



# State of Health in the EU Synthesis Report 2023

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State of Health in the EU

# Synthesis Report 2023

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# Foreword

Over the past few years, EU Member States have faced periods of intense crisis in the area of health. Millions of lives were lost to COVID-19, healthcare systems were seriously affected and our entire societies were challenged in unprecedented ways. Periods of crisis and upheaval however are also opportunities to build back better and stronger.

This is certainly true in the EU, where over the last four years paradigms are shifting and new directions are set in our health policy. A strong European Health Union is in motion, with flagship initiatives ushering in a new era for health in Europe and globally. While the EU and the world are still recovering from the impacts of the pandemic, and while in addition an energy crisis, the pressures of rising living costs and the reality of war on the European continent continue to take their toll on a daily basis, the EU is emerging from the crisis with more unity, coordination and determination for the future.

It is against this backdrop and with this outlook that we present the State of Health in the EU Report 2023. This report aims to highlight the main findings of the twenty-nine Country Health Profiles, which cover the status of Europe's health systems placing mental health under the spotlight. The country reports are authored by the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, and we are very grateful for this continued collaboration through the State of Health in EU project.

The 2023 Synthesis Report serves to highlight three key messages. First and foremost is the impact of COVID-19 on mental health, signaling the toll taken on citizens as well as the actions and reforms undertaken by Member States to address this growing challenge. The EU has stepped up its action through a new comprehensive approach to mental health, which aims to bring better mental healthcare services closer to communities, while breaking the stigma surrounding it.

The second key message focuses on growing health inequalities. We have witnessed the biggest reduction in life expectancy since World War II and we need to ensure that as we move forward from the pandemic, our health systems meet the needs of all Europeans. In this respect, tackling cancer, one of the most consequential public health threats of our times, is of fundamental importance to Europe's future. To address this, Europe's Beating Cancer Plan is our comprehensive vision to guide cancer patients and their families through every stage of the disease. This unprecedented and well-funded Plan is already delivering tangible outcomes and making a true difference for them.

The third key focus area draws attention to the need for continued investment in health, especially in prevention. In particular, as we embrace the digital transformation of healthcare, there should be a strong emphasis on inclusiveness and solidarity. The European Health Data Space is our ambitious proposal to empower our citizens with their own data, and truly unlock its potential to develop better treatment and care solutions for them.

We also have to focus on collectively improving our preparedness for future health crises. By building stronger and more sustainable health systems, we give them the tools they need to handle future challenges while still providing regular and emergency care.

Health must be viewed as an investment in our societies, our economies, and our future. This is the fundamental principle of our European Health Union and each of its pillars, which lay the foundations for more resilient health systems as well as reducing inequalities in health. To do this, we must have the right investment levels in our healthcare systems to ensure that they are better prepared for future crises and that their services are resilient, sustainable and accessible for every citizen.

I trust that this report and the twenty-nine Country Health Profiles it accompanies will provide valuable data and decision-making support to policymakers and citizens across Europe.

***Stella Kyriakides***

*European Commissioner for Health and Food Safety*

# Executive summary

The 2023 Synthesis Report highlights three key areas drawing on the 2023 Country Health Profiles prepared in the context of the *State of Health in the EU*

The *State of Health* in the EU project constitutes an important knowledge-brokering platform to support European policy makers in their quest to develop more effective, accessible and resilient health systems and more evidence-based health policies. Part 1 of this Synthesis Report highlights three key messages from the analysis of European health systems in the aftermath of the COVID-19 pandemic. Part 2 provides a snapshot of the key country findings in each of the 29 Country Health Profiles.

## 1 MENTAL HEALTH REFORMS ADDRESSING DE-STIGMATISATION, PREVENTION, TREATMENT AND REINTEGRATION ARE NEEDED

In order to support Member States and stakeholders, the EU has developed a new approach to effectively address mental health challenges in a comprehensive, multi-sectorial and prevention-oriented manner. Breaking stigma

and discrimination surrounding mental health, stepping up investment in mental healthcare and health systems reforms, including the mental health workforce will be key.

## 2 CLOSING HEALTH GAPS BY TACKLING HEALTH INEQUALITIES BOTH ACROSS AND WITHIN COUNTRIES REQUIRES A MULTI-SECTORAL APPROACH

Health inequalities in the Union have been on the rise in the aftermath of the COVID-19 pandemic. The COVID-19 pandemic led to a widening of the gap in life expectancy at birth between 2019 and 2021 across Member States. However, life expectancy estimates from 2022 show a narrowing of the gap, which is a positive trend but should be closely monitored going forward. At the same time,

unmet healthcare needs are also increasing. Instruments to address health inequalities and the related socio-economic and environmental determinants and behavioural factors, (such as the risks associated with unhealthy diets, physical inactivity, environmental pollution, tobacco and alcohol consumption), range from investment in health literacy to integrated care, health promotion and legislation.

## 3 INVESTMENTS TOWARDS RESILIENT AND ACCESSIBLE HEALTH SYSTEMS NEED CONTINUITY, UNDERPINNED BY ROBUST DATA COLLECTION MECHANISMS

Investments in public health, disease prevention and health systems should remain a key priority in the medium term. The COVID-19 pandemic revealed the fragility of health systems. Managing the pandemic required immediate efforts and large investments to provide enough workforce

and facilities to treat COVID-19 patients. Investments in surveillance and tracking and tracing systems were also made. In the aftermath, it is imperative that health systems can cope with future crises.

# Introduction

## The *State of Health in the EU* cycle of knowledge brokering

The *State of Health in the EU* is a recurring two-year cycle of knowledge brokering. The project is a partnership between the European Commission, the Organisation for Economic Co-operation and Development (OECD) Health Division and the European Observatory on Health Systems and Policies (hereafter the European Observatory). The project pools together the latest evidence on health systems in Europe and captures it in a series of concise, factual reports.



The joint OECD-Commission report *Health at a Glance: Europe* kicks off each two-year State of Health in the EU cycle with a horizontal, cross-country assessment of national health systems' performance in the EU. Its latest edition, *Health at a Glance: Europe 2022* was published on 5 December 2022, marking the launch of the fourth iteration of the *State of Health in the EU* cycle (2022-2024). Two thematic chapters focused on the impact of the pandemic on children and young people and the impact of the pandemic on non-COVID related care.

## The Country Health Profiles 2023

Experts from the OECD and the European Observatory have drafted 29 Country Health Profiles (CHPs) covering the 27 EU Member States and Norway and Iceland. The Country Health Profiles are designed to cover the latest challenges and health policy responses in a digestible format. They are built on a standard template and methodology, which is then adjusted on a case-by-case basis to capture adequately each country's policy context.

Each CHP starts by providing a short synthesis of the health status in the country and its main determinants. It then presents the organisation of the health system, followed by an analysis of its performance based on three dimensions – effectiveness, accessibility and resilience. This conceptual framework is based on the objectives set out in the Communication from the Commission on effective, accessible and resilient health systems<sup>1</sup>. This year, a spotlight theme was included in each CHP on mental health. This reflects the importance of the issue as echoed in the [Commission Communication for a comprehensive approach on mental health](#). It also builds on the findings of the *Health at a Glance: Europe 2022*.

Whenever appropriate, the CHPs 2023 also link the analytical insights presented in the text to the most important EU-level health policy initiatives and significant EU funding instruments.

## The Synthesis Report 2023

The objective of the *State of Health in the EU's* Synthesis Report is to highlight a selection of cross-cutting issues drawn from the Country Health Profiles.

This report (previously called “Companion Report”) consists of two parts. Part 1 presents three key messages reflecting trends and policy analysis drawing from the CHPs and other relevant sources. The aim is to provide a short and concise snapshot of the key developments and raise pertinent questions about the current state of health in the EU. Part 2 of the Synthesis Report presents a collection of one-page summaries of the key findings from all the CHPs, complemented by a graph giving salience to a specific topic for each country.

The *State of Health in the EU* project supports the Member States by strengthening the evidence base on health systems performance for the benefit of policymakers, stakeholders, researchers and the general public. The project provides academics, think tanks, public actors and the European Commission with quality analytical inputs to feed into their own policy activities – for example, the European Semester.

## The Voluntary Exchanges

The fourth and final deliverable of the *State of Health in the EU* cycle consists of a series of voluntary exchanges run by experts from the OECD and the European Observatory upon the request of health ministries after the publication of the CHPs. Their main objective is to enable better health policy development via facilitating the exchange of good policy practices across European countries. In 2022-2023, voluntary exchanges took place in Romania, Ireland, Italy and Sweden.

<sup>1</sup> See the 2014 Commission Communication on effective, accessible and resilient health systems

# 1 **PART 1**

**Health system reforms  
and investments in the  
wake of the COVID-19  
pandemic**





# 1. Key message – Mental Health reforms addressing de-stigmatisation, prevention, treatment and reintegration are needed

Already before the COVID-19 pandemic, 1 in 6 people in the EU <sup>2</sup> suffered from mental health issues, at a cost of 4% of GDP. This situation has worsened with the COVID-19 pandemic, with a long-term impact specifically on mental health, in particular among vulnerable groups such as children, the young, the elderly and those with pre-existing mental health conditions. Children and young people are worried about climate change, which has further led to anxiety and distress<sup>3</sup>. The war of aggression against Ukraine, along with the rise in living costs has worsened the already difficult situation.

In order to support Member States and stakeholders, the EU has developed a new approach to effectively address mental health challenges in a comprehensive, multi-sectorial and prevention-oriented manner. Breaking stigma and discrimination surrounding mental health, stepping up investment in mental healthcare and health systems reforms, including the mental health workforce will be key.

## Focus on mental health prevention and care services in the wake of the COVID-19 pandemic

According to the World Health Organization (WHO), the global prevalence of anxiety and depression increased by 25% in the first year of the COVID-19 pandemic<sup>4</sup>.

While comparable data remains scarce, national estimates for several EU countries show that the prevalence of symptoms of depression during the pandemic doubled compared to its pre-pandemic levels. Moreover, young people, women (not least in their role as carers for the family), people with lower socioeconomic status and people suffering from chronic conditions have been more severely impacted and have been more likely to develop symptoms of mental disorders<sup>5</sup>. Hence, there is a growing need to promote mental health, reduce inequalities in mental health status between and within Member States. A particular focus on individuals in disadvantaged circumstances is warranted<sup>6</sup>.

According to a recent Eurobarometer survey on mental health<sup>7</sup>, 46% of Europeans experienced an emotional or psychosocial problem, such as feeling depressed or anxious, in the past twelve months. At the same time, the survey indicates that while 89% of citizens view mental health promotion as important as physical health promotion. Referring to services, one out of every two individuals dealing with a mental health issue did not seek assistance from a professional. These findings emphasise the necessity for a comprehensive approach to mental health.

The mental health disorders reported in the Country Health Profiles range from depression to anxiety, bipolar disorders, schizophrenia, alcohol, and drug-use disorders. As discussed in the profiles, the prevalence of depression is higher in women than men. Population groups with a lower income have higher prevalence compared to higher income groups. For example, depression prevalence is up to three times higher in the lowest education group than in the highest. People in the lowest education group have more mental health issues.

<sup>2</sup> OECD/ European Union (2018), Health at a Glance: Europe 2018, [https://health.ec.europa.eu/system/files/2020-02/2018\\_healthatglance\\_rep\\_en\\_0.pdf](https://health.ec.europa.eu/system/files/2020-02/2018_healthatglance_rep_en_0.pdf)

<sup>3</sup> Commission Communication on a comprehensive approach to mental health

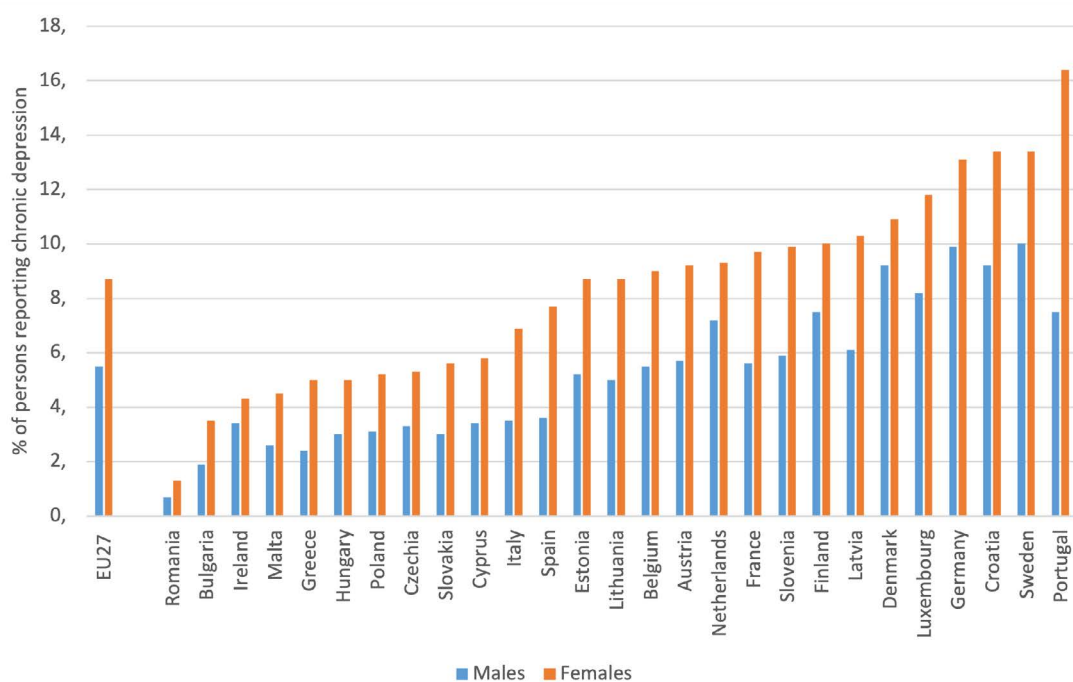
<sup>4</sup> Approved by Employment, social, health and consumer affairs policy Council configuration on 30 November 2023 - [pdf \(europa.eu\)](#).

<sup>5</sup> Approved by Employment, social, health and consumer affairs policy Council configuration on 30 November 2023 - [pdf \(europa.eu\)](#).

<sup>6</sup> Approved by Employment, social, health and consumer affairs policy Council configuration on 30 November 2023 - [pdf \(europa.eu\)](#).

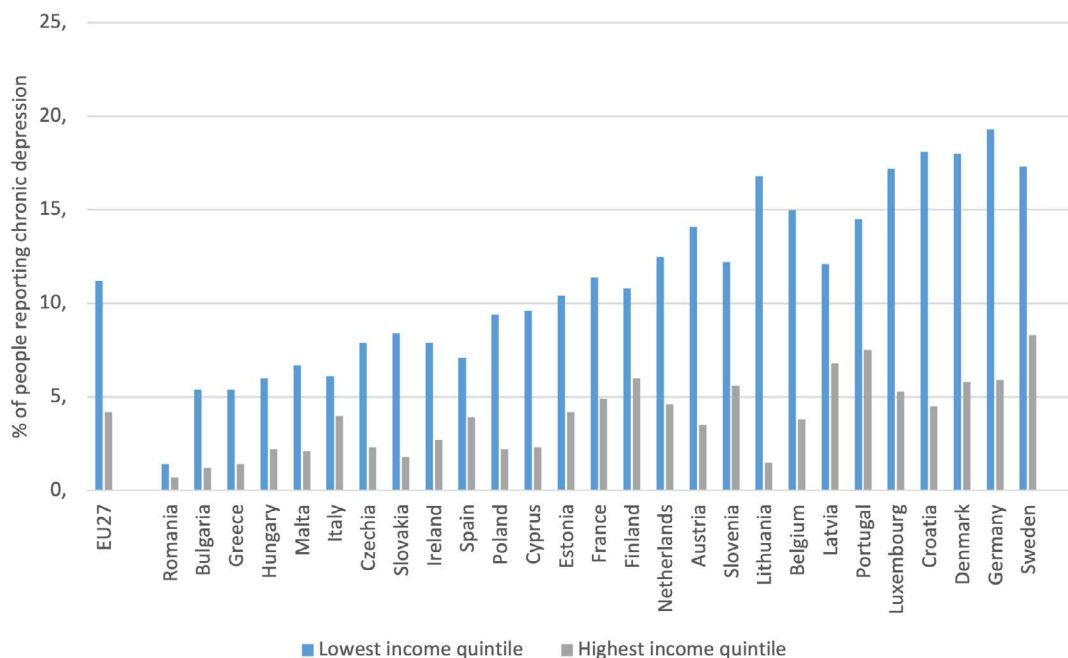
<sup>7</sup> [https://ec.europa.eu/commission/presscorner/detail/en/ip\\_23\\_4782](https://ec.europa.eu/commission/presscorner/detail/en/ip_23_4782)

**Figure 1: Self-reported prevalence of depression in the EU by sex, 2019**



Source: Eurostat

**Figure 2: Self-reported chronic depression in the EU by lowest and highest income quintile, 2019**



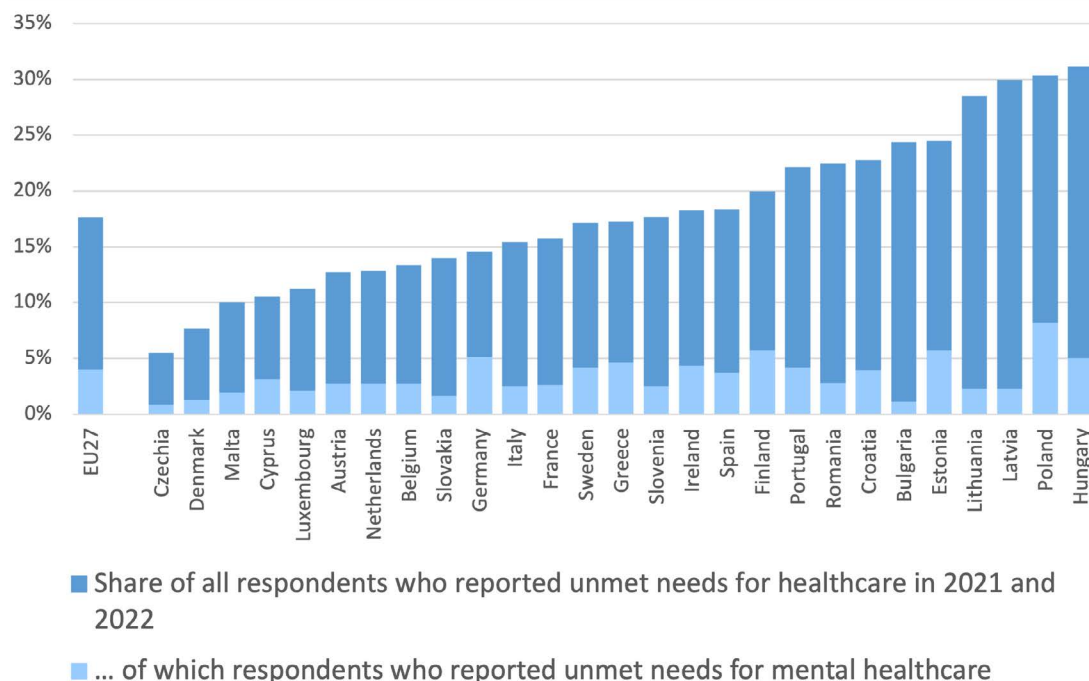
Source: Eurostat. Note: Countries ranked according to smallest to largest difference between lowest and highest income quintiles.

At the EU level, in 2020 suicide was the second leading cause of death among young people (15–29 years of age), after accidents (including road accidents). This in part also reflects a drop in road accidents as a result of the sharp economic contraction and the drop in mobility and car use in 2020. Across all age categories, suicide rates have decreased over the last decade and levelled out in recent years (EU average was 10.2 per 100 000 inhabitants in 2020), with Bulgaria, Cyprus, Denmark, Greece, Ireland, Italy, Luxembourg, Malta, Portugal, Romania, Slovakia and Spain showing the lowest rates. At the EU level, suicide rates are almost four times higher in men compared to women, while suicidal thoughts, also referred to as suicidal ideation<sup>8</sup>, is more common in women than men by a factor of 4 to 1.

A recent Eurofound survey asked respondents whether they had any current unmet healthcare needs and, if so, for what type of care, including mental healthcare. At EU level, the total share of respondents who reported unmet needs for healthcare was 18% and specifically for mental healthcare, the unmet need was 4%. The survey respondents reporting high levels of unmet mental healthcare needs were Estonia, Finland, and Poland. A recent Eurobarometer<sup>10</sup> survey found the EU-wide share of respondents who rated the quality of mental health services as “poor” in 2023 to be 7%.

A recent German study<sup>9</sup> found that while depressive symptoms declined from the first wave of the pandemic to summer 2020, they increased from October 2020 and remained relatively high throughout 2021, with another jump between 2021 and 2022. The social gradient in symptom levels between education groups with higher mean scores and proportions of positive screens for possible depression in those with the lowest levels of education, followed by the middle and high-level groups remained unchanged. Symptoms of anxiety also increased and self-rated good mental health decreased between 2021 and 2022. The study findings call for further continuous mental health surveillance. A particular focus on women and young adults, but also older people, may be warranted.

