European Commission

State of Health in the EU

Denmark

Country Health Profile 2021

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European Observatory on Health Systems and Policies
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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 Denmark, 2020

Demographic factors	Denmark	EU
Population size (mid-year estimates)	5 822 763	447 319 916
Share of population over age 65 (%)	19.9	20.6
Fertility rate[1] (2019)	1.7	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	40 464	29 801
Relative poverty rate[3] (%, 2019)	12.5	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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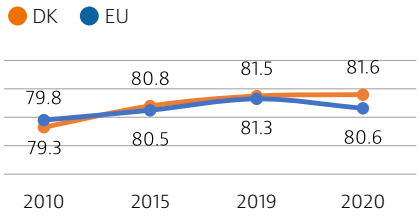
1 Highlights

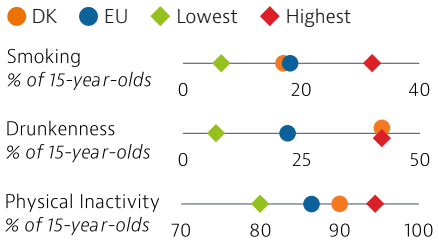
Life expectancy in Denmark in 2020 was one year higher than the EU average, partly because the number of COVID-19 deaths was much lower than in most other EU countries. Denmark quickly scaled up its testing capacity at the beginning of the pandemic, which enabled effective detection, tracing and isolation of confirmed cases early on. Rapid implementation of teleconsultations and lower than expected pressure on designated COVID-19 capacity ensured relatively low unmet needs during the pandemic.



Life expectancy at birth, years

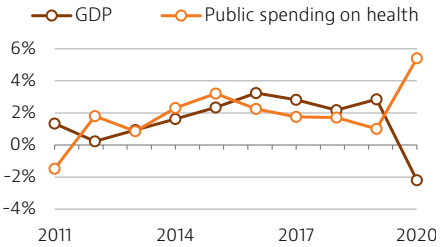
Health Status

Life expectancy in Denmark has increased more rapidly than the EU average since 2010 and continued to grow at least slightly in 2020, while it fell significantly in most EU countries because of COVID-19. Seven in ten Danes report being in good health, which is similar to the EU average. However, non-negligible socioeconomic differences in health status persist.



Risk factors

Smoking rates among both adults and adolescents have reduced sharply over the past two decades, and are now below the EU average. However, adolescents in Denmark drink more alcohol than their Nordic and EU peers. High rates of physical inactivity among adolescents are becoming an important public health issue.



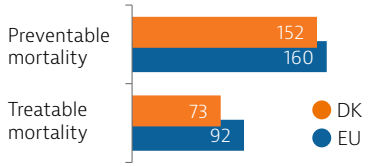
Annual change in real terms, %.

Health system

Spending on health in Denmark has remained slightly above the EU average over the past decade. Health expenditure grew at an average rate of 2 % per year in real terms between 2015 and 2019 – slightly slower than the EU average. As a result of the COVID-19 pandemic, public spending on health increased by over 5 % in 2020, while GDP fell by more than 2 %, temporarily increasing the health spending share of GDP.

Effectiveness

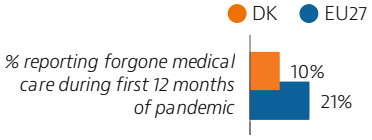
Mortality rates from preventable causes in Denmark in 2018 were close to the EU average. Lung cancer is the leading cause of preventable death – a legacy of high smoking rates among previous generations. Mortality rates from treatable causes are below the EU average, although higher than in Sweden and Norway.



Age-standardised mortality rate per 100 000 population, 2018

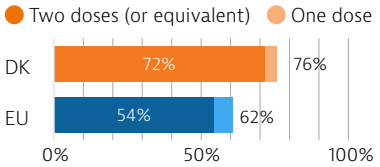
Accessibility

Danes reported low levels of unmet needs before the pandemic. During the first 12 months of the pandemic, levels of unmet needs were also lower than the EU average. Rapid expansion of telehealth ensured continuity of ambulatory care, but non-essential and elective care were delayed during the peaks of the first and second waves to free up hospital capacity for COVID-19 patients.



Resilience

Up to the end of August 2021, Denmark experienced 3.5 times fewer COVID-19 deaths relative to its population size than the EU average, although the COVID-19 death rate was higher than in Finland and Norway. As of the end of August 2021, 72 % of the Danish population had received two doses of the COVID-19 vaccine or equivalent – a proportion higher than the EU average.



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

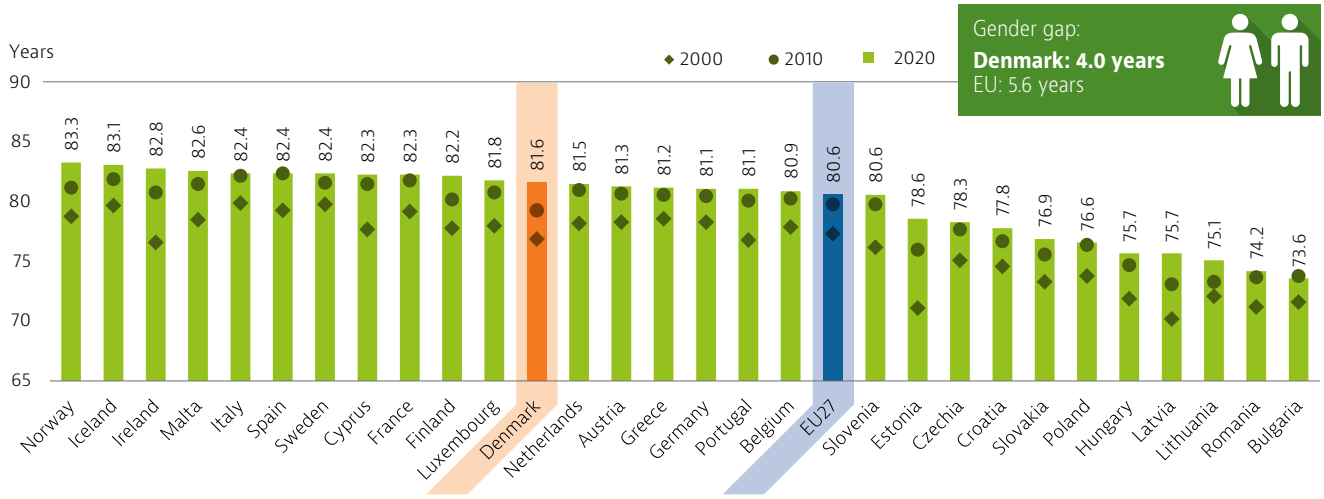
2 Health in Denmark

Life expectancy is higher than the EU average, but lower than in other Nordic countries

In 2020, life expectancy at birth in Denmark was 81.6 years – one year higher than the EU average, but lower than in other Nordic and many western European countries (Figure 1). Although the number of deaths was slightly higher in 2020 than in 2019 because of COVID-19, Denmark was the only EU country apart from Finland where life expectancy increased in 2020 despite the pandemic, albeit by just 0.1 years for both men and women.

On average, Danish women live four years longer than men (83.6 versus 79.6 years). However, the gap in life expectancy by gender has narrowed by more than six months since 2000, and is far below the EU average of 5.6 years.

Figure 1. Life expectancy is higher than the EU average, but lower than in other Nordic countries



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

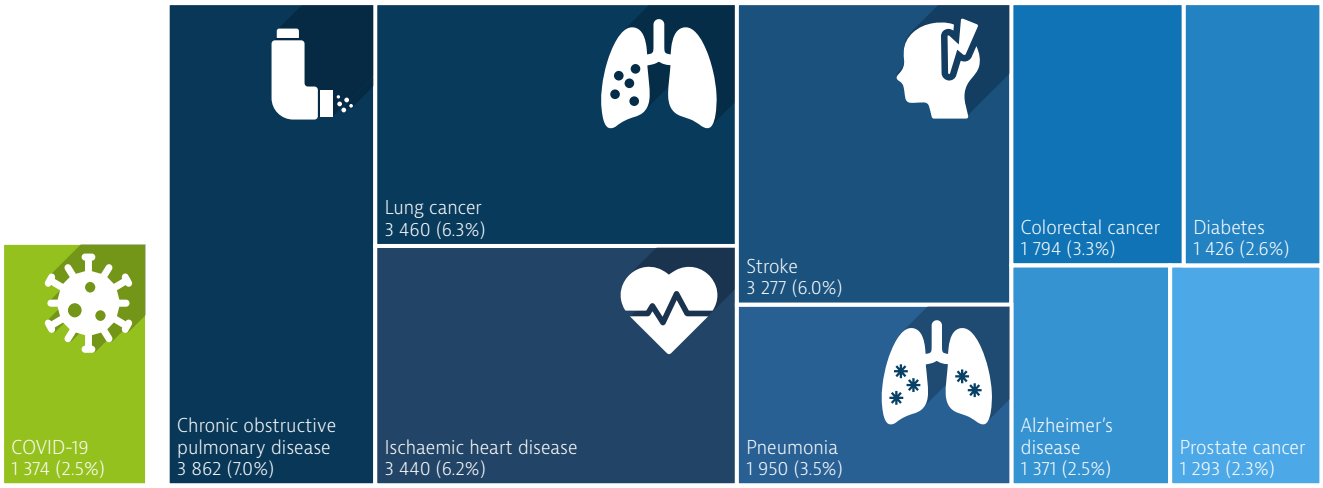
Circulatory diseases, cancer and respiratory diseases are the leading causes of death in Denmark

The steady increase in life expectancy in Denmark since 2000 has been driven by mortality reductions from some of the most frequent causes of death. Despite these reductions, the main causes of death in 2018 remained chronic obstructive pulmonary disease (COPD), lung cancer, ischaemic heart disease and stroke, which together accounted for more than one quarter of all deaths (Figure 2). Cancer is estimated to contribute to one quarter of all deaths, which has prompted a number of initiatives to strengthen cancer care (see Section 5.1).

In 2020, COVID-19 accounted for about 1 370 deaths in Denmark (2.5 % of all deaths). An additional 1 200 people died from COVID-19 during the first eight months of 2021. Most deaths were among older people (88 % were among those aged 70 and over by the end of August 2021).

The mortality rate from COVID-19 was 3.5 times lower in Denmark (about 440 per million population) than the EU average (about 1 590 per million) up to the end of August 2021, in part because of better containment measures (particularly during the first wave), a responsive and flexible health system, and more widespread testing (see Section 5.3).

Figure 2. Respiratory diseases, lung cancer and ischaemic heart disease are the main causes of death



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).

Most Danish people report being in good health, but social disparities exist

In 2019, about 70 % of Danish adults reported being in good health – a proportion close to the EU average. However, as in other countries, people on higher incomes are more likely to report being in good health: 81 % of Danish adults in the highest income quintile reported being in good health, compared with 62 % of those in the lowest. This income gap was similar to the EU average.

