

Annual Report on the National Health System of Spain 2011

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Annual Report on the National Health System of Spain 2011



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Health Care Barometer

National Catalogue of Hospitals

Catalogue of SNS Primary Care Facilities

Spanish National Health Survey
European Health Survey in Spain
Statistics on Specialised Care Health Facilities
Statistical use of the Minimum Data Set (MDS): Hospital demand and morbidity attended
SNS Key Indicators
Primary Care Information System of the SNS (SIAP-SNS)
SNS Waiting List Information System (SISLE)
Sub-Directorate General of Health Promotion and Epidemiology
Statistics on Vaccination
Statistics on Elective Termination of Pregnancy (ETOP)
Sub-Directorate General of Professional Regulation
Student places available in Specialised Health Care Training (FSE)
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Introduction

Article 63 of the Law on Cohesion and Quality in the National Health System (hereinafter SNS, for its acronym in Spanish) requires the Spanish Healthcare System Observatory to prepare an annual report on the state of the SNS, which is to be presented by the Ministry of Health, Social Services and Equality (MSSI) to the Interterritorial Council of the SNS.

The most recent report contains a description of the basic characteristics of Spain's public health care system and informs the reader of the main features of the SNS in 2011. The text is accompanied by data offering a vision of the sector's current situation and illustrating its structure and functioning this year.

The report begins by describing how responsibility for health is divided among the various public administrations, especially between the central government and the country's 17 autonomous communities, how the public administrations coordinate with each other and what kinds of services are provided. It goes on to discuss the population covered by the public health care system and relevant details regarding its functioning, from the perspective of the two care settings into which it is organised: Primary Care and Specialised Care.

Data about resources, personnel, care activity, quality and expenditure is provided for each of these two care settings.

Information about the medicines covered by the SNS prescription system and preliminary data on the health budget and expenditure round out the information concerning SNS functioning. Finally, some relevant data regarding the lifestyles and health of the Spanish population are included.

The legitimisation of any service organisation, and of course the SNS is just that, lies in elements of satisfaction; that is why this year's document has incorporated people's opinions about the health care system's functioning, as gleaned from the 2011 Health Care Barometer.

The main source of data pertaining to the autonomous communities and the cities with statutes of autonomy are the statistics and information systems regarding the health sector produced by the Ministry of Health, Social Services and Equality, which are part of the National Statistics Plan (PEN) 2009-2012 and the SNS Key Indicators (INCLASNS) database.

The SNS Key Indicators database covers the most relevant aspects of health and the Spanish health care system. The indicators included in the

database are selected by consensus among the administrations represented in the Interterritorial Council of the SNS. It was developed in collaboration with the autonomous communities through the Subcommittee of Information Systems of the Interterritorial Council of the SNS.

Data about the situation of the Information and Communication Technologies (ICT) in the SNS were taken from the 2011 update of the Health Care Online programme. The information about overweight in children comes from the growth surveillance study ALADINO, conducted by the Spanish Food Safety and Nutrition Agency (AESAN). The Directorate General of Professional Regulation furnished the data about professional training.

For data that is international in scope the databases Eurostat-Public Health Statistics, OECD Health Data and the WHO's European Health For All were used.

Summary

Division of powers and responsibilities in the area of health care

The SNS, the guarantor in Spain of universal health care coverage, was established in 1986 with the enactment of the General Health Care Act. The system is configured as a co-ordinated set of services, some of which are provided through the health services of the central government and some of which are provided through the health services of the autonomous communities. The SNS thus integrates all the functions and health care benefits that are the responsibility of the public authorities.

The central government has exclusive power and responsibility in the following areas: the foundations and co-ordination of the health care system, border health control and international relations and accords, and the approval of and legislation regarding medicines and health products.

All of the autonomous communities, by virtue of the Spanish constitution and their respective statutes of autonomy, have power and responsibility in health care, and each one has its own health service that encompasses all the publicly-operated health centres, services and establishments working in the area of health.

Since 2002 a decentralized system of health management has been in effect throughout national territory, although the central government manages health care in Ceuta and Melilla (the cities in North Africa that have their own statutes of autonomy). This management activity is carried out through the National Institute of Health Management (INGESA).

The 2003 Law on Cohesion and Quality in the SNS consolidated the constitutional right to health protection to which all of Spain's citizens are entitled.

Co-ordination of the SNS

The ongoing co-ordination and co-operation efforts made within the SNS are channelled through the Interterritorial Council of the SNS (CISNS), which is comprised of the Minister of Health, Social Services and Equality and the Regional Minister of Health of each autonomous community and of the autonomous cities of Ceuta and Melilla.

The CISNS operates through its Plenary sessions and the meetings of its Delegated Committee, Technical Committees and Working Groups. Resolutions are passed by consensus and take the form of recommendations.

Services provided

The SNS offers all citizens a large basket of services in the areas of public health, primary care, specialised care, urgent care, pharmaceutical benefits, ortho-prosthetics, dietetic products and transport provided in connection with health services.

All of the health services are free of charge at the time of use, except for the pharmaceutical benefits and ortho-prosthetics, for which there is a co-financing system involving co-payment by the user of the service.

The autonomous communities must guarantee the common service basket to all users of the SNS and they may also adopt additional service baskets not included in the general financing of the SNS benefits.

A similar situation occurs with the insurance mutuals for civil servants (MUFACE, MUJEJU, ISFAS), as they must guarantee the content of the common services of the SNS and can also adopt their own basket of services.

Population covered

In 2011, 98.3% of the 47.2 million residents in Spain comprise the population covered by the SNS, including the civil servants covered by insurance mutuals (MUFACE, MUGEJU and ISFAS) but who opt to receive health care benefits through the public sector. Citizens access the public health care services with their Individual Health Card (IHC), the document that identifies each citizen as a user of the SNS.

Functioning

Citizens generally have a positive opinion of the functioning of the SNS: 73% believe that it works well, although some believe that some kind of reform would be justified. Only 4.2% are dissatisfied and believe the system should be completely transformed.

Primary Care: resources, care activity, quality, satisfaction and expenditure

Public sector Primary Care is characterized by being highly accessible, as it offers the population a series of basic services available to it within 15

minutes of any place of residence. Its care-giving facilities include 3,006 health centres and 10,116 local health facilities, which employ over 35,000 doctors (around 29,000 general practitioners and slightly more than 6,000 paediatricians) and more than 29,000 nursing professionals.

In 2011 adult citizens consulted the general practitioner 5.6 times while children under the age of 15 were taken to the paediatrician 5.4 times. All together, the health system attended almost 279 million medical consultations. This figure combined with the over 139 million nursing consultations taking place means that the health centres and local health facilities have had more than 418 million contacts with patients.

In Primary Care consultations, the Information and Communication Technologies (ICT) are widely implemented, as the vast majority of general practitioners (almost 9 out of 10) use a computer to access their patients' clinical records.

The quality and results of the care provided by public sector Primary Care can be objectively appreciated by looking at: the low rates of incidence of some of the immunization-preventable diseases, the coverage of seasonal flu vaccination in the elderly and the diminishing need for hospitalisation due to acute diabetes-related complications, which has fallen to 2.8 hospital discharges for every 1,000 diabetics.

Satisfaction with the care received forms an integral part of the quality perceived by the users of the care services. The three most highly-valued aspects of the care provided in the Primary Care sector are: the proximity of the facilities, the confidence and security conveyed by the doctor and the interactions with the health care personnel.

Of every 100 Euros of the public sector's current expenditure on health, about 14 of them are devoted to Primary Care services, including the training of residents. Over the last nine years, the expenditure in Primary Care services has grown by 0.31 points.

Specialised Care: resources, care activity, quality, satisfaction and expenditure

Specialised Care is the care setting that interlocks with Primary Care, and it is characterised by the complexity of the care delivered. Depending on the characteristics of the patient and his or her process, the care is provided on an ambulatory or an inpatient basis in one of the 348 public hospitals in operation in Spain, which have a bed capacity of 111,000 beds. Of every 10 hospitals, 4 are public and 6 are private; although this proportion is inverted if examining the sector to which the beds belong: 7 belong to the public sector and 3 to the private sector.

Fifty per cent of the acute care hospitals, 30% of the psychiatric hospitals and 30% of the geriatric or long-term hospitals belong to the public sector. In terms of bed capacity, 75% of the beds in acute care hospitals, 34% of the beds in psychiatric hospitals and 37% of the beds in geriatric and long-term hospitals belong to the public sector.

The SNS hospitals and specialised care centres employ just over 79,000 doctors and 128,000 nurses, which represents almost 90% of the total of doctors and over 85% of all the nurses working in Spanish hospitals and specialised care centres. Looking at the situation by large specialty groups, of all the doctors 5 out of 10 work in a medical discipline, 3 out of 10 work in a surgical discipline, just over 1 works in the hospital's central services (medical specialties that support other medical specialties) and approximately 1 works in an emergency room.

Each year, public funding pays for 4.2 million of the discharges taking place in the hospitals of Spain (80% of the total number of discharges), 71.8 million consultations (87% of the total number of consultations) and 20.6 million emergencies (79% of the total number of emergencies). Ambulatory care for surgical processes is clearly on the rise: in 2011 this figure was 1.3 million (81% with public funding) out of the total of 4.7 million interventions.

Childbirth, puerperium and complications during pregnancy are the most frequent causes of hospitalisation in acute care hospitals in the SNS. They are followed, in order of importance, by circulatory system diseases, digestive system diseases, respiratory system diseases and cancer, in women. In men, the main causes of hospitalisation are circulatory system diseases, followed by digestive system diseases and tumours.

The number of patients on the surgery waiting lists as of 31 December 2011 is over 459,000 persons, with an average wait time of 73 calendar days. The average wait for a specialised ambulatory consultation is 58 calendar days.

Within the provisions of the new Law on Sexual and Reproductive Health and the Elective Termination of Pregnancy now in effect, about 118,000 abortions have been performed.

Organ transplantation is a technique that places those who perform such procedures in the technological avant-garde. Spain, with a donation rate of 35.3 for every one million inhabitants, has been and remains a world leader. Organ donation continues to increase and reached 1667 donors in 2011. This permitted a total of 4,222 solid organ transplants to be performed.

An idea of the quality of the care received in public hospitals can be obtained by looking at the decrease in caesarean rates in hospitals and at the low rates of hip fracture, which are indicative of efforts to avoid adverse effects. Further evidence of the quality of acute care is the clear decrease in in-hospital mortality following admission due to acute myocardial infarction.

The legitimization of any service organisation lies in citizen satisfaction. In 2011 the most highly-valued aspects of the care received during hospitalisation are the hospital's technological equipment and resources, the care and attention provided by the medical and nursing staff, and the information the patients receive about the progress of their health problem. The aspects that users value most highly with regard to consultations with SNS specialists are the number of specialties available, the technological equipment and resources available at the facilities, and the interactions with the personnel.

The waiting lists are a motive of concern, however, indicating that efforts toward improvement should be dedicated to this matter. Only 18% of adult citizens think that the waiting list situation has improved in the last year.

In terms of public current expenditure on health, of every 100 Euros spent more than 51 went to hospital and specialised care services, including the training of residents. Over the past nine years, this proportion has grown by 5 points.

Medicines

Public expenditure on medicines dispensed through the SNS medical prescription system has slowed, falling by 4 points over the last nine years. The 2011 figure represents 20.8% of the public current expenditure on health.

Together, public and private expenditure on medicines amounts to 1.8% of the GDP.

The medicines most consumed, and rising, are antihypertensive agents, followed by those taken for peptic ulcers and gastroesophageal reflux, hypolipidemic agents and antidepressants. The volume of generic medicines dispensed through the medical prescription system represents 27.4% of the total, which in financial terms is 11%.

Practically one quarter of citizens acknowledge that they store medicines at home; in half of these cases, they do so "*to make sure the medicines are always on hand.*"

As regards the implementation of electronic prescribing, over half of the citizens are aware of its existence, although only 27.8% have used it.

Professional training

With respect to the training of doctors, pharmacists, chemists, biologists, psychologists, medical radiophysicists and nurses, 2011 has seen an overall increase of more than 5% in the number of student places available, compared to 2008. This growth has occurred mostly thanks to the new nursing specialties and to the consolidation of previously-existing nursing specialties, midwifery and mental health.

Although in the case of medical specialties, during the same period, there has been a decrease of 1.3%, the distribution of this decrease by specialty is not homogeneous, but rather reflects the effort to give priority to the specialties considered to have shortages in the number of practitioners: orthopaedic surgery and trauma, paediatrics and its specific areas, urology, obstetrics and gynaecology. Also appreciable is the clear effort made to reduce the specialties with a surplus of practitioners: thorax surgery, vascular surgery, clinical neurophysiology and nuclear medicine.

Almost 34,000 candidates were admitted to the selective exams for the adjudication of student places in specialised training programmes, with a reduced number of foreigners. Over 8,200 students were given a place in a training program and over 7,700 new residents began their specialised training. Also this year, the Ministry of Education, Culture and Sport received over 5,900 recommendations for the granting of specialist qualifications to persons who had finished their specialised training.

Financing and health expenditure

Health care in Spain is a non-contributory benefit that is financed by taxes. For the year 2011, the initial health budgets drawn up by the central government and the Social Security Institute amounted to over 4.5 billion Euros. The budgetary allowance of the autonomous communities for the same year was over 57.4 billion Euros.

The public sector health expenditure, including expenditure on long-term care, is almost 75 billion Euros, which is more than 74% of the total health expenditure and 7.1% of the Gross Domestic Product (GDP). Spending in the private health sector represents 2.5% of the GDP.

The health expenditure – per inhabitant covered – of all the public sector health services of the autonomous communities, INGESA and the respective regional health administrations, but not including the expenditure incurred by the health services provided by other agents of the central government, is over 1,400 Euros.

Health status and lifestyles among the Spanish population

Situation in terms of health

The perception that a population has of its health is a good indicator of its health status and of its use of health care services. For the total of the Spanish

population, only 2 of every 10 inhabitants deem their health to be poor or very poor; men manifest a better perception of their health than women do.

Spain, with a life expectancy at birth of over 82 years, has one of the highest among industrialized countries.

Women live more years than men, but for a higher proportion of those years they are in poor health, as indicated by the figures of healthy life expectancy at birth, which in women is 57 years and in men is 59. Healthy life expectancy at the age of 65 is 7 years for women and just over 8 years for men.

In absolute terms, in the year 2010, more than 382,000 people died in Spain. Cause of death data show an epidemiological profile that has become a classic in Spain, and is much like that of nearby countries with similar socio-economic characteristics: cardiovascular diseases, cerebrovascular diseases and cancer are the top causes of death. The cancer that caused the most deaths among men was bronchial and lung cancer, while in women it was breast cancer.

Only 3 of every 1,000 babies born die during the first year of life, which constitutes a low infant mortality rate. Perinatal mortality is about 4 deaths per 1,000 live births. Of all the live births, 8% have a birth weight of less than 2.5 kg, with a clear increment being observed in recent decades. At the beginning of the 1990s, this figure was 3 points lower.

Child vaccination has attained high rates of coverage in children under 2, about 97% for diphtheria-tetanus-pertussis, measles and hepatitis B. Vaccination against human papillomavirus in adolescent girls, from 11 to 14 years of age, is now 65.5%.

In 2010 there were over 2,900 new diagnoses of HIV in Spain. As for the different transmission mechanisms, the incidence of new diagnoses is falling in users of intravenous drugs, while it is stable in heterosexual transmission and is growing in men who have sex with men. Nine hundred and thirty cases of AIDS were reported, of which 8 out of every 10 are men, with an average age of 42 years. Cases in heterosexuals represented 33% of the total.

Non-transmissible diseases and chronic diseases are now the primary causes of morbidity, mortality and incapacity. Diabetes is one of the most widely-spread diseases, with a prevalence of 6%. Other processes of major significance are high blood pressure, which affects 17.5% of the adult population and chronic bronchitis and emphysema, which affects 3.6% of the adult population.

Lifestyles

Twenty-five percent of adults state that they smoke daily and almost 40% assert that they have not consumed alcoholic beverages in the last year. As regards body weight, overweight or obesity is present in over 50% of

the population. Among children aged 6 to 9, the prevalence is 40%. The percentage of people aged 16 and older who say they engage in no physical activity whatsoever and do not walk regularly is 12%.

Compared to men, in women there is a lower proportion of daily smokers and a higher proportion (more than twice as many) who say they have not consumed alcohol in the past year. The prevalence of weight problems (overweight and obesity) is lower among women and girls. The proportion of adult women who say they engage in no physical activity whatsoever is greater than in men.

1. Division of powers and responsibilities in the area of health care

The Spanish Constitution of 1978 provides, in Article 43, that all citizens have the right to health protection and to health care.

The actions that enable this right to health protection to be made effective are regulated by a number of laws: the General Health Care Act (1986), the Law on Cohesion and Quality in the SNS (2003), the Law on the Rational Use of Medicine (2006) and the Public Health Act (2011).

The national health system of Spain (SNS) is the co-ordinated set of health services provided by the central government and by the health services operated by the autonomous communities, and it integrates all the health care functions and benefits that, under the law, are the responsibility of the public authorities.

The principles and substantive criteria that make it possible for the right to be exercised are:

- Public funding, universal access and services that are free of charge at the time of use.
- Rights and duties defined for the citizens and for the public authorities.
- Political decentralisation of health care to the autonomous communities.
- Delivery of comprehensive health care that pursues high levels of quality and is appropriately evaluated and overseen.
- Integration of different structures and public services at the service of health in the SNS.

1.1. The responsibilities and powers of the central government

- Foundations and general co-ordination of health care.
- Border health control and international relations and accords.
- Legislation related to pharmaceutical products.

Table 1.1. Responsibilities and powers of the Public Administrations in the area of health

Central government	Foundations and general co-ordination of health care	Interterritorial Council of the SNS
	Border health control	
	Pharmaceutical policies	
	Management of INGESA	
Autonomous communities	Health care planning	
	Public health	
	Management of Regional Health Services	
	Sanitation and hygiene	
Local governments	Collaboration in the management of public services	

Source: Division of responsibilities according to the Spanish Constitution of 1978, General Act 14/1986 of 26 April on Health Care and Law 16/2003 of 28 May on Cohesion and Quality in the SNS of 2003

‘Foundations and general co-ordination’ means that the central government establishes rules and legislation that determine minimum conditions and requisites, the aim of which is to achieve basic equality in the conditions of operation of the public sector health services. This includes establishing the means and the relationships that allow for reciprocal information exchange, technical homogeneity in particular aspects and joint action by the central and autonomous health authorities in the exercise of their respective responsibilities and powers.

The activities of border health control focus on the surveillance of and response to potential health risks derived from the import, export or transit of goods and from the international movement of travellers. Through international relations and health accords, Spain collaborates with other countries and international bodies in the following areas:

- Epidemiological monitoring.
- The fight against communicable diseases.
- The conservation of a healthy environment.
- The preparation, ratification and implementation of international agreements and legislation.
- Biomedical research and any other action deemed beneficial for the field of health.

In relation to pharmaceutical products, the responsibilities of the central government are as follows:

- Legislation concerning pharmaceutical products.
- Evaluation, approval and registration of medicines for human use, medicines for veterinary use and health products.

- Decision-making regarding public financing and the prices of medicines and health products.
- Guaranteeing the proper custody of narcotic substances in accordance with the provisions of international treaties.
- Importing, when necessary, urgent medicines manufactured outside of Spain and not approved in this country.
- Maintaining a strategic deposit of medicines and health products for use in emergencies and catastrophes.
- Acquisition and distribution of medicines and health products for international co-operation programmes.

The principles and substantive criteria used to promote the rational use of medicines are found in the 2006 Law on the Rational Use of Medicines and Health Products (*Ley 29/2006, de 26 de julio, de Garantías y Uso Racional de los Medicamentos y Productos Sanitarios*). The purpose of this law is to ensure the quality of pharmaceutical benefits throughout the SNS in a decentralized framework, in such a way that the primary objective – that all citizens have access to the medicine they need, when and where they need it and in conditions of effectiveness and safety – can be met.

This law regulates medicines for human use and health products, clinical research on them, their evaluation, approval, registration, manufacture, preparation, quality control, storage, distribution, circulation, traceability, marketing, information and advertising, importation and exportation, prescription and dispensation, the monitoring of the benefit-risk ratio, as well the means to ensure their rational use and the procedures for financing, where appropriate, with public funds.

The law's provisions also regulate excipients and materials used in the manufacture, preparation or packaging of medicines, and they lay down the general criteria and requirements applicable to veterinary medicines and in particular to special medicines, such as extemporaneous compounds and special medicines prepared industrially.

Without detriment to the powers and responsibilities of the autonomous communities, and where appropriate in co-ordination with them, the central government also acts in the following areas:

- Health monitoring of the environment and of foods, services and products directly or indirectly related to human use and consumption.
- Regulation, approval and registration (or recognition of third-party approval) of medicines for human and veterinary use, and, with respect to the former, the powers of inspection and quality control.
- Determination, in general terms, of the conditions and minimum technical requirements necessary for the approval and validation of the facilities and equipment at health centres and services.

- Promotion of quality in the SNS.
- Specialist health care training in teaching centres and units certified to provide such training.
- Implementation of the SNS Information System.

1.2. The responsibilities and powers of the autonomous communities

Under the Spanish Constitution and the respective statutes of autonomy, all autonomous communities have assumed responsibilities and powers in the area of health care. Each autonomous community has its own Regional Health Service, which is the administrative and management structure that integrates all the centres, services and facilities of that autonomous community, its provincial and local governments and any other intra-community administrations.

The central government manages the health care provided in the autonomous cities of Ceuta and Melilla, it does so through the National Institute of Health Management (INGESA).

Figure 1.1. Spain and its autonomous communities



Source: Ministry of Health, Social Services and Equality

The fact that the autonomous communities have assumed responsibilities and powers in the area of health care brings health management closer to citizens and also helps ensure:

- Equal access to benefits and to the right to health protection in conditions of equality throughout the country, thus facilitating the free movement of citizens.
- Quality in the evaluation of benefits brought by clinical advances, incorporating only the elements that contribute added value to health improvement, through the involvement of the entire health care system.
- Citizen participation in terms of both respect for individual decisions and in the consideration given to people's expectations as users of the health care system.

2. Co-ordination of the SNS

2.1. Interterritorial Council of the SNS (CISNS)

The Interterritorial Council of the SNS is the permanent body for the co-ordination, co-operation and communication of the Regional Health Services and between such services and the central government. Its purpose is to promote cohesion in the SNS through the effective and equitable guarantee of the rights of citizens throughout the country.

Comprising it are the Minister of Health, Social Services and Equality and also the Regional Ministers of Health. The Minister of Health acts as Chair, while Vice-Chair is the Regional Minister of Health elected by the other Regional Ministers of Health.

The CISNS operates through Plenary sessions and the meetings of its Delegated Committee, Technical Committees and Working Groups.

The Plenary is the highest body, and its members hold maximum responsibility for Spain's national health system. Plenary sessions take place at least four times a year. Resolutions are passed by consensus and take the form of recommendations.

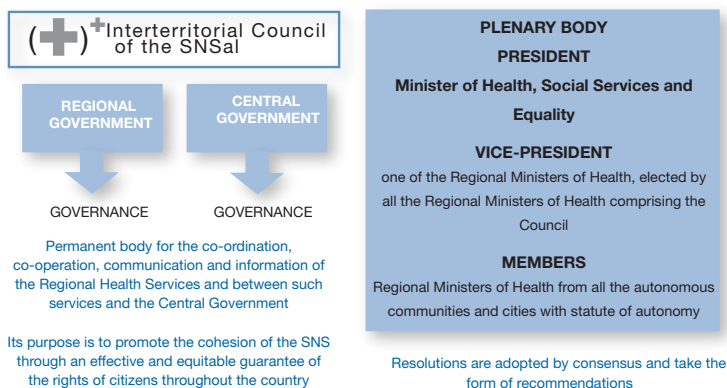
2.2. The Delegated Committee

Presided by the Secretary General of Health and Consumer Affairs and comprised also of a deputy minister from each autonomous community as representative of that community, the Delegated Committee acts as the support body that prepares the CISNS sessions and performs whatever functions the CISNS assigns to it. This Committee can create any subcommissions and working groups it may need to perform its duties.

The CISNS examines, discusses and, where appropriate, issues recommendations concerning:

- The essential functions within the SNS.
- The advisory, planning and evaluation functions within the SNS.
- The functions related to co-operation between the central government and the autonomous communities.

Figure 2.1. Interterritorial Council of the SNS



Source: Ministry of Health, Social Services and Equality

2.3. The Consultative Committee

This is a body attached to the CISNS and entrusted with making social participation in the SNS effective on an ongoing basis, through the institutional participation of union and business organisations. Its functions include informing, advising and making proposals about issues of special relevance in SNS functioning.

This Committee is comprised of the following members:

- Six representatives of the central government.
- Six representatives of the autonomous communities.
- Four representatives of local government.
- Eight representatives of business organisations.
- Eight representatives of the country's most significant union organisations.

3. Services provided

SNS benefits include preventive, diagnostic, therapeutic, rehabilitation and health promotion and maintenance activities, comprising a full set of services offered to citizens.

The basic service basket – the set of services that must be available in all autonomous communities – is laid down in the Law on Cohesion and Quality in the SNS (*Ley 16/2003, de 28 de mayo, de Cohesión y Calidad del Sistema Nacional de Salud*) and the Law's implementation provisions set forth in Royal Decree 1030, on the SNS service basket and the procedure for updating it (*Real Decreto 1030/2006, de 15 de septiembre, por el que se regula la cartera de servicios comunes del Sistema Nacional de Salud y el procedimiento para su actualización*). The different annexes of these regulations establish the common service baskets corresponding to public health, primary care, specialised care, urgent care, pharmaceutical benefits, ortho-prosthetics, dietetic products and health transport.

Royal Decree 1030/2006 has been updated on various occasions: Ministerial Order SAS/1904/2009, of July 8, modifies annex III of Royal Decree 1030/2006; Ministerial Order SAS/1466/2010, of May 28, modifies annex VI of Royal Decree 1030/2006 and Ministerial Order SPI/573/2011, of March 11, modifies annexes III and VII of Royal Decree 1030/2006. Additionally, in 2003 (Royal Decree 605/2003, of May 23) an information system was established to standardise treatment of SNS waiting lists, with the system being revised in 2011 (Royal Decree 1039/2011, of July 15), through regulations of framework criteria designed to ensure that the waiting period before accessing SNS benefits, in conditions of effective equality, will not exceed a given period of time.

3.1. The basic service basket available in all autonomous communities

Public health

This is the set of initiatives undertaken by the public administration at its various levels in order to preserve, protect and promote the health of all people through collective and social actions. These services are offered in an integrated manner, through both the public health structures of the public administrations and the SNS primary care infrastructure. The Primary Care service basket includes public health programmes implemented through actions applied at the individual level by Primary Care professionals.

The common service basket in the area of public health encompasses:

- Epidemiological information and surveillance.
- Health protection: design and implementation of health policies and the exercise of authority in the area of health care.
- Promotion of health and prevention of disease and deficiencies.
- Protection and promotion of environmental health.
- Promotion of food safety.
- Surveillance and control of possible health risks derived from the import, export or transit of merchandise and the international movement of travellers, by the health administration assigned these tasks.
- Protection and promotion of occupational health.

Primary Care

Primary Care is the initial, basic care level that ensures – on an ongoing basis – that patients receive appropriate care over their lifetime, in its role as the manager and co-ordinator of cases and flow regulator. It covers health promotion activities, health education, disease prevention, curative care, health maintenance and recovery, and also physical therapy and social work.

All of these activities, which target individuals, families and communities and use a biopsychosocial approach, are provided by interdisciplinary teams. High priority is given to the quality and accessibility of the actions, continuity of care in all settings in which it is delivered and the proper co-ordination of all the sectors involved.

The common service basket in Primary Care includes:

- Health care – on demand, programmed and urgent – at both the doctor's office and the patient's home.
- Recommendation or prescription and performance, where appropriate, of diagnostic and therapeutic procedures.
- Activities in the areas of prevention, health promotion, family care and community care.
- Public information activities and surveillance regarding health protection.
- Basic rehabilitation.
- Specific care and services concerning women, childhood, adolescence, adults, the elderly, groups at risk and chronic patients.
- Palliative care for patients in the terminal phase of an illness.

- Mental health care in co-ordination with Specialised Care services.
- Oral health care.

Specialised Care

Specialised Care encompasses curative, diagnostic, therapeutic and rehabilitation activities, as well as the activities of health promotion, health education and disease prevention whose nature requires that they be provided at this level. Specialised Care guarantees the continuity of comprehensive care for the patient, once the possibilities of Primary Care have been exhausted, and until that time at which the patient can return to the Primary Care level.

Specialised care is provided, when the patient's condition allows it, at specialised ambulatory care facilities or at day hospital.

The service basket in Specialised Care includes:

- Specialised care in consultations with specialists at ambulatory facilities.
- Specialised medical and surgical care at day hospital.
- Hospitalisation involving overnight stays.
- Primary Care support in cases of early hospital discharge and, where appropriate, home hospital.
- Recommendation or prescription and performance, where appropriate, of diagnostic and therapeutic procedures.
- Palliative care for patients in the terminal phase of an illness.
- Mental health care
- Rehabilitation in patients with treatable functional deficit.

Urgent care

Urgent care is provided to the patient when his or her clinical situation requires immediate attention. It can be delivered both in and out of health facilities, including the home of the patient or wherever he or she may be at the time of the emergency. It is available 24 hours a day and includes medical and nursing care, and collaboration by other professionals.

Urgent care is understood to be comprehensive and continual care that can be provided by Primary and Specialised Care, and by dedicated urgent care services.

The different parties involved in urgent care are co-ordinated through the hotlines 112, 061 and others, and by emergency and urgent care co-ordination centres, which guarantee accessibility and co-ordination of the resources available for this type of care around the clock.

Pharmaceutical benefits

This area of benefits covers medicines and health products, along with the various actions undertaken to ensure that patients receive them according to their clinical needs, in the precise dose for their individual requirements, during the appropriate period of time and at the lowest possible cost to them and to the community, in such a way that promotes the rational use of medicines.

In hospitalised patients pharmaceutical prescribing covers any product that the patient needs and is included in the common service basket.

In patients who are not hospitalised, it covers all products approved and registered by the Spanish Agency of Medicines and Health Products, extemporaneous formulations and officinal preparations created by the dispensing pharmacies as specified in Spain's National Pharmacopoeia, and allergy and bacterial vaccines. It excludes cosmetic and dietetic products, mineral waters, mouthwashes, toothpastes and other medicines, effects and accessories sold over the counter. Homeopathic medicines are also excluded.

For pharmaceutical benefits, there is a co-financing system involving co-payment by users. The contribution made by different segments of the population to the financing of the pharmaceutical expenditure is as follows:

	Population covered by the Social Security system	Population covered by Public Insurance Mutuels
Pensioners and their beneficiaries	0%	30%
Non-pensioners and their beneficiaries	40%	30%
Specific groups in either category		
People affected by Toxic Syndrome due to 1981 incident involving toxic cooking oil	0%	
AIDS patients	10% (maximum 2.64 Euros)	
People receiving chronic treatments		
Source: Ministry of Health, Social Services and Equality, 2011 data		

Ortho-prosthetic benefits

These benefits cover health products, whether implanted or not, that fully or partially replace a bodily structure, or that modify, correct or facilitate its

function. These benefits are provided by the Regional Health Services and economic assistance is given to affected individuals.

Dietetic products

This area covers the dietetic therapy treatments provided to persons having certain congenital metabolic disorders, and enteral nutrition at home for patients who, due to their clinical situation, cannot meet their nutritional needs through normal food ingestion. These benefits are provided by the Regional Health Services and economic assistance is given to affected individuals.

Health service transport

Transport provided in connection with health services is subject to the doctor's decision, based on the patient's clinical situation.

Clinical information and documentation services

Finally, the SNS offers a series of services that accompany the health care process:

- Informing patients and their family members or loved ones of their rights and duties, particularly to ensure that informed consent is obtained in a suitable manner.
- Performing administrative procedures that ensure continuity in the care process.
- Informing patients about all the care activities that will be performed on them.
- Issuing documents to patients for purposes of the processing and renewing of health leave, end of leave, etc. and clinical documents to be used in the assessment of incapacity or similar effects.
- Issuing the discharge report following hospitalisation or the report prepared by specialists after ambulatory consultation.
- Informing a patient about, or issuing to the patient a copy of his or her clinical record (or certain parts of it), when requested by the patient, without detriment to the facility's obligation to keep its own copy.
- Issuing documents related to certification of birth, death, etc. for the Civil Registry.

