Can people afford to pay for health care? New evidence on financial protection in Europe
WHO's new regional report published on World Health Day 2019

Why has WHO carried out a study on financial protection in Europe?

Financial protection is central to universal health coverage (UHC), which aims to ensure that everyone can use the health services they need without experiencing financial hardship. The Sustainable Development Goals (SDGs) call for the monitoring of financial protection as one of two indicators for UHC under SDG target 3.8. The WHO Regional Office for Europe is committed to supporting countries to move towards UHC, as reflected in two recent resolutions adopted by the WHO Regional Committee for Europe.

- EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020.

- EUR/RC67/R3 on the roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020.

This new study aims to monitor financial protection in a way that is relevant for all countries in the Region; offer countries tailored advice on how to make progress towards UHC; and enable countries to reduce out-of-pocket payments for the people most in need of protection.

What is new about the study?

Policy-relevant measurement with a focus on equity: The WHO Regional Office for Europe has developed an advanced method of measuring financial protection in response to concerns that the methods used to measure financial protection globally have limited relevance for Europe.

New numbers for Europe: The study provides up-to-date numbers using household-level data for 24 countries in Europe, drawing on the most recent year available (mainly 2016, 2015 and 2014).

Unmet need is part of the analysis: The study brings together for the first time data on financial hardship and unmet need for health care across Europe.

The story behind the numbers: The study combines analysis of household-level data with context-specific policy analysis. Drawing on country-level analysis, it links indicators of financial protection and unmet need to national policies and policy changes over time. This allows WHO to offer countries tailored advice on how to make progress towards UHC.

Who has carried out the study?

The study is led by the WHO Barcelona Office for Health Systems Strengthening in the Division of Health Systems and Public Health.

Country-level analysis is prepared by national experts in collaboration with WHO. The comparative analysis is carried out by WHO.

For further information on the study, contact Sarah Thomson and Tamás Evetovits and see our web pages.

How are the study's results being used?

The study's data on impoverishing and catastrophic health spending will soon be available via the Global Health Observatory[1] and the European Health Information Gateway.

These numbers are already being included in:

- HiT reports produced by the European Observatory on Health Systems and Policies
- Country Health Profiles produced by the European Commission in its *State of Health in the EU cycle*
- Health at a glance in Europe produced by the OECD
- EU country-specific recommendations as part of the European Semester

Some of the advantages of our new method for monitoring financial protection were highlighted in the WHO & World Bank 2017 global monitoring report Tracking universal health coverage.

Which countries are in the study and how were they selected?

The countries in the study span the geographical breadth of the WHO European Region, from Ireland in western Europe to Kyrgyzstan in central Asia. They cover:

- 18/33 high-income countries and 18/28 European Union (EU) countries: Austria, Croatia, Cyprus, Czechia, Estonia, France, Germany, Greece, Hungary, Ireland, Latvia, Lithuania, Poland, Portugal, Slovakia, Slovenia, Sweden and the United Kingdom;

- 2/14 upper-middle-income countries: Albania and Turkey; and

- 4/5 lower middle-income countries: Georgia, Kyrgyzstan, the Republic of Moldova and Ukraine.

Countries were selected to reflect a mix of stronger and weaker performance in terms of financial protection. The study also gives priority to countries in which it is possible to monitor trends over time; the financial and economic crisis is likely to have had a profound effect; reforms to move

[1] At global level, WHO will continue to report country-specific data using the SDG metrics, but regional data will also be published on the Global Health Observatory website.

towards UHC have been introduced or are soon to be implemented; and there is active policy dialogue.

Additional countries will be included in the second wave of monitoring (2019-2023), with the aim of covering 80% of the Region.

What are the study's main sources of data?

The study draws on microdata from national household budget surveys. National experts obtained access to survey microdata from national statistical offices.

Data on unmet need come from two surveys – European Union Statistics on Income and Living Conditions (EU-SILC) and the European Health Information Survey (EHIS) – available from the Eurostat database.

What is financial protection and how is it measured?

Out-of-pocket payments can create a financial barrier to access, resulting in unmet need, and lead to financial hardship among people using health services. Because all health systems involve some out-of-pocket payment, financial hardship linked to the use of health services can be a problem in any country. Lack of financial protection may lead to or deepen poverty, undermine health and exacerbate health and socioeconomic inequalities.

Financial protection is a key dimension of health system performance. It is measured using two well-established indicators.

Impoverishing health spending provides information on the impact of out-of-pocket payments on poverty. A household is considered to be *impoverished* if its consumption or income is above the poverty line before spending out of pocket and below it after spending out of pocket. A household can also experience impoverishing health spending if its consumption or income before spending out of pocket was already below the poverty line; it is *further impoverished* after spending out of pocket.

