European Commission









State of Health in the EU

Spain

Country Health Profile 2019

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

The Country Health Profile series

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

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

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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 28 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: http://www.oecd.org/health/Country-Health-Profiles-2019-Spain.xls

Demographic and socioeconomic context in Spain, 2017

Demographic factors	Spain	EU
Population size (mid-year estimates)	46 593 000	511 876 000
Share of population over age 65 (%)	19.0	19.4
Fertility rate[1]	1.3	1.6
Socioeconomic factors		
GDP per capita (EUR PPP[2])	27 600	30 000
Relative poverty rate[3] (%)	21.6	16.9
Unemployment rate (%)	17.2	7.6

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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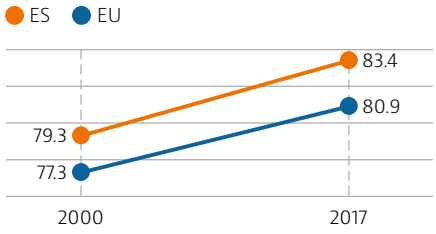
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1 Highlights

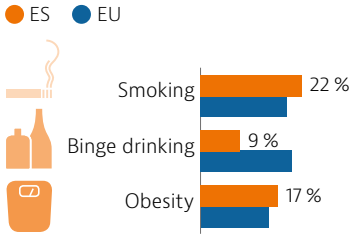
Spain has the highest life expectancy in the EU and social inequalities in health are less pronounced than in many other countries. However, many years of life in old age are lived with some chronic diseases and disabilities, increasing demands on health and long-term care systems. Health spending per capita in Spain is more than 15 % lower than the EU average. While most health spending is publicly funded, direct out-of-pocket spending by households accounts for a greater share than the EU average. The Spanish health system relies on a strong primary care system, but growing demands arising from the increasing burden of chronic diseases may require more and more efficient use of resources.



Life expectancy at birth, years

Health status

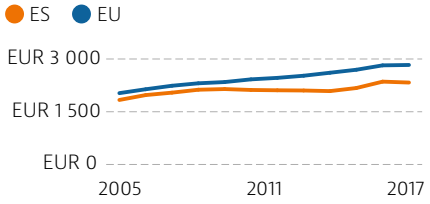
Life expectancy in Spain increased by more than four years since 2000 to reach 83.4 years in 2017, 2.5 years above the EU average. These gains have been driven mainly by substantial reductions in mortality rates from cardiovascular diseases, but mortality from Alzheimer's disease has increased as a result of the increase in life expectancy. Nearly 60 % of Spaniards aged 65 and over have at least one chronic disease, and more than one in five have some limitations in activities of daily living.



% of adults

Risk factors

While smoking rates have decreased over the past 15 years, more than one in five Spanish adults (22 %) still smoked daily in 2017, a higher rate than the EU average (19 %). Obesity rates have increased in Spain: one in six adults (17 %) was obese in 2017, also above the EU average (15 %). Conversely, alcohol consumption is relatively low, and the proportion of adults reporting heavy alcohol consumption is among the lowest in Europe (9 %).



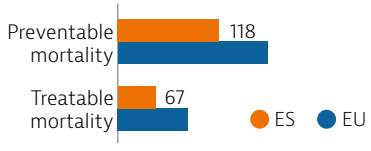
Per capita spending (EUR PPP)

Health system

Health spending per capita in 2017 reached EUR 2 371 (adjusted for purchasing power), more than 15 % below the EU average of EUR 2 884. Following the 2009 economic crisis, health spending remained flat or even decreased in some years, but has started to rise again since 2014. Health spending accounted for 8.9 % of GDP in 2017, below the EU average of 9.8 %.

Effectiveness

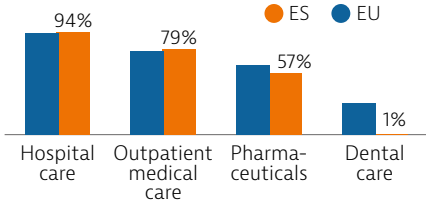
Spain has among the lowest mortality rates from preventable and treatable causes, pointing towards generally effective public health and health care interventions in avoiding premature mortality.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

All citizens in Spain are covered by statutory health insurance, but public coverage is lower for pharmaceuticals, and dental care is not covered. As a result, unmet needs for dental care are higher, particularly for people on low incomes. Waiting times for doctor consultations and elective surgery are persisting issues.



Public coverage for selected goods and services, 2016

Resilience



Budgetary pressures to respond to growing needs for health and long-term care will increase in the years ahead owing to population ageing. Some progress has been achieved in promoting greater care coordination for people with chronic conditions, but there is growing recognition by all stakeholders that strengthening primary care should be a key priority.

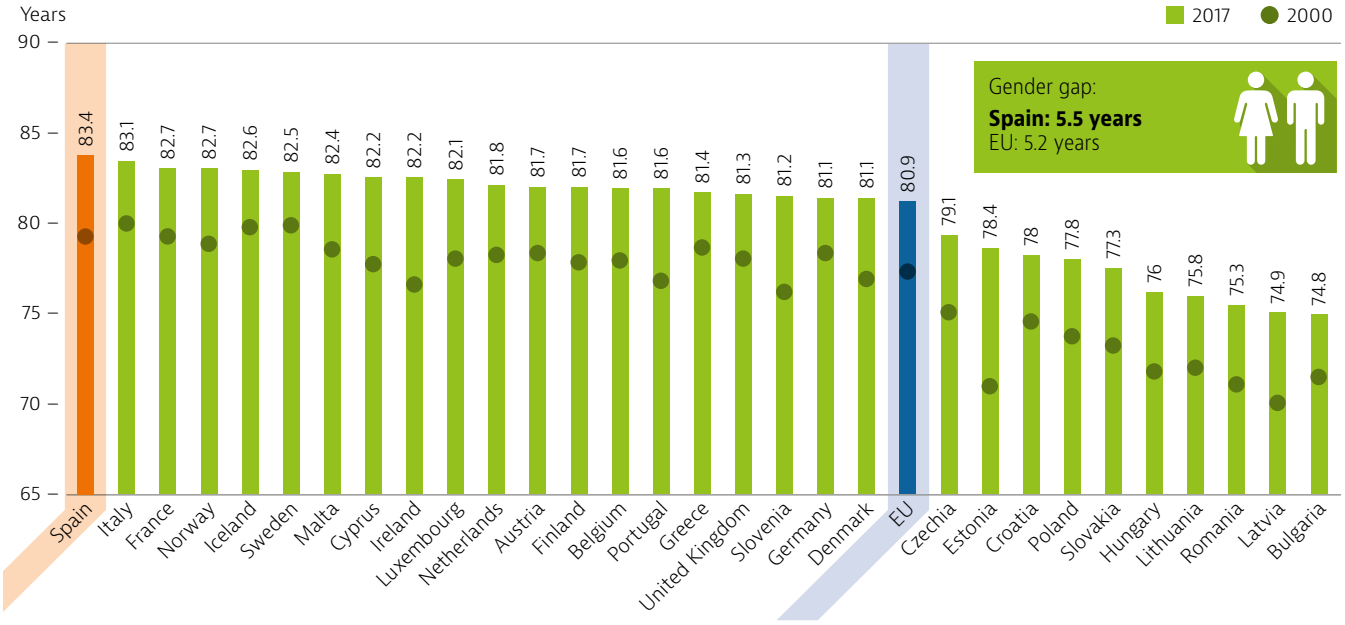
2 Health in Spain

Spaniards have the highest life expectancy among EU countries

In 2017, life expectancy reached 83.4 years in Spain, the highest level among EU countries (Figure 1). Life expectancy has increased by more than four years since 2000, more rapidly than the EU average (3.6 years).

The gender gap in life expectancy has narrowed since 2000 as the life expectancy of Spanish men increased more rapidly than that of women. Nonetheless, it remains fairly large, at 5.5 years.

Figure 1. Life expectancy in Spain is the highest in the EU



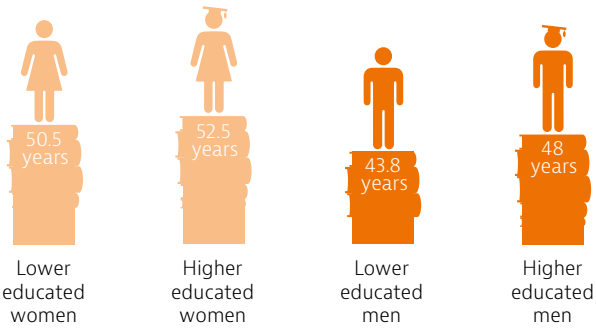
Source: Eurostat Database.

Social inequalities in life expectancy are less pronounced than in many other countries

Inequalities in life expectancy in Spain exist not only by gender but also by socioeconomic status, although they are less pronounced than in many other EU countries. The life expectancy of men at age 35 with the lowest level of education is more than four years less than for the most educated (Figure 2). This education gap in longevity is smaller among Spanish women, at about two years.

The gap can be explained at least partly by differences in exposure to various risk factors, including higher smoking rates and obesity rates among men and women with low levels of education. It also reflects differences in income level and living standards, which affect exposure to other risk factors.

