European Commission

State of Health in the EU

Spain

Country Health Profile 2021

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

The Country Health Profile series

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

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Data and information sources

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

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

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

Demographic and socioeconomic context in Spain, 2020

Demographic factors	Spain	EU
Population size (mid-year estimates)	47 332 614	447 319 916
Share of population over age 65 (%)	19.6	20.6
Fertility rate[1] (2019)	1.2	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	25 611	29 801
Relative poverty rate[3] (%, 2019)	20.7	16.5
Unemployment rate (%)	15.5	7.1

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

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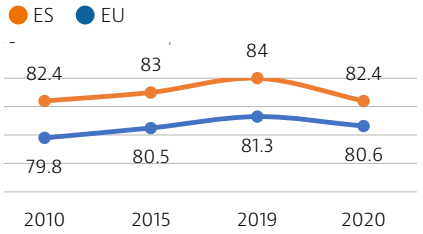
1 Highlights

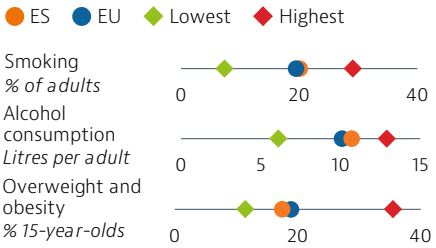
Life expectancy in Spain is among the highest in Europe, but it declined significantly in 2020 due to the impact of the COVID-19 pandemic. On average, the Spanish population spends more time living in good health compared to other EU countries, but risk factors such as alcohol consumption have increased. While the Spanish health system provides good access to high-quality care, the COVID-19 pandemic mobilised efforts on prevention and public health, temporary increasing the health workforce and use of digital health. Universal health care and a strong primary care system have been key in the response to the COVID-19 pandemic.



Life expectancy at birth, years

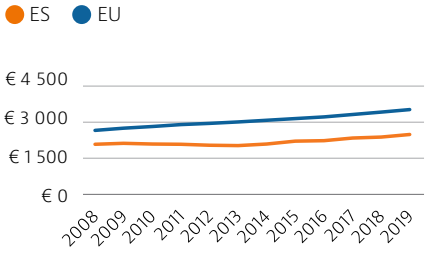
Health status

Life expectancy in Spain in 2020 was almost two years higher than the EU average, despite a fall of 1.6 years because of the high mortality registered during the COVID-19 pandemic. Before the pandemic, life expectancy had increased steadily in Spain by more than four years between 2000 and 2019, reaching 84 years in 2019. Historically, ischaemic heart disease, stroke and cancer have been leading causes of death.



Risk factors

Risk factors for health are major drivers of mortality in Spain. While tobacco consumption has fallen over the past two decades, one in five adults still smoked daily in 2019. Alcohol consumption has increased and was slightly higher than the EU average in 2019. Some 18 % of 15-year-olds were overweight or obese in 2018 – slightly below the average across EU countries.



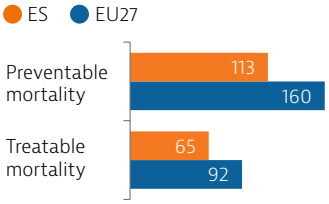
Per capita spending (EUR PPP)

Health system

Spending on health per capita remains lower in Spain than the EU average. There is a growing gap between Spain and EU countries in total health spending, indicating slower growth over the past decade. Since 2014, per capita spending has been increasing, reaching EUR 2 488 in 2019. Spain's out-of-pocket payment levels are well above the EU average (at 21.8 % compared to 15.4 % of total health expenditure in 2019), and consist mainly of co-payments for medicines, medical devices outside hospitals and dental care.

Effectiveness

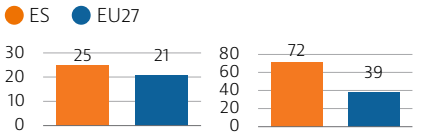
Mortality rates from preventable and treatable causes are lower in Spain than the EU average, boosted by effective public health and prevention policies before the COVID-19 pandemic. However, mortality rates from lung and colon cancer remain high.



Age-standardised mortality rate per 100 000 population, 2018

Accessibility

Access to health care is generally good in Spain. While unmet needs are very low for medical care, this is not the case for dental care. Access to health care services was disrupted during the first wave of the pandemic, but growing use of teleconsultations helped maintain access to care during the subsequent waves.

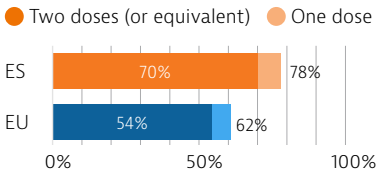


% reporting forgone medical care during first 12 months of pandemic

% using teleconsultation during first 12 months of pandemic

Resilience

The COVID-19 pandemic had a severe impact on Spain and specific measures were taken to coordinate response efforts. Spain continuously updated its vaccination campaign and at the end of August 2021, its vaccination rate was significantly higher than the EU average.



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

2 Health in Spain

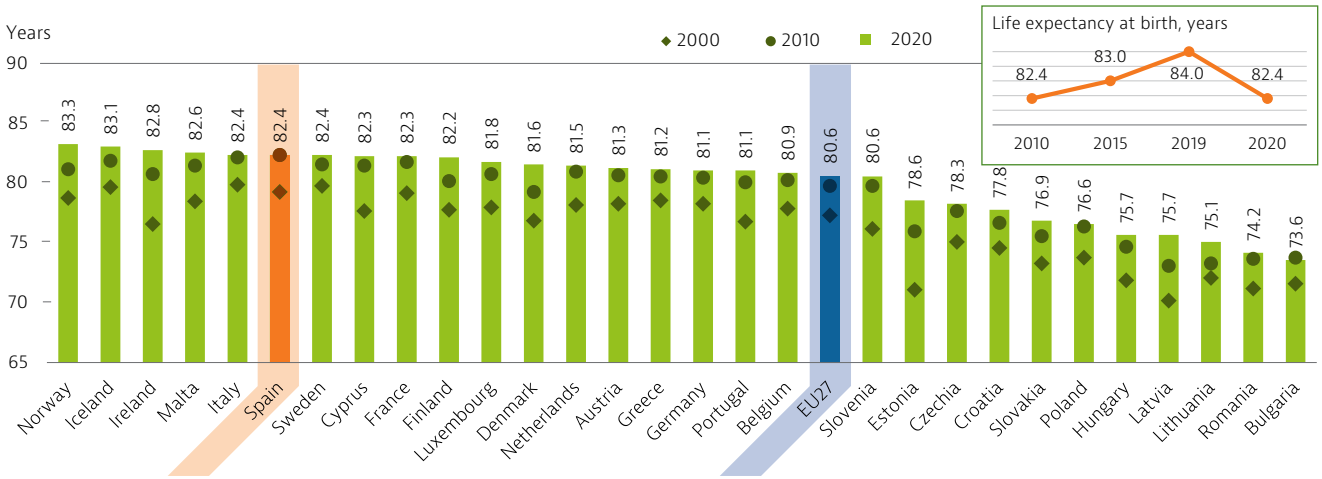
COVID-19 had a major impact on life expectancy, which was previously the highest in the EU

Life expectancy at birth in Spain increased by more than 4 years between 2000 and 2019, reaching 84 years in 2019 – the highest among EU countries. However, the COVID-19 pandemic resulted in a temporary fall of 1.6 years in 2020 (Figure 1), which was the largest reduction among EU countries.

Nevertheless, life expectancy remains above the EU average of 80.6 years.

Regional differences in life expectancy in the country decreased between 2006 and 2012 and widened again by 2017, showing differences in the regions' recovery following the financial crisis (Zueras, 2020). The gender gap is similar to the EU average, with Spanish women living on average 5.4 years longer than men in 2020.

Figure 1. Life expectancy in Spain remains above the EU average, despite a sharp decrease in 2020

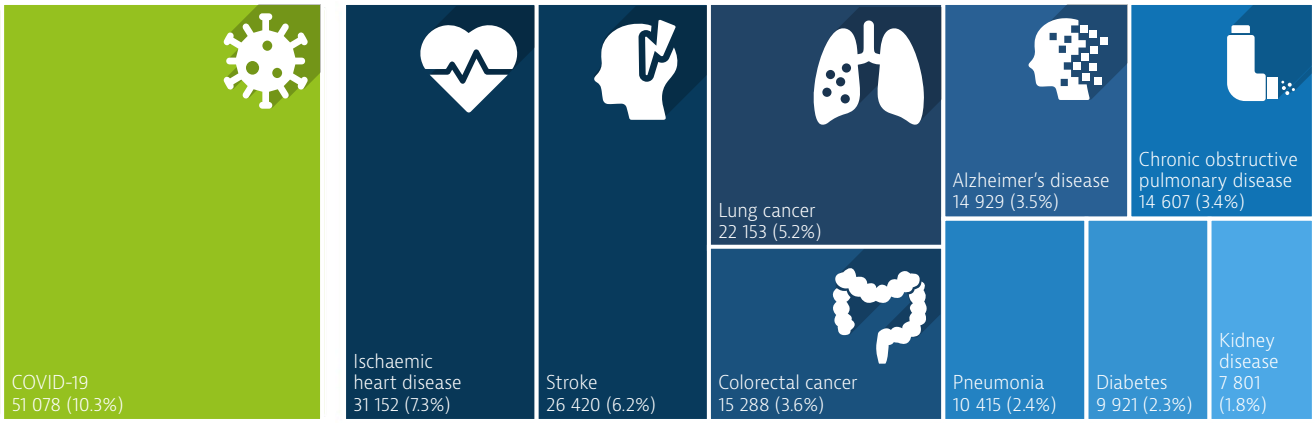


Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

Ischaemic heart disease, stroke and lung cancer were the main causes of death in recent years

The increase in life expectancy in Spain between 2000 and 2019 was driven mainly by reductions in mortality rates from circulatory diseases – notably ischaemic heart disease and cerebrovascular disease (stroke) – although they remained the leading causes of death in 2018 (Figure 2). Lung cancer remained the most frequent cause of death by cancer in 2018, although the mortality rate has also fallen since 2000 following reductions in smoking prevalence.

Figure 2. COVID-19 accounted for a high number of deaths in 2020



Note: The number of deaths from COVID-19 refer to 2020 and come from the epidemiological surveillance system, while the number of deaths by cause of death in 2018 comes from the statistics of deaths by cause of death. The size of the COVID-19 box is proportional to the size of the other leading causes of death in 2018.
Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

COVID-19 has accounted for a large number of deaths in Spain

In 2020, COVID-19 accounted for more than 51 000 deaths in Spain (over 10 % of all deaths). An additional 33 000 deaths were registered by the end of August 2021. Most deaths were among people aged 80 and over. The cumulative mortality rate from COVID-19 up to the end of August 2021 was higher in Spain than the average across EU countries, at about 1 780 per million population compared with an EU average of about 1 590.

