European Commission









State of Health in the EU

Belgium

Country Health Profile 2021

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

The Country Health Profile series

The State of Health in the EU's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in Belgium, 2020

Demographic factors	Belgium	EU
Population size (mid-year estimates)	11 522 440	447 319 916
Share of population over age 65 (%)	19.1	20.6
Fertility rate[1] (2019)	1.6	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	34 783	29 801
Relative poverty rate[3] (%, 2019)	14.8	16.5
Unemployment rate (%)	5.6	7.1

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat database.

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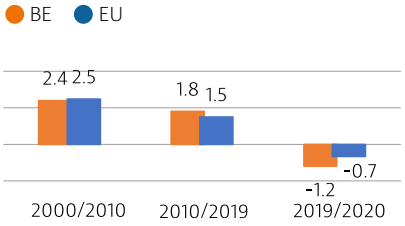
1 Highlights

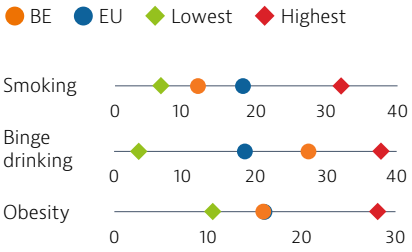
Life expectancy in Belgium remains slightly above the EU average, but it temporarily fell sharply in 2020 because of deaths due to COVID-19. While the Belgian health system provides good access to high-quality care, the COVID-19 pandemic highlighted important challenges with prevention and public health, the health workforce and quality of care in long-term care facilities for older people. The pandemic stimulated many innovative practices in Belgium that could be expanded to build a more resilient health care system.



Life expectancy gains, years

Health Status

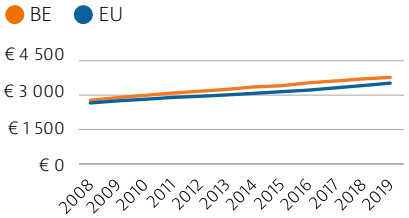
Life expectancy in Belgium increased more than the EU average between 2010 and 2019, but fell by more than a year in 2020 because of deaths due to COVID-19. About 60 % of the COVID-19 deaths in 2020 were among residents in long-term care facilities. As in many other countries, the mental health of many young people and adults in Belgium deteriorated greatly during the pandemic, with reports of anxiety and depression reaching much higher levels than in previous years.



Risk factors, % of adults

Risk factors

Risk factors for health are major drivers of ill health and mortality in Belgium. While tobacco consumption has substantially decreased over the past two decades, 15 % of adults were daily smokers in 2018. Nearly 30 % of adults reported regular heavy alcohol consumption in 2018, a rate well above the EU average. About 16 % of adults were obese in 2018, close to the EU average, but up from 12 % in 2001. Overweight and obesity among 15-year-old adolescents have also increased to 17 % in 2018, up from 11 % in 2002.



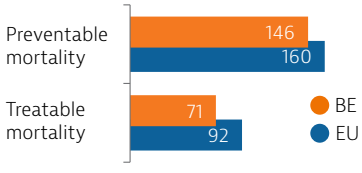
Per capita spending (EUR PPP)

Health system

Health spending per capita increased slowly between 2008 and 2019 and remains higher than the EU average. In 2019, health spending accounted for 10.7 % of GDP, up from 9.6 % in 2008, and also a higher share than the current EU average (9.9 %). Public spending accounted for 77 % of overall health spending – slightly less than the EU average of 80 %.

Effectiveness

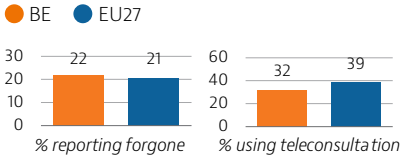
Avoidable mortality was slightly lower than the EU average before the pandemic, but higher than in many other western EU countries. This suggests that more could be done to save the lives of people through health promotion and a reduction of risk factors and through better health care.



Age-standardised mortality rate per 100 000 population, 2018

Accessibility

Although access to health care in Belgium is generally good, the COVID-19 pandemic significantly affected access to care in 2020: 22 % reported forgone care during the first 12 months of the pandemic, which is close to the EU average of 21 %. Growing use of teleconsultations helped maintain access to care during the pandemic.

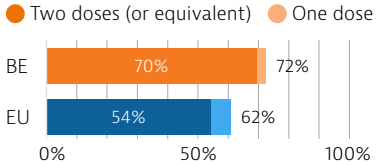


% reporting forgone medical care during first 12 months of pandemic

% using teleconsultation during first 12 months of pandemic

Resilience

Belgium was among the EU countries hardest hit by the COVID-19 pandemic in numbers of cases and deaths relative to its population size, particularly during the first wave. Belgium accelerated its vaccination campaign in the first half of 2021. By the end of August 2021, 70 % of the population had received two doses (or equivalent) of a COVID-19 vaccine.



Share of total population vaccinated against COVID-19 up to the end of August 2021

2 Health in Belgium

Life expectancy in Belgium remains slightly above the EU average, despite a sharp reduction in 2020

Life expectancy at birth reached 80.9 years in Belgium in 2019 and remains slightly above EU average (Figure 1), although it temporarily dropped by 1.2 years in 2020 because of deaths due to COVID-19. This was the biggest reduction since the Second World War, and one of the largest drops among EU countries. The gender gap in life expectancy was 4.5 years in 2019 (78.6 years for men and 83.1 years for women) – about one year below the EU average.

Figure 1. Life expectancy in Belgium is slightly above the EU average, despite a large reduction in 2020



Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

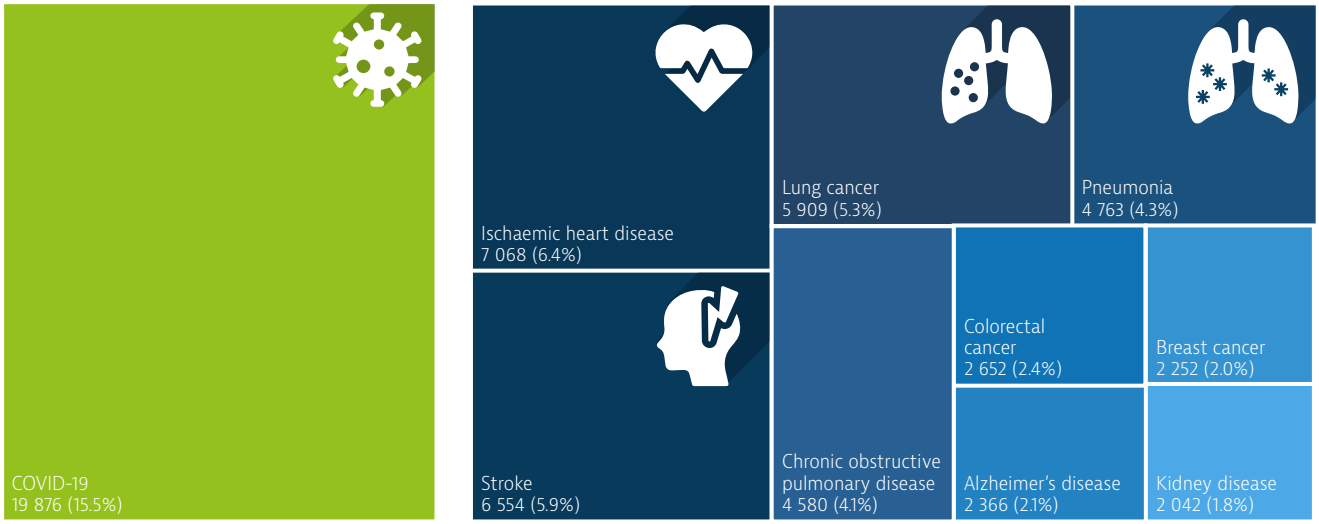
Ischaemic heart disease, stroke and lung cancer were the main causes of mortality before the pandemic, but COVID-19 was the leading cause of death in 2020

In 2018, circulatory diseases accounted for 26 % of all deaths in Belgium, followed by cancer (24 %). Looking at more specific diseases, ischaemic heart disease (6 % of all deaths) and stroke (6 %) were the leading causes of mortality, followed by lung cancer, which remained the most frequent cause of cancer death (Figure 2).

In 2020, COVID-19 accounted for nearly 20 000 deaths in Belgium (15 % of all deaths). The vast majority of deaths occurred among older people: about 94 % of deaths were among those aged 65 and over, and over 50 % among people aged 85 and over. The number of COVID-19 deaths was roughly equal (about 9 300 deaths) during the first wave in spring 2020 and the second wave in autumn 2020, although deaths during the first wave were concentrated in fewer weeks than those in the second wave. Another 5 500 people died from COVID-19 from January to August 2021.

The mortality rate from COVID-19 to the end of August 2021 was almost 40 % higher than the EU average (2 200 per million population compared with 1 590), mainly due to higher death rates during the first wave. However, while Belgium recorded deaths due to COVID-19 fairly accurately, several other EU countries are likely to have underestimated their rates because of limited testing and issues related to attribution of causes of death (Box 1).

Figure 2. Ischaemic heart disease, stroke and lung cancer were the main causes of death in recent years, but COVID-19 accounted for a large share in 2020



Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.
Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

Box 1. Belgium had a broader definition for recording COVID-19 deaths than many other EU countries

The number of deaths from COVID-19 reported by countries depends on their testing activities and whether they count only confirmed cases or also include suspected cases. In Belgium, reported COVID-19 deaths include both confirmed and suspected cases in any setting. Since many other EU countries only count confirmed cases, this makes it difficult to compare rates.

The indicator of excess mortality (defined as the number of deaths from all causes above what would have been expected based on the experience from previous years) can provide a measure of the impact of COVID-19 on total mortality that is less affected by cross-country differences in testing and cause-of-death registration practices. The number of COVID-19 deaths reported by Belgium in 2020 is very close to its number of excess deaths, providing validation of the registration approach used. In comparison, the number is much lower in several other EU countries, suggesting some underestimation of COVID-19 deaths. While Belgium reported the highest death rate from COVID-19 across the EU in 2020, it had the eighth highest excess mortality rate.

Most Belgians report being in good health, but over one in four adults have a chronic condition

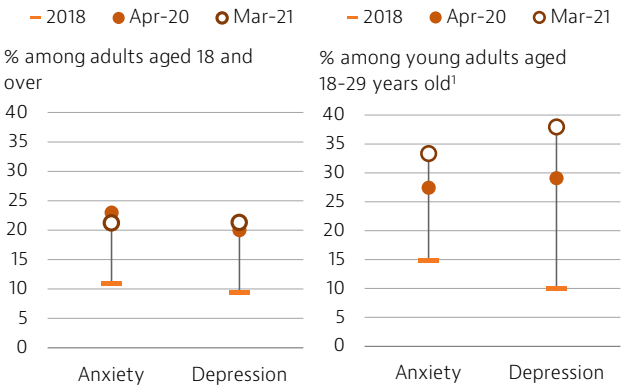
In 2019, about three quarters (74 %) of Belgian adults reported being in good health – a proportion higher than the EU average (69 %). However, as in other countries, there is a gap across income levels: 87 % of Belgian adults in the highest income quintile reported being in good health, compared with 59 % in the lowest. This difference is larger than in nearly all other western European countries. It is related to inequalities in exposure to risk factors and access to health care (see Section 3 and Section 5.2).