Social inequalities in health have increased in Denmark over the past decade, and calls to address these have strengthened in response to the COVID-19 pandemic. In November 2020, Danish Regions led an initiative calling on the government to pass a national public health law that would strengthen multisectoral collaboration on health promotion and reduce social inequalities in health, with 71 organisations as co-signatories. The initiative builds on the model in Norway, where a Public Health Law was introduced in 2012.

Nearly one in three adults in Denmark have a chronic condition

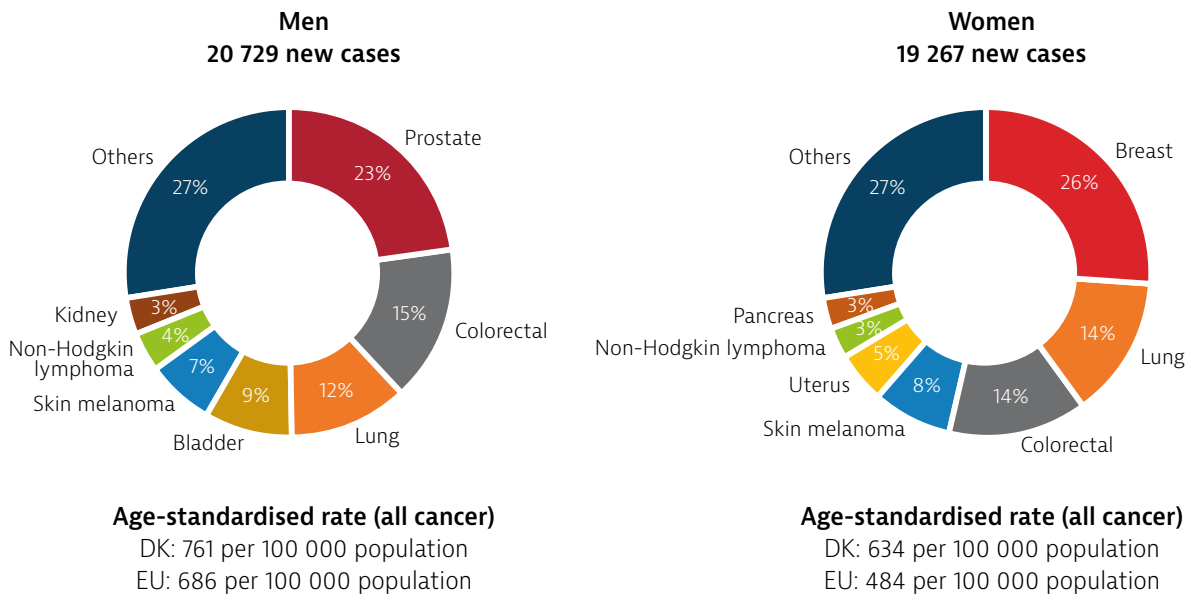
Around 31 % of Danish adults reported having at least one chronic condition in 2019 – a slightly lower proportion than in the EU as a whole (36 %), according to EU-SILC. Many chronic conditions increase the risk of severe complications from COVID-19. As with self-reported health, there is a considerable gap in prevalence of chronic conditions by income: 34 % of Danes in the lowest income quintile report having at least one chronic condition, compared with 24 % of those in the highest.

Cancer incidence rates are higher in Denmark than in the EU on average

According to estimates from the Joint Research Centre based on incidence trends from previous years, around 40 000 new cases of cancers were expected in Denmark in 2020[1]. Age-standardised incidence rates for all cancer types were expected to be higher than the EU averages for both men and women (Figure 3). About 17 000 people were expected to die of cancer, making it the leading cause of death in Denmark 2020. The main cancer sites among men are prostate, colorectal and lung, while among women breast cancer is the most frequently diagnosed cancer, followed by colorectal and lung cancer. Although cancer incidence has increased over the past few decades, in part thanks to more widespread screening, survival rates for several types of cancer have improved as a result of policy measures and improved treatments (see Section 5.1).

1. It should be noted that these estimates were made before the COVID-19 pandemic; this may have an effect on both the incidence and mortality rates of cancer during 2020

Figure 3. About 40 000 new cases of cancer were expected in Denmark 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

Four in ten deaths in Denmark can be attributed to behavioural risk factors

More than 40 % of deaths in Denmark can be linked to behavioural risk factors, including tobacco smoking, unhealthy diets, alcohol consumption and low physical activity – a rate similar to the EU average.

Together, these risk factors account for approximately one third of the disease burden in Denmark. Environmental factors such as air pollution also account for a considerable number of deaths – an estimated 1 500 deaths in 2019 were from exposure to fine particulate matter ($PM_{2.5}$) and ozone alone (Figure 4). This represented 3 % of all deaths, which is slightly below the EU average.

Figure 4. Behavioural and environmental factors account for more than 40 % of all deaths in Denmark

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).

Tobacco smoking has declined sharply and is now relatively low in Denmark

The proportion of Danish adults who smoke tobacco daily has fallen considerably in recent decades – from around 30 % in 2000 to 13 % in 2019[2]. As a result, Denmark is now among the EU countries with the lowest smoking rates. This reduction has been achieved in part through increases in tobacco prices and by imposing a ban on smoking in public spaces (see Section 5.1).

Smoking rates among adolescents are also now lower in Denmark than in most other EU countries, while remaining high compared to other Nordic nations. In 2018, 17 % of Danish 15-year-olds reported that they had smoked cigarettes in the past month, down from 21 % in 2014. However, tobacco products other than traditional cigarettes, like e-cigarettes, have become more popular in recent years.

Despite low alcohol consumption overall, adolescent binge drinking is a major public health concern

In 2019, Danes consumed on average 9.5 litres of alcohol per person aged 15 and over – more than their Nordic peers (6.1-8.2 litres) but less than the EU average (9.9 litres). Overall, consumption has decreased by about 25 % since 2000, but has stabilised in recent years.

Limited progress has been achieved in tackling excessive alcohol consumption among adolescents, however. In 2018, 42 % of 15-year-olds reported that they had been drunk more than once in their life – the highest proportion among all EU countries. Danish adolescents were also the most likely to report having been drunk in the past 30 days – around one third of 15-year-old boys and girls reported this – with no improvement observed since 2014.

Adult obesity rates are growing in Denmark

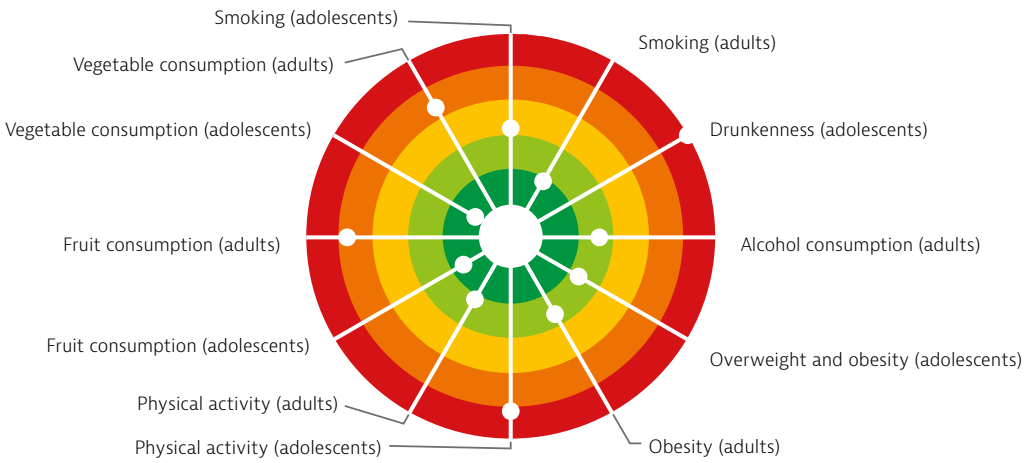
About 16 % of adults in Denmark were defined as obese in 2019, a share that has grown from 13 % in 2010 and is now equal to the EU average. This rising trend can be explained in part by poor nutritional habits. In 2019, only 46 % of Danish adults reported eating fruit or vegetables daily – a lower proportion than in most EU countries – and 90 % did not meet the Danish Food Administration's recommended fruit and vegetable intake of 600 g per day.

Obesity rates are growing, despite more Danish adults reporting that they do at least moderate physical activity each week than the proportion in most other EU countries. Nonetheless, more than a quarter of adults did not meet the WHO-recommended guideline for minimum physical activity per week in 2017.

Young people report eating more healthily than their EU peers, but physical activity is low

Danish adolescents are among the most likely in the EU to report consuming fruit and vegetables daily, but the proportion reporting engaging in at least moderate physical activity each day is among the lowest across EU countries (Figure 5). This is particularly the case among girls: only 7 % of 15-year-old girls in Denmark reported doing at least moderate physical activity in 2018 – nearly half the proportion of boys (13 %). Danish municipalities have launched various initiatives to improve nutrition and physical activity as part of their general responsibilities in health promotion. Obesity rates among adolescents remain lower than in most other EU countries, however.

Figure 5. Adolescent alcohol consumption and low physical activity are major public health issues



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 OECD Health Statistics, Danish National Health Survey 2017 and EHIS 2019 for adults indicators.

2. *The results from the National Health Profile of the Danish Health Authority show a smaller reduction, down to 17 % in 2017.*

4 The health system

Regional and local governments deliver health care; planning and regulation are overseen nationally

The Danish health system is largely tax funded with decentralised organisation. The national government leads on regulation, supervision, some planning and quality monitoring, while the five regions are responsible for defining and planning delivery of health services. The municipalities are responsible for health promotion, disease prevention, rehabilitation, home care and long-term care.

Overall planning and regulation have gradually been centralised to the national level. For example, as part of the 2007 administrative reforms, which saw the merging of regions and municipalities, the number of hospitals was halved. This was motivated by concerns that smaller hospitals were not able to provide high-quality specialty services. Results from the first decade indicate that hospital productivity has increased, while costs have remained stable (Christiansen & Vrangbaek, 2018). Centralised direction also played an important role in the response to COVID-19 (Box 1).

Box 1. National direction was crucial to the COVID-19 response, but legislative change was required

When the COVID-19 pandemic erupted, coordination across levels of government was required. The National Security Council, headed by the Prime Minister and including ministers of health, justice, foreign affairs, defence and finance, as well as leaders of the National Health Authority and the National Serum Institute (an agency subordinate to the Health Ministry in charge of communicable disease surveillance) held regular meetings from February 2020.

National and regional health authorities established a COVID-19 Intensive Task Force to oversee assessment and governance of resources needed during the pandemic.