However, the broader indicator of excess mortality, defined as deaths from all causes above what would normally be expected based on the baseline level from previous years, suggests that the death toll related to COVID-19 in 2020 could have been higher. Overall, between early March and the end of December 2020, excess mortality (about 82 000 deaths) was about 60 % greater than reported COVID-19 deaths (about 51 000).

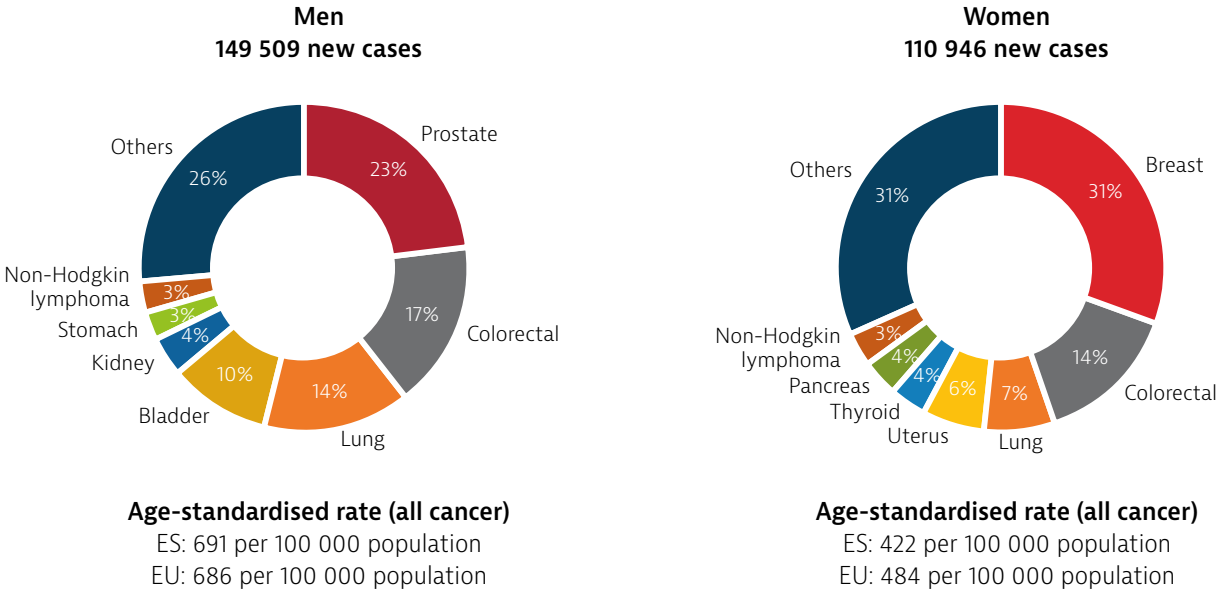
Most Spanish people reported being in good health before the COVID-19 pandemic

In 2019, 75 % of Spanish adults reported being in good health – a proportion higher than the EU average (69 %). However, as in other countries, people on higher incomes are more likely to report good health: 84 % in the highest income quintile reported being in good health compared with 70 % in the lowest. At the same time, 29 % of adults reported having at least one chronic condition – a lower proportion than the EU average (36 %). Many of these conditions increase the risk of severe complications from COVID-19.

The burden of cancer is higher for men than for women in Spain

According to the latest estimates from the Joint Research Centre based on incidence trends from previous years, around 260 000 new cases and about 110 000 deaths from cancer were expected in Spain in 2020, although the pandemic disrupted cancer screening and diagnosis in the country[1] (see Section 5.1). Figure 3 shows that the main cancer sites among men are prostate, colorectal and lung, while among women breast cancer is expected to be the leading cancer, followed by colorectal and lung cancer. The country's National Plan for Cancer was updated in March 2021; it aims to improve the quality of care received by cancer patients and the support provided to their families (see Section 5.1).

Figure 3. The burden of cancer in Spain is close to the EU average



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

1. *These estimates were made before the COVID-19 pandemic; this may have an effect on both the incidence and mortality rates of cancer during 2020.*

3 Risk factors

Behavioural and environmental risk factors continue to have an important impact on mortality

About one third of all deaths in Spain in 2019 can be attributed to behavioural risk factors – a lower proportion than the EU average (Figure 4).

The smaller overall share is mostly thanks to a much lower percentage of deaths attributed to dietary risks. Environmental factors such as air pollution also account for a considerable number of deaths (over 11 000 deaths in 2019), although this was also lower than the EU average.

Figure 4. Deaths attributed to dietary risks are much lower than the EU average in Spain

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

Smoking rates among adults in Spain remain high

While the proportion of adults smoking daily has decreased since 2000, it remains higher than in most EU countries (Figure 5). One in five adults (20 %) smoked daily in 2019 according to the National Health Survey, compared with 19 % on average across the EU[2]. This rate is mainly due to high smoking rates among men: 23 % reported that they smoked daily compared to only 17 % of women, but the reduction in smoking rates has been slower among women. Among 15-year-olds, 16 % reported smoking at least occasionally in 2018 – slightly less than the EU average of 18 %. The government has recently introduced public health measures to reduce the prevalence of smoking (see Section 5.1).

Alcohol consumption has increased over the pastdecade

Alcohol consumption among adults in Spain increased between 2010 and 2019 and is now higher than in many EU countries. However, only about 6 % of adults reported heavy episodic alcohol consumption (binge drinking[3]) in 2019 – the second lowest rate among EU countries. Over one in five 15-year-olds reported having been drunk more than once in their life in 2018, which is slightly below the EU average. The latest tax reform on alcoholic beverages of 2017 established a 4.3 % increase.

Overweight and obesity are growing issues in Spain

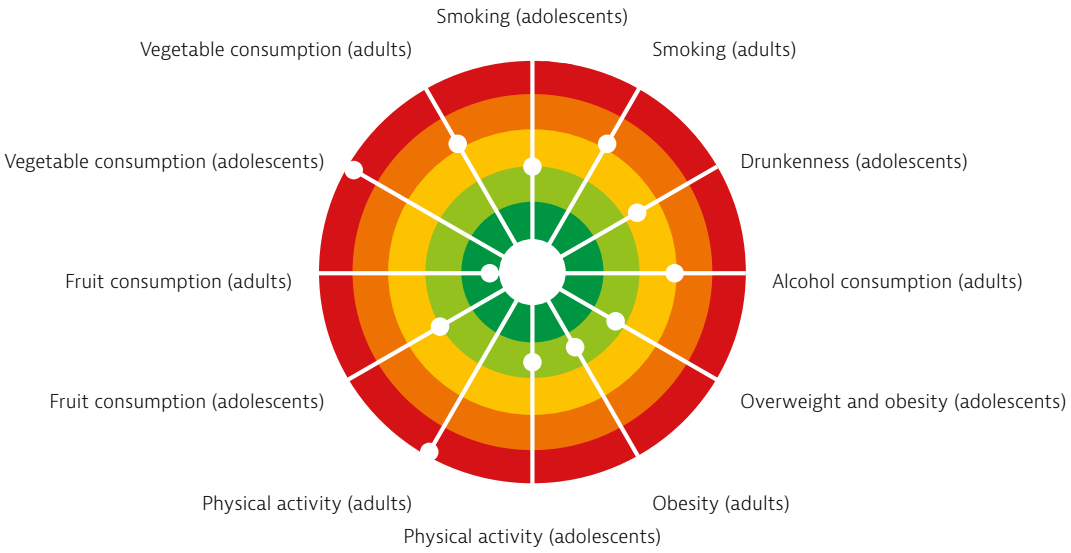
Some 18 % of 15-year-olds were overweight or obese in 2018 – a proportion that had increased slightly from 16 % in 2010 but was close to EU average of 19 %. A greater proportion of 15-year-old boys are overweight or obese (21 %) than girls (14 %), even though boys report being more physically active. The obesity rate

2. The latest survey on alcohol and drugs in Spain in 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 a reduction in the number of cigarettes smoked.
3. Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more for adolescents.

has also increased among adults: almost one in six were obese in 2019, up from one in eight in 2001.

This trend highlights the importance of dietary habits and physical activity. Three quarters of adolescents in Spain reported that they did not eat at least one portion of vegetables each day in 2018, which is the second highest proportion among EU countries. The rate of fruit consumption was slightly higher, yet two thirds of 15-year-olds reported that they did not eat at least one fruit per day.

Figure 5. Smoking, alcohol consumption 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.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescent indicators; and OECD Health Statistics, EU-SILC 2017, EHIS 2014 and 2019 for adults indicators.

4 The health system

Spain has a decentralised health system with national coordination

The national health system – Sistema Nacional de Salud (SNS) – is based on universal coverage and is mainly funded from taxes. While national planning and regulation remain the responsibility of the Ministry of Health, health competences and primary jurisdiction over operational planning at the regional level, resource allocation, purchasing and provision are devolved to the 17 regional health authorities. These often rely on the support of specialised national agencies such as the Network of Agencies for the Evaluation of Health Technologies and Benefits.

The SNS Interterritorial Council, which comprises the national minister and the 17 regional ministers of health, is responsible for high-level coordination of actions across the regional health systems. It also played a key governance role in Spain's health system response to the COVID-19 pandemic (Box 1). In 2020, a new national-level Secretary of State for Health was created to improve communication of national health strategies and to enhance co-operation and coordination both among territorial health administrations and with international organisations.

Spain's health spending has increased in recent years but remains below the EU average

In 2019, health spending per capita (adjusted for differences in purchasing power) amounted to EUR 2 488, which is 30 % below the EU average of EUR 3 523 (Figure 6). This equates to 9.1 % of GDP – also below the EU average of 9.9 %. Public funding as a proportion of total health expenditure was 70.6 % in 2019, which is a lower share than the EU average of 79.7 %. Although the share of public spending on health decreased from 75.1 % in 2009 to 70.3 % in 2014 as a result of the cost-cutting measures and

Box 1. The COVID-19 response is coordinated between the central government and the regions

