



World Health
Organization

REGIONAL OFFICE FOR Europe

Can people afford to pay for health care?

New evidence
on financial protection
in Europe



Summary

WHO Barcelona Office for Health Systems Strengthening

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage. It works with Member States across WHO's European Region to promote evidence-informed policy making.

A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring financial protection – the impact of out-of-pocket payments for health on living standards and poverty. Financial protection is a core dimension of health system performance and an indicator for the Sustainable Development Goals.

The Office supports countries to develop policy, monitor progress and design reforms through health system problem diagnosis, analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience. It is also the home for WHO training courses on health financing and health systems strengthening for better health outcomes.

Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Health Systems and Public Health of the WHO Regional Office for Europe.





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Abstract

Out-of-pocket payments for health can create a financial barrier to access, resulting in unmet need. They can also lead to financial hardship for people using health services. This report brings together for the first time data on unmet need and financial hardship to assess whether people living in Europe can afford to pay for health care.

Drawing on contributions from national experts in 24 countries, the report shows that financial hardship varies widely in Europe, and that there is room for improvement even in high-income countries that provide the whole population with access to publicly financed health services. Catastrophic health spending is heavily concentrated among the poorest households in all of the countries in the study. Where financial protection is relatively weak, catastrophic spending is mainly driven by out-of-pocket payments for outpatient medicines.

Health systems with strong financial protection and low levels of unmet need share the following features: there are no large gaps in health coverage; coverage policy is carefully designed to minimize access barriers and out-of-pocket payments, particularly for poor people and regular users of health services; public spending on health is high enough to ensure timely access to a broad range of health services without informal payments; and as a result, out-of-pocket payments are low, accounting for less than or close to 15% of current spending on health.

Gaps in coverage arise from weaknesses in the design of three policy areas: population entitlement, the benefits package and user charges (co-payments). The report summarizes actions that can reduce unmet need and financial hardship by strengthening coverage policy. It also highlights actions that should be avoided.

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Out-of-pocket payments undermine universal health coverage

Ensuring everyone can use the health services they need without experiencing financial hardship – universal health coverage – is a Sustainable Development Goal all countries have committed to reach by 2030 (United Nations, 2015), and a priority for the World Health Organization (WHO).

When people have to pay out of pocket for health care, some of them face barriers to access and forego treatment due to the cost involved; some pay and suffer financial hardship; and some experience both unmet need and financial hardship.

This study is the first systematic and comprehensive analysis of financial protection in Europe (WHO Regional Office for Europe, 2019). Drawing on contributions from national experts in 24 countries, it finds that:

- between 1% and 9% of households are pushed into poverty, or further into poverty, as a result of out-of-pocket payments;
- between 1% and 17% of households experience catastrophic health spending, which may mean they can no longer afford to meet other basic needs such as food, housing and heating;
- catastrophic health spending is consistently concentrated among the poorest 20% of the population;
- it is mainly driven by out-of-pocket payments for outpatient medicines; and
- the share of people foregoing needed health services, including prescribed medicines, is high in countries where financial protection is weak.

What is financial protection, why does it matter and how is it measured?

Financial protection is a core dimension of health system performance and central to universal health coverage.

People experience financial hardship when out-of-pocket payments are large in relation to their ability to pay for health care. Small out-of-pocket payments can cause financial hardship for poor households or those who have to pay for long-term treatment. Large out-of-pocket payments can lead to financial hardship for rich households as well as poor households.

Where health systems fail to provide financial protection, some people may be forced to choose between using health services and meeting other basic needs such as food, housing and heating; some may forego health care, resulting in unmet need. Lack of financial protection reduces access to health care, undermines health status, deepens poverty and exacerbates health and socioeconomic inequalities.

Because all health systems involve some out-of-pocket payment, financial hardship linked to the use of health services can be a problem in any country.

Financial protection is measured using two indicators:

Impoverishing health spending provides information on the impact of out-of-pocket payments on poverty. A household is impoverished if its consumption is above the poverty line before spending out of pocket and below it after spending out of pocket (it is no longer able to afford to meet basic needs). A household can also experience impoverishing health spending if its consumption before spending out of pocket was already below the poverty line (it was already unable to meet basic needs); it is further impoverished after spending out of pocket.

