Annual report on the National Health System of Spain 2012

Revised edition June 2015

REPORTS, STUDIES AND RESEARCH 2015
MINISTRY OF HEALTH, SOCIAL SERVICES AND EQUALITY

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

Spanish Healthcare System Observatory

Annual Report on the National Health System of Spain, 2012

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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 that the Spanish Healthcare System Observatory prepare an annual report on the state of the SNS, which is to be presented by the Ministry of Health, Social Services and Equality (MSSSI) to the Interterritorial Council of the SNS.

This new issue about the year 2012 constitutes the tenth edition of the report and it has a structure similar to the reports of previous years. It is organised into two parts: the first block describes the situation in terms of health and health care services, according to the information available when the document was being prepared. In 2011/2012 the government conducted a Spanish National Health Survey, an important information system that updated Spain's knowledge about the population's health and the use of health care services. The second section presents a summary of the most important events occurring in the National Health System of Spain over the course of the year, including the measures contained in the Health Care Reform of 2012.

The tasks of collecting and analysing data, co-ordinating the various departments involved and also drafting the final report are time-consuming processes. This means that while the report is being prepared new developments will certainly arise, but they cannot be included in this report because of its time frame, the year 2012.

In Part One, the document responds to questions of different types, such as: what is the life expectancy of the Spanish population, what have people died of, what are the chronic diseases they have suffered, what kind of lifestyle habits do they have, what resources does the health care system have, what does it do and how accessible is it, what is the health expenditure and how do the citizens perceive the system's equity and functioning.

Part Two, which looks particularly at the Health Care Reform of 2012, explores the implications and consequences of the urgent measures implemented to guarantee the sustainability of the SNS and to improve the quality and safety of its services, while ensuring at all times citizens' rights to health protection.

The annexes include a summary of the resolutions made by the SNS Interterritorial Council in the year 2012 and Royal Decree–Law 16/2012, of 20 April, on urgent measures to guarantee the sustainability and to improve the quality and safety of the system. This Royal Decree-Law is the main axis of the said reform. Also among the annexes is Royal Decree 1192/2012, of 3 August, which regulates entitlement of insured persons and beneficiaries to publicly-funded health care in Spain, through the SNS.

In sum, the Report provides an organised structure of data about health, the health care services and the most important developments in the SNS in 2012, with the aim of serving as a valid instrument for consultation by administrators, scholars and especially by citizens, the real legitimisers of any institution.

Summary

The most important data concerning health and health care services is summarised below.

Health status

- As of January 1, 2012 Spain had 47.3 million inhabitants, a birth rate of 10.2 births per 1,000 inhabitants and a mean maternal age of almost 32 years.
- Life expectancy at birth was 82.3 years (79.3 years for men and 85.3 years for women). Healthy life expectancy at birth was 66.4 years (67.0 years for men and 65.9 for women).
- One out of six adults had some kind of health problem. The most frequent problems were high blood pressure in men (17.4%) and osteoarthritis, arthritis and rheumatism in women (25.1%). Diabetes was more prevalent in men (7.1%) than in women (6.8%).
- The leading causes of mortality were ischaemic heart diseases in men and cerebrovascular diseases in women, although the number of deaths by these causes fell with respect to the preceding year.
- With regard to tumours, those responsible for the most mortality were bronchial and lung cancer and colon cancer. The cancer that caused the most deaths among men was bronchial and lung cancer, while among women it was breast cancer.
- The infant mortality rate was 3.2 deaths of babies under the age of one per 1,000 live births, meaning there was a reduction of 27% during the 2001-2011 period.
- The rise in the number of low birth weight babies has slowed in recent years: in 2011 the percentage of newborns weighing less than 2,500 grams at birth was 8.1%.
- As for the breastfeeding of children under age 5, at six weeks 72.4% of babies were fed fully or partially with their mother's milk, at 3 months the percentage was 66.5% and at 6 months it was 47.0%.

Lifestyle habits

- During the period covered by this report, the law that expanded the smoking prohibition in enclosed public areas entered its third year. On a scale of 1 to 10 the degree of acceptance expressed by citizens

regarding this measure was 7.6 points. People also expressed the opinion that compliance is higher in restaurants (8.2 out of 10) and lower in the areas near schools and hospitals (5.4 out of 10).

- Twenty-four percent of the adult population admitted smoking daily, while 3.1% were occasional smokers and 19.6% were ex-smokers who had given up the habit at least one year ago. By sex, the percentage of daily smokers was 27.9% in men and 20.2% in women.
- Among persons aged 15 years and over, 1.7% admitted consuming alcohol in quantities considered a long-term health risk; 2.0% in men and 1.4% in women.
- The number of admissions to alcohol abuse/dependence treatment programmes was close to 28,000, and the mean age of initiation in alcohol consumption was 18.9 years. The means of referral to these programmes was primarily the health care system (30.6%), followed by the individual's personal initiative (21.9%) or the initiative of family or friends (13.2%).
- A total of 40.9% of the population described itself as sedentary. By sex, 1 out of every 3 men (35.3%) and almost 1 out of every 2 women (46.2%) considered themselves sedentary.
- Obesity affected about 17% of the population aged 18 and over (18% of the men and 16% of the women). If overweight is included, then 53.7% of the population aged 18 and over was obese or overweight.
- The prevalence of child obesity has remained relatively stable since 1987; 27.8% display obesity or overweight, with a similar proportion in the two sexes; 1 out of 10 children was obese and 2 out of 10 were overweight.

Care resources

- A total of 28,771 general practitioners and 6,411 paediatricians were working in the Primary Care level of the SNS, making for a rate of 0.8 doctors per 1,000 inhabitants. There were 29,407 nursing professionals working in SNS Primary Care, which equals a rate of 0.6 nurses per 1,000 inhabitants.
- A total of 77,279 medical specialists were working in the Specialised Care level of the public network, along with 20,489 specialists-in-training, making the availability of specialists 2.1 per 1,000 inhabitants (1.7 and 0.4 respectively). There were 136,560 specialised nurses, which is a rate of 3.0 per 1,000 inhabitants.

- Nursing professionals constituted the most numerous group of professionals in the SNS, with 1.2 percentage points more than the group of doctors.
- In the 452 hospitals that belong to the public network of the SNS (which represents 59.2% of Spanish hospitals) there was a total of 113,518 beds available (79.6% of the total number of beds in the country), making the bed capacity 2.5 beds per 1,000 inhabitants. The public network of the SNS also had 32.6 day beds per 100,000 inhabitants.
- The technological resources of the SNS public network included 521 Computerised Axial Tomography (CAT) scanners (a rate of 11.3 per 1,000,000 inhabitants). The network had 279 Magnetic Resonance Imaging (MRI) scanners (a rate of 6.1 per 1,000,000 inhabitants). As for mammographs, there were a total of 421 in the public network (a rate of 9.1 per 1,000,000 inhabitants). The radiotherapy equipment (cobalt bombs and linear accelerators) consisted of 176 devices, a rate of 3.8 per 1,000,000 inhabitants.
- In 2012 there were 177 designated Reference Centres, Services and Units (CSUR) for 42 pathologies or procedures.
- The number of hospitals authorised to perform transplants was 44, with organ transplant programmes existing for kidney, liver, heart, lung, pancreas, the small bowel and others, for both adults and children. The number of co-ordination teams at the end of 2012 was 185, and these teams comprised 254 doctors and 158 nurses.
- The transfusion network in Spain consisted of 24 transfusion centres and 341 transfusion services associated with the centres. A total of 1,757,940 voluntary, non-remunerated donations took place, making the donation rate 38.2 donations per 1000 inhabitants.

Health care service activity

- In the 3,006 Primary Care Centres and 10,116 Local Primary Care Centres in operation in the SNS, approximately 259 million medical consultations took place during the year. This represents a per person frequentation rate of 5.6 visits per year.
- If the urgent care provided outside of normal working hours is also taken into account, the number of primary care medical consultations reaches 279 million. And if nursing activity is calculated along with medical activity, the volume exceeds 418 million contacts.
- About 97% of all the activity took place in some type of health care centre and the rest was at the patient's home, although the figures

vary depending on the type of professional involved. Care delivered at patients' homes represented 1.3% of all family medicine activity while it was 7.6% in the case of nursing.

- The different types of medical specialists in the SNS attended 75.5 million consultations (86.0% of the health care sector as a whole), 21.0 million of these consultations were emergencies (79.5% of the total number of emergencies).
- In the area of surgery, 3.4 million surgical interventions were performed. Among these, over 1 million were major outpatient surgery, which represents a substitution rate of over 30%. The surgical activity of SNS hospitals was 71.0% of the total surgical activity in Spain.
- In SNS hospitals over 368,000 births were attended (78.7% of the total), of which 21.8% were Caesarean. In the sector as a whole (public and private hospitals) the Caesarean rate was 25.0%.
- The rate of organ donors per 1,000,000 inhabitants was 34.8; in absolute values, 1.643 donors. The average age of the donors was 58.3 years, following the upward trend observed in recent years. The distribution by sex was similar to previous years; approximately 62% of donors were men and 38% women.
- Hematopoietic stem cell transplantation (HSCT) has become a well-established therapy. In 2012 about 3,000 transplants of this type were performed; two thirds were autologous and the remaining third allogeneic.

Professional regulation

- In 2012, the system had a total of 25,578 specialists-in-training belonging to the 58 health science specialties, in 3,011 accredited teaching units. In these units there were a total of 9,431 health professionals authorised to teach the future specialists.
- A total of 7,845 specialist-in-training slots were offered for the year 2012/13. This number was 5.1% lower than the preceding year, a reflection of how the system adapts to its changing needs and also to available resources.

Medicines

- In 2012 the pharmaceutical expenditure generated by SNS medical prescriptions was 9,770.9 million Euros, a reduction of 12.3% with respect to 2011.

- This was the first time since 2004 that public pharmaceutical spending was under 10,000 million Euros. In the second semester, with the application of Royal Decree-Law 16/2012, the savings in pharmaceuticals reached almost 1,107 million.
- The years 2010 and 2011 brought a slowdown in the growth of prescriptions invoiced to the SNS and in 2012 there was a reduction of 6.1% with respect to 2011.
- In 2012 the average expenditure per prescription also fell, continuing the trend begun in previous years, with an average reduction of 6.5% with respect to the preceding year.
- The use of generic medicines represented 39.7% of the total number of medicine packages invoiced to the SNS. In terms of the amount invoiced, 18.4% of the total invoiced corresponded to generic medicines.

Access to health care services

- In primary care, 40% of the patients seeking an appointment with the general practitioner were given one for the same day. For the rest, the mean wait time was 3.6 days.
- The number of patients waiting for an initial consultation in Specialised Care was, as of 31 December 2012, 42.2 per 1,000 inhabitants, with a mean wait time of 59 days. This is an increase of 3 days compared to the waiting list situation during the preceding six-month period.
- As of 31 December 2012, the number of patients on the structural waiting list was 12.8 patients per 1,000 inhabitants, which is an increase of one point compared to the first semester of the same year. Of this group, the percentage waiting for more than 6 months was 16.5%, while the mean wait time for the group as a whole was 100 days.
- The Interterritorial Council of the SNS (CISNS), acting on the proposal made by the Public Health Commission, approved the basic vaccination calendar for children.
- The percentage of children who received the basic series of recommended vaccinations in Spain was over 96%. A total of 93% of children aged 1 to 2 received the recommended booster vaccinations.
- The rate of vaccination against measles-mumps-rubella (MMR) in children aged 1 to 2 was over 97%, with over 90% also receiving

the recommended boosters. The percentage of adolescents (11-14 years old) who received three doses of the hepatitis B vaccination was 76.7%. In the 2011-2012 academic year vaccination coverage against the human papillomavirus was over 70% in girls aged 11-14.

- Seasonal flu vaccination in persons aged 65 and over has been falling in recent years, although the percentage of coverage continues to be almost 60%.
- Of women 50 to 69 years of age, 77.1% had been given a mammogram within the past two years.
- Nine out of 10 men and women aged 50 to 69 had never been tested for faecal occult blood and among those tested only 7% had been tested within the past two years.

Health expenditure

- In 2011 the Spanish health care system's total expenditure was 98,860 million Euros, which represents 9.3% of the GDP. Of this percentage, 6.8% was funded with public resources and 2.5% came from private resources.
- Regional governments, which funded 91.5% of the expenditure, were the agents bearing the greatest burden in the public funding of health care. With respect to the private expenditure, it was households that made the greatest contribution to the funding, with a participation of 76.6%.
- Over the 2007-2011 period, the average annual growth of the total health care expenditure was 2.5% (3.0% for the public expenditure and 1.4% for the private expenditure). However, during the last year, while the public sector health care expenditure fell by 3.4%, the private health care expenditure rose by 2.5%.
- In 2011 the expenditure dropped in all health care functions, except in auxiliary services and curative and rehabilitative care services. If changes in the capital formation expenditure are not considered, the differences are found primarily in the services aimed at prevention and public health, in medical products dispensed to outpatients and in long-term care services.
- With the exception of hospitals, there was less expenditure by all health care providers. The most significant decreases took place in residential nursing care establishments (11.2%), in retailers

and other medical product providers (5.9%) and in the general administration of health and health insurance (2.2%).

Health strategies

- The strategies in place during the year 2012 focused on cancer, ischaemic heart disease, diabetes, mental health, palliative care, stroke, COLD and rare diseases. In the year 2012 two new strategies were presented to the Interterritorial Council of the SNS (CISNS) for approval: one on chronicity and one on rheumatic and musculoskeletal diseases.

Network of Health Schools for Citizens

- The CISNS approved the creation of the Spanish Network of Health Schools for Citizens, a transversal instrument to support the strategies that the system has put in place. The objective of such schools is to promote and reinforce the capacity of individuals and the community to encourage greater autonomy, self-care and healthy lifestyles.

Spanish Network of Health Technology Agencies and SNS Benefits

- The CISNS adopted the proposal to create the Spanish Network of Health Technology Agencies and SNS Benefits. The aim of the network is to provide foundations for decision-making regarding the incorporation, financing or divestment conditions and appropriate use of health technologies, applying a uniform policy throughout the country, in order to promote equity and sustainability in the SNS.

e-Health

- Persons entitled to health protection are identified by means of an Individual Health Card (or TSI, for *Tarjeta Sanitaria Individual*), issued by each autonomous community to the population residing in its territory. This identification method depends on a SNS-wide management system using information and communication

technologies supported by the Ministry of Health. Each person is assigned a personal, unique and life-long identification code that enables him or her to move around within the health care system and receive care wherever he or she may be. During the year 2012 the TSI system processed 60.6 million messages and 23.5 million transactions were executed among the health care administrations.

- The interoperable Electronic Health Record system enables a patient's clinical information to be accessed from any place in the SNS and it can also be consulted by the patients themselves. This system too is supported by the system-wide technological infrastructures implemented by the SNS. At the end of 2012, ten autonomous communities were integrated into this system, albeit with varying degrees of development. As a result, the clinical information of 15,710,888 persons was available in conditions of interoperability.
- In 2012 the progressive implementation of electronic prescribing continued, mainly in SNS Primary Care Centres. The number of autonomous communities that have fully introduced this kind of system or are at an advanced stage was 12 compared to 8 the previous year. Of all the prescriptions dispensed, 58.3% were dispensed through electronic prescribing.

Citizen opinions and perception

- A total of 70.6% of citizens made a favourable assessment of Spain's health care system, believing it either "works quite well" or "works well but needs some changes."
- The level of satisfaction with how the public sector health care system works in Spain stood at 6.6 points out of a maximum score of 10.
- In 2012, there continued to be more citizens who prefer public health services over private health services.
- With the negative economic and financial situation as a backdrop, the idea of requiring all patients to contribute to the price of the medicines they acquire, on a sliding scale depending on the household's income, was viewed favourably by 42.5% of respondents.
- Of the citizens surveyed, 80.9% expressed the opinion that political leaders should adopt regulatory measures to prevent the misuse of public health care services, to ensure their quality and proper functioning.

Part I

Health
1. Health Status

1.1. Demographic data

As of 1 January 2012, Spain's population was 47.3 million inhabitants, with a slight numerical predominance of women (50.7%) over men (49.3%). Of this population, 58.5% lived in Andalucía, Cataluña, Madrid and Comunidad Valenciana.

Table 1.1. Official population by sex and autonomous communities, as of 1 January 2012

	Both sexes	% of total	Men	Women
Andalucía	8,449,985	17.9	4,180,285	4,269,700
Aragón	1,349,467	2.9	671,898	677,569
Asturias	1,077,360	2.3	516,420	560,940
Baleares	1,119,439	2.4	560,091	559,348
Canarias	2,118,344	4.5	1,056,240	1,062,104
Cantabria	593,861	1.3	289,999	303,862
Castilla y León	2,546,078	5.4	1,261,141	1,284,937
Castilla-La Mancha	2,121,888	4.5	1,069,648	1,052,240
Cataluña	7,570,908	16.0	3,741,628	3,829,280
Comunidad Valenciana	5,129,266	10.9	2,546,404	2,582,862
Extremadura	1,108,130	2.3	550,324	557,806
Galicia	2,781,498	5.9	1,343,328	1,438,170
Madrid	6,498,560	13.7	3,130,241	3,368,319
Murcia	1,474,449	3.1	742,727	731,722
Navarra	644,566	1.4	321,453	323,113
País Vasco	2,193,093	4.6	1,070,438	1,122,655
La Rioja	323,609	0.7	161,574	162,035
Ceuta	84,018	0.2	42,948	41,070
Melilla	80,802	0.2	41,569	39,233
Spain	**47,265,321**	**100**	**23,298,356**	**23,966,965**

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

Growth in the number of inhabitants in Spain has experienced a clear slowdown in the past three years, as Table 1.2. shows.

Table 1.2. Official population by autonomous community

	2000	2005	2010	2011	2012
Andalucía	7,340,052	7,849,799	8,370,975	8,424,102	8,449,985
Cataluña	6,261,999	6,995,206	7,512,381	7,539,618	7,570,908
Madrid	5,205,408	5,964,143	6,458,684	6,489,680	6,498,560
Comunidad Valenciana	4,120,729	4,692,449	5,111,706	5,117,190	5,129,266
Galicia	2,731,900	2,762,198	2,797,653	2,795,422	2,781,498
Castilla y León	2,479,118	2,510,849	2,559,515	2,558,463	2,546,078
País Vasco	2,098,596	2,124,846	2,178,339	2,184,606	2,193,093
Castilla-La Mancha	1,734,261	1,894,667	2,098,373	2,115,334	2,121,888
Canarias	1,716,276	1,968,280	2,118,519	2,126,769	2,118,344
Murcia	1,149,328	1,335,792	1,461,979	1,470,069	1,474,449
Aragón	1,189,909	1,269,027	1,347,095	1,346,293	1,349,467
Baleares	845,630	983,131	1,106,049	1,113,114	1,119,439
Extremadura	1,069,420	1,083,879	1,107,220	1,109,367	1,108,130
Asturias	1,076,567	1,076,635	1,084,341	1,081,487	1,077,360
Navarra	543,757	593,472	636,924	642,051	644,566
Cantabria	531,159	562,309	592,250	593,121	593,861
La Rioja	264,178	301,084	322,415	322,955	323,609
Ceuta	75,241	75,276	80,579	82,376	84,018
Melilla	66,263	65,488	76,034	78,476	80,802
Spain	**40,499,791**	**44,108,530**	**47,021,031**	**47,190,493**	**47,265,321**

Remarks: the figures refer to 1 January of each year and appear in order from highest to lowest according to the year 2012.
Source: National Statistics Institute (INE). Official population figures.

The youth dependency ratio[1] was 22.4%, while the birth rate was 10.2 births per 1,000 inhabitants and the mean maternal age was almost 32 years.

Twenty-five years ago, the youth dependency ratio was 29.5%, the birth rate was about 10.3 births per 1,000 inhabitants and the mean maternal age was just under 29 years.

Table 1.3. Youth dependency ratio

	1990	1995	2000	2005	2010	2011
Melilla	39.9	38.0	34.4	33.4	32.5	32.9
Ceuta	38.5	34.3	30.7	29.5	29.0	29.2
Murcia	35.8	29.7	25.9	24.9	25.5	25.9
Andalucía	35.0	29.9	26.1	24.1	24.0	24.2
Cataluña	26.8	21.9	20.1	20.9	23.2	23.7
Madrid	29.3	22.9	20.4	21.1	23.0	23.4
Navarra	26.6	21.6	20.0	21.0	22.8	23.2
Baleares	31.3	25.7	22.8	22.3	22.9	23.0
Castilla-La Mancha	30.0	27.8	25.3	22.9	22.4	22.6
Comunidad Valenciana	30.6	24.8	21.7	21.3	22.3	22.6
Spain	**29.5**	**24.5**	**21.6**	**21.1**	**22.1**	**22.4**
La Rioja	26.9	21.8	19.5	19.5	21.3	21.9
Extremadura	30.8	29.0	25.9	23.1	21.8	21.8
Canarias	33.5	27.6	23.7	22.1	21.5	21.4
Aragón	25.0	21.1	19.3	19.2	20.6	21.0
País Vasco	25.2	19.1	17.0	17.6	19.7	20.3
Cantabria	28.5	22.0	18.3	17.5	19.0	19.4
Castilla y León	25.4	21.6	18.8	17.6	18.2	18.4
Galicia	26.6	22.0	18.2	17.0	17.5	17.8
Asturias	24.8	19.0	15.6	14.8	15.8	16.2

Remarks: data appears in order from highest to lowest according to the year 2011.
Source: Ministry of Health, Social Services and Equality, SNS Key Indicators (INCLASNS).

Table 1.4. Birth rate per 1,000 inhabitants

	1990	1995	2000	2005	2010	2011
Melilla	18.0	17.4	16.9	15.2	18.4	19.4
Ceuta	14.7	15.1	14.0	14.9	15.8	15.2
Murcia	13.3	11.5	12.3	13.2	12.3	11.8
Madrid	10.1	9.3	10.8	11.8	11.6	11.3
Cataluña	9.4	8.9	10.2	11.6	11.5	11.1
Andalucía	12.9	11.2	11.1		11.2	10.8
Navarra	9.3	8.7	9.6	10.5	10.9	10.8
Castilla-La Mancha	11.5	10.2	9.6	10.1	10.8	10.4
Baleares	12.5	10.3	11.4	11.2	11.1	10.3
Spain	**10.3**	**9.2**	**9.9**	**10.8**	**10.5**	**10.2**
La Rioja	8.8	7.8	8.7	10.2	10.7	10.1
Comunidad Valenciana	10.5	9.4	10.1	11.1	10.4	9.9
País Vasco	7.8	7.4	8.4	9.3	9.9	9.9
Aragón	8.2	7.8	8.3	9.3	9.9	9.6
Cantabria	8.7	7.1	8.2	9.5	9.6	9.2
Extremadura	11.9	10.2	9.6	9.3	9.4	9.2
Canarias	12.5	10.9	11.1	10.4	8.8	8.3
Castilla y León	8.4	7.2	7.3	7.9	8.2	8.0
Galicia	8.2	6.9	7.2	7.8	8.1	7.9
Asturias	7.1	6.1	6.3	7.1	7.3	7.4

Remarks: data appears in order from highest to lowest according to the year 2011.
Source: Ministry of Health, Social Services and Equality, SNS Key Indicators (INCLASNS).

Table 1.5. Mean maternal age

	1990	1995	2000	2005	2010	2011
País Vasco	29.7	31.1	32.1	32.4	32.4	32.5
Galicia	27.8	29.2	30.5	31.3	31.9	32.2
Madrid	29.5	30.8	31.5	31.4	31.9	32.1
Navarra	29.9	31.0	31.7	31.8	31.6	32.1
Cantabria	28.7	30.0	31.1	31.6	31.9	32.0
Castilla y León	29.2	30.3	31.4	31.7	31.8	32.0
Asturias	28.1	29.5	30.7	31.4	31.7	31.8
Aragón	29.4	30.6	31.5	31.5	31.3	31.7
Spain	**28.9**	**30.0**	**30.7**	**30.9**	**31.2**	**31.5**
Extremadura	28.7	29.3	30.2	30.9	31.2	31.4
La Rioja	29.2	30.5	31.3	31.0	31.3	31.4
Castilla-La Mancha	29.1	29.8	30.6	30.7	30.9	31.3
Cataluña	29.1	30.3	30.9	30.9	31.1	31.3
Comunidad Valenciana	28.9	30.0	30.7	30.7	31.1	31.3
Baleares	28.5	29.7	30.3	30.3	30.8	31.1
Andalucía	28.6	29.5	30.1	30.4	30.7	31.0
Canarias	28.2	29.1	29.5	30.0	30.5	30.8
Murcia	28.7	29.6	30.1	30.1	30.6	30.7
Ceuta	…	29.5	29.3	29.7	29.8	29.8
Melilla	…	28.7	29.5	29.5	29.7	29.5

Remarks: data appears in order from highest to lowest according to the year 2011.
Source: Ministry of Health, Social Services and Equality, SNS Key Indicators (INCLASNS).

1.2. Life expectancy

In 2011, life expectancy (LE) at birth was 82.3 years (79.3 years for men and 85.3 years for women). The steady rise in LE that has been observed in recent decades has significant social and health-related consequences: growing numbers of older citizens and greater prominence of chronic diseases and disability in morbidity patterns.

The years lived by an individual are not always lived in a perfect state of health so the increase in a population's LE may not be accompanied by a good level of health. To explore this question it is necessary to use indicators such as healthy life expectancy (HLE), a set of indicators that takes into account not only the population's mortality but also the morbidity and disability it experiences.

Healthy life years (HLY) at birth was estimated to be 66.4 years (67.0 years for men and 65.9 for women). Since the year 2007, when it was 63.0 years (63.0 for men and 62.9 for women), the HLY at birth has increased by 3.4 years in the Spanish population as a whole. This increase was slightly higher in men, in whom it rose by 4 years, than in women, in whom it rose by just 3 years.

As for life expectancy at birth (LEB), this indicator increased during the same study period (2007-2011) by 1.2 years (1.5 years in men and 1 year in women). At birth, Spanish women can expect to live 6.1 years longer than men. However, when HLY at birth are considered, the difference in favour of women disappears and men can expect to live without limitation in their usual activity for 1.1 years longer than women.

Of the LEB years, 80.6% (84.5% in men and 77.3% in women) were lived without limitation.

At birth, the Spanish population could be expected to live 66.4 years without any limitation in their activity (HLY at birth). Between 2007 and 2011, the HLY rose by 3.4 years, while LEB rose by 1.2 years. This data suggests a compression of the morbidity of the Spanish population.

Table 1.6. Life expectancy (LE) and healthy life years (HLY) at birth and at age 65, by sex

	LE		HLY	
	2007	2011	2007	2011
At birth				
Both sexes	81.1	82.3	63.0	66.4
Men	77.8	79.3	63.0	67.0
Women	84.3	85.3	62.9	65.9
At age 65				
Both sexes	20.0	20.9	11.4	12.1
Men	17.8	18.7	11.5	12.4
Women	21.9	22.8	11.4	11.9

Source: Ministry of Health, Social Services and Equality. Healthy life expectancies in Spain, 2007-2011.

The percentage of the years of LEB lived without limitation was 80.6%, having risen since 2007, when it was 77.7%. The age to which 50% of the Spanish population could be expected to live without limitations in their activity was 73 years, slightly higher than the 2007 estimate. The HLY at the age of 65 (HLY65) were 12.1 years, which equalled almost 60% of the LE at that age. The HLY65 have increased slightly less than one year since 2007.

Men can be expected to live without limitation in their activity about one year longer than women. Although since 2007 the HLY has increased in both sexes, the greater increase observed in men resulted in an increase in the differences between the two sexes.

At birth, women can be expected to live 19 years with limitations in their activity, more than the estimate for men (12.3). In both sexes, the number of years lived with limitation fell by about 2 years between 2007 and 2011.

In 2011 the proportion of life expectancy at birth years that are lived without limitation was greater in men (84.5%) than in women (77.3%). In both sexes, the percentage has risen since 2007.

At the age of 65 years, men expected to live another 12.4 years of healthy life (66% of the LE at that age) while women expected to live another 11.9 years (52% of the LE65).

The gap between the autonomous communities with the highest and lowest HLY was 14 years. The differences have decreased slightly since 2007. Although no defined geographic pattern is visible, north-western Spain and certain communities on the Mediterranean had the lowest HLY figures.

Table 1.7. Life expectancy (LE) and healthy life years (HLY) at birth by autonomous community

	LE		HLY	
	2007	**2011**	**2007**	**2011**
Madrid	82.5	84.1	67.3	68.1
Navarra	82.5	83.8	62.8	70.5
Castilla y León	82.1	83.4	68.7	69.6
La Rioja	81.8	83.1	58.7	66.9
Castilla-La Mancha	81.5	83.0	67.1	69.5
Cataluña	81.6	82.8	60.8	66.3
País Vasco	81.6	82.8	63.3	68.0
Aragón	81.7	82.6	67.1	71.2
Cantabria	81.1	82.6	67.8	72.0
Spain	**81.1**	**82.3**	**63.0**	**66.4**
Baleares	81.7	82.2	61.7	65.6
Galicia	81.0	82.2	59.1	64.2
Murcia	80.5	82.0	60.0	65.3
Comunidad Valenciana	80.6	81.9	59.4	66.3
Canarias	80.4	81.8	63.9	57.9
Extremadura	80.6	81.8	63.8	67.4
Asturias	80.4	81.4	58.7	63.0
Andalucía	79.8	81.0	63.1	65.0
Ceuta and Melilla	79.5	80.3	53.3	62.4

Remarks: data appears in order from highest to lowest according to LE of 2011.
Source: Ministry of Health, Social Services and Equality. Healthy life expectancies in Spain, 2007-2011.

Table 1.8. Percentage of healthy life years (HLY) in life expectancy (LE) at birth and at age 65, by autonomous community

	At birth		At age 65	
	2007	**2011**	**2007**	**2011**
Cantabria	83.5	87.2	61.8	62.6
Aragón	82.2	86.2	63.2	62.1
Navarra	76.1	84.1	51.6	59.7
Castilla-La Mancha	82.3	83.7	55.4	57.1
Castilla y León	83.7	83.4	61.2	70.3
Extremadura	79.2	82.3	60.6	54.2
País Vasco	77.5	82.1	57.9	72.2
Madrid	81.6	81.0	65.3	57.3
Comunidad Valenciana	73.7	80.9	56.2	63.2
Spain	**77.7**	**80.7**	**57.0**	**58.1**
La Rioja	71.8	80.5	34.5	57.4
Andalucía	79.0	80.2	60.1	52.5
Cataluña	74.5	80.1	55.0	58.6
Baleares	76.5	79.8	49.0	56.9
Murcia	74.5	79.7	42.2	52.2
Galicia	73.0	78.1	49.4	53.5
Ceuta and Melilla	67.0	77.7	33.5	47.1
Asturias	73.0	77.4	50.6	53.5
Canarias	79.5	70.9	59.9	44.8

Remarks: data appears in order from highest to lowest according to HLY at birth in 2011.
Source: Ministry of Health, Social Services and Equality. Healthy life expectancies in Spain, 2007-2011.

Table 1.9. Difference between 2011 and 2007 in life expectancy (LE) and healthy life years (HLY) at birth and at age 65, by autonomous community

	At birth		At age 65	
	LE	**HLY**	**LE**	**HLY**
Madrid	1.6	0.8	1.1	-1.1
Cantabria	1.5	4.2	1.0	0.8
Murcia	1.5	5.3	0.9	2.4
Canarias	1.4	-5.9	0.9	-2.6
Castilla-La Mancha	1.4	2.4	0.9	0.8
Castilla y León	1.3	0.9	0.9	2.5
Comunidad Valenciana	1.3	6.8	0.8	1.8
Navarra	1.3	7.7	0.8	2.2
La Rioja	1.3	8.2	0.8	5.1
Spain	**1.2**	**3.5**	**0.9**	**0.7**
Andalucía	1.2	1.9	0.9	-1.0
Cataluña	1.2	5.5	0.9	1.3
Extremadura	1.2	3.5	0.8	-0.8
Galicia	1.2	5.1	0.8	1.3
País Vasco	1.2	4.7	0.8	3.6
Aragón	0.9	4.1	0.5	0.1
Asturias	0.9	4.3	0.8	1.0
Ceuta and Melilla	0.8	9.1	0.3	2.7
Baleares	0.6	3.9	0.4	1.8

Remarks: data appears in order from highest to lowest according to difference in LE at birth.
Source: Ministry of Health, Social Services and Equality. Healthy life expectancies in Spain, 2007-2011.

Table 1.10. Changes in life expectancy (LE) and healthy life years (HLY) at age 65, by autonomous community

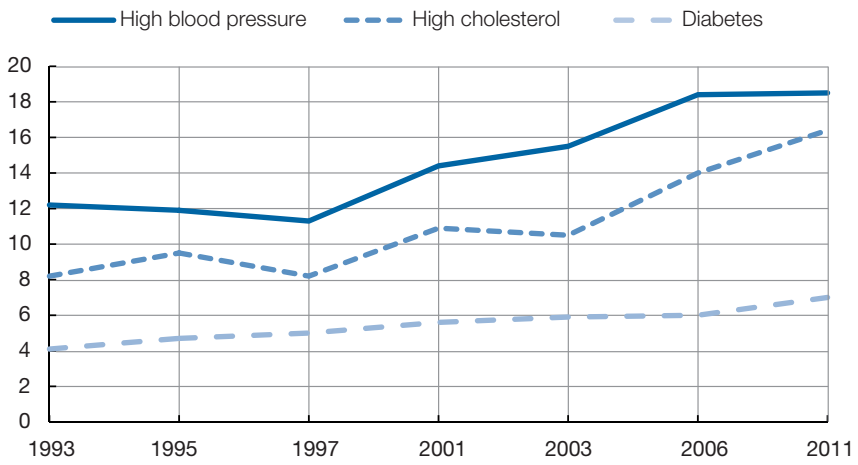
	LE		HLY	
	2007	**2011**	**2007**	**2011**
Madrid	21.0	22.0	13.7	12.6
Castilla y León	21.0	21.9	12.9	15.4
Navarra	21.1	21.9	10.9	13.1
País Vasco	20.6	21.4	11.9	15.5
La Rioja	20.5	21.3	7.1	12.2
Cantabria	20.2	21.2	12.5	13.2
Cataluña	20.3	21.2	11.1	12.4
Castilla-La Mancha	20.2	21.1	11.2	12.1
Galicia	20.3	21.1	10.0	11.3
Aragón	20.5	21.0	13.0	13.1
Spain	**20.0**	**20.9**	**11.4**	**12.1**
Baleares	20.3	20.7	10.0	11.8
Asturias	19.7	20.6	10.0	11.0
Canarias	19.7	20.5	11.8	9.2
Extremadura	19.6	20.5	11.9	11.1
Comunidad Valenciana	19.6	20.3	11.0	12.8
Murcia	19.4	20.3	8.2	10.6
Andalucía	18.8	19.7	11.3	10.3
Ceuta and Melilla	19.1	19.4	6.4	9.1

Remarks: data appears in order from highest to lowest, by life expectancy (LE) at birth in 2011.
Source: Ministry of Health, Social Services and Equality. Healthy life expectancies in Spain, 2007-2011.

1.3. Morbidity

Chronic and non-transmissible diseases have shown continued growth since the final decades of the 20th century and they have taken the place of infectious diseases as the leading causes of morbidity and mortality.

Graph 1.1. Changes in the prevalence (%) of chronic health problems in adults



Source: Ministry of Health, Social Services and Equality and the National Statistics Institute (INE). Spanish National Health Survey, 2011/2012.

One out of six Spanish adults has a chronic health problem, with women being affected more frequently than men.

Table 1.11 Chronic health problems (%) in women aged over 15, in order from more to less frequent

	Women
Osteoarthritis, arthritis or rheumatism	25.1
Chronic back pain (lumbar region)	22.8
Chronic back pain (cervical region)	21.9
High blood pressure	19.5
High cholesterol	16.8
Migraine or frequent headache	12.3
Chronic allergy	11.8
Anxiety	9.8
Depression	8.7
Thyroid problems	7.8
Diabetes	6.8
Asthma	4.8
Chronic bronchitis	3.4

Source: Ministry of Health, Social Services and Equality and the National Statistics Institute (INE). Spanish National Health Survey, 2011/2012.

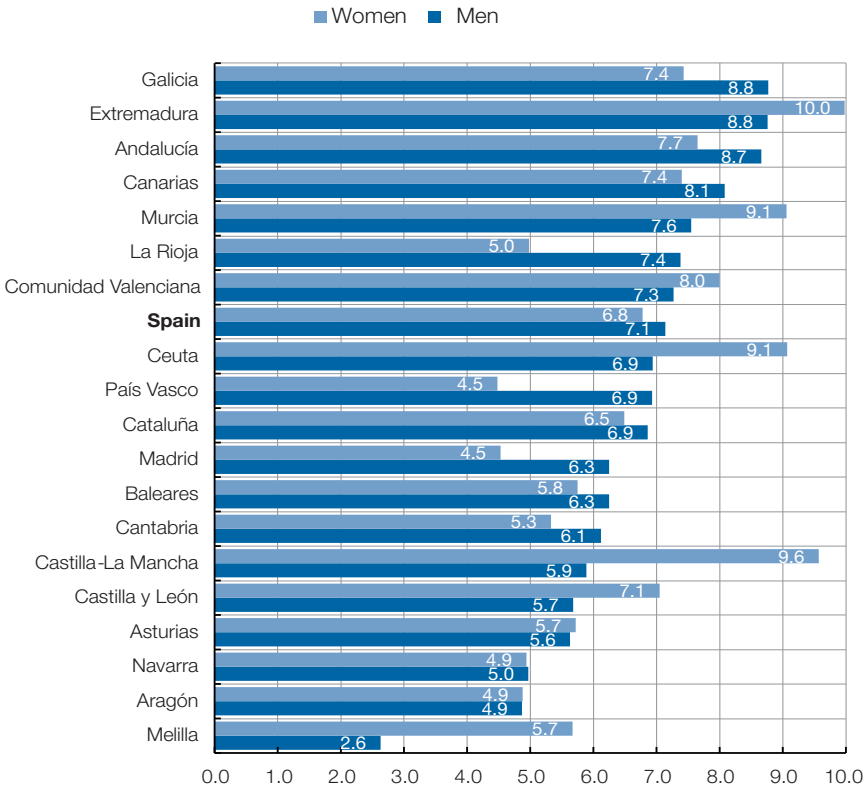
Table 1.12. Chronic health problems (%) in men aged over 15, in order from more to less frequent

	Men
High blood pressure	17.4
High cholesterol	15.9
Chronic back pain (lumbar region)	14.3
Osteoarthritis, arthritis or rheumatism	11.1
Chronic allergy	9.7
Chronic back pain (cervical region)	9.6
Diabetes	7.1
Migraine or frequent headache	4.2
Chronic bronchitis	4.2
Anxiety	3.5
Asthma	3.4
Depression	3
Thyroid problems	1

Source: Ministry of Health, Social Services and Equality and the National Statistics Institute (INE). Spanish National Health Survey, 2011/2012.

