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Can people afford to pay for health care?

New evidence on financial protection in Ireland

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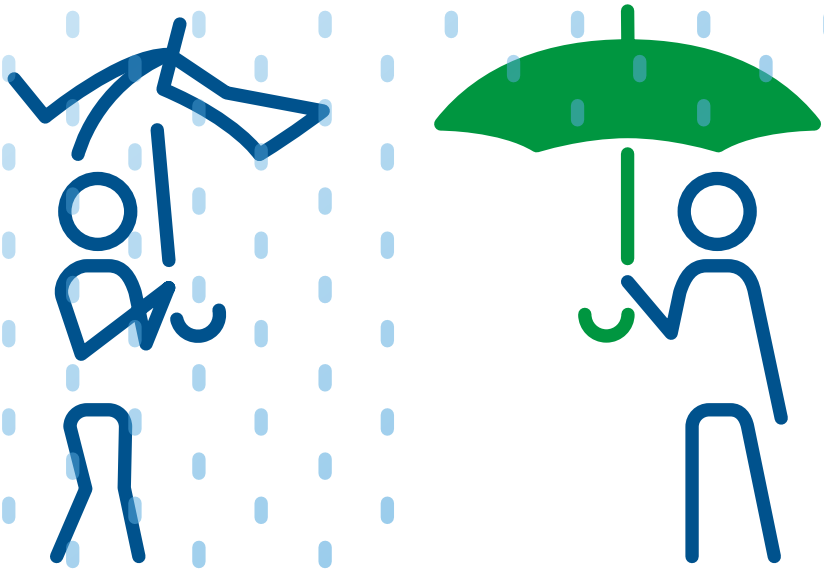

Summary

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Contents

This review assesses the extent to which people in the Republic of Moldova experience financial hardship when they use health services, including medicines. The analysis draws on household budget survey data collected annually by the National Bureau of Statistics of the Republic of Moldova (NBS) from 2008 to 2016. It focuses on two indicators of financial protection: catastrophic health spending and impoverishing health spending. It also considers the presence of access barriers leading to unmet need for health care.

Spending on health

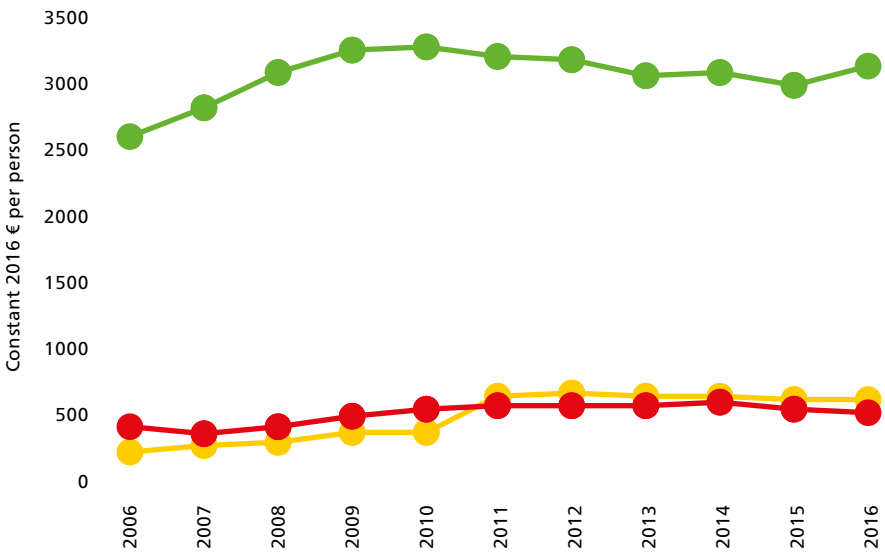
Research shows that financial hardship is more likely to occur when public spending on health is low in relation to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of current spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office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

Levels of public spending on health are lower in Ireland than in other countries in western Europe, both as a share of GDP and as a share of current spending on health. The out-of-pocket payment share of current spending on health is also relatively low (13% in 2016), because – unusually – most private spending on health is through private health insurance (PHI) (WHO, 2019). Ireland has the second-largest PHI market in the European Union (EU) after Slovenia, covering close to half of the population and accounting for 15% of current spending on health in 2016 (WHO, 2019).

As a result of significant budget cuts made in the wake of the 2008 financial and economic crisis, public spending on health per person fell steadily in real terms between 2010 and 2015 (Fig. 1). The public share of current spending on health fell from a peak of 79% in 2008 to a low of 70% in 2014, rising only slightly to 72% in 2016 (WHO, 2019). Public spending on health fell from 8.1% of GDP in 2009 to 5.4% in 2015 (WHO, 2019).

