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Healthcare in Europe: A review of healthcare data before COVID-19

The figures in this analysis provide the most up-to-date comparative picture of the situation of healthcare and hospitals

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Before the COVID-19 crisis, European healthcare systems were already facing numerous challenges: the long-term impacts of financial and economic crisis; the increasing demand of an ever-expanding ageing population; increasing numbers of chronic patients; increasing requests and availability of technological innovations; and new roles, new skills, and new responsibilities for the health workforce.

The figures given in this document provide the most up-to-date comparative picture of healthcare and hospitals in Europe. They aim to provide an overview of the healthcare systems within the EU member states before the pandemic. This edition will not only focus on hospital care but also on long-term care, a sector impacted heavily by the COVID-19 pandemic and often under-looked in healthcare but increasingly important with the rising elderly population. The article will also cover ambulatory care. Unfortunately, the data used for these two new sections are scarce, and the figures presented must be interpreted with caution, but at least provide a good indication of the pre-pandemic state of the health care systems.

The main source of data and figures is OECD Health Statistics (last update July 2021). Data on health expenditure as a percentage of total general government expenditure and on hospital beds in public or privately owned hospitals have been extracted from the Eurostat Database on Health (last update July 2021). All EU member states belonging to OECD are considered, plus Switzerland, the United Kingdom (UK) and Serbia (as HOPE has members in those countries), when data are available. In the text, these are reported as EU. When averages are reported, they result from our own calculation. The considered trends normally refer to the years 2016–2019. When data in 2016 or 2019 are not available, or they have not been gathered for enough countries, the closest year is considered.

Financial resources for healthcare

The current health expenditure per capita shows huge diversity in Europe. The total current health expenditure per capita in 2019 in the EU was between 2074 PPP\$ (purchasing power parity) in Latvia and 6518 PPP\$ in Germany, with an average of 4153 PPP\$. In Switzerland,

this indicator reached 7138 PPP. Since 2016, the total health expenditure per capita has varied positively in all the countries of this analysis. Major increases have been seen in Lithuania (30%), Czechia (28%) and Latvia (29%); smaller increases were registered in Greece (4%) and Switzerland (5%).

Current public health expenditure includes all schemes aimed at ensuring access to basic health care for the whole society, a large part of it, or at least some vulnerable groups. Included are government schemes, compulsory contributory health insurance schemes, and compulsory medical savings accounts. Current private health expenditure includes voluntary health care payments schemes and household out-of-pocket payments. The first component includes all domestic pre-paid health care financing schemes under which the access to health services is at the discretion of private players. The second component corresponds to direct payments for health care goods and services from the household primary income or savings: the payment is made by the user at the time of the purchase of goods or use of the service.¹

In 2019, the percentage of public sector health expenditure to the total current health expenditure was more than 70% in most countries, except for Latvia (61%), Greece (60%), Portugal (61%), Hungary (68%), Lithuania (66%) and outside the EU, in Switzerland (67%). In Luxembourg, Sweden and Germany, it was above 85%. The private share ranged from 40% in Greece to 15% in Germany, Sweden and Luxembourg (Chart 1).

In the last years, health expenditure of the public sector accounted on average for 77% of the total health expenditure.

Chart 2 shows the trend in the share of government expenditure in health from 2008 to 2019.

In 2019, the percentage of government expenditure devoted to health in the total health expenditure ranged from 11% in Greece to 19% in Ireland.

The average trends illustrated in Chart 2 are generally positive between 2008 and 2019. In some countries such as Greece, expenditure decreased until 2015 when it started to increase again.

Out-of-pocket payments show the direct burden of medical costs that households bear at



CHART 1**Total current health expenditure in PPP\$ per capita, share of public and private: Year 2019**

the time-of-service use.

In 2019, the household private contribution to healthcare spending in the EU accounted on average for 18% of total current health expenditure (down from 20% in 2016).

In 2019, the private contribution to healthcare spending was around 18% in the EU, ranging from 9% in France to 37% in Latvia. Other lowest values were registered in Luxembourg (10%), the Netherlands (11%) and Slovenia (12%), while the other highest values were registered in Greece (35%) and Lithuania (32%). It is worth noting that Latvia, Lithuania and Greece are at the same time among the countries with the lower current health expenditure on health in PPP\$ that year.

Between 2016 and 2019 the household out-of-pocket payments in PPP\$ per capita have increased in all the EU countries because of the increase in the demand of healthcare services and due to an increase in the total health expenditure. The exceptions were Switzerland (0%) and Luxembourg (-1%). The most relevant increases registered were in Estonia and Lithuania (30%), whereas the EU average increase was 11%.

Chart 3 illustrates the 2016–2019 trend of both the total current health expenditure per capita and the private households' out-of-pocket payments on health. The chart highlights the fast growth of both expenses in the countries shown at the upper right of the chart, such as Lithuania, Czechia and Estonia. For those shown in the lower-left of the chart, the out-of-pocket payments grew more slowly compared with the total current health expenditure.

In most of the EU member states, 30%–40% of current health expenditure (excluding investments and capital outlays) is devoted to hospital care (Chart 4).

More than 30%–40% of current health expenditure finances hospital care: 18%–30% for ambulatory care and 4–24% for long-term care,

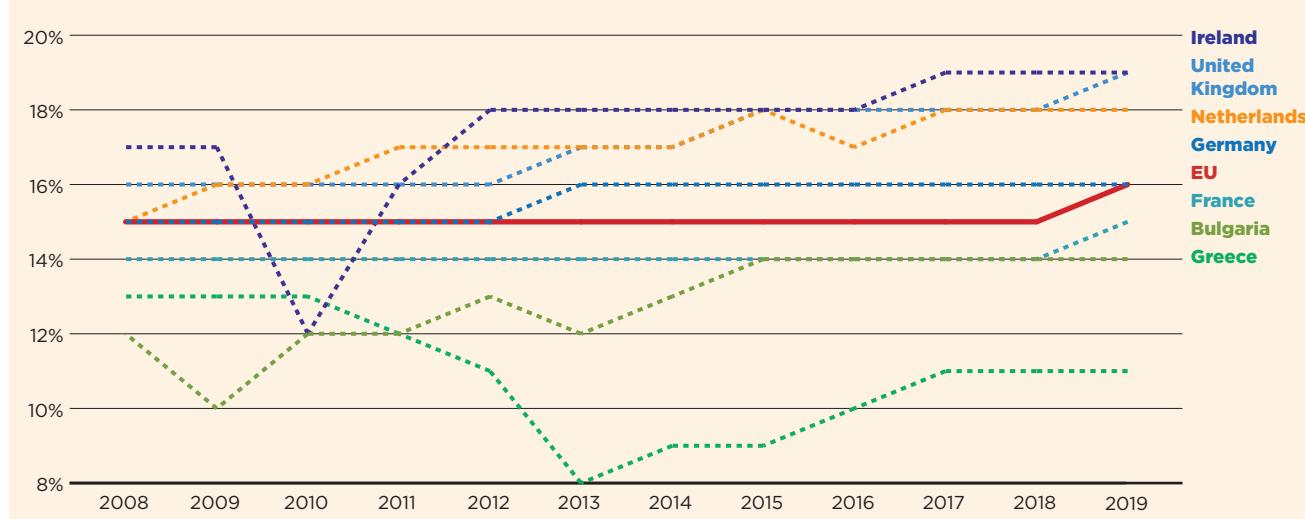
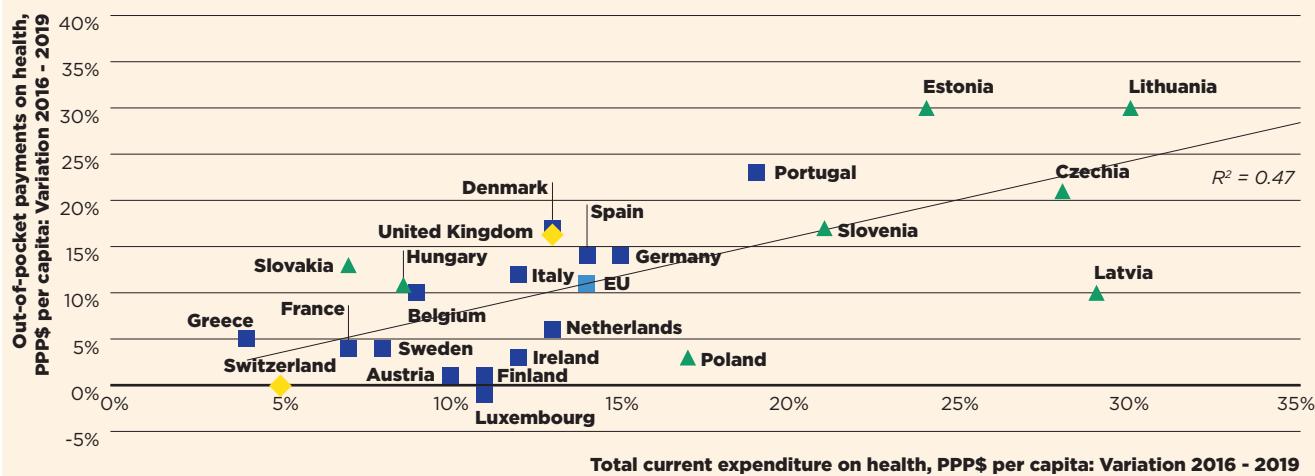
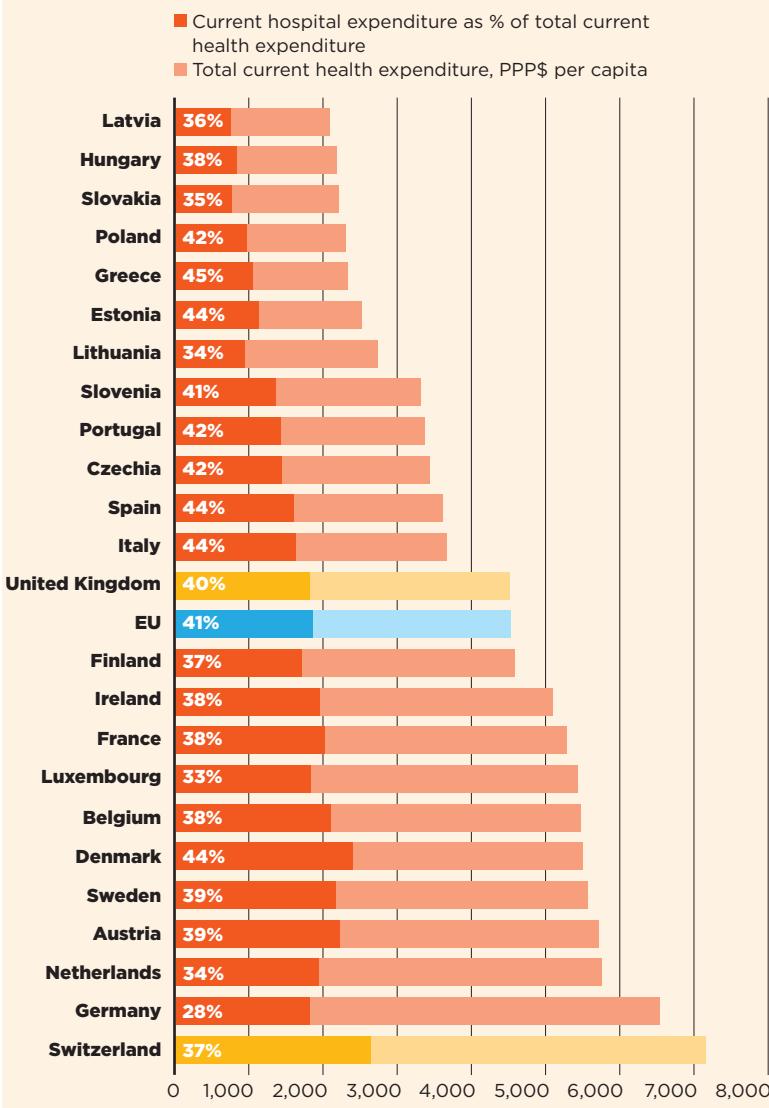
CHART 2**Total health expenditure as a percentage of total general government expenditure in the EU and some illustrative countries: Trend 2008–2019**

CHART 3**Comparison between the variation in the total current expenditure on health and out-of-pocket payments on health: Years 2016–2019****CHART 4****Current hospital expenditure as percentage of total current health expenditure, PPP\$ per capita: Year 2019**

which shows a hospital-centric health system in 2019.

In 2019, current hospital expenditure represented about 41% of total current health expenditure, ranging from 28% in Germany to 45% in Greece, and 44% in Estonia, Spain, Italy, and Denmark. In all countries, even if a part of the total health expenditure is always funded by private insurances and out-of-pocket payments, almost the entire amount of inpatient health expenditure is publicly financed. The total expenditure on in-patient care (PPP\$ per capita) in the EU follows a growing trend (Chart 5).

