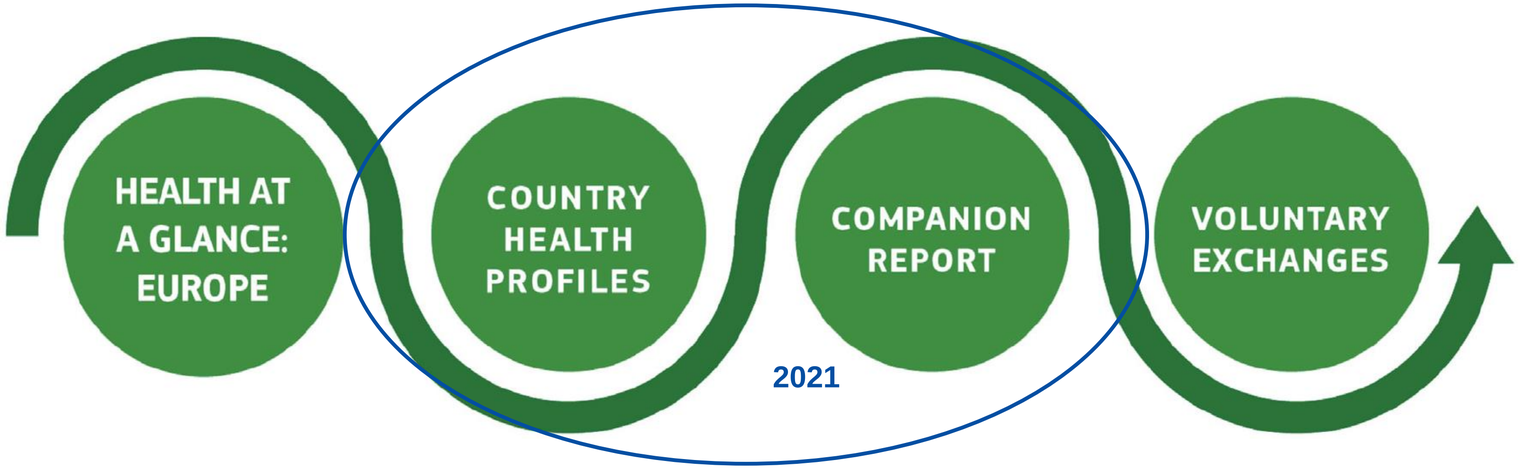
State of Health in the EU

Country Health Profiles 2021 – key findings

CoR Interregional Group on Health and Well-Being, 22 April 2022

The *State of Health in the EU* project

- Objective: strengthen the evidence base on health systems performance for the benefit of policymakers, stakeholders, researchers and general public
- A recurring, two-year cycle of knowledge brokering since 2016



European Commission

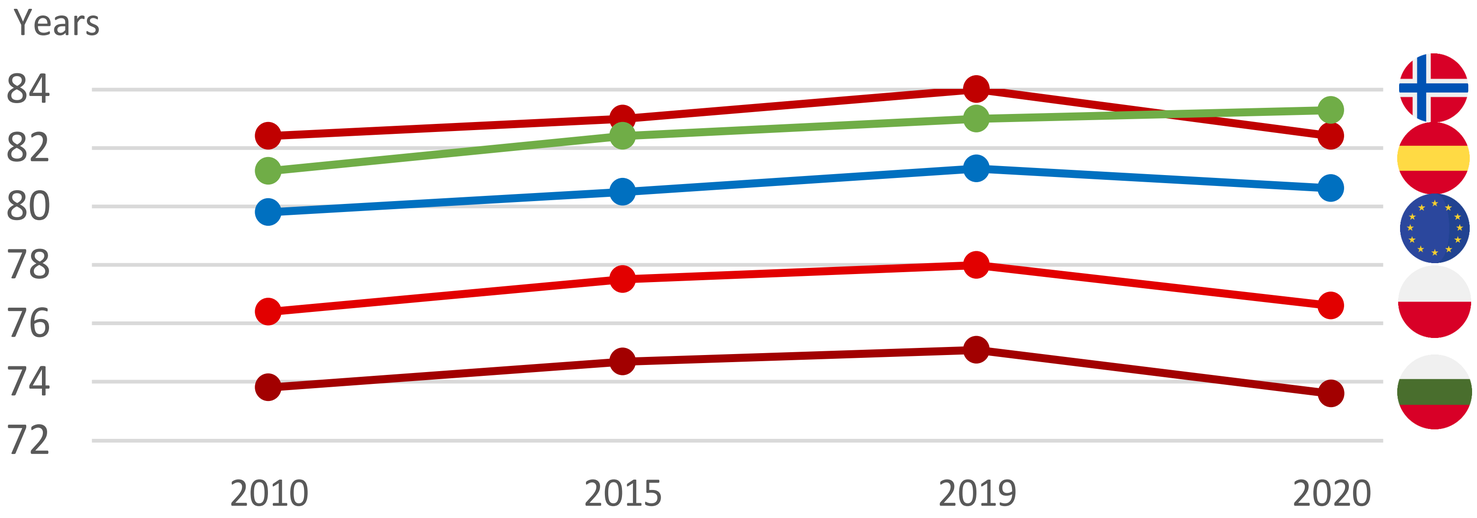
OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Country Health Profiles: Same structure, new focus