**Figure 3: Unmet mental healthcare needs and quality of mental health services in the EU**



Source: Eurofound 2022

<sup>8</sup> Harner B, Lee S, Duong TVH, Saadabadi A. Suicidal Ideation. 2023 Aug 24. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. PMID: 33351435

<sup>9</sup> Mauz E, Walther L, Junker S, Kersjes C, Damerow S, Eicher S, Hölling H, Müters S, Peitz D, Schnitzer S and Thom J (2023) Time trends in mental health indicators in Germany's adult population before and during the COVID-19 pandemic. Front. Public Health 11:1065938. doi: 10.3389/fpubh.2023.1065938

<sup>10</sup> [https://ec.europa.eu/commission/presscorner/detail/en/ip\\_23\\_4782](https://ec.europa.eu/commission/presscorner/detail/en/ip_23_4782)

The Commission Communication for a comprehensive approach on mental health adopted in June 2023 created a strategic framework for actions to address a wide range of mental health issues, with 20 flagship initiatives and EUR 1.23 billion in funding opportunities. It sets out three guiding principles that should apply to every citizen: i) access to adequate and effective prevention, ii) access to high quality and affordable mental healthcare and treatment and iii) reintegration in society after recovery. Key flagships include the European Mental Health Capacity Building Initiative, the European Depression and Suicide Prevention Initiative, a European Code for Mental Health, a prevention toolkit, a multidisciplinary training and exchange programme, technical support for mental health reforms across several sectors, and EU guidance on breaking through stigma and addressing discrimination. People in disadvantaged situations and particularly vulnerable groups, including children and the elderly, are particularly mentioned.

## Stepping up investment in the mental health workforce and improving care capacities for prevention, promotion and health literacy

The COVID-19 pandemic put the spotlight on increasing mental health issues. Due to already existing shortages in the health workforce and in view of the considerable workload and the mental health strain<sup>11</sup> caused by the pandemic, many health workers especially nurses considered the idea of resignation. Based on representative surveys of nurses in 2021<sup>12</sup>, up to 19% of respondents in Belgium and 45% of respondents in France reported that the crisis made them consider changing profession, with one in two working in public facilities reporting being in burnout. The recent European and Social Development Report<sup>13</sup> published by the European Commission also shows that the level of job strain for nurses is at 61%, twice the EU average. In addition, nurses report some of the highest levels of health and safety risks at work (69%). Furthermore, only 40% of nurses feel that they were paid fairly in relation to their efforts and achievements.

Disruptions in mental healthcare and new mental healthcare needs associated with the pandemic will have implications for years to come. The retention of health workforce also suffered from deteriorating staff wellbeing

as essential workers, including the health workforce, were under increased stress and mental health risks in addition to infection risk during the COVID-19 pandemic. Addressing these challenges will require additional resources. This includes providing sufficient and well-trained health workforce, as well as protective measures for their mental health and well-being. A better forecasting and planning of the size and skills of the workforce is key.

Discrimination and stigma around mental health conditions are wide-spread in social media and also in workplaces, with 50% of workers considering that disclosing a mental health condition would have a negative impact on their career<sup>14</sup>. Stigma and discrimination amplify the personal and economic impacts of mental ill-health. Stigma is both a risk factor for mental health problems and a consequence thereof, leading to underreporting, underdiagnosis and inherently poor medical care of mental health problems. Improving mental health literacy is important for health professionals but also for other professionals, such as teachers, school principals and the wider population. As announced in the Commission Communication on a comprehensive approach to mental health, stigma and discrimination will be addressed via transferring best practices, running awareness raising and communication activities, and developing EU guidance on breaking through stigma and tackling discrimination, in particular addressing the needs of people in disadvantaged situations and particularly vulnerable groups, including children and the elderly.

The Council of the European Union, in its conclusions on mental health<sup>15</sup> recognises that some Member States are facing shortages of mental health professionals and that investing in health also requires investing in health workforce.

Some countries envisage reforms and investments through the Recovery and Resilience Facility for mental healthcare (including prevention). For example, Belgium invests in community centres, where young people can find mental health services and peer support. Reforms tailored to mental healthcare are being undertaken by Greece, Portugal and Slovakia as part of their Recovery and Resilience Plans. Greece focuses on addictions and mental health, Slovakia aims at the modernisation of its mental health system and Portugal envisages the de-institutionalisation of patients, the developments of community mental health teams (40 new teams will be created) and improved community care facilities.

<sup>11</sup> Supporting mental health of health workforce and other essential workers, EXPH, October 2021

<sup>12</sup> OECD (2023), Ready for the Next Crisis? Investing in Health System Resilience, OECD Health Policy Studies, OECD Publishing, Paris, <https://doi.org/10.1787/1e53cf80-en>

<sup>13</sup> European Commission, Directorate-General for Employment, Social Affairs and Inclusion, Employment and social developments in Europe 2023, Publications Office of the European Union, 2023, <https://data.europa.eu/doi/10.2767/089698>

<sup>14</sup> OSH Pulse (flash Eurobarometer survey, 2022): 'Occupational safety and health in post-pandemic workplaces'. The report includes the results of questions on psychosocial risks and individual country factsheets and a follow-up expert article on mental health and the impact of the COVID-19 pandemic.

<sup>15</sup> Approved by Employment, social, health and consumer affairs policy Council configuration on 30 November 2023 - pdf (europa.eu).

The **EU4Health Programme** is supporting many actions on **mental health**. For example, through a EUR 11 million action with the World Health Organization, the Commission supports Member States in building capacity for an approach that promotes mental health across policies. A multi-disciplinary training programme for professionals on mental health and a cross-border exchange programme for mental health professionals, with a budget of EUR 9 million, will support the exchange of knowledge and best practices to promote a comprehensive, prevention-oriented approach to mental health. Another EUR 2 million action will develop a European Code for Mental Health, that will consist of science-based, easy-to-understand messages to empower EU citizens. Three competitive actions for a total of EUR 19 million have been launched on the prevention of Non-Communicable Diseases (NCDs) in the area of mental health. Another action under the 'Healthier Together' EU NCD initiative – Mental health will be implemented by the Member States' authorities and receive an EU contribution of EUR 6 million. The Commission supports with EUR 31.2 million the provision of psychological first aid to displaced people affected by the war of aggression against Ukraine through an action implemented by the Red Cross.

The EU funded project RESPOND<sup>16</sup> concluded that mental health needs to be taken into account in policy decisions and pandemic control measures to prevent unexpected short and long-term effects, such as increased suicide attempts among the youth and deterioration in the mental health of healthcare workers.

Inequalities in access to mental healthcare services and pediatric mental healthcare coverage across countries and regions need to be addressed. Stepping up investment to promote exchange programmes of mental healthcare professionals, task-sharing and new care delivery models need to go hand in hand with improving working conditions for mental healthcare workers and increased funding for community mental healthcare services. Complementary measures such as better data collection, such as through vignettes<sup>17</sup>, case studies of unmet needs in various Member States, provide a more insightful view of access challenges. Other solutions<sup>18</sup> to alleviate the mental health disease burden include community-based care, multidisciplinary care (building on multidisciplinary workforce teams and taking account of the mutual impact of mental health conditions and other non-communicable diseases) as well as social prescribing integrated into primary care. Social prescribing is a means of connecting people to a range of non-clinical services in the community to improve their health and well-being and is one solution identified by a recent report of the EU Expert Group on Health Systems Performance Assessment (HSPA)<sup>19</sup> and highlighted in the Commission Communication on a comprehensive approach to mental health.

<sup>16</sup> RESPOND project ([respond-project.eu](https://respond-project.eu))

<sup>17</sup> Improving access to healthcare through more powerful measurement tools, October 2021

<sup>18</sup> Referred to in the European Parliament's Draft Report on mental health (2023/2074(INI))

<sup>19</sup> Mapping metrics of health promotion and disease prevention for health system performance assessment ([europa.eu](https://europa.eu)), June 2023

## 2. Key message – Closing health gaps by tackling health inequalities both across and within countries requires a multi-sectoral approach

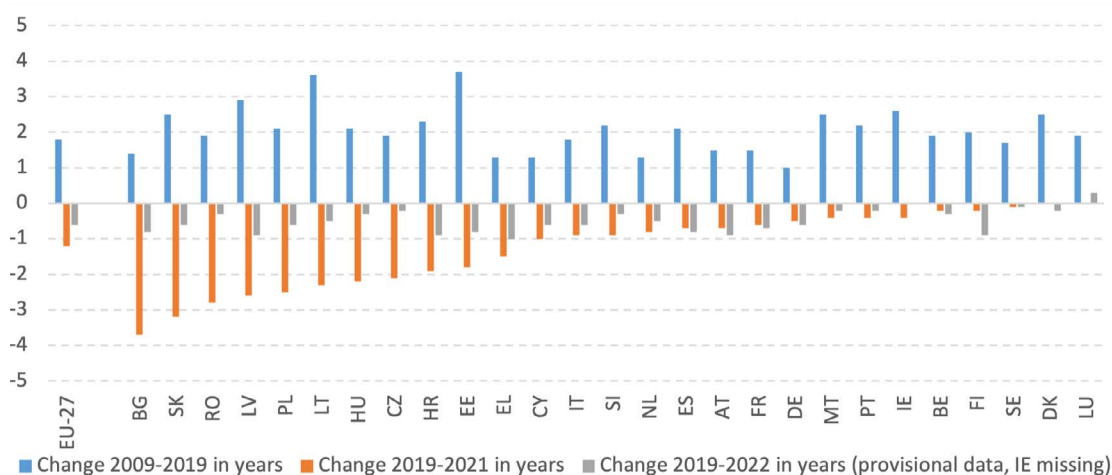
The COVID-19 pandemic led to a widening of the gap in life expectancy at birth between 2019 and 2021 across Member States. However, life expectancy estimates from 2022 show a narrowing of the gap, which is a positive trend but should be closely monitored going forward.

Current indicators fall short of shedding light on the coverage of health services essential to the populations that are left furthest behind, be it in terms of socio-economic groups or regional disparities in access to generalist/ primary and specialist care. Instruments to address health inequalities and the related socio-economic and environmental determinants and behavioural factors (such as the risks associated with unhealthy diets, physical inactivity, environmental pollution, tobacco and alcohol consumption) range from investment in health literacy to integrated care, health promotion and legislation.

The impact of COVID-19 resulted in unprecedented reductions in life expectancy. In the EU, life expectancy at birth was 80.1 years in 2021, one year less than in 2019 (81.3 years), the most severe recorded drop in such a short period of time since World War II. However, some countries like Belgium, Italy and Spain were able to recover initial losses in life expectancy already by 2021 as the number of deaths from COVID-19 and other causes fell. Provisional data for 2022 show that life expectancy is recovering across the EU. However, there is still over 7 months in life expectancy lost compared to 2019.

Across the board, the pandemic led to a sharp widening of the life expectancy gap across EU countries between 2019 and 2021. The fall in life expectancy was much greater in Central and Eastern European countries that already had lower life expectancy than Western European countries. Provisional data indicate that to some extent this gap reduced between 2021 and 2022, with a few countries continuing to lag behind.

**Figure 4: Change of life expectancy at birth before and during the COVID-19 pandemic by country**



Source: Eurostat (online data code: [demo\\_mlexpec](#))

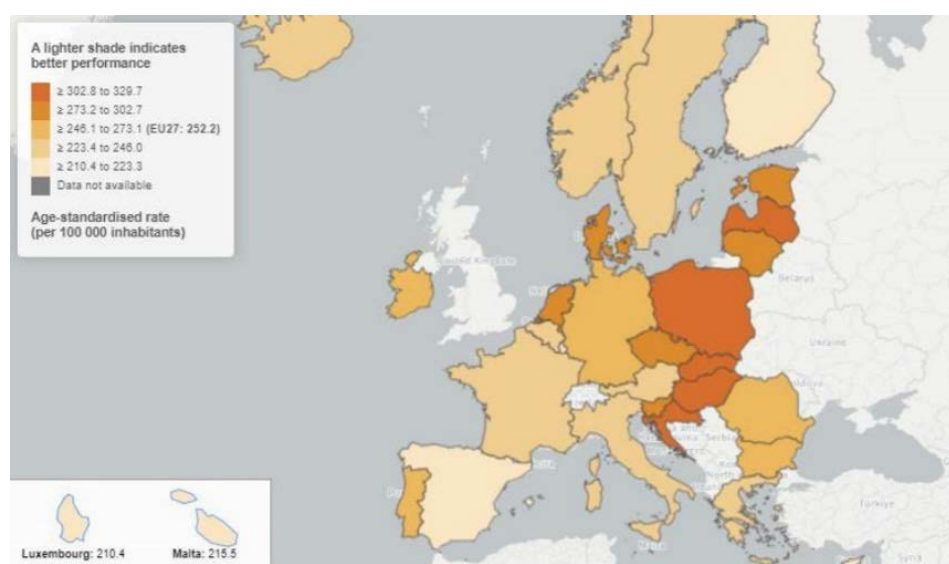


**Cardiovascular diseases (CVDs)** are the leading cause of death in the EU and in the world. Each year in the EU, more than 6 million people suffer from heart conditions and around 1.7 million people die from circulatory diseases. Cardiovascular diseases severely reduce healthy life expectancy and are responsible for 77% of the disease burden in Europe. Patients with CVDs have a higher risk to develop other diseases, including serious forms of COVID-19. Mortality rates for circulatory diseases dropped by 19% for the EU overall since 2011. However, among the Member States with a mortality level above the general EU level, there are 8 countries that reported a lower drop in mortality from CVDs since 2011. This issue raises concerns over lagging convergence across Member States.

**Cancer** is the second leading cause of mortality after CVDs and in 2022, a new case of cancer was diagnosed in the EU every 12 seconds. Assuming that these mortality (and cancer incidence) levels remain constant in the coming years, the number of diagnoses in the EU would increase by 18% in 2040 as compared to 2022. Population ageing would lead to a 26% increase in the number of people dying from cancer in 2040 as compared to 2022. However, at the same time 40% of all cancers can be prevented and the incidence and death rate of malignant neoplasms could be reduced, if what is already known is implemented.

The Commission supports Member States to reduce this diseases burden by launching two joint actions under the **Healthier Together** initiative. The first provides EUR 53 million to help Member States work together on diabetes and cardiovascular diseases. The other, with a budget of EUR 75 million, supports cooperation between Member States in addressing the root causes of heart disease and other non-communicable diseases. The Commission made a further EUR 5 million available for civil society organisations to help prevent cardiovascular diseases and diabetes and avoid their risk factors.

**Figure 5: Age-standardised death rate (per 100 000 inhabitants) of malignant neoplasms (2020) by country**



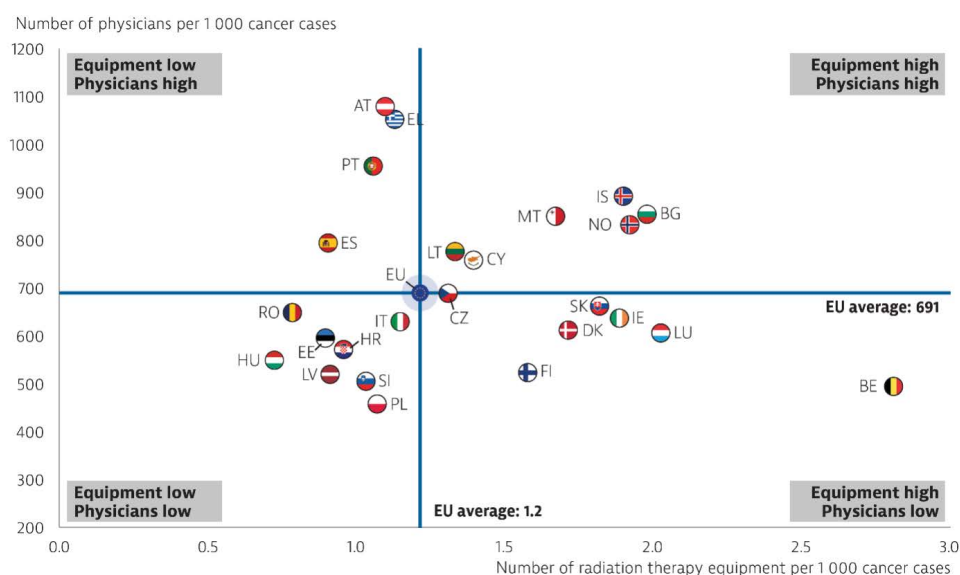
Source: European Cancer Inequalities Registry<sup>20</sup> based on Eurostat data.

<sup>20</sup> ECIR – European Cancer Inequalities Registry

Tackling cancer is of fundamental importance for Europe's future. **Europe's Beating Cancer Plan**<sup>21</sup>, complemented by the EU Cancer Mission<sup>22</sup> proposes actions at every stage of the disease: prevention (lifestyle, pollution, vaccination), early detection, diagnosis, treatment and quality of life. **The European Cancer Information System (ECIS) and the European Cancer Inequalities Registry (ECIR)** highlight differences between and within countries when it comes to the burden of cancer and access to cancer prevention and care. A large part of gender and socio-economic gaps are linked to modifiable risk factors for cancer, such as unhealthy lifestyles, which are more prevalent among men and people in low socio-economic groups. There are also pronounced inequalities across Europe in relation to exposure to environmental pollutants<sup>23</sup>, which together with exposure to occupational carcinogens may be responsible for over one tenth of the total cancer burden in Europe<sup>24</sup>. Through its data tool and report series, ECIR also shows differences in countries' healthcare systems capacities, such as the availability of comprehensive care structures, of national cancer screening schemes, of medical equipment, oncology medicines and health personnel. These factors are indicative of the capacity of a country to provide good quality of cancer care, particularly for people in vulnerable and low socio-economic groups.

The recently published European Environment and Health Atlas<sup>25</sup> presents information on how pollution and other environmental risks affect the health and well-being of Europeans. Moreover, an integrated zero pollution monitoring and outlook report<sup>26</sup> was published in December 2022.

**Figure 6: Age-standardised death rate (per 100 000 inhabitants) of malignant neoplasms (2020) by country**



Source: European Cancer Inequalities Registry, Country Cancer Profiles<sup>27</sup>. Data is taken from Eurostat and OECD Health Database. Notes: Data for 2020 or most recent year before 2020 and "EU" refers to the unweighted average of 23 Member States (DE, FR, SE, NL missing)

<sup>21</sup> [https://health.ec.europa.eu/system/files/2022-02/eu\\_cancer-plan\\_en\\_0.pdf](https://health.ec.europa.eu/system/files/2022-02/eu_cancer-plan_en_0.pdf)

<sup>22</sup> EU Mission: Cancer (europa.eu)

<sup>23</sup> Environmental indicators | ECIR – European Cancer Inequalities Registry (europa.eu)

<sup>24</sup> Beating cancer — the role of Europe's environment — European Environment Agency (europa.eu)

<sup>25</sup> <https://climate-adapt.eea.europa.eu/en/observatory>

<sup>26</sup> [https://environment.ec.europa.eu/publications/zero-pollution-monitoring-and-outlook-report\\_en](https://environment.ec.europa.eu/publications/zero-pollution-monitoring-and-outlook-report_en)

<sup>27</sup> ECIR – European Cancer Inequalities Registry



The graph shows the density of physicians and radiation therapy equipment across EU countries. It indicates that some and mainly Eastern and Central European countries (Romania, Hungary, Slovenia, Poland, Estonia, Latvia, Croatia and Italy) have lower density of physicians and radiation equipment than the EU average. Whilst being below average does not directly correlate with scarcity, shortages of both staff and equipment can hinder accessibility to timely cancer diagnosis and treatment.

In terms of **unmet needs**, new gaps were identified following the pandemic given the surge in demand, especially for medical (predominantly primary care). Self-reported unmet needs for medical examination (for reasons of cost, travel distance or waiting list) based on the Survey on Income and Living Conditions <sup>28</sup> (SILC) data increased from 1.7% in 2019 to 2.2% in 2022 in EU27 (still down from its peak level of 4% reached in 2013). In the first income quintile (the group with the lowest household disposable income), the increase was from 3.2% in 2019 to 3.7% in 2022 and in the fifth quintile (the wealthiest group) from 0.7% in 2019 to 1.1% in 2022. For dental needs, unmet needs due to costs, travel distance, or waiting list <sup>29</sup> widened from 2.8% in 2019 to 3.4% in 2022, with the first income quintile jumping from 5.9% to 6.3% and the fifth quintile from 0.8 to 1.1%. This widening of inequalities in terms of access to healthcare is expected to trigger a bigger burden of disease in the immediate to near future.

Moreover, in case people would need to pay health expenditure fully out of pocket, the **inequality in the distribution of income** would significantly worsen within Member States. Eurostat analyses<sup>30</sup> suggest that, for more than one third of Member States, the public coverage of healthcare benefits contributes at least as much to reducing **inequality in income distribution** as do all other social cash transfers taken together with the exception of pensions. This said, inequalities also exist between Member States with regard to the impact the public coverage of healthcare benefits has on income distribution. That suggests there is further potential for Member States to design healthcare coverage schemes in such a way that the impoverishing effects for households paying for healthcare out-of-pocket are further reduced.

## Digital transformation of health systems needs to ensure inclusivity by promoting digital health skills to the general public and to the health workforce

A June 2023 Eurobarometer <sup>31</sup> showed that **eHealth** is important in the minds of Europeans, with 76% of respondents expecting digital means to be used for

accessing or receiving healthcare services and believing that advanced connectivity and stronger cybersecurity will improve their daily use of digital tech. Two thirds of European citizens (67%) call for more education and training to develop their digital skills. In nine EU Member States, more than eight in ten respondents think digital technologies will be key for accessing or receiving healthcare services, with the highest proportions seen in the Netherlands (87%), Ireland (86%), and Denmark (85%). Respondents are least likely to do so in Romania (66%), Austria (67%), and Germany (71%).

