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HOPE HEALTHCARE DATA AND GOVERNORS' RESPONSES 2022

Contents

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

The figures given in the present document provide the most up-to-date comparative picture of the situation of healthcare and hospitals

Pascal Garel
HOPE Chief Executive

Even before the COVID-19 crisis, European healthcare systems were facing numerous challenges: the long-term impacts of the financial and economic crises; 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 in this document provide the most up-to-date comparative picture of the situation of healthcare and hospitals and aim to provide an overview of the healthcare systems within the European Union member states before the pandemic. This edition will not only focus on hospital care but also on long-term care, a sector greatly impacted by the COVID-19 pandemic and often over-looked in healthcare but increasingly important with the rising elderly population. It will also cover ambulatory care. Unfortunately, the data used for these two new additions are scarce, and the figures presented must be interpreted with caution, but at least they give 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 percentage of total general government expenditure and on hospital beds in public or private owned hospitals have been extracted from the Eurostat Database on Health (last update July 2021). All European Union member states belonging to OECD are considered, plus Switzerland, 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 (Chart 1). The amount of total current health expenditure per capita in 2019 was encompassed in the EU between 2074 PPP$ (purchasing power parity) in Latvia and 6518 PPP$ in Germany, with an average of 4153 PPP$. In Switzerland, this indicator even 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 account. 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 actors. 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 service.[1]

In 2019, the percentage of public sector health expenditure to the total current health expenditure was higher 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.

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

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

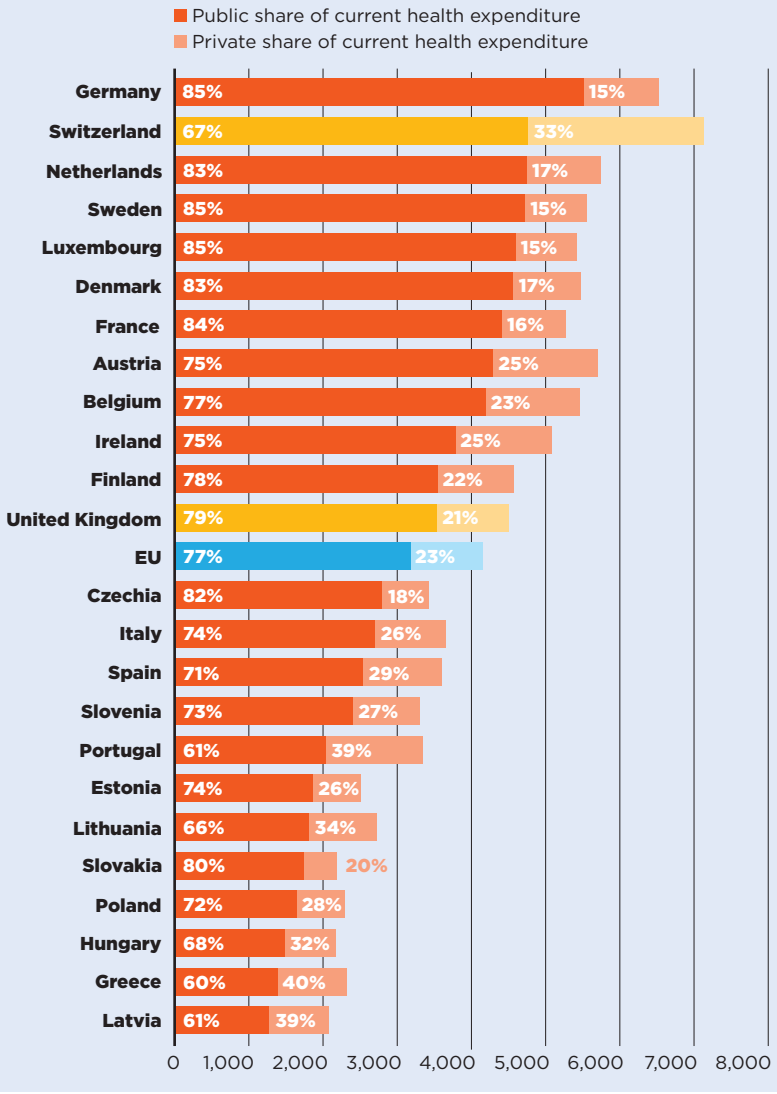
The average trends illustrated in Chart 2 are generally positive between 2008 and 2019. In some countries such as Greece, expenditure decreased until 2015, when it started to increase again.

Out-of-pocket payments show the direct burden of medical costs that households bear at 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, a small decrease from

CHART 1

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



the 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. The 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 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%). While the EU average was 11% increase.

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 of the upper right part of the graph, such as Lithuania, Czechia, and Estonia. For those 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.

More than 30%–40% of current health expenditure finances hospital care, whereas 18%–30% is devoted to ambulatory care and 4%–24% funds long-term care, showing a continued 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

CHART 2

Total health expenditure as percentage of total general government expenditure in the EU and some illustrative countries: Trend 2008 - 2019

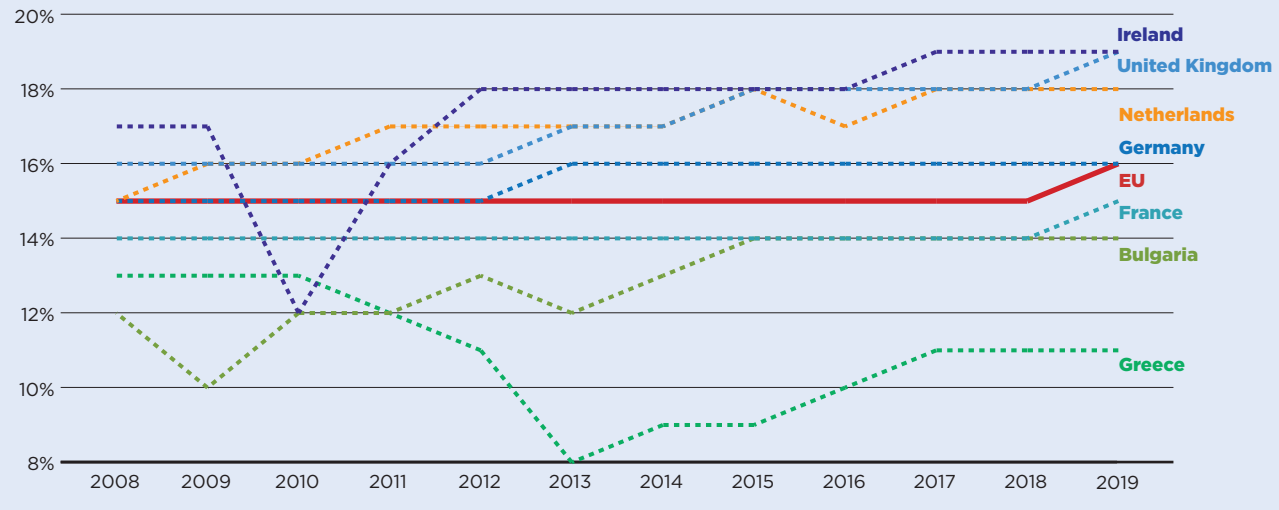


CHART 3

Comparison between the variation in the total current expenditure on health and out-of-pocket payments on health: Years 2016–2019

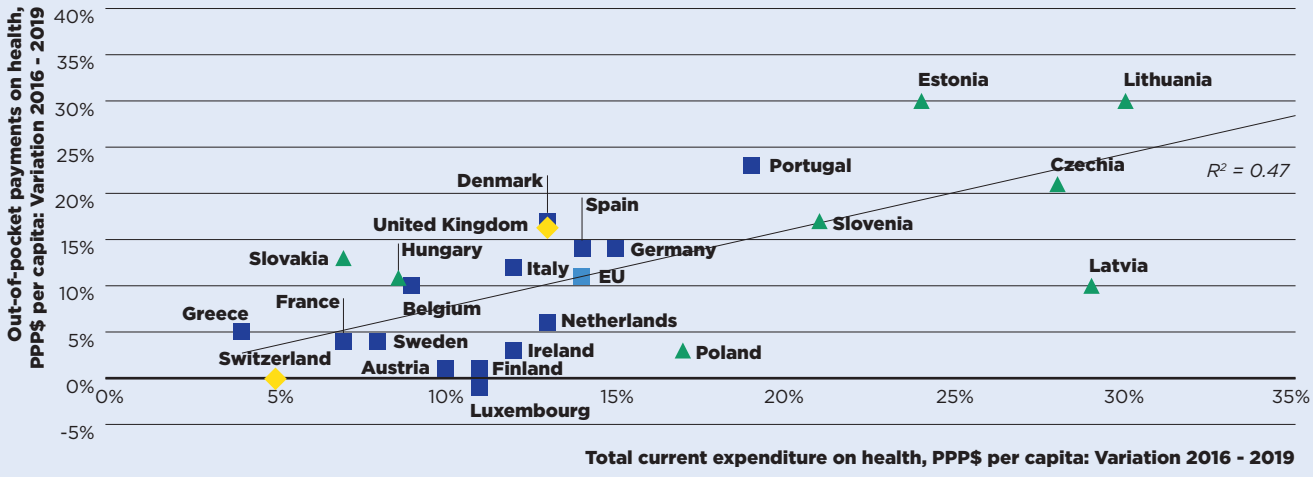
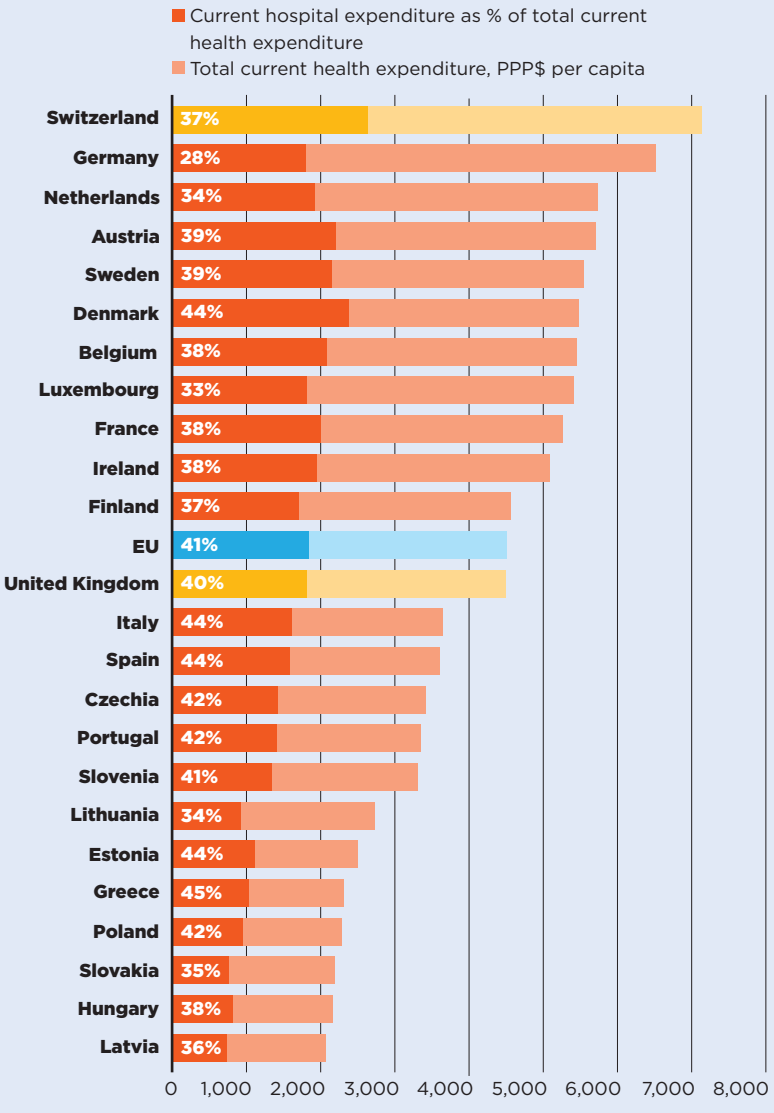