Over one in four Belgian adults (26 %) reported having at least one chronic condition in 2019 – a proportion much lower than the EU average (36 %), according to EU-SILC. As with self-reported health, there is a gap in the prevalence of chronic conditions by income group: 39 % of Belgian adults in the lowest income group reported having at least one chronic condition compared with 16 % in the highest.

The COVID-19 pandemic led to higher rates of mental distress

The mental health of many people in Belgium deteriorated during the pandemic. For example, the prevalence of anxiety and depression symptoms among adults more than doubled during the first wave, then fell during summer 2020 when the restriction measures were loosened (but not to pre-COVID-19 levels), and returned to similar rates during the second wave (Figure 3). By March 2021, the rates had lowered slightly, but remained almost twice the 2018 level.

Figure 3. The two lockdowns in 2020 had a negative impact on mental health



Note: 1. 2018 data for young adults refer to those aged 15-24.
Source: Sciensano (2021).

The mental health of young Belgians was particularly affected. Around 30 % of those aged 18-29 had symptoms of depression in April 2020 – a rate about three times higher than in 2018.

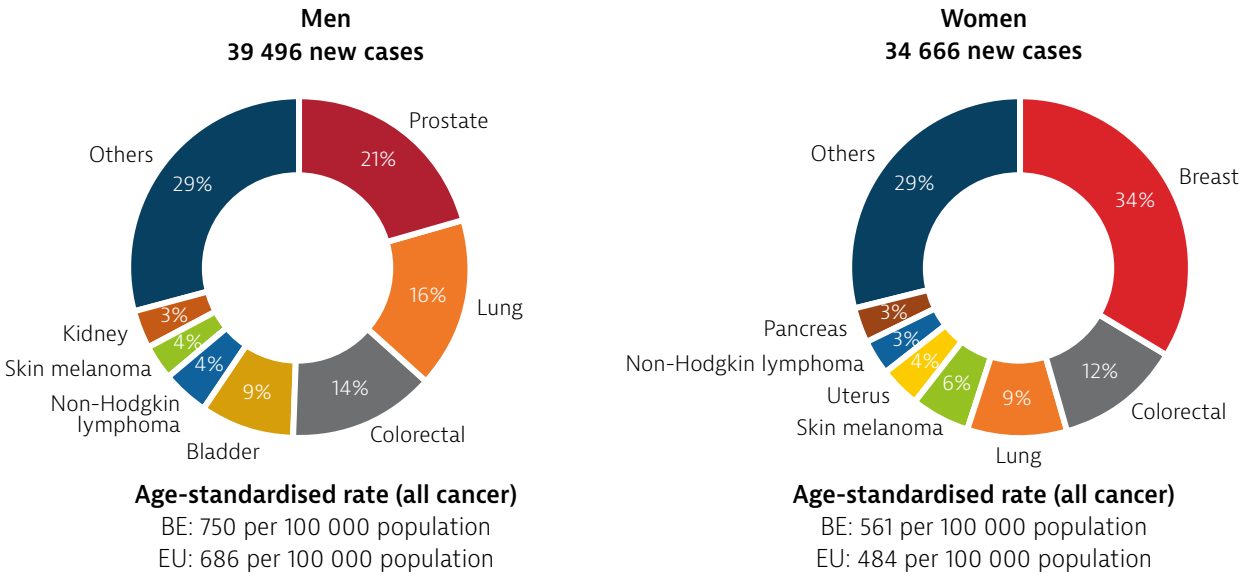
The situation further deteriorated from the second wave of the pandemic: nearly 40 % reported some symptoms of depression in March 2021. Since early April 2020, the Belgian public health care system has covered up to eight visits to a psychotherapist per year with a doctor's referral.

The incidence of cancer is greater in Belgium than the EU average

According to estimates from the Joint Research Centre, based on incidence trends from previous years, about 74 000 new cases of cancer and about 30 000 deaths from cancer were expected in Belgium in 2020. Cancer incidence in Belgium is greater than the EU average both for men and women. The most frequent cancer sites among men are prostate (21 %), lung (16 %) and colorectal (14 %), while among women breast cancer is the leading cancer (34 %), followed by colorectal (12 %) and lung cancer (9 %) (Figure 4).

The crude rate of cancer incidence increased by 11 % between 2006 and 2017, mainly due to population ageing and more widespread screening.

Figure 4. About 74 000 new cases of cancer were expected in Belgium in 2020



Note: Non-melanoma skin cancer is excluded. Uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

3 Risk factors

Behavioural risk factors are a major driver of mortality

Over one third of all deaths in 2019 can be attributed to behavioural risk factors, such as tobacco smoking, dietary risks, alcohol consumption and low physical activity, while air pollution also contributes to a sizeable number of deaths (Figure 5).

Tobacco smoking (including direct and second-hand smoking) was estimated to be responsible for about 20 000 deaths in Belgium in 2019 (18 %) – a share slightly higher than the EU average. Dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption) accounted for nearly 13 000 deaths (11 %) – a share well below the EU average. About 7 000 deaths (6 %) can be attributed

to alcohol consumption – a proportion similar to the EU average – while about 2 500 (2 %) are related to low physical activity. Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for about 3 800 deaths (3 %), mainly related to cardiovascular diseases, respiratory diseases and some types of cancer.

Figure 5. Tobacco, dietary risks and alcohol consumption are major contributors to mortality



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Excessive alcohol consumption remains higher than the EU average

While overall alcohol consumption has decreased in Belgium since 2000 and is now slightly below the EU average, excessive alcohol consumption (binge drinking [1]) is more common than in most other EU countries (Figure 6), and the gender gap is marked: 37 % of men reported binge drinking at least once per month in 2018 compared to 18 % of women.

Nearly one in five 15-year-olds reported having been drunk at least twice in their life in 2018, although this share is lower than in many other EU countries. Early drinking can lead to harmful alcohol consumption habits later in life.

Tobacco consumption has decreased and is lower than in many other EU countries

About one in seven adults were daily smokers in Belgium in 2018, a rate lower than in many other EU countries. Although smoking rates have decreased more among men than women, men (19 %) still smoke much more than women (12 %). Smoking rates among 15-year-olds have strongly declined and are now among the lowest among EU countries. The 2021 tobacco price increase should contribute further to reducing tobacco consumption (see Section 5.1).

However, use of e-cigarettes has become more popular, especially among teenage boys and young men. Nearly 9 % of men aged 15-24 reported smoking e-cigarettes at least once a week in 2018, compared with only 2 % of young women.

Overweight and obesity rates have increased, driven by poor nutrition and low physical activity

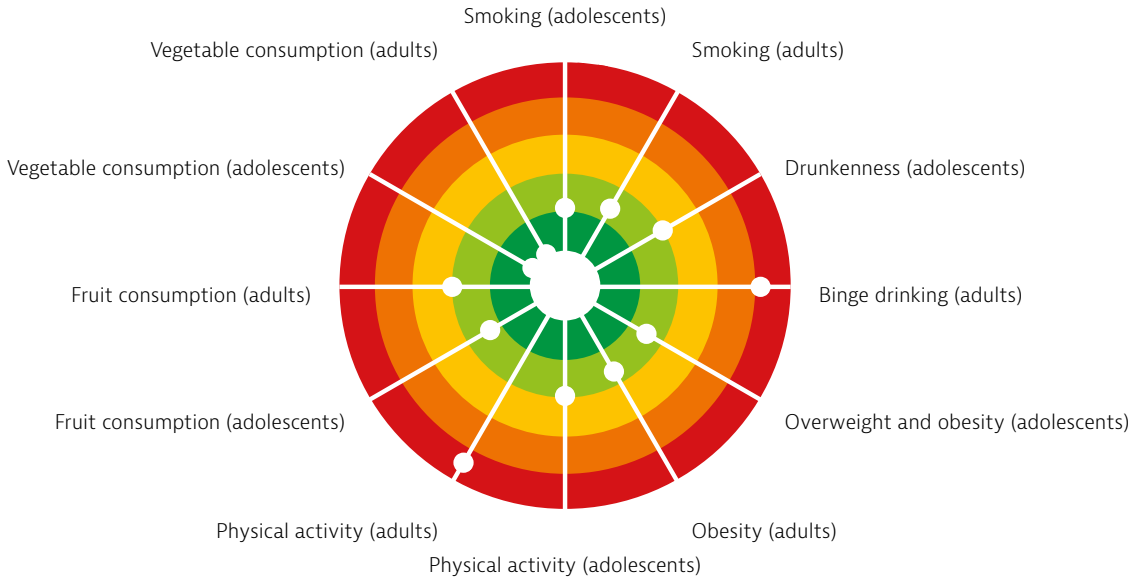
Over the past two decades, obesity rates among adults in Belgium increased by four percentage points to reach 16 % in 2018, but this remains lower than in most EU countries.[2] The rate of overweight and obesity among 15-year-olds has also risen steadily, from 11 % in 2002 to 17 % in 2018 – this is higher than in many other EU countries, but slightly below the EU average (19 %).

Poor nutrition, such as low consumption of fruit and vegetables and high intake of sweet beverages, contributes to the rise in overweight and obesity rates. In 2018, about 45 % of adults reported that they did not eat any fruit daily and 24 % did not eat any vegetables daily, while 64 % of 15-year-olds reported that they did not eat any fruit daily and 40 % did not eat any vegetables daily. Nevertheless, all these shares are lower than in many EU countries. According to a comprehensive food consumption survey, adolescents in Belgium were generally consuming lower amounts of fruit and vegetables per day than the EU average (Sciensano, 2019).

1: Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.
2: Based on actual measurements of people's height and weight, obesity rates in Belgium increased from 19 % in 2014 to 21 % in 2018.

Low physical activity is also an important risk factor in overweight and obesity. Belgian adults are less physically active than those in most EU countries: 44 % did not meet the WHO recommendation of at least 2.5 hours of moderate physical activity per week in 2018. Physical activity is also less common among adolescents than in many EU countries, and this is particularly the case among girls: only 10 % of 15-year-old girls reported doing at least moderate physical activity each day in 2018, compared to 20 % of boys.

Figure 6. Excessive alcohol consumption is an important public health issue



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; and EHIS 2018-2019 for adults indicators.

Social inequality contributes to health risks

Many behavioural risk factors in Belgium are more common among people with lower education or income levels. In 2018, 22 % of adults with no more than secondary education smoked daily, compared to only 10 % of those with tertiary education.