1. Highlights	
2. Health Status	*(2) Life expectancy, health inequalities, mortality, morbidity*
3. Risk Factors	*(3) Behavioural and environmental risk factors*
4. Health System	*(4) Organisation, financing, resources, service provision*
5. Performance of Health System	
5.1 Effectiveness	*(5.1) Avoidable mortality, avoidable admission, cancer screening and survival*
5.2 Accessibility	*(5.2) Unmet health care needs , health workforce shortage, waiting times*
5.3 Resilience	*(5.3) COVID-19 cases and deaths, containment measures, vaccination*
6. Key Findings	

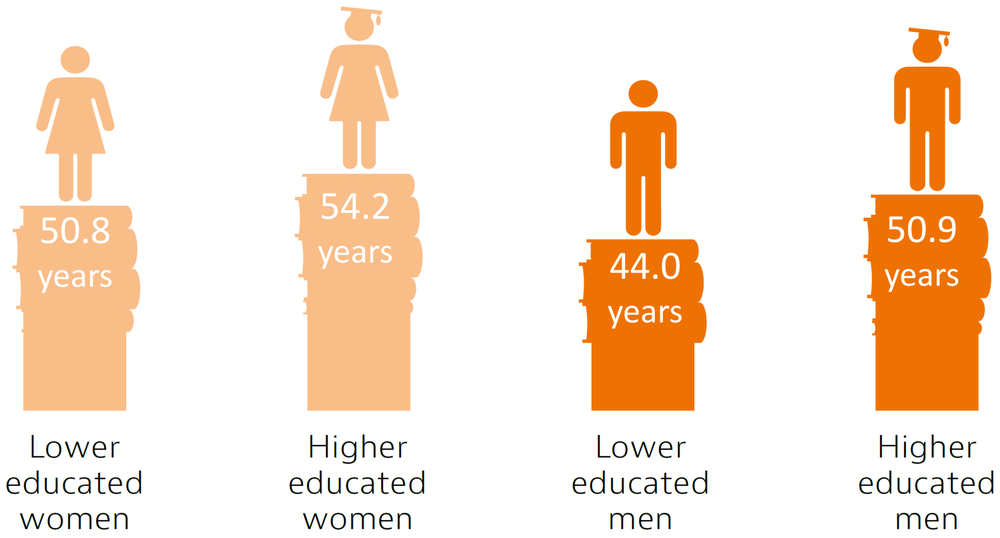
Life expectancy fell by 0.7 years in the EU in 2020, the biggest drop since WW II in many countries



- Large reductions in both Western and Central and Eastern European countries
- Only a few Nordic countries managed to avoid a fall

Source: Eurostat Database.