CHART 4

Current hospitals expenditure as percentage of total current health expenditure, PPP$ per capita: Year 2019



45% in Greece and 44% in Estonia, Spain, Italy, and Denmark, respectively. 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 financed publicly. The total expenditure on inpatient care (PPP$ per capita) in the EU follows a growing trend.

Although reforms have tried to make systems emphasise primary care more, 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.

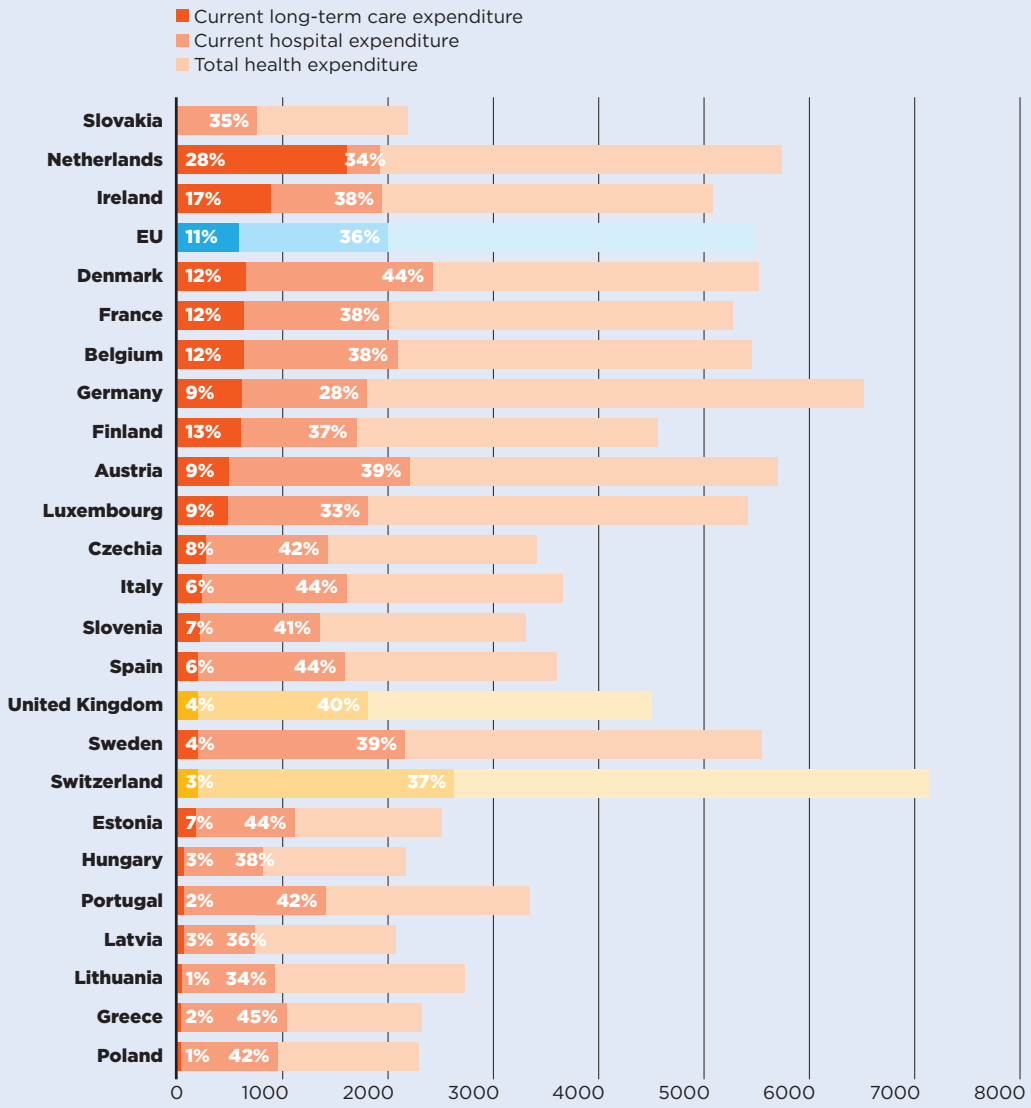
The EU average expenditure on ambulatory care is 25% of the total healthcare expenditure compared with 41% invested in hospitals. This situation is observed in most EU countries. The biggest differences between the two can be found in Greece (45% hospital, 19% ambulatory care), Spain (44% hospital, 22% ambulatory care), and 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 hospital care was Germany (28% hospital, 31% ambulatory care).

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

Another increasingly important area of healthcare is long-term care. Owing to the increasingly ageing population in Europe and the significant impact of the pandemic, it is important to revise its state before COVID-19. The spending in long-term care is also

CHART 5

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



> In 2019, the household private contribution to healthcare spending in the EU accounted, on average, for 18% of total current health expenditure, which represents a small decrease from 20% in 2016

extremely low compared with hospital expenditure. Long-term care (health and social) consists of a range of medical care, 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 (Charts 4–6).

From 2016 to 2019, the amount of expenditure on hospitals from the total healthcare expenditure increased by an average of 14% in the EU; the biggest increases in expenditure 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 among 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 the lowest in Sweden, Luxembourg (6%), Ireland (7%) and Switzerland (5%).

Healthcare capacity and delivery of care

In recent years, healthcare reforms or other initiatives implemented all over Europe have aimed at rationalising the use and provision of

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

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 (e.g., 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 the 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 organisation 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 to a decrease ranging between 9% and 41% during 2006–2016. Barely any changes happened in 2016–2019 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).