Parliament enacted emergency legislation in March 2020 that gave expanded time-limited powers (until 1 March 2021) to the Minister of Health to enforce adherence to testing, treatment, isolation and containment measures. The ability to invoke expanded powers during epidemics was enshrined in law through the new Epidemics Act, enacted in March 2021. At the same time, a 21-member parliamentary Epidemic Committee was appointed to oversee the use of power by the government under the newly adopted Act.

Source: COVID-19 Health System Response Monitor.

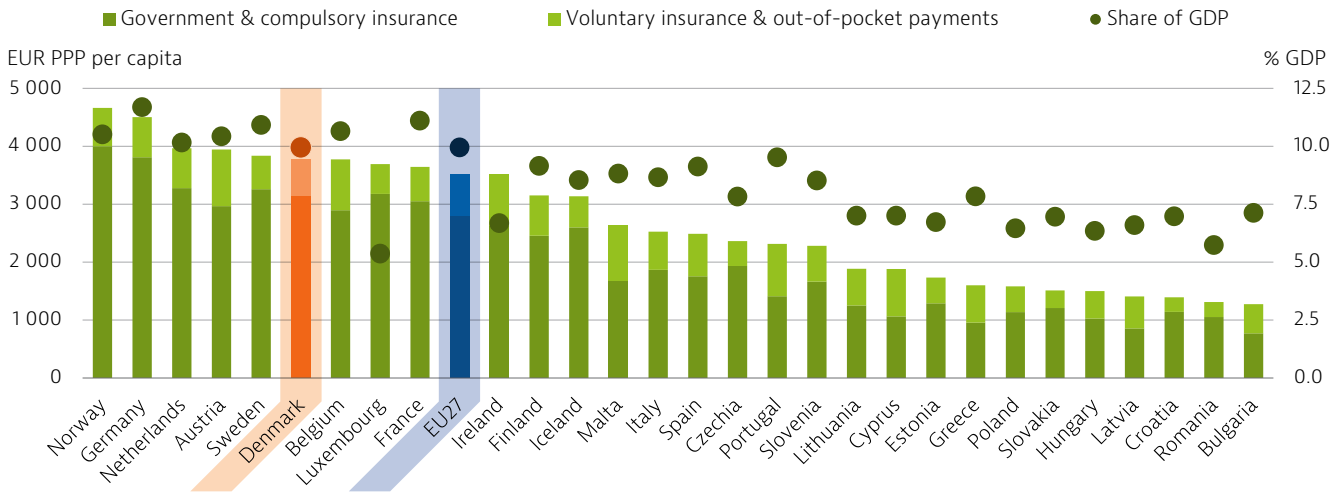
Health spending as a proportion of GDP is on par with the EU average

In 2019, Denmark spent 10.0 % of its GDP on health. This share is similar to the EU average (9.9 %) and in line with that in other Nordic countries (Figure 6). Spending per person was slightly higher than the EU average, at EUR 3 786 in 2019 compared with EUR 3 521 (adjusted for differences in purchasing power). Health spending in Denmark grew on average at a rate of 2 % per year in real terms between 2015 and 2019 – slightly slower than the EU average. Growth in health expenditure is curbed through a combination of levers, including annual budgets for regions and municipalities, collective purchasing and generic substitution for pharmaceuticals, and incentives to shift care from inpatient to outpatient settings.

Coverage is universal and automatic, with largely public financing

All Danish residents are automatically covered by the national health system. Financing comes predominantly from state-level general tax revenues and, to a lesser extent, a municipal income tax. The central government allocates block grants to regions and municipalities based on demographics and activity levels. The public share of health spending was 83 % in 2019. This was higher than the EU average (75 %) and has remained relatively stable over the past decade.

Figure 6. Per person, Denmark spends more on health than most other EU countries



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

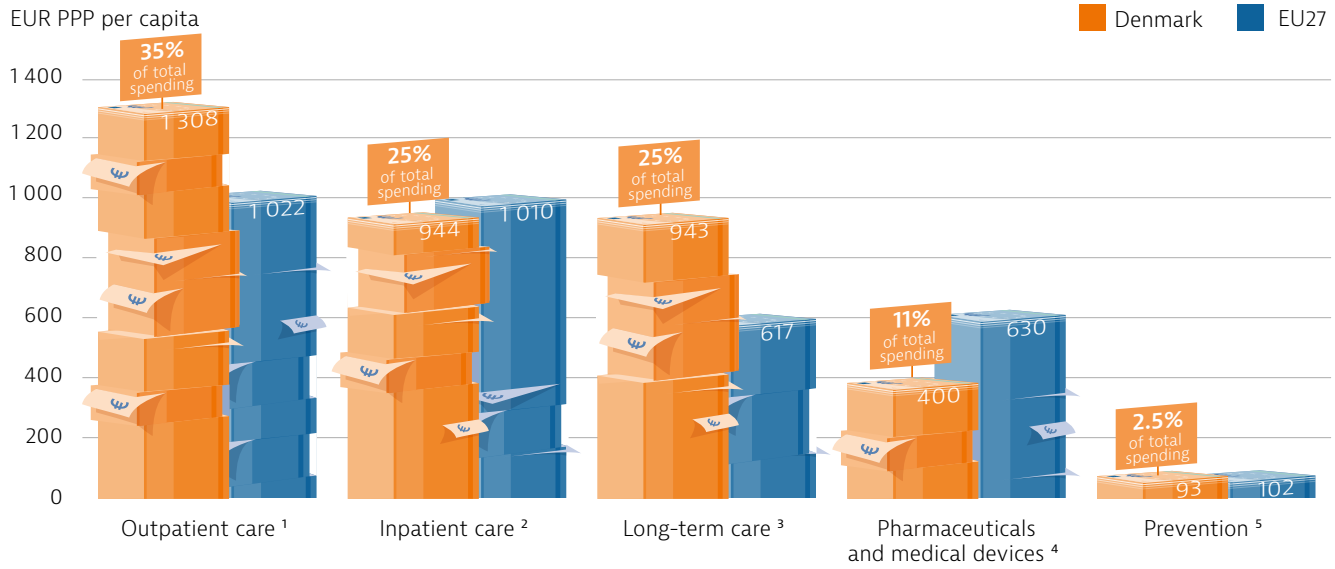
The highest share of health spending is on outpatient care, followed by inpatient and long-term care

Denmark's spending on outpatient care (including home care) in 2019 was notably higher than the EU average, both in per capita terms and as a share of total health spending (35 % compared with 30 %) (Figure 7). Inpatient care accounted for about 25 % of health spending – a lower share than the EU average. This share has decreased by 15 % in the past decade, reflecting reforms that have shifted care from hospitals to outpatient settings (see Section 5.1).

Spending on health-related long-term care in Denmark also accounted for around 25 % of all health spending – a much higher share than the EU average of 16 %. The proportion of spending on outpatient pharmaceuticals and medical devices is low, at just 11 % of total health expenditure in 2019, compared to an EU average of 18 %. Prevention programmes represented 2.5 % of health spending, which is slightly lower than the EU average of 2.9 %.

During the COVID-19 pandemic, funding injections were provided by central government to municipalities and regions (Box 2).

Figure 7. Denmark spends more on outpatient and long-term care than most other EU countries



Note: The costs of health system administration are not included. 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 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).

Box 2. Regions and municipalities received funding injections to support the pandemic response

Early in the COVID-19 crisis, it was announced that national authorities would accept budget over-runs by regions. In May 2020, the central government agreed to compensate regions for any additional expenditure in 2020 arising from the pandemic, and this was continued into 2021. Regions were allocated DKK 3.6 billion (EUR 498 million) in 2020 towards testing and personal protective equipment (PPE), and an additional DKK 3.2 billion (EUR 443 million) to compensate for COVID-19-related expenses in 2020. The new agreement for 2022 includes an additional DKK 1.7 billion (EUR 235 million) for COVID-19-related expenses in 2021.

The central government also allocated DKK 2.6 billion (EUR 360 million) in 2020 and DKK 1.3 billion (EUR 180 million) in 2021 to municipalities to help cover additional costs, including PPE and school cleaning expenditure.

Out-of-pocket spending on health is low, with some purchasing voluntary insurance

The share of health spending financed out of pocket in Denmark is low, at just 14 % of total health spending in 2019 – slightly lower than the EU average of 15 %. No co-payments are required for primary care visits or inpatient hospital care, including medicines prescribed during the stay, or specialist visits referred by a general practitioner (GP). Co-payments apply to partly covered services including outpatient medicines, dental services and physiotherapy. Although subsidies exist for these services, approximately four in ten Danes purchase complementary health insurance to cover cost-sharing. In addition, nearly one third of Danes hold supplementary health insurance, which provides expanded access to private providers and elective services, most often as a fringe benefit offered by employers. However, voluntary health insurance (VHI) represents only 2.5 % of health spending (see Section 5.2).

Denmark has more doctors and nurses per capita than the EU average

The number of doctors (4.2 per 1 000 population) and nurses (10.1 per 1 000 population) in Denmark is higher than the EU average (Figure 8). About one fifth of doctors are GPs – a similar proportion to the EU average. Several initiatives were implemented to increase the supply of GPs and nurses, both before and after the pandemic (see Section 5.2).

Denmark has relatively low utilisation of inpatient care and physician visits

Prior to the COVID-19 pandemic, Denmark had 2.6 hospital beds per 1 000 population, and the average length of hospital stay was 5.7 days – both values well below the EU averages. Following the implementation of policies aimed at shifting care to outpatient settings, the supply of hospital beds and average length of stay had been declining steadily over the past two decades (see Section 5.1). Despite relatively limited initial capacity, Denmark's hospital sector had sufficient surge capacity during the pandemic, albeit at the cost of suspending non-urgent care and elective surgeries (see Section 5.3).

