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Spain
Health system review

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PREFACE

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used to:

- learn in detail about different approaches to the organization, financing and delivery of health services, and the role of the main actors in health systems;
- describe the institutional framework, process, content and implementation of health care reform programmes;
- highlight challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national

statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situations. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to contact@obs.who.int.

HiTs and HiT summaries are available on the Observatory's website (www.healthobservatory.eu).

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This edition was written by Enrique Bernal-Delgado (Institute for Health Sciences in Aragon), Ester Angulo-Pueyo (Institute for Health Sciences in Aragon), Manuel Ridao-López (Institute for Health Sciences in Aragon), Rosa M Urbanos-Garrido (University Complutense of Madrid), Juan Oliva-Moreno (University of Castilla-La Mancha), and Daniel García-Abiétar (Foundation University Institute for Primary Health Care Research Jordi Gol i Gurina (IDIAPJGol)). It was edited by Cristina Hernández-Quevedo, working with the support of Anna Maresso and Ewout van Ginneken of the European Observatory on Health Systems and Policies.

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The Observatory is a partnership that includes the Governments of Austria, Belgium, Finland, Ireland, Netherlands (Kingdom of the), Norway, Slovenia, Sweden, Switzerland and the United Kingdom; the Veneto Region of Italy; the French National Union of Health Insurance Funds (UNCAM); the World Health Organization; the European Commission; the London School of Economics and Political Science (LSE); and the London School of Hygiene & Tropical Medicine (LSHTM). The partnership is hosted by the WHO Regional Office for Europe. The Observatory is composed of a Steering Committee, core management team, research policy group and staff. Its Secretariat is based in Brussels and it has offices at LSE and LSHTM in London and at the Technical University of Berlin. The Observatory team working on HiTs is led by Josep Figueras, Director; Elias Mossialos, Martin McKee, Reinhard Busse (Co-directors); Richard Saltman, Ewout van Ginneken and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Anna Maresso. The production and copy-editing process of this HiT was coordinated by Jonathan North, with the support of Lucie Jackson, Sarah Cook (copy-editing) and Steve Still (design and layout).

LIST OF ABBREVIATIONS

AC	Autonomous Community
AEMPS	Spanish Agency for Medicines
CHE	Current Health Expenditure
CISNS	Inter-territorial Council for the SNS
COPD	Chronic obstructive pulmonary disease
CT	Computerized tomography
EU	European Union
FBPS	Fund for Basic Public Services
FFS	Fee-for-service
GDP	Gross domestic product
HTA	Health Technology Assessment
INCLASNS	National Health System Key Indicators
INE	National Institute of Statistics
INGESA	Institute for Health Care Management
IPT	Therapeutic positioning reports
ISFAS	Social Institute for the Armed Forces
LHO	Local Health Office
MCSS	Collaborating Mutualities with the Social Security
MF	Mutual Funds
MRI	Magnetic Resonance Imaging
MISSM	Ministry of Inclusion, Social Security and Migration
MUFACE	Mutual Fund for State Civil Servants
MUGEJU	General Justice Mutual Fund
NGO	Non-governmental organization
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket
PCA	Primary care areas
PCC	Primary care centres

PET	Positron Emission Tomography
PFIs	Private Finance Initiatives
PHC	Primary health care
PPPs	Public-Private Partnerships
PPP	Purchasing Power Parity
PPS	Purchasing Power Standard
PSOE	Spanish Socialist Workers Party
RD	Royal Decree
RDL	Royal Decree-Law
RedETS	Spanish Network of Health Technology Assessment Agencies and Benefits of the National Health System
SNS	Spanish National Health System
SAAD	System for the assistance of dependent people
SDR	Standardized death rate
THE	Total health expenditure
UHC	Universal health coverage
VAT	Value Added Tax
VHI	Voluntary health insurance
WHO	World Health Organization

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ABSTRACT

This review of the Spanish health system analyses recent developments in health organization and governance, financing, health care provision, recent reforms and health system performance.

Overall health status continues to improve in Spain, which presents the highest life expectancy in the European Union – although some socioeconomic inequalities in health persist and risk factors such as overweight, tobacco and alcohol consumption and illegal drug use remain a concern.

The Spanish national health system (SNS) provides universal coverage, and it is mainly funded by taxes. Health competences are transferred to the regions, while the Ministry of Health is responsible for the overall coordination of the SNS. Health spending has seen a large increase as a percentage of GDP, following the COVID-19 pandemic in 2020, remaining high in 2021 (10.8% of GDP). While the benefits package is comprehensive, cost-sharing is required for pharmaceuticals and some prostheses; nonetheless, out-of-pocket (OOP) payments do not result in catastrophic spending for households. Co-payments have been largely reformed with further exemptions in place since 2020.

Primary care remains at the centre of the SNS, with the Family Doctor[1] acting as the gatekeeper to specialized and hospital care. The 2019 Strategic Framework for Primary and Community Care aims for primary care to adapt to and address new epidemiological, societal and technological challenges that have emerged over the last decade. Regarding provision of care, there is a shortage of physicians in some specialties and problems in covering vacancies in some rural areas of the country, particularly for primary care physicians.

Health system reforms since 2018 have focused on widening the population covered by the health system, reducing co-payments, improving the scope of coverage in terms of increasing provided services, and the

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* In primary care, General Practitioners are known as Family Doctors in Spain.

reinforcement of primary care. Future challenges for the health system include addressing access gaps, such as the limited coverage of some services (such as dental and optical care), and large waiting lists for some services. Some gaps in efficiency remain, such as the low numbers of qualified personnel in some medical specialties, the shortage of mental health resources, the underuse of effective treatments, and the overuse of non-appropriate or ineffective procedures.

EXECUTIVE SUMMARY

Spain is located in south-western Europe, bordered by France, Portugal and Morocco, and comprises the peninsular region, the Canary Islands, the Balearic Islands and the autonomous cities of Ceuta and Melilla. The Spanish population reached 48.4 million inhabitants in 2023, after a 4.3% increase since 2015, although fertility rates have remained low, and below the population replacement rate.

Spain is a parliamentary monarchy, politically organized as a quasi-federal state, where the 17 Autonomous Communities (ACs) hold full capacity in the planning, financing and provision of health care, education and social protection.

Average life expectancy at birth was 83.2 years in 2022, the highest in the EU. Self-reported health status and long-standing illness improved until 2019 but have worsened since 2020, mainly among the worse-off population. Some chronic conditions, such as high blood pressure and diabetes, have continued increasing. The obesity rate among adults has remained fairly stagnant at 16%, whereas the share of people who are overweight has continued to increase over the last few years. Obesity and overweight affected 39% of children aged 6 to 9 in the period 2018–2020, 10 percentage points higher than the WHO European average.

Tobacco is still the main cause of avoidable mortality in Spain, despite the constant reduction of daily smokers in recent years. Alcohol consumption and the consumption of illegal drugs have also increased.

The Spanish health system is decentralized, with national coordination

Coverage in the statutory 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 ACs, with the Ministry of Health being responsible for

the overall coordination of the health system under the governance of the Inter-territorial 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.

Opting out from SNS coverage is not allowed, although the population can buy voluntary health insurance (VHI) if they desire. Public servants within Mutual Funds are entitled to choose between public and private provision, with 21% of them choosing public. The major regulatory change on patient rights since 2010 was the Organic Law 3/2021, which legalizes and regulates euthanasia. The Law respects patients' autonomy and will to end their life when serious, chronic, disabling or hopeless illness is present.

Public spending is the main source of funding of the SNS, while out-of-pocket payments remain high and VHI keeps growing

Current health spending per capita has continued to rise in the last years but, in terms of GDP, health spending has remained stable, reaching 9.3% in 2019. However, as a consequence of the COVID-19 pandemic, a dramatic increase in health spending raised expenditure up to 11.0% of GDP in 2020, remaining high (10.8% of GDP) in 2021.

Public expenditure is the primary source of funding for health in Spain, representing 71.7% of total health expenditure in 2021 (70.6% in 2019). The main component of private spending, OOP spending, accounted for 20.6% of total health spending in 2021 (19.2% in 2019). Public funds come mostly from general taxes and the ACs manage most of the public health resources (92.2% of public health expenditure in 2020).

The basic benefits of the common package are not subject to any patient cost-sharing. Only pharmaceutical prescriptions and ortho-prosthetic devices incur co-payments. Although VHI plays a complementary role in the SNS, it has experienced strong growth in recent years, covering 20.8% of the population in 2021.

Shortages of some medical specialties, especially Family Doctors, remain; future needs may not be covered

The number of hospital beds has remained constant throughout the period 2015–2022, and rested at 296 beds per 100 000 inhabitants, with public beds representing 81.4% of the total in 2022. Capital investment has grown steadily, reaching 2.3% of total public health expenditure in 2022 (1.5% in 2013).

Since 2021, and as a result of the Recovery, Transformation and Resilience Plan, an increase in the density of medical equipment has been observed, reducing inequalities across the country and renewing obsolete medical equipment.

After the implementation of the 'Insurance ID card', the progress of the SNS eHealth Strategy has resulted in the SNS leading the implementation of the Patient Summary and the Electronic Prescription programmes, allowing the exchange of relevant clinical and pharmaceutical information across regions and cross-border.

The number of primary health care professionals has remained rather stable in the period 2014–2022, whereas for specialized care personnel, numbers of doctors and nurses have increased by 18% and 24%, respectively. Over the years the ratio of nurses to doctors has lingered below the OECD countries' average ratio (1.4 against 1.97).

There is a shortage of physicians in some specialties and problems in covering vacancies in some rural areas of the country; the lack of primary care physicians is the major concern. Projections for the next decade highlight shortages in some specific specialties, putting at stake the capacity of the system to cover future population needs. A plan led by the Ministry of Health aims to increase the number of graduates in Medicine as well as the number of medical interns, and to set up incentives to cover hard-to-fill positions.

Strengthening primary care, expanding dental care and developing a mental health strategy are among the priorities for the delivery of health services

As part of the reflection process following the COVID-19 pandemic, a national public health strategy was published in 2022, which created a reference framework for the coordination of all the actors involved in public

health. A Strategic Framework for Primary and Community Care agreed by the Ministry of Health and the ACs aims to meet the current needs and future challenges of primary care.

The large variation in prescriptions and the uneven growth in expenditure across regions raise concerns about the impact of pharmaceutical care on the overall efficiency of SNS resource allocation. Efforts to increase evidence-based prescription have led to great success in antibiotic prescribing and have reduced consumption of antidepressants and hypnotic drugs.

The national system for the assistance of dependent people (namely, SAAD) has been consolidated in recent years, and currently assists almost 1.3 million people. Some concerns about the sustainability of the current financing framework cast certain shadows on the system's longer-term development.

The SNS has drawn up a mental health strategy for the period 2022–2026, putting the focus on the inclusion of a gender perspective, the fight against stigma, the advocacy of a community approach to mental health care, and an enhanced role for informal caregivers.

The acknowledgement of unmet needs in dental care has led the SNS to approve a new Dental Health Plan, which aims to increase the share of the population eligible for public services and to extend the benefits package.

Recent reforms have aimed to facilitate access to health care for the most vulnerable

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 vulnerable groups. Since 2018, the basis for entitlement has returned to the condition of residency following new legislation on universal access to the SNS (reversing the policy in place between 2012 and 2017 when eligibility was linked to the legal and employment status of individuals). Another important development in coverage policy focuses on co-payments in pharmaceutical care, which have been largely reformed in Law 11/2020, with new exemptions benefiting 7.3 million people in 2024.

The 2019 Strategic Framework for Primary and Community Care sets out various measures, providing new impetus to primary care to adapt and address new epidemiological, societal and technological challenges.

Euthanasia has become a new benefit covered by the national health system, underwritten by Organic Law 3/2021. The Law guarantees patients autonomy and choice regarding their own death, while setting up the criteria and procedures for eligibility and delivery.

A draft law for the creation of the National Agency of Public Health is still being discussed in parliament and is expected to be approved in 2024.

Future challenges for the health system include improving access and technical efficiency

An independent evaluation of the SNS's response to the COVID-19 pandemic underscores some weaknesses, including the gap between public health services and the health care network, serious coordination failures with long-term and social care networks and significant shortcomings in epidemiological surveillance systems.

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. However, unmet needs in dental care are relatively high, and affect the poorest households the most. Moreover, despite the substantial share of private spending represented by OOP payments, the risk of catastrophic expenditure for households in Spain is among the lowest in the EU. Protection mechanisms (such as exemptions from co-payments), accessible primary care settings, services provided for free at the point of use, and the redistributive effect of public spending on health are deemed to be underlying factors supporting financial protection of the population.

The SNS performs well in terms of life expectancy, avoidable hospitalizations and avoidable mortality (both preventable and treatable mortality). However, the SNS records rates that are below the EU average in some cancer screening services, with a notable difference between high-income and low-income groups.

Major instruments to improve allocative efficiency within the SNS include the ACs' financing mechanism, the policy design towards universal health coverage (UHC), the evaluative instruments for the adoption of new technologies, and the purchasing instruments at AC level. Unfortunately, there are no formal evaluations of the implementation of these instruments or their actual impact on allocative efficiency.

Technical efficiency within the SNS is supported through various measures, including effective access to a comprehensive basket of benefits, the entry mechanisms for doctors to access hospital positions, and the strong regulation of salaries and drugs' pricing. Some gaps in efficiency remain, such as the low numbers of qualified personnel in some medical specialties, the shortage of mental health resources, the underuse of effective treatments, and the overuse of non-appropriate or ineffective procedures.

1

Introduction

Summary

- Spain is located in south-western Europe, bordered by France, Portugal and Morocco, and comprises the mainland peninsular region, the Canary Islands, the Balearic Islands and the autonomous cities of Ceuta and Melilla.

- The Spanish population reached 48.4 million inhabitants in 2023, after a 4.3% increase since 2015, although fertility rates have remained low, and below the population replacement rate. Life expectancy was 83.2 years in 2022, the highest in the EU.

- Spain is a parliamentary monarchy, politically organized as a quasi-federal state, where the 17 ACs hold full capacity in the planning, financing and provision of health care, education and social protection.

- In terms of macroeconomic indicators, both GDP and the budget deficit improved between 2014 and 2022, whereas cumulative general government gross debt continued to exceed GDP in that period. The unemployment rate has decreased since 2013, and as a result of the labour reform approved in 2022, the number of permanent contracts has increased, improving work stability.

- Self-reported health status and long-standing illness improved until 2019 but have worsened significantly since 2020, mainly among the worse-off population. The prevalence of some chronic conditions,

such as high blood pressure and diabetes, have continued to increase among the population.

- The obesity rate among adults has remained stagnant at 16%, whereas the overweight rate has continued to grow over the last few years. Obesity and overweight affected 39% of children aged 6 to 9 in the period 2018–2020, 10 percentage points higher than the WHO European average.

- Tobacco consumption is still the main cause of avoidable mortality in Spain, despite the constant reduction of daily smokers in recent years. Alcohol consumption and the consumption of illegal drugs have also increased.

1.1 Geography and sociodemography

Spain is located in south-western Europe, bordered by France, Portugal and Morocco. The Spanish territory, covering 505 955 km^2, includes the mainland peninsular regions, the Canary Islands (located in the Atlantic Ocean), the Balearic Islands (in the Mediterranean Sea) and two autonomous cities, Ceuta and Melilla, placed at the very north of the Morocco border. The climate is diverse, but the Mediterranean climate is predominant.

Administratively speaking, Spain is organized into 17 ACs (*Comunidades Autónomas,*) and two autonomous cities (Ceuta and Melilla) (Fig. 1.1). The official language is Spanish, which co-exists with three other official languages at regional level: Basque, Catalan and Galician.

In 2023, Spain had a population of 48.4 million inhabitants (INE, 2023a), an increase from the previous year (47.6 million) (Table 1.1). From 2015 to 2023, the population increased by 4.3%, although fertility rates remained low, and below the population replacement rate. The registered immigrants that reside in Spain accounted for 13.1% of the total population in 2023, reaching 6.37 million people. Morocco leads this number, followed by Romania and Colombia (INE, 2023a).

FIG. 1.1 Map of Spain

Source: WHO (2024), reproduced from Bernal-Delgado et al. (2018).

Notably, the rate of population natural increase has been negative since 2015; in 2022, the rate was -2.79 people per 100 000 inhabitants (-133 250 people). The mean age of the population rose from 42.5 in 2015 to 44.1 years in 2022, and the share of older people (aged 65 years or over) has steadily increased from 18.9% in 2015 to 20.3% in 2022. The Spanish population tends to concentrate in urban and coastal areas (81.1% of the population in 2021), a phenomenon that is steadily increasing. Table 1.1 shows the most recent demographic indicators for the country.

In 2022, 58.8% of people claimed to be religious (of whom 95.6% were Catholic), whereas 39.3% declared themselves atheist, agnostic or indifferent to religion (the highest proportion in the historical series). In the younger generations, 60.3% of those aged 18 to 24 and 57.9% of those aged 25 to 34 claimed to be non-religious (Fundació Ferrer I Guàrdia, 2023). Around 62.3% of the population aged between 15 and 64 years have attained upper secondary, post-secondary non-tertiary or tertiary education (Eurostat, 2023a).

TABLE 1.1 Trends in population/demographic indicators, selected years

	1995	2000	2005	2010	2015	2020	2022
Total population (millions)	39.4	40.3	43.7	46.6	46.4	47.3	47.6
Population aged 0 to 14 (% of total)	16.7	14.8	14.3	14.6	14.9	14.4	13.8
Population aged 65 and above (% of total)	15.1	16.6	16.6	17.2	18.9	19.7	20.3
Population growth (average annual growth rate)	0.2	0.8	1.7	0.5	-0.1	0.46	0.42
Population density (people per sq. km)	78.9	80.7	87.5	93.2	92.9	94.8	95
Fertility rate, total (births per woman)	1.2	1.2	1.3	1.4	1.3	1.2*	1.2 (2021)
Distribution of population (urban/total)	75.9	76.3	77.3	78.4	79.6	80.8	81.3

Source: World Bank (2023).

Note: * Extrapolated assuming the same as previous year.

1.2 Economic context

In macroeconomic terms, the last 15 years have been fluctuating between two worldwide shocks. Following an expansionary cycle, the economic and financial crisis resulted in a deep decrease in the GDP growth rate (-3.8% in 2009) (World Bank, 2023). After 2014, GDP recovered, reaching US$ 29 555 per capita in 2019 (World Bank, 2023). However, due to the COVID-19 pandemic, GDP growth rate plummeted at -11.8% in 2020 (US$ 26 984 per capita). GDP steadily recovered, reaching US$ 29 675 in 2022 (World Bank, 2023) (Table 1.2).

The public deficit has been reduced from 5.3% in 2015 to 4.7% of GDP in 2022, with a sharp increase in 2020 due to the pandemic response, reaching 10.1%. Cumulative public debt has increased from 103.3% of GDP in 2015 to 111.6% in 2022 (Eurostat, 2023b).

Government public expenditure has evolved in response to these variations, growing to cope with the economic and financial crisis in 2012, decreasing down to 42.3% in 2019, and sharply increasing again to 51.9% of GDP to manage the COVID-19 pandemic in 2020, the biggest percentage of GDP dedicated to public expenditure ever reported. In 2021 and 2022, public expenditure decreased to 50.6% and 47.4% of GDP, respectively (Eurostat, 2023b).

In 2021, public expenditure on health (€88 562 million) accounted for 7.2% of GDP (equivalent to 15.6% of total public expenditure), while social protection expenditure (such as unemployment benefits, pensions, and social care for dependent people) accounted for 20.3% of total GDP (Eurostat, 2023c) (see Section 3.1 *Health expenditure*).

Unemployment has been a major economic and social problem since the economic and financial crisis in 2008, reaching its highest level (26%) in 2013 when more than 6 million people were jobless. These figures improved in the following years and, despite the impact of the COVID-19 crisis, in 2020 the unemployment rate kept decreasing, reaching an employment rate of 11.7% at the end of 2023. For youth employment (people aged between 15 and 24), where figures are usually above the overall unemployment rates, rates also decreased from 46.2% at the end of 2015 to 28.4% at the end of 2023 (INE, 2023b).

From a gender perspective, unemployment among women remains higher than among men, and the observed reductions in rates do not translate into reductions in the gender gap within unemployment rates; on the contrary, there was a 2.8 percentage points difference in 2015 compared to 3.5 percentage points difference in 2022 (Eurostat, 2023d).

Importantly, a new 2021 National Labour reform agreed by the government, trade unions and employers' representatives, and aimed mainly at reducing part-time jobs, has translated into a structural change in the labour market (Royal Decree-Law 32/2021). Consequently, in 2022, Spain reached the highest number of salaried employees with permanent jobs ever, 14 250 000 people (1 591 700 more people than in 2021), and a historical minimum of salaried employees on temporary contracts, 3.1 million (1 194 000 fewer people than in 2021). In 2022, the overall temporary employment rate fell 7.5 percentage points, representing 17.9% of total employment; the reduction in the private sector was even larger, from 23.9% in 2021 to 14.8% in 2022 (Pérez-Rey & Lago Peñas, 2023).

In 2022, the median equivalized disposable income in Spain was €17 254 Purchasing Power Standard (PPS) per inhabitant, below the EU average of €18 706 (PPS). In terms of income distribution within the country, Spain showed a Gini coefficient of 32, slightly above the EU average of 29.6 (Eurostat, 2023e).

Nevertheless, the population at risk of poverty or social exclusion has slightly decreased over the years despite the impact of the COVID-19 pandemic. The percentage of this population subgroup was 28.7% in 2015,

decreased to 26% in 2022 (Eurostat, 2023f). Importantly, two legislative reforms were issued to reduce the rate of population at risk of poverty and improve their living conditions. Since 2019, the Minimum Interprofessional Wage has been adjusted annually considering the consumer price index; this measure resulted in a 22.3% increase from €736 to €900 per month in 2019; in 2023, the minimum wage reached €1080 per month (Royal Decree 1462/2018). Following a second reform, a Minimum Living Income is granted to those more disadvantaged (in terms of personal situation and economic vulnerability, as detailed in the law) (Law 19/2021). In 2023, 1.9 million people (677 150 households) benefited from the new measure (MISSM, 2023).

TABLE 1.2 Macroeconomic indicators, selected years (1995–2022)

	1995	2000	2005	2010	2015	2020	2022
GDP per capita (current US$)[a]	15 472	14 750	26 429	30 533	25 754	26 984	29 675
GDP per capita, PPP* (current international US$)[a]	16 418	21 517	27 703	31 984	34 696	37 766	46 332
GDP annual growth rate[a]	2.8	5.3	3.7	0.0	3.2	-11.2	5.8
Public expenditure (Government Expenditure as % of GDP)[b]	44.30	39.10	38.30	45.60	44.0	51.9	47.4
Government deficit/ surplus (% of GDP)[b]	-7	-1	+1.2	-9.4	-5.3	-10.1	-4.7
General government gross debt (% of GDP)[b]	61.7	57.8	42.4	60.5	103.3	120.3	111.6
Unemployment, total (% of labour force)[c]	20.7	11.9	9.2	19.9	22.1	15.5	12.9
Poverty rate (people at risk of poverty or social exclusion by age and sex as % of total population)[d]	–	–	24.3	26.1	28.6	27.0	26.0
Income inequality (Gini coefficient of disposable income)[e]	34	32	32.2	33.5	34.6	32.1	32

Sources: [a] World Bank (2023), [b] Eurostat (2023a), [c] Eurostat (2023c), [d] Eurostat (2023d), [e] Eurostat (2023e).

Note: * PPP = purchasing power parity.

1.3 **Political context**

Spain's political regime is a liberal democracy taking the form of a parliamentary monarchy. This is characterized by the King being the Head of State, and the separation of legislative, executive and judicial powers. Parliament is made up of two chambers, the Congress of Deputies (*Congreso de los Diputados,* the lower chamber) and the Senate (*Senado,* the upper chamber), while the executive government is run by the Prime Minister.

Since 1978, Spanish political organization has moved from a highly centralized country to a quasi-federal organization, where the 17 ACs play an essential role in the governing of the welfare state services (see Section 2.2 *Organization*). The ACs' financing mechanisms issued in 2001 and 2009, and most importantly, the development of the different statutes of autonomy[1], resulted in further decentralization and larger capacity in the planning, financing and provision of health care, education and social protection services for the regions.

From 2011 to 2018, Spain had a conservative government (Popular Party); from 2018 to 2023, the social democrat party (Spanish Socialist Workers Party, PSOE) governed the Executive. Until July 2023, the Spanish Government was in coalition with a leftist party (*Podemos*), supported in Parliament by other small regional nationalist parties, under which the aforementioned social and labour reforms were issued. Since November 2023, PSOE has governed in coalition with other leftist coalitions that reconfigured this political space (*Sumar*) and is supported again by other parties, mostly regional nationalists. This has resulted in a very fragmented lower chamber.

Spain is a Member State of the EU and belongs to the United Nations (UN), the World Health Organization (WHO), the European Economic Agreement (EEA), the Organisation for Economic Co-operation and Development (OECD), the World Trade Organization (WTO), the North Atlantic Treaty Organization (NATO) and the Council of Europe.

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[1] The statutes of autonomy have the character of bilateral agreements on the division of competences between the central and the regional governments, endorsed by both the national and the regional parliaments, within the general constitutional framework.

1.4 Health status

1.4.1 *Life expectancy*

Life expectancy at birth has increased steadily in Spain, reaching 84 years old in 2019 (Eurostat, 2023g). In 2020, and due to the COVID-19 pandemic, life expectancy decreased to 82.4 years, although it rapidly recovered to 83.2 years in 2022 (80.4 for men and 85.9 for women), higher than the EU average of 80.7 (Eurostat, 2023g) (Table 1.3). Despite these fluctuations, Spanish life expectancy is the highest in the EU (Eurostat, 2023g). By region, in 2021 the lowest average life expectancy was observed in the autonomous city of Ceuta (79.1 years), while the highest figure was observed in the AC of Madrid (85.3 years) (Ministry of Health, 2023b). This variation highly correlates with the median household income across regions (INE, 2023c).

1.4.2 *Mortality*

Spain recorded 464 417 deaths in 2022. The five leading causes of death that year (accounting for 28% of the overall death toll) were: COVID-19, which caused 31 606 confirmed deaths (6.8%); ischaemic heart diseases, causing 29 068 deaths (6.3%); cerebrovascular diseases, accounting for 24 688 deaths (5.3%); malignant neoplasm of lung, trachea and bronchi, causing 22 712 deaths (4.9%); and dementia, which caused 21 888 deaths (4.7%) (INE, 2023d).

Notably, since 2018 there has been an increase in suicide rates, reaching 8.4 cases per 100 000 inhabitants (4003 cases) in 2021. Half of all the cases were in people aged between 40 and 64 years (2016 persons), 31% were aged 65 years or older, 13.8% were aged 25–39 years and 5% were aged 10–24 years; three out of four people were men (2982 cases) (de la Torre Luque, 2023). Suicide has become the leading cause of death in young people and adolescents aged 12–29 in Spain, reaching a total of 336 deaths in 2021 (Pérez Diez et al., 2023).

In 2022, condition-specific age-standardized rates showed a cancer death toll of 215 cases per 100 000 inhabitants, while ischaemic heart disease was the cause of 55.6 deaths per 100 000 inhabitants and cerebrovascular events resulted in 47 deaths per 100 000 inhabitants. The death burden of these three pathologies has decreased since 2015, by 10%, 23% and 20%, respectively, reducing proportionally more in men than in women (Ministry of Health, 2023a).

The crude mortality rate fluctuated from 8.9 to 9.1 deaths per 1000 people in the period 2015–2019, rising to 10.4 deaths per 1000 people in 2020, likely influenced by the high toll of the COVID-19 pandemic – around 15% of all cases of death were due to COVID-19 (INE, 2023d) – and decreasing again in 2021 (9.5 deaths per 1000 people). These figures remained below the EU average of 11.9 deaths per 1000 in 2021 (Eurostat, 2023h). The overall standardized death rate (SDR) in Spain was 485.4 per 100 000 inhabitants (626.8 for men and 369.1 for women) in 2020, far below the 559.8 overall rate observed in the EU on average (713.9 for men and 434.4 for women) (WHO Regional Office for Europe, 2023a).

Regarding infant mortality, Spain has maintained low figures during the period 2015–2020 (around 2.7 cases per 1000 births), below the EU average of 3.5 cases per 1000 births in 2017 (WHO Regional Office for Europe, 2023b).

Regarding maternal mortality, Spain has experienced a decrease since 2010, from 17.57 in 2010 to 12.0 deaths per 100 000 live births in 2015 (see Table 1.3). Mortality from perinatal deaths per 1 000 births decreased from 15.44 in 1995 to 6.2 in 2015. Neonatal deaths per 1 000 live births decreased from 7.69 in 2000 to 3.7 in 2017 and post-neonatal deaths per 1 000 live births decreased from 2.96 in 2000 to 1.5 in 2015. The infant mortality rate also declined, from 17.8 in 1995 to 5 in 2017 (see Table 1.3), although it was still high in comparison to the EU (3.5) (WHO, 2019). The under-5 mortality rate declined almost three times, from 19.7 per 1 000 live births in 1995 to 5.7 in 2017 (World Bank, 2019a).

TABLE 1.3 Mortality and health indicators, selected years

	1995	2000	2005	2010	2015	2020 (or latest year available)
LIFE EXPECTANCY (YEARS) [a]						
Life expectancy at birth, total	78.1	79.3	80.2	82.1	82.7	82.2
Life expectancy at birth, male	74.5	75.9	76.9	79.1	80.3	79.5
Life expectancy at birth, female	81.7	82.7	83.5	85.0	85.4	85
Life expectancy at 65 years, male	16.1	16.6	17.3	18.4	18.8	18.3
Life expectancy at 65 years, female	20.0	20.5	21.1	22.4	22.6	22.3
MORTALITY, SDR PER 100 000 POPULATION [b]						
Circulatory diseases	241.7	197.9	171.9	137.6	122.4	108
Malignant neoplasms	179.8	170.4	159.7	152.4	141.6	131
Communicable diseases	8.7	11.9	12.1	8.9	8.7	7.3 (2017)
External causes [c]	28.1	26.4	23.3	15.7	14.3	35.5 (2021)
ALL CAUSES						
Infant mortality rate (per 1000 live births) [d]	5.5	4.4	3.8	3.2	2.7	2.7
Maternal mortality rate (per 100 000 live births) [d]	4.4	4	4	4	4	3.4

Sources: [a] Ministry of Health (2022a), [b] WHO Regional Office for Europe (2023a), [c] INE (2021), [d] WHO (2023).

Note: Life expectancy data featured here differ slightly from Eurostat data owing to methodological differences.

NONCOMMUNICABLE DISEASES

The prevalence of ischaemic cardiac diseases has remained stable among the population over 40 years of age, ranging from a prevalence of 3.7% in 2015 to 3.8% in 2022. Hypertension, diabetes and chronic obstructive pulmonary disease (COPD) have increased in prevalence: 12.5% in the case of hypertension from 16.4% in 2015 to 18.5% in 2022; 13% in the case of diabetes (from 6.7% to 7.5%), and 4% for COPD (from 3.4% to 3.5% in the population over 40). In the case of mental health disorders, there has been a 44% increase in overall prevalence, from 11.9% (15.7% in women and

7.9% in men) in 2015 to 17.2% (22.1% in women, 12.1% in men) in 2022 (Ministry of Health, 2023a).

Regarding cancer, the five-year prevalence in 2022 amounted to 873 168 cases, with breast, prostate, colorectum, bladder and lung cancers being the most prevalent neoplasms (Global Cancer Observatory, 2024). Estimations of the incidence of these five neoplasms between 2014 and 2022 suggest a decrease for men, with an increase for women except in colorectal cancer; so, breast cancer would have been increased from 85 to 103.3 per 100 000 women; bladder cancer from 8.8 to 10.5 per 100 000 women; and lung cancer from 16.6 to 23.2 per 100 000 women (REDECAN, 2023).

MATERNAL AND CHILD HEALTH

In the specific case of maternal and child mortality, maternal mortality shows a very small reduction since 2014, from 3.5 to 3.3 deaths per 100 000 live births in 2021 (INE, 2023g), while infant mortality has notably reduced since 2011 from 3.1 to 2.5 deaths per 1000 live births in 2021 (OECD, 2023a). In any case, infant mortality remains above other EU countries such as Finland, with 1.6 deaths per 1000 live births (OECD, 2023a).

SELF-REPORTED HEALTH STATUS

Self-reported health status improved from 72.4% of people reporting good or very good health in 2015 to 75.2% in 2019, decreasing gradually to 70.1% in 2022. Despite the decrease, this percentage remained above the EU average in 2022 (67.8%) (Eurostat, 2023i). Notably, differences in self-reported good or very good health among socioeconomic and gender groups have become wider during the period (see Section 7.5 *Health system outcomes*) (Eurostat, 2023i).

The percentage of people reporting long-standing illness or health problems (that is, self-reported morbidity) decreased from 33% in 2015 to 29% in 2019 (27.1% in males and 31.2% in females). However, since 2020 this percentage has risen sharply, reaching 39% in 2022 (37% in males and 41% in females) and placing Spain above the EU average (overall 36%) (Eurostat, 2023j). Finally, the share of people aged 65 and over reporting that they did not have severe difficulties in personal care or household activities was 71.2% in Spain in 2019, well above the 66% reported in 2014, although still below the EU average of 73.4% (Eurostat, 2023k).

MAJOR RISK FACTORS AFFECTING HEALTH STATUS

Around 31% of all deaths in Spain in 2019 can be attributed to behavioural risk factors, a percentage that is lower than the EU average of 39% (OECD/European Observatory on Health Systems and Policies, 2023). Tobacco, poor nutrition and alcohol consumption are the main risk factors for mortality in Spain, although their individual contributions to mortality are lower than the EU average (Fig. 1.2) (See also Box 5.1 in Chapter 5).

The obesity rate among adults reduced slightly to 16% in 2020, decreasing from the highest rate ever of 17% in 2017. Men have continued to show higher rates than women, as has been the case historically (16.5% compared to 15.5% in 2020) (Ministry of Health, 2023a). In addition, obesity is double in those groups with primary or secondary education compared to those with tertiary education (10% compared to 21%) (Eurostat, 2023l). Similarly, overweight continued its increase until 2020, reaching 37.6% that year (44.9% for men and 30.6% for women) (Ministry of Health, 2023a).

For children aged 6 to 9, the prevalence of both overweight and obesity was 39% in the period 2018–2020 and was similar for girls and boys. These figures were far above the average within the WHO European COSI survey countries, where 29% of children aged 7–9 years were living with overweight or obesity. Nonetheless, Spanish figures have slightly improved from the previous COSI survey wave conducted in 2015–2017, when the overall prevalence was over 40% (WHO Regional Office for Europe, 2022a).

Considering obesity separately, the prevalence rate for Spain in the period 2018–2020 was 16% (18% in boys and 14% in girls), 4 percentage points above the average prevalence rate (12%) of the COSI survey countries (14% in boys and 10% among girls). A slight reduction is observed in both girls and boys, compared to 2015–2017 (WHO Regional Office for Europe, 2022a).

Overall, smoking prevalence has decreased in Spain in the past decade following (and very likely attributable to) the implementation of national tobacco legislation. In 2020, 19.8% of the Spanish population over 15 were daily smokers (23.3% men and 16.5% women), a 14% decrease since 2014 (15% reduction in men and a 12% decrease in women) (Ministry of Health, 2023a). Despite the decrease, the share of daily smokers remains slightly higher than the EU average of 19.3% (Eurostat, 2023l). There are significant differences in daily tobacco consumption across income level quintiles. Hence, those in the most affluent quintile experienced a decrease in daily smoking from 20.9% in 2014 to 14.3% in 2019; among those with the lowest

incomes, however, the decrease was far smaller, from 28.0% in 2014 to 24.5% in 2019 (Eurostat, 2023l). Despite the observed reduction in smoking prevalence in Spain in recent years, the use of tobacco and related products continues to represent a high burden in terms of morbidity and is a main cause of avoidable mortality (around 22% of preventable deaths in 2020) (OECD/European Observatory on Health Systems and Policies, 2023).

In 2019, around 13% of the Spanish population drank alcohol daily, 2 percentage points less than in 2014 (15.3%), and well above the average percentage in the EU (8.4% in 2019). Alcohol consumption in the Spanish population over 15 years old increased from 10 litres per capita in 2009 to 10.7 litres in 2019, above the OECD average of 8.7 litres per capita (OECD, 2021). The number of risky drinkers (AUDIT scale >8 in men and >6 in women) has decreased slightly overall, from 6.2% in 2018 to 6% in 2022 (although in the case of women, it has increased from 4.7% to 4.8%) (Ministry of Health, 2023d).

Regarding the use of illegal drugs, cannabis is the substance with the highest use (during the preceding year) with the rate increasing from 9.2% in 2013/2014 to 10.5% in 2020 and remaining stable (10.6%) in 2022. According to the latest figures in 2022, prevalence of problematic cannabis consumption[2] among the population aged 15 to 64 years is 1.9%, but up to 22.6% of young people aged 15–24 have reported its consumption in the last 12 months (resulting in the age group with the highest consumption) (Ministry of Health, 2023d). Cocaine (powder and/or crack) use has remained stable over the last years from 2.2% in 2013 to 2.4% in 2022. According to the latest data, its consumption is higher in men than in women (3.6% compared to 1.1%), with men aged 35 to 44 years showing the highest prevalence (5.3%) (Ministry of Health, 2023d). In both cannabis and cocaine use, Spain ranks as a top consumer among European countries (European Monitoring Centre for Drugs and Drug Addiction, 2023).

In 2022, problem gambling[3] affected 1.3% of the population from 15 to 64 years old, which means a reduction compared with the 2% registered

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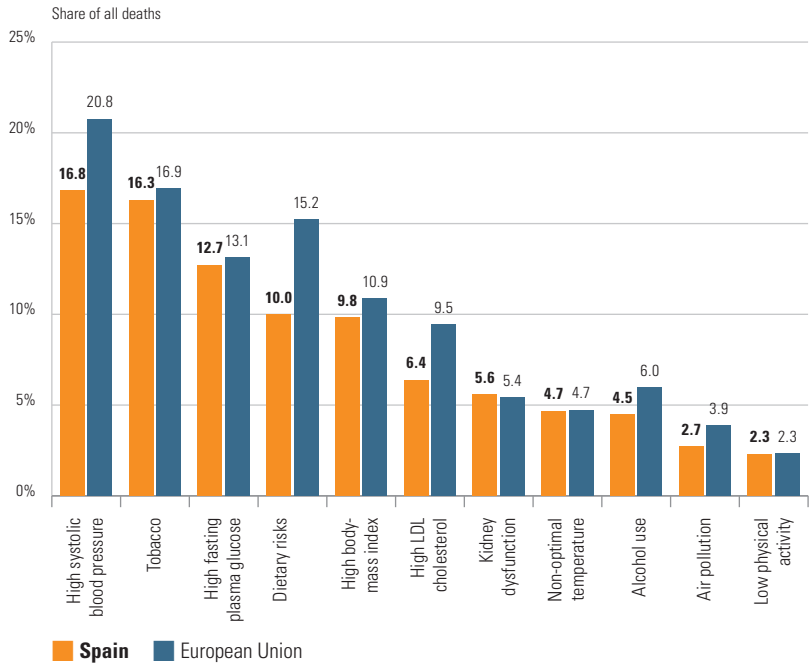
2 Problematic cannabis consumption is defined by the CAST scale. The CAST scale is a screening instrument consisting of six questions that seek to identify patterns or risk behaviours associated with cannabis use in the past year. A subject is considered to manifest problematic use when a score of 4 or more is obtained on the indicator.

