*Flu*nomics Report

From vaccination to protection – Understanding the influenza protection gap in older adults



Spain

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Spain

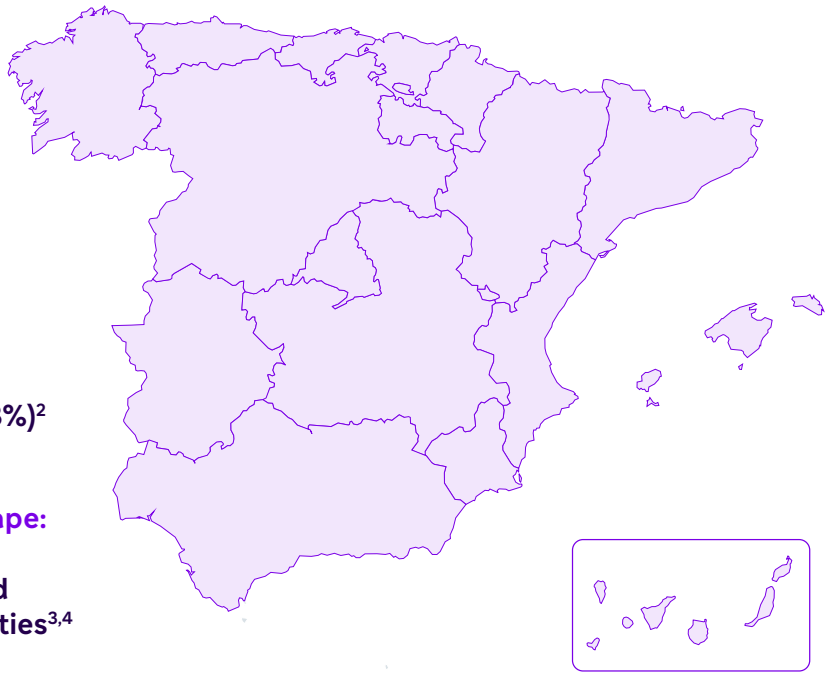
Spain's decentralized healthcare system creates regional variation in influenza vaccination implementation. While annual influenza vaccination is recommended nationally for all adults aged 60+ years, no preferential recommendations for specific vaccine types exist, and eligibility for age-specific vaccines varies across autonomous communities.

Spain at a glance

Total population (2026):
49.8 million[1]

Adults aged 65+ (2025):
10.2 million (20.8%)[2]

Regional landscape:
17 autonomous communities and 2 autonomous cities[3,4]



