

Can people afford to pay for health care?

New evidence
on financial protection
in Lithuania

Liuba Murauskienė
Sarah Thomson



Summary

WHO Barcelona Office for Health Systems Strengthening

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

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

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

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





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This review is part of a series of country-based studies generating new evidence on financial protection in European health systems.

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

Healthcare Financing
Health Expenditures
Health Services Accessibility
Financing, personal
Lithuania
Poverty
Universal Coverage

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This review assesses the extent to which people in Lithuania experience financial hardship when they use health care. The analysis draws on household budget survey data collected in 2005, 2008 and 2012 by Statistics Lithuania. It focuses on two indicators of financial protection: catastrophic out-of-pocket payments and impoverishing out-of-pocket payments. It also considers the presence of access barriers leading to unmet need for health care.

Spending on health

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

In Lithuania, public spending on health grew rapidly between 2005 and 2008, in line with the economy, pushing down the out-of-pocket share of total spending on health (Fig. 1). The economic crisis led to a huge drop in GDP in 2009, followed by a large rise in unemployment (Eurostat, 2018a). As public spending on health and other areas of social protection fell in response to unemployment and budget cuts, the out-of-pocket share of total spending on health rose (Kacevičius & Karanikolos, 2015). In 2012 the out-of-pocket share was 32% and by 2013 it was as high as it had been in 2005 (33%) – well above the European Union average (22%) – while the public share (66%) was well below the European Union average (73%). Fig. 2 shows that public spending on health now accounts for a relatively low share of GDP in Lithuania in comparison to countries with similar income levels.

Fig. 1. Out-of-pocket payments as a share of total spending on health

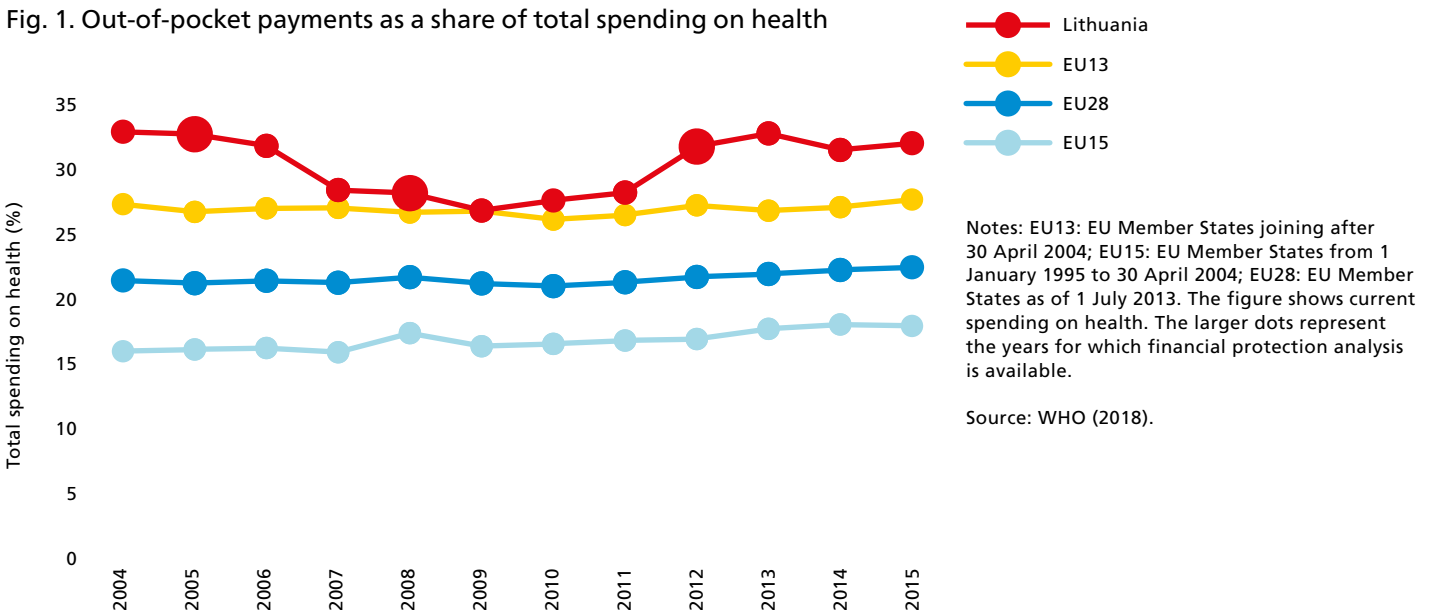
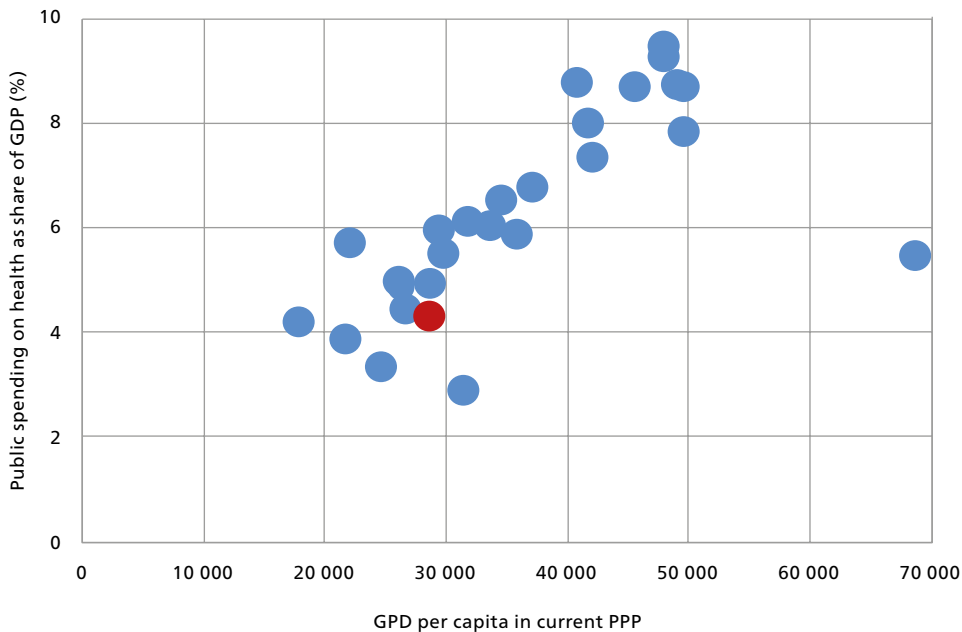


