



***Health:
the People's Right,
Everyone's Responsibility***

Health Policy for the Basque Country 2013- 2020

December 2013

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Back in 1946, the Constitution of the World Health Organization asserted that health was one of the fundamental rights of every human being. This same idea was upheld, two years later, in Article 25 of the Universal Declaration of Human Rights: *"Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services."*

The Government of the Basque Country, taking the view that people should be at the heart of all its policies and actions, indicated in its programme for government that it was going to strive to safeguard the social policies that form the basis of the welfare state that we fought so hard to create. Hence, we are paying special attention to the most vulnerable in society, not allowing anyone to be left behind. Our priority is to consolidate our healthcare system, ensuring that it is of high-quality and the admiration of others, prioritising prevention and fostering a culture of health, on the basis of the principles of universality, solidarity, equity, quality and civic engagement.

To this end, in tune with the concept of health as a human right, we present the 2013-2020 Health Plan entitled *"Health: the People's Right, Everyone's Responsibility. Health Policies for the Basque Country"*

Life expectancy in the Basque Country is among the best in the world for both men and women and, even more importantly, disability-free life expectancy has been increasing in both sexes. We should recognise the great collective effort that has been required to achieve the excellent health outcomes that we enjoy in the Basque Country. Nevertheless, in our society there continue to be socioeconomic and cultural inequalities, with negative repercussions for the most disadvantaged. Looking to the future, we must therefore address the so-called determinants of health to be able to tackle the factors that have an impact on the health of the population and that should be considered in all policy areas.

At the same time, it is important to note that the public is increasingly better informed and that individuals are taking more responsibility for their own health, while there are growing expectations of and demands on the health system and the management of public resources. This is as it should be, since we are talking about one of the cornerstones of the well-being of our society.

Hence, in accordance with the 1986 Ottawa Charter, we consider that improving health should be and is a shared goal across all parts of government as political measures, in whatever field, may influence health and, ultimately, should contribute to improving well-being of the population. This is the "Health in All Policies" concept. If we combine this inclusive inter-sectoral approach with individuals accepting co-responsibility - lifestyle habits being very important - we can hope to improve the final outcomes in health, equity and sustainability, the whole being greater than the sum of the parts.

The Health Plan that we are launching sets out the commitments of the Basque government with Basque society in this area and is, hence, a key tool for improving the health of the people of the Basque Country and enhancing their quality of life, reducing inequities and promoting organisational improvements. It also establishes directions to be taken and priorities for action for our entire health system over the coming years, to continue to provide users with a high-quality service and clinical safety, placing emphasis on three groups with specific needs: people with ill health, older individuals and children and young people, so that the system responds in the most suitable way to their different circumstances, requirements and priorities.

The seven-year period of the plan will enable us to incorporate likely advances in technology and procedures, implement the envisioned actions and evaluate their impact, to enable us to take the most appropriate measures according to the results observed and changes as they are identified.

We feel that this is the best kind of investment, as we, like Ralph W. Emerson, believe that "the first wealth is health".

Jon Darpón Sierra

Health Minister of

the Basque Country



In the Basque Country, the commitment of the public authorities with the people in terms of the development and application of law related to the protection and care of health is articulated in two documents: at the regulatory level, the basic instrument is the Basque Healthcare Standards Act (*Ley de Ordenación Sanitaria de Euskadi*); while the Health Plan is the highest level policy document for the planning and programming of the system.

That is, like a contract, the plan shapes and specifies the responsibilities of the authorities. To that end, it contextualises, directs and plans health policies to be followed by the Basque Government, together with various institutions and sectors in our region in the coming years, specifying programmes, measures and interventions that address a series of basic objectives and priorities based on identified needs. And, of course, it also defines the indicators for assessing progress towards objectives for health, management and quality of the system.

All this is consistent with the previous government health plans and in tune with key international agreements, such as the 2011 Río Political Declaration adopted by the World Health Organization (WHO) member states, the Health 2020 policy framework for the WHO European region (2012), and the Health for Growth Programme for the period 2014-2020 approved by the European Parliament and Council.

The document we present is the fruit of a participative process, benefiting from the work and input of healthcare and management professionals as well as experts representing industry and the third sector, patients themselves and many different institutions.

Further, it should be underlined that the plan is launched in the context of good health outcomes that are evidence of the great progress made over the last thirty years. And it is to be implemented in a period during which, predictions indicate, there will be a slowing of population growth and ongoing population ageing in the Basque Country. Another inescapable issue is the current difficult economic and social situation that calls on us to ensure that our health service remains public and universal and pay special attention to overcoming existing or potential inequalities.

In this context, the 2013-2020 Health Plan defines the directions and priorities to be addressed in the immediate future and places emphasis on certain

groups in our society, namely, older people, children and young people and, of course, all those with ill health. Striving to be both coherent and progressive and looking to the future, the commitment we make to society in this plan is structured around five main Priority Areas, 35 objectives and 146 actions.

Many of the tasks to be implemented are related to two horizontal themes that involve

1. Strengthening the Basque health system, in terms of equity and quality, and driving the "Health in All Policies" approach, as a way of ensuring that health is championed by all public institutions. This implies, then, good governance of the health system (on the basis the principles of equity, quality, efficiency and sustainability in public healthcare) and good governance for health (that is, considering health policies as a region-wide strategy), as well as making progress in gender issues and the development of channels of effective real public participation.
2. Prioritising activities related to health promotion and illness prevention and, specifically, those aiming to promote healthy environments and lifestyles through inter-sectoral collaboration, at local and community levels.

Given all this, the plan is laid out as a roadmap that, to be followed in an effective and enriching way, should be implemented with strong support for policies of and for health that are cross-sectoral. We are conscious of the complexity of this approach but also of the potential it offers to continue together ensuring and improving the overall well-being of everyone.

Our undertaking is to continue fostering co-responsibility, a shared commitment and collaboration, and synergies and interactions between all the institutions and sectors that have or could have an impact on everyone's good health. Ultimately, this is essential, as health and well-being of the population are not only the concern of the health system.

In the end, good health is a personal asset, which should be treasured by each of us, but it is also a common good to be cared for and safeguarded. As the Director General of the WHO said a few months ago, "*Universal coverage is the best way to cement the health gains made during the previous decade. It is a powerful social equalizer and the ultimate expression of fairness*".

With this same perspective of social justice, the Government of the Basque Country aims to continue progressing, offering the people - our reason for being - high-quality health provision achieving good health outcomes as effectively and efficiently as possible. At the same time, we have a clear will to uphold our principles and intrinsic values, namely sustainability as well as universality, solidarity, equity, quality, and civic engagement.

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INTRODUCTION

GUIDING PREMISE

Keeping people at the heart of all policies, the 2013-2020 Basque Health Plan considers in detail how to maintain and improve the health of the population in the region over the coming years.

For this, it is essential to ensure equity in and the sustainability of the health service, but also to position health as an asset in other public policies. That is to say, it is not only good, but also necessary to reconcile good governance OF the health system, which falls under the responsibility of the Department of Health, with good governance FOR health, which involves all parts of the public administration, the population and the productive sector.

MANDATE

The Health Plan represents a fundamental tool for promoting improvements in effectiveness and efficiency of health services, as provided for in the Healthcare Standards Act (*Ley de Ordenación Sanitaria 8/1997*)¹, the corresponding regulatory framework, which in Article 13 establishes that the Basque Health Plan is the highest level policy document for planning and programming of the health system. Once approved by the Basque Government, the proposal of the Department of Health is presented to the Basque parliament to be passed into legislation.

The aforementioned act also defines, in Article 2, the institutional framework for health, namely that it is incumbent on:

- all Basque public authorities to make it their mission to promote and improve health in all sectors of social and economic activity
- the Basque Government to defend this institutional framework for health in the Basque Country,... in all political sectors and by designing proactive multidisciplinary measures...

In this framework, the 2013-2020 Basque Health Plan has been based on the programmatic principles of organisation and functioning of the Basque health system (Healthcare Standards Act, Article 8), namely

- a/ the consideration of individuals as the main focus of the system
- b/ public participation, both in the formulation of plans and objectives and the monitoring and evaluation of implementation outcomes
- c/ a holistic view of the system in the planning of actions and the orientation thereof towards the

This cross-cutting approach, inter-departmental, inter-agency and inter-sectoral, is closely aligned with the principles of good governance in health policies established by the European Union (EU). In fact, said principles also underline the need and opportunity for taking a comprehensive view of health, understanding this focus to cover not only the job of the health sector to restore individuals with mild or severe illness to good health, but also the joint effort of all sectors to prevent illness and promote collective well-being.

promotion of good health and rehabilitation, as well as the prevention and cure of illness

d/ a primary focus of resources and actions on health promotion and illness prevention

e/ internal operation of the organisation through the principle of separation of regulatory functions and funding of the system from the provision of healthcare services

f/ the adequacy of the framework of public funding of the portfolio of healthcare services...

g/ arrangement, development and specialisation in the tasks of objective setting and resource allocation for the provision of health services

h/ improvement of the levels of competence in public centres...

i/ responsibility and involvement of healthcare professionals in organisational decisions and the management of resources...

j/ continuous evaluation of both public and subsidised components of the health system...

In addition, the 2013-2020 Basque Health Plan considers the measures required by Article 13.2 of the Healthcare Standards Act: evaluation of the health status and needs of the population, as well as the conditions of access to healthcare services; priority in health policy given to specific health conditions, health risks and social groups; guidelines and criteria for the portfolio of healthcare services offered and the necessary economic, human and material resources; and indicators for assessing progress towards health objectives.

ECONOMIC SITUATION

An instrument as important as the present Health Plan should be based on a careful analysis and diagnosis of the current situation. It is, therefore, necessary to establish a reference framework that ensures the adequate provision of healthcare with the available resources and also the incorporation of technological and procedural advances as evidence of their effectiveness emerges.

In this context, inter-sectoral involvement to support healthy lifestyles and early interventions is all the more important, encouraging the population to contribute to

maintaining the Basque Health Service.

The development of good health policies and ensuring the sustainability of the system within the criteria of universality, equity, co-responsibility and efficiency, are the key factors underpinning the future quality of life and well-being of Basque society.

THEME OF THE PLAN

Health: the People's Right, Everyone's Responsibility. The theme is a direct reflection of the way the plan was developed. It has been a dynamic process, open to input and active involvement of experienced technical and healthcare professionals; staff from the general administration and other parts of the public sector;

members of the public; and representatives from the productive sector.

It also expresses the sense that health is a core value that is above all a human right but that, nevertheless, is not without responsibilities.

DEVELOPMENT PROCESS

During 2011 and 2012, evaluations were undertaken of the 2002-2010 Health Plan, through quantitative methods and qualitative surveys of key experienced staff². In addition, horizontal and vertical themes to be considered were identified and objectives and indicators for the plan were defined, by a panel of experts convened for this purpose^a.

The present Plan incorporates the Basque Government's commitments to the people as set out in its Programme³.

The key contribution of the group of professionals, members of different sectors and institutions, and representatives of the third sector who participated in the design and development of the new 2013-2020 Health Plan for the Basque Country has been the specification of the Priority Areas, objectives and corresponding indicators.

^a. This panel was composed of professionals from the health sector and other departments of the Basque Government, technical specialists from the provincial and local public authorities, and representatives of the productive and third sectors.

JUSTIFICATION OF THE PERIOD OF THE PLAN

2020 is the year set by international organisations for achieving a series of health targets. Moreover, the period established, seven years, is similar to that for the previous plan and, as was the case at that time, it is considered a reasonable period to observe changes and results related to the population health objectives.

STRATEGIC ORIENTATION OF OTHER GOVERNMENTS AND OF SPECIALIST ORGANISATIONS

On 19 September 2011, the General Assembly of the United Nations adopted a declaration on the prevention and control of noncommunicable diseases⁴. This document points to cardiovascular and chronic respiratory diseases, cancer and diabetes as the most important to be tackled and recognises that these are all linked to common unhealthy behaviours: smoking, harmful use of alcohol, an unhealthy diet and a low level of physical activity. Moreover, it notes that there are risk factors that contribute to the increasing incidence and prevalence of these diseases: an uneven distribution of wealth, inadequate education, rapid urbanization, population ageing and the socioeconomic, gender, political, behavioural and environmental determinants of health. In addition, the rising levels of obesity are noted with concern, especial those among children and young people. To respond to this challenge, this declaration proposes a joint effort by society and all parts of government through collective and multi-sectoral action, at all levels of government with educational, legislative, regulatory and fiscal measures.

Following this UN declaration, the World Health Organization (WHO)⁵ adopted a global target of a 25% reduction in premature mortality due to noncommunicable diseases by 2025. Worldwide, many different professional organisations⁶ have backed this target and developed specific goals related to tobacco, alcohol, sedentarism, obesity, high blood pressure and dietary intake of fats, sugars and salt.

In 2005, the WHO created a Commission on Social Determinants of Health to collect scientific data on measures and interventions that favour equity in health. Its final report⁷ set the challenge of eliminating health inequity in a generation. In the 2011 Rio Political Declaration, the organisation expressed its determination to achieve social and health equity, calling on all nations to commit to global action: “all for equity” and “health for all”⁸.

In 2012, the 53 member countries of the WHO Regional Office for Europe adopted an agreement on a new common framework, -“*Health 2020: a European policy framework supporting action across government and society for health and well-being*”⁹-, in which they invited and encouraged all national, regional and local governments of the region to work to significantly improve the health and well-being of their populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality,

In 2007, the Commission of the European Communities adopted a new health strategy, “*Together for Health: A Strategic Approach for the EU 2008-2013*”¹⁰. Its core principles are:

1. A strategy based on shared health values (universality, high quality care, equity, solidarity, citizen empowerment and reducing health inequities)
2. Health is the greatest wealth

3. Health in All Policies (a term coined during the Finnish Presidency of the EU)

4. Strengthening the EU's voice in global health.

For the period 2014-2020, the European Parliament and Council have approved the regulation establishing the Health for Growth Programme¹¹. Its general objectives include: to foster innovation in healthcare and increase the sustainability of health systems; enable EU citizens to live in good health for longer; and protect the population against cross-border threats to health.

The Spanish Minister of Health, in tune with all these initiatives, set up a commission to reduce health inequalities¹²; and, during the 2010 Spanish Presidency of the EU, identified "Innovation in public health: monitoring social determinants of health and reduction of inequalities in health" as a priority.

STRUCTURE OF THE 2013-2020 HEALTH PLAN

The plan is structured around the following sections:

CONCEPTUAL FRAMEWORK

We first examine what is meant by health in the context of our society and the relations and interdependency between the health of individuals and the physical and social environment in which they are born, live, work and interact. Then, we set out the guiding premise of the plan: good governance is needed both OF and FOR health.

UNDERLYING PRINCIPLES

These are the guiding principles of the Basque health system, as well as the programmatic principles for its organisation and operation, as already established in the Basque Healthcare Standards Act.

CURRENT SITUATION

First, we review the main conclusions of the evaluation of the 2002-2010 Health Plan. We then describe the current situation regarding health and its determinants, moving on to consider the health status of the population in the Basque Country and the role played by the healthcare services. Lastly, we outline the challenges and opportunities that arise under the 2013-2020 Health Plan.

PRIORITY AREAS

Priority areas, with their corresponding objectives and indicators, clearly represent the core of this new health plan.

IMPLEMENTATION AND MONITORING

In this section, we indicate the organisational structure required to carry the plan forward, as well as the strategies and tools required for its coordination and the monitoring and evaluation of its effects.

APPENDICES

The Appendices complement the basic components in the earlier sections, presenting the glossary of terms and the references.

2.

CONCEPTUAL FRAMEWORK

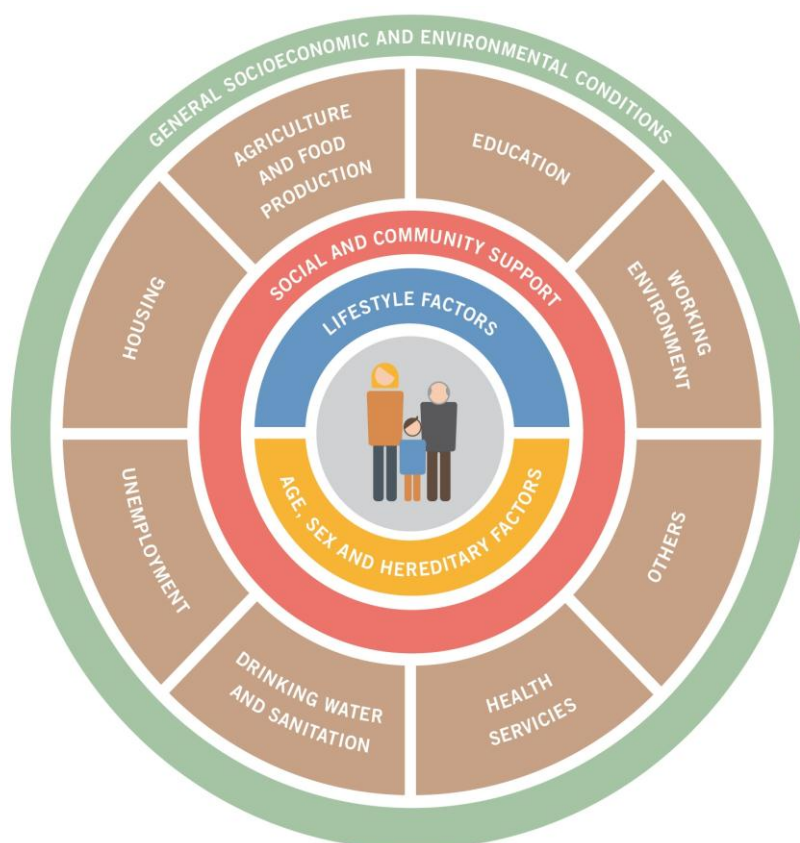
Health is, without doubt, one of the assets most valued by us all; in fact, good health is what enables us to dedicate ourselves to our aims and objectives in life with full energy and successfully develop our potential¹³. Likewise, poor health places restrictions on us, limiting our capacity to be and remain fully active.

Further, health is a major macroeconomic factor. It is a human right, a vital component of well-being, a global public asset and a key element of social justice and equity¹⁴. Meanwhile, ill health, entails high social costs, increases healthcare costs and affects healthcare

systems, generating demand for services and being a drain on resources.

The Basque Government has been and is sensitive to the interest in and growing evidence of social determinants of health. This concept, recognised since the 19th century, re-emerged strongly at the end of the 20th century. Indeed, a framework for the concept was already included by the Basque Department of Health in the definition of the plan for the 2002-2010 period (Figure 1).

Figure 1.
Model of
the social
determinants
of health

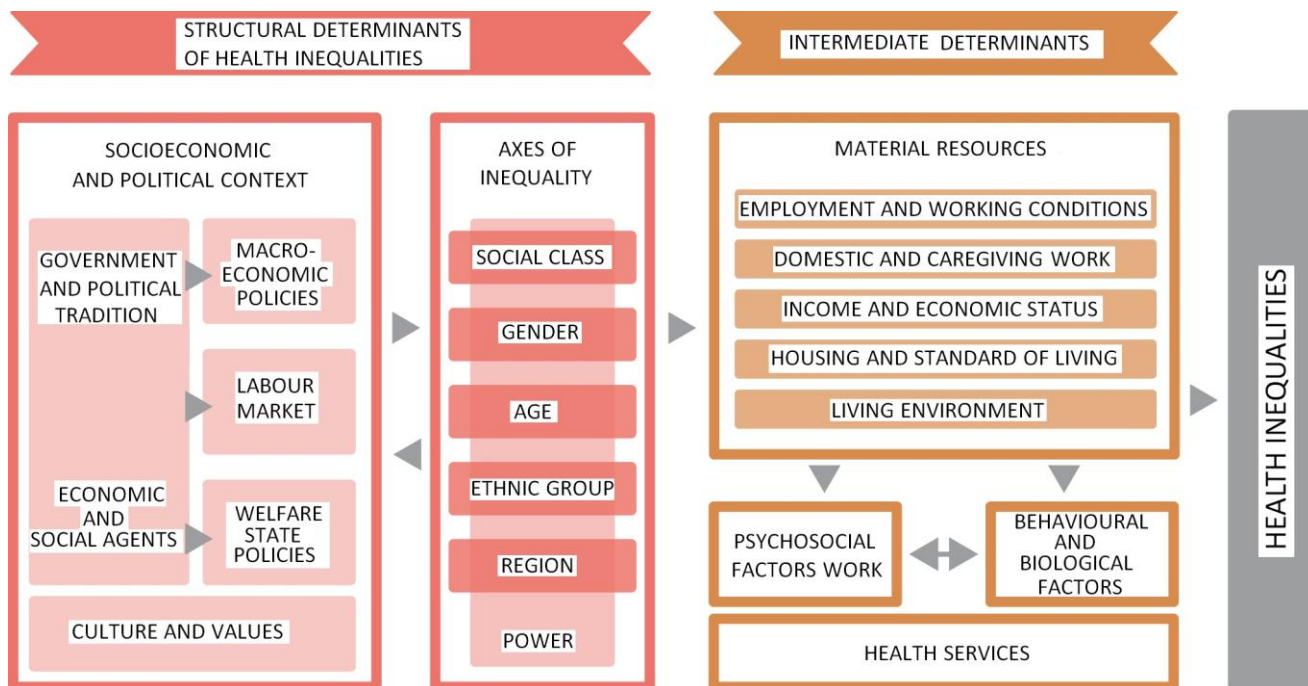


Source: Adapted from Dahlgren G, Whitehead M, 1991.¹⁵

Still valid two decades after it was developed, this model broadens the perspective beyond biomedicine, considering the impact of social determinants of health, in addition to individual genetic and biological factors. As illustrated in Figure 1, multiple factors are understood as concentric spheres of influence, acting inwards towards the centre. That is, general socioeconomic and environmental conditions influence living and working conditions that depend on access to basic services and resources; in turn, these factors influence community and social support, lifestyle and, finally, family and individual factors.

The Health Plan is based on recognition of a reality: the level of health of a population (its overall health) is closely related to the distribution of health across social groups. The level of health and health equity are two sides of the same coin. The Health Plan establishes objectives and strategies for improving health considering, at the same time and with the same priority, both the level of health and equity in health (where social inequities in health are understood as avoidable and unjust systematic differences between social groups by gender, social class, place of residence, country of origin, disability, or type of work or employment conditions)⁷.

Figure 2.
Conceptual framework for the
social determinants of health



Source: A proposal of policies and interventions to reduce social inequalities in health in Spain (adapted from Solar and Irwin, and Navarro)¹²

Structural determinants of health inequities (Figure 2) include factors related to the socioeconomic and political context that cannot be measured at the level of the individual, but rather depend on the characteristics of the social structure of a society. We are then dealing with the political tradition of governments and their macroeconomic and social policies concerning the labour market, housing, education and social welfare. We also need to consider the prevailing systems of governance, social values and cultural norms in the society as well as the collective value given to health. All of these contextual factors have a powerful influence on the patterns of social stratification that create and maintain social hierarchy and determine the social position individuals occupy according to their socioeconomic status, gender, level of education, place

of birth and other axes of social inequality.

This unequal social position, in turn, leads to inequalities in the distribution of intermediate determinants. These are the factors that underlie the relationship between structural determinants and health, namely, living and working conditions, psychosocial factors, including the extent and quality of social networks, stress and perceived control over one's life; and behaviours related to health, such as alcohol use, smoking, diet and participation in physical exercise.

Health systems also play a role in the creation of social inequalities in health as, even in places with free universal coverage, individuals with lower socioeconomic status face greater barriers to accessing healthcare.

NATURE OF THE INTERVENTIONS PROPOSED IN THE BASQUE HEALTH PLAN

The interventions may be targeted to individuals or structural in nature depending on the factors identified to be underlying the issue to be addressed. Interventions targeting individuals recognise personal independence as an essential factor for understanding why people do (or do not) choose to adopt healthy lifestyles. Structural interventions, on the other hand, consider the influence of individuals' physical, social and economic environments on these decisions and, hence, are focused on modifying these environments to encourage healthy choices^{16/17}. An effective anti-smoking strategy therefore includes interventions that are *individual-based* (such as advice on smoking, cessation treatments and health education) and others that are *structural* (legislative measures, taxation and modification of living conditions).

Interventions based on population-based strategies seek to address the causes of inequalities (structural determinants). These often determine individual risk factors.

Strategies targeting individuals, based on the provision of information and advice, are mostly implemented by healthcare services.

This Health Plan combines population and individual-based interventions to be carried out both by the health sector and other relevant sectors.

As in other regions/countries, there are substantial social inequalities in health in the Basque Country^{18/19/20}. Reducing these inequalities will therefore be a highly efficient way to improve the level of health in our region.

The growing prevalence of chronic illnesses, attributable to factors external to healthcare - such as, people's physical environment and the strength of their relationships with people around them -, have far-reaching implications for the sustainability of healthcare systems, making it essential that there is inter-sectoral action to tackle the challenge of chronicity.