In the case of diabetes, prevalence in men is greater than in women, although there are differences among the autonomous communities.

Graph 1.2. Prevalence of diabetes (%) in adult population, by autonomous community and sex



Remarks: data appears in order from highest to lowest according to prevalence in men. The information obtained through the interviews performed as part of the National Health Survey provides a good understanding of the real prevalence of the disease in the adult population. In the survey respondents are asked if they "have or have had" this problem. If the answer is yes, the next question is "did a doctor tell you that you have it?" and only respondents answering yes to both questions are computed.

Source: Ministry of Health, Social Services and Equality and the National Statistics Institute (INE). Spanish National Health Survey, 2011/2012.

Castilla-La Mancha is the autonomous community with the most striking difference between men and women, with a clear feminization of the disease; the same occurs in Ceuta.

Women in Extremadura and men in Galicia and Extremadura have the highest figures; La Rioja and País Vasco show a clearly male predominance.

1.4. General mortality

According to the most recent data available[2] in 2011 there were 387,911 deaths in Spain, 5,864 more than the preceding year. Of them 188,057 were women (2.2% more than the preceding year) and 199,854 were men (0.9% more).

The gross death rate was 841.0 deaths per 100,000 inhabitants, an increase of 1.4% with respect to the preceding year. The women's rate was 802.2 deaths per 100,000 women, while the men's rate was 881.1 per 100,000 men.

The three leading causes of death by major disease groups were circulatory system diseases (responsible for 30.5% of the total number of deaths), tumours (28.2%) and respiratory system diseases (10.9%).

The first two causes showed the same trend as in recent years: an upward trend in the case of tumours (2.0% more deaths) and a downward trend in the case of circulatory diseases (0.7%). In contrast, the deaths due to respiratory diseases rose by 4.9%, after falling the past two years.

The group with the greatest increase in deaths, in relative terms, was nervous system diseases (5.0%), the fourth most frequent cause of death. The main disease in this group was Alzheimer's, which caused 11,907 deaths, twice as many as in 2000.

The most frequent causes of death in both sexes were tumours and circulatory system diseases, but in different order for each case. Tumours were the first cause of death in men (with a rate of 295.3 deaths per 100,000) and the second cause in women (with 180.7). In both cases the rate was higher than the previous year's rate.

Looking at the diseases in more detail, ischaemic heart diseases (infarction, angina pectoris, etc.) and cerebrovascular diseases again occupied first and second positions in number of deaths. However, in both cases, there was a decrease in the number of deaths compared to the previous year (1.2% and 4.3%, respectively). Ischaemic diseases were the leading cause in men, while in women cerebrovascular diseases headed the list.

Regarding the tumours, the ones responsible for the highest mortality were lung and bronchial cancer (with 1.6% more deaths than in 2010) and colon cancer (with 4.0% more). By sex, the cancer that caused the most deaths among men was lung and bronchial cancer. Among women it was breast cancer, which increased by 0.4%.

The number of deaths due to traffic accidents decreased again this year. More specifically, the total was 2,116 persons, 9.4% fewer than in 2010. Since the beginning of the previous decade, traffic accident deaths have fallen by about two thirds.

Table 1.13. Deaths due to the leading causes

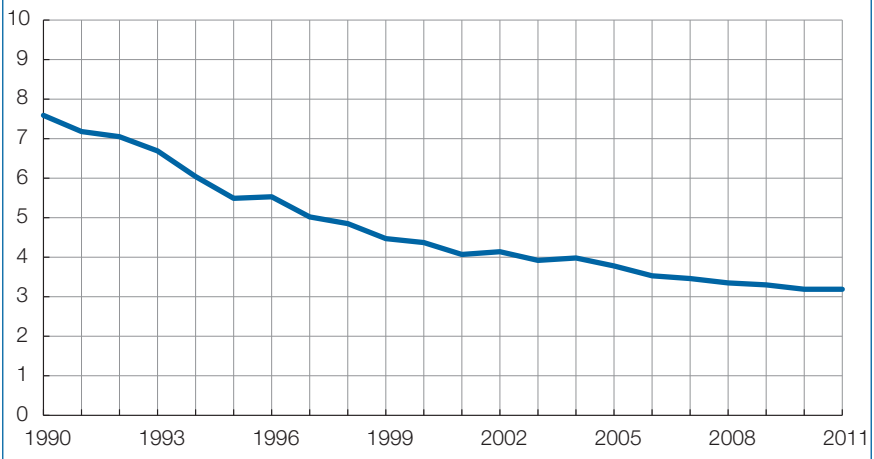
	2011		
	Total	**Men**	**Women**
Total deaths	**387,911**	**199,854**	**188,057**
Ischaemic heart diseases	34,837	19,925	14,912
Cerebrovascular diseases	28,855	12,152	16,703
Lung and bronchial cancer	21,058	17,479	3,579
Cardiac insufficiency	17,089	5,954	11,135
Chronic lower respiratory diseases	15,904	11,819	4,085
Dementia	14,583	4,780	9,803
Alzheimer's disease	11,907	3,528	8,379
Colon cancer	11,687	6,687	5,000
Diabetes mellitus	9,995	4,153	5,842
Hypertensive disease	9,669	3,193	6,476
Pneumonia	8,167	4,166	4,001
Renal failure	6,659	3,253	3,406
Breast cancer	6,399	85	6,314
Prostate cancer	6,034	6,034	…
Pancreas cancer	5,812	3,009	2,803

Remarks: causes having a relative weight of over 1.5%.
Source: National Statistics Institute (INE). Mortality by cause of death, 2011.

1.5. Infant mortality

The infant mortality rate was 3.2 deaths of infants under age one per 1,000 live births, which means a decrease of 27% in the 2001-2011 period and a decrease of 58% since 1990.

Graph 1.3. Infant mortality rate per 1,000 live births



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

Infant mortality continues to be an essential indicator in assessing the health status of a population, although in developed countries it has lost sensitivity as a gauge of the social and economic level of a community.

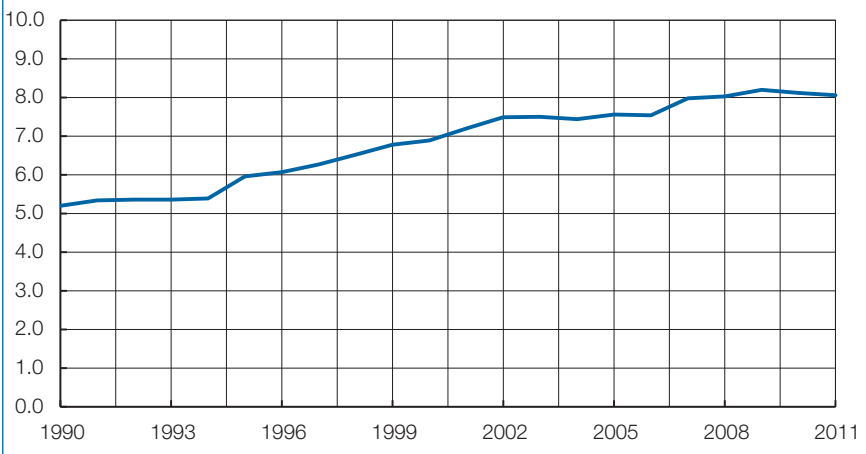
The top 10 causes of infant mortality, by number of deaths, were:

- Congenital malformations, deformities and chromosomal anomalies
- Neonatal haemorrhage
- Neonatal bacterial sepsis
- Intrauterine hypoxia and asphyxia at birth
- Respiratory difficulty in the neonate
- Sudden infant death syndrome
- Disorders related to short gestation and low birth weight
- Foetus and neonate affected by maternal complications during pregnancy
- Foetal and neonatal necrotising enterocolitis
- Foetus and neonate affected by complications involving the placenta or membranes

1.6. Low birth weight

In recent decades Spain has seen a significant increase in the proportion of babies weighing less than 2,500 grams at birth, although it appears that in the last few years this trend has been slowing. In 1990 the percentage was just over 5% and in 2009 it reached 8.2%, subsequently falling slightly to 8.12% in 2010 and then to 8.06% in 2011.

Graph 1.4. Neonates with low birth weights per 100 live births



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

Babies born with low birth weight have a greater risk of health problems and death, they need more hospitalisation after birth and they are more likely to develop disabilities.

Low birth weight is an important indicator of children's health because of its close relationship with infant morbidity and mortality; it is also a reflection of various adverse circumstances that accompany the pregnancy and it is linked to biological, demographic and socio-economic factors. However, the most important factors seem to be the mother's general state of health and nutrition, and so it is also a good indicator of the community's nutritional status.

Factors contributing to low birth weight include increasing maternal age, motherhood in adolescents, in vitro fertility treatments and harmful habits such as smoking and drinking. Furthermore, the broader use of certain techniques during birth, such as induction and Caesareans, has increased the survival rate of low birth weight babies that in the past would likely not have survived.

1.7. Breastfeeding

The percentage of children under age 5 who were fully or partially breastfed at six weeks of age was 72.4%. The percentage of fully or partially breastfed babies at three months of age was 66.5%, and at six months it was 47%. The latest data seems to indicate that there has been an upward trend since 1995.

Breastfeeding gives small children all the nutrients they need for healthy growth and development, and there is wide recognition of the advantages of breastfeeding at both the biological and the psychological level.

Table 1.14. Proportion of children under age 5 who were fully or partially breastfed during the first year of life

	Percentage at 3 months	Percentage at 6 months
1995	54.8	33.2
1997	58.6	35.3
2001	65.5	44.9
2006	63.3	38.8
2011	66.5	47.0

Source: Ministry of Health, Social Services and Equality. Spanish National Health Survey, 1995-2011.

The primary source of information about the number of breastfed babies are the health surveys performed through interviews.

Over recent decades more and more evidence has appeared confirming the health-related advantages of breastfeeding: there is sufficient evidence to state that breastfeeding reduces infant mortality and has health benefits lasting through adulthood.

1.8. Elective Termination of Pregnancy

The ETOPs performed in Spain are monitored and evaluated by an epidemiological surveillance system that receives information from the entire country.

Table 1.15. Number of health care centres notifying ETOPs. Number of ETOPs performed. Rates per 1,000 women between 15 and 44 years of age

	Centres notifying ETOPs	Total ETOPs	Rate per 1000 women
2012	188	112,390	12.0
2011	172	118,359	12.4
2010	146	113,031	11.5
2009	141	111,482	11.4
2008	137	115,812	11.8
2007	137	112,138	11.5
2006	135	101,592	10.6
2005	134	91,664	9.6
2004	133	84,985	8.9
2003	128	79,788	8.8

Remarks: the elective terminations of pregnancy corresponding to 2011 and 2012 have taken place under the conditions laid down in Spain's sexual health, reproduction and abortion law (*Ley Orgánica 2/2010, de 3 de marzo de salud sexual y reproductiva y de la interrupción voluntaria del embarazo*) since the date the law took effect, 5 July 2010.
Source: Ministry of Health, Social Services and Equality. Statistics on elective termination of pregnancy.

Table 1.16. Percentage distribution of ETOPs by type of health care centre

Year	Public sector health care centres			Private sector health care centres		
	total	hospital (%)	not hospital (%)	total	hospital (%)	not hospital (%)
2012	**6.5**	2.8	3.7	93.5	7.1	86.5
2011	**2.7**	1.6	1.0	97.3	8.2	89.1
2010	**1.8**	1.8		98.2	9.6	88.6
2009	**2.0**	2.0		98.0	10.3	87.7
2008	**1.9**	1.9		98.1	10.9	87.2
2007	**2.1**	2.1		98.0	10.6	87.4
2006	**2.5**	2.5		97.5	9.1	88.4
2005	**2.9**	2.9		97.1	9.9	87.2
2004	**3.6**	3.6		96.4	9.7	86.3
2003	**2.9**	2.4	0.4	97.2	10.2	87.0

Remarks: the elective terminations of pregnancy corresponding to 2011 and 2012 have taken place under the conditions set forth in Spain's sexual health, reproduction and abortion law (*Ley Orgánica 2/2010, de 3 de marzo de salud sexual y reproductiva y de la interrupción voluntaria del embarazo*) since the date the law took effect, 5 July 2010.
Source: Ministry of Health, Social Services and Equality. Statistics on elective termination of pregnancy.

Most of the interventions (86.5%) were notified from a non-hospital centre belonging to the private sector and were performed at the petition of the woman (91.3%). Most women were between 20 and 25 years of age (20.4%) with 8 weeks or less of gestation (68.2%).

Table 1.17. Percentage distribution of ETOPs by reason for the termination

	2012	2011
At woman's petition (%)	91.26	89.58
Serious risk to the life or health of the woman (%)	5.67	7.30
Serious risk of severe foetal anomalies (%)	2.78	2.73
Foetal anomalies incompatible with life or extremely serious and incurable disease (%)	0.27	0.30
Various reasons (%)	0.01	0.09

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

Medical causes represented 8.7% of the reasons for pregnancy termination: 5.7% were performed because of serious risk to the life or health of the woman, 2.8% because of the risk of severe foetal anomalies and 0.3% because of foetal anomalies incompatible with life or extremely severe and incurable disease.

2. Lifestyle habits

2.1. Tobacco use

The use of tobacco constitutes one of the leading causes of avoidable premature death.

The year 2012 marked two years since the enactment of the regulation[3] that expanded the smoking ban to all enclosed public areas. There is a high degree of political and social acceptance of the anti-smoking measures taken to protect the population's health. On a scale of 1 to 10, the degree of conformity by citizens stood at 7.6 points, higher than the preceding year, which was the law's first year in effect.

Table 2.1. Degree of agreement with the new Anti-Smoking Law

"In relation to the new Anti-Smoking Law that came into effect in January of 2011, to what extent do you agree with the following statements?" Level of agreement: on a scale from 1 *"totally disagree"* to 10 *"totally agree"*		
	2011	**2012**
The new Anti-Smoking Law is a good measure	7.1	7.6
The Law needs to be modified for the benefit of smokers	4.8	4.2

Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

Also becoming evident is greater disagreement with the possibility of modifying the law for the benefit of smokers (4.2 out of 10 in favour of such a modification, compared to 4.8 in 2011).

With regard to the specific aspect of the observance of the smoking ban in public areas, citizens believe there is a high degree of compliance in bars and restaurants (8.2 out of 10), and less compliance in the areas near schools and hospitals (5.4 out of 10).

Table 2.2. Opinion regarding the degree of compliance with the new Anti-Smoking Law

"As for the following measures included in the Law, what degree of compliance do you think there is? On a scale from 1 *"no compliance whatsoever"* to 10 *"full compliance"*		
Degree of compliance with:	**2011**	**2012**
The smoking ban in bars and restaurants	8.4	8.2
The smoking ban in the areas next to schools and hospitals	6.0	5.4

Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

These results are coherent with the significantly lower number of smoking-related complaints received that year in the Office of the Ombudsman.

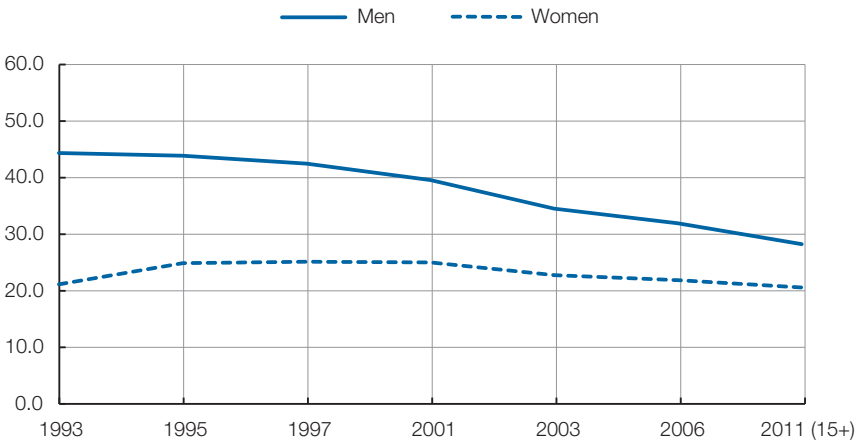
According to the Spanish National Health Survey, in Spain in 2011 24.0% of the population aged 15 and over smoked on a daily basis, while 3.1% was an occasional smoker and 19.6% described themselves as ex-smokers (who had stopped smoking at least one year ago). By sex, the percentage of daily smokers was 27.9% of men and 20.2% of women.

Table 2.3. Prevalence of daily tobacco use in the population aged 15 and over

	2011		
	Total	**Men**	**Women**
Comunidad Valenciana	27.6	32.5	22.8
Andalucía	27.1	29.7	24.6
Aragón	25.9	30.4	21.4
Murcia	25.0	30.4	19.5
Extremadura	24.7	29.3	20.2
Castilla-La Mancha	24.5	27.7	21.4
La Rioja	24.4	29.2	19.8
Spain	**24.0**	**27.9**	**20.2**
Cantabria	23.9	27.0	21.0
Navarra	23.3	25.0	21.8
País Vasco	23.3	26.9	19.9
Cataluña	23.0	28.7	17.6
Castilla y León	22.8	28.4	17.4
Baleares	22.7	25.0	20.5
Canarias	21.9	23.2	20.7
Asturias	21.8	23.1	20.6
Madrid	20.9	24.0	18.2
Galicia	20.3	25.1	15.9
Melilla	19.0	27.2	9.7
Ceuta	18.7	24.5	13.6

Remarks: data appears in order from highest to lowest according to the total.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS). August 2013. Data from the Spanish National Health Survey, 2011/2012.

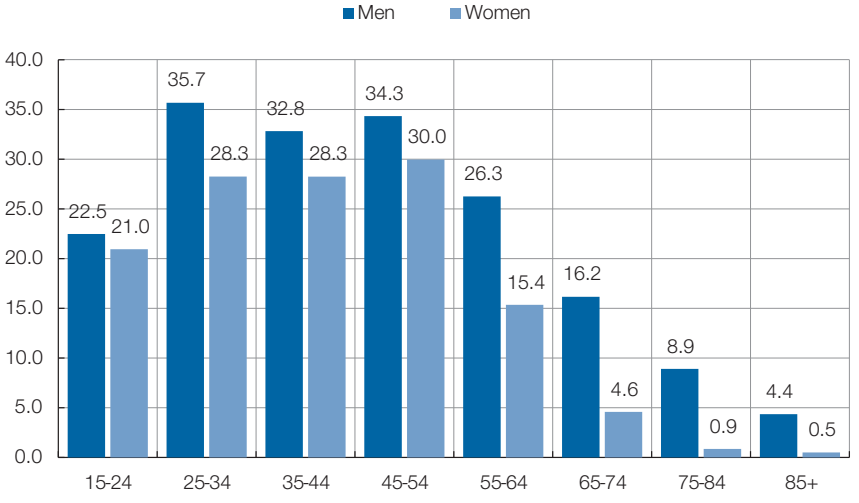
Graph 2.1. Changes in the proportion (%) of daily smokers



Remarks: population aged 16 and over, except for the year 2011 which refers to population aged 15 and over.
Source: Ministry of Health, Social Services and Equality / National Statistics Institute (INE). Spanish National Health Survey, 2011/2012.

Between 1993 and 2011 the percentage of the population that used tobacco on a daily basis fell continuously and almost the entire decrease was in men. Starting in 2003 a decline in the number of women smokers can also be seen, although it is less pronounced.

Graph 2.2. Daily tobacco use by sex and age group in population aged 15 and over



Source: Ministry of Health, Social Services and Equality / National Statistics Institute (INE). Spanish National Health Survey, 2011/2012.

The smoking habit in young people aged 15 to 24 affected 21.7% of the population, without much difference by sex (22.5% of men compared to 21.0% of women).

Of the persons who smoke daily, 28.7% consumed between 1 and 9 cigarettes per day, while 35.8% consumed between 10 and 19 per day, and 35.5%, 20 or more cigarettes per day.

The mean age at which smoking starts, among daily smokers, was 17.2 years, the figure being slightly later in women than in men.

The rate of adults who said they had quit smoking over one year ago but less than ten years ago was 24%. A person who quit smoking over 10 years ago is considered a "non-smoker."

Table 2.4. Rate of population aged 15 and over who quit smoking

	2011
	Total
Cantabria	28.0
Madrid	27.7
Cataluña	26.6
Aragón	26.5
Castilla y León	25.6
País Vasco	25.3
Spain	**24.0**
Asturias	23.9
Comunidad Valenciana	23.8
Extremadura	23.8
Baleares	23.6
La Rioja	23.3
Castilla-La Mancha	22.5
Galicia	22.1
Andalucía	21.4
Canarias	20.5
Navarra	20.0
Murcia	15.0

Remarks: data appears in order from highest to lowest.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS). August 2013. Data from the Spanish National Health Survey, 2011/-2012.

2.2. Alcohol consumption

Among people aged 15 and over, 1.7% admitted drinking alcohol in quantities considered a long-term health risk; in the case of adult men the figure was 2.0% while in adult women it was 1.4%.

The tendency to consume quantities that constitute a health risk has fallen; in 2006 the percentage of the population that admitted to at-risk drinking was 4.7%. The fall is evident in both sexes although it is more pronounced in men, who show a reduction from 6.8% to 2% in this period.

Table 2.5. Changes in the proportion (%) of the population aged 15 and over who admit to at-risk drinking

	2006	2009	2011
Persons who admit to at-risk drinking	4.7	3.2	1.7
Men	6.8	4.0	2.0
Women	2.7	2.5	1.4

Source: Ministry of Health, Social Services and Equality and National Statistics Institute (INE). Spanish National Health Survey, 2006, 2009 and 2011/12.

Table 2.6. At-risk drinking in population aged 15 and over

	2011		
	Total	**Men**	**Women**
Asturias	3.9	5.2	2.7
Castilla y León	3.6	4.8	2.5
País Vasco	3.2	3.9	2.7
Aragón	3.0	3.9	2.0
La Rioja	2.6	2.9	2.3
Castilla-La Mancha	2.4	3.6	1.1
Comunidad Valenciana	2.1	2.5	1.6
Ceuta	2.0	1.8	2.2
Baleares	1.7	1.8	1.6
Navarra	1.7	2.5	0.9
Spain	**1.7**	**2.1**	**1.4**
Canarias	1.6	2.3	0.9
Andalucía	1.3	1.8	0.8
Madrid	1.3	1.5	1.1
Cataluña	1.1	0.8	1.4
Galicia	0.9	0.7	1.2
Cantabria	0.9	0.5	1.2
Extremadura	0.8	1.5	0.3
Murcia	0.6	0.0	1.3
Melilla	0.0	0.0	0.0

Remarks: data appears in order from highest to lowest according to the total.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS) August 2013 version. Data from the Spanish National Health Survey, 2011/12.

Differences among the autonomous communities are seen; most of the at-risk drinking takes place in the central and northern parts of the country.

According to the data of the Spanish Observatory of Drugs and Addictions the admissions to treatment programs to combat alcohol abuse/dependence numbered 26,318 in 2008 and 27,958 in the year 2009.

Of the admissions to treatment for alcohol abuse, 19.3% were women, with the proportion of women being slightly lower among those treated for the first time than among those who had already been treated. The mean age of those admitted was 47.6 years.

The mean age at which alcohol consumption begins is 18.9 years. Looking at the mean age of persons admitted to treatment and the age at which drinking starts, on average these patients had been drinking for 28.7 years when they began treatment.

Of them 32.7% were unemployed (a lower proportion than in the group of persons admitted to treatment for abuse of illegal drugs), and unemployment is also higher among those who have already received treatment for the same substance (32.5%) and among women (31.1%).

The mode of referral that led these people to the programmes was primarily the health care system (30.6%), followed by personal initiative (21.9%) or the initiative of family or friends (13.2%).

2.3. Use of other psychoactive substances

This year in Spain there were 52,549 admissions to treatment for psychoactive substance abuse or dependence (not including alcohol and tobacco). The overall rate of admissions to treatment programmes in the country as a whole was 202.6 cases per 100,000 inhabitants.

The drugs prompting people to seek treatment have changed radically in recent years. Although the levels of admissions for heroin use have remained stable, admissions for cocaine and cannabis have risen. The latter was the most frequently consumed drug by the student population aged 14 to 18, with 33% of this group stating they had used it on at least one occasion.

Cocaine prompted 23,132 (44.0%) admissions to treatment, compared to 16,989 (32.3%) that were prompted by heroin, followed by cannabis with 9,503 admissions (18.1%). The proportion of admissions to treatment for other psychoactive substances was very low, in no case was it over 2%.

Cannabis was responsible for most (86.4%) of the treatment admissions in minors.

The average age of persons admitted to treatment was 33.1 years in admissions overall and 29.8 years in those being admitted for the first time.

Almost half (47.2%) of the persons sought treatment at their own initiative or at the recommendation of family or friends. The public sector health system had referred approximately one third (28.3%) of the persons seeking treatment.

2.4. Physical activity

Four out of 10 persons (40.9%) described themselves as sedentary (they do not engage in any physical activity in their free time), one out of three men (35.3%) and almost one out of two women (46.2%).

The percentage remains relatively stable from age 25 to 74. It tends to be a little higher in women and it also starts at an earlier age in women. It is lower among children and youth, and higher among the elderly.

Table 2.7. Sedentary lifestyle (%) by sex and age group. Population aged 5 and over

	Both sexes	Men	Women
Total	**40.9**	**35.3**	**46.2**
5-14	12.1	8.2	16.3
15-24	35.2	21.4	49.5
25-34	41.4	35.0	48.0
35-44	44.5	39.0	50.2
45-54	46.0	46.3	45.7
55-64	43.3	43.2	43.5
65-74	42.2	36.0	47.5
75-84	56.2	49.5	60.8
85+	76.9	66.2	82.6

Remarks: a person is considered sedentary if in his/her free time he/she does not usually engage in any physical activity such as walking, playing sports, doing fitness exercises, etc.
Source: Ministry of Health, Social Services and Equality / National Statistics Institute (INE). Spanish National Health Survey, 2011/2012.

Considering both their primary activity and their free time, 40.9% of adults (15-69 years) engaged in some kind of intense or moderate physical activity (for more than 10 minutes at least once in the last 7 days), 49.4% of the men and 32.4% of the women.

Different epidemiological studies have shown a consistent association between physical inactivity and diabetes mellitus, high blood pressure and osteoporosis. An appropriate level of physical activity is a healthy habit and the relationship between exercise and a reduced risk of heart problems has been amply demonstrated.

2.5. Obesity and overweight

The use of tobacco and alcohol, along with overweight and obesity, are risk factors for a wide array of diseases and health problems, including certain types of cancer and many chronic diseases.

Obesity affected about 17% of the population aged 18 and over (18% of the men and 16% of the women). If overweight is also considered, then 53.7% of the population aged 18 and over is obese or overweight.

Since the first Spanish National Health Survey was conducted in 1987, obesity has climbed in both sexes, with the trend being more pronounced in men than in women. In 1987, 7.4% of the population aged 18 and over had a Body Mass Index of 30 kg/m^2 or higher (obesity is considered a BMI of 30 or higher), while in 2011 this percentage had reached 17%.

Obesity appears more frequently as people grow older, although this trend changes starting at age 74. Obesity is also found more often at the lower ends of the socio-economic scale, with the rate rising from 8.9% in Class I to 23.7% in Class VI.[4]

Also noteworthy is the prevalence of underweight in women, especially between 18 and 24 years of age (12.4%), compared to 4.1% of men in the same age group.

Table 2.8. Prevalence of overweight per 100 inhabitants aged 18 and over

	2011		
	Total	**Men**	**Women**
Cantabria	42.4	52.6	32.3
Galicia	40.5	48.2	32.5
Extremadura	40.2	48.3	31.4
Asturias	38.5	48.5	29.6
Castilla y León	38.4	45.4	31.2
Navarra	38.2	46.5	30.3
La Rioja	38.1	49.3	26.5
Baleares	37.0	42.8	30.8
Murcia	36.8	45.1	28.7
Comunidad Valenciana	36.7	44.8	28.4
País Vasco	36.7	46.7	27.0
Spain	**36.7**	**45.1**	**28.1**
Andalucía	36.2	42.9	29.3
Cataluña	36.1	46.0	26.4
Aragón	35.8	46.5	24.3
Castilla-La Mancha	35.7	45.0	25.5
Canarias	35.1	39.6	30.5
Madrid	34.9	45.4	24.9
Ceuta	34.8	37.1	32.8
Melilla	32.4	37.0	27.1

Remarks: data appears in order from highest to lowest according to the total.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013. Spanish National Health Survey, 2011/2012.

Table 2.9. Body Mass Index (BMI) in adults and in children and teens

Adult population (aged 18 and over)	**Both sexes**	**Women**	**Men**
Underweight (>18.5 kg/m^2)	2.2	3.4	0.9
Healthy weight (18.5-24.9 kg/m^2)	44.2	52.4	35.9
Overweight (25.0-29.9 kg/m^2)	36.7	28.1	45.1
Obesity (≥30.0 kg/m^2)	17.0	16.0	18.0
Children and teens (aged 2 to 17)	**Both sexes**	**Girls**	**Boys**
Healthy weight/underweight	72.2	73.5	71.0
Overweight	18.3	16.9	19.5
Obesity	9.6	9.6	9.6

Remarks: Body Mass Index = weight (kg) / height (m) squared.
For children and teens (aged 2 to 17) the cut-off points are those published in Cole TJ, Bellizzi MC, Flegal KM, Dietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. BMJ 2000; 320: 1-6.
Source: Ministry of Health, Social Services and Equality / National Statistics Institute (INE). Spanish National Health Survey, 2011/2012 (2013).

The prevalence of child and youth obesity (aged 2 to 17) has remained relatively stable since 1987. In the year of this report, 27.8% of this population were obese or overweight. Of every 10 children one was obese and two were overweight, and the proportion was similar for the two sexes. There were no substantial differences with respect to 2006.

Table 2.10. Prevalence of obesity per 100 inhabitants aged 18 and over

	2011		
	Total	**Men**	**Women**
Ceuta	24.9	30.9	19.6
Extremadura	21.6	23.4	19.7
Andalucía	21.2	22.9	19.4
Castilla-La Mancha	20.6	22.4	18.7
Murcia	20.3	19.9	20.7
Galicia	19.2	20.0	18.4
Asturias	18.7	17.9	19.3
Canarias	18.2	17.8	18.6
Comunidad Valenciana	17.3	17.0	17.7
Spain	**17.0**	**18.0**	**16.0**
Aragón	15.7	16.4	14.8
País Vasco	15.3	15.2	15.3
Baleares	15.1	19.6	10.3
La Rioja	14.9	17.1	12.5
Madrid	14.3	15.9	12.7
Cataluña	14.3	14.6	13.9
Castilla y León	13.8	16.0	11.6
Melilla	12.8	12.1	13.6
Navarra	11.2	12.7	9.7
Cantabria	11.1	11.8	10.5

Remarks: data appears in order from highest to lowest according to the total.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013. Spanish National Health Survey, 2011/2012.

Table 2.11. Prevalence of overweight per 100 inhabitants aged 2 to 17

	2011		
	Total	**Men**	**Women**
Baleares	26.5	22.8	29.9
País Vasco	25.5	25.9	25.0
Galicia	23.8	27.0	20.3
Andalucía	21.3	24.2	18.4
Canarias	20.6	21.3	19.9
Castilla y León	20.3	20.9	19.6
Extremadura	19.8	15.9	23.5
Castilla-La Mancha	19.6	20.7	18.4
Spain	**18.3**	**19.5**	**16.9**
Melilla	18.0	18.6	17.0
Asturias	17.2	15.2	19.9
Comunidad Valenciana	16.2	16.8	15.7
Madrid	16.2	17.8	14.6
Navarra	15.8	15.5	16.2
Murcia	15.1	19.2	9.8
Cataluña	14.4	15.1	13.6
Aragón	13.4	11.4	15.6
La Rioja	12.4	16.4	8.2
Cantabria	9.6	13.4	5.3
Ceuta	7.9	14.0	0.0

Remarks: data appears in order from highest to lowest according to the total.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013. Spanish National Health Survey, 2011/2012.

Table 2.12. Prevalence of obesity per 100 inhabitants aged 2 to 17

	Total	Men	Women
Ceuta	24.7	32.0	15.2
Canarias	13.9	9.8	18.6
Murcia	12.6	9.5	16.8
Andalucía	11.7	12.3	11.1
Galicia	10.8	10.8	10.8
Madrid	10.6	11.8	9.4
La Rioja	9.7	7.9	11.6
Spain	**9.6**	**9.6**	**9.6**
Comunidad Valenciana	9.4	11.7	7.1
Asturias	9.3	9.6	9.0
Baleares	9.0	11.1	7.0
Extremadura	8.8	9.5	8.2
Melilla	8.5	7.4	10.2
Navarra	7.8	9.1	6.3
Castilla-La Mancha	7.2	5.8	8.8
Cataluña	7.2	5.0	9.7
País Vasco	7.0	8.0	5.7
Castilla y León	6.1	8.3	3.6
Cantabria	2.8	3.9	1.6
Aragón	2.7	4.1	1.1

Remarks: data appears in order from highest to lowest according to the total.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013. Spanish National Health Survey, 2011/2012.

The National Health System of Spain

3. Care resources

3.1. Practicing doctors

In the year analysed in this report, a total of 132,935 practicing doctors (including 20,489 specialists-in-training) were working for the SNS, which is a proportion of 2.9 doctors per 1,000 inhabitants.

Doctors are the primary decision-makers with regard to diagnoses and treatments and they give the orders generating most of the demand related to the other human resources in health care. Having an adequate supply of doctors, in both primary and specialised care and with a wide geographical distribution, is essential for ensuring that patients have access to quality health care.

Looking more closely at the care levels, 28,743 general practitioners and 6,424 paediatricians worked in the 3,006 Primary Care Centres and 10,116 Local Primary Care Centres, that is, 0.8 primary care doctors per 1,000 health card holders (the population covered by the SNS).

Table 3.1. SNS primary care doctors per 1,000 health card holders

	2008	2009	2010	2011
Castilla y León	1.1	1.1	1.1	1.1
Aragón	0.8	0.9	0.9	0.9
Extremadura	0.9	0.9	0.9	0.9
Spain	**0.8**	**0.7**	**0.8**	**0.8**
Asturias	0.7	0.7	0.7	0.8
Canarias	0.7	0.7	0.7	0.8
Cantabria	0.8	0.8	0.8	0.8
Castilla-La Mancha	0.8	0.8	0.8	0.8
Galicia	0.8	0.8	0.8	0.8
Murcia	0.7	0.7	0.7	0.8
Navarra	0.8	0.8	0.8	0.8
País Vasco	0.7	0.6	0.6	0.8
La Rioja	0.8	0.8	0.9	0.8
Andalucía	0.7	0.7	0.7	0.7
Cataluña	0.7	0.7	0.7	0.7
Comunidad Valenciana	0.7	0.7	0.7	0.7
Madrid	0.7	0.7	0.7	0.7
Ceuta	0.7	0.6	0.7	0.7
Melilla	0.8	0.7	0.7	0.7
Baleares	0.6	0.6	0.6	0.6

Remarks: data appears in order from highest to lowest according to the year 2011.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS). Data from the Primary Care Information System (SIAP).

In specialised care, the 452 hospitals belonging to the SNS public network[5] employed a total of 77,279 specialised doctors and 20,489 specialists-in-training, making the availability of specialists 2.1 per 1,000 inhabitants (1.7 and 0.4 respectively).