Social inequalities in life expectancy were already large before the pandemic



Education gap in life expectancy at age 30

EU: 3.4 years
Estonia: 8.5 years
Latvia: 8.0 years
Slovakia: 7.4 years

EU: 6.9 years
Slovakia: 14.8 years
Latvia: 11.0 years
Poland: 11.0 years

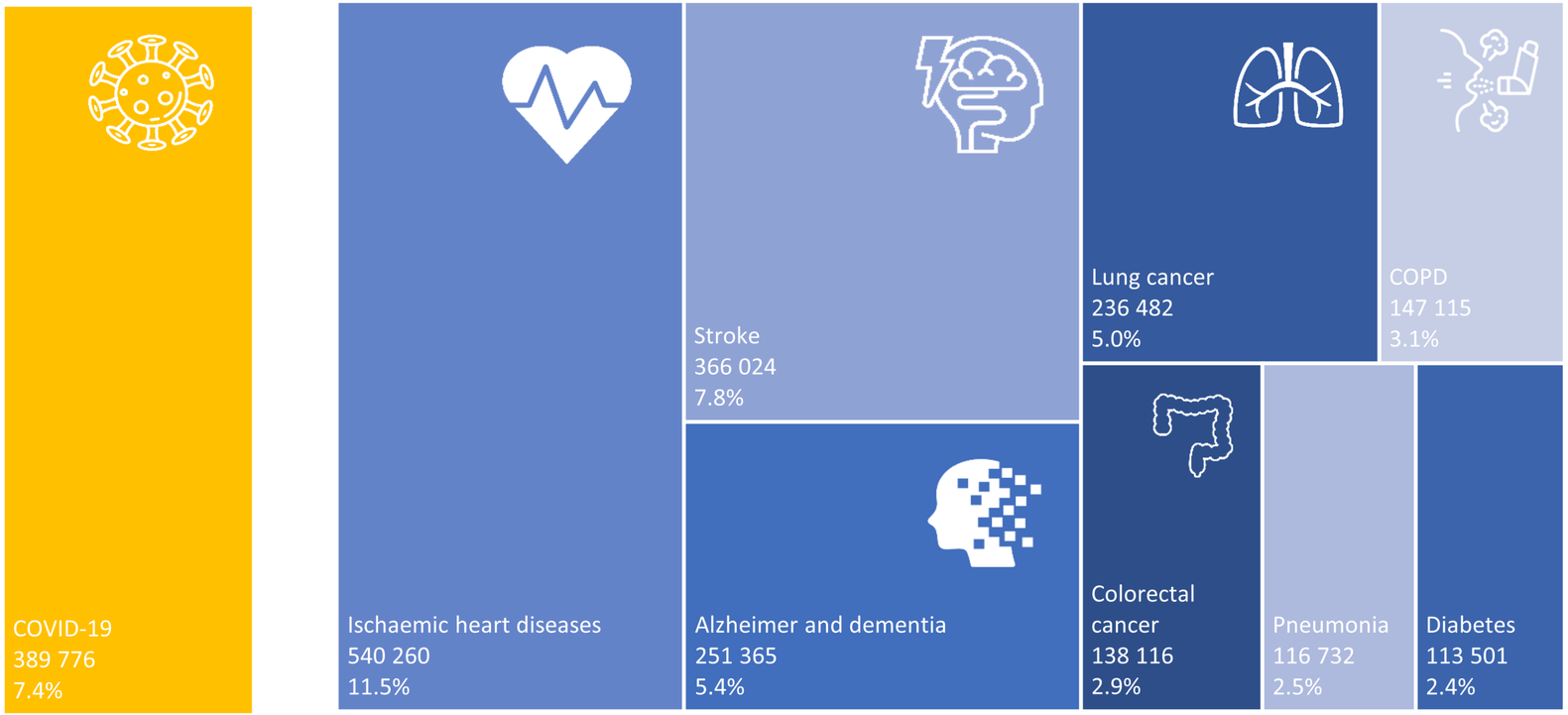
These inequalities will widen in 2020 and 2021 because the pandemic had bigger impact on disadvantaged groups

Mortality rates from COVID-19 were 40% to 80% higher among lowest income groups than highest-income groups in several EU countries

