European Commission

EUROPEAN SEMESTER THEMATIC FICHE
HEALTH AND HEALTH SYSTEMS

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1 Introduction

The health systems of European Union' Member States are a crucial part of Europe's high levels of social protection and cohesion and play a central role in modern societies. Health systems in EU Member States are varied, reflecting different societal choices. However, despite organisational and financial differences, they are built on common values, as recognised by the Council of Health Ministers in 2006[1]: universality, access to good quality care, equity and solidarity. The need to make health systems financially sustainable in a way which safeguards these values into the future is also widely recognised[2].

Over the last decade, European health systems have faced growing common challenges: population ageing associated with a rise of chronic diseases and multi-morbidity leading to growing demand for healthcare; increasing costs of innovative technology and medicines; shortages and uneven distribution of health professionals; and health inequalities and inequities in access to healthcare. Health systems need to be resilient: they must be able to adapt effectively to changing environments, tackling significant challenges with limited resources.

In recent years, the economic crisis has constrained the financial resources available and thus increased Member States' difficulties in ensuring their health systems' sustainability. In turn, this could jeopardise Member States' ability to provide universal access to good quality healthcare.

Ensuring universal access to cost-effective healthcare, including health promotion and prevention, in a financially sustainable manner is essential both for social cohesion, and for long-term economic growth, as a healthier population will improve labour market participation and labour productivity (Annual Growth Survey, 2016).

EU health systems are also increasingly interacting with each other. The entry into force of Directive 2011/24[3] was a key step in providing a legal framework for this interaction.

[1] Council Conclusions on Common values and principles in European Union Health Systems (2006/C 146/01): http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF

[2] http://www.consilium.europa.eu/en/press/press-releases/2015/05/12-ecofin-ageing-populations/ (ECOFIN Council meeting, 4 May 2015): http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ecofin/130261.pdf.

[3] Directive 2011/24/EU on the application of patients' rights in cross-border healthcare; OJ L 88, 04.04.2011

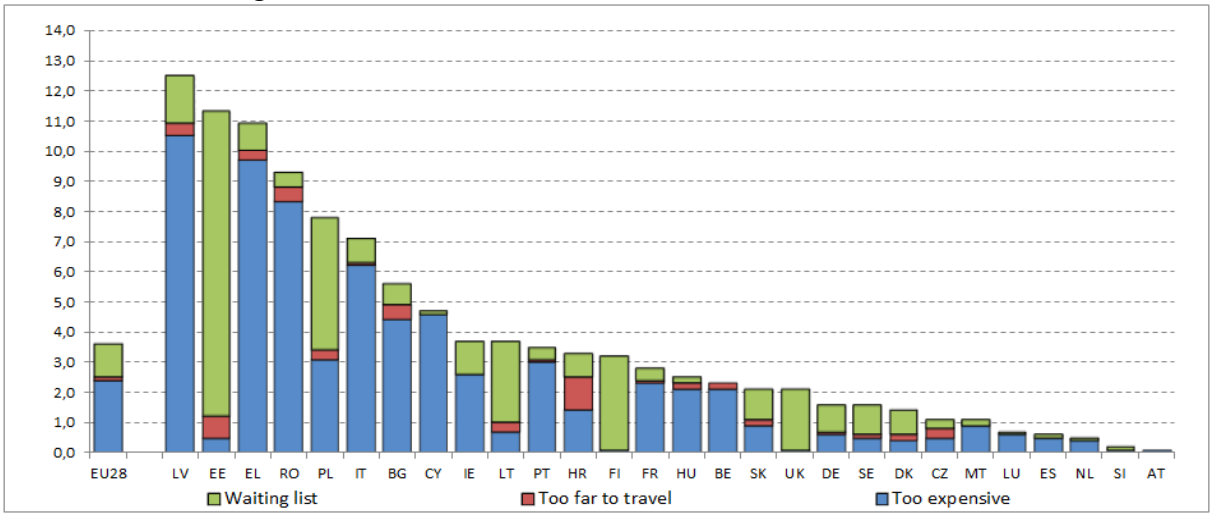
2 Identification of the challenges

2.1 Ensuring universal and equitable access to good quality health care

An indicator frequently used to show barriers in access to health care is patient self-reported unmet needs based on surveys. Reasons given for not receiving care include: excessive treatment costs, long waiting times, or having to travel too far to receive care[4].

A majority of the population in European countries (78% of all countries) reported levels of unmet care needs below 6%. However, in some countries a much higher proportion of people reported having unmet needs. The most common barriers for access to healthcare resulted from patients' inability and/or unwillingness to pay medical goods and services, while in some countries waiting times or travelling distance were an issue[5]. Access to healthcare could also be constrained by insufficient availability of healthcare infrastructure and health workforce.

