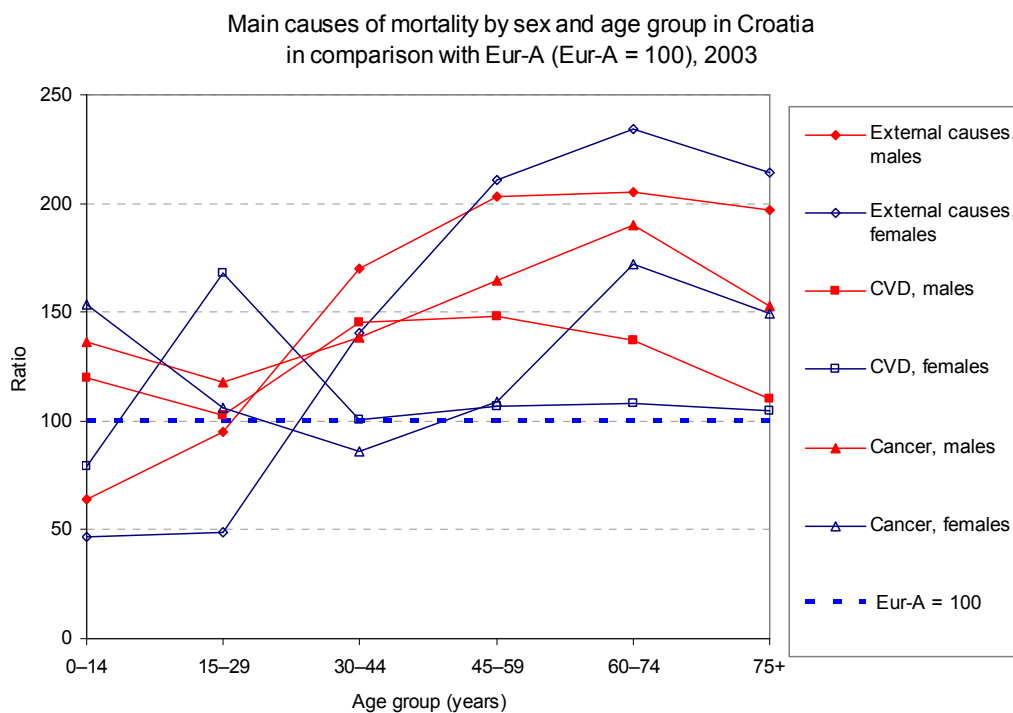
Among the countries of the WHO European Region in general, mortality rates for males and females in Croatia take a middle place. They are, however, the highest in the Eur-A group. There was a substantial increase in mortality rates in 1996–2000, followed by a significant drop in 2001. However, this decrease did not continue in 2002–2003. Excess mortality in Croatia, in comparison to the Eur-A average, is greater in the middle-aged and older population groups than in the younger age groups: in males aged 45 years and over, excess mortality is up to 60%; in females aged 60 years and over, it is about 50%. Mortality rates for women aged 15–44 years are at the same level as the average for Eur-A countries (Figure. Total mortality by sex and age group).



Main causes of death

In 2003, main noncommunicable diseases accounted for almost 87% of all deaths in Croatia; external causes for around 6%; and communicable diseases for less than 1%. In total, 53% of all deaths were caused by cardiovascular diseases (CVD) (15% more than the Eur-A average) and 23% by cancer (a little less than the 28% Eur-A average) (Annex. Selected mortality. Annex. Mortality data).