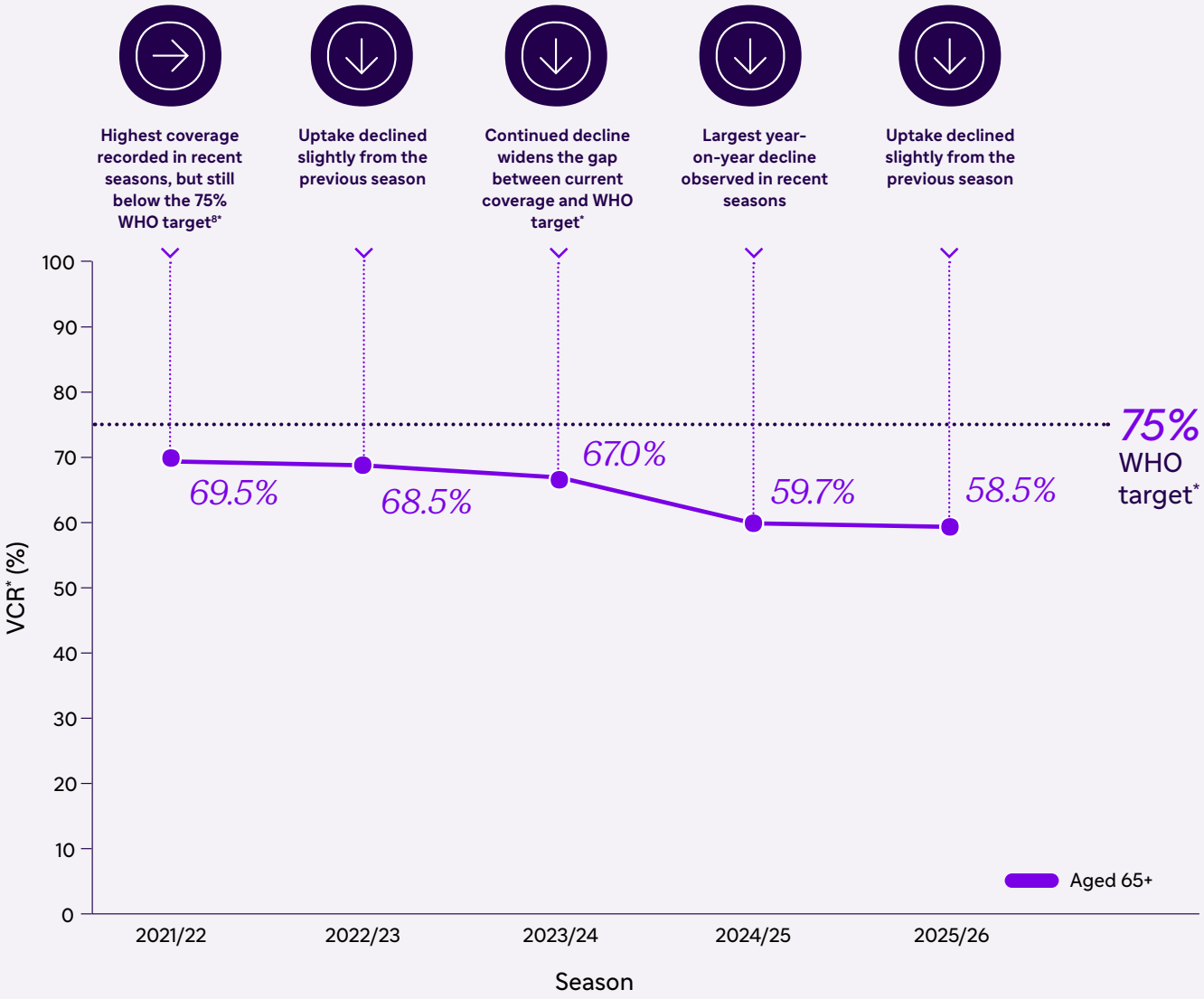
National influenza policy

Annual influenza vaccination is recommended nationally for **adults aged 60+ years** and **other eligible risk groups**.[5] However, autonomous communities determine how seasonal vaccination programs are implemented, so eligibility for age-specific vaccination varies across the country, and access to age-specific protection is inconsistent.

More than one in five people in Spain are aged 65+ years, making it one of the oldest populations in Europe.[2,6] Despite long-standing recommendations and a publicly funded vaccination program, influenza vaccination coverage has **declined by 11 percentage points since 2021/22**, remaining well below the **World Health Organization (WHO) target of 75%** in people over the age of 65.[7,8] The opportunity is no longer to define who should be protected, but to ensure national recommendations are translated into consistent, age-specific protection for all eligible older adults.

Declining vaccination coverage highlights the challenge of translating national recommendations into protection

Five-year influenza vaccination coverage rate (VCR)[7]



Gripómetro survey estimates from the 2022/23 campaign indicated **higher self-reported vaccination or intention to vaccinate** among adults aged 65+ years with additional risk factors (74.0%) than among the overall 65+ population (67.3%), suggesting higher reported uptake or intention among those with additional risk factors.[9] These estimates were collected during the early-to-mid campaign period and do not represent completed-season administrative coverage.[9]

A separate national analysis found that **vaccination coverage in 2023** was approximately **34% among adults aged 60–64 years**, compared with around **74% among adults aged 75+ years**, despite annual influenza vaccination being recommended for all adults aged 60+ years.[5,10] This suggests that implementation opportunities begin well before age 65 years.

Together, these findings indicate that implementation is not yet consistently translating into equitable access to age-specific protection across the eligible older adult population.

** VCR: vaccination coverage rate; WHO: World Health Organization.*

Healthcare professional (HCP) perspectives

Primary care HCPs point to the main challenges to improving influenza protection

Surveyed primary care HCPs described vaccine hesitancy, declining risk perception, and annual vaccination fatigue as main challenges to improving influenza protection among adults aged 65+ years.

What HCPs said*

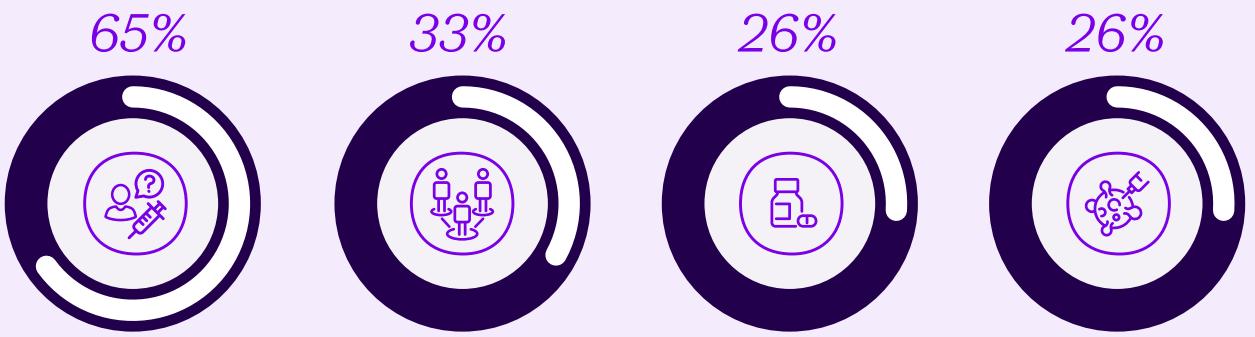


General practitioner (GP), Spain

> *"Hesitancy or pandemic/vaccine fatigue among some older adults, who often underestimate the severity of flu or who don't want to go to the health center each year if they don't perceive an immediate threat to their health."*

Primary care HCPs identify vaccine hesitancy and health system constraints as the leading barriers to improving influenza protection*

Most frequently identified themes from open-ended responses



Source: *Ipsos online survey conducted on behalf of Sanofi among HCPs in Spain; fieldwork conducted 7-26 June 2026. Results reflect the views and practices of the surveyed sample.*

Bases: *Primary care HCPs (n=105: 54 GPs/family physicians (FPs) and 51 nurses).*

***Question PA5:** Primary care HCPs were asked in their own words to summarize the main challenges to optimizing influenza protection among adults aged 65+ seen in their practice/pharmacy. Unprompted open-ended responses were collected with GenAI-supported probing and analyzed using generative AI (GenAI)-assisted thematic analysis of verbatim free-text responses to identify key themes. Themes shown represent mentions from open-ended responses and should not be interpreted as majority consensus. Quote reproduced from an individual HCP response.*

