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## SOCIAL NEEDS IN SPAIN

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# Health

Report

04

October 2019



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## Credits

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# INTRODUCTION



Good health is highly valued and is recognised as a fundamental right in the Spanish Constitution, which establishes that the public authorities are responsible for protecting citizens' health through the measures and services required to achieve this. In addition, health is central to three of the 20 basic principles of the European Pillar of Social Rights, approved in 2017. These principles enshrine the right of every person to "timely access to affordable, preventive and curative health care of good quality." Moreover, they explicitly recognise the right of people with disabilities to the income support and services they need to ensure their full participation in society and the economy, as well as the right to "affordable long-term care services of good quality, in particular home-care and community-based services."

Universal access, satisfactory care throughout people's lives (from birth to death) and services of good quality feature in every statement regarding the right to good health. In addition, these statements call for care to be affordable for all citizens. Healthcare and long-term care are both services that can cost far more than affected people are able to pay. Consequently, it is important to guarantee that a lack of financial wherewithal does not represent a barrier to entry to the system by using effective financial protection mechanisms. Nor should other factors such as gender, age or place of residence constitute barriers.

## HEALTH

There are many aspects and challenges involved in protecting good health, understood here to mean a state of physical, mental and social wellbeing rather than an absence of illness or disease (WHO, 1948). In this report, we analyse the basic challenges from the perspective of society's needs using a set of indicators that are useful for evaluating policies and their impact. This analysis is structured around the following challenges:



1. To maintain and improve the population's state of physical and mental health.

Individuals' state of health is dependent on numerous causes and on the structure of the population. In an ageing society, health problems change and the way they are tackled must be adapted. Health policies need to foster improvements in the population's levels of physical and mental health by means of satisfactory preventive and curative measures suited to the demographic needs and structures of the time.



2. To promote healthy lifestyles that will help to prevent disease.

The incidence of many diseases and health problems can be reduced if we adopt healthier lifestyles. Diet, physical exercise, alcohol consumption, smoking and drugs are major issues on which action can be taken. Monitoring the prevalence and evolution of the main risk factors helps to detect areas where it may be necessary to step up public health policies.



3. To guarantee access to healthcare.

Equitable access to healthcare is a basic social right in a developed country. To ensure that there is fair access, countries must have a healthcare system that can provide the required care to the people who need it, regardless of their personal circumstances.



4. To guarantee access to dependency care.

Increased life expectancy has made it necessary to accept long-term care for dependent people as a new social right. Universal access for all on an equal footing must be guaranteed by the public authorities to ensure that no-one is excluded from this care simply because they cannot afford to pay for it or because there is a shortfall in adequate service provision (day centres, homes, etc.).

# SPAIN

## In the realm of health, society must tackle four fundamental challenges:

(Expressed as a percentage of the total population)

### First challenge:

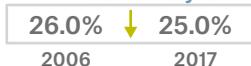


To maintain and improve people's state of health

#### Self-perceived ill health



#### The chronically ill



#### Limitations in performing activity of daily living



#### Severely limited senior citizens



#### Mental health problem



### Second challenge:



To promote healthy lifestyles

#### Sedentary lifestyle



#### Obesity



#### Insufficient consumption of fruit and vegetables



#### Heavy smoker



#### High alcohol consumption or binge drinking



#### Heavy cannabis use



### Third challenge:



To guarantee access to healthcare

#### Inability to access medical care



#### Inability to access dental care



#### Excessive delays or lack of medical care due to long waiting lists



#### Waiting lists for surgery



#### Decision not to take prescribed medication for financial reasons



#### Catastrophic health spending



### Fourth challenge:



To guarantee access to dependency care

#### Senior citizens' self-perceived need for help



#### Registered waiting list



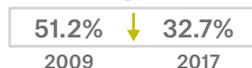
#### Demand for care among the elderly



#### Shortfall in the provision of care for the dependent elderly



#### Poor professionalisation among carers



## The most important issues

**1.** Now that the public dependency care system is operating, there has been an improvement in the degree to which the social need for long-term care in Spain is being met. However, there is still an unmet demand for care and inadequate professionalisation among those providing the care.

**2.** Even though people are taking more exercise and are eating more fruit and vegetables, the level of obesity has risen in recent years and is a serious public health problem in society today. Binge drinking, a phenomenon associated particularly with young people, has increased dramatically in recent years.

**3.** The health system in Spain is universal, meaning that almost nobody is unable to see a doctor for reasons of poverty, distance or because they cannot get an appointment. However, a certain percentage of low-income families have difficulties in areas such as purchasing medication or dental care, and they sometimes incur expenses that are excessive in relation to their ability to pay. In other instances, the barriers to access are long waiting lists, an aspect that worsened during the economic crisis.

**4.** People's perception of their state of health has improved considerably in recent years. The percentage of people whose poor health limited their ability to engage in daily activities has fallen and there are fewer senior citizens who believe they are severely limited. The percentage of chronically ill patients diagnosed with hypertension has also dropped, though other conditions such as diabetes, high cholesterol, anxiety, depression and other mental health disorders are on the rise. In addition, the percentage of chronically ill people at cardiovascular risk also fell by one percentage point between 2006 and 2017.

# SPAIN vs EUROPE

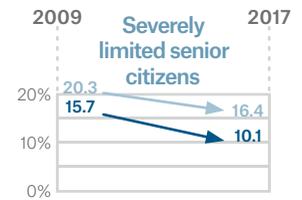
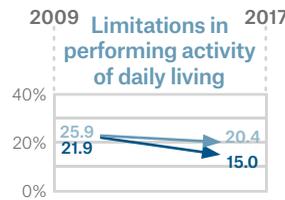
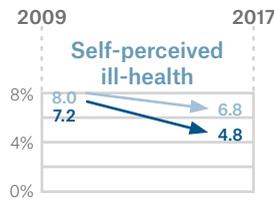
Spain → Europe →

(Expressed as a percentage of the total population)

## First challenge:



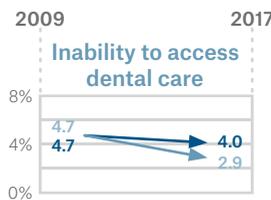
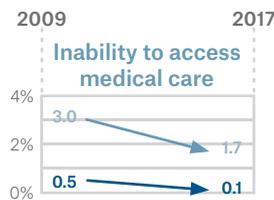
To maintain and improve people's state of health



## Third challenge:



To guarantee access to healthcare



Source: Compiled in-house using data from Eurostat (EU-SILC).

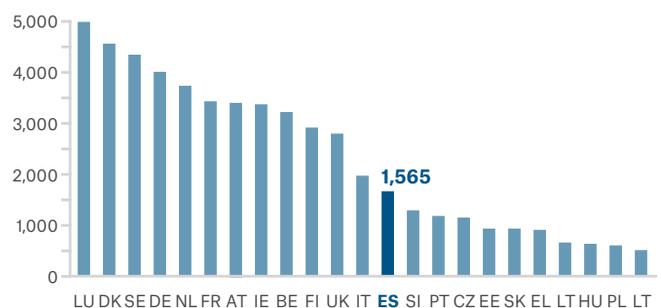
## The most important issues

- The percentage of adults who declare they are in poor health or suffer from a problem that makes it difficult to perform activities of daily living is lower in Spain than the European Union average, above all in 2017. This comparison has been arrived at by adjusting the differences in the age structures of the various countries; consequently the results are not affected by differing degrees of demographic ageing.
- There are also comparatively fewer people aged over 65 who state they suffer from severe limitations in their everyday lives due to health problems. Moreover, there was an evident improvement in this parameter between 2009 and 2017. Even though this information is not based on objective assessments of the degree of dependency or disability, this indicator can provide an estimate of the demand for long-term care among senior citizens.
- Almost nobody in Spain declares they were unable to visit a doctor because it was too expensive, too far to travel or due to a long waiting list in the previous year. As a result, Spain ranked top in this indicator in 2017. With regard to visits to dentists, inaccessibility is slightly higher than the European average and the reasons given are almost always of a financial nature.

## PUBLIC POLICIES

- Health spending per capita dropped dramatically due to the economic crisis. In 2013, this indicator began to rise again, though at a slower rate than during the period prior to the recession.
- Spain is mid-table in a ranking of EU countries by health spending.
- Spain is one of the top-ranking countries in the EU for its low levels of unnecessarily early deaths that could have been prevented by healthcare.
- There has been a significant rise in the percentage of the population that believes healthcare services have worsened.

Public healthcare spending per capita in the European Union at current prices, 2017 (in €)



Source: OECD Health Statistics 2018.

# THE SITUATION IN SPAIN



## First challenge:

To maintain and improve people's state of health

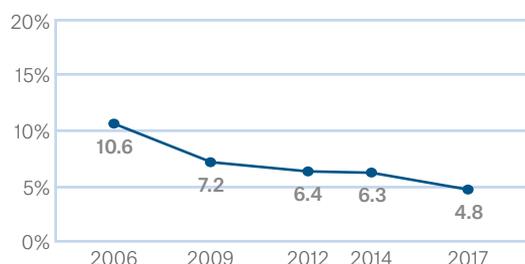
This challenge is measured using the indicators shown on this page. The meaning of the data is explained in the rest of the section.



### Key indicators on health problems among the Spanish population

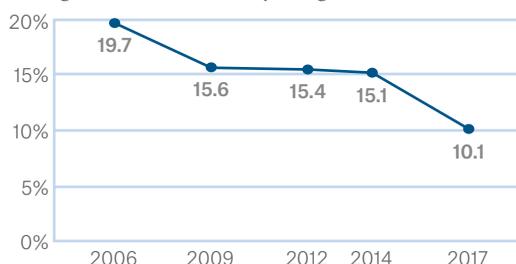
#### Self-perceived ill health:

Percentage of adults (people aged 16 or over) who declare that they have been in a poor or very poor state of health in the last twelve months. Age-adjusted percentage.



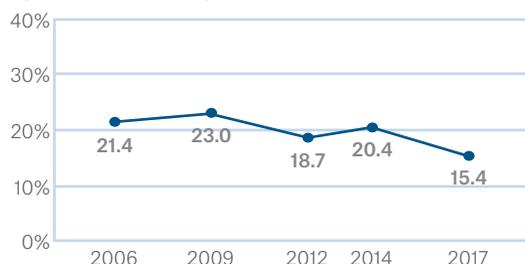
#### Severely limited senior citizens:

Percentage of senior citizens (people aged 65 or over) with health problems that have resulted in severe limitations affecting their activities of daily living in the last six months.



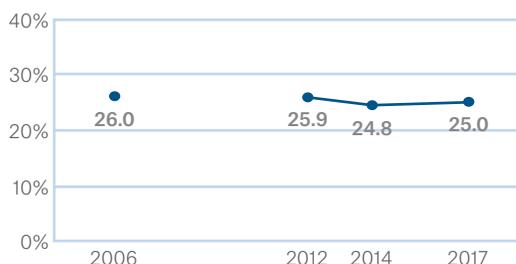
#### Limitations in performing activity of daily living:

Percentage of adults (people aged 16 or over) with health problems that have resulted in moderate or severe limitations affecting their activities of daily living in the last six months. Age-adjusted percentage.



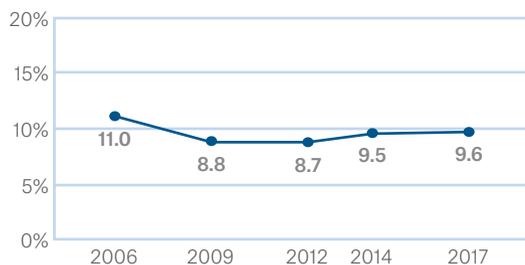
#### The chronically ill:

Percentage of adults (people aged 15 or over) who have been diagnosed by their doctor as suffering from one of the main diseases or chronic health problems that place them at risk of cardiovascular disease: hypertension, high cholesterol or diabetes. Age-adjusted percentage.



#### Mental health problem:

Percentage of adults (people aged 15 or over) who have been diagnosed by their doctor as suffering from depression, anxiety or other mental problem in the last twelve months. Age-adjusted percentage.



**Source:** Compiled in-house using microdata in the National Health Survey, the European Health Survey in Spain and the Living Conditions Survey.

The primary challenge in the health field is to ensure that the population is in the best possible health. Good health depends on numerous individual and collective factors (genes, lifestyles, salubrity of the environment, medical advances, etc.). There are also factors associated with the human lifecycle that strongly influence the incidence of certain diseases. The structure of the population (whether the population is younger or older) influences the state of health. Even though old age and illness do not always go hand in hand, people's state of health tends to decline as they age. Consequently, in assessments of advances or setbacks in this challenge, it is advisable to use standardised or age-adjusted indicators in order to eliminate the composition effects caused solely by the change in the age structure of the population. To circumvent this problem, the indicators chosen to represent this challenge have been age adjusted. Using a common age structure makes it easier to compare the rates and percentages of different population groups (different age groups). The baseline population taken is the European Standard Population (Waterhouse et al., 1976). The only exception relates to severe limitations among senior citizens, as this indicator by definition concerns only the population group aged 65 and over.

One of the indicators customarily used in relation to people's state of health is self-assessment. In the last ten years, people's perception of their state of health has improved considerably.

The data show that between 2006 and 2017 there was a one percentage point drop in the number of chronically ill people at risk of cardiovascular disease. Even so, it should be noted that chronic illnesses that are factors in cardiovascular risk affect a large part of the population: one in four people suffer from hypertension, high cholesterol or diabetes. There has been a downward trend among those suffering from high blood pressure, but not those suffering from diabetes or high cholesterol, as the percentage of people with these problems has risen by around 13% since 2006. Diabetes is a particularly serious problem, as this upward surge affects not only older people but also children (aged under 14), among whom the percentage stands at 0.1%, a figure that is low but which nevertheless doubled between 2006 and 2017.

The percentage of people with health problems that limit their daily activity also fell between 2006 and 2017, though the reduction is concentrated in 2017, so this trend will need to be confirmed by more data in the future. In previous years, this indicator remained relatively stable at around a fifth of the adult population. The percentage of older people who declared they faced serious limitations in performing activities of daily living also fell noticeably in 2017. This is important because if this trend continues, it implies greater independence and improved quality of life for the demographic group that will increase the most in the coming years.

According to the data collected in the National Health Surveys and the European Health Surveys in Spain between 2006 and 2012, the percentage of adults aged 15 and over who suffer from and have been diagnosed with depression, anxiety or other mental health problem has dropped by more than two points. Nevertheless, this downward trend came to a halt in 2014, with a higher incidence of mental health problems recorded in 2017 than in 2009. These mental health problems, particularly depression, are more frequently diagnosed among women than men.

## Second challenge: To promote healthy lifestyles



This challenge is measured using the indicators shown on this page. The meaning of the data is explained in the rest of the section.

### Key indicators on promoting healthy lifestyles

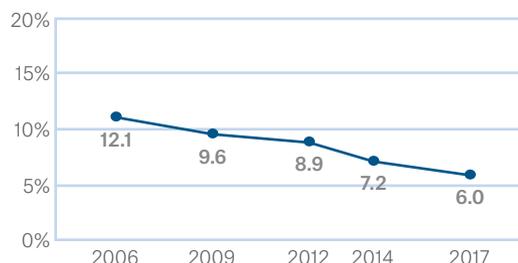
#### Sedentary lifestyle:

Percentage of adults (people aged 15 and over) who declare that they do no physical exercise in their free time. Age-adjusted percentage.



