CAN PEOPLE AFFORD TO PAY FOR HEALTH CARE?
NEW EVIDENCE ON FINANCIAL PROTECTION IN EUROPE

By: Sarah Thomson, Jonathan Cylus and Tamás Evetovits

Summary: New analysis shows that out-of-pocket payments lead to financial hardship for people using health services, even in high-income countries that cover the whole population. To strengthen financial protection, countries need to focus on the design of health coverage, paying attention to policy on co-payments for outpatient prescriptions – a key determinant of financial hardship, especially in countries where the scope of the publicly financed benefits package is adequate. Learning from a wealth of good practice in Europe, countries can improve co-payment policy by introducing exemptions for poor people, applying annual caps to all co-payments and replacing percentage co-payments with low fixed co-payments.

Keywords: Access, Affordability, Co-payments, Financial Protection, Universal Health Coverage

Out-of-pocket payments undermine universal health coverage in Europe

New evidence from the World Health Organization (WHO) Regional Office for Europe finds that when people have to pay out of pocket for health care, some of them face barriers to access and forego treatment due to the cost involved; some pay and suffer financial hardship; and some experience both unmet need and financial hardship.

The new WHO study draws on contributions from national experts in 24 countries in Europe, involving analysis of microdata from household budget surveys and analysis of national policy developments. It reveals that:

- between 1% and 9% of households are pushed into poverty, or further into poverty, as a result of out-of-pocket payments;
- between 1% and 17% of households experience catastrophic health spending, which may mean they can no longer afford to meet other basic needs such as food, housing and heating;
- catastrophic health spending is consistently concentrated among the poorest 20% of the population;
- it is mainly driven by out-of-pocket payments for outpatient medicines; and
Ensuring everyone can use quality health services without experiencing financial hardship – universal health coverage – is a Sustainable Development Goal (SDG targets 3.8.1 and 3.8.2) all countries have committed to reach by 2030, and a priority for WHO (see Box 1). This new study is the first systematic attempt to monitor financial protection in Europe.

**Financial protection is a core dimension of health system performance**

Out-of-pocket payments push people into poverty or make them even poorer

There is wide variation in the incidence of impoverishing health spending among European Union (EU) countries and among non-EU countries (see Figure 1).

The poorest households are most likely to experience financial hardship

The incidence of catastrophic health spending varies widely among EU countries (see Figure 2). Among non-EU countries, the incidence is generally high (over 12%). Across Europe, people in the poorest quintile are consistently most at risk of catastrophic health spending.

**Outpatient medicines are the main driver of financial hardship**

Out-of-pocket payments incurred by households with catastrophic health spending are mainly due to outpatient medicines, followed by inpatient care and dental care. The share of catastrophic health spending due to outpatient medicines is consistently higher than average in the poorest quintile (see Figure 3).

**Unmet need must be part of the analysis**

Financial protection indicators capture financial hardship arising from the use of health services without experiencing financial hardship – universal health coverage – is a Sustainable Development Goal (SDG targets 3.8.1 and 3.8.2) all countries have committed to reach by 2030, and a priority for WHO (see Box 1). This new study is the first systematic attempt to monitor financial protection in Europe.

**Box 1: What is financial protection, why does it matter and how is it measured?**

Financial protection is measured using two indicators:

- **Impoverishing health spending** provides information on the impact of out-of-pocket payments on poverty. A household is impoverished if its consumption is above the poverty line before spending out of pocket and below it after spending out of pocket (it is no longer able to afford to meet basic needs). A household can also experience impoverishing health spending if its consumption before spending out of pocket was already below the poverty line (it was already unable to meet basic needs); 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 for health care. This may mean the household can no longer afford to meet other basic needs.

Financial protection indicators can be calculated in different ways, using a range of metrics. The WHO Regional Office for Europe has developed new metrics to measure 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 the new WHO study 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.

All financial protection metrics draw on similar sources of data, typically household budget surveys; 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; and measure financial protection at the level of the health system, not at the level of different types of health care, diseases or patient groups.
of health services, but do not indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need. Bringing together data on financial hardship and unmet need 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. The incidence of catastrophic health spending and levels of unmet need are both relatively high in many countries, and income inequality in unmet need is also significant, indicating that health services in these countries are not affordable, especially for 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.