Fig. 2. Public spending on health and GDP per capita, European Union, 2015



Notes: PPP: purchasing power parity. Public refers to all compulsory financing arrangements. Lithuania is highlighted in red. The figure excludes Luxembourg.

Source: WHO (2018).

The health system did not undergo major changes between 2005 and 2012, in spite of the financial upheaval faced by society and the health budget (Murauskienė et al., 2013). It is predominantly publicly financed through a combination of compulsory contributions and budget transfers from the government to the National Health Insurance Fund.

Coverage, access and unmet need

Entitlement to health care is guaranteed in Article 53 of the Constitution and set out in the Health System Law of 1994, the Health Insurance Law of 1996 and decrees issued by the Ministry of Health. The scope of the publicly financed benefits package and user charges policy is defined by the Ministry of Health.

Health coverage is relatively complete for children up to the age of 18. Adults also benefit from free access to outpatient visits and inpatient care.

The main gaps in coverage are related to:

- percentage co-payments for outpatient prescribed medicines for adults;
- limited coverage of dental care for adults; and
- the linking of entitlement to health care to payment of contributions to the National Health Insurance Fund.

As a result, around 6–10% of the population is uninsured and only has access to emergency health care. This group of uninsured people is dominated by men and people of working age, some of whom may be working abroad but continue to be registered as resident in Lithuania.

Voluntary health insurance does not cover these gaps (Table 1). It is purchased by less than 1% of the population – mainly higher-paid employees – and its main role is to provide people with access to private providers (Kacevičius, 2016).

