How does Spain’s health sector contribute to the economy?
Health matters. The health sector is an important and innovative industry, as well as a source of stable employment for many people. Health systems support active and productive populations, reduce inequities and poverty, and promote social cohesion. A strong health system makes good economic sense and underpins the overall sustainable development agenda.

Countries around the world are grappling with the health, economic and fiscal implications of the COVID-19 pandemic. As they begin to recover from the crisis, difficult decisions will need to be made about how to allocate scarce resources. These snapshots share valuable evidence for policy-makers on how investing in health sectors and health systems helps to achieve national economic objectives.

This snapshot is part of a series developed by the European Observatory on Health Systems and Policies in collaboration with the WHO Barcelona Office for Health Systems Financing. It draws on cross-country comparable data and country-specific analysis and expertise to explore how well the health sector in Spain contributes to the economy – and how it can do more, especially in the context of COVID-19.

This text was written by Enrique Bernal-Delgado [Institute for Health Sciences in Aragon (IACS)] and Lynn Al Tayara (WHO Barcelona Office for Health Systems Financing), supported by Elisa Gomez and Jonathan Cylus from the European Observatory on Health Systems and Policies, José Cerezo, Sarah Thomson, Triin Habicht and Tamás Evetovits from the WHO Barcelona Office for Health Systems Financing. It draws on a previous report written by Sandra Garcia-Armesto and Enrique Bernal-Delgado [Institute for Health Sciences in Aragon (IACS)], supported by Erica Richardson from the European Observatory.
How does Spain’s health sector contribute to the economy?

The health sector makes up an important share of the Spanish economy, with new opportunities within the medical technology and pharmaceutical industries

The health sector in Spain plays a key role in the economy and has remained sizeable even in the face of economic downturns. In 2019, current health spending accounted for 9.1% of total gross domestic product (GDP), above the European Union (EU) average of 8.3% but similar to Italy (8.7%) and Finland (9.2%), while lower than neighbouring countries France (11.1%) and Portugal (9.5%), as seen in Fig. 1 (WHO, 2021).

Beginning in 2008, Spain faced a major multi-year economic crisis with a notable decline in GDP, a rise in unemployment and increased public debt (Royo, 2020). In response, Spain introduced austerity measures that reduced public spending on health and cut regional health budgets from 2012 to 2014 (Thomson et al., 2015). The Spanish economy has since recovered and the health share of the government budget (the priority given to health) has gradually increased from 13.6% in 2012 to 15.3% in 2019. It is slightly above the average for the EU-28, but still below high-income neighbouring countries (Fig. 1) (WHO, 2021).

Public spending on health grew substantially in response to the COVID-19 pandemic and is expected to remain high in 2022. This additional spending came from a number of sources, including an earmarked fund of 16 billion euros dedicated to health, education and supporting economic activity in autonomous communities (European Observatory on Health Systems and
Policies, 2020); up to 3.2 billion euros from the 2014–2020 European Regional Development Funds to finance testing, equipment, health workers and surveillance application development (European Observatory on Health Systems and Policies, 2020); and 7.3 billion euros to boost the budget of the Ministry of Health, strengthen primary care, target gaps in health coverage policy, reduce inequalities across autonomous communities and purchase COVID-19 vaccines (European Observatory on Health Systems and Policies, 2020).

Health-related industries play an important role in the economy. Despite the economic crisis caused by the COVID-19 pandemic, the health technology sector generated a turnover of 8.8 billion euros in 2020 and employed 28 500 people, which is significant for the Spanish economy but remains behind neighbouring countries like France (Federación Española de Empresas de Tecnología Sanitaria, 2020). Nearly 700 million euros out of the health budget in 2021 are dedicated to improving health technology and reinforcing the digitalization of the health system (European Observatory on Health Systems and Policies, 2020). For instance, autonomous communities are deploying Strategic Plans on Digital Health to transform the health systems in Spain through the creation of a National Health Data Space.

The COVID-19 pandemic has created further opportunities for digital technologies in health. The use of digital tools and teleconsultations became more frequent. Nevertheless, a lack of knowledge on the availability of these tools, as well as a dearth of skills and technical support were hindering factors to their rapid development and uptake, potentially impeding growth in the sector (European Observatory on Health Systems and Policies, 2021).