These cuts shifted €600 million on to households between 2008 and 2014 (Thomas et al., 2014), pushing up the out-of-pocket payment and PHI shares of current spending on health.

Fig. 1. Real spending on health per person by financing scheme



OOP: out-of-pocket payments. PHI: all voluntary health care schemes. Public: all compulsory financing arrangements.

Source: WHO (2019).

Coverage, access and unmet need

Ireland has an unusually complex system of entitlements to publicly financed health services.

Although everyone ordinarily resident is eligible to benefit from publicly financed health services, entitlement is largely determined on the basis of income and age.

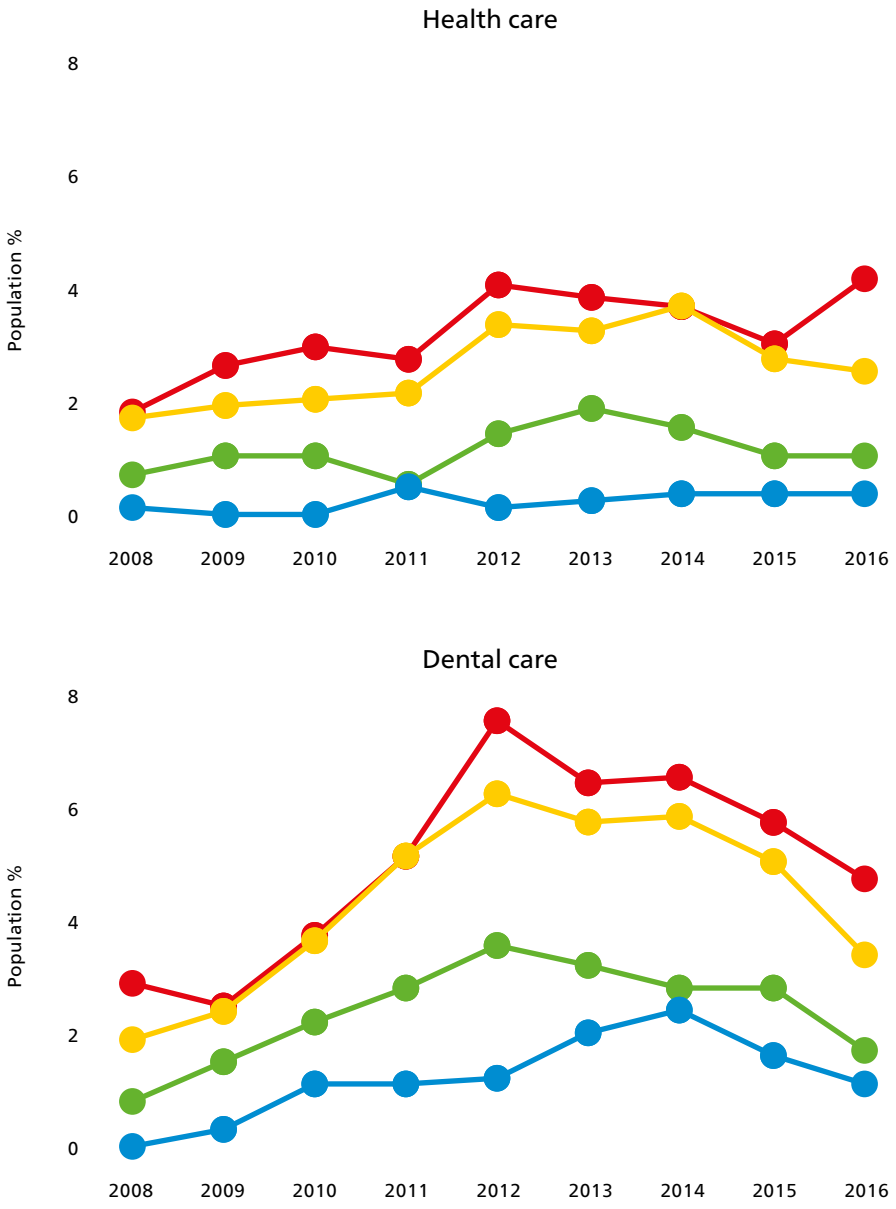
People below an income threshold (Category I, currently around 35% of the population) hold medical cards and have traditionally benefited from free access to all publicly financed health services, including free outpatient prescriptions. Following the crisis in 2008, however, this category faced user charges for outpatient-prescribed medicines for the first time. These prescription charges increased over time and dental care benefits were heavily reduced.