Figure 1: Self-reported unmet needs for medical examination because of cost, waiting time, and travelling distance



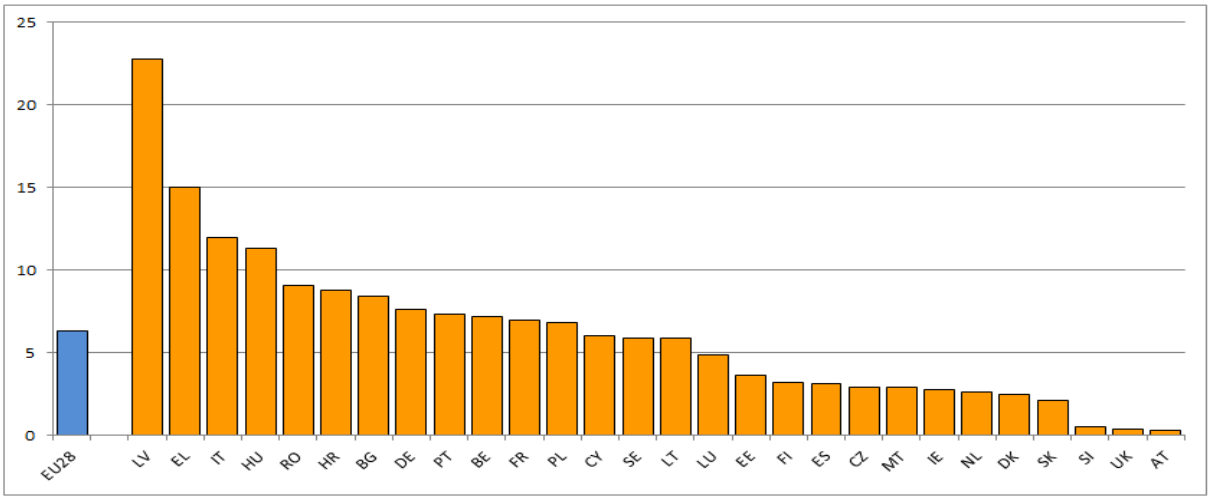
Source: EU-SILC (2014)

Although Member States agree to the common principle of equity of health systems, in practice gaps in equitable access to good quality healthcare can be found across the EU. Barriers to equity in access to healthcare can be multiple, and include financial, administrative, geographical, legal, cultural and organisational factors.

[4] Results are presented under section 2.

[5] Waiting times may occur for a variety of reasons including reasons related to insufficient or inadequate allocation of resources or to active management choices made health-system decision makers.

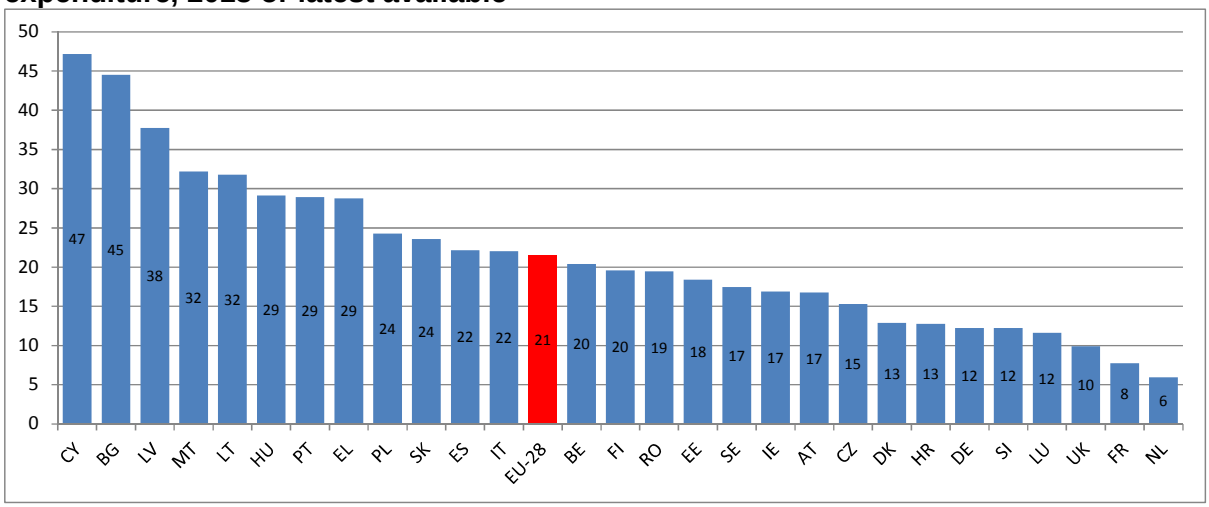
Figure 2: Income quintile gap for self-reported unmet need for medical care, 2014



Source: Eurostat, EU-SILC. Notes: all reasons; difference expressed in percentage points[6].

The self-reported unmet medical needs should also be seen in the context of objective measures of the use and expenditure on healthcare, such as the level of public, private and "out of pocket spending" on health care[7], which also provide information related to the financial protection of the population against the risks of ill-health, as well as the actual use of health services.

