European Commission









State of Health in the EU

Spain

Country Health Profile 2017

OECD
BETTER POLICIES FOR BETTER LIVES

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

The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health 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 Member States and the Health Systems and Policy Monitor network.

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Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 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 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:
http://dx.doi.org/10.1787/888933593836

Demographic and socioeconomic context in Spain, 2015

		Spain	EU
Demographic factors	Population size (thousands)	46 448	509 394
	Share of population over age 65 (%)	18.5	18.9
	Fertility rate[1]	1.3	1.6
Socioeconomic factors	GDP per capita (EUR PPP[2])	25 900	28 900
	Relative poverty rate[3] (%)	15.9	10.8
	Unemployment rate (%)	22.1	9.4

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 50% of median equivalised disposable income.

Source: Eurostat Database.

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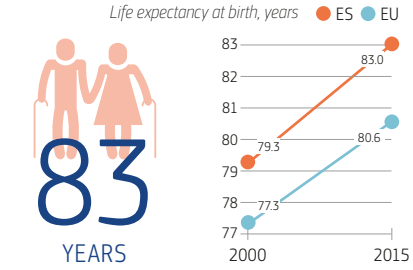
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1 Highlights

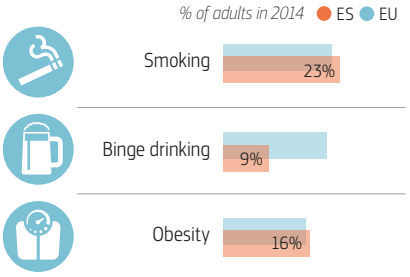
Life expectancy in Spain is the highest among all EU countries. Combined with low birth rates, the result is a growing share of the population aged over 65 and over 80. The main challenge facing the Spanish health system will be to pursue structural reforms to reallocate resources to more effective care and better manage chronic conditions outside hospital.

Health status



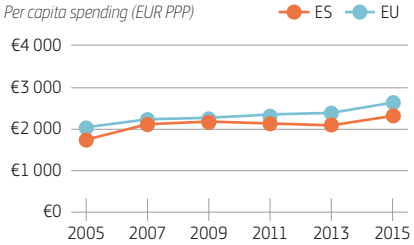
Life expectancy at birth in Spain reached 83 years in 2015, up from 79.3 years in 2000, and is currently the highest among EU countries. Since 2000, most life expectancy gains in Spain have been driven by reductions in mortality after the age of 65. At this age, Spanish men and women live on average an additional 21 years, of which less than half (45%) are lived free of disability.

Risk factors



Daily smoking among adults in Spain reduced from 32% in 2000 to 23% in 2014, but remains higher than the EU average. Less than one in ten adults report heavy alcohol consumption on a regular basis, well below the EU average of one in five. Obesity rates continue to increase in Spain and are now slightly above the EU average: one in six adults were obese in 2014, up from one in eight in 2001.

Health system

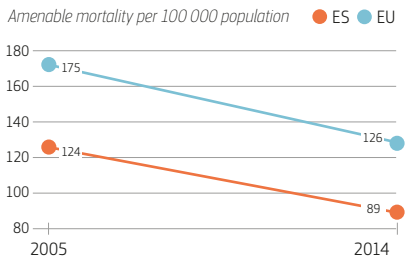


Following the economic crisis, health spending per capita in Spain decreased in real terms and relative to the EU average; however, spending started to rise again in recent years. In 2015, Spain spent EUR 2 374 per capita on health care compared to the EU average of EUR 2 797. This equals 9.2% of GDP, also below the EU average of 9.9%. Around 71% of health spending in Spain is publicly funded, whereas out-of-pocket payments account for 24% of total health spending, a much higher share than the EU average of 15%.

Health system performance

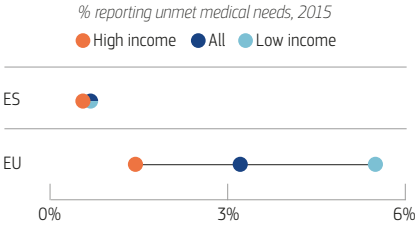
Effectiveness

Amenable mortality in Spain remains one of the lowest in EU countries, indicating that the health care system is effective in treating people with life-threatening conditions.



Access

Access to health care in Spain is generally good. Nonetheless, waiting times remain a concern, and unmet needs have grown for pharmaceuticals and services less covered by public health insurance, such as dental care.



Resilience



A series of emergency measures were taken after the economic crisis to reduce public spending on health, but most of these measures did not involve structural changes in the health system. With a rapidly ageing population, one of the main challenges for the Spanish health system will be to achieve further efficiency gains in health and long-term care delivery.

2 Health in Spain

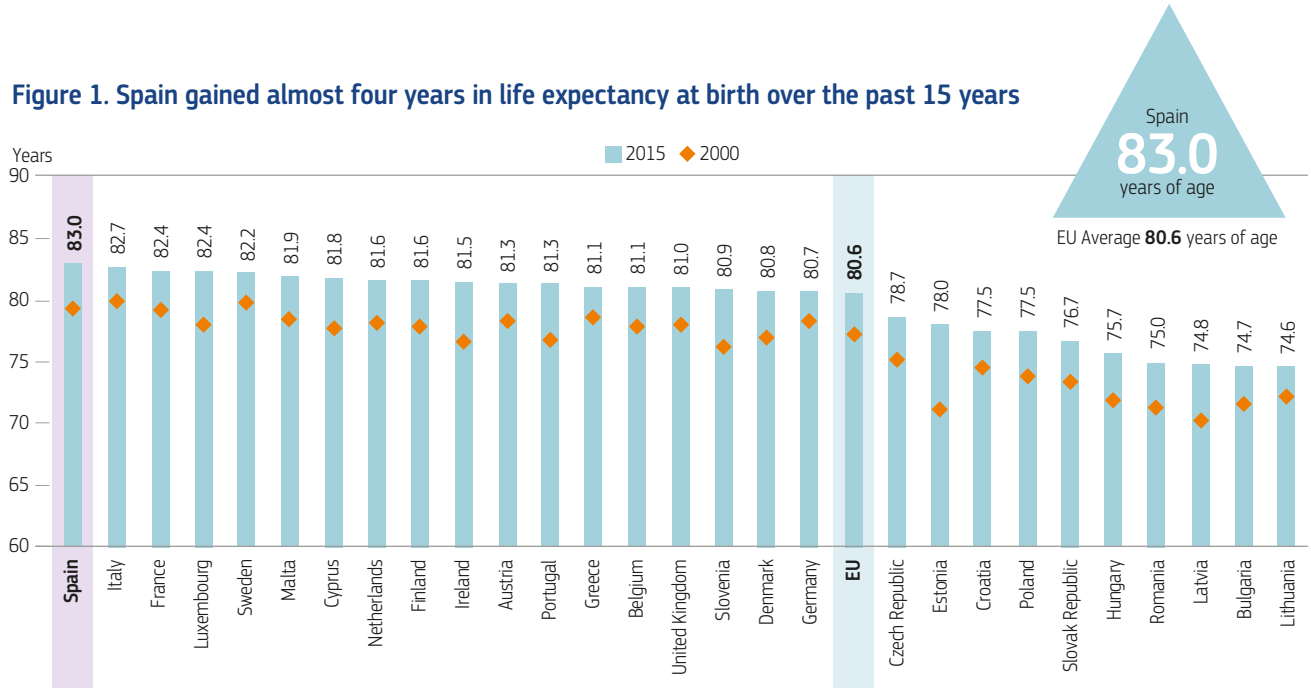
Life expectancy in Spain is the highest among EU countries

In 2015, Spain had the highest life expectancy among EU countries, with life expectancy at birth reaching 83.0 years, well above the EU average of 80.6 (Figure 1). This follows a strong and steady increase of four years since 2000.

Since 2000, most life expectancy gains in Spain have been driven by reductions in mortality rates after the age of 65. Life expectancy of Spanish women at age 65 reached 23.0 years in 2015 (up from 20.8 years in 2000) and that of men reached 19.0 years (up from 16.7 years in 2000). Nevertheless, not all of these additional years of life are lived in good health. At age 65, Spanish women can expect to live 9.0 of their remaining years free of disability (40% of their remaining years of life) and men 9.5 years (around 50%)..[1]

1. These are based on the indicator of 'healthy life years', which measures the number of years that people can expect to live free of disability at different ages..

