World Health Organization
REGIONAL OFFICE FOR Europe

Regional Committee for Europe
68th session

Rome, Italy, 17–20 September 2018

Provisional agenda item 5(d)

EUR/RC68/Inf.Doc./1

16 August 2018
180444
ORIGINAL: ENGLISH

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

Regional report summary

This document contains a summary of a new regional study on financial protection in Europe. The study's 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.

The present document sets out the motivation for monitoring financial protection in Europe, summarizes the study's main findings and highlights implications for policy.

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark Telephone: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eugovernance@who.int Web: http://www.euro.who.int/en/who-we-are/governance

Contents

Acknowledgements

This is a summary of a regional report produced by the WHO Barcelona Office for Health Systems Strengthening, Spain, which is part of the Division of Health Systems and Public Health, directed by Hans Kluge, in the WHO Regional Office for Europe. It was written by Sarah Thomson, Jonathan Cylus and Tamás Evetovits.

The regional report draws on a series of 25 country reviews prepared by national experts in collaboration with the WHO Barcelona Office. The series editors are Sarah Thomson, Jonathan Cylus and Tamás Evetovits. Individual country reports were edited by Marina Karanikolos, Mary MacLennan, Anna Maresso, Ilaria Mosca, Erica Richardson and Pooja Yerramilli.

The national experts are as follows:

Albania: Sonila Tomini, Florian Tomini
Austria: Thomas Czypionka, Gerald Röhrling, Eva Six
Croatia: Luka Vončina, Ivica Rubil
Cyprus: Antonis Kontemeniotis, Mamas Theodorou
Czechia: Daniela Kandilaki
Estonia: Andres Võrk, Triin Habicht
France: Damien Bricard
Georgia: Ketevan Goginashvili, Mamuka Nadareishvili
Germany: Martin Siegel, Reinhard Busse
Greece: Michalis Chletsos, Owen O'Donnell
Hungary: Péter Gaál, Ferenc Lindeisz
Ireland: Sara Burke, Bridget Johnston, Steve Thomas
Kyrgyzstan: Baktygul Akkazieva, Melitta Jakab, Jarno Habicht
Latvia: Maris Taube, Edmunds Vaskis, Oksana Nesterenko
Lithuania: Liuba Murauskienė, Sarah Thomson
Netherlands: Jelena Arsenijevic, Wim Groot
Poland: Marzena Tambor, Milena Pavlova
Portugal: Pedro Pita Barros, Ana Rita Borges
Republic of Moldova: Iuliana Garam, Mariana Zadnipru, Valeriu Doronin, Andrei Matei;
Slovakia: Mária Pourova
Slovenia: Eva Zver, Dusan Josar, Andrej Srakar
Sweden: Anna Glenngård, Sixten Borg
Turkey: Ali Riza Demirbas
Ukraine: Alona Goroshko, Natalia Shapoval, Taavi Lai
United Kingdom of Great Britain and Northern Ireland: Nora Cooke O'Dowd, Stephanie Kumpunen, Holly Holder.

WHO thanks national statistical offices for making household budget survey data available to the national experts. Data on financial protection were shared with nominated officials from individual Member States as part of a WHO consultation on universal health coverage indicators in 2017 and 2018. WHO gratefully acknowledges funding from the Department for International Development of the United Kingdom of Great Britain and Northern Ireland, under the Making Country Health Systems Stronger programme, and from the Government of the Autonomous Community of Catalonia, Spain.

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 (Maresso et al., 2015; Thomson et al., 2015). 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. This document summarizes the main findings from a new study of financial protection in Europe. The study's 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. It 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 work streams, as detailed below.

(a) New metrics for measuring financial protection: a new approach, building on established methods, has been developed after consultation with international experts, including colleagues in WHO and the World Bank.

(b) Country-level analysis for national policy development: over 50 national experts in 25 countries have produced a series of country reviews in 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). To facilitate comparison across countries, the reviews follow a standard template, draw on similar sources of data and use the same methods. The reviews are subject to external peer review. Preliminary estimates of financial protection indicators were shared with nominated officials from individual Member States through a consultation organized jointly by WHO headquarters and the Regional Office in 2017 and 2018. This country-level analysis sets a baseline for monitoring financial protection in the context of the SDGs.

(c) Policy lessons for the whole of the European Region: the final results of this study – a synthesis of evidence from 25 countries in Europe, with detailed policy analysis – will be published in a regional report, of which the present document is the summary.

6. The following sections set out the motivation for monitoring financial protection in Europe, summarize the study's main findings and highlight implications for policy.

Financial protection: a core dimension of health system performance

What is financial protection?

7. 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 medicines for chronic illness. Because all health systems involve some out-of-pocket payment, financial hardship can be a problem in any country.

Why does financial protection matter?

8. Where health systems fail to provide adequate financial protection, people 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. 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 financial protection measured?

9. Financial protection is measured using two well-established indicators.

(a) Catastrophic health spending occurs when the out-of-pocket amount a household pays for health care exceeds a predefined 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 (see Box 1).

(b) 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 predefined 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.

Box 1. Different ways of measuring catastrophic spending on health

Some studies define out-of-pocket health expenditures as catastrophic when they exceed a given percentage (e.g. 10% or 25%) of income or consumption. With this budget share approach, which is used in the SDGs (indicator 3.8.2), catastrophic expenditure is more likely to be concentrated among the rich than the poor (WHO & World Bank, 2015).

Other studies relate health expenditures to consumption, less a deduction for necessities. Everyone needs to spend at least some minimum amount on basic needs such as food and housing, and these absorb a larger share of the consumption or income of a poor household than a rich one. As a result, a poor household may not be able to spend much, if anything, on health care. By contrast, a rich household may spend 10% or 25% of its budget on health care and still have enough resources left over to avoid financial hardship.

Capacity-to-pay approaches deduct expenditures for basic needs in various ways. The main differences between them include: deducting actual spending versus a standard amount; using one item or a basket of items; the method used to derive the standard amount; and treatment of households where actual spending is below the standard amount. Some studies deduct all of a household's actual spending on food (Wagstaff & van Doorslaer, 2003). However, although poor households often devote a higher share of their budget to food, food may not be a sufficient proxy for nondiscretionary consumption. Also, spending on food reflects preferences, as well as factors linked to health spending: for example, households that spend less on food because they need to spend on health care will appear to have greater capacity to pay than households that spend more on food.

A second approach, aimed at addressing the role of preferences in food spending, is to deduct a standard amount from a household's total resources to represent basic spending on food (Xu et al., 2003, 2007). In practice, it is a partial adjustment to the actual food spending approach, because the standard amount is used only for households that spend more on food than the standard amount. For all other households, actual food spending is deducted instead of the higher, standard amount. Both the actual food and the standard food approaches therefore treat households where actual food spending is below the standard amount in the same way. Nevertheless, with the standard food approach, catastrophic spending may be less concentrated among the rich than with the actual food spending approach.

A third approach is to deduct a poverty line, essentially an allowance for all basic needs (Wagstaff & Eozenou, 2014). Depending on the poverty line used, this could result in a greater concentration of catastrophic spending among the poor than the rich.

Building on the second and third approaches, the WHO Regional Office for Europe deducts an amount representing spending on three basic needs: food, housing (rent) and utilities (Thomson et al., 2016). It deducts this amount consistently for all households. As a result, catastrophic spending is more likely to be concentrated among the poor with this approach than with all of the other approaches (Cylus et al., in press).

Source: adapted from WHO & World Bank (2017).

The added value of the Regional Office study

10. The study adds value in the following ways.

- 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 (Xu et al., 2003, 2007). In 2017, WHO and the World Bank published a new global study using Sustainable Development Goal metrics, with results up to 2010 (WHO & World Bank, 2017). The Regional Office analysis uses more recent data from 2014 or 2015 for most countries.
- Being relevant to all Member States of the Region: as demonstrated by a comparative analysis of three high-income countries released alongside the 2017 global study (Thomson et al., 2018). 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.
- Using 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 includes some distributional analysis, and finds that the incidence of catastrophic health spending is higher among rich people than poor people. The Regional Office metrics are better able to capture financial hardship among poor people; they also give visibility to people who are further impoverished after having to pay for health care at the point of use (Thomson et al., 2016; Cylus et al., in press).
- Developing actionable evidence for policy: the approach to monitoring is based on 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 (WHO & World Bank, 2017).

Methods, data sources and limitations

11. The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe, building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003). Financial protection is measured using two main indicators: catastrophic out-of-pocket payments and impoverishing out-of-pocket payments. Table 1 summarizes the key dimensions of each indicator.

Table 1. Key dimensions of catastrophic and impoverishing spending on health

	Catastrophic out-of-pocket payments
Definition	The share of households with *out-of-pocket payments* that are greater than 40% of household *capacity to pay for health care*
Numerator	Out-of-pocket payments
Denominator	Total household *consumption* minus a standard amount to cover basic needs; the standard amount to cover basic needs is calculated 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
Disaggregation	Results are disaggregated into household *quintiles* by consumption; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
	Impoverishing out-of-pocket payments
Definition	The share of households *impoverished* or *further impoverished* after out-of-pocket payments
Poverty line	A *basic needs line*, calculated 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
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments
Disaggregation	Results can be disaggregated into household quintiles by consumption and other factors where relevant

Note: see the glossary of terms for definitions of words in italics.
Source: Thomson et al. (2018).

12. The study uses anonymized microdata from household budget surveys. These surveys measure household spending on goods and services over a given period of time and include information about household characteristics. Most Member States in the Region conduct household budget surveys at regular intervals (Yerramilli et al., 2018).

13. Access to survey data was obtained by national experts from national statistical offices; in most cases, the study uses the most recent data available. Because household budget surveys can vary across countries in structure and implementation, the results of comparative analysis should be interpreted with a degree of caution (Eurostat, 2015).

14. Household spending on health – out-of-pocket payments – refers to formal and informal payments made by people at the time of using any health good or service delivered by any type of provider. They typically include consultation fees, payment for medications and other medical supplies, payment for diagnostic and laboratory tests, payments occurring during hospitalization and spending on alternative or traditional medicine. They do not include spending on health-related transportation or special nutrition, and are net of any reimbursement from the government, health insurance funds or private insurance companies.