Catastrophic health spending occurs when the amount a household pays out of pocket exceeds a predefined share of its ability to pay for health care. This may mean the household can no longer afford to meet other basic needs.

These indicators can be calculated in different ways, using a range of metrics. The WHO Regional Office for Europe has developed new metrics to measure financial protection in response to concerns that the method used to measure financial protection in the Sustainable Development Goals (SDG target 3.8.2), and other global approaches, pose a challenge for equity and have limited relevance for Europe.

Building on established methods, the metrics used in this study are less likely to underestimate financial hardship among poorer people than the SDG metrics because they account for differences in household

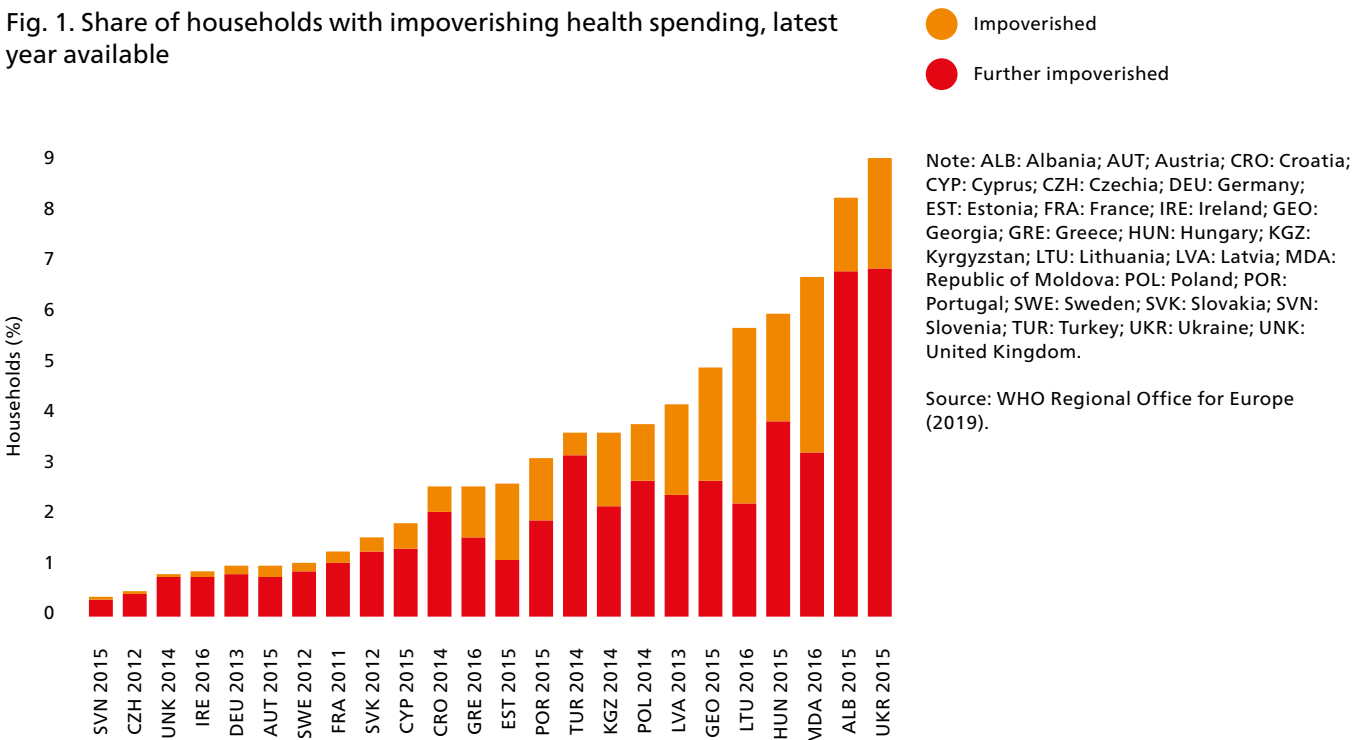
capacity to pay for health care (Cylus et al., 2018; WHO & World Bank, 2017). The aim is to measure financial protection in a way that is relevant to all countries in Europe, produces actionable evidence for policy and promotes policies to break the link between ill health and poverty.

