Spain

Health system summary 2024

European Observatory on Health Systems and Policies
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Contents

This Health System Summary is based on the *Spain Health System Review* (HiT) published in 2024 in the Health Systems in Transition (HiT) Series. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.

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How is the health system organized?

The Spanish national health system is highly decentralized, with health competences devolved to the regions

Organization

Coverage in the statutory Spanish National Health System (SNS) is virtually universal, mainly funded from taxes, and care is predominantly provided within the public sector and free of charge at the point of delivery. Health competences in the SNS are vested in the 17 Autonomous Communities (ACs), with the Ministry of Health being responsible for the overall coordination of the health system under the governance of the Interterritorial Council for the SNS (*Consejo Interterritorial del Sistema Nacional de Salud*, CISNS).

Two more statutory health systems are present: Mutual Funds providing health care for slightly over 2 million public servants and their beneficiaries; and the Mutualities for Accidents and Occupational Diseases. The private sector is an important player in the health system, providing services to the three statutory health systems. In general terms, capacity for policy development and implementation takes place at national and regional level (Box 1).

Box 1 Capacity for policy development and implementation

The SNS holds a high technical capacity for the design and development of health policies, at both national and regional levels. The hierarchical relationship between the regional Departments of Health (planning and purchasing) and the health services (provision), along with generally well resourced providers, facilitates the implementation of health policies. However, a gap persists when it comes to the evaluation of health policy implementation; this deficit in evaluation may be related to the proximity between the political actors and the policies' implementers. Other factors are the limited skills and capacity to evaluate, although the General Public Health Law (Law 33/2011) compels public administrations to carry out health impact assessments (HIA) for those plans and projects with a significant impact on health. Some evaluation efforts can be seen from the AEMPS (Agency for pharmaceutical and medical devices), the Spanish Network of Agencies for Health Technologies and Benefits Assessment, and some independent national agencies (such as AIReF or the Institute for Fiscal Studies). Importantly, the intersectoral approach and cooperation on the design and implementation of health policies are gaining momentum.

Planning

The locus for planning and regulation resides essentially in the Ministry of Health when it comes to nationwide laws and plans and lies with the Departments of Health of the 17 ACs when it comes to the local implementation of national laws or plans, or the development of regional regulation and policies, within their legal frameworks. National health strategies are designed and developed with the collaboration of the ACs to address specific health problems (such as cancer, chronic diseases, rare diseases, obesity, mental health problems, etc.) on a multi-year basis, and they are periodically updated. Some other strategies are centrally designed, such as the 2019 Strategic Framework for Community and Family Medicine, the 2021 Strategy for Digital Health, the 2022 Strategy for Public Health, and the 2022 Strategy of Public Health Surveillance.

Providers

The 17 ACs' health systems have full responsibility for the planning and provision of public health and health care services, whereas the Ministry of Health is responsible for health care provision for the two autonomous cities of Ceuta and Melilla.

Health services are delivered by a mix of public and private providers, with public provision having a prominent role in the SNS. In general, the ACs' health departments purchase health services with the Regional Health Service, which negotiates global annual contracts with its public providers of hospital care, primary care, preventive activities and long-term care services. Additionally, either the ACs' health departments or the regional health services may contract services from private providers, usually from hospitals or diagnostic labs, typically aimed at reducing waiting lists for surgical or diagnostic procedures.

How much is spent on health services?

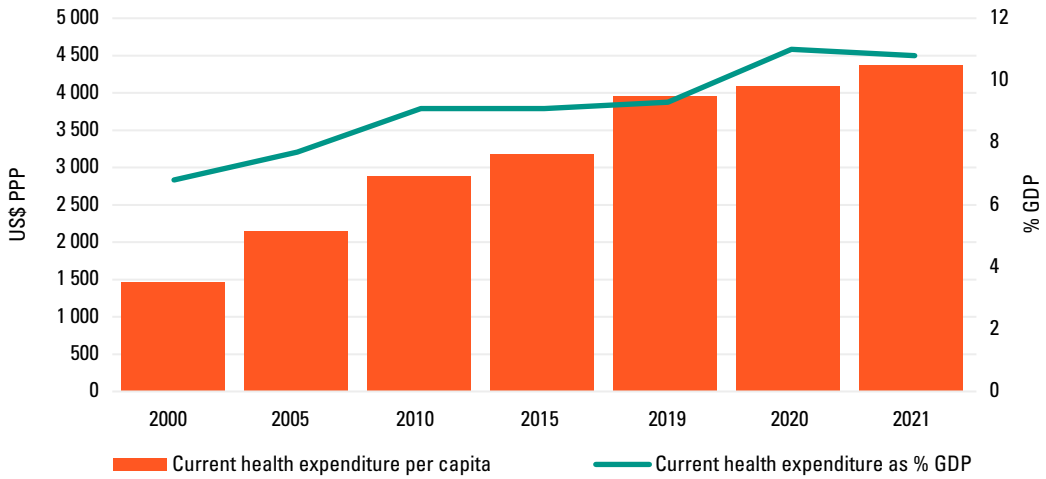
While public financing is the primary source of health care expenditure, out-of-pocket payments remain a relevant source of SNS funding

Funding mechanisms

Public funds – through general taxation – are the primary source of funding for health care in Spain. When it comes to private funding, payments come from a combination of out-of-pocket (OOP) payments and voluntary health insurance (VHI). The proportion of the population covered by VHI has grown rapidly in recent years.

Three main allocation mechanisms coexist: the Guarantee of Basic Public Services Fund (FGSPF), intended to ensure equal funding for equal needs for

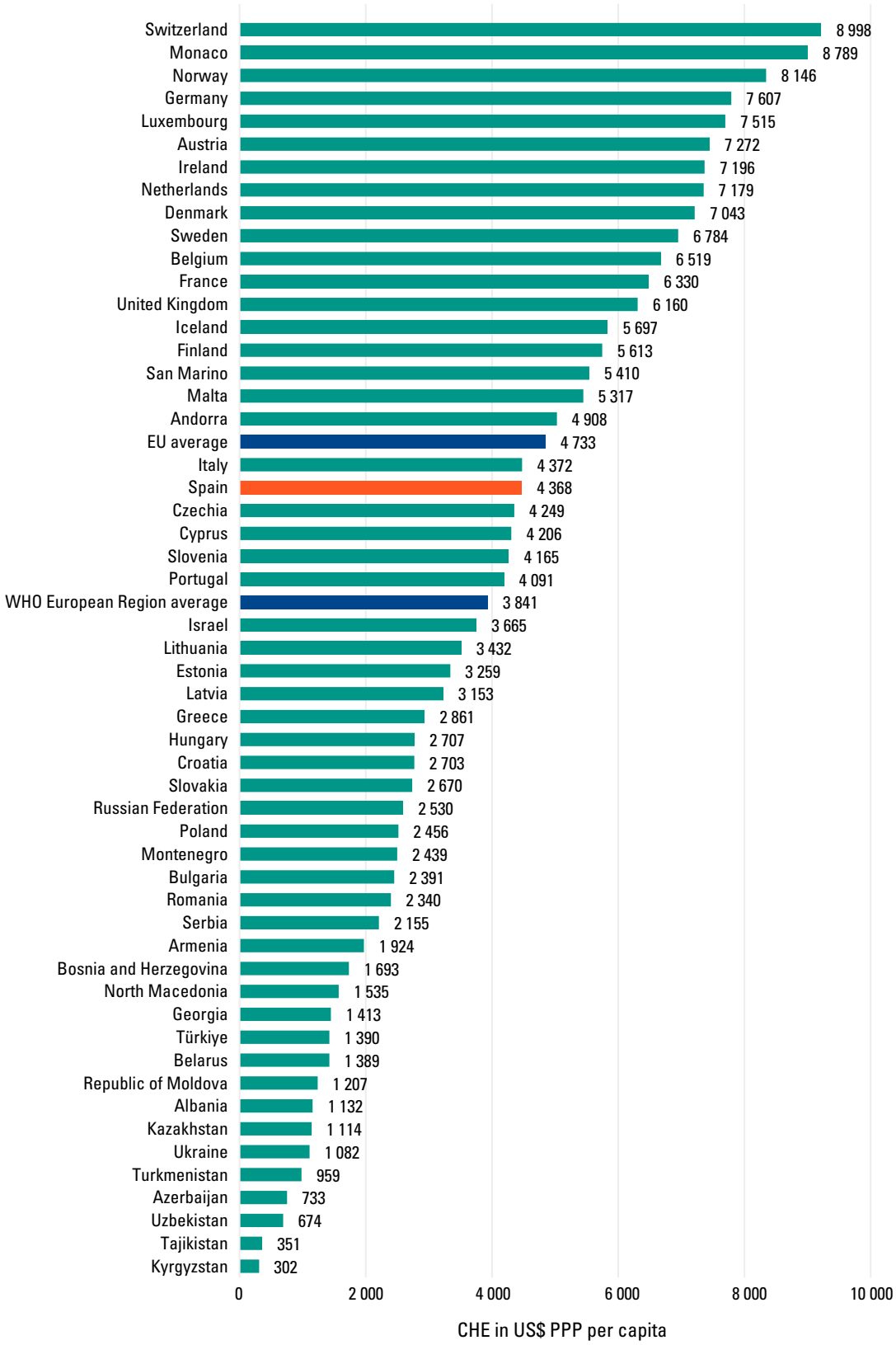
Fig. 1 Trends in health expenditure, 2000–2021 (selected years)