By specialty groups, out of every ten doctors there were:

- 4 specialists in one of the medical specialties (including internal medicine)
- 2 surgeons performing general surgery or specialised surgery
- 1 specialist in gynaecology and obstetrics
- 1 specialist in trauma and orthopaedics
- 1 specialist working in central services (the specialised medical services supporting clinical activities, e.g. radiology, laboratory, hospital pharmacy, anatomical pathology, etc.)
- 1 specialist working in the emergency department

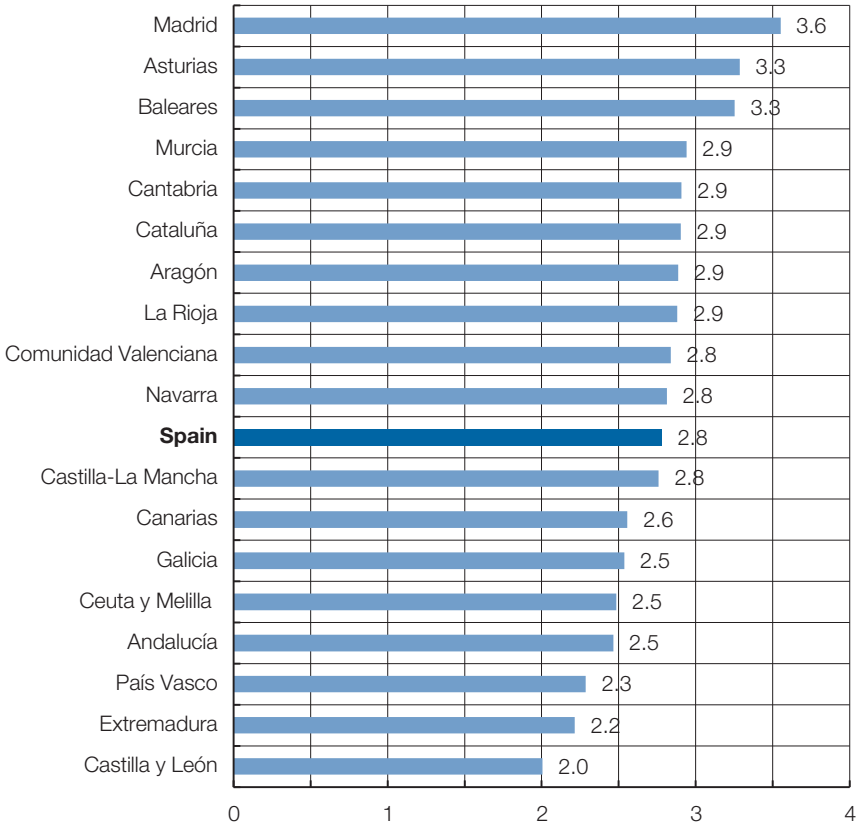
Table 3.2. SNS medical specialists per 1,000 inhabitants

	2008	2009	2010	2011
Aragón	2.4	2.5	2.5	2.6
Asturias	2.3	2.3	2.4	2.5
Madrid	2.3	2.3	2.3	2.5
País Vasco	1.9	1.8	2.3	2.4
Cantabria	2.2	2.2	2.2	2.2
Castilla y León	1.9	2.1	2.1	2.2
Castilla-La Mancha	2.0	2.3	2.2	2.2
Cataluña	2.4	2.4	2.2	2.2
Navarra	2.0	2.2	3.0	2.2
Spain	**2.0**	**2.0**	**2.1**	**2.1**
Galicia	2.0	2.1	2.1	2.1
Murcia	1.8	1.8	2.0	2.1
Baleares	1.8	1.9	2.0	2.0
Comunidad Valenciana	1.8	1.9	2.0	2.0
Extremadura	1.8	1.9	2.1	1.9
La Rioja	2.0	1.9	1.8	1.9
Andalucía	1.6	1.7	1.8	1.8
Canarias	1.6	1.7	1.8	1.8
Ceuta and Melilla	1.5	1.6	1.4	1.5

Remarks: medical specialists-in-training included. Data appears in order from highest to lowest according to the year 2011.
Source: Ministry of Health, Social Services and Equality. SNS Data Consultation Application. Data from the Specialised Care Information System (SIAE).

In the SNS, the ratio of specialised doctors (including specialists-in-training) to general practitioners was 2.8 to 1, with the numbers ranging from 2.0 in Castilla y León to 3.6 in Madrid.

Graph 3.1. Ratio of doctors working in specialised care to doctors working in primary care, in the SNS



Remarks: in specialised care specialists-in-training are also computed.
Source: Ministry of Health, Social Services and Equality. Prepared by the Sub-Directorate General of Health Information and Innovation, with data from the Primary Care Information System (SIAP) and the Specialised Care Information System (SIAE), 2011.

3.2. Practicing nurses

A total of 165,981 nursing professionals were working for the SNS in 2012, which is an availability rate of 3.6 nurses for every 1,000 inhabitants.

Nurses therefore comprise the most numerous group of professionals in the SNS, exceeding the number of doctors by 1.2 percentage points. As a professional group they play a fundamental role in care activities and care continuity, both in primary care centres and in hospitals.

Looking more closely at care levels, 29,407 nurses worked at primary care centres, which equals an availability rate of 0.6 per 1,000 health card holders.

Table 3.3. SNS nurses working in primary care per 1,000 health card holders

	2008	2009	2010	2011
Castilla y León	0.9	0.9	0.9	0.9
Extremadura	0.8	0.8	0.8	0.8
Aragón	0.7	0.7	0.7	0.7
Asturias	0.7	0.7	0.7	0.7
Cantabria	0.7	0.7	0.7	0.7
Castilla-La Mancha	0.7	0.7	0.7	0.7
Cataluña	0.6	0.7	0.7	0.7
Galicia	0.6	0.7	0.7	0.7
Navarra	0.7	0.7	0.7	0.7
País Vasco	0.6	0.6	0.6	0.7
La Rioja	0.7	0.7	0.7	0.7
Spain	**0.6**	**0.6**	**0.6**	**0.6**
Andalucía	0.5	0.6	0.6	0.6
Canarias	0.6	0.6	0.6	0.6
Comunidad Valenciana	0.5	0.6	0.6	0.6
Murcia	0.6	0.6	0.5	0.6
Melilla	0.7	0.7	0.7	0.6
Baleares	0.5	0.5	0.5	0.5
Madrid	0.5	0.5	0.5	0.5
Ceuta	0.6	0.5	0.6	0.5

Remarks: data appears in order from highest to lowest according to the year 2011.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS). Data from the Primary Care Information System (SIAP).

In the SNS public network 136,574 nursing professionals were working in specialised care, which is a rate of 3.0 per 1,000 inhabitants.

Table 3.4. SNS nurses working in specialised care per 1,000 inhabitants

	2008	2009	2010	2011
Aragón	3.6	3.7	3.7	3.9
Asturias	3.2	3.2	3.3	3.5
País Vasco	2.2	2.5	3.5	3.5
Cantabria	3.2	3.1	3.2	3.2
Madrid	2.9	3.0	3.1	3.2
Navarra	2.8	3.1	4.8	3.2
Castilla y León	2.9	3.0	3.1	3.1
Castilla-La Mancha	2.7	2.7	3.2	3.1
La Rioja	3.3	2.9	3.0	3.1
Spain	**2.7**	**2.7**	**3.0**	**3.0**
Cataluña	2.6	2.6	3.1	3.0
Galicia	2.9	3.0	3.1	3.0
Baleares	2.9	2.8	3.1	2.9
Ceuta and Melilla	2.8	2.9	2.9	2.9
Extremadura	2.8	2.7	2.7	2.8
Murcia	2.7	2.7	2.8	2.8
Canarias	2.5	2.5	2.7	2.7
Andalucía	2.4	2.4	2.7	2.6
Comunidad Valenciana	2.3	2.4	2.6	2.6

Remarks: data appears in order from highest to lowest according to the year 2011.
Source: Ministry of Health, Social Services and Equality. Prepared by the Sub-Directorate General of Health Information and Innovation, with data from the Specialised Care Information System (SIAE).

3.3. Hospital beds and day beds available in the SNS network of hospitals for public use

In the 452 hospitals in the SNS public network (59.2% of Spanish hospitals) there were 113,518 available beds (79.6% of the total number of beds in the country). These dates make the bed capacity 2.5 available beds per 1,000 inhabitants. The overall rate of available beds in Spain (both public and private) was 3.1 per 1,000 inhabitants.

Fifty-six of the 58 hospitals with from 501 to 1,000 beds are public, as are all of the 18 hospitals with more than 1,000 beds.

While the number of beds provides a good indication of the resources available for care involving overnight stays, to truly understand the capacity that hospitals have to carry out their activities it is important to also take into account the day beds for patients receiving care not

requiring or warranting overnight stays. The SNS had 32.6 day beds per 100,000 inhabitants.

Table 3.5. Number of hospital beds available and number of day beds in the SNS public network

	Hospital beds available		Day beds	
	Number	Rate per 1,000 inhab.	Number	Rate per 100,000 inhab.
Cataluña	25,792	3.5	4,713	64.5
Extremadura	3,467	3.2	247	22.8
Aragón	4,093	3.1	276	21.0
Asturias	3,036	2.9	416	39.5
Galicia	7,933	2.9	794	29.1
Castilla y León	6,917	2.8	567	22.8
País Vasco	5,948	2.8	405	19.0
La Rioja	883	2.8	69	22.1
Navarra	1,611	2.6	215	34.5
Spain	**113,518**	**2.5**	**15,044**	**32.6**
Castilla-La Mancha	4,839	2.4	584	28.6
Ceuta and Melilla	345	2.3	27	17.8
Baleares	2,345	2.2	266	24.4
Cantabria	1,294	2.2	263	45.5
Canarias	4,336	2.1	480	22.8
Comunidad Valenciana	10,253	2.1	1,239	24.8
Madrid	13,297	2.1	1,770	27.8
Murcia	3,008	2.0	404	27.5
Andalucía	14,121	1.7	2,309	27.9

Remarks: data appears in order from highest to lowest according to number of hospital beds available per 1,000 inhabitants.
Source: Ministry of Health, Social Services and Equality. Specialised Care Information System (SIAE), 2011.

3.4. Medical technology in the SNS public network

The expansion of medical technologies, most of which are located in hospitals, plays a major role in the improvement of the diagnosis and treatment processes of numerous diseases.

Computerised Axial Tomography (CAT) and Magnetic Resonance Imaging (MRI) are very useful to doctors during the diagnosis process of many diseases. The SNS public network had 521 CAT scanners: 11.3 per 1,000,000 inhabitants. The number of MRI scanners was 279: 6.1 per 1,000,000 inhabitants.

Table 3.6. Number of Computerised Axial Tomography (CAT) and Magnetic Resonance Imaging (MRI) scanners in the SNS public network

	Computerised Axial Tomography		Magnetic Resonance Imaging	
	Scanners	Rate per 1.000.000 inhab.	Scanners	Rate per 1.000.000 inhab.
Extremadura	17	15.7	7	6.5
Aragón	20	15.2	10	7.6
Castilla-La Mancha	29	14.2	11	5.4
Ceuta and Melilla	2	13.2	1	6.6
Galicia	35	12.8	21	7.7
La Rioja	4	12.8	2	6.4
Asturias	13	12.3	7	6.6
Cantabria	7	12.1	4	6.9
Comunidad Valenciana	58	11.6	34	6.8
Murcia	17	11.6	9	6.1
Cataluña	84	11.5	59	8.1
Spain	**8**	**11.3**	**279**	**6.1**
País Vasco	24	11.3	8	3.8
Navarra	7	11.2	2	3.2
Andalucía	92	11.1	26	3.1
Castilla y León	25	10.1	14	5.6
Madrid	62	9.7	51	8.0
Baleares	10	9.2	8	7.3
Canarias	15	7.1	5	2.4

Remarks: data appears in order from highest to lowest according to number of CAT scanners (rate per 1,000,000 inhabitants).
Source: Ministry of Health, Social Services and Equality. Specialised Care Information System (SIAE), 2011.

Mammograms facilitate the diagnosis of breast cancer, the most common type of cancer in women. Early diagnosis and intervention significantly increase the rates of survival of women with this type of tumour. The number

of mammographs in the network of SNS hospitals was 421, meaning there are 9.1 machines per 1,000,000 inhabitants.

Table 3.7. Number of mammographs in the SNS public network

	Machines	Rate per 1,000,000 inhab.
Aragón	27	20.5
Asturias	14	13.3
Ceuta and Melilla	2	13.2
Extremadura	14	12.9
La Rioja	4	12.8
Castilla y León	28	11.3
Cataluña	77	10.5
Spain	**421**	**9.1**
Andalucía	73	8.8
Castilla-La Mancha	18	8.8
Cantabria	5	8.6
Galicia	23	8.4
País Vasco	17	8.0
Madrid	49	7.7
Murcia	11	7.5
Baleares	8	7.3
Canarias	14	6.6
Comunidad Valenciana	33	6.6
Navarra	4	6.4

Remarks: data appears in order from highest to lowest, based on rate per 1,000,000 inhabitants.
Source: Ministry of Health, Social Services and Equality. Specialised Care Information System (SIAE), 2011.

Radiotherapy is used to treat many types of cancer. A high percentage of patients diagnosed with tumours undergo radiotherapy sessions. Radiotherapy resources (cobalt bombs and linear accelerators) in the network of SNS hospitals consisted of 176 machines, a rate of 3.8 per 1,000,000 inhabitants.

Table 3.8. Number of radiotherapy machines in the SNS public network

	Machines	Rate per 1,000,000 inhab.
La Rioja	2	6.4
Asturias	6	5.7
Cantabria	3	5.2
Galicia	13	4.8
Navarra	3	4.8
País Vasco	10	4.7
Canarias	9	4.3
Cataluña	30	4.1
Castilla y León	10	4.0
Spain	**176**	**3.8**
Extremadura	4	3.7
Andalucía	30	3.6
Comunidad Valenciana	18	3.6
Madrid	23	3.6
Murcia	5	3.4
Aragón	4	3.0
Baleares	3	2.7
Castilla-La Mancha	3	1.5
Ceuta and Melilla	0	0.0

Remarks: data appears in order from highest to lowest, based on rate per 1,000,000 inhabitants.
Source: Ministry of Health, Social Services and Equality. Specialised Care Information System (SIAE), 2011.

3.5. Reference Centres, Services and Units

With the aim of reinforcing the cohesion of the public health care system, Law 16/2003 on Cohesion and Quality in the SNS (*Ley 16/2003 de cohesión y calidad del SNS*) provided for the existence of reference services for pathologies that require a concentration of diagnostic and therapeutic resources in order to ensure care quality, safety and efficiency.

The Interterritorial Council of the SNS (CISNS) is the body in charge of designating these reference services, with the primary aim of guaranteeing equal access to high-quality, safe and efficient care for people

with pathologies that are not prevalent or that require highly specialised care.

Any diagnostic or therapeutic procedure the performance of which is deemed to warrant the designation of a Reference Centre, Service or Unit (CSUR) must already be included in the basic basket of SNS services.

The CISNS has progressively determined the groups of pathologies and procedures for which it is necessary to designate CSURs in the SNS, as well as the criteria that such health care centres must meet in order to be designated reference centres.

Since July 2007, when the CISNS passed the first resolution in this regard, 53 pathologies or procedures have been deemed to require CSUR designation, and the set of criteria to be met by centres in order to become reference centres has also been determined.[6]

As of 2012 a total of 177 CSURs, for 42 procedures and pathologies, have been designated by resolutions made by the Ministry of Health, Social Services and Equality, acting on the proposal of the CISNS. The table below shows the CSURs designated in 2012.

The care delivered in CSURs is financed by the Health Cohesion Fund (FCS).

The Health Cohesion Fund covers the cost of health services provided to patients who live in one autonomous community but are referred to another so that they can receive care at the reference centre designated by the Ministry of Health, Social Services and Equality.

Table 3.9. Reference Centres, Services and Units designated by the CISNS in 2012

Autonomous community	Pathology	Hospital
Andalucía	Brachial plexus surgery	Complejo Hospitalario Virgen del Rocío
	Surgery for movement disorders	Complejo Hospitalario Virgen de las Nieves
	Multiple sclerosis	Complejo Hospitalario Virgen de la Macarena
		Complejo Hospitalario Carlos Haya
Aragón	Multiple sclerosis	Hospital Universitario Miguel Servet
Asturias	Brachial plexus surgery	Hospital Universitario Central de Asturias
	Surgery for movement disorders	Hospital Universitario Central de Asturias
Castilla-La Mancha	Care for patients with complex spinal cord injuries	Hospital Nacional de Parapléjicos
Cataluña	Comprehensive care for adults with congenital cardiopathy	Hospital Universitario Vall d`Hebrón
	Brachial plexus surgery	Hospital Universitario de Bellvitge
		Hospital Sant Joan de Deu
	Surgery for movement disorders	Hospital Clínico y Provincial
	Multiple sclerosis	Hospital Universitario de Bellvitge
		Hospital Universitario Vall d`Hebrón
	Outer ear reconstruction	Hospital Universitario Vall d`Hebrón
Comunidad Valenciana	Brachial plexus surgery	Hospital General Universitario de Alicante
	Left ventricle repair surgery	Consorcio Hospital General Universitario de Valencia
	Multiple sclerosis	Hospital Universitario La Fe
Galicia	Surgery for movement disorders	Complejo Hospitalario Universitario de Santiago de Compostela
	Multiple sclerosis	Complejo Hospitalario Universitario de Santiago de Compostela
Madrid	Comprehensive care for adults with congenital heart disease	Hospital Universitario La Paz
	Comprehensive care for neonates with congenital heart disease and children with complex congenital heart disease	Hospital Universitario La Paz
	Brachial plexus surgery	Hospital Universitario La Paz

Table 3.9. Reference Centres, Services and Units designated by the CISNS in 2012 ***(Continuation)***

	Complex repair surgery of the mitral valve	Complejo Universitario Clínico de San Carlos
	Left ventricle repair surgery	Complejo Universitario Clínico de San Carlos
	Surgery for movement disorders	Hospital Universitario Ramón y Cajal
	Orbital decompression for thyroid-associated ophthalmopathy	Hospital Universitario Ramón y Cajal
	Refractory epilepsy	Hospital Universitario La Paz
	Multiple sclerosis	Hospital Universitario Ramón y Cajal
		Complejo Universitario Clínico de San Carlos
	Paediatric orthopaedics	Hospital Universitario Ramón y Cajal
	Heart transplant for children	Hospital Universitario La Paz
	Allogeneic hematopoietic stem cell transplantation for children	Hospital Universitario La Paz
Murcia	Multiple sclerosis	Hospital Universitario Virgen de la Arrixaca
País Vasco	Surgery for movement disorders	Hospital Universitario de Cruces

Source: Ministry of Health, Social Services and Equality, 2012.

3.6. Network of organ transplant units

In 2012 there were 44 hospitals authorised to perform organ transplants, with programmes for the transplantation of kidneys, liver, heart, lung, pancreas, small bowel and other organs, in both adults and children. The number of co-ordination teams has grown, rising from 139 in 1998 to 185 at the end of 2012. The teams are comprised of 254 doctors and 158 nurses. As for the work load, 95% of the doctors and 68% of the nurses perform co-ordination tasks on a part-time basis and are thus able to continue with their other activities. Of the doctors, 81% are specialists in critical care but in the case of nurses the percentage is just 43%.

The number of kidney transplant units (with the necessary technological and human resources) in Spain was 46, distributed in 40 hospitals (7 units for paediatric cases and 39 for adult cases); there is therefore 1 unit for every 1 million people. In the case of liver transplants, there are 29 units,

which means one for every 1.6 million people. In 2012 there were 21 units performing heart transplants (one for every 2.25 million people) and 7 health care centres with an active programme for lung transplants, each unit corresponding to a population of 6.75 million.

Table 3.10. Network of transplant units

Autonomous Community	Kidney Tx* units (paediatric)	Liver Tx* units (paediatric)	Heart Tx* units	Lung Tx* units	Units performing pancreas-kidney Tx* and other combinations
Andalucía	6 (1)	5 (1)	3 (1)	1	2
Aragón	1	1	1		
Asturias	1	1	1		
Baleares	1	1			
Canarias	2	1			1
Cantabria	1	1	1	1	1
Castilla y León	2	1	1		1
Castilla-La Mancha	2				
Cataluña	8 (2)	4 (1)	4 (1)	1	2
Comunidad Valenciana	5 (1)	3 (1)	1	1	1
Extremadura	1	1			
Galicia	2	2	2 (1)	1	2
Madrid	9 (2)	6 (2)	5 (2)	2	2(1)
Murcia	1	1	1		1
Navarra	1	1	1		
País Vasco	2 (1)	1			
La Rioja	1				
Total	**46 (7)**	**29 (5)**	**21 (5)**	**7**	**13 (1)**

Remarks: *Tx refers to transplant. In parentheses is the number of paediatric transplant teams.
Sources: Ministry of Health, Social Services and Equality. National Transplant Organisation, 2012.

3.7. Transfusion medicine

The blood transfusion network in Spain consists of 24 transfusion centres and 341 transfusion services, which are smaller and depend on the centres. In 2012 there were 1,757,940 voluntary, non-remunerated donations, which makes for a donation rate of 38.2 per 1,000 inhabitants.

Blood transfusion is an ongoing necessity, so widely used that guaranteeing the quality and safety of the procedure is absolutely vital, in order to avoid, particularly, the transmission of diseases.

In Spain, following European Union guidelines, a structure called the "National System for Transfusion Safety" (SNST, for its Spanish acronym) has been put in place (Article 36 of RD 1088/2005).

The structure is comprised of the Scientific Committee for Transfusion Safety (CCST, for its Spanish acronym), an expert advisory body the function of which is to establish guidelines regarding transfusion safety at the state level, and also the National Commission on Haemotherapy, a body that co-ordinates actions among autonomous communities. Also taking part in the system are the haemotherapy commissions of the autonomous communities that have such bodies, and hospital transfusion committees, where such committees exist.

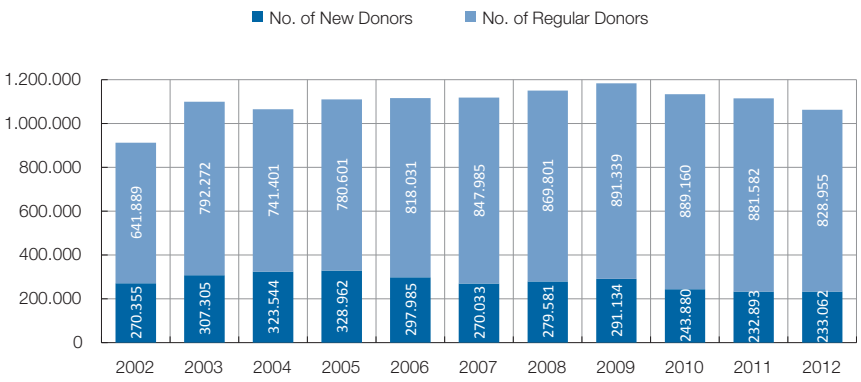
Table 3.11. Donation rates, by autonomous community

	Donation rate
País Vasco	47.1
Extremadura	46.9
Navarra	44.7
Castilla-La Mancha	42.5
Galicia	42.2
Cantabria	42.1
Asturias	40.0
Madrid	39.9
Spain	**38.2**
Cataluña	37.7
Comunidad Valenciana	37.6
La Rioja	37.2
Murcia	36.6
Baleares	36.5
Aragón	35.2
Castilla y León	35.2
Andalucía	34.5
Canarias	30.3

Remarks: the donation rate refers to the number of donations per 1,000 inhabitants. Data appears in order from highest to lowest by rate per 1,000 inhabitants.
Source: Information System of the National System for Transfusion Safety (SI-SNST), 2012 data. National Haemotherapy Plan.

These donations are the result of the act of solidarity of 1,062,017 blood donors, who all together enable the country to be self-sufficient in blood components.

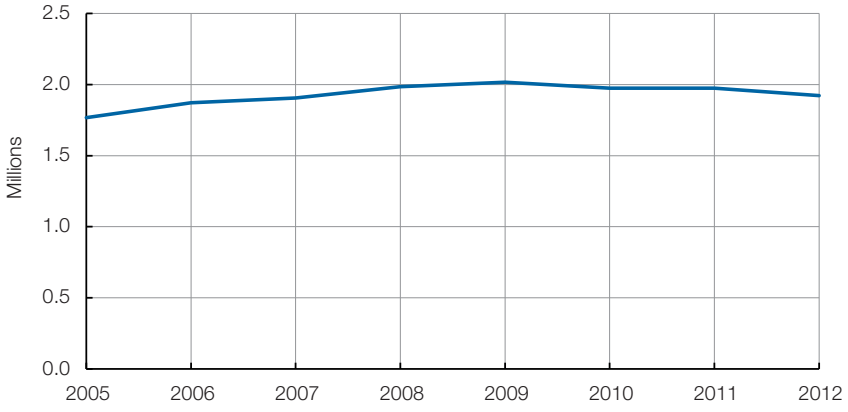
Graph 3.2. Number of blood donors in Spain



Source: Information System of the National System for Transfusion Safety (SI-SNST). National Haemotherapy Plan.

The number of donations has allowed the transfusion of 1,922,134 components and has provided industry with 364,823 litres of plasma for the preparation of plasma derivatives (coagulation factors, immunoglobulins, albumins).

Graph 3.3. Number of blood components transfused in Spain



Source: Information System of the National System for Transfusion Safety (SI-SNST). National Haemotherapy Plan.

4. Health care activity

4.1. Activity in Primary Care Centres

The overall mean number of visits per year to SNS primary care centres (family physicians and paediatricians) by health card holders (the population covered by SNS) is 5.6, meaning that about 259 million visits with doctors take place every year at the 3,006 Primary Care Centres and the 10,116 Local Primary Care Centres.

Table 4.1. Care activity in SNS Primary Care

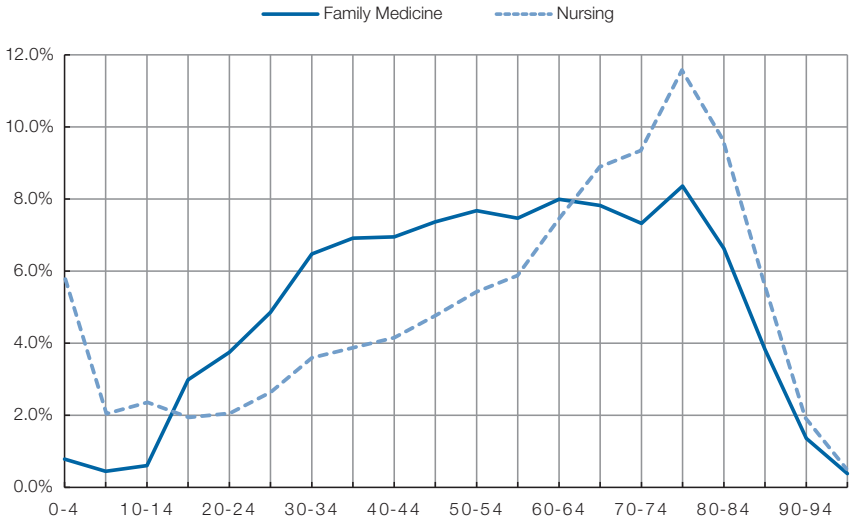
	Visits by health card holders per year			Number of visits
	2009	2010	2011	2011
In normal PC hours				
Medicine	5.6	5.4	5.6	258,775,162
Family medicine	5.6	5.5	5.6	223,643,239
Paediatrics	5.3	5.2	5.4	35,131,923
Nursing	2.9	2.8	2.8	131,578,006
Outside of normal hours: urgent PC services				
Medicine	0.5	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	278,995,308
Nursing	3.2	3.1	3.1	139,458,268

Remarks: the 2009 data on urgent PC includes 11 autonomous communities (68% of the population), the 2011 data on medicine includes 15 autonomous communities (80% of the population) and the 2011 data on nursing includes 14 autonomous communities (62% of the population).
Source: Ministry of Health, Social Services and Equality. Primary Care Information System (SIAP).

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

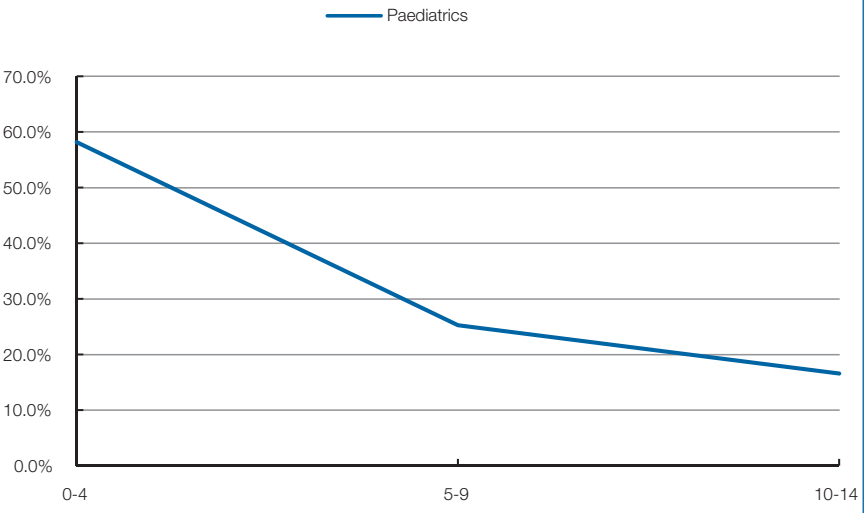
By sex, women generate a higher volume of visits than men do, in both family medicine (58.8%) and in nursing (56.2%), although in paediatrics male children generate more than half the total number of visits (52.1%).

Graph 4.1. Relative weight of each age group with respect to the total amount of activity in family medicine and nursing



Source: Ministry of Health, Social Services and Equality. Primary Care Information System (SIAP), 2011. SNS Data Consultation Application.

Graph 4.2. Relative weight of each age group with respect to the total amount of activity in paediatrics



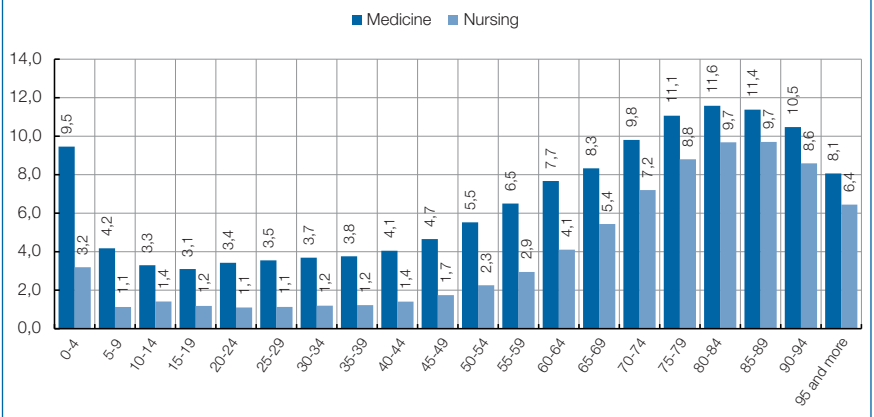
Source: Ministry of Health, Social Services and Equality. Primary Care Information System (SIAP), 2011. SNS Data Consultation Application.

The mean number of visits (taking place at a primary care centre or at the patient's home) was 5.6 medical visits per health card holder per year, with a rate of 5.6 for general practitioners and 5.4 for paediatricians. In nursing, the mean number of visits was 2.8 per health card holder per year.

As for where the care is provided, 97% of the overall activity took place in a primary care centre and 3% was at the patient's home, although the numbers vary considerably depending on what type of professional is involved.

Care provided at homes represents 1.3% (2.9 million visits) of all the activity in family medicine and in the case of nursing 7.6% (10 million visits). This mode of practice is very infrequent (15,700 visits) in paediatrics.

Graph 4.3. Mean number of visits in medicine and nursing, by age group



Source: Ministry of Health, Social Services and Equality. Primary Care Information System (SIAP), 2011. SNS Data Consultation Application.

By age groups, the mean number of visits in the 0-4 age groups was 9.5 but the rate fell to 3.1 in adolescents (15-19 years), which is the age group with the lowest rate of visits. The subsequent rise, which is initially very gradual, becomes more pronounced starting at age 45 and it reaches the highest rate of visits in persons aged 80-84, where there is an average of 11.6 visits per year.

In nursing the 0-4 age group has an average number of visits of 3.2 visits/year, falling to 1.2 in the 15-19 age group and to 1.1 in the 20-24 age group. A progressive rise begins starting at age 45, until reaching the 80-84 age group which, along with the 85-89 age group, is the population showing the highest number of visits, with an average of 9.7 visits per year.

4.2. Activity at hospitals

Each year approximately 4 million discharges take place in hospitals dependent on the SNS. This is 77.1% of the total number of discharges occurring in all Spanish hospitals.

Furthermore, in 2011, there were 75.5 million visits to different medical specialists of the SNS (86.0% of the total), 21.0 million urgent visits to SNS services (79.5% of the total) and 3.4 million surgical interventions by the SNS, of which over 1 million were performed as major outpatient surgery, meaning that the percentage of substitution is over 30%. The surgical activity of SNS hospitals represents 71.0% of Spain's total surgical activity.

In SNS hospitals over 368,000 births were attended (78.7% of the total), with 21.8% of them being Caesarean. In the sector as a whole (public and private hospitals) the Caesarean rate was 25.0%.

Table 4.2. Medical, surgical and obstetrical activity in hospitals and specialised care centres

	2009		2010		2011	
	SNS	Total	SNS	Total	SNS	Total
Discharges (thousands)	3,941.5	5,269.8	4,047.3	5,239.2	4,005.2	5,193.1
Discharges / 1000 inhab.	85,8	114.7	87.9	113.7	86.8	112.6
Visits (thousands)	70,041.1	82,142.4	74,337.5	85,561.9	75,468.1	87,749.7
Visits / 1000 inhab.	1,525.0	1,788.5	1,613.5	1,857.1	1,636.2	1,902.4
Urgent care visits	21,217.4	26,898.6	20,960.0	25,967.4	21,010.6	26,443.8
Urgent care visits /1000 inhab.	462.0	585.6	454.9	563.6	455.5	573.3
Surgical acts (thousands)	3,181.4	4,663.9	3,329.4	4,665.6	3,365.1	4,741.4
Surgical acts /1000 inhab.	69.3	101.5	72.3	101.3	73.0	102.8
Major outpatient surgery (thousands)	929.1	1,308.4	980.4	1,330.9	1,022.3	1,377.5
% major outpatient sur.	29.2	28.1	29.4	28.5	30.4	29.1
Vaginal births	299,833	364,881	298,185	358,563	288,373	351,432
Caesarean births	85,245	123,480	84,268	121,137	80,477	117,224
Total number of births	385,078	488,361	382,453	479,700	368,850	468,656
% of Caesarean births	22.1	25.3	22.0	25.3	21.8	25.0

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

Of all discharges in SNS acute care hospitals, 13% are related to childbirth, puerperium or 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 by relative weight, are diseases of the circulatory system (11.8%), followed by diseases of the digestive system and diseases of the respiratory system, with 10.2% and 8.9% respectively. Tumours are the cause in 8.8% of the cases.

In men, diseases of the circulatory system are the leading cause of hospitalisation, at 16.9% of all hospitalisations; next are 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 reason for hospitalisation more often in men (2.4% of total discharges) than in women (1.9% of total discharges).

Table 4.3. Hospitalisation in the SNS. Discharges by major disease group

	Mujeres		Hombres	
	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	11.6
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: disease groups with a relative weight of over 2.0% are considered major disease groups.
Source: Ministry of Health, Social Services and Equality. Discharge register-Minimum Data Set (MDS) of acute care hospitals of the SNS, 2010.

In recent decades, the number of surgical procedures performed on outpatients, with no overnight hospital stay, has increased significantly. Advances in medical technology, especially the widespread use of less invasive surgical techniques and better anaesthetics, are the factors that have made this progress possible.

Cataract operations are a good example of the surgery taking place predominantly in ambulatory mode; the aging of the population is one of the factors behind the increasing prevalence of this surgical procedure but even more important is the proven success, safety and cost-effectiveness of the surgery as an outpatient procedure.

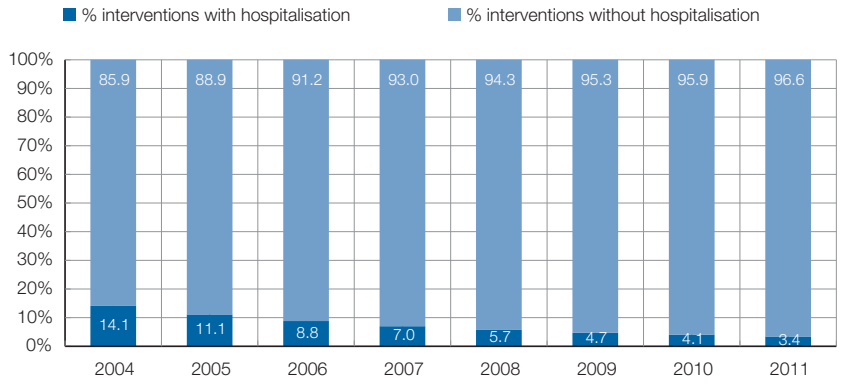
In 2011, as many as 96.6% of the cataract operations were performed without hospitalisation.

Table 4.4. Changes in cataract interventions, total number and proportion of procedures performed with and without hospitalisation

	Total number interventions	Interventions with hospitalisation	% interventions with hospitalisation	Interventions without hospitalisation	% interventions without hospitalisation
2004	168,330	23,800	14.1	144,530	85.9
2005	194,298	21,562	11.1	172,736	88.9
2006	217,088	19,064	8.8	198,024	91.2
2007	237,253	16,503	7.0	220,750	93.0
2008	244,844	13,886	5.7	230,958	94.3
2009	256,071	12,101	4.7	243,970	95.3
2010	266,729	11,012	4.1	255,717	95.9
2011	275,349	9,416	3.4	265,933	96.6

Source: Ministry of Health, Social Services and Equality. Discharge register-Minimum Data Set (MDS) of acute care hospitals of the SNS.

Graph 4.4. Changes in the proportion of cataract interventions performed with and without hospitalisation, with respect to the total number of cataract interventions



Source: Ministry of Health Social Services and Equality. Discharge register-Minimum Data Set (MDS) of acute care hospitals of the SNS.

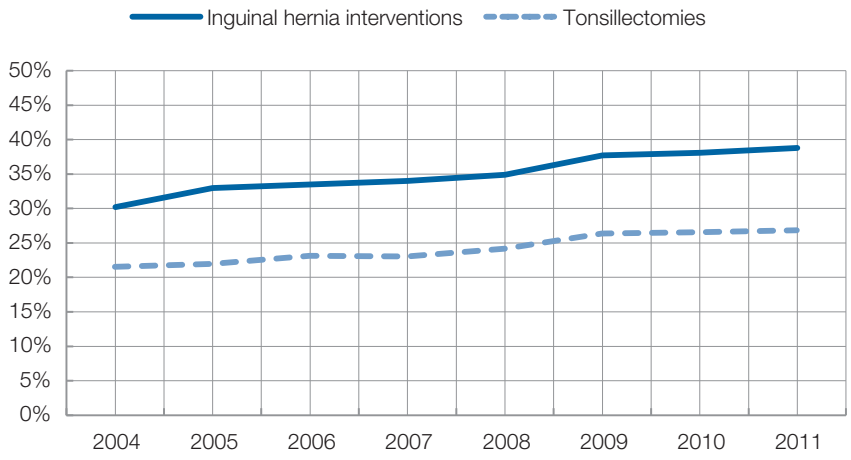
Other frequent processes, although less prevalent than cataract surgery, are ambulatory tonsillectomies and inguinal hernia interventions. In the year 2011, these procedures had a volume of activity, with and without hospitalisation, of 28,832 interventions in the case of tonsillectomies and 89,270 in the case of inguinal hernia. As in the case of cataracts, ambulatory surgery in both types of intervention has shown a sustained increase in recent years; in 2011 the percentage of interventions without hospitalisation was 26.7% and 38.8% respectively, whereas in 2004 the percentages were 21.4% and 30.2%.