All metrics draw on similar sources of data, typically household budget surveys; define out-of-pocket payments in the same internationally standard way as formal and informal payments made at the time of using any health care good or service provided by any type of provider; and measure financial protection at the level of the health system, not at the level of different types of health care, diseases or patient groups.

Out-of-pocket payments push people into poverty or make poor people even poorer

There is wide variation in the incidence of impoverishing health spending among European Union (EU) countries and among non-EU countries (Fig. 1).

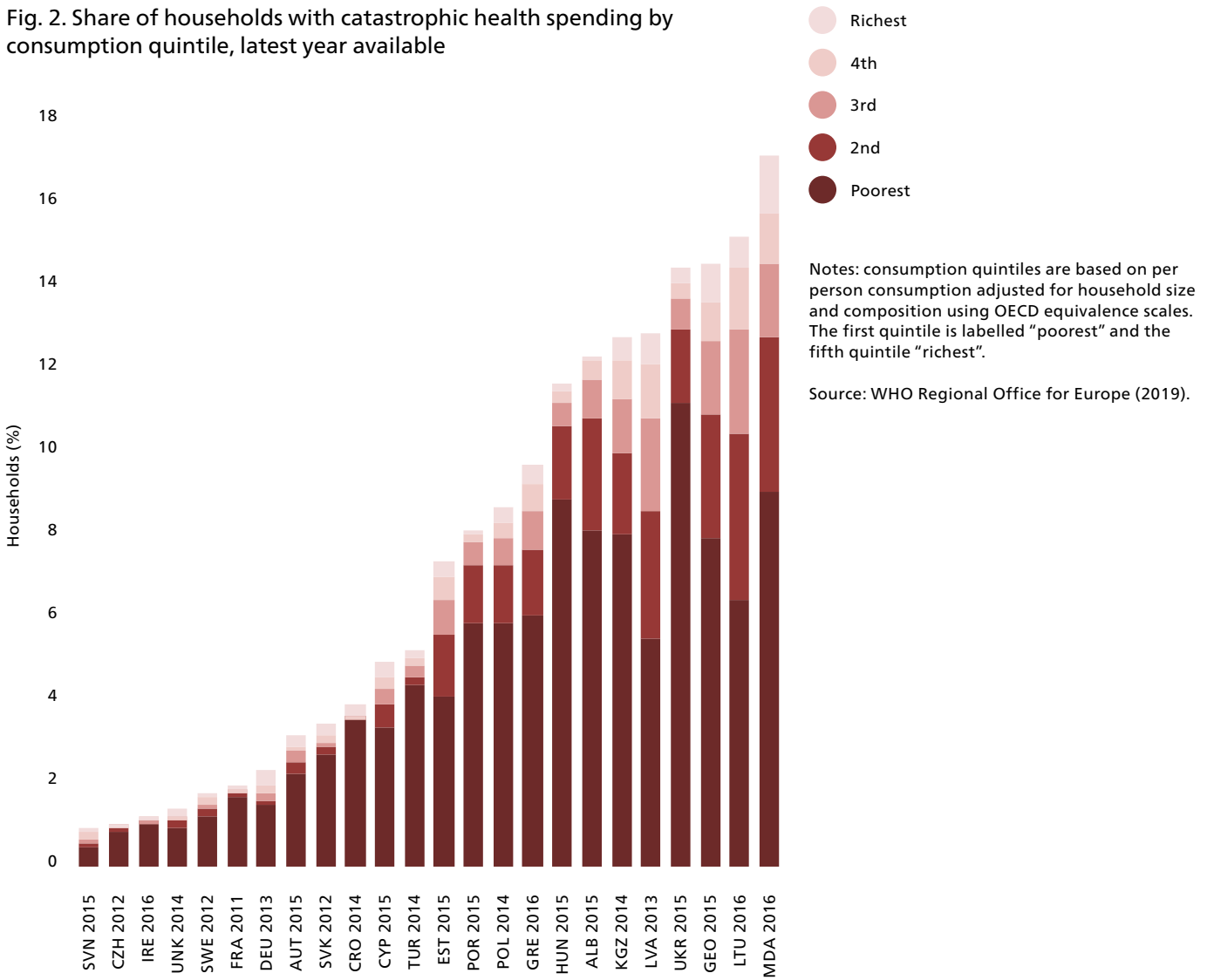
Fig. 1. Share of households with impoverishing health spending, latest year available



The poorest households are most likely to experience financial hardship

The incidence of catastrophic health spending varies widely among EU countries (Fig. 2). Among non-EU countries, the incidence is generally high (over 12%). Across Europe, people in the poorest quintile are consistently most at risk of catastrophic health spending.