People above the threshold (Category II) must pay the full cost of a visit to a general practitioner (GP) – €40–60 per visit – and substantial user charges for all other health services. They also experienced increases in user charges and a reduction in dental benefits following the crisis. In 2015, however, free GP care was introduced for children under 6 years and adults aged over 70 years and dental benefits were increased in 2017 (after the study period).

Unmet need for health care and dental care rose substantially between 2008 and 2012. It has fallen somewhat since then but remains higher than in 2008 (Fig. 2). Income inequality in unmet need has also grown over time and remains significant (Fig. 2). Income inequality in unmet need persists

even though access to publicly financed health services is determined by income. This suggests: first, the medical card system is not effective in ensuring equitable access to health care; and second, while PHI enhances access for those who have it, it exacerbates inequalities in the health system.

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



Notes: population is people aged 16 and over. Quintiles are based on income.

Source: EU-SILC data from Eurostat (2019).

Increasingly long waiting times for specialist treatment in public facilities are a major issue. They are the main reason people take up PHI, which plays a supplementary role, mainly providing people with faster access to planned hospital treatment and covering some or all of the cost of treatment in private hospitals and the cost of private beds in public hospitals, depending on the type of plan purchased.

People are encouraged to buy PHI through substantial tax subsidies, and since 2015 there have been financial penalties (higher premiums) for those who do not buy it before the age of 35. PHI does not fill all gaps in coverage, however: for example, it does not cover outpatient-prescribed medicines and offers limited coverage of primary care and dental care. Take-up of PHI is heavily concentrated among richer people.

The table below highlights key issues in the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of voluntary private health insurance in filling these gaps.

Gaps in coverage

Source: authors.

	Population entitlement	**Service coverage**	**User charges**
Issues in the governance of publicly financed coverage	Eligibility is based on residence, but access to services depends on income, age and health status	No waiting-time guarantees	Co-payments are applied to all services, including GP visits, for people without a medical card (Category II)
Main gaps in publicly financed coverage	About two thirds of the population do not have a medical card (people in Category II)	Very limited coverage of primary care, including GP visits, for over half of the population Very limited coverage of dental care for the whole population Long waiting times for diagnostic tests, outpatient specialist appointments, care in emergency departments and inpatient care	Primary care, including GP visits, for those without medical cards or GP visit cards Outpatient prescription medicines There is no overall cap on co-payments for GP visits, medical supplies and dental care
Are these gaps covered by PHI?	No; around 20% of the population does not have a medical card or PHI	Partly; PHI covers around 46% of the population, giving them preferential access to planned treatment in public hospitals based on ability to pay and some elective care in private hospitals, but PHI coverage of primary care is limited	Not really; some PHI plans cover primary care; most PHI plans do not cover the cost of medicines and long-term care; PHI plans may involve co-payments at the point of use

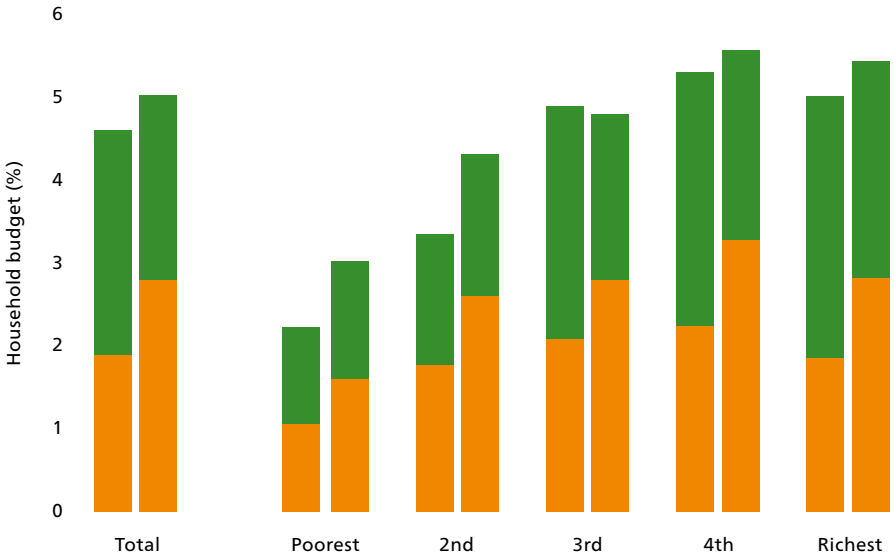
Household spending on health

Household budget survey data indicate that in 2015–2016, on average, households spent more buying PHI than they spent on health services, whereas in 2009–2010 they spent more on health services (Fig. 3).

Out-of-pocket payments per person decreased in absolute terms and as a share of household consumption between 2009–2010 and 2015–2016, driven by a fall among the three richest quintiles (Fig. 3). Out-of-pocket payments actually increased for the poorest two quintiles.