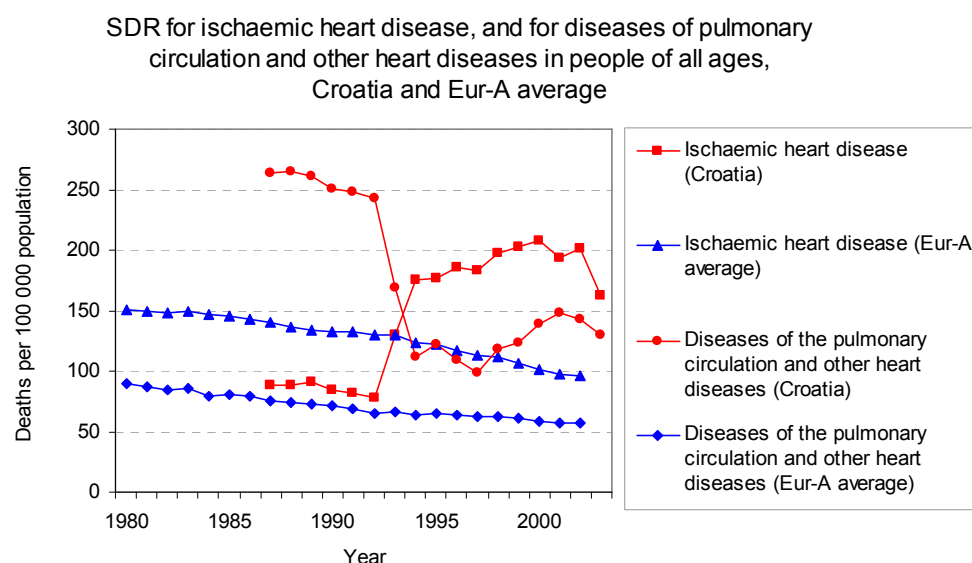
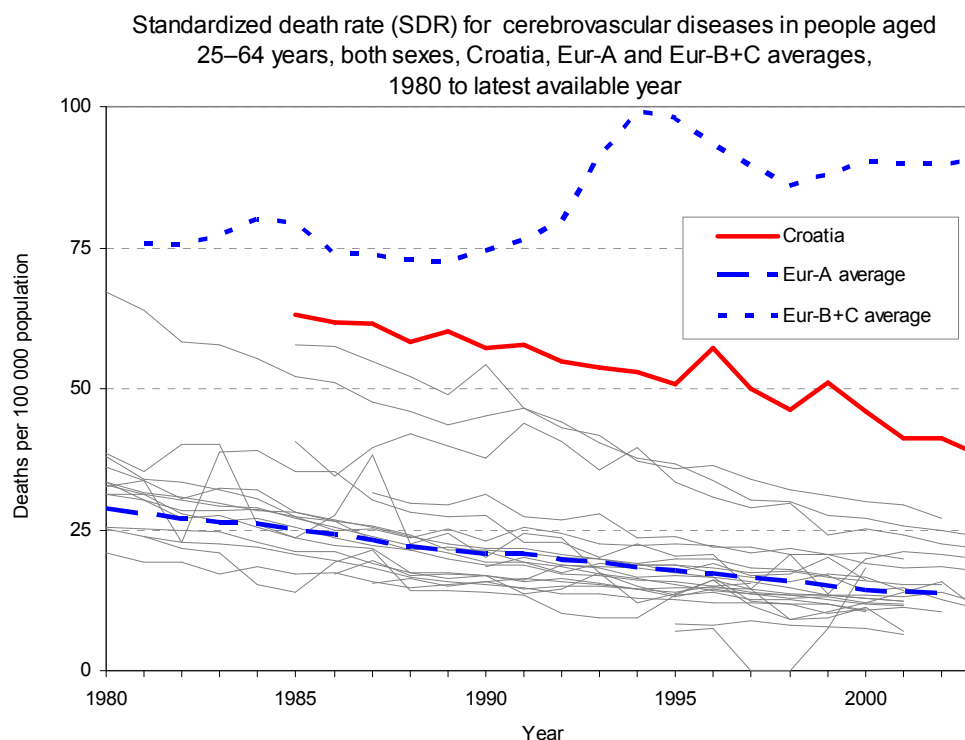
The risk of dying from CVD is about twice as high for Croatian men and women as the Eur-A average and this difference has not been diminishing over the years. Excess mortality from cancer is much lower – under 10% among women and about 25% among men. Comparison with the Eur-A average indicates that Croatian men and women are at greater risk of death from external causes; however, the rates for women in the 15–59 years age group are close to the Eur-A average (Figure. Main causes of mortality by sex and age group).



CVD

Among the Eur-A countries, mortality from CVD is highest in Croatia. In the period 1995–2001 the trend reversed. The rates were much elevated between 1996 and 2000 and at their highest level in 1998 (24% and 19% more than the 1995 rates for men and women respectively). After 1998, the rates started to decline and levelled off in 2002–2003. The gap between CVD mortality rates for Croatia and the Eur-A average rates is not yet diminishing.

Ischaemic heart disease is the single biggest killer in Croatia, responsible for almost 20% of all deaths in 2003, which is a larger share than the average for the Eur-A countries (15%). Yet, the largest excess mortality in Croatia, as compared to the Eur-A average, in particular with respect to the middle-aged population, is from cerebrovascular diseases, and from diseases of the pulmonary circulation and other heart diseases. The death rate for other heart diseases is the highest among the Eur-A countries. Only in Bulgaria, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia (countries in the same part of Europe as Croatia) are the death rates for other heart diseases higher. The practice of coding causes of death in Croatia was changed at the beginning of the 1990s and was reflected by an increase in the long-term trends in mortality from ischaemic heart disease and a decrease from diseases of the pulmonary circulation and other heart diseases (Figure. SDR for cerebrovascular diseases in people aged 25–64 years; Figure. SDR for ischaemic heart disease, and for pulmonary circulation and other heart diseases in people of all ages).

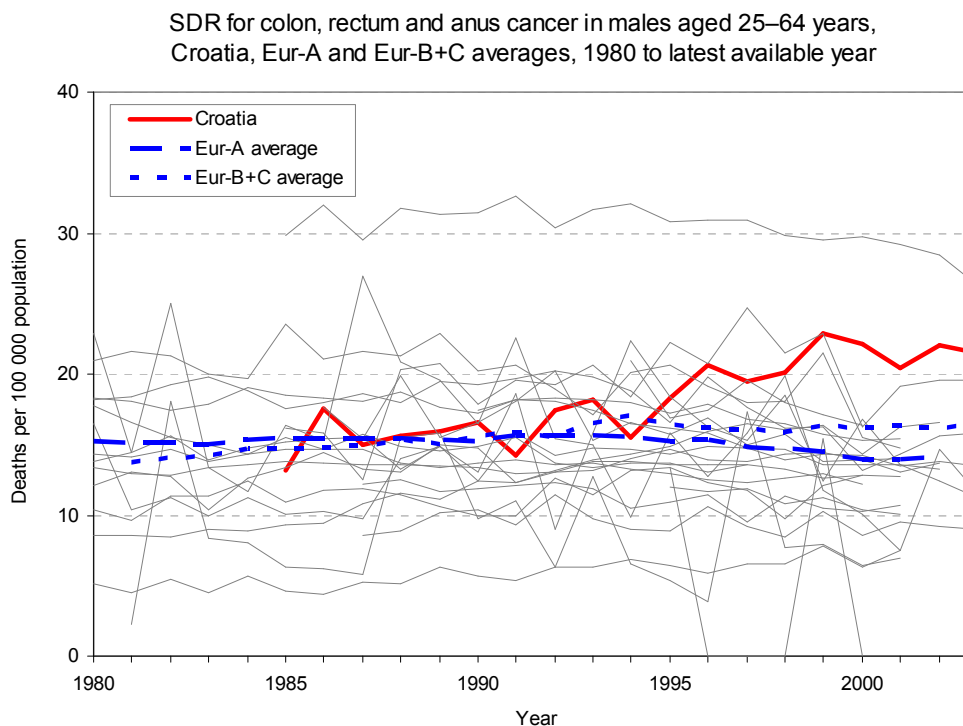


Cancer

Cancer accounted for 23% of all deaths in Croatia in 2003, which is lower than the average for Eur-A countries (28%). Yet, the risk of dying from cancer has been generally higher in Croatia than the Eur-A average since 1996 and, for much longer, in men below 65 years. Death rates from cancer increased in Croatia between 1995 and 2000 by about one fourth before dropping. The rates show a higher excess mortality for Croatian men (more than one fourth) than for women (less than one tenth) when compared with the Eur-A average. The male death rate is the third highest among countries of the WHO European Region.