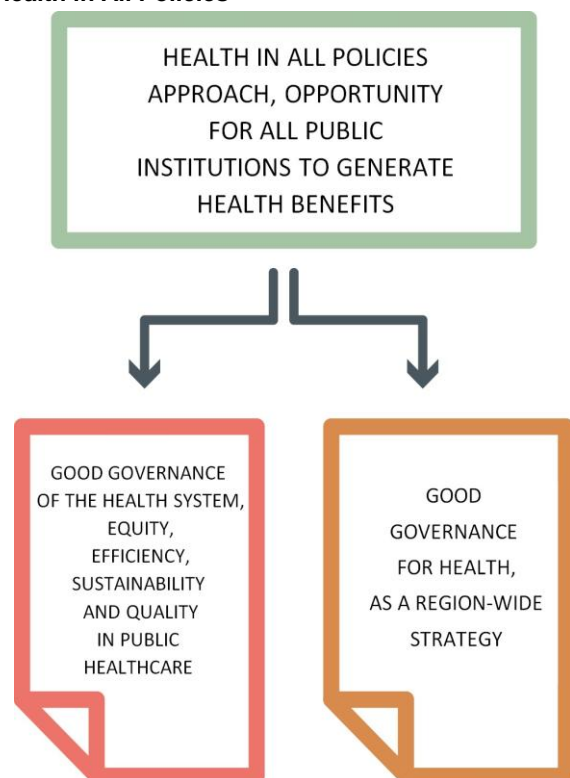
This framework for understanding the dimensions and factors underlying health goes beyond the traditional organisational approach focused on healthcare and public health. To achieve good management of health and of the well-being of the population we need to tackle the parallel challenges of:

- Governance OF health: strengthening the healthcare system in terms of equity, quality, efficiency and sustainability

- Governance FOR health: promoting cross-sectoral and inter-sectoral approaches in public administration, and the productive and third sectors. That is, combining the efforts of governments and other players with the goal of creating health as a vital factor in the well-being of the population¹⁴.

Management of the good health of the population requires strong leadership by the Basque Government through the Department of Health, with an organisational proposal for all institutions and society as a whole. This is what is known as Health in All Policies (HiAP)²¹ (Figure 3).

Figure 3.
Health in All Policies



Source: Own elaboration

HiAP is a focus applied to all public policies that systematically takes into account the implications for health of decisions adopted in diverse sectors. Further, it seeks to strengthen synergies and avoid potentially

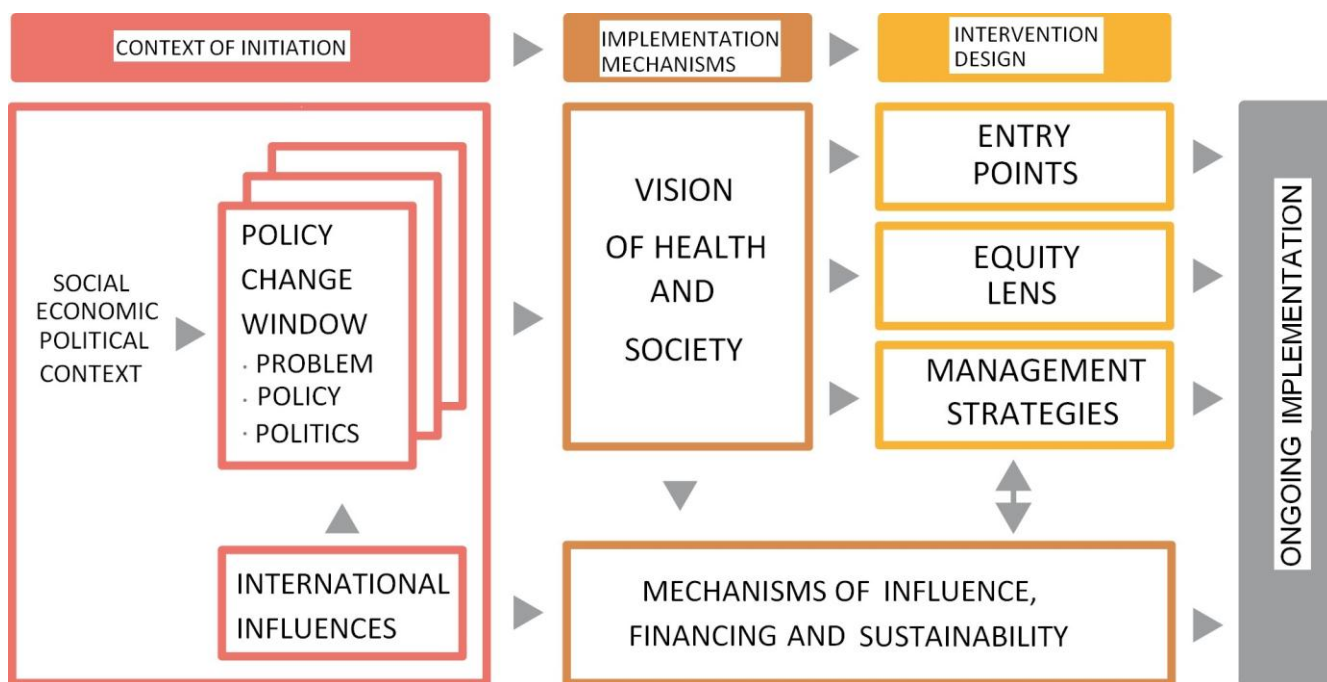
negative impacts, improving health and increasing equity²². (Figure 4)

Good governance, an ongoing concern of this and previous governments of the Basque Country, is increasingly emphasized in international fora^{23/24}. We understand good governance to be the process of cooperation, coordination and integration of agents, tools and programmes, in the spirit of non-competitive collaboration, subject to systematic structured rules and focused on improving efficiency, influencing the main determinants of health and seeking increased equity.

Good governance in local health structures is grounded in efficiency, healthcare improvement and a population approach in the local setting. The corresponding activities include:

- Interventions to improve clinical healthcare, progressively prioritising continuity of care planning at different levels of care, both between these levels and with social services.
- Population health interventions. Local health structures are not only healthcare orientated; they also have responsibilities for population health that require the integration of their services with other local agents (involved in education, healthy eating and physical activity promotion, and health inequality reduction), with mechanisms and procedures to strengthen civic engagement and utilise community health assets.
- Interventions focused on identifying efficiency improvement opportunities, eliminating duplicity and effectively combining services of different local agents.

Figure 4.
Conceptual framework for implementing the Health in All Policies approach



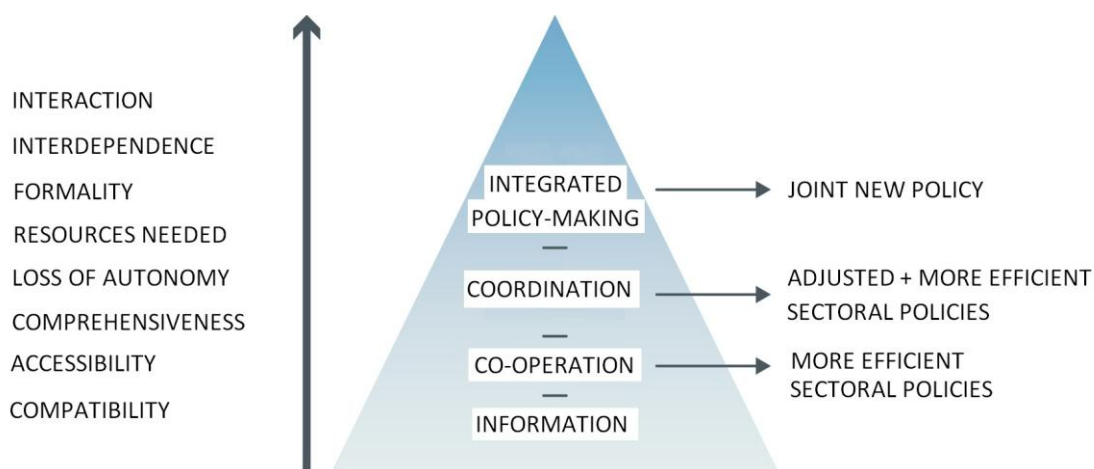
Source: Shankardass, Solar et al. 2011²⁵

Good governance OF the health system by the Department of Health and the Basque Health Service (*Osakidetza*) is achieved through the training of staff and this new way of working and managing health.

Good governance FOR health in the activities of public institutions is none other than the implementation

of this new HiAP approach. The ultimate goal is to improve the effectiveness and efficiency of public policies in terms of equity, well-being and health. (Figure 5)

Figure 5.
Pyramid for inter-sectoral action.
Integrated policy-making, policy
coordination and cooperation



Source: Adapted from Meijers and Stead, 2004²⁶

BASQUE GOVERNMENT PLANS AND THEIR IMPACT ON HEALTH

In line with the aforementioned considerations, to create a health plan that is a genuinely effective tool for improving the well-being of the population of the Basque Country, it is necessary to identify all policies envisioned

in the government plans for the period 2012-2016 (the 10th parliamentary term), that have a direct bearing on health. These are listed in the following table.

GOVERNMENT PLANS	DEPARTMENT
VI Plan for Gender Equality	Office of the Basque Prime Minister (<i>Lehendakaritza</i>)
2015 Plan for Science, Technology and Innovation	Economic Development and Competitiveness
	Education, Language Policy and Culture
2011-2014 Strategic Plan for Social Services	Employment and Social Policies
IV Environmental Framework Programme (2011-2014)	Environment and Territorial Policy
2014-2016 Basque Strategy for Public Innovation	Public Administration and Justice
Plan for the Basque Language (<i>Euskera</i>)	Education, Language Policy and Culture
2013-2020 Health Plan	Health

GOVERNMENT PLANS	DEPARTMENT
Health and Social Care Action Plan for Young People	Health
	Education, Language Policy and Culture
Programme for Health and Social Care for Older People	Health
	Employment and Social Policies
Plan for Addiction	Health
2020 Strategic plan for Physical Activity	Health
	Education, Language Policy and Culture
Educational Lesiure Plan for Adolescents	Education, Language Policy and Culture
	Health
Inter-Agency Plan for Family Support	Employment and Social Policies
Inter- Agency Plan for Social Inclusion	Employment and Social Policies
IV Plan for Immigration, Citizenship and Intercultural Coexistence	Employment and Social Policies
III Plan for Young People	Education, Language Policy and Culture
Plan for Sports for Young People	Education, Language Policy and Culture
Strategic Plan for Road Safety	Security
Civil Protection Plan	Security
Programme to Support Urban Rehabilitation and Regeneration	Employment and Social Policies
Master Plan for Sustainable Transport	Environment and Territorial Policy
Plan for Contaminated Soils	Environment and Territorial Policy
Water Management Plan	Environment and Territorial Policy
Strategic Plan for the Food Industry	Economic Development and Competitiveness
Plan for Employment	Employment and Social Policies
Occupational Health and Safety Strategy	Employment and Social Policies

GOVERNMENT PLANS	DEPARTMENT
Comprehensive Plan for Seasonal Work	Employment and Social Policies
	Economic Development and Competitiveness
Basque Retail Business Plan	Economic Development and Competitiveness
Comprehensive Plan for Agricultural Support	Economic Development and Competitiveness
2014-2017 Basque Plan for Statistics	<i>Eustat</i>

In turn, this exercise of identifying Basque Government policies with implications for health highlighted the need for an effort to coordinate and connect all these strategies and monitor them, given their potential impact on health.

Another of the foundations of this plan is civic engagement; this is already provided for in the programmatic principles of the Basque Healthcare Standards Act and is set out in detail in, for example, guidelines on the involvement of the community in an advisory role, contributing to the formulation of plans and to the monitoring and evaluation of results.

To promote civic engagement, this new Basque Health Plan sets objectives ranging from the provision of information, consultation and participation to the

empowerment of individuals, in order that members of the public become actively involved in the definition, organisation and improvement of health services, shifting away from the paternalistic concept of people as mere recipients.

In this way, people (both individuals and the community) are placed at the centre of the HiAP strategy, and likewise at the centre of the system itself. Emphasis is placed on strengthening people's capacity to take on responsibility for and make decisions about their own health and illnesses. Frameworks and tools are introduced for collaboration with patients' associations and the third sector; and channels are established for wider participation in the definition, organisation and improvement of health services.

3.

UNDERLYING PRINCIPLES

Keeping people at the heart of all policies and health improvement as the main goal and absolute priority, the 2013-2020 Basque Health Plan is based on a series of key principles that pervade all the strategies, actions and policies that it specifies and considers.

All these principles stem from the Healthcare Standards Act (*Ley de Ordenación Sanitaria 8/1997*) itself, the regulatory framework and route to be followed by this plan, prioritising the promotion of health and ensuring the sustainability of a high-quality Basque public health system.

Below, we list the principles underlying the 2013-2020 Basque Health Plan, with a brief indication of their characteristics and relevance in the context of this roadmap that is to guide institutional and social action in the Autonomous Region of the Basque Country in the field of health.

UNIVERSALITY

- Universal access to high-quality healthcare services, health protection and promotion, and illness prevention for everyone who lives in the Basque Country.

SOLIDARITY

- High-quality health provision for all everyone regardless of their economic means.
- The establishment of systems in the health sector for accountability to society.
- Co-responsibility of institutions and the population in relation to their mutual responsibility concerning health determinants and health-related behaviours.

EQUITY

- Lack of systematic and potentially avoidable differences in health and illness between population groups defined in social, economic, demographic or geographic terms. The achievement of equity in health implies that everyone has the same opportunity to reach their full health potential, regardless of their social circumstances (social position, gender, place of residence, type of work, income, level of education and country of origin).
- Emphasis on increasing equity in access to, use of and quality of care received from health services at all levels.
- Support for healthcare equity as part of a commitment to social justice.

QUALITY OF HEALTH SERVICES

- An endeavour to humanise care in the services provided to the population.
- Coordination between care levels
- Collaborative approaches at the micro level, local networks of organisations with healthcare and social responsibilities; and at the strategic level, corporate social responsibility.
- Promotion of research aiming to improve population health and guide the provision of health services. Development and innovation, fostering knowledge sharing between professionals.
- Efficiency in care processes, combined with clinical safety as a key element.

CIVIC ENGAGEMENT

- Participation of organisations of civil society in setting and implementing the health agenda.
- Promotion of self-help and personal responsibility.

SUSTAINABILITY

- Greater efficiency of the sector through the use of integrated care and public health models.
- Coordination between care levels and also of social services with other sectors.

4.

CURRENT SITUATION

EVALUATION OF 2002-2010 HEALTH PLAN

The main conclusions of the 2002-2010 Health Plan are the following:

- Life expectancy at birth has continued to increase, in both men and women, but differences between social groups have widened in women.
- Mortality has fallen among young people and overall due to external causes of death.
- Infant mortality has continued to fall.
- Prevalence rates of smoking and exposure to tobacco smoke have decreased, as has the consumption of illegal drugs.
- Differences in smoking between social groups have increased.

- The prevalence of regular alcohol use has increased.
- The prevalence of type 2 diabetes in over 64-year-olds has increased, especially in men.
- The prevalence of obesity and related illnesses has increased.
- Mortality due to cardiovascular diseases has declined, though it continues to be a leading cause of mortality, and social inequalities therein have grown in both men and women.
- Overall cancer mortality has fallen, as has mortality due to lung cancer in men and breast cancer in women; in contrast, lung cancer mortality has risen in women.

CURRENT STATUS OF HEALTH AND ITS DETERMINANTS

The current demographic situation in the Basque Country continues to follow the demographic trends that began at the turn of the century, namely, an increase in the population, a balance between births and deaths and a positive migration balance. Demographic projections made by *Eustat* for 2020 continue to show population growth but at a slower rate, and ongoing population ageing: over-64-year-olds are expected to represent 22.5% of the population by 2020, as a consequence of the increase in life expectancy at birth and the decrease in fertility, with a progressive increase in the mean age at childbearing.

Economic activity in the Basque Country underwent a long period of growth from the mid-1990s to around 2007, when the severity of the underlying economic situation began to become apparent and the current crisis began. In that year, we started to observe large year-on-year falls in GDP, in parallel with what was happening in the rest of Spain and across the EU. At the same time, unemployment rates started to increase, reaching 11.7% for women and 12.5% for men by 2012, according to

Eustat. Since 2009, there has been growth in temporary (relative to permanent) contracts. The risk of poverty for the population of the Basque Country rose to 7.3% in 2012, despite the Basque system for guaranteeing a basic income.

Some studies point to a possible weakening of social capital in the Population of the Basque Country, as the time dedicated to relationships and socialising has fallen (Time Budget Surveys, *Eustat*). However, according to the Basque Health Survey (*ESCAV*), the prevalence of women with low levels of affective social support, as measured by the Duke Social Support and Stress Scale, decreased between 2007 and 2013, while in men it remained stable. Nevertheless, it is important to consider the most disadvantaged social classes, in whom a lack of this type of support is much more common, in both men and women.

In recent years, air quality has considerably improved in the Basque Country. The percentage of days per year with acceptable or good air quality jumped from 94.6% in 2005 to 99.1% in 2010. Further, there was a marked

decrease in the number of poor quality air days in all zones, even those with the poorest results. Despite these improvements, however, in several areas in the Basque Country, PM10 levels have on some occasions exceeded the daily limit (50 µg/m³) set in current legislation.

Over the course of the last 20 years, the perception of Basque families of their physical and social environment has notably improved. In particular, the

HEALTH STATUS OF THE POPULATION OF THE BASQUE COUNTRY

Life expectancy in the Basque Country is gradually increasing in both men and women and at all ages. Though the life expectancy is higher in women (86.4 vs 79.5 years in men), men have made the greatest gains over the last decade, with an increase in life expectancy at birth of 3.7% (larger than the 2.9% increase seen in women). Since 2007, there has been a change in the trend in disability-free life-expectancy (DFLE), particularly in women. The years lived with disability (YLDs) increased from 9.1 to 10.3 in men and from 11.7 to 13.3 in women, in the period 2002-2013. The loss in observed DFLE may be explained by the prevalence of long-term limitations on activity increasing, by 10% in men and 32% in women over this period. Further, the prevalence of such limitations is higher the lower the socioeconomic status, this inequality being more marked in women than men.

In relation to self-perceived health in the Basque Country, this has improved over the last five years: 16% of men and 21% of women rated their health as average or poor in 2013, compared to 17% and 23% in 2007. Social inequalities in health have remained, however, and are particularly pronounced in women, for whom the relative index of inequality (RII) has doubled over the last decade (from 1.76 in 2002 to 2.55 in 2013), those with a lower socioeconomic status having poorer self-perceived health.

The number of people with chronic illnesses is progressively increasing in the Basque Country, as is the complexity of their conditions. It has been estimated that 38% of over-64-year-olds in the population have some type of chronic illness and that this figure is likely to double by 2040²⁷. The 2013 Basque Health Survey found even higher prevalence rates of chronic health problems (44.7% in men and 46.9% in women).

The percentage of patients with multiple conditions,

percentage of families rating the physical environment as healthy has increased (to 65.4% in 2009 from 50.8% in 1989; Survey on Living Conditions, *Eustat*).

In 2012, a satisfactory quality of drinking water was delivered to 98% of the population in the Basque Country. At the same time, the rate of food-borne infections and intoxications notified in recent years has decreased substantially, in terms of both the number of outbreaks and the number of people affected.

those who have two or more health problems and require medical care, is as high as 21% in men and 26% in women (Orueta et al., 2013)²⁸. The most common diseases are high blood pressure (18.7% in men and 19.4% in women), followed by anxiety/stress (7.3% and 14.1% respectively), diabetes mellitus (6.4% and 5.3%), joint diseases (2.3% and 5.3%), and depression (1.8% and 5.2%). The authors of this report describe a socioeconomic gradient for most health problems in both sexes, though more pronounced in women, with a higher burden of disease falling on residents of more disadvantaged areas.

The prevalence of mental health problems, specifically anxiety and depression, has substantially grown in the Basque Country (2013 Basque Health Survey), with increases of 35% in men and 40% in women between 2002 and 2013. Further, social inequalities in mental health have increased, especially in men.

Over recent years, the number of people requiring hospital admission has steadily risen. In 2011, there were 149 admissions per 1000 inhabitants, 1.6% higher than in the previous year. By broad diagnostic groups, the leading causes of morbidity were circulatory, digestive and respiratory system diseases in men, while admissions in women tended to be related to pregnancy, labour or postpartum complications, or circulatory and digestive system diseases. Specifically, the most common diagnoses on discharge were heart failure (2.6%), chronic bronchitis (2.4%) and inguinal hernia (2.3%) in men, and preterm labour (3.5%), cholelithiasis (2.4%), and heart failure (2.3%) in women.

Regarding mortality, the number of deaths has continued to grow over the last decade (increasing by 10% from 2001-2011), due to the ageing of the population. According to the Basque Mortality Register,

in 2011, cancer followed by cardiovascular disease were the leading causes of mortality, respectively accounting for 32% and 29% of all deaths; while in the case of women, cardiovascular diseases outranked cancer.

Screening programmes as a tool for prevention are widely available and have good acceptance among the population of the Basque Country. The programme for the early detection of breast cancer has good coverage, with participation by 80.66% of eligible women and 114,978 mammograms were completed in 2012. Data from the Basque Health Survey also indicate a progressive reduction in social inequalities in access to this programme. In 2008, the Basque screening programme for the early detection of colorectal cancer was launched and its coverage has steadily increased; in 2012, a total of 541,000 individuals were screened, the participation rates among 50- to 69-year-olds being 62% in men and 68% in women. In the same year, 115,008 children (65.6% and 66.2% of eligible boys and girls respectively) were seen by dentists under the Basque Child Dental Care Programme (*PADI*), with higher overall participation than the previous year (65.9% vs. 63.8% in 2011). Screening for Down's syndrome and other chromosomal abnormalities was piloted in 2009 and the following year started to be offered to all women attending the public health service for pregnancy care. It has good acceptance (being declined in less than 1% of cases), and 15,995 pregnant women participated in the programme in 2012. Lastly, neonatal screening, for the early detection of metabolic and other disorders, is offered for all infants born in the Basque Country and is rarely declined (2 cases in 2012).

The vaccination programme is one of the most important preventive interventions, especially with respect to infectious diseases. Over recent years, new vaccines (e.g., human papilloma virus) have been added

to the child vaccination schedule, and current rates of coverage are high across the series of vaccines (over 90%).

As for health-related behaviours, according to the 2013 Basque Health Survey, regular alcohol use has increased in our population in both women and men, and there is a socioeconomic gradient, in this case, in favour of the most disadvantaged (higher rates among the higher social classes). On the other hand, the prevalence of smoking has fallen, in both men and women, and there has been a marked decrease in exposure to second-hand smoke.

Data from the 2012 Survey on Drug Use in the Basque Country (*Euskadi y Drogas 2012*) indicates a significant fall in the prevalence of illegal drug use in the region, consolidating a trend observed since 2004, the year in which levels of use reached their historical peak. Nevertheless, the levels of experimental use continue to be high and, despite falls in recent years, the Basque Country continues to be among the regions/countries with the highest rates of cannabis use in the EU.

Regarding physical activity, over the last five years, the percentage of people considered sedentary has fallen by 17% in men (to 26.6% in 2013), but has not changed significantly in women (34.0% in 2013).

In the last 10 years, the situation with respect to obesity in the Basque Country has considerably worsened. The percentage of people over 16 years of age who are obese is 25% higher than in 2002. The distribution of obesity by social class shows that rates increase with decreasing socioeconomic status. However, the growth in the percentage of people who are obese in the better-off has resulted in a decrease in social inequalities in obesity.

HEALTH SERVICES

In 2009, 8.8% of GDP in the Basque Country was dedicated to health spending, with an expenditure of €2,602 per capita, which represents a substantial increase over the last decade (6.5% of GDP and €1,296 per capita in 2000). A total of 75% of this expenditure was covered by public funds (*Eustat*, Health account).

Drawing international comparisons, with OECD data for 2009, the per capita expenditure in the Basque Country was 3,658 purchasing power parity US dollars (PPP US\$), which is higher than in countries such as the United Kingdom (3,487), Finland (3,226) and Spain as a

whole (3,067), though lower than in Norway (5,352) and Switzerland (5,144), among others. Considering expenditure as a fraction of GDP, however, levels remain lower than in the most developed countries.

Performance indicators for the hospital sector show a dramatic increase in bed turnover rate, care activity per bed having almost doubled since 1986, through reductions in both mean length of all stays and of surgical stays. The mean hospital stay after surgery has decreased from 10.1 to 3.7 days between 1989 and 2009. It is clear that the alternatives to conventional inpatient care developed since the start of the 1990s, such as hospital at home schemes and short-stay units,

are in large part responsible for this decrease.

As for patient clinical safety, the prevalence of nosocomial infections in Basque Health Service hospitals was 6.4% in 2012, all of the organisations having current safety plans. Moreover, a corporate system for the notification of adverse effects is being rolled out to facilitate learning from experience and thereby enhance service user safety.

Surgical waiting lists in Basque Health Service organisations resulted in a mean waiting time of 52.1 days, 16% of patients awaiting treatment for more than three months. The mean duration of consultations was 9.6 minutes in primary care overall, being 10.6 minutes in the case of paediatric appointments.

In satisfaction surveys in 2012, overall care in Basque Health Service centres was rated very highly (excellent, very good or good) by 95% of users surveyed, with respect to primary care, outpatient appointments, hospital emergency services, and hospitalisation in general. According to the 2011 National Health Survey of the Spanish Ministry of Health, Social Services and Equality, 27% of the population in the Basque Country believes that the health system works fairly well and 54% that it works well but needs changes.

CHALLENGES AND OPPORTUNITIES FOR THE HEALTH PLAN

This health plan targets over 2 million people, and its final objective is to improve the health and well-being of all this population. As described above, the Basque Country is in a good starting position, with a high-quality health system that is well regarded by the population it serves, as well as good levels of health.

In this context, the challenges and opportunities the Health Plan should take up concern:

- Reaching an inter-agency commitment to ensure that health and health equity are adopted as shared goals across the government and other institutions.
- Reducing social and gender inequalities, even with the precarious situations created for many by the current economic crisis and associated risk of poverty.
- Ensuring that we maintain a health system that is of high quality and universal, by strengthening the level

of care that is least complex and closest to the home, in particular, primary care, to ensure access to care and minimise health inequities.

- Adapt the health system, improving quality and efficiency, to tackle the growing burden associated with multiple and chronic conditions, with person-focused comprehensive, integrated care throughout the health system, based on coordination and collaboration across all levels of care.
- Strengthen and consolidate intensive and/or long-term health and social care, setting up mechanisms and procedures to support coordination between the healthcare and social care sectors.
- Promote healthy environments and behaviours, through community projects, preferably carried out in the local setting with collaboration between different sectors.

