European Commission

State of Health in the EU

Synthesis Report 2025

Health Policy Reform Trends in the EU

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European Observatory on Health Systems and Policies
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Foreword

Europe's health systems continue to face immense public health challenges in a rapidly changing geopolitical environment. Epidemiological and demographic shifts, rising defence and climate related expenditures, high and/or growing economic inequality, and rapid technological change are putting European welfare systems under significant pressure. Without coordinated adaptation and transformation, these pressures risk deepening health inequalities and undermining the sustainability of care. As countries work to recover from recent crises and prepare for future challenges, strengthening health system effectiveness, accessibility and resilience has become even more urgent. The State of Health in the EU initiative, funded under the EU4Health Programme, continues to serve as a key source of evidence and inspiration for policy-makers, researchers and citizens across Europe.

This *Synthesis Report* draws together insights from the latest 2025 *Country Health Profiles* to take stock of current reforms and highlight how countries are addressing four major interconnected health system challenges: preventing non-communicable diseases (NCDs), strengthening primary care, accelerating digital health transformation, and promoting affordable access to pharmaceuticals and innovation. These challenges cut across all Member States, calling for both national action and collective European solutions. In this edition, a renewed focus is placed on how countries are responding to these challenges – exploring the policy approaches and reform pathways shaping health systems across the European Union (EU).

The report shows that Member States are stepping up primary prevention through stronger public health policies, reforming primary care to become more integrated and people-centred, investing strategically in digital health infrastructures, and redesigning pharmaceutical policies to improve affordability and sustainability in line with key EU legislations such as on Health Technology Assessment (HTA) and the European Health Data Space (EHDS). Primary care remains a crucial gateway to the health system, yet challenges such as general practitioner (GP) shortages and accessibility concerns, including the affordability of medicines, persist. Short- to medium-term digital innovation can help improve coordination and efficiency, while in the longer term, effective public health policies can help ease the burden on primary care. Together, these efforts demonstrate the creativity, determination and solidarity of European health systems in adapting to complex health, economic and demographic pressures and their commitment to build a strong European Health Union. Importantly, the report also shows how health systems can contribute to the competitiveness of the EU. It highlights innovation through pharmaceutical Research and Development (R&D) and investment in health-related information and communication technologies (ICT) as well as the potential to generate higher overall economic output from improved population health.

This edition reaffirms our shared commitment – from the European Commission, the European Observatory on Health Systems and Policies and the Organisation for Economic Co-operation and Development (OECD) – to provide robust analysis and comparative evidence that supports effective and equitable health policy. By learning from one another, Europe can continue to build healthier, fairer and more resilient health systems.

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Executive summary

The State of Health in the EU cycle is a knowledge-brokering project launched in 2016 and funded by the European Commission through the EU4Health Programme. Biennial publications pool together the latest data and in-depth analyses on health systems to strengthen the evidence base on their performance, supporting European policy-makers and other relevant health stakeholders in developing more effective, accessible and resilient health systems. This *Synthesis Report* draws on the 2025 *Country Health Profiles* to analyse recent health system reform trends and policy innovations across EU Member States. Part 1 examines current challenges and policy responses across four priority topics: 1) stepping up prevention of non-communicable diseases (NCDs); 2) strengthening primary care systems; 3) accelerating the adoption of digital health solutions; and 4) promoting affordable access to pharmaceuticals and innovation. Part 2 provides country-specific findings from each of the 29 *Country Health Profiles*, with accompanying illustrative charts highlighting key insights on health status and the performance of health systems in the EU Member States.

Key messages

1 Strengthening prevention to reduce the health and economic burden of NCDs

NCDs – including cancer, cardiovascular diseases, diabetes and chronic respiratory diseases – are the primary drivers of preventable morbidity and mortality across the EU. An estimated 2.4 million potential productive life years were lost in the EU in 2022 from premature mortality among the working-age population due to NCDs. Member States are deploying taxation, regulatory, communication and environmental policies targeting tobacco and nicotine products, alcohol, obesity and physical inactivity, particularly among youth. Continued adaptation is needed to address emerging challenges such as vaping and childhood obesity. Effective NCD prevention can mitigate the growth in long-term health care costs while improving EU labour force participation and productivity. Exploratory analyses suggest preventing all NCD deaths in the EU among the working-age population could increase the total cumulative working-life years between 2022 and 2040 by 1%, mitigating an otherwise expected 7% reduction of the workforce.

2 Transforming primary care from systems under strain to resilient foundations of health systems

Primary care – the first point of contact for care for patients – faces rising demand linked to an ageing population, workforce shortages and chronic underinvestment. Only one in five doctors in the EU are general practitioners (GPs). Member States are implementing targeted reforms to improve workforce distribution and retention through both financial and non-financial incentives, increasing training programmes, and deploying multidisciplinary teams as part of delivering new models of care. Efforts also focus on attracting more people to pursue careers in primary care. These reforms aim to transform primary care into a more integrated system that improves access, patient-centredness and efficiency while at the same time enhancing its role of gatekeeper to reduce hospital use.

3 Scaling digital health to address health system pressures

COVID-19 accelerated the digital transformation of health systems, demonstrating how digital tools can help ensure care continuity, support data-informed decisions and strengthen resilience. By the end of 2024, all EU Member States had implemented electronic health record (EHR) access services, with at least 80% of the population technically able to access their EHRs in 85% of countries. Member States are also expanding investment in e-prescriptions, artificial intelligence (AI) integration and digital governance, supported by over EUR 16 billion from the Recovery and Resilience Facility and other EU funding sources. These efforts, anchored in the European Health Data Space (EHDS) and AI Act, aim to respond to rising health care demands and workforce shortages while fostering innovation and high-skilled jobs in Europe's health sector.

4 Advancing pharmaceutical reforms for affordable access and innovation

Member States are employing a range of policy tools including targeted funding, incentives, regulatory updates and institutional reforms to expand coverage, reduce out-of-pocket costs, expedite access to new therapies, and contain pharmaceutical expenditure. These national efforts are increasingly aligned with the EU's revision of the pharmaceutical legislation under negotiation and the Health Technology Assessment regulation, with early signs of improved affordability and efficiency. Financial protection has been strengthened in several countries, while systems that combine substitution mandates, digital prescribing and aligned incentives now see generic uptake above two-thirds of eligible prescriptions. Collectively, these measures have curbed effective cost growth despite higher list prices for new therapies. Nonetheless, ongoing gaps in financial protection, combined with regulatory complexities and public funding constraints continue to hinder equitable access and innovation, particularly in areas of unmet medical need. Greater business investment in pharmaceutical R&D, anchored in Europe through robust research infrastructure and close partnerships between companies, universities and public research institutes, can drive further innovation and economic growth.

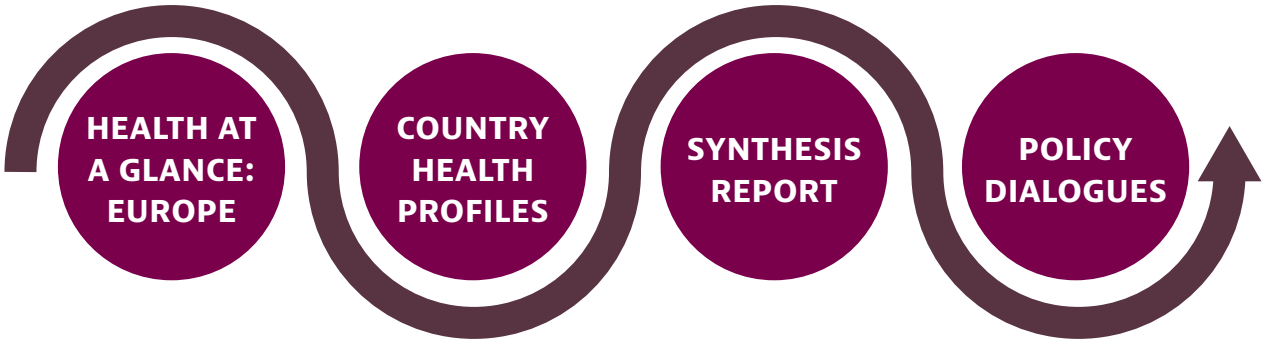
Conclusion

EU Member States are advancing a broad range of health system reforms. Some of these efforts are supported at EU level under a wide range of programmes (including EU4Health, Recovery and Resilience Facility, Cohesion Policy Funds, Technical Support Instrument, Digital Europe, and more), as well as through legislative and policy initiatives giving direction to tackle the growing burden of NCDs, to accelerate digitalisation, and to strengthen access to pharmaceuticals and primary care. These reforms offer triple dividends: improved population health outcomes, enhanced financial sustainability through prevention and efficiency gains, and significant economic benefits from increased labour productivity and innovation-driven growth in the pharmaceutical and health technology sectors.

Introduction

The State of Health in the EU cycle of knowledge brokering

The State of Health in the EU is a biennial cycle of knowledge brokering led and funded by the European Commission through the EU4Health Programme and delivered in collaboration with the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. It brings together the latest evidence on health systems in Europe and presents it in a series of concise, policy-relevant outputs.



Health at a Glance: Europe

The cycle begins with the joint OECD–European Commission report *Health at a Glance: Europe*, which provides a horizontal, cross-country assessment of health system performance in the EU. The latest edition, *Health at a Glance: Europe 2024*, was published on 18 November 2024 and marked the launch of the fifth cycle (2024–2026). It included two thematic chapters focused on health workforce shortages and trends in the health of Europe's ageing population.

The Country Health Profiles 2025

Experts from the OECD and the European Observatory have developed 29 *Country Health Profiles* for the 27 EU Member States, plus Norway and Iceland. These short, factual profiles summarise the latest health challenges and policy responses in each country, using a common template that is adapted to reflect national contexts.

Each profile begins with an overview of the population's health status and its determinants. It then describes the organisation of the health system and assesses its performance across three core dimensions: **effectiveness**, **accessibility** and **resilience**, as set out in the European Commission's Communication on effective, accessible and resilient health systems (European Commission, 2014).

A dedicated spotlight section focuses on **pharmaceuticals**, highlighting national policy developments in this area. Where relevant, the profiles also reference major EU health initiatives and funding instruments that support national reforms.

The Synthesis Report 2025

The *Synthesis Report* highlights key cross-country findings emerging from the *Country Health Profiles* and places them within broader reform trends. The report is structured around four cross-cutting themes: 1) stepping up prevention of non-communicable diseases (NCDs); 2) strengthening primary care; 3) accelerating the adoption of digital health solutions; and 4) promoting affordable access to

pharmaceuticals and innovation. These thematic sections reflect areas of increased reform activity reported in the 2025 *Country Health Profiles*. Initiatives and reforms in each of the thematic sections can strengthen health systems while also driving economic growth and boosting the EU's global competitiveness. This can be achieved by curbing health care expenditure, improving workforce productivity and participation in the labour market through better population health, and driving innovation in the EU's pharmaceutical and health technology sectors.

Part 2 of the *Synthesis Report* presents a collection of one-page summaries of the key findings from all the *Country Health Profiles*, complemented by a graph giving salience to a specific topic for each country.

The Policy Dialogues

The State of Health in the EU cycle also includes *Policy Dialogues* run by experts from the OECD and the European Observatory upon the request of health ministries. The main objective of these is to strengthen health policy by facilitating the exchange of policy practices across European countries.

Part I

Health system reform trends

REFORM AREA 1

Stepping up prevention of non-communicable diseases

Summary: Non-communicable diseases (NCDs), such as cancer, cardiovascular diseases (CVDs), diabetes and chronic respiratory diseases, are the leading causes of preventable illness and death in the EU. Their growing prevalence, including among young people, places increasing strain on individuals, health systems and economies. In response, countries have intensified multisectoral policy actions in recent years to address behavioural risk factors, including strengthening taxation and regulatory policies related to harmful alcohol consumption, (un)healthy diets, and consumption of tobacco and nicotine products, alongside efforts to promote physical activity.

Non-communicable diseases cause many premature and preventable deaths

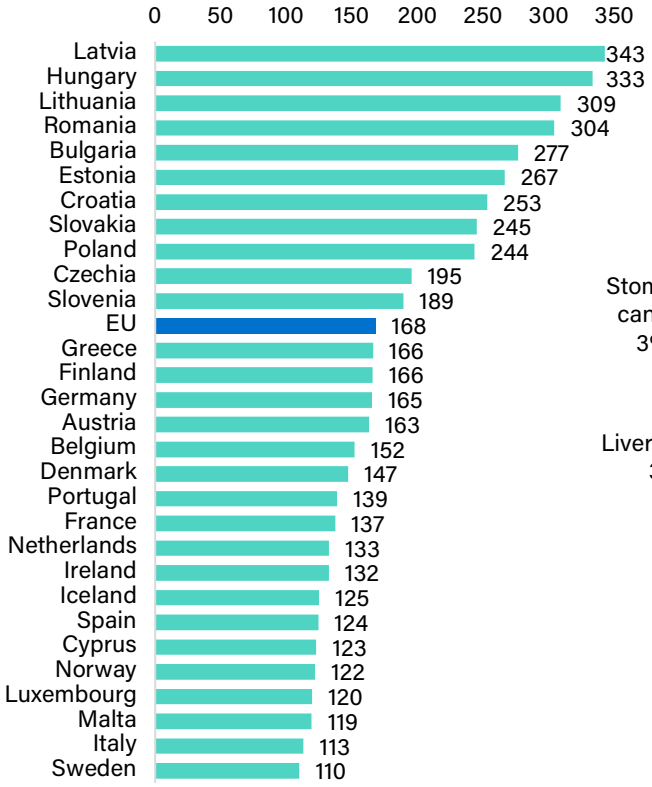
In 2022, more than 725 000 deaths in the EU could have been prevented through effective public health and prevention measures, with most of these deaths related to NCDs. Preventable cancers, CVDs and alcohol-related disorders together account for more than 50% of preventable deaths in the EU. Chronic obstructive pulmonary disease (COPD) also contributes to a large number of preventable deaths. The rate of preventable mortality in 2022 was lowest in Italy and Sweden (about 110 deaths per 100 000 population) while this was about three times higher in Hungary and Latvia (**Figure 1**).

In 2020, approximately 22 million people in the EU (5% of the population) were living with a cancer diagnosis. CVD affects an even wider population, with around 62 million people (14% of the population) living with the condition in 2021. Incidence continues to rise, with EU countries recording an estimated 1157 new CVD cases per 100 000 population in 2021 and 572 new cancer cases per 100 000 in 2022.

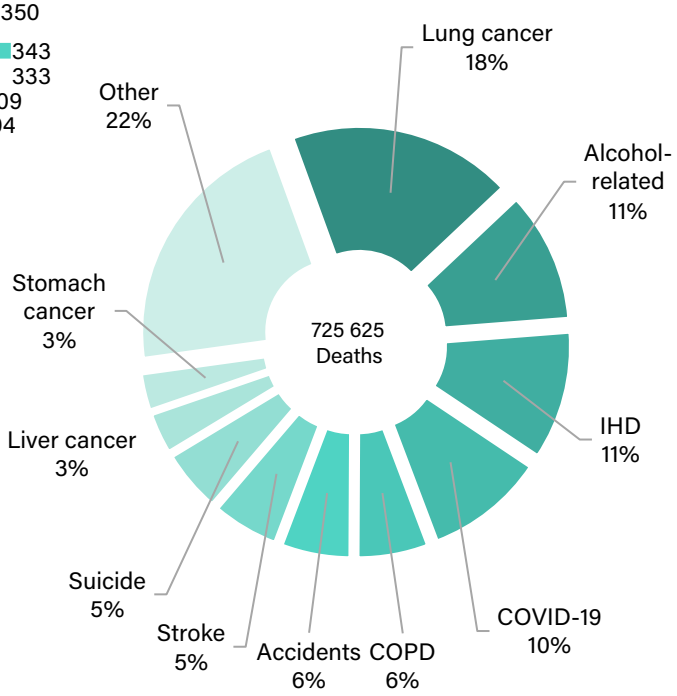
It is estimated that up to 80% of CVDs and type 2 diabetes can be prevented, up to half of cancer cases, and most chronic lung diseases like COPD (NCD Alliance, 2025). The causes of preventable NCDs are multifaceted, rooted in an interplay of genetic, behavioural, environmental and social determinants and risk factors, and amplified by population ageing. In some cases, such as lung cancer and alcohol-related disorders, use of tobacco products and harmful alcohol consumption are the key drivers; for others, unhealthy diet and insufficient physical activity are major contributors. Behavioural risk factors are the focus of this section, while recognising that broader influences, including occupational and environmental exposures, socioeconomic disadvantage and unequal access to health care, further shape patterns of disease and their risk factors.

Figure 1. Preventable cancers, cardiovascular diseases and alcohol-related disorders cause over half of preventable deaths in Europe

Age-standardised preventable mortality rate per 100 000 population, 2022



Preventable mortality distribution across the EU



Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. It refers to premature mortality (under age 75).
COPD: chronic obstructive pulmonary disease; IHD: ischaemic heart disease.

Source: Eurostat (hlth_cd_apr) (data refer to 2022).

In 2021, behavioural risk factors were estimated to account for roughly one quarter of all deaths in the EU (1 340 000 deaths), mainly due to unhealthy diet, tobacco use and harmful alcohol consumption, while air pollution contributed an additional 4%, according to estimates from the IHME Global Burden of Disease study (IMHE, 2025). In 2022, nearly one in five adults in the EU (19%) smoked daily, and each adult consumed on average 9.8 litres of pure alcohol per year (**Table 1**). Obesity affected 15% of adults, while only 31% engaged in physical activity more than three times per week. Patterns of diet also show room for improvement, with only about 60% of adults reporting daily fruit and vegetable consumption. For all risk factors, there were large disparities in prevalence between Member States.

Table 1. Fewer than one in three adults in the EU exercise more than three times a week, while one in seven are classified as obese

	Smoking Daily smokers (% adults)	**Alcohol** Litres consumed (per adult)	**Obesity** BMI≥30 (% adults)	**Fruit consumption** Not daily (% adults)	**Vegetable consumption** Not daily (% adults)	**Physical inactivity** 3 or less times per week (% adults)
EU	**18.5**	**9.8**	**14.6**	**38.6**	**40.4**	**69.4**
Austria	20.6	11.4	17.4	43.8	45.0	69.1
Belgium	15.4	7.8	15.5	38.7	20.2	73.8
Bulgaria	29.1	11.2	11.5	65.7	57.5	88.5
Croatia	22.1	10.8	16.5	47.1	43.3	85.9
Cyprus	22.5	5.1	13.3	32.1	34.9	58.6
Czechia	15.9	11.6	17.4	48.5	50.0	75.8
Denmark	11.7	9.5	19.2	52.2	45.5	40.4
Estonia	15.9	11.2	21.7	50.8	50.2	34.3
Finland	11.3	7.6	21.9	50.4	39.1	36.5
France	23.1	10.8	14.8	42.5	35.0	73.7
Germany	14.6	10.6	16.7	44.2	54.1	N/A
Greece	24.9	6.6	11.8	44.8	40.8	42.4
Hungary	24.9	10.8	21.8	58.7	67.2	74.1
Iceland	5.7	8.1	21.7	52.9	49.1	N/A
Ireland	14.0	10.3	19.4	35.5	27.7	50.8
Italy	19.5	8.0	7.0	15.9	24.1	74.5
Latvia	22.6	11.9	22.8	64.1	56.8	80.0
Lithuania	18.9	11.2	20.3	63.4	57.1	74.2
Luxembourg	18.1	10.7	16.9	44.8	42.0	70.3
Malta	20.6	6.6	25.8	38.1	55.6	66.5
Netherlands	13.2	8.3	13.6	36.0	29.0	40.9
Norway	7.0	6.6	16.6	43.6	35.4	57.4
Poland	17.1	10.5	18.4	43.8	40.9	70.3
Portugal	14.2	11.9	15.6	19.7	36.6	74.1
Romania	18.7	11.6	10.1	61.9	63.5	80.6
Slovakia	21.0	9.5	16.8	49.5	52.3	82.8
Slovenia	17.4	10.0	17.8	31.6	30.4	44.3
Spain	19.8	11.6	14.7	32.8	48.9	62.1
Sweden	8.5	7.5	17.0	51.7	41.4	40.1

Better than the EU average.
Close to the EU average.
Worse than the EU average.

Notes: The EU average is unweighted for smoking and alcohol consumption. The data relate to 2022 (or nearest year). The classification of countries as close to, better or worse than the EU average is based on one standard deviation from the average. Countries are classified as 'close to the EU average' (blue) whenever the value for that indicator is within one standard deviation from the EU average.

Sources: OECD Data Explorer (for smoking and alcohol consumption, complemented with data from the European Health Interview Survey (EHIS) 2019 for countries where more recent data on smoking are not available); European Union Statistics on Income and Living Conditions (EU-SILC) 2022 (for all other indicators, except for Germany and Iceland for which other data sources are used).

Socioeconomic and generational gaps in risk behaviours are widening across the EU, fuelling NCDs that erode health, productivity and economic potential

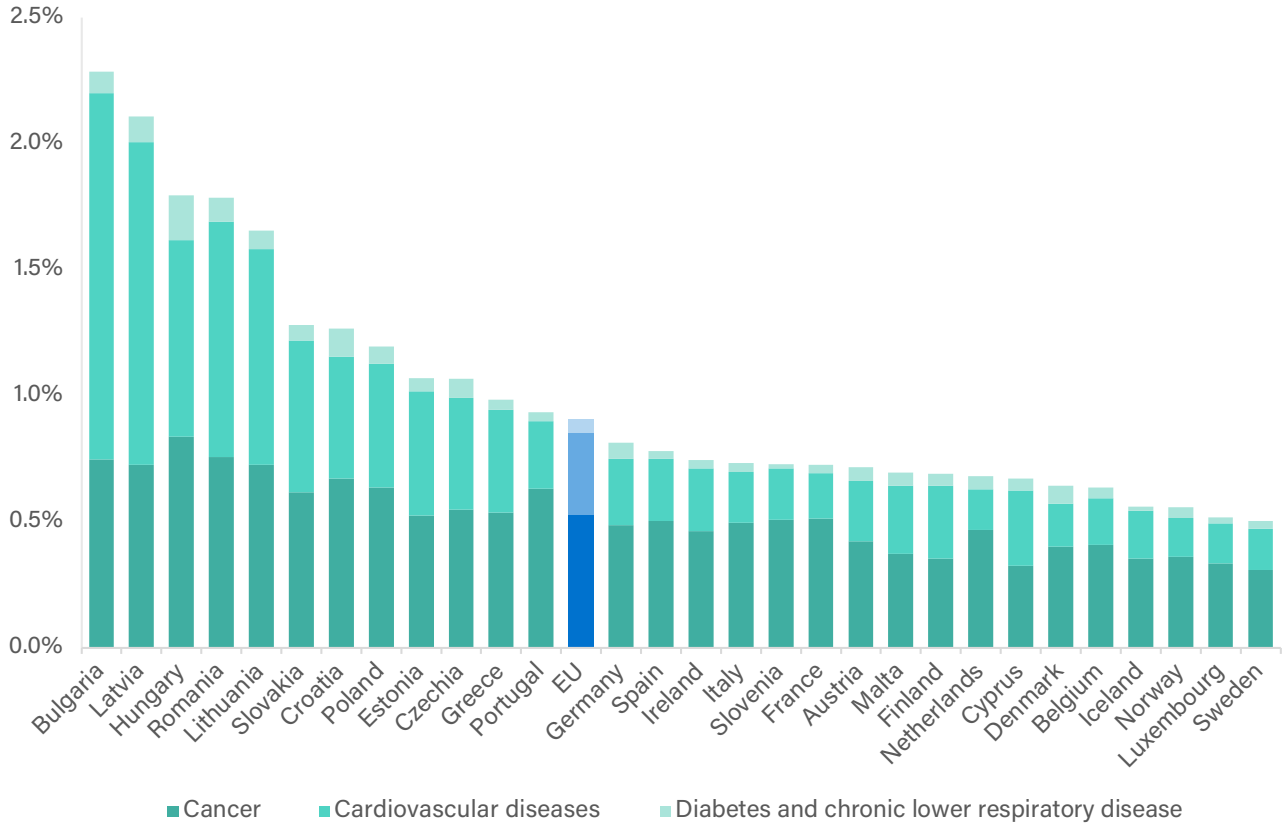
There are large socioeconomic disparities in smoking and obesity rates, often starting at a young age. The obesity rate among adults with low levels of education is more than 50% higher than among those with higher levels of education across the EU (17% compared to 11%). People with lower education levels are also 45% more likely to smoke than the most educated.

NCDs are also increasingly affecting younger populations, raising concerns that future generations may face even greater burden of disease than their predecessors. Across Europe, rates of childhood inactivity and obesity are rising. Although smoking rates among adolescents have declined over the last 20 years, use of electronic cigarettes (e-cigarettes) and other novel nicotine and tobacco products has become more common, with 21% of 15-year-olds in the EU reporting the use of e-cigarettes in 2022. This poses a substantial challenge to public health, especially as use of novel nicotine and tobacco products is a gateway to future use of traditional tobacco products. Harmful drinking patterns continue to be reported, with 23% of 15-year-olds reporting being drunk at least twice in their life.