Table 4.5. Changes in tonsillectomies and inguinal hernia interventions, total number and proportion of processes without hospitalisation

	2004		2011	
	Total number interventions	% interventions without hospitalisation	Total number interventions	% interventions without hospitalisation
Tonsillectomy	17,505	21.4	28,832	26.7
Inguinal hernia	69,370	30.2	89,270	38.8

Source: Ministry of Health, Social Services and Equality. Discharge register-Minimum Data Set (MDS) of acute care hospitals of the SNS.

Graph 4.5. Changes in the proportion of tonsillectomies and inguinal hernia interventions performed without hospitalisation

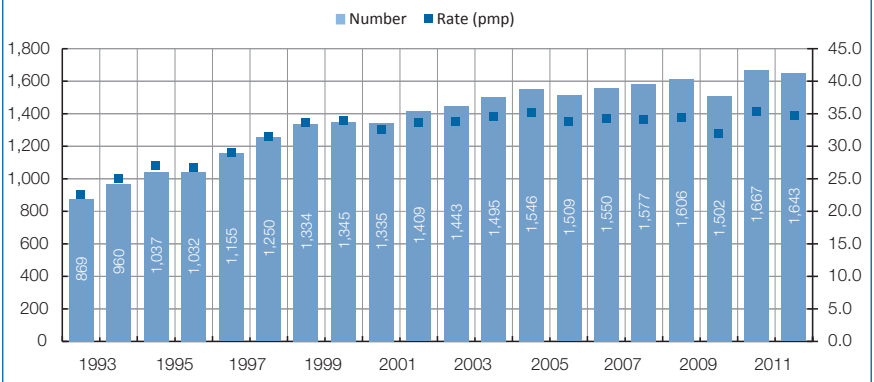


Source: Ministry of Health Social Services and Equality. Discharge register-Minimum Data Set (MDS) of acute care hospitals of the SNS.

4.3. Organ donation and transplants

In 2012 the rate of organ donors per million population (pmp) was 34.8, which in absolute values is 1,643 donors.

Graph 4.6. Changes in the total number and annual rate (pmp) of organ donors



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

The average age of the donors was 58.3 years, following the upward trend observed in recent years. The group of donors aged over 45 has risen from 57% in 1999 to almost 80% in 2012. Distribution by sex in 2012 remained similar to previous years, approximately 62% men and 38% women.

The profile of donors in terms of the cause of death has also changed: stroke as the cause of death has increased from 39% in 1992 to 62% in 2012; donors who died as a result of traumatic brain injury caused by a traffic accident currently represent only 6% of the donors, whereas in 1992 these cases accounted for 43%.

Although in Spain the situation with regard to donation is excellent, the aging of the population, the positive results obtained with transplants and, as a consequence, the higher number of cases in which a transplant is indicated, are resulting in longer waits for patients in need of an organ.

One of the alternatives to enlarge the pool of donors is non-heart-beating donation, or donation after cardiac death. In recent years this category of donors has increased progressively, reaching 9.8% of total donors (161/1643) in 2012.

Table 4.6. Distribution of transplants performed in the autonomous communities

Autonomous Community	Kidney transplant	Liver transplant	Heart transplant	Lung transplant	Pancreas transplant
Andalucía	457	203	32	24	18
Aragón	68	31	11	-	-
Asturias	50	27	16	-	-
Baleares	52	-	-	-	-
Canarias	91	29	-	-	5
Cantabria	36	16	20	34	1
Castilla y León	117	44	5	-	6
Castilla-La Mancha	55	-	-	-	-
Cataluña	559	180	52	66	15
Comunidad Valenciana	232	117	26	30	6
Extremadura	34	25	-	-	-
Galicia	138	91	25	35	5
Madrid	432	194	54	49	27
Murcia	76	48	1	-	-
Navarra	32	16	5	-	-
País Vasco	117	63	-	-	-
La Rioja	5	-	-	-	-
Ceuta	-	-	-	-	-
Melilla	-	-	-	-	-
TOTAL	**2,551**	**1,084**	**247**	**238**	**83**

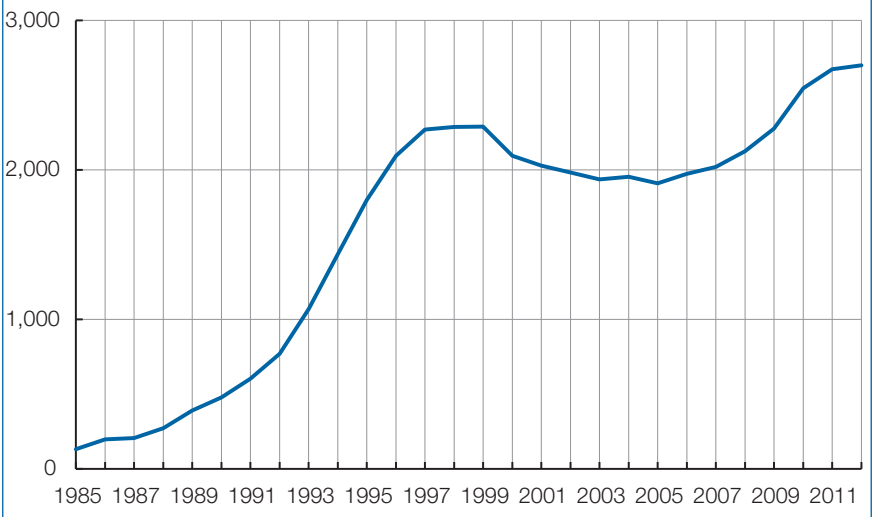
Source: Ministry of Health, Social Services and Equality. National Transplant Organisation (ONT), 2012.

Hematopoietic stem cell transplantation

Hematopoietic Stem Cell Transplantation (HSCT) using stem cells from umbilical cord blood (UCB), peripheral blood (PB) or bone marrow (BM) has become a consolidated therapy. Of particular interest are allogeneic transplants involving unrelated donors (URD).

In Spain the first HSCTs were performed in 1976 in Barcelona and since then over 40,000 transplants of this type have taken place.

Graph 4.7. Changes in the number of Hematopoietic Stem Cell Transplants



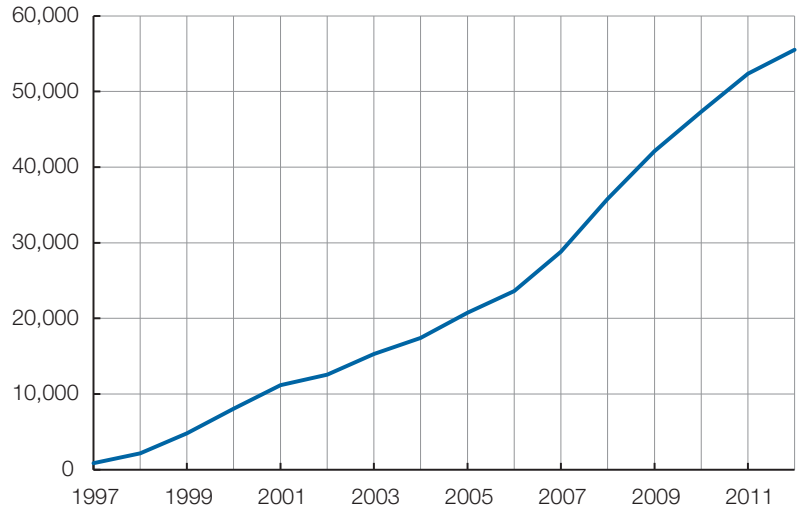
Source: Ministry of Health, Social Services and Equality. National Transplant Organisation (ONT).

Every year about 3,000 HSCTs are performed, of which two thirds are autologous (the cells come from the same patient) and the remaining third are allogeneic (the cells come from a different person). The sources of these cells can be relatives, the donor register or cord blood banks.

The main indications of HSCT include certain neoplasias (when all conventional treatment options have been exhausted), certain non-malignant diseases such as severe bone marrow aplasia, serious genetic diseases and autoimmune diseases.

To foment unrelated HSCT and the donation of UCB and of stem cells from peripheral blood and bone marrow, the Ministry of Health, Social Services and Equality developed the National Plan on Umbilical Cord Blood and the National Plan for Bone Marrow Donation.

Graph 4.8. Changes in the number of units of Umbilical Cord Blood (UCB)

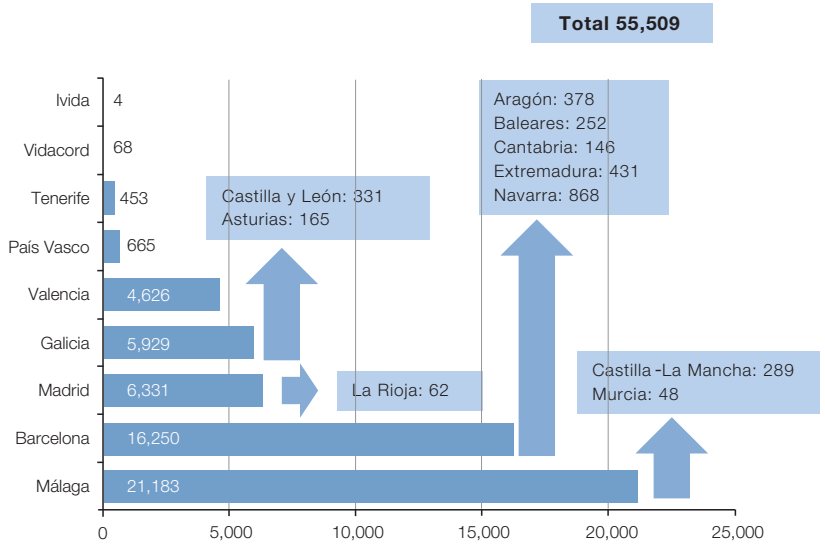


Source: Ministry of Health, Social Services and Equality. National Transplant Organisation (ONT).

The National Plan on Umbilical Cord Blood was launched in 2008 and by 2012 it had made Spain the third-ranking country in the storage of UCB, in absolute numbers. Furthermore, 10% of all the units stored in Bone Marrow Donors Worldwide (BMDW) are found in Spain's public banks.

A network is used for UCB storage, with a single bank being shared by different autonomous communities, a clear indication of the system's cohesion. Almost 2000 units of UCB have already been used in the treatment of patients in need of HSCT.

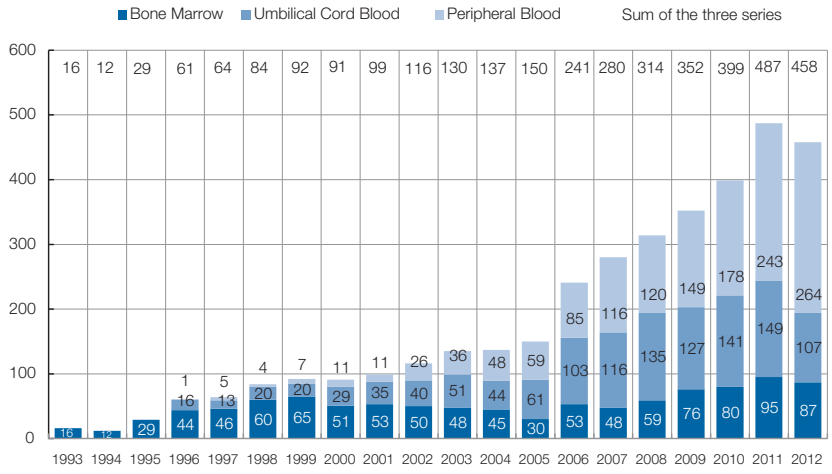
Graph 4.9. Distribution of umbilical cord blood (UCB) stored in Spain



Source: Ministry of Health, Social Services and Equality. National Transplant Organisation (ONT), 2012.

The National Plan for Bone Marrow Donation was put in place at the proposal of the Stem Cell Subcommission of the CISNS Transplant Commission, at its meeting in January of 2012. The initiative was taken because the National Plan on UCB was approaching its conclusion and also because the number of unrelated allogeneic transplants performed with peripheral stem cells was seen to be increasing steadily.

Graph 4.10. Changes in the source of stem cells in unrelated allogeneic Hematopoietic Stem Cell Transplantation (HSCT)



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

5. Professional regulation

5.1. Specialised Health Care Training

The number of persons hoping to begin Specialised Health Care Training in 2012, for which the application period was 2011/2012, increased somewhat, continuing the upward trend observed during the previous two years.

The total number of applicants was 37,799. This represents an overall increase of 3.8% with respect to the previous year. The growth can be explained mainly by the number of applicants hoping to further their training in nursing, which rose 13.6% compared to the previous year. Warranting special mention is medicine, where the number of applicants fell by 10.3%.

Table 5.1. Exams for admission to specialised training, 2011/12 application period

	Slots offered 2011/12	Admitted to exam in 2011/12	Adjudicated a training slot 2011/12	Slots unfilled	Variation in numbers admitted to exam 2011/12 *vs.* 2010/11 (%)
Doctors	6,704	13,584	6,704	0	-10.3
Pharmacists	309	1,388	309	0	0.6
Chemists	19	271	18	1	3.6
Biologists	52	734	52	0	28.9
Psycho-logists	141	3,693	141	0	13.4
Medical physicists	34	301	34	0	0.7
Nurses	1,002	17,828	1002	0	13.6
TOTAL	**8,261**	**37,799**	**8,260**	**1**	**3.8**

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

The selective exams for access to specialised training in all the fields were held on 28 January 2012, in 21 cities. Between the 2 April and 27 April the process of assigning the 8,261 slots took place.

For the 2012/2013 application period, the SNS Human Resources Commission, meeting in plenary session, determined how many specialised training slots would be available. To determine the number, the proposals made by the autonomous communities and the National Institute of Health Management (INGESA) were taken into consideration.

The number of slots was determined to be 7,845, of which 7,642 were in residency programmes and 193 were in programmes based on class attendance.

Table 5.2. Specialised training slots offered in the 2012/13 application period, by field

	Slots offered in residency prog.	Slots offered in class prog.	Slots reserved for the disabled	Total 2012/13
Medicine	6,240	149	447	6,389
Pharmacy	229	44	19	273
Chemistry	22	-	2	22
Biology	39	-	3	39
Psychology	128	-	9	128
Medical physics	31	-	2	31
Nursing	963	-	67	963
TOTAL	**7,652**	**193**	**549**	**7,845**

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

The number of slots offered depends on the system's need for specialists and on the resources available. This year it fell by 5.1% in global terms, compared to the previous period.

With the number of slots offered, plus the residents currently in training, it is estimated that it will be possible to cover more than 50% of the positions that become available – as a result of retirement – in all fields over the next 15 years, so the replacement of these professionals will not pose a significant problem.

Table 5.3. Changes in the number of slots in Specialised Health Care Training

	2008/09	2009/10	2010/11	2011/12	2012/13	% variation
Doctors	6,797	6,948	6,874	6,707	6,389	-4.7
Pharmacists	281	304	298	309	273	-11.6
Chemists	24	31	20	19	22	15.8
Biologists	42	39	41	52	39	-25.0
Psychologists	126	131	136	141	128	-9.2
Medical physicists	33	34	34	34	31	-8.8
Nurses	563	611	848	1,002	963	-3.9
TOTAL	**7,866**	**8,098**	**8,251**	**8,264**	**7,845**	**-5.1**

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

Seven percent of the slots adjudicated in specialised health care training were reserved for persons with a disability rating of 33% or higher, so as to meet the obligations derived from the UN Convention on the Rights of Persons with Disabilities.

The quota for non-EU citizens with degrees in medicine was limited to 8% for the first round of adjudications, compared to 10% in the preceding period. The quota for non-EU persons holding degrees in pharmacy and nursing was maintained, at 5% and 2% respectively. These applicants must have a residence permit or a study permit. They also must demonstrate a good command of Spanish, by being in possession of the C1 or C2 certificate, according to the Common European Framework of Reference for language levels.

5.2. Specialists-in-training

As of 31 December 2012, in Spain there were 29,578 residents being trained in the 58 health science specialties.

Table 5.4. Residents in training as of 31 December 2012

Specialty	Residents	Specialty	Residents
Family and Community Medicine	6,330	Sports and Exercise Medicine	286
Paediatrics and its specific areas	1,648	Microbiology and Parasitology	275
Internal Medicine	1,535	Paediatric Nursing	272
Anaesthesiology and Recovery	1,307	Occupational Medicine	255
Orthopaedic Surgery and Trauma	1,067	Preventive Medicine and Public Health	247
Obstetrics and Gynaecology	1,054	Geriatrics	233
Psychiatry	962	Neurosurgery	212
General and digestive system surgery	926	Mental Health Nursing	209
Diagnostic Radiology	878	Industrial and Galenic Pharmacy	205
Cardiology	756	Allergology	199
Obstetrical-Gynaecological Nursing	756	Radiation Oncology	196
Intensive medicine	744	Rheumatology	194
Ophthalmology	665	Clinical Biochemistry	186
Digestive system	570	Plastic, Cosmetic and Reconstructive Surgery	171
Pharmacy in Hospitals	506	Angiology and vascular surgery	169

Table 5.4. Residents in training as of 31 December 2012 *(Continuation)*

Specialty	Residents	Specialty	Residents
Clinical Psychology	498	Oral and Maxillofacial Surgery	154
Neurology	479	Nuclear Medicine	150
Haematology and Haemotherapy	463	Clinical Neurophysiology	142
Urology	456	Cardiovascular Surgery	118
Pneumology	438	Paediatric Surgery	105
Medical Oncology	424	Immunology	104
Physical Medicine and Rehabilitation	367	Medical Physics	100
Nephrology	352	Thoracic Surgery	98
Clinical Analysis	330	Forensic Medicine	65
Family and Community Nursing	324	Geriatric Nursing	58
Anatomical Pathology	319	Clinical Pharmacology	54
Otolaryngology	315	Occupational Nursing	18
Dermatology, medical-surgical and venereal	314	Radiopharmacy	18
Endocrinology and Nutrition	286	Medical Hydrology	16

Remarks: data appears in order from highest to lowest.
Source: Ministry of Health, Social Services and Equality. Sub-Directorate General of Professional Regulation.

5.3. Accreditation of teaching centres, units and structures

In 2012, there were 62 new accreditations granted along with 12 authorisations to increase an existing unit's teaching capacity. Two accreditations previously granted to teaching units were withdrawn and one precautionary suspension was lifted.

The number of teaching positions (authorised and equipped with the necessary technological and human resources) for the training of future specialists increased overall by 120 in 2012. By specialty, the greatest increment was in the nursing specialties, especially in Paediatric Nursing, where there was an increase of 24 in the number of teaching positions. Among the medical specialties, the greatest increase was in Medical Oncology (8 positions) and in Internal Medicine (5 positions).

At the end of 2012 there were 3,011 accredited teaching units (with a total of 9,431 teaching positions), of which 64 were Multiprofessional Teaching Units. These units are responsible for the training of residents in

a variety of fields, in specialties accessed from different degree programmes but carried out in similar areas of care activity.

In 2012 audits were conducted in 9 teaching centres.

Table 5.5. Increase in number of professionals authorised to teach specialists-in-training, by autonomous community

Andalucía	27
Comunidad Valenciana	27
Cataluña	17
Madrid	12
Galicia	11
Castilla y León	9
Castilla-La Mancha	8
Asturias	3
Murcia	2
País Vasco	2
Aragón	1
Cantabria	1
Baleares	0
Canarias	0
Extremadura	0
Navarra	0
La Rioja	0
Ceuta and Melilla	0
TOTAL	**120**

Remarks: data appears in order from highest to lowest.
Source: Ministry of Health, Social Services and Equality. Sub-Directorate General of Professional Regulation.

5.4. Recognition of foreign qualifications

In 2012 the qualifications of 711 health care professionals from other European Union countries were recognised.

Table 5.6. Recognition of EU qualifications in the health care professions	
TOTAL	**711**
Nurse responsible for general care	197
General practitioner	169
Medical specialist	161
Physical therapist	54
Odontologist	45
Specialist nurse	38
Pharmacist	26
Veterinarian	12
Optician-optometrist	3
Speech therapist	2
Medical physicist	2
Psychologist specialised in clinical psychology	1
Occupational therapist	1

Remarks: data appears in order from highest to lowest.
Sources: Ministry of Health, Social Services and Equality. Sub-Directorate General of Professional Regulation, 2012.

Looking at the distribution by country, the recognition of the qualifications of 121 general care nurses from Portugal is especially noteworthy, along with 14 midwives from the United Kingdom, 13 pharmacists and 64 doctors from Italy and 35 doctors from Germany, and 10 veterinarians from Italy.

As of 31 December 2012, a total of 3,753 applications seeking recognition of specialist qualifications obtained in non-EU countries were being processed. Of these applications 1,210 had been received in 2010, while 2,127 had been received in 2011 and 412 in 2012.

In 2012, certificates of recognition of non-EU specialist qualifications were issued to 112 applicants. With respect to the country of origin of these qualifications, a total of 29 were from Argentina or Cuba and 22 were from Venezuela.

Table 5.7. Recognition of qualifications of foreign health science specialists

Specialty	EU qualifi-cations	Non-EU qualifi-cations	Specialty	EU qualifi-cations	Non-EU qualifi-cations
Clinical Analyses	2		Internal Medicine	16	
Anatomical Pathology	2		Nephrology	1	2
Anaesthesiology	16	55	Pneumology	1	
Digestive system	2		Neurosurgery	2	7
Cardiology	7	1	Neurology	1	
Cardiovascular surgery	1		Obstetrics and Gynaecology	13	2
General and Digestive Surgery	17	4	Ophthalmology	3	2
Orthopaedic Surgery and Trauma	6		Medical Oncology	5	
Paediatric Surgery	1	1	Radiotherapy Oncology	4	
Plastic Surgery	7		Otolaryngology		3
Thoracic Surgery	1		Paediatrics	6	12
Dermatology	3	3	Clinical Psychology	1	
Mental Health Nursing	1		Preventive Med. and Public Health	2	
Obstetrical-Gynaecological Nursing	37		Psychiatry	6	2
Occupational Medicine	2		Diagnostic Radiology	3	1
Family and Community Medicine	25	11	Medical Physics	2	
Physical Medicine and Rehabilitation	1	1	Rheumatology	1	
Intensive Medicine	1	1	Urology	3	2

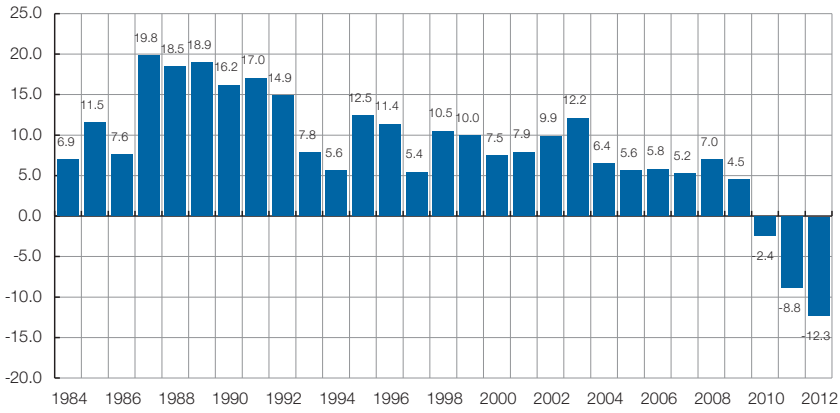
Sources: Ministry of Health, Social Services and Equality. Sub-Directorate General of Professional Regulation, 2012.

6. Medicines

6.1. Pharmaceutical expenditure

In 2012 the pharmaceutical expenditure generated by medical prescriptions invoiced to the SNS and paid for with public funds from the autonomous communities and INGESA was 9,770.9 million Euros. This is a reduction of 12.3% with respect to the amount corresponding to 2011. The amounts invoiced to the SNS for prescriptions have been decreasing since 2010.

Graph 6.1. Percentage increment in pharmaceutical expenditure on medical prescriptions invoiced to the SNS



Remarks: the pharmaceutical expenditure is the total retail value of the prescriptions invoiced to the SNS, VAT included, minus the contributions made by users and dispensing pharmacies and minus the deductions applicable by virtue of RDL 8/2010.
Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics, 1984-2012.

The changes in pharmaceutical spending during 2012 show significant decreases with respect to the same period of the previous year.

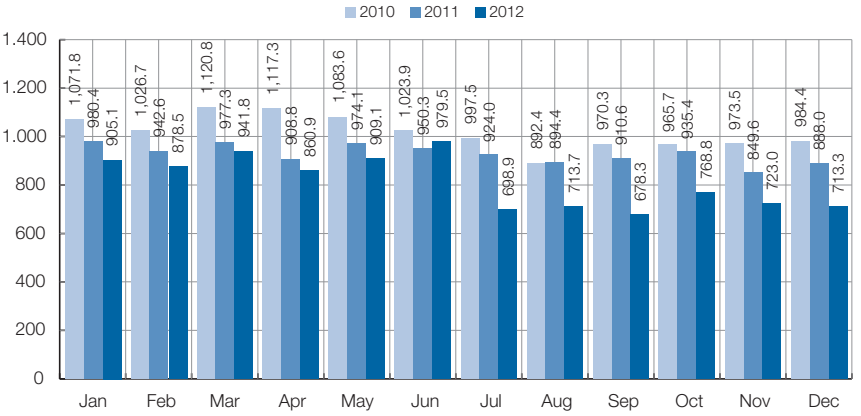
Table 6.1. Pharmaceutical expenditure on SNS medical prescriptions

	Pharmaceutical expenditure (millions of Euros)	% Δ 2012/2011
January	905.1	-7.7
February	878.5	-6.8
March	941.8	-3.6
April	860.9	-5.3
May	909.1	-6.7
June	979.5	3.1
July	698.9	-24.4
August	713.7	-20.2
September	678.3	-25.5
October	768.8	-17.8
November	723.0	-14.9
December	713.3	-19.7
Total	**9,770.9**	**-12.3**

Remarks: the pharmaceutical expenditure is the total retail value of the prescriptions invoiced to the SNS, VAT included, minus the contributions made by the user and by the dispensing pharmacy and minus the deductions applicable by virtue of RDL 8/2010.
Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics, 2012.

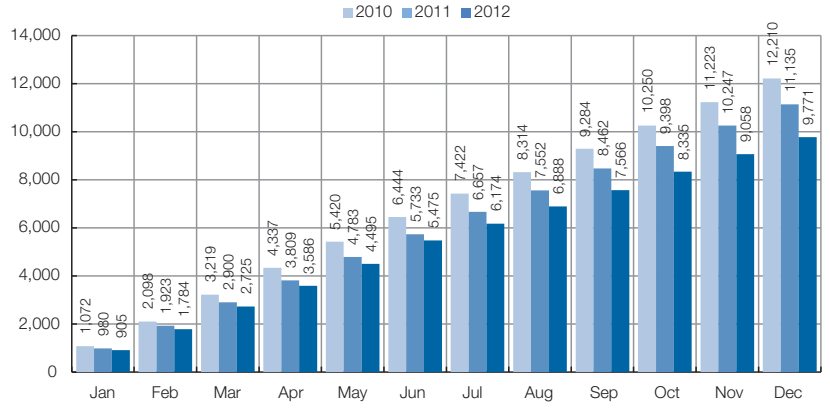
The year 2012 was the first time since 2004 that public spending on pharmaceuticals was less than 10,000 million Euros. In the second semester, with the application of Royal Decree-Law 16/2012, passed by the executive branch of the government, the savings in pharmaceuticals amounted to almost 1,107 million Euros. It was in July of 2012 that the amount invoiced to the SNS for medical prescriptions started to drop significantly, a result of the new measures regarding user contributions to pharmaceutical benefits and other measures designed to control pharmaceutical expenditure, such as price review and the setting of new prices for groups of related products.

Graph 6.2. Changes in the monthly pharmaceutical expenditure on SNS medical prescriptions (in millions of Euros)



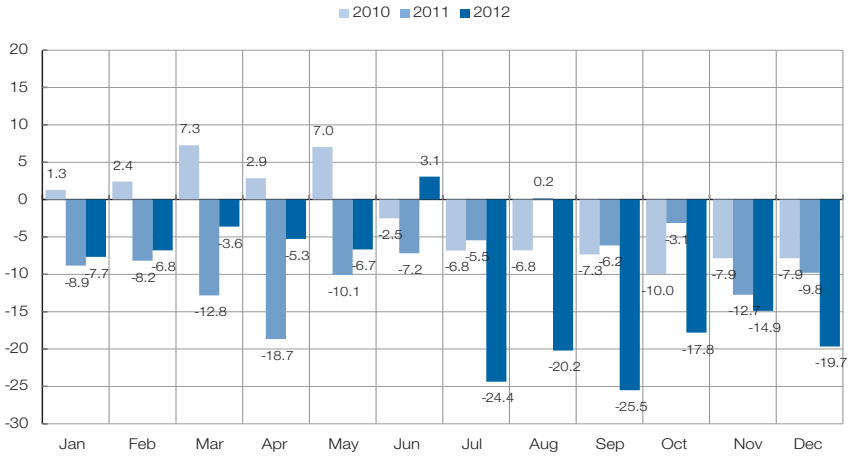
Remarks: the pharmaceutical expenditure is the total retail value of the prescriptions invoiced to the SNS, VAT included, minus the contributions made by the user and by the dispensing pharmacy and minus the deductions applicable by virtue of RDL 8/2010.
Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics.

Graph 6.3. Changes in pharmaceutical expenditure on SNS medical prescriptions, in accumulated monthly expenditure (millions of Euros)



Remarks: the pharmaceutical expenditure is the total retail value of the prescriptions invoiced to the SNS, VAT included, minus the contributions made by the user and by the dispensing pharmacy and minus the deductions applicable by virtue of RDL 8/2010.
Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics.

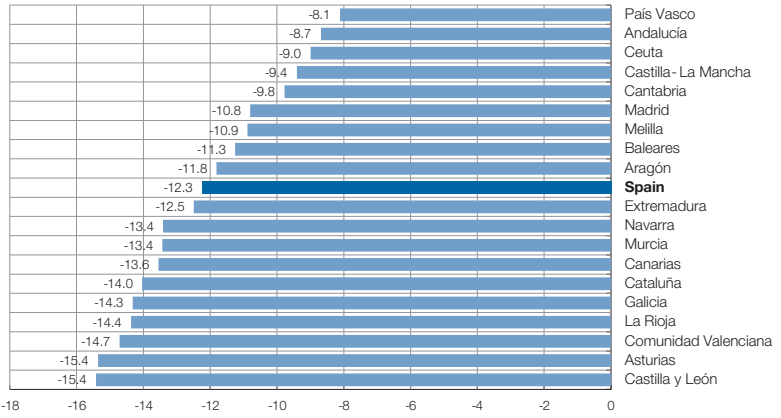
Graph 6.4. Changes in the monthly increment (%) in pharmaceutical expenditure on SNS medical prescriptions



Remarks: the pharmaceutical expenditure is the total retail value of the prescriptions invoiced to the SNS, VAT included, minus the contributions made by the user and by the dispensing pharmacy and minus the deductions applicable by virtue of RDL 8/2010.
Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics.

Comparing 2012 to 2011, the autonomous communities with the greatest reduction in the amount invoiced to the SNS for medical prescriptions were: Castilla y León (-15.4%), Asturias (-15.4%), C. Valenciana (14.7%) and La Rioja (-14.4%).

Graph 6.5. Percentage of variation in pharmaceutical expenditure by autonomous community

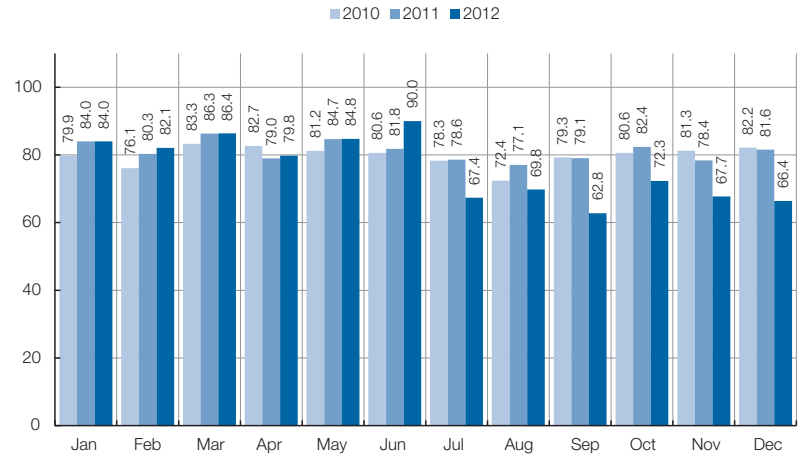


Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics, 2012.

6.2. Prescriptions invoiced to the SNS

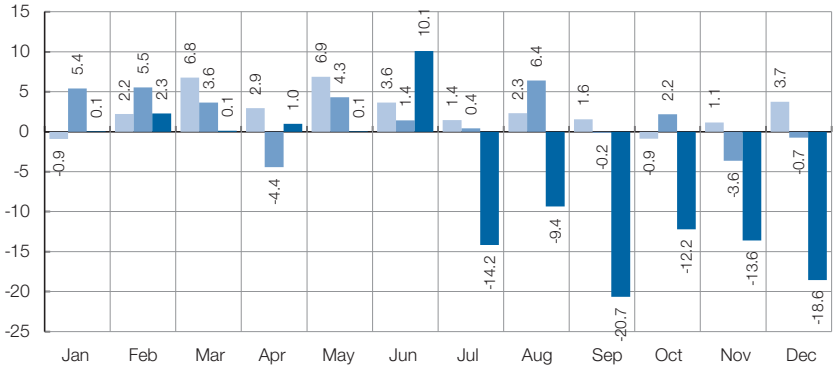
The number of prescriptions invoiced to the SNS in 2012 was 913.7 million. In 2010 and 2011 containment was observed in the growth of prescriptions invoiced to the SNS, while in 2012 there was a reduction of -6.1% with respect to 2011.

Graph 6.6. Changes in the number of medical prescriptions invoiced to the SNS, by month (in millions of prescriptions)



Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics.

Graph 6.7. Changes in the monthly increment (%) in the number of medical prescriptions invoiced to the SNS

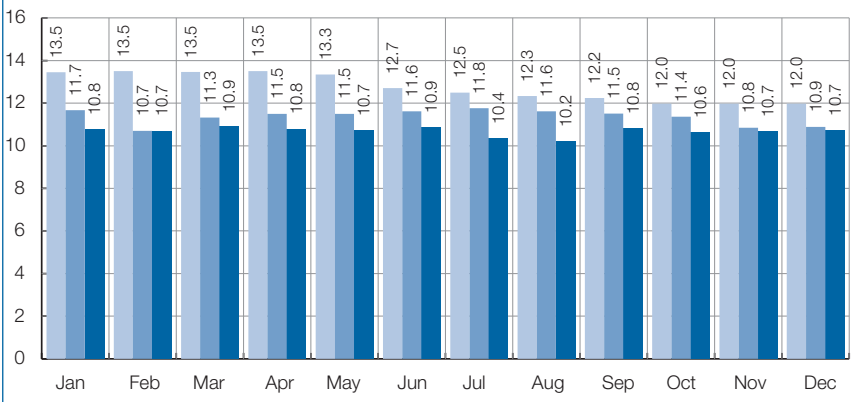


Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics.

6.3. Average expenditure per prescription

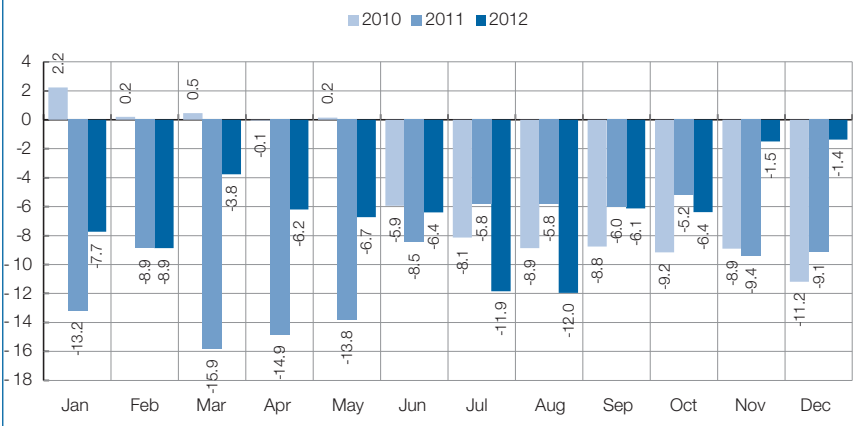
In 2012 the downward trend in the average expenditure per prescription continued, with an average reduction of 6.5% with respect to the preceding year.

Graph 6.8. Monthly changes in the average expenditure per prescription



Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics.

Graph 6.9. Changes in the monthly increase (%) in average expenditure per prescription



Source: Ministry of Health, Social Services and Equality. Medical prescription spending statistics.

6.4. Generic medicines

In 2012 the use of generic medicines represented 39.7% of the total number of medicine packs invoiced to the SNS. In January of 2012 the use of generics represented 38.4%, but by December of the same year the percentage had risen to 43.7%. In relation to the total retail value of the prescriptions invoiced to the SNS, 18.4% corresponded to generic medicines. Over the course of the year the percentage rose as the number of generic packs invoiced grew higher.

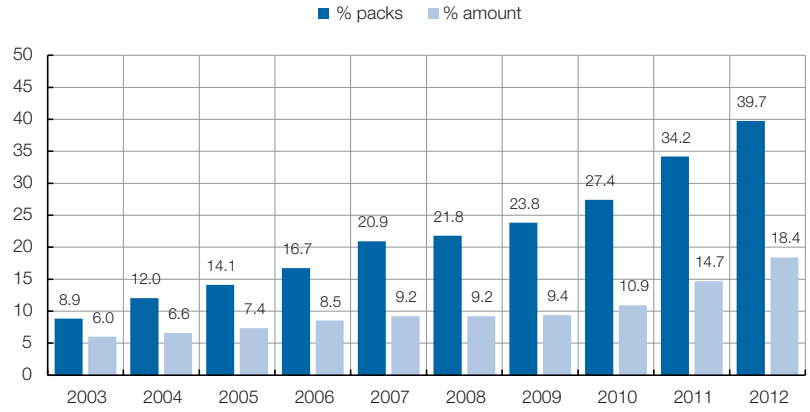
Table 6.2. Changes in the use of generic medicines (EFG)

	EFG/Total Medicines	
	% Packs	% Amount
January	38.4	17.8
February	38.1	17.6
March	37.6	17.3
April	37.5	17.1
May	38.0	17.5
June	38.3	17.8
July	39.4	18.8
August	39.9	19.2
September	42.6	19.7
October	43.0	19.7
November	43.3	19.7
December	43.7	19.9
Total year	**39.7**	**18.4**

Source: Ministry of Health, Social Services and Equality. Alcántara Information System, 2012.

