



EUROPEAN SEMESTER THEMATIC FACTSHEET

HEALTH SYSTEMS

1. INTRODUCTION

The health systems of EU Member States are a crucial part of Europe's high levels of social protection and cohesion.

Health systems in EU are varied and reflect different societal choices. Despite organisational and financial differences, they are built on the common values recognised by the Council of Health Ministers in 2006¹: universality, access to good quality care, equity and solidarity.

There is also a wide recognition of the need to make health systems fiscally sustainable in a way that safeguards these values for the future².

Over the last decade, European health systems have faced similar growing common challenges:

- European population is ageing and more exposed to multiple chronic diseases. This leads to higher demand for healthcare and increasing fiscal pressure;
- Costs of innovative technology and medicines increase and put a burden on public finances;
- Health professionals are unevenly distributed, with shortages in some areas of care; and
- Access to healthcare is not equally distributed and results in inequalities in health outcomes across society.

The Commission Communication on effective, accessible and resilient health systems³ defined a strategic agenda for health systems in the EU.

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 Council conclusions on Health systems and fiscal sustainability (8.11.2016): <http://data.consilium.europa.eu/doc/document/ST-14182-2016-INIT/en/pdf>.

³ COM(2014) 215 final: https://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/com2014_215_final_en.pdf.

Important contributions to this agenda came from the Joint Report on healthcare and long-term care systems and fiscal sustainability, which was prepared by the European Commission and the Economic Policy Committee⁴.

The European Pillar of Social Rights adopted in April 2017 states in Principle 16 that everyone has the right to timely access to affordable, preventive and curative healthcare of good quality.

Timely access means that everyone is able to access healthcare whenever they need it. This requires a balanced geographical location of health care facilities and health professionals, and policies to minimise long waiting periods.

Affordable healthcare means that people should not be prevented from using needed care because of the cost.

Good quality healthcare means that it should be relevant, appropriate, safe and effective.

EU health systems are increasingly interacting with each other. The Patients' Rights in Cross-Border Healthcare Directive⁵ was a milestone in providing a legal framework and policy tools for this cooperation. In particular, the directive provides clear rules and reliable information to patients on access and reimbursement for healthcare received in another EU country.

2. IDENTIFYING THE CHALLENGES

2.1. The health sector is a major source of employment

The 'health and social work' sector is the sector which saw the largest rise in employment in recent years with over 2.6 million new jobs (between

the first quarter of 2009 and the first quarter of 2017). Within the health and social sector, the increase in jobs was distributed as follows:

- in the 'human health' sub-sector: 960 500 new jobs, accounting for 36% of the new jobs created in the whole sector;
- in the 'residential care' sub-sector, 946 500 new jobs, 35% of the total; and
- in 'non-residential social work': 776 700 new jobs, 29% of the total.

The 'human health and social sector' accounted for 24 014 500 employees in the first quarter of 2017. Most of those — 13 601 700 employees — were employed in the 'human health' sub-sector. The 'residential care' subsector accounted for 5 066 800 employees, while 5 346 000 workers were employed in 'social work activities without accommodation'.

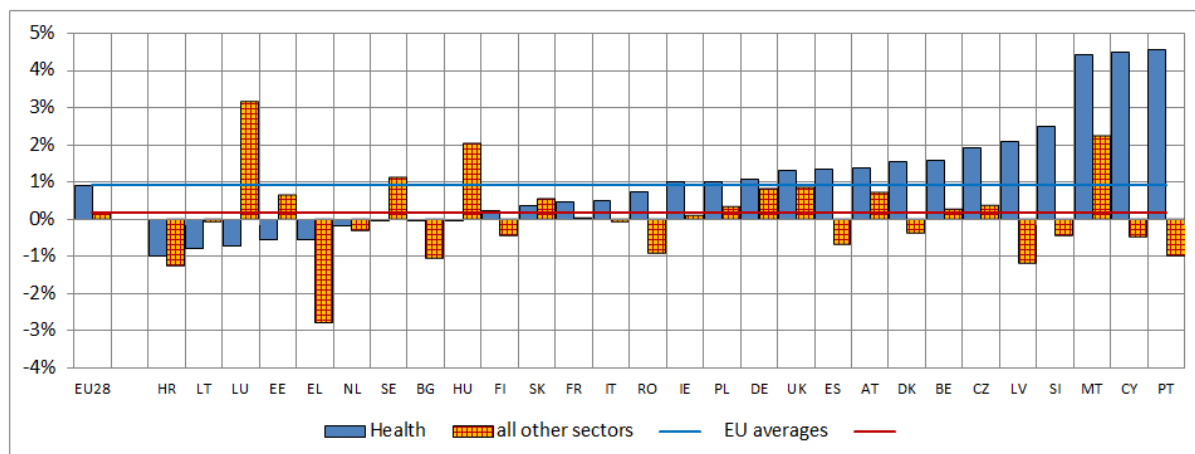
However, not all new jobs correspond with the new demand for healthcare: Europe's ageing population requires different skill sets and different ways of working across sectors and disciplines to provide effective care.

There are skills mismatches both in the nature and the distribution of skills across health professions. New forms of delivery of care that entail a shift of tasks (e.g. from physicians to nurses) and better integration may provide safer and more effective care at lower costs.

⁴ European Economy, Institutional Paper 37, October 2016: https://ec.europa.eu/info/publications/economy-finance/joint-report-health-care-and-long-term-care-systems-fiscal-sustainability-0_en.

⁵ Directive 2011/24/EU on the application of patients' rights in cross-border healthcare; OJ L 88, 4.4.2011.