Figure 2. The education gap in life expectancy is over 4 years for men and 2 years for women



Education gap in life expectancy at age 35:

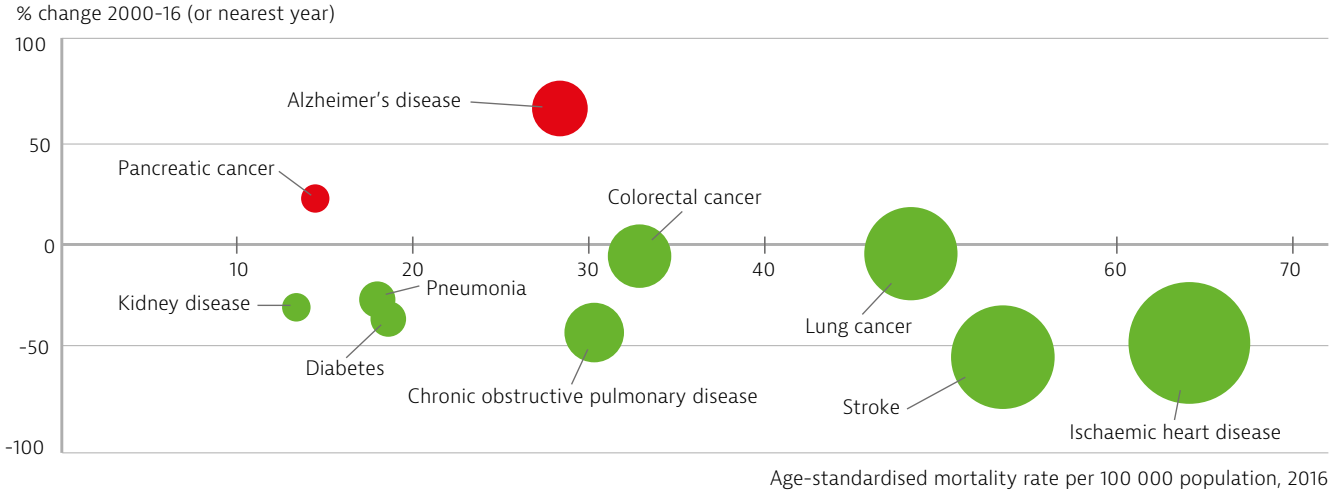
Spain: 2 years	Spain: 4.2 years
EU16: 3.6 years	EU16: 6.5 years

Note: Data refer to life expectancy at age 35. High education is defined as people who have completed tertiary education (ISCED 5-8) whereas low education is defined as people who have not completed secondary education (ISCED 0-2).
Source: Permanyer I et al. (2018), Demography, 55: 2045 (data refer to 2012-15); Eurostat Database for the EU average.

Ischaemic heart disease, stroke and lung cancer are still the leading causes of death

The increase in life expectancy in Spain since 2000 has been driven mainly by reductions in mortality rates from circulatory diseases, notably ischaemic heart disease and cerebrovascular disease (stroke), although they remain the leading causes of death in 2016 and further reductions may be threatened by rising obesity rates (see Section 3). Lung cancer, colorectal cancer and chronic obstructive pulmonary disease (COPD) also remain important causes of death, but their burden has decreased at least slightly since 2000. By contrast, mortality rates from Alzheimer's disease have increased sharply, although this is due at least partly to improvements in diagnostics and death registration practices (Figure 3).

Figure 3. Mortality rates decreased for cardiovascular diseases but increased for Alzheimer's disease



Note: The size of the bubble is proportional to the mortality rate in 2016.
Source: Eurostat Database.

Spaniards live the longest in the EU, but many report chronic diseases and disabilities in old age

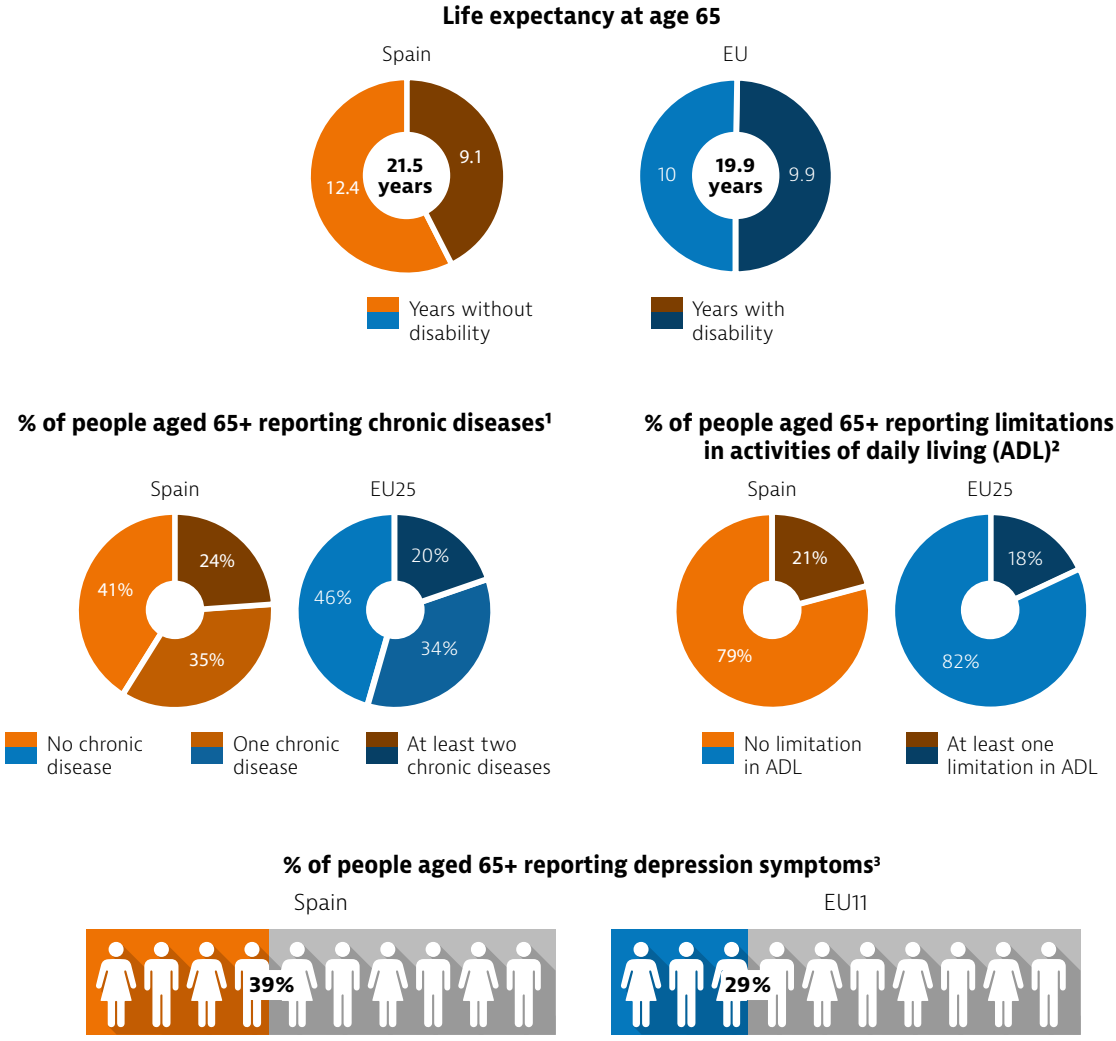
Older people make up a growing proportion of the Spanish population. Nearly one in five people (19 %) was aged 65 and over in 2018, up from one in nine (11 %) in 1980, and this share is projected to rise to more than one in three (36 %) by 2050.

Spanish people nowadays can expect to live an additional 21.5 years when they reach the age of 65, 1.5 years more than the EU average. However, many of these years are lived with some health issues and disabilities (Figure 4).

Nearly 60 % of people aged 65 and over reported having one or more chronic conditions in 2017, although this may not impede them from living a normal life and carrying on their usual activities if it is properly managed. More than one in five reported at least one limitation in activities of daily living, such as eating or dressing, which may require some long-term care assistance. Nearly 40 % also reported some symptoms of depression, a greater proportion than in other EU countries.[1]

1: According to the 2017 Spanish National Health Survey, 11 % of people aged 65 and over reported having been diagnosed for depression in the past year.

Figure 4. Spanish people live longer, but not all years of life in old age are lived in good health



Notes: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson disease, Alzheimer's disease and rheumatoid arthritis or osteoarthritis. 2. Basic activities of daily living include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet. 3. People are considered to have depression symptoms if they report more than three depression symptoms (out of 12 possible variables).
Sources: Eurostat Database for life expectancy and healthy life years (data refer to 2017); SHARE survey for other indicators (data refer to 2017).

3 Risk factors

Over one-third of deaths can be attributed to behavioural risk factors in Spain

Estimates suggest that over one-third of all deaths in Spain can be attributed to behavioural risk factors, including tobacco smoking, dietary risks, alcohol consumption and low physical activity, a slightly lower proportion however than the EU average (Figure 5; IHME, 2018).

Around 16 % (67 000) of all deaths in 2017 can be attributed to tobacco smoking alone (including direct and second-hand smoking). Dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption) are estimated to account for about 12 % (52 000) of all deaths. About 8 % (32 000) of deaths can be attributed to alcohol consumption, and 2 % (9 500) to low physical activity.

Figure 5. Behavioural risk factors account for more than one-third of deaths in Spain



Note: The overall number of deaths (140 000) related to these risk factors is lower than the sum of each one taken individually (160 000), because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable consumption, and high sugar-sweetened beverages and salt consumption.
Source: IHME (2018), Global Health Data Exchange (estimates refer to 2017).

Smoking rates among adults in Spain remain higher than in most other EU countries

While the proportion of adults smoking daily has decreased since 2000, it remains higher than in most EU countries (Figure 6). More than one in five adults (22 %) smoked daily in 2017 according to the National Health Survey, compared with 19 % on average across the EU.[2] Spanish men still smoke more than women (26 % for men and 19 % for women), but the reduction in smoking rates has been slower among women. More than in one in five 15- and 16-year-old adolescents in Spain reported smoking at least occasionally in 2015, which is close to the EU average.

Overweight and obesity among adolescents and adults are a growing issue in Spain

Nearly 20 % of adolescents were overweight or obese in 2013-14, a higher proportion than the average of 17 % in EU countries. A greater proportion of 15-year-old boys are overweight or obese (24 %) than girls (15 %), albeit boys report being more physically active.

The obesity rate has also increased among adults: one in six Spaniards were obese in 2017, up from one in eight in 2001. This is related to low physical activity among adults as well as unhealthy nutritional habits. While the proportion of Spanish adults who reported that they eat at least one fruit daily in 2017 was among the highest in the EU, only about 35% of adults reported eating at least one vegetable per day, close to the EU average of 36 %.

