Can people afford to pay for health care?

New evidence on financial protection in North Macedonia

Vladimir Dimkovski
Ilaria Mosca

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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New evidence on financial protection in North Macedonia

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This review is part of a series of country-based studies generating new evidence on financial protection in health systems in Europe. Financial protection is central to universal health coverage and a core dimension of health system performance.

Although access and financial protection have improved in North Macedonia in recent years, catastrophic health spending remains a problem, particularly for poorer households, and is largely driven by out-of-pocket payments for outpatient medicines.

To improve access and financial protection, the health system should: de-link entitlement from payment of contributions for the whole population, so that access to health care no longer depends on health insurance status; simplify the complex design of user charges and strengthen protection against co-payments for outpatient medicines; improve the affordability of outpatient prescribed medicines by enhancing the selection and purchasing of medicines and regularly updating the positive list; address informal payments, starting with better monitoring; and increase public investment in the health system through sustained rises in the priority given to health in allocating government spending.

Abstract

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Keywords

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HEALTH EXPENDITURES
HEALTH SERVICES ACCESSIBILITY
FINANCING, PERSONAL
NORTH MACEDONIA
POVERTY
UNIVERSAL COVERAGE
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This review assesses the extent to which people in North Macedonia experience financial hardship when they use health services, including medicines. The analysis covers the period from 2006 to the present day, drawing on data from household budget surveys carried out annually between 2006 and 2018 by the State Statistical Office in North Macedonia, data on unmet need for health care up to 2019 and information on coverage policy up to 2021. 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 and dental care.
Spending on health

Research shows that financial hardship is more likely to occur when public spending on health is low in relation to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; 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 as a share of GDP in North Macedonia is low compared to European Union (EU) countries. Although it is higher than average for upper middle-income countries, the gap has narrowed over time as public spending on health in North Macedonia has lagged behind GDP growth – it fell substantially from 5% of GDP in 2003 to 4% in 2007 and since then has failed to recover its 2003 peak. In 2018 public spending on health accounted for 13% of government spending and 3.8% of GDP (Fig. 1).

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**Fig. 1. Public spending on health as a share of GDP**

<table>
<thead>
<tr>
<th>Year</th>
<th>EU</th>
<th>North Macedonia</th>
<th>Upper middle-income countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>7</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>2001</td>
<td>6</td>
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<tr>
<td>2017</td>
<td>6</td>
<td>2.8</td>
<td>2.7</td>
</tr>
<tr>
<td>2018</td>
<td>6</td>
<td>2.7</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Source: WHO (2020).

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National health accounts data show the health system’s heavy reliance on out-of-pocket payments. In 2018 the out-of-pocket payment share of current spending on health was 42%, far above the EU average of 22% (Fig. 2).
North Macedonia has a system of mandatory health insurance managed by a single purchasing agency, the FZO, and financed through a combination of payroll taxes and transfers from the state budget.

In the context of high unemployment and considerable informality, the health system’s heavy reliance on out-of-pocket payments and funding from payroll taxes, combined with relatively low contribution rates and low transfers from the state budget, limits resilience to economic shocks and has led over time to fiscal pressure and hospital deficits.

Government payment of FZO contributions on behalf of people with low incomes (2009), people in vulnerable situations (2012) and people receiving the guaranteed minimum income (2019) has aimed to promote equitable access to health care and, by acting as an automatic stabilizer, to secure a more steady flow of public funds to the health system. Other reforms have focused on enhancing efficiency through changes to provider payment mechanisms.

Note: Since 2017 North Macedonia has tracked health spending using the System of Health Accounts (SHA) 2011 methodology, leading to a break in time series in the data on health spending. From 2017 onwards, data on health spending in North Macedonia are less comparable to data on health spending in other countries in the western Balkans.

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

There is a degree of uncertainty about population coverage due to the lack of recent census data (as the last census was in 2002). Recent estimates suggest that publicly financed mandatory health insurance covered 89% of the population in 2018. Uninsured people are only entitled to publicly financed emergency care and mandatory vaccinations. They are most likely to be people without regular employment and employees with a salary payment delay.

The publicly financed benefits package includes coverage of dental care for adults, but coverage of outpatient medicines is limited. Over time, coverage of inpatient medicines has increased.