CHART 6

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

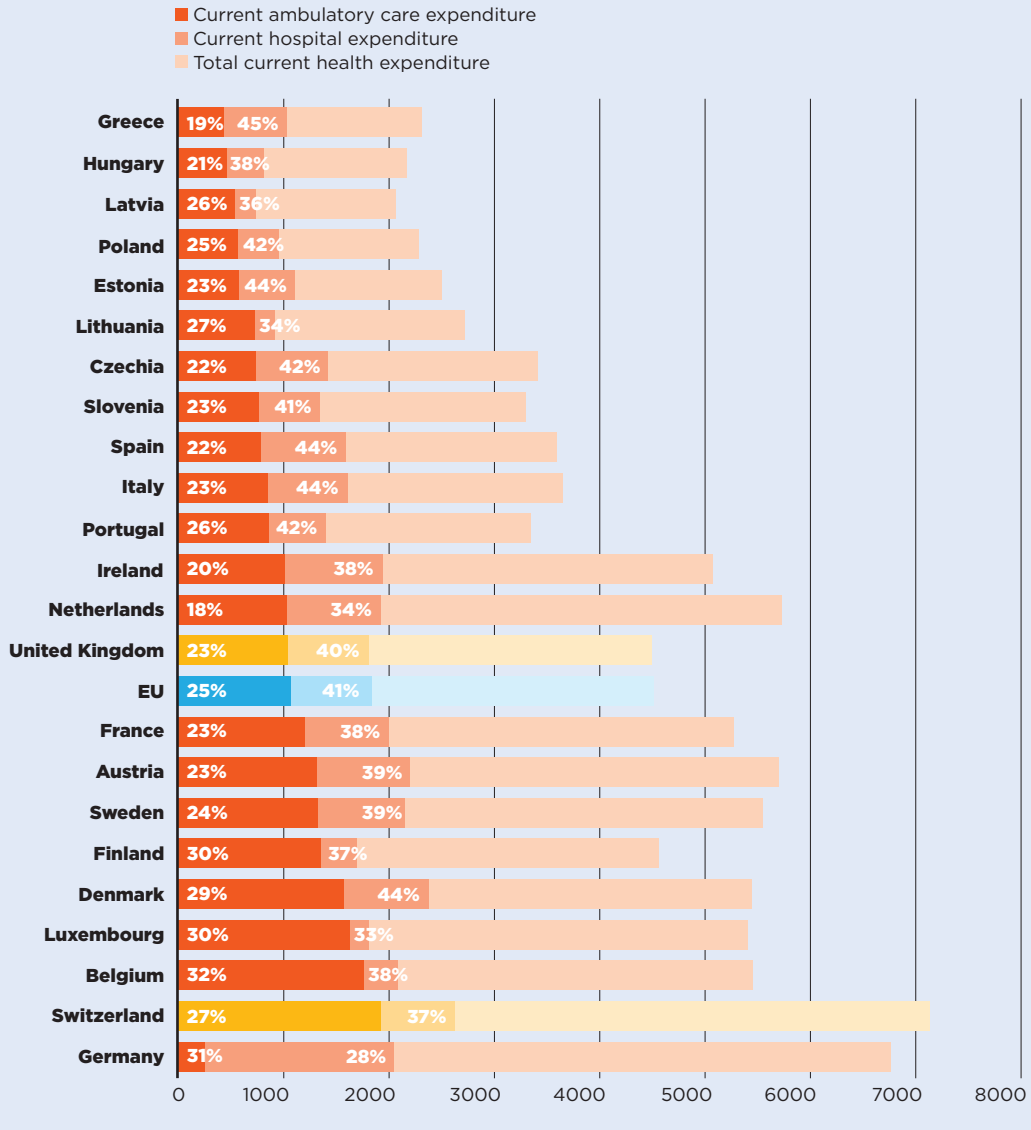
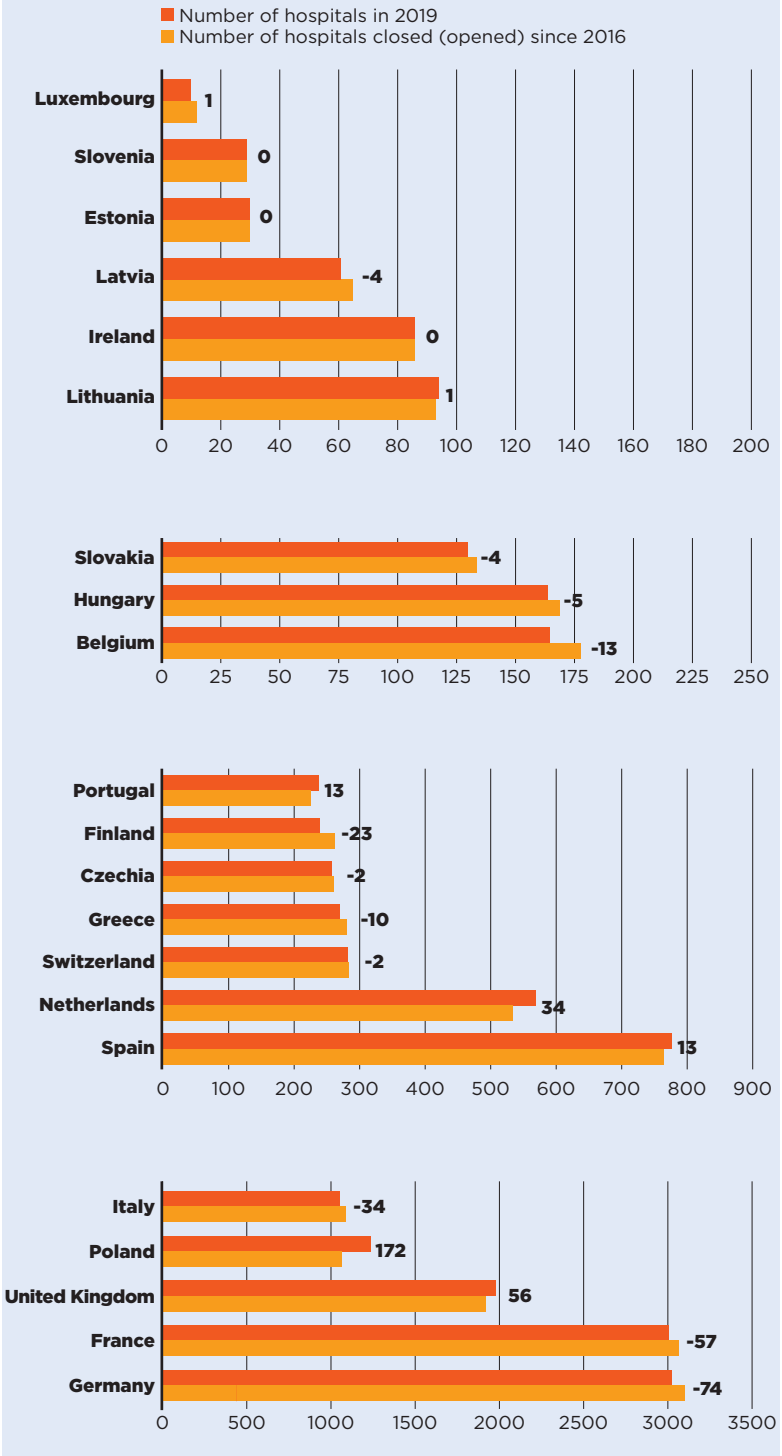


CHART 7

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



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 which was in many countries accompanied by a slight increase in the number of private inpatient beds. The biggest increases during this time 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) showing an increase (28%). 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 lowest were Slovenia, Lithuania (1%) and Croatia (2%) (Chart 10).

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) while the other lowest figures were in the 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).

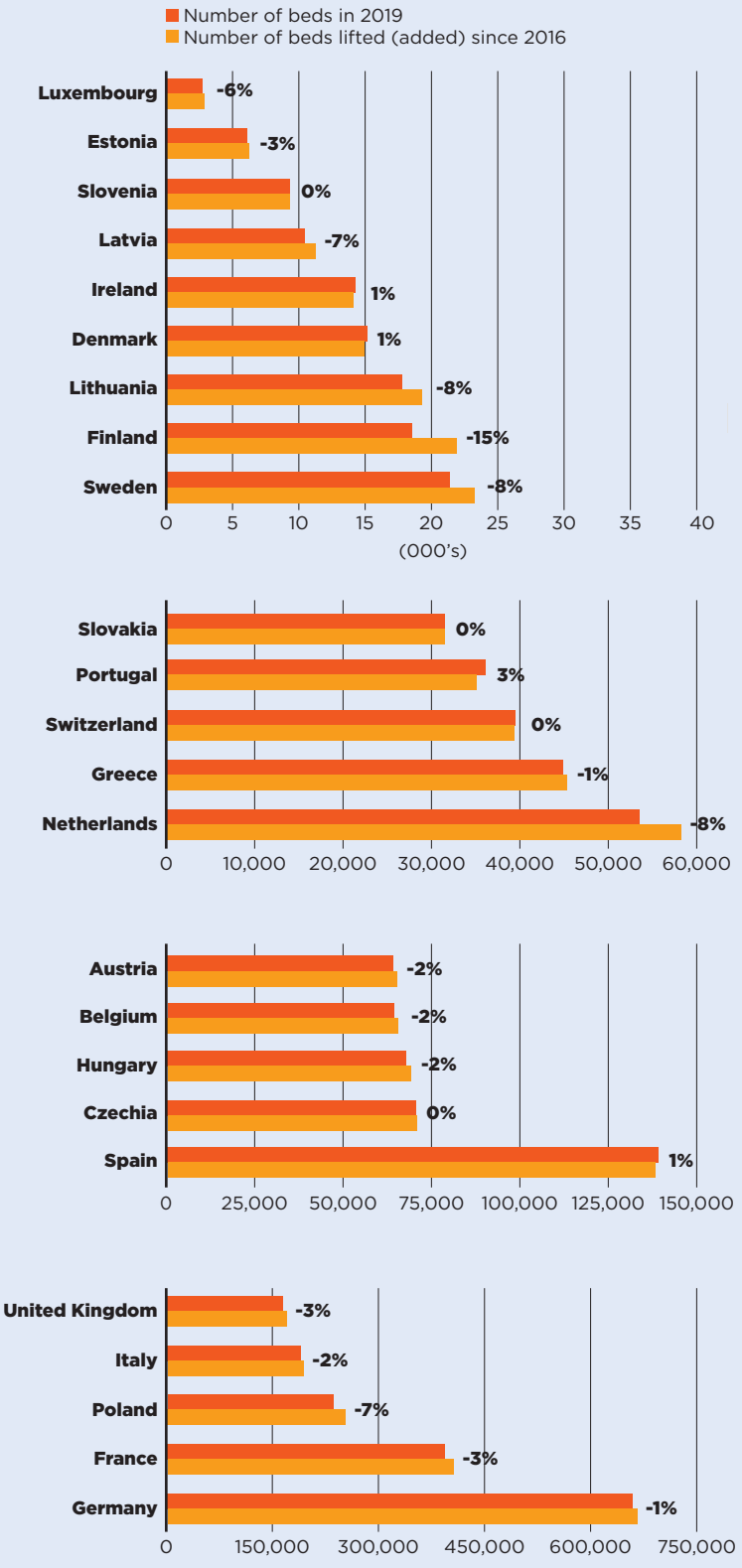
Residential long-term care facilities are establishments primarily engaged in providing residential long-term care that combines nursing, supervisory or other types of care as required by the residents. In these establishments, a significant part of the production process and the care provided is a mix 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 in habitants 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%).

To better understand the state of the healthcare system in the EU we also need to look at the number of primary healthcare units, however there is hardly any data available or from recent years. The countries with available data from 2000 to 2009 (most recent years

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



available) are Bulgaria, Croatia, Czechia, Estonia, Hungary, Lithuania, Latvia, Finland, Portugal, Slovenia, Slovakia, Sweden, and Romania. They show minimal increases, with the biggest increase taking place in Latvia (from 116 to 121) and the biggest decrease in Croatia (from 79 to 73) (Chart 12).

The number of acute care discharges involves the entire pathway of hospitalisation of a patient, who usually stays in hospital for at least one night and then is 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 inpatient 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, as it is commonly acknowledged that too short a length of stay might 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 might 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 corresponds to a mean rate of discharges by 17% and a mean length of stay of 8 days for acute care hospitals. Chart 13 shows that both indicators are higher than the EU average in France, Latvia, Czechia, Hungary, Austria, and Germany.