Catastrophic health spending occurs when the amount a household pays out of pocket exceeds a predefined share of its ability to pay. This may mean the household can no longer afford to meet other basic needs like food, housing and heating or cannot afford to meet basic needs without drawing on savings, selling assets or borrowing.

Both indicators assess a household's out-of-pocket payments in relation to a pre-defined threshold, but each indicator can be calculated in different ways.

The WHO Regional Office for Europe has developed an advanced method of measuring financial protection in response to concerns that the method used to measure financial protection in the SDGs (SDG target 3.8.2), and other global approaches, pose a challenge for equity and have limited relevance for Europe.

Building on established methods, the metrics used in this report are less likely to underestimate financial hardship among poorer people than the SDG metrics because they account for differences in household capacity to pay for health care. The aim is to measure financial protection in a way that is relevant to all countries in Europe, produces actionable evidence for policy and promotes policies to break the link between ill health and poverty.

Regardless of the metrics used, most studies of financial protection draw on the same type of data and all define out-of-pocket payments in the same internationally standard way as:

- formal and informal payments made at the time of using any health care good or service provided by any type of provider;

- including user charges (co-payments) for covered services and direct payments for non-covered services; and

- excluding any pre-payment in the form of taxes, contributions or insurance premiums and any reimbursement by a third party such as the government, a health insurance fund or a private insurance company.

Financial protection should be measured at the level of the health system rather than at the level of different types of health care, different diseases or different patient groups.

What are the study's main findings on financial protection?

The incidence of *impoverishing health spending* in the study countries ranges from 0.3% to 9.0% of households. There is wide variation among EU countries (from 0.3% to 5.9%) and among non-EU countries also (from 3.6% to 9.0%).

The incidence of *catastrophic health spending* ranges from 1% to 17% of households in the study countries. It varies widely among the 18 EU countries in the study, including wide variation among countries that joined the EU after 30 April 2004.

Catastrophic health spending is consistently heavily concentrated among the poorest fifth of the population.

Out-of-pocket payments incurred by households with catastrophic health spending are mainly due to outpatient medicines, followed by inpatient care and dental care.

Why does the study look at unmet need alongside financial hardship?

Financial protection indicators capture financial hardship arising from the use of health services, but do not indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need. Bringing together for the first time data on financial hardship and unmet need across Europe reveals the following findings.

- In countries where the incidence of catastrophic health spending is very low, unmet need also tends to be low and without significant income inequality.

- In a few countries, the incidence of catastrophic health spending is relatively low, but there is a high level of unmet need, particularly among poor households, which suggests that health care is not as affordable as the financial protection indicators alone imply.

- In many countries, the incidence of catastrophic health spending and levels of unmet need are both relatively high, and income inequality in unmet need is also significant, indicating that health services are not at all affordable, and that if everyone were able to use the services they needed, financial hardship would be even greater, particularly among poorer households.

- Some health services – notably dental care – are a much greater source of financial hardship for richer households than poorer households. This reflects higher levels of unmet need for dental care among poorer households than richer households in most countries.

- Outpatient medicines are an important source of financial hardship in many countries and among the poorest quintile in most countries. Unmet need for prescribed medicines is also generally higher in countries with a higher incidence of catastrophic health spending, which indicates that out-of-pocket payments for medicines lead to both financial hardship and unmet need for poorer people.

What factors strengthen financial protection?

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

- there are no large gaps in coverage;

- coverage policy is carefully designed to minimize access barriers and out-of-pocket payments, particularly for poor people and regular users of health services;

- public spending on health is high enough to ensure relatively timely access to a broad range of health services without informal payments; and as a result

- out-of-pocket payments are low, accounting for less than or close to 15% of current spending on health.

There is a strong association between the incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health, suggesting that the out-of-pocket payment share can be used as a proxy indicator for financial protection when data on financial protection are lacking.

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

health or reductions in out-of-pocket payments are not enough to improve financial protection in all contexts. Coverage policies play a key role in determining financial hardship, not just patterns of spending on health.

How can countries address gaps in coverage?

People are exposed to out-of-pocket payments and unmet need when there are gaps in coverage. Gaps in coverage arise from weaknesses in the design of three policy areas:

- the basis for population entitlement leaves some people without access to publicly financed health services;
- the range of services that is publicly financed – the benefits package – is narrow, or there are issues relating to the availability, quality and timeliness of these services; and
- there are user charges (co-payments) in place for services in the benefits package.

Weaknesses in coverage policy undermine equity and efficiency by creating financial barriers to access; shifting the financial burden of paying for health care on to those who can least afford it – poor people and regular users of health services; and encouraging inefficient patterns of use.

The report summarizes actions that can reduce unmet need and financial hardship by strengthening coverage policy. It also highlights actions that should be avoided.

What are the study's key messages on population entitlement?

