



World Health  
Organization

REGIONAL OFFICE FOR Europe



Factsheet - Sustainable Development Goals: health targets

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# Financial protection and the Sustainable Development Goals

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



When people have to pay out of pocket for health:



some face barriers to access and forego treatment



some pay and experience financial hardship



some are affected in both ways

Lack of financial protection in health systems can reduce access to health care, undermine health status, deepen poverty and exacerbate inequality

In the WHO European Region:

the share of households with catastrophic health spending ranges from 1% to 17%



the main drivers of financial hardship are outpatient medicines and dental care



households with catastrophic health spending may struggle to pay for other basic needs, such as food, housing and heating








Countries can strengthen financial protection by:

✓ redesigning coverage policy to reduce unmet need and financial hardship for the people most in need of protection

✓ supporting changes to coverage policy with adequate public investment in the health system

# Financial protection and the Sustainable Development Goals

-  Financial protection is a core dimension of health system performance and central to universal health coverage. The goals of universal health coverage are to ensure that everyone can use the quality health services they need without experiencing financial hardship (1).
-  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 paying for long-term treatment such as medicines for chronic illness. Large out-of-pocket payments can lead to financial hardship for rich households as well as poor households.
-  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.
-  A recent WHO study of financial protection in 24 countries in the WHO European Region found evidence of catastrophic and impoverishing health spending (two indicators commonly used to monitor financial protection; see Key definitions) even in the Region's richest countries (2). The study identified the people most likely to experience financial hardship and the health services that lead to financial hardship.
-  Countries can strengthen financial protection by redesigning coverage policy to reduce unmet need and financial hardship for the people most in need of protection and, where necessary, supporting changes to coverage policy with adequate public investment in the health system.



**1** NO POVERTY



**3** GOOD HEALTH AND WELL-BEING



**10** REDUCED INEQUALITIES



# Facts and figures

Financial protection affects many of the Sustainable Development Goals (SDGs), particularly:

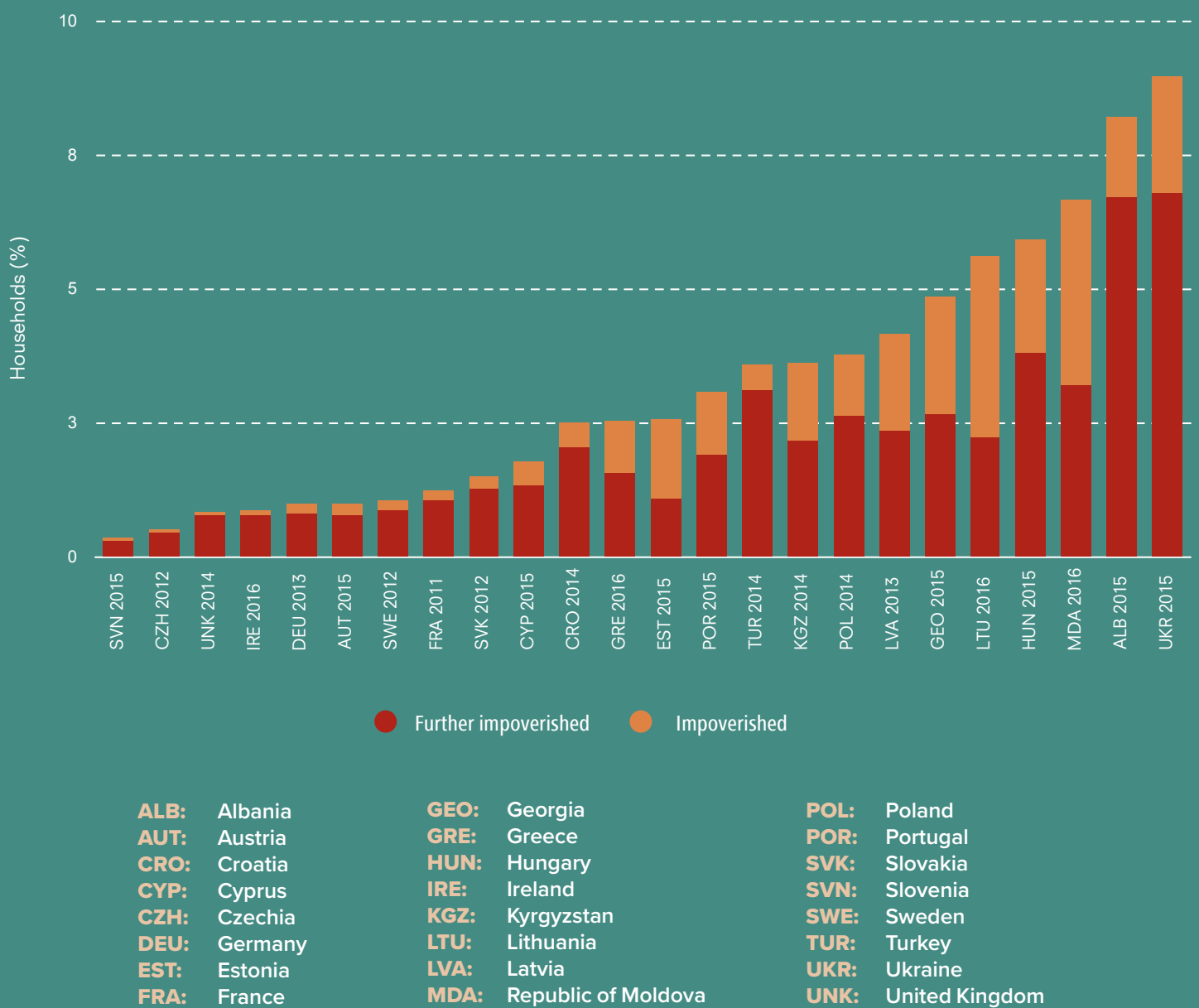
1.1: eradicate extreme poverty for all people everywhere	10.1: progressively achieve and sustain income growth for those on low incomes
1.2: reduce at least by half the proportion of men, women and children living in poverty according to national definitions	10.2: empower and promote the social, economic and political inclusion of all
3.8: achieve universal health coverage, including financial risk protection and access to quality essential health-care services	Indicator 3.8.2 for SDG 3.8 assesses the proportion of the population with large household expenditures on health as a share of total household expenditure or income