Protection gaps have consequences beyond influenza

Influenza is often viewed as a seasonal respiratory illness, but its consequences extend well beyond the respiratory system. In Spain, influenza infection has been associated with an increased risk of acute cardiovascular events, including myocardial infarction (heart attack) and ischemic stroke, particularly among older adults and people living with underlying health conditions.[11,12]

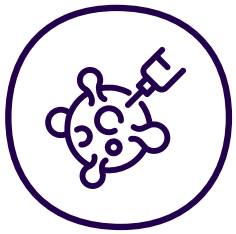
Acute cardiovascular events



>2-fold

higher incidence of hospitalization for acute myocardial infarction or ischemic stroke remained for up to 60 days after hospital-tested, laboratory-confirmed influenza[12*]

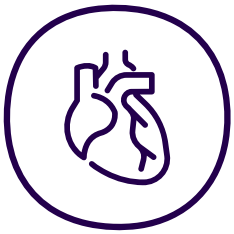
Hospital-tested, lab-confirmed influenza



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higher incidence of hospitalization for acute myocardial infarction or ischemic stroke during first 14 days after hospital-tested, laboratory-confirmed influenza[12*]

Type 1 myocardial infarction (heart attack)



23%

higher risk during influenza epidemic periods vs. non-epidemic periods[11]

Growing evidence linking influenza infection with cardiovascular complications is beginning to influence clinical practice. According to the 2025 European Society of Cardiology (ESC) Clinical Consensus Statement on Vaccination as a New Form of Cardiovascular Prevention, influenza vaccination is increasingly recognized as an **important component of cardiovascular risk reduction**.[13] These findings reinforce the importance of implementing influenza vaccination recommendations including the role of vaccination in cardiovascular prevention among people with established cardiovascular disease or elevated cardiovascular risk.[13]

** Compared with each individual's baseline periods in a self-controlled case-series analysis.*

HCP perspectives

The relationship between influenza and cardiovascular disease is not only supported by emerging evidence, but also reflected in routine clinical practice

Cardiologists report that hospitalization following influenza is frequently driven by the decompensation of underlying chronic conditions, particularly cardiovascular disease, reinforcing that the **consequences of influenza extend well beyond respiratory infection**.

What HCPs said*



Cardiologist, commenting on the main impact that flu and flu complications among older adults (aged 65+) have on the secondary care health system

> *"Overwhelmed hospitals and a drastic increase in costs due to readmissions, longer stays, and high morbidity and mortality due to cardiovascular and respiratory complications during the seasonal peak [leading to] financial pressure."*

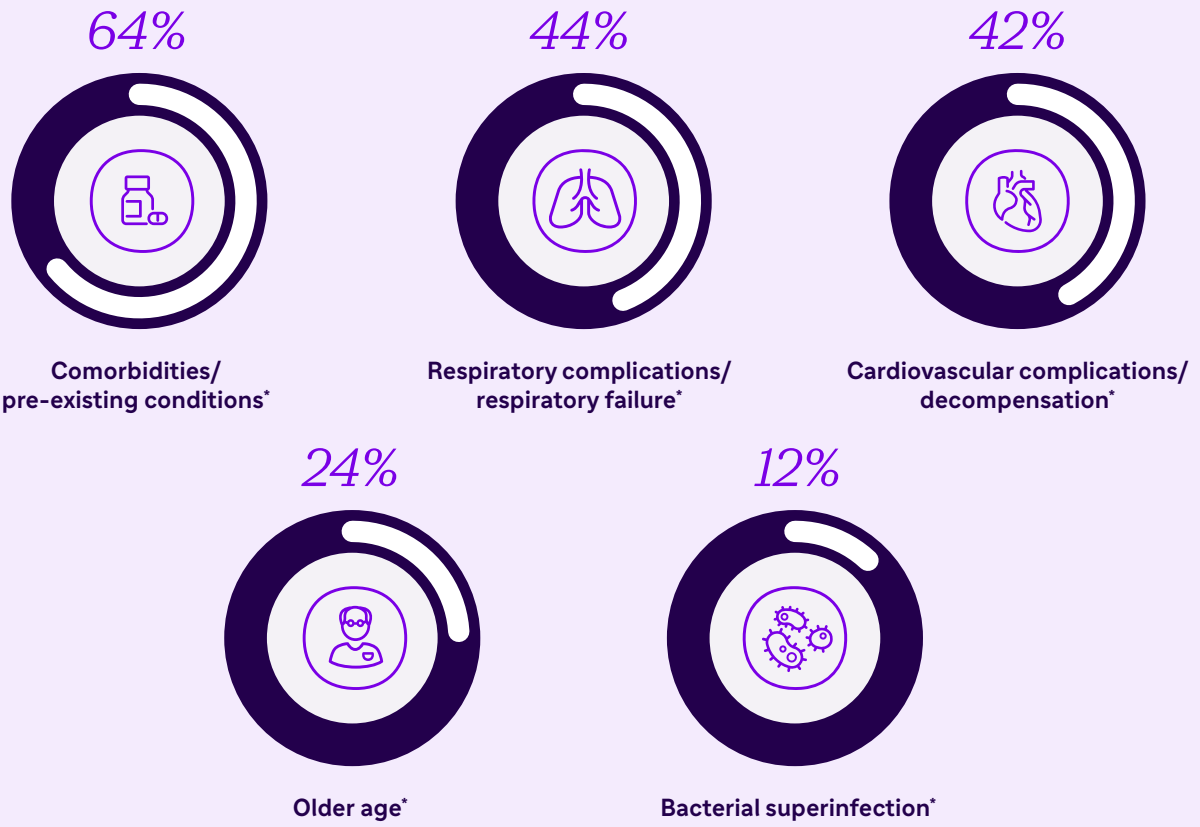
Source: *Ipsos online survey conducted on behalf of Sanofi among HCPs in Spain; fieldwork conducted 7-26 June 2026. Results reflect the views and practices of the surveyed sample.*