Table 1. Gaps in coverage

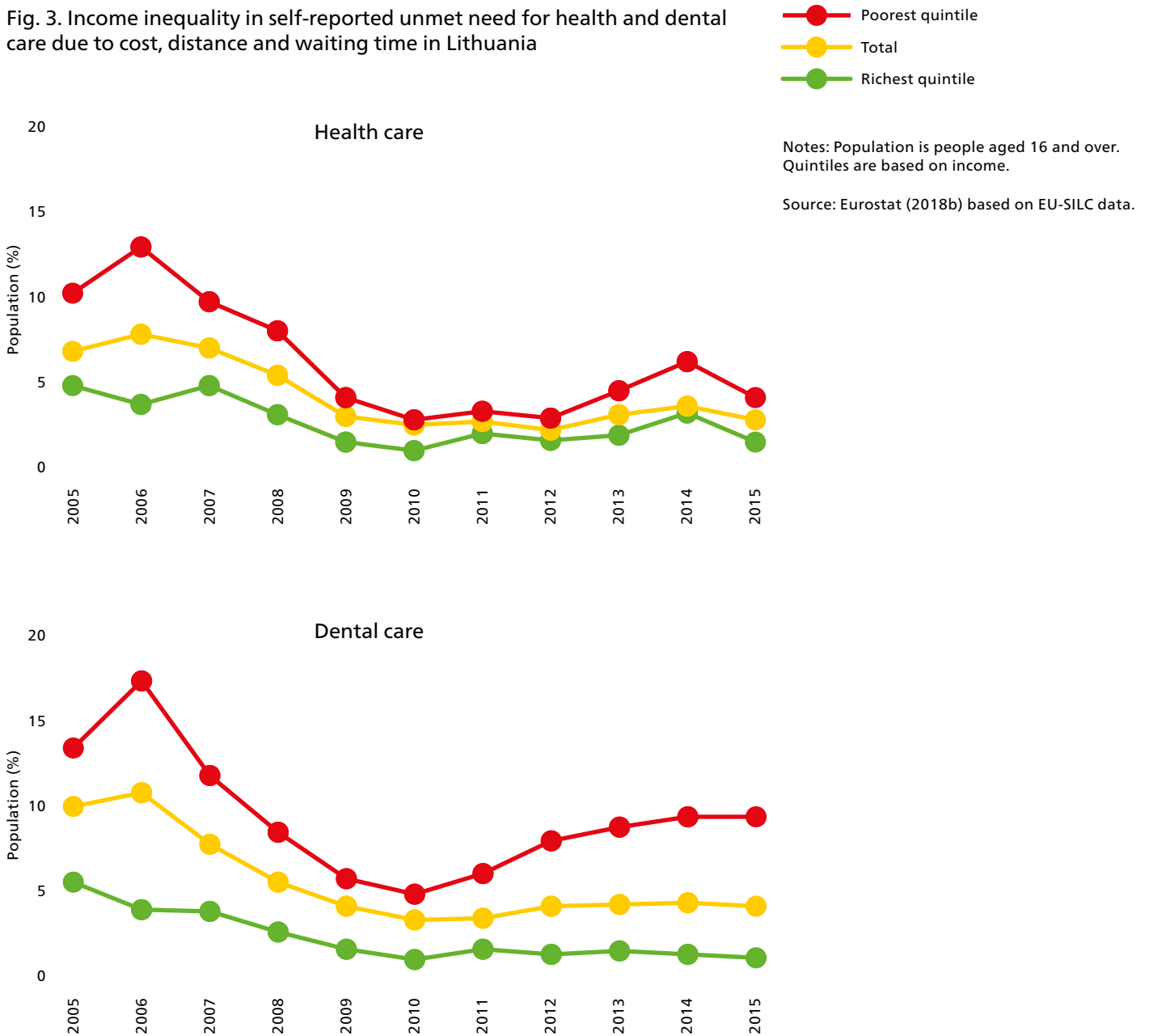
Source: authors

	Population entitlement	Service coverage	User charges
Issues in the governance of publicly financed coverage	Entitlement depends on payment of contributions	Limited positive list for medical products; lack of waiting time guarantees during the study period	Use of percentage co-payments; weak protection for adults; inadequate regulation of extra billing
Main gaps in publicly financed coverage	Around 6–10% of the population are uninsured, although some of these people are likely to be working abroad	Dental care for adults; waiting times	Outpatient prescription medicines for adults
Are these gaps covered by voluntary health insurance?	No	No; VHI covers less than 1% of the population; its main role is to provide access to private providers	No

European Union data indicate that self-reported unmet need for health and dental care fell between 2006 and 2010 but rose after 2010 (Fig. 3). Inequalities in unmet need for dental care are substantial and have been growing since 2010. Inequalities in unmet need for health care are smaller than for dental care but have also been growing since 2012. For both health and dental care, the increase in inequality reverses the previous positive trend.

National survey data suggest that barriers to access may be more widespread than the European Union data show. They also show that unmet need for prescribed medicines is higher than unmet need for health care in general among retired, inactive and unemployed people (Statistics Lithuania, 2015).

Fig. 3. Income inequality in self-reported unmet need for health and dental care due to cost, distance and waiting time in Lithuania