Notwithstanding this broad range of views concerning the digital transformation, the COVID-19 pandemic acted as a **catalyst for new ways of healthcare delivery**, in particular **telemedicine**. Moreover, innovations such as the **EU Digital COVID Certificate** <sup>32</sup> not only facilitated travel but also helped keep people safe and boosted the EU's economy by making it possible for businesses to (keep) open. There have been remarkable achievements in the uptake of digital health, specifically, **ePrescriptions, exchanges of medical records and teleconsultations** in many EU countries during the pandemic. The move towards remote consultations helped to maintain care continuity in this area and holds real potential to increase accessibility. In particular, innovation in healthcare delivery (telemedicine applications, digital mental health support interventions, such as those delivered via the Web and apps or suicide hotlines) is well-placed to support the treatment of certain mental health conditions and their effects. For example, under the Recovery and Resilience Plan, France aims at reinforcing its suicide prevention line <sup>33</sup>.

At the same time, **digital skills** across countries and across the different age groups show large differences. Digital skills differ widely by socio-economic group within Member States. In 2022 for the EU, one in two individuals with high formal education would make an appointment with a practitioner via a website and this group was more than twice as likely to make such an appointment compared to individuals with no or low formal education. In the last decade all groups increased their use of on-line appointments. However, individuals with higher education increased their use faster, leading to a proportionally increased disparity among groups. Efforts must be made to avoid that digital health transformation leads to a widening of health inequalities going forward.

<sup>28</sup> "Self-reported unmet needs for medical examination", [hlth\\_silc\\_08](#), EU-SILC

<sup>29</sup> "Self-reported unmet needs for medical examination", [hlth\\_silc\\_08](#), EU-SILC

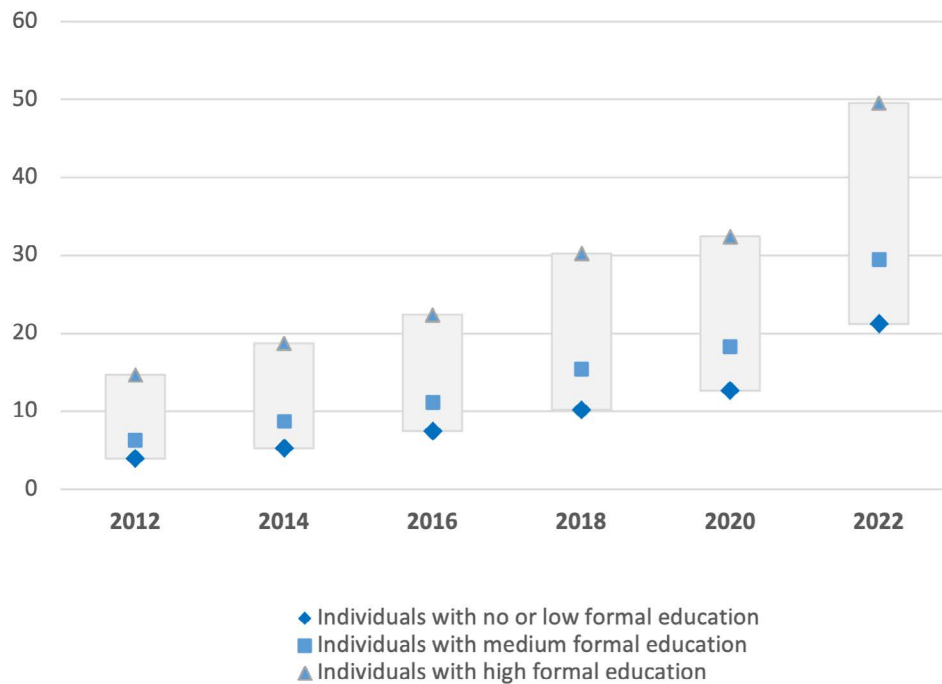
<sup>30</sup> Impact of health social transfers in kind on income distribution and inequality - Statistics Explained (europa.eu)

<sup>31</sup> Eurobarometer: Europeans believe digital technologies will be crucial in their daily lives | Shaping Europe's digital future (europa.eu)

<sup>32</sup> [https://commission.europa.eu/strategy-and-policy/coronavirus-response/safe-covid-19-vaccines-europeans/eu-digital-covid-certificate\\_en](https://commission.europa.eu/strategy-and-policy/coronavirus-response/safe-covid-19-vaccines-europeans/eu-digital-covid-certificate_en)

<sup>33</sup> <https://sante.gouv.fr/prevention-en-sante/sante-mentale/la-prevention-du-suicide/article/la-politique-de-prevention-du-suicide>

**Figure 7: Proportion of individuals aged 16-74 making an appointment with a medical practitioner via a website by level of education and year (% of individuals)**



Source: Eurostat. Note: In 2020, the EU27 value is an estimate by Eurostat.

The **use of Artificial Intelligence (AI)** in health (including promoting digital health skills to the health workforce) holds great opportunities for innovation and healthcare delivery. Nevertheless, it is vital to acknowledge upfront the need for addressing related biases and equity issues. To this end, the Commission has taken concrete steps, such as the proposal for the European Health Data Space (EHDS) and proposing the AI Act, which aims to eliminate bias, including bias based on gender, race, ethnicity, disability, socio-economic status and other socio-demographic factors, in high-risk AI systems used in healthcare. The EHDS proposal establishes a framework for ensuring the availability of diverse, high-quality data essential for training, testing, and validating AI systems. This infrastructure would also play a pivotal role in advancing research and development in healthcare AI and, in the process, helps rectify biases and promote equity.

**Digital skills indicators** are some of the key performance indicators in the context of the Digital Decade, which sets out the EU's vision for digital transformation. The Digital Compass sets out an aim for 80% of EU citizens aged 16 to 74 years old to have at least basic digital skills by 2030. Moreover, 100% access to a patient's own electronic health records by 2030 is a key eHealth indicator. In 2021, the share of people aged 16 to 74 who had at least basic overall digital skills varied across the EU, with the highest share recorded in Finland and the Netherlands (both 79%), followed by Ireland (70%) whilst the lowest share was recorded in Romania (28%), followed by Bulgaria (31%) and Poland (43%) <sup>34</sup>.

<sup>34</sup> How many citizens had basic digital skills in 2021? - Products Eurostat News - Eurostat (europa.eu)

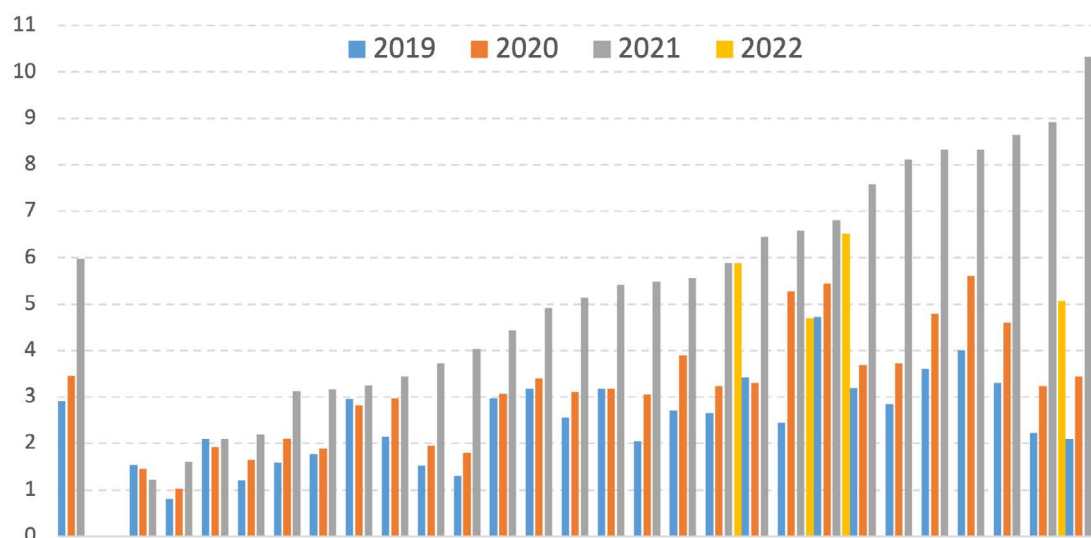
### 3. Key message – Investments towards resilient and accessible health systems need continuity, underpinned by robust data collection mechanisms

Investments in public health, disease prevention and health systems should remain a key priority in the medium term. The COVID-19 pandemic revealed the fragility of health systems. Managing the pandemic required immediate efforts and large investments to provide enough workforce and facilities to treat COVID-19 patients. Investments in surveillance and tracking and tracing systems were also made. In the aftermath, it is imperative that health systems can cope with future crises. Building resilience in health systems needs strategic investments in health reforms, infrastructure and workforce. Developing stronger health data collection, storage and exchange systems in compliance with the applicable data protection legislation<sup>35</sup> whenever personal data are processed, is a prerequisite for improving the quality of crisis response and addressing investment needs. Digital tools hold promise for developing more accurate and timely reporting.

The share of spending on prevention in current health expenditure plateaued below 3% across the EU over the period 2014-2019. **Spending on preventive care** rose to 3.5% in 2020, marking a budget increase by a quarter compared to 2019, driven in particular by increased spending on disease detection programmes. The share of spending on prevention in 2021 then further jumped to

6% of total health spending across the EU. This reflects increased spending on immunisation programmes (COVID-19 vaccines) triggered by the pandemic. The overall increase since 2019 was primarily driven by the public health response to COVID-19. It remains to be seen if this investment will be sustained in the coming years.

**Figure 8: Spending on preventive care as % of total expenditure on health**



The percentage of people working in the health sector comprises 8.5% of total EU workforce in 2023, up from 7.3% in 2008. Notably, more than three quarters of staff currently employed in human health activities in the EU are female. At the same time, the demand for healthcare has increased due to population ageing and the growing burden of chronic conditions. Health workforce shortages currently exist in all countries (especially nurses and primary care professionals), exacerbated by skill mismatches and uneven health workforce distribution between countries and within them (rural/ urban, capital/ provinces). Going forward, the demand for health workforce will continue to grow as the population ages (by 2050, around 30% of the EU population will be 65 or older<sup>36</sup>, up from 21% in 2022) coupled with an increase in the prevalence of chronic diseases. The challenge is compounded by the ageing of the workforce itself. The expected shortage of healthcare professionals worldwide<sup>37</sup> revolves not only around recruitment and retention but also around relevant job-related skills, including digital skills to transform health systems, optimal use of Artificial Intelligence for diagnosing and treating diseases and agility to respond to future crises. Hence, there is an urgent need to invest in health workforce.

In 2020, the European Commission launched the **Pact for Skills**, a shared engagement model for skills development in Europe, promoting upskilling and reskilling of health workers, with a focus on the digital domain. With the emergence of new technologies and the digital arena becoming more widespread, keeping the digital skills of health staff and of patients up to date will require a deliberate policy effort in order to support equal access to services and to uphold universal health coverage values. Investments in **digital skills** and **digital health literacy** (including for the general public and patients) would be a welcome development as investments in infrastructure will not directly build trust nor ensure take-up by the target group of users.

## Investments in public health, disease prevention and healthcare across Member States are important in building health resilience

The pandemic revealed the need for increased vigilance and investment in all Member States to ensure that they are adequately prepared to deal with future health crises and are also able to preserve the quality of care for all other illnesses and conditions. This includes ensuring and investing in surge capacity in health facilities and health professionals, adequate stocks of supplies (and manufacturing capacity), the availability and effectiveness of contact tracing systems, testing and laboratory capacity, qualitative and accessible health datasets and health data sharing including through early warning and surveillance systems. In the years preceding 2020, prior to the onset of

COVID-19, **healthcare expenditures** kept pace with GDP growth, levelling out below 10% of GDP in most countries. As of 2021, however total healthcare spending amounted to almost 11% of GDP in the EU and almost 16% of all public spending in the EU, an increase attributed to the investments made to address the COVID-19 pandemic. In the longer run, targeted reforms and investments are needed to bolster the resilience of health systems. Such reforms and investments can build on Member States' **Recovery and Resilience Plans** and be implemented whilst creating synergies with Cohesion Policy Funds such as the **European Regional Development Fund** and the **European Social Fund Plus** as well as the **Technical Support Instrument**.

The **Recovery and Resilience Facility (RRF)** is the central instrument of Next Generation EU (NGEU), the EU's recovery plan out of the COVID-19 crisis for building back better with a focus on the digital and green transition. Health system resilience is also one of the key pillars. The total estimated expenditure of health-related measures across the 27 recovery and resilience plans amount to **EUR 43 billion**. **A considerable share of the investments are focused on digitalising health services (EUR 14 billion)**, modernising primary care, transitioning from hospital to outpatient care, increasing the quality of diagnosing and treating patients, addressing staff shortages and expanding and upgrading healthcare infrastructure. In addition, a further **EUR 5 billion** is planned for investing into long-term care.

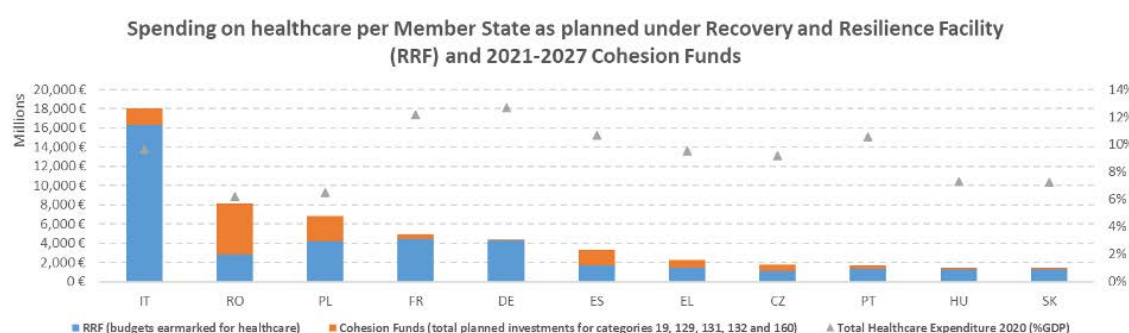
**Cohesion Policy Funds**, including the **European Regional Development Fund (ERDF)** and the **European Social Fund Plus (ESF+)** with an overall budget of **EUR 373 billion** – excluding Member State co-funding – provide grants to Member States and their regions to improve their health systems' resilience, accessibility and effectiveness. The ESF+ will provide **EUR 4.8 billion** of support to health and long-term care. Delivery of family and community-based care services as well as measures to enhance accessibility, effectiveness and resilience of health systems will take up the largest share of this, together with access to long-term care and active/healthy ageing. The ERDF will invest **EUR 6.1 billion** in health infrastructure and equipment, including for social inclusion and healthcare digitalisation. When considering specific investments into healthcare, including Member State co-funding, some **EUR 16 billion** are planned for the 2021-2027 programming period of the Cohesion Policy funds, of which around **EUR 2 billion** for healthcare digitalisation and e-Health. In addition, a further **EUR 4 billion** is planned for investing into long-term care.

<sup>36</sup> ESTAT Europop 2023 projections

<sup>37</sup> WHO - Health Workforce

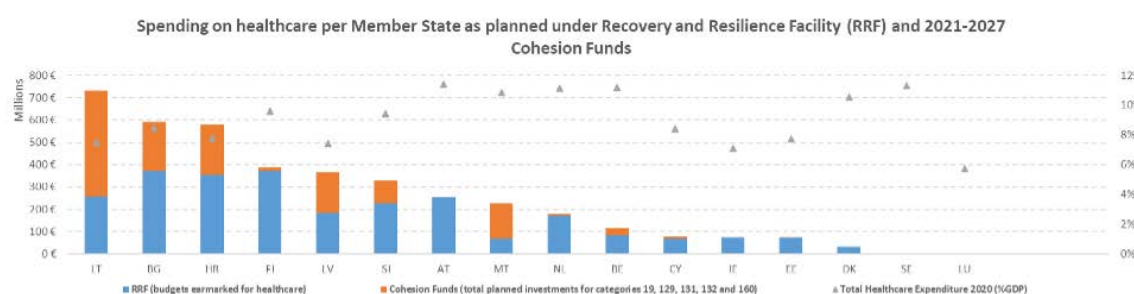
For some Member States EU funds are significant in terms of budget size for their health systems. However, for the EU overall this needs to be nuanced. To put budgets into perspective, the EUR 43 billion under the RRF and the EUR 16 billion under Cohesion Funds, together amount to a budget that would on average be spent every year in the EU on new buildings and equipment for health systems. However, the RRF and Cohesion Policy Funds will be spread out over several years (committed up to 2027 in the case of Cohesion Policy Funds). In this regard, the health reforms under the Recovery and Resilience Plans and the health Country Specific Recommendations adopted under the European Semester are crucial to ensure health investments, both from EU Funds and national funds, are properly steered to secure a maximum return-on-investment.

**Figure 9: Spending on healthcare per Member State as planned under RRF and 2021-2027 Cohesion Funds (spending above EUR 1 billion)**



Source: European Commission

**Figure 10: Spending on healthcare per Member State as planned under RRF and 2021-2027 Cohesion Funds (spending below EUR 1 billion)**



Source: European Commission

Investing in more resilient health systems, in particular in prevention and health system preparedness is not the only way of improving population health. A focus on determinants outside the health sector as such is also warranted. For example, despite the progress made, over 10% of premature deaths in the EU each year are still related to environmental pollution. Under the Green Deal initiatives, such as the 8th Environmental Action Programme and the Zero Pollution Action Plan, further targets have been set to address environmental pollution and human health such as reducing by more than 55% the health impacts (premature deaths) of air pollution. In addition, climate change triggers more extreme weather events and heatwaves, which have been estimated to have caused about 61 000 deaths in 2022, the hottest summer ever recorded in Europe<sup>38</sup>. For the 2021-27 period, Cohesion Policy funding is delivering more than EUR 118 billion investment in climate action. This represents a significant contribution to EU climate goals in line with the European Green Deal, to secure a sustainable path towards a climate neutral Europe. Overall, for the 2021-2027 period, 30% of the EU budget will be spent on greening and climate action. Moreover, for the Recovery and Resilience Facility as a whole, estimated climate expenditure amounts to about 40%.

#### **Good data generation, collection and analysis**

are essential to underpin effective and patient-centred public health strategies and health system reforms. The experience of the COVID-19 pandemic has brought into focus the urgent need to develop more robust, interoperable data collection infrastructure. This represents a critical weakness, because the quality of data available largely defines the quality of decision-making, which is then reflected in healthcare and public health outcomes. Better health data which is comparable, timely and which includes sex, age and other relevant breakdowns is necessary. There are significant data gaps in return-on-investment monitoring, health workforce, digital health and digital skills as well as the use and cost-effectiveness of Artificial Intelligence. In the aftermath of the COVID-19 pandemic, efforts to build stronger, interoperable data systems enabling timely monitoring and analysis of health data should be a core part of strategies to build long-term resilience.

The proposed **European Health Data Space (EHDS) Regulation** will be a significant milestone in establishing a framework to access timely and comparable health data. It proposes to be built around two pillars, in compliance with the applicable data protection legislation:

1. **The primary use of data: Empowering patients and supporting their free movement by increasing digital access to and control of their electronic personal health data while facilitating a genuine single market for electronic health record systems, medical devices, and high-risk Artificial Intelligence (AI) systems.**
2. **The secondary use of data: Providing a consistent, efficient, and trustworthy set-up for the use of health data for research, innovation, policy-making and regulatory activities.**

Cross-border MyHealth@EU services – ePrescription and Patient Summary – are being gradually introduced across the Union as part of the future European Health Data Space.

<sup>38</sup> Ballester, J., Quijal-Zamorano, M., Méndez Turrubiates, R.F. et al. Heat-related mortality in Europe during the summer of 2022. *Nat Med* 29, 1857–1866 (2023). <https://doi.org/10.1038/s41591-023-02419-z>, <https://www.nature.com/articles/s41591-023-02419-z>.

## Concluding remarks

The 2023 Synthesis Report focuses on three key messages. The first message raises attention to the mental health impacts of COVID-19, signaling the toll taken on individuals as well as the actions and reforms taken by Member States to address this growing challenge. The second key message signals the need to address health inequalities and avoid a growing divide. With the biggest reduction in life expectancy since World War II, as we exit from the pandemic, health systems must meet the needs of all Europeans. In particular, as we embrace the digital transformation of healthcare, there should be a strong emphasis on inclusiveness and solidarity. Tackling cancer is also of fundamental importance to Europe's future and Europe's Beating Cancer Plan proposes actions at every stage of the disease. The third key message focuses on continued investment in health and preparing health systems for the next crises. This requires also increased attention to and investments in addressing environmental determinants of health. In addition, the need for comparable and valid health data is key and the future European Health Data Space will facilitate this process.