Figure 3: Private household out-of-pocket expenditure as % of total current health expenditure, 2013 or latest available



Source: Eurostat, OECD (IT,UK); WHO HfA-DB (IE, MT), SHA 1.0. Data for 2012, 2011 (BG, PT, SI, SK), 2010 (LV). WHO HfA-DB reports on private household out-of-pocket expenditure as percentual share of total health expenditure.

[6] The difference (gap) between the percentage of the population from the bottom (q1) and top (q5) income quintile with self-reported total unmet needs for medical examination during theprevious 12 months. The first quintile group represents the 20% population with the lowest income, and the fifth quintile group represents the 20% of the population with the highest income.

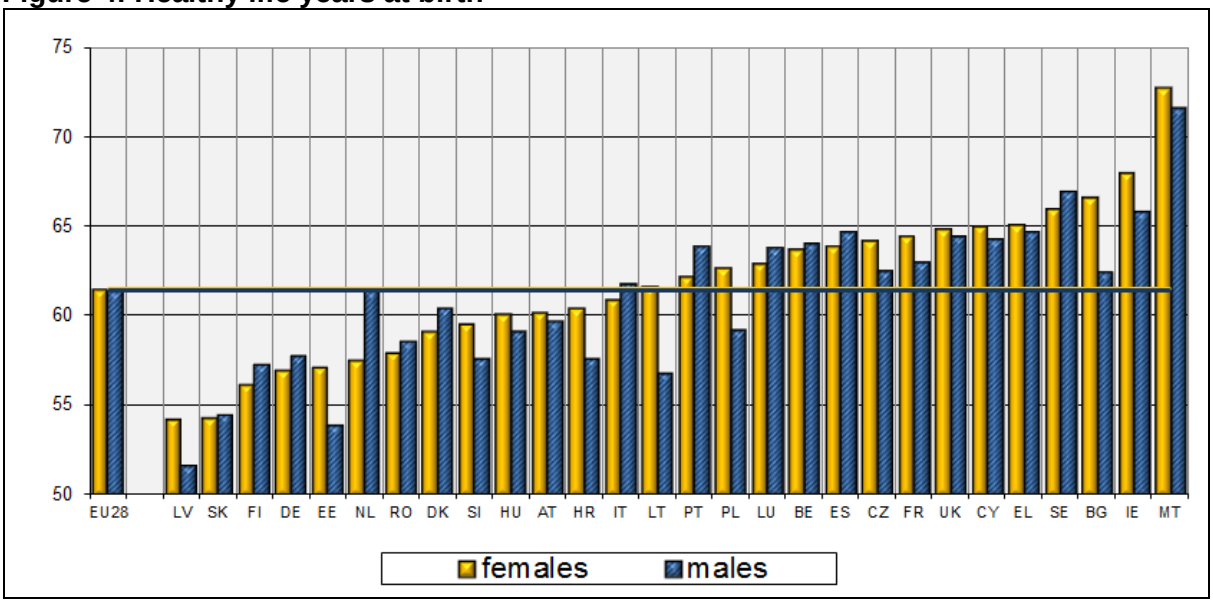
[7] Out-of-pocket expenditure are the sum of co-payment to the various insurance funds present in the health care system and of over-the-counter (and other direct) payments for goods and services purchased by private households as direct and ultimate payer.

2.2 Strengthening the effectiveness and efficiency of health care systems

Against a background of rising demand and constrained resources, providing universal access to high quality care, while ensuring sustainability of health systems, requires increased efficiency and effectiveness in health spending. The challenge is to identify cost-effective ways to finance, organise and deliver care, in order to allow the achievement of better health outcomes with more rational use of available resources. In this context, short-term savings might lead to higher costs in the mid to long-term.

Looking at healthy life expectancy large differences can be observed across Member States, and between males and females, which depend on a wide range of factors.

Figure 4: Healthy life years at birth



Healthy Life Years at birth by gender, 2013 - Source: Eurostat

A large number of studies have looked at the relation between the expenditure on health care (expressed by per capita expenditure on health) and health outcomes (including life expectancy, healthy life expectancy, patient satisfaction, amenable mortality[8] and health status inequalities across population groups). These analyses may be further improved by taking into consideration intrinsic differences in population conditions and other determinants of the health status of the population (e.g. demographic structure, income and education levels, nutritional habits, smoking and alcohol consumption patterns, physical activity, etc.), as well as developing health outcome indicators which better reflect the performance of the healthcare system (e.g. amenable mortality) and building a deeper understanding on how specific health policies impact them[9].