The Spanish pharmaceutical industry also plays a notable role in the economy and is expected to grow from 23.7 billion US dollars in 2016 to 25.1 billion US dollars by 2021 (from 21.4 billion euros to 22.7 billion euros)¹ (IQVIA, nd; Global Data, 2017). Although it was affected by austerity measures including pharmaceutical price containment measures in 2010, tax incentives have allowed the industry to recover (Pharmaceutical Executive, 2019). Given the strong government support, a highly qualified workforce, infrastructure for innovation and research and development (R&D) as well as demand for innovative medicines, the pharmaceutical industry can be an important engine for growth and has been providing stability to the economy in the past decade (Global Data, 2017).

Health-related R&D, vital to innovation, also supports economic growth. In 2019, around 12% of the Spanish government’s total R&D budget was allocated to health, above Germany (5.1%) but lower than Norway (15.6%) and the United Kingdom (21.5%) (OECD, 2020a). Investments in innovations in e-health, particularly the use of Electronic Health Records, teleconsultations, artificial intelligence and big data would provide an additional boost to the economy.

Although the health sector in Spain is a stable source of jobs, precarious working conditions have led to workforce shortages

Health sector employment in Spain has remained stable over the past decade despite broader labour market fluctuations (Fig. 2). The health sector accounted for 4.2% of the economically active population in 2018, which is below the EU average (5.3%), Italy (5.6%), Germany (7.7%), France (6.6%) and Finland (7.2%) and on a par with Portugal (4.2%) that same year (Eurostat, 2020a). The health share of the economically active population has been growing slightly since 2008, remaining stable even as unemployment peaked at 26% in 2013 (Eurostat, 2020a).

The COVID-19 crisis seems unlikely to alter the stable trend of health employment, as health professionals continue to be in high demand. The health sector nevertheless needs to address major challenges relating to the precarious nature

¹ Calculation based on an average exchange rate of 1 US dollar = 0.9035 euros, 2016 prices
of jobs and poor working conditions to maintain or increase the supply and quality of the health workforce.

Austerity measures in response to the 2008 economic crisis led to greater use of temporary contracts (Casasnovas, Seguí & Arasanz Goset, 2021), deterioration of job quality (OECD and European Observatory on Health Systems and Policies, 2019), increased statutory working hours and reduction in the salaries of health workers (by 7.2%); most of these workers are in the public sector (Thomson et al., 2015). This caused many health workers to migrate in search of better opportunities (Bernal-Delgado et al., 2018; OECD and European Observatory on Health Systems and Policies, 2019). The number of temporary contracts has grown substantially in recent years, rising from 28.5% in 2019 to 41.9% in 2021 (OECD and European Observatory on Health Systems and Policies, 2021), and the current workforce is rapidly ageing. As a result, Spain needs to address health worker shortages, especially in remote rural areas where some positions are hard to cover. The number of physicians in Spain was 4.4 per 1000 population in 2021, slightly above the EU average and increasing from 3.9 in 2019 (OECD and European Observatory on Health Systems and Policies, 2021). However, the number of practicing nurses, at 5.9 nurses per 1000 population, is low and still significantly below the EU average of 8.4 and most western European countries (OECD and European Observatory on Health Systems and Policies, 2019). Variation in health worker ratios across autonomous communities, which are particularly large for nurses, is a further challenge (Instituto español de investigación enfermera, 2020).

Aware of these workforce challenges, the Ministry of Health increased the number of vacancies for medical specialties, particularly primary care, and for nurse training in 2020. Additionally, in response to workforce challenges stemming from the COVID-19 pandemic, the government provided financial bonuses and raised salaries in some regions, (European Observatory on Health Systems and Policies, 2020), adopted faster recruitment tracks and eased the re-registration process allowing foreign-trained health workers, retired doctors, final year medical students, trainees and those who passed the 2019–2020 medical examinations to participate in the pandemic response (European Observatory on Health Systems and Policies, 2020; Williams et al., 2020a). Nevertheless, the pandemic’s physical and mental toll is significantly affecting workers with many reporting poor job satisfaction due to the unfavourably long working hours and many catching the virus while performing their job (Casasnovas, Seguí & Arasanz Goset, 2021).