# 2 **PART 2**

## **Key findings from the Country Health Profiles**

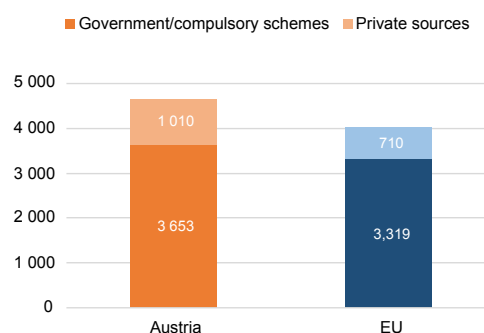




# I AUSTRIA

- Life expectancy at birth in Austria was 81.1 years in 2022, which is 0.4 years higher than the EU average but about 2 years lower than the levels in the EU countries with the highest longevity. As in most other EU countries, life expectancy fell between 2019 and 2022, mainly because of COVID-19. The gender gap in life expectancy remained marked in 2022, but was slightly less than the EU average.
- Circulatory diseases and cancer are the main causes of death in Austria, followed by COVID-19 in 2020 and 2021. The burden of cancer is increasing in an ageing population. Screening and other opportunistic diagnostic testing came to a near standstill during the first months of the pandemic in 2020, but it rebounded quickly so that the overall impact remained limited.
- Unhealthy lifestyles and behavioural risk factors remain important drivers of mortality in Austria: about 36 % of deaths in 2019 could be attributed to smoking, dietary risks, alcohol and low levels of physical activity. Smoking and alcohol consumption among adolescents and adults in Austria remain above the EU averages.
- Austria has one of the most expensive health systems in the EU. Health spending per capita was the third highest in the EU in 2021, and spending is also high relative to GDP. Despite an increase in the public share of spending since the onset of the pandemic, the share of out-of-pocket payments remains above the EU average. Nevertheless, access is generally not considered an issue, and Austria has low levels of unmet medical needs.
- Despite recent reforms to strengthen primary care and improve coordination and the efficiency of the multi-layered administration of the health system, progress is slow, and the health system remains structurally and financially fragmented. Ongoing efforts are successfully reducing the volume of hospital inpatient activity in favour of outpatient treatment, but establishment of 75 multi-disciplinary primary care units across the country is behind schedule. The health system remains hospital-centric, with the highest share of spending still devoted to inpatient care.
- Austria had the second highest density of doctors in the EU in 2021, but the proportion of general practitioners is one of the lowest in the EU. The number of practising nurses is increasing, but the demand for healthcare is also growing due to population ageing. There are ongoing debates about imbalances between regions, medical specialities and an ageing physician workforce. Efforts are under way to increase the number of medical students and to make less popular career choices – including general practice, public health and practice in rural areas – more attractive.
- Health services were heavily affected during the first wave of COVID-19 between April and June 2020, and to a lesser extent during the second wave in late 2020, but rebounded afterwards. COVID-19 contributed to an increase in the use of telemedicine and digital health services, such as electronic prescribing. Additional investments since the pandemic continue to focus on prior efforts in primary care and long-term care. Despite the strong electronic infrastructure and progress in primary data use, secondary use of data for health system governance and research remains limited.
- The prevalence of mental health disorders is estimated to be slightly higher in Austria than the EU average, driven by anxiety, depressive, and alcohol and drug-use disorders. Mental ill health is an increasingly recognised public health issue in Austria, and there are now several initiatives to provide easily accessible support and care – in particular for vulnerable groups, such as adolescents and women. However, provision of mental healthcare remains fragmented, and access barriers are generally more significant than for other types of care.

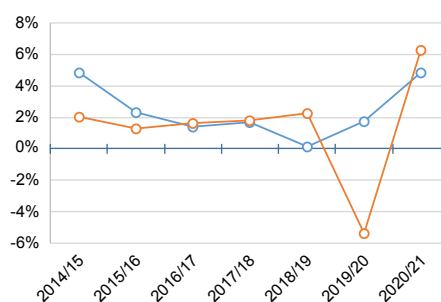
Health expenditure per capita, 2021



# I BELGIUM

- In 2022, life expectancy at birth in Belgium stood over 1 year above the EU average, at 81.8 years, reflecting slightly above-average gains in two decades preceding the COVID-19 pandemic and a comparatively low decline throughout the pandemic years. While cancer and circulatory diseases remained the two leading causes of death in 2020, COVID-19 was the leading single cause of death in Belgium, responsible for over one in every six fatalities. Excess mortality peaked at over 17 % in 2020, after which it remained relatively low in the subsequent two years.
- Behavioural risk factors were linked with more than one third of all deaths in Belgium in 2019 – a figure that was slightly lower than the EU average. Although per capita alcohol consumption was slightly lower than the EU average in 2019, the proportion of Belgian adults who regularly engage in heavy drinking remains significantly higher than in most other EU countries. Additionally, heavy drinking is relatively prevalent among adolescents. Thanks to government policy to curtail tobacco use, smoking rates among both adults and teenagers have seen substantial reductions over the past decade. However, the use of e-cigarettes has concurrently increased in popularity among teenagers.
- Between 2019 and 2021, health spending in Belgium rose by 3.4 % in real terms, in large part reflecting an increase in government and social health insurance spending in 2021 aimed at addressing the COVID-19 emergency. In 2021, health expenditure accounted for 11 % of GDP – a share equal to the EU average. Nearly 37 % of health spending was allocated to inpatient care, which exceeded the EU average both in per capita terms and as a share of total health spending. Private sources contributed to over 22 % of total health spending, a greater proportion than the EU average of 19 %.
- Only 1.0 % of the Belgian population reported unmet needs for medical care in 2022 compared to 2.2 % across the EU. However, they were disproportionately concentrated among individuals in the lowest income quintile, and Belgium had one of the widest income-based gaps in unmet needs for medical care among western European countries. In 2020, over 5 % of Belgian households experienced catastrophic spending on health – a figure that surged to over 12 % among households in the lowest income quintile. In 2022, the government took steps to reduce the incidence of catastrophic spending among low-income households.
- Despite significant increases in the numbers of doctors and nurses over the past decade, staff shortages remain a challenge in the Belgian healthcare system. In 2022, more than 80 % of hospitals reported closing beds owing to staff shortages. To address workforce shortages, Belgium has implemented various measures, including reforming remuneration schemes, adjusting the quotas of medical students and introducing the role of advanced practice nurse.
- In 2019, an estimated 17 % of the Belgian population experienced a mental health disorder – a proportion in line with the EU average. Suicide remains a public health concern in Belgium, accounting for 1.4 % of all deaths recorded in 2020. Although Belgium's suicide rate has decreased in tandem with the EU average over the past two decades, it remains notably higher than the EU average for both men and women. The country has implemented reforms in recent years aimed at improving the integration and accessibility of mental health services, but the fragmentation of responsibilities between federal, state and federated entities hampers the effectiveness and accessibility of mental health services, and individuals seeking specialist mental healthcare often face long waiting times.

Public spending on health and GDP trends



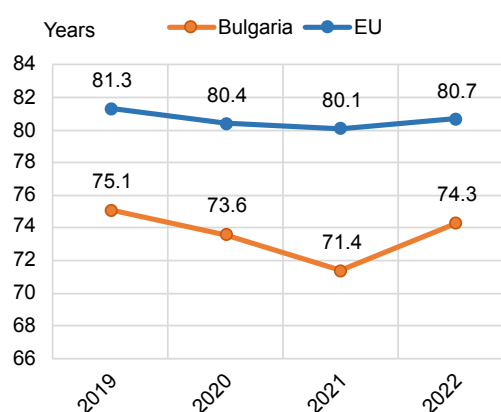
# I BULGARIA

- Life expectancy at birth in Bulgaria was increasing before the COVID-19 pandemic, but it dropped by 3.7 years between 2019 and 2021 to 71.4 years – the lowest level in the EU and the lowest in Bulgaria for two decades. Although life expectancy recovered to reach 74.3 years in 2022, it is still the lowest in the EU. Circulatory diseases, like stroke, ischaemic heart disease and COVID-19, were the main drivers of mortality in 2021. High rates of excess mortality in 2020-22 also suggest that direct mortality due to COVID-19 was underreported, and that indirect mortality due to COVID-19 occurred – probably because of postponed or forgone care.
- Bulgaria has high preventable mortality rates, driven by COVID-19, stroke, ischaemic heart disease, lung cancer and alcohol-related diseases in 2020. Behavioural risk factors – particularly high smoking rates and poor nutrition and physical activity habits – are contributing factors. In contrast to an EU-wide decline, mortality from treatable causes in Bulgaria increased between 2018 and 2020, and the rate is now more than double the EU average.
- Per capita spending on health has been growing but, at EUR 1 708 in 2021, is less than half the EU average of EUR 4 028. Public financing for healthcare is among the lowest in the EU at 65 %, meaning that out-of-pocket payments are very high: at 34 % of current health expenditure, they are the highest share in the EU.
- Beyond the implications of out-of-pocket payments on healthcare affordability, several other challenges hamper access to care. Roughly 12 % of the population does not have health insurance, and quarterly referral quotas to specialised care sometimes present a barriers to accessibility. There is also uneven distribution of services and workforce across locations and professions, with physicians and facilities concentrated in urban areas. Combined with an oversupply of acute hospital beds and a shortage of general practitioners and nurses, access to outpatient care in rural regions is undermined. The 2023 National Map of Long-term Health Needs aims to address regional inequities in health, including in accessibility.
- Bulgaria has some of the EU's lowest cancer screening rates, with significant socioeconomic and geographic disparities. These are related to weak public understanding, fragmented implementation

and a lack of financial resources. COVID-19 also undermined cancer-related primary prevention. Low screening rates, cancer mortality rates and low attendance at preventive check-ups suggest a level of underdiagnosis and challenges to providing effective care. Bulgaria's first National Cancer Plan was adopted in early 2023 to improve cancer prevention and management.

- Catalysed by the COVID-19 pandemic, Bulgaria has bolstered its health information system to enhance care coordination, access and continuity. In accordance with a national EU-funded health information system, several elements of digital and e-health were introduced between 2020 and 2022, including e-referrals, e-prescriptions, electronic patient records and specialised systems for tracking and analysing medicinal products. Bulgaria's Recovery and Resilience Plan and the EU Cohesion Policy intend to provide further funding and structure to these efforts.
- According to the data, Bulgaria has a considerable but comparatively low mental health burden. The most common mental health disorders are anxiety, depressive and alcohol and drug-use disorders. Pre-pandemic prevalence of depression was lower than the EU average, but with significant disparities by income and gender. The Bulgarian mental health system is historically based on inpatient psychiatric care, but the National Strategy for Mental Health 2021-30 strives to strengthen community-based, comprehensive services, especially for vulnerable populations.

Life expectancy at birth



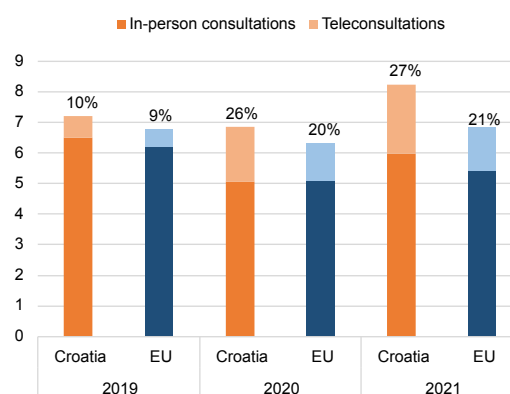
# I CROATIA

- Croatia achieved steady improvements in life expectancy until 2019, but the COVID-19 pandemic resulted in a drop of nearly 2 years in life expectancy by 2021. Excess mortality increased to 19 % in 2021 compared to the average recorded in the five years prior to the pandemic. Croatians aged 65 have a lower life expectancy than their counterparts in the EU overall, and spend a much larger share of their remaining years with multiple chronic conditions and activity limitations, suggesting that more could be done to bolster healthy ageing.
- Tobacco consumption is a major public health issue. Little progress has been made in reducing smoking rates due to lenient anti-tobacco policies. Alcohol consumption also contributes to mortality from cardiovascular diseases and cancer. Another major risk factor is poor nutrition. Obesity rates among adults and children are increasing, and 23 % of adults in Croatia are obese – far exceeding the EU average of 16 %.
- Croatia has undertaken a number of health reforms in recent years, but its hospital capacity has only declined marginally in the last few decades, which might indicate scope for moving more services to outpatient settings. Amendments to the Health Care Act in March 2023 have brought a new focus to strengthening primary and outpatient care and improving coordination and integration of care. Key indicators on quality of care are still missing, undermining efforts to monitor health system performance, but Croatia aims to establish a comprehensive national health quality and safety system.
- Mortality rates from preventable and treatable causes of death are higher in Croatia than in many other EU countries, and increased in 2020 as a result of the COVID-19 pandemic. Lung cancer is a particular concern: mortality from this cause of death is the second highest in the EU, and exceeded mortality from COVID-19 in 2020. Croatia has a comparatively high coverage rate for cervical cancer screening, but a low rate for colorectal cancer screening.
- The public benefits package is comparatively generous, given Croatia's GDP per capita, and this helps to protect the population from private out-of-pocket expenditure and catastrophic health spending, which are both less prevalent than in EU countries with similar income levels. Despite the pandemic, the rate of self-reported unmet needs also remained comparatively low,

and an increasing share of teleconsultations helped to maintain access to health services.

- The COVID-19 pandemic was a major shock to Croatia's health system. Despite a drop in its GDP, the government increased public spending on health to deal with the pandemic. Croatia has developed a national Recovery and Resilience Plan for 2021–26 that will boost health sector investment, including in cancer care, hospital infrastructure, hospital care quality improvements and the digital transformation of the health system, complemented by support through the EU Cohesion Policy 2021–27. Croatia is also working on improving integration of care and human resources planning to be better prepared for future shocks to its health system.
- Poor mental health imposes a substantial burden on Croatia's health system and society, as it does in other EU countries, and is likely to have worsened as a result of the COVID-19 pandemic. Of those who reported unmet needs for healthcare in 2021 and 2022, one in six had mental healthcare needs, resulting in a high share of total hospital treatment days and sizeable direct and indirect economic costs. Croatia has adopted a new national strategy for mental health until 2030, but is still at the beginning of plans to move mental health services out of institutions and into communities.

Number of doctor consultations per capita

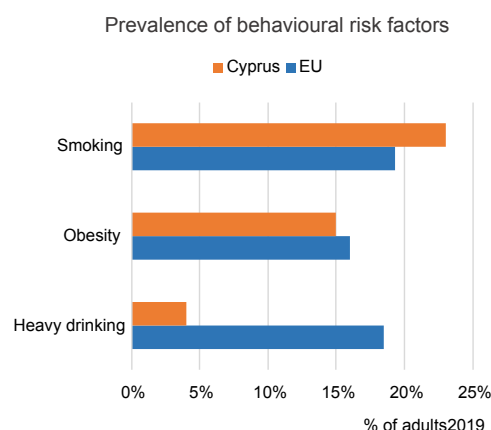


# I CYPRUS

- While life expectancy in Cyprus is high (81.7 years in 2022), 78 % of Cypriots report being in good health. Almost one fifth (19 %) of all deaths in Cyprus in 2019 could be attributed to tobacco consumption (including direct and second-hand smoking), which is above the EU average (17 %). However, deaths attributable to other behavioural risk factors are below the EU averages, including alcohol consumption (4 % in Cyprus; 6 % across the EU) and dietary risk factors (14 % in Cyprus; 17 % across the EU).
- Rates of mortality from preventable and treatable causes were low in Cyprus before the pandemic. The main cause of preventable mortality was lung cancer, which is consistent with high smoking rates – particularly among Cypriot men. However, the high levels of mortality attributed to COVID-19 in 2021 are likely to increase preventable mortality rates in that year. The main causes of treatable mortality in Cyprus are ischaemic heart disease, breast cancer and colorectal cancer, although cancer mortality in Cyprus is among the lowest in the EU. However, data limitations mean that attributing low treatable mortality rates to the performance of specific parts of the system is not possible.
- The growth in public spending on health began from a low base and started before the COVID-19 pandemic, in line with health financing reforms that sought to improve financial protection and reduce out-of-pocket expenditure in Cyprus. Out-of-pocket spending as a share of total health spending fell markedly from 34 % in 2019 to 18 % in 2020 and 10 % in 2021. This is likely to reduce levels of catastrophic spending on health significantly.
- Before the reforms introducing the General Healthcare System in Cyprus, long waiting times were an important barrier to medical care, and patients frequently paid out of pocket in full to access services more quickly. Now most capacity in the private sector has been contracted by the Health Insurance Organisation to provide publicly funded services. It is therefore difficult to disentangle the impact of increased demand due to COVID-19 infections and the health system treating more patients who were previously unable to access services.
- During the first waves of the pandemic, hospital capacity was expanded to meet increased demand – particularly for intensive care unit beds – by moving routine services to private hospitals and reserving beds in the public sector for COVID-19

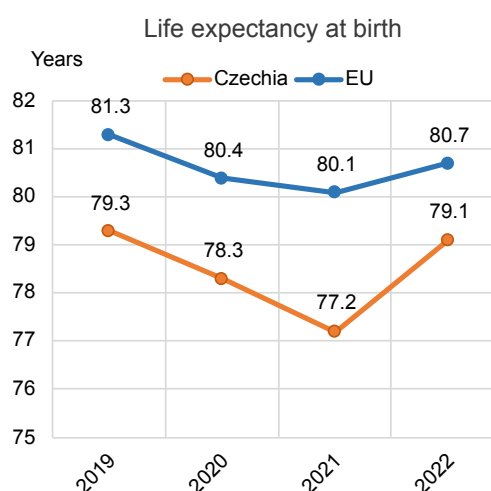
patients. However, despite the contracting in of extra capacity, there was still a drop in the volume of elective surgical procedures performed in 2020. The extra capacity was used in 2021 to try and clear the backlog of cases, and the volume of elective care provided was increased markedly to avoid longer waiting times. The key capacity constraint currently is health workforce shortages, particularly for nurses.

- The current priority for financial and capital investments in the health system is digitisation to support quality of care, efficiency and informed decision making. Investments through the Recovery and Resilience Plan and EU Cohesion Policy should make an important contribution to this. The overall aim of the investment programme is to upgrade buildings and equipment to improve working conditions for staff and enable them to provide high-quality care, and to improve the retention and recruitment of health workers.
- Mental health is an important issue in Cyprus that exerts a particularly high burden through indirect costs, such as high levels of unemployment for people with chronic mental health conditions. Wider health system reforms consolidated the public provision of mental health services as part of a universal benefits package. An EU-funded project has sought to extend provision for especially vulnerable groups, such as asylum seekers, who are not entitled to access statutory health services.



# I CZECHIA

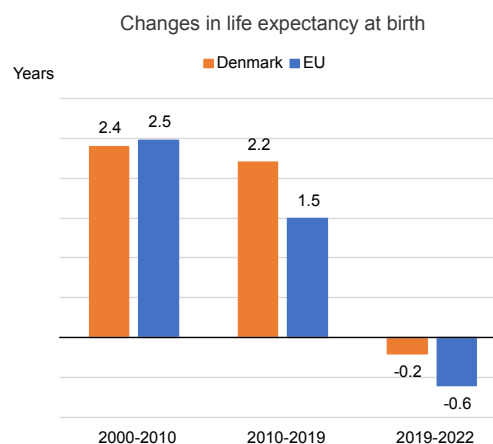
- Life expectancy at birth in Czechia in 2022 (79.1 years) was about 1.5 years below the EU average (80.7 years). While it increased by more than 4 years in the two decades before the pandemic, it fell by more than 2 years in 2020 and 2021, before rebounding close to its pre-pandemic level in 2022. Circulatory diseases, cancer and COVID-19 were the leading causes of death in 2021.
- Nearly half of all deaths in Czechia in 2019 can be attributed to behavioural risk factors, including dietary risks, tobacco smoking, alcohol consumption and low levels of physical activity. While tobacco smoking has fallen below the EU average, excessive alcohol consumption rates remain among the highest in the EU, and obesity rates have increased to above the EU average.
- Health spending in Czechia accounted for 9.5 % of GDP in 2021, which is 2 percentage points above the pre-pandemic level, but well below the EU average of 11.0 %. Per capita spending was a quarter lower than the EU average, but the public share of health spending is the highest among EU countries (86 % compared to an EU average of 81 %).
- Czechia provides a broad benefits package, with relatively low unmet medical care needs for financial reasons. Nearly half of out-of-pocket spending by households goes on pharmaceuticals.
- Mortality rates from preventable and treatable causes were 25 % higher than the EU averages in 2020. Following previous improvements, preventable mortality increased during the pandemic because of COVID-19 deaths. Ischaemic heart disease and colorectal cancer are the leading treatable causes of mortality.
- Screening programmes for breast, cervical and colorectal cancer are well established, with participation rates above the EU averages, but the pandemic disrupted these programmes, causing backlogs that may hinder the early detection of cancer.
- The COVID-19 pandemic challenged the provision of elective (non-urgent) care. While recovery in the volume of diagnostic exams in 2021 was strong, surgical activities such as knee replacements had not yet recovered. The recent Czech health system performance assessment framework calls for development of a monitoring system of waiting times for elective surgery and other health services.
- Czechia will invest EUR 1.1 billion in healthcare under its National Recovery Plan, representing over 16 % of the Plan's total investment. This mainly focuses on improving cancer care capacity and technologies, expanding and modernising medical training facilities, and supporting the digital transformation of the health system.
- While the density of doctors and nurses has increased over the past decade, demand for care has also increased owing to population ageing. The medical workforce is ageing too: over one-third of all doctors in 2021 were aged over 55 and may be expected to retire in the coming decade. In response, the government has provided additional funding to keep increasing by at least 15 % the number of students in Czech medical schools compared to 2018. Actions have also been taken to attract more students in nursing and retain nurses in the profession by improving their pay rates.
- About one in seven people in Czechia were estimated to have a mental health disorder in 2019. The most prevalent were depressive, anxiety, and alcohol and drug-use disorders. The Health 2030 strategy sets out major actions for mental healthcare reform related to mental health promotion and care provision, including tackling stigma through national campaigns, greater integration of people with mental health conditions in society, and enhancement of coordination between health and social care.