The burden of NCDs impacts not only the health of individuals. It also drives up demand for health and long-term care, and reduces labour force participation and productivity among the working-age population. NCDs contribute to higher unemployment, absenteeism, presenteeism (i.e. being at work while sick, resulting in reduced productivity) and loss of potential productive life years. In the EU, about 424 000 people aged 25–64 died from major NCDs (CVDs, cancers, respiratory diseases and diabetes) in 2022. Assuming that these people would have been employed until age 65 at the same employment rate as the rest of the population, this results in an estimated 2.4 million potential productive life years lost in the EU in 2022 due to these NCDs, based on OECD/EU (2016) updating previous estimates to 2022 for the EU-27 (OECD & European Union). These losses of potential productive life years were particularly high in Bulgaria, Hungary, Latvia, Lithuania and Romania. In keeping with this, exploratory analyses based on an extrapolation of Eurostat population and mortality data for 2022 suggest that preventing mortality from NCDs would increase the total cumulative working-life years in the EU between 2022 and 2040 by around 1% (**Figure 2**). This suggests that the expected decline in workforce size by about 7% due to demographic ageing over this period would be reduced by approximately 12%. In some countries, including Denmark, France, Hungary, Norway, Romania and Sweden, the reduction could reach 25% or more. This effect is mainly driven by reductions in deaths from cancer. However, there are big differences across Member States, largely reflecting variations in mortality from CVDs.

Despite much talk about the need to place greater focus on prevention, only about 4% of total health spending on average in the EU was allocated to prevention in 2023, although this is an increase from just 3% before the pandemic. Spending levels on prevention in 2023 were approximately 36% lower than in 2022, largely reflecting reductions in COVID-19 related expenditure (e.g. on vaccinations).

Figure 2. Cumulative working-life year gains from preventing NCDs (2022–2040): cancer has the greatest impact, but cardiovascular disease drives differences across countries



Notes: The Y axis shows percentage gains in working-life years that could be achieved by preventing major NCDs in each country, countering an otherwise reduction in workforce size and working-life years in most countries due to population ageing. Estimates are based on a closed-cohort simulation of EU residents in mid-2022, using Eurostat population counts and 2022 age-specific mortality rates. Cohorts are advanced annually based on observed mortality, with no migration after 2022.

Sources: EC estimates based on Eurostat population and mortality data, following the selection of age groups (25yo–64yo) and diseases for the work-up of "potentially productive life years foregone" by OECD/EU (2016).

What measures have countries implemented in recent years to enhance prevention efforts against NCDs?

Addressing the health, societal and economic burden from NCDs requires coordinated, multisectoral strategies targeting risk factors across the life course. In recent years most Member States have strengthened population-level interventions, such as taxation, access restrictions (e.g. age restrictions on purchasing alcohol, and tobacco and nicotine products), marketing restrictions and environmental regulations, to help reduce behavioural risk factors.

The EU has also strengthened its support to Member States and stakeholders through strategic frameworks like Healthier Together and financing mechanisms like the EU4Health Programme, which promote evidence-based prevention, and equitable and sustainable health systems (**Box 1**). Together, these efforts are helping the EU move toward a more coordinated prevention-oriented approach to reducing the avoidable burden of NCDs.

Box 1. EU instruments supporting prevention of NCDs

- **Europe's Beating Cancer Plan (2021–ongoing)** – flagship strategy for cancer prevention, early detection, treatment and survivorship. Mirroring the health-in-all-policies approach, it mobilises substantial funding from diverse EU funding streams such as EU4Health, Horizon Europe and Digital Europe.
- **EU4Health Programme (2021–2027)** – the primary EU health fund (€4.4 billion), it requires that **at least 20% of the budget is allocated to health promotion and disease prevention**.
- **European Social Fund Plus (ESF+) (2021–2027)** – investment in people and social inclusion, including a dedicated **health strand of €413 million**, supporting crisis preparedness, health system reform and implementation of best practices for health promotion and disease prevention.
- **Healthier Together – EU NCD Initiative (2022–2027)** – cocreated with Member States and stakeholders to address health determinants, CVDs, diabetes, chronic respiratory diseases, mental and neurological disorders. It promotes prevention and early detection and is supported through the EU4Health programme and other EU funds.
- **EU Cardiovascular Health Plan (forthcoming)** – currently in preparation, with adoption planned for the end of 2025, this plan will complement other NCD strategies and will aim to address prevention, early detection and screening, treatment, care and rehabilitation. With support of the EU4Health programme, the Commission has already committed more than €160 million to preventing and managing CVDs, including **€53 million for the JACARDI joint action and €76 million for PreventNCD**.

Many countries have also implemented overarching strategies to tackle NCDs, with some developing complementary policies targeting specific risk factors or diseases (notably cancer and CVDs). For example, Bulgaria, Czechia, Poland, Romania and Spain have implemented national cardiovascular health strategies focused on prevention, early detection, treatment and rehabilitation. These plans complement EU-level efforts by addressing national differences in CVD epidemiology, providing policy and legal frameworks for action, allocating resources, and coordinating actions across sectors and regions.

Countries continue to strengthen tobacco control with many aiming to achieve a smoke-free generation by 2040

Tobacco control is one of the most advanced areas of NCD prevention in Europe, with countries implementing a mix of fiscal, regulatory and behavioural strategies to reduce use of tobacco and nicotine products, and reshape social norms. Nevertheless, tobacco remains responsible for 700 000 deaths per year in the region, 50% of smokers die prematurely, and smoking rates are not declining fast enough to meet Europe's Beating Cancer Plan's 2040 goal of a tobacco-free Europe, where less than 5% of the population uses tobacco. In response, the EU and Member States have stepped up efforts in recent years to strengthen tobacco control policies. This includes an increasing number of countries such as Finland, the Netherlands (**Box 2**) and Slovenia, that have adopted 'endgame' objectives, aiming to eliminate tobacco and nicotine use within a generation.

Box 2. The Netherlands' Smoke-Free Generation initiative

The adult smoking rate in the Netherlands dropped significantly from over 21% in 2010 to 13% in 2022, well below the EU average of 19%. This sustained decline reflects a comprehensive and evolving national strategy to reduce use of tobacco and nicotine products. In 2018, the Netherlands adopted the goal of achieving strict tobacco control measures, committing to achieving a smoke-free generation by 2040, and tobacco control policies have intensified since. Smoke-free zones have been progressively extended to include public spaces, playgrounds and school premises, supported by municipalities and civil society organisations.

To reduce the visibility and appeal of tobacco products, plain packaging and retail display bans were introduced between 2020 and 2022. Fiscal measures play a key role with excise taxes increasing prices, and online sales of tobacco and e-cigarettes were banned in July 2023. Targeted efforts to curb vaping among youth have gained traction too. From January 2024, flavoured e-cigarettes were prohibited. In parallel, a major reform of the retail environment came into effect in July 2024, banning tobacco sales in supermarkets. This halved the number of authorised points of sale from about 10 000 to 4400 specialist outlets. A national retailer registry aims to further strengthen regulatory oversight and improve monitoring of tobacco sales. In March 2025, an action plan against vaping was launched in order to further reduce the use of e-cigarettes. The plan includes among other actions a further reduction in points of sale and strengthening enforcement against illegal sales.

Excise taxation remains key to the tobacco control framework, helping to reduce affordability and potentially generating revenue for health promotion depending on how revenues are used. It is estimated that taxation has contributed to a 40% decline in smoking rates in the EU over the last decade (European Commission, 2025a). On 16 July 2025, the Commission adopted a proposal for a recast of the Tobacco Taxation Directive (European Commission, 2025a). This revision aims to modernise the current legal framework for tobacco excise duties by better aligning the taxation of tobacco and related products with public health objectives. The Commission proposal extends the Directive's scope to include products previously excluded, such as smokeless tobacco products (namely, chewing and nasal tobacco), liquids (nicotine-containing and nicotine-free) for e-cigarettes, nicotine pouches and other nicotine products. The Commission proposal harmonises the tax rules and introduces minimum rates for these products. Additionally, raw tobacco is included in the Tobacco Taxation Directive's scope to improve monitoring of its movement within the EU and thereby contribute to the fight against illicit tobacco trade.

Taxation reforms have been seen in a number of Member States in recent years. For example, Bulgaria, Czechia, Estonia, Finland, Latvia, Lithuania and Slovakia have adopted multi-year tax escalators, while France and Portugal now link tobacco prices to inflation. Nordic countries, particularly Norway, maintain the highest price levels and have the lowest smoking rates in the EU. Affordability remains high in parts of southern and eastern Europe, where smoking rates are higher.

The main EU legislation on tobacco control is the Tobacco Products Directive 2014/40/EU, which regulates the manufacture, presentation, and sale of tobacco and related products across the EU, and the Tobacco Advertising Directive 2003/33/EC. At the Member State level, standardised (plain) packaging, adopted in at least eight countries, has reduced brand appeal and reinforced health warnings. Advertising, promotion and sponsorship bans are widespread, while Belgium, the Netherlands and Slovenia have introduced point-of-sale display bans. Smoking restrictions in public places have also expanded significantly. Indoor bans are nearly universal, with outdoor restrictions in parks, playgrounds and transport

areas growing, especially in northern and western Europe.

Major recent policy initiatives focus on strengthening regulation of novel tobacco and nicotine products, including e-cigarettes, heated tobacco and nicotine pouches. Several countries, including Denmark, Estonia, Iceland, Latvia, Lithuania, the Netherlands, Portugal and Slovenia, have banned flavoured tobacco products, while Germany, Ireland, Portugal and Slovakia have extended excise taxes to e-cigarettes and heated tobacco.

Policies to tackle harmful alcohol use are being strengthened in many Member States, but cultural and economic factors limit progress in some countries

Harmful alcohol consumption places a significant burden on health systems. It is estimated that on average across EU countries 2.6% of total annual health care spending is related to treating diseases caused by harmful alcohol consumption (OECD, 2021). Across the EU, alcohol control policies focus on taxation and pricing, marketing restrictions, and restrictions on availability. Many countries are integrating these measures into comprehensive national strategies to reduce alcohol-related harm (OECD, 2021). For example, several countries, including Belgium, Luxembourg, Slovakia and Slovenia, have recently adopted national alcohol strategies to coordinate fiscal, regulatory and preventive action.

Pricing policies remain the most widely applied tool. Recent excise duty increases in countries such as Czechia (2025–2026), Estonia (2025) and Spain (2025) aim to reduce affordability. Countries including Finland, Norway and Sweden combine high excise taxes with state retail monopolies restricting alcohol sales, contributing to some of the lowest levels of alcohol consumption in Europe, and generating public revenue. In contrast, many southern traditional wine-producing countries like Portugal continue to exempt wine from excise duties, reflecting cultural and economic constraints.

Access controls vary widely. Nordic countries maintain strict retail monopolies and age restrictions, though Finland's 2024 Alcohol Act allowing stronger drinks in supermarkets sparked debate about youth access. Sweden also introduced certain relaxations in 2025 by allowing small-scale producers to make 'farm sales.' Other countries are restricting access further. Denmark banned sales of drinks above 6% alcohol to under-18s in April 2025, while Greece strengthened age verification and Spain introduced new laws banning alcohol sales to minors.

Lastly, marketing restrictions are being strengthened as evidence grows on their impact on youth drinking. Ireland's Public Health (Alcohol) Act 2018 introduced one of Europe's most comprehensive frameworks, combining advertising bans, minimum unit pricing (alongside Slovakia), and health warnings. Comparable measures exist in Iceland and Norway, while Lithuania, Slovenia and Spain have tightened advertising rules. Lithuania's 2016–2018 reforms reduced alcohol-related mortality, although later policy relaxations have raised concerns about reversal.

Member States are increasingly implementing multisectoral policies to address the growing burden of obesity, unhealthy diets and physical inactivity

Member States are strengthening population-wide strategies to reduce obesity and improve diet quality, signalling a shift from individual behaviour change to multisectoral policies that promote healthier food choices and physical activity (OECD, 2022). Most countries now have specific obesity prevention plans in place that advance cross-sectoral approaches to address the issue.

Salt and sugar reduction measures are expanding through both voluntary and fiscal mechanisms. Twelve EU countries have implemented taxes on sugary drinks, with taxes on salt less common but found in some countries (e.g. Denmark, Hungary). Many countries also have voluntary reformulation

agreements in place with the food industry to reduce sugar, salt and/or trans fats in food (e.g. Austria, Belgium, Estonia, France, Greece, Malta, the Netherlands, Portugal, Sweden, Spain). Nutrition and food labelling policies also encourage voluntary reformulation efforts, as well as providing information to support healthier eating among the population. Most EU countries now recommend the use of interpretive front-of-pack labels.

Recognising the growing challenge of obesity among children, recent years have seen a strengthening of efforts to reduce unhealthy diets among children in many countries by restricting advertising times on TV or near schools, and by regulating stronger school meal standards (e.g. Bulgaria, Czechia, Portugal, Spain). Spain's School Meal Reform Law (2025), for example, mandates daily fruit/vegetables and weekly fish, limits processed foods, bans sugary drinks, and requires 45% local/seasonal produce in schools to tackle childhood obesity.

Physical activity promotion increasingly integrates health with education, transport and urban planning. Some examples include Malta's 2025–2030 strategy and Slovakia's 2024–2030 plan, which emphasise life-course, multisectoral approaches. Hungary's 2024 Activity Prescription Programme allows general practitioners (GPs) to prescribe physical activity. Growing 'active mobility' and 'healthy city' strategies embed active living into daily life through car-free zones, cycling paths, congestion charges and tax breaks for active travel (OECD, forthcoming).

REFORM AREA 2
Strengthening primary care

Summary: Primary care is a top EU reform priority, with the sector under pressure from ageing populations, chronic diseases and workforce shortages, leading to unmet needs. Only 20% of EU doctors are GPs, while over a third of adults report long-standing health issues. To strengthen primary care systems, countries are implementing reforms to attract and retain staff through financial incentives and expanded training. New integrated, community-based care models are being developed, expanding the roles of nurses and pharmacists, and scaling digital tools. The goal is to transform primary care into a resilient, patient-centred backbone for health systems, improving access and quality, especially in underserved areas.

Primary care reforms are high on the policy agenda

According to the European Observatory's *Health Reform Tracker*, primary and ambulatory care are among the top three reform areas across countries over the past seven years (2018–2024) (European Observatory on Health Systems and Policies, 2025). Across the EU, primary care reforms converge around a shared agenda: tackling workforce shortages, improving access and continuity, scaling digital tools (see 'Reform area 3'), and promoting more integrated, community-based and patient-centred care. While approaches vary, common trends and reforms can be observed: countries are attempting to transform primary care from a fragmented, under-resourced component into a resilient, multidisciplinary, digitally enabled backbone of health systems. The challenge now lies in sustaining these reforms, ensuring equitable access, and aligning national efforts with EU-level support to further strengthen primary care.

Population ageing, rising NCD prevalence and workforce shortages are straining primary care capacity and access

Primary care is a crucial gateway to the health system. It is widely recognised as the cornerstone of equitable, effective and resilient health systems, ensuring access to essential health and social services delivered close to where people live, as well as helping to reduce the use of more expensive hospital care. It serves as the first point of contact for most health needs, and the main setting for prevention, diagnosis and management of chronic conditions as well as coordination of care across levels (OECD, 2020; Rajan et al., 2024).

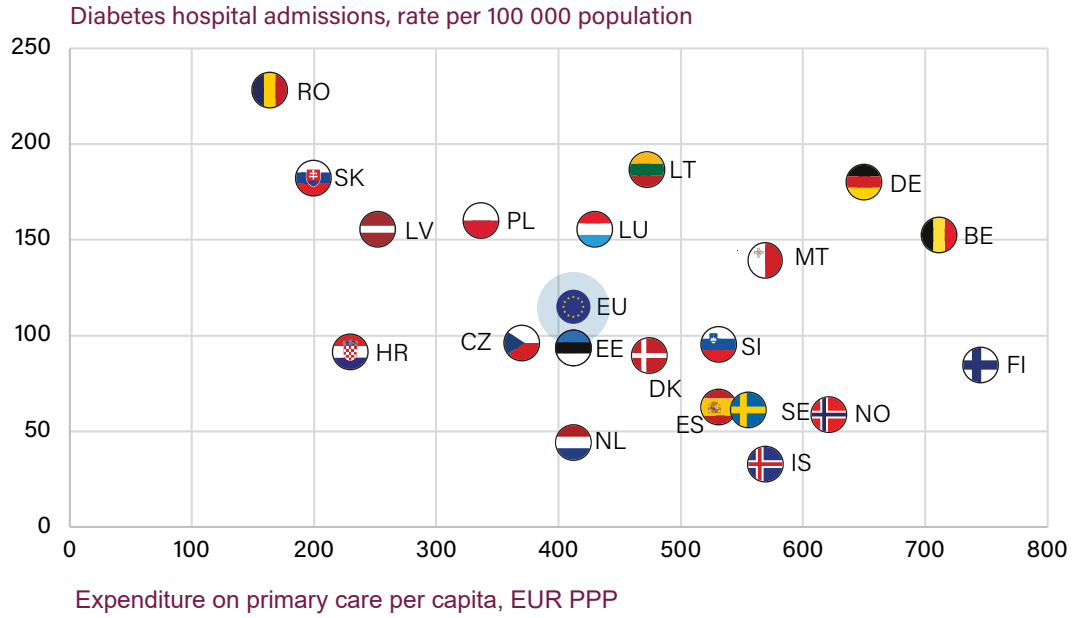
Yet across the EU, primary care is under mounting pressures. Demand continues to rise as populations age, and chronic diseases and multimorbidity become more prevalent. In 2024, over a third of European adults (35%) reported a long-standing illness or health problem, and this proportion reached 60% among people aged over

65. In 2024, 22% of adults in the EU were aged 65 or older; by 2050 this share is expected to reach 30%. These shifts take place in a context of pre-existing capacity issues, which are exacerbated by workforce shortages and maldistribution and underinvestment in primary care. In 2023, EU countries on average allocated two times less health expenditure to primary care than to inpatient care, and the share allocated to primary care has not increased over the past decade.

These challenges not only translate into higher avoidable emergency department visits and hospital admissions in some countries, but also into unmet needs for primary care, including longer waiting times to see a GP (also called family doctors in some countries). According to the *Eurofound Living and Working in the EU survey*, around 3% of adults across the EU reported unmet needs for primary care in 2024, with the rate at least two times higher than the EU average in Estonia, Finland, Latvia, Lithuania, Poland and Sweden (Eurofound, 2024).

A key performance indicator for primary care is its capacity to manage chronic conditions in the community, thereby avoiding costly hospital admissions. Avoidable hospital admission rates for chronic conditions that can be treated in primary care are often used for this purpose. When comparing avoidable hospital admission rates for diabetes with levels of per capita spending on primary care across EU countries, a clear pattern emerges. In general, countries that allocate more to primary care tend to have lower rates of avoidable hospital admission for diabetes (**Figure 3**). This highlights the importance of primary care as the key setting for managing patients with chronic conditions and providing integrated, patient-centred care.

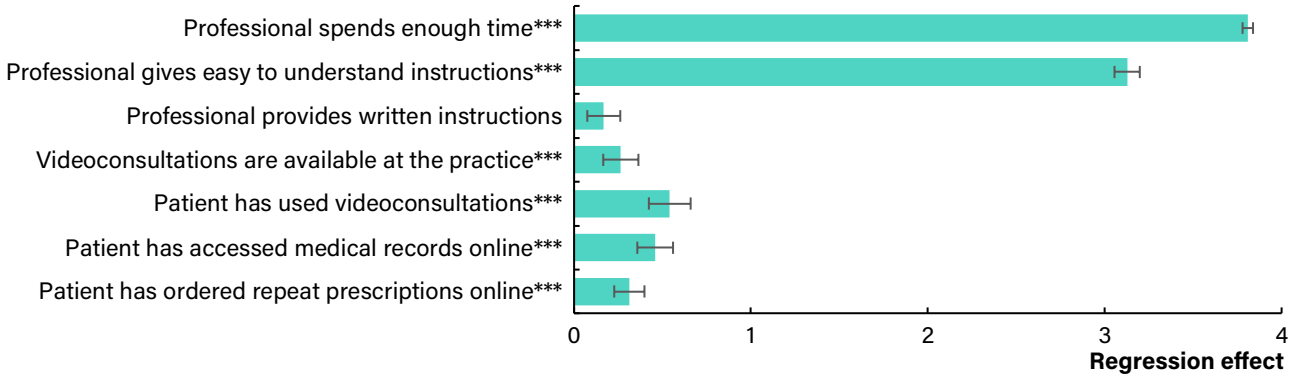
Figure 3. Countries with high per capita spending on primary care tend to have lower hospital admission rates for diabetes



Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Data Explorer (DSD_HCQO@DF_PC).

The importance of strong primary care for the management of patients with one or more chronic conditions is also reflected in the results of the 2023–24 OECD *Patient-Reported Indicator Surveys* (PaRIS) (OECD, 2025). A key finding from this survey is that people living with chronic conditions report better physical and mental health when they receive care that is centred on their needs. The results show that primary care can be made more person-centred when health professionals spend enough time with patients, explain things in a way that is easy to understand and provide written instructions about how to manage care at home. Digitalisation matters too, including the availability of digital consultations, patient's access to their electronic medical records, and the possibility of ordering repeat prescriptions online (**Figure 4**).

Figure 4. Sufficient consultation time, effective and accessible communication, and use of digital tools are all associated with a more person-centred care experience



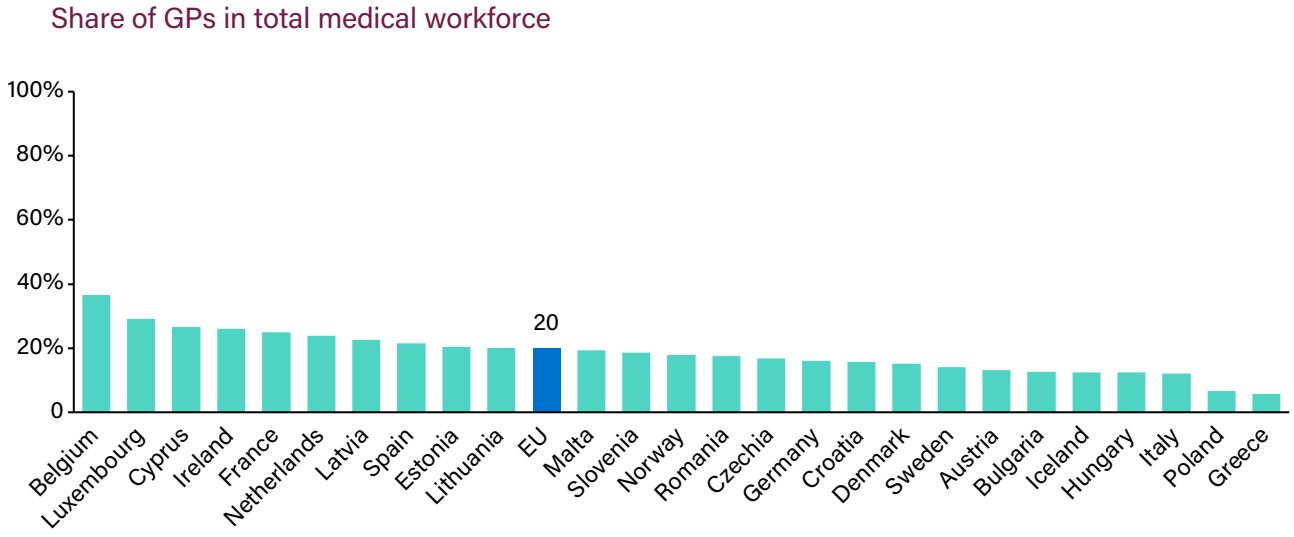
Notes: Based on responses from patients with at least one chronic condition in all OECD countries participating in the survey, including 11 EU countries (Belgium, Czechia, France, Greece, Italy, Luxembourg, the Netherlands, Portugal, Romania, Slovenia and Spain), Norway and Iceland. Statistical significance: *** $p<0.05$. Bars show regression effects and 95% confidence intervals of selected practice and patient characteristics on the person-centred care score. Coefficients on the X-axis represent the change in the person-centred care score associated with each characteristic compared to patients without that characteristic.

Source: OECD (2025).

EU countries are implementing a range of measures to attract, retain and better distribute primary care providers

A key challenge affecting primary care in most EU countries is a shortage of GPs and other primary care providers (e.g. family nurses), coupled with unequal distribution between rural and urban areas, and between private and public sectors. On average across EU countries, only one in five doctors (20%) was a GP in 2023 (**Figure 5**), down from 22% in 2013. These shortages are driven by limited numbers of medical graduates choosing general medicine and inadequate alignment between training systems and labour market needs, while large numbers of primary care workers reach retirement age. Poor working conditions and high workloads contribute to the declining attractiveness of primary care as a speciality as well as to retention issues. GPs are also often concentrated in urban and affluent areas, leaving rural and socioeconomically deprived regions underserved. This maldistribution arises from factors such as better professional opportunities, higher incomes, greater access to hospitals and specialist support, improved infrastructure, and lifestyle amenities in urban centres, which make them more attractive to health care providers.