15. A limitation common to all analysis of financial protection is that it measures financial hardship among households who are using health services, and does not capture financial barriers to access that result in unmet need for health services. For this reason, the Regional

Office study systematically draws on analysis of unmet need, where available, to complement analysis of financial protection (see Box 2).

Box 2. Unmet need for health care

Financial protection indicators capture financial hardship among people who incur out-of-pocket payments through the use of health services. They do not, however, indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need for health care. Unmet need is an indicator of access, defined as instances in which people need health care but do not receive it because of access barriers.

Information on health care use or unmet need is not routinely collected in the household budget surveys used to analyse financial protection. These surveys indicate which households have not made out-of-pocket payments, but not why. Households with no out-of-pocket payments may have no need for health care, be exempt from user charges or face barriers to accessing the health services they need.

Financial protection analysis that does not account for unmet need could be misinterpreted. A country may have a relatively low incidence of catastrophic out-of-pocket payments because many people do not use health care, owing to limited availability of services or other barriers to access. Conversely, reforms that increase the use of services can increase people's out-of-pocket payments – for example, through user charges – if protective policies are not in place. In such instances, reforms might improve access to health care but at the same time increase financial hardship.

The country reviews draw on data on unmet need to complement the analysis of financial protection. They also draw attention to changes in the share and distribution of households without out-of-pocket payments. If increases in the share of households without out-of-pocket payments cannot be explained by changes in the health system – for example, enhanced protection for certain households – they may be driven by increases in unmet need.

Every year, European Union Member States collect data on unmet need for health and dental care through the European Union Statistics on Income and Living Conditions (EU-SILC). Although this important source of data lacks explanatory power and is of limited value for comparative purposes because of differences in reporting by countries, it is useful for identifying trends over time within a country (Arora et al., 2015; EXPH, 2016, 2017).

EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS) carried out every five years or so. The second wave of this survey was conducted in 2014. A third wave is scheduled for 2019.

Whereas EU-SILC provides information on unmet need as a share of the population aged over 16 years, EHIS provides information on unmet need among those reporting a need for care. EHIS also asks people about unmet need for prescribed medicines.

Source: WHO Barcelona Office for Health Systems Strengthening.

Comparing financial protection across countries in Europe

How many households face financial hardship?

16. The incidence of catastrophic out-of-pocket payments ranges from 1% to 15% of households in the countries in the Regional Office study (Fig. 1). The incidence of impoverishing and further impoverishing out-of-pocket payments ranges from 0.3% to 8.2% of households (Fig. 2). 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?

17. Catastrophic out-of-pocket payments are heavily concentrated among the poorest consumption quintile in all the countries in the study (Fig. 1). 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 years in many countries, including Austria, Estonia, Germany, Ireland, Lithuania and Latvia. 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?

18. 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 (Fig. 3). 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 (Fig. 3). Data on unmet need suggest that poor people are less likely to seek dental care than rich people (Eurostat, 2018), which underlines the importance of analysing financial protection and unmet need in tandem.

Fig. 1. Share of households with catastrophic out-of-pocket payments by consumption quintile, latest year available

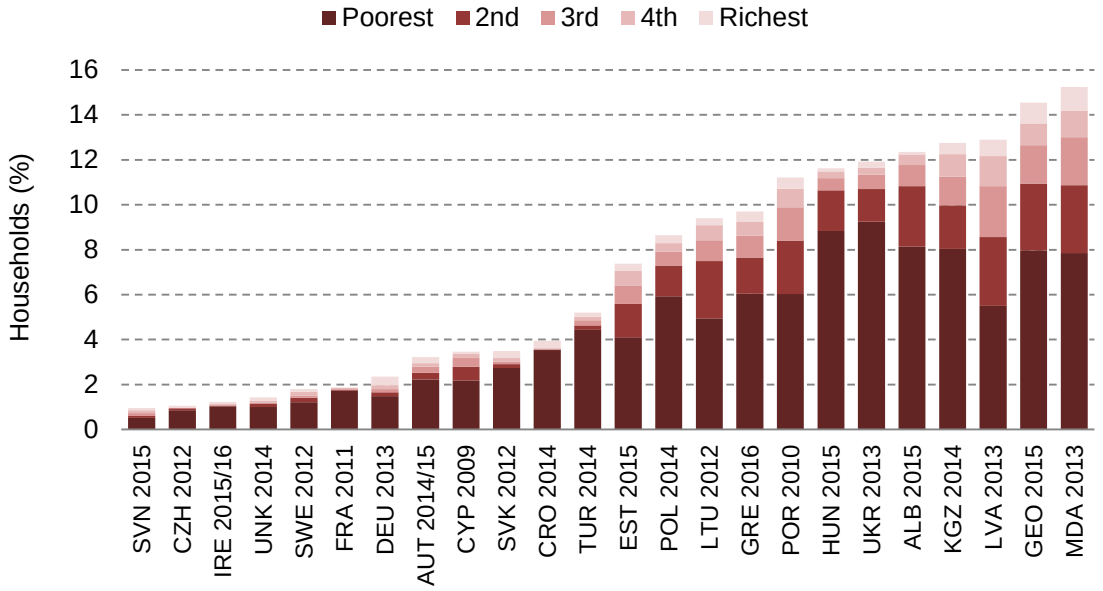
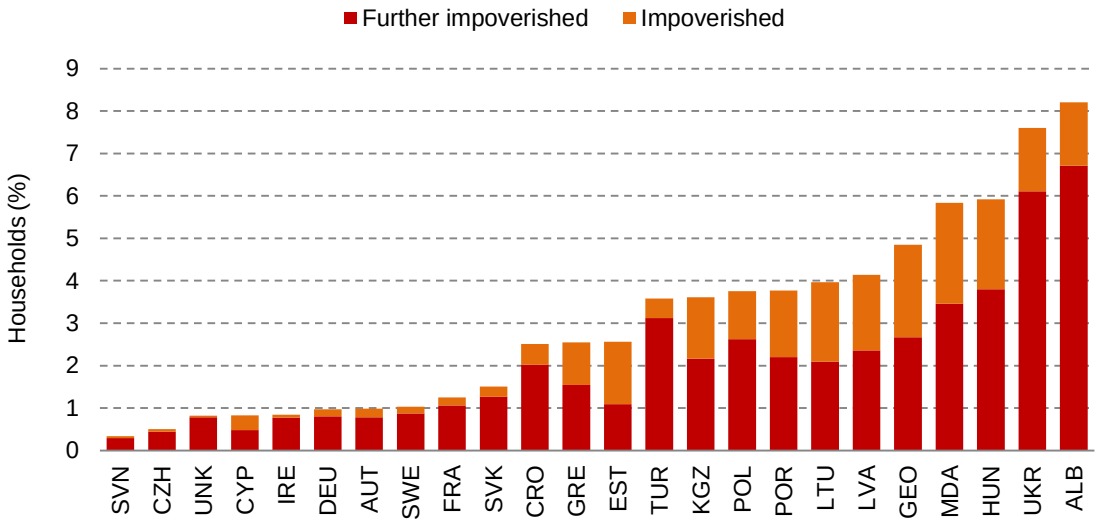
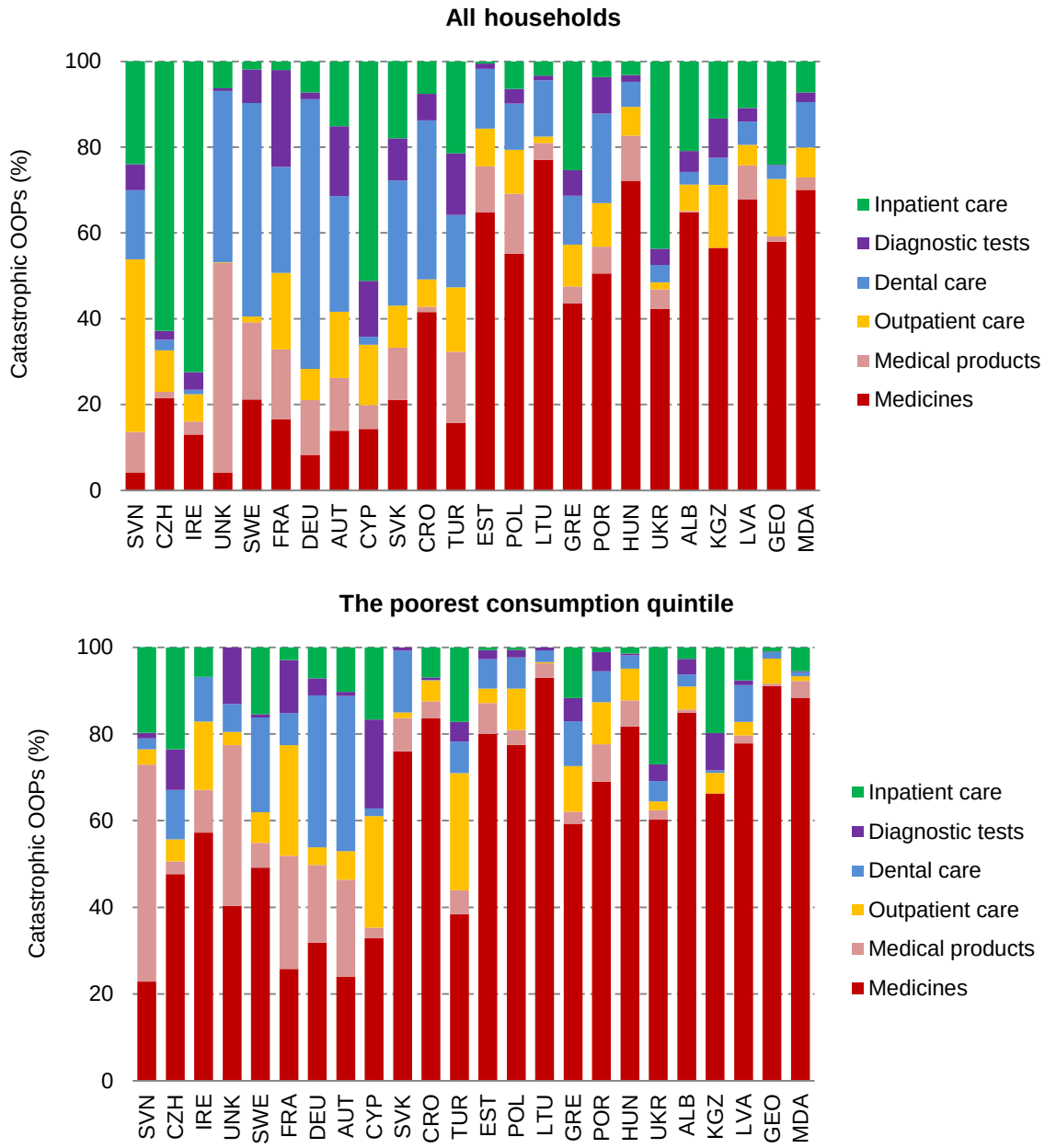


Fig. 2. Share of households impoverished or further impoverished after out-of-pocket payments, latest year available



Note: years as in Fig. 1.
Source: WHO Barcelona Office for Health Systems Strengthening.