Note: The data refer to 2017. High education is defined as people who have completed a tertiary education whereas low education is defined as people who have not completed their secondary education.
Source: Eurostat database

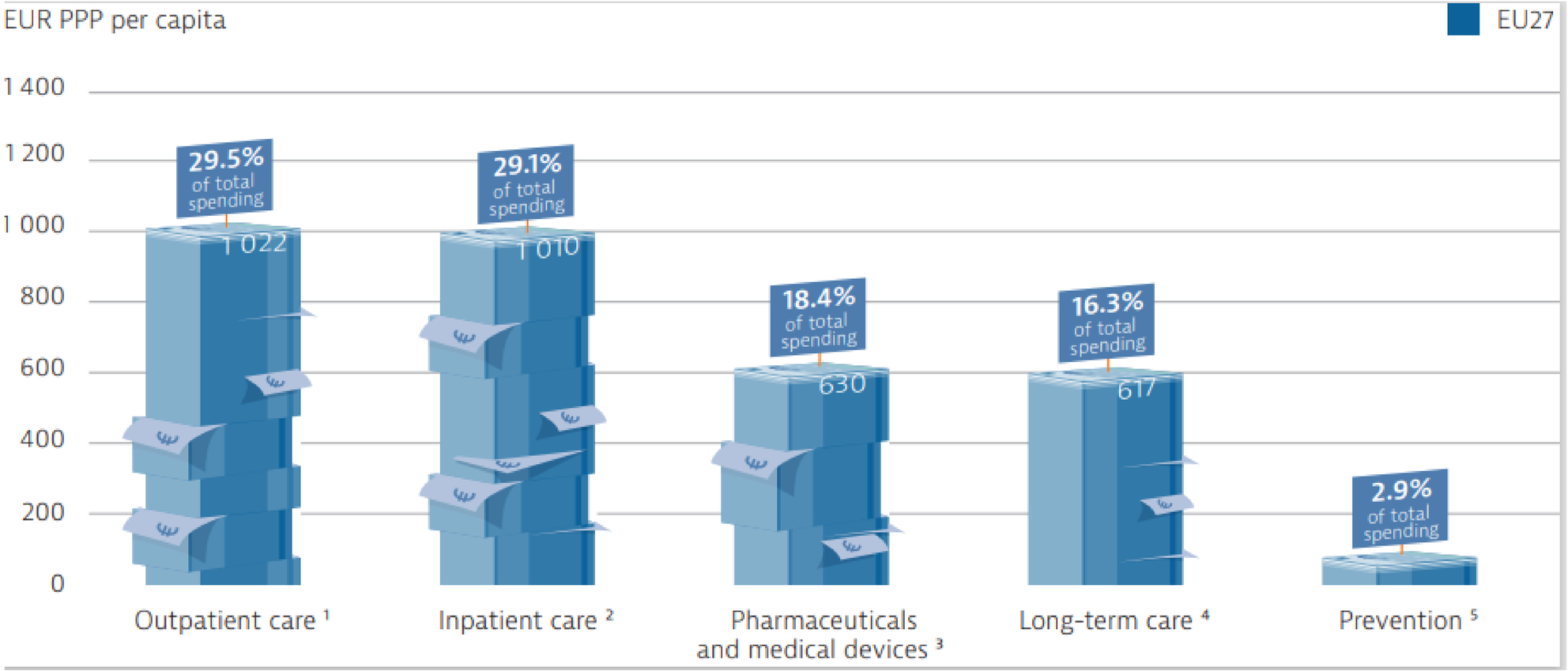
Putting COVID-19 deaths in perspective

Cardiovascular diseases and cancers are the leading causes of death in Europe (“silent pandemic”)



Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018.
Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020).