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

☰ The incidence of impoverishing health spending ranges from 0.3% to 9.0% of households in the WHO European Region (Fig. 1). There is wide variation among European Union (EU) countries (from 0.3% to 5.9%) and among non-EU countries (from 3.6% to 9.0%).

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



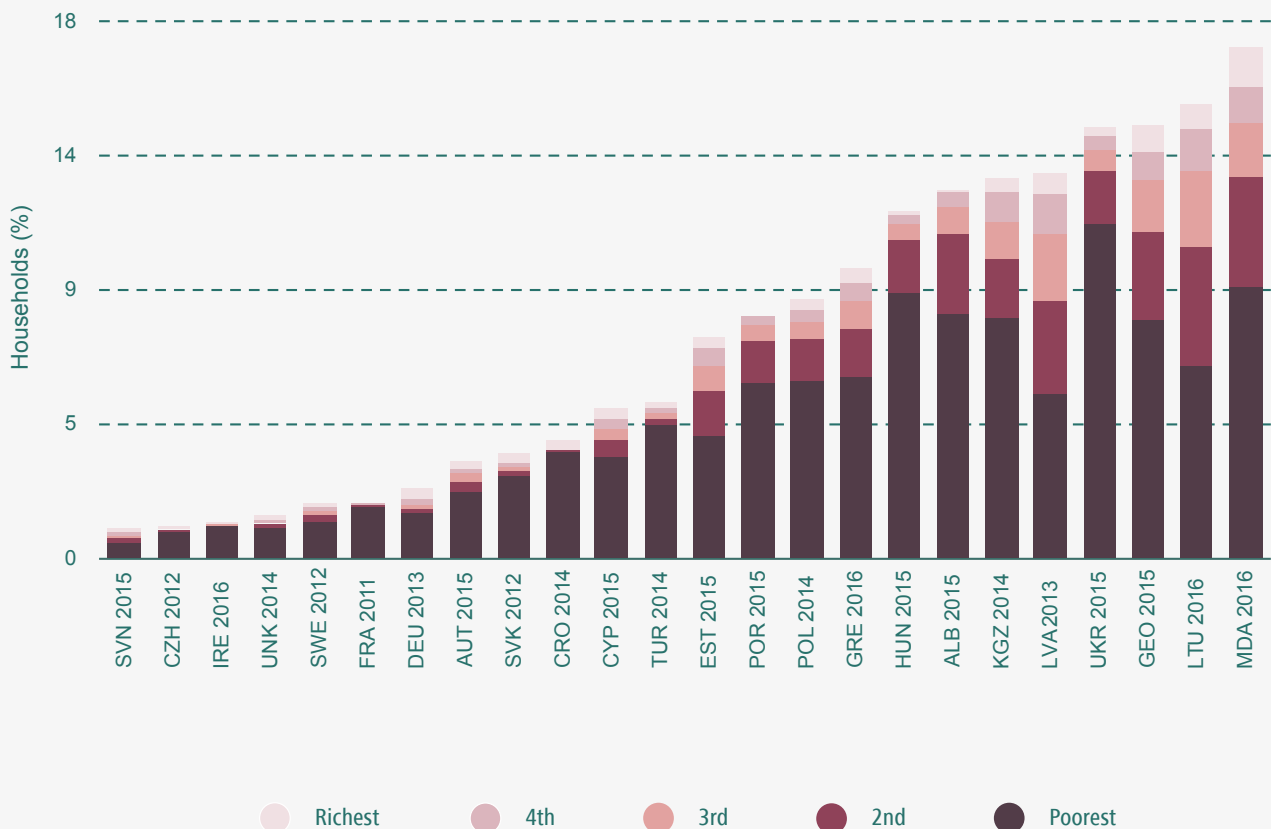
Note: a household is impoverished if its total consumption is below the poverty line after out-of-pocket payments (i.e. it is no longer able to afford to meet basic needs); it is further impoverished if its total consumption is below the poverty line (i.e. it is already unable to meet basic needs) and it incurs out-of-pocket payments.