3.2. Additional service baskets offered by autonomous communities

Each autonomous community, in the exercise of its powers and responsibilities, can approve its own service baskets, but such baskets must comprise the common service basket that is guaranteed to all SNS users.

The autonomous communities that decide to offer a technique, technology or procedure not included in the basic common service basket must provide the additional resources needed. In no case will these additional services be included in the general financing of SNS benefits.

3.3. The service baskets offered by insurance mutuals

The insurance mutuals for civil servants must guarantee the content of the SNS common service basket and they may also adopt their own service baskets.

The patient's economic participation in pharmaceutical benefits is generally 30%.

4. Population covered

In 2011, of Spain's 47.2 million residents 98.3% were covered by the SNS. This figure includes the civil servants covered by insurance mutuals (MU-FACE, MUGEJU and ISFAS) but who opt to receive health care benefits through the public sector.

Citizens access public sector health services with their Individual Health Card (IHC), an identification card issued by the Regional Health Service to users of the SNS in that autonomous community. The cards contain basic information about the cardholder, his or her entitlement in pharmaceutical benefits and the regional health service or other body in charge of that individual's health care.

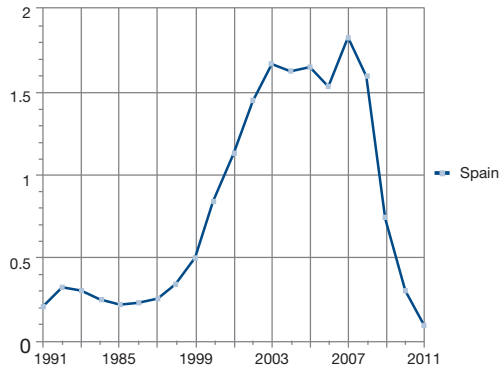
An individual residing in a given autonomous community has a card issued to him or her by that community, with whatever particular characteristics the card may have. The card is valid in that autonomous community and also during temporary displacements to other parts of the country.

Table 4.1. Official population figures by autonomous community

Autonomous community	2009	2010	2011
Andalucía	8,302.923	8,370.975	8,424.102
Aragón	1,345.473	1,347.095	1,346.293
Asturias	1,085.289	1,084.341	1,081.487
Baleares	1,095.426	1,106.049	1,113.114
Canarias	2,103.992	2,118.519	2,126.769
Cantabria	589,235	592,250	593,121
Castilla y León	2,563.521	2,559.515	2,558.463
Castilla-La Mancha	2,081.313	2,098.373	2,115.334
Cataluña	7,475.420	7,512.381	7,539.618
Comunidad Valenciana	5,094.675	5,111.706	5,117.190
Extremadura	1,102.410	1,107.220	1,109.367
Galicia	2,796.089	2,797.653	2,795.422
Madrid	6,386.932	6,458.684	6,489.680
Murcia	1,446.520	1,461.979	1,470.069
Navarra	630.578	636,924	642,051
País Vasco	2,172.175	2,178.339	2,184.606
La Rioja	321,702	322,415	322,955
Ceuta	78,674	80,579	82,376
Melilla	73,460	76,034	78,476
Spain	46,745.807	47,021.031	47,190.493

Source: National Statistics Institute (INE). Official population figures

Figure 4.1. Percentage of interannual variation in total population



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. National Statistics Institute. Municipal Registers of Inhabitants

The growth in Spain's number of inhabitants has experienced a considerable slowdown since 2003 and a drastic slowdown since 2007.

Table 4.2. Proportion of foreigners in the total population, by autonomous community

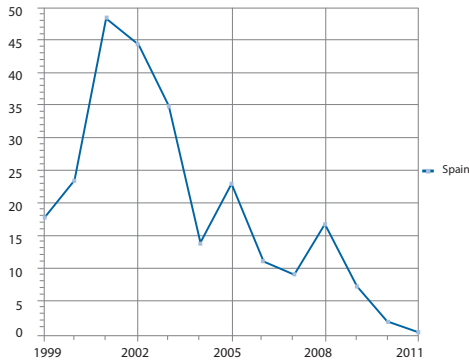
Autonomous community	2009	2010	2011
Andalucía	8.1	8.4	8.7
Aragón	12.8	12.8	12.7
Asturias	4.3	4.5	4.7
Baleares	21.7	21.9	21.8
Canarias	14.3	14.5	14.4
Cantabria	6.5	6.6	6.6
Castilla y León	6.5	6.6	6.8
Castilla-La Mancha	10.9	10.9	11.0
Cataluña	15.9	16.0	15.7
Comunidad Valenciana	17.5	17.5	17.2
Extremadura	3.4	3.6	3.8
Galicia	3.8	3.9	4.0
Madrid	16.7	16.7	16.5
Murcia	16.3	16.5	16.4
Navarra	11.2	11.2	11.2
País Vasco	6.1	6.4	6.6
La Rioja	14.6	14.5	14.3
Ceuta	4.5	5.0	6.0
Melilla	10.3	11.7	12.8
Spain	12.1	12.2	12.2

Source: National Statistics Institute (INE). Official population figures

In 2011 the number of foreign inhabitants was 5.7 million, a figure that represents 12.2% of the total population.

Baleares is the autonomous community with the most foreign residents (21.8%), followed by Comunidad Valenciana (17.2%). In contrast, Extremadura and Galicia have the smallest foreign population, with 3.8% and 4.0% respectively.

Figure 4.2. Percentage of interannual variation in foreign resident population



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. National Statistics Institute. Municipal Registers of Inhabitants.

The percentage of interannual variation in the number of foreign residents in Spain has shown a clear downward trend since the beginning of the decade that started in 2000, breaking with a previous upward trend.

The countries of the European Union as a whole (EU-27) had a total of 33.3 million foreign residents in 2011, which accounts for 6.6% of the total. The majority of these foreign residents, 20.5 million, are from non-EU countries, while the rest, 12.8 million, are from other EU member states.

In absolute numbers, Spain is the EU-27 country with the second highest population of foreign residents. Its foreign population is exceeded only by that of Germany, which has over 7 million residents born elsewhere.

5. Functioning

Over 70% of Spain's citizens hold a positive opinion of the functioning of the SNS; 24.2% think that the health care system works quite well and 48.9% believe that it works well but is in need of changes, enough to justify a possible reform. The need for a reform is more palpable for 21.9% of the population, as this proportion asserts that the health system works well but fundamental changes must be made to it. The number of citizens who express dissatisfaction and see a clear need to completely transform the system is well below one out of ten respondents (0.42), a figure similar to that observed in previous years.

Table 5.1. Satisfaction with health care system, by percentage of population expressing each opinion

	2009	2010	2011
Works well	69.2	73.9	73.1
Needs changes	25.3	21.6	21.9
Needs to be transformed	4.7	3.5	4.2

Source: Ministry of Health, Social Services and Equality. Sociological Research Centre (CIS). Health Care Barometer

By sex, there are fewer women than men who believe the system works quite well (22.1% and 26.5% respectively). In addition, women tend to be more overtly critical, since 23.4% of them state that basic changes are necessary, even though some things do work well. Men express this sentiment 3 percentage points less often (20.4%).

When respondents are asked to give a score to the functioning of the health care system (with a score of 1 meaning very dissatisfied and 10 meaning very satisfied), the score given is 6.6, reflecting a moderate but constant increase over the years.

SNS activity is organised into two settings or levels: Primary Care and Specialised Care, in which spontaneous access by citizens and technological complexity have an inverse relationship.

Table 5.2. Organisation of care services

	Primary Care	Specialised Care
Characteristics	Accessibility	Technical complexity
Activities	Health promotion and disease prevention, with enough resolution capacity to respond fully to the most frequent health problems	Diagnostic and therapeutic resources of greater complexity and cost, which show increased efficiency when concentrated in fewer facilities
Access	Spontaneous	Through referrals made by Primary Care doctors
Care facilities	Health centres and local health facilities	Specialised care centres and hospitals
Type of care provision	At care centres or facilities, and at the patient's home	On an outpatient basis or with hospitalisation

Source: Ministry of Health, Social Services and Equality

5.1. Primary Care: resources, activity, quality, satisfaction and expenditure

The Primary Care level offers the population a series of basic services that can be accessed within 15 minutes from any place of residence. The main facilities for care delivery are the health centres, where multi-disciplinary teams composed of general practitioners, paediatricians, nurses and administrative personnel work, and in some centres social workers, midwives and physical therapists are also available.

This care level is where most activities of health promotion, health education, disease prevention, curative care, health maintenance and recovery, rehabilitation and social work take place.

Curative care is provided on demand, in a programmed or urgent manner, both at the health centre and at the patient's home; it includes the indication or prescription – and, if necessary, the performance – of diagnostic and therapeutic procedures.

In addition, doctors and nurses provide care continuously, even at the patient's home if urgent health problems make house calls necessary.

This care level includes all the activities focused on disease prevention, health promotion and education, family care and community care. Public information and surveillance activities are performed in

relation to health protection and physical rehabilitation services are also available.

In addition, numerous specific activities are carried out, mostly focusing on particular groups:

- Adolescent health: advice on healthy lifestyles (the use of tobacco, alcohol and other addictive substances), on eating disorders and body image, and the promotion of healthy conduct in relation to sexuality.
- Women's health: family planning, care during pregnancy and the puerperium, early diagnosis of gynaecological and breast cancer, early detection and care of problems related to climacterium.
- Children's health: detection of health problems, nutritional assessment, prevention of sudden infant death syndrome, general information regarding child development, health education and prevention of childhood accidents, guidance in the detection and prevention of sleep and sphincter problems.
- Adult health, risk groups and chronic patients: health status assessment and evaluation of risk factors, advice concerning healthy lifestyles, detection of health problems, education, care for polymedicated patients and those with multiple pathologies.
- Geriatric health: health promotion and disease prevention, detection and care of individuals at risk, home health care for persons with mobility problems.
- Detection and response to gender violence and abuse: especially in minors, the elderly and the disabled.
- Oral health: curative care, diagnostic and therapeutic activities, health promotion, health education.
- Treatment of acute odontology processes, preventive care in pregnant women, preventive measures and care for children.
- Care for terminal patients: comprehensive, ongoing and individualised care provided at the home or at health care facilities.
- Mental health care: promotion of mental health and mental illness prevention activities, detection and response to mental health problems in co-ordination with specialised care.

5.1.1. Physical resources

The SNS has 3,006 facilities known as health centres (*centros de salud*) and 10,116 establishments known as local health facilities (*consultorios locales*), where professionals from the nearest health centre go regularly to see patients in that area, in an effort to bring basic services closer to the population.

Table 5.3. Health centres and local health facilities in Spain, by autonomous community

Autonomous community	Health centres			Local health facilities		
	2009	2010	2011	2009	2010	2011
Andalucía	390	405	408	1,116	1,112	1,111
Aragón	117	119	119	915	872	873
Asturias	68	68	68	151	150	150
Baleares	57	57	57	103	103	105
Canarias	108	108	108	155	155	155
Cantabria	42	42	41	121	106	106
Castilla y León	243	244	246	3,647	3,661	3,651
Castilla-La Mancha	200	200	202	1,113	1,111	1,105
Cataluña	415	415	424	831	827	832
Comunidad Valenciana	259	265	275	583	589	581
Extremadura	110	110	107	414	413	413
Galicia	390	391	393	93	88	83
Madrid	258	258	260	158	158	158
Murcia	79	80	81	189	190	186
Navarra	54	54	56	244	244	248
País Vasco	135	135	135	185	185	185
La Rioja	19	19	19	174	174	174
Ceuta y Melilla	7	7	7	0	0	0
Total	2,951	2,977	3,006	10,192	10,138	10,116

Source: Ministry of Health, Social Services and Equality. Primary Care Information System (SIAP)

5.1.2 Human resources

Over 35,000 doctors work at SNS health centres and local health facilities (around 29,000 general practitioners and just over 6,000 paediatricians), of whom half are women (5 out of 10). Also working in these establishments are 29,000 nurses, of whom 8 out of 10 are women.

Table 5.4. Human resources in public sector Primary Care: doctors and nurses. Total, rate per 10,000 SNS users and percentage who are women

	2009		2010		2011		
	Total	Rate per 10,000 inhab.	Total	Rate per 10,000 inhab.	Total	Rate per 10,000 inhab.	% who are women
Doctors	34,642	7.4	34,966	7.5	35,167	7.6	51.7
Family Medicine	28,405		28,641		28,743		
Paediatrics	6,237		6,325		6,424		
Nursing	28,660	6.2	28,970	6.2	29,407	6.3	76.7

Source: Ministry of Health, Social Services and Equality. Primary Care Information System (SIAP)

The rate of primary care doctors per 10,000 SNS users is 7.6 and the rate of nurses is 6.3.

Figure 5.1. Human resources in public sector Primary Care: rate of doctors per 10,000 SNS users

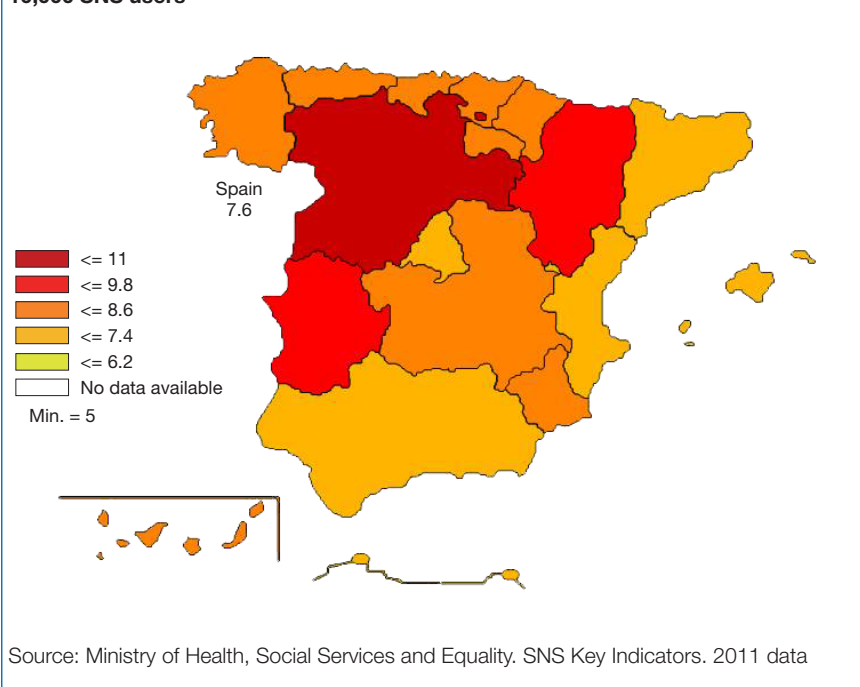
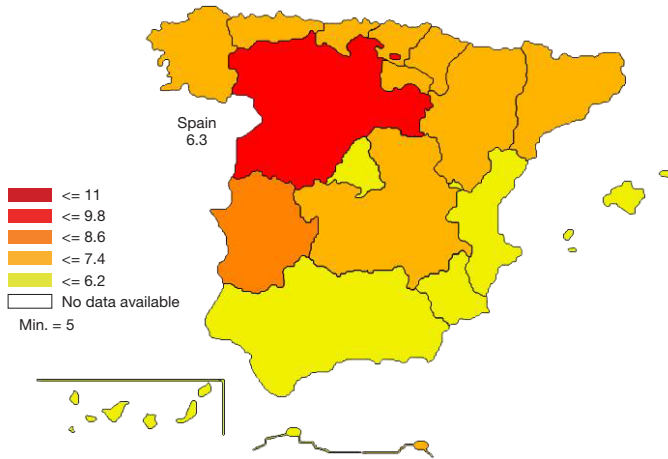


Figure 5.2. Human resources in public sector Primary Care: rate of nurses per 10,000 SNS users



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. 2011 data

Table 5.5. Human resources in public sector Primary Care: doctors and nurses per autonomous community

Autonomous community	Family medicine			Paediatrics			Nursing		
	2009	2010	2011	2009	2010	2011	2009	2010	2011
Andalucía	4,748	4,836	4,837	1,098	1,128	1,130	4,437	4,639	4,922
Aragón	990	998	998	167	169	171	933	949	941
Asturias	670	670	671	127	128	129	771	744	718
Baleares	525	528	526	141	139	136	545	547	540
Canarias	1,101	1,141	1,159	302	306	309	1,177	1,170	1,193
Cantabria	360	363	368	74	76	79	375	378	381
Castilla y León	2,383	2,384	2,386	287	283	289	2,105	2,110	2,116
Castilla-La Mancha	1,401	1,409	1,413	249	251	253	1,466	1,469	1,476
Cataluña	4,486	4,431	4,499	995	1,005	1,067	5,053	5,016	5,147
Comunidad Valenciana	2,665	2,713	2,724	756	766	777	2,734	2,828	2,828
Extremadura	810	811	812	134	135	135	898	900	901
Galicia	1,888	1,896	1,886	328	324	336	1,819	1,819	1,811
Madrid	3,513	3,524	3,523	875	886	886	3,245	3,280	3,287
Murcia	819	827	828	239	239	240	800	794	817
Navarra	377	379	384	98	101	101	448	452	454
País Vasco	1,382	1,437	1,445	303	320	318	1,570	1,570	1,570
La Rioja	220	226	216	39	44	43	204	225	225
Ceuta y Melilla	67	68	68	25	25	25	80	80	80
Spain	28,405	28,641	28,743	6,237	6,325	6,424	28,660	28,970	29,407

Source: Ministry of Health, Social Services and Equality. Primary Care Information System (SIAP)

Table 5.6. Human resources in public sector Primary Care: percentage who are women, by autonomous community

Autonomous community	Family Medicine	Paediatrics	Nursing
Andalucía	43.3	60.1	63.3
Aragón	45.3	71.9	86.5
Asturias	53.7	65.9	83.6
Baleares	46.4	61.0	92.2
Canarias	47.5	65.0	d.n.a.
Cantabria	47.3	69.6	86.6
Castilla y León	43.7	69.6	84.2
Castilla-La Mancha	41.6	63.2	67.2
Cataluña	d.n.a.	d.n.a.	d.n.a.
Comunidad Valenciana	45.8	69.9	72.1
Extremadura	39.9	64.4	66.4
Galicia	45.1	66.7	80.7
Madrid	67.8	75.8	85.0
Murcia	43.7	62.1	64.6
Navarra	52.6	79.2	94.5
País Vasco	51.0	65.7	91.3
La Rioja	39.9	72.1	91.6
Ceuta y Melilla	32.4	44.0	81.3
Spain	48.4	67.1	76.7

Remarks: d.n.a.: data not available

Source: Ministry of Health, Social Services and Equality. Primary Care Information System (SIAP) 2011 dat

5.1.3. Activity

The overall annual rate of visits per inhabitant to SNS primary care facilities is 6.0, which means that around 259 million consultations are attended at health centres and local health facilities every year.

If the urgent care provided outside of normal working hours is taken into account, the number of consultations reaches 279 million. And if nursing activity is calculated along with medical activity, the volume exceeds 418 million.

Table 5.7. Care activity in public sector Primary Care: number of consultations and rate of visits by SNS users per year

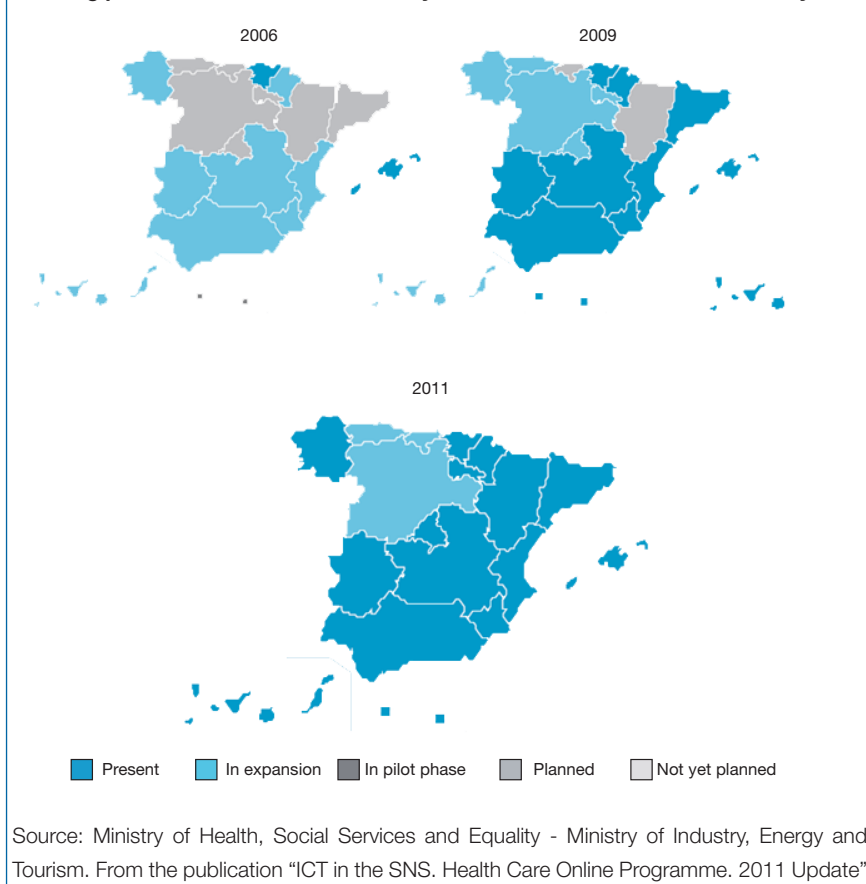
Rate of visits by SNS users per year				No. of consultations
	2009	2010	2011	2011
In normal PC hours				
Medicine	5.6	5.4	5.5	258,775,162
Family Medicine	5.6	5.5	5.6	223,643,239
Paediatrics	5.3	5.2	5.4	35,131,923
Nursing	2.9	2.8	2.8	131,578,006
Outside of normal hours: PC emergencies				
Medicine	0.5	0.5	0.5	20,180,146
Nursing	0.3	0.3	0.3	7,880,262
Total				
Medicine	6.1	5.9	6.0	278,955,308
Nursing	3.2	3.1	3.1	139,458,268

Source: Ministry of Health, Social Services and Equality. Primary Care Information System (SIAP)

Care-giving activity in Primary Care makes considerable use of Electronic Health Records (EHR). According to the 2011 Health Care Barometer, the vast majority of general practitioners (almost 9 out of 10) check their patients' health records on the computer, while just 2.2% continue using paper records and 3.7% use both systems.

Similarly, in 2011 fourteen autonomous communities and INGESA (the institute that manages the health care services provided in Ceuta and Melilla) have a Primary Care EHR system that can be consulted from any health centre within that community.

Figure 5.3. Evolution of health records in Primary Care: implementation of systems enabling patient EHR to be consulted anywhere in the autonomous community



In the year 2011 efforts were devoted to furthering the project called Electronic Health Records in the SNS (EHR-SNS), the purpose of which is to guarantee accessibility, by citizens and health professionals, to the clinical documentation that is most relevant for the health care of each patient, regardless of where that information is stored.

5.1.4. Quality and outcomes of Primary Care

Incidence of vaccine-preventable diseases

The systematic vaccination of children has done a great deal to reduce the morbidity and mortality of diseases that can be prevented by vaccination.

The year 2011 marks the 9th anniversary of the European region being declared polio free. However, until wild poliovirus transmission has been eliminated around the world the risk of importation remains present and it is thus important to maintain high rates of vaccination coverage and keep the flaccid paralysis surveillance system active and alert. Polio vaccination coverage in Spain is 97.1%.

The systematic introduction of the vaccine against diphtheria, tetanus and pertussis in 1965 brought a very significant drop in the incidence of these diseases. The last case of diphtheria in Spain was notified in 1986. Since 2000 vaccination coverage has been higher than 95%.

The incidence of tetanus has remained stable over recent years, with a rate of 0.02 reported cases for every 100,000 inhabitants.

Despite high vaccination coverage against parotitis, in 2010 and 2011 an increase in the incidence of this disease was observed. The number of cases went from 6.0 per 100,000 inhabitants in 2010 to 10.0 per 100,000 in 2011, apparently indicating the beginning of a new epidemic wave. The cases appear mainly in adolescents and young adults who have been correctly vaccinated with two doses of the combined MMR vaccine. A similar situation is occurring in other European countries and the U.S. The limited effectiveness of the vaccine and the fact that protection wanes over time are allowing parotitis to follow its cyclical presentation, just as it did in the pre-vaccine period, with epidemic waves every 3 or 4 years.

In 2011 the number of reported measles cases was eleven times higher than in 2010 (3,512 reported cases, which constitutes a rate of 7.4 cases per 100,000 inhabitants, compared to 302 cases and an incidence of 0.7 cases per 100,000 inhabitants).

In general, the outbreaks originated in unvaccinated groups of children, some belonging to marginal populations and others belonging to families who are against vaccination.

The objective of eliminating measles and rubella from the WHO European Region, which was put back to the year 2015, requires attaining and maintaining high vaccination coverage and reinforcing epidemiological surveillance.

In 2011 there were 11 confirmed cases of rubella, nine of which were laboratory-confirmed and two were clinically compatible. The average incidence of rubella at the national level was 0.02 cases per 100,000 inhabitants. No outbreaks or imported cases were reported. No cases of congenital rubella syndrome were reported.

In the case of pertussis, incidence varies from year to year, showing the cyclical pattern lasting 2-3 years that is the typical behaviour of this disease. In 2011 a total of 3,240 cases were reported, representing a rate of 7.0 report-

ed cases per 100,000 inhabitants. In recent years pertussis has been a cause of concern because of the increasing frequency and severity of the illness in nursing babies and due to the number of cases detected in vaccinated children.

Table 5.8. Vaccine preventable diseases: reported cases and rates per 100,000 inhabitants

	Reported cases			Rate of reported cases per 100,000 inhabitants		
	2009 inhabitants	2010	2011	2009	2010	2011
Diphtheria	0	0	0	0.0	0.0	0.0
Parotitis	2,172	2,705	4,615	4.8	6.0	10.0
Poliomyelitis	0	0	0	0.0	0.0	0.0
Rubella	30	12	11	0.1	0.0	0.0
Measles	44	302	3,512	0.1	0.7	7.4
Tetanus	9	11	10	0.0	0.0	0.0
Pertussis	538	884	3,240	1.2	1.9	7.0

Source: Carlos III Health Institute. Institute of Epidemiology. Epidemiological bulletins

In Spain chickenpox was included in the list of notifiable diseases in 1904. These diseases had to be reported to what was called the weekly numerical declaration (total weekly number of cases showing commencement of symptoms). In 1997 a plan for individualised notification of chickenpox and herpes zoster was developed, but chickenpox surveillance is not yet consolidated at the national level. In 2011 a total of 136,823 cases of chickenpox were reported to the numerical declaration. This figure reflects an average incidence of 289.3 per 100,000 inhabitants; in 2010, the figure was 157,114, which is a rate of 374 cases per 100,000 inhabitants.

The data appearing in this section was taken from the Epidemiological Commentary on Mandatory Notification and the Microbiological Information System of 2011, published in the Weekly Epidemiological Bulletin (*Boletín Epidemiológico Semanal*) prepared by the National Epidemiological Centre of the Carlos III Health Institute.

Vaccination coverage against seasonal flu in the elderly

The flu is a common infectious disease that affects people of all ages and can have a major impact on the population's health as well as on the health care system.

Flu vaccination in risk groups and in elderly chronic patients offers a safe and effective means to prevent the flu and also to reduce its epidemiological impact, along with the risk of serious complications and death.

Seasonal flu vaccination in persons aged 65 and over has fallen in recent years, although the percentage of coverage is still almost 60%. In the 2011-2012 season over 5 million elderly persons were vaccinated, which constitutes coverage of 57.7%.

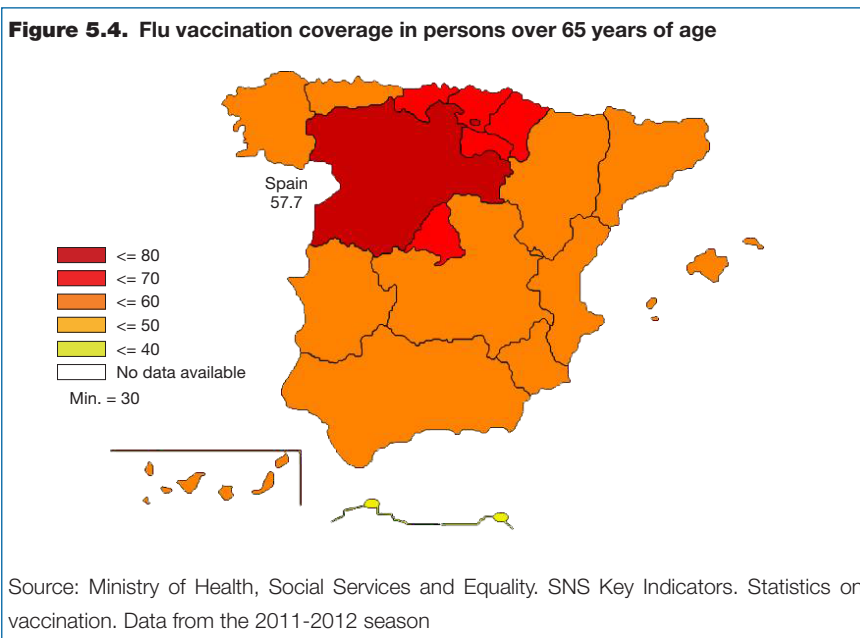


Table 5.9. Percentage of flu vaccination coverage in population aged 65 and over

	2009/2010 season	2010/2011 season	2011/2012 season
Total	65.7	56.9	57.7

Remarks: no data available for Ceuta

Source: Ministry of Health, Social Services and Equality, SNS Key Indicators. Vaccination statistics report

Rate of hospitalisation due to acute diabetes complications

The reduction in the need for hospitalisation as a consequence of good prior control of certain illnesses does not measure only the care provided at the primary care level, but rather all the care provided on an ambulatory

basis (which can be both primary and specialised). Although there are variations due to the patient's individual factors, Primary Care plays a relevant role in the control of a series of pathologies, such as diabetes.

The rate of hospitalisation due to acute diabetes complications is 2.8 discharges for every 1,000 diabetics (2.9 in males and 2.7 in females).

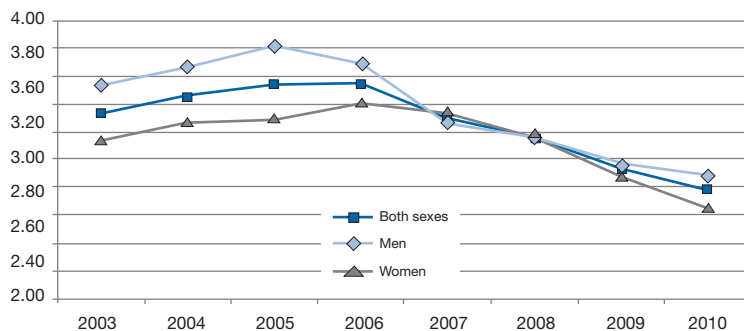
Table 5.10. Rate of hospital discharges for acute diabetes complications, per 1,000 diabetics

	2008	2009	2010
Both sexes	3.2	2.9	2.8
Men	3.2	3.0	2.9
Women	3.2	2.9	2.7

Source: Ministry of Health, Social Services and Equality. Minimum Data Set (MDS) on discharges at SNS hospitals

A clear decline in hospital admissions due to severe decompensation in diabetic patients has been evident in recent years, and the differences between the sexes also seem to be disappearing.

Figure 5.5 Rate of hospital discharges due to acute diabetes complications per 1,000 diabetics



Source: Ministry of Health, Social Services and Equality. MDS on discharges at SNS hospitals

Satisfaction with the care received in Primary Care consultations

Citizen opinion of the organisational and specifically care-related aspects of the care received was studied by the Health Care Barometer, which analyses 15 organisational and care-related components of the care provided in consultations.