5.

PRIORITY AREAS

- OBJECTIVES

- ACTIONS

- INDICATORS

In preparing the Health Plan, great efforts have been made to ensure that the proposals are both progressive and coherent between Areas, as well as with the objectives and indicators. The Technical Coordinating Committee played a key role in ensuring this coherence.

It should be underlined in this introduction that some specific objectives relate to issues that lie within the competence of other Departments of the Basque Government, as well as that of local authorities (provincial and city/town councils), and the third sector.

This section is structured around five Areas, each with its own set of objectives, actions and indicators. Areas 1 and 5 are horizontal themes, while Areas 2 to 4 focus on specific groups in the population.

FIRST AREA: *To include health and health equity in all public policies and strengthen the Basque health system, in terms of equity and quality.* Objectives and specific horizontal mechanisms are established to put health on the agendas of other sectors and institutions with the goal of maximising health equity. In addition, channels for real effective public participation are to be strengthened and the requirements for good governance for health defined.

SECOND AREA: *To intervene at the population level*

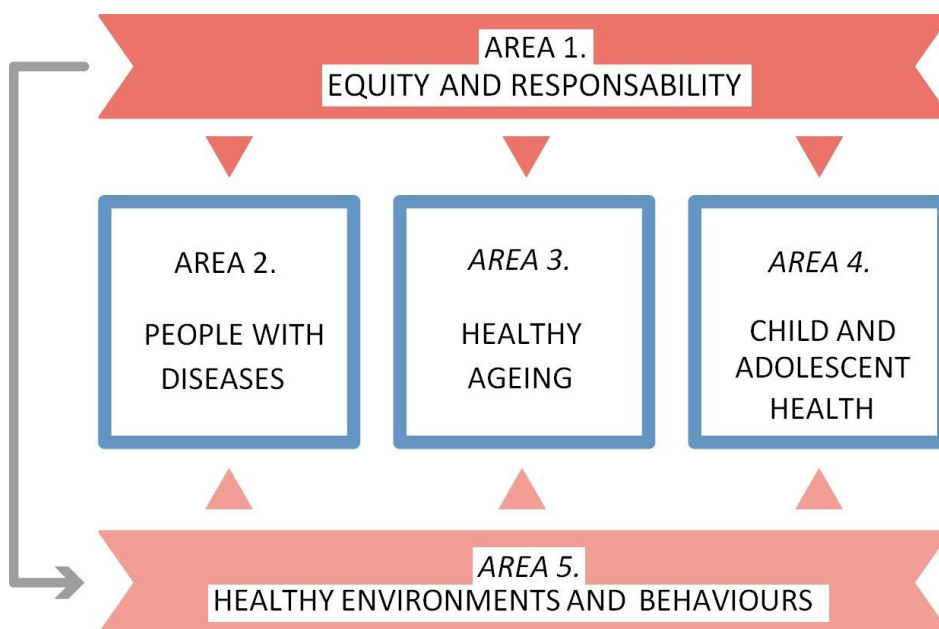
to decrease morbidity and mortality as well as maximise patient independence in diseases with the greatest impact on the population. Objectives and actions are identified for care processes, with a holistic view, chronic patient management (chronicity and loss of independence), the rational use of medications and deprescribing, clinical safety and end-of-life care. Specific objectives are formulated for the most important health problems.

THIRD AREA: *To promote healthy ageing.* Active ageing is to be supported with interventions focused on maintaining individuals' independence. Mechanisms are proposed for comprehensive patient assessment, interdisciplinary management, and ICT training, as well as encouraging volunteering and enabling people to remaining in their own communities.

FOURTH AREA: *To improve the living conditions and health opportunities for children and young people.* Steps are to be taken to ensure that children and young people have the tools they need to make healthy and safe decisions.

FIFTH AREA: *To enhance the environment and healthy lifestyles through inter-sectoral collaboration and work at the local and community levels* (Figure 6).

Figure 6.
Linkages between and integration of the Areas



Source: Own elaboration

5.1.

PRIORITY AREA 1: EQUITY AND RESPONSIBILITY

INCLUDE HEALTH AND HEALTH EQUITY IN ALL PUBLIC POLICIES AND STRENGTHEN THE BASQUE HEALTH SYSTEM, IN TERMS OF EQUITY AND QUALITY

GOAL: TO REDUCE SOCIAL AND GENDER-BASED HEALTH INEQUITIES IN THE POPULATION OF THE BASQUE COUNTRY, IMPROVING THE SITUATION OF THE MOST DISADVANTAGED GROUPS

Life expectancy continues to progressively increase in the Basque Country. However, the achievements in terms of health outcomes have not benefited all social groups equally. Hence, there are social inequities in health, characterised as avoidable and unjust differences in health between groups defined socially, economically, demographically or geographically²⁹.

The factors that determine health are multiple and complex. Approaches based exclusively on healthcare have shown to be insufficient, being unable to maximise health and promote health equity. Indeed, factors that depend on sectoral actions undertaken outside the health sector play an important role in community health. This highlights the need for HiAP and for combining individual health actions, which are primarily the focus health service activity, with actions at the population level, aiming to modify the "causes of the causes" associated with health and illness. Both approaches are necessary and are complementary to promote health and prevent illness in our region. This perspective underlies the actions in this Area, aiming to reduce health inequities in the population of the Basque Country.

MAGNITUDE AND DISTRIBUTION OF SOCIAL INEQUITIES IN HEALTH

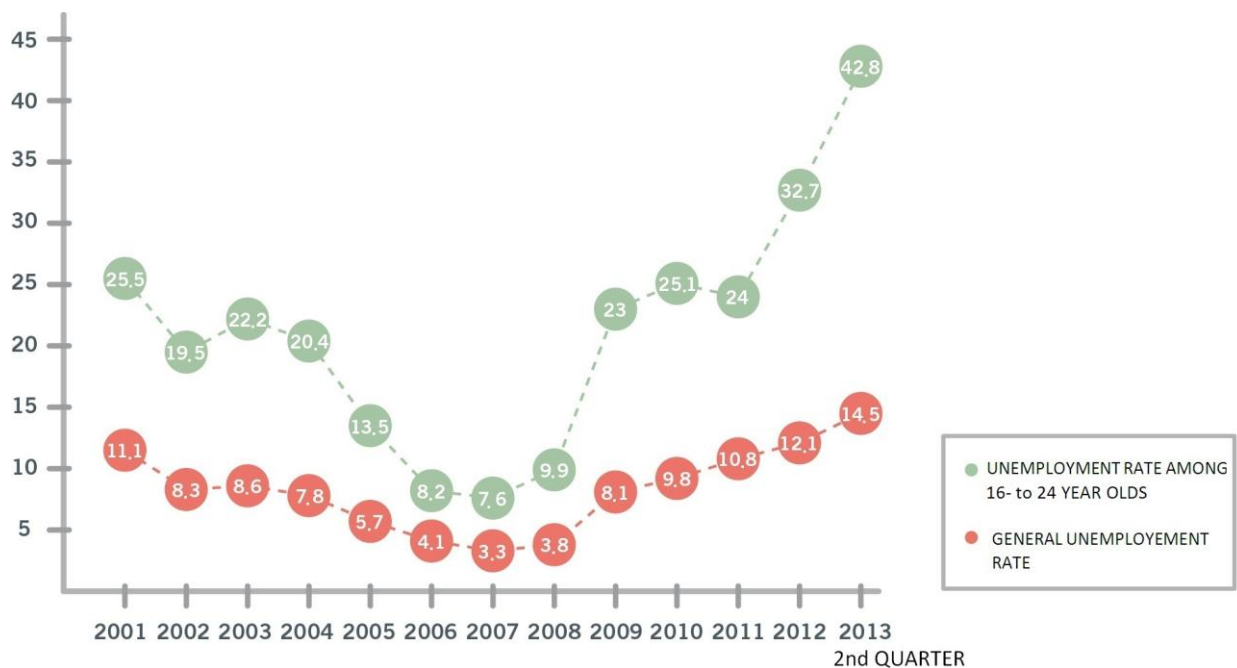
SOCIAL DEPRIVATION AND HEALTH

The economic and material resources of families and households are among the most important social determinants of health and quality of life. The current economic crisis means a growth in the number of people in a precarious situation and at risk of poverty associated with living on a low income; at the same time, it may be a threat to the standards of health and welfare achieved in recent years in the Basque Country.

According to the Survey on Poverty and Social Inequalities³⁰, the economic crisis has translated to an increase in the risk of poverty in the period 2008-2012 (from 4.1 to 7.3%), exacerbating the position of the least well-off and highlighting some of the most severe consequences of existing inequalities. These include an increase in the number of households with severe food insecurity, from 2.1% in 2008 to 3.1% in 2012.

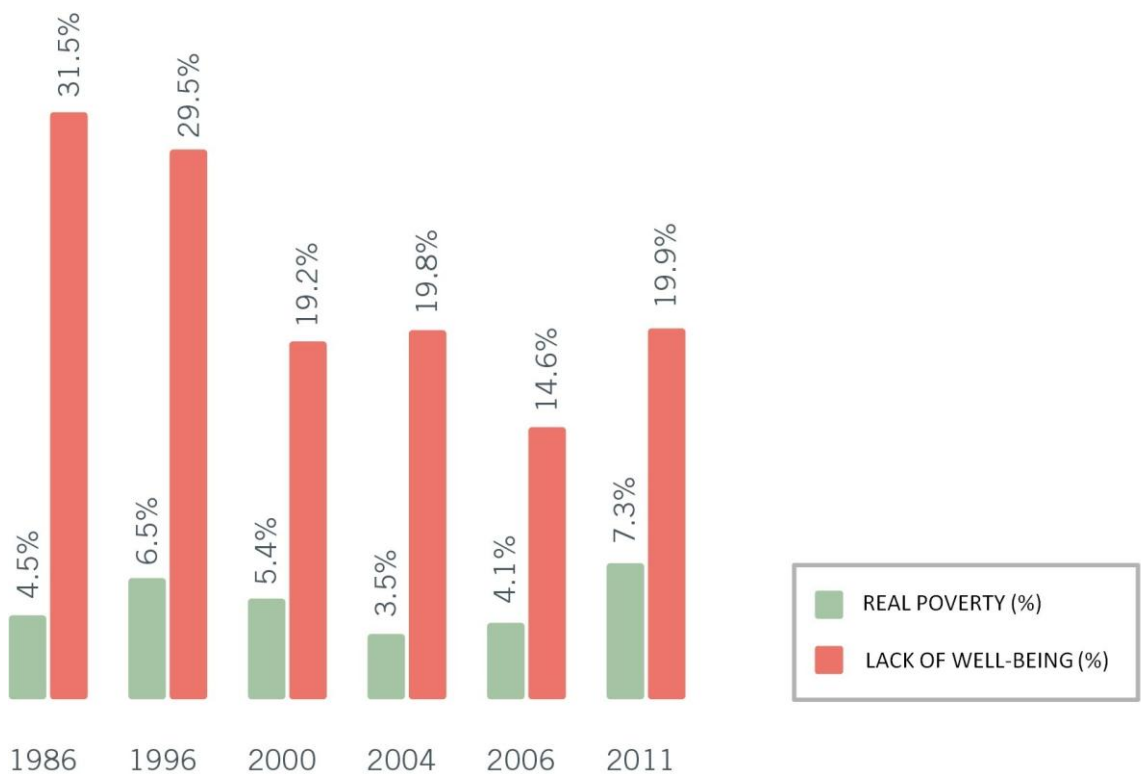
Poverty increases in parallel with rising unemployment. Employment status, employment quality and, in particular, lack of employment are also factors that have an impact on health. After more than 15 years in which unemployment rates fell, the last five years have seen an increase in unemployment and a worsening of working conditions. These trends, as well as having an impact at the personal, family and social levels, increase people's risk of becoming ill and of dying prematurely, as well as increasing the risk of health inequities (Graphs 1 and 2).

Graph 1. Rate of unemployment in the Basque Country, 2001-2013



Source: Eustat, Survey on the Population in Relation to Activity³¹

Graph 2. Poverty and lack of social well-being in the Basque Country, 1986-2012



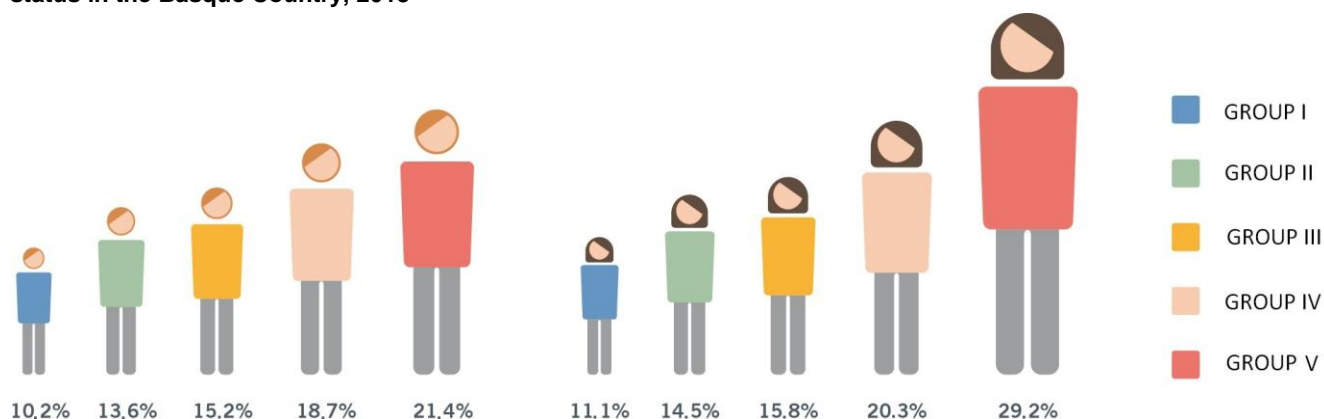
Source: Department of Employment and Social Policy. Survey on Poverty and Social Inequalities³⁰

INEQUITIES IN SELF-PERCEIVED HEALTH, DISABILITY AND LIFE EXPECTANCY

Self-perceived health is a measure of how individuals rate their own health and has been recognised to be a good predictor of morbidity and mortality at the population level.

Data from the 2013 Basque Health Survey indicate that both men and women from the lowest social class have a higher prevalence of poor self-perceived health, the differences being greater in women (Graph 3).

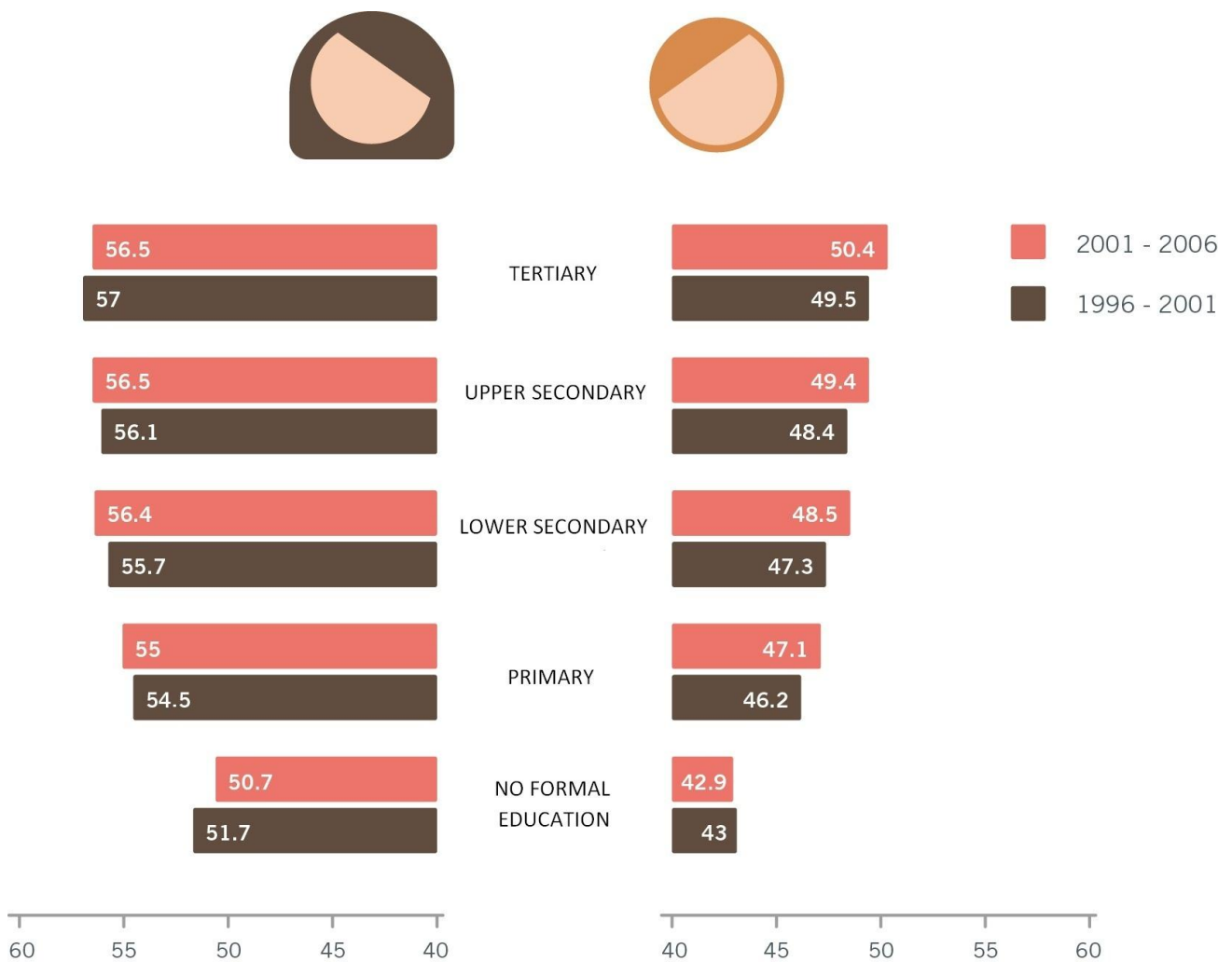
Graph 3.
Age-standardised prevalence of poor self-perceived health by sex and socioeconomic status in the Basque Country, 2013



Source: 2013 Basque Health Survey

Life expectancy at the age of 30 years is higher in women than men and in those with higher levels of education, and it has increased between 1996-2001 and 2001-2006. In this latter period, the magnitude of the inequity, namely the gap in life expectancy, at this age between those with no formal education and those with university qualifications was 7.6 years in men and 5.8 years in women, greater than it had been in 1996-2001 period (6.5 years in men and 5.3 years in women) (Graph 4).

Graph 4.
Changes in life expectancy at the age of 30 by age and level of education in the Basque Country, 1996-2001 and 2001-2006

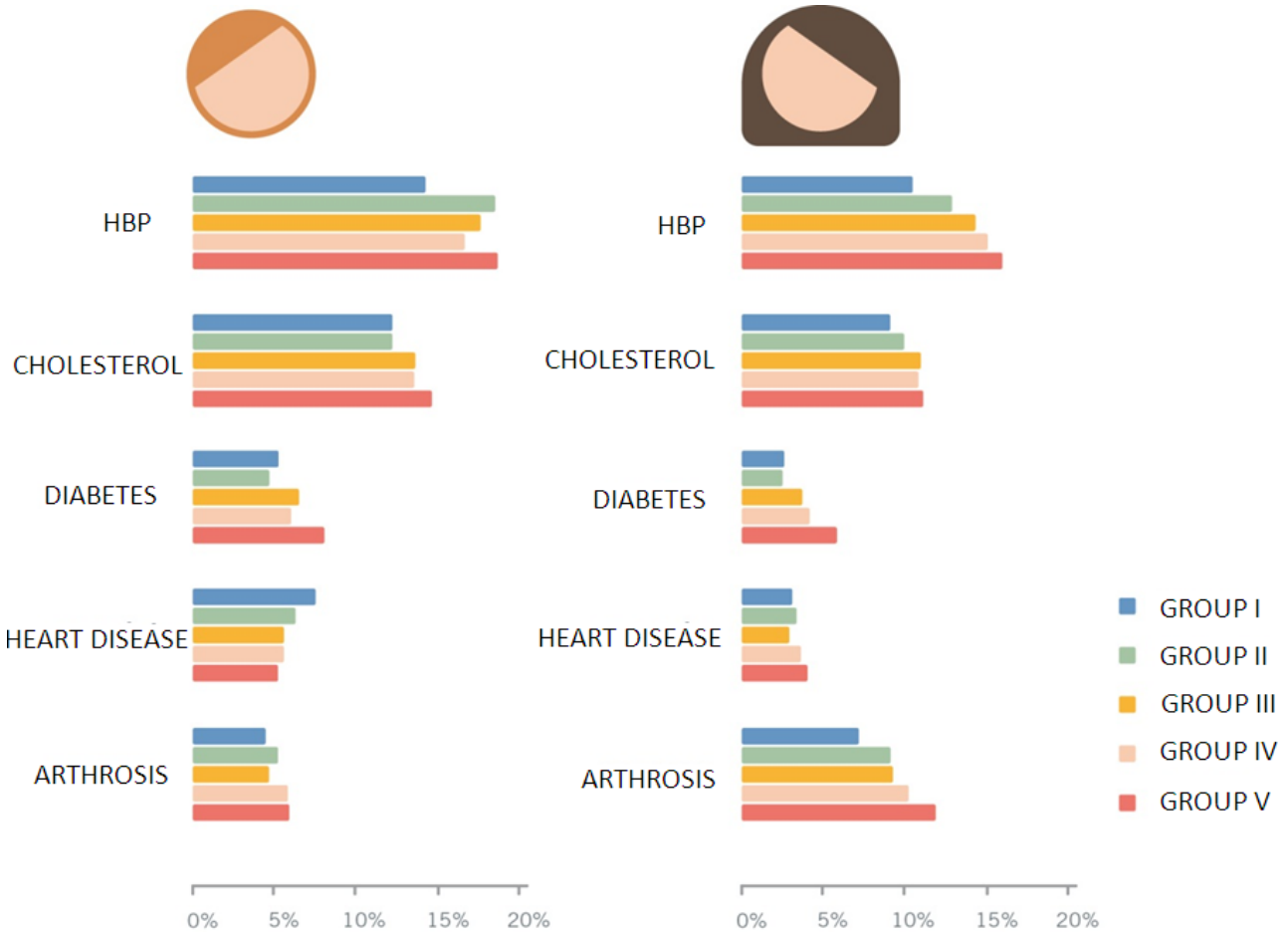


Source: Service for Health Research [OSAGIM]³²

INEQUITIES IN MORBIDITY

In the 2013 Basque Health Survey, the prevalence rates of the most common chronic problems in the population indicated socioeconomic inequities in men in high blood pressure, cholesterol-related problems, arthrosis and diabetes, their prevalence increasing with each step down the social ladder. In women, there was also a clear socioeconomic gradient in inequalities in the main chronic problems, with the same pattern of inequity as seen in men (Graph 5).

Graph 5.
Age-standardised prevalence rates of chronic health problems by sex and socioeconomic status in the Basque Country, 2013



Source: 2013 Basque Health Survey

INEQUITIES IN LIFESTYLES

Social inequities in health can also be analysed in terms of lifestyles. For example, between 1997 and 2003, there was a strong trend towards smoking cessation in the better-off. In 2013, the prevalence of smoking increased with each step down the socioeconomic ladder, especially in the 15- to 44-year-olds: in this age group, 19% of males and 17% of females were regular smokers in the least disadvantaged, compared to 30% of males and 29% of females in the most disadvantaged group (Graph 6). Since 2002, these inequalities have decreased in men but not in women.

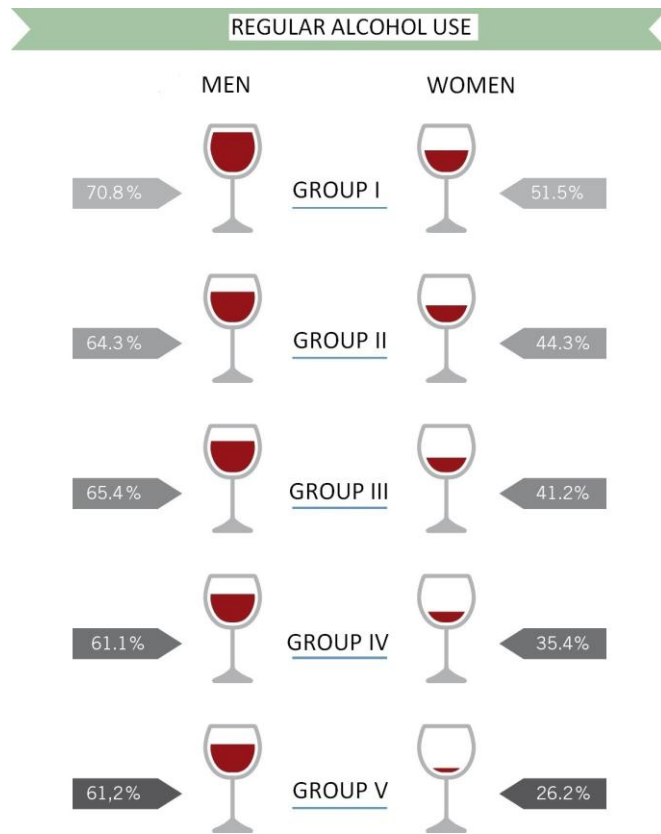
Graph 6.
Age-standardised prevalence of smoking
in 15- to 44-year-olds by sex and
social class in the Basque Country, 2013



Source: 2013 Basque Health Survey

Regarding alcohol, regular use is directly correlated with socioeconomic status: the higher the social class, the greater the use of alcohol, the same pattern of inequity being present in both sexes (Graph 7).

