World Health Organization
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Can people afford to pay for health care?

New evidence on financial protection in Spain

Rosa M. Urbanos-Garrido
Luz María Peña-Longobardo
Micaela Comendeiro-Maaløe
Juan Oliva
Manuel Ridao-López
Enrique Bernal-Delgado

Spain

WHO Barcelona Office
for Health Systems Financing

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Abstract

This review is part of a series of country-based studies generating new evidence on financial protection in European health systems. Financial protection is central to universal health coverage and a core dimension of health system performance. Despite worsening during the economic crisis from 2008 to 2014, the incidence of catastrophic health spending in Spain is much lower than would be expected given Spain's relatively heavy reliance on out-of-pocket payments. This can be explained by strengths in the design of coverage policy in the National Health System (NHS): entitlement to the NHS based on residence, with the same degree of entitlement for undocumented migrants; a generally comprehensive benefits package; limited use of co-payments; and multiple mechanisms to protect people from co-payments. There are gaps in coverage, however. Catastrophic spending is driven by dental care and medical products in all consumption quintiles, mainly because dental and optical care for eyesight problems are largely excluded from NHS coverage. Catastrophic spending in the poorest quintile is also driven by outpatient medicines, reflecting co-payments and inadequate protection for low-income households of working age. To reduce unmet need and financial hardship, policy should focus on expanding NHS coverage of dental care and optical care and further improving the design of co-payments to strengthen protection for poorer households in all age groups.

Keywords

HEALTHCARE FINANCING
HEALTH EXPENDITURES
HEALTH SERVICES ACCESSIBILITY
FINANCING, PERSONAL
POVERTY
SPAIN
UNIVERSAL COVERAGE

About the series

This series of country-based reviews monitors financial protection in European health systems by assessing the impact of out-of-pocket payments on household living standards. Financial protection is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection may reduce access to health care, undermine health status, deepen poverty and exacerbate health and socioeconomic inequalities. Because all health systems involve a degree of out-of-pocket payment, financial hardship can be a problem in any country.

How do country reviews assess financial protection? Each review is based on analysis of data from household budget surveys. Using household consumption as a proxy for living standards, it is possible to assess:

- how much households spend on health out of pocket in relation to their capacity to pay; out-of-pocket payments that exceed a threshold of a household's capacity to pay are considered to be *catastrophic*;

- household ability to meet basic needs after paying out of pocket for health; out-of-pocket payments that push households below a poverty line or basic needs line are considered to be *impoverishing*;

- how many households are affected, which households are most likely to be affected and the types of health care that result in financial hardship; and

- changes in any of the above over time.

Why is monitoring financial protection useful? The reviews identify the factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and

others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage. A limitation common to all analysis of financial protection is that it measures financial hardship among households who are using health services, and does not capture financial barriers to access that result in unmet need for health care. For this reason, the reviews systematically draw on evidence of unmet need, where available, to complement analysis of financial protection.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate comparison across countries, the reviews follow a standard template, draw on similar sources of data (see Annex 1) and use the same methods (see Annex 2). Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by WHO/Europe and WHO headquarters. The country consultation includes regional and global financial protection indicators (see Annex 3).

What is the basis for WHO's work on financial protection in Europe? The Sustainable Development Goals adopted by the United Nations in 2015 call for monitoring of, and reporting on, financial protection as one of two indicators of universal health coverage. WHO support to Member States for monitoring financial protection in Europe is also underpinned by the European Programme of Work, 2020–2025 (United Action for Better Health in Europe), which includes moving towards universal health coverage as the first of three core priorities for the WHO European Region. Through the European Programme of Work, the WHO Regional Office for Europe will work to support national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments for health. A number of other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

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Authors
Rosa M. Urbanos-Garrido
Luz María Peña-Longobardo
Micaela Comendeiro-Maaløe
Juan Oliva
Manuel Ridao-López
Enrique Bernal-Delgado

Editors
José Cerezo Cerezo
Sarah Thomson

Series editors
Sarah Thomson
Jonathan Cylus
Tamás Evetovits

Abbreviations

EHIS	European Health Interview Survey
EU	European Union
EU15	European Union Member States prior to 1 May 2004
EU28	EU Member States prior to 31 January 2020
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
ISFAS	Social Institute for the Armed Forces
MUFACE	Mutual Fund for State Civil Servants
MUGEJU	General Justice Mutual Fund
NHS	National Health System
OECD	Organisation for Economic Co-operation and Development
PADI	Plan for Dental Care in Childhood
UNESPA	Unión Española de Entidades Aseguradoras y Reaseguradoras
VHI	voluntary health insurance

Executive summary

Spain was hit hard by the global financial and economic crisis that began in 2008. Following cuts to public spending on health from 2012 to 2014, public spending on health began to decline as a share of gross domestic product, widening the gap between Spain and other countries in western Europe. At the same time changes to coverage policy limited access to the Spanish National Health System (NHS) among undocumented migrants (a policy that was reversed in 2018) and increased co-payments for outpatient prescribed medicines and medical products.

This review is the first comprehensive and up-to-date country-specific analysis of financial protection in Spain. Drawing on microdata from annual household budget surveys carried out by the National Statistics Institute of Spain from 2006 to 2019 (the latest data available at the time of publication), and data on unmet need for health services, it finds that:

- in 2019 0.8% of households were impoverished or further impoverished after out-of-pocket payments, up from 0.2% in 2006; in the same year 1.6% of households experienced catastrophic health spending, up from 1.0% in 2006;

- 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 started to fall in 2016, it was still above pre-crisis levels in 2019;

- catastrophic spending is concentrated in the poorest quintile; the increase in catastrophic incidence over time was almost entirely driven by a substantial increase in the poorest quintile;

- the characteristics of households with catastrophic spending changed during the study period, shifting from households headed by older people and retired people to households headed by people of working age (between 35 and 50 years), employed people, unemployed people and couples with children;

- catastrophic spending is driven by dental care and medical products in all quintiles, mainly because dental care and optical care for eyesight problems largely are excluded from coverage by the Spanish NHS, especially for adults; in the poorest quintile, catastrophic spending is also driven by spending on outpatient medicines, which are subject to NHS co-payments; and

- unmet need (a measure of access) is below the European Union (EU) average for health care and prescribed medicines but above the EU average for dental care; unmet need for dental care grew sharply during the economic crisis; there is substantial socioeconomic inequality in unmet need for dental care and, to a lesser extent, health care and prescribed medicines.

In addition to increases in catastrophic health spending and unmet need, the crisis was also associated with an increase in waiting times, a longstanding issue in the Spanish NHS.

Despite worsening during the economic crisis, the incidence of catastrophic spending in Spain is much lower than would be expected given Spain's relatively heavy reliance on out-of-pocket payments – a finding that can be explained by strengths in the design of NHS coverage policy and the highly redistributive effect of public spending on health; for instance:

- entitlement to the NHS is based on residence and undocumented migrants are entitled to the same degree of coverage as residents;

- the NHS benefits package covers a wide range of health services, with very little regional variation in benefits, and there is an even distribution of health centres across the country;

- co-payments in the NHS apply only to outpatient prescribed medicines and ortho-prosthetic devices;

- there are multiple protection mechanisms for co-payments, including: reduced co-payments and a cap of €4.24 per prescription item for most outpatient prescribed medicines for chronic conditions; exemptions from co-payments for disadvantaged groups of people (which have been expanded since 2020); and an income-based cap on co-payments for outpatient prescribed medicines for most pensioners; and

- the in-kind benefits of public spending on health and education increase the incomes of the poorest households and reduce income inequalities.

Despite these strengths, there are gaps in coverage, which are reflected clearly in the study's findings on financial protection.

To improve access and financial protection in Spain, policy should focus on:

- addressing the most important gaps in coverage by expanding entitlement to dental care, optical care for eyesight problems and hearing aids;

- further improving the design of co-payments to strengthen protection for poorer households in all age groups by, for example, extending the income-related cap for co-payments for most pensioners to all non-pensioner households;

- addressing waiting times for medical examinations and specialist care, which can result in financial hardship and unmet need and exacerbate socioeconomic inequalities in access to services; policy options include: reinforcing the effectiveness of primary care by ensuring it is resourced and staffed adequately; reviewing the efficiency and equity of tax subsidies for voluntary health insurance premiums, which mainly benefit richer households; and reviewing current policy towards mutual funds, which allows civil servants to opt for private provision; and

- removing the administrative barriers undocumented migrants and others face in obtaining access to NHS services to which they are entitled.

Strengthening access and financial protection is likely to require additional public investment in the health system. To ensure additional spending meets equity and efficiency goals, it should be targeted carefully to reduce unmet need and financial hardship for low-income households.

1. Introduction

This review assesses the extent to which people in Spain experience financial hardship when they use health services, including medicines. It covers the period from 2006 to the present day (September 2021), drawing on data from household budget surveys carried out annually between 2006 and 2019, data on unmet need for health services up to 2019 and information on health coverage policy up to 2021.

Previous research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

Spain was hit hard by the global financial and economic crisis that began in 2008 (referred to as the economic crisis in Spain). The crisis had a significant impact on people's capacity to pay for health services. As GDP dropped, unemployment soared and income inequality increased. The share of the population at risk of poverty or social exclusion grew among children and working-age people and fell among older people. Although the economy began to recover in 2014, levels of unemployment and poverty were still higher in 2019 than they had been in 2008.

Public spending on health as a share of GDP grew as the economy retracted in the first part of the study period, then fell from 2012 to 2014 following sharp budgetary adjustments – austerity measures introduced during the crisis in the context of the European Stability Mechanism (WHO, 2021). As public spending on health declined, the out-of-pocket payment share of current spending on health grew, rising from 19% in 2009 to 23% in 2014. In 2018 the out-of-pocket payment share of 22% was one of the highest in western Europe (WHO, 2021).

During the economic crisis significant changes were made to all three dimensions of coverage policy (population entitlement, the benefits package and user charges) with the aim of shifting health care costs on to households. Since 2018 some of these changes have been reversed. The Government has also introduced new measures to expand access to dental care and reduce user charges (co-payments), particularly for people in vulnerable situations.

This review is the first country-specific, comprehensive and up-to-date analysis of financial protection in Spain (Yerramilli et al., 2018). The few studies that include analysis of financial protection in Spain are mostly global or regional comparisons using different metrics from this study and drawing on different sources of survey data; some of them focus only on people aged over 50 years (Saksena et al., 2014a, 2014b; Palladino et al., 2016; Arsenijevic et al., 2016). The most recent of these earlier studies found that despite the increase in out-of-pocket payments during the economic crisis, the risk of catastrophic health spending is low in Spain compared to other countries in Europe (Bernal-Delgado et al., 2018). More recent work focusing specifically on Spain and covering the period from 2008 to 2015 did not find any change in catastrophic health spending over time (López-López et al., 2021). Although this study also draws on household budget survey data, it uses different metrics from the analysis in this review.

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of health coverage and access to health care. Sections 4 and 5 present the results of the statistical analysis, with a focus on out-of-pocket payments in Section 4 and financial protection in Section 5. Section 6 provides a discussion of results of the financial protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy. Annex 1 provides information on household budget surveys, Annex 2 the methods used, Annex 3 regional and global financial protection indicators and Annex 4 a glossary of terms.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found in Annexes 1–3.

2.1 Analytical approach

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus et al., 2018; WHO Regional Office for Europe, 2019), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003). Financial protection is measured using two main indicators: catastrophic out-of-pocket payments and impoverishing out-of-pocket payments. Table 1 summarizes the key dimensions of each indicator. For more information on how these indicators are calculated and relate to global indicators, see Annexes 2 and 3.

Table 1. Key dimensions of catastrophic and impoverishing spending on health

	Impoverishing health spending
Definition	The share of households *impoverished* or *further impoverished* after *out-of-pocket payments*
Poverty line	A *basic needs line*, calculated as the average amount spent on food, housing (rent) and *utilities* (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household *consumption* distribution who report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development (OECD) equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, *basic needs* for food, housing and utilities; this standard amount is also used to define a household's *capacity to pay for health care* (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household *quintiles* by consumption and by other factors where relevant, as described above
Data source	Microdata from national *household budget surveys*
	Catastrophic health spending
Definition	The share of households with out-of-pocket payments that are greater than 40% of household *capacity to pay for health care*
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a *poverty line* (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

Note: see Annex 4 for definitions of words in italics.

Source: WHO Regional Office for Europe (2019).

2.2 Data sources

The study analyses anonymized microdata for 2006–2019 from the household budget survey conducted annually by the National Statistics Office of Spain. The data sample consisted of 19 339 households in 2006, 21 460 in 2007, 21 995 in 2008, 22 271 in 2009, 22 118 in 2010, 21 604 in 2011, 21 731 in 2012, 21 961 in 2013, 22 040 in 2014, 22 020 in 2015, 21 908 in 2016, 21 951 in 2017, 21 270 in 2018 and 20 676 in 2019.

Household budget surveys collect information on health spending in a structured way, dividing health spending into six broad groups: medicines, medical products, outpatient care, dental care, diagnostic tests and inpatient care. Spending on mental health services is not assigned a specific category and may therefore be reported under most of these groups.

In 2016 the Spanish survey introduced two changes to the classification of types of health care. First, dental care materials such as dentures, implants and braces are now classified as "medical products", implant procedures as "dental care" and orthodontic procedures as "outpatient care". If respondents are not able to make the distinction themselves, implants and dentures are classified as "medical products" and orthodontics as "outpatient care". Second, the "medical products" and "diagnostic tests" categories now include more subcategories, providing more granular information than previously.

As a result of these changes, it is not possible to compare the breakdown of out-of-pocket payments by all types of health care before and after 2016. Before 2016 all dental care spending was classified under the category "dental care". After 2016 "dental care" spending is classified in three categories: "dental care", "medical products" and "outpatient care". This break in series is indicated by a space in the relevant figures in Sections 4 and 5.

All currency units in the study are presented in euros, with notes on inflation-adjusted spending where relevant.

3. Coverage and access to health care

This section briefly describes the governance and dimensions of publicly financed health coverage – population entitlement, the benefits package and user charges (co-payments) – in Spain and reviews the role played by voluntary health insurance (VHI). It then summarizes information on access, use and unmet need for health care services.

3.1 Coverage

The National Health System (NHS) is widely decentralized. The 17 regional governments known as Autonomous Communities are responsible for health care planning and management, resource allocation, purchasing and service provision, with the national Ministry of Health mainly playing a stewardship and coordination role. Coverage policy, however, is governed centrally by the national Ministry of Health and the highest governing body of the NHS – the Inter-territorial Council – a collegiate governance body comprising the 17 regional health ministers and the national Minister of Health.

Most of the population is covered by the NHS, which is mainly financed through general taxes, with services largely provided in public facilities. People have access to a wide range of publicly financed benefits, although coverage of dental care is very limited. Health services are usually free at the point of use. Co-payments are limited to outpatient prescribed medicines and ortho-prosthetic devices (such as supportive braces and splints, prostheses, wheelchairs, crutches and hearing aids).

Coverage policy experienced far-reaching reforms, mainly in 2012, in the context of the 2008 financial and economic crisis (Table 2).

- The basis for population entitlement to the NHS was changed from residence to "being insured" ("asegurado" in Spanish) based on social security status, which restricted access for undocumented migrants.

- More than 400 medicines, mainly for minor conditions, were excluded from NHS coverage.

- Co-payments for outpatient prescriptions were introduced for pensioners and increased for non-pensioners, including children. The 2012 reforms opened the door for the introduction of co-payments in several new areas (non-urgent health-related transport; ortho-prosthetic devices; dietary products for medical purposes; and outpatient chemotherapy and other medicines dispensed free of charge in hospital outpatient departments). However, co-payments in new areas were introduced only for ortho-prosthetic devices.

Since 2018 different regulations have restored the universality of the NHS and strengthened protection from co-payments for people in vulnerable situations.

Table 2. Changes to coverage policy, 2006–2021

Source: authors.

Year	Change	Health service targeted	Population group targeted
2012	Basis for entitlement changed from residence to "being insured" based on social security status	All health services	People not registered for social security
	Introduction of percentage co-payments for pensioners (10% or 60%) with monthly income-related caps	Outpatient prescription medicines, ortho-prosthetic devices (such as supportive braces and splints, wheelchairs, crutches and hearing aids) and dietary products for medical purposes	Pensioners
	Increase in percentage co-payments for non-pensioners from 40% to 50% or 60%, depending on income	Outpatient prescription medicines, ortho-prosthetic devices and dietary products for medical purposes	Active population and children
	Introduction of a fixed co-payment of €1 per prescription in Catalonia and Madrid	Outpatient prescription medicines	Covered population
	Exclusion of more than 400 medicines (mainly for treating minor conditions) from the common benefits package	Outpatient prescription medicines	Covered population
2013	Fixed co-payment of €1 per prescription in Catalonia and Madrid suspended	Outpatient prescription medicines	Covered population
2018	Basis for entitlement re-established as residence	All health services	Mainly undocumented migrants
2019	Entitlement to hearing aids extended to young adults	Hearing aids	Young adults aged 18–25
2020	Exemption from co-payments for low-income people	Outpatient prescription medicines, ortho-prosthetic devices and dietary products	People eligible for the guaranteed minimum income scheme
2021	Exemption from co-payments extended to other groups of people	Outpatient prescription medicines and ortho-prosthetic devices	Low-income pensioners, moderately and severely disabled children and households receiving child benefits

3.1.1 Population entitlement

The study covers three distinct periods in terms of population entitlement.

Before 2012 the basis for entitlement to the NHS was residence. The NHS covered 99.5% of the population. The 0.5% of the population without NHS coverage comprised high-income self-employed people who were not obliged to register for social security. This apparent contradiction has its origin in the fact that, until the mid-1980s, the system was based on social security principles.

In 2012 Royal Decree Law (RDL) 16/2012 (Ministry of the Presidency, 2012) changed the basis for entitlement from residence to "being insured" based on social security status. The following groups were entitled to the NHS: employees contributing to the social security system and their dependants (spouse, dependent former spouse and dependants under 26 years old or with a significant disability); pensioners; people receiving unemployment benefits; and unemployed people who were no longer entitled to unemployment benefits. The new regulation mainly affected people without European Union (EU) citizenship, effectively excluding undocumented migrants from coverage; the precise number of people excluded from coverage is not known. Undocumented non-

EU citizens were entitled to emergency care only for serious illness or accidents until discharge, obstetric care and child health services for people under 18 years old. Some regional governments found ways to bypass the national legislation, however, and tried to ensure access to health care for undocumented migrants.

In 2018 RDL 7/2018 (Ministry of the Presidency, 2018) re-established residence as the basis for entitlement to the NHS. Undocumented migrants recovered full entitlement to the NHS but only after being in Spain for more than 90 days; those needing health care within 90 days require a report from social services certifying they have met the entitlement criteria, which may result in administrative barriers to access for some undocumented migrants.

Asylum seekers are entitled to the same benefits as residents (governed by a different regulation, Law 12/2009), but delays in the recognition of asylum-seeker status may jeopardize access to health services. Foreigners legally reunited with relatives residing in Spain are also protected by RDL 7/2018. In practice, however, they too face obstacles in the recognition of their right to health care.

Some civil servants of the central administration, members of the armed forces and members of the judiciary – in total around 2 million people – are covered automatically by the Mutual Fund for State Civil Servants (MUFACE), the Social Institute for the Armed Forces (ISFAS) and the General Justice Mutual Fund (MUGEJU), respectively. These mutual funds are financed partially by contributions. People covered by mutual funds can choose once or twice a year, depending on the fund, to have their care delivered by the NHS or by private providers contracted by the funds. Those who opt for provision through private providers are entitled to the services covered by the NHS and may also benefit from shorter waiting times.

3.1.2 Service coverage

Before 2012 the NHS had a comprehensive nation-wide **common package** of benefits. The Autonomous Communities were entitled to add new benefits through a regional **complementary package** if they provided the financial resources themselves, but there was very little regional variation in benefits.

In 2012 RDL 16/2012 divided the NHS common package into three packages, which still apply today.

- The common basic package is free of charge. It includes all health care prevention, diagnosis, treatment and rehabilitation services, as well as emergency medical transportation.

- The common supplementary package includes services that may be subject to co-payments, such as outpatient prescriptions, medical and dietary products and non-urgent medical transportation.

- The common accessory package is vaguely described as all activities, services or techniques that are not considered to be essential or are used as aids for chronic care, with co-payments. This third package has only partially been defined and is pending regulation.

The 2012 law also excluded more than 400 medicines, mainly for minor conditions (Puig-Junoy et al., 2016), from the common package.

The **common basic package** is defined by the Inter-territorial Council based on proposals submitted by the Commission on Benefits, Insurance and Financing and the technical advice of the Spanish Network of Agencies for Health Technology Assessment and Benefits. It includes a comprehensive range of services available without co-payment:

- **primary care services:** acute and chronic care, health promotion and prevention activities, physiotherapy, mother and child care, mental health care, palliative care, medical counselling and basic dental health services; and

- **specialist services:** any diagnostic and therapeutic procedure to be provided as outpatient specialist 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 and emergency care.

The **complementary package** allows Autonomous Communities to add any technique, technology or procedure not covered by the common basic package if they provide the resources needed for their financing and can meet three conditions: justification for the need; allocation of sufficient financial resources for the common basic package; and adherence to the budgetary stability criteria established by the Ministry of Finance.

There are three main gaps in NHS service coverage: dental care for adults; optical care for eyesight problems for children and adults; and hearing aids for people over 26 years old.

Dental care covered by the NHS is free at the point of use and mainly provided by private solo or group practices, but the range of covered services is limited. Adults are entitled to tooth extraction and treatment of infections or inflammatory processes. Caries prevention (application of topical fluoride, dental fillings and fissure sealants) and preventive measures are covered for pregnant women (as part of the protocol for a healthy pregnancy). Children are entitled to caries prevention and counselling on hygiene measures provided by paediatricians and nurses and, in some regions, as part of the Plan for Dental Care in Childhood (PADI), a plan funded by the Autonomous Communities and provided in public settings or private dental clinics for children up to the age of 15. PADI includes some endodontic and orthodontic treatments as well as emergency care. Since 2015 the NHS has covered dental implants for people who have lost teeth due to cancer treatment and people with congenital malformations. All other dental services have to be paid for fully out of pocket or through VHI.

With the exception of diagnoses in preventive programmes for children under 16, **optical care for eyesight problems is not covered**. People must pay the full price out of pocket for services provided by opticians. There are no official statistics on unmet need for optical care.

Hearing aids are covered by the NHS only for children and young people up to 26 years. Before 2019 hearing aids were covered only for children up to 18.

Despite the introduction of policies such as waiting time guarantees (see section 3.2), waiting times are a problem, particularly for specialist consultations and some surgical procedures.

3.1.3 User charges (co-payments)

Before 2012 co-payments for NHS services applied only to outpatient prescription medicines. Pensioners and some other groups of people were exempt from co-payments (Table 3).

Table 3. User charges for outpatient prescription medicines before 2012

Source: authors.

Type of user charge	Exemptions	Cap
Most medicines for chronic conditions: percentage co-payment of 10% of the retail price with a cap of €4.24 per prescription item **All other medicines:** 40% of the retail price (or 30% for people covered by MUFACE, MUGEJU and ISFAS who did not benefit from the exemption for pensioners)	• Pensioners (those not covered by MUFACE, MUGEJU and ISFAS only) • People receiving non-contributory pensions or social integration income • People requiring treatment due to occupational illness and injury • People with toxic shock syndrome • A small number of people with disabilities	No

In 2012 RDL 16/2012 abolished the exemption from co-payments for outpatient prescriptions for pensioners and increased existing co-payments for everyone else (Table 4).

Two regions (Catalonia and Madrid) introduced a fixed co-payment of €1 per outpatient prescription, but this measure was suspended after the Supreme Court found it to be unconstitutional because Autonomous Communities are not entitled to set user charges.

The splitting of the common package into three parts introduced by RDL 16/2012 opened the door to the introduction of new co-payments for ortho-prosthetic devices (such as supportive braces and splints, prostheses, wheelchairs, crutches and hearing aids), dietary products for medical purposes and outpatient medicines dispensed in hospital pharmacies – for example, chemotherapy (the latter has not been applied and is not expected to happen).

However, RDL 16/2012 kept important protection mechanisms in place – notably, exemptions from co-payments for some social beneficiaries and the reduced rate for co-payments for a wide range of medicines for chronic conditions. The reduced rate (known as aportación reducida) applied to 46% of the covered medicines that can be dispensed in pharmacies in 2018 (Ministry of Health, 2019).