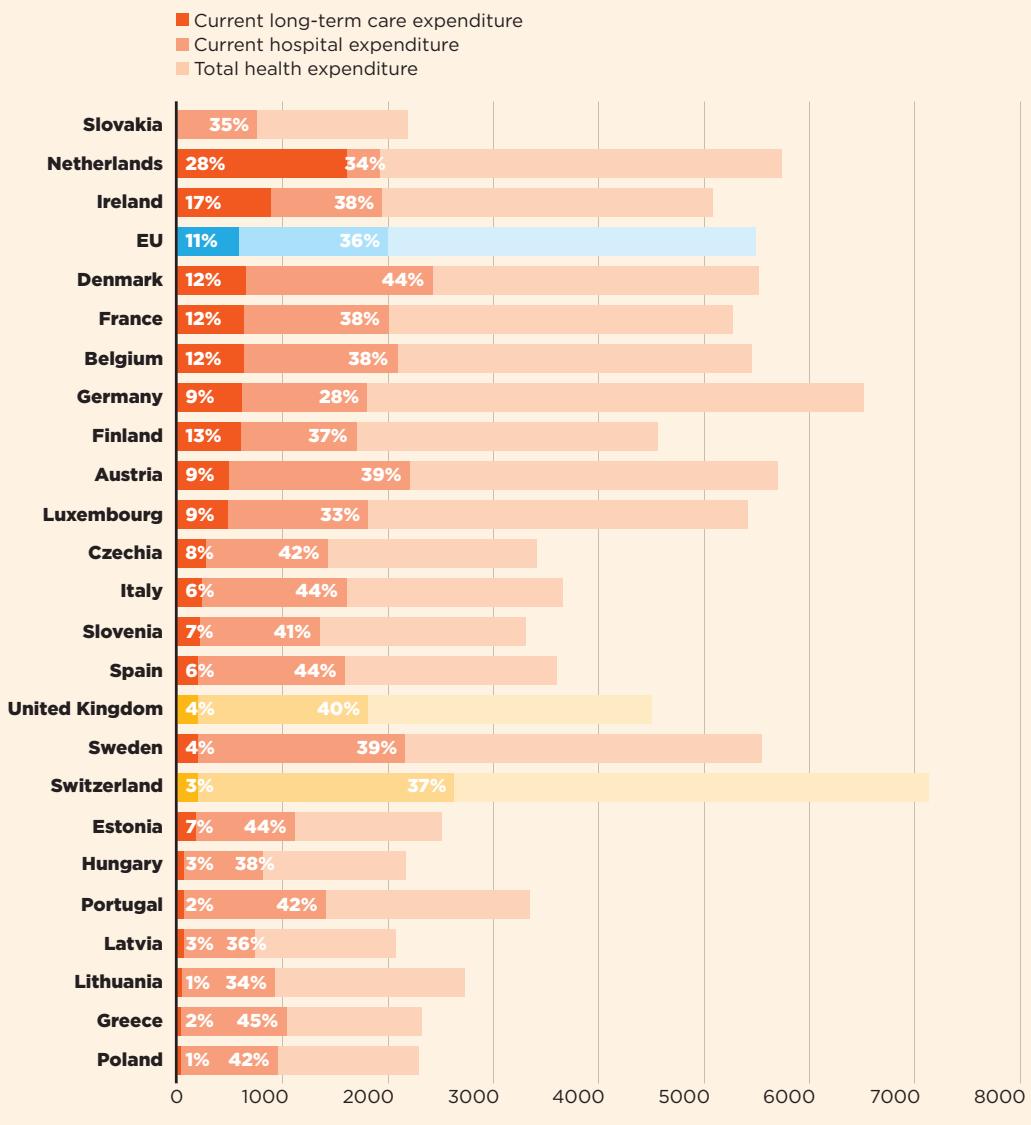
Although reforms have encouraged systems to have a greater emphasis on primary care, the data from 2019 still show major differences between countries. Ambulatory care is defined as establishments that are primarily engaged in providing health care services directly to outpatients who do not require inpatient services. This includes both offices of general medical practitioners and medical specialists, and establishments specialising in the treatment of day-cases and in the delivery of home care services.

The EU average expenditure on ambulatory care was 25% of the total healthcare expenditure compared with 41% invested in hospitals; this situation is seen in most EU countries (Chart 6). The biggest differences between the two can be found in Greece (45% hospital, 19% ambulatory care), Spain (44% hospital, 22% ambulatory care), Estonia and Italy (44% hospital, 23% ambulatory care). The smallest differences are in Luxembourg (33% hospital, 30% ambulatory care) and Belgium (38% hospital, 32% ambulatory care). The only EU country that spent more on ambulatory care than on hospital care was Germany (28% hospital, 31% ambulatory care).

Furthermore, the lowest expenditures on ambulatory care were seen in the Netherlands (18%), Greece (19%) and Ireland (20%), whereas the highest were observed in Belgium (32%), Germany (31%) and Finland (31%).

CHART 5

Current hospital expenditure and long-term care expenditure as a percentage of total current health expenditure in PPP\$ per capita: Year 2019



More than 30%-40% of current health expenditure finances hospital care: 18%-30% is located for ambulatory care and 4%-24% for long-term care, showing a hospital-centric health system in 2019

Another increasingly important healthcare area is long-term care; due to the increasingly elderly population in Europe and the big impact of the pandemic, it is important to review its state to that before COVID-19. The spending in long-term care is also extremely low compared with hospital expenditure. Long-term care (health and social) consists of a range of medical, personal care and assistance services that are provided with the primary goal of alleviating pain and reducing or managing the deterioration in health status for people with a degree of long-term dependency.

The EU average is 10%, with the lowest expenditure found in Poland, Lithuania (1%), Greece (2%), Switzerland, Latvia, and Hungary (3%). The highest expenditure was in the Netherlands (28%) and Ireland (17%). The country with the smallest difference in expenditure between hospital care and long-term care was the Netherlands, while Poland and Greece had the biggest difference, as well as the smallest expenditure.

From 2016 to 2019, expenditure on hospitals as part of the total healthcare expenditure increased by an average of 14% in the EU; the biggest increases took place in Latvia (31%), Czechia (24%) and Poland (22%). There were no decreases in any of the EU countries with available data showing an overall positive trend. Greece (4%), France (6%) and Switzerland (5%) had the smallest increases in the EU.

When comparing the variation of hospital expenditure with ambulatory care there is also a positive trend, with an average EU increase of 11%, except in Poland (-15%), Finland (-8%), Switzerland (-6%). The biggest increase was observed in Latvia (66%).

Long-term care expenditure also follows a positive trend, with a 13% average increase in the EU and no decreases in any of the countries with available data. The biggest increases were observed in Estonia (106%), and lowest in Sweden, Luxembourg (6%), Ireland (7%) and Switzerland (5%).

Between 2016 and 2019, the number of hospitals decreased in most of the countries, with the number of hospital beds decreasing to about 2%

Healthcare capacity and delivery of care

In recent years, healthcare reforms or other initiatives implemented all over Europe aimed at rationalising the use and provision of hospital care, improving its quality and appropriateness, and reducing its costs.

The number of hospital facilities decreased in most countries while the number of hospital beds dropped off on average. These reforms and initiatives also resulted in a broad reduction of acute care admissions and length of stay, as well as in improvements in the occupancy rate of acute care beds.

This was made possible thanks to a package of financial and organisational measures addressed to improve coordination and integration between the different levels of care, increase the use of day-hospital and day-surgery and introduce new and more efficient methodologies of hospital financing to incentivise appropriateness (for example, the replacement of per diem payments – known to encourage longer hospitalisation – by

prospective payment).

In most European countries these policies led to changes in the management of patients within hospitals and offered a possibility to reduce the number of acute care hospital beds.

However, the bed-occupancy rates registered more disparate trends across Europe, depending also on the demographic and epidemiological structure of population and from the specific organization of local, social, and healthcare systems, i.e., the structure of primary care, the presence and the efficiency of a gate-keeping system, the modality of access to secondary care, availability of home care and development of community care.

Between 2016 and 2019 the number of hospitals decreased in most of the countries, with the number of hospital beds decreasing to about 2%.

The total number of hospitals barely decreased in 2019 compared with a decrease ranging between 9% and 41% during 2006–2016. Minimal changes happened in 2016–2019

CHART 6

Current hospital expenditure and ambulatory care expenditure as a percentage of total current health expenditure in PPP\$ per capita: Year 2019

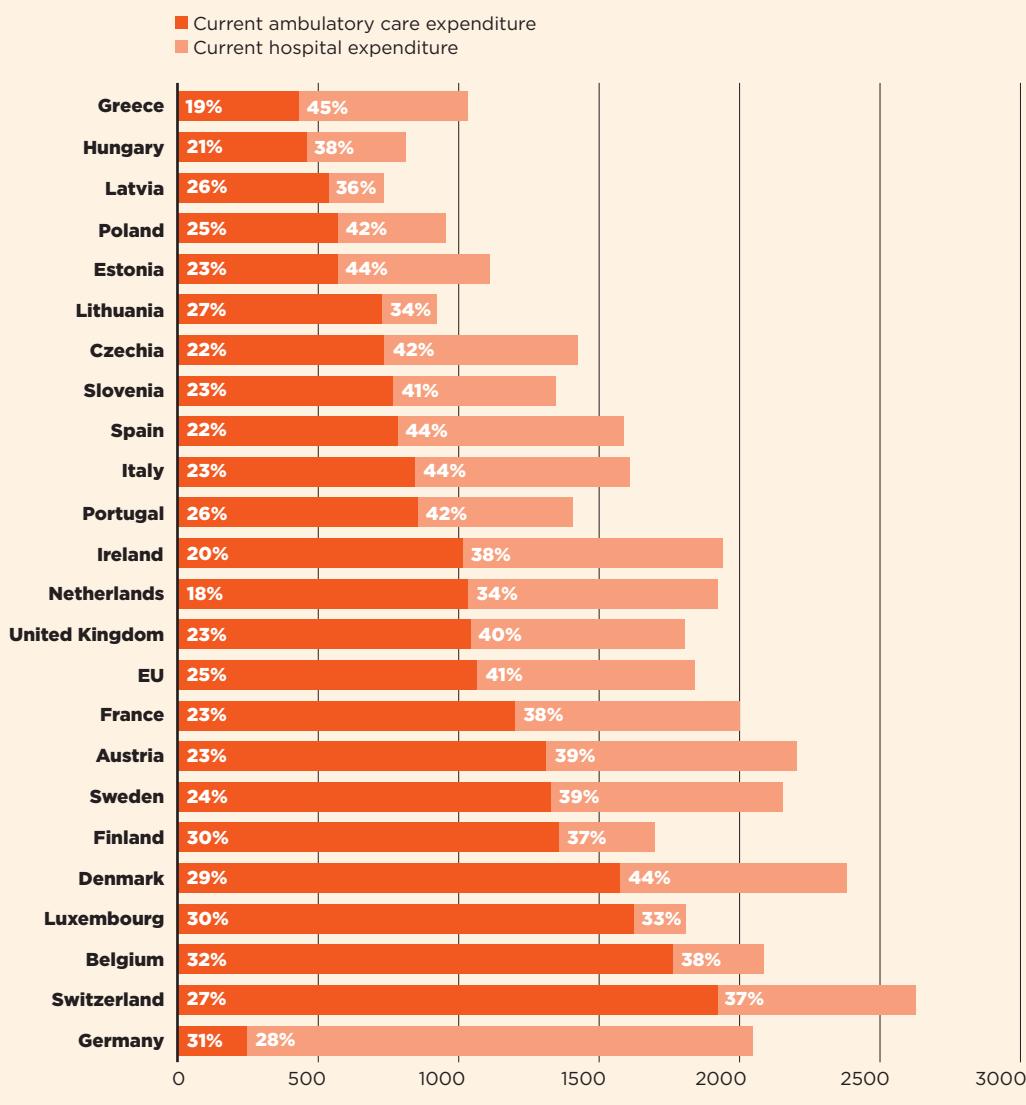
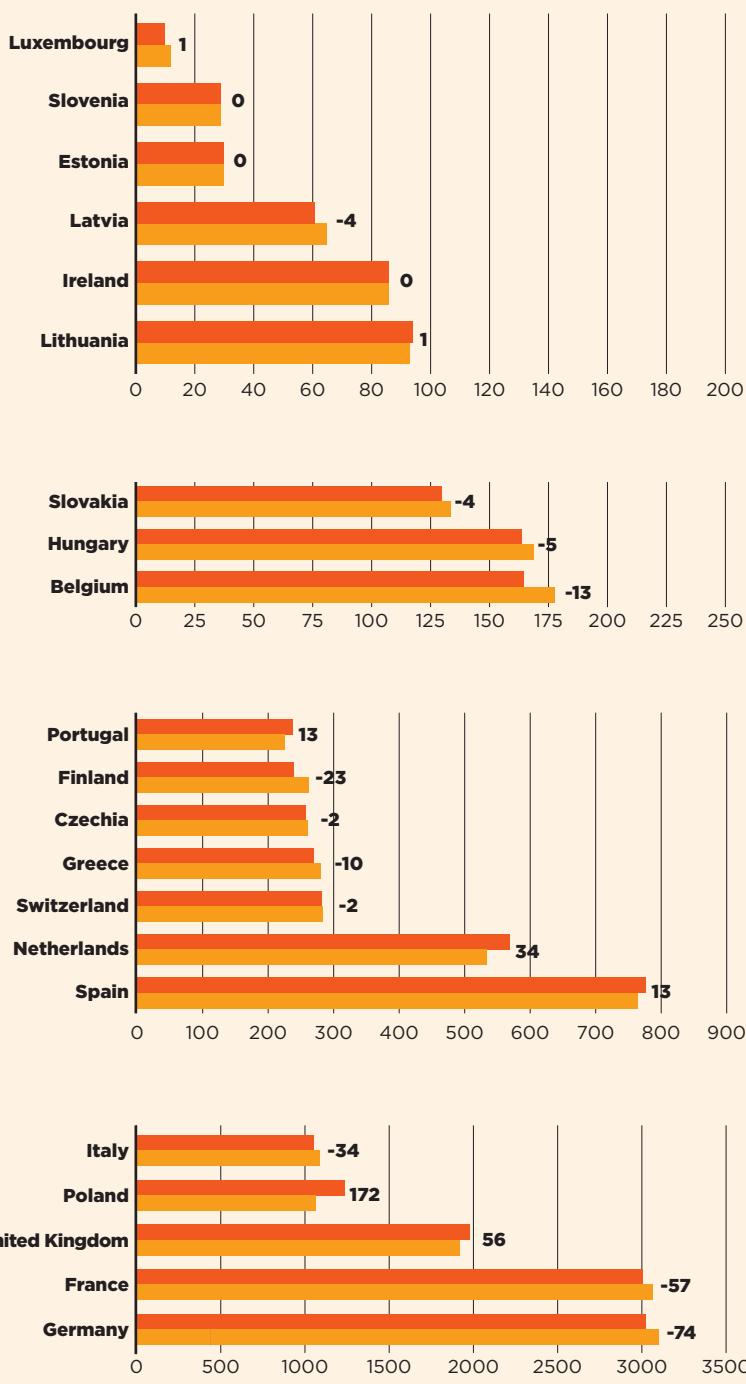


