

Executive summary

European countries have achieved major gains in population health in recent decades. Life expectancy at birth in European Union (EU) member states has increased by more than six years since 1980, to reach 79 years in 2010, while premature mortality has reduced dramatically. Over three-quarters of these years of life can be expected to be lived free of activity limitation. Gains in life expectancy can be explained by improved living and working conditions and some health-related behaviours, but better access to care and quality of care also deserves much credit, as shown, for instance, by sharply reduced mortality rates following a heart attack or stroke.

Many health improvements have come at considerable financial cost. Until 2009, health spending in European countries grew at a faster rate than the rest of the economy, and the health sector absorbed a growing share of the gross domestic product (GDP). Following the onset of the financial and economic crisis in 2008, many European countries reduced health spending as part of broader efforts to reign in large budgetary deficits and growing debt-to-GDP ratios. Although these cuts might have been unavoidable, some measures may have an impact on the fundamental goals of health systems. Continuous monitoring of data and indicators on health and health systems is therefore important; it provides indications of the potential short and longer-term impact of changing economic circumstances and health policies on health care access, quality and health outcomes.

This second edition of *Health at a Glance: Europe* presents the most recent comparable data for selected indicators of health and health systems in 35 European countries – the 27 member states of the European Union, five candidate countries and three EFTA countries – up to 2010. The selection of indicators has been based on the European Community Health Indicators (ECHI) shortlist, a list of indicators that has been developed by the European Commission to guide the development and reporting of health statistics. In addition, the publication provides detailed information on health expenditure and financing trends, using results from the OECD, Eurostat and WHO annual joint health accounts questionnaire. It also includes a new chapter on quality of health care, reflecting the progress achieved under the OECD Health Care Quality Indicators project. The data presented here come mainly from official national statistics, collected individually or jointly by the OECD, Eurostat or WHO-Europe, as well as multi-country surveys such as the Health Behaviour in School-aged Children (HBSC) survey.

Health at a Glance: Europe 2012 presents trends over time and variations across European countries under five broad topics: 1) population health status; 2) risk factors to health; 3) resources and activities of health care systems; 4) quality of care for chronic and acute conditions; and 5) health expenditure and financing sources. It offers some explanation for these variations, providing background for further research and analysis to understand more fully the causes underlying such variations and to develop policy options to reduce gaps with those countries that are achieving better results. Many indicators provide a breakdown by sex and age in each country, and several include a further breakdown by

income or education levels. These indicators show that there may be as much variation within a country by sub-national regions, socio-economic groups or ethnic/racial groups as there is across countries.

Health status has improved dramatically in European countries, although large gaps persist

- Life expectancy at birth in EU member states has increased by over 6 years between 1980 and 2010. On average across the European Union, life expectancy at birth for the three-year period 2008-10 was 75.3 years for men and 81.7 years for women. France had the highest life expectancy for women (85.0 years), and Sweden for men (79.4 years). Life expectancy at birth in the EU was lowest in Bulgaria and Romania for women (77.3 years) and Lithuania for men (67.3 years). The gap between EU member states with the highest and lowest life expectancies at birth is around 8 years for women and 12 years for men (Figure 1.1.1).
- On average across the European Union, healthy life years (HLY) at birth, defined as the number of years of life free of activity limitation, was 62.2 years for women and 61.0 years for men in 2008-10. The gender gap is much smaller than for life expectancy, reflecting the fact that a higher proportion of the life of women is spent with some activity limitations. HLY at birth in 2008-10 was greatest in Malta for women and Sweden for men, and shortest in the Slovak Republic for both women and men (Figure 1.1.1).
- Life expectancy at age 65 has also increased substantially in European countries, averaging 16.5 years for men and 20.1 years for women in the European Union in 2008-10. As for life expectancy at birth, France had the highest life expectancy at age 65 for women (23.2 years) but also for men (18.7 years). Life expectancy at age 65 in the European Union was lowest in Bulgaria for women (16.9 years) and Latvia for men (13.2 years) (Figure 1.2.1).
- Large inequalities in life expectancy persist between socio-economic groups. For both men and women, highly educated persons are likely to live longer; in the Czech Republic for example, 65-year-old men with a high level of education can expect to live seven years longer than men of the same age with a low education level (Figure 1.2.3).
- It is difficult to estimate the relative contribution of the numerous non-medical and medical factors that might affect variations in life expectancy across countries. Higher national income is generally associated with higher (healthy) life expectancy, although the relationship is less pronounced at the highest income levels, suggesting a “diminishing return” (Figure 1.1.2).
- Chronic diseases such as diabetes, asthma and dementia are increasingly prevalent, due either to better diagnosis or more underlying disease. More than 6% of people aged 20-79 years in the European Union, or 30 million people, had diabetes in 2011 (Figure 1.14.1). Better management of chronic diseases has become a health policy priority for many EU member states.