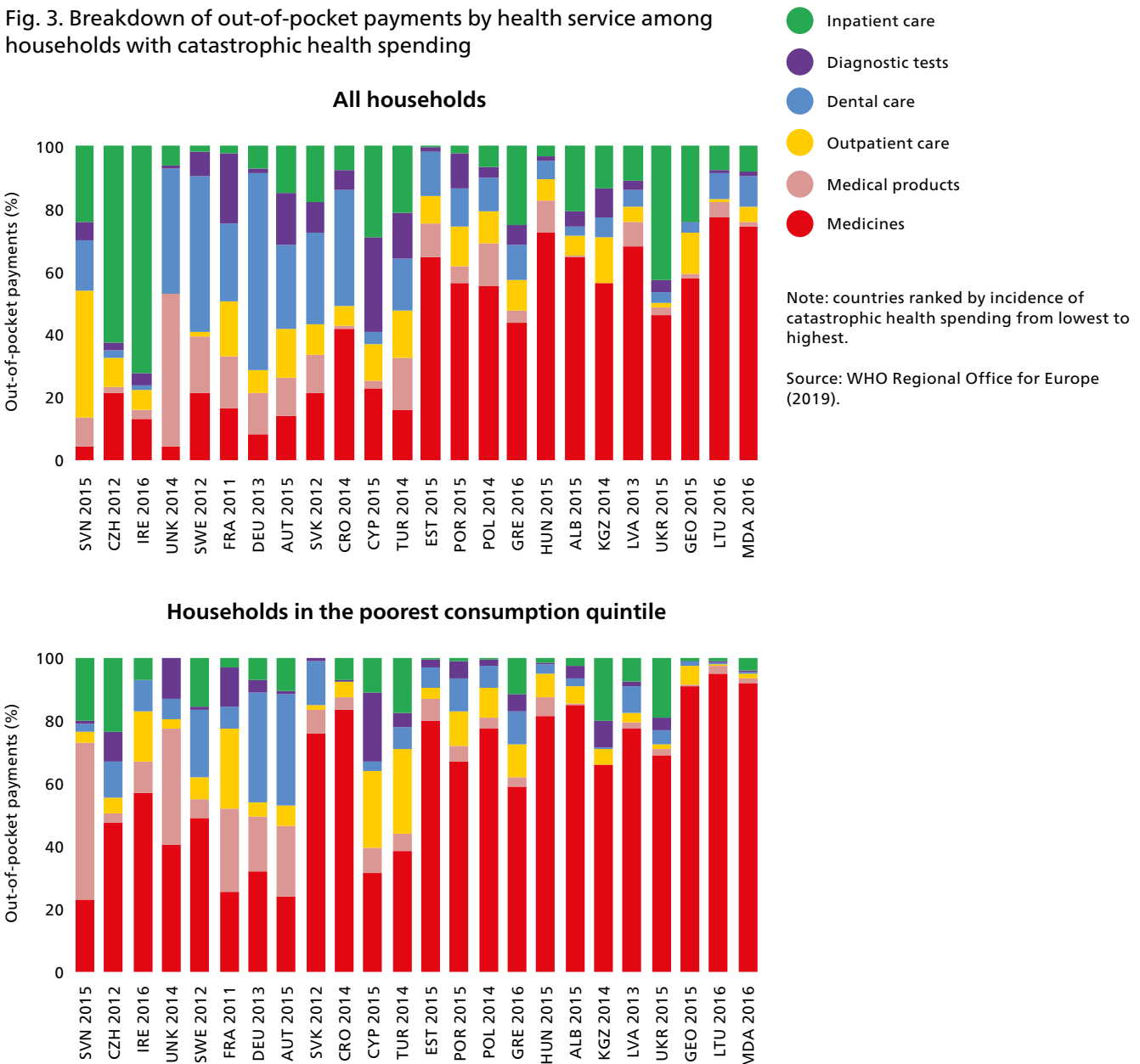
Fig. 2. Share of households with catastrophic health spending by consumption quintile, latest year available



Outpatient medicines are the main driver of financial hardship

Out-of-pocket payments incurred by households with catastrophic health spending are mainly due to outpatient medicines, followed by dental care and inpatient care. The share of catastrophic health spending due to outpatient medicines is consistently higher than average in the poorest quintile (Fig. 3).