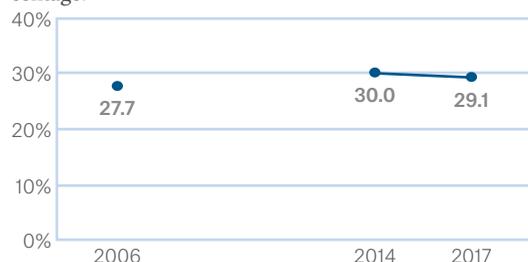
#### Heavy smokers:

Percentage of adults (people aged 15 and over) who smoke 20 cigarettes or more a day. Age-adjusted percentage.



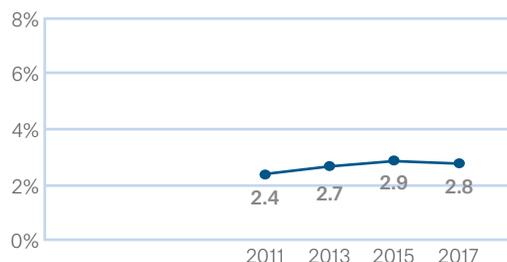
#### Insufficient consumption of fruit and vegetables:

Percentage of adults (people aged 15 and over) who do not eat fruit and vegetables on a daily basis. Age-adjusted percentage.



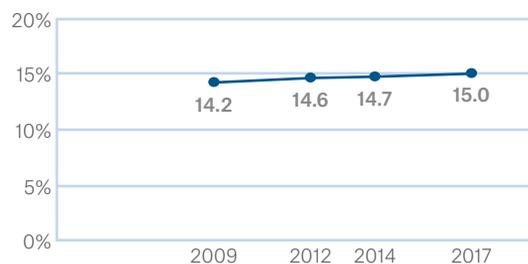
#### Heavy cannabis use:

Percentage of adults between the ages of 15 and 64 who smoke cannabis on a daily basis. Age-adjusted percentage.



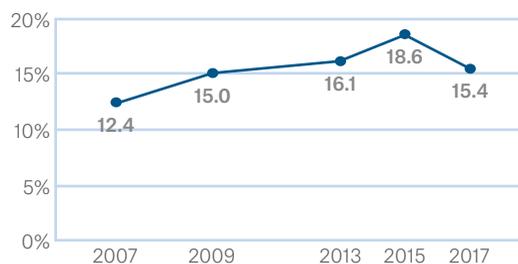
#### Obesity:

Percentage of adults (people aged 15 and over) with a body mass index above 30 kg/m<sup>2</sup>. Age-adjusted percentage.



#### Heavy alcohol consumption or binge drinking:

Percentage of adults between the ages of 15 and 64 who have drunk more than five alcoholic drinks (in the case of a man) or four (in the case of a woman) within a period of two hours in the last 30 days. Age-adjusted percentage.



#### Source:

Survey on Alcohol and Other Drugs in Spain, the Spanish Observatory on Drugs and Addictions and compiled in-house using microdata in the National Health Survey and European Health Survey in Spain.

There are many scientific studies that demonstrate the positive association between regular moderate physical exercise and a reduced risk of suffering from cardiovascular diseases, hypertension, type 2 diabetes, mental health problems (depression or anxiety) and obesity, among other chronic illnesses. Between 2012 and 2017, the percentage of the population that took no exercise in their free time fell by almost seven percentage points. Sedentary behaviour is more common among women than men, particularly in the youngest (aged 15 to 34) and oldest (aged over 80) age groups.

Just as regular physical exercise helps to reduce the risk of certain diseases, so eating a healthy diet is key to preventing a large number of chronic illnesses and other health problems. Regular consumption (on a daily basis) of fruit and vegetables is a good indicator for studying this healthy lifestyle habit among the population. The data in the National Health Survey and the European Health Survey in Spain show that the percentage of the population who do not eat sufficient fruit and vegetables has fallen since 2009. Nevertheless, 29% of the population aged 15 and over continued to consume an inadequate amount of fruit and vegetables in 2017. The highest percentages of the population eating an unhealthy diet are concentrated among the youngest age groups.

Clinical studies also indicate that obesity is a major risk factor for cardiovascular diseases and other chronic illnesses and health problems, among them hypertension, high cholesterol and diabetes. The data collected in health surveys show there is a high prevalence of obesity in Spain and that there has been an upward trend in obesity since 2009.

The first drugs that people consume are tobacco, alcohol and cannabis, and this consumption begins at an early age of between 16 and 18 according to the Survey on Alcohol and Drug Use in Spain (EDADES - 2017 data) or even earlier at the age of 14 according to the Survey on Drug Use in Secondary Education in Spain (ESTUDES).

Whereas heavy smoking on a daily basis has fallen by half in the last ten years, lower levels of consumption, especially the consumption of fewer than ten cigarettes, has risen by more than 40%. Daily consumption of alcohol has fallen in recent years, reaching a historic low in 2017 of 7.4%. Similarly, high alcohol consumption dropped in 2017. Nevertheless, binge drinking has risen considerably from 4.9% of the population aged between 15 and 64 in 2005 to a record high of 17.9% (18.6%, age-adjusted) ten years later.

With regard to the consumption of other drugs, the illegal drug most consumed by people aged 16 to 64 is cannabis. Between 2011 and 2015, the population aged 15 to 64 that smoked cannabis on a daily basis rose by half a percentage point. There are twice and up to three times the percentage of cannabis consumers, and particularly problem cannabis users (those who obtain a score higher than four on the Cannabis Abuse Screening Test), as there are of users of other drugs such as cocaine, ecstasy, amphetamines, hallucinogens, heroin and volatile inhalants.

The profile of cannabis consumers is characterised by a much higher percentage of pupils who have to repeat a year of schooling, have poor marks at school (failed subjects) and poor relationships with their parents and who consume a number of different drugs (polyconsumption), problems that are exacerbated among troublemaking cannabis consumers. The data in the Survey on Alcohol and Other Drugs in Spain (EDADES) also show that cannabis use is associated with a higher prevalence of problems with family, friends and their physical health, psychological issues, traffic accidents, problems at work, financial difficulties, problems with the police or the law, having sexual relations that in other circumstances would not have occurred or having unprotected sex.

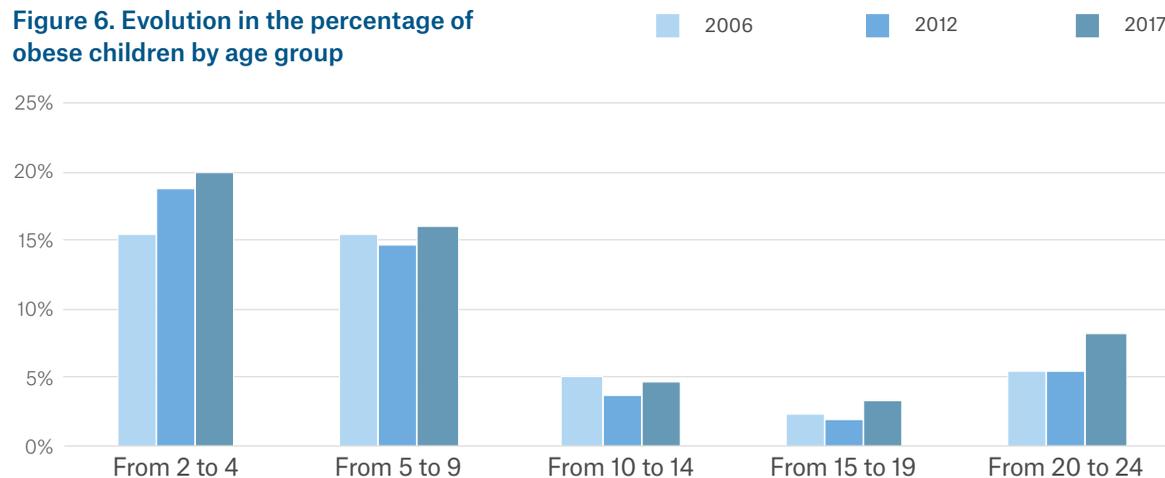
## OBESITY AMONG CHILDREN AND TEENAGERS

Obesity is a serious public health problem. It is associated with an increased risk of suffering from coronary and cardiovascular diseases, diabetes and certain types of tumours, and it is also linked with a higher probability of mental health problems (Eurostat, 2018). All of this implies substantial direct and indirect costs that put tremendous pressure on the health system as a whole. It is particularly worrying in the case of children, among whom there is a very high prevalence of obesity that has risen continually over the last ten years. Obese children tend to remain obese in adulthood and have a greater likelihood of suffering at an earlier age the diseases associated with obesity.

In 2017, obesity affected 20% of children between the ages of two and four, 16% of those aged between five and nine, and 4.7% of those aged between ten and 14.

Obesity rates drop during adolescence but rise once again as teenagers grow older: in 2017, obesity affected 3.2% of teens aged between 15 and 17; 8.2% of young adults aged between 18 and 24 (compared with 5.5% in 2006); and 11% of adults aged between 25 and 34.

**Figure 6. Evolution in the percentage of obese children by age group**



Source: National Health Survey.

## BINGE DRINKING AND OTHER PROBLEMS

Binge drinking is a phenomenon associated particularly with young people. In 2017, 25% of young people aged 20 to 24 had engaged in binge drinking in the last 30 days. It is more common among men than women. Moreover, young people's consumption is associated with high-proof alcohol.

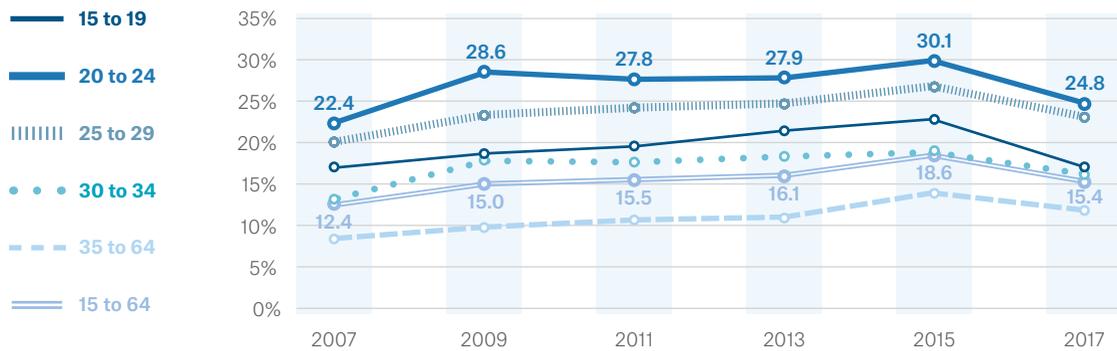
If we compare the data for Spain with the figures for European Union countries, the European Health Interview Survey data show that binge drinking in the last twelve months is also concentrated in other countries among younger age groups, particularly among young adults aged between 20 and 24. In any event, Spain is one of the countries with the lowest percentage of binge drinkers. If we analyse these data in conjunction with the population's socio-economic circumstances, we can see that in general, apart from the occasional exception, in most European Union countries, including Spain, binge drinking increases as income rises (the higher the income quintile, the higher the percentage of the population that engages in binge drinking).

Binge drinking is particularly serious due to its association with the consumption of other drugs. According to the Survey on Alcohol and Other Drugs in Spain (EDADES) and the Survey on Drug Use in Secondary Education in Spain (ESTUDES), drug use is more common among students who have engaged in binge drinking than among those who have not. The data in the 2015 Survey on Alcohol and Other Drugs in Spain (EDADES) show that one in five people who engaged in binge drinking consumed cannabis, whereas among those who did not, the prevalence was below 5%.

The data in the 2017 Survey on Alcohol and Other Drugs in Spain (EDADES) also point to the fact that certain problems are more widespread among those who binge drink than among the general population aged 15 to 34. Whereas 3.4% of the population aged 15 to 34 have had problems or fights with family or friends, this percentage rises to 8.9% among those who have engaged in binge drinking in the previous 30 days. This disparity can also be seen in problems to do with physical health (3.3% as opposed to 1.6%), road accidents (1.7% as opposed to 0.7%) and having unprotected sex (1.4% as opposed to 4.2%).

## BINGE DRINKING

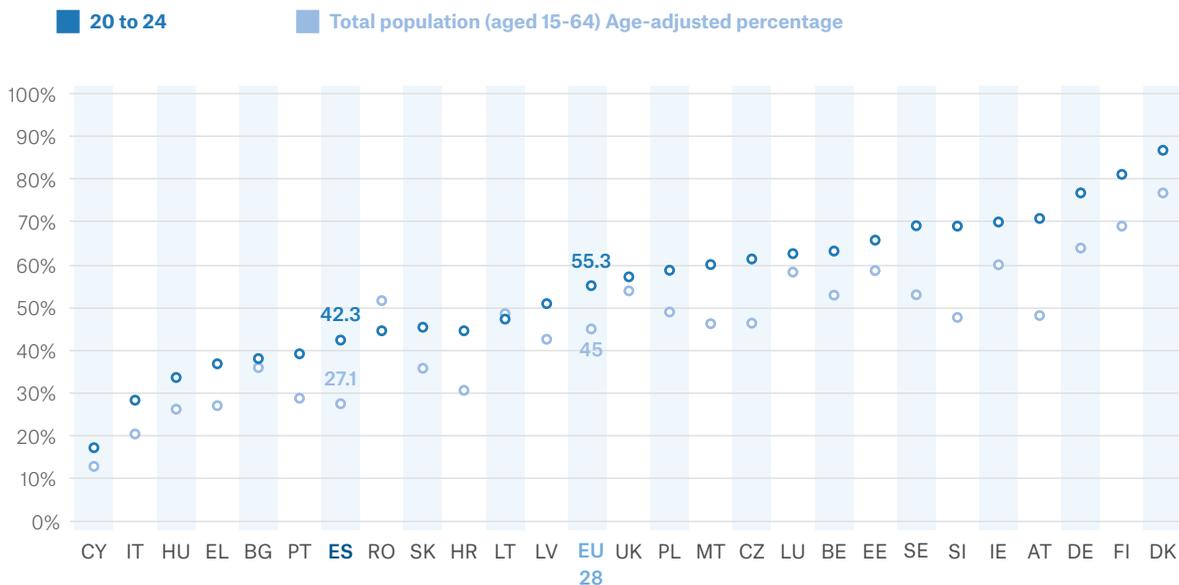
Figure 7. Spain: Percentage of the population aged 15 to 64 that engaged in binge drinking in the last 30 days by age group, 2007-2017



**Source:**

Survey on Alcohol and Other Drugs in Spain. Spanish Observatory on Drugs and Addictions.

Figure 8. Europe: Percentage of the population aged 15 to 64 who consumed more than 5-6 standard alcoholic units on the same occasion in the last twelve months by age and country, 2014



**Source:**

European Health Interview Survey, Eurostat.

## Third challenge: To guarantee access to healthcare

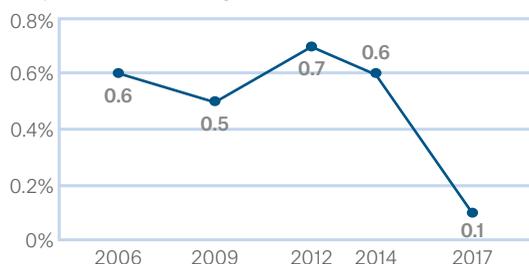
This challenge is measured using the indicators shown on this page. The meaning of the data is explained in the rest of the section.