2.3 Health expenditures makes up a large and growing share of GDP

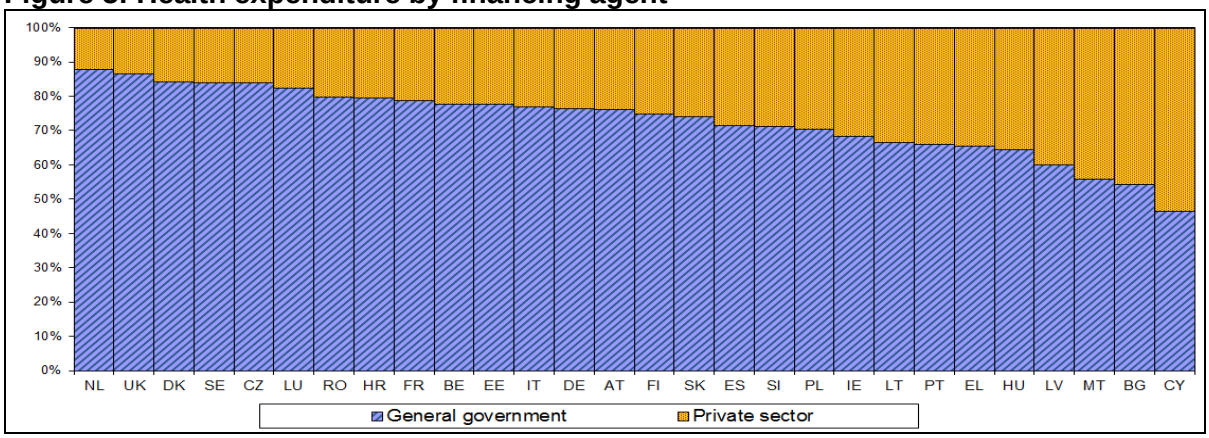
The public sector plays a major role in the financing of health services: in two thirds of Member States, more than 70% of health expenditure is funded by the public sector. Figure 5 shows the share of public and private financing to healthcare systems across EU countries.

[8] A death can be considered as amenable if it could have been avoided through good quality health care.

[9] See for instance RIVM et al 2015 for a series of extensive system-wide efficiency analyses, applying various relevant methods and considering various (also quality adjusted) health outcomes and correcting for relevant factors such as lifestyle, GDP and educational levels.
Full reference "Erasmus University, Erasmus Medical Center and the Dutch Institute for Public Health and the Environment (RIVM), 2015, Comparative efficiency of health systems, corrected for selected lifestyle factors", available from: http://ec.europa.eu/health/systems_performance_assessment/publications/index_en.htm

Member States with a relatively high share of private health expenditure are CY (54% of total health expenditure), BG (46%), MT (44%), LV (40%), HU, EL, PT, and LT (above 33%). The MS with the highest share of health expenditure funded by the government are the NL and UK (above 85%), DK, SE, CZ, LU (above 80%).

