



Highlights on health in Andorra 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

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Summary: findings and policy considerations

Life expectancy

According to WHO estimates, a person born in Andorra in 2003 can expect to live 73.0 years on average: 76 years if female and 69 years if male. Since 1999, Andorrans have gained about 2.2 years in 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, 2004a)

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

Infant mortality

WHO estimated that in 2003, there was a probability that for every 1000 live births in Andorra, almost five children would die before five years of age, compared to the Eur-A average of between five and six per 1000 live births.

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)

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

Selected demographic and socioeconomic information

Population profile

In mid-2003, the population of Andorra was approximately 71 000, about 93% in urban areas (WHO, 2005).

In 2003, the percentage of the population 60 and over was 21.8, well above the Eur-A average.

The birth rate in Andorra was 1.3 in 2003 at the low end of the scale for Eur-A (Table. Selected demographic indicators). The population increase between 1993 and 2003 was 1.7%, the fourth largest in the European region (WHO, 2005).

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

Indicators	Andorra	Eur-A		
	Value	Average	Minimum	Maximum
Population (in 1000s)	69 739	–	–	–
0–14 years (%)		–	–	–
15–64 years (%)		–	–	–
65+ years (%)		–	–	–
Urban population (%) ^a	92.1	78.5	50.8	100.0
Live births (per 1000) ^b	11.5	10.7	8.6	21.7
Natural population growth (per 1000)	7.7	1.1	–2.9	15.9
Net migration (per 1000)	6.4	3.5	–0.5	8.8

^a2001; ^b2000.

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.

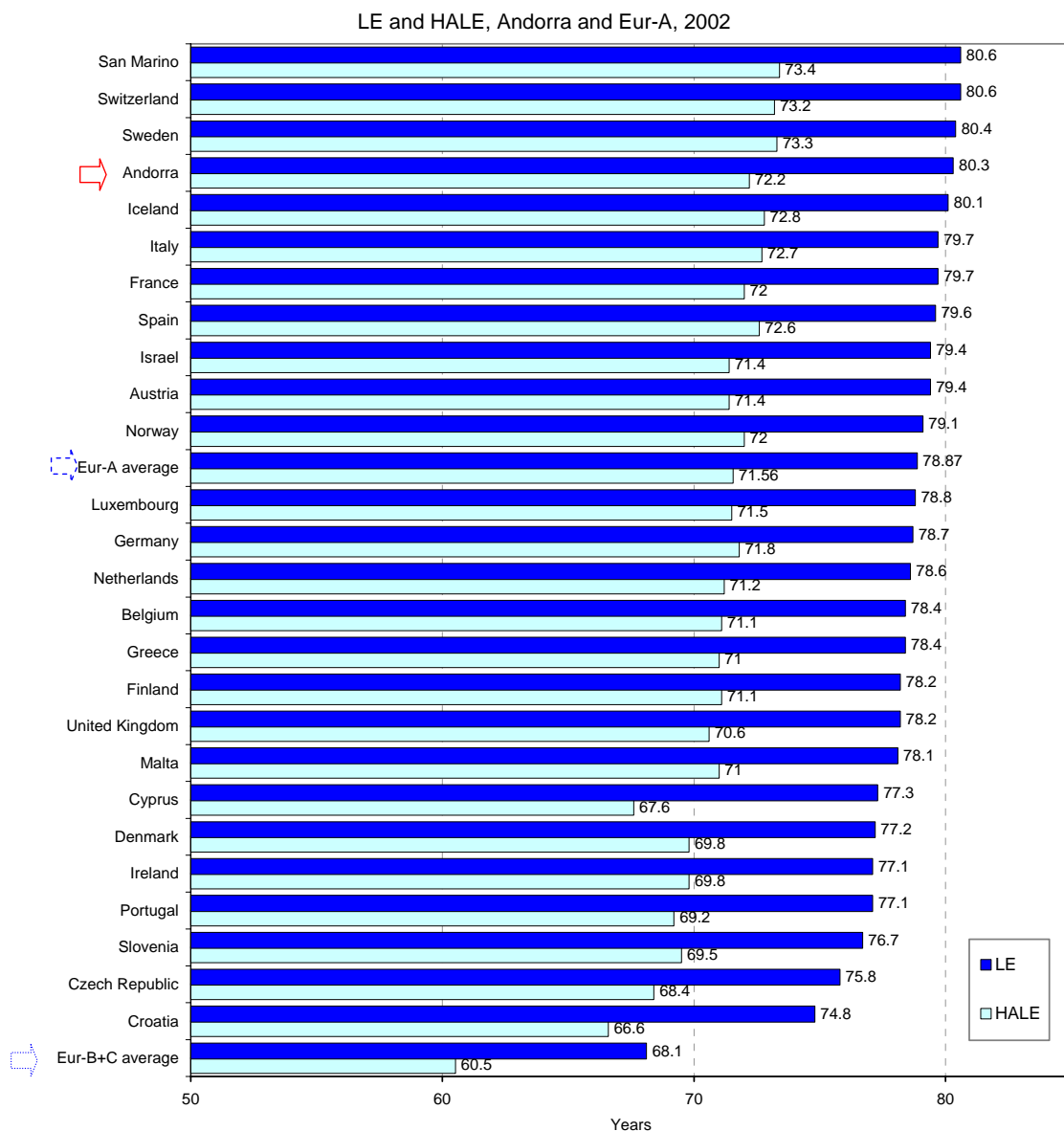
In Andorra, per capita gross national income, adjusted for purchasing power parity, was US \$29 463 in 2002 (WHO, 2005).