CHART 7

Number of hospitals in 2019 and number of hospitals closed (opened) since 2016. The four clusters are grouped considering the total number of hospitals in 2016: <100; 100>200; 200>500; >500

■ Number of hospitals in 2019
■ Number of hospitals closed (opened) since 2016



in Ireland, Estonia, Slovenia (0%) and Lithuania (+1%). The biggest decrease took place in Luxembourg (-17%) and the biggest increase in Poland (+16%) (Chart 7).

In the same period, few changes in the number of hospitals beds were registered in Slovenia, Switzerland, Slovakia, and Czechia (0%) The biggest increase was 3% in Portugal. Major decreases were registered in Finland (-15%), Sweden and the Netherlands (-8%) (Chart 8).

Moreover, there were on average 466 hospital beds for 100,000 inhabitants in the EU in 2019, ranging from 207 in Sweden to 791 in Germany (Chart 9).

Between 2008 and 2016, there was a decrease in the total number of beds that was, in many countries, accompanied by a slight increase in the number of private inpatient beds (Chart 10). The biggest increases in these years were in Romania (+560%) and Bulgaria (+154%). However, in 2019 there were few increases in private beds, with only some countries, such as Romania and Lithuania (28%) showing an increase; there was even a decrease in some countries. In 2019, countries with the highest percentage of private beds were Belgium (74%) and Germany (60%). Those with the fewest were Slovenia, Lithuania (1%) and Croatia (2%).

The rate of acute care hospital beds for 100,000 inhabitants in 2019 in the EU ranged from 234 in Sweden to 791 in Germany. The other highest figures were in Austria (719) and Hungary (691) whereas the other lowest figures were in UK (245), Denmark (259) and Ireland (288).

Between 2016 and 2019, the number of acute care hospital beds per 100,000 populations registered an average reduction by 4% in EU. The most significant decreases were in Finland (-16%), Sweden (-12%) and Luxembourg (-11%). The only exception was Portugal (4%), and Slovakia, Greece, Italy, and Denmark showed no significant changes (Chart 11).

Residential long-term care facilities are establishments primarily engaged in providing residential long-term care that combines nursing, supervisory or other types of care as required by the residents. In these establishments, a significant part of the production process and the care provided is a mix of health and social services, with the health services being largely at the level of nursing care, in combination with personal care services. They include long-term nursing care facilities and other residential long-term care facilities.

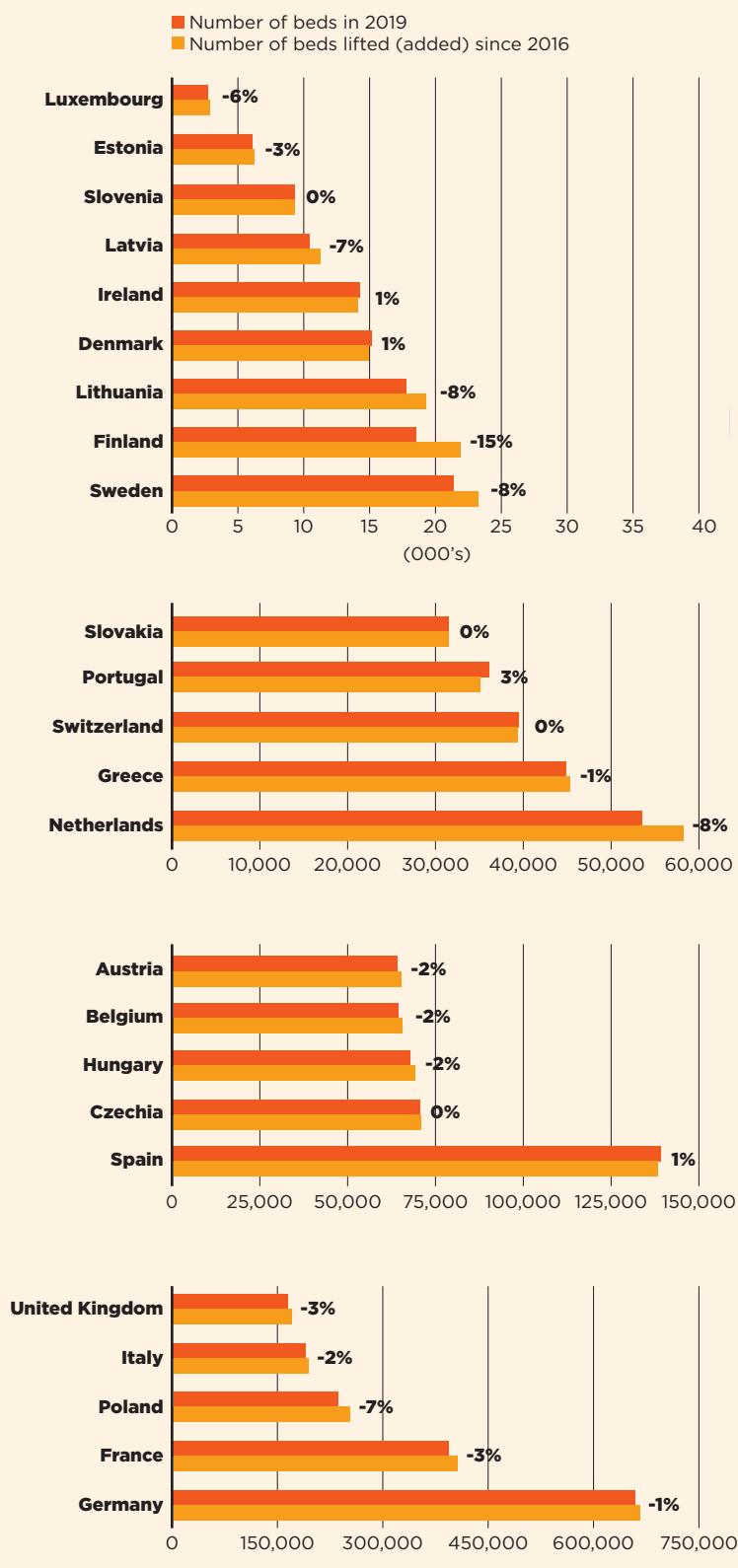
The number of long-term beds per 100,000 inhabitants in 2019 in the EU was 768, ranging from 27 in Bulgaria to 1378 in the Netherlands. On average there was a 2% increase in the number of beds per 100,000 inhabitants from 2016 to 2019, with a few countries having a bigger than average increase such as Serbia (+20%) and Austria (+12%). Although most countries show a positive increase a few had a decrease in the number of beds per 100,000 inhabitants: Croatia (-8%), Bulgaria (-11%) and Denmark (-17%) (Chart 12).

To better understand the state of the healthcare system in the EU, we also need to look at the number of primary healthcare units;



CHART 8

Number of hospital beds in 2019 and number of beds lifted (added) since 2016. The four clusters are grouped considering the total number of hospital beds in 2014: <25,000; 25,000>50,000; 50,000>150,000; >150,000



however, there are few data available, or from recent years. The countries with available data from 2000 to 2009 (most recent years available) are Bulgaria, Croatia, Czechia, Estonia, Hungary, Lithuania, Latvia, Finland, Portugal, Slovenia, Slovakia, Sweden, and Romania. They show minimal increases, with the biggest increase occurring in Latvia (from 116 to 121) and the biggest decrease in Croatia (from 79 to 73).

The number of acute care discharges involves the entire pathway of hospitalisation of a patient, who normally stays in hospital for at least one night and is then discharged, returns home, is transferred to another facility, or dies. Curative care comprises health care contacts during which the principal intent is to relieve symptoms of illness or injury, to reduce the severity of an illness or injury, or to protect against exacerbation and/or complication of an illness or injury that could threaten life or normal function. Curative care includes all components of curative care of illness (including both physical and mental/psychiatric illnesses) or treatment of injury, diagnostic, therapeutic and surgical procedures, and obstetric services. It excludes rehabilitative care, long-term care, and palliative care.

The average length of stay measures the total number of occupied hospital bed-days, divided by the total number of discharges. In 2019, the average length of stay in acute care hospitals ranged from 10 bed-days in Hungary and in Czechia to 6 bed-days in Sweden, Ireland, and Belgium.

In 2019, the rates of in-patient discharges in the European countries were quite dissimilar, ranging from 25 discharges per 100 in Germany to 11 discharges per 100 in Italy.

The average length of stay is around 8 days in the EU.

The link between the rate of admissions and the length of stay can be a very sensitive issue for hospitals, since it is commonly acknowledged that too short length of stay may increase the risk of re-admissions with a consequent waste of resources both for the hospital and for the patients and their careers. At the same time, staying too long in a hospital may indicate inappropriate settlements of patients, also causing a waste of resources.

Chart 13 compares the rate of hospital discharges and the average length of stay for acute care hospitals in 2019. The last updated data show that the average European figures correspond to a mean rate of discharges of 17% and a mean length of stay of 8 days for acute care hospitals. The chart shows that both indicators are higher than the EU average in France, Latvia, Czechia, Hungary, Austria, and Germany.

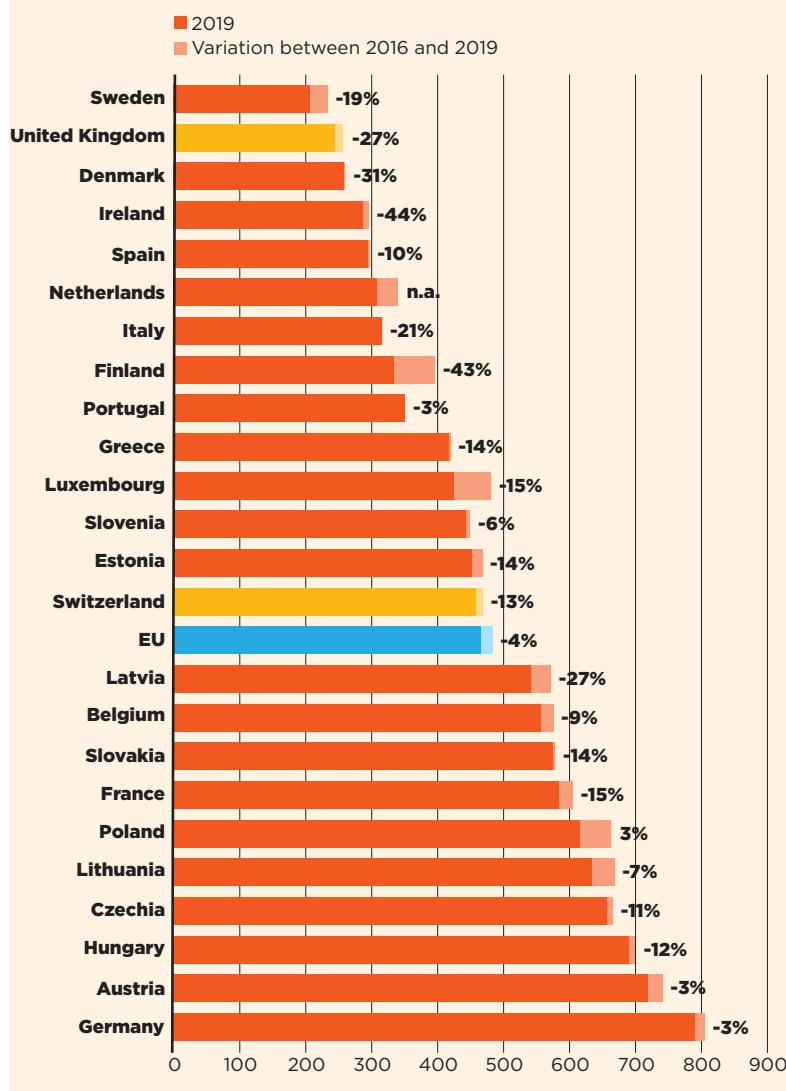
The bed occupancy rate represents the average number of days when hospital beds are occupied during the whole year and generally mirrors how intensively hospital capacity is used.