Figure 5. Only one in five doctors in the EU is a GP



Notes: The EU average is unweighted. Data pertain to 2023 or the latest year available. The data include only GPs or family doctors working in primary care; they do not include doctors with other specialisations (e.g. general internal medicine) or without any specialisation who may also work in primary care.

Source: OECD Data Explorer (DF_PHYS_CAT).

Efforts to improve the distribution and retention of primary care providers are being pursued through financial as well as non-financial incentives. This recognises that financial incentives alone are not effective, and that policies to boost attraction and retention require a set of comprehensive measures. Financial incentives including higher salaries, bonuses, higher capitation rates and relocation support are used to attract GPs to underserved areas such as in parts of Austria, Estonia and Sweden. Czechia, Greece and Slovakia have introduced subsidies for young doctors specialising in general medicine, while Slovenia implemented new payment models and financial incentives to support GPs and paediatricians, particularly in the public sector. In Spain, hard-to-fill GP posts are incentivised through financial bonuses, housing support, career development opportunities and improved work–life balance measures.

Training and professional development are being scaled up in various EU countries to alleviate workforce shortages. Latvia prioritises applicants who commit to rural practice and Malta offers improved career prospects in family medicine. Austria plans to introduce a new five-year specialty in general and family medicine in mid-2026, along with start-up incentives for hard-to-fill posts in underserved areas. Some countries have restructured specialist training in general medicine (e.g. Denmark, Iceland) and expanded training capacity in the field (e.g. Belgium, France, the Netherlands, Poland, Portugal, Sweden).

Expanding the scope of practice and promoting task-shifting between doctors and other health professionals are also central features of primary care reforms. Nurses and midwives are taking on broader responsibilities in several countries (e.g. Denmark, France, Lithuania, Slovenia and Spain). Bulgaria, meanwhile, has implemented reforms to enable physician assistants, nurses and other paramedical staff to run independent practices and prescribe selected medicines. In Belgium, France, Ireland, Poland and Portugal, pharmacists have been given enhanced roles to reduce demand for GP consultations. In Romania, GPs now play a stronger role in screening and prescribing medicines for non-complex

cases (i.e. patients with uncomplicated or less severe diabetes that can be safely managed in primary care) to increase the attractiveness of the profession. Some countries have created new roles in primary care – for example, Latvia introduced the general care nurse, and Belgium and Slovakia established the practice assistant to support GPs with administrative tasks.

New care models and ways of working aim to strengthen care coordination, integration and quality in primary care

EU countries are expanding local health units and care networks to strengthen the coordinating role of primary care and improve quality. Greece and Portugal have expanded local health units and family health teams (**Box 3**), while Denmark, Luxembourg, Norway and Poland have created networks and clusters to manage and coordinate chronic care along the patient pathway. In France, communities of health professionals coordinate outpatient providers across territories. In Romania, newly established integrated community centres bring together family physicians, social workers, community nurses, specialists and Roma health mediators. To strengthen collaboration and coordination, Slovenia created an Institute of Family Medicine and upgraded the payment model of family medicine clinics and integrated model practices with family medicine clinics.

Box 3. Greece introduced a new model for coordinated primary care

To address long-standing challenges in ensuring access to high-quality primary care, Greece expanded its network of local health units and centres in 2017 to improve access to preventive care, health promotion and chronic disease management. Moreover, the personal doctor system, introduced in 2022 and reinforced in 2024, further strengthens the role of GPs as the first point of contact. All adults are required to register with a doctor who provides treatment, preventive care and care coordination. As of June 2025, unregistered adults are automatically enrolled, while children under 16 may register voluntarily with a paediatrician.

Many reforms aim to improve access, coverage and continuity of primary care, especially in underserved and rural areas

Measures to improve access to and coverage of primary care services, in particular in underserved and rural areas, have been a focus of reforms in several Member States. For example, in France, multidisciplinary health centres have been established to address the challenge of 'medical deserts' – severely underserved areas where residents face major barriers to accessing needed health services. To shift from opportunistic to organised screening, Romania has recently launched regional pilots for breast and colorectal cancer, including mobile units in underserved areas, supported by EU Cohesion Funds.

Portugal and Slovakia are using Recovery and Resilience Facility (RRF) funding to establish new or renovate outpatient clinics in underserved areas. In Czechia, subsidies are provided for the establishment of new primary care practices in underserved areas, while in Germany GPs in some states receive a lump-sum payment for providing care in rural areas. The distribution of primary care is also a main priority for Denmark's 2024 health care reform (**Box 4**).

Box 4. Denmark's 2024 health care reform aims to improve access to primary care

A major 2024 health care reform introduced a national allocation model for GPs, limiting new provider numbers to municipalities with critical shortages, and restricting GP employment in some university hospitals to redirect GPs toward other less well-served areas. This agreement runs until a new national distribution model is established in 2027. The reform aims to expand the GP workforce from 3500 to at least 5000 by 2035, improve distribution, and introduce new delivery models, allowing regions to establish their clinics and contract private companies. It will also introduce a new fee structure with higher compensation for practitioners serving patients with greater health care needs. Task-sharing, with nurses, midwives and advanced practice nurses that increasingly provide preventive and clinical care within GP practices and communities, will play a central role.

To improve access to primary care and reduce reliance on emergency departments, some countries have extended the opening hours of primary care centres and strengthened after-hours care. In Austria, Lithuania and Luxembourg, for instance, group practices or primary care units are required to ensure reasonably long opening hours. Some countries have closed gaps in primary care benefits coverage. In Ireland, free access to primary care has been extended to children up to 8 years of age, with a government commitment to further expand this to age 12. Spain plans to include new diagnostic procedures into the primary care benefit package.

REFORM AREA 3
Accelerating digital health adoption in the EU

Summary: The COVID-19 pandemic served as a catalyst for the EU and its Member States to accelerate the digital transformation of health care, underpinned by the European Health Data Space (EHDS) Regulation, Artificial Intelligence (AI) Act and increased funding. Investment in health-related information and communication technologies (ICT) has grown by about 30% compared with the pre-pandemic era, and all Member States now provide some form of electronic health record (EHR) access, with this digital push already improving health system efficiency and resilience. However, meaningful use among the population remains limited: only around 28% of EU citizens access their EHRs, with substantial disparities across countries and socioeconomic groups. The next phase of digital transformation should focus on execution at scale including adapting to new technological developments such as AI, whilst ensuring security, strengthening interoperability, improving digital skills and governance to ensure that increased adoption translates into consistent, measurable health system improvements across the EU.

A post-pandemic surge in investment is fuelling the EU's strategic push for a digital health ecosystem

The COVID-19 pandemic underscored the vital role of digital technologies in ensuring service continuity, enabling faster and more accurate data-driven decision-making, and strengthening system resilience. When strategically implemented, digital health tools extend access through remote care; reduce waiting times via automated triage and scheduling; and hold potential to alleviate workforce pressures by supporting task-shifting and minimising administrative burdens. They can also support delivery of more proactive, personalised and integrated care – particularly in community-based settings – and empower patients to take a more active role in managing their health. Investments in digital health are now seen as key to tackling the pressing challenges facing health systems today. Moreover, beyond the benefits to health and health care, investment in digital health stimulates innovation, creates high-skilled jobs and fosters the growth of Europe's health technology sector, contributing to the broader digital economy.

Initiatives such as the EHDS, the Apply AI Strategy and the Digital Decade Policy Programme 2030, which sets ambitious targets including universal access to EHRs, reflect the heightened importance and broad-scope potential of digital health (**Box 5**). These efforts aim to create a connected European health ecosystem where data flows securely across borders, empowering research, public health and clinical decision-making. It is estimated that implementation of the EHDS will save the EU economy approximately €11 billion over 10 years due to better access to and exchange of health data and more availability of health data for research, innovation and policy-making (European Commission, 2024).

Box 5. The EU is providing regulatory, financial and technical support to accelerate the digital health transformation

Since 2021, the EU has developed a comprehensive framework to support Member States in the digitalisation of their health systems, combining coordinated regulation, targeted funding and technical assistance.

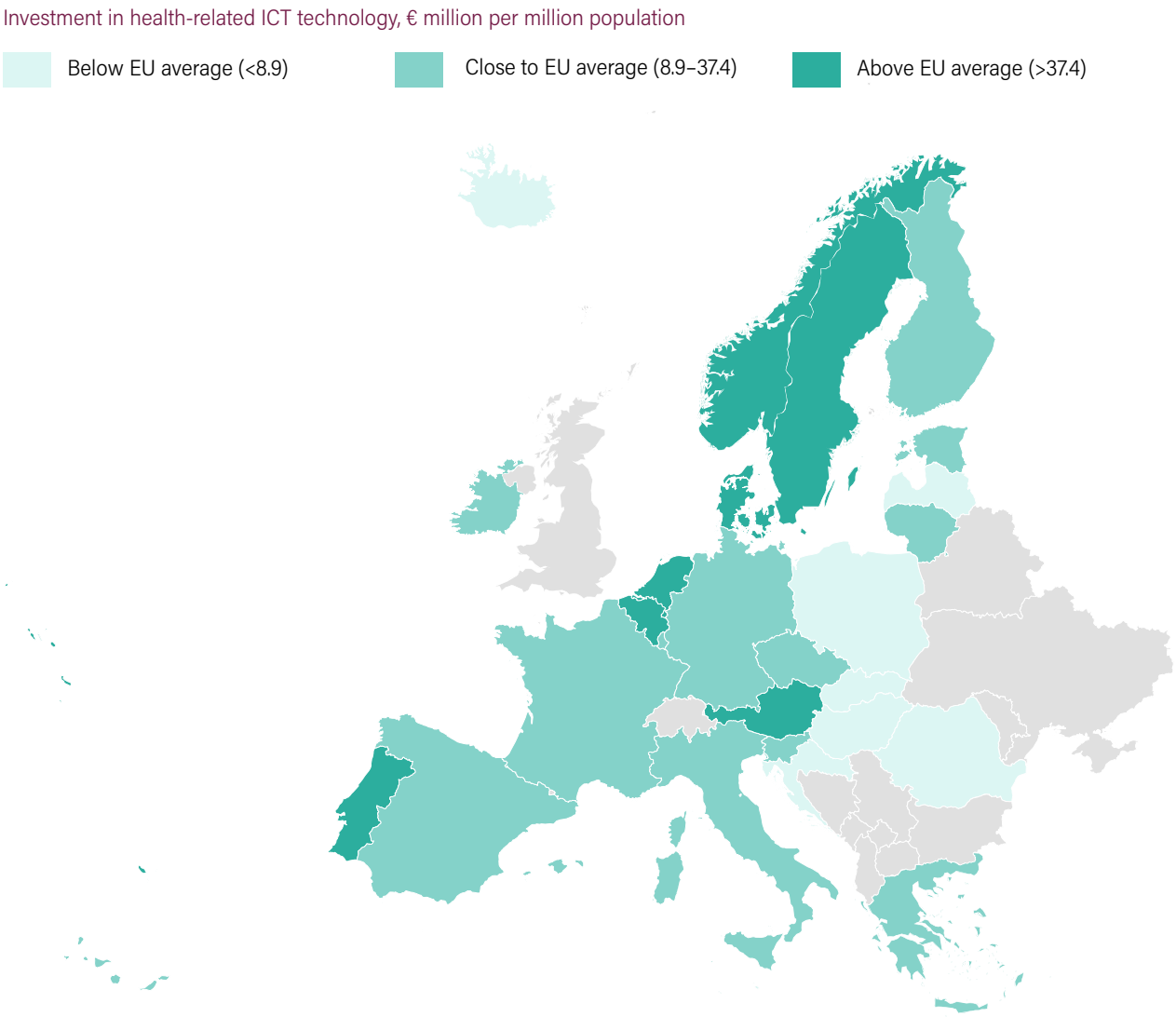
The European Health Data Space Regulation (EU 2025/327), in force since March 2025, is the cornerstone of this framework. It establishes a shared legal and technical infrastructure to enable EU citizens to access and control their EHRs across borders, while facilitating the secure secondary use of health data for research, innovation and policy-making. Implementation is phased: patient summaries and e-prescriptions must be exchangeable across borders by March 2029, followed by medical imaging, laboratory results and discharge reports by March 2031 (European Commission, 2025b).

The EHDS aligns with the Digital Decade Policy Programme 2030, which aims to ensure universal access to medical records and digital identity. The MyHealth@EU platform supports implementation by linking national systems for e-prescriptions and patient summaries. Complementing the EHDS, the Data Act – fully applicable from September 2025 – sets cross-sector rules to strengthen data accessibility and interoperability. In addition, the Apply AI Act adopted in 2024, and with measures applying gradually from 2025–2026, regulates the use of AI in health care, ensuring safety, transparency and accountability, particularly for high-risk applications like diagnostic tools, and eliminating bias in high-risk AI systems used in health care. In January 2025, the Commission also launched a comprehensive action plan to improve the cybersecurity of hospitals and health care providers in light of health care systems increasingly becoming targets of cyber and ransomware attacks. The plan is built around four pillars (Prevent, Detect, Respond & Recover, Deter) with the aims of increasing operational resilience; establishing EU-wide early-warning and incident-response services; and supporting health care institutions (especially smaller ones) with guidance, training and funding on cybersecurity.

Digital health has also become a key priority under the EU's post-COVID recovery agenda. Member States have allocated around €14.5 billion from the Recovery and Resilience Facility (RRF) to upgrade EHR systems, expand e-prescription services and develop telehealth platforms. These efforts are supported at EU level by more than €2 billion in additional funding through various initiatives including EU4Health; the Digital Europe Programme, Connecting Europe Facility and Horizon Europe, Cohesian funds and the Technical Support Instrument (TSI).

Member States have increased investment in recent years to strengthen digital infrastructure, interoperability, governance frameworks and digital skills among the health workforce. Across the EU, investment in health ICT increased by an average of 29% from the 2015–2017 period to 2021–2023 (Eurostat, 2025). Only Estonia, Luxembourg and Malta saw a decline in investment; however, this should be placed within the context that these Member States were ranked as having the highest maturity of online health-related services in both 2022 and 2024, according to the eGovernment Benchmark. In 2024, Ireland, Romania and Slovakia were ranked as having the lowest maturity, but Ireland and Romania made significant progress in improving their digital maturity score in 2024. Investment in health ICT in 2021–2023 was on average higher in some Nordic and Western European countries compared with elsewhere in the region (**Figure 6**).

Figure 6. Investment in health information and communication technology is generally greater in Nordic countries and some Western European countries



Notes: The data relate to three-year average (2021–2023) expenditure on ICT equipment and computer software, and databases in the human health and social work sector (the data for Italy, Latvia, Luxembourg, Netherlands and Norway are only available until 2022, so they relate to a two-year average only). The classification of countries as close to, below or above the EU average is based on one standard deviation from the average.

Source: Eurostat database (nama_10_a64_p5).

All EU Member States have established some form of electronic health record access service

Recent years have seen rapid progress in the adoption of EHRs, e-prescriptions and other digital health services, in line with the requirements of the EHDS. By the end of 2024, all EU Member States, Iceland and Norway had established some form of EHR access service, as revealed in the *2025 Digital Decade eHealth Indicator Study*, and in 85% of countries 80–100% of the population were technically able to access their EHRs (European Commission & Capgemini Invent, 2025). Most countries offer centralised access, while Ireland, Italy, Spain and Sweden have adopted a regional approach. Secure access is typically ensured via EU-compliant electronic identification (eID) schemes, now in place in 21 countries. EHR access is typically provided through national online portals or health apps, such as *Masanté.be* in Belgium, *Mon espace santé* in France, *HSE App* in Ireland, *esveikata.lt* portal and *esveikata App* in Lithuania, *Gesondheets*

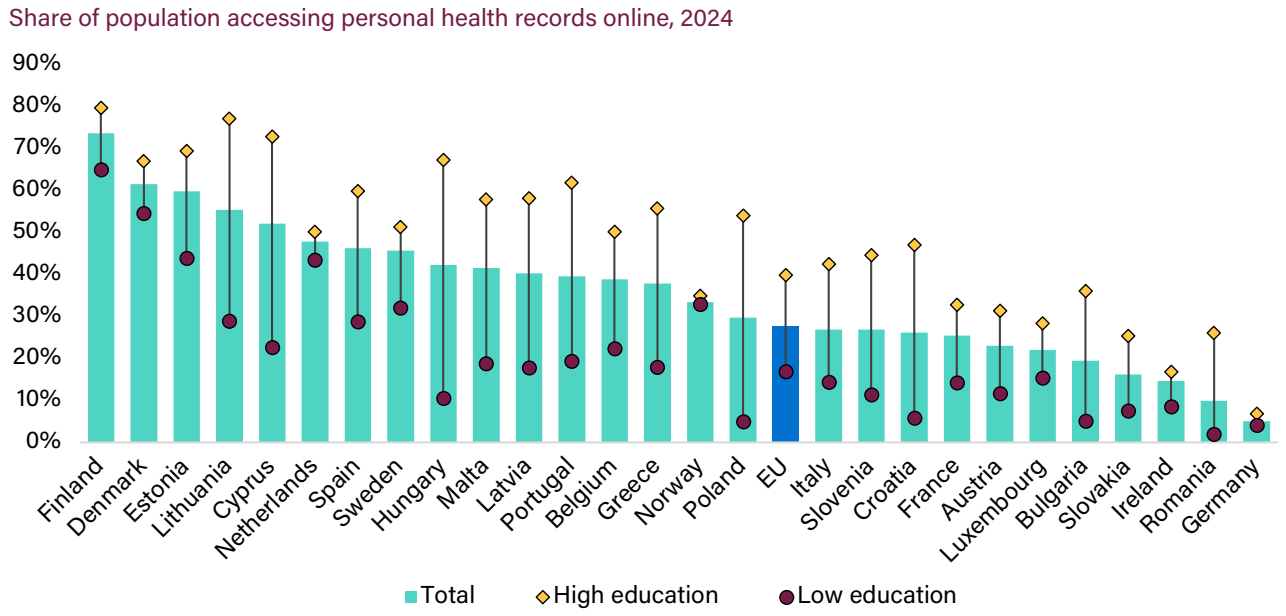
App in Luxembourg, *Heilsuvera* in Iceland, *SNS24* in Portugal, *MyHealth* in Greece and *sundhed.dk* in Denmark (**Box 6**). While functionalities vary, these platforms commonly offer access to e-prescriptions and test results, secure messaging with providers, appointment booking, and the submission of sick-leave certifications.

Despite this widespread availability, actual use remains uneven: in 2024, the share of the population accessing their personal health records online ranged from 73% in Finland to just 5% in Germany, averaging 28% across the EU (**Figure 7**). All countries reported education-related disparities in access, with only 17% of people with low education levels using these services compared to 40% among those with higher education. Unless proactively addressed, such disparities in access to digital health services risk widening existing health inequalities.

Box 6. Denmark's patient portal is widely used by professionals, patients and the wider population

In Denmark, citizens can access their health data via the platform sundhed.dk, with over 3 million visits monthly, offering secure records, test results, vaccination history and e-prescriptions. The shared Medication Record ensures real-time access to prescriptions for both citizens and professionals, and supports secure communication across all health care providers. sundhed.dk provides a nearly complete national appointment system, improving coordination and patient access.

Figure 7. Socioeconomic disparities in accessing EHRs between and within countries are substantial



Note: Low education is defined as the population with no more than lower secondary education (ISCED levels 0–2), whereas high education is the population with tertiary education (ISCED levels 5–8).

Source: Eurostat (isoc_ci_ac_i).

Digital health tools are underpinning new health care service delivery models

EHRs, e-prescriptions and e-dispensation are fundamentally reshaping care pathways by enabling real-time data exchange, integrated workflows and more data-driven decision-making. Many countries are leveraging these tools to shift from reactive to preventive care, automating reminders for screening, vaccination or chronic disease reviews, and offering online booking, as seen in Estonia, France, Iceland and Lithuania. Coordination is also being improved through e-referrals, which reduce administrative burden and make specialist access more transparent and traceable. Estonia's e-ambulance exemplifies the clinical value of connected health records: emergency crews can instantly retrieve critical information, such as blood type, allergies, current medications and recent treatments, using a patient's national ID, supporting faster and safer decision-making in urgent situations. Similarly, Greece's unified electronic booking system manages over 700 000 monthly appointments and, with expansion to outpatient services in public hospitals as of October 2025, is expected to handle around 7 million appointments annually.

Building on this digital infrastructure, telemedicine has evolved from a contingency tool into a core component of health care access. In Finland, public 'digital clinics' are now the primary first-contact option in most regions, offering virtual triage and consultations to over 3.3 million residents and reducing the burden on in-person services. Austria is formalising this 'digital before outpatient before inpatient' approach in its latest planned reforms, aiming to create a digital front door to relieve pressure on hospitals. This synergy between robust EHRs and telehealth also enables advanced care models. Portugal's NHS, for instance, supports a large-scale hospital-at-home programme that treated over 11 500 patients in 2024 using 'virtual' beds. Similarly, Greece is developing a nationwide hospital-at-home programme, supported by remote care centres equipped with advanced digital monitoring tools.

Artificial intelligence is increasingly in use to provide accurate diagnostics and personalised treatments, and streamline administrative processes

Advances in AI hold immense transformative potential for health systems, offering capabilities such as interpreting medical imaging, predicting clinical progression, automating administrative tasks and supporting clinical decision-making through data-driven insights. Member States are progressively taking steps to harness the potential of AI. For example, Hungary is piloting the use of AI-based decision support in pathology diagnostics; Sweden uses AI in cancer screening (**Box 7**); and Portugal is testing AI-driven e-triage to reduce dermatology backlogs. Greece has introduced AI-powered digital assistants to help patients navigate the health portal, while Denmark allocated DKK 40.6 million (€5.4 million) in 2025 for AI projects on bone fracture analysis, home visit logistics and speech-to-text tools. In Czechia, several Medical Device Regulation (MDR)-certified AI applications are being integrated into clinical workflows and their use reimbursed, such as for diabetic retinopathy screening. The European Commission has also launched COMPASS-AI, a flagship initiative under the Apply AI Strategy that aims to build a multidisciplinary expert community and deploy practical guidelines to responsibly and effectively integrate AI in clinical health care, with an initial focus on cancer care and services in remote areas (European Commission, 2025c).

Advances in AI nevertheless bring challenges, including ensuring data privacy and patient trust; educating and training health professionals; mitigating and monitoring algorithmic bias; and integrating AI safely and ethically into care. To support ethical and equitable adoption of AI, the EU has introduced the AI Act. This is complemented by some national initiatives, such as those in Sweden (**Box 7**) and Norway's Joint AI Plan for Healthcare 2024–2025, which outlines a cross-agency advisory board, regulatory guidance, quality frameworks and training

strategies for AI in health services. Going forward, responsible deployment of AI will require further governance reforms, clear standards for use, and broad stakeholder collaboration to ensure AI scalability that enhances care equitably while safeguarding safety and trust.

Box 7. Sweden is strengthening governance to help integrate AI applications ethically and safely into its health care system

Sweden has adopted a coordinated nationwide strategy to integrate AI into its publicly funded health care system. Anchored in the government's *Vision eHealth 2025* and the national AI strategy, the country has invested significantly in digital infrastructure and governance. The flagship *Information-Driven Healthcare* programme (2019–2024) brought together all 21 regional health authorities with academia and industry to develop privacy-preserving AI tools and scale successful pilots. Real-world applications are already delivering results: AI-assisted mammography screening detected 4% more breast cancer cases while halving the workload of radiologists; predictive models reduce missed appointments and enable early infection detection in neonatal care; and AI triage tools in primary care streamline workflows and reduce administrative burden.

Post-pandemic, several EU countries are strategically leveraging digital platforms to enhance real-time health system oversight

Between 2022 and 2025, several countries have made the real-time surveillance tools from the COVID-19 pandemic a permanent part of their health systems to strengthen preparedness and oversight. Cyprus, for instance, is rolling out its CY-ESM platform to modernise infectious disease tracking under a One Health approach. Ireland has launched a national outbreaks hub and is replacing legacy systems to reinforce monitoring of antimicrobial resistance (AMR) and health care-associated infections (HCAIs). This data-driven oversight also extends to system performance and cost control. Ireland now operates its Health System Performance Assessment (HSPA) framework via an online dashboard. Italy's AIFA Monitoring Registries track the real-world use and clinical appropriateness of high-cost medicines, while Portugal's SNS Control and Monitoring Centre uses digital analytics to audit over €3 billion in health claims annually, flagging billing irregularities. Collectively, these tools enable a shift from periodic reporting to continuous, actionable oversight.

Digital platforms are also being used to capture patient feedback systematically. Greece, for the first time, is implementing a Digital Tool for Assessing Inpatient Experience. This system automatically sends an SMS to patients five days after discharge from any public hospital, gathering feedback on everything from staff communication to cleanliness. Operational since July 2025, this initiative aims to use patient satisfaction data to support evidence-based health policies.

