Can people afford to pay for health care?

New evidence on financial protection in Cyprus

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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.

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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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Corrigendum

The following change was made to the electronic file on 4 March 2021: Fig. 8 (page 12) has been updated to reflect the data on out-of-pocket payments currently available in the WHO Global Health Expenditure Database.
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This review assesses the extent to which people in Cyprus experience financial hardship when they use health services, including medicines. The analysis draws on household budget survey data collected by the Cyprus Statistics Service in 2003, 2009 and 2015 (the latest data available at the time of publication). 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 has always been low in Cyprus compared to other European Union (EU) countries. In 2018 (the latest year for which internationally comparable health spending data are available) public spending on health as a share of GDP was lower than in any other EU country and well below expected in Cyprus, given the size of its GDP (Fig. 1). As a result, out-of-pocket payments have generally accounted for close to half of total spending on health (among the highest in the EU) (WHO, 2020).

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**Fig. 1. Public spending on health and GDP per person in the EU, 2018**

Notes: public spending refers to all compulsory financing arrangements. The figure excludes Ireland and Luxembourg.

Source: WHO (2020).
Cyprus was hit heavily by the financial crisis that began in 2008. In the years that followed, unemployment quadrupled (Fig. 2), out-of-pocket payments per person fell in response to the economic downturn (Fig. 3) and the Government introduced stringent austerity measures, which led to a sustained decline in public spending on health per person (Fig. 3). By 2018 public spending on health per person still had not reached pre-crisis levels.

**Fig. 2. Unemployment in Cyprus and the EU**

![Graph showing unemployment in Cyprus and the EU from 2003 to 2019.](Image)

**Source:** Eurostat (2020).

**Fig. 3. Health spending per person by financing scheme**

![Graph showing health spending per person by financing scheme from 2000 to 2018.](Image)

**Note:** the figure shows current spending on health.

**Source:** WHO (2020).
Coverage, access and unmet need

Before 2019 Cyprus had a complex system of health coverage with significant gaps in the share of the population covered. Reforms introduced in 2013, following the global financial crisis, increased complexity and shifted health-care costs onto households. The health sector experienced stringent austerity measures, including restrictions to coverage and budget cuts, leading to a reduction in staff salaries and an exodus of doctors from public hospitals to private clinics.

A major reform was initiated in June 2019 to simplify coverage policy, strengthen access and financial protection and address fragmentation and other inefficiencies in the health system, including waiting times for treatment in public facilities and very high out-of-pocket payments. The new General Health System is being implemented following a phased approach.

**Population entitlement**: Until 2013 the basis for entitlement was linked mainly to EU citizenship and income; as a result, only 85% of the population was entitled to publicly financed health care. Migrants from non-EU countries were not covered and obliged by law to purchase private health insurance (Theodorou et al., 2012). Between 2013 and June 2019 the basis for entitlement was restricted even further and population coverage fell to 75% (OECD & WHO, 2017). A key feature of the new system introduced in 2019 is that entitlement is no longer linked to citizenship, income and payment of contributions but based on legal residence (OECD & WHO, 2019).

**Service coverage**: The main gaps in the publicly financed benefits package are for dental care for adults, long-term care, rehabilitation and palliative care. However, budgetary pressures and staff shortages have led to long waiting times for some services. In the absence of waiting time guarantees, problems with waiting times encourage many beneficiaries to use privately provided health services, for which they pay the full cost out of pocket. The limited range of medicines available in public pharmacies also pushes many people to pay out of pocket in private pharmacies.

**User charges**: Before 2013 there were no user charges (co-payments) for outpatient prescribed medicines, diagnostic tests or inpatient care, while fixed co-payments were relatively low (€2) for outpatient visits, with exemptions for some low-income households and people aged over 65 years. In 2013 user charges were introduced for outpatient prescribed medicines, diagnostic tests and emergency department visits, largely without exemptions, and existing user charges were increased. In 2019 the user charges policy was simplified. Protection against user charges was strengthened; for example, exemptions now apply to almost all co-payments and there is an annual cap covering all co-payments, which is set a more protective rate for children and people with a low income.