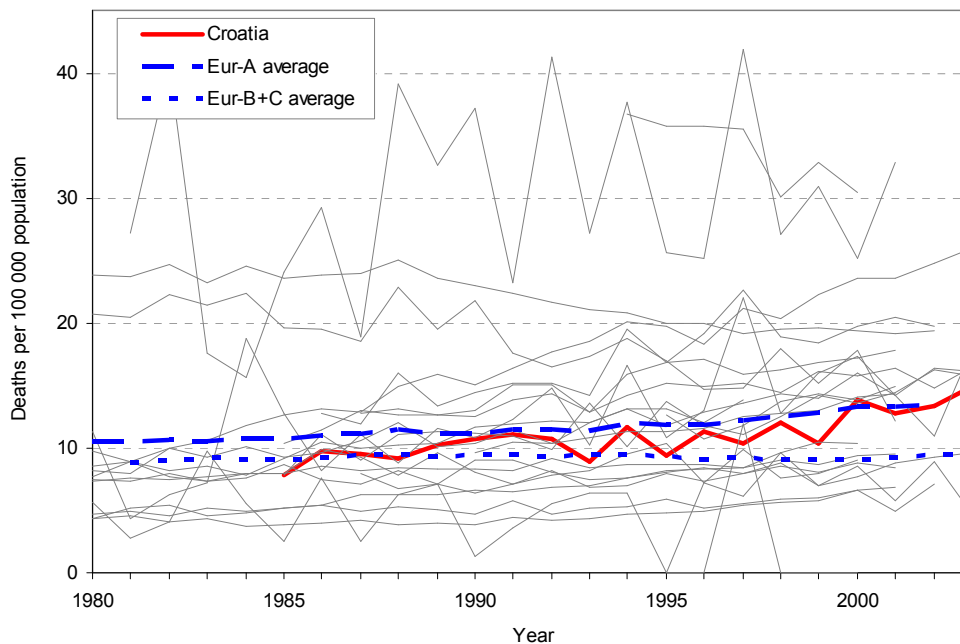
Among men in Croatia, the risk of dying from cancer of the stomach, trachea, bronchus, lung, colon, rectum, anus and pancreas rates second highest among the Eur-A countries; in first place comes the risk of dying from cancer of the lip, oral cavity and pharynx. The rates for all these cancers, except stomach cancer, place Croatia among the six countries in the WHO European Region with the highest death rates. There has been no decline in excess mortality of Croatian men from these diseases. A 24% increase in

mortality from prostate cancer in 2003, after a decline in 1998–2002, further worsens the position for Croatian men (Figure. SDR for colon, rectum and anus cancer in males aged 25–64 years).

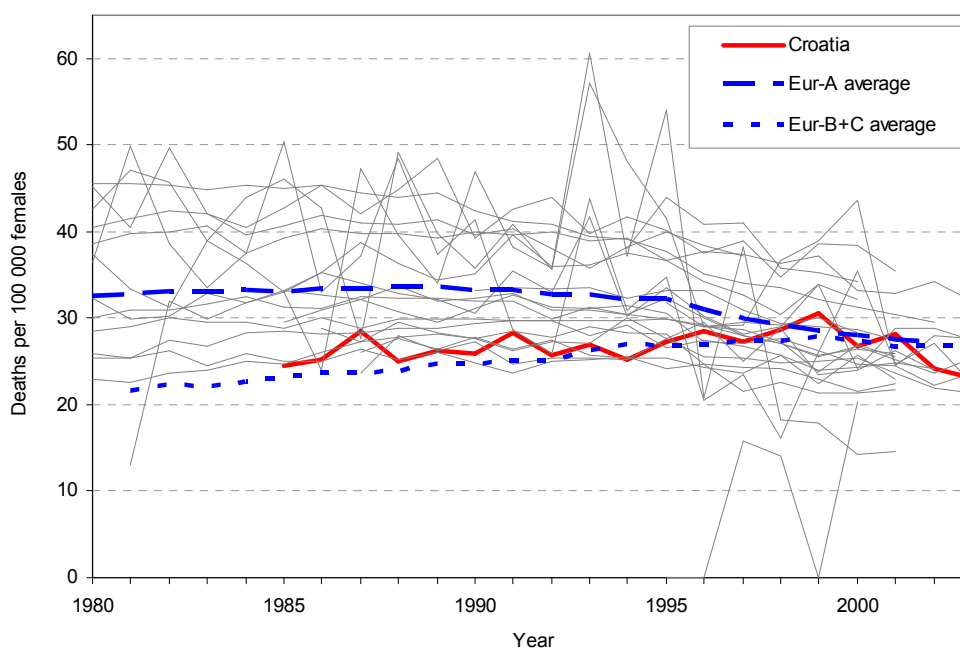


As regards women, mortality from breast cancer decreased after 2000 to rates below the Eur-A average, as was the case before 1998. The risk of dying from cancer of the cervix uteri and other parts of the uterus is higher for Croatian women than for women in the Eur-A countries on average. Since the risk of dying from these diseases is decreasing in Croatia in parallel with the average for the Eur-A countries, the gap is not diminishing. Also, death rates from cancer of the ovary, colon, rectum and anus are above the Eur-A averages but this gap has decreased in later years. The largest excess mortality of Croatian women, as compared with the Eur-A average, is from stomach cancer. Here the difference between the two rates was 80% in 2002. Mortality from cancer of the trachea, bronchus and lung in women is slowly increasing and is close to the Eur-A average. In 2003, the rates for the 25–64 years age group exceeded the Eur-A average (Figure. SDR for TBL cancer in females aged 25–64 years; Figure. SDR for breast cancer in females aged 25–64 years).

