EUROPEAN UNION STRATEGY IN THE FIELD OF HEALTH

Assoc. prof. Mădălina-Gabriela ANGHEL PhD *(madalinagabriela_anghel@yahoo.com)*
„Artifex" University of Bucharest
Prof. Constantin ANGHELACHE PhD *(actincon@yahoo.com)*
Bucharest University of Economic Studies / „Artifex" University of Bucharest
Doina AVRAM Ph.D Student *(doina.avram@gmail.com)*
Bucharest University of Economic Studies

Abstract

Health is one of the main concerns in the European Union and aims to increase as far as possible through living and working conditions, the unaffected health period, being protected against illness, accidents and other possibilities of shortening longevity. Conditions that can ensure sustainable health for the entire population are manifested in many ways. First, food consumption, working conditions, the environment and social policy. The competence of the European bodies in the field of health and treatment services is one of the points that the Member States are considering. The European Union considers that Member States must strive to ensure, as far as possible, the continuity of standard measures, while at the same time ensuring the conditions for the recovery of the workforce.

Keywords: *medical condition, treatment, medical staff, living conditions, sustainable health*

JEL Classification: I11, I18

Introduction

The European Union places a great emphasis on ensuring preventive treatment, the first target of health insurance. The analysis also covers the curative treatment conditions that meet all the requirements for bringing the affected persons to normal health conditions. The study also covers the provisions of the European strategy to ensure better living conditions. Each member country is expected to implement a national health security system, to provide the whole population with medications and treatments that have a preventive effect than those who have a curative meaning, ie after the outbreak is detached. Information on the European Union shows that there is a common set of health indicators, from which Europe and all member countries through a general agreement include the best methods and treatments in the national health system. The calculation of national indicators refers to average life

expectancy, life expectancy, mortality, birth rate, infant mortality, and several other indicators. The problem is that the ones outlined in the European Union Health Strategy are correctly implemented by each Member State.

Literature review

Bjarnason-Wehrens et al (2010) said that in most European countries fewer than half of cardiovascular patients benefit from cardiac rehabilitation (CR) programs. De Vos (2012) demonstrated the importance of raising patients' awareness of the benefits of cardiac rehabilitation. Kuitto conducted a study demonstrating that disaggregated social spending measures are of considerable importance in understanding the realities of contemporary social policy (2011). Wendt (2009) presented a typology of health care systems that simultaneously takes into account data on spending, funding, provision and access to healthcare in 15 European countries. Helmert, Cacace, Grimmeisen, Wendt, and Rothgang (2005) conducted a research that tended to converge in the role of the state for the three main dimensions of health systems, namely service delivery, funding and regulation. Sjostrom, Oja, Hagstromer, Smith and Bauman (2006) conducted a study that found that two-thirds of adult populations in European countries are insufficiently active for optimal health benefits. Dodd, Al-Nakeeb, Nevill and Forshaw (2010) investigated the prevalence and grouping of five life-style risk factors at a UK higher education institution, namely: psychological stress, physical activity, fruit and vegetable intake , alcohol consumption, smoking and demographic factors, women with a higher psychological stress than men. Arbyn, Raifu, Weiderpass, Bray and Anttila (2009) demonstrated that there are remarkable contrasts in cervical cancer mortality, especially among the old and new EU Member States, which may be explained by differences in preventive strategies, thus, in the old Member States, the cervical cancer mortality rate has declined, in some eastern European countries it has remained constant or even increased, as is the case with Romania or Bulgaria. Stuckler, Basu, Suhrcke et al. (2009) investigated how economic changes have affected mortality rates over the past three decades and identified how governments could reduce adverse effects. Nichols, Townsend, Scarborough and Rayner (2013) showed that although recent odds of coronary heart disease (CHD) in many countries are now less than half that of the early 1980s, trends in mortality rates vary significantly between EU countries. Jagger, Gillies, Moscone et al (2009), based on the fact that there are substantial inequalities between EU Member States at 50, demonstrated that without major improvements in population health, the objective of increasing the participation of the elderly in force work will be difficult to accomplish in all EU countries.

Research methodology, data, results and discussions

The average life expectancy at birth is measured by the healthy life expectancy indicator at birth and takes into account the number of neonates with perfect health or born with some congenital medical problems. Healthy years of life are an indicator that measures the relative health of the working population and is determined by everyone's living conditions. In 2014, the number of years of health, the anticipation of the number of years of health at birth was estimated at 61.4 years for female and 61 for male. There are states in the European Union, such as Sweden and Denmark, where life expectancy is much higher for women than for men.