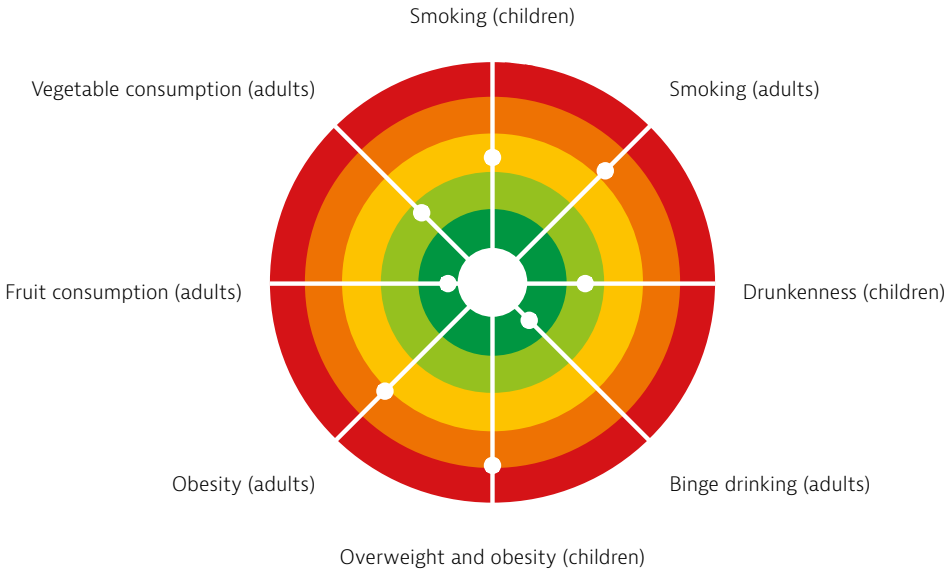
2: The latest survey on alcohol and drugs in Spain 2017 provides different results: it shows an increase in the percentage of daily smokers to 34 % among people aged 15-64, which is a higher level than that registered before the first tobacco law of 2005, but the number of cigarettes smoked has reduced.

Spain has fewer problems with heavy alcohol consumption than other countries

On a more positive note, the proportion of adults who report regular heavy alcohol consumption in Spain (binge drinking) is well below that of most EU countries (9 % compared with 20 % across EU countries in 2014).[3] Overall alcohol consumption among adults in Spain has reduced substantially since 2000.

Fewer 15-year-olds report having been drunk on several occasions than in other countries. Nonetheless, more than one in five reported such underage risky alcohol consumption in 2013-14.

Figure 6. Smoking and obesity are important public health issues 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 ESPAD survey 2015 and HBSC survey 2013-14 for children indicators; and EU-SILC 2017, EHIS 2014 and OECD Health Statistics 2019 for adults indicators.

3: Binge drinking in the European Health Interview Survey (EHIS) of 2014 was defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year. The results from a more recent Spanish national health interview survey in 2017 show a higher rate (15 %), which may be partly explained by the use of a broader definition of binge drinking (five or more drinks for men and four or more drinks for women).

4 The health system

The health system is based on national principles but decentralised in organisation and delivery

Spain's national health system, the *Sistema Nacional de Salud* (SNS), is based on the principles of universality, free access, equity and fairness of financing, and is mainly funded from general taxation. The 17 regional departments of health have primary jurisdiction over strategic and operational planning at the regional level, resource allocation, purchasing and provision, often with support from specialised agencies such as the Network of Agencies for the Evaluation of Health Technologies and Benefits. National planning and regulation are the responsibility of the Ministry of Health, Consumption and Social Welfare. The highest body for coordination is the SNS Interterritorial Council, which comprises the national and the 17 regional ministers of health.

The SNS coexists with two other statutory subsystems: the three mutual funds catering for civil servants, the armed forces and the judiciary; and the mutual funds for accidents and occupational diseases.

Reforms in the Spanish health system over the past decade have been influenced by measures responding to the economic crisis under the EU stability programme. Introduced in the early 2010s, these reforms have changed the governance of the SNS (notably by centralising spending rules) and redefined co-payments by patients for medicines and some other ancillary benefits.

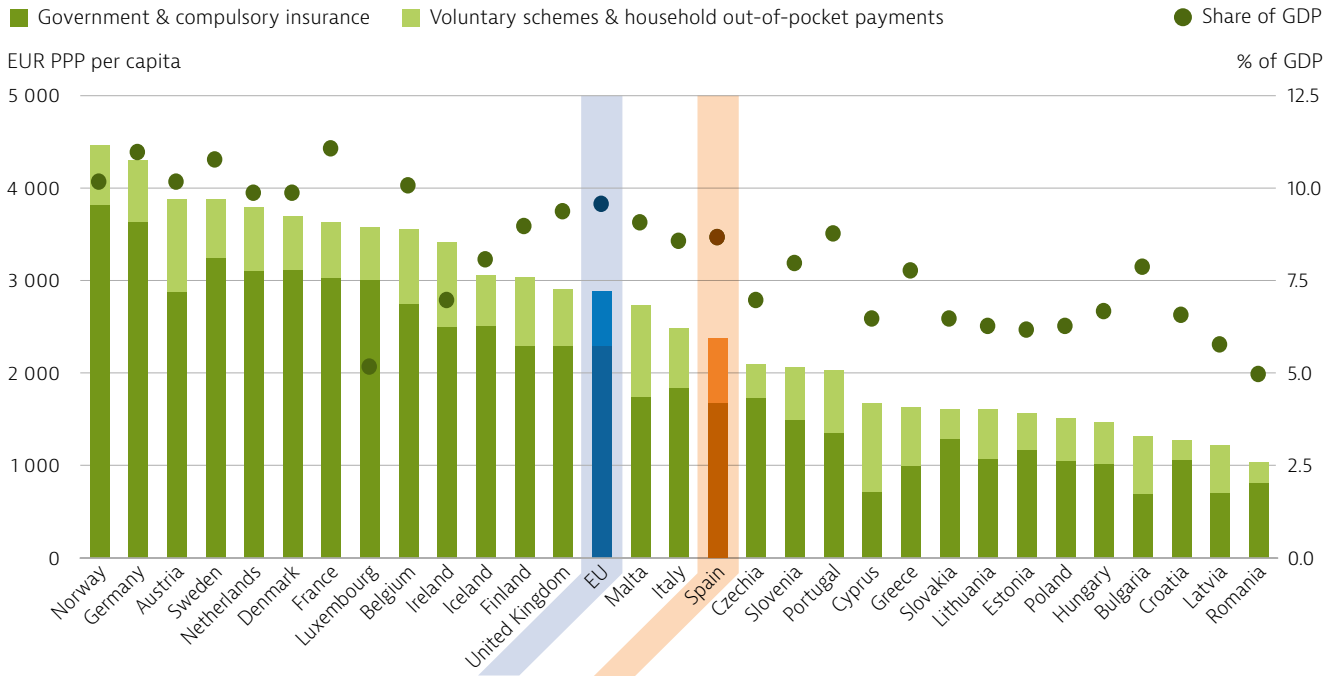
Health coverage entitlement was restricted in 2012 and linked to individuals' legal and working status, but a royal decree-law in July 2018 restored universality to the SNS. In the new regulation, irregular immigrants have recovered eligibility to the same full coverage as any other Spanish national.

Health spending in Spain is lower than the EU average

In 2017, health spending per capita (adjusted for differences in purchasing power) was EUR 2 371, 15 % below the EU average of EUR 2 884. Health spending accounted for 8.9 % of GDP, also below the EU average of 9.8 % (Figure 7).

Public spending accounted for 71 % of all health spending in 2017, less than the EU average of 79 %. The share of public spending on health decreased after the 2009 economic crisis due to cost-cutting measures and greater co-payments for pharmaceuticals. It has started to rise again in recent years, although it remains below its pre-crisis level.

Figure 7. Spain spends less on health than the EU average



Source: OECD Health Statistics 2019 (data refer to 2017).

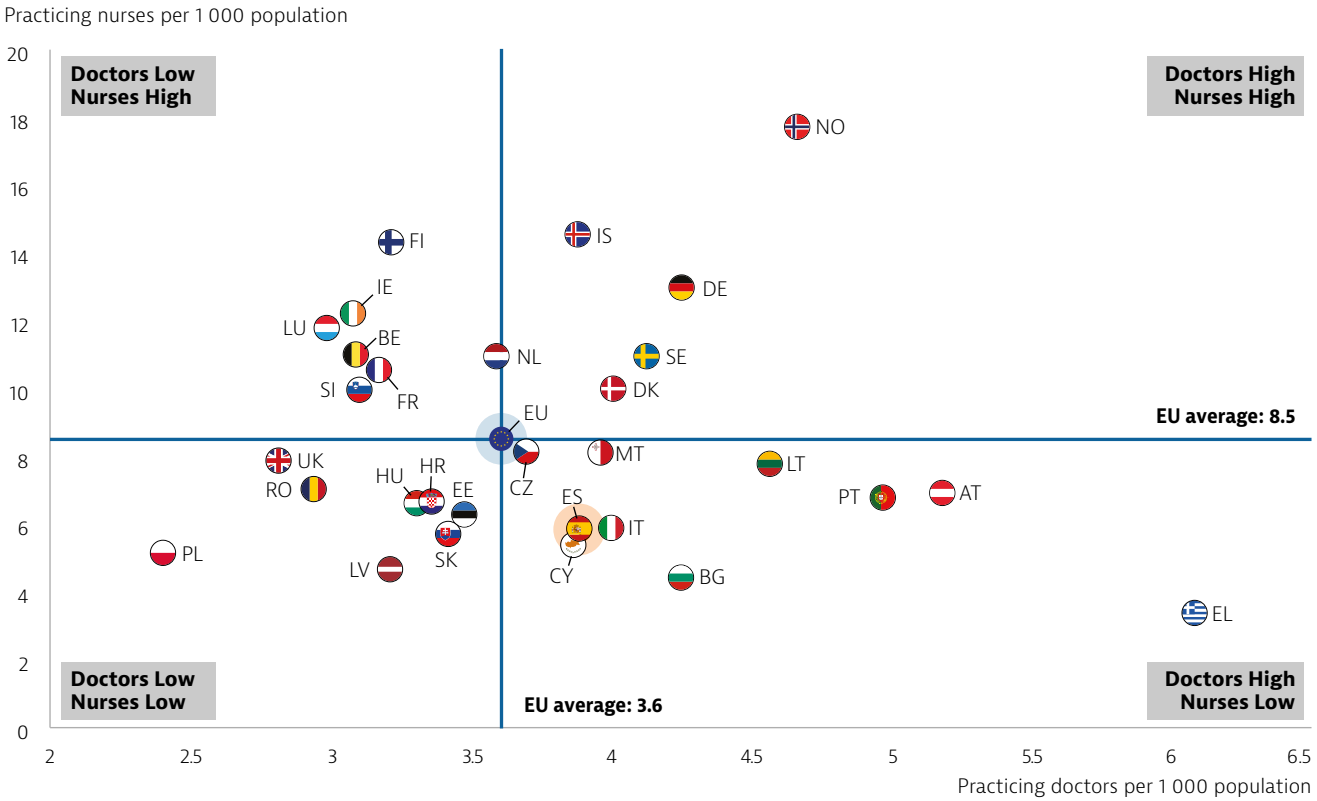
Out-of-pocket payments for pharmaceuticals are substantial

Out-of-pocket (OOP) payments increased steadily between 2010 and 2014, before falling slightly since 2015 to reach 24 % of total health expenditure in 2017. This is well above the EU average of 16 %. OOP payments mainly consist of co-payments for pharmaceuticals and medical devices outside hospitals. After the 2012 reform, the level of cost-sharing for pharmaceuticals was increased and based on income level and employment status, including a monthly spending cap to protect pensioners (Section 5.2).