Table 5.11. Assessment of the care provided in Primary Care consultations

	2009	2010	2011
Nearness of the facilities	7.7	7.9	8.1
Working hours of the facilities	7.2	7.4	7.6
Interactions with the health personnel	7.4	7.5	7.8
Care received at home, in house calls made by medical and nursing staff	7.0	7.1	7.3
Amount of time the doctor devotes to each patient	6.6	6.8	7.0
Familiarity with the patient's health history and monitoring of health problems	7.1	7.3	7.5
Ease with which appointments can be made	6.5	6.9	7.1
Confidence and security conveyed by the doctor	7.4	7.5	7.8
Time spent in waiting room prior to being received by the professional	5.6	5.8	5.9
When necessary, the general practitioner refers the patient to a specialist	7.2	7.3	7.4
Technological equipment and resources at the facilities	6.7	6.9	6.9
Information received about the patient's health problem	7.2	7.3	7.5
Advice given by the doctor about diet, exercise, smoking, alcohol, etc.	7.1	7.3	7.4
Time that passes between asking for an appointment and seeing the doctor	6.2	6.4	6.5
Time it takes to receive the results of diagnostic tests	5.2	5.5	5.7

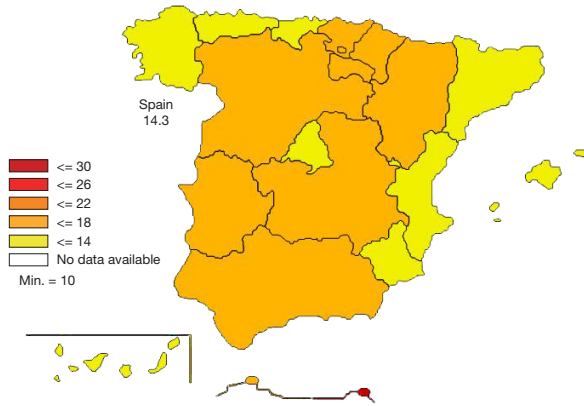
Source: Ministry of Health, Social Services and Equality. Health Care Barometer

If a score of 1 is taken to mean total dissatisfaction and 10 total satisfaction, all components exceed 5.0 and the three highest scoring components are: the proximity of the facilities (8.1), the confidence and security conveyed by the doctor (7.8) and the interactions with the health care personnel (7.8).

5.1.5. Public sector health expenditure in Primary Care

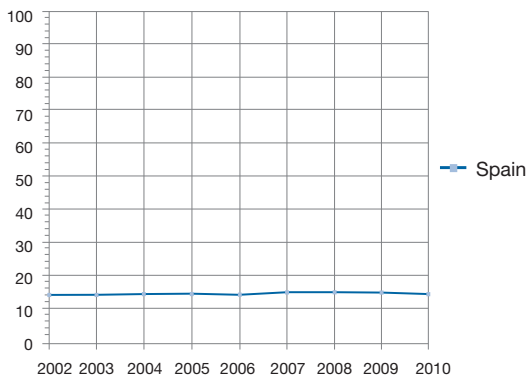
Primary care services account for 14.3% of the public sector's current expenditure on health. These services include the medical and preventive services performed by general practitioners, paediatricians, nurses and other health or non-health personnel at the first level of health care, including the training of residents.

Figure 5.6. Percentage of current expenditure on health that goes to Primary Care services, by each autonomous community



Ministry of Health, Social Services and Equality. SNS Key Indicators. Public Expenditure on Health Statistical Report. 2010 data

Figure 5.7. Changes in the percentage of current expenditure on health that goes to Primary Care services



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Public Expenditure on Health Statistical Report.

5.2. Specialised Care: resources, activity, quality, satisfaction and expenditure

Specialised Care is provided in specialised care centres and hospitals, on an outpatient or an inpatient basis. Following the care process, the patient and the corresponding clinical information return to the Primary Care physician who, because he or she has access to the entirety of the patient's health history, is in a better position to ensure a correct overall clinical and therapeutic vision. This helps make sure that subsequent care is also equitable, regardless of the patient's place of residence or individual circumstances of autonomy, since the care can be delivered even in the patient's home, when necessary.

Specialised Care includes curative, diagnostic, therapeutic care and rehabilitation activities, as well as health promotion, health education and disease prevention activities whose nature requires that they be provided at this level. Specialised Care guarantees the continuity of comprehensive care for patients, once the possibilities of Primary Care have been exhausted and always in co-ordination with the first care level. It is delivered in different ways depending on the patient and the process: in specialised ambulatory consultations, at day hospital and through hospitalisation involving overnight stays.

A patient gains access to urgent care at hospitals – available 24 hours a day for patients experiencing an acute clinical situation requiring immediate attention by hospital services, through a referral by the primary care doctor or specialist or when, for reasons of urgency or when life is in danger, therapeutic measures available only in hospital settings are needed.

Specialised Care encompasses: ambulatory visits with specialists, day hospital, both medical and surgical, overnight hospitalisation, support for primary care services in cases of early discharge and home hospital, palliative care for terminal patients, mental health care and rehabilitation for patients with functional deficits. It also includes intensive care services, anaesthesia and recovery, haemotherapy, rehabilitation, nutrition and dietetics, care during pregnancy, family planning and assisted reproduction.

5.2.1. Hospitals and bed capacities

In Spain there are 790 functioning hospitals (1.8 per 100,000 inhabitants) with a total bed capacity of 162,603 (352.5 per 100,000 inhabitants).

Out of every 10 hospitals, 4 are public and 6 are private, although this proportion inverts when looking at the sector to which the beds belong: of every 10 beds, 7 are public and 3 are private.

By function, 7 out of every 10 hospitals are devoted to acute pathologies, 1 is a psychiatric hospital and 2 are devoted to geriatric and long-term care patients. Of every 10 beds, 8 are found in acute care hospitals, 1 is in a psychiatric hospital and 1 is in a geriatric and long-term care hospital.

In terms of function and sector, 50% of the acute care hospitals and 75% of the acute care beds are found in the public sector. Thirty percent of the psychiatric hospitals and 34% of the beds for psychiatric patients are owned by the public sector, and the figure is very similar in the case of geriatric and long-term care hospitals. Here, 30% of hospitals and 37% of beds are of this type.

Table 5.12. Hospitals and beds by function: total, rate per 100,000 inhabitants and proportion that are public

	Total			Rate per 100,000 inhabitants			% that are public		
	2009	2010	2011	2009	2010	2011	2009	2010	2011
Hospitals	803	794	790	1.8	1.8	1.8	43.7	44.0	44.1
Beds	161,549	161,022	162,603	351.7	349.5	352.5	68.2	68.1	68.3
Acute care									
Hospitals	588	578	577	1.3	1.3	1.3	48.5	49.3	49.4
Beds	132,368	131,832	133,216	288.2	286.1	288.9	75.0	75.1	75.6
Psychiatric care									
Hospitals	91	90	88	0.2	0.2	0.2	34.1	30.0	29.5
Beds	15,259	14,729	14,440	33.2	32.0	31.3	39.2	35.5	33.7
Geriatric and long-term care									
Hospitals	124	126	125	0.3	0.3	0.3	28.2	29.4	29.6
Beds	13,922	14,461	14,947	30.3	31.4	32.3	35.3	37.8	36.6

Source: Ministry of Health, Social Services and Equality. National Catalogue of Hospitals (31 December 2009, 2010 and 2011).

Table 5.13. Hospitals by type and autonomous community

Autonomous community	Public, for civilians	Public, run by the Ministry of Defence	MATEP	Private, charitable	Private, non-charitable	Total
Andalucía	47	1	1	8	48	105
Aragón	18	1	1	2	7	29
Asturias	9	0	0	5	6	20
Baleares	11	0	1	2	8	22
Canarias	14	0	0	2	21	37
Cantabria	4	0	1	2	1	8
Castilla y León	16	0	0	9	12	37
Castilla-La Mancha	21	0	1	0	10	32
Cataluña	55	0	6	54	96	211
Comunidad Valenciana	35	0	2	3	23	63
Extremadura	10	0	0	2	6	18
Galicia	14	0	1	2	22	39
Madrid	33	1	3	12	32	81
Murcia	10	0	1	2	13	26
Navarra	4	0	0	5	2	11
País Vasco	18	0	3	7	16	44
La Rioja	3	0	0	0	2	5
Ceuta	1	0	0	0	0	1
Melilla	1	0	0	0	0	1
Spain	324	3	21	117	325	790

Remarks: MATEP = Insurance Mutuals for Occupational Accidents and Diseases

Source: Ministry of Health, Social Services and Equality. National Catalogue of Hospitals (updated 31 December 2011)

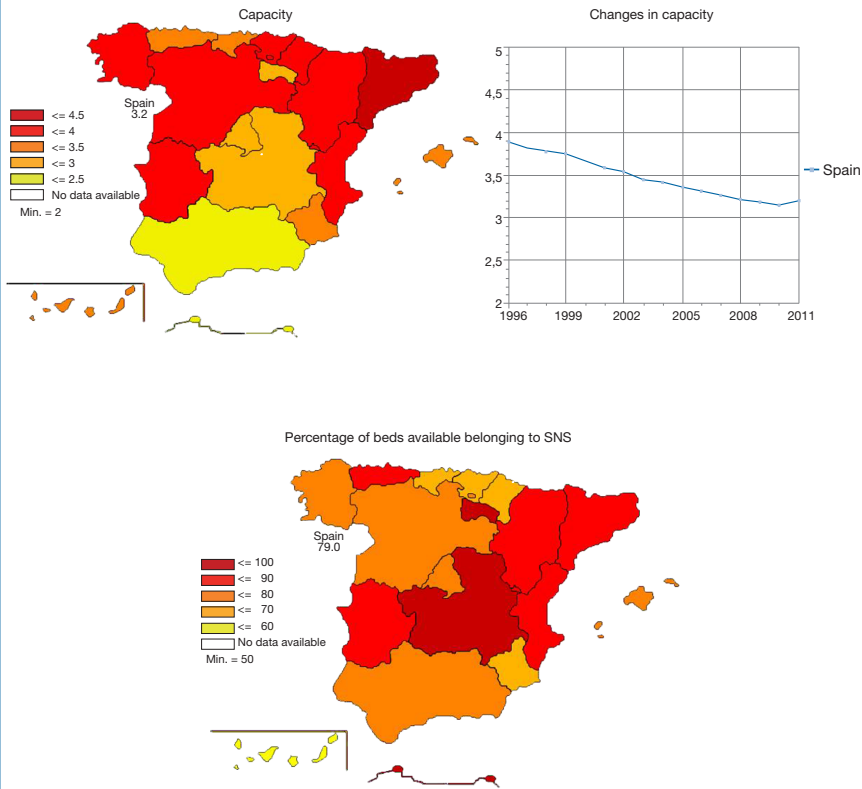
Table 5.14. Bed capacity by type and autonomous community

Autonomous community	Public, for civilians	Public, run by the Ministry of Defence	MATEP	Private, charitable	Private, non-charitable	Total
Andalucía	16,551	225	102	1,351	4,002	22,231
Aragón	4,191	200	157	475	422	5,445
Asturias	3,112	0	0	640	394	4,146
Baleares	2,539	0	40	210	880	3,669
Canarias	4,741	0	0	238	2,683	7,662
Cantabria	1,362	0	30	530	120	2,042
Castilla y León	7,417	0	0	1,412	854	9,683
Castilla-La Mancha	5,297	0	10	0	476	5,783
Cataluña	14,369	0	346	8,796	11,068	34,579
Comunidad Valenciana	11,695	0	258	448	1,847	14,248
Extremadura	3,708	0	0	204	201	4,113
Galicia	7,765	0	14	274	2,165	10,218
Madrid	14,364	520	330	2,383	4,540	22,137
Murcia	3,120	0	30	220	1,277	4,647
Navarra	1,389	0	0	904	121	2,414
País Vasco	5,763	0	116	1,154	1,203	8,236
La Rioja	804	0	0	0	124	928
Ceuta	252	0	0	0	0	252
Melilla	170	0	0	0	0	170
Spain	108,609	945	1,433	19,239	32,377	162,603

Remarks: MATEP = Insurance Mutuals for Workplace Accidents and Work-Related Illnesses

Source: Ministry of Health, Social Services and Equality. National Catalogue of Hospitals (updated 31 December 2011)

Figure 5.8. Beds available per 1,000 inhabitants

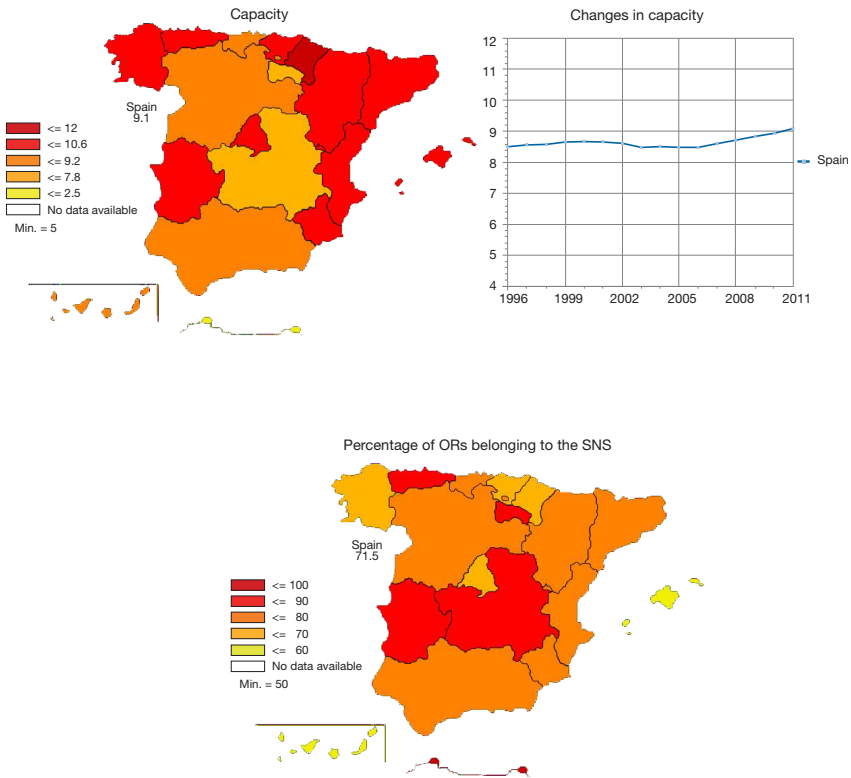


Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Health Establishments Providing Inpatient Care and on Specialised Care Facilities, 2011 (preview edition)

Remarks: the SNS has some facilities that are privately-owned but form part of the *network of hospitals for public use* or have signed an agreement with the SNS by which the facility provides care to the public. The private facility thus makes available all of its care-related activity to the SNS population assigned to it. Normally in such cases a large part of the facility's activity is derived from this agreement.

The reduction in the number of beds being used coincides with the increase in day hospital places for “hospitalisation” lasting just a few hours, whether for diagnostic purposes, clinical research, multiple explorations or treatments that cannot be performed in ambulatory settings but that do not require an overnight stay.

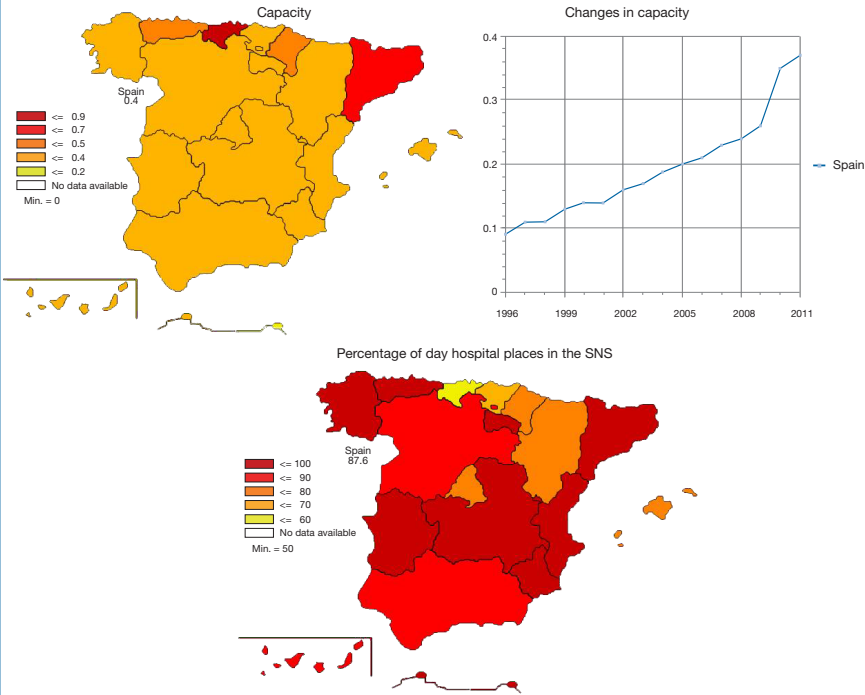
Figure 5.9. Functioning ORs per 100,000 inhabitants



Remarks: the SNS has some facilities that are privately-owned but form part of the *network of hospitals for public use* or have signed an agreement with the SNS by which the facility provides care to the public. The private facility thus makes available all of its care-related activity to the SNS population assigned to it. Normally in such cases a large part of the facility's activity is derived from this agreement

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Health Establishments Providing Inpatient Care and on Specialised Care Centres, 2011 (preview edition)

Figure 5.10. Functioning day hospital places, per 1,000 inhabitants



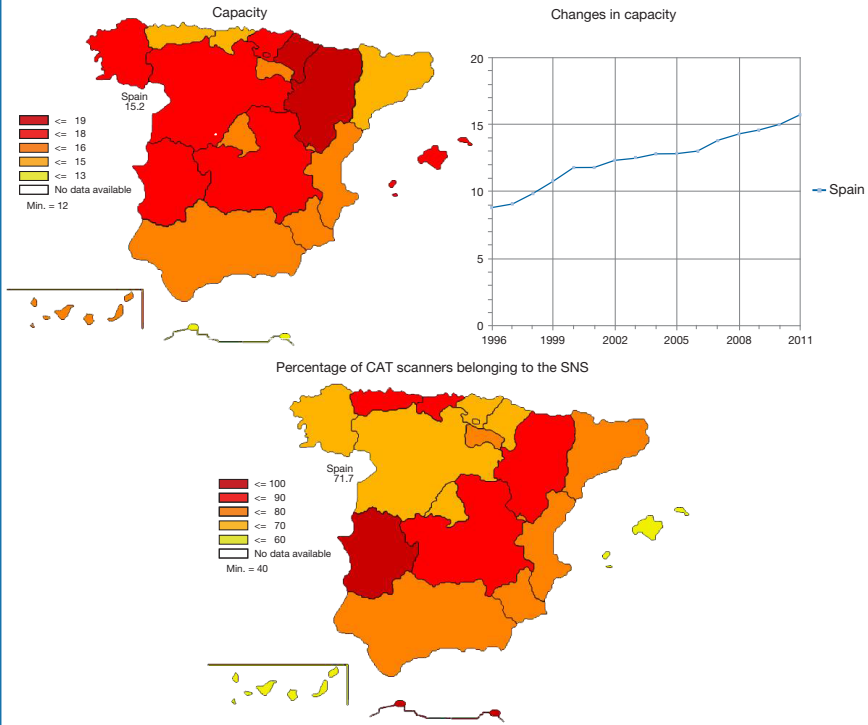
Remarks: the SNS has some facilities that are privately-owned but form part of the *network of hospitals for public use* or have signed an agreement with the SNS by which the facility provides care to the public. The private facility thus makes available all of its care-related activity to the SNS population assigned to it. Normally in such cases a large part of the facility's activity is derived from this agreement.

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Health Establishments Providing Inpatient Care and on Specialised Care Facilities, 2011 (preview edition)

5.2.2. Advanced technology equipment at hospitals and associated centres

Excluding dialysis equipment, Computerised Axial Tomography (CT or CAT) is the most widely-extended advanced technology in hospitals and associated centres, with a total of 699 machines which is 15.2 machines per 1,000,000 inhabitants; it is followed by Magnetic Resonance Imaging (MRI), with 510 machines which is 11.1 machines per 1,000,000 inhabitants.

Figure 5.11. Rate of CAT scanners per 1,000,000 inhabitants



Remarks: the SNS has some facilities that are privately-owned but form part of the *network of hospitals for public use* or have signed an agreement with the SNS by which the facility provides care to the public. The private facility thus makes available all of its care-related activity to the SNS population assigned to it. Normally in such cases a large part of the facility's activity is derived from this agreement.

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Establishments Providing Inpatient Care and on Specialised Care Facilities, 2011 (preview edition)

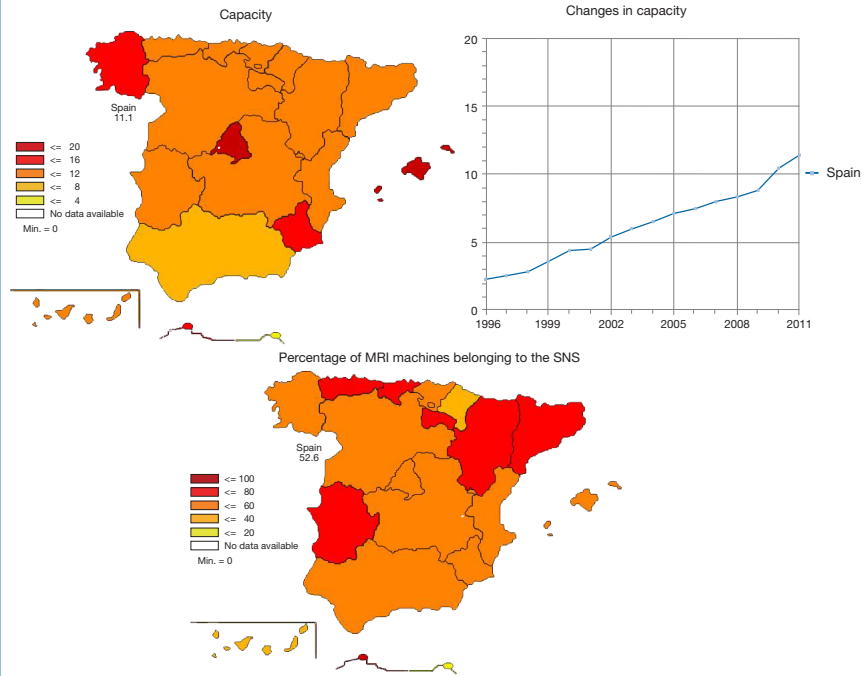
Table 5.15. Advanced technology at hospitals and associated centres, total and rate per 1,000,000 inhabitants

	2009		2010		2011	
	Total	Rate per million inhab.	Total	Rate per million inhab.	Total	Rate per million inhab.
CAT scan	693	14.0	690	15.0	699	15.2
Magnetic Resonance Imaging	459	10.0	492	10.7	510	11.1
Gamma camera	232	5.1	237	5.1	226	4.9
Haemodynamics equipment	227	5.0	233	5.1	242	5.2
Single photon emission computed tomography (SPECT)	57	1.2	63	1.4	68	1.5
Digital angiography	192	4.2	195	4.2	206	4.5
Extracorporeal lithotripsy	93	2.0	93	2.0	94	2.0
Cobalt bomb	30	0.7	28	0.1	26	0.6
Particle accelerator	183	4.0	192	4.2	199	4.3
Positron emission tomography (PET)	46	1.0	55	1.2	57	1.2
Mammographs	508	11.1	563	12.2	572	12.4
Bone densitometers	208	4.5	218	4.8	226	5.0
Haemodialysis equipment	4,105	89.4	4,259	92.4	4,298	93.9

Source: Ministry of Health, Social Services and Equality. National Catalogue of Hospitals 2012 (updated 31 December 2011)

There are 572 mammographs at hospitals and associated centres. Early breast cancer diagnosis facilitates intervention and increases survival rates.

Figure 5.12. Rate of MRI machines per 1,000,000 inhabitants



Remarks: the SNS has some facilities that are privately-owned but form part of the *network of hospitals for public use* or have signed an agreement with the SNS by which the facility provides care to the public. The private facility thus makes available all of its care-related activity to the SNS population assigned to it. Normally in such cases a large part of the facility's activity is derived from this agreement.

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Health Establishments Providing Inpatient Care and on Specialised Care Facilities, 2011 (preview edition)

5.2.3. Human resources

Just over 79,000 doctors work in SNS hospitals and specialised care centres (making the rate 17.2 specialised doctors per 10,000 inhabitants), of whom 4 out of 10 are women. Over 128,000 nurses work at these facilities (making the rate 27.9 per 10,000 inhabitants), of whom 9 out of 10 are women. Looking at the situation in terms of large specialty groups, 5 out of 10 work in a medical discipline, 3 out of 10 work in a surgical discipline, just over 1 out of 10 works in the hospital's central services (clinical analysis, microbiology, radiodiagnostics) and approximately 1 out of 10 works in an emergency room.

Table 5.16. Human resources in public sector Specialised Care: doctors and nurses working in hospitals and specialised care centres. Total, rate per 10,000 inhabitants and percentage who are women

	2008		2009		2010		
	Total	Rate per 10,000 inhab.	Total	Rate per 10,000 inhab.	Total	Rate per 10,000 inhab.	% who are women
Doctors	73,446	16.1	75,997	16.5	79,159	17.2	42.7
Internal medicine and medical specialties	20,571	26.5	21,738	27.0	26,511	27.9	88.4
General surgery and surgical specialties	12,626		12,970		14,306		
Traumatology	4,174		4,235		4,475		
Obstetrics/ Gynaecology	4,369		4,436		4,427		
Paediatrics	3,609		3,836		3,775		
Psychiatry	3,063		3,215		3,125		
Central services	15,621		15,743		12,454		
Intensive medicine	2,440		2,414		2,284		
Rehabilitation	1,336		1,364		1,429		
Urgent care	5,637		6,046		6,373		
Nurses	120,991		26.5		124,080		

Source: Ministry of Health, Social Services and Equality. Statistics on Health Establishments Providing Inpatient Care.

5.2.4. Activity

Every year there are over 5.2 million hospital discharges in Spain. Of them 4.2 million (80.7% of the total) are financed by the SNS.

In addition, every year 82.6 million consultations with different medical specialists take place (87.3% of which are financed by the SNS), 26.2 million emergencies are attended (78.6% are financed by the SNS) and 4.7 million surgical interventions are performed. Of these interventions 1.3 million are major outpatient surgery. Over 479,721 births have been attended at hospitals, of which 121,436 were caesarean deliveries.

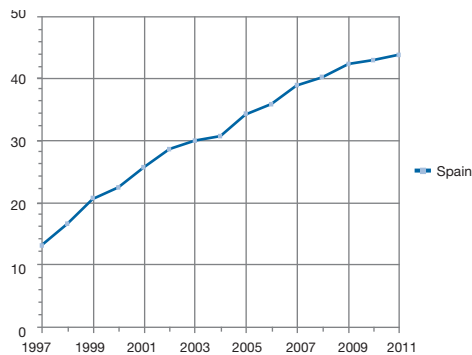
Table 5.17. Medical, surgical and obstetrical activity taking place in hospitals and specialised care centres: total, rate per 1,000 inhabitants and percentage of them financed by the SNS

	2008		2009		2010	
	Total	% financed by SNS	Total	% financed by SNS	Total	% financed by SNS
Discharges (thousands)	5,282.5	78.4	5,269.8	78.7	5,220.6	80.7
Discharges /1000 inhab.	115.9		114.7		113.3	
Consultations (thousands)	79,614.0	86.4	82,142.4	86.2	82,631.6	87.3
Consultations / 1000 inhab.	1,746.2		1,788.5		1793.5	
Urgent care services (thousands)	26,249.1	76.9	26,898.6	77.1	26,206.4	78.6
Urgent care services /1000 inhab.	576.0		585.6		568.8	
Surgical acts (thousands)	4,567.7		4,663.8		4,657.9	
Surgical acts /1000 inhab.	100.2		101.5		101.1	
Major outpatient surgery (thousands)	1,259.3	77.8	1,308.4	79.3	1,352.7	81.1
Major outpatient surgery / 1000 inhab.	27.6		29.0		29.4	
Vaginal births	385,859		364,881		358,285	
Caesarean births	128,255		123,480		121,436	
% caesarean births	24.9		25.3		25.3	
Total births	514,114		488,361		479,721	

Remarks: preliminary results, 2010

Source: Ministry of Health, Social Services and Equality. Statistics on Health Establishments Providing Inpatient Care.

Figure 5.13. Changes in outpatient surgical procedures as percentage of the total number of surgical procedures performed in the SNS



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Health Establishments Providing Inpatient Care and MDS on Hospitalisation and Outpatient Activity in the SNS

Looking at the changes in the share of outpatient surgical interventions in the total number of interventions performed each year, a clear trend towards increased day surgery is evident in the surgical activity taking place within the SNS.

5.2.5. Causes of hospitalisation

Of all discharges in SNS acute care hospitals, 13% are for childbirth, puerperium and complications during pregnancy; this cause represents 25.7% of the total number of visits to acute care hospitals by women.

Other causes of hospitalisation in women, in descending order of importance, are diseases of the circulatory system (11.8%), followed by diseases of the digestive system and those of the respiratory system, with figures of 10.2% and 8.9% respectively. Tumours represent 8.8%.

In men, the most frequent cause of hospitalisation is also diseases of the circulatory system, at 16.9%; followed by diseases of the respiratory system, at 14.7%, and of the digestive system, at 14.4%. Tumours represent 11.2%.

Mental health disorders are the cause of hospitalisation more often in men (2.4% of total discharges) than in women (1.9% of total discharges).

Table 5.18. Hospitalisation in the SNS: discharges by main disease groups, by sex and rate per 10,000 inhabitants

	Women		Men	
	Discharges	Discharges/ 10,000 inhab	Discharges	Discharges/ 10,000 inhab
TOTAL	1,909,188	816.8	1,721,082	758.3
Childbirth, puerperium and complications during pregnancy	467,031	199.8		
Circulatory system	225,551	96.5	291,435	128.4
Digestive system	195,025	83.4	248,302	109.4
Respiratory system	170,779	73.1	253,300	111.6
Tumours	168,673	72.2	192,823	85.0
Injuries and poisonings	150,285	64.3	158,613	69.9
Genital-urinary system	116,885	50.0	100,299	44.2
Osteomuscular system and connective tissue	106,956	45.8	85,718	37.8
Nervous system	55,905	23.9	57,524	25.3
Mental health disorders	35,495	15.2	41,923	18.5

Remarks: Only disease groups with a relative weight of over 2.0% have been included as principal disease groups.

Source: Ministry of Health, Social Services and Equality. MDS on discharges at SNS hospitals, 2010.

5.2.6. Waiting list

Surgical waiting list

As of 31 December 2011, the number of patients on the structural waiting list was over 459,000, which represents an increase in absolute terms of over 67,000 persons with respect to December 2010. In terms of population, the number of patients on a waiting list is 11.7 per 1000 inhabitants.

The structural waiting list consists of patients waiting for a non-urgent surgical intervention the delay of which is attributable to the organisation and to available resources. All such patients are added to a register of patients waiting for an intervention. The date the patient is entered in the register is the date the intervention was ordered by the doctor. As of 31 December 2011, less than 10% of the patients on the list have been on it for longer than six months. The average wait time is 73 calendar days, which is 8 more days than in 2010. The wait time is obtained by calculating the difference between the date the recount takes place and the date of entry on the register.

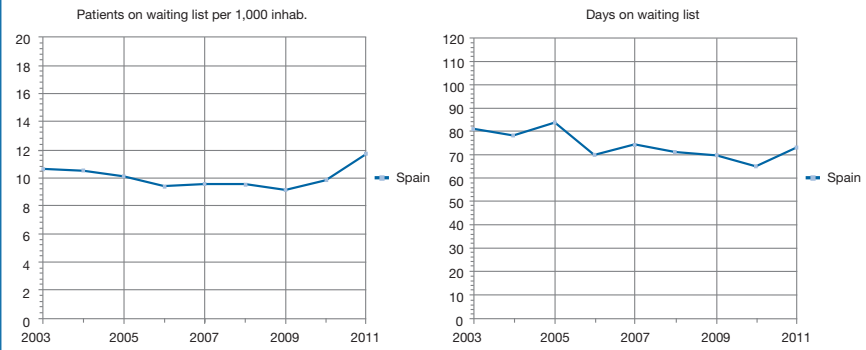
Table 5.19. Situation of the surgery waiting list in the SNS

Specialty	Total patients on structural wait list (*)	No. of patients per 1000 inhab.	% on it more than 6 months	Average wait time (days)
TOTAL	459,885	11.7	10.0	73
General and digestive surgery	87,152	2.2	7.8	71
Gynaecology	22,566	0.6	3.3	56
Ophthalmology	92,541	2.4	12.3	64
ENT	32,921	0.8	7.0	68
Traumatology	126,688	3.2	13.5	83
Urology	31,789	0.8	5.0	63
Heart surgery	2,886	0.1	2.1	67
Angiology/vascular surgery	11,085	0.3	17.2	82
Maxillofacial surgery	6,664	0.2	7.9	82
Paediatric surgery	11,623	0.3	7.5	84
Plastic surgery	13,786	0.4	12.0	98
Thoracic surgery	1,208	0.0	14.3	95
Neurosurgery	7,719	0.2	9.6	90
Dermatology	9,581	0.2	0.1	42

Remarks: * Data from one Regional Health Service not included.

Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS). Data from 31 December 2011

Figure 5.14. Changes in the number of patients on waiting list for non-urgent surgical interventions per 1,000 inhabitants and days of wait



Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS)

Table 5.20. Situation of the waiting list for specialised ambulatory consultations in the SNS

	Number of patients waiting per 1000 inhab.	% given appointment over 60 days after referral	Average wait time
TOTAL	36.1	38.2	58
Gynaecology	2.5	40.6	86
Ophthalmology	6.3	43.8	72
Traumatology	5.6	39.6	53
Dermatology	4.3	41.5	55
ENT	2.0	23.6	39
Neurology	1.7	42.8	58
General and digestive system surgery	1.4	24.2	43
Urology	1.4	35.0	53
Digestive system	1.9	33.9	51
Cardiology	1.3	36.4	57

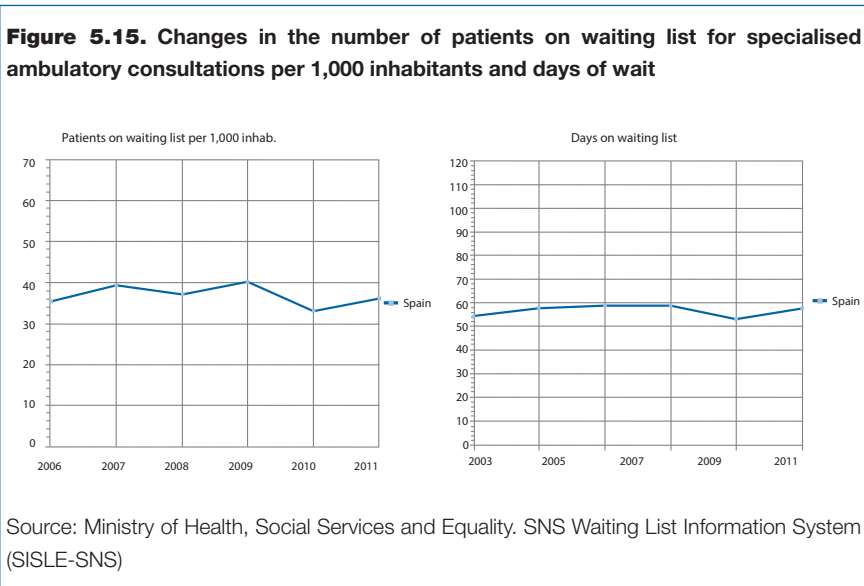
Remarks: this information covers 14 autonomous communities and INGESA; in one autonomous community the data is from June 2011. The basic specialties represent 80% of the total of specialised ambulatory consultations.

Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS). 2011 data

Specialised ambulatory consultations

As of 31 December 2011, the number of patients waiting for an initial consultation in Specialised Care was 36.1 out of every 1,000 inhabitants.

The average wait time is 58 calendar days and about 38% of the cases must wait for more than 60 days between the date the referral was made and the appointment.



5.2.7. Elective Termination of Pregnancy (ETOP)

ETOPs performed in 2011 took place within the new conditions set forth in Spain's recently enacted sexual health and reproduction law (*Ley Orgánica 2/2010, de 3 de marzo de salud sexual y reproductiva y de la interrupción voluntaria del embarazo*) as of the day the law took effect, which was July 5th.

The monitoring and evaluation of the ETOPs performed in Spain takes place through an epidemiological surveillance system that receives information from the entire country. The Ministry of Health, Social Services and Equality analyses the information received.

Each ETOP performed must be reported by the performing doctor to the health authorities of the autonomous community where it takes place, which in turn enters the data in an online application developed by the

Ministry of Health, Social Services and Equality, with the collaboration of the autonomous communities, and which has been operating since January of 2011.

Table 5.21. ETOPs in Spain by age group, by autonomous community

Autonomous community	Total	<15	15-19	20-24	25-29	30-34	35-39	40-44	>44
Andalucía	23,281	111	3,329	5,876	5,480	4,441	2,899	1,040	105
Aragón	2,892	16	309	651	664	629	456	157	10
Asturias	2,713	1	272	507	666	624	479	150	14
Baleares	3,571	9	367	720	862	784	603	212	14
Canarias	6,232	21	707	1,399	1,412	1,273	1,002	382	36
Cantabria	1,185	2	125	222	234	294	221	74	13
Castilla-La Mancha	4,192	14	550	1,009	936	840	598	222	23
Castilla y León	3,582	15	471	769	795	745	556	213	18
Cataluña	21,474	68	2,277	4,341	4,876	4,928	3,601	1,289	94
Comunidad Valenciana	10,589	48	1,404	2,238	2,337	2,365	1,568	567	62
Extremadura	1,657	6	268	424	359	292	209	92	7
Galicia	4,141	14	432	934	902	880	675	263	41
Madrid	20,702	68	2,104	4,512	4,934	4,589	3,237	1,159	99
Murcia	4,561	20	531	1,008	1,061	1,031	650	246	14
Navarra	844	10	106	162	198	186	136	41	5
País Vasco	4,138	10	416	851	1,003	934	649	254	21
La Rioja	495	0	78	96	118	97	73	27	6
Ceuta	24	0	3	5	5	5	3	3	0
Melilla	125	0	17	46	26	15	14	7	0
Non-residents	1,961	22	365	425	405	314	289	125	16
Spain	118,359	455	14,131	26,195	27,273	25,266	17,918	6,523	598

Source: Ministry of Health, Social Services and Equality. Statistics on elective termination of pregnancy. 2011 data

5.2.8. Donation and transplant of solid organs

Organ transplantation is now a common technique in medicine that places those who perform such procedures in the technological avant-garde. Scientific advances are allowing a larger number of diseases to be treated by means of transplant. In Spain, transplant activity is continuous and stable.

The factor that limits transplant activity is the number of donors and organs generated. Spain, with a donation rate of 35.3 for every one million inhabitants, has been and remains a world leader.

In the year 2011 there were 1,667 organ donors in Spain. This donation activity made it possible for over 4,222 solid organ transplants to be performed: 2,498 kidney transplants, 1,137 liver transplants, 237 heart transplants, 230 lung transplants, 111 pancreas transplants and 9 intestinal transplants.

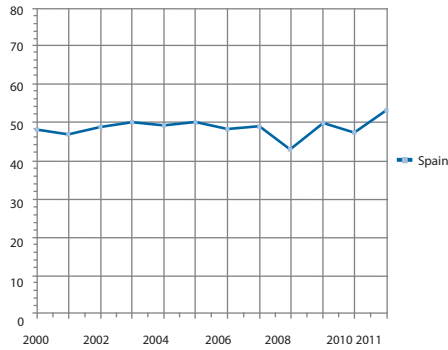
Donation by living donors is also significant, with 312 kidney transplants and 28 liver transplants.

Table 5.22. Solid organ donors and transplants performed: total and rate per 1,000,000 inhabitants

	2009		2010		2011	
	Number	Rate / million inhab.	Number	Rate / million inhab.	Number	Rate / million inhab.
Organ donors	1,606	34.4	1,502	32.0	1,667	35.3
Kidney transplants	2,328	49.8	2,098	47.3	2,498	52.9
(living donor)	235	5.0	240	5.4	312	5.1
Liver transplants	1,099	23.5	971	20.7	1,137	24.1
(living donor)	29	0.6	20	0.4	28	0.4
Heart transplants	274	5.9	217	5.2	237	5.0
Lung transplants	219	4.7	235	5.0	230	4.9
Pancreas transplants	97	2.1	94	2.0	111	2.4
Intestinal transplants	11	0.2	5	0.1	9	0.2

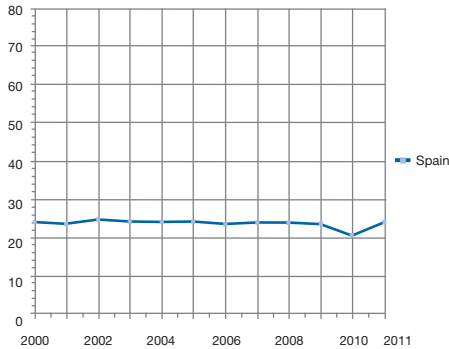
Source: Ministry of Health, Social Services and Equality. National Transplant Organisation (ONT)

Figure 5.16. Changes in rate of kidney transplants per 1,000,000 inhabitants



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. National Transplant Organisation (ONT)

Figure 5.17. Changes in rate of liver transplants per 1,000,000 inhabitants



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. National Transplant Organisation (ONT)

5.2.9. Quality and outcomes of Specialised Care

Rate of caesarean

Out of every 100 births attended in Spain, 25 are caesarean deliveries.

Table 5.23. Rate of caesarean deliveries, per 100 births attended

	2009	2010	2011
SNS	22.1	22.0	21.8
Outside the SNS	37.0	37.9	36.8
Total	25.3	25.3	25.0

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Specialised Care Facilities

There is a clear difference between the rate of caesareans in the births attended by the SNS (about 21 of every 100), and in those attended outside of the SNS (almost 35 of every 100). This difference has been present for over 15 years.

The proportion of caesareans performed within the total number of births attended by the SNS showed continuous growth until 2006, at which time a clear downward trend began.

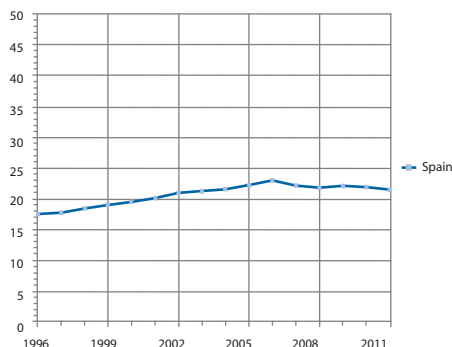
Table 5.24. Rate of caesarean deliveries in births attended by the SNS, by autonomous community

Autonomous community	2009	2010	2011
Andalucía	22.1	22.1	22.1
Aragón	19.0	17.8	18.4
Asturias	21.4	19.0	17.0
Baleares	20.3	20.3	20.5
Canarias	19.6	19.2	20.0
Cantabria	22.4	20.4	18.8
Castilla y León	25.9	25.9	25.6
Castilla-La Mancha	22.8	22.7	23.4
Cataluña	22.6	23.2	23.0
Comunidad Valenciana	24.6	24.2	24.4
Extremadura	28.6	28.0	27.7
Galicia	24.0	23.0	22.6
Madrid	22.5	22.9	21.6
Murcia	21.5	21.7	21.7
Navarra	15.4	15.5	15.7
País Vasco	12.7	12.8	12.6
La Rioja	18.7	19.2	19.1
Ceuta	23.2	22.5	21.6
Melilla	27.7	28.0	29.0
Spain	22.1	22.0	21.8

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Specialised Care Facilities

The figures of the different Regional Health Services vary considerably, from the 28.0% observed in Melilla or the 27.7% observed in Extremadura to the 12.3% of Rioja and the 12.8% of the Basque Country.

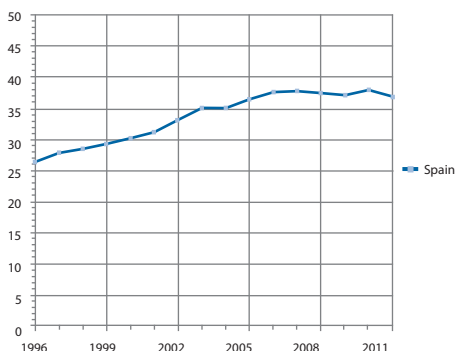
Figure 5.18. Changes in rate of caesarean deliveries in births attended by the SNS



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Health Establishments Providing Inpatient Care and on Specialised Care Facilities

The proportion of caesareans in births not attended by the SNS is higher than in births attended by the SNS; the data illustrate the steady growth of this procedure until 2006, at which time a descent began that has put the figure at around 35%.

Figure 5.19. Changes in rate of caesarean deliveries in births not attended by the SNS



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Health Establishments Providing Inpatient Care and on Specialised Care Facilities

Rate of hip fractures in hospitalised patients

The avoidance of adverse effects in hospitalised patients is a primary concern in Spain's health system. In recent years patient safety has become a major focus in day-to-day care activity. Patient safety indicators refer to events that should happen infrequently, although the occurrence of isolated adverse events does not necessarily mean that a patient safety problem exists.

The rate of in-hospital hip fractures measures the number of discharges with a hip fracture diagnosis in any of the secondary diagnosis codes, out of the total number of discharges.

The figures are very low and stable for both men and women.

Year	Total	Women	Men
1997	0.06	0.06	0.05
1998	0.06	0.06	0.05
1999	0.05	0.05	0.05
2000	0.05	0.05	0.05
2001	0.05	0.05	0.05
2002	0.05	0.05	0.04
2003	0.05	0.05	0.05
2004	0.06	0.06	0.05
2005	0.05	0.05	0.05
2006	0.05	0.05	0.04
2007	0.05	0.05	0.05
2008	0.05	0.05	0.05
2009	0.05	0.05	0.04
2010	0.05	0.06	0.05
2011	0.05	0.05	0.04

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. MDS on discharges at SNS hospitals

Table 5.26. Rate of in-hospital hip fractures, per 100 discharges, by autonomous community

Autonomous community	2009	2010	2011
Andalucía	0.04	0.04	0.04
Aragón	0.04	0.05	0.05
Asturias	0.05	0.04	0.05
Baleares	0.04	0.06	0.05
Canarias	0.03	0.03	0.04
Cantabria	0.06	0.04	0.06
Castilla y León	0.04	0.04	0.05
Castilla-La Mancha	0.06	0.07	0.04
Cataluña	0.04	0.05	0.04
Comunidad Valenciana	0.05	0.05	0.05
Extremadura	0.08	0.06	0.05
Galicia	0.04	0.05	0.05
Madrid	0.06	0.08	0.06
Murcia	0.06	0.06	0.06
Navarra	0.06	0.04	0.06
País Vasco	0.04	0.06	0.05
La Rioja	0.03	0.06	0.06
Ceuta	0.05	0.07	0.03
Melilla	0.03	0.03	0.03
Spain	0.05	0.05	0.05

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators

In-hospital mortality following acute myocardial infarction

The progress made in the diagnosis and treatment of acute problems has brought significant improvements in the prognosis of potentially fatal pathologies. The advances in both medical and surgical interventions and, especially, modern intensive care, have reduced the risk of death and disability. One indicator of care quality is in-hospital mortality following acute myocardial infarction, which measures the number of discharges due to post-infarction death, out of the total number of discharges following acute myocardial infarction.

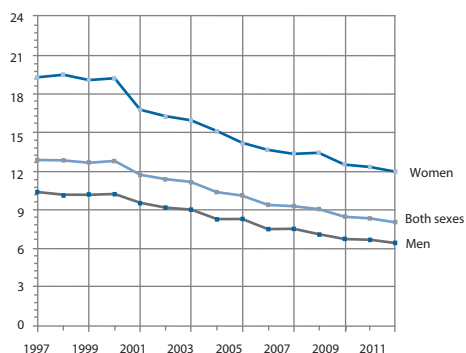
The gross rate by autonomous community shows, in most cases, a downward trend.

Table 5.27. In-hospital mortality following acute myocardial infarction, per 100 discharges for acute myocardial infarction, by autonomous community

Autonomous community	2008	2009	2010
Andalucía	9.9	9.0	8.9
Aragón	9.5	10.4	11.7
Asturias	10.4	10.6	9.3
Baleares	8.3	8.5	7.0
Canarias	7.4	6.4	7.2
Cantabria	8.5	8.3	8.8
Castilla y León	10.3	9.4	8.7
Castilla-La Mancha	8.9	7.2	8.2
Cataluña	8.4	7.9	7.6
Comunidad Valenciana	9.6	8.9	9.4
Extremadura	10.6	10.1	9.2
Galicia	9.0	7.7	7.5
Madrid	7.4	7.2	7.2
Murcia	8.6	8.7	8.4
Navarra	9.4	6.0	5.1
País Vasco	7.6	8.6	7.7
La Rioja	8.9	10.4	7.6
Ceuta	11.7	5.4	9.6
Melilla	7.2	14.8	17.6
Spain	9.0	8.4	8.3

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators

Figure 5.20. Changes in in-hospital mortality following acute myocardial infarction, per 100 discharges for acute myocardial infarction



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. MDS on discharges at SNS hospitals

The trends are clearly favourable, both for men and for women, although the figures for women are much higher. Data from the countries around Spain also tend to show differences between the sexes.

Satisfaction with the care received during hospitalisation

The most highly-valued aspects of the care received during hospitalisation are: the equipment and technological resources offered by hospitals (7.9); the care and attention received by nursing staff (7.4) and by medical staff (7.4) and the information patients receive about the evolution of their health problem (7.4). In all editions of the Health Care Barometer, these four aspects were also the most highly valued.

Table 5.28. Evaluation of the care provided in public hospitals

	2009	2010	2011
Aspects related to food and comfort (meals, bathrooms and general room features)	6.3	6.5	6.6
Administrative paperwork for admission	6.2	6.3	6.5
Wait time in the case of non-urgent admission	4.5	4.7	4.8
Care and attention received by medical staff	7.2	7.2	7.4
Care and attention received by nursing staff	7.2	7.3	7.4
Number of persons sharing a room	5.5	5.7	5.8
Interaction with non-health personnel (orderlies, administrators)	6.9	6.8	7.0
Technological equipment and resources available at the hospitals	7.7	7.8	7.9
Information received about the patient's health problem	7.2	7.2	7.4
Advice given by the doctor about diet, exercise, smoking, alcohol, etc.	7.1	7.1	7.3
Remarks: scores given by both hospitalised and non-hospitalised patients. Scale from 1 ["totally unsatisfactory"] to 10 ["totally satisfactory"].			
Source: Ministry of Health, Social Services and Equality. Health Care Barometer			

The lowest score corresponds to the wait time for non-urgent admission (4.8), the only aspect that received a score lower than 5 points. In past editions of the Health Care Barometer its score has never been higher than 5, the minimum score for being considered acceptable (or approved).

Satisfaction with care received in consultations with specialists

In 2011 the most highly-valued aspects of the care received in consultations with public sector specialists are: the number of specialties to which patients have access (7.6); the equipment and technological resources available at specialised care centres (7.5) and the interaction with health staff (7.4).

The least-valued aspects are related to delays during the care process: the time spent waiting before entering the doctor's office (5.6); the time it takes to receive the results of diagnostic tests (5.0), which receives a passing score for the first time, and the time between asking for an appointment and seeing the doctor (4.9).

Table 5.29. Evaluation of consultations with SNS specialists

	2009	2010	2011
Amount of time the doctor devotes to each patient	6.3	6.5	6.6
Number of specialties available	7.4	7.5	7.6
Time spent waiting before entering the doctor's office	5.5	5.6	5.6
Doctor's familiarity with the patient's health history	6.5	6.6	6.8
Confidence and security conveyed by the doctor	7.0	7.1	7.2
Ease with which appointments can be made	5.4	5.6	5.7
Technological equipment and resources at the facilities	7.3	7.4	7.5
Interactions with the health personnel	7.2	7.2	7.4
Information received about the patient's health problem	7.0	7.1	7.2
Advice given by the doctor about diet, exercise, smoking, alcohol, etc.	6.9	7.0	7.1
Time that passes between asking for an appointment and seeing the doctor	4.8	4.9	4.9
Time it takes to receive the results of diagnostic tests	4.7	4.9	5.0

Remarks: scores given by both hospitalised and non-hospitalised patients. Scale from 1 ["totally unsatisfactory"] to 10 ["totally satisfactory"].
Source: Ministry of Health, Social Services and Equality. Health Care Barometer

Awareness and expectations of citizens regarding delays during care process

The waiting lists continue to be a motive of concern for citizens, indicating that more efforts toward improvement need to be dedicated to this matter.

When citizens are asked what they think of the actions being taken by the health authorities to improve the waiting list situation, 33.2% believe

that something is being done, which is 3.7% less than in 2010. Moreover, 36.3% believe that no action is being taken to improve the situation, while 30.2% say they do not know.

Table 5.30. “Do you think the health authorities are taking action to improve the waiting list situation?”

	2009	2010	2011
Yes	41.3	36.9	33.2
No	35.4	33.5	36.3
Don't know	23.1	29.3	30.2
No answer	0.2	0.3	0.3

Source: Ministry of Health, Social Services and Equality. Health Care Barometer

As regards changes in the waiting lists, the findings show that almost half of the respondents (45.1%) believe that the problem remains the same. Fewer people than before believe that the situation has improved and there are more people who think it has worsened or who have no opinion on the matter.

Table 5.31. “In general, do you think that over the past twelve months the waiting list problem...?”

	2009	2010	2011
Has improved	20.7	21.1	18.2
Has worsened	13.1	11.7	18.2
Is the same	50.8	49.7	45.1
Don't know	15.2	17.3	18.3
No answer	0.1	0.2	0.2

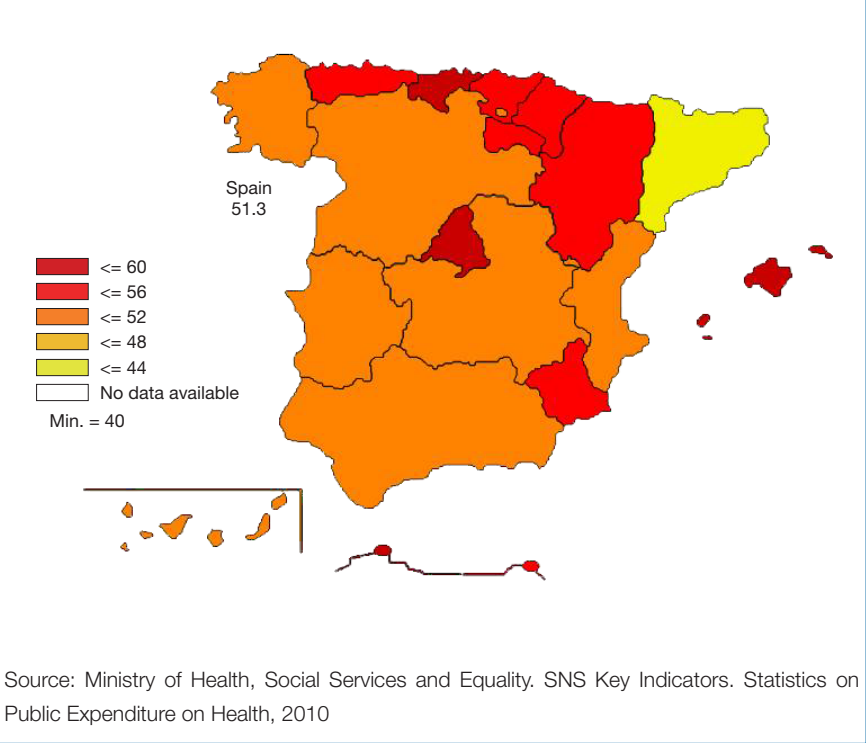
Source: Ministry of Health, Social Services and Equality. Health Care Barometer

5.2.10. Public sector health expenditure in Specialised Care

Hospital and specialised care services account for 51.3% of the public sector's current expenditure on health. This includes the care provided by specialist doctors and other health and non-health personnel the purpose

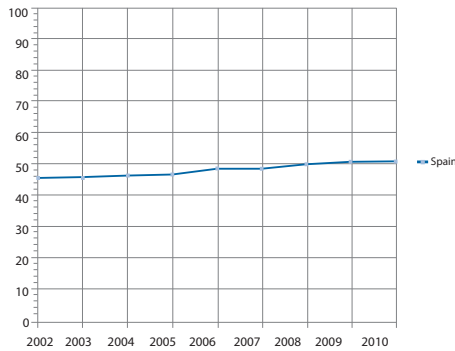
of which is to maintain and improve patient health through care activities performed in hospitals and specialised care centres. It includes the services provided through agreements between the government and private facilities for activities within this care level, and the training of residents. In the past five years the figure has risen by 5 points; in 2002 the percentage was 46.3%.

Figure 5.21. Percentage of public current expenditure on health that goes to Specialised Care services



Public current expenditure on health includes the expenditure financed by the public health care system (excluding capital expenditure), whether the expenditure is incurred by the system’s own resources or by external resources through agreements between the SNS and the private sector.

Figure 5.22. Changes in public current expenditure on health that goes to Specialised Care services



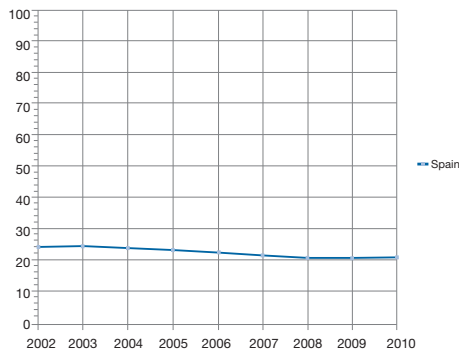
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Public Expenditure on Health.

5.3. Medicines

5.3.1. Expenditure on prescriptions

Public expenditure on medical prescriptions is 20.8% of the total expenditure. This amount does not include the pharmaceutical products dispensed directly in health care facilities. The figure is more than four points lower than the 2002 figure (24.3%), indicating the presence of a downward trend.

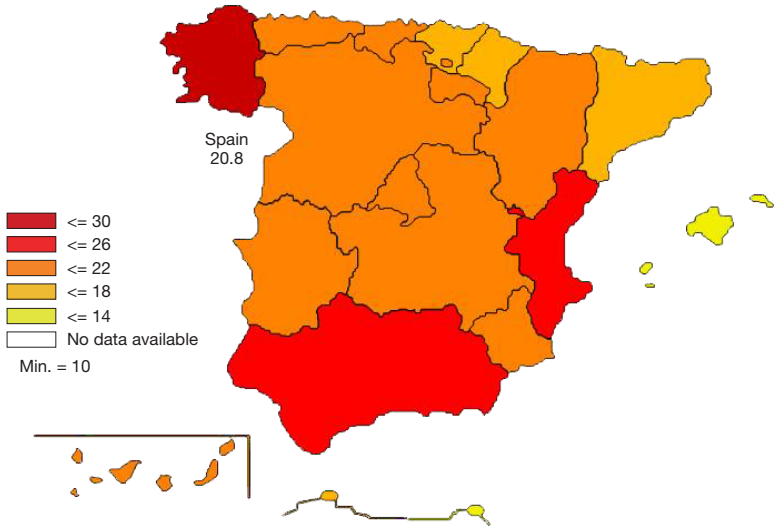
Figure 5.23. Changes in the public expenditure on health that goes to medical prescriptions, as percentage of the public current expenditure on health



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Public Expenditure on Health

The current expenditure includes what is financed by the public system (excluding investments), whether the expenditure is incurred by the system's own resources or by external resources through agreements between the SNS and private facilities.

Figure 5.24. Percentage of public current expenditure on health that goes to medical prescriptions



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Public Expenditure on Health, 2010

The total health expenditure on medicines and health products as a percentage of Spain's Gross Domestic Product (GDP) is 1.8%. The table below shows comparative figures for the EU countries belonging to the OECD.

Table 5.32. Total expenditure on medicines and health products, as percentage of GDP, in the EU countries belonging to the OECD

EU countries	2008	2009	2010
Germany	1.6	1.7	1.7
Austria	1.4	1.4	1.3
Belgium	1.6	1.7	1.7
Denmark	0.8	0.8	0.8
Slovakia	2.2	2.4	2.4
Slovenia	1.5	1.7	1.8
Spain	1.6	1.8	1.8
Estonia	1.2	1.6	1.4
Finland	1.2	1.3	1.2
France	1.8	1.9	1.9
Greece	2.4	d.n.a.	d.n.a.
Hungary	2.3	2.5	2.6
Ireland	1.5	1.7	1.7
Italy	1.6	1.6	1.6
Luxembourg	0.6	d.n.a.	d.n.a.
Netherlands	1.1	1.2	1.1
Poland	1.6	1.7	1.6
Portugal	2.1	2.1	2.0
United Kingdom	1.0	d.n.a.	d.n.a.
Czech Republic	1.4	1.5	1.5
Sweden	1.2	1.3	1.2

Remarks: Greece's figure for 2008 is from 2007. d.n.a.: data not available
Source: OECD Health Data 2012, online database

5.3.2. Consumption of medicines

In recent years the most consumed medicines, in terms of quantity and by group, are those taken for the cardiovascular system (401.5 DDD per 1,000 inhabitants/ per day, or 401.5 DDD/1000/Day), followed by those taken for the alimentary tract and metabolism (231.1 DDD/1000/Day) and the nervous system (226.2 DDD/1000/Day). This information is obtained from the reports on SNS medical prescription invoicing, which indicate the packages dispensed at pharmacies and invoiced to the SNS, measured by the Daily Defined Dose (DDD).

By pharmaceutical, antihypertensives acting on the renin-angiotensin system are the most consumed (158.9 DDD/1000/Day), followed by pharmaceuticals for peptic ulcer and gastroesophageal reflux (116.5, DDD/1000/Day), hypolipidemic agents (82.5 DDD/1000/Day) and anti-depressants (61.2 DDD/1000/Day). These figures indicate, in all cases, an upward trend in recent years.

Table 5.33. Consumption of medicines invoiced to the SNS expressed in Daily Defined Dose per 1,000 inhabitants, grouped by the anatomical/therapeutic/chemical group (ATC) to which they belong

Main groups of the ATC classification	2008	2009	2010
A Alimentary tract and metabolism	216.8	228.9	231.1
Antacids	2.7	2.5	2.4
Pharmaceuticals for peptic ulcer and gastroesophageal reflux	100.8	109.6	116.5
Pharmaceuticals used to treat diabetes	60.4	62.0	55.8
B Blood and blood-forming organs	104.6	108.3	120.8
C Cardiovascular system	373.5	389.0	401.5
Cardiac glycosides	4.9	4.6	4.4
Antiarrhythmic agents, class I and III	3.0	2.9	3.0
Antihypertensive agents	9.1	9.1	9.1
Diuretics	41.9	44.9	44.8
Beta-blockers	20.8	20.8	21.3
Calcium channel blockers	37.8	37.3	36.7
Agents acting on the renin-angiotensin system	145.8	153.1	158.9
Serum lipid-reducing agents	66.7	74.0	82.5
G Genito-urinary system and sex hormones	33.0	34.1	36.1
Sex hormones and modulators of the genital system	10.4	10.2	10.6
H Systemic hormonal preparations, excluding sex hormones and insulins	24.3	25.2	26.3
J Anti-infectives for systemic use	21.7	21.6	20.9
Antibacterials for systemic use	19.7	19.7	19.9
M Osteomuscular system	84.9	88.3	87.7
Non-steroidal anti-inflammatory and antirheumatic products	58.3	60.9	59.8
N Nervous system	207.2	216.8	226.2
Analgesics	32.2	35.0	36.5
Ansiolitics	50.6	51.2	51.9
Hypnotics and sedatives	24.9	25.8	26.8
Antidepressants	55.0	57.7	61.2
R Respiratory system	89.2	93.8	91.6
Drugs for obstructive airway diseases	44.3	45.4	44.1

Source: Ministry of Health, Social Services and Equality. OECD Health Data 2012, online database

The Defined Daily Dose (DDD) is a technical measure that represents the average maintenance dose per day when a drug is used for its main indication in adults.

The pharmaceuticals used to treat diabetes show a consumption level of 55.8 DDD/1000/Day.

The consumption of anti-infective agents for systemic use is 20.9 DDD/1000/Day. The Ministry of Health, Social Services and Equality has organised campaigns – aimed at both doctors and patients – to encourage prudent use of antibiotics, so as to preserve their efficacy and avoid the appearance of bacterial resistance.