Fig. 3. Breakdown of out-of-pocket payments by health service among households with catastrophic health spending



Unmet need must be part of the analysis

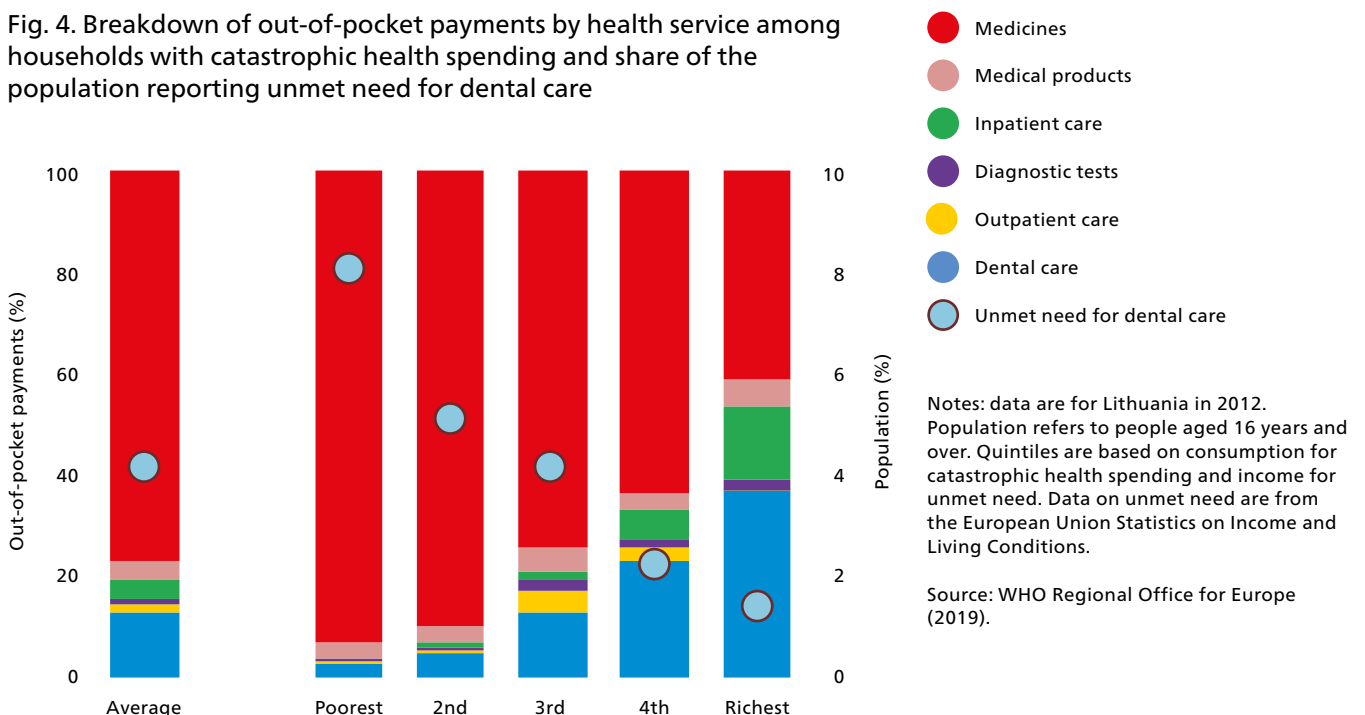
Financial protection indicators capture financial hardship arising from the use of health services, but do not indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need. Bringing together data on financial hardship and unmet need reveals the following findings.

In countries where the incidence of catastrophic health spending is very low, unmet need also tends to be low and without significant income inequality. The incidence of catastrophic health spending and levels of unmet need are both relatively high in many countries, and income inequality in unmet need is also significant, indicating that health services in these countries are not affordable, especially for poorer households.

Some health services – notably dental care – are a much greater source of financial hardship for richer households than poorer households (Fig. 4). This reflects higher levels of unmet need for dental care among poorer households than richer households in most countries.