SDR for trachea, bronchus and lung cancer in females aged 25–64 years, Croatia, Eur-A and Eur-B+C averages, 1980 to latest available year



SDR for breast cancer in females aged 25–64 years, Croatia, Eur-A and Eur-B+C averages, 1980 to latest available year

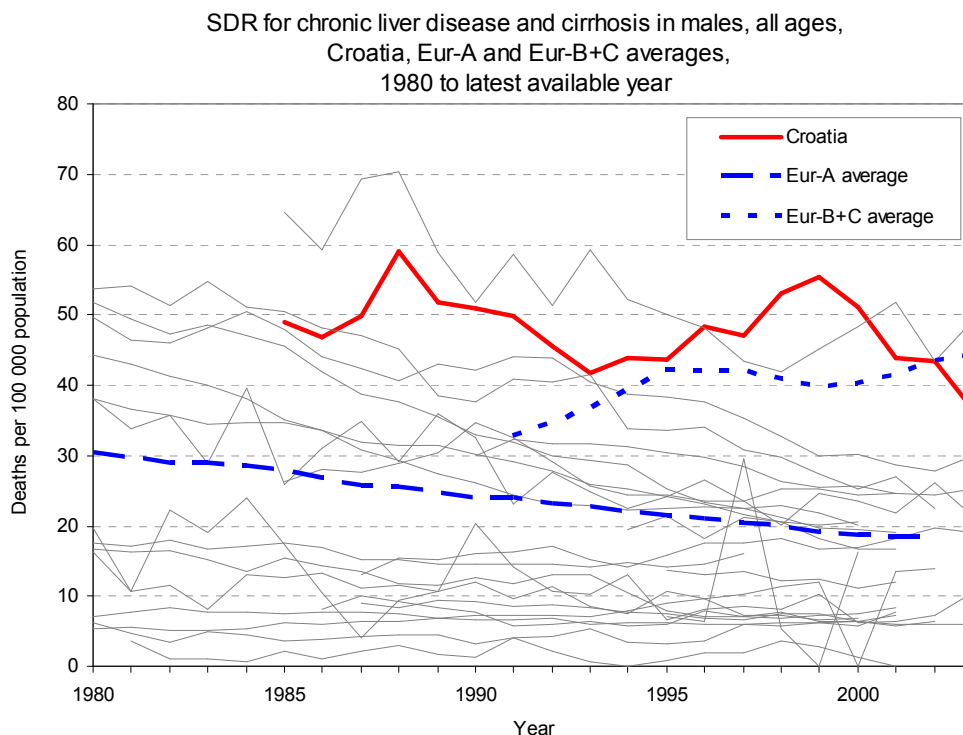


Respiratory diseases

In 2003, respiratory diseases accounted for 4.9% of all deaths in Croatia. Mortality rates among men fluctuated between periods of decrease and increase. However, the rates for men in general and those for men in the 65 and over age group are somewhat below the Eur-A averages. For years, Croatian men under 65 years have been at a higher risk of death from respiratory diseases than the average rate for Eur-A countries. Mortality rates for respiratory diseases among women are lower than the Eur-A average. Among men, mortality from pneumonia is a little lower than from chronic lower respiratory diseases and among women the order is reversed. Rates for mortality from pneumonia fluctuate greatly in comparison to the Eur-A averages; recently they have increased.

Digestive diseases

Mortality rates from diseases of the digestive system are higher than the Eur-A averages. For men they are the second highest among the Eur-A countries; rates for women are in fourth place. The trend shows some decline but only among people below 65 years. Death rates for chronic liver disease and cirrhosis in both men and women are the second highest among the Eur-A countries. (Figure. SDR for chronic liver disease and cirrhosis in males, all ages).