Base: *Cardiologists who provided responses to this open-ended question (n=50; total cardiologist sample n=53).*

**** Question SB4:*** *Cardiologists were asked in their own words to summarize the main impact influenza and its complications among adults aged 65+ have on the secondary-care health system, considering firstly overall system-level impact and secondly the impact on their day-to-day practice. Unprompted open-ended responses were analyzed using GenAI-assisted thematic analysis of verbatim free-text responses to identify key themes. Themes shown represent mentions from open-ended responses and should not be interpreted as majority consensus. Quote reproduced from an individual cardiologist response.*

Cardiologists identify chronic disease decompensation as a key driver of influenza-related hospitalization

Most frequently reported factors leading to hospitalization following influenza



Key takeaway: These frontline experiences reinforce the importance of consistently implementing influenza vaccination recommendations: preventing influenza in adults aged 60+ years has the potential to reduce both respiratory illness and broader cardiovascular complications.

Source: *Ipsos online survey conducted on behalf of Sanofi among HCPs in Spain; fieldwork conducted 7-26 June 2026. Results reflect the views and practices of the surveyed sample.*

Base: *Cardiologists who provided responses to this open-ended question (n=50; total cardiologist sample n=53).*

**** Question SA2b:*** *Cardiologists were asked in their own words and based on their clinical experience what key factors lead to hospitalization for patients with flu. Unprompted open-ended responses were analyzed using GenAI-assisted thematic analysis of verbatim free-text responses to identify key themes. Themes shown represent mentions from open-ended responses and should not be interpreted as majority consensus. Quote reproduced from an individual cardiologist response.*

Spain's surveillance confirms that severe influenza burden is concentrated among older adults, but important evidence gaps remain

Spain's 2024/25 surveillance demonstrates that severe influenza burden increases progressively from age 60 years[14]

	2024/25 surveillance findings	Why does this matter?
	Adults aged 60–69, 70–79 and 80+ years accounted for **74% of all laboratory-confirmed influenza hospitalizations** captured through Spain's Acute Respiratory Infection Surveillance System (SiVIRA) (1,891 of 2,559 hospitalized cases).	Severe influenza burden is concentrated among older adults from the point at which influenza vaccination is recommended nationally.
	**Hospitalization rates increased progressively with age**, with the highest rates observed among adults aged 80+ years, followed by those aged 70–79 years.	The increasing severity of influenza with age reinforces the rationale for providing age-specific influenza protection as the risk of severe influenza increases with age.
	The **median age** of patients hospitalized with influenza was **75 years**, and 77.3% had at least one chronic condition.	Older adults and people living with chronic disease experience a disproportionate share of severe influenza outcomes.
	**Hospital mortality increased** from **5.1%** in adults aged 60–69 years to **10.6%** in adults aged 80+ years.	As the risk of severe outcomes increases with age, ensuring that adults receive protection aligned with their age-related risk becomes increasingly important.

Spain's surveillance demonstrates that **severe influenza burden increases with age**. Although the 2025/26 season was characterized by fewer estimated influenza infections than 2024/25, influenza-related hospitalizations and deaths increased, reinforcing that seasonal burden cannot be assessed by case numbers alone.[15,16]

SiVIRA surveillance provides valuable age-stratified information on severe influenza, but **comparable age-specific reporting is not routinely available for all outcomes**, including influenza-related deaths, intensive care unit (ICU) admissions, and cardiovascular complications, while vaccination status is not routinely linked to severe outcomes.[14-16] As a result, it remains difficult to assess whether age-specific vaccination strategies are **consistently translating into appropriate protection** for older adults.

Severe influenza places substantial pressure on Spain's healthcare system

Economic modeling suggests that greater use of age-specific influenza vaccination among eligible older adults could substantially reduce healthcare utilization and generate societal and healthcare savings.[17]

Modeling suggests age-specific influenza vaccination could reduce influenza-related burden compared with standard vaccination[17]

	Potential reduction per influenza season*	What does this mean
Influenza cases Preventing infections reduces the number of people who develop influenza	**54,039** influenza cases	Fewer people get sick with influenza
GP consultations† Fewer mild-to-moderate cases lead to fewer visits to primary care	**7,733** GP consultations	Less pressure on primary care services
Emergency department visits Preventing illness reduces the need for urgent care	**1,585** emergency department (ED) visits	Fewer modeled emergency department visits
Cardiorespiratory hospitalizations Fewer severe complications result in fewer hospital admissions	**30,772** hospitalizations	Less strain on hospital capacity and resources
Hospital bed-stays Fewer admissions translate into fewer days spent in hospital	**265,632** hospital bed-days	Capacity released during peak periods
Deaths Preventing severe outcomes saves lives	**1,203** deaths	Lives saved

Economic modeling suggests that, compared with standard-dose influenza vaccination, age-specific influenza vaccination for eligible older adults could substantially reduce healthcare utilization across the care pathway while generating approximately **€30.5 million in societal savings** and almost **€10 million in direct healthcare savings over a single influenza season**.[17] These findings reinforce that consistently implementing Spain's age-specific influenza vaccination recommendations represents an investment in healthier aging, reducing avoidable healthcare utilization while strengthening health system resilience.[17]

