

# OECD *Multilingual Summaries*

## Health at a Glance: Europe 2010

*Summary in English*



- This special edition of *Health at a Glance* focuses on health issues across the 27 European Union member states, three European Free Trade Association countries (Iceland, Norway and Switzerland) and Turkey. It gives readers a better understanding of the factors that affect the health of populations and the performance of health systems in these countries. Its 42 indicators present comparable data covering a wide range of topics, including health status, risk factors, health workforce and health expenditure.
- Each indicator in the book is presented in a user-friendly format, consisting of charts illustrating variations across countries and over time, brief descriptive analyses highlighting the major findings conveyed by the data, and a methodological box on the definition of the indicators and any limitations in data comparability. An annex provides additional information on the demographic and economic context within which health systems operate.
- This publication is the result of collaboration between the OECD and the European Commission, with the help of national data correspondents from the 31 countries.

## Executive summary

European countries have achieved major gains in population health over recent decades. Life expectancy at birth in European Union (EU) countries has increased by six years since 1980, while premature mortality has reduced dramatically. Improvements in living and working conditions and in some health-related behaviours have contributed greatly to these longevity gains, but progress in medical care also deserves much credit. Health systems are of growing size and complexity in European countries, and spending on health care has never been higher, consuming an ever-increasing share of national income.

This first edition of *Health at a Glance: Europe*, the result of a long-standing collaboration between the OECD and the European Commission, presents a set of key indicators of health and health systems in 31 European countries – the 27 member states of the European Union, and Iceland, Norway, Switzerland and Turkey. 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 (European Commission, 2010a). However, a number of indicators in this report differ from ECHI definitions because of data availability or constraints, or in some instances because ECHI indicators are not yet ready for implementation. The publication also provides detailed information on health expenditure and its financing, building on the OECD's established data collection and expertise in this area. The data presented in the publication come mainly from official national statistics, as gathered in *OECD Health Data*, the *Eurostat Statistics Database* and WHO-Europe's *Health for All Database*.

*Health at a Glance: Europe 2010* presents evidence of wide variations across European countries in population health status, risk factors for health, the inputs, outputs and outcomes of health care systems, and levels of health expenditure and financing sources. It offers some explanation for these variations, providing a background to understand more fully the causes underlying such variations and to develop policy options to reduce gaps across countries. It should also be noted that while basic population breakdowns by sex and age are presented, this publication does not generally provide detail by sub-national regions, by socio-economic groups or by ethnic/racial groups. For many indicators, readers should keep in mind that there may be as much variation *within* a country as there is *across* countries.

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

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- Life expectancy at birth in EU countries has increased by six years since 1980, reaching 78 years in 2007. On average across the 27 EU countries, life expectancy at birth for the three-year period 2005-07 stood at 74.3 years for men and 80.8 years for women. France had the highest life expectancy at birth for women (84.4 years), while Sweden had the highest life expectancy for men (78.8 years). Life expectancy at birth in the European Union was lowest in Romania for women (76.2 years) and Lithuania for men (65.1 years). The gap between countries with the highest and lowest life expectancies at birth is around eight years for women and 14 years for men.
- Whether the gains in life expectancy involve additional years of life lived in good health has important implications for health and long-term care systems in Europe. Healthy life years at birth is defined as the number of years of life in which a person's day-to-day activities are not limited by a condition or health

problem. In 2005-07, healthy life years stood at 61.3 years for women and 60.1 years for men, on average, in the European Union. The gender gap is much smaller than for life expectancy, reflecting the fact that a higher proportion of women's lives are spent with activity limitations. Healthy life years at birth in 2005-07 was greatest in Malta for both men and women, and shortest in Latvia for women and Estonia for men.

- Life expectancy at age 65 has also increased substantially over the past decades in European countries. The average in 2005-07 for the 27 EU countries was 15.9 years for men and 19.5 years for women. As for life expectancy at birth, France had the highest life expectancy at age 65 for women (22.6 years) but also for men (18.1 years). Life expectancy at age 65 was lowest in Eastern Europe – in Latvia for men (12.7 years) and in Bulgaria for women (16.3 years).
- As is the case at birth, the gender gap for healthy life years at age 65 is much narrower than for life expectancy. In 2005-07, men were slightly favoured, at 8.4 years *versus* 8.1 years for women.
- It is difficult to estimate the relative contribution of the numerous medical and non-medical factors that might affect variations in (healthy) life expectancy. Higher national income is generally associated with higher life expectancy across European countries, although the relationship is less pronounced at higher levels of national income, suggesting a “diminishing return” after a certain level. Other determinants of health also play an important role.

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### *Risk factors to health are changing*

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- Many EU countries have achieved remarkable progress in reducing tobacco consumption, although it is still a leading cause of early death. Much of this decline can be attributed to policies at national and EU level promoting public awareness campaigns, advertising bans and increased taxation. Less than 18% of adults in Sweden and Iceland now smoke daily, down from over 30% in 1980. However, almost 40% of adults in Greece continue to smoke on a daily basis. Smoking rates are also relatively high in Bulgaria, Ireland and the Netherlands.
- Alcohol consumption has also fallen in many European countries over the past three decades. Curbs on advertising, sales restrictions and taxation have proven to be effective measures to reduce alcohol consumption. Traditional wine-producing countries such as Italy, France and Spain have seen their alcohol consumption per capita drop substantially since 1980. On the other hand, consumption rose significantly in a number of countries including Ireland, the United Kingdom and some Nordic countries.
- More than half of the total adult population across the European Union are now overweight or obese. This is also true in 15 of the 27 EU countries. The prevalence of obesity – which presents greater health risks than overweight – varies from less than 10% in Romania, Switzerland and Italy to over 20% in the United Kingdom, Ireland, Malta and Iceland. On average across EU countries, 15.5% of the adult population is obese.
- The rate of obesity has more than doubled over the past 20 years in most EU countries for which data are available. The rapid increase occurred regardless of what the levels of obesity were two decades ago. Obesity more than doubled in both the Netherlands and the United Kingdom between 1988 and 2008, even though the rate in the Netherlands is currently less than half that of the United Kingdom.
- Because obesity is associated with higher risks of chronic illnesses, it is linked to significant additional health care costs. A recent study in England estimated that total costs linked to overweight and obesity could increase by as much as 70% between 2007 and 2015, and be 2.4 times higher by 2025 (Foresight, 2007).