RDL 16/2012 also introduced new protections, such as a monthly cap on co-payments for most pensioners (those not covered by the mutual funds) that is linked to income and applied automatically in pharmacies through the e-prescription system, and an exemption from co-payments for unemployed people who are no longer entitled to unemployment benefits.

Protection mechanisms have been strengthened even further since 2020. Exemption from co-payments was extended in 2020 to recipients of the guaranteed minimum income (RDL 20/2020 (Ministry of the Presidency, 2020a)). In 2021 exemption was extended to low-income pensioners, moderately and severely disabled children and households receiving child benefits (Law 11/2020 (Ministry of the Presidency, 2020b)). A draft bill on "equity, universality and cohesion of the NHS" (which recently has undergone public consultation and is being finalized) includes avoiding the introduction of new co-payments as one of its objectives (Ministry of Health, 2021a).

Table 4. User charges for publicly financed health services, 2021

NA: not applicable.
Source: authors.

Service area	Type of user charge	Exemptions	Cap
Outpatient visits	None	NA	NA
Dental care	None	NA	NA
Diagnostic tests	None	NA	NA
Inpatient care	None	NA	NA
Inpatient medicines	None	NA	NA
Emergency care	None	NA	NA
Outpatient prescription medicines	**Most medicines for chronic conditions:** percentage 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% All others with an annual income > €100 000: 60%	• 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 • Since 2021: pensioners with incomes < €5 635 or €11 200 if they are not obliged to pay personal income tax	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
Ortho-prosthetic devices (such as supportive braces and splints, prostheses, wheelchairs, crutches and hearing aids)	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

3.1.4 The role of VHI

VHI mainly plays a supplementary role in Spain, offering people faster access to treatment with a wide range of benefits depending on the premium paid. Some people also buy complementary VHI covering dental care.

It is estimated that in 2018 VHI covered around 8.4 million people – 18% of the population (Unión Española de Entidades Aseguradoras y Reaseguradoras [Spanish Association of Insurers and Reinsurers] (UNESPA), 2019). This figure does not include the 1.8 million civil servants and their beneficiaries (covered by MUFACE, MUGEJU and ISFAS) who opt to use health services delivered by private providers. The share of the population with VHI varies widely across regions. Madrid, Catalonia and the Balearic Islands show the highest rates of coverage (UNESPA, 2019). In addition to regional variation, household budget survey data show how uptake varies by consumption quintile. In 2019 around 40% of households in the richest quintile had bought VHI compared to only 10% in the poorest quintile. Around 11% of the population has VHI covering dental care.

Due to the heterogeneity of UNESPA reports it is difficult to estimate yearly coverage figures for the study period. However, the number of people with VHI seems to have grown in recent years. The VHI share of current spending on health has also grown steadily over time, rising from 5.9% in 2013 to 7.1% in 2018 and accounting for 24% of private spending on health.

There is a widespread perception that privately provided health care offers advantages in terms of faster access and greater comfort compared to the NHS (Epstein & Jiménez-Rubio, 2019), especially given the progressive increase in waiting times for specialist consultations and some surgeries exacerbated by the economic crisis, which may explain why VHI has grown since 2013. According to the national health barometer survey for 2019, 78% of those with VHI said the main reason for buying VHI was to ensure faster access to treatment through private provision (Ministry of Health, 2019). In this context, and given the marked income gradient in VHI uptake, VHI may be playing a role in exacerbating the inequalities in access to health care.

Unlike in most EU countries, the Government provides tax subsidies to some of those who buy VHI. Self-employed workers and companies buying VHI for their employees are allowed to deduct VHI premiums from taxable income. The 2021 budget increased insurance premium taxes from 6% to 8%, but VHI was exempt from the increase.

Table 5 highlights key issues relating to the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

Table 5. Gaps in publicly financed benefits and VHI coverage

Source: authors.

Coverage dimension	Population entitlement	The benefits package	User charges (co-payments)
Issues in the governance of publicly financed coverage	Administrative barriers can hamper access to treatment for people wanting to be treated outside their own Autonomous Community and access to entitlements for undocumented migrants	Budgetary pressures leading to long waiting times for elective surgery, outpatient specialist visits and diagnostic tests	Percentage co-payments for outpatient prescribed medicines and ortho-prosthetic devices (such as supportive braces and splints, prostheses, wheelchairs, crutches and hearing aids) No exemptions for children and many low-income households No cap on co-payments for non-pensioners
Main gaps in publicly financed coverage	None for residents	Limited coverage of dental care, optical care and hearing aids	Outpatient prescribed medicines, ortho-prosthetic devices
Are these gaps covered by VHI?	No	Partially: 18% of the population has VHI, offering faster access to outpatient specialist care and diagnostic tests; around 11% of the population has VHI covering dental care	No; VHI rarely covers co-payments for outpatient prescription medicines

3.2 Access, use and unmet need

The process of decentralizing the health system, completed in 2002, has led to a significant increase in the number of health centres and a more even distribution across the country, resulting in a low level of geographical barriers to access. Financial barriers to access are also low for most health services thanks to limited use of co-payments and a relatively comprehensive benefits package. Waiting times are the most important barrier to access. Among people who think that the NHS needs major reforms (31%), 87% reported waiting times as the main problem to be fixed (Ministry of Health, 2019).

Waiting times for surgery have risen since 2010, when the health budget cuts began. The share of people waiting for more than two months for an outpatient visit has increased since 2011 (Oliva et al., 2018). Official data indicate that from 2006 to 2019, the average waiting time for non-urgent surgery and for a first consultation with a specialist rose from 70 to 115 days and from 54 to 81 days, respectively; the number of people waiting for non-urgent surgery per 100 000 people also rose from 9.4 to 14.8 (Ministry of Health, 2021b).

Different policies have been introduced to reduce waiting times, including regional maximum waiting times for surgical procedures defined by law. The implementation of these measures has been uneven across regions, most of them starting in the early 2000s and Asturias being the last in 2018. If the maximum waiting time is exceeded, people are offered an alternative provider, public or private. Not all regions assure maximum times for outpatient specialist visits, however.

Other measures have focused on increasing the volume of surgical procedures – for example, by extending the working time for surgeons on a fee-for-service basis or increasing funding for new equipment – but without much success.

European Union Statistics on Income and Living Conditions (EU-SILC) data indicate that unmet need (Box 1) due to cost, distance or waiting times is substantially higher for dental care than for health care. Unmet need for health care is consistently much lower in Spain than the EU average (Fig. 1). In contrast, unmet need for dental care in Spain was above the EU average in 2019, following a large increase during the economic crisis (Fig. 1).

On average, unmet need grew in Spain during the years of the economic crisis from 2008 to 2014 and began to fall from 2014 onwards (Fig. 1). The rise was particularly sharp for unmet need for dental care. Looking at income inequality in unmet need, it is clear that the increase in unmet need over time was largely driven by an increase among the poorest quintile (Fig. 2). Income inequality in unmet need for health care fell after 2014 and had disappeared by 2018 (Oliva et al., 2018), but income inequality in unmet need for dental care has persisted; the share of people in the poorest quintile with unmet need for dental care was twice as high in 2019 as it had been in 2006 (12% versus 6%) (Urbanos-Garrido, 2020).

EU-SILC data show very little variation in unmet need for health or dental care by age.

Box 1. Unmet need for health care

Financial protection indicators capture financial hardship among people who incur out-of-pocket payments when using health services. They do not, however, indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need for health care. Unmet need is an indicator of access, defined as instances in which people need health care but do not receive it because of access barriers.

Information on health care use or unmet need is not collected routinely in the household budget surveys used to analyse financial protection. These surveys indicate which households have not made out-of-pocket payments, but not why. Households with no out-of-pocket payments may have no need for health care, be exempt from user charges or face barriers to accessing the health services they need.

Financial protection analysis that does not account for unmet need could be misinterpreted. A country may have a relatively low incidence of catastrophic out-of-pocket payments because many people do not use health care, owing to limited availability of services or other barriers to access. Conversely, reforms that increase the use of services can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place. In such instances, reforms might improve access to health care but at the same time increase financial hardship.

This review uses data on unmet need to complement the analysis of financial protection. It also draws attention to changes in the share and distribution of households without out-of-pocket payments. If increases in the share of households without out-of-pocket payments cannot be explained by changes in the health system – for example, enhanced protection for certain households – they may be driven by increases in unmet need.

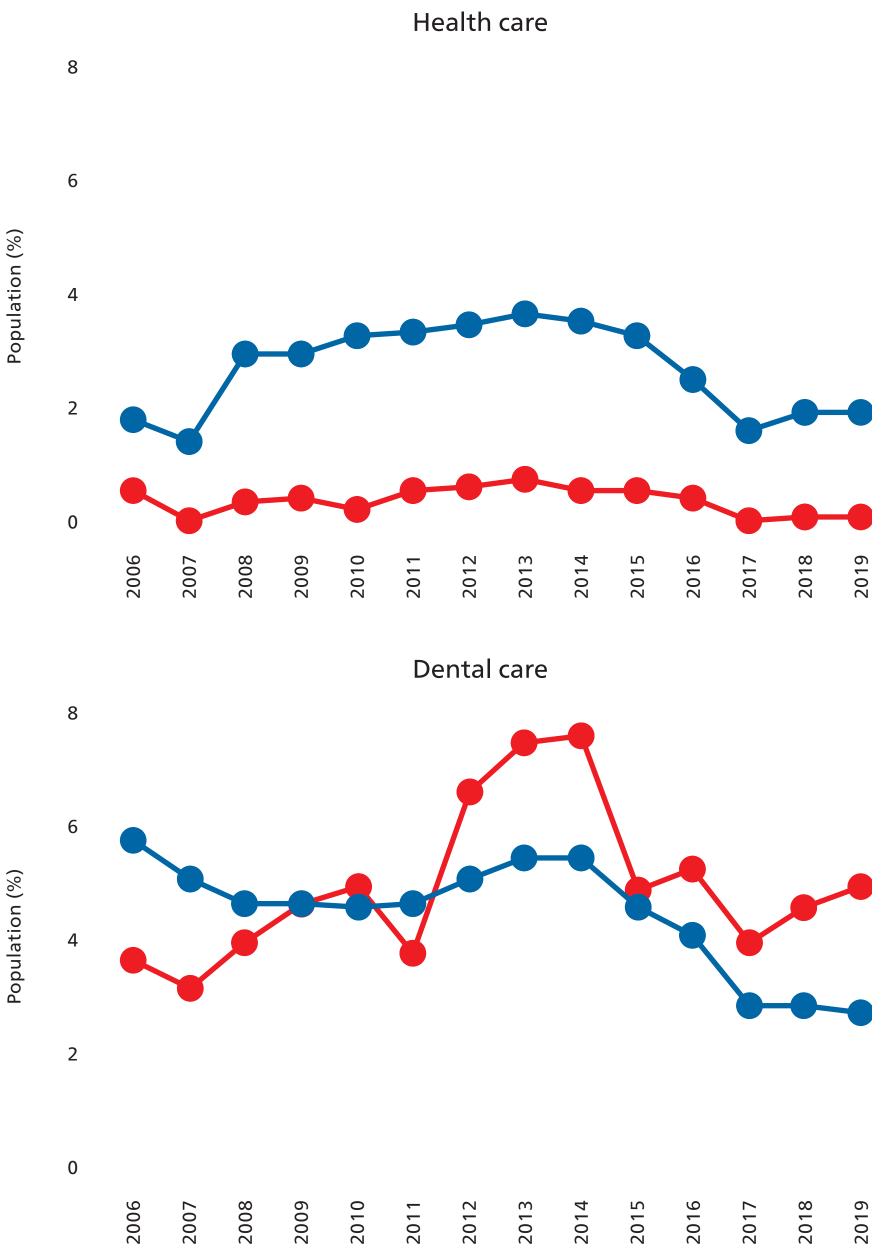
Every year, EU Member States collect data on unmet needs for health and dental care through the EU-SILC. These data can be disaggregated by age, gender, educational level and income. Although this important source of data lacks explanatory power and is of limited value for comparative purposes because of differences in reporting by countries, it is useful for identifying trends over time within a country (Arora et al., 2015; European Commission Expert Panel on Effective Ways of Investing in Health, 2016, 2017).

EU Member States also collect data on unmet needs through the European Health Interview Survey (EHIS) carried out every five years or so. The second wave of this survey was conducted in 2014. A third wave was launched in 2019.

Whereas EU-SILC provides information on unmet needs as a share of the population aged over 16 years, EHIS provides information on unmet needs among those reporting a need for care. EHIS also asks people about unmet needs for prescribed medicines.

Source: WHO Regional Office for Europe (2019).

Fig. 1. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, Spain and EU



EU
Spain

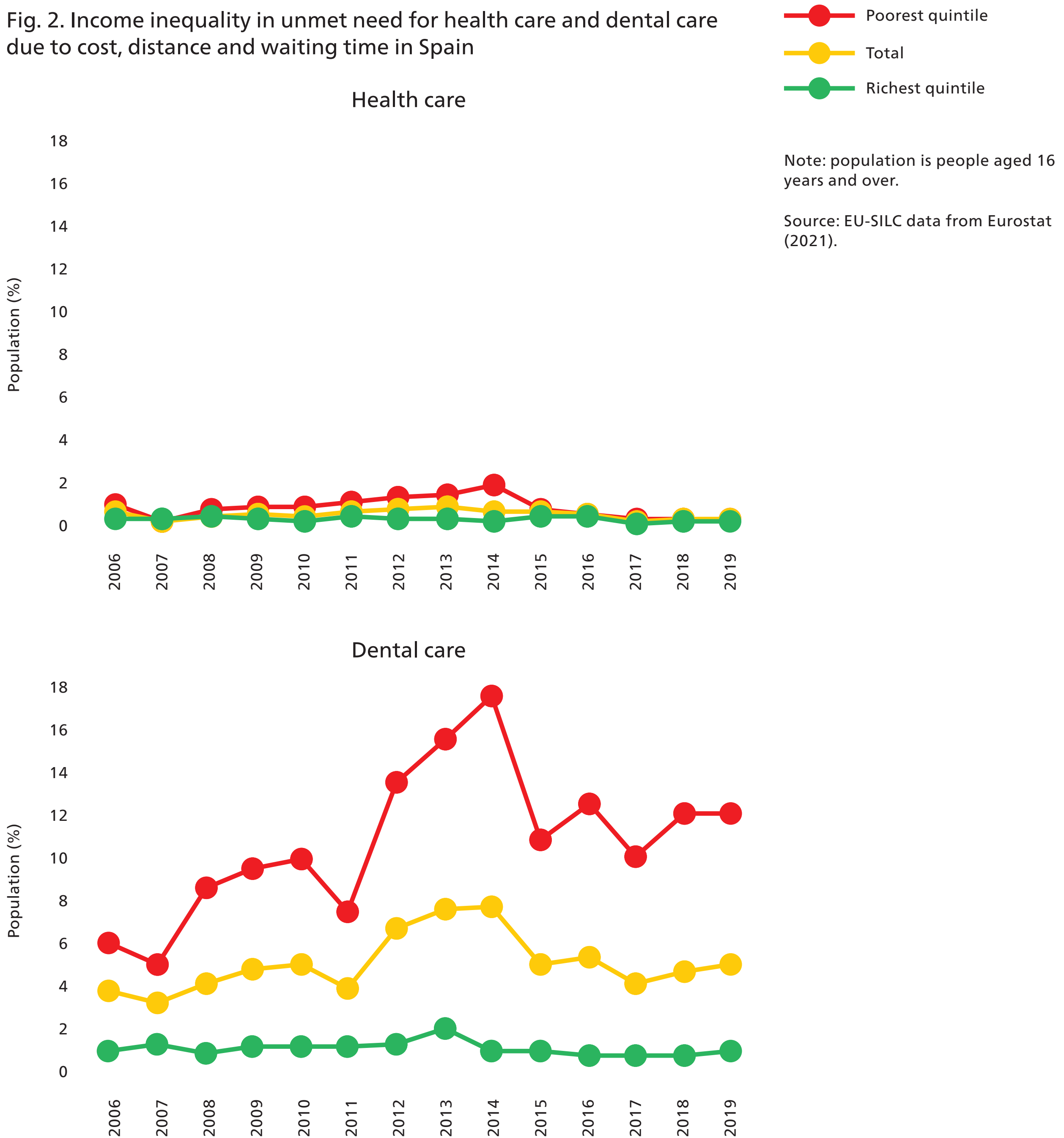
Note: population is people aged 16 years and over.

Source: EU-SILC data from Eurostat (2021).

EHIS data on unmet need for health care, dental care and prescribed medicines due to cost show three things (Fig. 3). First, they confirm that dental care is a much larger driver of unmet need due to cost than health care or prescribed medicines in Spain and the EU, and it is the one area of care in which Spain performs badly compared to the EU average. Second, they confirm that unmet need is consistently below average among older people in Spain (those aged over 65 years). Third, although socioeconomic

inequality in unmet need due to cost – measured here in terms of level of education – is evident for health care, dental care and prescribed medicines, it is most apparent for prescribed medicines, where it is more than three times higher in the least educated people than in the most educated people. EHIS data on unmet need for mental health services due to cost indicate that it is lower in Spain (1.6% in 2014) than the EU average (2.7%).

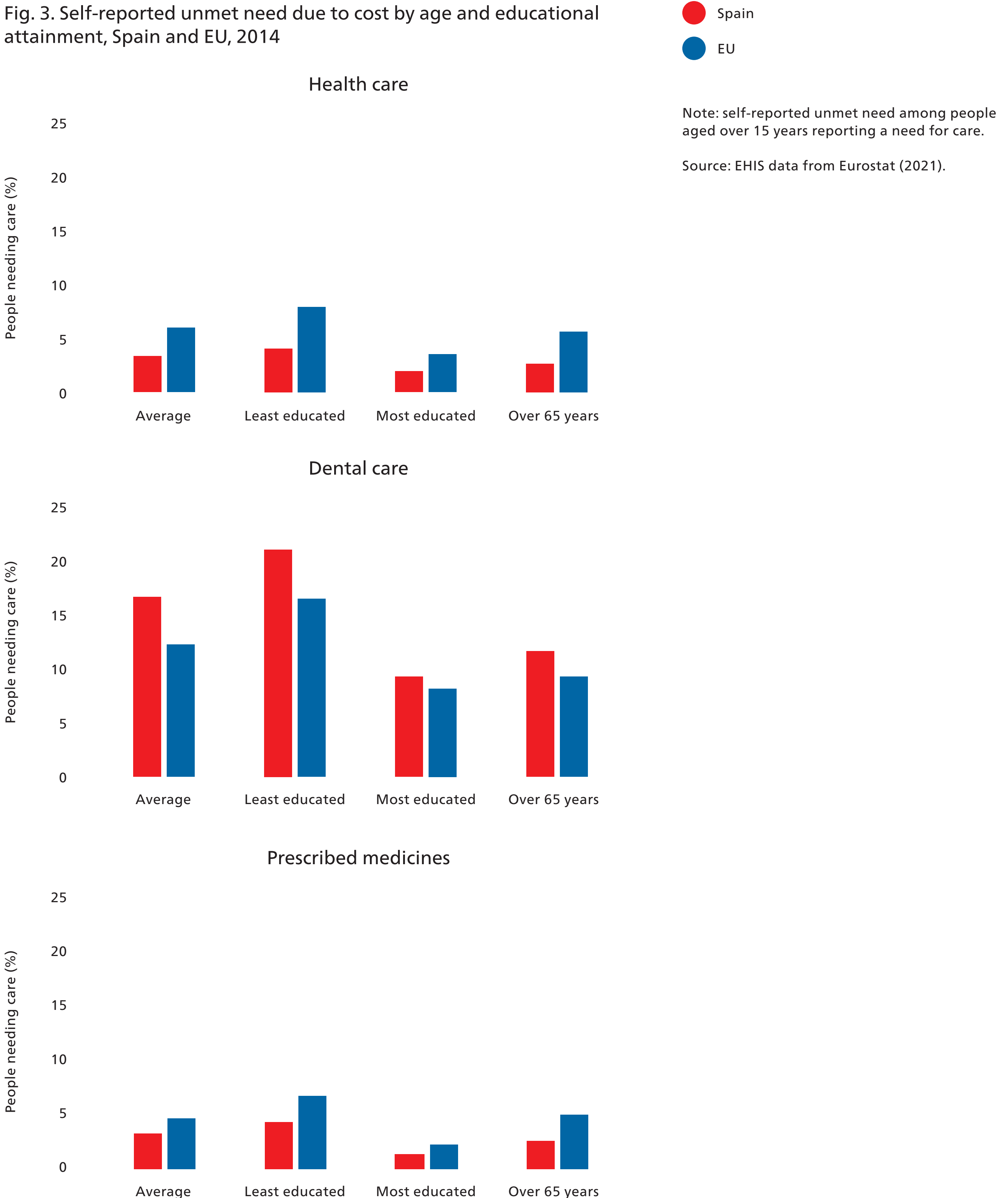
Fig. 2. Income inequality in unmet need for health care and dental care due to cost, distance and waiting time in Spain



Note: population is people aged 16 years and over.

Source: EU-SILC data from Eurostat (2021).

Fig. 3. Self-reported unmet need due to cost by age and educational attainment, Spain and EU, 2014



Note: self-reported unmet need among people aged over 15 years reporting a need for care.

Source: EHIS data from Eurostat (2021).

Relatively low levels of unmet need for health care in Spain reflect its large network of health centres, access to a comprehensive benefits package and the absence of co-payments for physician visits, diagnostic tests and inpatient care.

This contrasts with dental care, for which the benefits package is very limited, especially for adults. As a result, even though covered dental services are free at the point of use, most dental care is not covered and must be paid for out of pocket. Financial barriers to accessing dental services were exacerbated during the economic crisis, as household incomes fell (Urbanos Garrido, 2020).

Socioeconomic inequality in unmet need for prescribed medicines may reflect co-payments for outpatient prescribed medicines and limited protection from co-payments for low-income children and people of working age. Protection for low-income households has been strengthened since 2020, but children and working-age people still lack a cap on co-payments.

A recent study shows that those who report problems buying medicines prescribed by NHS doctors are mainly working people with a household income of less than €900 a month and pensioners with a monthly income of less than €600 (Rodríguez-Feijoó & Rodríguez Caro, 2021). Similarly, those benefiting from nongovernmental organizations such as the Banco Farmacéutico [Pharmaceutical Bank], which provides medicines free of charge to low-income households, tend to be adults with a low level of education, unemployed, with a functional disability and with one or more children (Rubio-Varela et al., 2021).

Administrative barriers may also limit access to prescribed medicines (Public Ombudsman, 2017). Co-payments and the cap on co-payments for outpatient prescribed medicines are based on annual income assessments provided by the Revenue Agency (Ministry of the Treasury) and updated by the National Social Security Institute for the previous year. This can lead to difficulties for people who retire, lose their jobs or experience a fall in income during the course of the year and have to wait for the end of the tax year for a new income assessment.

The relatively small share of the population reporting unmet need for mental health care due to cost reflects the fact that this type of care is covered by the NHS and visits do not involve co-payments. However, the low availability of psychologists and psychiatrists in Spain compared to other EU countries (Public Ombudsman, 2020a; Eurostat, 2021), and anecdotal evidence, suggest that waiting times for psychological and psychiatric attention are a substantial barrier to access (Public Ombudsman, 2020b). Unfortunately, the way in which waiting times are monitored and reported varies widely across autonomous communities.

3.3 Summary

Although the Spanish NHS is largely decentralized to the 17 Autonomous Communities, coverage policy is governed centrally by the national Ministry of Health and the Inter-territorial Council of regional health ministers.

Important changes to coverage policy were introduced in 2012, in the context of the economic crisis. Some key changes have since been reversed.

The basis for entitlement to NHS services is residence, with undocumented migrants entitled to the same degree of coverage as residents. As a result, population coverage is near universal. In 2012 the basis for entitlement was restricted to "being insured" based on social security status, which limited access for undocumented migrants, but this change was reversed in 2018.

The NHS benefits package is comprehensive, with very little regional variation. The main gaps in coverage are dental care, which is very limited for adults, and optical care for eyesight problems (glasses, contact lenses) and hearing aids, which are not covered for adults over 26 years. These services are largely paid for out of pocket.