Source: WHO Regional Office for Europe, 2019 (2).

# Out-of-pocket payments are most likely to lead to financial hardship for the poorest households

- ☞ The incidence of catastrophic health spending ranges from 1% to 17% of households in the Region (Fig. 2). It varies widely among EU countries. Among non-EU countries, the incidence is generally consistently high (over 12%). Across the Region, people in the poorest quintile are most likely to experience catastrophic health spending (Fig. 2).

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



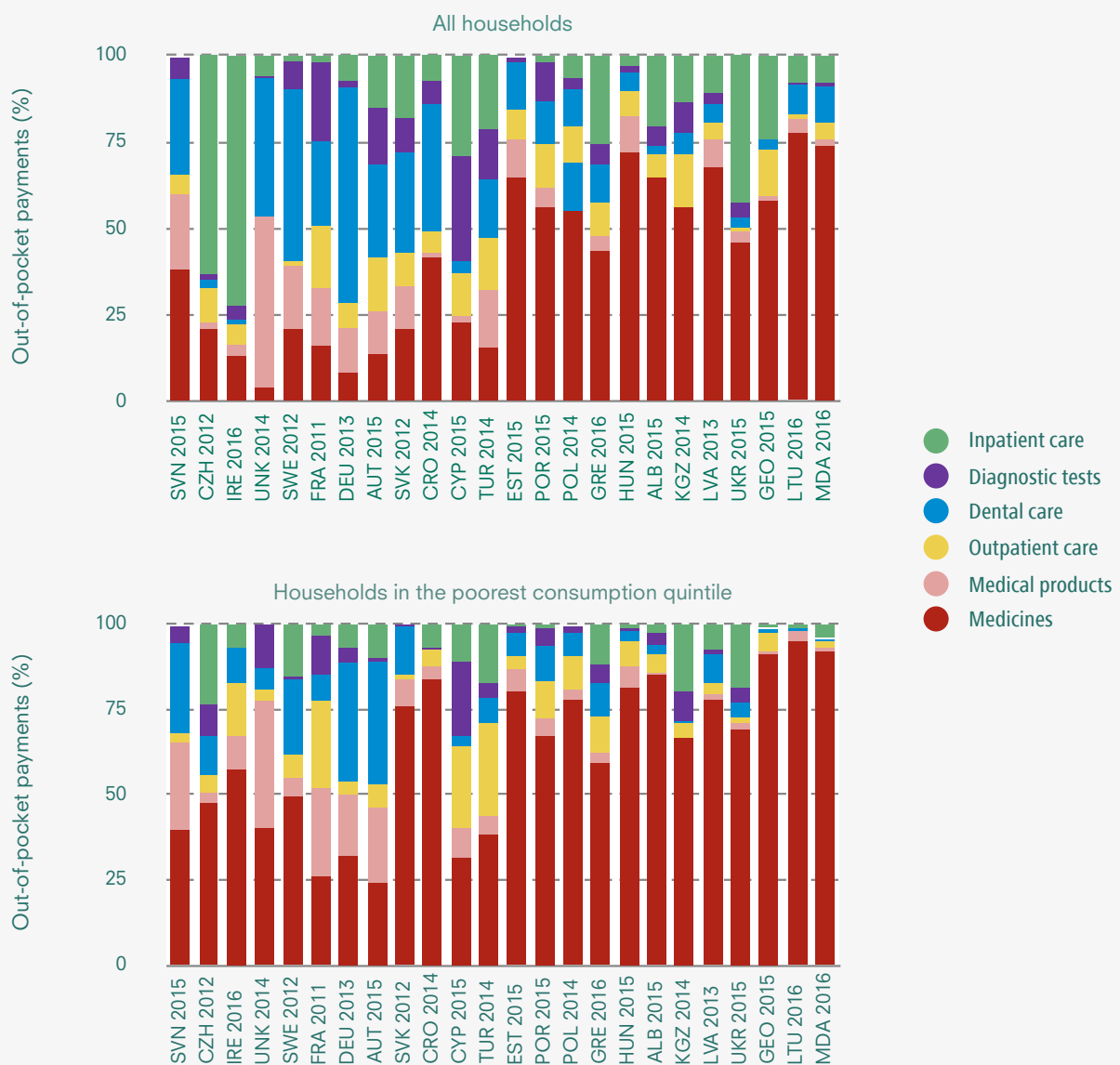
Notes: consumption quintiles are based on per person consumption using the Organisation for Co-operation and Development's equivalence scales, with the first quintile labelled poorest and the fifth quintile richest; some households may appear to be richer than they actually are because they have borrowed money to finance spending on health (or other items) but it can be safely assumed that households in the poorest quintile are genuinely poor. See Fig. 1 for country codes.

Source: WHO Regional Office for Europe, 2019 (2).