Voluntary health insurance (VHI) is expensive and does not provide full coverage. Spending through VHI accounts for around 10% of private spending on health, which suggests VHI has limited ability to address high out-of-pocket payments.
The table below highlights key issues relating to the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

<table>
<thead>
<tr>
<th>Issues relating to governance of publicly financed coverage</th>
<th>Population entitlement</th>
<th>The benefits package</th>
<th>User charges (co-payments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 2013 entitlement was based on citizenship and income; there was no entitlement for migrants from non-EU countries</td>
<td>Budgetary pressures lead to staff shortages and long waiting times in public facilities</td>
<td>User charges have increased since 2013</td>
<td></td>
</tr>
<tr>
<td>From 2013 to 2019, in addition to citizenship and income, entitlement was also dependent on having paid taxes and social security contributions (for pensions and other non-health benefits) and (for civil servants) contributions earmarked for health</td>
<td>A limited range of therapeutic options exist for medicines in public pharmacies</td>
<td>Under the new system there is an annual cap on all co-payments (which is lower for children and people with low incomes), but there are no exemptions from user charges based on income</td>
<td></td>
</tr>
<tr>
<td>These restrictions were abolished in 2019</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Main gaps in coverage

<table>
<thead>
<tr>
<th>Prior to 2019 around 25% of the population were not entitled to publicly financed coverage</th>
<th>There are long waiting times for some services, especially for surgical procedures and diagnostic tests</th>
<th>Prior to 2019 non-beneficiaries paid the full price of services based on prices set by the Ministry of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of dental care is limited</td>
<td>There is insufficient coverage of long-term nursing care, palliative care and rehabilitation</td>
<td>Under the current system, user charges are applied to all services (including medicines and emergency department visits) except inpatient care</td>
</tr>
</tbody>
</table>

Are these gaps covered by VHI?

| Yes, to a large extent for people who have opted for a VHI contract with generous coverage | Yes, to a large extent for people who have opted for a VHI contract with generous coverage | No |

Self-reported unmet need for health and dental care due to cost, distance and waiting time in Cyprus was on a par with the EU average in 2008 but grew between 2008 and 2014, particularly for dental care. Socioeconomic inequality in unmet need is substantial; it is especially pronounced for dental care (Fig. 4). The increase in unmet need over time is echoed by data on the use of public facilities, which grew steadily until 2012 and then fell (outpatient services) or stagnated (inpatient care), reflecting higher user charges, staff shortages and growing capacity constraints.
Can people afford to pay for health care in Cyprus?

Fig. 4. Income inequality in unmet need due to cost, distance and waiting time

Health care

Dental care

Note: population is people aged 16 years and over.

Household spending on health

Household budget survey data show that household spending on health increased substantially from 2003 to 2009 and then fell in 2015 (Fig. 5). Although out-of-pocket payments fell in absolute terms, however, they increased as a share of total household spending, rising from 5% in 2009 to 6% in 2015. This increase reflects a decline in household spending in the years following the financial crisis.

In 2003 and 2009 outpatient medicines and outpatient care accounted for the largest share of out-of-pocket spending; around 50% on average (Fig. 6). The other half was driven mainly by inpatient care and diagnostic tests. This pattern changed in 2015, when the shares spent on outpatient medicines and diagnostic tests grew, reducing the proportion spent on outpatient care and inpatient care.