In 2019, the average acute care occupancy rate in Europe was equal to 75%, but the gap between the highest and the lowest rate was 16 percentage points (p.p.).

Between 2008 and 2019, the average rate of acute bed occupancy decreased in Europe. The

CHART 9

Number of hospital beds per 100,000 inhabitants in 2019 and percentage of beds per 100,000 lifted (or added) since 2016



biggest reductions were in Hungary (-4.7), Slovakia (-3.20) and Czechia (-3.20). A particularly big increase was observed in Luxembourg (6.90). These large variations are usually due to changes in the number of admissions, average length of stay and the extent to which alternatives to full hospitalisation have been developed in each country (Chart 14).

Despite the growing interest in self-treatment and the growing role of digital health especially during the pandemic, health workers remain the crucial component of health systems, providing health services to the population. Despite the numbers of health workers tending to grow in the last 15 years, policy makers are raising issues about the upcoming retirement of the 'baby-boom' generation of doctors and nurses, exacerbating the workforce shortage. Health workforce concerns shifted from worries on shortages towards issues related to the right skill-mix, to better respond to evolving population health needs. The financial constraints are leading in most European countries to a decrease in the resources available for healthcare professionals, reducing the possibilities of hiring new staff. Additionally, several countries, especially in central and eastern Europe, are experiencing migrations of their healthcare workforces.

European countries, European organisations and EU institutions are discussing possible impacts and achievable solutions to these issues. Interestingly, several countries are shifting competences from doctors to nurses, creating new educational pathways and bachelors' degrees targeted to nurses. In many cases, nurses and general practitioners acquire new skills and competencies relieving the burden of hospital care by enforcing primary care institutions and community services.

The trends described above are likely to have major impacts on the hospital sector, as in-patient care alone absorbs about a third of the healthcare resources and because the

CHART 10

Beds in private owned hospitals as % of beds in all hospitals: Years 2008, 2016, 2019

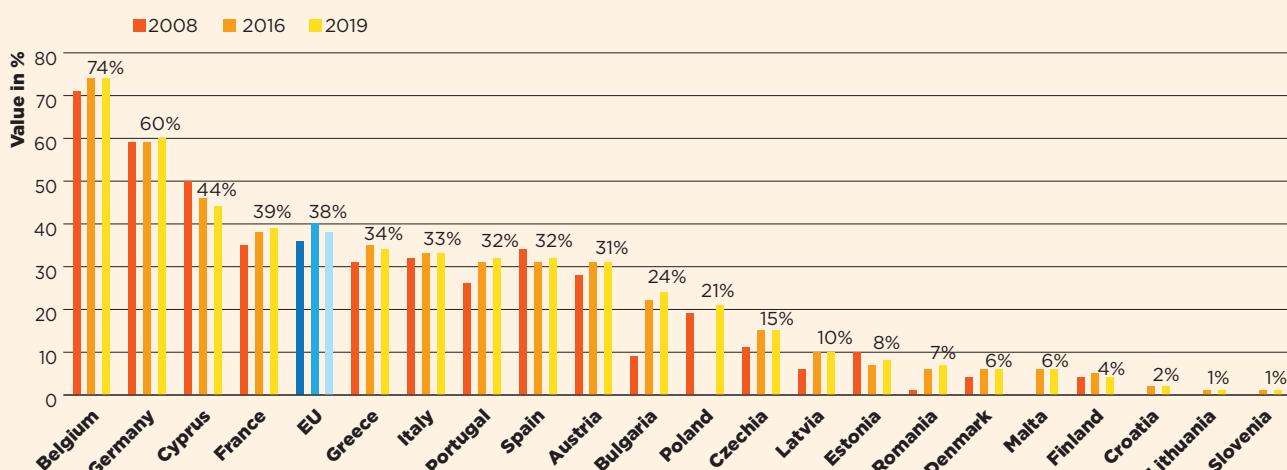
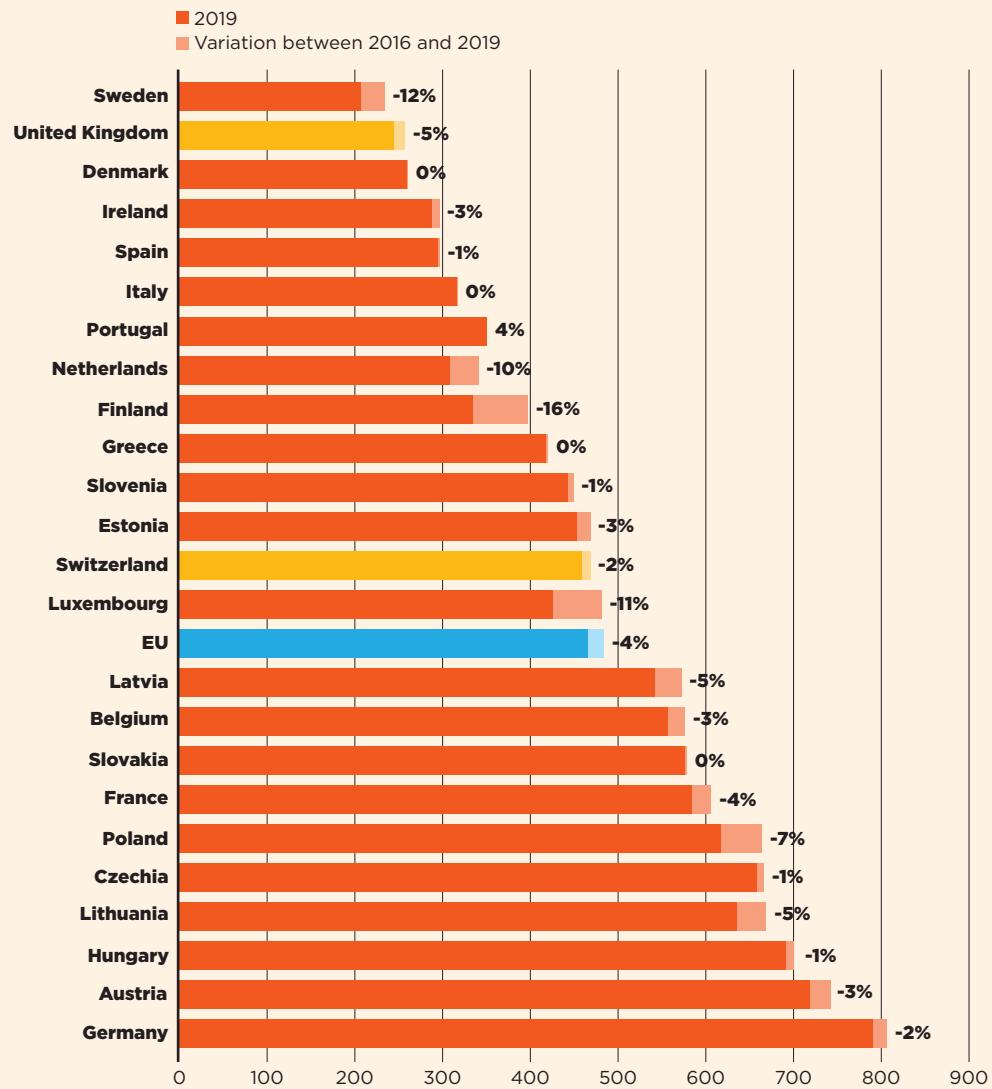


CHART 11

Number of acute care hospital beds per 100,000 inhabitants in 2019 and percentage of beds per 100,000 lifted (or added) since 2016



An overview of the European healthcare workforce in 2019 showed an average rate of about 2.5 nurses per physician



hospital sector gives work to more than half of active physicians.

An overview of the European healthcare workforce in 2019 showed an average rate of approximately 2.5 nurses per physician.

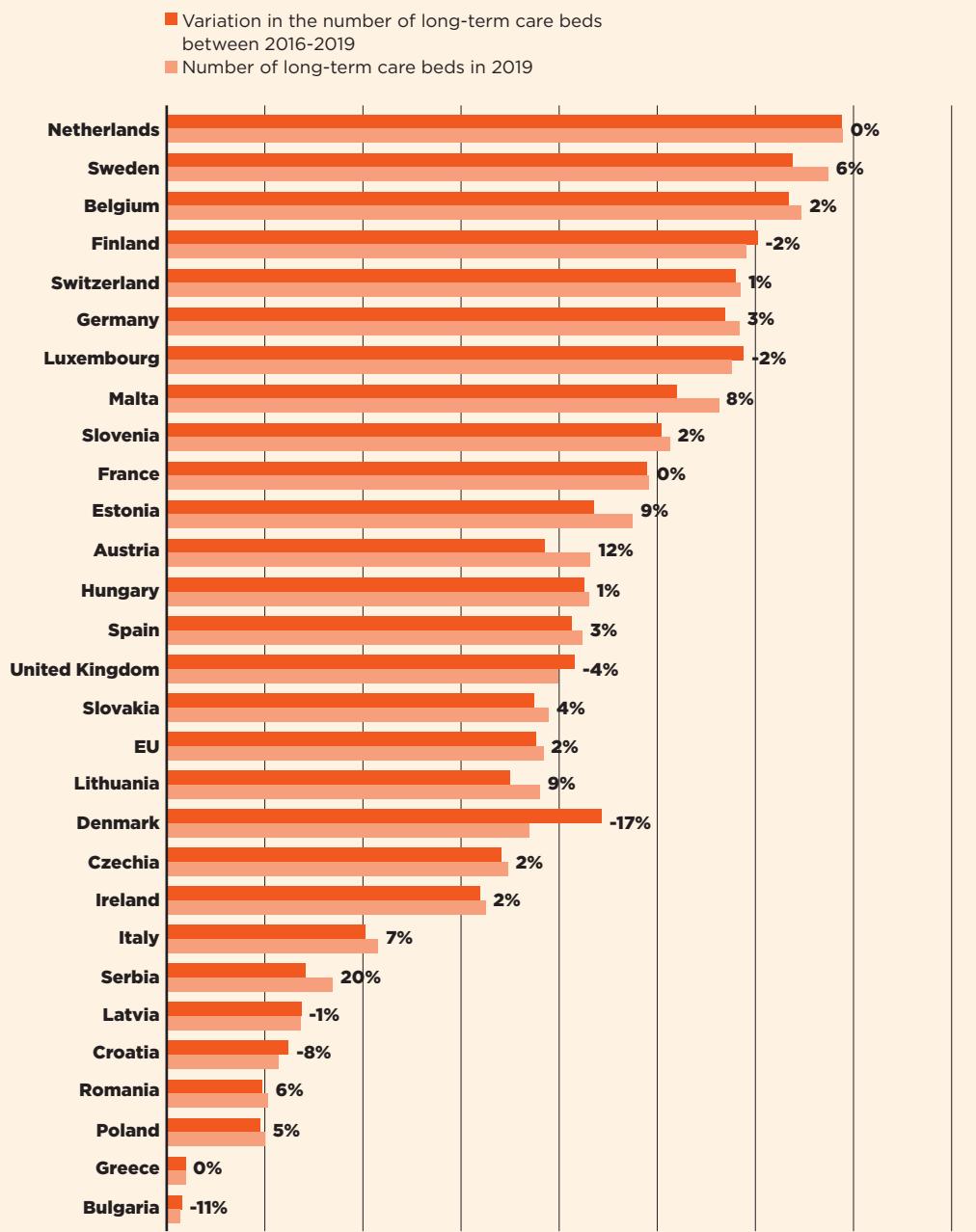
In 2019, the share of practising nurses per 100,000 registered the lowest values in Greece (338), Latvia (439), Poland (510) and Spain (589). The highest values were in Germany (1395), Belgium (1107), Sweden (1085) and Switzerland (1796). For the same year, the lowest shares of practising physicians were registered in Poland (238), the UK (295), Belgium (316) and France (317) whereas the highest values were seen in Austria (532), Lithuania (457) and Germany (439) (Chart 15).