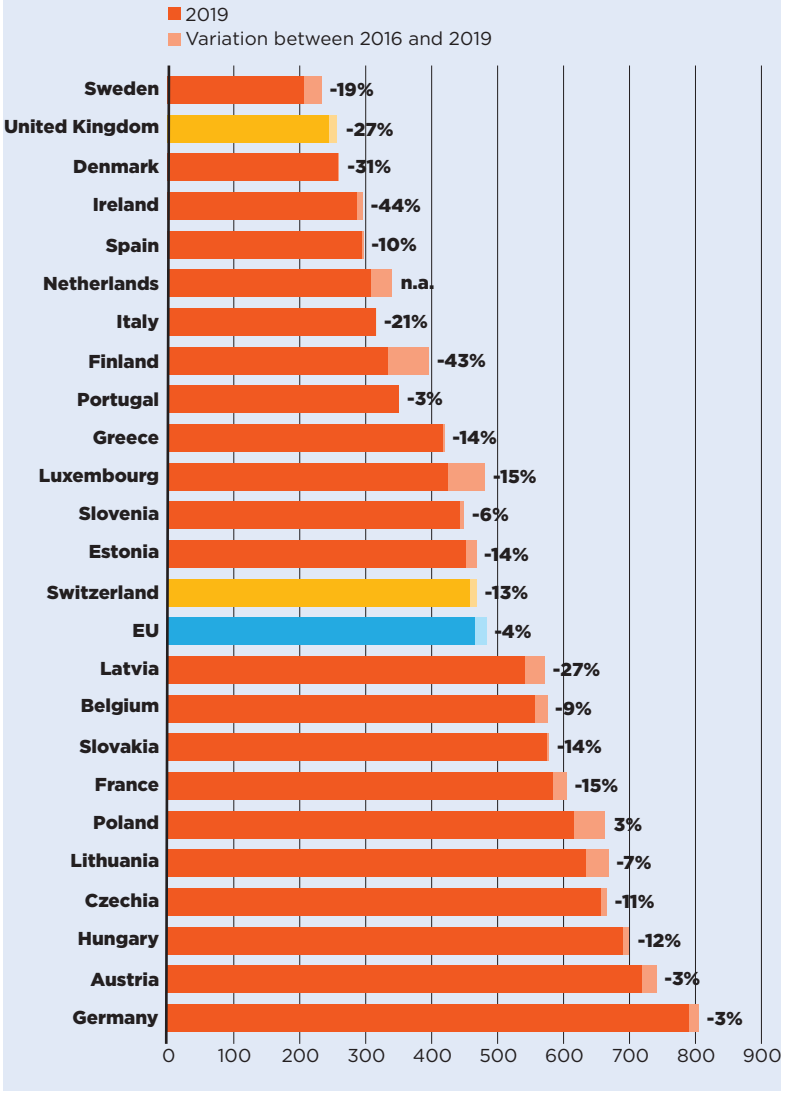
The bed occupancy rate represents the average number of days when hospital beds are occupied during the whole year and generally mirrors how intensively hospital capacity is used.

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 biggest reductions were in Hungary (-4,7), Slovakia (-3,20) and Czechia (-3,20). A

CHART 9

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



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).

Healthcare workforce

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 health workers numbers 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 in the health field. 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 workforce.

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 addressed to nurses. In many cases, nurses and general practitioners acquire new skills and competences, relieving the burden of hospital care by enforcing primary care institutions and community services (Chart 15).

The trends described above are likely to have major impacts on the hospital sector, since inpatient care alone absorbs about a third of the

CHART 10

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

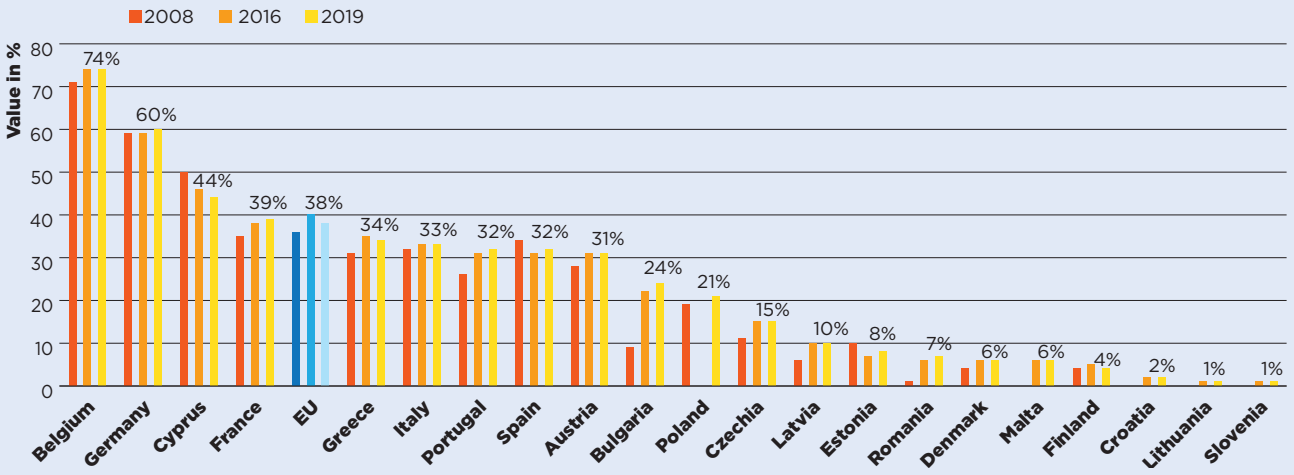
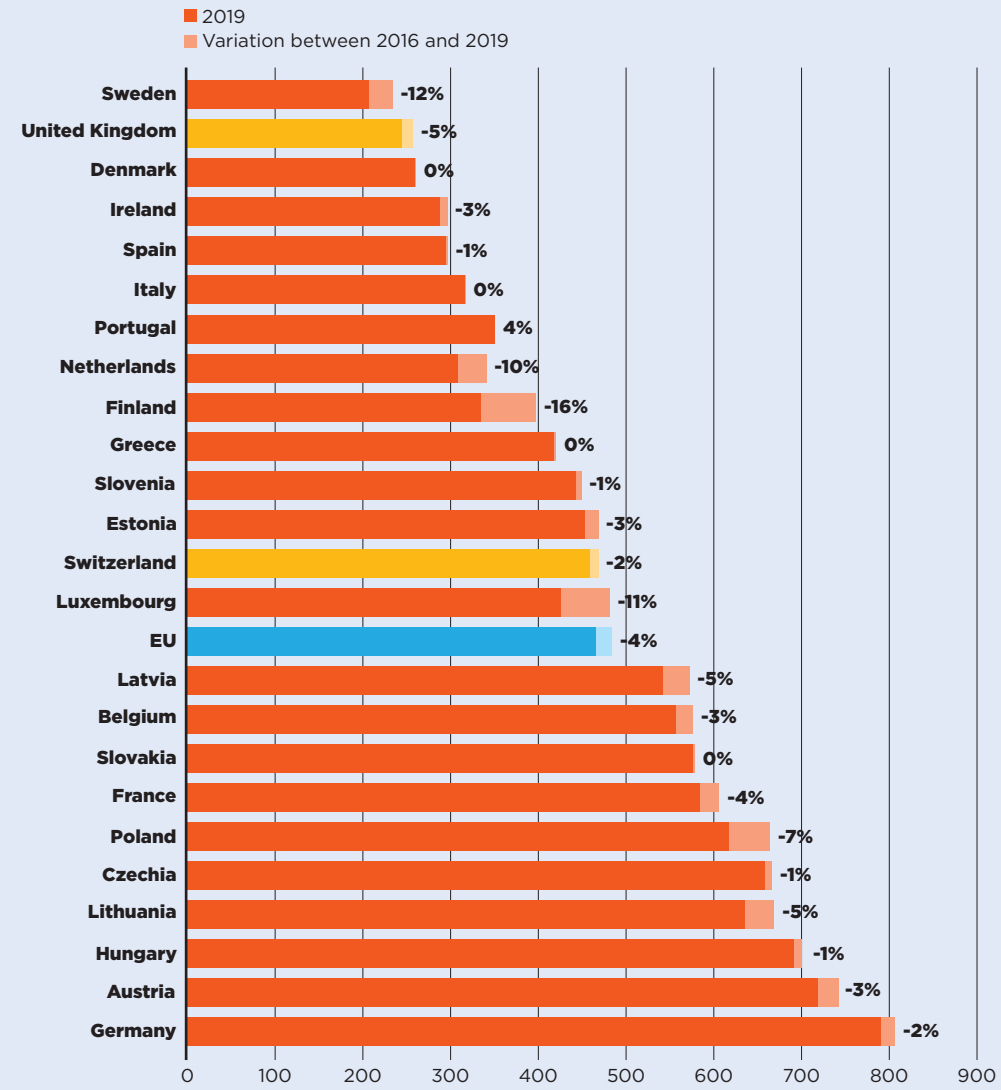


CHART 11

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 composition of the European healthcare workforce in 2019 shows an average rate of about 2.5 nurses per physician

healthcare resources and because the hospital sector gives work to more than half of active physicians.