Figure 1 – Evolution of jobs in health and in all other sectors



Average annual changes in jobs between 2009 (Q1) and 2017 (Q1) in human health and in all other sectors
Source: Eurostat, labour force survey.

Workers in the health and social work sector have a level of education far above the average of all sectors. As shown in the Annex, the number of workers with tertiary education (i.e. a degree from university or another higher education institution) is consistently higher in the health and social sector than in the whole economy.

In the EU in 2016, 33.9% of all workers held a tertiary degree; in the health and social work sector this value was 43.4%. The percentage of workers with an upper or post-secondary education was 48% for the whole economy and 45% in the health and social work sector. To complete the picture, 17.9% of all workers held no more than a lower secondary degree, while this percentage was only 11.5% in health and social work sector⁶.

Health and social work remains a sector heavily biased towards a female workforce: four out of five workers in this sector are women and the percentage remained substantially unchanged in the period under consideration.

An effective and accessible health sector contributes also indirectly to economic growth and prosperity: it helps people achieve and maintain good health status

and thus guarantee broader participation in the labour force and higher productivity.

2.2. Fiscal sustainability of health systems

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. This situation is potentially challenging the sustainability of public finances, especially in the context of an ageing population.

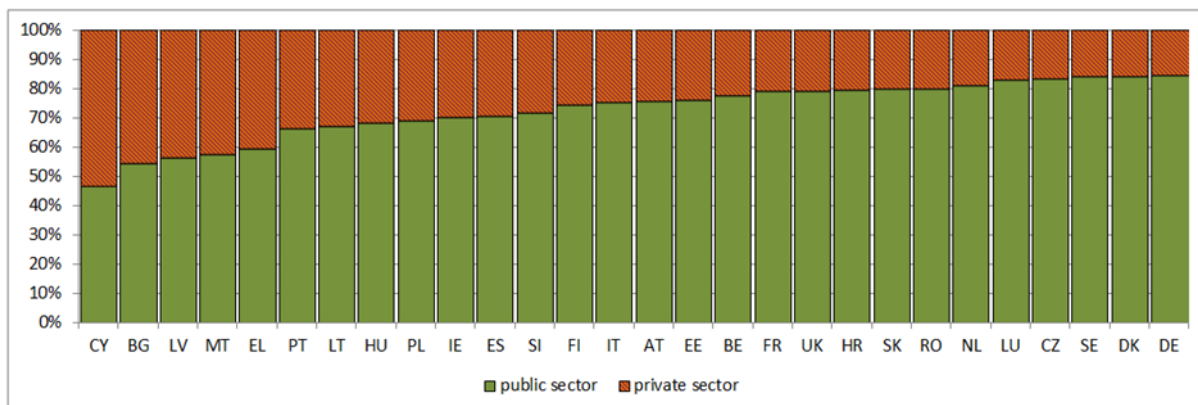
Figure 2 shows the share of public and private financing to healthcare systems across EU countries. Member States with a relatively high share of private health expenditure are Bulgaria (46% of total health expenditure), Greece (above 41%), Cyprus (54%), Latvia (44%), and Malta (43%)⁷.

Member States with the highest share of health expenditure funded by the government are the Czech Republic (83%), Denmark (84%), Germany (85%), Luxembourg (83%), the Netherlands (81%), and Sweden (84%).

⁶ Tertiary degree corresponds to ISCED levels 5 and 6. Secondary degree corresponds to ISCED 3 and 4. Lower secondary degree (and less) is represented by ISCED 0, 1 and 2.

⁷ The private component may be driven by supply-induced demand and by how this influences patients' choices. It may therefore overestimate the actual financing needs.

Figure 2 – Health financing



Health expenditure by financing agent – Source: OECD, Eurostat, WHO – 2016 or most recent data

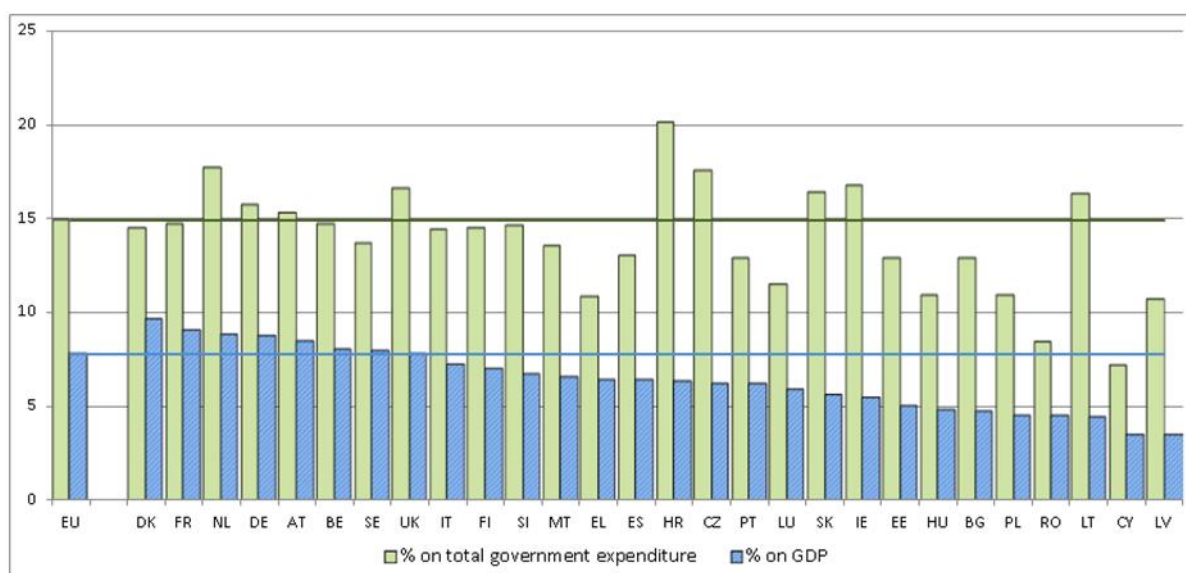
Figure 3 shows the levels of public expenditure on health in EU Member States, expressed both as a percentage of GDP and as a percentage of total general government expenditure.