Countries are also harnessing digital platforms to tackle operational inefficiencies, particularly medicine shortages. Croatia's e-medicines platform consolidates national data on medicine availability and shortages, complementing the EU-wide European Shortages Monitoring Platform (ESMP), fully operational since 2025. Iceland has introduced a public dashboard for antibiotic use to strengthen antimicrobial stewardship.

Finally, EU Member States are reinforcing institutional capacity to steer the digital transition, in line with the EHDS regulation. Belgium established its Health Data Agency (HDA) in 2023 to coordinate secondary data use and serve as its national Health Data Access Body (HDAB).

In France, the *Agence du Numérique en Santé* (ANS) continues to guide national digital strategy through its *Doctrine du numérique en santé 2025*, while the Health Data Hub supports the technical infrastructure and secondary-use governance under the *Système National des Données de Santé* (SNDS) framework. These national bodies form the backbone for implementation of the EHDS, which must be fully operational across the EU by 2029.

The EU and Member States are investing in digital skills and competencies in the health workforce, but gaps remain

Ensuring health care professionals have the right digital skills is critical to the safe and effective use of digital health technologies. However, many health care professionals report lacking digital skills and competencies, especially for using emerging technologies (Williams et al., 2025). To overcome these skills gaps, the EU funds numerous initiatives, including projects under EU4Health, ERASMUS+ and the DIGITAL Europe programme via the European Health and Digital Executive Agency (HaDEA). Many Member States are also using RRF and Technical Support Instrument funding to support education and training, while making the improvement of digital skills and competencies of health professionals a core aim of their digital health strategies (e.g. Belgium, France, the Netherlands).

Despite this momentum, progress remains uneven: gaps persist in course availability for more advanced areas such as AI and robotics, especially in non-English languages and across different professional levels. In many countries, digital training is still limited to basic ICT competencies, with few offerings embedded in formal education pathways or continuing professional development systems. Closing these gaps will require sustained reforms to health education and training systems, ensuring that digital competencies are systematically integrated into curricula and supported throughout professionals' careers.

REFORM AREA 4

Promoting affordable access to pharmaceuticals and innovation in the EU

Summary: Between 2020 and 2025, EU countries implemented wide-ranging pharmaceutical reforms to improve access, reduce out-of-pocket (OOP) costs, and sustain innovation amid rising prices for new medicines and growing health care demand. Measures include expanded public coverage, expedited access to new therapies, more effective pricing and reimbursement tools, and policies to boost generics and biosimilars. While disparities remain, especially in access and financial protection, early evidence shows progress on affordability, availability and efficiency. Ongoing EU-level reforms, including the revised pharmaceutical legislation and HTA regulation, are expected to reinforce national efforts and help close cross-country gaps.

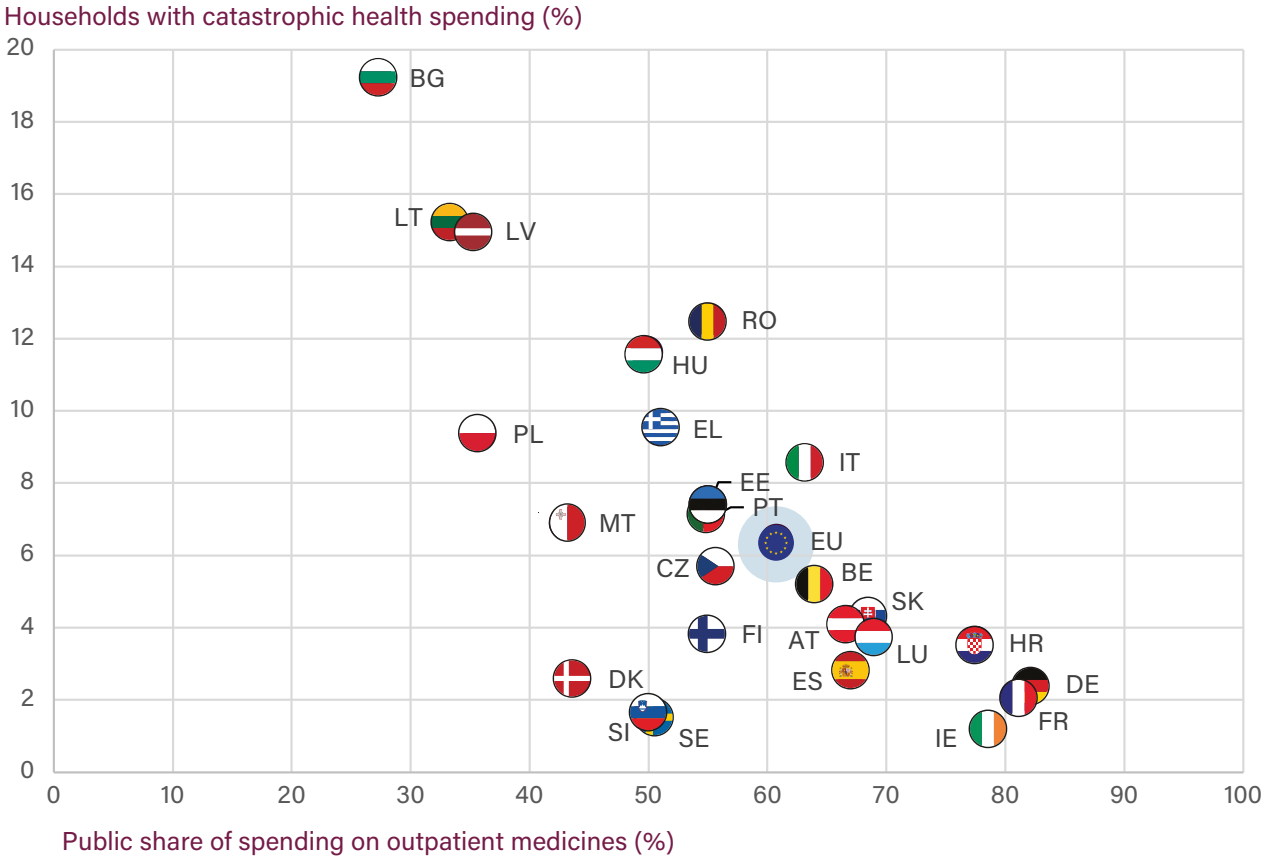
Pharmaceutical spending, affordability and access: a growing challenge in the EU

Sustained innovation in the pharmaceutical sector has underpinned major advances in modern medicine, contributing to better outcomes and longer lives. However, these gains are unfolding amid mounting pressures on health systems – population ageing, the rising burden of NCDs and growing demand for care. In this context, the elevated launch prices of many new therapies are adding to upward pressure on pharmaceutical spending across the EU (ESIP & MEDEV, 2024).

In 2023, EU countries spent an average of €510 per capita on retail pharmaceuticals, with substantial cross-country variation: spending was more than twice as high in Bulgaria, Germany and Malta as in Denmark, Estonia and the Netherlands. Retail medicines accounted for 13% of total health expenditure on average, but exceeded 25% in Bulgaria, Greece and Romania. Retail spending alone understates the full pharmaceutical bill. Among EU countries with data on inpatient pharmaceutical spending, retail medicines represented roughly 60% of total pharmaceutical expenditure in 2023, with the remaining 40% incurred in hospitals. This split varies widely between EU countries, reflecting differences in procurement models, prescribing practices and system organisation.

Public financing remains the main payer for retail pharmaceuticals in most EU countries. In 2023, about 61.5% of spending was covered by government schemes or compulsory health insurance; 35.5% was paid OOP; and 3.0% by voluntary insurance. Cost sharing for pharmaceuticals was, however, markedly higher than for health care in general, with around 80% of total health expenditure covered by public sources. There is also a wide disparity in OOP spending across EU countries, ranging from just 12% in France to 78% in Bulgaria. High burdens for outpatient medicines are also reported in several other countries, such as Hungary, Latvia, Lithuania, Poland and Romania, raising concerns about financial protection and equitable access (**Figure 8**). At EU level, 6% of households report catastrophic health spending, and one-third of these cases are driven by OOP payments for outpatient medicines (WHO Regional Office for Europe, 2025) (**Figure 8**).

Figure 8. More public spending on outpatient medicines means fewer households face catastrophic spending



Note: Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).
Sources: WHO Regional Office for Europe (2025).

These challenges are further compounded by disparities in availability and timeliness of access. Of the medicines centrally approved by the EU between 2020 and 2023, an average of 46% were available to patients (i.e. listed for reimbursement) across EU countries at the start of 2025 – but availability ranged from 90% in Germany to 10% in Malta. Time to reimbursement averaged 578 days after EU marketing authorisation and reached over 800 days in Portugal, Romania and Lithuania (Newton et al., 2025).[1]

Seeking to lift some financial pressure from health systems, policies to promote rational prescribing and shift use toward cost-effective options have supported higher generic uptake: across 18 EU countries, generics rose from 39% of volume in 2010 to 51% in 2023. However, uptake still lags in several settings due to prescriber and pharmacist preferences, patient mistrust or information gaps, limited incentives and uneven enforcement of generic substitution policies.[2]

1 It is important to acknowledge the limitations of EFPIA's W.A.I.T. metric. Differences in product sampling, country definitions and company launch strategies, as well as the interplay between national pricing, HTA and reimbursement processes complicate strict cross-country comparability. In addition, early-access pathways, sub-national restrictions and confidential managed-entry agreements are not fully captured. Cross-country comparisons are therefore indicative rather than strictly comparable.

2 Cross-country comparisons should be interpreted with care, as not all systems have the same 'headroom' to increase generic use at a given time. Structural factors, such as the share of off-patent molecules, timing of loss of exclusivity, the mix of biologics and orphan drugs (with thinner biosimilar competition), manufacturers' entry decisions in smaller markets, and national rules on International Nonproprietary Name (INN) prescribing, substitution, pricing and reimbursement, constrain the addressable market. Lower generic shares therefore do not necessarily signal weaker policy performance.

At EU level, the revision of the pharmaceutical legislation and the Health Technology Assessment (HTA) Regulation can reinforce national efforts by enabling timelier and more affordable access to clinically valuable innovations, amid rising prices of new medicines, while preserving incentives for research and development (R&D).

What reforms are countries implementing to promote affordable access to pharmaceuticals and innovation?

EU countries are pursuing a broad mix of reforms to keep medicines affordable while sustaining innovation, focusing on: 1) expanding financial protection to reduce OOP burdens; 2) accelerating access to (innovative) medicines through timely and predictable pathways; 3) improving pricing and reimbursement to contain costs; and 4) promoting the cost-effective use of generics and biosimilars.

1. Expanding financial protection to reduce out-of-pocket burdens

The first set of reforms aims to shield households from excessive health care costs: by increasing the public share of outpatient medicine costs, governments can reduce the number of families facing potentially catastrophic OOP payments. To achieve this, some countries are widening the scope of reimbursable medicines; Bulgaria, for instance, has expanded its 'positive list' of covered medicines. Others, like Cyprus, are limiting patient costs through caps or fixed fees. Spain's recent reforms expanded exemptions, benefiting over 7 million people, while Austria is freezing prescription fees to offset inflationary pressures, and lowering the income threshold for exemptions, allowing more citizens to receive medicines with no OOP fees.

Governments are also tackling indirect costs: Romania and Slovakia have reduced the value-added tax (VAT) rate on medicines. Recognising that a lack of awareness can undermine these protections, Czechia and Estonia now automatically apply exemptions and caps at the pharmacy, ensuring eligible patients do not overpay. Alongside these broad measures, targeted schemes in Latvia and Romania provide full public coverage for specific emergencies or diseases.

Countries with higher public coverage are seeing fewer households face catastrophic health spending (see **Figure 8**).

2. Accelerating access to (innovative) medicines through timely and predictable pathways

A second strand of reforms focus on enabling earlier and more predictable access to pharmaceutical innovation. While countries need to balance optimal use of resources (i.e. not paying higher prices for innovations that do not offer additional benefits) with ensuring optimal care for their citizens, tailored approaches become necessary when existing alternatives are suboptimal or non-existent. For example, Hungary offers access while HTA processes are ongoing; Belgium has broadened compassionate-use programmes for serious conditions; and a number of countries are piloting fast-track procedures for novel or high-impact therapies. To improve timeliness, Lithuania has introduced legal deadlines for pricing and reimbursement decisions, although it faces implementation challenges. In Greece, the national wholesaler, IFET, operates an early access scheme, which is now guided by a new gatekeeping committee that assesses unmet clinical need and expected benefits to ensure sustainability, predictability and fairness.

Dedicated funding mechanisms are also being used to prevent delays in the launch of high-value treatments. Italy's Innovative Medicines Fund has allocated €1.3 billion in 2025 for drugs granted innovative status, alongside a dedicated €100 million budget for reserve antibiotics targeting priority pathogens. Reimbursement flexibility has also increased: Slovakia has relaxed cost-effectiveness thresholds in defined cases, while Belgium and Hungary allow conditional coverage during ongoing evaluation or price negotiations. Malta, Latvia and Slovakia have established procedures to consider extraordinary

reimbursement requests for treatments not covered on their positive lists. Efforts to improve supply-side reliability are also gaining traction. Luxembourg is planning a national purchasing and logistics centre to better manage stocks of critical and shortage-prone medicines. While it is too early to measure broad system impacts, countries deploying expedited access pathways and dedicated funding report faster availability of selected therapies.

Against this backdrop, EU-level reforms are expected to reinforce these national efforts. The HTA Regulation, which entered into force in 2025, aims to streamline joint clinical assessments and reduce duplication (see **Box 8**). In parallel, the revision of EU pharmaceutical legislation seeks to support broader and earlier product launches while fostering more timely competition.

Box 8. EU countries are moving on two fronts to strengthen innovation capacity

Europe's pharmaceutical sector is competitive and innovative, and plays a vital role in supporting public health and building resilient health systems. However, it faces mounting structural challenges, including public funding constraints and intensifying global competition. Recent EU-level initiatives, echoing the priorities set out in the 2024 *Future of European Competitiveness* report, emphasise the importance of a more predictable regulatory environment and increased investment in pharmaceutical R&D.

First, countries are aligning national processes to enable faster, more equitable access to innovation. The Health Technology Assessment Regulation (2021/2282) establishes a common EU framework for joint clinical assessments, designed to streamline evidence requirements and accelerate access to high-value medicines. In conjunction with its application as of January 2025, many EU Member States are updating national legislation and HTA guidelines and expanding institutional capacity.

Second, governments are reinforcing Europe's pharmaceutical R&D and industrial base through four main policy levers:

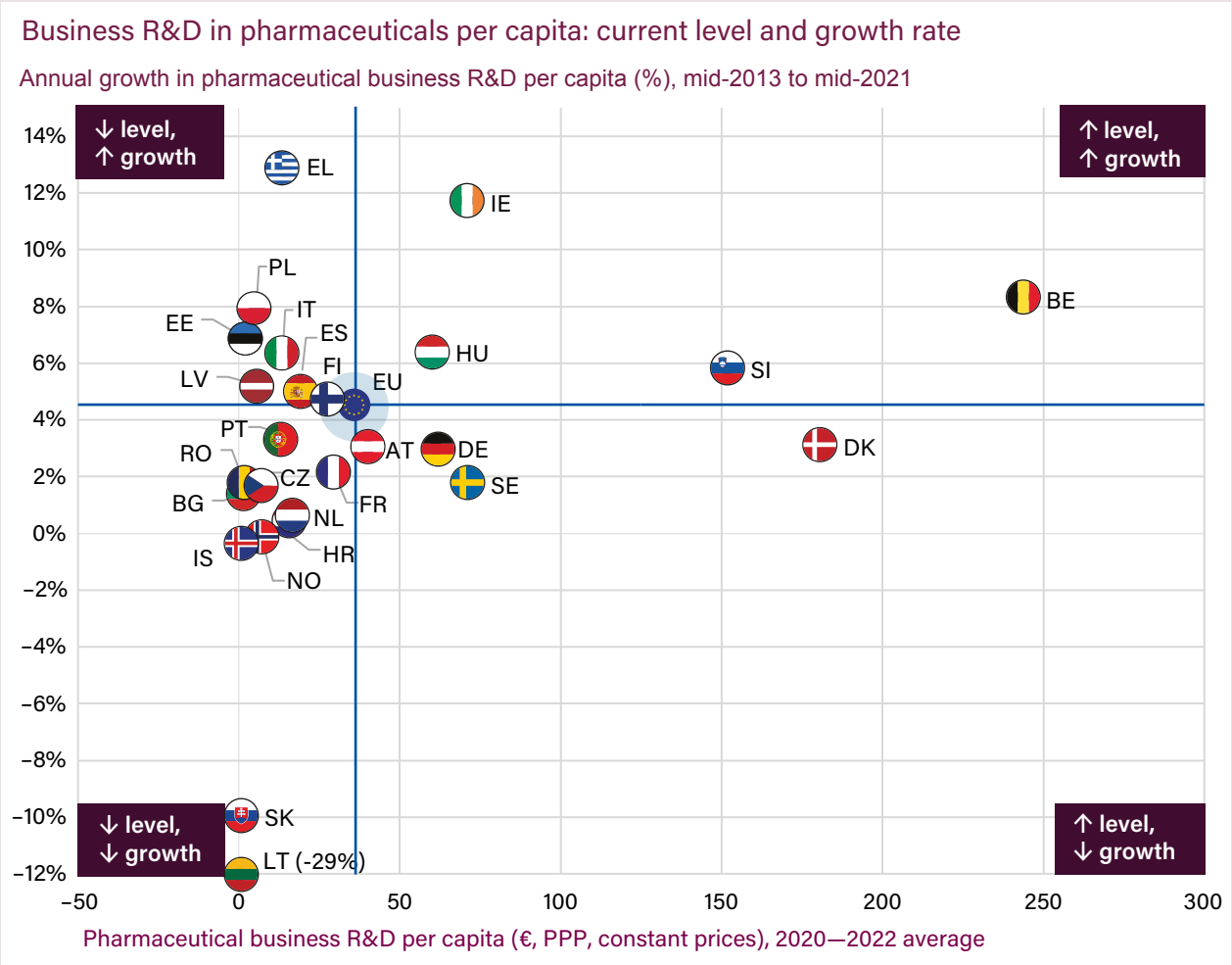
1. Public financial support through dedicated fiscal measures along the R&D cycle, including tax incentives, targeted relief measures, and mechanisms allowing clawbacks to be offset against R&D expenditures.
2. Direct public funding for non-commercial clinical trials and for research areas with limited commercial pull.
3. Investment in R&D infrastructure and collaborative ecosystems, such as public–private partnerships, interoperable health data systems, open-access translational centres, regional biotech clusters and specialised research hubs.
4. Strengthening domestic manufacturing and export capacity through state aid as part of broader life sciences and industrial strategies.

Despite these efforts, significant disparities in private pharmaceutical R&D investment remain across the EU. In 2021, the EU average stood at approximately €35 per capita, with average annual growth of 4.5% in the period 2013–2021. A small group of countries combines both high investment levels and above-EU growth, most notably Belgium, Hungary, Ireland and Slovenia, indicating the emergence of dynamic innovation hubs (**Figure 9**).

Box 8 Continued

Looking ahead, the proposed EU Biotech Act aims to further streamline regulatory frameworks across HTA, clinical trials and adjacent domains, strengthening alignment between EU-level tools and national implementation efforts.

Figure 9. Uneven levels and growth in business pharmaceutical R&D point to a few dynamic innovation hubs



Notes: The EU average is weighted. Values are computed per capita using year-specific populations. Annual series are deflated with national deflators, then converted using year-specific PPPs before forming three-year averages. The Y-axis shows growth between 2012–2014 and 2020–2022 as a compound annual growth rate (CAGR) computed midpoint-to-midpoint. The X-axis shows the level of pharmaceutical business R&D investment per capita. PPP: purchasing power parity; R&D: research and development.

Source: OECD Data Explorer (DF_ANBERDi4).

3. Improving pricing and reimbursement to contain costs

A third strand of reforms focus on cost containment through stronger pricing and reimbursement mechanisms alongside the promotion of cost-effective alternatives. To ground coverage and pricing decisions on transparent, evidence-informed processes, many EU countries have reinforced their HTA capacity and governance structures. Slovenia exemplifies this trend; in July 2025, it established its Quality Health Care Agency to implement the EU HTA Regulation with support from the EU's Technical

Support Instrument, and is currently developing national bylaws and methodological guidance.

Countries increasingly deploy multiple pricing instruments in combination to manage costs. External and internal reference pricing shape list prices in systems such as Germany, Latvia and the Netherlands. Austria, Czechia and Finland have taken this further by linking the prices of selected new medicines to those of existing generics or biosimilars. Tailored agreements have also proliferated, including rebates, clawbacks, expenditure caps and price-volume arrangements.

Regular reviews of price and reimbursement lists provide an additional safeguard against cost drift: Czechia conducts periodic reassessments of reimbursement prices, while Spain and Sweden have revisited pricing for older medicines or products with limited competition. Greece has recently implemented targeted price increases to sustain older, low-cost medicines, a measure designed to prevent shortages, and Belgium applies mandatory price reductions in specified categories.

Despite overall rising pharmaceutical spending across the EU, driven primarily by the introduction of new high-cost therapies rather than by surges in the volume of medicines consumed, these pricing and reimbursement measures are containing the effective cost growth ultimately borne by health care systems (ESIP & MEDEV, 2024; OECD & European Commission, 2024).

4. Promoting cost-effective use of generics and biosimilars

Policy has increasingly focused on prescribing and dispensing behaviour to expand the use of generics and biosimilars. Many countries mandate or promote International Nonproprietary Names (INN) prescribing to encourage the use of lower-cost equivalents. Greece and Portugal apply particularly stringent INN rules, while Denmark and Latvia require pharmacists to substitute with the lowest-priced equivalent unless clinical justification is provided. Pharmacies in numerous systems are also required to offer lower-priced alternatives and inform patients of price differences at the point of sale.

Digital tools are supporting more cost-conscious prescribing. In Austria, Bulgaria and Greece, e-prescribing systems and clinical decision-support tools help guide therapeutic choices towards more cost-effective options and enable real-time monitoring of prescribing behaviours. Early evaluations suggest these tools are improving generic substitution rates.

Financial incentives are also being aligned with policy goals: France and Hungary link prescribing feedback or pay-for-performance schemes to the use of cost-effective medicines, while Denmark and others have adjusted pharmacist remuneration to favour the dispensing of cheaper options. In Germany, patients pay higher co-payments when selecting products priced above an internal reference level, while co-payments are waived for lower-cost alternatives. Italy's 2024 reform decoupled pharmacy remuneration from retail prices, addressing a long-standing mark-up bias against generics.

Several countries have taken steps to improve public confidence in generics. Luxembourg and Norway have run public information campaigns to dispel safety concerns, while Greece now requires explicit patient consent when a branded product is chosen over a generic. Targeted policies are also accelerating biosimilar uptake: Finland introduced phased substitution for biosimilars in 2024, starting with enoxaparin and expanding to insulin and other biologics; early results indicate rapid growth in dispensing without safety concerns. Italy has achieved high biosimilar penetration in the hospital sector, often exceeding 80–90% shortly after market entry for products such as infliximab and rituximab, through the use of competitive hospital tenders. These efforts have generated a few billion euros in cumulative savings in Italy over the past decade. France and Germany have complemented procurement strategies with prescriber targets and mechanisms to share realised savings, further boosting adoption.

Overall, systems that combine substitution mandates, digital prescribing support tools and aligned incentives now report generic usage above two-thirds of eligible prescriptions and very high biosimilar shares in priority therapeutic areas. By contrast, countries with weaker enforcement, fewer incentives or lower acceptance continue to lag behind.

Early evidence from the 2020–2025 period points to meaningful progress on affordable access to (innovative) medicines as several EU Member States, supported by EU-level instruments, have achieved shorter wait times for selected therapies, extended co-payment protection to millions more people, implemented measurable rebates and paybacks that moderate effective prices and sustained growth in the use of generics and biosimilars.