Household spending on health

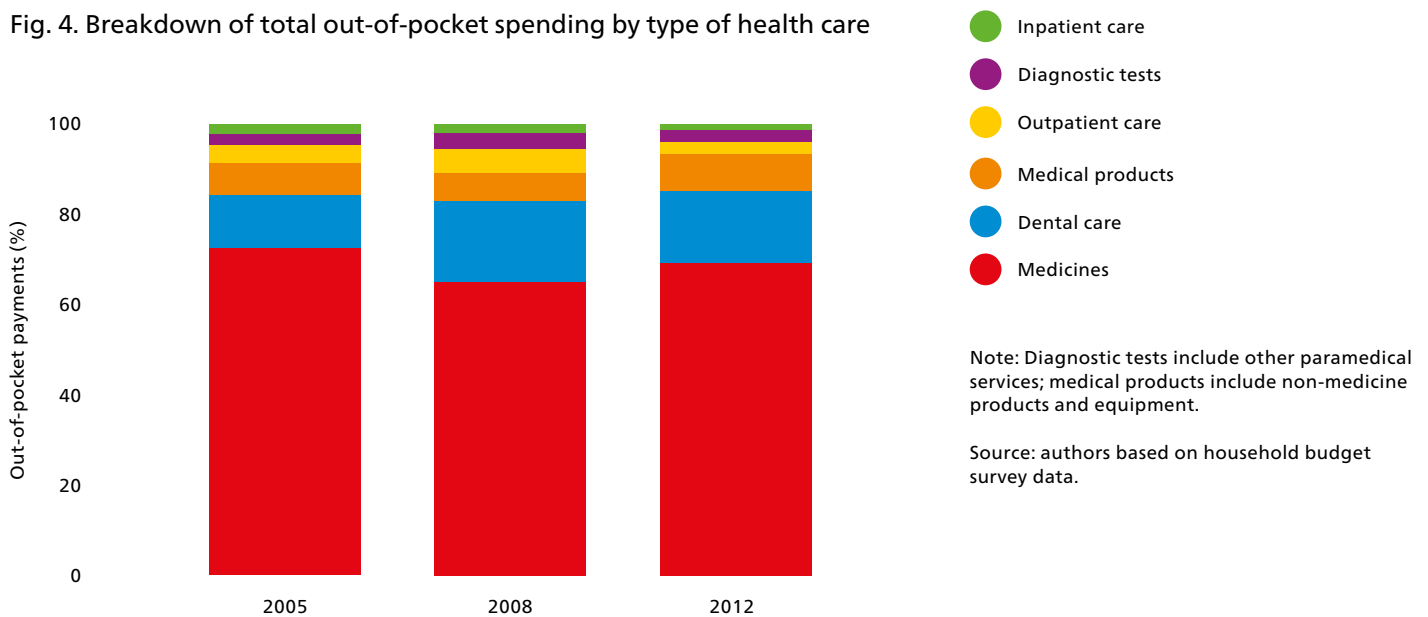
Household budget survey data indicate that just over half of all households in Lithuania (55%) paid for health care out of pocket in 2012. Households without any out-of-pocket payments are more likely to be poor than rich, perhaps reflecting exemption from co-payments for dental care and medicines for some very vulnerable households. It may also reflect greater unmet need for health and dental care among poorer households.

Between 2008 and 2012, the share of households without any out-of-pocket payments rose from 25% to 45%. This large increase occurred in spite of the fact that there was no change in exemption from user charges during this period. It may in part reflect unmet need for dental care, which rose between 2011 and 2014, especially for the poorest quintile.

Household budget survey data show that out-of-pocket payments have increased steadily over time in nominal terms and as a share of total household spending. They are mainly driven by spending on medicines (Fig. 4). Dental care is the second largest item of household spending on health, but it is heavily concentrated among richer households. The average amount spent out of pocket on dental care did not change between 2008 and 2012, while the average amount spent out of pocket on medicines grew considerably.

Data from other surveys suggest that informal payments are a problem, but more so for inpatient care than for outpatient care (Murauskienė et al., 2013).