Table 5.34. Changes in the consumption of generic medicines as a percentage of the total retail value of pharmaceuticals invoiced to the public health care system, in some EU countries

	Germany	Spain	France	Italy	Portugal	United Kingdom	Slovak Republic
2000	31.9	2.9	d.n.a.	d.n.a.	0.1	20.5	46.3
2001	30.0	4.7	2.9	d.n.a.	0.3	17.0	43.7
2002	29.9	5.2	3.9	d.n.a.	1.9	18.9	40.9
2003	30.4	6.0	5.1	d.n.a.	6.4	22.6	40.5
2004	34.3	6.6	6.4	2.2	9.0	25.0	42.4
2005	34.6	7.4	7.4	3.0	14.0	24.9	40.7
2006	35.9	8.5	8.3	3.4	16.7	27.8	39.1
2007	36.4	9.2	9.3	4.9	19.5	27.3	37.4
2008	36.8	9.2	9.4	6.2	20.2	24.5	38.9
2009	35.9	9.4	10.4	6.0	19.6	26.4	39.4
2010	34.7	10.9	11.5	7.2	d.n.a.	27.6	39.9

Remarks: d.n.a.: data not available

Source: OECD Health Data 2012, online database

Table 5.35. Changes in the consumption of generic drugs as a percentage of the number of packs invoiced to the public health care system, in some EU countries

	Germany	Spain	France	Italy	Portugal	United Kingdom	Slovak Republic
2000	46.7	3.1	d.n.a.	d.n.a.	0.1	65.6	79.6
2001	49.0	5.3	6.0	d.n.a.	0.3	68.5	77.1
2002	50.5	7.0	8.0	d.n.a.	1.3	70.8	75.2
2003	52.6	8.9	10.6	d.n.a.	4.7	71.5	74.5
2004	55.0	12.0	12.5	4.7	6.5	72.5	75.4
2005	59.3	14.1	14.9	5.7	10.4	73.6	75.0
2006	63.6	16.7	17.5	6.4	12.4	68.5	73.7
2007	67.6	20.9	19.5	8.1	14.9	70.8	72.5
2008	70.8	21.8	21.7	10.7	16.9	71.5	69.2
2009	72.4	23.8	22.6	11.6	20.1	72.5	68.2
2010	73.7	27.4	24.5	13.9	d.n.a.	73.6	68.0

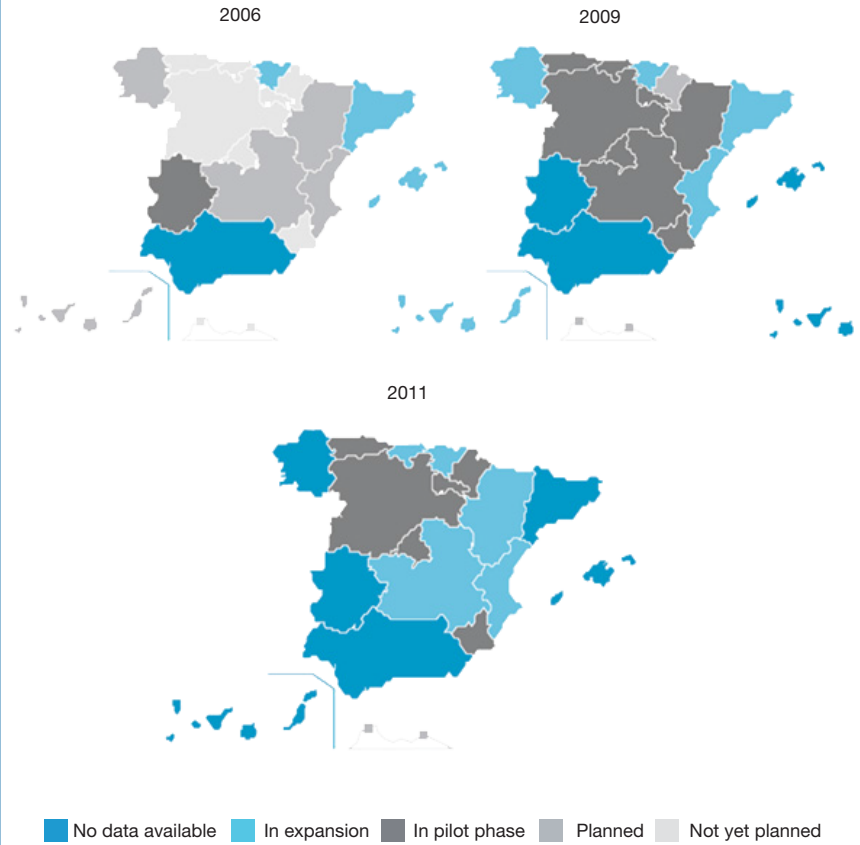
Remarks: d.n.a.: data not available
Source: OECD Health Data 2012, online database

The volume of generic drug consumption in the SNS prescription system is growing year by year and in 2010 it represented 27.4% of the total, which in economic terms is 10.9%. Although the figures, both in consumption volume and in monetary value, are certainly on the rise, Spain is still far from the situation of some of the other European countries.

5.3.3. Citizen awareness of electronic prescribing

In 2011, electronic prescribing is present in the SNS health centres of six autonomous communities, while five autonomous communities are currently in the expansion phase and six are beginning their pilot projects.

Figure 5.25. Changes in the presence of electronic prescribing in SNS health centres



Source: Ministry of Health, Social Services and Equality - Ministry of Industry, Energy and Tourism. From the publication "ICT in the SNS. Health Care Online Programme. 2011 Update"

Without regard to the degree of implementation of electronic prescribing in the various autonomous communities, over half of Spain's citizens (52.2%) know that this type of prescribing system exists, but only 27.8% have used it.

There is still a significant proportion of citizens, 40.6%, that is not aware of its existence.

Yes, I know it exists and I have used it	27.8
Yes, I know it exists but I have never been prescribed any medicines through this system	24.4
It does not exist	7.0
I don't know if it exists	40.6
No answer	0.2

Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2011

5.3.4. Storage of medicines in people's homes

The use of pharmaceuticals is a matter of undeniable importance in health care, both for its repercussions in the expenditure of the SNS and for its potential iatrogenic consequences due to inappropriate use.

One aspect of this matter that is quite well-known by both citizens and health professionals is the storing of medicines that occurs in many homes. These medicines tend to be used without the necessary clinical oversight and on many occasions they expire and end up in the rubbish bin or in a selective pick-up point. But, furthermore, this storing of pharmaceuticals carries with it a superfluous expenditure which, at the very least, could be lowered by reducing the volume of the medicines stored.

To learn more about citizen behaviour in relation to the storing of medicines, in 2011 the Health Care Barometer included three questions on this topic. The findings reveal that people do indeed store medicines at home and they do so in significant amounts.

Practically one quarter of citizens (23.7%) acknowledge that in their homes they have full packages of medicines prescribed by their doctors.

	Total
Yes	23.7
No	75.9
No answer	0.4

Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2011

Table 5.38. "And most of these full packages are...?"	
	Total
Medicines prescribed in advance (so I do not run out)	48.6
Packages that went unused because my treatment was changed	35.3
Medicines that you decided not to take	22.7
No answer	6.3
Remarks: Multiple response question	
Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2011	

Half of the people who store medicines at home were prescribed the products in advance so that they would not run out during their treatment (48.6%). In 35.3% of the cases they accumulated unused medicines because their treatments were changed and 22.7% stored them because they decided not to take them (even though they had been prescribed by their doctors).

Table 5.39. "Approximately how many full packages do you have at home at this time?"	
Fewer than 5	64.4
Between 5 and 10	21.3
Between 11 and 20	6.0
More than 20	1.9
Don't know	1.7
No answer	4.8
Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2011	

Almost 9 out of every 10 people (85.7%) who store medicines have between 1 and 10 full packages.

5.4. Professional training

5.4.1. Specialised health care training

Official training programmes in the health science specialties

In 2011 the official training programme for the specialty of Mental Health Nursing was set forth in Ministerial Order SPI/1356/2011, of 11 May. The order updated the previous training programme and expanded the training period from 1 to 2 years.

Accreditation of teaching centres and units for specialised health care training

In 2011 a total of 358 new accreditation procedures were initiated and 368 were completed, some of which had begun in preceding years.

Table 5.40. Accreditation of teaching centres and units for specialised health care training

	Total
Requests submitted/received	358
Favourable resolutions	368
Initial accreditations	187
Re-accreditations	141
Increases in teaching capacity	31
Incorporation of additional divisions to pre-existing teaching unit	d.n.a.
Reduction in teaching capacity	5
Loss of accreditations	6

Remarks: the favourable resolutions for initial accreditations include new accreditations of centres, units and divisions.

Of the 368 accreditations granted, it is interesting to note that 65 are Multiprofessional Teaching Units (UDM), with a significant increase in the number of places in which to study one of the nursing specialties (EIR) and a reaccreditation of the places in which to study one of the medical specialties (MIR)

d.n.a.: data not available

Source: Ministry of Health, Social Services and Equality. Directorate General of Professional Regulation, 2011

Specialised training offered

The number of student places available for specialised health care training in 2011/12 was published in two ministerial orders:

- Ministerial Order SPI/2549/2011, of 19 September, for doctors, pharmacists, chemists, biologists, biochemists, psychologists and medical radiophysicists.
- Ministerial Order SCO/2548/2011, of 19 September, for the nursing specialties.

Between the 2008/09 academic year and 2011/12 an overall increase of 5.1% was observed in the number of student places available. This growth is due to the incorporation of new nursing specialties and to the consolidation of previously existing nursing specialties (midwifery and mental health). As for medical specialties, the number of places available in this period saw a slight reduction (-1.3%, which in absolute numbers is a total of 90 places).

Table 5.41. Changes in the number of student places for specialised health care training

	2008/09	2009/10	2010/11	2011/12	2008/09- 2011/12 % increase
Doctors	6,797	6,948	6,874	6,707	-1.3
Pharmacists	281	304	298	309	10.0
Chemists	24	31	20	19	-20.8
Biologists	42	39	41	52	23.8
Psychologists	126	131	136	141	11.9
Medical physicists	33	34	34	34	3.0
Nurses	563	611	848	1,002	78.0
TOTAL	7,866	8,098	8,251	8,264	5.1

Source: Ministry of Health, Social Services and Equality. Directorate General of Professional Regulation, 2011

In response to the studies performed in 2007 and 2009 on human resource needs in specialised medicine and in accordance with existing budgetary possibilities, the Ministry and the SNS Human Resources Commission made great efforts during this period to ensure that training for the specialties with shortages received priority and that the number of places in the specialties with surpluses be reduced. In the case of Family and Community Medicine, although this specialty is deemed to have a shortage of practitioners, the number of places fell by 1.7%. This figure must be contextualised in relation to the increase in the number of new general practitioners and of residents being trained in this specialty during this period.

Table 5.42. Changes in the number of student places available for specialised training in specialties with a shortage of professionals

	2008/09	2009/10	2010/11	2011/12	% increase
Anaesthesia and recovery	337	342	342	331	-1.8
Orthopaedic surgery and trauma	213	224	224	231	8.5
Family and community medicine	1,892	1,904	1,919	1,860	-1.7
Obstetrics and gynaecology	260	277	273	266	2.3
Paediatrics and its specific areas	395	410	418	423	7.1
Urology	93	94	99	98	5.4

Remarks: According to the study conducted in 2009

Source: Ministry of Health, Social Services and Equality. Directorate General of Professional Regulation, 2011

Table 5.43. Changes in the number of student places available for specialised training in specialties with a surplus of professionals

	2008/09	2009/10	2010/11	2011/12	% increase
Allergology	58	59	60	57	-1.7
Cardiovascular surgery	29	27	26	20	-31.0
Thoracic surgery	24	25	17	14	-41.7
Haematology and haemotherapy	121	126	123	124	2.5
Physical medicine and rehabilitation	98	102	98	100	2.0
Nuclear medicine	47	48	43	39	-17.0
Nephrology	96	94	93	91	-5.2
Pneumology	110	116	114	110	0.0
Clinical neurophysiology	51	47	38	42	-17.6

Remarks: According to the study conducted in 2009

Source: Ministry of Health, Social Services and Equality. Directorate General of Professional Regulation, 2011

Selective exams and adjudication of student places for specialised health care training

The number of candidates who applied for and were allowed to register for the selective exams held to allocate the places available for the 2010/2011 academic year (Ministerial Orders SAS/2448/2010 and SAS/2447/2010) was 33,746.

Table 5.44. Candidates registered for the 2010/11 exam

Doctors	13,203
Pharmacists	1,278
Chemists	252
Biologists	543
Psychologists	3,113
Medical physicists	286
Nurses	15,071
Total	33,746

Source: Ministry of Health, Social Services and Equality. Directorate General of Professional Regulation, 2011

These figures represent a 24% increase in the number of candidates compared to the preceding year (2009/10), due mainly to the 70% rise in the nursing candidates, thanks no doubt to the high number of student places

available in this training programme (848 places, 38.7% more than the year before).

In the other fields, the number of candidates also increased, albeit to a lesser degree. The exception is medicine, where the number of candidates fell by 2% (13,203 compared to the 13,480 of the 2009/10 exam).

As for distribution by sex, 75.46% of the candidates were women.

With regard to the number of foreign candidates allowed to register for the selective exam for doctors, the 2010/11 exam presented a reduction of 2.05% over the preceding year (6,039 compared to 6,176 for the year 2009/10). Of the candidates for this year's exam, 551 came from countries of the European Union (compared to 539 the preceding year) and 5,488 were from outside the EU (compared to 5,637 in 2009/10). In relation to the non-European candidates, 3,945 had no family ties with EU nationals and did not have a residence permit. This means they could occupy no more than 10% of the total student places available (688), at first call, although the figure could increase to 1,032 positions in the event that a second call was required.

In the period from 30 March to 25 April, the 8,251 student places available for the 2010/11 academic year were adjudicated, with four of the places going unfilled: 1 in medicine, 2 in pharmacy and 1 in chemistry. All four belonged to private centres that have the right to withhold their consent to the candidates, although they did not make use of this option on this occasion.

Table 5.45. Student places allocated for the academic year 2010/11

Doctors	6,873
Pharmacists	296
Chemists	20
Biologists	40
Psychologists	136
Medical physicists	34
Nurses	848
Total	8,247

Source: Ministry of Health, Social Services and Equality. Directorate General of Professional Regulation, 2011

Residents in training

In 2011, a total of 7,777 new residents began their specialised health care training and were added to the National Register of Specialists in Training. In the same period, annual and final evaluations were taken by 26,681 residents in training. A total of 5,914 official certificates of completion of training were

issued and the Ministry of Education, Culture and Sport awarded specialist qualifications to these newly-trained specialists.

5.4.2. Ongoing training

In 2011, Spain's Constitutional Court delivered a judgment (*Sentencia 1/2011, de 14 de febrero de 2011*) on positive conflict of jurisdiction cases 4824-2002, 4825-2002, 4826-2002, 4827-2002 and 4828-2002 and also appeal 1065-2004 challenging the constitutionality of certain legal provisions. These actions had been lodged by the Government of Aragón in relation to various collaboration agreements involving the ongoing training of health professionals and with respect to articles 35.1 and 4 of the 2003 Law on the Regulation of Health Professions [*Ley 44/2003, de 21 de noviembre, de ordenación de las profesiones sanitarias*].

The judgment partially confirms the existence of positive conflicts of jurisdiction and it grants the appeal against the aforementioned provisions. The judgment has the following implications:

- The accreditation, the issue of certificates, the preparation of evaluation and monitoring reports and the evaluation and supervision of the ongoing training activities of health professionals is the jurisdiction of the autonomous communities and therefore the central government cannot delegate them to other public bodies or institutions.
- The accreditation of activities, programmes and out-of-hours care centres is the jurisdiction of the autonomous communities, although the latter must respect the guidelines, criteria and requisites established by the Commission on Ongoing Training.

Actions by the Commission on Ongoing Training in the Health Professions

In 2011, the Commission on Ongoing Training in the Health Professions, in Plenary Session, resolved to prepare a document that would offer a synthesis of all the agreements reached since the body was formed. These agreements address the following questions:

- How to update the procedure, criteria and requisites for the accreditation of ongoing training centres.
- How to update the procedure, criteria and requisites for the accreditation of ongoing training programmes.
- Mutual recognition among the different accreditation systems.

- Proposed procedure, criteria and requisites for the development of Accreditation and Advanced Accreditation diplomas.
- Procedure to follow when training facilities fail an audit: definition of actions to be taken in response to significant discrepancies between the accredited activity and the results of the audit.

Accreditation of second-level training courses in radiological protection for professionals who perform interventional radiological procedures

In 2011, the number of courses seeking accreditation was 19 and the number of professionals who completed such courses was 242.

Accreditation requests	19
Number of autonomous communities seeking accreditation of courses	9
Accreditations granted, following favourable report by the National Commission on Medical Radiophysics	18
Courses in the process of completing the necessary paperwork	9
Courses in the process of completing the complementary paperwork required by the National Commission on Medical Radiophysics	4
Participants that have successfully finished the course	242
Source: Ministry of Health, Social Services and Equality, 2011	

6. Financing and health expenditure

6.1. Initial budgets for health care

Health care is one of the main instruments in Spain's policies of income redistribution: each person pays taxes according to his or her economic ability and receives health services according to his or her health needs.

Health care for common illnesses and non-occupational accidents is a non-contributory benefit financed through taxes and included in the general funding of each autonomous community.

Table 6.1. Initial budget allocations by the central government and the Social Security Institute for health care, in millions of Euros

	2009	2010	2011
Central government and Social Security (CG and SS)			
Central government	2,607.7	2,464.0	1,694.2
Insurance mutuals for civil servants	2,060.5	2,104.7	2,088.4
Social Security	1,828.4	1,935.1	1,635.8
Total CG and SS without consolidation of autonomous communities (AC)	6,496.6	6,503.8	5,418.3
(-)Transfers to AC	1,702.9	1,607.5	898.6
Total CG and SS consolidated with AC	4,793.6	4,896.2	4,519.6

Source: Ministry of Health, Social Services and Equality

For the year 2011 the initial budget allocations of the autonomous communities amounted to €57,408.5 million.

Table 6.2. Initial health care budget in millions of Euros, by autonomous community

Autonomous Community	2009	2010	2011
Andalucía	9,826.5	9,827.4	9,379.1
Aragón	1,879.7	1,907.6	1,849.1
Asturias	1,559.0	1,640.0	1,551.7
Baleares	1,257.5	1,176.3	1,176.3
Canarias	2,929.9	2,857.0	2,540.9
Cantabria	793.6	795.9	729.7
Castilla y León	3,408.7	3,518.6	3,461.6
Castilla-La Mancha	2,852.6	2,918.5	2,814.1
Cataluña	9,426.2	9,888.3	9,200.9
Comunidad Valenciana	5,660.0	5,720.3	5,515.3
Extremadura	1,717.7	1,664.3	1,572.1
Galicia	3,767.1	3,728.8	3,547.3
Madrid	7,122.5	7,081.2	7,134.4
Murcia	1,853.7	1,984.8	2,023.5
Navarra	906.9	986.8	971.9
País Vasco	3,546.4	3,630.3	3,506.2
La Rioja	452.6	412.0	434.3
Spain	58,960.6	59,738.2	57,408.5

Source: Ministry of Health, Social Services and Equality

6.2. Health expenditure

6.2.1. Health expenditure and its relation to the GDP

Spanish data puts public sector health expenditure, including spending on long-term care, at almost 75,000 million Euros. This figure represents 74.2% of the country's total health expenditure, which is nearly 101,000 million Euros. The total health expenditure is 9.6% of the country's GDP. The public sector health expenditure represents 7.1% of the GDP and the expenditure per inhabitant is 1,622 Euros.

Table 6.3. Total health expenditure: public and private in millions of Euros and as percentage of GDP

	2009		2010		2011	
	Millions of Euros	% of GDP	Millions of Euros	% of GDP	Millions of Euros	% of GDP
Public expenditure on health	71,169.6	6.5	75,395.3	7.2	74,732.3	7.1
Private expenditure on health	26,115.7	2.4	25,496.9	2.4	26,008.5	2.5
Total health expenditure	97,285.3	8.9	100,892.3	9.6	100,740.8	9.6

Remarks: these figures follow the SHA (System of Health Accounts) method
Source: OECD Health Data 2012, online database

Looking at public spending on health in terms of function, about half of the expenditure goes to hospital and specialised care services (55.9% and 38,700 million Euros), the second largest proportion is for pharmaceutical benefits (19.3% and 13,380 million Euros) and primary care services take up 15.5% and 10,700 million Euros.

Table 6.4. Public expenditure on health by function

	2009		2010		2011	
	Millions of Euros	% of GDP	Millions of Euros	% of GDP	Millions of Euros	% of GDP
Hospital and specialised care services	36,767	55.2	39,001	55.5	38,700	55.9
Primary health care services	10,444	15.7	10,840	15.4	10,700	15.5
Services related to public health	785	1.2	1,158	1.6	761	1.1
Collective health care services	1,886	2.8	2,044	2.9	2,029	2.9
Pharmacy	12,721	19.1	13,435	19.1	13,380	19.3
Transport, prostheses and therapeutic appliances	1,221	1.8	1,286	1.8	1,339	1.9
Capital expenditure	2,803	4.2	2,564	3.6	2,260	3.3
Total consolidated expenditure	66,626	100	70,328	100	69,169	100

Remarks: these figures follow the methodology used in Spain's Public Expenditure on Health Statistics. The data from years 2009 and 2010 are provisional
Source: Ministry of Health, Social Services and Equality. Public Expenditure on Health Statistical Report

As for the economic classification of the budget items, without including long-term care, 4 out of every 10 Euros of the public sector health expenditure go to the remuneration of employees. In absolute numbers, this amounts to over 31,000 million Euros. Care provided through private facilities with public funds represents 10.6% (7,555 million Euros) of the total expenditure.

The services devoted to public health represent 1.1% of the expenditure. This seemingly small relative amount is the result of accounting system definitions and classifications. Many activities related to public health, disease prevention and health promotion take place at the Primary Care level but are not reflected specifically as such in accounting records.

Table 6.5. Public expenditure on health, composition according to economic classification in millions of Euros and as percentage of total

	2008		2009		2010	
	Millions of Euros	% of total	Millions of Euros	% of total	Millions of Euros	% of total
Remuneration of employees	29,025	42.2	31,329	43.3	31,038	43.6
Intermediate consumption	13,691	19.9	14,640	20.2	13,967	19.6
Consumption of fixed assets	224	0.3	274	0.4	284	0.4
Contracts with private facilities	7,644	11.1	7,538	10.4	7,555	10.6
Current transfers	15,295	22.2	15,834	21.9	16,037	22.5
Capital expenditure	2,949	4.3	2,701	3.7	2,341	3.3
Total expenditure in these sectors	68,828		72,316		71,222	
Intersectorial transfers	2,202		1,989		2,053	
Total consolidated expenditure	66,626	100	70,328	100	69,169	100

Remarks: these figures follow the methodology used in Spain's Public Expenditure on Health Statistics. The data from years 2009 and 2010 are provisional
Source: Ministry of Health, Social Services and Equality. Public Expenditure on Health Statistical Report.

EU Member States (EU-27) spend an average of 9.0% of their GDP, although the figures range from the 12% that the Netherlands, Germany and France spend to the 6% of Estonia and Romania.

Table 6.6. Total health expenditure as percentage of GDP in the EU-27 countries

Countries of the EU-27	Total health expenditure as % of GDP		
	2008	2009	2010
Germany	10.7	11.7	11.6
Austria	10.5	11.2	11.0
Belgium	10.0	10.7	d.n.a.
Bulgaria	7.0	7.2	d.n.a.
Cyprus	6.9	7.4	7.4
Denmark	10.2	11.5	11.1
Slovakia	8.0	9.2	9.0
Slovenia	8.3	9.3	9.0
SPAIN	8.9	9.6	9.6
Estonia	6.0	7.0	6.3
Finland	8.3	9.2	8.9
France	11.0	11.7	11.6
Greece	10.1	10.6	10.2
Hungary	7.5	7.7	7.8
Ireland	8.9	9.9	9.2
Italy	8.9	9.3	9.3
Latvia	6.6	6.8	d.n.a.
Lithuania	6.6	7.5	7.0
Luxembourg	6.8	7.9	d.n.a.
Malta	8.3	8.5	8.6
Netherlands	11.0	11.9	12.0
Poland	6.9	7.2	7.0
Portugal	10.2	10.8	10.7
United Kingdom	8.8	9.8	9.6
Czech Republic	6.8	8.0	7.5
Romania	5.4	5.6	6.0
Sweden	9.2	9.9	9.6
Total EU-27	8.4	9.2	9.0

Remarks: the data from Belgium does not include investments. The EU-27 total is the arithmetic mean.
The figures follow the SHA (System of Health Accounts) method
d.n.a.: data not available
Source: OECD Health Data 2012, online database

Table 6.7. Total health expenditure per inhabitant adjusted for purchasing power parity in the EU-27 countries, in US dollars

Countries of the EU-27	1999	2010
Netherlands	2,178.0	5,056.2
Luxembourg	2,383.8	4,786.0
Denmark	2,410.5	4,463.9
Austria	2,761.7	4,394.8
Germany	2,589.5	4,338.4
France	2,396.0	3,974.0
Belgium	2,047.9	3,968.8
Sweden	2,129.5	3,757.7
Ireland	1,573.6	3,718.2
United Kingdom	1,676.9	3,433.3
Finland	1,741.1	3,250.9
SPAIN	1,450.5	3,076.4
Italy	1,884.7	2,963.7
Greece	1,467.7	2,913.7
Portugal	1,328.8	2,727.7
Slovenia	1,303.5	2,428.5
Malta	1,415.1	2,272.7
Slovakia	598.8	2,095.5
Cyprus	1,079.0	1,972.6
Czech Republic	938.4	1,883.6
Hungary	809.9	1,600.5
Poland	567.5	1,388.7
Estonia	513.9	1,293.8
Lithuania	480.9	1,280.5
Latvia	385.5	1,194.0
Romania	208.3	595.8
Bulgaria	d.n.a.	d.n.a.

Remarks: data ordered by the variable "total health expenditure" (in US dollars) for the year 2010. No data available for Bulgaria. In Cyprus and Latvia, the data is from 2008. In Lithuania, Luxembourg and Spain, the data is from 2009

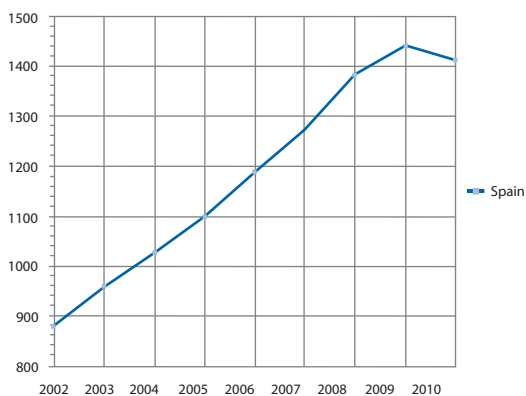
d.n.a.: data not available

Source: WHO (HFA-DB) 2012, online database

6.2.2. Public expenditure on health per inhabitant covered

The public expenditure on health per inhabitant covered of all the public sector health services of the autonomous communities and INGESA (for the cities with statutes of autonomy, Ceuta and Melilla) and the respective regional health administrations is over 1,400 Euros per year, for the year 2010. In 2002 it was 881 Euros.

Figure 6.1. Changes in the public sector health expenditure in the autonomous communities, in Euros per inhabitant covered



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. Statistics on Public Expenditure on Health, 2012

This figure does not include the expenditure incurred by the health services provided by other agents of the central government.

The number of inhabitants covered is considered to be the number of persons appearing in the municipal population records as of 1 January of the year of reference, minus the groups that make use of insurance mutuals for civil servants (MUFACE, MUGEJU and ISFAS) and are thus covered by private insurance companies, as of 31 December of the preceding year.

Table 6.8. Public sector health expenditure by the autonomous communities per inhabitant covered, in Euros

Autonomous Community	2008	2009	2010
Andalucía	1,330.6	1,310.5	1,264.8
Aragón	1,512.1	1,610.8	1,562.4
Asturias	1,481.3	1,661.8	1,589.7
Baleares	1,265.3	1,301.1	1,464.0
Canarias	1,446.3	1,494.3	1,418.4
Cantabria	1,378.1	1,429.1	1,501.0
Castilla y León	1,510.3	1,472.1	1,505.6
Castilla-La Mancha	1,303.7	1,504.7	1,465.2
Cataluña	1,380.4	1,449.5	1,465.5
Comunidad Valenciana	1,273.0	1,353.3	1,380.8
Extremadura	1,616.0	1,695.0	1,666.5
Galicia	1,442.1	1,507.1	1,438.5
Madrid	1,261.0	1,335.0	1,207.2
Murcia	1,581.6	1,646.2	1,609.0
Navarra	1,513.7	1,633.6	1,606.2
País Vasco	1,579.7	1,692.1	1,687.5
La Rioja	1,548.7	1,515.0	1,546.7
Ceuta	1,516.1	1,565.1	1,573.6
Melilla	1,730.4	1,723.7	1,644.0
Spain	1,382.4	1,440.8	1,412.8

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators

7. Health status and lifestyle of the Spanish population

As of 1 January, 2011 Spain's population is 47.2 million inhabitants, with a slight predominance of women (50.7%). The 16 and under age group represents almost 16% of the total, while persons aged 65 and over comprise over 17%.

Table 7.1. The population structure, percentage distribution by age

Age group	Population	% of total
0-15	7,446,863	15.8
16-44	19,729,393	41.8
45-64	11,920,680	25.3
65 and over	8,093,557	17.2
Total	47,190,493	100.0

Source: National Statistics Institute (INE). Official population figures. 2011 data

7.1. Situation in terms of health

7.1.1. Self-assessment of health

The perception that a population has of its health is a good indicator of its health status and of its use of health care services. In the Spanish population as a whole, 2 out of every 10 inhabitants deem their health to be poor or very poor; the data show that men have a better perception of their health than women do.

Figure 7.1. Negative self-assessment of health, percentage distribution

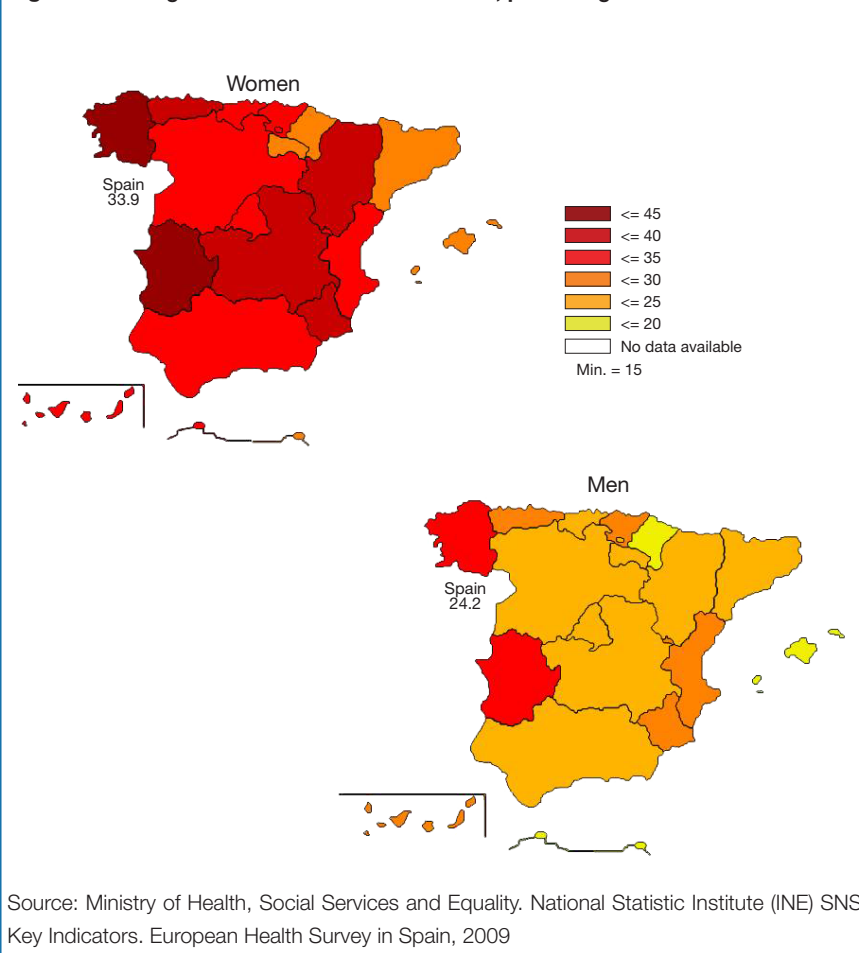


Table 7.2. Negative self-assessment of health: percentage distribution in population as a whole, by sex

	2003	2006	2009
Total	28.7	30.0	29.1
Women	32.9	35.0	33.9
Men	24.3	24.9	24.2

Source: Ministry of Health, Social Services and Equality. National Statistic Institute (INE) SNS Key Indicators. National Health Survey of Spain (ENSE). European Health Survey in Spain

7.1.2. Life expectancy and healthy life expectancy

In the population as a whole, Spain (2010) has a life expectancy at birth of 82.2 years, which is higher than the EU-27 country average of 79.7 years. By sex, the life expectancy at birth for Spanish women and men is 85.3 years and 79.1 years, respectively. For the EU-27 as a whole, the figures are 82.6 for women and 76.7 for men.