Similarly, 22 % of people with no more than secondary education were obese in 2018, compared to only 12 % of those with higher education. This higher prevalence of risk factors among socially disadvantaged groups largely contributes to inequalities in health and life expectancy.

4 The health system

Compulsory health insurance ensures near universal coverage in Belgium

Coverage is nearly universal in Belgium, with 99 % of the population covered for health services. The remainder of the population are those who have not fulfilled administrative requirements (such as having a regular address). Belgium's compulsory health insurance is implemented through five private, not-for-profit national associations of sickness funds, one fund for railway personnel and one public sickness fund. It is managed by the National Institute of Health and Disability Insurance (INAMI-RIZIV). This public body determines reimbursement criteria, establishes and controls the budget, informs health care providers, promotes quality of care and organises negotiations between stakeholders.

The federal authorities and federated entities have different responsibilities for health

Federal authorities are responsible for regulating compulsory health insurance, health products and

the health professions, and for setting ambulatory and hospital budgets. Federated entities (regions and communities) are responsible for health promotion and prevention, organisation of primary care, social services and community care, financing hospital infrastructure and heavy medical equipment, and establishing hospital licensing standards. Inter-ministerial conferences are organised regularly to facilitate co-operation between the federal authorities and federated entities. Governance mechanisms were put in place during the COVID-19 pandemic to manage the crisis (Box 2).

Over one tenth of Belgium's GDP is spent on health

Belgium spent 10.7 % of GDP on health in 2019 – a share higher than the EU average (9.9 %). Health spending reached EUR 3 773 per capita in 2019 (adjusted for differences in purchasing power), which is slightly higher than the EU average (EUR 3 523) (Figure 7).

Public financing and compulsory private health insurance coverage made up 77 % of all health expenditure in 2019, compared with the EU average (80 %). Direct out-of-pocket (OOP) payments made up 18 % of overall health spending, while voluntary health insurance (VHI) accounted for the remaining 5 %.

Box 2. The COVID-19 pandemic was managed through new committees and at various governance levels

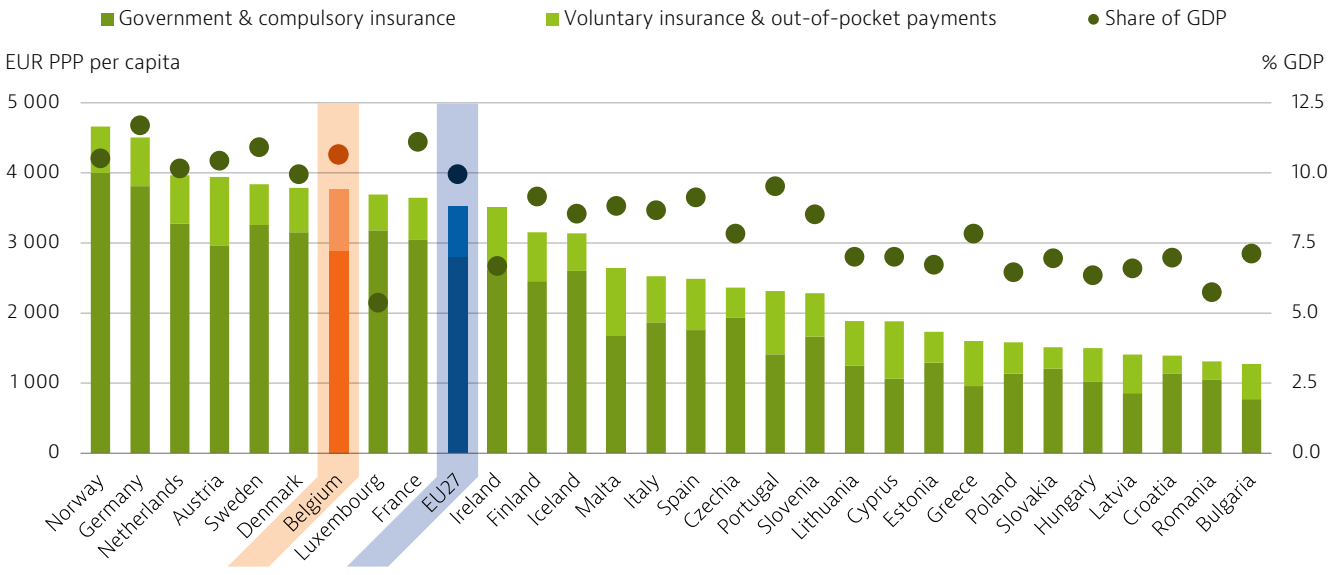
Since 12 March 2020, the National Security Council, comprising the Prime Minister, Deputy Prime Ministers and Ministers-President of the regions and communities, has led policy responses to COVID-19. The National Crisis Centre provides advice to the Council, supported by the Risk Assessment Group and the Risk Management Group. Many other advisory bodies, task forces and working groups share expert analysis and recommendations to support evidence-based decisions.

One key body – the Interministerial Public Health Conference, which was formed in the early 1980s to coordinate health policies across all Belgian authorities – actively participates in policy responses. It is composed of the eight ministries responsible for health or health-related topics among the Belgian authorities. Belgium is a federal state with three communities (Flemish, French and German) and three regions (Flemish, Walloon and Brussels) that have their own governance. Federal laws do not take precedence over regional decrees, so coordination across all authority levels is crucial.

Since 27 March 2020, the federal government has had special powers to act without going through the usual legislative procedures, to respond to the emergency in a timely manner. The scope of these powers entails urgent provisions relating to public health, public order, social services and safeguarding the economy and citizens.

In July 2020, municipalities received more power to take direct action if outbreaks occur. Although they cannot go against the legislation of federal and federated authorities, they can decide, for example, to implement more stringent measures in the case of outbreaks in their municipality without having to wait for approval from the federal government and federated authorities.

Figure 7. Health spending per capita and as a share of GDP is above the EU average



Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

The compulsory health insurance scheme, managed by INAMI-RIZIV, allocates a prospective budget to the sickness funds to finance the health care costs of their members. The budget is adjusted each year according to inflation and to a legal "real-growth norm", which guarantees stable funding for the health system. The legislated ceiling on public expenditure on health was reduced from a growth rate (in real terms) per year of 4.5 % in 2005-12 to 2 % in 2013. It was increased to 3 % in 2014 and then lowered to 1.5 % to contain costs from 2015. In 2020, the budgetary objective was maintained, although additional resources were provided to cover additional COVID-19 spending (see Section 5.3).

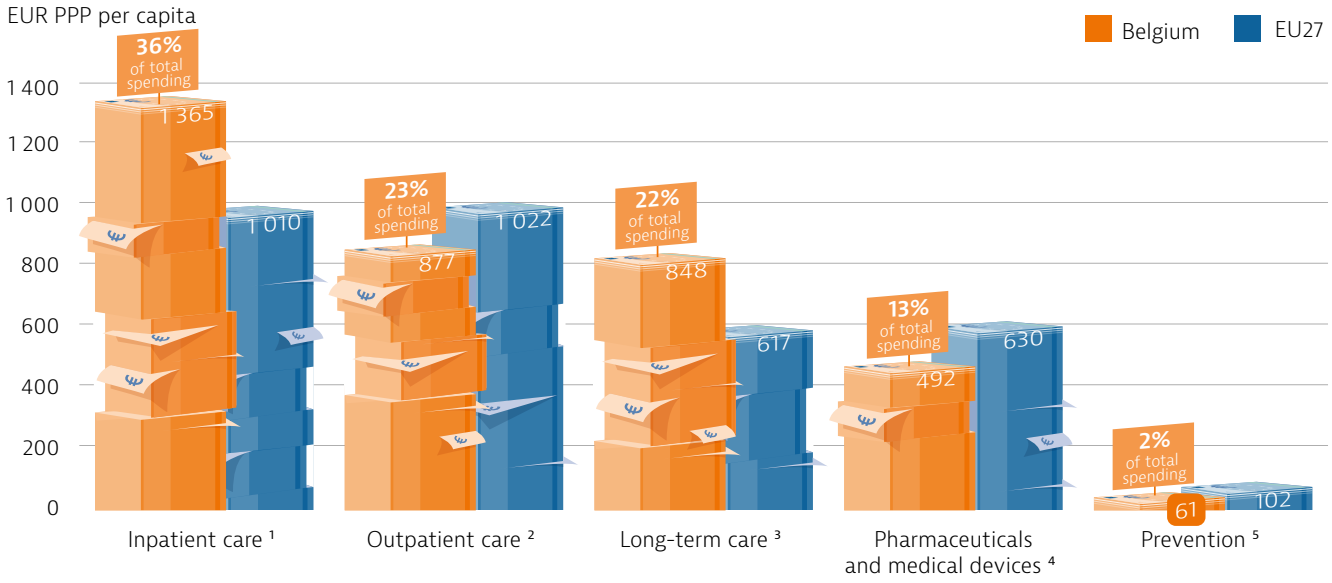
Funding of the health system has diversified to rely less on payroll contributions

Social contributions paid by employees, independent workers and employers make up the bulk of financial contributions to the health system. However, since 1995, reforms have diversified the funding sources to other revenue sources such as value-added taxes and subsidies from the state, to rely less on payroll contributions. Patients also contribute through OOP payments, which vary according to the status of the individual (some groups have access to preferential reimbursement), the type of service and the amount of co-payments already made. These user charges apply for most services, including general practitioner (GP) consultations and home visits, specialist consultations, outpatient pharmaceuticals, physiotherapy and inpatient hospital stays (per day).

Together, inpatient and outpatient care account for nearly 60 % of health spending

The largest category of health spending in Belgium is inpatient care, which accounted for over 36 % of all health expenditure in 2019 – higher than the EU average of 29 % (Figure 8). Nearly one quarter of health spending was allocated to outpatient care. Spending on the health component of long-term care (LTC) is substantially higher than in the EU overall, accounting for over one fifth of all health spending. One eighth of health spending was allocated to pharmaceuticals and medical devices dispensed outside hospitals. This category does not include pharmaceutical expenditure in hospitals, which is reported under inpatient or outpatient care. Spending on prevention accounted for only 1.6 % of all health spending, a share lower than the EU average of 2.9 %, but this only includes spending dedicated to organised prevention programmes and is thus underestimated.

Figure 8. Most health spending is on inpatient and outpatient care, with little on prevention



Note: The costs of health system administration are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes only the health component; 4. Includes only the outpatient market; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

Patients are free to consult any general practitioner or specialist

In Belgium, patients can consult any GP or specialist without referral (no gatekeeping). Primary care doctors are mostly self-employed. While most GPs work in solo practices, group practices are gaining popularity: 40 % of GPs worked in group practices in 2016, up from 30 % in 2011. A smaller share (9 % in 2016) collaborate in a formal network where they have regular contact and share medical records. Specialist care can be accessed mainly in hospital

outpatient departments but also in private practices. In 2018, Belgians had on average seven consultations per year with a doctor – slightly higher than the EU average. Doctors are mainly paid by fee for services. Community health centres with capitation-based remuneration are slowly increasing, from 53 centres in 2003 to 160 centres in 2016.