NHS health and dental services are almost entirely free at the point of use. Co-payments for NHS services are limited to outpatient prescribed medicines and ortho-prosthetic devices (such as supportive braces and splints, prostheses, wheelchairs, crutches and hearing aids). These items are subject to percentage co-payments that are reduced significantly for most medicines for chronic conditions and most pensioners and slightly reduced for low-income children and people of working age. Pensioners are also protected by a monthly income-related cap on co-payments for outpatient prescribed medicines.

Co-payments changed substantially in 2012. The changes affected many households, but were particularly significant for pensioners, who previously had been exempt from co-payments. The 2012 changes kept in place other exemptions from co-payments, however, and introduced a cap to protect pensioners. Exemptions from co-payments have been strengthened since 2020, including for low-income households, but evidence of socioeconomic inequality in access to prescribed medicines indicates a need for greater protection for low-income households.

Waiting times are a significant barrier to access and have increased notably since 2010 despite regional waiting times guarantees and a set of additional measures that vary across regions. The increase in waiting times may explain growing take-up of supplementary VHI offering faster access to treatment, which covers just over a fifth of the population on average, rising to a third of the population in some regions. VHI is likely to exacerbate inequalities in access to health care because it is more prevalent among richer households.

Administrative barriers can also limit access to NHS services, particularly for people who experience a change in financial circumstances and must wait for the new tax year to benefit from reduced co-payments, but also for undocumented migrants (legal loopholes and delays in getting social

services to authorize access); foreigners legally reunited with relatives residing in Spain; and asylum seekers (delays in the process of being recognized as asylum seekers).

Unmet need for health services varies by type of care in Spain: it is much higher for dental care than for health care or prescribed medicines due to limited NHS coverage of dental care for adults. Very low levels of unmet need for health care – consistently well below the EU average – reflect a large network of health centres, access to a comprehensive benefits package and the absence of co-payments for physician visits, diagnostic tests and inpatient care.

Unmet need, particularly for dental care, increased during the economic crisis. The increase over time was largely driven by rising unmet need among poorer people. Income inequality in unmet need for health care fell after the crisis, but has persisted for dental care. Unmet need for dental care was twice as high in 2019 as it had been in 2006. There does not seem to be much variation in unmet need for health or dental care by age.

4. Household spending on health

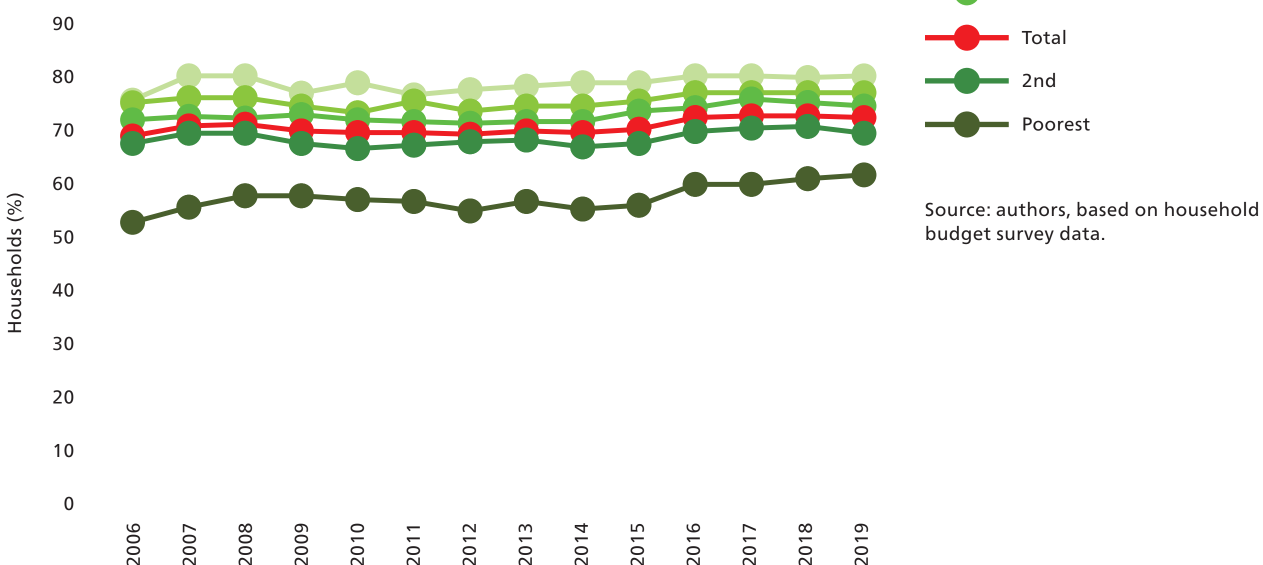
The first part of this section uses data from the household budget survey to present trends in household spending on health – that is, out-of-pocket payments, the formal and informal payments made by people at the time of using any good or service delivered in the health system. The second part uses household budget survey data to review trends in spending on VHI premiums. The third and fourth parts describe the role of informal payments and draw on data from national health accounts to review trends in public and private spending on health over time.

4.1 Out-of-pocket payments

Nearly three quarters (73%) of households reported out-of-pocket spending in 2019, up from 68% in 2006 (Fig. 4). The increase was most pronounced in the poorest quintile. The share of households with out-of-pocket payments rose before the economic crisis, fell in the early years of the crisis and rose between 2013 and 2019, reflecting an increase in user charges (co-payments) in 2012 and improved household capacity to pay for health care from 2014 onwards, as the economy began to recover.

Richer households are consistently more likely to incur out-of-pocket payments than poorer households (Fig. 4). The gap between the richest and poorest quintiles narrowed during the study period due to a sharp increase in the share of households reporting out-of-pocket payments in the poorest quintile, which rose from 52% in 2006 to 62% in 2019.

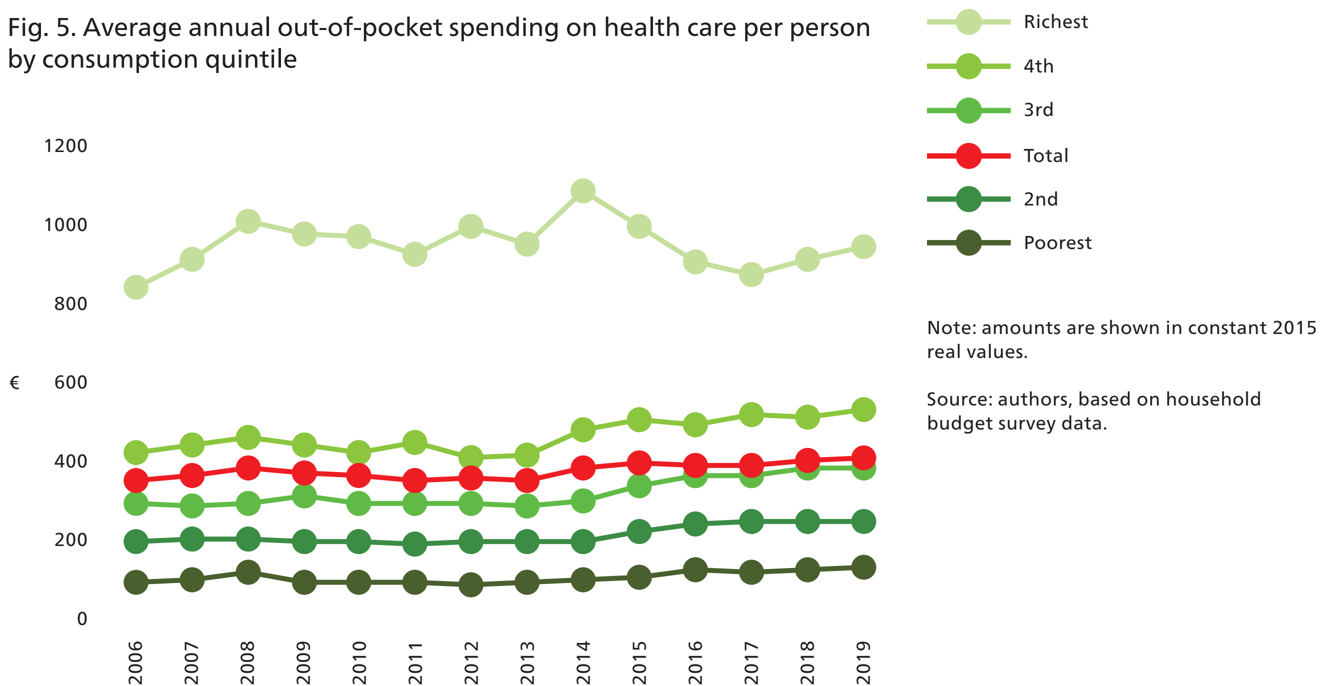
Fig. 4. Share of households with out-of-pocket payments by consumption quintile



Source: authors, based on household budget survey data.

The average annual amount spent out of pocket increased in real terms from €344 per person in 2006 to €381 in 2008, fell to €345 in 2013 and then rose again to €403 in 2019 (Fig. 5). The sharpest rise was in 2014. Richer households consistently spend more on health than poorer households; in 2019 they spent more than three times as much as the poorest quintile. During the study period the increase in the amount spent out of pocket was largest for the poorest quintile (51%) and smallest for the richest (12%).

Fig. 5. Average annual out-of-pocket spending on health care per person by consumption quintile

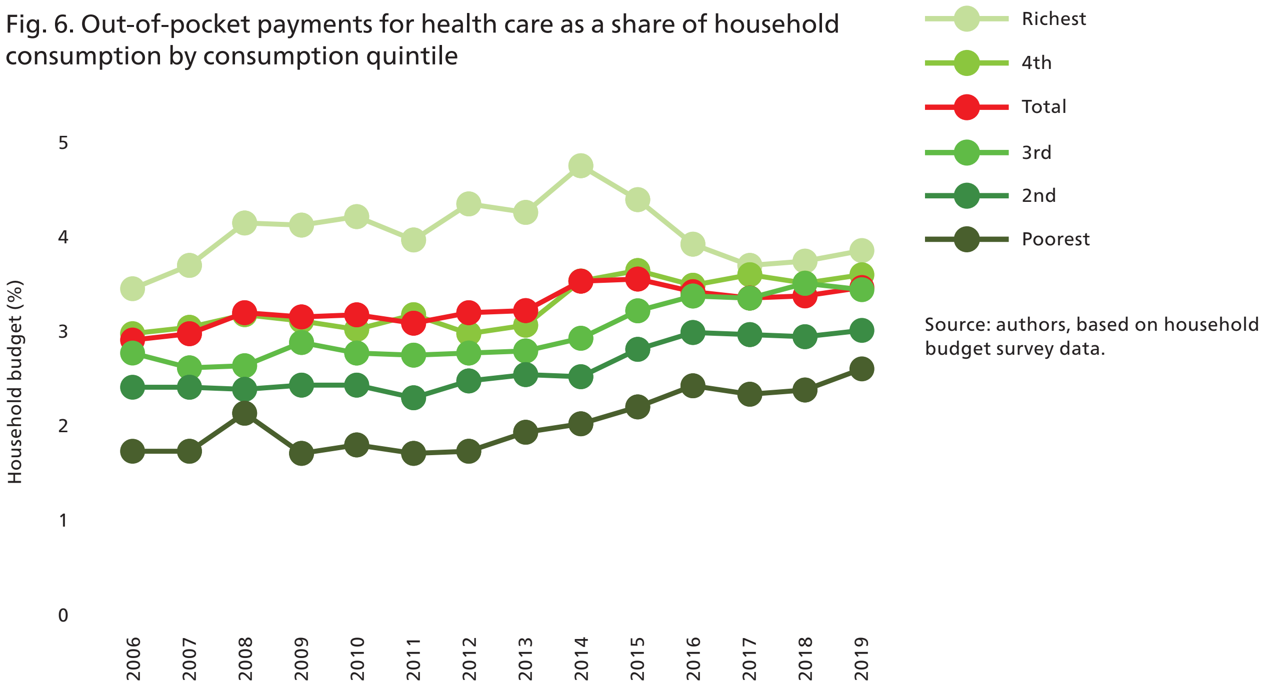


Note: amounts are shown in constant 2015 real values.

Source: authors, based on household budget survey data.

Out-of-pocket payments also increased as a share of household consumption (the household budget) (Fig. 6). The largest increase was in the poorest quintile, which experienced the sharpest reduction in total consumption and in capacity to pay for health care during the crisis years. Between 2007 and 2014, capacity to pay for health care fell by 24% in the poorest quintile, compared to 20% on average (data not shown).
The gap between the quintiles narrowed during the study period.

Fig. 6. Out-of-pocket payments for health care as a share of household consumption by consumption quintile



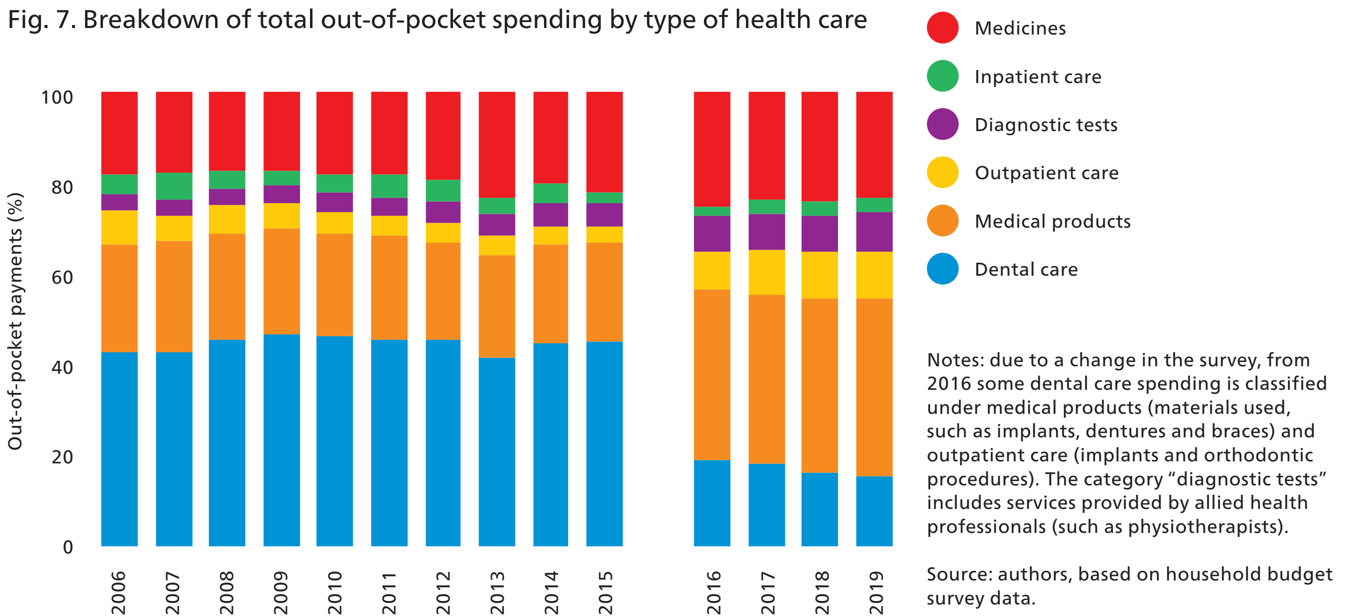
Source: authors, based on household budget survey data.

Out-of-pocket payments are mainly driven by dental care (16% in 2019), which is mostly excluded from NHS coverage, medical products (39%, roughly divided into optical care for eyesight problems and orthopaedic material) and medicines (23%) (Fig. 7). All of these categories of care are subject to NHS co-payments. Inpatient care, diagnostic tests and outpatient care, which are fully covered by the NHS (without co-payments), together accounted for only 20% of out-of-pocket payments in 2019.

Due to a change in the survey from 2016, some dental care spending is classified under medical products (the *materials* used in dental procedures, such as implants, dentures and braces) and outpatient care (implants and orthodontic *procedures*). As a result, it is not possible to compare these three categories before and after 2016. However, Fig. 7 shows the dental care-related categories together (in blue, orange and yellow) and it is possible to see a small decline in their share of household spending on health during the economic crisis. The diagnostic test share increased after the crisis, perhaps reflecting longer waiting times for specialist treatment.

The outpatient medicines share of out-of-pocket spending increased over time, rising from 18% in 2006 to 23% in 2019. The most visible rise occurred in 2013, after the introduction of new and higher co-payments for outpatient prescribed medicines. The outpatient medicine share fell again in 2014, but it is worth noting that before the 2012 changes to coverage policy, outpatient medicines accounted for a maximum of 18% of out-of-pocket spending and after the changes it accounted for a maximum of 25%.

Fig. 7. Breakdown of total out-of-pocket spending by type of health care

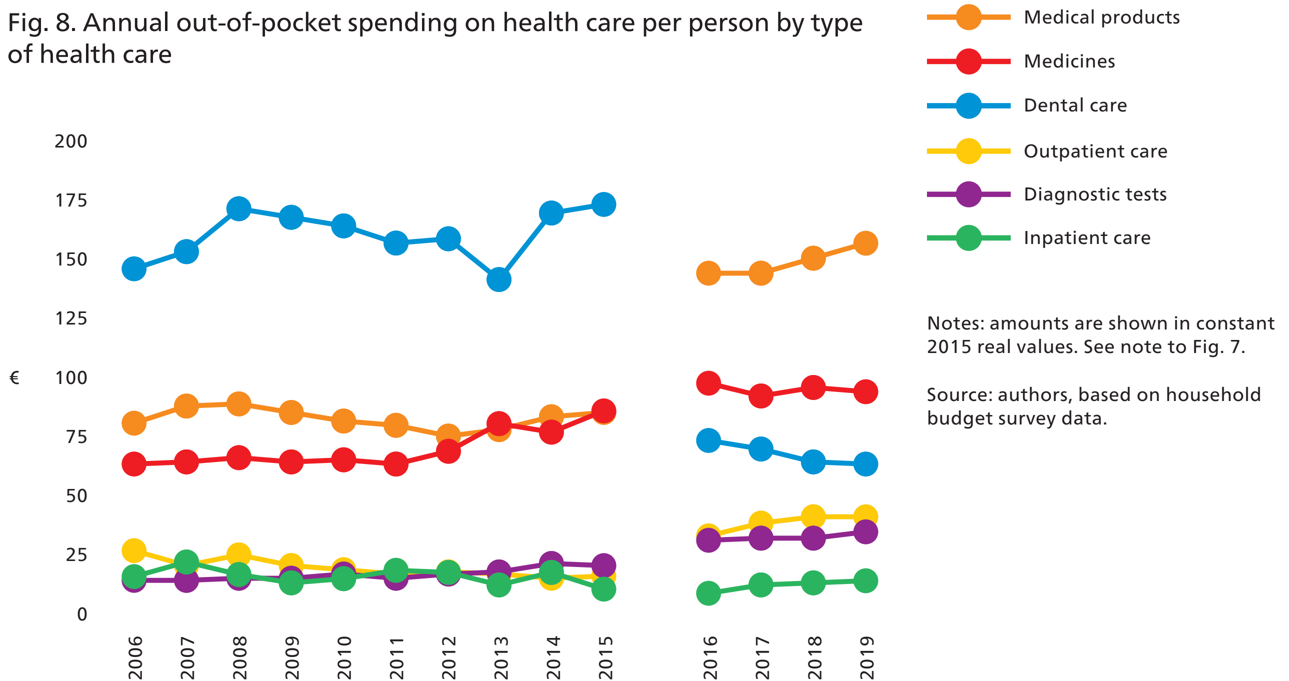


Notes: due to a change in the survey, from 2016 some dental care spending is classified under medical products (materials used, such as implants, dentures and braces) and outpatient care (implants and orthodontic procedures). The category "diagnostic tests" includes services provided by allied health professionals (such as physiotherapists).

Source: authors, based on household budget survey data.

Out-of-pocket spending on dental care and medical products fell during the economic crisis but spending on outpatient medicines rose steadily between 2012 and 2016 (Fig. 8). The rise in spending on outpatient medicines occurred in all quintiles.

Fig. 8. Annual out-of-pocket spending on health care per person by type of health care

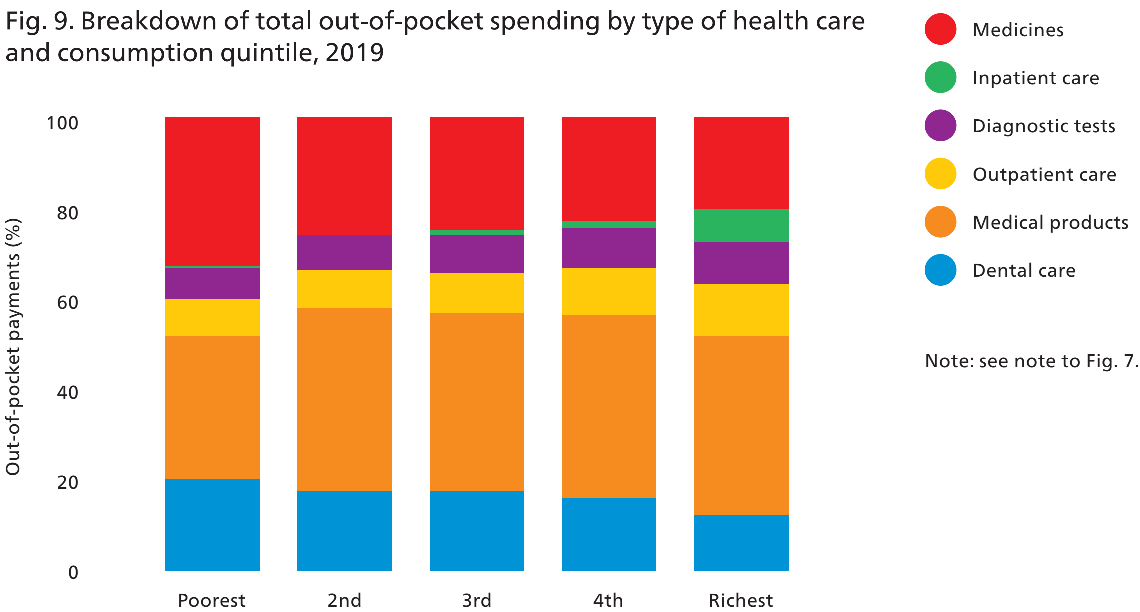


Notes: amounts are shown in constant 2015 real values. See note to Fig. 7.

Source: authors, based on household budget survey data.

Fig. 9 shows the distribution of out-of-pocket spending by type of health care and quintile in 2019. There is a clear social gradient in out-of-pocket spending on the three dental care-related categories – dental care, medical products and outpatient care – and for outpatient medicines and inpatient care. Richer households devote a larger share of out-of-pocket spending to the dental care-related categories and inpatient care, while poorer households devote a larger share to outpatient medicines. This suggests that poorer households prioritize spending on outpatient medicines over dental care, which is reflected in the high degree of income inequality in unmet need for dental care (see Fig. 2).

Fig. 9. Breakdown of total out-of-pocket spending by type of health care and consumption quintile, 2019



Note: see note to Fig. 7.

The trend in the distribution of out-of-pocket spending by consumption quintile over time suggests that the social gradient in dental care and outpatient medicines (proxied by the change over time in spending share across quintiles) was exacerbated during the economic crisis (Fig. 10).