Fig. 3. Breakdown of catastrophic out-of-pocket payments by health service



Notes: OOPs: out-of-pocket payments. Diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment. Households ranked by incidence of catastrophic out-of-pocket payments from lowest to highest. Years as in Fig. 1.
Source: WHO Barcelona Office for Health Systems Strengthening.

Factors that strengthen financial protection

19. 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 (GDP) – 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); and
- unmet need for health and dental care is low, with minimal inequality in unmet need across different groups of people.

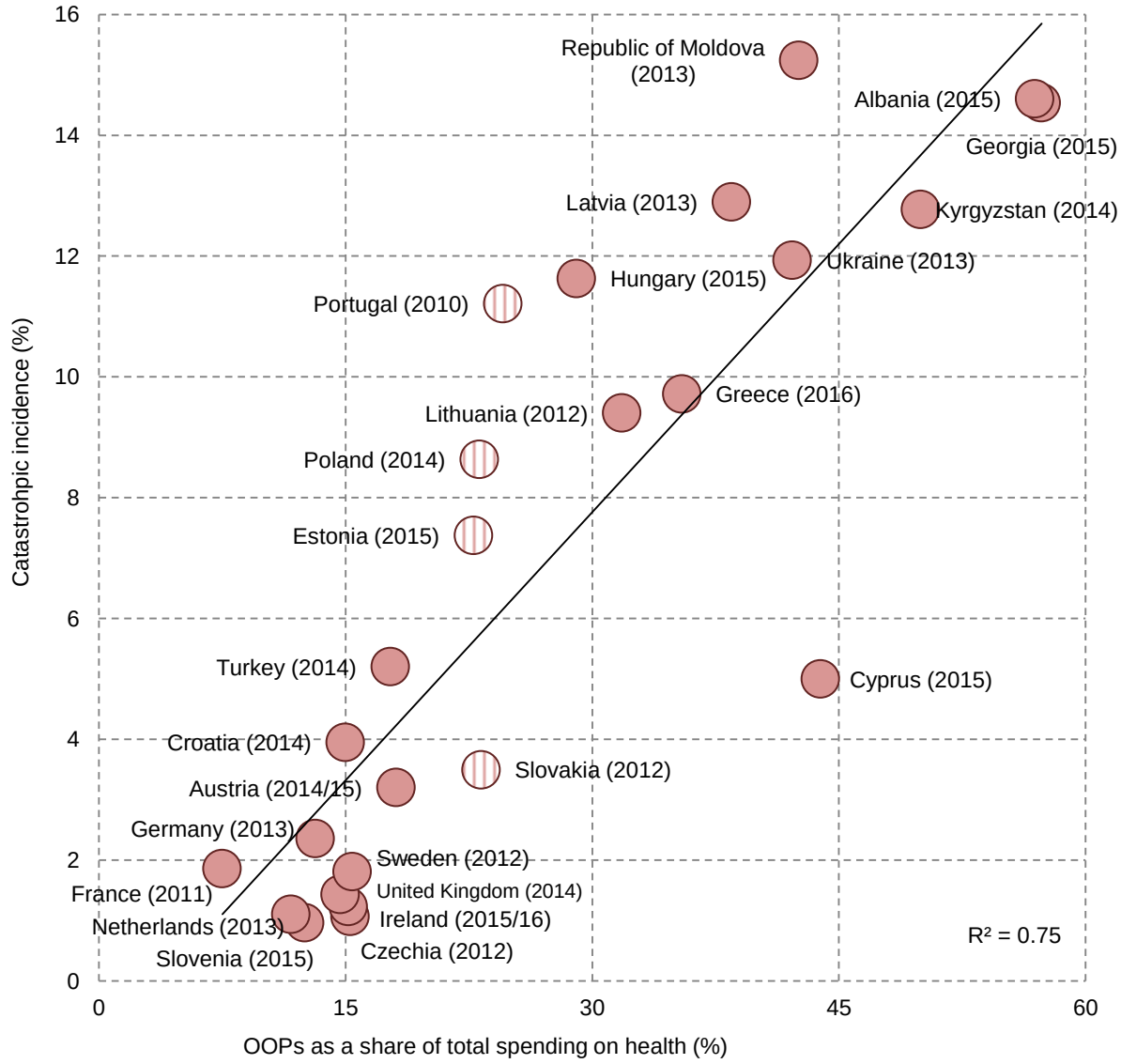
Financial protection is stronger where out-of-pocket payments are low

20. The incidence of catastrophic out-of-pocket payments rises as the out-of-pocket share of total spending on health rises (Fig. 4). It is generally very low in countries where the out-of-pocket share of total spending on health is close to or less than 15%.

21. The relationship between catastrophic incidence and the out-of-pocket share of health spending is fairly strong, but policy choices also matter. For example, in Estonia, Poland, Portugal and Slovakia – highlighted in Fig. 4 – out-of-pocket payments account for around 23% of total spending on health and yet the incidence of catastrophic health spending in these countries varies considerably, ranging from 3.5% to 11.2%.

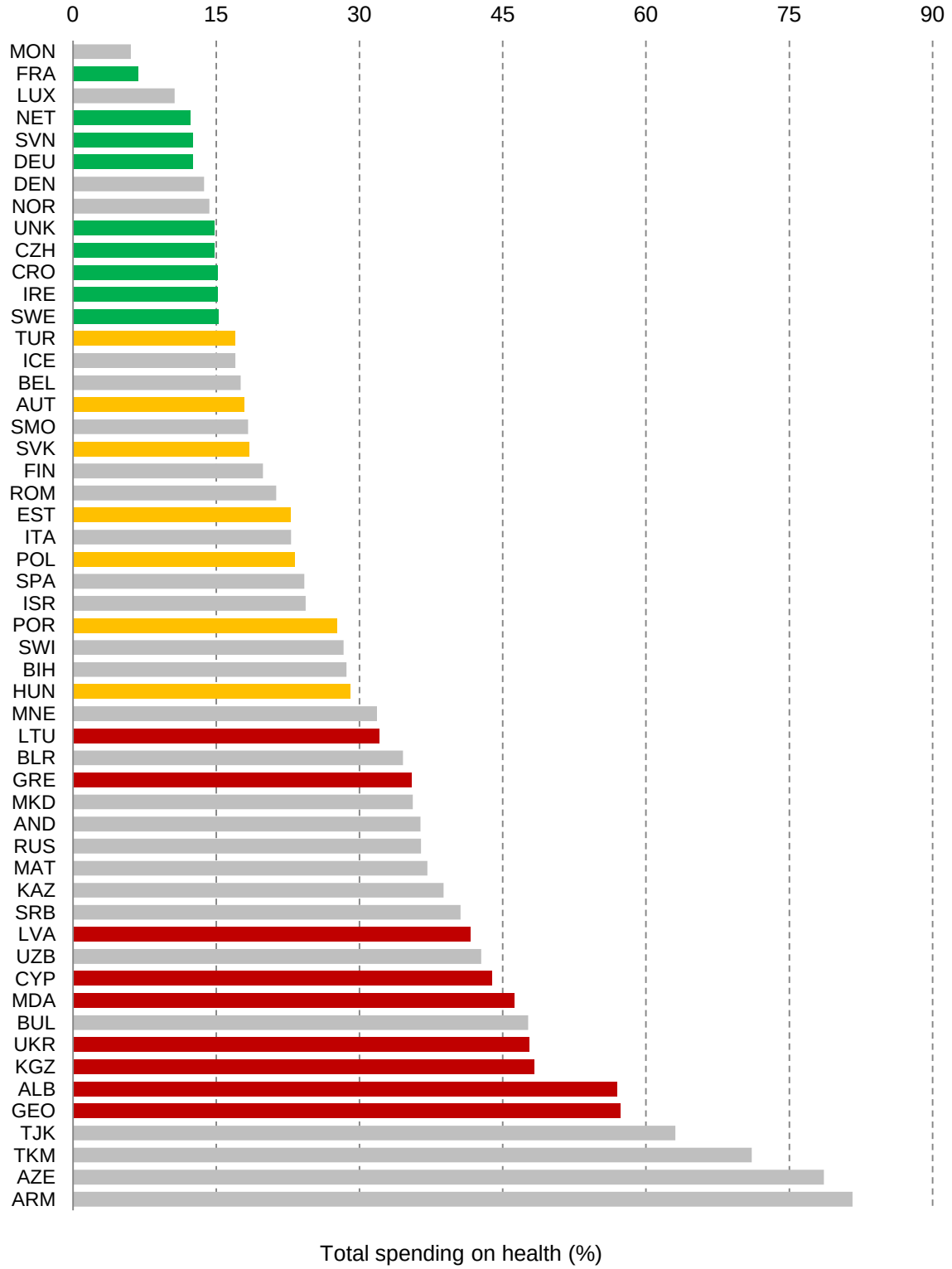
22. Fig. 5 shows the variation in the out-of-pocket share of total spending on health across the Region.