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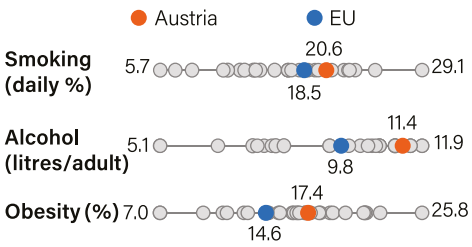
Part II

Key findings from the Country Health Profiles

- Austria's life expectancy reached 82.3 years in 2024, surpassing its pre-pandemic peak and sitting about half a year above the EU average. However, marked inequalities persist: highly educated men live over six years longer than their least-educated counterparts. Reductions in cardiovascular disease mortality drive longevity gains, yet cardiovascular disease still accounts for over one third of deaths, with incidence well above EU levels. By contrast, cancer mortality is comparatively low, though cases are projected to rise sharply by 2040.
- Behavioural and environmental risks account for 29 % of deaths in Austria, led by diet-related factors, with air pollution adding a further 4 %. Smoking remains elevated among adults and adolescents and may have risen post-pandemic, while alcohol consumption is high. Obesity has increased to 17.4 % of adults, with adolescent overweight and obesity reaching nearly 23 %. These risks are concentrated among lower-education groups, where obesity is nearly twice as prevalent, underscoring the need for intensified prevention.
- Austria's social health insurance system ensures near-universal coverage but ranks among the most expensive in the EU. In 2023, per capita health expenditure reached EUR 4 901 – 28 % above the EU average. Although public spending is high in absolute terms, its share of total health expenditure is below the EU average, resulting in a comparatively greater reliance on **out-of-pocket** payments. Despite having one of the highest physician densities in the EU, Austria continues to face regional disparities, a declining share of general practitioners and significant projected nursing shortages. These challenges have prompted a continued expansion of multidisciplinary primary care models.
- Austria delivers strong outcomes once patients enter care, but prevention remains a weak link. In 2022, treatable mortality was 23 % below the EU average, while preventable mortality was only slightly below and remains high for Western Europe, driven by lung cancer, alcohol and ischaemic heart disease. Immunisation performance is mixed, with low influenza uptake despite expansion of free vaccination and a sizeable measles surge in 2024. Screening is uneven: organised breast screening stagnates at relatively low participation, while opportunistic cervical and colorectal testing is widespread.
- Coverage is near-universal and benefits are broad, yet access is becoming uneven as an expansion of private non-contracted practice raises out-of-pocket costs and creates longer waits for public contracted practices. While overall unmet needs remain low, regional workforce gaps, especially in general practice, sustain variability in waiting times. Ongoing reforms seek to expand team-based primary care and introduce targeted workforce incentives.
- Austria is gradually rebalancing care away from its hospital-centric model. Bed supply fell 10 % between 2017 and 2023, yet capacity remains high at 6.6 per 1 000 inhabitants and elective volumes are well above EU levels. Health ICT investment ranks second in the EU, though uptake of the ELGA electronic health record lags; new reforms mandate its use and expand telehealth services. Conversely, antibiotic consumption is low at 11.3 DDD per 1 000 per day, well below EU levels, representing a key strength.
- Austria's retail pharmaceutical spending is about 10 % above the EU average per capita, reflecting high overall spending and broad insurance coverage. While robust retail price regulation has helped contain outpatient pharmaceutical spending, rising pressures stem from hospitalprocured medicines; to address this, a newly established Federal Appraisal Board is tasked with improving HTA for high-cost therapies. However, the scope for savings is limited by low generic penetration, uneven uptake of biosimilars and the absence of international non-proprietary name prescribing and pharmacy-level substitution. In contrast, pharmaceutical R&D investment is comparatively strong, supported by generous tax incentives.

Risk factors



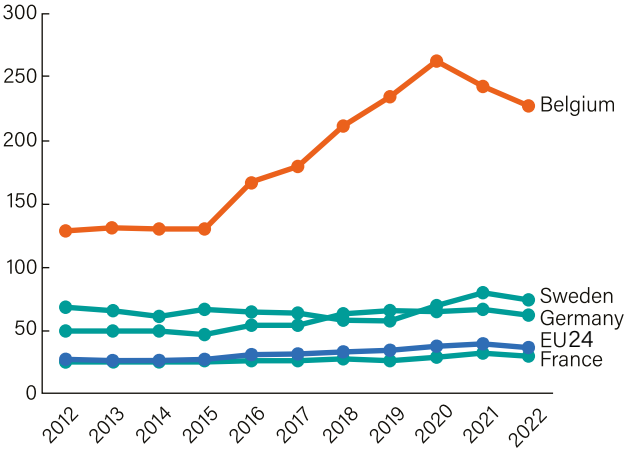
Adults, 2022 (or nearest year)

- The health status of the Belgian population is generally good. In 2024, life expectancy in Belgium reached 82.6 years, nearly one year higher than the EU average. After a notable decline of 1.3 years during the first year of the COVID-19 pandemic in 2020, life expectancy rebounded to reach a new all-time high in 2024. Cancer and circulatory diseases are the two leading causes of death, responsible for nearly half of all deaths.
- Behavioural and environmental risk factors accounted for 26 % of all deaths in Belgium in 2021, which was nonetheless slightly lower than the EU average of 29 %. While adult and adolescent smoking in Belgium have dropped in the last decade, heavy alcohol drinking among adolescents and lack of physical activity among adults are two important public health issues in Belgium.
- In 2023, per capita health expenditure in Belgium was nearly 20 % higher than the EU average and represented 10.8 % of Belgium's GDP, also above the EU average of 10.0 %. Public sources accounted for 74 % of health expenditure in 2023, below the EU average of 80 %. Out-of-pocket payments accounted for the bulk of private financing, reaching 22 % of total health spending - well above the EU average of 16 %, mostly driven by fee supplements.
- In 2024, only 1.5 % of the Belgian population in need of medical care reported facing unmet needs due to costs, travel distance or waiting times - a proportion less than half the EU average (3.6 %). However, unmet needs are disproportionately concentrated among individuals on low incomes. Income-related disparities in unmet needs are even more pronounced for dental care, which is less comprehensively publicly covered in Belgium as in many other EU countries.
- Belgium's screening rates for breast, cervical, and colorectal cancers are close to EU average, but remain well below the EU's 90 % target of the eligible population. However, significant regional disparities exist, with Flanders showing much higher coverage than Brussels and Wallonia for breast and cervical cancer screening.
- Despite an increase in the number of doctors and nurses, Belgium faces ongoing staffing shortages. In 2023, Belgium had 3.4 doctors per 1 000 population, well below the EU average of 4.3, but a relatively high nurse density with 11.5 nurses per 1 000 population, above the EU average of 8.4. Yet hospitals face difficulties in recruiting and retaining enough nurses. The shortage of nurses in hospital settings has important consequences for hospital bed closures and more broadly for the quality of care in hospitals.
- Belgium has significantly increased its investment in health information and communication technology in recent years to support the digitalisation of its health system. A growing proportion of Belgians are using digital tools to make online medical appointments and access their health records. A central component of the eHealth Action Plan (2025-2027) is the development of the future Belgian Integrated Health Record, a digital platform providing real-time access to comprehensive patient information for health professionals across different care settings.
- Belgium's per capita spending on retail pharmaceuticals was 6 % below the EU average in 2023. While generic medication use has increased over the past decade, Belgium's uptake remains low compared to other EU countries. On the positive side, Belgium is the leader in pharmaceutical R&D investment, with R&D spending per capita five times greater than the EU average in 2022, highlighting its strong innovative environment supported by a dense network of research centres, top scientific talent, and strong public-private partnerships.

Pharmaceuticals

Business enterprise R&D in the pharmaceutical industry

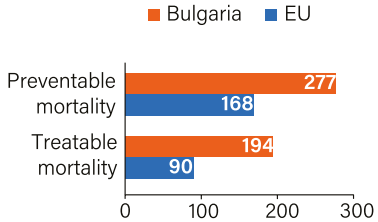
EUR PPP per capita, constant prices (2022)



Note: The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_ANBERDi4).

- Bulgaria's life expectancy remains the lowest in the EU at 75.9 years in 2024, nearly six years below the EU average, with a wide 7.4-year gender gap. Mortality is dominated by cardiovascular disease, responsible for more than 60 % of deaths, with high incidence and signs of poorer survival after events, although a 2024 reform that fully reimburses essential cardiovascular medicines is demonstrating early positive outcomes. Rapid ageing and high multimorbidity add pressure, while observed cancer rates are depressed by competing cardiovascular risks and possible underdiagnosis.
- Behavioural and environmental risks drive a high mortality burden in Bulgaria, accounting for 36 % of deaths compared with 29 % in the EU. Adult smoking remains the highest in the EU and adolescent tobacco and e-cigarette use is widespread, while alcohol use is also elevated. Although adult obesity is relatively low, poor diets and some of the EU's lowest physical activity levels fuel rising adolescent obesity. Recent measures include higher tobacco excise taxes and school food standards, yet risk factors remain concentrated among less educated groups.
- Bulgaria operates a centralised social health insurance system with a single purchaser and GP gatekeeping, but low public funding leaves households financing the EU's highest out-of-pocket share. Spending is concentrated in hospitals and pharmaceuticals to the detriment of outpatient care and prevention. Despite above-average doctor density, primary care is weak and a severe nurse shortage creates a 1:1 nurse-to- doctor ratio, half the EU average. This financing and workforce mix limits effective coverage and strains care continuity for chronic conditions.
- Bulgaria's avoidable mortality remains among the highest in the EU: preventable deaths rose during the pandemic, and treatable mortality has seen little improvement for a decade and is more than twice the EU average, with stroke and ischaemic heart disease driving both. Policy responses are under way: free cardiovascular medicines, new interventional stroke centres and a shift to population-based cancer screening, including cervical screening launched in 2025 and colorectal plans. At the same time, vaccine uptake is persistently low, notably HPV, highlighting the need to pair service reforms with stronger prevention and communication.
- Coverage gaps and financing design continue to strain access and financial protection in Bulgaria, with an estimated 6-12 % of residents uninsured. The 2024 removal of hospital volume caps should reduce delays, but heightens the need for more strategic purchasing. Public coverage is comprehensive for inpatient care, but shallow for outpatient services and medicines, driving the EU's highest out-of- pocket share and widespread catastrophic spending, largely from pharmaceuticals. Geographic workforce imbalances further limit access, prompting new incentives and a national strategy for 2027.
- Bulgaria's hospital sector is oversized and inefficient: bed density is more than 50 % above the EU average, discharge rates are over twice as high, yet occupancy is only 57 % and stays are short, indicating a model of high-volume, inefficient care. Weak gatekeeping and case-based incentives steer demand to hospitals. Eliminating payment ceilings in 2024 improved access, but exposed liabilities and widened budget gaps despite a larger 2025 NHIF allocation. Workforce measures tie medical students to posts and expand GP training, but nursing shortages persist. Digital uptake remains low, while AMR efforts build on mandatory e-prescribing.
- Owing to its comparatively small total health expenditure, Bulgaria devotes a large share of its health spending to medicines. Caps and clawbacks have improved transparency and generated refunds, yet overspending persists. Public coverage for outpatient drugs is the lowest in the EU, leaving households to pay about three quarters out of pocket, with recent measures easing costs for cardiovascular treatments and children. Access to new medicines is broad but delayed by listing rules and budget cycles. While a national tracking system is significantly improving shortage management, brand prescribing and no pharmacy substitution limit generic savings.

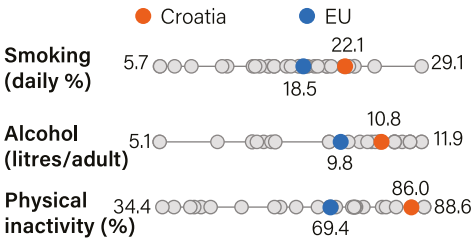
Effectiveness



Age-standardised rate per 100 000 population, 2022

- Life expectancy in Croatia surpassed its pre-pandemic level, reaching 79.1 years in 2023, which was 2.6 years below the EU average. A significant gender gap persists: women live 5.8 years longer than men, which is larger than the EU average gap (5.2 years), largely due to higher rates of unhealthy behaviours among men. At age 65, life expectancy also lags behind the EU average and shows a similar gender gap.
- In 2021, an estimated half a million Croatians lived with a cardiovascular disease, with over 50 000 new cases estimated for that year. Croatia's cancer incidence rate in 2020 was approximately 12 % higher than the EU average, but prevalence was lower, reflecting lower survival rates for some cancers and higher overall mortality in Croatia compared to other EU countries.
- Behavioural risk factors were estimated to account for 32 % of deaths in Croatia in 2021, with air pollution contributing another 6 %. Daily smoking rates remain high (22 % in 2019 compared to an EU average of 19 %), and about 25 % of 15-year-olds reported smoking or vaping in 2022 – among the highest in the EU. Despite tobacco control policies, enforcement remains weak. Obesity affected 17 % of adults in 2022, which is above the EU average (15 %), and obesity is nearly twice as common among those with lower education levels. To address this, Croatia has adopted the Obesity Prevention Action Plan 2024-27.
- Croatia's rates for mortality from preventable and treatable causes remain well above EU levels. Risk factors such as alcohol use, smoking, poor diet, physical inactivity and obesity contribute significantly to preventable deaths – especially from ischaemic heart disease, which is the leading cause of both preventable and treatable deaths. In 2022, COVID-19 accounted for 10 % of preventable deaths, ranking behind lung cancer (18 %), alcohol-related diseases (11 %) and ischaemic heart disease (10 %).
- Croatia's mandatory social health insurance system covers about 99 % of the population, and public funding accounts for a large share of health expenditure. Although Croatia's per capita health spending in 2023 was low (just over half the EU average), public sources funded 85 % of this amount, exceeding the EU average (80 %).
- Croatia offers a generous public benefits package that protects citizens from high out-of- pocket costs and catastrophic health spending. Overall, rates of self-reported unmet needs for medical care are lower than the EU average, even among those at risk of poverty.
- The resilience of Croatia's health system is bolstered by growing human and healthcare resources. The main challenges are in geographical distribution and sufficient supply in rural and less populated areas. Waiting times remain a political issue, and while policies such as priority waiting lists have been implemented, their effectiveness requires evaluation.
- Investment in health infrastructure is supported by EU funding – particularly through the Recovery and Resilience Facility and Cohesion Policy. Croatia has intensified its investment in health information and communication technology in recent years, supporting the digitalisation of health services.
- Pharmaceutical policy is a national focus. In 2023, 19 % of Croatia's health spending went on retail pharmaceuticals, compared to an EU average of 13 %. However, per capita spending on retail pharmaceuticals in Croatia (EUR 391) was among the lowest in the EU, and far below the average of EUR 510. Public coverage was strong, with 74 % of retail pharmaceutical costs covered – one of the highest rates in the EU, and above the EU average of 62 %.

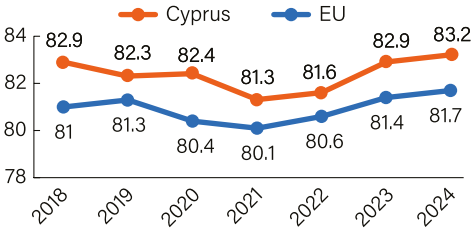
Risk factors



Adults, 2022 (or nearest year)

- Life expectancy at birth in Cyprus is high (83.2 years in 2024), and 75 % of Cypriots report being in good health, though there is a gap by income level that is particularly pronounced for women. The share of the population aged 65 and over in Cyprus grew from 11 % in 2000 to 18 % in 2024, and given demographic trends is projected to increase to 22 % by 2050. Among the population aged 65 and over in 2022, more than 40 % of Cypriot women and men reported multiple chronic conditions.
- Roughly 27 % of all deaths in Cyprus in 2021 can be attributed to behavioural risk factors (tobacco consumption, dietary risks, alcohol consumption and low physical activity). Smoking in particular is a public health concern, as rates are among the highest in Europe – especially among men. While younger generations are smoking fewer cigarettes, use of e-cigarettes has become popular.
- Since the implementation of the General Healthcare System in 2019, there has been continued growth in the share of public spending on health. The reforms have improved financial protection and drastically reduced out-of-pocket spending in Cyprus. Out-of-pocket spending as a share of total health spending fell from 44 % in 2018 to 18 % in 2023. This is likely to have reduced levels of catastrophic spending on health significantly.
- Mortality rates for preventable and treatable causes are very low in Cyprus compared to the EU averages. The main cause of preventable mortality is lung cancer, which is consistent with high smoking rates – particularly among Cypriot men. The main causes of treatable mortality in Cyprus are ischaemic heart disease, diabetes, colorectal cancer and breast cancer. This highlights the ongoing challenge of strengthening cancer screening programmes. However, data limitations mean that attributing low treatable mortality rates to the performance of specific parts of the health system is not possible.
- Before the reforms introducing the General Healthcare System in Cyprus, long waiting times were an important barrier to medical care, and patients frequently paid out of pocket in full to access services more quickly. Now most capacity in the private sector has been contracted by the Health Insurance Organisation to provide publicly funded services. There are ongoing health workforce challenges, as doctors are primarily employed in the private sector and nurses in the public sector. Generally, there is a growing need for nurses in Cyprus, and the numbers of new nursing graduates are very low.
- Current priorities for financial and capital investments in the health system focus on modernising infrastructure, digitalisation, promoting evidence-based practices and quality monitoring, and upskilling the workforce. Via its Recovery and Resilience Plan, Cyprus has allocated EUR 101 million for these priorities to make the health system more effective, efficient and informed. EU funding support is also under way for the establishment of a capacity master plan to provide a planning and decision-making framework for the health system.
- Public financing now covers 71 % of retail pharmaceutical spending in Cyprus, which is the sixth highest in the EU and highlights the strength of financial protection in the General Healthcare System. While approval and reimbursement processes are slightly quicker in Cyprus than the EU averages, the country suffers from the "small market" problem -not being a sufficiently attractive market for pharmaceutical manufacturers -meaning that fewer products are available, undermining competition and resulting in inelastic pricing.

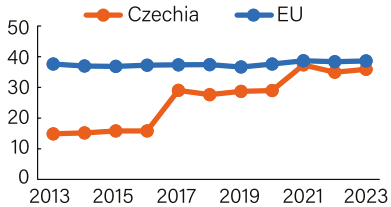
Health status



Life expectancy at birth

- Life expectancy in Czechia reached 80.3 years in 2024, surpassing its pre-pandemic level but remaining 1.4 years below the EU average. The country's mortality is shaped by a high burden from cardiovascular diseases and cancer, which together accounted for over 63 % of all deaths in 2023. In addition, health outcomes for older people lag behind EU peers: at age 65, Czechs have a shorter life expectancy and live a smaller proportion of their remaining years free from disability.
- Behavioural risk factors contribute significantly to mortality in Czechia, with poor diet, alcohol use, and smoking being the primary drivers. Adult alcohol consumption is a persistent challenge, ranking among the EU's highest at over 11 litres per capita in 2023, a consumption level largely unchanged over two decades. While daily adult smoking has fallen to 16 %, below the EU average, this progress has been countered by a rapid rise in e-cigarette use, particularly among adolescents and young adults.
- Czechia's compulsory social health insurance system delivers virtually universal coverage, with public sources accounting for 85 % of health spending. Overall expenditure, however, remains low at EUR 2 910 per capita in 2023, 24 % below the EU average. Spending is concentrated on outpatient and inpatient care, while long-term care and prevention are comparatively underfunded. Although the density of doctors and nurses is in line with the EU average, the system faces nurse shortages leading to reported ward closures.
- Czechia's health outcomes reveal scope for improvement. In 2022, preventable mortality was 16 % higher and treatable mortality 26 % higher than EU averages, while admission rates for ambulatory-care- sensitive chronic conditions were 18 % above the EU average in 2023, largely driven by admissions for congestive heart failure. Prevention programmes show mixed performance: influenza vaccination coverage for older people is low at just over half the EU average, while HPV vaccination for adolescent girls exceeds the EU average. Cancer screening uptake is strong for breast and cervical cancer, with screening volumes being less disrupted by the pandemic relative to the EU average.
- Financial access to healthcare in Czechia is strong, supported by a broad benefits package and high public coverage. As a result, self-reported unmet needs for medical and dental care are among the lowest in the EU, and out-of- pocket spending accounts for 14 % of total health expenditure. Nearly the entire population can access a general practitioner within a reasonable travel time, yet shortages in some rural and border regions continue to pose challenges. The planned operationalisation of the e-Žádanka electronic referral system in 2026 is expected to enhance waiting-time management and improve access to specialist care. In addition, Czechia is addressing waiting times for selected elective care with increased reimbursements, with volumes for hip and knee replacements surging after reimbursement caps were lifted during the pandemic.
- After a period of pandemic-related volatility, public health spending per capita returned to its pre-pandemic growth trend in 2023, with EU funds supporting key infrastructure modernisations. To address future needs and an ageing workforce, the country has expanded its training pipeline, increasing medical school intake by 20 % since 2019, and boosting the number of nursing students starting in 2025. A recent rebound in antibiotic consumption has put Czechia off track to meet its 2030 reduction target.
- Retail pharmaceutical spending in Czechia accounts for around 15 % of total health expenditure, with out-of-pocket payments covering a share higher than the EU average. However, the market is increasingly shaped by hospital procurement, which now represents over one-third of total pharmaceutical spending. This is driven by a system where high-cost, innovative therapies are administered exclusively in accredited hospitals, which receive dedicated budgets from health insurance funds to finance them. The country maintains a high generic medicine uptake of around 63 % and promotes biosimilars effectively through mandatory price reductions. While pharmaceutical R&D investment is low at just one fifth of the EU average, Czechia is a strong performer in clinical trials, consistently exceeding the EU average.

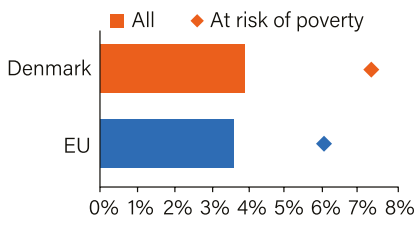
Resilience



Nursing graduates per 100 000 population

- Life expectancy at birth in Denmark was 82.3 years in 2024, slightly above the EU average, but below most other Nordic countries. Cancer is the leading cause of death, responsible for over one-quarter of all deaths, with lung cancer claiming the most lives.
- Although tobacco smoking in Denmark has declined sharply over the past two decades, prevalence remains higher than in other Nordic countries. Adult obesity has nearly doubled since 2000, reaching 19 % in 2022 -substantially above the EU average of 15 %. While alcohol consumption among adults has decreased and now falls below the EU average, risky behaviours persist among adolescents. In 2022, 45 % of Danish 15-year- olds reported having been drunk more than once in their life-the highest share in the EU. Since 2025, Danish law has prohibited 16-and 17-year- olds from purchasing drinks with an alcohol content above 6 %, but beer and other lower-strength beverages remain accessible to under-18s, unlike in most other Nordic and EU countries.
- Denmark fares comparatively well on cancer prevention and care. Human papillomavirus vaccination coverage is very high among 15-year-old girls and boys. Cancer screening participation for breast, cervical and colorectal cancers are well above the EU averages. Earlier diagnosis and improved treatments have raised five-year survival rates for many common cancers, allowing Denmark to catch up with other Nordic countries. The new cancer plan released in 2025 focuses more on the quality of life for cancer patients and survivors.
- Nearly 4 % of Danish adults reported unmet medical care needs due to cost, travel distance or waiting times in 2024, a slightly higher proportion than the EU average. This proportion is substantially higher among Danish people with low incomes and at risk of poverty (over 7 %). Unmet needs are greater for dental care because it is less covered by public insurance. Over 9 % of Danish adults reported some unmet dental care needs in 2024, and this proportion reached 23 % among those at risk of poverty.
- In late 2024, a major health reform was announced to address demographic pressures and reduce inequalities in access to care while reshaping governance. By 2027, the reform aims to reduce the number of regions from five to four and create 17 local health councils. It also sets ambitious targets for primary care, notably to increase the number of general practitioners from 3 500 to 5 000 by 2035, improve their geographic distribution and support new models of service delivery.
- Denmark's healthcare digital transformation is highly advanced. It is based on a secure and standardised national health IT infrastructure. The shared Medication Record and near-universal appointment system provide real-time access to data and prescriptions across patients and providers. In 2024, nearly 60 % of Danes booked appointments online and accessed their health records, far above EU averages, though uptake is lower among people with a lower level of education.
- Spending on retail pharmaceuticals per capita in Denmark is among the lowest in the EU, while public coverage of retail pharmaceuticals is relatively low (42 % compared to the EU average of 62 %). However, this does not take into account pharmaceutical spending in hospital, which accounts for 38 % of total pharmaceutical spending and is fully publicly covered. Generics make up 70 % of the pharmaceutical market in volume, a much higher share than the EU average of 51 %. The pharmaceutical sector, which is part of the broader life science sector, has become a growth engine of the Danish economy, with a 2024 strategy aiming to make Denmark Europe's leading life science country by 2030.