Numbers of doctors and nurses are increasing

The number of practising doctors was 3.2 per 1 000 population in 2019 – well below the EU average of 3.9 (Figure 9). Over the past decade, this number has increased at a slower rate in Belgium than in most EU countries, but the number of new medical graduates has risen substantially in recent years, which should contribute to increasing the supply (see Section 5.2).

The number of nurses has increased over the past decade to reach 11.1 per 1 000 population in 2018, up from 9.3 in 2008. Although this is well above the EU average (8.4 per 1 000 population), the patient-to-nurse ratio remains high in hospitals, and there have been difficulties in recruiting nurses in some areas.

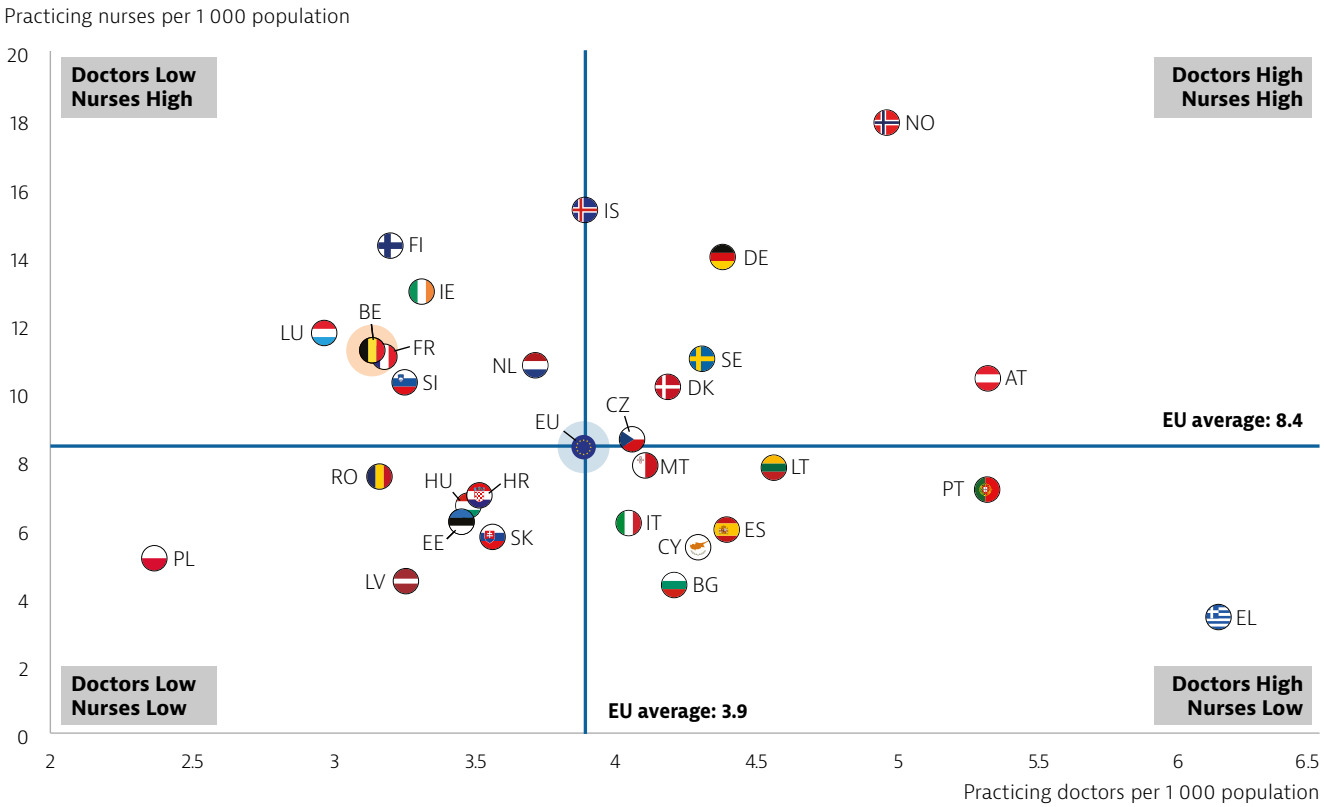
The position of advanced practice nurse was legally created in 2019 to enable greater task-sharing with doctors and improve career prospects for nurses (e.g. supporting care coordination or providing psychosocial care). While specific job descriptions and educational requirements have not yet been defined, the proposal includes prescribing autonomously in their specialty field or in close co-operation with a physician (Gerkens & Merkur, 2020).

Belgium has slightly more hospital beds than the EU average, but a slightly lower average length of stay

In 2019, the number of hospital beds per population in Belgium (5.6 per 1 000) was slightly higher than the EU average (5.3). As in nearly all other EU countries, hospital bed numbers have declined steadily since the early 2000s, coinciding with a reduction in the average length of stay, which is slightly lower in Belgium (7.0 days) than the EU average (7.4 days).

Within the first couple of months of the pandemic, a number of hospital beds were transformed into intensive care unit (ICU) beds (see Section 5.3).

Figure 9. Belgium has fewer doctors but more nurses per capita than the EU average



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2019 or the nearest year).

5 Health system performance

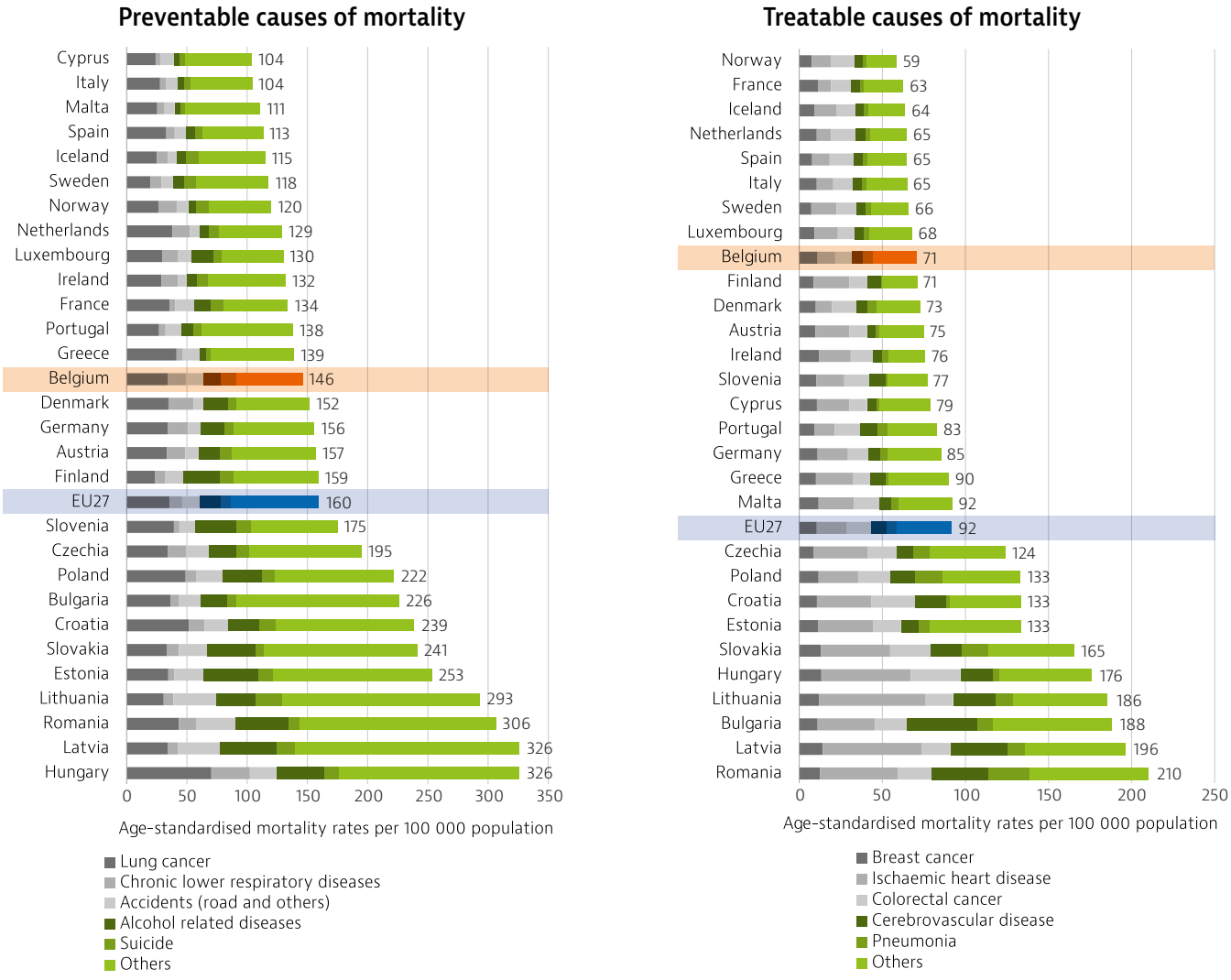
5.1 Effectiveness

Mortality from treatable causes is low but preventable mortality is near the EU average

Belgium fares well in terms of mortality from treatable causes; this indicates that the health care system is generally effective in saving the lives of people with life-threatening conditions (Figure 10).

However, preventable mortality was higher in Belgium than in many other western European countries (albeit lower than the EU average), indicating that further progress can be made in reducing premature deaths through public health and prevention policies. The leading causes of preventable mortality in 2017 were lung cancer, accidents, chronic lower respiratory diseases, alcohol-related diseases and suicide. Deaths from COVID-19 will greatly increase the overall number of preventable deaths in 2020 and 2021.

Figure 10. Preventable and treatable causes of mortality are lower than the EU average



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2018, except for France 2016).

Strengthening public health policies could reduce preventable mortality

As noted in Section 4, Belgium spends relatively little on public health and disease prevention, allocating only 1.6 % of overall health expenditure to organised prevention programmes – less than the EU overall (2.9 %).