# Outpatient medicines are the main driver of financial hardship

- Out-of-pocket payments incurred by households with catastrophic health spending are mainly for outpatient medicines, followed by dental care (Fig. 3).
- 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**



Notes: countries ranked by incidence of catastrophic health spending from lowest to highest; spending on mental health services is not reported separately and spending on long-term care is excluded; medicines are for outpatient use; medical products include things such as corrective lenses, hearing aids, crutches and wheelchairs; diagnostic tests include services supplied by paramedical practitioners. See Fig. 1 for country codes.

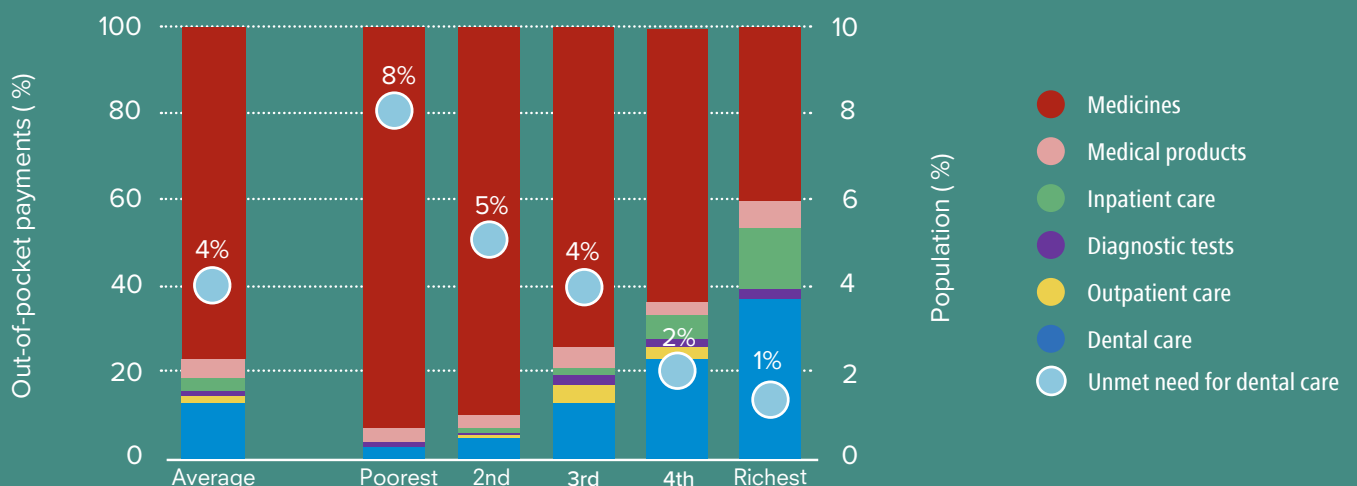
Source: WHO Regional Office for Europe, 2019 (2).

# 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. In many countries, the incidence of catastrophic health spending and levels of unmet need are both relatively high, and income inequality in unmet need is also significant, indicating that health services are not easily affordable, particularly for poorer households.
- ☞ Some health services – notably dental care – are often a 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**



*Note:* data are for Lithuania in 2012 for people aged 16 years and over; quintiles are based on consumption for catastrophic health spending and income for unmet need; data on unmet need are from the EU Statistics on Income and Living Conditions (3).

*Source:* WHO Regional Office for Europe, 2019 (2).



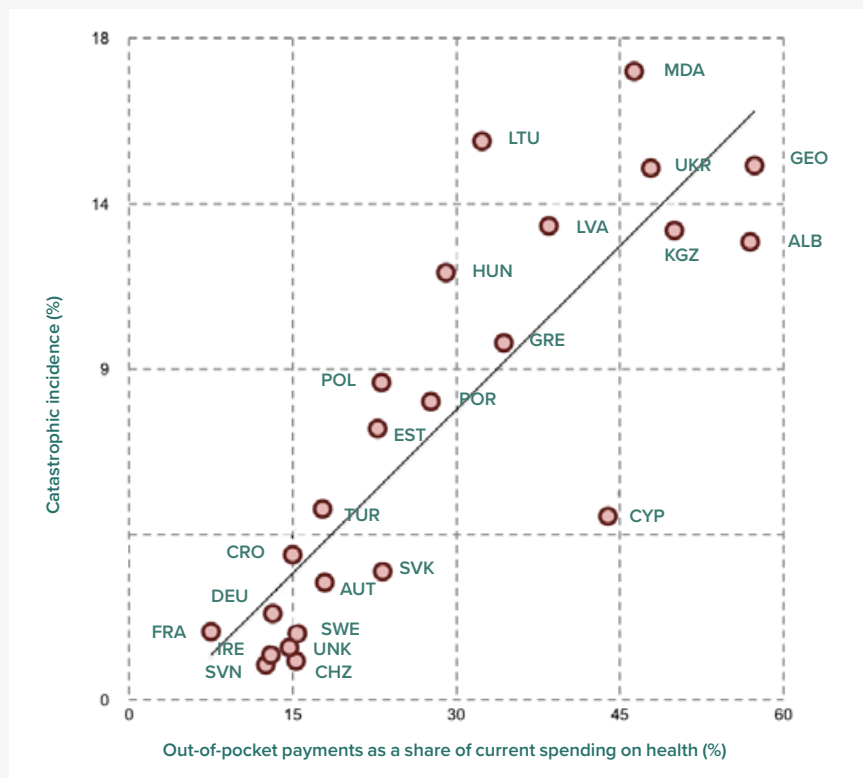
# Factors that strengthen financial protection

