Can people afford to pay for health care?

New evidence on financial protection in Albania

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Sonila M. Tomini

Summary
The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage. 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 universal health coverage 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 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 Country Health Policies and Systems of the WHO Regional Office for Europe.
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Document number: WHO/EURO:2020-1357-41107-55852

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This review assesses the extent to which people in Albania experience financial hardship when they use health services, including medicines. The analysis draws on household budget survey data collected by the Institute of Statistics of Albania in 2008–2009 and 2015. It focuses on two indicators of financial protection: catastrophic health spending and impoverishing health spending. 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 current spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

Public spending on health is low in Albania. In 2016, it was lower in Albania (2.8% of GDP) than in most other upper middle-income countries in the WHO European Region (Fig. 1).
Out-of-pocket payments have almost always been the largest single source of funding for the health system in Albania. In 2016, they accounted for 58% of current spending on health, which is very high compared to European Union (EU) countries and high compared to other upper middle-income countries in the European Region (Fig. 2).
Out-of-pocket payments per person grew at a faster rate than public spending on health between 2009 and 2016 (Fig. 3). The slow pace of growth in public spending on health per person since 2009 and the fall in this spending since 2014 are worrying trends.

Fig. 3. Spending on health per person, by financing scheme

Note: public refers to all compulsory financing arrangements.
Source: WHO (2020).
Coverage, access and unmet need

Health coverage in Albania is provided through the mandatory health insurance system administered by a single purchasing agency, the Mandatory Health Insurance Fund (MHIF). For employees and other economically active people, entitlement to MHIF benefits is linked to payment of contributions. MHIF membership is voluntary for self-employed people, small family businesses and farmers. The MHIF calculates and collects voluntary contributions for self-employed people and people who are not registered as social beneficiaries.

The MHIF only covers about two thirds of the population on average, falling to about half of people in the poorest quintile.

Uninsured people are entitled to free emergency care (since 2013), a free annual basic health check-up (since 2015) and free visits to general practitioners (GPs, since 2017). They must pay out of pocket for all other health services (including medicines, diagnostic tests and non-emergency specialist care), leading to substantial inequalities in access to health care and in financial hardship.

For insured people, the publicly financed benefits package is relatively comprehensive. It does not cover dental care for adults, however, and publicly financed coverage of dental care for children, students and people receiving social assistance is limited to treatment in public facilities, even though most dental care is provided by private dentists. The range of covered products grew between 2009 and 2018 but remains low by European standards.

Outpatient specialist visits and inpatient care with referral are free at the point of use for insured people only. Co-payments are applied to outpatient prescribed medicines, medical products and some diagnostic tests. Although pensioners, people with disabilities, children aged under 1 year and people with selected conditions (cancer, tuberculosis, blindness and other conditions) are exempt from co-payments, there are no exemptions for poor people and no annual caps on co-payments.

Out-of-pocket payments also occur when people use private facilities or have to pay informally in public facilities (see the section on household spending on health).

Voluntary health insurance plays a very minor role. It does not address gaps in publicly financed coverage.

Self-reported unmet need for health care and dental care is a significant problem, with much higher rates in Albania than the EU average and evidence of sharp socioeconomic inequality (INSTAT, 2020) (Fig. 4). The main cause of unmet need for health care and dental care in Albania is cost.
The table below highlights key issues in the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of voluntary health insurance in filling these gaps.

### Gaps in coverage

<table>
<thead>
<tr>
<th>Issues in the governance of publicly financed coverage</th>
<th>Population entitlement</th>
<th>The benefits package</th>
<th>User charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entitlement depends on payment of contributions</td>
<td>Benefits not backed by adequate public funding, leading to informal payments</td>
<td>Complex co-payment policy, which lowers transparency</td>
<td></td>
</tr>
<tr>
<td>People not covered by the MHIF tend to be informal workers, poor people, those from minority communities and people living in deprived areas; these people are entitled to publicly financed emergency care, GP visits and an annual basic health check-up</td>
<td></td>
<td>Weak protection from co-payments: although exemptions are widespread, they are not based on income, so poor people are not automatically exempt, and there are no annual caps on co-payments</td>
<td></td>
</tr>
<tr>
<td>People not covered by the MHIF tend to be informal workers, poor people, those from minority communities and people living in deprived areas; these people are entitled to publicly financed emergency care, GP visits and an annual basic health check-up</td>
<td>No; the voluntary health insurance market is neither developed nor comprehensive</td>
<td>Dental care for adults; widespread informal payments for services and supplies that should be free of charge, which place a greater financial burden on poorer people</td>
<td>High percentage co-payments for outpatient prescribed medicines for covered people</td>
</tr>
</tbody>
</table>