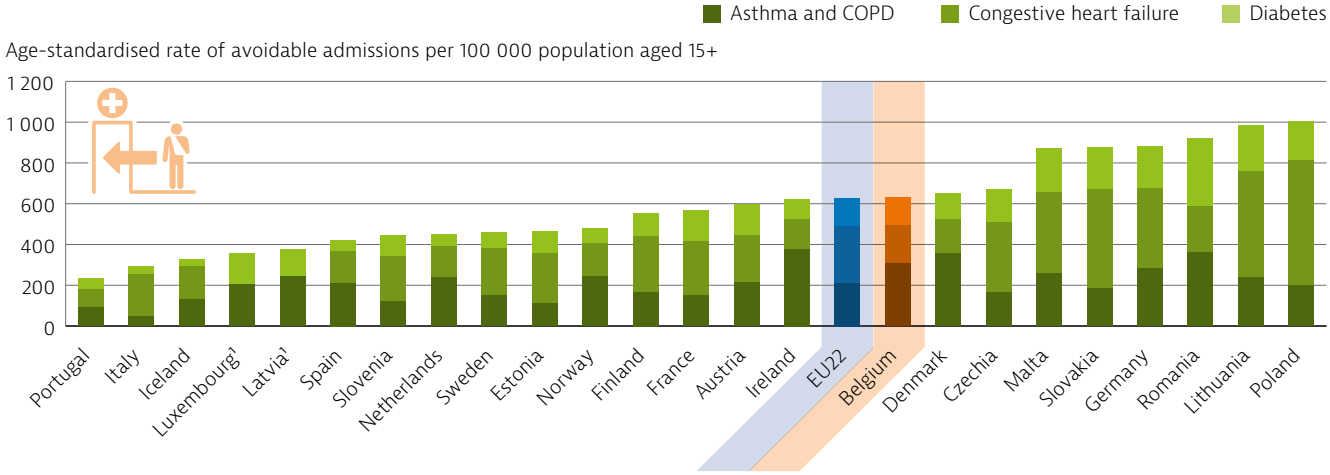
Sharing of responsibilities for public health and prevention programmes requires strong intergovernmental collaboration, and a protocol agreement on prevention between the federal state and the federated entities was concluded in 2016. In recent years, the federated entities have launched several initiatives to strengthen public health policies, notably in tobacco and alcohol control. At the federal level, a ban on the sale of tobacco products to young people under 18 took force in 2019, and plain packaging for tobacco products in 2020. From January 2021, the price of a cigarette package increased from EUR 6.80 to EUR 7.50 on average, and the price of tobacco rose by EUR 1.50 per 50 g.

In 2016, taxes on alcohol were increased, based on the quantity of alcohol in drinks. In addition, there has been a ban on the sale of hard liquor to 16-17-year-olds since 2018, although beer and wine purchases are permitted for this age group.

Potentially avoidable hospital admissions are higher than in many other EU countries

Avoidable hospital admissions for chronic conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and congestive heart failure have fallen over the past decade and are similar to the EU averages (Figure 11). Admission rates for asthma and COPD remained well above the EU average in 2019, which suggests room for improvement in primary care to manage these conditions better. New care pathways for people with diabetes have been developed in recent years, with multidisciplinary teams involving GPs, specialists and other health care providers.

Figure 11. Potentially avoidable hospital admissions for chronic conditions are slightly higher than the EU average



Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Belgium aims to further strengthen its cancer prevention and care

Over the last decade, Belgium has developed a comprehensive strategy to improve cancer prevention and care. The Cancer Centre, hosted by Sciensano, monitors progress on the components of the cancer strategy across all governance levels and acts as an advisory scientific body. The Belgian strategy is aligned with the overall priorities set out in the Europe's Beating Cancer Plan (European Commission, 2021a).

The federated entities are responsible for the organisation of cancer screening programmes. The Flemish government organises programmes for colorectal, cervical and breast cancers, while the Walloon government has implemented colorectal and breast cancer screening programmes. In Brussels, a screening programme for breast cancer is in place and another for colorectal cancer is in a pilot stage.

Two thirds (67 %) of women aged 50-69 reported that they were screened for breast cancer in the past two years in 2018. Regular screening for colorectal cancer is not yet as widespread, but 36 % of men and women aged 50-79 reported that they had been screened over the past two years in 2018 – up from about 10 % in 2008.

The quality of cancer care in Belgium has improved over recent decades, through the introduction of multidisciplinary teams and cancer networks, greater use of clinical guidelines, more rapid access to innovative medicines and, since 2008, additional funding to increase the oncology-specialised workforce. The position of oncology nurse was created in 2009; in 2020 Belgium had about 3 200 oncology nurses – up from 530 in 2010. Treatments are also concentrated in a few hospitals for some rare or complex cancers to improve quality of care and survival rates.

Belgium compares well with other EU countries for five-year survival rates following many common cancers, based on the most recent comparative data available. As in other EU countries, survival rates from lung cancer remain low (Figure 12).

Figure 12. Belgium compares well with other EU countries for five-year cancer survival rates



Prostate cancer
Belgium: 94 %
EU23: 87 %

Childhood leukaemia
Belgium: 91 %
EU23: 85 %

Breast cancer
Belgium: 86 %
EU23: 82 %

Cervical cancer
Belgium: 65 %
EU23: 63 %

Colon cancer
Belgium: 68 %
EU23: 60 %

Lung cancer
Belgium: 18 %
EU23: 15 %

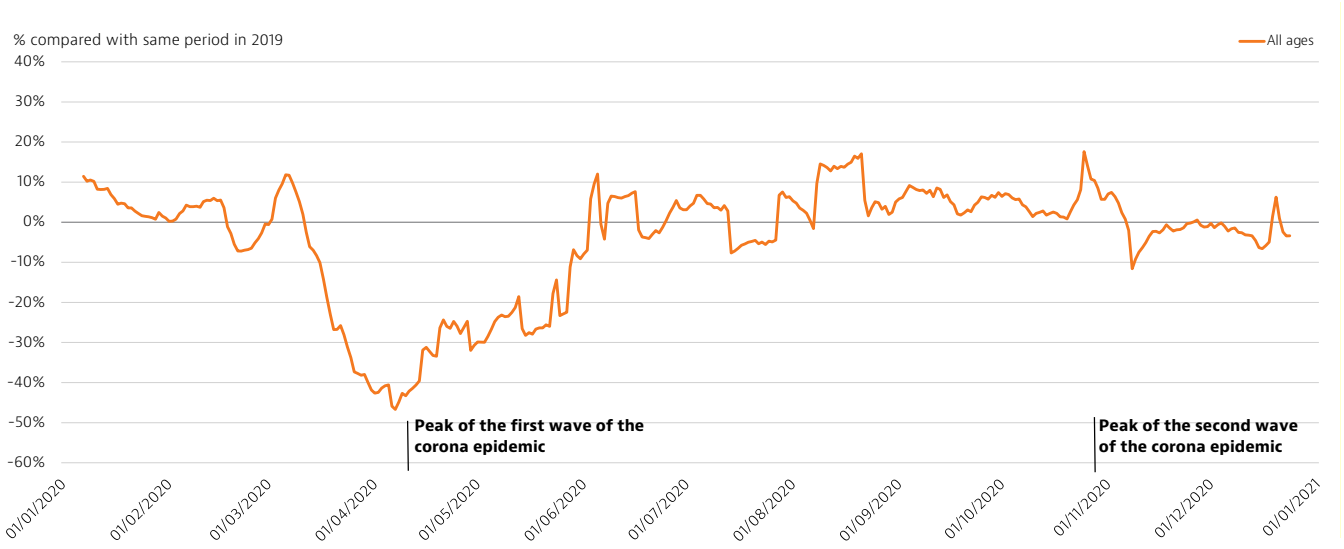
Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

The COVID-19 pandemic disrupted cancer screening programmes and diagnoses

The containment measures to reduce the spread of COVID-19 had a negative impact on the take-up of cancer screening programmes in 2020, particularly during the first wave, as people were advised to stay at home and were afraid of being infected.

New cancer diagnoses declined sharply from March to May 2020 (Figure 13). The numbers increased during summer 2020, and dropped again during the second peak of the epidemic, although much less than during the first peak.

Figure 13. The lockdown during the first wave contributed to a sharp decrease in new cancer diagnoses



Note: All cancers excluding non-melanoma skin cancer.
Source: Adjusted from Peacock et al. (2021).

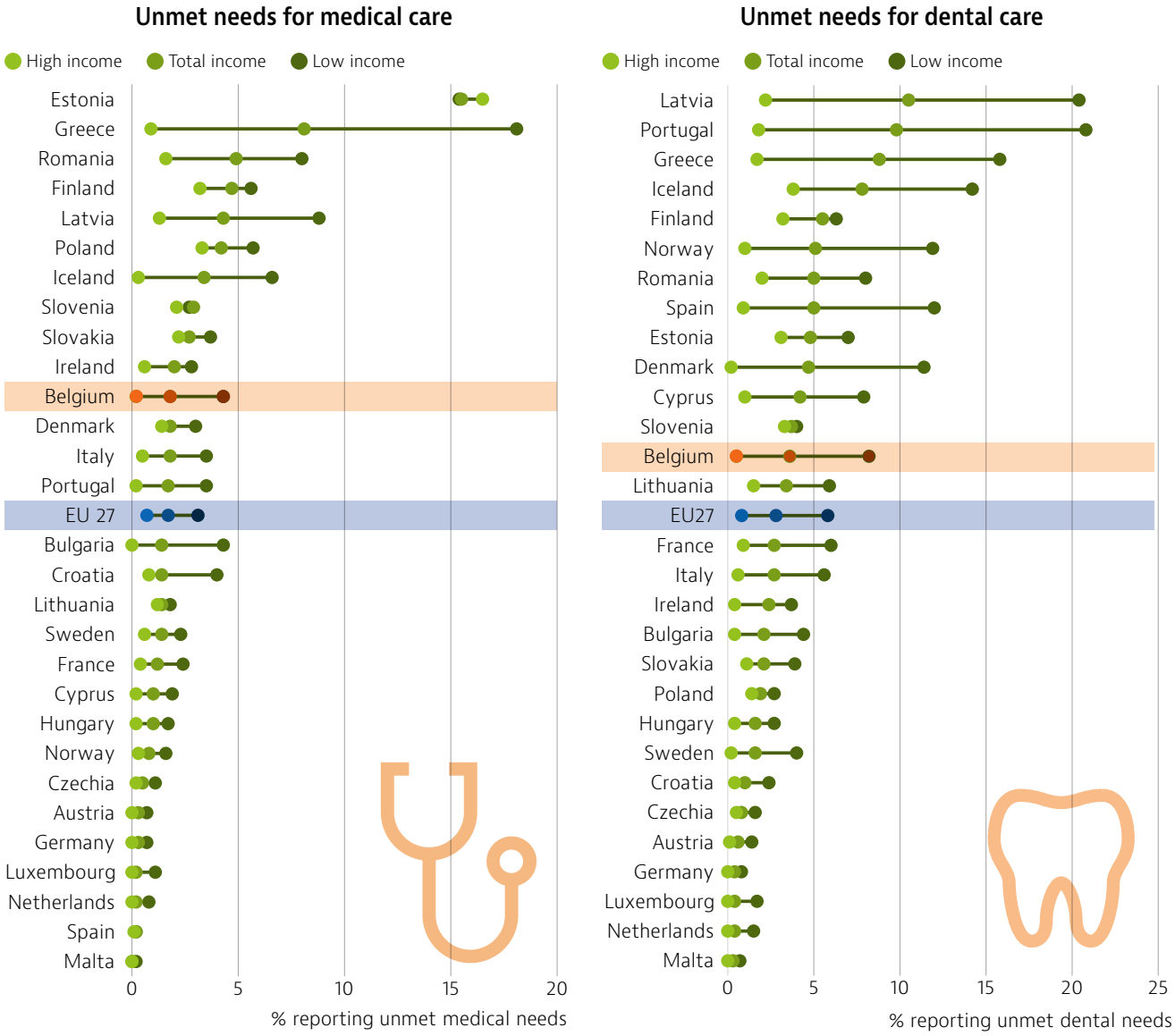
5.2 Accessibility

Unmet medical and dental care needs are relatively low, but higher among people on low incomes

Some people face greater barriers to medical care for financial or other reasons. About 4 % of people in the lowest income quintile reported unmet medical needs in 2019, mainly due to costs, compared with 0.2 % in the highest (Figure 14). This gap between the poorest and richest quintiles is the largest among all western EU countries and above the EU average.