For all quintiles, spending on PHI premiums per person increased substantially in absolute terms and as a share of household consumption (Fig. 3).

Fig. 3. Out-of-pocket payments and PHI premiums as a share of household consumption by consumption quintile, 2009–2010 and 2015–2016



Out-of-pocket payments

PHI premiums

Source: authors based on household budget survey data.

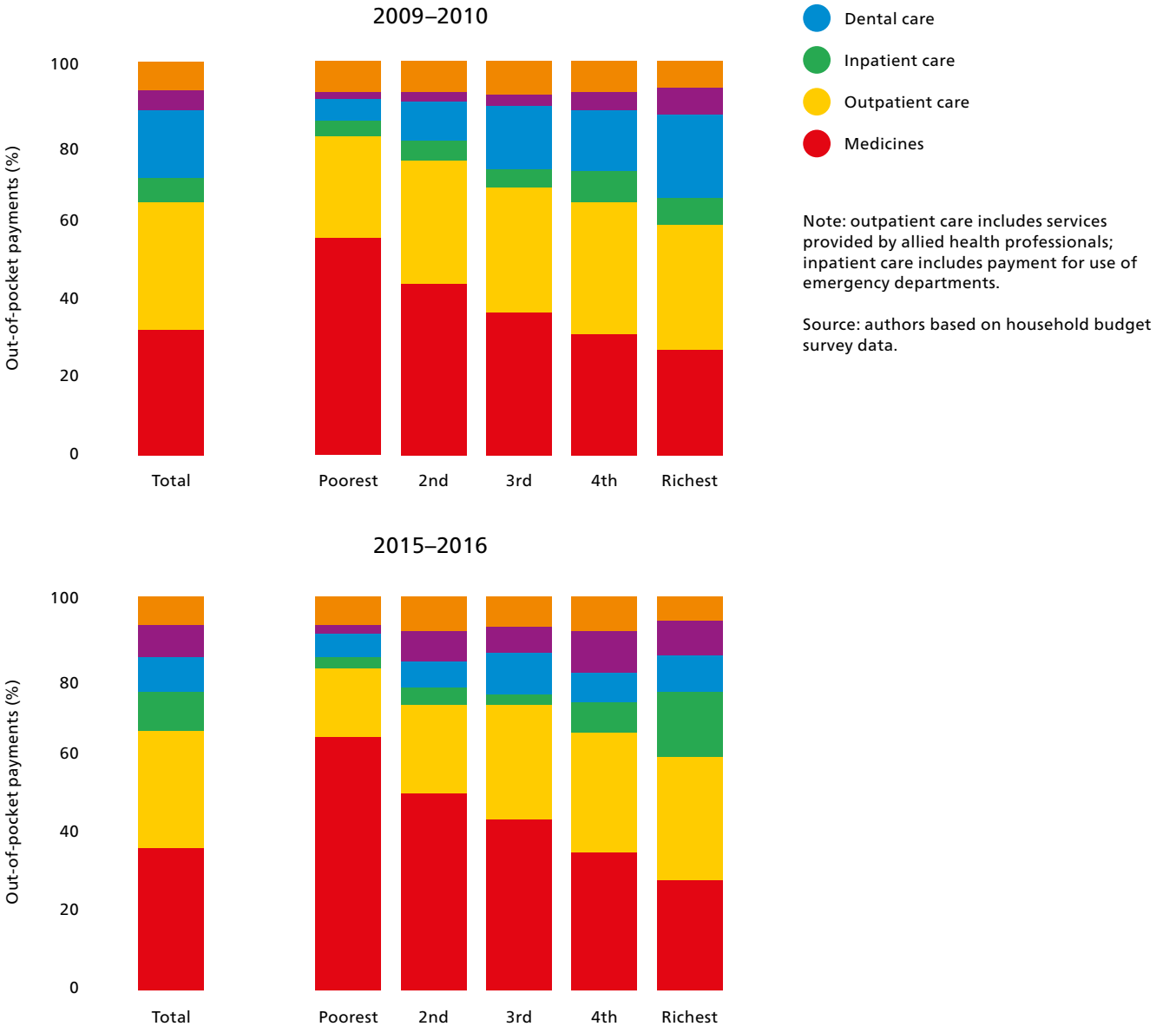
In 2009-2010, most out-of-pocket spending was on outpatient care and outpatient medicines, followed by dental care (Fig. 4). In 2015–2016, most out-of-pocket spending was on outpatient medicines and outpatient care, followed by inpatient care.