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



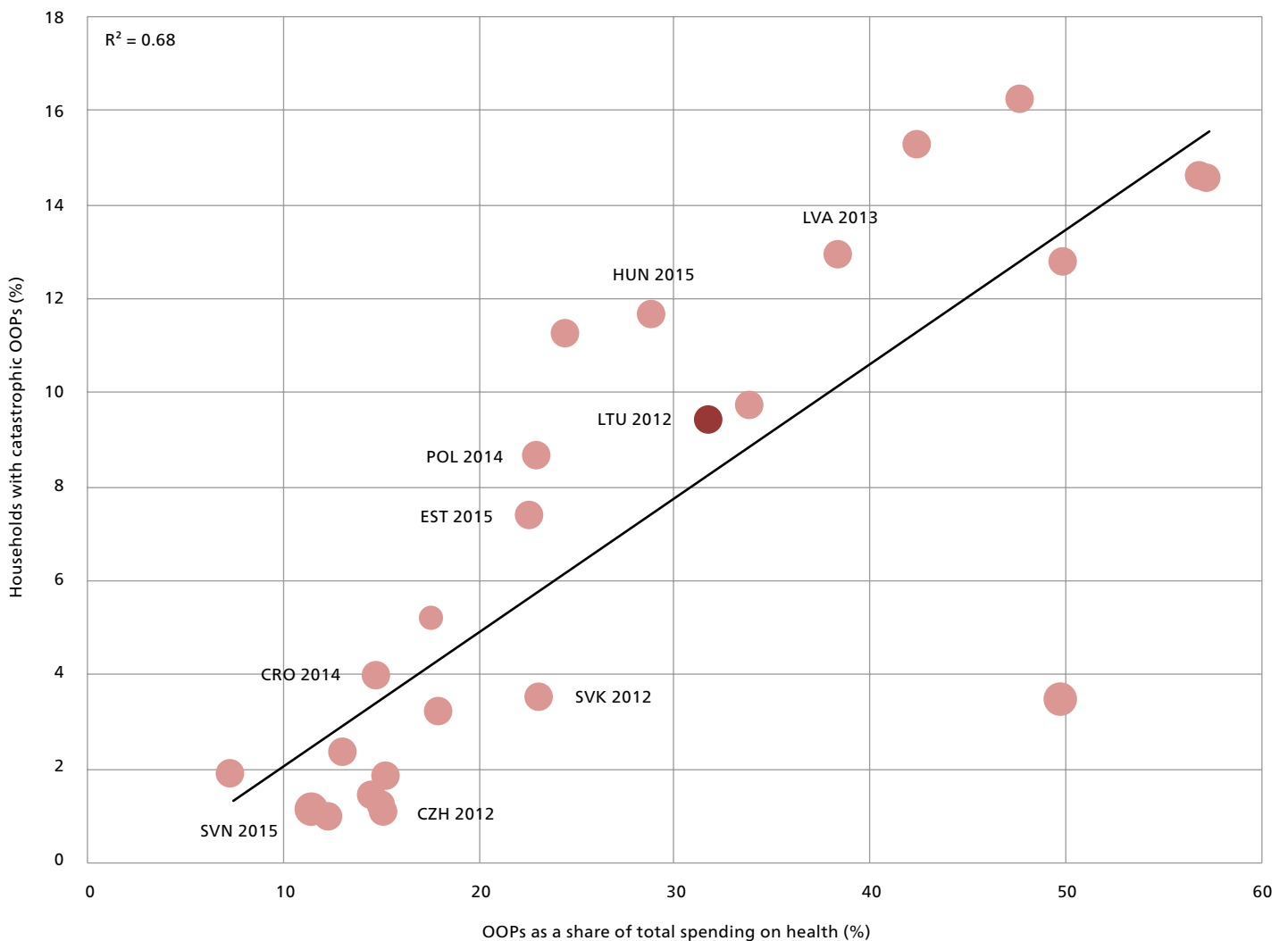
Financial protection

Financial protection is weak in Lithuania compared to other European Union countries (Fig. 5).

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

Notes: CZH: Czechia; EST: Estonia; CRO: Croatia; HUN: Hungary; LTU: Lithuania; LVA: Latvia; OOP: out-of-pocket payments; SVK: Slovakia; SVN: Slovenia; POL: Poland. Lithuania is highlighted in dark red. The OOP data are for the same year as the catastrophic spending data. R²: coefficient of determination.

Sources: WHO Barcelona Office for Health Systems Strengthening and WHO (2018).



Just over 9% of households experienced catastrophic out-of-pocket payments in 2012 (Fig. 6). Catastrophic spending affects the poorest households the most. It is also heavily concentrated among older households. Over time, however, it has become an increasing problem for younger households. Among households with catastrophic spending, the share of households headed by a person aged between 30 and 60 years rose from 14% in 2008 to 32% in 2012.

In 2012, 4% of households were impoverished or further impoverished as a result of having to pay out-of-pocket for health (Fig. 7). The poverty line reflects the cost of spending on basic needs (food, rent and utilities) among a relatively poor part of the Lithuanian population (those between the 25th and 35th percentiles of the consumption distribution, adjusted for household size and composition). The average monthly cost of meeting these basic needs – the basic needs line – was €242 in 2012.