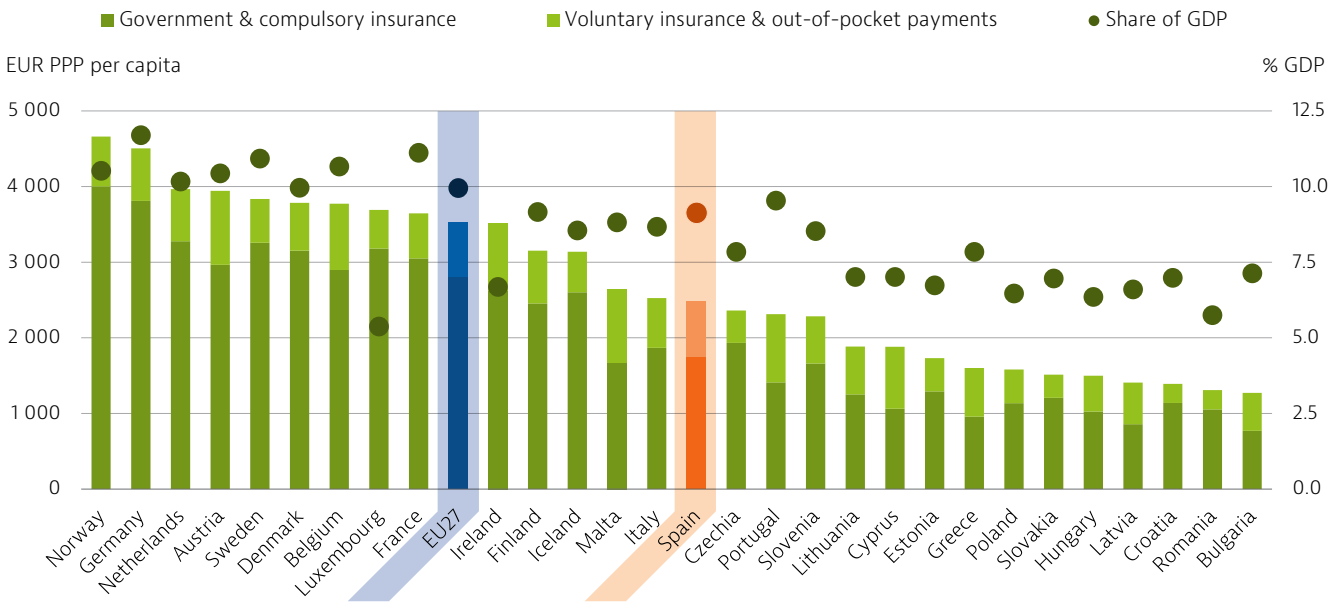
At the beginning of the pandemic, a Royal Decree declaring a "state of alarm" on 14 March 2020 transferred responsibility from the autonomous regions to the national government to implement measures to mitigate the COVID-19 crisis. The Royal Decree also put all publicly funded health authorities throughout the country under the direct orders of the Minister of Health, who was mandated to guarantee consistency and equity in the provision of health care services across the country. Nonetheless, all decisions were discussed within the SNS Interterritorial Council.

After the expiration of the state of alarm, regions and municipalities recovered decision-making capacity for the COVID-19 response in health and social affairs. With the aim of harmonising the response to new outbreaks throughout the country, in July 2020, the Ministry of Health and the regions agreed on a COVID-19 response plan. Under the plan, regional health authorities determine the measures to be implemented depending on their local epidemiological situation and their capacity to implement contingency measures, while acting in coordination with the Ministry of Health and the Interterritorial Council.

Source: COVID-19 Health System Response Monitor.

greater co-payments for medicines introduced after the 2009 economic crisis, it has started to rise again in recent years (see Section 5.3). Throughout 2020, the government approved extra injections of funds for the regions totalling EUR 12.2 billion to address the soaring health sector costs of the COVID-19 pandemic.

Figure 6. Spain spends less per capita on health care than many other EU countries

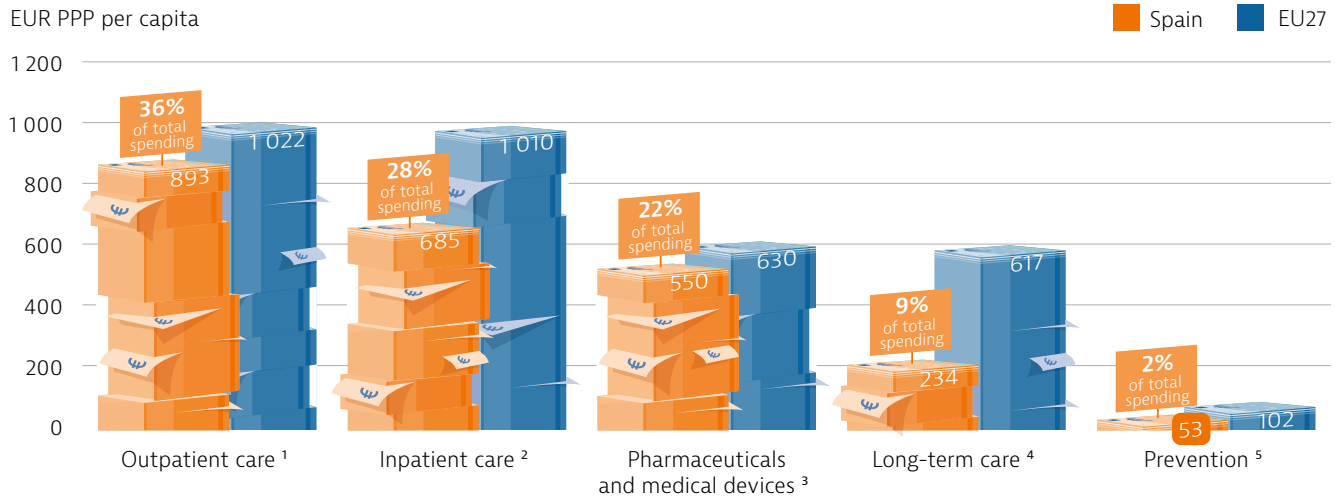


Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

Pharmaceutical care makes up more health spending than in the EU

Spain spends less per capita on the various categories of health care than the EU averages (Figure 7). Reflecting its relatively strong primary care services, the largest share of health care spending (36 % in 2019) in Spain was on outpatient care, with 25 % spent on inpatient care. A further 22 % was spent on pharmaceutical care, which is higher than the EU average (20 %). At EUR 53 per capita, spending on preventive services is about half the EU average of EUR 102. Spending on long-term care (LTC) also accounts for a relatively low share of overall expenditure (9.4 % compared with an EU average of 16.3 %).

Figure 7. Spain spends most per capita on outpatient care, but less than the EU average



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

Most out-of-pocket payments are for pharmaceuticals, but exemptions exist for vulnerable groups

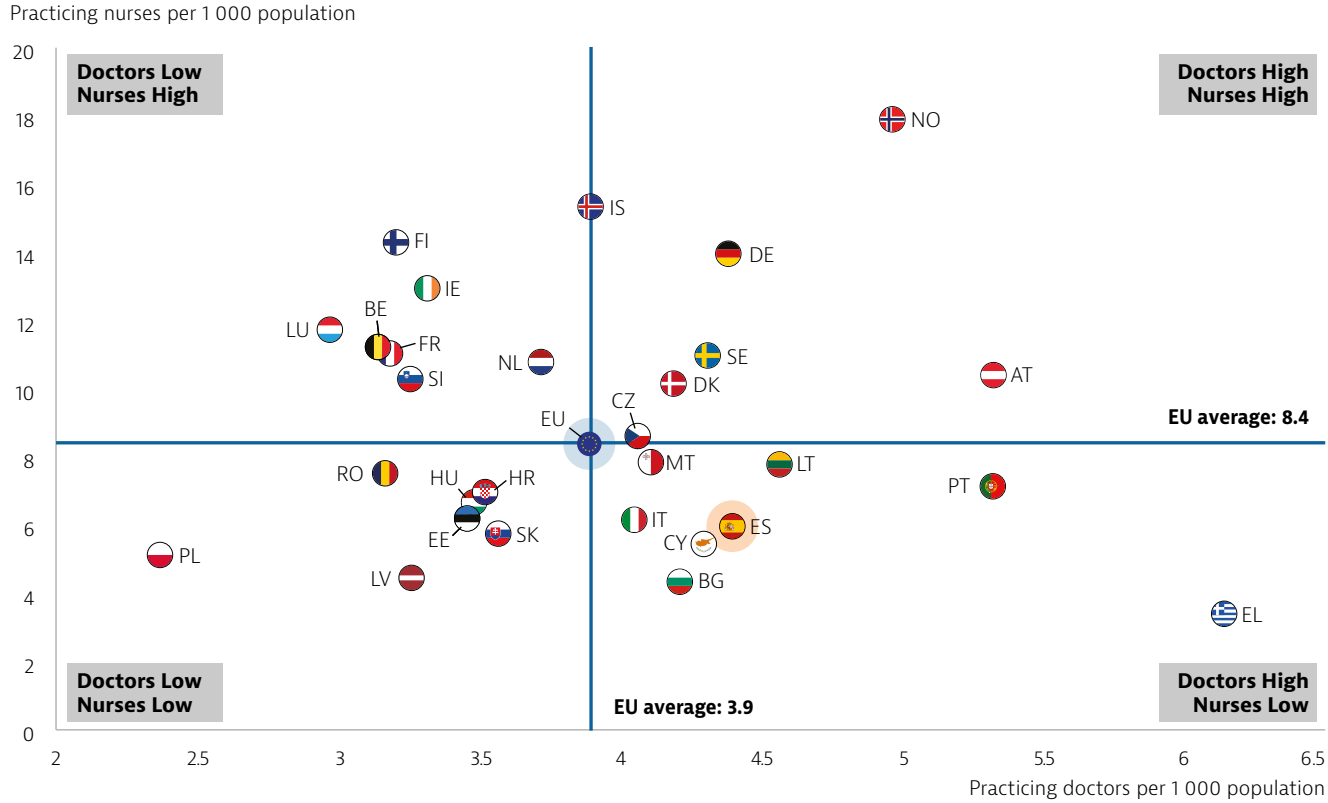
Out-of-pocket (OOP) payments increased steadily between 2010 and 2014, before falling slightly to reach 21.8 % of current health expenditure in 2019. Consisting mainly of co-payments for medicines, medical devices outside hospitals (including ortho-prosthetic devices such as wheelchairs, hearing aids and similar) and dental care, Spain's OOP payment levels are well above the EU average of 15.4 %. After an overhaul in 2012, the rates of cost-sharing for patients were increased and calculated according to income level and employment status, including monthly caps to protect pensioners. Important exemptions for other vulnerable groups have also been introduced and further expanded in recent years (see Section 5.2). Testing and treatment costs for COVID-19 are covered by the SNS and provided free of charge. Self-testing for COVID-19 is available, although confirmation if positive requires a PCR test prescribed by a doctor.

The numbers of doctors and nurses have increased in recent years, but so have temporary contracts

The numbers of doctors and nurses in Spain have been on the rise. The number of doctors per 1 000 inhabitants is slightly above the average across EU countries (4.4 compared to 3.9 in 2019), while the proportion of nurses (excluding nursing assistants), at 5.9 per 1 000 inhabitants, is still much lower than the average across EU countries of 8.4 (Figure 8). The proportion of general practitioners (GPs) in the country is similar to the EU average (20.8 % compared to 20.6 %).

The distribution of doctors and nurses varies across regions, and is also uneven between urban and rural areas (see Section 5.2). Moreover, the use of temporary contracts within the SNS has grown over time: 41.9 % of all employees were on temporary employment contracts in 2020, up from 28.5 % in 2012 (INE, 2021).

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



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

Hospital bed numbers have remained low, while numbers of long-term care beds have increased

Prior to the pandemic, the number of hospital beds was relatively low (3 per 1 000 population in SNS hospitals) compared to the EU average (5.3), remaining unchanged since 2012. The share of public beds in use in SNS hospitals increased slightly from 79.5 % in 2015 to 80.7 % in 2018 (Ministry of Health, 2021a). Meanwhile, the number of LTC beds for older people increased sharply – from 19.2 beds per 1 000 population aged 65 and over in 2005 to 43.7 in 2018 – slightly more than a two-fold increase in 13 years. This increase took place mainly in LTC institutions, following the approval of social care legislation in 2006 that created the System for the Promotion of Personal Autonomy and Assistance for People in a Situation of Dependency.