Unmet need for prescribed medicines is generally higher in countries with a higher incidence of catastrophic health spending, which indicates that out-of-pocket payments for medicines lead to both financial hardship and unmet need for poorer people.

Fig. 4. Breakdown of out-of-pocket payments by health service among households with catastrophic health spending and share of the population reporting unmet need for dental care



Factors that strengthen financial protection

Health systems with strong financial protection and low levels of unmet need share the following features:

- there are no major gaps in health coverage;
- coverage policy is carefully designed to minimize access barriers and out-of-pocket payments, particularly for poor people and regular users of health services;
- public spending on health is high enough to ensure timely access to a broad range of health services without informal payments; and, as a result
- out-of-pocket payments are low, accounting for less than or close to 15% of current spending on health.

The strong association between the incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health (Fig. 5) suggests that the out-of-pocket payment share can be used as a proxy indicator for financial protection when data on financial protection are lacking.

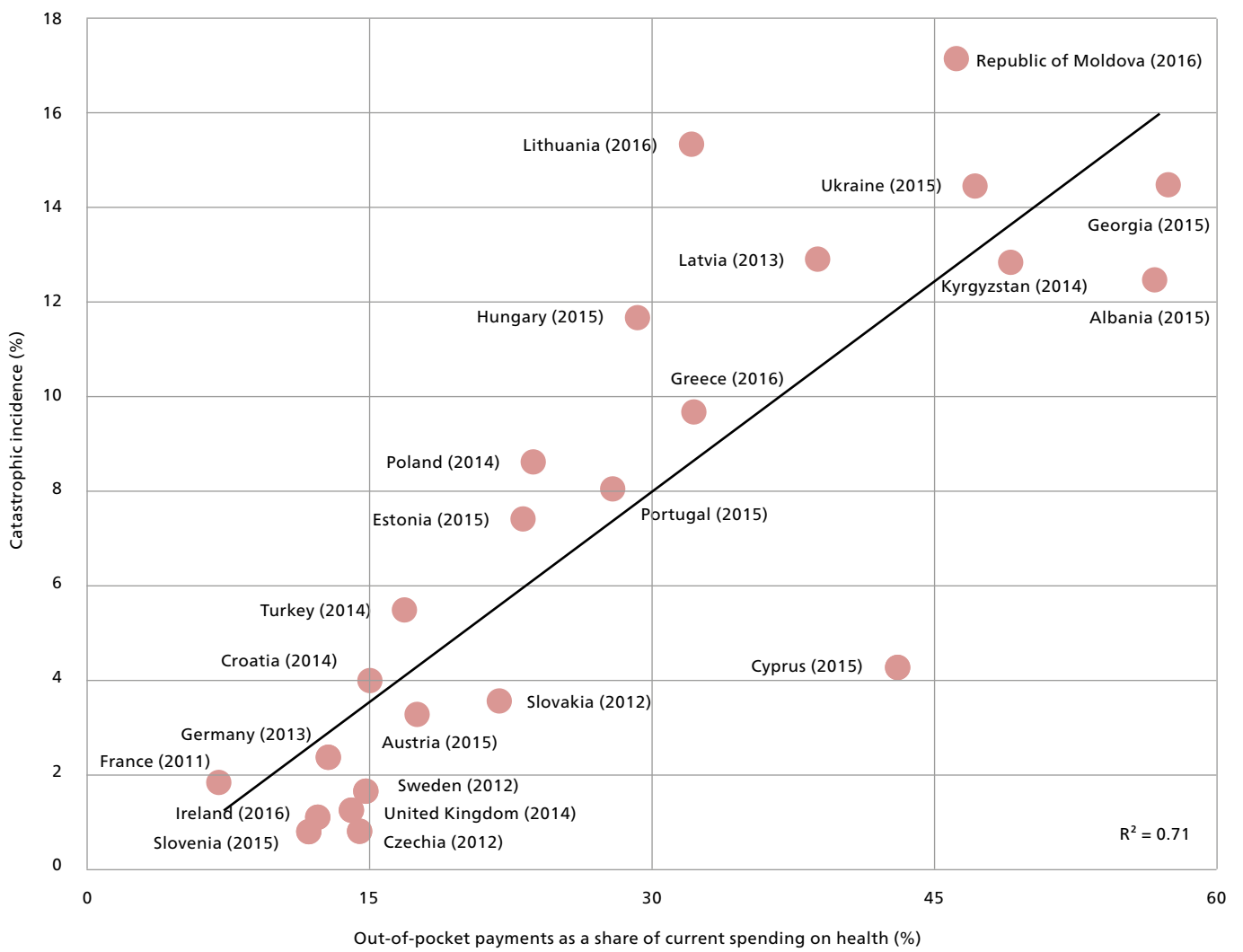
Across countries, public spending on health is shown to be much more effective in reducing out-of-pocket payments than voluntary health insurance. Increases in public spending on health or reductions in out-of-pocket payments are not enough to improve financial protection in all contexts, however. Coverage policies play a key role in determining financial hardship, not just patterns of spending on health.

