

# Has Spain's management of COVID-19 been a failure? Errors, lessons and recommendations

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## Index

Summary.....	2
(1) How many cases, how many deaths .....	3
(2) The key factors.....	5
(3) Strengths and weaknesses of the Spanish response .....	10
(4) What to do from now on.....	14
(5) Conclusions.....	16

## Summary<sup>1</sup>

Spain has been one of the countries that has recorded the greatest impact of COVID-19 in the world, both in terms of infections and deaths, over the first half of 2020. The limited knowledge about the nature of the virus, the lack of a homogeneous and reliable counting method in the various countries, and the distinct rates at which the disease unfolded hinder comparisons and prevent the establishment of cast-iron certainties. Even with these reservations, and bearing in mind the information now available, it is possible to postulate certain hypotheses regarding the reasons that account for the severity of the disease's spread in Spain.

The possible explanatory factors, which are manifold and complex, point to human geography (high population density and the intensity of foreign connections and domestic mobility, particularly as far as Madrid and Barcelona are concerned), demographics (ageing) and cultural habits (sociability and intergenerational cohabitation), but also to failings in the public health system. Notable among these are the lack of preparation and experience concerning pandemics in primary healthcare, hospital shortcomings, malpractice in many old peoples' homes, less-than-ideal coordination between administrations and the delays in instituting social distancing measures.

The analysis also includes important positive aspects of the Spanish response (social resilience, comparatively strict application of the social distancing measures once they had been decreed, and the creditable performance of the health system outside the

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<sup>1</sup> Part of this text, now enlarged and updated, was published in the first sections of the jointly produced document by Charles Powell, Ignacio Molina & José Pablo Martínez (Coords.) (2020), *España y la crisis del coronavirus: una reflexión estratégica en contexto europeo e internacional*, Elcano Royal Institute, Madrid, June, [www.realinstitutoelcano.org/wps/portal/rielcano\\_es/contenido?WCM\\_GLOBAL\\_CONTEXT=/elcano/elcano\\_es/zonas\\_es/documento-espana-y-la-crisis-del-coronavirus](http://www.realinstitutoelcano.org/wps/portal/rielcano_es/contenido?WCM_GLOBAL_CONTEXT=/elcano/elcano_es/zonas_es/documento-espana-y-la-crisis-del-coronavirus). The authors would like to thank in particular Carmen González Enríquez, whose contributions are evident in various passages of this analysis.

major cities), which ended up proving its effectiveness at flattening the infection curve in the second half of spring. The provisional conclusions seek to help in managing the easing of lockdown and to prepare for possible secondary outbreaks of coronavirus and other infections in the future.

### **(1) How many cases, how many deaths**

Five months have elapsed since the declaration of emergency issued by the World Health Organisation (WHO) and many aspects of COVID-19 remain as yet unknown. Its frequency and mortality are so varied and heterogeneous in terms of intensity and geography that, for now, there are no conclusive answers and this impedes any rigorous attempt to analyse the way different countries have managed it. However, although there remain unanswered questions about the nature and evolution of the pandemic and there are clear problems in the comparative counting of infections, as will be noted below, there are already enough elements to start to delve into the possible reasons for Spain having had so many cases and deaths.

According to the information reported by the countries themselves, Spain (which is the 30<sup>th</sup> largest country in the world in terms of population) was eighth in terms of absolute number of cases at the beginning of July 2020, behind the US, Brazil, Russia, India, Peru, Chile and the UK.<sup>2</sup> However, bearing in mind the vertiginous rates at which coronavirus has spread recently in various non-European countries, it is highly likely that in coming months it will drop back several positions (and be overtaken by Mexico, Pakistan, South Africa, Iran, Saudi Arabia and possibly Bangladesh and Turkey). If measurement of the frequency of officially acknowledged cases is calculated relative to the population, Spain approaches the start of summer occupying the 15<sup>th</sup> position worldwide, behind various countries in the Persian Gulf and Latin America as well as the US, although consistently at the forefront in Europe (where only Luxembourg and Sweden exceed it).

The above statistics are, as mentioned, the officially acknowledged ones and it is imperative to view them with consummate care, both because of the scant transparency shown by some countries and because of the objective counting difficulties associated with an illness where a considerable proportion of infected patients show few symptoms or are asymptomatic. Moreover, there are enormous differences in the ability of national health systems to detect and quantify cases. Some (such as South Korea, Germany and Denmark) have shown greater efficiency when it comes to identifying infected patients in the initial phases of the epidemic, while others (such as the US, Russia, the UK and Spain itself) ramped up testing only when they became significantly affected, and finally there are those that have not been able to get even close to measuring the true extent of the pandemic. Whatever the case may be, and however cautiously the data are treated due to this widespread overburdening of capacities, there can be little doubt that Spain is at the forefront of COVID-19 incidence, at least in Europe, and this is also confirmed

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<sup>2</sup> The source of official data used in this analysis is the European Centre for Disease Prevention and Control (ECDC), an EU agency. See <https://www.ecdc.europa.eu/en/geographical-distribution-2019-ncov-cases>.

by the first studies into seroprevalence where, in theory, problems of undercounting are avoided.<sup>3</sup>

The questions and lack of homogeneity regarding the official information also arise when one turns to the number of deaths, a statistic that has understandably been viewed as more important for determining the real impact of the disease.<sup>4</sup> Thus, according to the official statistics, at the beginning of July Spain ranked seventh in the world in terms of absolute number of deaths (below six more populous countries, namely the US, Brazil, the UK, Italy, France and Mexico). When the ranking is carried out relative to population size, and once micro-countries have been removed, Spain is ranked only behind Belgium and the UK. Here once again, as with the number of cases, the difficulties in gathering information cast doubt on the reliability of the international comparison of mortality rates. An alternative measurement to the official figures consists of taking, as a proxy indicator, the difference between the total deaths recorded and those expected based on historical trends for the same period. These contrasts reveal the scant credibility of the official information reported in some Asian and Latin American countries (in some cases, they barely account for 15% of the excess deaths actually occurring). In others, such as China, the problem is not the low capacity for managing records so much as opacity.