EU countries allocate little - less than 3% - of total health expenditure to prevention (average)

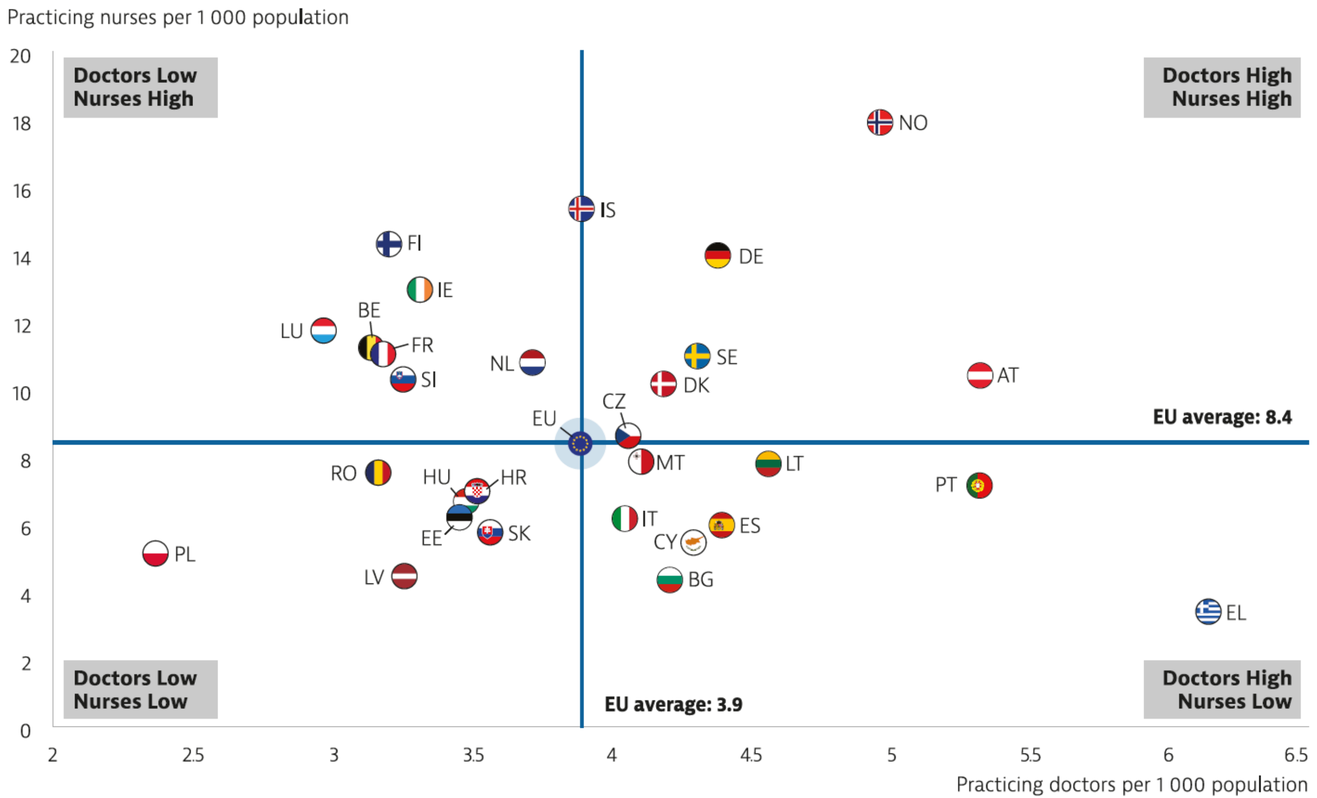


Note: The costs of health system administration are not included. 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