# I DENMARK

- Life expectancy at birth in Denmark in 2022 was more than half a year higher than the EU average (81.3 years compared to 80.7 years), but lower than in many other Nordic and western European countries. Life expectancy in Denmark fell by 0.2 years between 2019 and 2022, but this reduction was less than the EU average fall (0.6 years). Cancer is the leading cause of death in Denmark, and lung cancer remains the most frequent cause of death by cancer.
- Although tobacco smoking in Denmark has decreased sharply over the past two decades, smoking rates remain higher than in other Nordic countries. Excessive alcohol consumption among adults and adolescents also remains much higher than in other EU countries. While the obesity rate among adults was similar to the EU average in 2019 (16 %), this proportion has gone up over time, and more recent data show a further increase to 18.5 % in 2021.
- Health spending per capita in Denmark is higher than the EU average, and the share of public funding (85 %) is also greater than the EU average (81 %). Denmark's universal tax-financed health system provides a comprehensive benefits package to all residents, although coverage is more limited for pharmaceuticals and dental care, as in other EU countries. Health spending as a share of GDP rose to 10.8 % in 2021, due mainly to the increase in public spending on health during the first two years of the pandemic.
- Denmark fares better than most EU countries on avoidable mortality, which points to an effective public health and healthcare system. Lung cancer, chronic obstructive pulmonary disease and alcohol-related deaths were the leading causes of preventable mortality in Denmark in 2020. Recent national efforts to prevent smoking and reduce alcohol drinking have focused on younger generations.
- Denmark was one of the few EU countries that was almost able to maintain the number of doctor consultations during the first year of the pandemic in 2020, thanks to extensive use of teleconsultations. However, hospital activities and elective surgical procedure numbers fell in 2020 and 2021, resulting in a backlog of patients waiting for treatment. Waiting times for surgical operations increased by 50 % between the first quarter of 2020 and the fourth quarter of 2022, and the increase was even greater for some interventions, such as hip and knee replacements.
- Workforce shortages are the main capacity constraint in addressing the backlog of patients created during the pandemic. The government has set a goal to bring down waiting times for surgical operations to pre-pandemic levels by the end of 2024, and has provided substantial additional funding to the regions to support increased surgical activities.
- The burden of mental health in Denmark is high, with estimates that over one in six people had a mental health issue in 2019. There are substantial gender and socioeconomic gaps in the prevalence of depression, with people on lower incomes – especially women – more likely to report depression. The government launched a 10-year plan in 2022 to improve psychiatry and mental health in Denmark, identifying children and young people, and adults with severe mental health issues, as particular target groups. The plan includes 19 objectives, along with a set of proposed indicators to monitor progress over time.



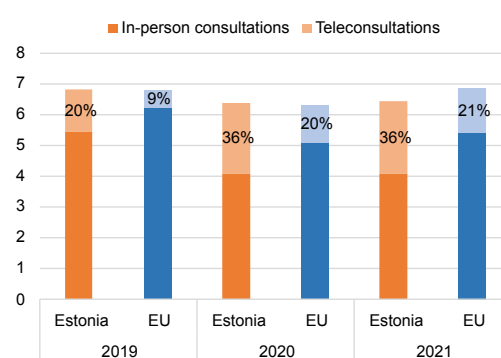
# I ESTONIA

- Life expectancy at birth in Estonia fell by 0.8 years between 2019 and 2022 during the COVID-19 pandemic, compared to an EU average fall of 0.6 years. Before this, it had risen by nearly 8 years since the start of the millennium, to a pre-COVID-19 peak of 79 years. However, the gender gap is wide: in 2022, women in Estonia could expect to live an average of 8.7 years longer than men, compared to the EU average gender gap of 5.4 years.
- Estonia also has marked health inequalities by socioeconomic status. At age 30, life expectancy for men with lower education levels is 9.3 years shorter than for those with higher levels. Estonia also has one of the widest gaps in self-reported health status across income groups in the EU. These socioeconomic disparities are shaped by risk factors that are more prevalent among Estonians with lower education levels, who are more likely to smoke and to be obese.
- Since 2014, Estonia has implemented comprehensive national strategies to reduce alcohol and tobacco use, as the key risk factors behind the country's preventable mortality rates. Before 2020, preventable mortality rates had been falling, but from 2021, COVID-19 deaths have been classed as preventable and the number of COVID-19 deaths in Estonia was high. By the end of 2021, only 17 % of adults aged 60 and over had received a primary COVID-19 vaccination and two booster doses.
- Progress in health system efficacy in Estonia is reflected in falling rates of treatable mortality – more Estonians are surviving strokes and accessing cancer screening. However, COVID-19 has led to delays in preventive cancer care, and the Estonian Health Insurance Fund continues to report underutilisation of its cancer prevention budget, despite increasing coverage of breast, cervical and colorectal cancer screening.
- Public expenditure on health in Estonia increased between 2019 and 2021, reflecting the growing role of government transfers in financing healthcare as the system moves away from reliance on employer contributions through social health insurance. However, the share of out-of-pocket expenditure remains high, causing financial hardship for more than 7 % of all Estonian households.
- Estonia has seen significant reductions in unmet needs for medical care: the rate declined significantly between 2019 and 2022, from 15.5 % to 9.1 %. Thanks to improvements in dental care coverage,

only 2.5 % of Estonians reported not seeking dental services due to cost, distance or waiting times in 2021. Access to services has also improved thanks to significant reductions in waiting times for some elective procedures, such as hip or knee replacements and cataract surgery. These were high and exceeded legally defined standards before the renewal of the waiting lists system in 2022.

- Estonia is not training enough family doctors to meet future needs projections. Admissions quotas to medical and nursing courses have increased recently, but the size of the new intake is still below projected requirements to meet future demand. While recent changes have made medical specialty training more flexible, health workforce shortages remain an urgent issue.
- The burden of common mental health problems and unmet needs for mental health services was high during the COVID-19 pandemic, and there was a sharp rise in the number of alcohol-related deaths between 2020 and 2022. To address this, Estonia established a Mental Health Department for central coordination of mental health policy in 2022, and set priorities for action in the Mental Health Action Plan 2023-26 to strengthen provision of mental health services, as well as prevention and mental health promotion efforts.

Number of doctor consultations per capita



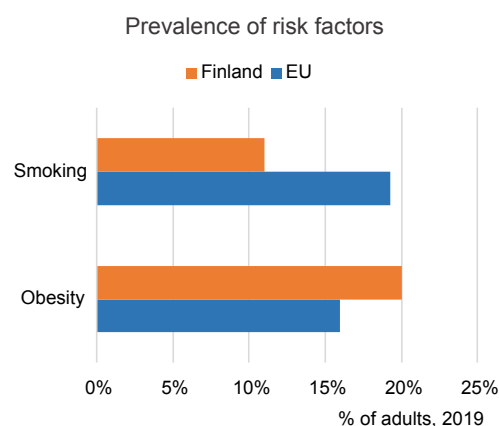


# I FINLAND

- During the first two years of the pandemic, life expectancy in Finland fell only slightly, but the reduction in 2022 was much greater and the largest in over 50 years. This reduction was driven mainly by higher deaths from COVID-19, particularly among people aged over 80.
- About 35 % of all deaths in Finland in 2019 could be attributed to behavioural risk factors. Although progress has been achieved in reducing tobacco and alcohol consumption, obesity and overweight are growing public health concerns. In 2019, 20 % of adults were obese, up from 11 % in 2000, and the adult obesity rate was higher than in most EU countries. Overweight and obesity rates among adolescents in 2022 (24 %) were also higher than the EU average (21 %).
- Finland's health expenditure reached 10.3 % of GDP in 2021 – a large increase compared to 2019 due mainly to the increase in health spending during the first two years of the pandemic. Health spending as a share of GDP remained lower than the EU average in 2021 (11.0 %), however.
- All residents are covered by the health system, but most employees benefit from occupational healthcare that provides quicker and free access to some services, while other parts of the population face copayments and waiting times. In 2022, a larger proportion of the population (6.5 %) reported unmet medical care needs in Finland than the EU average (2.2 %), mostly related to waiting times.
- While waiting times for elective surgical procedures did not increase much during the first year of the pandemic, they went up substantially in 2021 and 2022, despite a rebound in volumes of surgical activity following the reduction in 2020. The number of people on waiting lists for more than 6 months for treatments such as hip and knee replacements increased sharply in 2021 and 2022. The main priority of Finland's Recovery and Resilience Plan is to address this backlog as quickly as possible.
- Shortages of health and long-term care workers are growing concerns, with employers having difficulties in recruiting many categories of staff, including general practitioners, nurses and homecare assistants. The Ministry of Social Affairs and Health launched a five-year programme in November 2021 to increase the supply of health and social

care workers in response to population ageing. The main measures are to increase student intakes in health education and training programmes, review the division of roles and responsibilities between professions in health service delivery, make greater use of digital solutions, and improve working conditions to attract and retain more workers in the health and social care sector.

- A major reform implemented in January 2023 reorganised health and social services in Finland through the creation of well-being services counties (21 counties and the City of Helsinki). These are financed from the state budget and governed by elected councils. The Ministry of Social Affairs and Health has strengthened its role in steering the health system through greater involvement in annual planning and investment.
- Even before the pandemic, the burden of mental ill health was significant: an estimated one in six Finns had a mental health issue in 2019. The most frequent causes were depression, anxiety, and alcohol and drug use. Suicide rates remain much higher in Finland than the EU average, despite a significant reduction in the past 15 years. The National Mental Health Strategy and Programme for Suicide Prevention aims to promote the mental health of children and young people, increase the resources available for mental health services in primary care, and strengthen coordination between primary and specialist care.



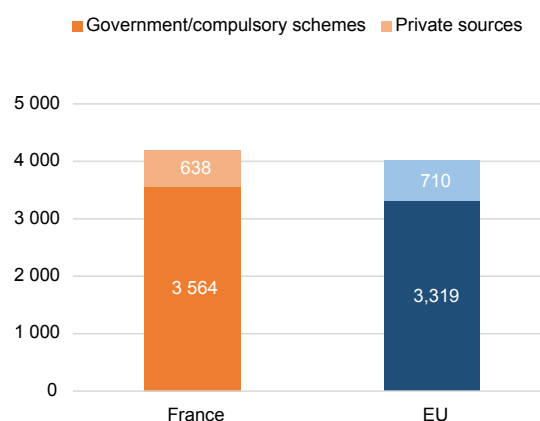
# I FRANCE

- Life expectancy in France remains substantially higher than the EU average, but it fell by more than half a year between 2019 and 2022 due to deaths from COVID-19, bad flu seasons and heatwaves in 2022.
- Behavioural risk factors – notably smoking, poor nutrition, alcohol drinking and lack of physical activity – contributed to about one third of all deaths in France in 2019. Public health has traditionally been neglected in France. Smoking rates and heavy drinking among adults have decreased over the past decade, but remain above the EU average.
- Health spending in France increased to 12.3 % of GDP in 2021, which was the second highest share in the EU after Germany and over 1 percentage point above pre-pandemic levels, although it fell slightly in 2022. The peak in 2021 was due mainly to the large increase in public spending on health during the pandemic.
- The French health system provides good financial access to care, with low out-of-pocket payments. Unmet needs for medical care are generally low, but they are higher among people on low incomes – particularly for services that are less comprehensively covered by public insurance such as optical and dental care, although public coverage has improved since 2021.
- Low numbers of general practitioners practising in underserved areas (“medical deserts”) have raised growing concerns about access to care. A series of measures have been implemented over the past decade to attract and retain more doctors in underserved areas, including financial incentives to set up their practice in these areas and the creation of multidisciplinary health centres. The number of medical students has also increased sharply in recent years, and since 2017 40 % of all postgraduate internship positions must be allocated to general medicine. Other recent measures also aim to expand the roles of other health professionals to improve access to primary care – especially nurses and pharmacists. A new role of medical assistant was introduced to reduce the administrative tasks of general practitioners.
- To help maintain access to care during the pandemic, France rapidly changed the regulation on teleconsultations to scale them up, and they reached a peak of 24 % of all doctor consultations during the first lockdown in spring 2020. Thereafter, their

popularity waned as confinement measures were lifted, and they made up only 4 % of all doctor consultations in 2021.

- Public spending on health grew by nearly 9 % in 2021, driven mainly by a catch-up effect following the drop in healthcare activities caused by the disruption to services in 2020, as well as the cost of the COVID-19 testing and vaccination campaigns. Preliminary estimates indicate that growth in public spending on health in 2022 returned close to the long-term trend, with a 2 % increase in real terms.
- Recent additional budget allocations to the health system aim to restore the financial capacity of public hospitals, improve the working conditions and pay rates of health professionals (especially nurses) to increase retention rates, improve coordination between ambulatory and hospital care, increase digitalisation of the health system and modernise the long-term care sector. Some of these new investments are supported by EU funds.
- The prevalence of mental health issues in France is estimated to be slightly higher than the EU average. The most common issues are anxiety and depression. Substantial gender and income disparities exist, with individuals on lower incomes – particularly women – experiencing higher rates of depression. Despite improved public coverage of psychotherapy since 2022, challenges persist in the availability and coordination of care for those with mild-to-moderate disorders.

Health expenditure per capita, 2021



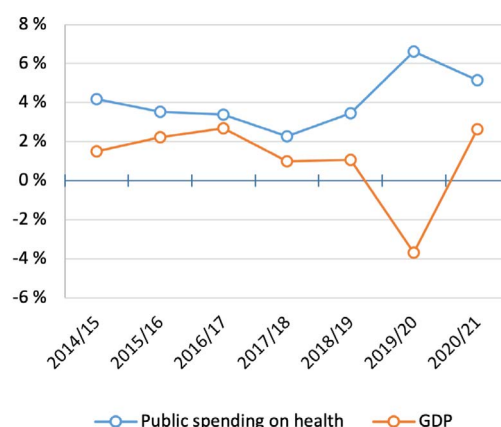
# I GERMANY

- Germany's life expectancy was equal to the EU average in 2022, at 80.7 years. The impact of the COVID-19 pandemic on life expectancy was more moderate in 2020 than in 2021, but overall life expectancy fell by approximately seven months between 2019 and 2022, which is on a par with the EU average. As in other EU countries, men have a lower life expectancy than women in Germany, but the gender gap of almost five years is slightly below the EU average.
- Smoking and unhealthy diets represent the largest behavioural risk factors in Germany. While the total rate of adult and adolescent smokers has declined slowly in recent years, the emergence of electronic cigarettes and pipes has attracted young people in particular. Fuelled by low levels of physical activity and unhealthy diets, the rate of overweight and obese adolescents has also been increasing steadily, underlining the need for targeted prevention measures. Moreover, heavy drinking is still a major problem in Germany, and 8 % of all deaths are linked to alcohol. These risk factors are also driving the leading causes of preventable mortality – lung cancer, alcohol-related diseases and ischaemic heart disease.
- In 2021, spending on health in Germany was the highest in the EU. There was a considerable increase in the growth rate of public funding between 2019 and 2020, and 2021 due to the COVID-19 pandemic. The largest share of health expenditure goes on inpatient care, reflecting Germany's large hospital sector, followed by outpatient care. At 12 % in 2021, out-of-pocket payments in Germany rank among the lowest in the EU. Payments for long-term care and pharmaceuticals account for the majority of out-of-pocket spending.
- Germany has high numbers of nurses, physicians and hospital beds per capita. While the number of physicians in hospitals has been increasing since the introduction of the diagnosis-related group-based payment system in 2004, the number of nurses working in hospitals is not sufficient. Changes to hospital payment rules to exclude the costs of nursing personnel from the case-based payment system are designed to increase the number of nurses in these facilities. Moreover, in addition to increasing the number of nursing graduates, the dedicated Nursing Training Initiative contains several measures aimed at attracting more people to the profession.
- The numbers of hospital beds and hospital

discharges in Germany are very high. A new Government Commission has been established to propose solutions to the hospital-reliant health system, with a view to strengthening decisions on allocation and increasing efficiency. Proposals include the introduction of a new remuneration system for inpatient care provision and the possibility of providing ambulatory care within hospitals.

- The strategic priority of nurturing a pandemic-resilient health system is embedded within Germany's Recovery and Resilience Plan, which dedicates funding to digital and technical strengthening of public health services and to wide-ranging modernisation of hospitals, encompassing digital infrastructure, emergency capacities, telemedicine and information technology and cybersecurity, as well as the development of COVID-19 vaccines.
- Anxiety and depressive disorders, as well as alcohol and drug-use disorders, make up the bulk of Germany's mental health burden; they also disproportionately affect those in lower income groups. During the COVID-19 pandemic, over one third of reported unmet healthcare needs were related to mental healthcare. In particular, the pandemic exacerbated risk factors and highlighted the link between precarious financial circumstances and heightened risk of depression. Some 64 % of people in Germany living in households with financial difficulties were at risk of depression during the pandemic, compared to 42 % of people without financial difficulties.

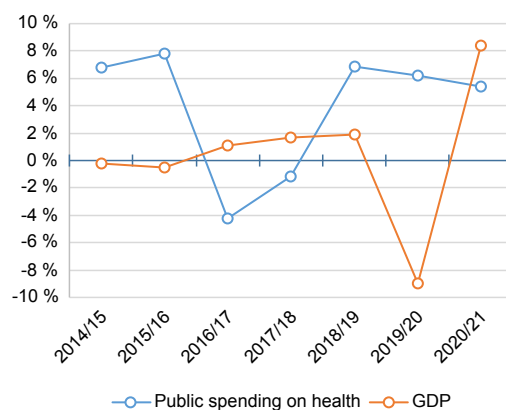
Public spending on health and GDP trends



# I GREECE

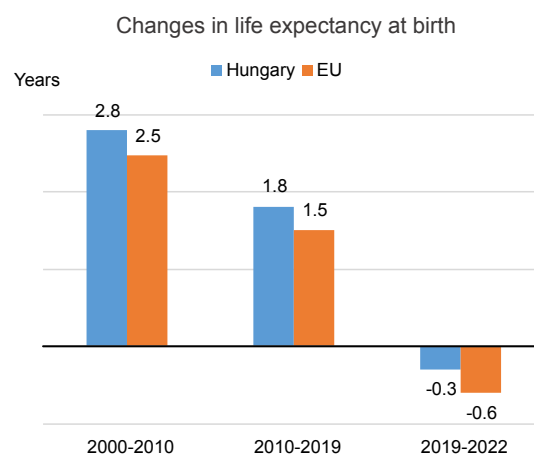
- COVID-19 erased 1 year of life expectancy gains in Greece, and average life expectancy at birth was back at 2012 levels in 2022. At 80.7 years, life expectancy is now lower than in most other southern and western European countries, but equal to the EU average. The sources of this impact can be seen in the number of recorded COVID-19 deaths, which in 2020 represented the fourth highest cause of mortality (after diseases of the circulatory system, cancers and respiratory diseases), and in the higher excess mortality rates reached between 2020 and 2022.
- High smoking rates and obesity, particularly among adolescents, are two behavioural risk factors of concern, contributing to a substantial number of deaths in 2019. The downward trend in preventable mortality was reversed in 2020, mainly as a result of COVID-19 deaths but also due to the persistent impact of lung cancer – the leading cause of preventable deaths. Strengthened tobacco control policies introduced in 2019 showed promise, but enforcement of smoking bans in public places such as bars and restaurants appears to have dissipated in the post-COVID-19 resumption of social and economic activity.
- Total health spending and the public share of this expenditure increased in 2021. Nevertheless, at EUR 1 874 per capita, Greece has among the lowest rates of spending on health in the EU. Out-of-pocket payments remain high, accounting for one third of all spending on healthcare. This fuels unmet needs for medical care due to costs, and high levels of catastrophic spending on health, particularly among the poorest households.
- Accessibility of services is sustained by near universal population coverage, a broad benefits package and enhanced use of remote consultations during the pandemic, but Greece still registers a high degree of forgone care for both medical and dental care. Monthly quotas on some reimbursed physician visits, tests and medicine prescriptions modulate the supply of publicly funded health services, while shortages of physicians and nurses are a key barrier to adequate staffing of public facilities, including the primary care structures at the centre of ongoing reforms.
- Health system strengthening in the wake of the pandemic has focused not only on shoring up health workforce capacity through better remuneration and significant improvements to medical education and training but also on continued efforts to improve the provision and efficiency of primary care – not least through the long-awaited introduction of a gatekeeping system, better care integration frameworks and upskilling in digital health techniques for medical staff. A national action plan is also in place to address antimicrobial resistance, which is one of the most pressing potential health emergencies facing all countries.
- Strategic priorities are supported by the health sector investments contained in Greece's Recovery and Resilience Plan and EU Cohesion Policy instruments, which channel funding into the upgrading of building infrastructure and equipment in primary care centres and public hospitals, as well as various actions designed to implement the digital transformation of health services. Financing is also provided to buttress the wide-ranging measures within the national public health prevention strategy Spyros Doxiadis.
- Depression and anxiety, as well as alcohol and drug-use disorders, make up the bulk of Greece's mental health burden; they also disproportionately affect those in lower-income groups. During the COVID-19 pandemic, over one quarter of reported unmet healthcare needs were related to mental healthcare. Ongoing reforms have gradually been shifting provision away from institutionalised care to delivery of community-based services. The National Action Plan for Public Health 2021-25 and the new National Action Plan for Mental Health 2021-2030 contain multi-faceted policies and interventions to reconfigure the provision of mental health services over the next decade.