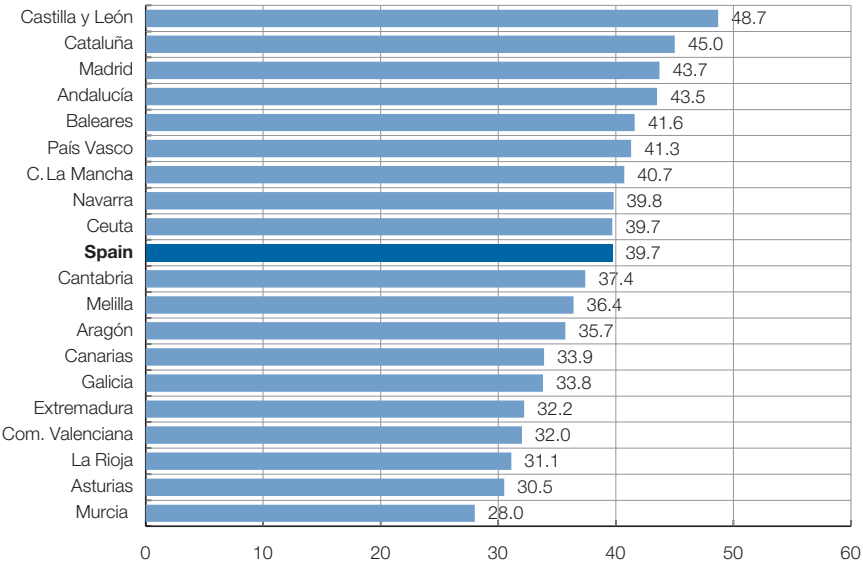
The use of generic medicines has grown considerably in recent years. The percentage of generic packs in the total number of pharmaceutical packs consumed more than quadrupled from 2003 to 2012, with the percentage rising from 8.9% to 39.7%. As regards the presence of generics in the total retail value of prescriptions invoiced to the SNS, the percentage has grown from 6.0% in 2003 to 18.4% in 2012.

Graph 6.10. Changes in the use of generic medicines (% of total number of packs - % of total retail value of prescriptions invoiced to the SNS)



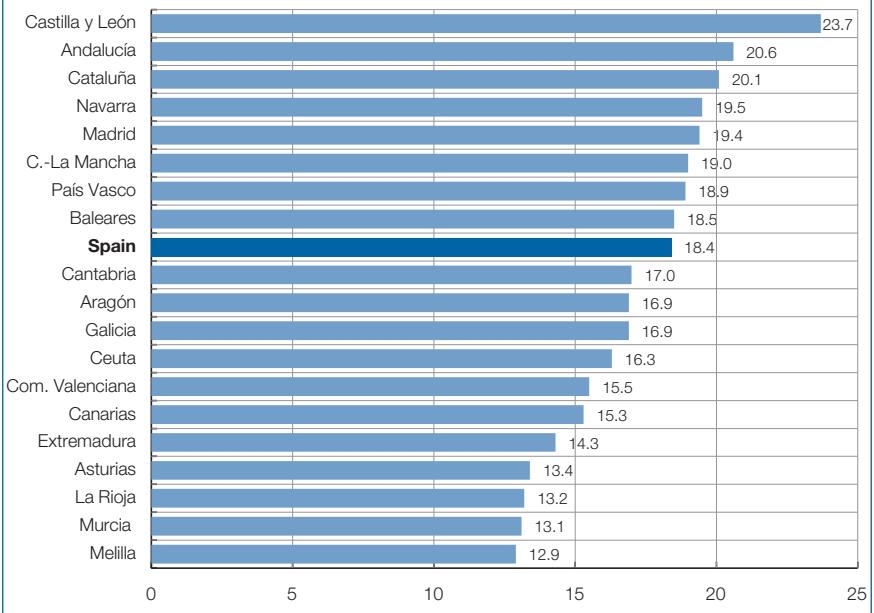
Source: Ministry of Health, Social Services and Equality. Alcántara Information System, 2012.

Graph 6.11. Generic medicines (%) in the total of medicines consumed, by autonomous community (packs)



Source: Ministry of Health, Social Services and Equality. Alcántara Information System, 2012.

Graph 6.12. Generic medicines (%) in the total of medicines consumed, by autonomous community (retail value)



Source: Ministry of Health, Social Services and Equality. Alcántara Information System, 2012.

6.5. Citizen information about medicines

With regards to information about medicines, 87.9% of citizens obtain information about the medicines they use from doctors. A smaller percentage of them obtain information from pharmacists (36.3%) and from the product leaflet (29.7%). Other sources of information are nursing professionals (10.9%), friends and family (3.4%), Internet (2.2%) and the health authorities (2.0%).

The degree of trust that citizens have in the various agents matches the frequency with which they turn to them for information. Maximum trust is placed in doctors and pharmacists, the professionals to whom citizens most often turn for information.

Table 6.3. Source of citizen information about medicines

Information about medicines is obtained mainly from... (*)		The degree of trust afforded to the source of information is...	
		High or quite high	Low or none
The doctor	87.9	93.4	5.2
Nurses	10.9	70.1	23.2
Pharmacists	36.3	84.0	12.8
The product leaflet	29.7	73.4	20.9
Friends and family	3.4	23.0	71.5
Internet	2.2	9.7	79.9
The health authorities	2.0	57.0	31.7

Remarks: (*) a maximum of 3 responses allowed.
Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

6.6. Buying medicines on Internet

The vast majority of the population surveyed (97.1%) say they have never bought medicines over the Internet. Only 0.67% of the persons surveyed say they have made such purchases and 36.4% of the persons who have bought medicines online chose this method because they found medicines that are not sold at pharmacies.

Most of the persons surveyed (78.8%) believe that the medicines sold over the Internet are not safe.

7. Access to health care services

7.1. Appointments with the general practitioner

Primary Care is the first care level, the one closest to the citizens. Its main characteristic is its accessibility.

The number of medical appointments registered in Primary Care Centres and Local Primary Care Centres exceeds 258 million, of which 86% are attended by a family physician.

Of every 10 persons, 4 state that when they request an appointment with the family physician for the same day, they "always or almost always" are given an appointment for the same day.

Table 7.1. Appointments with the general practitioner

"When you request a same-day appointment with your general practitioner at the health care centre, how often is such an appointment available…?"

	2008	2009	2010	2011	2012
Always + almost always	45.3	40.7	41.6	39.5	39.2
Never + almost never	50.7	55.2	57.6	58.4	58.8
Don't know/No answer	4.1	4.1	0.8	2.1	2.0

Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2008-2012 (2013).

Those who "never or almost never" obtained the appointment for the same day (6 of every 10 citizens) had to wait an average of 3.6 days to see the doctor.

7.2. Access to specialised ambulatory care

The activity related to the specialised ambulatory care within hospitals and in specialty centres associated with hospitals is calculated to be 87.8 million consultations, of which 36.4% are initial consultations. Of all the consultations taking place, over 87% are financed by the SNS.

Overall, the surgical specialties, not including gynaecology and obstetrics, represent 39% of the total number of consultations, with trauma and ophthalmology being the most frequented specialties, at 12% and 10% of the total, respectively.

Forty percent of the consultations are in medical specialties, 9% in gynaecology and obstetrics and 3% in paediatrics.

In 2012 the proportion of patients waiting for an initial consultation in one of the basic specialties was 42.2 per 1,000 inhabitants, with a mean wait time of 59 days. This is an increase of 3 days compared to the waiting list situation during the preceding six months.

Table 7.2. Specialised ambulatory care waiting list in the SNS, as of 31 December 2012

	Total initial consultations and basic specialties		
	Number of patients waiting per 1,000 inhab.	**% patients given appointment over 60 days after referral**	**Average wait time (days)**
Gynaecology	4.4	41.5	85
Ophthalmology	9.2	44.8	75
Traumatology	8.6	41.2	64
Total	**42.2**	**36.5**	**59**
Cardiology	2.1	36.1	59
Digestive system	3.0	36.6	57
Dermatology	6.6	39.8	56
Neurology	2.5	37.2	53
Urology	2.1	32.2	53
ENT	2.7	24.9	41
General and digestive surgery	2.0	21.6	41

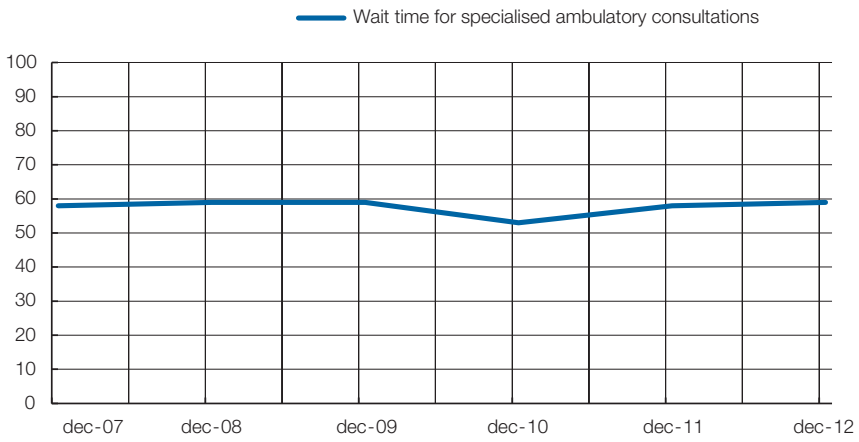
Remarks: data appears in order from highest to lowest according to average wait time.
Percentage of basic specialties in total of specialised ambulatory consultations: 78%
Information refers to 15 autonomous communities and INGESA (for Ceuta and Melilla).
Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS).

Table 7.3 Changes in specialised ambulatory care waiting list in the SNS

	Number of patients waiting per 1,000 inhab.	% patients given appointment over 60 days after referral	Average wait time (days)
December 2007	39.3	34	58
June 2008	37.1	…	59
December 2008	37.5	37	59
June 2009	39.1	…	52
December 2009	40.2	37	59
June 2010	39.8	…	53
December 2010	33.0	35	53
June 2011	40.4	…	52
December 2011	36.1	38	58
June 2012	35.9	…	53
December 2012	42.2	36	59

Remarks: there is a break in the data series because starting in June 2012 the absolute numbers refer to all 17 autonomous communities and INGESA (from 2007 to 2011, inclusive, the data were from 16 autonomous communities and INGESA).
Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS).

Graph 7.1. Changes in the waiting list for specialised ambulatory consultations in the SNS, according to average wait time (days)



Remarks: the 2012 data includes figures from the 17 autonomous communities and INGESA. For the 2007-2011 period the data comes from only 16 autonomous communities and INGESA.
Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS).

7.3. Wait times for scheduled surgery

In 2011 in Spain 3.4 million surgical interventions were performed in SNS hospitals. This is 71% of the interventions performed in all of the country's hospitals.

Since 2004 the SNS has been monitoring wait times related to scheduled surgery (that is, non-urgent surgery).

The available data shows an upward trend since 2009 in the indicators regarding surgery wait times, although it is important to note that in 2012 there was a break in the data series because that year the data from all 17 autonomous communities and INGESA began to be computed (previously the data of only 16 autonomous communities was included).

As of 31 December 2012, the proportion of patients on the structural waiting list (those waiting for a non-urgent surgical intervention, with a wait that can be attributed to questions of organization and available resources) was 12.8 patients per 1,000 inhabitants, an increase of one percentage point over the first semester of the same year. The percentage of patients having to wait for over 6 months was 16.5%, while the mean wait time was 100 days for the group as a whole.

Table 7.4. Surgery waiting list in the SNS. Changes December 2004-December 2012

	Number of patients	% of patients waiting over 6 months	Average wait time (days)
December 2004	391,445	9.1	78
December 2005	385,050	9.5	83
December 2006	362,762	7.1	70
December 2007	376,242	7.4	74
December 2008	364,397	6.7	71
December 2009	372,468	5.7	67
December 2010	392,072	5.4	65
December 2011	459,885	10.0	73
June 2012	536,911	9.8	76
December 2012	571,395	16.5	100

Remarks: direct comparisons between the number of patients in 2012 and those of previous semesters are not possible, due to the inclusion of another autonomous community (Madrid).
Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS).

Table 7.5. Surgery waiting list in the SNS. Distribution by specialties, as of 31 December 2012

Specialty	Patients on structural waiting list (*)	Patients /1,000 inhab.	% waiting over 6 months	Average wait time (days)
Thoracic surgery	1,375	0	19.9	152
Neurosurgery	9,683	0.3	24.2	151
Plastic surgery	15,826	0.4	18.6	124
Traumatology	166,302	4.4	23.1	122
Angiology/vascular surgery	16,481	0.4	19.6	112
Total	**571,395**	**12.9**	**16.5**	**100**
Paediatric surgery	14,550	0.4	14.4	100
General and digestive surgery	108,508	2.8	14.7	97
ENT	38,831	1.0	15.0	93
Maxillofacial surgery	8,296	0.2	11.5	90
Urology	39,691	1.0	12.1	86
Ophthalmology	110,812	2.9	14.2	81
Cardiac surgery	3,277	0.1	7.1	73
Gynaecology	25,015	0.7	5.9	70
Dermatology	12,748	0.3	1.6	50

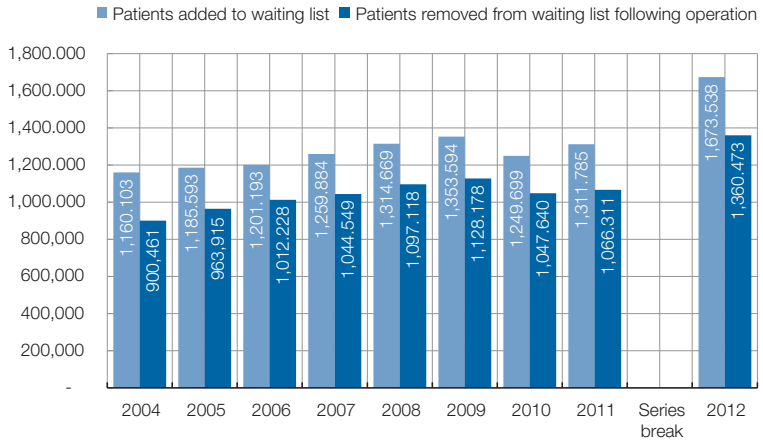
Remarks: data appears in order from highest to lowest according to average wait time.
(*) In one regional Health Service the total surgery waiting list data was estimated using selected processes: the percentage of patients waiting more than 6 months and the average wait time correspond to these processes.
Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS).

Table 7.6. Surgery waiting list in the SNS. Distribution by selected processes, as of 31 December 2012

	Patients on structural waiting list (*)	Patients /1,000 inhab.	% waiting more than 6 months	Average wait time (days)
Hip prosthesis	12,772	0.3	26.9	128
Hallux valgus	17,152	0.5	25.9	123
Varicose veins in lower extremities	15,528	0.4	22.8	117
Arthroscopy	21,595	0.6	23.7	116
Adenotonsillectomy	11,274	0.3	19.4	100
Cholecystectomy	14,237	0.4	17.5	99
Total of selected processes	**92,558**	**5.2**	**18.0**	**98**
Carpian tunnel	12,438	0.3	17.0	97
Cataracts	90,599	2.4	14.8	92
Inguinal/crural hernia	24,020	0.6	13.7	92
Benign prostatic hyperplasia	5,985	0.2	15.0	90
Pilonidal cyst	4,964	0.1	13.7	89

Remarks: data appears in order from highest to lowest according to average wait time.
Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS).

Graph 7.2. Changes in surgical activity originating from SNS waiting lists



Remarks: the 2004-2011 data corresponds to 15 autonomous communities and INGESA. There is a break in the data series in 2012, when the data includes 16 autonomous communities and INGESA.
Source: Ministry of Health, Social Services and Equality. SNS Waiting List Information System (SISLE-SNS).

The proportion of citizens who believe that the health authorities are taking action to reduce the waiting lists has declined over the past few years.

Exploring the opinions of citizens about the circumstances they believe should be taken into account in determining the order of patients on the waiting list, the criterion most often cited (53.8% of the responses) is "the repercussion the health problem requiring surgical intervention has on the patient's autonomy." The other circumstances are cited in similar proportions, with a small difference in favour of the date the patient was placed on the waiting list as the main criterion (36.0%).

Table 7.7. Circumstances for determining the order of the surgery waiting list

"In patients with the same health problem and need for an operation, which of the following circumstances do you believe should be taken into account in determining the surgery waiting list?" Maximum of 3 responses allowed.	
The date the patient was placed on the waiting list	36.0
The health problem prevents the patient from working	34.7
The health problem has repercussions on the patient's ability to care for the persons under his or her charge	33.7
The health problem has repercussions on the patient's autonomy and ability for self-care	53.8
Don't know	7.8
No answer	1.3

Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

7.4. Childhood vaccination programmes

Access by children to systematic vaccination against vaccine-preventable diseases has considerably reduced the morbidity and mortality of such diseases.

In 2012, the CISNS adopted, in plenary session and at the proposal of the Public Health Commission, a basic vaccination calendar, the centralised purchase of vaccines (flu vaccine and those recommended on the vaccine calendar) and an expert study upon which to base the proposal for the 2013 calendar, unifying the complete calendar. The vaccination calendar adopted by the CISNS recommends the systematic vaccination of children against: diphtheria, tetanus, pertussis and poliomyelitis, measles, mumps and rubella (combined MMR), Haemophilus influenzae type b (Hib), hepatitis B, meningococcal meningitis C, chicken pox and human papillomavirus.

Table 7.8. The common basic vaccination calendar approved by the CISNS in 2012	
First year of life	Hepatitis B (HB) vaccination at 0, 2 and 6 months, with a 1 year implementation period
	Meningococcal C (MenC) vaccination at 2 and 4 months, with a 1 year implementation period
Second year of life	DTPa-IPV-Hib, 4th booster dose at 18 months, with a 1 year implementation period
	Combined MMR, 1st dose at 12 months, with a 1 year implementation period
3 to 6 years of age	DTPa, 5th booster dose at 6 years, with a 1 year implementation period
	Combined MMR, 2nd dose at 3-4 years of age, with a 3 year implementation period
10-16 years of age	Td, 6th booster dose at 14 years, with a 1 year implementation period

Source: Ministry of Health, Social Services and Equality. CISNS Activity Report, 2012.

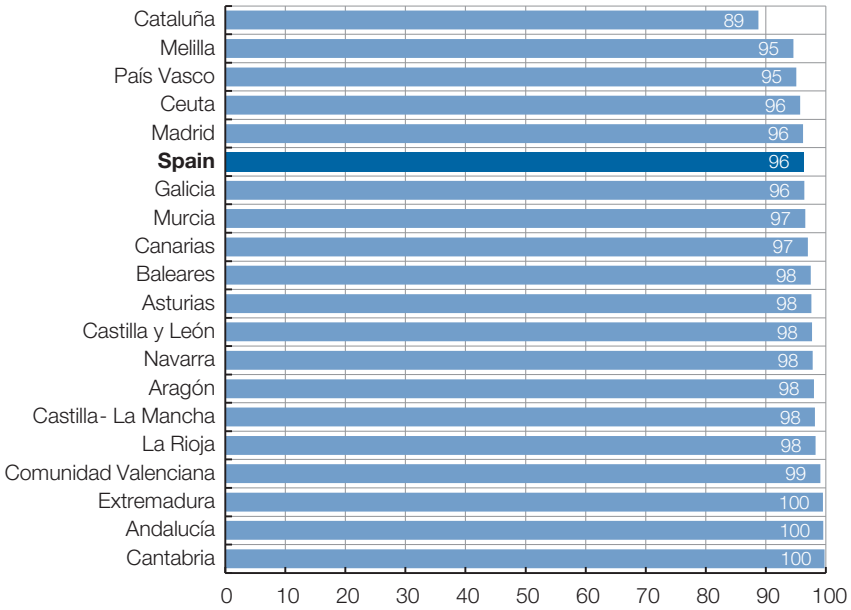
Over 96% of children in Spain have received the basic series of recommended vaccinations.

Table 7.9. Primary vaccination coverage (basic series)

	2008	2009	2010	2011	2012
Poliomyelitis	96.7	95.9	96.6	97.1	96.3
Diphtheria-tetanus-pertussis (DTPa)	96.7	95.9	96.6	97.1	96.3
Haemophilus influenzae type b (Hib)	96.7	95.9	96.6	97.1	96.3
Hepatitis B	96.5	95.5	96.5	96.6	95.8
Meningococcal diseases-serogroup C	97.2	97.4	97.8	98.0	96.6

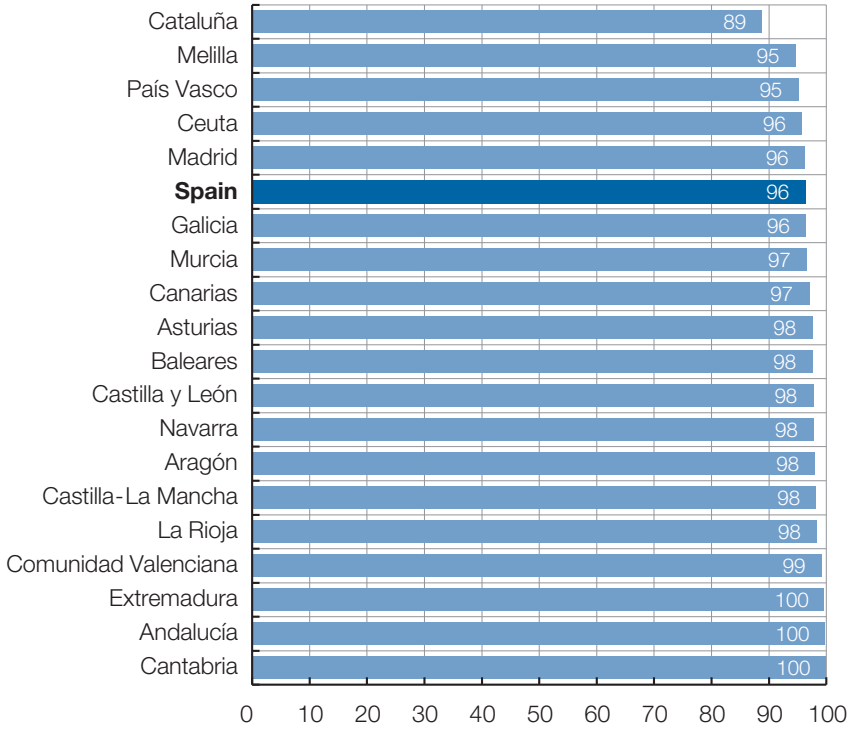
Remarks: primary vaccination coverage refers to the percentage of children aged 0 to 1 who have received three doses of vaccine against poliomyelitis, diphtheria-tetanus-pertussis (DTPa), Haemophilus influenzae type b (Hib), hepatitis B and two doses of vaccination against serogroup C meningococcal disease. Only doses administered as part of the Official Vaccination Services are used to calculate vaccination coverage. Vaccines acquired at dispensing pharmacies or administered in the private health care sector are not included.
Source: Ministry of Health, Social Services and Equality. Vaccination statistics.

Graph 7.3. Vaccination coverage (%) against poliomyelitis, in infants (0-1 year) by autonomous community



Remarks: 2012 data, in order from lowest to highest.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013.

Graph 7.4. Vaccination coverage (%) against diphtheria-tetanus-pertussis, in infants (0-1 year) by autonomous community



Remarks: 2012 data, in order from lowest to highest.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013.

The percentage of children aged 1 to 2 who received the recommended booster vaccinations was over 93% in all cases.

Table 7.10. Booster vaccination coverage (%): vaccinated children aged 1-2

	2008	2009	2010	2011	2012
Poliomyelitis	94.8	94.1	93.7	94.3	92.9
Diphtheria-tetanus-pertussis (DTPa)	94.8	94.1	93.7	94.1	93.1
Haemophilus influenzae type b (Hib)	94.8	94.1	93.7	94.1	92.9
Meningococcal diseases-serogroup C	96.0	96.5	94.2	98.8	94.8

Source: Ministry of Health, Social Services and Equality. Vaccination statistics.

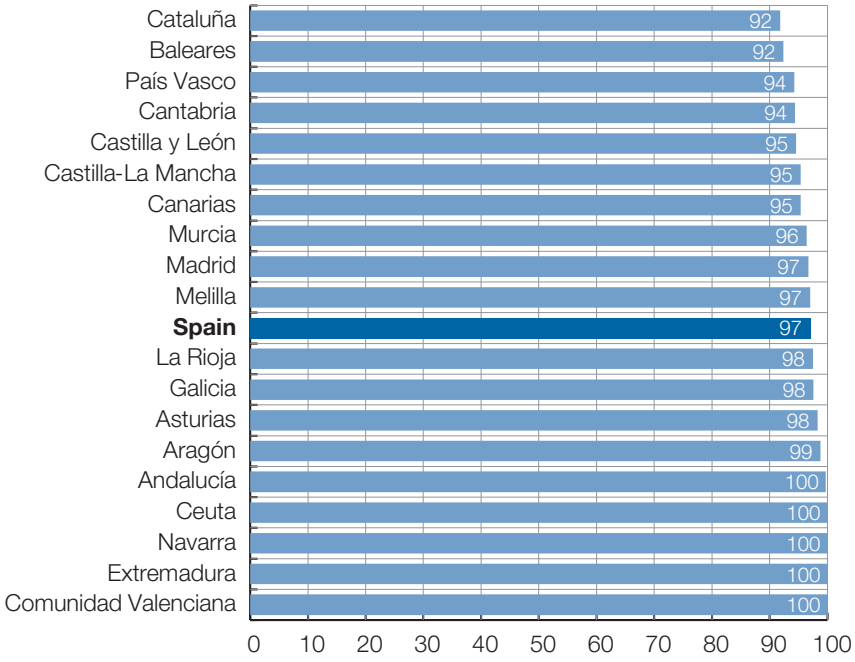
Vaccination against measles-mumps-rubella (MMR) in children aged 1 to 2 was over 97%, with over 90% also receiving the recommended boosters.

Table 7.11. Vaccination coverage (%) against measles-mumps-rubella, in children aged 1-6

	2008	2009	2010	2011	2012
First dose: children aged 1 to 2	97.6	97.4	95.5	96.8	97.1
Second dose: children aged 3 to 6	94.4	90.4	92.3	91.3	90.3

Source: Ministry of Health, Social Services and Equality. Vaccination statistics.

Graph 7.5. Vaccination coverage (%) against measles-mumps-rubella, in children aged 1-2, by autonomous community



Remarks: 2012 data, in order from lowest to highest.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013.

The percentage of adolescents (aged 11-14) who received three doses of the hepatitis B vaccine was 76.7%.

Table 7.12. Vaccination coverage (%) against hepatitis B, in adolescents					
	2008	2009	2010	2011	2012
Adolescents (aged 11-14) with 3 doses	83.4	82.7	79.1	79.4	76.7
Source: Ministry of Health, Social Services and Equality. Vaccination statistics.					

In the 2011-2012 academic year vaccination coverage against the human papillomavirus (HPV) was over 70% in girls aged 11-14.

Table 7.13. Vaccination coverage (%) of girls aged 11-14 against human papillomavirus (3 doses), academic year 2011-2012			
	Population	No. doses	%
La Rioja	1,449	1,374	94.8
Castilla y León	9,434	8,491	90.0
Melilla	544	484	89.0
Canarias	9,447	8,066	85.4
Navarra	2,958	2,522	85.3
Cataluña	36,218	30,514	84.3
Murcia	7,267	6,058	83.4
País Vasco	9,590	7,848	81.8
Asturias	3,513	2,762	78.6
Ceuta	530	416	78.5
Extremadura	5,236	4,089	78.1
Cantabria	2,214	1,707	77.1
Aragón	5,429	4,095	75.4
Madrid	28,230	20,508	72.6
Galicia	10,146	7,315	72.1
Comunidad Valenciana	23,591	16,808	71.2
Spain	**211,593**	**149,907**	**70.8**
Castilla-La Mancha	9,812	5,603	57.1
Baleares	4,415	2,340	53.0
Andalucía	41,570	18,907	45.5
Remarks: data in order from highest to lowest according to coverage. Source: Ministry of Health, Social Services and Equality. Vaccination statistics.			

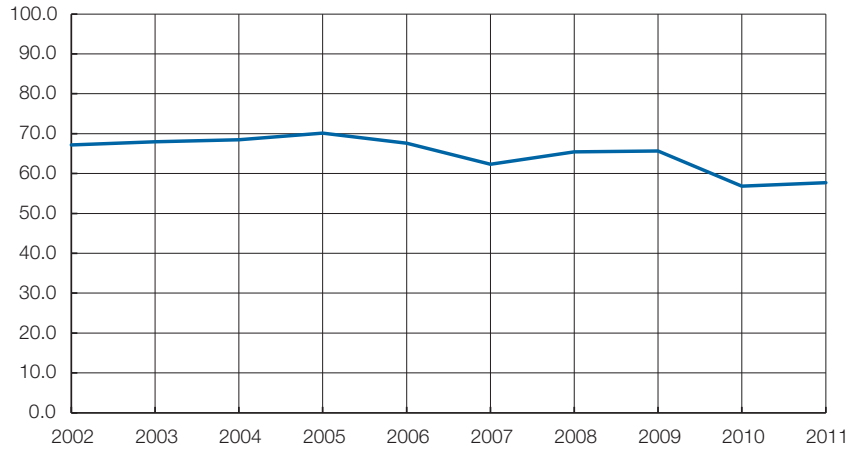
7.5. Seasonal flu vaccination among the elderly

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

At certain times of the year the flu can put the health care system under enormous strain in its care-giving activity. Its repercussion in terms of morbidity and mortality is greater among older persons and among those with chronic health problems.

Seasonal flu vaccination in persons aged 65 and over has been falling in recent years, although the percentage of coverage is still around 60%.

Graph 7.6. Changes in flu vaccination coverage in persons aged 65 and over. Spain, 2002-2011



Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013.

Table 7.14. Flu vaccination coverage in persons aged 65 and over by autonomous community	
	2011
Castilla y León	70.8
La Rioja	69.2
País Vasco	68.1
Cantabria	67.6
Navarra	66.0
Madrid	60.2
Castilla-La Mancha	59.7
Canarias	59.5
Aragón	58.8
Asturias	58.4
Spain	**57.7**
Extremadura	56.3
Galicia	55.2
Cataluña	55.0
Comunidad Valenciana	54.1
Murcia	53.1
Andalucía	52.8
Baleares	50.2
Melilla	32.9
Ceuta	31.6
Remarks: data appears in order from highest to lowest. Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013.	

7.6. Breast cancer screening

The type of tumour responsible for the highest mortality among women is breast cancer.

Eight of every 10 women aged 50 to 69 (77.1%) have had a mammogram within the past two years, either through public or private sector health care.

Table 7.15. Percentage of women aged 50 to 69 who have had a mammogram

	2011
Navarra	88.8
Murcia	86.9
País Vasco	86.5
Cataluña	83.7
Galicia	83.3
Castilla-La Mancha	80.9
Madrid	80.2
Extremadura	77.9
Aragón	77.2
Spain	**77.1**
Cantabria	76.9
Canarias	76.6
Asturias	75.9
Castilla y León	74.5
Comunidad Valenciana	71.2
La Rioja	69.7
Andalucía	66.3
Baleares	65.1
Ceuta	40.2
Melilla	33.7

Remarks: data appears in order from highest to lowest.
Source: Ministry of Health, Social Services and Equality. SNS Key Indicators (INCLASNS), August 2013. Data obtained as part of the Spanish National Health Survey.

Women with a lower level of education have a lower likelihood of having a mammogram in the recommended period (70%) and over 10% of this group has never had a mammogram.

In contrast, women who have completed secondary school or obtained higher education show a greater likelihood (82%) of having had a mammogram in the recommended period.

Table 7.16. Having a mammogram in the recommended period for purposes of breast cancer screening. Percentage distribution by level of education. Women aged 50 to 69

	Total	In the past 2 years	Over 2 but less than 3 years ago	Over 3 years ago	Never
Total	**100**	**77.05**	**9.48**	**5.89**	**7.59**
No reading or writing, or did not complete primary education	100	70.0	12.3	6.9	10.9
Primary education	100	79.1	8.2	5.9	6.8
First stage of secondary education	100	75.4	10.0	6.6	8.0
Second stage of secondary education, advanced vocational training or equivalent	100	82.0	7.2	4.9	5.9
University education	100	79.2	10.1	4.2	6.5

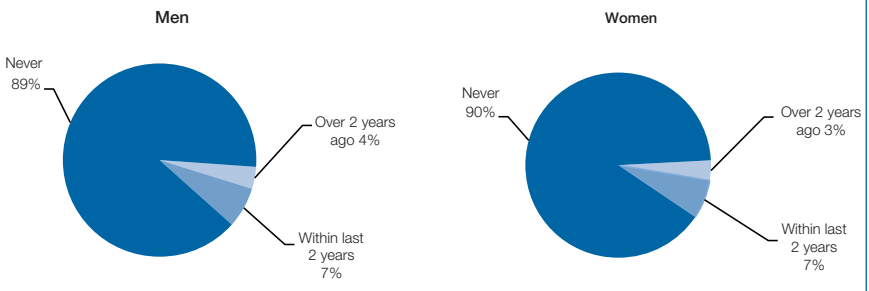
Source: Ministry of Health, Social Services and Equality and the National Statistics Institute (INE). Spanish National Health Survey, 2011/12.

7.7. Faecal occult blood test

Testing for faecal occult blood is one of the recommendations of the SNS Cancer Strategy, because colon cancer is one of the most frequent types of cancer in both sexes; in 2011 it was the cause of death of 6,687 men and 5,000 women.

However, according to the 2011/12 Spanish National Health Survey, as many as 9 out of 10 men and women aged 50 to 69 had never been tested for faecal occult blood. The test has been performed, within the last two years, on only about 7% of this group.

Graph 7.7. Testing for faecal occult blood. Percentage distribution, by sex, in the population aged 50 to 69



Source: Ministry of Health, Social Services and Equality and the National Statistics Institute (INE). Spanish National Health Survey, 2011/12.

8. Health expenditure

8.1. Changes in the health expenditure

Using the method recommended in the System of Health Accounts, in 2011 the total expenditure of the Spanish health care system, understanding this to be the sum of public and private care resources, was 98,860 million Euros (72,217 million by the public sector and 26,643 million by the private sector).

Table 8.1. Total health expenditure, public and private. Millions of Euros, percentage structure, percentage of gross domestic product (GDP) and Euros per inhabitant

	2007	2008	2009	2010	2011
Millions of Euros					
Total health expenditure	89,422	97,250	100,872	100,770	98,860
Public sector health expenditure	64,253	71,028	75,378	74,773	72,217
Private sector health expenditure	25,169	26,222	25,495	25,998	26,643
Percentage structure					
Total health expenditure	100.0	100.0	100.0	100.0	100.0
Public sector health expenditure	71.9	73.0	74.7	74.2	73.0
Private sector health expenditure	28.1	27.0	25.3	25.8	27.0
Percentage of GDP					
Total health expenditure	8.5	8.9	9.6	9.6	9.3
Public sector health expenditure	6.1	6.5	7.2	7.1	6.8
Private sector health expenditure	2.4	2.4	2.4	2.5	2.5
Euros per inhabitant					
Total health expenditure	1,978	2,107	2,158	2,143	2,095
Public sector health expenditure	1,421	1,539	1,612	1,590	1,530
Private sector health expenditure	557	568	545	553	565

Source: Ministry of Health, Social Services and Equality. System of Health Accounts, 2007-2011.

In the 2007-2011 period, the share of the public sector health expenditure in the total health expenditure increased by 1.1 percent, rising from 71.9% in 2007 to 73% in 2011.

Over the course of this five year period, the total health expenditure grew by an average annual rate of 2.5%. While the public sector health

expenditure presented a growth rate of 3%, the expenditure by the private sector grew more modestly, the average rate being 1.4%.

However, in 2011, the components of the health expenditure showed the opposite behaviour. The public sector health expenditure fell by 3.4% while the private sector health expenditure grew by 2.5%.

Thus, the total health expenditure represented 9.3% of the GDP, with 6.8% being financed by public resources and 2.5% being financed by private resources.

In relation to the population, the total health expenditure increased from 1,978 Euros per inhabitant in 2007 to 2,095 Euros per inhabitant in 2011, which is an average annual increase of 1.4% over the five year period.

8.2. Health expenditure by function

The expenditure in curative and rehabilitative care was 56,316 million Euros in 2011, absorbing more than half of the total health expenditure.

Table 8.2. Total health expenditure by health care function (millions of Euros)

	2007	2008	2009	2010	2011
Curative and rehabilitative care services	49,130	54,372	56,067	55,873	56,316
Long-term care services	8,357	8,975	9,931	10,830	10,328
Services ancillary to health care	4,332	4,865	5,121	5,126	5,199
Health products dispensed to out-patients	19,114	20,396	20,973	21,155	19,910
Prevention and public health services	2,175	2,244	2,691	2,272	2,125
Health administration and health insurance	3,008	3,047	3,204	3,018	3,008
Capital formation of health care provider institutions	3,305	3,351	2,885	2,496	1,974
Total health expenditure	**89,422**	**97,250**	**100,872**	**100,770**	**98,860**

Source: Ministry of Health, Social Services and Equality. System of Health Accounts, 2007-2011.

To be more exact, in 2011, 57% of the total health expenditure went to curative care services and rehabilitative care services. Next in importance were the expenditures on health products dispensed to outpatients (20.1%), on long-term care (10.4%) and on ancillary services, which represented 5.3% of the total health expenditure.

The weight of the expenditures in the main health care functions during the 2007-2011 period diverge: while the expenditure on curative

and rehabilitative care services, on long-term care and on services ancillary to health care rose by 2.0 percentage points, 1.1 percentage points and 0.4 percentage points, respectively, the expenditure on health products dispensed to outpatients fell by 1.2 percentage points.