Note: PPP = purchasing power parity.

Source: WHO, 2024.

Fig. 2 Current health expenditure (US$ PPP) per capita in WHO European Region countries, 2021



Note: EU: European Union.

Source: WHO, 2024.

basic services (health, education and social services); the Global Sufficiency Fund, covering the gap between expenditure needs for each AC and the resources provided by the FGSPF and regional fiscal capacity; and the so-called 'convergence' funds (namely, Competitiveness, Cooperation and Inter-territorial Compensation funds), which try to reduce economic imbalances across ACs.

Health expenditure

The COVID-19 pandemic led to a dramatic increase in health expenditure in Spain, from 9.3% of GDP in 2019 to 11.0% in 2020, remaining this high (10.8% of GDP) in 2021 (Fig. 1). While above the WHO European Region average, health spending (US$ PPP) per capita is well below other European countries such as France, Germany, Sweden and the United Kingdom, and below the EU average (Fig. 2).

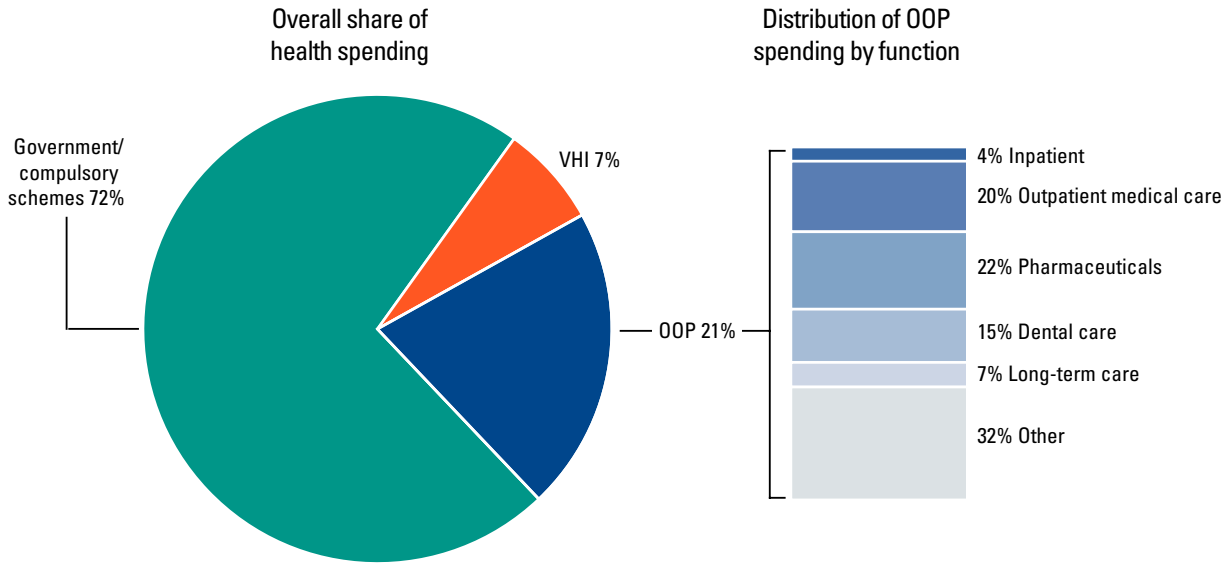
Health expenditure from public sources accounted for 71.7% of total health expenditure in 2021. The main component of private spending, OOP spending, accounted for 20.6% of total health spending in 2021. Although VHI plays a complementary role in the SNS, it has experienced a strong rise in recent years, covering 20.8% of the population in 2021 and representing 7% of health expenditure.

Out-of-pocket payments

OOP payments represented 20.6% of total health expenditure in 2021 (Fig. 3). The benefits package is comprehensive, and cost-sharing is limited to pharmaceutical prescriptions and some prosthetic devices, both of which incur co-payments. Patients mainly pay directly out of pocket for dental services, which only have limited coverage under the benefits package, and for optical care, which is outside public coverage except for a few very limited conditions.

According to national data, in 2022 average total OOP payments accounted for €1228 per household, representing 3.9% of the overall household budget. Pharmaceuticals (drug prescription co-payments and over-the-counter payments) represented 24.4% of household health expenditure, while prosthetic and medical devices (corrective lenses, orthopaedic material, etc.) reached 36%; dental care represented 17.3% of household health expenditure (INE, 2023).

Fig. 3 Composition of out-of-pocket payments, 2021



Notes: OOP: out-of-pocket; VHI: voluntary health insurance. VHI also includes other voluntary prepayment schemes. The EU average is weighted.

Sources: OECD, 2023; Eurostat, 2023.

Coverage

The SNS provides universal population coverage, with residency as the basis of entitlement. Undocumented migrants have eligibility to full coverage like any other Spanish national. Public insurance for health care is compulsory (individuals cannot opt out).

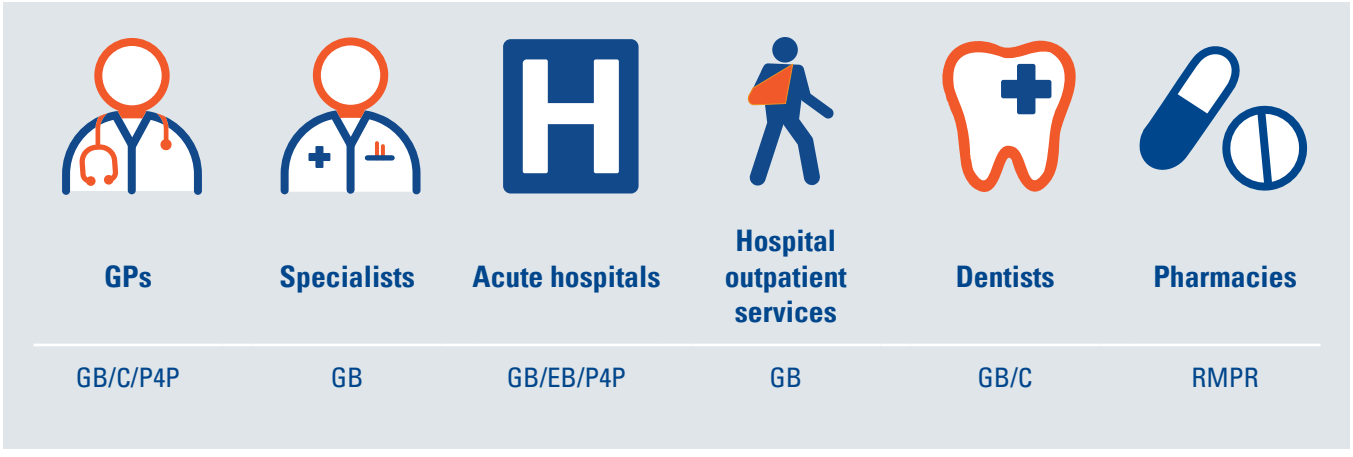
While cost-sharing is required for a limited number of services and patients make direct payments for services not covered by the SNS, OOP payments do not result in catastrophic spending for households (Box 2). Co-payments have been largely reformed with further exemptions for various groups (for example, low-income pensioners, recipients of the guaranteed minimum income benefit, disabled children and households receiving child benefits) in place since 2020. Although effective health coverage has substantially improved in recent years, some access gaps remain (see the section on Accessibility and financial protection).