### Are these gaps covered by voluntary health insurance?

<table>
<thead>
<tr>
<th>Are these gaps covered by voluntary health insurance?</th>
<th>No</th>
</tr>
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</table>

Source: authors.
Household spending on health

Household budget survey data indicate that out-of-pocket payments per person grew substantially between 2009 and 2015, both in real terms and as a share of total household spending. The out-of-pocket share of total household spending rose on average from 2.6% in 2009 to 3.6% in 2015 (Fig. 5). The rise was smallest for the poorest quintile, however.

During the study period, there were no coverage changes likely to result in significantly lower out-of-pocket payments for poor people, and growth in public spending on health per person slowed after 2009 and has stalled since 2014. This suggests that the slower rate of increase in out-of-pocket payments among the poorest quintile may reflect rising unmet need for health care, especially among poor people.

Outpatient medicines are the main driver of out-of-pocket spending, followed by inpatient care (Fig. 6). The outpatient-medicine share of out-of-pocket spending rose sharply between 2009 and 2015, while the inpatient-care share fell. This shift was driven mainly by an increase in household spending on outpatient medicines and, to a lesser extent, by a reduction in household spending on inpatient care. Possible explanations for this large increase include: a reduction in access to publicly financed health services (including medicines); an expanded list of covered medicines coupled with high user charges, which increased access to medicines but also increased out-of-pocket payments; and increases in the price of medicines coupled with the use of percentage co-payments for outpatient prescriptions, which exposes people to changes in price.
Informal payments are widespread, particularly for inpatient care, and are likely to impose a particularly heavy financial burden on the poorest households. There is some evidence to suggest they have fallen over time, and this may reflect intensive information campaigns against informal payments introduced in 2013.
Financial protection

Financial protection is weak in Albania compared to other countries in the European Region.

In 2015, 8% of households experienced impoverishing health spending, which is higher than in most other countries (Fig. 7). Between 2009 and 2015, the share of households impoverished and further impoverished after out-of-pocket payments decreased from 9% to 8%, driven by a fall in the share of further impoverished households.

The incidence of catastrophic spending on health in Albania is also among the highest in Europe (Fig. 8).
Fig. 8. Incidence of catastrophic spending on health and the out-of-pocket share of total spending on health in selected European countries, latest year available

Notes: $R^2$: coefficient of determination. The out-of-pocket payment data are for the same year as those for catastrophic spending. Albania is highlighted in red.

Source: WHO Regional Office for Europe (2019).
In 2015, 12.5% of households experienced catastrophic out-of-pocket payments, up slightly from 11.9% in 2009 (Fig. 9). Catastrophic spending affects the poorest households the most (Fig. 9). It is also heavily concentrated among older households and households with children.

![Fig. 9. Share of households with catastrophic spending, by consumption quintile](source)

Source: authors, based on household budget survey data.
The main driver of catastrophic spending was inpatient care in 2009 and outpatient medicines in 2015 (Fig. 10). In 2009, outpatient medicines were the main driver of catastrophic spending for the poorest quintile only. By 2015, it was the main driver for all except the richest quintile.

Fig. 10. Breakdown of catastrophic spending, by type of health care and consumption quintile

Notes: OOPs: out-of-pocket payments. Diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data.
Factors that strengthen and undermine financial protection

Under the policies in place during the study period, the main gaps in coverage were related to:

- the linking of entitlement to employment status and payment of contributions (from 2013), MHIF membership being voluntary for self-employed people, small family businesses and farmers, and the fact that voluntary contributions are collected by the MHIF rather than the tax authority, which collects mandatory contributions: as a result, the MHIF covers a very low share of the population;

- limited entitlement for people lacking MHIF coverage, especially to outpatient medicines and non-emergency specialist care;

- lack of dental-care coverage for adults – entitlement for others is limited to public facilities, but most dental treatment takes place in private facilities; and

- widespread and heavy user charges in the form of percentage co-payments for outpatient prescribed medicines, and for medical products, diagnostic tests and other paramedical services, with no exemptions from user charges for poor people and no annual cap on co-payments: poor people and those who have to pay for long-term treatment such as medicines for chronic illness face financial hardship, while inadequate regulation leads to high prices; inappropriate prescribing and dispensing are also likely to contribute to financial hardship.