Long-term care is the expenditure category that experienced the highest average annual growth rate in the 2007-2011 period, 5.4%, followed by ancillary services, with 4.7%, and curative and rehabilitative care services, with 3.5%.

In the last year of this period expenditure fell in all health care functions, except in ancillary services and curative and rehabilitative care services. If the changes in the capital formation expenditure of health care provider institutions are not considered, the differences are found in the services aimed at prevention and public health, in health products dispensed to outpatients and in long-term care services.

8.3. Health expenditure by provider

Looking at expenditure by the different health care providers, the expenditure of hospitals, which was 41,704 million Euros in 2011, absorbs the highest percentage of the total health care expenditure.

Table 8.3. Total health expenditure by health care provider (millions of Euros)

	2007	2008	2009	2010	2011
Hospitals	35,757	40,045	41,595	41,096	41,704
Residential nursing care establishments	5,277	5,590	6,335	7,125	6,324
Providers of ambulatory care	23,944	25,855	26,095	26,155	25,790
Retailers and other providers of health products	19,114	20,396	20,973	21,155	19,909
Providers offering and managing programmes on public health	925	820	1,197	796	779
General administration of health and health insurance	3,463	3,579	3,659	3,337	3,264
Other branches of activity	938	962	1,016	1,105	1,088
Rest of the world (*)	4	3	2	2	1
Total health expenditure	**89,422**	**97,250**	**100,872**	**100,770**	**98,860**

Remarks: (*) This item includes amounts paid to international health organisations. For INGESA it includes some medicines that, although they cannot be sold in Spain, are necessary for specific treatments.
Source: Ministry of Health, Social Services and Equality. System of Health Accounts, 2007-2011.

More specifically, in 2011, 42.2% of the total health expenditure was generated by the country's hospitals. The expenditure of ambulatory care providers was 26.1%, that of retailers and other providers of health products, 20.1%, and that of residential nursing care establishments, 6.4%.

In the 2007-2011 period, the contributions of the main health care providers to the total health expenditure were inconsistent: the expenditure of hospitals rose by 2.2 percent, the expenditure of residential nursing care establishments rose by 0.5 percent, the expenditure of ambulatory care providers fell by 0.7 percent and that of retailers and other providers of health products (mainly pharmacies) fell by 1.2 percent.

In the 2007-2011 period, the expenditure of residential nursing care establishments experienced the highest annual rate of growth (4.6%). Following it were the expenditure of hospitals (3.9%) and the expenditure of other branches of activity[7] (3.8%).

In the last year, with the exception of hospitals, the expenditure of all health care providers dropped. The most significant decreases took place in residential nursing care establishments (11.2%), in retailers and other providers of health products (5.9%) and in the general administration of health and health insurance (2.2%).

8.4. Health expenditure by source of financing

The health expenditure of the public administrations in 2011 was 72,217 million Euros, almost three quarters of the total health expenditure.

Table 8.4. Health expenditure by source of financing (millions of Euros)

	2007	2008	2009	2010	2011
Public administrations	64,253	71,028	75,378	74,773	72,217
Central government	623	609	918	550	508
Regional governments	58,048	64,493	68,537	68,522	66,066
Local governments	1,079	1,154	1,277	1,008	976
Social Security administrations	4,502	4,772	4,645	4,692	4,668
Private sector	25,169	26,222	25,495	25,998	26,643
Private insurance companies	5,619	5,632	5,752	5,404	5,490
Direct out-of-pocket payment by households	18,285	19,729	19,081	19,936	20,417
Non-profit institutions serving households[a]	619	341	374	406	373
Corporations (other than health insurance companies)[b]	646	520	287	252	363
Total health expenditure	**89,422**	**97,250**	**100,872**	**100,770**	**98,860**

Remarks: [a]break in the data series in 2008 due to the changes in Spain's national accounting procedures. [b]Includes only capital expenditure.
Source: Ministry of Health, Social Services and Equality. System of Health Accounts, 2007-2011.

Since 2009, the year that the long-standing upward trend of health expenditure ended, public administrations expenditure has decreased by 4.2%, as a consequence of the extraordinary deficit-reduction measures adopted in May 2010 because of the severe economic downturn. Particularly noteworthy among the drops in public sector health expenditure is the spending on pharmaceuticals and other non-durable health products, which, since 2009, has fallen 8.9%.

With respect to private expenditure, it was households that made the greatest contribution, with a share of 76.6%. Of the out-of-pocket health expenditure by households, 45.8% went to curative and rehabilitative care services; 36.5% went to health products dispensed to outpatients; 17.2% went to long-term care services; and 0.5% went to health care's ancillary services.

8.5. Public expenditure on health by autonomous communities

The consolidated public expenditure on health by autonomous communities in 2011 was 62,169 million Euros, which represents 5.9% of the GDP.[8]

The autonomous communities with the highest percentages in terms of health expenditure as a share of the GDP were Extremadura (9.9% of

the GDP), Castilla-La Mancha (8.3% of the GDP) and Murcia (8.1% of the GDP). At the other end of the spectrum were Madrid (4.4%), Baleares (4.8%) and Cataluña (5.1%).

Table 8.5. Consolidated public expenditure on health by autonomous community

	Millions of Euros	% of GDP	Euros per inhabitant
País Vasco	3,566	5.4	1,632
Asturias	1,721	7.6	1,591
Murcia	2,266	8.1	1,541
Navarra	988	5.3	1,538
Extremadura	1,693	9.9	1,526
Aragón	2,051	6.1	1,523
Castilla-La Mancha	3,067	8.3	1,450
La Rioja	461	5.7	1,428
Cataluña	10,120	5.1	1,342
Total spent by sector	**62,169**	**5.9**	**1,322**
Comunidad Valenciana	6,717	6.6	1,313
Castilla y León	3,332	6.0	1,302
Madrid	8,418	4.4	1,297
Cantabria	767	5.8	1,293
Canarias	2,731	6.5	1,284
Galicia	3,556	6.3	1,272
Baleares	1,273	4.8	1,144
Andalucía	9,442	6.6	1,121

Remarks: data in order from highest to lowest, according to Euros per inhabitant.
Source: Ministry of Health, Social Services and Equality. Statistics on Public Expenditure on Health (EGSP), 2011.

In 2011, 45.0% of the public expenditure on health made by this sector was generated by three autonomous communities: Andalucía, Cataluña and Madrid, which spent 10,120 million Euros, 9,442 million Euros and 8,418 million Euros, respectively. In contrast, La Rioja, Cantabria and Navarra were the autonomous communities generating the smallest expenditure, in absolute values.

In relation to their population, the autonomous communities with the largest public expenditure on health were País Vasco (1,632 Euros per inhabitant), Asturias (1,591 Euros per inhabitant) and Navarra (1,538 Euros per inhabitant). The communities with the smallest public expenditure on

health were Andalucía (1,121 Euros per inhabitant), Baleares (1,144 Euros per inhabitant) and Galicia (1,272 Euros per inhabitant).

To analyse the distribution of the public expenditure on health among the autonomous communities and the weight of the expenditure in each of the regional economies, it is also useful to look at the health expenditure as a percentage of the GDP indicator, detailed above.

The total expenditure of the autonomous communities sector decreased by 2.1% in 2011. The communities that most reduced their health expenditure were Baleares, with a reduction of 18.8%, Cantabria, 10.6% and Castilla y León, 7.9%. The expenditure grew in only four communities, with increases ranging from 1.1% in Murcia to 14.3% in Madrid.

However, over the period 2007-2011, the health expenditure of this sector experienced an average annual growth of 3.3%. By autonomous communities, the highest growth was in Murcia, with an average annual growth of 6.6%, and also in Madrid, with 5.6%, and in Castilla-La Mancha, with 4.9%. La Rioja and Cantabria are the only two communities in which the health expenditure fell in terms of the average annual growth over the last five year period.

Table 8.6. Consolidated public expenditure on health by autonomous community. Interannual variation 2011-2010 and average growth rate (AGR) 2007-2011

	Interannual variation 2011/2010	AGR 2007-2011
Madrid	14.3	5.6
Aragón	3.0	4.2
Asturias	2.9	4.9
Murcia	1.1	6.6
Navarra	-1.1	4.5
País Vasco	-1.1	4.2
La Rioja	-1.2	-4.6
Comunidad Valenciana	-1.3	4.7
Total spent by sector	**-2.1**	**3.3**
Extremadura	-2.2	2.6
Canarias	-4.3	2.1
Castilla-La Mancha	-4.3	4.9
Cataluña	-5.3	3.1
Andalucía	-5.7	1.6
Galicia	-6.9	0.7
Castilla y León	-7.9	2.0
Cantabria	-10.6	-1.8
Baleares	-18.8	1.3

Remarks: data appears in order from highest to lowest according to interannual variation 2011/2010. Data expressed as percentages.
Source: Ministry of Health, Social Services and Equality. Statistics on Public Expenditure on Health (EGSP), 2011.

Table 8.7. Consolidated public expenditure on health by autonomous community. Structure according to economic classification, in percentages

	Remuneration of personnel	Intermediate consumption	Contracts with private centres	Current transfers	Capital expenditure
Castilla y León	57.0	14.1	5.1	21.6	2.2
Baleares	54.7	19.4	9.0	15.2	1.7
Cantabria	52.3	20.1	4.5	20.0	3.1
Castilla-La Mancha	51.9	18.8	6.7	19.7	2.9
Aragón	51.8	24.3	4.0	18.4	1.5
País Vasco	51.7	20.7	7.1	17.0	3.5
Andalucía	50.7	20.4	4.7	23.5	0.8
Extremadura	50.6	21.4	4.4	21.2	2.4
Galicia	49.5	18.7	5.6	23.7	2.5
Navarra	49.3	19.7	7.6	17.5	5.9
Canarias	49.1	19.7	10.0	20.0	1.2
Murcia	48.1	23.4	7.3	19.0	2.2
La Rioja	47.5	24.6	7.4	18.3	2.1
Total spent by sector	**46.1**	**22.6**	**9.3**	**19.9**	**2.0**
Asturias	45.3	26.5	7.2	20.2	0.9
Madrid	44.3	30.8	8.2	15.6	1.1
Comunidad Valenciana	36.7	31.1	6.6	23.4	2.2
Cataluña	36.2	19.0	24.0	18.1	2.8

Remarks: data appears in order from highest to lowest according to personnel remuneration. To calculate the percentages, expenditure on consumption of fixed assets (amortizations) is excluded. The Statistics on Public Expenditure on Health take into account amortization data only for expenditure agents considered foundations.
Source: Ministry of Health, Social Services and Equality. Statistics on Public Expenditure on Health (EGSP), 2011.

In 2011, in the autonomous communities sector, 46.1% of the public expenditure on health went to personnel remuneration. Next in importance were intermediate consumption, with 22.6%, current transfers, with 19.9%, and purchases from the private sector through long-term contracts, which amounted to 9.3% of public expenditure on health.

9. Strategies of the SNS

9.1. Health Strategies

The objective of the SNS Health Strategies is to enhance the quality of the care provided to patients with certain pathologies of high prevalence or that have a high social and economic cost, in a co-ordinated manner by all the regional health services, in order to reinforce the principles of equity and cohesion in the health care of all citizens.

The development of strategies follows a well-defined and consolidated process, with the Interterritorial Council of the SNS (CISNS) deciding, based on the proposal of the Ministry of Health, Social Services and Equality, which specific pathologies should be targeted in a strategy.

This decision goes hand in hand with a number of actions in the areas of implementation, awareness, training and research, which are agreed upon and approved by the CISNS and then put in place by the autonomous communities.

The strategies in effect in 2012 focused on cancer, ischaemic heart disease, diabetes, mental health, palliative care, stroke, COPD, rare diseases, chronicity and rheumatic and musculoskeletal diseases. The strategies on chronicity and rheumatic and musculoskeletal diseases were presented and approved by the CISNS during the year 2012.

One of the greatest strengths of the system used to develop strategies is the participation of the agents involved in the pathologies targeted: professionals participate through their scientific societies, patients through their associations and researchers through their institutions (institutes, agencies, universities, health research networks and other bodies working in this field). In addition, both the central and the regional governments take part. All of these agents are members of the Institutional and Expert Committee of each strategy.

The strategies are evaluated on a regular basis. First, information regarding the indicators is gathered and analysed, and then a report is drawn up for the CISNS. In 2012, the results of the evaluation of the stroke and rare disease strategies were presented and approved by the CISNS. One major achievement in the implementation of the stroke strategy was the creation of stroke units in all the autonomous communities. As for rare diseases, the strategy has contributed to increased visibility, recognition and better handling of each of the diseases, and it has also stimulated research.

Table 9.1. Situation of the SNS Health Strategies

SNS Strategy	2006	2007	2008	2009	2010	2011	2012
Cancer	APPR		EVA	UPD			
Ischaemic Heart Disease	APPR		EVA	UPD			EVA
Mental Health	APPR			EVA and UPD			
Palliative Care		APPR			EVA and UPD		
Diabetes	APPR				EVA		UPD
Stroke			APPR				EVA
COPD				APPR			EVA
Rare Diseases				APPR			EVA
Chronicity							APPR
Rheumatic and Musculoskeletal Diseases							APPR

Remarks: APPR = approved, EVA= evaluated, UPD= updated
Source: Ministry of Health, Social Services and Equality. Sub-Directorate General of Quality and Cohesion.

In each strategy, after completing the evaluation, the pertinent objectives and recommendations are reviewed and, if necessary, modified, taking into account the new scientific evidence available and the results of the evaluation. In 2012, the diabetes strategy was updated following analysis of the evaluation's results and the identification of areas in need of improvement, by the evaluation committee.

The results of the strategy's evaluation and update are disseminated through scientific gatherings organised by the Ministry of Health, Social Services and Equality and through the official channels of the Regional Ministries of Health. The results are also publicised by participating scientific societies and through contributions to scientific journals.

9.2. Spanish Network of Health Schools for Citizens

One of the aims of the SNS Strategy on Chronicity is for health professionals and citizens to have shared responsibility in caring for this kind of health problem and in using health and social services appropriately. To this end, it is considered necessary to increase the awareness of professionals and the population at large, ensuring that patients have sufficient and appropriate

information to adopt an active and engaged attitude towards self-care, helping them become involved in decision-making regarding their health.

For this reason, on 27 June 2012, in plenary session, the CISNS approved the creation of the Spanish Network of Health Schools for Citizens, a transversal instrument to support strategies put in place by the system. The objective of such schools is to reinforce the capacity of individuals and the community to promote greater autonomy, self-care and healthy lifestyles.

The idea behind the Network is to encourage initiatives and experiences in patient schools, active patient programmes, expert patient programmes, community schools, networks of professional and non-professional caregivers and other arrangements that support self-care, in all autonomous communities. Placing high priority on equity, the Network gives citizens the opportunity to participate in their own care and to express their opinions as users of the health care system. This will certainly enhance the effectiveness of the actions taken.

9.3. Network of Health Technology and SNS Benefits Assessment Agencies

On 29 February 2012, the CISNS, in plenary session, passed a resolution to develop and update the SNS basket of services and to create the Spanish Network of Health Technology and SNS Benefits Assessment Agencies, the purpose of which is to evaluate medical techniques and procedures, for inclusion, exclusion and/or modification of conditions in the basket of SNS services.[9]

On 3 October 2012, the CISNS, with the ratification of the plenary body, created the Spanish Network of Health Technology and SNS Benefits Assessment Agencies. The creation of this Network was also laid down in Royal Decree Law 16/2012 on Urgent Measures to Guarantee the Sustainability of the SNS *(Real Decreto Ley 16/2012 de 20 de abril de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejora de la calidad y seguridad de sus prestaciones*) as it modified Articles 20 and 21 of the Spanish Law on Quality and Cohesion in the SNS (*Ley 16/2003 de cohesión y calidad del Sistema Nacional de Salud*).

Its objective is to support decision-making concerning the incorporation, financing or disinvestment conditions, and appropriate use of health technologies, by applying common criteria all over the country, through the corresponding regional health services, with a view to promoting equity and sustainability in the SNS.[10]

The Network is comprised of:

- Health Technology Assessment Agency of Carlos III Health Institute (AETS)
- Health Technology Assessment Agency of País Vasco (OSTEBA)
- Health Technology Assessment Unit of the Laín Entralgo Agency of the Community of Madrid (UETS)
- Health Technology Assessment Agency of Galicia (Avalia-t)
- Health Information, Assessment and Quality Agency of Cataluña (AIQS)
- Health Technology Assessment Agency of Andalucía (AETSA)
- Assessment and Planning Service of the Canary Health Services (SESCS)
- Health Sciences Institute of Aragón (IACS)
- Other SNS units and bodies, designated for this purpose by the autonomous communities

The functions of the Network of Health Technology and SNS Benefits Assessment Agencies are:

- To act consensually in its interactions with the central co-ordination bodies in the area of health and health service research.
- To collaborate in the identification and prioritization of the needs and opportunities existing in health technology assessment.
- To collaborate, using pre-existing structures and participating in international bodies, in the detection of emerging technologies and benefits.
- To collaborate with the Directorate General of the SNS Basic Service Basket and Pharmacy –the body responsible for organising the limited and monitored use of emerging technologies in the SNS (prior to possible inclusion in the basic service basket)– in the projects involving these technologies and in all aspects related to the update of the service basket.
- To participate in the preparation, adaptation and update of clinical practice guides, within the SNS Clinical Practice Guide Programme, which is managed by Guía Salud.
- To organise the preparation of the health technology assessment reports.
- To promote the economic assessment of health technologies and the active incorporation of this information, along with the ethical, social, legal and organisational dimensions, into the key information used in decision-making, whenever necessary.

- To favour the dissemination and implementation of health technology assessment reports at the national level, by means of informative and training activities targeting professionals in different decision-making capacities and in the different spheres of the SNS.
- To promote the presence and active participation of this Network in international forums and bodies, acting in a unified manner but without detriment to the individual participation of each of the network's members in the international forums, bodies, programmes or projects that may require or permit it.
- To promote initiatives and programmes at the international level, in the field of health technology assessment, particularly in the framework of the European Union and the Spanish-speaking world.

9.4. e-Health

9.4.1. Individual Health Card

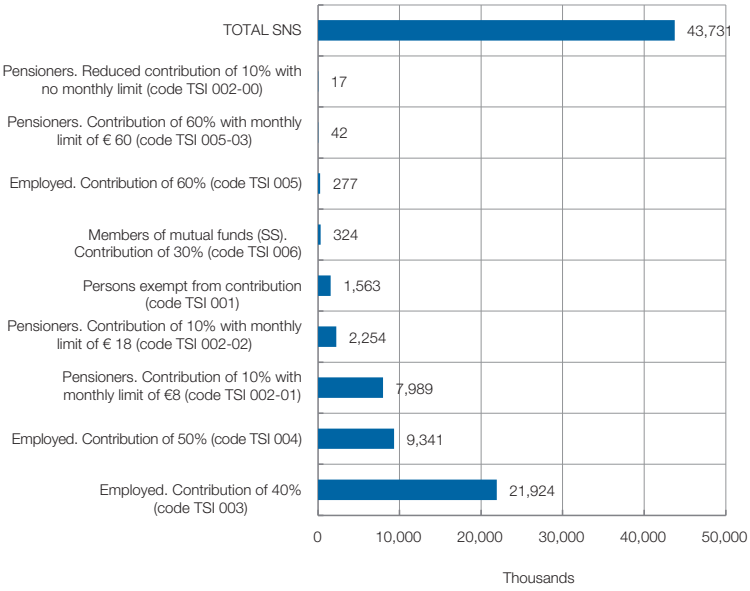
For the right to health protection to be made effective all over the SNS, there must be a standardized system for identifying all the persons entitled to this protection. This identification is made possible by the Individual Health Card (*Tarjeta Sanitaria Individual*, or TSI) issued by each autonomous community to the population living within its territory. To facilitate the management of the TSI, and to guarantee the secure and positive identification of each person, the Ministry of Health, Social Services and Equality registers health system users in a SNS Protected Population database and generates for each person a unique personal identification number, which lasts the person's lifetime. This number is linked to all other personal identification codes that a person may be assigned over his or her lifetime by the autonomous community. This allows all the clinical information associated with such identification codes to be retrieved at a later time.

The Protected Population Database is one of the strategic tools of the SNS. Maintained by the Ministry of Health, Social Services and Equality, it contains basic information about the users of the public health care system.

The TSI-SNS system was built after the transfer of powers in the area of health to the autonomous communities in 2001. The system's implementation followed a multi-step process by which autonomous communities were gradually phased into the system and which concluded in 2010. In June 2012, to comply with the provisions of RDL 16/2012, the system was linked to and updated with data from the National Social Security Institute (INSS), the body responsible for recognising the condition of insured persons and their

beneficiaries and to assign the type of contribution that individuals must make to pharmaceutical benefits.

Graph 9.1. SNS protected population (insured persons and beneficiaries)



Source: Ministry of Health, Social Services and Equality. SNS-Individual Health Card database (BDTSI-SNS), December 2012.

In the year 2012 the administrations using this system sent 60.6 million messages and carried out 23.5 million transactions.

9.4.2. Electronic Health Records

The new information and communication technologies (ICT) are increasingly present in the health care system and they have become a tool commonly used in its daily operations. The most essential element is the Electronic Health Record (EHR), which brings together the clinical information and relevant care management details that are useful for the different health professionals working with a single patient. The Electronic Health Record is the fruit of observations and decisions made throughout the individual's care process. The clinical information must also be accessible to the patient, in appropriate formats and with the pertinent security and confidentiality measures.

The regional health services, mostly since the beginning of this century, have made great progress in implementing electronic health record systems that are capable of providing, within their respective territories, the utilities mentioned above. However, in a health care system that is divided into regions, as is the case in Spain, where every year about 4 million people receive medical attention in an autonomous community other than the one they live in, it is necessary to move beyond the regional level, extending the benefits provided by technology and making the patient's health record available all over the country.

For this reason, the Ministry has been promoting, since 2006, a system that permits interoperability between the health records of the autonomous communities, so that when citizens travel from one autonomous community to another, the most important information in their health records is available to the nursing and medical professionals that care for them. Similarly, citizens should be able to electronically access a summary of their most relevant health information and also see which health care centres and services have accessed their health information.

At the end of 2012, ten autonomous communities had been integrated into this system, albeit with varying degrees of development, making the clinical information of 15,710,888 persons available for consultation by professionals. This represented 163.3% more implementation than the year 2011, which closed with 4 autonomous communities connected and able to issue clinical information, and a total of 6,215,443 citizens covered.

In some cases the autonomous communities had the capability to issue clinical reports regarding their patients ("issuer mode") and also to consult the clinical information of patients from other communities ("recipient mode"). In other cases the autonomous community was able to operate only in one mode or the other.

Graph 9.2. Situation of the electronic health records in the autonomous communities, by service level

Source: Ministry of Health, Social Services and Equality. EHR-SNS database, 2012.

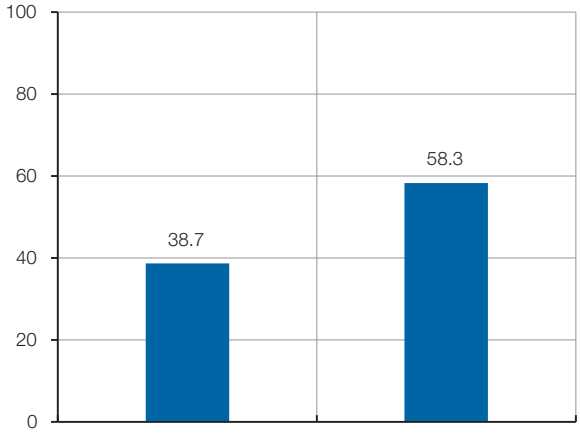
9.4.3. Electronic prescribing

The introduction of an electronic system for the management of SNS medical prescriptions is another objective towards which autonomous communities have been working for some time at a regional level. In 2012 the implementation of e-prescribing systems continued to progress, primarily in SNS Primary Care Centres. Twelve autonomous communities have fully introduced this type of system or have reached an advanced stage, compared to 8 the previous year.

Graph 9.3. Implementation of e-prescribing in Primary Care Centres

Source: Ministry of Health, Social Services and Equality, 2012.

Graph 9.4. Prescriptions dispensed through e-prescribing system, as percentage of total



Source: Ministry of Health, Social Services and Equality.

Almost 6 out of 10 prescriptions dispensed (58.3%) were dispensed using an e-prescribing system.

As regards citizen awareness, in Spain as a whole, over half of the citizens were aware that medicines could be prescribed electronically, while 39.9% also said they had used the system.

Table 9.2. Awareness of e-prescribing

"Do you know if there is an 'electronic prescribing system' in your autonomous community? That is, is there a system that enables the pharmacy to use a computer to access the prescriptions made by your doctor?"

	2011	2012
Yes, it exists and I have used it	27.8	30.9
Yes, it exists but I have never been prescribed medicines through this system	24.4	22.6
No, it does not exist	7.0	7.8
I don't know if it exists	40.6	38.3
No answer	0.2	0.3

Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

For most of the people who have used it, the primary benefit of this system is that people no longer need to go to the doctor just to have their prescriptions renewed (83.3% of responses, in a question allowing multiple responses).

Also, 38.8% believe that the system reduces the tendency to hoard medicines at home. It is worth remembering that the previous year 23.7% of citizens recognised that they accumulated whole packages of medicines prescribed by their doctors.

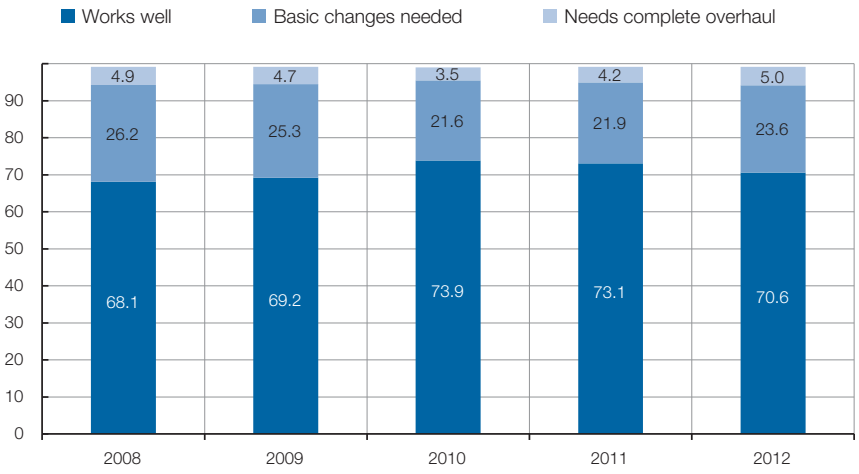
Efforts are being made by the Ministry of Health, Social Services and Equality and the autonomous communities to develop a system that would make e-prescribing interoperable throughout the SNS, so that patients can obtain their medicines at any dispensing pharmacy in the country, regardless of where in the public sector health care system the medicines were prescribed.

10. Citizen opinions and perception

10.1. Opinions regarding the functioning of the health care system

Citizens generally expressed a favourable view of the functioning of Spain's health care system: 7 out of 10 (70.6%) stated that it works quite well or that it works well but needs some changes.

Graph 10.1. Opinions (%) regarding the functioning of the health care system



Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

The level of satisfaction with how the public sector health care system in Spain works was found to be 6.6 points.

The level of satisfaction with the functioning of the public sector health care system was identical in men and women.

To better understand citizen opinion regarding the functioning of public sector health care, people's satisfaction with specific care services was explored.

Table 10.1. Opinions regarding public health care services

"Based on your experience with them or the idea you have of them, please rate the following public health care services." Scale of 1 "totally unsatisfactory" to 10 "totally satisfactory"

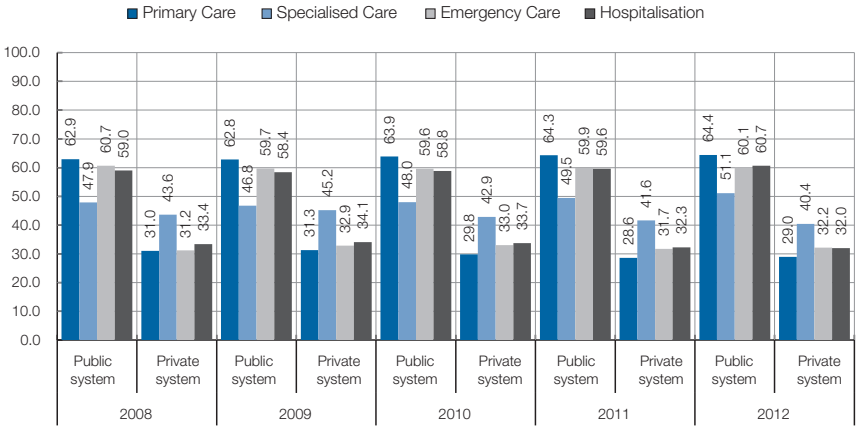
	2010	2011	2012
Primary care (visits with family physician and paediatrician in public Primary Care Centres)	7.1	7.3	7.3
Specialised care (visits with specialists in public sector health care centres)	6.7	6.9	6.8
Emergency care in public hospitals	6.0	6.1	6.1
Hospitalisation and care in public hospitals	6.7	6.9	6.8

Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

10.2. Choosing between public and private health care

In 2012, there continued to be more citizens who prefer public health care over private health care.

Graph 10.2. Percentage of population preferring public or private health care services



Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2008-2012.

Results indicate that if it were possible to choose one type of services over the other based on specific qualitative factors, such as the ones detailed below, citizens would choose public health care services when considering five factors and private health care services when considering two other factors.

Table 10.2. Percentage of qualitative aspects in the choice between public and private health care services

"In your personal case, in the hypothetical situation that you could choose, would you prefer public health care or private health care when considering…?"			
2012	**I would choose public**	**I would choose private**	**Either one**
The technology and resources available	66.9	23	8.9
The skill/expertise of the doctors	61.0	18.2	19.7
The skill/expertise of the nurses	60.2	18.4	19.8
The speed with which you are attended	32.6	61.5	4.9
Information you receive about your health problem	49.5	31.2	17.8
Pleasant interactions with professionals	45.1	38.7	15.3
The comfort of the facilities	38.2	52.2	8.4

Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

Public sector health care centres would be chosen when considering the technology and resources available; the skill of the medical and nursing professionals; the information you receive [as a patient] about your health problem and the pleasant interactions you have with professionals [as a user].

The two factors that would motivate citizens to choose private health care centres are the *speed with which patients are attended* and the *comfort of the facilities*.

As for the proportion of citizens who state that either option would be satisfactory, the factors in which there is the most agreement in this respect are the *skill and expertise of the nurses* and the *skill and expertise of the doctors*.

10.3. Equity in the provision of services

A decade after concluding the process by which responsibility and powers in the area of health were transferred to the autonomous communities, almost a quarter of citizens (23.9%) continued to have no opinion about the effects that this transfer has had on the management of health care services.

Another quarter of the respondents (24.8%) stated that they receive better health care services with decentralised management, although this figure has fallen 5 points since 2008, when such an opinion was held by 30% of citizens.

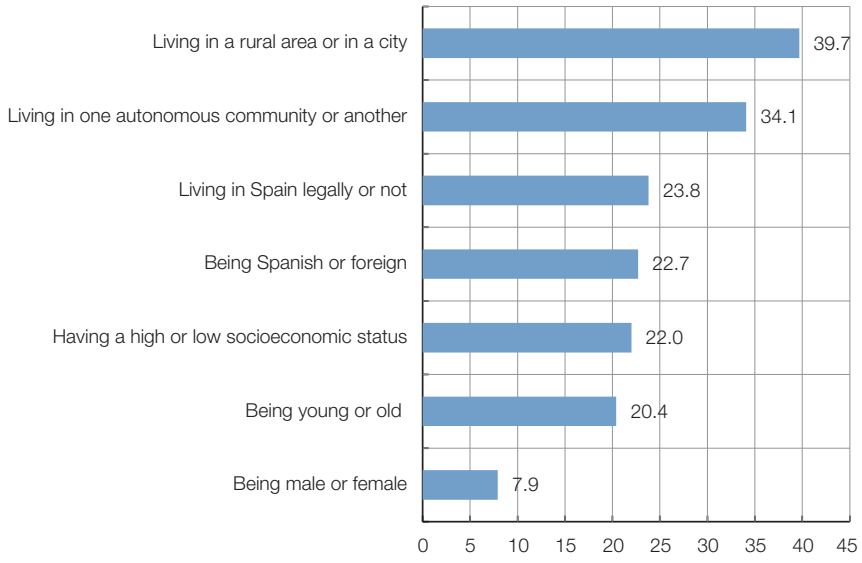
For a larger proportion (38.5%) the services now managed by the autonomous communities are the same as when they were managed centrally. For one out of ten citizens (12.1%), the autonomous communities offer worse services than when health care was provided by the central government.

Slightly more than one third of the persons interviewed (36.5%) stated that they have no opinion about whether there are differences between the health care services that their autonomous community provides and those provided in other autonomous communities.

The most commonly held opinion (34.6%) was that the services of their autonomous community are the same as those of others. About 16.2% stated that the health care services of their autonomous community are better than those offered by other communities; for 11.9% they are worse.

For more than 8 out of 10 citizens (82.5%), the autonomous communities should reach an agreement with each other when it comes to offering new services to the population.

Graph 10.3. Opinions regarding the existence of inequalities in the provision of public sector health care



Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

Most citizens were of the opinion that in the provision of health care services by the SNS there are few differences related to the patient's sex (7.9%), age (20.4%) or social level (22.0%), although a considerable number stated that there is inequality in SNS services depending on whether the person lives in a rural or urban area (39.7%) and depending on his or her autonomous community (34.1%).

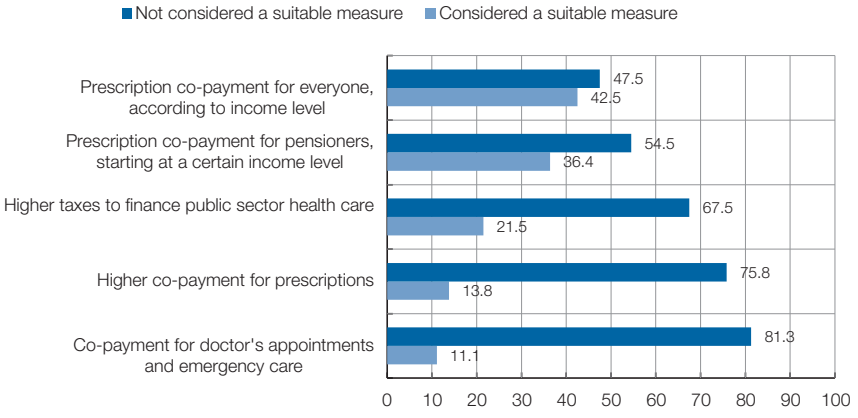
10.4. Opinions regarding the measures to be taken in relation to health care services

The health care system, which makes a significant contribution to social cohesion, is the object of a great deal of citizen interest.

Against the backdrop of the severe financial and economic difficulties affecting the country, the Health Care Barometer of 2012 asked citizens whether patients should have to make monetary contributions to receive care and whether the government should take steps to enable the health care services to be maintained with the same benefits, coverage and level of quality.

In general, acceptance of these measures was low. The possibility of all patients being required to make a copayment for prescriptions, depending on the person's income, generated the lowest level of disagreement: 42.5% agree with applying such a measure, compared to 47.5% who reject it.

Graph 10.4. Opinions (%) regarding the suitability of measures requiring copayment for health care services



Source: Ministry of Health, Social Services and Equality. Health Care Barometer, 2012.

The highest level of disagreement was generated by the possibility of making patients share in the cost of doctor's appointments and visits to emergency services: 8 out of every 10 persons express disagreement with these hypothetical measures.

The majority (75.8%) also disagree with the idea of increasing the amount that patients currently pay for their prescriptions, and with the idea of raising taxes and devoting the additional revenue to public sector health care: almost 7 out of 10 persons rejected such a measure.

The citizens surveyed were asked whether political leaders should adopt regulatory measures to prevent the misuse of public sector health care, so as to ensure their quality and proper functioning. The response was overwhelmingly positive: 80.9% answered that such measures should be adopted.

Part II

Health Care Reform 2012

11. Health Care Reform 2012

The National Health System of Spain, a co-ordinated set of health care services provided by the central government and by the regional health services of the autonomous communities, guarantees health protection throughout the country and is one of the major achievements of Spain's welfare state, because of its quality, its universal coverage, the breadth of its benefits, its financing based on a progressive tax scheme and its solidarity with the least advantaged. All of this has put the SNS on the cutting edge of health care and has enabled it to become a model known around the world.

All of the countries in the European Union are analysing and adopting measures to optimize their care and pharmaceutical models and, particularly, the pharmaceutical expenditure and its weight in the health expenditure as a whole. The introduction of measures of this kind has been very intense in recent times, especially in those countries in which the financial and economic crisis has hit the hardest.

The situation of indebtedness of the public health care system and the severe economic downturn that Spain is experiencing have exposed weaknesses in the SNS.

The public authorities, in an effort to better manage the system's capacities, have made reforms intended to increase its sustainability, heighten its management efficiency, promote savings and economies of scale, introduce new tools based on the new technologies, enhance its territorial cohesion, co-ordinate its health and social services and, especially, guarantee equal treatment in the entire national territory, with a basic basket of common services available throughout the country.

To put it briefly, the reform has the fundamental objective of improving the sustainability and preserving the quality of the public health care system, while guaranteeing at all times the right of citizens to health protection and to public, free and universal health care.

To reach these objectives, the Government passed Royal Decree-Law 16/2012, of 20 April, on urgent measures to guarantee the sustainability of the SNS and improve the quality and security of its benefits (*Real Decreto-ley 16/2012 de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones*), which sets forth the broad areas of action.

11.1. Measures pertaining to healthcare provision

11.1.1. Entitlement

All Spaniards, as well as foreign nationals who reside in Spain, have the right to health protection and are entitled to the health care provided by the SNS.

Royal Decree-Law 16/2012, with its amendment of Law 16/2003 on Cohesion and Quality in Spain's National Health System (*Ley 16/2003, de 28 de mayo, de cohesión y calidad del Sistema Nacional de Salud*), has reinforced the regulatory framework governing access to public sector health care, putting in place a new regime that defines entitlement using the concepts of insured persons and beneficiaries.