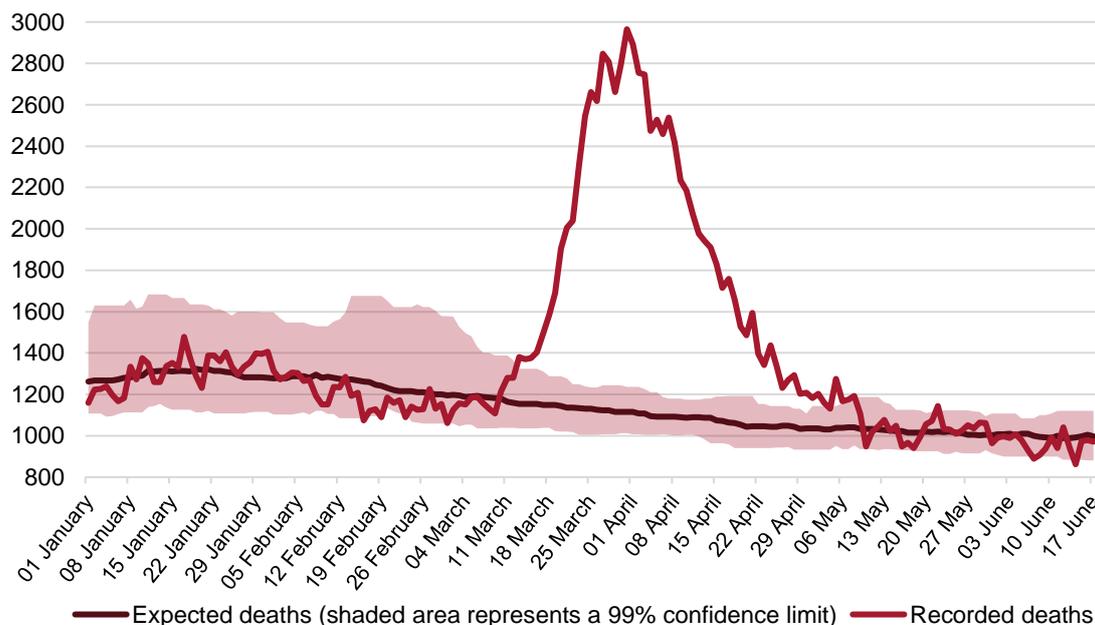
In Western countries the veracity of the data is greater. In some of them, such as Belgium and Germany, even suspect cases are counted, meaning that their official data and their excess deaths relative to the historical average almost converge. In others, where COVID-19 patients are deemed only to be people who have had a positive PCR or similar test result, such as Spain, Italy and the UK, the reported number of deaths due to the disease is around 60% of the total increase in deaths. Thus, as far as Spain is concerned, in the period from March to June 2020 rather more than 28,000 deaths were certified as owing to coronavirus, whereas the monitoring system of the Carlos III Health Institute (see Figure 1) recorded 43,000 excess deaths, which the National Statistics Institute raised to 48,000.

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<sup>3</sup> See the comparative study carried out by scientists at Imperial College London, [https://www.nature.com/articles/s41586-020-2405-7\\_reference.pdf](https://www.nature.com/articles/s41586-020-2405-7_reference.pdf), which calculates the real percentages of the infected population in selected European countries: Spain, with 5.5% of its population infected ranks only behind Belgium (8%) and ahead of the UK (5.1%), Italy (4.6%), Sweden (3.7%), France (3.4%) and Germany (0.9%). The official Spanish study into seroprevalence, carried out on the basis of a large sample, reported a final result of 5% immunity. See the article in *The Lancet*, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31483-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31483-5/fulltext). These data suggest that some 2.5 million people in Spain have been infected, whereas the officially detected cases approach only 300,000.

<sup>4</sup> The figure for deaths is more important than that of infections not only because of the human impact involved but also because it enables the management of the pandemic to be evaluated rather better. In the final analysis, a large number of infected patients, capable of being treated by the national health system, would gradually help to achieve so-called 'herd immunity'. No country has adopted such a strategy but, despite this, many cases and few deaths would be an indicator of healthcare efficacy. There are no positive aspects, by contrast, of a high mortality rate.

**Figure 1. Difference in Spain between expected and recorded deaths**



Source: Daily Mortality Monitoring System (EuroMOMO), Carlos III Institute of Health, Ministry of Science and Innovation (data collected 3 July).

These attempts to control undercounting are still provisional and will vary as the records are updated and the course of the disease continues to unfold, particularly in non-Western countries. In the currently available figures there are already various Latin American countries (Peru, Ecuador) clearly placed above Spain, but if the comparison is restricted to countries in Europe, then Spain and the UK lead the actual excess deaths per capita, followed by Italy, Belgium, the Netherlands, Sweden, Switzerland and France respectively.<sup>5</sup> Thus all the available data point to Spain being one of the countries in Europe, and at the start of summer also in the world, with the greatest incidence. What are the reasons for such a high position in the rankings of cases and deaths due to the virus?

## (2) The key factors

Bearing in mind the ways in which the virus is transmitted there are various factors that account for its spread, the most prominent for an infectious disease being population density and high mobility. This would account for the lower incidence of the disease in countries with low population densities and fewer travel links to territories where outbreaks have occurred and, on the contrary, greater transmission in large conurbations, with significant travel flows to and from abroad (tourists, professionals, immigrants and students), densely occupied housing and congested public transport

<sup>5</sup> Newspapers such as the *New York Times*, the *Financial Times* and *El País* have undertaken comparisons showing which countries reflect reality with vary degrees of precision. Prominent in Europe is the information provided by the EuroMOMO (European Mortality Monitoring) network, which is a system that sets out to track daily excess deaths in collaboration with the governments of 24 states, the ECDC and the WHO: <https://euromomo.eu>.

networks.<sup>6</sup> It is no coincidence that, according to the excess deaths figures available at the end of June, among the areas most affected are New York (with an excess death rate of 251%) and the main globalised metropolitan areas of Western Europe, including Madrid (157%) and Catalonia (106%).<sup>7</sup> Moreover, Madrid and Barcelona are not only highly interconnected with the world, but also with the rest of Spain, something that would have contributed –particularly in the case of the capital– to subsequently spreading the disease around the country.

Another important factor seems to be everything related to forms of socialisation. Some countries habitually maintain an interpersonal distance in excess of 1.5 metres (since getting closer than this is considered intrusive). In others, however, such as Spain, France and Italy, there is a tendency towards physical proximity and greetings that involve contact between hands, faces and bodies.<sup>8</sup> Here again New York serves as an example: the incidence has been much greater in the outlying districts of the city (where the population tends to be more black and Latino, there are more people per household and there are more intense connections with kin and friends) than in Manhattan.<sup>9</sup>

The age distribution is another decisive factor in the incidence of COVID-19. Not only are there fewer infections among children and young people but mortality rises steeply among older people. This factor puts Spain at a disadvantage, by being one of the most aged countries in the world (see Figure 2) where close daily intergenerational contact prevails, even if the elderly relative lives in an old people's home.