In 2015, public expenditure on health amounted to 7.8% of GDP in the EU as a whole. Eight Member States have a health expenditure-to-GDP ratio equal to or above the weighted EU average: Belgium, Denmark, Germany, France, the Netherlands, Austria, Sweden and the United Kingdom. The Member States with the lowest share of public health expenditure were Cyprus and Latvia (3.5%), and below

5% were Bulgaria, Estonia, Lithuania, Hungary, Poland, and Romania.

On average, public expenditure on health amounted to 15% of total government expenditure in the EU in 2015. Member States above the EU value were the Czech Republic, Germany, Croatia, Ireland, Lithuania, the Netherlands, Austria, Slovakia and the UK. The Member States with the lowest values were Cyprus (7.2%) and Romania (8.4%), followed by Greece, Latvia, Hungary, Poland (all below 11%), and Luxembourg (11.5%)⁸.

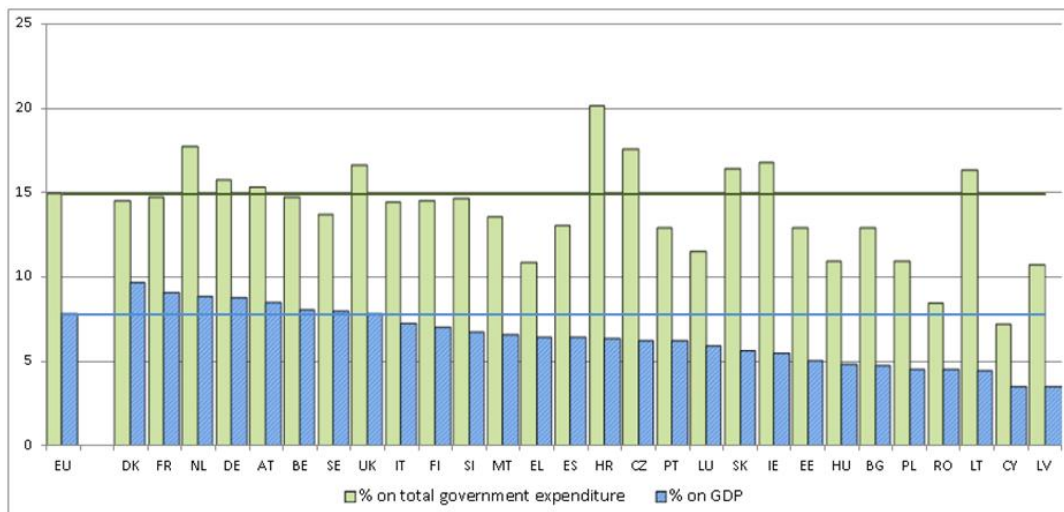
Figure 3 – Public expenditure on health



Public health expenditure as a% of total government expenditure and of GDP
Source: Eurostat, United Nations Statistics Division; 2013 or most recent data – Commission services' calculations

⁸ However, some countries have a system of clawbacks in place in many areas of health expenditure. This means that the recorded level of public expenditure may underestimate the actual level.

Figure 3 – Public expenditure on health



Public health expenditure as a% of total government expenditure and of GDP

Source: Eurostat, United Nations Statistics Division; 2013 or most recent data – Commission services' calculations

Public health expenditure is among the largest and fastest growing spending items for governments.

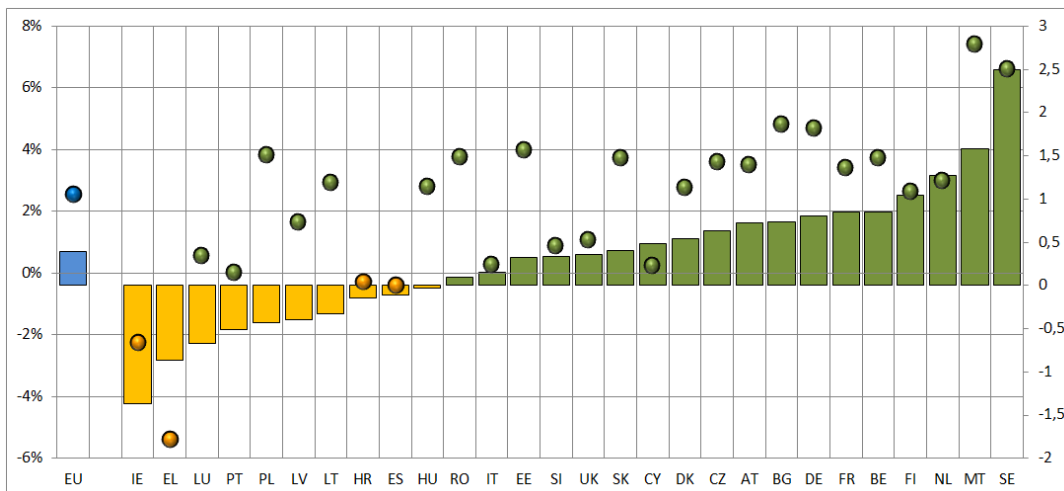
Figure 4 shows the increase in public health expenditure as a percentage of GDP between 2008 and 2014 (in pps). The same figure shows the average annual increase of public real per capita expenditure on health during the same years, expressed by circles.