The large number of patients needing hospitalisation for more severe cases of COVID-19 in spring 2020 put a strain on acute beds and intensive care unit (ICU) beds. Most hospitals had to create additional space for COVID-19 patients by diverting space away from other patients at the onset of the crisis. This reallocation was meant to keep COVID-19 and other patients separate, or to keep beds free in case infection rates surged later in the year (see Section 5.3).

5 Performance of the health system

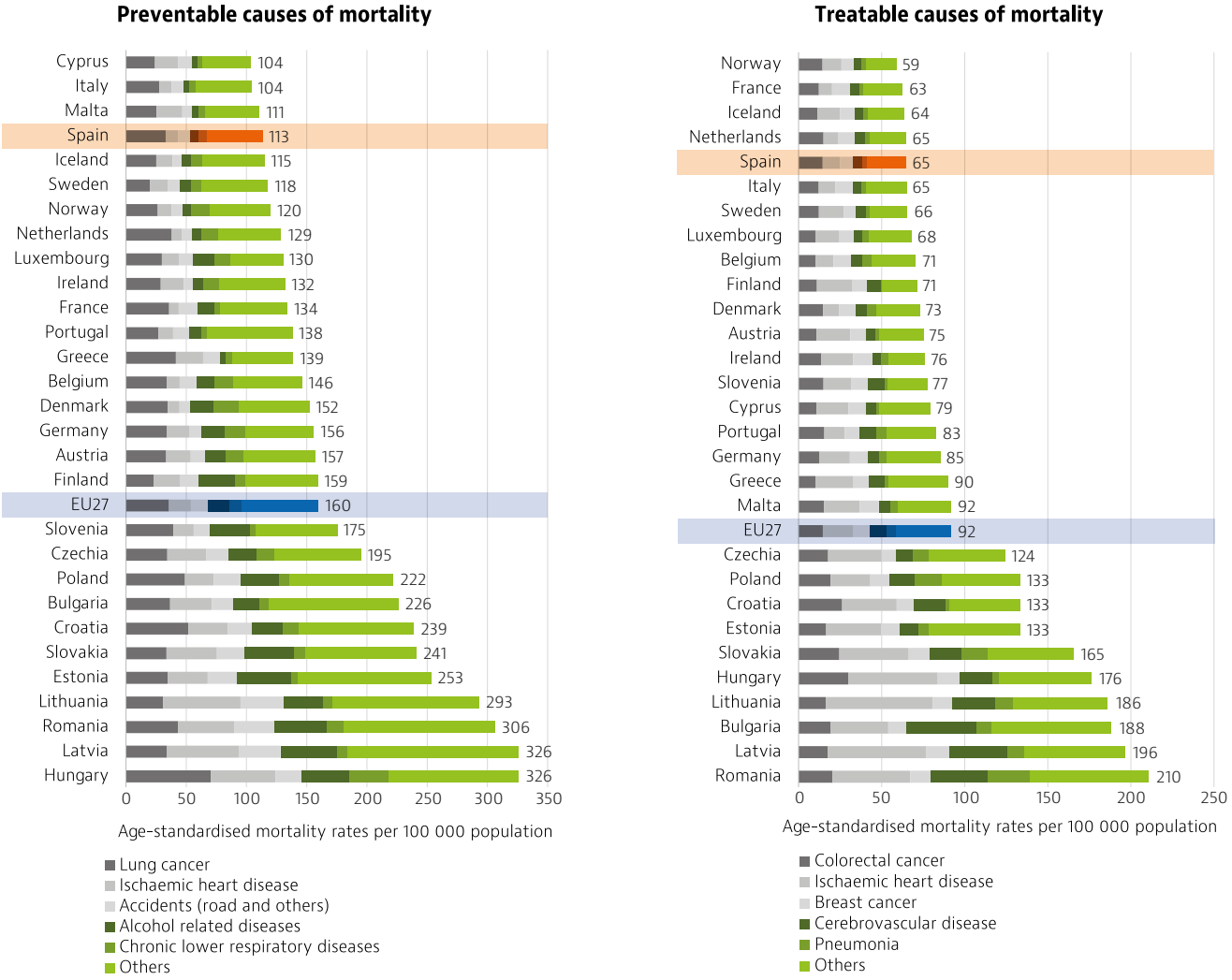
5.1 Effectiveness

Spain has some of the lowest mortality rates from preventable and treatable causes

Preventable mortality rates in Spain before the COVID-19 pandemic were among the lowest in the EU (Figure 9), boosted by effective public health and prevention policies and low mortality rates from ischaemic heart disease (in particular among women), road accidents and other accidental deaths, and alcohol-related diseases. Although there is a clear decreasing trend since 2016, mortality rates from lung cancer remain high and close to the EU average (33 per 100 000 population, compared to 36 in the EU), reflecting high smoking rates (see Section 2).

Mortality rates from treatable causes that should not have occurred in the presence of timely and effective health care are among the lowest in Europe and have decreased since 2011 (from 74 per 100 000 population in 2011 to 65 in 2018). These favourable trends are linked to the low mortality rate for ischaemic heart disease (which is considered both preventable and treatable) and to similarly low mortality rates for cerebrovascular diseases (stroke) and breast cancer. These low mortality rates also reflect (at least in part) relatively low incidence of some of these diseases in Spain compared to the EU average. However, the mortality rates for other types of cancer, such as colorectal cancer, are higher and remain closer to the EU average.

Figure 9. Mortality rates from preventable and treatable causes in Spain are significantly below the EU averages



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

Several public health initiatives have addressed risk factors

The main law regulating smoking in public places and tobacco advertising was passed in 2005 and strengthened in 2010. The 2010 law expanded smoke-free locations to include any public place, and promoted implementation of smoking cessation programmes, particularly in primary care. It also prohibited tobacco advertising on audio-visual forms of communication. In 2017, packaging regulations changed: labels now had to include health warnings, requirements were outlined for the quality and safety of additives, and a common format of notifications on e-cigarettes was required. Taxes on cigarette packs and rolling tobacco were also raised.

With the aim of improving the health of consumers and reducing overweight and obesity levels, in 2019 the government and the food industry reached an agreement to cut the content of sugar, salt and fat in more than 3 500 food and drink products over the next three years, with the voluntary commitment of nearly 400 companies. These ingredients are expected to be cut by around 10 %, on average. More recently, the nutritional labelling system Nutri-score entered into force in 2021. While its use is voluntary, some food industry organisations have announced that they will apply it.

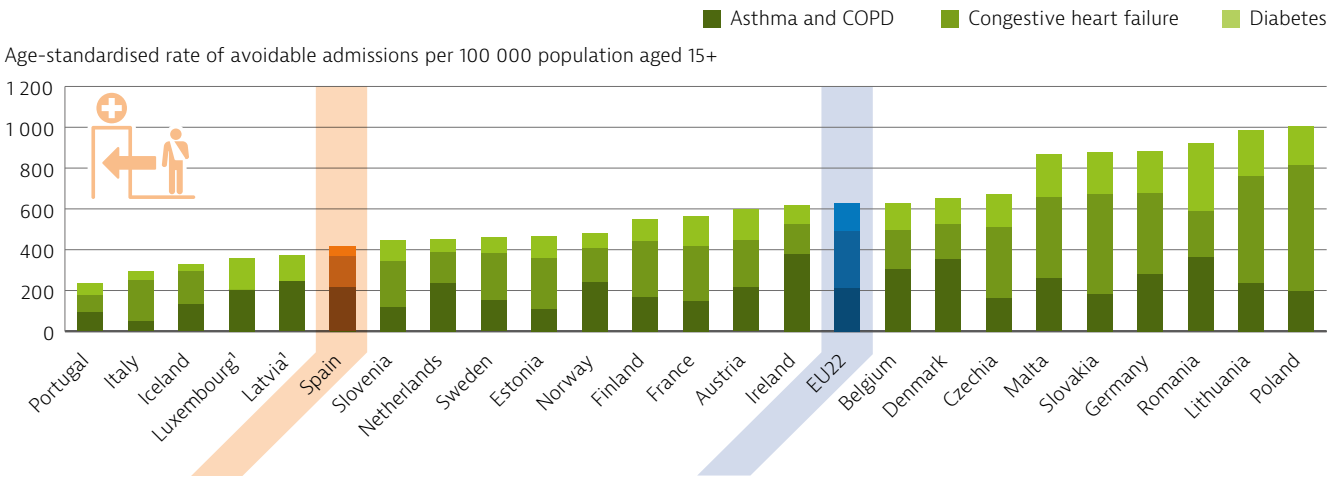
Influenza vaccination has been stepped up for the population in Spain

Influenza vaccination coverage among older people in Spain was decreasing before the COVID-19 pandemic, with only 55 % of people aged 65 and over vaccinated in 2019. This was down from 66 % in 2009, but still higher than the EU average. In September 2020, the Ministry of Health launched a national campaign to promote influenza vaccination among the population, to protect vulnerable people and to avoid a possible overlap of the seasonal influenza epidemic and the COVID-19 pandemic. The Ministry purchased an additional 5 million doses of influenza vaccine compared to 2019, to reinforce the capacities of the regional health systems. The vaccination campaign started earlier than usual and the vaccination rate for people over 65 went back up to 66 % during the 2020/21 season.

Low numbers of avoidable hospital admissions are achieved through good primary care and integration

The admission rates for diabetes and congestive heart failure in Spain are among the lowest in the EU, while admission rates for asthma and chronic obstructive pulmonary disease (COPD) are close to the average across EU countries (Figure 10). As well as reflecting the lower prevalence of these conditions in Spain compared to many other EU countries, these low avoidable admission rates reflect a relatively strong primary care system and an efficient care integration model, where GPs act as gatekeepers and teams provide acute and chronic care, as well as some health promotion and preventive services, for the whole population. In addition, all care levels act de facto as integrated providers, facilitating continuity of care and reducing the risk of fragmentation. The Strategic Framework for Primary and Community Care was designed in 2019 to enhance primary care and patient involvement in the Spanish health system. However, implementation of the Strategy, with the regions as the main actors, has been slowed down due to the pandemic.