The number of doctors and nurses has increased, with a shift towards temporary contracts

The number of doctors and nurses in Spain has increased in recent years, both in absolute numbers and relative to the population size. As shown in Figure 8, the number of doctors per 1 000 population is slightly higher than the EU average (3.9 versus 3.6 in 2017). The proportion of nurses is well below the EU average (5.7 per 1 000 population versus 8.5), as the number of nurses in Spain does not include nurse assistants although they perform similar tasks to many nurses elsewhere in Europe. There are reports of increasing shortages of nurses, and the growing use of temporary and part-time contracts also results in large turnover (European Commission, 2019a). Overall in the SNS, 30 % of all employees were on temporary contracts in 2017, up from 27 % in 2012 (Sanidad CCOO, 2017). The Ministry of Finance signed an agreement with the unions in March 2017 to reduce temporary employment contracts below 8 % to increase job stability in the health sector.

Figure 8. Spain has a relatively high number of doctors but a low number of nurses



Note: The number of nurses in Spain does not include nurse assistants, although they perform similar tasks to many nurses elsewhere in Europe. In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital. 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).
Source: Eurostat Database (data refer to 2017 or the nearest year).

Primary care faces the challenge of responding to a growing burden of chronic diseases

Primary care remains a central tenet of the Spanish health system. General practitioners (GPs) and nurses provide acute and chronic care to the whole population, and also provide specific preventive and health promotion services targeting children, women and older people. GPs act as gatekeepers to more specialised care and play a crucial role in continuity of care between primary and secondary levels. Secondary care takes the form of outpatient specialised care, inpatient care, day care or emergency care. All health professionals in the SNS are salaried workers.

Population ageing and the growing burden of chronic conditions are putting additional demands on primary care. Despite this increasing pressure, public spending on hospitals accounts for a growing share of public spending, while the share allocated to primary care stagnates (European Commission 2019a). In response to the challenges faced by the primary care system, a new Strategic Framework for Primary and Community Care was adopted in April 2019 (Box 1).

Some regional initiatives are designed to enhance integrated care

Some autonomous communities have implemented structural and organisational reforms in recent years to strengthen integrated care. For instance, the Basque Country has developed new administrative bodies (known as integrated health care organisations), consisting of collaborating hospitals and primary care centres. In Andalusia, 14 health care management areas (covering part of the territory) jointly manage both primary and hospital care services. In Catalonia, health care integration areas aim to provide comprehensive care to the whole population in a specific territory.

The Spanish health system benefits from EU Structural Funds

Spain is receiving considerable funding to modernise its health system through the EU Structural and Investment Funds. During the 2014-2020 period, Spain will receive just over EUR 500 million to invest in its health system. Most of this funding is allocated to the development of eHealth (EUR 257 million), health infrastructure (EUR 177 million) and to improve access to health and social services (EUR 67 million) (European Commission, 2016).

Box 1. A Strategic Framework for Primary and Community Care aims to enhance primary care and patient involvement in the Spanish health system

In April 2019, a new Strategic Framework for Primary and Community Care was adopted by the Interterritorial Council of the SNS. The ambitious plan consists of six main objectives, each of which is accompanied by specific actions that are expected to be monitored over time. These include strengthening the governance role of the Interterritorial Council over primary care, consolidating a new policy on financial and human resources issues, improving quality and coordination of care, reinforcing the community's orientation of primary care and increasing the use of information and communication technologies. The strategy was designed by the Ministry of Health, autonomous communities, professional organisations and patient organisations.

5 Performance of the health system

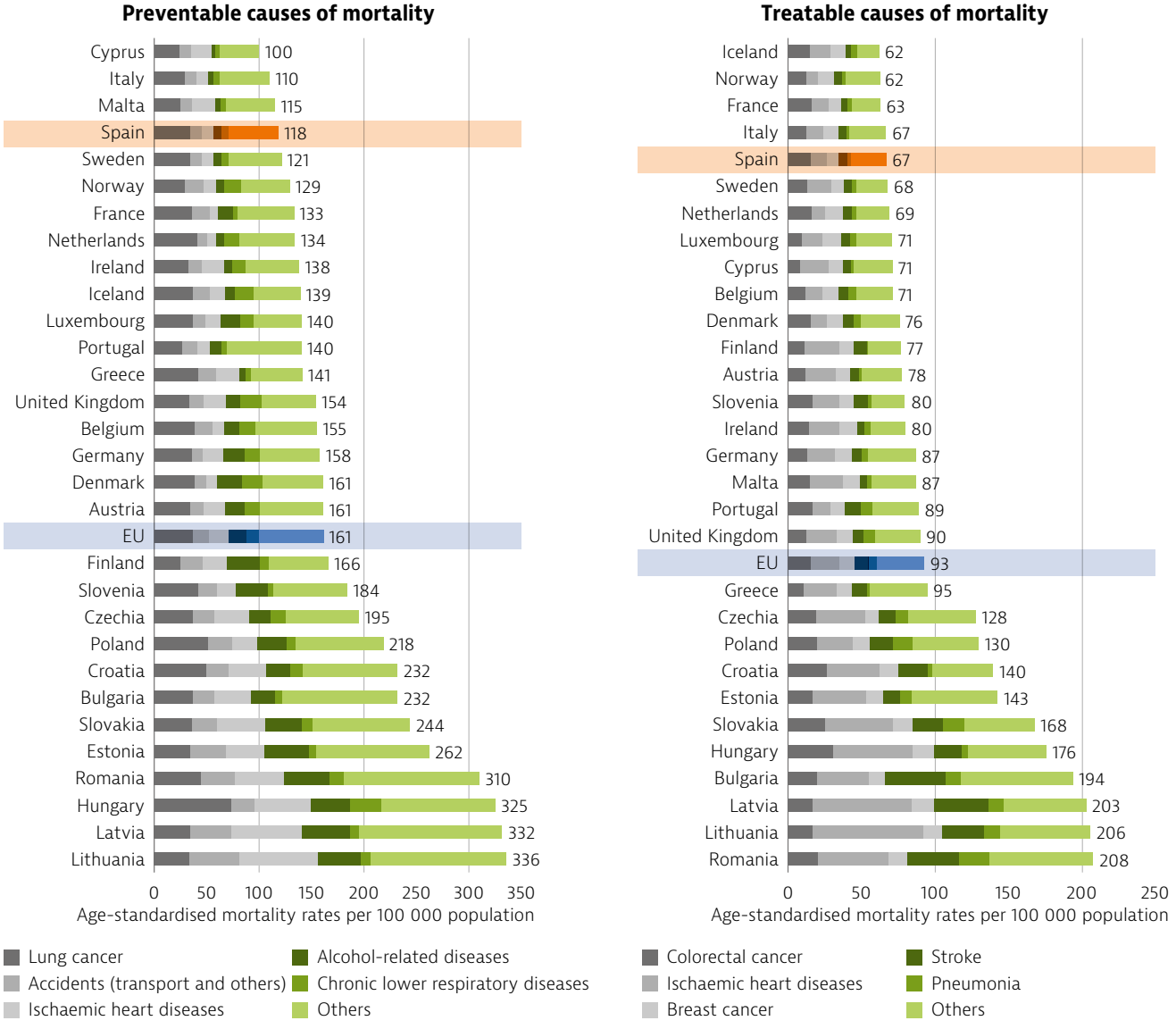
5.1. Effectiveness

Mortality rates from preventable and treatable causes are low

Preventable mortality rates in Spain are among the lowest in the EU, driven by low mortality rates from ischaemic heart disease (particularly among women), road accidents and other accidental deaths, and alcohol-related diseases (Figure 9). On the other hand, mortality rates from lung cancer continue to be high (particularly among men) and close to the EU average, reflecting a historical pattern of Spanish men smoking more than women.

Treatable causes of mortality are also among the lowest in Europe, indicating that the Spanish health system is generally effective in treating people with life-threatening conditions. These favourable outcomes are largely due to low mortality rates from ischaemic heart disease and cerebrovascular diseases (stroke). Mortality rates from some types of cancer, such as colorectal cancer, are closer to the EU averages.

Figure 9. Mortality from preventable and treatable causes is lower than in most EU countries



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Mortality from treatable (or amenable) causes is defined as death that can be mainly avoided through health care interventions, including screening and treatment. 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 2016).

Several public health initiatives have been implemented to address important risk factors

Spain's low levels of preventable death can be explained at least partly by strong public health policies. An anti-tobacco law was adopted in 2005 and reinforced in 2010. The 2010 law strengthened the regulations around retail sales and advertising of tobacco products; increased the protection of minors and non-smokers by expanding smoke-free locations to any public place; and promoted the implementation of smoking cessation programmes, particularly in primary care. At the same time, taxes on cigarettes were raised, by 3 % for a pack of cigarettes in 2013, then by a further 2.5 % in 2017, along with a 6.8 % increase in taxes for rolling tobacco.