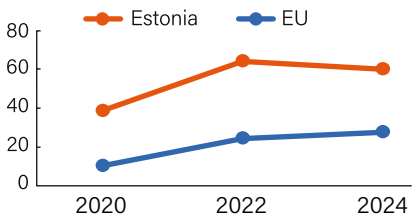
Accessibility



% reporting unmet medical care needs, 2024

- After a temporary decline during the pandemic years, life expectancy in Estonia rebounded and reached an all-time high of 79.6 years in 2024. Socioeconomic health inequalities are large: people from higher socioeconomic groups report better health, lead healthier lifestyles and live 8-10 years longer than people from lower socioeconomic groups. There are also large gender health disparities: Estonian women live considerably longer than men, but also report worse health for longer.
- Alcohol consumption among adults has remained stable over the past decade. It was around 10 % higher than the EU average in 2022, and remained above 10 litres per capita in 2023 despite policy efforts aiming to reduce consumption to under 8 litres per capita. An increase in adolescent vaping rates has also prompted stricter regulation of e-cigarettes. Adults in Estonia are the most physically active in the EU, but Estonian adolescents are among the least physically active.
- There is a shortage of health professionals in family medicine and mental healthcare – particularly in rural areas. Estonia had fewer doctors and nurses per 1 000 population in 2023 than the EU averages. Moreover, in 2022, 43 % of doctors were aged 55 and over, suggesting that workforce shortages are likely to worsen in the future. While efforts have been made to increase health workforce training capacity, current medical and nursing graduate output is below projected requirements and below the EU averages.
- There was a sharp drop in the uptake of vaccinations in Estonia following the COVID-19 pandemic. The Ministry of Social Affairs has responded by commissioning a study to improve vaccination management and communication strategies, and the vaccination schedule for human papillomavirus has been updated in response to the decreased uptake. While human papillomavirus vaccination uptake reached a new high in 2024, measles vaccination uptake was still below the vaccination coverage rate in 2021, falling to 83.3 % in 2024.
- Some 22 % of current health expenditure was from out-of- pocket payments in 2023. Despite lowered annual ceilings on copayments, out-of- pocket payments on outpatient medicines constitute a major driver of financial hardship. Large increases in outpatient specialist consultation, prescription and daily inpatient fees were introduced in 2025; these may further erode the health system's financial protection and exacerbate unmet needs for care, which are already high.
- Estonia has reduced excess hospital bed capacity over time. Between 2018 and 2023, bed capacity per 1 000 population declined by over 9 %, but curative care bed occupancy rates have consistently been below 70 % since 2020. Overall, chronic conditions are managed well in the community, with low hospital admission rates. The Hospital Network Development Plan, which was adopted in December 2024, aims to consolidate the hospital network further – from the current 20 facilities to 17 facilities by 2040.
- Estonia is one of the EU leaders in digital health. It stands out as an early adopter of digital health tools, and has invested consistently in health information and communications technology. Public use of online resources for accessing health records and booking appointments increased markedly between 2020 and 2024, and is well above the EU average for all socioeconomic groups. Scope for better cross-linking between different health databases for research and decision making has been identified, and improvements to data governance are under way.
- Estonia's new national HTA guideline came into effect in 2025, with both clinical and economic evaluations forming the evidence base for reimbursement decisions. Estonia has scope to increase the use of generic medicines to reduce costs and improve access to medicines. The share of generic medicines in Estonia's pharmaceutical market was 39 % in 2024, which is below the EU average (51 % in 2023).

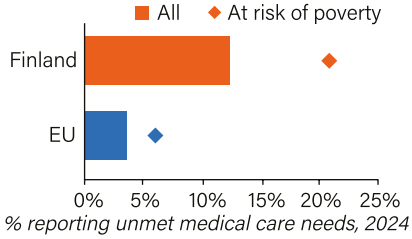
Resilience



% population accessing health records online

- In 2024, life expectancy at birth reached 82.4 years slightly above the EU average but still below that of other Nordic countries, except Denmark, and has not yet fully rebounded to pre-pandemic levels.
- While avoidable mortality from treatable causes continues to fall, the preventable death rate remains high, driven by alcohol-related causes, suicides and smoking-related diseases. Rising obesity and mental health concerns – particularly among young people – reflect growing public health challenges. Daily smoking rates are among the lowest in the EU. Finland continues to pursue its national goal of reducing tobacco and nicotine product use to under 5 % of the population by 2030.
- Cancer screening participation is among the highest in the EU. National programmes for breast, cervical and colorectal cancer are well established, and coverage is especially high among women.
- Finland's 2023 structural reform shifted responsibility for health and social services from municipalities to well-being services counties and the City of Helsinki, and to central government. This reorganisation aims to improve coordination and reduce regional disparities. Although early implementation strengthened integration and accountability, all counties began their first year with deficits, raising concerns about the sustainability of service delivery under strict fiscal constraints.
- Per capita health spending in Finland is close to the EU average. In 2023, public funding reached 81 % – its highest level in two decades – while out-of-pocket payments declined to 14 %. However, new cost-containment measures introduced in January 2025 raised copayments for primary and specialist care. These increases may undermine affordability, particularly for low-income and high-need users.
- Despite universal coverage, Finland continues to report high levels of unmet needs. In 2024, 12.4 % of people with healthcare needs reported being unable to access services – the second highest rate in the EU. Those at risk of poverty are almost twice as likely to be affected as other socioeconomic groups. Long waiting times and high out-of-pocket costs – particularly for dental services and outpatient medicines – together with uneven access to primary care across public, occupational and private schemes remain key barriers to access.
- Workforce shortages continue to disrupt service continuity. Although Finland trains a high number of nurses, the supply of physicians is below the EU average. Persistent regional imbalances in physician availability, rising reliance on part-time and agency staff, and increased unemployment among assistant nurses point to ongoing mismatches between supply and demand. The number of medical graduates rose to 13.1 per 100 000 in 2023 but is still too low to meet growing care needs.
- Public investment in digital health has enabled Finland to become a leader in telemedicine and health information access. All well-being services counties operate digital clinics as the first point of contact for care. In 2024, 74 % of the population accessed their health records online and 64 % booked appointments online – far exceeding EU averages. These platforms improve efficiency and help mitigate workforce constraints, although access varies by age and digital literacy.
- Finland has achieved measurable success in reducing antibiotic consumption and strengthening stewardship. Antibiotic use has already fallen below the national 2030 target, with 74 % of consumption made up of antibiotics in the WHO Access category. These results reflect Finland's strong surveillance systems, effective prescribing controls and high-performing primary care.
- Although pharmaceutical spending is lower than the EU average, affordability continues to pose a challenge. In 2023, households paid 39 % of outpatient pharmaceutical costs. While biosimilar use is growing, barriers such as pharmacy incentives, prescriber preferences and regulatory delays still hinder competition and reduce the pace of uptake.

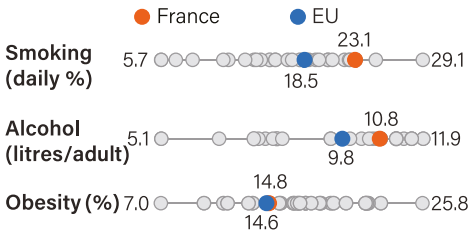
Accessibility



% reporting unmet medical care needs, 2024

- Life expectancy in France was 1.4 years above the EU average in 2024. However, large disparities exist by gender and socioeconomic status. At age 35, men with tertiary education can expect to live 8.0 years longer than those without a secondary education diploma; this gap is 5.4 years among women.
- Around one-quarter of all deaths in 2021 can be attributed to behavioural and environmental risk factors. Nearly one-quarter of adults (23 %) continue to smoke daily, one of the highest proportions in the EU. More positively, regular cigarette smoking among 15-year- olds is lower than in many EU countries. While alcohol consumption among adults has reduced, it remains higher than the EU average. Obesity rates have risen to match the EU average. Smoking and obesity rates are particularly high among people with lower education levels, contributing to lower life expectancy.
- Health spending per capita in France is in the top third of EU countries. It represented 11.5 % of GDP in 2023, the second highest share after Germany.
- Financial access to care is strong: France has one the lowest shares of out-of- pocket payments paid directly by households in the EU. Self-reported unmet medical needs due to cost, distance and waiting times are limited, though above the EU average. Barriers are greater for those at risk of poverty, particularly for services that are less covered. In 2024, nearly 14 % of people at risk of poverty reported unmet dental care needs.
- Access to general practitioners remains a challenge in underserved "medical deserts". Measures to address the shortage of doctors in certain regions include financial incentives for doctors to settle in these areas, the expansion of multidisciplinary health centres, and the increase in the number of medical students and postgraduate training places in general medicine. In 2025, a bill sought to restrict new practices in already well-served areas, but awaits Senate adoption.
- Nurse shortages intensified after the pandemic. Demand for nursing is projected to rise by 50 % between 2021 and 2050, while supply would grow by only 37 % under current policies. High dropout rates among nursing students and low hospital retention rates (only half of hospital nurses remain in the job after ten years) constrain supply growth. To improve attractiveness and retention, a 2025 legislation redefined and expanded the scope of practice of nurses for the first time in two decades. The principle of mandatory nurse-to- patient ratios was also introduced in 2025 to improve hospital patient safety and nurse wellbeing, with implementation foreseen in 2027.
- Digitalisation has accelerated in recent years. E-prescriptions, launched in 2022, accounted for 30 % of all prescriptions in 2023. A shared electronic health record (Mon espace santé) is being deployed, including shared information between patients and their healthcare providers, imaging and biology results, and hospitalisation discharge information. The use of digital tools -from online appointment booking to teleconsultations -has surged in recent years, though inequalities exist across age and socioeconomic groups.
- Retail pharmaceutical spending per capita in France was about 10 % higher than the EU average in 2023. Public and compulsory private insurances cover 83 % of retail pharmaceutical expenditure, a share much higher than the EU average of 62 %. While the share of generic medicines has increased markedly over the past decade from 25 % in 2010 to 42 % in 2023, it remains below the EU average of 51 %. France ranks third in the EU for pharmaceutical R&D investment, behind Germany and Belgium, indicating relatively strong innovation capacity.

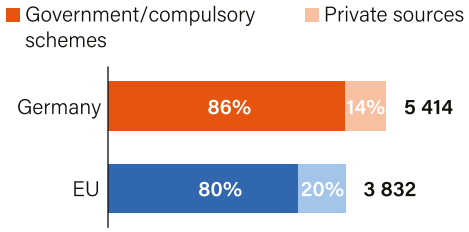
Risk factors



Adults, 2022 (or nearest year)

- Life expectancy in Germany recovered from its temporary decrease during the COVID-19 pandemic and stood at 81.5 years in 2024 – nearly equal to the EU average. Cardiovascular diseases, such as ischaemic heart disease and stroke, and cancer are the leading causes of death. The share of older people in Germany is rising, and nearly half of those aged 65 and over live with multiple chronic conditions. This highlights a growing need to maintain quality of life and care for people living longer with complex health needs.
- Behavioural risk factors continue to drive a large share of the disease burden. While smoking and alcohol use have declined among adults, they have increased among adolescents, and obesity rates remain high among both age groups. Socioeconomic inequalities in risk factors are larger in Germany than in most other EU countries. This underscores the need for strengthened prevention policies targeting modifiable risk factors, including smoking, alcohol use, poor diet and physical inactivity.
- While some prevention and early detection policies have been introduced, and Germany has the highest level of per capita spending on prevention in the EU, the evidence points to gaps in addressing behavioural risk factors across all age groups. Premature deaths from preventable causes in Germany are particularly driven by lung cancer, alcohol-related diseases and ischaemic heart disease.
- Germany has expanded national cancer screening programmes for breast, colorectal and cervical cancers, aligning with EU guidelines, while an organised screening programme for lung cancer that targets high-risk groups is being developed. Participation varies by screening programme, with policy efforts under way to improve outreach, bolster mobile access and integrate genomic medicine.
- Germany provides universal health coverage with a generous benefits package, backed by high public funding for health and low out-of- pocket expenditure – which is mainly spent on long-term care and pharmaceuticals. Full copayment exemptions apply to children, while partial exemptions and income-based copayment caps are available for those on low incomes or social welfare.
- Self-reported unmet needs for medical and dental care in Germany remain well below the EU averages, but unmet mental healthcare needs have risen sharply, and reached among the highest levels in the EU in 2024. This reflects a persistent shortage of outpatient psychotherapists, and suggests that the system is struggling to meet growing demand – especially after the COVID-19 pandemic.
- Hospital capacity and activity levels in Germany remain among the highest in the EU, leading to inefficiencies. Germany continues to report the highest rates of avoidable hospital admissions for chronic conditions such as heart failure, chronic obstructive pulmonary disease and diabetes. Ongoing hospital reforms aim to shift more care to outpatient settings and reduce overcapacity by introducing service groups, which will facilitate more effective planning and specialisation. These transformations will be complemented by new financing mechanisms.
- Despite significant investment in digitalisation of the health system, progress remains uneven. Low reported use of electronic health records reflects historical obstacles such as technical limitations and narrow provider participation. However, the nationwide rollout of the electronic patient file for 89 % of the population covered by statutory health insurance began in 2025, aiming to empower citizens to access their personal health records electronically via a secure platform.
- Pharmaceutical spending in Germany is the highest in the EU, but coverage and access are strong. Germany plays a leading role in pharmaceutical innovation, accounting for one third of all pharmaceutical research and development spending in the EU. It also leads in early phase clinical trial activity, supported by strong research infrastructure, public–private collaboration and targeted investment policies.

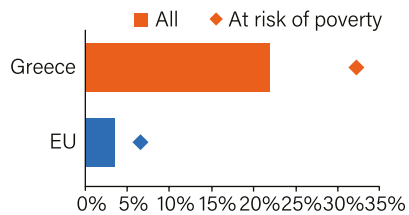
Health Spending



Health spending per capita (EUR PPP), 2023

- Cardiovascular diseases and cancer are the leading causes of death and disability in Greece, with over half of all deaths attributed to these conditions. While life expectancy (81.9 years in 2024) has rebounded since the pandemic, and is now slightly higher than the EU average, more than half of the years lived after age 65 are spent with disabilities or chronic conditions – particularly among women.
- Nearly one third of deaths in Greece are linked to modifiable risk factors such as smoking, poor diet, low physical activity and air pollution. Despite some progress – like reduced alcohol consumption and adult smoking rates – Greece still faces high adolescent obesity and smoking rates. Public health initiatives, including anti-smoking laws and a new National Action Plan against Childhood Obesity, aim to address these issues.
- Greece spends significantly less on healthcare than the EU average, both in terms of GDP share and per capita expenditure. Public funding covers only 61 % of health costs, leaving households to shoulder a high financial burden through out-of-pocket payments (34 % of health spending). Pharmaceuticals and inpatient care are the main drivers of this private expenditure, along with dental care.
- In 2022, Greece's avoidable mortality rate was just below the EU average, but preventable deaths surged during the pandemic and have not fully returned to pre-pandemic levels. COVID-19, lung cancer and ischaemic heart disease were leading causes. Mortality from treatable causes – largely due to cardiovascular diseases and cancers – has declined but still accounts for a significant share of avoidable deaths. The government has responded with targeted prevention initiatives, including free cardiovascular screening and establishment of specialised stroke care units.
- Greece has the highest levels of unmet healthcare needs in the EU, especially among low-income groups. In 2024, over one in five Greeks reported unmet medical needs due to cost, waiting times or distance to travel – six times the EU average. The situation is worse for those at risk of poverty, with 32 % reporting unmet medical needs and 53 % reporting unmet dental care needs. These disparities are driven by limited public coverage, high out-of- pocket payments and service access barriers.
- Reforms aim to improve access to services through primary care expansion and digital health services. The "personal doctor" scheme, expanded in 2024, mandates adult registration with a primary care provider to improve care coordination and access. Telemedicine infrastructure has also been extended, particularly in remote areas, and digital tools like ePrescriptions are enhancing access to medications for patients with chronic conditions.
- Greece is investing in digital health and infrastructure to improve system resilience and reduce waiting times. Major reforms include the Unified Digital List of Surgeries, which has reduced surgical waiting times, but concerns remain about equity and capacity – especially with the introduction of privately paid operations in public hospitals. Nearly 30 digital readiness measures in the health sector are prioritised in the National Digital Transformation Strategy, which fully operationalised the electronic health record system in 2025.
- Greece spends more per capita on retail pharmaceuticals than other EU countries: retail medicines accounted for 27 % of health spending in 2023 – double the EU average. While the spending trend for retail pharmaceuticals has fluctuated in recent years, per capita pharmaceutical spending in hospitals has grown significantly, due to higher demand from an ageing population requiring hospital services and increased use of expensive new medicines. Despite policy efforts, generics account for only 34 % of reimbursed medicines by volume, although they represent a high share of sales value, indicating relatively high prices.

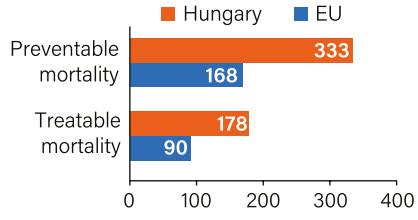
Accessibility



% reporting unmet medical care needs, 2024

- Life expectancy in Hungary stood at 77.0 years in 2024, which is 4.7 years below the EU average. As in other EU countries, there is a large gender gap in life expectancy: Hungarian women generally live 6.3 years longer than men – a greater gap than the EU average of 5.2 years. In 2023, the leading causes of death in Hungary were cardiovascular diseases (including ischaemic heart disease and stroke) and cancer, which together accounted for over 70 % of all deaths.
- Hungarians smoke, drink and experience obesity at significantly higher rates than the EU averages. These risk factors are especially pronounced among men and people with lower education levels. Behavioural risk factors drive poor health outcomes and contribute to health inequalities.
- Per capita health expenditure in Hungary is comparatively low, at EUR 1 925, which is approximately half the EU average. Public financing for healthcare has gradually increased over recent years, accounting for 74 % of current health spending in 2023, but it remains below the EU average of 80 %. Consequently, private spending plays a prominent role, and out-of- pocket payments made up 23 % of health expenditure in 2023 – significantly higher than the EU average of 16 %.
- Mortality rates from preventable and treatable causes were among the highest in the EU in 2022. Lung cancer, ischaemic heart disease and alcohol-related diseases were the three leading causes of preventable mortality, while ischaemic heart disease, colorectal cancer and stroke were the main drivers of treatable mortality. These health outcomes reflect longstanding public health challenges and the limited effectiveness of interventions. A prevention programme through which general practitioners can prescribe physical activity is being piloted in 30 municipalities. Initiatives in cancer screening are also under way, spearheaded by the National Cancer Plan.
- Although the shares of Hungarians reporting unmet needs for medical or dental examination are low compared to the EU averages, high out-of- pocket payments can create financial barriers to accessing care – particularly for pharmaceuticals, outpatient services and dental care. Mental healthcare is one area where unmet needs for treatment have been increasing – particularly in the years since the COVID-19 pandemic.
- Use of digital tools in healthcare has grown significantly in recent years. The proportion of Hungarians making medical appointments online is growing, while the share of those accessing their health records online increased from 17 % in 2020 to 42 % in 2024. Citizens can access their health records through a single centralised interface following electronic identification authentication. Hungary has a central information technology system, which almost all publicly funded healthcare institutions use. The centralised digital system includes an outpatient pathway management tool that links providers and patients, helping to streamline appointments and patient flows.
- Hungary's health system is supported by EU funding across multiple instruments, including the Recovery and Resilience Plan. Investments support key reforms, such as upgrading infrastructure, reducing informal payments, enhancing digital tools and strengthening primary care. Together, these funds aim to enhance Hungary's health system resilience and efficiency.
- Pharmaceutical spending accounts for a large share of total health expenditure, and just over half of retail pharmaceutical costs are paid out of pocket by patients. Although per capita spending on pharmaceuticals is below the EU average, household payments are high due to copayments and limited reimbursement coverage. A special reimbursement scheme helps to mitigate costs for vulnerable groups, but financial protection mechanisms to protect patients from out-of-pocket payments could be improved. To support the availability of new medicines, early access schemes grant access to therapies for severe diseases, allowing temporary use before full marketing and reimbursement authorisation.

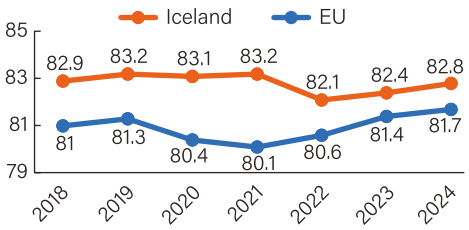
Effectiveness



Age-standardised rate per 100 000 population, 2022

- Iceland maintains a relatively high life expectancy at 82.8 years in 2024, over a year above the EU average, though still 0.4 years below its pre-pandemic level. The gender gap is small, yet longevity differs markedly by education, with men without secondary schooling living 5.1 years less than university graduates. Cardiovascular diseases and cancer caused 54 % of deaths in 2023, while COVID-19 fell below 2 %. Strong prevention keeps CVD incidence and prevalence below EU levels, but population ageing will lift cancer incidence by over 50 % by 2040, straining capacity and survivorship care.
- Behavioural and environmental risks account for 26 % of deaths in Iceland, below the EU average but still substantial. Daily smoking has fallen to the lowest level in Europe, yet adolescent e-cigarette use is rising; in response, strengthened labelling rules took effect in 2025 and flavour bans start in 2028. While alcohol use remains low, obesity is high and increasing, driven by poor diets despite high physical activity. Policy responses include a 2024 obesity strategy, free primary-school lunches from 2025 and targeted treatment measures.
- Iceland's tax-funded, residence-based system delivers universal coverage through a single purchaser and predominantly public providers. Per-capita spending aligns with the EU average but takes a smaller GDP share; the public share is high and out-of- pocket payments relatively low. Referral guidance introduced in 2024 strengthens primary care coordination, with children exempt from referral requirements from 2025. Despite major hospital investments, capacity is constrained by staffing gaps and skill-mix imbalances, especially GP shortages and nursing deficits, driving high occupancy and pressure on emergency and surgical services.
- Iceland combines very low preventable and treatable mortality with strong prevention and primary care. Preventable deaths were 26 % below the EU average in 2022, and treatable mortality about one third lower. Vaccination coverage is high, with gender-neutral HPV vaccination since 2023. Cancer screening has been consolidated under a national centre, with HPV-DNA testing and a 2025 rollout of population colorectal screening. Avoidable hospitalisations are low, especially for diabetes, reflecting the effective implementation of nurse-led primary care.
- Near-universal public coverage and high financial protection underpin access in Iceland, with hospital and outpatient care largely publicly financed. Coverage is comparatively weaker for pharmaceuticals and adult dental care, concentrating out-of- pocket spending on these items despite recent protections for children. Performance on waiting times is mixed: targeted purchasing has cut hip and knee replacement waits, but cataract surgery backlogs have worsened, prompting multi-year contracting to expand elective capacity.
- Iceland's hospital capacity and patient flow are increasingly constrained. Bed density is low at about half the EU average, while occupancy routinely exceeds 85 %, with shortages of long-term care places further delaying discharge and contributing to emergency department crowding. Workforce reforms are under way: nursing graduation rates are well above the EU average, but medical graduate output remains slightly below, with a new foundation year introduced to broaden clinical experience. Digital investment has accelerated, yet remains substantially below EU levels. By contrast, antimicrobial stewardship is exemplary: antibiotic consumption is low, and a 2025 plan targets a further 20 % reduction by 2029.
- Iceland channels most pharmaceutical spending through retail pharmacies, with per capita outlays 6 % below the EU average but 16 % above the Nordic average. The country uses a graduated co-payment system placing relatively high household burdens, with public insurance covering only 41 % of retail pharmaceutical expenditure compared to the EU average of 62 %. Centralised reimbursement leverages Nordic HTA and joint negotiations, strict external reference pricing, tenders and strong generic-substitution incentives. While market entry timelines are rapid, Iceland's selective listing approach results in a narrower reimbursed medicine portfolio than in the EU on average, particularly for oncology medicines, reflecting a deliberate value-based strategy.

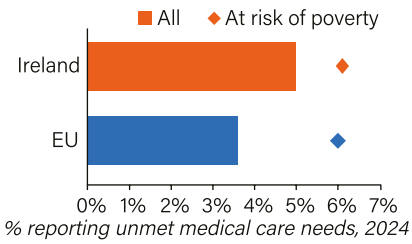
Health status



Life expectancy at birth

- Ireland's life expectancy reached 82.9 years in 2023, ranking 8th in the EU and exceeding the EU average by one and a half years. Cancer is the leading cause of death (28 %), closely followed by cardiovascular diseases (28 %). Despite Ireland's relatively young demographic profile, with 16 % of the population aged 65 and over compared to the EU average of 22 %, approximately 15 % of the population experiences either cardiovascular disease or cancer. Cardiovascular disease incidence remains 15 % below the EU average, whilst cancer incidence exceeds it by 12 %.
- Behavioural and environmental risk factors account for 26 % of deaths in Ireland, slightly below the EU average of 29 %, with tobacco consumption representing the principal contributor. Ireland demonstrates strong tobacco control success, with daily smoking declining to 14 % in 2024, well below the EU average of 19 %, though e-cigarette use among 15-year- olds has surged to 18 %. Adult obesity prevalence of 19 % is of concern and remained above the EU average in 2022. Health inequalities are significant, with obesity 7 percentage points more prevalent among adults with lower education levels.
- Per capita health spending reached EUR 4 474 in 2023, 17 % above the EU average. Ireland's system combines universal hospital coverage with means-tested primary care, leading 46 % of the population to maintain voluntary private health insurance to circumvent public system delays. Acute care capacity is constrained: hospital bed density is 43 % below the EU average, and Ireland records the EU's highest bed occupancy rate. These pressures contribute to long waiting times, with nearly two-thirds of patients waiting more than 12 weeks for elective surgery.
- Ireland's health system demonstrates strong performance across key quality indicators: avoidable mortality is 21 % below the EU average. Treatable stroke mortality ranks among the EU's lowest and acute myocardial infarction mortality is 10 % lower than the EU. Screening participation excels for breast and cervical cancers, while colorectal screening lags at 48 %. Despite overall progress, gaps remain in chronic disease management, with hospitalisations for COPD and asthma at nearly double the EU average despite the implementation of ad-hoc integrated care programmes.
- Over half of Ireland's population lacks medical or GP visit entitlements and incurs costs of EUR 55-75 per primary care consultation. Public funding patterns diverge markedly from the EU average, with only 78 % of hospital care being publicly funded while pharmaceutical coverage exceeds the EU average at 79 %. Geographic disparities exacerbate access challenges, with two-fold variations in GP density across counties resulting in workforce shortages in rural areas.
- Sláintecare reforms are progressing, with decentralisation into six Health Regions in 2024 and gradual efforts to expand universal coverage. While workforce capacity is increasing, retention challenges persist, as evidenced by only 37 % of specialist doctors accepting posts in Ireland in 2023. Ireland's antimicrobial consumption is 13 % above the EU average, requiring a 27 % reduction to meet 2030 targets.
- Ireland maintains controlled retail pharmaceutical expenditure at EUR 474 per capita, 7 % below the EU average, achieved through strategic pricing frameworks including manufacturer rebates and monthly household spending caps. However, medicine access faces significant delays: new therapies require 645 days from EU marketing authorisation to patient access, with only 31 % of medicines approved centrally accessible to Irish patients. Generic medicine uptake has plateaued at 44 % since 2020, below the EU average of 51 %. Ireland excels in pharmaceutical R&D investment, double the EU average, and has the second-highest patent filing rate per capita, while maintaining its position as the EU's leading pharmaceutical manufacturer with 21 % of total production.