Fig. 4. Incidence of catastrophic spending on health and the out-of-pocket share of total spending on health, latest year available



Notes: OOPs: out-of-pocket payments. Data on out-of-pocket payments are for the same year as data for catastrophic incidence. Spending on health refers to current spending. Years as in Fig. 1.
Sources: WHO Barcelona Office for Health Systems Strengthening; WHO (2018).

Fig. 5. Out-of-pocket payments as a share of total spending on health, WHO European Region, 2015



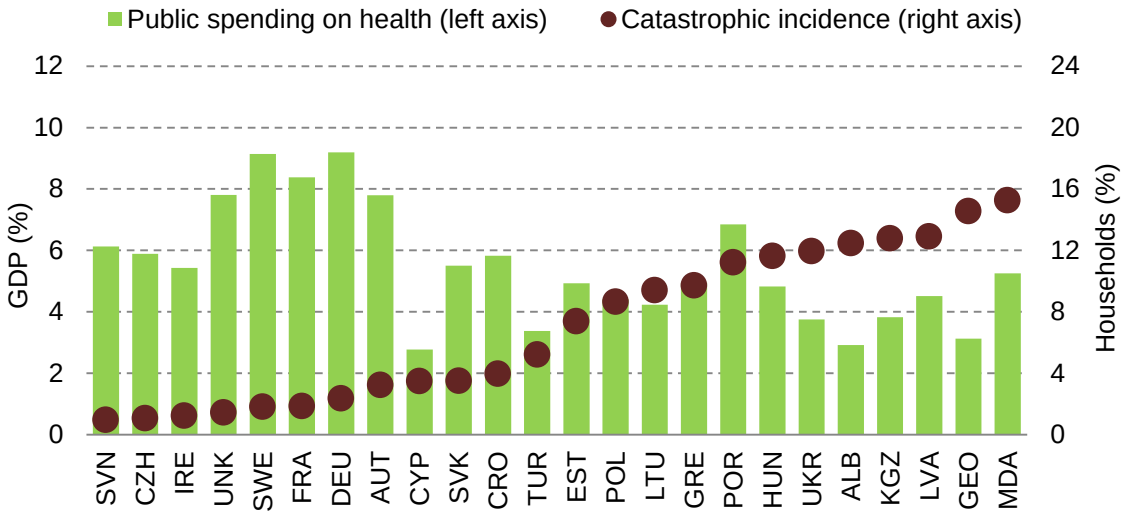
Notes: total spending refers to current spending on health. The coloured bars represent the countries in the study. Green: countries where out-of-pocket payments account for 15% or less of total spending on health. Yellow: countries where out-of-pocket payments are between 15% and 30%. Red: countries where out-of-pocket payments are above 30%.
Source: WHO (2018).

Financial protection is stronger where public spending on health is high

23. The out-of-pocket share of total spending on health is linked to the amount countries devote to public spending on health as a share of GDP. Public spending on health as a share of GDP is an outcome of the size of the government budget relative to GDP (fiscal space) and the priority given to the health sector when allocating the government budget.

24. Fig. 6 shows how public spending on health as a share of GDP tends to be higher in countries with stronger financial protection. The relationship between catastrophic incidence and the level of public spending on health is not as strong as it is for the out-of-pocket share of health spending (Fig. 4). Again, there are exceptions, indicating the importance of policy choices as well as spending levels.

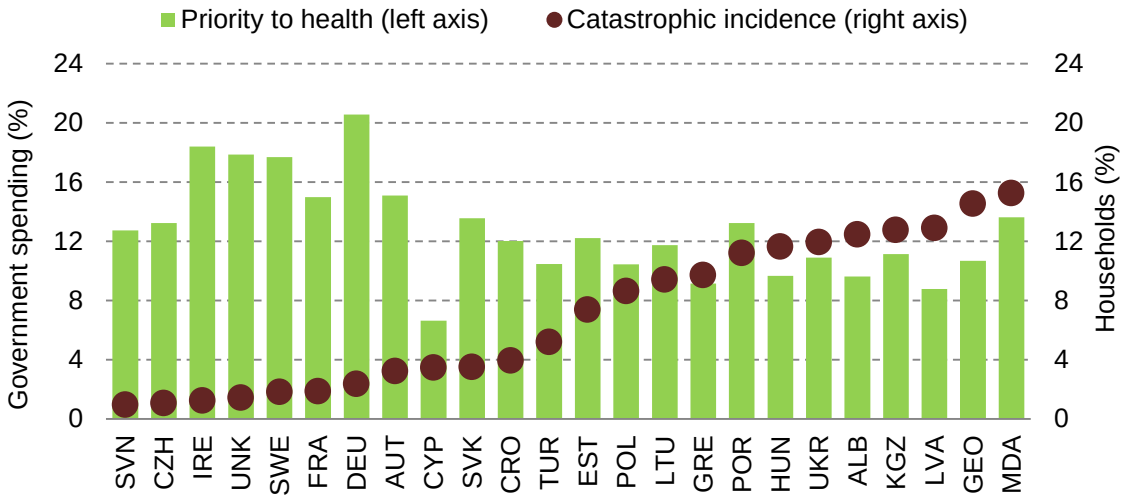
Fig. 6. Public spending on health as a share of GDP and share of households with catastrophic out-of-pocket payments



Notes: countries ranked by catastrophic incidence from lowest to highest. Public refers to all compulsory financing arrangements. Spending refers to current spending on health. Data on public spending on health are for the same year as data for catastrophic incidence (see Fig. 1).
Sources: WHO Barcelona Office for Health Systems Strengthening; WHO (2018).

25. The size of the government budget reflects taxation policy. While this is a policy area in which ministers of health should be involved, they will often have more direct influence over the share of the government budget allocated to the health system. Often referred to as the priority given to health, this share tends to be higher in countries with stronger financial protection (Fig. 7).

Fig. 7. Public spending on health as a share of total government spending and share of households with catastrophic out-of-pocket payments



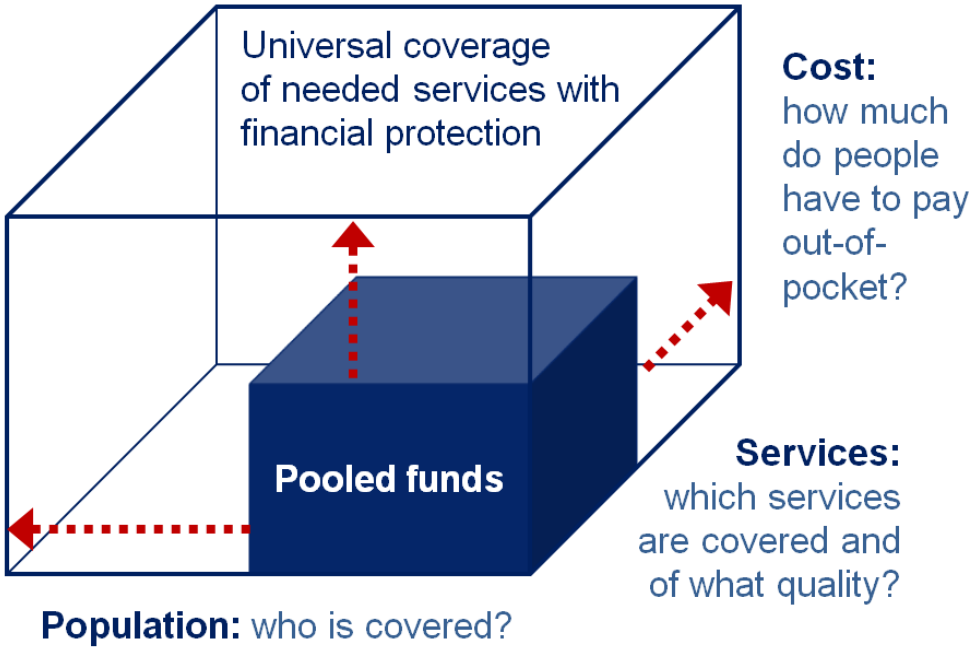
Notes: countries ranked by catastrophic incidence from lowest to highest. Public refers to all compulsory financing arrangements. Data on public spending on health are for the same year as data for catastrophic incidence (see Fig. 1).
Sources: WHO Barcelona Office for Health Systems Strengthening; WHO (2018).

Financial protection is stronger where coverage policies are carefully designed

26. Financial protection is stronger where 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).

27. Health coverage has three dimensions – population, services and cost – as shown in Fig. 8.

Fig. 8. The three dimensions of the universal health coverage cube



Source: adapted from WHO (2010).

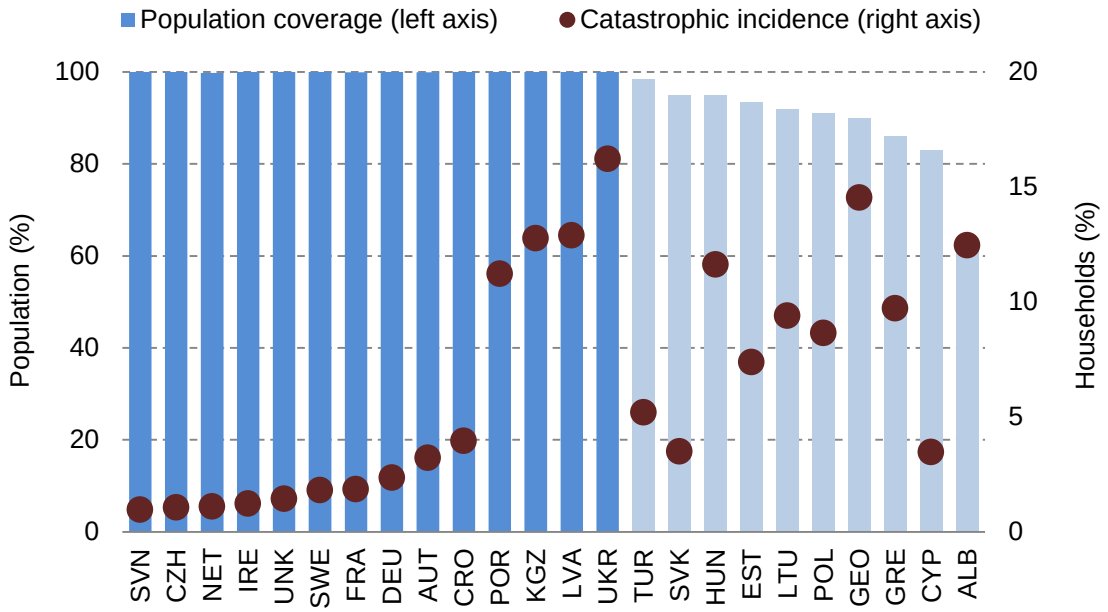
Population entitlement

28. The Regional Office analysis finds that population entitlement to publicly financed health care is a prerequisite for financial protection, but not a guarantee of it. In Fig. 9, the incidence of catastrophic out-of-pocket payments varies across countries that offer universal or near-universal population coverage (those in darker blue).