Box 2 What are the key gaps in coverage?

People have access to a comprehensive range of publicly financed benefits with the exception of the limited coverage for dental care (which, while improving over the last few years, is variable across ACs) and optical care (which is outside public coverage). Co-payments are limited to outpatient-prescribed medicines and orthoprosthetic devices. Since 2018, when full population coverage of the SNS was restored, further regulation has increased protection against co-payments for the most vulnerable groups through new exemptions. Nevertheless, the lack of a cap on cost-sharing for active workers acts as a barrier to access outpatient prescriptions for those with low incomes (Rodríguez-Feijoó & Rodríguez-Caro, 2021).

The incidence of catastrophic spending in Spain is low compared to other EU countries. In 2019, only 0.8% of households were impoverished or further impoverished after OOP payments for health care. The main sources of catastrophic spending were dental care and medical products. For the poorest quintile, spending on outpatient medicines drives catastrophic spending (Urbanos-Garrido et al., 2021).

Fig. 4 Provider payment mechanisms in Spain



Notes: GB: global budget; C: capitation; P4P: pay-for-performance (e.g., quality, uptake of programmes); EB: episode-based payment; RMPR: retailer margin price reimbursement.

Paying providers

All health professionals in the SNS are salaried workers, with most of them being civil servants. For SNS doctors and nurses, remuneration is composed of a 'basic' pay, on-duty payments and 'supplementary' stipends (Fig. 4). The basic pay component includes the actual salary and bonus linked to length of service (in Spanish, *trienios*). On-duty payments are fixed according to the number of on-duty services delivered in a month. Supplementary remunerations are set according to position characteristics, performance and professional career.

In the case of family doctors (general practitioners, GPs), the salary includes a capitation component (about 10% or 15% of the total salary), which considers the size and demographic structure of the population registered to them, and a small amount linked to performance.

What resources are available for the health system?

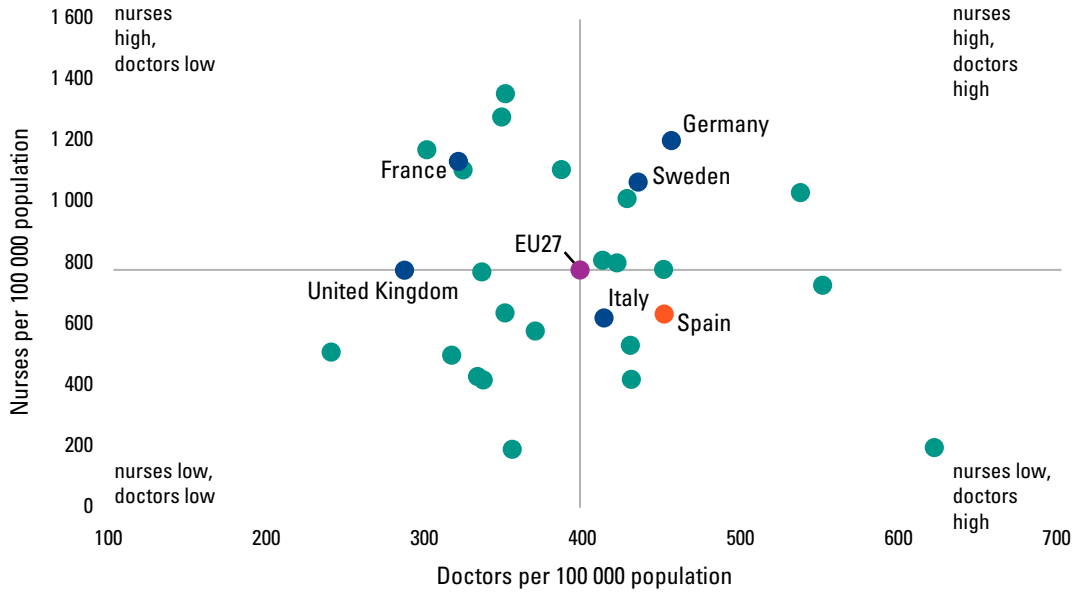
Shortages of health professionals exist, in particular for family doctors in rural areas

Health professionals

The number of practising medical doctors in Spain is significantly above the EU average and has been following a growing trend over the last decade, reaching 449 per 100 000 inhabitants in 2021 (EU average of 396 in 2021). The number of nurses has also increased since 2014 but remains below the EU average, at 634 nurses per 100 000 inhabitants in 2021 (compared to an EU average of 779) (Fig. 5).

There is a shortage of physicians in some specialties and in some rural areas, particularly for family

Fig. 5 Practising nurses and physicians per 100 000 population, 2021



Source: Eurostat, 2023.

doctors. In March 2023 the Commission on the SNS Human Resources approved a technical document providing guidance for identifying these hard-to-fill positions in primary care, and for the incentives that could be used to attract health care professionals to fill these roles.

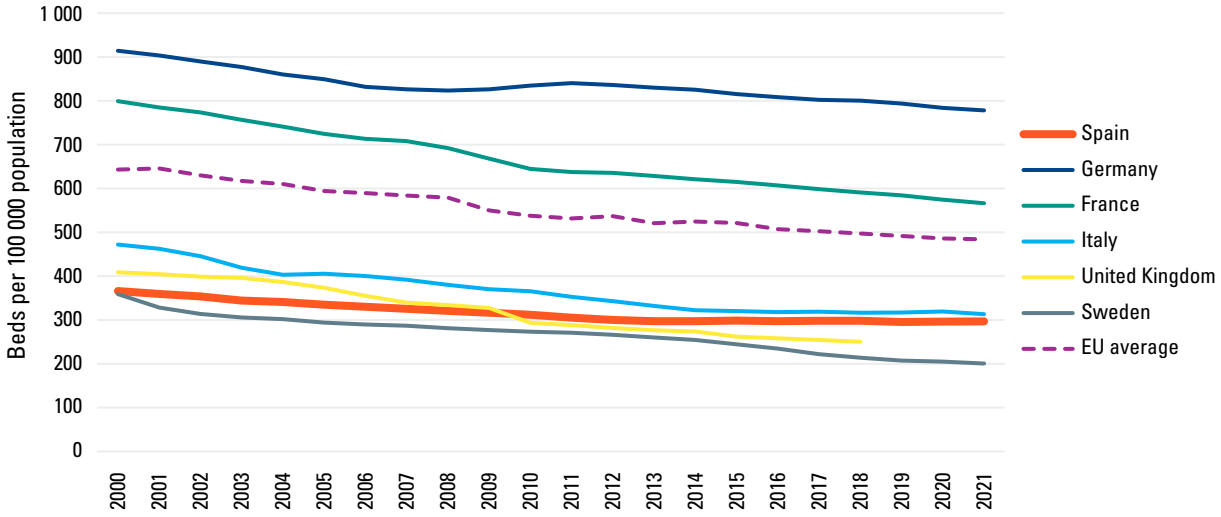
Health infrastructure

The number of hospitals per million inhabitants has barely changed from 16.5 in 2015 to 16.4 in 2021, despite the increase in the number of hospitals (from 765 to 776). This figure is far below the OECD average, with a rate of 27.4 hospitals per million inhabitants in 2021.

The number of hospital beds has remained stable since 2013, resting at 296 beds per 100 000 inhabitants in 2021. Spain exhibits a lower number of total hospital beds compared to the EU average (525 beds per 100 000 population in 2021), although this number has not suffered the sharp decrease experienced in other comparator countries (Fig. 6).

In terms of high-tech imaging, the SNS has 21.4 CT scanners per million inhabitants, slightly above France, but far below both Germany and Italy. Further, Spain has 20.3 MRI units per million inhabitants, well below France, but above other countries such as Sweden (Fig. 7).

Fig. 6 Hospital beds per 100 000 population in Spain and selected countries, 2000–2021



Source: Eurostat, 2023.