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

- no major gaps in health coverage;
- coverage policy (the way in which health coverage is designed and implemented) minimizes 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; and
- 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 rough proxy for financial protection when data on financial protection are lacking. On its own, however, it does not provide actionable evidence for policy.

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



Notes: 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. See Fig. 1 for country codes.

Source: WHO Regional Office for Europe, 2019 (2).

# Commitment to act

*The Tallinn Charter: health systems for health and wealth*, signed by all Member States in the WHO European Region in 2008, stated that “It is unacceptable that people become poor as a result of ill health” (4). The Charter promotes equity, solidarity, financial protection and better health through health system performance monitoring, assessment and improvement. Member States reaffirmed their commitment to the Charter’s values in 2018 (5).

The 2030 Agenda for Sustainable Development adopted by the United Nations in 2015 called for the monitoring of, and reporting on, financial protection as part of achieving universal health coverage (6). SDG 3.8 is to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (6). The WHO Regional Committee for Europe’s resolution EUR/RC67/R3 on the roadmap to implement the 2030 Agenda for Sustainable Development called on WHO to support Member States in moving towards universal health coverage (7); a call to which WHO responded in its *Thirteenth general programme of work 2019–2023* (8).

WHO support to Member States is underpinned by the European Programme of Work 2020–2025 (United Action for Better Health in Europe), which includes moving towards universal health coverage as the first of three priorities for the Region (9). Through the Programme, the WHO Regional Office for Europe works to support national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps.

Across countries, public spending on health is shown to be much more effective than voluntary health insurance in reducing out-of-pocket payments (2,10). 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 (2).

Gaps in coverage arise from weaknesses in the design of three policy areas: the basis for population entitlement leaves some people without access to publicly financed health services; the benefits package is narrow or there are issues relating to the availability, quality and timeliness of these services; and there are user charges (co-payments) in place for services in the benefits package.

The first step to strengthening financial protection is to identify gaps in coverage (Table 1). The next is to address them by redesigning coverage policy. The experience of countries in the WHO European Region suggests that the following policies are most likely to protect people from unmet need and financial hardship linked to out-of-pocket payments (2):

- ☞ cover the whole population, including refugees and migrants; break any link between entitlement and payment of contributions;
- ☞ use fair and transparent processes to define a broad benefits package, including essential medicines and dental care;
- ☞ exempt poor people and regular users of health care from co-payments, cap all co-payments and replace percentage co-payments with low fixed co-payments;
- ☞ lower expectations about voluntary health insurance as it usually exacerbates inequalities; and
- ☞ support changes to coverage policy with adequate public investment in the health system.

There is a wealth of good practice in the WHO European Region. 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 (2).

**Table 1. Gaps in coverage in health systems of WHO European Region Member States**

POLICY AREA	ISSUES IN THE GOVERNANCE OF PUBLICLY FINANCED COVERAGE	MAIN GAPS IN PUBLICLY FINANCED COVERAGE	ARE THESE GAPS COVERED BY VOLUNTARY HEALTH INSURANCE (VHI)?
POPULATION ENTITLEMENT	<p>Entitlement based on employment or payment of contributions rather than residence</p> <p>Entitlement may also vary based on income, age or health status</p> <p>Limited entitlement for refugees and migrants</p>	<p>People of working age, particularly unemployed people, self-employed people and those lacking stable employment</p> <p>Refugees and migrants</p>	<p>No; VHI may be available but is unlikely to be affordable for these groups of people</p>
THE BENEFITS PACKAGE	<p>Benefits package too narrow to meet population health needs</p> <p>Benefits package not supported by adequate levels of public spending on health, resulting in unfunded mandates, implicit rationing and informal payments</p> <p>No or limited processes in place to set priorities, and no or limited use of health technology assessments and other tools to identify cost-effective services</p> <p>Referral systems lacking or inadequately regulated; inadequate oversight of prescribing and dispensing of medicines; provider incentives not aligned across the system</p> <p>Lack of waiting time guarantees</p>	<p>Dental care for adults</p> <p>Medical products</p> <p>Outpatient medicines, including recommended or prescribed over-the-counter medicines</p> <p>Long waiting times for specialist consultations and inpatient care</p> <p>Issues with supply and quality push people to use private providers</p>	<p>VHI covers dental care in some countries, but those unable to afford dental care are unlikely to buy VHI</p> <p>Very few VHI products are designed to cover outpatient medicines</p> <p>VHI provides faster access to treatment in many countries</p> <p>VHI is mainly taken up by people in higher socioeconomic groups, which exacerbates inequalities in access to health services</p>
USER CHARGES (CO-PAYMENTS)	<p>Weak design of co-payment policy: no exemptions for poor people and regular users; no or inadequate caps; percentage co-payments rather than low fixed co-payments</p> <p>Balance billing is permitted</p> <p>Extra billing is not well regulated</p>	<p>Outpatient prescription medicines</p> <p>Dental care</p>	<p>VHI covering co-payments exists in several countries but only covers most of those who need protection in Croatia, France and Slovenia; even in these countries there are gaps in VHI coverage</p>

Sources: Sagan & Thomson, 2016 (10); WHO Regional Office for Europe, 2019 (2).