Most gaps in population coverage occur because entitlement is based on employment or payment of contributions. This automatically excludes people, particularly in countries that lack effective mechanisms to enforce collection, and is more likely to affect relatively vulnerable groups of people.

Where gaps in population coverage are significant, they lead to high levels of unmet need and financial hardship. Population coverage is not a useful instrument for rationing because it is likely to exacerbate inefficiencies in service use and inequalities in use and health. Excluded people will have to rely on emergency services and may experience an avoidable deterioration in health status.

Offering a split benefits package – a situation in which publicly financed entitlements vary based on whether people have paid contributions – is likely to have a disproportionately negative impact on people with lower socioeconomic status, entrenching inequalities.

Even where the whole population is covered, some groups may be systematically underserved, particularly undocumented migrants, Roma and people with mental health problems.

The share of the population entitled to publicly financed health services should not be used as an indicator of financial protection. This study shows how the incidence of catastrophic health spending varies hugely across countries that cover the whole population.

What are the study's key messages on the benefits package?

Out-of-pocket spending on medicines is the main driver of financial hardship in most countries. In some countries, the number of outpatient medicines covered by the publicly financed benefits package is low and requires urgent policy attention. The over-the-counter share of spending on medicines is relatively high in some of the high-income countries in the study, which may reflect a narrow benefits package or barriers to obtaining prescriptions from outpatient physicians.

Coverage of dental care for adults is very limited in some countries, including high-income countries. Lack of dental care coverage leads to financial hardship for richer households, who can afford to pay out of pocket, and unmet need for poorer households. This pattern is also likely to apply to preventive services, underlining the importance of ensuring that such services are adequately covered and free at the point of use, at least for poor people.

Problems with service availability, timeliness and quality may increase out-of-pocket payments. If levels of public spending on health are inadequate and lead to *implicit* rationing – for example, as a result of unfunded mandates – informal payments are likely to be a problem. Informal payments are not the most important source of financial hardship, even in countries where they are significant, but their informal nature makes it impossible to protect people through exemptions.

The design of the benefits package offers valuable opportunities for explicit rationing through priority-setting processes. These processes can be used to ensure publicly financed health services are cost-effective and match population health needs as closely as possible. They can also help tackle out-of-pocket payments and other inefficiencies arising from inappropriate use of health services.

What are the study's key messages on user charges (co-payments)?

Co-payment design is a key factor influencing financial protection. It is the most important factor in countries where financial hardship is driven by outpatient medicines and the scope of the benefits package is adequate.

Exemptions for poor people are the single most effective co-payment design feature in terms of access and financial protection. All countries can and should exempt poor people, beginning with people receiving social benefits, a group that is administratively relatively easy for the health system to identify.

Caps also protect people if they are applied to all co-payments over time rather than narrowly focused on specific items or types of service – and if they are low enough. Ideally, they should be set as a very low share of household income. Caps alone are unlikely to be sufficient to protect poor people, however.

If co-payments are used, they should be low and clearly defined so people know what they are expected to pay. In contrast to low fixed co-payments, percentage co-payments shift financial risk from purchasing agency to households and expose people to health system inefficiencies. This is particularly problematic in contexts where pricing, prescribing and dispensing are not adequately controlled.
Co-payment policy should pay attention to all three design features (exemptions, caps and type of co-payment); be designed around people rather than around items, services or diseases; and be as simple as possible to minimize confusion and enhance transparency.

User charges are not an effective rationing instrument due to strong and consistent evidence that they reduce necessary and unnecessary use in equal measure. Most decisions about health-care use and costs are made by health-care providers.

How can countries act on the study's evidence?

The first step to strengthening financial protection is to identify gaps in coverage in a given context. The next is to find ways of addressing them through a careful redesign of coverage policy. The design of user charges plays an important role because it explicitly allows the health system to target the people most in need of protection.

Taking steps to benefit the most disadvantaged people first – an approach known as progressive universalism – is vital in contexts where public resources are severely limited. It also offers advantages in countries that do not face a severe budget constraint, enabling them to meet the challenge of leaving no one behind by ensuring that poor people gain at least as much as those who are better off at every step on the path to UHC.

Progressive universalism rests on the ability to identify the health services most likely to lead to financial hardship, the people most likely to be affected and the root causes of gaps in coverage. This in turn requires indicators and metrics amenable to equity analysis, like the ones used in this report.

To be effective, changes to coverage policy should be supported by an adequate level of public spending on health. Countries in which the out-of-pocket payment share of current spending on health is relatively high will need to invest more publicly in the health system to reduce out-of-pocket payments. Simply increasing public spending might not be enough to improve outcomes for those most in need, however. The sequencing of policy is therefore important. Some countries will need to redesign coverage policy *at the same time* as seeking additional public investment in the health system.

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.