**Modeled estimates comparing an age-specific influenza vaccination scenario versus a standard influenza vaccination scenario for adults aged 65+ years in Spain.[17] These are modeled estimates for adults aged 65+ years, assuming unchanged vaccination coverage between the modeled strategies. Results are conditional on the study's model assumptions and should not be interpreted as representing all age-specific influenza vaccines or the potential impact of increasing vaccination uptake.[17]*

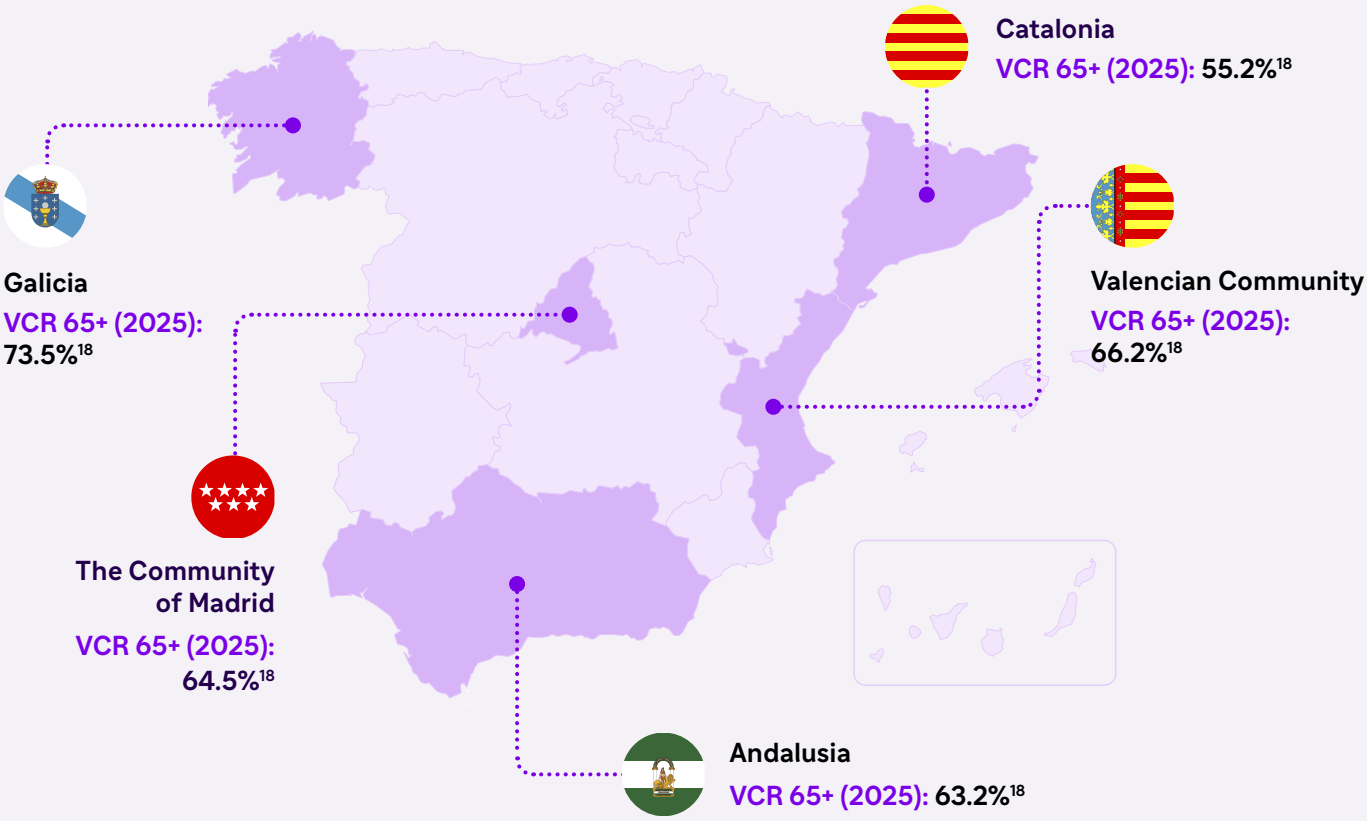
† GP = general practitioner.

How age-specific vaccination recommendations differ across Spain

While annual influenza vaccination is recommended nationally for adults aged 60+ years,[5] regional guidance on age-specific influenza vaccination varies across Spain, as illustrated below. Regional recommendations and delivery arrangements therefore contribute to differences in vaccine access across Spain.

National recommendation

Annual influenza vaccination is recommended nationally for adults aged 60+ years and other eligible risk groups.[5] National recommendations recognize that different influenza vaccine formulations may be appropriate for older adults,[5] but age-specific vaccination is not implemented consistently across Spain, with approaches varying between autonomous communities.



The Community of Madrid

- **Population (2025): 7.11 million**[19,20]
- **Adults aged 65+ years (2025): 1.3 million (18.9%)**[20]

One of Spain's largest influenza vaccination networks, yet uptake remains below the WHO target

Recommendation: Madrid's recommendation to vaccinate all adults aged **60+ years** aligns with national vaccination eligibility guidance, while vaccine formulation is determined through regional policy and procurement.[21]

Implementation: Around **800 vaccination sites** across primary care, hospitals and residential care facilities provide broad access for eligible adults.[21]

Opportunity: Despite **strong alignment with national recommendations**, vaccination coverage (64.5%) remains below the WHO target. Improving uptake is the next step to ensure recommendations consistently translate into protection.