The first step to strengthening financial protection is to identify gaps in coverage in a given context. The next step is to find ways of addressing them through a careful redesign of coverage policy.

Fig. 5. Incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health, latest year available

Notes: R^2 : coefficient of determination. Data on out-of-pocket payments are for the same year as data on catastrophic incidence. The association between catastrophic incidence and the out-of-pocket payment share excluding out-of-pocket payments for long-term care is almost identical ($R^2 = 0.70$).

Source: WHO Regional Office for Europe (2019).



Addressing gaps in coverage to reduce financial hardship

Gaps in coverage arise from weak design in three policy areas.

First, the basis for **population entitlement** leaves some people without access to publicly financed health services. Most gaps in population coverage occur because entitlement is linked to employment or payment of contributions. This automatically excludes people, particularly in countries that lack effective mechanisms to enforce collection, and tends to affect relatively vulnerable groups of people.

Second, the range of services that is publicly financed – **the benefits package** – is narrow, or there are issues relating to the availability, quality and timeliness of these services. In some countries, the number of outpatient medicines covered by the publicly financed benefits package is low and requires urgent policy attention. Coverage of dental care for adults is also very limited in some countries, including some high-income countries.

Third, there are **user charges** (co-payments) in place for services in the benefits package, and protection mechanisms are inadequate.

Weaknesses in coverage policy undermine equity and efficiency by creating financial barriers to access; shifting the financial burden of paying for health care on to those who can least afford it – poor people and regular users of health services; and encouraging inefficient patterns of use.

Acting on the evidence: better co-payment policy is key

Co-payment policy is a key determinant of financial protection in European health systems (Fig. 6). It is the most important factor in countries where financial hardship is driven by outpatient medicines and the scope of the publicly financed benefits package is adequate.

This study finds that the countries with the strongest financial protection apply co-payments sparingly or carefully design co-payment policy to protect people from financial hardship through three mechanisms.

Exemptions for poor people are the single most effective mechanism for improving access and financial protection. All countries can and should exempt poor people, beginning with people receiving social benefits, a group that is administratively relatively easy to identify.

Annual caps on co-payments can protect people if they are applied to all co-payments. Ideally, they should be set as a very low share of household income. Caps alone are unlikely to be sufficient to protect poor people, however.