The combination of these two measures gives a better understanding of public expenditure on health. Variations in the levels of health expenditures on GDP are in fact the result of the combined trends of both, public expenditure on health and GDP.

A relative increase in health expenditure as a percentage of GDP can actually be the net effect of a decrease of both measures, with the GDP decreasing more than expenditures (and vice versa). Per capita values provide therefore additional information to assess the trends: if health expenditure increase as a share of GDP and decrease in per capita terms, it is likely that the country's GDP is declining faster than health expenditure.

Growth paths should be analysed jointly with the initial value. A lower or higher than average starting point may give a different interpretation to increases and decreases in healthcare expenditure.

Figure 4 – Growth of public expenditure on health as% of GDP and per capita



Increase in public expenditure on health as a% of GDP (2008-2014, p.p. right scale) and average annual increase on real per-capita public expenditure on health (circles, 2008-2014, left scale)

Source: WHO Health for All database – Commission services' calculations.

Pressure for higher health spending is going to stay.

According to the 2015 Ageing Report, a further increase in the share of public health expenditure on GDP is expected from now to 2060. The main drivers for this increase are:

- growing incomes and rising expectations towards high-quality health services;
- ageing population; and
- technological advancements.

In the 'Ageing Working Group (AWG) reference scenario', public expenditure on health in the EU will increase by 0.9 pp. of GDP until 2060 (Figure 5). The 'AWG risk scenario' estimates an average increase of expenditure of 1.6 pp. of GDP by 2060 (Annex).

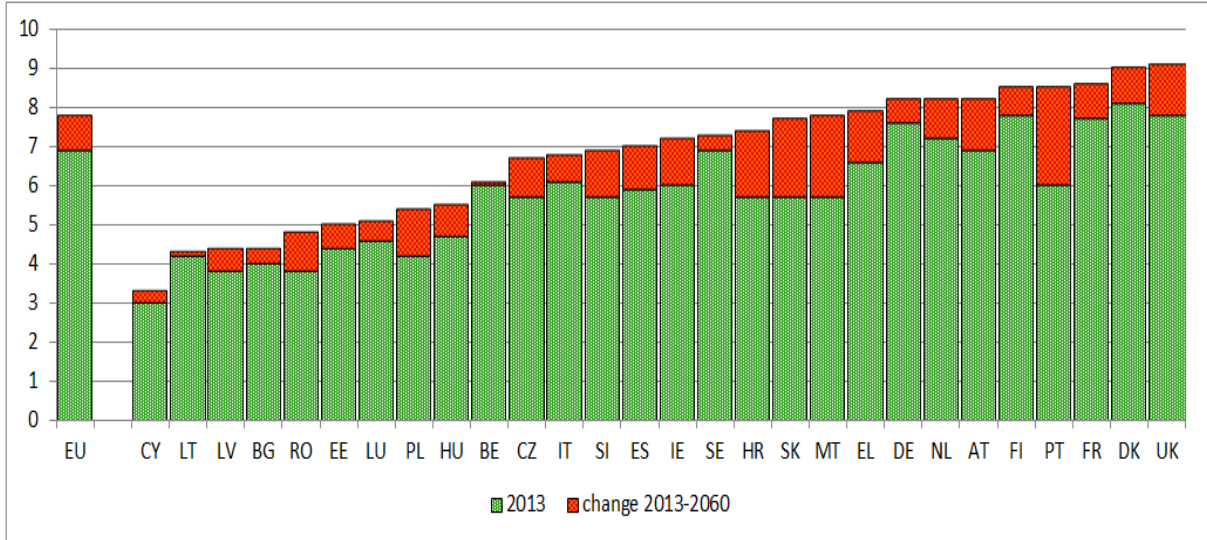
An essential EU objective is to ensure the sustainability of public finances, including over a mid- and long-term perspective. For many EU countries, sustainability risks for public finances are related to a substantial degree from the projected impact of age-related public spending

on healthcare and long-term care. In addition to fiscal challenges, healthcare and long-term care systems often face common structural challenges that relate to an inefficient distribution and use of resources across functional areas of spending. The OECD estimates that one fifth of health expenditure makes little or no contribution to improving people's health. In some cases, it even results in worse health outcomes. Countries could potentially spend significantly less on healthcare without worsening health system performance or health outcomes⁹.

Additional challenges are:

- unequal access to healthcare;
 - frequent budget overruns;
 - competing fiscal pressures from various ministries;
 - changing policy priorities;
 - fraud or corruption; and
- the lack of information on value for money of investment in healthcare and long-term care systems.

Figure 5 – Baseline situation and projected expenditure in health care EU countries over 2013-60, AWG reference scenario



Source: Based on Ageing Report 2015 – Commission services.

⁹ OECD; Tackling Wasteful Spending on Health; January 2017 – <http://www.oecd.org/health/tackling-wasteful-spending-on-health-9789264266414-en.htm>.

2.3. Access to effective health systems contributes to social cohesion

The most common barriers for access to healthcare resulted from patients' inability and/or unwillingness to pay for medical goods and services. In some countries waiting times or travelling distance were an issue. 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 by health system decision-makers.