3 Problem gambling and gambling disorders are defined according to the DSM-5 scale. A score of 1 to 3 on the DSM-5 scale would be considered problem gambling, representing excessive gambling behaviour, experiencing some problem gambling, but without a very significant impact. A score equal to or greater than 4 would be considered gambling disorder..

in 2018. Around 0.4% of the population reported a gambling disorder in 2022, a figure (slightly) smaller than 0.5% in 2018. Among students aged 14 to 18 years old, 3.4% were considered problematic gamblers – Lie/Bet scale – in 2023 (6% in boys and 2% in girls). In both age groups, the problem of gambling coexists with binge drinking or daily tobacco consumption (Ministry of Health, 2023e).

According to the 2022 behavioural addiction survey, 3.5% of the population aged 15–64 years was affected by potential compulsive internet use in 2022, a higher percentage than in 2015 (2.9%). Among adolescents aged 14–18, the increase is more evident: 20.5% were at high risk of compulsive internet use in 2023 compared to 16.4% in 2014. As in previous years, the prevalence is higher in girls (25.9%) than in boys (15.3%) (Ministry of Health, 2023e).

FIG. 1.2 Major risk factors affecting health status, latest available year



Source: IHME (2021).

2

Organization and governance

Summary

- Coverage in the statutory 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 health system are the responsibility of the 17 ACs, with the national government being responsible for the overall coordination of the health system under the governance of the CISNS.

- Two other statutory systems for health care are present: Mutual Funds catering 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. It provides VHI schemes to individuals and provides services to the three statutory health systems.

- The intersectoral approach towards health policies has translated into several initiatives, including a VAT increase for sugary and

sweetened beverages, a new Law on traffic and road safety, and the Climate Change and Energy Transition Law.

- Recent regulation is paving the way for the reinforcement and empowerment of health technologies and pharmaceutical assessment; for example, financing high economic impact drugs currently requires the assessment of both costs and outcomes.

- Opting out from SNS coverage is not allowed, although the population can buy VHI if they desire. Public servants within Mutual Funds are entitled to choose between public and private provision, with 21% of them choosing public.

- The major regulatory change on patient rights since 2010 was the Organic Law 3/2021, which legalizes and regulates euthanasia. The Law respects patients' autonomy and will to end their life when serious, chronic, disabling or hopeless illness is present.

2.1 Historical background

The first Compulsory Sickness Insurance in Spain (*Seguro Obligatorio de Enfermedad*) was created in 1942. Social security-related health care was run by the Ministry of Labour and Social Security through the National Institute of Social Insurance (*Instituto Nacional de Previsión*) from 1942 to 1977, by the new Ministry of Health and Social Security between 1977 and 1981, and from then on by the Ministry of Health (see Section 2.2 in García-Armesto et al., 2010). The 1986 Health Care General Act resulted in the formal transformation of the health system from a system of social security (Bismarck model) to a national health service (Beveridge model), with a progressive transition from payroll contributions to general taxation as the main source of financing. This transition was completed in 1999. Three publicly funded mutual funds were the exception: MUFACE, MUGEJU and ISFAS, which cater exclusively to public employees working in government departments (see Section 2.2 *Organization*). Over the last two decades[4], the Spanish National Health System (*Sistema Nacional de Salud*) has expanded

[4] Please see García-Armesto et al. (2010) for information on earlier developments.

its legal framework towards effective universal coverage (see Section 3.3.1 *Coverage*).

The 1978 Constitution allowed for decentralization, which was an incremental process. As a common base, public health and health care planning competences had been transferred to all 17 ACs between 1979 and 1981 (see Section 2.2 in García-Armesto et al., 2010). The National Institute of Health (*Instituto Nacional de la Salud,* INSALUD) managed the social health insurance network centrally from 1978; the transfer to the regional health services was sequential and took place over a period of 21 years, between 1981 and 2002. Seven ACs with a self-governing tradition or backed up by a strong regional identity received health care management competences between 1981 and 1994 (AC of Catalonia, 1981; Andalusia, 1984; Valencia and Basque Country, 1988; Navarre and Galicia, 1991; Canary Islands, 1994). The remaining ten had to wait until 2002. At this time, the INSALUD disappeared and transformed into the National Institute of Health Care Management (*Instituto Nacional de Gestión Sanitaria,* INGESA), in charge of health care management in the two autonomous cities (Ceuta and Melilla). The coordination among the regional health services falls under the responsibility of the CISNS (see Section 2.2 *Organization*).

2.2 Organization

Coverage in the statutory SNS is virtually universal, mainly funded from taxes, and care is predominantly provided within the public sector. Provision is free of charge at the point of delivery, except for outpatient pharmaceutical prescriptions and specific orthoses and orthopaedic prostheses (see Sections 3.3.1 *Coverage* and 6.1 *Analysis of recent reforms*).

Since January 2002, all the 17 ACs have organized and managed public health care services with an ample degree of self-government, although the austerity and stability measures implemented by the Ministry of Finance in the aftermath of the economic and financial crisis in 2008 *de facto* reduced regional autonomy (Ministry of Finance, 2010). INGESA, an administrative entity under the Ministry of Health, oversees health care management in the two autonomous cities of Ceuta and Melilla (see Section 1.1 *Geography and sociodemography*). Financing is not earmarked for health care, and it is

regulated in the context of the financing of the ACs, where the Spanish Government devolves taxes and sets subsidies according to need-determined formulas established in the current regional financial scheme (see Sections 3.3.2 *Collection* and 3.3.3 *Pooling and allocation of funds*).

LEGAL FRAMEWORK

The process of health care decentralization to ACs was completed in 2002, and three laws were enacted in 2003 looking for better institutional integration, coordination and cohesion of the SNS, updating and homogenizing legislation for statutory personnel, and regulating the different types, roles, training and career paths of health professions and specializations (see García-Armesto et al., 2010 for more information). Law 33/2011 on General Public Health enhanced the coordination mechanisms for epidemic surveillance and control.

Royal Decree-Law 16/2012, which linked the basis of entitlement to the condition of being employed (and increased cost-sharing), was partially amended in the Royal Decree-Law 7/2018, tying entitlement back to the condition of residency (see Sections 3.3 *Overview of the statutory financing system* and 6.1 *Analysis of recent reforms*). In the 2020 General Budget Law (Law 11/2020), cost-sharing was reduced as a financing mechanism through multiple exemptions (see Section 3.4 *Out-of-pocket payments*).

The regulation of health professionals (Law 55/2003) was partially amended by Royal Decree-Law 12/2022, limiting temporary contracts in the SNS (see Section 4.2.5 *Physicians' career paths*).

STATUTORY SYSTEMS FRAMEWORK

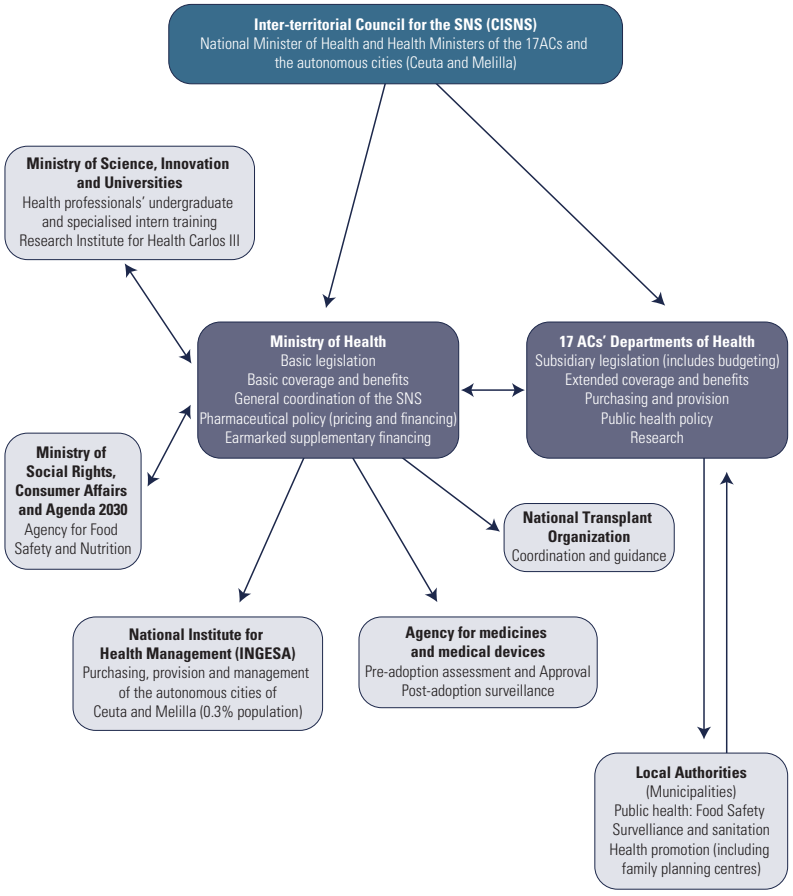
The SNS comprises the 17 ACs' health systems with full responsibility for the planning and provision of public health and health care services (Fig. 2.1). The Ministry of Health is responsible for health care provision for the two autonomous cities of Ceuta and Melilla through INGESA. These two cities have responsibilities, however, for public health issues.

The Mutual Funds represented €2292 million (2.6% of the public expenditure on health) in 2021, covering slightly over 2 million affiliates, insurees and beneficiaries in that year (Ministry of Health, 2023f). The basis for affiliation is being a state civil servant (MUFACE), a member of

the judiciary (MUGEJU) or a member of the military (ISFAS). Mutual Funds' affiliates are entitled to opt for either public or private provision; around 73% of MUFACE affiliates in 2022 (Ministry of Treasury, 2023); 92% of MUGEJU members in 2021 (Ministry of Justice, 2022); and 91% of ISFAS affiliates in 2022 (Ministry of Defence, 2023) opted for private provision, representing approximately 79% of total affiliates. However, as the population pyramid of Mutual Funds' members gets older and the morbidity burden increases, the proportion of affiliates relying on public provision is increasing over time (Pinilla, López-Valcárcel & Bernal-Delgado, 2024). Those beneficiaries who opt for private provision have direct access (without referral from primary care) to specialized care and may benefit from faster access to treatment. Unlike the general system, the funding scheme is composed of a budgetary contribution from the central government as the employer (around 80%) and of employees' contributions (around 20%), with variation across Mutual Funds. In addition, the cost-sharing mechanism is also different, with a fixed 30% co-payment in the case of pharmaceuticals, orthoses and orthopaedic devices (see Section 3.3 *Overview of the statutory financing system*).

The third statutory subsystem is specific for work-related accidents and occupational diseases. Provision is channelled through several associated entities known as 'Collaborating Mutualities with the Social Security' (*Mutuas Colaboradoras con la Seguridad Social,* MCSSs). MCSSs are not-for-profit organizations under the regulatory supervision of the Ministry of Inclusion, Social Security and Migration (MSSM) (see Section 3.3 *Overview of the statutory financing system*). The share of total public expenditure on MCSSs reached 1.6% in 2021 (Ministry of Health, 2023f).

FIG. 2.1 Overview of the statutory health system



Source: Authors' own elaboration.

ACTORS IN THE HEALTH SYSTEM

In the context of the SNS, there are two main actors: the Ministry of Health and the regional departments of health in the 17 ACs (see Fig. 2.1).

THE MINISTRY OF HEALTH

The Spanish Ministry of Health mainly plays the role of stewardship and coordination with the assistance of the CISNS. The CISNS is a collegiate governance body that unites the Health Minister of Spain and health ministers of the 17 ACs and the autonomous cities of Ceuta and Melilla. The Ministry

of Health relies on the work of the Agency for Medicines and Medical Devices, the National Transplants Organization, the Agency for Food Safety and Nutrition (under the Ministry of Social Rights, Consumption and Agenda 2030) and the Health Institute Carlos III (*Instituto de Salud Carlos III,* ISCIII) (under the Ministry of Science, Innovation and Universities), which combines health technology assessment, research centres, the National Centre of Epidemiology, the National School of Public Health, public health laboratories and biomedical research coordination and financing[5]. Notably, the Ministry of Health finances and governs health care for the autonomous cities of Ceuta and Melilla through the centrally managed INGESA. Since 2013, INGESA has had the additional task of organizing centralized purchasing and public auctions for certain goods and services (including some medicines), on behalf of those ACs which formally signed up for this common service.

The General Secretary for Digital Health, Information and Innovation was created within the Ministry of Health in 2020, which includes a General Directorate on digital health and information systems, with the aim of addressing the digital modernization, improvement and transformation of the SNS (Royal Decree 735/2020).

REGIONAL DEPARTMENTS OF HEALTH IN THE ACS

Once the decentralization process came to an end in 2002, decentralization deepened and ACs gained influence in the development of the SNS. The main actors in the ACs are the Departments of Health, which play the role of a Health Authority (that is, regulation, planning, budgeting and third payer), backed mainly by two specialized agencies, one aimed at managing health services provision, and another devoted to public health actions (that is, epidemiological surveillance, health protection and health promotion). Some ACs also benefit from the existence of a health technology assessment (HTA) body, being part of a national network of regional HTA bodies (for example, the Spanish Network of Health Technology Assessment Agencies and Benefits of the National Health System, RedETS).

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[5] Although the ISCIII fell under the remit of the Ministry of Health until 2008, between 2008 and 2011 it was put under the shared remit of the Ministries of Health and Science and Innovation, and from 2012 to 2020 was the responsibility of the Ministries of Health and the Economy. Since 2020, the ISCIII has been part of the Ministry of Science and Innovation (currently known as the Ministry of Science, Innovation and Universities).

Greater complexity is observed in the regional 'agencies' that provide health services, where the two main actors are the primary health care (PHC) and the specialized care divisions, providing hospital outpatient and inpatient care. Resources and services are distributed across the territory according to primary care and health care areas. Primary Care Areas (PCAs), the most basic geographical health demarcation, are perfectly nested into the health care areas, the demarcation where specialized care is provided. This design, with primary care areas nested into health care areas, facilitates continuity across care levels. Each AC defines the number of PCAs and health care areas according to the distribution and density of the population in the region (Ministry of Health, 2022a).

PHC settings, whose ownership is fundamentally public, provide care through primary care teams mainly composed of specialized Family Doctors (who act as gatekeepers), paediatricians and staff nurses (see Section 5.3 *Primary care*). When it comes to specialized care, and in particular to hospital care, although the model of care is quite homogeneous all over the country (that is, outpatient specialized care is linked to hospital departments, each hospital department has a fixed number of beds, small hospitals with fewer services are clustered to big hospitals that provide high-tech services or take over the most complex cases, etc.), there is a greater variety with respect to ownership (for example, public, NGOs, private non-for-profit, for-profit) and organizational models (see Section 5.4 *Specialized care*).

THE PRIVATE SECTOR

The private sector is an important player in the SNS. The private sector provides VHI schemes to individuals (20.8% of the total population in 2021, excluding Mutual Funds members) (see Section 3.5 *Voluntary health insurance*). It constitutes the alternative network of providers for 79% of those civil servants insured within the Mutual Funds (Ministry of Defence, 2023; Ministry of Justice, 2022; Ministry of Treasury, 2023); it provides dental care and optical care not covered by the national health system, although it mainly plays a supplementary[6] role offering people faster access to treatment. Also, it is closely intertwined with the public sector, specifically in hospital care (since some services are often contracted-out, such as diagnostic tests) and pharmaceutical care (since pharmacies are private providers).

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[6] Supplementary as defined in Mossialos & Thomson (2004).

SOCIAL AND PROFESSIONAL ACTORS

There have not been significant changes in the representative structure of social and professional actors, nor in their usual roles in recent years. However, it is worth mentioning that, as a reaction to the alleged work overload and precarious working conditions for professionals in primary care, which intensified during the COVID-19 pandemic, health care unions and professional organizations have been intensively raising awareness of the situation and negotiating better labour conditions.

2.3 Decentralization and centralization

The decentralization of health and health care services was completed in 2002 with the decentralization of public and social security health care centres, services and competencies to the ACs (see more detailed information in García-Armesto et al., 2010). This resulted in ACs enjoying greater capacity for regulation, planning and, above all, financial autonomy. Nonetheless, as the Funding Regulation Framework was last reformed in 2009 (Law 22/2009), some ACs are strongly urging for a new reform that updates the distribution and compensation mechanisms. Importantly, these demands should be seen in the context of the recent experience of the COVID-19 pandemic, when the national government assumed centralized control during the outbreak, which partially and temporarily limited the competences of the ACs during the periods of declared 'states of alarm' (Royal Decrees 463/2020, 926/2020, 956/2020), which ended in May 2021.

2.4 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 combat specific health problems (such as cancer, chronic diseases, rare

diseases, obesity, mental health problems, etc.) over 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 (Ministry of Health, 2019a) (see Section 6.1 *Analysis of recent reforms*), the 2021 Strategy for Digital Health (Ministry of Health, 2021b), the 2022 Strategy for Public Health (Ministry of Health, 2022b) and the Strategy of Public Health Surveillance (Ministry of Health, 2022c).

BOX 2.1 Is there sufficient 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 level. 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. As poor evaluations would potentially generate political costs, trial and error experiments are the only accepted evaluative method. 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. Nevertheless, some health policies have been evaluated by the Spanish Independent Fiscal Authority (*Autoridad Independiente de Responsabilidad Fiscal,* AIReF), in the context of the so-named 'Spending Review', the evaluation of public spending for the 2017–2020 Stability Programme Update (AIReF, 2023). Consequently, the spending in medicines dispensation (2019) and the pharmaceutical spending in hospitals and investment in capital goods (2020) have been analysed. The new cycle of the Spending Review (2022–2026) plans to address Mutual Funds' expenditure, among other spending areas. As the ACs can request evaluations from the AIReF, some of them have also commissioned AIReF to evaluate human resources policies in health care and other regional policies. Importantly, the intersectoral approach and cooperation on the design and implementation of health policies is gaining momentum (see Section 2.5 *Intersectorality*).

Financial and planning instruments are not usually coupled, so central strategies often generate controversy with some ACs, and have implementation problems. Moreover, ACs elaborate and develop their own health plans and strategies according to their needs and priorities. In addition, the Ministry of Health periodically elaborates studies on the needs of the healthcare workforce to facilitate human resources planning, in collaboration with the ministries with competency in Education and Universities (see Section 4.2 *Human Resources*).

2.5 **Intersectorality**

Several initiatives have been implemented in recent years by different ministries, aimed at improving health indicators. For example, the General Budget Law (Law 11/2020) regulated a VAT increase for sugary and sweetened beverages from 10% to 21%, following the example of AC of Catalonia, which implemented a similar measure in 2017 (Law 5/2017). While in the case of Catalonia studies show a reduction in consumption between 7.7% (Vall-Castelló et al., 2020) and 17% (Royo-Bordonaba et al., 2022), at a national level the measure has reduced average consumption, with the greatest reduction (13%) concentrated in the poorest third of households (Martínez-Jorge et al., 2022). Previous tax reforms had increased taxation on alcohol and tobacco products, although they were implemented with no specific commitment to increase health protection (see Bernal-Delgado et al., 2018).

A new Law on traffic and road safety was enacted in 2021 (Law 18/2021), toughening sanctions and penalties in the areas of speed control, alcohol consumption, unused seat belts and mobile phone use. The Law also provides greater protection for vulnerable road users such as cyclists.

In turn, the Climate Change and Energy Transition Law (Law 7/2021) enforces greenhouse gases emissions by 2030 to become 23% lower than 1990 figures and aims for 74% of electricity generation to come from renewable sources by 2030. Climate neutrality must be achieved no later than 2050. The Law also compelled municipalities with more than 50 000 inhabitants to establish low emission zones before 2023.

Notably, after the outbreak of the COVID-19 pandemic, the Spanish Government created the Inter-ministerial Coordination Committee, a

working group aimed at coordinating the government's transversal response to the pandemic. Chaired by the Minister of the Presidency (*Ministro de la Presidencia*), it was integrated by the Minister of Health (vice-president) and by members from different ministries (Foreign Affairs, Home Office, Transport, Agriculture, Social Security, Economy, Finance, Industry, Commerce and Tourism, Work, Consumption, Science and Innovation, and Territorial Policy).

2.6 Health information systems

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 are meant to support the joint governance of the SNS and are hosted and maintained in the Ministry of Health (for example, pharmacovigilance, national health survey, health barometer, daily mortality monitoring system and the SNS key indicators); others, hosted by the ACs, focus more on informing regional policies (including allocation of the regional budget, and waiting lists monitoring), monitoring and surveillance of health determinants, and purchasing agreements between the Departments of Health, the regional health service and the care providers (that is, hospitals and primary care centres). Finally, the National Statistics Plan establishes 39 statistical operations on health issues (INE, 2024).

Importantly, the decision on which health information systems are of national interest and the mechanism for reporting from the ACs to the Ministry of Health are discussed and agreed in a dedicated task force within the CISNS. Additionally, the 2021 Digital Health Strategy widens the role of the health information systems by increasing their interoperability and enhancing data analysis (Ministry of Health, 2021b) (see Section 4.1.3 *Information technology and eHealth*).

Health information systems of interest for the whole SNS can be found at the Ministry of Health statistical website (Ministry of Health, 2023g). The website lists the different health information systems available by thematic area: health and lifestyles, centres and resources, activity in primary care, activity in specialized care (including hospital care), medicines and health care products, financing and health care spending, and users' and citizens' perspectives on the health system.

There are two national health information systems of major relevance in health protection and prevention, resulting from the national network of epidemiological vigilance (set up in 1995, Royal Decree 2210/1995) and the system for pharmacovigilance (set up in 2002, currently regulated in the Royal Decree 577/2013).

2.7 Regulation

2.7.1 *Regulation and governance of third-party payers*

The role of third-party payers in the SNS is assumed by the health departments of the 17 ACs and INGESA (Fig. 2.1); they act both as public insurers (that is, guaranteeing access to the basket of benefits covered by the public system) and as service funders, purchasing required services from public and private providers (see Section 3.3.3 *Pooling and allocation of funds*). The Mutual Funds for civil servants establish multi-year purchasing agreements with public and private providers against a fixed per-capita premium. In the case of occupational diseases and accidents, the Collaborating Mutualities with the Social Security purchase or provide the corresponding services, mainly funded with employers' contributions.

2.7.2 *Regulation and governance of provision*

No major changes have been observed when it comes to regulation and governance of provision in the last decade. Table 2.1 briefly exhibits the main providers in place, the aspects that require regulation and the institution that exerts governance or stewardship (that is, the central government or the ACs). In general terms, health care services – except pharmaceutical care – are fully governed by the ACs, including those activities related to planning, accreditation, quality assurance, financing and pricing. Legislation is shared by the central and AC governments. In this case, the national regulation (that is, the basic legislation common to all the ACs) frames the ACs' legislation. While the central government has the responsibility of licensing and pricing within pharmaceutical care, the remaining roles are regulated by the ACs

in line with the national regulatory frameworks. Lastly, legislation and accreditation of higher education for the health professions falls under the responsibility of the Ministry of Science, Innovation and Universities; in turn, the regulation of specialized health training (for example, medical or nursing internships) is a responsibility of the Ministry of Health.

When it comes to the formal relationship with care providers, AC Departments of Health contract with both public and private providers in terms of number of services, their quality and cost. In the case of public providers, the relationship is based on a framework contract between the Health Department and the Regional Health Service (another public body, hierarchically linked to it: see Section 3.3.4 *Purchasing and purchaser–provider relations*), which cascades down into multiple purchasing agreements with those providing the service. Clinical management framework agreements between managers and clinical units are not generalized, nor do they seem to have a central role in clinical management. Although not legally binding, the agreements are monitored by the manager and their performance is considered in future negotiations. In the case of private providers, usually hospitals that provide subsidiary services to meet the needs of the public system (such as waiting list programmes, beds for palliative care, etc.), several services are purchased, and providers are paid according to public predefined tariffs (see Section 3.3.4 *Purchasing and purchaser–provider relations*). When it comes to pharmaceutical care, ACs reimburse retail pharmacies for drug dispensation according to the pricing mechanisms regulated by the corresponding central government bodies (see Section 5.6 *Pharmaceutical care*).

Unlike this general scheme, Private Finance Initiatives (PFIs) and the Public-Private Partnerships (P-PPs) provision schemes, that once were established in the region of Valencia and Madrid, have exhausted their momentum; some of the planned P-PPs in Madrid were converted into PFIs, and Valencia has reversed the P-PP model in four out of the five areas where it had established such partnerships: that is, the flagship Alzira P-PP (2018), as well as those in Torrevieja (2021), Denia (January 2024) and Manises (May 2024). However, the AC has announced the intention to maintain the Elx-Vinalopó P-PP contract through yearly extensions after its completion in 2025.

TABLE 2.1 Overview of the regulation of providers

	LEGISLATION	PLANNING	LICENSING ACCREDITATION	PRICING TARIFF SETTING	QUALITY ASSURANCE	PURCHASING FINANCING
Public health services	ACs (*)	ACs	ACs	ACs	ACs	ACs
Ambulatory care (primary and secondary care)	ACs (*)	ACs	ACs	ACs	ACs	ACs
Inpatient care	ACs (*)	ACs	ACs	ACs	ACs	ACs
Dental care	ACs (*)	ACs	ACs	ACs	ACs	ACs
Pharmaceuticals (ambulatory)	ACs (*)	ACs + CG	ACs	CG	ACs (*)	ACs (*)
Long-term care	ACs (*)	ACs	ACs	ACs	ACs	ACs
University education of personnel	CG	ACs + CG	CG	ACs (*)	ACs	ACs

Source: Authors' own elaboration.

Note: ACs = Competence of the Autonomous Communities; ACs (*) = ACs' role is mediated and framed by a national framework regulation (e.g., basic legislation, guidance) common to all ACs; CG = Competence of the Central Government.

2.7.3 *Regulation of services and goods*

BENEFITS PACKAGE

Until 2012, the Spanish SNS had a comprehensive common benefits package, free of co-payments, except for the flat 40% rate on the retail price of prescribed medicines (with exemptions made for pensioners and certain chronic conditions), and some specific products and prostheses. ACs were able to complement the SNS common basket within their territory with additional services. The new 2012 regulation changed the co-payment scheme and categorized the SNS common basket into three different benefit packages: a) the basic package for all those insured and their dependents, which includes 'essential' services, including medical visits and hospitalizations; b) a 'supplementary' package, cost-shared by patients, including pharmaceutical benefits (in practice, co-payments affect mainly outpatient pharmaceutical prescriptions and specific orthoses and

orthopaedic prostheses); and, c) an 'accessory' package, which includes 'non-essential' activities, vaguely defined and not further regulated (see Sections 3.3.1 *Coverage* and 6.1 *Analysis of recent reforms*). In addition to these benefits, ACs could add into their basket new benefits not covered by the SNS, for which they will have to establish their own necessary additional resources.

Decision-making regarding the inclusion of new benefits is undertaken by the CISNS upon the proposals submitted by the Commission on Benefits, Insurance and Financing and the (mandatory) technical advice of the Spanish Network of Agencies for the Evaluation of Health Technologies and Benefits (see next section, and Bernal-Delgado et al., 2018, for more information).

HEALTH TECHNOLOGY ASSESSMENT

Legislation passed in 2012 (Royal Decree-Law 16/2012) stressed the need for evaluation, paving the way for the reinforcement and empowerment of the network of HTA agencies (that is, agencies in AC of Catalonia, the Basque Country, Galicia, Aragon, Andalusia, the Canary Islands and Madrid, as well as the Health Institute Carlos III). Within their current mandate, HTA agencies have reviewed the value of existing benefits, coordinated, and designed *ad hoc* evaluative studies for the adoption of new technologies (except for medicines, which are a competence of the Spanish Agency for Medicines (AEMPS)) and standardized methodologies for HTA evaluation (REDETS, 2023).

In the case of pharmaceuticals, the information system known as VALTERMED was introduced in 2019 as a new tool for the evaluation of health outcomes in drugs with a high economic impact (Ministry of Health, 2021a). These evaluations are used to inform decisions about pharmaceutical provision during the different stages of the drug cycle, in particular decisions on value-based reimbursement agreements with pharma companies or resources allocation. However, up to April 2024 only 16 pharmacoclinical protocols and four health outcomes reports have been published. In 2020, the SNS Drug Evaluation Network (REvalMed) was launched, leading to the inclusion of economic evaluation criteria in the so-called 'therapeutic positioning reports' (IPTs), with the aim to inform decisions on drug pricing and reimbursement. Notably, the economic evaluation in IPTs was abolished by the national court in July 2023 following a successful lawsuit filed by the Spanish Association of the Pharmaceutical Industry.

2.7.4 *Regulation and governance of pharmaceuticals*

The Spanish pharmaceutical sector is one of the most regulated sectors of the Spanish economy. In addition to the centralized approval mechanism provided by the European Medicines Agency (EMA), AEMPS must approve the effective commercialization of any drug and regulates drug pricing and public reimbursement. Once commercialization is approved, companies might apply for public reimbursement; in this case, the Inter-ministerial Commission on Prices of Medicines, an administrative advisory body of the Ministry of Health, will make a decision according to a number of criteria: a) severity, duration and consequences of the disease for which the drug is indicated; b) specific needs of certain groups; c) therapeutic and social value and incremental clinical benefit in terms of cost-effectiveness; d) budgetary impact; e) existence of drugs or other therapeutic alternatives at a lower price or lower cost of treatment; and, f) the degree of innovation of the drug under evaluation.

Notably, there is tension between the Ministry of Health and the ACs' health departments regarding drugs approval and pricing – since decisions on drugs approval and pricing lies with the Ministry of Health, while pharmaceutical care expenditure is entirely assumed by the ACs ("my treat, your payment"). The epitome of this tension can be seen in the negotiation of the funding method for 'direct acting antiviral drugs' for Hepatitis C, where an unprecedented, earmarked fund was set up according to a price-volume scheme, to be charged to ACs and paid back to the central government in 10 years (without interest and with a two-year grace period) (Campillo-Artero, Garcia-Armesto & Bernal-Delgado, 2016; Ministry of Health, 2020a).

The regulation scheme issued in the 2006 Act for Guarantees and Rational Use of Pharmaceuticals and Health Products (Law 29/2006) has not significantly changed in terms of actors and responsibilities (see Table 6.9 in García-Armesto et al., 2010). Several legal provisions were issued since 2010 partially amending or adapting Law 29/2006, in a new context of reduced fiscal revenues and a growing public deficit (Bernal-Delgado et al., 2018). The most recent reforms have included the launching of the information system VALTERMED in 2019 (see Section 2.7.3 *Regulation of services and goods*) and the Action Plan for the Consolidation of Therapeutic Positioning Reports in the SNS (February 2020), which has included the establishment

of the SNS Drug Evaluation Network (REvalMed) (see Section 2.7.2 *Regulation and governance of provision*) and shortening the approval delays for the public financing of pharmaceuticals.

2.7.5 *Regulation of medical equipment, devices and aids*

Since Royal Decree 1030/2006, legislation that defined the common benefits package and the updating procedure (see García-Armesto et al., 2010 for more information), the first substantial reform was issued in Royal Decree 16/2012 (and subsequent legislation), which aimed at implementing urgent measures to guarantee the sustainability of the SNS in the aftermath of the global economic crisis (see García-Armesto et al., 2010, and Bernal-Delgado et al., 2018, for more information). Since then, several ministerial executive orders have regulated the authorization and inclusion of different procedures, medical devices and aids as part of the common benefits basket, as well as the methodology for its update. During the last five years, the list of dietetic products, prostheses and orthoprostheses, and some monitoring devices has been updated (Orders SSI/366/2018, SCB/1242/2018, SCB/45/2019 and SND/44/2022, ministerial resolutions 2020 and 2022 (Ministry of Health, 2023h) (see Section 7.2 *Accessibility*).

2.8 Person-centred care

2.8.1 *Patient information*

Details on what type of information patients have access to and how accessible the information is are summarized in Table 2.2. Patient information is usually placed on accessible institutional websites, using static documents and interactive tools. Further, foreign patients who do not speak any of the official languages in Spain (see Section 1.1 *Geography and sociodemography*) may benefit from the mediation and interpretation services provided by third parties (for example, not-for-profit organizations, NGOs or municipalities).

The level of satisfaction exhibited by the Spanish population regarding the information received during their contact with health care professionals is

high. Generally, this level of satisfaction improved from 2010 to 2022, except for primary care practitioners, where the score remained similar (7.3 and 7.4 – out of 10 – in 2010 and 2023, respectively). The level of satisfaction with the information received from specialists increased from 7.1 in 2010 to 7.7 in 2023, even more when the respondent had been hospitalized (7.98 out of 10 in 2023)[7] (Ministry of Health, 2024a).

TABLE 2.2 Patient information

TYPE OF INFORMATION	IS IT EASILY AVAILABLE?	COMMENTS
Information about statutory benefits	Yes	The Ministry of Health and the regional departments of health provide information in their institutional websites (e.g., https://www.sanidad.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/home.htm). The Mutual Funds have a similar approach (see MUFACE site as an example: https://www.muface.es/muface_Home/muface_Index).
Information on hospital clinical outcomes	Partial	The Ministry of Health provides information at AC level and autonomous cities throughout the National Health System Key Indicators (INCLASNS) for a number of selected performance indicators on access, effectiveness, use, pertinence and safety (see https://inclasns.sanidad.gob.es/main.html). The Ministry of Health also provides the Model of Indicators for the analysis of hospitalization (iCMBD) (https://icmbd.sanidad.gob.es/icmbd/login-success.do). Some ACs' observatories provide disaggregated information on a number of indicators; for example, the Observatory of Health Outcomes of the AC of Madrid (https://www.comunidad.madrid/servicios/salud/observatorio-resultados-servicio-madrileno-salud).
Information on hospital waiting times	Yes	The Ministry of Health publishes biannual statistical reports at country level and, since February 2017, at regional level with all the available information for the series since 2012 (https://www.sanidad.gob.es/estadEstudios/estadisticas/inforRecopilaciones/listaEspera.htm). ACs display information (i.e., surgical, diagnostic, outpatient specialist visits) in terms of patient rights, responsiveness and statistics. In some ACs, patients can consult their status in the waiting list either online or by phone.
Comparative information about the quality of other providers (e.g., Family Doctors)	Partial	The Ministry of Health provides benchmarks by type and size of hospital of different results indicators through the Model of Indicators for the analysis of hospitalization (iCMBD) (https://icmbd.sanidad.gob.es/icmbd/login-success.do). Some ACs' observatories provide information in such a way that comparison and benchmarking is possible. Only in a few cases is information on primary care or social care included.

[7] In 2022, there was a change in the methodology used to collect information, moving from personal to telephone interview, which must be considered when assessing the time series.

TYPE OF INFORMATION	IS IT EASILY AVAILABLE?	COMMENTS
Patient access to own medical record	Yes	For full access to one's own medical record, it is necessary to activate a specific administrative procedure to ensure secure access. The accessed content may vary across ACs, although patient summary and e-prescription information is the same and interoperable across the EU. Access information is available here: https://www.sanidad.gob.es/areas/saludDigital/historiaClinicaSNS/Accesos_HCD_SNS.htm or in the portal 'Carpeta Ciudadana' here: https://carpetaciudadana.gob.es/carpeta/clave.htm, where it is not necessary to have an active health card to be able to consult reports generated in the SNS.
Interactive web or 24/7 telephone information	Yes	Usually, citizens and patients have access to web-based services where they can get information on their topic of interest, book medical visits, process paperwork or apply for documents. In addition, through the call centre for emergencies (112 or 061), ACs facilitate contact 24/7.
Information on patient satisfaction collected (systematically or occasionally)	Yes	Since 1995, a population-based survey, representative at AC level, has been carried out. The so called 'Healthcare Barometer' is annually published and a number of selected indicators are reported as part of the INCLASNS* information system (https://pestadistico.inteligenciadegestion.sanidad.gob.es/publicoSNS/S/barometro-sanitario; and https://inclasns.sanidad.gob.es/main.html).
Information on medical errors	Partial	INCLASNS* includes several indicators that are annually reported at AC level. The Ministry of Health also includes a range of indicators on safety events through the Model of Indicators for the analysis of hospitalization (iCMBD) (https://icmbd.sanidad.gob.es/icmbd/login-success.do). In turn, the existing ACs' observatories provide information at provider level, usually at hospital level, as primary care safety events are not routinely studied.

Source: Authors' own elaboration.

2.8.2 *Patient choice*

Law 41/2002 on Patient Autonomy, Rights and Duties on Information and Clinical Documentation framed the regional regulation on patient rights, as for example, information rights, second medical opinion or maximum acceptable waiting times. In general, patient choice has been well developed in the case of Family Doctors, although in practice, choice is usually confined to those doctors practising in the same primary care team and restricted by the fact that PHC doctors may only register a limited number of patients. In the case of outpatient visits to specialists (as they require referral from a Family Doctor), or in the case of hospitals where the population is allocated to administrative areas usually set up around a single hospital, the implementation of patient choice has *de facto* limitations; the complex organization of hospital specialties and subspecialties, as well as

shifts and changes in staff, do not facilitate personalized appointments, and it is even difficult to guarantee that review consultations are attended to by the same doctor. Civil servants insured in Mutual Funds enjoy a larger degree of choice (see Section 2.2 *Organization*) as they are entitled (usually on a yearly basis) to opt for either public or private provision. More nuanced information is provided in Table 2.3.

TABLE 2.3 Patient choice

TYPE OF CHOICE	IS IT AVAILABLE?	DO PEOPLE EXERCISE CHOICE? ARE THERE ANY CONSTRAINTS (E.G., CHOICE IN THE REGION BUT NOT COUNTRY-WIDE)? OTHER COMMENTS?
CHOICES AROUND COVERAGE		
Choice of being covered or not	No	
Choice of public or private coverage	Partial	The only genuine choice lies with public employees insured in Mutuality Funds; currently approximately 79% choose private coverage. However, for those services partially covered within the public sector (e.g., dental and optical care, orthoprostheses, long-term care, home care, pharmaceutical care, etc.) all individuals can opt to pay out-of-pocket or buy private health insurance to cover those needs. VHI has been increasing in Spain. The proportion of the population covered by VHI has rapidly grown in recent years, from 15.8% in 2015 to 20.8% in 2021 (IDIS, 2022).
Choice of purchasing organization	Partial	Only for those services partially covered in the benefits package for the SNS where VHI plays a complementary role (dental and optical care, ortho-prostheses, long-term care, home care, pharmaceutical care, etc.).
CHOICE OF PROVIDER		
Choice of primary care practitioner	Yes	In practice, choice is usually confined to Family Doctors within the same primary care team and restricted by the fact that primary care doctors may only register a limited number of patients.
Direct access to specialists	Partial	Family Doctors act as gatekeepers deciding on the need for a patient to visit a specialist, except for the Mutual Funds' affiliates, who may gain access directly to specialists.
Choice of hospital	Partial	Hospital choice for elective conditions, although regulated as a right, is not generally used. Nevertheless, choice in some ACs is linked to second opinion (e.g., https://www.saludinforma.es/portalsi/web/salud/bioetica-salud/atencion-sanitaria/segunda-opinion-medica#decreto_35_2010) or programmes on maximum waiting times (e.g., https://www.saludinforma.es/portalsi/web/salud/bioetica-salud/plazos-prestacion-asistencial/derecho-a-ser-atendido-tiempo-maximo). Patients with urgent conditions might access any A&E department at any hospital in the network. Madrid is the only big AC organized in one health area, thus allowing hospital choice across its whole territory.