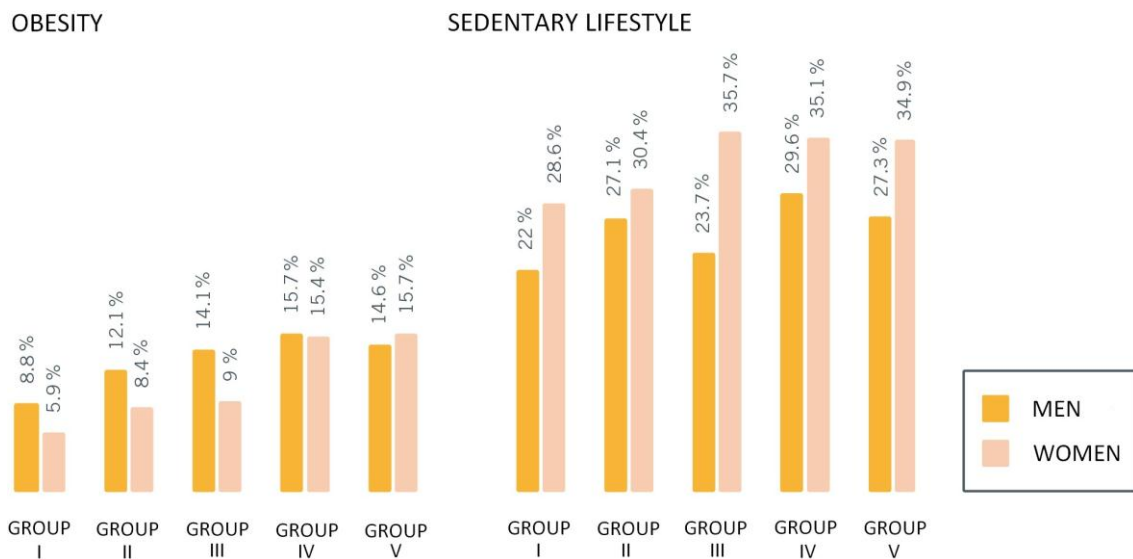
Graph 7.
Age-standardised prevalence
of alcohol use by sex and social
class in the Basque Country, 2013



Source: 2013 Basque Health Survey

In the case of obesity, inequities observed in 1997 have remained, the differences being more marked among women. Concerning physical activity, inequities have narrowed over the same period, the prevalence of sedentary behaviour decreasing overall but more in the most disadvantaged groups. Nevertheless, these groups remain the most sedentary, although the social differences are smaller than for obesity (Graph 8).

Graph 8.
Age-standardised
prevalence of
people with obesity
and sedentary
lifestyle, by sex and
socioeconomic
status in the
Basque Country,
2013



Source: 2013 Basque Health Survey

OBJECTIVES AND ACTIONS

OBJECTIVE 1.1.

HEALTH IN ALL POLICIES

To reach an inter-agency commitment to promote inter-sectoral action as a horizontal theme in governmental strategy, focused on ensuring that health and health equity are adopted as shared goals across government and all public policies (HiAP).

ACTIONS

1.1.1 Create and set in motion an inter-departmental and inter-agency Steering Committee for the Health Plan, chaired by the Basque Prime Minister, to drive forward the inter-sectoral action with the following functions:

1.1.1.1. To ensure policies are developed and that they are applicable, accepting shared responsibility for the commitments made in this Health Plan, in relation to the distribution of powers of Basque Government Departments, Provincial Councils and local authorities.

1.1.1.2. To identify and develop public policies with the greatest potential to influence equity in health, propose actions to reduce inequalities across the social gradient, and mobilise the resources necessary to implement them, as well as mechanisms to evaluate them.

1.1.2 Establish and set in motion the Technical Committee for HiAP led by the Department of Health with participation from all relevant sectors, with the goal of supporting the Steering Committee for the Health Plan through the following functions:

1.1.2.1. Provide support and advice for the development and monitoring of sectoral plans, to ensure that they follow the HiAP approach and are focused on social determinants of health and health equity. To this end, it has the following functions:

- To raise awareness in governmental and non-governmental agents at regional, provincial and council levels of the principles of the HiAP strategy and provide them with tools for its implementation
- To prepare a report every two years on the ratification of and commitment to the Health Plan by each of the sectors involved.

1.1.2.2. Promote health and health equity impact assessment of public policies in both healthcare and other sectors. Develop and systematise the use of health impact assessment as a tool to be applied to sectoral plans and interventions.

1.1.2.3. Assess the impact of the Health Plan and prepare an annual report on the results to be presented to the Steering Committee for the Health Plan.

INDICATORS	2020 TARGET	SOURCE
<i>Creation and launch of the Steering Committee for the Health Plan and the HiAP Technical Committee</i>	<i>Dec 2013 / March 2014</i>	<i>Basque Government, Department of Health</i>
Ratification of the commitment of sectors to the Health Plan	First report in 2016	Basque Government
Report on inequities by sector	First report in 2016	Department of Health
Annual report on the ratification of the Health Plan	First report in 2015	Department of Health

OBJECTIVE 1.2.

EQUITY

To strengthen equity in the Basque health system.

ACTIONS

1.2.1 Systematically incorporate an equity-based perspective in all the plans and interventions for the health system and public health. This implies:

- targeting resources to groups that are the most disadvantaged socially and in terms of health status.
- assessing the impact of health policies, including different health funding models and organisational models for health services, on health and health equity, using methodologies such as the Health Equity Audit.

1.2.2. Incorporate the social determinants of health perspective in health surveillance, promotion and protection and healthcare services.

1.2.3. Make it a priority in health policies to address the major health problems in the population groups most affected by social inequity (by social class, gender, country of origin, level of disability, etc.).

1.2.4. Ensure universal access to health services,

continuity of care and high-quality integrated care for everyone living in the Basque Country, eliminating the barriers that place certain groups of people at a disadvantage in access to healthcare, including:

- physical and transport barriers (given the range of functional ability in the population).
- gender barriers.
- social stigma due to certain diseases and disorders.
- social, cultural and economic barriers.

1.2.5. Strengthen care at the level that is the least complex and closest to the home, specifically primary care, this being the setting that ensures access to care and minimisation of health inequities.

1.2.6. Develop and strengthen community action on health, through interventions at the population level with participation and active involvement of all the players at the local level.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of the total healthcare budget dedicated to primary care (ambulatory care)	20% (2011)	>25%	<i>Eustat</i> - Health account
Disease-free life expectancy (DFLE)	Men: 69.3 years Women: 73.1 years (2013)	Men: ↑5% Women: ↑5%	Basque Health Survey
Social inequalities in life expectancy at the age of 30 years ^b	Men: 14% Women: 9% (2001-2006)	Men: ↓10% Women: ↓5%	Basque Health Survey
Inequalities in access to healthcare services (surgical waiting lists)	--	Progressive reduction	Basque Health Service
Inequalities in poor self-perceived health by social class in both sexes	RII Men: 2.40 RII Women: 2.55 (2013)	Men: ↓10% Women: ↓20%	Basque Health Survey

^b Difference in life expectancy between the top (percentile 100) and bottom (percentile 1) of the social scale. A measure calculated using regression models that take into account the entire socioeconomic distribution of the population eliminating the potential effect of differences in the sizes of socioeconomic groups on the magnitude of health inequalities

OBJECTIVE 1.3.

STRUCTURAL AND INTERMEDIATE DETERMINANTS

To support the development of public policies acting on structural and intermediate determinants of health and inequities in health.

ACTIONS

1.3.1 The Steering Committee for the Health Plan will promote interventions that strengthen social cohesion and well-being to generate health benefits and increase equity in health:

- policies for redistribution and social protection, universal access to high-quality public education from early childhood; access to adequate decent housing; active transport, and inclusive urbanism.
- measures to improve safety and to reduce stress in schools and in the workplace.
- measures and initiatives to improve employment and working conditions.
- regulatory measures and initiatives on models of work and working hours, as well as school and leisure hours, in order to help people achieve a better work-life balance.

1.3.2. The HiAP Technical Committee will develop the proposals for coordinated intervention to strengthen social cohesion and well-being in the following areas:

1. integrated and coordinated surveillance of environmental risks.
2. food safety surveillance.
3. urban mobility and public transport planning, facilitating healthy options such as walking and cycling.

4. the development of indoor and outdoor spaces for physical activity with universal access.

5. support for the shared use of public spaces criteria prioritising intergenerational use and adapting them for the most vulnerable groups: older people, children, and people with disability.

6. inclusive design and operation of cities to the benefit of everyone by including the gender perspective. Safe and inclusive urbanism, urban map analysis to identify black spots.

7. working conditions and the work-life balance.

8. inclusive education measures.

9. social protection and redistribution of resources.

10. measures for confronting the stigma of mental illness.

11. raising awareness of the importance of social determinants of health among the general population and professionals in all sectors including the health sector.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Youth unemployment rate (16- to 24-year-olds)	Men: 35.1% Women: 30.4% (2012)	15%	<i>Eustat</i> . Population in Relation to Activity
Risk of poverty. Gini coefficient of personal income ^c	0.533 (2009)	↓5%	<i>Eustat</i> . Personal and family income
Percentage of households in	Men: 3.7%	↓10%	Department of Employment and Social

^c Gini coefficient: an indicator of inequality, ranging between 0 and 1. A score of 0 corresponds to perfect equality (everybody has the same income), while a score of 1 corresponds to maximum inequality (1 person has all the resources, the rest having none).

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
real poverty considering the individual of reference	Women: 11.1% (2012)		Policy. 2012 Survey on Poverty and Social Inequalities
Rate of homelessness	Men: 1.6‰ Women: 0.4‰ (2012)	↓10%	<i>Eustat</i> . Survey on the homeless
Education dropout rate ^d (18- to 24-year-olds)	Men: 8.3% Women: 7.1% (2012)	↓10%	<i>Eustat</i> . Population in Relation to Activity

^d Education dropout rate: percentage of the population that has completed no more than the first stage of secondary education and is not studying or following a training course. Eustat

OBJECTIVE 1.4.

PARTICIPATION AND EMPOWERMENT

To promote the participation and empowerment of people recognising differences in terms of gender, and the diversity of groups and situations, developing different empowerment strategies for women and men.

ACTIONS

1.4.1 Update the "Charter of Rights and Responsibilities for Patients and Other Users" of the Basque Health Service.

1.4.2. Develop empowerment strategies for individuals with ill health and their families, especially those from the most disadvantaged groups. In these strategies, consideration is to be given to gender differences.

1.4.3. Develop Schools of Patients[°] to strengthen patient independence and promote healthy lifestyles among caregivers and the general public.

1.4.4. Develop frameworks and tools for collaboration with patients' associations and the third sector, promoting co-responsibility among these groups regarding their relationship with the health system. Encourage patients' associations to run activities and develop tools for sharing knowledge and concerns regarding the health problems they are focused on, by offering them training, as well as supervising and being involved in their activities.

1.4.5. Develop prevention and awareness programmes for young people on healthy lifestyles, in the face of violence, in particular, violence against females and peer-to-peer violence. Additionally, support the promotion of non-stigmatising attitudes towards mental illness.

1.4.6. Coordinate and strengthen community participation using the existing instruments (Health Councils) and establish new mechanisms for public participation in the phases of planning, implementation and evaluation of health services and in community-based interventions for health promotion at all levels.

1.4.7. Ensure that the gender perspective is considered in all training programmes for health professionals.

INDICATORS	2020 TARGET	SOURCE
Active and operational Health Council	2 meetings/year	Department of Health
Percentage of patients participating in Schools for Patients [°] in each priority health problem	>50%	Basque Health Service - Unit for Care Integration and Chronicity
Update and publish a new Charter of Rights and Responsibilities for patients and users of the Basque Health System	No later than 2015	Department of Health

[°] Schools of Patients (in Basque, *Osasun Eskola*): a resource of the Basque Department of Health and the Basque Health Service (*Osakidetza*) with the mission to facilitate, providing information and training, the acquisition of knowledge and skills in disease self-management and health promotion among patients, caregivers and the general public

OBJECTIVE 1.5.

VIOLENCE AGAINST FEMALES

To strengthen efforts to prevent and respond to violence against females in the healthcare services, fostering shared decision making between all stakeholders.

ACTIONS

1.5.1 Promote mechanisms for the prevention and early detection of violence against females as well as for monitoring and tackling with this type of violence.

1.5.2. Improve the coordination between healthcare and health and social services for girls and women who are victims of violence against females.

INDICATORS	2020 TARGET	SOURCE
Creation of an administrative unit for promoting and coordinating equal opportunities policies in the Basque Health Service ^f	2015	Basque Health Service

^f This administrative unit is cited in Decree 213/2007 of 17 November, its mission being to lead the promotion and coordination of equal opportunities policies in the Basque Health System (*Osakidetza*).

OBJECTIVE 1.6.

MONITORING HEALTH INEQUITIES

To promote and develop monitoring and research on health inequity.

ACTIONS

1.6.1 Create a Health Observatory as a body for research, analysis and communication that will focus on the determinants of health and health inequities, with a gender perspective. This organisation will produce regular reports on social inequities in health in the Basque Country, with recommendations and proposals for intervention.

1.6.2. Consider incorporating equity in health, gender and inter-sectoral perspectives as quality criteria, for research projects on health and on the use of healthcare and health and social care services funded by the Basque Department of Health and other institutions.

1.6.3. Include social stratification variables in all the health information systems to enable the analysis of social inequities in health status, in health determinants and in the use and quality of healthcare services.

INDICATORS	2020 TARGET	SOURCE
Creation of the Basque Health Observatory	2015	Department of Health
Inclusion of social stratification variables in health information systems	2016	Department of Health Basque Health Service
Report on social inequities in health	2015	Department of Health

OBJECTIVE 1.7.

RESEARCH AND INNOVATION

To promote research and innovation as a source of knowledge generation for improving healthcare and the quality, effectiveness and efficiency of the health system.

ACTIONS

1.7.1 Promote and fund research (basic, clinical, epidemiological, translational, and health services, etc.) on:

- The causes of disease processes and their detection and treatment, including the incorporation of new paradigms such as personalised or precision medicine.
- The evidence for and causes of inequities in health.
- The efficacy of health interventions, including healthcare.

1.7.2. Promote rapid transfer of research results to clinical practice.

1.7.3. Design an innovation plan for the Basque health system.

1.7.4. Develop and consolidate mechanisms for supporting and driving research and innovation (training, spaces for creativity and innovation, and knowledge networks, among others).

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Publications in high-ranking journals (number)	722 (2011)	↑40%	Basque Foundation for Health Innovation and Research (BIOEF)

5.2.

PRIORITY AREA 2: PEOPLE WITH ILL HEALTH

INTERVENE TO HELP PEOPLE WITH HEALTH PROBLEMS TO DECREASE MORBIDITY AND MORTALITY AS WELL AS DISABILITY ASSOCIATED WITH ILL HEALTH

This second Area includes the curative, rehabilitative and palliative objectives and actions for people with the following conditions: cancer, diabetes mellitus, mental disorders, bone, joint, and muscle diseases, cardiovascular, chronic respiratory, and neurodegenerative diseases, and communicable diseases including those transmitted sexually, as well as all rare diseases. Special emphasis is placed on the burden of disease caused by multi-morbidity, chronic conditions and high-dependency. It also addresses specific issues related to patients on multiple medications, clinical safety measures, workers with work-related health problems, and end-of-life and/or palliative care.

Integrated care is a model for the organisation of healthcare that seeks to improve health outcomes, by integrating care processes and centring them on the

patient. The objectives and actions in this Area emphasise the following elements: a) care pathways as the embodiment of care processes from the point of view of integration; b) coordination between levels of care to provide a good service to users; and c) rehabilitation processes that are personalised and provided in the patient's own environment, whenever possible.

According to the 2013 Basque Health Survey, almost one fifth of the population (21.7% of men and 12.9% of women) had not sought medical attention in the previous year. Approximately a third of the population was seen by a doctor once or twice, more than a third was seen between 3 and 9 times and 1 in 10 more than 10 times a year. The last of these groups of users, so-called "frequent attenders", corresponds to around 224,000 people in our region (Table 1).

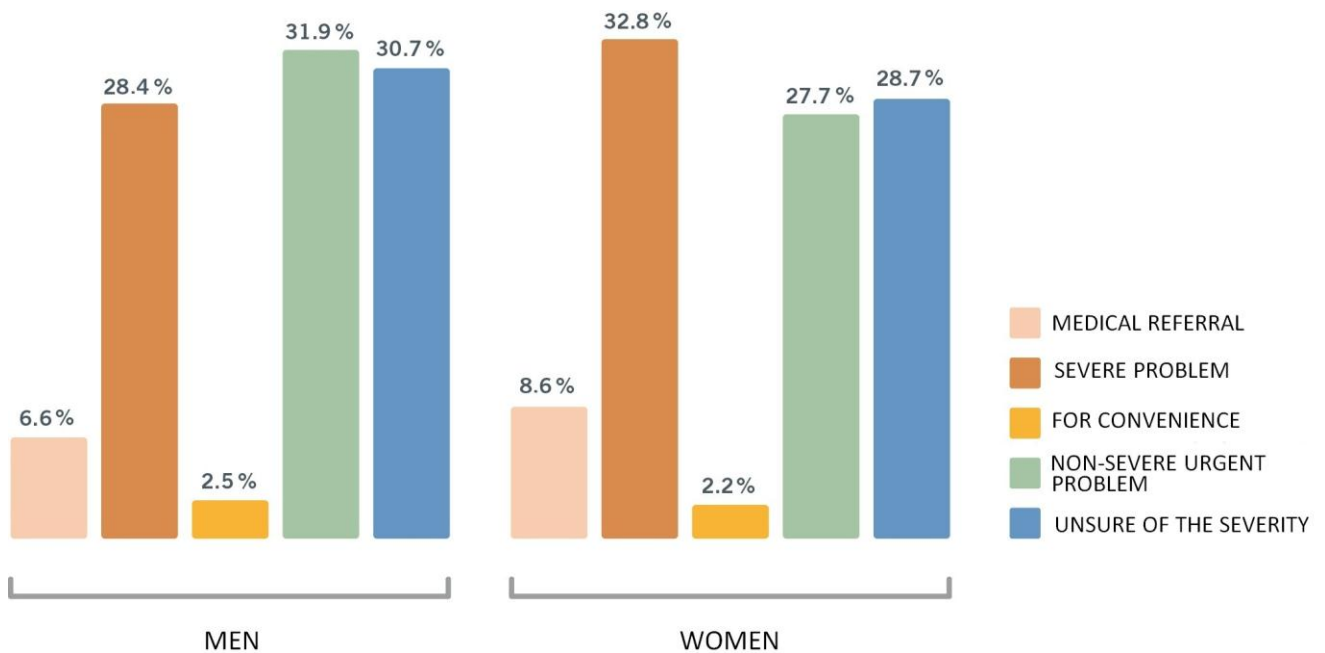
Table 1.
Distribution of the population in the Basque Country (%) by frequency of seeking medical attention in the previous year, 2013

NO. OF CONSULTATIONS/ YEAR	MEN	WOMEN	BOTH SEXES
None	21.7	12.9	17.2
1 or 2	34.5	32.8	33.6
3 to 9	35.6	42.9	39.3
10 or more	8.2	11.4	9.9

Source: 2013 Basque Health Survey

Around 30% of people who attended emergency departments considered that they had a mild health problem that needed to be addressed immediately; 30% thought they had a severe health problem; 30% did not know the severity of their problem; 2% considered that attending the emergency department was the most convenient option (although their problem was mild); and 8% had been referred by a doctor in another health provider (Graph 9).

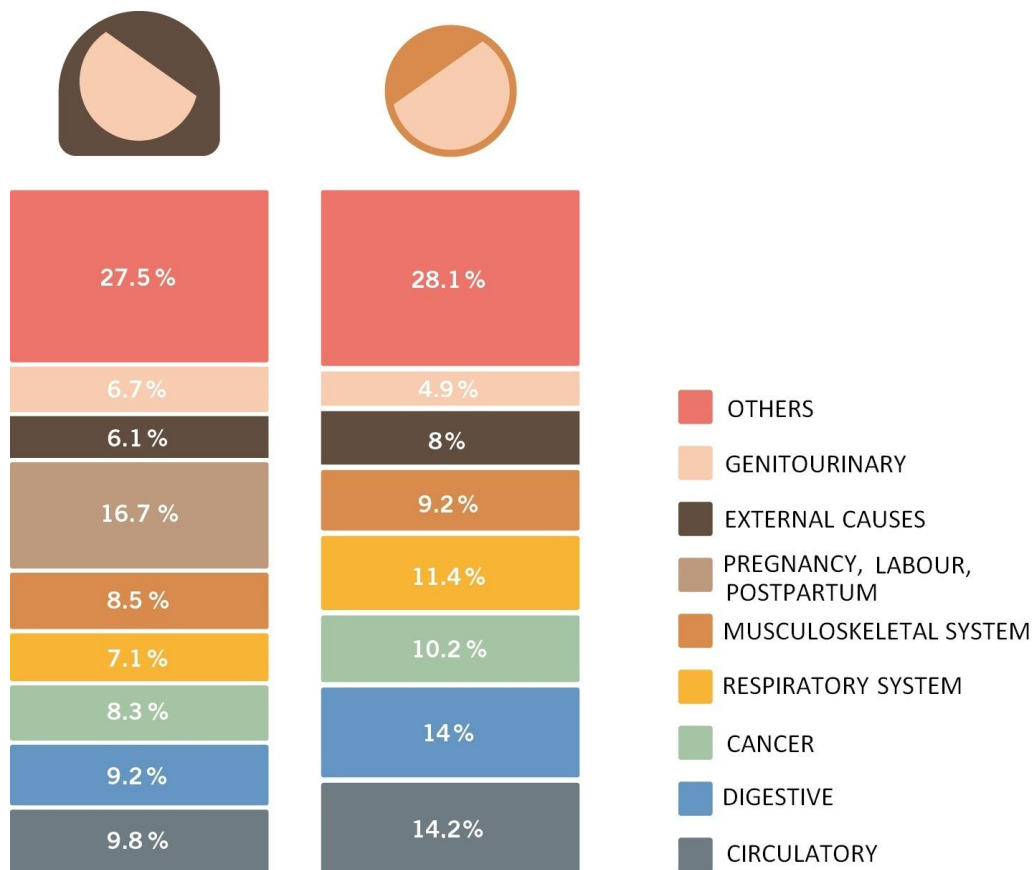
Graph 9.
Reasons for attending emergency departments in the Basque Country by self-perceived severity, 2013



Source: 2013 Basque Health Survey

Hospital discharge data (from the MBDS) indicate that the number of recorded discharges from public and private hospitals in the Basque Country in 2011 was 1.6% higher than the year before. As can be seen in Graph 10, showing the morbidity rates as a function of broad diagnostic groups, diseases of the circulatory, digestive, and respiratory systems are the most common diagnoses at discharge in men, while in women admissions are most frequently related to pregnancy, labour and postpartum, followed by circulatory and digestive system diseases.

Graph 10.
Hospital discharge by broad diagnostic group and sex.
Acute public and private hospitals in the Basque Country, 2011



Source: 2011 Basque Hospital Discharge Records.

CANCER

In 2010, cancer was the leading cause of death in men and the second leading cause in women. The incidence was 711.59 in men and 456.60 in women per 100,000; the mortality rate due to cancer was 354.52 cases in men and 204.09 in women per 100,000. The age-standardised incidence rate, calculated using the European standard population, has slightly increased between 2000 and 2010, by 0.2% per year in men and

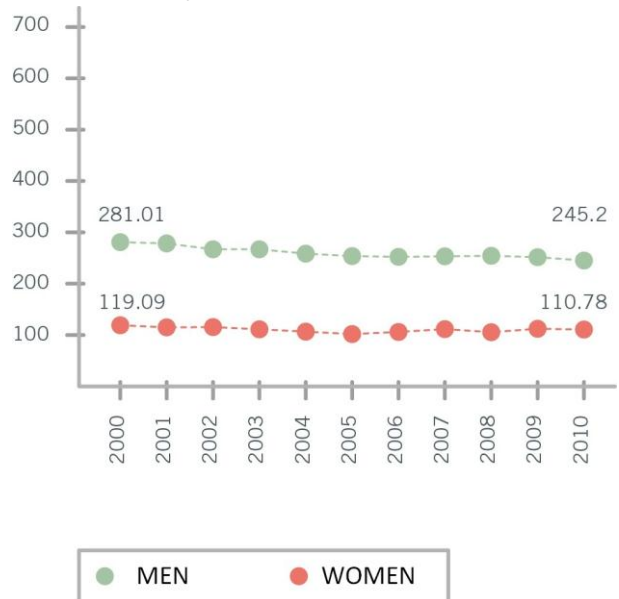
1.1% per year in women (Graph 11), while mortality due to cancer decreased by 1.5% and 0.7% per year in men and women, respectively, in this period (Graph 12).

In the population under 65 years of age, the incidence rate of cancer was 297.22 in men and 253.27 in women per 100,000 and mortality rates were 113.97 in men and 68.47 in women per 100,000.

Graph 11.
Age-standardized incidence ratio of malignant tumours in the Basque Country, 2000-2010



Graph 12.
Age-standardised mortality rate due to malignant tumours in the Basque Country, 2000-2010



European age-standardised rate per 100,000
Sources: Basque Mortality and Cancer Registries

The most common type of cancer in women in the Basque Country in 2010 was breast cancer, with an incidence rate of 126.57 per 100,000 and a mortality rate of 27.95 per 100,000. The European age-standardised incidence rate increased by 1.5% per year and mortality decreased 2.5% per year between 2000 and 2010. The second most common type of cancer in women was colorectal cancer, with an incidence rate of 65.72 per 100,000 and a mortality rate of 25.60 per 100,000; the age-standardised rates show an upward trend in the incidence (1.7% per year) and a decreasing mortality (1.4% per year). Tracheal, bronchial and lung cancer in women ranks fourth in terms of incidence and third in terms of mortality due to cancer; the age-standardised incidence rates having increased by 7.9% and mortality by 7.7% per year between 2000 and 2010.