These figures provide evidence of the trends for the management of healthcare professionals, especially concerning the allocation of resources and responsibilities between physicians and nurses. In the EU, the average rate of nurses per physicians is about 2.4 points. In 2019, the highest values were in Germany

In 2019, according to available data, physicians working in hospital (full or part time) were around over 50% of the total, with the EU average reaching 67%

CHART 12

Number of long-term care beds per 100,000 inhabitants in 2019 and percentage of beds per 100,000 lifted (or added) since 2016



(5.4), Luxembourg (4.0), Belgium (3.5) and Switzerland (4.0). In these countries, there is a high shift of competencies from physicians to nurses. Conversely, in countries where the values are lowest – such as Lithuania (1.7), Latvia (1.4), Spain (1.4) and Italy (1.4) – physicians continue to perform most of the clinical activities.

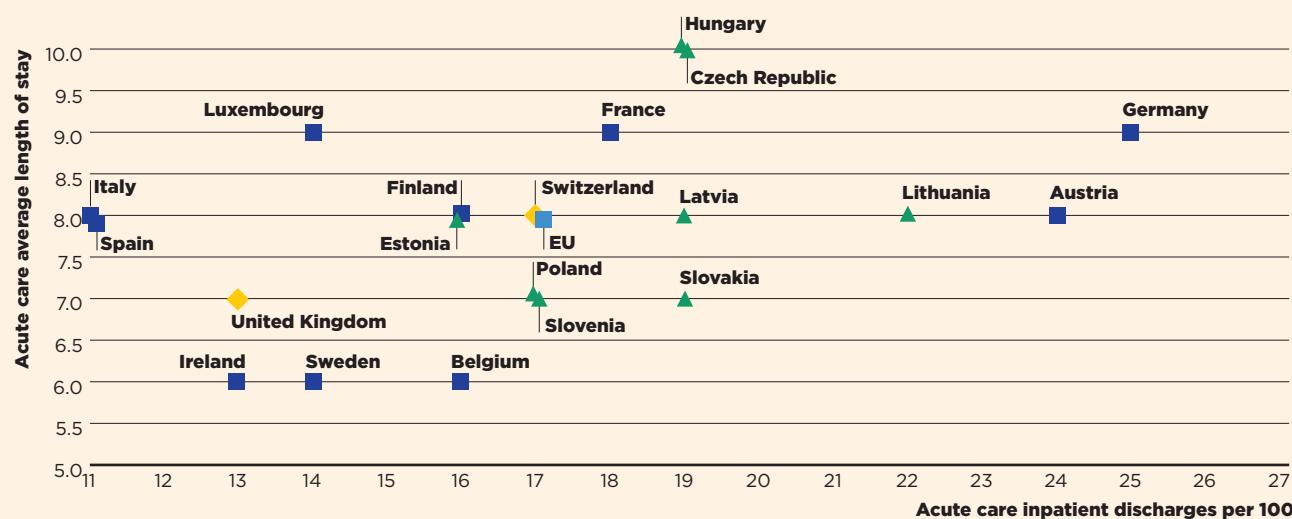
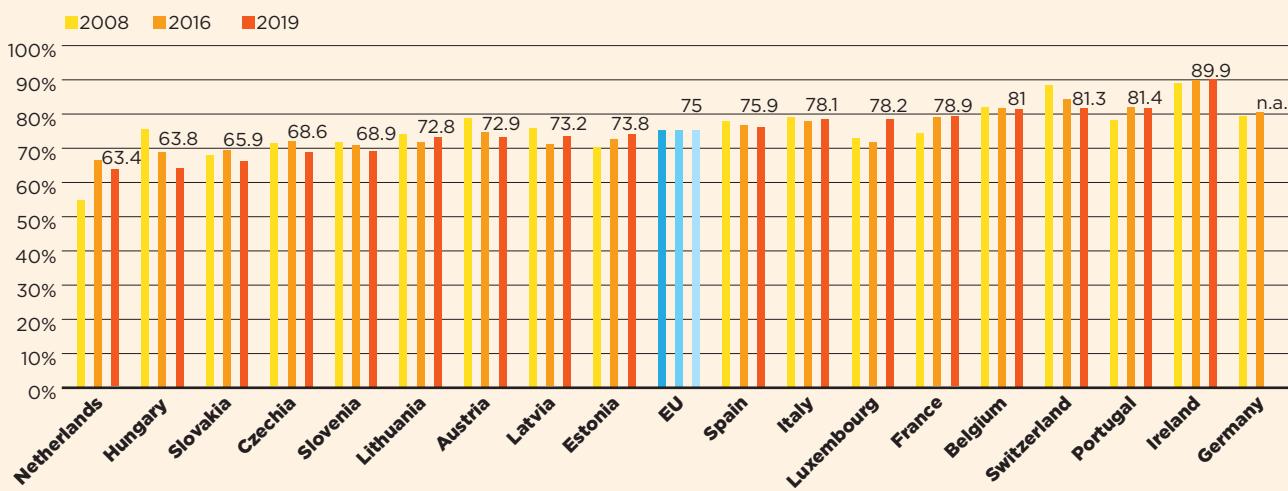
In 2019, according to available data, physicians working in hospital (full or part time) were around over 50% of the total, with the EU average reaching 67%

The highest rates registered are in Belgium (209%), France (83%) and Switzerland (77%). By contrast, the lowest values are the Netherlands (36%), Latvia (45%), Spain (54%),

Ireland and Austria (55%).

The long-term workforce can be categorised as formal and informal, and as there are sparse data available for informal workers, we will focus on the formal workers exclusively; these include nurses and personal care workers. Moreover, we will focus on long-term workers working with the 65-years-old and over population.

Data for long-term care formal workers per 100,000 population aged 65 years old and over in 2016–2019 were only available in a few countries; Portugal, Spain, Germany, Switzerland, Austria, the Netherlands, Estonia, Denmark, Sweden, Luxembourg, Slovakia, Ireland, and Hungary. In 2019, Sweden (11,900)

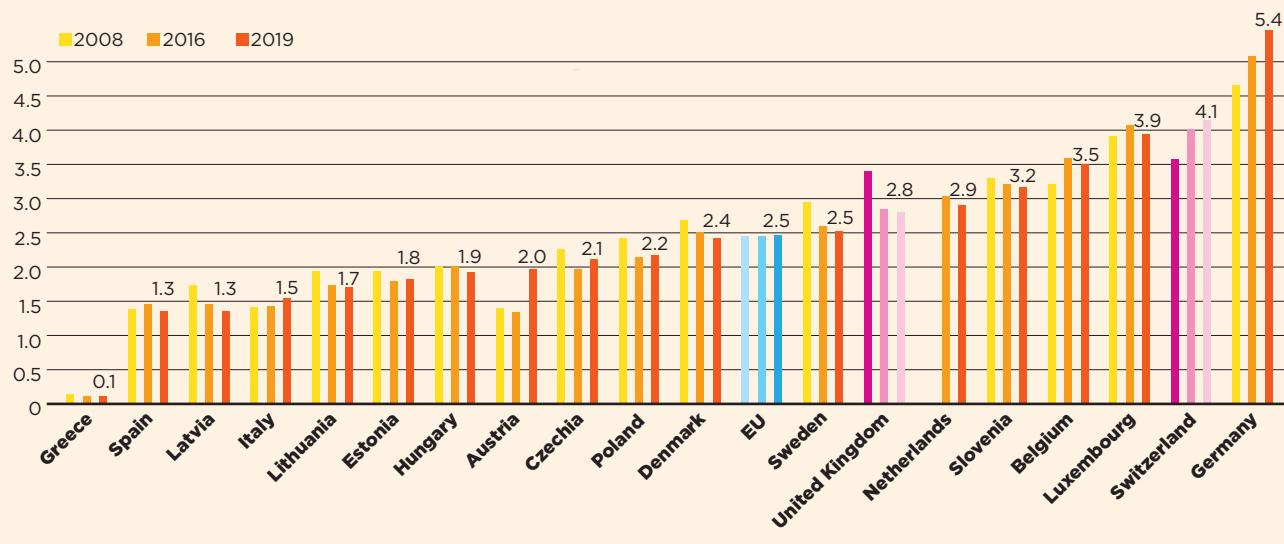
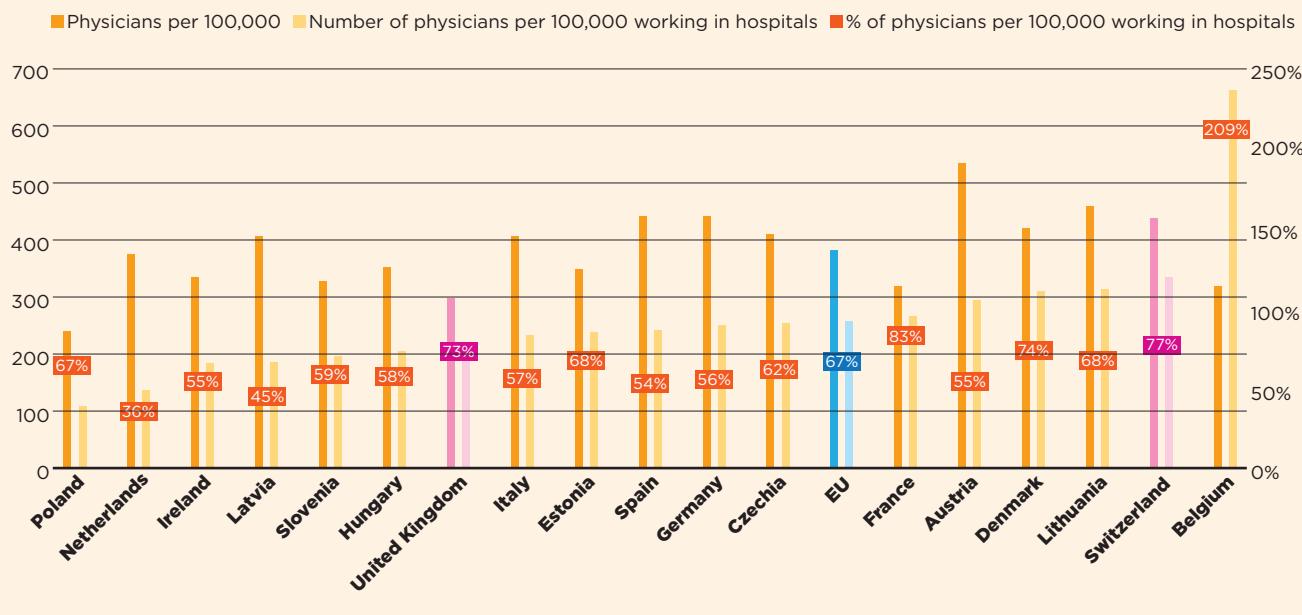
CHART 13**Comparison between the rate of inpatient discharges per 100 and average length of stay in acute care hospitals: Year 2019****CHART 14****Bed occupancy rate for acute care hospitals: Years 2008, 2016, 2019**

had the highest number of formal workers per 100,000 population aged 65 years old and over, whereas the lowest was found in Portugal (800). From 2016 to 2019, Portugal (+14%), Spain (+7%), Germany (+6%), Switzerland and Austria (+2%) had an increase in the number long-term care formal workers per 100,000 population aged 65 years old and over, whereas Estonia (-2%), Denmark (-3%), Sweden (-4%), Luxembourg (-5%), Slovakia, Ireland (-7%), and Hungary (-14%) had a decrease in the number for workers. There was no significant change in the Netherlands.

Long-term workforce is also categorised by those working in institutions and those working at patients' homes. Long-term care at home is provided to people with functional restrictions who mainly reside at their own home. It also applies to the use of institutions on a temporary basis to support continued living at home – such as in the case of community care and day care centres, and respite care. Home care

also includes specially designed or adapted living arrangements (for example, sheltered housing) for persons who require help on a regular basis while guaranteeing a high degree of autonomy and self-control, and supportive living arrangements. Long-term care institutions herein refer to nursing and residential care facilities which provide accommodation and long-term care as a package. They refer to specially designed institutions or hospital-like settings where the predominant service component is long-term care, and the services are provided for people with moderate to severe functional restrictions.

For this, data are only available for a handful of countries: Estonia, Denmark, Hungary, Germany, Netherlands, Luxembourg, Austria, Portugal, and Switzerland. In countries where data are available, there is a higher percentage of workers working in institutions than at patients' homes. The percentage of long-term care workers working at an institution varied

CHART 15**Rate of practising nurses per physician: Years 2008, 2016, 2019****CHART 16****Number of physicians per 100,000 inhabitants and number and % of physicians per 100,000 inhabitants working in hospitals: Year 2019**

from 83% in Portugal to 21% in Estonia. While for those at home it ranged from 79% in Estonia to 17% in Portugal.