TYPE OF CHOICE	IS IT AVAILABLE?	DO PEOPLE EXERCISE CHOICE? ARE THERE ANY CONSTRAINTS (E.G., CHOICE IN THE REGION BUT NOT COUNTRY-WIDE)? OTHER COMMENTS?
Choice to have treatment abroad	Partial	If a specific treatment cannot be provided within the public sector, patients are allowed to get treatment abroad, fully covered by the SNS. Otherwise, choice is confined to the provisions in Royal Decree 81/2014 on cross-border health care (Directive 2011/24/EU) (see Section 2.8.4 *Patients and cross-border health care*).
CHOICE OF TREATMENT		
Participation in treatment decisions	Yes	This item was regulated in Law 41/2002 on patient autonomy and rights and obligations regarding clinical information and documentation. Importantly, the ACs have regulated how to exert the right of last wills in a living testament.
Right to informed consent	Yes	This item was regulated in Law 41/2002 on patient autonomy and rights and obligations regarding clinical information and documentation and subsequent executive decrees by the ACs.
Right to request a second opinion	Partial	Only regulated, as such, in some ACs but widely recognized as a referral procedure requested by the patient. In those ACs where this right is not effective, individual patients tend to look for a second opinion in the private sector.
Right to information about alternative treatment options	Partial	Not regulated specifically, it is assumed to be part of the bioethical principles of the clinical professions and good clinical practice principles. The latest 2022 Code of Medical Deontology explicitly included this question (https://www.cgcom.es/sites/main/files/minisite/static/828cd1f8-2109-4fe3-acba-1a778abd89b7/codigo_deontologia/18).
Right to request the necessary help to die	Yes	In addition to the expression of last wills, euthanasia has been regulated by the Organic Law 3/2021. The Law specifies the conditions for a patient to be eligible, as well as the different procedures in assessment and, eventually, in life termination (see Section 5.10 *Palliative care*).

Source: Authors' own elaboration.

2.8.3 *Patient rights*

Human rights, information, consent, confidentiality and privacy are well recognized in the Spanish legislation on patient rights since the General Healthcare Act 14/1986, where patient rights and duties were defined for the first time. Since then, several laws have developed new rights on personal data protection (Organic Law 15/1999), patient autonomy (Law 41/2002) and rights in public health (Law 33/2011). The major regulatory change on patient rights since 2010 has been the Organic Law 3/2021, which legalizes and regulates euthanasia. The Law respects the autonomy and will to end the life of someone who is in a situation of serious, chronic and disabling or hopeless illness, with unbearable suffering that cannot be alleviated in acceptable conditions. In accordance with those principles,

ACs have developed regional norms and executive decrees (see Section 5.10 *Palliative care*). Table 2.4 provides further details on how patients might exert their rights in the context of rights protection, complaints, liability and compensation.

TABLE 2.4 Patient rights

	Y/N	COMMENTS
PROTECTION OF PATIENT RIGHTS		
Does a formal definition of patient rights exist at national level?	Y	Several national laws include legal provisions with the formal definition of patient rights (Law 14/1986, Organic Law 15/1999, Law 41/2002, Law 26/2011, Law 33/2011 and Royal Decree-Law 1/2013).
Are patient rights included in legislation?	Y	There are several laws which include patient rights, although the most specific legislation might be found in Law 41/2002 basic regulation (i.e., mandatory all over the country) of the patient's autonomy, and rights and duties on clinical information.
Does the legislation conform with WHO's patient rights framework?	Y	All dimensions of the WHO's patient rights framework can be extensively found in the Spanish legislation.
PATIENT COMPLAINTS AVENUES		
Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?	Y	All health care providers (primary care centres, outpatient specialists' centres, hospitals) have admission services that include a desk where patients and relatives are assisted, and eventual suggestions or complaints are collected. Besides physical desks, online help desks are available on institutional websites.
Is a health-specific Ombudsman responsible for investigating and resolving patient complaints about health services?	Y	No health-specific Ombudsman exists at the national or AC level (known as 'Defensor del pueblo'), but there is a non-health specific one. Interestingly, a great deal of this non-health-specific Ombudsman activity, at national or AC level, is related to health and social care issues.
Other complaint avenues?	Y	The different ACs' health councils, collegiate bodies composed of stakeholders including patients and civil society, among others, hold the responsibility of promoting patient and individual rights. On the other hand, patients' and consumers' associations usually act as external controllers.
Choice to have treatment abroad	Partial	If a specific treatment cannot be provided within the public sector, patients are allowed to get treatment abroad, fully covered by the SNS. Otherwise, choice is confined to the provisions in Royal Decree 81/2014 on cross-border health care (Directive 2011/24/EU) (see Section 2.8.4 *Patients and cross-border health care*).
LIABILITY/COMPENSATION		
Is liability insurance required for physicians and/or other medical professionals?	Y	In general terms, ACs' health authorities ensure civil liability of their professionals contracting with private insurance companies (up to a limit). In turn, medical and nursing colleges also channel insurance plans for their members. It is worth noting that, besides liability, the public insurer (that is, ACs' Health Authority) has a body of inspectors who, among other responsibilities, assesses any eventual violation of patient rights and acts accordingly within its legal attributions.

	Y/N	COMMENTS
Can legal redress be sought through the courts in the case of medical error?	Y	The judiciary, as an independent body, is in any case available for the citizens. Usually, courts of justice wait for the internal audit that the ACs' Health Authorities' inspectors do *ex officio*.
Is there a basis for no-fault compensation?	Y	The no-fault compensation is regulated in Law 4/1999 and the claiming procedure in Law 39/2015. In Law 4/1999, regulation issues that no-fault compensation is not applicable in unpredictable or unavoidable events, according to the current state of knowledge.
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?	Y	Compensation for both types of damage. Interestingly, the lack of compensation scales (still pending regulation on civil and criminal liability) leads the judiciary to discretionarily determine amounts during the litigation process.
Can class action suits be taken against health care providers, pharmaceutical companies, etc.?	Y	Collective actions are possible through individual or class action; in the class action, claimants have to bear the legal costs.

Source: Authors' own elaboration.

2.8.4 *Patients and cross-border health care*

Individuals who belong to EU Member States and enjoy membership rights to their public health care systems continue to carry these rights within Spain's social security regulations, in particular Regulation EC 987/2009 of the European Parliament and the Council (complemented in 2010), laying down the procedure for the implementation of Regulation EC 883/2004 on the coordination of social security systems. The latest Spanish regulation in this respect is Royal Decree 81/2014, transposing the EU cross-border health care Directive 2011/24/EU.

A follow-up report on cross-border health care shed light on the limited impact of the implementation of this latter regulation on Spanish insurees. In 2021, a) five prior authorization requests were submitted and two authorized; and b) the number of requests for reimbursement for health care not subject to prior authorization was five and only three of them were finally granted (European Commission, 2023a).

3

Financing

Summary

- Current health spending per capita has continued to rise in the last years but, in terms of GDP, health spending has remained stable, reaching 9.3% in 2019. However, as a consequence of the COVID-19 pandemic, a dramatic increase in health spending raised expenditure up to 11.0% of GDP in 2020, remaining this high (10.8% of GDP) in 2021.

- Public expenditure is the primary source of funding for health in Spain, representing 71.7% of total health expenditure in 2021 (70.6% in 2019). The main component of private spending, OOP spending, accounted for 20.6% (19.2% in 2019) of total health spending in 2021.

- Public funds come mostly from general taxes and the ACs manage most of the health resources (92.2% of public health expenditure in 2020).

- The basic benefits of the common package are not subject to any patient cost-sharing. Only pharmaceutical prescriptions and ortho-prosthetic devices are subject to co-payments.

- 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.

- Collection and pooling mechanisms, purchasing and provision relationships, provider financing mechanisms and workforce payments have not experienced significant changes over the last 10 years.

3.1 Health expenditure

According to Spain's Health Accounts System (Ministry of Health, 2023i), health expenditure in Spain has kept growing after recovering from the economic and financial crisis (2008–2014). The growth of health expenditure in terms of GDP has also increased, accounting for 9.3% in 2019, the year before the COVID-19 pandemic (Table 3.1). The pandemic forced the mobilization of extraordinary resources, in such a way that total health spending increased from €115 512 million in 2019 to €122 852 million in 2020 and to €131 894 million in 2021. The 10.2% fall in nominal Spanish GDP in 2022 because of the pandemic produced a relative increase in health expenditure as a share of GDP in 2020 (up to 11.0%), slightly decreasing in 2021 (10.8% of GDP) due to the improvement of the Spanish economy compared to 2020 (although it did not reach 2019 levels) (INE, 2023e).

The increase in health spending was asymmetric in 2020 and 2021. While public health spending increased by 10.3% between 2019 and 2020 (from €81 675 million in 2019 to €90 126 million in 2020), private spending shrank by 4% (from €34 019 million in 2019 to €32 658 million in 2020). In 2021, public health spending increased by 5.1% (€94 694 million) and private spending increased by 14.2% (Ministry of Health, 2023j).

National statistics show that the share of public health expenditure as a proportion of total health expenditure (THE) increased between 2005 and 2010 (from 71.6% to 74.4%) and subsequently dropped until 2019 (70.6%), increasing to 73.5% in 2020, dropping again in 2021 (71.7%). Public health spending contracted sharply in 2011 and 2012, due to the economic and financial crisis, only to grow again as of 2014 (Ministry of Health, 2023j). Official data suggest that the reduction was attributable to a decrease in personnel (both in salaries and workforce numbers), outpatient pharmaceuticals and investment expenditure (Ministry of Health, 2023j). Although public health spending grew continuously from 2014 to 2019, private health spending grew more intensely. In 2021, hospital and specialized care (including hospital drugs) accounted for 61.6% of public expenditure

on health; in turn, outpatient pharmaceuticals and primary care represented 14.6% and 14.5% respectively (Ministry of Health, 2023i).

Private expenditure on health (as a percentage of THE) has followed a U-shaped progression since 2000, with a strong change in trend in 2010. Since then, this share increased from 25.6% in 2010 to 29.4% in 2019 to 26.5% in 2020 and to 28.3% in 2021 (Ministry of Health, 2023j). OOP payments, mainly to cover pharmaceutical co-payments and the purchase of medical devices such as glasses or hearing aids and dental care, represent the main part of private health spending in Spain (between 73% and 78% of private spending, depending on the year considered) (see Section 3.4 *Out-of-pocket payments*). VHI, mainly in the form of supplementary premiums (see Section 3.5 *Voluntary health insurance*), experienced strong growth in recent years, increasing its contribution to private spending from 19.0% in 2010 to 24.4% in 2021 (Ministry of Health, 2023j).

TABLE 3.1 Trends in health expenditure in Spain, 2000 to latest available year (selected years)

EXPENDITURE	2000	2005	2010	2015	2019	2020	2021
Current health expenditure per capita in International US$ (PPP) [a]	1 471	2 152	2 895	3 185	3 959	4 085	4 368
Current health expenditure as % of GDP [b, c]	6.8	7.7	9.1	9.1	9.3	11.0	10.8
Public expenditure on health as % of total expenditure on health [b]	71.6	71.6	74.4	71.3	70.6	73.5	71.7
Domestic general government health expenditure per capita, PPP (current international $) [a]	1 064	1 540	2 155	2 271	2 793	2 988	3 127
Private expenditure on health as % of total expenditure on health [b]	28.4	28.4	25.6	28.7	29.4	26.5	28.3
Public expenditure on health as % of general government expenditure [b]	12.6	14.4	14.7	14.8	15.3	15.0	n.a.
Government health spending as % of GDP [b]	5.2	5.8	7.0	6.6	6.6	8.1	7.7
OOP payments as % of total expenditure on health [b]	24.3	21.1	19.8	22.0	21.4	19.2	20.6
OOP payments as % of private expenditure on health [b]	83.1	75.4	78.4	76.7	73.0	72.5	73.0
Private insurance as % of private expenditure on health [b, c]	n.a.	20.5	19.0	20.8	24.3	24.7	24.4

Sources: [a] WHO (2024); [b] Ministry of Health (2023j); [c] INE (2023e).

Note: n.a. = not available.

According to WHO Global Health Expenditure data, in 2021 Spain invested 10.7% of its GDP in health[8]. This level was in line with other countries which have national health service-type systems, such as Denmark (10.8%), although far from the levels of the United Kingdom (12.4%) and Sweden (11.3%), and from countries with Social Health Insurance-based models, such as France or Germany, with higher percentages of GDP devoted to health (12.3% and 12.9%, respectively) (Fig. 3.1 and 3.2). In 2020, because of the first year of the COVID-19 pandemic, Spain increased its spending on health to reach 10.8% of its GDP (Fig. 3.2). On average, European countries reinforced their health spending, with the United Kingdom and Spain being the countries with the strongest relative increases (Fig. 3.2). Per capita health expenditure in Spain grew from US$ 3984 PPP in 2019 to US$ 4368 PPP in 2021 (Fig. 3.3)[9].

The share of the public sector in current health expenditure in 2021 (71.6%) is lower than in Germany, France and Italy (79.1%, 75.6% and 75.5%, respectively) in that year. Sweden and the United Kingdom showed even higher values (85.9% and 83.7%, respectively) (Fig. 3.4). In turn, public expenditure on health as a share of general government expenditure was 15.2% in 2021, below the percentages from the United Kingdom, Germany and Sweden (22.4%, 20.0% and 19.6%, respectively), in line with France (15.8%) and above Portugal and Italy (14.7% and 12.4%, respectively) (Fig. 3.5) (WHO, 2024).

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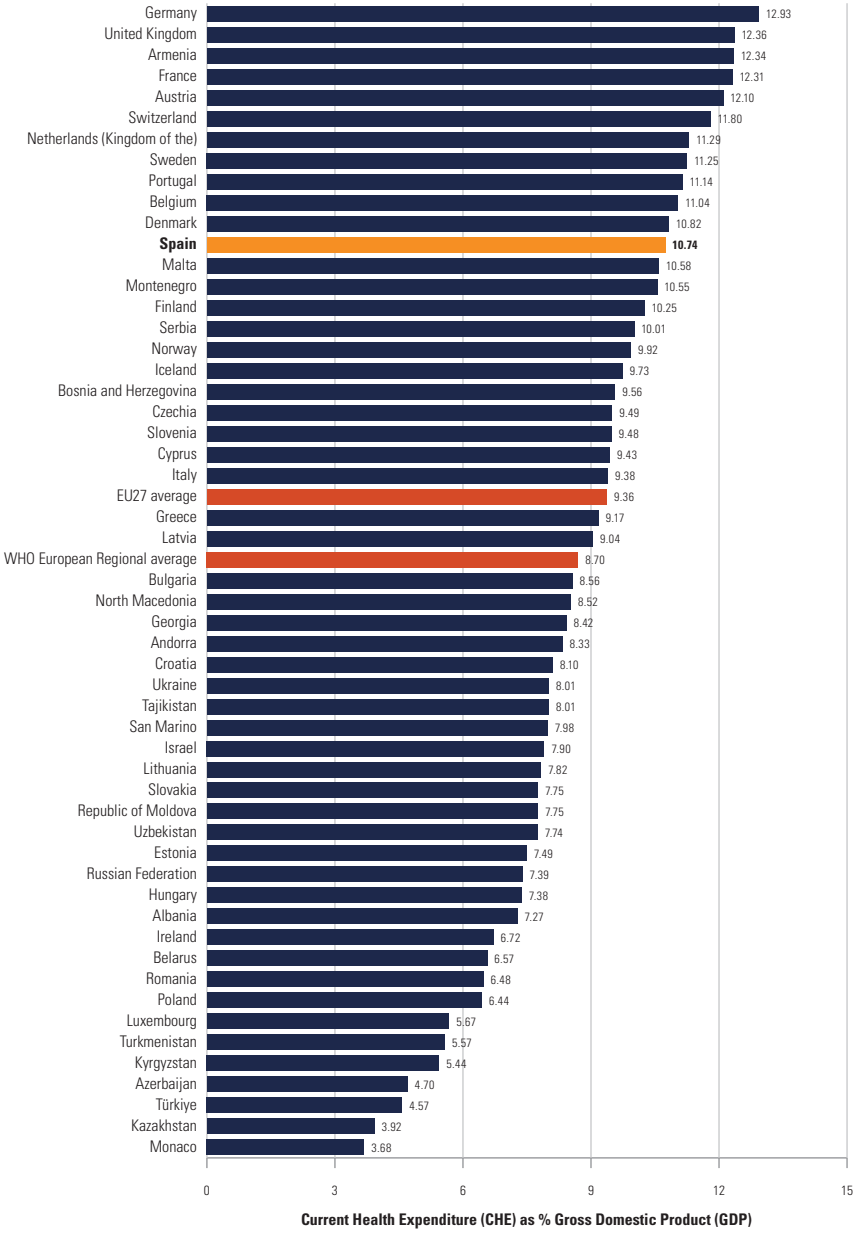
[8] International data from the Global Health Expenditure Database differ slightly from Spanish national statistics owing to differences in methodology.

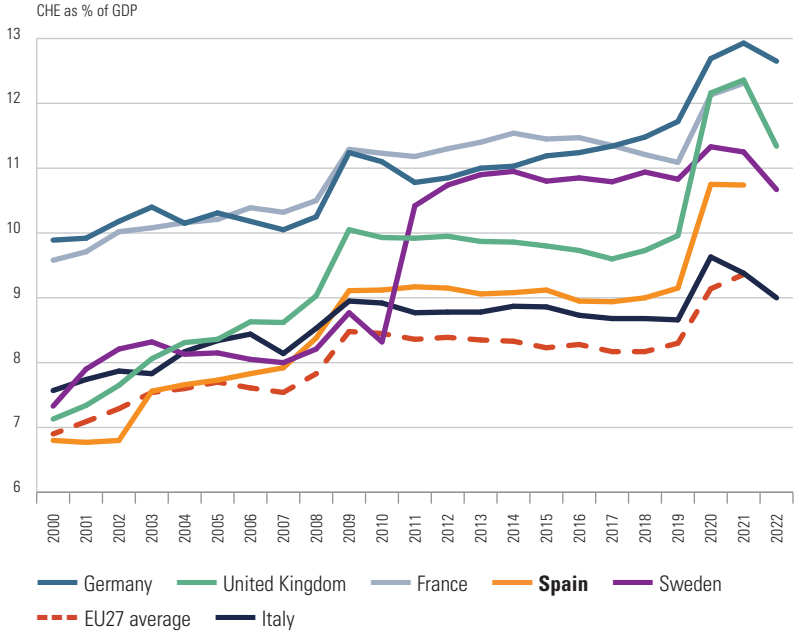
[9] To properly interpret these figures, it should also be noted that the United Kingdom and Spain were two of the European countries whose economies suffered dramatic GDP reductions, mostly in 2020 (in Spain, GDP fell 11.3% in real terms, 10.2% in nominal terms) (INE, 2023e). Therefore, when interpreting these data, one should consider both the nominal growth of health spending and the fall in GDP in each country.

FIG. 3.1 Current health expenditure as a share (%) of GDP in the WHO European Region, 2021



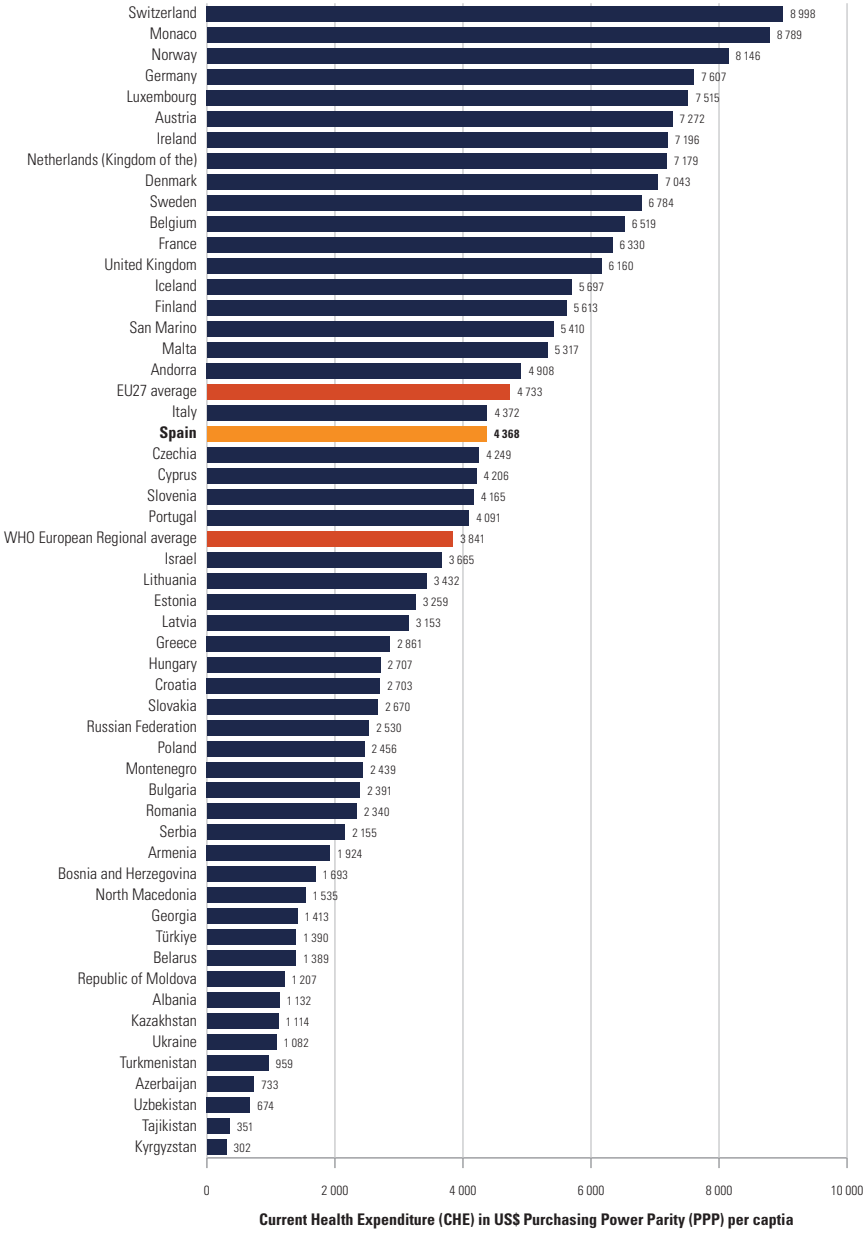
Source: WHO (2024).

FIG. 3.2 Trends in current health expenditure as a share (%) of GDP in Spain and selected countries, 2000 to latest available year



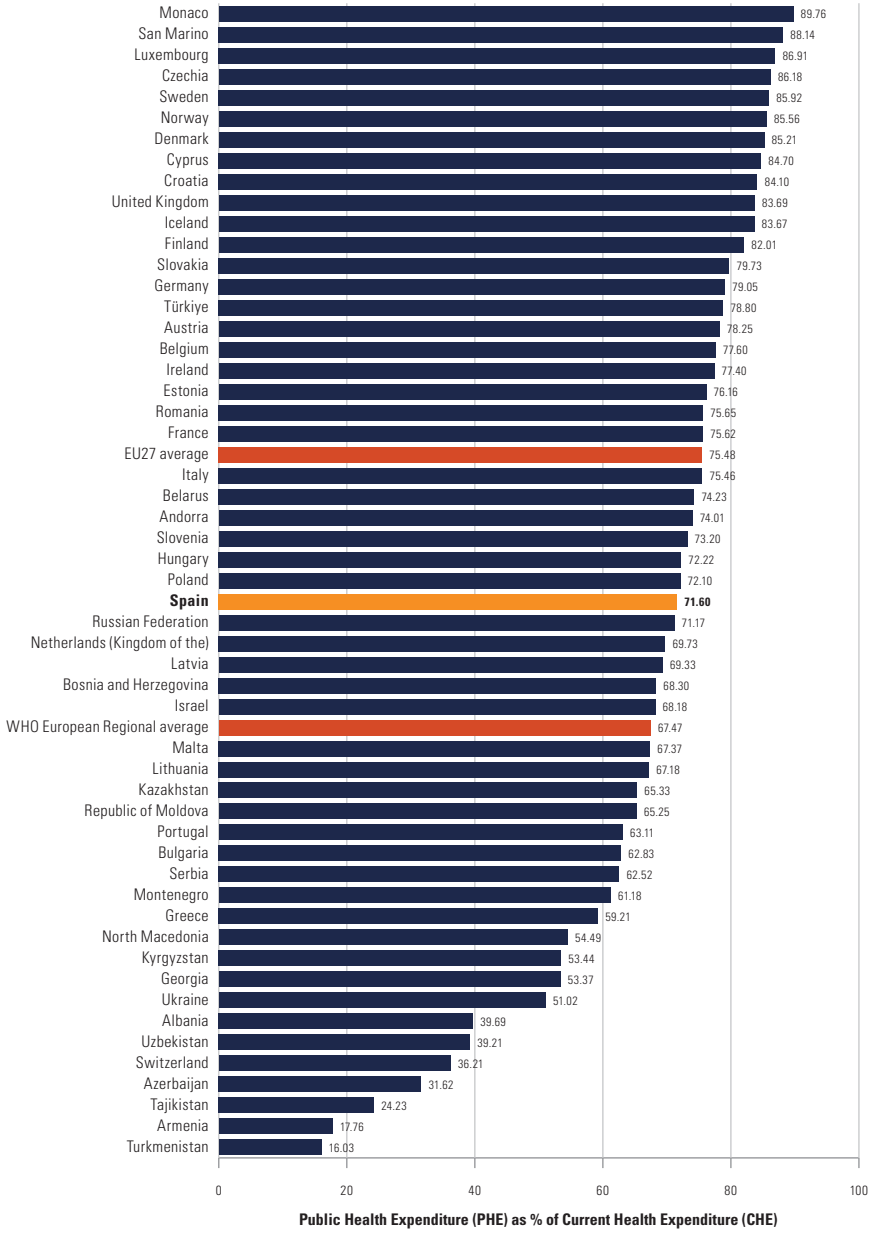
Source: WHO (2024).

FIG. 3.3 Current health expenditure in US$ PPP per capita in the WHO European Region, 2021



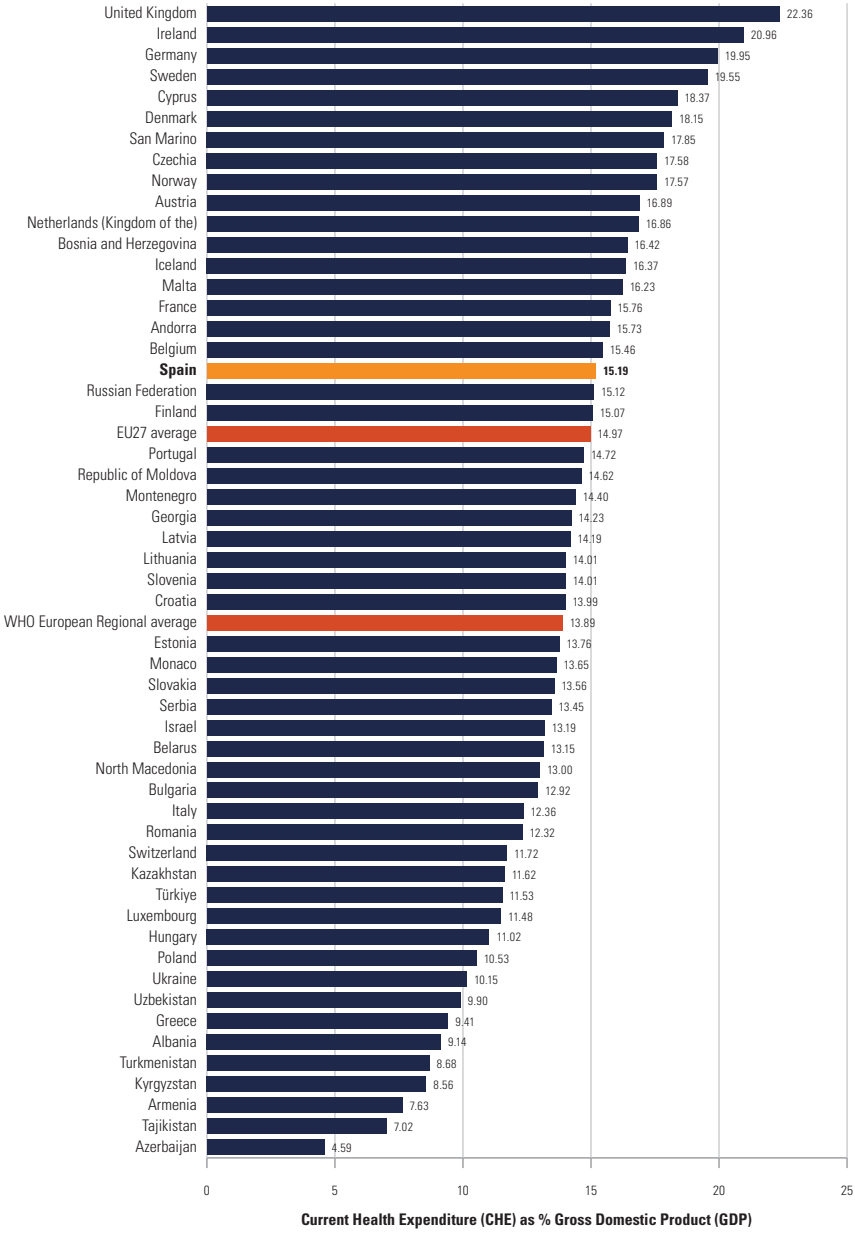
Source: WHO (2024).

FIG. 3.4 Public expenditure on health as a share (%) of current health expenditure in the WHO European Region, 2021



Source: WHO (2024).

FIG. 3.5 Public expenditure on health as a share (%) of general government expenditure in the WHO European Region, 2021



Source: WHO (2024).

When considering all current health expenditure (that is, both public and private financing), inpatient care and public health were mainly funded by government budgets in 2021 (86.4% and 98.3%, respectively). Outpatient care showed a 32.9% share of OOP payments that year, while pharmaceutical care showed a 52.9% share. Long-term care was mainly financed with government funds (78.2%) (see Table 3.2).

TABLE 3.2 Expenditure on health (as % of health spending, 2021) according to function and type of financing

	INPATIENT CARE	OUTPATIENT CARE	LONG-TERM CARE	PHARMACEUTICALS AND OTHER HEALTH PRODUCTS *	PUBLIC HEALTH	ADMINISTRATION	OTHER SERVICES **	REST OF THE WORLD	TOTAL
Public financing	**88.5%**	**59.0%**	**78.2%**	**46.8%**	**98.3%**	**46.2%**	**100.0%**	**100.0%**	**71.7%**
General government	86.4%	53.6%	78.2%	44.9%	98.3%	41.1%	15.5%	33.3%	**68.2%**
Mandatory health insurance	2.1%	5.4%	0.0%	1.9%	0.0%	5.1%	84.5%	66.7%	**3.5%**
Private financing	**11.5%**	**41.0%**	**21.8%**	**53.2%**	**1.7%**	**53.8%**	**0.0%**	**0.0%**	**28.3%**
Private out-of-pocket	2.5%	32.9%	21.8%	52.9%	0.0%	0.0%	0.0%	0.0%	**20.6%**
Private insurance	7.7%	7.6%	0.0%	0.4%	0.0%	53.8%	0.0%	0.0%	**6.9%**
Other (e.g. not-for-profit)	1.3%	0.5%	0.0%	0.0%	1.7%	0.0%	0.0%	0.0%	**0.7%**
Total expenditure (m €)	**60 796**	**28 978**	**6 541**	**27 879**	**2 575**	**3 949**	**1 262**	**4**	**131 984**
	46.1%	22.0%	5.0%	21.1%	2.0%	3.0%	1.0%	0.0%	**100.0%**

Source: Ministry of Health (2023b).

Note: * Includes outpatient prescriptions, as pharmaceutical expenditure in hospitals is included in inpatient care. ** Social security services provided in the household and other services provided by public institutions (not social security).

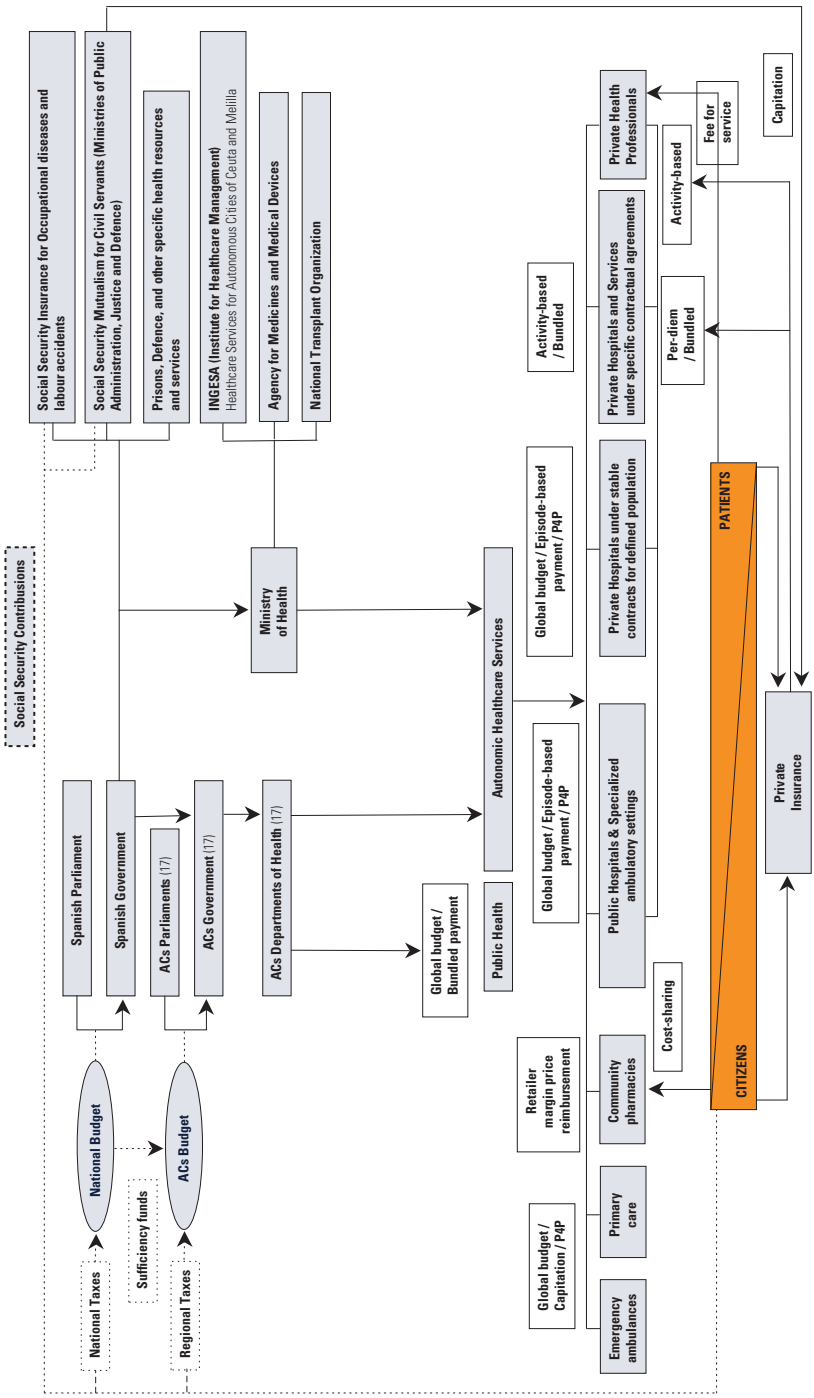
3.2 Sources of revenue and financial flows

Public funds – through general taxation – are the primary source of funding for health care in Spain (73.5% of THE in 2020 and 71.7% in 2021) (Ministry of Health, 2023i). In turn, Mutual Funds catering for civil servants, the armed forces and the judiciary (MUFACE, ISFAS and MUGEJU, respectively) (see Section 2.2 *Organization*) are financed from a mix of payroll contributions and public transfers. Additionally, Collaborating Mutualities with Social Security, which cover accidents and occupational diseases, are financed by employers' contributions (see Section 2.2 *Organization*).

When it comes to private funding, payments come from a combination of OOP payments (co-payments and direct payments) and VHI. In 2021, VHI financed 7.7% of total inpatient care (€4659 million). Likewise, 7.6% of all outpatient care was financed by VHI (€2209 million). However, as dental care, optical care for eyesight problems and hearing aids are mostly excluded from public coverage, the proportion of OOP payments corresponding to outpatient care is high. These benefits are hardly covered by private insurance, except for dental care, which in 2020 had covered around 5 million people (UNESPA, 2021). In turn, VHI only covered 183 080 people for long-term care services in 2021 (UNESPA, 2022). Within the public system, outpatient drug prescriptions and some supplementary services within the benefits package are the only health services whose costs are shared by patients. In practice, co-payments currently affect outpatient pharmaceutical prescriptions and specific orthoses and orthopaedical prostheses (see Section 3.4 *Out-of-pocket payments*). Exceptionally, some VHI schemes partially reimburse policyholders for the cost of medications (see Table 3.3).

Fig. 3.6 provides an overview of SNS financial flows and pooling agencies.

FIG. 3.6 Financial flows



Source: Authors' own compilation.

Note: Dotted lines represent sources of revenue; dashed lines represent the allocation of funds, flows and main allocation mechanisms.

3.3 Overview of the statutory financing system

3.3.1 *Coverage*

BREADTH: WHO IS COVERED?

Between 2012 and 2017 the right to health care was linked to the legal and employment status of individuals (Bernal-Delgado et al., 2018). In 2018, the Spanish Parliament approved a reform whereby the basis for entitlement returned to the condition of residence, which had been the case before 2012 (Royal Decree-Law 7/2018). Under the new law, undocumented migrants regained eligibility to full coverage like any other Spanish national. Public insurance is compulsory (individuals cannot opt out).

SCOPE: WHAT IS COVERED?

Royal Decree-Law 16/2012 regulates the benefits package provided by the SNS with a view to define what benefits should be co-financed by patients. Two categories of services were defined: the common package with three subcategories – basic package, supplementary package and accessory services – common to the 17 regional health services composing the SNS, and the complementary package, decided under the rule of the ACs (see Section 2.7.3 Regulation of services and goods).