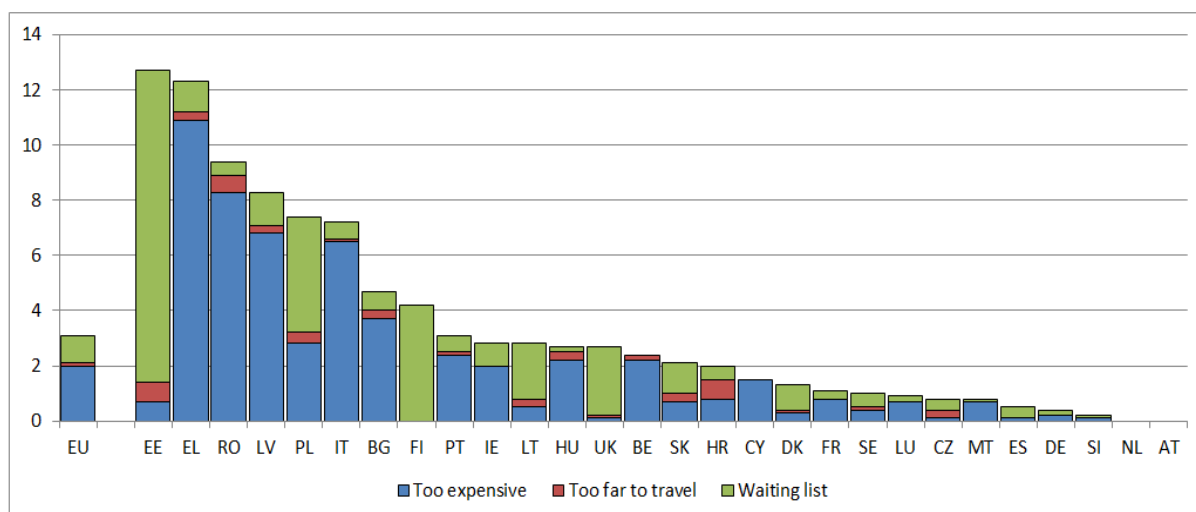
Access to healthcare could also be hindered

by insufficient availability of healthcare infrastructure and health workforce.

An indicator which is frequently used to show barriers in access to healthcare is patient self-reported unmet needs¹⁰. This indicator is now adopted in the social scoreboard that forms part of the social pillar.

In four out of five European countries less than 5% of the population reported levels of unmet needs for medical examination. However, in some countries, the proportion of people reporting unmet needs was considerably higher¹¹.

Figure 6 – Self-reported unmet needs for medical examination because of cost, waiting time, and travelling distance



Source: EU-SILC (2015)

¹⁰ Self-reported unmet needs for medical care concern a person's own assessment of whether he or she needed examination or treatment for a specific type of health care, but did not have it or did not seek it because of the following three reasons: 'Financial reasons', 'Waiting list' and 'Too far to travel'. The problems that people report in obtaining care when they are ill often reflect significant barriers to care.

¹¹ With specific reference to Greece, the dramatic reduction of salaries and the surge in unemployment in a fragmented health insurance system with weak redistribution caused a considerable drop in coverage and eligibility for public healthcare. While there is evidence of overconsumption of healthcare services before the crisis in Greece (as reflected by the high level of out-of-pocket payments), this became no longer affordable with the crisis. Universal coverage was introduced by subsequent reforms in 2014 and in 2016. The impact of these reforms on unmet needs is not yet captured by available data.

Gaps in self-reported access to good quality healthcare can be found across the EU, despite Member States agreeing to the common principle of equity of health systems. Barriers to equity in access to healthcare can be multiple, and include financial, administrative, geographical, legal, cultural and organisational factors.

The self-reported unmet medical needs should also be seen against objective measures of the use and expenditure on healthcare. For example, the level of public, private and out-of-pocket spending on healthcare¹², which also provide information related to the financial protection of the population against the risks of ill-health, and the current use of health services.

Providing sustainable universal access to high quality care requires increased efficiency and effectiveness in health spending, against a background of rising demand and constrained resources. The challenge is to identify cost-effective ways to finance, organise and deliver care, to achieve better health outcomes using available resources more rationally.

Across the board cuts in spending aimed at delivering short-term savings and which do not target the cost-effectiveness of the system, might lead to higher expenditure in the mid to long-term.

In particular, many Member States perceive it as a challenge to improve access to affordable medicines. In fact, a high number of new medicines are forecast to be launched in the next years, creating higher financing needs compared to the last decade.

The nature of new medicines is gradually changing: innovations are based on complex and costly biopharmaceuticals

and increasingly target smaller population groups. Public and private payers for healthcare increasingly grapple with how to afford the rising number of these medicines.

Several deaths in Europe still occur too early. In the EU, 1.69 million people below 75 years died in 2014. Of these, around 562 034 deaths could be considered as premature. Those deaths could have been avoided in the light of current medical knowledge and technology. Heart attacks and strokes combined accounted for almost half of these total avoidable deaths.