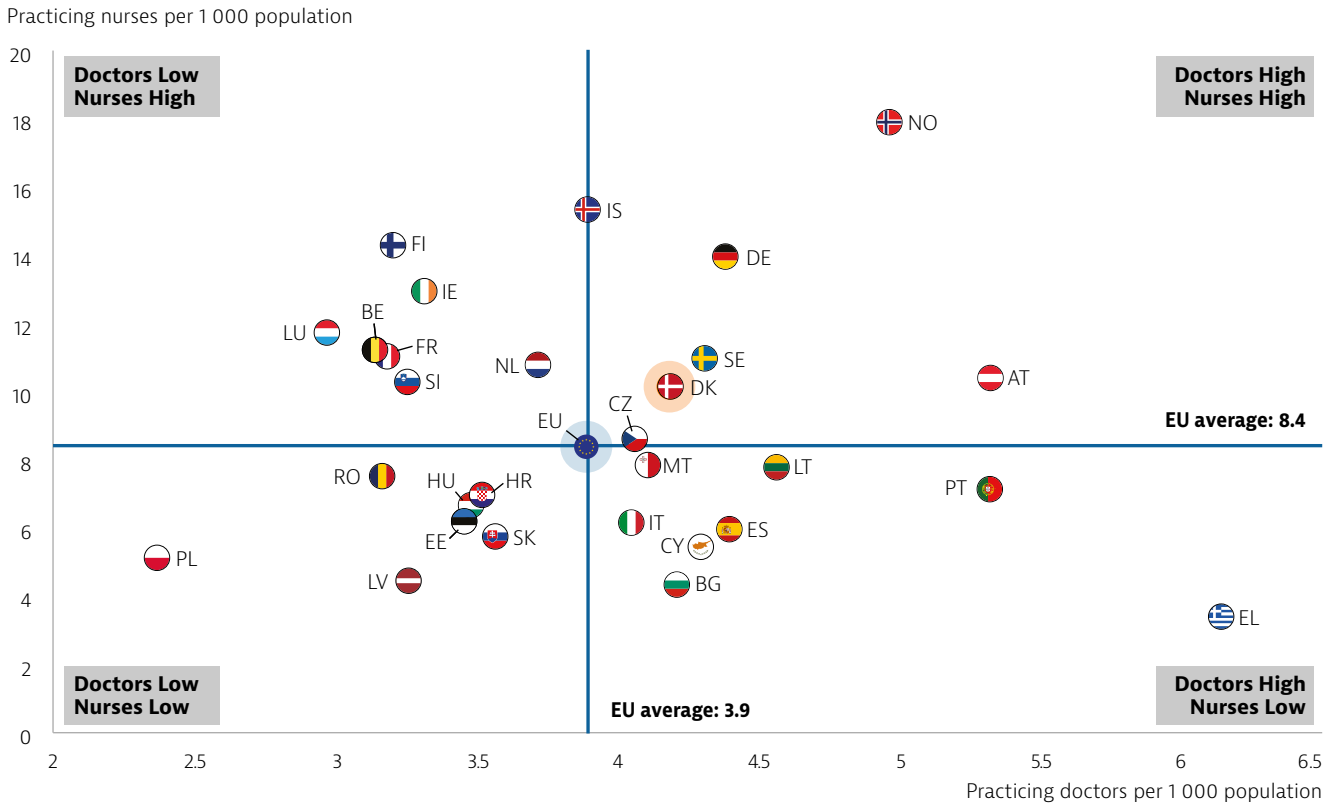
Danes also have one of the lowest rates of physician visits in the EU, averaging just 4.0 visits per person per year in 2019, compared to an EU average of 6.7.

Health care delivery is predominantly the responsibility of regional health authorities

Regional authorities are responsible for organisation and delivery of health care services in Denmark. People are generally required to register with a GP, who provides primary care and plays a gatekeeping role for access to hospital and most specialist care. GPs are predominantly self-employed, with 46 % in solo practices in 2019.

Practically all hospital beds (94 %) are publicly owned and operated by the regions; the remainder are in smaller private specialty hospitals. Outpatient specialty care is delivered at hospital-based ambulatory clinics by doctors employed by public hospitals or by private self-employed specialists in privately owned facilities.

Figure 8. Denmark has a relatively high number of doctors and nurses



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 Performance of the health system

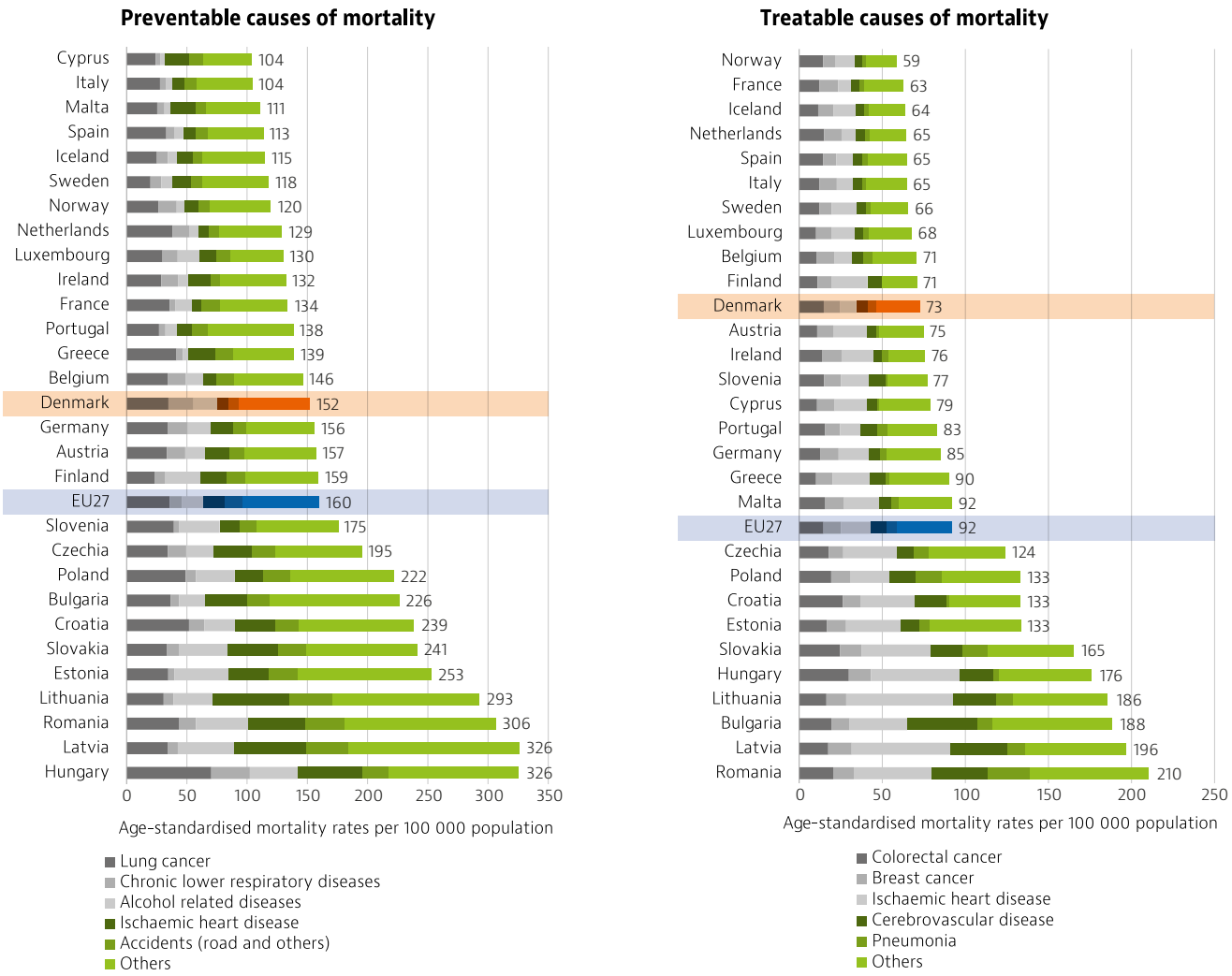
5.1 Effectiveness

Mortality from treatable causes is low, but more could be done to reduce preventable deaths

The rate of deaths considered to be largely preventable through effective public health and primary care interventions in Denmark in 2018 was slightly below the EU average. The leading causes were lung cancer, alcohol-related deaths and chronic lower respiratory tract diseases (Figure 9). Although the rate of preventable deaths fell by 17 % between 2011 and 2018, which is considerably more than the 10 % EU average fall, further prioritisation of public health and prevention policies – particularly around tobacco and alcohol control – would help Denmark reduce these deaths even further (see Section 3).

The mortality rate from causes deemed treatable through timely and effective health care in Denmark was firmly below the EU average in 2018. The main drivers were colorectal and breast cancer and ischaemic heart disease. This rate fell by 20 % between 2011 and 2018 – about twice the EU average fall (11 %). This testifies to the Danish health system's capacity to provide effective and timely treatment for life-threatening conditions.

Figure 9. Rates of preventable and treatable deaths are below 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).

Tobacco policies have reduced smoking, with greater focus recently on children and adolescents

Denmark's smoking rate has decreased over the past two decades – from 30 % of adults being daily smokers in 2000 to 18 % in 2020. This is less than the current EU average of 20 %. Nevertheless, new tobacco products such as e-cigarettes are becoming more popular. The Danish authorities have implemented several policies to achieve a "smoke-free generation" of children and young people by 2030, which is also a goal of the National Cancer Plan. In April 2021, stricter restrictions on tobacco advertising were introduced: visible tobacco products in shops and flavourings in tobacco and e-cigarette products were banned. In April 2020, the price of a pack of cigarettes was raised, and prices will increase further in 2022.

Alcohol control policies are less stringent than in other Nordic countries

Excessive alcohol consumption among young people remains a major public health issue (see Section 3). Although Danish adolescents generally drink less than 20 years ago, in recent years there have been increases in both the share of 15-year-olds who have tried alcohol (Tolstrup et al., 2019) and alcohol-related hospitalisations among young people (Danish Health Data Authority, 2020). Danish adolescents have comparably easier access to alcohol than those in other Nordic countries in two ways. First, the legal age for purchasing beer and wine is lower, at 16 compared to 18 years. Second, sales of beverages containing alcohol up to 16.5 % alcohol by volume are allowed in Danish supermarkets and other retail stores, while in Finland, Norway and Sweden, beverages containing above 3.5-5.5 % alcohol by volume can only be sold in government-owned monopoly stores.

The influenza vaccination was offered to more people during the pandemic

Influenza vaccines are recommended and offered free of charge to high-risk groups, including adults aged 65 and over, pregnant women, those with chronic conditions and immunocompromised people. During the 2020/21 winter season, the volume of vaccines purchased nationally was increased by 60 %, and the target population expanded to include front-line health care workers. The target vaccination rate for older adults was increased from 50 % in 2019/20 to 75 %, in line with the WHO recommendation.

COVID-19 delayed non-essential care, but the health system remained responsive to changing needs

At the peak of the first COVID-19 wave during March-April 2020, the Danish Health Authority instructed hospitals to postpone non-essential care and elective procedures to free up capacity for COVID-19 patients, while ensuring access to acute and cancer care. In mid-April 2020, the authorities allowed providers to resume non-COVID-19-related elective procedures, and private hospitals were contracted to help treat patients whose non-elective care and treatment had been postponed. Activity levels resumed pre-pandemic levels around June 2020 for ambulatory care services and in mid-September 2020 for hospital services.