Fig. 10. Breakdown of total out-of-pocket spending by type of health care and consumption quintile

Medicines
Inpatient care
Diagnostic tests
Outpatient care
Medical products
Dental care

Notes: OOPs: out-of-pocket payments. See note to Fig. 7

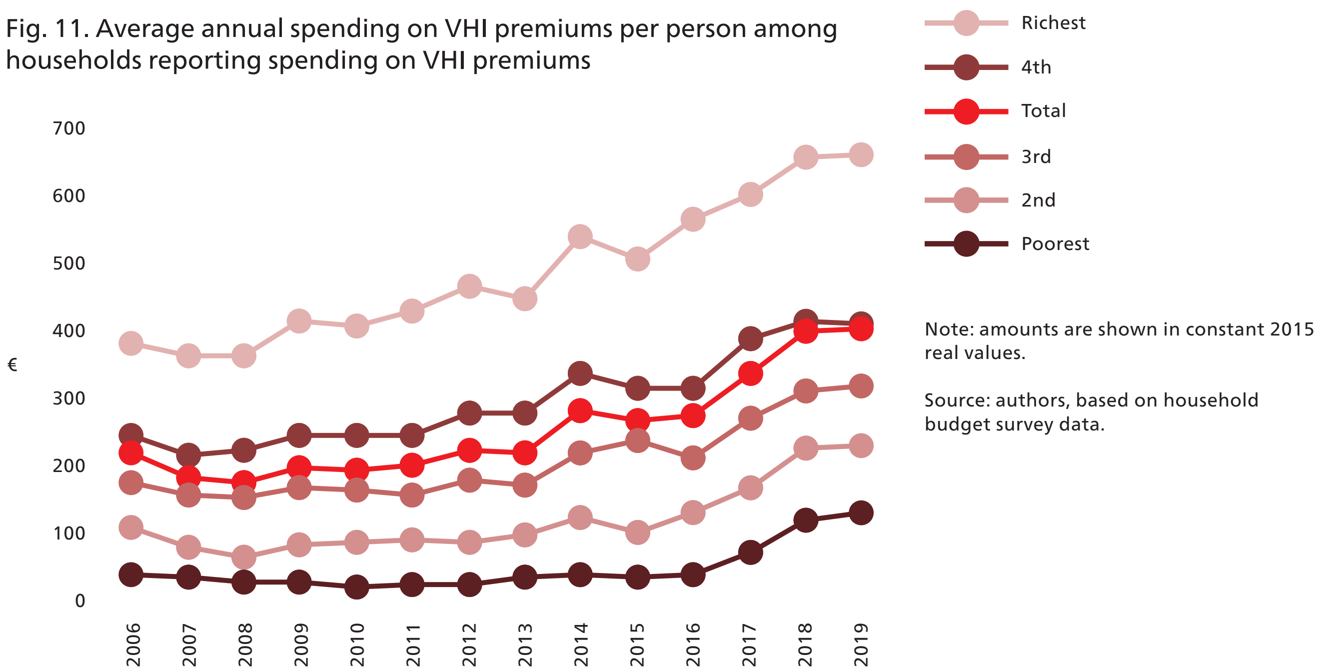
Source: authors, based on household budget survey data.

4.2. VHI premiums

In 2019 annual spending on VHI premiums per person, in households with VHI, was around €400 (Fig. 11). Spending on VHI premiums doubled during the study period (Fig. 11). The steepest rise occurred from 2014, as the economic recovery began.

Although take-up of VHI (demonstrated through reported spending on VHI premiums) is much more prevalent among richer than poorer households and became even more so over time, the increase in spending on VHI premiums was greatest in the two poorest quintiles. As a result, while richer households consistently spend much more on VHI premiums than poorer households, the gap in spending on VHI premiums across quintiles narrowed over time.

Fig. 11. Average annual spending on VHI premiums per person among households reporting spending on VHI premiums

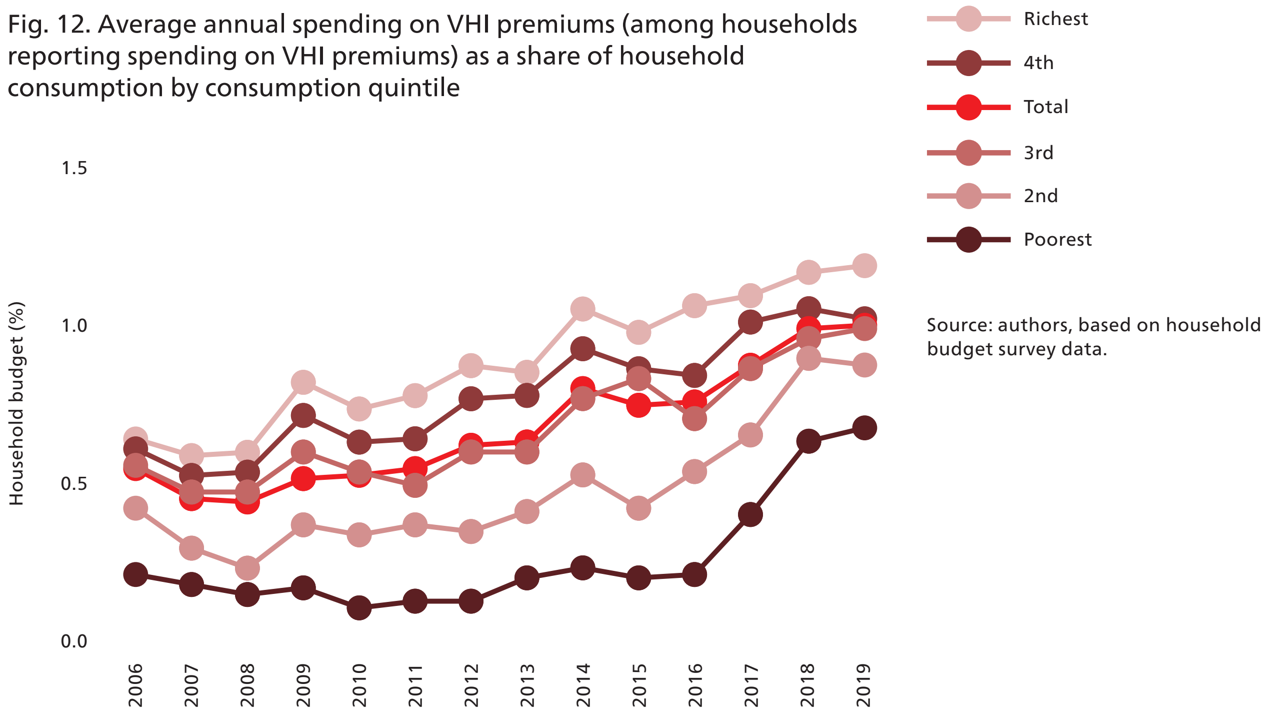


Note: amounts are shown in constant 2015 real values.

Source: authors, based on household budget survey data.

Richer households not only spend more on VHI premiums than poorer households, but also spend more as a share of total household spending (Fig. 12). In 2019 VHI premiums accounted for 1% of total household spending on average among households reporting spending on VHI premiums (Fig. 12). The VHI share of household spending doubled on average during the study period, with increases in all quintiles.

Fig. 12. Average annual spending on VHI premiums (among households reporting spending on VHI premiums) as a share of household consumption by consumption quintile



Source: authors, based on household budget survey data.

Fig. 13 shows out-of-pocket payments as a share of total household spending among households with spending on VHI premiums. When compared to Fig. 6, which shows out-of-pocket payments as a share of total household spending for all households, it is evident that VHI reduces the financial burden of out-of-pocket payments in the richer quintiles but not in the poorest quintile. This may be because VHI tends to cover inpatient care, outpatient specialist care and some dental care – the types of health care that richer households are more likely to spend on – but rarely covers outpatient medicines, which poorer households are more likely to spend on.

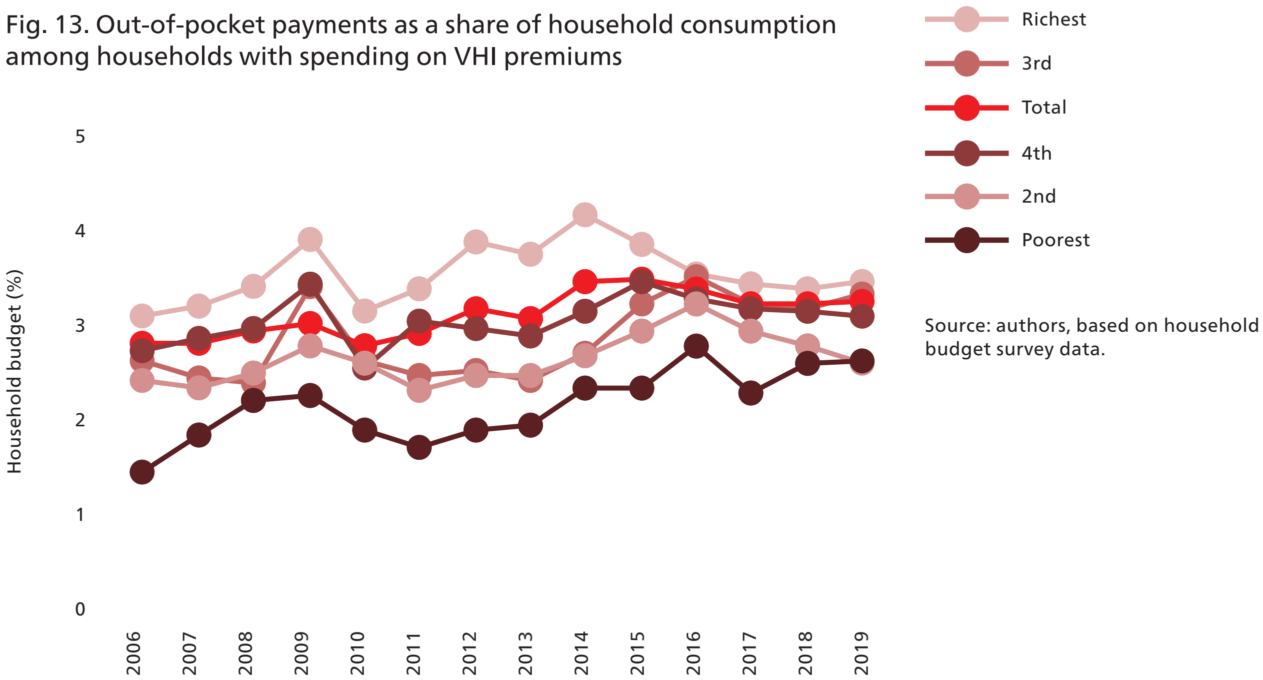


Fig. 13. Out-of-pocket payments as a share of household consumption among households with spending on VHI premiums

Source: authors, based on household budget survey data.

4.3 Informal payments

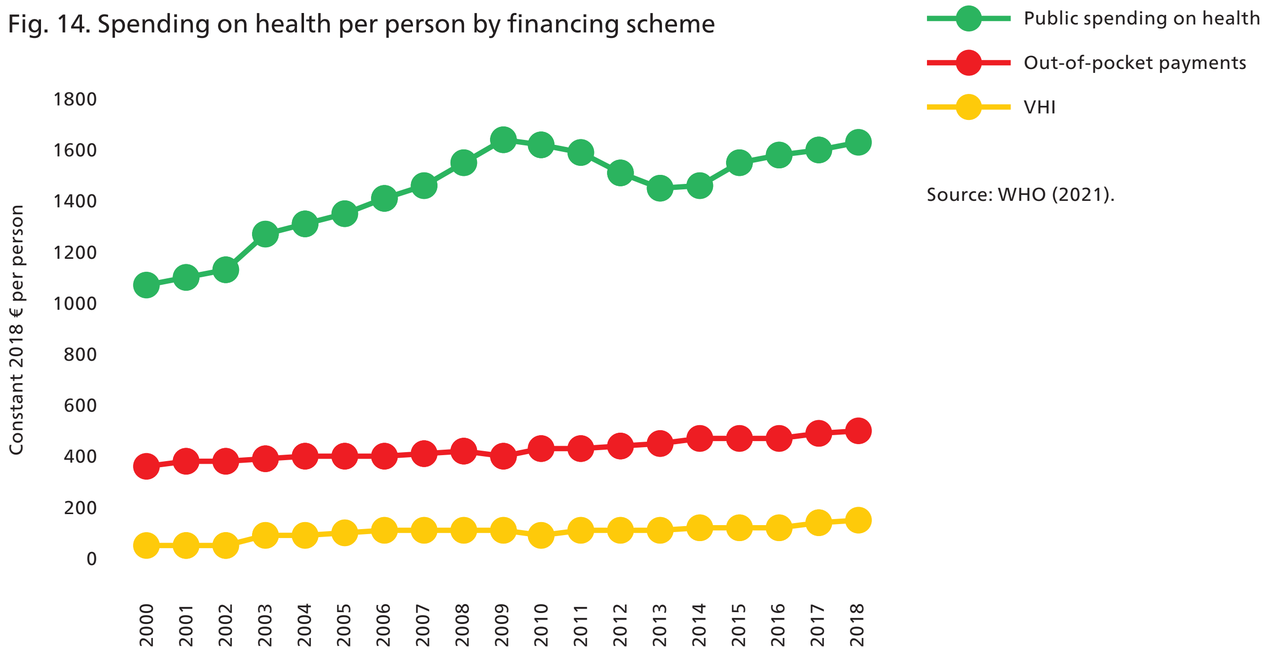
Informal payments do not seem to be an issue in the Spanish health system. Eurobarometer surveys consistently find Spain to have one of the lowest levels of self-reported informal payments in the EU (European Commission, 2014, 2017, 2020).

4.4 Trends in public and private spending on health

National health accounts data show a clear procyclical pattern in the evolution of public spending on health per person (Fig. 14). Public spending on health grew steadily from 2003 to 2009 then declined sharply from 2010 to 2013, following budget cuts amounting to €9 billion in the context of the economic crisis and the European Stability Mechanism. Public spending on health rose again from 2014 as the economy began to recover, but at a slower rate of growth than before the crisis.

Out-of-pocket payments per person increased throughout the study period, falling only once, in 2009, just after the start of the economic crisis. Spending on VHI per person also increased throughout the study period, especially from the onset of economic recovery from 2014.

Fig. 14. Spending on health per person by financing scheme



Source: WHO (2021).

The out-of-pocket payment share of current spending on health in Spain has always been above the average for European Union Member States prior to 1 May 2004 (EU15). Before the economic crisis it had been declining steadily in Spain, reaching a low of 19% in 2009 (Fig. 15). As a result of growth in out-of-pocket payments and a sharp decline in public spending on health during the crisis, the out-of-pocket share of current spending on health in Spain increased from 19% in 2009 to 23% in 2014 (Fig. 15). With the economic recovery and growth in public spending on health, it fell slightly to 22% in 2015. In 2018 it remained well above its pre-crisis level and the EU15 average, on a par with Italy but substantially higher than in other countries in western Europe.

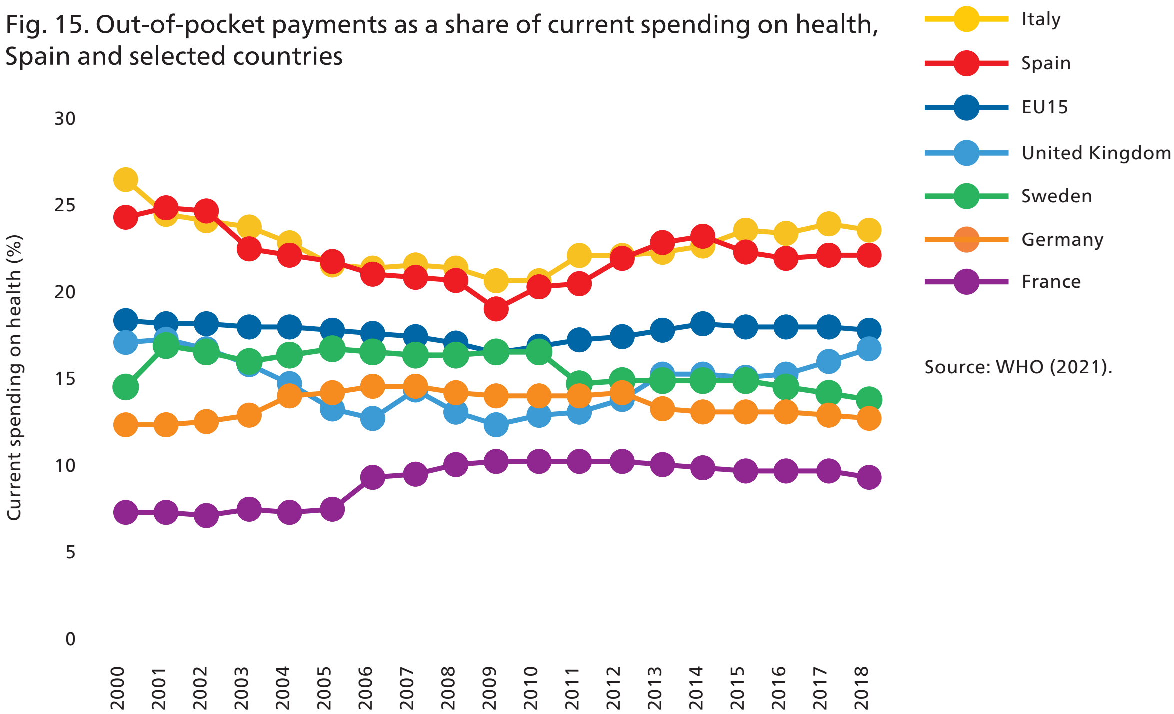
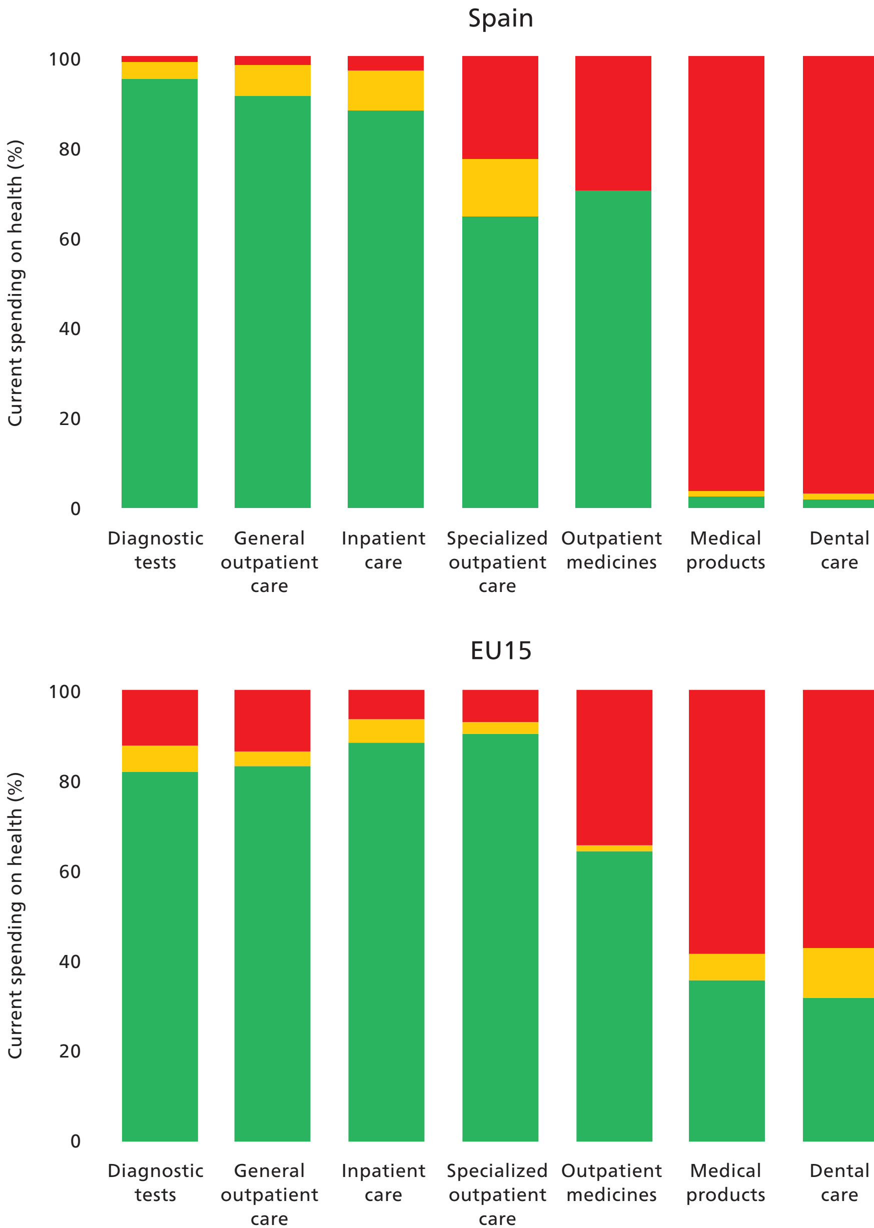


Fig. 15. Out-of-pocket payments as a share of current spending on health, Spain and selected countries

Source: WHO (2021).

Broken down by health service and financing scheme, national health accounts data show how the out-of-pocket payment share of current spending in Spain is usually negligible for service areas fully covered by the NHS – outpatient care (with the exception of outpatient specialist care), diagnostic tests and inpatient care – and lower in Spain than the average for EU15 countries (Fig. 16). VHI plays a role in financing these service areas in Spain and is particularly important in financing outpatient specialist care, reflecting waiting times for this type of care (see Section 3). In contrast, out-of-pocket payments play an important role in financing spending on dental care (only a very limited range of services is covered by the NHS) and medical products and outpatient medicines (subject to NHS co-payments) in Spain – more so than in other EU15 countries on average. For these areas of care, the role of VHI is very limited or non-existent. Dental care and medical products are almost entirely financed through out-of-pocket payments.

Fig. 16. Breakdown of current spending on health, by health service and financing scheme, Spain and EU15, 2019



Source: OECD (2021).

4.5 Summary

Nearly three quarters (73%) of households reported out-of-pocket spending in 2019, up from 68% in 2006. The increase was particularly pronounced among the poorest quintile. During the early years of the economic crisis, the share of households with out-of-pocket payments fell, but it rose again from 2013, reflecting an increase in co-payments in 2012 and improved household capacity to pay for health care from 2014 onwards as the economy began to recover.

The amount spent out of pocket increased during the study period in real terms and as a share of total household spending, with the sharpest rise in 2014. By both measures, richer households systematically spend more on health than poorer households, but the increase in the amount and share of total household spending was largest in the poorest quintile. The gap between the quintiles narrowed during the study period.

Out-of-pocket payments are mainly driven by dental care, which is mostly excluded from NHS coverage, and medical products and medicines, which are subject to co-payments. Inpatient care, diagnostic tests and outpatient care, which are fully covered by the NHS, together accounted for under 15% of out-of-pocket payments before 2016 and under 20% after 2016.

The dental care-related shares (dental care, medical products and outpatient care) fell slightly during the economic crisis. The diagnostic test share increased after the crisis, perhaps reflecting longer waiting times for specialist treatment. The outpatient medicines share of out-of-pocket spending increased over time, most visibly in 2013 after the introduction of new and higher co-payments for outpatient prescribed medicines. The outpatient medicines share fell again in 2014, but it is worth noting that before the 2012 changes to coverage policy outpatient medicines accounted for a maximum of 18% of out-of-pocket spending and after the changes for a maximum of 25%.

Out-of-pocket spending on dental care and medical products fell during the economic crisis but spending on outpatient medicines rose steadily between 2012 and 2016. The rise in spending on outpatient medicines occurred in all quintiles.

The distribution of out-of-pocket spending by type of health care varies by quintile. Richer households devote a larger share of out-of-pocket spending to the dental care-related categories (dental care, medical products and outpatient care) and inpatient care, while poorer households devote a larger share to outpatient medicines. This suggests that poorer households prioritize spending on outpatient medicines over dental care, which is reflected in the high degree of income inequality in unmet need for dental care.

In 2019 annual spending on VHI premiums per person, in households with VHI, was around €400. Spending on VHI premiums doubled during the study period. The steepest rise occurred from 2014, as the economy began to recover. Although take-up of VHI (demonstrated through reported spending on VHI premiums) is much more prevalent among richer than

poorer households and became even more so over time, the increase in spending on VHI premiums was greatest in the two poorest quintiles.

VHI reduces the financial burden of out-of-pocket payments in the richer quintiles but not in the poorest quintile. This is probably explained by the fact that VHI tends to cover inpatient care, outpatient specialist care and some dental care (a pattern confirmed by data from national health accounts) – the types of health care that richer households are more likely to spend on – but rarely covers outpatient medicines, which poorer households are more likely to spend on.

National health accounts data show that as a result of sustained growth in out-of-pocket payments and a sharp decline in public spending on health during the economic crisis, the out-of-pocket payment share of current spending on health rose from 19% in 2009 to 23% in 2014, surpassing the EU average. With the economic recovery and an increase in public spending on health, it fell slightly to 22% in 2015. In 2018 it remained well above its pre-crisis level, close to the EU average but substantially higher than in other countries in western Europe.

Data from national health accounts confirm that spending on dental care and medical products is almost entirely financed through out-of-pocket payments in Spain, and to a much greater extent than in other EU15 countries on average.

5. Financial protection

This section uses data from the Spanish household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households that use health services. The section shows the relationship between out-of-pocket spending on health and risk of impoverishment, and presents estimates of the incidence, distribution and drivers of catastrophic out-of-pocket payments.