Although the MHIF does not cover dental care for adults, dental care is not a major driver of catastrophic spending, reflecting unmet need driven by the high cost to households of paying out of pocket for inpatient care and medicines.

Publicly financed health services suffer from poor quality and a high incidence of informal payments. The latter undermines collective financing, increases corruption, reduces transparency in the health system and places a particularly heavy financial burden on poor households.

Policy attention should focus on improving financial protection for poor households, who are also most at risk of delaying or foregoing care. There is some evidence to suggest that the apparent improvement in financial protection among the poorest households over time is the result of an increase in unmet need for health care.
Implications for policy

Financial protection in Albania is weak in comparison to many other European countries. In 2015, one in eight households incurred catastrophic out-of-pocket payments, with the payments being concentrated among the poorest quintile. Levels of unmet need for health care are also high.

Lack of financial protection can be attributed to low levels of public spending on health and weaknesses in the following aspects of coverage policy.

- The way in which entitlement to MHIF benefits is designed means that the MHIF only covers around two thirds of the population on average. Uninsured people have access to a very limited range of publicly financed health care; they are also more likely to be poor, come from minority groups and live in deprived areas. Efforts to strengthen financial protection and reduce unmet need should start by delinking entitlement to MHIF benefits from payment of contributions so that the MHIF automatically covers the whole population. Linking entitlement to payment of contributions is particularly challenging given Albania’s large informal sector.

- The MHIF does not cover dental care for adults. Lack of dental-care coverage results in high levels of unmet need.

- MHIF coverage is limited by a complex system of user charges, which are particularly heavy for outpatient medicines.

Outpatient medicines are the main driver of financial hardship, reflecting gaps in coverage and inadequate regulation. The growing role of outpatient medicines in driving financial hardship is worrying because of the lack of mechanisms to protect poor people. Many people are not entitled to publicly financed outpatient medicines because they are not covered by the MHIF. In addition, the outpatient medicines covered by the MHIF are subject to high percentage co-payments and there are no exemptions explicitly targeting poor households, nor is there any annual cap on co-payments. To improve financial protection, international experience indicates the following protective features of coverage and co-payment policy for outpatient prescriptions: the use of low fixed co-payments rather than percentage co-payments; exemption from co-payments for low-income households; and an annual income-related cap covering all co-payments. Attention should also be paid to the way in which medicines are selected for coverage and to ensuring that physicians, pharmacists and people are able to prescribe, dispense and use the cheapest alternatives.

Informal payments are a problem in outpatient and inpatient public facilities and cause financial hardship. Their informal nature makes it impossible to ensure protection for poor people. They also add to complexity and undermine transparency in the health system.
Strengthening financial protection will require additional public investment in the health system and a greater focus on poor households. Low public spending on health (just under 3% of GDP in 2016), high reliance on out-of-pocket payments (58% of current spending on health in 2016), significant gaps in coverage and widespread informal payments are the main factors undermining financial protection. Any additional investment in the health system should be used to extend entitlement to MHIF benefits to the whole population, find ways to improve access and financial protection for poor households and frequent users of health services (for example, people with chronic conditions), and improve transparency. Better use of resources will also help.
References


\(^1\) All websites accessed on 27 October 2020.
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 reported levels of consumption expenditure or income over a given time period. The available data rarely capture all of the financial resources available to a household – for example, resources in the form of 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 health spending. 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 and households who are further impoverished.

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 balance billing (a system in which providers are allowed to charge patients more than the price or tariff determined by the third-party payer), extra billing (billing for services that are not included in the benefits package) 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 person: 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 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 exacerating health and socioeconomic inequalities.
Further impoverished households: Poor households (those whose equivalent person total consumption is below the poverty line or basic needs line) who incur 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 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.

Impoverished households: Households who were non-poor before out-of-pocket payments, but are pushed below the poverty line or basic needs line after out-of-pocket payments.

Impoverishing out-of-pocket payments: Also referred to as impoverishing health spending. 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.

Informal payment: A direct contribution made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services to which patients are entitled.

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: formal co-payments (user charges or user fees) for covered goods and services; formal payments for the private purchase of goods and services; and 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 households into quintiles based on per equivalent person 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:** Everyone can 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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The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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