Figure 1. Spain gained almost four years in life expectancy at birth over the past 15 years



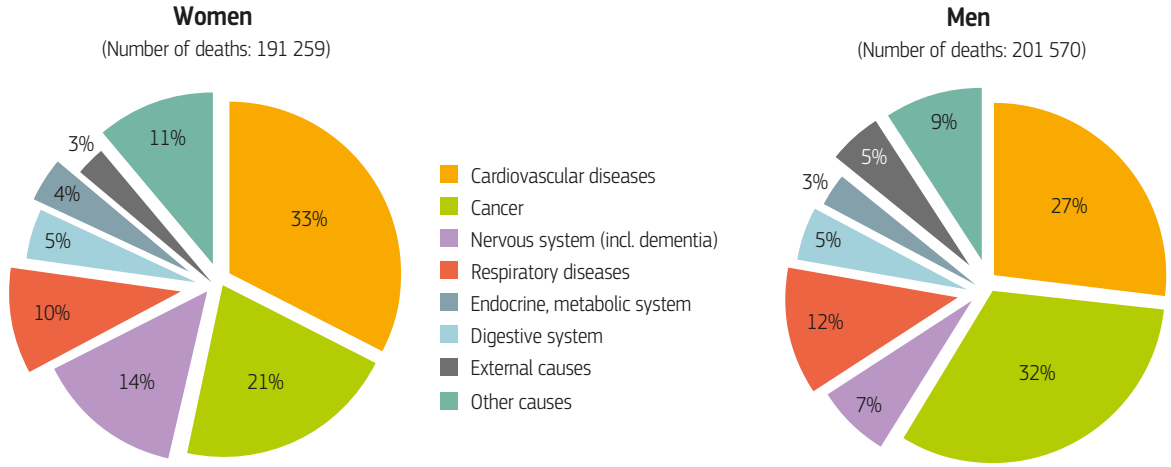
Source: Eurostat Database.

The majority of deaths in Spain are due to cardiovascular diseases or cancer

Although death rates due to cardiovascular diseases in Spain are among the lowest in the EU, they represent the main cause of death in Spain, accounting for 30% of all deaths in 2014 (33% of deaths among women and 27% among men) (Figure 2). Cancer is the second most important cause of mortality, accounting for 27% of all deaths (21% among women and 32% among men). Deaths from respiratory diseases represent 11% of all deaths (10% among women and 12% among men), followed by deaths from nervous system diseases (including dementia) at 10% (14% among women and 7% among men).

Looking at trends in more specific causes of death, heart diseases were still the leading cause of death in Spain in 2014 (Figure 3). Deaths due to Alzheimer's disease and other dementias became the third leading cause of death, reflecting the effect of population ageing, better diagnosis, lack of effective treatments as well as more precise coding. Lung cancer remained the main cause of death from cancer, reflecting the long-term consequences of high smoking rates. Colorectal cancer was the second leading cause of cancer death. On a more positive note, deaths from transport accidents fell substantially after 2000 thanks to a number of policies aimed to improve road safety (see Section 5.1).

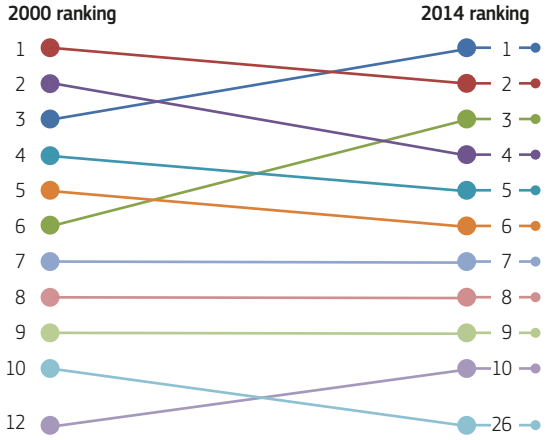
Figure 2. Cardiovascular diseases and cancer account for over 55% of all deaths in Spain



Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: Eurostat Database (data refer to 2014).

Figure 3. Cardiovascular diseases remain the leading cause of death, but death from dementias is rising



		% of all deaths in 2014
1	Other heart diseases	9%
2	Ischaemic heart diseases	8%
3	Alzheimer and other dementia	8%
4	Stroke	7%
5	Lung cancer	5%
6	Lower respiratory diseases	4%
7	Colorectal cancer	4%
8	Diabetes	2%
9	Pneumonia	2%
10	Kidney diseases	2%
26	Transport accidents	1%

Source: Eurostat Database.

Musculoskeletal problems are among the main causes of disability-adjusted life years lost

In 2015, the leading causes of disability-adjusted life years (DALYs)[2] lost in Spain, taking into account both mortality and morbidity, were musculoskeletal disorders (including low back and neck pain), ischaemic heart diseases, and Alzheimer's disease and other dementias (IHME, 2016). The estimated number of DALYs due to musculoskeletal problems has gone up since 2000 due to population ageing but also to the growing prevalence of certain risk factors such as obesity and physical inactivity. Whereas the disability and mortality burden from ischaemic heart diseases has dropped since 2000, DALYs associated with Alzheimer's disease and other dementias have increased substantially.

Self-reported data from the European Health Interview Survey (EHIS) indicate that close to one in five people in Spain live with hypertension, one in thirteen live with depression and one in fourteen live with diabetes. People with the lowest level of education are three times more likely to live with depression, and three-and-a-half times more likely to live with diabetes, than those with the highest level of education.[3]

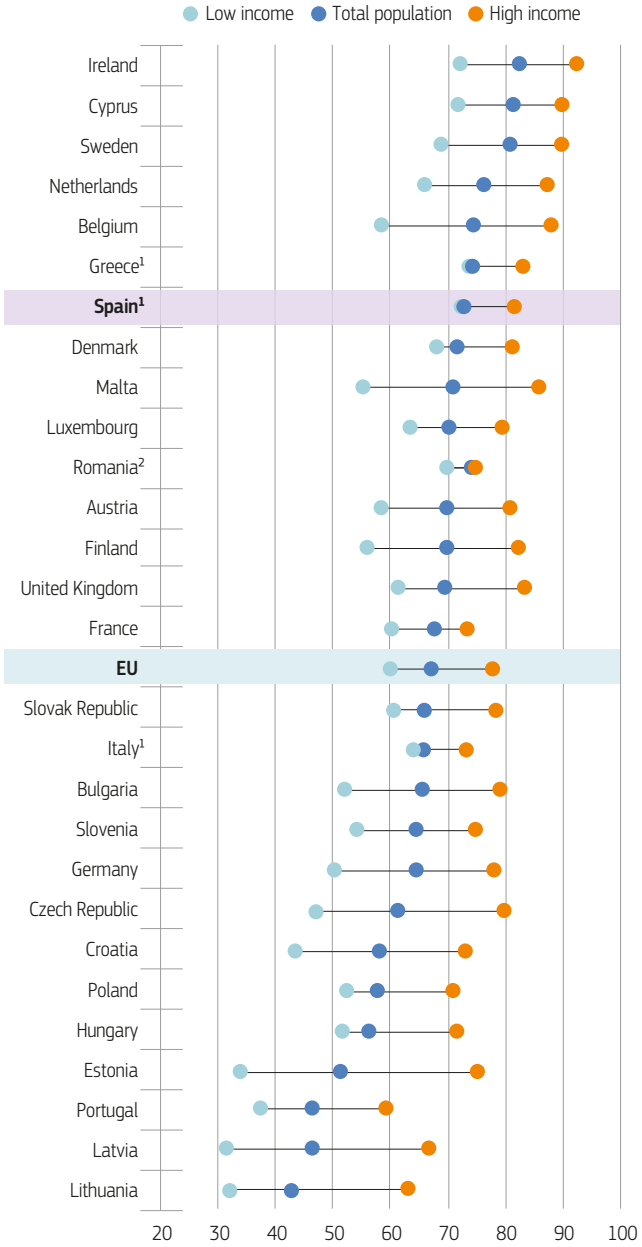
2. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

3. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

Most people in Spain report being in good health, though differences exist across income groups

More than 70% of the Spanish population reports being in good health, a slightly higher proportion than the EU average of 68%. Disparities in self-rated health exist across income groups, but the gap is narrower than in most other EU countries: over 80% of people in the highest income group reported being in good health in 2015, compared with just over 70% of people in the lowest income group (Figure 4).

Figure 4. Most Spanish people report being in good health



1. The shares for the total population and the low-income population are roughly the same.
2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

3 Risk factors

Behavioural risk factors are important determinants of health in Spain

Based on IHME estimations, around 25% of the overall burden of disease in Spain in 2015, measured in terms of DALYs, could be attributed to behavioural risk factors, including smoking, alcohol use, dietary risks and physical inactivity (IHME, 2016).

Smoking remains high among adults, despite some reduction

Some 23% of adults in Spain reported to be daily smokers in 2014, down from 32% in 2000. Despite this reduction, smoking rates in Spain remain among the highest in EU countries and are one of the main causes of premature death (Figure 5). A greater proportion of men (26%) smoke compared to women (19%). Smoking rates among 15-year-olds also decreased substantially, from 28% in 2001–02 to 9% in 2013–14 (10% for girls and 8% for boys), and are now lower than in most EU countries. This reflects the positive impact of tobacco control policies (see Section 5.1).