Figure 5: Health expenditure by financing agent

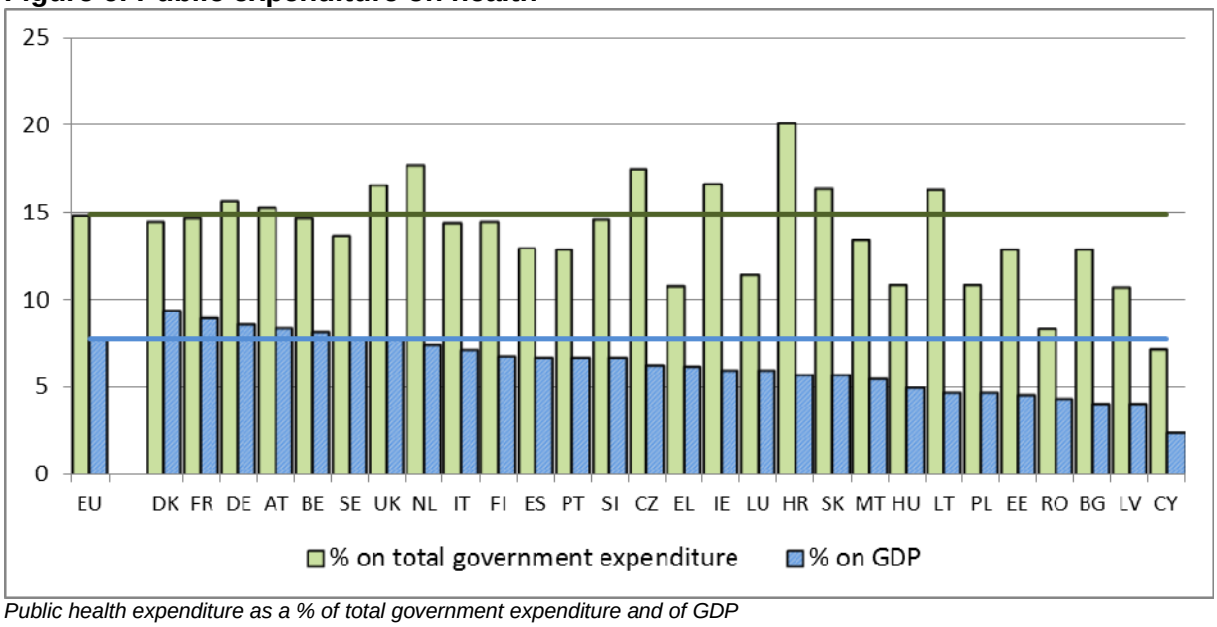


Source: Eurostat, OECD, WHO – 2014 or most recent data

Figure 6 shows the levels of public expenditure on health in EU Member States, expressed both as a percentage of GDP and as a percentage of total general government expenditure. Seven Member States have a health expenditure-to-GDP ratio equal to or above the weighted EU average in 2012 (7.8% of GDP): DK, FR, DE, AT, BE, SE and UK. The Member State with the lowest share of public health expenditure was CY (2.5% pf GDP), LV, BG, RO, EE, PL, LT and HU (below 5% of GDP).

Expressing health spending as a percentage of total government expenditure shows nine Member States above the EU value (14.9%): HR, NL, CZ, IE, UK, SK, LT, DE and AT. The Member States with the lowest public expenditure in health, as a share of total public expenditure are CY (7.2%), RO (8.4%), LV, EL, PL, HU (below 11%), and LU (11.5%).

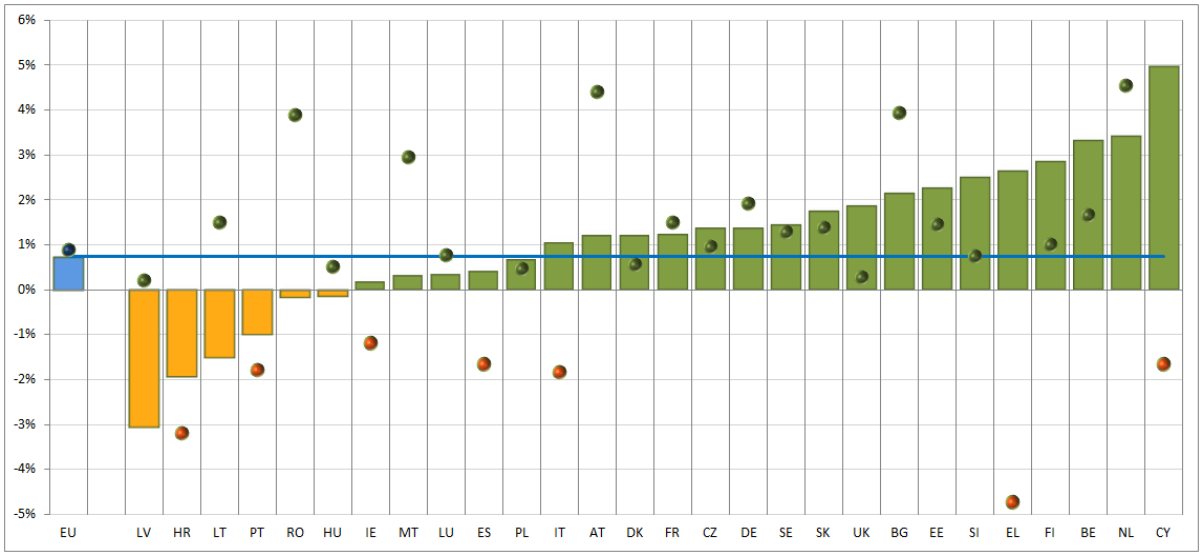
Figure 6: Public expenditure on health



Public health expenditure as a % of total government expenditure and of GDP
Source: Eurostat, United Nations Statistics Division; 2012 or most recent data – Commission services' calculations

Health spending is among the largest and fastest growing spending items for governments. Figure 7 shows the annual increase in public health expenditure as a percentage of GDP between 2008 and 2013. The same figure shows the average annual increase of public real per-capita expenditure on health during the same years, expressed by circles. The combination of the two measures gives a better understanding of public expenditure on health. In the case of countries with decreasing GDP over this period of time, such as Ireland, Spain, Italy, Greece and Cyprus, the growth of public expenditure on health as a share of GDP is linked to the fact that GDP decreased faster than health expenditure per capita. The opposite situation applies to Latvia, Lithuania, Romania and Hungary (in the period under analysis), where the growth of GDP exceeded the growth of public expenditure on health.

Figure 7: Growth of public expenditure on health as % of GDP and per capita



Average annual increase in public expenditure on health as a % of GDP (2008-2013) and average annual increase on real per-capita public expenditure on health (circles, 2008-2013)

Source: Eurostat, OECD, WHO – Commission services' calculations.

Growing incomes, population ageing, rising expectations towards high-quality health services and technological advancements are expected to increase pressure for higher health spending. According to the 2015 Ageing Report[10], a further increase in the share of public health expenditure on GDP is expected from now up to 2060. According to the "AWG reference scenario"[11], public expenditure on health (including health care and long-term care) in the EU will increase by 2.0 % of GDP until 2060 (Figure 9). In the "AWG risk scenario"[12] an avera ge increase of expenditure of 4.0 % of GDP is estimated up to 2060 (Figure 10).