Figure 10. Spain has a low rate of avoidable hospital admissions compared to most EU countries

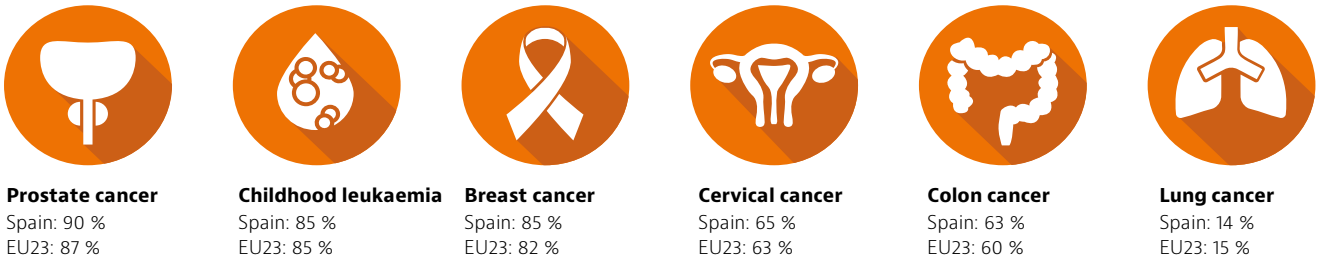


Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Quality of cancer care in Spain has improved over time

Spain achieves slightly better results than the average across EU countries when it comes to survival following diagnosis of different cancers (such as breast, colon and prostate cancer). Survival rates from lung cancer remain low in Spain, as in other EU countries (Figure 11). Since the early 2000s, 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. For example, colon cancer survival rates have increased from 57 % to 63 % in the last decade. In March 2021, Spain updated its 10-year National Plan for Cancer, aiming to improve the quality of care received by cancer patients and the support provided to their families. The strategy builds on the European Code Against Cancer and is aligned with the Europe's Beating Cancer Plan (European Commission, 2021a).

Figure 11. Five-year survival rates are higher than the EU average for many types of cancer

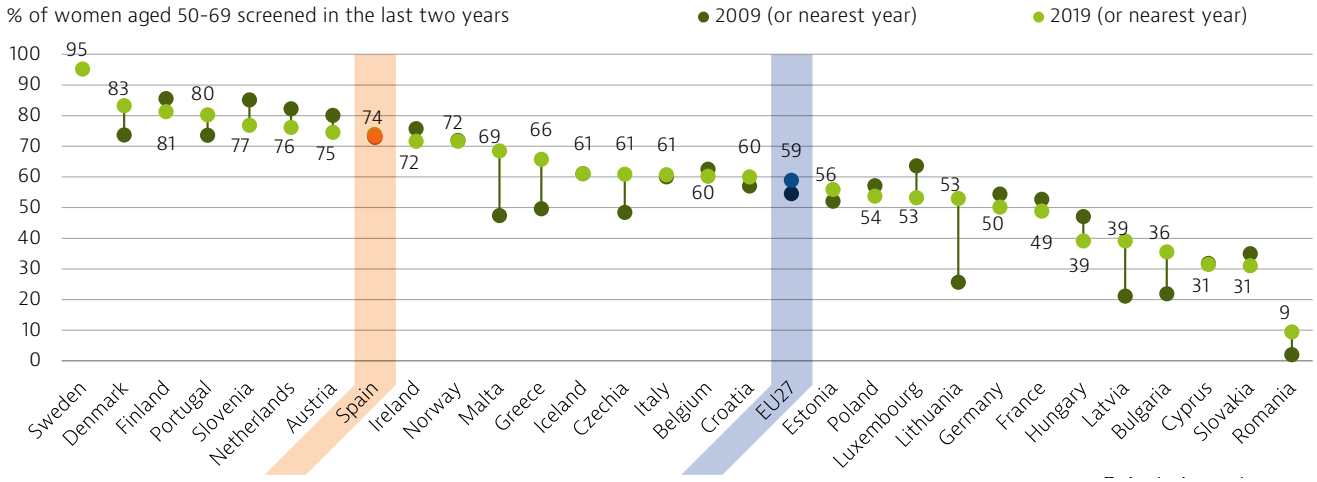


Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

The COVID-19 crisis has negatively affected cancer screening programmes in Spain

In 2020, 74 % of women aged 50-69 had participated in breast cancer screening in the last two years in Spain – well above the average across EU countries in 2019 of 59 % (Figure 12). Previously, the share of women screened for breast cancer was 73 % in 2009, reaching 82 % in 2017. There is evidence that the COVID-19 pandemic disrupted cancer screening and diagnosis in the country: comparing data during the first lockdown period (March to June 2020) with the same period in the previous year, a reduction of 21 % of newly diagnosed cancer cases was reported (SEOM, 2021). To understand the impact of the COVID-19 pandemic on cancer care, the Ministry of Health and the regions agreed to pursue a more detailed assessment of the impact of the pandemic (Ministry of Health, 2021b).

Figure 12. Before the COVID-19 pandemic, breast cancer screening rates for women in Spain were high



Note: The EU average is unweighted. For most countries, the data are based on screening programmes, not surveys.
Sources: OECD Health Statistics 2021 and Eurostat Database.

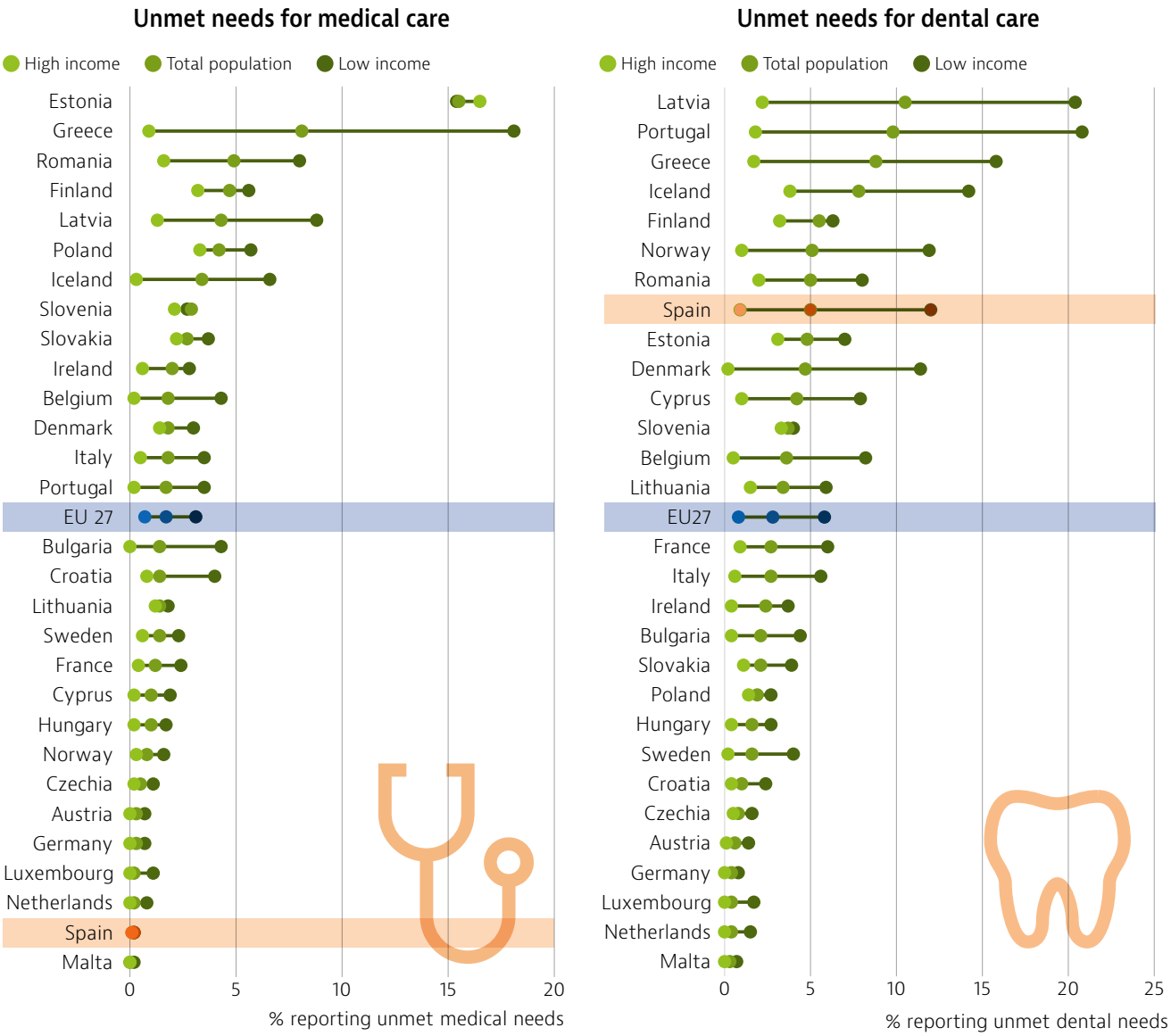
5.2 Accessibility

Prior to the COVID-19 pandemic, Spain recorded very low unmet needs for medical care

In 2019, unmet medical care needs relating to cost, distance or waiting times were very low in Spain – reported by only 0.2 % of the population in 2019, which is well below the EU average of 1.7 %. Furthermore, the difference between people in the highest and lowest income quintiles was minimal (Figure 13). However, this was not the case for dental care, as most people are not covered for dental services. In 2019, 5 % of the population reported forgoing dental care for financial reasons, or because of distance or long waiting times, and the rate was much greater among people in the lowest income quintile (12 %) than those in the highest (roughly 1 %).

The COVID-19 crisis and related containment measures limited access to health services in 2020. A survey carried out in February and March 2021 found that 25 % of the Spanish population reported having forgone a needed medical examination or treatment during the first 12 months of the pandemic. This share was larger than those in neighbouring countries such as France (16 %), and was higher than the EU average (21 %) (Eurofound, 2021)[4].

Figure 13. Unmet needs for dental care are much greater than those for health care



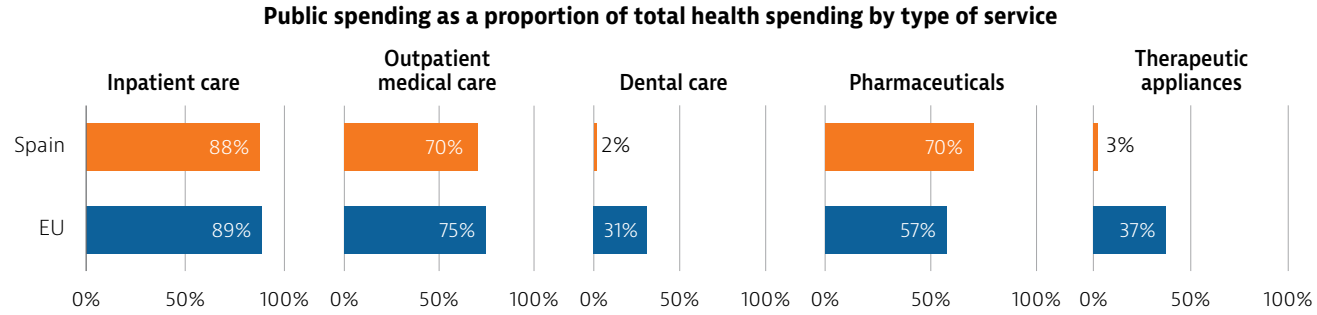
Note: Data refer to unmet needs for a medical or dental examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data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

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

Beneficiaries are entitled to a broad package of care, but coverage for dental care is limited

The SNS provides a comprehensive package of benefits covering primary, outpatient and inpatient care, as well as all licensed prescription pharmaceuticals. A limited range of dental services are available for the general population – including information and education, treatment of acute dental processes, minor surgery and treatment for some lesions – and services for some patient groups such as pregnant women and children. Currently, for other dental care procedures, the population must pay for elective dental care, which is linked to a very low share of public funding (Figure 14). Notably, Spain's Recovery and Resilience Plan, funded by the EU, aims to expand coverage in a number of areas, including dental care, health promotion and preventive care.