Distribution of health resources

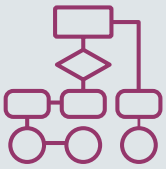
The distribution of public primary care premises (primary care centres and local health offices) across ACs shows wide differences, with a 28-fold difference between the ACs with the highest and lowest number (Castile-Leon with 168 premises per 100 000 population compared to Madrid, with 6 centres per 100 000 inhabitants). These ratios reflect both the population differences between rural and urban areas and the regulated effort to maintain accessibility to primary care centres in rural areas. The distribution of (functioning) hospital beds per 1000 inhabitants across ACs is somewhat uneven: in 2022, the lowest rate was 2.4 beds per 1000 inhabitants (Andalusia) and the highest was 3.8 beds per 1000 inhabitants (Catalonia). In the case of available beds in same-day care, differences are bigger, and they persist over time, with almost a three-fold extreme difference between ACs. The distribution of physicians and nurses presents some variation across ACs that has persisted over the years, with around a two-fold difference between the ACs with the highest and lowest figures.

Fig. 7 Magnetic resonance imaging (MRI) and computed tomography (CT) scanners in Spain, per million population, 2021

	MRI scanners per 1 000 000 population	CT scanners per 1 000 000 population
Spain	20.5	21.5
France	17.0	19.5
Germany	35.2	36.5
Sweden	17.2	23.0
Italy	32.0	39.0

Source: OECD, 2024.

How are health services delivered?



The strength of primary health care is key for the good performance of the national health system

Public health

Competences in public health planning and provision were transferred to the 17 ACs and the two autonomous cities of Ceuta and Melilla between 1979 and 1981. Public health within ACs has a dedicated structure where a public health authority, usually a General Directorate within the Health Department, has a wide remit, including: a) ensuring the enforcement of the regulations passed to support public health policies; b) holding the executive planning role for operational public health services; c) coordinating population-based programmes (such as vaccination or cancer screening programmes); and d) monitoring the health status, health determinants and health risks of the population residing in the AC.

Beyond the monitoring and surveillance activities provided within the public health structure, the SNS primary care doctors and nurses are the core public health agents, although they are mainly focused on prevention programmes (including vaccination programmes for infants and older people, primary and secondary prevention of noncommunicable diseases, opportunistic screening activities and counselling activities).

Other relevant public health agents are teachers and NGOs, who work as mediators in the implementation of disease prevention and health promotion programmes, as well as municipalities, which are crucial actors in the actual provision of sanitation and environmental protection and, in larger cities, in food safety control, animal slaughter regulation and local health promotion programmes.

Primary and ambulatory care

Primary health care (PHC) is essentially provided by public providers where specialized family doctors and staff nurses make up 'PHC teams'. They might be complemented with paediatricians and specialized paediatric nurses, physiotherapists, dentists, psychologists and social workers. Family doctors are the first contact point for the health system and act as gatekeepers. They are key informants for the notification of communicable diseases and are members of sentinel networks for the monitoring of public health problems.

PHC professionals provide a comprehensive range of services under three modalities: appointments requested by the patient (on-site or by telephone), planned visits and emergency visits (in PHC settings or as home visits). Some services are provided in close coordination with other specialized services, such as the early detection and treatment of mental health conditions, and follow-up of terminally ill patients.

The relatively low rate of avoidable admissions for chronic conditions, the low levels of unmet needs for medical examination, and the general satisfaction of Spaniards regarding PHC services reflect the effectiveness of primary care in the SNS (Box 3).

Specialized ambulatory care includes diagnostic, therapeutic and rehabilitation activities, as well as those of health promotion, health education and disease prevention, which are provided at the outpatient, specialized care level until the patient is transferred back to PHC. Importantly, 23% of outpatient specialized visits (between 9% and 50% depending on the AC) were provided by private providers in 2021 (Ministry of Health, 2023a).

Box 3 What are the key strengths and weaknesses of primary care?

Keys to the success of PHC are the institutional design of the SNS according to administrative health care areas, where all residents are registered to a Family Doctor with sufficient skills to provide a comprehensive range of services, accompanied by staff nurses with high capacities in family and community medicine, a constant interaction with referral specialists, particularly in the case of patients with chronic conditions, fostering care continuity and a longitudinal perspective of patients and families' health life-cycle.

Despite the general satisfaction with PHC services, around 28.3% of survey respondents also declared in 2022 that, if they had to choose, they would prefer a private provider (Ministry of Health, 2023b). This result might have to do with the increasing waiting times experienced in 2022 in providing an appointment when transfers to another provider for additional testing was required (Ministry of Health, 2023b).

Regarding the primary care workforce, primary care nurses are likely to be under resourced, even when having a major role in health promotion and disease prevention, as well as in the continuity of care for patients with chronic conditions: the nurse to doctor ratio was just 0.9 nurses per doctor in 2022 (Ministry of Health, 2023a). Further, the specialty of family and community medicine is not a preferred choice among candidates applying for medical residency programmes. Finally, nurses with a specialty in family and community nursing have difficulty accessing positions in primary care centres, which tend to be occupied mainly by hospital nurses.

Hospital care

Spanish public hospitals are organized according to area and cover any type of demand coming from the reference population, that is, the population residing in the health care area. Depending on the severity and clinical complexity of the condition, smaller hospitals can refer patients to a bigger hospital. All ACs have at least one public general hospital with the full range of specialties available. Private hospitals make a substantial contribution to the provision of secondary care: for example, on average 22.5% of discharges and 32.6% of surgical interventions (2021 data) were from this sector (Ministry of Health, 2023a).

The SNS was designed to foster integrated care, with PHC being the main actor (Box 4).

Box 4 Are efforts to improve integration of care working?

There are some key elements favouring care integration in the SNS, including: a) the population ought to be registered with a single Family Doctor who acts as gatekeeper; b) in this capacity, Family Doctors will decide on the need for a transfer to specialized care and provide continuity to clinical decisions, ideally shared with the specialist, sometimes acting merely as a consultant; and c) Family Doctors, along with nursing staff, provide close follow-up over time for the duration of the patient's conditions.

However, financing and purchasing mechanisms in the SNS, such as global budgets and framework contracts do not contain the incentives required to enhance care continuity. As a result, some ACs are implementing additional purchasing mechanisms such as: formal governance mechanisms bound by law, as in the case of the Integrated Health Organizations (OSIs) in the Basque Country or the Integrated Management Organizational Structures (EOXIs) in Galicia and certain areas of Andalusia and Catalonia (SEDAP, 2020); the stratification of the population using formal risk-stratification tools to identify those that would benefit the most, and then prioritize care efforts (Ministry of Health, 2018); or implementing evidence-based pathways in specific complex clinical conditions towards care continuity. Despite the existence of formal evaluation (although limited in scope) of some of these initiatives, the lack of publicly available data and the lack of independent evaluations impede full understanding of the impact of these programmes (Bernal-Delgado & Angulo-Pueyo, 2023).

Pharmaceutical care

Pharmaceutical care is provided by doctors, as prescribers and overall supervisors of treatment; nurses, particularly in PHC; and pharmacists, as dispensers and health community agents, supervising treatment adherence and early detection of side-effects. Regarding the distribution of medicines, the system is organized around wholesalers, mainly made up of cooperatives of pharmacists. Regulations restrict the dispensation of prescription drugs to qualified pharmacists, include rules to prevent the geographical concentration of pharmacies, and require a five-year university degree – not only to dispense but also to own a pharmacy – and compulsory enrolment in the College of Pharmacists.

Palliative care

Palliative care may take the form of dedicated beds in acute hospitals, outreach services provided by specialists in palliative care with (or without) the involvement of PHC professionals, non-specialized services directly provided by PHC professionals, beds in not-for-profit or for-profit hospitals (purchased by the public system or privately provided), private services paid directly by the patient, or services provided in the context of the SAAD (System for the assistance of dependent people).

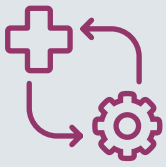
Since 2021, euthanasia has been part of the benefits package of the SNS, regulated by Organic Law 3/2021. The Law specifies the conditions for a patient to be eligible, as well as the different procedures for assessment and, eventually, the termination of life.