# Monitoring progress

WHO uses global and regional metrics to monitor financial protection in the WHO European Region (2). 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 goods or services 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, different diseases or different patient groups.

Global-level monitoring is based on metrics defined under the SDGs. While these metrics allow countries in the WHO European Region to be compared with countries in the rest of the world, they have disadvantages that limit their relevance for policy.

## SDG 3.8 indicator

- 3.8.2. Proportion of the population with large household expenditures on health as a share of total household expenditure or income

**SDG 3.8** (achieve universal health coverage) includes financial risk protection and access to quality essential health-care services.

**Catastrophic health spending** as defined in indicator 3.8.2 is based on the budget share approach: large household expenditures on health as a share of total household consumption or income (greater than 10% or 25% of total household consumption or income) (11). This metric does not account for differences in household ability to pay for health care (2,11).

**Impoverishing health spending** is not specifically included as a measure in the SDGs. However, WHO and the World Bank monitor impoverishing health spending globally using absolute poverty lines of US\$ 1.90 and US\$ 3.20 a day (for extreme and moderate poverty, respectively, in purchasing power parity). Using these absolute poverty lines, many Member States of the WHO European Region have zero incidence of impoverishing health spending (11).

To address these limitations, the WHO Regional Office for Europe developed new metrics to monitor financial protection (12,13). Building on established methods (14–16), the new metrics aim to monitor financial protection in a way that is relevant to all countries in the WHO European Region, to produce actionable evidence for policy and to promote policies to break the link between ill health and poverty.

## Indicators of financial protection

**Catastrophic health spending:** the share of households with out-of-pocket payments greater than 40% of capacity to pay for health care. Capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs (food, housing and utilities) (17).

**Impoverishing health spending:** households pushed below or further below a relative poverty line by out-of-pocket payments. The share of households with impoverishing health spending (households who are impoverished or further impoverished after out-of-pocket payments) measured using a relative poverty line reflecting basic needs (food, housing, utilities) (17).

Global metrics and those used by the WHO Regional Office for Europe for catastrophic health spending are underpinned by different assumptions, reflecting different normative principles.

**The global metric for catastrophic health spending (SDG 3.8.2, the budget share approach)** assumes all a household's resources are available to pay for health care. It applies the same effective threshold (10% or 25%) to rich and poor households alike (budget share), which means poor households – even those living in extreme poverty – must spend at least 10% (or 25%) of their budget on health to be counted as experiencing financial hardship. As a result, SDG 3.8.2 finds that catastrophic health spending is more often concentrated among the rich than the poor (11,13,18), posing a challenge for equity analysis and pro-poor policy action.

**The WHO Regional Office for Europe metric for catastrophic health spending (a capacity-to-pay approach)** assumes that households need to spend a minimum amount on basic needs such as food, housing and utilities before they can pay for health care (17). With this approach, catastrophic health spending is consistently concentrated among poor people (Fig. 2), providing a clear signal for policy action (2,13).

**The measurement of impoverishing health spending used by the WHO Regional Office for Europe also differs from the global metric used by WHO and the World Bank in two main ways.**

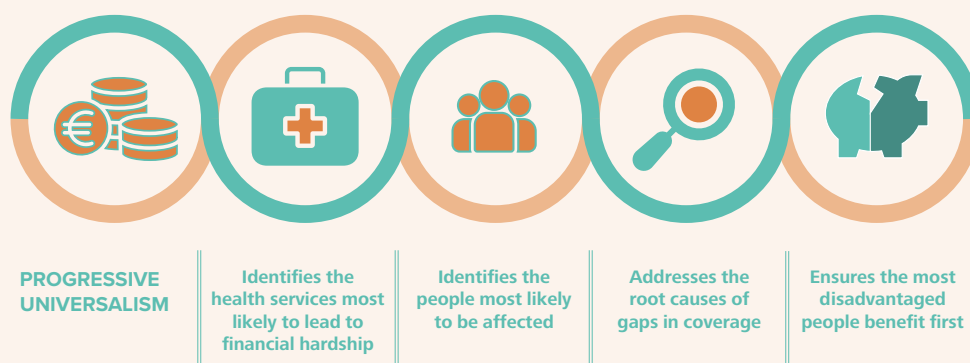
- ☞ It uses a relative poverty line (a basic needs line) that is better able to reflect national poverty levels than the very low absolute poverty lines used at global level because it is derived from household spending patterns observed in each country.
- ☞ The global metric only counts people who cross the poverty line after incurring out-of-pocket payments: *impoverished households*. The metric used by the WHO Regional Office for Europe also counts people who are already poor and whose poverty is made worse by having to pay out of pocket for health services: *further impoverished households* (Fig. 1).