The SNS basic benefits package includes all health care prevention, diagnosis, treatment and rehabilitation services, as well as emergency medical transportation. Hence, the basic package includes a comprehensive basket of primary health care benefits (for example, acute and chronic care, health promotion and disease prevention activities, physiotherapy, mother and child care, mental health care, palliative care, medical counselling, basic dental health services, etc.), and specialized health care benefits (for example, any diagnostic and therapeutic procedure to be provided as outpatient specialized care, inpatient acute or long-term care, day care surgical or medical care, palliative care, acute or long-term mental health care, home care, organ transplants, emergency care, etc.). The supplementary package essentially includes pharmaceutical prescriptions and orthoses and orthopaedic

devices (Ministry of Health, 2023h). The accessory package has been vaguely described in Royal Decree-Law 16/2012 as all activities, services or techniques, without benefit, that are not considered essential and/or are used as aid-devices for chronic care improvement (Royal Decree-Law 16/2012). This third package, born in times of austerity, was, arguably, a category for broader exclusions from public financing, which were not activated. To date (June 2024), no related regulations have been issued.

Finally, there is a complementary package: ACs may incorporate into their own benefits package any technique, technology or procedure not covered by the common package of the SNS. For an AC to cover these complementary services, it must ensure financial sufficiency and meeting budget stability criteria; it must also inform the CISNS (Article 2, Royal Decree Law 16/2012).

The draft Law on the Universality of the National Health System is currently being debated in Parliament (June 2024). This law seeks to restore the benefits package as a single portfolio (see Section 6.2 *Future developments*).

DEPTH: HOW MUCH OF THE COST IS COVERED?

The benefits in the common basic package are not subject to any patient cost-sharing. Instead, pharmaceutical prescriptions and orthoprosthetic devices under the supplementary common package are subject to co-payments. Royal Decree-Law 16/2012 indicates that co-payments must be set on the final product price and be fixed according to annual household income and a maximum ceiling of monthly payments (see Section 3.4 *Out-of-pocket payments* and Table 3.3). The accessory services (when regulations are issued following approval of the new draft law on the benefits package) should be subject to the same cost-sharing scheme.

Finally, in the case of the complementary package of services, funding is decided at ACs level, but the effective adoption of those new benefits is conditional on ACs' capacity to pay for them.

BOX 3.1 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). Health services are usually free at the point of use. Co-payments are limited to outpatient-prescribed medicines and orthoprosthetic devices (such as supportive braces and splints, prostheses, wheelchairs, crutches, glasses, hearing aids, etc.) and there are several protection mechanisms for co-payments (see Section 3.4 *Out-of-pocket payments*).

Coverage policy experienced far-reaching reforms, mainly in 2012, in the context of the financial and economic crisis. Co-payments for outpatient prescriptions were introduced for pensioners and opened the door for the introduction of co-payments in three new areas (orthoprosthetic devices; dietary products for medical purposes; and outpatient chemotherapy and other medicines usually dispensed free of charge in hospital outpatient departments, but the latter was not applied). 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 (see Section 3.4 *Out-of-pocket payments* and Table 3.3). Nevertheless, the lack of a cap on cost-sharing for active workers acts as a barrier to access outpatient prescriptions for those with lower incomes (Rodríguez-Feijoó & Rodríguez-Caro, 2021).

Despite worsening during the economic and financial crisis, the incidence of catastrophic spending in Spain is much lower than would be expected given Spain's relatively heavy reliance on OOP payments, a finding that can be explained by strengths in the design of SNS coverage policy and the highly redistributive effect of the public expenditure in health. In 2019, only 0.8% of households were impoverished or further impoverished after OOP payments. In the same year, 1.6% of households experienced catastrophic health spending. The incidence of catastrophic OOP payments in Spain is low compared to other European countries, and in line with Sweden and the United Kingdom. Much of the increase in catastrophic spending took place between 2008 and 2014, reflecting a decline in household capacity to pay for health care in the context of the economic crisis, particularly for poorer households. Although the incidence of catastrophic spending fell after the crisis, in 2019 it was still above pre-crisis levels, being concentrated in the poorest quintile. The main sources of catastrophic spending were dental care and medical products in all quintiles. In the poorest quintile, catastrophic spending is also driven by spending on outpatient medicines (Urbanos-Garrido et al., 2021).

3.3.2 *Collection*

GENERAL GOVERNMENT BUDGET

The vast majority of public expenditure on health in Spain is funded through general taxation (see Section 3.2 *Sources of revenue and financial flows*). The Spanish tax system is highly decentralized. The current regional financial scheme came into force in 2011 after approval in 2009 (Organic Law 3/2009 and Law 22/2009), and it is based on a combination of own taxes, participation in general taxes and transfers for the majority of regions, ruled by the so-called 'Common Regime model'[10]), where the responsibility for tax collection is shared by the Spanish Fiscal Revenue Agency (*Agencia Estatal de Administración Tributaria,* AEAT) and the regional financial authorities.

Leaving aside social security contributions (which are earmarked for pensions and other monetary benefits), the system tax revenues come both from taxes linked to production and imports ('indirect taxes', such as Value Added Tax, VAT) and 'direct taxes', that is, taxes on income and wealth. ACs are also responsible for the collection of those taxes assigned to the regional level (inheritance taxes, wealth transfer taxes) and share tax collection for VAT, personal income tax and excise taxes. In the year 2022, tax revenues amounted to €255 463 million. Direct taxes amounted to €145 121 million (56.8% of the total), with income tax being the most relevant, with €109 485 million in revenue (75% of total direct taxes). Indirect taxes collected €108 480 million (42.5% of the total), with VAT being the most relevant figure (€82 595 million), followed by special taxes (€20 224 million) (AEAT, 2022).

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10 Two ACs, the Basque Country and Navarre, enjoy a special financial regime based on particular legislation (namely, 'derechos forales'), acknowledged in the Spanish Constitution. By virtue of this specific legislation, regional authorities collect all the taxes levied in their corresponding territories, and then reimburse the central government for the services that the latter provides to the citizens of those regions (that is, non-devolved services, as for example, national defence).

TAXES, CONTRIBUTIONS OR PREMIUMS POOLED BY A SEPARATE AGENCY

The second statutory health care system, the Mutual Funds (MUFACE, MUGEJU and ISFAS) (see Section 2.2 *Organization*), is partly funded by the contributions of their affiliates. The contribution rates are set by the central government in the general budget law each year. Currently, Mutual Funds public employees pay a monthly premium between €20 and €50 (note that this amount is for the policyholder, irrespective of the beneficiaries), according to their professional category (a total of six groups or levels exist among the civil servants), which covers up to 15% of the overall expenditure; the remaining 85% is covered from the budget of the Ministry of Finance, which collects funds from income tax revenues, mainly (Ministry of Defence, 2023; Ministry of Justice, 2022; Ministry of Treasury, 2023).

BOX 3.2 Is health financing fair?

The SNS funding, except for co-payments on medicines prescribed in primary care, is covered through general taxes. Therefore, the greater the progressiveness of the fiscal system, the more progressive will be the financing of the health system (this is the principle of vertical equity). Evidence on the progressivity of the Spanish tax system in recent years is limited, although as the relative weight of indirect taxation has increased (as compared to more progressive taxes, such as income taxes), we should assume a decrease in progressivity.

On the other hand, although private financing has experienced some increase in recent years, due to the evolution of VHI (see Section 3.5 *Voluntary health insurance*), OOP payments have experienced a slight reduction (from 22% in 2015 to 21.5% in 2019 and 20.6% in 2021) (Ministry of Health, 2023j). Irrespective of this evolution, the relatively high reliance on OOP payments is not translating into households' catastrophic expenditure (Urbanos-Garrido et al., 2021) due to three facts: a) the limited number of benefits where cost-sharing applies, b) a rather progressive design of co-payments in the 2012 reform (Izquierdo, 2019); and c) the exemption of co-payments for the most vulnerable populations expanded in the latest 2020 reform (General Budget General Law 11/2020) (see Section 3.4 *Out-of-pocket payments*).

3.3.3 *Pooling and allocation of funds*

ALLOCATION FROM COLLECTION AGENCIES TO POOLING AGENCIES[11]

Regional public services including health care are funded after fiscal revenues collection using a complex system of transfers seeking the reduction of funding imbalances across ACs (see Section 3.2 *Sources of revenue and financial flows*). Thus, three main allocation mechanisms coexist; a) the Guarantee of Basic Public Services Fund (*Fondo de Garantía de Servicios Públicos Fundamentales,* FGSPF), intended to ensure equal funding for equal needs for basic services (health, education and social services); b) 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, c) the so-called 'convergence' funds (namely, Competitiveness, Cooperation and Inter-territorial Compensation funds), which try to reduce economic imbalances across ACs.

The FGSPF is allocated to the ACs according to a needs-based weighted formula. This formula includes the size of the population to be served (weighting 30% in the formula), the age-weighted population covered by the SNS (38%), the population aged 16 and younger (20.5%) and the population aged 65 and over (8.5%), and several structural factors such as geographical extension (1.8%), population density (1.6%) and insularity (0.6%). It is funded with 75% of the tax revenues corresponding to the ACs and a contribution from the central government (Treasury Department, 2024).

The Fund for Global Sufficiency covers public spending needs (including health care) when the sum of the ACs' own fiscal revenues and the FGSPF fall short. This Fund is calculated according to the actual health expenditure of the AC and will be negative in those ACs (typically, high-income regions) where transfers from the FGSPF and regional tax revenues exceed the financial needs for the AC. The negative amount will be deducted from the regional participation in central taxes the following year.

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[11] Note that this allocation to pooling agencies section refers to the 'Common Regime of the ACs', which includes all ACs except the Basque Country and Navarre, as they enjoy a different financial regime in which they collect all the taxes levied in their corresponding territory and make their allocation decisions in the corresponding regional parliament. This section also does not address the Mutual Funds for civil servants for which funding is allocated as part of the central government budgeting decisions.

Additionally, some regions still receive transfers from the ACs' Financing Fund, established in 2014 and comprising the Liquidity Funds which were set up in 2012 as extraordinary funding instruments during the economic and financial crisis. The Financing Fund currently includes: a) the Autonomous Liquidity Fund (*Fondo de Liquidez Autonómico*), consisting of loans from the central government to prevent regions from resorting to debt markets; b) the Financial Facility Fund, aimed at refinancing regional debt; and c) the REACT-EU Liquidity Fund, which channels aid from the Next Generation funds and was implemented in 2020 in the context of the governmental response to the COVID-19 pandemic, with a view to protect public services and reactivate the economy (Ministry of Finance, 2020).

Finally, the compensation funds are mainly a) the Healthcare Guarantee Fund, managed by the Ministry of Health, aiming at covering assistance provided in a particular AC to those citizens residing in a different AC; this Fund is extra-budgetary, and has partially compensated expenses in primary care and pharmaceutical expenses in prescriptions (Resolution of 17 November 2020); and b) the Healthcare Cohesion Fund, funded by the Ministry of Health, with a similar aim but restricted to the so-called Reference Centres, Services and Units, in charge of providing highly specialized care or rare diseases care for patients from any AC, and then requiring the concentration of a minimum number of patients (Royal Decree 1302/2006); this fund is no longer extra-budgetary since 2021.

ALLOCATING RESOURCES TO PURCHASERS

In the case of ACs, once the regional budget allocation is endorsed by the regional parliament, the third-party budget-setting and split-purchasing role is played by the health departments in the 17 ACs (and INGESA for the autonomous cities of Ceuta and Melilla, see Section 2.2 *Organization*) which 'purchase' services from either public or private providers for all the residents in the AC. In the case of civil servants, the Mutual Funds, which receive the corresponding share of the budget (as well as the affiliates' contributions), purchase services from both private and public providers, depending on the decision of their affiliates, who generally opt for either type of provider on a yearly basis.

BOX 3.3 Are resources put where they are most effective?

From a financial perspective, the current allocation mechanisms have not been able to achieve the reduction of financing inequalities across ACs as most funding allocations largely guarantee the ACs' ability to maintain the financial *status quo* (that is, their relative level of expenditure), perpetuating financing imbalances across ACs. Despite the action of fiscal equalization mechanisms, such as the FGSPF, the available resources for financing health services exhibit significant disparities across ACs (Pérez-García & Peiró-Moreno, in press). The whole model has been criticized for its complexity and low transparency (Herrero-Alcalde & Tamayo-Lorenzo, 2023), and some improvements in the risk-adjusted resource allocation formula have been recommended by the experts (Expert Commission for the Review of the Regional Funding Model, 2017)[12].

In the SNS, priority setting is made explicit in strategic plans at national level that translates into regional implementation. However, these plans, which aim at coordinated action in strategic health domains across ACs, do not usually translate into funding allocation decisions; hence, the ACs ought to budget the implementation with the Fund for Basic Public Services (FBPS) and their own fiscal capacities and then allocate funds and resources to the corresponding providers.

With regard to guiding the allocation decisions upon evidence about effectiveness and cost-effectiveness, Royal Decree-Law 16/2012 established that new techniques, technologies and procedures should be compulsorily evaluated prior to their introduction in the SNS. Evaluations are the responsibility of the Spanish Network of Agencies for Health Technologies and Benefits Assessment. In addition, a new evaluative mechanism was introduced in 2020 (known as the 'Plan for the consolidation of the therapeutic positioning reports of drugs in the SNS' (*'Plan para la consolidación de los informes de posicionamiento terapéutico de los medicamentos en el Sistema Nacional de Salud'*) to include cost-effectiveness and budgetary impact assessments in the adoption and pricing decisions of new drugs with high economic impact (Vida, Oliva & Lobo, 2023). During a two-year pilot phase, the percentage of therapeutic positioning reports (IPTs) incorporating economic evaluations remained low and exhibited significant heterogeneity in their quality (Vallejo-Torres, Oliva & Lobo, in evaluation). In 2023, the Spanish courts voided the 2020 Plan on formal grounds (National High Court, 2023) (see Section 2.7.3 *Regulation of services and goods*).

Within each AC, the usual purchasing mechanism between the regional Department of Health and the regional health service, then cascading down to

[12] A recent report (Ministry of Finance, 2021) proposes a new risk-adjusted resource allocation formula. However, the political context makes a reform of the financing model highly unlikely.

care providers, heavily relies on global budgets and framework contracts. The design of these framework contracts hardly promotes effectiveness, quality of care, continuity and efficiency. However, some regions have implemented additional purchasing policies to improve performance, for example, the creation of a single governance body coordinating hospital and primary care providers fostering care continuity in the Basque Country, targeting populations according to risk-stratification in Navarre, or implementing normative care pathways or adapting health information systems for continuous evaluation and improvement in Aragon (Bernal-Delgado & Angulo-Pueyo, 2023).

3.3.4 *Purchasing and purchaser–provider relations*

Public provision in the SNS plays a prominent role and, in general, the public bodies in charge of purchasing (that is, the ACs' health departments) purchase the services from another public body, hierarchically linked to the former, the so-called Regional Health Service (RHS). The latter runs all inpatient and outpatient health care centres. Generally, the health department annually 'contracts' (and budgets) the services with the Regional Health Service that, in turn, negotiates global annual contracts with its providers. Additionally, either the ACs' health departments or the RHSs may contract services from private providers, usually from hospitals or diagnostic labs.

Within this general scheme, RHSs contract hospital care, primary care, preventive activities and long-term care services. Public hospitals are financed through global budgets, mainly considering the actual expenditure in the previous year, although some adjustment to quality and new services may be used. In turn, primary care services are contracted upon a global budget for acute, chronic and preventive care services, slightly nuanced according to population demographics and dispersion. The primary care 'contract' reflects specific objectives prioritizing certain care or preventive programmes, and includes some incentives linked to the achievement of certain prescription targets aimed at increasing the appropriate use of drugs. There are a few exceptions to this model: a) the externalization of primary care by way of the so-called EBAS (*Entidades de Base Asociativa*) in the AC of Catalonia, which are 'limited societies of primary care practitioners that provide care to a defined population according to a contract with the Health Department (since 1996, only 11 EBAS have been created in Catalonia, a model that seems self-limited in its ability to generalize); and, b) primary care

provided in the context of a P-PP in the region of Valencia (see Section 2.7.2 *Regulation and governance of provision*).

In addition to public providers, a certain amount of activity is contracted out to private providers, typically aimed at reducing waiting lists for surgical procedures or high-technology diagnostic tests, but also to complement long-term care services and palliative care, among others. These are generally prospective volume-contracts with some ex-post correction clauses. Depending on the nature of the activity, the public purchaser determines the basis for payment; hence, long-term care activity is usually financed in terms of stays, whereas surgical interventions and diagnostic tests follow a fee-for-service (FFS) scheme based on a public tariff. Contracts with private providers have been observed to increase since the mid-1990s; in 2020, they accounted for 10% of the total public health expenditure (Ministry of Health, 2023i).

3.4 Out-of-pocket payments

OOP payments play a significant role in Spain. They represented 20.6% of total health expenditure in 2021. According to the latest data from the General Household Budget Survey, overall household expenditure on health rose from €17 859 million in 2015 to €23 379 million in 2022, representing 3.9% of the household budget (INE, 2023f).

The average annual expenditure on health by household increased from €972 in 2015 to €1048 in 2019, decreasing to €1001 in 2020, pulled down by the fall in households' spending as a result of the COVID-19 pandemic. Household expenditure increased again, reaching €1228 in 2022. In 2020, spending on drugs, medical products and medical appliances increased in terms of the share of both the family budget (1.6% in 2015 compared to 2.4% in 2022), and average expenditure, rising from €389 in 2015 to €746 in 2022 (Table 3.3) (INE, 2023f).

3.4.1 *Cost-sharing (user charges)*

Cost-sharing is mainly applied in the form of co-payments, and these are detailed in Table 3.3. In essence, before 2012 co-payments for SNS services only applied to outpatient prescription medicines, and pensioners and some other groups of people were exempt from co-payments. The reform issued in 2012 (Royal Decree-Law 16/2012) and consolidated in 2015 (Royal Decree-Law 1/2015) changed the cost-sharing scheme. First, the system foresees cost-sharing for drug prescription and for other benefits in the common supplementary and accessory baskets – the common basic basket remains exempted. More precisely, the reform opened the door for the introduction of new co-payments for orthoprosthetic devices (such as supportive braces and splints, prostheses, wheelchairs, crutches, hearing aids, etc.), dietary products for medical purposes and outpatient medicines dispensed in hospitals' pharmacies, for example, chemotherapy (the latter has not been applied and is not expected to happen). Second, the reform abolished the exemption from co-payments for outpatient prescriptions for pensioners and increased existing co-payments for other groups, linking the amount to pay to income. In addition, the reform expanded protection mechanisms; notably, caps in pensioner co-payments, exemptions from co-payments for some beneficiaries of social benefits and a reduction of the co-payment rate in a wide range of medicines for chronic conditions. Moreover, specific groups such as AIDS drugs dispensed in pharmacies and drugs indicated for treating chronic diseases are subject to a 10% co-payment capped at €4.24 per prescription, irrespective of whether patients are active workers[13].

Since 2020, protection mechanisms have been strengthened even further. In 2020, exemption from co-payments was extended to recipients of the guaranteed minimum income (Royal Decree-Law 20/2020), which provides a uniform minimum income floor throughout Spain, with benefits varying depending on family size and composition. In 2021, full exemption was extended to low-income pensioners, moderately and severely disabled children, and households receiving child benefits (Law 11/2020).

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[13] In the Mutual Funds statutory system, civil servants pay 30% of the medicine price, irrespective of whether they are active workers or pensioners.

TABLE 3.3 User charges for publicly financed health services, 2023

SERVICE AREA	TYPE OF USER CHARGE	EXEMPTIONS AND OR REDUCED RATES	CAP ON SPENDING	OTHER PROTECTION MECHANISMS
Primary care	None	N/A	N/A	N/A
Outpatient visits	None	N/A	N/A	N/A
Dental care	None (for basic preventative services covered by the SNS)	N/A	N/A	VHI
Diagnostic tests	None	N/A	N/A	N/A
Inpatient care	None	N/A	N/A	N/A
Inpatient medicines	None	N/A	N/A	N/A
Emergency care	None	N/A	N/A	N/A
Outpatient prescription medicines	**Co-payments** **Most medicines for chronic conditions:** Co-payment of 10% of the retail price up to a maximum amount of €4.24 per prescription item (updated annually in line with inflation). **All other medicines:** Pensioners with an annual income <€100 000: 10%. Pensioners with an annual income >€100 000: 60%. People covered by MUFACE, MUGEJU and ISFAS: 30% All others with an annual income <€18 000: 40%. All others with an annual income €18 000–€100 000: 50%.	People receiving non-contributory pensions or social integration income (*rentas de inserción social*). Unemployed people who have exhausted their unemployment benefits. People requiring treatment due to occupational illness or injury. People with toxic shock syndrome. A very small number of people with disabilities. Since 2020: people receiving the guaranteed minimum income. Since 2021: minors with a recognized degree of disability equal to or greater than 33%. Since 2021: people receiving benefits for a dependent child or minor in a permanent family foster care scheme.	Pensioners (excluding pensioners covered by MUFACE, MUGEJU and ISFAS): annual income <€18 000: €8.23 a month. annual income €18 000–€100 000: €18.52 a month. annual income >€100 000: €61.75 a month.	VHI reimbursement.

	All others with an annual income >€100 000: 60%. Medicines provided in hospital outpatient departments for a set of serious diseases that require hospital diagnosis or intensive follow-up (cystic fibrosis, multiple sclerosis, Hepatitis C, HIV, oral chemotherapy, rheumatoid arthritis, etc.) are exempt from co-payment. Co-payment threshold for non-residents or nonregistered foreigners was fixed to 40% of the retail price, irrespective of their income level by the Royal Decree-Law 7/2018.	Since 2021: pensioners with incomes <€5635 or €11 200 if they are not obliged to pay personal income tax		
Orthoprosthetic devices (e.g. supportive braces and splints, prostheses, wheelchairs, crutches, hearing aids, etc.).	**Co-payments** as for outpatient prescription medicines.	In general, as for outpatient prescription medicines; prostheses for breast and upper and lower limbs, wheelchairs and wheelchair accessories are exempt from co-payment; some regions have further exemptions for people with disabilities.	No overall cap; a cap per item varies from €0 to €36 per item and is not linked to income.	VHI reimbursement.

Source: Urbanos-Garrido et al. (2021).

Note: N/A: not applicable; OOP: out-of-pocket.

3.4.2 *Direct payments*

The National Household Budget survey cannot distinguish between cost-sharing in the Statutory SNS (that is, co-payments) and direct payments for services not covered by the SNS.

Thus, 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 expenditure on

health, while prosthetic and medical devices (corrective lenses, orthopaedic material, etc.) reached 36%; dental care represented 17.3% of household expenditure on health (INE, 2023f).

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. Similarly, while the SNS covers aesthetic treatments related to medical conditions, other cosmetic surgery falls outside the benefits package and must be paid for directly out of pocket. Patients may purchase VHI to cover some of these services if they wish.

3.4.3 *Informal payments*

Informal payments do not seem to be an issue in the Spanish health system. Eurobarometer surveys consistently find Spain to have one of the lowest levels of self-reported informal payments in the EU (European Commission, 2017, 2020, 2023b).

3.5 Voluntary health insurance

One in five Spanish people hold VHI plans in addition to having universal, compulsory public coverage. Spending on VHI has grown steadily over time, from 5.95% of overall health expenditure in 2015 to 6.89% in 2021, representing 24.4% of private spending on health (Ministry of Health, 2023j). The proportion of the population covered by VHI has rapidly grown in recent years, from 15.8% of the population in 2015 (7.3 million people) to 20.8% of the population in 2021 (IDIS, 2022). At the end of 2022, collective health insurance (insurance bought by employers) represented 29.8% of premiums and 34.1% of insurees (ICEA, 2023). Around 11% of the population holds additional VHI covering dental care (8% in 2015) (UNESPA, 2022). Notably, the share of the population with VHI varies widely across ACs, with Madrid, Catalonia and the Balearic Islands having the highest share (UNESPA, 2022).

VHI in Spain is generally supplementary and independent of the statutory SNS, offering faster access to outpatient specialist care, inpatient

care and diagnostic tests (Epstein & Jiménez-Rubio, 2019). However, in dental care VHI plays a complementary role. Policyholders tend to be people aged between 31 and 60 years old, employees in large companies and individuals living in better-off households. In 2019, around 40% of households in the richest income quintile had bought VHI compared to only 10% in the poorest quintile (Urbanos-Garrido et al., 2021).

There are fiscal advantages for those who purchase a VHI plan, although advantages may vary across ACs. For example, self-employed workers are allowed to deduct VHI premiums from taxable income and employees are allowed to deduct employer-purchased VHI premiums from taxable income (up to a limit of €500 per covered person a year or €1500 per covered person with a disability). All insurance premiums are exempt from VAT. VHI premiums are also exempt from the insurance premium tax.

Notably, the health insurance sector is highly concentrated. According to the General Directorate of Insurance and Pension Funds, 91 companies operated in this market in 2022, with an unequal distribution of premiums (only five of them accumulated 76.6% of total premiums) (Ministry of Economy, 2023).

Compared to the health sector, the private insurance market in long-term care and home care, usually complementary to the health insurance package, is underdeveloped in Spain. Only 10 companies operated in the sector in 2022. The number of insured has gone from 68 380 in 2020 to 183 080 in 2021 and 163 752 in 2022. This figure represents 0.4% of the Spanish population aged 18 and over (Ministry of Economy, 2023). Compared with the €10 371 million billed by the health insurance market, the market for long-term and home care premiums hardly billed €15.76 million in 2022 (Ministry of Economy, 2023).

3.6 Other financing

3.6.1 *External sources of funds*

A remarkable source of financing has recently come from the NextGenerationEU funds. Articulated in Spain through the Recovery, Transformation and Resilience Plan (*Plan de Recuperación, Transformación*

y Resiliencia), the first stage of the plan has brought an additional €1069 million, allocated for 'the renewal and expansion of the capacities of the SNS'. Of these funds, 74.5% were allocated to the Investment Plan for high-tech equipment in the SNS (Spanish Government, 2024). Within the same Plan, the Council of Ministers on 30 November 2021 approved the so-called Strategic Projects for Economic Recovery and Transformation (PERTE) dedicated to 'Vanguard Health', whose main lines are innovation and development of advanced therapies, promoting personalized precision medicine, the digital transformation of the SNS and strengthening primary care (see Section 4.1.1 *Infrastructure, capital stock and investments*). An investment of €1469 million was foreseen to be executed in the period 2021–2023.

Although Spain is not a country with a solid tradition of private donations to the health system, several donations of high-tech health equipment have been made by the Foundation of Amancio Ortega, founder of Inditex, in recent years. The latest, dated 2021, consisted of ten units of proton therapy equipment valued at €280 million.

3.6.2 *Other sources of financing*

In addition to the aforementioned sources, the Ministry of Economy has promoted in recent years various initiatives aimed at financing investment costs, including under the Innovative Technology Public Procurement (IPP) and Pre-Commercial Procurement (PCP) programmes. IPP involves the public procurement of a good or service that does not currently exist on the market at the time of purchase but can be developed within a reasonable timeframe and requires new or improved technology. PCP involves the acquisition of R&D services to develop prototypes of initial products or services that are technologically innovative, which will be exclusively used to validate technology, with no commercial purposes. Several ACs have initiated some programmes although there are no official figures available to assess their actual impact. Lastly, non-governmental organizations (NGOs) represent an additional (but modest) source of private financing. Their contributions represented €594 million in 2021, 1.59% of private health spending and 0.45% of total health spending (Ministry of Health, 2023j).

3.7 **Payment mechanisms**

This section provides an overview of payment mechanisms as per the financial flows shown in Fig. 3.6; a distinction is made between the health services and personnel payments, which is summarized in Table 3.4.

3.7.1 *Paying for health services*

Paying for health services combines several mechanisms depending on the type of service. Those mechanisms may vary across ACs, depending on the degree of separation between purchasing and providing functions within the AC.

Most of the publicly funded health services use global budgets as the funding mechanism. The system builds on a framework agreement between the Regional Health Service and the provider (that is, hospitals, primary care settings), namely, *contratos-programa, contratos de gestión* or *contratos clínicos*. These agreements regulate the quantity of services and the overall budget, but also introduce quality-oriented elements aligned with the objectives of the regional strategies on quality and safety; typically, waiting list reduction programmes, extension of day-case surgery, reduction of safety events, etc. In addition, part of the compensation to providers may be based on outcomes set upon territorial objectives (included either in each AC health plan or within the objectives of the Regional Health Service in question), such as accessibility, responsiveness and attention to chronic patients.

Interestingly, since 2010 there are some examples where regional Departments of Health have aimed at contracting integrated services – services that usually were separately provided by primary care or hospital providers with a weak coordination among levels. In the Basque Country, integrated health care organizations have been developed since 2011 and financial agreements affect the whole continuum of care; in the AC of Catalonia, since 2014 it is possible for a provider to be commissioned to provide all services for a defined population (that is, hospital care, primary care, mental health and long-term care). In both regions the compensation mechanism follows a population-based payment model considering the size of the population and specific characteristics of the population such as risk stratification and socioeconomic deprivation.

SPECIALIZED CARE: PAYMENT TO HOSPITALS

With some exceptions, public hospitals are normally funded through global budgets. The main part of the budget is fixed by means of a formula that accounts for the number of discharges, the case-mix weight (generally episode-based all-patient Diagnosis Related Groups (AP-DRGs)) and a structure-related tariff. Some procedures are excluded from this financing formula and are paid following an FFS mechanism.

In addition to the regular mechanism, two cases may deserve further detail. In the AC of Catalonia, the Regional Health Service purchases hospital services from the Comprehensive Healthcare System for Public Utilization in Catalonia (*sistema sanitario integral de utilización pública de Catalunya,* SISCAT), which brings together all centres providing publicly funded health care services. As provisioned by Regional Decree 118/2014 on contracting and provision of health care services, the basic payment mechanism takes the hospital discharge as the unit of payment, although weighted according to the complexity of the case-mix and the structure of the hospital. Unlike the general scheme, the case-mix of a hospital is calculated using the 'relative resource intensity' (a ratio between average relative weight based on AP-DRGs of the hospital and the average weight for the whole SISCAT), a factor linked to the accomplishment of objectives and a structural factor that relies on the type of hospital – from centres that complement acute hospitals' activity to high complexity hospitals. In summary, the economic compensation given to a hospital is a function of the discharge-related activity measured as the sum of the weighted case-mix and the weighted structural components. In turn, outpatient activity developed in a hospital (for example, outpatient consultations to specialists, activity in the A&E departments, day care) is compensated separately using public tariffs.

Another singularity within the SNS is applied within the remaining P-PPs in the AC of Valencia (see Section 2.7.2 *Regulation and governance of provision*). Under the P-PP scheme, the Health Department sets a standard payment per capita to cover all the population needs in a particular 'health care area', including hospital costs. The contractual agreement (and subsequent payment mechanism) aims at avoiding patient selection as well as reductions in volume or quality.

Finally, in addition to using the public network of providers, all regional health services also use private hospitals to deliver certain services, usually

surgical procedures, specific diagnostic tests, and long-term and palliative care (see Section 2.7.2 *Regulation and governance of provision*). Contracts with private providers are usually set in the context of reducing waiting lists or early discharge programmes. Bundled payment is the usual payment mechanism for surgical or diagnostic tests provision – the fee is based on annually updated public tariffs, different across ACs. In the case of long-term or palliative care, *per diem* fees are the most common payment scheme and the unit price depends on the condition of the patient, the therapeutic complexity and the characteristics of the hospital.

PRIMARY CARE

Primary care is mainly delivered by public health care providers. As in the case of hospitals, contractual agreements are set following a benefits package-based approach, based on the activity carried out by primary care professionals and on quality indicators, although their definition is not homogeneous across regional health services. Typically, the primary care management structure of the health care area signs an annual framework contract with the regional health service, based on capitation criteria (with some elements of demographic structure and population dispersion) and including some specifications linked to the priorities of the regional Department of Health. These contract specifications cascade down, translating into contracts with each primary care team – that is, the group of specialized doctors and nurses in charge of primary care in each health care area (see Section 2.2 *Organization*). It is a negotiated process, where the parties set up objectives on high-value care; for example, the adequate use of prescriptions or the implementation of integrated care paths for patients with chronic conditions or those experiencing multimorbidity. There are marginal exceptions to this rule. In the AC of Catalonia or the Basque Country, for example, the basic compensation given to primary health care centres is complemented according to risk-stratification formulas, while in Valencian P-PPs health care provision is contracted out as part of the concession, and primary care funding is part of the capitation payment system (Bernal-Delgado et al., 2018).

PHARMACEUTICAL CARE

Pharmaceutical outpatient prescriptions and pharmaceutical care provided in hospitals follow completely different payment schemes. In the former, there is a mixture of public budget reimbursement to retail pharmacies and patients' cost-sharing, while in the latter, pharmaceuticals are funded as part of the hospital payment system.

With regard to outpatient prescribed medicines (that is, medicines prescribed in a primary care setting or by an outpatient specialist), the SNS reimburses to the retail-pharmacies the drugs included in the benefits package. Maximum reimbursement rates (that is, reference prices) are set as the average of the price of the three cheapest products belonging to the group of bioequivalent medicines or reference set. As there is cost-sharing, retailers directly collect user charges from patients over the counter, and the regional Health Service is billed monthly for the rest of the cost. According to Royal Decree-Law 4/2010, the retailer's margin is set at 27.9% of the consumer price (capped when the manufacturer's selling prices are over €91.63). This margin is set at €38.37 per package for those medicines whose factory price is greater than €91.63, and equal to or less than €200, €43.37 per package when the industrial price is between €200 and €500, and €48.37 per package for those medicines whose industrial price is greater than €500. Additionally, progressive deductions based on the total amount of sales are applied on the pharmacies' monthly bill by way of contributions to the SNS. The scale of discounts ranges from 7.8% (total sales between €37 501 and €45 000) to 20.0% (sales amount over €600 000) (Royal Decree-Law 4/2010).

When it comes to public expenditure on pharmaceuticals provided in a hospital, payment is part of the aforementioned payments to hospitals. However, the actual cost is specific to each hospital, as in most cases hospitals directly purchase drugs from the producers. There is also a list of reference prices for hospital medicines that have biosimilars or generic competitors. Interestingly, a few hospitals in at least three ACs (Andalusia, Catalonia and Valencia) have implemented shared-risk agreements with pharmaceutical companies in order to guarantee patient access to therapeutic innovations without assuming the whole financial risk associated with uncertainty over effectiveness (Clopes et al., 2017; Guarga et al., 2022[14]).

[14] It should also be noted that hospitals are responsible for an increasing portion of retail distribution of medicines (over 33%), since high-cost pharmaceuticals for chronic diseases that were previously delivered at retail pharmacies are now dispensed by hospitals free of charge for patients.

TABLE 3.4 Provider payment mechanisms

PROVIDERS / PAYERS	MINISTRY OF HEALTH	REGIONAL MINISTRY OF HEALTH / HEALTH SERVICE	SHI FUNDS [a]	OTHER SHI SYSTEMS [b]	LOCAL HEALTH AUTHORITY [c]	PRIVATE / VHI [d]
Family Doctors	GB/C/P4P	GB/C/P4P	C	n.a.	n.a.	AB/EB/FFS
Ambulatory specialists	GB	GB	C	n.a.	n.a.	AB/EB/FFS
Other ambulatory provision	GB	GB	C	n.a.	n.a.	AB/EB
Acute hospitals	GB/EB/P4P	GB/EB/P4P	C	EB	n.a.	AB/EB
Other hospitals [e]	GB/EB	GB/EB	C	EB	n.a.	AB/EB
Hospital outpatient	GB	GB	C	n.a.	n.a.	AB/EB
Dentists	GB/C	GB/C	n.a.	n.a.	n.a.	AB/EB/FFS
Pharmacies	RMPR	RMPR	RMPR	n.a.	n.a.	FFS
Public health structures	GB/BP	GB/BP	n.a.	n.a.	GB/BP	n.a.
Social care	GB/BP	GB/BP	n.a.	n.a.	BP	n.a.

Source: Authors' elaboration.

Notes: GB: global budget; AB: Activity-based; EP: episode-based payment; C: capitation; P4P: pay-for-performance (e.g., quality, uptake of programmes); BP: bundled payment; FFS: fee-for-service; RMPR: retailer margin price reimbursement; n.a.: not applicable.

[a] Mutual Funds (MUFACE, MUGEJU, ISFAS) act as insurers and purchasers; b Other SHI systems Accident and labour diseases mutualities; c Municipalities; d Payments to providers under VHI schemes vary widely; the table lists the most frequently used; e Other hospitals may be monographic centres (e.g., oncologic), traumatology and rehab centres, or long-term care centres.

PUBLIC HEALTH SERVICES

These services are generally funded as part of the primary care payment mechanisms. However, population-oriented services, such as vaccination campaigns or population screening programmes (breast, colorectal or cervical cancer) (see Section 5.1 *Public health*), are funded through earmarked budgets. Additional surgical or medical treatments derived from screening programmes are funded within the described payment mechanisms for primary or hospital care. Lastly, ACs' health departments award grants to municipalities and not-for-profit organizations (such as, foundations, associations or charities) to complement public health programmes on drug

abuse, health education at schools, secondary prevention in mental health, occupational risks, and health promotion among population minorities, among others.

3.7.2 *Paying health workers*

Although the Ministry of Public Administration regulates the basic salary and working conditions for SNS civil servants, ACs' health departments have the capacity to vary some of the salary components that make up the total remuneration (see Section 2.3 *Decentralization and centralization*). This geographical diversity in salaries is not explained by differences in productivity, quality standards or purchasing power; rather, it is the negotiation capacity of trade unions based in the region, bilateral negotiations and the specific context of the human resources policy in the public sphere in each AC which determine the final pay level.

All health professionals in the SNS are salaried workers, with the vast majority of them being civil servants. In the specific cases of doctors and nurses, remuneration of SNS workers is composed of 'basic' pay, on-duty payments and 'supplementary' stipends. The former 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. In turn, supplementary remunerations are set according to position characteristics, performance (in-kind benefits set upon some organizational goals) and professional career (bonuses associated with, for example, seniority or scientific achievements). Finally, in the case of Family Doctors, the salary includes a capitation component (amounting to about 10% or 15% of the total salary), which considers the size and demographic structure of the population registered to them and some additional small amount linked to performance. Each AC publishes its own definition of the capitation component. In the case of some hospital specialists, there is an additional FFS amount linked to waiting list reduction programmes. In addition, although with a very uneven implementation across ACs, a small part of the salary is based on pay-for-performance schemes more oriented to pay complementary activities (for example, participation in quality control committees, doing research) than to rewarding actual clinical performance (Repullo-Labrador & Freire-Campo, 2024).

Unlike this general scheme, there are a number of SNS hospitals where the legal framework of application for workers is the labour legislation for the private sector. The workers' salaries in these hospitals include supplementary remunerations linked to productivity.

In 2021, the overall public expenditure on health personnel costs reached €38 778 million, 43.0% of the public expenditure on health (Ministry of Health, 2023i). The overall payroll decreased between 2010 and 2014, increasing again thereafter, especially in 2020 during the COVID-19 pandemic. Although health professionals' average salaries are not regularly reported, there are some estimated data available from different sources; the most recent report details the remuneration of physicians in the public system (Granada Medical Union, 2019). It should be noted that rather negligible differences were identified in the average salary between specialists and Family Doctors (see Table 3.6), with the caveat that productivity complements are not included in the study and the medical on-call shifts may vary between both primary and hospital care. Moreover, the report does point out significant differences in pay at the regional level.