Dental care

Dental care is predominantly provided by private solo practices, with negligible participation of public providers and no major changes in recent years. Dental care for the adult population in the public sector is generally provided by Family Doctors, although in some urban centres the PHC team includes dentists. The basket of publicly paid services is rather limited: teeth extraction, treatment of infections or inflammatory processes, caries prevention, preventive measures in pregnant women, and caries prevention and counselling on

hygiene measures for children. Consequently, unmet dental care needs for economic reasons are substantial in Spain and have increased in the last decade (see also the section on Accessibility and financial protection).

What reforms are being pursued?



Recent reforms have focused on strengthening coverage and reinforcing primary care

Major health reforms in Spain have been implemented through various laws and strategies addressing the scope, breadth and depth of the SNS coverage, with special emphasis on the most vulnerable groups (Box 5).

The basis for entitlement to health care reverted to the condition of residency in Royal Decree-Law 7/2018 on universal access to the SNS; between 2012 and 2017 eligibility had been linked to the legal and employment status of individuals. Currently, the only non-entitled residents are foreigners granted temporary residence for family reunification, and those foreigners whose country of origin has signed bilateral agreements with Spain regarding the provision of health care services to its nationals, or people who have a third party obliged to pay for any health services provided.

Co-payments in pharmaceutical care have been largely reformed in Law 11/2020, with new exemptions that will benefit 7.3 million people in 2024.

Additionally, euthanasia has been covered by the SNS since 2021, underwritten by Organic Law 3/2021. The Law guarantees patient autonomy and choice regarding their own death, while also setting criteria and procedures for eligibility and delivery.

The 2019 Strategic Framework for Primary and Community Care provides renewed impetus to primary care to address new epidemiological, societal and technological challenges. This Strategic Framework consists of six strategic lines: reinforcing the Interterritorial Council commitment to PHC leadership; consolidating the budget and human resources policies to guarantee PHC effectiveness and quality; improving quality of care and coordination of PHC with other levels of assistance; reinforcing the orientation of services towards the community, health promotion and disease prevention; promoting the use of information and communication technologies; and promoting education and research in PHC.

Box 5 Key health system reforms over the last 10 years

2018 **Royal Decree-Law 7/2018, of 27 July 2018, on universal access to the SNS** which, in particular, returns the basis for entitlement to residency.

2019 **Strategic Framework for Primary and Community Care**, providing new impetus to primary care to adapt and address the new epidemiological, societal, workforce and technological challenges.

2020 **Law 11/2020, of 30 December 2020, on the General State Budget for the year 2021** which, in particular, introduces wide-scale exemptions from co-payments.

2021 **Organic Law 3/2021, of 24 March 2021, for the regulation of euthanasia**, which introduces coverage for euthanasia by the national health system.

Looking ahead, three draft laws are currently before parliament:

- the draft law on the universality of the SNS, which seeks to widen health care coverage in those population subgroups that are still undercovered, to gather benefits into a single package, and prohibit new co-payments;
- the draft law for the consolidation of equity and cohesion, which among other things aims to implement the intersectoral Health in All Policies approach by incorporating Health Impact Assessments into policy processes; and
- the draft law for the creation of a National Agency of Public Health.

How is the health system performing?

The SNS performs well in health system quality and outcomes, but some gaps in access and technical efficiency remain

Health system performance monitoring and information systems

While the SNS has sufficient capacity both in terms of policy design and implementation at the national and regional levels, the evaluation of public policies is not undertaken systematically. Some evaluation efforts include those studies led by AEMPS (Agency for pharmaceutical and medical devices), the Spanish Network of Agencies for Health Technologies and Benefits Assessment, and some independent national agencies (such as AIReF or the Institute for Fiscal Studies).

Over the last three decades, the SNS has developed and implemented a very rich data landscape, headed by the digitalization of numerous health information systems. Some of them support the joint governance of the SNS and are hosted and maintained in the Ministry of Health (for example, pharmacovigilance, the national health survey, the Health Barometer, daily mortality monitoring system and the SNS key indicators); others, hosted by the ACs, focus more on informing regional policies (for example, the allocation of the regional budget, and monitoring of waiting lists), monitoring and surveillance of health determinants, and purchasing agreements between the regions and care providers.

In December 2021, the Ministry of Health released the National Strategy on Digital Health with a focus on enhancing e-Health, aiming to develop digital health services and the full interoperability of health care information across ACs, and data analysis enhancement.

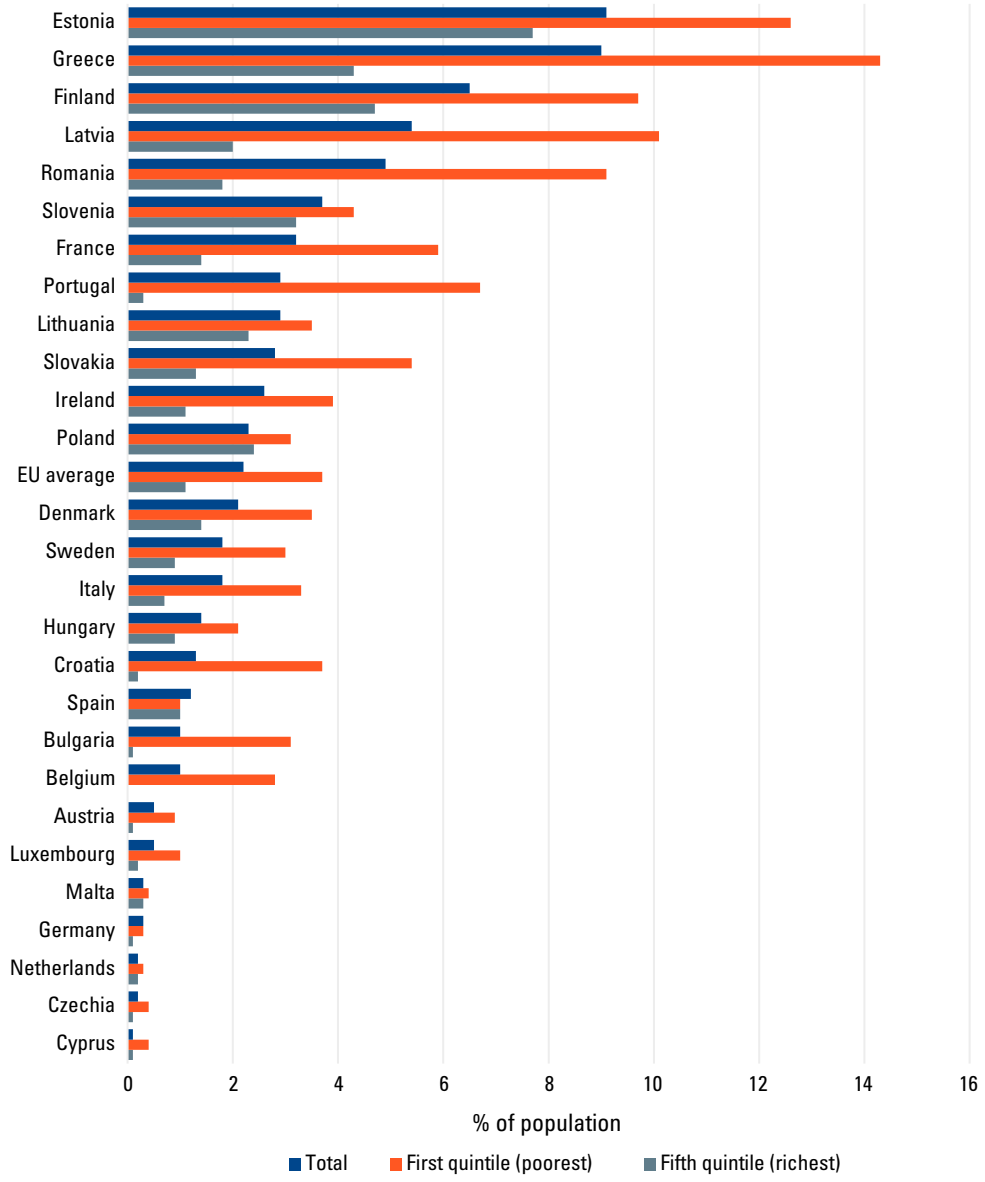
Accessibility and financial protection

Although effective health coverage has substantially improved in recent years, some access gaps remain: for example, administrative barriers to obtaining residency status, which is the basis for entitlement; administrative barriers to obtaining the guaranteed minimum income, which is the basis for exemption from co-payments; limited coverage of some services (such as dental care); and larger waiting lists in terms of the number of patients or delays in receiving treatment.