29. Countries with universal population coverage usually link entitlement to residence status. In contrast, many of the countries with lower levels of population coverage (in lighter blue) and a generally higher incidence of catastrophic out-of-pocket payments link entitlement to employment status or payment of contributions, and lack effective mechanisms to enforce participation or to protect vulnerable groups such as long-term unemployed people.

30. Some of the countries with lower levels of population coverage link entitlement to household income – for example, Cyprus. The relatively low incidence of catastrophic out-of-pocket payments in Cyprus reflects the limited use of co-payments.

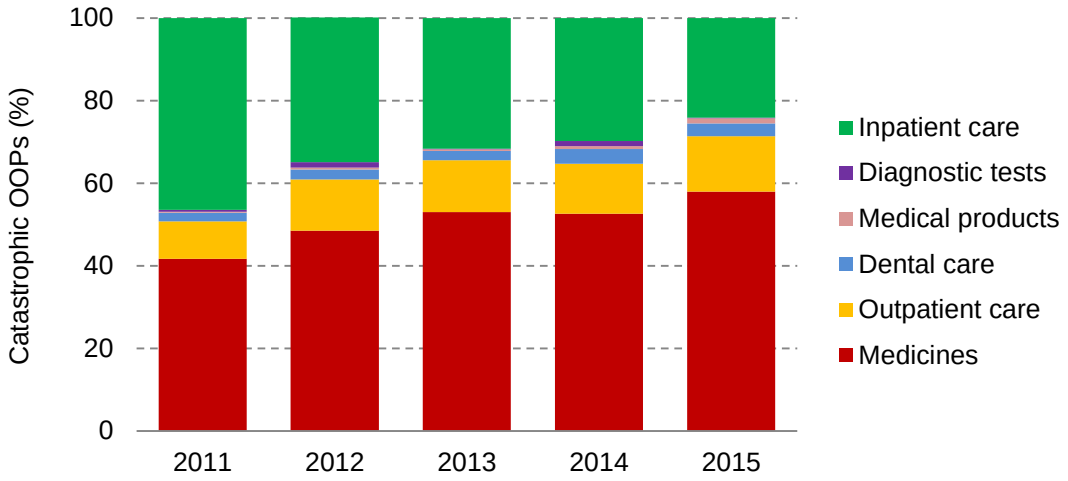
Fig. 9. Share of the population entitled to publicly financed health services and share of households with catastrophic out-of-pocket payments



Notes: countries ranked by share of population covered (from highest to lowest) and catastrophic incidence (from lowest to highest). Data on coverage are for the same year as data on catastrophic incidence (see Fig. 1). OECD data on coverage are used for all countries except Albania, Croatia, Cyprus, Georgia, Kyrgyzstan, Latvia and Ukraine.
Sources: WHO Barcelona Office for Health Systems Strengthening; OECD (2018).

31. One of the most significant coverage expansions to have taken place in the last few years shows why population entitlement does not guarantee financial protection. Georgia extended the share of the population entitled to publicly financed health care from 20% in 2011, 45% in 2012 and 85% in 2013 to over 90% in 2014. The incidence of catastrophic out-of-pocket payments fell in 2012 and 2013 but rose again in 2014 and 2015 (Goginashvili & Nadareishvili, in press). As more people were covered, more people were able to use health services and unmet need declined, leading to a major improvement in access to health care – particularly inpatient care. However, outpatient medicines were not included in the new publicly financed benefits package; many people were also exposed to substantial co-payments for newly covered services. The coverage expansion significantly improved financial protection related to inpatient care, but did not improve financial protection related to outpatient medicines (Fig. 10).

Fig. 10. Breakdown of catastrophic out-of-pocket payments by health service in Georgia



Notes: OOPs: out-of-pocket payments. Diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.
Source: Goginashvili & Nadareishvili (in press).

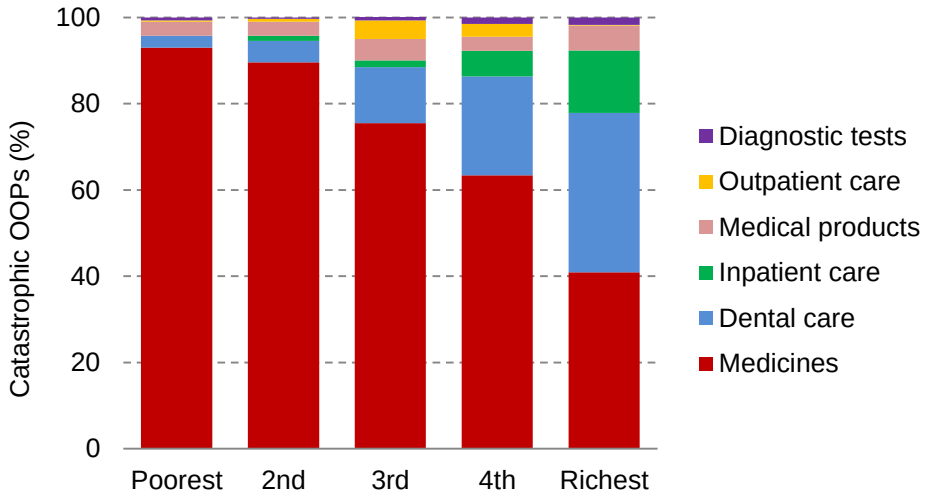
Service coverage

32. The scope and quality of service coverage – the publicly financed benefits package – is important for financial protection. While it is not easy to compare the scope of service coverage across countries, because countries do not usually define the benefits package in detail, it is clear that, in most of the countries in the study, the biggest gaps in coverage are for outpatient medicines and dental care. In some countries, essential medicines lists do not include all the highly cost-effective medicines and supplies needed to treat noncommunicable diseases.

33. Gaps in the scope and quality of service coverage are likely to affect different groups of people differently, 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. Fig. 11 clearly illustrates this in the case of Lithuania, where dental care is not covered for adults. Dental care accounts for barely any catastrophic spending on health among the poorest households, but accounts for over a third of catastrophic spending among the richest (Murauskienė & Thomson, 2018). EU-SILC data show that in the same year, less than 2% of the richest households reported unmet need for dental care in Lithuania, compared with 8% of the poorest (Eurostat, 2018).

34. This pattern of gaps in service coverage leading to financial hardship for the rich and unmet need for the poor is likely to be particularly strong for preventive services. It underlines the importance of ensuring that such services are systematically included in publicly financed benefits packages, as well as making sure that people who are not covered have access to primary care (including prevention), not just emergency services.

Fig. 11. Breakdown of catastrophic out-of-pocket payments by health service and consumption quintile in Lithuania, 2012



Notes: OOPs: out-of-pocket payments. Diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.
Source: Murauskienė & Thomson (2018).

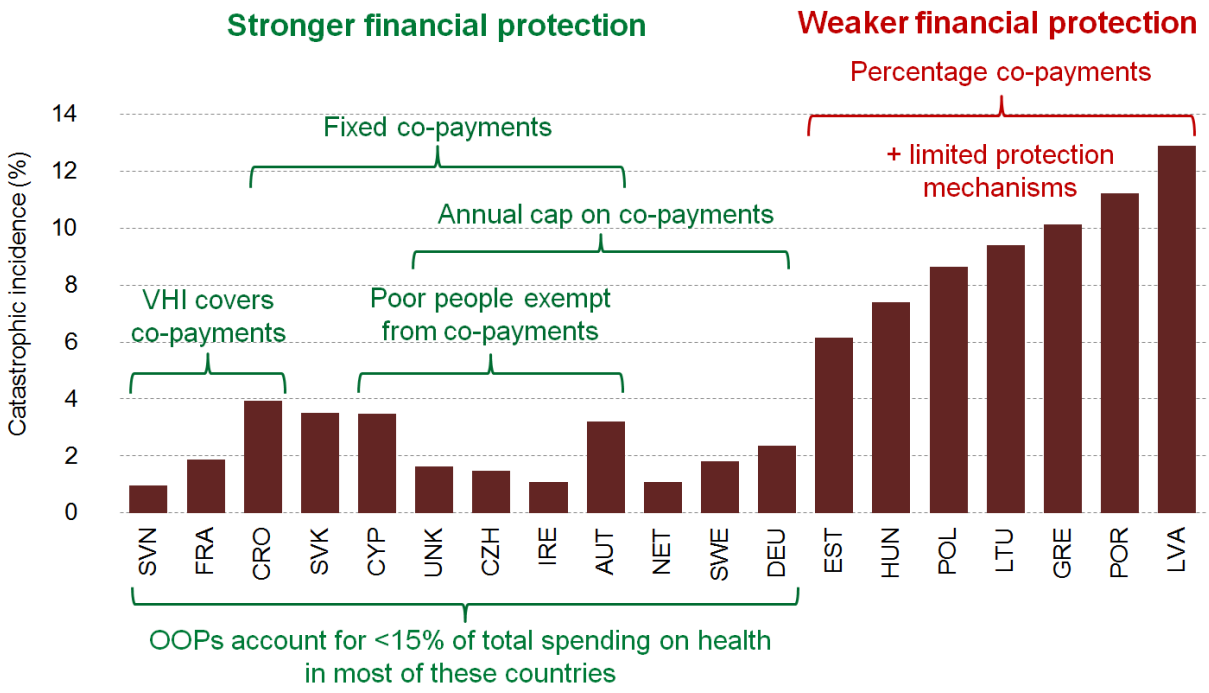
User charges

35. User charges can create barriers to accessing health care. By shifting health-care costs on to households, they can also lead to financial hardship. The design of user charges policy plays a critical role in determining the extent and distribution of out-of-pocket payments for covered health services. The Regional Office study finds that the countries with the strongest financial protection have carefully redesigned their user charges policy to protect against financial hardship through three key mechanisms:

- low fixed co-payments rather than percentage co-payments;
- exemptions for poor people and regular users of health services; and
- annual caps on all co-payments per person.