Access to care and health workforce shortages

Countries entered the pandemic with different health workforce capacity

2019

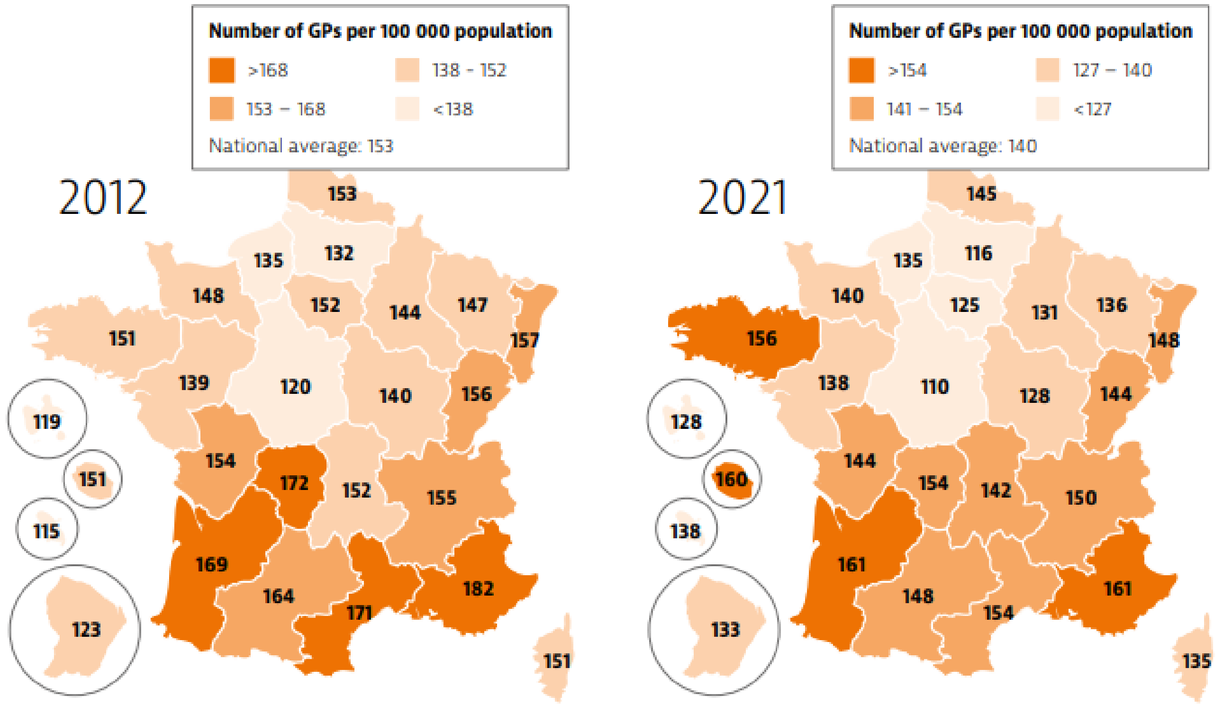


Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large over-estimation of practicing doctors (e.g. around 30% in Portugal. In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Country Health Profiles 2021 (using data from OECD Health Statistics 2021; data refer to 2019 or nearest year)

The density and shortage of health workers varies widely across but also within countries

"**Medical deserts**" are not a new problem in many countries, but limited access to GPs has worsened in several countries

Figure 14. The density of GPs fell in almost all regions in France between 2012 and 2021



Source: DREES (2021).

Source: France: Country Health Profile 2021

Strategies to address health workforce shortages

Train more doctors, nurses and other health workers

- ✓ Increase the “numerus clausus” in countries where it was too low
- ✓ Take advantage of strong interest of many young people to pursue careers in the health sector in post-COVID context
- ✓ Ensure proper mix in physician training between GPs and specialists

Increase retention rates of current health workers

- ✓ Improve working conditions and reduce undue work pressures
- ✓ Increase salaries of categories of health workers who have been under-valued (e.g. nurses and health care assistants)
- ✓ Provide special incentives to promote a more equal geographic distribution of doctors and other health workers

Innovate in health service delivery

- ✓ Optimise the use of current health workers by expanding the roles of nurses (e.g. nurse practitioners) and pharmacists
- ✓ Promote greater teamwork and task sharing
- ✓ Promote greater patient self-care through health literacy

Some key findings

- COVID-19 highlighted the need to invest more in health systems to make them more robust and agile, and better prepared to respond to unexpected shocks.

- More investment is needed on prevention and public health interventions to reduce modifiable risk factors to health and exposure to environmental risks.

- Many countries also need to invest more in their health workforce to address shortages by promoting greater training and retention. Further investment is particularly needed to avoid shortages in primary care to respond to the needs of ageing populations and the growing burden of chronic conditions.