A small share of the population reported unmet needs for medical examinations in 2022, far below the EU average (Fig. 8). However, unmet needs in dental care are relatively high, and affect the poorest households the most.

Recent health system reforms that have occurred in Spain since 2018 regarding accessibility have focused on widening the covered population (in particular, with the basis for entitlement returning to the condition of residency), establishing wider exemptions for co-payments, and on increasing the scope of coverage (that is, increasing the provision of services such as euthanasia).

Fig. 8 Unmet needs for a medical examination (due to cost, waiting time or travel distance), by income quintile, EU/EEA countries, 2022



Notes: EU: European Union. Data refer to 2022.

Source: Eurostat, 2024.

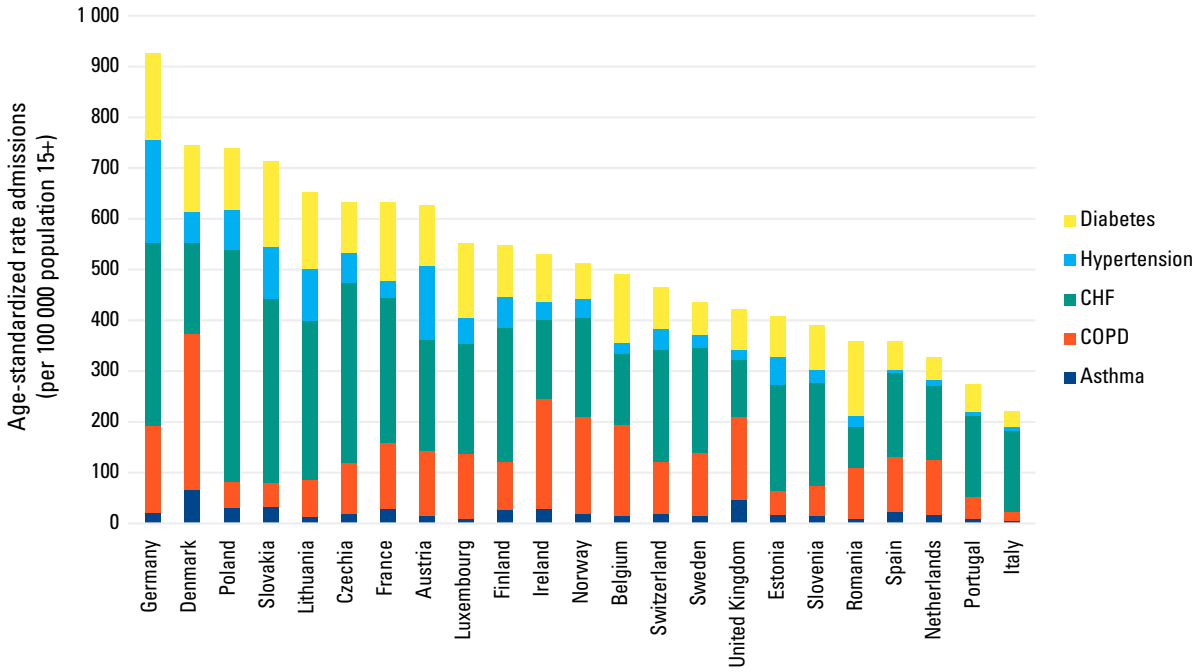
Health care quality

The SNS draws on a long tradition of developing and implementing quality and safety initiatives, currently stemming from the 2010 Plan for Healthcare Quality, which includes 12 national health strategies focused on the most relevant health problems. Since 2018, four new strategies were agreed by the CISNS, in particular, strategies on cancer, cardiovascular diseases, mental health, and primary and family care.

Looking at potentially avoidable hospitalizations, Spain has the fourth lowest overall rate of potentially avoidable hospitalizations among EU countries that collect this data, standing out for its low rates in diabetes and hypertension admissions (Fig. 9). Importantly, in-country data show variations in potentially avoidable hospitalizations in chronic conditions as large as three times across 2400 primary care areas across the SNS (Martínez-Lizaga et al., 2023).

The Healthcare Barometer provides a view on patient satisfaction with the SNS (Box 6).

Fig. 9 Avoidable hospital admission rates for asthma and chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes, 2021



Notes: France data from 2015; Slovakia and the Netherlands data from 2019 (latest available).
Source: OECD, 2023 (data refer to 2021 or nearest year).

Box 6 What do patients think of the care they receive?

The only countrywide information of patients' and citizens' opinions about the SNS is the Health Barometer, where the results to questions on overall satisfaction, interaction with professionals and waiting lists are provided.

In 2023, figures regarding the overall satisfaction of the population with the SNS have slightly worsened compared to those in 2019, with an overall score of 6.3 out of 10 (6.7 in 2019). Primary care visits and specialized ambulatory care are the two items in which patient satisfaction has decreased over time, while inpatient care and emergencies have a higher score than in 2019. Finally, the overall score of the SNS has decreased since 2019; around 56.1% believe that the SNS works well or very well in 2023, while in 2019 this figure was 72.1% (Ministry of Health, 2024). These data, to some extent, corroborate a public perception of deterioration of the SNS, especially in primary care, since the COVID-19 pandemic.