A vital aspect of the SDGs is the pledge to leave no one behind (19). To meet this challenge requires data, indicators and metrics amenable to equity analysis, such as those developed and used by the WHO Regional Office for Europe (Box 1). These metrics draw attention to people who are barely visible within global metrics. As a result, they enable policy responses that are more likely to protect people in poverty and other people at high risk of unmet need and financial hardship linked to out-of-pocket payments.

## Box 1. Leaving no one behind

**Progressive universalism:** this approach works to ensure no one is left behind by taking steps to benefit the most disadvantaged people first (20). Such an approach 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 (Table 1).

Co-payment policy is a key determinant of financial protection in health systems in the WHO European Region (2). 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. Countries can improve co-payment design by introducing exemptions for poor people, applying annual caps to all co-payments and replacing percentage co-payments with low fixed co-payments. 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.



# WHO support to its Member States

The WHO Regional Office for Europe aims to provide policy-makers with robust, context-specific and actionable evidence that they can use to move towards universal health coverage. It supports Member States through:

- ☰ the development and use of policy-relevant metrics to monitor financial protection;
- ☰ country-level reviews of financial protection, produced in collaboration with national experts, which aim to identify the factors that strengthen or undermine financial protection and provide context-specific recommendations for policy;
- ☰ regional analysis of financial protection; the first comparative analysis of financial protection in 24 countries was published in 2019 (2) with a second analysis extended to 35 countries due to be published in 2022; and
- ☰ analysis of policy options for reducing unmet need and financial hardship.

The results of the WHO Regional Office for Europe's analysis of financial protection are being widely used by the European Commission, the European Observatory on Health Systems and Policies, the Organisation for Economic Co-operation and Development and WHO headquarters (11,21–24).

## Partners

The WHO Regional Office for Europe collaborates with a range of partners to move towards universal health coverage by strengthening financial protection, including:

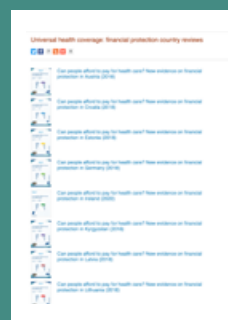
- ☰ European Commission
- ☰ European Observatory on Health Systems and Policies
- ☰ Organisation for Economic Co-operation and Development
- ☰ World Bank Group

## Resources



### Can people afford to pay for health care? New evidence on financial protection in Europe (2019)

<https://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2019/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019>



### Universal health coverage: financial protection country reviews

<http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/clusters/universal-health-coverage-financial-protection/universal-health-coverage-financial-protection-country-reviews>

# Key definitions

## Capacity to pay for health care

Measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. This amount is deducted consistently for all households. It is referred to as a poverty line or basic needs line.

## Catastrophic health spending (catastrophic out-of-pocket payments)

An indicator of financial protection. It can be measured in different ways. The WHO Regional Office for Europe defines it as out-of-pocket payments that exceed 40% of a household's capacity to pay for health care, which includes households that are impoverished and further impoverished.

## Co-payments (user charges or user fees)

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

## Financial hardship

Experienced when out-of-pocket payments are large in relation to the ability to pay for health care.

## Financial protection

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

## Impoverishing health spending (impoverishing out-of-pocket payments)

An indicator of financial protection. Out-of-pocket payments that push people into poverty or deepen their poverty.

## Out-of-pocket payment (household expenditure on health)

Any payment made by people at the time of using any health good or service provided by any type of provider. Out-of-pocket payments include formal co-payments (user charges or user fees) for covered goods and services, formal payments for the private purchase of goods and services and informal payments for covered or privately purchased goods and services. It excludes pre-payment (e.g. taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company.