Unfortunately, data regarding other health professionals' salaries are limited; in the field of nursing, no recent disaggregated information has been found, as in the case of physicians, although analyses of the remuneration of nurses in six regions of northern Spain showed an average gross monthly salary of €2377, with significant differences between regions (Cabrera García, 2018).

When comparing health professional salaries with the average wage for full-time employees across all the sectors in Spain, primary care doctors in 2021 earned as much as 2.4 times the average wage, hospital specialists 2.7 times the average salary, and nurses 1.4 times the average salary. Table 3.6 compares this indicator across several EU countries (OECD, 2023a).

TABLE 3.5 Remuneration of doctors in Spain (annual income), 2019

	TYPE 1	TYPE 2	TYPE 3	TYPE 4
Family Doctors	€59 834	€63 378	€72 318	€81 287
Specialists	€59 490	€63 074	€72 073	€81 004

Source: Granada Medical Union (2019).

Note: Type 1 profile: temporary interim or substitute young doctor (30 years of age or older), without exclusive dedication to the public health system; Type 2 profile: temporary interim or substitute young doctor (30 years of age or older) with exclusive dedication to the public health system; Type 3 profile: doctor who is in the central part of his professional activity (40 years of age or older). Statutory (i.e., special category of civil servant) and with exclusive dedication to the public health system. Type 4 profile: physician who is in the final stage of his professional activity (55 years of age or older). Statutory and with exclusive dedication to the public health system.

TABLE 3.6 Remuneration of health professionals, ratio to average wage, 2021

	PRIMARY CARE PHYSICIANS	HOSPITAL	HOSPITAL NURSES
Netherlands (Kingdom of the)	2.2	3.2	1.2
Portugal	2.2	2.2	1.0
Spain	2.4	2.7	1.4
Sweden	2.3	2.2	1.0

Source: OECD (2023b).

4

Physical and human resources

Summary

- The number of hospital beds has remained constant throughout the period 2015–2022 and rested at 296 beds per 100 000 inhabitants in 2022, with public beds representing 81.4% of the total.

- Capital investment has grown steadily up to 2.3% of the total public health expenditure in 2021 (1.5% in 2013).

- Since 2021, and as a result of the national Recovery, Transformation and Resilience Plan, an increase in the density of medical equipment has been observed, reducing inequalities across the country and renewing obsolete medical equipment.

- After the implementation of the 'Insurance ID card', the progress of the SNS eHealth Strategy has resulted in the SNS leading the implementation of the Patient Summary and the Electronic Prescription, allowing the exchange of relevant clinical and pharmaceutical information across regions and cross-border.

- The number of primary health care professionals has remained rather stable in the period 2014–2022, whereas the numbers of specialized care personnel, doctors and nurses, have increased 18% and 24%, respectively. Over the years, the ratio of nurses to

doctors has lingered below the OECD countries' average ratio (1.4 against 1.97).

- There is a shortage of physicians in some specialties and problems in covering vacancies in some rural areas of the country; the lack of primary care physicians is the major concern. A plan led by the Ministry of Health aims to increase the number of graduates in Medicine as well as the number of medical interns, and to set up incentives to cover hard-to-fill positions.

4.1 Physical resources

4.1.1 *Infrastructure, capital stock and investments*

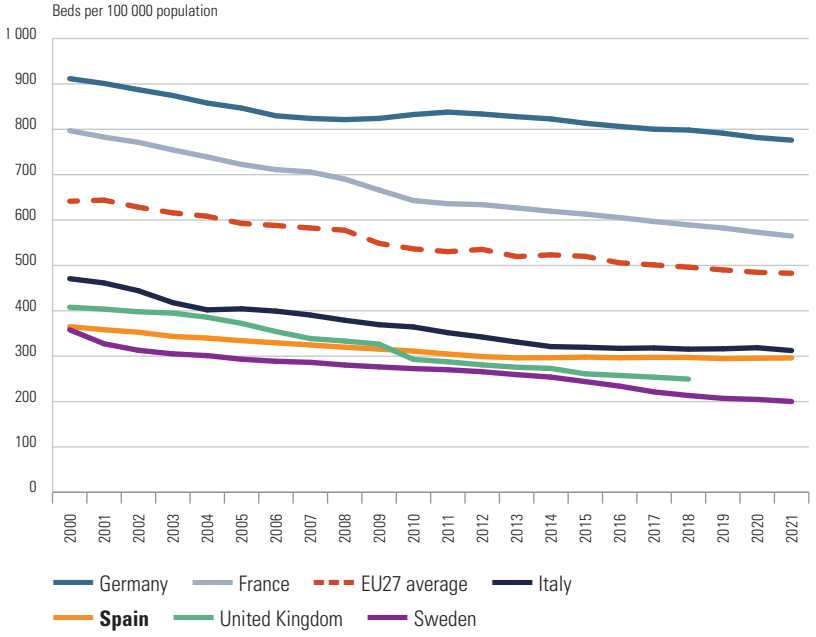
INFRASTRUCTURE

The number of hospital beds has remained stable throughout the period 2015–2022, resting at 296 beds per 100 000 inhabitants in 2022. The share of public beds has increased from 79.9% in 2015 to 81.4% in 2022 (Ministry of Health, 2023a).

Although the total number of hospital beds has remained stable, different trends can be observed depending on the type of bed during the period 2015–2020. In particular, there has been a significant increase in the number of internal medicine beds (50%), ICU beds (23%) and paediatric surgery beds (16%) (Ministry of Health, 2022d).

International data highlight that Spain exhibits a lower number of total hospital beds compared to the EU average (524.8 beds per 100 000 population in 2021), although this number has not suffered the sharp decrease experienced in other countries (Fig. 4.1).

FIG. 4.1 Total hospital beds per 100 000 population in Spain and selected countries, 2000–2021



Source: Eurostat (2023o).

There has been a 4.3% decrease in the number of long-term care beds in institutions and hospitals per 1000 people aged 65 and over in Spain since 2011 (slightly below the -4.7% decrease observed in the OECD countries), reaching 45.4 beds per 1000 population aged 65 and over in 2021; this figure is in line with the OECD average of 45.6 beds (OECD, 2023a). In 2020, long-term care facilities accounted for 5% of total health expenditure, below the EU average of 10% (OECD/European Union, 2022). In addition to long-term care resources in the health system, the social system provides services in nursing homes. In the social system, the number of beds increased by 7% from 2015 to 2021, representing 62.7% of public beds in 2021, well above the 56% share in 2015 (AEDGSS, 2023).

BOX 4.1 Are health facilities appropriately distributed?

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, 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 the Canary Islands and Cantabria (30 and 85 beds per 100 000 inhabitants, respectively) (Ministry of Health, 2023a).

In the case of primary care premises (that is, centres and local health offices), the distribution across ACs shows wide differences, with a 28-fold extreme difference between Castile-Leon (168 premises per 100 000 population) and Madrid, with six centres per 100 000 inhabitants (Ministry of Health, 2023n). This is a reflection of the difference between the rural and urban environments and the effort to maintain accessibility to primary care centres.

Regarding beds in nursing homes, in 2021 six out 10 beds were public. However, notable differences in the share of long-term care public beds were observed, with a higher share in Castile Leon (76%), the Basque Country (73%), Castile La Mancha (72%) and Catalonia and Cantabria (71%); in contrast, 42% of beds in nursing homes are public in Madrid (AEDGSS, 2023).

CURRENT CAPITAL STOCK

The number of hospitals per million inhabitants 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 (OECD, 2023b).

In 2021, 60.3% (468) of the 776 hospitals in Spain were part of the SNS. Overall, 71.9% of hospitals had fewer than 200 beds; 16 hospitals, all of them in the public sector, had more than 1000 beds (Ministry of Health, 2022e).

According to the information system on specialized centres, most of the hospitals are classified as general hospitals (63% in the SNS and 66% in the private sector): 7% in the SNS and 15% in the private sector were monographic hospitals dedicated to oncological, maternal or rehabilitation care; 95 hospitals in the SNS were considered medium- or long-term care

hospitals (20%) against 17 private hospitals (5.5%); finally, 45 mental health hospitals are owned by the SNS (9.6%) and 42 (13.6%) are in the private sector (Ministry of Health, 2022e). As a note of clarification, besides monographic hospitals, general hospitals may have dedicated departments or units for obstetric care, mental health, oncology or rehabilitation.

According to the Information System for Primary Care, the SNS had 3042 primary care centres and 9998 local health offices in 2022 (see definitions in Section 5.3 *Primary Care*). The number of primary care centres and local health offices has remained stable over the years (Ministry of Health, 2023k).

REGULATION OF CAPITAL INVESTMENT

Capital investments are a usual part of the annual public budget for health care in the regions; thus, it depends on the allocation of investment resources after the discussion on the annual regional budget in the regional parliaments. However, the Spanish public sector has usually had to resort to PFIs to tackle restrictions on public investment. This mechanism was particularly relevant in the aftermath of the 2008 economic and financial crisis. The Ministry of Economy has promoted in recent years various initiatives aimed at financing investment costs, including the Innovative Technology Public Procurement programmes and Pre-Commercial Procurement (see Sections 3.6.1 *External sources of funds* and 3.6.2 *Other sources of financing*).

In the current period of study, NextGenerationEU funds have been articulated in Spain through the Recovery, Transformation and Resilience Plan (*Plan de Recuperación, Transformación y Resiliencia*), where 74.5% of funds in health were allocated to the Investment Plan for high-tech equipment in the SNS (Ministry of Health, 2021c). Another mechanism for capital investment is found within the PERTE (Projects for Economic Recovery and Transformation) dedicated to 'Health of Vanguard', approved by the Council of Ministers on 30 November 2021; one of the financing priorities has been the development of a digital SNS and strengthening primary health care through digital transformation (Spanish Government, 2021).

INVESTMENT FUNDING

Public capital investments in Spain experienced a significant decrease, from 4.4% of total public health expenditure in 2008 to hardly reaching 1.5% in 2013. Since then, capital investment has grown steadily, reaching 2.3% of total expenditure in 2021 (Ministry of Health, 2023i). In absolute numbers, capital expenditure plummeted from €2966 million in 2008 to €924 million in 2013 – as a reflection of the austerity measures implemented in the aftermath of the 2008 economic and financial crisis – and then increased again, reaching €2038 million in 2021 (Ministry of Health, 2023i[15]).

In 2020, there was a dramatic increase in capital investments as high as 73.5% (with respect to 2019) meant to address the impact of the COVID-19 pandemic. In 2021, the percentage of total public health expenditure allocated for capital investment varied across regions, ranging from 0.6% in Asturias to 4% in Castile-La Mancha (Ministry of Health, 2023i). Although several ACs have initiated some Innovative Technology Public Procurement programmes and Pre-Commercial Procurement programmes, there are no official data showing the actual investment amounts.

4.1.2 *Medical equipment*

EQUIPMENT INFRASTRUCTURE

The vast majority of high-tech resources and units in the SNS are placed in inpatient settings. The remaining high-tech units are installed in outpatient specialized premises run by the hospital to which they are hierarchically linked, and whose professional staff is part of the hospital.

In 2021, the Spanish Government, as part of the Recovery, Transformation and Resilience Plan, implemented the INVEAT Plan aimed at renewing obsolete equipment and improving the density of technology per inhabitant. The Plan had a total budget of €796 million (of which, €400 million was invested in 2021) and included linear accelerators, computerized tomography

[15] In response to the investment cuts established by austerity policies between 2010 and 2014, some equipment and technology needs were moved from the investment chapter to current expenses on goods and services (rent, payment for consumables, etc.). This option continues to be used, although there are no estimations on the actual budgetary impact.

(CT), magnetic resonance imaging (MRI), positron emission tomography (PET), PET-CT, gamma camera, digital brachytherapy equipment, vascular angiography, neuroradiological angiography and haemodynamics' theatres (Ministry of Health, 2021c).

Medical equipment has increased from 2015 to 2021. Provisional values show us that PET scanners increased from 1.6 to 2.1 machines per million inhabitants; gamma cameras from 6.6 to 7.3 devices per million inhabitants; mammography machines from 16.3 to 17.3 per million inhabitants; CT scanners from 18 to 21.4 machines per million inhabitants; MRI devices from 15.9 to 20.3 per million inhabitants; and radiation therapy equipment from 4.9 to 7.3 per million inhabitants (OECD, 2023a). As compared to other OECD countries, the SNS ranks 23rd (out of 30 countries) in the rate of CT exams, slightly below the median rate in the case of PET scans and above the median rate of the OECD in MRI exams, occupying 6th place (OECD, 2023a).

In 2021, a 1.8-fold difference across regions was observed in CT scanners per 100 000 inhabitants (Extremadura showing the highest number with 2.8 and La Rioja showing the lowest with 1.6 CT scanners per 100 000 habitants). Similarly, there was a 2.2-fold difference in MRI devices across regions (2.3 MRI devices in the Balearic Islands compared to 1.0 in Cantabria, per 100 000 inhabitants). Regional differences were also found in haemodynamic equipment (2.3-fold difference) with Madrid and Cantabria being the extreme cases, at 0.78 and 0.34 per 100 000 inhabitants, and up to seven-fold difference in haemodialysis equipment (with Navarre and Cantabria showing the highest (17.3) and lowest (2.8) numbers per 100 000 inhabitants, respectively) (Ministry of Health, 2023a).

In terms of high-tech imaging examinations (a measure of the utilization intensity of those infrastructures), the SNS yields 134 CT scans per 1000 individuals and 110 MRI exams per 1000 inhabitants (OECD, 2023a) (Table 4.1).

TABLE 4.1 Items of functioning diagnostic imaging technologies (MRI units and CT scanners) per 1000 population, 2021

	SPAIN (PER 1000 INHABITANTS)	OECD 30 (PER 1000 INHABITANTS)
MRI exams	110	84
CT scan exams	134	165

Source: OECD (2023a).

4.1.3 *Information technology and eHealth*

The SNS eHealth strategy, conceived in the early 2000s, led to the development and implementation of three major eHealth projects. First, the 'Insurance ID card', fully implemented in 2010, entailed the provision of a unique e-identifier to every Spanish resident, allowing the secured exchange and management of personal data (Ministry of Health, 2023l). Based on these ID cards, Electronic Medical Records were developed aimed at exchanging relevant clinical information across the SNS with a view to guarantee access to patients and doctors irrespective of the AC of residence or treatment. Currently, the 17 ACs and INGESA can issue different clinical reports upon request, including the 'patient summary', which includes a subset of relevant data for the patients in order to be provided appropriate care if they move to another region.

Likewise, full interoperability of Electronic Prescription across the country was accomplished in March 2019, with all ACs' developments certified by the Ministry of Health, allowing any doctor to e-prescribe and any retailing pharmacy to dispense medicines to patients irrespective of the region where they were prescribed. These achievements have paved the way for the fruitful participation of Spain in 'MyHealth@EU', the name coined for the EU's patient summary and e-prescription projects, and already operational in 11 Member States, which enables sharing e-prescriptions and patient summaries across countries within the EU (Ministry of Health, 2023l).

Regarding teleconsultations, since the COVID-19 pandemic there has been a significant increase in the use of remote consultations with the share of adults receiving services from a doctor via telemedicine sharply increasing

from 48.2% in 2020 to 71.6% in 2021 (OECD/European Union (2022). In 2021, the number of annual teleconsultations per person reached 3.1, whereas the number of in-person consultations was 4.8 (OECD, 2023a). Importantly, in December 2021, the Ministry of Health released the National Strategy on Digital Health with a focus on enhancing e-Health (see Section 2.6 *Health information system*). This Strategy develops three action lines: the development of digital health services targeting people, organizations and processes; the full interoperability of health care information across regions; and data analysis enhancement (Ministry of Health, 2021b). The Strategy also includes the development of the National Health Data Space for the secondary use of data in the context of the creation of the European Health Data Space for secondary use (so-named 'HealthData@EU') (European Parliament, 2024). For this purpose, several Inter-Ministerial and Inter-territorial technical working groups have been set up to discuss the governance, the bases of legitimacy of the reuse of data, the organization of the national space in the context of a federal health system, and the technological elements of the secondary use of health data.

4.2 Human resources

4.2.1 *Planning and registration of human resources*

There has been a substantial increase in the number of medical schools in Spain, from 28 in 2010 to 53 in 2023 (public and private), offering a total of 7519 places in that year (Ministry of Science, Innovation and Universities, 2023). Nevertheless, there were 6316 graduates in Medicine in 2023, the lowest number since 2016, and below the European Regional average (15.3 graduates per 100 000 population) (Barber-Pérez & González López-Valcárcel, 2022; WHO Regional Office for Europe, 2022b).

Specifically, in order to increase the number of graduate physicians, 706 new places for Medicine Degrees at public universities were offered in the academic year 2023–2024, reaching a total of 6106 places in the first-year course. Public universities received €52 million from the Spanish Government to support this increase (Royal Decree 698/2023).

In any case, the number of new graduates did not match the number of vacancies in the Medical Internship Programme (known as 'MIR'), the

nationwide specialization programme that establishes a doctor's entitlement to practise in the SNS (for example, in 2023 there were 8772 vacancies, Order SND/990/2023).

This mismatch between new graduates and the offer of specialist training places, which exists concurrently with an unbalanced replacement rate (for example, 60% of the Family Doctors are over 50 years of age) may lead (if it has not already) to a shortage of medical doctors for some specialties.

In order to foresee an appropriate number of physicians for each specialization according to unmet needs, the Ministry of Health periodically orders a report assessing the supply and demand of medical specialties. The report aims to help inform decision-making about variables affecting physician availability: age of retirement, number of Medical Internship vacancies or the overall Medicine University quote.

The latest report published in January 2022 (Barber-Pérez & González López-Valcárcel, 2022) stated that in 2021 the specialties with the largest deficits were: family medicine (with the highest predicted shortage in 2027), anaesthesiology, geriatrics, psychiatry and radiology (the reference point to determine the gaps was a 2021 expert survey assessing needs at the time). In a predictive model on mid-term needs, these specialties also forecast deficits in covering needs in 2028. On the other hand, clinical analysis, cardiac surgery and internal medicine were the specialties with the largest surplus in 2021. Regarding the future needs of the health system, based on country demographics and need ratios, the report's authors concluded that long-term needs for physicians would increase by 9% in 2035. In addition, as a sharp increase in the ageing population (particularly those aged 80 and over) is expected in the upcoming years, the SNS would need more physicians treating chronic and multimorbid patients (primary care and internal medicine) and fewer paediatricians. Based on this evidence, the Inter-territorial Council mandated the Spanish Ministry of Health to increase the number of positions for the Medical Internship Programme. Consequently, since 2019 there has been a significant growth in the number of positions, from 6797 vacant positions to cover in the 2019 call to 8772 in the 2024 call (29% increase) (AMIR, 2024). Likewise, the number of positions for training in the six nursing specialties has also increased – even more than in the case of physicians, from 1092 nurse training vacancies to cover in the 2019 call, to 2108 in the 2024 call (93% increase) (Order SND/990/2023).

Registration, licensing and access to specialization of health professionals in Spain is regulated by the Health professions organization Law (Law 44/2003). Since 2003, there have been very few changes to the registration and licensing requirements set out in the legal text.

4.2.2 *Trends in the health workforce*

Relative to the averages in the European Union, Spain has a higher density of doctors and a lower density of nurses (Fig. 4.2). As Fig. 4.3 shows, the number of practising medical doctors in Spain is significantly above the EU average and follows the same growing trend as in other EU countries. Thus, from 380 active physicians per 100 000 inhabitants in 2014, the number has increased, reaching 449 in 2021. The largest increase was in the period from 2018 to 2019 (402 to 440). The EU average ranged from 302 active physicians per 100 000 population in 2015 to 325 in 2021 (Eurostat, 2023m).

In contrast, in the case of nurses, the rate in Spain remains below the EU average (Fig. 4.4). In 2021, there were 634 nurses per 100 000 inhabitants in Spain, whereas the EU average in 2020 was 779 (Eurostat, 2023m). The ratio of nurses to doctors in 2021 was 1.41, below the EU average of nearly 2 (1.97) (Eurostat, 2023m[16]).

The primary care workforce remained constant throughout the period 2014–2022, ranging between 76 and 78 primary care physicians (Family Doctors) per 100 000 assigned population and from 65 to 70 per 100 000 assigned population in the case of PHC nurses. In contrast, the number of specialized care staff has increased in recent years: the number of specialist physicians working in hospitals and outpatient specialized settings has increased from 181 per 100 000 inhabitants in 2014 to 214 in 2022. Similarly, staff nurses working in hospitals and outpatient specialized premises rose from 314 to 387 nurses per 100 000 inhabitants in the period 2014–2022 (Ministry of Health, 2023a).

Health care staff in Spain are older than the European average. Specifically, in 2020, 32% of doctors are over 55 years old in Spain, whereas this percentage is 30.1% in Europe. In the case of nurses, in Spain 20.9% are

[16] This relatively lower nurses' density is influenced by the fact that Spain does not report nurse assistants (or nursing aides) in the statistics. This constitutes a large category of workers in the SNS. Midwives are included in the ratio.

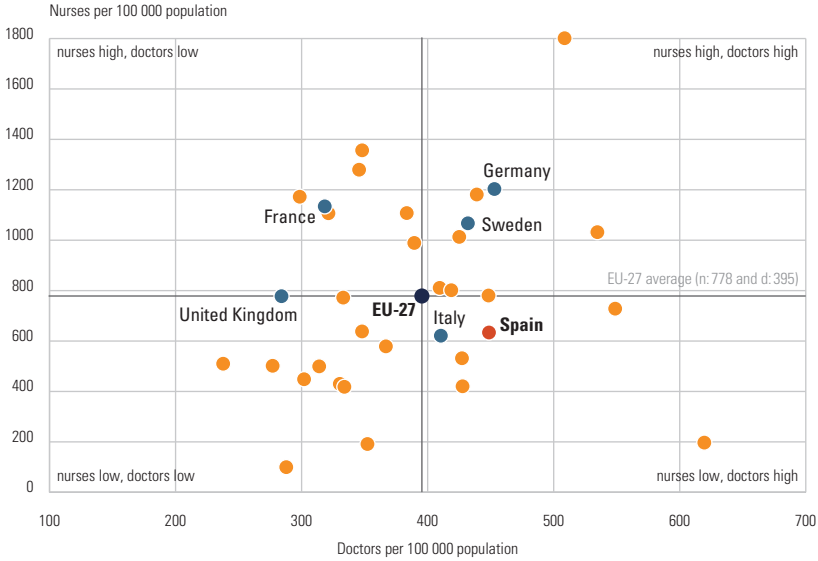
over 55 years old, while in Europe this percentage is 18% (WHO Regional Office for Europe, 2022b).

From a gender perspective, the number of women accessing staff positions as physicians has continued to grow, from 52.6% in 2015 to 57.6% in 2021, which is above the European average of 52% (Eurostat, 2023n). In public centres, the figure reaches 61% of physicians. The number of women accessing staff positions has varied according to the workplace; in 2020, 62% of PHC physicians were women (11 percentage points more than in 2010, and 6 percentage points more than in 2015), but in the case of hospitals and outpatient specialized settings, the share of women remained slightly lower (55% of medical staff in 2020), although improving on 2015 figures, with a 5.3 percentage points increase. However, the gender gap remains as women are not reaching leadership positions in health care, professional organizations, academic positions and research. For example, just 26% of women held the position of head of department at medical universities in the academic year 2020–2021 (Santucci et al., 2023).

In the case of dentists, although there are some working as salaried staff in primary care settings, most are private providers that generally work in small practices and increasingly as salaried workers in franchising companies. From 2010 to 2020 there has been a 43% increase in the number of dentists. In 2020, the average ratio of inhabitants per dentist was 1192, with Madrid showing the lowest number at 778 inhabitants per dentist and Castile La Mancha the highest across regions at 2021 inhabitants per dentist (General Council of Dentists, 2022).

In the case of pharmacists, in 2022 there were 79 288 registered pharmacists in Spain, with 71.9% of them being women. Around 56 502 pharmacists (71%) worked at community pharmacies that year: 45% of them were owners of community pharmacies, whereas 44.2% worked as assistant pharmacists. Spain has one of the highest rates of pharmacists in the EU, with 126 pharmacists per 100 000 inhabitants in 2021, showing a 5% increase from 2015 to 2021 (Eurostat, 2023m). The variation in the rate of pharmacists across ACs in 2022 ranged from 123 per 100 000 inhabitants in the Balearic Islands to 232 per 100 000 inhabitants in Navarre (General Council of the Official College of Pharmacists, 2023).

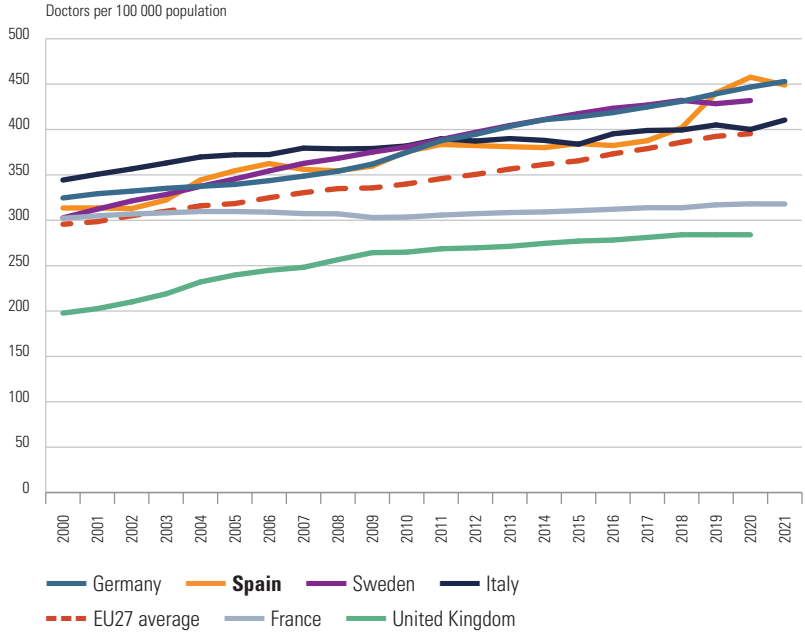
FIG. 4.2 Practising nurses and physicians per 100 000 population, latest available year



Source: Eurostat (2023o).

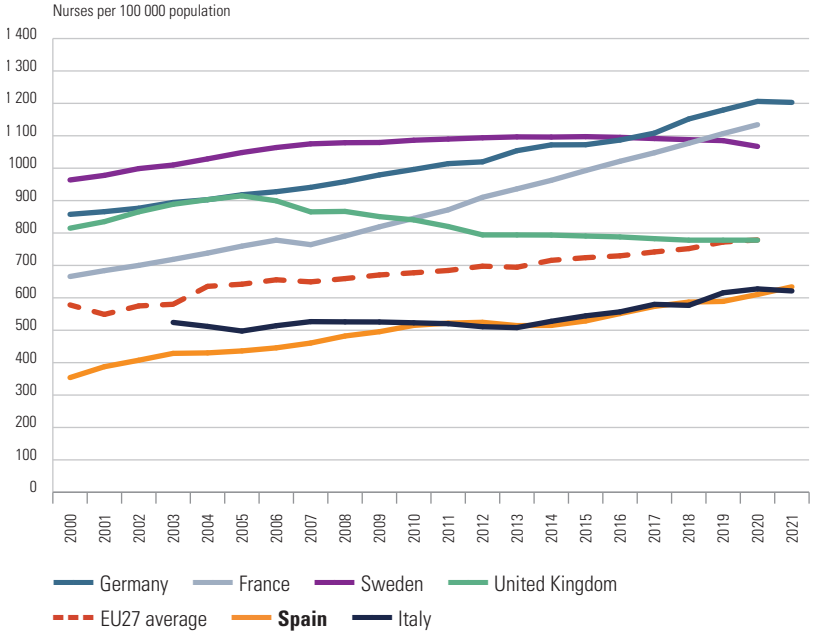
Note: Data for Spain is for 2021.

FIG. 4.3 Number of physicians per 100 000 population in Spain and selected countries, 2000 to latest available year



Source: Eurostat (2023o).

FIG. 4.4 Number of nurses per 100 000 population in Spain and selected countries, 2000 to latest available year



Source: Eurostat (2023o).

BOX 4.2 Are health workers appropriately distributed?

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, respectively. Specifically, the number of primary care workers in 2022 ranged from 62 in the Balearic Islands to 110 in Castile-Leon in the case of physicians per 100 000 assigned population (1.8-fold difference), and from 51 in Madrid to 92 in La Rioja for nurses per 100 000 assigned population (1.8-fold difference). Regarding specialized care workers, in 2022 values ranged from 161 doctors per 100 000 inhabitants in Andalusia to 270 doctors in Asturias (1.7-fold difference), and from 333 nurses per 100 000 inhabitants in Andalusia to 691 nurses per 100 000 inhabitants in Navarre (2.1-fold difference) (Ministry of Health, 2023a).

There is a shortage of physicians in some specialties and problems in covering vacancies in some rural areas, both in primary and hospital settings. The major problem regarding this issue is the lack of primary care physicians. There are Medical Internship vacancies in family medicine that are not filled, and some trained doctors prefer to work in emergency units or in the private sector as these may offer better conditions. In order to solve the problem, in March 2023 the Commission on the SNS Human Resources approved a technical document providing guidance for the identification of these hard-to-fill positions in primary care, as well as the type of incentives that could be used to make these positions appealing to health care professionals (Ministry of Health, 2023m). This document was one of the action points foreseen within the National Strategy for Primary Care for the period 2022–2023. Some examples of the 13 criteria defining these positions are: distance from the primary care setting to the referral hospital longer than 70 km (or that it takes more than 40 minutes getting to the hospital by car); positions with more than 40 attended patients per day; positions where population density is lower than the average in the region; positions where the ageing index is above the regional average; or positions where housing rental prices are above the regional average. If a primary care practice fulfils at least five of those criteria, regions could incentivize the position using, among other things, extra payments and bonuses, facilitating access to housing, improving professional careers, having preferential access to continuous learning or investigation projects, or implementing measures meant to reconcile work and private life (Ministry of Health, 2023m).

4.2.3 *Professional mobility of health workers*

Spain is a net importer of doctors, and together with Germany and the United Kingdom was one of the main countries of destination in absolute terms for foreign-trained doctors and nurses in 2020 (WHO Regional Office for Europe, 2022b). The immigration of non-specialist doctors, who mainly come from Latin America, correlates with the economic cycle and with public spending on health. In that regard, until 2019 there has been a continuous increase in the number of doctors trained in foreign countries, when 6354 physicians entered Spain to work. The decrease observed during the COVID-19 pandemic was overcome in 2021 with an inflow of 4293 qualified Medicine graduates (Barber-Pérez & González López-Valcárcel, 2022). There is a high demand in the private sector for these non-specialist doctors. Speeding up the official recognition of medical degrees has become a policy instrument for workforce management when the SNS is suffering from some extreme shortage (Barber Pérez & González López-Valcárcel, 2024).

When it comes to outflows, in the aftermath of the economic crisis (after 2012) the number of physicians requesting the 'certificate of good standing' required to work in other EU countries increased from 2405 in 2012 to 4100 in 2019. In 2020, requests decreased to 3559. However, many doctors ask for more than one competence certificate (they are different for each country), and in many cases they do not move to another country, so the actual number of Spanish doctors arriving in other countries is lower (Barber-Pérez & González López-Valcárcel, 2022). According to OECD figures, in 2020, 204 new Spanish physicians enlarged the number of doctors working in foreign countries (Barber-Pérez & González López-Valcárcel, 2022). The usual destinations for doctors have been the United Kingdom, France, Germany, Ireland and Belgium. When it comes to Family Doctors, the underlying reasons for this outflow are insufficient salary, job insecurity and timeframes of contracts, excessive workload, poor primary care governance and lack of flexibility (Calderón-Larrañaga et al., 2024).

Similar behaviour was observed in the case of nurses; between 2010 and 2013, 4580 nurses requested the 'certificate of good standing' from the Ministry of Education; in 2014, 8000 nurses were working abroad (Galbany-Estragués & Nelson, 2016), while in 2022 the number reached approximately 1100 nurses. In this case, the main destinations have been Norway, the United Kingdom and Ireland (General Council of Nurses, 2023).

4.2.4 *Training of health personnel*

In 2022, 31 293 medical doctors were trained within the medical residents' programmes. The specialty of Family and Community Medicine was the specialty for most residents in training (8477 residents, 27.1% of the total), followed by paediatrics (1909) and internal medicine (1758). Likewise, Family and Community Nursing was the nursing specialty for most nurses in training (1416 in 2022, 42%), followed by obstetric gynaecological nursing (865, 26%) and mental health nursing (486, 14%) (Ministry of Health, 2023o).

On a different note, prompted by the Recovery, Transformation and Resilience Plan, the Ministry of Health and the Ministry of Universities promoted in 2022 the requirements and procedures for the inclusion of new specialties in health sciences (medical and nursing internship programmes) (Royal Decree 589/2022). The first new specialty proposed under this new regulation is the title of specialist in Emergency and Emergency Medicine (Royal Decree 610/2024).

4.2.5 *Physicians' career paths*

Physician careers, regulated in Article 38 in Law 44/2003, have not changed in recent years. The upgrading mechanisms foreseen in this Law, and which entail salary supplements or training benefits, are dependent on ACs' policies, which may translate into differences across regions.

The large increase of temporary workers in the public sector over the years (from 28.5% in 2012 to 41.9% in 2020) (Hernández Pascual & Cabezón Rodríguez, 2022) has prompted some reforms to improve job stability. Hence, from July 2022, temporary contracts in the SNS must be limited to a maximum of three years' duration and are restricted to specific situations (for example, health programmes) or to cover long-run vacancies. In the case of need for the specific post to remain, health authorities are obliged to create a permanent position in the corresponding health care provider (Royal Decree-Law 12/2022). In the specific case of primary care, the objective is to reduce the share of temporary contracts below 8% (Ministry of Health, 2021d).

4.2.6 *Other health workers' career paths*

As in the case of doctors, other health workers' careers are regulated in Article 38 in Law 44/2003 and no changes have been observed since the last HiT report except the implementation of policies improving job stability.

Notably, an important achievement in nursing has been the approval of nursing prescriptions. Since October 2018, nurses are entitled to decide on the medicine indication, and utilize and provide prescription drugs, subject to the existence of protocols and clinical guidelines that should specify in which cases prior medical validation is needed. Additionally, nurses can prescribe the vaccines included in the official vaccination calendar or those related to specific vaccination campaigns. To prescribe, staff nurses are required to obtain a certification demonstrating professional experience or having passed a specific training programme (Royal Decree 1302/2018).

5

Provision of services

Summary

- As part of the reflection process following the COVID-19 pandemic, a national public health strategy was published in 2022, which created a reference framework for the coordination of all the actors involved in public health.

- A Strategic Framework for Primary and Community Care agreed by the Ministry of Health and the ACs aims to meet the current needs and future challenges of primary care.

- The large variation in prescriptions and the uneven growth in expenditure across regions raise concerns about the impact of pharmaceutical care on the overall efficiency of SNS resource allocation. Efforts to increase evidence-based prescribing have led to great success in antibiotic prescribing, although have failed in the reduction of the consumption of antidepressants and hypnotic drugs.

- The national system for the assistance of dependent people (namely, SAAD) has been consolidated in recent years, and it currently assists almost 1.3 million people. Some concerns about the sustainability of the current financing framework cast certain shadows on the system's longer-term development.

- The SNS has drawn up a mental health strategy for the period 2022–2026, putting the focus on the inclusion of a gender

perspective, the fight against stigma, the advocacy of a community approach to mental health care, and an enhanced role for informal caregivers.

- The acknowledgement of unmet needs in dental care has led the SNS to approve a new Dental Health Plan, which aims to increase the share of the population eligible for public services and to extend the benefits package.

5.1 Public health

5.1.1 *Public health institutions and authorities*

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 (see Section 2.3 *Decentralization and centralization*). Public health within ACs has a dedicated structure where a public health authority, usually a General Directorate within the Health Department, a) ensures the enforcement of the regulations passed to support public health policies; b) holds the executive planning role for operational public health services; c) coordinates population-based programmes (such as vaccination or cancer screening programmes); and, d) monitors 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 PHC doctors and nurses are the core public health agents; they represent the main workforce in the deployment of population-based programmes, although they are mainly focused on prevention programmes (infant and older people vaccination programmes, primary and secondary prevention of noncommunicable diseases, opportunistic screening activities, counselling activities).

Other relevant public health agents are teachers and NGOs, who work as mediators in the implementation of prevention and health promotion programmes, as well as municipalities, as critical 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 (such as healthy cities networks).

Besides the public health activities developed at regional level, the Ministry of Health, through the General Directorate of Public Health, holds responsibility for certain public health tasks such as international health activities, international movement of commodities and passengers, food safety regulation, the system of alerts for health emergencies and, notably, the coordination of the 17 public health units of the ACs' Departments of Health and INGESA (see Section 2.2 *Organization*). This coordination usually takes place within the ICISNS, particularly throughout the working groups that compose the Public Health Commission, where public health strategies are agreed, ensuring cohesion and quality across the country.

5.1.2 *Public health strategies*

An important milestone was the publication of Law 33/2011 on Public Health, which issued the principles and actions to include 'Health in All Policies' in institutional actions on health, and sought to update and upgrade the coordination mechanisms amongst the 17 AC Departments of Health and INGESA, essentially in terms of epidemic surveillance and control, and the provision of common benefits: namely, a common vaccination calendar, common neonatal screening tests and cancer screening. Some elements, such as the creation of a National Agency for Public Health, have recently been approved as a draft law (See Section 6.2 *Future developments*).

Importantly, the reflection process following the COVID-19 pandemic prompted the publication of the national public health strategy (Ministry of Health, 2022b), creating a reference framework for the coordination of all the actors involved in public health. In addition, the Strategy has been thought of as an instrument that efficiently articulates and links the different public health initiatives developed at international level, translating actions into national, regional and local policies. Main strategic lines are strengthening public health to improve the health of the population; modernizing public health surveillance and ensuring preparedness to respond to health risks and emergencies; improving health and well-being through the promotion of healthy, safe and sustainable lifestyles and environments; and promoting health and health equity throughout the life course.

In the specific case of public health surveillance, the Strategy aims to leverage health information in a timely manner, since the COVID-19 pandemic revealed weaknesses and structural failures in surveillance. The

general objective is to set up a flexible, homogeneously developed National Surveillance Network in the SNS. The network will collect, analyse, interpret and disseminate information about health population status, health determinants and public health risks, generating knowledge to reinforce preparedness, to support decision-making and to evaluate public health actions. The Strategy has 30 objectives grouped into seven strategic lines, notably the development of a workforce policy to guarantee the quality and effectiveness of public health surveillance, an authoritative role for public health surveillance in decision-making, and a new governance framework for public health surveillance based on a National Network, where hubs are the general directorates of public health in the ACs.

5.1.3 *Immunization*

In 2021 and 2022, the effective implementation of the COVID-19 vaccination programme was notable, with Spain being one of the leading countries in terms of timely coverage; for example, Spain was the first country to vaccinate 100% of the population aged 80 and older and reached high vaccination coverage rates in people over 12 years of age with a complete vaccination schedule. More than 39.1 million inhabitants, or 92.8% of the population, were vaccinated. Furthermore, 80% of people aged 40 and older were covered with a booster (Ministry of Health, 2022f).