Figure 14. Public financing is high except for dental care and therapeutic appliances

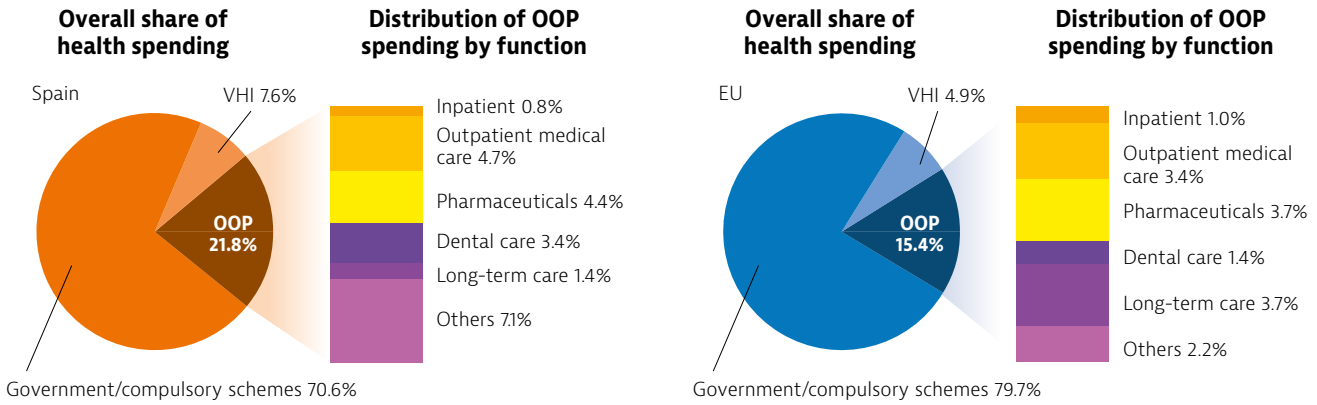


Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Outpatient care, pharmaceuticals and dental care are key drivers of out-of-pocket spending

Following the economic crisis in 2008, the share of OOP payments in health spending increased from 19.0 % in 2009 to 21.8 % in 2019. This is well above the EU average of 15.4 % (Figure 15). Despite good public coverage for pharmaceuticals, OOP payments are still relatively high, following a series of measures adopted in 2012 that increased co-payments for medicines for most of the population. Household spending on outpatient care also accounted for a large share of OOP spending, as did spending on dental care, for which treatment and prosthetics are not covered by the SNS. Since 2017, the government has taken a series of measures to progressively reduce the financial burden of medical expenses on households. Further, from May 2020 and January 2021, new co-payment exemptions of 33 % or more for pharmaceuticals were issued for people receiving the minimum living wage, pensioners with an annual income below EUR 11 200, people receiving social security benefits for caring for one child, and those aged under 18 years with a recognised disability.

Figure 15. The share of out-of-pocket payments is higher than the EU average



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

Measures have been implemented to reduce inequalities in access to medicines

Spain was one of the founders of the Valletta Declaration, the international collaboration aiming to improve cost–effectiveness and decrease inequalities in access to medicines. The main goals of its pharmaceutical policies are aligned with the new pharmaceutical strategy for Europe adopted in November 2020 (European Commission, 2020b). To address shortages of medicines, in 2019 the SNS Interterritorial Council approved a plan by the Spanish Agency of Medicines and Healthcare Products to guarantee medicine supplies and improve coordination.

Some recent initiatives by the Ministry of Health include Valtermed – an information system in the SNS to assess the real therapeutic value of drugs; BIFIMED – an interactive tool providing information about the public financing of medicines; an action plan to promote the use of biosimilars and generics in the SNS; REvalMed – the Medicines Evaluation Network of the SNS; and a new personalised medicine strategy. In June 2021, the INVEAT Plan was approved, offering over 750 high-tech devices that aim to provide greater capacity to diagnose diseases in early stages. In addition, Spain's Recovery and Resilience Plan sets out a new approach for rational use of medicines and ensuring sustainability.

Unequal distribution of doctors hinders access, but new policies aim to increase their numbers

As noted in Section 4, the number of doctors per 1 000 population in Spain is slightly above the EU average, but their geographical distribution is unequal. For example, while Castilla y León had 1.12 GPs per 1 000 population in 2019, the Balearic Islands had 0.62 (Ministry of Health, 2021a). In March 2019, the Ministry of Health announced that the number of postgraduate training places would increase by 7 % in 2020, with a particular focus on increasing places in family and community medicine, in response to renewed concerns about shortages of primary care doctors. Further, the 2019 Strategic Framework for Primary and Community Care was developed, with the aim of reducing inequalities in access to health care.

Access to health services was disrupted for non-COVID-19 patients in the first wave of the pandemic

During the state of alarm, most elective surgery was postponed or cancelled (except for cancer treatment) and, in general, people opted to delay their visits to hospital, even in urgent cases. This could have led to worsening of conditions that, if treated earlier, would have had a better prognosis. For example, the Society of Cardiology noted that in-hospital mortality of acute myocardial infarction almost doubled in the first month of Spain's lockdown (Rodríguez-Leor et al., 2020). Similarly, most outpatient consultations with specialists were cancelled and, despite first consultations being prioritised above follow-ups, this may have led to a delay in diagnosis of some conditions. In the case of cancer, for instance, the Society of Medical Oncology estimates that there were 21 % fewer new diagnoses, which may have led to worse disease prognosis (see Section 5.1). In mid-May 2020, the Ministry of Health issued recommendations for the phased and safe reintroduction of surgical activities and established criteria to prioritise patients (for surgery) depending on the epidemiological situation.

The use of telehealth sped up during the COVID-19 crisis

Over the last decade, some regions have promoted greater use of telehealth to improve access to care, particularly for patients with chronic conditions. The Basque Country, for example, developed a telehealth service for patients with cardiac heart failure to support self-management and to monitor physiological measurements that are reviewed remotely by specialists. Remote consultation and telemedicine were enhanced by the pandemic, with the aim of limiting patients' physical presence in health care centres. Thus, phone triage was generalised for all patients requiring a primary care consultation or a specialised care follow-up consultation. Furthermore, remote contact systems were implemented to enhance communication across care levels (such as via videoconference or synchronic message systems).

Some 72 % of the population in Spain reported having had a medical consultation online or by telephone during the first 12 months of the COVID-19 pandemic – the highest percentage across all EU countries and well above the EU average of 39 % (Eurofound, 2021). Initiatives within Spain's Recovery and Resilience Plan will also boost the digitalisation of health care services, interoperability and network services.

5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic[5]. As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Spain, with over 84 000 COVID-19 deaths recorded between March 2020 and end of August 2021. Measures taken to contain the pandemic also had a severe impact on the economy: Spain's GDP fell by 11 % in 2020, compared to an average of 6.2 % in the EU.

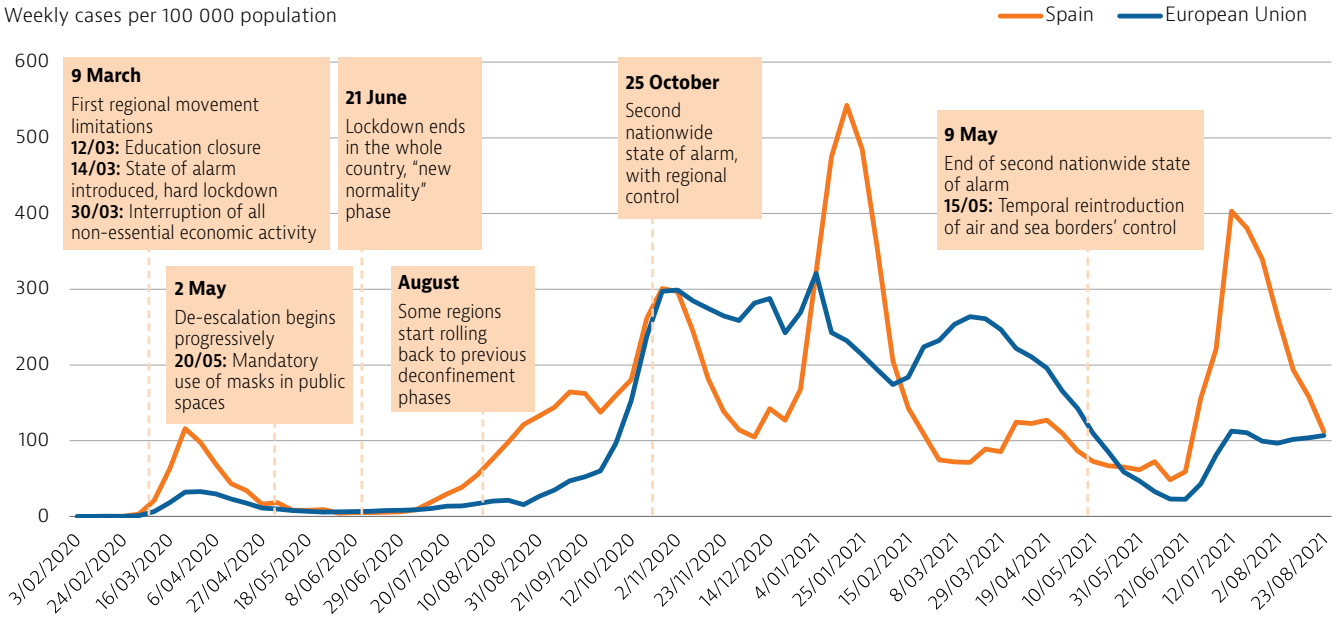
Spain adopted a raft of mitigation measures to contain successive waves of the pandemic

Spain was one of the first European countries to experience a severe outbreak of COVID-19. In early March 2020, in Madrid, parts of the Basque Country (Vitoria) and La Rioja (Labastida), schools and universities were closed and remote working was recommended. On 14 March 2020, the government closed national borders and declared a state of alarm, enforcing severe restrictions: all shops, bars, restaurants and entertainment venues were closed; gatherings and public events were banned; all education was moved online; and a lockdown was enforced. All non-essential economic activity was also restricted between 30 March and 9 April 2020 to accelerate control of transmission, thereby avoiding a collapse of health services.

In April 2020, case numbers decreased sharply, and the health and education sectors established prevention, hygiene and health promotion measures so that they could remain open. From May, a de-confinement strategy commenced with mandatory use of masks in public spaces. An enhanced surveillance strategy was also deployed. In June 2020 there was controlled reopening; however, by the end of July, case numbers were on the rise – earlier than in the rest of the EU.

