

Executive summary

The COVID-19 outbreak has spread in 2020 to become the most severe pandemic in the last one hundred years. The public health crisis has led to a major economic crisis, which will have serious consequences on individual and societal well-being both now and in the future. COVID-19 has exposed latent health system fragilities that existed before the outbreak. Despite much talk of health spending being an investment rather than a cost, policy approaches had not changed significantly before the crisis. Health spending overwhelmingly goes on curative care, not prevention.

The staggering impact of COVID-19 on our society and economy has abruptly brought public health back to the top of the policy agenda. COVID-19 mortality has a clear social gradient, which is a bleak reminder of the importance of the social determinants of health.

The COVID-19 pandemic has highlighted the need to consider the resilience of health systems as an equally important dimension of health system performance alongside accessibility, quality of care and efficiency.

The resilience of health systems to COVID-19

By the end of October 2020, over 7 million people were infected and 220 000 had died from COVID-19 across EU countries, Iceland, Norway, Switzerland and the United Kingdom. During the first wave of the pandemic, the virus particularly affected a number of Western European countries, notably Belgium, France, Italy, the Netherlands, Spain and the United Kingdom, as well as Sweden. However, since August 2020, the virus also started to spread more widely across Europe.

A few countries have managed to minimise the health and economic impacts of COVID-19

Providing an overall assessment of country responses to COVID-19 is difficult at this time, given that the pandemic is still very active across the world. European countries struggled to varying degrees to respond to the first wave of the pandemic in Spring 2020 and to the second wave in Autumn 2020. Many countries struggled during the initial months of the crisis to increase the availability of masks and other personal protective equipment. Most countries also struggled to scale-up their testing capacity, which limited the effectiveness of testing, tracking and tracing efforts. This left them with few options to contain the spread of the virus during the first wave, necessitating more stringent confinement measures.

Outside of Europe, Korea is a good example of a country that has managed to control the COVID-19 outbreak through quick, effective and targeted measures, thereby avoiding full lockdowns. New Zealand has been another successful example. In Europe, up until October 2020, a few countries like Finland, Norway and Estonia were better able to contain the spread of the virus and mitigate the economic consequences, in part because of geographic factors (lower population density) but also because of timely implementation of targeted containment measures, and strong trust and compliance by populations.

Older people have been disproportionately hit, with residents in long-term care facilities particularly at risk

The virus has disproportionately hit older people and those with underlying health conditions. In nearly all countries, at least 90% of COVID-19 deaths were amongst people aged 60 and over. In many countries, about half or more of COVID-19 deaths were amongst residents in long-term care (LTC) facilities. The initial response in many countries focused on protecting patients and workers in hospitals. It was only later that similar measures were taken to protect residents and workers in LTC facilities. In several countries, there was at least a two-month lag between the first reported COVID-19 cases and the issuance of guidelines to prevent infections in LTC institutions. In a quarter of countries for which information is available, it took two weeks longer to restrict visits in nursing homes than the restrictions imposed in public spaces. The first wave of the pandemic highlighted the crucial importance of protecting older people and other vulnerable populations from COVID-19 to reduce hospitalisations and deaths.

There has been a clear social gradient in COVID-19 deaths

Poor people, people living in deprived areas and ethnic minorities have also been disproportionately affected. This highlights the need for a strong focus on policies to tackle the social determinants of health, including inclusive social and economic policies and interventions beyond the health system that address the root causes of inequalities.

Addressing the health and welfare impact of air pollution

Between 168 000 and 346 000 premature deaths across EU countries can be attributed to air pollution from fine particles alone

While most of the attention in 2020 was on COVID-19, it is important not to neglect other important risk factors to health, including environmental factors like air pollution. Although air quality has improved in most European countries over the past two decades, pollution levels remain above the WHO guidelines in most countries, particularly in large cities. This has serious consequences for people's health and mortality. Across EU countries, an estimated 168 000 to 346 000 premature deaths can be attributed to exposure to air pollution from fine particles (PM_{2.5}) alone in 2018. The mortality of air pollution is particularly high in Central and Eastern Europe because of greater use of fossil fuels. Within each country, disadvantaged groups are disproportionately affected due to greater exposure to air pollution and greater susceptibility to serious health consequences.

Air pollution causes about EUR 600 billion in economic and welfare losses annually across EU countries, equivalent to 4.9% of EU GDP in 2017

The economic and welfare losses from air pollution are substantial. New estimates of the impact of PM_{2.5} and ozone show that losses amounted to about EUR 600 billion in 2017 or 4.9% of GDP across the EU as a whole. This is due mainly to the impact these air pollutants have on mortality, but also to the lower quality of life and labour productivity for people living with related diseases, and higher health expenditure.