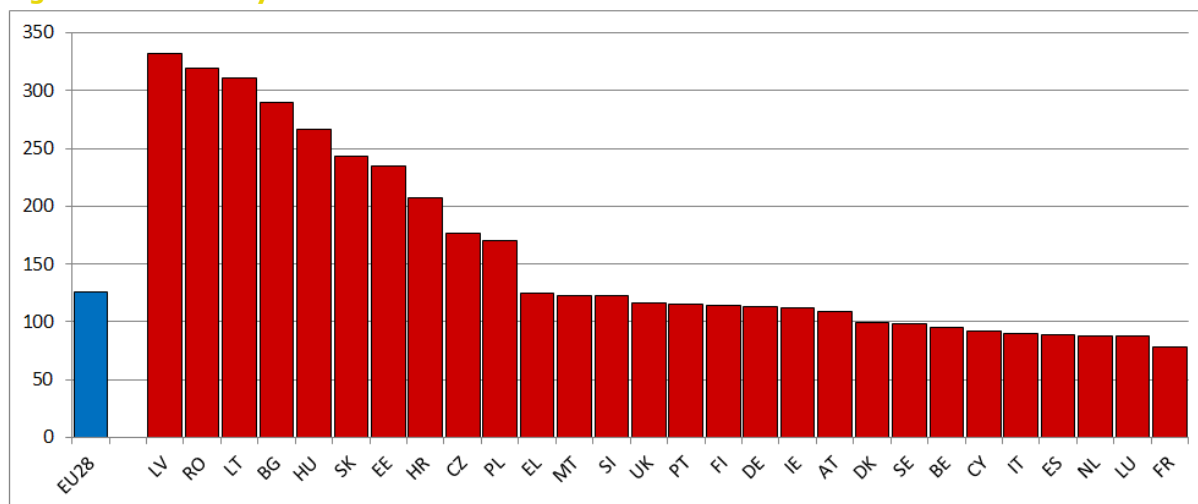
The concept of mortality amenable to healthcare is based on the idea that certain deaths (for specific age groups and from specific diseases) could be 'avoided'. In other words, certain deaths would not have occurred at this stage — if there had been timely and effective healthcare in place.

This indicator on amenable mortality is used in a global context of health system performance assessments to provide some indication of the quality and performance of healthcare policies.

The shares of deaths that are amenable through optimal healthcare among all deaths of people aged under 75 in 2013 vary considerably between EU Member States.

¹² Out-of-pocket spending refers to direct payments for goods and services from the household primary income or savings, where the payment is made by the user at the time of the purchased of goods or the use of the services either without any reimbursement or as cost-sharing with an organised scheme. This indicator is also potentially influenced by patients' choices. The cross-country comparability of the data is currently limited due to the level of precision in which SHA 2011 has been implemented in EU countries.

Figure 7 – Mortality amenable to healthcare



Source: Eurostat Database (2014)

3. IDENTIFYING APPROPRIATE 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 cooperation mechanisms to support national reforms. The aim is to improve the performance of health systems in the EU. Mechanisms include HTA, eHealth and digital health, health system performance assessment, workforce planning, European reference networks, etc.¹³

This cooperation intends to improve efficiency and effectiveness of health systems in order to ensure fiscal sustainability and access to good quality healthcare services for all.

The EC-EPC Joint Report on healthcare and long-term care systems (2016) identifies a number of areas where improvements could increase the cost-effectiveness of health systems in the medium and long-term and their long-term sustainability.

Appropriate policy levers include:

Improving the governance of the systems.

- 1) Strengthening the cooperation between fiscal and health policy authorities and employing a wide range of budgetary planning tools to support efficiency, transparency and accountability;
- 2) Setting up information technology and data management strategies, to support monitoring and governance and strengthening the fight against corruption, fraud and misuse of public resources;
- 3) Assessing reforms *ex-ante* and *ex-post* in a systematic and formalised way based on evidence and implementing health system performance assessment;
- 4) Clearly defining the roles of public authorities for long-term care services, aiming at integrating medical and social services via a legal framework and improving administrative efficiency;
- 5) Improving the adequacy and quality of human resources in the health sector by adapting planning to needs, adjusting incentives, exploring the possibility to recruit physicians across borders, and planning for the long term;

Promoting the sustainability and efficiency of financing and expenditure

¹³ https://ec.europa.eu/health/home_en.

6) Ensuring that the publicly reimbursed benefits packages are based on cost-effectiveness and equity criteria and that cost-sharing schemes supports the containment of public spending, while preserving access;

7) Designing wages and purchasing mechanisms to promote efficiency and equity;

8) Moving health systems away from the traditional hospital-centric model, by giving a stronger role of gatekeeping and referral to primary care and promote coordination and integration of care;

9) Enhancing the sustainability of hospital care by improving financing arrangements, reducing operational costs and improving comparison of hospital performance and benchmarking;

10) Strengthening the cost-effective use and the affordability of medicines, by promoting public procurement and the role of generics and biosimilars¹⁴, appropriate price-control policies and promoting rational use of medicines.

11) Further exploring mechanisms of cross-country cooperation to address the issues of availability and accessibility of medicinal products in EU countries. This should include appropriate regulatory mechanisms at EU level and joint procurement agreements;

12) Enabling HTA-informed, cost-effective coverage decisions for new and existing technologies, including through cooperation between Member States;

Improving access, quality, and effectiveness of care

13) Strengthening policies for health promotion and disease prevention: promoting campaigns on risk factors, developing integrated multi-sectorial and

multi-stakeholder initiatives and aligning financial plans to policy timelines;

14) Increasing accessibility to good quality care by reducing waiting times and the households' financial burden of health expenditure, including informal payments;

15) Taking into account the needs of vulnerable groups, in particular through relevant fiscal and social protection policies, intersectional cooperation in care service delivery, culturally sensitive services;

16) Providing suitable levels of care to those in need by promoting and assessing quality and effectiveness;

17) Promoting independent living and supporting the delivery of health and long-term care services at home and in the community rather than in institutional settings, when appropriate;

18) Promoting healthy ageing and preventing physical and mental deterioration of people with chronic conditions.

4. CROSS-EXAMINATION OF POLICY STATE OF PLAY

Several Member States have introduced and implemented substantial measures to increase access to health services while maintaining quality and sustainability of the system.

Bulgaria, Estonia, Malta, Austria and Poland addressed substantial reforms to strengthen primary care and better coordinate with hospital and specialised care. In addition, Sweden also allocated increased funds to improve the accessibility of healthcare services.

Cyprus has embarked on a redesign of its health system to entitle access to healthcare to the whole population and reduce high out-of-pocket payments.