36. The link between co-payment design and the incidence of catastrophic spending on health is illustrated in Fig. 12.

Fig. 12. Catastrophic incidence and the design of co-payments for outpatient medicines in high-income countries



Notes: OOPs: out-of-pocket payments. VHI: voluntary health insurance.
Source: WHO Barcelona Office for Health Systems Strengthening.

37. Low fixed co-payments rather than percentage co-payments: when user charges are in the form of percentage co-payments, people must pay a share of the service price out of pocket. Percentage co-payments have several disadvantages: people's exposure to out-of-pocket payments will depend on the price and quantity of services they require; unless the price is clearly known in advance, people may face uncertainty about how much they have to pay out of pocket; and those with illnesses that require more expensive treatment will have to pay more out of pocket than those with illnesses that can be treated more cheaply, which may be perceived as unfair.

38. In spite of these disadvantages, many countries in Europe use percentage co-payments, particularly for outpatient medicines. The negative effect of this form of co-payment is magnified:

- when there is considerable variation in prices, as is the case for medicines;
- for people who have a condition that requires higher-cost medicines;
- when medicine prices are relatively high (e.g. due to inadequate regulation); and
- when doctors and pharmacists are not required or do not have incentives to prescribe and dispense cheaper alternatives (e.g. generic medicines).

39. Several of the high-income countries in the Regional Office study use fixed co-payments for outpatient medicines (Fig. 12), enhancing transparency and equity, as well as financial protection. Fig. 4 shows how the incidence of catastrophic out-of-pocket payments varies across four countries with the same share of total spending on health out of pocket, with relatively low incidence in Slovakia and much higher incidence in Estonia, Poland and Portugal, even though Portugal spends more on health than the other countries, and has higher

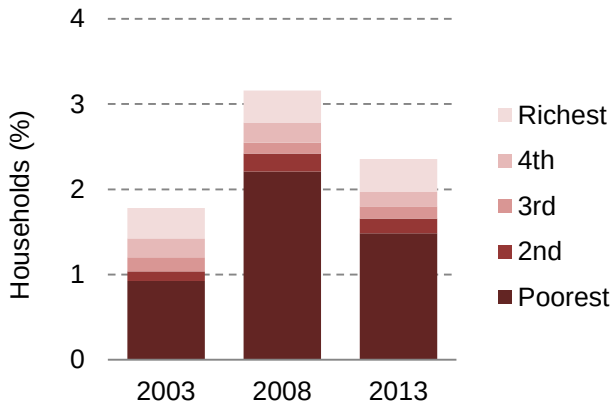
public spending. The four countries have similar levels of income and poverty, and only one obvious difference in health coverage: Slovakia uses very low fixed co-payments for outpatient medicines (Fig. 12), while the other three use percentage co-payments instead, with limited exemptions and without a cap (Pita Barros & Borges, in press; Pourova, in press; Tambor & Pavlova, in press; Võrk & Habicht, 2018).

40. Exemptions for poor people and regular users of health services: although there is strong and consistent evidence showing that user charges have an unduly negative effect on poor households and regular users of health services (Swartz, 2010), very few countries in Europe explicitly exempt these groups of people from co-payments. Only five of the high-income countries in the Regional Office study exempt poor people from co-payments for outpatient medicines; all five countries have a low incidence of catastrophic spending on health (Fig. 12).

41. In one of these countries, the United Kingdom, where the catastrophic incidence is very low (1.4% in 2014), regular users of health services – people aged over 60 and people with chronic illnesses – are exempt from co-payments for prescribed medicines; poor people, children aged under 18 and pregnant women are also exempt. As a result, around 90% of all outpatient prescribed medicines in England are dispensed without co-payment (Cooke O'Dowd et al., 2018).

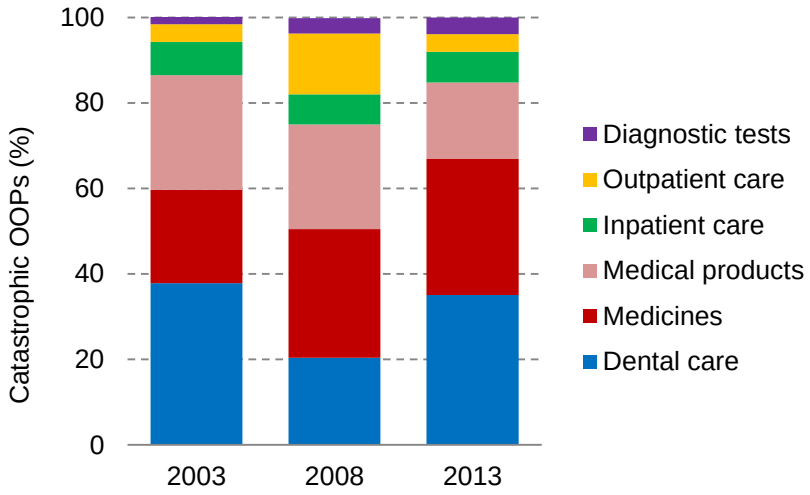
42. Policy changes within countries provide evidence of the importance of exempting poor people from co-payments. In 2004, Germany introduced a new co-payment for outpatient visits and replaced exemptions for poor people with an annual income-related cap on co-payments. In 2012, the outpatient visit co-payment was abolished. Looking at catastrophic incidence over time (Fig. 13) and the breakdown of catastrophic out-of-payments (Fig. 14) shows, first, that the introduction and abolition of the co-payment for outpatient visits coincided with a rise and then a fall in catastrophic incidence, which was largely driven by an increase in out-of-pocket spending on outpatient care; and, second, that even a carefully designed cap on co-payments, such as the one in Germany, may not be as protective for poor households as an exemption from co-payments – the incidence of catastrophic spending fell after the abolition of the outpatient visit co-payment, but remained higher than it had been before the abolition of the exemption (Siegel & Busse, 2018).

Fig. 13. Share of households with catastrophic out-of-pocket payments by consumption quintile in Germany



Source: Siegel & Busse (2018).

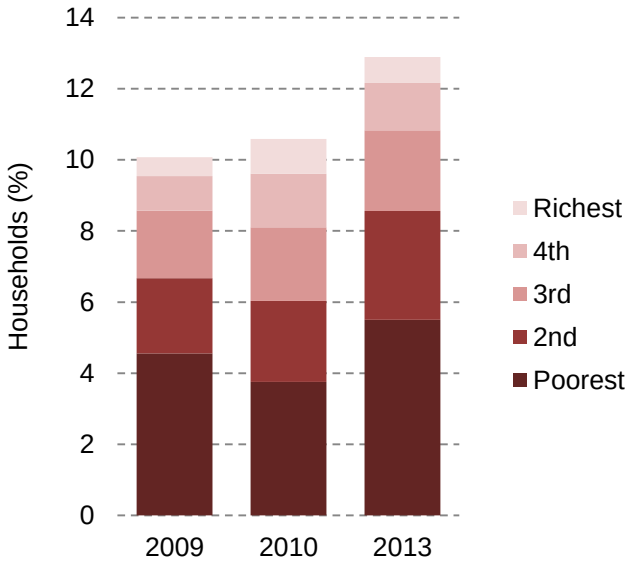
Fig. 14. Breakdown of catastrophic out-of-pocket payments in the poorest consumption quintile by health service in Germany



Notes: OOPs: out-of-pocket payments. Diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.
Source: Siegel & Busse (2018).

43. Evidence of the positive impact of exempting poor people from co-payments also comes from Latvia. In response to the economic crisis, Latvia introduced an exemption from co-payments for very poor people in 2009, extended exemptions to other poor people in 2010, and then abolished the exemptions for all except the very poorest households in 2012 (Taube et al., 2018). These policy changes coincide with a fall in the incidence of catastrophic out-of-pocket payments among the poorest consumption quintile in 2010, followed by an increase in 2013 (Fig. 15).

Fig. 15. Share of households with catastrophic out-of-pocket payments by consumption quintile in Latvia



Source: Taube et al. (2018).

44. Annual caps on all co-payments per person: exempting people from co-payments is important to ensure that targeted groups do not have to pay anything out of pocket. Caps have a different protective effect: limiting the amount that must be paid out of pocket. They can be applied per item or service provided or per person or household in a given period of time. If they are applied per person, they can be set as a fixed amount or as a share of income. Caps that apply to people over time offer stronger protection than caps applied to specific items or services. The use of income-related caps, as in Austria and Germany, enhances equity by ensuring that more of the financial burden of out-of-pocket payments is borne by richer households.

45. Austria introduced an income-related cap on co-payments for prescriptions in 2008, set at 2% of net annual income. The cap, combined with a reduction in VAT for all medicines in 2009, is likely to be behind the decrease in out-of-pocket payments for outpatient medicines between 2004/05 and 2009/10. There was no change in catastrophic incidence during this period, but the medicines share of catastrophic out-of-pocket payments fell sharply for the poorest consumption quintile, while the medical products share, which was not capped, grew (Fig. 16) (Czypionka et al., 2018). The growth in the medical products share may also reflect a reduction in eye-care coverage in 2005.