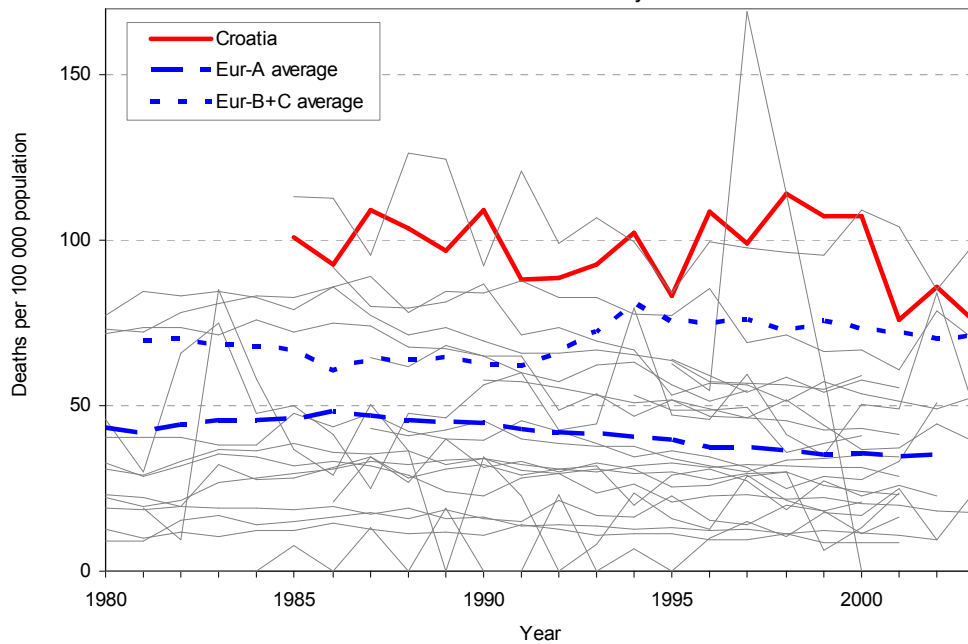


External causes

In 2003, mortality rates from external causes were 43% higher in Croatia than the Eur-A average level, with a higher excess among men than women.

Suicide is the main external cause of death in men and the second in women. Rates have been declining since 1998 but are higher than the Eur-A averages for both men and women. Excess mortality is particularly high for both men and women aged 65 years and over. The difference was two-fold in 2003 (Figure. SDR for suicide in males aged 65+ years).

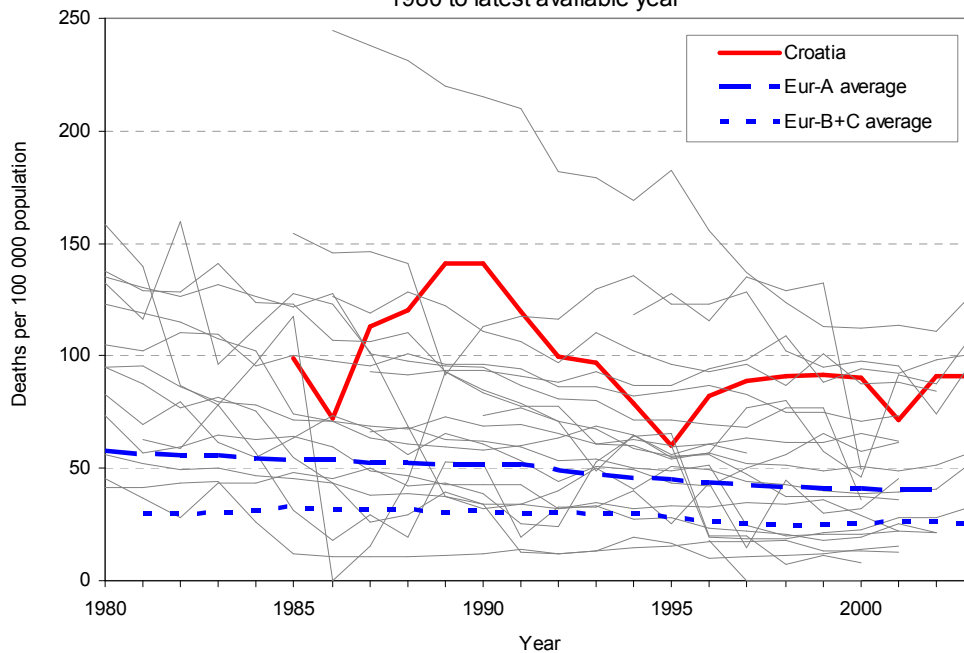
SDR for suicide and self-inflicted injury in males aged 65+ years, Croatia, Eur-A and Eur-B+C averages, 1980 to latest available year



In Croatia, motor vehicle traffic accidents are the second most important external cause of death in men; in women, accidental falls have the same standing. In both cases, the rates are higher than the Eur-A averages and this gap has been increasing since the mid-1990s.

The risk of dying from accidental drowning, exposure to smoke, fire and flames, and homicide is higher in Croatia than in the other Eur-A countries on average (Figure. SDR for accidental falls in people aged 65+ years).

SDR for accidental falls in people aged 65+ years, Croatia, Eur-A and Eur-B+C averages, 1980 to latest available year



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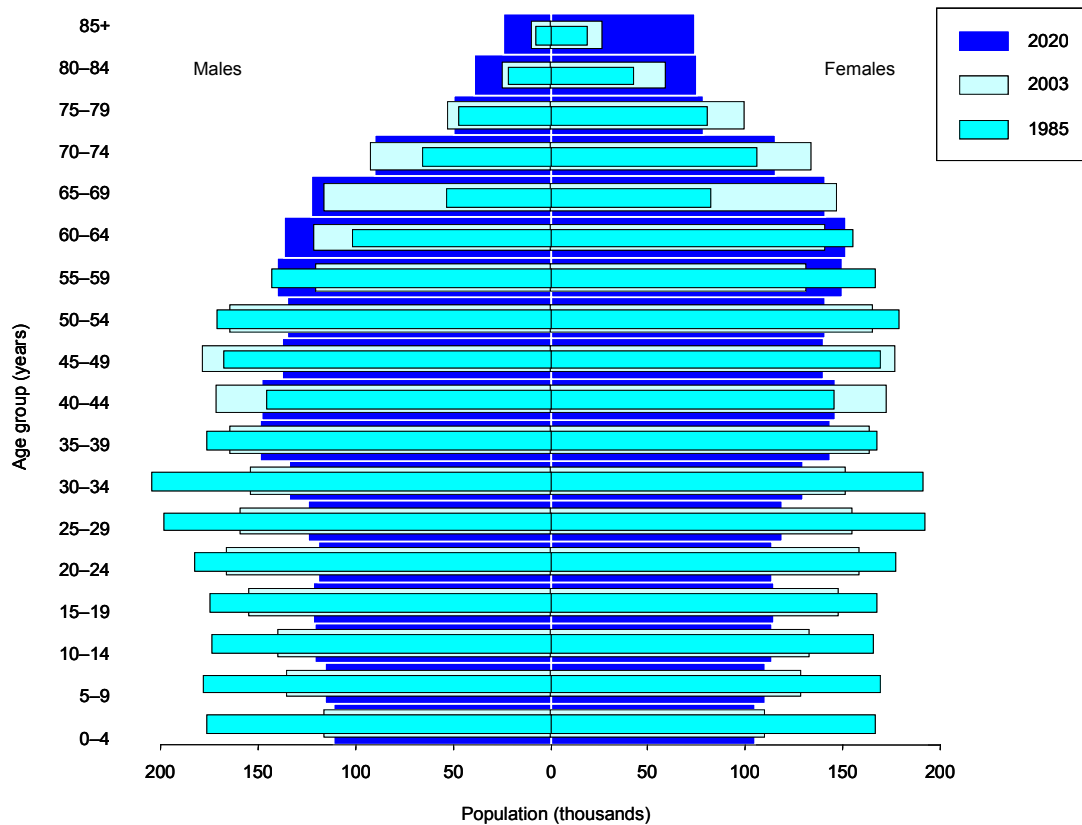
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Annexes