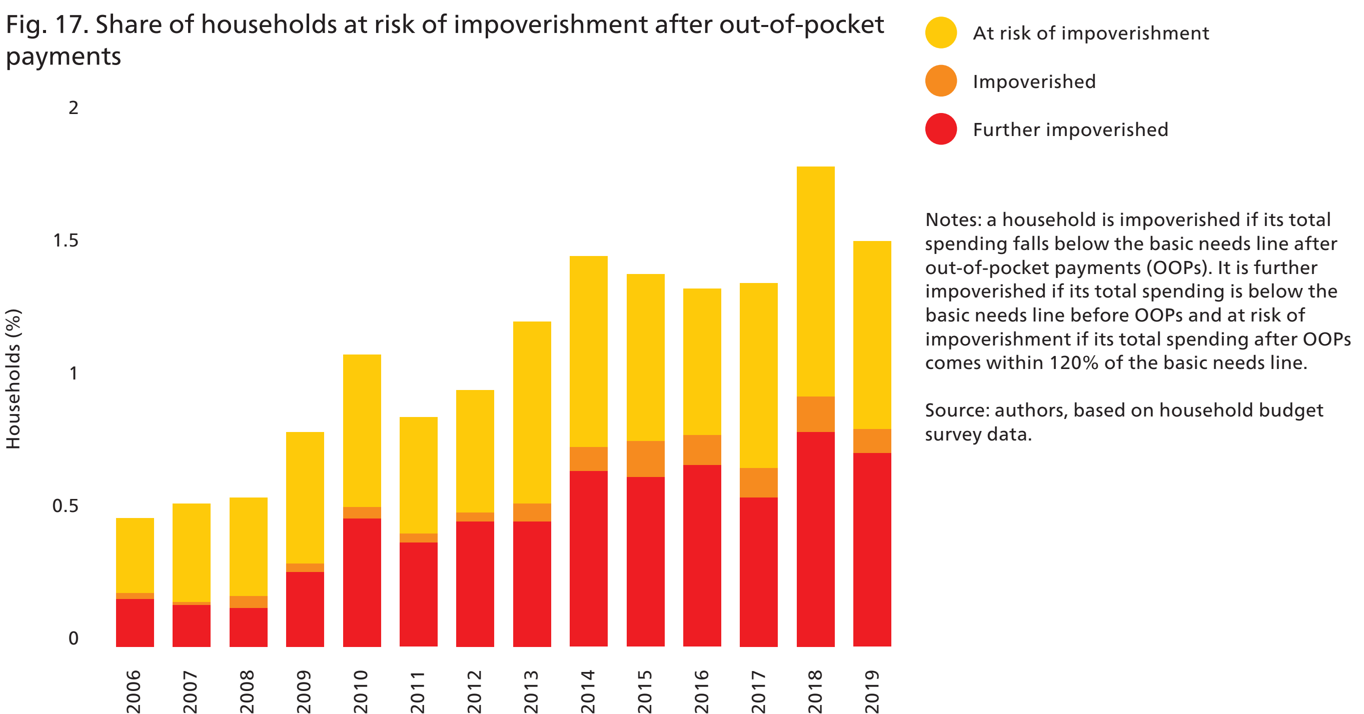
5.1 How many households experience financial hardship?

5.1.1 Out-of-pocket payments and risk of impoverishment

Fig. 17 shows the share of households at risk of impoverishment after out-of-pocket spending on health. The poverty line reflects the cost of spending on basic needs (food, rent and utilities) among a relatively poor part of the Spanish population (households between the 25th and 35th percentiles of the consumption distribution, adjusted for household size and composition). The average monthly cost of meeting these basic needs per household – the basic needs line – was €532 in 2019 (in constant 2015 real values).

In 2019 1.5% of households were at risk of impoverishment after out-of-pocket health spending, up from 0.5% in 2006 (Fig. 17). The share of households impoverished or further impoverished after out-of-pocket payments rose during the study period from a very low base of 0.2% to 0.8%.

Fig. 17. Share of households at risk of impoverishment after out-of-pocket payments



Notes: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments (OOPs). It is further impoverished if its total spending is below the basic needs line before OOPs and at risk of impoverishment if its total spending after OOPs comes within 120% of the basic needs line.

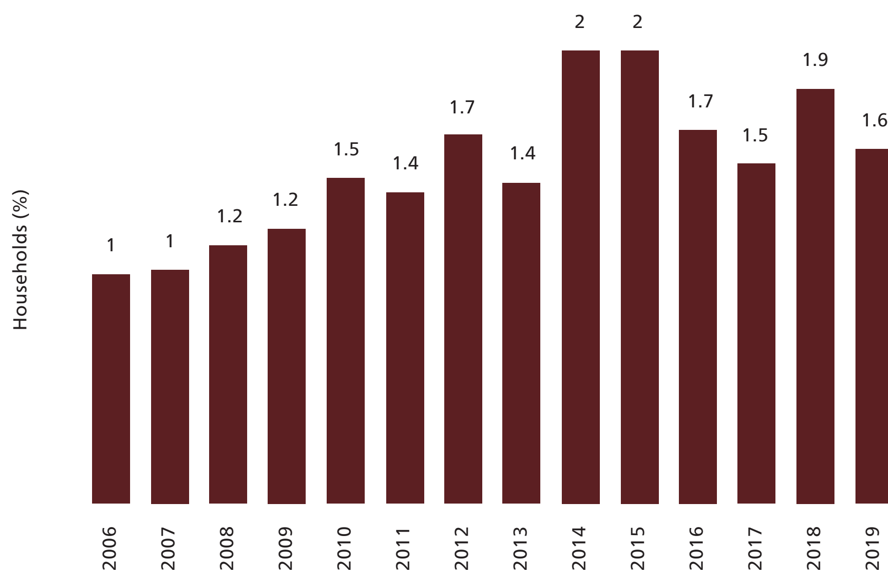
Source: authors, based on household budget survey data.

5.1.2 Catastrophic out-of-pocket payments

Households with catastrophic levels of out-of-pocket spending are defined (in this review) as those who spend more than 40% of their capacity to pay for health care. This includes households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they had no capacity to pay before paying out of pocket for health care).

In 2019 1.6% of households experienced catastrophic levels of health spending, up from 1.0% in 2006 (Fig. 18). Despite some fluctuation, the incidence of catastrophic health spending rose from 2006 to reach a peak of 2% in 2014 and 2015, reflecting a decline in household capacity to pay for health care in the context of the economic crisis. Although the incidence fell after the crisis (in 2016), in 2019 it was still above pre-crisis levels.

Fig. 18. Share of households with catastrophic out-of-pocket payments



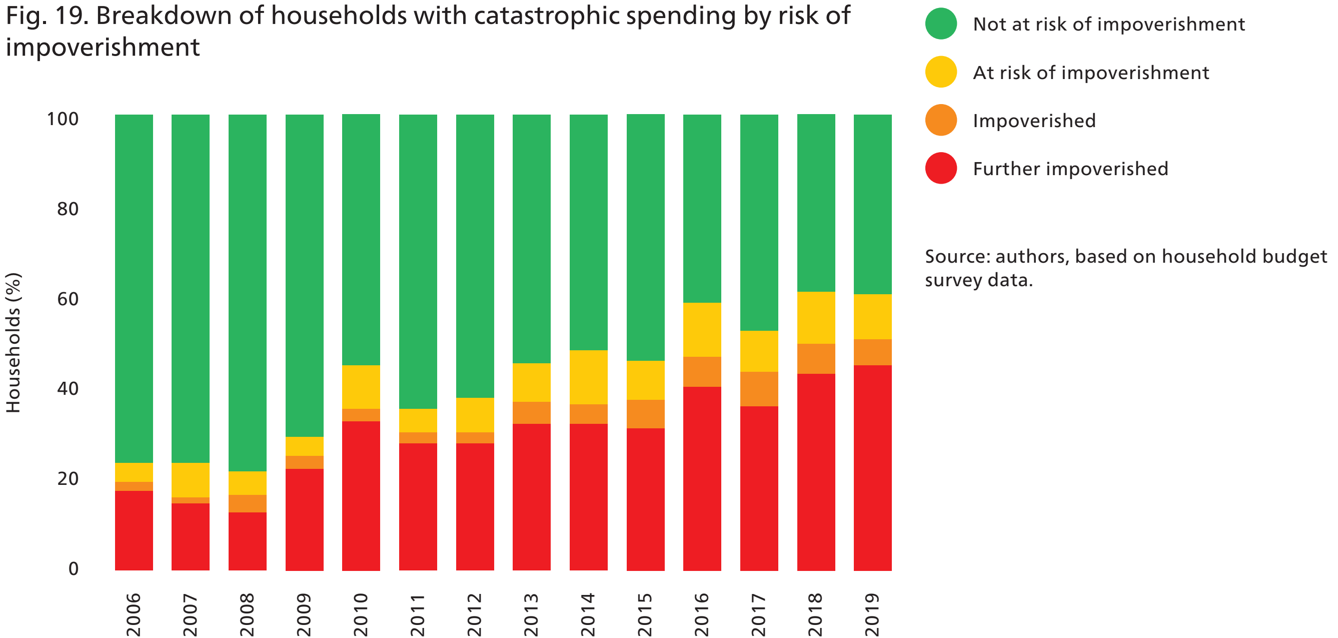
Source: authors, based on household budget survey data.

5.2 Who experiences financial hardship?

Catastrophic health spending was initially concentrated among households who are not at risk of impoverishment, but in 2010 and 2013 the balance shifted as the share of households at risk of impoverishment, impoverished or further impoverished increased and continued to increase for the rest of the study period (Fig. 19).

The incidence of catastrophic health spending varies significantly across consumption quintiles and is concentrated among the poorest quintile, especially after 2009 (Fig. 20). The increase in catastrophic incidence over time was almost entirely driven by a substantial increase among the poorest quintile. The share of households in the poorest quintile among all households with catastrophic spending grew from around 31% in 2006 to 68% in 2019. In contrast, for the richest quintile this share fell from 32% to 10%. There was little change among the middle quintiles. In 2019 more than 5% of households in the poorest quintile experienced catastrophic health spending, compared to under 1% in the richest quintile.

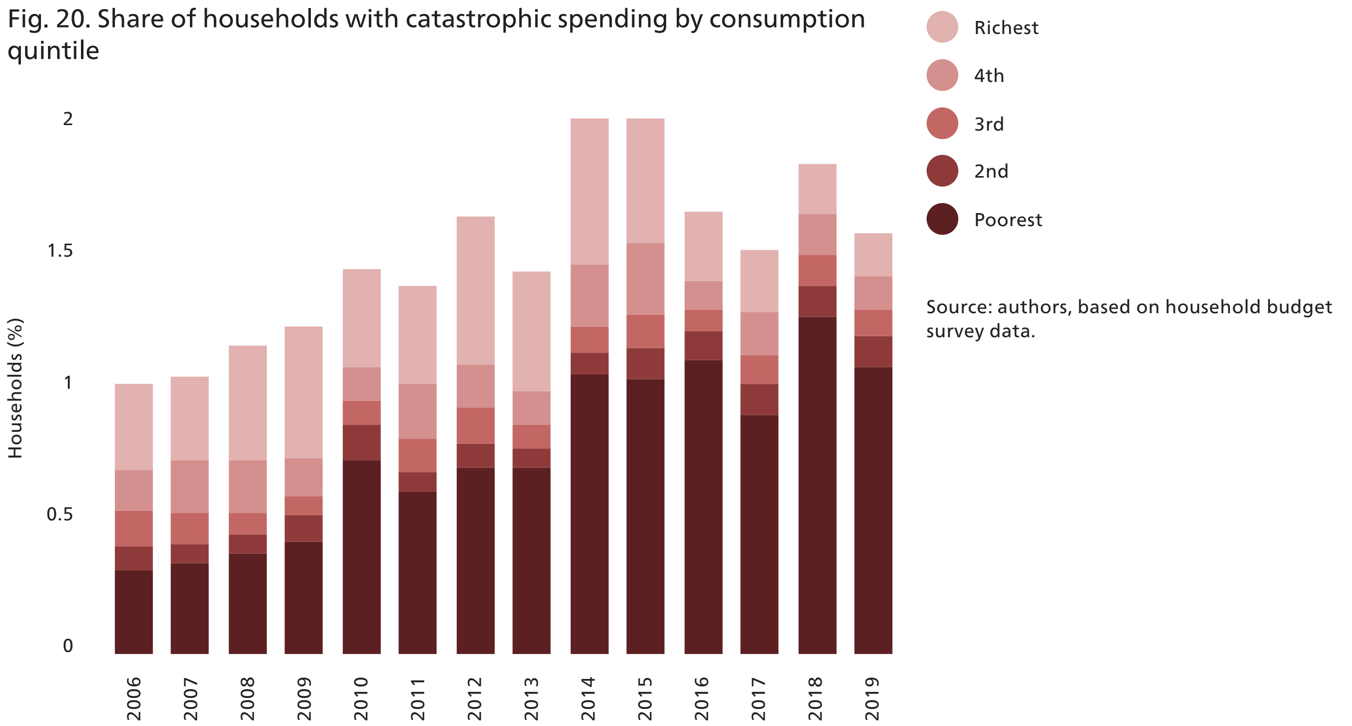
Fig. 19. Breakdown of households with catastrophic spending by risk of impoverishment



Source: authors, based on household budget survey data.

The evolution of catastrophic spending in the poorest quintile is linked more to a reduction in their capacity to pay for health care in the context of the economic crisis than to an increase in their out-of-pocket spending. Between 2007 and 2014, capacity to pay for health care fell by 24% in the poorest quintile, compared to 20% on average.

Fig. 20. Share of households with catastrophic spending by consumption quintile

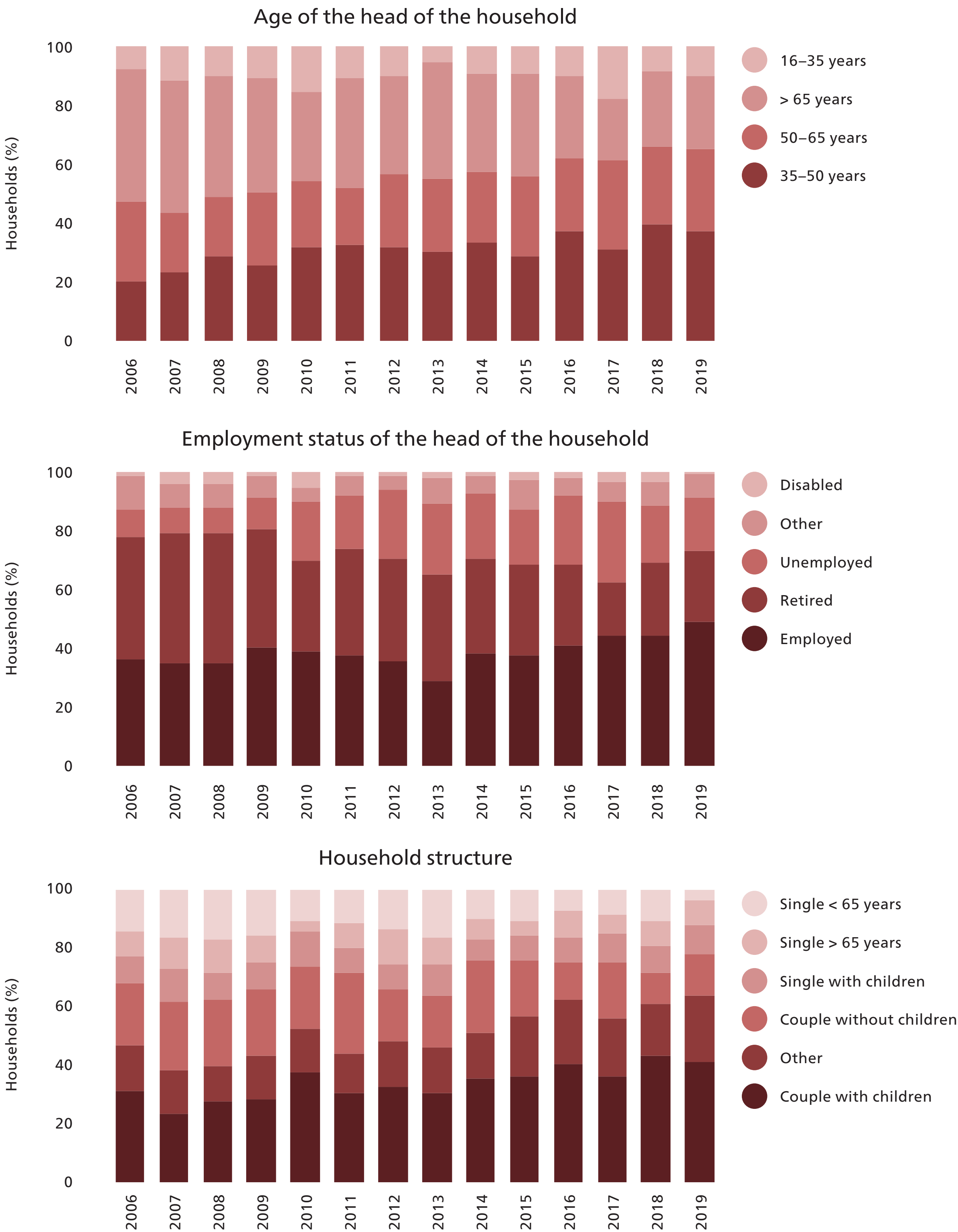


Source: authors, based on household budget survey data.

The characteristics of households with catastrophic spending changed during the study period (Fig. 21). Catastrophic spending was initially concentrated in households headed by older people and retired people but shifted after the economic crisis to households headed by people of working age (between 35 and 50 years old), employed people, unemployed people and couples with children.

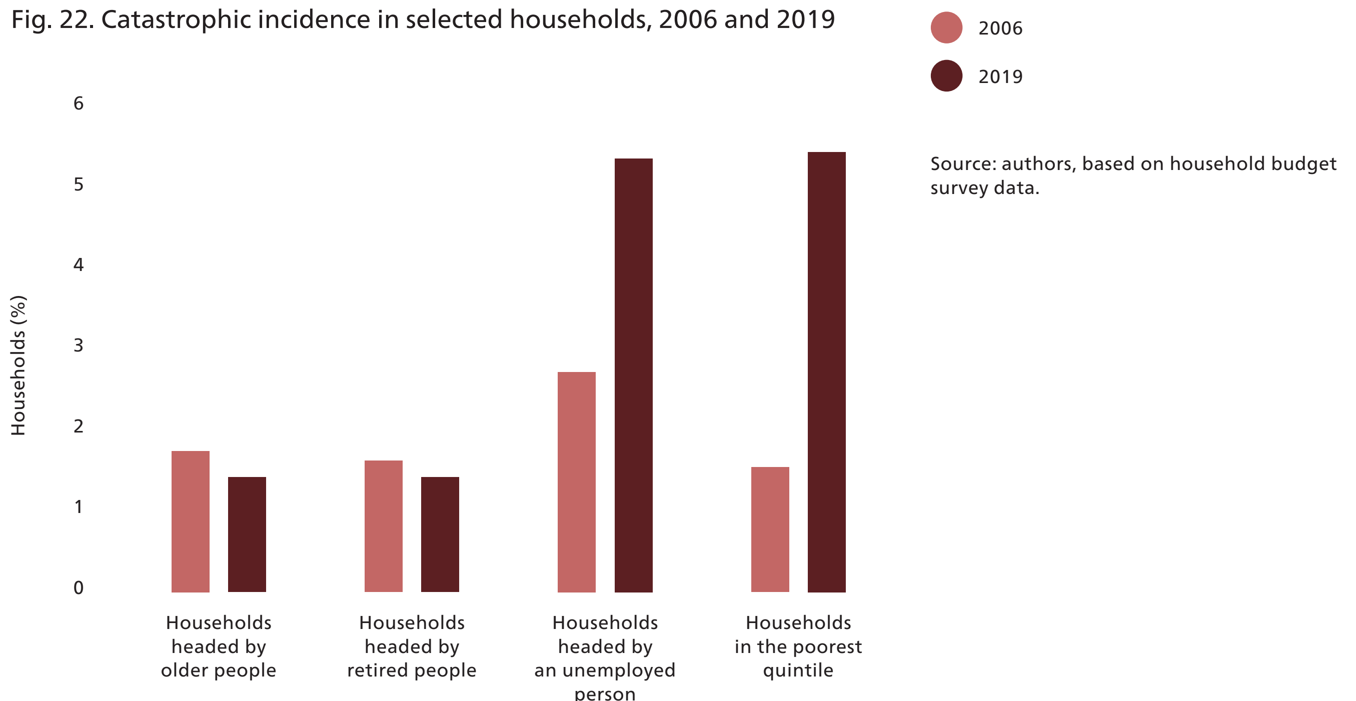
Fig. 21. Breakdown of households with catastrophic spending by age and employment status of the head of the household and by household structure

Source: authors, based on household budget survey data.



Catastrophic incidence fell slightly over time in households headed by older people and retired people (Fig. 22) but became more heavily concentrated among poorer households (data not shown). The opposite trend was observed in households headed by an unemployed person, where catastrophic incidence almost doubled, and in households in the poorest quintile, where catastrophic incidence tripled. In 2019 households headed by an unemployed person in the poorest quintile showed the highest catastrophic incidence of any group of people (10%).

Fig. 22. Catastrophic incidence in selected households, 2006 and 2019

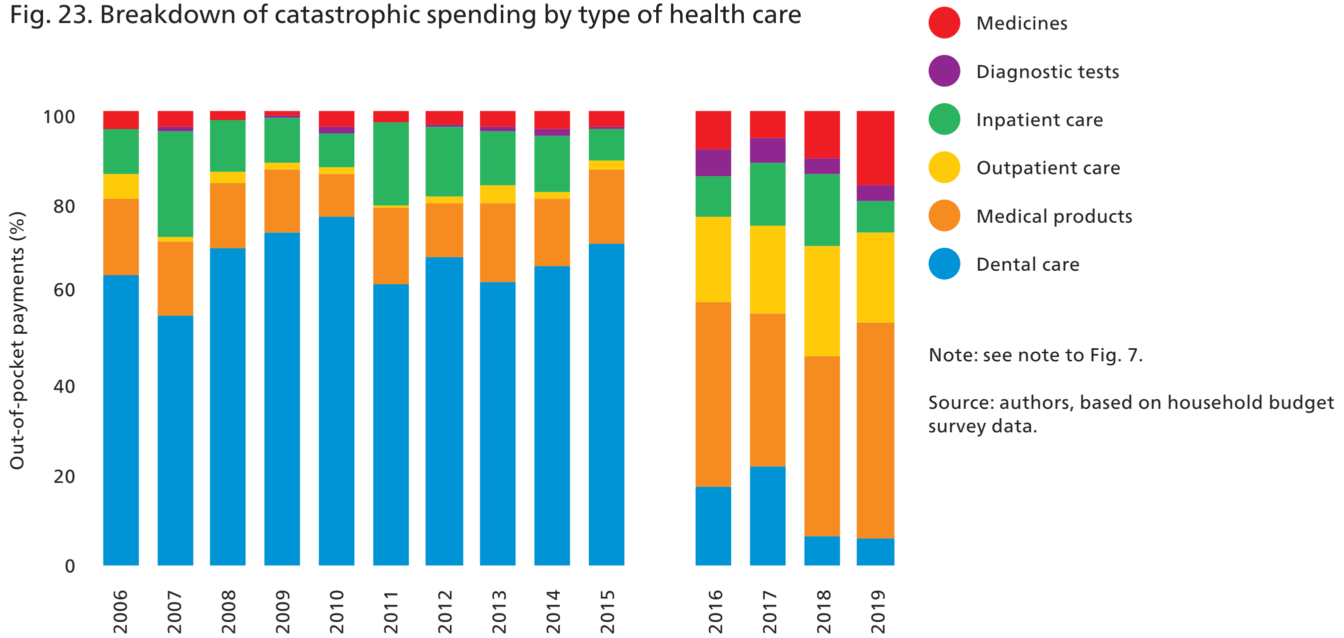


Source: authors, based on household budget survey data.

5.3 Which health services are responsible for financial hardship?

Catastrophic health spending is mainly driven by the three dental care-related categories (dental care, medical products and outpatient care), which together accounted for almost 75% of catastrophic spending in 2019, followed by outpatient medicines (16%) (Fig. 23). Over time, the dental care-related share of catastrophic spending fell as the shares taken up by outpatient medicines and diagnostic tests increased.

Fig. 23. Breakdown of catastrophic spending by type of health care



Note: see note to Fig. 7.