Portugal implemented significant reforms in 2016 and 2017 to ensure universal health coverage.

Bulgaria took steps to increase outpatient care where the low public coverage of

¹⁴ A *generic medicine* is a pharmaceutical product that is the same as a medicine that has already been authorised (the 'reference medicine'). It contains the same active substance(s) as the reference medicine. A *biosimilar medicine* is highly similar in all essential aspects to an already approved biological medicine.

outpatient medical services makes it difficult for some people to access healthcare.

Austria introduced a new DRG (diagnosis-related-groups) system for payment in the hospital ambulatory area to relieve pressure from the inpatient sector and to incentivise the use of day clinic and ambulatory services.

Latvia and Poland initiated reforms to increase the availability of health workforce.

Hungary and Romania took first actions to increase wages for health professionals.

Latvia, Poland, Portugal and Romania announced measures to attract physicians and nurses to work in peri-urban or rural areas.

Latvia and Malta reduced waiting times, while Romania reorganised parts of the ambulatory care system.

Italy, Malta, Portugal and Slovenia developed and implemented ICT solutions to reduce the waiting times for healthcare services.

Spain, Italy, Portugal and Slovakia are implementing reforms such as centralisation of procurement, uptake of generics and development of HTA bodies. The end goal is to increase access to medicines and ensure their cost-effective use.

Latvia and Romania put in place plans to enhance accountability and transparency mechanisms in the health system.

The State of Health in the EU cycle¹⁵ presents evidence on health policies in Europe. In particular, country health profiles give more detailed analyses of the policy state of play in every Member State.

The companion report builds on the findings of the country profiles and emphasises cross-cutting policy implications.

Date: 26.9.2017

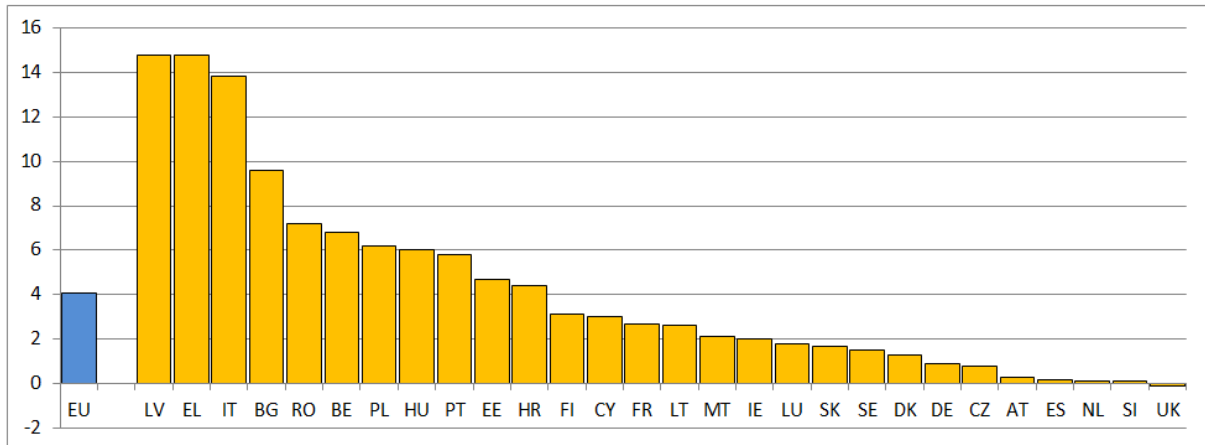
¹⁵ https://ec.europa.eu/health/state/summary_en.

5. USEFUL RESOURCES

- Communication from the Commission on effective, accessible and resilient health systems (COM(2014) 215 final)
https://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/com2014_215_final_en.pdf
- Joint report on health care and long-term care systems and fiscal sustainability — European Economy, Institutional paper 37, October 2016; DG Economic and financial affairs, and the Economic Policy Committee
https://ec.europa.eu/info/publications/economy-finance/joint-report-health-care-and-long-term-care-systems-fiscal-sustainability-0_en
- State of Health in the EU: Country health profiles
https://ec.europa.eu/health/state/country_profiles_en
- Health at a Glance: Europe 2016 — State of Health in the EU Cycle, OECD Publishing, Paris
https://ec.europa.eu/health/state/glance_en
- European semester thematic factsheet on Public finance sustainability
- WHO Health for All Database
- OECD Health database
- European Commission ECHI data tool
https://ec.europa.eu/health/indicators/indicators_en
- Opinion from the Expert panel on effective ways of investing in health on the 'Typology of health policy reforms and framework for evaluating reform effects'
https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/013_healthpolicyreforms_reformeffects_en.pdf
- Opinion from the Expert panel on effective ways of investing in health on 'Access to health services in the European Union'
https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/015_access_healthservices_en.pdf
- Opinion from the Expert panel on effective ways of investing in health on the 'Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems'
https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/004_definitionprimarycare_en.pdf
- Report from the EU expert group on health systems performance assessment 'So What? Strategies across Europe to assess quality of care'
https://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/sowhat_en.pdf
- Report from the EU expert group on health systems performance assessment 'Blocks: Tools and methodologies to assess integrated care in Europe'
https://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/2017_blocks_en_0.pdf