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

According to WHO (2005) estimates, a person born in Andorra in 2003 can expect to live 81.0 years on average, among the highest in the Eur-A: 84.0 years if female and 78.0 years if male. Since 1999, Andorrans have gained about 2.2 years in LE.

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 Andorra, WHO (WHO 2005) estimates that people can expect to be healthy for about 89% of their lives. They lose an average of 8.8 years to illness – the difference between LE and HALE. This loss is higher than the Eur-A average (7.3 years) and the Eur-B+C average (7.6 years).

Since women live longer and since the possibility of deteriorating health increases with age, women lose more healthy years of life (9.1 years) than men (7.0 years). Nevertheless, the longer LE for women in Andorra gives them about three extra years of healthy life. According to estimates (WHO, 2005) for 60 year-olds in Andorra, the HALE for women (19.9 years) is more than three years longer than that for men (16.6 years) (Figure. LE and HALE).

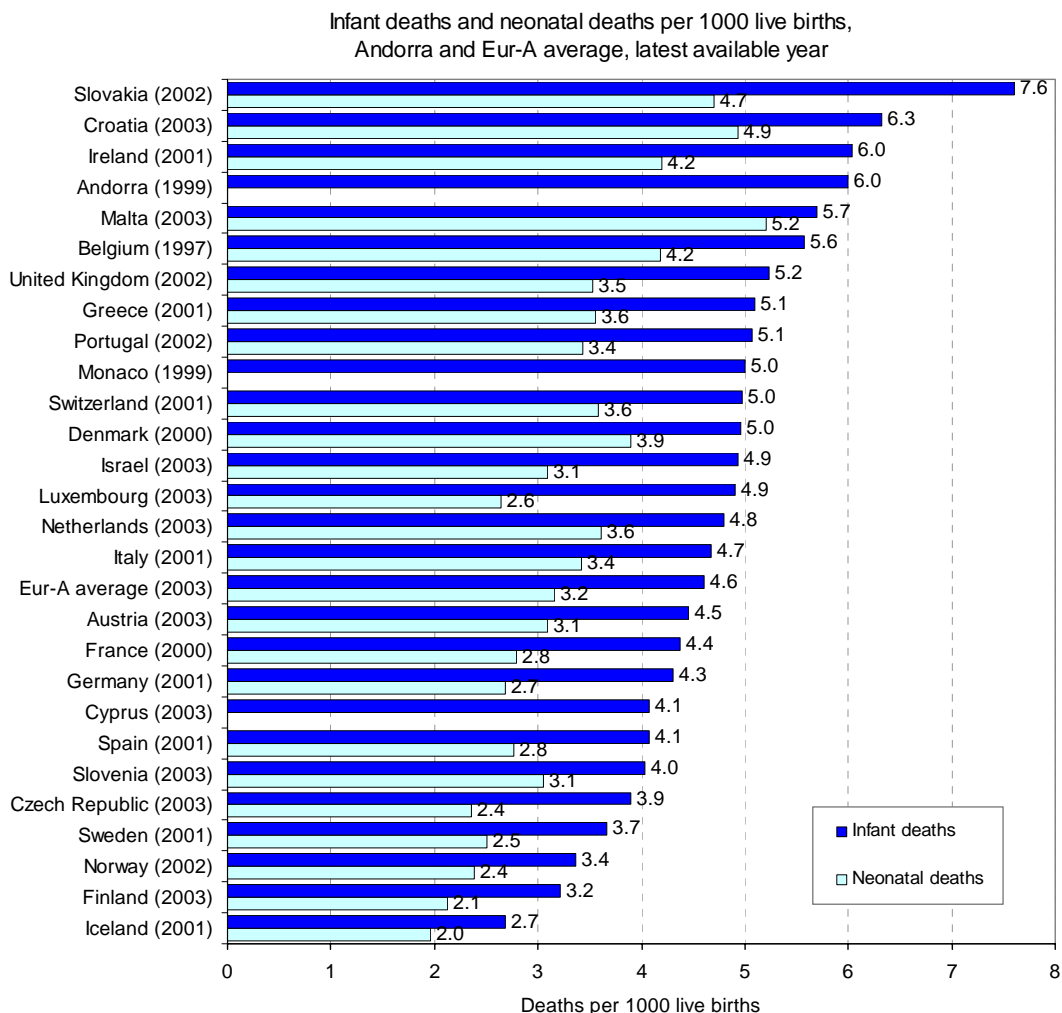


Source: WHO (2003c).

Mortality

Infant, neonatal and child mortality

WHO estimated that in 2003, there was a probability that for every 1000 live births in Andorra, almost five children would die before five years of age, compared to the Eur-A average of between five and six (WHO, 2005) (Figure. Infant deaths and neonatal deaths).



References

Council of Europe (2005). Recent demographic developments in Europe 2004. Strasbourg, Council of Europe.

Health Evidence Network (2003a). What are the main risk factors for disability in old age and how can disability be prevented? Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/HEN/Syntheses/20030820_1, accessed 11 October 2005).

Health Evidence Network (2003b). What is the efficacy/effectiveness of antenatal care? Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/HEN/Syntheses/20030820_1, accessed 11 October 2005).