### Key indicators on difficulties accessing healthcare in Spain

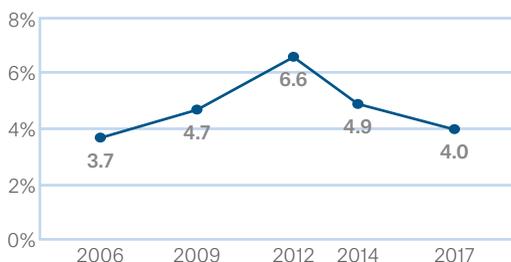
#### Inability to access medical care:

Percentage of adults (people aged 16 or over) who on some occasion in the last twelve months did not go to the doctor for financial reasons or because it was too far or because they had to wait too long.



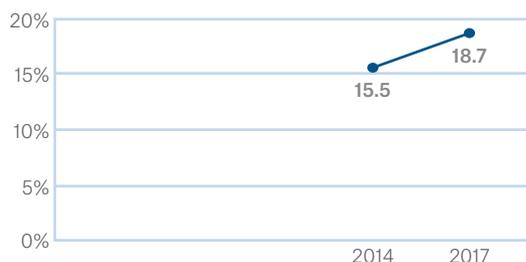
#### Inability to access dental care:

Percentage of adults (people aged 16 or over) who on some occasion in the last twelve months did not go to the dentist for financial reasons or because it was too far or because they had to wait too long.



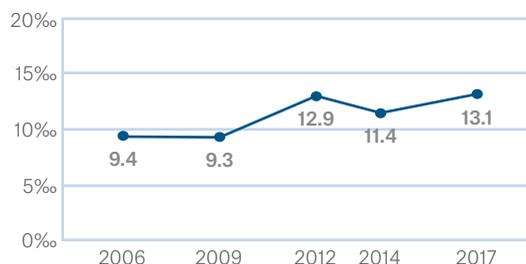
#### Lack of medical care or excessive delay due to waiting lists:

Percentage of adults (people aged 15 or over) with a need in the last twelve months for medical attention that they believe they received late or not at all due to a waiting list.



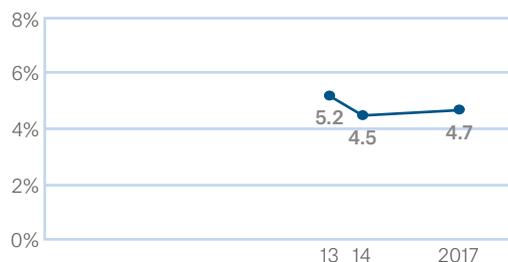
#### Waiting lists for surgery:

Per thousand inhabitants, patients awaiting surgery whose wait for their operation is attributable to organisational issues and available resources.



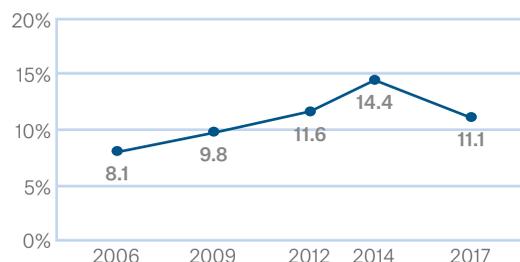
#### Decision not to take prescribed medication for financial reasons:

Percentage of adults (people aged 18 or over) who for financial reasons stopped taking medication prescribed by a doctor in the public health system in the previous year.



#### Catastrophic health spending:

Percentage of people in the first quintile whose health-related spending exceeds 40% of their ability to pay. Ability to pay is measured by subtracting basic standard spending on food, energy and housing from the household's total spending.



#### Source:

Compiled in-house using data in the National Health and the European Health Surveys, the Living Conditions Survey, the Household Budget Survey (EPF), the Health Barometer and the National Health System Waiting Lists Information System.

In Spain, virtually every citizen has healthcare coverage. According to the data in the 2017 National Health Survey, 99% of citizens receive public healthcare through the National Health System or through a government-funded mutual society that contracts healthcare out to private provider. In addition, almost no-one states they have been unable to go to the doctor due to the high cost or because it was too far to travel or they would have had to wait too long.

This nigh-on universal coverage does not, however, guarantee effective access to the package of services required to safeguard people's health. Firstly, there are areas of care that the public health system does not cover completely in Spain, such as dental and psychological care, some vaccines and certain rehabilitation treatments. In other instances, such as prescription charges, patients contribute to the financing of health spending by making a copayment. In such cases, a lack of financial resources may to a certain extent make access to healthcare difficult. Moreover, there are social minorities excluded from the right to healthcare whose situation is difficult to ascertain through household surveys. Notable among such groups are undocumented immigrants, who were excluded from regular healthcare coverage by Royal Decree Law 16/2012 except in special circumstances (children, pregnant women, emergencies, asylum seekers and human-trafficking victims). This situation was subsequently reversed by means of Decree Law 7/2018.

Barriers to healthcare do not derive solely from low incomes that make it difficult for some families to cover the costs of copayments or of services not provided by the public health system. If the health system does not operate as it should, citizens may not receive the attention they require to safeguard their health in a timely manner. Limited human and material resources lead to excessively long waiting lists and reduce the time doctors can devote to patients, thereby increasing the risk of errors in diagnoses or treatment regimes. Similarly, organisational and management failings can mean that available resources are not used in an optimal manner. For families on medium and low incomes, who do not usually have complementary private health insurance, it is especially important for the health system to work well. The data in the last National Health Survey, conducted in 2017, reveal that 15% of the adult population has private health insurance, but there are significant differences

depending on income level: among families with a net income of less than €1,050 a month, fewer than 4% have private health insurance, as opposed to 41% of families with incomes of more than €3,600 a month. One of the problems that traditionally worry health system users in Spain is waiting lists. According to the data in the last two health surveys, between 15% and 20% of adults who needed medical attention in the previous year indicated that they had not received this care or had been given it too late on at least one occasion due to the existence of waiting lists. Even though this question did not feature as such in earlier surveys, making it difficult to analyse changes, the perception of the problem seems to have been no better in 2017 than it was in 2014. The official figures for waiting lists for surgery show that since the start of the economic crisis, there has been an increase in the number of patients waiting for an operation. Moreover, the average waiting time has grown (from 70 days in 2006 to a maximum of 115 in 2016). More recent data show there has been an improvement but the figures remain worse than they were prior to the economic crisis.

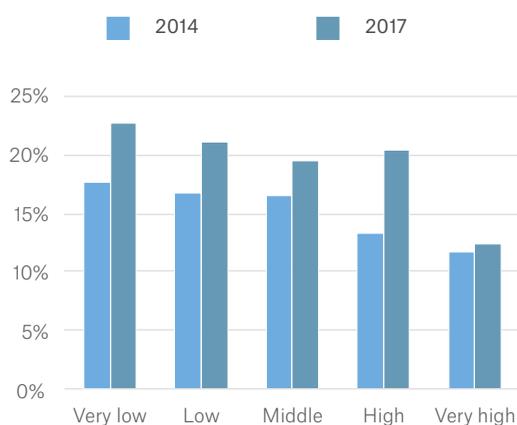
Dental care is one of the areas with a very limited public service, although there has been a gradual expansion to cover children in recent times. This means that visiting the dentist is an expense that families find difficult to meet in times of financial hardship. The inability to access dental care fell in Spain in the years leading up to the financial crisis but worsened during the recession, with 7% or more of adults unable to visit the dentist in the period 2012-2014. The reasons families gave for this were overwhelmingly financial rather than any difficulties related to transport, the distance to services or waiting lists.

## SOCIAL INEQUALITIES AFFECTING ACCESS

Difficulties in accessing healthcare vary according to income level, but income is not always the determining factor. In the case of a lack of medical attention or excessive delay due to waiting lists, only those with very high incomes of more than €3,600 a month in 2017 presented indicators that were clearly lower than the average (figure 10).

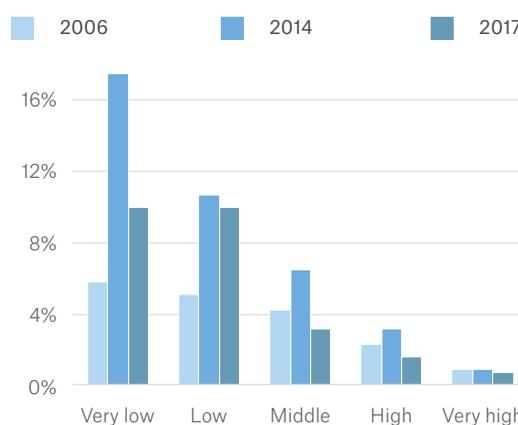
In addition, these people were the only group for whom the situation did not worsen between 2014 and 2017.

**Figure 10. Percentage of adults who did not receive medical care or faced an excessive delay due to waiting lists by level of income**



**Source:** Compiled in-house using data in the 2014 European Health Survey in Spain and the 2017 National Health Survey.

**Figure 11. Percentage of adults with an unmet need for dental care by level of income**



**Source:** Compiled in-house using data in the Living Conditions Surveys.

The public authorities and citizens share the cost of medication needed to treat health problems. The copayment mechanism is useful for reducing public spending and, in theory, it makes the use of medication efficient. However, inadequate design may have a detrimental impact on health and equity of access. This may occur if people, for financial reasons, reduce compliance with the treatment necessary to safeguard their health or have to spend an excessive proportion of household income on medication.

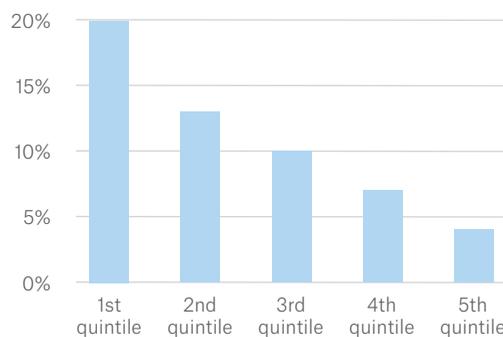
The Health Barometer indicates that among those surveyed, the percentage of people who for financial reasons have stopped taking medication prescribed by the public health system has fallen. However, this percentage has doubled to over 10% among groups such as the unemployed. Even though this copayment on medication has varied since 2012 in accordance with the patient's income level, there are no monthly upper limits to what patients pay except in the case of pensioners. Among the unemployed, only those whose benefit entitlement has run out are exempt from this copayment and the rest have to pay just like people in work.

Spending on medical treatment and other health items and services that are not fully covered by the public system can be difficult for people on low incomes who have health problems. According to European criteria, healthcare spending is regarded as catastrophic when it absorbs more than 40% of the household's ability to pay once spending to cover basic standard consumption in food and housing, energy and water has been taken into account. The incidence of catastrophic health spending among households in the first quintile almost doubled between 2006 and 2014 due to the combined impact of the financial crisis and the reform of the medication copayment system, and it did not begin to drop until 2017.

## WHEN TAKING CARE OF HEALTH COSTS TOO MUCH

The two most recent Living Conditions Surveys make it possible to analyse the difficulties people face in accessing basic public services. The data collected show that in 2016, nine out of every ten households had used health services in the previous twelve months (GP, specialist, dentist, prescriptions, etc.). Six out of every ten families had to make health-related payments at some point, and for one in ten covering this spending was difficult or very difficult. The degree of difficulty is clearly connected with income level: it affected 20% of people in the first income quintile, but just 4% of the group with the highest incomes.

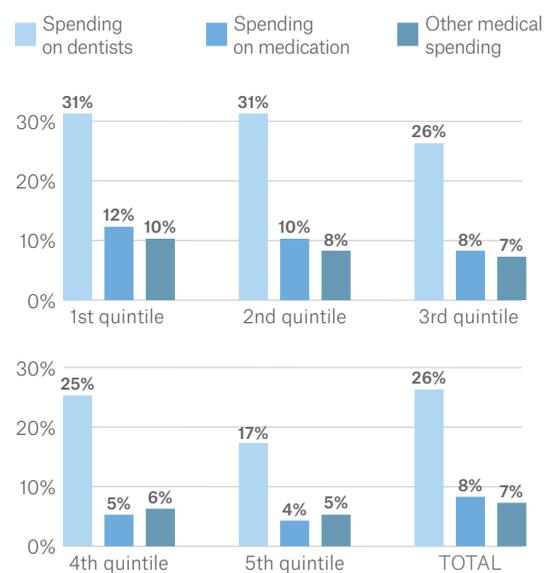
**Figure 12. Percentage of people whose households found it difficult to afford payments to use health services in the previous twelve months by income quintile**



**Source:** Compiled in-house using data in the 2016 Living Conditions Survey.

The 2017 survey contained different questions, but it too confirmed that health-related payments are a major burden for some families. Particularly notable is spending on dental care, which is perceived as a heavy financial burden by 26% of the population (a quarter of users). In the case of spending on other specialists or purchasing medication, the percentage exceeds 10% in the quintile with the lowest incomes, and is 5% or less among the highest-income group.

**Figure 13. Percentage of people whose households made health-related payments perceived as a heavy financial burden during the previous year**



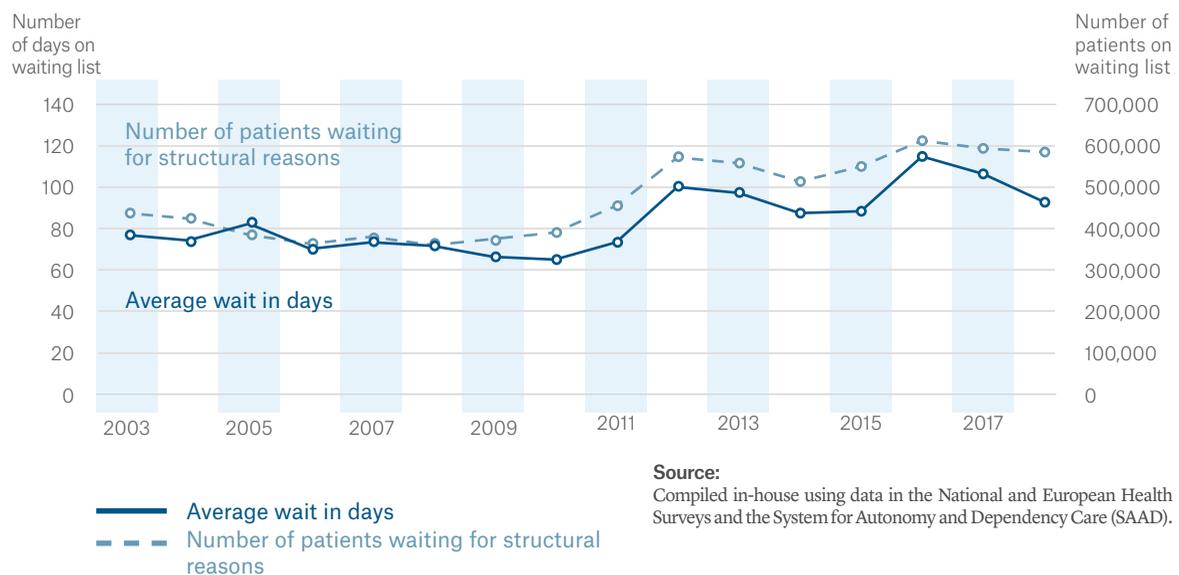
**Source:** Compiled in-house using data in the 2017 Living Conditions Survey.

## THE HEALTH SERVICE IN TIMES OF CRISIS

Official data regarding waiting lists published by the Ministry of Health since 2003 show that there is an objective reality behind citizens' perceptions. The number of patients on a structural waiting list for surgery (meaning patients waiting for an operation and whose wait is attributable

to the organisation of available resources) and the average number of days spent waiting fell in the years prior to the economic crisis but rose rapidly in 2011 and 2012, two years in which the public's perception of the problem worsened.