Source: authors, based on household budget survey data.

Dental care-related out-of-pocket payments are the main driver of catastrophic spending in all quintiles (Fig. 24). In the poorest quintile catastrophic spending is also driven by spending on outpatient medicines. The breakdown of catastrophic spending in the other quintiles should be interpreted with caution because of the small numbers involved, leading to considerable fluctuation. The only relatively clear pattern in the other quintiles is the role of inpatient care, which is evident in the two richest quintiles, negligible in the second and third quintiles and largely absent in the poorest quintile.

Fig. 24. Breakdown of catastrophic spending by type of health care and consumption quintile

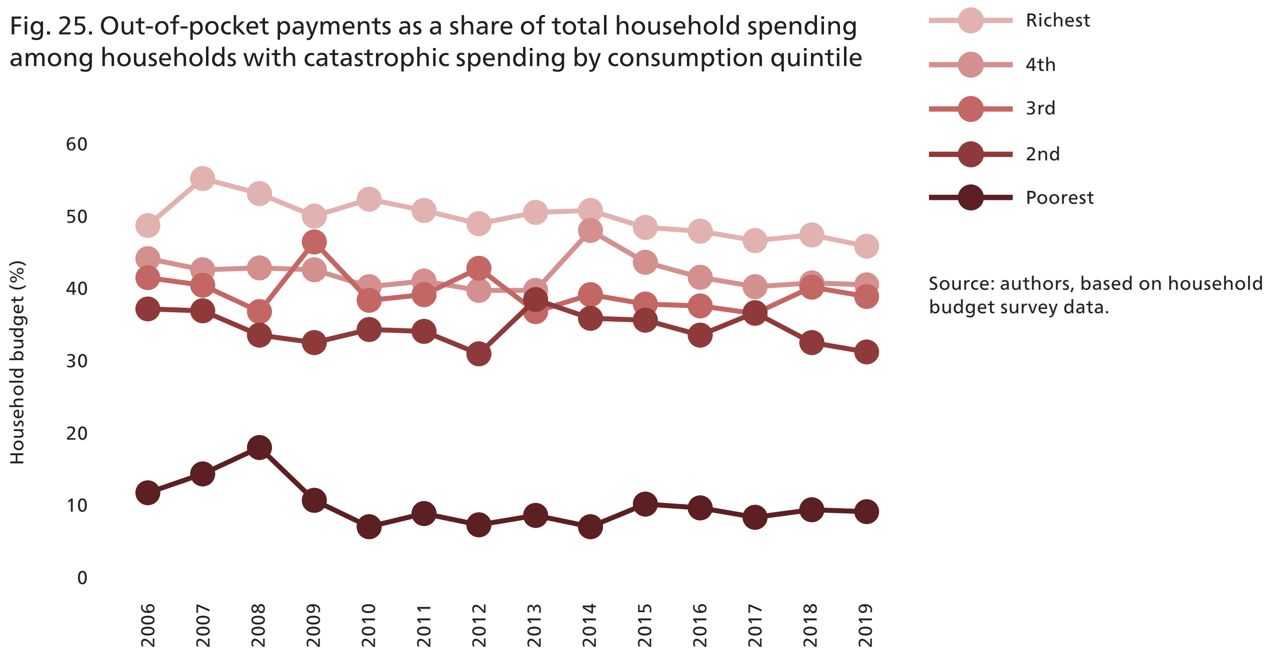
Notes: OOPs: out-of-pocket payments. See note to Fig. 7

Source: authors, based on household budget survey data.

5.4 How much financial hardship?

In households with catastrophic health spending, the average amount spent out of pocket as a share of total household spending rises progressively with income (Fig. 25). Over time there was a substantial reduction in the out-of-pocket payment share of total household spending in the poorest consumption quintile, particularly from 2008 to 2014, reflecting a particularly large reduction in capacity to pay for health care in this quintile during the economic crisis.

Fig. 25. Out-of-pocket payments as a share of total household spending among households with catastrophic spending by consumption quintile

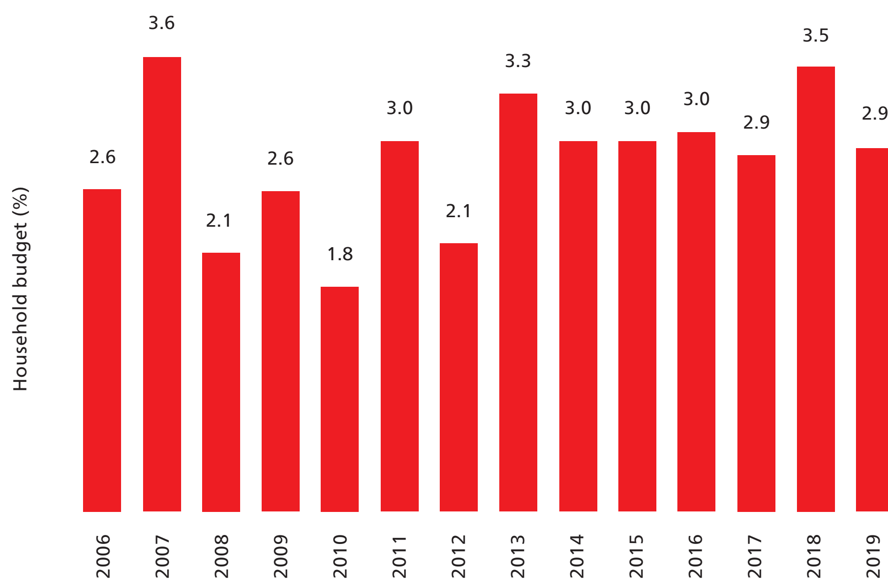


Source: authors, based on household budget survey data.

For further impoverished households the average out-of-pocket payment share of total household spending fluctuated during the study period, ranging from around 2% to over 3% (Fig. 26). It is consistently higher than the average for the poorest quintile, however (see Fig. 6). This highlights that even a seemingly low out-of-pocket payment share can be catastrophic for poor households. The out-of-pocket payment share was generally lower during the hardest years of the economic crisis, reflecting increased pressure on poor households' capacity to pay for health care.

Fig. 26. Out-of-pocket payments as a share of total household spending among further impoverished households

Source: authors, based on household budget survey data.



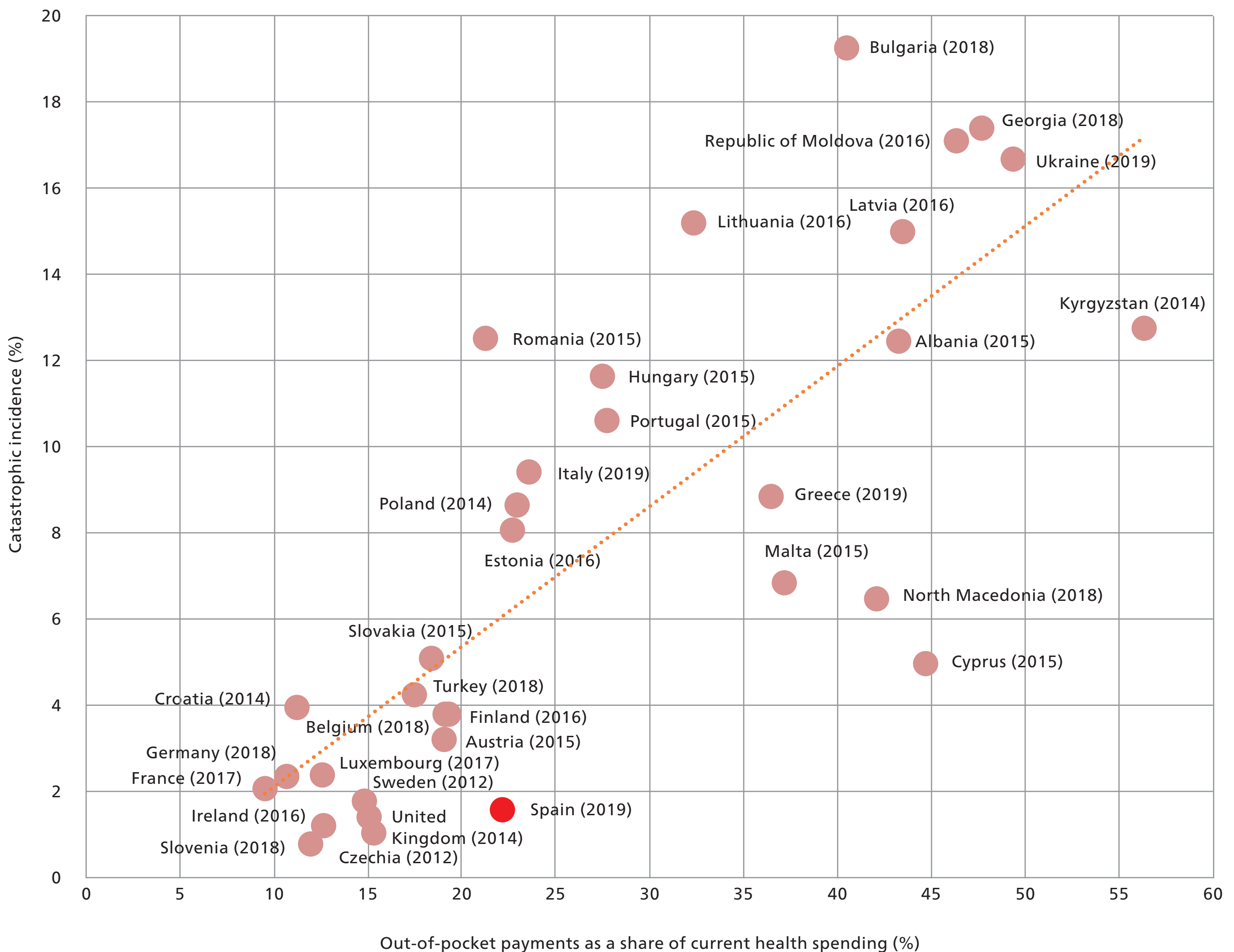
5.5 International comparison

The incidence of catastrophic out-of-pocket payments in Spain is low compared to other European countries. It is on a par with Sweden and the United Kingdom, even though the out-of-pocket payment share of current spending on health is substantially higher in Spain than in those countries (Fig. 27).

Fig. 27. Incidence of catastrophic spending on health and out-of-pocket share of current spending on health in selected European countries, latest year available

Notes: data on out-of-pocket payments are for the same year as those for catastrophic spending, except for Greece, Italy, Spain and Ukraine, which show out-of-pocket payment data for 2018. Spain is highlighted in red.

Sources: WHO Regional Office for Europe (2019) and updated unpublished analysis.



5.6 Summary

The incidence of catastrophic out-of-pocket payments in Spain is low compared to other European countries. It is on a par with Sweden and the United Kingdom, even though the out-of-pocket payment share of current spending on health is substantially higher in Spain than in those countries.

In 2019 0.8% of households were impoverished or further impoverished after out-of-pocket payments, up from 0.2% in 2006. In the same year 1.6% of households experienced catastrophic health spending, up from 1.0% in 2006.

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.

Catastrophic spending is concentrated in the poorest quintile. In 2019 more than 5% of households in the poorest quintile experienced catastrophic health spending, compared to under 1% in the richest quintile. The increase in catastrophic incidence over time was almost entirely driven by a substantial increase in the poorest quintile.

The characteristics of households with catastrophic spending changed during the study period. Catastrophic spending initially was concentrated in households headed by older people and retired people but shifted after the economic crisis to households headed by people of working age (between 35 and 50 years old), employed people, unemployed people and couples with children. In 2019 households in the poorest quintile headed by an unemployed person had the highest catastrophic incidence of any group of people (10%).

Catastrophic health spending is mainly driven by the dental care-related categories (dental care, medical products and outpatient care), which together accounted for almost 75% of catastrophic spending in 2019, followed by outpatient medicines (16%). Over time, the dental care-related share of catastrophic spending fell as the shares taken up by outpatient medicines and diagnostic tests increased.

Dental care-related out-of-pocket payments are the main driver of catastrophic spending in all quintiles. In the poorest quintile catastrophic spending is also driven by spending on outpatient medicines. The breakdown of catastrophic spending in the other quintiles should be interpreted with caution because of the small numbers involved, leading to considerable fluctuation. The only relatively clear pattern in the other quintiles is the role of inpatient care, which is evident in the two richest quintiles, negligible in the second and third quintiles and largely absent in the poorest quintile.

In households with catastrophic health spending, the average amount spent out of pocket as a share of total household spending rises progressively with income. For further impoverished households, the average out-of-pocket payment share of total household spending (1.6% in 2019) is consistently higher than the average for the poorest quintile. This indicates that even a seemingly low out-of-pocket payment share can be catastrophic for poor households.

6. Factors that strengthen and undermine financial protection

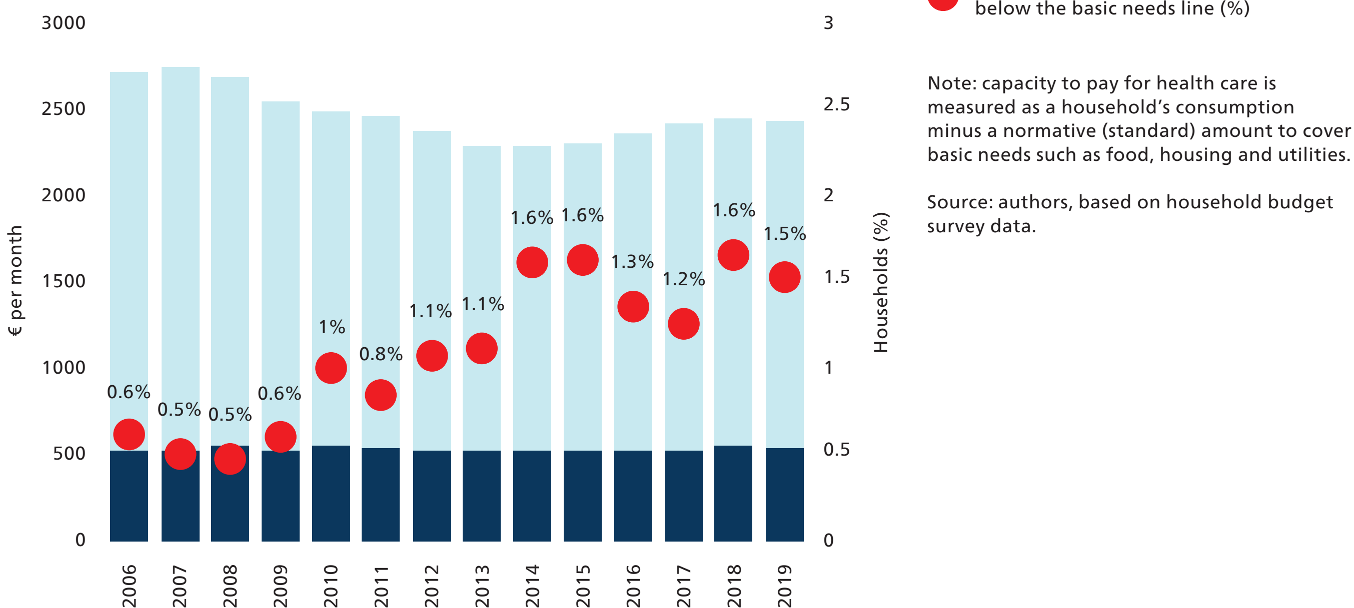
This section considers the factors which may be responsible for financial hardship caused by out-of-pocket payments in Spain and which may explain the trend over time. It begins by looking at factors outside the health system affecting people's capacity to pay for health care – for example, changes in incomes and the cost of living – and then looks at factors in the health system.

6.1 Factors affecting people's capacity to pay for health care

The economic crisis in Spain had a significant impact on people's capacity to pay for health services as GDP dropped, unemployment soared and income inequality grew. GDP fell from the third quarter of 2008 to the end of 2009 and again from the beginning of 2011 to 2013, shrinking overall by almost 9% in cumulative terms; it would not reach its 2008 level until 2016 (Eurostat, 2021). Between 2008 and 2013 over 3.6 million jobs were lost. Unemployment rose from 8% in 2007 to 26% of the active population in 2013 before slowly falling to 14% in 2019 – still far above pre-crisis levels (Eurostat, 2021). The main indicator of income inequality, the Gini index, increased from 32.4 in 2008 (an already very high figure) to 34.2 in 2012 and remained persistently high in the following years, only falling to 33.0 in 2019 (World Bank, 2021).

Household budget survey data show how the share of households living below the basic needs line rose from 0.5% in 2008 to 1.6% in 2014 (Fig. 28). While the cost of meeting basic needs (food, housing, utilities) did not really change during the study period, households' capacity to pay for health care decreased steadily during the economic crisis, reaching a low in 2013.

Fig. 28. Changes in the cost of meeting basic needs, capacity to pay for health care and the share of households living below the basic needs line, in real terms



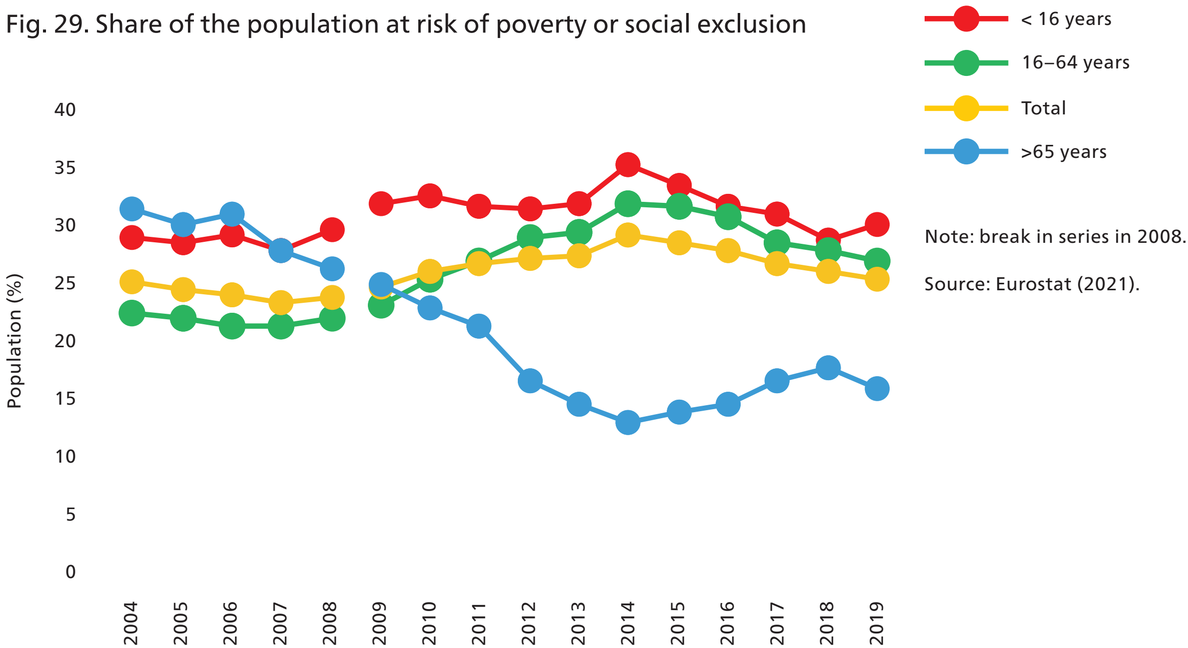
Note: capacity to pay for health care is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities.

Source: authors, based on household budget survey data.

Fig. 29 shows how the economic crisis affected the share of the population at risk of poverty or social exclusion. This share, which was already very high before the crisis, rose even further from 2008 to 2014. The rise was particularly sharp among children and working-age people, reflecting widespread unemployment. In contrast, the relative position of older people improved dramatically because they were less likely to be affected by unemployment and state pensions were spared the cuts that affected almost all other aspects of social spending during the crisis.

The fall in household capacity to pay for health care and the change in the distribution of people at risk of poverty or social exclusion are likely to have played a major role in the increase in catastrophic health spending during the economic crisis (see Fig. 18). They also explain in large part the shift in catastrophic incidence away from older or retired households to working-age households and households headed by unemployed people (see Fig. 21).

Fig. 29. Share of the population at risk of poverty or social exclusion



Note: break in series in 2008.

Source: Eurostat (2021).

6.2 Health system factors

In 2018 – the latest year for which internationally comparable health spending data are available – public spending on health as a share of GDP was roughly in line with GDP per person in Spain (Fig. 30). It is low in comparison to other countries in western Europe. One reason for this is that the share of the government budget allocated to health in Spain (15% in 2018), while close to the EU15 average (15%), is much lower than in countries like Germany, Sweden and the United Kingdom (over 19%) (Fig. 31).

Fig. 30. Public spending on health and GDP per person, EU28, 2018

EU28: EU Member States prior to 31 January 2020.

Note: the figure excludes Ireland and Luxembourg.

Source: WHO (2021).

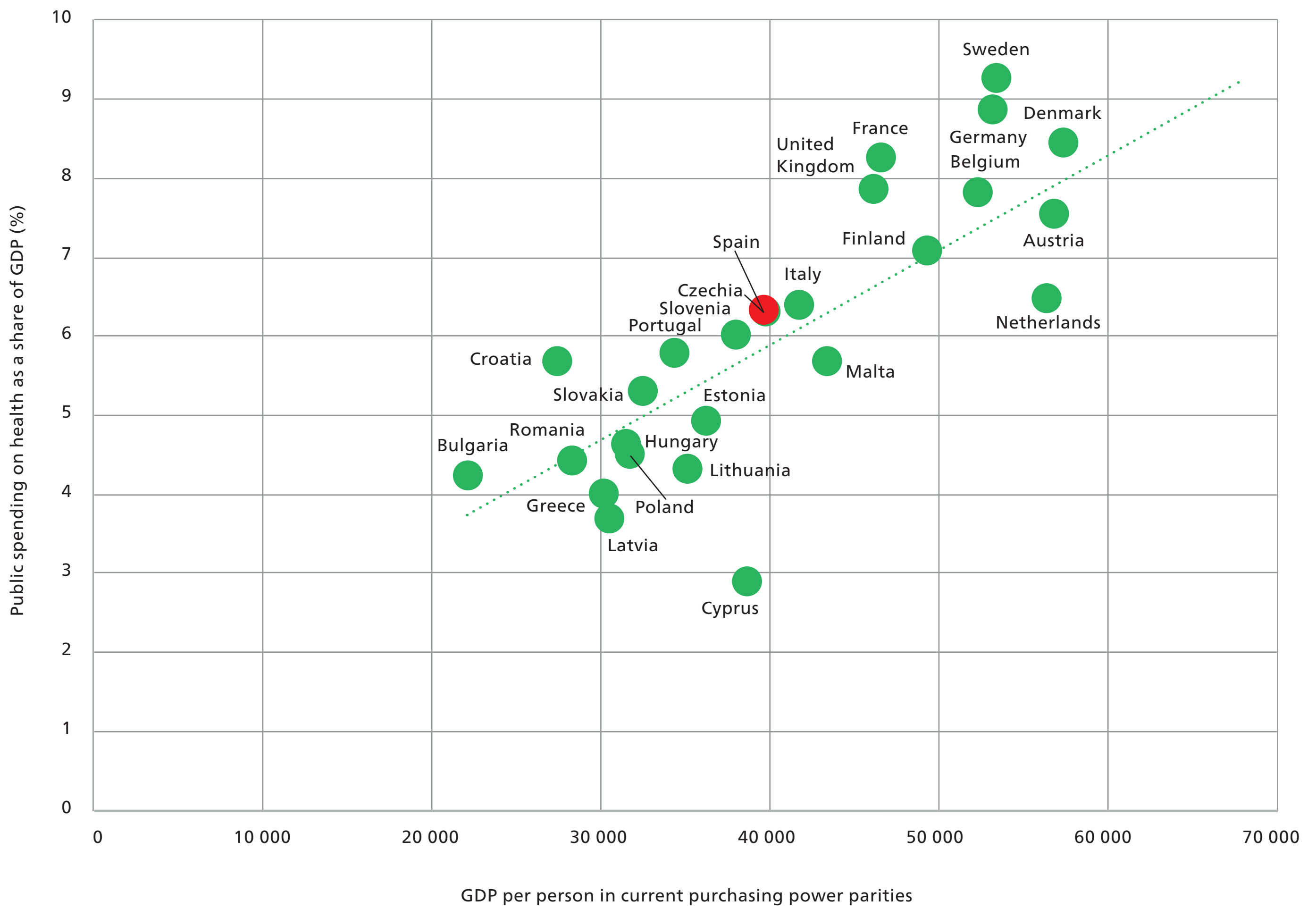
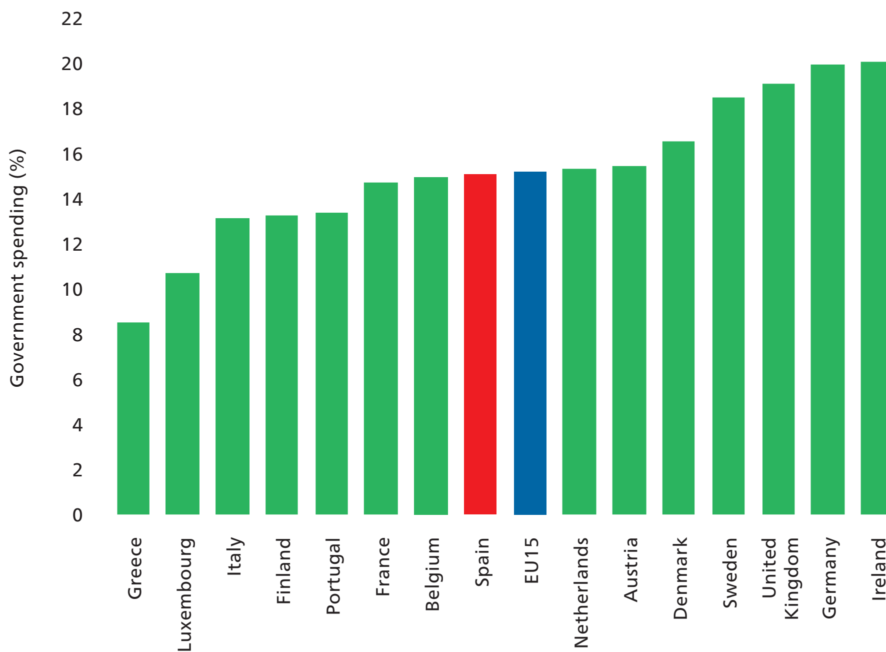