In table no. 1 presents aspects of life expectancy at the age of 65, the two sexes. It follows that both men and women have a positive tendency to increase their average life expectancy.

Healthy life years in the European Union in 2014

Table no. 1

	Healthy life years in absolute value at birth		Healthy life years and life expectancy at age 65 by sex	
GEO/INDIC_HE	Females	Males	Females	Males
Belgium	63.7	64.5	11.0	11.0
Bulgaria	66.1	62.0	9.6	8.7
Czech Republic	65.0	63.4	9.3	8.5
Denmark	61.4	60.3	12.8	11.0
Germany	56.5	56.4	6.7	6.8
Estonia	57.1	53.2	6.0	4.9
Ireland	67.5	66.3	12.3	11.4
Greece	64.8	64.1	7.1	7.7
Spain	65.0	65.0	9.4	10.1
France	64.2	63.4	10.7	10.4
Croatia	60.0	58.6	5.8	6.0
Italy	62.3	62.5	7.3	7.8
Cyprus	66.3	66.1	8.8	10.4
Latvia	55.3	51.5	4.6	4.0
Lithuania	61.7	57.6	6.1	6.1
Luxembourg	63.5	64.0	10.8	11.3
Hungary	60.8	58.9	6.1	6.0
Malta	74.3	72.3	13.7	13.3
Netherlands	59.0	63.3	10.2	10.7
Austria	57.8	57.6	7.7	8.4
Poland	62.7	59.8	8.1	7.5
Portugal	55.4	58.3	5.6	6.9
Romania	59.0	59.0	5.7	5.9
Slovenia	59.6	57.8	8.6	7.8
Slovakia	54.6	55.5	3.6	4.3
Finland	57.5	58.7	9.3	8.8
Sweden	73.6	73.6	16.7	15.2
United Kingdom	64.2	63.4	10.6	9.7
Iceland	66.9	70.8	15.1	15.4
Norway	69.8	72.2	15.9	15.3
Switzerland	57.7	61.4	9.6	10.6

Source: Eurostat

In this table are presented a series of data showing by addition (cumulation), which is actually the average life expectancy in each country. It is found that the first place is Sweden with 16.7 years for women and 15.2 years for males, followed by Malta with 13.7 years for women and 13.3 years for males, then Ireland for 12.3 years at women and 11.4 years for men. In terms of these data, Romania is somewhere among the last countries in the European Union. Romania is Latvia, with 4.6 years for women and 4.0 years for men, while the other countries are above Romania.

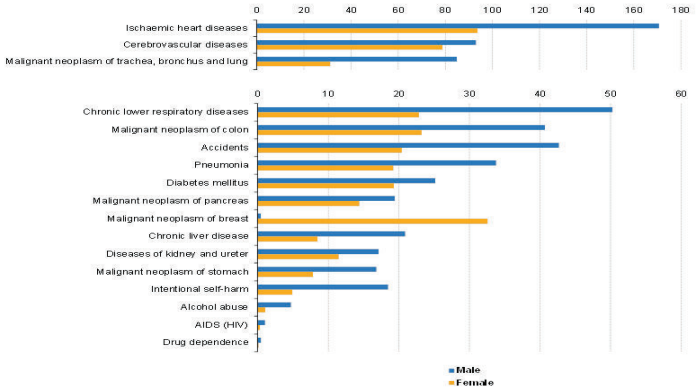
In analyzing the state of health of the population in the European Union, we can analyze the state of health through the causes of death.

Analyzing all the deaths of the population, there are some conditions that are general and occur in most of the European Union states, but there are others that are country-specific, depending on their climate, living conditions and many other factors that influence and an effect on health and, implicitly, on average life expectancy.

In figure no. 1 shows the evolution of the causes of standard deaths per 100,000 inhabitants between 2004 and 2014. It is noted that in 2009, the majority of the causes of death were at the level of 100 deaths at the level of 100,000 inhabitants on average throughout the Union EU.

Causes of death — standardised death rate per 100 000 inhabitants, males, EU-28, 2004-2014 (2009 = 100)

Figure no. 1



Note: the figure is ranked on the average of male and female. Note the difference in the scales employed between the two parts of the figure. For the age standardisation, among older people, the age group aged 85 and over was used rather than separate age groups for 85-89, 90-94 and 95 and over.
Source: Eurostat (online data code: hlth_cd_asdr2)

Source: Eurostat

Among the causes of death in the European Union's system of analysis are diseases of the nervous system, malignant neoplasm cancer, general cancer,

cardiovascular diseases and transport accidents. Of these, only causes of death due to the nervous system increased almost throughout the years 2004 - 2014.