Unmet needs are even greater for dental care: 8 % of people in the lowest income quintile reported unmet needs mainly for financial reasons, compared with only 0.5 % in the highest. This high proportion among people on low incomes is mainly a result of dental care being less covered by social health insurance. This gap is also above the EU average.

Figure 14. Belgians on low incomes are much more likely to report unmet needs for care

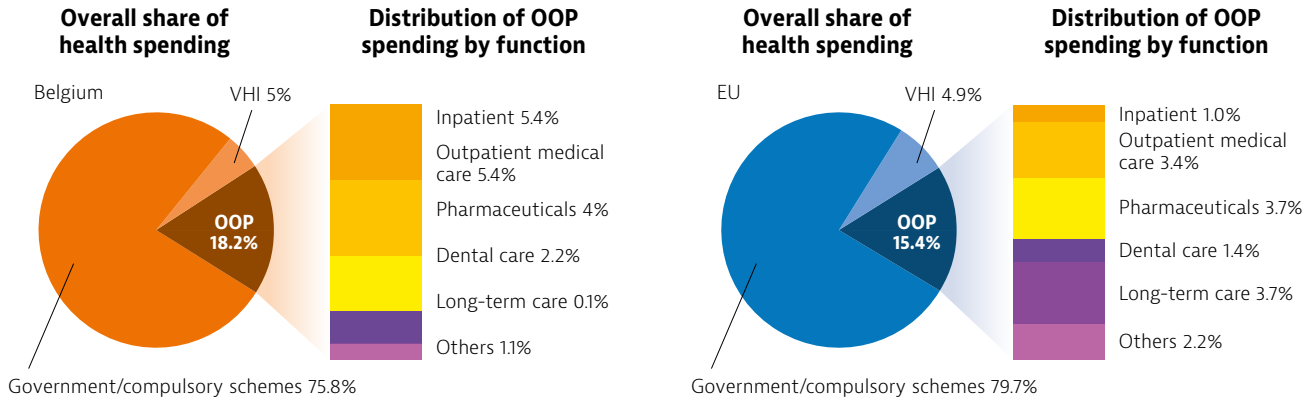


Note: Data refer to unmet needs for a medical or dental examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2019, except Iceland 2018).

Out-of-pocket spending is mostly driven by outpatient and inpatient care and pharmaceuticals

As noted in Section 4, the range of health services and goods covered by the compulsory health insurance is broad, but most people are subject to some cost-sharing. Many Belgians also have VHI, but the share of health spending paid directly by households is still 18 % – a higher share than that in the EU overall (15 %) (Figure 15). A large part of this OOP spending is on user charges for outpatient care (5 %), inpatient care (5 %) and pharmaceuticals (4 %). OOP spending on dental care as a share of all health spending is relatively low because dental care costs are generally lower than the other main categories. About 37 % of dental expenditure was covered by the compulsory health insurance in 2018 – the lowest coverage among health services.

Figure 15. Most out-of-pocket spending relates to outpatient and inpatient care and pharmaceuticals



Note: The EU average is weighted. VHI also includes other voluntary prepayment schemes.
Source: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

Concerns about shortages of doctors have prompted an increase in medical students

As noted in Section 4, the number of doctors per population in Belgium has increased marginally over the past decade, and about 44 % of doctors are now over the age of 55, raising concerns about shortages in the future. A medical workforce planning system has been developed over the past two decades to monitor supply and demand, allowing the government to adjust the quotas of medical students. The number of medical graduates has more than doubled over the past decade (over 2 000 in 2019, up from about 850 in 2009).

Looking forward, the absolute number of GPs is expected to increase slightly (by 3 %) between 2021 and 2026.[3] At the same time, the proportion of GPs aged 50 and over is expected to decrease sharply as many new GPs will enter the profession and the baby-boom generation will continue to retire (Lefèvre & Gerkens, 2021).

Access to health services was disrupted during the pandemic, but telehealth services increased

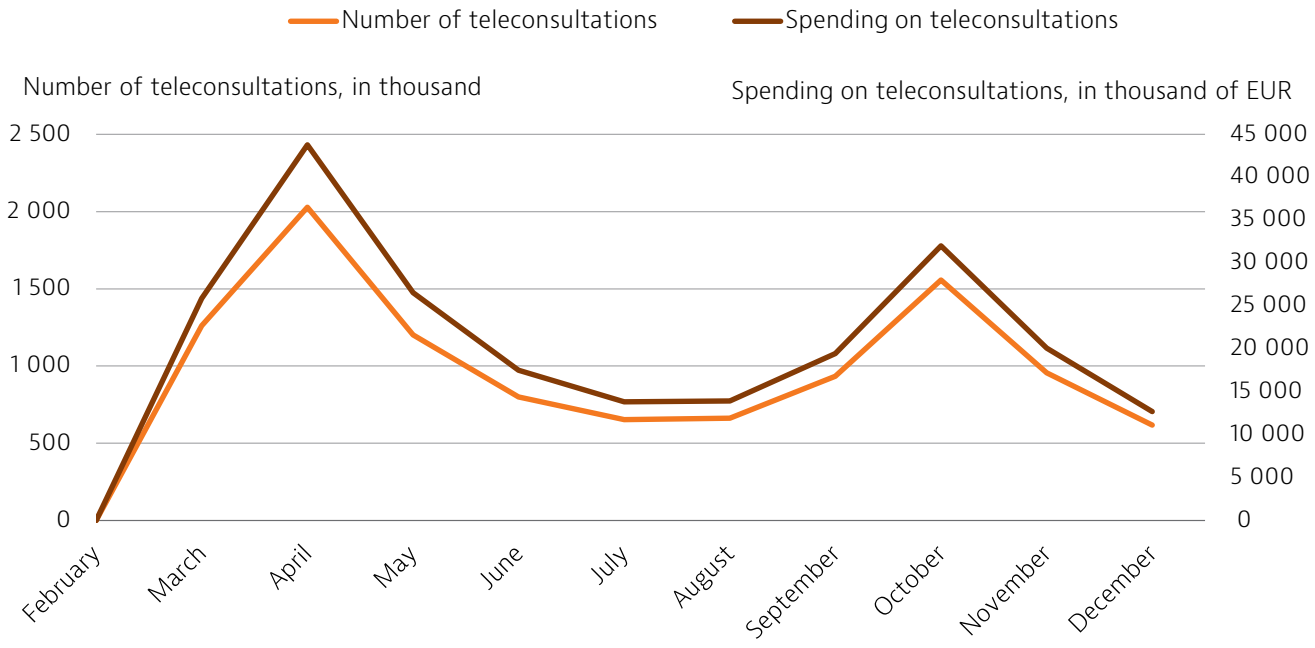
During the first wave of the pandemic, the number of doctor visits, ambulatory surgeries and cancer diagnoses decreased because of the mobilisation of resources for COVID-19 patients and people's fear of being infected in medical settings. Over one fifth (22 %) of Belgians reported that they had some unmet health care needs during the first 12 months of the pandemic – a share close to the 21 % EU average (Eurofound, 2021)[4].

To maintain access to care, regulations were introduced to promote the use of telemedicine, and new conditions of entitlement and reimbursement of teleconsultations were implemented. Reimbursement was set at EUR 20 per COVID-19 consultation, and physicians could use teleconsultations without knowing the patient beforehand. Belgium will invest further in e-health in the coming years, as part of the Economic and Resilience Plan (see Section 5.3).

3: However, the number of full-time equivalent GPs is expected to decrease slightly between 2021 and 2026, based on the assumptions that more women will become GPs and that their activity rate is lower overall.
4: The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.

The number of teleconsultations peaked during the two waves in 2020, but fell when restrictions were lifted, suggesting that physical consultations remain the preferred option for Belgians in most cases (Figure 16).

Figure 16. Teleconsultations peaked during the two waves of the pandemic in 2020



Source: INAMI-RIZIV (data refer to 2020).

5.3 Resilience

This section on resilience focuses mainly on the impacts of and policy responses to the COVID-19 pandemic.[5] As noted in Section 2, the pandemic had a major impact on population health in Belgium in 2020 and the first half of 2021. The restriction measures taken to contain the pandemic led to a major contraction of the economy in 2020: GDP fell by 6.4 % in 2020, which is comparable to the drop in the EU as a whole, and it is not projected to return to 2019 levels before 2022. The unemployment rate increased in 2020, particularly among young people.

A broad set of containment measures was implemented to control the pandemic

The first cases of COVID-19 were identified in Belgium in early February 2020. By the end of August 2021, over one million people (about 10.3 % of the population) had been diagnosed with COVID-19.

In early March 2020, various initiatives were taken at different levels without consultation or consistency. In response, on 12 March 2020 the federal authorities announced that they would ensure greater national coordination (Van de Voorde et al., 2020).