In 2011, the law on food safety and nutrition included a cross-sectorial strategy on nutrition, physical activity and obesity prevention (Box 2). One of the goals of the strategy is to reduce overweight and obesity among children, by prohibiting food and beverages high in saturated fatty acids, salt and sugars in schools, and more broadly by tightening regulations around children's menus.

Box 2. Strategy on nutrition, physical activity and obesity prevention (NAOS)

The NAOS Strategy, managed by the Agency for Consumer Affairs, Food Safety and Nutrition, aims to curb the growth in obesity in the Spanish population. It was launched in 2005 and strengthened by the law on food security and nutrition adopted in 2011. More recently, work has been undertaken to develop a set of indicators to assess progress in its implementation and to develop accreditation criteria for those schools interested in implementation of health promotion activities on nutrition, physical activity and obesity prevention (AECOSAN, 2019).

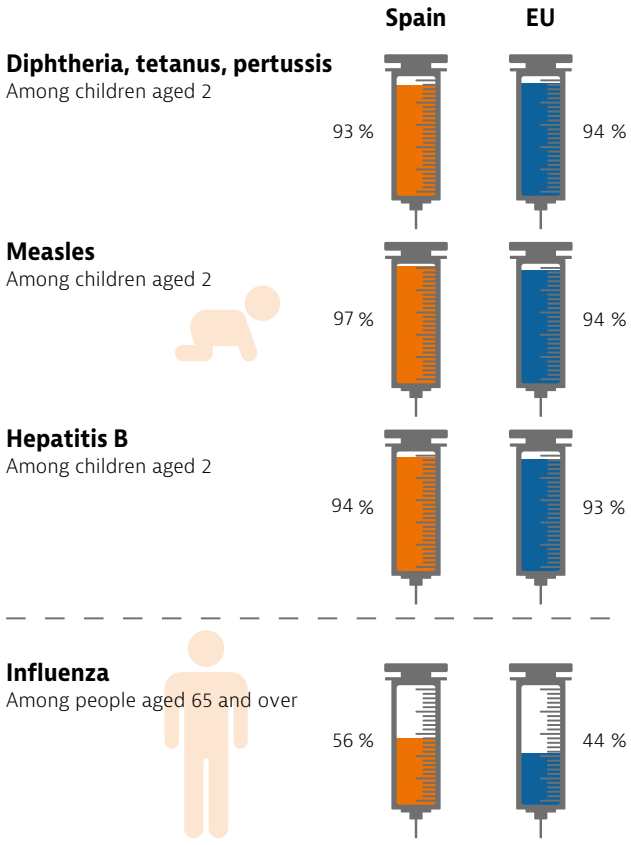
In 2018, the Ministry of Health, Consumption and Social Welfare announced new measures to reinforce the NAOS Strategy, including an initiative on new front-of-package labelling using the Nutriscore model. By using an easy-to-understand colour code (based on the traffic light approach), this initiative aims to provide citizens with more accurate information on nutritional food quality, although the measure has not yet been implemented. In early 2019, the Ministry also signed an agreement with almost 400 food companies, who committed to reduce the content of saturated fatty acids, salt and added sugar in their products.

Vaccination coverage among children and older people can be improved

While vaccination coverage among children for measles remains above the 95 % WHO target, it was below that threshold in 2018 for diphtheria, tetanus and pertussis as well as for hepatitis B (Figure 10). Childhood vaccination is provided in primary care centres, where virtually the entire population goes for outpatient perinatal and paediatric care.

With 56 % of people aged 65 and over vaccinated in 2017, influenza vaccination coverage among older people is above the EU average. However, the flu vaccination rate has decreased by almost 10 percentage points over the past decade, moving further away from the WHO target of 75 % of people in that age group.

Figure 10. Vaccination coverage is high for measles but lower for other infectious diseases



Note: The data refer to the third dose for diphtheria, tetanus and pertussis, and hepatitis B, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository for children (data refer to 2018); OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or nearest year).

To improve vaccination coverage of people across all ages and enhance national coordination, a common vaccination calendar was agreed in 2018 and will be implemented across all the autonomous communities from 2019 (Box 3).

Box 3. A common vaccination calendar comes into use in 2019

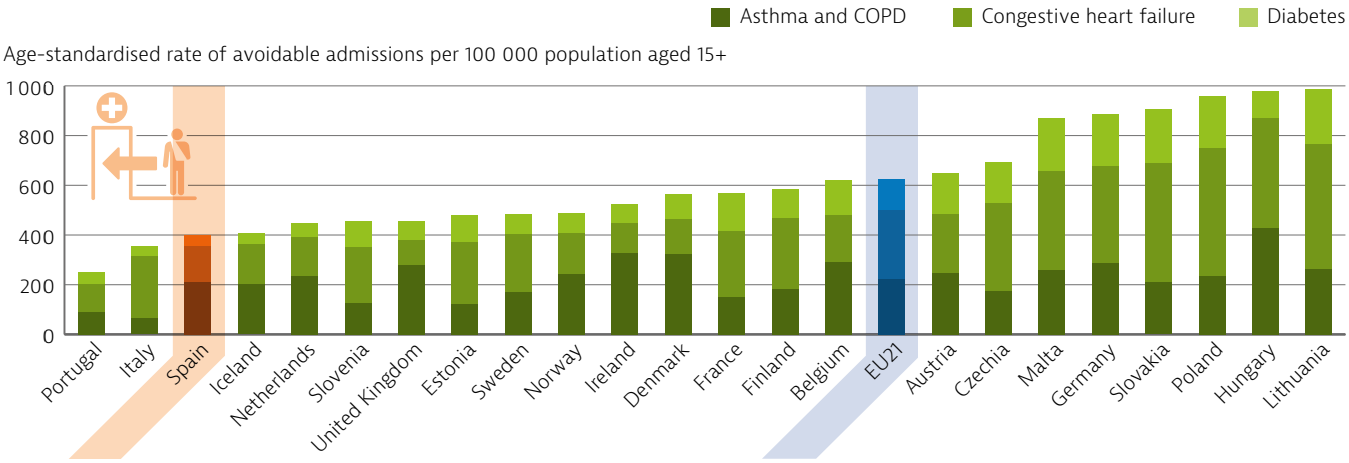
In November 2018, the SNS Interterritorial Council approved a common vaccination schedule for people of all ages across the country beginning before birth with the vaccination of pregnant women and extending to people aged 65 and older. It includes systematic administration of vaccines for the prevention of 14 infectious diseases, based on available scientific evidence.

The strategy aims to take advantage of any contact with the health system to recruit unvaccinated people up to the age of 18 (for example, girls for the human papillomavirus vaccine, and both girls and boys for hepatitis B and meningococcal disease C), and to provide vaccination against tetanus, diphtheria and measles, rubella and mumps among adults. The new calendar also includes recommendations for vaccination of people at greater risk of complications due to chronic conditions.

Avoidable hospital admissions are below the EU average for some chronic diseases

For several communicable or chronic diseases, admissions to hospital can be avoided through well-organised prevention and outpatient care. The admission rates for diabetes and congestive heart failure in Spain are among the lowest in the EU. However, they are only close to the EU average for asthma and COPD, suggesting room for further improvement in the management of these chronic diseases (Figure 11).[4]

Figure 11. Avoidable hospital admissions are below the EU average in Spain



Source: OECD Health Statistics 2019 (data refer to 2017 or the nearest year).

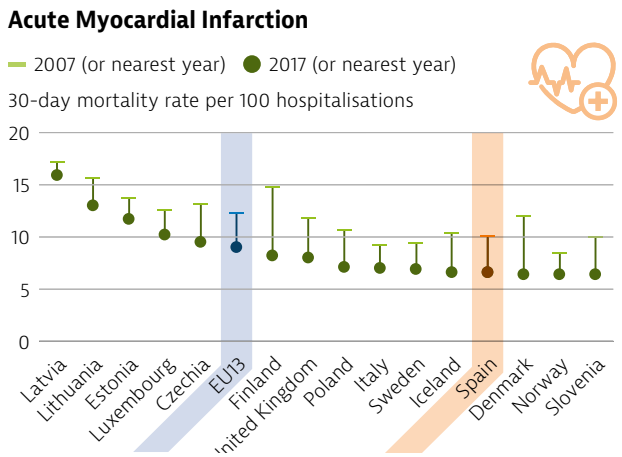
Hospitals generally provide high-quality treatment for people requiring acute care

The quality of acute care in hospitals for life-threatening conditions, such as acute myocardial infarction (AMI), has generally improved in Spain over the past decade, and fewer people die after being admitted for an AMI (Figure 12). These improvements reflect a number of changes, including better organisation and coordination of emergency care that allows quicker access to thrombolysis, and the extension of primary percutaneous coronary interventions.

However, the mortality rates for people admitted for AMI vary substantially across regions and hospitals. In 2016, the rates in some autonomous communities were twice as high as in others (INCLASNS, 2019), reflecting differences in the capacity to provide leading-edge emergency care and primary percutaneous coronary interventions.

4: The data on avoidable hospital admissions are different and generally lower than those reported in Health at a Glance: Europe 2018 because they exclude admissions for people aged under 15 and the rates have been age-standardised to take into account differences in population structures across countries.

Figure 12. 30-day mortality following hospital admission for acute myocardial infarction has fallen



Note: Figures are based on patient data and have been age/sex standardised to the 2010 OECD population aged 45+ admitted to hospital for AMI.
Source: OECD Health Statistics 2019.

Cancer survival rate is above the EU average for most types of cancer

Spain achieves slightly better results than the EU average when it comes to survival following diagnosis of different cancers (such as breast cancer, colon cancer and prostate cancer), with the exception of lung cancer, which is slightly below average (Figure 13). Screening programmes for breast and colorectal cancer have been extended, allowing earlier diagnosis, although further progress can be achieved in covering more fully the respective population target groups. The quality of cancer care has improved through the introduction of multidisciplinary teams and cancer networks, greater use of clinical guidelines and more rapid access to innovative pharmaceuticals.