The positive thing is that positive methods have been used for some European countries and they have to transfer them to other member countries so that the causes of death, especially cancer, ischemic attacks of the cardiac system are prevented and treated.

It is positive that from 135 deaths to 100,000 inhabitants registered in 2004 due to accidents, in 2013 the number of these accidents was 73 people per 100,000 inhabitants.

The analysis may be deepened but it is important to stress that the European Union is working hard to find ways to substantially prevent the causes of death and to avoid other causes that are usually not very well known.

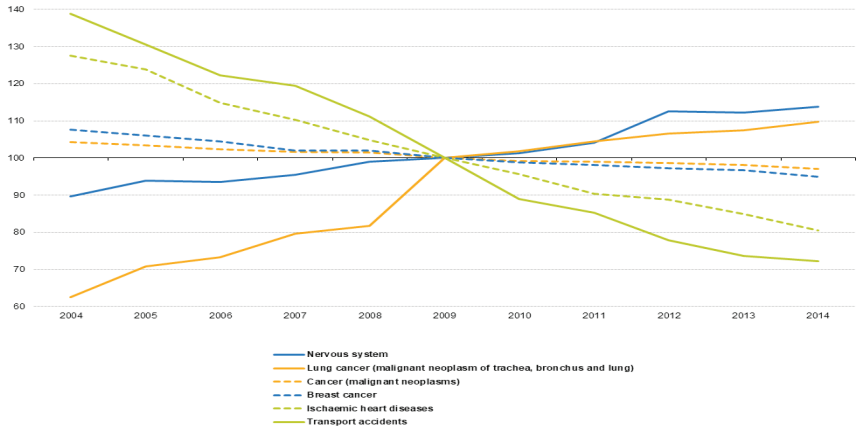
Regarding the evolution of health status, we find that in 2013 there was a 10% reduction in deaths due to living and working conditions, mostly in men, by 33.6%.

A policy of the European Union can only be one in which recommendations, possibilities for mutual support and, above all, standard models that have to be respected are taken into account.

In figure no. 2 shows the causes of death, the standard death rate per 100,000 inhabitants including the same medical causes plus breast cancer as well as other causes of death other than those mentioned.

Causes of death — standardised death rate per 100 000 inhabitants, females, EU-28, 2004-2014 (2009 = 100)

Figure no. 2



Note: 2004, 2005 and 2010, provisional. 2011-2014: for the age standardisation, among older people, the age group aged 85 and over was used rather than separate age groups for 85-89, 90-94 and 95 and over.
Source: Eurostat (online data codes: hlth_cd_asdr and hlth_cd_asdr2)

Source: Eurostat

It is noted that from 2004 to 2009, most causes of death, less cardio-vascular, long-term cancer, and average causes of nervous system damage have steadily increased in 2013. Other causes of death, malignant- neoplasm, breast cancer, ischemic attack or transport accidents have fallen steadily to some performances that are worthy of emphasis in this aspect of the analysis.

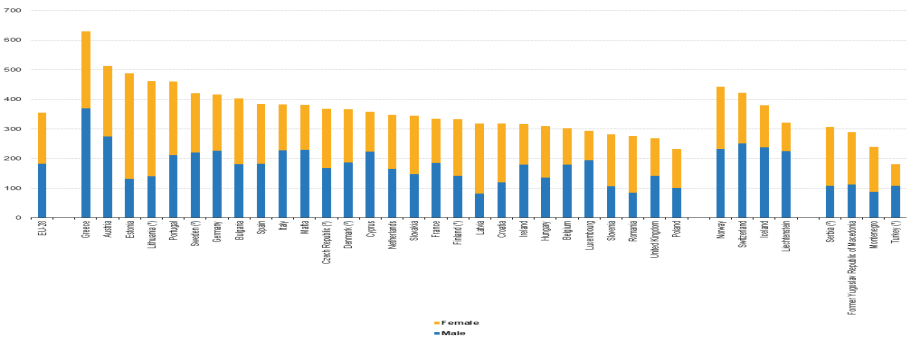
Against the backdrop of the European Union's attention to the evolution of the health status of the population, attention is equally important to the prevention of disease-causing illnesses and those that affect health. Non-monetary statistics, without taking into account the costs incurred, show that in most countries protection measures have succeeded in reducing the number of accidents, and a gender analysis shows that the protection provided has had positive effects . Some countries have better living conditions and the overall health system is better outlined, taking a great deal of measures that do not meet in other Member States.