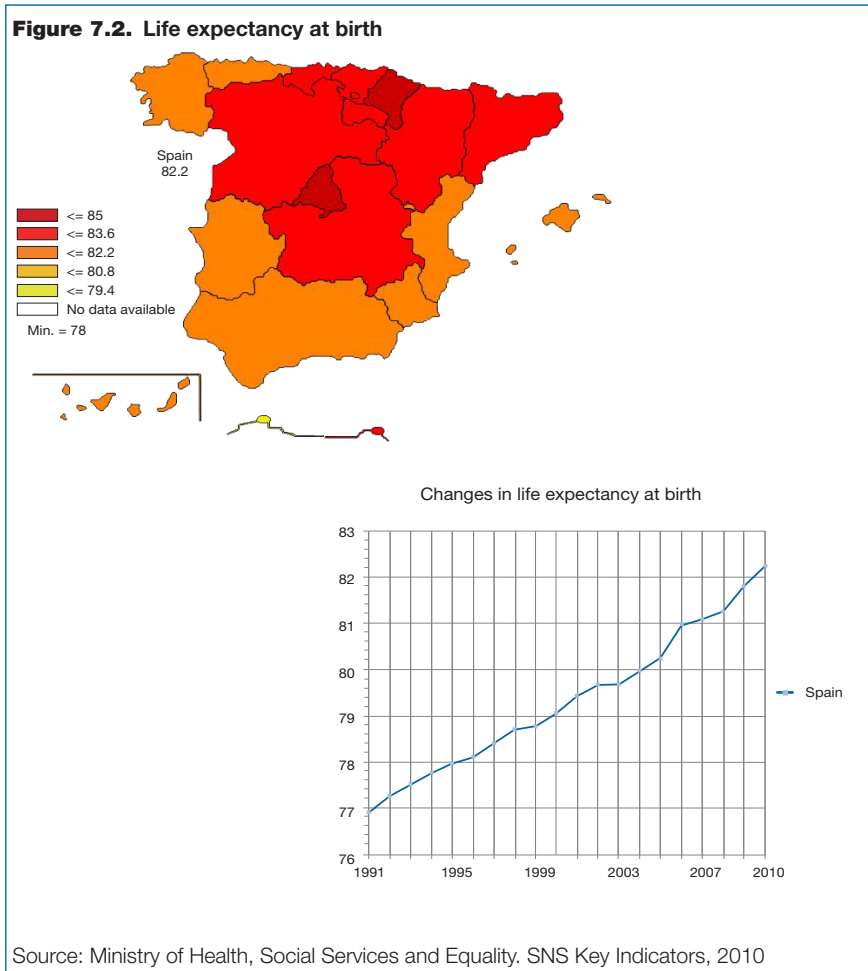
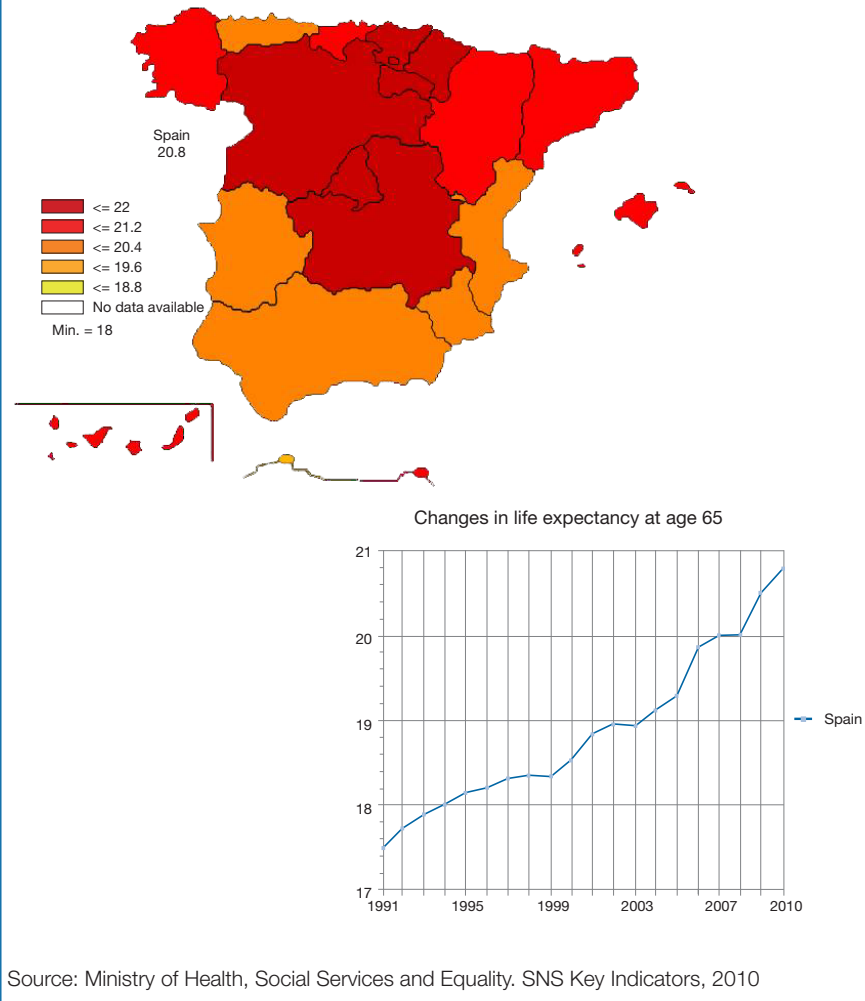


Figure 7.3. Life expectancy at age 65



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators, 2010

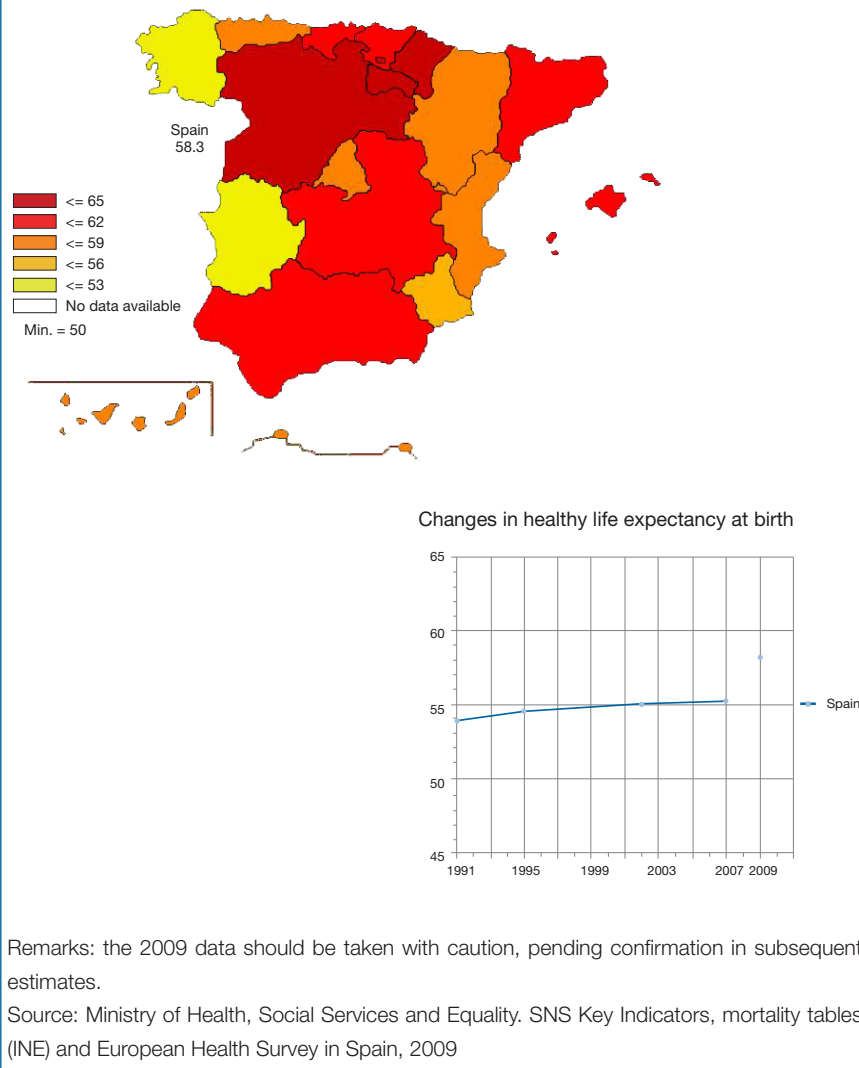
Table 7.3. Life expectancy at birth and at age 65, by sex and autonomous community

	At birth		At age 65	
	Women	Men	Women	Men
EU-27	82.6	76.7	20.9	17.3
Spain	85.3	79.1	22.7	18.6
Andalucía	84.0	77.9	21.5	17.6
Aragón	85.6	79.5	23.1	18.9
Asturias	84.9	77.5	22.5	17.7
Baleares	84.7	79.0	22.1	18.6
Canarias	85.2	79.1	22.7	18.8
Cantabria	86.0	78.6	23.6	18.5
Castilla y León	86.6	79.9	24.0	19.3
Castilla-La Mancha	85.7	80.3	22.9	19.5
Cataluña	85.6	79.4	23.0	18.8
Comunidad Valenciana	84.6	78.8	22.0	18.2
Extremadura	84.4	78.2	22.0	17.9
Galicia	85.4	78.6	22.9	18.6
Madrid	86.6	80.8	23.8	19.6
Murcia	84.7	79.2	21.9	18.4
Navarra	87.0	81.0	23.9	19.8
País Vasco	86.0	79.4	23.6	18.8
La Rioja	86.1	80.5	23.0	19.3
Ceuta	82.0	75.8	20.8	16.9
Melilla	85.1	79.3	22.3	18.3

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. National Statistics Institute. 2010 data

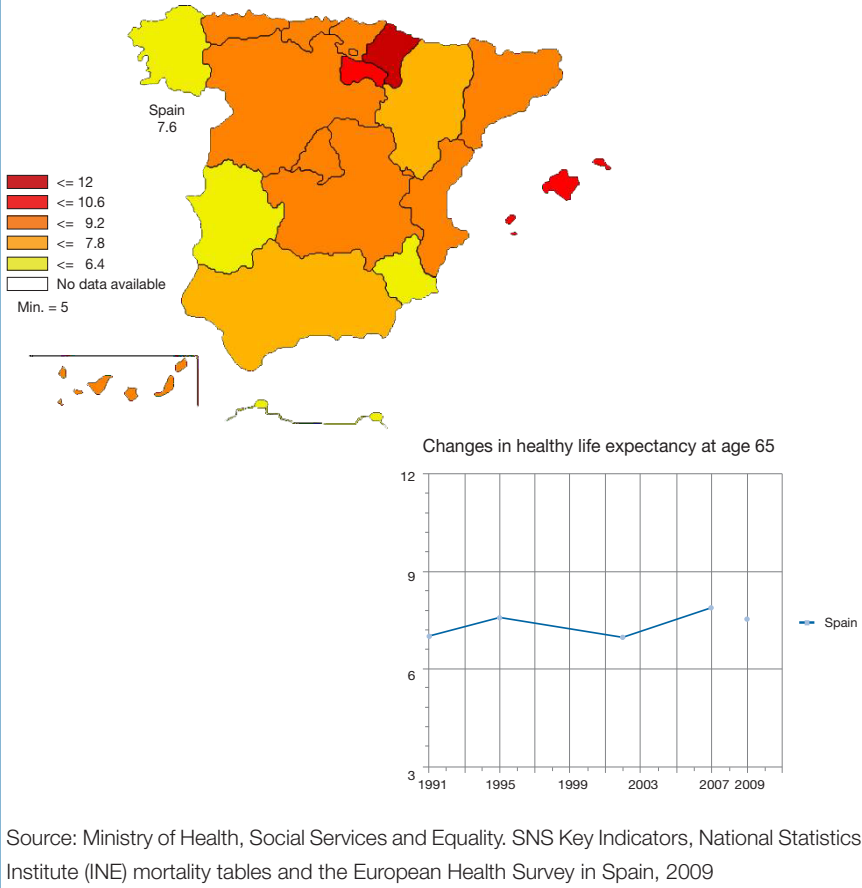
Life expectancy at age 65 shows the same tendency, as the figure for Spain (20.8 years) is higher than for the EU-27 (19.1 years). By sex, at age 65 Spanish women have a life expectancy of 22.7, compared to 20.9 for women in the EU-27 as a whole; in the case of men, 65-year-old Spanish men have a life expectancy of 18.6 compared to 17.3 for men in the EU-27.

Figure 7.4. Healthy life expectancy at birth



The growth seen in the 2009 data may reflect a certain instability in the assessment of perceived health, although methodological questions cannot be ruled out; in both cases, the figures should be taken with caution, pending confirmation in subsequent estimates, when the self-assessment of health data obtained through the National Health Survey 2011/2012 becomes available.

Figure 7.5. Healthy life expectancy at age 65



The 2009 data may be the reflection of instability in the assessment of perceived health, although methodological questions cannot be ruled out. The figures, like that of healthy life expectancy at birth, should be taken with caution, pending confirmation in subsequent estimates, when the self-assessment of health data obtained through the National Health Survey 2011/2012 becomes available.

Table 7.4. Healthy life expectancy at birth and at age 65, by sex and autonomous community

Autonomous community	At birth		At age 65	
	Women	Men	Women	Men
Andalucía	59.1	60.5	6.5	6.7
Aragón	55.6	61.1	6.3	9.1
Asturias	57.5	59.1	7.5	9.5
Baleares	61.2	61.5	10.6	8.3
Canarias	55.3	57.0	7.1	8.6
Cantabria	59.8	61.9	8.5	8.5
Castilla y León	60.6	64.7	8.3	10.2
Castilla-La Mancha	55.8	62.5	6.5	10.7
Cataluña	60.6	60.9	8.4	8.5
Comunidad Valenciana	57.4	57.3	7.3	8.6
Extremadura	49.2	56.2	4.5	7.4
Galicia	51.5	53.5	4.4	6.4
Madrid	56.8	60.9	8.1	8.5
Murcia	50.8	56.3	4.7	6.5
Navarra	63.9	64.1	12.0	10.0
País Vasco	60.5	60.0	8.2	8.8
La Rioja	63.9	62.8	8.9	10.2
Ceuta	56.9	59.7	4.0	7.8
Melilla	56.9	59.7	4.0	7.8
Spain	57.1	59.4	7.1	8.3

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. National Statistics Institute. 2009 data

Healthy life expectancy

Healthy life expectancy refers to the years a person can be expected to live without limitations in his or her daily activity. It is the same as disability-free life expectancy.

A wide range of factors affect life expectancy and the number of years lived in good health: a higher national income (such as the Gross Domestic Product per capita) is generally associated with a higher life expectancy at birth and also a higher healthy life expectancy, although the relation is not as strong in the higher levels of national income. Apart from health expenditure, a number of other factors play a decisive role in the number of years lived in good health; some factors that explain the increase in life expectancy at age 65 include advances in medical care,

better access to health care, healthier life styles and better living conditions before and after age 65. And for both men and women, people with a higher level of education have better chances of living longer.

Recent studies have shown an association between higher levels of education and a higher disability-free life expectancy at age 65, and for both men and for women, the differences were greater in disability-free life expectancy than in life expectancy alone.

In Spain, in 2009, healthy life expectancy at birth was 57.1 years for women and 59.1 for men. By autonomous community, the highest healthy life expectancy figures are found in the women of Navarra and La Rioja (63.9 years in both); and in men they are found in Castilla y León (64.7). The lowest healthy life expectancy at birth for women is found in Extremadura (49.2); in the case of men, it is found in Galicia (53.5).

Healthy life expectancy at age 65 is 7.1 years for women and 8.3 years for men. Women from Navarra have the best healthy life expectancy at age 65 (12 years) while the women of Ceuta and Melilla have the worst (4 years for both). As for men, the healthy life expectancy at age 65 is best in Castilla-La Mancha (10.7 years), while the worst is in Galicia (6.4 years).

The healthy life expectancy, both at birth and at age 65, is lower in women; compared to men, women live more years and a greater proportion of them are lived in poor health.

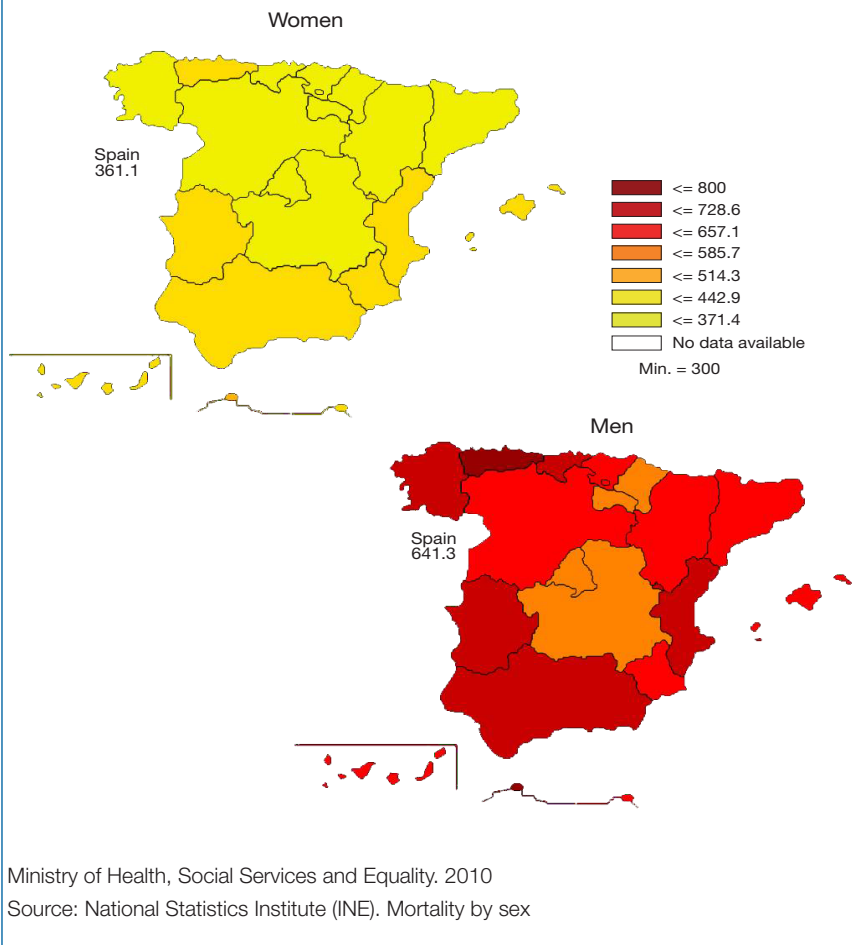
7.1.3. Mortality by leading causes of death

In absolute terms the number of deaths in Spain in 2010 was 382,047 (183,926 women and 198,121 men), with a gross death rate of 829.2 deaths per 100,000 inhabitants (786.8 deceased women out of 100,000 women and 872.9 deceased men out of 100,000 men).

	2008		2009		2010	
	Number of deaths	Rate per 100,000 inhab.	Number of deaths	Rate per 100,000 inhab.	Number of deaths	Rate per 100,000 inhab.
Men	199,647	886.8	199,095	878.2	198,121	872.9
Women	186,677	808.8	185,838	799.0	183,926	786.8
Total	386,324	847.3	384,933	838.1	382,047	829.2

Source: National Statistics Institute (INE). Mortality by cause of death

Figure 7.6. Rate of death per 100,000 inhabitants adjusted by age and sex



Cause of death data show an epidemiological profile that has become a classic in Spain and is much like that of nearby countries with similar socio-economic characteristics: cardiovascular disease, cerebrovascular disease and cancer are the top causes of death. Death due to one of the cardiovascular diseases, the leading cause of death in Spain, represents 31.2% of the total number of deaths.

In the group of cardiovascular diseases, ischaemic heart diseases are the leading cause of death among men (20,226 deaths) and cerebrovascular diseases are the leading cause among women (17,529 deaths).

The tumours responsible for the highest mortality were bronchial and lung cancer (20,755 deaths). By sex, the cancer that caused the most deaths

among men was bronchial and lung cancer (17,303 deaths), while in women it was breast cancer (6,295 deaths)

Table 7.6. Deaths from the leading causes, by sex

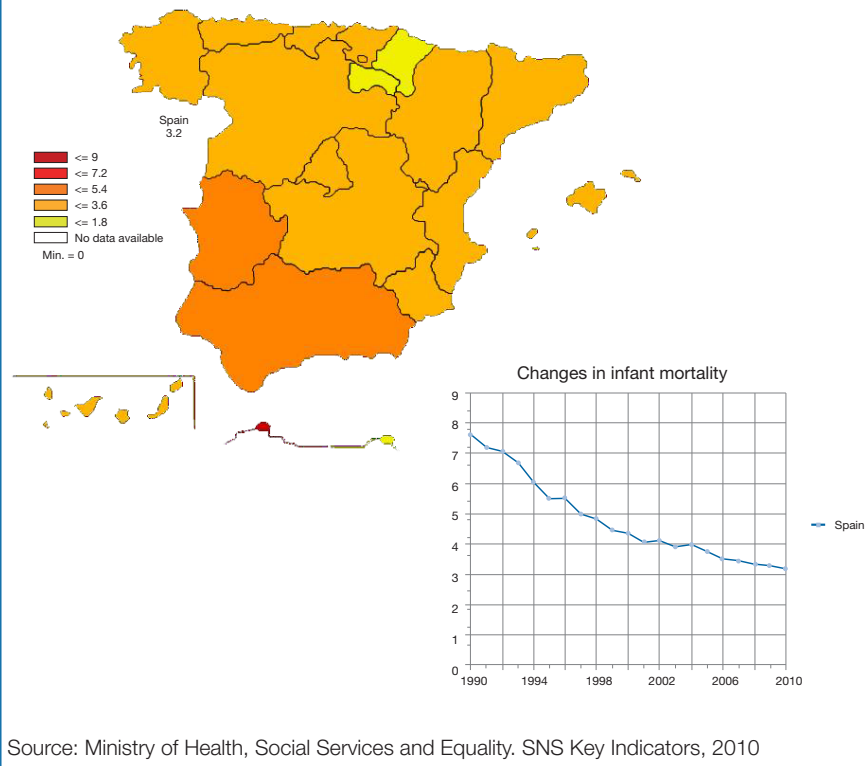
	Both sexes	Men	Women
All causes	382,047	198,121	183,926
Ischaemic heart disease	35,268	20,226	15,042
Cerebrovascular diseases	30,161	12,632	17,529
Malignant trachea, bronchial or lung tumour	20,755	17,303	3,452
Cardiac insufficiency	16,038	5,598	10,440
Chronic lower respiratory disease	15,676	11,644	4,032
Mental health disorders	14,821	5,058	9,763
Alzheimer's disease	11,343	3,426	7,917
Malignant colon tumour	11,241	6,527	4,714
Diabetes mellitus	9,799	4,108	5,691
Hypertensive diseases	9,474	3,124	6,350
Pneumonia	7,525	3,771	3,754
Nephritis, nephritic syndrome and nephrosis	6,462	3,171	3,291
Malignant breast tumour	6,371	76	6,295
Malignant prostate tumour	5,875	5,875	0
Malignant stomach tumour	5,851	3,601	2,250
Malignant pancreas tumour	5,716	3,000	2,716

Remarks: included here are the causes of death with a relative weight of 1.5% or more, ordered by relative weight.
Source: National Statistics Institute (INE). Mortality by cause of death, 2010

7.1.4. Infant mortality

Infant mortality in Spain is low and falling. Only 3 out of every 1,000 live births die during the first year of life (2 during the neonatal period and one in the postneonatal period). By sex, there is a slight predominance of deaths in boys (3.3) compared to girls (3.1).

Figure 7.7. Infant mortality rate per 1,000 live births



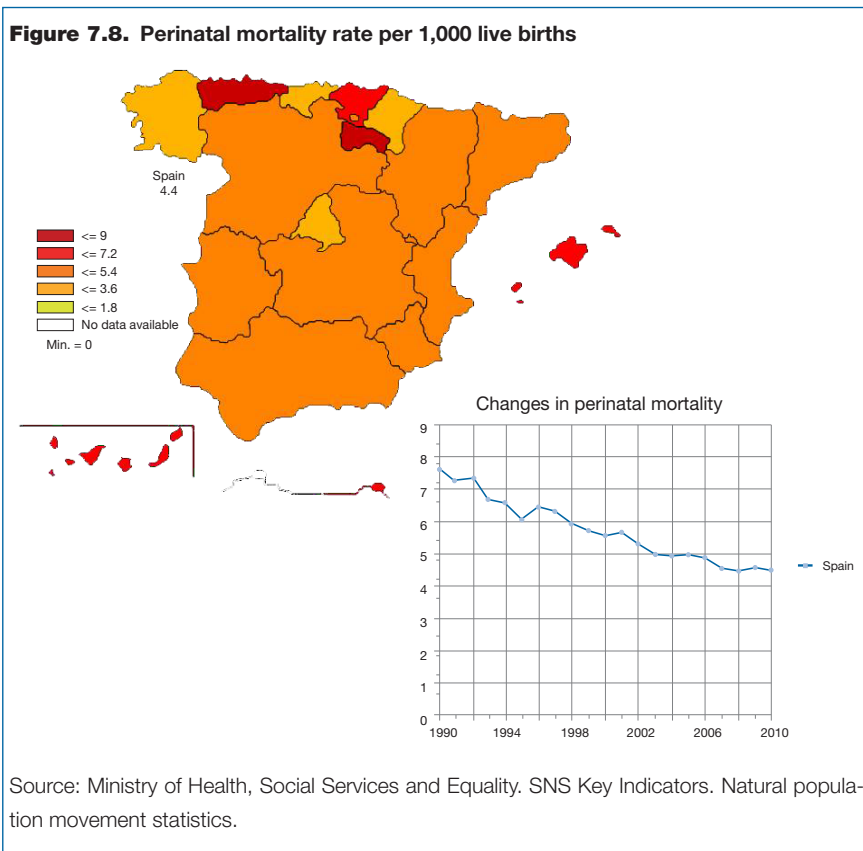
Perinatal mortality in Spain also shows a clear downward tendency, with the current figure being about 4 deaths out of every 1,000 live births. Perinatal mortality includes foetal deaths and the deaths of live births within the first seven days of life. It is considered to be directly related to health care services: their development, accessibility, coverage and quality.

Table 7.7. Infant mortality per 1,000 live births and its components: neonatal, postneonatal and perinatal mortality per 1,000 live births

	2008			2009			2010		
	Total	Women	Men	Total	Women	Men	Total	Women	Men
Infant mortality	3.3	3.0	3.7	3.3	3.0	3.5	3.2	3.1	3.3
Neonatal mortality	2.1	1.9	2.4	2.1	2.0	2.3	2.1	2.0	2.2
Postneonatal mortality	1.2	1.1	1.3	1.1	1.0	1.2	1.1	1.1	1.1
Perinatal mortality	4.4	4.0	4.7	4.5	4.3	4.7	4.4	4.4	4.4

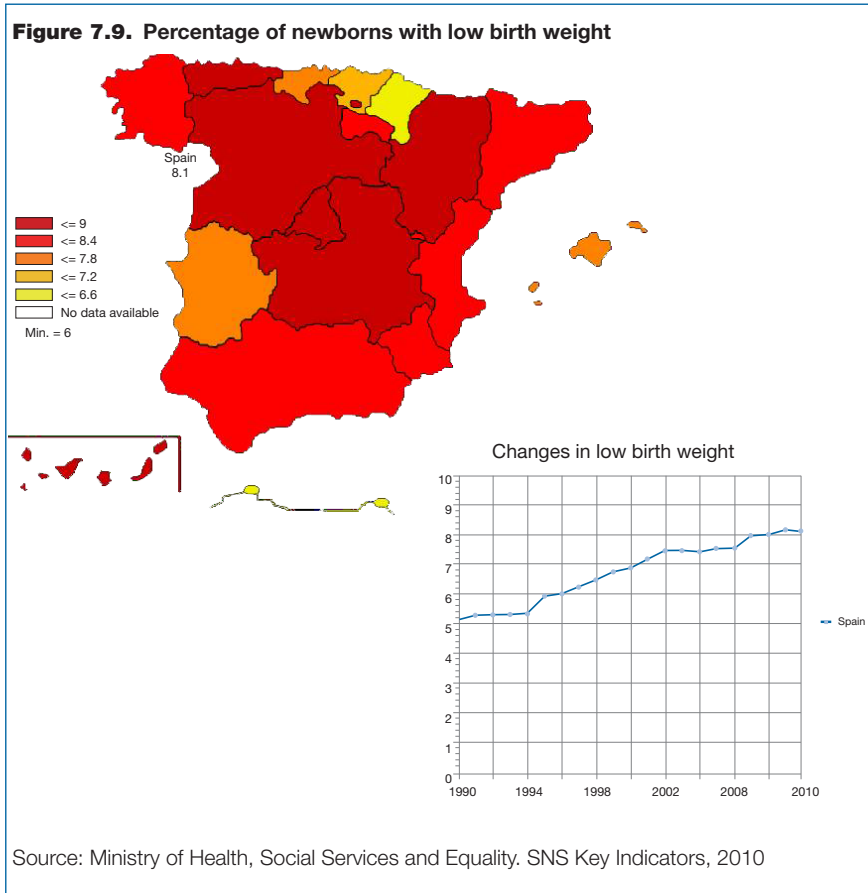
Remarks: *Infant mortality*: number of infant deaths occurring during the first year of life. *Neonatal mortality*: number of infant deaths occurring during the first 28 days of life. *Postneonatal mortality*: number of infant deaths occurring between 29 days and one year of life. *Perinatal mortality*: number of foetal deaths at 24 or more weeks of gestation and number of infant deaths occurring in the first seven days of life.
Source: National Statistics Institute (INE). Infant and perinatal mortality

Figure 7.8. Perinatal mortality rate per 1,000 live births



7.1.5. Low birth weight

Low birth weight, defined as weight at birth of less than 2,500 grams, is an important indicator of infant health, because of the close relationship between birth weight and infant morbidity and mortality. Babies born with low birth weight have a greater risk of health problems and death, they need more hospitalisation after birth and are more likely to develop disabilities.



In recent decades Spain has witnessed a significant increase in the proportion of babies with low birth weight; in 1990 the percentage was just over 5% and in 2010 it is over 8%. Factors contributing to low birth weight include the increasing age of mothers at birth, adolescent motherhood, in vitro fertility treatments and harmful habits such as smoking and alcohol consumption; also, the wider use of techniques to control childbirth, such as induction and caesarean deliveries, which have increased the survival rate of babies with low birth weight.