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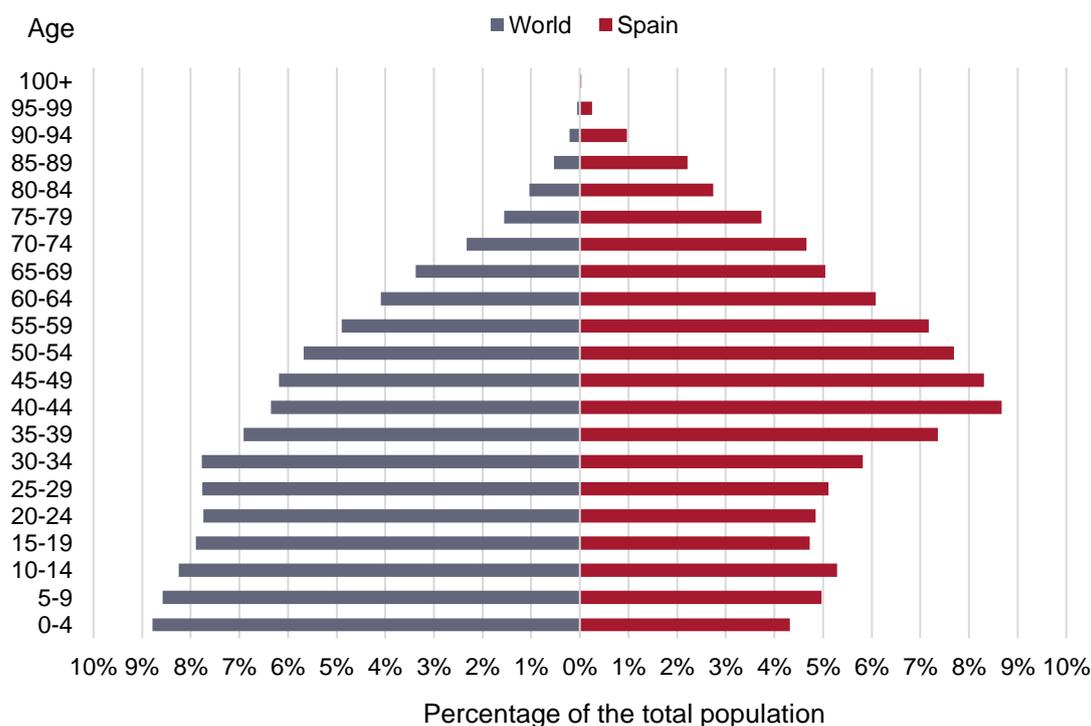
<sup>6</sup> Spain has one of the lowest population densities in the whole of Western Europe (exceeded only by Ireland and the Scandinavian countries) when it is measured in terms of total inhabitants per square kilometre. However, it has the second highest “lived” density in the whole of the EU, after the small nation of Malta. This is due to the fact that, as the specialist in urban studies Alasdair Rae has pointed out, barely 13% of its surface area is actually inhabited and this gives support for making density measurements that are not strictly arithmetical. <https://theconversation.com/think-your-country-is-crowded-these-maps-reveal-the-truth-about-population-density-across-europe-90345>.

<sup>7</sup> The excess mortality was 81% in the Paris region, 99% in London and 124% in Lombardy. The virus reached a number of Latin American cities later, given that their degree of global connection is lower (and to a large extent channelled through migratory ties), but its spread has subsequently been extremely high. Lima, with an excess death rate approaching 300%, is the case with the most acute impact currently known about. See data for the various metropolitan areas in the *Financial Times*: <https://www.ft.com/content/a26fbf7e-48f8-11ea-aeb3-955839e06441>.

<sup>8</sup> Carmen González Enríquez, “Is Spain doing well or badly in its response to COVID-19?”, Elcano Expert Comment 15/2020 [http://www.realinstitutoelcano.org/wps/portal/rielcano\\_en/contenido?WCM\\_GLOBAL\\_CONTEXT=/elcano/elcano\\_in/zonas\\_in/commentary-gonzalez-enriquez-is-spain-doing-well-or-badly-in-its-response-to-covid-19](http://www.realinstitutoelcano.org/wps/portal/rielcano_en/contenido?WCM_GLOBAL_CONTEXT=/elcano/elcano_in/zonas_in/commentary-gonzalez-enriquez-is-spain-doing-well-or-badly-in-its-response-to-covid-19).

<sup>9</sup> The authors are grateful to Marta Bengoa-Calvo for her emphasis on this point.

**Figure 2. Demographic distribution in Spain and the world (2019)**



Source: United Nations Population Division.

Thus the countries most affected ought to be those that are most aged, with large, densely populated urban areas and highly mobile inhabitants, and exhibiting social conduct based on physical proximity. This is a pattern applicable to Spain and the other Western European countries with high infection rates, but it is not consistently confirmed elsewhere: Japan, the most aged country in the world, with a high population density and well interconnected with China (the original source of the pandemic), has recorded very few deaths. And while cultural social distancing, the widespread use of masks and mobile phone applications have served as protective measures in East Asian countries, it is likely that there are additional elements that need to be borne in mind. The earliest scientific studies put forward conjectures such as the climate, pollution, the diversity of virus strains, the possibility of greater propagation and mortality due to genetic susceptibility and even the volume and intensity of speech (generally high in Spain) having a bearing on the rate at which the virus spreads.<sup>10</sup>

But among these other factors worthy of consideration is the key issue of the response of the public health service and national healthcare capabilities. There have already been some attempts to compare and evaluate countries' management efforts,<sup>11</sup> but they have

<sup>10</sup> See the summary in *Science*, <https://www.sciencemag.org/news/2020/05/why-do-some-covid-19-patients-infect-many-others-whereas-most-don-t-spread-virus-all>.

<sup>11</sup> See the so-called GRID Index (*Global Response to Infectious Diseases, GRIDTM*), created in Australia (<https://www.cmawebline.org/ontarget/grid-index-tracking-the-global-leadership-response-in-the-covid-19-crisis/>), or *How well have OECD countries responded to the coronavirus crisis?*, a report published by The Economist Intelligence Unit (<https://www.eiu.com/n/quality-of-oecd-countries-response-to-the-pandemic/>).

been rather superficial attempts that have failed to take into account the complexity of the various factors contributing to the spread and mortality of the virus. Without isolating the structural causes set out above, an attempt to measure national management will tend to take the dependent variable itself –the number of deaths– as the main supposedly explanatory indicator and therefore the Western European countries that recorded the most deaths in spring (Belgium, Spain, Italy and the UK) appear in the final places in these initial indices.