**Fig 2** Jobs in the health sector have remained stable in Spain despite labour market fluctuations

<table>
<thead>
<tr>
<th>Year</th>
<th>Employed in health</th>
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<tbody>
<tr>
<td>1990</td>
<td>5.0</td>
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Source: Eurostat (2020a); IMF (2020).
Spain achieves good health outcomes at low cost, fostering a healthy and productive workforce

Spain achieves good health outcomes despite spending less on health per person and as a share of GDP than many other western European countries. In 2017, Spain reported a treatable mortality lower than the EU average: 66 deaths per 100,000 people could have been avoided through access to quality health care compared with the EU average of 109 deaths per 100,000 (OECD, 2020b). Spain had the highest life expectancy in Europe at 83.5 years in 2019 (World Bank, 2021), but fell substantially in 2020 as the result of the COVID-19 pandemic (OECD and European Observatory on Health Systems and Policies, 2021). It has also made real progress with the infant mortality rate at 2.7 per 1000 live births in 2018, down from 4.4 per 1000 in 2000. Preventable mortality is among the lowest in the EU in part because of preventive services provided within primary care and public health initiatives targeting smoking and obesity rates (OECD and European Observatory on Health Systems and Policies, 2019).

This suggests that the Spanish health system is efficient. Although levels of spending on health are low compared with neighbouring countries, resources are put to relatively good use; 12 countries spent more on health in 2017 but only two attained a treatable mortality level lower than that of Spain (Fig. 3). The Spanish health system generally provides timely, effective and good-quality care, averting the death of many people under 75 years of age, notably thanks to a strong primary care model. It has important implications for enhancing labour force participation and productivity as well as decreasing vulnerability to COVID-19.

There is, however, room for improvement. According to the World Bank’s Human Capital Index, as a result of investments in health care (and education), a child born in Spain today can expect to be 73% as productive by age 18 relative to a child with a complete education and full health (Human Capital Index 0.73), equivalent to the EU average but behind the United Kingdom (78%) and France (76%) (World Bank, 2020). Waiting times for specialist care are also a longstanding and growing concern in Spain.

Spain has achieved great COVID-19 vaccination rates: in January 2022, 84.1% of the population over 5 years old had received two doses, and 53% of children between 5 and 11 years had received at least one dose (Ministerio de Sanidad, nd). Vaccination coverage in Spain is lower than the WHO target for measles, with 94% coverage for the second dose, and could be improved on other infectious diseases such as diphtheria, pertussis and tetanus (96% coverage in 2019) despite vaccines being offered in primary health-care centres and awareness campaigns (Bernal-Delgado et al., 2018; OECD and European Observatory on Health Systems and Policies, 2019; WHO, 2020).

Keeping people healthy across the life course contributes to a healthy and productive workforce, enabling people to participate in the labour market for longer. Obesity is a growing issue, more prevalent among Spanish children and adolescents than in many other EU countries (Bernal-Delgado et al., 2018; OECD and European Observatory on Health Systems and Policies, 2019, 2021), with labour force participation among older workers in line with the EU average. The proportion of the population aged 55–64 years old working in Spain was 62% in 2019, similar to the EU average (63%) and above France (57%) and Italy (57%) but below Denmark (73%), Germany (74%) and the Netherlands (72%) (Eurostat, 2020b). Health status is a deciding factor in exiting the labour force early in Spain. In 2012, 29.3% of people aged 50–69 years who were in receipt of a pension reported that they stopped working because of poor health or disability, well above the EU average of 21% (Eurostat, 2019). Additionally, similar to France but more than in Italy, about 60% of Spaniards report having at least one chronic condition after age 65 and more than one in five experiences disabilities and health conditions that impede activities of daily living (OECD and European Observatory on Health Systems and Policies, 2019).

Health inequalities across socioeconomic status also affect labour force participation. An approximately 4-year gap in life expectancy exists between people with high socioeconomic status in comparison to those with lower socioeconomic
status (OECD and European Observatory on Health Systems and Policies, 2019). During the COVID-19 pandemic, visits for diagnoses related to socioeconomic and housing problems have increased, emphasizing the importance of social determinants of health and the central role of primary care in addressing health inequalities (Lopez Segui et al., 2021).

Households are better protected from financial hardship than in most other European countries because of the strong design of health coverage policy

The goals of universal health coverage are to ensure that everyone can use the quality health services they need without experiencing financial hardship (United Nations, 2015). Universal health coverage is central to health and well-being, alleviates poverty, reduces socioeconomic inequalities, contributes to health security and boosts economic growth (Cylus, Govin & Smith, 2018). Financial protection, which is central to universal health coverage and health system performance, is measured using two indicators: catastrophic health spending and impoverishing health spending.