By August and September 2020, the central government delegated the management of mitigation measures to the regions, which applied mixed policies (see Section 4). The second wave of the pandemic faded from October, while the number of cases in most other EU countries was peaking. A third wave began in Spain in late December 2020 and peaked in mid-January 2021, reaching a 14-day cumulative incidence of around 1 000 cases per 100 000 population. Case numbers fell sharply after that, as regions tightened their mitigation measures according to their epidemiological situation (for example, imposing closures and curfews, and limiting the number of people allowed in gatherings), and in February 2021, the incidence rate was below the EU average (Figure 16). With the end of the nationwide state of alarm and increasing vaccine coverage (with over 95 % of those aged 70 and over vaccinated) during the summer of 2021, the fifth wave mainly affected younger age groups. Regions responded by re-implementing control measures.

Figure 16. Coordination of the COVID-19 response was initially concentrated at the central level



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

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

Fast-track measures were adopted in the pandemic via a new early response plan

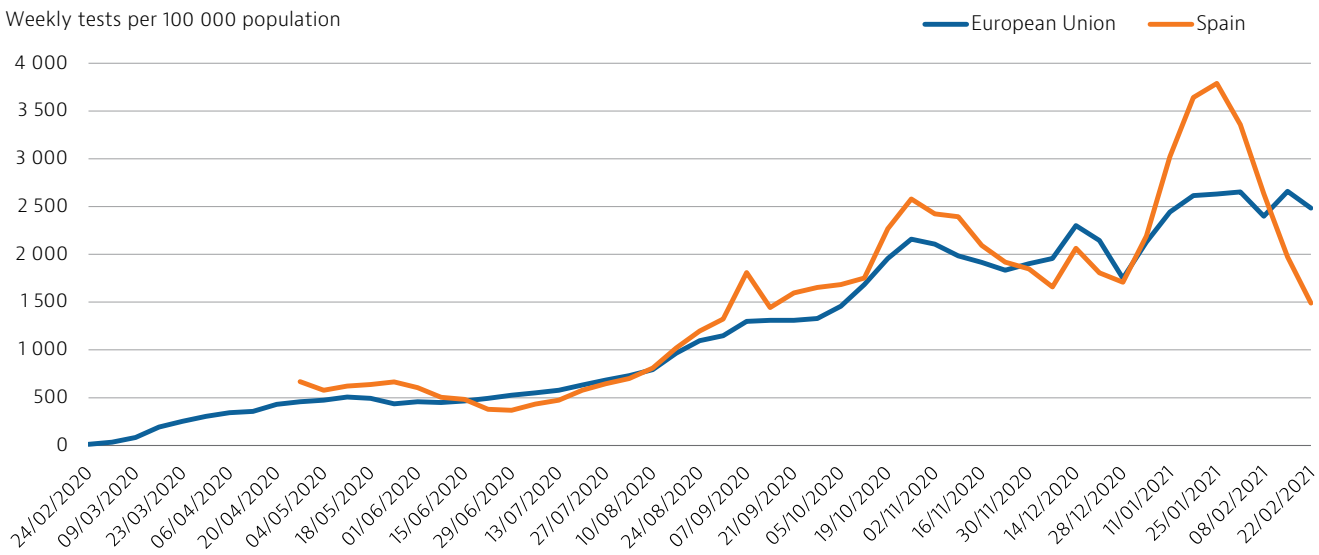
Although Spain had a pre-existing influenza pandemic plan in place since 2005 (updated in 2006 with reference to SARS-CoV-1), this was insufficient to deal with the first wave of the COVID-19 (SARS-CoV-2) pandemic. Subsequently, a new early response plan was developed in 2020, which specified the adoption of various fast-track measures in response to epidemiological changes in the incidence of COVID-19. More recently, Spain's Recovery and Resilience Plan includes a reform of the public health system by developing strategic and operative tools as a basis for a more ambitious public health system that is more integrated. This includes measures announced by the government on the creation of a new public health authority and improvements to the disease surveillance system.

Testing capacity was in line with the rest of the EU, and expanded as more tests became available

Testing capacity in Spain was in line with the EU average at the start of the pandemic (Figure 17), although the incidence of COVID-19 was higher in Spain than other EU countries. Until 5 April 2020, the SNS processed around 15 000-20 000 tests per day. In early April, the government purchased 1 million rapid COVID-19 antibody tests to complement PCR tests in high-prevalence environments, such as hospitals, nursing homes and assisted living homes. From 13 April 2020, regional authorities were entitled to make use of the testing capacity of private laboratories located in their regions. Laboratories (including public, university and private) were accredited to cope with the needs for PCR testing.

An information system (SERLAB) was set up to share the results of diagnostic tests (from both public and private providers) at the national level. This facilitated generation of real-time data that helped with managing the pandemic. Testing capacity was increased from September 2020 with the use of rapid antigen tests. As of 22 July 2021, antigen tests (or any test) for COVID-19 self-diagnosis can be purchased without a medical prescription. These can be advertised to the general public and do not have a fixed price; however, positive tests must be confirmed with a subsequent PCR test prescribed by a doctor.

Figure 17. Testing rates increased greatly during the second and third waves of the pandemic



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

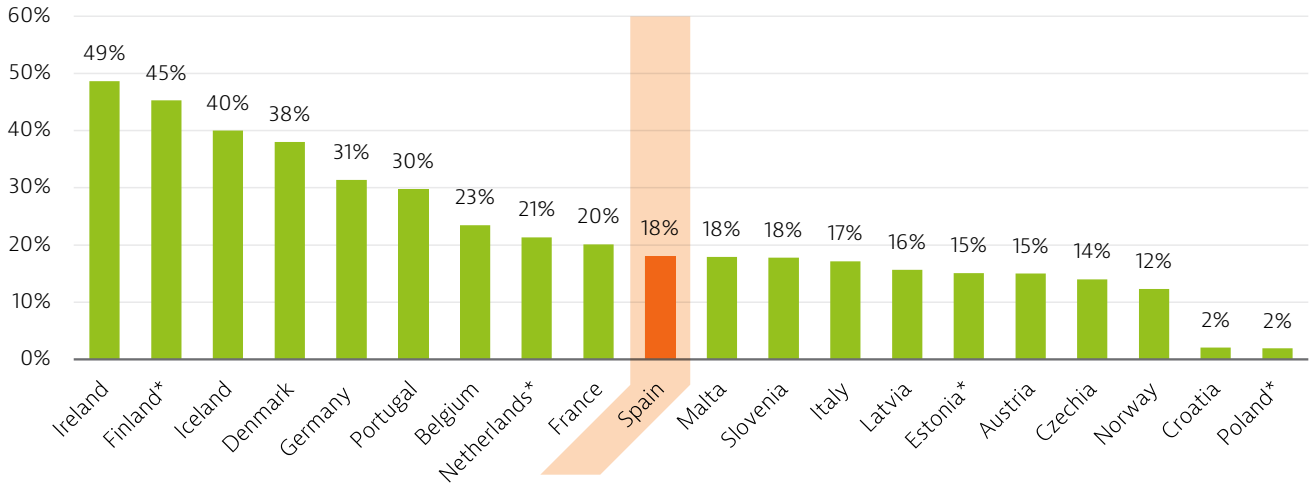
An application was developed to support contact tracing, but use was unequal across the country

In late August 2020, the Ministry of Economy and Digital Transformation released the app "RadarCOVID", enabling contact tracing through mobile Bluetooth exchange to send out and receive anonymous identifiers. If users tested positive for COVID-19, they could input a code provided by the regional health system to notify all their contacts, who then received a warning. Although downloading and/or using the app was not mandated by the Ministry of Health, regional health authorities encouraged its use. Between late August 2020 and the end of April 2021, approximately 18 % of the Spanish

population had installed the app on their mobile phones (Figure 18). National data show that only 1 % of those with COVID-19 included this information in the app from July 2021 – down from 2 % in March 2021 (SEDIA, 2021). Implementation was unequal across the country, with regions such as Catalonia and Madrid implementing the app later than other regions, having made it operational within their information systems and contact tracing processes.

Figure 18. The Spanish app to facilitate contact tracing has not been downloaded extensively

% of the population who downloaded the app



*Note: Data as of April 2021. * Data to Autumn 2020.*
Source: National data.

Measures were introduced to distribute health workers according to need

During the state of alarm, the Minister of Health was temporarily authorised to perform any needed actions on human resources that could strengthen the health system. Furthermore, some requirements were loosened to facilitate hiring of additional health care professionals under short-term, freelance or temporary contracts, and for medical students and student nurses to participate in some complementary activities by the end of their training. To cover potential staff shortages due to COVID-19, from 30 September 2020, regional authorities were able (as an exceptional and temporary measure) to reallocate health care personnel to different specialty units within the same hospital, and personnel from hospitals could be transferred to primary care centres (and vice versa). Military medical personnel were also used to strengthen the national health system across all Spain's territory at the start of the pandemic (March 2020).

This action was reinforced by the creation of a nationwide information system, in which both public and private facilities reported their health care provision capacity. With this real-time information, decision making and resource allocation can be more effective and efficient.

Spain acted quickly to increase intensive care unit bed capacity

At the onset of the COVID-19 crisis, Spain had 10 ICU beds per 100 000 population (2017 data). This was more than three times lower than the number of ICU beds in Germany (33) and below the average across the EU (13) (OECD/EU, 2020), although still sufficient to cover regular needs. ICU bed capacity in public hospitals was almost doubled at the peak of the pandemic, increasing from 4 446 beds at the outset to 7 930 in just two months. This increase was achieved through reallocating resources from other units (such as post-surgery recovery units and neonatal ICUs) and adapting surgical beds with monitoring equipment and ventilators, some of which were manufactured nationally. The government also requested that all ICU beds in private hospitals should be made available for use by the regional health services; however, only around 15 % were used.

The government and the regions have responded to the demand for personal protective equipment

At the beginning of the pandemic, Spain as many other EU countries, experienced an acute shortage of personal protective equipment (PPE) due to low levels of national production and of emergency stocks. Taking remedial action to avoid future shortages in future outbreaks, since May 2020 regions are

responsible for maintaining a strategic reserve that secures five weeks' supply of PPE (facemasks, safety goggles, gloves, gowns), diagnostic tools, medicines and ventilators. Furthermore, as part of the plan for an early response to control the COVID-19 pandemic (published on 16 July 2020), a national strategic stockpile is maintained as a reinforcement measure for regions to guarantee the supply of any essential product.

Primary care played a key role in the early detection and monitoring of COVID-19 patients

At the beginning of the pandemic, primary care centres called off non-urgent consultations and implemented an e-prescription mechanism for chronic patients to renew their prescriptions automatically, thereby avoiding visits to primary care premises. Primary care centres dedicated specific spaces to treat COVID-19 patients, designed specific circuits to separate respiratory and infectious patients, reinforced home care and telemedicine, and set up early detection and surveillance protocols (alongside public health services in the regional health authorities).