In men, the type of cancer responsible for the most deaths is tracheal, bronchial and lung cancer; in 2010, its incidence rate was 97.38 per 100,000 people and mortality rate was 82.28 per 100,000 people. Unlike in women, the age-standardised incidence and mortality rates fell by 1% and 0.8% per year respectively between 2000 and 2010. The second most common type of cancer in men was colorectal cancer, with an incidence rate of 123.99 and mortality rate of 51.90 per 100,000 in 2010. In this case, the age-standardised incidence and mortality rates both increased, by 3.3% and 1.1% per year respectively, between 2000 and 2010. Prostate cancer was the most common type of cancer (149.85 cases per 100,000) but ranked third in terms of mortality (31.99 per 100,000) in 2010. The age-standardised incidence increased 1.7% per year, whereas mortality has decreased 2.0% per year between 2000 and 2010.

In men, the type of cancer responsible for the most

CARDIOVASCULAR DISEASES

Together with cancer, cardiovascular diseases are the main cause of death and hospitalization. The mortality rates due to diseases of the circulatory system decreased by 3.7% in men and 4.1% in women between 2000 and 2010. Nevertheless, the leading causes of mortality in 2010 were ischaemic heart disease in men (89.17 per 100,000) and cerebrovascular disease in women (70.77/100,000).

According to the 2011 registry for risk stratification of chronic patients, the prevalence of high blood pressure was 18.7% in men and 19.4% in women; that of ischaemic heart diseases was 2.9% in men and 1.2% in women, and that of cerebrovascular disease was 2.0% in men and 1.9% in women²⁸.

DIABETES MELLITUS

In year 2000, it was estimated that the prevalence of type 2 DM in over-24-year-olds in the Basque Country was 4.6% and the incidence 5 cases per 1,000³³. More recent data, from the 2011 registry for risk stratification of chronic patients, indicated that 6.4% of men and 5.3% of women in the Basque country had known diabetes²⁸. The 2013 Basque Health Survey shows that its prevalence has increased in those above 64 years of age, especially among 65- to 74-year-old men (Table 2).

Table 2.
Prevalence (%) of diabetes by age (years)
and sex in the Basque Country, 2002-2013

	MEN			WOMEN		
	2002	2007	2013	2002	2007	2013
0-14	-	-	-	-	0.4	0.4
15-24	0.5	0.1	-	0.1	0.2	0.4
25-44	0.8	0.6	0.7	0.5	0.6	0.5
45-64	3.7	5.9	7.2	3.1	3.5	4.3
65-74	11.5	11.3	18.9	8.1	9.8	12.3
>=75	12.2	14.1	19.6	9.7	9.9	15.2

Source: 2013 Basque Health Survey

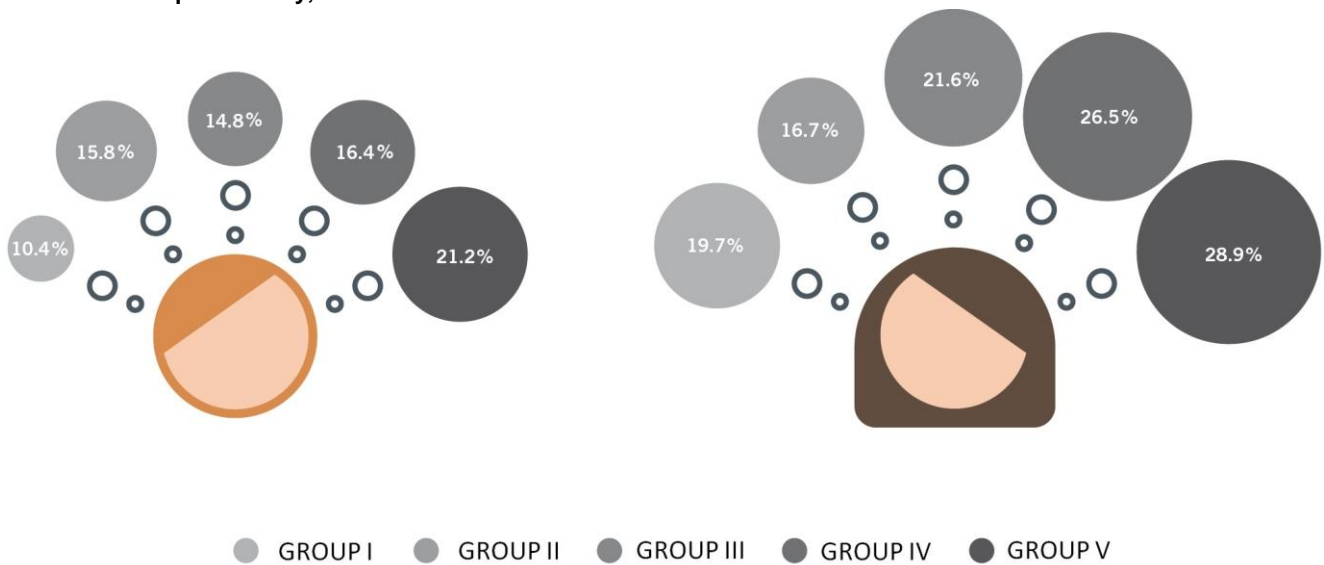
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

In 2011, the prevalence of chronic obstructive pulmonary disease (COPD) in the Basque Country²⁸ was 3.0% in men and 1.5% in women, while the prevalence of asthma was 2.7% in men and 2.9% in women. In that year, the rate of hospital attendance for COPD was 11.61 in men and 2.46 in women per 1,000, with a readmission rate of 24%. The mortality rates due to COPD were 50.11 in men and 25.51 in women per 100,000.

MENTAL HEALTH

In 2013, 24.3% of women and 15.5% of men reported symptoms of anxiety and/or depression. These figures increased with age, particularly from 45 years of age onwards. Further, the prevalence of anxiety and depression increased with each step down the social ladder: 19.7% of women and 10.4% of men in the least disadvantaged group had these symptoms compared to 28.9% of women and 21.2% of men in the most disadvantaged group (Graph 13).

Graph 13.
Age-adjusted prevalence of anxiety and depression by social class and sex in the Basque Country, 2013



Source: 2013 Basque Health Survey

MULTIPLE MORBIDITY

According to the 2011 registry for risk stratification of chronic patients, 21.2% of men and 25.9% of women had two or more chronic conditions²⁸.

OBJECTIVES AND ACTIONS

OBJECTIVE 2.1.

PATIENT-CENTRED INTEGRATED HEALTH AND SOCIAL CARE

To promote healthcare that is based on a holistic, integrated, patient-centred approach, especially in chronic patients and those with multiple conditions, and ensure continuous, efficient, personalised, evidence-based care.

ACTIONS

2.1.1. Support continuity of care through the use of clinical care pathways⁹ for the most common conditions.

2.1.2. Encourage the development and use of clinical practice guidelines.

2.1.3. Enhance professional competencies through continuing professional development and the development of new roles, including training at undergraduate and postgraduate levels.

2.1.4. Promote new tools for providing care such as virtual environments and remote consultations.

2.1.5. Facilitate the care of patients in their own environment, respecting their wills and preferences.

2.1.6. Develop strategies and mechanisms (training and education, access to consultations, etc.) aiming to minimise the impact on the health of informal caregivers of caregiving for individuals with ill health.

⁹ Also called care paths or maps

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Implementation of care pathways in Integrated Healthcare Organisations (IHOs)	--	100%	Basque Health Service - Unit for Care Integration and Chronicity
Training programme for caregivers of individuals with priority diseases	--	2016	Department of Health Department of Employment and Social Policy Basque Health Service

OBJECTIVE 2.2.

PROPER USE OF MEDICATIONS

To promote the proper use of medications through coordinated/integrated interventions involving primary care, specialised care, mental health and pharmacy units, in particular for patients on multiple medications and for drugs requiring close monitoring.

ACTIONS

2.2.1. Develop a process for shared drug prescribing (hospital/primary care/pharmacy) that promotes treatment adherence and the safe use of drugs and is based on clinical practice guidelines.

2.2.2. Encourage deprescribing and the monitoring of drug interactions in patients on multiple medications.

2.2.3. Support continuing education for health professionals that is not funded by the healthcare product and service industry.

2.2.4. Develop programmes for the surveillance of antimicrobial resistance and antibiotic susceptibility.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Installation of a system for shared prescribing	--	2015	Department of Health Basque Health Service
Antimicrobial resistance and antibiotic susceptibility surveillance programme	--	2015	Department of Health Basque Health Service

OBJECTIVE 2.3.

CLINICAL SAFETY

To achieve the highest level of clinical safety in the provision of healthcare.

ACTIONS

2.3.1. Introduce incidence information and notification systems.

2.3.2. Promote programmes aiming to improve clinical safety in healthcare, ensuring the unambiguous identification of patients; and safety in the use of medications, blood and blood derivatives and other healthcare products, and surgical and radiological safety;

and minimising the risk of healthcare-associated infections, falls and pressure ulcers.

2.3.3. Promote a culture of safety through informal events (talks, meetings, etc.) to raise awareness and more formal training (workshops, courses, etc.) for health professionals, who, in turn, will be involved with activities to inform and engage patients.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Level of effective use of the incident notification systems	5% (2012)	20% of departments/units/services of 100% of the IHOs/Health Regions	Basque Health Service – Clinical safety
Introduction of a system/protocol for unambiguous patient identification	75% (2013)	100%	Basque Health Service – Clinical Safety

OBJECTIVE 2.4.

END-OF-LIFE AND PALLIATIVE CARE

To provide high-quality, comprehensive, personalised care to people requiring end-of-life and/or palliative care and their families.

ACTIONS

2.4.1 Develop and offer a plan for palliative care in each IHO. The plan should be the product of a consensus on a health and social care model for palliative care that is comprehensive, ethical and multidisciplinary in nature, considering the map of available resources.

2.4.2. Promote the use of advance directives in the Basque Country.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Palliative care plans in use in IHOs/Health Regions	--	100%	Basque Health Service
Percentage of people that have an advance care directive	Men: 1.2% Women: 1.1% (2012)	>15%	Department of Health Basque Health Service

OBJECTIVE 2.5.

CANCER

To promote a model of care for individuals with cancer involving multidisciplinary teams focused on providing integrated, comprehensive and coordinated, personalised care.

ACTIONS

2.5.1. Strengthen Cancer Committees in IHOs that provide cancer care for the assessment, treatment and follow-up of cases, with special emphasis on the role of primary care.

2.5.2. Strengthen psychological support in healthcare processes.

2.5.3. Maintain the coverage of the programme for early detection of breast cancer.

2.5.4. Extend the coverage of the screening programme for colorectal cancer, improving the level of participation and detection rates.

2.5.5. Promote personalised medicine for cancer processes on the basis of sound scientific evidence.

2.5.6. Actions related to the prevention of cancer included in Area 5.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of cancer cases reviewed by cancer committees	--	>75%	Basque Health Service
Incidence of cancer in under 65-year-olds (cases/100,000)	Men: 246.52 Women: 203.02 (2010)	Men: ↓10% Women: ↓10%	Basque Cancer Registry
Mortality due to cancer in under 65-year-olds (cases/100,000)	Men: 99.25 Women: 55.37 (2011)	Men: ↓10% Women: ↓10%	Basque Mortality Registry
Incidence of lung cancer in under 65-year-olds (cases /100,000 people)	Men: 30.24 Women: 12.98 (2010)	Men: ↓10% Women: stop the upward trend	Basque Cancer Registry
Mortality due to lung cancer under 65-year-olds (cases/ 100,000 people)	Men: 29.91 Women: 11.46 (2011)	Men: ↓10% Women: stop the upward trend	Basque Mortality Registry
Incidence of colon, rectal and anal cancer (cases/100,000)	Men: 89.12 Women: 39.06 (2010)	Men: ↓10% Women: ↓10%	Basque Cancer Registry
Mortality due to colon, rectal and anal cancer (cases /100,000 people)	Men: 30.9 Women: 13.6 (2011)	Men: ↓10% Women: ↓5%	Basque Mortality Registry
Participation in the screening programme for the early detection of colorectal cancer	Men, first round: 62% Women, first round: 68% (2012)	Men, first round: ↑10% Women, first round: ↑10%	Screening programme for colorectal cancer
Incidence of breast cancer (cases /100,000 people)	Women: 95.34 (2010)	↓5%	Basque Cancer Registry
Mortality due to breast cancer (cases /100,000 people)	Women: 18.1 (2011)	↓10%	Basque Mortality Registry

European age-standardised rates per 100,000

OBJECTIVE 2.6.

CARDIOVASCULAR DISEASES

To decrease morbidity and mortality due to cardiac and cerebrovascular diseases, increase survival and maximise the level of independence and quality of life of affected individuals, taking into account social and gender differences.

ACTIONS

2.6.1 Improve the detection and control of high blood pressure

2.6.2 Encourage the revascularization of patients with acute coronary syndrome within the period established by international guidelines

2.6.3. Improve the care for patients with chronic heart failure through enhancing continuity of care and coordination between all levels of care.

2.6.4. Introduce cardiovascular rehabilitation programmes for all patients with cardiovascular disease

2.6.5. Establish a home-based, personalised early rehabilitation programme for patients with stroke (cerebrovascular accident)

2.6.6. Actions related to the prevention of cardiovascular disease included in Area 5.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Women/men ratio for revascularization	0.67 (2012)	>0.8	Basque Health Service
Percentage of cardiac patients participating in programmes for cardiac rehabilitation	--	>75%	Basque Health Service
Early mortality due to acute myocardial infarction (25- to 74-year-olds) (cases/100,000 people)	Men: 47.74 Women: 7.05 (2011)	Men: ↓10% Women: stabilise rate	Basque Mortality Registry
Percentage of patients with stroke that have a personalised plan for early rehabilitation	Men: 19.8% Women: 20.2% (2012)	>75%	Basque Health Service

OBJECTIVE 2.7.

DIABETES AND METABOLIC SYNDROME

To reduce morbidity and mortality associated with metabolic syndrome and type 2 DM and the rate and number of microvascular and macrovascular complications, raising awareness among clinicians of existing social and gender differences.

ACTIONS

2.7.1. Strengthen the efforts of health professionals to empower patients with diabetes through Schools of Patients.

2.7.2. Develop high-quality and integrated care for diabetic foot patients.

2.7.3. Improve the coverage of screening for diabetic retinopathy and peripheral vascular disease in primary care.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of people with type 2 DM with glycosylated haemoglobin <7%	Men: 42.63% Women: 42.35% (April 2013)	>50%	Basque Health Service
Social inequality in the prevalence of type 2 DM	Men: RII 1.15 Women: RII 2.26 (2013)	Men: ↓5% Women: ↓5%	Basque Health Survey
Severe renal failure associated with diabetes per million people (PMP)	Men: 19 PMP Women: 6 PMP (2012)	↓10%	Basque Kidney Patient Information Unit (UNIPAR)
Rate of amputations in people with type 2 DM (cases/100,000 diabetic patients)	Men: 8.59 Women: 2.75 (2011)	Men: ↓15% Women: ↓15%	MBDS
Early mortality due to type 2 DM (25- to 74-year-olds) (cases/100,000)	Men: 7.6 Women: 2.5 (2011)	Men: ↓10% Women: ↓10%	Basque Mortality Registry

OBJECTIVE 2.8.

OBESITY

To design and implement healthcare interventions for tackling obesity.

ACTIONS

2.8.1 Monitor body mass index and waist circumference in primary care and hospital consultations.

2.8.2. Provide training for primary care clinicians on brief counselling on obesity.

2.8.3. Develop interventions for the diagnosis, treatment and individualised monitoring of people with obesity, avoiding stigmatisation.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of people with overweight	Men: 43.0% Women: 28.2% (2013)	Men: ↓10% Women: ↓10%	Basque Health Survey
Percentage of people with obesity	Men: 13.9% Women: 12.6% (2013)	Men: ↓10% Women: ↓10%	Basque Health Survey
Social inequality in the prevalence of obesity	Men: RII 1.64 Women: RII 2.82 (2013)	Men: ↓10% Women: ↓15%	Basque Health Survey

OBJECTIVE 2.9.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

To improve the early diagnosis, treatment and quality of life of people with COPD.

ACTIONS

2.9.1. Promote the systematic use of spirometry testing for COPD in at-risk patients in primary care.

2.9.2. Introduce pulmonary rehabilitation for patients with COPD.

2.9.3. Strengthen smoking prevention and treatment with cessation programmes.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Rate of readmission within 30 days in patients with COPD	Men: 20% Women: 17%	↓15%	Basque Health Service
Percentage of patients with COPD with access to a rehabilitation programme	--	>75%	Basque Health Service

OBJECTIVE 2.10.

MENTAL ILLNESS

To ensure adequate care for patients with mental illness, in accordance with the guidelines of the Basque Strategy for Mental Health and fight against stigma.

ACTIONS

2.10.1. Formalise protocols for suicide prevention at the community level and, specifically, in people with a diagnosis of mental illness and/or known risk factors, taking into account the gender perspective.

2.10.2. Continue to develop and improve individualised treatment plans³⁴.

2.10.3. Shift the balance of care towards the community setting for long-term severe mental health problems.

2.10.4. Improve the coordination between mental health and primary care services.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Mortality due to mental illness (cases/100,000)	Men: 21.1 Women: 18.8 (2011)	↓10%	Basque Mortality Registry
Social inequality in the prevalence of suicidal ideation by sex	Men Group I: 3.9 Group V: 6.0 Difference: 2.1% Women Group I: 2.7 Group V: 7.3 Difference: 4.6% (2013)	Men: ↓5% Women: ↓10%	Basque Health Survey
Mortality due to suicide (cases/100,000)	Men: 9.5 Women: 3.4 (2011)	Men: ↓10% Women: ↓5%	Basque Mortality Registry
Use of anxiolytics and antidepressants (in DIDs) ^h	Anxiolytics: 54 Antidepressants: 61 (2012)	Stop the upward trend	Department of Health - Pharmacy Office

^hDefinition of DID: In accordance with the recommendations of the World Health Organization on Drug Utilization Research, the consumption of drugs is expressed in defined daily doses (DDD) per 1000 inhabitants per day (DIDs), where the DDD is a technical unit of measure that is the assumed average maintenance dose of a drug by a given route of administration for its main indication in adults; DDDs for active ingredients are established by the WHO.

OBJECTIVE 2.11.

SEXUALLY TRANSMITTED INFECTIONS

To decrease the rates of sexually-transmitted infections and late diagnosis of HIV, placing special emphasis on prevention.

ACTIONS

2.11.1. Develop population-based prevention programmes, placing special emphasis on young people and men who have sex with men, and empower women, helping them make their own choices concerning their sexuality, adopt self-care practices and reduce high-risk behaviours.

2.11.2. Encourage HIV testing among people that engage in high-risk behaviours.

2.11.3. Improve surveillance, early diagnosis and treatment of sexually transmitted infections.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
No. of new cases of HIV infection	Men: 132 Women: 29 (2012)	↓10%	Basque Plan for AIDs and Sexually-Transmitted Infections
Rate of late HIV diagnosis	Men: 43% Women: 59% (2012)	↓30%	Basque Plan for AIDs and Sexually-Transmitted Infections
No. of reported cases of syphilis	Men:147 Women: 41 (cases 2012)	↓30%	Department of Health - Basque Microbiological Information System (SIMCAPV)
No. of reported cases of gonorrhoea	Men: 159 Women: 32 (cases 2012)	↓30%	Department of Health - Basque Microbiological Information System (SIMCAPV)

OBJECTIVE 2.12.

OTHER PRIORITY ILLNESSES

To improve the care for people with illnesses with a significant impact on their quality of life and on public health: bone, joint and muscle diseases, chronic renal failure, infections, neurodegenerative diseases, and rare diseases.

ACTIONS

2.12.1. Develop programmes for the surveillance, early diagnosis and treatment of infections with a significant impact on public health. Develop antimicrobial stewardship programmes.

2.12.2. Promote coordinated action between levels of care for the early diagnosis and treatment of chronic renal failure.

2.12.3. Encourage the authorisation of organ donation in advance directive documents.

2.12.4. Establish common criteria for the use of orphan¹ and non-orphan drugs and other products that are covered by the public health service for the treatment and care of people with rare diseases.

2.12.5. Define and introduce a psychogeriatric health and social care model for people with dementia.

2.12.6. Design and introduce clinical practice guidelines on chronic pain, encouraging the coordination and integration across all levels of care.

¹ Orphan drugs are defined as medications intended to diagnose, prevent or treat a disease that affects less than 5 people per 10,000. They are used to treat severe or disabling illnesses and are unlikely to be developed as they are considered not commercially viable.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Patients on kidney dialysis per million people (PMP)	110/PMP (2012)	↓5%	Basque Health Service - Basque Kidney Patient Information Unit (<i>UNIPAR</i>)
Rare disease registry established		2014	Department of Health-Registry Unit

5.3.

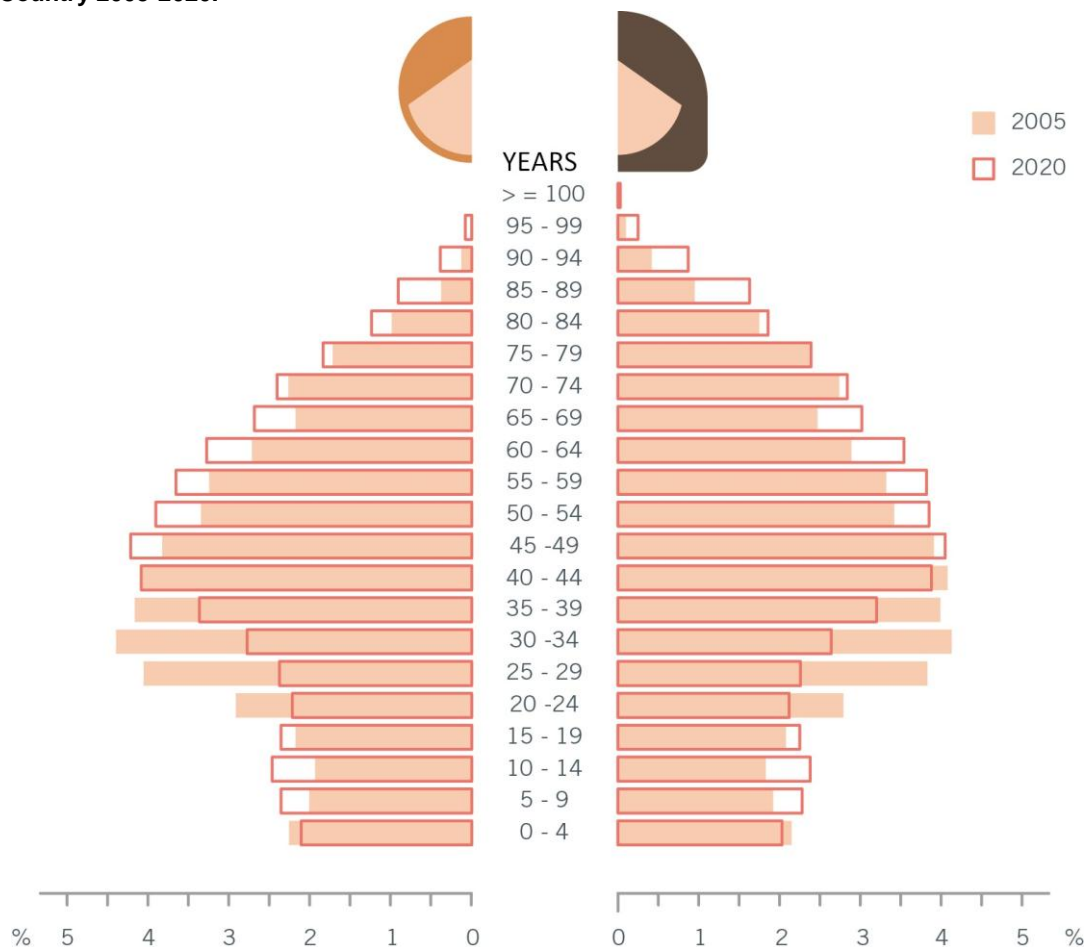
PRIORITY AREA 3: HEALTHY AGEING

ENCOURAGE HEALTHY AGEING

Life expectancy in the Basque Country is among the highest in the world, and the population over 64 years of age is expected to grow 26.5% by 2020, the number of over-84-year-olds increasing by as much as 104%³⁵. This Area concerns the objectives and actions for active ageing, coordination of intensive and/or long-term health and social care services, provision of adequate

healthcare for older people, promotion of independence, adherence to advance directives, and new ICTs for improving quality of life and well-being, as well as supporting volunteering and personal and intergenerational relationships. According to the *Eustat* Demographic Projections for 2020, the population of the Basque Country is still ageing (Graph 14).

Graph 14.
Population pyramid of the
Basque Country 2005-2020.



Source: *Eustat*

Under-20-year-olds represented 16.4% of the overall population in the Basque Country in 2005, and this figure will reach 18.3% by 2020, with over 61,000 more young people. However, the number of over-64-year-olds will increase substantially, with 110,000 more people joining this age group, increasing the contribution of this group to the total population from 18.5% in 2005 to 22.5% by 2020. The greatest percentage increase is expected in the over 84-year-olds, growing from 2.0% of the total population in 2005 to 4.1% by 2020, as a consequence of this very old segment growing faster (+5.31% per year) than the overall older population (+1.66% per year). With this, the size of the population aged 85 or over doubles from 42,800 to 93,000, meaning over 50,000 more very old people in 15 years.