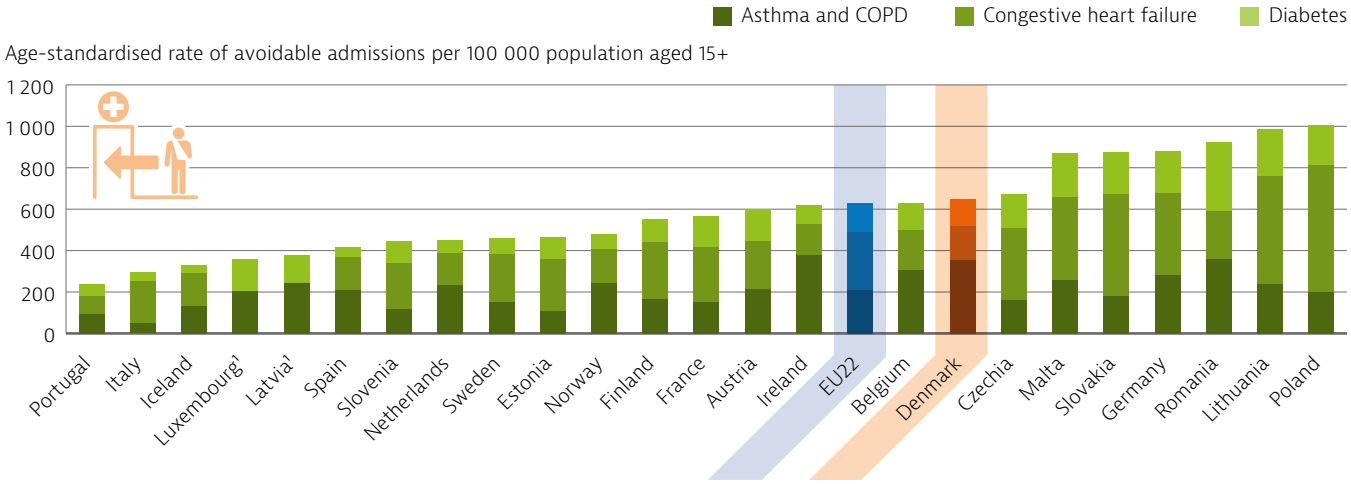
While non-essential care also had to be delayed during the second wave, smaller reductions in activity levels were observed, although this wave was longer and had a higher number of cases and hospitalisations. This suggests that the Danish health care system was generally able to alleviate the impacts on non-COVID-19 patients. Activity levels for both ambulatory and hospital sectors resumed pre-pandemic levels by mid-February 2021 (Danish Health Authority, 2021). The one-month waiting time guarantee for accessing diagnosis and treatment that has been in place for several years was suspended until September 2020 for psychiatric care and until March 2021 for other care.

Avoidable hospital admissions could be reduced by better management of chronic conditions

Hospital admission rates in Denmark remain high for some chronic conditions that could be managed effectively in outpatient settings – particularly asthma and COPD, for which Denmark reported one of the highest rates in the EU in 2019 (Figure 10). Conversely, hospitalisation rates for diabetes and congestive heart failure are lower than in most other EU countries.

Reducing preventable hospitalisations is a national policy goal. Since 2017, telephone self-management support has been provided to individuals at high risk of acute admissions – often those with multiple chronic conditions (Fredens et al., 2020). As of 2019, an element of regional funding is dependent on performance related to coordination of care. In June 2021, the government announced the establishment of 21 "health clusters", representing collaborations between regional and municipal health services tasked with strengthening prevention and care coordination activities for patients – particularly those with chronic conditions. They are expected to be launched in July 2022.

Figure 10. Asthma and COPD represent more than half of all avoidable hospital admissions



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).

Cancer survival is generally good, but incidence and mortality remain high

Survival rates following diagnosis for various types of cancer in Denmark compare favourably with most other EU countries (Figure 11). Overall cancer survival rates increased from 59 % in 2008-10 to 67 % in 2016-18 (Ministry of Health, 2021).

Lung cancer is responsible for most cancer deaths. Mortality rates are the third highest in the EU, and five-year survival rates remain low, as in other EU countries.

Standardised care pathways were introduced in 2007 to improve the quality of cancer care. In 2021, 29 cancer pathways detail standardised clinical guidelines and waiting time goals for diagnosis, treatment and rehabilitation. The current National Cancer Plan for 2017-20 included ambitious goals, many of which were continued into 2021 in response to the COVID-19 pandemic (Ministry of Health, 2021). The objectives of the Plan are consistent with those of the Europe's Beating Cancer Plan (European Commission, 2021a), including improving diagnostic and treatment capacity as well as quality of life for patients and survivors.

Figure 11. Five-year cancer survival rates for common cancers are above the EU average

Prostate cancer	Childhood leukaemia	Breast cancer	Cervical cancer	Colon cancer	Lung cancer
Denmark: 86 %	Denmark: 94 %	Denmark: 86 %	Denmark: 70 %	Denmark: 62 %	Denmark: 17 %
EU23: 87 %	EU23: 85 %	EU23: 82 %	EU23: 63 %	EU23: 60 %	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.

Cancer care was a priority, but COVID-19 had some impact on screening and treatment referrals

When the first and second waves of the pandemic forced the postponement of elective care, the Danish Health Authority instructed providers to prioritise cancer screening and treatment. Nonetheless, reductions in screening rates for several types of cancer were observed during both waves, and activity did not return to pre-pandemic levels until February 2021.

Access to cancer treatment seems to have been less affected, however. In 2020, the number of patients referred to cancer pathways was comparable to previous years, and 80 % of enrolled patients completed their care within the recommended time frames – a rate similar to that observed prior to the pandemic.

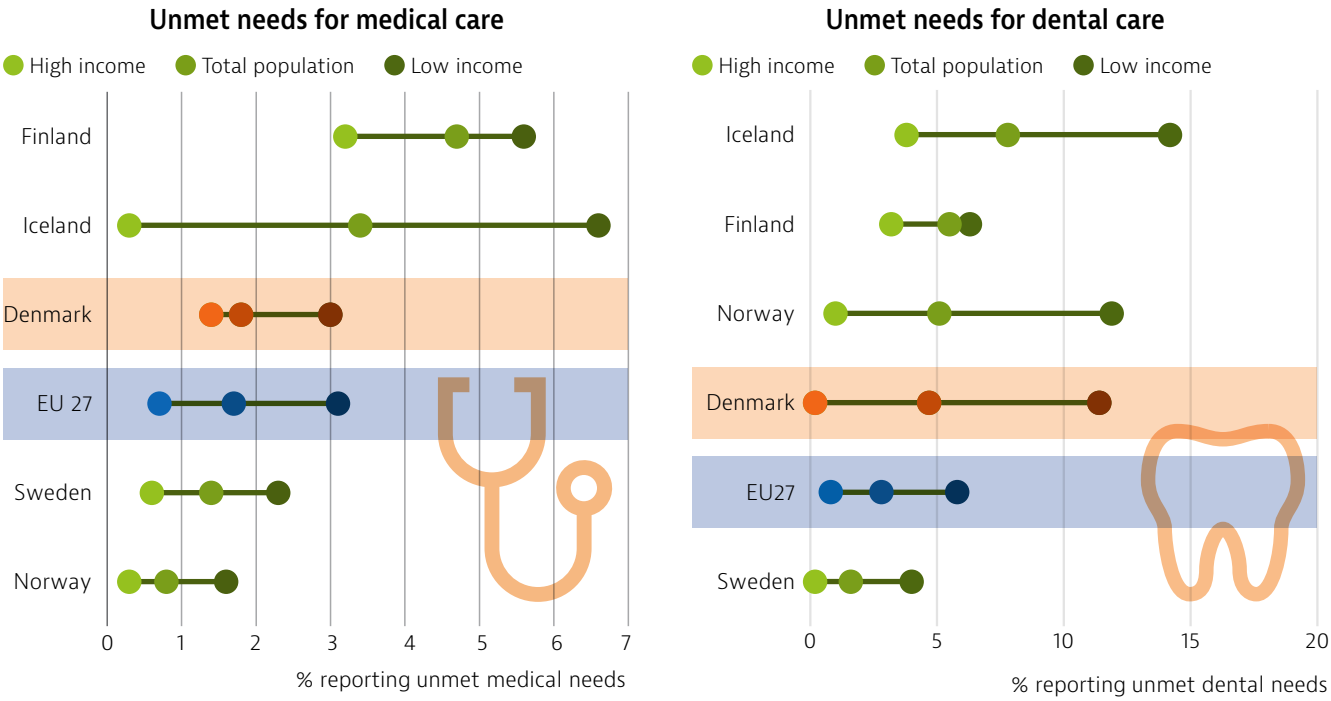
5.2 Accessibility

Extensive public coverage for medical services results in low levels of unmet needs

All legal Danish residents, including registered immigrants and asylum-seekers, are automatically covered by the tax-funded national health system, while undocumented migrants have access to acute care only. The system covers most of the costs of covered medical services (see Section 4). Fewer than 2 % of the population reported unmet needs for medical care due to cost, distance or waiting times in 2019, mainly driven by waiting times. The difference in unmet medical needs between people in the lowest and highest income quintiles is smaller than that in the EU as a whole (Figure 12).

Unmet needs for dental care are higher: 4.7 % of Danes reported them in 2019, largely driven by affordability. Inequalities by income were larger than in the EU overall, with more than 11 % of people in the lowest quintile reporting unmet dental care needs compared to less than 1 % of those in the highest.

Figure 12. Unmet needs for medical examinations are low but for dental care are higher

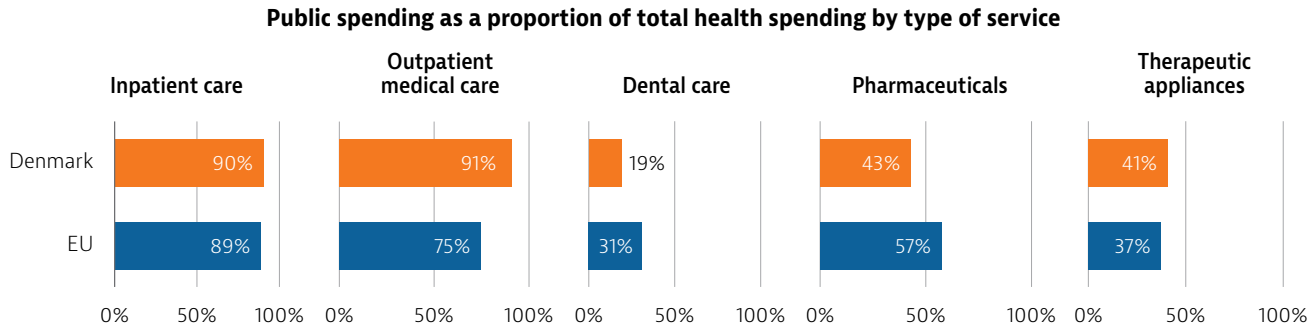


Note: Data refer to unmet needs for a medical or dental examination or treatment due to costs, distance to travel or waiting times.
Source: Eurostat Database, based on EU-SILC (data refer to 2019, except Iceland 2018).