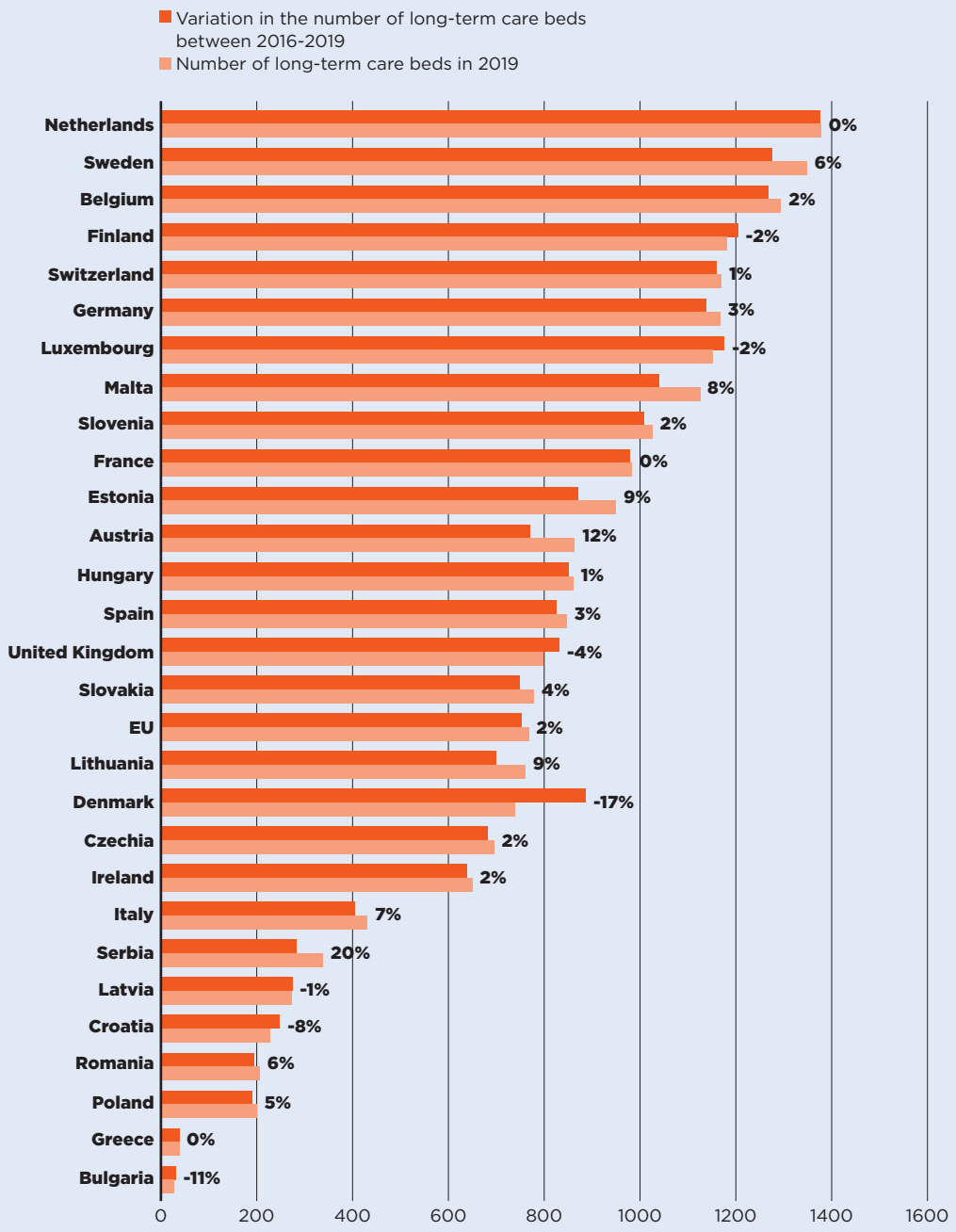
An overview of the composition of the European healthcare workforce in 2019 shows an average rate of about 2.5 nurses per physician.

In 2019, the share of practising nurses per 100,000 inhabitants was lowest in Greece (338), Latvia (439), Poland (510) and Spain (589) (Chart 16). The highest values belong to Germany (1395), Belgium (1107), Sweden (1085) and Switzerland (1796). For the same year, the lowest share of practising physicians was registered in Poland (238), the UK (295), Belgium (316) and France (317) whereas the highest values were in Austria (532), Lithuania (457) and Germany (439) (Chart 17).

These figures provide evidence 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

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



> 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%

rate of nurses per physicians is about 2.4 points. In 2019, the highest values were in Germany (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%). On the other side, 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, as there is not much data available for informal workers, this focuses 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; Netherlands; Estonia,

CHART 13

Comparison between the rate of inpatient discharges per 100 and average length of stay in acute care hospitals: Year 2019

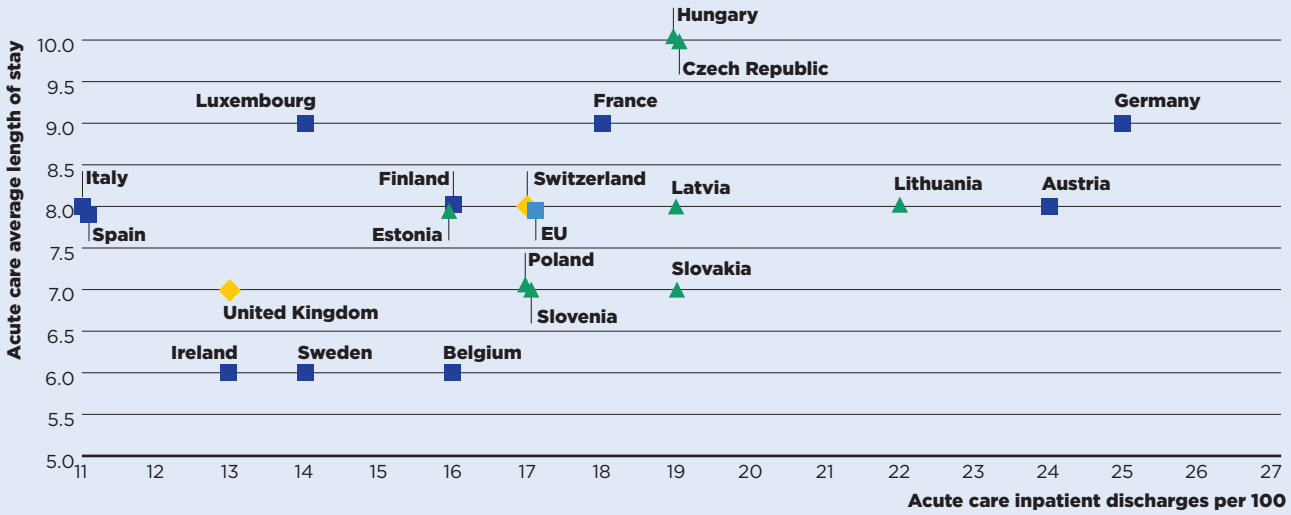
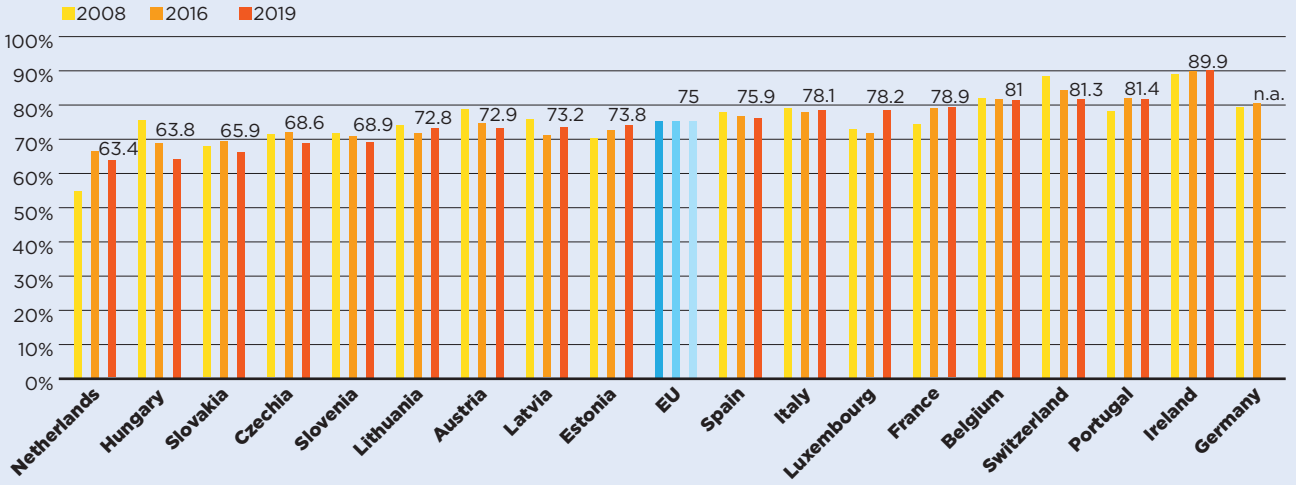


CHART 14

Bed occupancy rate for acute care hospitals: Years 2008, 2016, 2019



Denmark; Sweden; Luxembourg; Slovakia; Ireland; and Hungary. In 2019, Sweden had the highest number of formal workers per 100,000 population aged 65 years old and over (11,900), while 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 as 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 community care and day care centres and respite care. Home care also includes specially designed or adapted living arrangements (for instance, sheltered house) 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