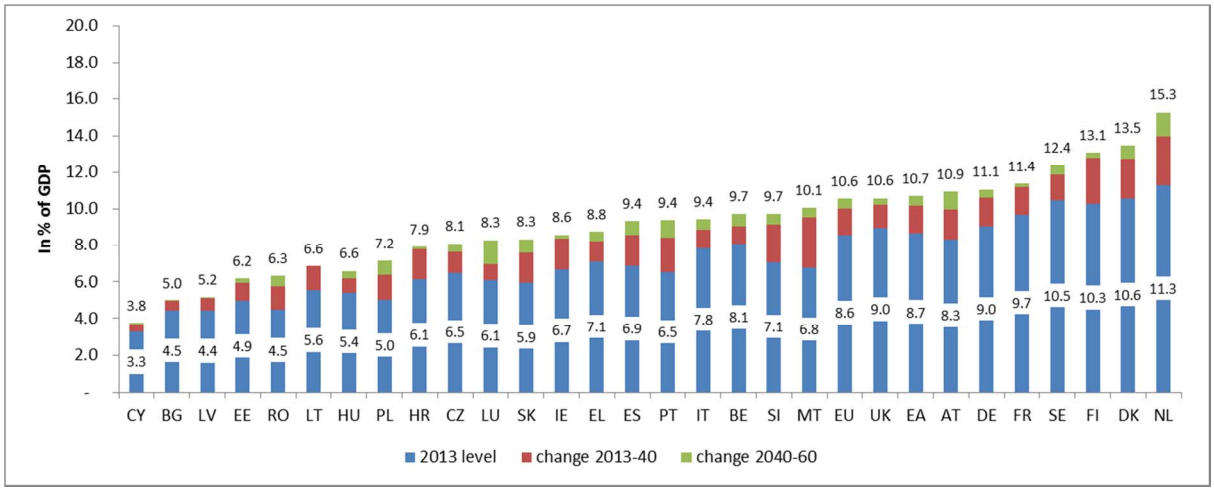
[10] http://ec.europa.eu/economy_finance/publications/european_economy/2015/pdf/ee3_en.pdf

[11] "AWG reference scenario": Health care: takes into account the impact of demographic ageing and income but is balanced by improvements in health status; Long-term care: Assumes the half of the projected gains in life expectancy is spent without disability.

[12] "AWG risk scenario": Non-demographic driver may exercise an upward push on costs in the health care and long-term care areas. In order to gain further insights into the possible importance of such developments, another set of projections were run which assumes the partial continuation of recently observed trends in health care expenditure due to, e.g. technological progress. Moreover, an upward convergence of coverage and costs to the EU average is assumed to take place in long-term care.

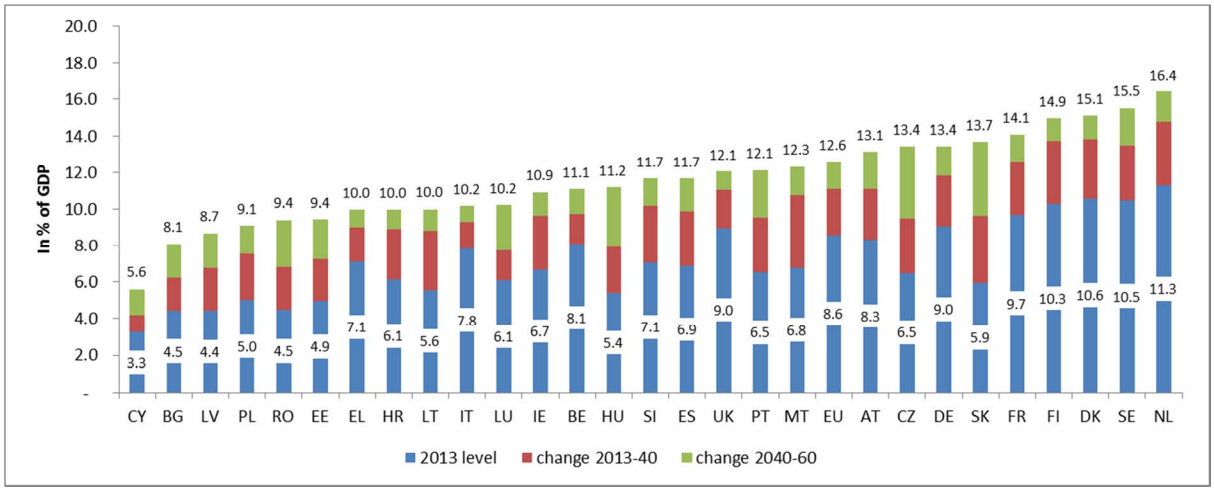
A key EU objective is to ensure sustainability of public finances, including in a mid- and long-term perspective. For many EU countries, sustainability risks for public finances are related to a substantial degree from the projected impact of age-related public spending on healthcare and long-term care.[13]

Figure 9: Projected expenditure in health care and long-term in EU countries over 2013-60, AWG reference scenario



Source: Based on Ageing Report 2015 – Commission services.