Public health authorities in the regions set up testing premises in both primary care centres and hospitals. Additionally, primary care coordination and response teams were set up to assess patients via telephone or to deliver home visits to monitor the progress of self-isolating patients.

Specific containment measures and additional resources were applied in long-term care facilities

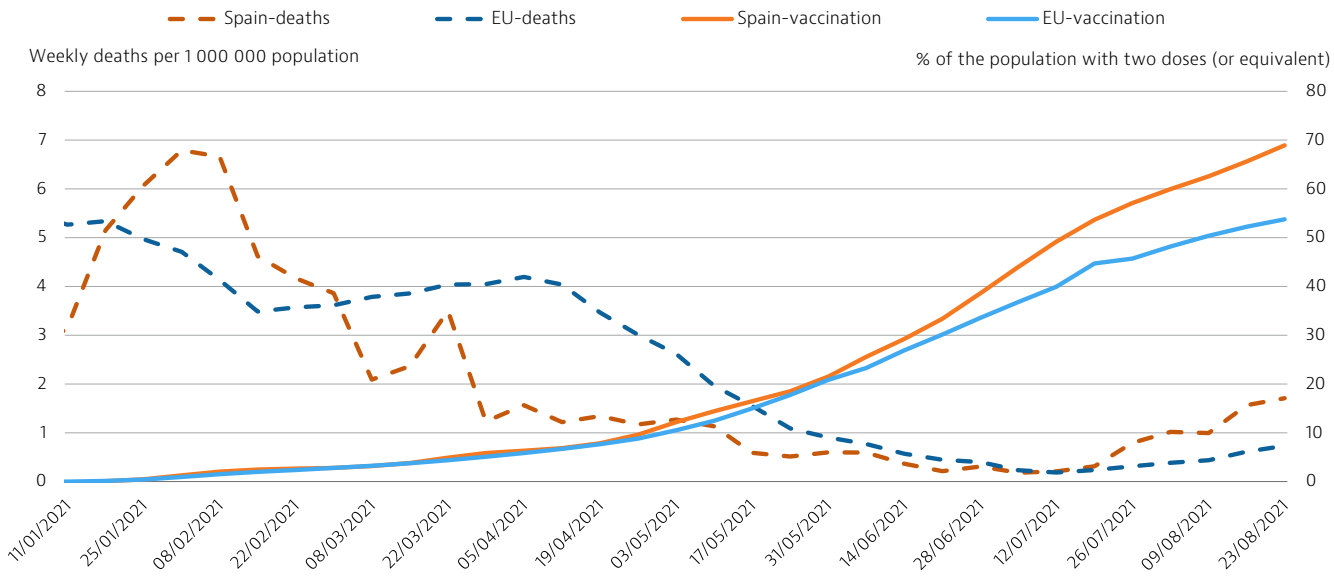
Regions are responsible for public LTC facilities and services in Spain but, in response to the severe outbreaks in care homes, the national government took temporary control in mid-March 2020. An extraordinary budget of EUR 300 million for LTC services was made available, and the government established protocols for the operation of LTC facilities – limiting visits, enhancing supplies of personal protective equipment and introducing testing in care homes as a priority. The government also mandated the intervention of military emergency units in care homes to provide support for overwhelmed care workers. This situation lasted until summer 2020, when coordination of the COVID-19 response returned to the regions. Stringent visiting protocols remained in place, and additional policies to protect LTC facilities users – including community services and workers – were adopted, including their designation as a priority group in the COVID-19 vaccination campaign.

Spain's vaccination campaign began in late December 2020 and was updated as the pandemic evolved

The COVID-19 vaccination strategy was presented on 24 November 2020: vaccination is voluntary and free of charge. This strategy is implemented at the regional level and is based on the recommendations of the European Commission and other international institutions (including ECDC and WHO). To prioritise vulnerable groups, the Spanish population was divided into 15 groups to be vaccinated in three consecutive stages throughout 2021. Older people and disabled people in residential facilities, health and social care personnel working in care facilities and non-institutionalised people receiving LTC in the community – totalling 2.5 million people – were the first groups to receive the COVID-19 vaccine in the first trimester of 2021.

The vaccination strategy was updated on several occasions, including updates related to guidelines for people who have already had COVID-19 (February 2021) and to the use of the AstraZeneca vaccine (April 2021). As of the end of August 2021, around 70 % of the population had received two doses (or equivalent) of the COVID-19 vaccine, which is well above the EU average of 54 % (Figure 19). To support decision making on the vaccination strategy, a national information system was set up to allow all regions to share vaccination information in real time.

Figure 19. Vaccination speed quickly accelerated and surpassed the EU average



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

Spain is embarking on a major programme to modernise health information systems

In Spain, the regions have full responsibility for planning and development of digital health services. Before the pandemic, most regional health systems had already implemented e-prescriptions, electronic health records and web portals or mobile applications through which citizens can access their health data and manage their medical appointments. The SNS embarked on an ambitious programme of technological modernisation, for which a new General Secretariat for Digital Health, Information and Innovation was established. Its main objectives are development of digital public services, enhancement of e-health, improvement of the interoperability of clinical and health information systems with national and international databases, promotion of innovation, and reinforcement of performance assessment and data analysis capabilities. This initiative is consistent with the plan to develop a European Health Data Space to promote better exchange and access to different types of health data (such as electronic health records, genomics data, data from patient registries and so on), and to support health care delivery, health research and policy making (European Commission, 2021b).

EU funding will bolster health infrastructure investment

Spain is on track to receive a substantial amount of EU funding to strengthen and modernise its health system, improve cohesion and help finance the high costs of the fight against the COVID-19 pandemic. On 16 June 2021, the European Commission endorsed Spain's Recovery and Resilience Plan, which devotes EUR 2 billion to the country's health investments. Priority areas established by Spain's Plan include a new public health system, greater investment in e-health and surveillance systems, and strengthening the universality of the health system (Spanish Government, 2021). Furthermore, the European Commission has granted EUR 3.7 billion for Spain's recovery efforts and digital and green transition under REACT-EU, the Recovery Assistance for Cohesion and the Territories of Europe (European Commission, 2021c). These funds will be transferred directly to regions to support them in strengthening the welfare state, protecting public health services and reactivating the economy after the impact of the pandemic (Treasury Ministry, 2021).

6 Key findings

- Life expectancy in Spain was the highest in the EU in 2019, but fell substantially in 2020 due to the COVID-19 pandemic. Public health policies contributed to low levels of preventable mortality before the pandemic, and mortality rates from treatable causes decreased between 2011 and 2018 due to improved health system performance.

- While the proportion of adults smoking daily has decreased since 2000, it remains higher than in most EU countries, particularly among men. Taxes on tobacco products have been increased, and further regulation on packaging and labelling was introduced in 2017, outlining rules on health warnings, use of additives and e-cigarettes. Moreover, obesity rates among adolescents and adults have increased. The government has reached agreement with the food industry to cut the content of sugar, salt and fat and, more recently, the nutritional labelling system Nutri-score has been introduced.

- Following the economic crisis in 2008, health spending decreased for several years, but it started to increase again from 2014 and is expected to increase further due in part to EU funds. In 2019, Spain allocated 9.1 % of its GDP to health spending, which is lower than the EU average (9.9 %). Per capita spending climbed to EUR 2 488 in 2019, although it is also still below the EU average. Spain's Recovery and Resilience Plan has been endorsed by the European Commission and devotes EUR 2 billion to health investments. Further, EU funds from the REACT-EU package are expected to strengthen and modernise the health system and help finance the high costs of the fight against the COVID-19 pandemic.

- While potentially avoidable hospital admission rates for some chronic conditions such as diabetes are relatively low in Spain, they are close to the EU average for asthma and chronic obstructive pulmonary disease. More investment in primary care from national funds would help to spur improvement, as this area has not been prioritised by Spain under EU-funded programmes. Over the last decade, all regions have promoted greater use of telehealth to improve access to care, particularly for patients with chronic conditions. These activities were enhanced during the COVID-19 pandemic and further developments are under way.

- Primary care remains a central element of the Spanish health system, with general practitioners and nurses providing care and health promotion and preventive services. Primary care was key during the COVID-19 pandemic to reinforce home care and to facilitate early detection through testing and contact tracing, as well as in monitoring COVID-19 patients and implementation of the vaccination strategy. The Recovery and Resilience Plan envisages full implementation of the Strategy on Primary and Community Care adopted in 2019.

- Spain was one of the first European countries affected by the COVID-19 pandemic. Along with nationwide mitigation measures aimed at preventing transmission of the virus, the country had to act quickly to increase intensive care unit bed capacity, and measures were introduced to facilitate the best distribution of the health workforce. Preparedness measures honed during the pandemic response will be further strengthened by initiatives to be funded under the Recovery and Resilience Plan, including creation of a new public health authority and improving public health surveillance.

Key sources

Bernal-Delgado E et al. (2018), *Spain: health system review. Health Systems in Transition*, 20(2):1-179.

OECD/EU (2020), *Health at a Glance: Europe 2020 – State of Health in the EU Cycle*. Paris, OECD Publishing.

References

EU Expert Group on Health Systems Performance Assessment (HSPA) (2020), *Assessing the resilience of health systems in Europe: an overview of the theory, current practice and strategies for improvement.*

Eurofound (2021), *Living, working and COVID-19 survey, third round* (February-March 2021).

European Commission (2020b), *A pharmaceutical strategy for Europe.*

European Commission (2021a), *Europe's Beating Cancer Plan.*

European Commission (2021b), *The European Health Data Space.*

European Commission (2021c), *Press Release 29 July 2021.*

INE (2021), *Encuesta de Población Activa 2020*, Madrid.

Ministry of Health (2021a), *Key indicators of the national health system* (INCLASNS) http://inclasns.msssi.es/main.html.

Ministry of Health (2021b), *Covid-19 pandemic and the prevention and control of cancer*, Madrid.

Rodríguez-Leor O et al. (2020), *Impact of the COVID-19 pandemic on the Health care in interventionist cardiology in Spain,* REC Interventional Cardiology, 2:82-89.

SEDIA (2021), *RadarCOVID Statistics,* Madrid, https://radarcovid.gob.es/estadisticas/descargas-radar.

SEOM (2021), *COVID-19 y cancer*, Madrid.

Spanish Government (2021), *Recovery and Resilience Plan*, Madrid.

Treasury Ministry (2021), *Press Note,* Madrid, https://www.hacienda.gob.es/es-ES/Prensa/En%20Portada/2021/Paginas/20210529-REAC-UE.aspx.

WHO Regional Office for Europe, European Commission, European Observatory on Health Systems and Policies (2021), COVID-19 Health Systems Response Monitor – Spain.

Zueras (2020), *Trends in disease-free life expectancy at age 65 in Spain: Diverging patterns by sex, region and disease*, PLoS One, 15(11): e0240923.

Country abbreviations

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

European Commission

State of Health in the EU
Country Health Profile 2021

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

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

Each country profile provides a short synthesis of:

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

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

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

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