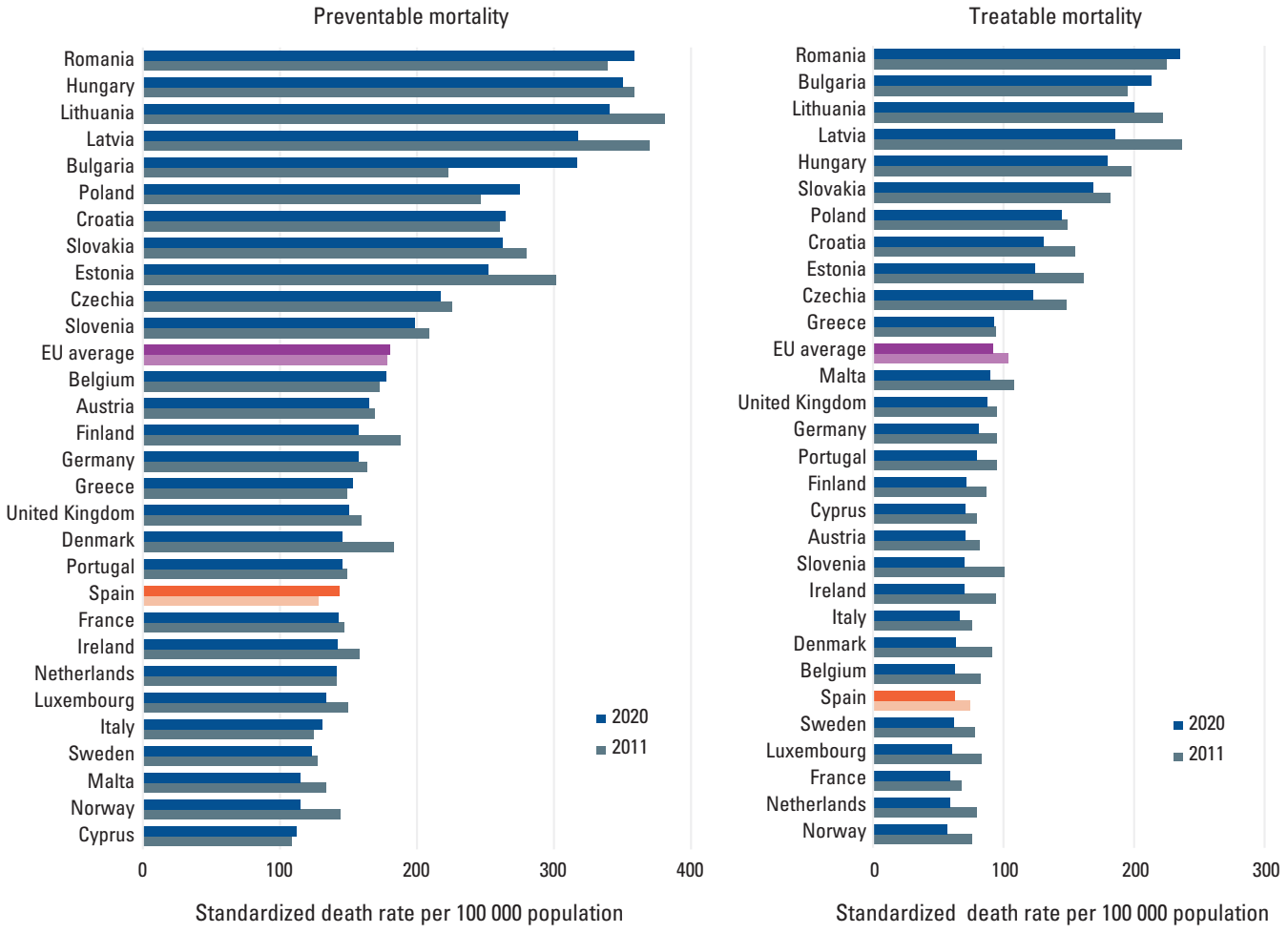
Health system outcomes

Spain had among the lowest rates of avoidable mortality in the EU in 2020 (Fig. 10). The rate of preventable mortality, which had been declining in the years prior to the COVID-19 pandemic, absorbed the impact of COVID-19, as such deaths are counted as preventable deaths. Consequently, the preventable mortality rate in Spain increased from 110 deaths per 100 000 population in 2019 to 143 deaths per 100 000 population in 2020.

Nevertheless, the preventable mortality rate is still much lower than the EU average and may be related in part to public policies, legislation and initiatives aiming to minimize health risk factors, including: the introduction of an excise tax on sugar-sweetened beverages in 2021; the 2022 Public Health Strategy; and the 2019 Strategic Primary Care Framework and the related 2022–2023 Action Plan (see Box 7).

In 2020, the rate of mortality due to treatable causes slightly reduced to 62.2 deaths per 100 000 inhabitants from 65.8 deaths in 2015. This is well below the 2020 EU average of 91.7 deaths per 100 000 population (Fig. 10). The sustained reduction in treatable mortality may be partly explained by efforts to improve timely access to effective treatments in acute ischaemic stroke and acute ischaemic heart disease, to maintain and increase coverage in population cancer screening programmes, and to improve care continuity for older patients with chronic conditions.

Fig. 10 Mortality from preventable and treatable causes, 2011 and 2020



Note: United Kingdom data from 2018.

Source: Eurostat, 2023.

Box 7 Are public health interventions making a difference?

Tobacco consumption in Spain has experienced a reduction in the past decade: in 2020, 19.8% of the population over 15 were daily smokers (23.3% men and 16.5% women) compared to 23% in 2014 (27.6% men and 18.6% women) (Ministry of Health, 2023a). Law 42/2010 on tobacco control and advertising, as well as a stronger fiscal policy against tobacco (with 78.4% of the retail price being taxes), are likely to have contributed to this continuous reduction (SEE, 2017).

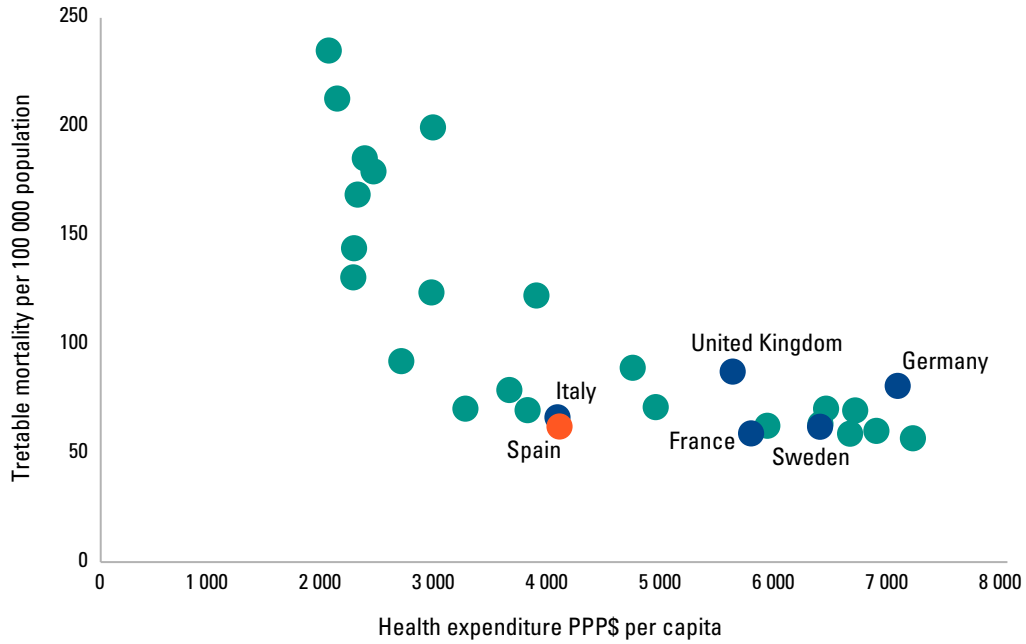
Alcohol consumption among adults in Spain increased between 2010 and 2021 and is now higher than in many other EU countries, and slightly above the EU average. However, only about 6% of adults reported regularly engaging in heavy drinking in 2019 – the third lowest rate among all EU countries and considerably lower than the EU average (18.5%) (OECD/European Observatory on Health Systems and Policies, 2023).

Obesity and overweight in Spain are a matter of growing concern, especially among children. For those aged 6–9 years, the implementation of the Nutrition, Physical Activity and Obesity prevention Strategy (NAOS) has resulted in a decrease in the prevalence rate for overweight among children (AECOSAN, 2019). A first assessment of the implementation of fiscal measures on sugary drinks by increasing their VAT from 10% in 2018 to 21% in 2021 (Law 11/2020) has resulted in a 13% drop in the consumption of this type of beverage, and subsequently a 10.5% reduction of snack consumption compared to 2018 (Martínez-Jorge et al., 2022).

Health system efficiency

A cursory illustration of the health system's performance in terms of input costs and outcomes can be obtained by plotting current health expenditure against the treatable mortality rate (Fig. 11). Spain's treatable mortality rate is among the lowest in the EU, at 63 per 100 000 inhabitants in 2020 – in line with France (60) and Sweden (62). In 2020, health expenditure per capita was notably lower in Spain than in either France or Sweden, despite the exceptional increase of public funds dedicated to address the needs arising from the COVID-19 pandemic. These basic results suggest that given its expenditure levels, Spain has been able to secure very good and efficient outcomes on this metric.

Fig. 11 Treatable mortality per 100 000 population vs. health expenditure per capita, 2020



Note: 2018 data for United Kingdom.

Sources: WHO, 2024; Eurostat, 2023.

Factors that may explain technical efficiency in the SNS are: the strong gatekeeping system, the administrative distribution of the population into health care areas, along with a strongly hierarchical organization mainly based of public providers, which greatly reduces coordination costs; and, although with some flaws, the strong centralized regulation of drug pricing, as well as some long-standing policies on reference prices, prescription by active ingredient and dispensation of generic drugs, which have brought down unit prices of pharmaceuticals to be among the lowest in the EU (see Box 8).

Box 8 Is there waste in pharmaceutical spending?

The SNS has implemented some policies for the control of drug expenditure but the effectiveness of these measures has not been as strong as expected: the average expenditure per prescription billed has increased by 12.8%, from €10.81 in 2015 to €12.20 in 2022, while pharmaceutical expenditure per capita has increased by 21.1%, from €213.70 in 2015 to €269.60 in 2022 (Ministry of Health, 2023c).

Regarding the number of prescribed drugs, appropriate utilization remains the big challenge for pharmaceutical care in the SNS. The large variation in prescriptions suggests that prescription policies have not been equally effective in the reduction of the variation across ACs: for example, in 2022, the number of prescriptions for antidepressants varied almost three times across ACs (Ministry of Health, 2023a).

The use of cost-effectiveness criteria as a guide in the decision process for reimbursement and pricing of a drug is not common in the SNS, although the Spanish regulatory framework envisages its use. Methodological (different cost-effectiveness criteria) and administrative or political barriers are hindering its full implementation (Oliva-Moreno et al., 2020). The recently launched VALTERMED, an information system to determine the therapeutic value of a drug in real practice of high-cost pharmaceuticals, can be a tool for the inclusion of economic evaluations in decision-making.