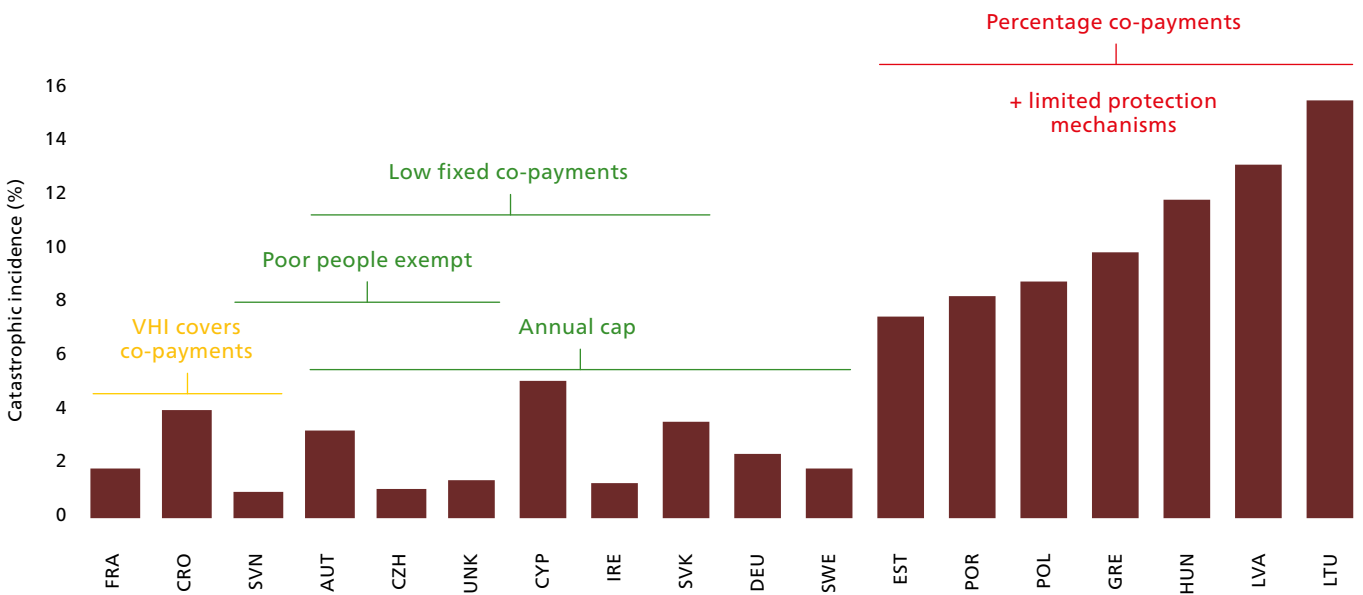
If co-payments are used, they should be low and clearly defined so people know what they are expected to pay. In contrast to **low fixed co-payments**, percentage co-payments shift financial risk from purchasing agency to households and expose people to health system inefficiencies. This is particularly problematic in contexts where pricing, prescribing, dispensing and referral are not adequately regulated.

Co-payment policy should pay attention to all three mechanisms (exemptions, caps and type of co-payment); aim to protect people rather than diseases, services or specific items; and be as simple as possible to minimize confusion.

Fig. 6. Catastrophic health spending and the design of co-payments for outpatient prescribed medicines in high-income countries

Note: VHI: voluntary health insurance.

Source: WHO Regional Office for Europe (2019).



The role of voluntary health insurance

Voluntary health insurance can enhance financial protection at health system level if it covers co-payments *and* covers most of the population, including most poor people. Only three countries meet these conditions: Croatia, France and Slovenia.

In these countries, voluntary health insurance is made accessible to all those who want to purchase it through regulation (open enrolment and community-rated premiums in Croatia and Slovenia). It is affordable because the government pays premiums for very poor people in Croatia and France; in Slovenia, very poor people are exempt from co-payments and do not need voluntary health insurance.

Voluntary health insurance generally exacerbates inequalities in access to health services, however (Sagan & Thomson, 2016). It is also a more regressive means of financing the health system than public spending on health.

Progressive universalism ensures no one is left behind

Better co-payment policy plays an important role in reducing financial hardship because it allows the health system to target the people most in need of protection.

Taking steps to benefit the most disadvantaged people first – an approach known as progressive universalism (Gwatkin & Ergo, 2011) – is vital in contexts where public resources are severely limited. It also offers advantages in countries that do not face a severe budget constraint, enabling them to meet the challenge of leaving no one behind by ensuring that poor people gain at least as much as those who are better off at every step on the path to universal health coverage.

Progressive universalism rests on the ability to identify the health services most likely to lead to financial hardship, the people most likely to be affected and the root causes of gaps in coverage. This in turn requires indicators and metrics amenable to equity analysis, like the ones used in this report.

To be effective, changes to coverage policy should be supported by an adequate level of public spending on health. Countries in which the out-of-pocket payment share of current spending on health is relatively high will need to invest more publicly in the health system to reduce out-of-pocket payments. Simply increasing public spending might not be enough to improve outcomes for those most in need, however. The sequencing of policy is therefore important. Some countries will need to redesign coverage policy at the same time as seeking additional public investment in the health system.

There is a wealth of good practice in Europe. Lessons can be learned from countries with strong financial protection and countries where financial protection is weak overall but steps have been taken to protect poor people.

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The WHO Regional Office for Europe

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

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