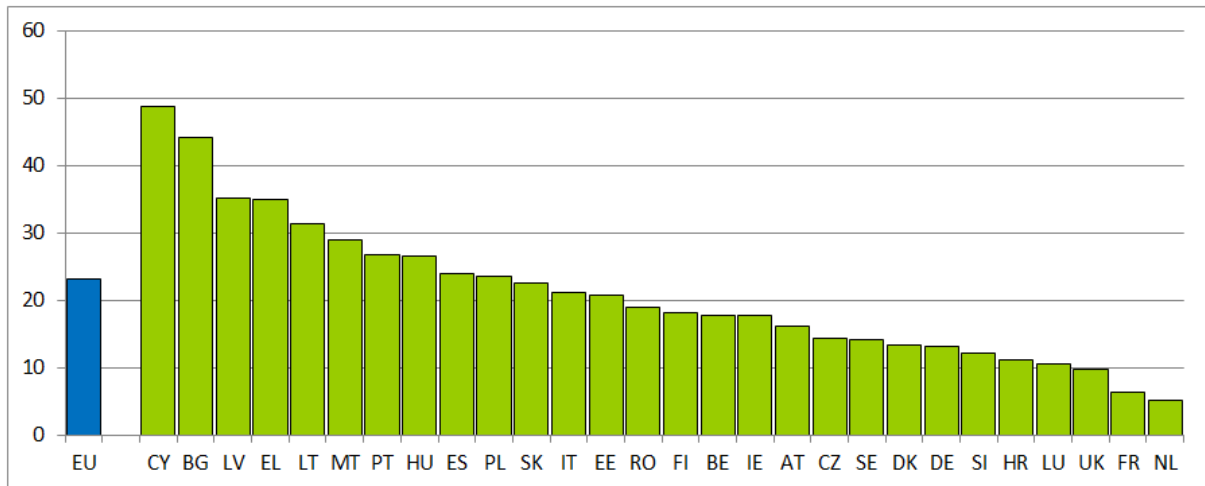
ANNEX

Figure A: Income quintile gap¹⁶ for self-reported unmet need for medical care, 2015



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

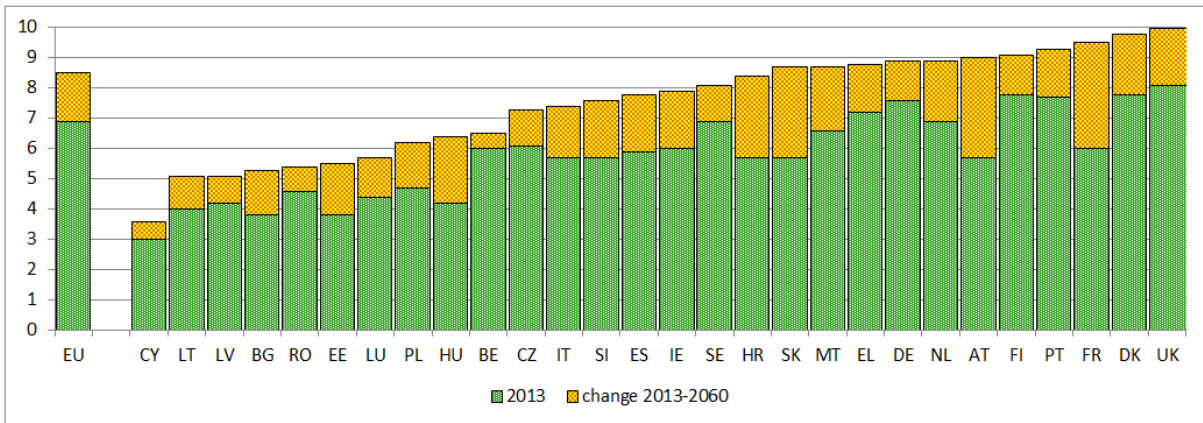
Figure B: Private household out-of-pocket expenditure as% of total current health expenditure, 2014 or latest available



Source: WHO HfA-DB

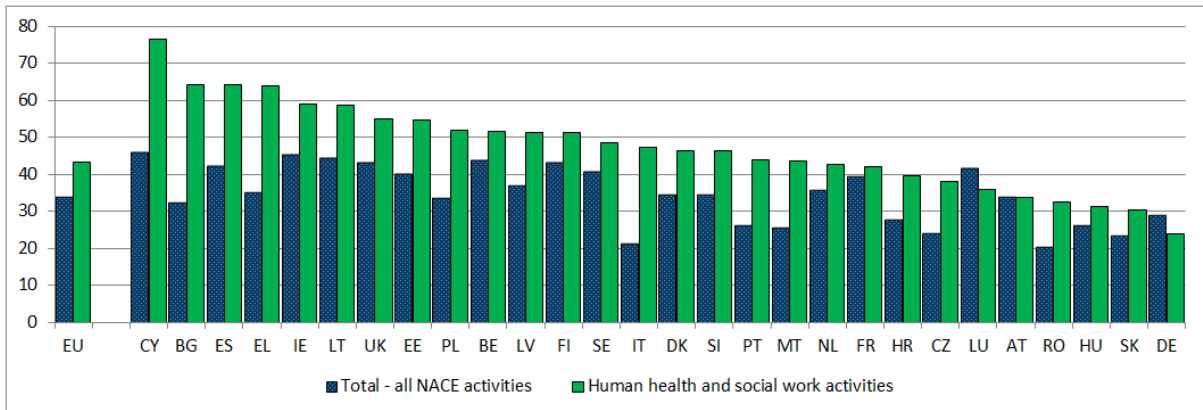
¹⁶ The difference (gap) between the percentage of the population from the bottom (q1) and top (q5) income quintile with self-reported total unmet needs for medical examination during the previous 12 months. The first quintile group represents the 20% population with the lowest income, and the fifth quintile group represents the 20% of the population with the highest income.

Figure C: Projected expenditure in health care in EU countries over 2013-60, AWG risk scenario



Source: Based on Ageing Report 2015 — Commission services.

Figure D: 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, 2016 — Source: Eurostat