Catalonia

- **Population (2026): 8.2 million**[22]
- **Adults aged 60+ years: 2.16 million (26.3% of population)**[22]

A proactive approach, but the lowest influenza vaccination coverage among the five regions

Recommendation: Adults aged **60–79 years** are recommended to receive one age-specific influenza vaccine, while adults aged **80+ years** are recommended to receive an alternative age-specific influenza vaccine.[23] Adults aged 60+ years living in residential care or receiving home assistance are also included in the 80+ years recommendation.[23]

Implementation: Catalonia delivers vaccination through a **coordinated region-wide campaign** with clear coverage targets and broad delivery across regional health services.[23]

Opportunity: Despite a **differentiated age-specific vaccination strategy**, Catalonia has the lowest vaccination coverage (55.2%) among the regions analyzed. Improving uptake is essential to ensure age-specific recommendations translate into protection.



Andalusia

- **Population (2025): 8.68 million**[24]
- **Adults aged 60+ years (2025): 2.26 million (26.0%)**[24]

Proactive invitation model with further opportunity to increase uptake

Recommendation: For the 2025/26 season, Andalusia recommends age-specific influenza vaccination for adults aged **80+ years**.[25]

Implementation: The 2025/26 program extends the use of age-specific influenza vaccination in Andalusia to an age-based population program for adults aged **80+ years**, alongside its use in residential and high-dependency settings.[25]

Opportunity: Andalusia demonstrates how regions can build on national recommendations by **expanding access to age-specific influenza vaccination**. Continued efforts to maximize uptake among eligible adults could help ensure this expanded recommendation translates into improved protection.



Valencian Community

- **Population (2025): 5.4 million**[26]
- **Adults aged 65+ years (2025): 1.1 million (20.4%)**[27]

Structured primary care delivery, but implementation alone is insufficient

Recommendation: Influenza vaccination is recommended from age 60, in line with national eligibility guidance, with an age-specific vaccination approach recommended for adults **aged 65+**.[28]

Implementation: Influenza vaccination is delivered through a **structured, primary care-led program** as part of the region's seasonal respiratory vaccination campaign.[28]

Opportunity: While delivery is well established, **aligning age-specific vaccination more closely with the national recommendation** could strengthen protection for adults aged 60+ years from the point they become eligible.



Galicia

- **Population (2025): 2.7 million**[26]
- **Adults aged 65+ years (2025): 729,829 (26.9%)**[27]

Highest reported influenza vaccination coverage among the five regions assessed

Recommendation: Adults aged **65+ years** are recommended to receive an age-specific influenza vaccine, with additional recommendations for selected risk groups in line with regional guidance.[25]

Implementation: Galicia has expanded eligibility for age-specific influenza vaccination to include all adults aged **65+ years** within its regional vaccination program.[25]

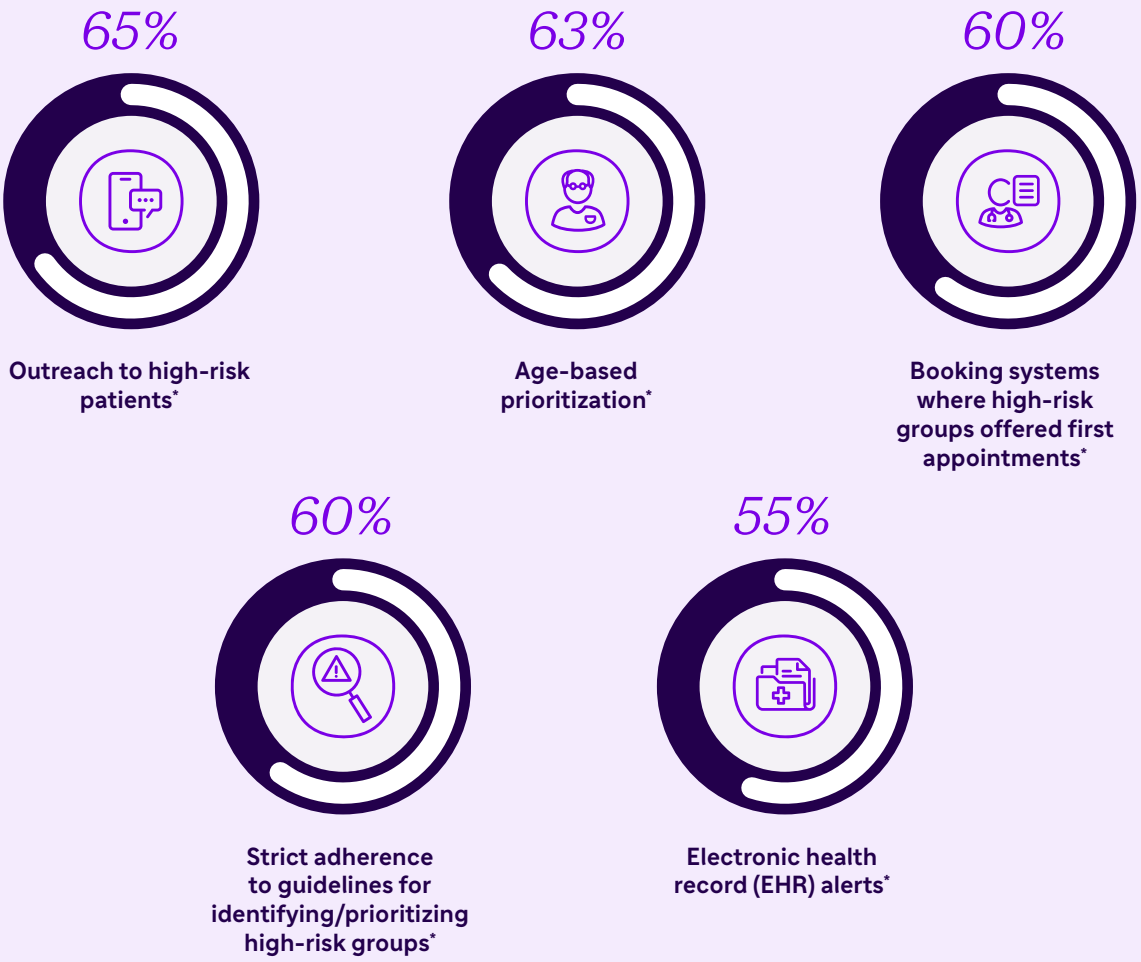
Opportunity: This approach creates an opportunity to monitor, over time, how vaccination coverage **translates into improved clinical outcomes for older adults**, generating evidence that could inform other autonomous communities.