Public spending on health and GDP trends



# I HUNGARY

- The COVID-19 pandemic interrupted the gradual convergence of life expectancy in Hungary with the EU average, and the gap stood at 4.5 years in 2022. Pre-pandemic gains in life expectancy are attributed to reductions in mortality from circulatory diseases – the leading cause of death in Hungary – followed by cancer. Hungarian men are expected to live nearly 7 years less than women, which can largely be attributed to greater prevalence of risk factors among men.
- Hungary has a rapidly ageing population, with over one fifth of the country aged 65 and over in 2020, many of whom report suffering from multiple chronic conditions. In fact, Hungary has the highest share of older men and women reporting limitations in basic activities of daily living in the EU.
- Dietary risks and smoking are significant population health risks in Hungary: Hungarians were some of the heaviest smokers in the EU in 2019. There is a pronounced gender gap, as over a third of Hungarian men smoke daily, compared to over one fifth of women. Furthermore, measured obesity has increased from 29 % of adults in 2009 to 33 % in 2019, and is particularly a concern among adolescents: 25 % of 15-year-olds were overweight or obese in 2022. As in all EU countries, there are pronounced differences in the impact of risk factors between socioeconomic groups.
- Health expenditure in Hungary has risen in recent years, fuelled by spending related to the COVID-19 pandemic. Nevertheless, Hungary spent less than half the EU average per capita in 2021, ranking the sixth lowest among EU countries. Although out-of-pocket payments for healthcare decreased in 2021, at 25 % they were considerably higher than the EU average (15 %), as a result of only partial cost coverage for several health goods and services. Nearly half of all household out-of-pocket spending goes towards pharmaceuticals.
- Care provision in Hungary is heavily reliant on hospitals, with bed densities well above the EU average, and nearly one third of healthcare spending dedicated to inpatient care. The wide-ranging new health reform adopted in December 2022 plans to strengthen primary care and encourage group practices, particularly to enhance integrated care for patients with chronic conditions and to deliver improved preventive services.
- Hungary's Recovery and Resilience Plan forecasts approximately EUR 1.3 billion for health sector investment. This includes upgrading of infrastructure and equipment in health facilities and spearheading the drive for greater digitalisation, with a focus on transforming information technology frameworks, developing telemedicine and remote monitoring solutions, as well as rolling out mobile health applications. Support from the EU Cohesion Policy will also go towards infrastructure improvements.
- With a growing private care system in Hungary, many health professionals work multiple jobs within and across the public and private sectors. Furthermore, higher salaries and better working conditions abroad continue to be incentives for emigration to other countries. The government has partly addressed health workforce retention challenges through significant wage increases for doctors, dentists and pharmacists, implemented in stages over the last three years. Other measures to prevent doctors from working in the public and private sectors were also part of the legislation, although they have only partially been implemented so far.
- Depressive and anxiety disorders are the largest mental healthcare issues in Hungary, and have the greatest impact on lower-income groups. Hungary has one of the highest suicide rates among men in the EU. During the COVID-19 pandemic, around 15 % of reported unmet healthcare needs were related to mental healthcare. A new National Public Health Programme for 2030 is expected to include mental health policies, and is currently in development.

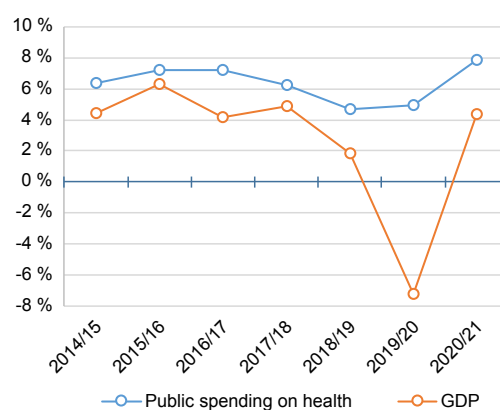




# I ICELAND

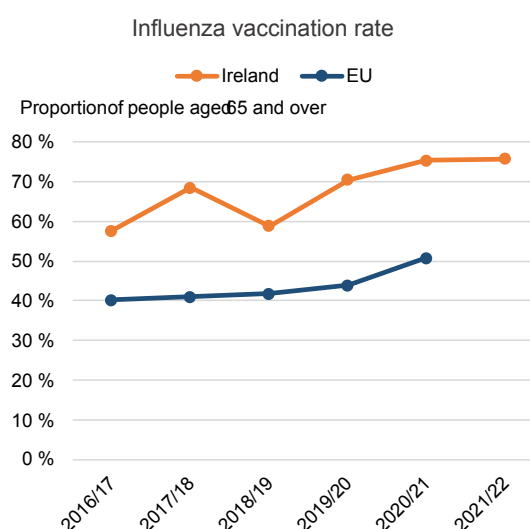
- In 2022, Iceland's life expectancy at birth stood at 82.1 years. While this exceeded the EU average by around 1.5 years, it fell short of Iceland's pre-pandemic life expectancy by over 1 year. This decrease was concentrated entirely in 2022, when Iceland experienced a significant surge in mortality – primarily attributed to a notable increase in COVID-19 fatalities, which occurred after two years of minimal deviations from the pre-pandemic mortality baseline.
- In 2019, behavioural risk factors for health were associated with over a third of all fatalities in Iceland. Despite comparatively low alcohol consumption, heavy drinking is more common among Icelanders than in the rest of Europe. Additionally, overweight and obesity rates are significantly higher than the EU averages for both adults and adolescents. Although policy initiatives have been implemented to tackle these risks in recent years, their impact on population-level rates is yet to be observed. Following a large decrease over the past two decades, the prevalence of smoking in Iceland is the lowest in Europe.
- Iceland's health expenditure was slightly below the EU average in 2021, with private sources accounting for 16.3 % of health spending – a lower share than the EU average of 19 %. Health spending per person on inpatient, outpatient and long-term care nearly aligned with the EU average, while spending on retail pharmaceuticals was comparatively low. However, it constituted a larger proportion of out-of-pocket spending by households. Between 2019 and 2021, health spending per capita in Iceland increased by 8.4 % in real terms, driven primarily by increased public financing aimed at expanding care capacity to address the COVID-19 emergency.
- In 2020, Iceland had one of the lowest potentially avoidable mortality rates in Europe – a testament to the efficacy of its disease prevention efforts as well as the effectiveness of its healthcare system in treating life-threatening conditions. Screening rates for breast cancer align with the EU average, and for cervical cancer exceed the EU average, but the country has not yet implemented a colorectal cancer screening programme. Immunisation rates for influenza and human papillomavirus consistently surpass those of most other European countries.
- The pandemic exacerbated historically long waiting times for elective surgical procedures, intensifying the urgency to address this issue. Several initiatives to reduce waiting times have been undertaken since 2016, but they have achieved relatively modest results. As in most other European countries, in 2020 disruptions caused by COVID-19 caused a sizeable decline in the volume of elective surgical procedures performed, resulting in a patient backlog that was only partly cleared in 2021. Conversely, the pandemic had a negligible impact on volumes of cancer-related surgery and other critical procedures.
- Iceland has identified key healthcare infrastructure strengthening needs, particularly in terms of its hospital bed capacity, which is among the lowest in Europe. Against the backdrop of ongoing investment to expand acute care capacity in Landspítali – Iceland's primary hospital – projected demographic shifts and the associated changes in disease burden are expected to necessitate significant additional hospital capacity expansions in the medium term.
- In 2019, 16 % of Iceland's population suffered from a mental health disorder – a slightly lower proportion than the EU average. The COVID-19 pandemic had a negative impact on population mental health – particularly among young people – and on mental health services, which are facing extended waiting times and shortages of clinical staff. Iceland's suicide mortality rate exceeds the EU average by over a fifth. As in other countries, suicide is significantly more prevalent among men. Iceland leads Europe in consumption of antidepressants, with almost 16 % of its population receiving prescriptions in 2021. To enhance the mental well-being of its population, the Icelandic government has developed a comprehensive mental health plan, coupled with several cross-sectoral programmes.

Public spending on health and GDP trends



# I IRELAND

- Life expectancy at birth in Ireland was higher than the EU average in 2021, at 82.4 years, reflecting major gains attained in the two decades preceding the COVID-19 pandemic, and comparatively low mortality from all causes (including COVID-19) during the pandemic years. In 2020, cancer emerged as the leading cause of death, accounting for more than 29 % of all deaths. This reflects higher incidence of cancer in Ireland than in other EU countries, where circulatory diseases are the most common cause of death.
- Behavioural risk factors contributed to more than one third of all deaths in Ireland in 2019. The adult smoking rate had been decreasing until 2019, but has since stabilised at a level below the EU average. While obesity rates remain high, indications of improved dietary habits and increased physical activity in recent years indicate potential future declines. Excessive alcohol use among adults is a concern, with rates of alcohol consumption and heavy drinking declining but still above the EU averages.
- Health spending per capita in Ireland increased by over 12 % in real terms between 2019 and 2021, driven in large part by increased public financing aimed at expanding care capacity to address the COVID-19 emergency. Ireland's health expenditure per capita was close to the EU average in 2021, with private sources accounting for over 22 % of spending – above the EU average of 19 %.
- Public hospitals in Ireland continue to face capacity constraints due to increasing demand and an insufficient supply of acute care beds. While substantial funding was allocated to expand inpatient capacity, recruitment challenges and construction inflation have slowed their operationalisation. Against the backdrop of continued efforts to expand acute care capacity, projections still indicate a deficit of over 900 hospital beds in 2023 – a comparable amount to the additional number of beds deployed since the beginning of the pandemic.
- Significant investments have been made to expand the health workforce since the pandemic began, primarily in acute care. However, there are concerning shortages of general practitioners, which pose a risk to the practical implementation of the shift towards a more efficient, primary care-focused system – a crucial aspect of the Sláintecare reform, which aims to achieve universal healthcare.
- Ireland outperforms most EU countries in preventing mortality from preventable and treatable causes. Ireland's comparatively low COVID-19 mortality can be attributed in part to the successful rollout of its COVID-19 immunisation programme, which in parallel saw an increase in uptake of flu vaccination. Alongside initiatives to enhance accessibility of primary care to improve chronic condition management, Ireland is implementing measures to address the backlog in cancer screening caused by COVID-19 restrictions.
- In line with its goal to establish a universal healthcare system, Ireland has made significant strides to expand eligibility to free services. While inpatient charges in public hospitals have been abolished, limited capacity hinders the accessibility of free hospital care, as backlogs accumulated throughout the pandemic aggravated already extensive waiting lists. To address the inequalities arising from the tiered design of its healthcare system, Ireland is implementing various measures to alleviate waiting lists in public hospitals and a new public-only consultant contract.
- The burden of mental ill health in Ireland is high, with over 1 million individuals estimated to have a mental health disorder in 2019. Ireland's Strategy to Reduce Suicide has contributed to declining suicide rates over the past decade. In recent years, the surge in demand for mental health services has led to prolonged waiting times for specialist mental healthcare – particularly for adolescent services. To address this challenge, Ireland revised its strategy to strengthen mental healthcare services, and allocated a record budget of EUR 1.2 billion to mental health services in 2023.



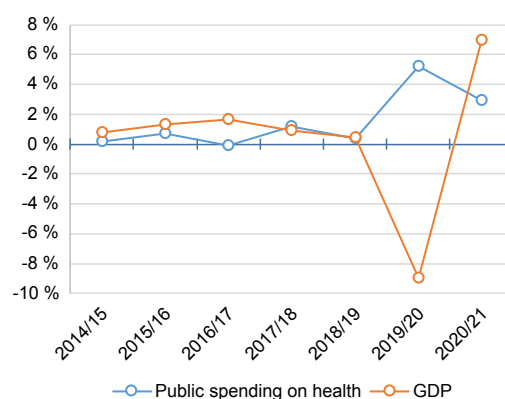
# I ITALY

- In 2022, Italy's life expectancy at birth was the third highest in the EU, at 83.0 years. This figure marked a partial recovery from a significant decline in 2020, although it remained over 6 months below its pre-pandemic level. While COVID-19 accounted for more than 10 % of all deaths in Italy in 2020, circulatory diseases and cancer remained the primary causes of death, and were responsible for more than half of total fatalities. After peaking in 2020, excess mortality remained stable at approximately 10 % above its pre-pandemic baseline, with a slight increase in 2022, despite a sizeable decline in the number of confirmed COVID-19 deaths.
- Approximately one third of all deaths in Italy can be attributed to behavioural risk factors. While the adult smoking rate saw a gradual but steady decline in the decade leading up to the pandemic, between 2019 and 2022 it rose by over 1 percentage point. While obesity rates remain comparatively low, the high prevalence of physical inactivity among both adults and children compounds risks of increasing its prevalence in the future. On a positive note, alcohol consumption and regular heavy drinking rates among Italians are significantly less prevalent than in most other EU countries.
- Italy's health expenditure, both as a share of GDP and per capita, is lower than the EU average – primarily due to comparatively low government spending. Between 2019 and 2021, health expenditure per capita increased by nearly 7 %, driven entirely by increased public spending to tackle the COVID-19 emergency. Despite this rise in publicly financed expenditure, Italy's share of health spending financed out of pocket, which is largely driven by direct payments for outpatient specialist care and pharmaceuticals, remains significantly above the EU average.
- Despite the severe mortality impact from the pandemic, in 2020 Italy reported one the lowest mortality rates from preventable causes in the EU. Additionally, Italy boasts relatively low rates of avoidable hospital admissions, indicating successful management of chronic conditions in outpatient settings, although noteworthy variations exist among regions. As in most other countries, COVID-19 restrictions in 2020 led to a severe decline in cancer screening rates and a subsequent accumulation of a backlog of diagnostic procedures.
- In 2021, Italy had an average density of doctors and a below-average density of nurses compared to the EU averages. Although Italy's doctor-to-population ratio has increased in recent years, several regions

experience shortages – particularly of general practitioners. Italy's doctor population is among the oldest in the EU, and there are concerns that the current health workforce training pipeline may struggle to compensate for the expected retirement-related attrition. In response, the government has taken decisive action to address past shortcomings in workforce development – including through its Recovery and Resilience Plan.

- In 2021, reported unmet needs for healthcare in Italy were low, and in line with the pre-pandemic period, with cost being their main determinant. Citizens are entitled to a comprehensive array of services, but public coverage for outpatient specialist care – including dental care – is comparatively low. While modest copayments are applied to a wide range of healthcare goods and services, the vast majority of out-of-pocket expenditure consists of direct payments for over-the-counter drugs and outpatient specialist consultations.
- The burden of mental ill health in Italy is comparable to the EU average, with approximately one in every six people estimated to have had a mental health disorder in 2019. While a significantly larger proportion of Italian women reported suffering from depression, income-related disparities in depression prevalence among Italians are the smallest across the EU. Mental healthcare is organised locally by mental health departments, which coordinate delivery of services across a tiered structure comprising primary care, outpatient and inpatient mental healthcare. As in other countries, suicide is more prevalent among men, but Italy's suicide rate remains consistently among the lowest in the EU.

Public spending on health and GDP trends





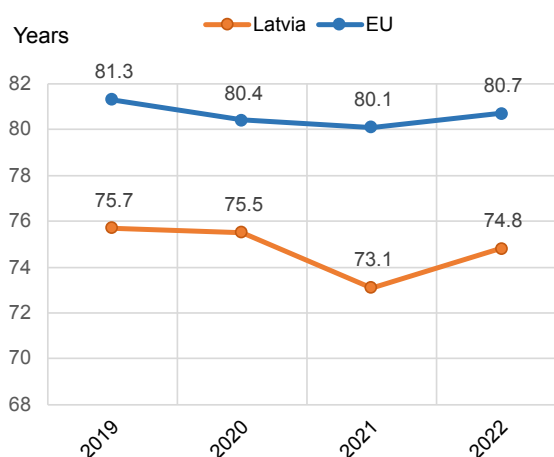
# I LATVIA

- At 74.8 years, life expectancy at birth in Latvia in 2022 was 6 years below the EU average, but this masks a very wide gender gap: life expectancy for men was only 69.8 years in 2022, which is nearly 10 years less than for women (79.6 years). During the three-year period of the pandemic, there was a drop in life expectancy in Latvia of 0.9 years, and despite gains in 2022, it has not yet reached pre-pandemic levels. Only half of the Latvian population reports being in good health.
- Smoking and alcohol consumption are important contributors to ill health in Latvia, especially among men. Although the smoking rate among adults fell to 23 % in 2019, this is still much higher than the EU average (19 %). Obesity is also much more prevalent in Latvia than across the EU. In contrast, overall heavy drinking among Latvians is much lower than the EU average, but this masks considerable differences in consumption by gender, with 6.5 % of women but 24 % of men reporting heavy drinking. In recent years, a wide range of health promotion activities have been put in place to raise awareness and encourage behaviour change.
- Latvia has a tax-based national health service. The state is the main purchaser of health services from a mix of public and private providers. Health spending per capita has more than doubled in Latvia in the past decade, although it remains among the lowest in the EU. During the COVID-19 pandemic, additional resources were allocated to the health system, and these were instrumental in supporting the country's pandemic response.
- Out-of-pocket spending on healthcare is high in Latvia, particularly for outpatient pharmaceuticals, and 5.4 % of Latvians reported unmet needs for medical care in 2022. Access to healthcare is also hampered by annual treatment quotas and low service tariffs, which result in long waiting times and lead many patients to pay for private healthcare. Some mechanisms are in place to protect people from catastrophic spending or underutilisation of required services, but socioeconomic inequalities in access to healthcare persist.
- Between 2011 and 2019 there was a decrease in mortality from both preventable and treatable causes. Nevertheless, the treatable mortality rate in Latvia was more than double the EU average in 2020, driven by high rates of mortality from ischaemic heart disease and stroke. There was no

significant reduction in mortality rates within 30 days of hospital admission for heart attack and stroke between 2011 and 2021, and they remain high.

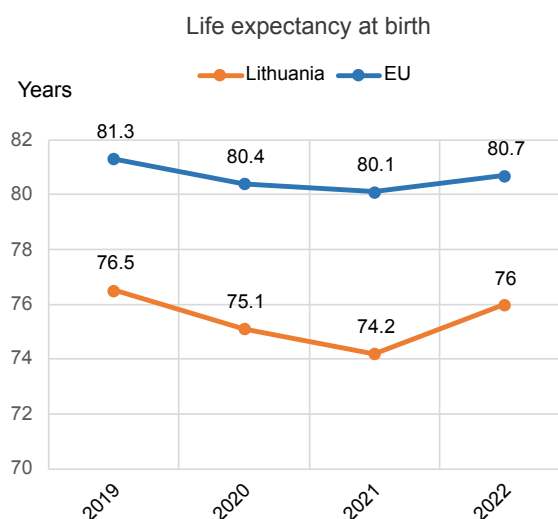
- Health workforce shortages also contribute to waiting times for elective care and geographical inequalities in access to medical care. Latvia has implemented a range of retention policies in recent years to improve availability of services, particularly in rural areas. These included significant pay rises between 2018 and 2021 and other financial incentives. A new initiative to standardise remuneration procedures and improve both pay and working conditions for medical professionals is under development.
- The COVID-19 pandemic has highlighted the need for major investment in the Latvian health system to strengthen its resilience. Some 10 % of the total budget of EUR 1.8 billion for Latvia's Recovery and Resilience Plan is for investments and reforms in the health sector, with a particular focus on upgrading hospital and outpatient infrastructure. Advancing digitisation of the health system and increasing the uptake of digital solutions to ensure access to care are also key components of a new Digital Health Strategy (2023-29).
- Latvia has one of the highest male suicide rates in the EU, and undiagnosed depression among men is an important public health issue. Mental healthcare was made a major priority area in health policy. A new Plan for the Improvement of the Organisation of Mental Health Care 2023-25 was recently approved, focusing on development of outpatient and community-based mental health services, provided the necessary funding can be found.

Life expectancy at birth



# I LITHUANIA

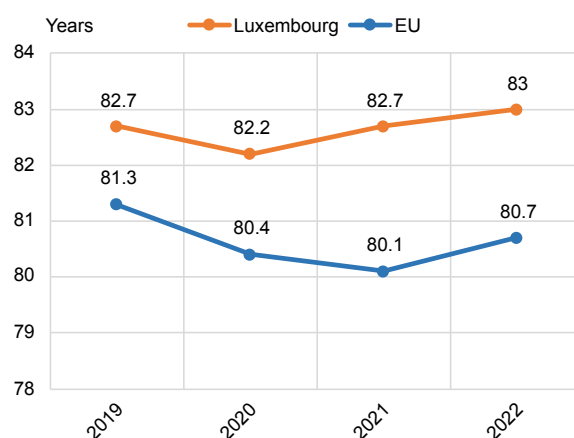
- Population health has been affected very negatively by the pandemic, with a substantial drop in life expectancy due to COVID-19, while the pre-existing very high burden of cardiovascular disease persists. Average life expectancy at birth fell to 74.2 years in 2021 before recovering to 76 years in 2022, which is almost 5 years below the EU average.
- High rates of alcohol and tobacco consumption among men contribute to higher mortality rates and lower life expectancy. Despite a drop in overall levels of smoking among adolescents, the increasingly common use of electronic cigarettes and vapes among children is a growing concern, and there have been calls for better regulation and action to tackle the easy accessibility of vaping products for children.
- Public spending on health increased to 5.4 % of GDP in 2021, reflecting not only investment in the COVID-19 response but also a consistent increase in public funding for health. At the same time, out-of-pocket spending remained very high, mostly driven by household payments for medicines and dental care. In response, there has been a significant expansion in coverage of outpatient prescription medicines for the treatment of certain conditions, including cancer and cardiovascular diseases.
- A major restructuring was initiated in 2022 that aims to create a new model of service provision in primary care and reorganise the hospital network, with a view to improving the quality and accessibility of services. For the reforms to achieve their goals, the key challenges relate to whether there is sufficient clarity about restructuring the hospital network, ensuring co-operation with stakeholders (particularly general practitioners) and overcoming longstanding health workforce issues.
- Projected shortages of healthcare workers – particularly of nurses, general practitioners and certain medical specialties – remain an engrained issue, along with uneven healthcare workforce distribution across regions. Some improvement in retention and planning was seen at the national level, but many municipalities and providers still lack planning mechanisms. Updated forecasts provide a better idea of future demand, but they do not account for sub-national differences or the additional expectations brought about by the current reform, which promises to improve accessibility.
- High levels of treatable and preventable mortality, avoidable hospitalisations and in-hospital mortality show persistent challenges to improving access and effectiveness of healthcare and public health services in Lithuania. The planned reform suggests that strengthening primary care and optimising specialist care is currently a key priority. Investing in improved service quality and accessibility through the Recovery and Resilience Plan and EU Cohesion Policy should also contribute to improved efficiency of the health system, along with strengthening capacity for health technology assessment, aiming for more rational use of existing resources and continuing digitalisation.
- Health system resilience has been tested during the pandemic, with capacity to care for COVID-19 patients stretched at peak times, while planned services and preventive programmes had to be postponed. By 2022, full service utilisation had not yet been restored to pre-pandemic levels across specialties. Some evaluations seeking to learn lessons from the pandemic have been carried out. Ensuring preparedness for future shocks remains a priority, and the 2022 EU Regulation on serious cross-border threats to health can serve as an impetus for stronger emergency preparedness.
- The government has expanded mental health services at the primary care level and provided additional funding to mitigate the impact of the pandemic. The suicide rate has been falling steadily over the past decade, and did not increase during the pandemic, although it remains very high – especially for men.