The increase in life expectancy in the Basque Country has been accompanied by an increase in the DFLE in men, while the DFLE at 65 years of age has decreased for the first time in women (Graph 15).

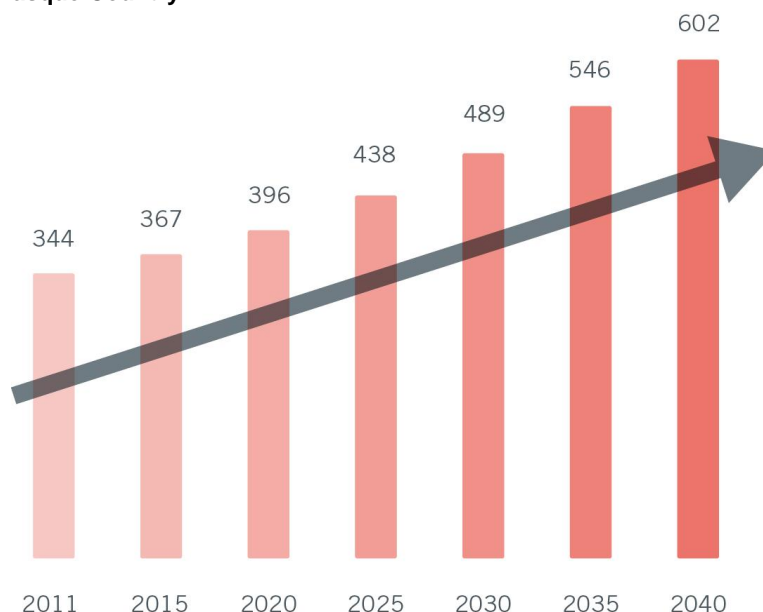
Graph 15.
Disability-free life expectancy (DFLE)
and years lived with disability (YLDs)
at 65 years of age.
Basque Country 2002-2013



Source: 2013 Basque Health Survey

In the Basque Country, an increasing number of people have chronic and complex conditions. Currently, 38% of over-64-year-olds in the Basque Country have some type of chronic health problem, and it is estimated that the number of patients with chronic disease will double by 2040 (Graph 16).

Graph 16.
Forecast increase in the number
(in 1000s) of chronic patients over
64 years of age in the Basque Country



Source: Spanish National Institute of Statistics. Forecast for 2040

A Basque Government policy document putting forward strategies to advance the well-being and fair treatment of ageing people³⁶ establishes proposals for adapting health models to the process of ageing and to reassess the value of old age, taking advantage of the contribution that older people can potentially make to the community. The measures proposed are classified into three groups: the first, those aiming to facilitate independence and the integration of older people as active and dynamic members of society, for as long as they are of sound mind; the second, measures for when elderly people need support; and the third, measures focused on breaking negative stereotypes and preventing discrimination against older people.

In sphere of long-term health and social care, new services need to be promoted closer to where people live (prepared meals, laundry services, physiotherapy, podiatry, transportation, mobile libraries, etc.). Support to informal caregivers must be strengthened through professional support at home providing advice and answering their queries about the care required. Problems of accessibility in the home are also to be addressed to minimise obstacles to individuals performing activities of daily living. According to the Basque Department of Housing, Public Works and Transport, the urban environment is vulnerable or very vulnerable in 31% of census tracts in Basque Country in terms of accessibility, structural stability, habitability and energy efficiency, as well as social vulnerability³⁷.

Professionals should adopt a case management approach in their interactions with users, assigning a single professional to guide families throughout the care process and coordinate all the interventions. Ways for

older people and those with disabilities to participate in their communities will be identified and supported, paying particular personalised attention to those who are most isolated and lonely.

The WHO Global Network of Age-friendly Cities and Communities³⁸ is an international project to help cities prepare for two worldwide trends: rapid population ageing and growing urbanisation. The Network focuses on environmental, social and economic factors that influence the health and well-being of older people. An age-friendly city is an inclusive accessible urban environment that encourages active ageing. It is vital to achieve the participation of older people. Their contributions are important for assessing the age-friendliness of cities, setting priorities, proposing solutions and monitoring progress. Supported by the WHO, the capitals of all three Basque provinces have joined this Network. The associated initiatives are based around eight domains: outdoor spaces and buildings; transportation; housing; social participation; respect and social inclusion; civic participation and employment; communication and information; and community support and health services.

The Basque public telecare service is in the portfolio of services offered by the Department of Employment and Social Policy. Enabling people to remain in their own environment, it avoids them becoming isolated. The target population is over 65-year-olds living alone and individuals considered at-risk due to intellectual, physical or sensory disabilities regardless of the recognised degree of disability, as well as individuals diagnosed with mental illnesses who are recognised to have limited independence or be at risk of social exclusion.

OBJECTIVES AND ACTIONS

OBJECTIVE 3.1.

ACTIVE AGEING

To foster active ageing and independence among older people, giving priority to a community approach to health, its determinants and the local setting with actions that are both inter-sectoral and participative.

ACTIONS

3.1.1. Promote the implementation of the Age-friendly Cities programme in the Basque Country, together with the Association of Basque Municipalities (*Eudel*) and the relevant areas of the Basque Government.

3.1.2. Develop initiatives at the local level to promote physical activity in older people, with an efficient use of public and private resources.

3.1.3. Encourage interpersonal and intergenerational relationships; participation in associations and clubs; lifelong learning and empowerment; individual hobbies and interests; volunteering and community service.

3.1.4. Strengthen knowledge and skills of caregivers, patients and their families regarding healthy lifestyles, the most common diseases and accidents in older people, and coping with disability.

3.1.5. Encourage and develop volunteering among older people, in line with family policies of public institutions.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of people living in cities that have joined the WHO Age-friendly Cities Network	37% (2011)	>75%	Eudel Department of Health <i>Eustat</i>
Percentage of over 64-year-olds considered sedentary	Men: 28% Women: 44%	Men: ↓10% Women: ↓15%	Basque Health Survey
Percentage of over-60-year-olds who are a member of an association or club	Men: 10% Women: 14%	Men: ↑15% Women: ↑15%	<i>Eustat</i> . 2009 Survey on Living Conditions

OBJECTIVE 3.2.

HEALTH AND SOCIAL CARE

To reach an agreement on adequate intensive and/or long-term health and social care for older people and promote its provision through interdisciplinary case management for medically fragile and highly-dependent individuals.

ACTIONS

3.2.1 Develop and introduce a multidisciplinary and multi-sectoral instrument for comprehensive geriatric assessment, focused on the prevention, detection and management of problems in over-75-year-olds as well as people of younger ages who are medically fragile, have multiple conditions and/or cognitive impairment.

3.2.2. Develop and introduce a shared electronic health and social care record.

3.2.3. Establish and implement mechanisms and procedures to improve the coordination between healthcare and social services with the participation of the third sector, in residential care homes and other health and social care settings, using guidelines and protocols and applying the criteria of equality and effectiveness, thereby avoiding the risk of exclusion.

3.2.4. Promote integrated health and social care teams.

3.2.5. Develop the portfolio of health and social care services.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of highly-dependent and medically fragile patients that have undergone comprehensive health and social care needs assessment	Men: 3.48% Women: 2.74% (2012)	>50%	Office for Health and Social Care Services
Access to health records by professionals across health and social care services	--	2015	Basque Health Service
Percentage of health centres with integrated health and social care teams	--	>80%	Basque Health Service

OBJECTIVE 3.3.

FUNCTIONAL ABILITY AND INDEPENDENCE

To adapt healthcare to tackle the health problems associated with ageing as efficiently as possible, prioritising recovery and minimising loss of functional abilities.

ACTIONS

3.3.1 Develop a care plan for older people based on a holistic and inclusive approach to health problems, including coordination between health and social services at the local level and strengthening rehabilitation in the community.

3.3.2. Identify the health problems that cause functional impairment, disability, loss of independence, malnutrition, and social isolation in older people. Develop disease-specific prevention, care and rehabilitation programmes, paying particular attention to gender differences.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of health centres with a care plan for older people	--	100% in 2016	Basque Health Service

OBJECTIVE 3.4.

NEW TECHNOLOGIES

To adapt new technologies for elderly people, on the basis of evidence on their usefulness and efficiency, in line with the Strategy for Public Innovation of the Basque Government.³⁹

ACTIONS

3.4.1 Design and undertake assessments of the efficacy and cost-effectiveness of new technologies before their adoption.

3.4.2. Establish a portfolio of technical services for older people in their own home applying the criteria of sustainability and equity in funding.

3.4.3. Empower older people to ensure that a technological gap does not create or increase inequity in the use of technologies.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Establishment of a portfolio of ICT services for older people	--	2015	Basque Department of Health

OBJECTIVE 3.5.

CARE AT HOME

To ensure continuity of care for older people in their own home/environment.

ACTIONS

3.5.1 Develop and put into practice strategies for coordination between professionals in health and social care services to provide comprehensive and continuous personalised care for older people and those with disability, encouraging shared decision making between providers .

3.5.2. Integrate household and community services (prepared meals, laundry services, transportation, mobile libraries, etc.) into the portfolio of services currently offered (visits from doctors and nurses, supply of prescriptions, physiotherapy, podiatry, etc.).

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of over 75-year-olds with one or more hospital re-admission within one month	Men: 10.49% Women: 7.80% (2012)	↓20%	Basque Health Service

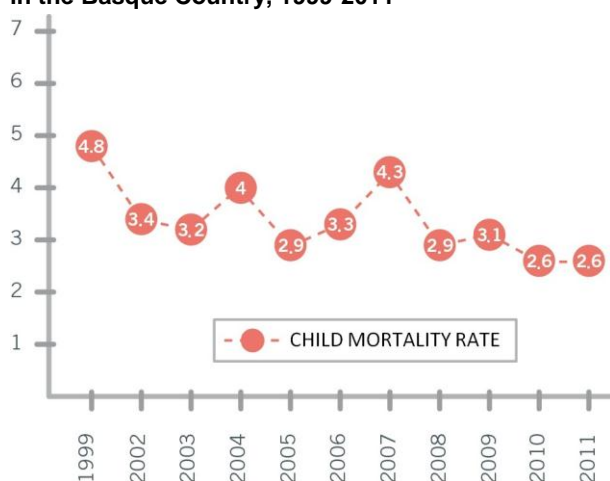
5.4. PRIORITY AREA 4: HEALTH OF CHILDREN AND YOUNG PEOPLE

DEVELOP POLICIES FOR IMPROVING THE ABILITY OF CHILDREN AND YOUNG PEOPLE TO MAKE HEALTHY LIFESTYLE CHOICES, TO MINIMISE THEIR RISK OF UNHEALTHY BEHAVIOURS AND IMPROVE THEIR SOCIAL AND AFFECTIVE OPPORTUNITIES, WITH A GENDER PERSPECTIVE

Health in adulthood is closely related to that in the early years of life. It is vital to achieve the best possible health outcomes in all children, ensuring equity in access to all the interventions and actions proposed.

According to the Mortality Registry, the rate of infant mortality (under one year of age) in the Basque Country in 2011 was 2.6 deaths per 1000 live births. This rate has been slowly decreasing since 1999 (by a cumulative total of 46%). Over the same period, perinatal mortality (stillbirths and deaths in the first week of life) has also decreased by 23% to a rate of 4.7/1000 live births in 2011 (Graphs 17 and 18).

Graph 17.
Child mortality rate (per 1000 live births)
in the Basque Country, 1999-2011



Graph 18:
Perinatal mortality rate (per 1000 live births) in the
Basque Country, 1999-2011



Source: Basque Mortality Registry

According to the mortality registry, the most common causes of mortality in children under one year of age in 2011 were perinatal conditions and congenital abnormalities, together accounting for 80% of the overall mortality in this age group. Low birth weight is another important factor related to perinatal mortality. According to the data of the Basque programme for neonatal screening for congenital diseases, the percentage of infants with low birth weight (under 2,500 g) remained steady at around 7% throughout the period 2001-2012.

According to a study on childhood and the environment in Gipuzkoa (the INMA project)⁴⁰, the rates of exclusive and non-exclusive breastfeeding at six months are 26% and 53%, respectively.

The programme of prenatal screening for Down's syndrome and other chromosomal abnormalities⁴¹ was extended in 2010 to all women receiving pregnancy care through the public health service. In 2012, 15,995 pregnant women participated in the programme. Over

the period 2009-2012, the rate of positive cases in this programme was 5.3%.

The newborn hearing screening programme was started in 2003 with the objective of detecting deafness before three months of age. In the period 2009-2011, the incidence of hearing loss was 5 per 1000 live births while the incidence of severe or moderate hearing loss was 2.8 per 1000 live births.

The Basque programme for neonatal screening for congenital diseases⁴² was launched in 1982 with screening for hypothyroidism and hyperphenylalaninaemia (PKU, phenylketonuria). Over the years, other disorders for which there is evidence of benefits of early detection have been added. Currently, the screen tests for the following conditions: hyperphenylalaninaemia (PKU), congenital hypothyroidism, medium-chain acyl-CoA dehydrogenase deficiency, cystic fibrosis, and sickle-cell disease (Table 3).

Table 3.
Cases detected in the Basque neonatal screening programme

CASES DETECTED IN THE NEONATAL SCREENING PROGRAMME. BASQUE COUNTRY 1982-2012		
	NUMBER OF AFFECTED INDIVIDUALS (Rate)	NUMBER OF CARRIERS (Rate)
Hyperphenylalaninaemia - phenylketonuria (PKU)	37 (1/15,610)	
Congenital hypothyroidism	155 (1/3,726)	
Medium-chain acyl-CoA dehydrogenase deficiency	2 (1/64,024)	2 (1/64,024)
Cystic fibrosis	10 (1/6,440)	34 (1/1,894)
Sickle-cell disease	11 (1/2,896)	137 (1/232)
Number of infants tested	577,602	

Source: Basque programme for neonatal screening for congenital diseases

The model for early years care⁴³ includes all the interventions focused on children up to six years of age, as well as their families and environments, and has the goal of responding as rapidly as possible to the short- and long-term needs of children diagnosed with or at risk of developmental disorders (Spanish White Paper on Early Care and Royal Board on Disability).

In 2011, the Inter-Agency Commission on Early Care (*Comisión Interinstitucional para Atención Temprana*) was created including representatives from the three key

areas: healthcare, social care and education. Its objective is to build a model for integrated healthcare, social care, and education providing professionals with instruments for assessing biological, psychological and social risk factors (in prenatal, perinatal and postnatal periods) and protocols for a coordinated, multidisciplinary approach to special needs.

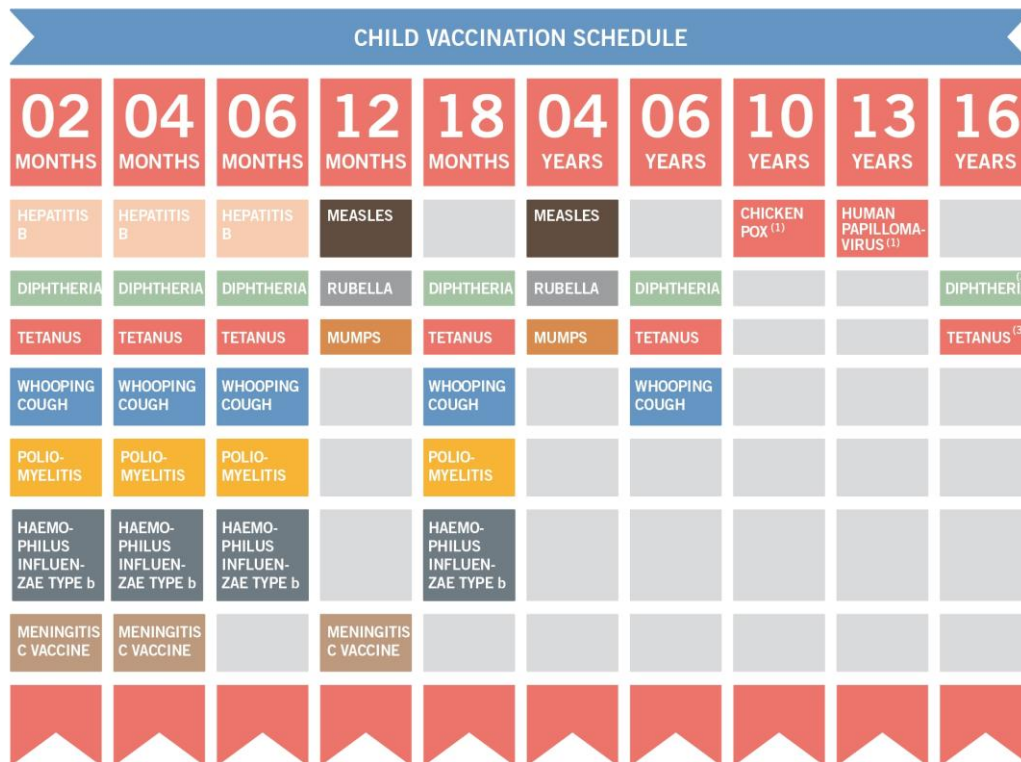
Approximately 10% of children have or are at risk of developmental delays or difficulties. This means an estimated 2,000 new cases in the Basque Country every

year, around 1,400 corresponding to children born prematurely.

Regarding the vaccinations, it is estimated that over 94% of children in the Basque Country are fully covered **Figure 7.**

Child vaccination schedule in the Basque Country, 2013

up to 18 months of age, and coverage remains above 90% for all the vaccines given to children at older ages. Figure 7 illustrates the vaccination schedule in the Basque Country as of 1 January 2013.



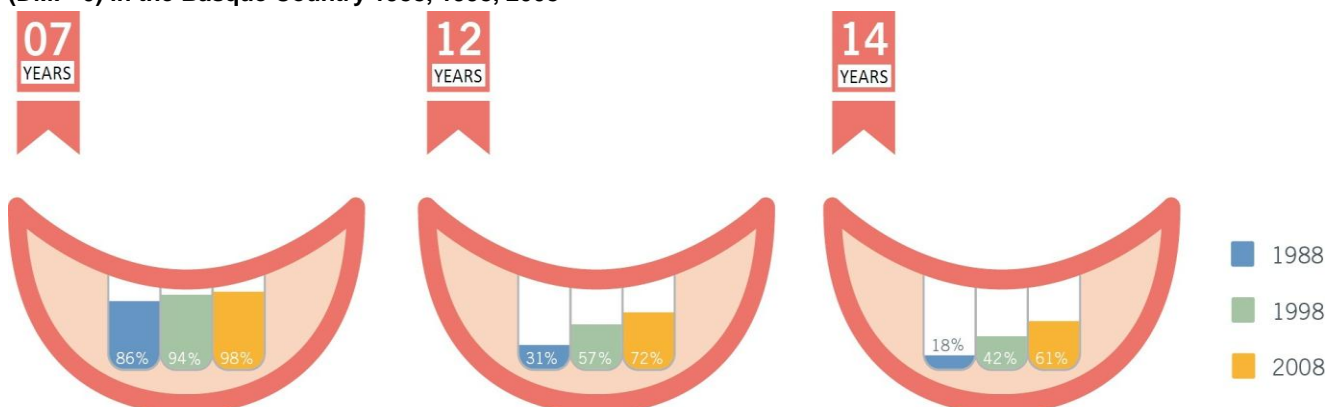
Source: Basque Child Vaccination Programme, Office for Public Health and Addictions

Evaluation of the Child Dental Care Programme (PADI) indicates a marked improvement in child dental health from 1988 to 1998; and this positive trend continued, though more slowly, in the following decade (Graph 19).

The high percentage of children with no experience

of dental caries at 14 years of age in 2008 (61%) is an excellent result, and augers well in terms of the chances of coming generations enjoying better oral health as adults. The percentage of children that were caries free (DMF=0) was, however, negatively correlated to social class and, despite the good results, a third of the child population do not participate in PADI.

Graph 19.
Percentage of children without caries experience (DMF=0) in the Basque Country 1988, 1998, 2008



According to the 2005 Basque Survey on Nutrition⁴⁵, 12.2% of 4- to 18-year-olds were obese, 12.7% of boys and 11.7% of girls. The highest rates of obesity were found in 11- to 14-year-olds in boys (19.4%) and 15- to 18-year-olds in girls (15.6%) (Graph 20). Considering socioeconomic status, the prevalence of obesity was higher in the most disadvantaged groups, in both sexes.

Graph 20.
Percentage of 4- to 18-year-olds
with obesity or overweight by age
and sex in the Basque Country, 2005



Source: Basque Survey on Nutrition, 2005

Forty percent of all 12- to 18-year-olds in the Basque Country reported being concerned about their weight, 52% of girls and 28% of boys; among those with obesity, the rate was as high as 68%.

Overall, 58.9% of girls were classified as sedentary, a considerably higher percentage than in boys (35.5%). In the 15- to 18-year-old age group, the percentage was higher (67%) in girls and lower (31%) in boys.

Mortality due to external causes in young people between 15 and 29 years of age was 13.9/100,000 in 2011, representing 56% of the overall mortality in this age group. This type of mortality has fallen steadily between 1998 and 2011. In this age group, road traffic accidents and suicide were the main causes of death (Graph 21).

Graph 21.
External causes of death
(mortality rates/100,000) in young people
(15-29 years old) in the Basque Country,
1998-2009



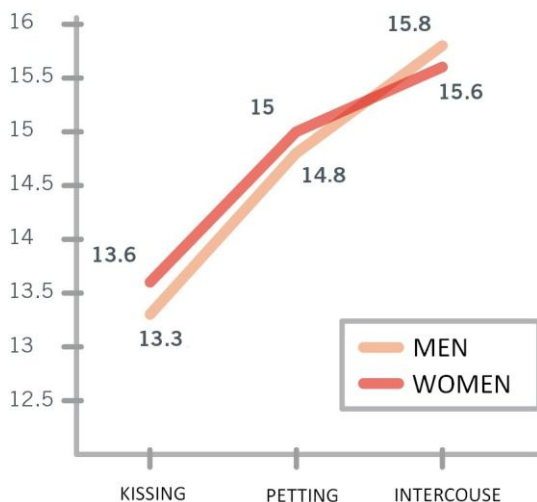
1998: Mean of the three-year period 1996-1998; European age-standardised rate/100,000 people
 Source: Basque Mortality Registry, Department of Health

Males have better mental health than females. According to 2013 Basque Health Survey, in 15- to 24-year-olds, the prevalence of anxiety and depression symptoms is higher in females (18.4% vs. 10% in males) and suicidal ideation is more common (3.8% vs. 2.0% in males). Anxiety, depression and suicidal ideation are more common among the most socioeconomically disadvantaged in both sexes.

Adolescence is a stage of transition between childhood and adulthood, associated with very important changes, given that in this period sexual orientation and gender identity are being formed, adult sexual feelings emerge and affective bonds are reorganised.

According to a study on patterns of sexual behaviour in adolescents and the status of sex education in secondary education in the Basque Country⁴⁶, a third of pupils in the final years of compulsory secondary education (ESO, ~15-16 years of age) are highly sexually active (Graph 22). Further, girls tend to have higher levels of sexual experience than boys at all levels of school education.

Graph 22.
Mean age at initiation of sexual activities among
adolescents (in compulsory secondary and
post-compulsory education) in the Basque
Country by sex



Source. Sexuality in adolescence in the Basque Country: patterns of sexual behaviour in adolescents and the status of sex education in compulsory secondary education in the Basque Country⁷. EHU-UPV 2011

Overall, 10% of sexually active adolescents did not use condoms for sexual intercourse. One in five of the sexually active female adolescents did not use this type of protection; of these 52% took oral contraceptives and 88% had a stable partner.

OBJECTIVES AND ACTIONS

OBJECTIVE 4.1. CHILD HEALTH

To promote child health using comprehensive interventions, supporting families with the process of child rearing, as the ideal time and place for activities promoting healthy lifestyles and prevention of high-risk behaviours.

ACTIONS

4.1.1. Consolidate the programmes for prenatal screening⁴⁰ and for neonatal screening for congenital disorders⁴¹, the latter programme including hearing loss screening.

4.1.2. Promote, protect and support the maintenance and duration of breastfeeding given the physical and emotional benefits, respecting the mother's wishes.

4.1.3. Increase the percentage of children receiving dental care under the Child Dental Care Programme (PADI), promoting access and take-up among the most disadvantaged social groups.

4.1.4. Promote genetic counselling for people with rare genetic disorders.

4.1.5. Be alert to the risk of child malnutrition and develop mechanisms for its prevention and treatment in coordination with social and education services.

4.1.6. Develop mechanisms to prevent, address and monitor child vulnerability (neglect and abuse as well as the consequences of violence against females).

4.1.7. Improve the coordination between health and social care services and the support to families in relation to mental illness in childhood and adolescence, keeping in mind the need for coordination with schools and other education services.

INDICATIONS	STATUS QUO	2020 TARGET	SOURCE
Percentage of low birth weight infants	7% (2012)	↓10%	Neonatal screening programme
Percentage of infants breastfed for at least six months	26% (2008)	>35%	Basque Health Service
Percentage of eligible children receiving care under the programme	66% (2012)	>75%	Child Dental Care Programme (PADI)
Percentage of children that are caries free at 12 years of age (DMF=0)	74% (2008)	80%	Child Dental Care Programme (PADI)

OBJECTIVE 4.2.

EARLY YEARS CARE

To develop and implement the Model for Early Years Care⁴³ among healthcare, social and education services, encouraging shared decision making between these providers.

ACTIONS

4.2.1 Design mechanisms that enable the early identification of vulnerable families and individuals at risk of developmental problems, as well as assessment and monitoring of their status.

4.2.2. Establish protocols and identify the multidisciplinary and inter-agency care resources to facilitate the processing of cases, and ensure coordination between healthcare structures, as well as the involvement of and support for families.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
IHOs/Health Regions that have adopted the Model for Early Years Care	One	All	Basque Health Service

OBJECTIVE 4.3.