It is of course not easy to evaluate governments' management records. For example, African countries (including Spain's neighbour Morocco) have had a low mortality rate from the virus up till now, which could be due to a better combination of the factors mentioned above, to the existence of others currently unknown, to the fact that the disease is still starting to spread, to their greater experience in dealing with epidemics or simply to shortcomings in the records. Despite all this, it is possible to offer some analytical pointers that try to keep the apparently significant variables (involving geography, demography, social behaviour, level of development and data reliability) under control. Thus a possible example of good management based on number of deaths would be Germany. Sweden by contrast preferred to avoid a lockdown strategy and exhibits data that are much higher than its Scandinavian neighbours.

What of Spain? It does not of course number among the most successful cases, in light of the very considerable incidence of infections and deaths. It is true that the high number of patients who have recovered suggests efficiency and the response deployed since mid-way through March shows that Spain has both weaknesses and strengths (which are set out in the following section). But, as will immediately be pointed out, these weaknesses include nothing less than failures to prevent and detect the disease, insufficient hospital resources and delays in terms of imposing personal distancing measures (masks, limitations on crowds and the banning of mass events) as well as restrictions on mobility. The fact is that even at the beginning of February the scientific community was warning about the virulence of SARS-CoV2,<sup>12</sup> and on 28 February the WHO, in its report following its mission's visit to China, recommended taking lockdown measures as drastic as those that had been applied by the Chinese.<sup>13</sup> On that same day Germany tightened control of its borders and cancelled large-scale events.<sup>14</sup> In Spain, as is well known, popular festivals and demonstrations were allowed up to 10 days later.

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<sup>12</sup> See this summary in STAT dated 4 February: <https://www.statnews.com/2020/02/04/two-scenarios-if-new-coronavirus-isnt-contained/>. Three weeks later, Marc Lipsitch, an epidemiologist at Harvard University, said that the virus would probably not be contained and around 40%-70% of the global population would be infected. His warnings can be read in James Hamblin (2020), 'You're likely to get the coronavirus', *The Atlantic*, 24/II/2020, <https://amp.theatlantic.com/amp/article/607000/>. We are grateful to Miguel Hernán for drawing this article to our attention.

<sup>13</sup> The report of 28 February from the WHO committee that visited China is at [https://www.who.int/publications/i/item/report-of-the-who-china-joint-mission-on-coronavirus-disease-2019-\(covid-19\)](https://www.who.int/publications/i/item/report-of-the-who-china-joint-mission-on-coronavirus-disease-2019-(covid-19)).

<sup>14</sup> See 'Germany tightens border checks in bid to curb coronavirus spread', *Bloomberg*, 28/II/2020, <https://www.bloomberg.com/news/articles/2020-02-28/germany-steps-up-quarantines-to-contain-coronavirus-spread>.

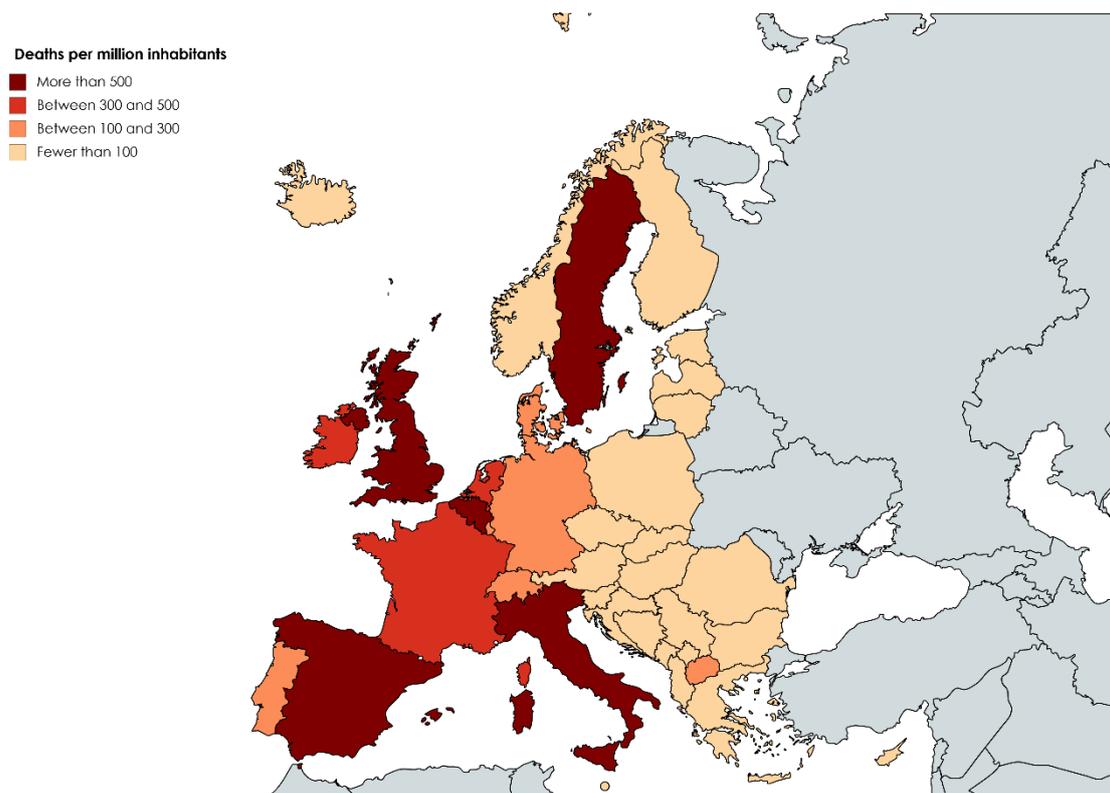
In any event, the real impact that the management may have had needs to be contextualised with a comparative overview of the whole of Western Europe (see Figure 3), and this shows that the disease has had a similar impact on certain contiguous states sharing propitious features, in accordance with the demographic, geographical and social hypotheses set out above. This greater a priori vulnerability has also meant that, thanks to their lockdown measures, France, Italy, Belgium and Spain may have averted many more deaths than the other countries in their vicinity.<sup>15</sup> And if attention turns to Portugal, which has better statistics, the fact is that it differs little from the adjacent Spanish regions. Considering the structural variables, it may be said that the response of the Spanish government (in terms of the state of alarm and lockdown) came late for Madrid and Barcelona in particular, but not for many other parts of the country.<sup>16</sup> And what is really striking is that countries such as the UK, the US and Sweden reacted so late after having seen the experiences of Italy and Spain on the news for weeks, as well as boasting epidemiology departments that are among the best in the world. The pressure of not wanting to paralyse the economy has been a decisive factor in all countries.