**Figure 14. Evolution in waiting lists for surgery since 2003**



## Fourth challenge: To guarantee access to dependency care

This challenge is measured using the indicators shown on this page. The meaning of the data is explained in the rest of the section.



### Key indicators on problems accessing dependency care in Spain

Legend in the graphs segmented by population group

- Population aged 65 and over
- ■ ■ ■ ■ Population aged 65 to 79
- Population aged 80 and over

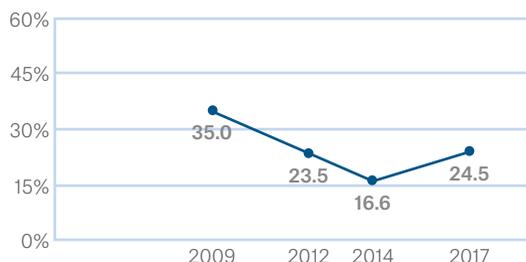
#### Senior citizens' self-perceived need for help:

Percentage of senior citizens (aged 65 and over) who face difficulties in some basic or instrumental activity of daily living and who believe they need more help than that which they are currently receiving.



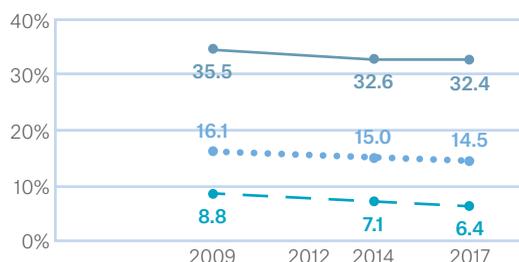
#### Registered waiting list:

Percentage of people of any age recognised as being dependent who are on the waiting list for services or other benefits from the System for Autonomy and Dependency Care (SAAD).



#### Demand for care among the elderly:

Percentage of senior citizens (aged 65 and over) with an estimated need for care according to health surveys.



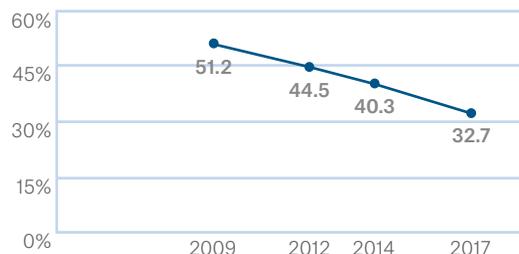
#### Shortfall in the provision of care for dependent senior citizens:

Percentage of senior citizens (aged 65 and over) with an estimated need for care who are not receiving care from the SAAD (because they have not requested it, because their application has been turned down, because they are on a waiting list, etc.).



#### Poor professionalisation among carers:

Percentage of benefits awarded by the SAAD consisting of aid for care in the family environment, expressed as a percentage of all benefits awarded.



Source:

Compiled in-house using data in the National and European Health Surveys and the System for Autonomy and Dependency Care (SAAD).

Dependency care is a right whose full provision as the fourth pillar of the welfare state (together with education, pensions and healthcare) is essential for meeting the needs of an ageing society. In Spain, the system for providing care to dependent people was launched just over ten years ago following the approval in December 2006 of Law 39/2006 on promoting personal independence and care for dependent people. The implementation of this system has been gradual and very slow, coinciding, as it did, with the economic crisis. Consequently, the indicators concerning the coverage and adequacy of the care provided are particularly important in this realm in order to evaluate unmet needs and to plan the additional investment needed.

One of the problems of the System for Autonomy and Dependency Care (SAAD), introduced in 2007, is the long wait before care benefits are received. In 2012, five years after the system came into operation, almost a quarter of the people assessed as dependent were waiting to receive care. During the financial crisis, the registered waiting list fell gradually, but this was due in large measure to the fact that the process for new dependency recognitions was halted and the deadline for incorporating moderately dependent people was extended to 2015. At the end of 2017, the percentage of dependent people waiting to be attended to was still similar to that recorded in 2012, though there was a downward trend.

Senior citizens are the main users of the dependency care system, as more than 70% of all beneficiaries are over the age of 65. For this group, it is possible, moreover, to estimate the real demand for care using the replies given in health surveys concerning their difficulties in performing basic activities of daily living (feeding themselves, getting out of bed, dealing with personal hygiene, etc.) and instrumental activities of daily living (cooking, shopping, household chores, etc.). If we apply an approximation of the official scale, we find that around 15% of senior citizens face limitations severe enough to require care provision by the SAAD. Among people aged over 80, the dependency rate is much higher, verging on 33%. The percentage of dependent senior citizens showed a slight downward trend in the period 2009-2017. The improvement is particularly noticeable among people aged between 65 and 79, as they enjoy greater autonomy than ten years ago. The evolution of this social need in the future will depend on the outcome of two opposing forces: the ageing of the population, which will lead to increased demand for care, and the overall

improvement in people's health, which could result in a reduction in the demand for care.

The implementation of the dependency care system has had a positive impact on access to long-term care, especially among the elderly over 80 years of age. However, the need for care remains insufficiently met if we bear in mind the figures on senior citizens' limitations found in health surveys. In 2017, almost half the senior citizens with an estimated need for care were outside the system. In many cases, these are people who have not applied to be assessed (or re-evaluated) by the SAAD as dependent. In some instances, people have requested this but their assessment has not yet been finalised.

This unmet need for dependency care is also reflected in the responses given by senior citizens who find it difficult to perform activities of daily living on their own: more than four in ten state they do not receive any help or that they receive less help than they require. The self-perceived need for help has fallen in the 65-79 age group, but not among those aged 80 and over, half of whom feel they need more help with at least one basic or instrumental activity of daily living. To meet this social need to a satisfactory degree, the care provided needs to be increased in both breadth and depth.

In addition to reaching all those who need care, the system ought to provide services that are sufficient and appropriate to needs. A major problem for the SAAD from the outset has been the excessive importance of financial benefits over direct services, and in particular the emphasis on the financial benefit paid for care in the family environment. This benefit, intended in the law to be exceptional, is a very small amount of financial aid granted to the family member caring for a dependent person in a manner that is incompatible with services such as home care or day centres. These benefits began by exceeding 50% of the total and still in 2014 were more than 40%, though there are major differences between autonomous communities. By late 2017, these benefits accounted for a third of the total, still a long way from the limited role they were intended to play by the law. This indicator reveals the degree of professionalisation in the SAAD: the lower the total financial aid for care in the family environment, the greater the professionalisation.

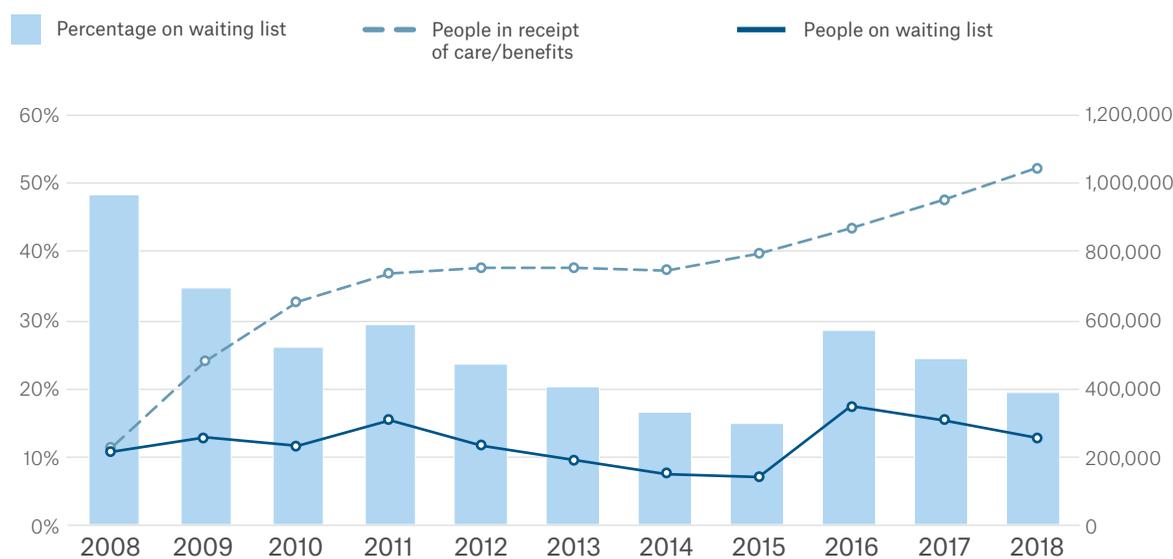
## THE CONSTRUCTION OF THE SYSTEM FOR AUTONOMY AND DEPENDENCY CARE (SAAD)

The number of dependent people served by the SAAD increased rapidly in the early years after the law came into force and amounted to more than 700,000 users in 2011. At that point, the number stabilised due to regulatory and procedural changes that slowed the incorporation of new cases and delayed the inclusion in the system of people with moderate dependency (those with the lowest level of dependency on the scale of those with a right to care). In 2015, the number of beneficiaries began

to rise again, eventually exceeding more than a million people in 2017.

The evolution in the registered waiting list reflects the various periods of advances and halts as the system moved towards full implementation. The reduction in the waiting list in recent years is different in nature to the fall that occurred in the period 2012-2015, which was due more to the deaths of people waiting for benefits than an increase in the number of beneficiaries.

**Figure 16. Number of people with a recognised right receiving care or benefits and on the waiting list (right axis), and the waiting list as a percentage of the total number of people with a recognised right (left axis)**



**Source:**  
Compiled in-house using data in the Information System of the System for Autonomy and Dependency Care (SI-SAAD).

## CARING FOR DEPENDENT RELATIVES: A HARD TASK FOR FAMILIES

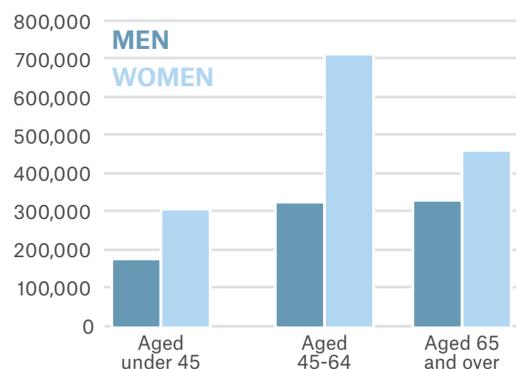
According to the 2016 Living Conditions Survey, some 3 million (amounting to one in six) households have someone at home who needs care due to their advancing years or because they suffer from a chronic illness. Of these, only 14% receive care at home from a paid carer, and only 4% of them have more than 20 hours of care a week. In general, families must pay for this care, especially when the number of hours rises, be it for services contracted privately or because of the copayment demanded by the SAAD (the data makes it impossible to distinguish between these two situations). It should be remembered that the maximum home care provided by the SAAD is around 16 hours per week in the case of extremely dependent people. Almost half of the households who receive these services find the cost of carers difficult or very difficult to cover, and although income levels do make a difference, the gap between income quintiles is not so pronounced as in the case of other types of payment.

As a consequence, there are around 930,000 households with an unmet need for home care, either because they receive no care at all or because the care provision is less than the hours required.

Seven out of ten cases give financial reasons as the grounds for why they do not have the necessary care. However, the second most important reason is the non-availability of these services (10% point to this as the prime reason).

Family involvement in care provision continues to cover some of the gaps in the system: 11% of adults care for a senior citizen or for someone with a chronic illness living in their own home or elsewhere, and 6% spend more than 20 hours a week providing this care. This intensive care, which cannot easily be combined with employment, is provided by women more than by men, and mainly middle-aged women (aged 45-64).

**Figure 17. Number of adults who spend more than 20 hours a week caring for relatives who are senior citizens or who suffer from chronic illnesses and need long-term care.**



Source:  
Compiled in-house using data in the 2016 Living Conditions Survey.

# THE SITUATION IN EUROPE



Figure 18. Summary of Spain's position in a ranking of health-related social needs in the European Union

## First challenge:



To maintain and improve people's state of health

### Self-perceived ill health:

Percentage of adults (people aged 16 or over) who declare that they have been in a poor or very poor state of health in the last twelve months. Age-adjusted percentage.



### Limitations in performing activity of daily living:

Percentage of adults (people aged 16 or over) with moderate or severe limitations affecting their activities of daily living in the last six months. Age-adjusted percentage.



### Severely limited senior citizens:

Percentage of senior citizens (aged 65 or over) with health problems that have resulted in severe limitations affecting their activities of daily living in the last six months.



## Third challenge:



To guarantee access to healthcare

### Inability to access medical care:

Percentage of adults (people aged 16 or over) who on some occasion in the last twelve months did not go to the doctor (excluding dentists) for financial reasons or because it was too far or because they had to wait too long.



### Inability to access dental care:

Percentage of adults (people aged 16 or over) who on some occasion in the last twelve months did not go to the dentist for financial reasons or because it was too far or because they had to wait too long.



Source:  
Compiled in-house using data from Eurostat (EU-SILC).

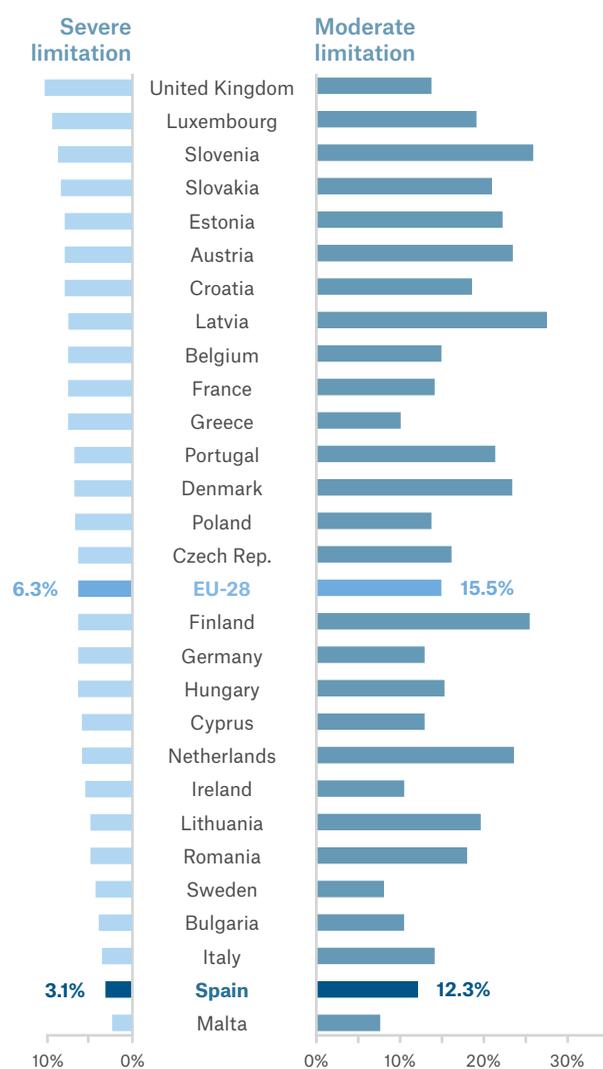
## State of health

Spain is an area of Europe that enjoys relatively high levels of good health. This is reflected in objective indicators, among them lifespan and the mortality and morbidity rates, but also in citizens' perceptions. Adjusting for age to prevent any undue influence of the various population pyramids, the percentage of the adult population who perceive their state of health to be poor is lower in Spain than the European average, and this advantage grew in 2017, the year in which the country ranked sixth for this parameter. Even though the morbidity rates are not very different to those of the European Union as a whole, Spain has succeeded in reducing the morbidity rate associated with the main diseases more quickly and intensively than other countries since the 1990s. Spain currently ranks among the five countries in the European Union with the lowest morbidity rates for ischemic heart disease, cerebrovascular disease and breast cancer and in some cases leads the table. Among the negative trends, it should be noted that the mortality rate among women for lung cancer is lower than the European average but it is nevertheless rising. Also on the rise since the beginning of this century is the incidence of syphilis and other sexually transmitted diseases (Ministry of Health, Social Services and Equality, 2017) in Spain and in Europe as a whole. Between 2012 and 2016, the number of cases of gonorrhoea, one of the diseases that has spread the most, went from seven to 15 out of every 100,000 inhabitants in Spain and from 13 to 19 out of every 100,000 inhabitants across the whole of the European Union according to data supplied by the European Centre for Disease Prevention and Control.