Health Evidence Network (2005). What is the effectiveness of antenatal care? (Supplement) Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/HEN/Syntheses/20030820_1, accessed 15 January 2006).

OECD (2004). Ageing and employment policies. Paris, Organisation for Economic Co-operation and Development (http://www.oecd.org/document/37/0,2340,en_2649_201185_32019685_1_1_1_1,00.html, accessed 14 November 2005).

WHO (2003a). Managing newborn problems: a guide for doctors, nurses and midwives. Geneva, World Health Organization (<http://www.who.int/reproductive-health/publications/mnp/mnp.pdf>, accessed 13 October 2005).

WHO (2003b). The WHO reproductive health library, version 6. Geneva, World Health Organization (<http://www.who.int/reproductive-health/rhl/index.html>, accessed 11 October 2005).

WHO (2003c). The world health report 2003 – Shaping the future. Geneva, World Health Organization (<http://www.who.int/whr/2003/en>, accessed 11 October 2005).

WHO (2004). The world health report 2004 – Changing history. Geneva, World Health Organization (<http://www.who.int/whr/2004/en>, accessed 11 October 2005).

WHO (2005). WHO Statistical Information System (WHOSIS) [web site]. Geneva, World Health Organization
http://www3.who.int/whosis/country/country_select.cfm?path=whosis,inds,country_select&language=english, accessed 15 December 2005).

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 11 October 2005).

WHO Regional Office for Europe (2005). European health for all database (HFA-DB) [online database]. Copenhagen, WHO Regional Office for Europe (<http://www.euro.who.int/hfadb>, accessed 20 January 2005).

World Bank (2005). World development indicators 2005. Washington, DC, World Bank (<http://devdata.worldbank.org/wdi2005/home.htm>, accessed 28 September 2005).

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 groups² 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.

² 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

<i>Causes of death</i>	<i>ICD-10 code</i>
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
 <i>Technical terminology</i>	
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).