CHILD AND ADOLESCENT OBESITY

To reduce child and adolescent obesity by means of a prevention plan with measures based on physical activity and healthy eating habits.

ACTIONS

4.3.1 Encourage inter-agency agreements with the food and catering industry for reducing the percentage of sugars, saturated fats and salt in processed and prepared foods.

4.3.2. Promote nutrition education and healthy lifestyles in family, school and community settings.

4.3.3. Develop interventions for the diagnosis, treatment and personalised monitoring of people with obesity, avoiding stigmatisation.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of 4- to18-year-olds who are overweight or obese	Overweight Obese Boys: 15.3% 11.7% Girls: 16.6% 12.7% (2005)	↓10%	Survey on Nutrition
Salt content in school meals	9.8 g/day (2009)	<5 g/day	Department of Health
Percentage of calories from total and saturated fats in school meals	--	Total fats < 30% Saturated fats <10%	Department of Health
Percentage of young people (15- to 24-year-olds) who are sedentary during their leisure time	Males: 25.1% Females: 44.1% (2013)	↓20%	Basque Health Survey

OBJECTIVE 4.4.

ADOLESCENCE AND EARLY ADULTHOOD

To encourage healthy lifestyles and decrease high-risk behaviours in young people.

ACTIONS

4.4.1 Introduce health consultations on specific issues for young people, especially for females (covering affective and sexual education, harassment, violence against females and peer-to-peer violence, and substance abuse).

4.4.2. Encourage the inclusion in school curricula of skills and conceptual, procedural and attitudinal contents related to healthy behaviours (considering eating habits, physical activity, and substance abuse and addiction including alcohol and tobacco use, and affective and sexual relationships).

4.4.3. Develop programmes for raising awareness and preventing violence, in particular violence against females, in education and community settings.

4.4.4. Support and drive forward measures for multi-sectoral interventions to reduce road traffic-related accidents in the framework of the Basque Strategic Plan for Road Safety.

4.4.5. Promote the development of the Youth Plan, encouraging active and healthy leisure activities through community action programmes (health and education authorities, city/town councils, etc.).

4.4.6. Encourage engagement, involvement in associations and clubs, volunteering, and intergenerational relationships. To this end, establish protocols and procedures in collaboration with the Offices for Youth and Family.

4.4.7. Promote affective and sexual education for adolescents and young adults with collaboration in the policy areas of Health, Education and Youth at all governmental levels.

4.4.8. Other actions on physical activity and healthy eating habits included in Area 5.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Mortality rate due to road traffic accidents (15- to 29-year-olds) (cases/100,000 people)	Male: 6.7 Female: 2.0 (2011)	Male: ↓20% Female: ↓20%	Mortality Registry
Mortality rate due to suicide (15- to 29-year-olds) (cases/100,000 people)	Male: 7.1 Female: 1.6 (2011)	Male: ↓20% Female: ↓20%	Mortality Registry
Termination of pregnancy (TOP) in females under 20 years of age (cases/1000 women)	10.02 (2011)	↓50%	TOP Registry

5.5.

PRIORITY AREA 5: THE ENVIRONMENT AND HEALTHY BEHAVIOURS

ENCOURAGE THE PROMOTION OF HEALTH, AND HEALTHY ENVIRONMENTS AND LIFESTYLES BY MEANS OF INTER-SECTORAL COLLABORATION AT LOCAL AND COMMUNITY LEVELS

The measures and actions conceived for this Area consider a broad, inter-sectoral perspective, working together with the rest of the Departments of the Basque Country Government and other Basque institutions. They include measures for the promotion of physical activity, healthy eating habits, mental health, and healthy work and leisure environments; as well as measures for the prevention of obesity, tobacco and alcohol use, and behavioural addictions (Table 4).

Table 4.
Age-standardised prevalence (%)
of the main risk factors for ill health
in the population over 14 years of age

	MEN	WOMEN
Overweight	43.0	28.2
Obesity	13.9	12.6
Smoking	24.1	18.7
Regular alcohol use	63.3	37.6
Sedentary lifestyle	26.6	34.0

Source: 2013 Basque Health Survey

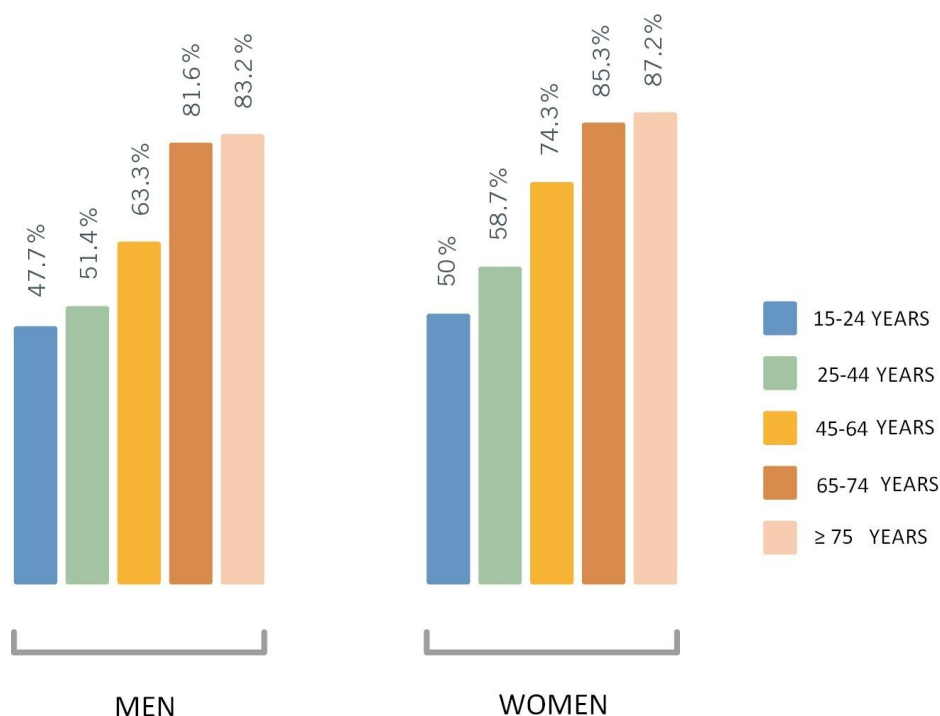
According to the 2013 Basque Health Survey, more women (69.2%) than men (62.0%) eat fruit on a daily basis, and women also eat more vegetables than men (32.1% vs 21.7%). In both sexes, the rate of daily consumption of fruit and vegetables increases with age (Graph 23) and it is lower in the most disadvantaged groups.

The rate of daily consumption of fruit and vegetables

is lower in the most disadvantaged groups, in both sexes.

A total of 60.0% of men and 54.0% of women eat meat three or more times per week, while 38.8% of men and 43.5% of women eat fish three or more times per week; both rates having fallen compared to 2007 in both sexes.

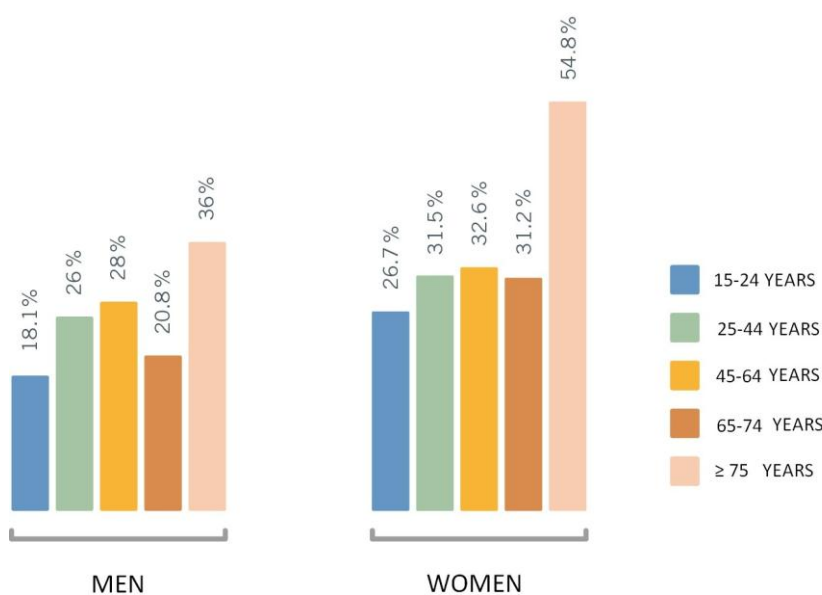
Graph 23.
Prevalence of
daily fruit
consumption
by sex and age
in the Basque
Country 2013



Source: 2013 Basque Health Survey

Physical activity reduces morbidity and mortality associated with heart disease, high blood pressure, stroke, diabetes, osteoporosis, metabolic syndrome, colon cancer, breast cancer and mental disorders, among other conditions. According to the 2103 Basque Health Survey, a sedentary lifestyle was more common among women (34.0%) than men (26.6%) (Graph 24); however, between 2007 and 2013, the percentage of physically active women remained steady (34.6% in 2007), while men have become less physically active (32.0% in 2007). A sedentary lifestyle was also more common among people from the most disadvantaged social groups.

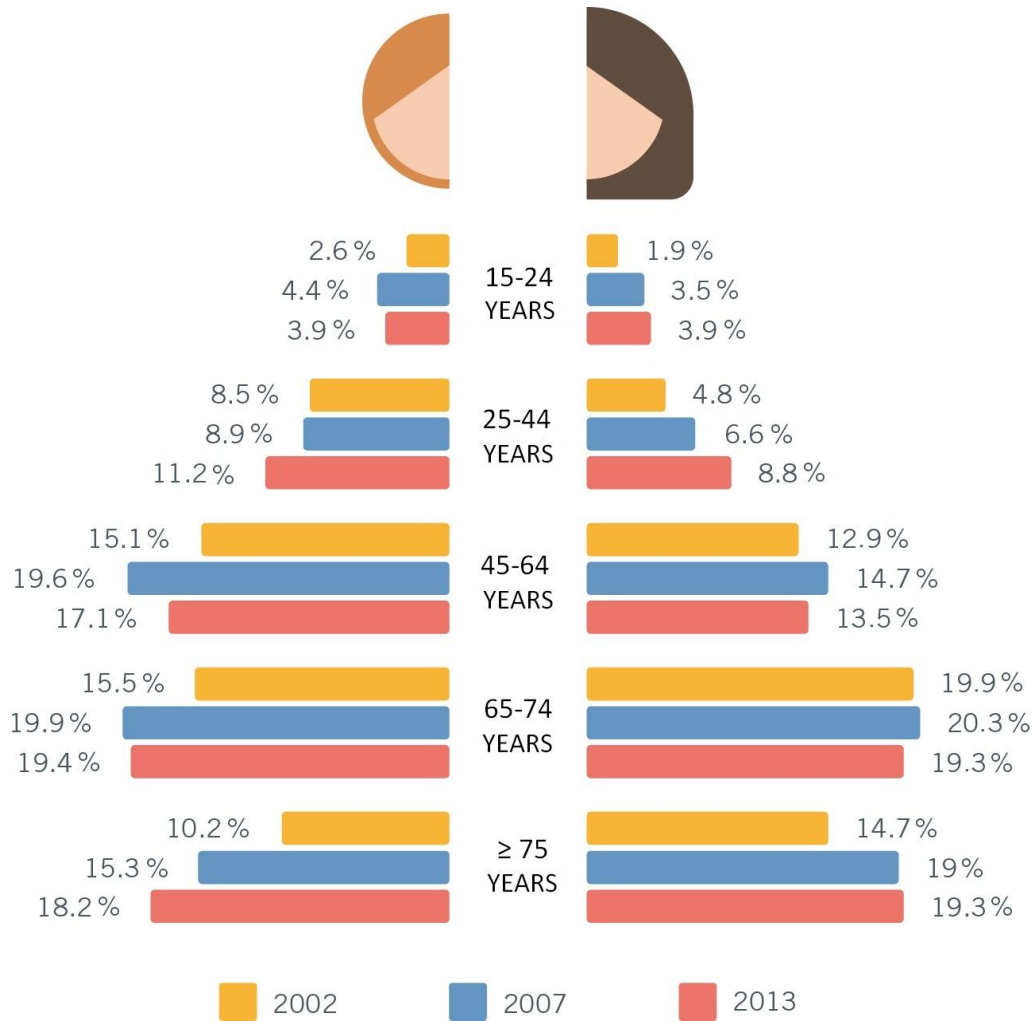
Graph 24.
Prevalence of
sedentary
behaviour by
age and sex
in the Basque
Country, 2013



Source: 2013 Basque Health Survey

According to the 2013 Basque Health Survey, the prevalence rate of obesity was higher in men (14.1%) than in women (12.3%) and higher among the most socioeconomically disadvantaged groups. In recent years, the prevalence of obesity has increased, particularly among young adults (25-44 years old) in both sexes (Graph 25).

Graph 25.
Prevalence of obesity by age
and sex in the Basque Country,
2002-2013

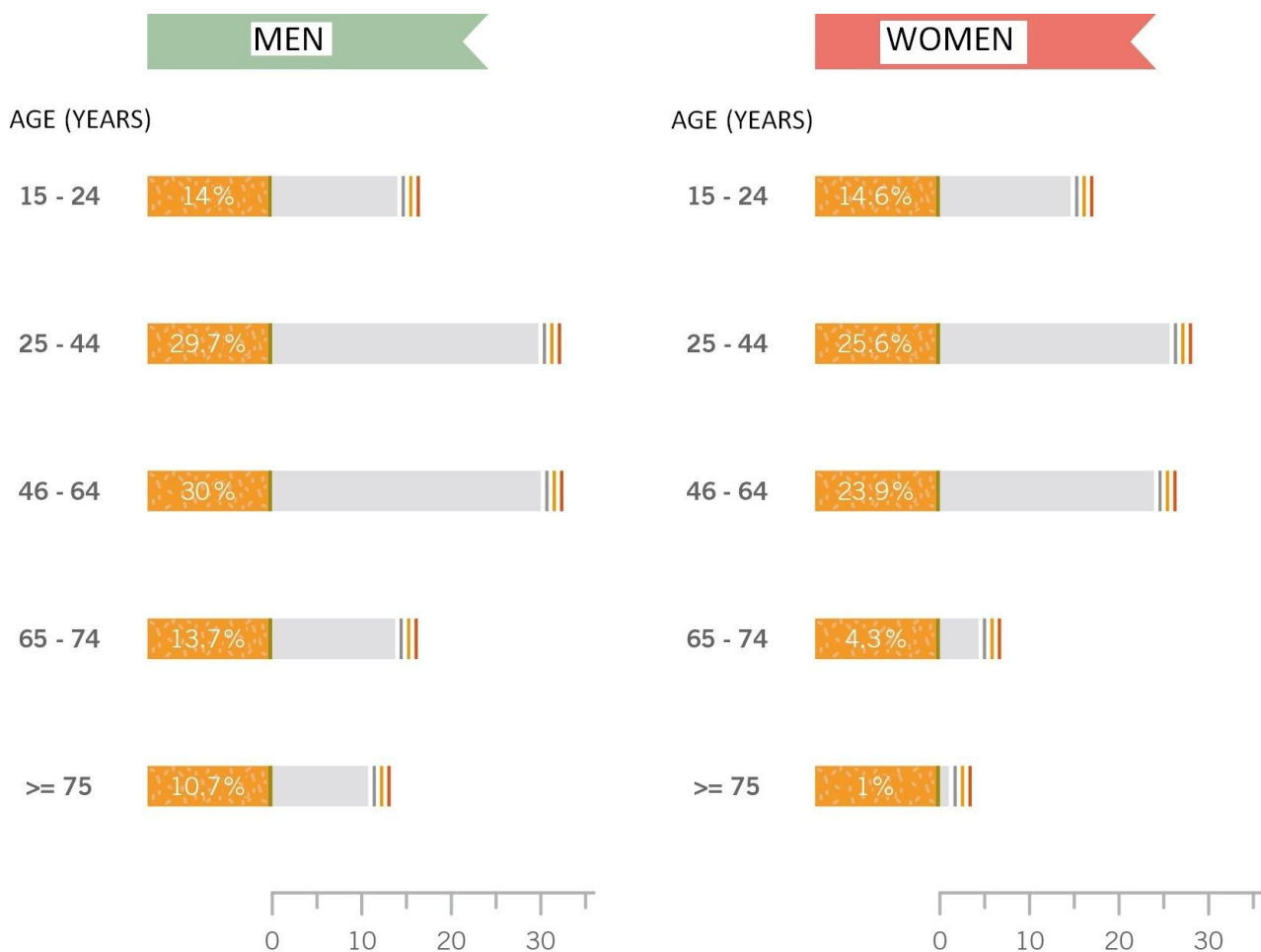


Source: Basque Health Survey

Smoking represents a key high-risk factor for disease and death. According to recent Basque Health Surveys, rates of smoking have steadily decreased since 1997 in men; in women, however, they have remained stable, even increasing slightly between 2002 and 2007. In 2013, the prevalence rates of smoking were 24.1% in men and 18.7% in women. A decrease observed in women between 2007 and 2013 was mainly due to falls in the prevalence of smoking among 15- to 24-year-olds (10.9%) and 25- to 44-year-olds (6.2%) (Graph 26).

The prevalence of smoking is higher among the most disadvantaged social groups at all ages, although the inequalities are particularly pronounced among young people (15-44 years old). The rate of secondhand smoke exposure (passive smoking) halved between 2007 (33.3%) and 2013 (15.5%), but there is a trend to higher exposure among people lower down the social scale.

Graph 26.
Prevalence of smoking by age
and sex in the Basque Country, 2013



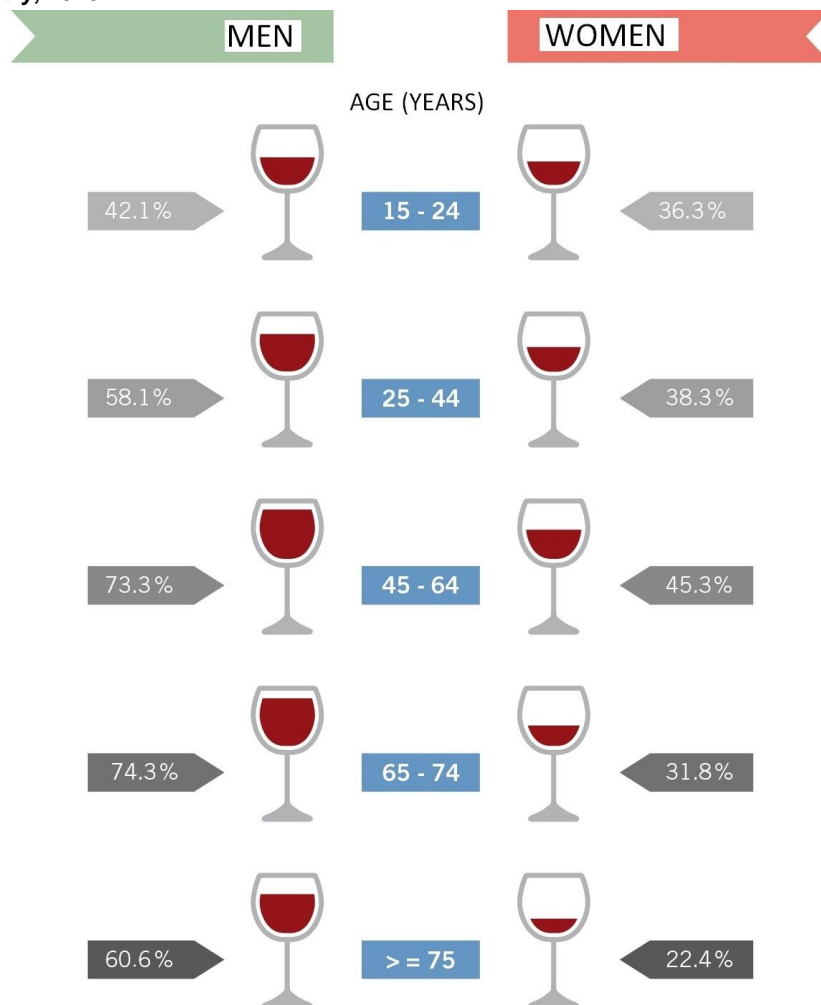
Source: 2013 Basque Health Survey

The mean age of smoking initiation is around 17 years of age and there has been a decrease in the percentage of adolescents starting to smoke before the age of 15.

Excessive alcohol use is another risk factor of poor health; in particular, alcohol abuse is one of the main avoidable causes of neuropsychiatric disorders, cardiovascular disease, and various types of cancer as well as liver cirrhosis. According to the 2013 Basque Health Survey, regular alcohol use has increased in recent years, from 58.9% (2012) to 63.3% (2013) in men, and from 29.3% (2002) to 37.6% (2013) in women. This increase has been observed in all age groups, except 15- to 24-year-olds, among whom the rate has fallen in both males (from 51.5% to 42.1%) and females (from 37% to 36.3%) (Graph 27).

The prevalence of alcohol use is higher among the best-off, especially in women among whom the rate in the highest social class is twice that in the lowest class.

Graph 27.
Age-standardised prevalence of regular alcohol use by age and sex in the Basque Country, 2013



Source: 2013 Basque Health Survey

In 2013, the age-standardised prevalence of heavy episodic (binge) drinking was 11.9% in men and 5.5% in women (Table 5). The rates of this type of problematic drinking were also higher among the best-off.

Table 5.
Prevalence (%) of binge drinking
by sex and age

	MEN	WOMEN
15- to 24-year-olds	17.5	9.1
25- to 44-year-olds	13.5	7.9
45- to 64-year-olds	13.5	5.2
65- to 74-year-olds	8.0	1.3
≥75-year-olds	3.0	0.7

Source: 2013 Basque Health Survey

Alcohol use starts at an early age, in general between 14 and 18 years of age (mean: 17 years). Nevertheless, those starting to drink before the age of 13 are very much in a minority (6.5%).

The age of initiation of cannabis and other illegal drug use is less than 20 years of age, according to the 2012 Survey on Drug Use in the Basque Country. For the most widely used substances, the age of initiation has remained stable and does not differ by socioeconomic status.

Between the sexes, however, there are significant differences in problematic or high-risk substance use. Excessive alcohol, tobacco, cannabis and polydrug use is more common in men, while women tend to abuse over-the-counter psychoactive drugs.

Non-substance addictions such as gambling and problematic Internet use are on the rise. Slightly more men than women are involved in these addictive behaviours (Table 6).

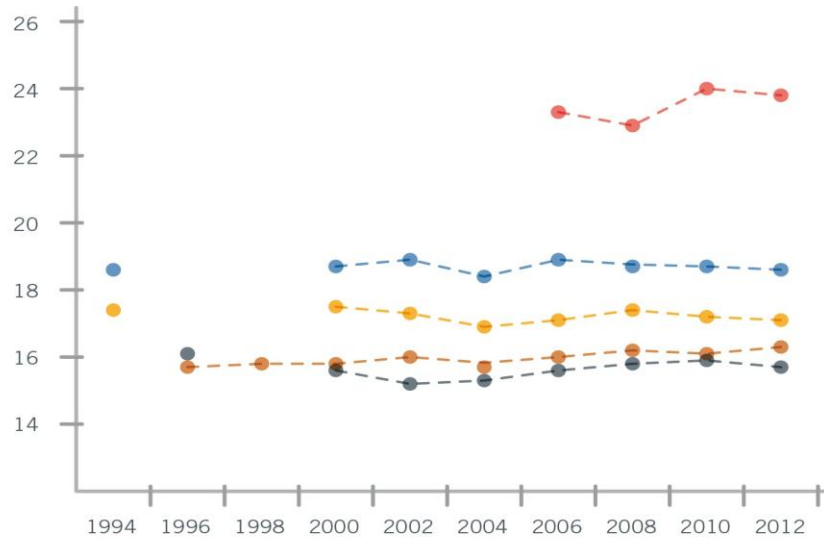
Table 6.
Prevalence of problematic behaviour
(related to behavioural addictions)
by sex in the Basque Country, 2012

	MEN	WOMEN	TOTAL	SEX RATIO MALE/FEMALE
Regular gambler	26.5	18.8	22.6	1.4
At risk/problem gambling	3.6	2	2.8	1.8
At risk/problematic Internet use	3.3	2.7	3.0	1.2

Source: 2012 Survey on Drug Use in the Basque Country

Graph 28:
Mean age at initiation of tobacco, alcohol and other substance use

For the most widely used substances, the age of initiation of use has remained stable (Graph 28) and does not differ by socioeconomic status.