# LUXEMBOURG

- Life expectancy in Luxembourg remains among the highest in the EU. It rebounded from a temporary decline in 2020 to reach 83.0 years in 2022.
- Over one third of all deaths in Luxembourg in 2019 could be attributed to behavioural risk factors, including smoking tobacco, dietary risks, alcohol consumption and low physical activity. Smoking, being overweight or obese, and heavy drinking have a negative impact on life expectancy. Heavy drinking rates in Luxembourg remain among the highest in the EU, and continue to be a major public health challenge.
- The share of public spending on health in Luxembourg is the second highest in the EU, accounting for 86.0 % compared to the EU average of 81.1 %. Health spending per capita is also among the highest in the EU, although it represents a relatively small share of Luxembourg's GDP (5.7 %). Out-of-pocket spending is the equal lowest in the EU (along with France), at 9 %, and is considerably below the EU average (15 %).
- These health financing statistics indicate not only Luxembourg's strong overall economic performance but also the very broad coverage of the social health insurance scheme in terms of benefits and costs. Consequently, unmet needs for medical and dental treatments are among the lowest in Europe, and continue to decrease. Only 0.5 % of the population reported unmet needs for medical care due to costs, distance to travel or waiting times in 2022, which is far below the EU average of 2.2 %.
- Luxembourg continues to have low rates of preventable mortality, highlighting the effectiveness of concentrated public health campaigns. Cancer remains the leading cause of premature death. Colorectal and breast cancers are the most common treatable causes of mortality, while lung cancer is the most common preventable type of cancer.
- Public spending on health has increased continuously in the last few years, and saw a spike during the pandemic. Only a small portion of Luxembourg's total investment in its Recovery and Resilience Plan is dedicated to the healthcare sector, but the investment flows that are included seek to implement a national digitalisation strategy in the health system, target telemedicine solutions for remote medical follow-up of patients and establish a Digital Registry of Health Professionals.
- Waiting times for medical care are a reason for concern in Luxembourg – especially for specialist care, diagnostic tests, hospital emergency departments and cancer care. Patient triage and care pathways in emergency departments, as well as decentralisation of diagnostic services around four hospital centres, aim to reduce waiting times.
- Luxembourg continues to rely strongly on foreign health professionals, adding to the country's capacity constraints. With the creation of new education and training programmes, the government aims to attract more citizens to the medical and nursing professions, and to increase the domestic supply of health and care personnel.
- The COVID-19 pandemic had a significant impact on the mental health of the population, particularly among younger people: 33 % of children aged 6-11 and 43 % of children aged 12-16 reported that their satisfaction with life had decreased. Anxiety, depression, and alcohol and drug-use disorders make up the bulk of Luxembourg's mental health burden; they also disproportionately affect those in lower income groups. Unmet needs for mental healthcare are below the EU average but represent one fifth of all unmet needs for healthcare. The new National Mental Health Plan, which was delayed by the pandemic, was launched in July 2023.

Life expectancy at birth



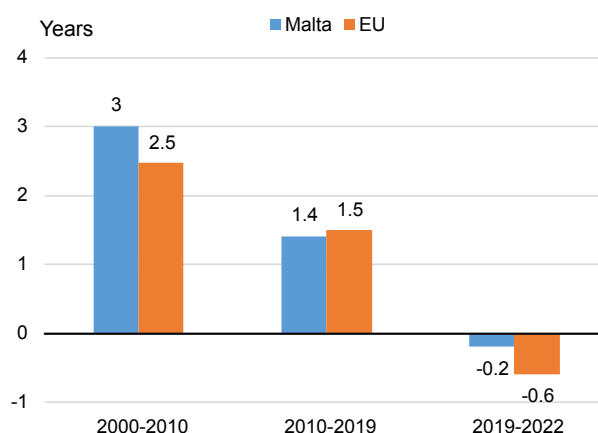
# I MALTA

- Life expectancy in Malta increased rapidly in the decade preceding COVID-19, reaching 82.9 years in 2019. However, during the first year of the pandemic, it fell by more than half a year due to the high number of deaths, to rebound only slightly in both 2021 and 2022. At 82.7 years in 2022, life expectancy in Malta was still the fourth highest in the EU. Circulatory diseases and cancer were the leading causes of deaths in Malta in 2020. A National Cancer Plan 2017-22 was rolled out to improve prevention, care coordination and access to cancer care.
- More than one in four adults in Malta were obese in 2019, and nearly one in three adolescents were obese in 2022. These rates are the highest in the EU and have continued to increase in recent years. Key risk factors are low physical activity and poor nutrition. To counteract the high prevalence of cardiovascular diseases and diabetes, the government has been implementing a mixture of legislative, policy and regulatory approaches, including expansion of primary care and remote monitoring services as part of its new National Health Systems Strategy for 2023-30, as well as targeted initiatives in schools.
- The Maltese national health service is financed through general taxation and offers universal access to a comprehensive benefits package. Health spending in Malta has grown over the last decade. However, despite further increases in response to the COVID-19 pandemic, the share of public spending on total health expenditure (67 %) remains low compared to other tax-based systems. Since the private sector plays an important role in complementing service provision, out-of-pocket spending on health is relatively high (30 %).
- Cancer screening programmes are receiving focused attention as part of broader measures to improve prevention. Following implementation of two National Cancer Plans, upcoming initiatives plan to expand the services available within the national health service, including genetic services and home-based treatment options.
- Broad population coverage has translated into a track record of low unmet needs for healthcare in Malta, with few differences observed across income groups. Similarly, reported levels of unmet needs for dental care were among the lowest in the EU in 2022, both on average and by income level. Despite good population coverage, however, Malta is experiencing population ageing and increasing immigration –

trends that may cause a shift in population demands for healthcare, and call for an expansion of health system capacity.

- Malta's Recovery and Resilience Plan dedicates one fifth of its total funding to healthcare investment, focusing on building and improving digital health tools and capacity, and on infrastructural improvements. These investments are complemented by the EU Cohesion Policy, which also channels funding into health equipment, health infrastructure and e-health services and applications. A dedicated Health Workforce Strategy and a new Digital Health Strategic Roadmap focus on priority areas to build health system resilience.
- Mental health services have undergone significant improvements in Malta in recent years. Network community services for outpatient care, including home-based care, have been expanded, providing more opportunities for management of patients outside hospitals and at the community level. Nevertheless, the COVID-19 pandemic has taken a toll on mental health. One fifth of unmet healthcare needs reported in Malta during the pandemic were for mental healthcare. Adequately capturing and meeting the mental health needs of migrant and refugee populations also remains an important issue.

Changes in life expectancy at birth



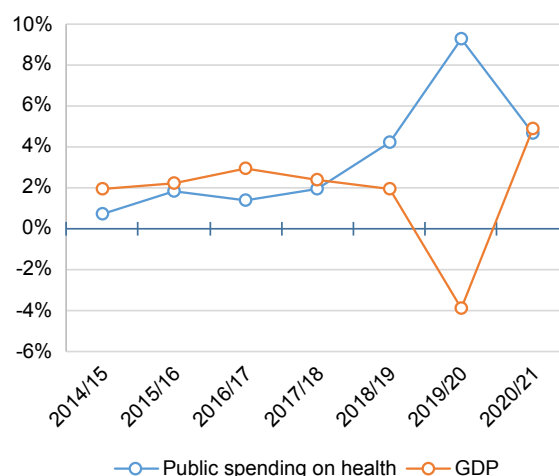
# I NETHERLANDS

- In 2022, life expectancy at birth in the Netherlands stood one year above the EU average at 81.7 years, reflecting gains in line with the EU average in two decades preceding the COVID-19 pandemic and a slightly below-average decline throughout the pandemic years. Cancers and diseases of the circulatory system were the most common causes of death in 2021, collectively accounting nearly half of all deaths, while COVID-19 was responsible for over one in every ten fatalities. Between 2020 and 2022, excess mortality in the country stabilised around 13 % above pre-pandemic levels, declining only marginally following its peak in 2020.
- Prevalence of behavioural risk factors was linked to more than a third of all deaths in the Netherlands in 2019 – a share slightly below the EU average. In recent years, new tobacco control measures led to reduced smoking rates in the country, which now stand below the EU average. While alcohol consumption declined over the past two decades and is lower than in most other EU countries, heavy drinking remains prevalent, with almost 20 % of Dutch adults reporting regular heavy consumption in 2019.
- Between 2019 and 2021, health spending in the Netherlands rose by over 12 % in real terms, in large part due to increased spending from government and social health insurance required to address the COVID-19 crisis. In 2021, health expenditure constituted 11.3 % of GDP – slightly above the EU average – but in per capita terms it was the third highest in the EU after Germany and Austria. Nearly 28 % of health spending was allocated to long-term care, which exceeded the EU average both in per capita terms and as a share of total health spending. Private sources contributed to 15 % of total health spending, which is below the EU average of 19 %.
- In 2021, the Netherlands had a slightly lower density of doctors compared to the EU average, while the density of nurses was higher. Although the share of doctors working as general practitioners is slightly above the EU average, the Dutch healthcare system faces a shortage of general practitioners, which is projected to intensify in the coming years. Shortages of nurses in hospitals also emerged during the pandemic, which saw a concomitant rise in the number of nurses opting for self-employment as a

means to obtain better working conditions.

- The Netherlands outperformed most EU countries in averting mortality from generally preventable and treatable causes in 2020, with mortality rates 21 % and 36 % below their respective EU averages. The pandemic adversely impacted cancer screening programmes in the Netherlands, yet its impact was comparatively limited. Following a decline in new cancer diagnoses in 2020, screening activity rebounded in 2021 and 2022, with observed incidence rates suggesting a substantial clearance of the diagnostic backlog accumulated in 2020.
- The prevalence of mental health disorders in the Netherlands is higher than the EU average, with an estimated 18 % of the population affected in 2019. Depression rates were higher among Dutch women, whereas men were more than twice as likely to die by suicide than women. Suicide remains a public health concern in the Netherlands, constituting over 1 % of deaths in 2021 and rising slightly over the past decade in contrast with the EU trend. As demand for specialist mental health services increased in the aftermath of the pandemic, an insufficient supply of mental health professionals resulted in waiting times that consistently surpass the established threshold for a large share of patients. In 2021, the Dutch government rolled out an action plan to alleviate waiting lists for specialist mental healthcare through an intra-regional mechanism of patient transfers.

Public spending on health and GDP trends

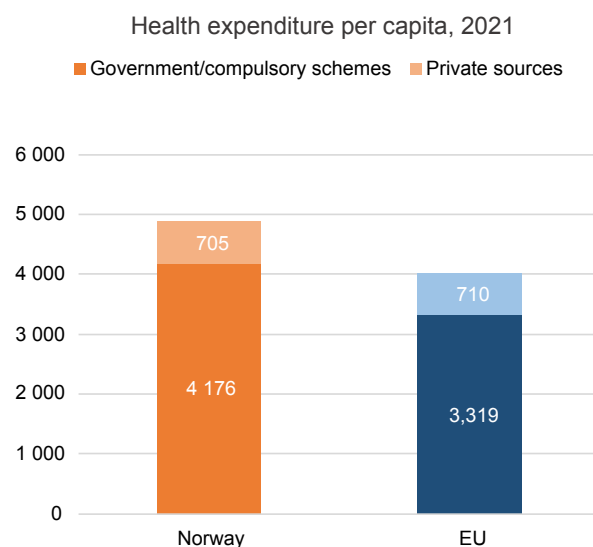


# I NORWAY

- In 2022, Norway's life expectancy at birth stood at 82.6 years – nearly 2 years above the EU average. While it remained above its pre-pandemic level during the first two years of the pandemic, life expectancy fell by half a year in 2022, largely due to a significant increase in COVID-19 deaths. In 2020, the leading causes of mortality were cancer and circulatory diseases, which accounted for more than half of all fatalities.
- About a third of all deaths in Norway in 2019 were linked to behavioural risk factors – a proportion below the EU average. While adult obesity rates are low compared to the EU average, adolescent overweight and obesity rates have been rising toward levels close to the EU average. Smoking prevalence is also among Europe's lowest, and snus is the predominant tobacco consumption mode, which is especially popular among young adults. Due to strict sales and advertising policies and high excise duties, per capita alcohol consumption is nearly one quarter below the EU average.
- Norway's health expenditure ranks among the highest in Europe on a per capita basis, although it is below the EU average when measured as a share of GDP. Government funding accounts for 86 % of health spending – a high share compared to other European countries. Norway allocates a large proportion of its health budget to long-term care, while expenditure on outpatient pharmaceuticals is comparatively low both in per capita terms and as a proportion of total spending. Health expenditure per capita grew by 4.3 % in real terms between 2019 and 2021 – a relatively modest increase, which was primarily driven by government spending in 2021.
- Norway's healthcare system offers universal access to a comprehensive benefits package. While public coverage is among the highest in Europe, the proportion of expenditure financed out of pocket is in line with the EU average, owing to the near-absence of private health insurance. Unmet medical care needs are low across all income groups, and are predominantly related to waiting times. However, unmet dental care needs are high and exhibit relatively wider income-based disparities.
- Owing to a comparatively low disease burden and high quality of acute care, Norway has one of the lowest death rates from potentially treatable causes in Europe. Cancer screening programmes faced challenges in 2020, with breast cancer diagnoses falling by 9 % from the previous year. However, diagnostic backlogs were swiftly resolved, and the

breast cancer screening rate exceeded its pre-pandemic level in 2022. Furthermore, in late 2022, Norway initiated a population-based screening program for colorectal cancer.

- While Norway boasts among the highest numbers of doctors and nurses per capita in Europe, in recent years both hospitals and municipalities have begun experiencing staffing difficulties, with low numbers of nurses and GPs in various regions. Norway trains fewer medical graduates annually than the EU average, but produces a much higher number of nursing graduates. Recognising the importance of maintaining an adequate supply of skilled health professionals amid an ageing population, Norway is developing a long-term health workforce development strategy.
- The prevalence of mental health disorders in Norway is slightly above the EU average, with an estimated 17.6 % of the population affected in 2019. These disorders imposed a significant financial burden on the healthcare system, accounting for as much as 20 % of total healthcare expenditure that year. Depression rates are higher among Norwegian women, and depression is more prevalent among individuals on lower incomes. Suicide remains a public health concern, constituting over 1.6 % of deaths in 2021. Despite the absence of a discernible impact of the pandemic on the mental health of Norwegians or demand for mental health services, Norway implemented various measures aimed at reinforcing mental health promotion and prevention efforts in the last two years.

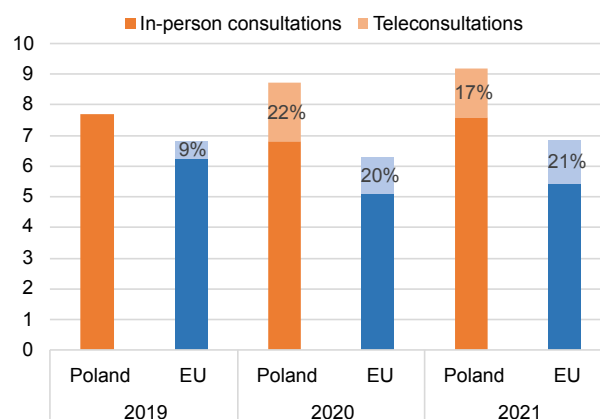




# I POLAND

- The COVID-19 pandemic had a greater impact on mortality in Poland than in most other EU countries, with life expectancy at birth falling by 2.5 years in 2020-21. However, the trend was reversed and life expectancy improved, returning to 77.4 years in 2022. Excess deaths surpassed COVID-19 deaths reported in 2020 and 2021, which may be an indication of underreporting of COVID-19 deaths or of other challenges, such as delayed access to healthcare services during the pandemic.
- Behavioural and environmental risk factors account for a significant number of deaths, and tobacco smoking and poor diet are major contributors to mortality in Poland. Relatively high use of e-cigarettes and increasing rates of overweight and obesity among young people are public health concerns.
- About 72 % of total health spending comes from public sources, with the rest paid privately by households – primarily in the form of out-of-pocket spending, with nearly two thirds of this spent on medicines. Overall, health spending remains skewed towards inpatient rather than outpatient care, and the shares of funding allocated to long-term care and prevention are relatively low. Funding trends have reinforced the weakness of primary care, which remains underdeveloped. Total spending on health remains very low in Poland compared to other countries.
- The key challenge facing the health system is the shortage of health workers. Poland has among the lowest numbers of doctors and nurses per capita in Europe, and the numbers of medical and nursing graduates have been persistently low. However, increasing wages for health workers has challenged the financial viability of some community hospitals. Increases in the pricing of hospital services in 2023 should alleviate some of this pressure.
- Preventable and treatable mortality rates reveal weaknesses in the health system's ability to prevent disease and treat patients. Preventable mortality has been persistently higher than the EU average, and progress in reducing mortality from treatable causes has stagnated or regressed since 2014. Immunisation and screening data are incomplete, but rates appear to have worsened in some areas. Avoidable hospital admissions for some of the most common chronic conditions are among the highest in Europe, indicating shortcomings in the provision of outpatient care.
- Poland has been the largest recipient of Ukrainian refugees since the Russian invasion of Ukraine in February 2022. Special coverage provisions have been implemented to extend social health insurance coverage to 1.4-2 million Ukrainian refugees, but this puts pressure on the health system's resources.
- Overall, public spending on health has increased over the last decade, and will be supplemented by substantial investment in the health sector earmarked in the national Recovery and Resilience Plan and the EU Cohesion Policy. These will focus on reforming the hospital sector, developing digital health and strengthening the health workforce. There are also plans to strengthen capacity to monitor and detect potential epidemiological threats, but other threats – such as rising antibiotic consumption – may need further attention.
- Prevalence of mental health problems in Poland is among the lowest in the EU, but this may be an underestimate of the true burden due to a lower level of mental illness awareness, higher mental health stigma and worse access to mental health services. Provision remains heavily reliant on psychiatric hospitals, but efforts are being made to shift mental healthcare to the community and reduce stigma. A new draft Mental Health Protection Programme for 2023-30 is currently under public consultation.

Number of doctor consultations per capita





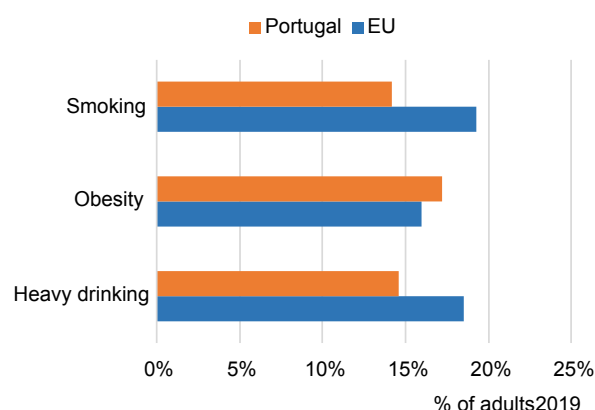
# I PORTUGAL

- In 2022, life expectancy at birth in Portugal exceeded the EU average by one year, reflecting major advances in the two decades preceding the COVID-19 pandemic and a near-full recovery from the nearly 10-month decline during the pandemic's first year. Circulatory diseases and cancer were the leading causes of mortality in 2020, accounting for half of all deaths. Excess mortality in Portugal remained relatively stable at approximately 12 % above its pre-pandemic baseline, declining marginally after peaking during the first year of the pandemic.
- In 2019, nearly one third of deaths in Portugal were linked to behavioural risk factors – a lower proportion than in most other EU countries. Although smoking rates have decreased in recent years, heavy drinking has become more common. Obesity is also a growing concern, with over 17 % of adults categorised as obese, and both adults and teenagers reporting among the lowest rates of regular physical activity in the EU.
- Portugal's health expenditure amounted to 11.1 % of GDP in 2021 – a share in line with the EU average, but over one third lower than the EU average in per capita terms. Between 2019 and 2021, health spending increased by 14 % in real terms, driven by a 18.5 % rise in public spending to respond to the COVID-19 emergency and alleviate care backlogs. Despite this increase, private health spending accounted for over one third of Portugal's total health expenditure – a share nearly double the EU average.
- In 2021, Portugal allocated 44 % of its overall health expenditure to outpatient care – the largest share among EU countries and also surpassing the EU average in per capita terms. A comparatively low share of expenditure was publicly funded, but the recent abolition of user charges in the National Health Service is expected to reduce this gap. Conversely, Portugal dedicated only 5 % of its health budget to long-term care, highlighting the country's reliance on informal care arrangements for its provision.
- The Portuguese National Health Service is encountering challenges in retaining general practitioners and nurses, as relatively low pay and stressful working conditions impinge on the attractiveness of working in the public sector. While the government has taken steps to improve nurse retention, insufficient efforts to address the shortfall of general practitioners in the face of significant

attrition have resulted in decreased coverage, as the number of registered users decreased by over 0.5 million between January 2020 and 2023. The extent of accessibility challenges arising from insufficient staffing varies across services and regions, with southern regions typically experiencing more severe difficulties. Against this backdrop, the government has set up measures to incentivise young doctors to establish their practices in underserved areas.