Risk factors to health are changing

- Most European countries have reduced tobacco consumption via public awareness campaigns, advertising bans and increased taxation. The percentage of adults who smoke daily is below 15% in Sweden and Iceland, from over 30% in 1980. At the other end of the scale, over 30% of adults in Greece smoke daily. Smoking rates continue to be high in Bulgaria, Ireland and Latvia (Figure 2.5.1).

- Alcohol consumption has also fallen in many European countries. Curbs on advertising, sales restrictions and taxation have all proven to be effective measures. Traditional wine-producing countries, such as France, Italy and Spain, have seen consumption per capita fall substantially since 1980. Alcohol consumption per adult rose significantly in a number of countries, including Cyprus, Finland and Ireland (Figure 2.6.1).
- In the European Union, 52% of the adult population is now overweight, of which 17% is obese. At the country level, the prevalence of overweight and obesity exceeds 50% in 18 of the 27 EU member states. Rates are much lower in France, Italy and Switzerland, although increasing there as well. The prevalence of obesity – which presents greater health risks than overweight – ranges from 8% in Romania and Switzerland to over 25% in Hungary and the United Kingdom (Figure 2.7.1). The obesity rate has doubled since 1990 in many European countries (Figure 2.7.2). Rising obesity has affected all population groups, to varying extents. Obesity tends to be more common among disadvantaged social groups, and especially women.

The number of doctors and nurses per capita is higher than ever before in most countries, but there are concerns about current or future shortages

- Ensuring proper access to health care is a fundamental policy objective in all EU member states. It requires, among other things, having the right number of health care providers in the right places to respond to the population's needs. There are concerns in many European countries about shortages of doctors and nurses, although recent public spending cuts on health in some countries may have led to at least a temporary reduction in demand.
- Since 2000, the number of doctors per capita has increased in almost all EU member states. On average across the European Union, the number of doctors grew from 2.9 per 1 000 population in 2000 to 3.4 in 2010. Growth was particularly rapid in Greece and the United Kingdom (Figure 3.1.1).
- In nearly all countries, the balance between generalist and specialist doctors has changed such that there are now more specialists (Figure 3.1.2). This may be explained by a reduced interest in traditional “family medicine” practice, combined with a growing remuneration gap between generalists and specialists. The slow growth or reduction in the number of generalists raises concerns in many countries about access to primary care for certain population groups.
- There are also concerns about possible shortages of nurses, and this may well intensify in the future as the demand for nurses continues to increase and the ageing of the “baby boom” generation precipitates a wave of retirements among nurses. Over the past decade, the number of nurses per capita has increased in nearly all EU member states (Figure 3.3.1). The increase was particularly large in Denmark, France, Portugal and Spain. However, recently there has been a reduction in nurses employed in some countries hardest hit by the economic crisis. In Estonia, the number of nurses increased to 2008, but has decreased since then, with a resulting fall from 6.4 per 1 000 population in 2008 to 6.1 in 2010.