The situation with regard to limitations in activities of daily living due to health problems has also evolved favourably in Spain in comparison with its European neighbours. Following its mid-table position in 2009, the data for 2017 place Spain as the fourth country in the European Union with the lowest percentage of adults who declare that they suffer from some type of limitation (moderate or severe), and as the second country in a comparison of just severe limitations (figure 19). If the data for 2018 confirm this trend, it would be an improvement with potentially positive implications with regard to the future demand for long-term care. Indeed, it is among the population of adults over the age of 65 that there has been the biggest drop in the prevalence

of self-perceived severe limitations, both in Spain and in the average across the European Union. Using more recent data, Spain would occupy the fifth best position in the European ranking.

**Figure 19. Percentage of adults suffering from limitations that affect their activities of daily living, distributed according to the degree of limitation, 2017**



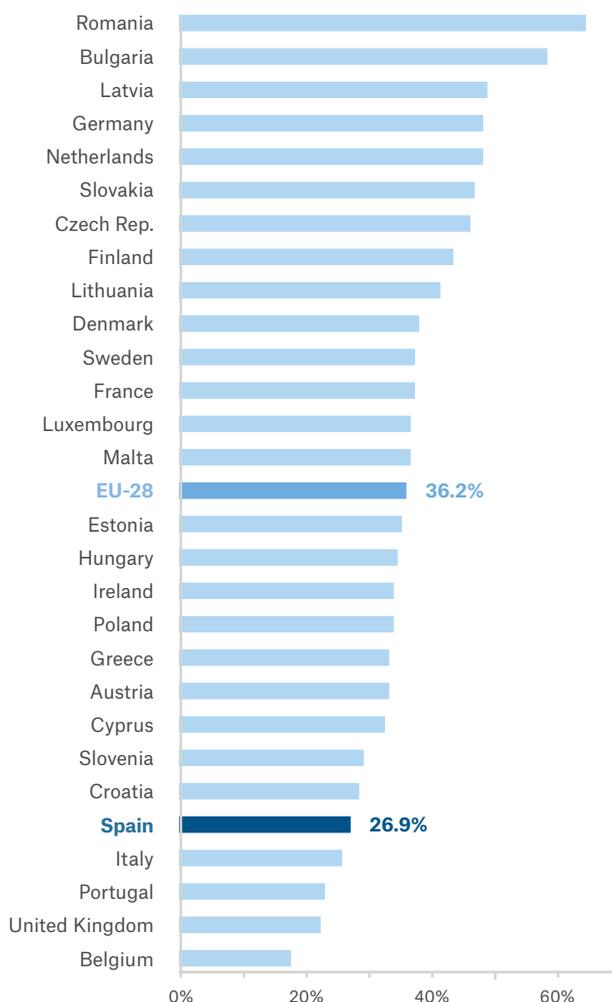
**Note:** Age-adjusted percentages.  
**Source:** Compiled in-house using data from Eurostat (EU-SILC).

## Healthy lifestyle habits

Spain occupies a mid-table position with regard to the adoption of healthy lifestyle habits in Europe, though there are differences depending on the indicator considered: Spain has a healthier diet, but also a higher level of consumption of illegal drugs such as cocaine or cannabis. Twenty-three per cent of adults smoke on a daily basis, a percentage similar to the European average and one that represents an improvement over the past. Patterns of alcohol consumption are not easily comparable due to differences in national customs: Spain has comparatively more people who drink on a daily basis but also a higher percentage of people who are teetotal according to the data collected by Eurostat.

Adherence to the Mediterranean diet is often regarded as one of the factors that might explain the longer lifespan in countries such as Spain, which, together with France, leads the European ranking for this indicator. The Mediterranean diet, which is rich in fruit, vegetables, grains, legumes, fish and olive oil, is deemed by the World Health Organization to have proven positive effects on people's health. According to the data for 2014, Spain stands out within the European Union as a country with a low percentage of the population who do not eat enough fruit and vegetables (figure 20).

**Figure 20. Percentage of adults (people aged 15 and over) who do not eat sufficient fruit and vegetables, 2014**



**Note:**

Age-adjusted percentages.

**Source:**

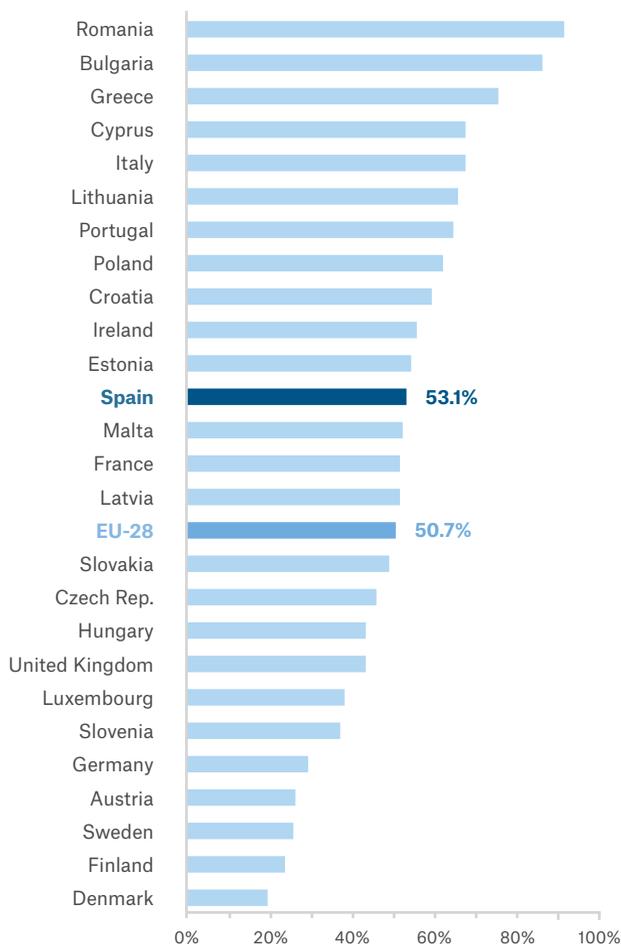
Compiled in-house using Eurostat, European Health Interview Survey data.

Along with diet, another factor that may have health-related consequences is citizens' habits in relation to physical activity. Spain does not emerge in a positive light in this area: just over half (53.1%) of adults dedicate no time during the week to physical activities regarded as beneficial for health. According to this indicator, the European average is 50.7%, whereas the rates in countries with the lowest levels of sedentary lifestyles (Austria, Sweden, Finland and Denmark) are around 20%. The greatest age-related differences in relation to the European average are to be found among senior citizens (aged over 65). In light of the importance of exercise in improving quality of life and preventing diseases (at any age), it is important to encourage physical activity, particularly among senior citizens.

Obesity is a growing health problem in Europe due to the combination of poor diets and insufficient physical activity. In 2014, Spain as a country had a prevalence of obesity higher than the European average (figure 22). The problem tends to increase with age in all countries and does so particularly in Spain, where adults aged over 65 are comparatively more obese (23.8%) than the average of the EU-28 (19.9%). However, perhaps the most worrying trend in Europe, in addition to that among adults over the age of 65, is the rise in obesity among young people. The rate of obesity among adults aged 25 to 34 stood at 10% in the EU and at 11.2% in Spain.

With regard to drug use, in 2015 Spain was one of the five countries in the European Union with the highest prevalence of illegal drug use among teenagers and young adults aged 15 to 34. Cannabis is the most widespread illegal drug consumed by the European population. In most countries, the percentage of teenagers and adults aged 15 to 34 who had consumed cannabis in the previous twelve months rose between 2008 and 2016. However, Spain is one of the seven countries in the European Union where this consumption fell between 2008 and 2016.

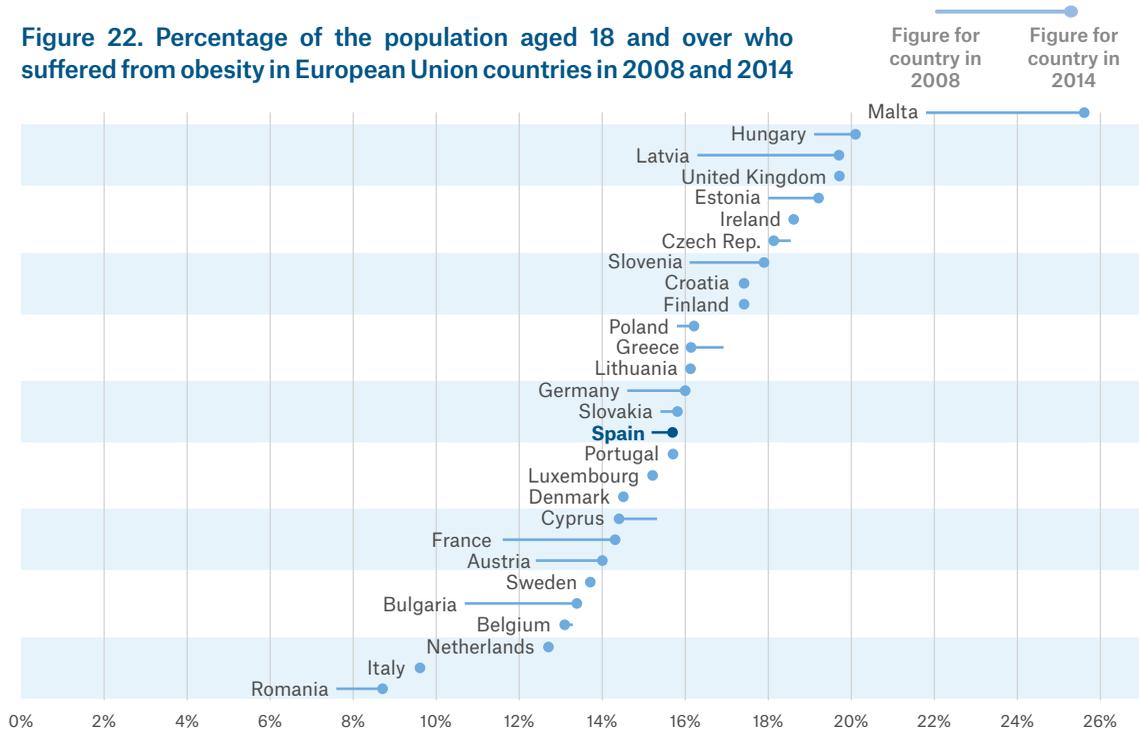
**Figure 21. Percentage of adults (people aged 15 and over) who took no physical exercise regarded as beneficial for health during the week in 2014**



**Note:**  
Age-adjusted percentages.

**Source:**  
Compiled in-house using Eurostat, European Health Interview Survey data.

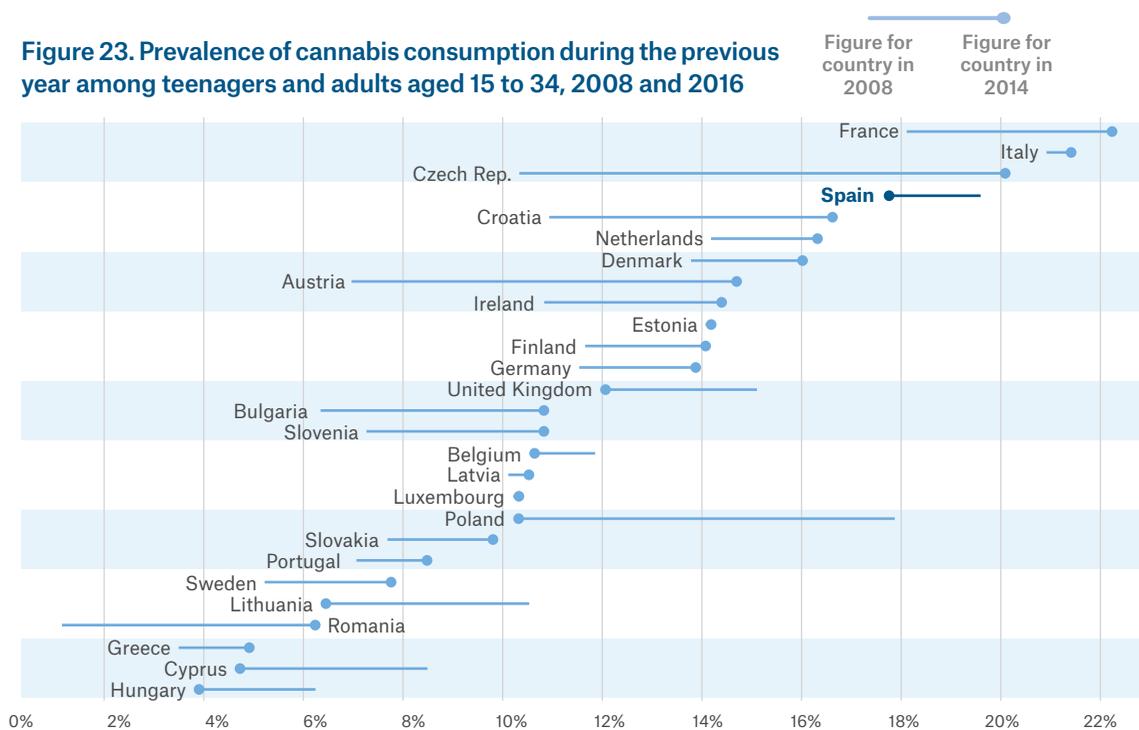
Figure 22. Percentage of the population aged 18 and over who suffered from obesity in European Union countries in 2008 and 2014



Source: Compiled in-house using Eurostat, European Health Interview Survey data.

Note: Age-adjusted percentages.