HCP perspectives

HCPs identify practical opportunities to strengthen influenza prevention

Surveyed HCPs working in primary care are already using a range of implementation strategies to identify and prioritize eligible older adults for influenza vaccination. Expanding these approaches more consistently across Spain could **help translate national recommendations into protection from the point adults become eligible**.

Tools or strategies operated to identify/prioritize high-risk older adults



Source: *Ipsos online survey conducted on behalf of Sanofi among HCPs in Spain; fieldwork conducted 7-26 June 2026. Results reflect the views and practices of the surveyed sample.*

Bases: *Primary care HCPs (n=105: 54 GPs/FPs and 51 nurses).*

**** Question PB6:*** *Primary care HCPs were asked what tools or strategies they operate in their practice/pharmacy to ensure high-risk older adults are identified and prioritized for flu vaccination; respondents could select multiple responses from a list of potential response options. The figures shown were not necessarily the most frequently selected answer options by surveyed HCPs.*

What HCPs said*



Primary care physician, Spain

"The most relevant improvement [in flu protection policy for older adults (65+)] would be to implement a proactive and systematic outreach and reminder system for vaccination for older adults, integrated into all care levels. This would enable automatic identification of eligible patients, reduce lost opportunities and increase vaccine coverage via personalized reminders and active follow-up throughout the campaign."



Key takeaway: The challenge for Spain is no longer defining who should be protected, but ensuring that protection is delivered consistently across all eligible older adults. By rebuilding vaccination uptake from the point of eligibility, strengthening regional implementation, and improving recognition of influenza's broader health burden, Spain can reduce avoidable severe disease and build a more resilient approach to protecting its aging population.

Source: *Ipsos online survey conducted on behalf of Sanofi among HCPs in Spain; fieldwork conducted 7-26 June 2026. Results reflect the views and practices of the surveyed sample.*

Bases: *Primary care HCPs (n=105: 54 GPs/FPs and 51 nurses).*

**** Question PB5:*** *Primary care HCPs were asked in their own words to give one policy change they felt would most improve flu protection for older adults (aged 65+). Unprompted open-ended responses were analyzed using GenAI-assisted thematic analysis of verbatim free-text responses to identify key themes. Themes shown represent mentions from open-ended responses and should not be interpreted as majority consensus. Quote reproduced from an individual PCP response.*

Closing the gap between risk and protection

Spain has established strong national influenza vaccination policies, but important opportunities remain to ensure that **all adults aged 60+ years** receive protection that reflects their age-related risk.

1 Recognize influenza prevention as an essential component of healthy aging

Challenge

Influenza continues to be **viewed primarily as a respiratory infection** despite growing evidence that it contributes to cardiovascular complications, hospitalization, functional decline, and wider health system burden in adults aged 60+ years.

Opportunity

Position influenza prevention as a **core component of healthy aging** and prevention of severe influenza outcomes in older adults.

How this could be achieved

- **Embed influenza vaccination into cardiovascular prevention and healthy aging strategies** for adults aged 60+ years and those living with chronic conditions.
- **Increase awareness among HCPs and the public** of the broader cardiovascular consequences of influenza and the role of vaccination in healthy aging and disease prevention.

2 Align regional eligibility for age-specific influenza vaccination across autonomous communities

Challenge

Although annual influenza vaccination is recommended nationally for adults aged 60+ years, **implementation of influenza vaccination, and in particular age-specific influenza vaccination, varies across autonomous communities**. As a result, older adults become eligible for age-specific vaccination at different ages depending on where they live.

Opportunity

Align age-specific vaccination recommendations so eligible older adults receive **equitable access** to age-specific vaccination from the point they become eligible.

How this could be achieved

- **Align age-specific vaccination eligibility across autonomous communities** to reduce unwarranted regional variation.
- **Share successful regional implementation approaches** to support more consistent protection for older adults.

3 Increase influenza vaccination uptake among eligible adults

Challenge

Even where influenza vaccination recommendations are in place, **eligible older adults are not always identified, invited, and vaccinated** with an age-specific influenza vaccine.

Opportunity

Increase uptake by **proactively identifying and vaccinating eligible unvaccinated adults**, while supporting vaccine selection in line with applicable recommendations and available age-specific influenza vaccines.

How this could be achieved

- **Strengthen proactive invitation and reminder systems** to identify and vaccinate eligible adults earlier.
- **Equip HCPs** with the **tools and support needed** to consistently recommend age-specific influenza vaccination in routine care.