Figure 10: Projected expenditure in health care and long-term in EU countries over 2013-60, AWG risk scenario



Source: Based on Ageing Report 2015 – Commission services.

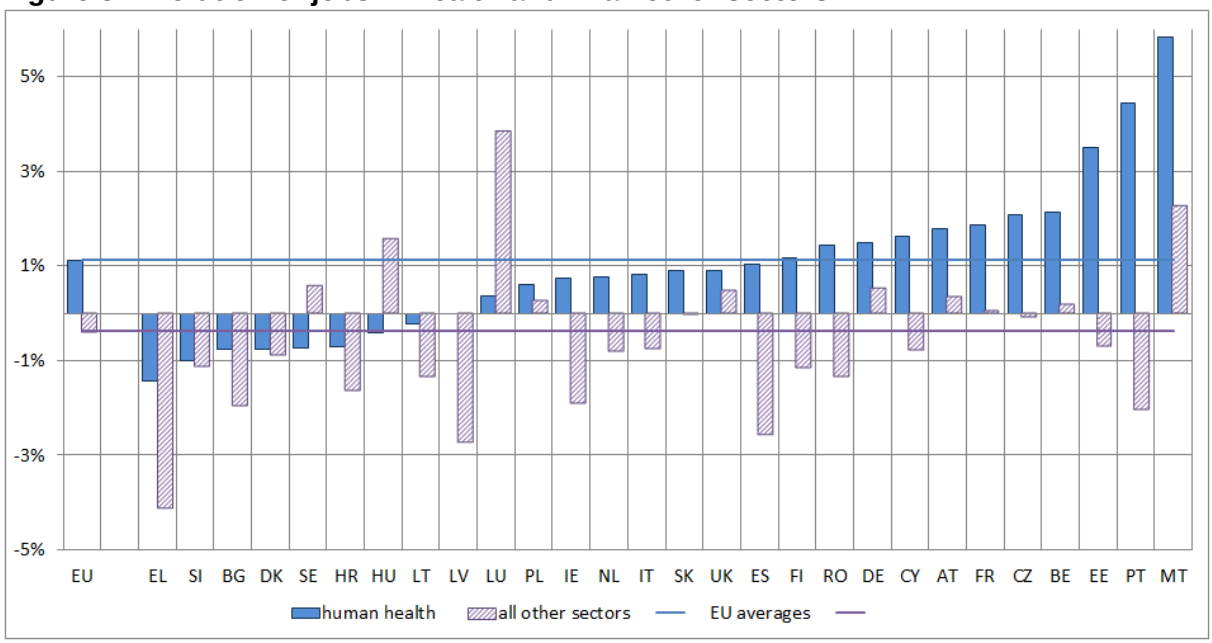
[13] For details about the sustainability indicators, see: the "Thematic summary on public finance sustainability" and Chapter 1 in European Commission (DG ECFIN), 2016, "*Fiscal Sustainability Report 2015*", European Economy, Institutional paper 018. EC, Brussels. http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

2.4 Employment in the health sector has risen significantly in the last years and represents a potential for high-skilled and flexible employment

The 'health and social work' sector[14] is the sector which saw the largest rise in employment in recent years (and notably between the second quarter of 2008 and the second quarter of 2015) with over 2.6 million new jobs. Within the health and social sector, the biggest increase in jobs took place in the 'residential care' sub-sector[15] (1,113,000 new jobs, accounting for 42% of the new jobs created in the sector), followed by the 'human health' sub-sector (with a net balance of 833,000 new jobs, 33% of the total) and by 'non-residential social work' (644,000 new jobs, 25% of the total).

With regard to absolute figures across the EU, the 'human health and social sector' accounted for 23,400,500 employees in the second quarter of 2015. The majority of them – 13,293,700 employees – were employed in the 'human health' subsector; the 'residential care' subsector accounted for 4,965,600 employees, while 5,141,200 workers were employed in 'social work activities without accommodation'.