The intention was to put an end to the multiplicity of rules that have been used to regulate health care and to clarify which persons can access health care and the requisites that must be met, with the ultimate aim of ensuring the right to health.

Thus, starting on 24 April 2012, the date Royal Decree-Law 16/2012 entered into effect, the following have the status of insured persons, for purposes of health care in Spain:

- Workers who are employed by an employer or are self-employed, persons who receive a Social Security pension, recipients of any regular benefit from the Social Security system, including unemployment benefits or compensation, persons whose unemployment benefits or compensation have ended but are still unemployed and minors who are wards of the state.
- Also included in the category of the insured are persons who meet none of the preceding conditions but are Spanish nationals residing in Spain, nationals of another Member state of the European Union (EU), of the European Economic Area (EEA) or of Switzerland who reside in Spain and are registered in the Central Registry of Foreign Nationals and also nationals of a third country who are authorised to live in Spain, provided they do not have an annual income higher than 100,000 Euros and do not have mandatory health care coverage for another reason.
- The beneficiaries of an insured person include the spouse or person with a similar affective relationship; the ex-spouse, when he/she is supported by the insured person; the children or siblings of the insured person when such persons are supported by him/her and are under the age of 26, or over the age of 26 in the case of a disability

rating of 65% or higher; minors who are under the insured person's or spouse's guardianship or are his/her foster child.
- Persons who are neither insured nor beneficiaries of an insured person can obtain health care benefits by paying the fee derived from the signing of a special agreement.

Recognition of status as an insured person or beneficiary is now the task of the National Social Security Institute and the right to health care is made effective by the regional health care administrations, which will facilitate citizen access to health care services by issuing individual health cards.

The new regulations have made it necessary to put in place implementing provisions[11] about how insured status is recognised and also about the special agreement.

11.2. Measures pertaining to the service basket

Law 16/2003 states that one of its objectives is to guarantee equity, ensuring that access to health services and therefore the right to health protection can be exercised in conditions of equality throughout the territory, making the free movement of citizens possible. The law provides that the health care benefits set forth in the catalogue of SNS services will be made effective through the common service basket of the SNS.

Royal Decree 1030/2006, of 15 September, which establishes the common service basket of the SNS and the procedure for updating it, includes in its different annexes the content of the common service basket in the areas of public health, primary care, specialised care, urgent care, pharmaceutical benefits, ortho-prosthetics, dietetic products and patient transport.[12]

Royal Decree-Law 16/2012, of 20 April, on urgent measures to guarantee the sustainability of the SNS and improve the quality and safety of its benefits, differentiates among:

- the basic common basket of SNS care services, which includes all prevention, diagnosis, treatment and rehabilitation activities that take place in health care centres or social health care centres, as well as urgent patient transport. The foregoing is entirely covered by public financing.
- the supplementary common basket, which includes benefits that are provided by means of ambulatory dispensation and are subject to user contribution (pharmaceutical benefits, ortho-

prosthetic benefits, dietetic products and non-urgent patient transport).
- the common basket of accessory services, which includes all activities, services and techniques that are not considered essential although they may contribute to or support improvement in chronic pathologies.

Royal Decree-Law 16/2012 represents a new framework for the regulation of health care benefits, which has translated into a series of actions undertaken jointly by the Ministry of Health, Social Services and Equality and the autonomous communities, which are the bodies entrusted with making effective the service basket in their respective territories.

11.2.1. The basic common basket

In 2012, the Ministry of Health, Social Services and Equality and the autonomous communities made an effort to define and update the basic basket of SNS services, in the areas prioritised by a working group created by the CISNS for this purpose on 29 February 2012.

The work was done with the assistance of expert groups comprised of professionals designated by the autonomous communities and the Ministry, with the participation of scientific societies and the Spanish Network of Health Technology and SNS Benefits Assessment Agencies.

The expert groups drew up preliminary proposals detailing the contents of the corresponding section of the service basket, detecting services that should be excluded because they have become obsolete, others in which the conditions of use need to be modified or whose actions should be the object of an official protocol, and still others, not currently included, that have proven their safety, efficacy and efficiency and are thus worthy of being added to the service basket.

The following areas were addressed:

- Genetics
- Assisted reproduction
- Neonatal screening tests and cancer screening tests
- Surgical implants

The results of the work of each of the expert groups are discussed below:

Genetics: Genetic diseases and disorders are very numerous and of low prevalence in most cases. This, along with the high number of and continual advances in genetic analyses, means that a regulatory framework is needed to define the content of this basket, in terms of both the diseases and the clinical analyses that facilitate their diagnosis and treatment. The proposal drawn up by the group of experts creates a framework for the area of genetics within the basic basket of SNS services, defining the main aspects as follows: genetic counselling (access and indication criteria) and genetic analyses, determining the general requirements they must fulfil, the types of analysis to be included in the basket and the indication criteria for each one.

It also proposes that an exclusively technical committee be created and linked to the Commission on Benefits, Entitlement and Financing (CPAF). Its purpose would be to provide advisory services in everything concerning genetics in the basic common basket of SNS services and its functions would include examining the methodology used to update and define the common basket of services in the area of genetics and making proposals as to the update and definition of the said basket.[13]

Assisted human reproduction: Royal Decree 1030/2006 provided for assisted human reproduction for patients with diagnosed sterility or established clinical indication, citing the techniques included but without defining the operational aspects. This resulted in differences among the autonomous communities.[14]

The group of experts, taking into account the scientific evidence linked to the different assisted reproduction techniques, has drawn up a proposal putting forward criteria regarding access to these treatments under the law, that is, by patients with diagnosed sterility or established clinical indication.

It has drawn up a list of the techniques and their indication criteria, including aspects related to semen washing as a means of preventing transmission of chronic viral diseases and to pre-implantation genetic diagnosis, with the aim of defining this basket by specifying the techniques it includes and the criteria that patients must meet, in order to ensure appropriate and effective use of these techniques for patients who have received a diagnosis of sterility or who have an established clinical indication, taking into account at the same time the protection of possible offspring.

Neonatal screening: the list of specific diseases for which screening is done varies considerably among the autonomous communities. The group of experts on neonatal screening has drawn up a document on

such screening, which will be the basis for determining the corresponding basic service basket, which is not very detailed in the law.[15-16]
As for neonatal screening for endocrine and metabolic disorders, the group of experts proposes:

– That a population-wide endocrine-metabolic screening programme be included in the basic service basket of the SNS, to detect: congenital hypothyroidism, phenylketonuria, cystic fibrosis, medium chain acyl-CoA dehydrogenase deficiency, long chain 3-hydroxyacyl-CoA dehydrogenase deficiency, glutaric acidemia type 1 and sickle-cell anaemia. This programme will be accompanied by the development of a neonatal screening information system that allows for the correct monitoring and evaluation of these population-wide programmes and the development of a quality management system that enables all autonomous communities to perform these screening processes in the same way. To this end, it is essential that protocols be drawn up and introduced in the SNS.
– That the autonomous communities where there is currently population-wide neonatal screening for maple syrup urine disease, isovaleric acidemia and homocystinuria, which are not included in the proposal for the basic basket, take part "provided they meet certain quality criteria" in a 2-year "pilot program" that will study the future inclusion of these conditions in the basic service basket.
– That consideration be given to the possibility of including congenital adrenal hyperplasia, galactosemia and biotinidase deficiency in the basic basket (at the end of 2013).

Cancer screening: the expert group in this area proposes that the following screening tests be included in the basic basket of SNS services:
– Breast cancer screening: the target population is women aged 50 to 69. Screening test: mammogram. Interval between explorations: 2 years.
– Colorrectal cancer screening: the target population is men and women aged 50 to 69. Screening test: faecal occult blood. Interval between explorations: 2 years.
– Cervical cancer screening: the target population is asymptomatic women who are or have been sexually active, between the ages of 25 and 65. Screening test: Pap smear. Recommended interval between explorations: 3-5 years.

In addition, the autonomous communities, INGESA and insurance mutuals for civil servants will guarantee individual risk assessment for persons who

meet the criteria concerning hereditary cancer risk and if confirmed, that person will be monitored as established in specific action protocols.
Also, without detriment to the evaluations performed by the autonomous communities, a state-level evaluation of cancer screening will be performed in the SNS as a whole, within the period set by the Commission on Benefits, Entitlement and Financing.

Surgical implants[17]*:* The surgical implants expert group, which reports to the Advisory Committee on Ortho-Prosthetic Benefits, has worked on the catalogue of implants. Participating in the group are the autonomous communities that have been involved in the cataloguing of implants (Andalucía, Asturias, Baleares, Cataluña, Comunidad Valenciana and Murcia), the Department of Health Products of the Spanish Agency of Medicines and Health Products (AEMPS) and the Spanish Network of Health Technology and SNS Benefits Assessment Agencies. The appropriate Assessment Agency is to prepare a report on the implants about which there are doubts concerning their efficacy or safety.
The surgical implants group put the tasks to be performed in order of priority, and agreed to address first the ophthalmological, cardiac, vascular, neurological and osteoarticular implants, which represent approximately 92% of consumption.
The documents drawn up by the implants group will subsequently be debated with experts designated by the autonomous communities, by the Ministry of Health, Social Services and Equality and by the pertinent scientific societies, and once agreement has been reached, they will be analysed with the sector, represented by the Spanish Federation of Health Technology Companies (FENIN).
The documents drawn up by the different expert groups, which contain the proposals for defining the common service basket, will be considered final once the reports by the network of assessment agencies have been examined.
It is planned that these proposals will be reflected in a ministerial order concerning the update and specification of the service basket, in order to create a common catalogue of surgical implants that will make it possible to offer citizens a more homogenous basic service basket all over the country.

11.2.2. Supplementary common basket

Since the publication of Royal Decree-Law 16/2012, of 20 April, on urgent measures to guarantee the sustainability of the SNS and improve the quality

and safety of its benefits, work is going towards its implementing regulations, addressing the regulation of the supplementary common service basket, which includes pharmaceutical benefits, ortho-prosthetic benefits, dietetic products and non-urgent patient transport. The following initiatives are being discussed:

Ortho-prosthetic benefits[18]*:* these are regulated in Annex VI of Royal Decree 1030/2006, of 15 September, which establishes the common service basket of the SNS and the procedure for updating it. The said Annex VI details the content of the common service basket in the area of ortho-prosthetic benefits, determining the groups and subgroups corresponding to surgical implants and to external ortho-prostheses (wheelchairs, external prostheses, orthoses and special ortho-prostheses).

The autonomous communities, the National Institute of Health Management (INGESA) and the insurance mutuals for civil servants have drawn up their own catalogues of external orthoprostheses, with varying levels of disaggregation and different amounts that can be publicly financed.

Ortho-prosthetic products are not subject to price-setting mechanisms, in contrast with medicines, the prices of which are controlled by the state, and also with dietetic products, whose financing limits are regulated by Royal Decree 1205/2010, of 24 September, which determines how the inclusion of dietetic foods for special medical uses in SNS dietetic products benefits is to be decided and how financing limits are to be established.

All this means that there are currently differences, depending on the territory in question, in the contents of ortho-prosthetic benefits, in how the benefits are provided to users and in how much is paid for each product. For this reason, the ortho-prosthetic benefits Advisory Committee saw the need to take several initiatives, including the creation of a common catalogue and the establishment of financing limits.

A number of actions were undertaken to arrive at a supplementary common basket for ortho-prosthetic benefits. The first step was the publication of Royal Decree 1506/2012, of 2 November, which regulates the supplementary common basket for SNS ortho-prosthetic benefits and lays the foundations for setting the financing limits in ortho-prosthetic benefits. Their aim is to achieve greater homogeneity in the content of these benefits in the different autonomous communities, so as to ensure that equity in access is preserved. This Decree provides that the definition and update of the common catalogue and the setting of the corresponding financing limits will be by ministerial order.

For this reason the initial plan was to regulate all of the aspects related to supplementary ortho-prosthetic benefits through a ministerial order, but it proved to be very difficult to establish financing limits because of the lack of knowledge of the orthotic and prosthetic device market. It was therefore decided that the regulations would be developed in two stages. In the first stage a computer system (SIRPO) will be developed to receive communications regarding ortho-prosthetic products at the SNS. With this system, information about the products on the market and their prices will be compiled so that the types of products can be described, a common catalogue drawn up and financing limits established. Meanwhile, to enable the companies to inform the SIRPO about their products, the Director General of the Basic Common Basket of SNS Services and Pharmacy will issue a resolution containing the classification of the different sections of the ortho-prosthetic service basket, which will include products with similar characteristics, designs and functions. The first classification to be published will be the one on wheelchairs, because wheelchairs represent over one third of the expenditure in this type of benefit. The preliminary version of the order provides that the classification of the remaining sections of the supplementary ortho-prosthetic benefits will be established no more than 12 months after the order enters into force.

With this information it will be possible to begin the second phase, which involves developing the common catalogue of the supplementary ortho-prosthetic benefits and the corresponding financing limits, as provided in Royal Decree 1506/2012. This will make it possible to offer a more rational and homogenous coverage to all users of the SNS.

Dietetic product benefits[19]*:* The contents of the dietetic product benefits are addressed in Annex VII of Royal Decree 1030/2006, of 15 September, which establishes the common service basket of the SNS and the procedure for updating it. The said annex specifies the pathologies and clinical situations for which dietetic products are financed in the framework of the SNS.

The products eligible for financing had the same offer price for the entire SNS but each autonomous community applied a different factor to transform the offer price into a final price, which meant that the final price that each autonomous community paid for the same product was different. This resulted in each citizen, when the user contribution was applied, having to pay a different amount for the same product, depending on the autonomous community in which he or she lived. Thus, the first step that needed to be taken was the publication of Order

SSI/2366/2012, of 30 October, which establishes the common factor for the invoicing of dietetic products.
The application of this order has made it possible to obtain, based on the offer price, a single invoice price for each product all over the country. This is the final price of each product when it is dispensed by pharmacies and invoiced to the SNS.
Progress has also been made in establishing a supplementary common basket of benefits involving dietetic products. To ensure that the basket includes only treatments backed by scientific evidence attesting to their efficacy and utility for pathologies requiring home enteral nutrition, the L-glutamine modules have been eliminated. Also, the incorporation of new treatments for this basket will be studied, such as ketogenic diets for adults with refractory epilepsy, lysine intolerance treatment, etc. The aim of this process is to make more efficient use of resources and have a basket better suited to patient needs.

Non-urgent patient transport[20]*:* Annex VIII of Royal Decree 1030/2006, of 15 September, which establishes the common service basket of the SNS and the procedure for updating it, regulates the area of patient transport. It states that patient transport, which must be accessible to persons with disability, consists of the transport of patients for health reasons only, when their clinical situation prevents them from using ordinary means of transport. The said annex does not distinguish between urgent and non-urgent patient transport, although urgent patient transport is addressed in Annex IV of the aforementioned Royal Decree, within the common basket of services in the area of urgent care, such as patient transport, whether by land, air or sea, assisted or not assisted, as required by the clinical situation of the patient, in those cases in which such transport is necessary to take the person to the health care centre so that the urgent situation can be attended in the best possible way.
Royal Decree-Law 16/2012, of 20 April, states that non-urgent patient transport is within the supplementary common basket, indicating that it must be prescribed by a doctor and have clinical justification.
Several actions have been carried out to achieve a more rational use of non-urgent patient transport, mainly through the limitation of its use to situations in which it is really necessary for clinical reasons only. To this end, it was necessary to define this type of transport and the criteria for its use, through a working group with representatives of the autonomous communities who wished to participate in it, appointed by the Commission on Benefits, Entitlement and Financing (CPAF).

11.2.3. Common basket of accessory services

Royal Decree-Law 16/2012 contemplates for the first time the concept of a common basket of accessory services for the SNS, indicating that it includes all those activities, services or techniques that are not considered essential although they may contribute to or support improvement in chronic pathologies, and which are subject to user co-payment and/or reimbursement. It further provides that the accessory services to be included, the financing limits and the correction coefficients to be applied to determine the final invoicing to the regional health services by the providers, and also the user co-payment and reimbursement details applicable in each case, will be approved by order of the Minister of Health, Social Services and Equality, as recommended by the CISNS, at the proposal of the Commision on Benefits, Entitlement and Financing. The activities, services and techniques included in this basket will become effective when they are approved by an order issued by the Minister of Health, Social Services and Equality. It also points out that user contribution or reimbursement, as the case may be, will be governed by the same rules that govern pharmaceutical benefits, taking as reference the final invoice price that is decided for the SNS. This basket has yet to be developed.

11.2.4. Service baskets offered by the insurance mutuals for civil servants (MUFACE, MUGEJU and ISFAS)

The insurance mutuals for civil servants –which are *Mutualidad General de Funcionarios Civiles del Estado* (MUFACE), *Instituto Social de las Fuerzas Armadas* (ISFAS), and *Mutualidad General Judicial* (MUGEJU)– can, within their area of activity, approve their own basket of services which must include, at least, the common service basket of the SNS. For this reason, all the aforementioned actions concerning the service basket also apply to the insurance mutuals.

11.2.5. Additional service baskets offered by autonomous communities

Royal Decree-Law 16/2012, of 20 April, provides that the autonomous communities can, within their remit, approve their own baskets of services

which must include, at least, the common service basket of the SNS in its basic, supplementary and accessory modes, and the modes must be guaranteed to all users of the system. In addition, the autonomous communities can add techniques, technologies and procedures not included in the SNS common service basket to their own basket of services, establishing the additional resources that are needed. To do so, they must assign the economic resources necessary to ensure the financing of the basic basket of services, and it is mandatory, for the approval of a complementary service basket by an autonomous community, that the autonomous community show financial sufficiency by meeting criteria regarding budget stability.

In all cases, these complementary services or benefits must fulfil the same requirements as those established for the incorporation of new techniques, technologies or procedures to the common service basket, and they will not be included in the general financing of SNS benefits.

The autonomous communities will inform the Ministry of Health, Social Services and Equality of the complementary services not included in the SNS common service basket, after their effective incorporation to the community's own service basket. These services will be included in the corresponding information system and all the costs of their application to insured persons, or their beneficiaries, will be covered by the autonomous community's budget.

11.3. Cohesion measures and financial guarantees

11.3.1. Care Guarantee Fund

Royal Decree–Law 16/2012, of 20 April, creates the Care Guarantee Fund (FOGA), which is extrabudgetary, in order to guarantee the cohesion and equity of the SNS, by covering the movement among autonomous communities and the cities of Ceuta and Melilla of people entitled to receive care in the SNS.

The FOGA will compensate the regional health services and the cities of Ceuta and Melilla for the care services they provide to patients from other autonomous communities, within the framework of the basic service basket and the supplementary basket.

The types of stay to be compensated are:

– Stays lasting less than one month (short duration): these will be paid at the national rates established.

– Stays lasting one month or more (long duration): these will be paid in accordance with the monthly per capita amount used in the health care accounting statistics of the system of health accounts.

The Health Cohesion Fund regulates the financing of health care services referred by one autonomous community to another.

11.4. Measures pertaining to pharmaceutical benefits

Royal Decree-Law 16/2012 contains measures pertaining to pharmaceutical benefits, such as: amendments to Law 29/2006, of 26 July, on guarantees and rational use of medicines and health products; to Royal Decree 823/2008, of 16 May, which sets the mark-ups, deductions and discounts corresponding to the distribution and dispensation of medicines for human use, as well as measures pertaining to pharmaceutical care in hospitals, social care centres and psychiatric care centres, and to the preparation of medicines in hospital pharmacy services. It also introduces amendments to Royal Decree 1718/2010, of 17 December, regarding medical prescriptions and dispensation orders.

11.4.1. The prescription, financing and prices of medicines and health products

Prescription

The prescription of medicines included in the reference price system or that belong to homogeneous pharmaceutical groups (medicines having the same active ingredient, the same presentation and the same dosage) not included in the reference price system must be as follows:

a) In acute processes: generally, by active ingredient
b) In chronic processes:

– First treatment with this medicine: prescription must generally be by active ingredient
– Continued treatment with this medicine: prescription can be by brand name, provided it is the brand with the lowest price in its homogenous group

Prescription by brand name is permitted only when the principle of greatest efficiency for the SNS is respected, and in the case of non-substitutable medicines.

In prescription by active ingredient, the pharmacist will dispense the medicine with the lowest price in that homogeneous group and, if two have the lowest price, the generic medicine or biosimilar will be chosen.

Variations have thus been made with respect to the previous regulations, which required in all cases prescription by active ingredient and dispensation of the presentation with the lowest price in the homogeneous group.

The possibility of prescription by brand name existed only for cases considered exceptional because of the patient's therapeutic needs and for cases of medicines belonging to groups comprised of only one medicine and its sub-licences, at the same price as the reference medicine.

With respect to prescription by active ingredient and the lowest prices in the homogeneous groups, a new system has been introduced to manage voluntary price reductions with no change in the national code. This system allows for a monthly update of medicine prices based on the applications for voluntary price reductions submitted by the pharmaceutical companies, and it also gives the other companies the option to lower their price to the lowest price in that group. In addition, it is provided that the automatic update of the lowest prices in the group will take place every three months.

The autonomous communities will provide their prescribers with an electronic prescribing system that is common and interoperable. This system will include a prescribing support subsystem that contains relevant information, such as: the medicines available, medicines that have been withdrawn, alerts; databases on drug interaction; treatment protocols by pathology; treatment cost and therapeutic alternatives based on efficiency criteria.

The list of medicines excluded from SNS pharmaceutical benefits can be updated by means of a resolution that sets forth the justification for a given medicine's exclusion. The reason justifying exclusion must be one of the following:

- The creation of a list of selected prices that does not include that medicine.
- Co-existence of that medicine with a non-prescription medicine that has the same active ingredient and dose.
- The medicine is considered an OTC (over-the-counter) product in Europe.
- The medicine's active ingredient does not have a favourable and sufficiently-documented profile in terms of its safety and efficacy, following years of experience and extensive use.

– The medicine is indicated in the treatment of minor symptoms.
– The medicine fulfils any of the criteria for non-inclusion in public financing set forth in the Decree-Law.

This regulation significantly changes the previous situation: it improves and speeds up the revision process for the exclusion of medicines and it establishes price controls in the marketing of excluded medicines. Formerly, when a medicine ceased to be financed the price was not subject to any type of control, which had negative repercussions on citizen access to medicines.

The Directorate General of the Basic Basket of SNS Services and Pharmacy excluded certain medicines from the pharmaceutical benefits, in its Resolution of 2 August 2012.

To ensure that all users can acquire pharmaceuticals in conditions of equity, it is expressly stated that autonomous communities cannot unilaterally establish singular, specific exceptions regarding the prescription, dispensation and financing of medicines or health products.

The CISNS Permanent Commission on Pharmacy can allow an exception to this rule for one or more autonomous communities, when justified by that community's particularities.

Financing

The criteria for the non-inclusion of certain categories of medicines or products in the SNS financing system have been broadened and now apply to: medicines dispensed without a prescription, medicines not used in the treatment of clearly defined pathologies and medicines that were authorised in their day but that currently present an unfavourable risk/benefit ratio in the diseases for which they are indicated.

The most noteworthy novelty is that, in decisions regarding the public financing of new medicines, the innovation component is to be taken into account. The new medicine must bring undeniable therapeutic improvements by modifying or improving the course of the disease, the prognosis or the therapeutic outcome of the intervention. Also to be taken into account is the medicine's contribution to the sustainability of the SNS such as when, for the same health outcome as offered by another medicine, the new medicine contributes positively to the GNP. Consideration will also be given to return mechanisms (discounts and price review) in the case of innovative medicines.

The Decree-Law also provides for the possibility of price intervention in the case of medicines not included in the public financing system, with a notified price scheme being established for this purpose. The notified price scheme will also be applied to medicines financed by the SNS when such medicines are prescribed outside the SNS, through the private health sector:

authorised companies can market the medicines dispensed in Spain using the notified price scheme, which means they inform the MSSSI of the product's price so that the Department of Pharmacy can, if deemed necessary, lodge a protest in the public interest.

In short, a notified price scheme is introduced and applied to dispensations in Spain, more specifically, to the medicines and health products not included in the public financing system. It also applies to medicines included in the financing system when such medicines are prescribed outside of the system.

Prices

An Advisory Committee for the Financing of SNS Pharmaceutical Benefits is created to act in an advisory, evaluation and consultation capacity as regards the pertinence, improvement and follow-up of the economic evaluation necessary to support decision-making by the Interministerial Commission on Medicine Prices. It will be comprised of a maximum of seven members, to be appointed by the head of the Department of Pharmacy. The members will be highly reputable professionals with extensive experience in pharmaco-economic evaluation.

Price reviews that lower a product's price at the request of the company are restricted to those that involve a reduction of at least 10% of the highest industrial price as applied to the public financing system. Previously there were no limitations.

A reference price system is applied to the financing of medicines prescribed and dispensed through the SNS and paid for with public funds. The reference price is the maximum amount of financing authorised for the presentations of the medicines in each of the sets established.

The main modifications refer to the expansion of the creation of sets; it is no longer necessary that a generic medicine or biosimilar exist in order to create a set; a set can be created when the medicine or its main active ingredient was approved ten or more years ago in a European Union Member State; and, in the creation of sets of medicines for hospital use, extra-large hospital packs are now to be included. With respect to the procedure for establishing the lowest prices of new homogeneous groups, it is provided that this will take place automatically in the corresponding positive list. The review of the lowest prices of existing groups will take place quarterly. It is now mandatory for the companies whose presentations have the lowest price in each group to assume the obligation of meeting all supply needs at dispensing pharmacies.

The selected price system affects financed medicines subject to reference prices and can also be applied to medicines not included in the financing system but that are deemed to be of interest for public health.

The previous version of Law 29/2006 provided that the executive branch of the government would regulate, by royal decree, the criteria and procedure of

the selected price system. The new article 93 bis introduces a series of variations in the regulations. Especially noteworthy are: the power the MSSSI has to propose to the Interministerial Price Commission that the selected price mechanism be applied to medicines and health products that are eligible for financing and the establishment of an effective period of two years for the selected price.

11.4.2. Contributions by users and their beneficiaries

The new regulations make the system more equitable because the contribution, or co-payment, that users must make is based on the person's income, on whether the person is employed or receives a pension and on whether the condition is chronic.

In addition, ambulatory pharmaceutical benefits are defined as the pharmaceuticals provided to outpatients through a dispensing pharmacy or through a hospital pharmacy service, which means the medicines dispensed in hospitals to ambulatory patients are also subject to co-payment, under conditions identical to those applied when the dispensation takes place in a dispensing pharmacy.

This reform establishes the percentages of the contribution that users must make to the sales price of the medicines. The percentage applicable, which is from 10% to 60%, is proportional to the user's income, with contribution limits for certain categories of medicines and persons, and with some groups of users and their beneficiaries being exempt from contribution. This measure entered into effect on 1 July 2012.

The user contributions are as follows:

In general*:*

- 60% of the retail price: this is the amount paid by users and their beneficiaries when the person's annual income is 100,000 Euros or higher, as it appears on his or her income tax form, in the box reserved for the general and savings tax base.
- 50% of the retail price: this is the amount paid by workers and their beneficiaries when the person's annual income is equal to or higher than 18,000 Euros but less than 100,000 Euros, as it appears on his or her income tax form, in the box reserved for the general and savings tax base.
- 40% of the retail price: this is the amount paid by workers and their beneficiaries when the person does not belong to either of the previous categories.
- 10% of the retail price: this is the amount paid by persons who receive Social Security pensions, with the exception of persons belonging to the first category.

Maximum contribution:

- Reduced contribution medicines: 10% of the retail price for medicines belonging to the ATC groups that have reduced contribution (maximum contribution in 2012: €2.64 until 30 June and €4.13 as of 1 July).
- Pensioners (and their beneficiaries):
- €8/month for persons with an annual income below 18,000 Euros.
- €18/month for persons with an annual income between 18,000 and 100,000 Euros.
- €60/month for persons with an income above 100,000 Euros.

Exempt from contribution: users and their beneficiaries who belong to one of the following categories:

- People affected by toxic syndrome following 1981 incident involving toxic cooking oil and disabled people in the cases set forth in their specific legal framework.
- People who receive social assistance benefits.
- Persons who receive non-contributory pensions.
- Unemployed people whose unemployment benefits have ended, while they remain unemployed.
- Treatments for work-related accidents and occupational diseases.

The measure maintains the 30% contribution by those who belong to the insurance mutuals MUFACE, ISFAS or MUGEJU, or who belong to the mutuals' passive classes (retired civil servants, beneficiaries).

As a consequence of this new framework and in relation to the protection of personal data, the disclosure and processing of data without the party's consent is now possible when the respective administrations –fiscal authorities, Social Security management bodies, MSSSI and other health administrations– need to access the data in order to determine the contribution corresponding to each user. The information will be processed by the corresponding health administration for the sole purpose of incorporating it into the information system linked to the individual health cards (TSI).

11.4.3. Official SNS medical prescriptions

In connection with the new framework of user contributions to pharmaceutical benefits, some new basic criteria have been established to differentiate among official prescription forms. In the upper right hand corner a new coding system appears, as follows:

a) Code TSI 001 for users exempt from contribution
b) Code TSI 002 for users with a contribution of 10%
c) Code TSI 003 for users with a contribution of 40%
d) Code TSI 004 for users with a contribution of 50%
e) Code TSI 005 for users with a contribution of 60%
f) ATEP for prescriptions pertaining to work-related accidents and occupational diseases
g) NOFIN for prescriptions of medicines and health products not financed by the SNS

This is a significant modification and makes unnecessary the system traditionally used for differentiating between SNS prescriptions under the previous framework: workers (green forms) and pensioners (red forms).

In June of 2012, to comply with the provisions of Royal Decree-Law 16/2012, the Individual Health Card System of the SNS (TSI-SNS) was linked to and updated with data from the National Institute of Social Security (INSS), the agency responsible for recognising the condition of insured persons and beneficiaries and for determining the type of contribution they must make.

Table 11.1. Population covered by the SNS (insured persons and beneficiaries)

Level of contribution	Pharmacy codes	Total in SNS
Exempt from contribution	TSI 001	1,563,105
Pensioners. Reduced contribution of 10% with no monthly limit	TSI 002-00	16,835
Pensioners. Reduced contribution of 10% up to €8 per month	TSI 002-01	7,989,348
Pensioners. Reduced contribution of 10% up to €18 per month	TSI 002-02	2,253,624
Pensioners. Contribution of 60% up to €60 per month	TSI 005-03	42,458
Workers. Contribution of 40%	TSI 003	21,924,212
Workers. Contribution of 50%	TSI 004	9,340,742
Workers. Contribution of 60%	TSI 005	276,780
Insurance mutuals. Contribution of 30%	TSI 006	324,128
Total		**43,731,232**

Remarks: the TSI-SNS system was constructed following the transfer of power in the area of health to the autonomous communities in 2001. The autonomous communities were gradually incorporated into the system in a process that ended in 2010.
Source: SNS-Individual Health Card database (BDTSI-SNS), December 2012.

11.4.4. Deductions and discounts for dispensing pharmacies

The previous system established a scale of deductions in the prices that pharmacies pay for the prescriptions and dispensation orders of medicines financed with public funds from the autonomous communities, INGESA and insurance mutuals (MUFACE, MUGEJU and ISFAS). The scale of deductions, based on sales volume, allowed pharmacies that sold less to pay less for SNS prescribed medicines. It also exempted a certain number of pharmacies from payment for these medicines and increased the amount paid by pharmacies that have high volumes of sales.

For pharmacies that have lower sales volumes, the new framework brings changes in the requisites that must be met for the application, in their favour, of a correction index for the mark-ups corresponding to prescriptions and dispensation orders of medicines for human use: it eliminates both the requisite that the pharmacy be located in an isolated or socially underprivileged area and the requisite of it being open to the public for at least a period equivalent to 11 months in the calendar year prior to the application of such mark-up correction index.

11.4.5. Management of payments by the pharmaceutical industry

The manufacturers and importers of medicines and/or health products that have public financing are required to make quarterly payments to the SNS of certain percentages that are set depending on the sales volume of their products dispensed in pharmacies, through SNS prescription or dispensation order. The amounts are reduced by a certain percentage according to the company's classification in the framework of *Plan Profarma*.

The modification provides that the reductions that can affect these returns will take effect starting with the most recent resolution of the *Plan Profarma*.

State intervention in the area of medicines and health products financed by the SNS must be based on complete and solid information about the consumption of products, so as to allow proper control of the system's pharmaceutical benefits. For this reason, MSSSI, the health authorities of the autonomous communities, MUFACE, MUGEJU and ISFAS and, where

appropriate, the suppliers and their professional bodies, must make available the following information:

a) Invoicing data pertaining to official SNS prescriptions dispensed by pharmacies, aggregated into provinces and autonomous communities, on a monthly basis.
b) Data on the acquisitions by pharmacy services at SNS health care centres and social care centres and the payments made for medicines and health products, on at least a monthly basis and aggregated into provinces and autonomous communities.

To reach the goals of efficiency and sustainability in SNS pharmaceutical benefits, administrative and regulatory measures designed to stimulate competition among providers of pharmaceutical inputs will be implemented every financial year, resulting in lower unit prices.

Any action having a limiting effect on competition will be considered contrary to the principles of efficiency and sustainability and will be actively pursued by the competent authorities.

11.4.6. Pharmaceutical care in hospitals

Royal Decree-Law 16/2012 requires that a hospital pharmacy service be established in:

a) All hospitals that have 100 or more beds.
b) All social care centres that have 100 or more beds for patients with a high degree of dependence.
c) Psychiatric centres that have 100 or more beds.

These centres can enter into agreements with larger hospitals, which will exempt them from this requirement, provided they have a medicine deposit linked to the hospital pharmacy service of the reference hospital in the network of public hospitals in the corresponding health area or zone.

Hospitals, social care centres that provide specific health care and psychiatric centres that do not have their own hospital pharmacy service, and are not required to have one, must have a deposit. This deposit is to be linked to a pharmacy service in the same health area, under the responsibility of the head of the service, in the case of public hospitals, or to a dispensing pharmacy in the same pharmaceutical zone or to a hospital pharmacy service, in the case of a hospital in the private sector.

11.4.7. The handling and transformation of medicine preparations

To improve the efficiency of medicine use in hospitals, autonomous communities can grant authorisation to hospital pharmacy services in that region to carry out fractionation, dosage customisation and other operations that transform medicines.

The authorisation must be granted in such a way that ensures compliance with the technical guidelines for best practices, as applicable, by the hospital pharmacy services where these operations will take place.

The guidelines for handling, fractionation and dosage customisation will be drawn up under the guidance of the Directorate General of the Basic Common Basket of SNS Services and Pharmacy, with the collaboration of AEMPS and of experts of high prestige.

11.4.8 Application of Royal Decree-Law 16/2012

In the second half of 2012 the measures set forth in Royal Decree Law 16/2012 came into effect:

- Modifications of contributions by users and their beneficiaries, in accordance with their income level and their status as worker or pensioner (1 July).
- Update of the maximum amount that can be paid by citizens for those medicines and health products belonging to groups with reduced contribution, from €2.64 to €4.13 (1 July).
- Exclusion of medicines from the public financing system: the Directorate General of the Basic Basket of SNS Services and Pharmacy updated the list of medicines excluded from pharmaceutical benefits by putting into effect Resolutions of 2 August 2012 and 17 September 2012.
- Update of the lowest prices of the homogeneous groups: the first update took place on 1 July 2012 and subsequently it will take place on a quarterly basis.

User contribution in pharmaceutical benefits. 2012		
	User Contribution (Euros)	Contribution by Users as % of Total Retail Value
January	60,354,300	5.7
February	61,344,034	6.0
March	64,322,400	5.8
April	56,732,762	5.7
May	61,816,565	5.8
June	63,828,101	5.6
July	86,978,451	10.2
August	89,262,261	10.2
September	81,695,193	10.0
October	99,267,497	10.6
November	93,834,713	10.6
December	91,351,753	10.5

Remarks: contributions by users to total retail value of prescriptions invoiced to the SNS, VAT included.
Source: Ministry of Health, Social Services and Equality. Subdirectorate General for the Quality of Medicines and Health Products. Statistics on medical prescription invoicing.

These measures, along with the ones already in place (new references prices in compliance with Resolution of 28 December 2011 of the Directorate General of Pharmacy and Health Products; application of the scale of deductions to pharmacy mark-ups and deductions to the medicines dispensed by the pharmacies in application of Royal Decree-Law 8/2010), have resulted in the amount invoiced to the SNS for pharmaceuticals in the year 2012 being less than 10,000 million Euros (9,770.9 million Euros), which had not occurred since 2004.

More data on medicines and pharmaceutical expenditure in 2012 can be found in Chapter 6 of this report.

11.5. Measures pertaining to human resources

In the finances of the regional health services, the funds earmarked for human resources are the largest budget item. The diversity of regulatory frameworks and the organisational complexity of the qualifications, categories and work statuses of employees in the 17 regional health services have led to highly variable situations. Such variability seriously hinders the implementation of efficiency and organisation programmes that autonomous communities are trying to put in place to combat the current economic crisis and it also limits the freedom of movement of workers among health services.

One urgent task is ensuring the mobility of health professionals through the creation of a common catalogue of professional categories and their equivalents.

There are other measures that take on particular importance in a context of economic crisis; they are the measures aimed at rationalising public expenditure and increasing management efficiency in the regional health services.

11.5.1. Professional regulation

Official training for medical specialists wishing to acquire a subspecialty is based on a residency system and this is now the only way for specialists to acquire a Diploma in a Specific Skill Area (ACE). The number of years of professional experience as a specialist that is required in order to access an ACE residency has been reduced from 5 to 3 years.

The idea behind this measure is to make ACE diplomas a natural element for perfecting the skills and furthering the knowledge of specialists, by making this training option available to them in a more reasonable period of time than initially established.

The composition of ACE Committees has also been clarified; their members will be proposed by the national commission or commissions of the pertinent specialty or specialities. Also, access to a diploma in a newly-created Specific Skill Area will be possible for those professionals who have already served in that skill area, through a transitional access route.