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

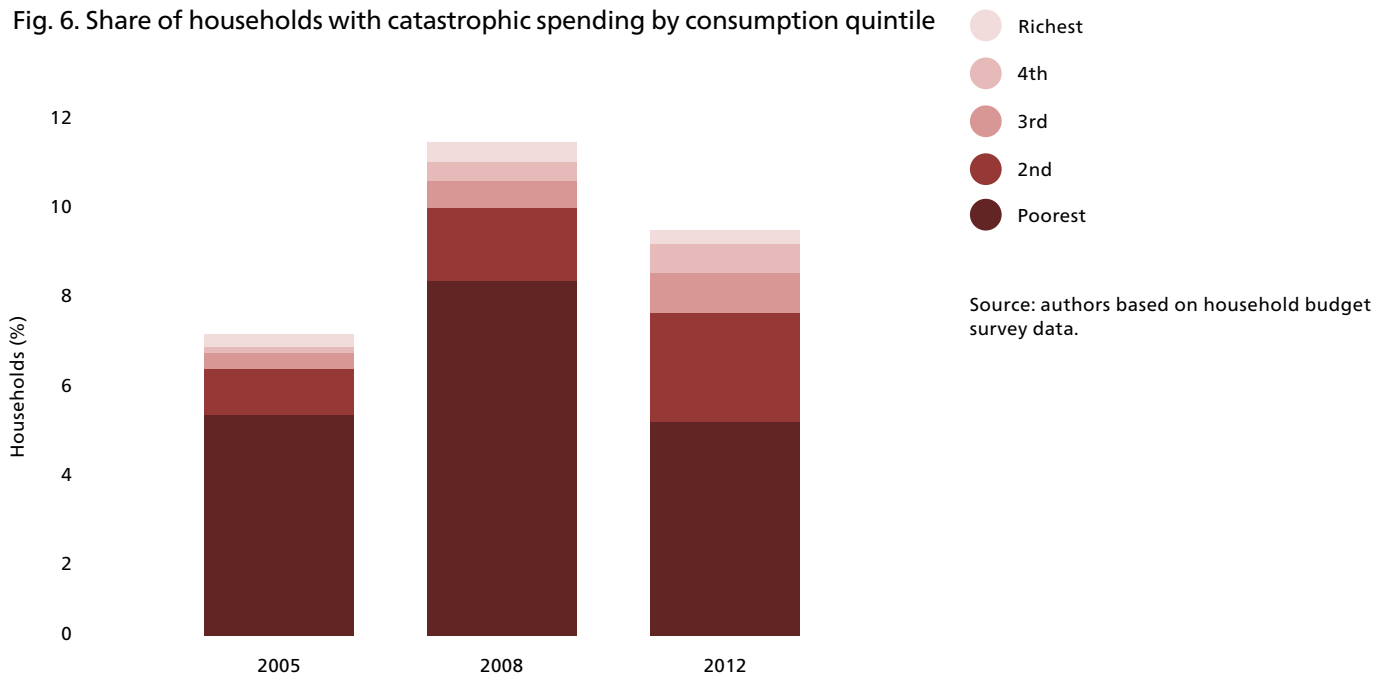
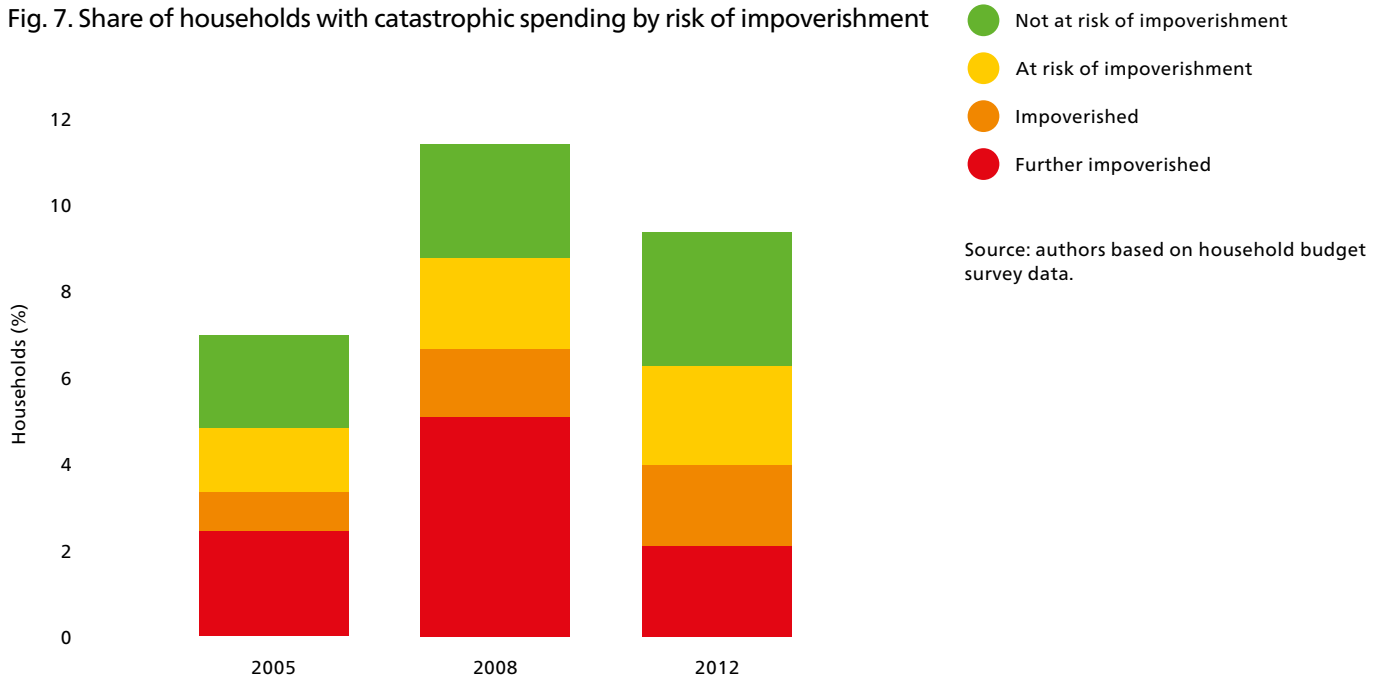


Fig. 7. Share of households with catastrophic spending by risk of impoverishment



Source: authors based on household budget survey data.