Other public health programmes remain active since their introduction over the last decades. Coverage of vaccination programmes for children remains high and stable over time: in 2022, a 95% coverage rate was seen for primo-vaccination in polio, DTaP, triple viral, pneumococcal, and meningococcal vaccines, while a 91% coverage rate has been reached for the chickenpox (Varicella) vaccine (Ministry of Health, 2023p). In 2022, flu vaccination in people aged 65 and over had a 68.6% coverage rate, mainly due to the combination of both flu and COVID-19 annual vaccination campaigns (Ministry of Health, 2023a).

BOX 5.1 Are public health interventions making a difference?

Tobacco consumption has experienced a reduction in the past decade: in 2020, 19.8% of the Spanish population over 15 were daily smokers (23.3% men and 16.5% women) against 23% in 2014 (27.6% men and 18.6% women) (Ministry of Health, 2023a). People with higher income levels record lower prevalence rates, although reductions are observed also for the worse-off. For the better-off, the observed decrease in smoking was from 20.4% in 2014 to 14.3% in 2019; whereas for the worse-off, the decrease was from 27.4% in 2014 to 24.5% in 2019 (Eurostat, 2023k). 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 allegedly behind this continuous reduction (SEE, 2017).

Alcohol consumption among adults in Spain increased between 2010 and 2021 and is now higher than in many 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%). Nearly one in four (24%) 15-year-old children reported having been drunk more than once in their life in 2022, a proportion above the EU average (18%) (OECD/European Observatory on Health Systems and Policies, 2023).

Obesity and overweight in Spain are a matter of growing concern, with a greater impact on people with lower levels of formal education, and especially children. Although a slight improvement has been observed in obesity in adults (decreasing from 17% in 2014 to 16% prevalence in 2020), overweight continued to increase until 2020, reaching a prevalence rate of 37.6% (44.9% for men and 30.6% for women) (Ministry of Health, 2020b). For children (6–9 years old), the implementation of the Nutrition, Physical Activity and Obesity prevention Strategy (NAOS) has resulted in a decrease of the overweight prevalence (AECOSAN, 2019). Interestingly, 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). It is notable that deaths attributed to dietary risks are much lower in Spain (10%) than the EU average (17%) (OECD/European Observatory on Health Systems and Policies, 2023).

5.1.4 *Screening programmes*

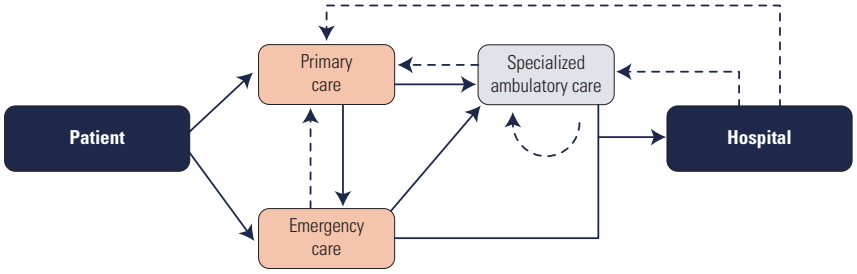
The Health Departments of ACs are responsible for the executive coordination of population-based screening programmes. Regarding cancer screening, there has been an increase in coverage, which has been particularly high in the case of colorectal cancer. Coverage for population-based breast cancer screening programmes has slightly increased over time, from 75.2% in 2015 to 81.9% in 2020 (Ministry of Health, 2023a). The population-based screening programme for colorectal cancer has witnessed a sharp increase; faecal occult blood tests covered 32% of the target population in 2020 (12.4% in 2014) similarly for both men and women (Ministry of Health, 2020b). Pap-smear tests have remained stable, above 70% of the eligible population, since 2014. However, coverage is greater in the better-off (higher income) populations: 6% higher for breast cancer and colorectal cancer screenings, and 10% higher for cervical cancer (2017 data). Differences across ACs are also notable (Ministry of Health, 2023r; Ministry of Health, 2020b).

5.2 **Patient pathways**

Within the SNS, the typical patient pathway is shown in Fig. 5.1, which applies to the whole country. As Family Doctors play a gatekeeping role in the SNS, they are the first point of contact with the health system (see Section 5.3 *Primary care*). As the only exception, residents may freely access A&E departments without the need for a referral from primary care[17] (see Section 5.5 *Urgent and emergency care*).

[17] Interestingly, the affiliates of the Mutual Funds (see Section 2.2 *Organization*) are allowed to directly get an appointment with a specialist without being referred by a Family Doctor.

FIG. 5.1 Patient pathway



Source: Authors' elaboration.

In general, upon the onset of symptoms, individuals will visit or get a remote consultation (telephone call or online), with the PHC doctor with whom they are registered. The episode can be resolved by direct prescription or recommendation, follow-up in the same premises, or may require further diagnostic procedures. In this case, the patient will be given an appointment for testing (that is, lab and X-ray tests) and another appointment to return to the Family Doctor's office where the results will be available in a few days. The Family Doctor's clinical judgement will determine whether referral to specialized care is required; Family Doctors in Spain are trained and equipped to deal with a wide range of conditions, thus patients will mostly have their problem solved at this care level.

When referral is necessary, the patient will be provided with an appointment for the corresponding specialist, usually in an outpatient setting. Based on the Family Doctor's referral report and their clinical assessment, the specialists will decide on the need for further testing or inpatient procedures or will prescribe the treatment and either send the patient back to the Family Doctor or arrange follow-up visits. Once the specialist discharges the patient, a report is sent to the referring Family Doctor.

If the decision involves inpatient care, the patient will be admitted to the corresponding hospital service, the timing depending on the waiting time for the corresponding procedures (diagnostic or surgical). Doctors have the right to prioritize patients according to their clinical judgement in order to accelerate the process. Once discharged from the hospital, the patient is given an appointment for ambulatory follow-up, either at the specialized

ambulatory services hierarchically linked to the hospital department, or at PHC level where PHC physicians and nurses will take over managing the prescriptions recorded in the clinical report at discharge.

Should the patient's condition be considered chronic at any of the previous stages, or at the time of their discharge from specialized care, the Family Doctors would require the intervention of the PHC nurse for support and coordination of continuous follow-up and, depending on the social situation, for assessment by social services. If required, patients can be referred to rehabilitation services either by the specialist or by the Family Doctor.

Besides this regular pathway, two emergency mechanisms are available for patients to freely walk in: PHC centres (PCCs) and hospital emergency wards. The former varies according to supply organization and expected demand: in rural, dispersed areas, there is a 24-hour service, while in urban highly populated areas, PHC services are complementary to hospital A&E wards, with a timetable covering 3pm to 8pm. In turn, hospital emergency departments offer 24/7 services. In addition, if the patient's condition does not allow for walking-in, patients can demand a home visit by the PHC service or use the emergency call centre to request a mobile emergency team. Patients are advised to use PHC emergency services over hospital emergency wards for non-life-threatening conditions. Waiting times are shorter and staff are normally equipped to deal with most of the common urgent conditions; should it be necessary in the end, patients referred to the hospital emergency departments from PHC have priority in terms of emergency admission.

5.3 Primary care

PHC is essentially provided by public providers where specialized family doctors and staff nurses make up 'PHC teams[18]'. Depending on planning criteria, they might be complemented with paediatricians and specialized paediatric nurses, physiotherapists, dentists, psychologists and social workers.

This model, designed in the 1986 General Health Act, remains fairly homogeneous across the country, although three different managerial models coexist: a) the classical structure where, in the same health care area, PCCs with a hierarchical dependency on the regional service are run independently from specialized care; b) integrated management, with a single manager running the continuum of care services, spanning primary and specialized care; and, c) the externalization of PCCs by way of different management mechanisms from public municipal consortia to public-private partnerships (P-PPs) (see Section 2.7.2 *Regulation and governance of provision*) or 'for-profit limited partnerships' (known as *Entidades de Base Asociativa,* based in the AC of Catalonia) (see Section 3.3.4 *Purchasing and purchaser–provider relations*).

PHC professionals provide a comprehensive range of services under three modalities: appointments demanded by the patient (on-site or by telephone), planned visits and emergency visits. These visits can take place in the PCC or as home visits. Planned visits follow the recommendations contained in a number of protocols and guidelines clustered in three overarching programmes: child care (vaccination programmes, early detection of health problems, caries prevention and health education), women's health (rubella vaccination, pregnancy and post-partum follow-up, contraceptive methods, menopause counselling and opportunistic detection of cancer), and care of adults and older people (chronic conditions such as diabetes, heart failure and COPD, vaccination for influenza, prevention of cardiovascular disease and follow-up of HIV/AIDS patients). Other activities carried out in PCCs are early detection of frailty situations, counselling on alcohol and tobacco consumption, counselling for chronic conditions, minor surgical procedures, detection of and assistance for those in situations of domestic violence and child abuse, and community outreach actions.

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[18] Except in dental and optical care, the number of private practices providing primary care is almost negligible, and the services included are limited.

Notably, some services are provided in close coordination with other specialized services, such as the early detection and treatment of mental health conditions (for example, addictive behaviour, anorexia, depressive disorders), and follow-up of terminally ill patients. There are additional services such as rehabilitation in the centres with a physiotherapist (see Section 5.7 *Rehabilitation/intermediate care*) or basic dental care in those centres that have a dentist (see Section 5.12 *Dental care*).

Finally, PHC doctors (first contact point for the system and hence the current gatekeepers of the system) are a privileged source of information for the assessment of community health and in particular for epidemiological surveillance; thus, according to the prescriptions of the public health authority (general directorate), they play the role of key informants for the notification of communicable diseases and are members of sentinel networks for the monitoring of public health problems (such as epidemic follow-up and monitoring adverse events associated with drugs utilization).

Moreover, in an effort to increase care continuity and coordination between levels, some ACs are enhancing the role of PHC in the implementation of pathways of care for specific conditions (for example, acute treatment of ischaemic stroke or acute coronary disease) (Bernal-Delgado & Angulo-Pueyo, 2023).

In 2022, public PHC providers received 256.7 million visits to PHC doctors, 156.4 million visits to PHC nurses and 32.7 million emergency visits. On average, this represents 5.4 visits to a Family Doctor per registered individual and an annual total of 6956 visits per Family Doctor. In the case of nurses, the average is 3.2 visits per individual and a total of 4734 visits per nurse (Ministry of Health, 2023k).

A Strategic Framework for Primary and Community Care was agreed by the Ministry of Health and the ACs in 2019 (See 6.1 *Analysis of recent reforms*), aimed at meeting the current needs and challenges of PHC (Ministry of Health, 2019a).

BOX 5.2 What are the key strengths and weaknesses of primary care

Indirect evidence of the effectiveness of primary care in the Spanish SNS can be seen in the relatively low rate of avoidable admissions for chronic conditions (OECD, 2023a), the low levels of unmet needs for medical examination, and the general satisfaction of Spaniards regarding PHC services – in 2022, around 79% of Spaniards declared having received good or very good assistance in PHC (Ministry of Health, 2023c). Keys for success are arguably the institutional design of the SNS according to administrative health care areas (see Section 2.2 Organization), 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. In the period between 2017 and 2021, primary care expenditure increased by 31.5% (Ministry of Health, 2023i).

The distribution of resources enables easy access to health care by the Spanish population; however, one survey shows that only 23.4% of people in 2022 who required care were assisted on the same day or the day after (Ministry of Health, 2023c). Additionally, and despite the general satisfaction with PHC services, around 28.3% of users also declared in 2022 that, if they had to choose, they would prefer a private provider (Ministry of Health, 2023c). This result might have to do with the increasing waiting times in 2022 in providing an appointment when transfers to another provider for additional testing is required (Ministry of Health, 2023c). Finally, there are two relevant issues that concern the primary care workforce. On the one hand, primary care nurses, who have a major role in health promotion and disease prevention, as well as in the continuity of care for patients with chronic conditions, are likely to be under resourced (the nurse to doctor ratio was just 0.9 nurses per doctor in 2022 (Ministry of Health, 2023a). On the other hand, the specialty of family and community medicine is not a preferred choice among candidates applying for medical residency programmes (Barber & González López-Valcárcel, 2022). Additionally, nurses with a specialty in family and community nursing have difficulty accessing positions in PCCs, which tend to be occupied mainly by hospital nurses, who, in the final stages of their working life, seek to avoid afternoon and night shifts.

5.4 Specialized care

Specialized care in the SNS can take the form of outpatient specialized care, inpatient care, day-case care or emergency care.

5.4.1 *Specialized ambulatory care*

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 specialized care level on an outpatient basis until the patient is transferred back to PHC.

Between 2015 and 2019, the number of specialized ambulatory care visits increased by 6%, from 79.7 million in 2015 to 83.6 million in 2019, reducing to 72.7 million in 2020 due to the COVID-19 pandemic. On average, there were 2260 outpatient specialized visits per 1000 inhabitants in 2021. This activity is highly variable across ACs, ranging from 1783 to 2871 visits per 1000 inhabitants (Ministry of Health, 2022d). 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).

5.4.2 *Day care*

Day care includes diagnostic, therapeutic (such as chemotherapy, haemodialysis) and rehabilitation activities for patients who require continuous specialized care, as well as care for patients who are eligible for a major outpatient surgery that does not require an overnight stay in hospital.

Between 2015 and 2019, the number of sessions in day-care hospitals increased by 20%, from 5.1 million admissions in 2015 to 6.2 million in 2019 (5.2 million in 2020 due to the COVID-19 pandemic). For surgical cases, the increase was 6%, from 1.21 million in 2015 to 1.28 million in 2019; in this case, variation across ACs ranged in 2019 from 24% of the total surgical activity to 40%. Additionally, the trend has varied substantially across ACs, with some reducing the proportion of day-case surgeries over the years while other ACs have had the opposite experience; notably, Navarre and the Canary Islands experienced an increase of 26% and 28% in day cases, respectively (Ministry of Health, 2022d).

5.4.3 *Inpatient care*

SNS hospitalizations have remained constant over the last few years, from 5.2 million in 2015 to 5.2 million in 2019. However, in 2020 and 2021, hospitalizations experienced a reduction (4.5 million and 4.8 million, respectively) attributable to the effects of the COVID-19 pandemic (Ministry of Health, 2023a). In population rates, the SNS yielded 107.8 hospital admissions per 1000 inhabitants in 2021 (between 83.7 and 139.6 admissions per 1000 inhabitants depending on the AC of residence), and 105.6 surgical interventions per 1000 inhabitants (ranging from 74.1 to 136.1 interventions across ACs) (Ministry of Health, 2023a).

Unlike primary care, private hospitals make a substantial contribution to the provision of secondary care (22.5% of the discharges, between 8.6% and 43.2% depending on the AC), and 32.6% of surgical interventions (between 17.3% and 47.9%) (2021 data). Compared to 2015, private hospitalizations decreased by 1 percentage point, while surgical interventions increased by 3.3 percentage points (Ministry of Health, 2023a).

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 (see Section 2.2 *Organization*). Depending on the severity and clinical complexity of the condition (and actual capabilities), 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.

Bigger hospitals might also play the role of a 'tertiary' hospital for a broader area of reference, usually within the AC, act as a general hospital or as a referral hospital for other hospitals in the ACs, and in some cases may provide specific services nationwide (for example, transplants, paediatric cardiac surgery, treatment for rare diseases, etc.). The latter received recognition as a 'national reference service' after being authorized by the Ministry of Health (Bernal-Delgado et al., 2018; Ministry of Health, 2024b). In addition, there have been mergers of hospitals in almost all ACs, either as 'hospital consortia', where neighbouring hospitals provide complementary services, or as 'hospital networks', with the largest acting as the central hub, providing common ancillary services.

When it comes to the benefits package, the common package for the whole SNS covers specialized treatment and diagnosis (see Section 3.3.1 *Coverage*). Interestingly, although very few, there are some single-specialty

hospitals in the network. They focus on a single specialty, usually obstetrics and neonatology (maternity hospitals), geriatrics, psychiatry, orthopaedics, ophthalmology or oncology. The trend, though, has been to integrate them into more complex managerial structures associated with big general hospitals.

When it comes to ownership and governance models in particular in hospital care, there is a greater variety as compared to primary care. At least five models co-exist:

a) Public hospitals owned and managed directly by the public system, bound by the Public Administration legal framework, whose personnel are salaried civil servants.

b) Public self-managed hospitals owned by the public system but based on the legal structure of a Foundation or a Public Company. This model, for example, implies that personnel are hired according to private legal frameworks.

c) Hospitals owned by companies, usually within the health sector, that enjoy a stable contractual relation with the ACs' health authorities. These are under the framework of a P-PP, where the Health Authority pays a *per capita adjusted premium* for the company to take over health care provision (that is, all services included in the benefits package) for the population living in a health care area. This initiative has been limited to some health care areas in some ACs, Valencia and Madrid being the best-known examples.

d) Private hospitals and services owned by private foundations, workers' mutualities or religious charities that enjoy a stable contractual relationship and are complementary to public provision. This case is notably observed in the AC of Catalonia, as part of the Hospital Network for Public Utilization (XHUP, acronym in Catalan).

e) Privately owned hospitals and clinics that provide specific services to the public system that usually act as a supplementary network covering some diagnostic tests and procedures, elective surgery in the context of waiting lists' reduction programmes, palliative care, long-term care and non-acute mental health care.

Finally, 64% of public general hospitals in Spain are (or can become, after due accreditation) teaching hospitals, authorized to teach undergraduate students. (Medical schools are usually associated with high-tech hospitals; however, teaching hospitals are not owned or run by universities.) Another

accreditation process determines the hospitals, centres and services that are accredited for the training of health sciences specialists (Ministry of Health, 2022e).

BOX 5.3 Are efforts to improve integration of care working?

The SNS was designed to foster integrated care, with PHC being the main actor. 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 the clinical decisions, ideally shared with the specialist, sometimes acting as mere consultant; and, c) Family Doctors, along with the nursing staff, provide close follow-up over time for the duration of the patient's conditions.

However, financing and purchasing mechanisms in the SNS do not favour care continuity; thus, global budgets and framework contracts do not entail the incentives required to enhance care continuity, particularly in chronic and fragile patients. 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 the AC of 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 (Adjusted Morbidity Groups, GMA) (Ministry of Health, 2018a); implementing normative (that is, evidence-based) pathways, then re-engineering existing processes in specific complex clinical conditions towards care continuity (OSIS and EOXIs); unfolding skills-shifting programmes to allow more flexibility in the continuation of care; and adapting information systems for digital management and evaluation of care processes. Although limited in scope, some formal evaluation is available of the OSI in the Basque Country, of the care pathways in multimorbid patients in Navarre, and of the Strategy for Diabetes in Aragon. However, the development of fit-for-purpose information systems is key to fostering improvements in the quality of care. The lack of publicly available data and the lack of independent evaluations impede full understanding of the programmes' impact (Bernal-Delgado & Angulo-Pueyo, 2023).

BOX 5.4 What do patients think of the care they receive?

The only countrywide information of patients' and citizens' opinion about the SNS is the Health Barometer (Ministry of Health, 2023c), where questions on overall satisfaction, interaction with professionals and waiting lists are provided.

According to the latest 2023 Health Barometer, 81.4% of the patients in the survey reported receiving good or very good care in primary care in 2023, 1.7 percentage points higher than in 2022 (79.7%). Some 69.8% of patients did not receive an appointment on the first day or the day after they requested it; among those, 56.3% received the appointment seven or more days after the request. In the case of inpatient care, 82.8% of patients reported receiving good or very good care, no significant change compared to 2019. Finally, for emergency care, without specifying whether this care was provided in hospitals or in primary care, 75.2% of patients reported receiving good or very good care, a figure similar to that of 2019 (Ministry of Health, 2023c).

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, 2024a). These data, to some extent, corroborate a perception of deterioration of the SNS, especially the perception of primary care, particularly since the COVID-19 pandemic.

5.5 Urgent and emergency care

In Spain, patients with an acute illness will most often walk into hospital emergency wards or PHC emergency facilities (66% of cases in 2019) (Atlas VPM, 2019; Ministry of Health, 2022d); when this is not the case, they either call the PCC directly to request a home visit (which is the regular procedure for bedridden patients already on a home visits regime for mild exacerbations of their condition outside the normal appointment schedule), or the emergency call centre. The operator at the call centre will conduct a short interview to determine the nature of the emergency and decide on the resources to be mobilized. In some simple cases, they will provide advice on how to proceed, assessing whether the person can cope with the situation. They may either send an emergency mobile team immediately or switch the

person to the medical team for further enquiry or specific clinical advice. If the mobile team is called upon, they will arrive at the location. Depending on the assessment of the patient's condition made by the coordination centre, the mobile team could consist of an emergency doctor and a nurse with basic equipment or an intensive care mobile unit. The patient will be assessed to determine the course of action: either treatment will be provided in situ, leaving a copy of the emergency report detailing diagnosis, procedures and prescriptions, or the patient will be stabilized and evacuated to the hospital emergency ward. In 2021, around 89.8% of patients assisted in a hospital emergency ward were discharged or admitted into the hospital in less than three hours (Ministry of Health, 2023a).

As access to hospital emergency wards is unrestricted, patients can inappropriately choose (and often do so) to walk in for other conditions requiring procedures subject to waiting lists to 'jump the queue' or may use emergency services to obtain a quick set of examinations that their family doctor has not deemed necessary. With the aim to make better use of the A&E departments, the SNS has responded to this reality quite homogeneously across the country; no payment at the point-of-care has been set up; in primary care there has been an extension of the time schedule so emergencies are assisted until the evening; also in primary care information campaigns raising awareness on the importance of the proper use of emergency services has been released; and in hospital settings triage systems aimed at prioritizing patients at admission or intermediate services to get patients under observation have been set up.

In 2022, the SNS assisted 637 urgent visits per 1000 inhabitants in primary care settings (stable since 2016). In 2021, there were 591 contacts per 1000 inhabitants in A&E hospital departments (7% less than in 2016) and in 2020, the SNS provided a tele-response to 186 urgent consultations per 1000 inhabitants through the 24/7 emergency phone numbers (061/112), which was 41% greater than in 2016 (Ministry of Health, 2023a).

5.6 **Pharmaceutical care**

The Spanish pharmaceutical sector is one of the most regulated sectors of the Spanish economy (Bernal-Delgado et al., 2018) (see also Section 2.7.4 *Regulation and governance of pharmaceuticals* and Section 6.1 *Analysis of recent reforms*).

Pharmaceutical care, as part of the SNS common benefits package, covers all medicines and health products approved, registered and eligible for reimbursement (see Section 3.3.1 *Coverage*). The basket does not include cosmetic formulae, dietary products, mineral water, elixirs, toothpaste and other health products, over-the-counter medicines, homoeopathic remedies, or any advertised item or accessory targeting the general population. Pharmaceutical care is provided by a) doctors, as prescribers and overall supervisors of treatment; b) nurses, particularly in PHC, in their role as supervisors of adherence and side-effects, and prescribers of a protocolized list of drugs; and c) 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. In 2021, 19 companies had 97% of the market share (with four of these companies having a 70% market share) of pharmaceutical distribution in Spain (FEDIFAR, 2022), comprising 22 198 pharmacy retailers (which are independent authorized agents that enjoy protective regulation that limits competition at the level of distribution) (General Council of the Official College of Pharmacists, 2023). Regulations restrict the dispensation of prescription drugs to qualified pharmacists, include rules to prevent the geographical concentration of pharmacies, and, especially, require a five-year university degree – not only to dispense but also to own a pharmacy – and compulsory enrolment in the College of Pharmacists (Law 16/1997). The authorization to open a pharmacy entails an automatic agreement with the regional health authorities for the dispensation of medicines prescribed in the SNS. In the case of drugs eligible for public reimbursement, the reimbursement of retail pharmacists and wholesalers relies on fixed and price-proportional mark-ups of the consumer price before tax.

BOX 5.5 Is there waste in pharmaceutical spending?

In 2023, the overall number of pharmaceutical prescriptions (not including hospital prescriptions) in Spain increased 33.4%, reaching an overall expenditure of €12.7 billion, €3.2 billion more than in 2015 (Ministry of Health, 2023q). The growth between 2022 and 2023 varied substantially between Spanish ACs. In fact, the growth in prescriptions differed as much as 2.3 times between the region of Murcia with the largest increase (4.6%) and Andalusia, which experienced only a 2% growth. In terms of expenditure, the region of Cantabria showed the highest increase (4.9%) and the Basque Country, the smallest one (1.7%). Finally, the average reimbursement price (€11.30) was observed to vary from €12.20 in the Balearic Islands to €10.80 in Madrid (Ministry of Health, 2023q). If this variation were not a reflection of differences in the regional populations' burden of disease, there would be a need to deploy programmes aiming at cost-containment and the reallocation of resources in those ACs with higher spending.

On a different note, the SNS has implemented some policies for the control of drug expenditure; on the side of controlling unit prices, three intertwined policies were implemented: reference-price setting, prescription by active ingredient and dispensing generic drugs. The effectiveness of these measures has been proven to be dubious, as the average expenditure per prescription billed has increased by 12.8%, from €10.81 in 2015 to €12.20 in 2022 and the pharmaceutical expenditure per capita has increased by 21.1%, from €213.70 in 2015 to €269.60 in 2022 (Ministry of Health, 2023q).

Regarding the number of prescribed drugs, appropriate utilization remains the big challenge for pharmaceutical care in the SNS. Indeed, 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, antidepressants varied almost three times across ACs, from 77.4 to 146.8 defined daily doses per 1000 inhabitants per day (DHD); hypnotic drugs varied as much as 2.5 times, from 25.6 to 64.3 DHD, depending on the AC; and variation in antibiotics varied 1.6 times, from 13.1 to 21.2 DHD (Ministry of Health, 2023a).

Pharmaceutical spending in hospitals has grown by 86% in recent years, from €5153 million in 2014 to €9606 million in 2023 (Ministry of Treasury, 2024). Oncological therapies, rheumatoid arthritis, biologically synthesized drugs, orphan drugs, immunosuppressive therapies, etc., are the main drivers of this expense. The hospital pharmaceutical market is less transparent, and unit prices are directly negotiated between hospitals and distribution companies, which translates into greater spending variability across hospitals and ACs, and allocative inefficiencies (AIReF, 2020).

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 contemplates its use. Methodological (different cost-effectiveness criteria) and administrative barriers (for example, political) are hindering its full implementation (Oliva-Moreno et al., 2020). The recently launched VALTERMED (see Section 2.7.3 *Regulation of services and goods*), an information system to determine the therapeutic value of a drug in real practice in pharmaceuticals with high economic impact, can be a tool for the inclusion of economic evaluations in decision-making.

5.7 Rehabilitation/intermediate care

The provision of rehabilitation has not experienced any noticeable change over recent years. Rehabilitation care is usually provided by dedicated hospital outpatient and inpatient departments. Between 2015 and 2019, the number of rehabilitation and physiotherapy sessions (including inpatient and outpatient secondary care services) has remained constant, from 29.5 million sessions in 2015 to 30.1 million sessions in 2019 (Ministry of Health, 2022d). Interestingly, some PCCs provide continuity of care through physiotherapists, either through PHC physiotherapists or as an outreach service provided by hospital rehabilitation professionals (see Section 5.3 *Primary care*).

When it comes to intermediate care, from 2015 to 2019 the number of 'at home' hospitalizations increased 24%, from 93 105 to 115 877 patients. In 2019, the number of patients included in these 'early-discharge' programmes reached 25.6 per 10 000 inhabitants for an average of 10 visits per patient. Implementation is largely uneven across ACs, both in the number of patients using this care (53.2-fold difference) as well as regarding the number of visits per patient (10.8-fold difference) (Ministry of Health, 2022d).

Finally, a good range of outpatient physiotherapeutic treatments is provided in solo or small private practices. In private hospitals, between 2015 and 2019 the number of rehabilitation and physiotherapy sessions increased 14%, from 7.4 million sessions in 2015 to 10.6 million sessions in 2019 (Ministry of Health, 2022d).

5.8 Long-term care

Long-term care can take the form of inpatient care in dedicated long-term hospital beds or 'single-specialty' geriatric hospitals, or as part of the services provided in the context of Law 39/2006 for the Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency (namely SAAD).

When it comes to dedicated long-term hospital beds, which cover palliative care needs, either in chronic patients or patients with cancer, the SNS has 8532 long-term care beds that represent 7.5% of public beds, and 77% of long-term care beds in the country, according to 2020 data (Ministry of Health, 2022d).

When it comes to SAAD, services are provided through a network of social centres and services available in the ACs, including regional public institutions such as nursing homes, services provided by the municipalities, and national reference centres for support of specific causes of disability, as well as accredited partner private centres. ACs have the responsibility to set up this network of providers where NGOs and not-for-profit institutions are considered as priority partners. Priority in access to services is determined by the assessment of the applicants' degree of dependency and financial assets. Services are co-paid according to the type of service required and the ability to pay.

The benefits package comprises the following services: a) promotion of personal autonomy and prevention of dependency; b) tele-assistance; c) home aids (housekeeping, personal care, day-centre, and specialized day-care services); and d) residential services (nursing homes for dependent older people or residential stays for dependent persons, adapted to the type of disability).

In addition to care benefits, there might also be financial benefits, based on the degree of dependency and financial status. Financial benefits are mainly linked to support the provision of services outside the SAAD network, as follows: a) financial benefits linked to purchasing services outside the network when there is no public or private partner centre available to provide the benefits; b) financial benefit for care provision within the family when a relative is acting as principal carer; it would only apply when the applicant is being nursed at home, provided that physical and living conditions for care are met; and c) financial benefit for paid personal care assistance, intended to support the hiring of professional services.

According to December 2022 consolidated figures, SAAD has recognized benefits to 1 290 608 individuals. As for the composition of services, 70.1% of benefits have been personal services and 29.9% have been financial benefits, resulting in 1.34 benefits per beneficiary (MDSyA2030, 2023a). The total cost of the system at the end of 2022 reached close to €10 000 million, which represents an expenditure of €8321 per beneficiary (MDSyA2030, 2023b). The development of the SAAD has resulted in an increase of professionals working in the social sector; thus, since 2016 the number of workers has increased by 47%, from 460 000 workers in 2016 to 677 000 in 2022 (MDSyA2030, 2023c).

5.9 Services for informal carers

Services provided by informal carers are one of the benefits included in the SAAD. Although exceptional, regulations foresee that this type of provision should only be considered under specific circumstances. It entails an economic aid (for example, monetary benefit) paid to the household where the beneficiary is cared for, or to an external informal carer who looks after the dependent individual for a limited time every day. Informal carers must enter an agreement with the IMSERSO (Institute for older people and social services), a public body of the Ministry of Social Rights and Agenda 2030. In December 2022, out of the 1 727 429 services provided to 1 290 608 individuals entitled as SAAD beneficiaries, 517 053 (30%) corresponded to informal care services (MDSyA2030, 2023d).

Regarding international comparisons, a recent report on 18 OECD countries using 2019 data found that, on average, 13% of people aged 50 and over reported having informal care at least weekly; in Spain, this figure reached 12% that year. In turn, 62% of those providing daily informal care were women, reaching 64% in Spain in 2019 (OECD/EU, 2020).

5.10 Palliative care

Palliative care in Spain 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 or not by the public system), OOP services, or services provided in the context of the SAAD. Depending on the place of residence and the centre of treatment, the pathway followed by a patient with palliative care needs varies substantially and the treatment might involve a variety of providers. A guide has recently been published to serve as an orientation and action guide for all professionals, both in specific units and in any other primary care service, hospital or residential centre which assists palliative patients (GPCSNS, 2021). In Spain, there are large territorial variations in the place of death (home, hospital or long-term care centre) due to cancer, but the existence of home palliative care is not a clear factor. Dying in hospital is an urban phenomenon, and having higher education increases the probability of home death while death at a long-term care centre is more frequent as one goes down in the educational level (López-Valcárcel et al., 2019).

Recently, euthanasia has been included within the benefits package of the SNS (See 6.1 *Analysis of recent reforms*). The procedure, including governance, providers and processes, has been strongly regulated by Organic Law 3/2021. Generally, after the patient requests to be provided with euthanasia assistance from their usual doctor (usually a Family Doctor) and signs a thorough informed consent, the Family Doctor must contact a consultant doctor who will issue a medical report on the case. If both physicians agree that the request complies with the provisions of the law, the Family Doctor sends a report with all the information to the regional Commission of Guarantees and Evaluation for the Provision of Assistance in Dying, which prepares a report and notifies the resolution. If the resolution is favourable, euthanasia can be carried out. The process can take between 30 and 40 days after the original request (Ministry of Health, 2021e).

5.11 Mental health care

Mental health care in the SNS is provided in PHC (early detection of mental health conditions and symptomatic treatment and follow-up of patients treated by psychiatrists at the specialized level), outpatient specialized settings (some specific services for child disorders and drug addictions), and hospital beds (for acute episodes). Over the years, a clear trend of deinstitutionalization has been expanded all over the country with day-care or night-care services, complementary to acute hospital services, as well as reintegration activities led by NGOs, not-for-profit associations and small

private companies, in close coordination with the SNS. The SNS common benefits package covers diagnosis and follow-up of mental health conditions, psychopharmacotherapy, and individual, group or family psychotherapy (excluding hypnosis and psychoanalysis), with no cost-sharing.

After the COVID-19 pandemic, concern with mental health provision has become more evident. For this reason, a Mental Health Strategy has been drawn up in the SNS for the period 2022–2026 (Ministry of Health, 2022g), which has been accompanied by a 2021–2024 Mental Health and COVID-19 Action Plan with a financial endowment of €100 million. The improvement of mental health care at all levels of the SNS – both in hospitals and in primary care – is one of the main measures included in the new Plan, together with specialized training in mental health. Additionally, a new Commissioner of Mental Health was appointed by the Ministry of Health in April 2024, with the aim of shifting the focus on social determinants of mental health conditions and slowing down the prescription volumes of psychotropic drugs.

The Mental Health Strategy incorporates as key principles the inclusion of a gender perspective, the fight against stigma and the increased role of patients and their families, and advocates a community model of mental health care and shared decision-making. Among the strategic lines are those focused on care for children and adolescents and the prevention and care of suicidal behaviour, with specific suicide prevention services, including a mental health crisis hotline (operating since May 2022) and a new medical specialty in child and adolescent psychiatry (created in 2021) (Ministry of Health, 2022g).

Official reports on the current state of mental health care in Spain show that between 2015 and 2019 the number of psychiatrists experienced a 17% increase (from 3455 to 4064 doctors), while the number of beds for psychiatric services (from 12 259 to 12 355 beds), the number of visits (from 4 964 105 to 4 991 555 consultations) and the number of sessions in day-care settings (from 805 822 to 831 347 stays) remained constant during that period (Ministry of Health, 2022d). When it comes to pharmaceuticals, there has been an increase in the prescription of hypnotics and sedative drugs (from 30.9 DHD in 2015 to 35.2 DHD in 2022) and antidepressants (from 73.1 DHD in 2015 to 98.8 DHD in 2022), with a large variation across ACs (Ministry of Health, 2023a).

5.12 Dental care

Dental care in Spain 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 (application of topical fluoride, dental fillings, fissure sealants), preventive measures in pregnant women (as part of the protocol for a healthy pregnancy) and, for children, caries prevention and counselling on hygiene measures, as part of the services provided by PHC paediatricians and nurses.

The basic funding mechanism for dental care services, other than the aforementioned, is mainly OOP with some exceptions since 2015 (dental implants for certain patients under oncologic treatments leading to lost teeth and for patients with congenital malformations with anodontics), although it is possible to find VHI policies including dental services (see Section 3.3.1 *Coverage* and Section 3.4 *Out-of-pocket payments*). In this sense, private spending per inhabitant is highly variable between ACs, with a difference of more than double between the AC with the highest spending and the one with the lowest spending (€87 and €35, respectively) in 2019 (Ministry of Health, 2022h).

Consequently, unmet dental care needs for economic reasons are substantial in Spain and have increased in the last decade. Indeed, dental care is the main health care service responsible for financial hardship in families, accounting for 50% of catastrophic spending in 2019 regardless of the income quintile (Urbanos-Garrido et al., 2021). The verification of unmet needs in dental care has led the SNS to approve a Dental Health Plan in 2022, budgeted with €112 million during 2022 and 2023 (€44 and €68 million, respectively) to expand the dental health services included in the benefits package (Ministry of Health, 2022h) (see Section 6.1 *Analysis of recent reforms*).

6

Principal Health Reforms

Summary

- 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.

- The basis for entitlement reverted to the condition of residency in Royal Decree-Law 7/2018 on universal access to the SNS; between 2012 and 2017 eligibility was linked to the legal and employment status of individuals.

- The 2019 Strategic Framework for Primary and Community Care sets out various measures, providing new impetus to primary care to adapt and address new epidemiological, societal and technological challenges.

- 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.

- Euthanasia will be covered by the SNS from 2021, underwritten by Organic Law 3/2021. The Law guarantees patient autonomy and choice regarding their own death, while also setting up criteria and procedures for eligibility and delivery.

- A draft law for the creation of the National Agency of Public Health is being discussed in parliament and is expected to be approved in 2024.

6.1 Analysis of recent reforms

Table 6.1 lists the most recent health system reforms that have occurred in Spain since 2018. These have focused on widening the covered population, the reinforcement of primary care, broadening exemptions for co-payments, and the scope of coverage in terms of increasing the provision of services.

TABLE 6.1 Major health reforms

YEAR	REFORM
2018	**Royal Decree-Law 7/2018, of 27 July 2018, on universal access to the National Health System**. In particular: basis for entitlement returns to the condition of residency.
2019	**Strategic Framework for Primary and Community Care**. Provides 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**. In particular: large exemptions from co-payments.
2021	**Organic Law 3/2021, of 24 March 2021, for the regulation of euthanasia**. In particular: euthanasia now covered by the national health system.

Source: Authors' own.

6.1.1 *Changes in the breadth of coverage*

Until 2012, the basis for health coverage entitlement by the population was independent of the employment status and personal wealth of the individuals (García-Armesto et al., 2010) (see Section 2.2 *Organization*). However, in the aftermath of the 2008 economic and financial crisis, and because of Spain's commitment to its Stability Programme (2010), a substantial reform of the scope, breadth and depth of SNS coverage was issued in Royal Decree-Law 16/2012. In terms of entitlement, Royal Decree-Law 16/2012, and subsequent legislation (Royal Decree-Law 1192/2012) changed the legal basis of health coverage, linking the right to the legal and employment status of individuals (Bernal-Delgado et al., 2018).

In 2018, the new cabinet led by the social-democrats mandated the new Health Minister to restore the *status quo* before Royal Decree-Law 16/2012. After meeting civil society associations and organizations, such as Amnesty International and Doctors of the World, as well as some professional associations (such as Family and Community Medicine, Public Health) and trade unions in the sector, a dedicated Inter-territorial Council was held on 28 June 2018 in which the Ministry and the regional health authorities set up the path to restore the legal basis for coverage entitlement as it used to be before 2012. The Spanish Parliament approved the legislation (Royal Decree-Law 7/2018) in September 2018.

With this new legislation, the basis for entitlement reverted to the condition of residency. In the new law, undocumented migrants, those most affected by Royal Decree-Law 16/2012, recovered eligibility to full coverage, just like any other Spanish national. Since then, regional health authorities are required to issue a health insurance card to undocumented migrants, accrediting residence in Spain for more than 90 days. In the interim period, a report from the social services department is required for them to access health care, except in the case of emergency care and child and perinatal care.