Efforts to reduce air pollution need to focus on the main sources of emissions. These include the use of fossil fuels in energy production, transportation and the residential sector, as well as industrial and agricultural activities. The EU recovery plan from the COVID-19 crisis provides a unique opportunity to promote a green economic recovery by integrating environmental considerations in decision-making processes, thereby supporting the achievement of the 2030 EU national emission reduction targets.

The health sector itself can contribute to achieving this objective by minimising its own environmental footprint. Through multi-sectoral approaches, public health authorities can also contribute to

environmentally friendly urban and transport policies, which may also promote greater physical activity.

Reducing other important risk factors to health

Beyond environmental issues, a number of modifiable risk factors also have important impacts on people's health and mortality, notably smoking, alcohol consumption, unhealthy nutrition, lack of physical activity and obesity.

Smoking remains the most important cause of premature mortality across the EU, accounting for about 700 000 deaths per year

Despite progress in reducing smoking rates over the last decades, tobacco consumption remains the largest behavioural risk factor to health, accounting for about 700 000 deaths per year across EU countries.

Harmful consumption of alcohol is responsible for another 255 000 to 290 000 deaths per year across EU countries. While alcohol control policies have reduced overall alcohol consumption in many countries over the past decade, heavy alcohol consumption remains an issue. One-third of adults report at least one "binge drinking" event in the past month, and more than one-fifth of adolescents aged 15 years old report having been drunk more than once in their life.

More than one in six adults are obese across EU countries, and there are wide socio-economic disparities in overweight and obesity rates

Adult obesity rates continue to increase in most EU countries, with more than one in six adults being obese in the EU. Obesity is also a recognised risk factor for complications from COVID-19. There are large socio-economic inequalities in overweight and obesity rates, often starting at a young age. For example, overweight and obesity rates among children are about two times greater among those living in the lowest income families compared to those living in the highest income families.

Ensuring universal and effective access to care for all the population

Most EU countries have achieved universal coverage for a core set of health services, which is crucial to deal effectively with the COVID-19 pandemic. However, the range of services covered and the degree of cost-sharing vary substantially. Effective access to different types of care can also be restricted because of shortages of health workers, long waiting times or long travel distances to the closest health care facility.

Only a small share of the population reported unmet needs for health care in most EU countries in 2018. Still, this proportion was nearly five times higher among low-income households than high-income households across the EU as a whole. Further, the affordability of health services can be restricted when they involve high out-of-pocket payments. On average across EU countries, around one-fifth of all health spending is paid out-of-pocket by households, but this proportion exceeds more than one-third in Latvia, Bulgaria, Greece and Malta. In general, countries that have a high share of out-of-pocket spending also have a higher proportion of the population facing catastrophic out-of-pocket payments for health services, particularly among low-income groups.

The COVID-19 pandemic highlighted the shortages of health workers in many countries, and the need for mechanisms to mobilise human resources quickly in times of crisis

Although the number of doctors and nurses has increased over the past decade in nearly all EU countries, shortages persist in many countries. These shortages were thrown into sharp relief during the COVID-19 pandemic, when health workers were put under intense pressure. Many

countries have sought to mobilise additional staff quickly, often by recalling inactive and retired health professionals and mobilising students in medical, nursing and other health education programmes nearing the end of their studies. Some countries were also able to redeploy some of the staff from less affected regions to those that were more affected. This crisis also highlights the needs for creating additional reserve capacity that can be quickly mobilised.

Waiting times for elective surgery are likely to increase further following the COVID-19 pandemic

Long waiting times for health services like elective surgery have been a longstanding issue in many EU countries. Even before the COVID-19 pandemic, waiting times for elective surgery were on the rise in many countries, as the demand for surgery increased more rapidly than supply. These waiting times are likely to increase further in the short term in several countries as many elective surgeries were postponed during the pandemic. Countries like Denmark and Hungary that have succeeded in achieving lasting reductions in waiting times for many elective health services typically combine some supply-side and demand-side interventions along with a regular monitoring of progress.

Monitoring and improving the *State of Health in the EU*

Health at a Glance: Europe 2020 is the result of ongoing close collaboration between the OECD and the European Commission to improve country-specific and EU-wide knowledge on health issues as part of the Commission's *State of Health in the EU* cycle.