Another indicator measuring health is given by the number of physicians in each country. This indicator, also calculated at 100,000 inhabitants, highlights different situations. Thus, the number of doctors and assistants in the 28 Member States is appropriate. This is a year-on-year increase, as in 2014 Greece holds the record at the highest rates, with 612 generalists on 100,000 inhabitants, Austria with 505; followed by Portugal with 443, Lithuania 431, Sweden 412, Germany 411. There is also a situation where the number of physiotherapists and physicians is smaller. From this point of view, we can give Portugal, where the number is only 231 physiotherapists and doctors per 100,000 inhabitants. Romania is somewhat lower than these countries, with almost 360 physiotherapists and doctors per 100,000 inhabitants.

Another indicator that we considered in this analysis of the conditions of the health of the population is the number of dentists, dentists and pharmacists. Based on comparative studies, we find that in some Member States this indicator has increased. Thus, Greece and Bulgaria have 98 profile cadres, Slovakia 49, Malta 37, Poland 34, and in Romania there are 31 dentists per 100,000 inhabitants. In Figure no. 3 is the number of physiotherapists.

Number of physicians, per 100 000 inhabitants, by sex, EU, 2015

Figure no. 3



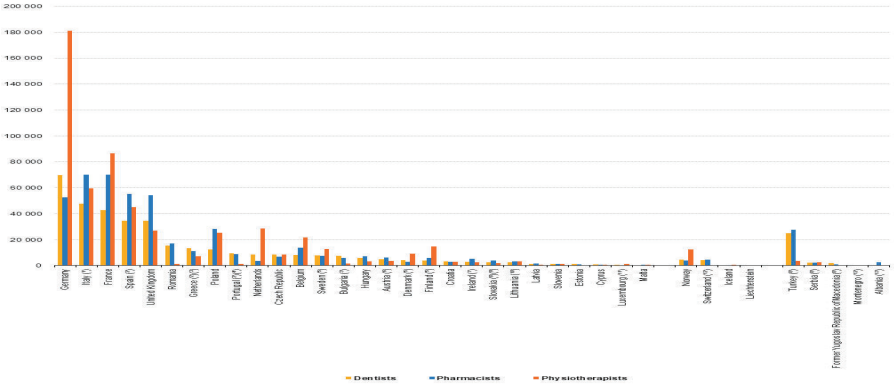
(*) Estimates.
(*) 2014.
(*) 2013.
Source: Eurostat (online data codes: hlth_rs_phys and demo_pjan)

Source: Eurostat

Figure 4 shows the situation in each of the EU Member States in terms of the number of dentists, pharmacists and physiotherapists operating in each country. Romania is somewhere in the middle of this graphic representation, with a low level of physiotherapists, but a reasonable number of dentists and pharmacists.

Number of dentists, pharmacists and physiotherapists in the EU in 2015

Figure no. 4



Note: ranked on dentists.
(*) Dentists and pharmacists: estimates.
(*) Dentists: licensed to practise.
(*) Pharmacists: professionally active.
(*) Physiotherapists: estimate.
(*) 2014.
(*) Physiotherapists: the self-employed and those employed by institutions other than hospitals are excluded.
(*) Dentists and pharmacists: licensed to practise.
(*) Dentists and pharmacists: professionally active.
(*) Physiotherapists: 2014.
(**) Pharmacists: licensed to practise.
(**) Excluding stomatologists and maxillofacial surgeons.
(**) Physiotherapists: not available.
(**) 2012. Dentists and physiotherapists: not available.
Source: Eurostat (online data code: hlth_rs_prs1)

Source: Eurostat

Other countries, such as Finland, have very high performance in terms of the three categories. The category that raises some problems is that of dentists and a qualitative analysis of the value of their preparation highlights other shortcomings in the health system of Europeans.
It follows from the above that the European Union needs to implement a more rigorous program on health standards to be implemented by member countries.

Conclusion

In this article, the authors sought to highlight the state of health in the European Union and the policy that the European Union intends to implement in this area. From this point of view, there are some conclusions. The first conclusion is that vigorous measures, such as harmonization and development of relationships, specialized scientific exchanges, research into the production of medicines, research into what needs to be done in the general health system in the European Union concerns the causes of death and the applicable treatments. The second conclusion is that member countries, in order to achieve a higher standard of health, need to make financial efforts and allocate additional amounts that can be used in this area. A final conclusion, if we can say so, refers to the fact that a number of the European Union, especially those that have joined later, have some lag behind in terms of alignment with standards.

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