Unmet need for prescribed medicines is 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.

**Factors that strengthen financial protection**

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

- there are no major gaps in health coverage;
- coverage policy – the way in which coverage is implemented and governed – is carefully designed to minimise 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

---

**Figure 1: Share of households with impoverishing health spending, latest year available**

![Graph showing share of households with impoverishing health spending](image1)

Note: ALB: Albania; AUT: Austria; CRO: Croatia; CYP: Cyprus; CZE: Czechia; DEU: Germany; EST: Estonia; FRA: France; IRE: Ireland; GEO: Georgia; GRE: Greece; HUN: Hungary; KGZ: Kyrgyzstan; LIT: Lithuania; LVA: Latvia; MDA: Republic of Moldova; POL: Poland; POR: Portugal; SWE: Sweden; SVK: Slovakia; SVN: Slovenia; TUR: Turkey; UKR: Ukraine; UNK: United Kingdom.

Source: [1]

**Figure 2: Share of households with catastrophic health spending by consumption quintile, latest year available**

![Graph showing share of households with catastrophic health spending by consumption quintile](image2)

Notes: consumption quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales. The first quintile is labelled “poorest” and the fifth quintile “richest”.

Source: [1]

**Figure 3: Breakdown of out-of-pocket payments by health service among households with catastrophic health spending in the poorest consumption quintile**

![Graph showing breakdown of out-of-pocket payments by health service](image3)

Note: countries ranked by incidence of catastrophic health spending from lowest to highest.

Source: [1]
Transforming societies

Eurohealth — Vol.25 | No.3 | 2019

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

The strong association between the incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health (see Figure 4) suggests that the out-of-pocket payment share can be used as a proxy indicator for financial protection when data on financial protection are lacking.

Figure 4: Incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health, latest year available

Notes: R²: coefficient of determination. Data on out-of-pocket payments are for the same year as data on catastrophic incidence.

The association between catastrophic incidence and the out-of-pocket payment share excluding out-of-pocket payments for long-term care is almost identical (R² = 0.70).

Source: 1

Better co-payment policy plays an important role in reducing financial hardship

Addressing gaps in coverage to reduce financial hardship

Across countries, public spending on health is shown to be much more effective in reducing out-of-pocket payments than voluntary health insurance.1 Increases in public spending on health or reductions in out-of-pocket payments are not enough to improve financial protection in all contexts, however. Coverage policies play a key role in determining financial hardship, not just patterns of spending on health.

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.
There is a wealth of good practice in countries with strong financial protection and countries where financial protection is weak overall but steps have been taken to protect poor people.\[1\]

**Acting on the evidence: better co-payment policy is key**

The first step to strengthening financial protection is to identify gaps in coverage in a given context. The next step is to find ways of addressing them through a careful redesign of coverage policy.

Co-payment policy is a key determinant of financial protection in European health systems (see Figure 5). It is the most important factor in countries where financial hardship is driven by outpatient medicines and the scope of the publicly financed benefits package is adequate.

Countries can improve co-payment policy by introducing exemptions for poor people, applying annual caps to all co-payments and replacing percentage co-payments with low fixed co-payments.

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.\[1\]

**Acting on the evidence: progressive universalism ensures no one is left behind**

Better co-payment policy plays an important role in reducing financial hardship because it allows the health system to target the people most in need of protection. Taking steps to benefit the most disadvantaged first – an approach known as progressive universalism\[2\] – 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 universal health coverage.

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 those developed and used by WHO in Europe.\[1\] [1]

**References**

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

By: WHO Regional Office for Europe

Copenhagen: WHO Regional Office for Europe, 2019

Number of pages: 79; ISBN: 978 92 890 5331 0


This new study brings together for the first time data on unmet need and financial hardship to assess whether people living in Europe can afford to pay for health care.

Drawing on contributions from national experts in 24 countries, the study shows that financial hardship varies widely in Europe, and that there is room for improvement even in high-income countries.

Through analysis of microdata from household budget surveys and analysis of national policy developments, the study identifies practical steps countries can take to reduce unmet need and financial hardship. It also highlights actions that should be avoided.