In 2016, the European Commission launched the *State of Health in the EU* cycle to assist EU Member States in improving the health of their citizens and the performance of their health systems. *Health at a Glance: Europe* is the first product of the two-year cycle, presenting every even-numbered year extensive data and comparative analyses that can be used to identify both the strengths and the opportunities for improvement in health and health systems.

The second step in the cycle is the *Country Health Profiles* for all EU countries. The next edition of these profiles will be published in 2021 jointly with the European Observatory on Health Systems and Policies, and will highlight the particular characteristics and challenges for each country. A *Companion Report* from the European Commission accompanies the release of the profiles. The final step in the cycle is a series of *Voluntary Exchanges* with Member States. These are opportunities to discuss in more detail some of the challenges and potential policy responses.

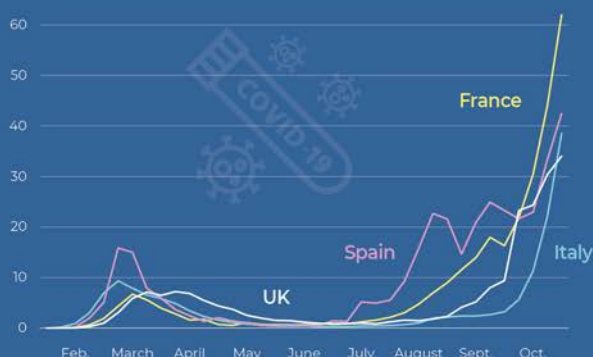
For more information, please consult: ec.europa.eu/health/state.

Infographic 1. Key facts and figures from *Health at a Glance: Europe*

The two waves of COVID-19

First wave in Spring 2020 followed by second wave in Autumn 2020

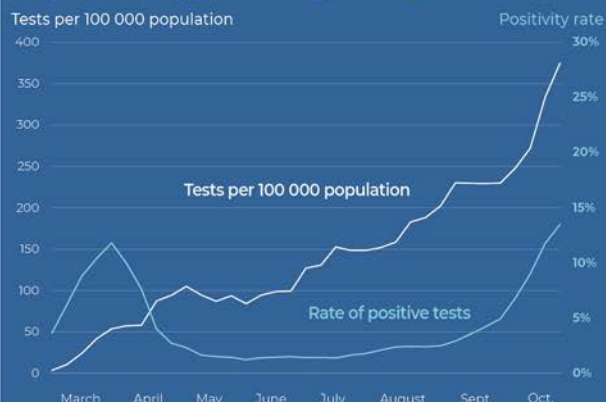
Reported daily cases per 100 000



Source: ECDC (data up to end October 2020).

More tests and more positive cases

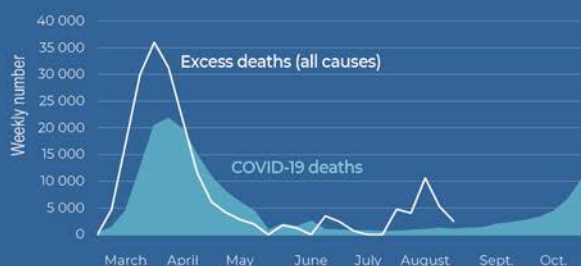
Daily tests per 100 000 population (left-hand axis) and rate of positive tests (right-hand axis), EU average



Source: ECDC (data up to end October 2020).

High and resurging fatalities from COVID-19

COVID-19 and excess deaths peaked in the Spring and are on the rise again (EU average)



Note: Data on excess deaths only available until end of August at time of writing.
Source: ECDC (for COVID-19 deaths), OECD based on Eurostat data (for excess deaths).

COVID-19 has disproportionately impacted vulnerable groups



Across EU countries, around 90% of reported COVID-19 deaths have been among people over 60 years old. In many countries, about half of all deaths have been among people living in nursing homes.

The poor, those living in deprived areas and ethnic minorities have also been disproportionately affected.



Source: ECDC.

Too many people are still exposed to high levels of air pollution

Air pollution emissions (fine particles, $PM_{2.5}$) have reduced by 25% since 2005 in the EU.



Still, about 75% of people in European capitals were exposed to $PM_{2.5}$ levels above the WHO guideline between 2016-2018.



Across EU countries, between 168 000 and 346 000 deaths each year can be attributed to air pollution ($PM_{2.5}$).

Source: European Environment Agency, IHME.

Massive welfare and economic losses from air pollution

In terms of premature death, loss of productivity and higher health spending

Worth €600 billion or 4.9% of EU GDP in 2017



Source: OECD.



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