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.

Early implementation of the new legislation was uneven across ACs, and some reports warned of the actual difficulties for undocumented migrants to effectively exercise their rights (Doctors of the World, 2018; Yosisanidaduniversal, 2019). No formal procedure has been established to assess the impact of this new policy. However, the Interterritorial Council held on 28 June 2018 agreed on the creation of a joint committee, made up of representatives from organizations defending universal coverage (amongst others, Amnesty International, the Spanish Federation of Associations that Defend Public Health (FADSP), Doctors of the World, *SOS Racismo* and *Yo Sí Sanidad Universal,* the Spanish Association for family and community medicine, and the Spanish Association of Public Health and Health Management (SESPAS).

Currently, there are still some gaps in achieving effective access; migrants face administrative barriers, such as legal loopholes and delays in getting access to social services in the first 90 days; the process of being

recognized as an asylum seeker may suffer from substantial delays; and, unlike the rest of the population, undocumented migrants co-pay a fixed 40% of the retail price of pharmaceuticals, irrespective of their income level (Urbanos-Garrido et al., 2021).

6.1.2 *Reinforcement of primary care*

Despite the strength of primary care in Spain, which is an indispensable pillar in guaranteeing effective UHC, there was a need to adapt the role of primary care to new sociodemographic, epidemiological and technological conditions. Since 2018, an open discussion process fostered by the Ministry of Health has highlighted several challenges, including the need to increase capacity to address health problems, improve care continuity, derive a clearer orientation towards health promotion and community health, improve coordination with public health authorities, and develop new skill profiles and adapted training. Following this open debate, a Strategic Framework for Primary and Community Care was agreed by the Ministry of Health and the ACs in 2019 (Ministry of Health, 2019a).

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 prevention; promoting the use of information and communication technologies; and promoting education and research in PHC (Ministry of Health, 2019a). In 2021, an Action Plan for Primary and Community Care was designed to effectively implement the priority actions of the Strategy during 2022–2023 (Ministry of Health, 2021d), in particular the reinforcement of PHC resources, measures to tackle short-term job contracts, actions to incentivize applications for hard-to-fill positions, and the reorganization of PHC to improve coordination with social services. Additionally, in 2021 the government earmarked more than €230 million for the deployment of the digital transformation of PHC for the years 2022 and 2023.

Importantly, also within the Strategic Framework for Primary and Community Care, the SNS approved a Dental Health Plan in 2022, aiming to increase coverage and benefits, as well as supply premises with new staff

and equipment. The plan, budgeted with €112 million for the years 2022 and 2023 (€44 million and €68 million respectively), was estimated to expand the common basket of dental health services to 13 million people. Specifically, the plan extends coverage to children up to the age of 14, pregnant women, head and neck cancer patients and adults with intellectual disabilities or with neuromuscular diseases. The new services include periodic check-ups and preventive treatments for all prioritized groups, as well as repositioning and stabilizing affected teeth in the case of trauma in children and young people and people over 14 years of age with some disabilities (Ministry of Health, 2022h).

6.1.3 *Changes in the depth of coverage*

Law 11/2020, on the General State Budget for the year 2021 in Spain, was enacted to establish the budgetary framework for the government's expenditure and revenue for the fiscal year 2021. The Law aimed to address the economic and social challenges posed by the COVID-19 pandemic, including specific funds to resource welfare (that is, health care, education and social services) and to protect workers and small and medium-sized enterprises, as well as to provide stimulus to the Spanish economy, particularly through sustainable and environmental-protective activities. Importantly, this Law included a specific article reforming patient cost-sharing policy, aimed at increasing protection for the most vulnerable.

The General State Budget for 2021 was inevitably conditioned by the effects of the public health emergency caused by the COVID-19 pandemic and the resulting global economic disruption. Given the very fragmented lower chamber of parliament (*Congreso de los Diputados*) (see Section 1.3 *Political context*), obtaining a majority vote in parliament was one of the big challenges of the new government during its first year in office. In the end, the Law was approved with an ample majority of 189 parliamentary members (out of 350).

Law 11/2020[19] amended cost-sharing provisions applied on outpatient medicines and orthoprosthetic devices in Royal Decree-Law 1/2015, including new exemptions from co-payments for: a) people receiving the guaranteed minimum income; b) pensioners with annual incomes <€5635

[19] The use of the General Budget Law as the legal framework has to do with the fact that the reform had an impact on state revenues.

(or €11 200 if they are not obliged to pay personal income tax); c) moderately and severely disabled children; and, d) people receiving benefits for a dependent child or minor in a permanent family foster care scheme (see Section 3.4.1 *Cost-sharing (user charges)*).

As a consequence of these legal provisions, 7.3 million people were exempted from co-payments in 2024, compared to the 2.2 million people exempted before the implementation of Law 11/2020 (Ministry of Health, 2024b).

Nevertheless, co-payments and other potential protection mechanisms are still a topic of public debate, including options such as applying co-payment caps also to active workers (currently, only pensioners benefit from these caps), designing a co-payment mechanism that is more proportional to income or even the option of eliminating co-payments altogether.

6.1.4 *Changes in the scope of coverage*

On 24 March 2021, Spain became the fourth European country to regulate euthanasia and medically assisted suicide after the Kingdom of the Netherlands (2002), Belgium (2002) and Luxembourg (2009) (Organic Law 3/2021 on the Regulation of Euthanasia). This law aimed to provide a systematic and balanced legal response to guaranteeing the rights of those individuals who express their wish to die. Specifically, the Law aims to a) guarantee patients' access to high-quality palliative care and support services for decision-making; b) guarantee the right of patients to request and receive assistance to die in a dignified and painless manner; c) establish a clear and secure legal framework for the practice of euthanasia, guaranteeing the rights of both patients and health care professionals; and d) establish the requirements for patients to be able to request euthanasia and the procedures to be followed by health care professionals (see Section 5.10 *Palliative care*).

In 2017, the parliament approved a bill presented by the Socialist Group to regulate euthanasia in the country. However, the law did not pass until 2020 owing to opposition from right-of-centre parties, mainly influenced by some conservative medical groups, religious organizations and pro-life associations. The Council for Nursing supported the law; the College of Physicians, although supportive of the notion of patient autonomy, strongly recommended the need to reinforce palliative care; and the Council of

Psychologists expressed their willingness to contribute to the implementation of the legal provisions along with other care professionals. After its approval in the Senate, the Organic Law came into force in June 2021.

In practical terms, euthanasia became a new benefit covered by the SNS. Euthanasia can be delivered in public or private centres as well as at a patient's home and, depending on the patient's wish, it can be provided by a qualified care professional or can take the form of medically assisted suicide. In both cases, patients and families are assisted by health care professionals.

In addition to the general conditions, to be eligible a patient has to: a) be of legal age and be capable and conscious at the time of the request; b) suffer from a serious and incurable illness or a serious, chronic and disabling condition, certified by the responsible physician; c) have made two requests voluntarily and in writing, or by another means that allows evidence to be provided, and that is not the result of any external pressure, leaving a separation of at least fifteen calendar days between both; and, d) provide prior informed consent to receive the provision of assistance to die.

Regarding implementation, there are two major instruments: firstly, the Commission for Guarantees and Evaluation, a collegiate body that is responsible for the legal recognition of the right to aid in dying benefit; and secondly the Handbook of good practice for euthanasia, where roles, procedures and conscientious objection are thoroughly described (Ministry of Health, 2021e). Importantly, in the first months after the Law was enacted, the ACs had to develop the legal framework at regional level, providing the Commission with a register of professionals who object to delivering euthanasia, and set up the means and procedures to fully implement the Law.

6.2 Future developments

6.2.1 *Draft law on the National Agency for Public Health*

Law 33/2011, of 4 October 2011, on Public Health and the conclusions of the Spanish National Parliament on the Social and Economic Reconstruction of the Kingdom of Spain in 2020 (*Congreso de los Diputados,* 2020) set up the need to create a national public health agency. In turn, the Recovery, Transformation and Resilience Plan established the reforms and investments

necessary for the renewal and expansion of the capacities of the SNS, specifically for public health through the implementation of the three strategic and operational instruments provided for in Law 33/2011: the Public Health Strategy, the Public Health Surveillance Network and the National Agency for Public Health. The Draft law to create the Agency was submitted to parliament in 2024 (BOCG, 2024).

The National Agency for Public Health is designed to have countrywide responsibility in: a) surveillance, identification and assessment of the health status of the population and its determinants, as well as of associated problems, threats and risks, paying special attention to social inequalities in health; b) provision of public information of and communication on health status and potential risks; c) coordination of preparedness and response action for health crises and emergencies; d) coordination with the public health services and the health care services of the ACs and the cities of Ceuta and Melilla; e) reinforcement of the capacities, guidance and support for public health action and the evaluation of public health interventions, particularly policies on health determinants and inequalities.

6.2.2 *Draft laws aiming to improve the foundational principles of the National Health System*

Two relevant draft laws are currently in parliamentarian discussion; thus, 1) the draft law on the Universality of the SNS (Draft Law, 2024a) that seeks to widen health care coverage in those population subgroups still undercovered, and to amend the current distinction between the core, supplementary, accessory and complementary benefits, gathering benefits in a single package, and cancelling the possibility for the regions to offer complementary benefits, as well as the prohibition of new co-payments. Works in the parliamentary commission debating this bill are expected to be finalised this term; and, 2) the draft law for the consolidation of equity and cohesion, accepted for amendments in the parliament of the nation (Draft Law, 2024b).

7

Assessment of the Health System

Summary

- An independent evaluation of the SNS's response to the COVID-19 pandemic underscores some weaknesses, including the gap between public health services and the health care network, serious coordination failures with long-term and social care networks, and significant shortcomings in epidemiological surveillance systems.

- 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. However, unmet needs in dental care are relatively high, and affect the poorest households the most.

- Despite the substantial share of private spending represented by OOP payments, the risk of catastrophic expenditure for households

in Spain is among the lowest in the EU. Protection mechanisms (such as exemptions from co-payments), accessible primary care settings, services provided for free at the point of use, and the redistributive effect of public spending on health are deemed to be underlying factors supporting financial protection of the population.

- The SNS performs well in terms of life expectancy, avoidable hospitalizations and avoidable mortality (both preventable and treatable mortality). However, the SNS records rates that are below the EU average in some cancer screening services, with a notable difference between high-income and low-income groups.

- Major instruments to improve allocative efficiency within the SNS include the ACs financing mechanism, the policy design towards UHC, the evaluative instruments for the adoption of new technologies, and the purchasing instruments at AC level. Unfortunately, there are no formal evaluations of the implementation of these instruments or their actual impact on allocative efficiency.

- Technical efficiency within the SNS is supported through various measures, including effective access to a comprehensive basket of benefits, the entry mechanisms for doctors to access hospital positions, and the strong regulation of salaries and drug pricing. Some gaps in efficiency remain, such as the low numbers of qualified personnel in some medical specialties, the shortage of mental health resources, the underuse of effective treatments, and the overuse of non-appropriate or ineffective procedures.

7.1 Health system governance

The SNS is deeply regulated, including planning and financing mechanisms, distribution of resources, purchasing and provision of services and goods, the benefits package (scope, depth and breadth), the adoption of new technologies, and citizen and patient rights (see Section 2.7 *Regulation*).

In terms of patient rights, SNS regulation incorporates the WHO patient rights framework under the overarching 1986 Health General Act (see Section 2.1 *Historical background*). Furthermore, avenues to make complaints have been explicit and accessible since the early 1990s, and liability and compensation mechanisms are available both within the health system and through external bodies such as the Ombudsman[20] (see Section 2.8 *Person-centred care*) or the judiciary. In 2021, euthanasia was regulated (Organic Law 3/2021); the Law specifies the conditions for a patient to be eligible, as well as the different assessment procedures to be followed, and eventually for the termination of life (see Section 5.10 *Palliative care*).

Patients and citizens also have accessible information on statutory benefits, access to their own medical records, interactive 24/7 information sites at AC level, and information on hospital waiting times (see Section 2.8 *Person-centred care*). Despite the availability of performance information at AC level, stakeholders only have partial access to comparative information on the quality and safety of specific providers, although some ACs release this type of information. Notably, the level of satisfaction exhibited by the national population with regard to the information received in their contacts with health care professionals is high and has tended to improve since 2010; in 2023, people showing no satisfaction at all with the information provided on their health problem was 3.3% for people receiving primary care, 3.2% for those receiving specialized care, and 3.2% for those attending public hospitals (see Box 5.4) (Ministry of Health, 2024a).

When it comes to patient choice, opting out of the statutory public system for health is not possible. Within the public system, patient choice has been well developed in the case of Family Doctors, although there is a limit to the number of individuals allocated to each doctor and choice is confined to the same PHC team (see Section 2.8.2 *Patient choice*). In the case of outpatient visits to specialists (as they require referral from the Family Doctor) or in the case of hospitals (where the population is allocated to administrative areas, usually set up around a single hospital), the implementation of patient choice is *de facto* limited. Interestingly, public servants insured in Mutual Funds are entitled to annually choose between public and private providers – approximately 80% of public servants choose private provision, although the share has decreased slightly over the years

[20] There is no health-specific Ombudsman but a general (for any topic) Ombudsman usually assists citizens with claims on health issues.

(see Section 2.2 *Organization* (IDIS, 2022)). Finally, although patient participation in treatment decisions is regulated by law (for example, they have the right to consent or not to treatment, and in some ACs they are entitled to request a second opinion), the actual exercise of this right is still suboptimal; in the 2023 Healthcare Barometer, 20.8% of patients in PHC (0.7 percentage points higher than in 2018), 22.8% of patients attending specialized visits (1.7 percentage points lower than in 2018), and 27.7% of patients receiving hospital care (1.6 percentage points higher than 2018) reported that they were not given the option to participate in decisions about their health problem (Ministry of Health, 2019b, 2024a).

BOX 7.1 SNS response to the COVID-19 pandemic

In 2021, the CISNS commissioned an independent evaluation on its response to the COVID-19 pandemic, with the results published in December 2023 (Hervada-Vidal et al., 2023). The methodology followed the ECDC and WHO 'After-Action Reviews' guidelines. The final report highlights both successes and shortcomings. The role played by health professionals, the successful vaccination campaign, the establishment of a unified command at the onset of the pandemic, and the ongoing communication between the central and regional governments, as well as the rapid application of information and communication technologies, the implementation of Temporary Employment Regulation Files (ERTEs) and comprehensive social protection measures, are deemed good practices.

Conversely, the evaluation underscores that Spain was insufficiently prepared to face a pandemic and that the legal framework was not adequate to deal with the health crisis. Some errors in the pandemic response are attributed to pre-existing problems within the health system, such as the gap between public health services and the health care network, serious shortcomings in epidemiological surveillance systems, the absence of an adequate information system at a national level, structural understaffing for the day-to-day activity of public health services, poor coordination between the health care system and the long-term care network, the lack of protocols in residences for the older population and vulnerable groups, and coordination failures in multiple areas, which were unsuccessfully addressed by the CISNS.

This 2023 report outlines a roadmap with the necessary reforms. Although policy-makers have not been able to translate the results into national policies as yet – the report was only recently made available – the creation of a Public Health National Agency will be discussed in the national Parliament in 2024 (see Section 6.2 *Future developments*).

Overall, the SNS has sufficient capacity both in terms of policy design and implementation, at national and regional level, facilitated by the numerous governance mechanisms in place (see Section 2.7 *Regulation*). The evaluation of public policies, however, lags behind, despite the evaluation efforts by 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) (see Box 2.1).

The governance features depicted above are reflected in Spain's overall high position in the Transparency International Ranking, where Spain ranked 19th among EU countries in 2023, with no significant change in the perception of corruption since 2016 (Transparency International, 2023).

7.2 Accessibility

7.2.1 *Coverage*

Since 2018, changes to SNS coverage have affected the breadth (who is entitled?), the scope (what is covered?) and the depth (how much of the cost is shared?) of coverage.

In terms of breadth of coverage, since 2018 (Royal Decree-Law 7/2018) residence has been re-established as the basis for entitlement to health services covered by the SNS and delivered by providers owned or contracted by the SNS at regional level. Asylum seekers and refugees are entitled to the same benefits as residents. Undocumented migrants are also entitled to the same benefits as residents after being in Spain for 90 days or through a report from social services (see Section 3.3.1 *Coverage*).

In terms of scope, the major change has been the inclusion of euthanasia. ACs must provide this new service according to Organic Law 3/2021, implementing the legal prescriptions and clinical guidelines at regional level (Ministry of Health, 2021e) (see Section 5.10 *Palliative care*). In 2022, 288 patients were given access to this benefit (out of the 576 applicants (50%)); reasons for withdrawal were postponement (22 cases, 3.8%), rejection by the Guarantee and Assessment Board (16 cases, 2.8%), patient revocation (1 case); and death before delivery (152 cases, 26.4%) (Ministry of Health, 2023s).

Some other services have been widened within the scope of the benefits package, notably: children and young adults up to the age of 26 are now eligible for hearing aids; the transformation of cervical cancer screening into a population-based programme (Order SCB/480/2019); and the use of diabetes flash monitoring in both diabetes type 1 and type 2 (Resolution, 2020, 2022).

Finally, in terms of cost-sharing, major legislation has been issued. Since 2020, protection mechanisms have been strengthened through the exemption from co-payments for recipients of the guaranteed minimum income (Royal Decree-Law 20/2020) and for low-income pensioners, moderately and severely disabled children and households receiving child benefits (Law 11/2020) (see Section 3.4 *Out-of-pocket payments*).

Despite the advances in recent years, there are still some gaps in coverage or barriers to accessibility. The application of protection mechanisms may be hindered by a) administrative barriers, loopholes and delays in the recognition of entitlement, such as for those applying for the guaranteed minimum income, asylum seekers, undocumented migrants, foreigners legally reunited with relatives in Spain, and people wanting to be treated outside their region; b) limited coverage of dental care, optical care and hearing aids, especially for adults; and c) cost-sharing design (for example, no caps are applied to low-income workers) and delays in updating the income status of an individual or family. In general, VHI premiums only partially cover dental care or optical care and negligibly reimburse co-payments (see Section 3.5 *Voluntary health insurance*).

7.2.2 *Waiting lists*

Given the design of the SNS, where resources are distributed to administrative areas where the resident population is allocated (see Boxes 4.1 and 4.2), the major driver of accessibility challenges is waiting times.

According to a ministerial report from 2023, with data up to 30 June 2023 (Ministry of Health, 2023t):

Surgical procedures: around 819 964 patients were waiting for non-urgent surgery in the SNS on 30 June 2023 (a 9% increase, compared to the same period in 2022). The average waiting time was 112 days (113 days in 2022). Around 17.4% of patients receiving surgery had been on the waiting

list for more than six months (similar to 2022). Figures corresponding to the year before the COVID-19 pandemic (2019) were similar to 2022 data.

The specialty with the longest average waiting time continues to be plastic surgery (225 days), followed by neurosurgery (192 days) and traumatology (133 days). Cardiac surgery, with an average waiting time of 58 days, and dermatology and ophthalmology, with 66 and 78 days, respectively, are the specialties with the shortest average waiting times.

Outpatient visits to specialists: On 30 June 2023, 78.5 out of every 1000 people were registered on a waiting list for a first consultation. This rate is similar to that of June 2022. The average waiting time for these patients is 87 days, 8% higher than in June 2022, and without having yet returned to the pre-pandemic figures of June 2019 (81 days). The longest waiting times for a first consultation are observed in neurology (118 days), dermatology (99 days) and traumatology (90 days). The shortest waiting times are observed in general surgery (54 days) and gynaecology (58 days).

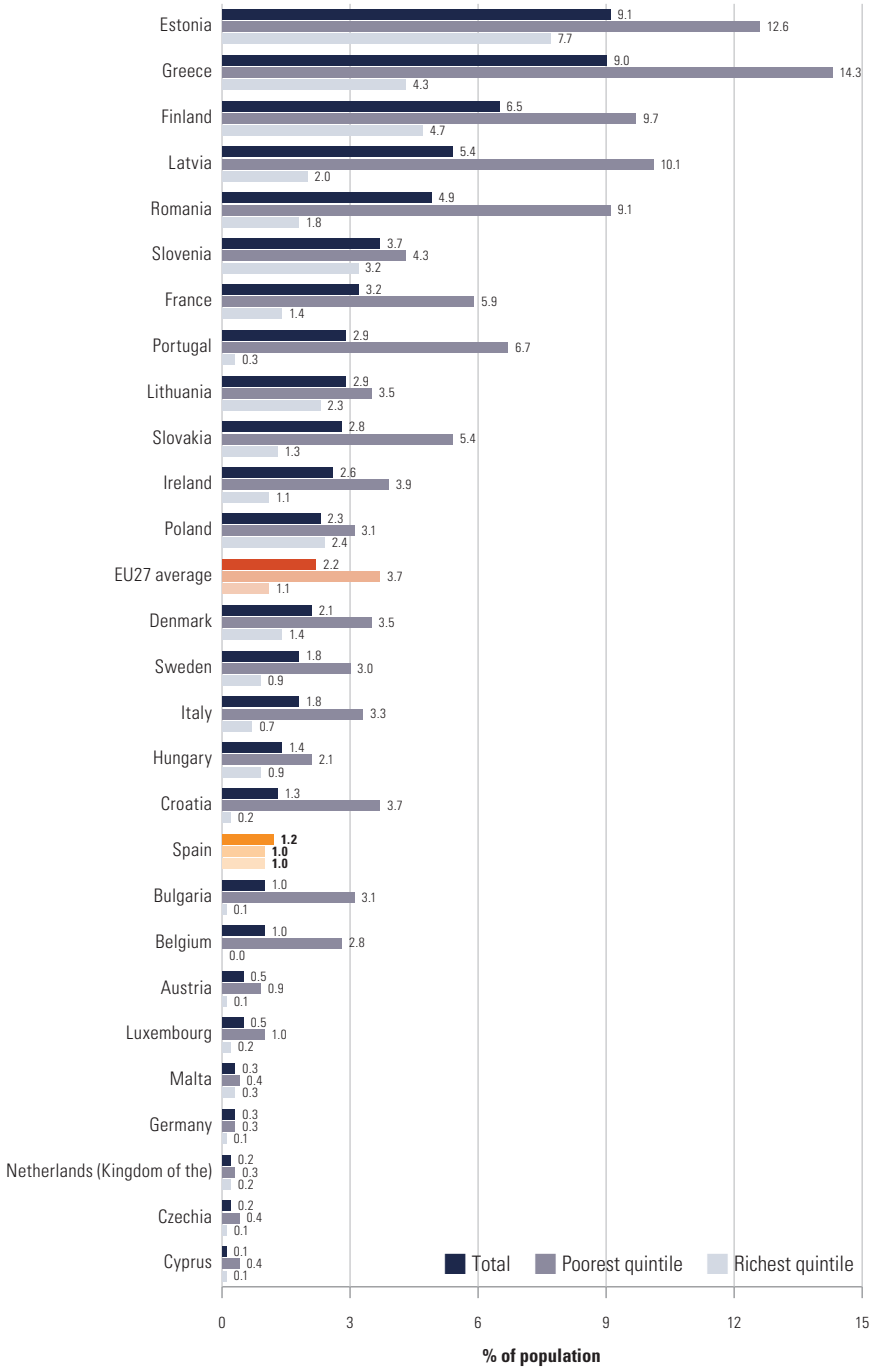
Importantly, regarding the five clinical procedures subject to specific monitoring in terms of waiting time guarantees since 2011 (heart valve surgery, coronary heart surgery, cataract, knee, and hip replacement), all of them are below the normative threshold of 180 days (Royal Decree 1039/2011). Coronary heart surgery has the shortest waiting time (40 days) and knee replacement is the procedure with the longest wait period (134 days). Further, the low availability of psychologists and psychiatrists and non-official reports suggest that waiting times for psychological and psychiatric attention are a substantial barrier to accessing mental health services (Urbanos-Garrido et al., 2021).

The 2023 Health Barometer provides the perspective of patients regarding the availability of resources in the SNS through several questions: around 33.9% of interviewees said that waiting times had worsened in the previous 12 months, 38.2% experienced more than a three-month time-lag between referral from the primary care physician to the specialist, and 69.8% reported that it took more than 24 hours to get an appointment with a primary care doctor, with nine days of average time-lag (Ministry of Health, 2024a). These figures have worsened dramatically compared to 2019, when 50.6% of interviewees declared that it took more than 24 hours to obtain an appointment with the primary care doctor, with 5.8 days of average time-lag (Ministry of Health, 2019c).

7.2.3 *Unmet needs*

A small share of the Spanish population aged 16 and over reported unmet needs for medical examinations in 2022, far below the EU average: just 1.2% of this population reported unmet needs for reasons due to cost, distance or waiting time, compared to the 2.2% EU average (Eurostat, 2023p). Differences between those in the highest and those in the lowest income quintile are very small, with Spain being one of the countries with the smallest difference (Fig. 7.1). However, the rate has worsened as compared to 2019, when just 0.2% of the population reported some unmet needs for medical care (the EU average in 2019 was 0.7%) (Eurostat, 2023p). The underlying reason for unmet needs in medical examination is the increase in waiting times, particularly to access primary care. Household spending on health, however, does not seem to be an underlying cause of unmet needs in the country. In 2022, just 0.1% of the population aged 16 and over declared unmet needs for this reason (as compared to 1.1% in the EU) (Eurostat, 2023p). However, there are some noteworthy gaps in unmet needs. Primarily, unmet needs in dental care (examination and treatment) are above the EU average: around 4.5% of the population aged 16 and over declared to have experienced unmet needs, mainly due to economic reasons in 2022 (compared to the EU average of 2.9) (Eurostat, 2023u). Secondly, unmet needs affect the migrant population, with 10.6% of migrants declaring some unmet need for medical examination or dental care (Fares, Domínguez & Puig-Junoy, 2023).

FIG. 7.1 Unmet needs for a medical examination (due to cost, waiting time or travel distance), by income quintile, EU/EEA countries, 2022



Source: Eurostat (2024).

Finally, access to cancer screening services appears to be different across income quintiles. In pap smear tests, 25.6% of women in the 1st income quintile (poorest) received an examination in the previous 12 months as compared to 38.5% of women in the 5th income quintile (richest), notably lower than the EU average for women in the 1st quintile (EU averages: 30.2% in the 1st income quintile; 41.6% in the 5th income quintile) (Eurostat, 2023r). Finally, among those individuals in the 1st income quintile, 11.6% declared getting a colorectal cancer screening test in the last year, against the 19.6% in the 5th income quintile (EU averages of 18.1 and 21.5, respectively). In all the aforementioned preventive services it can be observed that the difference between Spain and the EU average is clearly smaller for the best-off (Eurostat, 2023s). In the specific case of X-ray screening for breast cancer, although well above the EU average, Spain showed differences by income quintile: 66.6% of women in the 1st income quintile declared getting an X-ray examination in the last two years (58.6% in the EU), while 78.7% of those in the 5th quintile declared having an examination (73.8% in the EU) (Eurostat, 2023q).

7.3 Financial protection

In 2021 (latest consolidated information), 71.7% of total health expenditure was publicly funded via taxation, with the remaining financing coming from OOP expenditures (20.6%) and VHI schemes (7.7%). It is worth noting that overall, the share of private expenditure on health as a proportion of current health spending has slightly reduced, from 28.7% in 2015 to 28.3% in 2021, with a notable reduction of the OOP share, by 1.4 percentage points in the same period. At the same time the overall share of VHI as a proportion of current health spending increased slightly from 5.95% in 2015 to 6.89% in 2021 (see Section 3.1 *Health expenditure*) (Ministry of Health, 2023j).

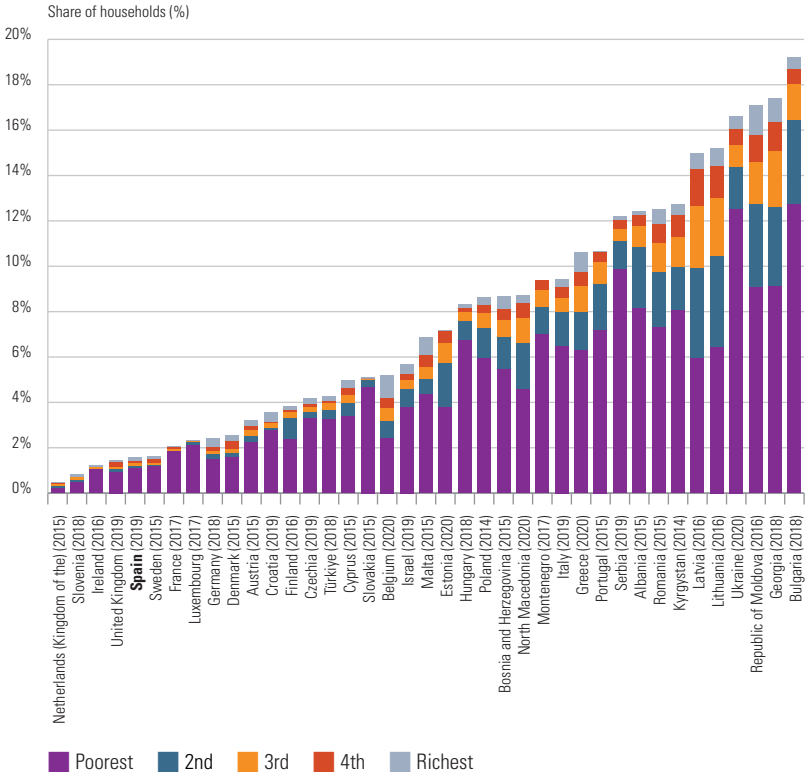
Within private expenditure on health, the share of VHI increased from 20.8% to 24.4% in 2021 (Ministry of Health, 2023j). This growth has represented a small increase in household expenditure on health, from 3.5% in 2015 to 3.9% in 2022 (average expenditure increase from €972 to €1229 per household). However, differences across income quintiles are notable: the poorest devoted 2.9% of the family budget to health (€403), while the richest devoted 4.8% of theirs (€2484) (INE, 2023f). Despite

the substantial amount of private spending (either in OOP payments or VHI) (see Sections 3.4 *Out-of-pocket payments* and 3.5 *Voluntary health insurance*), the risk of catastrophic expenditure for households in Spain is minor (Fig. 7.2). The latest evidence shows that in 2019, 0.8% of households (about 150 000 households) were impoverished or further impoverished after OOP payments, up from 0.2% in 2006 (Urbanos-Garrido et al., 2021). In the same year, 1.6% of households (about 300 000) experienced catastrophic health spending, up from 1.0% in 2006. Much of this increase took place between 2008 and 2014, reflecting a decline in household capacity to pay for health care, particularly for poorer households, in the context of the global financial and economic crisis that began in 2008. Although the incidence of catastrophic spending started to fall in 2016, it was still above economic pre-crisis levels in 2019. Catastrophic spending was concentrated in the poorest fifth of the population in all years (Urbanos-Garrido et al., 2021).

On average, catastrophic spending was driven by dental care and medical products. In the poorest quintile, catastrophic spending was also driven by OOP payments for outpatient medicines (Urbanos-Garrido et al., 2021), although just 3.6% of the interviewees in the latest 2023 Health Barometer wave declared having stopped taking medications prescribed by a public sector physician because of economic reasons, the same percentage as in 2016 (Ministry of Health, 2024a).

All in all, the incidence of catastrophic spending is much lower than would be expected given Spain's relatively heavy reliance on OOP payments – a finding that can be explained by the many protective features of coverage policy and the redistributive effect of public spending on health, which reduces income inequality (see Section 3.4 *Out-of-pocket payments*). There are strengths in all three dimensions of coverage. The basis for population entitlement to the SNS is residence and undocumented migrants are entitled to the same degree of coverage as residents. The SNS benefits package covers a wide range of health services, with very little regional variation in benefits and an even distribution of health centres across the country (see Section 3.3.1 *Coverage*). There are no co-payments for SNS health and dental visits, diagnostic tests or inpatient care. Where co-payments apply, for outpatient prescribed medicines and medical products, they are accompanied by multiple protection mechanisms (Urbanos-Garrido et al., 2021).

FIG. 7.2 Share of households with catastrophic health spending by consumption quintile, latest year



Source: WHO Barcelona Office for Health Systems Financing (2023).

7.4 Health care quality

The SNS draws on a long tradition of developing and implementing quality and safety initiatives (Ministry of Health, 2023u). Many of the current lines of work can be regarded as stemming from the 2010 Plan for Healthcare Quality, developed within the 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 (Ministry of Health, 2022d). Other notable programmes within the 2010 Quality Plan are: the national network for development and implementation of Clinical Guidelines (GUIASALUD); the do-not-do strategy (in collaboration with scientific

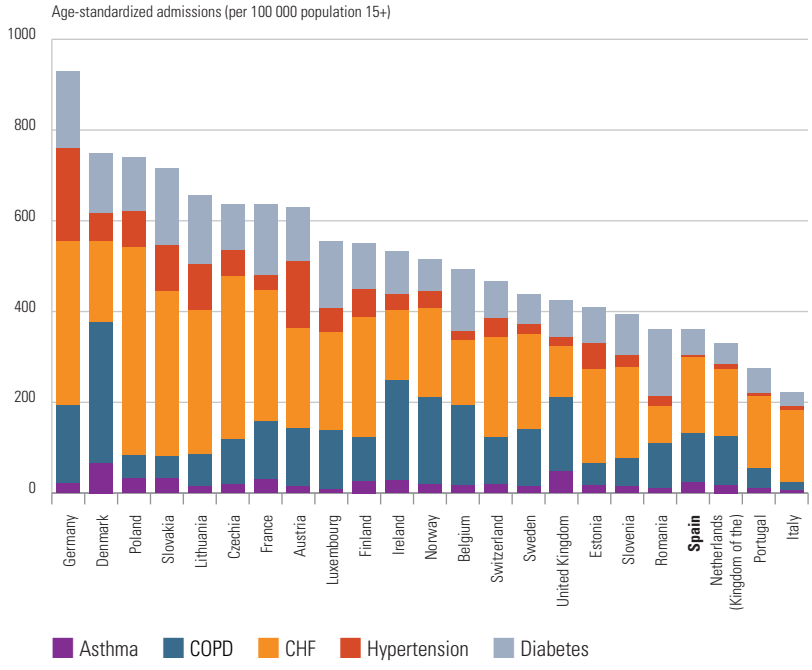
societies); the national catalogue of best quality practices; the catalogue of quality standards and recommendations (Ministry of Health, 2023u); and the Strategy for patient safety (Ministry of Health, 2023v). Finally, there are some strategies around medicines, including: the National Plan for Antibiotic Resistance (AEMPS, 2023), with a specific programme for prescription adequacy, and VALTERMED, aiming at the evaluation of health outcomes in drugs with a high economic impact (Ministry of Health, 2021a).

Some global indicators shed light on the SNS's uneven performance in the quality (and safety) of the provision of care. In particular, **cancer screening figures** show: a) a post-pandemic reduction in breast cancer screening (from 81.5% coverage in 2017 to 73.8% in 2020); a slight increase in the coverage of cervical cancer screening (68.4% in 2021 compared to 67.7% in 2011); and a steady and significant increase in colorectal cancer screening coverage (6.8% coverage in 2011 compared to 31.9% in 2020) (Ministry of Health, 2023r). In comparative terms, although breast cancer screening figures were well above the OECD average (73.8% vs. 54.3%) in 2021, Spain ranked below Denmark, which exhibited the highest rate at 83% coverage (OECD, 2023a). In cervical cancer, Spain was 15 percentage points above the OECD average (68.4% vs. 53.4%), but well below Sweden, which had the highest rate (78.5%). Notably, for colorectal cancer the SNS coverage is below the OECD average (31.9% vs. 44.2%) and far below Finland, which showed the highest coverage at 79.4% (Ministry of Health, 2023a; OECD, 2023a).

Looking at **potentially avoidable hospitalizations**, according to the Spanish institutional design, this indicator must be interpreted as an indication of the quality of the continuity of care in a number of disease areas. Spain has the fourth lowest overall rate of potentially avoidable hospitalizations among EU countries that collect this data (Fig. 7.3), standing out for its low rates in diabetes and hypertension admissions, but with a higher share of congestive heart failure (CHF) and COPD hospitalizations. Importantly, in-country data shows variations in potentially avoidable hospitalizations in chronic conditions as large as three times across 2400 primary care areas across the SNS. Considering the interquartile ratio of standardized rates (in other words, the 3rd quartile to 1st quartile ratio), avoidable hospitalizations in the period 2018–2020 varied as much as 1.8 times in the case of congestive heart failure, 10 times in the case of acute complications of diabetes, 4.2 times in asthma and 2 times in COPD (Martínez-Lizaga et al., 2023).

In 2021, safety events in surgical care in Spain show remarkably better figures than the OECD average in postoperative pulmonary embolism or deep vein thrombosis (232 compared to 467 events per 100 000 hip and knee surgeries, respectively), although performance is far from the 57 events per 100 000 surgeries in Italy. Obstetric trauma in instrumented vaginal delivery showed to be lower than the OECD average as well (4.7% compared to 5.7%), although far from the 1.1% in the case of Lithuania. Finally, hip fracture surgery initiation within two days of hospital admission in people aged 65 and over is far below the OECD average (57.1% of people-initiated surgery in Spain compared to 80.1% in the OECD), although values improved by 14 percentage points as compared to 2011 data (42.9%). In any case, Spain remains far below the best performing countries in the EU such as the Kingdom of the Netherlands (96.1%) (OECD, 2023a).

FIG. 7.3 Avoidable hospital admission rates for CHF, hypertension, diabetes, asthma and COPD, 2021 or latest available year

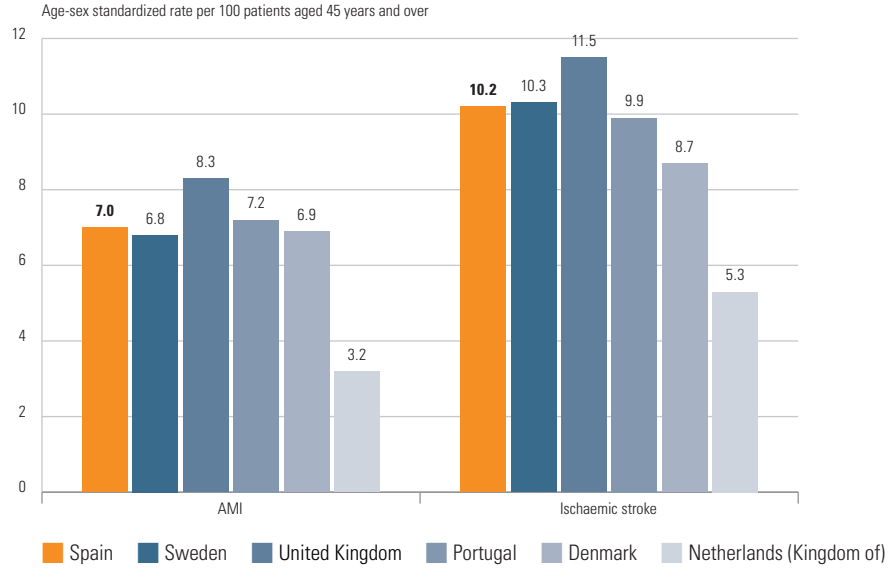


Source: OECD (2023b).