Public coverage of pharmaceuticals and dental care is low, but outpatient care coverage is generous

Unmet needs for dental care can be explained in part by the relatively low levels of coverage by the statutory system. In 2019, just 19 % of dental care spending was publicly covered, compared to 31 % across the EU (Figure 13). Similarly, coverage of outpatient pharmaceutical costs was lower than the EU average of 57 %, at 43 % of total expenditure. Meanwhile, outpatient care coverage is more generous than across the EU overall.

Figure 13. Public coverage is above EU average for outpatient care but lower for dental care and pharmaceuticals



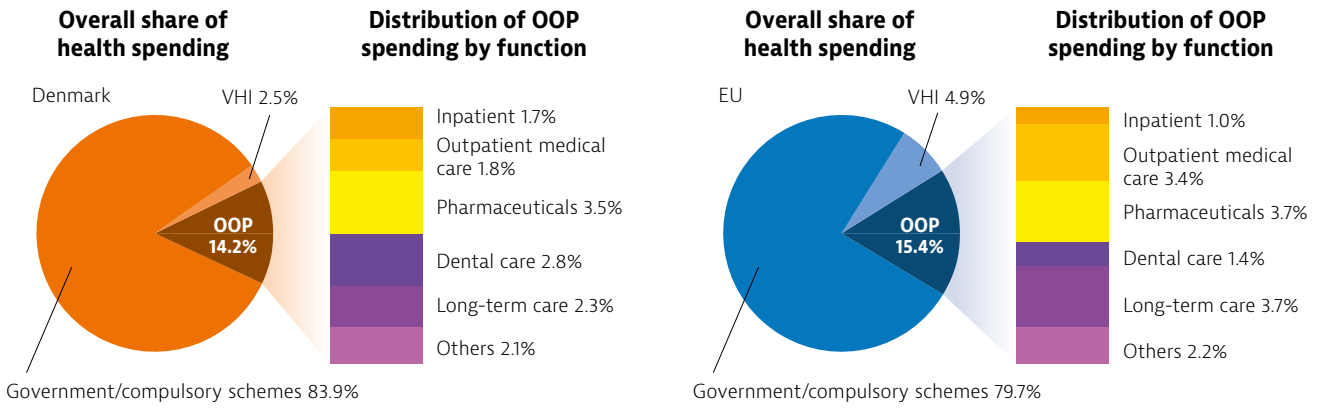
Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Hospital administered medicines are free of charge for patients.
Source: OECD Health Statistics 2021 (data refer to 2019).

Lower coverage rates for outpatient pharmaceuticals and dental services lead to a concentration of out-of-pocket (OOP) expenditure in these areas: together, they contributed to 44 % of total OOP spending in Denmark in 2019 (Figure 14). Subsidies exist for outpatient prescription medicines, dental care and physiotherapy.

The share of pharmaceutical costs subsidised increases with greater expenditure, which is fully covered once an annual ceiling of DKK 4 270 (EUR 591) has been met.

Overall, OOP expenditure accounted for 14.2 % of health expenditure in Denmark in 2019 – a share that has remained stable over the past decade. This is slightly lower than the EU average of 15.4 %.

Figure 14. The largest shares of out-of-pocket spending are on pharmaceuticals and dental care



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

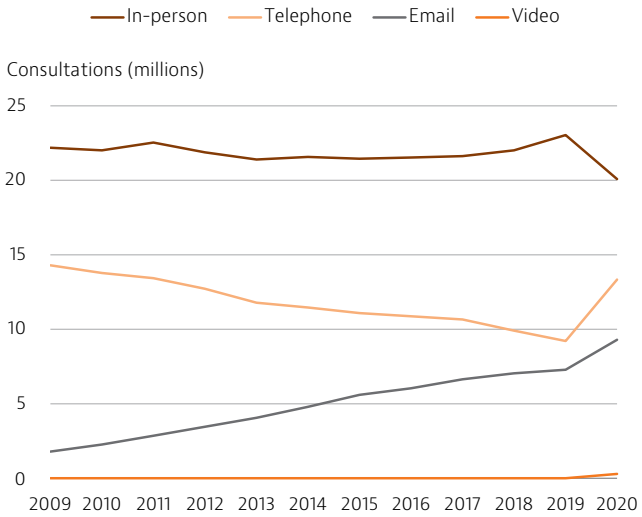
Teleconsultations helped to retain low rates of unmet needs for medical care during the pandemic

Teleconsultations were scaled up rapidly during the first wave of the pandemic. Video consultations with GPs and some specialists were made possible through the national "Min Læge" (My Doctor) mobile application. To incentivise provision, reimbursement fees for physicians were increased. The Health Ministry funded all information technology-related costs.

A rise in the use of video, telephone and email consultations (Figure 15) contributed to a 9 % higher overall number of GP consultations in 2020 than 2019, despite a 13 % reduction in in-person visits. Video consultations also quickly expanded for the outpatient specialty sector, helping to keep overall consultation volumes in 2020 similar to levels before the pandemic.

According to a Eurofound survey, 46 % of Danes received an online or telephone medical consultation during the first 12 months of the pandemic – more than the EU average (39 %). Danes were also among the least likely in Europe to report not receiving a needed medical examination or treatment during the first 12 months: just 10 % compared to a 21 % EU average (Eurofound, 2021)[3]. Denmark's Recovery and Resilience Plan, funded by the EU's Recovery and Resilience Facility for 2021-26, includes four investments in the health care system, one of which supports digital transition objectives, including increasing the use of telemedicine.

Figure 15. In-person GP consultations decreased in 2020, while teleconsultations increased



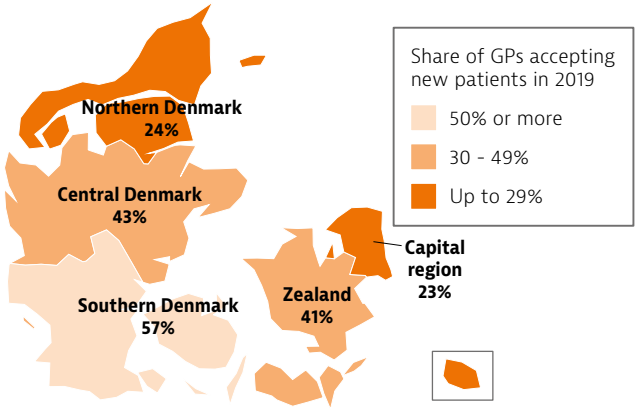
Note: Data refer to day-time consultations.
Source: Danish Health Authority (2021).

Denmark has a high supply of doctors, but GP choice is restricted in practice

The number of doctors and nurses per population in Denmark is slightly higher than the EU average (see Section 4). However, Denmark faces GP shortages – particularly in rural and remote areas. In 2019, only 37 % of GPs were accepting new patients, down from 51 % in 2015. There was, however, wide geographical variation between regions (Figure 16). This means that, in practice, many Danes have difficulty finding a GP if they move or want to change their regular doctor. A number of initiatives have been introduced to increase the supply of GPs and improve their geographical distribution (Ministry of Health, 2020).

3. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies*

Figure 16. There is wide variation in the share of GPs accepting new patients across regions



Source: Ministry of Health (2020) (data refer to 2019).

The government announced plans in 2019 to employ 1 000 new nurses in the hospital sector – half by December 2020 and with the remainder during 2021. In June 2020, a government-appointed task force presented 23 recommendations to strengthen the health and care sector workforce (Ministry of Finance, 2020). In 2021, it was announced that the number of training slots for specialist physicians was to be increased by 8 % by 2023.

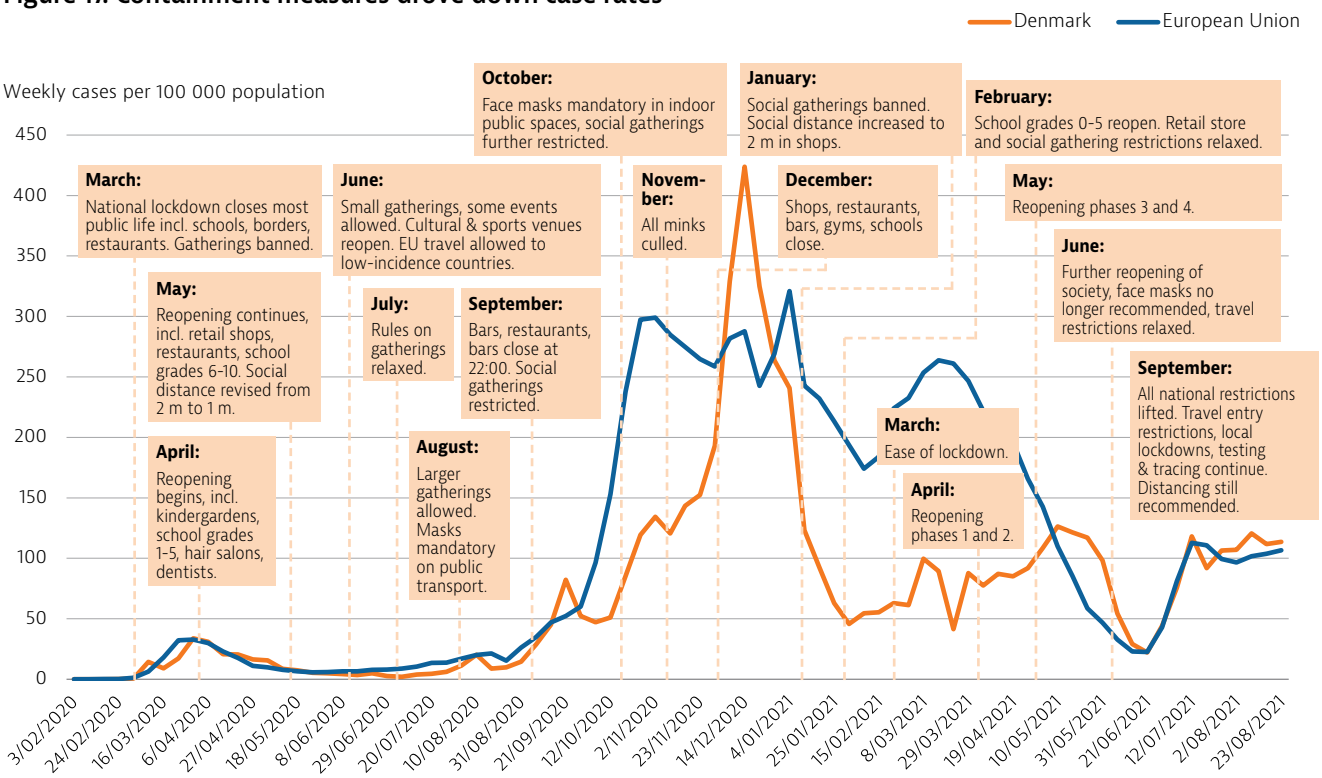
5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic[4]. As noted in Section 2, the pandemic had a smaller impact on population health and mortality in Denmark in 2020 and the first eight months of 2021 than in most other EU countries. Danish GDP fell by over 2 % in 2020, which is notably less than in many European countries.