Methodology

Flunomics brings together ***publicly available epidemiological, vaccination, economic and policy evidence*** to examine ***how influenza affects older adults*** across ***nine countries***:



Canada | England | France | Germany | Italy | Japan | Portugal | Spain | United States

Together, these data provide a broader understanding of how influenza burden, protection, and health system performance interact in aging populations.

The report incorporates ***the most recent evidence available for each country at the time of analysis***, including data from the ***2025/26 influenza season where published***. Where newer surveillance data were not yet available, the latest validated national datasets and longer-term trends were used to provide context. As reporting schedules differ between countries, the reference period varies by market.

The evidence framework

Flunomics examines five interconnected dimensions of protection:

Dimension	Focus
Epidemiological impact	Influenza burden, including cases, hospitalizations, ICU admissions and mortality, with a focus on older adults.
Vaccination coverage	Influenza vaccination coverage trends among older adults, including the most recent publicly available national estimates.
Economic impact	Published evidence describing the direct and indirect costs of influenza to individuals, health systems and society.
Policy & system impact	How vaccination recommendations are implemented in practice, including delivery, access, surveillance and system performance.
Opportunity	Evidence-informed opportunities to strengthen protection for older adults based on observed burden and implementation gaps.

Country approach

Each country chapter follows a consistent analytical framework comprising five sections:

1. **Epidemiological impact**
2. **Vaccination coverage**
3. **Economic impact**
4. **Policy & system impact**
5. **What needs to change**

Recognizing that ***health systems are organized differently across countries***, policy and system analyses are undertaken either at national level or through selected regional case studies, depending on how influenza vaccination programs are delivered. This approach allows the report to assess how policy translates into real-world protection while respecting ***differences in governance***, ***implementation and data availability***.

Interpreting the findings

Flunomics is intended to ***support informed discussion rather than direct comparison between countries***. Surveillance systems, case definitions, reporting practices, age thresholds and data availability differ substantially across markets. As a result, vaccination coverage is the only indicator presented comparatively across all countries; all other findings are interpreted within their national context.

Where evidence gaps exist – particularly in age-specific hospitalization, mortality or economic data – they are explicitly identified throughout the report. These ***gaps are treated as important findings***, highlighting ***opportunities to strengthen surveillance***, ***improve visibility of influenza burden and better inform future policy and implementation***.

Dr Marco Del Riccio contributed the foreword and provided scientific advice on the identification, interpretation, and presentation of evidence included in this report.

Survey research element

To support the findings of this report and further explore the burden of influenza in each of the countries covered by this report, ***Sanofi sponsored an independent survey of frontline HCPs*** to understand real-world perspectives on optimizing influenza protection among older adults, the extent and challenges of annual flu burden, and how well existing guidelines translate into successful implementation.

Ipsos, a market research agency based in the UK, conducted the research on behalf of Sanofi. The following table summarizes the key aspects of survey design.

Survey parameters	
Data collection:	Computer-Assisted Web Interviewing (CAWI). A semi-structured questionnaire designed to collect both quantitative metrics (closed list, option select, rating scale, numeric responses) and qualitative feedback (open-ended free-text response), rendered for online self-completion by respondent. All respondents were self-selecting, all data shown is therefore based on those healthcare professionals who chose to take part in the survey
Sample type:	Non-probability, unstratified, therefore not designed to be statistically representative of the respective HCP universes in each country. Instead, specific minimum numerical targets for subgroups (region, years in practice, practice type) were applied to ensure a good level of sample diversity and geographical coverage
Sample source:	Online panels of relevant HCPs who have opted-in to receive invitations to participate in market research surveys
Sample size:	n=1353 across 8 countries and 5 HCP classifications (countries/HCP types per table below)
Sample quotas:	Applied to country and HCP type within country (see quota table below)
Data analysis:	• Responses aggregated into simple descriptive statistics (e.g. percentage of sample selecting response option/range of response or mean score for numeric responses) • Open-ended/free-text questions were analyzed by generative AI and organized into response themes (percentage of sample where all or part of response attributed to derived theme) • No weighting or calibration applied to dataset
Eligibility and screening criteria:	• Must have spent between 3-40 years working within current role • Must spend 70% of professional time in clinical setting (seeing patients/customers) • GPs/FPs/Nurses working in clinic/office-based practices; Pharmacists working in retail pharmacies (single location or with multiple branches under same ownership); Specialists working in clinic/medical centers or in hospital settings; Cardiologists must not be working in specialized fields only • Minimum 150 (primary care HCPs) and 100 patients (secondary care HCPs) seen in a typical month and at least 20% within defined older age category • No pharmaceutical company work as consultant or researcher
Fieldwork dates:	28th May to 13th July 2026 inclusive

Survey sample size by country and HCP type									
HCP type*	England	France	Germany	Italy	Spain	Portugal	Canada	USA	Total
Primary care									
GP/FP*	100	101	100	101	54	50	51	155†	**712**
Retail Pharmacist	-	50	51	-	-	-	31	54	**186**
Nurse	-	-	-	-	51	-	-	-	**51**
Secondary care									
Pulmonologist	50	50	-	-	-	-	-	-	**100**
Cardiologist	-	50	50	-	53	50	51	50	**304**
Total	**150**	**251**	**201**	**101**	**158**	**100**	**133**	**259**	**1353**

** HCP = healthcare professional; GP = general practitioner; FP = family practitioner.*

† 50 working in health systems/large clinics and included internal medicine working in primary care.

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