Despite worsening during the economic crisis, financial hardship in Spain is one of the lowest in the EU, and much lower than would be expected given Spain’s relatively heavy reliance on out-of-pocket payments. In 2019 (the latest year for which data are available), just 1.6% of households in Spain experienced catastrophic health spending and 0.8% were impoverished or pushed further into poverty by out-of-pocket payments (Fig. 4) (Urbanos-Garrido et al., 2021).

This can be explained by strengths in the design of the National Health System (NHS) coverage:

- Entitlement to the NHS is based on residence
- The NHS benefits package covers a relatively wide range of health services, with very little regional variation
- User charges (co-payments) apply only to outpatient prescribed medicines and ortho-prosthetic devices
- There are multiple protection mechanisms from existing co-payments, such as reduced co-payments and a cap of €4.24 per item for most outpatient prescribed medicines for chronic conditions; exemptions from co-payments

**Source:** Eurostat (2017); WHO, Global Health Expenditure Database (2021).

**Notes:** PPP Int$, purchasing power parity in international dollars.
for disadvantaged groups of people (recently expanded); and income-based monthly caps on co-payments for prescriptions for most pensioners.

Challenges remain, however. The incidence of catastrophic health spending in 2019 is still above pre-financial crisis levels and is heavily concentrated among the poorest households (Urbanos-Garrido et al., 2021). Out-of-pocket spending as a share of current health spending is high compared with the rest of western Europe as it accounted for 21.8% of current health spending in 2019, above Germany (12.8%), the United Kingdom (17.1%) and the EU average (21.6%) (Eurostat, 2020c). The main drivers of out-of-pocket payments are dental care (mostly excluded from public coverage); medical products (including optical care for eyesight problems and orthopaedic material) and medicines, both subject to co-payments. Levels of self-reported unmet need due to cost, distance or waiting time are higher for dental care (5% of the population in 2019) than health care (0.2%), particularly for the poorest fifth of the population (12% for dental care) (Urbanos-Garrido et al., 2021). This leads to forgone care and adverse repercussions on health outcomes and labour productivity.

In January 2021, Spain introduced new exemptions from user charges for outpatient medicines, benefiting 6 million people, and increased public spending on dental care. The government is also aiming to remove administrative barriers to care for people in precarious situations (for example, undocumented migrants) to NHS services to which they are entitled (WHO Regional Office for Europe, 2021). These coverage policy reforms were introduced in spite of restricted fiscal capacity resulting from the COVID-19 pandemic (WHO Regional Office for Europe, 2021).

In addition to increases in catastrophic health spending and unmet need, the 2008 economic crisis was also associated with an increase in waiting times, a longstanding issue in the Spanish NHS. Waiting times for medical examinations and specialist care can result in financial hardship and unmet need and exacerbate socioeconomic inequalities in access to services (Urbanos-Garrido et al., 2021).

The COVID-19 pandemic severely disrupted primary care in 2020. There were significant reductions in the annual incidence of several conditions commonly seen in primary care compared with the average for the 2017–2020 period. This is mainly due to the prioritization of COVID-19 care to the detriment of face-to-face scheduled visits for the detection and monitoring of chronic diseases, which fell by almost 41% during 2020 (Sisó-Almirall et al., 2021).

**Fig 4** Though rates have increased, few households are impoverished, further impoverished or at risk of impoverishment as result of paying out-of-pocket payments

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

Improving working conditions and addressing precariousness of temporary jobs would address health workforce shortages and boost the job market.

Making jobs in the Spanish health sector more secure and attractive with competitive remuneration and well-defined career paths could curb some outflow of skilled personnel. It could also attract younger workers as older people retire and cover some positions in rural areas, tackling distributional issues. Although measures to reduce temporary employment contracts, increase vacancies and make career paths more accessible are in place there is scope for more task-shifting in the health sector, expanding the role of nurses and other health workers, and promoting team-work collaboration.

Investing in public health and strengthening primary care is essential to reduce behavioural risks and ensure long-term workforce sustainability.

Although preventive services are provided within primary care and public health initiatives are in place in Spain (OECD and European Observatory on Health Systems and Policies, 2019), additional preventive measures, especially targeting young people, would address behavioural risk factors such as obesity. Strengthening primary care can also address pent up demand and re-start community health activities disrupted by the pandemic. Even if Spain has the longest life expectancy in Europe, there is scope for improving chronic conditions and morbidity and targeting early retirement.