Quality of care has improved in most European countries, though all countries can do better, particularly to avoid hospital admissions for people with chronic diseases

- There has been progress in the treatment of life-threatening conditions such as heart attack, stroke and cancer in all reporting European countries. Mortality rates following hospital admissions for heart attack (acute myocardial infarction) have fallen by nearly 50% between 2000 and 2009 (Figure 4.3.3) and for stroke by over 20% (Figure 4.4.3). These improvements reflect better acute care and greater access to dedicated stroke units in countries like Denmark and Sweden.
- Survival rates for different types of cancer have also improved in most countries, reflecting earlier detection and greater treatment effectiveness (Figures 4.7.2 and 4.8.2). While survival rates for breast cancer remain below 80% in the Czech Republic and Slovenia, they have increased by over 10 percentage points between 1997-2002 and 2004-09. These two countries also witnessed substantial gains in survival rates for colorectal cancer (Figure 4.9.2).
- It is more difficult to monitor quality of care in the primary care sector, as in most countries there are fewer data than in the hospital sector. Avoidable hospital admission is often used as an indicator of either access problems to primary care or the quality and continuity of care. There is general consensus that asthma and diabetes should largely be managed through proper primary care interventions to avoid exacerbation and costly hospitalisation. While hospital admissions for asthma are low in certain countries, they are much higher in others, such as the Slovak Republic (Figure 4.1.1). In all European countries, there are too many hospital admissions for uncontrolled diabetes (Figure 4.2.1).

Growth in health expenditure has slowed or fallen in many European countries

- Growth in health spending per capita slowed or fell in real terms in 2010 in almost all European countries, reversing a trend of steady increases. Spending had already started to fall in 2009 in countries hardest hit by the economic crisis (*e.g.* Estonia and Iceland), but this was followed by deeper cuts in 2010 in response to growing budgetary pressures and rising debt-to-GDP ratios. On average across the EU, health spending per capita increased by 4.6% per year in real terms between 2000 and 2009, followed by a fall of 0.6% in 2010 (Figure 5.2.2).
- Reductions in public spending on health were achieved through a range of measures, including reductions in wages and/or employment levels, increasing direct payments by households for certain services and pharmaceuticals, and imposing severe budget constraints on hospitals. Gains in efficiency have also been pursued through mergers of hospitals or accelerating the move from inpatient care to outpatient care and day surgery.
- As a result of the negative growth in health spending in 2010, the percentage of GDP devoted to health stabilised or declined slightly in many EU member states. In 2010, EU member states devoted on average 9.0% (unweighted) of their GDP to health spending (Figure 5.3.1), up significantly from 7.3% in 2000, but down slightly from the peak of 9.2% in 2009.
- The Netherlands allocated the highest share of GDP to health in 2010 (12%), followed by France and Germany (both at 11.6%). In terms of health spending per capita, the Netherlands (EUR 3 890), Luxembourg (EUR 3 607) and Denmark (EUR 3 439) were the

highest spenders among EU member states. Austria, France and Germany followed, at over EUR 3 000 per capita. Bulgaria and Romania were the lowest spending countries, at around EUR 700.

- The public sector is the main source of health care financing in all European countries, except Cyprus (Figure 5.6.1). In 2010, nearly three-quarter (73%) of all health spending was publicly financed on average in EU member states. Public financing accounted for over 80% in the Netherlands, the Nordic countries (except Finland), Luxembourg, the Czech Republic, the United Kingdom and Romania. The share was the lowest in Cyprus (43%), and Bulgaria, Greece and Latvia (55-60%).
- The economic crisis has affected the mix of public and private health financing in some countries. Public spending has been cut for certain goods and services, often combined with increases in the share of direct payments by households. In Ireland, the share of public financing of health spending decreased by nearly 6 percentage points between 2008 and 2010, and stands now at 70%, while the share of out-of-pocket payments by households increased. There have also been substantial falls in Bulgaria and the Slovak Republic.
- After public financing, the main source of funding for health expenditure in most countries is out-of-pocket payments. Private health insurance financing only plays a significant role in a few countries. In 2010, the share of out-of-pocket payments was highest in Cyprus (49%), Bulgaria (43%) and Greece (38%). It was the lowest in the Netherlands (6%), France (7%) and the United Kingdom (9%). Its share has increased over the past decade in about half of EU member states, most notably in Bulgaria, Cyprus, Malta and the Slovak Republic (Figure 5.6.3).
- The economic crisis and growing budgetary constraints have put additional pressures on health systems in many European countries. Several countries that have been hardest hit by the crisis have taken a series of measures to reduce public spending on health. It will be important to monitor closely the short and longer-term impact of these measures on the fundamental goals of health systems in European countries of ensuring proper access and quality of care.



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