The first COVID-19 wave in the spring of 2020 was better contained than the second wave

The first case of COVID-19 in Denmark was detected on 27 February 2020. A national lockdown was declared on 11 March, which closed schools, borders, restaurants and shops, mandated remote working and banned social gatherings (Figure 17). Early implementation of these measures – three days ahead of the registration of the first COVID-19 death in Denmark – helped to curb the spread of the virus. Enforcement of containment measures required emergency legislation (see Box 1). Denmark was one of the first countries in Europe to start reopening, in April 2020. A gradual, phase-wise approach was taken, which allowed different regions to reopen at different rates, depending on their level of infection control.

Figure 17. Containment measures drove down case rates



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and authors for containment measures.

4. *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).*

Cases continued to decrease throughout the summer, but started to rise again in August 2020. During the autumn, containment measures were localised at first, but were gradually expanded to national restrictions as cases started to rise. An outbreak of COVID-19 in mink farms necessitated swift action to mitigate the spread to humans (Box 3). The second wave peaked around December 2020-January 2021. National containment measures were relaxed starting in February 2021, continuing throughout spring. From 10 September 2021, COVID-19 was no longer considered a "critical threat to society", resulting in lifting of national restrictions. Travel entry restrictions and local lockdowns have continued, and distancing is still recommended.

By the end of June 2021, 5.0 % of the population had been diagnosed with COVID-19 – considerably lower than the EU average (8.2 %). This figure may be an underestimate, however, given that some infected individuals are asymptomatic and do not seek tests. A large population-based study commissioned by the Danish Parliament indicated that, by May 2021, 8.6 % of the population aged 12 and over had developed antibodies against SARS-CoV-2.

Box 3. Swift containment measures halted transmission of COVID-19 variants found in minks to humans

SARS-CoV-2 was first detected in mink farms in North Jutland in June 2020, and thereafter spread to other areas of the country. After transmission to humans was confirmed, Danish authorities mandated strict containment measures in affected municipalities, and introduced mass population testing.

Several virus variants were detected in minks. Out of concern that some of these might become resistant to vaccines, Danish authorities ordered all mink – about 11 million animals – to be culled in November 2020. A ban on mink farming was introduced, which applies until January 2022. Restrictions in the affected municipalities were lifted in December 2020.

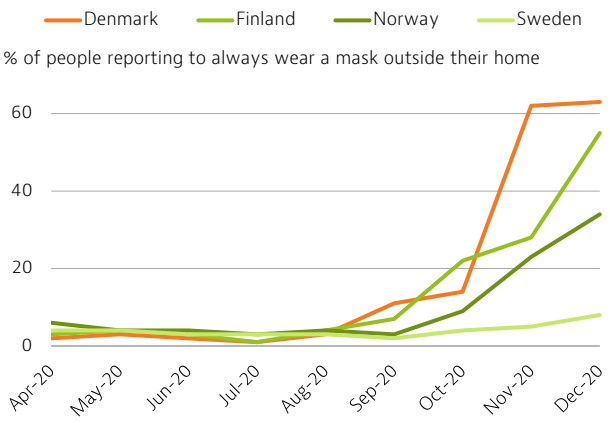
In total, SARS-CoV-2 was detected in one quarter of Danish mink farms (290), representing the majority of the 400 mink farms in Europe where the virus was reported. One-fifth of people connected to mink farms became infected. The outbreak prompted an ECDC investigation, which recommended greater monitoring of SARS-CoV-2 across all European mink farms.

Source: Larsen et al. (2021).

Mask-wearing was uncommon, but increased in line with policy mandates during the second wave

As in other Nordic countries, Denmark did not mandate the use of face masks at first, although it was recommended in certain situations. As a result, Denmark had among the lowest rates of mask-wearing outside the home among European countries until August 2020 (Figure 18), when masks became mandatory on public transportation. In October 2020, when face masks were mandated in all public indoor spaces, their use quickly increased, with more than 60 % of the population reporting that they wore a mask outside their home. Municipalities provided free masks for individuals facing financial difficulties. From June 2021, the Danish Health Authority stopped recommending use of masks, except on public transportation and for quarantined and symptomatic individuals, and masks were no longer required on public transportation from August.

Figure 18. Levels of mask-wearing were low until summer 2020, with a rapid increase during autumn



Source: YouGov data (http://www.coviddatahub.com/)

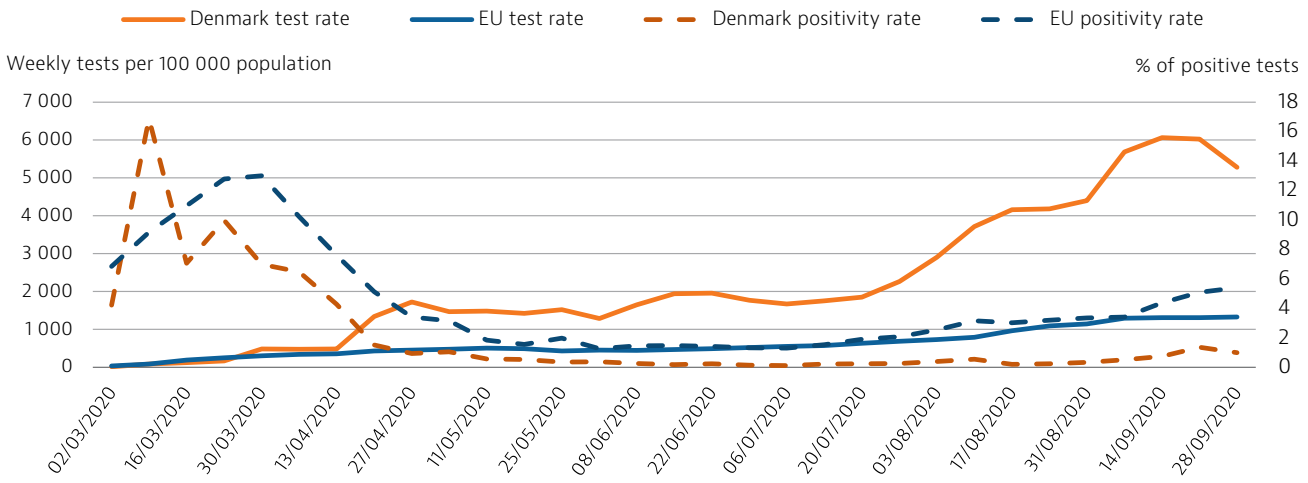
Initial testing capacity was high and boosted by the private sector during the second wave

Denmark was quick to scale up its diagnostic testing capacity for COVID-19. The national testing strategy gradually changed from a conservative approach – according to which only those with severe symptoms were tested, to a broader and more aggressive strategy including people with mild symptoms in March 2020, asymptomatic individuals in April and others in May. Tests are free for everyone, including foreign citizens and tourists.

In April 2020, high-throughput testing sites were established quickly, helping Denmark reach the highest number of daily tests in Europe early in the pandemic. Private laboratories helped expand antigen (rapid) test capacity during the second wave, when patients faced longer waiting times. Denmark's test rates remained above those in other Nordic countries and the EU average throughout the pandemic.

Positivity rates peaked at nearly 17 % in early March 2020 but declined with expanded testing capacity and a broadening of test eligibility criteria. From the end of April 2020, positivity rates remained below 2 %, which is notably lower than the EU average (Figure 19).

Figure 19. From April 2020, testing rates in Denmark remained higher than the EU average



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

Several policies helped to expand availability of medical equipment and medicines

While diagnostic laboratory capacity was expanded early in the pandemic, shortages of supplies needed for testing machines were experienced – such as plastic trays, chemical substances and pipettes. In March 2020, the Health Ministry mandated private companies, regions and municipalities to inform the Danish Medicines Agency about their stocks of pharmaceuticals and medical equipment, to allow them to be redistributed to parts of the health system with greatest need. The Agency also launched the "Denmark helps Denmark" campaign, an online platform allowing private firms to donate their PPE and disinfectant supplies to front-line health personnel. In August 2020, the government launched a new agency tasked with ensuring the supply of testing capacity and PPE. Ventilators were made available by the military and private hospitals, which are required to provide their supplies and general capacity in an emergency situation, according to the General Health Law. It did not become necessary to use these additional resources, however.

The contact tracing strategy shifted, adding a mobile application and supportive policies

Denmark's contact tracing strategy initially required people who tested positive to track down recent contacts themselves. The government set up a call centre in May 2020 to assist individuals with tracing and isolation. In June, a contact tracing unit was established under the national Patient Safety Agency, tasked with contacting all individuals testing positive and offering them advice about tracing their contacts. By the height of the second wave in January 2021, municipalities took on a shared role in contact tracing activities, as well as providing support to quarantined individuals.

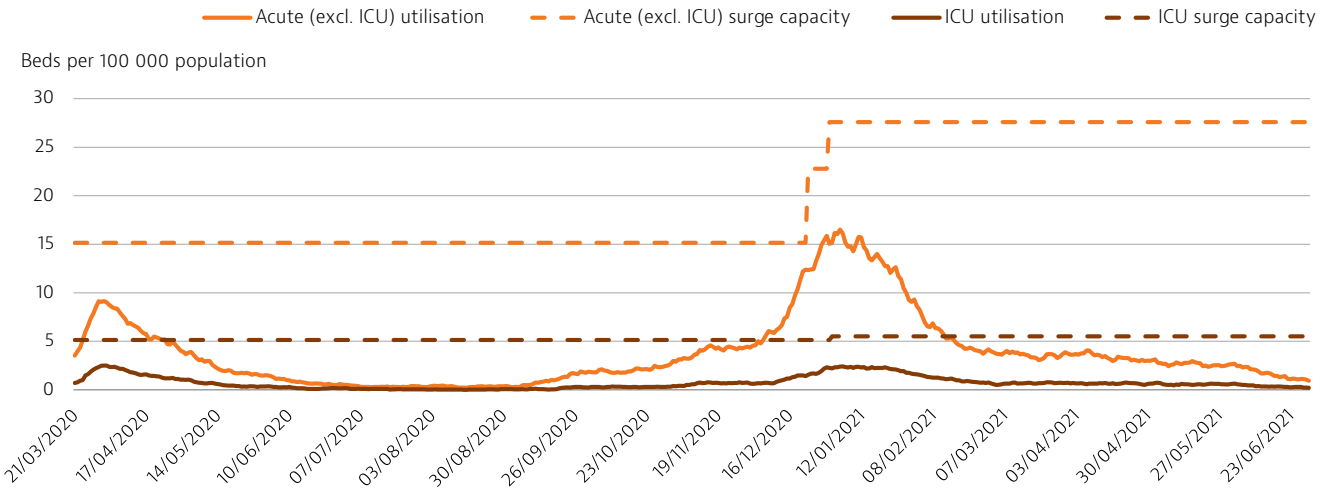
A mobile application, "Smitte|Stop" (Infection|Stop), was launched in June 2020 to assist with contact tracing, based on anonymised Bluetooth technology. The app received half a million downloads within 10 days of launching. By the end of June 2021 it had been downloaded more than 2.3 million times, with 76 886 users logging a positive result, and more than 114 000 users booking a COVID-19 test as a result of a notification received from the app.