Figure 23. Prevalence of cannabis consumption during the previous year among teenagers and adults aged 15 to 34, 2008 and 2016



Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

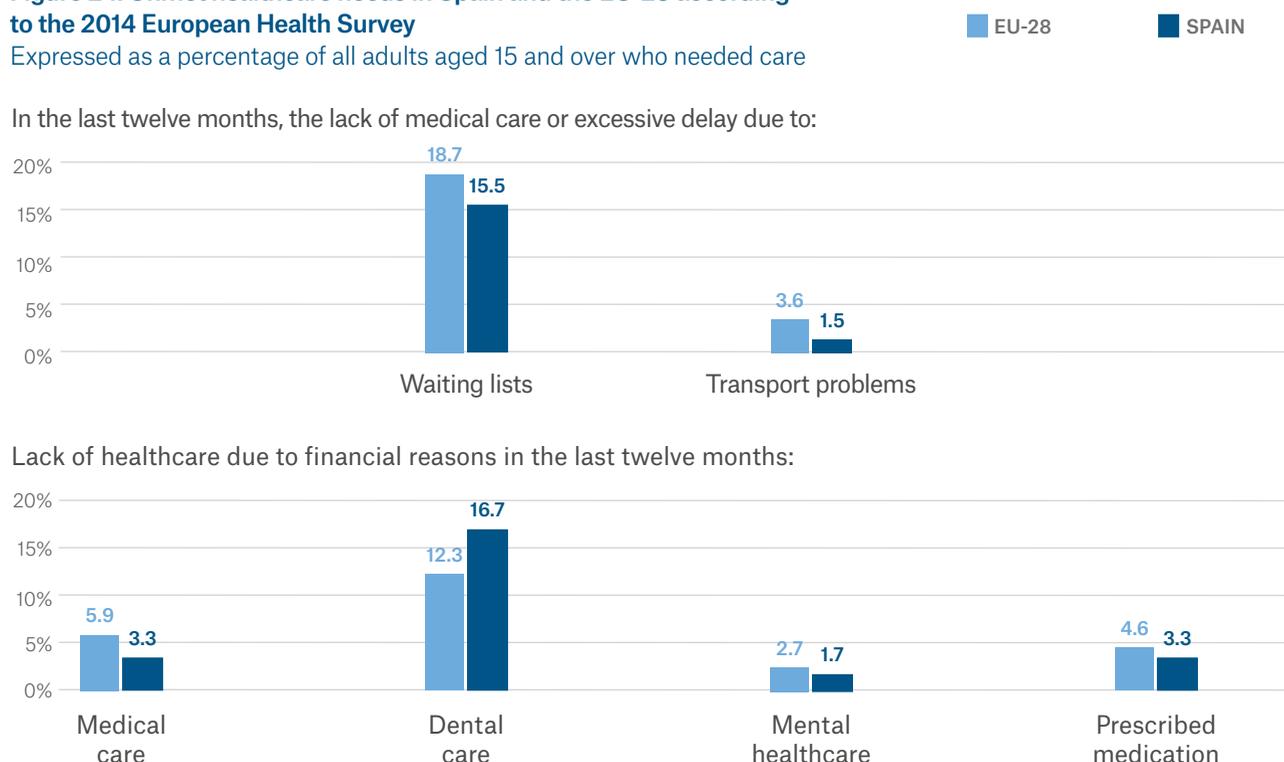
## Access to healthcare

Most European countries have universal health systems geared towards guaranteeing healthcare for all their citizens. As a result, the indicators concerning the inaccessibility of the health system are very low in this region of the world: fewer than 5% of adults declare they did not visit the doctor or dentist during the previous year for financial reasons or because of waiting lists or because it was too far to travel. In the case of general healthcare, the values for this indicator are practically zero in Spain, which tops a European ranking for 2017 in which the worst positions are occupied by Greece and Estonia (with values exceeding 10%). With regard to dental care, the inability to access this type of care exceeded 10% in Portugal, Greece and Estonia but nowhere else. This indicator rose in Spain during the financial crisis and went on to exceed the European average, which was still the case in 2017 (4% in Spain as opposed to the European average of 2.9%).

The European Health Survey carried out in European countries around 2014 included detailed questions to make it possible to compare access to healthcare (figure 24). The results expand on and confirm the situation outlined above: the Spanish healthcare system is one of the most accessible for citizens as far as general medical care, medication and mental healthcare are concerned, but performed worse than the European average in dental care. Conversely, Spain dropped down the table to eleventh position due to responses given to the question in the survey regarding the excessive delay in healthcare due to waiting lists.

**Figure 24. Unmet healthcare needs in Spain and the EU-28 according to the 2014 European Health Survey**

Expressed as a percentage of all adults aged 15 and over who needed care



**Source:**  
Compiled in-house using data in the 2014 European Health Survey in Spain and from Eurostat for the European average.

## Access to dependency care

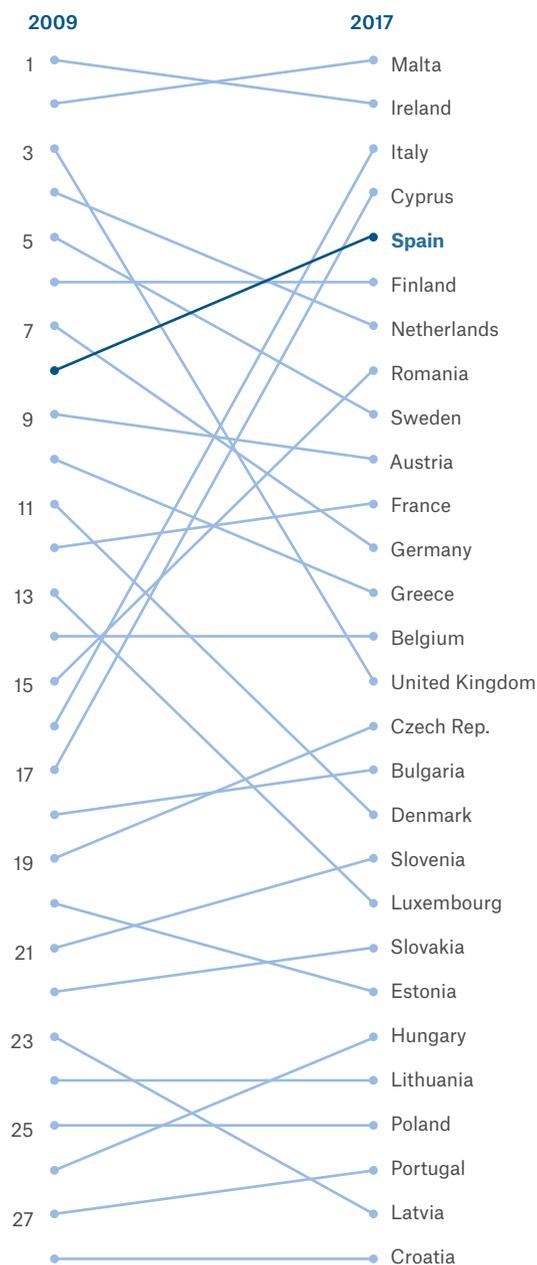
The ageing population will mean that there will be a growing demand for long-term care in all countries, though people's state of health may influence the way this evolves. The social need for this type of care among senior citizens can be estimated by analysing the frequency with which people in this group declare they are severely limited by health problems when it comes to performing activities of daily living. The available data show that Spain obtained better results in this indicator than the European average in both 2009 and 2017 following a greater reduction than that observed in Europe as a whole. It should be noted, however, that the figures are based on a single question that has a certain subjective element to it, as a consequence of which this improvement should be viewed with caution.

There is no European statistic that makes it possible to analyse how meeting this social need has evolved in the various countries, but the OECD furnishes comparable data for 18 Western countries (OECD, 2017). According to their figures, the percentage of senior citizens receiving long-term care in Spain remains lower than the OECD average (13%) even though it rose between 2005 and 2015, when it stood at 8.5%. In addition, a higher proportion of senior citizens receive care in their own homes. This reflects not only people's preferences, but also restrictions associated with the lack of places in residential care homes and day centres available for them.

## Spain's position in the ranking of society's health-related needs in the EU.

Countries arranged from best to worst in each of the indicators.

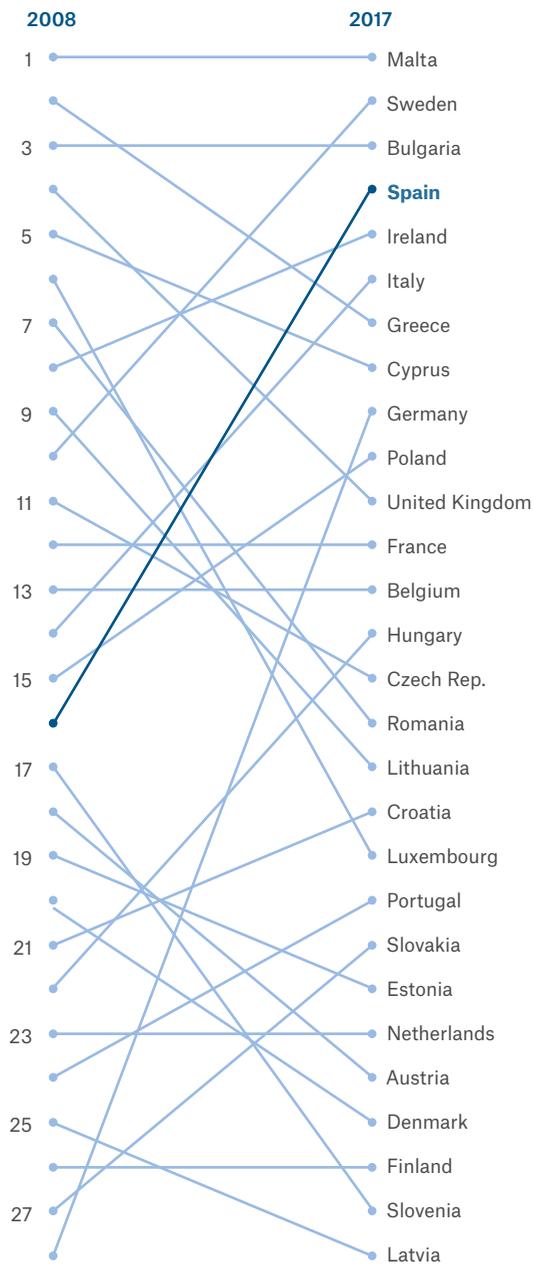
Figure 25. Self-perceived ill health



**Source:**  
Compiled in-house using data from Eurostat (EU-SILC).

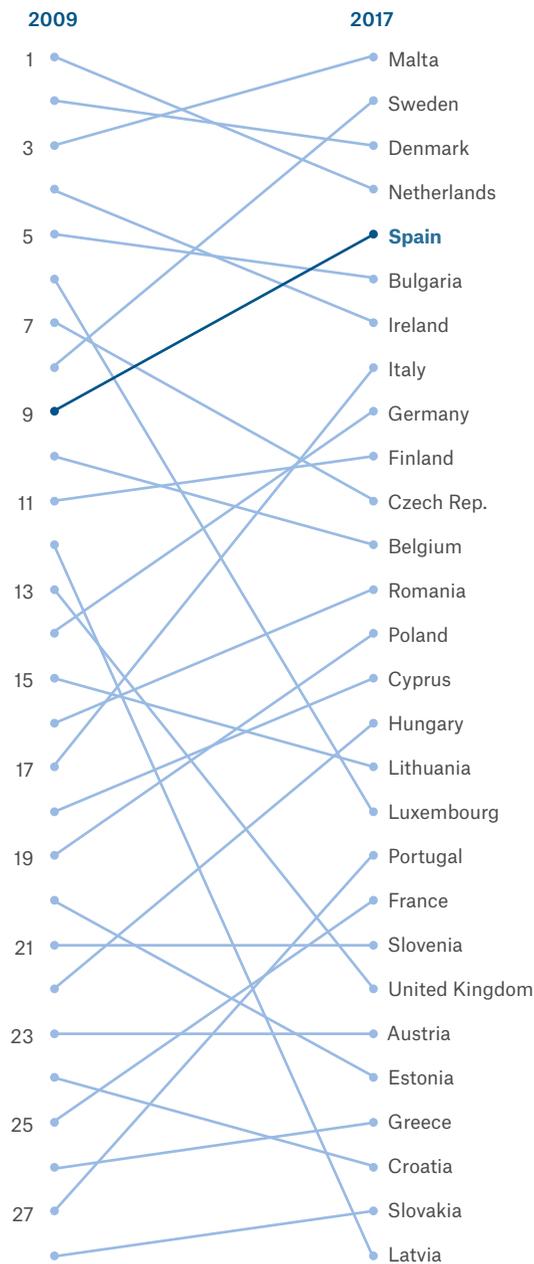
**Note:**  
The 2009 figure for Croatia is from the year 2010. The data for Ireland, the United Kingdom and Malta for 2017 in self-perceived ill health and limitations in daily living activity are from 2016.

**Figure 26. Limitations in performing activity of daily living**



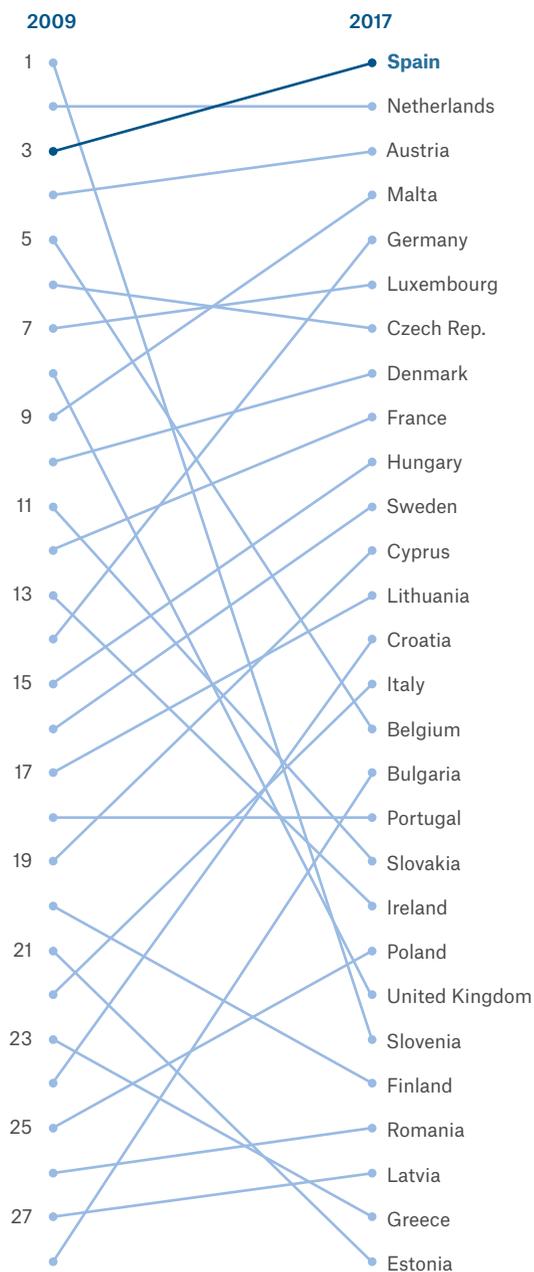
**Source:** Compiled in-house using data from Eurostat (EU-SILC).