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<sup>15</sup> See the Imperial College London study cited above, which includes a counterfactual model according to which these four countries (with similar demographic, density and urban mobility characteristics) would have exceeded 10 deaths per 1,000 inhabitants at the beginning of May had they not implemented any restrictions. Other countries included in the study would have had between six and eight deaths per 1,000 inhabitants (Austria, the UK, Germany, Switzerland and Denmark) while Sweden and Norway would not have exceeded three. If this model is correct, some responses may indeed be judged as more effective, all other things being equal (Austria, Germany, Denmark and even France), and others as less effective (the UK and Sweden). In this case, Spain would not feature in either extreme. See [https://www.nature.com/articles/s41586-020-2405-7\\_reference.pdf](https://www.nature.com/articles/s41586-020-2405-7_reference.pdf).

<sup>16</sup> See Oriol Güell *et al.* (2020), 'La avalancha que asfixió a los hospitales', *El País*, 5/VII/2020, <https://elpais.com/sociedad/crisis-del-coronavirus/2020-07-04/la-avalancha-que-asfixio-a-los-hospitales.html>.

**Figure 3. Deaths reported per million inhabitants (COVID-19) in Western Europe**



Source: Johns Hopkins Coronavirus Resource Center (data viewed on 3 July).

### (3) Strengths and weaknesses of the Spanish response

Spain's health has been a traditional source of national pride and the fact remains that, despite the fall in public spending on health since the Great Recession, the Spanish national health system continues to occupy a mid- to high position in the comparative rankings. In some indicators (for example medical staff per inhabitant) it emerges better than in others, such as the low number of nursing staff and beds, although the number of ICU beds is around the OECD average (see Figure 4).

Be that as it may, COVID-19 has revealed its weaknesses, both in terms of public health policy and patient healthcare.

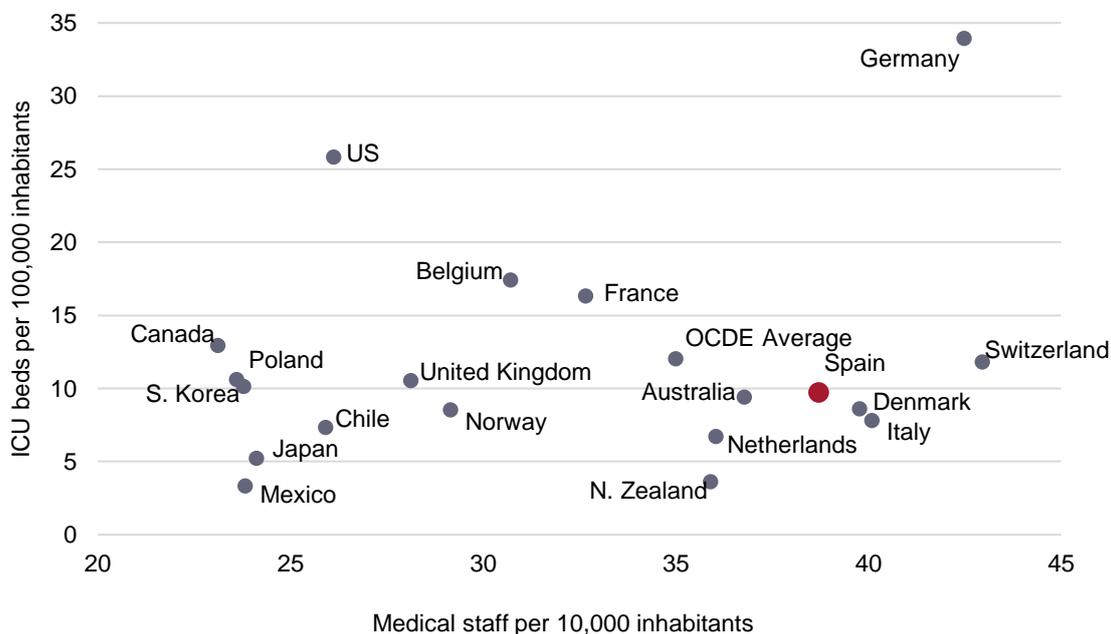
- (a) The system is designed in a relatively efficient way to offer primary care, treat common illnesses and deal with epidemics similar to those already known. But Spain (which, like the rest of Europe, had not suffered either SARS or MERS) had neither the experience nor enough resources to prevent, detect or deal with a pandemic of this nature, despite the fact that the current National Security Strategy (ESN) has been vainly warning of this threat since 2017. This is a picture that highlights shortcomings in public health, which include the need to improve handwashing culture among the general public and even among health professionals<sup>17</sup> and at least

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<sup>17</sup> See 'The impact of cross-cultural differences in handwashing patterns on the COVID-19 outbreak (cont.)

two striking aspects of patient care: the sorry situation in many old peoples' homes (where approximately half of coronavirus victims may have died without being able to receive hospital care), and the lack of personal protective equipment for health workers, which led to a large number of infections.

**Figure 4. Medical staff and ICU beds per population (most recent year available)**



Source: Beyond Containment: Health systems' responses to COVID-19 in the OECD, OECD.

(b) Numerous epidemiologists have for some time been denouncing the cuts inflicted on the system, and the consequent lack of human and material resources. The public health apparatus, including the Coordination Centre for Health Emergencies and Alerts (CCAES), which has led the management of the crisis, currently accounts for only 1% of the health budget. In light of recent months' events this figure explains the shortcomings, ranging from the collection of data, including tracing capabilities, to the shortage of ventilators and testing units.<sup>18</sup> To a large extent, however, Spain shares these limitations with other European countries, which have also had to deal with an ill-prepared public health system, a shortage of intensive care units and the urgent need for medical supplies, manufacture of which predominantly relies on China.

magnitude', [https://www.researchgate.net/publication/340050986\\_The\\_Impact\\_of\\_Cross-Cultural\\_Differences\\_in\\_Handwashing\\_Patterns\\_on\\_the\\_COVID-19\\_Outbreak\\_Magnitude](https://www.researchgate.net/publication/340050986_The_Impact_of_Cross-Cultural_Differences_in_Handwashing_Patterns_on_the_COVID-19_Outbreak_Magnitude), and a study regarding the degree of compliance and determining factors governing advice on hand hygiene at <https://www.sciencedirect.com/science/article/abs/pii/S0213005X07743094?via%3Dihub>.