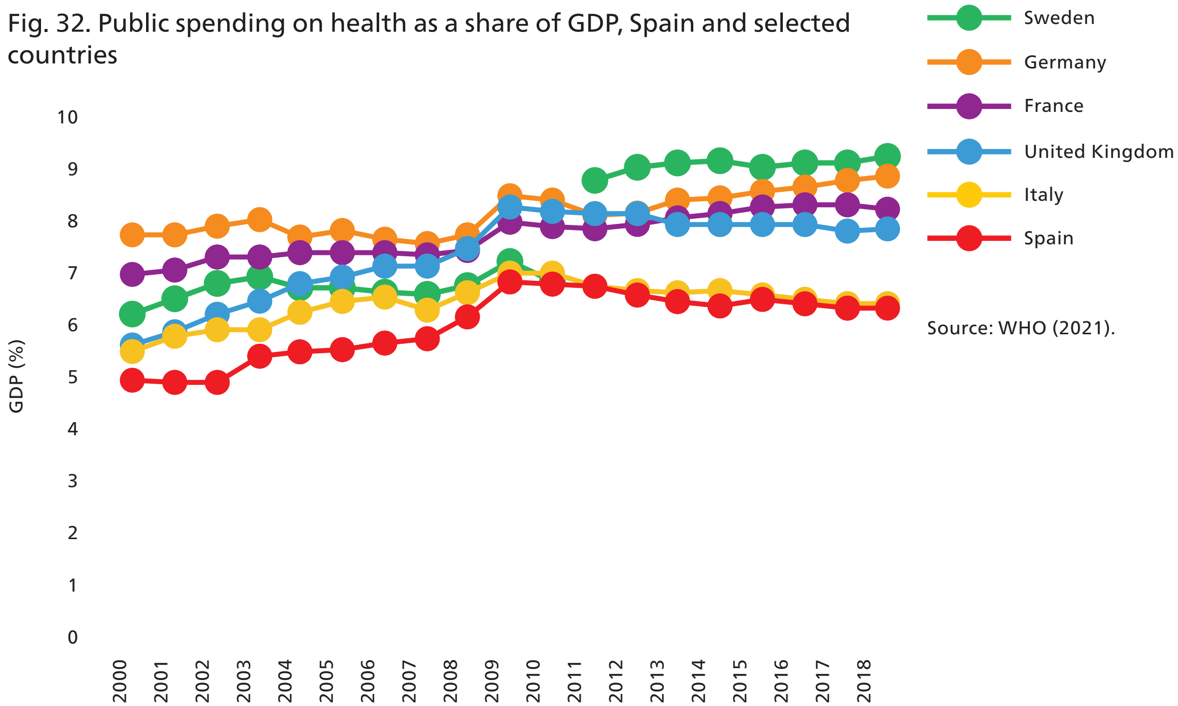
Fig. 31. Share of government spending allocated to health, EU15, 2018

Source: WHO (2021).



Before the crisis, public spending on health in Spain had been growing steadily as a share of GDP, rising from 5% in 2000 to close to 7% in 2009, which significantly narrowed the gap with other countries (Fig. 32). The increase in 2009 and 2010 reflected the crisis-related fall in GDP. Once the health budget was cut in 2011 and 2012, public spending began to decline as a share of GDP, falling to just over 6% in 2018 and once again widening the gap with other countries.

Fig. 32. Public spending on health as a share of GDP, Spain and selected countries

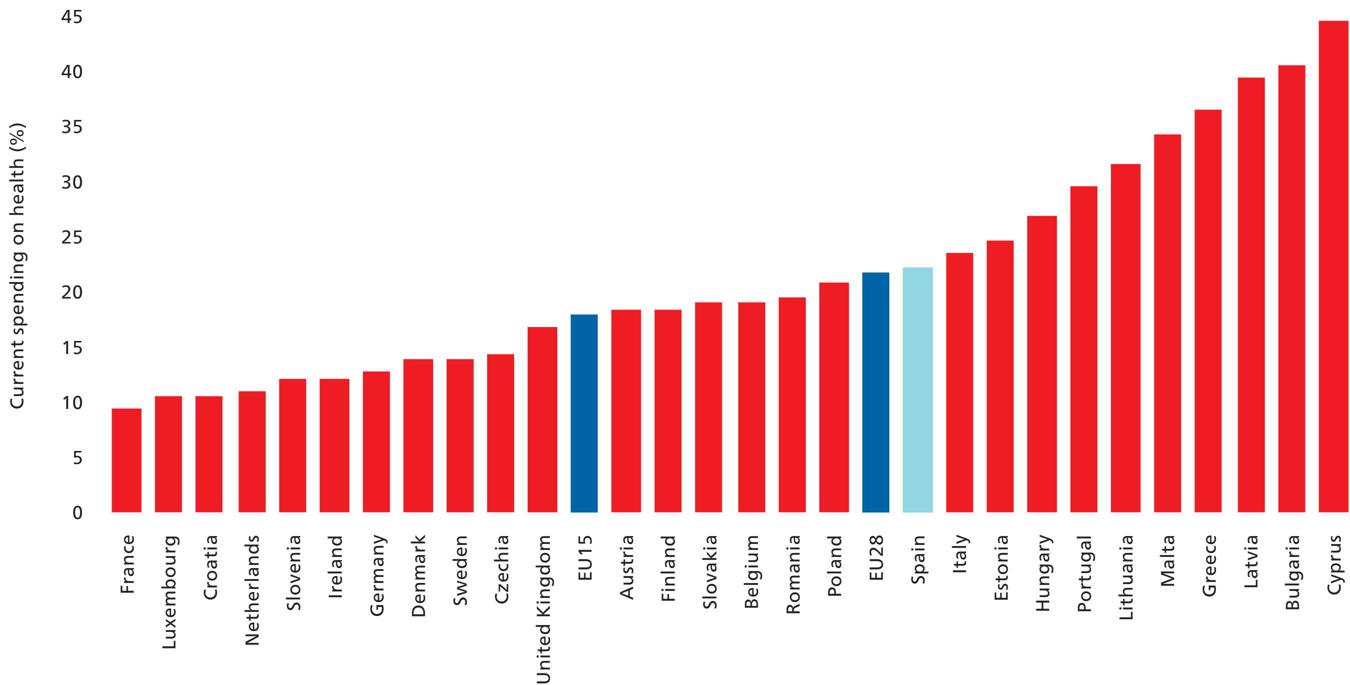


Source: WHO (2021).

As shown in section 4.4, cuts to public spending on health during the crisis, combined with steady growth in out-of-pocket spending, pushed up the out-of-pocket payment share of current spending on health from 19% in 2009 to 23% in 2014 (see Fig. 15). At 22% in 2018, the out-of-pocket payment share was, with Italy, the highest in western Europe and higher than in several countries in eastern Europe (Fig. 33).

Fig. 33. Out-of-pocket payments as a share of current spending on health, EU, 2018

Source: WHO (2021).



The incidence of catastrophic health spending in Spain nevertheless is much lower than would be expected given Spain's relatively heavy reliance on out-of-pocket payments (see Fig. 27) – a finding that can be explained by the many protective features of coverage policy and the redistributive effect of public spending on health.

Coverage policy in Spain is relatively simple in comparison to many other countries in Europe. In addition to this clear advantage, there are strengths in all three dimensions of coverage.

First, the basis for **population entitlement** to the NHS is residence and undocumented migrants are entitled to the same degree of coverage as residents. As a result, the NHS covers virtually the whole population. In 2012 the basis for entitlement was restricted to "being insured" based on social security status, which limited access for undocumented migrants, but this change was reversed in 2018.

Second, the NHS **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.

Third, there are no **co-payments** for NHS health and dental visits (although dental care benefits are very limited), diagnostic tests or inpatient care. Where co-payments apply – for outpatient prescribed medicines and ortho-prosthetic devices – they are accompanied by protection mechanisms:

- exemptions from co-payments for people in vulnerable situations, which have been expanded since 2020;

- reduced rates (a percentage co-payment of 10%) and a cap on co-payments per prescription for most outpatient prescribed medicines for chronic conditions, which means that these medicines do not cost more than €4.24 each; in 2018 nearly half of all medicines that can be dispensed in pharmacies fell into this category;

- percentage co-payments are linked to household income but the protective effect is limited because low-income people of working age still have to pay 40% of the price; the percentage co-payment falls from 60% for people with an annual income over €100 000 to 50% (€18 000–100 000) or 40% (less than €18 000), and to 10% for pensioners earning less than €100 000; and

- an income-related monthly cap on co-payments for outpatient prescribed medicines for most pensioners (those not covered by the mutual funds).

As a result, a significant share of out-of-pocket payments is for co-payments that are linked to income in different ways.

In addition, public spending on health and education was found to increase household income by 15% (Goerlich-Gisbert, 2016) and reduce income inequality by 24% before the 2008 financial and economic crisis and by 19% between 2012 and 2015, with a greater effect in poorer households (Calonge-Ramírez & Manresa-Sánchez, 2019). Between 2013 and 2018 this in-kind redistribution reduced the Gini coefficient by 8.5% and pensions reduced it by a further 29% (López-Laborda et al., 2020).

Despite these strengths, gaps in coverage persist. These gaps are reflected clearly in the study's findings on financial protection (summarized in Section 5).

Financial hardship is largely driven by out-of-pocket payments for **dental care.** In 2015, before a change in the household budget survey, dental care accounted for half of catastrophic spending in the poorest quintile and over two thirds in the other quintiles. From 2016, after the change, some dental care is categorized under medical products (dental materials) and outpatient care (some dental procedures). Together, these three categories accounted for almost 75% of catastrophic health spending on average in 2018, followed by outpatient medicines (16%) (see Fig. 23).

Catastrophic spending on dental care reflects the virtual exclusion of dental care from the NHS benefits package, especially for adults. Limited coverage of dental care not only leads to financial hardship for households in all quintiles, but also explains the relatively high levels of unmet need for dental care in Spain – above the EU average – and stark socioeconomic inequality in unmet need for dental care (see Fig. 1–3). If people did not face financial barriers to accessing dental care, catastrophic incidence probably would be higher.

In 2021 the Government allocated an additional €49 million to the Autonomous Communities to spend on expanding dental care coverage. This is a step in the right direction but will not be enough to address a major gap in coverage.

Some of the catastrophic spending on **medical products** reflects out-of-pocket payments for optical care for eyesight problems (such as glasses and contact lenses, which accounted for 18% of out-of-pocket spending in 2019) and hearing aids, which are not covered for adults over 26 years old. The remainder is likely to be due to out-of-pocket payments for ortho-prosthetic devices (such as supportive braces and splints, prostheses, wheelchairs and crutches). As with dental care, spending on medical products leads to financial hardship for households in all quintiles. There are no official statistics on unmet need for optical care due to cost.

The **outpatient medicines** share of out-of-pocket spending rose after the increase in co-payments in 2012. There was also an increase in the role of outpatient medicines in driving catastrophic spending affecting mainly the poorest quintile (see Fig. 24), where catastrophic spending is concentrated (see Fig. 20).

Socioeconomic inequalities in unmet need for prescribed medicines are also notable (see Fig. 3). For example, the Health Barometer carried out by the Spanish Centre for Sociological Research (2019) found that 2.3% of the population reported having stopped taking some prescribed medicines due to cost in 2019, down from 4% in 2015 (Ministry of Health, 2016). There is also evidence showing that the increase in co-payments in 2012 decreased adherence to effective medicines – especially high-priced medicines – among pensioners and people with high co-payments; low-income pensioners were particularly likely to be affected (Puig-Junoy et al., 2014; Puig-Junoy et al., 2016; González et al., 2017; Aznar-Lou et al., 2018; Hernández-Izquierdo et al., 2019; Serra-Buriel et al., 2021).

These findings suggest that although the design of co-payments for outpatient prescribed medicines and ortho-prosthetic devices includes some protective features, it is not sufficiently protective to prevent financial hardship among poor households of any age. The level of percentage co-payments for ortho-prosthetic devices and outpatient prescribed medicines for non-chronic conditions is very high for children and working-age people (40–60%) and there is no monthly cap on co-payments for these groups of people. Notably, there are no exemptions for most children (only for those with a severe disability), which is unusual by European standards (WHO Regional Office for Europe, 2019).

New exemptions from co-payments for outpatient prescribed medicines introduced in 2020 and 2021 aim to reduce unmet need and financial hardship among around six million poorer people – recipients of the new guaranteed minimum income scheme, households receiving child benefits, low-income pensioners and moderately and severely disabled children. Further steps are likely to be needed, however, to ensure that children and people of working age benefit from at least the same degree of protection from co-payments as most pensioners.

The role of **inpatient care** in driving financial hardship has varied over time but is mainly a source of financial hardship for households in the richer quintiles, which may reflect a preference to use private facilities for some specific services.

Diagnostic tests have become a more important driver of financial hardship since 2016, particularly among households in the poorest quintile (see Fig. 23 and 24).

Out-of-pocket payments for inpatient care, diagnostic tests and outpatient care may reflect long **waiting times** for NHS benefits such as specialist consultations and some surgeries. **Waiting lists** are a longstanding issue and an important access barrier despite the introduction of a range of policies aimed at reducing waiting times. They may result in unmet need or financial hardship for people who are not covered by VHI, exacerbating inequalities in access to health care. Civil servants covered by mutual funds also benefit from shorter waiting times, another source of unequal access in the health system (Palm et al., 2021).

Finally, **administrative barriers** – for example, the requirement for non-EU migrants who have been in Spain for less than 90 days to obtain a report of need from social services to access health care – may lead to unmet need and financial hardship for undocumented migrants and asylum seekers who are not granted asylum.

The study's findings indicate that while the Spanish health system provides relatively strong financial protection, more needs to be done to strengthen financial protection for poorer households in all age groups and to reduce financial barriers to dental care, optical care and outpatient prescribed medicines. Achieving this is likely to require additional public investment in the health system, which should be carefully targeted to improve access and financial protection for low-income households.

6.3 Summary

The economic crisis in Spain had a significant impact on people's capacity to pay for health services. As GDP dropped, unemployment soared and income inequality increased, and the share of the population at risk of poverty or social exclusion grew among children and working-age people and fell among older people.

A sharp decline in household capacity to pay for health care and the change in the distribution of people at risk of poverty or social exclusion are likely to have played a major role in the increase in catastrophic health spending during the study period. They also explain a large part of the shift in catastrophic incidence away from older or retired households to working-age households and households headed by unemployed people.

Before the crisis public spending on health in Spain had been growing steadily as a share of GDP, significantly narrowing the gap with other countries in western Europe. Following cuts to public spending on health during the crisis, public spending began to decline as a share of GDP, widening the gap.

Cuts and steady growth in out-of-pocket spending pushed up the out-of-pocket payment share of current spending on health and increased the incidence of catastrophic health spending and unmet need for health care and (especially) dental care.

Nevertheless, the incidence of catastrophic spending in Spain is much lower than would be expected given Spain's relatively heavy reliance on out-of-pocket 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.

Coverage policy in Spain is relatively simple in comparison to many other countries in Europe. In addition to this clear advantage, there are strengths in all three dimensions of coverage. The basis for population entitlement to the NHS is residence and undocumented migrants are entitled to the same degree of coverage as residents. The NHS 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. There are no co-payments for NHS 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.

Despite these strengths there are gaps in coverage, and these gaps are reflected clearly in the study's findings on financial protection.

Financial hardship is largely driven by out-of-pocket payments for **dental care** and **medical products**, reflecting the virtual exclusion of dental care and optical care for eyesight problems from the NHS benefits package, especially for adults. Limited coverage of these explains the relatively high levels of unmet need for dental care in Spain (there are no data on unmet need for eye care).

The **outpatient medicines** share of out-of-pocket spending rose after the increase in co-payments in 2012 and the role of outpatient medicines in driving catastrophic spending has also increased over time. It is an important driver of financial hardship in the poorest quintile, where catastrophic spending is concentrated. This suggests that the design of co-payments for outpatient prescribed medicines and ortho-prosthetic devices is not sufficiently protective for poor households of any age. There are no exemptions for most children, which is unusual by European standards, and there is no cap on co-payments for children or working-age people.

Out-of-pocket payments for inpatient care, diagnostic tests and outpatient care are likely to be due in part to long waiting times for NHS benefits such as specialist consultations and some surgeries. Waiting times may result in unmet need or financial hardship for people who are not covered by VHI, exacerbating inequalities in access to health care. Civil servants and others covered by the mutual funds (MUFACE, MUGEJU and ISFAS) also benefit from shorter waiting times, another source of unequal access in the health system.

Finally, administrative barriers may lead to unmet need and financial hardship for undocumented migrants and asylum seekers who are not granted asylum.

7. Implications for policy

Financial protection is relatively strong in Spain compared to many other countries in Europe due to strengths in the design of NHS coverage and the highly redistributive effect of public spending on health. The incidence of catastrophic health spending is lower than would be expected given Spain's relatively heavy reliance on out-of-pocket payments, reflecting: universal entitlement to the NHS, including for undocumented migrants; the broad scope of NHS health services, with little regional variation and a large national network of health centres; and limited use of co-payments, which apply to outpatient prescribed medicines and ortho-prosthetic devices only.

Despite these strengths there are gaps in coverage. These gaps are reflected clearly in the study's findings on financial protection.

- Catastrophic health spending is concentrated in the poorest households. In 2019 more than 5% of households in the poorest quintile experienced catastrophic health spending, compared to under 1% in the richest quintile.
- Financial hardship is driven in all quintiles by out-of-pocket spending on dental care and medical products, mainly because dental care and optical care for eyesight problems are largely excluded from NHS coverage, especially for adults; in the poorest quintile it is also driven by spending on outpatient medicines, which are subject to co-payments.
- Unmet need (a measure of access) is below the EU average for health care and prescribed medicines but above the EU average for dental care. There is substantial socioeconomic inequality in unmet need for dental care and, to a lesser extent, health care and prescribed medicines.

The economic crisis in Spain was associated with an increase in catastrophic health spending and unmet need, especially unmet need for dental care. The increase in catastrophic spending was almost entirely driven by a substantial increase in the poorest quintile, reflecting a sharp decline in household capacity to pay for health care as GDP fell and unemployment rose. During the crisis there was also a shift in catastrophic incidence away from older or retired households to working-age households and households headed by unemployed people. Although catastrophic incidence fell after the crisis, in 2019 it was still above pre-crisis levels.

To reduce unmet need and financial hardship, policy should focus on strengthening protection for poorer households in all age groups, expanding NHS coverage of dental care and optical care and improving the design of co-payments for outpatient prescribed medicines and ortho-prosthetic devices.

Out-of-pocket spending on outpatient medicines is an important driver of financial hardship among poor households – even more so since the coverage restrictions introduced in 2012. Reforms introduced since then have reinstated entitlements for undocumented migrants (2018) and extended exemption from co-payments to some groups of people in vulnerable situations (2020 and 2021).

Reducing financial hardship for the poorest quintiles will require further changes to the design of co-payments, including the extension of the income-related cap on co-payments for most pensioners to all non-pensioner households.

Other steps to reduce socioeconomic inequality in unmet need and financial hardship include policies to limit waiting times for specialist care and address administrative barriers. Out-of-pocket spending on diagnostic tests has become a larger driver of financial hardship in all quintiles over time, perhaps due to a rise in waiting times for medical examinations and specialist care. Growing uptake of VHI is also likely to be related to longer waits. Waiting times could be addressed through policies to reinforce the effectiveness of primary care by ensuring it is resourced and staffed adequately. It is also worth reviewing the efficiency and equity of tax subsidies for VHI, which mainly benefit richer households, and of allowing people covered by the mutual funds to opt for private provision. Both policies exacerbate inequalities in access to health care. Addressing the administrative barriers undocumented migrants and others face in obtaining access to NHS services to which they are entitled should be a priority.

Strengthening access and financial protection is likely to require more adequate public financing. Notably, the Spanish parliament's Commission for Social and Economic Reconstruction recommended an increase in public spending on health so that it reaches the EU average as a share of GDP by the end of the current term (Congress of Deputies, 2020). **To ensure that additional public spending meets equity and efficiency goals, it should be targeted carefully to reduce unmet need and financial hardship for low-income households.**

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Annex 1. Household budget surveys in Europe

What is a household budget survey? Household budget surveys are national sample surveys that aim to measure household consumption of goods and services over a given period of time. In addition to information about consumption expenditure, they include information about household characteristics.

Why are they carried out? Household budget surveys provide valuable information on how societies and people use goods and services to meet their needs and preferences. In many countries, the main purpose of a household budget survey is to calculate weights for the Consumer Price Index, which measures the rate of price inflation as experienced and perceived by households (Eurostat, 2015). Household budget surveys are also used by governments, research entities and private firms wanting to understand household living conditions and consumption patterns.

Who is responsible for them? Responsibility for household budget surveys usually lies with national statistical offices.

Are they carried out in all countries? Almost every country in Europe conducts a household budget survey (Yerramilli et al., 2018).

How often are they performed? EU countries conduct a household budget survey at least once every five years, on a voluntary basis, following an informal agreement reached in 1989 (Eurostat, 2015). Many countries in Europe conduct them at more frequent intervals (Yerramilli et al., 2018).

What health-related information do they contain? Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP) (United Nations Statistics Division, 2018). A new European version of COICOP known as ECOICOP, intended to encourage further harmonization across countries, was introduced in 2016 (Eurostat, 2016).

Information on health-related consumption comes under COICOP code 6, which is further divided into three groups, as shown in Table A1.1. In this study, health-related information from household budget surveys is divided into six groups (with corresponding COICOP codes): medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3).

In a very small minority of countries in Europe (Belgium, France, Luxembourg and Switzerland), people entitled to publicly financed health care may pay for treatment themselves, then claim or receive reimbursement from their publicly financed health insurance fund (OECD, 2019). In a wider range of countries, people may also be reimbursed by entities offering voluntary health insurance – for example, private insurance companies or occupational health schemes.

To avoid households reporting payments that are subsequently reimbursed, many household budget surveys in Europe specify that household spending on health should be net of any reimbursement from a third party such as the government, a health insurance fund or a private insurance company (Heijink et al., 2011).

Some surveys ask households about spending on voluntary health insurance. This is reported under a different COICOP code (12.5.3 Insurance connected with health, which covers "Service charges for private sickness and accident insurance") (United Nations Statistics Division, 2018).