**Figure 27. Severely limited senior citizens**



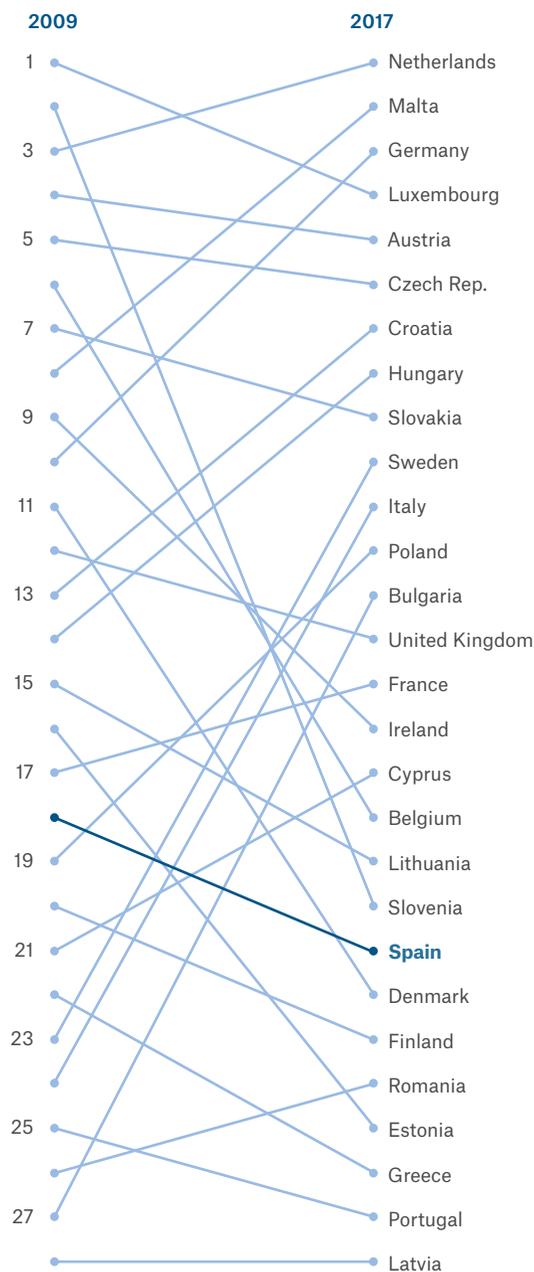
**Source:** Compiled in-house using data from Eurostat (EU-SILC).

Figure 28. Inability to access medical care



Source: Compiled in-house using data from Eurostat (EU-SILC).

Figure 29. Inability to access dental care



Source: Compiled in-house using data from Eurostat (EU-SILC).

# PUBLIC POLICIES



## Health spending and resources

One of the most important areas of public spending in Spain is health, which amounts to almost 6.3% of GDP. In the last 20 years, the system has expanded for a number of reasons. Firstly, the universal nature of the system, though limited in some phases due to the introduction of more restrictive access criteria, has meant that the size of the population served has grown constantly over the years. Secondly, the changes in the age structure of the population, with an increasingly large proportion of senior citizens over the age of 65, has led to an increase in chronic and long-term diseases, which has in turn put upward pressure on spending.

The strains caused by the combination of the universality of the system, the growing demand for healthcare and the budgetary restrictions affecting all public spending policies have not always been resolved in the form of an increase in the allocation of financial resources. Prior to the start of the last financial crisis, the trend in per capita spending was clearly upwards in real terms. The decline in economic activity and the period of budgetary consolidation that followed brought this trend to an end, with a considerable drop in the indicator back to the levels of ten years earlier. Since 2013, the indicator has begun to rise again, though at a slower pace than during the economic boom that preceded the recession.

The indicators most commonly used to compare health spending in European countries show that the level in Spain is below the average, although in terms of its position in the ranking, Spain is in the middle of the table. The relative level of spending is very similar to that of Italy and Portugal, giving rise to a certain Mediterranean model as regards the allocation of public funds to healthcare. One notable fact is that in general there is a close correlation between this indicator and countries' level of wealth. Those in Eastern Europe are a long way from the European average.

Spain's position in the middle of the ranking of European Union countries is also confirmed when the assessment of spending is analysed not in relation to population size but on the basis of each country's GDP. In any event, this gives rise to a certain improvement in Mediterranean systems, with the exception of Greece. Public spending on health has, however, grown very slowly in Spain in comparison with GDP in recent years, with the value for 2017 (6.3%) lower than that for 2009 (6.8%).

Figure 30. Spain: public spending on health per capita in real terms (taking 2016 as the baseline)



Source:

Key indicators of the Spanish National Health System (Ministry of Health, Social Services and Equality).

Figure 31. European Union: public spending on health per capita, 2017 (in €)

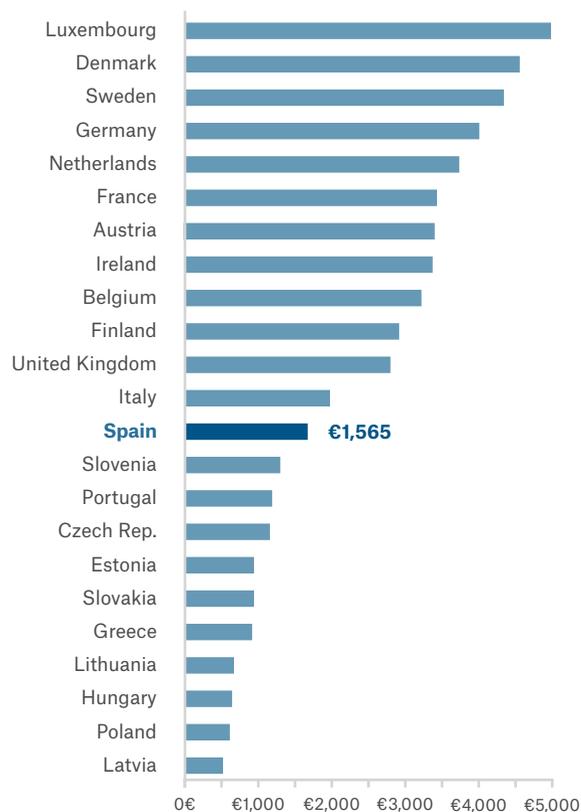
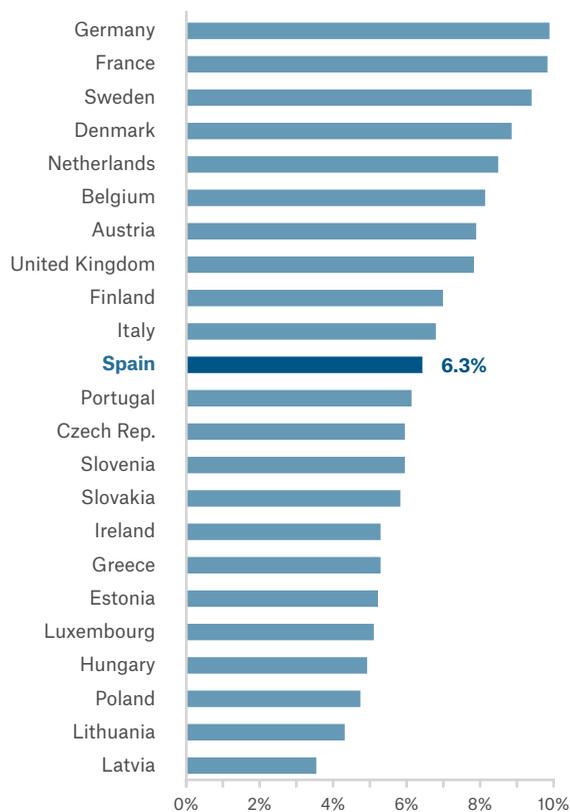


Figure 32. European Union: public spending on health as a percentage of GDP, 2017



Source: 2018 OECD Health Statistics.

Source: 2018 OECD Health Statistics.

## Financing pharmaceutical spending

Spending on pharmaceutical products in Spain has traditionally been a significant cost and higher than the European average as a proportion of total public spending on health. The part of this spending covered by patients used to be relatively small due in part to free prescriptions for incapacity benefit recipients and pensioners, who account for a large and growing proportion of medication consumption.

This situation changed with the reform introduced by Royal Decree 16/2012 on urgent measures to ensure the sustainability of the Spanish National Health System and to improve the quality and security of its services. Following this reform, incapacity benefit recipients and pensioners pay 10% of the cost of their medication unless they have an income of more than €100,000, in which case they pay 60%.

Monthly maximum limits were established of €8 for those on incomes below €22,000, €18 for those on incomes up to €100,000 and €60 for those on incomes higher than €100,000. Those in employment in the same income brackets pay 40%, 50% and 60% of the price with no monthly maximum limit. There are exemptions for groups such as incapacity benefit recipients and pensioners receiving non-contributory benefits, the unemployed whose benefit entitlement has expired and treatments needed for a work-related disease, and a maximum of €4.13 has been established for each prescription for the chronically ill. It is important to note that public employees, both those currently in work and retired, were excluded from the copayment reform and continue to contribute 30% of the cost with no monthly maximum limit and regardless of their income level.

## The challenge of long-term care

According to the OECD, long-term care is the element of health spending that has risen the most in recent years due to the ageing of the population. The latest projections calculate that the proportion of GDP allocated to this care could double or more by the year 2060 (OECD, 2017).

There are currently significant differences in the public funds allocated to this policy in the various countries in the OECD. A number of countries in northern Europe are at the top of the ranking, allocating to long-term care more than 2% of their GDP. Spain remains well below the average, despite the increase in spending since the System for Autonomy and Dependency Care (SAAD) was put in place in 2007, as it devotes just 0.8% of GDP to long-term care. This percentage is almost five times lower than the amount spent on long-term care in the Netherlands. In Spain, there are also fewer formal carers per thousand inhabitants, and fewer places in care institutions, than the average in the 18 countries of the OECD for which comparable data exist.

The organisation of the care system determines the level and structure of the spending in the various countries. Spain devotes approximately two-thirds of its spending to people residing in institutions, a percentage similar to the OECD average. This percentage is higher in countries such as Canada, Estonia, Iceland and Hungary, but much lower in others, among them Denmark, Poland and Finland.

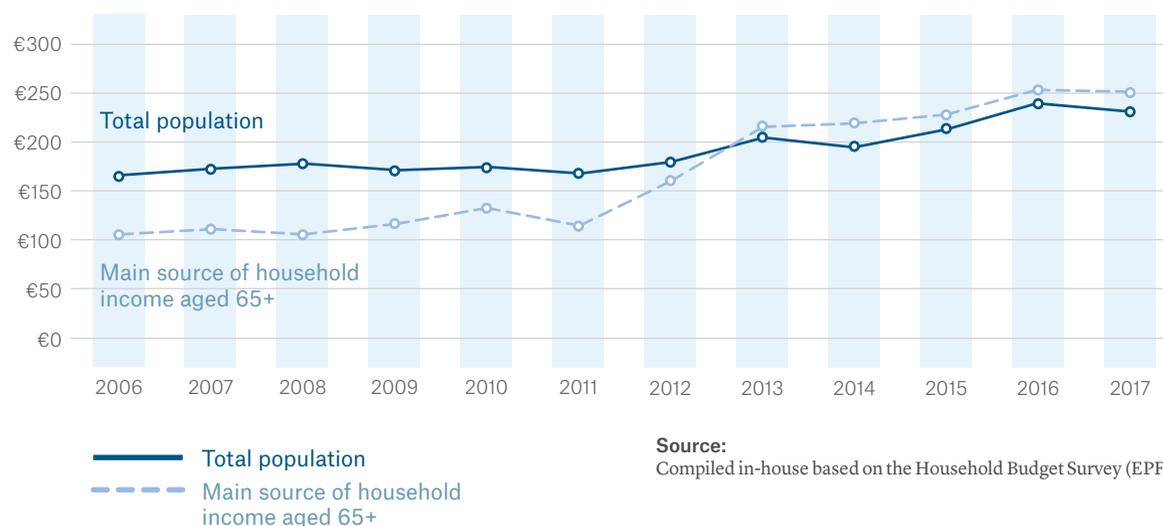
## FAMILIES' SPENDING ON PHARMACEUTICAL PRODUCTS RISES AFTER THE COPAYMENT REFORM

The copayment reform of 2012 increased the percentage of the cost of medication that is paid by users, especially in the case of incapacity benefit recipients and pensioners. This change is reflected in the average spending on pharmaceutical products per household, which rose in families led by persons aged 65 and over from €100 in 2011 to some €220 in 2013, according to Household Budget Survey (EPF) data.

This means that expenditure on medication accounts for a larger proportion of household spending following the copayment reform. If we look at income levels, the largest increase is to be found in households in the second,

third and fourth deciles, the income brackets in which most incapacity benefit recipients and pensioners are to be found. Even though the new copayment system has the benefit of differentiating payments on the basis of income level, unlike the previous system, it still contains aspects that have been questioned by health experts. One of these aspects is the lack of monthly maximum limits for people in jobs and the unemployed, which may ultimately turn the copayment into a veritable 'tax on illness' for people who have multiple health problems. Another aspect is the fact that the general mechanism is not applied to the Civil Service mutual societies.

Figure 33. Average spending on pharmaceutical products per household, 2006-2017



## Coverage of the health system

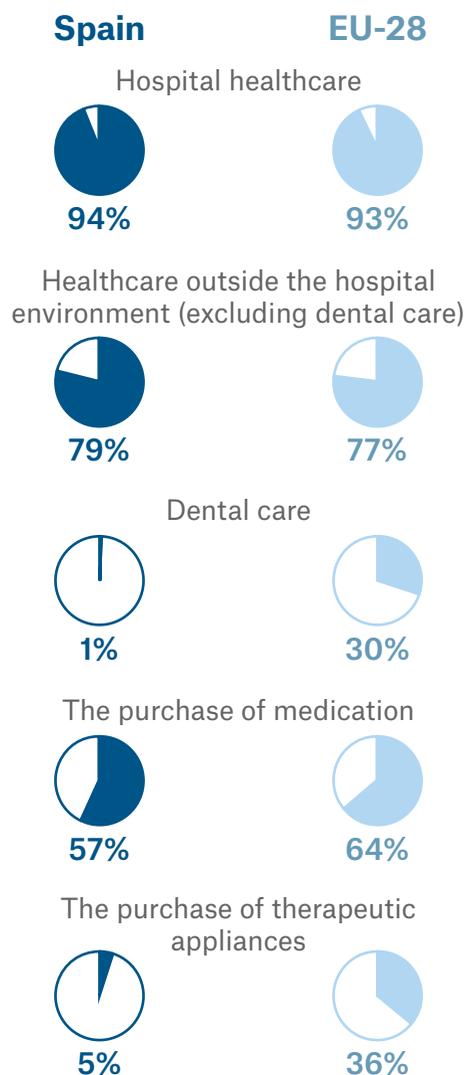
Most countries in the European Union, including Spain, have universal or almost universal health systems. Private health insurance is held by 15% of Spain's population, a higher percentage than in countries like Sweden, Lithuania and Bulgaria, where it is almost non-existent. Within Europe, there are some countries (France, Netherlands, Slovenia, Belgium and Croatia) where more than half of the population has private cover that complements or supplements the public system. In the case of France, virtually all citizens have private health insurance that covers the cost of the public system copayments.

The scope of the cover provided depends on the percentage of the population covered (breadth of the cover), but also on the type of services and other benefits included (depth of the cover) and the proportion of the costs covered (extent of the cover). The OECD compares the overall cover for five central functions, delimited according to the definitions in the System of Health Accounts: i) hospital healthcare, ii) healthcare outside the hospital environment (excluding dental care), iii) dental care, iv) the purchase of medication, and v) the purchase of therapeutic appliances (hearing aids, glasses, etc.). To do this, it analyses the percentage of total spending for each function that is financed by the public purse.

Spain is about average in healthcare provision in and outside the hospital environment, but below the average in relation to the purchase of pharmaceuticals. In addition, very little public spending goes towards dental care and the purchase of therapeutic devices and hence this expenditure is far below the European average.

**Figure 34. Healthcare cover for certain goods and services, 2016**

(Public spending and expenditure on compulsory health insurance as a proportion of total spending per type of service)



**Source:**  
OECD/EU (2018).

Other types of indicator that make it possible to interpret the cover offered by the public health system are the number of healthcare staff and the prevention of diseases through vaccination programmes. In recent years, there has been a gradual, albeit moderate, rise in the number of healthcare staff, an increase that was particularly modest during the economic crisis. In the most common vaccination programmes, the results vary, with no notable changes in primary vaccination but a considerable drop since the start of the recession in flu vaccination for people aged over 64.