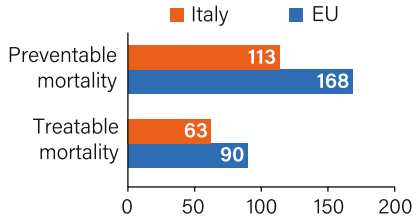
Accessibility



% reporting unmet medical care needs, 2024

- In 2024, Italy's life expectancy reached 84.1 years, the highest in the EU, surpassing pre-pandemic levels for the first time following a rebound of 0.6 years from 2023. Cardiovascular diseases and cancer remain the leading causes of mortality, accounting for 31 % and 23 % of deaths respectively. These conditions contribute to a high burden of disease: over 15 % of the population lives with cardiovascular disease, more than 6 % has a history of cancer, and nearly half of adults with hypertension are either undiagnosed or untreated.
- Behavioural risk factors were linked with nearly one in four deaths in 2021; poor diet was the largest contributor, followed by tobacco use. While adult smoking rates have plateaued at just under 20 %, youth nicotine consumption is rising sharply, with 27 % of 15-year-olds reporting recent use – ten percentage points above the EU average. Although Italy's childhood overweight rates remain below the EU average, adolescent physical activity is the lowest in the EU and obesity rates are high.
- Italy's National Health Service provides universal health coverage through regionally-governed provider networks. Current health spending per capita is 19 % below the EU average, with a comparatively high share financed out-of- pocket. Resources are concentrated on outpatient care and pharmaceuticals, with only 10 % allocated to long-term care. While Italy reported 5.4 doctors per 1 000 population, exceeding the EU average by 25 %, nurse density stood at only 6.9 per 1 000, over 20 % below the EU average. General practice is under severe strain, with over half of GPs exceeding their maximum caseload of 1 500 patients per physician.
- Italy achieves strong health outcomes, with avoidable mortality rates significantly below the EU average and the lowest hospital admission rates for chronic conditions in the EU. Influenza vaccination coverage among older adults remains above the EU average at 53 %, but HPV vaccination rates among 15-year- old girls have declined to 55 %, falling below the EU average of 63 %. Cancer screening participation has yet to fully recover from the pandemic-induced disruption, with rates remaining markedly low for cervical cancer screening in southern regions.
- While virtually all hospital care costs are publicly funded, lower public financing rates for outpatient care services and nearly non-existent public coverage for dental care contribute to high out-of- pocket spending levels. These access barriers disproportionately affect lower-income groups, creating marked socioeconomic inequalities in unmet healthcare needs. Despite improving regional compliance with essential service standards, several southern and smaller regions continue to underperform in key areas.
- Waiting times pose a significant challenge to Italy's healthcare system. While waiting times for elective surgery are relatively short, access to diagnostics and specialist consultations remains limited, resulting in high rates of foregone care. While publicly-funded health spending has returned to 2019 levels, extensive EU funding has been mobilised to support investments in digitalisation and infrastructure upgrades. Diverging trends in medical and nursing training risk exacerbating workforce imbalances, as an increase in medical training contrasts with a decline in nursing graduates. High antibiotic consumption undermines ongoing efforts to control antimicrobial resistance.
- Retail medicines accounted for 17 % of Italy's health spending in 2023, four percentage points above the EU average. At the same time, Italy's pharmaceutical market is dominated by hospital procurement, accounting for three-quarters of total spending compared to 41 % across the EU. Although this approach enables tighter price control and greater negotiating leverage, hospital pharmaceutical spending often exceeds its budget, triggering industry payback mechanisms. Against this backdrop, Italy provides faster access to new medicines than most EU countries and leads in biosimilar adoption, although uptake of generics remains low. Despite modest R&D investment, Italy maintains competitive patent filing rates and clinical trial activity in line with EU averages.

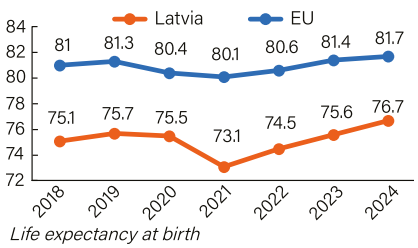
Effectiveness



Age-standardised rate per 100 000 population, 2022

- At 76.7 years, life expectancy at birth in Latvia in 2024 was 5 years below the EU average, with men living almost 10 years less than women. In 2022, Latvians at age 65 had some of the lowest rates of life expectancy and healthy life years in the EU, even though before the COVID-19 pandemic Latvian life expectancy had been one of the most rapidly improving in the EU. In 2024, only 49 % of Latvians reported being in good health, with large gender and income disparities.
- Poor diet was the leading behavioural risk factor contributing to deaths in Latvia in 2022. Additionally, high rates of alcohol and tobacco consumption – especially among men – contribute to higher mortality rates and lower life expectancy. Use of e-cigarettes among adolescents is also a public health concern: 28 % of Latvian adolescents reported vaping in the past month, compared to 21 % across the EU.
- In 2023, public funding covered 59 % of health spending in Latvia, compared to the EU average of 80 %. Meanwhile, out-of-pocket payments accounted for 35 % of health expenditure – one of the highest shares in the EU and over twice the EU average (16 %). This reliance places a significant financial burden on households – particularly among lower-income groups. Despite measures such as reduced copayments and exemptions for vulnerable populations like children, pregnant women and severely disabled individuals since 2009, outpatient pharmaceuticals remain a major contributor to out-of-pocket expenses.
- Latvia continues to face significant challenges in avoidable mortality, with high rates from both preventable and treatable causes. Some progress in reducing preventable deaths was disrupted by a high number of COVID-19 deaths in 2021. The leading causes include heart disease, alcohol-related illnesses, lung cancer and stroke. Mortality from treatable causes also remains high; heart disease and stroke are major contributors. Although chronic condition management outside hospitals and the performance of primary care have improved, avoidable hospital admissions rates are high.
- Health workforce shortages across multiple staff categories remain an issue, with physician and nurse densities below the EU averages. While numbers of medical graduates exceed the EU average, numbers of nursing graduates remain well below. To address these shortages, Latvia's Healthcare Workforce Development Strategy 2025-29 aims to improve working conditions, modernise training and introduce new roles. EU-funded initiatives also aim to recruit 450 health professionals to the public sector by 2029 to counteract health workforce ageing.
- Health services are predominantly concentrated in urban areas, limiting access for rural populations. Many general practitioner practices are centralised in the Greater Riga area, and access to primary and specialised care decreases with distance from the capital. Efforts to address these disparities include developing regional hospital networks, centralising care, expanding telemedicine and offering incentives to attract health professionals to rural or underserved areas.
- Recent reforms in Latvia emphasise digital health readiness through initiatives like improved data exchange within the EU, but also through the Digital Health Strategy (2023-29), which focuses on digitalising health data, improving data accessibility, and promoting telemedicine and remote health solutions.
- In 2023, spending on pharmaceuticals constituted a significant proportion of health expenditure in Latvia; this is above the EU average, even though the country has one of the highest generics adoption rates in the EU. Reforms introduced in January 2025 have sought to reduce outpatient pharmaceutical prices. While numbers of pharmaceutical patent applications and clinical trial activity are low compared to larger EU countries, the pharmaceutical research and development sector has been highlighted as an important area for future investment.

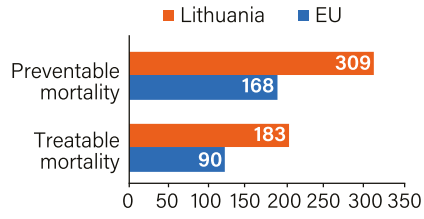
Health status



Life expectancy at birth

- Life expectancy at birth in Lithuania has increased substantially and faster than in any other EU country on average since 2010, but at 77.6 years in 2024 remained among the lowest in the EU. At the same time, the gap of almost 9 years in life expectancy between women and men remains among the largest. Only 49 % of Lithuanians considered themselves to be in good health in 2024 – the lowest share in the EU – and self-reported health is even worse for those in the poorest income quintile.
- Alcohol consumption and smoking, together with growing overweight and obesity rates, contribute substantially to mortality. Strong alcohol control measures introduced before 2020 had a positive effect on population health; however, this progress is fragile and dependent on maintaining policies that reduce the availability, affordability and marketing of alcohol. While rates of cigarette smoking have fallen, rates of vaping among adolescents have increased, despite the introduction of strong regulation.
- Current public expenditure on health remains relatively low in Lithuania, at around 5 % of GDP, but it has been growing faster than the EU average, with higher spending sustained even after the COVID-19 pandemic. EU funds contribute particularly to investments in infrastructure and digital health. At the same time, the Lithuanian health system continues to rely heavily on out-of-pocket payments that lead to comparatively high levels of financial hardship. Efforts are on the agenda in 2025 to reduce copayments for publicly financed services. These aim to restrict private providers charging extra for publicly funded services.
- Healthcare effectiveness has been lagging in Lithuania, ultimately resulting in high levels of avoidable mortality, driven predominantly by premature deaths from ischaemic heart disease. Recent reforms aim to emphasise more functional and multidisciplinary primary care, as well as streamlining approaches to cancer screening and treatment.
- Resilience strengthening has included a greater focus on preparedness for emergencies at the provider and municipality levels, and expanding training for health personnel. EU funding is being used to improve infrastructure and to future-proof services in relation to acute shocks, such as conflicts or pandemics. Lithuania has historically had extensive physical infrastructure, with large hospital capacity translating into a high number of hospitalisations. The number of hospital beds is now close to the EU average, but hospitalisation rates remain higher. This suggests that the large bed capacity does not improve access to care, as the major constraint is health workforce shortages.
- There are notable workforce shortages and large disparities between regions – particularly for nurses and some physician specialties (family doctors, internists and specialist doctors). Recent efforts have focused on increasing health professionals' wages, more balanced training and collaboration with municipalities to attract more physicians to rural areas. Health workforce shortages contribute to longer waiting times, which have grown substantially since the COVID-19 pandemic for some specialties and for elective surgical procedures in the public system, and remain an important barrier to accessing services.
- Coverage of outpatient medicines has improved substantially since 2020, as a result of concerted policy efforts that have introduced exemptions from copayments for vulnerable groups, brought in annual caps, expanded the positive list and removed percentage copayments. However, out-of-pocket spending on non-reimbursed (both prescribed and over-the- counter) medicines remains high. Access to new medicines is hampered by capacity constraints in conducting health technology assessment, but recent EU-wide developments aim to address this issue.

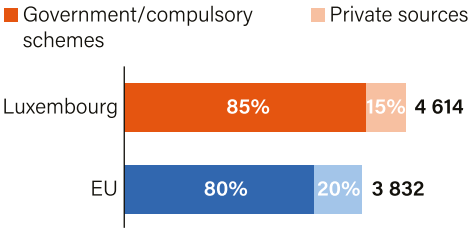
Effectiveness



Age-standardised rate per 100 000 population, 2022

- Life expectancy in Luxembourg reached 83.5 years in 2024 – nearly two years above the EU average. The gender gap in life expectancy is also narrower than in most EU countries. Although life expectancy at age 65 is high, many years are lived with activity limitations. Cardiovascular diseases and cancer remain the leading causes of death and disability, accounting for half of all deaths.
- One in four deaths in Luxembourg in 2021 was linked to behavioural risk factors. Tobacco use has declined among adults and adolescents, but use of e-cigarettes has increased concurrently among teenagers. The proportion of adolescents in Luxembourg reporting that they have been drunk more than once in their life has decreased sharply, becoming one of the lowest across the EU in 2022. In contrast, obesity and low physical activity – especially among adolescents – are growing concerns. Luxembourg is preparing a comprehensive public health strategy, which is needed for planning and coordination of prevention efforts.
- Luxembourg's health spending per capita is among the highest in the EU. Public expenditure on health increased over the past decade to 85 % of total spending in 2023, reflecting the broad benefits package, and the share of out-of- pocket payments was among the lowest in the EU at 10 %. Consequently, the share of people with healthcare needs reporting unmet needs due to cost, distance to travel or waiting times (1.9 %) was below the EU average of 3.6 % in 2024.
- Most health spending in Luxembourg is on outpatient care (33 %), which results in part from efforts to avoid unnecessary hospitalisations and to manage chronic conditions within community-based settings. In contrast, spending on prevention declined from 7 % during the COVID-19 pandemic to 3 % in 2023, which was below the EU average (4 %).
- Luxembourg fares better than most EU countries on preventable and treatable mortality rates, reflecting targeted national strategies including cancer screening programmes and action plans on prevention. New patient pathways and competence networks may help to reduce avoidable hospital admissions for chronic conditions, which are above EU average. Patient-reported experiences with primary care are very positive, but self-management support is an area identified for improvement.
- Luxembourg faces challenges in healthcare access due to its small population, limited specialised services and long waiting times across various areas – including emergency, diagnostic and cancer care. The country has implemented several initiatives – such as expanding out-of- hours care, setting waiting-time targets and decentralising imaging services – which have helped to reduce some delays, although disparities and high demand persist.
- Luxembourg relies heavily on foreign-trained health workers. To strengthen domestic capacity, the country has introduced new education programmes and recruitment platforms, but significant gaps remain between training capacity and future staffing needs.
- Digital transformation of the health system has been prioritised. A new, integrated national digital health infrastructure will facilitate appointment scheduling and secure billing. Uptake of the electronic health record has seen an important increase among both providers and patients. A national digital strategy aims to create a secure, artificial intelligence-powered health data ecosystem.
- Retail pharmaceutical spending per capita in Luxembourg is higher than the EU average, while out-of- pocket costs for pharmaceuticals remain below the EU average. Generic medicine use is limited, and inappropriate prescribing persists – especially among older adults. Ongoing reforms aim to improve access, efficiency and oversight, including establishing a national agency for medicines and a national purchasing and logistics centre.

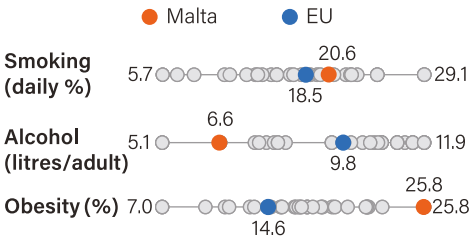
Health Spending



Health spending per capita (EUR PPP), 2023

- At 83.3 years in 2024, Malta's life expectancy at birth was one of the highest in the EU. The share of people aged 65 and over increased by 50 % in Malta between 2000 and 2024. In addition to living longer, people in Malta tend to live healthier lives, with fewer activity limitations than the EU average.
- Overweight and obesity are urgent public health issues in Malta: rates among adults and adolescents are the highest in the EU. Key contributors are poor nutrition and low levels of physical activity. As with other behavioural risk factors, socioeconomic disparities are seen with obesity: those with lower education levels are about twice as likely to be obese as those with higher education levels. Several policy efforts are under way to reduce behavioural risk factors and promote healthier lifestyles.
- Malta is among the EU countries with the lowest rates of avoidable mortality. Ischaemic heart disease accounted for a quarter of all deaths from treatable causes. In response, and as part of wider efforts to combat the growing burden of non-communicable diseases, Malta is launching the Non-Communicable Diseases Prevention Framework (2025-35).
- Malta's tax-based health system provides its population with near universal coverage and access to a comprehensive benefits package. Private providers play a key role in delivering services – particularly in primary, outpatient and dental care – and many patients elect to access private service providers and pay out of pocket. Consequently, the share of out-of- pocket spending on health in Malta was high: at 31 % in 2023, it was more than twice the EU average of 16 %.
- Despite high out-of- pocket spending, broad coverage for Maltese citizens and residents ensures that unmet needs for medical examination were among the lowest in the EU. In 2024, only 0.5 % of individuals who had a need reported that they were unable to access medical care – seven times lower than the EU average. While elective dental care is usually subject to out-of- pocket payments or financial means testing for public coverage, emergency dental care is fully covered, which keeps unmet needs for dental care low. In 2024, Malta had the lowest unmet needs for dental examination in the EU.
- Challenges that threaten the preparedness and resilience of the health system in Malta include rising temperatures and other impacts of climate change, shortfalls in emergency department capacity, and a recent spike in antibiotic consumption. However, key strengths exist too, including leveraging digital tools for care provision and integration. Policy efforts are under way to strengthen interoperability of electronic patient records, expand telemedicine and remote patient monitoring services, and provide a digital clinical platform for healthcare professionals.
- As a small island nation of just over half a million inhabitants, Malta faces some unique health challenges. To strengthen its capacity to address these issues and build a more resilient, sustainable health system, Malta engages proactively in multilateral collaboration through the EU and the WHO Regional Office for Europe; it has also entered into various bilateral agreements.
- Malta has the second highest per capita expenditure on retail pharmaceuticals in the EU. Out-of- pocket spending on pharmaceuticals in Malta is high relative to other EU countries, but despite this, unmet needs are low: people on low incomes or with chronic conditions are generally exempt from charges for medicines included in the Government Formulary List. The Maltese pharmaceutical industry is an important supplier of generic medicines, but the government has sought to strengthen its position in the pharmaceutical sector through dedicated research and development centres to support ongoing innovation.

Risk factors

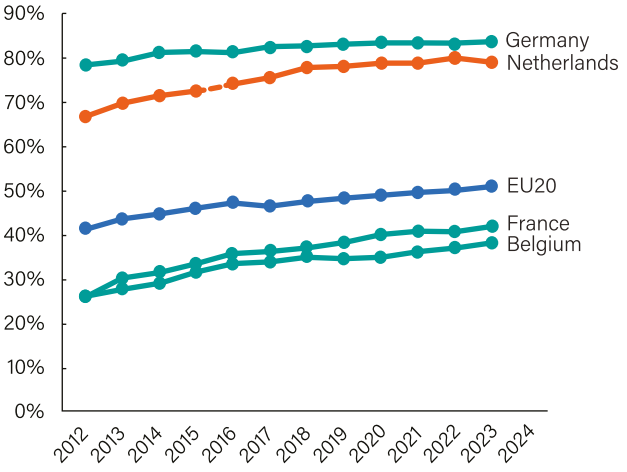


Adults, 2022 (or nearest year)

- In 2024, life expectancy in the Netherlands reached 82 years, slightly above the EU average but still below pre-pandemic levels. Women in the Netherlands live shorter lives than their EU counterparts, partly due to higher historical smoking rates. Cancer and circulatory diseases remained the leading causes of death in 2023, together accounting for nearly half of all fatalities, followed by Alzheimer's disease and other dementias.
- Behavioural and environmental risk factors contributed to 26 % of all deaths in 2021, slightly below the EU average of 29 %. Tobacco smoking among adults has declined significantly from 21 % in 2010 to 13 % in 2022, reflecting comprehensive tobacco control measures introduced in 2015. While obesity rates among adults remain below the EU average, it has increased over the past decade. Socio-economic inequalities in exposure to risk factors are wide: tobacco smoking among adults with lower education is nearly three times higher than among those with higher education, while obesity prevalence is over two times higher amongst the least educated compared to the most educated.
- In 2023, per capita health expenditure in the Netherlands was over 25 % higher than the EU average, although health spending accounted for a slightly lower share of GDP (9.8 % compared to an EU average of 10.0 %). Following the huge increase in public expenditure on health during the first two years of the pandemic, public spending on health fell in real terms in 2022 and 2023. As a result, health spending as a share of total government expenditure fell to 16 % in 2023, below pre-pandemic level, showing reduced budgetary commitment to health.
- In 2023, government schemes and compulsory social health insurance covered 83 % of health expenditure in the Netherlands, exceeding the EU average of 80 %. This strong public coverage keeps out-of- pocket payments low at 12 %, below the EU average of 16 %. Despite a high level of financial protection, significant access issues remain, with unmet medical needs disproportionately affecting low-income groups. Mental healthcare gaps are also particularly high: 9 % of adults needing mental health support in 2024 reported some unmet needs, above the EU average of 7 %.
- Despite the growing number of doctors and nurses, the Dutch health system faces growing workforce shortages due to growing demand, particularly among nurses, psychologists and GPs. While there has been a large increase in the number of nursing graduates, high turnover rates remain an issue. Job vacancy rates remain high across key health professions, raising concerns about accessibility of the system.
- The Netherlands leads the EU in digital health investment. Public engagement with digital tools, such as access to electronic health records and making appointments with doctors online, is also higher in the Netherlands than the EU average. There is also less inequality in the use of these digital tools across socio-economic groups than in most other countries.
- The Netherlands has the lowest spending on pharmaceuticals per capita in the EU, thanks to lower volumes of medicines consumed and strict price controls including external reference pricing and health insurer-led generic drug tendering. Generics dominate the market, making up nearly 80 % of pharmacy dispensed units, supported by incentives for cost-effective prescribing. However, these policies have contributed to intermittent supply shortages. Despite higher-than-average pharmaceutical clinical trials and patent applications per capita, the Netherlands invests less in pharmaceutical R&D compared to peer EU countries.

Pharmaceuticals

Share of generics in the pharmaceutical market (volume)

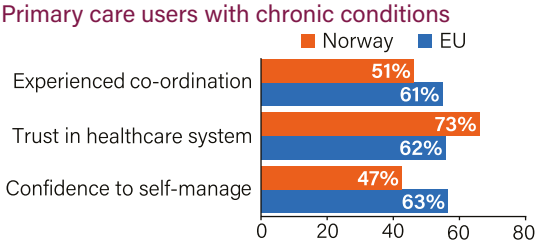


Note: The data show the percentage of the generic market in volume. The EU average is weighted.
Source: OECD Data Explorer (DF_GEN_MRKT).

- Norwegians enjoy longer and healthier lives than most Europeans. In 2024, life expectancy at birth reached 83.3 years -1.6 years above the EU average. While mortality from cancer and cardiovascular diseases has declined over time, these remain the leading causes of death. Notably, Norway has the highest cancer incidence rate in Europe -highlighting the importance of strengthening cancer prevention strategies and improving quality of life for patients.
- Behavioural risk factors are responsible for 22 % of all deaths in Norway -a relatively low share compared to other European countries. However, obesity is a growing concern: one in six adults are obese, a rate that now exceeds the EU average. Adolescent obesity is also rising fast. In response, Norway introduced a ban in 2025 on advertising unhealthy food to children under 18.
- Norway's health system is comparatively well resourced. In 2023, Norway was the highest spender on health, with per capita spending nearly 1.5 times higher than the EU average. Government funding accounts for 86 % of total health spending -a high share compared to most European countries. Norway also has one of the highest ratios of doctors and nurses. Despite this, the country faces challenges in recruiting and retaining healthcare professionals and continues to experience geographical inequalities in access to general practitioners.
- Norway consistently ranks among the best-performing countries in terms of preventable and treatable mortality, supported by strong vaccination coverage and comprehensive cancer screening programmes. Further, over 90 % of primary care users with chronic conditions report receiving good quality care. However, perceptions of care coordination are lower than in many EU countries, and Norway records relatively high rates of avoidable hospital admissions for some conditions manageable in primary care. This indicates a need to enhance the effectiveness and integration of primary care services.
- Norway ensures broad access to healthcare and high levels of financial protection. Yet gaps remain, particularly for low-income groups. High out-of-pocket costs for dental care contribute to unmet needs, although access among younger people is improving. Elective care waiting times have also increased in recent years, representing a key accessibility challenge, leading to new government initiatives aimed at reversing this trend.
- Norway is prioritising health system resilience and emergency preparedness, reporting one of the highest crisis preparedness scores among EU countries. Norway is a leader in digital health, with robust infrastructure for sharing patient data and accessing medical records. Recent AI-powered tools to interpret radiology images have been developed to reduce waiting times. To address workforce sustainability, policies are being implemented to improve task allocation and ensure more efficient use of healthcare workers' skills.
- In 2022, Norway allocated just 7 % of total health expenditure to retail pharmaceuticals -one of the lowest shares in Europe. This reflects both high total health spending and the impact of regulatory measures promoting rational drug use and rapid growth in the generics and biosimilars market. Although R&D investment is limited, Norway demonstrates strong innovation capacity, as evidenced by a high number of patent applications and clinical trial activity.