Figure 13. Five-year survival rates are higher than the EU average for many types of cancer



Prostate cancer
Spain: 90 %
EU26: 87 %

Breast cancer
Spain: 85 %
EU26: 83 %

Colon cancer
Spain: 63 %
EU26: 60 %

Lung cancer
Spain: 14 %
EU26: 15 %

Note: Data refer to people diagnosed between 2010 and 2014.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

5.2. Accessibility

Unmet needs for medical care are low but higher for dental care

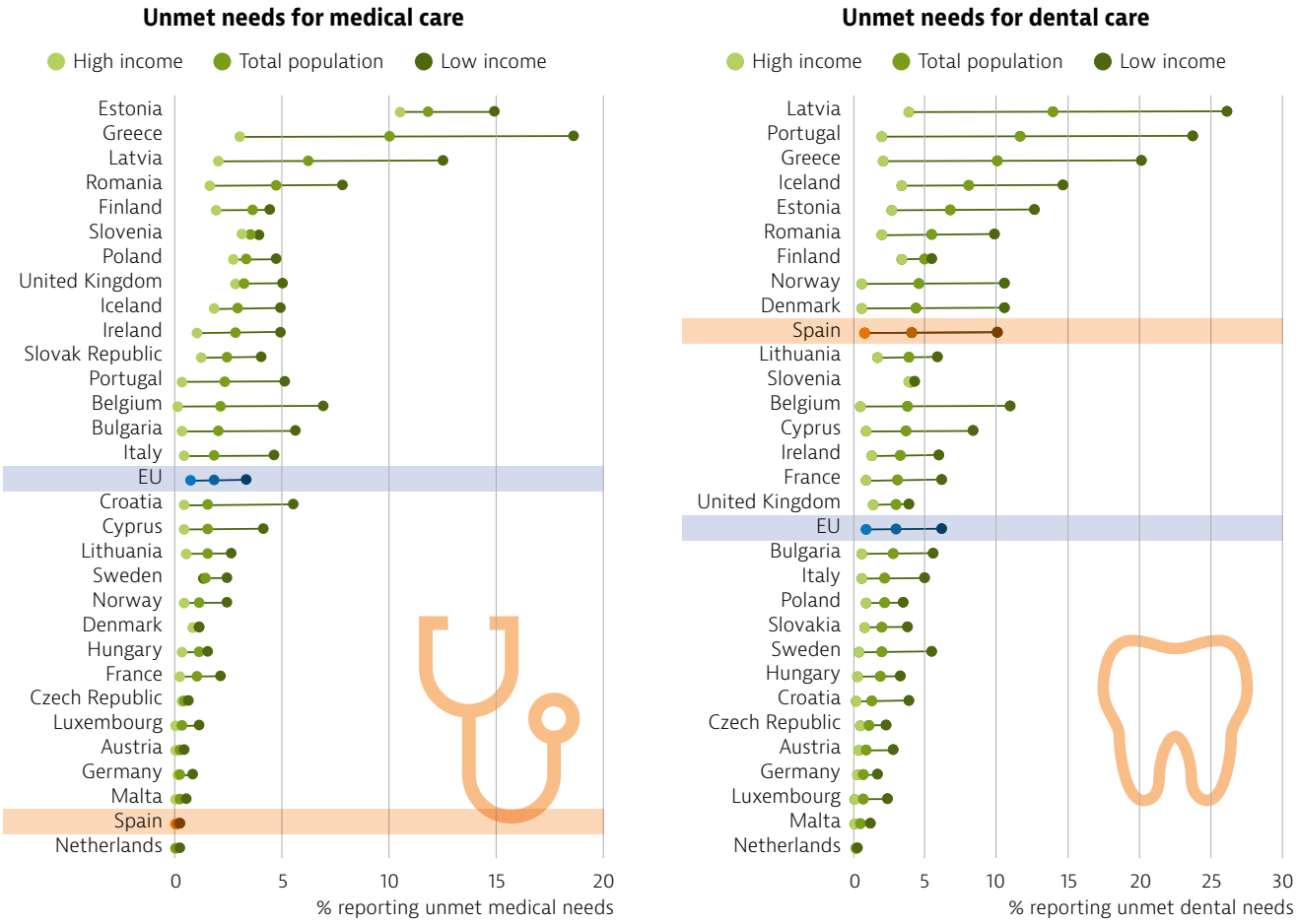
As noted in Section 4, virtually all Spanish citizens are covered by the SNS, which covers most of the costs for health services provided in hospitals and ambulatory settings. Based on the EU-SILC survey, unmet medical care needs relating to cost, distance or waiting times are very low in Spain, having been reported by only 0.1 % of the population in 2017. Furthermore, there is almost no difference between people in the highest and lowest income quintiles (Figure 14).

However, unmet dental care needs are greater because the vast majority of dental care services are not covered under the statutory health insurance. In 2017, 4 % of the population reported going without dental care for reasons relating to cost, distance or waiting time, a slightly higher proportion than the EU average (3 %). The rate of unmet dental care needs is much greater among people in the lowest income quintile (10 %) than those in the highest (less than 1 %)[5].

Specific groups of the population (such as asylum seekers, irregular migrants and homeless people) can face greater barriers to accessing health care and dental care for administrative and other reasons.

5: *The 2014 EHIS results show greater levels of unmet needs for medical and dental care because they exclude all the respondents who did not have any medical or dental care needs. The results indicate that slightly more than 3 % of the Spanish population reported some unmet medical care needs for financial reasons, and the rate was much greater among people on low incomes (7 %) than among those on high incomes (only 1 %). For dental care, 17 % of the population reported some unmet needs in 2014, with the proportion again much greater among people on low incomes (37 %).*

Figure 14. Spaniards report low levels of unmet needs for medical care but higher for dental care

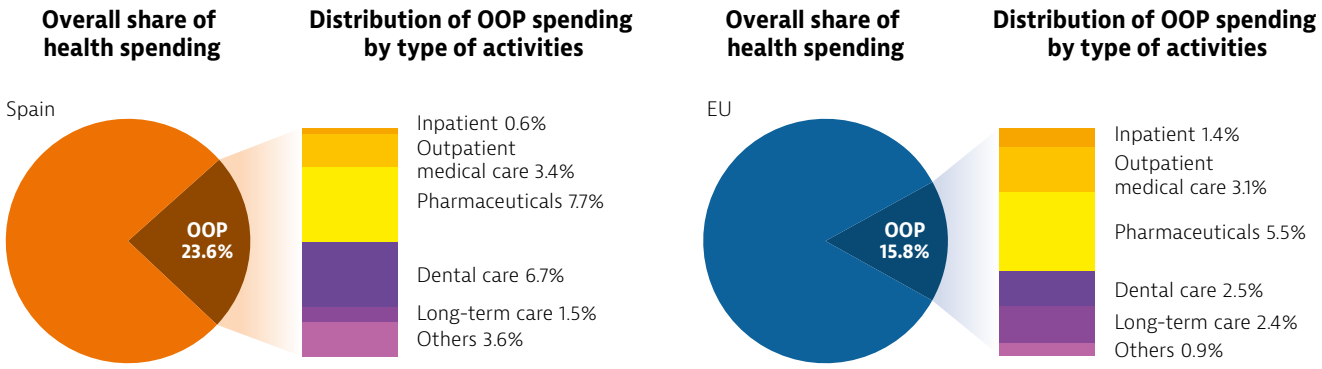


Note: Data refer to unmet needs for a medical and dental examination or treatment due to cost, distance or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2017).

Out-of-pocket payments are high, driven by spending on pharmaceuticals and dental care

Following the economic crisis, the share of OOP payments in health spending increased from 20 % in 2009 to 25 % in 2014 as cost-sharing increased for pharmaceuticals and other services. This share came down slightly to 24 % in 2017 but remains well above the EU average of 16 %. OOP payments are particularly concentrated on pharmaceuticals because these are less covered, and dental care because these are not covered (Figure 15).

Figure 15. Out-of-pocket payments are higher than the EU average



Sources: OECD Health Statistics 2019 (data refer to 2017).

Medical workforce planning has been hampered by lack of clear vision and coordination

Beyond financial barriers, access to care may also be restricted because of limited availability of health care professionals. There are growing concerns about shortages of doctors in the near future, as more than one-third of doctors in Spain in 2017 were aged over 55 and can therefore be expected to retire in the coming years. These concerns are not new and led to a substantial increase in the number of students admitted to medical schools between 2006 and 2010. However, after the economic crisis, the Ministry of Health, Consumption and Social Welfare called for a reduction in the number of students admitted to medical schools in 2012, following the results of a medical workforce planning exercise that projected some surpluses of doctors. These projection results reflected the reality at that time that a growing number of newly trained doctors were unemployed or migrating to other countries. However, in recent years, the main concerns have reverted to shortages.

A longstanding issue in medical education and training policies in Spain is that the number of medical graduates greatly exceeds the number of available postgraduate specialty training places to allow new graduates to complete their training. This issue highlights the need to improve planning and the criteria for educational authorities to open medical schools, as well as the need for autonomous communities to improve planning and funding of postgraduate training places.

As a step to reduce the gap between the number of new medical graduates and the number of specialty training places, the number of training places will increase by about 12 % in 2020 (close to 1 000 additional places in absolute numbers), and a particular focus will be on increasing the number of places in family and community medicine, in response to concerns about shortages of primary care doctors.

The scope of practice of nurses has recently been expanded

New legislation adopted in 2018 expanded the role of nurses with the required qualifications to allow them to prescribe medicines and vaccinations included in the official vaccination calendar, with a view to improving access to care for the population and enhancing the career prospects of nurses. The new law also clarified the accreditation requirements for nurses to be able to perform these more advanced roles.

Many regions have promoted the use of telehealth

In response to geographical barriers in accessing some specialised services and improve care continuity, some autonomous communities have promoted a greater use of telehealth, particularly for patients with chronic conditions. For example, in Galicia, a telehealth service has been developed to help patients with COPD manage their condition, while at the same time enhancing the provision of routine primary care services. In the Basque Country, a telehealth service has been developed for patients with heart failure to support self-management and monitor physiological measurements that are reviewed remotely by specialists (United4Health, 2016).