- Portugal outperforms most EU Member States in preventing hospitalisations due to ambulatory care-sensitive conditions, reflecting the Portuguese health system's emphasis on outpatient medical care. Alongside initiatives to expand its primary care network, Portugal is taking measures to tackle the backlog in cancer screening and surgery caused by COVID-19 restrictions, and to improve efficiency and integration of health services at all levels.
- The prevalence of mental health disorders in Portugal is among the highest in the EU, with an estimated 22 % of the population affected in 2019. Portuguese women report higher rates of depression than men, while men are nearly four times more likely to die by suicide. Although suicide rates are lower than the EU average and have fallen by over 10 % in the past decade, it remains a public health concern – particularly in the southern regions. Specialist services face constraints due to staff shortages and a lack of standardised referral criteria, leading to long waiting lists. Portugal's National Mental Health Plan is expected to improve the availability of mental health services and to mitigate regional disparities in supply in the coming years.

Prevalence of behavioural risk factors

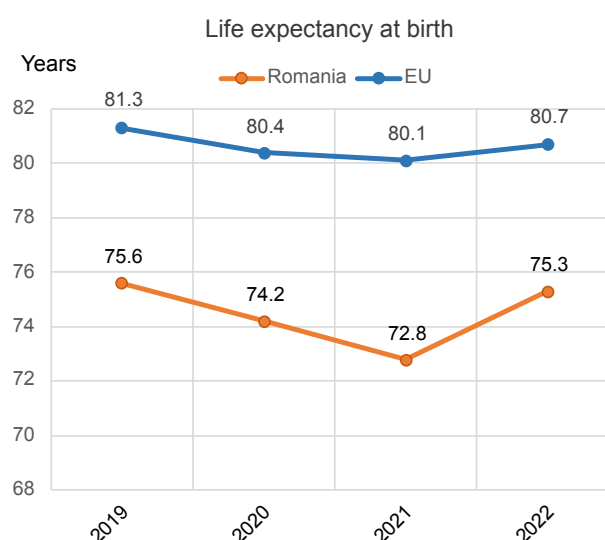


# I ROMANIA

- Average life expectancy at birth in Romania was 75.3 years in 2022, having dropped by nearly 3 years – to 72.8 years – between 2019 and 2021 due to the impact of the COVID-19 pandemic, before recovering. COVID-19 was the second leading cause of preventable mortality in Romania, and vaccination coverage rates in the country are low.
- In 2022, Romanians reported high levels of self-perceived health as very good or good (73.3 %), which is higher than the EU average (68.0 %). The positive assessment of self-perceived health is high for both men and women, and across income groups.
- There is great scope for public health work to mitigate behavioural and environmental risk factors in Romania. While adult obesity rates are the lowest in the EU, poor diet, tobacco smoking and alcohol consumption are major contributors to mortality. In 2022, life expectancy at birth was 71.5 years for men and 79.3 years for women. This gender gap is largely explained by differences in tobacco and alcohol consumption patterns. In 2019, 30.6 % of Romanian men smoked daily and 53.1 % reported heavy drinking; among Romanian women, 7.5 % smoked daily and 18.0 % reported heavy drinking.
- In 2022, 4.9 % of Romanians reported having unmet medical care needs due to costs, distance to travel or waiting times (over double the EU average of 2.2 %) with three quarters of these citing cost as the main factor. Out-of-pocket spending on health accounted for 21 % of current health expenditure in 2021, which is higher than the EU average of 15 %. The main driver of out-of-pocket spending is outpatient pharmaceuticals, but dental care costs are also significant. Resource constraints also limit access to medical care – particularly health workforce shortages. Romania trains large numbers of doctors and nurses – well above the EU average – but many choose to practise abroad.
- The Romanian health system is hospital-centric, with high bed capacity. Patients seeking timely care often bypass primary care facilities and go directly to hospitals. As a result, nearly half of all health financing in Romania goes towards inpatient care. Bypassing primary care is partly the result of patient preference but also due to the limited availability of GPs, particularly in rural areas. The weakness of primary care has serious implications for reducing avoidable mortality rates, which are the highest in the EU.
- Per capita spending on health in Romania was the lowest in the EU in 2021. The social health

insurance system that finances healthcare offers a comprehensive benefits package. Compared to other EU countries, coverage is less generous around outpatient pharmaceuticals and dental care. Despite coverage being compulsory, about 12 % of the population is uninsured. Uninsured people include those working and living abroad, those working informally, unemployed people who are not registered for social welfare and those lacking personal identification cards (an issue more prominent among marginalised groups, such as Roma citizens).

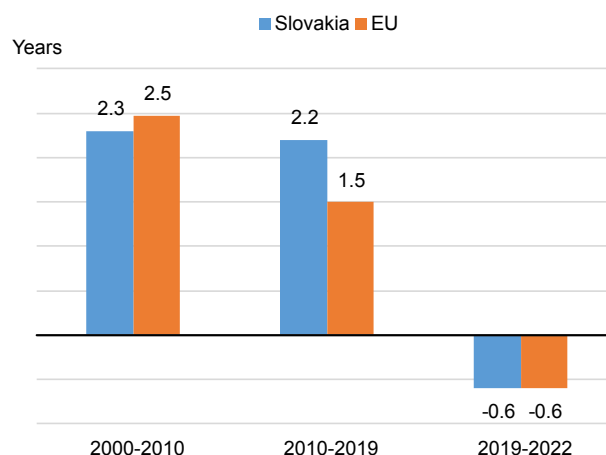
- Romania is using a large share of funds made available through the EU's Recovery and Resilience Plan as well as EU Cohesion Policy to focus on modernising its hospital infrastructure. The aim is to ensure patient safety and reduce care-related infections, and further investment are planned for digitalisation in healthcare and to improve the accessibility, effectiveness and resilience of the health systems.
- Prevalence of mental illness and levels of unmet needs for mental healthcare are formally low in Romania compared to EU levels. However, these findings should be interpreted with caution, as mental ill health-related stigma may disguise the true level of need. Current provision of mental healthcare remains hospital-centric, but ongoing planning aims to develop mental health service provision in the community and to improve access to care.



# I SLOVAKIA

- Life expectancy in Slovakia grew more rapidly than the EU average in the decade before the pandemic but it fell by more than half a year between 2019 and 2022. Cardiovascular diseases, COVID-19 and cancer were the leading causes of death in Slovakia in 2021.
- Nearly half of all deaths in Slovakia in 2019 could be attributed to behavioural risk factors. Dietary risks and tobacco smoking are the two main risk factors contributing to mortality. High smoking prevalence among adults and adolescents remains a public health concern, especially among those with lower education levels. The adult obesity rate is higher than the EU average, and poor nutrition and physical inactivity contribute to this growing risk factor.
- Health spending in Slovakia accounted for 7.8 % of GDP in 2021 – far below the EU average of 11.0 %. About 80 % of health spending is publicly financed, which is close to the EU average. Out-of-pocket spending accounted for 19 % of overall health expenditure, a higher share than the EU average of 15 %, as private health insurance plays a very minor role. Despite a protective cap, a large part of out-of-pocket spending is on pharmaceuticals.
- Slovakia provides a broad benefits package, but unmet medical care needs are slightly higher than the EU average – mainly due to waiting times, which disproportionately affect people in lower income groups.
- Mortality rates from preventable and treatable causes were among the highest in the EU in 2020. After a steady decline over the past decade, high COVID-19 mortality drove up the preventable mortality rate, and the treatable mortality rate was over 80 % higher than the EU average. While prevention and health promotion are on the policy agenda, investment remains low.
- The COVID-19 pandemic disrupted the introduction of cancer screening programmes and challenged provision of elective care. There was a sharp reduction in surgical interventions such as hip and knee replacements in 2020 and 2021, and no evidence shows any meaningful reduction in the backlog of patients waiting for elective surgery in 2021.
- The number of hospital beds in Slovakia is above the EU average, while the bed occupancy rate is relatively low, suggesting room for efficiency improvements. Investment in modernisation of hospitals is the main priority for health investment from the Recovery and Resilience Plan. A hospital network reform aims to reassess the need for acute care beds to improve efficiency and quality of care.
- The numbers of physicians and nurses per 1 000 population are lower in Slovakia than the EU averages, and shortages of health workers are a longstanding concern. The average age of general practitioners is 57, and 41 % are beyond the standard retirement age. The recent pay increase aimed to eliminate health workers' pay differentials with neighbouring countries, but it did not address other important aspects of difficult working conditions. Increasing the attractiveness of the nursing profession and staff retention are key to addressing current shortages.
- The limited access to innovative pharmaceuticals, especially for cancer treatment, was addressed by legislative changes in 2022, which led to a greater number of new pharmaceuticals being reimbursed. One of the consequences is increased pharmaceutical expenditure and additional pressure on public budgets.
- One in seven Slovaks had a mental health issue in 2019. Progress has been achieved over the past decade in reducing mortality rates from suicide, particularly among men. Accessibility of mental health services is limited, mainly due to insufficient numbers of trained specialised health workers, low levels of financing and stigma. To improve accessibility, funding has been prioritised to strengthen community services and outpatient care for mental health.

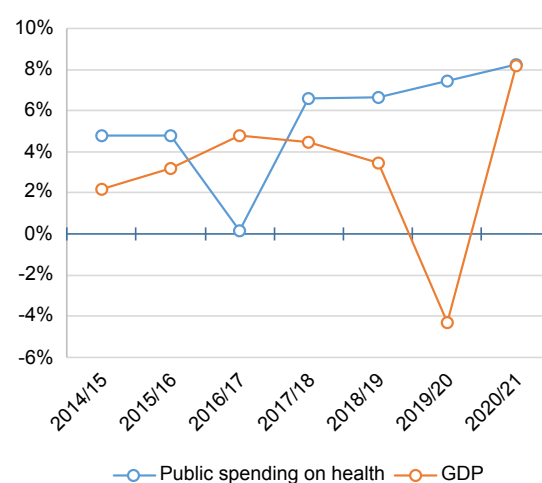
Changes in life expectancy at birth



# I SLOVENIA

- Life expectancy at birth in Slovenia rebounded to 81.3 years in 2022 after dropping by 1 year in 2020. While the main causes of death were circulatory diseases and cancer, COVID-19 had a significant impact on mortality rates, accounting for 14.4 % of deaths in 2020.
- Over one third of deaths in Slovenia are linked to behavioural and environmental risk factors, driven by poor diet and alcohol consumption. Additionally, obesity is becoming a major public health issue, with more than half of adults being overweight or obese; meanwhile, the rates for adolescents have been increasing steadily over the last two decades. In response, the government has developed a comprehensive and multi-sectoral National Nutrition and Physical Activity Strategy 2015-25 to improve the nutrition and exercise habits of the population and to tackle obesity. However, the COVID-19 pandemic may have hampered these efforts, especially for children aged 6-15.
- At EUR 2 665 per capita, Slovenia's health expenditure is about two thirds of the EU average. For the past 10 years, public spending on health has increased gradually. Slovenia's COVID-19 response increased public spending on health precipitously to reach 73.7 % of total health expenditure in 2021.
- Slovenia's social health insurance-based system provides near universal coverage via a single payer. Extensive utilisation of complementary health insurance, a generous public benefits package and strong financial protection measures contribute to low out-of-pocket expenditure and low health-related catastrophic spending. Catalysed by a steep rise in premiums, a reform of the Health Care and Health Insurance Act abolished complementary health insurance in July 2023; it will be replaced by a fixed compulsory contribution.
- Cancer is a top priority for Slovenia's health agenda. Successive structured national approaches, including screening programmes for breast, cervical and colorectal cancers, have improved detection since 2000. In 2021, the breast and colorectal cancer screening rates for target populations were above the EU averages; however, disparities by geography, age and income constrain further progress. The third National Cancer Control Programme aims to mitigate increasing cancer incidence, increase cancer survival rates and improve the quality of life of patients with cancer.
- Several persistent factors challenge access to care in Slovenia. Waiting times for secondary specialist care contribute to high self-reported unmet needs for medical care, and people in the lowest income quintile still report higher unmet needs than those in the highest. Recent reforms and investments to tackle this issue have not yet produced results. Meanwhile, workforce shortages – especially in primary healthcare settings – and uneven geographical distribution accentuate access issues. Following the pandemic, further reforms targeting primary healthcare and health workforce issues are under discussion.
- Funding under Slovenia's Recovery and Resilience Plan and EU Cohesion Policy will be invested in treatment of communicable diseases and digital transformation of healthcare. Other financing is dedicated to enhancing health system accessibility, effectiveness and resilience, as well as investing in health equipment.
- Anxiety, depression, and alcohol and drug-use disorders make up the bulk of Slovenia's mental health burden. Although Slovenia reports a lower prevalence of mental health disorders than the EU as a whole, there are wide gender and income disparities. During the COVID-19 pandemic, around one seventh of reported unmet healthcare needs were related to mental healthcare. Several measures, including the National Mental Health Programme 2018-28, aim to tackle unmet needs for mental healthcare and access inequalities by encouraging a shift from hospital-based to community-based and integrated care.

Public spending on health and GDP trends



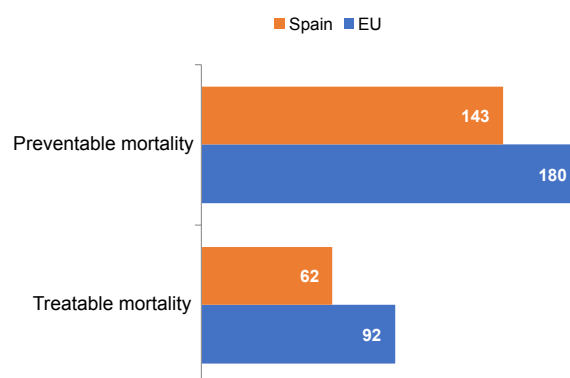
# I SPAIN

- Spain had the highest life expectancy in the EU in 2022, at 83.2 years, despite a temporary decline in 2020 during the first year of the COVID-19 pandemic. While Spaniards tend to live longer lives than many other Europeans, they are also more likely to report chronic conditions in older age. After peaking with COVID-19 in 2020, excess mortality declined in 2021, but it surged again in 2022 despite the sizeable year-on-year decline in the number of confirmed COVID-19 deaths.
- In 2021, Spain dedicated 10.7 % of GDP to health expenditure. While health spending per capita has been growing over the last decade, it is about one third below the EU average. Out-of-pocket spending – just over one fifth of total health spending – was above the EU average. Despite this, Spain has high financial protection, and guarantees universal health coverage with a comprehensive health benefits package. Public expenditure is the main source of health financing in Spain, but there also has been a steady increase in voluntary health insurance in recent years.
- Spain's rates of mortality from preventable and treatable causes are below the EU averages. The country's low rates of hospital admissions for congestive heart failure and diabetes relative to other EU countries can be linked in part to strengths in its primary care system. However, there are many areas where improvements to and increased investment in primary health can be made, and the sector is starting to implement reforms. One large issue to be addressed is the healthcare worker shortages given the difficulty of resourcing doctors and nurses in some rural areas and the persisting shortage of nurses overall.
- Unmet healthcare needs rose during the second year of the pandemic in Spain, although they remained at a very low level. However, the gap in unmet needs between the richest and the poorest population groups remains high for dental care. Public financing is low for dental care and therapeutic appliances, including optical care such as glasses. Although out-of-pocket spending in Spain remains relatively high, exemptions for a wide range of groups protect households from catastrophic spending.
- Spain's Recovery and Resilience Plan dedicates EUR 1.7 billion to health sector investment, focusing on boosting high-tech medical equipment in hospitals, improving health system preparedness, strengthening health promotion and digital transformation of healthcare. Dedicated strategies

such as the Primary and Community Care Action Plan 2022-23, the Public Health Strategy 2022 and the Digital Health Strategy 2021 reflect important lessons from the pandemic experience, and target key areas to build health system resilience.

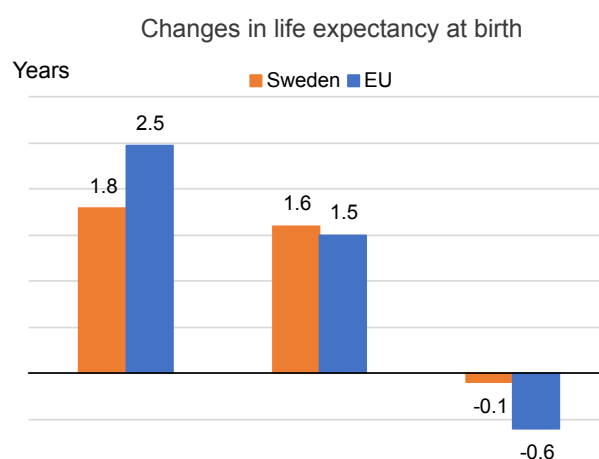
- Amidst health workforce pressures and shortages – particularly of nurses, general practitioners, paediatricians and specific medical specialists – the government has implemented measures to reduce temporary contracts and increase numbers of vacancies in medical specialisation and nurse training programmes. These measures aim to bolster longer-term workforce capacity and enhance access to services.
- The burden of self-reported mental health disorders in Spain is high, affecting 18 % of its population in 2019. Mental healthcare is provided by the National Health Service. The COVID-19 pandemic may have resulted in a substantial percentage of individuals reporting unmet needs for mental healthcare in Spain. An updated mental health strategy has been put in place to improve the mental health of the population. In particular, strategies have been implemented to support patients and families affected by suicidal behaviour. In addition, a medical specialty of child and adolescent psychiatry was created in 2021.

Preventable and treatable mortality rates



# I SWEDEN

- Life expectancy in Sweden is among the highest in the EU, reaching 83.1 years in 2022. Following a reduction of 0.8 years in 2020 due to deaths from COVID-19, it rebounded in 2021, and remained close to its pre-pandemic level in 2022. The gap in life expectancy by socioeconomic status is greater than the gap by gender. At age 30, women with higher levels of education could expect to live 6.8 years longer than those with lower levels in 2021, while the gap was 5.9 years among Swedish men.
- Sweden performs better than most other EU countries on many behavioural risk factors, except certain aspects of nutrition. As in other countries, overweight and obesity rates have increased among adolescents and adults, but they remain lower than the EU average.
- The COVID-19 pandemic resulted in disruption of hospital and other health services in Sweden, as in other EU countries. Large amounts of non-urgent hospital procedures were postponed during the first year of the pandemic, resulting in fewer hospital stays and surgical procedures in 2020. Hospital activity went up slightly in 2021, but still remained below pre-pandemic levels. The reductions in activity resulted in increased waiting times for interventions such as hip and knee replacements in 2020 and 2021. While waiting times for these surgical interventions started to decrease in 2022, they remained higher than before the pandemic.
- Use of teleconsultations increased sharply during the pandemic as a way to maintain access to care while reducing the risk of infections, and nearly half of Swedish adults reported having had at least one during the first year of the pandemic. Legislation passed in 2022 aims to integrate teleconsultations better into local health systems. However, there are concerns that some teleconsultations may offer low-value care and that they might increase inequality in access, as they are mainly used by people with higher education and income levels.
- In 2021, Sweden's health expenditure as a share of GDP reached 11.2 %, which is slightly higher than the EU average (11.0 %) and also higher than before the pandemic (10.8 % in 2019). This rise was mainly driven by increases in public spending on health during the pandemic. The public share of health spending in Sweden (86 %) was significantly higher than the EU average (81 %) in 2021.
- The number of hospital beds per 1 000 population in Sweden is the lowest in the EU, partly because most rehabilitation and long-term care beds are not located in hospitals. Recent evaluations indicate that the overall number of hospital beds is not sufficient. In response, the government asked the National Board of Health and Welfare to allocate SEK 2 billion (EUR 175 million) to the regions to increase the number of public beds in 2023. The Board is also working on a national plan to address hospital bed shortages.
- Shortcomings in the long-term care sector in Sweden garnered increased public and political attention during the pandemic. To address workforce shortages in long-term care, Sweden's Recovery and Resilience Plan has allocated a budget of EUR 452 million to upskill and train new staff.
- About one in six people (17%) had a mental health issue in Sweden in 2019, which is close to the EU average. The most common mental health issues are anxiety and depressive disorders. The mental healthcare system fosters a community-based approach. A new mental health strategy to address mental illness and promote suicide prevention is under development.





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