User charges (co-payments), mainly in the form of percentage co-payments, apply to all health services except emergency care and primary care visits to GPs, gynaecologists, paediatricians and dentists. Several measures are in place to protect people from co-payments, including exemptions based on income (for people receiving social benefits), a cap per episode and an annual cap on all co-payments linked to household income and age group. However, these protective measures do not apply to outpatient medicines or medical products.

In 2018 VHI accounted for just 0.09% of total spending on health. It mainly plays a supplementary role, allowing people to opt for non-contracted health services in private hospitals.

Table 1. Gaps in publicly financed and VHI coverage

<table>
<thead>
<tr>
<th>Coverage dimension</th>
<th>Population entitlement</th>
<th>Service coverage</th>
<th>User charges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issues in the governance of publicly financed coverage</strong></td>
<td>Entitlement is based on payment of contributions</td>
<td>Almost no medicines have been added to the positive list since 2008</td>
<td>User charges for outpatient prescribed medicines can be high if medicines priced at the reference price are not available</td>
</tr>
<tr>
<td></td>
<td>Employees with a salary payment delay of more than 60 days become “passive insured people” and lack coverage</td>
<td>There is poor service quality and infrastructure in public hospitals</td>
<td>No annual cap on co-payments for outpatient medicines and medical products</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informal payments are common, particularly for gynaecology services in primary care</td>
<td>Some exemptions for low-income people, but not for co-payments for outpatient prescribed medicines or medical products</td>
</tr>
<tr>
<td><strong>Main gaps in publicly financed coverage</strong></td>
<td>Around 10% of those entitled to FZO coverage are uninsured</td>
<td>Outpatient medicines</td>
<td>No; VHI covering co-payments is available but uptake is extremely low (&lt;50 policies sold in 2018)</td>
</tr>
<tr>
<td><strong>Are these gaps covered by VHI?</strong></td>
<td>No</td>
<td>VHI covers services provided by private hospitals, but uptake is low (&lt;1% of the population)</td>
<td></td>
</tr>
</tbody>
</table>

Source: authors.
EU-SILC data suggest that access to dental care is relatively good in North Macedonia, with low levels of unmet need overall, although income-related inequalities in unmet need persist (Fig. 3). Over time, unmet need for health care has fallen to the EU average, but age and income inequalities remain significant.

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

Note: population is people aged 16 years and over.

Source: Eurostat (2020), based on EU-SILC data.
Household spending on health

Household budget survey data show that 46% of households reported making out-of-pocket payments in 2018, down from 62% in 2006.

Out-of-pocket payments have decreased steadily over time, particularly among the poorest quintiles. In all years studied, out-of-pocket payments accounted for 3% of household budgets on average, which is lower than in some central and eastern European countries and on a par with Croatia.

In 2018 outpatient medicines comprised the largest share of out-of-pocket spending (80%), followed by outpatient care (12%) (Fig. 4). There is significant variation across consumption quintiles, with outpatient medicines accounting for almost all out-of-pocket spending among the poorer quintiles, while the richer quintiles spend more on all other types of health care.

Informal payments are particularly present in gynaecological services in primary care, although they are perceived as normal by most people. A challenge in health systems with pervasive informal payments is that it is difficult to introduce policies to protect poor people and regular users of health care services from exposure to out-of-pocket payments.

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

Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment. Since 2015 paramedical services have been split between diagnostic tests and outpatient care.

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

The share of households with catastrophic health spending is higher in North Macedonia than in many EU countries, but lower than in Greece and Latvia, which have similar levels of out-of-pocket payments (as a share of current spending on health). It is also lower than expected given the very high out-of-pocket payment share of current spending on health in North Macedonia (Fig. 5).

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

Notes: the out-of-pocket payment data are for the same year as those for catastrophic spending. North Macedonia is highlighted in red.

Sources: WHO Regional Office for Europe (2019); WHO (2020).
In 2018, 6.5% of households experienced catastrophic health spending, down from 9.6% in 2006. The declining share of households with catastrophic out-of-pocket payments has been largely driven by a reduction in incidence in the two poorest quintiles. This could reflect governmental measures over time to extend coverage to different population groups, particularly for people with low incomes and other groups of people in vulnerable situations; a faster than average growth in income among the poorest quintile; and a decline in unemployment and poverty.