**Figure 35. Healthcare personnel and vaccination cover**

	2006	2009	2014	2016
Specialist medical staff per thousand inhabitants	1.64	1.81	1,81	1.90
Primary medical staff per thousand people assigned to them	0.73	0.74	0.76	0.77
Cover (percentage) of adults over the age of 64 vaccinated against flu	67.6%	65.7%	56.2%	55.5%
Cover (percentage) of MMR (measles, mumps and rubella) vaccinations (primary vaccination)	96.9%	97.4%	96.1%	96.7%
Cover (percentage) of polio vaccinations (primary vaccination at the age of 0-1)	97.6%	95.9%	96.6%	97.2%

**Source:**

Key indicators of the Spanish National Health System (Ministry of Health, Social Services and Equality).

## The efficiency of the public health system

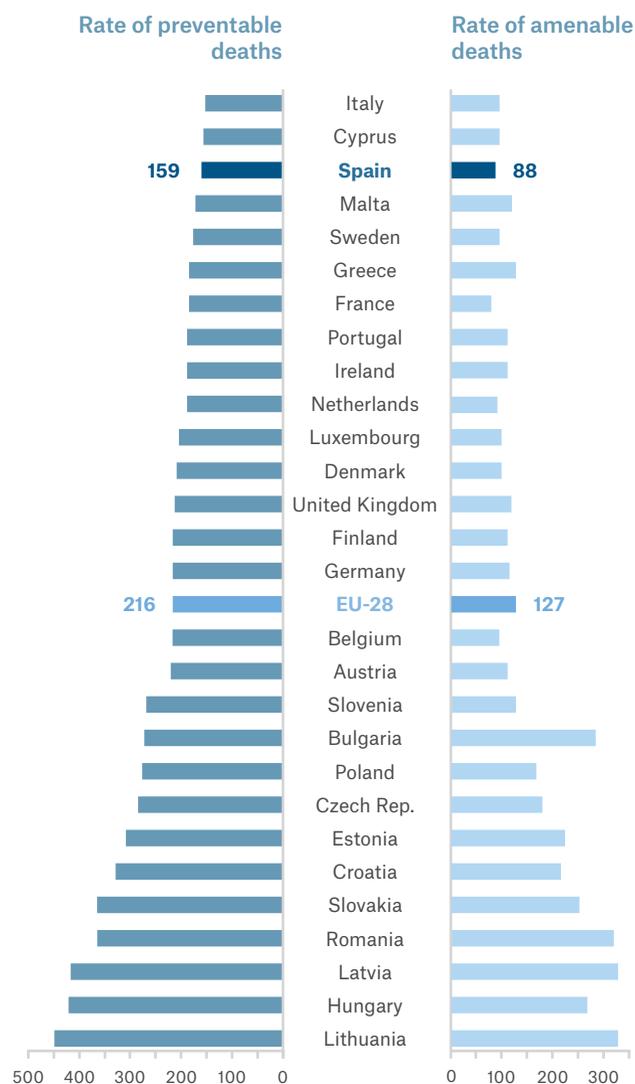
One result common to comparative analyses of public health systems is that traditionally Spain ranks higher in efficiency indicators than it does in spending indicators. One of the possible indicators that can be used to measure these results is the rate of unnecessarily early and medically preventable deaths. This indicator is frequently used in the analysis of the quality and outcomes of health systems.

This indicator makes it possible to distinguish between amenable (treatable) deaths and preventable deaths. A death is deemed to be amenable if, in the light of current medical knowledge and technology, all or most deaths due to this cause, taking age limits into account, could have been prevented by means of quality healthcare. A death is preventable if, in the light of current knowledge of the factors that determine health, all or most deaths due to this cause, taking age limits into account, could have been prevented by public health interventions in the broadest sense. Whereas the first of these indicators makes reference to shortcomings attributable to the health system, the second is related to the capacity of health policies.

As some studies show, more amenable deaths were traditionally recorded in Spain than those categorised as preventable (Oliva et al., 2016). Nevertheless, the differences have gradually reduced over the years, fundamentally due to the greater fall in amenable deaths, part of a general downward trend in both causes. The economic crisis, however, put a halt to this trend, so much so that the rate of preventable deaths actually rose at some point during these years.

When Spain's data are compared with those of other European countries, it ranks highly, with results noticeably better than those of countries with relatively higher spending on health. As the OECD points out (2017), this good result is due to a large extent to the falls and decreasing rates of death due to ischemic heart disease and stroke.

**Figure 36. Rate of unnecessarily early and medically preventable deaths, 2015**  
(Standardised rates per thousand inhabitants)



**Source:**  
OECD Health Statistics 2018.

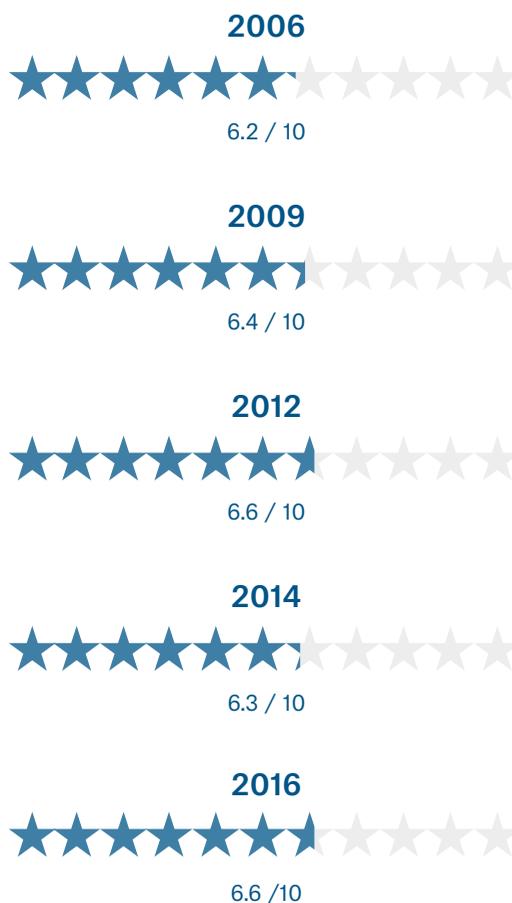
## The degree of satisfaction among users of the health system

One of the mainstays of any health system is citizens' perception of the quality of the healthcare services they receive from the public system. Generally, the system is highly rated in comparison with other areas of public spending. Fiscal barometers, such as the one used by the Institute of Fiscal Studies, usually identify healthcare spending as one of the few for which Spanish citizens would be prepared to pay more tax.

As figure 37 shows, the data that sum up the general level of satisfaction with the health system have been relatively stable in the last ten years, which seems to indicate that, despite the slight reduction during the worst moments of the economic crisis, the severe downturn in the economy during this period did not erode the public's evaluation of the system to any lasting or significant degree. Even so, when this assessment is broken down into different areas, citizens' perception of the quality of the services provided shows growing dissatisfaction. In the case of primary healthcare, the percentage of people surveyed who thought this type of service had worsened rose by more than 20 points during the recession. And this figure increased by almost 30 points in the other areas. In every area, the perception of the decline in the quality of the system is considerably greater than before the economic crisis.

Figure 37. Perception of the health system

Overall satisfaction with the public health system (from 1 to 10 [1: very dissatisfied; 10: very satisfied])



### Perception of the health system

Percentage of those surveyed who believe...

	2006	2009	2012	2014	2016
... primary healthcare has grown worse	5.2%	8.3%	19.8%	29.7%	21.2%
... specialist healthcare consultations have grown worse	6.5%	9.7%	22.1%	37.3%	28.7%
... inpatient care has grown worse	5.3%	8.9%	21.1%	35.6%	27.3%
... A&E has grown worse			28.3%	43.1%	35.2%

**Source:**

Health Barometer (Ministry of Health, Consumer Affairs and Social Welfare).

## EVALUATING THE DEGREE OF FINANCIAL PROTECTION: CATASTROPHIC SPENDING ON HEALTH

The degree of financial protection in relation to health is measured using the indicators of ‘catastrophic spending’ (when spending on health takes up more than 10% of a household’s income) and ‘impoverishment from medical expenses’ (healthcare spending leaves the family below the poverty line).

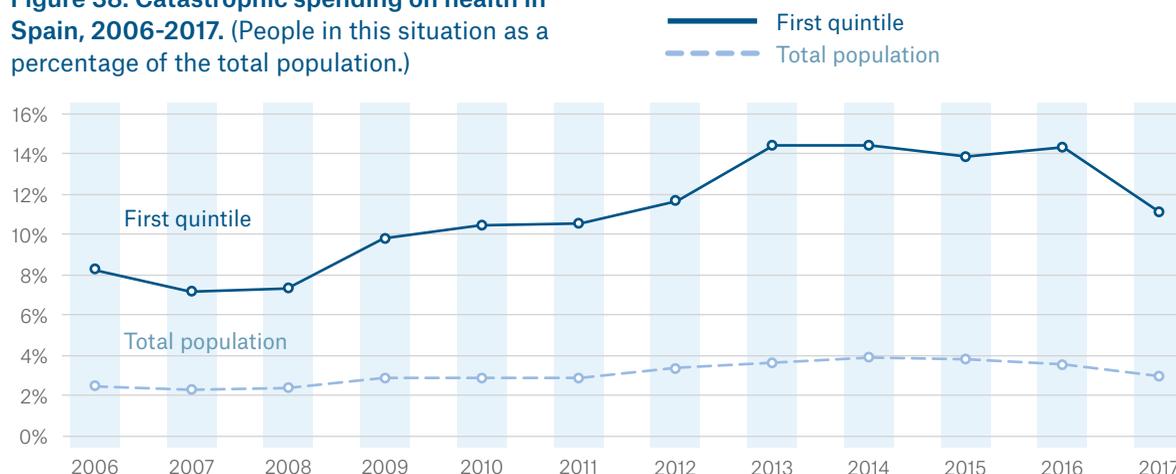
The Regional Office for Europe of the World Health Organization recently devised a methodology applicable to the Household Budget Surveys (EPF) in Spain. Each household’s ability to pay is calculated by subtracting from their financial resources a standard amount to cover the cost of food, housing, energy and water (around €450 a month in 2017 for a single-person household).

The household is deemed to have catastrophic healthcare spending when payments exceed 40% of this calculated ability to pay.

Using this definition, the incidence of catastrophic spending rose in Spain between 2006 and 2016, with two moments of obvious impact associated with the start of the economic crisis and the copayment reform (2013). The increase was particularly severe among families in the worst socioeconomic circumstances.

In households with a negative ability to pay (households whose resources do not even cover the cost of their basic needs), any healthcare payment is by definition catastrophic.

**Figure 38. Catastrophic spending on health in Spain, 2006-2017.** (People in this situation as a percentage of the total population.)



Source: Compiled in-house using data in the Household Budget Surveys (EPF).

# CONCLUSIONS

## 1 People's state of good health

One of the most important goals of efforts to meet society's needs in any country is to improve the population's state of health. The set of data concerning the state of health of the Spanish population show that there has been a considerable improvement in recent years. There has also been a reduction in the percentage of people whose poor health limits their ability to pursue daily activities and in the percentage of the chronically ill diagnosed with hypertension. There has, however, been a rise in other diseases such as diabetes and high cholesterol as well as anxiety, depression and other mental disorders.

## 2 Healthier lifestyles

Mention must also be made of the improvements in the promotion of healthy lifestyles. In recent years, there has been a reduction in the number of people living purely sedentary lives, as well as an increase in the proportion of the population following a healthy diet, a key factor in preventing chronic illnesses and other health problems. There has, however, been a rise in the incidence of obesity, with its prevalence among children being particularly worrying due to its short-term and long-term impact on their health, and because of the associated substantial direct and indirect costs to the health system.

## 3 Few barriers to access to the health system

Of all the countries in Europe, Spain is the one that has the best access to the health system; in other words, it is the country where the population has the fewest problems in accessing health services. Universal coverage means that hardly anyone has to forego seeing their doctor due to a lack of money or because of the distance or because they cannot get an appointment. Even so, this coverage does not guarantee effective access to the package of services necessary to safeguard people's health. Difficulties of access in some aspects, such as visits to the dentist or the purchase of medication, are higher than the European average, essentially because of financial issues. Low-income families sometimes find themselves facing health-related costs that are excessive in relation to their ability to pay. These problems doubled during the economic crisis due to the combined impact of the fall in income and the medication copayment reform. In other instances, barriers to access are due to waiting lists, a problem that also worsened during the recession.

## 4 Increasing dependency care

The implementation of the public dependency care system has improved the degree to which society's need for long-term care is met. Nevertheless, there still exists an unmet need for care, as well as insufficient professionalisation among carers. One of the problems in the System for Autonomy and Dependency Care (SAAD) has been the lengthy delays in the provision of services and benefits. In any event, even though the percentage of dependent senior citizens has fallen slightly in recent years, the ageing of the population inevitably means there will have to be an increase in cover and in the amount of care provided.

## 5 Doing better than Europe

The level of satisfaction connected with some of the challenges that affect society's health-related needs is, in general, higher in Spain than in the rest of Europe. Objective indicators such as life expectancy and the mortality and morbidity rates, but also citizens' own perceptions, reflect the fact that the population in Spain is in a better state of health than the populations of most other European countries. There are also comparatively fewer people over the age of 65 who declare that they suffer severe limitations in their everyday lives due to health problems, an indicator in which there has, moreover, been an improvement in the last ten years.

## 6 Worse than Europe

The situation with regard to healthy lifestyle habits is not as positive, as Spain occupies a mid-table position in Europe. The Spanish diet is healthier, but there is a higher consumption of illegal drugs such as cocaine and cannabis. Spain and other countries in Europe are very alike with regard to the percentage of people who smoke every day or who consume alcohol, but it is behind in terms of the physical activities deemed beneficial to health, the incidence of obesity and young people's use of illegal drugs.

## 7 Trends in health-related spending

The levels of expenditure on health in recent years have been detrimentally affected by the strains caused by the combination of the universal nature of the system, the growing demand for healthcare and the budgetary restrictions affecting all public spending policies. Spending per capita rose in the years leading up to the economic crisis, at which time this trend came to an end. Since the economy began to recover, the amount of spending per capita has risen again, though at a slower pace than prior to the recession. Despite the upward trend over the long term, Spain continues to occupy a mid-table position among European countries, both as regards per capita spending and as a percentage of GDP.

## 8 Expenditure on medication and copayment

A significant proportion of healthcare spending in Spain goes towards expenditure on pharmaceutical products, which has traditionally been a considerable burden and is higher than the European average within all public healthcare spending. Until recently, the amount of this spending that patients covered out of their own pocket was relatively small, in part due to the exemption of incapacity benefit recipients and pensioners, who are responsible for a high and growing proportion of the consumption of medication. The introduction of the copayment system, however, increased the percentage of the cost covered by users, particularly in the case of incapacity benefit recipients and pensioners. This change has led to an increase in average spending on pharmaceutical products per household, with medication now absorbing a larger proportion of family income in households in the middle-to-low income brackets.

## 9 Efficiency in healthcare spending

Despite the reduction in the financial resources allocated to the public health system, Spain comes out as one of the top countries in a ranking of the effectiveness of this spending. The indicators on unnecessarily early and medically preventable deaths failed to improve during the economic crisis but even so they remained lower than those of other countries with higher spending. However, this greater efficiency and the tendency to improve seem not to be perceived by the public, who believe that healthcare services have deteriorated in most of the main areas.

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