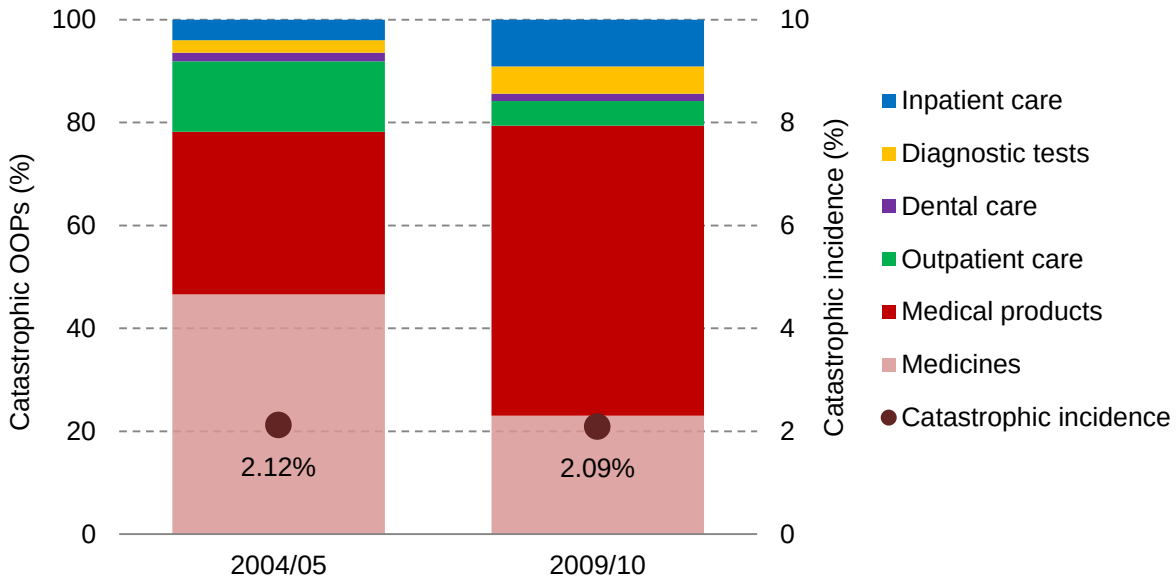
46. Only two countries in the study – Czechia and Germany – cap all co-payments. The cap in Germany is set at 2% of gross income per person per year, lowered to 1% for people who can demonstrate that they have a chronic condition; it must be applied for on an annual basis, however (Siegel & Busse, 2018). In Czechia, the cap was originally set as a fixed amount for everyone, but in 2009 a lower cap was introduced for children aged under 18 years and people aged 65 years and over (Kandilaki, in press).

47. A simple and people-centred co-payment design is best: in many countries in Europe, co-payment design is complex and protection mechanisms may involve bureaucratic processes. For example, some countries use a mix of fixed co-payments and percentage co-payments; have multiple rates of reimbursement; apply exemptions to particular types of medicine or medicines for specific conditions rather than to people; and apply caps to specific items or services rather than to people over time. In addition, people may have to apply retrospectively to benefit from caps and enhanced coverage, and may be required to provide extensive supporting documentation.

48. Complex or bureaucratic design – especially a narrow focus on specific items or services – is likely to confuse people and undermine the effectiveness of protection mechanisms. A better approach is to focus on people and design protection around people rather than around items and services. This will be particularly beneficial for people with one or more chronic illnesses, who are likely to be users of multiple services.

49. Some of the countries in the Regional Office study are taking steps to simplify and strengthen co-payment policy. Estonia sets a threshold for out-of-pocket payments for selected prescription items; once this threshold has been reached, the percentage co-payment is reduced (Võrk & Habicht, 2018). Initially, people were required to apply for the benefit retrospectively, and could only do so four times a year. In 2018, the system was simplified so that the reduced co-payment is applied automatically, using the e-prescribing system. The threshold was also reduced from €500 to €300. Both measures are likely to improve financial protection.

Fig. 16. Breakdown of catastrophic out-of-pocket payments in the poorest consumption quintile by health service in Austria



Notes: OOPs: out-of-pocket payments. Diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment including (in these two time periods) dental products.
Source: Czypionka et al. (2018).

The role of voluntary health insurance

50. Some countries use voluntary health insurance (VHI) to protect people, but it is only shown to be protective where it:

- explicitly covers user charges;
- covers most of the population, including most poor people; and
- is free for poor people.

51. Only three countries in Europe meet these conditions: Croatia, France and Slovenia (Vončina & Rubil, 2018; Bricard, in press; Zver et al., in press). In all other instances, VHI tends to exacerbate inequalities in access to health care (Sagan & Thomson, 2016).

52. There is no association between spending on VHI and the out-of-pocket share of total spending on health in Europe or even globally (WHO, 2018). This indicates that VHI is not an effective mechanism for lowering out-of-pocket payments at health system level, except in the rare examples highlighted here.

53. VHI premiums can pose problems of affordability for households and undermine equity in financing (Burke et al., in press). In Croatia, for example, VHI premiums per household accounted for 1.7% of total household spending on average in 2014, but had a regressive distribution, accounting for 3.1% of total household spending in the poorest quintile and 1.1% in the richest (Vončina & Rubil, 2018).

54. Table 2 summarizes some of the most common gaps in coverage in European health systems.

Table 2. Common gaps in coverage in European health systems

	Population entitlement	Service coverage	User charges
Issues in the governance of publicly financed coverage	Entitlement depends on household income, employment status or payment of contributions rather than residence Limited entitlement for migrants	The benefits package does not cover the full spectrum of services, from prevention, treatment and rehabilitation to palliative care The benefits package does not address all illnesses Benefits vary based on entitlement status No or limited use of health technology assessment to identify and prioritize cost-effective services Referral systems not in place or not adequately regulated Inadequate regulation of prescribing and dispensing Provider incentives not aligned across the system Lack of waiting time guarantees	Weak design of co-payment policy, including: • application of user charges to primary care, including outpatient medicines • application of user charges without adequate protection for poor people and regular users of services • use of percentage co-payments • exemptions focus on specific items or specific illnesses rather than on people • caps are per item or service (i.e. they do not cover all co-payments) rather than per person over time Inadequate regulation of extra billing by providers
Main gaps in publicly financed coverage	People of working age, particularly unemployed people, self-employed people and those lacking stable employment Migrants	Dental care for adults Medical products Outpatient medicines, including recommended or prescribed over-the-counter medicines Long waiting times for specialist consultations and inpatient care	Outpatient prescription medicines Dental care
Are these gaps covered by VHI?	No; VHI may be available but is unlikely to be affordable for these groups of people	VHI covers dental care in some countries VHI provides faster access to treatment in many countries However, VHI is mainly taken up by people in higher socioeconomic groups, which exacerbates inequalities in access to health services	VHI covering co-payments only covers most of those who need protection in Croatia, France and Slovenia; but even in these countries there are gaps in VHI coverage

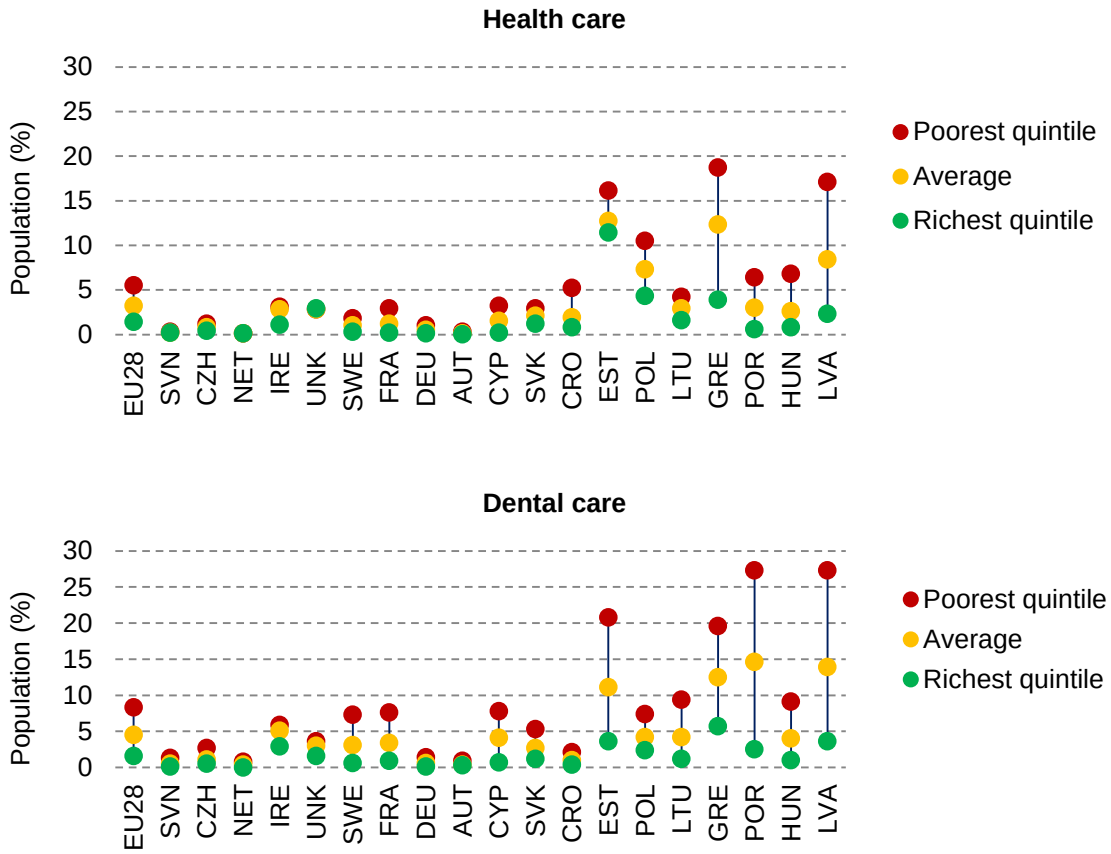
Source: WHO Barcelona Office for Health Systems Strengthening.