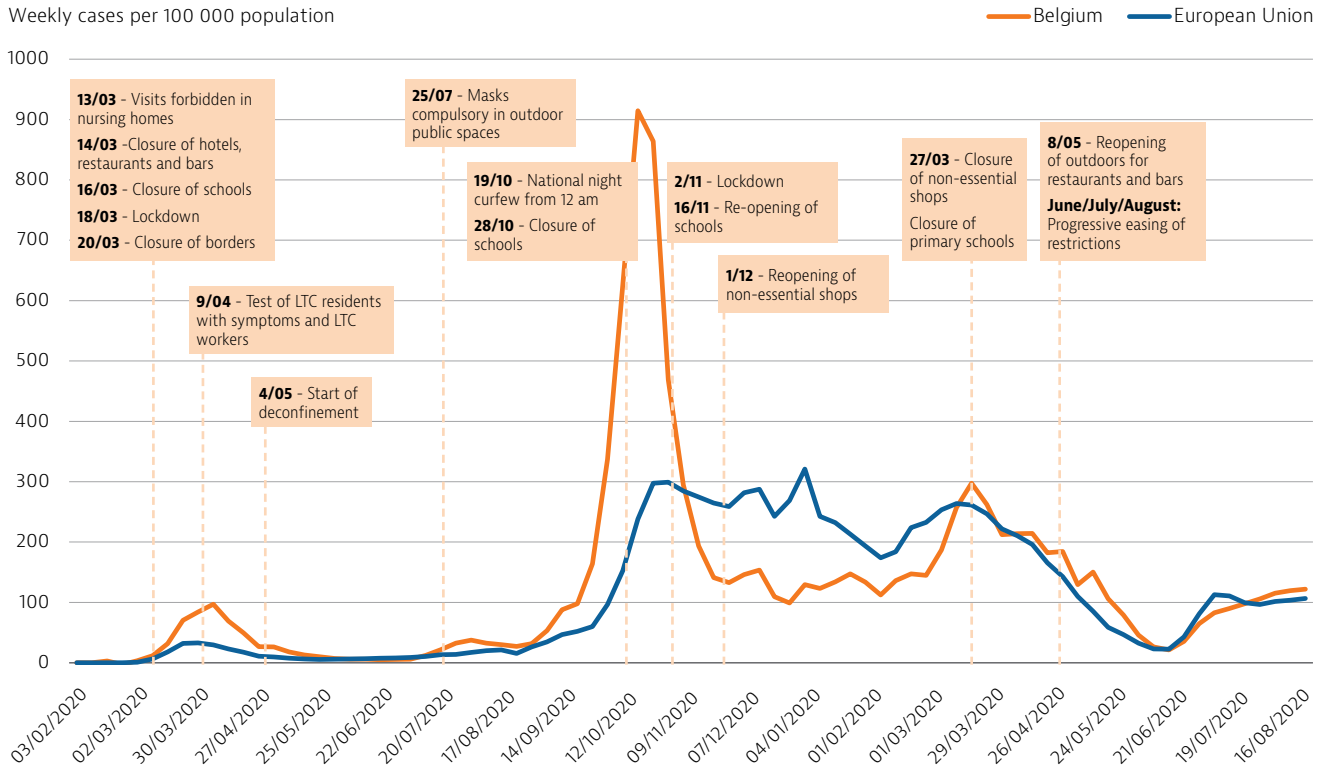
Six days later, the government implemented a first lockdown, including school closures and banning of mass gathering and visits in LTC facilities. These measures resulted in a sharp drop in the number of COVID-19 cases in the following weeks, although transmission was never entirely suppressed: the number of cases was never brought down close to zero for a long period (Figure 17).

From the end of April to June 2020, the containment measures were loosened, and schools reopened gradually from mid-May. However, case numbers started to go up again slowly in July and August 2020, followed by a sharp rise in September to reach a peak in October 2020. In response, Belgium implemented another set of restriction measures, including a curfew from midnight to 05:00 (with some stricter schedules depending on the region) and closures of bars and restaurants, followed by closures of non-essential shops and services. Belgium also took measures to limit close contacts in outdoor places, with face masks and physical distancing. Most teaching moved online for older students, while schools remained open with additional protective measures for children below age 13-14.

5: *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

The number of cases then fell, and in December 2020, non-essential shops reopened. However, the number of cases started to increase again in March 2021; in response, non-essential shops and primary schools were closed again. In April 2021, as cases went down, primary schools resumed and restaurants and other services reopened. During summer 2021, many restrictions on activities were eased, while protective sanitary measures were maintained.

Figure 17. The number of COVID-19 cases reached its highest peak during the second wave in the Autumn 2020



Note: The number of COVID-19 cases in Belgium and other countries was greatly underestimated during the first wave in spring 2020 due to more limited testing. The EU average is unweighted (the number of countries included in the average varies depending on the week).
Source: ECDC data for COVID-19 data and authors for containment measures.

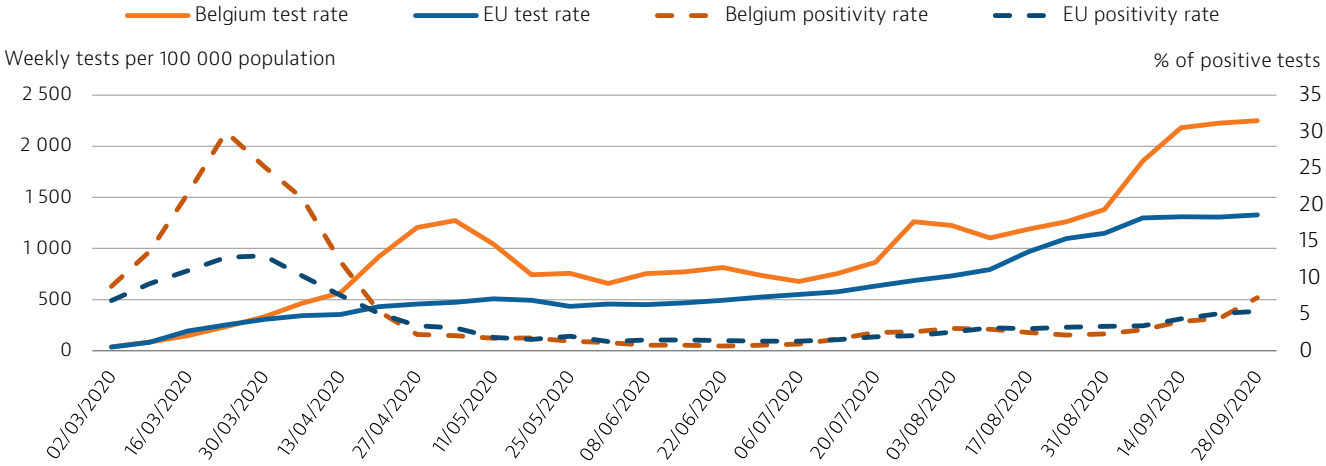
A shortage of face masks was an issue at the beginning of the pandemic

As in many other countries, the national stock of face masks was insufficient in Belgium when COVID-19 started, because millions had reached their expiry date and the stock had only been partly replenished. In addition, the worldwide supply was initially very limited. Following the increased availability of face masks a few months into the pandemic, Belgium implemented compulsory mask-wearing in specific settings, such as public transport and high schools from May 2020 and outdoor public spaces from July 2020.

Testing capacities were scaled up rapidly in Belgium

Belgium developed capacity to promote mass testing more quickly than many other EU countries. At the beginning of the pandemic, only possible cases among hospitalised people and health workers were tested, explaining the high positivity rates during the first few weeks. However, the number of tests increased rapidly from mid-March to May 2020, allowing a greater number of people to be tested (Figure 18). This rapid increase was achieved by mobilising greater laboratory capacity and via implementation of a national platform in April 2020.

Figure 18. Belgium increased testing capacity more quickly than many other EU countries



Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

In September 2020, Belgium launched Coronalert, an application to trace cases and inform Belgians when they had been in contact with a positive case. By the end of April 2021, it had been downloaded over 2.7 million times (23 % of the population). About 31 800 people who had tested positive had notified their "contacts" via the app by early September 2021 (Interfederal Committee Testing & Tracing, 2021).

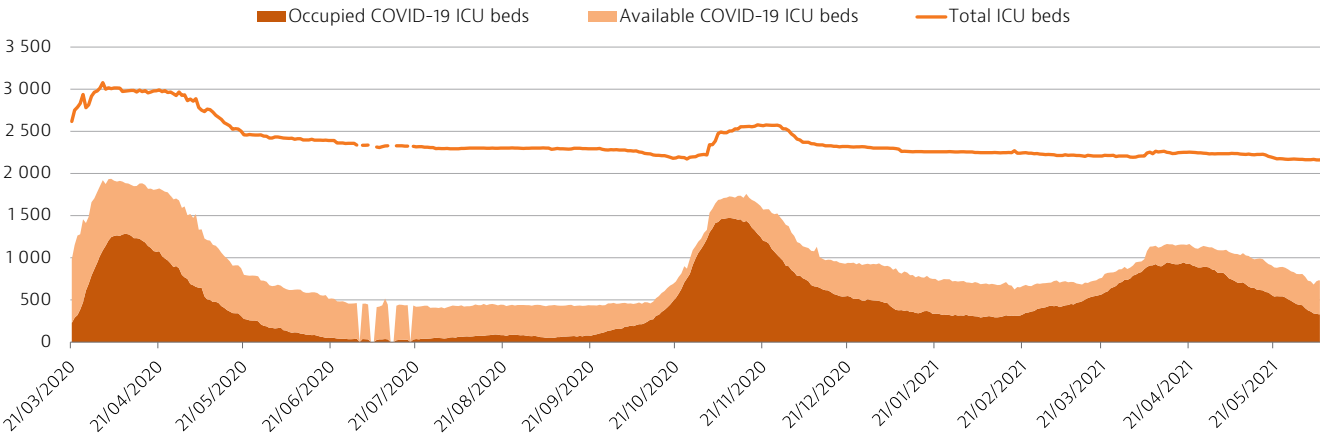
The pandemic put hospitals under severe strain, but mobilisation of resources was swift

At the start of the pandemic, each hospital followed a predefined emergency plan to increase response capacity. Initially two and then nine hospitals were appointed as reference hospitals to admit COVID-19-patients, but by mid-March 2020, all hospitals were urged to create capacity (including beds and ventilators), mainly by cancelling elective procedures to keep ICU beds available and free up operating and recovery rooms. The target was to keep 60 % of ICU beds for COVID-19 patients.

On 21 March 2020, about 1 000 COVID-19 ICU beds and a total of 2 600 ICU beds were available (Figure 19). At the end of the first lockdown, Belgium introduced a bed plan, with hospitals in less affected areas reserving fewer COVID-19 ICU beds. The number of ICU beds and COVID-19 ICU beds evolved depending on the pandemic waves up to May 2021.

Due to the cancellation or postponement of elective treatments, volumes of non-COVID-19 hospital care decreased considerably, especially during the first wave; essential hospital care also decreased to some extent. For example, essential admissions for conditions such as stroke declined by 19 % in March and 16 % in April 2020. However, in May 2020, the decrease was only 2 %, although it was 3 % in June 2020 (Van de Voorde et al., 2020). Even with available essential hospital care, people with mild stroke symptoms may have avoided hospitals because of the fear of contracting COVID-19. In addition, such symptoms could have gone unnoticed because of reduced social interactions.

Figure 19. Over 1 000 ICU beds were created during the first wave of the pandemic



Note: Some data are not available between 21/06/2020 and 21/07/2020.
Source: Adjusted and updated from Van de Voorde et al. (2020).

The increase in ICU beds was difficult to implement in some hospitals because of a lack of nurses with ICU expertise. When necessary, nurses with similar expertise were used in combination and under the supervision of nurses with ICU expertise. Other strategies included overtime (including cancelling holidays), ICU training, recruitment of temporary nurses, increasing the number of patients per nurse, mobilising nursing teachers or nurses working in other sectors and transferring some nursing tasks to available physicians (Van de Voorde et al., 2020).

The regions managed to mobilise additional staff to respond to the surge in demand for care by using a "health reserve", comprising health professionals, students and retired health professionals. For instance, by the end of March 2020, Flanders had over 2 500 volunteers through this platform. The Belgian army also provided organisational support to hospitals from 23 October 2020.