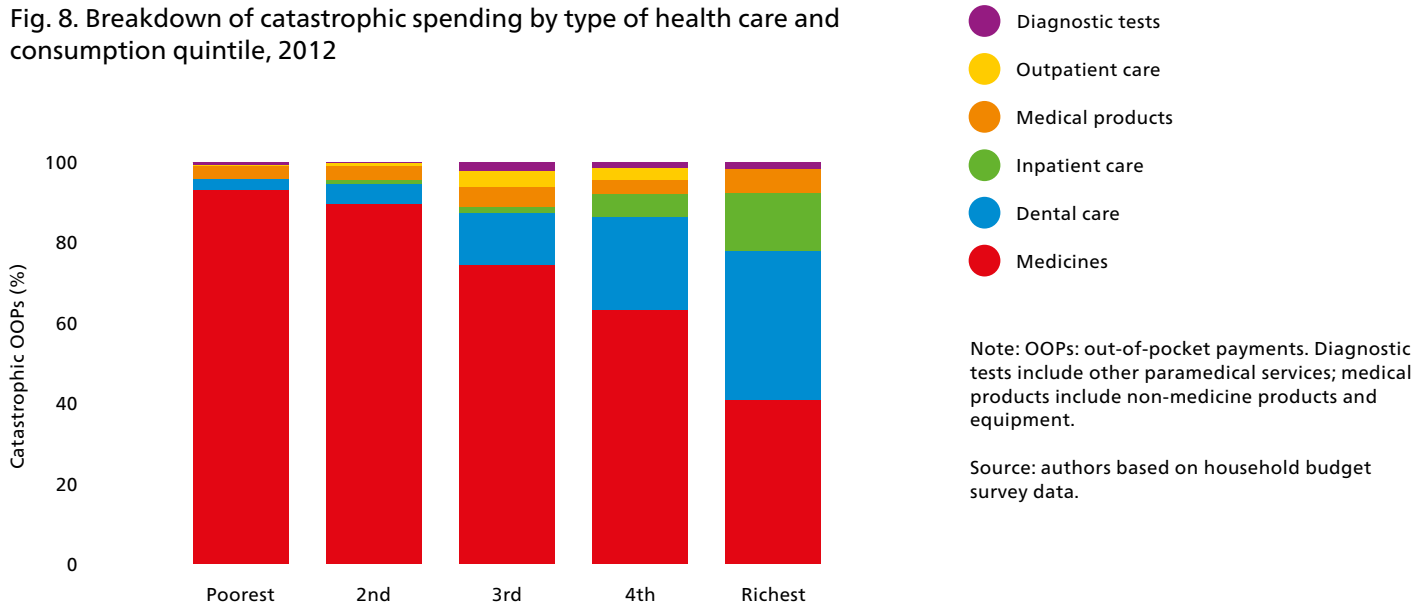
Outpatient medicines are the largest single cause of catastrophic spending for the population as a whole; they account for almost all catastrophic spending among the poorer households (Fig. 8). The outpatient medicines share of overall catastrophic spending has grown substantially over time, rising from 50% in 2008 to 77% in 2012.

Dental care is the second largest driver of catastrophic out-of-pocket payments, but mainly affects richer households due to the access barriers and unmet need experienced by poorer households. The dental care share of catastrophic spending halved between 2008 and 2012, perhaps in response to the financial pressure households faced during and after the economic crisis.

Inpatient care accounts for around 15% of catastrophic spending among the richest quintile, but a much lower share for the other quintiles.

The incidence of catastrophic out-of-pocket payments was higher in 2012 than in 2005. It has grown steadily over time for households in the three middle quintiles. A small reduction in the overall incidence of catastrophic spending on health between 2008 and 2012 was driven entirely by a fall in incidence among the poorest quintile.

Fig. 8. Breakdown of catastrophic spending by type of health care and consumption quintile, 2012



Factors that strengthen and undermine financial protection

Household budget survey data suggest that people's capacity to pay for health fell as a result of the economic crisis. At the same time, a marked decline in public spending on health per person in the years following the crisis pushed up the out-of-pocket share of total spending on health (Fig. 1). Both factors may explain why the incidence of financial hardship has grown over time among the middle three quintiles (Fig. 6).

For the poorest quintile, financial protection deteriorated between 2005 and 2008 and improved between 2008 and 2012 (Fig. 6). The apparent improvement is likely to reflect changes in the composition of this quintile over time. Between 2005 and 2008, older people experienced an increasing risk of poverty compared to the rest of the population, largely because pensions failed to keep pace with growth in other sources of income; as a result, they accounted for a greater share of the poorest quintile in 2008 than 2005. Pensioner poverty is a challenge for financial protection due to higher rates of health care need among older people. The situation was reversed between 2008 and 2012, as pensions remained stable while unemployment rose and wages fell. People of working age became poorer as a result, and the share of older people in the poorest quintile fell. During this period the share of households with catastrophic spending headed by people under the age of 60 more than doubled.

Lithuania's limited coverage of outpatient medicines for adults is the most important health system factor leading to financial hardship. The weak design of co-payment policy for outpatient prescribed medicines – for

example, the use of percentage co-payments, very limited protection for poor households and regular users, and the lack of a cap on co-payments – means patients bear much of the financial burden of high prices and of inappropriate prescribing and dispensing.

Pharmaceutical policy changes introduced in 2009 and since 2017 are likely to have reduced medicine prices, but not enough to achieve a significant improvement in financial protection.