Expanding NHS coverage for dental and optical care and reducing co-payments would strengthen financial protection and reduce unmet need.

Although catastrophic incidence is relatively low, financial hardship and unmet need in Spain are mainly caused by out-of-pocket payments for dental care, optical care, and outpatient prescription medicines especially among lower-income households. Reducing unmet need and financial hardship requires expanding NHS coverage for dental and optical care and reducing co-payments for outpatient prescribed medicines and ortho-prosthetic devices (for example, by extending the income-related cap on co-payments for most pensioners to non-pensioner households). Although Spain introduced new protective measures during COVID-19, more can done (WHO Regional Office for Europe, 2021).
Description of the health system

The statutory Spanish health-care system is based on an NHS (SNS; Sistema Nacional de Salud) covering >99% of the population. Two subsystems coexist: the Mutual Funds and the Mutualities run by the social security system. (Bernal-Delgado et al., 2018).

Regulation, management and delivery of health services are highly decentralized. The SNS regulates and coordinates the overall health system and monitors performance under the Interterritorial Health Council; the 17 autonomous communities ensure the financing, organization and delivery of care services with the support of specialized entities (Bernal-Delgado et al., 2018).

Entitlement is based on residence. The NHS benefit package covers a wide range of health services, although coverage of dental care is limited. User charges (co-payments) apply only to outpatient prescribed medicines and ortho-prosthetic devices. There are multiple protection mechanisms from existing co-payments (Urbanos-Garrido et al., 2021). Primary care is central in the Spanish health system, with a strong system of referral to specialized care (Urbanos-Garrido et al., 2021). Coverage policy is determined centrally by the national Ministry of Health and the Interterritorial Health Council. Regions can provide additional benefits, but in practice, there is little regional variation. Regions can also manage public spending on health and introduce policies to reduce waiting times.

The SNS is mainly funded from general taxes. Out-of-pocket payments are relatively high, accounting for one fifth of current expenditure (Bernal-Delgado et al., 2018). Voluntary health insurance plays a supplementary role, offering faster access to treatment, and covers just over one fifth of the population, rising to one third in some regions. It is likely to exacerbate inequalities in access to health care as it is more prevalent among richer households (Urbanos-Garrido et al., 2021).

REFERENCES


Eurostat (2017). Treatable mortality per 100,000 population.  

Eurostat (2019). Main reason for economically inactive persons who receive a pension to quit working (%). *Eurostat Data Browser*.  


Eurostat (2020b). Employment rate of older workers, age group 55–64.  


### Key indicators

<table>
<thead>
<tr>
<th></th>
<th>Spain</th>
<th>EU Average</th>
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<tbody>
<tr>
<td>People aged 65 and above (% of total)</td>
<td>19.7</td>
<td>20.5</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>83.5</td>
<td>81.1</td>
</tr>
<tr>
<td>GDP per person (PPP US$)</td>
<td>43,625</td>
<td>48,340</td>
</tr>
<tr>
<td>Current health spending per person (PPP US$)</td>
<td>3,984</td>
<td>4,010</td>
</tr>
<tr>
<td>Health spending paid out of pocket (% of current health spending)</td>
<td>21.8</td>
<td>21.6</td>
</tr>
</tbody>
</table>

**Source:** WHO Global Health Expenditure Database (2021); World Bank, World Development Indicators (2021).

**Note:** Data for 2019; PPP US$, purchasing power parity in US dollars.

The European Observatory on Health Systems and Policies is a partnership hosted by WHO that includes international agencies, national governments, decentralized authorities and academic research institutes. It supports and promotes evidence-informed policy-making, using comparative analysis of European health systems and trends to give decision-makers insights into how their own and other systems operate; what works better or worse in different contexts; and why. Ultimately the Observatory aims to help countries strengthen their health systems to improve their peoples' health and well-being. It engages directly with policy-makers and works with a range of experts not least its Health Systems and Policies Network, whose members provide key knowledge and insights into health systems in countries.

WHO Barcelona Office
for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health systems financing for universal health coverage. It works with Member States across WHO’s European Region to promote evidence-informed policy-making. A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring financial protection – the impact of out-of-pocket payments for health on living standards and poverty. Financial protection is a core dimension of health system performance and an indicator for the Sustainable Development Goals. The Office supports countries as they develop policy, monitor progress and design reforms and is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.