Curative and intensive care bed capacity was sufficient to handle the surge in demand

According to Denmark's pandemic preparedness plan, regions are responsible for developing contingency plans to ensure hospital capacity during national emergencies. Initial calculations at the beginning of the pandemic overestimated the national surge capacity required (Danish Parliament, 2021), and were revised down in spring 2020. During the peak of the first wave in early April 2020, around half the national surge capacity – acute and intensive care unit (ICU) beds – reserved for COVID-19 patients was used, reaching 2.5 occupied ICU beds and 6.7 occupied acute (excluding ICU) beds per 100 000 population (Figure 20).

During the second wave, the Danish Health Authority asked regions to increase their acute bed surge capacity by 50 %, while ICU surge capacity was maintained at existing levels. Utilisation peaked in early January 2021, with 2.4 occupied ICU beds and 14.1 acute beds per 100 000. At the end of May 2021, the Authority instructed regions to resume normal operations, as COVID-19 patients were anticipated to be able to be handled within the remit of the existing, non-surge hospital capacity. The second wave also saw hospitals co-operating to a larger extent than during the first wave, helping to offload non-COVID-19 patients from regions struggling to cope with patient numbers.

Figure 20. Surge acute care bed capacity had to be increased during the second wave



Note: Surge capacity refers to the number of beds reserved for COVID-19 patients. Utilisation refers to patients with confirmed COVID-19. Total national surge capacity was increased on 23 December 2020 by all regions following an official request by the government, and further on 31 December 2020, after two regions decided to increase their capacity.
Source: National Serum Institute.

Health workforce capacity was expanded in various ways during the first wave

During the spring of 2020, Denmark used several approaches to boost its health workforce capacity. Regional health authorities (responsible for organising hospital services) established reserve lists where retired health professionals, as well as medical and nursing students, could sign up to provide services if needed in the event of a surge. This necessitated fast-track retraining in some cases, particularly for roles in ICU and ventilator facilities. Similarly, nurses from surgical departments, which saw a decline in activity due to delayed elective operations, were reassigned to COVID-19 wards. During the lockdown, childcare facilities and schools remained open specifically for children of health care workers to enable them to go to work.

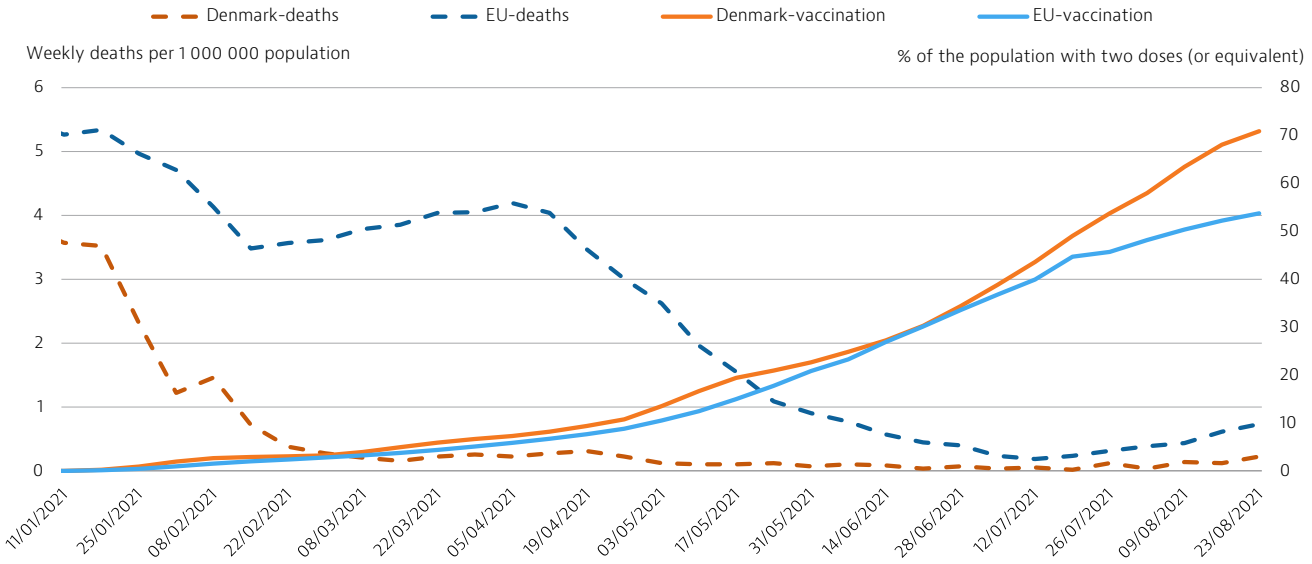
Denmark's vaccine strategy contributed to the full reopening of society by September 2021

As with all other EU countries, Denmark started COVID-19 vaccinations at the end of December 2020. Populations were prioritised according to risk, with nursing home residents, people at risk of severe COVID-19 complications (with certain chronic conditions), older adults and front-line workers first in line. Vaccinations are free and voluntary, and are administered as part of the national vaccine programme. The National Serum Institute is responsible for purchasing and distributing vaccines to regions, based on population size. Regions organise delivery; administration occurs at vaccination stations, nursing homes and hospitals, and at home for some vulnerable groups. In mid-February 2021, the government invited private providers to join vaccination efforts, alongside GP offices and pharmacies.

The vaccine strategy was revised several times. In March 2021, older adults were prioritised to a greater degree. Following reports of rare but potentially fatal blood clots, the Danish Health Authority paused AstraZeneca vaccinations in mid-March and removed them from the national programme in April. In early May, the vaccine developed by Johnson & Johnson was also removed following similar reports, since the risks were considered to outweigh the benefits, given the low infection rates prevailing at the time. Those who had received a first AstraZeneca dose were offered a second dose of an mRNA vaccine. Both vaccines remain available following a risk assessment by a doctor, outside the national vaccination programme. In July, the national vaccination programme was expanded to 12-15-year-olds. By the end of August 2021, 76 % of the population had received at least one vaccine, and 72 % had received two doses (or equivalent) – a much higher share than the EU average (Figure 21).

In May 2021, the government launched the "Corona pass" mobile app that uses data from COVID-19 tests, vaccinations and recovery from disease, to grant access to events, restaurants and domestic travel. From July, it could also be used for travel within EU/EEA countries. Following full national reopening in September 2021, the "Corona pass" was no longer required for entry to public institutions and events.

Figure 21. The share of people vaccinated against COVID-19 was higher than the EU average at the end of 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 cases and Our World in Data for vaccination rates.

Denmark's health information technology structure complements the European Health Data Space strategy

Denmark has a world-class health information technology infrastructure, which played a significant role in management of the COVID-19 pandemic. National exchange of data is possible through electronic medical records that are accessible to individuals and health professionals at all levels. The system facilitates digital referrals, prescriptions and visits, as well as access to laboratory test results. Providers can also use the national online health information portal to communicate with other providers regarding referrals, discharges and prescriptions. Unique electronic personal identifiers are used to connect data across registries and databases.

During COVID-19, this infrastructure made real-time epidemiological surveillance possible. Denmark is one of only six countries in Europe that make health care data readily and securely available to the research community through real-time remote access services or a research data centre. The Danish Health Data Authority, a subdivision of the Ministry of Health established in 2015, provides access to health data related to service, quality, utilisation and clinical registries for clinicians, the public and researchers. In March 2021, a unified data portal was launched to strengthen access to health data for researchers. Several features of the Danish health information system therefore complement the European Health Data Space initiative, which aims to promote better exchange of and access to health data for research and policy purposes (European Commission, 2021b).

6 Key findings

- Life expectancy in Denmark in 2020 was 81.6 years – one year higher than the EU average. Denmark was one of the only two EU countries where life expectancy continued to grow at least modestly in 2020, despite the pandemic – partly because the number of COVID-19 deaths was much lower than in most other EU countries.

- Some behavioural risk factors remain important public health issues in Denmark. Although smoking rates are below the EU average, Denmark has a higher share of deaths attributable to tobacco smoking than most other EU countries, and respiratory conditions are among the leading causes of preventable mortality. Recently announced tobacco control policies are expected to contribute to improvements in this area. High rates of physical inactivity and excessive alcohol drinking among adolescents, as well as growing obesity rates and poor nutritional habits among adults, are other important public health issues.

- Denmark spent 10 % of GDP on health care in 2019 – a similar share to the EU average. Overall, the system appears to allocate and use its resources efficiently. Concerted policy efforts have succeeded in shifting care from inpatient to community settings. Denmark's investments in digital care options have enabled eHealth and telehealth options, which have improved accessibility – particularly through the pandemic.

- Danish residents enjoy universal access to a comprehensive package of health services. Unmet needs for medical care are generally low. However, because dental care is less well covered, unmet needs and out-of-pocket spending for dental services are higher, particularly among lower income groups.

- The mortality rate from COVID-19 between early March 2020 and end of August 2021 was three-and-a-half times lower in Denmark than the EU average, in part because of better containment measures (particularly during the first wave), responsive and flexible health system, and more widespread testing.

- At the start of the pandemic, testing was quickly scaled up to achieve one of the highest testing rates in Europe. Widespread testing enabled the country to be one of the first in Europe to relax containment measures and reopen society in April 2020. During the second wave in autumn 2020 and winter 2021, private laboratories were mobilised to provide additional testing support.

- The health system remained responsive to changing needs throughout the COVID-19 pandemic. Hospital and intensive care unit bed capacity was never exhausted, and private hospitals provided additional hospital capacity. Co-operation between hospitals across regions improved during the second wave of the pandemic in autumn 2020. While elective surgeries were postponed during the peaks of the first and second waves, activity levels for primary care were maintained at regular levels, in part thanks to rapid national rollout of app-based teleconsultations. As a result, unmet health care needs during the first twelve months of the pandemic were among the lowest in Europe.

- As with all other EU countries, Denmark started COVID-19 vaccinations at the end of December 2020. Populations were prioritised according to risk, with nursing home residents, other older adults, people at risk of severe COVID-19 complications and front-line workers first in line. By the end of August 2021, 76 % of the Danish population had received at least one vaccine, and 72 % had received two doses when recommended, a higher share than the EU average.

Key sources

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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		

European Commission

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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