Annex. Age Pyramid

AGE PYRAMID FOR CROATIA, 1970, 2001 AND 2020 (PROJECTED)

Age pyramid for Croatia



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

Annex. Selected mortality

Selected mortality in Croatia compared with Eur-A average

Condition	SDR per 100 000		Excess mortality in Croatia (%)	Total deaths in Croatia (%)	Total deaths in Eur-A (%)
	Croatia (2003)	Eur-A average (2002)			
Selected non-communicable conditions	819.8	533.8	53.6	86.5	82.4
<i>Cardiovascular diseases</i>	499.6	243.4	105.3	52.7	37.6
Ischaemic heart disease	186.9	95.9	94.9	19.7	14.8
Cerebrovascular diseases	141.6	61.1	131.8	14.9	9.4
Diseases of pulmonary circulation and other heart disease	127.6	56.6	125.4	13.5	8.7
<i>Malignant neoplasms</i>	214.3	181.5	18.1	22.6	28.0
Trachea/bronchus/lung cancer	46.2	37.1	24.5	4.9	5.7
Female breast cancer	25.2	27.0	-6.7	2.7	4.2
Colon/rectal/anal cancer	27.2	20.7	31.4	2.9	3.2
Prostate	29.1	25.1	15.9	3.1	3.9
<i>Respiratory diseases</i>	46.1	47.8	-3.6	4.9	7.4
Chronic lower respiratory diseases	19.3	20.2	-4.5	2.0	3.1
Pneumonia	22.2	16.2	37.0	2.3	2.5
<i>Digestive diseases</i>	42.7	30.8	38.6	4.5	4.8
Chronic liver disease and cirrhosis	23.3	12.6	84.9	2.5	1.9
<i>Neuropsychiatric disorders</i>	17.1	30.3	-43.6	1.8	4.7
Communicable conditions	8.5	8.4	1.2	0.9	1.3
AIDS/HIV	0.0	1.1	-100.0	0.0	0.2
External causes	57.7	40.3	43.2	6.1	6.2
<i>Unintentional</i>	39.0	28.7	35.9	4.1	4.4
Road traffic injuries	15.0	9.9	51.5	1.6	1.5
Falls	12.6	6.1	106.6	1.3	0.9
<i>Intentional</i>	18.7	11.6	61.2	2.0	1.8
Self-inflicted (suicide)	17.1	10.6	61.3	1.8	1.6
Violence (homicide)	1.5	1.0	50.0	0.2	0.2
Ill-defined conditions	17.3	20.9	-17.2	1.8	3.2
All causes	947.6	647.8	46.3	100.0	100.0

Annex. Mortality data

Mortality data

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

Causes of death	Sex	Croatia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	63.7	-3.2	49.4	-2.4	151.7	-3.8
	M	74.6	-2.7	55.3	-2.5	170.5	-3.9
	F	52.2	-3.9	43.3	-2.4	131.9	-3.8
<i>Infectious and parasitic diseases</i>	M	0.8	-6.1	1.4	-1.1	10.9	-7.0
	F	0.6		1.1	-3.0	9.5	-6.6
Intestinal infectious diseases	M	0.0	-12.5	0.2	-0.7	5.1	-8.2
	F	0.4		0.1	-7.3	4.7	-7.9
<i>Malignant neoplasms</i>	M	4.0	2.5	3.3	-1.8	5.1	-1.9
	F	2.1	-6.4	2.6	-1.8	4.2	-1.9
<i>Cardiovascular diseases</i>	M	0.9	-7.6	1.4	-3.1	3.3	1.1
	F	0.6	-5.6	1.3	-2.5	2.6	0.1
<i>Respiratory diseases</i>	M	1.3	-8.4	1.4	-4.3	35.9	-5.0
	F	1.3	-6.2	1.0	-4.2	30.7	-5.0
Pneumonia	M	0.9	-8.5	0.5	-6.0	20.9	-4.9
	F	0.9	-6.0	0.4	-5.1	17.9	-4.7
<i>Certain conditions originating in perinatal period</i>	M	451.0	-1.4	255.3	-2.1	607.6	-2.7
	F	331.6	-1.6	202.3	-1.6	427.5	-2.7
Congenital malformations & chromosomal abnormalities	M	17.7	-2.2	11.6	-2.9	24.2	-2.8
	F	11.5	-4.7	10.0	-3.3	21.0	-2.6
<i>Ill-defined causes</i>	M	1.6	-9.8	5.0	-3.9	5.6	-0.6
	F	1.0	-10	3.4	-4.2	4.6	-1.0
<i>External causes of injury & poisoning</i>	M	9.6	-4.2	7.0	-4.0	29.0	-3.4
	F	7.0	-5.2	4.6	-3.2	18.1	-3.1
Road traffic injuries	M	4.1	-4.1	2.5	-4.5	4.7	-2.6
	F	2.8	-5.1	1.7	-4.8	3.0	-1.6