For all quintiles, outpatient medicines accounted for a higher share of out-of-pocket payments in 2015–2016 than in 2009–2010, corresponding to the introduction of, and increases in, co-payments for outpatient prescriptions for medical card holders (people in Category I) and increases in the monthly cap on these co-payments for all households.

Out-of-pocket payments for dental care dropped sharply between the two survey periods for all except the poorest quintile, coinciding with major reductions in dental care benefits for all households.

Spending on PHI premiums was remarkably resilient during the crisis, even in the face of substantial increases in premiums. Households appear to have traded off the need to pay out of pocket for dental care and GP visits with the need to keep hold of their PHI policies. This may in part explain the rapid increase in unmet need for health care and dental care between 2008 and 2012 (Fig. 2).

Fig. 4. Breakdown of total out-of-pocket spending by type of health care and consumption quintile



Note: outpatient care includes services provided by allied health professionals; inpatient care includes payment for use of emergency departments.

Source: authors based on household budget survey data.

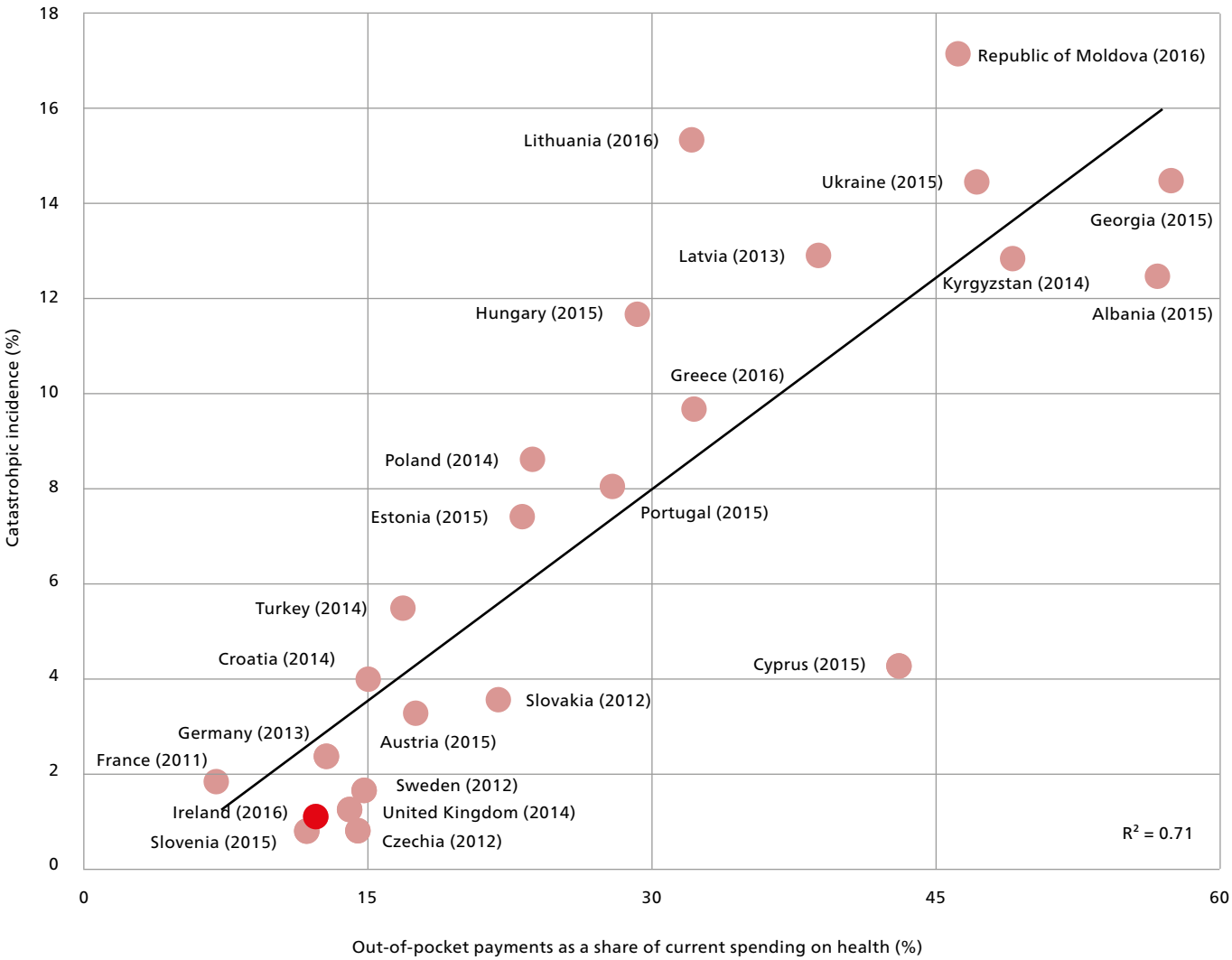
Financial protection

The incidence of catastrophic out-of-pocket payments is low in Ireland in comparison with many other EU countries (Fig. 6). Ireland's low incidence may reflect unmet need for health care owing to financial barriers to access and some of the longest waiting times for specialist inpatient care in the EU.