Are household budget surveys comparable across countries?
Classification tools such as COICOP (and ECOICOP in Europe) support standardization, but they do not address variation in the instruments used to capture data (e.g. diaries, questionnaires, interviews, registers), response rates and unobservable differences such as whether the survey sample is truly nationally representative. Cross-national variation in survey instruments can affect levels of spending and the distribution of spending across households. It is important to note, however, that its effect on spending on health in relation to total consumption – which is what financial protection indicators measure – may not be so great.

An important methodological difference in quantitative terms is **owner-occupier imputed rent**. Not all countries impute rent and, among those that do, the methods used to impute rent vary substantially (Eurostat, 2015). In this series, imputed rent is excluded when measuring total household consumption.

Table A1.1. Health-related consumption expenditure in household budget surveys

Source: United Nations Statistics Division (2018).

COICOP codes	Includes	Excludes
06.1 Medical products, appliances and equipment 06.1.1 Pharmaceutical products 06.1.2 Other medical products 06.1.3 Therapeutic appliances and equipment	This covers medicaments, prostheses, medical appliances and equipment and other health-related products purchased by individuals or households, either with or without a prescription, usually from dispensing chemists, pharmacists or medical equipment suppliers. They are intended for consumption or use outside a health facility or institution.	Products supplied directly to outpatients by medical, dental and paramedical practitioners or to inpatients by hospitals and the like are included in outpatient services (06.2) or hospital services (06.3).
06.2 Outpatient services 06.2.1 Medical services 06.2.2 Dental services 06.2.3 Paramedical services	This covers medical, dental and paramedical services delivered to outpatients by medical, dental and paramedical practitioners and auxiliaries. The services may be delivered at home or in individual or group consulting facilities, dispensaries and the outpatient clinics of hospitals and the like. Outpatient services include the medicaments, prostheses, medical appliances and equipment and other health-related products supplied directly to outpatients by medical, dental and paramedical practitioners and auxiliaries.	Medical, dental and paramedical services provided to inpatients by hospitals and the like are included in hospital services (06.3).
06.3 Hospital services	Hospitalization is defined as occurring when a patient is accommodated in a hospital for the duration of the treatment. Hospital day care and home-based hospital treatment are included, as are hospices for terminally ill persons. This group covers the services of general and specialist hospitals; the services of medical centres, maternity centres, nursing homes and convalescent homes that chiefly provide inpatient health care; the services of institutions serving older people in which medical monitoring is an essential component; and the services of rehabilitation centres providing inpatient health care and rehabilitative therapy where the objective is to treat the patient rather than to provide long-term support. Hospitals are defined as institutions that offer inpatient care under the direct supervision of qualified medical doctors. Medical centres, maternity centres, nursing homes and convalescent homes also provide inpatient care, but their services are supervised and frequently delivered by staff of lower qualification than medical doctors.	This group does not cover the services of facilities (such as surgeries, clinics and dispensaries) devoted exclusively to outpatient care (06.2). Nor does it include the services of retirement homes for older people, institutions for disabled people and rehabilitation centres providing primarily long-term support (12.4).

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Annex 2. Methods used to measure financial protection in Europe

Background

The indicators used for monitoring financial protection in Europe are adapted from the approach set out in Xu et al. (2003, 2007). They also draw on elements of the approach set out in Wagstaff & Eozenou (2014). For further information on the rationale for developing a refined indicator for Europe, see Thomson et al. (2016) and WHO Regional Office for Europe (2019).

Data sources and requirements

Preparing country-level estimates for indicators of financial protection requires nationally representative household survey data that includes information on household composition or the number of household members.

The following variables are required at household level:

- total household consumption expenditure;
- food expenditure (excluding tobacco and alcohol if possible);
- housing expenditure, disaggregated by rent and utilities (such as water, gas, electricity and heating); and
- health expenditure (out-of-pocket payments), disaggregated by type of health care good and service.

Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP) (United National Statistics Division, 2018).

If the survey includes a household sampling weight variable, calculations should consider the weight in all instances. Information on household or individual-level characteristics such as age, sex, education and location are useful for additional equity analysis.

Defining household consumption expenditure variables

Survey data come in various time units, often depending on whether the reporting period is 7 days, 2 weeks, 1 month, 3 months, 6 months or 1 year. It is important to convert all variables related to household consumption expenditure to a common time unit. To facilitate comparison with other national-level indicators, it may be most useful to annualize all survey data. If annualizing survey data, it is important not to report the average level of out-of-pocket payments only among households with out-of-pocket payments, as this will produce inaccurate figures.

Total household consumption expenditure not including imputed rent

Household consumption expenditure comprises both monetary and in-kind payment for all goods and services (including out-of-pocket payments) and the money value of the consumption of home-made products. Many household budget surveys do not calculate imputed rent. To maintain cross-country comparability with surveys that do not calculate imputed rent, imputed rent (COICOP code 04.2) should be subtracted from total consumption if the survey includes it.

Food expenditure

Household food expenditure is the amount spent on all foodstuffs by the household plus the value of the family's own food production consumed within the household. It should exclude expenditure on alcoholic beverages and tobacco. Food expenditure corresponds to COICOP code 01.

Housing expenditure on rent and utilities

Expenditure on rent and utilities is the amount spent by households on rent (only among households who report paying rent) and on utilities (only among households who report paying utilities) including electricity, heating and water. These data should be disaggregated to correspond to COICOP codes 04.1 (for rent) and 04.4 and 04.5 (for utilities). Care should be taken to exclude spending on secondary dwellings. Imputed rent (COICOP code 04.2) is not available in all household budget surveys and should not be used in this analysis.

Health expenditure (out-of-pocket payments)

Out-of-pocket payments refer to formal and informal payments made by people at the time of using any health service provided by any type of provider (COICOP code 06). Health services are any good or service delivered in the health system. These typically include consultation fees, payment for medications and other medical supplies, payment for diagnostic and laboratory tests and payments occurring during hospitalization. The latter may include a number of distinct payments such as to the hospital, to health workers (doctors, nurses, anaesthesiologists etc.) and for tests. Both cash and in-kind payments should be included if the latter are quantified in monetary value. Both formal and informal payments should also be included. Although out-of-pocket payments include spending on alternative or traditional medicine, they do not include spending on health-related transportation and special nutrition. It is also important to note that out-of-pocket payments are net of any reimbursement to households from the government, health insurance funds or private insurance companies.

Estimating spending on basic needs and capacity to pay for health care

Basic needs expenditure is a socially recognized minimum level of spending considered necessary to ensure sustenance and other basic personal needs. This report calculates household-specific levels of basic needs expenditure to estimate a household's capacity to pay for health care.

Households whose total consumption expenditure is less than the basic needs expenditure level generated by the basic needs line are deemed to be poor.

Defining a basic needs line

Basic needs can be defined in different ways. This report considers food, utilities and rent to be basic needs and distinguishes between:

- households that do not report any utilities or rent expenses; their basic needs include food;
- households that do not report rent expenses (households that own their home outright or make mortgage payments, which are not included in consumption expenditure data), but do report utilities expenses; their basic needs include food and utilities;
- households that pay rent, but do not report utilities expenditure (for example, if the reporting period is so short that it does not overlap with billing for utilities and there is no alternative reporting of irregular purchases); their basic needs include food and rent;
- households that report paying both utilities and rent, so that their basic needs include food, utilities and rent.

Adjusting households' capacity to pay for rent (among renters) is important. Household budget surveys consider mortgages to be investments, not consumption expenditure. For this reason most do not collect household spending on mortgages. Without subtracting some measure of rent expenditure from those who rent, renters will appear to be systematically wealthier (and have greater capacity to pay) than identical households with mortgages.

To estimate standard (normative) levels of basic needs expenditure, all households are ranked based on their per (equivalent) person total consumption expenditure. Households between the 25th and 35th percentiles of the total sample are referred to as the representative sample for estimating basic needs expenditure. It is assumed that they are able to meet, but not necessarily exceed, basic needs for food, utilities and rent.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household's consumption and affect household ranking. Where this is an issue, it may be preferable to rank households by per equivalent person non-out-of-pocket payment consumption expenditure.

Calculating the basic needs line

To begin to calculate basic needs, a household equivalence scale should be used to reflect the economy scale of household consumption. The Organisation for Economic Co-operation and Development equivalence scale (the Oxford scale) is used to generate the equivalent household size for each household:

equivalent household size = 1 + 0.7*(number of adults – 1)
+ 0.5*(number of children under 13 years of age)

Each household's total consumption expenditure (less imputed rent), food expenditure, utilities expenditure and rent expenditure is divided by the equivalent household size to obtain respective equivalized expenditure levels.

Households whose equivalized total consumption expenditure is between the 25th and 35th percentile across the whole weighted sample are the representative households used to calculate normative basic needs levels. Using survey weights, the weighted average of spending on food, utilities and rent among representative households that report positive values for food, utilities and rent expenditure, respectively, gives the basic needs expenditure per (equivalent) person for food, utilities and rent.

Note again that households that do not report food expenditure are excluded as this may reflect reporting errors. For households that do not report any rent or utilities expenses, only the sample-weighted food basic needs expenditure is used to represent total basic needs expenditure per (equivalent) person. For households that report utilities expenditures but do not report any rent expenses, the two basic needs expenditure sample-weighted averages for food and utilities are added to calculate total basic needs expenditure per (equivalent) person. For households that report rent expenditures but do not report any utilities expenses, the two basic needs expenditure sample-weighted averages for food and rent are added to calculate total basic needs expenditure per (equivalent) person. For households that report both rent and utilities, the three basic needs expenditure sample-weighted averages for food, utilities and rent are added to calculate total basic needs expenditure per (equivalent) person.

Calculating basic needs expenditure levels for each household

Calculate the basic needs expenditure specific to each household by multiplying the total basic needs expenditure per (equivalent) person level calculated above by each household's equivalence scale. Note that a household is regarded as being poor when its total consumption expenditure is less than its basic needs expenditure.

Capacity to pay for health care

This is defined as non-basic needs resources used for consumption expenditure. Some households may report total consumption expenditure that is lower than basic needs expenditure, which defines them as being poor. Note that if a household is poor, capacity to pay will be negative after subtracting the basic needs level.

Estimating impoverishing out-of-pocket payments

Measures of impoverishing health spending aim to quantify the impact of out-of-pocket payments on poverty. For this indicator, households are divided into five categories based on their level of out-of-pocket spending on health in relation to the poverty line (the basic needs line):

- no out-of-pocket payments: households that report no out-of-pocket payments;
- not at risk of impoverishment after out-of-pocket payments: non-poor households (those whose equivalent person total consumption exceeds the poverty line) with out-of-pocket payments that do not push them below 120% of the poverty line (i.e. households whose per equivalent person consumption net of out-of-pocket payments is at or above 120% of the poverty line);
- at risk of impoverishment after out-of-pocket payments: non-poor households with out-of-pocket payments that push them below 120% of the poverty line; this review uses a multiple of 120%, but estimates were also prepared using 105% and 110%;
- impoverished after out-of-pocket payments: households who were non-poor before out-of-pocket payments, but are pushed below the poverty line after out-of-pocket payments; in the exceptional case that capacity to pay is zero and out-of-pocket payments are greater than zero, a household would be considered to be impoverished by out-of-pocket payments; and
- further impoverished after out-of-pocket payments: poor households (those whose equivalent person total consumption is below the poverty line) who incur out-of-pocket payments.

Estimating catastrophic out-of-pocket payments

Catastrophic out-of-pocket payments are measured as out-of-pocket payments that equal or exceed some threshold of a household's capacity to pay for health care. Thresholds are arbitrary. The threshold used most often with capacity to pay measures is 40%. This review uses 40% for reporting purposes, but estimates were also prepared using thresholds of 20%, 25% and 30%.

Households with catastrophic out-of-pocket payments are defined as:

- those with out-of-pocket payments greater than 40% of their capacity to pay; i.e. all households who are impoverished after out-of-pocket payments, because their out-of-pocket payments are greater than their capacity to pay for health care; and
- those with out-of-pocket payments whose ratio of out-of-pocket payments to capacity to pay is less than zero (negative); i.e. all households who are further impoverished after out-of-pocket payments, because they do not have any capacity to pay for health care.

Households with non-catastrophic out-of-pocket payments are defined as those with out-of-pocket payments that are less than the pre-defined catastrophic spending threshold.

For policy purposes it is useful to identify which groups of people are more or less affected by catastrophic out-of-pocket payments (equity) and

which health services are more or less responsible for catastrophic out-of-pocket payments.

Distribution of catastrophic out-of-pocket payments

The first equity dimension is expenditure quintile. Expenditure quintiles are determined based on equivalized per person household expenditure. Household weights should be used when grouping the population by quintile. Countries may find it relevant to analyse other equity dimensions such as differences between urban and rural populations, regions, men and women, age groups and types of household.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household's consumption and affect household ranking. Where this is an issue, it may be preferable to calculate quintiles based on non-health equivalized per person household expenditure.

Structure of catastrophic out-of-pocket payments

For households in each financial protection category, the percentage of out-of-pocket payments on different types of health goods and services should be reported, if the sample size allows, using the following categories, with their corresponding COICOP categorization: medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3). Where possible, a distinction should be made between prescription and over-the-counter medicines.

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Annex 3. Regional and global financial protection indicators

WHO uses regional and global indicators to monitor financial protection in the European Region, as shown in Table A3.1.

Table A3.1. Regional and global financial protection indicators in the European Region

Regional indicators +	Global indicators
Impoverishing out-of-pocket payments	
Risk of poverty due to out-of-pocket payments: the proportion of households further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment after out-of-pocket payments using a country-specific line based on household spending to meet basic needs (food, housing and utilities)	Changes in the incidence and severity of poverty due to household expenditure on health using: • an extreme poverty line of PPP-adjusted US$ 1.90 per person per day • a poverty line of PPP-adjusted US$ 3.10 per person per day • a relative poverty line of 60% of median consumption or income per person per day
Catastrophic out-of-pocket payments	
The proportion of households with out-of-pocket payments greater than 40% of household capacity to pay for health care	The proportion of the population with large household expenditure on health as a share of total household consumption or income (greater than 10% or 25% of total household consumption or income)

Note: PPP: purchasing power parity.

Sources: WHO headquarters and WHO Regional Office for Europe.

Regional indicators

The regional indicators reflect a commitment to the needs of European Member States. They were developed by the WHO Barcelona Office for Health Systems Financing (part of the Division of Country Health Policies and Systems in the WHO Regional Office for Europe), at the request of the WHO Regional Director for Europe, to meet demand from Member States for performance measures more suited to high- and middle-income countries and with a stronger focus on pro-poor policies, in line with Regional Committee resolutions (see Annex 2).

At the regional level, WHO's support for monitoring financial protection is underpinned by the Tallinn Charter: Health Systems for Health and Wealth, Health 2020 and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020, all of which include the commitment to work towards a Europe free of impoverishing payments for health.

Global indicators

The global indicators reflect a commitment to global monitoring. They enable the performance of Member States in the European Region to be

easily compared to the performance of Member States in the rest of the world.

At the global level, support by WHO for the monitoring of financial protection is underpinned by World Health Assembly resolution WHA64.9 on sustainable health financing structures and universal coverage, which was adopted by Member States in May 2011. More recently, with the adoption of the 2030 Agenda for Sustainable Development and its concomitant Sustainable Development Goals (SDGs) in 2015, the United Nations has recognized WHO as the custodian agency for SDG3 (Good health and well-being: ensure healthy lives and promote well-being for all at all ages) and specifically for target 3.8 on achieving universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Target 3.8 has two indicators: 3.8.1 on coverage of essential health services and 3.8.2 on financial protection when using health services.

The choice of global or regional indicator has implications for policy

Global and regional indicators provide insights into the incidence and magnitude of financial hardship associated with out-of-pocket payments for health, but they do so in different ways. As a result, they may have different implications for policy and suggest different policy responses.

For example, the global indicator defines out-of-pocket payments as catastrophic when they exceed a fixed percentage of a household's consumption or income (its budget). Applying the same fixed percentage threshold to all households, regardless of wealth, implies that very poor households and very rich households spending the same share of their budget on health will experience the same degree of financial hardship.

Global studies find that this approach results in the incidence of catastrophic out-of-pocket payments being more concentrated among richer households (or less concentrated among poorer households) (WHO & World Bank 2015; 2017). With this type of distribution, the implication for policy is that richer households are more likely to experience financial hardship than poorer households. The appropriate policy response to such a finding is not clear.

In contrast, to identify households with catastrophic out-of-pocket payments, the regional indicator deducts a standard amount representing spending on three basic needs – food, housing (rent) and utilities – from each household's consumption expenditure. It then applies the same fixed percentage threshold to the remaining amount (which is referred to as the household's capacity to pay for health care). As a result, although the same threshold is applied to all households, the amount to which it is applied is now significantly less than total household consumption for poorer households but closer to total household consumption for richer households. This implies that very poor households spending small amounts on out-of-pocket payments, which constitute a relatively small share of their total budget, may experience financial hardship, while wealthier households are assumed to not experience hardship until they

have spent a comparatively greater share of their budget on out-of-pocket payments.

The approach used in the European Region results in the incidence of catastrophic out-of-pocket payments being highly concentrated among poor households in all countries (Cylus et al., 2018). For countries seeking to improve financial protection, the appropriate response to this type of distribution is clear: design policies that protect poorer households more than richer households.

Recent global studies most commonly report impoverishing out-of-pocket payments using absolute poverty lines set at US$ 1.90 or US$ 3.10 a day in purchasing power parity (WHO & World Bank 2015; 2017). These poverty lines are found to be too low to be useful in Europe, even among middle-income countries. For example, the most recent global monitoring report suggests that in 2010 only 0.1% of the population in the WHO European Region was impoverished after out-of-pocket payments using the US$ 1.90 a day poverty line (0.2% at the US$ 3.10 a day poverty line) (WHO & World Bank, 2017).

European studies make greater use of national poverty lines or poverty lines constructed to reflect national patterns of consumption (Yerramilli et al., 2018). While national poverty lines vary across countries, making international comparison difficult, poverty lines constructed to reflect national patterns of consumption – such as that which is used as the poverty line for the regional indicator – facilitate international comparison (Saksena et al., 2014).

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Annex 4. Glossary of terms

Ability to pay for health care: Ability to pay refers to all the financial resources at a household's disposal. When monitoring financial protection, an ability to pay approach assumes that all of a household's resources are available to pay for health care, in contrast to a capacity to pay approach (see below), which assumes that some of a household's resources must go towards meeting basic needs. In practice, measures of ability to pay are often derived from household survey data on reported levels of consumption expenditure or income over a given time period. The available data rarely capture all of the financial resources available to a household – for example, resources in the form of savings and investments.

Basic needs: The minimum resources needed for sustenance, often understood as the consumption of goods such as food, clothing and shelter.

Basic needs line: A measure of the level of personal or household income or consumption required to meet basic needs such as food, housing and utilities. Basic needs lines, like poverty lines, can be defined in different ways. They are used to measure impoverishing out-of-pocket payments. In this study the basic needs line is defined as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, adjusted for household size and composition. Basic needs line and poverty line are used interchangeably. See poverty line.

Budget: See household budget.

Cap on benefits: A mechanism to protect third-party payers such as the government, a health insurance fund or a private insurance company. A cap on benefits is a maximum amount a third-party payer is required to cover per item or service or in a given period of time. It is usually defined as an absolute amount. After the amount is reached, the user must pay all remaining costs. Sometimes referred to as a benefit maximum or ceiling.

Cap on user charges (co-payments): A mechanism to protect people from out-of-pocket payments. A cap on user charges is a maximum amount a person or household is required to pay out of pocket through user charges per item or service or in a given period of time. It can be defined as an absolute amount or as a share of a person's income. Sometimes referred to as an out-of-pocket maximum or ceiling.

Capacity to pay for health care: In this study capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. This amount is deducted consistently for all households. It is referred to as a poverty line or basic needs line.

Catastrophic out-of-pocket payments: Also referred to as catastrophic health spending. An indicator of financial protection. Catastrophic out-of-pocket payments can be measured in different ways. This study defines them as out-of-pocket payments that exceed 40% of a household's

capacity to pay for health care. The incidence of catastrophic health spending includes households who are impoverished and households who are further impoverished.

Consumption: Also referred to as consumption expenditure. Total household consumption is the monetary value of all items consumed by a household during a given period. It includes the imputed value of items that are not purchased but are procured for consumption in other ways (for example, home-grown produce).

Co-payments (user charges or user fees): Money people are required to pay at the point of using health services covered by a third party such as the government, a health insurance fund or a private insurance company. *Fixed co-payments* are a flat amount per good or service; *percentage co-payments* (also referred to as co-insurance) require the user to pay a share of the good or service price; *deductibles* require users to pay up to a fixed amount first, before the third party will cover any costs. Other types of user charges include *balance billing* (a system in which providers are allowed to charge patients more than the price or tariff determined by the third-party payer), *extra billing* (billing for services that are not included in the benefits package) and *reference pricing* (a system in which people are required to pay any difference between the price or tariff determined by the third-party payer – the reference price – and the retail price).

Equivalent person: To ensure comparisons of household spending account for differences in household size and composition, equivalence scales are used to calculate spending levels per equivalent adult in a household. This review uses the Oxford scale (also known as the Organisation for Economic Co-operation and Development equivalence scale), in which the first adult in a household counts as one equivalent adult, subsequent household members aged 13 years or over count as 0.7 equivalent adults and children under 13 count as 0.5 equivalent adults.

Exemption from user charges (co-payments): A mechanism to protect people from out-of-pocket payments. Exemptions can apply to groups of people, conditions, diseases, goods or services.

Financial hardship: People experience financial hardship when out-of-pocket payments are large in relation to their ability to pay for health care.

Financial protection: The absence of financial hardship when using health services. Where health systems fail to provide adequate financial protection, households may not have enough money to pay for health care or to meet other basic needs. Lack of financial protection can lead to a range of negative health and economic consequences, potentially reducing access to health care, undermining health status, deepening poverty and exacerbating health and socioeconomic inequalities.

Further impoverished households: Poor households (those whose equivalent person total consumption is below the poverty line or basic needs line) who incur out-of-pocket payments.

Health services: Any good or service delivered in the health system, including medicines, medical products, diagnostic tests, dental care, outpatient care and inpatient care. Used interchangeably with health care.

Household budget: Also referred to as total household consumption. The sum of the monetary value of all items consumed by the household during a given period and the imputed value of items that are not purchased but are procured for consumption in other ways.

Household budget survey: Usually national sample surveys, often carried out by national statistical offices, to measure household consumption over a given period of time. Sometimes referred to as household consumption expenditure or household expenditure surveys. European Union countries are required to carry out a household budget survey at least once every five years.

Impoverished households: Households who were non-poor before out-of-pocket payments, but are pushed below the poverty line or basic needs line after out-of-pocket payments.

Impoverishing out-of-pocket payments: Also referred to as impoverishing health spending. An indicator of financial protection. Out-of-pocket payments that push people into poverty or deepen their poverty. A household is measured as being impoverished if its total consumption was above the national or international poverty line or basic needs line before out-of-pocket payments and falls below the line after out-of-pocket payments.

Informal payment: a direct contribution made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services to which patients are entitled.

Out-of-pocket payments: Also referred to as household expenditure (spending) on health. Any payment made by people at the time of using any health good or service provided by any type of provider. Out-of-pocket payments include: formal co-payments (user charges or user fees) for covered goods and services; formal payments for the private purchase of goods and services; and informal payments for covered or privately purchased goods and services. They exclude pre-payment (for example, taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company.

Poverty line: A level of personal or household income or consumption below which a person or household is classified as poor. Poverty lines are defined in different ways. This study uses basic needs line and poverty line interchangeably. See basic needs line.

Quintile: One of five equal groups (fifths) of a population. This study commonly divides households into quintiles based on per equivalent person household consumption. The first quintile is the fifth of households with the lowest consumption, referred to in the study as the poorest quintile; the fifth quintile has the highest consumption, referred to in the study as the richest quintile.

Risk of impoverishment after out-of-pocket payments: After paying out of pocket for health care, a household may be further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment. A household is at risk of impoverishment (or not at risk of impoverishment) if its total spending after out-of-pocket payments comes close to (or does not come close to) the poverty line or basic needs line.

Universal health coverage: Everyone can use the quality health services they need without experiencing financial hardship.

Unmet need for health care: An indicator of access to health care. Instances in which people need health care but do not receive it due to access barriers.

User charges: Also referred to as user fees. See co-payments.

Utilities: Water, electricity and fuels used for cooking and heating.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00   Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int

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