Effectiveness

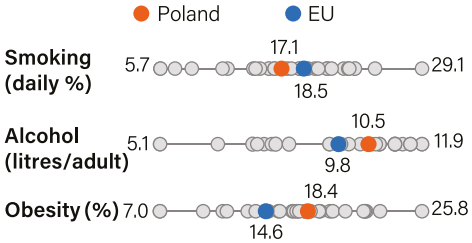
Primary care users with chronic conditions



% of people reporting positive experiences, 2023

- Although lower than the EU average, in 2024, life expectancy at birth in Poland was 78.7 years – the highest it has ever been. However, 47 % of men and 56 % of women aged 65 and over are living with multiple chronic conditions. This contributes to healthy life expectancy being much lower in Poland than the EU average. At age 65, women in Poland can expect 8.6 years of healthy life expectancy and men 7.8 years, compared to averages of 9.2 years and 8.9 years, respectively, across the EU.
- Tobacco use and alcohol consumption are major contributors to mortality and morbidity in Poland, and the socioeconomic inequalities in exposure to behavioural and environmental risk factors are wide. High smoking rates among adolescents in Poland and the uptake of e-cigarettes, as seen across Europe, are key policy concerns that have prompted policy makers to tighten regulation of the tobacco market and to regulate e-cigarettes in a similar way. The average alcohol consumption among adults in Poland has fallen to 10 litres per capita; just above the EU average of 9.8 litres in 2022. Since 2020, Poland has strengthened fiscal measures targeting alcohol and tobacco consumption.
- High preventable and treatable mortality rates reveal weaknesses in the health system's ability to prevent disease and treat patients. Preventable mortality has been persistently higher than the EU average, and strengthening and developing cancer screening programmes has been a focus for policy makers. Avoidable hospital admissions for some of the most common chronic conditions are among the highest in Europe, indicating shortcomings in the provision of outpatient care.
- Total spending on health remains very low in Poland compared to the EU average, but it has increased over the past two decades. Over three quarters of total health spending comes from public sources, but almost one quarter come from private sources – mostly out-of- pocket spending on medicines. Overall, health spending favours inpatient rather than outpatient care, and the shares of funding allocated to long-term care and prevention are among the lowest in the EU.
- Unmet needs for medical care are relatively high in Poland, and long waiting times have been a key factor. Limited fiscal resources allocated to the health system and shortages of health workers underpin access barriers such as waiting times. There are also large disparities in the geographical distribution of health workers and infrastructure, which may result in variable access to services. Targeted spending increases have enabled hospitals to treat more patients and reduce waiting times, but there is still scope for further reductions. A key policy focus has been on expanding the health workforce to increase capacity in the health system.
- Poland has been a major beneficiary of co-financed EU support for health system strengthening across multiple instruments, and is the largest beneficiary under the EU Cohesion Policy. Poland's Recovery and Resilience Plan aims to support restructuring of the hospital sector, accelerate the digital transformation of health services, increase the health workforce and develop research in medical sciences.
- The statutory system in Poland provides comprehensive coverage for inpatient pharmaceuticals, but coverage of outpatient pharmaceuticals is more restricted. Only one third of retail pharmaceutical expenditure was covered by social health insurance in 2023. Financial coverage of inpatient medicines is comprehensive, including high-cost newer treatments and cancer care. Time to access new medicines varies, but is expedited for medicines with high clinical value. While local pharmaceutical research and development capacity and investment is limited, Poland is well embedded in global pharmaceutical research and development networks, and pharmaceutical innovation is important for the country's economic future.

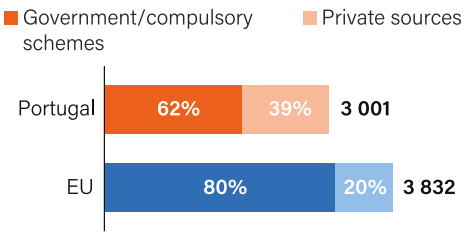
Risk factors



Adults, 2022 (or nearest year)

- Life expectancy in Portugal climbed to 82.7 years in 2024, about one year above the EU average, yet healthy life expectancy at age 65 trails the EU average. Women live 5.6 years longer than men but spend a smaller share of those years in good health, and rapid ageing means that more than one third of the population will likely be aged 65 and over by 2050. Cardiovascular diseases and cancer account for roughly half of all deaths. Stroke mortality has fallen by 29 % since 2012, yet progress against ischaemic heart disease has been slower, and cancer cases are expected to rise 20 % by 2040, adding to up to 1.5 million people (around 15 % of the population) already living with a cardiovascular disease and/ or cancer.
- Momentum on behavioural risk factors has waned: smoking prevention action has stalled while cigarettes have become more affordable, and alcohol consumption is the highest in the EU with binge drinking and alcohol-related admissions on the rise. The adult obesity rate remains at about 16 %, while the education gradient in obesity is the widest in the EU.
- Portugal's expenditure on health corresponds to 10 % of GDP, yet outlays per capita are one fifth below the EU average and public sources cover only 62 % of health expenditure, leaving households to pay 29 % out of pocket – one of the highest shares in the EU. At the same time, prevention absorbs just 2 % of spending. Overtime hours for NHS doctors rose 51 % between 2018 and 2022, and estimates suggest the NHS would need another 6 100 doctors and 3 900 nurses to end stopgap staffing.
- Portugal's strong preventive policies and quality primary care have driven preventable and treatable mortality 17 % below the EU average and kept avoidable hospitalisations among the lowest in the EU. Addressing persistent low-value care (for example high caesarean section rates or delayed hip fracture surgery) and embedding systematic patient experience monitoring will be important to sustain these gains.
- Administrative hurdles are gradually easing, and graduate training capacity is expanding, yet working arrangements remain rigid. Paper-free prescribing, self-certified sick leave and a triage platform using artificial intelligence have reduced bureaucracy for clinicians. While medical school graduates have risen by 46 % since 2010, one quarter of family medicine residency positions went unfilled in 2024. Advanced nursing or pharmacist roles are still rare, limiting the system's ability to respond to the high level of unmet needs. Portugal's health system is among the EU's most digitally mature, relying on its digital capacity to widen access and advance priorities such as home hospitalisation.
- Medicines spending is tilting toward hospitals, which now account for 45 % of pharmaceutical expenditure, after outlays more than doubled since 2014. Retail prescriptions remain only 55 % subsidised, while the mean wait from EU approval to first reimbursement decision is 840 days. Medicines alone accounted for 42 % of catastrophic health spending. A 2024 scheme now fully covers prescriptions for 140 000 low-income pensioners. Cost-saving alternatives have become more widespread: generics represented 53 % of retail pharmaceuticals sold by volume in 2024, and biosimilars captured over 60 % of units consumed. An export-oriented manufacturing base and a doubling of annual clinical trial starts to 186 in 2024 point to growing research and development (R&D) momentum, yet business investment in pharmaceutical R&D remains low, at less than one third of the EU average.

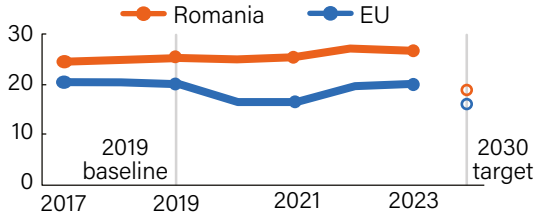
Health Spending



Health spending per capita (EUR PPP), 2023

- Life expectancy in Romania remains among the lowest in the EU. Following the sharp drop during the COVID-19 pandemic, life expectancy rebounded and reached a new all-time high of 76.6 years in 2024, but is still over five years below the EU average. Cardiovascular diseases and cancer are leading causes of morbidity and disability.
- Behavioural risks like poor diet, smoking, alcohol, and physical inactivity contributed to nearly 30 % of all deaths in 2021, while another 6 % of deaths can be attributed to air pollution. Public health and primary prevention efforts are still limited, with only 1 % of total health spending allocated to prevention in 2023. The new primary care initiative "Riskogramme", launched in 2024, targets early detection of chronic conditions and behavioural risk factors in adults aged over 40.
- Health spending per capita is the lowest in the EU. In 2023, per capita health spending was less than half the EU average. Out-of- pocket payments accounted for over 23 % of total spending, a higher than the EU average of 16 %, driven mainly by direct payments for outpatient pharmaceuticals. Unmet medical and dental care needs are among the highest in the EU, with particularly high rates among people at risk of poverty.
- The health system remains hospital-centric. Avoidable hospital admissions for many chronic conditions are high, reflecting longstanding gaps in primary care capacity and coordination. Through the EU-funded Recovery and Resilience Plan (RRP) and other EU funds, Romania is investing in developing the primary care infrastructure, promoting care integration and providing financial incentives for prevention.
- Childhood vaccination rates are very low despite recent policy measures. The childhood vaccination rate against measles was the lowest in the EU in 2024, and Romania accounted for 67 % of all measles cases in the EU between August 2024 and August 2025. Influenza vaccination among older people and HPV vaccination also remains well below EU averages, reflecting vaccine hesitancy and system-level barriers.
- Antimicrobial resistance (AMR) is a major concern. Romania reported the highest level of bacterial resistance in the EU in 2022-23. Following a slight and temporary decline during the pandemic, antibiotic use rose again, putting the country off track to meet its 2030 reduction target. New monitoring rules introduced in 2024 require pharmacists to record and report dispensing to curb inappropriate use.
- Retention issues continue to contribute to the shortages of doctors and nurses, and there are particular concerns about the current and future supply of general practitioners (GPs). Poorer regions have the lowest GP densities, worsening unmet needs for primary care. Teleconsultations and other digital health tools could improve access, but uptake is constrained by limited digital literacy and poor infrastructure. EU funds, including the Recovery and Resilience Facility, provide funding support to Romania to modernise hospitals and primary care practices, accelerate digital transformation, upskill the workforce and establish integrated community centres.
- Retail pharmaceutical spending per capita is lower than the EU average, yet accounts for 26 % of total health expenditure -the third highest share in the EU. Patients pay about half of retail medicine costs out of pocket, reflecting limited reimbursement for prescribed products and the high purchase of over-the- counter medicines which is not covered publicly. Access to innovative medicines is long, but the use of compassionate and early-access pathways speed up access for patients with serious conditions to receive promising treatments before official listing.

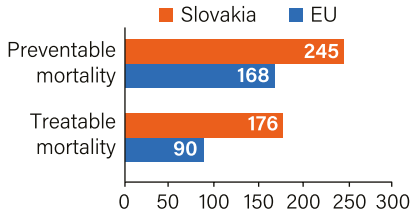
Resilience



Antibiotic consumption, defined daily doses per 1 000 pop. per day

- Slovakia's life expectancy recovered to 78.6 years in 2024, yet remains 3.1 years below the EU average, with a wide 6.7-year gender gap. Cardiovascular diseases and cancer are the dominant causes of death, accounting for over two-thirds of all mortality. While the prevalence of cardiovascular disease is comparable to the EU average, its incidence is nearly 25 % higher, suggesting greater exposure to risk factors or gaps in early prevention. Cancer incidence is also slightly above average, but lower prevalence indicates higher mortality – an issue the updated National Oncology Plan seeks to address.
- Behavioural and environmental risk factors contribute significantly to Slovakia's mortality burden, accounting for 35 % of all deaths. Smoking rates among both adults and adolescents remain high, while the growing use of e-cigarettes has prompted new taxes and proposed flavour bans as part of efforts to reinforce the national tobacco control strategy.
- Although average alcohol consumption has declined to 9.5 litres per capita, harmful drinking patterns persist among young people. Obesity is also on the rise, affecting 17 % of adults and 22 % of 15-year-olds, largely due to poor dietary habits and low levels of physical activity. A new national strategy for 2024–2030 has been introduced to address these risk factors.
- Slovakia's social health insurance system ensures near-universal coverage through three competing insurers, although the main public insurer has experienced persistent deficits until recently. Overall health spending remains low, at EUR 2 088 per capita, with public funding accounting for 79 % of total expenditure. Out-of-pocket payments are above the EU average, particularly for pharmaceuticals.
- Spending is heavily skewed toward inpatient care and outpatient medicines, while prevention and long-term care remain comparatively underfunded. Despite relatively high hospital capacity, chronic workforce shortages – just 3.8 doctors and 5.7 nurses per 1 000 population, continue to undermine the accessibility and quality of service delivery.
- Avoidable mortality in Slovakia remains among the highest in the EU, with preventable deaths in 2022 nearly double the EU average and treatable deaths approximately 50 % higher. Ischaemic heart disease, alcohol-related conditions, and lung cancer are the leading contributors.
- Spending on prevention remains limited, representing just 3 % of total health expenditure. Vaccination uptake is among the lowest in the EU for both influenza and HPV, while breast cancer screening coverage continues to lag behind the more established cervical and colorectal programmes. Persistently high cancer mortality and relatively slow access to innovative therapies highlight systemic shortcomings in early detection, prevention, and treatment pathways.
- Waiting times remain the main barrier to timely access in Slovakia, though the recent introduction of maximum waiting time guarantees seeks to mitigate this issue. Public coverage is generally robust for hospital and outpatient care but remains below the EU average for dental services and pharmaceuticals.
- Vulnerable groups, particularly Roma communities, continue to face substantial access barriers despite the expansion of health mediator programmes. Severe shortages of general practitioners and paediatricians, driven by an ageing workforce and limited retention, further restrict access to primary care.
- Slovakia faces significant efficiency challenges, with a hospital bed supply well above the EU average but low occupancy rates. While EU funds are supporting the modernisation of hospitals and primary care, progress on strategic reform has been slow. Public health spending surged in 2023 and is projected to continue rising, compounding fiscal pressures from hospital debt and insurer deficits. Meanwhile, chronic workforce shortages, lagging digitalisation and missed targets for antibiotic reduction threaten the system's long-term sustainability.
- Due to Slovakia's comparatively low total health expenditure, pharmaceuticals consume a disproportionately large share of the national health budget. Rapidly rising spending has prompted new cost-containment measures for 2025, including stricter listing rules and a VAT cut, which are projected to save EUR 200 million. While public coverage includes a broad range of medicines, it is comparatively shallow in depth, as co-payments and spending on non-reimbursed goods leave households with a substantial out-of-pocket burden. Furthermore, access to innovative therapies is often delayed, and while generics hold a large market share, the uptake of biosimilars remains weak.

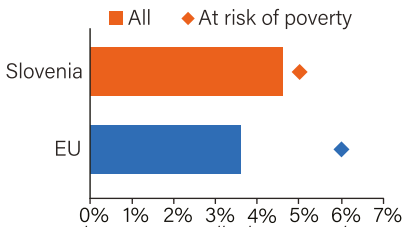
Effectiveness



Age-standardised rate per 100 000 population, 2022

- Life expectancy at birth and age 65 is high, and most Slovenians report being in good health. However, health disparities by gender and income are higher in Slovenia than the EU averages, with fewer women and low-income groups reporting good or very good health.
- Cardiovascular disease and cancer incidence rates are higher in Slovenia than on average across the EU. These rates are influenced by behavioural and environmental risk factors, which contribute to nearly a third of all deaths. Overweight and obesity – especially among adolescents – are major public health concerns. While overall adult smoking rates have fallen, the daily smoking rate among women has stagnated. Alcohol consumption has remained stable and is close to the EU average.
- Overall health spending in Slovenia has been increasing steadily over the past decade, but has consistently remained below the EU average. In 2023, almost three quarters of health spending was publicly funded, while complementary voluntary health insurance drove just over half of private spending. The majority of the population who were liable for copayments took out such insurance, contributing to historically low levels of out-of-pocket spending in Slovenia. The 2024 abolition of complementary voluntary health insurance covering copayments, and the shift to a fixed compulsory contribution under the public health insurance scheme to accompany the removal of copayments, will alter expenditure dynamics.
- Although mortality from preventable causes declined in 2022, it was higher than pre-pandemic levels and above the EU average. COVID-19 remained a leading cause of preventable mortality in Slovenia, along with lung cancer and alcohol-related causes. In contrast, treatable mortality rates have been decreasing steadily, and are consistently below the EU average. Along with ischaemic health disease, colorectal and breast cancers accounted for almost a quarter of treatable deaths. Screening programmes for major cancers are in place, with plans to expand to gastric, lung and prostate cancers.
- Slovenia reports mixed results on quality indicators, but scores highly on patient-reported experience measures. Although results from quality indicators for primary healthcare and hospital care are better than the EU averages, improvements have been gradual. The National Strategy for Quality and Safety in Healthcare aims to integrate quality monitoring better, supported by the new Slovenian Quality Health Care Agency, which will serve as the central institution for improved healthcare quality and safety.
- While Slovenia reports higher unmet needs for medical examinations than the EU average, mainly due to long waiting times, these needs are lower than the EU average among people at risk of poverty. The health system remains relatively centralised, with most professionals in the public sector, but workforce shortages in both primary and hospital care contribute to delays in accessing care. A comprehensive set of policies aims to improve workforce retention and sustainability, including financial and non-financial incentives for health professionals and students, new payment models for healthcare workers and primary healthcare clinics, increased funding and training opportunities, and task-shifting measures. Other policies have expanded the number of general practitioner offices and increased digitalisation of community health centres to aid accessibility.
- Pharmaceuticals accounted for over a third of household out-of- pocket payments. Until 2024, the substantial role of voluntary health insurance helped to keep these costs relatively low compared to the EU average. Medicines still contribute to a relatively significant share of catastrophic health spending for those in the lowest income quintile. The removal of copayments in 2024 for services covered under the public benefits package aims to mitigate these inequalities. Pharmaceutical spending in Slovenia has been rising steadily, especially in the retail sector, which the upcoming health technology assessment activities of the new Slovenian Quality Health Care Agency aim to tackle through evidence-based pricing and reimbursement evaluations.

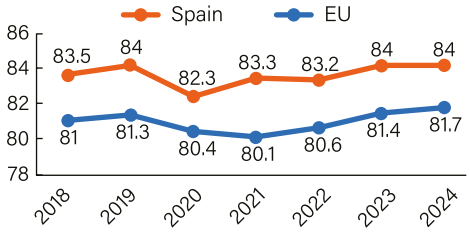
Accessibility



% reporting unmet medical care needs, 2024

- Spain had among the highest life expectancies in the EU in 2024, at 84 years, despite a temporary decline during the COVID-19 pandemic. While the gender gap in life expectancy at birth favours women, healthy life expectancy at age 65 was lower for women than men. Cardiovascular diseases and cancer are the primary drivers of morbidity and disability – similar to the trend across the EU. Incidence rates for both cardiovascular diseases and cancer are higher among men than women.
- In 2023, Spain dedicated 9.2 % of GDP to health expenditure – slightly less than the EU average of 10 %. While health spending per capita has grown over the last decade, it remained about one fifth below the EU average. Out-of- pocket spending, representing 21 % of total health spending, is well above the EU average (16 %). Despite this, Spain has a high level of financial protection, and guarantees universal health coverage with a comprehensive health benefits package.
- Outpatient care received the largest share of health funding in 2023, supporting a strong primary care system and ambulatory sector. Several regions have invested in structural changes to enhance integrated care between the primary care and hospital sectors, while the national Primary and Community Care Action Plan 2025-27 promotes capacity building within the primary care workforce.
- Spain's rates of mortality from preventable and treatable causes were among the lowest in the EU in 2022. The country's low rates of hospital admissions for congestive heart failure and diabetes are linked in part to strengths in its primary care system and continuity of healthcare. Patients value the quality and patient-centredness of the health system, and report a high level of trust in the national health system.
- Unmet healthcare needs remain low in Spain, especially for medical care. However, unmet needs among those at risk of poverty are high for dental care. Despite improvements in recent years, the package of publicly paid services for dental care is limited, and optical care is not covered. Although out-of- pocket spending in Spain has remained relatively high compared to the EU average, exemptions for a wide range of groups protect households from catastrophic spending.
- Public funding of healthcare has continued to grow in Spain. The health sector is also supported by significant EU funding: under the Recovery and Resilience Plan, Spain allocated EUR 2.4 billion to health, while the EU Cohesion Policy (2021-27) allocates EUR 1.1 billion to various healthcare investments, with key priorities including health infrastructure, digital health services and applications, and health equipment.
- Shortages of medical professionals affect remote and rural areas; concerns are also growing about future shortages in some specialties – particularly primary care professionals. Some measures have been implemented to increase the low numbers of medical graduates, as the demographic profile of the medical workforce presents further challenges: 43 % of doctors were aged 55 and over in 2022. Recent strategies also aim to tackle geographical inequalities in the health workforce by offering incentives for health professionals to practise in underserved areas.
- Spending per capita on retail pharmaceuticals in Spain was 7 % below the EU average in 2023. Household spending accounts for just over a quarter of spending on outpatient pharmaceuticals, but catastrophic spending is low. The time to access new medicines is longer than the average across the EU, but coverage for these medicines is 50 % higher than the EU average. A draft law reforming pharmaceutical legislation has the potential to shorten timelines, and various measures are in place to facilitate access to new medicines.

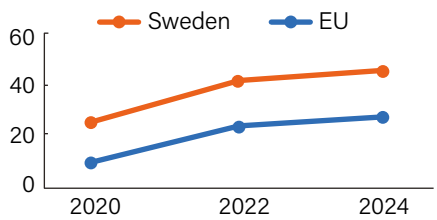
Health status



Life expectancy at birth

- Sweden demonstrates excellent population health outcomes, with life expectancy at birth reaching 84.1 years in 2024, nearly two and a half years above the EU average and the highest in the EU. Cardiovascular diseases and cancer remain the main causes of mortality, collectively accounting for 54 % of all deaths. While incidence and prevalence rates for these conditions are above the EU average, this reflects the strength of the health system, with advanced case detection leading to more people living longer with managed disease. Sweden leads the EU in healthy ageing, with 65-year- olds enjoying the highest healthy life expectancy in the EU.
- Behavioural and environmental risk factors caused one-quarter of deaths in Sweden in 2021, below the EU average. Poor diet is the leading contributor, followed by tobacco use. While Sweden has the EU's lowest adult smoking rates, adolescent e-cigarette use is rising. Despite high adult physical activity levels, poor diet and low adolescent fruit consumption contribute to adult obesity rates above the EU average.
- Sweden's highly decentralised healthcare system provides universal coverage financed predominantly by public sources, resulting in low out-of- pocket payments. Resources are heavily oriented towards outpatient services and long-term care, while inpatient care accounts for a below-average share of 22 %. While doctor and nurse densities remain well above the EU average, sizeable regional disparities in their availability persist despite recent efforts to expand permanent staffing and reduce reliance on temporary locum doctors.
- Sweden leads the EU in avoidable mortality with treatable mortality 34 % below the EU average and preventable mortality 35 % lower, the best performance in the EU. High vaccination coverage supports this success, including influenza uptake exceeding the EU average and HPV vaccination at 85 %. Cancer screening participation is exceptional, with breast, cervical and colorectal screening rates substantially exceeding EU averages. Strong outpatient care effectiveness is demonstrated by hospital admissions for chronic conditions 25 % below the EU average.
- Sweden has high public coverage for inpatient and outpatient care, keeping financial barriers to access low. However, unmet medical needs rates slightly exceed the EU average, driven primarily by long waiting times, with about 30 % of patients waiting beyond the mandated 90-day specialist consultation limit. Sweden is increasing the annual out-of-pocket ceiling for medicines to address rising costs. At the same time, it is expanding public dental coverage for younger and older age groups.
- Sweden faces significant hospital capacity challenges; with the EU's lowest hospital bed density, nursing staff shortages undermine expansion efforts causing surgical backlogs, as 45 % of patients wait beyond the 90-day guarantee for elective procedures. Medical and nursing education reforms are underway, though clinical placement bottlenecks persist. Conversely, Sweden leads in technology-enabled healthcare with the third-highest health ICT investment and strong digital tool adoption. The country is a European frontrunner in antimicrobial resistance, maintaining the second-lowest antibiotic consumption in the EU.
- Despite high overall health spending, Sweden's retail pharmaceutical expenditure per capita is 11 % below the EU average, reflecting a robust cost-containment framework driven by mandatory generic substitution, expanding use of confidential rebates and rigorous health technology assessments. Despite this rigorous framework, Sweden provides faster access to new medicines than most EU countries, with a median time to availability of 361 days. The country's pharmaceutical R&D ecosystem is a key strength, with business R&D investment per capita more than double the EU average.

Resilience



% population accessing health records online


OECD
BETTER POLICIES FOR BETTER LIVES


European
Commission


European
Observatory
on Health Systems and Policies
a partnership hosted by WHO