Summing up

Future challenges in Spain include the sustainability of the primary care health workforce

Coverage within the decentralized SNS is virtually universal, and provision of services is free of charge at the point of care. The benefits package is comprehensive and while cost-sharing is required for pharmaceuticals and some prostheses, OOP payments do not result in catastrophic spending for households. Co-payments have been largely reformed with further exemptions in place since 2020. The most recent health care reforms in Spain have been directed towards maintaining the universality of the SNS, as well as promoting equity and cohesion.

The SNS performs well in health system quality and outcomes. Spain has the highest life expectancy among EU countries, while rates for avoidable hospitalizations and avoidable mortality (from both preventable and treatable causes) are among the lowest. Only a small share of the population reports unmet needs for medical care, with minimal differences across income quintiles. There is, however, room for improvement in addressing unmet needs for dental and optical care, as well as for mental health care.

As with many other European countries, one of the major health system challenges is securing an adequate health workforce to meet SNS needs. The number of practising medical doctors in Spain is significantly above the EU average and has been following a growing trend. However, the shortage of physicians in some specialties and problems in covering vacancies in some rural areas of the country remain a challenge. A plan led by the Ministry of Health aims to increase the number of medical graduates and medical interns, and to set up incentives to cover hard-to-fill positions.

Population health context

Key mortality and health indicators

Life expectancy (years)[a]	2022
Life expectancy at birth, total	83.2
Life expectancy at birth, male	80.4
Life expectancy at birth, female	85.9
Mortality (per 100 000)[b]	**2020**
All causes	
Circulatory diseases	108
Malignant neoplasms	131
Communicable diseases	7.3 (2017)
External causes of death[c]	35.5 (2021)
Infant mortality rate (per 1000 live births)[d]	2.7
Maternal mortality rate (per 100 000 live births)[d]	3.4

Note: Life expectancy data featured here differ slightly from Eurostat data owing to methodological differences.
Sources: [a]Ministry of Health, 2022; [b]WHO Regional Office for Europe, 2023; [c]INE, 2021; [d]WHO, 2023.

References

AECOSAN (2019). Estudio sobre la alimentación, actividad física, desarrollo infantil y obesidad en España [Surveillance study of the growth, nutrition, physical activity, child development and obesity in Spain]. Aladino. Madrid: Agencia Española de Consumo, Seguridad Alimentaria y Nutrición.

Bernal-Delgado E, Angulo-Pueyo E (2023). Purchasing arrangements to strengthen the quality of chronic care in three Spanish autonomous communities: case study. Geneva: World Health Organization/Paris: Organisation for Economic Co-operation and Development. Licence: CC BY-NC-SA 3.0 IGO.

Eurostat (2023). Eurostat database [online database]. Luxembourg: Eurostat.

Eurostat (2024). Eurostat database [online database]. Luxembourg: Eurostat.

INE (2021). Deaths by cause of death. Madrid: Instituto Nacional de Estadística.

INE (2023). Household Budget Survey 2022. Madrid: Instituto Nacional de Estadística .

Martínez-Jorge A et al. (2022). Los efectos del aumento del IVA en el consumo de las bebidas azucaradas en España [Effect of VAT increase in sugary and sweetened beverages]. ESADE.

Martínez-Lizaga N et al. (2023). Atlas de Hospitalizaciones Potencialmente Evitables por condiciones crónicas por zona básica de salud 2018–2020 [Atlas of Potentially Avoidable Hospitalizations in patients for chronic conditions 2018–2020 (1.0.0)]. Zenodo (https://doi.org/10.5281/zenodo.7851752).

Ministry of Health (2018). Informe del proyecto de Estratificación de la Población por Grupos de Morbilidad Ajustada (GMA) en el Sistema Nacional de Salud 2014–2016 [Report of the project on Population Stratification by Adjusted Morbidity Groups (AMG) in the National Health System]. Madrid: Ministerio de Sanidad (https://www.sanidad.gob.es/areas/calidadAsistencial/estrategias/abordajeCronicidad/docs/informeEstratificacionGMASNS_2014-2016.pdf).

Ministry of Health (2022). Healthcare Planning in the Territory in the Autonomous Communities [Ordenación sanitaria del Territorio en las Comunidades Autónomas]. Madrid: Ministerio de Sanidad.

Ministry of Health (2023a). National Health System Key Indicators [online database]. Madrid: Ministerio de Sanidad (https://inclasns.sanidad.gob.es/main.html).

Ministry of Health (2023b). Barómetro Sanitario 2022 [Healthcare Barometer 2022]. Madrid: Ministerio de Sanidad, Centro de Investigaciones Sociologicas (https://www.sanidad.gob.es/estadEstudios/estadisticas/inforRecopilaciones/barometro/home.htm).

Ministry of Health (2023c). Medical Prescription Billing Information System [online dataset]. Madrid: Ministerio de Sanidad, Servicios Sociales e Igualdad (https://www. sanidad.gob.es/areas/farmacia/consumoMedicamentos/facturacionRecetas/CCAA_ INGESA/2023/diciembre.htm).

Ministry of Health (2024). Barómetro Sanitario 2023 [Healthcare Barometer 2023]. Madrid: Ministerio de Sanidad, Centro de Investigaciones Sociológicas (https:// www.sanidad.gob.es/estadEstudios/estadisticas/BarometroSanitario/Barom_Sanit_2023/ Barom_Sanit_2023_totales/es8823mar.pdf).

OECD (2023). OECD Health Statistics. Paris: OECD Publishing.

OECD (2024). OECD Health Statistics. Paris: OECD Publishing.

OECD/European Observatory on Health Systems and Policies (2023). Country Health Profile: Spain. State of Health in the EU. Paris: OECD Publishing/Copenhagen: WHO Regional Office for Europe (on behalf of the European Observatory on Health Systems and Policies) (https://www.oecd-ilibrary.org/social-issues-migration-health/spain-country-health-profile-2023_71d029b2-en).

Oliva-Moreno J, Puig-Junoy J, Trapero-Bertran M, Epstein D, Pinyol C, Sacristán JA (2020). Economic Evaluation for Pricing and Reimbursement of New Drugs in Spain: Fable or Desideratum? Value in Health, 23:25–31.

Rodríguez-Feijoó S, Rodríguez-Caro A (2021). El copago farmacéutico en España tras la reforma del año 2012 desde la perspectiva del usuario. ¿Evidencias de inequidad? [Pharmaceutical co-payment in Spain after the 2012 reform from the user's perspective. Evidence of inequity?]. Gac Sanit, 35(2):138–44. doi:10.1016/j.gaceta.2019.09.009 (in Spanish).

SEDAP (2020). Modelos de atención integrada en España [Integrated care models in Spain]. Sociedad Española de Directivos de Atención Primaria (https://www.sedap.es/wp-content/uploads/2020/12/modelosai_sedap-091220.pdf).

SEE (2017). Evaluación de las políticas de control del tabaquismo en España (Leyes 28/2005 y 42/2010) Revisión de la evidencia [Evaluation of the policies controlling tobacco consumption in Spain (Laws 28/2005 and 42/2010). Review of the evidence]. Madrid: Grupo de Trabajo sobre Tabaquismo de la Sociedad Española de Epidemiología (https://www.seepidemiologia.es/documents/dummy/V9.0%20-%20Libro%20Tabaquismo%202017%20-%20Abierto%20Final.pdf).

Urbanos-Garrido R, Peña-Longobardo LM, Comendeiro-Maaløe M, Oliva J, Ridao-López M, Bernal-Delgado E (2021). Can people afford to pay for health care? New evidence on financial protection in Spain. Copenhagen: WHO Regional Office for Europe.

WHO (2023). Data platform. Geneva: World Health Organization.

WHO (2024). Global health expenditure database. Geneva: World Health Organization.

WHO Regional Office for Europe (2023). European Health Information Gateway. Copenhagen: WHO Regional Office for Europe (https://gateway.euro.who.int/en/indicators/hfamdb_113-sdr-all-causes-per-100-000/).

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