In 2019, the average number of physicians and nurses graduated for every 100,000 inhabitants were respectively about 15 and 41 in the EU. However, the values across countries were quite different. The number of medical graduates per 100,000 inhabitants ranged from 10 in France and Estonia to 24 and 25 in Latvia and Ireland, respectively. The number of nurses graduated per 100,000 inhabitants ranged from 11 and 18 in Luxembourg and Italy to 82 and 108 in Finland and Switzerland (Charts 16 and 17).

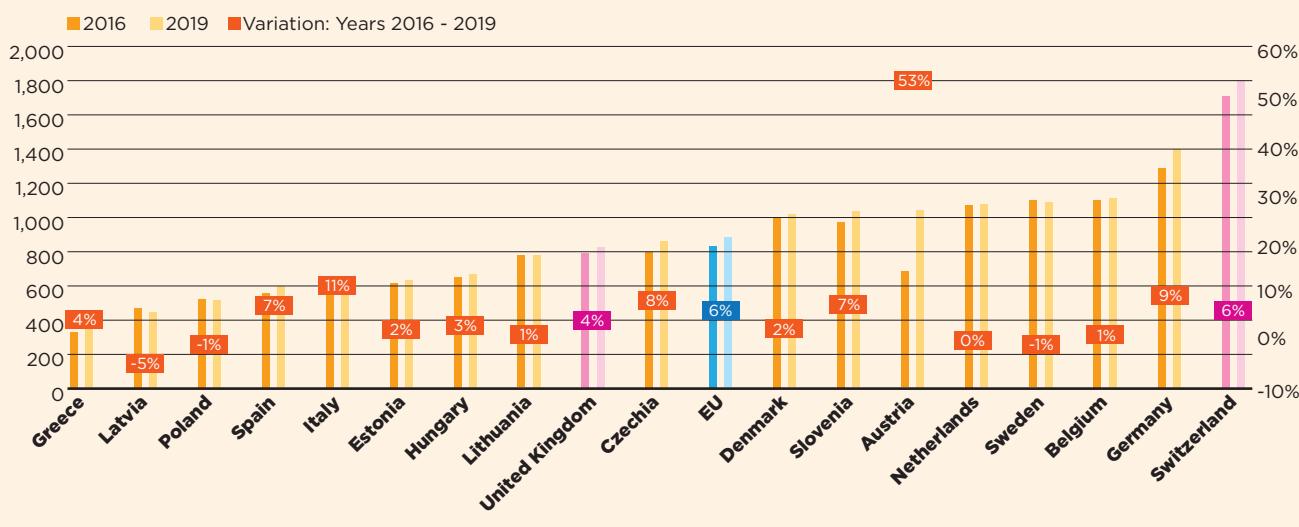
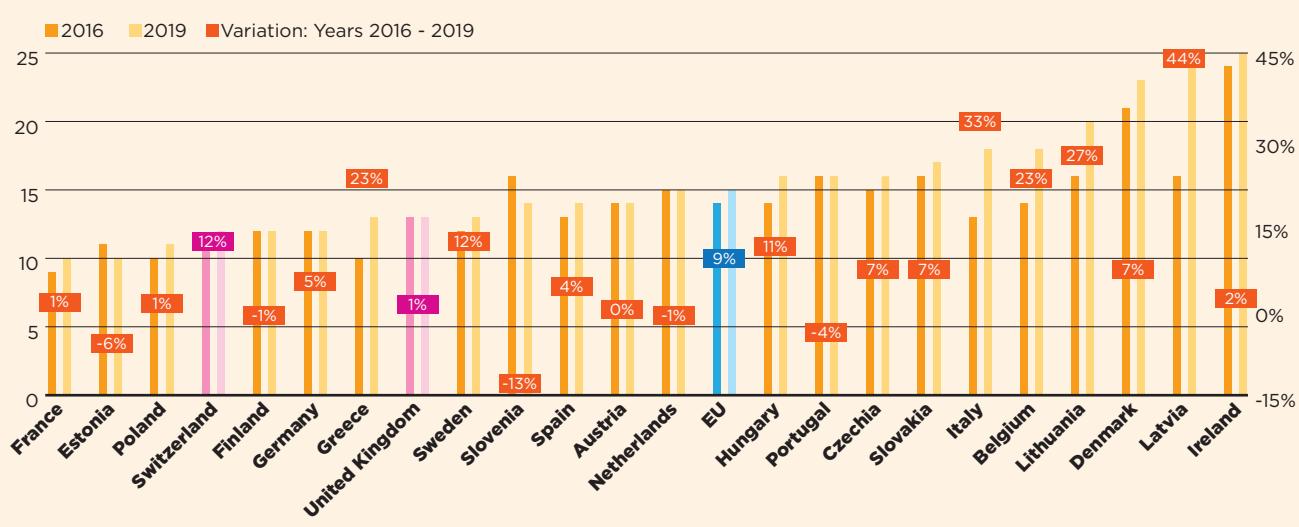
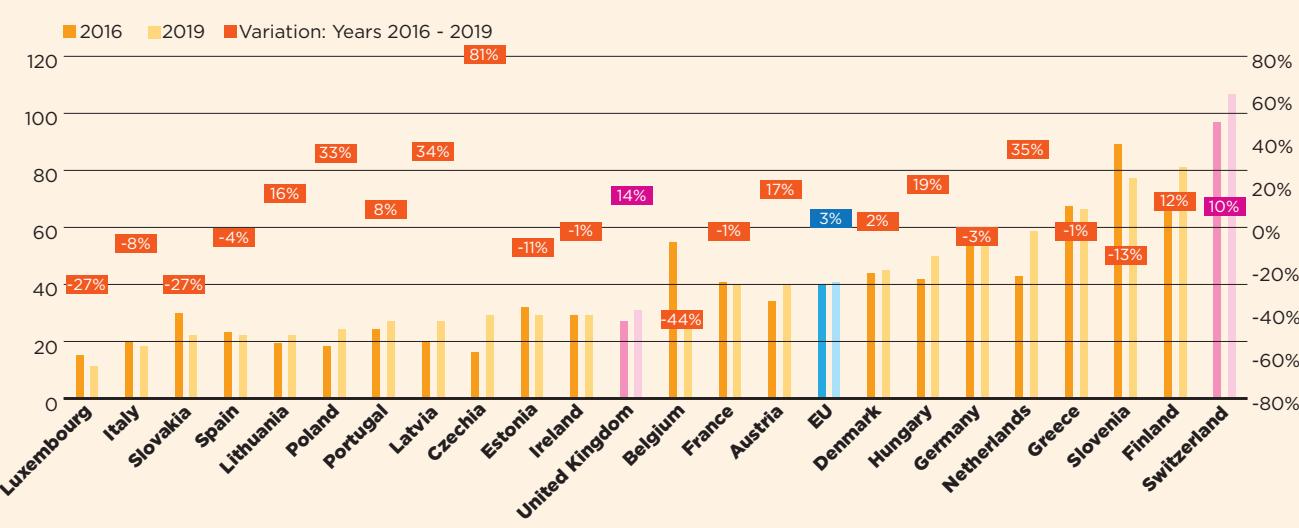
Compared with 2016, the number of medical graduates per 100,000 inhabitants in the EU registered an overall positive variation (Chart 18). The countries that registered the highest increases were Latvia (+44%), Italy (+33%),

Lithuania (+27%), Greece and Belgium (+23%). Minor positive variations occurred in Switzerland, Sweden (+12%), and Hungary (+11%) whereas decreases occurred in Slovenia (-12%), Estonia (-6%), Portugal (-4%), the Netherlands and Finland (-1%). The number of nurses graduated per 100,000 inhabitants showed different trends across the EU. Major positive variations were registered in Czechia (81%), the Netherlands (35%), Latvia (34%) and Poland (33%), whereas minor positive variations were registered in Denmark (2%), and Portugal (8%). The most relevant decreases were registered in Belgium (-44%) and Slovakia (-27%) (Chart 19).

Reference

1 OECD. A System of Health Accounts 2011. Revised edition – March 2017:166–81.



CHART 17**Number of practising nurses per 100,000 inhabitants: Years 2016–2019****CHART 18****Number of medical graduates per 100,000 inhabitants: Years 2016–2019****CHART 19****Number of nurses graduated per 100,000 inhabitants: Years 2016–2019**

HOPE Governors' responses

HOPE Governors discuss their national COVID vaccination programmes and delivery, and the consequences of the pandemic on physical and mental healthcare provision to non-COVID patients

*Data were obtained from the OECD, Eurostat and WHO. When data were not available for one of the specific years, the closer year was used (denoted by *).*

AUSTRIA



Mr Nikolaus Koller
HOPE Governor

COVID-19 vaccination: how did it go, and what was the involvement of hospital and healthcare services, adherence of healthcare staff?

Austria determined a country-wide prioritisation. The prioritisation focuses on medical criteria for people with a high risk of severe and fatal outcomes when infected with SARS-CoV-2, or with high exposition while being part of essential services (e.g., health care staff, long-term care staff). The organisation and planning of the vaccinations was done regionally, on the level of the federal states. In the beginning of the vaccination process the in the EU known lack of sufficient vaccination doses led to fewer possible immunisations. First batches of vaccines were assigned to residents of retirement and nursing homes, the respective personnel and to health care workers and were administered on-site. These groups were followed by the general population of and over the age of 80. Gradually the pace picked up, with more doses available vaccines were further administered to the most vulnerable groups in age and underlying disease.

By 31 May 2021, 41% of the Austrian population had received at least one dose of the COVID-19 vaccine. A dashboard is available with online tracking of the progress and actual delivery of vaccine doses: <https://info.gesundheitsministerium.at/>. Austria is set on having immunised all people who want to receive the vaccination by the end of July 2021.

The health care workers were immunised directly in the hospitals and the adherence of

physicians was very high, whereas nurses and other health care professions had a vaccination rate of approximately 50%-60%. Some federal states have vaccination centres for the general public, others also relied on their general practitioners right from the start of the vaccination process. In addition, mobile vaccination sites ('Impfboxen') were installed to offer low-threshold access to the COVID-19 vaccination.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?

During the three COVID-19 waves, some or all elective surgeries in the federal states had to be reduced to ensure enough capacities for COVID-19 patients in intensive care units. Until now, these treatments are being made up for. The long-term consequences cannot substantially be determined at this point. Mental health is a big focus, as depression, anxiety disorders and other mental health problems have been aggravated during the pandemic. In the Ministry of Health, an advisory group of experts works on necessary measures to be taken, also addressing the mental health state of children and juveniles and the subsequent issues arising.

We commissioned a study on the impact of the pandemic on inpatient care in Austria in 2020 (available at <https://jasmin.goeg.at/1633/>). Unfortunately, the study is only available in German. Result is: In the areas analysed there

AUSTRIA

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	9.7%	10.4%	10.4%
General government/compulsory current health expenditure, as % of total current health expenditure	75.0%	74.0%	75.2%
Hospital current health expenditure, as % of total current health expenditure	38.7%	38.3%	38.6%
Household out-of-pocket health expenditure, as % of total current health expenditure	18.2%	19.2%	17.7%
All hospital beds per 100,000 inhabitants	769.3	742.1	718.9
Acute care hospital beds per 100,000 inhabitants	631.9	558.7	531.2
Average length of stay for acute care hospitals (bed-days)	6.7	6.4	6.3
Practising physicians per 100,000 inhabitants	460.4	513.0	532.0
Practising nurses per 100,000 inhabitants	636.0*	677.0*	1037.0

*Only nurses employed in hospitals were included

was, with the exception of strokes, a reduction in inpatient stays in the months of March to May 2020 and in November and December 2020 compared with previous years, although the reduction during the second lockdown was not as significant. Due to sufficient personal protective equipment, more testing possibilities

and an increased knowledge about COVID-19 gained over the course of the first phase of the pandemic, the reduction was comparatively moderate, taking into account the relatively high number of hospitalised COVID-19 patients.

DENMARK



**Mrs Eva
Weinreich-Jensen**
HOPE Governor

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff?

In general, there has been a high willingness in Denmark to receive the vaccine. By mid-September 2021, all citizens over the age of 12 had been offered vaccination against COVID-19. As of today, more than 4.4 million citizens have been vaccinated with at least one dose; this is equivalent to more than 75% of the total population and over 86% of the population above 12 years.

The Danish COVID-19 Vaccination programme is centrally governed. The Danish Health Authority has been responsible for planning the programme and determines who should be vaccinated and in which order. At first, the limited supply of vaccine was prioritised to citizens in nursing homes, health staff and the elderly and vulnerable population. Afterwards the roll-out has generally been based on age.