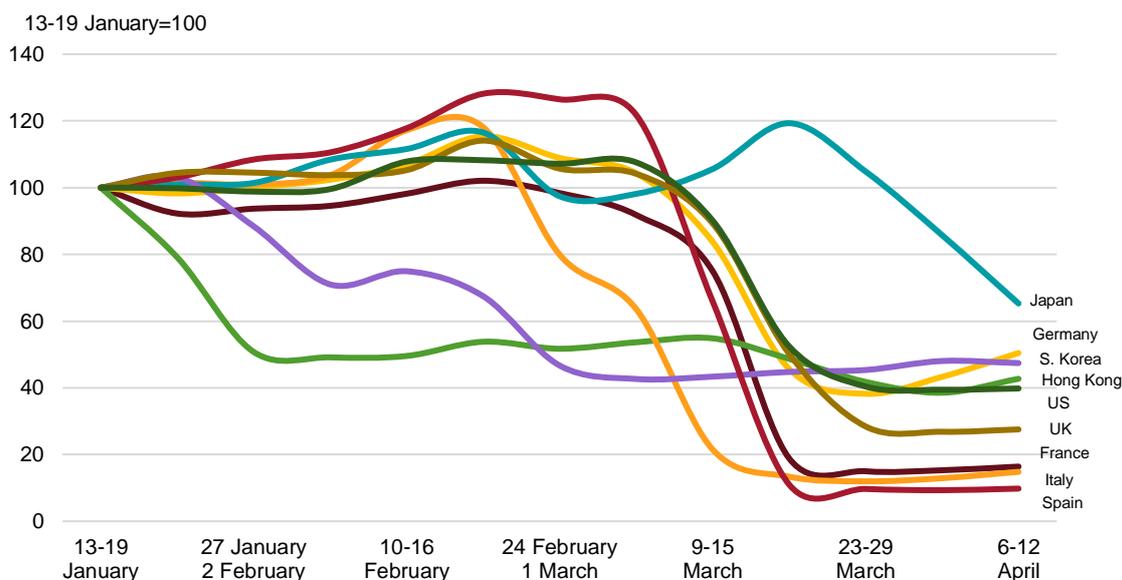
<sup>18</sup> See the interview conducted with the epidemiologist Miquel Porta (2020), *El Mundo*, <https://www.elmundo.es/ciencia-y-salud/salud/2020/04/08/5e8cd62421efa0e8588b45f5.html>.

(c) In terms of governance, another widespread problem in Europe has been a lack of coordination, whether among experts and decision-makers or among the various agencies and levels of administration. This latter aspect has been aggravated in certain countries with a compound territorial structure (for example, the US, the UK, Italy and Belgium). In the case of Spain, a range of managerial failings have been identified between the central government and the autonomous communities (regions), including the lack of reliable and homogeneous data identified by the National Network of Public Health Surveillance. As Miquel Porta has pointed out, 'if legislation had been passed 10 or 20 years ago compelling each autonomous community to provide epidemiological information to the central government's epidemiological surveillance system and it had been equipped with the material, human and institutional resources needed, we would now be much better off'.

On the other hand, certain circumstances can be viewed as strengths, in the sense that they have aided Spain's response capability for dealing with the health crisis:

(a) Leaving aside the debate about the possible delay in imposing restrictions on mobility and announcing the lockdown, the strict degree of compliance with the quarantine and the use of masks (see Figures 5 and 6) as well as their effectiveness in flattening the infection curve (see Figure 7) is undeniable. The Spanish public has displayed remarkable discipline and civic responsibility, complemented by a solid state performance, starting from the declaration of the state of alarm on 14 March, particularly considering that it was one of the strictest in Europe (and therefore not without controversy).<sup>19</sup>

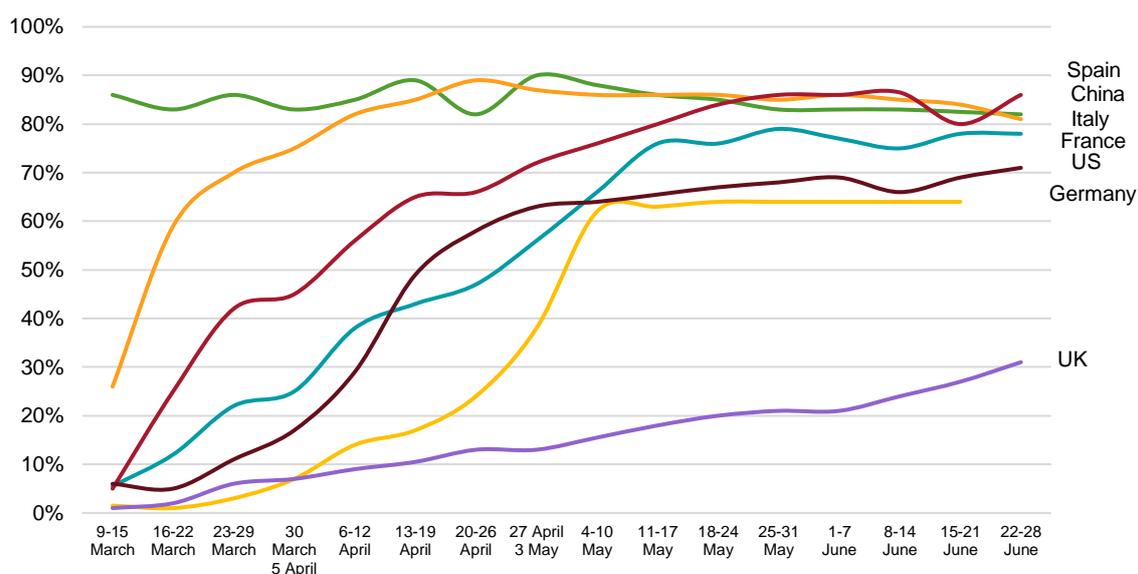
**Figure 5. Evolution of personal mobility**



Source: Mobility trend reports from Apple (these reports reflect the requests for map directions on Apple devices).

<sup>19</sup> See 'Effectiveness of the measures to flatten the epidemic curve of COVID-19. The case of Spain', <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7166106/>.