As regards the accreditation of teaching centres and units, the Royal-Decree Law increases the flexibility of the procedure for approving the general accreditation requirements of teaching centres and units that provide specialist training, by no longer requiring a report by the Professional Forum as a previous step. In addition, management processes have been clarified, distinguishing between the MSSSI body responsible for quality, which has the duty of evaluating the functioning and quality of the training system, and the body responsible for specialised health training in the relevant ministerial department, which has the duty of handling the requests for authorisation made by training centres and units.

11.5.2. State register of health care professionals

The State Register of Health Care Professionals (REPS)[21] has the following objectives:

– to ensure that the general population and institutions have access to information regarding the situation of health care professionals,

covering different aspects of professional practice, including accreditation of good practice.
- to facilitate the planning of human health resources and to coordinate the human resource policies of the SNS.

In 2012 work has gone into the drafting of a royal decree that will regulate how the REPS functions. The preliminary text of this decree provides that the register will contain the following public data:

The professional's name, degree, specialty, Specific Skill Area Diploma and Accreditation and Advanced Accreditation Certificates (for these three documents the dates they were obtained and revalidated will be included), place of work, category and function.

The preliminary draft also foresees the incorporation of two key points from Directive 2011/24/EU of the European Parliament and Council of 9 March 2011, on the application of patients' rights in cross-border health care. The REPS will include information about the professional liability insurance systems and similar guarantees that health professionals must have in order to pay damages that may be awarded as a result of the care they provide.

In addition, using the information contained in REPS, Spain will provide the authorities of other Member States, when requested through the Internal Market Information (IMI) system, with pertinent information regarding the right of the health professionals to practice their profession.

11.5.3. Professional categories

It is of urgent importance to ensure that health professionals have greater mobility, through the creation of a common catalogue of professional categories and their equivalents. This will enable professionals to apply for jobs offered in other regional health services, thus improving the quality of care provided.

As provided in Art. 37 of the Framework Statute (EM) applicable to the statutory employees of the health services, in order to guarantee mobility in terms of effective equality of statutory employees throughout the SNS, the Ministry of Health will, based on the report prepared by the SNS Human Resources Commission, proceed to standardise the different classes and functionary categories of statutory employees, to the extent necessary to allow the desired mobility among the regional health services.

In this regard, Royal Decree Law 1/2012 modifies Art. 15 of Law 55/2003 of the EM, on the creation, modification and suppression of professional categories of statutory personnel, giving the MSSSI the task of preparing a common catalogue that establishes equivalencies among the professional

categories of statutory personnel in the SNS, and also designing a procedure by which these categories are to be updated regularly.

To meet this objective, a working group with the participation of the autonomous communities and the MSSSI was created by a CISNS resolution on 29/02/2012.

When the group completed its task, the plenary body of the SNS Human Resources Commission, along with the plenary body of the CISNS, adopted on 20/12/2012 the chart of equivalencies of professional categories in the SNS and the initial draft of the standardisation procedure, which were included in the preliminary text of the royal decree calling for a common catalogue of equivalents of professional categories of statutory health personnel and the regulation of its update, as a consequence of the creation, modification and suppression of professional categories of this type of personnel within the SNS.

11.5.4. Complementary remunerations

The Framework Statute (EM) was modified to introduce the concept of complementary remuneration associated partially (as a variable component) with the activity that is actually performed, depending on the evaluation of the statutory personnel's performance with regard to the principles of equality, objectivity and transparency.

This allowed a revision of the remuneration model, a question that the MSSSI and the autonomous communities were already working on in response to a CISNS resolution dated 29/02/2012.

In short, the idea was to formulate a new remuneration model in which the health professional would be paid not only for who he or she is and what he or she does but also for *how* he or she does it and *how much* he or she does it, factors which would be rewarded with a variable component of greater significance.

11.5.5. Economic benefits in situations of temporary incapacity of statutory personnel

Royal Decree Law 1/2012 added a new provision to the EM (the 15th additional provision) leaving in the hands of the regional health services the decision as to whether to extend to statutory personnel the provisions of Art. 21 of legislative RD 4/2000 of 23 June, which approves the consolidated text of the Law on Social Security of Government Employees, in relation to the economic benefits received in situations of temporary incapacity.

Subsequently, however, the provisions of legislative RD 4/2000 were made more complete and were applied to all civil servants by virtue of Royal Decree-Law 20/2012, of 13 July, on measures to guarantee budgetary stability and competitiveness. As a result the discretional complement to the benefits received during a situation of temporary incapacity (TI) will be not more than 50% (of the remuneration received the month before) in the first three days of each TI process, not more than 75% of this amount up through day 20 of the process, and 100% starting on day 21. The benefit will be 100% from that day on, until three months have passed from day 1 of the process.

11.5.6. Integration of civil servants working for public health care institutions

RD-Law 1/2012 provides that civil servants working for public health care institutions in the regional health services will be integrated into the category of indefinite statutory employees, without detriment to their consolidated rights.

Such integration is voluntary; however, if the worker chooses to continue in his or her current category, he or she will be transferred to administrative bodies not belonging to the public health care institutions, as part of the mobility processes established for this purpose by the autonomous communities.

Integrating this collective is another step in the standardisation of the provisions applicable to people working in SNS health care institutions.

11.5.7. Social action benefits for statutory personnel

This type of benefit[22] can be received only by personnel whose current administrative situation is active service, and not by persons of retirement age, which is the age specified for this purpose by legislation concerning Social Security.

11.5.8. Suppression of the "quota and zone services" mode of employment

The personnel who receive payment based on the quota and zone system will be integrated into the statutory personnel category, without detriment to their consolidated rights.

The deadline established for such integration is 31/12/2013, which coincides with the deadline established for the integration of civil servants working for public health care institutions.

As of that date the quota and zone mode of employment will be eliminated and the Order of 8 August 1986, on the remuneration of these professionals, repealed.

Members of this group received a basic remuneration for a 2.5 hour workday but also had a quota of individual health cards assigned to them for which they received a co-efficient. The variable triennial payments of these employees consisted of 10% of the basic remuneration of the previous year.

The aim of this integration is to make the workday and remuneration system of statutory personnel the general norm and for all workers to have full-time dedication, except in those cases provided for by law.

11.6. Measures pertaining to health management. Centralised purchasing

11.6.1. Centralised purchasing platform

The negative economic situation that began in 2008 has made it necessary to adopt measures aimed at increasing efficiency in the application of resources, by all of the public administrations.

The introduction of a tendering system for aggregate purchases in the SNS is yet another step forward in fulfilling the provisions of Royal Decree 16/2012, of 20 April, on urgent measures to guarantee the sustainability of the SNS and to improve the quality and safety of its benefits, in line with the agreements reached in the CISNS on 3 October 2012, which resolved to create a Commission and two Working Groups (one for medicines and one for health products) with representatives from all the autonomous communities, to work towards a centralised purchasing platform.

This action furthers the line already being followed by the MSSSI, which has led to aggregate purchases of flu vaccines, the recommended childhood vaccines and other vaccines for adults.

Background information:

- No common catalogue for the entire SNS.
- No common purchasing policy within the SNS.
- No channels by which autonomous communities are able to share information.

– Inefficient acquisition: the same products are purchased from the same suppliers but at different prices and under different conditions.
– Variability in products and medicines: no common criteria and basic requisites within the SNS.
– Negative impact on quality and equity in health care.

Objectives:

– To create a uniform policy and procedure for purchasing in the SNS.
– To maintain a competitive market: avoiding a single supplier for the entire SNS.
– To unify the technical criteria used in the autonomous communities: improving quality and equity.
– To enhance transparency in the process: unifying criteria related to the derived contracts.
– To draw up a centralised purchasing catalogue: technological platform.
– To heighten efficiency in the administration.
– To modernise the tendering process: electronic tendering.

The activities of these Working Groups led to agreements to initiate the first two processes for the aggregate purchasing of medicines and health products, with the adhesion of fourteen autonomous communities plus the INGESA health care centres of Ceuta and Melilla. The participating administrations are: Aragón, Asturias, Baleares, Castilla y León, Castilla-La Mancha, Comunidad Valenciana, Canarias, Cantabria, Extremadura, Galicia, Madrid, Murcia, Navarra, La Rioja, Ceuta and Melilla. The period established for this aggregate purchasing programme was two years (2013/2014), with the possibility of a one year extension.

The agreements reached by the administrations participating in this procedure involved the following products:

– Medicines: two types of active ingredients, epoetins and anti-TNF monoclonal antibodies.[23]
– Health products: examination gloves and surgical gloves; reactive strips to measure blood glucose (with auto-analyser); and material for incontinence.

The benefits of this action are not just economic. Rationalising SNS procurement policies through aggregate purchasing has the following positive effects:

- It strengthens the efficiency of the SNS in making acquisitions, thus increasing savings.
- It contributes to the homogenisation of products and medicines used in the SNS, reducing their variability, which is an evident technical improvement.
- It helps establish quality standards throughout the SNS, which brings better quality and equity to the health care system.
- It offers security to suppliers, by enhancing market stability with a common purchasing procedure for the entire system. This is especially significant in relation to payment terms.

One important aspect of this initiative is its focus on purchasing goods that are used commonly throughout the SNS, good that thus have considerable scope for enhancing the benefits of economies of scale.

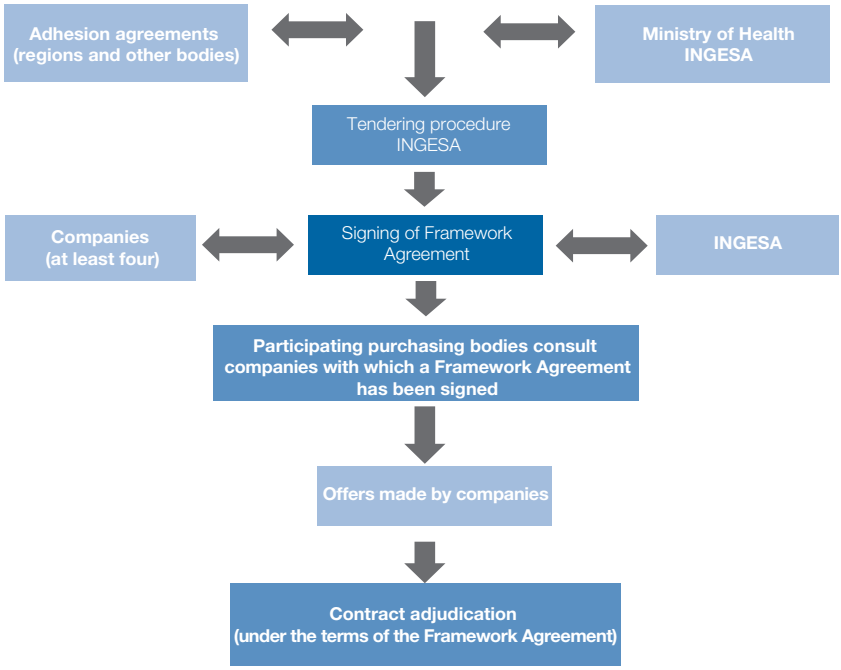
Also, the initiative has intentionally not been given an exclusive nature, in terms of the goods, nor an excluding nature in terms of the procedures. This means, in relation to the goods, that health care services will provide patients with the medicine or health product called for by their clinical situation; if the solution available through aggregate purchases is appropriate for the patient's needs, he or she will be given that one (which will have benefited from the economies of scale) but if this is not the case, the health care services will provide the solution that is most appropriate from a clinical perspective.

Along these same lines, in relation to the procurement procedures, the regional health services will perform any other procedures deemed necessary, so as to respond to the needs not suitably covered by the aggregate purchases.

The articulation of this aggregate purchasing system is based on the mechanism specified in paragraph 2 of the 28th additional provision of legislative Royal Decree 3/2011, of 14 November, which approves the consolidated text of the Public Sector Contracting Law. Specifically, it entails the adoption of a centralised framework agreement (through INGESA) for the selection of prices and suppliers.

Once this selection has been made, through the appropriate framework agreements, the participating administrations will sign the respective derived contracts as laid down in Art. 198 of the Public Sector Contracting Law.

Graph 11.1. Chart of the Centralised Purchasing Platform



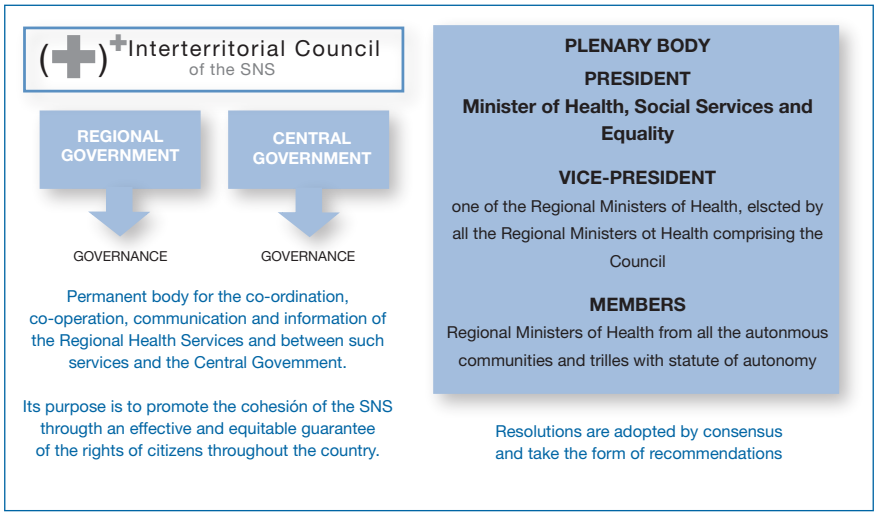
Source: INGESA.

Annex A: Interterritorial Council of the SNS Resolutions 2012

The Interterritorial Council of the SNS (CISNS) is a permanent co-ordination and co-operation body and as such it is the main instrument in the configuration of the SNS.

Its purpose is to promote cohesion in the SNS and to facilitate co-ordination among the autonomous communities and the central government, with the effective and equitable guarantee of citizen rights in the entire country.

The Plenary is the highest body and its members hold maximum responsibility for Spain's national health system.



In the year 2012, the CISNS held five plenary sessions: 29 February, 18 April, 27 June, 3 October and 20 December. In these sessions the most important subjects affecting health care in Spain were addressed.

The subjects discussed in plenary session have already been dealt with by standing committees, reporting commissions and dependent groups. As a curiosity we would point out that the session held on 29 February was number 100.

Working Groups

The CISNS resolved to create Working Groups to address the following issues:

- Development of basic service basket.
- System for the ongoing update of the SNS catalogue of benefits.
- Remuneration model of the SNS.
- Professional categories in the SNS. Chart of equivalencies.
- Model for professional development in the SNS.
- Map of existing Information and Communication Technologies (ICT) and proposals for the expansion of applications and programmes.
- Centralised purchasing platform.

Vaccines

The CISNS approved the proposal formulated by the Public Health Commission regarding the following aspects:

A) Basic vaccination calendar.
B) Centralised purchase of vaccines.
C) Technical study regarding proposal for 2013 calendar, unifying calendar throughout the country.

Health care

The CISNS approved the basic criteria regarding the SNS individual health card (interoperability criteria).

- It ratified the proposal submitted by the CISNS Delegated Committee regarding the European complaint that certain Spanish public hospitals reject the European Health Insurance Card (EHIC) when the patient has private health insurance. The proposal's terms are as follows:

  1. The health services of the autonomous communities that are members of this Interterritorial Council undertake to instruct the health care centres under their power about the meaning of the European Health Insurance Card (EHIC) as a document issued by the competent authorities and that certifies that the holder is entitled to receive health care. In particular, they will instruct them that the mere presentation of the EHIC by a citizen of an EU Member state is enough to enable that person to receive

health care, with no further requisites involving alternative forms of insurance or payment obligations.

2. In the event that the EHIC is not initially presented by the EU citizen, any additional requirements that the health care centres may make will be conditioned by the presentation at a later time of the EHIC and when the presentation occurs, the complementary requirements will be void.

- It acknowledged that it was sufficiently informed about the draft of the Royal Decree by which the format of individual health cards is standardised throughout the SNS.
- It acknowledged that it was sufficiently informed about the draft of the Royal Decree regulating entitlement of persons to receive public health care in Spain through the SNS.
- It acknowledged that it was sufficiently informed about the preliminary draft of the ministerial order establishing the basic requisites of the Special Agreement for the Provision of Health Care that can be signed by persons not entitled to health care in the SNS.
- It issued a favourable opinion of the Mutual Recognition Agreement (Certificates and Authorisations).

Network of health technology assessment agencies

- It approved the creation of the Spanish Network of Health Technology and SNS Benefits Assessment Agencies.
- It issued a favourable opinion of the work plan of the Spanish Network of Agencies 2012.

SNS sustainability

It acknowledged that it was sufficiently informed about the resolution concerning measures to improve the sustainability of the SNS.

The basket of services

The proposal regarding the SNS centres, services and units that are to be designated "reference centres" was approved.

- It acknowledged that it was sufficiently informed about the preliminary Ministerial Order that specifies the criteria for the

inclusion of dietetic foods for special medical uses in the SNS dietetic product benefits, as well as their financing limits.
- It approved the protocol concerning myoelectric prosthesis, developed by the Advisory Committee on Ortho-Prosthetic Benefits.
- It acknowledged that it was sufficiently informed about the preliminary Royal Decree that regulates the supplementary common basket for SNS ortho-prosthetic benefits and lays the foundations for setting the financing limits.
- It acknowledged that it was sufficiently informed about the preliminary Ministerial Order that sets the common invoicing factor for dietetic products included in the benefits.
- It acknowledged that it was sufficiently informed about the preliminary Ministerial Order that defines the supplementary common services basket concerning non-urgent patient transport in the SNS.
- It acknowledged that it was sufficiently informed about the preliminary Ministerial Order establishing user contribution to dietetic products included in the benefits, and also the resolution concerning the assessment of thickening modules in dietetic product benefits.
- It acknowledged that it was sufficiently informed about the preliminary Ministerial Order regulating the supplementary ortho-prosthetic benefit of wheelchairs.
- It acknowledged that it was sufficiently informed about the situation of SNS waiting lists as of June 2012.

Health strategies

- It approved the update of the SNS Diabetes Strategy.
- It issued a favourable opinion of the SNS Chronicity Strategy.
- It issued a favourable opinion of the SNS Rheumatic and Musculoskeletal Diseases Strategy.
- It acknowledged that it was sufficiently informed about the evaluation of the SNS Rare Diseases Strategy.
- It acknowledged that it was sufficiently informed about the 2011-2012 Programme to Enhance Safety in Intensive Care Units.

Clinical protocols

- It issued a favourable opinion of the guide for providing care to women with endometriosis in the SNS.

– It issued a favourable opinion of the document on multiple chemical sensitivity.
– It issued a favourable opinion of the document: "Haemophilia: Recommendations and Therapeutic Guidelines."

Resolutions concerning the Care Guarantee Fund

– It acknowledged that it was sufficiently informed about the Care Guarantee Fund (FOGA).

Resolutions pertaining to pharmaceutical benefits

– It created a Working Group to develop the criteria for a Master Positive List.
– It acknowledged that it was sufficiently informed about the proposal regarding update procedures and reduced contributions in SNS pharmaceutical benefits.
– It acknowledged that it was sufficiently informed about the proposal to define minimum criteria in the area of pharmaceutical regulation.
– It acknowledged that it was sufficiently informed about the homogeneous groups of medicines: system for handling the voluntary price reductions with no change in the National Code and the update of information about the lowest prices.
– It acknowledged that it was sufficiently informed about the following resolutions concerning Royal Decree Law 16/2012:

    • Resolution establishing a common procedure for the reimbursement of the amounts paid by patients for pharmaceuticals.
    • Interpretive resolutions concerning contribution levels.
    • Report on the forecasts for savings derived from the application of the updated CPI. Resolution of 31 May 2012, of the Directorate General of the Basic Basket of SNS Services and Pharmacy, which updates the maximum amount corresponding to medicines belonging to the ATC groups with reduced contribution (published in the Official State Bulletin on 9 June 2012).
    • Report concerning the update of the positive list (definancing).

Resolutions pertaining to medicines

- It approved the Strategy on Counterfeit Medicines for the period 2012-2015.
- It approved the Action Plan in the Spanish System for the Pharmacovigilance of Medicines for Human Use.
- It acknowledged that it was sufficiently informed about the document: "Proposal for collaboration in the preparation of reports on the therapeutic ranking of medicines."
- It adopted the protocol: "Strategy in the Treatment of Hepatitis C with new Protease Inhibitors (Boceprevir and Telaprevir).
- It issued a favourable report on the protocol for the use of the new anti-coagulant pharmaceuticals.

Resolutions pertaining to human resources

- It acknowledged that it was sufficiently informed about the consensus document drawn up by the Professional Development Working Group: "Continuing Professional Development and Continued Professional Education."
- It acknowledged that it was sufficiently informed about the proposal regarding the standardisation of professional categories of statutory personnel in the SNS.
- It acknowledged that it was sufficiently informed about the report recommending a national study, as proposed by the CISNS, on the real dimensions of and most appropriate solutions to aggressions against health professionals. Motion approved in the Senate on 13/09/2012.

Annex B: Royal Decree-Law 16/2012 and Royal Decree 1192/2012

Annex B1

Royal Decree-Law 16/2012, of 20 April, on urgent measures to guarantee the sustainability of the SNS and to improve the quality and safety of its benefits (*Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones)*.

(see Annex below: text in Spanish)

Annex B2

Royal Decree 1192/2012, of 3 August, which regulates the entitlement of persons to receive public health care in Spain through the SNS *(Real Decreto 1192/2012, de 3 de agosto, por el que se regula la condición de asegurado y de beneficiario a efectos de la asistencia sanitaria, con cargo a fondos públicos, a través del Sistema Nacional de Salud)*.

(see Annex below: text in Spanish)

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Acronyms and abbreviations

A

ACE	*Área de Capacitación Específica* (Specific Skill Area)
AEMPS	*Agencia Española de Medicamentos y Productos Sanitarios* (Spanish Agency of Medicines and Health Products)
AAR	Average Annual Rate
AP	*Atención Primaria* (Primary Care)
ATC	Anatomical Therapeutic Chemical classification system
ATEP	*Accidentes de Trabajo y Enfermedad Professional* (Work-related Accidents and Occupational Illness)
AVS	*Años de Vida Saludable* (Healthy Life Years)
AVSn	*Años de Vida Saludable al nacer* (Healthy Life Years at birth)
AVS65	*Años de Vida Saludable a los 65 años* (Healthy Life Years at 65)

B

BMDW	Bone Marrow Donors Worldwide
BMI	Body Mass Index

C

CAT	Computed Axial Tomography
CCAA	*Comunidades Autónomas* (Spain's autonomous communities)
CCST	*Comité Científico para la Seguridad Transfusional* (Scientific Committee for Transfusion Safety)
CISNS	*Consejo Interterritorial del Sistema Nacional de Salud* (Interterritorial Council of the SNS)
CMA	*Cirugía Mayor Ambulatoria* (Major Outpatient Surgery)
CMBD	*Conjunto Mínimo Básico de Datos* (Minimum Data Set)
COPD	Chronic Obstructive Pulmonary Disease
CPAF	*Comisión de Prestaciones, Aseguramiento y Financiación* (Commission on Benefits, Entitlement and Financing)
CSUR	*Centros, Servicios y Unidades de Referencia* (Reference Centres, Services and Units)

D

DK	Don't Know
DRG	Diagnosis Related Groups
DTPa	Combined vaccine against Diphtheria-Tetanus-Pertussis

E

EEE	*Espacio Económico Europeo* (European Economic Area)
EFG	*Especialidades Farmacéuticas Genéricas* (Generic Pharmaceutical Specialties)
EGSP	*Estadística de Gasto Sanitario Público* (Statistics on Public Expenditure on Health)
EHIC	European Health Insurance Card
EHIS	European Health Interview Survey
EM	*Estatuto Marco* (Framework Statute applicable to statutory personnel)
ENSE	*Encuesta Nacional de Salud de España* (Spanish National Health Survey)
EPOC	*Enfermedad Pulmonar Obstructiva Crónica* (Chronic Obstructive Pulmonary Disease, COPD)
ETOP	Elective Termination of Pregnancy
EU	European Union
EV	*Esperanza de Vida* (Life Expectancy)
EVS	*Esperanza de Vida en Salud* (Healthy Life Expectancy)
EVn	*Esperanza de Vida al nacer* (Life Expectancy at birth)
EV65	*Esperanza de Vida a los 65 años* (Life Expectancy at 65)

F

FCS	*Fondo de Cohesión* (Health Cohesion Fund)
FENIN	*Federación Española de Empresas de Tecnología Sanitaria* (Spanish Federation of Health Technology Companies)
FOGA	*Fondo de Garantía Asistencial* (Care Guarantee Fund)
FSE	*Formación Sanitaria Especializada* (Specialised Health Care Training)

G

GDP	Gross Domestic Product

GRD *Grupos Relacionados de Diagnóstico* (Diagnosis Related Groups)

H

Hib Haemophilus influenzae type b
HLE Healthy Life Expectancy
HLY Healthy Life Years
HLYb Healthy Life Years at birth
HLY65 Healthy Life Years at 65
HPV Human Papillomavirus
HSCT Hematopoietic Stem Cell Transplantation

I

IMC *Índice de Masa Corporal* (Body Mass Index)
IMF *Importes Máximos de Financiación* (Financing Limits)
IMI *Información de Mercado Interior* (Internal Market Information)
INCLASNS *Indicadores Clave del SNS* (SNS Key Indicators)
INCLASNS-BD *Base de datos Indicadores Clave del SNS* (SNS Key Indicators Database)
INE *Instituto Nacional de Estadística* (National Statistics Institute)
INGESA *Instituto Nacional de Gestión Sanitaria* (National Institute of Health Management)
INSS *Instituto Nacional de la Seguridad Social* (National Institute of Social Security)
IRPF *Impuesto sobre la Renta de las Personas Físicas* (Personal Income Tax)
ISFAS *Instituto Social de las Fuerzas Armadas* (Social Institute of the Armed Forces insurance mutual)
IT *Incapacidad Temporal* (Temporary Incapacity, TI)
IVA *Impuesto sobre el Valor Añadido* (Value Added Tax, VAT)
IVE *Interrupción Voluntaria del Embarazo* (Elective Termination of Pregnancy, ETOP)

L

LE Life Expectancy
LEB Life Expectancy at Birth

LE65 Life Expectancy at 65

M

MMR Combined Measles-Mumps-Rubella vaccine
MO *Médula Ósea* (Bone Marrow)
MSSSI *Ministerio de Sanidad, Servicios Sociales e Igualdad* (Ministry of Health, Social Services and Equality)
MUFACE *Mutualidad General de Funcionarios Civiles del Estado* (Mutual Insurance for State Employees)
MUGEJU *Mutualidad General Judicial* (Mutual Insurance for Employees of the Judiciary)

N

NA No Answer
NC *No contesta* (No Answer, NA)
NMR Nuclear Magnetic Resonance
NOFIN Not financed
NS *No sabe* (Don't Know, DK)

O

ONT *Organización Nacional de Trasplantes* (National Transplant Organisation)

P

PC Primary Care
PIB *Producto Interior Bruto* (Gross Domestic Product)
PMP *Por millón de población* (per million population)
PNH *Plan Nacional de Hemoterapia* (National Haemotherapy Plan)
PTTP *Patologías, Técnicas, Tecnologías y Procedimientos* (Pathologies, Techniques, Technologies and Procedures)
PVP *Precio Venta al Público* (Retail Price)

R

REPS *Registro Estatal de Profesionales Sanitarios* (State register of health care professionals)

RMN *Resonancia Magnética Nuclear* (Nuclear Magnetic Resonance, NMR)

S

SCU *Sangre de Cordón Umbilical* (Umbilical Cord Blood, UCB)

SIAE *Sistema de Información de Atención Especializada* (Specialised Care Information System)

SIAP *Sistema de Información de Atención Primaria* (Primary Care Information System)

SIFCO *Sistema de Información Fondo de Cohesión* (Health Cohesion Fund Information System)

SI-SNST *Sistema de Información del Sistema Nacional para la Seguridad Transfusional* (Information System of the National System for Transfusion Safety)

SNS *Sistema Nacional de Salud* (Spain's National Health System)

SNST *Sistema Nacional para la Seguridad Transfusional* (National System for Transfusion Safety)

SP *Sangre Periférica* (peripheral blood)

SRP *Sarampión, Rubeola, Parotiditis* (combined Measles-Mumps-Rubella vaccine, MMR)

SS Seguridad Social (Social Security)

T

TAC *Tomografía Axial Computarizada* (Computed Axial Tomography, CAT)

TAM *Tasa Anual Media* (Average annual rate)

TI Temporary Incapacity

TNF Tumour Necrosis Factor

TPH Trasplante de Progenitores Hematopoyéticos (Hematopoietic Stem Cell Transplantation, HSCT)

TSE Tarjeta Sanitaria Europea (European Health Insurance Card)

TSI *Tarjeta Sanitaria Individual* (individual health card)

TSNU *Transporte Sanitario no Urgente* (non-urgent patient transport)

TSS *Tesorería de la Seguridad Social* (Social Security Treasury Office)

Tx	Transplant

U

UCB	Umbilical Cord Blood
UE	Unión Europea (European Union, EU)

V

VAT	Value Added Tax
VPH	*Virus del Papiloma Humano* (Human Papillomavirus, HPV)

Sources

Health Care Barometer

A set of statistics managed by the Ministry of Health, Social Services and Equality in collaboration with the Sociological Research Centre (CIS). 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, citizen awareness and/or attitudes with regard to 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, his or her 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

National Catalogue of Hospitals

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

Its general objective is to offer basic information about the hospitals that exist throughout Spain.

The variables gathered are the hospital's details (name, address, telephone and fax numbers, ID code), total number of beds, care function, its place in legal and organisational structures, existence of agreement with the private sector or with the Social Security body responsible for managing health care in that area, and whether 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 managed 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 in the SNS.

The variables gathered include the health care centre's details (name, address, telephone, town and municipality), type of centre (Primary Care Centre or Local Primary Care Centre), place in organisational structure and whether 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 determine the number of people who reside in and have their usual domicile in each municipality. All people living in Spain are required to register with the local population record 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 its place.

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 managed by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities and INGESA. Part of the National Statistics Plan 2009-2012.

Its general objective is to gather information about hospitalisation processes (diagnosis, co-morbidity, 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, and financing. 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 managed 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 other 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 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 organ, the health care centre and the autonomous community.

The data is gathered and published on an annual basis.

More information at:

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

Spanish National Health Survey (ENSE)

Set of statistics managed by the Ministry of Health, Social Services and Equality in collaboration with the National Statistics Institute. Part of the National Statistics Plan 2009-2012.

Its general objective is to provide 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 habitat, 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

Healthy life expectancies in Spain, 2007-2011

Report presenting the evolution of healthy life expectancy in two periods of time, with the main objective of better understanding its tendencies, both in Spain's population as a whole and in the various autonomous communities.

The continuing increase observed in recent decades in life expectancy (LE), primarily in more developed countries, brings significant consequences in terms of health and social care, due to the higher number of elderly people and the predominance of chronic diseases and incapacity in morbidity patterns.

The healthy life expectancy (HLE) is based on a set of indicators that takes into account not only the population's mortality but also the morbidity and disability it experiences. The indicator healthy life years (HLY) is the name for HLE when the health measure used is the global activity limitation index (GALI).

GALI is a simple subjective disability index designed and validated specifically to compare the HLY indicator among European countries. To obtain the HLY estimate for Spain and its autonomous communities in the periods studied, the life tables created by the Subdirectorate of Health Information and Innovation were used. The health information comes from national health surveys performed in Spain with representative samples of the Spanish population of those years.

More information at:

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

Statistics on Specialised Care Centres

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 of Ceuta and Melilla. 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 outpatient health care centres, which are the main providers of specialised care services. Such data makes it possible to create indicators, study the sector's functioning and monitor its development.

As study variables it uses: the care services offered, bed capacity, technological equipment, staffing, discharges, length of stay, consultations, admissions, diagnostic techniques, activity in other areas, surgical activity, obstetric activity, urgent care services, expenditures, investments and income. As classification variables it uses the type of specialised care centre: inpatient care (hospital), outpatient care, type of care provided, type of centre in terms of financing, its place in the legal structure, whether it has a contract with the SNS, and whether 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/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm

Health Strategies of the SNS

The SNS Health Strategies are intended to help the system respond to illnesses that are of high prevalence or have serious repercussions on the health care system and society. The development of the strategies is regulated by Art. 75

of Law 16/2003, of 28 May, on Quality and Cohesion in the SNS, pursuant to the provisions of Art. 70 of the General Health Care Act (Law 14/1986, of 25 April).

The Health Strategies are founded upon the principles of equity and territorial cohesion and their aim is to ensure that all citizens have access, under the same conditions, to the actions and procedures that have proven their effectiveness in improving health and quality of life.

More information at:

http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/abordajecronicidad.htm

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. 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 centres, 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.msssi.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 of Ceuta and Melilla.

The SNS Key Indicators comprise a prioritized set of information covering the most relevant aspects of health and the health care system in Spain. The indicators are selected by consensus among the bodies represented on the SNS Interterritorial Council (CISNS). Development is overseen by the CISNS Subcommission 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. Part of the National Statistics Plan 2009-2012.

Its general objective is to gather information about the sociodemographic 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 health care centres 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 aimed at ensuring that SNS benefits are accessed within a reasonable period, so that such access can take place under conditions of effective equality.

The general objective of the lists 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, after 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

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

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

Its general objective is to provide information about staffing, care activity (general and in specific services) and number of physical and/or functional SNS health care centres whose purpose is to provide primary care.

As study variables, it uses personnel, activity and primary care centres.

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

The Health Care Online programme began in 2006, as a way to promote the use of Information and Communication Technologies (ICT) 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 all the autonomous communities.

The programme receives funding from the European Regional Development Fund (ERDF) and it provides a framework in which to harmonize eHealth agendas at the central and regional levels, in order to improve the quality of health care by using ICT 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 is aimed at the exchange of clinical information by autonomous communities.

More information at:
www.red.es/media/2012-07/1343654162527.pdf

Systematic Vaccinations

Statistical information managed by the Ministry of Health, Social Services and Equality in collaboration with the Health Departments of the autonomous communities and the competent authorities of 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, 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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List of Endnotes

1 Ratio (%) of the number of inhabitants under the age of 15 (potentially dependent population) to the number of inhabitants aged 15 to 64 (potentially active population).

2 National Statistics Institute, 2011.

3 *Ley 42/2010, de 30 de diciembre, por la que se modifica la Ley 28/2005, de 26 de diciembre, de medidas sanitarias frente al tabaquismo y reguladora de la venta, el suministro, el consumo y la publicidad de los productos del tabaco* (BOE 31-XII-2010).

4 Occupational social class: the social classes used in the Spanish National Health Survey 2011/12 are those proposed in 2012 by the Spanish Epidemiology Society's Working Group on Determinants, as adapted for the Survey. They consist of groups of occupations coded in accordance with the National Occupations Classification that entered into effect in 2011 (CN=-11). The 6 groups used were the following:
I. Directors and managers of establishments having 10 or more employees and professionals traditionally associated with 5-year University degrees or similar.
II. Directors and managers of establishments having fewer than 10 employees, professionals traditionally associated with 3-year University degree programmes and other professional activities that provide technical support. Athletes and artists.
III. Intermediate occupations and the self-employed.
IV. Supervisors and workers in skilled technical occupations.
V. Skilled workers in the primary sector and semi-skilled workers.
VI. Unskilled labour.

5 The SNS public network is comprised of all publicly-owned and financed health care centres plus those centres that are privately owned (whether for-profit or not-for-profit) but have entered into substitution agreements with the SNS or belong to a Network of Public Use, which means they are financed by public funds.

6 http://www.msssi.gob.es/profesionales/CentrosDeReferencia/home.htm

7 The category "Other branches of activity" includes households as providers of home care, as long as the services provided are linked to social benefits awarded for this purpose.

8 While interpreting this data it is important to keep in mind that 8.2% of Spain's public sector health expenditure is not broken down into autonomous communities in the Statistics on Public Expenditure on Health (EGSP).

9 http://.msssi.gob.es/gabinete/notasPrensa.do?id=2537

10 http://www.periodistadigital.com/salud/farmacia/2012/09/17/

11 Royal Decree 1192/2012, of 3 August, which regulates the entitlement of persons to receive public health care in Spain through the SNS.

12 http://www.msssi.gob.es/profesionales/prestacionesSanitarias/home.htm

13 http://www.msssi.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/3AtencionEspecializada/AE-5-IndicacionDiagnosticos.htm

14 http://www.msssi.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/3AtencionEspecializada/home.htm

15 http://www.msssi.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/2AtencionPrimaria/AP-ServiciosEspecificos.htm

16 http://www.msssi.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/1PrestacionSaludPublica/home.htm

17 http://www.msssi.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/6PrestacionOrtoprotesica/home.htm

18 http://www.msssi.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/6PrestacionOrtoprotesica/home.htm

19 http://www.msssi.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/7PrestacionProductosDieteticos/home.htm

[20] http://www.msssi.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/8PrestacionTransporteSanitario/home.htm

[21] Created by the incorporation of a new provision (10th additional provision) to Law 16/2003, of 28 May.

[22] https://intranet.msc.es/servFormacion/accionSocial/home.htm

[23] Epoetins:

The main indication of these medicines is the treatment of anaemia associated with chronic renal insufficiency, and also anaemia in patients undergoing chemotherapy for solid tumours. They are not indicated for the treatment of the usual types of anaemia (iron-deficiency and megaloblastic).

Epoetins are administered intravenously and they are not available in dispensing pharmacies, as they are deemed medicines for hospital use. Their dispensation to outpatients takes place in hospital pharmacy services.

Anti-TNF monoclonal antibodies:

These are immunosuppressive agents that reduce the levels of tumour necrosis factor (TNF) of auto-immune diseases and they also act by reducing other biological markers characteristic of situations involving chronic inflammation (rheumatoid arthritis, inflammatory bowel diseases, psoriatic arthritis, ankylosing spondylitis...) not affecting the number of leukocytes or of monocytes, which leads to a quick reduction of the inflammation.

These medicines are administered intravenously. In the SNS, their dispensation to outpatients takes place in hospital pharmacy services.

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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