There are large differences in the structure of out-of-pocket spending across quintiles (Fig. 7). In all years the share of out-of-pocket spending on outpatient medicines was higher in poorer households, while the outpatient care share was similar across quintiles and the shares spent on diagnostic tests and inpatient care were higher in richer households.
Fig. 6. Breakdown of out-of-pocket spending by type of health care

<table>
<thead>
<tr>
<th>Year</th>
<th>Outpatient care</th>
<th>Inpatient care</th>
<th>Medical products</th>
<th>Dental care</th>
<th>Diagnostic tests</th>
<th>Medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>25%</td>
<td>30%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>2009</td>
<td>28%</td>
<td>28%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>2015</td>
<td>30%</td>
<td>26%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Note: diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data.

Fig. 7. Breakdown of out-of-pocket spending by type of health care and consumption quintile in 2015

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Outpatient care</th>
<th>Inpatient care</th>
<th>Medical products</th>
<th>Dental care</th>
<th>Diagnostic tests</th>
<th>Medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>2nd</td>
<td>28%</td>
<td>28%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>3rd</td>
<td>30%</td>
<td>26%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>4th</td>
<td>32%</td>
<td>24%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Richest</td>
<td>35%</td>
<td>22%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Note: diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data.
Financial protection

In 2015 1.7% of households experienced impoverishing health spending and 5% (around 40,000 people) experienced catastrophic health spending. This is higher than in many other EU countries, but low in relation to the very high out-of-pocket payment share of current spending on health in Cyprus (Fig. 8).

Fig. 8. Incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health in selected European countries, latest year available

Notes: data on out-of-pocket payments are for the same year as data on catastrophic health spending.
Source: WHO Barcelona Office for Health Systems Financing (catastrophic incidence) and WHO Global Health Expenditure Database (out-of-pocket payments).
Between 2009 and 2015 there was a sharp increase in the incidence of impoverishing health spending (Fig. 9) and catastrophic health spending (Fig. 10).

**Fig. 9. Share of households at risk of impoverishment after out-of-pocket payments**

![Chart showing the percentage of households at risk of impoverishment from 2003 to 2015.](chart)

**Notes:** A household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments. It is further impoverished if its total spending is below the basic needs line before out-of-pocket payments, and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic needs line.

**Source:** Authors, based on household budget survey data.

**Fig. 10. Share of households with catastrophic spending by consumption quintile**

![Chart showing the percentage of households with catastrophic spending from 2003 to 2015.](chart)

**Source:** Authors, based on household budget survey data.

Across all years analysed, catastrophic spending is heavily concentrated among households in the poorest quintile (Fig. 10). In 2015, 17% of households in the poorest quintile experienced catastrophic health spending, compared to under 2% in the richest quintile. Small households and households with at least one person aged over 65 years are more likely to experience catastrophic spending than larger or younger households.
The incidence of catastrophic spending also varies by coverage status (Fig. 11). Households who are publicly covered and do not have voluntary health insurance (VHI) are most likely to experience catastrophic spending, followed by those with no coverage at all and those who are publicly covered and also have VHI. Households who rely exclusively on VHI are least likely to experience catastrophic spending.

Fig. 11. Catastrophic incidence by coverage status

Note: VHI: voluntary health insurance.
Source: authors, based on household budget survey data.
In 2015 catastrophic spending was mainly driven by diagnostic tests and inpatient care, followed by outpatient medicines (Fig. 12). This was a shift from 2009, when catastrophic spending was mainly driven by inpatient care. Across all years studied, the main drivers of catastrophic spending in the poorest quintile are outpatient medicines and outpatient care (Fig. 13).

**Fig. 12. Breakdown of out-of-pocket payments by type of health care in households with catastrophic spending**

![Diagram showing the breakdown of out-of-pocket payments by type of health care in households with catastrophic spending for 2003, 2009, and 2015.]

**Fig. 13. Breakdown of out-of-pocket payments by type of health care and consumption quintile in households with catastrophic spending in 2015**

![Diagram showing the breakdown of out-of-pocket payments by type of health care and consumption quintile in households with catastrophic spending in 2015 for the poorest, 2nd, 3rd, 4th, and richest quintiles.]