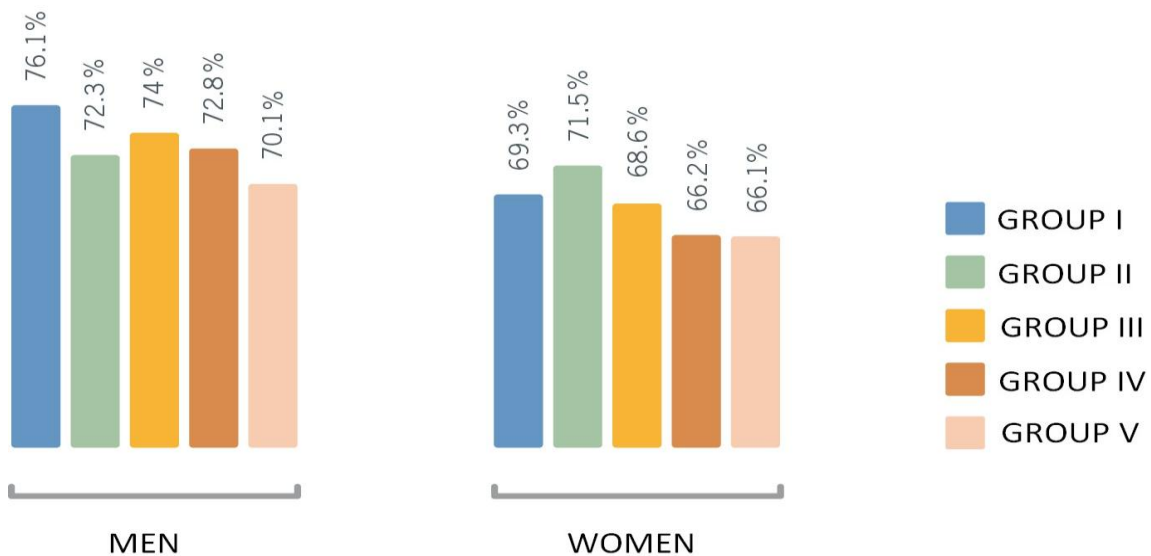


● ALCOHOL		16.1		15.6	15.2	15.3	15.6	15.8	15.9	15.7
● TOBACCO		15.7	15.8	15.8	16	15.7	16	16.2	16.1	16.3
● CANNABIS	17.4			17.5	17.3	16.9	17.1	17.4	17.2	17.1
● ANY OTHER ILLEGAL DRUGS	18.6			18.7	18.9	18.4	18.9	18.7	18.7	18.6
● PSYCHOACTIVE DRUGS WITH OR WITHOUT PRESCRIPTION							23.3	22.9	24	23.8

Source: 2012 Survey on Drug Use in the Basque Country

Graph 29.
Age-standardized mean score on the Mental Health Inventory-5 by sex and socioeconomic status in the Basque Country, 2013

According to the measure used in the 2013 Basque Health Survey (the Mental Health Inventory-5 score), men have better mental health than women in the overall population and in each age group; the differences between the sexes increasing with age. As can be seen, mental health generally worsens as you go down the social scale in both sexes, with larger inequities in women (Graph 29).

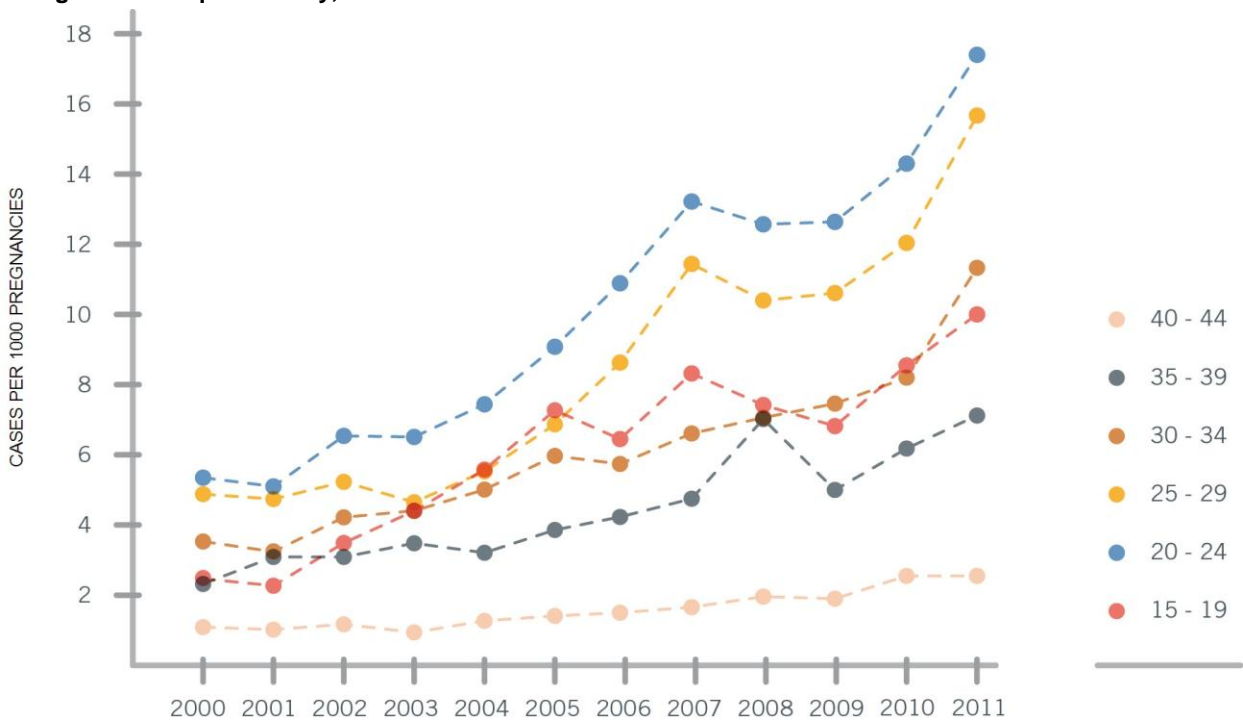


Source: 2013 Basque Health Survey

REPRODUCTIVE HEALTH

According to the 2011 Basque TOP registry, 4,138 induced terminations were performed: 24.2% in 25- to 29-year-olds and 10.3% in under 20-year-olds. The rate of TOPs (number of terminations per 1000 women of 15 to 44 years of age) has increased from 2.60 in 1993 to 9.90 in 2011. The highest rates are observed in women between 20 and 30 years of age (Graph 30).

Graph 30.
Rate of induced terminations of pregnancy (TOP)
by age (years) among women of reproductive age
living in the Basque Country, 2000-2011



Source: TOP Registry, Department of Health⁴⁷

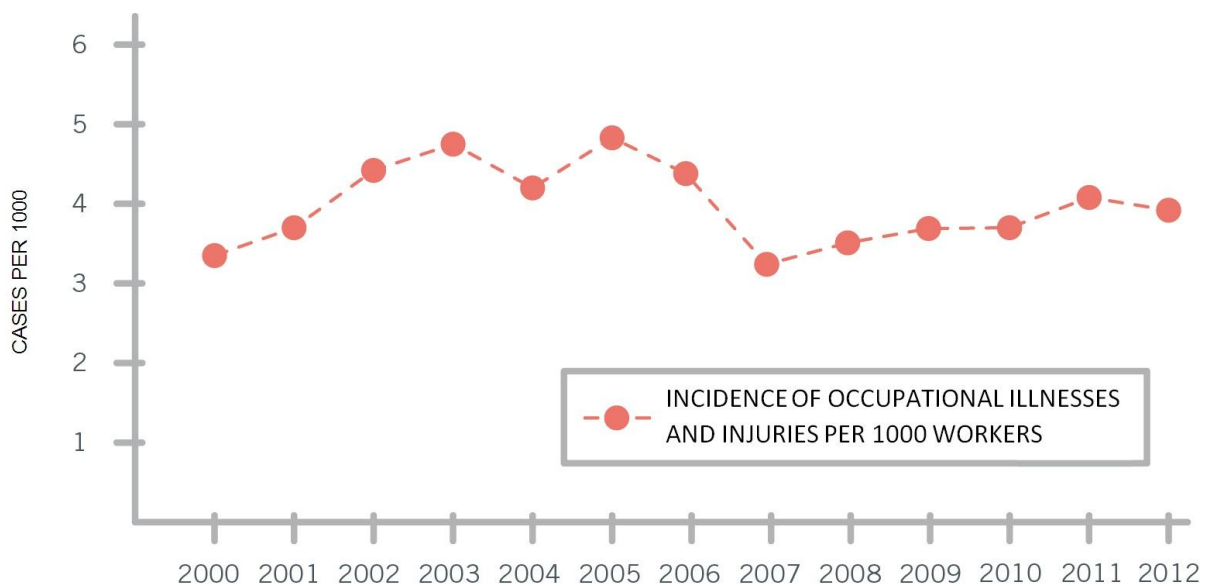
According to *Eustat*, the number of births per year in the Basque Country grew by 15.7% from 2001 to 2011. This growth is mainly due to an increase in fertility rates in women above 35 years of age, from 21 to 32 births per 1000 women over this period. There is particularly notable rise in the number of children born from women at the extremes of maternal age. In 2011, the fertility rate of women above 40 years of age has reached 7.9/1000 women and that of women under 20 years of age 6.0/1000 women, up from 3.3/1000 and 3.7/1000 respectively in 2001.

HEALTH AND SAFETY AT WORK

According to Basque Institute of Safety and Health at Work (OSALAN), there has been a marked increase in hearing problems (noise-induced hearing loss), a progressive increase in the diseases of the nervous system (carpal tunnel syndrome and related conditions) and of the respiratory system, and a slight increase in occupational cancer. On the other hand, we have seen a progressive decline in infectious illnesses, and in skin, muscle and tendon problems.

The incidence rate of occupational illnesses and injuries rose between 2000 and 2006. The marked decrease in 2007 is attributable to changes in occupational ill-health reporting systems. In the following years, there was a slow but steady increase in the incidence of recognised work-related illnesses and injuries, increasingly dominated from 2007 onwards by health problems for which no sick leave is taken, unlike in the previous period (Graph 31).

Graph 31.
Incidence of occupational illnesses and injuries in the Basque Country, 2000-2012



Source: Basque Institute of Safety and Health at Work (OSALAN)

OBJECTIVES AND ACTIONS

OBJECTIVE 5.1.

PHYSICAL ACTIVITY

To promote physical activity in the population in accordance with the guidelines and strategies defined in the Basque Plan for Physical Activity.

ACTIONS

5.1.1. Train health professionals, teachers and others in the education sector and local council staff, in the promotion of physical activity and provision of health-related advice to the population.

5.1.2. Develop specific initiatives at the local level, strengthening the channels of communication between healthcare and education centres and local physical activity facilities.

5.1.3. Stimulate innovation in the promotion of physical activity.

5.1.4. Promote healthy urbanism in Basque municipalities, including specific measures for promoting physical activity in urban planning and design tools. Promote the network of pedestrian-friendly cities (*Red de Ciudades que Caminan*).⁴⁸

5.1.5. Adapt the physical activity programmes offered and associated resources to suit the needs and preferences of different sub-groups of the population, in particular women.

5.1.6. Increase the number of hours dedicated to physical activity per week at all levels of education.

INDICATORS	STATUS QUO ^o	2020 TARGET	SOURCE
Prevalence of sedentary lifestyle	Men: 26.6% Women: 34.0% (2013)	Men: ↓10% Women: ↓↓15%	Basque Health Survey
Social inequalities in sedentary lifestyle by sex and social class	RII Men: 1.44 RII Women: 1.18 (2013)	Men: ↓10% Women: ↓10%	Basque Health Survey

OBJECTIVE 5.2.

HEALTH AND NUTRITION

To design and implement a strategy for healthy eating habits for the population of the Basque Country, taking into account social and gender differences in dietary patterns.

ACTIONS

5.2.1. Monitor the pattern of eating habits in the population of the Basque Country and make dietary recommendations.

5.2.2. Improve the collaboration between all the stakeholders (institutions, industry and society) with the aim of reaching a consensus on the goal of reducing the intake of sugars, salt and saturated fats.

5.2.3. Facilitate, together with the Offices for Consumer Affairs, Commerce and Economic Development, access to high-quality healthy, varied, fresh food.

5.2.4. Train clinicians in nutrition-related care, including provision of brief advice and prescribing healthy diets.

5.2.5. Promote research into healthy eating habits and innovation in this field.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Prevalence of daily fruit consumption	Males: 62.0% Females: 69.2% (2013)	Males: ↑20% Females: ↑20%	Basque Health Survey
Prevalence of daily vegetable consumption	Males: 21.7% Females: 32.1% (2013)	Males: ↑20% Females: ↑20%	Basque Health Survey
Percentage of calories from total and saturated fats in school meals	--	Total fats < 30% Saturated fats <10%	Department of Health
Salt content of institutional meals	9.8 g/day 2009	<5 g/day	Department of Health

OBJECTIVE 5.3.

SEXUAL AND REPRODUCTIVE HEALTH

To promote a healthy, pleasurable and egalitarian sexuality.

To provide a comprehensive, continuous and high-quality reproductive care.

ACTIONS

5.3.1. Design information and education programmes on sexual health, based on gender equality and respecting sexual diversity.

5.3.2. Promote the provision of sexual healthcare across all levels of care, taking into account the different contexts of vulnerability and diversity.

5.3.3. Improve access to contraception.

5.3.4. Ensure an integrated healthcare process from the pre-conception stage through pregnancy, labour, birth, and postnatal periods to care of the infant, in accordance with clinical practice guidelines based on the best available evidence.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of women with an adequate intake of folic acid before and through pregnancy	50% (2011) ⁴⁹	>70%	Basque Health Service
Percentage of the target population cared for using an integrated care pathway from pregnancy to the postpartum period	--	100%	Basque Health Service
Episiotomy rates in normal vaginal deliveries (%)	36% (2010) ⁵⁰	<15%	Basque Health Service
Rate of induced terminations (cases per 1000 women of reproductive age)	9.9 (2011)	↓50%	TOP Registry

OBJECTIVE 5.4.

ADDICTIONS

To prevent addictive behaviours (use of alcohol, tobacco and other substances, as well as non-substance-related addictions); reduce and delay the age of initiation of smoking, and alcohol and other substance use; and minimise the harm caused by addictions.

ACTIONS

5.4.1. Develop the strategic directions and actions set out in the IV Plan for Addictions⁵¹, especially measures focused on:

- Delaying the age of substance use initiation.
- Decreasing the presence and availability of tobacco, alcohol and other addictive substances.
- Strengthening universal prevention programmes as well as those targeting particularly vulnerable groups, with an emphasis on family, school and community settings.
- Promoting healthy and pro-social lifestyles, behaviour and values, through inter-agency coordination and collaboration with the third

sector.

- Consolidating the strategy for reducing risk and harm.

5.4.2. Take forward the strategy for creating a tobacco-free society in our region.⁵²

5.4.3. Develop interventions for decreasing high-risk alcohol use.

5.4.4. Promote efforts to tackle non-substance-related addictions through both prevention and treatment.

5.4.5. Revise and update the legislation on addiction.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Social inequality in the prevalence of smoking (15- to 44-year-olds)	RII Males: 2.03 RII Females: 2.37 (2013)	Males: ↓20% Females: ↓20%	Basque Health Survey
Prevalence of exposure to secondhand smoke	Men: 17.1% Women: 15.6% (2013)	Men: ↓50% Women: ↓50%	Basque Health Survey
Advice on smoking in primary care (% of smokers)	33.7% (2012)	>60%	Basque Health Service
Percentage of smokers in cessation treatment	Men: 1.9% Women: 2.5% (2013)	↑15%	Basque Health Service
Age of initiation of alcohol use	Males: 15.8 years old Females: 17.3 years old (2012)	18 years old	Survey on Drug Use in the Basque Country
Prevalence of at-risk alcohol use among 15-to 24-year-olds	Males: 17.3% Females: 17.9% (2013)	↓30%	Basque Health Survey

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Prevalence of weekend binge drinking among young people (15- to 34-year-olds)	Males: 15.7% Females: 7.0% (2012)	Males: ↓20% Females: ↓20%	Survey on Drug Use in the Basque Country
Prevalence of health problems related to at-risk alcohol use	Males: 25.1 Females: 14.7 (2013)	↓10%	Basque Health Survey
Prevalence of daily cannabis use among young people (15- to 34-year-olds)	Males: 2.5% Females: 0.9% (2012)	Males: ↓10% Females: ↓10%	Survey on Drug Use in the Basque Country

OBJECTIVE 5.5.

MENTAL HEALTH

To promote mental and emotional health, taking into account social and gender differences.

ACTIONS

5.5.1. Identify and develop inter-sectoral policies and interventions to strengthen community networks and enhance social engagement, with a special emphasis on reaching women, minors and older people.

5.5.2. Design interventions to prevent stress, anxiety and depression focusing on the most vulnerable groups and the workplace in general.

5.5.3. Design community-based interventions in areas at high risk of social exclusion and marginalisation, to act on the determinants of mental health and addiction.

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Social inequality in the prevalence of good mental health by social class and sex (MHI-5)	Men Group I: 76.1% Group V: 70.1% Difference: 6.0% Women Group I: 69.3% Group V: 66.1% Difference: 3.2% (2013)	Men: ↓50% Women: ↓30%	Basque Health Survey

OBJECTIVE 5.6.

ENVIRONMENT

To ensure a high-quality environment by controlling and monitoring environmental risks (water, food, air and soil) and make related information available to the public.

ACTIONS

5.6.1. Promote institutional coordination in the control and monitoring of environmental risks.

5.6.2. Improve the quality of environmental data and make it more readily accessible to the public.

5.6.3. Improve food and drink safety, reinforcing public

knowledge of food- and drink-related health risks and engagement in minimising these risks.

5.6.4. Develop biomonitoring programmes for environmental exposure to harmful substances in the general population and particularly in the most vulnerable groups (pregnant women, children, etc.).

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Percentage of the population living in areas with PM10 air pollution levels < 20 µg/m ^{3j}	59% (2012)	75%	Department of Health
Percentage of the population receiving drinking water with treatment by-product levels < 50 µg/l	47% 2012	>95%	Department of Health (EKUIS)

^j corresponding to the annual mean (limit) for suspended particulate matter with a diameter of less than 10 µm in the WHO air quality guidelines

OBJECTIVE 5.7.

WORKING ENVIRONMENT

To prevent the most important risk factors for occupational injuries and illnesses among the working population, taking into account social and gender differences.

ACTIONS

5.7.1. Develop and improve the surveillance mechanisms for work-related risk factors as well as occupational injuries and illnesses.

5.7.2. Develop the Occupational Health and Safety Strategy.⁵³

5.7.3. Promote research on health and accidents at work

5.7.4. Promote the intervention of health and safety services and occupational health committees focused on prevention of work-related stress and mental illness.

5.7.5. Foster and facilitate healthy working conditions (physical activity, healthy eating, prevention of addictions, etc.).

INDICATORS	STATUS QUO	2020 TARGET	SOURCE
Incidence rate of work-related illness	Men: 4.16‰ Women: 1.51‰ (2012)	↓10%	Basque Institute for Health and Safety at Work
Fatal work-related injuries	Men: 8.7/100,000 Women: 0.9/100,000 (2012)	↓10%	Basque Institute for Health and Safety at Work
Percentage of companies with assigned health and safety officer(s) or a dedicated internal service to oversee health and safety matters	54.3% (2012)	>95%	Basque Institute for Health and Safety at Work

6.

IMPLEMENTATION AND MONITORING

IMPLEMENTATION AND MONITORING OF THE 2013-2020 HEALTH PLAN

As stipulated in the Healthcare Standards Act, the Health Plan is the document that frames all the public policies in the field of health in the Basque Country.

This Health Plan marks the start of a process of comprehensive change in healthcare for the population of the Basque Country. The strategies and actions contained in the plan are to be rolled out at regional, health organisation, and council levels, among others. From now on, work must start with the different stakeholders involved to detail and implement the

MANAGEMENT OF THE HEALTH PLAN

The Health Plan is not just an expression of good intentions; rather it serves as a roadmap from the Department of Health for change in the model of care over coming years. The Department will be responsible for the execution of the projects and public and transparent evaluation of the objectives. Specifically, the Department undertakes to implement the projects designed, and annually both monitor indicators assessing progress towards the objectives set and report to the Health Committee of the Basque Parliament.

The good management of health and well-being of the population poses two closely related challenges:

- Governance for health: promoting cross-sectoral and inter-sectoral approaches in public administration, and the productive and third sectors. That is, combining the efforts of governments and other players with the goal of creating health as a vital factor in the well-being of the population.
- Governance of the health system: strengthening the healthcare system in terms of equity, quality, efficiency and sustainability.

Management of the good health of the population requires strong leadership by the Basque Government through the Department of Health, with an organisational proposal for all institutions and society as a whole. This is what is known as HiAP.

The organisational structure for the management, promotion, monitoring and evaluation of the Health Plan,

projects for change.

Evaluation, monitoring and accountability are essential to ensure the proper implementation of this plan through continuous improvement and re-adjustments in the Priority Areas for action. The principles for evaluation of the plan seek to ensure assessment of the effects of the specific actions proposed on the health of the population of the region, in relation to reducing inequities and strengthening the healthcare system.

on the basis of the aforementioned criteria and vision, is as follows:

A.- Governance FOR health

A.1.- Inter-departmental Level

1.- Steering Committee

2.- HiAP Technical Committee

A.2.- Inter-agency Level

B.- Governance OF the health system

B.1.- Intradepartmental Level: Department of Health-Basque Health Service

1.- Department of Health Management Committee

2.- Health Plan Technical Committee

A. GOVERNANCE FOR HEALTH

A.1.- INTER-DEPARTMENTAL LEVEL

1.

Steering Committee for the 2013-2020 Health Plan

COMPOSITION	
CHAIR	The Basque Prime Minister
DEPARTMENTS OR OFFICES REPRESENTED AT THE LEVEL OF DEPUTY MINISTER	Prime Minister's Office Technology, Innovation and Competitiveness Commerce and Tourism Agriculture, Fisheries and Food Policy Social Policy Housing Economy and Budgets Education Culture, Youth and Sport Health The Health Service The Environment Transport Regional and Urban Planning

The mission of this Steering Committee is to review and approve strategies and objectives in the Health Plan from a HiAP perspective and this regional administration's focus on sustainable development. The members undertake to promote in their respective areas the principles of sustainability in sectoral policies and strengthen civic engagement in current fora and processes.

Functions:

- To ensure policies are developed and that they are applicable, accepting shared responsibility for the commitments made in this Health Plan, in relation to the distribution of powers of the Basque Government Departments.
- To identify and develop public policies with the greatest potential to influence equity in health, propose actions to reduce inequities across the social gradient, and mobilise the resources necessary to implement them, as well as mechanisms to evaluate them.

2.

HiAP Technical Committee

Actions and functions:

- To propose and design suitable actions to develop the strategies for intervention proposed in the Plan, and prioritise them in relation to the available resources.
- To be proactive in presenting proposals to advance the HiAP approach in the internal coordination of the Basque Government.
- To raise awareness in governmental and non-governmental organisations at regional, provincial and council levels of the principles of the HiAP strategy and its implementation.
- To prepare a report every two years on the ratification of and commitment to the Health Plan by each of the sectors involved.
- To promote health and health equity impact assessment of public policies in both healthcare and other sectors.
- To assess the health results achieved under this Health Plan and prepare an annual report on these

results to be presented to the Steering Committee.

- To monitor progress towards the objectives of the Health Plan, as well as propose changes and re-adjustments in the objectives and actions of the Plan.
- To perform training interventions for staff of public bodies on the HiAP strategy, inter-sectoral and inter-agency coordination, mechanisms to facilitate public participation, and methods and tools for assessing the impact of all public policies on health.

COMPOSITION	
CHAIR	Head of the Office for Public Health and Addictions
OTHER MEMBERS	Specialised staff from the Offices of the Deputy Ministers represented on the Steering Committee

A.2.- INTER-AGENCY LEVEL

Governance for health can be managed through the existing structures of the Basque Health Council and Health Councils for the regions of Araba, Bizkaia and Gipuzkoa previously set up under Decree 260/1999.

The aforementioned Decree establishes the membership of these Councils and their functions, which include consultation and advisory powers for the

definition of general plans and objectives for the system, as well as for the monitoring and final evaluation of the results of their implementation.

In this way, the 2013-2020 Health Plan establishes the Basque Health Council as the governmental structure for health.

B. GOVERNANCE OF HEALTH

INTRA-DEPARTMENTAL LEVEL

1.

Department of Health Management Committee

COMPOSITION	
CHAIR	The Basque Health Minister
MEMBERS	Deputy Minister; Director of the Basque Health Service; Heads of the Offices for Public Health and Addictions, Health Insurance and Procurement, Pharmacy, Health Research and Innovation, Health Planning, Management and Evaluation, Legal, Financial and General Services, as well as of the Cabinet Office.

2.

Technical Committee for the Health Plan

Answering to the Management Committee of the Department of Health, this committee is responsible for developing the programme to evaluate the implementation of the actions and is the guarantor of all aspects of the process that fall within the competence of the Department of Health.

In this role, it is advised and supported by the current services, committees and structures of the Department of Health: the Basque Foundation for Health Innovation and Research (*BIOEF*), the Basque Office for Health Technology Assessment (*OSTEBA*), the Pharmacy Office, Basque Health Service committees, and Department of Health advisory committees.

Functions:

- To conduct regular evaluations to monitor the progress of the Health Plan.
- To focus the process of health procurement towards the policy objectives and strategies of the Health Plan
- To make progress with the integration of programmes, with their corresponding budgets, to improve sustainability.
- To monitor the actions to improve the quality of care through programme contracts and agreements
- To conduct evaluations based on the indicators

established in the programme contracts.

- To collaborate in the design and introduction of the Public Health interventions related to the Health Plan, as well as monitor these interventions, in accordance with the corresponding indicators established.
- To introduce procedures, methods and tools to evaluate policies, programmes and projects in relation to their effects on the health of the population and the distribution of these effects across the population.

7.

APPENDICES

7.1. APPENDIX 1: GLOSSARY OF TERMS

AIDS	acquired immune deficiency syndrome
COPD	chronic obstructive pulmonary disease
DFLE	disability-free life expectancy
DM	diabetes mellitus
DMF	decayed-missing-filled index
EU	European Union
<i>Eustat</i>	Basque Institute of Statistics (<i>Instituto Vasco de Estadística</i>)
GDP	gross domestic product
HBP	High Blood pressure
HiAP	Health in All Policies
HIV	human immunodeficiency virus
ICT	information and communication technology
IHO	integrated health organisation
MBDS	minimum basic data set
OECD	Organisation for Economic Co-operation and Development
PKU	phenylketonuria
PM10	suspended particulate matter with a diameter of less than 10 µm

PMP	per million people
RII	relative index of inequality
TOP	termination of pregnancy
UN	United Nations
WHO	World Health Organization

7.2. Appendix 2: References

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