In recognition of the exceptional situation, Belgium offered a one-off bonus to all health professionals who worked in hospitals under specific conditions between September and December 2020, from a budget of EUR 200 million.

The response in nursing homes improved, but some recommendations remained difficult to implement

The first wave of the pandemic affected LTC facilities severely in Belgium, as in several other western European countries. As of January 2021, about 60 % of all COVID-19 deaths were among LTC residents.

A series of measures were taken by the National Security Council to protect people in nursing homes; the federated entities were responsible for their implementation. These measures aimed to increase hygiene and infection control measures and to test, trace, isolate and organise transfers of severe cases to hospitals. From March 2020, the army provided support in some LTC facilities facing major outbreaks. In summer 2020, the limitations on social interactions for LTC residents were relaxed to some extent because of well-being concerns.

Recommendations on testing and isolation could not always be implemented in nursing homes. During spring and summer 2020, a relatively small study showed that only 68 % of surveyed nursing homes tested residents and 60 % isolated positive cases in a single room or with another COVID-19-positive case (MSF, 2020).

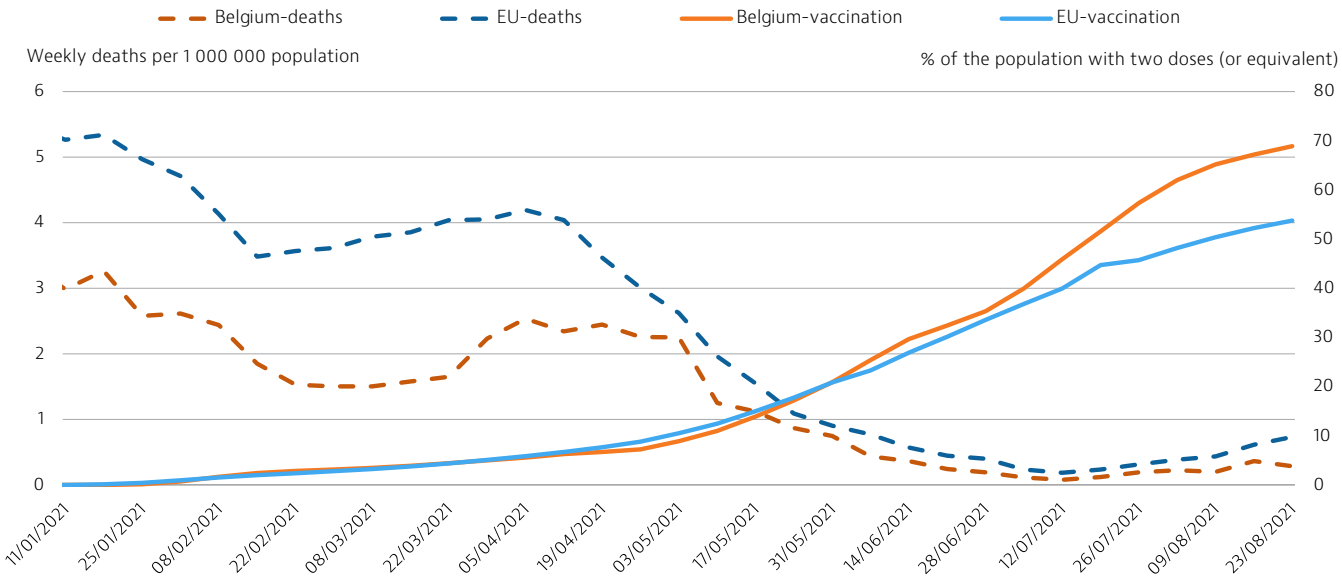
In 2021, the Flemish government undertook to make EUR 577 million available each year for the LTC sector, on top of the EUR 525 million already provided. About EUR 412 million is for wage increases in the social and health care workforce and EUR 165 million is dedicated to structural measures (recruitment, digitalisation, infrastructure). In addition, over 100 000 Flemish care workers received a one-off payment of up to EUR 300 by March 2021.

Belgium rolled out the COVID-19 vaccination campaign in 2021

Following approval of the first vaccines against COVID-19 in late December 2020 and early January 2021, the vaccination campaign started slowly in Belgium, mainly due to low stocks, but it accelerated from April 2021. The target population groups were gradually widened to include all adults and adolescents aged over 12 in June 2021. About 66 % of 12-15-year-olds had received at least a first dose by mid-September 2021.

By August 2021, about 70 % of the population had received two doses (or equivalent), a proportion much higher than the EU average (Figure 20). This rate varies starkly by region, from 50 % in Brussels to 78 % in Flanders. Among health workers, 80 % of doctors, pharmacists and dentists and about 74 % of nurses had received at least one dose by the end of May 2021, but only 64 % of physiotherapists (Sciensano, 2021).

Figure 20. The share of Belgians vaccinated against COVID-19 was well above the EU average in August 2021



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 deaths and Our World in Data for vaccination rates.

The public health budget evolved substantially to support health system responses to COVID-19

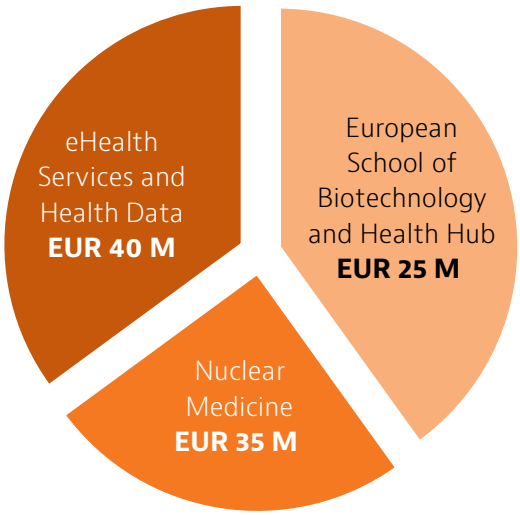
In 2020, Belgium decided to maintain its overall budgetary objective for public spending on health, on the basis that the reduction of non-essential care would compensate for COVID-19-related health spending. However, a reallocation in the form of a cash advance of EUR 2 billion was provided to hospitals to pay for some COVID-19-related costs. An exceptional allocation of EUR 1.242 billion was also added to cover COVID-19 spending, such as tests, PPE, triage centres and COVID-19 care provided by nurses. At the level of the communities and regions, additional resources were also earmarked to purchase equipment in hospitals and the LTC sector.

In response to issues that emerged during the crisis, the initial budgetary target for public spending on health was increased by 7.5 % in 2021 (from about EUR 28 billion in 2020 to EUR 30 billion in 2021). This includes an allocation of about EUR 400 million to increase the remuneration of nurses (especially in hospitals), EUR 200 million to improve access to mental health care and EUR 600 million to make health professions more attractive, including EUR 500 million for salary increases. In addition, as in 2020, Belgium budgeted a separate additional allocation of EUR 1 221 million for COVID-19 health responses in 2021.

Belgium plans to re-establish a public expenditure growth ceiling in 2022, which is expected to be set at 2.5 % per year, and to keep the additional separate allocations for COVID-19 prevention and care.

Belgium's Recovery and Resilience Plan was adopted in June 2021. The EU-funded Plan will support further investments in the health system, with a total budget of EUR 99.8 million over a five-year period. The main priority areas include e-health and health data – notably development of standardised data sets that focus on specific themes (e.g. allergies or vaccination) and that can be shared between all health workers (nurses, physicians, physiotherapists); creation of an integrated tracking system for consumption of medicines and operationalisation of teleconsultations; creation of a European School of Biotechnology and Health Hub; and greater investment in nuclear medicine (Figure 21).

Figure 21. The Recovery and Resilience Plan allocates EUR 99.8 million to investments in the health sector



Source: Belgium Recovery Plan (2021).

6 Key findings

- Life expectancy in Belgium in 2020 remained slightly above the EU average, although it temporarily dropped by 1.2 years because of deaths due to COVID-19 – a larger reduction than the 0.7 years across EU countries. Belgium was among the EU countries hard hit by the pandemic, with nearly 20 000 deaths in 2020 and another 5 500 by the end of August 2021.

- Other important risk factors for health also continue to be major drivers of mortality in Belgium – notably smoking (accounting for an estimated 20 000 deaths in 2019), alcohol consumption and obesity. Tobacco control policies have managed to reduce smoking rates, but other public health policies have been less successful in reducing alcohol consumption and other modifiable risk factors. Environmental factors like air pollution also result in a sizeable number of deaths (about 3 800 deaths in 2019) from circulatory diseases, respiratory diseases and some types of cancer.

- The incidence of cancer is greater in Belgium than the EU average, and about 30 000 people were expected to die from cancer in 2020. Over the last decade, Belgium has developed a comprehensive strategy to improve cancer prevention and care. However, the COVID-19 crisis had a negative impact on cancer screening and care, as some services and interventions were disrupted.

- The number of doctors in Belgium has increased more slowly than in most EU countries over the past decade and is now well below the EU average. About 44 % of doctors are over 55, raising concerns about growing shortages in the future. In response, the number of students admitted to medical schools has increased in recent years, which will result in a growing supply of new doctors.

- Belgium spent 10.7 % of its GDP on health in 2019, a share higher than the EU average of 9.9 %. Most health spending is publicly funded (77 %), which is slightly less than the EU average (80 %). Between 2015 and 2019, the legislated ceiling on growth in public spending on health was set at 1.5 % per year in real terms to contain costs. In 2020, in response to the pandemic, Belgium maintained its overall budgetary objective while at the same time allocating additional funds to cover COVID-19 spending in hospitals and other settings. In 2021, the initial budgetary target was to increase public spending on health by 7.5 % as a response to issues that emerged during the crisis. Additional spending is also provided to pay for other COVID-19-related costs.

- A broad set of measures were implemented to contain the spread of COVID-19 from the beginning of the pandemic. Insufficient crisis preparedness at the onset of the pandemic, including a lack of face masks and limited testing capacity, led to rapid spread of the virus. However, Belgium managed to increase its testing capacity and supply of face masks and other personal protective equipment by the time the first lockdown was lifted in May 2020.

- The first wave of COVID-19 put hospitals under severe strain, but mobilisation of resources was swift. Additional ICU beds rapidly became available to respond to the surge in demand. However, there was a lack of staff with ICU expertise, especially nurses, which prevented further increases. Workforce strategies included increasing nurse numbers through reallocation, overtime and recruitment.

- About 60 % of all COVID-19 deaths in 2020 were among residents of long-term care facilities. The response in nursing homes improved gradually over time, although recommendations on testing and isolating suspected or confirmed cases remained difficult to implement.

- While access to health care is generally good in Belgium, the COVID-19 crisis and related containment measures limited access to some services. Some 22 % of Belgians reported unmet health care needs in the first 12 months of the pandemic, which is close to the EU average (21 %). To help maintain access to care, new regulations were introduced to scale up telemedicine. It will be important to assess the efficiency of the many innovative practices adopted during the pandemic, to keep and further develop those that worked well.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

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State of Health in the EU
Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

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