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### *Shortages of health workers is a concern in many countries*

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- There are concerns in many European countries about shortages of doctors. The number of doctors per capita varies greatly, and is lowest in Turkey, followed by Poland and Romania. Doctor numbers are also relatively low in the United Kingdom and Finland.
- Since 2000, the number of physicians per capita has however increased in all European countries, except the Slovak Republic. On average, the number grew from 3.0 doctors per 1 000 population in 2000 to 3.3 in 2008. It increased particularly rapidly in Ireland, rising by nearly 50%. A large part of this increase was due to the recruitment of foreign-trained physicians, with the share of foreign-trained doctors tripling during that period. Similarly, the number of doctors per capita in the United Kingdom increased by 30% between 2000 and 2008, rising from 2.0 per 1 000 population to 2.6.
- In contrast, there has been virtually no growth in the number of doctors per capita in France and Italy since 2000. Following a reduction in the number of new entrants in medical schools during the 1980s and 1990s, the number of doctors per capita in Italy peaked in 2002, and has declined since then. In France, the number peaked in 2005, and the decline is expected to continue over the next ten years.
- In nearly all countries, the balance between general practitioners and specialists has changed over past decades, with the number of specialists increasing much more rapidly. As a result, there are more specialists than generalists in most countries, except Romania and Portugal. This may be explained by a reduced attractiveness in the traditional mode of practice of general/family practitioner, as well as a growing remuneration gap. The slow growth or reduction in the number of generalists per capita raises concerns about access to primary care. Many countries are considering ways to improve the attractiveness of general practice as well as developing new roles for other health care providers, such as nurses.
- There are also concerns about shortages of nurses in many European countries. Nurses play an important role in providing health care not only in traditional settings such as hospitals and long-term care institutions but increasingly in primary care, especially in offering care to the chronically ill, and in patients' homes. In 2008, there were about 15 nurses per 1 000 population in Finland, Iceland, Ireland and Switzerland, and slightly fewer in Denmark and Norway. Turkey had the fewest nurses, followed by Greece, Bulgaria and Cyprus, at less than five per 1 000 population.
- Since 2000, the number of nurses per capita has increased in all European countries, except Lithuania and the Slovak Republic. The increase was particularly large in Portugal, Spain, France and Switzerland.

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### *Growing health expenditure puts pressure on government budgets*

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- Health expenditure has risen in all European countries, often increasing at a faster rate than economic growth, resulting in a rising share of GDP allocated to health. In 2008, EU countries spent, on average, 8.3% of their GDP on health, up from 7.3% in 1998. However, the share of GDP allocated to health spending varies considerably across countries, ranging from less than 6% in Cyprus and Romania to more than 10% in France, Switzerland, Germany and Austria.

- In some countries, the recent economic downturn resulted in a marked increase in the ratio of health spending to GDP. In Ireland, the percentage of GDP devoted to health increased from 7.5% in 2007 to 8.7% in 2008. In Spain, it rose from 8.4% to 9.0%.
- In 2008, Norway spent the most on health per capita among European countries, with spending of about EUR 4 300. Switzerland, Luxembourg and Austria were the next highest spending countries. Most northern and western European countries spend between EUR PPP 2 500 and 3 500 per person, that is, 10% to 60% more than the EU average. Those countries spending below the EU average are eastern and southern European countries such as Turkey, Romania, Bulgaria, Poland and Hungary.
- Health expenditure per capita tends to be positively correlated with GDP per capita, although the association is stronger among European countries with low GDP per capita. Even for countries with similar levels of GDP per capita, there can be substantial differences in health expenditure. For example, Spain and France have similar GDP per capita, but Spain spends less than 80% of the level of France on health.
- Health systems are sometimes criticised for being overly focused on “sick care”: for treating the ill, but not doing enough to prevent illness. Only around 3% of current health expenditure is spent on prevention and public health programmes on average in EU countries.
- The public sector is the main source of health financing in all European countries, except Cyprus. On average, nearly three-quarter of all health spending was publicly financed in 2008, through general taxation or social security contributions. In Luxembourg, the Czech Republic, the Nordic countries (except Finland), the United Kingdom and Romania, public financing accounted for more than 80% of all health expenditure.
- The size and composition of private financing differs across countries. In most countries, it is in the form of out-of-pocket payments by patients. Private health insurance accounts for only around 3-4% of total health expenditure on average across EU countries. However, in some countries, it plays a significant role. In Germany, it provides primary coverage for certain population groups. In France, private health insurance finances 13% of overall spending, but provides complementary and supplementary coverage in a universal public system.
- Given the current need to reduce budget deficits in many countries, governments may be faced with difficult policy choices in the short-term. They may either have to curb the growth of public spending on health, cut spending in other areas, or raise taxes or social security contributions to reduce their deficits. Improving productivity within the health sector may help to reconcile these pressures, for example through more rigorous assessment of health technologies or increased use of information and communication technologies (“eHealth”). These initiatives may also have the added benefit of improving the quality of care, which is another area of collaboration between the OECD and the European Commission.

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