**Figure 6. People stating that they wear masks in public places**



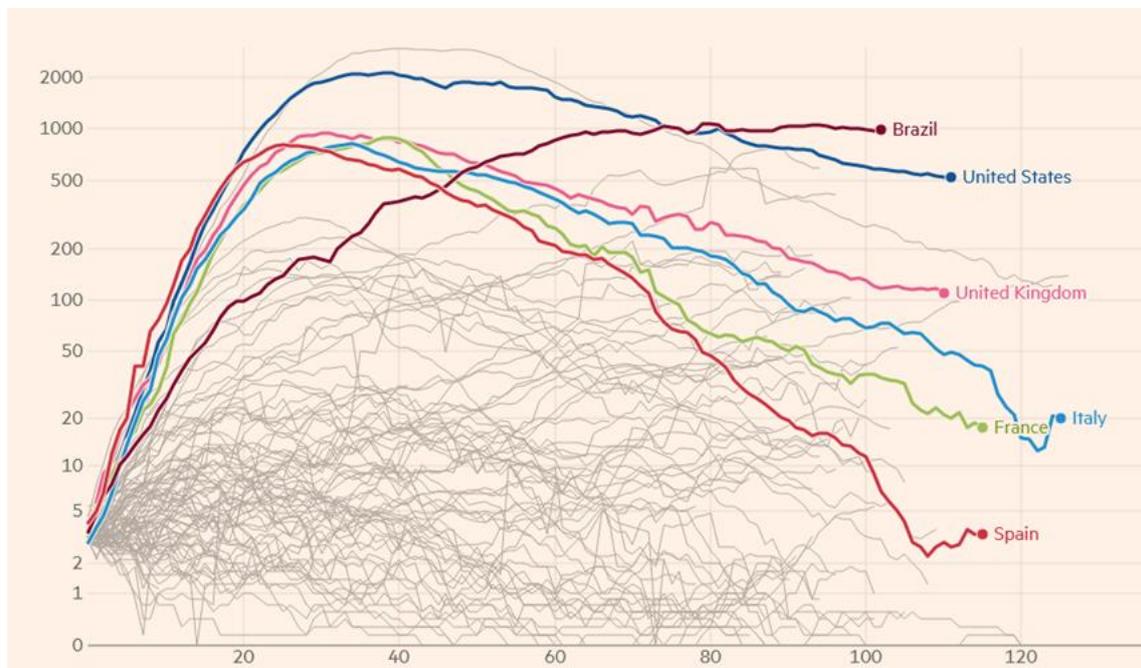
Source: YouGov (data accessed 3 July).

- (b) Social resilience and support for the lockdown measures, despite the emergence of protests, particularly in the city of Madrid halfway through May. Up to 97.3% of the Spanish public canvassed in April viewed the measures taken to combat the pandemic as ‘necessary’ or ‘very necessary’, while 91% said they were experiencing a ‘very good’ or ‘reasonably good’ lockdown.<sup>20</sup> Despite the controversy engendered by its complexity and gradualness, as many as 69% even approved the government’s de-escalation plan.<sup>21</sup> This attitude is important for maintaining social distancing measures and even, if the epidemiological situation requires it, returning to lockdown.
- (c) Despite the stressful situations that have been endured and the way some hospitals were overwhelmed in Madrid and Barcelona (where it should not be forgotten that half the country’s deaths occurred), in the rest of the country the health system and other public services did not break down. In general, there has been clear professionalism on the part of medical staff and other public employees, who have proved capable of adapting their work, with a certain degree of improvisation, to the state of alarm, applied for the first time in a general and prolonged way.

<sup>20</sup> Special CIS barometer, April 2020.

<sup>21</sup> Ongoing Metroscopia COVID-19 barometer, ‘Acertios y errores en la gestión de la epidemia’, 11/VI/2020.

**Figure 7. Evolution of the infection curve (average daily deaths during the previous week starting from the first record exceeding three daily deaths)**



Source: Financial Times Coronavirus Tracked.

#### (4) What to do from now on

At a national level, with the de-escalation now under way, but also with a view to future pandemics or fresh outbreaks of coronavirus, there is a wide consensus on the need to attend internally both to the capacities for detecting infections (testing, tracing and isolation), for the health service response (in primary and hospital care), and for the collection and systematisation of data in an effective and homogeneous way.<sup>22</sup> Not only has there been undercounting of infections and deaths in excess of the European average (owing to the lack of tests), the available information has not always been communicated transparently.<sup>23</sup> Moreover, the central government and the autonomous communities have to coordinate with each other better, and this applies both to the delivery of care and public health, in an effort to avoid the errors of the past and ensure that COVID-19 or a new virus does not slip through the cracks in the system.<sup>24</sup>

At an EU level, competences in matters of health reside fundamentally in the member states, which was a stumbling block to the efficient coordination of managing the crisis in its most acute phase and now complicates joint emergence from the lockdowns, with

<sup>22</sup> See the series of documents for combatting COVID-19 from the Barcelona Global Health Institute at <https://www.isglobal.org/es/-/isglobal-lanza-una-serie-de-documentos-analizando-la-estrategia-de-desconfinamiento-ante-la-covid-19>.

<sup>23</sup> See Kiko Llaneras (2020), 'Los problemas de usar datos del siglo pasado para una pandemia del siglo XXI', *El País*, 21/VI/2020. <https://elpais.com/sociedad/crisis-del-coronavirus/2020-06-20/los-problemas-de-usar-datos-del-siglo-pasado-para-una-pandemia-del-siglo-xxi.html?prm>.

<sup>24</sup> See the excellent account published in *El País*: 'El agujero negro por el que se coló el virus', 13/VI/2020, <https://elpais.com/sociedad/2020-06-13/el-agujero-negro-por-el-que-se-colo-el-virus.html>.

shared mechanisms for tracking and tracing infections. Without such coordination, in which Spain could make good use of its experience of the disease, and also with the management of major traveller flows, it will be easier for new outbreaks to emerge. There currently remain many questions about immunity to COVID-19, but when there is more information it may be possible to arrange a standardised health certificate at the European level. This would enable health criteria to be combined with the recuperation of mobility, averting possible widespread quarantines, something that will also require reliable PCR or other rapid tests.

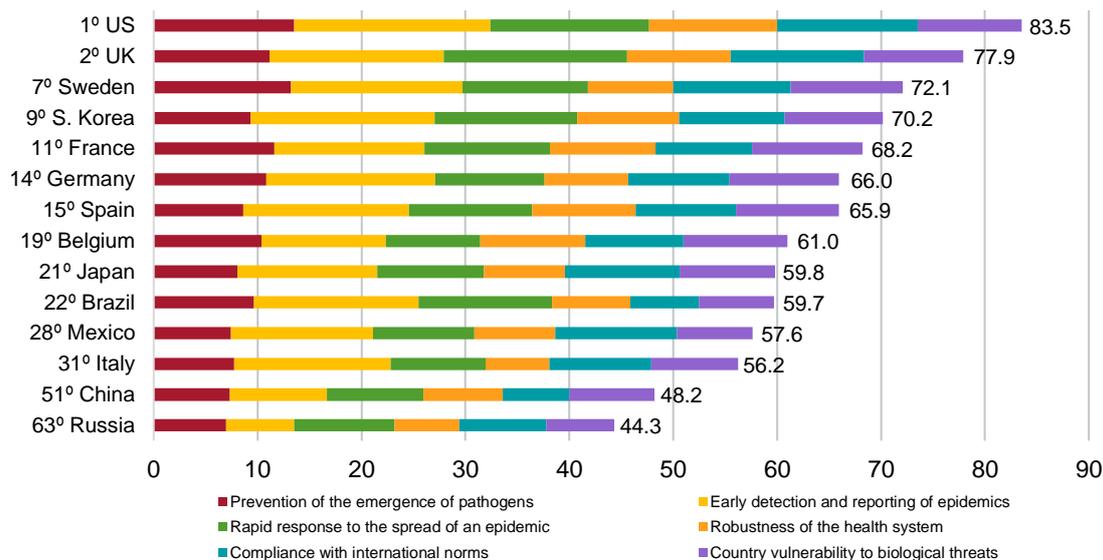
To avoid the problems that arose with healthcare and pharmacological supplies at the outbreak of the pandemic, the EU also has to work in a coordinated fashion over the coming months and years on the production and/or purchase and distribution of potential treatments and vaccines for COVID-19 and on the manufacture of strategic supplies so as to be better prepared for the next pandemic. In their historic agreement of 18 May 2020 the French President Emmanuel Macron and the German Chancellor Angela Merkel decided that the European Commission could incur debt of up to €500 billion, while also calling in the first article of the agreement for 'European health sovereignty',<sup>25</sup> a goal to which Spain should actively contribute.