The self-reported use of non-prescribed medicines is very high in Lithuania compared to other European Union countries, especially among people over 65. In 2014, close to 70% of people aged 65 and over reporting use of non-prescribed medicines in Lithuania compared to around 30% on average in the European Union (Eurostat, 2018c). High use in Lithuania may reflect both the easy availability of over-the-counter medicines and incentives encouraging people to use them, and is likely to play a role in causing financial hardship.

Limited coverage of dental care for adults means dental care leads to financial hardship, but only among those who can afford to access services. It would be a much greater cause of financial hardship if poorer households did not experience high levels of unmet need for dental care.

Children up to the age of 18 benefit from the most complete health coverage. They enjoy free access to all publicly financed health care. This strongly protective policy towards children is reflected in the very low share of households with children among households with catastrophic out-of-pocket payments.

Implications for policy

Financial protection is weak in Lithuania compared to other European Union countries. Catastrophic out-of-pocket payments affect the poorest households the most and are also heavily concentrated among older households.

Financial protection has deteriorated over time. The share of households experiencing financial hardship was higher in 2012 than in 2005. Between 2008 and 2012, this share rose in the three middle quintiles but fell significantly in the poorest quintile.

Strengthening the income support system for pensioners and unemployed people would help to break the links between poverty, ill health and financial hardship. The apparent improvement in financial protection for the poorest quintile between 2008 and 2012 cannot be explained by pro-poor changes in the health system. Rather, it is likely to be related to the effects of the crisis. Following the crisis, the share of pensioners in the poorest quintile fell and unmet need for dental care rose. More recently, as unemployment has declined and wages grown faster than pensions, the incidence of catastrophic out-of-pocket payments in the poorest quintile is likely to have increased.

Outpatient medicines are by far the most important cause of financial hardship and a relatively important factor behind self-reported unmet need for health care. The medicines share of catastrophic spending has

grown substantially over time, rising from 50% in 2008 to 77% in 2012. Among the poorest 40% of households, medicines account for 90% of catastrophic spending.

Policy attention should focus on improving access to and the affordability of outpatient prescribed medicines. Reforms introduced in 2009, 2017 and 2018 have aimed to lower medicine prices and encourage appropriate prescribing and dispensing. These are essential steps in the right direction, but further action is needed. The reasons for Lithuania's relatively high use of non-prescribed medicines, especially among people aged over 65, and the impact of this form of self-treatment on financial protection, could also be explored further.

Major improvement in financial protection is only likely to be achieved by strengthening the design of coverage and co-payment policy, especially for outpatient medicines. At present, co-payment policy for outpatient prescribed medicines shifts the financial risk associated with high prices and inappropriate prescribing and dispensing onto households. A more protective approach would be to exempt poor households and regular users of outpatient medicines; introduce an income-related cap on all co-payments; and use fixed rather than percentage co-payments.

Barriers to accessing dental care should be a matter of policy concern. The limited coverage of dental care for adults results in financial hardship for richer households and a high level of unmet need among poorer households.

Extending the coverage all children currently enjoy to poorer adults would do much to alleviate financial hardship and break the link between poverty and ill health. Children up to the age of 18 benefit from free access to all publicly financed health care. This strongly protective policy towards children is reflected in the very low share of households with children among households with catastrophic out-of-pocket payments.

The creation of a register of people eligible to contribute to the NHIF reveals that around 6–10% of the population is uninsured, mainly men of working age. Although some of these people are likely to be living abroad, this issue warrants policy attention. Many other EU countries cover the whole population, most often by linking entitlement to residence rather than payment of contributions.

Stronger financial protection will require additional public investment in the health system. Public spending on health is lower than Lithuania can afford given its level of GDP (Fig. 2), partly due to a decline in public spending in the years after the crisis, but also as a result of the very small size of its government – in 2015 Lithuania had the second-lowest ratio of public spending to GDP in the European Union.

Any increase in public spending on health should be used to prioritize stronger protection for poor adults and regular users of outpatient medicines and other health services. It may also be possible to pay for some improvement in financial protection through better use of existing resources.

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Glossary of terms

Ability to pay for health care: Ability to pay refers to all the financial resources at a household's disposal. When monitoring financial protection, an ability to pay approach assumes that all of a household's resources are available to pay for health care, in contrast to a capacity to pay approach (see below), which assumes that some of a household's resources must go towards meeting basic needs. In practice, measures of ability to pay are often derived from household survey data on 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. 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 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 or over count as 0.7 equivalent adults and children under 13 count as 0.5 equivalent adults.

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

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

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

Further 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 incurs out-of-pocket payments.

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

Household budget: Also referred to as total household consumption. The sum of the monetary value of all items consumed by the household during a given period and the imputed value of items that are not purchased but 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 pre-payment (for example, taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company.

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

Quintile: One of five equal groups (fifths) of a population. This study commonly divides 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: All people are able to use the quality health services they need without experiencing financial hardship.

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

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

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

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