The authorities in Denmark's five regions have been administering and carrying out the vaccinations. The regions are administrative entities at a level above the municipalities and below the central government and in charge of health care and public hospitals.

Most citizens were invited for vaccination through a secure public e-mail system (eBoks) that allows them to book a time for vaccination digitally. Most vaccinations take place in regional vaccination centres established for this specific purpose. Some take place in more local settings with outgoing units from the vaccination centres carrying out the vaccinations: for instance, for residents and staff at nursing homes or immobile citizens. Vaccination of hospital staff and hospitalised patients is administered at the hospitals. Vaccination is voluntary and free of charge.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?

It has been very important for the Danish regions to find out the consequences of coronavirus for non-COVID patients. Therefore, the regions created a panel of experts, which has been investigating the consequences on the health and well-being in Denmark and make recommendations. Although Denmark was in an extraordinary situation as a result of the coronavirus, the situation has shown that the Danish Healthcare System overall has been able to adapt to a crisis situation. Examination and treatment of patients with acute and life-threatening diseases has been prioritised and maintained throughout the entire pandemic. In an international perspective, cancer treatment in Denmark has, for instance, performed well during the crisis. However there has been a periodically decline in the activity in the non-acute and non-life-threatening areas, so that health care resources could be prioritized to treat corona patients.

Studies indicate that some citizens have experienced an impact on their mental health during the pandemic due to, for example, increased loneliness and isolation. It is likely that mental health will normalise for many in the wake of the crisis, but for some groups, we can expect more long-term negative effects. It is not yet possible to assess whether the mental health of the population in general will return to the same level as before coronavirus, once society is reopened, or whether the people who have been affected negatively will have poorer mental health in the long run. This requires follow-up studies and an increased focus moving ahead.

DENMARK

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	9.5%	10.1%	10.0%
General government/compulsory current health expenditure, as % of total current health expenditure	84.0%	84.1%	83.2%
Hospital current health expenditure, as % of total current health expenditure	44.5%	44.3%	43.5%
Household out-of-pocket health expenditure, as % of total current health expenditure	14.1%	13.7%	14.2%
All hospital beds per 100,000 inhabitants	357.1	259.6	259.3
Acute care hospital beds per 100,000 inhabitants	350.8	252.5	248.0
Average length of stay for acute care hospitals (bed-days)	3.5	n.a.	n.a.
Practising physicians per 100,000 inhabitants	357.9	4000	4190
Practising nurses per 100,000 inhabitants	955.3	995.0	1010.1

ESTONIA

Dr Urmas Sule
HOPE President

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff?

The vaccination target in Estonia was for 70% of adults to be vaccinated by the start of autumn; unfortunately, this does not seem to have been achieved in time. From the start, Estonian data were very similar to those in Sweden, the main difference being Sweden has a greater number of elderly people already vaccinated. Today our numbers are lower. The vaccination programme started just after Christmas 2020, with healthcare workers and older people in care homes. This was a wise decision as hospitalisation cases dropped among the elderly (from over 20% to 1% among residents of care homes). The decrease of morbidity among healthcare professionals has also been remarkable, and this significantly increased the capacity of the health care system to cope with the crises. Later the State Immunoprophylaxis Expert Committee gave new instructions on selection of risk groups to vaccinate next, step by step. As there was very high demand at the start, this was done according to the amount of vaccine available in Estonia at that moment. Vaccination centres opened in May 2021 and vaccination was available to all adults in Estonia, including non-nationals. In addition to the vaccination centres, hospitals and family physicians continued to carry out vaccinations. As of September 2021, 66% of the adult population, including 72% of elderly people, had been vaccinated. Our biggest challenge concerning vaccination today is primarily a socio-psychological one.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?

There was a considerable burden on hospitals during the second wave, because infection rates increased rapidly and many people needed specialised care. In March and April during the peak, there were over 700 people (over 54 per 100 000 inhabitants) hospitalised with COVID.

Our health professionals have given their best to solve the crisis. We were also able to widely involve medical and nursing students with cooperation of University of Tartu and two Health Care Colleges.

To contain the virus, strict restrictions were also established by the Government of Estonia from 11 March 2021. The synergies between these activities were finally effective.

Long-COVID, mental health and waiting lists are also areas of concern in Estonia. Mental health problems – depression, anxiety, burnout, etc – had already emerged during the first wave of the virus crisis, and been exacerbated by the second wave. Continuous feeling of danger and stress among health professionals and other professions who have close contact with other people, has had and will have long-term effect on mental health.

During this difficult time, the Estonian Hospitals' Association was also negotiating with health care workers' unions regarding a collective agreement. In the last days of April 2021, after long discussions through a national conciliator, the Hospitals Association, the Medical Association, the Healthcare Workers Professional Association and the Professional Association of Clinical Psychologists reached an agreement, and a new collective deal was signed. This agreement contained for the first time also clauses about workers' mental health and care. Unfortunately, the Nurses Union separated and did not sign this agreement, but the interests of nursing staff are considered in the same way.

The annual increase in morbidity started three months earlier than last year. At the beginning of September 2021, the Estonian government decided to implement a new COVID-19 risk level assessment model. The introduction of the new matrix will help to assess the situation of COVID-19 in the country more realistically, as more than half of the population have been vaccinated for COVID-19 at least once, which was not considered in the previous risk matrix.

ESTONIA

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	5.7%	6.3%	6.7%
General government/compulsory current health expenditure, as % of total current health expenditure	77.0%	75.7%	74.5%
Hospital current health expenditure, as % of total current health expenditure	47.9%	46.7%	44.4%
Household out-of-pocket health expenditure, as % of total current health expenditure	20.7%	22.7%	23.9%
All hospital beds per 100,000 inhabitants	563.2	468.6	453.0
Acute care hospital beds per 100,000 inhabitants	412.1	344.3	331.8
Average length of stay for acute care hospitals (bed-days)	5.7	5.7	5.4
Practising physicians per 100,000 inhabitants	334.2	346.0	347.0
Practising nurses per 100,000 inhabitants	641.5	610.0	624.0

GERMANY



Dr Gerald Gass
HOPE Governor

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff?

From end of December 2020, Germany followed a stepwise and group-wise vaccination approach to prioritise COVID-19 vaccination (Vaccination approach RKI). The five groups were defined by the Robert-Koch-Institut (RKI) in the form of a recommendation. As in Germany it is up to the Federal states (Bundesländer) to translate these recommendations into binding legal acts, there were minor differences in the definition of the priority groups and in the timing of the vaccinations between the Bundesländer. In the first phase (28 December 2020 to 7 April 2021), the vaccinations were carried out exclusively in vaccination centres set up for this purpose. As of 7 April 2021, vaccinations were also administered by general practitioners and by in-house company doctors. Hospital staff were immunised as the first priority group from January 2021. For this purpose, the German hospitals received the corresponding doses for the vaccination of their staff. Beyond that, hospitals were not involved in the vaccination of the population. As of mid-September (15 September 2021), 63% of the total population is fully vaccinated and 67% of the total population is at least partially vaccinated (primary vaccination). As in many other European countries, Germany is currently discussing different motivational/incentive systems and

mandatory options.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?

As in our neighbouring countries, the unprecedented COVID-19 crisis has created major challenges for regular inpatient and outpatient care. In Germany, the Federal States (Bundesländer) are responsible for the on-site organisation and planning of hospital care. In 2020, from mid-March onwards, the Bundesländer enacted regulations to create a legal framework for the downscaling of elective care procedures to be prepared for a worst-case scenario. The German hospitals largely followed the national request and the regional regulations. All decisions taken by the hospitals were guided by the principle that the evaluation of elective procedures is subject to the primacy of medicine. Decisions were taken most carefully after an in-house evaluation of each individual medical situation. Thanks to the treatment capacities in the German hospital sector, the teams were fortunately able to catch up on most of the procedures in the subsequent summer months. We can be grateful that we are currently not struggling with an unmanageable backlog situation. However, consequences on the care delivered to non-COVID patients, both in terms of somatic and mental health, must be further evaluated.

GERMANY

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	10.3%	11.2%	11.7%
General government/compulsory current health expenditure, as % of total current health expenditure	75.1	84.3	84.6
Hospital current health expenditure, as % of total current health expenditure	28.6%	28.7%	27.6%
Household out-of-pocket health expenditure, as % of total current health expenditure	14.0%	12.9%	12.7%
All hospital beds per 100,000 inhabitants	821.4	806.3	791.5
Acute care hospital beds per 100,000 inhabitants	613.0	605.6	595.0
Average length of stay for acute care hospitals (bed-days)	8.3	7.6	7.6*
Practicing physicians per 100,000 inhabitants	354.1	419.0	439.0
Practicing nurses per 100,000 inhabitants	1113.1	1282.1	1395.0

LUXEMBOURG



Mr Marc Hastert
HOPE Governor

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff?

On 12 September 2021, Luxembourg had 1067 active infections and a total of 77,100 infections since February 2020. In total, 834 people have died since March 2020. Yet, there are only 27 people in the hospital due to COVID-19, including 9 people in ICU. Seventy-two per cent of the eligible population (12+) are fully vaccinated and 1000 people are vaccinated every day with EMA-approved vaccines. The AstraZeneca vaccine is only used in the older population and for younger patients on a voluntary basis. In hospitals, 75% of workers are

vaccinated, professionals always have priority, but it is not mandatory. This will not change in the future. The current practice in hospitals is for workers to perform a test before starting the day; this is only a recommendation but, if they refuse, they will be assigned to a service without risk to patients. Visitors also require testing, and a COVID-19 passport is currently being implemented.

Meanwhile, a general COVID check obligation will apply in hospitals in future: according to this, every person entering a hospital must in principle show proof of vaccination, a negative test result or recovery. Only emergency patients are exempt.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?

Concerning non-COVID patients, there have been few issues thus far, except in mental health, but this is a pre-existing problem as

there are not enough psychiatric centres. COVID-19 counselling centres have been closed and the general practitioners are the points of contact. There is also a two-way stream being implemented in emergency services for COVID-19 patients and for non-COVID-19 patients.

LUXEMBOURG

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	6.5%	5.2%	5.4%
General government/compulsory current health expenditure, as % of total current health expenditure	87.3%	83.7%	85.0%
Hospital current health expenditure, as % of total current health expenditure	31.9%	31.2%	33.4%
Household out-of-pocket health expenditure, as % of total current health expenditure	9.9%	10.7%	9.6%
All hospital beds per 100,000 inhabitants	556.8	480.6	426.5
Acute care hospital beds per 100,000 inhabitants	432.2	389.9	329.4
Average length of stay for acute care hospitals (bed-days)	7.3	7.4	7.4
Practising physicians per 100,000 inhabitants	271.6	288.0	n.a.
Practising nurses per 100,000 inhabitants	n.a.	1720	n.a.

PORUGAL



Prof Carlos Pereira Alves
HOPE Governor

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff?

Vaccination in Portugal is centralised, managed by the Vaccination Task Force, designated by the Government. Vaccination is administrated by the Portuguese National Health Service (Serviço Nacional de Saúde – SNS) network, following the Vaccination Plan against COVID-19, which is dynamic and adjusted according to the evolution of scientific knowledge, the epidemiological situation at each moment and the availability of vaccines.

The plan foresees three phases. At the moment, Portugal is in the third phase, vaccinating mostly young people and a second dose to the rest of eligible population. An average daily rate in the fourth week of September 2021 was 34,515 vaccinated people (with the record of 148,000 on 12 July 2021).

As of 26 September 2021, 88% of the population had already received at least the first dose of the vaccine and 85% of the population has already been fully vaccinated, meaning that

98% of all of those eligible for vaccines – anyone over 12 – have been fully vaccinated.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?

In order to give priority to COVID patients, the activities in the Portuguese National Health Service were suspended for some time in 2020, so public hospitals carried out 18% fewer operations than the year before. At the end of 2020, hospitals started recovery plans that had to be interrupted at the beginning of 2021 due to the second wave of COVID-19 that overcrowded the institutions, preventing them, even for safety reasons, from allocating resources to non-COVID patients. Currently most institutions have already resumed recovery plans for suspended non-COVID activities, so they either work normally or with extended schedules to restore the waiting lists, but it will be a slow process.

PORUGAL

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	9.3%	9.4%	9.5%
General government/compulsory current health expenditure, as % of total current health expenditure	71.7%	69.3%	71.8%
Hospital current health expenditure, as % of total current health expenditure	37.7%	41.3%	42.0%
Household out-of-pocket health expenditure, as % of total current health expenditure	24.5%	22.8%	20.1%
All hospital beds per 100,000 inhabitants	339.1	339.3	350.1
Acute care hospital beds per 100,000 inhabitants	332.7	325.3	332.7
Average length of stay for acute care hospitals (bed-days)	8.3	8.9	9.3
Practising physicians per 100,000 inhabitants	n.a.	n.a.	n.a.
Practising nurses per 100,000 inhabitants	n.a.	n.a.	n.a.