Note: France data from 2015; Slovakia and Netherlands (Kingdom of the) data from 2019 (latest available).

With regard to **hospital mortality**, figures have remained rather stable since 2015 for acute myocardial infarction and ischaemic stroke, with dramatic variations across hospitals (Comendeiro-Maaløe et al., 2022; Estupiñán-Romero et al., 2023). Compared with other OECD countries, using linked data from 2021, which allows for the consideration of after-discharge deaths, the 30-day hospital acute myocardial infarction mortality rate after admission for Spain was 7% (9% in 2011), 2 percentage points lower than the OECD average, similar to Danish and Swedish rates, but far from the 3.2% case-fatality rate exhibited in the Kingdom of the Netherlands (OECD, 2023a) (Fig. 7.4). Regarding mortality after ischaemic stroke, the Spanish rate was 10.2% in 2021, a slight improvement compared to 11.4% in 2011. In comparative terms, Spain performed better than the OECD average (which was 2 percentage points higher) and ranked in line with Sweden and Portugal, although far from the 5.3% rate in the Kingdom of the Netherlands (OECD, 2023a) (Fig. 7.4).

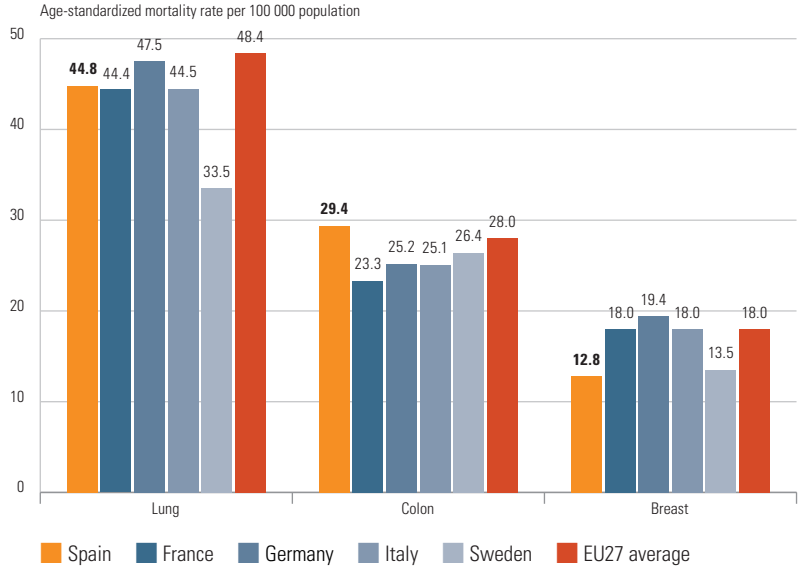
FIG. 7.4 30-day mortality rates after hospital admission based on linked data in 2021



Source: OECD (2023a).

Regarding cancer mortality, in 2020 Spain exhibited a slightly higher mortality rate than the EU average in colon cancer (29.4 cases vs. 28 cases per 100 000 population) (Fig. 7.5). In contrast, Spanish mortality rates were lower than the EU average in the case of lung cancer (44.8 compared to 48.4 cases per 100 000 population) and breast cancer (12.8 compared to 18 cases per 100 000) (OECD, 2024).

FIG. 7.5 Age-standardized mortality rate per 100 000 population for lung, colon and breast cancer, 2020



Source: OECD (2024).

In terms of adequate and safe prescribing of medicines in primary care, Spain ranks high in the overall volume of prescribed antibiotics, with 18.4 DDD per 1000 population (below the 23.1 DDD per 1000 population in 2019), above the OECD average (13.5 DDD per 1000 population) and far above 7.2 DDD per 1000 population in Austria, the country with the lowest rate (OECD, 2023a). Likewise, the volume of opioids was remarkably high – 21 DDD per 1000 population in 2021 (higher than the 2019 rate of 19.6 DDD per 1000 population), well above the OECD average (13.2 DDD per 1000 population) and far above 6 DDD per 1000 population in Italy, the country with the lowest rate (OECD, 2023a). When it comes to

the use of appropriate treatments in nosocomial infection within intensive care units, the 2022 ENVIN-UCI study (registry-based study for the surveillance of nosocomial infection in ICU) revealed an improvement in the appropriateness of antibiotic therapy, particularly in catheter-associated bacteremia: 12% of patients with pneumonia associated with mechanical ventilation in 2022 did not receive the proper treatment as compared to 14.4% in 2016; and 8.8% of patients with catheter-associated bacteremia did not receive the appropriate antibiotic as compared to 18.8% in 2016 (SEMICYUC, 2022).

7.4.1 *Patient view*

The Healthcare Barometer provides a view on patient satisfaction with the SNS. In 2023, 56.7% of the general population gave a positive assessment to the SNS. Nonetheless, 28.5% of the interviewees think that, although some things work, fundamental changes are needed, and 14.3% think that the SNS does not work properly and needs profound changes (Ministry of Health, 2024a). In 2017, the proportion of respondents showing discontent was 31.6%, 11 percentage points lower than in the latest 2023 report. Nonetheless the overall satisfaction with the SNS functioning in 2023 is 6.3 out of 10, just slightly below the 6.7 that it was in 2017. Finally, those declaring having received good or very good primary care in 2023 is 81.4% (in contrast with 87.4% in 2017); those reporting having good or very good outpatient specialized care were 82.8% (similar to 2017, 83.5%); and those declaring having received good or very good hospital care were 89.6%, slightly above the 2017 figure (86%) (Ministry of Health, 2018b, 2024a).

In recent years, primary care services, having been weakened in the aftermath of the COVID-19 pandemic, have been the focus of media attention, translating into the perception of a deep crisis and the need for refoundation. Whether this atmosphere of crisis in primary care has affected citizens is a new question in the 2023 Health Barometer. Slightly more than half of the people interviewed (53%) have not felt affected, 21.9% have been somewhat affected and around 22.1% say they have been affected quite a lot (13.7%) or a great deal (8.4%) (Ministry of Health, 2024a).

In terms of patient-centredness in ambulatory care, 85% of patients declared having been involved in the decision-making over their own care in 2021. As compared to OECD countries, Spain ranked slightly above the average (84%), improving over time to reach a level far above the result of 61.2% in 2010 (OECD, 2023a). Nonetheless, Spanish figures are far from the 94% of patients declaring that they took part in health care decision-making in Austria, the country with the highest figures) (OECD, 2023a).

Testifying to the level of confidence in public health care services, in 2023, when interviewees were asked if they or a member of their household (who depends on them) had to use a health service and had a choice between a public or a private provider, 70% of respondents would choose public primary care services, 57.2% would choose public outpatient specialists, 75.8% public hospitals and 72.6% public emergency services (Ministry of Health, 2024a), improving those figures from 2017 (67.8%, 54.6%, 66.7% and 65%, respectively) (Ministry of Health, 2018b). The decision to opt for VHI rests overwhelmingly on the desire to reduce the time period to access the needed medical appointment or treatment, as reported by 75.5% of respondents in 2023 (Ministry of Health, 2024a).

7.5 Health system outcomes

7.5.1 *Avoidable mortality and policies*

In 2020, Spain had among the lowest rates of avoidable mortality in the EU (Fig. 7.6). Preventable deaths[21], which had been declining in the years prior to the pandemic, suffered from the deadly impact of the COVID-19 pandemic, raising preventable mortality rates from 110 deaths per 100 000 population in 2019 to 143 deaths per 100 000 population in 2020, an increase of 30%[22] (OECD/European Observatory on Health Systems and Policies, 2023).

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21 Preventable mortality: deaths that could have been avoided by public health interventions focusing on wider determinants of health.

22 Since 2021, death from COVID-19 has been classified as preventable under this metric as it is deemed to be a vaccine-preventable condition.

The low rates of preventable mortality[23] in Spain may be related in part to public policies, legislation and initiatives aiming to minimize health risk factors (see Bernal-Delgado et al., 2018; and Sections 2.4 *Regulation and Planning* and 5.1 *Public Health*). These include:

a) the 2021 amendment to the Law on Traffic Circulation of Motor Vehicles and Safety, increasing efforts to reduce road traffic accidents while setting targets for reductions by the end of the decade (see Section 2.5 *Intersectorality*);

b) the introduction of an excise tax on sugar-sweetened beverages in 2021, with a focus on lower-income households (see Section 2.5 *Intersectorality*);

c) the introduction of the Nutri-score food labelling system in 2021, enabling companies in the food industry to label the grade of healthfulness of a given food product on a voluntary basis;

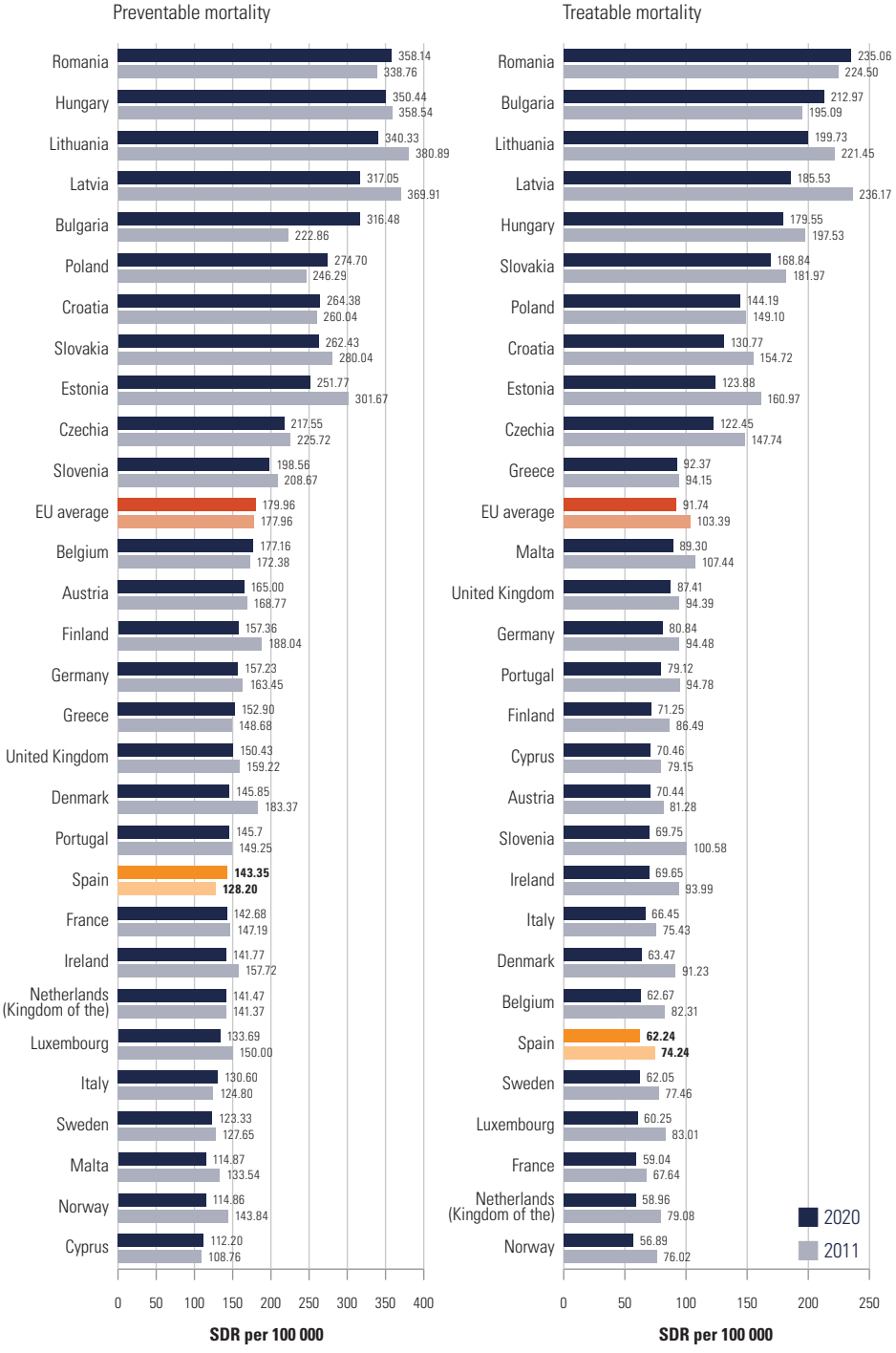
d) the National Strategic Plan for the Reduction of Childhood Obesity 2022–2030, a collaborative, intersectoral plan developed to provide a roadmap to reduce child and adolescent overweight and obesity in Spain by 25% by 2030;

e) the Public Health Strategy 2022, a common strategy to strengthen public health across all regions (see Section 5.1 *Public Health*); and

f) the Strategic 2019 Primary Care Framework and the Primary and Community Care Action Plan 2022–2023, that has mobilized over €750 million for activities to improve primary care infrastructure, equipment and performance (see Section 6.1 *Analysis of recent reforms*).

[23] Treatable mortality: death from causes that should not occur if people have access to timely and effective health care.

FIG. 7.6 Mortality from preventable and treatable causes in Spain and EU/EEA countries, 2011 and 2020 (or latest available year), all persons, age-standardized death rates per 100 000 population

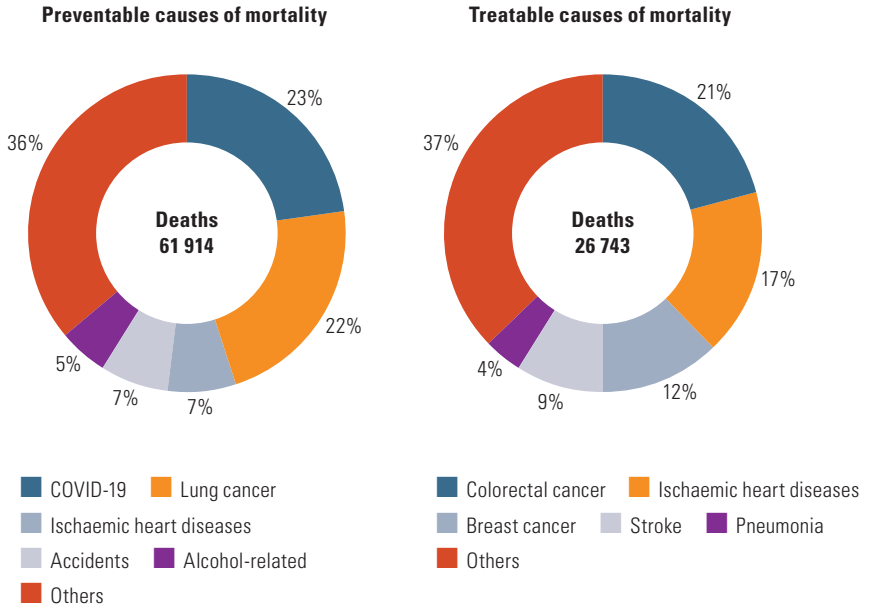


Source: Eurostat (2023o).

Note: United Kingdom data from 2018.

Mortality from treatable causes declined sharply from 103.6 deaths per 100 000 inhabitants in 2000 to 65.8 deaths in 2015 (see Bernal-Delgado et al., 2018). In 2020, treatable mortality slightly reduced to 62.2 deaths per 100 000 inhabitants. This is well below the 2020 EU average of 91.7 deaths per 100 000 population (Eurostat, 2023o)[24]. Fig. 7.7 outlines the main causes driving avoidable mortality in Spain, from both preventable and treatable causes.

FIG. 7.7 Main causes of avoidable mortality in Spain, 2020



Source: OECD/European Observatory on Health Systems and Policies (2023).

Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g., ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death.

[24] More recent data for 2021 show that age-standardized mortality rates for treatable conditions have notably improved, exhibiting 51 deaths per 100 000 population (OECD, 2023a).

The sustained reduction in treatable mortality may be partly explained by a constant effort to: improve access to effective treatments in acute ischaemic stroke and acute ischaemic heart disease (notably, the deployment of 'Code Stroke' ('*Código Ictus*') and 'code myocardial infarction' programmes) reducing time to treatments; maintain and increase coverage in population cancer screening programmes (in particular colorectal cancer); maintain or deepen policies meant to reduce unmet needs for medical examinations with small differences across income quintiles; and improve care continuity for older patients with chronic conditions.

7.5.2 *Equity in outcomes*

Life expectancy at the age of 30 in Spain varies across genders and educational levels. According to national statistics, in 2021 life expectancy at the age of 30 was 53.6 years (the same as in 2016), 50.9 in the case of men and 56.3 in the case of women (also invariant to 2016). In 2021, those with the highest educational level (that is, tertiary studies) have three more years of life expectancy as compared to those with primary education, without changes over time. Among men, the difference in life expectancy at the age of 30 between the better-off (highest educational attainment level) and the worse-off (lowest educational attainment level) was 4.3 years, favouring those with tertiary studies; in the case of women, the difference in life expectancy was 3.2 years favouring the better-off. The gap has not reduced over the years (INE, 2023h).

Healthy Life Years (that is, disability-free life expectancy), which was close to 70 years until 2020, reduced dramatically in the aftermath of the COVID-19 pandemic. In 2021, Eurostat reported that on average Spaniards could enjoy 62.8 years free of disease, below the EU average (63.6 years) and similar between men and women (63 and 62.6 years respectively) (Eurostat, 2023t).

Considering self-reported health status (see Section 1.4 *Health status*), self-perceived good health was 8 points higher in 2015 in the most affluent individuals than for those in the lowest income group (81% vs. 73%), whereas in 2022 the difference reached 15 percentage points (78.9% vs. 63.6%). The difference between men and women remained at about 5 percentage points, with 72.8% and 67.6% of men and women respectively declaring good or very good health in 2022 (Eurostat, 2023i).

Risk factors in the younger cohorts of the population – those aged 15 to 29 – are distributed differently across income quintiles (see Section 1.4 for details of risk factors impacting on the entire population). In the 15–29 age group, although Spain ranked slightly better than the EU regarding obesity in 2019 (5.4% compared to 6.5%), differences across income quintiles were dramatic that year (5.7% for the 1st (poorest) income quintile as compared to 2.1% in the 5th (richest) income quintile).

Daily smoking of more than 20 cigarettes remained slightly better in Spain as compared with the EU (4.9% compared to 5.9% of the population aged 15 to 29), improving since 2014 by 1 percentage point. However, differences across income quintiles were relevant: 6.7% of those in the 1st quintile self-declared being heavy smokers (20 or more cigarettes a day) against 3.6% of those in the 5th quintile in 2019.

Heavy episodic drinking at least once a month was far below the EU average: 8.7% of the population aged 15 to 29 against 20.3% in the EU, and remarkably better than in 2014, with 12.2% of this population subgroup declaring heavy drinking at least once a month. Again, differences across income quintiles were important, although in this case with better results for poorer groups (7.9% in the 1st quintile compared to 12.3% in the 5th quintile). Finally, in 2019, 7.3% of the younger population (aged 15 to 29) consumed more than five pieces of vegetable or fruits, below the average of 11.5% of the EU, although slightly improving on the 2014 figure of 6.9%. By educational level, 10.6% of young people aged 15 to 29 reported this level of consumption of vegetables or fruits, as opposed to 4.4% with the lowest level of educational attainment (Eurostat, 2023l).

7.6 Health system efficiency

Despite the efforts made to improve efficiency, academic and political actors recognize the lack of systematic and comprehensive studies evaluating the efficiency of the health system and public policies, and the need to create a dedicated and independent national agency for the evaluation of the health system (AES, 2014, 2020; Vida, Oliva & Lobo, 2023; Spanish Socialist Workers' Party, 2023; Popular Party, 2023).

7.6.1 *Allocative efficiency*

MACRO LEVEL

There are three main policy instruments in Spain supporting allocative efficiency at the macro level: a) the financing mechanism of the ACs whose main goal is the even financing of welfare state services (that is, health, education and social services) across the country; b) a policy design towards UHC; and c) guidance on the adoption of new technologies.

1. AC financing mechanism. Health services (as well as education and social services) are mainly funded with resources from the Fund for Basic Public Services (FBPS). This Fund represents 75% of ACs' aggregated fiscal resources and seeks to evenly provide sufficient funding to the ACs according to a formula of 'weighted need' (see Section 3.3.3 *Pooling and allocation of funds*). This Fund is complemented with a general fund, the Fund for Global Sufficiency (FGS), which largely guarantees the financial *status quo* of the ACs according to the relative level of expenditure at the time of the decentralization of health care competences in 2001 (see García-Armesto et al., 2010). Unfortunately, this second mechanism has largely hampered the reallocation of funds across ACs, as it has *de facto* perpetuated financing imbalances across ACs, and is not driven by differences in need.

2. Policy design towards universal health coverage. Since 2018, several policies have been introduced to reduce gaps and aim for full UHC. The most important reforms have been: 1) returning to residence status as the basis of entitlement (see Section 3.3.1 *Coverage*, and *Chapter 6*); 2) expanding some benefits (see Sections 2.7.5 *Regulation of medical equipment, devices and aids* and 7.2 *Accessibility*); and, 3) the extension of co-payment exemptions to people benefiting from the guaranteed minimum income scheme, to pensioners with low incomes, to moderately and severely disabled children and to households receiving child benefits (see Section 3.4 *Out-of-pocket payments*). However, some gaps in the achievement of full UHC remain (see Section 7.2).

3. Guidance for the adoption of new technologies. Although cost-effectiveness is required by law as a main point when making decisions on resource allocation, few steps have been taken to include efficiency in the decision-making equation. It is worth highlighting the role of the Spanish Network of Agencies for Health Technologies and Benefits Assessment that,

within its current mandate, has reviewed the value of existing benefits, has designed and coordinated *ad hoc* evaluative studies for the adoption of new technologies (except for drugs that are a competence of AEMPS), and has standardized methodologies for HTA evaluation (REDETS, 2023).

This approach has indeed superseded the classical priority-setting mechanism based on health strategies or general plans – inspirational documents whose recommendations were not always based on effectiveness. In the case of pharmaceuticals, VALTERMED has become an instrument for the evaluation of health outcomes in drugs with a high economic impact (Ministry of Health, 2021a). These evaluations are used to inform decisions about pharmaceutical provision during the different stages of the drug cycle. In 2020, the SNS Drug Evaluation Network (REvalMed) was launched, heading to the inclusion of economic evaluation criteria in the so-called 'therapeutic positioning reports' aiming to inform decisions on drug pricing and reimbursement. Unfortunately, the economic evaluation in these reports was declared null by the National Court in July 2023 following a successful lawsuit filed by the Spanish Association of the Pharmaceutical Industry (see Section 2.7.3 *Regulation of services and goods*).

Spanish independent bodies, such as the National Commission for Markets and Competition, highlighted in 2022 the inadequacies of economic evaluation in funding and pricing decisions, and recommended its incorporation into the therapeutic positioning reports (CNMC, 2022). Along the same lines, AIReF, especially in its first review of public spending on medicines, recommended applying 'binding' cost-effectiveness criteria 'systematically' to decisions on the pricing and public financing of medicines (AIReF, 2019). These reports, among others, have led an academic debate on the actual impact of these instruments on achieving allocative efficiency; for example, the analysis of the governance of new technologies assessment instruments based on other countries' experiences has backed the debate on the need for an independent assessment body (Vida, Oliva & Lobo, 2023).

MESO LEVEL

Once funds arrive at each AC, the corresponding regional parliament approves the budget for the Department of Health, with this resource allocation generally relying on previous expenditure. Then, the Department of Health and the regional health services allocate funds through the

purchase of services to mostly public providers by using global budgeting. Global budgeting covers PCCs and hospitals providing primary, as well as hospital, emergency and pharmaceutical care for all residents in a health care area. Purchasing is operationalized through framework agreements that include the global budget for the year, estimated from actual expenditures incurred during the previous year, which are paid retrospectively. Framework agreements broadly specify the volume of services to be provided, as well as some quality and efficiency goals. Payroll costs, any reward to the centres or individuals (if it exists, it tends to be small), ancillary services and maintenance and investments are included in the global budget.

A variety of purchasing instruments in addition to global budgeting have had to be implemented to enhance allocative efficiency, while producing good health outcomes. Some notable examples include: the creation of governance bodies integrating the continuum of care, such as the integrated health organizations in the Basque Country (*Organizaciones Sanitarias Integradas*); the use of population or patient risk stratification estimates in the allocation of funds; the development and inclusion of new roles and skill shifting, effectively allowing case-management or disease-management approaches; and the purchase of normative care pathways, providing guidance about which services to purchase (that is, highly effective procedures) and from whom (that is, which care professional) (Bernal-Delgado & Angulo-Pueyo, 2023).

Unfortunately, there are no formal evaluations, either at macro or meso level, that could provide guidance on how to improve allocative efficiency.

7.6.2 *Technical efficiency*

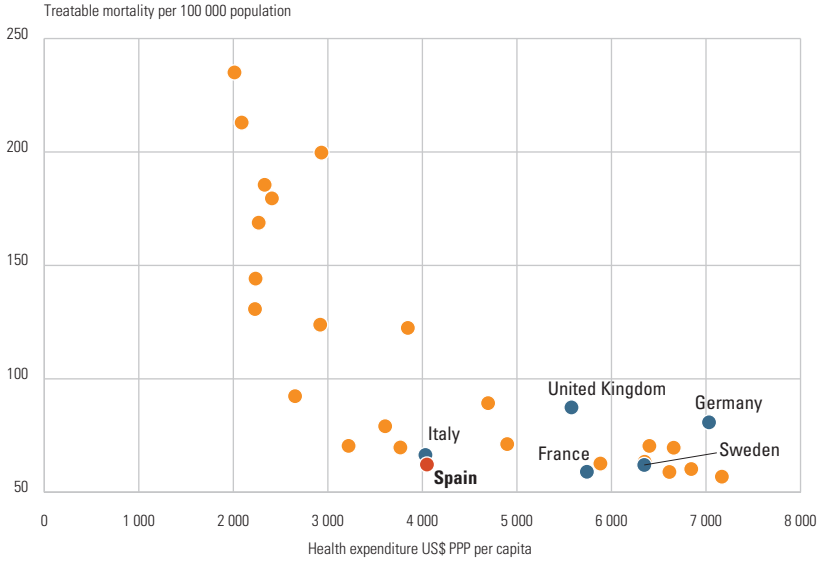
One way to provide a very cursory illustration of how the health system is performing in terms of input costs and outcomes is to plot current expenditure on health against the treatable mortality rate. Although we must be mindful that it is not possible to effectively disentangle the role of health behaviours and other determinants of the health care system in influencing the level of mortality due to treatable causes, Fig. 7.8 provides a useful entry point for discussion. As mentioned in Section 7.5, 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). Additionally, 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 (see Section 3.1 *Health expenditure*). These basic results suggest that given its expenditure levels, Spain has been able to secure very good and efficient outcomes on this metric.

Moreover, in an OECD report analysing how the institutional design of health systems gets value for money (in other words, countries' expenditure against health outcomes), Spain's SNS achieves strong results for technical efficiency (Lorenzoni et al., 2018). Among the report findings, factors that could explain SNS technical efficiency are: a) the strong regulation of medical staff in hospitals, with a physician workforce that enters the health system through the national residency programme (see Section 4.2 *Human Resources*); b) the existence of a clear benefits package, regulated by law and with a clear governance mechanism for its update (see Section 2.7.3 *Regulation of services and goods*); c) the strict regulation of salaries that translates into a restrained growth of the public budget (salaries represent 57% of hospital expenditure and 84% of primary care expenditure) (Ministry of Health, 2023f); d) effective access to the extensive benefits, equal to all citizens (see Section 3.3.1 *Coverage*); and e) the high level of financial protection for health care users (see Section 7.3 *Financial protection*).

Other factors that may explain technical efficiency in the SNS are: a) the strong gatekeeping system (except in the case of access to hospital emergency wards and Mutuality Funds whose beneficiaries may opt for direct access to specialized care) that translates into a truly principal-agent relationship, where a highly qualified Family Doctor makes decisions on the best course of action for a particular patient; b) 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, c) 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 (Bernal-Delgado et al., 2018), which has dragged down unit prices of pharmaceuticals to be among the lowest in EU.

FIG. 7.8 Treatable mortality per 100 000 population vs. health expenditure per capita, 2020



Sources: WHO Global Health Expenditure Database; Eurostat (2023o).

Note: 2018 data for United Kingdom.

7.6.3 *Gaps in technical efficiency*

Despite these good indications of technical efficiency, decisive improvements could be made in a number of areas, notably in human resources and the adequate use of treatments.

HUMAN RESOURCES

In addition to the already mentioned imbalance between the numbers of doctors and staff nurses (see Section 4.2 *Human resources*), there is a need for professions that are better equipped to meet population needs in the upcoming decades. Notably, the current deficit of specialists in family and community medicine, which is expected to worsen in the upcoming years (Barber-Pérez & González López-Valcárcel, 2022), may put at stake the SNS approach to care continuity. Moreover, there is a need for new roles, such as disease consultants, hospital-liaison nurses, case-management nurses

in primary care, community-liaison nurses and health counsellor nurses, while the inclusion of physiotherapists and social workers in primary care has been shown to be a clear asset to improve quality in the provision of chronic care (Bernal-Delgado & Angulo-Pueyo, 2023). Physiotherapists are notably underrepresented within the SNS; although in general terms the number of registered physiotherapists per 100 000 population is close to the EU average (Eurostat, 2023v), just 10% of physiotherapists in Spain have a position in the public system (Europapress, 2023). The sectoral trade union of nurses, SATSE and the College of Physiotherapists has recurrently highlighted the need for the inclusion of more physiotherapists in the SNS, alleging important cost savings (€4800 million annually) in terms of preventing the use of more complex specialized services and sick leave days (Europapress, 2023).

On a different note, the development of subspecialties and clinical units focused on specific technologies and procedures, which some argue are key to obtaining the required expertise, may in turn hinder technical efficiency in the absence of population planning for highly specialized services; indeed, the growth of medical staff in hospitals can be inefficient if it does not fully match the appropriate population demand for these subspecialties.

There is one specific case worth differentiating: mental health care. In a nutshell, in Spain more than one in six people had a mental health issue in 2019. The most common mental health issues in Spain are depression and anxiety, and Spain was the second largest consumer of prescribed anxiolytics in the EU in 2021 (OECD/European Observatory on Health Systems and Policies, 2023). The estimated societal cost of depressive disorders in the Spanish adult population was calculated to be as high as €6145 million, with indirect costs related to long-term sick leave and permanent disabilities accounting for 60.5% (Vieta et al., 2021). In contrast, mental health services are underutilized in Spain, possibly indicating problems with access to such services (Lazarus et al., 2022). Prompted by the impact of the COVID-19 pandemic on mental health, the National Strategy for Mental Health 2022–2026 aims to improve services and support for families promoting a comprehensive community care model. The Strategy emphasizes the need for specialized human resources – psychologists, psychotherapists, mental health nurses and occupational workers – at community level, explicitly recognizing the weaknesses of the current hospital-centric SNS mental health system (Ministry of Health, 2022g).

INAPPROPRIATE USE OF RESOURCES

The presence of systematic differences in standardized population utilization rates of treatments may reflect underuse of treatments that have been proven effective, overuse of treatments in non-eligible patients, overuse of treatments when a more cost-effective alternative exists, the overuse of treatments that have been shown to be ineffective for most of the population treated, or the provision of low quality and unsafe services. Large variations in the rates of these treatments would represent failures in technical efficiency that, given the institutional design of the SNS, could also turn into a deficit of allocative efficiency. The AtlasVPM project provides a systematic assessment of the SNS, nationwide and regionwide, on multiple conditions and treatments and has found gaps in the effectiveness and efficiency of the health system that would require corrective policies (Angulo-Pueyo et al., 2022). Recently, the project has provided evidence on unwarranted and systematic variations in orthopaedic surgery (Ridao-López et al., 2020), low value care (Angulo-Pueyo et al., 2020), hospital quality (Comendeiro-Maaløe et al., 2022), quality of diabetes care, including suboptimal and unsafe prescriptions in diabetes (Angulo-Pueyo et al., 2023), and the uneven dispensation of antibiotics or opioids (Angulo-Pueyo et al., 2024).

8

Conclusions

The decentralized Spanish national health system is virtually universal and mainly funded from taxes; it provides care free of charge at the point of delivery using a vast network owned by the public sector, complemented by private providers where needed.

In the period covered in this report, the SNS has addressed some of the long-lasting challenges that hindered effective access to UHC. Thus, in 2018 the basis for entitlement returned to the condition of residency; in 2020, co-payments in pharmaceutical care were largely reformed with the inclusion of new exemptions benefiting 7.3 million people in 2024 and improving the financial protection of the most vulnerable; and euthanasia services were added to the benefits package covered by the SNS in 2021. However, it has become evident that there is a need to strengthen primary care, expand dental care and solve the shortage of human resources and services in some specialties to make access truly effective.

Importantly, as part of the reflection process following the COVID-19 pandemic, addressing some coordination gaps across and within institutions emerged as paramount requirements in effectively tackling future emergencies. This translated into action – with a national public health strategy and the proposal to create a National Agency of Public Health, which is under way.

There are remaining challenges, nevertheless, that will require action in the coming years to have an impact on the sustainability and resilience of the Spanish health system. Among these challenges is the need to deepen policies aimed at tackling the determinants of health, specifically tobacco and alcohol consumption, overweight and obesity in younger populations. Just as important is the need to deepen the effective coverage of mental health care, rehabilitation services, and dental and optical care, particularly

for people from the most deprived households. The need for primary care to adapt and address new epidemiological, societal and technological challenges requires a continuous effort on the part of the health system – and addressing the shortage of physicians in some specialties is intricately linked to this goal, given that the lack of primary care professionals is a major concern, along with the wider issue of the longer-term projected mismatch between increasing health needs and health workforce capacity. Related to this is the need for better coordination between the public health system, the health care system and the social sector, especially, to cover the needs of elderly people and mental health patients. Moreover, growing waiting times, importantly in primary care, have increased the perception among the population that there is weakened access to the health system, potentially increasing the inequalities between the better-off and the worse-off. While the list seems long, most of these challenges are common to health systems throughout Europe, where improving health system performance is often not far from the centre of policy agendas. In Spain, as in other countries, there is a need for instruments that can provide a clearer view on what constitutes value for money, addressing salient and persistent inefficiencies, such as the uneven use of effective treatments and the overuse of non-appropriate or ineffective procedures. Finally, in line with the goal of sustainability, there is a need for more and better evaluation, particularly for the adoption of new treatments and technologies, as well as for the assessment and appraisal of the impact of public policies on the health of the population.

9

Appendices

9.1 References

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Royal Decree 589/2022, 19 July, regulating the transversal training of specialties in Health Sciences, the procedure and criteria for the proposal of a new specialist title in Health Sciences [Real Decreto 589/2022, de 19 de julio, por el que se regulan la formación transversal de las especialidades en Ciencias de la Salud, el procedimiento y criterios para la propuesta de un nuevo título de especialista en Ciencias de la Salud]. Available at: https://www.boe.es/eli/es/rd/2022/07/19/589/con (accessed 23 October 2023).

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Royal Decree-Law 1/2015, 24 July, approving the the Law on guarantees and rational use of medicines and health products [Real Decreto Legislativo 1/2015, de 24 de julio, por el que se aprueba el texto refundido de la Ley de garantías y uso racional de los medicamentos y productos sanitarios]. Available at: https://www.boe.es/eli/es/rdlg/2015/07/24/1/con (accessed 21 November 2023).

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Royal Decree-Law 32/2021, 28 December, on urgent measures to the labour reform, guaranteeing job stability and changing the job market [Real Decreto-ley 32/2021, de 28 de diciembre, de medidas urgentes para la reforma laboral, la garantía de la estabilidad en el empleo y la transformación del mercado de trabajo]. Available at: https://www.boe.es/buscar/act.php?id=BOE-A-2021-21788 (accessed 3 July 2023).

Royal Decree-Law 12/2022, 5 July, modifying Law 55/2003 [Real Decreto-ley 12/2022, de 5 de julio, por el que se modifica la Ley 55/2003, de 16 de diciembre, del Estatuto Marco del personal estatutario de los servicios de salud]. Available at: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-11132 (accessed 6 July 2023).

Royal Legislative Decree 1/2013, 29 November, approving the Consolidated Text of the General Law on the Rights of Persons with Disabilities and their Social Inclusion [Real Decreto Legislativo 1/2013, de 29 de noviembre, por el que se aprueba el Texto Refundido de la Ley General de derechos de las personas con discapacidad y de su inclusión social]. Available at: https://www.boe.es/buscar/act.php?id=BOE-A-2013-12632 (accessed 9 July 2024).

9.3 Useful websites

Health Barometer
https://www.sanidad.gob.es/estadEstudios/estadisticas/BarometroSanitario/home_BS.htm

Interterritorial Council of the National Health System
https://www.sanidad.gob.es/organizacion/consejoInterterri/home.htm

Key indicators of the SNS. Database [Indicadores Clave del Sistema Nacional de Salud: Base de datos]
https://inclasns.sanidad.gob.es/main.html

Data Science for Health Services and Policy Research Group
https://cienciadedatosysalud.org/en/

National Institute of Statistics (INE)
www.ine.es

National Office of clinical practice guidelines (GUIASALUD)
http://www.guiasalud.es/home.asp

National System for the assistance of dependent people (SAAD) Information System
https://imserso.es/autonomia-personal-dependencia/sistema-autonomia-atencion-dependencia-saad/el-saad/sistema-informacion-sistema-autonomia-atencion-dependencia-sisaad

https://imserso.es/web/imserso/el-imserso/documentacion/estadisticas/sistema-autonomia-atencion-dependencia-saad

Public Health Expenditure Statistics (EGSP)
https://www.sepg.pap.hacienda.gob.es/sitios/sepg/es-ES/Presupuestos/DocumentacionEstadisticas/Estadisticas/Paginas/Estadisticas.aspx

Quality Plan for the National Health System
https://www.sanidad.gob.es/organizacion/sns/planCalidadSNS/

SNS Statistical portal
https://www.sanidad.gob.es/estadEstudios/portada/home.htm

Spanish Agency of Medicines and Health Products (AEMPS)
http://www.aemps.gob.es/

Spanish Association of Public Health and Health Administration (SESPAS)
http://www.sespas.es/

Spanish Observatory on Drugs and Addictions (OEDA)
http://www.pnsd.msssi.gob.es/profesionales/sistemasInformacion/home.htm

9.4 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: https://eurohealthobservatory.who.int/publications/i/health-systems-in-transition-template-for-authors.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European

Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.

2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border health care.

3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers are paid.

4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.

5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care,

mental health care, dental care, complementary and alternative medicine, and health services for specific populations.

6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.

7. Assessment of the health system: provides an assessment based on the stated objectives of the health system, financial protection and equity in financing; user experience and equity of access to health care; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.

8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.

9. Appendices: includes references, useful websites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with one another to ensure that all stages of the process are as effective as possible, and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

9.5 About the authors

Enrique Bernal-Delgado (MD PhD) is a senior researcher in health services and policy research. He is also Master in Public Health and Master in Health Economics. After a period as Visiting Scholar at The Dartmouth Institute (Dartmouth Medical School, NH, USA), he founded the Data Science for Health Services and Policy Research group at the Institute for Health Sciences in Aragon (IACS) where he currently holds the position of senior scientist.

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