## Informal payment

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

## Universal health coverage

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



# References

1. The world health report. Health systems financing: the path to universal health coverage. Geneva: World Health Organization; 2010 (<https://www.who.int/whr/2010/en/>, accessed 21 December 2020).
2. Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: WHO Regional Office for Europe; 2019 (<https://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2019/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-europe-2019>, accessed 21 December 2020).
3. Eurostat: European Union statistics on income and living conditions [online database]. Brussels: European Commission; 2020 (<https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions>, accessed 28 April 2020).
4. Tallinn Charter: health systems for health and wealth. Copenhagen: WHO Regional Office for Europe; 2008 (<https://www.euro.who.int/en/publications/policy-documents/tallinn-charter-health-systems-for-health-and-wealth>, accessed 21 December 2020).
5. Health systems for prosperity and solidarity: leaving no one behind. Copenhagen: WHO Regional Office for Europe; 2018 (Outcome statement from the High-level Meeting in Tallinn, Estonia, 13–14 June 2018; <https://www.euro.who.int/en/media-centre/events/events/2018/06/health-systems-for-prosperity-and-solidarity-leaving-no-one-behind/documents/meeting-documents/outcome-statement-health-systems-for-prosperity-and-solidarity-leaving-no-one-behind.-tallinn,-estonia,-13-14-june-2018-2018>, accessed 21 December 2020).
6. Transforming our world: the 2030 agenda for sustainable development. New York: United Nations; 2015 (<https://sustainabledevelopment.un.org/post2015/transformingourworld/publication>, accessed 21 December 2020).
7. WHO Regional Committee for Europe resolution EUR/RC67/R3 on the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being. Copenhagen: WHO Regional Office for Europe; 2017 (<https://www.euro.who.int/en/health-topics/health-policy/sustainable-development-goals/publications/2017/the-roadmap-to-implement-the-2030-agenda-for-sustainable-development,-building-on-health-2020,-the-european-policy-for-health-and-well-being>, accessed 21 December 2020).
8. Thirteenth general programme of work 2019–2023. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>, accessed 28 April 2020).
9. European Programme of Work (2020–2025): United Action for Better Health in Europe. Copenhagen: WHO Regional Office for Europe; 2020 (<https://www.euro.who.int/en/health-topics/health-policy/european-programme-of-work/about-the-european-programme-of-work/european-programme-of-work-20202025-united-action-for-better-health-in-europe>, accessed 21 December 2020).
10. Sagan A, Thomson S. Voluntary health insurance in Europe: role and regulation. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies; 2016 (<https://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2016/voluntary-health-insurance-in-europe-role-and-regulation-2016>, accessed 21 December 2020).
11. Tracking universal health coverage: 2017 global monitoring report. Geneva: World Health Organization and World Bank; 2017 ([https://www.who.int/healthinfo/universal\\_health\\_coverage/report/2017/en/](https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/), accessed 21 December 2020).

12. Thomson S, Evetovits T, Cylus J, Jakab M. Monitoring financial protection to assess progress towards universal health coverage in Europe. *Public Health Panorama*. 2016;2(3):357–366.
13. Cylus J, Thomson S, Evetovits T. Catastrophic health spending in Europe: equity and policy implications of different calculation methods. *Bull World Health Organ*. 2018;96:589–664. doi: 10.2471/BLT.18.209031.
14. Xu K, Evans D, Kawabata K, Zeramdini R, Klavus J, Murray C. Household catastrophic health expenditure: a multicountry analysis. *Lancet*. 2003;362(9378):111–177. doi: 10.1016/S0140-6736(03)13861-5.
15. O'Donnell O, van Doorslaer E, Wagstaff A, Lindelow M. Analyzing health equity using household survey data: a guide to techniques and their implementation. Washington (DC): World Bank; 2008 (WBI Learning Resources Series 42480; <https://openknowledge.worldbank.org/handle/10986/6896>, accessed 28 April 2020).
16. Wagstaff A, Eozenou P. CATA meets IMPOV: a unified approach to measuring financial protection in health. Washington (DC): World Bank; 2014 (Policy Research Working Paper 6861; <http://documents.worldbank.org/curated/en/114091468149393397/pdf/WPS6861.pdf>, accessed 28 April 2020).
17. Global Health Observatory indicator metadata registry list [website]. Geneva: World Health Organization; 2020 (<https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4989>, accessed 1 May 2020).
18. WHO, World Bank. Tracking universal health coverage: first global monitoring report. Geneva: World Health Organization; 2015 ([https://apps.who.int/iris/bitstream/handle/10665/174536/9789241564977\\_eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/174536/9789241564977_eng.pdf?sequence=1), accessed 28 April 2020).
19. Leaving no one behind: the imperative of inclusive development. Report on the world social situation 2016. New York: United Nations; 2016 (<https://www.un.org/development/desa/socialperspectiveondevelopment/2016/09/06/world-social-situation-2016-leaving-no-one-behind-the-imperative-of-inclusive-development/>, accessed 21 December 2020).
20. Gwatkin D, Ergo, A. Universal health coverage: friend or foe of health equity. *Lancet*. 2011; 377(9784):2160–2161. doi: 10.1016/S0140-6736(10)62058-2.
21. Global monitoring report on financial protection in health 2019. Geneva: World Health Organization and World Bank; 2019 ([https://www.who.int/healthinfo/universal\\_health\\_coverage/report/2019/en/](https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/), accessed 21 December 2020).
22. State of health in the EU companion report 2019. Brussels: European Commission; 2019 ([https://ec.europa.eu/health/state/summary\\_en](https://ec.europa.eu/health/state/summary_en), accessed 21 December 2020).
23. Health system reviews (HiT series). Copenhagen: European Observatory on Health Systems and Policies; 2020 (<http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits>, accessed 28 April 2020).
23. OECD, European Union. Health at a glance: Europe 2020: state of health in the EU cycle. Paris: OECD Publishing; 2020. doi: <https://doi.org/10.1787/82129230-en>.



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