CHART 15

Rate of practising nurses per physician: Years 2008, 2016, 2019

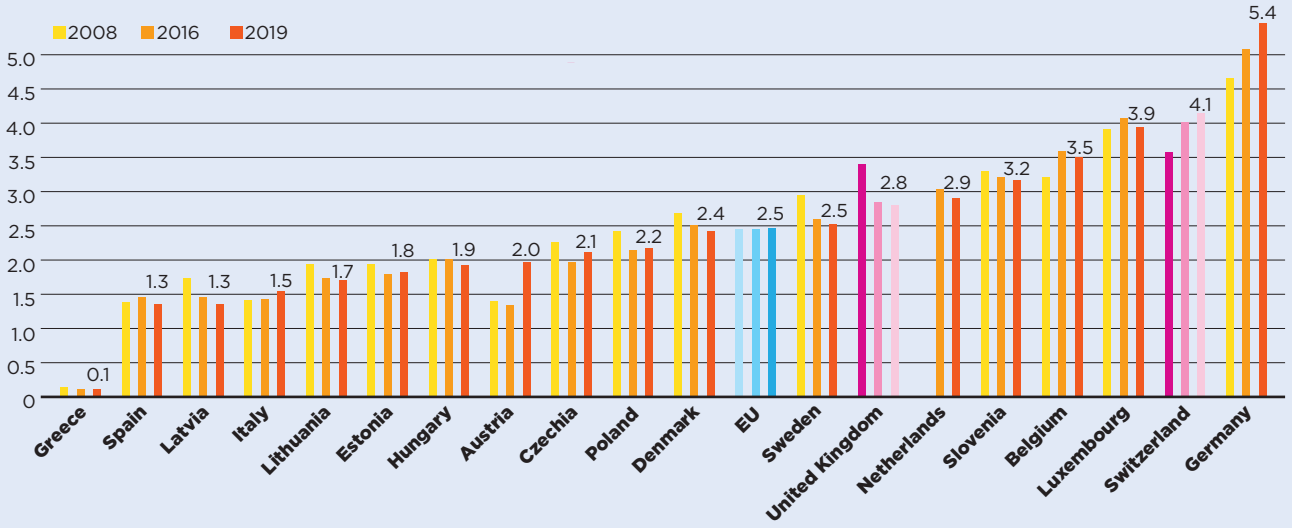
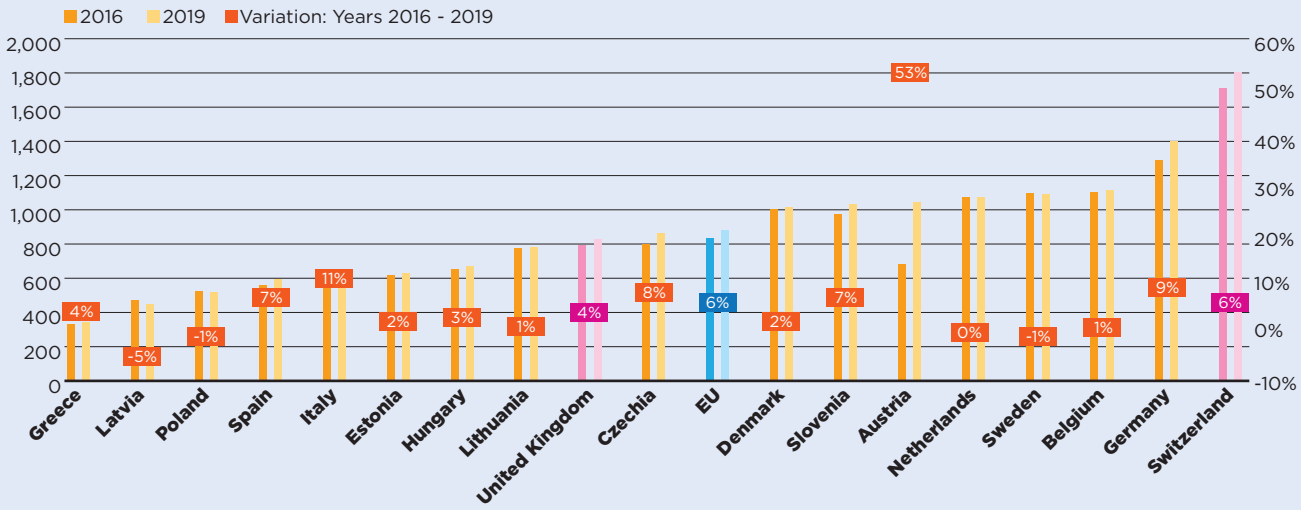


CHART 16

Number of practising nurses per 100,000 inhabitants: Years 2016–2019



patients' homes. The percentage of long-term care workers working at an institution varied 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.

Compared to 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 were seen in Switzerland, Sweden (+12%), and Hungary (+11%), where as there were decreases 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 (Chart 19). 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%).

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

CHART 17

Number of physicians per 100,000 inhabitants and number and % of physicians per 100,000 inhabitants working in hospitals: Year 2019

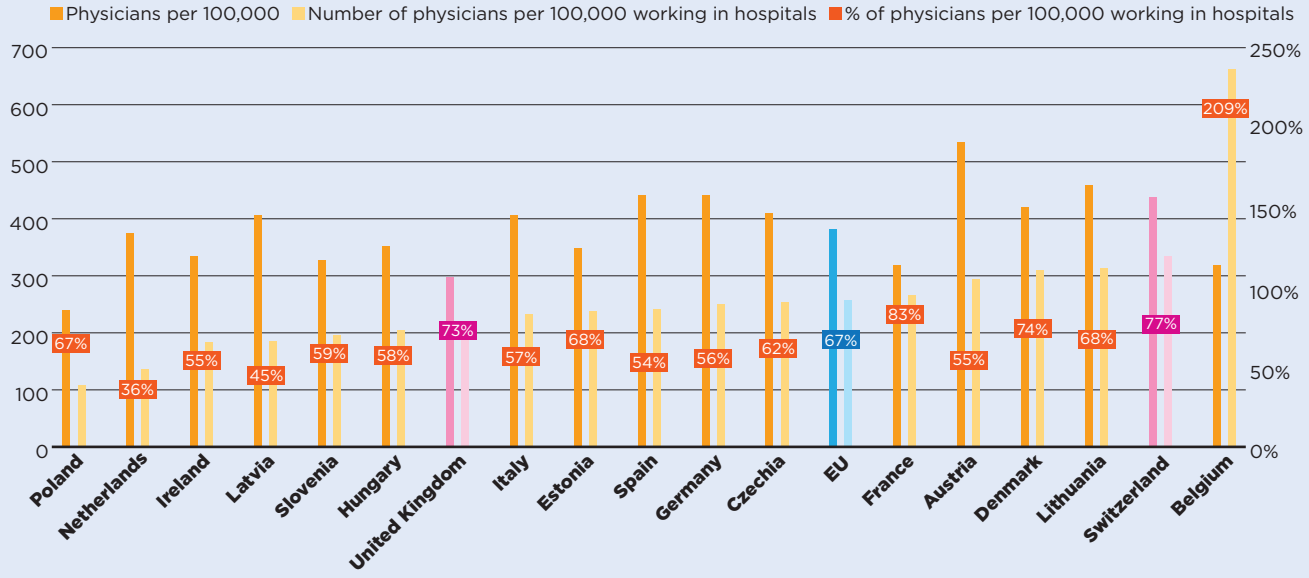


CHART 18

Number of medical graduates per 100,000 inhabitants: Years 2016–2019

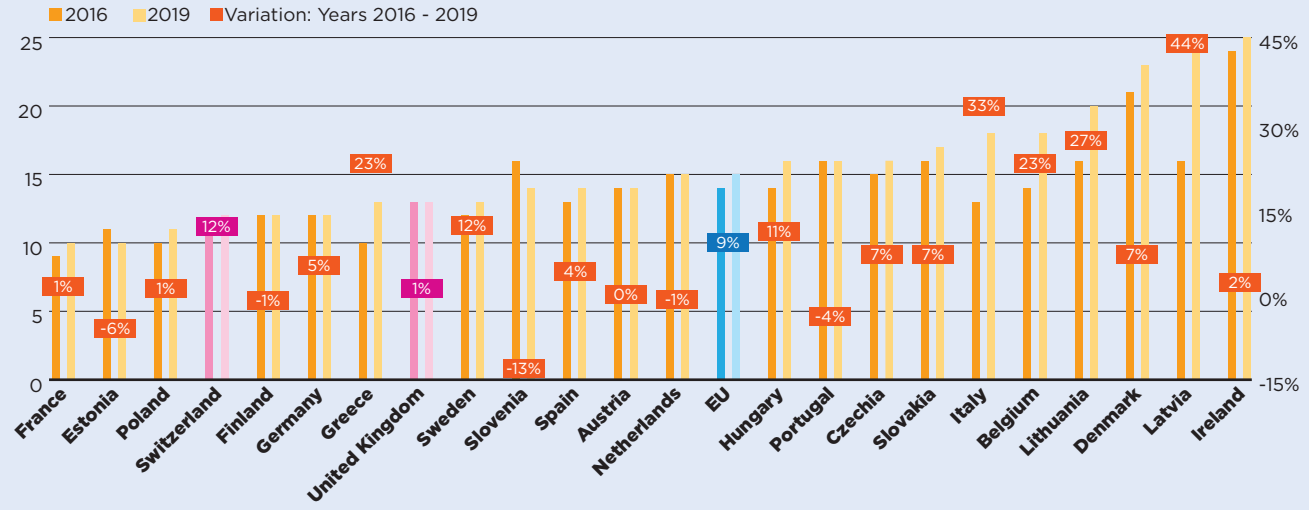
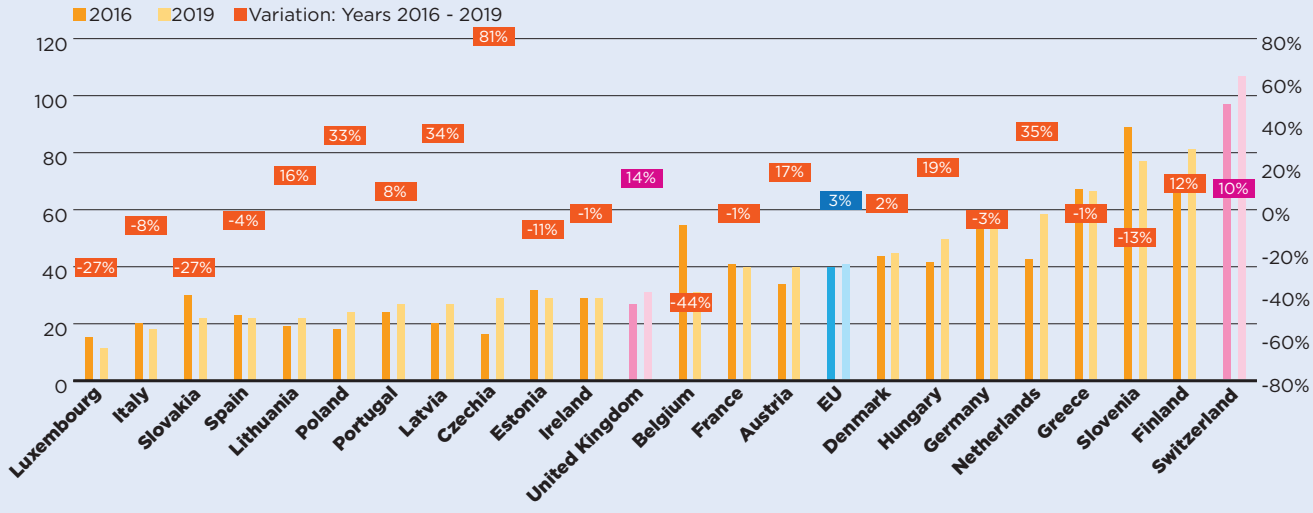


CHART 19

Number of nurses graduated per 100,000 inhabitants: Years 2016–2019



HOPE Governors' responses

HOPE Governors discuss their national COVID programmes and delivery, and the consequences of the pandemic on somatic 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

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health?