Table 7.8. Newborns with low birth weight (<2500gr) by autonomous community, per 100 live births

Autonomous community	2008	2009	2010
Andalucía	7.8	8.1	8.1
Aragón	8.4	7.8	8.5
Asturias	9.0	9.0	8.8
Baleares	7.2	7.8	7.6
Canarias	8.1	8.6	8.6
Cantabria	7.3	7.9	7.2
Castilla y León	8.2	8.3	8.9
Castilla-La Mancha	8.6	8.1	8.6
Cataluña	8.0	8.4	8.0
Comunidad Valenciana	8.3	8.4	8.3
Extremadura	8.0	7.8	7.6
Galicia	8.1	8.0	8.1
Madrid	8.2	8.5	8.5
Murcia	7.7	7.9	7.8
Navarra	7.8	8.3	6.4
País Vasco	7.1	6.8	7.0
La Rioja	9.4	7.6	7.9
Ceuta	7.4	7.6	6.2
Melilla	5.4	4.8	6.5
Spain	8.0	8.2	8.1

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators

7.1.6. Routine vaccination coverage in children

Vaccination rates reflect the percentage of children that receive the respective vaccination within the recommended period. To determine vaccination coverage, only the doses administered as part of the Official Vaccination Services have been computed; vaccines acquired in pharmacies and administered through the private health sector are not included.

The percentage of vaccination coverage expresses, in the case of primovaccination, the percentage of children aged 0 to 1 who have received three doses of vaccine against poliomyelitis, diphtheria-tetanus-pertussis (DTPa), *Haemophilus influenzae* type b (Hib), hepatitis B and two doses of meningitis vaccine against meningococcal C.

Booster coverage is the percentage of children aged 1 to 2 who have received a booster dose of vaccine against poliomyelitis, diphtheria-tetanus-pertussis (DTPa), *Haemophilus influenzae* type b (Hib) and meningo-

coccal C disease; the percentage of children aged 4 to 6 who have received a booster dose against diphtheria-tetanus-pertussis (DTPa or dTpa), and the percentage of adolescents aged 14 to 16 who have received a booster dose against tetanus-diphtheria (Td).

Routine vaccination coverage in children under one year of age is 97.1% for poliomyelitis, 97.1% DTP (diphtheria-tetanus-pertussis), 96.6% for hepatitis B and 97.1% for *Haemophilus influenzae* type b (Hib). For meningitis C vaccination coverage is 98.8. Among children between 1 and 2 years of age, 96.8% have received the combined vaccine against measles/mumps/rubella (MMR).

The rate of primovaccination against measles/mumps/rubella expresses the percentage of children aged 1 to 2 who have received one dose of the MMR vaccine. For the second dose, the age group is 3 to 6 years of age.

Vaccination coverage against hepatitis B in adolescents corresponds to the percentage of adolescents (aged 11-14) who have received the third dose of vaccine against hepatitis B. Coverage in 2011 is 96.6%.

Table 7.9. Routine vaccination coverage in children

	2009	2010	2011
Poliomyelitis	95.9	96.6	97.1
DTP (diphtheria-tetanus-pertussis)	95.9	96.6	97.1
Hib (Haemophilus influenzae type b)	95.9	96.6	97.1
Meningitis C	96.5	94.2	98.8
Hepatitis B	95.5	96.5	96.6
Measles-mumps-rubella (MMR)	97.4	95.5	96.8
Poliomyelitis booster	94.1	93.7	94.3
DTP (diphtheria-tetanus-pertussis) booster	94.1	93.7	94.1
Hib (Haemophilus influenzae type b) booster	94.1	93.7	94.1

Remarks: the data on boosters for poliomyelitis, DTP and Hib refer to one dose
 Source: Ministry of Health, Social Services and Equality. Directorate General of Public Health, Quality and Innovation. Vaccination coverage

7.1.7. Human papillomavirus

Vaccination coverage against human papillomavirus (HPV)

Human papillomavirus (HPV) is one of the most common sexually transmitted infections. HPV infections usually disappear by themselves within two years but they sometimes persist and can cause precancerous lesions on the cervix, which if not treated can evolve into cervical cancer in 20-30 years.

HPV prevalence is associated with age, with the highest prevalence being found in the years around the time that sexual intercourse begins (ages 15-25), depending on the sexual behaviour patterns of the community. A marked reduction then appears, between the ages 25-40, and the rate remains stable after age 40. The prevalence of HPV infection in Spain (approximately 3.4%) is among the lowest in Europe, according to studies performed on the population as a whole.

Vaccination coverage against HPV in adolescent girls (aged 11-14) expresses the percentage of girls in this age group that have received the third dose of the vaccine.

Table 7.10. Vaccination coverage against human papillomavirus

Autonomous community	Population	Doses administered	%
Andalucía	40,655	15,475	38.1
Aragón	5,602	4,323	77.2
Asturias	3,559	2,597	73.0
Baleares	4,415	2,340	53.0
Canarias	9,934	7,137	71.8
Cantabria	2,203	1,792	81.3
Castilla y León	9,954	8,652	86.9
Castilla-La Mancha	9,902	5,414	54.7
Cataluña	34,674	27,982	80.7
Comunidad Valenciana	23,307	15,063	58.3
Extremadura	5,518	4,148	75.2
Galicia	10,149	6,808	67.1
Madrid	28,148	16,822	59.8
Murcia	7,573	6,001	79.2
Navarra	2,964	2,726	92.0
País Vasco	8,822	8,099	91.8
La Rioja	1,439	1,367	95.0
Ceuta	d.n.a.	d.n.a.	d.n.a.
Melilla	520	449	86.3
Spain	209,338	137,195	65.5

Remarks: d.n.a.: data not available
Source: Ministry of Health, Social Services and Equality. Vaccination statistics. 2011 data

7.1.8. HIV and AIDS

In 2010 there were 2,907 new diagnoses of HIV (a rate of 88.5 per one million inhabitants); 8 out of 10 were men and the median age was 35 years. Trans-

mission in men who have sex with men was the most frequent (46%) with the next most frequent type of transmission being between heterosexuals (33%). At a greater distance is transmission between intravenous drug users (6%). Depending on the transmission mechanism, the incidence of new diagnoses shows different trends: among intravenous drug users it is falling, among heterosexuals it is stable and among men who have sex with men it is on the rise.

In 2010 a total of 930 new cases of AIDS were reported; almost 8 out of 10 were in men. The median age was 42 years and was slightly higher for men than for women (42 as compared to 40). The cases affecting heterosexuals represented 33% of the total, while intravenous drugs users were 28% and men who have sex with men 26%. Although in absolute numbers transmission through unprotected heterosexual activity affects more men than women, the figure takes on special relevance in women because it represents 60% of their diagnoses. Transmission between men who have sex with men represents 34% of the cases affecting men.

Since the beginning of the epidemic in Spain a total of 80,827 cases of AIDS have been reported. In recent years a decline has been observed in the main transmission categories, both in men and in women.

Table 7.11. HIV and AIDS: new diagnoses, rates per million inhabitants, median age and distribution according to transmission category, by sex

HIV / AIDS surveillance	HIV			AIDS		
	Total	Women	Men	Total	Women	Men
New cases	2,907	521	2,386	930	210	720
Rate per million inhabitants	88.5	31.2	147.8	20.2	9.0	31.7
Median age (years)	35	35	35	42	40	42
Distribution (%) by transmission category						
Men who have sex with men	46.1		56.1	26.5		34.2
Intravenous drug users	5.9	6.7	5.7	28.3	30.4	27.6
Recipients of blood products	0.0	0.0	0.0	0.1	0.0	0.1
Recipients of blood transfusions	0.0	0.0	0.0	0.2	0.0	0.3
Mother-child	0.4	0.8	0.3	0.3	1.0	0.1
Unprotected sex between heterosexuals	33.1	79.8	22.9	33.1	58.6	25.7
Other exposure /Unknown/Not available	14.5	12.7	14.9	11.5	10.0	11.9
Total	100	100	100	100	100	100

Remarks: new diagnoses of HIV infection and rate per million inhabitants are drawn from the data of the 17 autonomous communities not corrected for delay in reporting.

Source: Ministry of Health, Social Services and Equality - Ministry of Science and Innovation, 2010. New HIV Diagnoses Information System and National Registry of AIDS Cases

7.1.9. Chronic diseases

The main health problems and most prevalent diseases have gradually evolved in developed countries. Non-transmissible diseases and chronic diseases have replaced infectious diseases as the main causes of morbidity and mortality, due to the fall in the latter type of disease. Non-transmissible diseases and chronic diseases are also responsible for a large part of the limitations experienced by elders in their daily activity.

Diabetes

Diabetes is a chronic metabolic disease; it is one of the most widespread diseases in the population and it represents the fourth or fifth leading cause of death in developed countries.

Diabetics who have not been diagnosed or who have poorly-controlled diabetes are at greater risk of developing cardiovascular diseases such as myocardial infarction and stroke; they also have a greater risk of losing their vision, experiencing kidney failure or requiring the amputation of an extremity. About 10-20% of diabetics die from kidney failure and about 50% die from cardiovascular disease.

Diabetes rates are shooting up all over the world, reaching almost epidemic proportions.

Type 1 diabetes represents just 10-15% of all diabetes cases. It is the predominant form in the younger age groups of most developed countries. There is alarming evidence that the onset of type 1 diabetes is occurring at ever earlier ages in children.

Type 2 diabetes is largely preventable. Risk factors such as overweight, obesity and lack of physical activity can be modified and can help reduce the complications associated with diabetes; however, in most countries, the prevalence of overweight and obesity continues to rise.

The economic impact of diabetes is significant: around one quarter of the medical expenditure incurred in connection with this disease goes to controlling high blood sugar, another quarter goes to treating long-term complications and the rest goes to general medical care. The rise in costs underscores the importance of providing quality care in the treatment of diabetes and its complications.

In Spain, the prevalence of diabetes in adults is almost 6%, with the rate being slightly lower in women (5.8%) than in men (6.0%).

Table 7.12. Prevalence of diabetes mellitus per 100 inhabitants in the population aged 16 and over

Autonomous Community	2003	2006	2009
Andalucía	7.3	7.3	6.1
Aragón	5.1	5.3	6.4
Asturias	3.6	6.7	5.5
Baleares	7.0	5.5	2.9
Canarias	7.2	5.9	6.4
Cantabria	4.1	5.3	6.1
Castilla y León	4.8	6.9	5.7
Castilla-La Mancha	7.5	7.8	6.6
Cataluña	5.7	5.7	4.9
Comunidad Valenciana	7.0	6.5	6.3
Extremadura	7.0	8.8	7.8
Galicia	6.3	6.4	6.5
Madrid	4.3	4.4	5.3
Murcia	5.6	6.4	8.1
Navarra	3.2	5.8	4.9
País Vasco	4.5	5.4	6.5
La Rioja	3.2	4.2	6.3
Ceuta	7.7	9.1	9.4
Melilla	7.7	9.1	10.5
Spain	5.9	6.2	5.9

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators

Table 7.13. Prevalence of diabetes mellitus per 100 women aged 16 and over

Autonomous Community	2003	2006	2009
Andalucía	9.0	7.1	7.4
Aragón	5.7	5.9	6.2
Asturias	4.0	6.1	5.8
Baleares	8.1	6.3	3.6
Canarias	7.1	7.2	6.8
Cantabria	4.5	5.8	4.8
Castilla y León	5.6	6.2	5.5
Castilla-La Mancha	8.2	9.8	6.4
Cataluña	5.5	5.9	4.1
Comunidad Valenciana	6.6	5.3	6.4
Extremadura	6.2	9.3	7.3
Galicia	5.4	6.0	6.8
Madrid	4.7	4.1	4.2
Murcia	6.1	6.0	7.8
Navarra	3.6	5.6	4.9
País Vasco	4.0	4.5	6.0
La Rioja	3.1	3.6	5.5
Ceuta	9.6	12.6	10.0
Melilla	9.6	12.6	13.8
Spain	6.2	6.1	5.8

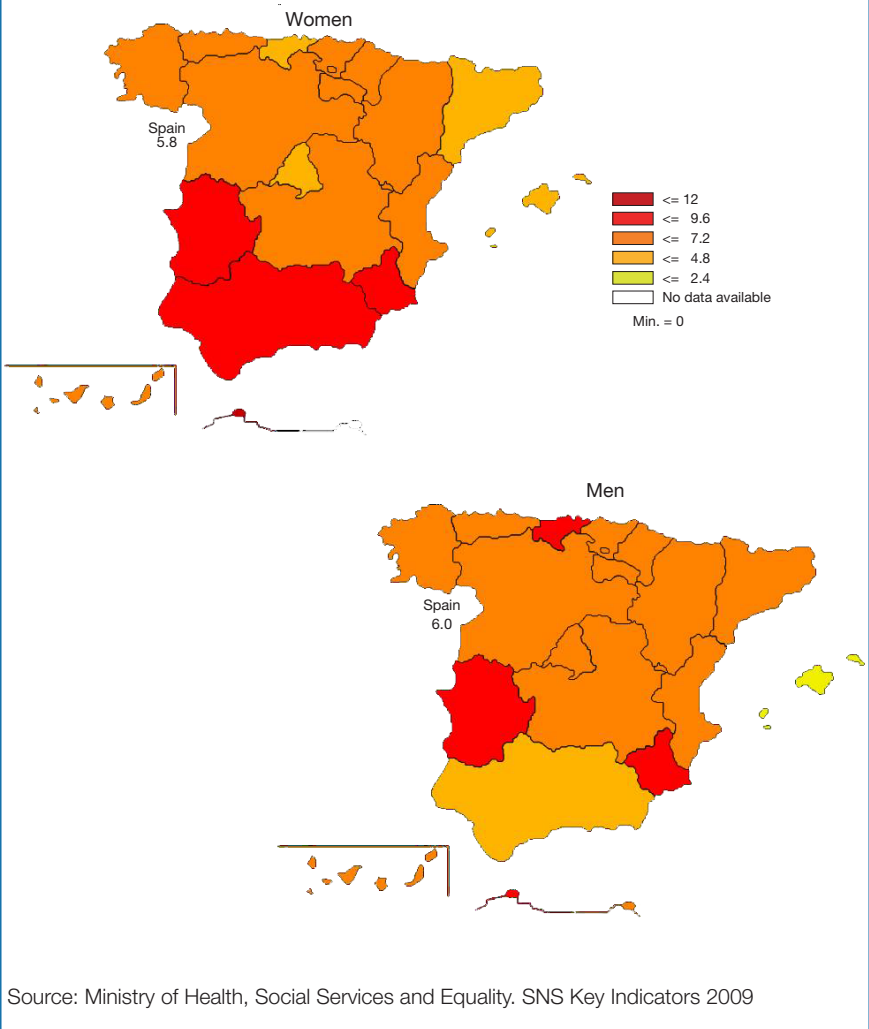
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators

Table 7.14. Prevalence of diabetes mellitus per 100 men aged 16 and over

Autonomous Community	2003	2006	2009
Andalucía	5.7	7.5	4.7
Aragón	4.6	4.7	6.6
Asturias	3.1	7.4	5.2
Baleares	5.9	4.7	2.2
Canarias	7.3	4.6	6.0
Cantabria	3.6	4.7	7.5
Castilla y León	4.0	7.6	5.8
Castilla-La Mancha	7.0	5.9	6.7
Cataluña	5.9	5.6	5.8
Comunidad Valenciana	7.4	7.8	6.3
Extremadura	7.8	8.3	8.3
Galicia	7.3	6.9	6.2
Madrid	3.9	4.8	6.5
Murcia	5.1	6.8	8.4
Navarra	2.8	6.0	4.9
País Vasco	5.2	6.3	7.0
La Rioja	3.3	4.9	7.1
Ceuta	5.8	5.6	7
Melilla	5.8	5.6	7.1
Spain	5.6	6.4	6.0

Source: Ministry of Health, Social Services and Equality. SNS Key Indicators

Figure 7.10. Prevalence (percentage) of diabetes mellitus in population aged 16 and over



Hypertension

Like diabetes and overweight/obesity, hypertension increases the risk of cardiovascular diseases and different types of cancer.

Table 7.15. Percentage of persons aged 16 and over who say they have hypertension

Autonomous Community	Total	Women	Men
Andalucía	16.5	18.9	14.0
Aragón	17.4	20.4	14.3
Asturias	17.9	18.8	16.9
Baleares	16.7	16.5	16.9
Canarias	18.1	19.1	17.2
Cantabria	17.2	16.0	18.5
Castilla y León	18.2	20.0	16.3
Castilla-La Mancha	17.6	18.9	16.4
Cataluña	17.9	18.9	16.8
Comunidad Valenciana	16.0	16.2	15.7
Extremadura	21.7	22.4	21.0
Galicia	22.7	25.8	19.2
Madrid	15.6	17.4	13.7
Murcia	20.3	21.9	18.6
Navarra	14.2	15.5	12.9
País Vasco	17.8	19.4	16.0
La Rioja	16.6	17.1	16.2
Ceuta	16.9	19.0	14.8
Melilla	16.3	17.4	15.2
Spain	17.5	19.0	15.9

Source: Ministry of Health, Social Services and Equality. National Statistics Institute (INE). European Health Survey in Spain, 2009

Numerous epidemiological studies have demonstrated that the risk of cerebrovascular disease and ischaemic heart disease is associated with high blood pressure. In addition, hypertension is a causal factor in cardiac insufficiency, aortic aneurysm, renal insufficiency and peripheral arterial disease, and moreover is the cause of a considerable percentage of deaths in Spain; it is estimated that untreated hypertension is the cause of a quarter of the strokes occurring in people with hypertension.

According to the European Health Survey in Spain (2009) a total of 17.5% of those surveyed said they had this disease; the autonomous communities with the highest percentages of people aged 16 and over affected by hypertension are Galicia (22.7%), Extremadura (21.7%) and Murcia (20.3%). In contrast, Comunidad Valenciana (16%), Melilla (16.3%) and Andalucía (16.5%) have the lowest percentage of population with hypertension.

The different percentages appearing in the sex disaggregation are due to the fact that the data is not age standardized, but instead includes aggregated national estimates that represent gross indicators for respondents aged 16 and over.

Chronic bronchitis and emphysema

Chronic obstructive pulmonary disease (COPD), a term used for chronic bronchitis and emphysema, causes a large amount of disability, negatively affects the patient's quality of life and also has high costs. COPD patients are often smokers or ex-smokers and the symptoms rarely develop before the age of 40.

In the European Health Survey in Spain (2009), a total of 3.6% of the respondents aged 16 and older said they had chronic bronchitis and/or emphysema. The rate is slightly higher in men than in women (3.8% compared to 3.3%, respectively).

As for the autonomous communities, the highest prevalence is found in Galicia (5.5%) and Ceuta and Melilla (4.9% for both); the lowest figures are in the Basque Country (1.7%), Navarra (1.8%) and Madrid (2.3%).

Table 7.16. Percentage of persons aged 16 and over who say they have chronic bronchitis and emphysema, by sex

Autonomous Community	Total	Women	Men
Andalucía	3.6	3.1	4.2
Aragón	2.4	1.8	3.0
Asturias	4.4	3.5	5.3
Baleares	2.6	1.9	3.3
Canarias	3.1	2.7	3.5
Cantabria	3.2	3.0	3.3
Castilla y León	3.8	3.7	3.9
Castilla-La Mancha	3.6	3.9	3.2
Cataluña	3.7	3.2	4.3
Comunidad Valenciana	4.6	4.7	4.5
Extremadura	4.7	4.3	5.1
Galicia	5.5	5.0	6.1
Madrid	2.3	2.5	2.0
Murcia	4.7	5.6	3.8
Navarra	1.8	1.5	2.1
País Vasco	1.7	0.9	2.7
La Rioja	3.2	3.7	2.6
Ceuta	4.9	4.0	5.9
Melilla	4.9	5.5	4.2
Spain	3.6	3.3	3.8

Source: Ministry of Health, Social Services and Equality. National Statistics Institute (INE). European Health Survey in Spain, 2009

7.2. Lifestyles

7.2.1. Tobacco use

The use of tobacco products is one of the leading causes of avoidable premature deaths. One out of four citizens aged 16 or over smokes daily (26.2%), one out of five claims to be an ex-smoker (20.4%) and one out of two (49.7%) has never been a smoker.

The number of daily smokers over the age of 16 is much lower in women (21.3%) than in men (31.2%), and many more of those who claim to be ex-smokers are men (26.3%) than women (14.7%), a difference of about 12 percentage points. Among the respondents who have never smoked, the proportion of women is much larger (60.7%) than that of men (38.4%).

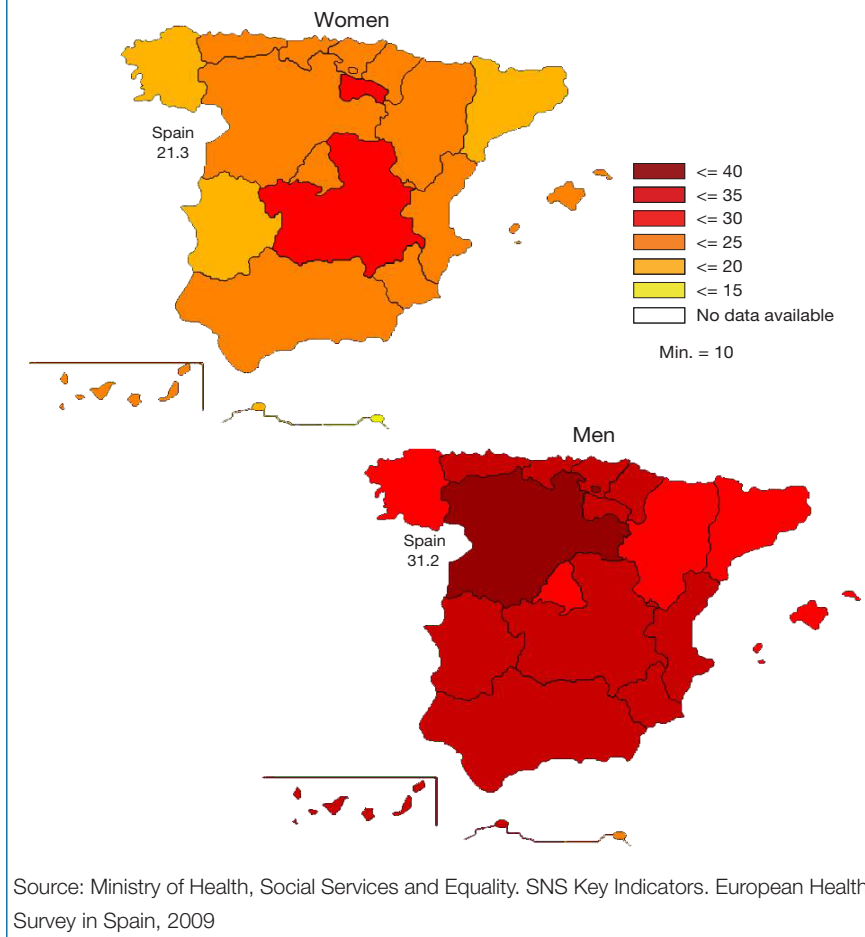
By age group, in both men and women the percentage of smokers is highest among those aged 25 to 54, although the figures are different: close to 40% in men and almost 30% in women. In young people aged 16 to 24, the smoking habit affects 26.3% of the population (28.9% of men and 23.5% of women). This is the age group that has the smallest difference between men and women; less than 5 percentage points.

Table 7.17. Tobacco use in population aged 16 and over. Percentage distribution by age and sex

	Total	Women	Men
Daily smoker	26.2	21.3	31.2
16-24 years	26.3	23.5	28.9
25-34 years	32.8	28.6	36.8
35-44 years	33.4	29.2	37.5
45-54 years	34.0	29.7	38.4
55-64 years	19.7	13.2	26.6
65-74 years	10.4	5.4	16.3
75 and over	5.4	2.3	9.8
Occasional smoker	3.7	3.3	4.2
Ex-smoker	20.4	14.7	26.3
Never been a smoker	49.7	60.7	38.4
Total	100	100	100

Source: Ministry of Health, Social Services and Equality. National Statistics Institute (INE). European Health Survey in Spain, 2009

Figure 7.11. Daily tobacco use. Percentage distribution of women and men aged 16 and over



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. European Health Survey in Spain, 2009

7.2.2. Alcohol consumption

The consumption of alcoholic beverages has become an enormous public health problem in most developed countries, due to both its continuous growth and its negative consequences. Less than 4 of every 10 persons aged 16 and over say they have not consumed alcoholic beverages in the past year; the proportion of women is twice that of men. The remainder (64.6%) of the population aged 16 and over have consumed alcohol in the past year; the figure is 76.9% in men and 52.9% in women. By age, the percentage of those who have consumed alcohol in the past year is lower in the older groups, and in these groups the tendency is more pronounced in women.

Table 7.18. Consumption of alcoholic beverages in the past 12 months. Percentage distribution in population aged 16 and over by age and sex

Age group	Total	Women	Men
Has consumed alcohol	64.6	52.9	76.9
16-24 years	70.5	65.7	75.1
25-34 years	71.4	61.5	80.9
35-44 years	70.0	60.4	79.3
45-54 years	68.8	56.9	81.0
55-64 years	62.0	48.1	76.8
65-74 years	51.8	35.3	71.5
75 and over	38.1	24.2	57.8
Has not consumed alcohol	35.4	47.1	23.1
Total	100	100	100

Source: Ministry of Health, Social Services and Equality. National Statistics Institute (INE). European Health Survey in Spain, 2009

By sex, women in Cataluña show the highest percentage of having consumed alcohol in the past twelve months (60.5%). Among men, those from Madrid show the highest percentage (82.5%).

Table 7.19. Percentage of women and men aged 16 and over who say they have consumed alcoholic beverages in the past 12 months, by autonomous community

Autonomous Community	Women	Men
Andalucía	47.7	71.8
Aragón	50.0	68.6
Asturias	53.2	79.4
Baleares	52.0	75.9
Canarias	47.0	72.8
Cantabria	38.4	75.8
Castilla y León	38.9	75.4
Castilla-La Mancha	45.8	76.5
Cataluña	60.5	80.0
Comunidad Valenciana	58.4	79.2
Extremadura	47.8	81.8
Galicia	47.9	75.7
Madrid	60.1	82.5
Murcia	56.4	71.7
Navarra	53.0	80.1
País Vasco	55.8	78.2
La Rioja	55.2	77.5
Ceuta	33.8	33.3
Melilla	35.0	55.5
Spain	52.9	76.9

Source: Ministry of Health, Social Services and Equality. European Health Survey in Spain, 2009

7.2.3. Overweight and obesity

The consumption of tobacco and alcohol, along with overweight and obesity, increases a person's risk for a wide array of diseases and health problems: hypertension, hypercholesterolaemia, type 2 diabetes, coronary diseases, certain kinds of cancer and many other types of chronic diseases.

Table 7.20. Overweight and obesity in population aged 18 and over. Percentage distribution by age and sex

	Total	Women	Men
Overweight	37.7	29.9	45.5
18 - 24 years	18.5	13.8	23.2
25 - 34 years	31.4	21.4	40.7
35 - 44 years	36.9	26.1	47.2
45 - 54 years	41.1	30.8	51.4
55 - 64 years	45.7	40.1	51.4
65-74 years	47.6	43.6	52.1
75 and over	43.7	39.0	50.2
Obesity	16.0	14.7	17.3
18 - 24 years	5.2	4.4	5.9
25 - 34 years	9.8	7.2	12.2
35 - 44 years	14.6	11.5	17.6
45 - 54 years	17.4	14.8	20.0
55 - 64 years	22.8	20.6	24.9
65-74 years	25.7	27.4	23.9
75 and over	21.1	23.9	17.1

Remarks: *Overweight*: Body mass index = [Weight (kg) / Height (m²)] between 25.0 and 29.9 kg/m².

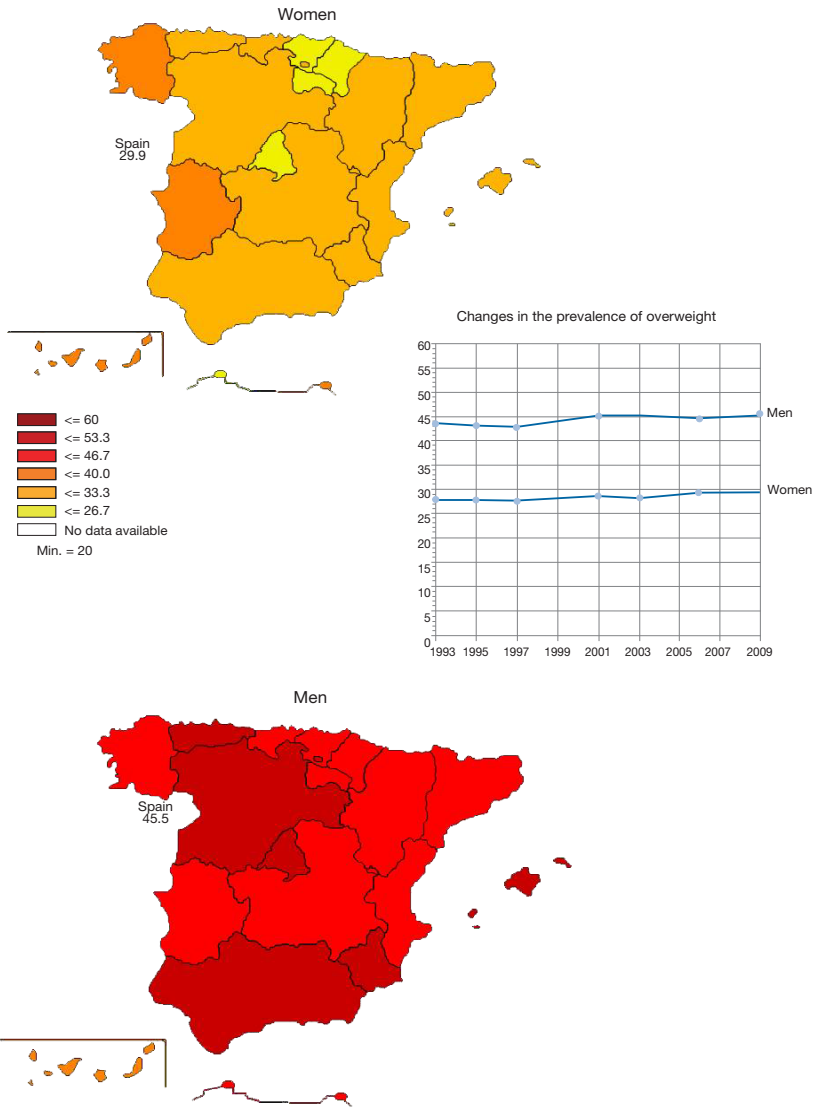
Obesity: Body mass index = [Weight (kg) / Height (m²)] >=30.0 kg/m².

Source: Ministry of Health, Social Services and Equality. National Statistics Institute (INE). European Health Survey in Spain, 2009

Over half of the population aged 18 and over weighs more than their recommended weight. According to their body mass index (BMI), 37.7% of adults are overweight and 16.0% of them are obese.

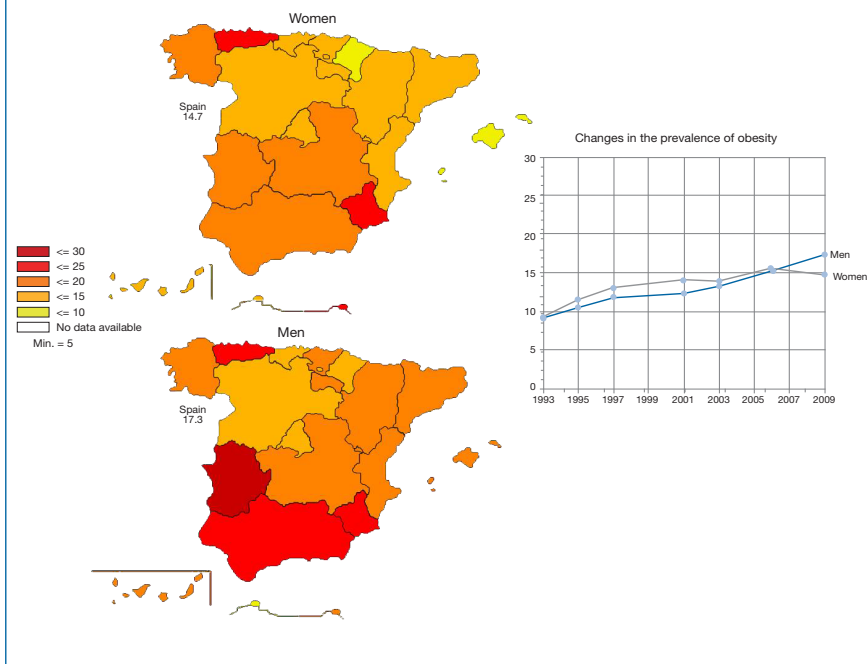
In both men and women obesity is more frequent in the older age groups, except in the population aged 75 and over, where it decreases. The prevalence of overweight and obesity, taken together, in the population aged 18 and over (53.7%) shows higher values in men (62.8%) than in women (44.6%) in all age groups.