Unmet need must be part of the analysis

55. Analysis of financial protection would not be complete – and could be misinterpreted – without considering evidence on unmet need for health services (see Box 2). A country may have a low incidence of catastrophic out-of-pocket payments because people are prevented from using health care owing to the limited availability of services, long waiting times or financial and other types of access barriers. Conversely, reforms that strengthen access to health care may increase financial hardship. The removal of access barriers, leading to greater use of services, will increase people's exposure to out-of-pocket payments – for example, through user charges – if protective policies are not in place.

56. Comparable data on unmet need are only available for European Union Member States. Fig. 17 shows income inequalities in self-reported unmet need for health and dental care, with countries ranked by incidence of catastrophic out-of-pocket payments from lowest to highest. Average levels of unmet need and inequalities in unmet need tend to be very low in countries with the strongest financial protection. People generally have better – and more equitable – access to health care than dental care.

Fig. 17. Unmet need for health and dental care due to cost, distance or waiting time, 2015



Notes: countries ranked by catastrophic incidence from lowest to highest. Population refers to people aged over 16. Quintiles are based on income. Current European Union Member State (EU28) data are for unmet need only, not catastrophic incidence.
Source: Eurostat (2018) based on EU-SILC data.

Implications for policy

57. 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.

58. How you monitor financial protection matters: to inform policy and help countries move towards universal health coverage, monitoring needs 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.

59. The incidence of catastrophic out-of-pocket payments is generally low in countries where out-of-pocket payments do not account for more than 15% of total spending on health. 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 on health increases.

60. 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.

61. 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.

62. 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.

63. 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.

64. 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.

65. 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.

66. 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.

67. 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.

68. 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. 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.

69. 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.

References[1]

Arora V, Karanikolos M, Clair A, Reeves A, Stuckler D, McKee M (2015). Data resource profile: the European Union Statistics on Income and Living Conditions (EU-SILC). Int J Epidemiol. 44:451–461.doi:10.1093/ije/dyv069.

Bricard D (in press). Can people afford to pay for health care? New evidence on financial protection in France. Copenhagen: WHO Regional Office for Europe.

Burke S, Johnston B, Thomas S (in press). Can people afford to pay for health care? New evidence on financial protection in Ireland. Copenhagen: WHO Regional Office for Europe.

Cooke O'Dowd N, Kumpunen S, Holder H (2018). Can people afford to pay for health care? New evidence on financial protection in the United Kingdom. Copenhagen: WHO Regional Office for Europe.

Cylus J, Thomson S, Evetovits T (in press). Catastrophic health spending in Europe: equity and policy implications of different calculation methods. Bull World Health Organ.

Czypionka T, Röhrling G, Six E (2018). Can people afford to pay for health care? New evidence on financial protection in Austria. Copenhagen: WHO Regional Office for Europe.

Eurostat (2015). Household Budget Survey 2010 Wave EU Quality report. Brussels: Eurostat (http://ec.europa.eu/eurostat/documents/54431/1966394/LC142-15EN_HBS_2010_Quality_Report_ver2+July+2015.pdf/fc3c8aca-c456-49ed-85e4-757d4342015f).

Eurostat (2018). EU statistics on income and living conditions (EU-SILC) [online database]. Brussels: European Commission (http://ec.europa.eu/eurostat/web/income-and-living-conditions/data/main-tables).

EXPH (2016). Access to health services in the European Union – final opinion. Brussels: European Commission (https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/015_access_healthservices_en.pdf).

EXPH (2017). Opinion on benchmarking access to healthcare in the EU. Luxembourg: Publications Office of the European Union (https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/docsdir/opinion_benchmarking_healthcareaccess_en.pdf).

Goginashvili K, Nadareishvili M (in press). Can people afford to pay for health care? New evidence on financial protection in Georgia. Copenhagen: WHO Regional Office for Europe.

Kandilaki D (in press). Can people afford to pay for health care? New evidence on financial protection in Czechia. Copenhagen: WHO Regional Office for Europe.

[1] All websites accessed on 6 June 2018.

Kontemeniotis A, Theodorou M (in press). Can people afford to pay for health care? New evidence on financial protection in Cyprus. Copenhagen: WHO Regional Office for Europe.

Maresso A, Mladovsky P, Thomson S, Sagan A, Karanikolos M, Richardson E et al., editors (2015). Economic crisis, health systems and health in Europe: country experience. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Murauskienė L, Thomson S (2018). Can people afford to pay for health care? New evidence on financial protection in Lithuania. Copenhagen: WHO Regional Office for Europe.

OECD health statistics [online database]. Paris: Organisation for Economic and Co-operation and Development; 2018 (http://www.oecd.org/health/health-systems/health-data.htm).

Pita Barros P, Borges A (in press). Can people afford to pay for health care? New evidence on financial protection in Portugal. Copenhagen: WHO Regional Office for Europe.

Pourova M (in press). Can people afford to pay for health care? New evidence on financial protection in Slovakia. Copenhagen: WHO Regional Office for Europe.

Sagan A, Thomson S (2016). 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 (http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2016/voluntary-health-insurance-in-europe-role-and-regulation-2016).

Siegel M, Busse R (2018). Can people afford to pay for health care? New evidence on financial protection in Germany. Copenhagen: WHO Regional Office for Europe.

Swartz K (2010). Cost-sharing: Effects on spending and outcomes. Research Synthesis Report No. 20. Princeton: Robert Wood Johnson Foundation (https://pdfs.semanticscholar.org/ca7c/49c9b664c681ed836aa38b913a37a35e0004.pdf).

Tambor M, Pavlova M (in press). Can people afford to pay for health care? New evidence on financial protection in Poland. Copenhagen: WHO Regional Office for Europe.

Taube M, Vaskis E, Nesterenko O (2018). Can people afford to pay for health care? New evidence on financial protection in Latvia. Copenhagen: WHO Regional Office for Europe.

Thomson S, Figueras J, Evetovits T, Jowett M, Mladovsky P, Maresso A, et al. (2015). Economic crisis, health systems and health in Europe: impact and implications for policy. Maidenhead: Open University Press (http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2015/economic-crisis,-health-systems-and-health-in-europe.-impact-and-implications-for-policy-2015).

Thomson S, Evetovits T, Cylus J, Jakab M (2016). Monitoring financial protection to assess progress towards universal health coverage in Europe. Public Health Panorama 2(3):357–66

(http://www.euro.who.int/en/publications/public-health-panorama/journal-issues/volume-2,-issue-3,-september-2016/original-research2).

Thomson S, Evetovits T, Cylus J (2018). Financial protection in high-income countries. A comparison of the Czech Republic, Estonia and Latvia. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/2018/financial-protection-in-high-income-countries.-a-comparison-of-the-czech-republic,-estonia-and-latvia-2018).

Vončina L, Rubil I (2018). Can people afford to pay for health care? New evidence on financial protection in Croatia. Copenhagen: WHO Regional Office for Europe.

Võrk A, Habicht T (2018). Can people afford to pay for health care? New evidence on financial protection in Estonia. Copenhagen: WHO Regional Office for Europe.

Wagstaff A, Eozenou P (2014). CATA meets IMPOV: a unified approach to measuring financial protection in health. Washington (DC): The World Bank (Policy Research Working Paper No. 6861).

Wagstaff A, van Doorslaer E (2003). Catastrophe and impoverishment in paying in health care: with applications to Vietnam 1993-98. Health Econ. 2(11):921–934.

WHO (2010). The World Health Report. Health systems financing: the path to universal health coverage. Geneva: World Health Organization (http://www.who.int/whr/2010/en/).

WHO (2018). Global Health Expenditure Database [online database]. Geneva: World Health Organization (http://apps.who.int/nha/database/Select/Indicators/en).

WHO, World Bank (2015). Tracking universal health coverage: first global monitoring report. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf?ua=1).

WHO, World Bank (2017). Tracking universal health coverage: 2017 global monitoring report. Geneva: World Health Organization (http://www.who.int/healthinfo/universal_health_coverage/report/2017/en).

Xu K, Evans D, Carrin G, Aguilar-Rivera A, Musgrove P, Evans T (2007). Protecting households from catastrophic health spending. Health Aff (Millwood). 26(4):972–983.

Xu K, Evans D, Kawabata K, Zeramdini R, Klavus J, Murray C (2003). Household catastrophic health expenditure: a multicountry analysis. Lancet 362:111–117.

Yerramilli P, Fernández O, Thomson S (2018). Financial protection in Europe: a systematic review of the literature and mapping of data availability. Health Policy 122(5). doi:https://doi.org/10.1016/j.healthpol.2018.02.006 (http://www.healthpolicyjrnl.com/article/S0168-8510(18)30049-6/fulltext).

Zver E, Josar D, Srakar A (in press). Can people afford to pay for health care? New evidence on financial protection in Slovenia. Copenhagen: WHO Regional Office for Europe.

Glossary of terms

Ability to pay for health care: Ability to pay refers to all the financial resources at a household's disposal. In the monitoring of 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 consumption expenditure or income and may not fully capture all of a household's financial resources– for example, 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. The terms 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 spending on health. 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 (because they no longer have any capacity to pay after incurring out-of-pocket payments) and households who are further impoverished (because they have no capacity to pay from the outset).

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).

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 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 extra billing (a system in which providers are allowed to charge patients more than the price or tariff determined by the third-party payer) 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 adult: 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 years 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 impoverishing out-of-pocket payments: An indicator of financial protection. Out-of-pocket payments made by households living below a national or international poverty line or a basic needs line. A household is further impoverished if its total consumption is below the line before out-of-pocket payments and if it then incurs out-of-pocket payments.

Health service: 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.

Impoverishing out-of-pocket payments: 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.

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: (a) formal co-payments (user charges or user fees) for covered goods and services; (b) formal payments for the private purchase of goods and services; and (c) informal payments for covered or privately purchased goods and services. They exclude prepayment (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 the population into quintiles based on 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: A state of affairs in which all people are able to use the high-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 owing to access barriers.

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

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

= = =