Mortality data contd

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

Causes of death	Sex	Croatia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	64.5	-5.1	56.0	-2.3	161.0	-0.9
	M	97.6	-5.6	82.0	-2.3	241.7	-1.0
	F	30.2	-2.9	29.3	-2.2	79.0	-0.6
<i>Infectious and parasitic diseases</i>	M	0.9	-8.3	1.2	1.5	12.3	3.0
	F	0.0	-12.5	0.8	1.9	5.1	2.5
<i>Malignant neoplasms</i>	M	6.3	-2.2	6.2	-1.0	8.8	-1.9
	F	7.9	8.9	4.7	-1.4	7.7	-1.9
<i>Cardiovascular diseases</i>	M	3.9	-5.6	4.1	-2.4	17.6	0.0
	F	1.1	-7.1	2.3	-2.0	7.3	-0.9
<i>Respiratory diseases</i>	M	0.9	-8.3	1.4	-3.6	6.9	0.2
	F	0.4	-5.6	0.9	-2.7	3.8	-1.1
<i>Digestive diseases</i>	M	1.3	-5.6	0.9	-3.5	8.0	3.0
	F	0.7	-2.1	0.5	-3.8	3.7	3.1
<i>Ill-defined causes</i>	M	5.0	-5.8	4.0	-3.1	11.6	7.1
	F	2.0	-5.6	1.4	-1.3	3.3	5.8
<i>External causes</i>	M	68.8	-6.3	58.3	-1.4	162.4	-1.6
	F	15.3	-3.3	14.4	-1.6	36.9	-0.2
Road traffic injuries	M	34.8	-0.3	28.5	-1.3	27.8	-1.5
	F	9.1	2.2	7.3	-1.4	8.0	0.3
Accidental drowning	M	1.7	-4.8	1.3	-2.2	10.8	-3.9
	F	0.0	-12.5	0.2	-2.1	1.9	-2.2
Accidental poisoning	M	1.7	-8.1	2.8	0.0	19.1	3.3
	F	0.9	6.2	0.7	0.8	4.4	2.5
Self-inflicted (suicide)	M	18.2	-2.8	12.7	-1.8	36.8	0.0
	F	3.2	-4.8	3.1	-2.2	5.8	-1.3

Mortality data contd

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

Causes of death	Sex	Croatia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	145.9	-3.6	120.3	-2.5	453.8	-0.7
	M	211.1	-3.8	161.6	-2.6	700.0	-0.8
	F	80.9	-2.8	78.5	-2.1	215.6	-0.2
<i>Malignant neoplasms</i>	M	40.1	-2.1	27.6	-2.3	40.2	-2.8
	F	31.5	-2.1	31.3	-2.0	43.8	-1.4
Trachea/bronchus/lung cancer	M	7.0	-5.5	5.0	-3.4	7.3	-4.2
	F	4.3	5.7	2.8	-0.6	2.2	-1.0
Female breast cancer	F	6.6	-3.2	10.0	-2.6	10.0	-2.3
<i>Cardiovascular diseases</i>	M	44.5	-1.4	26.1	-2.5	158.6	-0.4
	F	14.6	-2.7	10.4	-2.1	45.3	0.0
Ischaemic heart disease	M	21.0	-0.9	11.8	-3.1	73.7	-2.2
	F	2.9	-5.2	2.4	-2.7	14.4	-1.3
Cerebrovascular diseases	M	7.5	-4.7	4.4	-3.2	24.6	-0.4
	F	5.8	-3.7	3.6	-2.5	10.6	-1.3
<i>Respiratory diseases</i>	M	4.8	-0.2	3.9	-3.5	34.3	0.9
	F	2.4	-0.4	2.2	-2.0	9.8	0.8
<i>Digestive diseases</i>	M	18.2	-4.2	12.6	-2.4	50.2	1.4
	F	6.6	3.3	5.4	-1.7	19.4	4.1
<i>External causes</i>	M	81.4	-4.6	58.8	-1.2	299.5	-1.9
	F	12.9	-5.1	15.1	-1.8	58.9	-1.0
Road traffic injuries	M	26.7	4.7	16.0	-0.5	31.4	-1.7
	F	4.5	-1.2	3.9	-2.0	7.1	-0.5
Self-inflicted (suicide)	M	29.3	-0.1	21.2	-1.5	54.9	-2.4
	F	4.4	-6.4	5.8	-2.2	7.9	-2.5