Figure 7.12. Prevalence of overweight in women and men aged 18 and over



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. European Health Survey in Spain, 2009

Figure 7.13. Prevalence of obesity in women and men aged 18 and over



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators. European Health Survey in Spain, 2009

Among children aged 6 to 9, the problem of excess weight (overweight and obesity) is present in 4 out of 10 children and it is more prevalent in boys (5 out of 10) than in girls (4 out of 10).

Table 7.21. Overweight and obesity in children aged 6 to 9. Percentage distribution by sex

	Total	Girls	Boys
Overweight	26.2	25.7	26.7
Obesity	18.3	15.5	20.9

Remarks: calculated with the WHO child growth standards. Overweight is considered to be between 1 and 2 standard deviations. Obesity is considered to be + 2 standard deviations. The child obesity data has a $p < 0.05$.

Source: Ministry of Health, Social Services and Equality. Spanish Food Safety and Nutrition Agency (AESAN). Growth surveillance study ALADINO (study conducted by AESAN on diet, physical activity, child development and obesity) in 2010/2011

Figure 7.14. Prevalence of obesity and overweight in girls aged 6 to 9

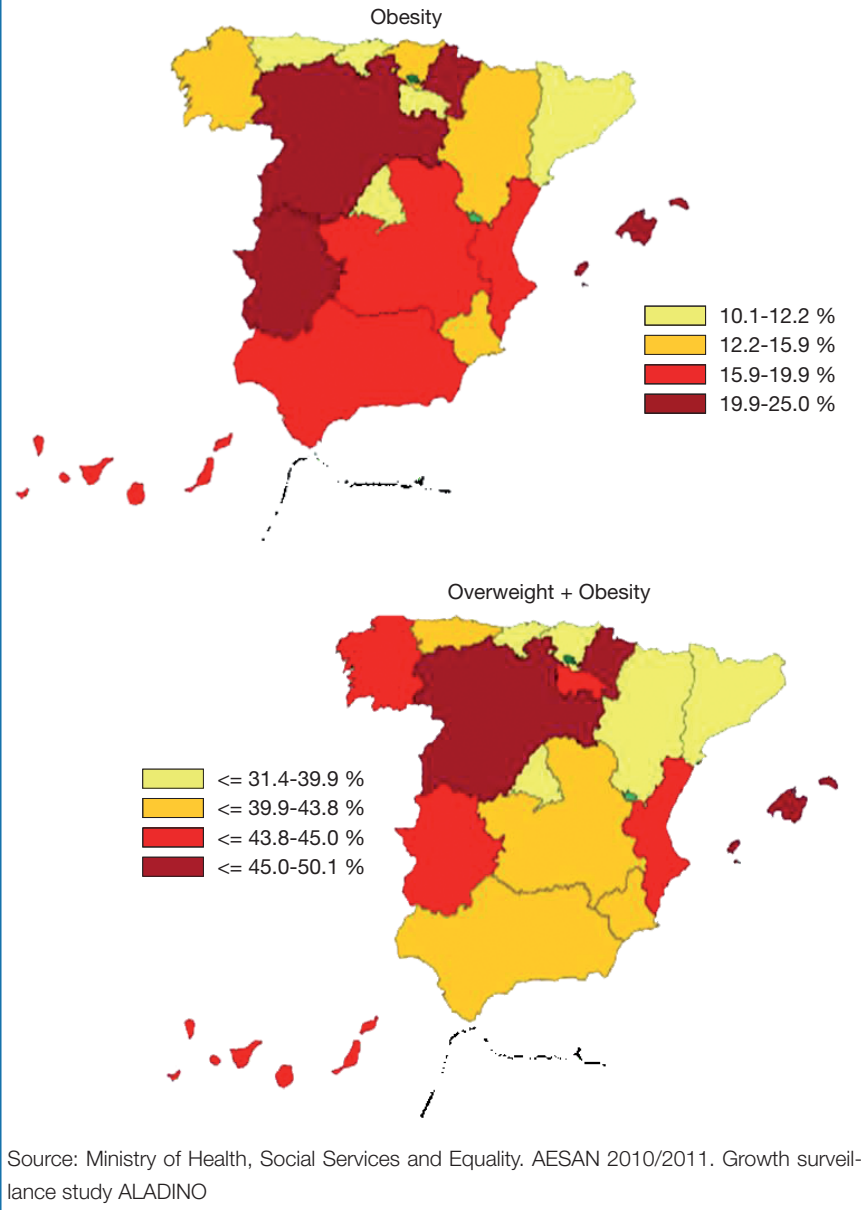
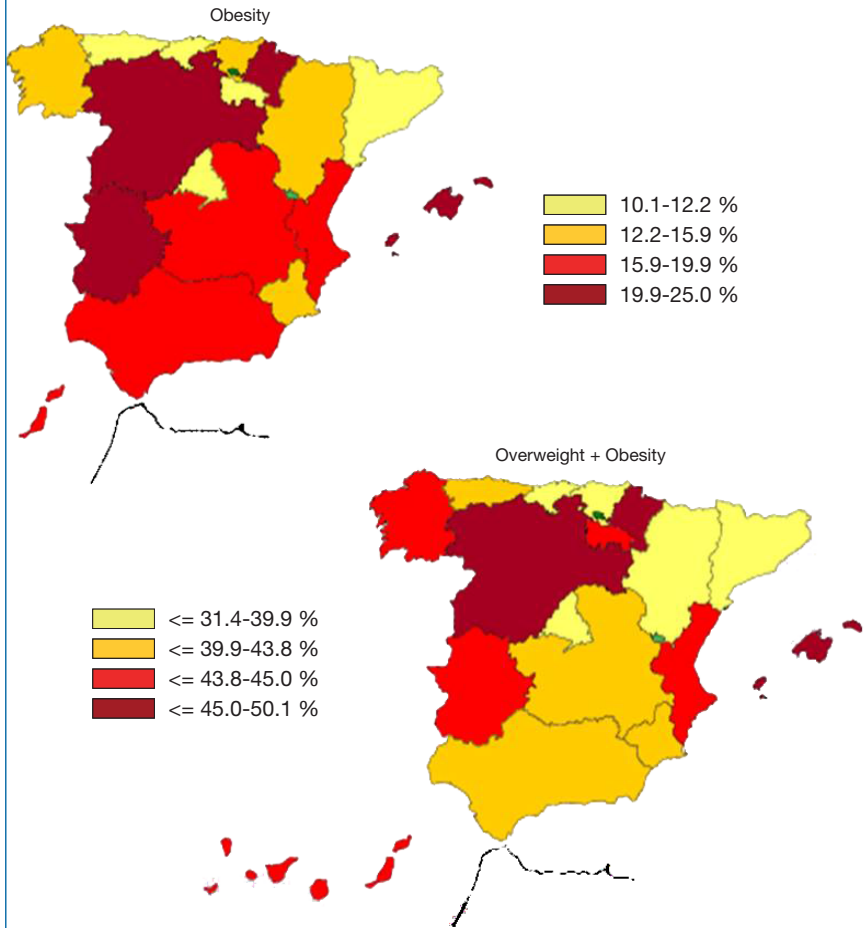


Figure 7.15. Prevalence of obesity and overweight in boys aged 6 to 9



Source: Ministry of Health, Social Services and Equality. AESAN 2010/2011. Growth surveillance study ALADINO

7.2.4. Physical activity

An appropriate amount of physical activity is a healthy habit; a number of different epidemiological studies have consistently shown the relationship between exercise and a lower risk of heart problems. Other important diseases have also been associated with the lack of physical activity: diabetes mellitus, hypertension and osteoporosis.

Table 7.22. Percentage of the population aged 16 and over who say they have not engaged in physical activity within the last 7 days

	Total	Women	Men
No physical activity	12.1	13.3	10.9
16-24 years	7.1	8.6	5.6
25-34 years	10.0	10.9	9.2
35-44 years	9.5	8.9	10.0
45-54 years	10.6	9.6	11.5
55-64 years	10.4	10.1	10.8
65-74 years	12.8	15.5	9.7
75 and over	31.4	35.2	25.5

Source: Ministry of Health, Social Services and Equality. National Statistics Institute (INE). European Health Survey in Spain, 2009.

In the population aged 16 and over, 12.1% say that they have not engaged in vigorous or moderate physical activity in the last seven days and that they do not walk regularly. The percentage is higher among women (13.3%) than among men (10.9%). Starting at age 65, the percentage of women who say they do not exercise increases considerably, quite a bit more than the increase shown by men in this age group.

Women from Ceuta and Melilla are the ones most likely to say they do not engage in physical activity (59.1% and 46.8% respectively). The women least likely to say they do not engage in any physical activity are from the autonomous communities of Aragón (5.1%), Madrid (5.6%) and Castilla y León (6.1%).

As for men, more than 3 out of 10 residents of Ceuta say they do not engage in any physical activity, while 2 out of 10 residents of La Rioja, Melilla, Cantabria and Baleares say they do not. The autonomous communities with the lowest proportion of men saying they do not engage in any physical activity are Madrid (5.4%), Castilla y León (5.9%) and Aragón (6.3%).

Table 7.23. Percentage of women aged 16 and over who say they have engaged in physical activity within the last 7 days, by autonomous community

Autonomous community	Total	Vigorous physical activity	Moderate physical activity	Light physical activity	No physical activity
Andalucía	100	11.7	38.6	31.7	18.1
Aragón	100	13.9	60.1	20.9	5.1
Asturias	100	13.7	15.8	50.9	19.7
Baleares	100	23.5	19.9	34.7	21.9
Canarias	100	11.1	67.8	7.0	14.2
Cantabria	100	19.5	12.3	47.5	20.6
Castilla y León	100	16.6	60.0	17.3	6.1
Castilla-La Mancha	100	16.5	46.9	17.6	19.1
Cataluña	100	17.1	34.3	36.9	11.8
Comunidad Valenciana	100	18.5	46.1	24.3	11.2
Extremadura	100	11.2	39.5	34.2	15.2
Galicia	100	17.7	50.6	21.8	10.0
Madrid	100	19.4	50.4	24.6	5.6
Murcia	100	16.7	35.6	25.6	22.2
Navarra	100	4.8	19.4	59.4	16.4
País Vasco	100	11.7	38.2	31.6	18.6
La Rioja	100	11.4	11.3	56.5	20.9
Ceuta	100	9.6	8.9	22.4	59.1
Melilla	100	4.9	9.8	38.5	46.8
Spain	100	15.7	42.7	28.4	13.3

Remarks: the activity refers to the most demanding physical activity of the last 7 days.
Source: Ministry of Health, Social Services and Equality. European Health Survey in Spain, 2009

Table 7.24. Percentage of men aged 16 and over who say they have engaged in physical activity in the last 7 days, by autonomous community

Autonomous community	Total	Vigorous physical activity	Moderate physical activity	Light physical activity	No physical activity
Andalucía	100	32.8	27.8	27.6	11.9
Aragón	100	30.2	34.4	29.0	6.3
Asturias	100	28.8	17.2	37.6	16.4
Baleares	100	41.0	11.8	24.9	22.3
Canarias	100	30.6	52.9	7.1	9.3
Cantabria	100	28.7	8.4	39.7	23.3
Castilla y León	100	35.5	33.6	25.1	5.9
Castilla-La Mancha	100	28.2	25.6	28.8	17.4
Cataluña	100	32.5	21.0	37.1	9.4
Comunidad Valenciana	100	40.1	22.4	27.8	9.7
Extremadura	100	25.1	27.8	35.7	11.5
Galicia	100	37.8	26.8	24.5	11.0
Madrid	100	40.4	28.3	26.0	5.4
Murcia	100	35.1	19.9	30.3	14.7
Navarra	100	20.1	24.0	47.9	8.0
País Vasco	100	34.4	18.6	30.0	17.0
La Rioja	100	22.3	14.8	37.4	25.5
Ceuta	100	24.8	9.7	32.7	32.8
Melilla	100	22.8	22.2	29.7	25.4
Spain	100	34.4	26.0	28.0	10.9

Remarks: the activity refers to the most demanding physical activity of the last 7 days. Ministry of Health, Social Services and Equality. European Health Survey in Spain, 2009

Acronyms and abbreviations

A

AC	Autonomous communities
AESAN	<i>Agencia Española de Seguridad Alimentaria y Nutrición</i> Spanish Food Safety and Nutrition Agency
ALADINO	<i>Alimentación, Actividad Física, Desarrollo Infantil y Obesidad</i> Study on Diet, Physical Activity, Child Development and Obesity
ATC	Anatomical Therapeutic Chemical classification system

B

BES	<i>Boletín Epidemiológico Semanal</i> Weekly Epidemiological Bulletin
BMI	Body Mass Index

C

CAT	Computed Axial Tomography
CIS	<i>Centro de Investigaciones Sociológicas</i> Sociological Research Centre
CISNS	Interterritorial Council of the SNS

D

DDD	Daily Defined Dose
DTP	Diphtheria, Tetanus and Pertussis

E

EHR	Electronic Health Record system
EHR-SNS	Electronic Health Records in the National Health System of Spain

EIR	<i>Enfermeros Internos Residentes</i> Nurses in specialised training programme
ENSE	<i>Encuesta Nacional de Salud de España</i> Spanish National Health Survey
ERDF	European Regional Development Fund
ETOP	Elective Termination of Pregnancy
EU	European Union
EUROSTAT	Statistical Office of the European Union

F

FSE	<i>Formación Sanitaria Especializada</i> Specialised Health Care Training
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G

GDP	Gross Domestic Product
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H

Hib	Haemophilus influenzae type b
HIV	Human Immunodeficiency Virus
HPV	Human papillomavirus

I

ICD 9-CM	International Classification of Diseases, 9th Revision - Clinical Modification
ICT	Information and Communication Technologies
INCLA-SNS	SNS Key Indicators
INE	<i>Instituto Nacional de Estadística</i> National Statistics Institute
INGESA	<i>Instituto Nacional de Gestión Sanitaria</i> National Institute of Health Management
ISFAS	<i>Instituto Social de las Fuerzas Armadas</i> Social Institute of the Armed Forces Mutual Insurance

M

MATEP	<i>Mutua de Trabajo y Enfermedad Profesional</i> Work and Occupational Illness Mutual Insurance
MDS	Minimum Data Set
MIET	Ministry of Industry, Energy and Tourism
MIR	<i>Médico Interno Residente</i> Specialised Medical Training Residency Program
MMR	Measles-Mumps-Rubella
MRI	Magnetic Resonance Imaging
MSSSI	Ministry of Health, Social Services and Equality
MUFACE	Mutual Insurance for Government Employees
MUGEJU	Mutual Insurance for Employees of the Judiciary

N

NAOS	Strategy for Nutrition, Physical Activity and the Prevention of Obesity
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O

OECD	Organisation for Economic Co-operation and Development
ONT	<i>Organización Nacional de Trasplantes</i> Spain's National Transplant Organisation

P

PC	Primary Care
PEN	<i>Plan Estadístico Nacional</i> National Statistics Plan
PPP	Purchasing Power Parity

S

SHA	A System of Health Accounts
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SIAP	<i>Sistema de Información de Atención Primaria</i> Primary Care Information System
SISLE-SNS	<i>Sistema de Información de Listas de Espera del SNS</i> SNS Waiting List Information System
SNS	<i>Sistema Nacional de Salud</i> National Health System
SS	Social Security

T

Td	Tetanus-Diphtheria
TSI	<i>Tarjeta Sanitaria Individual</i> Individual Health Card

U

UDM	<i>Unidades Docentes Multiprofesionales</i> Multiprofessional Teaching Units
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W

WHO	World Health Organisation
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Sources

Health Care Barometer

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the Sociological Research Centre (CIS). It is part of the National Statistics Plan 2009–2012.

Its general objective is to gather information, using questionnaires and direct personal interviews, about citizen perception of the health care system, its functioning, the impact of measures linked to health policy, people's awareness and/or attitudes regarding health problems of particular interest at a given time, the degree of penetration of information campaigns and the re-evaluation of aspects analysed in previous periods.

The study variables in the standard part of the questionnaire are: assessment of SNS, assessment of public sector health care services, waiting lists, degree of equity in access to the services and the decentralization of health management. The variable part of the questionnaire covers different dimensions that are selected for the study each year. The classification variables are age, sex, level of education, occupation, size of municipality in which the respondent lives, income level and the autonomous community in which he or she lives.

The data is gathered and published on an annual basis.

More information at:

<http://www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/informeAnual.htm>

Weekly Epidemiological Bulletin (BES)

The Weekly Epidemiological Bulletin (BES) is a publication for all individuals, bodies and institutions working in the area of public health and epidemiological surveillance. Its main objective is to provide useful information to public health professionals and to disseminate consolidated information obtained from the Spanish Epidemiological Surveillance Network to these professionals and to the System's reporting sources (professionals working in primary and specialised care, doctors, microbiologists, nurses and others).

More information at:

<http://www.isciii.es/ISCIII/es/contenidos/fd-servicios-cientifico-tecnicos/fd-vigilancias-alertas/boletines.shtml>

National Catalogue of Hospitals

Directory maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities, the Ministry of Defence, the competent authorities of Ceuta and Melilla and the hospitals themselves.

Its general objective is to offer basic information about all the hospitals in Spain.

The variables gathered are the facility's details (name, address, telephone and fax numbers, identification code), total number of beds, care function, hospital type, existence of agreement with private sector facility or with the Social Security body responsible for managing health care in that area and whether or not the hospital is accredited as a teaching centre.

The data is gathered and published on an annual basis.

More information at:

<http://www.msssi.gob.es/ciudadanos/prestaciones/centrosServiciosSNS/hospitales/home.htm>

Catalogue of SNS Primary Care Facilities

Directory maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities and INGESA.

Its general objective is to offer basic information about the primary care facilities existing within the SNS.

The variables gathered include the facility's identification (name, address, telephone, town and municipality), whether it is a health centre or local health facility, legal structure and whether or not it is accredited as a teaching centre.

The data is gathered and published on an annual basis.

More information at:

<http://www.msssi.gob.es/ciudadanos/prestaciones/centrosServiciosSNS/hospitales/home.htm>

Official population figures

Statistical information maintained by the National Statistics Institute (INE) in collaboration with local governments. It is part of the National Statistics Plan 2009-2012.

Its general objective is to find out the number of people who reside in and have their usual domicile in each municipality. All people living in Spain are re-

quired to register with the local records office of the municipality in which they usually reside. People who live in various municipalities must register only in the one in which they spend the most months of the year. The formation, maintenance, revision and custody of the municipal population records is the duty of the local government, as established in the rules adopted jointly by the Ministry of Economy and Finance and the Ministry for the Public Administrations, at the recommendation of the Council on Municipal Population Records.

The variables include name and surname, sex, usual residence, place and date of birth, National Identification Document number (DNI) or - in the case of foreigners - the ID document used in place of the DNI.

The data is gathered monthly and published on an annual basis, with reference to January 1st of each year.

More information at:

<http://www.ine.es/jaxi/menu.do?type=pcaxis&path=/t20/e260&file=inebase&N=&L=0>

Minimum Data Set (MDS)

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities and INGESA. It is part of the National Statistics Plan 2009–2012.

Its general objective is to gather information about hospitalisation processes (diagnosis, comorbidity, type of care and type of process) with or without overnight stay in public and private hospitals.

The variables covered include dates of admission and discharge, main diagnosis, secondary diagnosis, diagnostic and therapeutic procedures, destination and situation upon discharge, patient record and hospital codes, how the care is financed. The classification variables are age, sex, place of residence, place of hospitalisation.

The data is gathered and published on an annual basis.

More information at:

<http://www.msssi.gob.es/estadEstudios/estadisticas/cmbdhome.htm>

Mortality by cause of death

Statistical service maintained by the National Statistics Institute (INE) in collaboration with the Statistics Institutes and the Health Departments of the autonomous communities, and the Civil Registries (Ministry of Justice). It is part of the National Statistics Plan 2009-2012.

Its general objective is to contribute to a better understanding of mortality in relation to the basic cause of death, distinguishing between late foetal deaths and early foetal deaths, and supplying information with which to construct health indicators.

The study variables include deceased persons and late foetal deaths. The classification variables are cause of death, sex, age, month of death, province of residence and province in which the death occurred.

The data is gathered monthly and published on an annual basis.

More information at:

<http://www.ine.es/jaxi/menu.do?type=pcaxis&path=/t15/p417&file=inebase&N=&L=0>

Organ Donation and Transplants

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities. It is part of the central government's inventory of statistics.

Its general objective is to learn about the activity of organ donation, extraction and transplant.

As study variables it uses donors, extractions performed and transplants performed. The classification variables used are the health care facility involved, the autonomous community and the organ.

The data is gathered and published on an annual basis.

More information at:

<http://www.ont.es/infesp/Paginas/Datos.aspx>

European Health Survey in Spain, 2009

Service maintained by the National Statistics Institute (INE) in collaboration with the Ministry of Health, Social Services and Equality (MSSSI). It is part of the National Statistics Plan 2009-2012.

Its general objective is to gather information, through questionnaires and direct personal interviews, about health determinants, socio-demographic variables, how people take care of their health and how they make use of health care services.

The study variables are weight and height, tobacco use, consumption of alcohol, physical activity, use of illegal drugs, hospitalisation, consultations with doctors and dentists, use of medicines, preventive practices. The classi-

fication variables are age, sex, marital status, education level, income level, economic activity and occupation.

The data is gathered and published every five years.

More information at:

<http://www.msssi.gob.es/estadEstudios/estadisticas/EncuestaEuropea/home.htm>

Spanish National Health Survey (ENSE)

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the National Statistics Institute. It is part of the National Statistics Plan 2009-2012.

Its general objective is to gather information about perceived morbidity, use of health care services, health behaviour and habits, and preventive activities.

Data is gathered by means of a questionnaire and a direct personal interview and the study variables are self-assessment of health, limitations in activity, use of health services and medicines, health habits, health care coverage. The classification variables are age, sex, size of place of residence, country of origin and socioeconomic status (level of education, occupation and income).

The data is gathered and published every five years.

More information at:

<http://www.msssi.gob.es/estadEstudios/estadisticas/encuestaNacional/home.htm>

Diseases of compulsory notification

Statistical information maintained by the National Epidemiological Centre of the Carlos III Health Institute, in collaboration with the Ministry of Health, Social Services and Equality and the autonomous communities. Surveillance takes place through the Epidemiological Surveillance Network, a public health surveillance system that integrates the surveillance networks of the different autonomous communities. It is part of the National Statistics Plan 2009-2012.

Its general objective is to gather information about the transmissible diseases subject to surveillance, which are those specified in Royal Decree 2210/1995 of 28 December, by which the National Network of Epidemiological Surveillance is created, and in European Commission Decisions 2009/312/EC of 2 April and 2009/539/EC.

Its study variables are the incidence of diseases that are the object of surveillance in the community, their epidemiological patterns, possible risk factors, age and sex.

The data is gathered and published on a weekly basis in the Weekly Epidemiological Bulletin (BES).

More information at:

<http://www.isciii.es/ISCIII/es/contenidos/fd-servicios-cientifico-tecnicos/fd-vigilancias-alertas/enfermedades.shtml>

Statistics on Specialised Care Facilities

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities and the competent authorities in Ceuta and Melilla. It is part of the National Statistics Plan 2009-2012.

Its general objective is to gather information about the care activity, the economic and teaching activities, and the structural characteristics of the establishments providing inpatient care (hospitals) and also of establishments providing outpatient care, which are the main providers of specialised care services. Such data makes it possible to create indicators, study how the sector functions and monitor and analyse its progress.

As study variables it uses: the care services offered, bed capacity, technological equipment available, staffing, discharges, length of stay, consultations, admissions, diagnostic techniques, activity in other areas, surgical activity, obstetric activity, urgent care services, expenditure, investments and income. As classification variables it uses the type of specialised care facility: inpatient care facility (hospital), outpatient care facility, type of care provided, type of facility in terms of financing, its legal structure, whether or not it has a contract with the SNS and whether or not it is an accredited teaching centre.

The data is gathered and published on an annual basis.

More information at:

<http://www.msssi.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm>

National AIDS Statistics

Statistical information maintained by the National Epidemiological Centre of the Carlos III Health Institute, in collaboration with the Ministry of Health, Social Services and Equality and the General Directorates of Public

Health of the autonomous communities. It is part of the National Statistics Plan 2009-2012.

Its general objective is to find out the number of AIDS cases and the risk factors. Its study variables are the number of cases, risk factors, age and sex.

The data is gathered on an ongoing basis and it is published twice yearly.

More information at:

<http://www.isciii.es/ISCIII/es/contenidos/fd-servicios-cientifico-tecnicos/fd-vigilancias-alertas/fd-enfermedades/sida.shtml>

Growth Surveillance Study ALADINO (AESAN study on diet, physical activity, child development and obesity)

The study conducted by the Ministry of Health, Social Services and Equality through the Spanish Food Safety and Nutrition Agency (AESAN) as part of the Strategy for Nutrition, Physical Activity and the Prevention of Obesity (NAOS). It took place between October 2010 and May 2011 all over Spain. The study universe consisted of girls and boys aged 6 to 9. The sample size was 7,659 schoolchildren.

The information was gathered through various questionnaires. The school questionnaires were completed by the directors of the schools selected for participation, and the family questionnaires were completed by the parents of the students randomly selected from among that school's student body. The examiner questionnaires were completed during the interview conducted personally by examiners sent to the schools to obtain body weight, height, hips and waist measurements using high precision measurement devices.

More information at:

www.naos.aesan.msssi.gob.es

EUROSTAT- Public Health Statistics Database

Statistical information maintained by the Statistical Office of the European Union (EUROSTAT) in collaboration with the National Statistics Institutes of the different countries comprising the European Union.

Its objective is to compile data from European National Statistics Institutes and produce data comparable at the European Union level, following a single methodology.

It periodically releases statistical information concerning the European Union and its member states.

More information at:

http://epp.eurostat.ec.europa.eu/portal/page/portal/health/public_health/data_public_health/database

Public Expenditure on Health

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities, MUFACE, MUGEJU, ISFAS, National Institute of Social Security, Ministry of Defence and Ministry of the Interior. It is part of the National Statistics Plan 2009-2012.

Its general objective is to obtain the aggregate figures of public expenditure on health; classification by national accounting aggregates and economic, functional and by-sector classification of expenditure; territorial breakdown of public expenditure on health; and methodological approximation to the OECD's System of Health Accounts (SHA).

The study variables of an economic nature are: employee remuneration, intermediate consumption, agreements between the SNS and private facilities, current transfers, capital expenditure. As functional variables it uses: hospital and specialised services, primary care services, public health services, collective health services, pharmacy, transportation, prostheses. Its national accounting variables are: collective consumption, individual consumption, non-market production, market production. As classification variables, it uses: the services provided and the agents incurring the expenditure.

The data is gathered and published on an annual basis.

More information at:

<http://www.mssi.gob.es/estadEstudios/estadisticas/inforRecopilaciones/gastoSanitario2005/home.htm>

SNS Key Indicators (INCLA-SNS)

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities and the competent authorities in Ceuta and Melilla.

The SNS Key Indicators database contains prioritized information covering the most relevant aspects of health and the Spanish health care system. The indicators are selected by consensus among the bodies represented on

the SNS Interterritorial Council (CISNS). Development is overseen by the CISNS Subcommittee on Information Systems.

More information at:

http://www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/inclasSNS_DB.htm

Elective Termination of Pregnancy

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities. It is part of the National Statistics Plan 2009-2012.

Its general objective is to gather information about the socio-demographic characteristics and the health conditions in which elective terminations of pregnancy take place, the characteristics of the women who undergo the procedure and of the facilities that perform them.

The study variables are reason for aborting, weeks of gestation and method used.

The data is gathered on a quarterly basis and published annually.

More information at:

<http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/embarazo/home.htm>

SNS Waiting Lists

Statistical information maintained by the Health Departments of the autonomous communities and INGESA. Data is gathered in accordance with Royal Decree 1039/2011, of 15 July, which establishes framework criteria to ensure that the wait before accessing SNS benefits does not exceed a given time, so that access can take place in conditions of effective equality.

Its general objective is to provide information on the number of patients waiting for a planned surgical intervention and the number of patients waiting for a Specialised Care consultation, as of the established cut-off date.

The data is published twice-yearly, once the CISNS has been informed of the data. The cut-off dates are December 31st and June 30th every year.

More information at:

<http://www.msssi.gob.es/estadEstudios/estadisticas/inforRecopilaciones/listaEspera.htm>

OECD - Health database

This database brings together the statistics and indicators compiled by the Organisation for Economic Co-operation and Development (OECD) in collaboration with 34 states, one of which is Spain.

The aim is to provide comparable information about health and health care systems in all OECD countries, to enable international analysis and comparisons to be performed. The database includes indicators pertaining to health expenditure, the personnel and equipment dedicated to health care services, care activity, health status and life styles.

More information at:

<http://stats.oecd.org/index.aspx>

WHO - European Health for All database (HFA-DB)

This database offers a selection of health statistics regarding the 53 countries of the WHO European Region, covering basic demographic data, health status, health determinants and risk factors, resources dedicated to health care, people's use of health care and expenditure.

Its general objective is to provide information about the countries and regional analyses, and to present the results in tables, graphs and maps that can be exported for later use.

The data is compiled from various sources, including a network of experts from the countries, the WHO/Europe, the United Nations, the Statistical Office of the European Union (EUROSTAT) and the Organisation for Economic Co-operation and Development (OECD).

More information at:

<http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-health-for-all-database-hfa-db2>

Primary Care Information System of the SNS (SIAP-SNS)

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities and INGESA, MUGEJU and ISFAS. It is part of the National Statistics Plan 2009-2012.

Its general objective is to provide information about staffing, care activity (general and specific services) and number of physical and/or functional facilities within the SNS the purpose of which is to provide primary care.

As study variables, it uses personnel, activity and primary care facilities. The data is gathered and published on an annual basis.

More information at:

<http://www.msssi.gob.es/estadEstudios/estadisticas/estadisticas/estMinisterio/siap.htm>

ICT in the SNS: the Health Care Online programme. 2011update

This report discusses the actions carried out in 2011 in the framework of the Health Care Online programme. The primary sources of information were the Health Departments of the autonomous communities and INGESA. Data was gathered by means of a questionnaire.

The Health Care Online programme began in 2006, as a way to promote the use of information and communication technology in the SNS; it is a joint initiative of the Ministry of Health, Social Services and Equality (MSSSI), the Ministry of Industry, Energy and Tourism (MIET), using Red.es and the Health Departments of the autonomous communities.

The programme is financed by the European Regional Development Fund (ERDF) and it provides a framework in which to harmonize eHealth agendas at the state and regional levels, in order to improve the quality of the health care service by using information and communication technology efficiently

Its main objectives are to promote and complement the projects undertaken by the autonomous communities (electronic health records, e-prescribing and internet-based appointment scheduling), by providing infrastructure and associated ICT services, and to support the information systems of the Regional Health Services of the autonomous communities so that they can join the Electronic Health Records in the SNS project (EHR-SNS), which focuses on the exchange of clinical information by autonomous communities.

More information at:

http://www.msc.es/profesionales/hcdsns/TICS/TICS_SNS_ACTUALIZACION_ES_2010.pdf

Systematic Vaccinations

Statistical information maintained by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities and the competent authorities in Ceuta and Melilla. It is part of the central government's inventory of statistics.

Its general objective is to better understand the vaccinations administered in the population, particularly with regard to the vaccination calendar.

As study variables it uses type of vaccine and doses administered. The classification variable is age.

The data is gathered and published on an annual basis.

More information at:

<http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/vacunaciones/coberturas.htm>

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The Annual Report prepared by the Spanish Healthcare System Observatory provides, as it has in past years, a summary of the current state of Spain's national health system and insight into its evolution year by year. Its purpose is to offer all interested persons updated information about the situation and interventions that have taken place in Spain. This overview contributes to the transparency of the national health system and is useful for anyone wishing to obtain a better understanding of it during the period analysed.



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