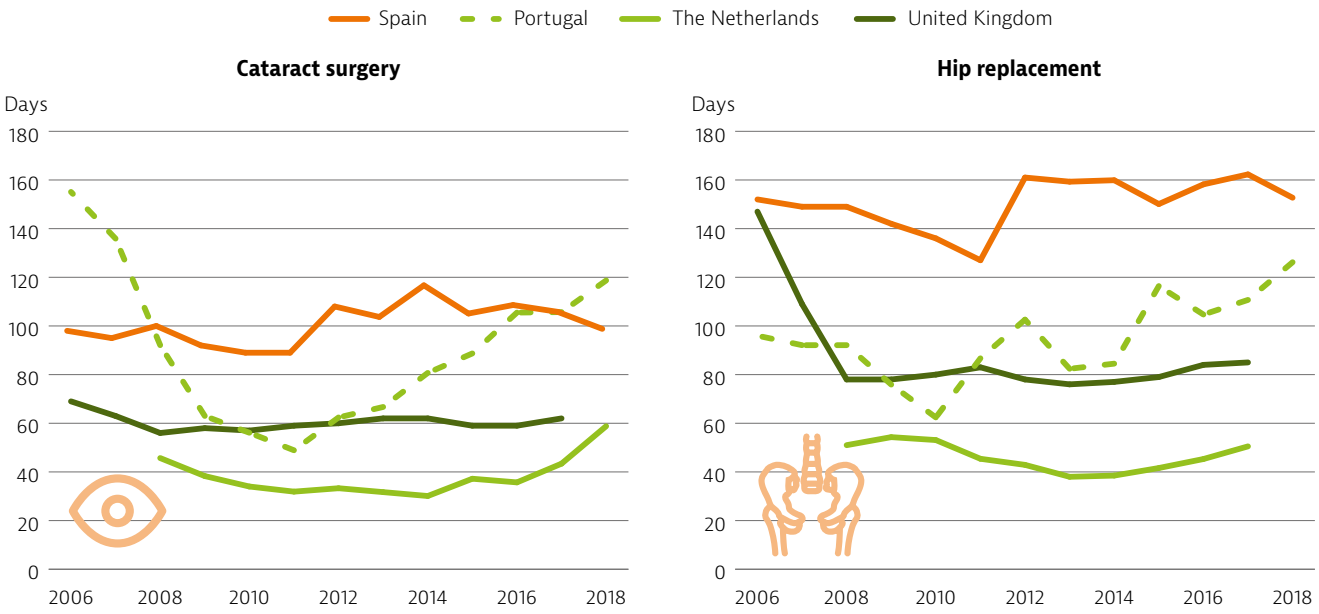
Waiting times for elective surgery are a persisting issue

Long waiting times for elective surgery have been a longstanding issue in the SNS. Following some reductions before the economic crisis, waiting times for surgical procedures like cataract removal and hip replacement started to rise again since 2011 following budgetary restrictions (Figure 16). On average across the country, waiting times for cataract surgery increased from about 90 days in 2010 to 100 days in 2018. Similarly, waiting times for hip replacement increased on average from about 135 days in 2010 to 150 days in 2018.

There are substantial regional variations in waiting times. For example, half the patients in Castilla-La Mancha and the Canary Islands waited more than 150 days for a hip replacement in 2018, while in other regions like Madrid, La Rioja and Navarra, the median waiting time was only about 50 days (Figure 17).

Policies implemented in different regions to reduce waiting times have focused 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. In addition, some maximum waiting times have been defined by law: once the maximum waiting time is exceeded, the patient is offered an alternative provider, either public or private. However, these measures have not been sufficient to meet the even faster growing demand for these surgeries in many regions.

Figure 16. Waiting times for elective surgery in Spain increased after 2011



Note: The data relate to median waiting times, except for the Netherlands and Spain where they relate to average waiting times because there is no sufficiently long time series for the median (the average is higher than the median because it gives a greater weight to people waiting for a very long period).
Source: OECD Health Statistics 2019.

Figure 17. Waiting times for hip replacement are three times greater in some regions



Source: Ministry of Health, 2019 (data refer to 2018), https://www.mscbs.gob.es/estadEstudios/estadisticas/inforRecopilaciones/docs/Datos_por_comunidades_autonomas_jun2018.pdf

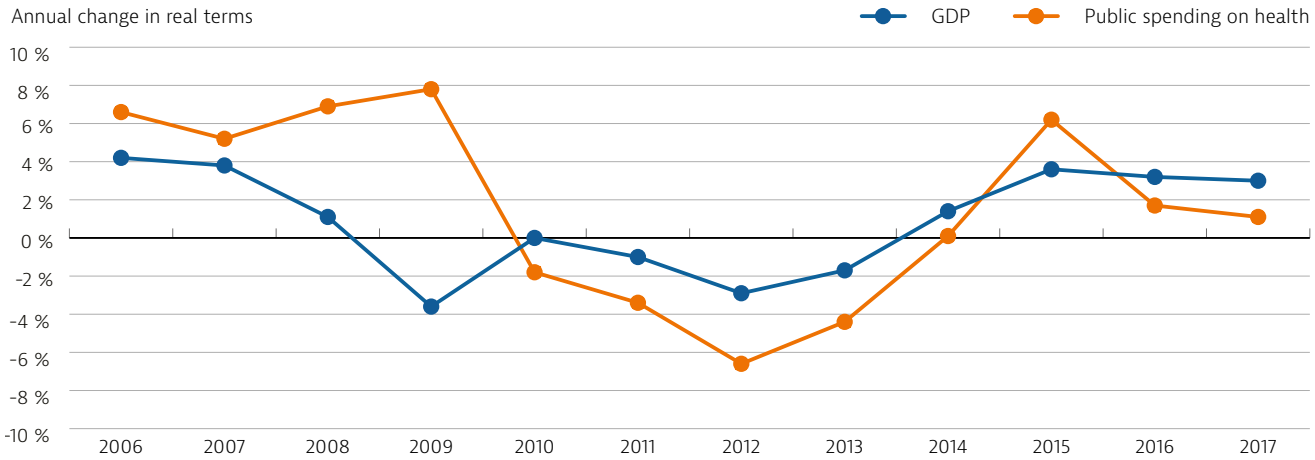
5.3. Resilience[6]

Health spending has grown in line with GDP since 2010

Following the economic crisis in 2009 and the subsequent prolonged recession, public spending on health decreased for several years before it started to grow again in recent years (Figure 18).

Looking ahead, population ageing and moderate economic growth are projected to add pressure to public spending on health and long-term care in the coming years and decades. It is projected that public spending on health may increase by 0.5 percentage point of GDP between 2016 and 2070, while public spending on long-term care is projected to grow by 1.3 percentage points, contributing to fiscal sustainability risks in the medium and longer term (European Commission-EPC, 2018).

Figure 18. Public spending on health has started to rise again following several years of reductions



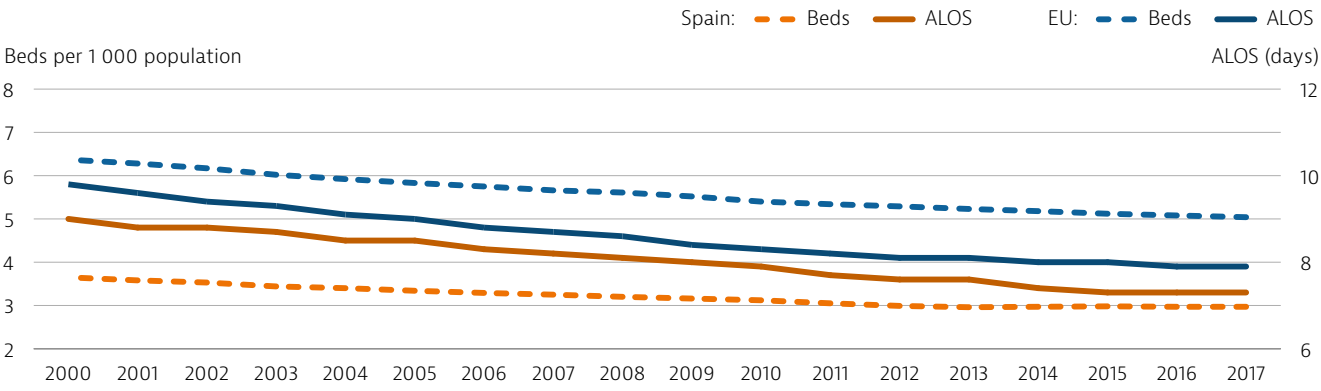
Source: OECD Health Statistics 2019; Eurostat Database.

Hospitals have become more efficient

As mentioned in Section 4, the number of hospital beds has declined since 2000 and was well below the EU average in 2017. This reduction in bed capacity has been accompanied by a steady reduction in the average length of stay (ALOS) (Figure 19). These trends reflect a significant shift from inpatient activities in hospitals to outpatient activities in or outside hospitals.

Day surgery rates in Spain have increased for many procedures, such as cataract surgery, tonsillectomy (the removal of tonsils, an operation mainly performed on children) and inguinal hernia repair (Figure 20). Nonetheless, there are still plenty of opportunities to promote the use of day surgery for many more interventions, when these surgical procedures are needed.