SPAIN

Mrs Sara Pupato Ferrari
HOPE Governor

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff?

In September 2021, there were more than 37 million people vaccinated (78% of the population, being 75% fully vaccinated). Vaccination is seen as one of the main achievements of health care services, either at central level, the Ministry of Health, or at regional levels. Organisation is perceived as effective by the population. All types of facilities are being used for the Vaccination Programme. Neither health care professionals nor the general population encountered problems being vaccinated. Vaccine hesitancy is not significant. A COVID passport is seen as one of the potential solutions for the tourism sector crisis.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?

As in other EU countries, the delivery of non-COVID-related health care services has been directly pressured and often compromised at all levels because of the pandemic. In general, there has been a postponement of elective medical procedures while there has been an increase in digital healthcare technologies use for regular consultations.

Postponement of elective medical procedures was mainly due to the lack of workforce, operating rooms and availability of beds. Some professionals were reallocated.

Waiting lists have increased approximately from 7% to 19% depending on the region.

Studies done during the first wave showed: a decrease in cancer routine procedures; 97% of consultations were by phone; and 20% fewer biopsies and consultations. It is estimated that in this period 1 out of 5 patients has had a delayed diagnosis. There has also been a decrease in the number of urgent consultations for stroke, cardiovascular and neurological conditions in emergency rooms, by 15%-32% depending on the region. For primary care, studies show 75% fewer face-to-face consultations and an important increase in telemedicine. From the patients' point of view, procedures planned before the pandemic were delayed or cancelled, and problems with medications were also reported. Temporary closure of primary care centres occurred and waiting lists for family care doctors have increased from 1-3 days to 3-6 days in 2020. A mental health study has shown an increase of eating disorders in children and adolescents during the pandemic. In public health, as the workforce was prioritised to the pandemic, screening programmes were affected as well as usual networks for other diseases.

Although the pandemic is still affecting healthcare services directly, great efforts are being made during 2021 to ensure access, rapid and appropriate services to non-COVID patients to recover the pre-pandemic situation. Waves of COVID infection and lack of workforce appear to be the main obstacles to achieving this goal.

SPAIN

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	8.4%	9.0%	9.1%
General government/compulsory current health expenditure, as % of total current health expenditure	73.3%	71.6%	70.6%
Hospital current health expenditure, as % of total current health expenditure	40.9%	43.3%	44.2%
Household out-of-pocket health expenditure, as % of total current health expenditure	20.7%	22.0%	21.8%
All hospital beds per 100,000 inhabitants	319.7	296.6	294.6
Acute care hospital beds per 100,000 inhabitants	255.9	246.9	247.5
Average length of stay for acute care hospitals (bed-days)	6.5	6.0	6.0
Practicing physicians per 100,000 inhabitants	354.5	382.0	440.0
Practicing nurses per 100,000 inhabitants	482.2	551.0	589.0

SWEDEN

Mr Erik Svanfeldt
HOPE Governor

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff?

In Sweden, vaccination is voluntary and the willingness to be vaccinated is generally high. As of 22 September 2021, 83% of all residents aged 16 and over had received at least one dose and 75% had received two doses. The rate of vaccination was higher among elderly people, as this age-group had been given priority, and the lowest among 16- and 17-year-olds who could start receiving the vaccine at the end of the summer of 2021. From October 2021, it will be possible also for young people aged 12-15 to get vaccinated in Sweden.

Statistics also showed that the vaccination rate was much higher among healthcare staff compared with other people of working age. But among social care staff, the figures were about the same as for the population in general.

A big challenge is the fact that the vaccination rate is lower among residents born outside Sweden, and among persons with low education and low incomes. This is something that requires targeted actions, and great efforts are being made to reach these groups as well.

In Sweden, vaccination is a regional responsibility. COVID-19 vaccinations take place in many different settings: often in temporary premises or drive-in centres, but sometimes also

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at primary care centres and hospitals. To reach out wider, the regions have also started mobile vaccination services offering vaccination outside schools, universities, churches, sports arenas etc.

Sweden has mainly used the Pfizer/BioNTech vaccine, but also the Moderna vaccine.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?

The COVID-19 pandemic has had many different effects on the Swedish healthcare services. Before the pandemic, Sweden had a low number of ICU beds, but then hospitals in a short time managed to transform wards into intensive care units, and transfer healthcare professionals from one part of the system to

another. There was also a significant increase of digital services, a change that is expected to continue.

At the same time, there was less pressure on other parts of hospital services (cardio, cancer) and less pressure on primary care. Planned treatment was postponed and waiting times were extended. Between March 2020 and January 2021, the total number of surgeries decreased by 22% compared with the same period in 2019–2020. The number of planned surgeries decreased by 30%. The largest decreases in the total number of surgeries/interventions occurred in orthopaedics, general surgery and ophthalmology. The number of people waiting more than 90 days for a surgery/intervention has increased significantly since March 2020.

SWEDEN

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	8.2%	10.9%	10.9%
General government/compulsory current health expenditure, as % of total current health expenditure	81.9%	84.3%	84.9%
Hospital current health expenditure, as % of total current health expenditure	n.a.	38.5%	38.8%
Household out-of-pocket health expenditure, as % of total current health expenditure	16.3%	14.5%	13.9%
All hospital beds per 100,000 inhabitants	280.5	233.8	207.1
Acute care hospital beds per 100,000 inhabitants	255.1	215.3	190.4
Average length of stay for acute care hospitals (bed-days)	6.2	5.6	5.4
Practising physicians per 100,000 inhabitants	368.0	423.0	432.0*
Practising nurses per 100,000 inhabitants	1078.0	1093.0	1085.0*

UNITED KINGDOM



Ms Layla McCay
HOPE Governor

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff?

By September 2021, the UK had had over 7 million cases¹ and 156,000 deaths where COVID-19 was recorded on the death certificate.² The more transmissible delta variant led to a large uptick in cases from July 2021 onwards, with cases peaking at over 60,000 on one day; however, the vaccination roll out has helped break the link between cases and deaths. Public Health England estimates that over 143,000 hospitalisations for those over 65 have been prevented as a result of the vaccination programme, and estimated deaths prevented are now over 105,000.³

Initially the vaccination programme was managed by hospitals but has since been well established at local sites in primary care and mass vaccination sites. Healthcare staff, the elderly and vulnerable were initially prioritised but now over 80% of people aged 16 and over have had both vaccinations (over 43 million people) and nearly 89% have had one dose.⁴ The latest figures we saw suggested 90 % of frontline staff have been fully vaccinated and 80% of all staff had received both doses. Some NHS organisations have started to redeploy staff who have not been vaccinated away from the frontline. Research shows high vaccination trust compared to other countries, with a study in June noting 87% of respondents 'had faith in

the jab'.⁵ Reasons given by people to not get vaccinated are mainly fear of side effects, and long impacts that people did not feel could yet be known. Research by the Office of National Statistics (ONS) also showed a secondary factor of people feeling they did not think COVID-19 vaccines were necessary as they did not think it was a significant risk to them, often because they were younger and did not think they would develop serious symptoms, or they would not need to the jab because they felt they were taking adequate steps to avoid catching COVID-19.⁶

The UK initially took a policy of a three-month gap between doses which led to more people being vaccinated, but with the delta variant spike during the summer, people were encouraged to bring their vaccination forward to the eight-week mark.⁷

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?

The main challenge is the backlog of care. Nearly 5.5 million people were waiting for treatment as of June 2021, the highest number since records began;⁸ in February 2020 before the pandemic, this stood at under 4.5 million. It is estimated that over 7 million people did not come forward for treatment during the pandemic that would have come forward

usually and there is now a question of how many of those people will present for treatment, increasing the demand on the service as it recovers. More than 300,000 people in June 2021 were waiting more than 52 weeks; this is compared with just over 1600 in February 2020.

There has also been a rise in some mental health issues, with data showing a considerable rise in young people treated for eating disorders as well as those waiting for treatment, the latter

of which increased 173% from the end of 2019/20 to the end of 2020/21.⁹

Research predicts England will have up to 10 million people who need support with mental health issues because of the pandemic.¹⁰ Long-COVID is also a topic of interest in the UK, both in the general public and across NHS staff, with figures in April suggesting that over 120,000 health care workers may have been affected.¹¹

UNITED KINGDOM

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	9.1%	9.9%	10.2%
General government/compulsory current health expenditure, as % of total current health expenditure	81.1%	79.6%	78.5%
Hospital current health expenditure, as % of total current health expenditure	n.a.	41.6%	40.2%
Household out-of-pocket health expenditure, as % of total current health expenditure	13.2%	15.4%	16.0%
All hospital beds per 100,000 inhabitants	333.3	257.5	n.a.
Acute care hospital beds per 100,000 inhabitants	n.a.	n.a.	n.a.
Average length of stay for acute care hospitals (bed-days)	6.3	6.0	5.9*
Practising physicians per 100,000 inhabitants	257.0	278.0	295.0
Practising nurses per 100,000 inhabitants	866.7	787.0	820.0

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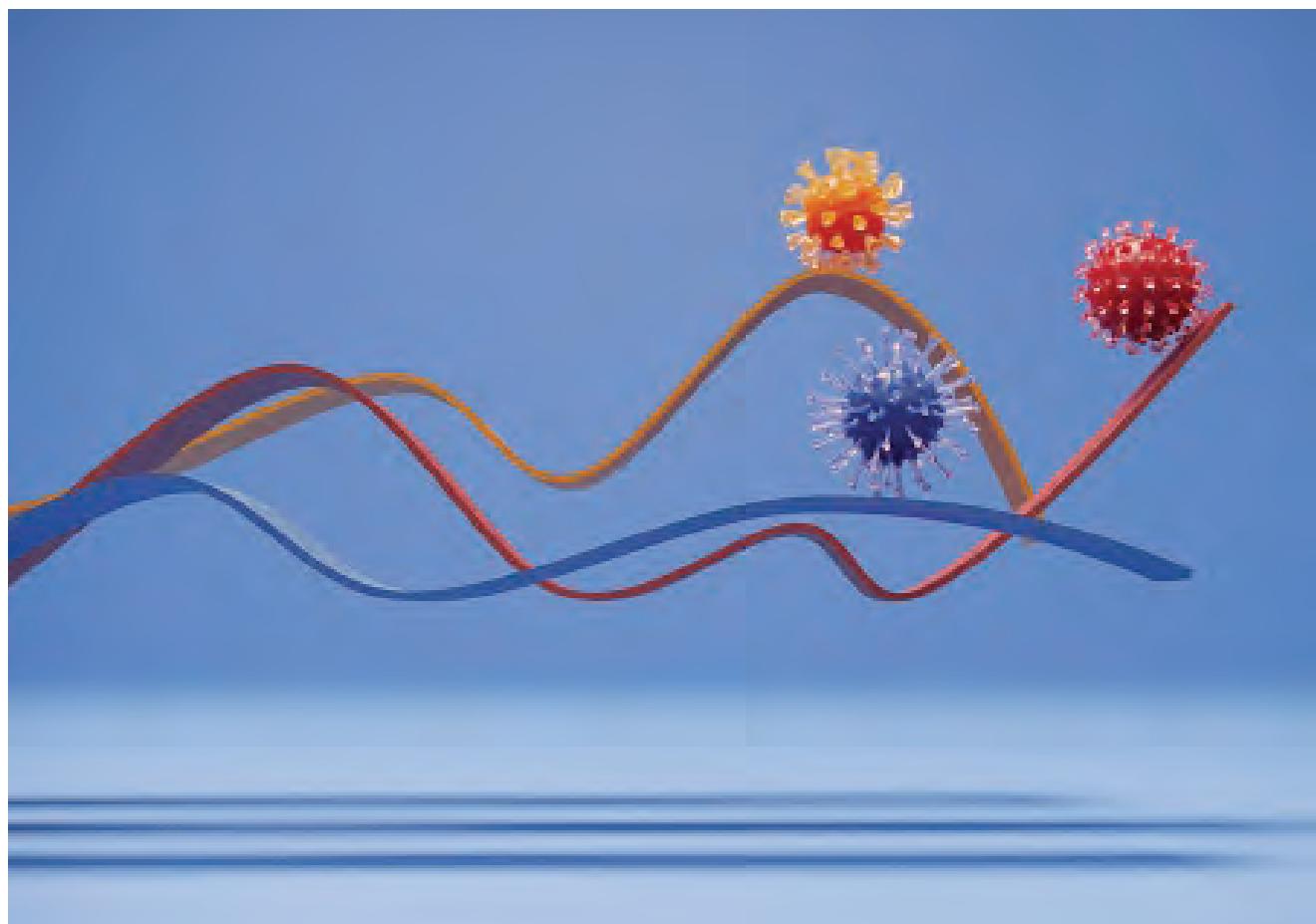
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