As far as the international dimension is concerned, global health policy is coordinated (highly imperfectly, it has to be said) by the WHO, which monitors national systems in terms of preparation, alerts, research and healthcare provision in situations with an international impact. The COVID-19 crisis has revealed weaknesses both in the general system and in many national systems. Moreover, trust in the ability of health systems to cope with pandemics (see the GHS Index in Figure 8, headed by the adversely affected US and UK, and where Spain was placed in a remarkable 15<sup>th</sup> position out of 195 countries) meant that the need to equip them with specific capabilities for the management of the crisis and strategic reserves of supplies and medication was underestimated.

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<sup>25</sup> See the joint declaration made by Merkel and Macron at <https://www.bundestkanzlerin.de/resource/blob/656734/1753772/414a4b5a1ca91d4f7146eeb2b39ee72b/2020-05-18-deutsch-franzoesischer-erklaerung-eng-data.pdf>.

**Figure 8. Global Health Security Index 2019 (0-100)**



Fuente: Global Health Security Index 2019.

Just as has occurred with so many national health systems (including Spain), the WHO has not emerged unscathed from this crisis, but this does not mean that it should be dismantled, as the US President, Donald Trump, has suggested. On the contrary, without overlooking the mistakes that have been made, what needs to be done is to provide it with more resources. It is particularly important to invest in a more reliable information system. It is a pity that the WHO (although the same applies to the EU) has not been capable of drawing up a protocol for collecting homogeneous data that would enable appropriate comparisons to be made between countries. Governments are acting amid this uncertainty basing themselves on indices drawn from other countries, in such a way that they are all learning from each other in a cumulative process of experiences, successes and failures.

## (5) Conclusions

It is not possible to answer the question that opened this analysis with any certainty. The data available point to the bulk of the infections and deaths occurring Spain during this health crisis being attributable to structural causes it shares with various Western European neighbours (fundamentally Italy, France and Belgium) and which are linked to geographical (large, hyper-connected urban areas) demographic (ageing) and sociological (habits of proximity) factors. That being said, it also seems clear that there is a significant element of additional explanation connected to the political management of health. In some cases it is a matter of systemic factors (lack of preparation for pandemics, material shortages in primary and hospital healthcare, lack of connection between old people's homes and clinical care, and the lack of coordination between administrations) and, in others, circumstantial factors (delays in advising and imposing distancing measures at the beginning of March). On the other hand, the response since the lockdown has also included positive points of management, both in terms of what it

means for the way public services are operated and how the public behaves, such that it achieved an effective flattening of the infection curve in May.

In any event, the impact of COVID-19 has shown that Spain, like many other countries, has to work hard on improving its internal capability for managing pandemics. Apart from the specific mistakes, which are subject to the healthy accountability that is the hallmark of a democracy, the mistakes of forecasting and reaction that have been noted (which for some have constituted a failure and for others are understandable given that we are facing the greatest pandemic of the last 100 years) are not really the fault of an individual government at a particular moment in time. Rather, the lack of preparation of the state itself has been revealed, where this is understood in a broad way, including not only public authorities (which naturally are those that bear the brunt of responsibility) but also members of the public themselves. Learning the lessons of this crisis for the future should also involve paying attention to the following issues:

- (a) Prevention, involving difficult cultural shifts relating to social distancing in the social, work and school settings, to personal protection and to handwashing.
- (b) Detection and the broadening of tracing instruments, both traditional and modern (with the inclusion of big data tools).
- (c) Isolation protocols for diagnosed cases and possible lockdowns if they give rise to community infection.
- (d) The protection of vulnerable groups, with special emphasis on the elderly, but also on the children of less advantaged families (who have suffered considerably with the lockdown) and immigrants lacking decent housing (as confirmed by the fresh outbreak in July among temporary workers in Lleida and Huesca).
- (e) The healthcare response, strengthening primary care and hospital, but also the public health system, which is at the front line in containing epidemics.
- (f) Strategic production and stocks of health and pharmacological supplies, including research into vaccines and treatments.
- (g) The improvement of (visual) communication formats with the public, incorporating clear messages and the use of control panels, maps and graphic information.
- (h) Coordination and collaboration (in other words, better joint governance) between the central government and the autonomous communities.

At the EU level, and despite the distribution of powers in the health arena between the EU and its members, Spain should support effective EU mechanisms for managing future health crises (supply of medical equipment and the design of a sort of European state of alarm) and harmonisation of the oversight and monitoring of infections in the immediate term. The high mobility within Europe, the desirable porosity of borders in the Schengen Area and the importance of tourism make it advisable to work towards, rather than interoperability with third-party countries' systems and equipment (in the use of

apps, for example), the existence of an EU technological and healthcare sovereignty. In this regard Spain needs to be more proactive than passive in greater cooperation and integration. This crisis has shown once again that EU policies (the internal market and Schengen) cannot be separated from many domestic policy areas, including health.

As far as the global health system is concerned, Spain and the rest of the EU should work to strengthen the national health systems least well prepared to manage epidemics and link the work of the WHO to that of the global organisations devoted to tourism and trade (in the current absence of a similar structure of international governance regarding migration), such that the protocols of security and mobility enabling human and trade flows to be restored (through, for example, standardised health certificates) are coordinated. Spain, as the open country that it is, has much at stake in the resolution of this crisis, from the health but also from the economic perspective. To this end it needs to be a secure place at a domestic level, but must also contribute to fight the pandemic at an international level, because for as long as the virus remains active in the rest of the world, neither Spain nor Europe will be safe.