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

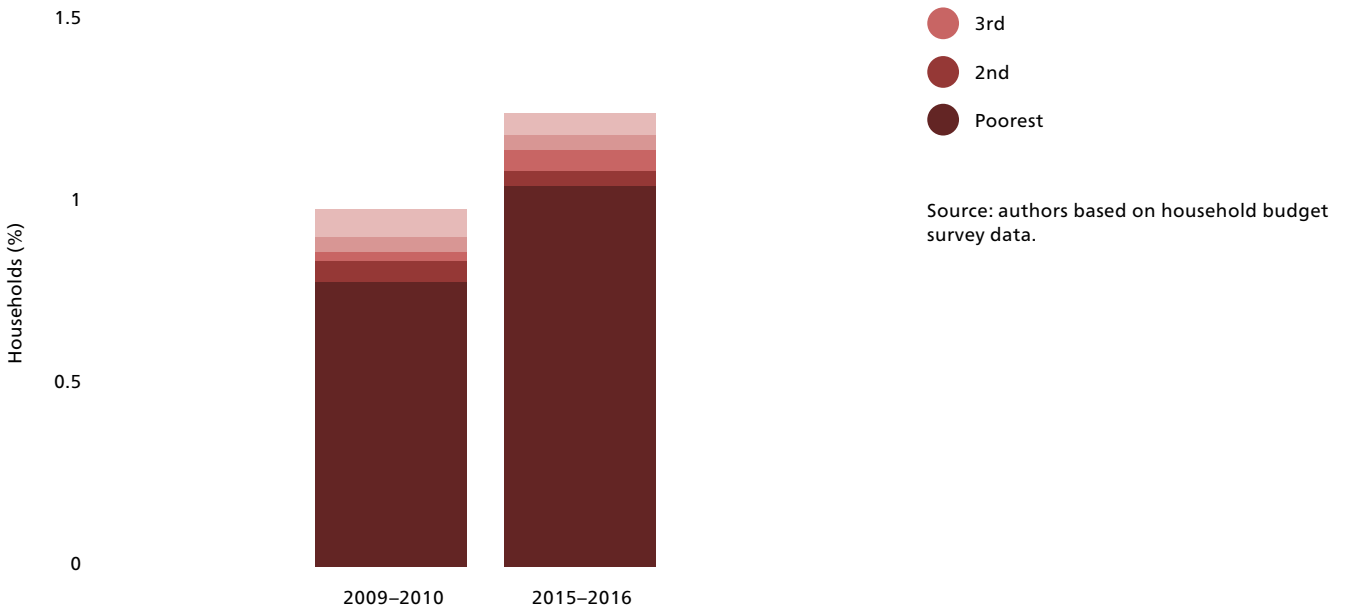
Notes: R^2: coefficient of determination. The out-of-pocket payment data are for the same year as the catastrophic spending data. Ireland is highlighted in red.

Source: WHO Regional Office for Europe (2019).



In 2015–2016, nearly 1% of households were impoverished or further impoverished by out-of-pocket payments and 1.2% of households (involving about 64 000 people) experienced catastrophic health spending, an increase from 0.5% and 1% respectively in 2009–2010. Financial hardship is heavily concentrated among poor households (Fig. 6) and medical card holders (people in Category I). During the study period, the share of households with catastrophic spending among the poorest quintile rose from 3.9% to 5.2%, while the share of medical card holders among households with catastrophic spending rose from 77% to 86%.

Fig. 6. Share of households with catastrophic spending by consumption quintile

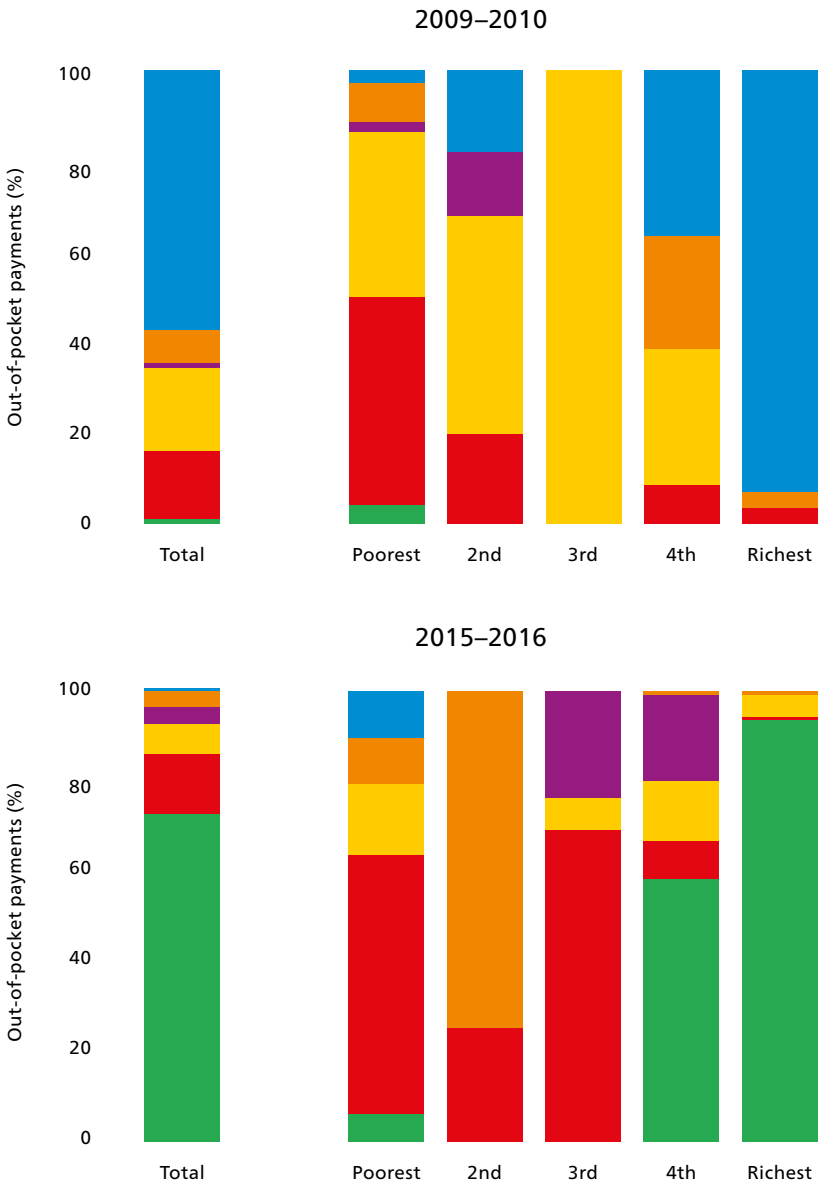


Source: authors based on household budget survey data.

In 2009–2010, catastrophic spending mainly went towards dental care. By 2015–2016, the largest share was spent on inpatient care. In both survey periods, this reflects spending among households in the two richest quintiles. Note that data for all except the poorest quintile need to be interpreted with caution due to the small numbers involved.

For households in the poorest quintile, catastrophic spending is consistently driven by out-of-pocket payments for outpatient medicines (Fig. 7). The outpatient medicines share and the dental care share rose between 2009–2010 and 2015–2016, raising concerns about the effectiveness of the medical card system and the impact of policies such as the introduction of prescription charges for medical card holders, increases in the cap on these charges and reductions in dental care benefits.

Fig. 7. Breakdown of catastrophic spending by type of health care and consumption quintile



Notes: outpatient care includes services provided by allied health professionals and consultants; inpatient care includes payment for use of emergency departments. Data for all except the poorest quintile need to be interpreted with caution due to the small numbers involved.

Source: authors based on household budget survey data.

Factors that strengthen and undermine financial protection

The low incidence of catastrophic health spending in Ireland can be attributed to the fact that the poorest 35% of the population (Category I) has free access to most health services, including outpatient-prescribed medicines before 2010. This degree of protection for poor households is unusual among EU countries. For those who have to pay user charges, there are annual caps on co-payments for outpatient-prescribed medicines and inpatient care. High take-up of PHI also provides some protection from having to pay out of pocket for specialist care. As a result of these factors, the out-of-pocket payment share of current spending on health is relatively low.

There are gaps in coverage, nevertheless, particularly for outpatient-prescribed medicines and dental care for all households and outpatient care for non-medical card holders (Category II). These gaps were expanded during the financial and economic crisis, leading to higher financial hardship and greater unmet need. The increase in the share of people with catastrophic health spending between 2009–2010 and 2015–2016 was concentrated among poorer households (Fig. 6), resulting in a substantial shift in the distribution of catastrophic and impoverishing health spending towards very poor households. This shift may also be linked to rising poverty levels during and after the crisis.

The pattern of out-of-pocket payments among households with catastrophic spending (Fig. 7) closely mirrors gaps in coverage and coverage-policy changes over time.

- For the poorest quintile, catastrophic spending is almost entirely driven by outpatient medicines, outpatient care and medical products. Over time, the outpatient medicines and dental care share increased, while the outpatient care share fell, reflecting a significant reduction in the range of dental services available to medical card holders, the introduction of outpatient prescription charges for medical card holders in April 2010 and increases in, and caps for, these charges in 2013 and 2014. The European Health Interview Survey carried out in 2014 shows that unmet need for prescribed medicines is much higher in Ireland than the EU average and much higher among people with lower socioeconomic status.

- Among households in the other quintiles, catastrophic spending shifted from outpatient care and dental care to outpatient medicines and inpatient care, reflecting growing unmet need for dental care in response to serious reductions in dental care benefits for Category II in 2010 and 2012.

- The fall in the outpatient care share of catastrophic spending, seen across all except the richest quintile, may reflect the extension of GP visit cards to all children under 6 and all adults over 70 years of age from July 2015.

Cuts in dental benefits for all households and cuts in the number of health workers are associated with a steady increase in unmet need for health care and dental care between 2008 and 2012, particularly among poorer households. As waiting times for specialist care increased, many people continued to pay rising PHI premiums instead of paying out of pocket for dental care or outpatient care.

Implications for policy

The study's findings raise several implications for policy.

First, cuts in public spending on health have shifted costs onto households and are associated with increased financial hardship and unmet need, particularly among poor people.

Second, even relatively low user charges – the prescription charges introduced for Category I in 2010 and increased in 2013 and 2014 – can lead to financial hardship for very poor households and, at the same time, present a financial barrier to access. Although the medical card system successfully protects many households from financial hardship, there are clearly gaps in coverage for the poorest households. The Sláintecare proposals aim to reduce prescription charges, which will improve financial protection. The results of this study suggest the proposals should go further, however, and exempt poor households from prescription charges altogether.

Third, household spending on PHI premiums during the study period suggests that lifetime community rating encouraged some people to buy PHI for the first time and encouraged those with PHI to retain policies even when premiums were rising sharply. This appears to have crowded out some out-of-pocket spending over time – notably spending on dental care – possibly contributing to rising unmet need following the crisis.

Although PHI is likely to reduce out-of-pocket payments for those who have it, spending on PHI premiums represents a significant and growing financial burden on households, accounting for around 3% of household consumption in 2015–2016 (up from 2% in 2009–2010). The introduction of lifetime community rating in 2015 probably added to this financial burden.

PHI also undermines equity and efficiency in the health system, particularly through the presence of substantial tax subsidies that benefit those who are able to spend more on PHI rather than targeting those with lower incomes.

Finally, the reduction in out-of-pocket spending per person among the three richest quintiles and the shift in out-of-pocket spending away from dental care at a time when entitlement to publicly financed health care was being cut, including a serious reduction in dental care benefits, coincides with substantial growth in unmet need for health care and dental care across all quintiles. Income-related inequality in unmet need also grew, particularly for dental care. If unmet need had not grown, it is possible that the increase in catastrophic health spending over time would have been even greater.

Policy attention should now focus on:

- improving protection for medical card holders (Category I) by exempting them from prescription charges and increasing dental benefits;
- reducing out-of-pocket payments for outpatient-prescribed medicines and dental care for households in Category II by changing from the current system of patients paying the full cost of prescription up to a high annual cap to an income-related cap, and by introducing universal vouchers for dental care;
- extending publicly financed GP care to households on lower incomes;
- expanding prevention and community care services to help limit inappropriate patterns of demand for GP and specialist care;
- reducing co-payments for inpatient care;
- introducing waiting-time guarantees for public hospital services to reduce the need for people to pay out of pocket for private outpatient specialist care;
- simplifying what is at present an unusually complex set of entitlements to publicly financed health services; and
- introducing steps to address inequalities and inefficiencies linked to the presence of an unusually large market for supplementary PHI.

Many of these policy measures are set out in the Sláintecare proposals, which if implemented would reduce financial hardship and unmet need for many households.

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Glossary of terms

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

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

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

Budget: See household budget.

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

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

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

Catastrophic out-of-pocket payments: Also referred to as catastrophic health spending. An indicator of financial protection. Catastrophic out-of-pocket payments can be measured in different ways. This study defines them as out-of-pocket payments that exceed 40% of a household's capacity to pay for health care. The incidence of catastrophic health spending includes households who are impoverished and households who are further impoverished.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Ukraine
United Kingdom
Uzbekistan