Excessive alcohol consumption is relatively low among adults but high among adolescents

In 2014, just over 9% of adults reported regular heavy alcohol consumption (binge drinking[5]),well below the EU average of 20% (Figure 5). However, a higher proportion of adolescents reported having been drunk several times in their life: more than 20% of 15-year-old boys and girls reported in 2013–14 having been drunk more than once, which is close to the EU average (25%).

Overweight and obesity rates are relatively high, especially among adolescents

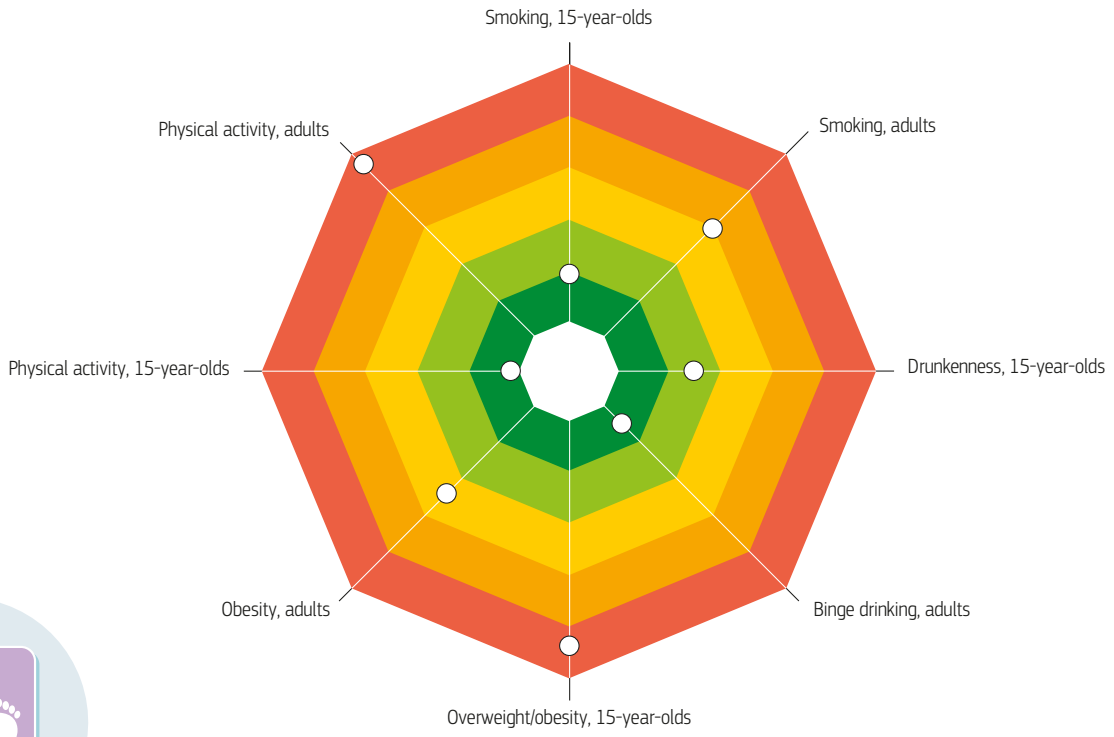
Overweight and obesity rates among adolescents and adults increased over the past decade and are now higher than the EU average (Figure 5). In 2014, one in six adults (16.2%) were obese, up from one in eight (12.6%) in 2001. A substantial gap in obesity rates exists by education level: people with the lowest level of education are more than two times more likely to be obese than the most educated.

The overweight and obesity rate among 15-year-old adolescents also grew from 16% in 2001–02 to 20% in 2013–14, which is higher than the EU average of 18%. This rate is substantially higher among Spanish boys (24%) than girls (15%). The Spanish government adopted new policies in 2011 to improve nutrition and reduce obesity among children (see Section 5.1).

Physical activity among adults is particularly low

The relatively high obesity rate among adults in Spain is partly linked to low levels of physical activity (Figure 5). In 2014, less than 50% of adults reported doing at least moderate physical activity each week, the second lowest rate among EU countries (after Romania). On a more positive note, physical activity among 15-year-olds in Spain is relatively high compared with other EU countries.

Figure 5. Rates of smoking, obesity and physical inactivity among adults are high in Spain



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.

Source: OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).

5. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

4 The health system

Spain has a decentralised health system under national coordination

The Spanish National Health System (known as the *Sistema Nacional de Salud,* NHS) is funded from taxes and predominantly operates through its public network of providers. In 2002, health competences were devolved to the regional level, resulting in 17 regional health ministries with primary jurisdiction over the organisation and delivery of health services within their territory. The Ministry of Health, Social Services and Equality is responsible for certain strategic areas and for national monitoring of health system performance.

The highest body for coordination is the NHS Interterritorial Council, which gathers national and regional Ministers of Health. The main purposes of this Council are: to act as a coordinator, more than a regulatory agency; to plan the national response to disease outbreaks; and to discuss the impact of new laws at the regional level.

Health spending in Spain is below the EU average

In 2015, health expenditure per capita in Spain was EUR 2 374, below the EU average of EUR 2 797. Health spending in Spain accounted for 9.2% of GDP in 2015, also below the EU average of 9.9% (Figure 6). Around 71% of health spending in Spain is publicly funded, below the EU average of 79% (see Section 5.2). The 2014–2020 European Structural and Investment Funds provided approximately EUR 500 million to Spain to invest in its health system, including in medical research and development and eHealth.

Substantial variations arise in health spending per capita across regions. The regions of Basque Country, Principality of Asturias and Navarre spend over 30% more on health per capita than the region of Andalusia.

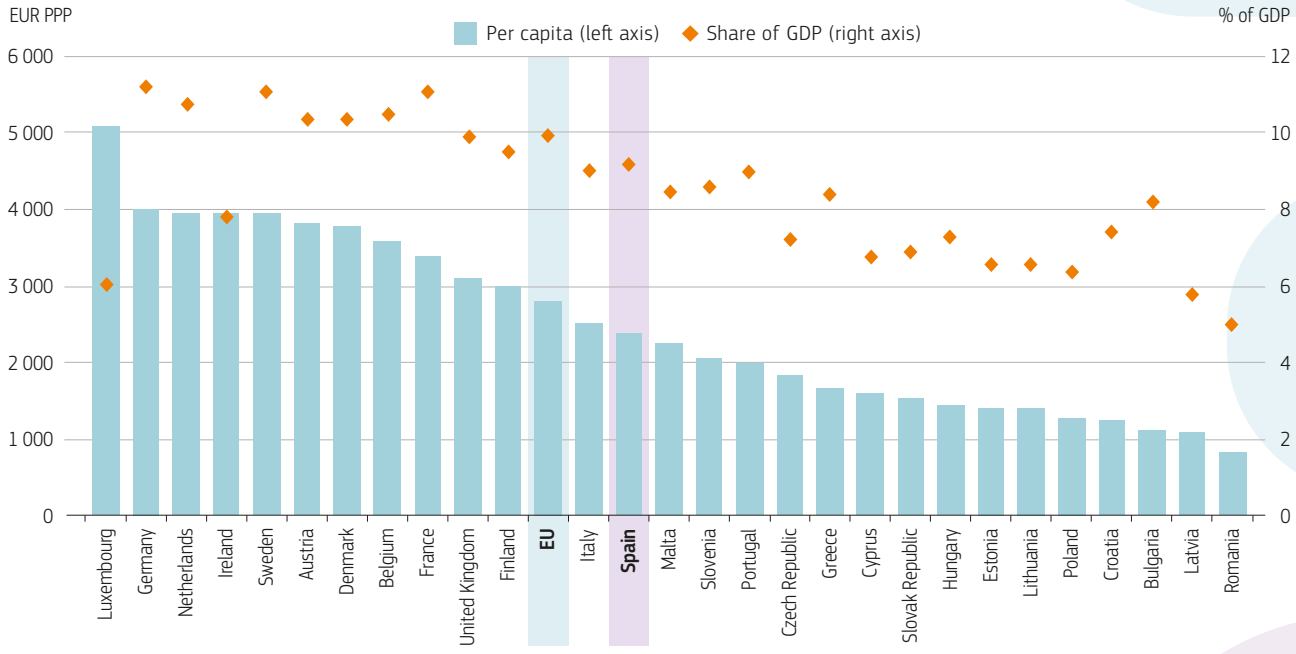
Nearly all the population is covered by health insurance

In 2014, the NHS covered 99.1% of the resident population, to which should be added civil servants who can opt out to choose fully private insurance (accounting for 0.8% of the population in 2014). Total population coverage was thus 99.9%. In 2012, health service coverage was restricted for some nonregistered immigrants (see Section 5.2).