Can people afford to pay for health care in Cyprus?
Factors that strengthen and undermine financial protection

The factors that undermine financial protection in Cyprus include:

- persistently low levels of public spending on health (well below what would be expected given the size of Cyprus’ economy);
- long-standing budget and capacity constraints in public facilities, leading to problems with timely access and pushing many people to pay for privately provided medicines, diagnostic tests, consultations and inpatient treatment;
- the presence of a large market for privately provided health services, including medicines, which draws human resources away from the publicly financed part of the health system and exacerbates health system inequalities and inefficiencies;
- a sharp decline in household capacity to pay for health care between 2009 and 2015, reflecting rising unemployment, poverty and income inequality in the context of the economic crisis; and
- a procyclical pattern of public spending on health and social protection in the years following the 2008 financial crisis, which weakened the safety net, exacerbated budget and capacity constraints in public facilities and shifted health-care costs onto households.

The share of households with catastrophic health spending is low in Cyprus when compared to countries with similarly high levels of out-of-pocket payments. The factor most likely to account for this relatively low incidence is the near total absence of user charges for publicly financed health services before 2013. There were no user charges at all for covered people aged over 65 years and some covered low-income people. For all other covered people, the only user charge in place was a fixed co-payment of €2 for an outpatient visit.

Policy responses to the 2008 crisis, including a lasting decline in public spending on health per person, are likely to have contributed both to rising unmet need between 2008 and 2014 and to the increase in catastrophic health spending between 2009 and 2015. These policy responses include:

- the further restriction of the basis for entitlement, reducing the share of the population covered from 85% to 75%;
- the introduction of new user charges for outpatient prescriptions, laboratory tests and emergency services, and an increase in existing user charges for outpatient visits; and
- the cutting of budgets and movement of public sector health staff to the private sector, negatively affecting waiting times for publicly financed treatment.
The General Health System launched in 2019 is expected to reduce unmet need and financial hardship by:

- changing the basis for entitlement from citizenship, income and payment of contributions to residence, which extends publicly financed coverage to the 25% of the population that was previously not covered;

- simplifying user charges and improving protection mechanisms – for example, exemptions now apply to almost all co-payments and there is a new annual cap covering all co-payments, with a more protective rate for children and people with a low income;

- introducing a single-payer system in which the purchasing agency (the Health Insurance Organization) purchases services from public and private providers, with the aim of reducing fragmentation, lowering waiting times, improving quality of care and reducing out-of-pocket spending; and

- increasing public investment in the health system.
Implications for policy

Financial protection is weaker in Cyprus than in many other EU countries, having deteriorated over time. The incidence of catastrophic health spending rose from 3.5% of households (20 000 people) in 2009 to 5.0% of households (around 40 000 people) in 2015.

Catastrophic spending is most likely to affect poor people, older people and people who are publicly covered and do not have voluntary health insurance. The increase in catastrophic spending in 2015 was driven mainly by an increase in the poorest quintile.

Outpatient medicines are the main driver of catastrophic spending among the poorest quintile, followed by outpatient care. Among richer quintiles, financial hardship is mainly driven by spending on inpatient care and diagnostic tests.

Access to health care, measured in terms of unmet need, was on a par with the EU average in 2008 but grew between 2008 and 2014, particularly for dental care. Socioeconomic inequality in unmet need is substantial.

Policy responses to the 2008 crisis – sustained cuts to public spending on health and social protection and coverage restrictions – are likely to have contributed to rising unmet need and catastrophic health spending between 2009 and 2015. By 2018 public spending on health per person had still not reached pre-crisis levels.

The General Health System launched in 2019 is a major step forward for Cyprus. It is expected to reduce unmet need and financial hardship through a range of measures.

Key implementation challenges remain, however, including political support to ensure that the reforms stay on track, the purchasing of health services continues to be strengthened and public spending on health continues to increase at a steady pace.
References


1. All websites accessed on 10 December 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 exacerbating 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.
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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