Different virus variants (and corresponding protection measures), especially seasonal ones, led to different stress situations and requirements in the hospitals. In 2020, the general measures included putting lockdown into effect, to prevent the spread of infection, and implementation of a test system. Protection measures were implemented in hospitals. Additional hospital capacities were created for these unknown and un-assessable hospitalisation needs.

The Ministry commissioned a study on the impact of the pandemic on inpatient care in Austria in 2020 (see https://jasmin.goeg.at/1633/). The results showed that in the areas analysed there was – with the exception of stroke – 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 PPE, more testing possibilities and increased knowledge about COVID-19 gleaned during the first phase of the pandemic, the reduction was comparatively moderate considering the considerable number of hospitalised COVID-19 patients.

The vaccination programme commenced in 2021. The Delta variant brought with it an increased risk of infection with a similar severe course of disease and hospitalisation requirements as before. This was the first time for an increased capacity utilisation with intensive care capacities regionally exceeding the utilisation limit. In all federal states, elective surgeries had to be reduced to some extent to enable adequate capacity for COVID-19 patients in intensive care units. By 2022, the Omicron variant changed some of the framework conditions. Compared with Delta, the Omicron variant is more infectious, but the course of the disease is milder (also due to vaccination) although the targeted level of vaccinations could not be achieved. Nevertheless, the high number of cases resulted in a high rate of hospitalisation. This again led to increased capacity utilisation, mainly regarding normal care capacities. At the same time, incapacity to work and segregation led to staff absence.

A (seasonal) additional demand for different resources has not yet been considered by structural planning in the health care system. In addition to the physical availability of beds, the utilisation of normal and/or intensive care units, as well as sick or separated health care staff, are limiting factors. In addition to regular monitoring activities, structural-, organisational- and personnel-related measures must be taken to ensure appropriate capacities in hospitals (e.g., beds, staff, equipment, protective gear). Flexible deployment of staff and flexible use of capacities are central to this. Framework conditions at federal and state levels are also important. The main objective is to cope with the (at least to some extent) seasonal increase in demand for COVID supplies care while largely maintaining standard care.

Also, mental health is a big focus, because depression, anxiety disorders and other mental

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**

health problems were aggravated or increased during the pandemic. An advisory group of experts in the Ministry of Health works on necessary measures, also addressing the mental health of children and juveniles and the subsequent issues arising in these populations. Various measures to improve the supply of specialists for psychiatry and psychotherapeutic medicine and for child and adolescent psychiatry are being examined, and thereby being able to offer patients easy and accessible comprehensive and multidisciplinary care.

To achieve the best possible coverage of demand, both specialties have already been classified as shortage subjects, and in the field of child and adolescent psychiatry, the training key was expanded by law at the beginning of 2022 to be able to train more physicians in this specialty. Additional quality assurances must be implemented to accompany such measures. Also, social paediatric facilities and child and adolescent psychiatric networks are included in comprehensive care considerations.

BELGIUM

Mr Francis De Dree
HOPE Governor

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff, etc?
In Belgium, 52% of the population have received the dose of the vaccine, producing a sharp decrease of infections during the past two months. There are only 1000 people in hospital due to COVID-19 and 400 people in the ICU. The vaccination strategy is based on age and comorbidities and takes place mainly in vaccination centres. However, some hospitals are used for specialised vaccination, e.g., for oncology patients. The strategy challenges are mainly people not wanting to receive the vaccination and uncertainty. This varies among regions: vaccination willingness is high in Flanders and lower in Wallonia and Brussels.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health?
During the two first waves of COVID, impact on care delivered to non-COVID patients was significant, notably given legal restrictions on hospitals. For 2020 and 2021, hospitals' main activities decreased by 10%–20%. Teleconsultation partially replaced in-person care. More than 30% of the Belgian adult population received care by phone and/or online, which is significantly lower than the OECD average.

COVID had a huge impact on mental health. Nearly 20% of the total population declare symptoms of depression (an increase of 100% compared with the pre-COVID period).

BELGIUM

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	**9.7%**	**10.8%**	**10.7%**
General government/compulsory current health expenditure, as % of total current health expenditure	75.5%	77.3%	76.8%
Hospital current health expenditure, as % of total current health expenditure	**35.7%**	**36.1%**	**38.3%**
Household out-of-pocket health expenditure, as % of total current health expenditure	20.2%	18.0%	18.2%
All hospital beds per 100,000 inhabitants	**624.9**	**576.4**	**556.7**
Acute care hospital beds per 100,000 inhabitants	559.4	512.1	500
Average length of stay for acute care hospitals (bed-days)	**7.4**	**6.8**	**6.5**
Practising physicians per 100,000 inhabitants	292.1	307.0	316.0
Practising nurses per 100,000 inhabitants	**632**	**1090**	**1037**

BULGARIA

Mr Krasimir Grudev
HOPE Governor

COVID-19 vaccination: how did it go, what was the involvement of hospital and healthcare services, adherence of healthcare staff?
Since the beginning of the pandemic, the total number of confirmed cases of coronavirus in Bulgaria is 1,253,934 (17.6% of the population), of which 1,207,195 (17% of the population) have been cured to date. Of these, the number of medics with proven coronavirus infection is 25,751 (38% of all). There are no data on the actual number of people who have become infected; it is assumed that the number is five-times more.

The number of deaths from COVID-19 as of 21 September 2022 was 37,694 (3% of confirmed cases and 0.53% of the population).

Currently, 1% of all available hospital beds, in a small number of hospitals, are engaged in the fight against the COVID pandemic.

The total number of doses of the COVID-19 vaccine administered was 4,540,537 (64% of the population). 2,071,300 people (29% of the population) were fully vaccinated.

As of 21 September 2022, 881,410 had received a booster dose, of which 72,704 had received a second booster.

Almost all hospitals have by now restored normal work practices and admission of patients.

However, the trend of increasing complicated medical cases in non-COVID patients due to untimely treatment or lack of treatment due to the pandemic continues. Cases of long COVID are also increasing. Clinical pathways have been developed and are already being implemented for the rehabilitation of patients with long COVID or with other complications due to a more severe COVID infection.

Research on the impact on the mental health of non-COVID patients has not been carried out in our country.

BULGARIA

	2008	2016	2019
Total current health expenditure as % of gross domestic product (GDP)	**n.a**	**n.a**	**n.a**
General government/compulsory current health expenditure, as % of total current health expenditure	n.a	n.a	n.a
Hospital current health expenditure, as % of total current health expenditure	**n.a**	**n.a**	**n.a**
Household out-of-pocket health expenditure, as % of total current health expenditure	n.a	n.a	n.a
All hospital beds per 100,000 inhabitants	**660.8**	**726.9**	**641.2**
Acute care hospital beds per 100,000 inhabitants	554.4	603.1	641.2
Average length of stay for acute care hospitals (bed-days)	**n.a**	**n.a**	**4.7**
Practising physicians per 100,000 inhabitants	366.4	n.a	n.a
Practising nurses per 100,000 inhabitants	**431.3**	**n.a**	**n.a**

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, etc?
When immunisation of the public began, vaccination was organised primarily based on six priority groups in vaccination centres, and later also in medical practices and pharmacies. In addition to vulnerable patient groups, vaccination was offered as early as possible to hospital personnel as one of the priority groups. The demand from hospital employees was generally very high. Batches of the vaccine for the vaccination centres were delivered directly to hospitals to allow vaccination of personnel on site.

Institutionally-related mandatory vaccination has been in place Germany since 16 March 2022. This stipulates that those persons employed in hospitals that had not submitted proof of vaccination or recovery by 15 March 2022, and that are not subject to any medical contraindication for a COVID-19 vaccine, were to be reported by the hospitals to the competent public health authority. This measure was founded on the grounds of protection of patients from others in order to reduce transmission frequency by specialised staff and was to serve as the precursor for general mandatory vaccination of the public. The attempt to introduce mandatory vaccination for the public failed in April 2022. An important argument for rejecting general mandatory vaccination was that it would not necessarily prevent transmission. Against this backdrop, institutionally-related mandatory vaccination has also become the focus of attention of a politically controversial discussion.

A questionnaire undertaken by the German Hospital Institute in March 2022 shows that, on 23 March 2022, 94% of hospital employees were fully vaccinated or recovered. According to occupational groups, the average reporting rate in the nursing service (7%) was somewhat higher than for doctors (3%).

As of 2 September 2022, 77.9% of the public had received primary immunisation and 62% an additional booster vaccination; 8.7 % have already received a second booster vaccination. There is no approved vaccine available for 4 million of the 18 million unvaccinated, partly due to age (predominantly children are affected) or intrapersonal factors, such as a disability or other pre-existing medical conditions and predispositions (e.g., rare coagulation disorders).

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health?
Beds in German hospitals were kept free to ensure sufficient capacity available for the care of coronavirus patients, and planned treatments were postponed. According to the Federal Statistical Office, it is to be assumed that, in addition to this, many people have also delayed essential hospitalisation, partly also in order not to overburden the healthcare system. The number of treatment cases and bed occupancy rate in 2021 remain under the pre-pandemic level. The number of treatment cases fell from 19.4 million in 2019 to 16.7 million in 2021. Bed occupancy decreased from 77.2% to 68.0%. As these changes have serious repercussions on the financing related to the German Radiological Society (DRG) of hospital services, the publicly led debate on financial relief measures from policy makers to secure patient care is ongoing.