Mortality data contd

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

Causes of death	Sex	Croatia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	639.4	-1.0	435.6	-1.3	1294.9	-0.6
	M	929.2	-0.9	580.1	-1.4	1981.7	-0.6
	F	362.5	-1.4	293.3	-1.0	698.9	-0.5
<i>Malignant neoplasms</i>	M	323.1	0.7	218.2	-1.2	323.2	-1.9
	F	165.4	0.4	155.0	-1.0	186.1	-0.5
Trachea/bronchus/lung cancer	M	118.2	1.8	65.9	-1.5	101.4	-2.9
	F	24.1	10.3	21.8	3.4	15.4	1.0
Female breast cancer	F	37.0	-1.8	44.0	-2.2	45.3	0.1
<i>Cardiovascular diseases</i>	M	317.3	0.1	156.4	-2.6	793.1	-0.1
	F	107.3	-0.4	50.9	-2.5	271.7	-0.6
Ischaemic heart disease	M	159.8	1.2	86.2	-3.3	435.3	-0.7
	F	35.5	0.3	17.8	-3.4	111.1	-0.6
Cerebrovascular diseases	M	68.2	-2.6	23.7	-2.6	168.6	-0.9
	F	38.9	-0.6	14.5	-2.1	88.4	-1.4
<i>Respiratory diseases</i>	M	26.9	0.7	20.3	-1.7	108.7	-1.4
	F	6.2	-2.8	10.2	-1.3	24.5	-0.7
<i>Digestive diseases</i>	M	92.4	-0.9	49.6	-0.8	129.7	0.7
	F	26.6	-3.6	20.3	-0.7	57.3	1.9
<i>External causes</i>	M	103.2	-2.4	62.8	-1.0	409.2	-0.9
	F	22.8	-4.2	20.9	-0.9	89.1	-1.1
Road traffic injuries	M	28.0	1.2	13.0	-1.3	28.5	-1.8
	F	4.2	-3.4	4.1	-2.1	7.5	-1.4
Self-inflicted (suicide)	M	42.8	1.7	23.1	-1.1	68.1	-2.4
	F	10.0	-1.9	8.5	-1.2	10.2	-3.4

Mortality data contd

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

Causes of death	Sex	Croatia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	2399.7	-2.3	1570.9	-1.9	3411.7	-0.1
	M	3447.1	-2.3	2156.9	-2.1	4996.4	0.1
	F	1597.1	-3.0	1069.2	-1.9	2339.0	-0.6
<i>Malignant neoplasms</i>	M	1166.4	-1.3	851.3	-1.4	1002.5	-0.8
	F	474.8	-1.0	439.8	-1.1	438.9	-0.7
Trachea/bronchus/lung cancer	M	370.4	-1.7	261.8	-1.9	321.7	-1.5
	F	54.3	1.4	59.0	0.2	37.1	-1.4
Female breast cancer	F	76.2	-1.8	79.7	-1.6	68.7	1.3
<i>Cardiovascular diseases</i>	M	1527.9	-2.4	744.9	-3.6	2903.0	0.6
	F	785.4	-3.6	335.7	-3.9	1507.8	-0.3
Ischaemic heart disease	M	657.3	-1.2	381.3	-4.2	1582.2	1.2
	F	284.7	-1.5	133.5	-4.6	731.4	0.5
Cerebrovascular diseases	M	459.1	-3.8	143.3	-3.7	833.7	0.2
	F	277.5	-4.6	86.7	-4.1	528.9	-0.8
<i>Respiratory diseases</i>	M	186.3	-0.9	144.0	-3.5	303.0	-2.4
	F	60.9	0.3	62.5	-2.4	68.6	-3.6
<i>Digestive diseases</i>	M	201.0	-1.9	111.6	-1.6	193.0	0.1
	F	89.0	-1.4	54.1	-1.7	94.2	0.2
<i>External causes</i>	M	151.0	-2.5	79.3	-1.4	320.0	1.0
	F	55.2	-3.0	32.1	-2.1	88.7	-0.5
Road traffic injuries	M	28.3	0.1	14.8	-3.0	24.3	-1.5
	F	10.6	0.9	5.9	-3.4	9.5	-1.0
Self-inflicted (suicide)	M	56.5	-0.8	24.5	-1.6	60.5	-0.8
	F	18.3	-0.8	8.7	-2.6	12.7	-3.1

Mortality data contd

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

Causes of death	Sex	Croatia (2003)		Eur-A (2002)		Eur-B+C (2003)	
		Rate	Change (%)	Average	Change (%)	Average	Change (%)
All causes	Both	11839.8	2.0	8059.6	-1.0	12338.8	0.0
	M	14050.3	2.6	9832.0	-1.1	14838.0	0.1
	F	10865.0	1.8	7112.5	-0.9	11421.7	0.0
<i>Malignant neoplasms</i>	M	2455.4	7.1	2231.1	-0.4	1489.3	1.2
	F	1192.3	4.9	1136.2	-0.4	721.7	0.8
Trachea/bronchus/lung cancer	M	429.6	8.2	457.1	-0.7	323.5	1.0
	F	93.0	9.9	102.7	1.5	55.6	0.5
Female breast cancer	F	181.9	6.5	159.6	-0.4	92.0	3.1
<i>Cardiovascular diseases</i>	M	8594.5	2.7	4356.2	-2.1	10221.2	0.4
	F	7651.9	2.2	3577.9	-1.9	8805.6	0.4
Ischaemic heart disease	M	3157.7	1.3	1708.0	-2.2	4925.6	1.4
	F	2616.1	0.7	1150.0	-2.2	4028.6	1.2
Cerebrovascular diseases	M	2288.0	1.3	1119.8	-2.5	3004.4	0.7
	F	2113.0	0.6	1026.9	-2.4	2967.6	0.5
<i>Respiratory diseases</i>	M	1113.2	5.3	1156.5	-2.4	824.1	-2.1
	F	518.3	4.6	591.9	-2.1	302.3	-3.2
<i>Digestive diseases</i>	M	351.3	0.6	340.3	-1.1	270.4	0.3
	F	260.8	4.1	279.8	-0.4	175.0	1.1
<i>External causes</i>	M	420.6	1.2	275.0	-0.6	604.2	0.1
	F	281.1	1.7	187.8	-1.2	172.4	-1.2
Road traffic injuries	M	41.9	5.8	28.1	-2.2	34.6	-3.1
	F	13.5	0.5	10.0	-3.1	14.7	-1.7
Self-inflicted (suicide)	M	99.6	-0.5	49.5	-1.6	86.6	-1.1
	F	21.2	-2.5	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*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 groups¹ 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).