The co-payments were increased in 2012

Following the economic crisis, a nationwide law was implemented to ensure the fiscal sustainability of the NHS; the law also aimed to improve the quality and safety of services. The so-called Royal Decree Law 16/2012 of 20 April 2012 included a series of emergency measures, with the main ones aiming to: categorise the benefits package to limit and control the increase in public costs; establish new co-payment thresholds for medications and common supplementary and ancillary services; and update the 2006 law on

Figure 6. Health expenditure per capita and as a share of GDP in Spain are below the EU average



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

pharmaceutical drug prescription. The decree revised co-payments for supplementary services such as medication prescriptions, non-emergency transport, prostheses and appliances. Pharmaceutical benefits for pensioners entail a new 10% co-payment up to a certain ceiling for people with income below EUR 100 000 per year, while co-payments for people under 65 are structured according to three income-tested levels (see Section 5.2). Exemptions were kept for the long-term unemployed and non-contributory pensioners.

Spain has a high number of doctors and a low number of nurses

While the number of doctors per 1 000 population in Spain is higher than the EU average (3.8 versus 3.6 in 2015), the number of nurses is well below (5.3 per 1 000 population in Spain versus 8.4 in the EU) (Figure 7), although this does not include nurse assistants. The nurse-to-doctor ratio in Spain (at 1.4) is one of the lowest among EU countries.

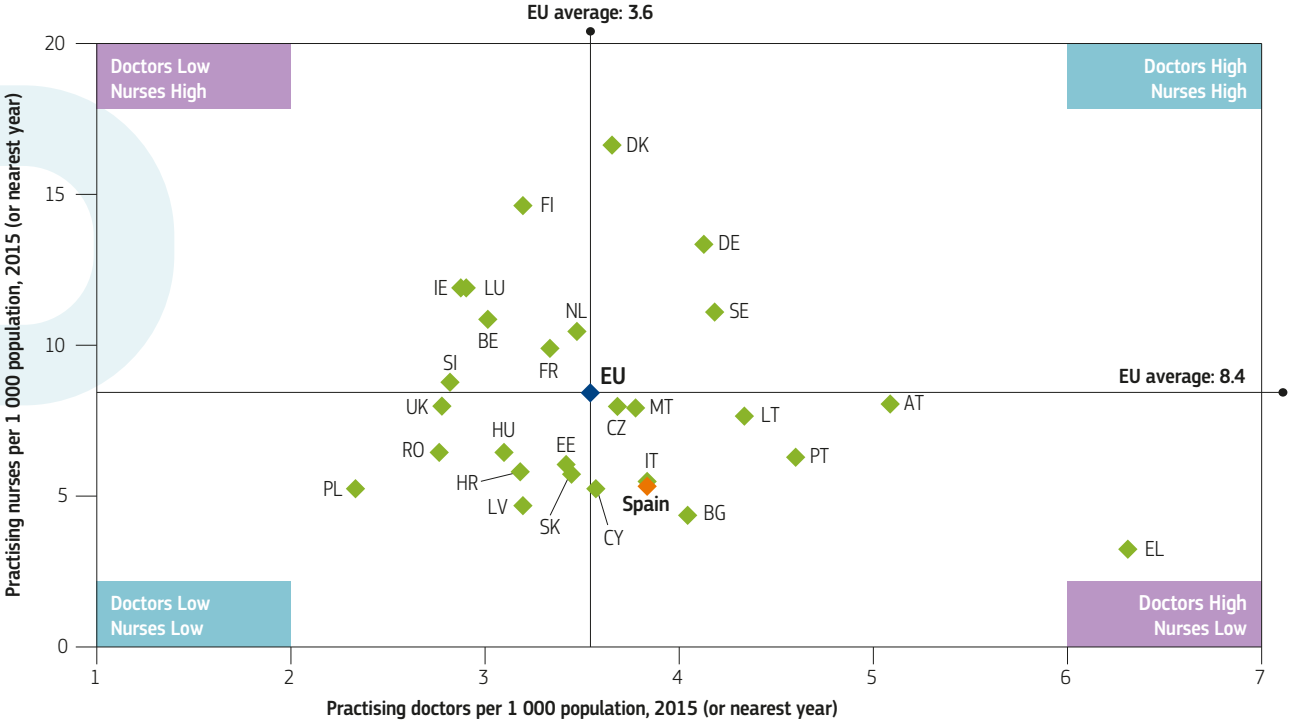
Primary care services are offered by multidisciplinary teams

Primary care delivery is entirely public and most providers are salaried employees within the public sector. Primary health care centres are run by multidisciplinary teams composed of General Practitioners (GPs), paediatricians, nurses and social workers. Some also include physiotherapists and dentists' surgeries, and are linked to basic laboratory and image diagnostic resources. Such group practice aims to achieve better coordination of health care and between health and social care sectors.

BOX 1. THE SPANISH BENEFITS BASKET

The current benefits package is defined by a *common* package and a *complementary* package. The common package includes three types of services: a) Basic services – prevention, diagnostic, treatment and rehabilitation services and emergency transport – which are publicly financed at 100%; b) Supplementary services – such as pharmaceutical drugs, orthopaedic services and non-urgent transport – which are subject to a certain level of cost sharing; and c) Ancillary services – this part of the package remains to be defined. The *complementary* package comprises services and products that are all defined by the regions and paid with regional funds. Examples of such services include fertility treatments or sex reassignment surgery (Gallo and Gené-Badia, 2013). Although this benefits package is comprehensive, coverage for certain types of services – such as dental care – is limited to emergency cases and preventive dentistry for children, although this varies across regions.

Figure 7. Spain has more doctors per capita than the EU average but less nurses



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital. Nurse assistants who are not recognised as nurses are not included in any country. In Spain, the number of these 'nurse assistants' is almost two times greater than the number of nurses.

Source: Eurostat Database.

5 Performance of the health system

5.1 EFFECTIVENESS

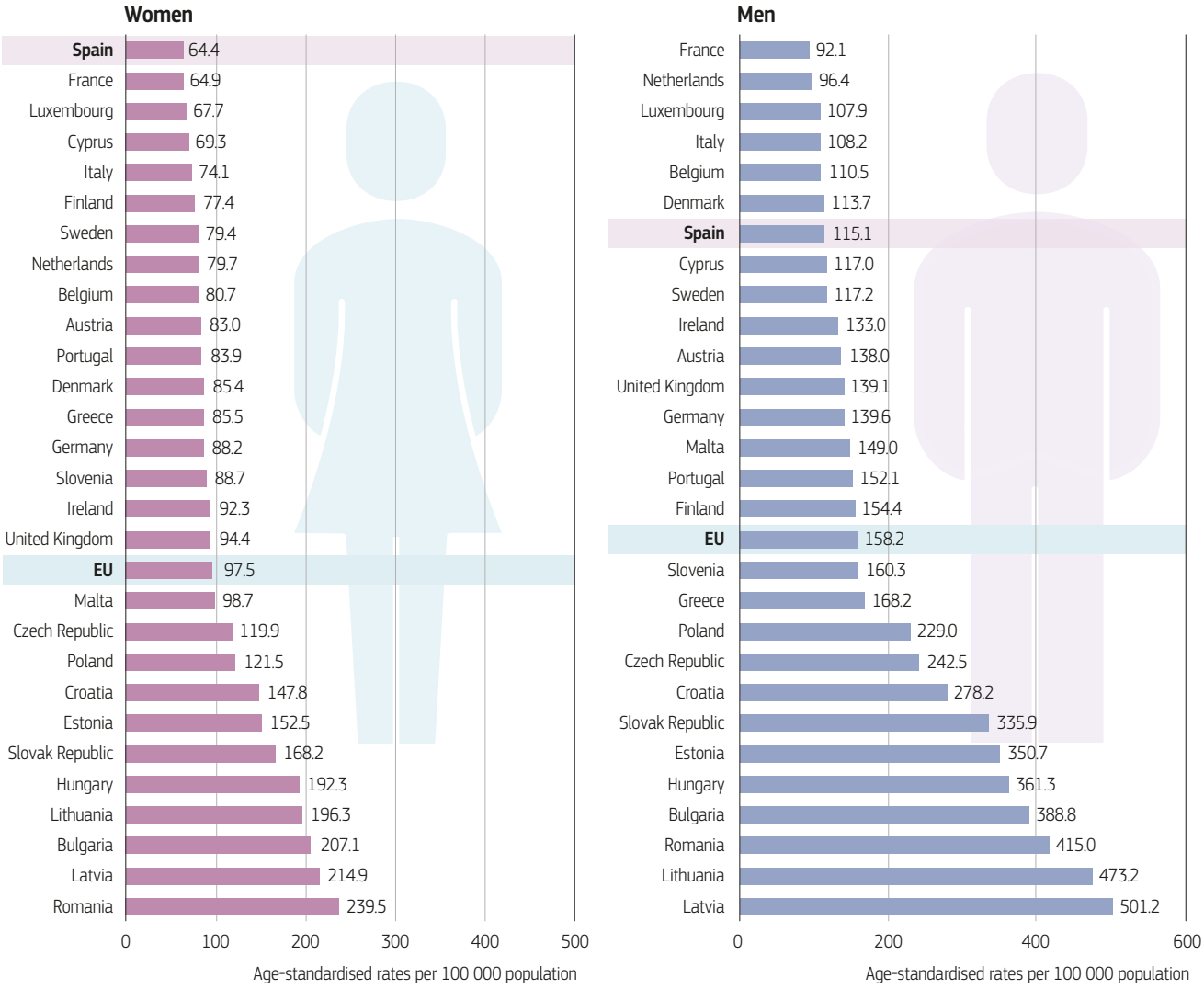
Low amenable mortality rates point towards an effective health care system

Amenable mortality provides a general indication of the effectiveness of the Spanish health care system in treating people with life-threatening conditions[5]. Spain has the lowest amenable mortality rates for women among EU countries, and amenable mortality rates for men are also well below the EU average (Figure 8). This good result is to a large extent due to low and declining mortality rates from ischaemic heart diseases and stroke.

Public health policies have effectively tackled certain behavioural risk factors

Since 2000, mortality from several preventable causes of death has been reduced in Spain. The mortality rate from lung cancer decreased following reductions in smoking. Deaths from chronic liver disease and cirrhosis, which are closely related to excessive alcohol consumption, came down sharply. Deaths from transport accidents also reduced greatly (see Section 2).

Figure 8. Spain has lower amenable mortality rates compared with most EU countries

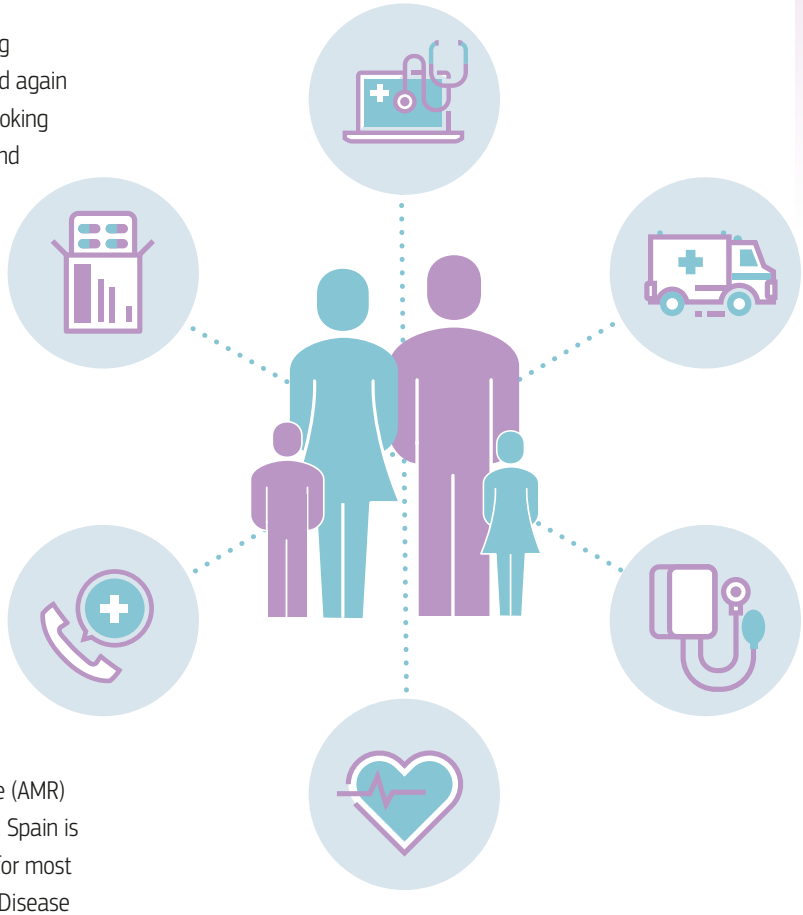


Source: Eurostat Database (data refer to 2014).

5. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

Public health interventions have played an important role in combating unhealthy lifestyles and behaviours, reducing preventable mortality. The Tobacco Law of 2005 (modified again in 2010) restricted tobacco advertising and prohibited smoking in public spaces. The Spanish government also adopted and enforced stricter laws on road safety, including the use of seat belts, speed limit control and drink-and-driving regulations (Dirección General de Tráfico, 2016).

In 2011, the Spanish government adopted a new law on Food Security and Nutrition, with one of the goals being to reduce overweight and obesity among children. This law included the prohibition in schools of food and beverages high in saturated fatty acids, salt and sugars, and regulation around children's menus. Since 2015, education and health authorities can allow any advertising and promotional campaigns in schools, but only when they believe that the activity is in the health interest of children.



Spain adopted in 2014 a national antimicrobial resistance (AMR) strategy to tackle this growing public health issue (Box 2). Spain is in the top tier of countries with the highest rates of AMR for most pathogens under surveillance by the European Centre for Disease Prevention and Control, including salmonella and campylobacter (ECDC, 2017). An important driver of this situation is Spain's current high level of antibiotic consumption, one of the highest among European countries.

Quality of acute care in hospitals improved

The quality of acute care in hospitals shows improvements, notably in the area of cardiovascular care. Between 2003 and 2015, the 30-day mortality rate following admission to hospital for an acute myocardial infarction (AMI or heart attack) was reduced by one-third (OECD, 2017). This reduction was associated with a rapid increase in the number of coronary angioplasties, one of the main treatments for AMI. Similarly, during the same time period, the 30-day mortality rate for people admitted for stroke substantially reduced. The Interterritorial Council adopted national strategies to improve the quality of care for ischaemic heart diseases in 2006 and for stroke in 2008.

BOX 2. **SPAIN'S NATIONAL AMR STRATEGY**

In 2014, Spain introduced a four-year Strategic Action Plan to reduce the risk of antibiotic resistance – following the recommendation from the European Commission for EU Member States. The plan is structured around six priority areas for action: surveillance, research, prevention, control, training and communication – in both human and veterinary health (i.e. One-Health approach). The overall objective is to curb AMR through promoting a more rational use of antibiotics. At the international level, Spain is an active member of the Joint Programming Initiative on Antimicrobial Resistance and the Global Health Security Agenda – both initiatives aim to coordinate health policy strategies to address AMR.

Patient safety also improved

Since 2005, the Spanish government has put in place various actions to improve patient safety. These include the promotion of a culture of patient safety among professionals and patients, implementing information systems to monitor patient safety incidents, implementing safe practices, promoting research and development on patient safety, and involving patients in the development of strategies related to patient safety (Ministry of Health, 2011). For example, a five-point checklist is now used in intensive care units to reduce catheter-related bloodstream infections. Spain also uses indicators to monitor the compliance of hospitals in reducing health care-associated infections through improved hand hygiene. A 2015 evaluation showed an improvement in most indicators between 2009 and 2013 (Ministry of Health, 2015).

5.2 **ACCESSIBILITY**

Reductions in coverage followed after the financial crisis

As described in Section 4, the Spanish NHS covers nearly all (99.9%) of the population. However, following the 2008 financial crisis, the Royal Decree Law 16/2012 redefined health service coverage in terms of scope, breadth and depth.

One important consequence was the change in eligibility criteria, moving from universal entitlement based on residency to social insurance entitlement, with coverage including workers affiliated with the Social Security, pensioners and recipients of social benefits. Nonregistered immigrants were thus excluded from full coverage from NHS services, with the exception of emergency services and maternal and child care. There is no agreement on the exact number of people who lost their entitlement to health services, as some regions did not follow this restrictive policy.

Although unmet needs for basic medical care are low, perception of regional inequalities is rising

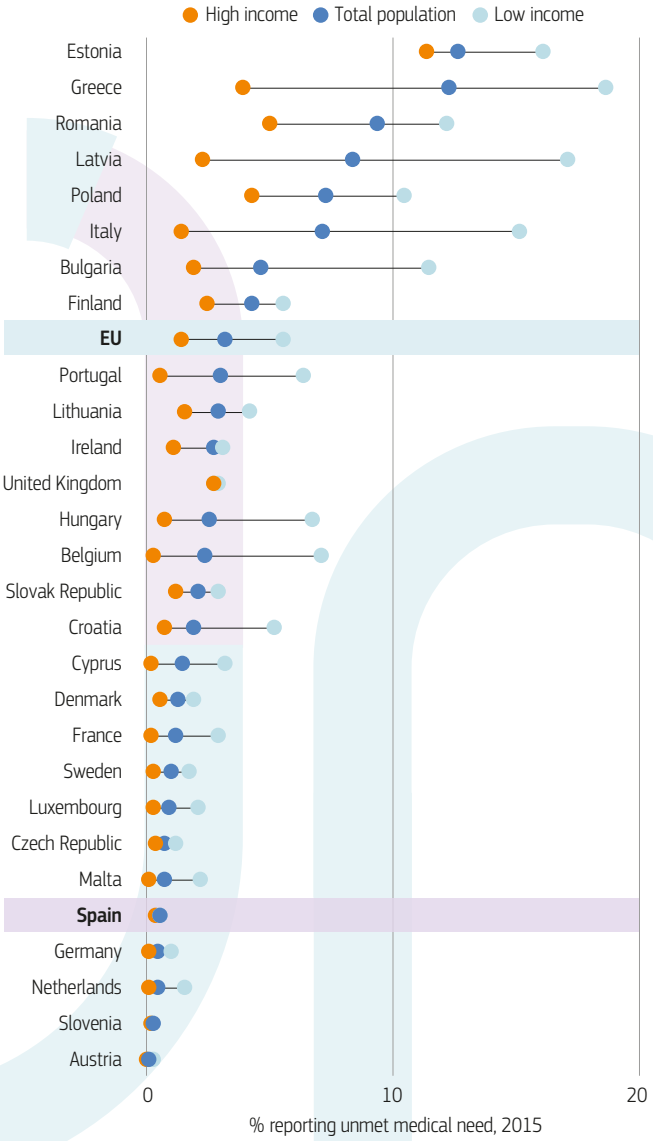
The proportion of people in Spain reporting unmet needs for a medical examination for financial reasons, waiting times or geographic distance to services remained low following the economic crisis, and is among the lowest in the EU (Figure 9). Waiting time is the main reason cited for unmet needs.

Services that are less covered under the public scheme – such as dental care – show higher rates of unmet needs (4.9% on average in 2015, based on EU-SILC).

In addition, a national 2016 Health Barometer survey found that 4.4% of the population in Spain reported having stopped taking prescribed medications because these were too expensive.

The same Health Barometer shows a steady increase in the proportion of people who think that waiting lists are worsening, with a rise from 12% in 2010 to 28% in 2016 (Ministry of Health, 2016). In addition, the perception of inequalities in timely access to care across regions is growing: the percentage of people who believe that health services are offered equally across all regions in Spain decreased from 44% in 2010 to 38% in 2016.

Figure 9. Unmet needs or medical care are relatively low in Spain



Note: The data refer to unmet needs for a medical 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 2015).

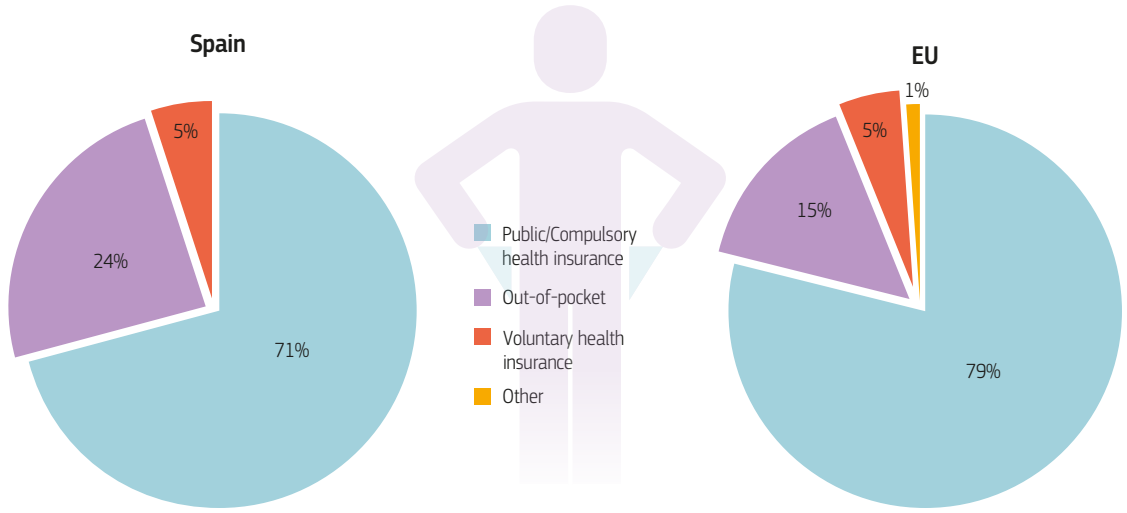
Out-of-pocket spending is on the rise, driven by dental care and pharmaceuticals

Households are paying an increasing share of health services directly. Up to the economic crisis, the share of out-of-pocket spending as a percentage of current health expenditure decreased, from 25% in 2001 to 20% in 2009. After that, however, it went back up to 24% in 2015, a much higher percentage than the 15% average in the EU (Figure 10). Out-of-pocket spending mostly covers co-payments for prescribed medicines, dental care and optical care.

Voluntary health insurance accounts for 5% of overall health spending and plays a supplementary role, providing faster access, greater consumer choice and improved amenities.

The increase in the amount and share of direct out-of-pocket spending resulted partially from the reduced coverage for certain services and goods following the 2012 reform, notably for pharmaceuticals. The Royal Decree Law of 2012 increased the pharmaceuticals co-payment structure for workers and pensioners earning more than EUR 18 000 per year (Table 1). In addition, increases in waiting times led people who can afford it to seek care in the private sector and pay a greater amount out-of-pocket.

Figure 10. Out-of-pocket payments represent a large share of total health expenditure in Spain



Source: OECD Health Statistics, Eurostat Database (data refer to 2015).

Table 1. Increased cost-sharing for pharmaceuticals was introduced in 2012

	WORKERS		PENSIONERS	
	OLD	NEW	OLD	NEW
Long-term unemployed and non-contributory pensioners	0%	0%	0%	0%
Income < €18 000/year	40%	40%	0%	10% ceiling €8/month
Income > €18 000/year	40%	50%	0%	10% ceiling €18/month
Income > €100 000/year	40%	60%	0%	60% ceiling €60/month

Source: Gallo and Gené-Badia, 2013.

Figure 11. The proportion of people on waiting lists is up to five times greater in some regions than in others

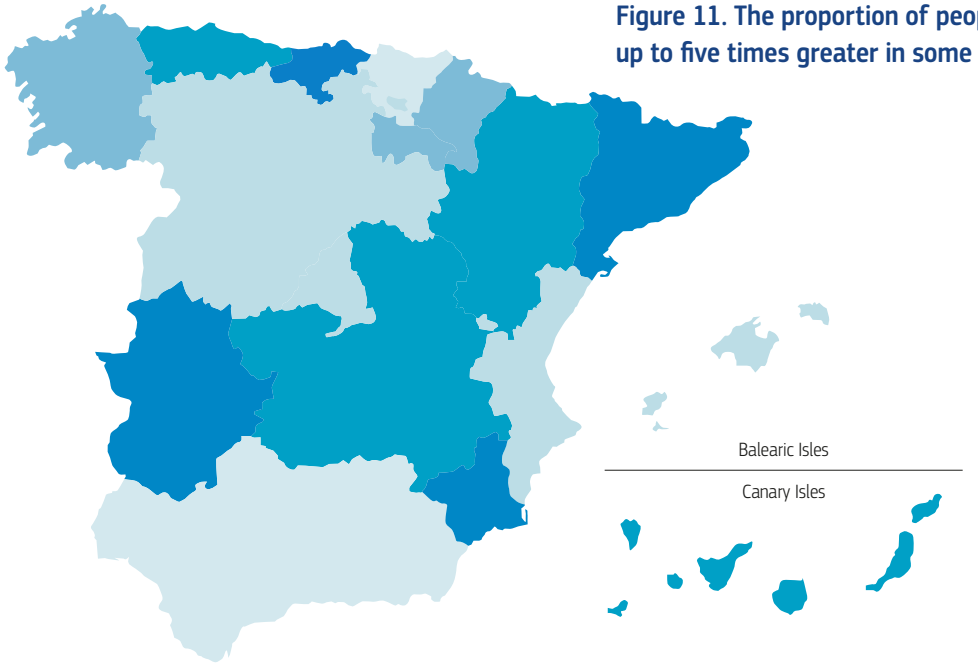
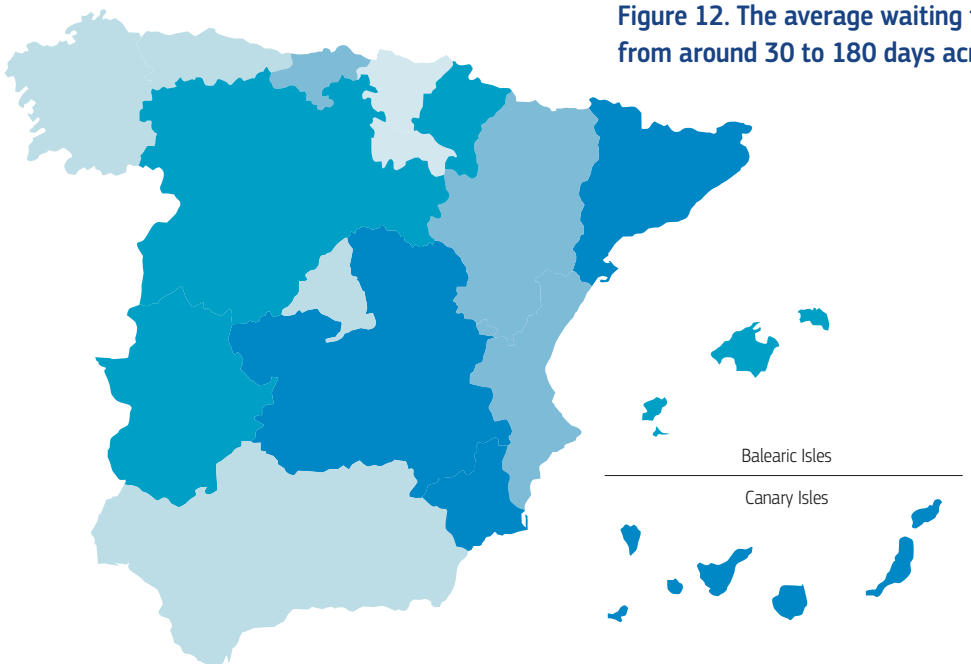


Figure 12. The average waiting time for surgery ranges from around 30 to 180 days across regions



Note: NHS stands for *Sistema Nacional de Salud* (National Health Service).

Source: Ministry of Health, 2016 (data refer to 2016).

Waiting times continue to be a challenge as the demand for services grows

Long waiting times for some services, notably for elective (non-emergency) surgery, have been a longstanding issue in the NHS in Spain. Following some reduction before the economic crisis, the average waiting times for elective surgery such as cataract surgery or hip replacement increased between 2010 and 2016, and are well above the level in other EU countries such as Italy and Portugal. In addition, large variations exist across regions (Figures 11 and 12). The number of patients on the waiting list per 1 000 population is well above the national average in regions such as Catalonia, Extremadura, Murcia and Castilla-La Mancha. Patients in regions like Canary Islands, Catalonia and Castilla-La Mancha wait on average more than 160 days for surgery, compared to less than 50 days in other regions.

Measures implemented to reduce waiting times focus mainly on increasing the volume of surgical procedures, for instance, by extending the working time for surgeons on a fee-for-service basis and increasing funding to purchase more equipment (Siciliani, Borowitz and Moran, 2013), but this growing supply does not seem to be sufficient to meet the even-faster-growing demand in some regions.

5.3 **RESILIENCE**[6]

The Spanish health system had to adapt to the economic crisis and increase efficiency

The resilience of the Spanish health system was tested following the economic crisis in 2008. Public spending on health was reduced as part of broader efforts to reduce budgetary deficits, and only started to increase again in 2014 (Figure 13). Cost-cutting measures taken in the years following the crisis involved cutting staff and the salaries of health care personnel (in 2010), and reducing the scope, breadth and depth of public coverage (in 2012) (see Sections 4 and 5.2).

Looking ahead, health and long-term care expenditure in Spain are expected to rise as a share of GDP due to population ageing and technological progress. According to the 2015 European Commission Ageing Report projections, public spending on health care in Spain is expected to increase by more than 1% of GDP between 2013 and 2060 based on the baseline scenario. Public spending on long-term care is expected to grow even more, by 1.4% of GDP over the same time period (European Commission and European Policy Committee, 2015).

Efficiency measures have targeted the hospital sector

As in other countries, the hospital sector in Spain accounts for a large share of overall health spending (more than a quarter of all spending in 2014). Between 2000 and 2014, the number of hospital beds per capita decreased steadily by 20%. This reduction was accompanied by a reduction in the average length of stay in hospital, from 9.0 days in 2000 to 7.4 days in 2014 (Figure 14). The reduction in average length of stay was supported by the introduction of early discharge programmes.

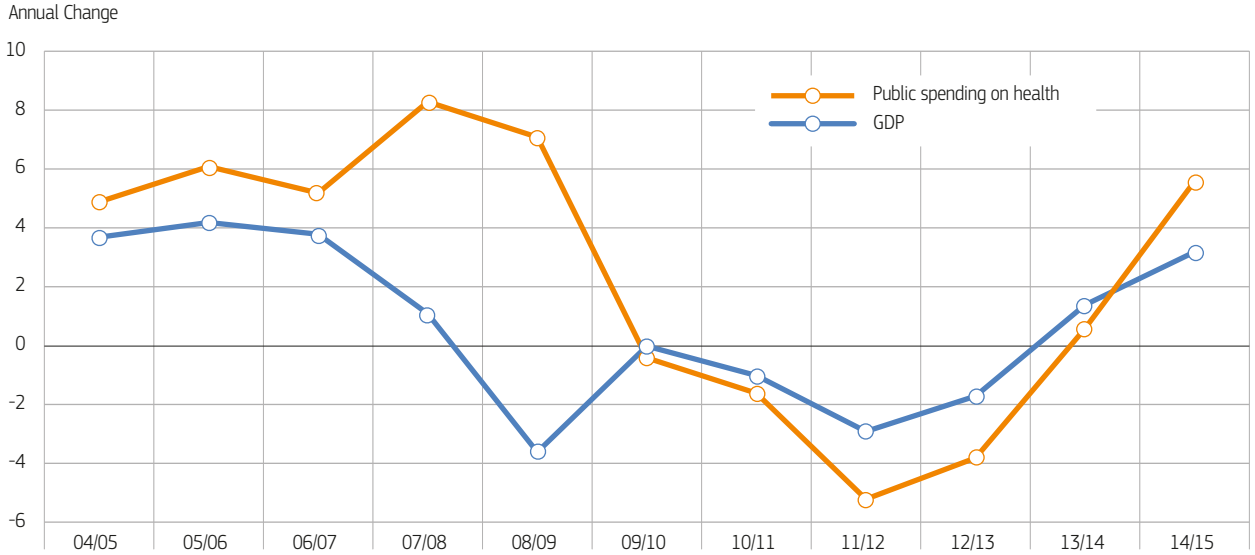
Progress was achieved in shifting care away from the more expensive hospital inpatient care to day care and ambulatory (or outpatient) care. For example, the use of ambulatory surgery went up in Spain for operations such as cataract surgery (98% in 2015, up from 89% in 2005) and tonsillectomy (31% in 2015, up from 22% in 2005). Nevertheless, room remains for further development of day surgery, as Spain still lags behind many other EU countries such as Finland, Sweden, the Netherlands and the United Kingdom in the use of day surgery.

Pharmaceutical spending has been curbed by a greater use of generics and price reductions

Spain adopted a number of measures to contain spending on pharmaceuticals by accelerating entry of generics in the market and making the reference price system more responsive. As early as 2006, Spain implemented regulatory measures mandating pharmacists to substitute the medicine prescribed with the cheapest generic. As a result, the share of the generic market grew quickly over the past decade, reaching 48% of the total reimbursed market in volume in 2015, up from only 14% in 2005 (Figure 15). In addition, the prices of generics have fallen by a quarter since 2008 and a further rebate was imposed on all drugs covered by the NHS for outpatient and inpatient care (Belloni, Morgan and Paris, 2016).

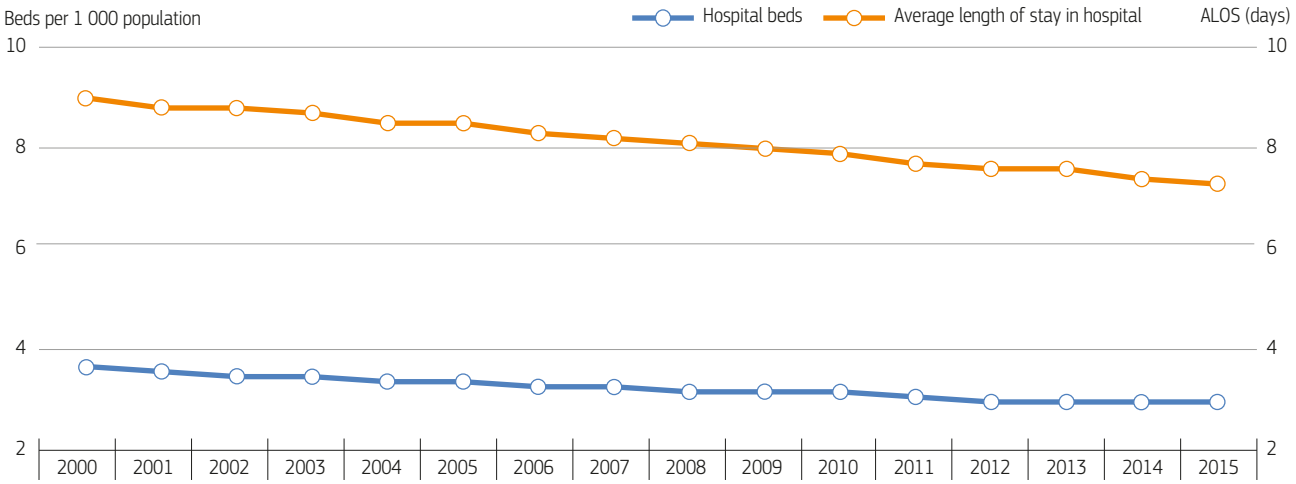
6. Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises..

Figure 13. Public spending on health reduced sharply in Spain after the economic crisis



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

Figure 14. Spain reduced the number of hospital beds and average length of stay over the past decade



Source: Eurostat Database.

As a consequence, pharmaceutical spending decreased on average by 1% per year in real terms between 2009 and 2014, but started to rise again in 2015.

Promoting better geographic distribution and retention of health workers is a challenge

The number of students entering medical education increased by over 50% between 2004 and 2014, in response to concerns about possible future shortages of doctors. While the overall number of physicians is likely to continue to increase, large variations in the availability of doctors across regions persist, ranging from 2.7 doctors per 1 000 population in Andalucía to 5.3 physicians per 1 000 population in Navarra. These disparities are partly related to the fact that there is no regulation concerning the choice of practice location for self-employed doctors.

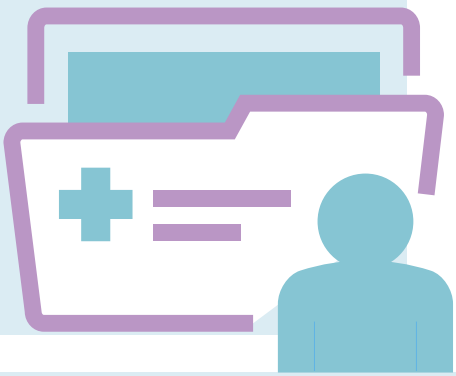
The relatively low number of nurses per capita in Spain is not a new phenomenon, but concerns are growing about nursing shortages. Over the past few years, the number of students entering into nursing education remained relatively stable, with the number of new graduates averaging around 10 000 per year between 2009 and 2014. The economic crisis and reductions in health budgets had important implications on the emigration of nurses from Spain. In 2014 and 2015, more than 2 000 nurses trained in Spain moved each year to the United Kingdom to take advantage of better job opportunities. This raises the issue of whether Spain is getting a good return on its public investments in nursing education.

BOX 3. SPANISH *ATLAS ON VARIATIONS IN MEDICAL PRACTICE*

The *Spanish Atlas on Variations in Medical Practice* is a bottom-up collaborative health services research project that aims to describe systematic and unwarranted variations in medical practice. This atlas evaluates the health care provided to 35 million people from 180 health areas in 16 autonomous communities (with the exception of Madrid). Variations in medical practice have been analysed in many clinical areas, including orthopaedics, general surgery, paediatrics, cardiovascular procedures and mental health conditions, among others.

The 2015 Atlas, for instance, showed noticeable regional differences in avoidable hospitalisations for chronic illnesses of frail elderly patients. Rates varied from 23 avoidable hospitalisations per 10 000 population in certain areas of Andalucía to above 100 in some areas of Asturias, Murcia, Madrid and Valencia. Significant variations also exist in knee replacement rates across regions in Spain, and cannot be explained only by variations in need.

Source: Excerpt from OECD (2014).



Spain is reallocating resources from low-value care to more effective care

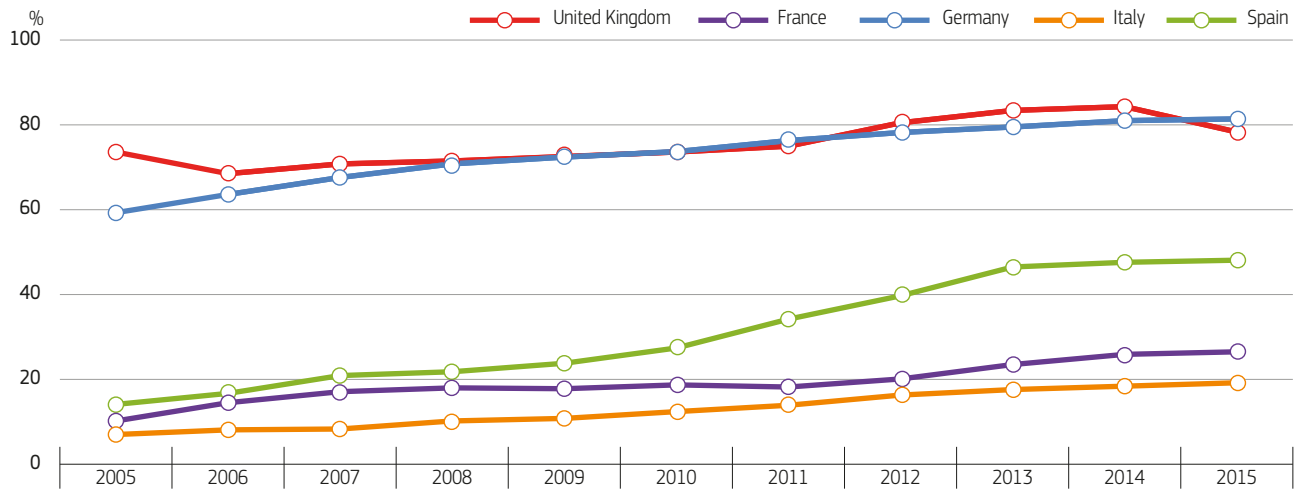
Spain is one of the first EU countries to have developed an atlas to identify unwarranted variations in health care activities (Box 3).

There is substantial evidence of an overuse of many surgical procedures across hospitals and regions in Spain. For example, rates of knee replacements vary more than five-fold across different regions in Spain (OECD, 2014). It is difficult to imagine that these variations reflect differences in need. Rather, people in some regions must receive interventions that in other regions are considered unnecessary, or else severe under-provision of services occurs in those regions with the lowest intensity of interventions.

On a more positive note, the recent success in reducing unnecessary caesarean sections in many public hospitals provides a good example of the possibility of reducing the overuse of certain interventions through the development and implementation of clinical guidelines in a way that involves all key stakeholders. Nevertheless, the challenge remains to extend this approach to all regions and hospitals (OECD, 2014).

In 2013, the Ministry of Health established the 'Commitment for the Quality of the Scientific Societies in Spain'. Its main goal is to reduce unnecessary health interventions by setting up a series of 'do not do' (no hacer) recommendations across health service delivery. The Ministry worked together with the Spanish Society of Internal Medicine and the GuíaSalud in coming up with recommendations targeting specific areas of health care.

Figure 15. The share of the generic market (in volume) has increased rapidly in Spain



Source: OECD Health Statistics 2017.

6 Key findings

- Life expectancy at birth in Spain is the highest among all EU Member States. Spain also has one of the lowest amenable mortality rates in the EU, due notably to relatively low and declining mortality rates from ischaemic heart diseases and stroke. Preventable mortality has come down substantially, reflecting, at least partly, public health interventions to promote healthier lifestyles. Nonetheless, smoking rates among adults remain high compared to the EU average, and obesity rates are growing among both adolescents and adults.

- Following the economic crisis, a series of urgent measures were put in place to reduce public spending on health, notably by reducing the scope, breadth and depth of public coverage. These reforms shifted some of the costs for health care and pharmaceuticals to households. The share of direct out-of-pocket spending has increased since 2009, accounting for 24% of overall health spending in 2015, a much higher level than the EU average of 15%.

- Spain has a decentralised health system under national coordination. Since 2002, the organisation and delivery of health services have been devolved to 17 regional health administrations. Important variations arise across regions, not only in health spending, but also in the supply of doctors and other health workers, health care activities and waiting times

- Waiting times for different health services are a longstanding issue in Spain. Following some reduction before the economic crisis, the average waiting times for elective surgery, such as cataract surgery or hip replacement, have increased and are now well above the level in other countries such as Italy and Portugal. This is due to the demand for these procedures increasing more rapidly than the supply.

- At the same time, substantial evidence exists of an overuse of many surgical procedures in Spain. Knee replacement rates vary more than five-fold across different regions, and wide variations are observed in cardiac procedures and caesarean sections. These variations are too large to be explained solely by differences in need. The recent success in reducing unnecessary caesarean sections in many public hospitals provides a good example of the possibility of reducing the overuse of certain interventions through the development and implementation of clinical guidelines involving all key stakeholders. The challenge is to extend this approach to all regions and hospitals to reduce low-value care.

- The shift from more expensive inpatient hospital services towards ambulatory care preceded the economic crisis and was pursued in recent years. The number of hospital beds decreased steadily and was accompanied by reductions in average length of stay in hospital. The use of ambulatory surgery rose for many interventions, although room remains for further development of day surgery to achieve efficiency gains and free up resources.

- Health and long-term care expenditure in Spain are expected to rise in future years as a share of GDP due to population ageing and technological progress. Further efficiency gains in health and long-term care delivery will be needed to address the growing needs of an ageing population in an affordable way.



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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		

European Commission

State of Health in the EU

Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and 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. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

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 Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

Each Country Health Profile provides a short synthesis of:

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- the effectiveness, accessibility and resilience of the health system

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