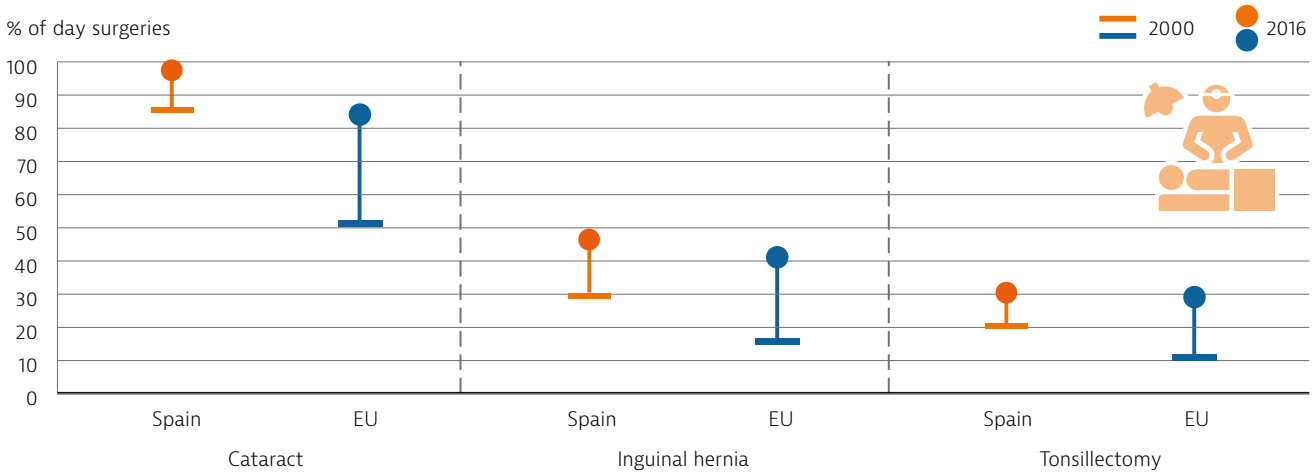
Figure 19. The number of hospital beds and average length of stay have declined over the past decade



Source: Eurostat Database.

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

Figure 20. The use of day surgery has increased in Spain, but there is room for further growth



Source: OECD Health Statistics 2018; Eurostat Database (data refer to 2000 and 2016, or the nearest years).

Efforts have been undertaken to reduce low-value care

In the context of tight budgetary constraints following the economic crisis, a number of initiatives were launched to tackle the high rates of low-value care provided in hospitals and other parts of the health system, and to promote better allocation of resources towards higher-value care.[7]

The Ministry of Health, Consumption and Social Welfare, with the technical support of GuíaSalud (a national programme for the development and implementation of clinical guidelines), invited over 40 medical scientific societies to provide five recommendations along the lines of the Choosing Wisely initiative initially launched by the American Board of Internal Medicine (MSSSI, 2017). This initiative led to the identification of a number of unnecessary or harmful services and implementation of local measures to reduce them in each autonomous community (Bernal-Delgado et al., 2018).

The work to monitor and reduce low-value care was supported by the preparation of an atlas of variations in medical procedures with low levels of effectiveness, which raised awareness of unwarranted variations across regions and hospitals (García-Armesto et al., 2016). These include, for example, significant variations in rates of tonsillectomy in children, prostatectomy for benign conditions in men and hysterectomy for benign conditions in women (Bernal-Delgado et al., 2018).

Moreover, health technology assessment processes have been introduced and expanded in recent years to improve decision making regarding health services coverage (see Box 4).

Efforts to promote more appropriate use of antibiotics continue

In addition to efforts to promote a more appropriate use of procedures, since the early 2000s Spain has also been developing and implementing a broad national, multisectoral plan to tackle antimicrobial resistance. This includes promoting more appropriate use of antibiotics – for instance, through a nationwide stewardship programme that systematically feeds back data on antibiotic use to prescribers.

It is estimated that about 1 800 people die yearly in Spain due to infections from eight antimicrobial-resistant bacteria, and this number could increase to 77 700 people by 2050 if nothing is done to fight antimicrobial resistance or to develop new antibiotics (OECD, 2018).

In March 2019, the SNS Interterritorial Council approved an updated One-Health national plan for 2019-2022 that aims to reduce consumption of antibiotics in both humans and animals. The plan includes a programme to optimise use of antibiotics by health care providers; a national network of laboratories to support the system for surveillance of health care-associated infections; rapid diagnostic tests; delayed antibiotic prescribing; and nationwide public awareness campaigns.

7: Low-value care is defined as procedures or activities that are performed with no evidence-based benefit to patients (effectiveness).

Box 4. Health technology assessment is playing a more critical role in decision making

The Spanish Network of Agencies for Health Technology Assessment and Services of the NHS is playing a growing role in evaluating new technologies to support decisions regarding the updating of the benefits package of the NHS, including inclusion, exclusion or appropriate use of health technologies. Regulation explicitly requires appraisal by the Spanish Network as a preliminary step (European Commission, 2019b).

The Network is composed of eight public health technology bodies: seven at the regional level and one at the national level. In the pharmaceutical area, the Spanish Medicines Agency and the Ministry of Health introduced therapeutic positioning reports, which evaluate comparative efficacy and safety and introduce usage and monitoring criteria for new drugs and existing drugs seeking reimbursement. The objective is to accelerate the pricing and reimbursement process and to generate a single, national relative effectiveness report, avoiding additional regional evaluations, thus contributing to reducing the long delays in market access experienced in the last few years. This system shares a number of similarities with the system envisaged by the European Commission.

Since 2013, the Network has produced 278 assessment reports, 24 clinical guidelines and 22 methodological guidance reports (REDETS, 2019). More recently, it has explored new ways to increase patient participation in the development of assessments and guidelines.

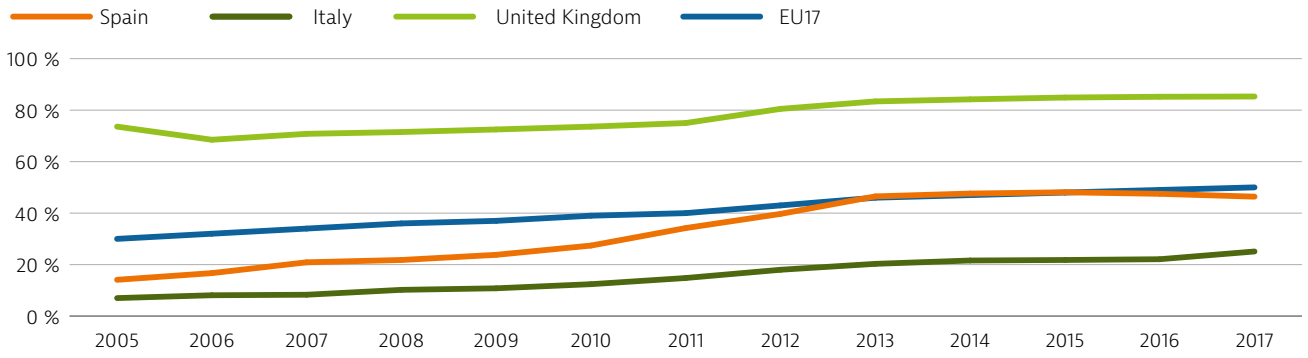
Use of generic medicines grew after the economic crisis, but has now stabilised

Spain has fostered the use of generic medicines to moderate growth in pharmaceutical spending. Between 2009 and 2014, the share by volume of generic medicines in the pharmaceutical market doubled from 24 % to 48 %, remaining fairly stable since then at a level close to the EU average (50 %), but well below that in countries like the United Kingdom (Figure 21).

With new pharmaceutical regulations in 2011 and 2014, policies such as reference prices, prescription by active ingredient and dispensation of generic drugs were strengthened. In practice, the Ministry of Health, Consumption and Social Welfare sets the maximum price at which a drug could be financed by the public sector, physicians have to prescribe using the active principle and retail pharmacists have to dispense the cheapest drug within the group – usually a generic.

The Spanish health system has also progressively included coverage for biosimilars. At the end of 2016, 93 biosimilar medicines were covered by the SNS, corresponding to eight active ingredients. However, only three of the biosimilars can be dispensed in community pharmacies, hence their use is mainly centred in hospitals for the time being. Each year more biosimilars are included as the patents of the original biological medicines expire (MSCBS, 2019).

Figure 21. The share of generics has stabilised in recent years



Note: Data refer to the share of generics in volume.
Source: OECD Health Statistics 2019.

6 Key findings

- Life expectancy in Spain is the highest in the EU, although many years of life after age 65 are spent with some chronic diseases and disabilities, adding pressure to health and long-term care systems.
- Preventable and treatable causes of mortality are lower in Spain than in most EU countries, reflecting strong public health policies and the effectiveness of the health care system in treating people with life-threatening conditions. Further progress in reducing mortality from important causes of death such as lung cancer and colorectal cancer could be achieved by reducing risk factors like smoking and increasing screening rates.
- Obesity rates have increased in Spain, which may hamper progress in further reducing cardiovascular mortality and other obesity-related causes of death. One in six adults was obese in 2017, up from one in eight in 2001. In 2005, the government launched a strategy to improve nutrition, promote physical activity and prevent obesity, followed by new measures in 2011, but the effects so far appear to be modest.
- Following the economic crisis, health spending decreased for several years, but started to increase again from 2015. In 2017, Spain allocated 8.9 % of its GDP to health spending, a lower proportion than the EU average of 9.8 %. Budgetary pressures in the coming decades are expected to arise from growing needs for health care and long-term care due to population ageing.
- While potentially avoidable hospital admissions for some chronic diseases such as diabetes are comparatively low in Spain, they are close to the EU average for others. Regional initiatives have been launched to promote more integrated care for the growing number of people living with chronic conditions. A number of telehealth services have also been implemented in different regions to overcome geographic barriers and promote care continuity. One challenge for the future will be to scale up those initiatives that are proving to work well.
- The number of doctors, nurses and other people employed in the national health system has increased over the past few years, but a large number are on temporary contracts, increasing turnover rates. Concerns about shortages of nurses and doctors – particularly of general practitioners – are growing as many approach retirement age. More coherent medical education and training policies have been hampered by the lack of a clear and shared vision between educational and health authorities on needs over the medium and long term.
- The role of nurses in the provision of some services was expanded in 2018 to increase access to care and improve career prospects for nurses and retention rates. Nurses are now allowed to prescribe some medicines and vaccines included in the official vaccination calendar.
- Primary care remains a central element of the Spanish health system, with general practitioners and nurses providing care for the whole population, as well as preventive and health promotion services targeting children, women and elderly people. However, growing demands on the primary care system arising from population ageing may require more and a better use of resources. A new Strategic Framework for Primary and Community Care was adopted in April 2019, including a set of ambitious goals, but the budget to support implementation has not yet been allocated.

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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	United Kingdom	UK

European Commission

State of Health in the EU
Country Health Profile 2019

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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