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

DENMARK

Mrs Eva M 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 Denmark, there has been a great willingness to get vaccinated. By August 2022, 84% of the population over the age of 5 years had received the first dose and 77% of the population over the age of 18 years had received second and third doses. Citizens over the age of 5 years were previously invited to receive the first, second and third dose – this former vaccination programme has now been phased out and replaced by a new programme. If citizens do not receive the first three doses, they are still recommended to have them.

Based on previous experience, it is expected that COVID-19 will be a seasonal disease – we also know that the risk of a severe COVID-19 infection is higher in older age. In Autumn 2022, the vaccine will first be offered to residents of nursing homes and citizens over 85 years of age. For this group, it was available from 15 September 2022. Following this, the vaccine was offered to citizens over 50 years of age from 1 October. Employees from the healthcare sector who have close contact with patients and citizens who are in risk of severe COVID-19 will be offered a booster vaccine from 1 October 2022. The vaccines offered are variant-updated versions of Pfizer and Moderna vaccines.

Citizens will be offered the vaccine via digital post, whereafter it will be possible to book a timeslot for the vaccination. Citizens will be able to get vaccinated at public vaccination centres, private vaccination centres and some general practitioners.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?
The situation for other patients is, as in other EU countries, affected by delays. There is an agreement with the government to catch up on all the surgeries, but the work of reducing the delays is ongoing.

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	784%	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	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 at the beginning of 2021 was for 70% of adults to be fully vaccinated by the start of Autumn. We did not reach that goal by Autumn 2021, but in Autumn 2022, 75.8% of adults and 65.2 % of the whole population are vaccinated. The vaccination programme started with healthcare workers and older people in care homes, but since May 2021, vaccination has been available for everyone. Health care staff has been willing to being vaccinated, which has resulted in a positive outcome of decreasing numbers of infections in staff. The support of health care workers was confirmed with the signing of national collective agreement in 2021 where it was stated that vaccinated workers receive additional vacation bonuses while non-vaccinated workers do not. Our vaccination plans are currently being renewed by the government to consider new vaccines.

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health (figures available, measures taken, etc)?
During different phases of the pandemic, there has been a need to postpone planned health care services for non-COVID patients. Medical departments and hospitals have been working overtime as much as possible to get these services back on track. But in doing so, the hospitals face difficulties not only with lack of staff but also with funding. There is a separate funding measure for COVID treatment in the Health Insurance Fund and for 2023 there is also a separate budget planned to deal with the longer waiting times for planned care.

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%	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**

LUXEMBOURG

Mr Marc Hastert
HOPE Governor

What were the consequences on the care delivered to non-COVID patients both on somatic and mental health and strategy to avoid having to reschedule hospital care?
The right to protection of one's health is a right that every citizen can claim from the state as a subject of rights. The state is therefore obliged to manage its health system in such a way that situations leading to non-treatment or insufficient treatment are avoided.

Concerning the impact on the care of non-COVID patients, there have not been many issues so far, except for mental healthcare, but this is an established 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 was also a two-way stream implemented in emergency services for COVID-19 patients and for non-COVID-19 patients.

Generally speaking, the number of hospitalisations remained stable and did not increase alarmingly, and the situation of the health system in the Grand Duchy of Luxembourg was not overloaded due to COVID-19 hospitalisations, both during the Delta and Omicron periods.

With uncertainties for the future, a group of experts convened by the government recommended the introduction of a partial vaccination obligation that applies to people over the age of 50 (residents). Partial vaccination is therefore intended to be risk-targeted and would concern only a fraction of the general population. The primary objectives are the maintenance of a fully functioning health system for COVID and non-COVID patients, the protection of the vulnerable and a normalisation of life for most citizens.

Some particular features of Luxembourg (a very open society; high mobility of the population; a very high number of cross-border workers) make it unfeasible to contain the circulation of the virus at the level of the whole society. Therefore, the main purpose of compulsory vaccination is to protect the health services, and in particular hospitals (intensive care and normal care), to ensure normal functioning.

Hospital beds and hospital staff workload are at the forefront of the debate on partial and sectoral vaccination. The acceptable burden on intensive care units, hospitals, society and the economy must be decided at the political level and ultimately by society as a whole. However, from the hospitals' point of view, the critical level, which corresponds to 38 intensive care beds and 138 normal care beds occupied by

COVID-19 patients, is declared when there is a need to cancel clinical interventions.

The age threshold proposed by the experts is 50 years because older age is associated with a risk of severe COVID complications and the risk factors and co-morbidities that predispose to severe COVID are also more frequent from the age of 50 onwards.

However, a sectoral vaccination requirement for the health and care sectors would only be recommended in the case of a highly virulent variant. Even then, vaccination should provide at least 50% protection against infection and transmission. All things considered; this is unlikely with current vaccines. Therefore, the majority of the expert group considers that a sectoral vaccination obligation cannot be recommended at this time.

It is therefore strongly recommended that the vaccination status – even independently of SARS-CoV-2 – should be subject to special regulations governing the responsibilities of persons working in the health and care sectors towards care recipients. This would include the obligation to disclose one's vaccination status.

At present, only a draft law on compulsory vaccination has been timetabled with the proviso that it will only be finalised if the health situation worsens to such an extent that no other outcome is possible.

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%
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**	**1172**	**n.a**

PORTUGAL

Prof Carlos Pereira Alves
HOPE Governor

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

According to the Portuguese Central Administration of the Health System (ACSS) data, primary and hospital healthcare activity in the National Health Service (Serviço Nacional de Saúde – SNS) registered a significant recovery up to the end of February 2022.

In the first two months of 2022, 40.4% more surgeries were performed compared with 2021. The median waiting time on the surgical waiting list was 3.1 months at the end of February, which corresponds to a 24.8% reduction compared with 2021.

SNS hospitals carried out 15.6% more medical appointments compared to the same period in 2021, which is still in line with the values recorded in the same period of 2020 and 2019.

The data also indicate that emergency episodes recorded up to February, were above (55.2%) that of 2021 but still below (-19%) the pre-pandemic figures.

In primary healthcare there were around 5.3% fewer medical appointments than in 2021 but 10.4% more than in 2020. Of this total, 43.3% of medical appointments were face-to-face, which corresponds to a 38.4% increase over the same period in 2021.

PORTUGAL

	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**

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 always voluntary and the willingness to get vaccinated is generally high. By September 2022, 87% of all residents aged 12 and over had received at least one dose and 85% had received two doses of vaccine. A total of 67% of all residents aged 18 and over had even received a third dose. The rate of vaccination is higher among elderly people, as this age group has been given priority. In February 2022, elderly people were recommended to take a fourth dose, and by September 2022 approximately 76% of all residents aged 65 and over had received four doses. In August 2022, the Public Health Agency of Sweden recommended that everyone aged 65 and over, and persons aged 18 and over belonging to any of the risk groups, take a booster dose.

Statistics shows that the vaccination rate is much higher among healthcare staff compared with other persons of working age.

In Sweden, individual regions are responsible for vaccinations. Vaccination for COVID-19 has taken place in many different settings, often in temporary premises or drive-in centres, but also in primary care centres and hospitals.

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 in the spring of 2020, hospitals managed to quickly transform wards into ICUs, and transfer healthcare professionals from one part of the system to another. There was also a significant increase of digital services.

At the same time, there was initially less pressure on other parts of hospital services (cardiology, oncology) 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 to 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.

Although many people still fall ill with COVID, there are now (September 2022) significantly fewer people who need hospital care. Apart from a peak in the beginning of 2022 when the regions once again had to postpone planned treatments, the hospitals are trying to reduce the backlog for surgery from 2021. A problem then is the lack of qualified healthcare staff, e.g., specialist nurses.

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**	**1093**	**1085***

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?
The UK has now vaccinated 45 million people (93.2% of the population aged 12+); 42 million had a second dose (87.2%), and 33 million had a booster dose (68.7%). A fourth dose was offered this Spring to people aged over 75, adult care home residents, and individuals aged 12 and over who are immunosuppressed.

In early 2022, it had been intended to mandate vaccination as a condition of deployment for healthcare workers. However, on 31 January 2022, amidst concerns about the impact on capacity, and views that the staff vaccination rate was high, the Government revoked this imminent requirement, and this policy remains. Local leaders continue to encourage vaccine uptake at a local level.

The UK has experienced three major COVID-19 waves in 2022 and anticipates a particularly significant one in Autumn/Winter 2022. This will likely occur alongside seasonal flu. As such, plans are underway for vaccination for both infections. The NHS recommends covid, flu, and pneumococcal vaccines should be promoted and given together wherever possible, especially where this might improve uptake. The autumn booster programme is expected to include all adults over age 65, care home residents and staff, clinically vulnerable adults aged 16 to 64, and frontline social care and health workers, to maintain their protection over

the winter against severe COVID-19, reducing hospitalisation and death over this period.

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

In England there are currently about 6.5 million people awaiting NHS care, as well as significant pressure on urgent and emergency care. Significant progress has been made, but the waiting list for physical and mental health care does continue to grow. Progress has focused on eliminating the 104+ week waiting list by July 2022 with good results. The aim to deliver around 30% more elective activity by 2024/25 than before the pandemic is intended to address backlogs, but there is a range of capacity challenges, including ongoing COVID-19 waves, staff sickness, staff vacancies, and patient flow issues.

Our summary of progress against recovery targets in England up to the end of June 2022 can be found at www.nhsconfed.org/articles/what-latest-data-tells-us-about-progress-against-targets).

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%
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**

Andrea Porter, Content Director – Secondary Care
andreaporter@cogora.com

Rod Tucker, Clinical Assistant
rodtucker@cogora.com

James Depree, Art Director
jamesdepree@cogora.com

David Ling, Commercial Director
davidling@cogora.com

Edward Burkle, Executive Director
edwardburkle@cogora.com

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