Figure 8: Evolution of jobs in health and in all other sectors



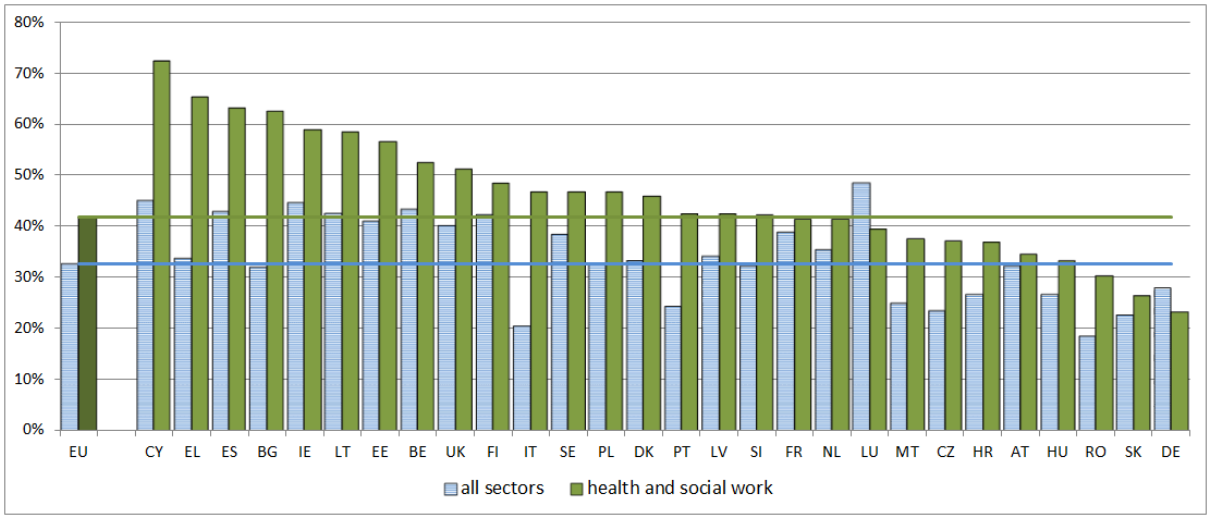
Average annual changes in jobs between 2008 (Q2) and 2015 (Q2) in human health and in all other sectors - Source: Eurostat, labour force survey.

Workers in the health and social work sector have an education level far above the average of all sectors. As Figure 9 shows, the presence of workers with tertiary education is consistently higher in the health and social sector than in the whole economy.

[14] The 'Health and social work' sector includes three sub-sectors: 'human health', 'residential care', and 'non-residential social work'. For some statistics no breakdown is available; in order to present comparable data it is therefore necessary to present the aggregate value for the whole sector. A detailed analysis on health and social services from an employment and economic perspective is available in the EU Employment and Social Situation - Quarterly Review - December 2014, available here: http://ec.europa.eu/social/keyDocuments.jsp?pager.offset=0&langId=en&mode=advancedSubmit&policyArea=0&subCategory=0&year=0&country=0&type=0&advSearchKey=quarterlyreview&orderBy=docOrder

[15] This sector is composed both by activities which may be ascribed to human health and to social care, but under the current classification it is difficult to estimate the relative weights of the two sub-components.

Figure 9: Workforce's level of education



Employment of workers holding a tertiary degree as a percentage of total employment in health and social work and in all sectors, 2014 - Source: Eurostat

In the European Union as a whole, in 2014, 33% of all workers held a tertiary degree (corresponding to ISCED-1997 levels 5 and 6); in the health and social work sector this value was 42%, i.e. close to one worker out of two held a tertiary degree. The percentage of workers with an upper or post-secondary education (ISCED 3-4) was 48.3% for the whole economy and 45.4% in the health and social work sector. To complete the picture, 19.1% of all workers held no more than a lower secondary degree (ISCED 0-2), while this percentage was only 12.8% in health and social work sector.

According to Commission estimations, around 15% of all people holding tertiary education at the age of 30-34 are employed by the health and social work sector[16].

3 Identification of policy levers to address the challenges

The Communication from the Commission on Effective, Accessible and Resilient Health Systems proposes an EU agenda with a number of actions to improve the performance of health systems in the European Union. While this is primarily a task for the Member States, the Commission communication highlights a number of initiatives through which the EU can support policy makers in the Member States..

Member States' future ability to provide universal and equitable access to high quality care will depend on making health systems more resilient, more capable of coping with the challenges ahead and while remaining cost-effective and fiscally sustainable.

In view of the need to continue reforms to enhance the cost-effectiveness of healthcare and ensure adequate access, the 2016 Annual Growth Survey called for Member States to introduce measures to ensure a sustainable financing basis, encourage the provision of and access to effective primary health care services, the cost-effective use of medicines, better public procurement, improve integration of care through up to date information channels (such as e-health), assess the relative effectiveness of health technologies and to encourage health promotion and disease prevention.

The EC-EPC Joint report on Health Systems (2010)[17] identified a number of areas where improvements could increase the cost-effectiveness of health systems in the medium and long term as well as their long-term sustainability. These included:

- sustainable financing basis to the sector, a good pooling of funds and a resource allocation that is not detrimental to more vulnerable groups.
- improvement in life-styles and access to more effective health promotion and disease prevention.
- improving and better distribute primary health care services and reducing the unnecessary use of specialist and hospital care;
- cost-effective use of medicines while allowing for innovation in the health sector;
- improving the general governance (coherence of decision-making and management) of the system;
- improving data collection and information channels and using available information to support performance improvement;
- using health technology assessment more systematically to help decision-making processes;
- a balanced mix of different staff skills and preparing for potential staff needs due to ageing.

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[17] http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf