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

This document describes the relevance of monitoring financial protection to support evidence-informed decisions on the path to universal health coverage and summarizes key policy messages from a new study of financial protection in Europe. Financial protection is central to universal health coverage and a core dimension of health system performance.
The Tallinn Charter: Health Systems for Health and Wealth states that "it is unacceptable that people become poor as a result of ill-health". Resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020 called on Member States to work towards a Europe free of impoverishing out-of-pocket payments for health; requested the Regional Director to provide tools and support to Member States for the monitoring of financial protection and to pursue the commitments agreed in the Tallinn Charter; and requested the Regional Director to report on implementation, focusing mainly on financial protection, in 2018. In addition to meeting this reporting requirement, this document and the summary of the regional report (information document EUR/RC68/Inf.Doc./1) respond to resolution EUR/RC67/R3 – on the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020 – which calls on WHO to support Member States in moving towards universal health coverage.

The study monitors financial protection in a way that produces actionable evidence for policy, promotes pro-poor policies to break the link between ill-health and poverty, and is relevant to all Member States in the Region. Policy messages of regional relevance are based on in-depth analysis of the experience in 25 Member States from across the European Region.

This document is submitted as a working document to the 68th session of the Regional Committee. A summary of the study findings is provided in an information document under the same title. Country-level analytical reports are being published on the WHO website and serve as background documentation for the regional report.

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Background

1. Financial protection is central to universal health coverage and a core dimension of health system performance. The Tallinn Charter: Health Systems for Health and Wealth states that "it is unacceptable that people become poor as a result of ill-health". The Charter promotes equity, solidarity, financial protection and better health through health system performance monitoring, assessment and improvement.

2. The financial and economic crisis tested the ability of the Member States of the WHO European Region to meet the commitments they made in Tallinn. In collaboration with the Government of Norway, WHO organized two high-level meetings in Oslo in 2009 and 2013 to identify ways of overcoming the challenges posed by the crisis. With the European Observatory for Health Systems and Policies, WHO also carried out a major study on health system responses to the crisis. This provided ample evidence of the importance of strengthening equity, solidarity and financial protection in an economic crisis. It also highlighted the need for timely performance monitoring to support policy responses.

3. At its 65th session, in 2015, the WHO Regional Committee for Europe adopted resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020, in which it:

- called on Member States to work towards a Europe free of impoverishing out-of-pocket payments for health;
- requested the Regional Director to provide tools and support to Member States for the monitoring of financial protection and to pursue the commitments agreed in the Tallinn Charter; and
- requested the Regional Director to report on implementation, focusing mainly on financial protection, in 2018.

4. The Sustainable Development Goals (SDGs) adopted by the United Nations in 2015 also call for monitoring of, and reporting on, financial protection as one of two indicators for universal health coverage. Resolution EUR/RC67/R3 – on the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020 – calls on WHO to support Member States in moving towards universal health coverage.

5. In response, the WHO Regional Office for Europe initiated a new study of financial protection in Europe to support Member States with monitoring, analysis and policy recommendations. This work is being carried out by the WHO Barcelona Office for Health Systems Strengthening, Spain, in the Division of Health Systems and Public Health, as part of a project with three workstreams:

- developing new metrics for measuring financial hardship building on established methods – the new approach has been reached after consultation with international experts, including colleagues in WHO and the World Bank;

- producing country-level analysis for national policy development, working closely with over 50 national experts in 25 countries[1] – this sets a baseline for monitoring financial protection in the context of the SDGs; country reports are being published throughout 2018;
- deriving lessons for policy from regional analysis.

6. The aim is to monitor financial protection in a way that produces actionable evidence for policy, promotes pro-poor policies to break the link between ill-health and poverty, and is relevant to all Member States in the Region.

7. Preliminary estimates of financial protection indicators were shared with individual Member States through a consultation organized jointly by WHO headquarters and the Regional Office in 2017 and 2018.

8. The results of this study, which includes detailed policy analysis, were presented at the high-level technical meeting, Health Systems for Prosperity and Solidarity: Leaving No One Behind (Tallinn, Estonia, 13–14 June 2018), hosted by the Government of Estonia to celebrate 10 years of the Tallinn Charter. A synthesis of evidence from 25 countries in Europe is contained in a summary of the regional report that is being submitted to the 68th session of the Regional Committee (information document EUR/RC68/Inf.Doc./1).

9. The following sections set out the motivation for and relevance of monitoring financial protection in Europe and highlight implications for policy.

Financial protection: a core dimension of health system performance

What is financial protection?

10. Universal health coverage ensures that everyone can use the high-quality health services they need without experiencing financial hardship. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the time of using any health care good or service – are large in relation to their ability to pay for health care. Even small out-of-pocket payments can cause financial hardship for poor households and those who have to pay for long-term treatment such as medication for chronic conditions. Because all health systems involve some out-of-pocket payment, financial hardship can be a problem in any country.

Why does it matter?

11. 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

[1] The countries are a mix of high-income countries (Austria, Cyprus, Czechia, Estonia, France, Germany, Greece, Hungary, Ireland, Latvia, Lithuania, Netherlands, Poland, Portugal, Slovakia, Slovenia, Sweden and the United Kingdom of Great Britain and Northern Ireland) and middle-income countries (Albania, Croatia, Georgia, Kyrgyzstan, Republic of Moldova, Turkey and Ukraine).

reducing access to health care, undermining health status, deepening poverty and exacerbating health and socioeconomic inequalities. Recognizing this, WHO and the World Bank have long regarded financial protection as a core dimension of health system performance assessment. The SDGs include financial protection as a measure of universal health coverage (indicator 3.8.2).

How is it measured?

12. Financial protection is measured using two well established indicators:

- catastrophic health spending occurs when the out-of-pocket amount a household pays for health care exceeds a pre-defined share of its ability to pay for health care, which may make it difficult for the household to meet other basic needs; it is measured in different ways, with metrics varying in how they define ability to pay for health care;
- impoverishing health spending provides information on the impact of out-of-pocket payments on poverty, and is measured by looking at a household's position in relation to a pre-defined poverty line before and after incurring out-of-pocket payments; a household is considered to be impoverished if its consumption or income is above the poverty line before out-of-pocket payments and below it after out-of-pocket payments; metrics differ in the type of poverty line they use.

The added value of the Regional Office study

13. Filling a major gap in health system performance assessment in Europe: when the study began, the only previous analysis of financial protection covering multiple European countries was a global study drawing on data from the 1990s. In 2017 WHO and the World Bank published a new global study using SDG metrics, with results up to 2010. The Regional Office analysis uses more recent data from 2014 or 2015 for most countries.

14. Being relevant to all Member States of the Region, including high-income countries, as demonstrated by a comparative analysis of Czechia, Estonia and Latvia released alongside the 2017 global study. Analysis produced for the earlier global study showed a level of incidence of catastrophic health spending that was implausibly low for many countries in Europe. In the 2017 global study, the incidence of impoverishing health spending is implausibly low owing to the use of international poverty lines, such as US$ 1.90 or US$ 3.10 a day.

15. Using newly developed policy-relevant metrics: the first global study did not consider the distribution of catastrophic health spending across different groups of people or look at which health services are responsible for catastrophic out-of-pocket payments. The 2017 global study does include some distributional analysis, but finds that the incidence of catastrophic health spending is higher among rich people than poor people owing to the metrics used, which do not account for the cost of meeting basic needs. The Regional Office metrics are better able to capture financial hardship among poor people (see paragraph 18). They also give visibility to people who are further impoverished after having to pay for health care at the point of use.

16. Developing actionable evidence for policy: the approach to monitoring in the Region is based on in-depth, country-level analysis, allowing results to be linked to health system

policies. This context-specific analysis is an important complement to global monitoring, as the 2017 global report clearly acknowledges.

How many households face financial hardship?

17. The incidence of catastrophic out-of-pocket payments ranges from 1% to 15% of households in the countries in the Regional Office study. The incidence of impoverishing and further impoverishing out-of-pocket payments ranges from 0.3% to 8.2% of households. A household is impoverished if its total spending falls below the poverty line after out-of-pocket payments. A household is further impoverished if it is already poor and incurs out-of-pocket payments.

Who experiences financial hardship?

18. Catastrophic out-of-pocket payments are heavily concentrated among the poorest consumption quintile in all countries. Individual country reviews provide more detailed information on the characteristics of households with catastrophic out-of-pocket payments. Catastrophic spending on health is concentrated among people aged over 60 in many countries, including Austria, Estonia, Germany, Ireland, Latvia and Lithuania. In Germany, however, it is more concentrated among people receiving social benefits or dependent on income from spouses than among pensioners, while in Croatia and Lithuania it is concentrated among households without children. In contrast, catastrophic spending in the United Kingdom is concentrated among younger people and households with children. These cross-country differences in the distribution of catastrophic incidence highlight the importance of being able to identify people who are particularly vulnerable within income and age groups.

Which health services are responsible for financial hardship?

19. Across the study countries, catastrophic out-of-pocket payments are more likely to be made for outpatient medicines where financial protection is weaker, and more likely to be spent on dental care where financial protection is stronger.

20. Within countries, there is a similar pattern: catastrophic out-of-pocket payments among poorer households are more likely to be made for outpatient medicines, whereas among richer households they are more likely to be made for dental care. Data on unmet need suggest that poorer people are less likely to seek dental care than richer people, which underlines the importance of analysing financial protection and unmet need in tandem.

Factors that strengthen financial protection

21. Health systems with strong financial protection share the following features:

- out-of-pocket payments are low, accounting for no more than 15% of total spending on health;
- public spending on health is high relative to gross domestic product – this is closely related to the priority given to health within government budgets;

- coverage policies are carefully designed to minimize out-of-pocket payments and there are mechanisms in place to protect poor people and other vulnerable groups from user charges (co-payments);
- unmet need for health and dental care is low, with minimal inequality in unmet need across different groups of people.

Implications for policy

22. It is not enough to monitor access to health services; monitoring financial protection should be a core component of health system performance assessment within and across countries. The Regional Office study is the first to systematically monitor financial protection in Europe, filling a significant gap in health system performance assessment. It has shown how access to health services cannot be fully understood by looking at unmet need (or at service coverage, as in the SDGs). Unmet need and financial protection must be considered in tandem because financial protection may appear to be strong where unmet need is high, if people are unable to use health services due to access barriers; it may deteriorate as unmet need falls if reforms that improve access increase financial hardship among those using services.

23. How you monitor financial protection matters. To inform policy and help countries move towards universal health coverage, monitoring needs to be able to produce actionable evidence. Actionable evidence comes from context-specific policy analysis. This study is based on country-level analysis, which allows indicators to be linked to policies and policy changes over time. It uses metrics that are sensitive to, and give visibility to, the financial hardship faced by poor households.

24. The incidence of catastrophic out-of-pocket payments is generally very low in countries where the out-of-pocket share of total spending on health is close to or less than 15%. Financial protection is weaker where out-of-pocket payments are high and public spending on health is low. There is increasing variation in financial protection across countries as the out-of-pocket share of total spending increases.

25. Ensuring high levels of public spending on health plays a vital role in reducing out-of-pocket payments, but coverage policies are also important. This analysis finds that differences in financial hardship are partly explained by variations in health spending across countries – particularly variation in the priority given to health when allocating government spending. However, increases in public spending or reductions in out-of-pocket payments are not, in themselves, a guarantee of better financial protection. Coverage policy is an equally important explanatory factor.

26. Coverage policy is the primary mechanism through which households are exposed to out-of-pocket payments. It also determines how out-of-pocket payments are distributed across different groups of people. Gaps in coverage mean households must spend out of pocket or forego the use of health services.

27. Population entitlement to publicly financed health care is a prerequisite for financial protection, but not a guarantee of it. Many countries with lower levels of population coverage and a higher incidence of catastrophic out-of-pocket payments link entitlement to employment

or payment of contributions, but lack effective mechanisms to enforce participation or to protect vulnerable groups such as long-term unemployed people.

28. Gaps in the scope and quality of service coverage affect different groups of people differently, often leading to financial hardship for richer households who are able to pay out of pocket, but resulting in unmet need for poorer households who forego or delay seeking care. Outpatient medicines and dental care for adults are common gaps in service coverage.

29. Countries can significantly improve financial protection through a careful redesign of user charges to minimize co-payments, with additional protection for poor people and regular users of health services.

30. Weak coverage design shifts the burden of paying for health care on to those who can least afford it: poor people, people with chronic conditions and older people. This undermines equity in financing the health system and equity in the use of health services. It also undermines efficiency. Out-of-pocket payments for medicines are a major driver of financial hardship in Europe, particularly among poor people. Medicines are an integral part of primary care. There is no economic case for making people pay for primary care, including medicines.

31. When coverage design is weak, inefficiencies in the health system can exacerbate financial hardship. For example, if people have to pay a percentage of the price of prescribed medicines, their exposure to out-of-pocket payments will increase as prices rise or where prescribers and dispensers do not face appropriate or aligned incentives. Addressing inefficiencies can improve financial protection.

32. Unmet need for health services tends to be high in countries where financial protection is weak; it has grown since the financial and economic crisis. Given the widespread application of user charges in many countries in Europe, without adequate protection for poor and regular users it is possible that, if more people had been able to use health services during the study period, the out-of-pocket payment burden would have been higher and the extent of financial hardship worse than the current analysis indicates.

33. There is a wealth of good practice in Europe; lessons can be learnt from countries with strong financial protection and countries where financial protection is weak overall but steps have been taken to protect poor people. Protecting poor households is a priority in high-performing health systems. To be effective, protection should be aimed at people, not at specific items or services. In any country, poor people and regular users of health services are likely to be most vulnerable to financial hardship. Other groups of people may also be vulnerable, depending on context – particularly on the extent of migration and the quality of social protection policies.

34. Policy action to improve financial protection will reduce unmet need and alleviate poverty linked to the use of health services, with positive effects for people and society.

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