Financial hardship continues to be concentrated in the poorest quintiles, however (Fig. 6). In 2018 three-quarters of all households with catastrophic spending were found in the two poorest quintiles. Financial hardship is also heavily concentrated among households with at least one member aged over 60 years.

Outpatient medicines are the main driver of catastrophic health spending; their share has increased over time, rising from about 60% in 2006 to 78% in 2011 and then fluctuating around this level (Fig. 7). Outpatient care is generally the second-largest driver, followed by inpatient care.

In 2018 medicines accounted for 96% of out-of-pocket payments among households with catastrophic spending in the poorest quintile compared to only 31% in the richest quintile (Fig. 8). This pattern has been relatively consistent over time.
Fig. 7. Breakdown of catastrophic health spending by type of health care

Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment. Since 2015 paramedical services have been split between diagnostic tests and outpatient care.

Source: authors, based on household budget survey data.

Fig. 8. Breakdown of catastrophic spending by type of health care by quintile, 2018

Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment. Since 2015 paramedical services have been split between diagnostic tests and outpatient care.

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

Coverage is relatively comprehensive and results in low levels of unmet need for health care and dental care.

Despite the reduction in financial hardship over time, gaps in coverage persist. These include:

• the linking of entitlement to FZO benefits to payment of contributions, resulting in about 10% of the population being uninsured (based on population numbers from the last official census held in 2002);

• the fact that employees whose wages are not paid on time (and delayed for more than 60 days) automatically lose their FZO entitlement;

• the complex design of co-payment policy and the predominant use of percentage co-payments, which expose people to price and changes in price;

• the presence of informal payments in outpatient care (notably in gynaecological care), which may lead to financial hardship; and

• various factors relating to outpatient medicines – the limited coverage of outpatient medicines; the lack of updating (since the late 2000s) of the INNs covered by the positive list; the fact that protection mechanisms for co-payments do not apply to outpatient medicines; the tendency to prescribe, dispense and use brand name medicines; and (up until 2019) the stringent sales quotas for pharmacies, which limited the volume of medicines to be covered in a month.

Public spending on health has lagged behind GDP growth and fallen over time, reflecting a decline in public spending on health as a share of government spending. The gap in the level of public spending on health in North Macedonia and EU countries has widened significantly since the mid-2010s. This entrenches the health system’s heavy reliance on out-of-pocket payments, which accounted for 42% of current spending on health in 2018.
Implications for policy

Financial protection in North Macedonia is weaker than in many EU countries, but stronger than in Greece, Hungary, Latvia and Lithuania.

Catastrophic health spending affects the poorest households the most. In 2018 the poorest consumption quintile accounted for half of all households with catastrophic spending; together, the two poorest quintiles accounted for more than three quarters of all households with catastrophic spending. Catastrophic spending is also heavily concentrated among households consisting of older people.

Medicines are by far the largest driver of catastrophic spending, followed by outpatient care and inpatient care. Medicines account for almost all catastrophic spending among people in the two poorest quintiles, and their contribution to financial hardship has increased over time.

Catastrophic health spending reflects gaps in all three dimensions of coverage.

- **In 2018 around 10% of the population was estimated to be uninsured** (based on population numbers from the last official census held in 2002). This reflects a complex system in which entitlement to FZO benefits is linked to payment of contributions and entitlement is withheld from people whose wages have not been paid for more than 60 days. Linking entitlement to payment of contributions is particularly challenging in North Macedonia, where unemployment and labour market informality are high. Since the late 2000s the Government has taken steps to reduce this gap by paying contributions on behalf of people with low incomes and other population groups in vulnerable situations, but more needs to be done.

- **Although the benefits package is fairly comprehensive and includes coverage of dental care for children and adults, coverage of outpatient medicines is limited.**

- **Percentage co-payments are applied to all health services except emergency care and primary care visits.** The Government has introduced important protective measures, including exemptions from co-payments based on income (for people receiving social benefits) and an annual cap on co-payments linked to household income and age group. Protection mechanisms do not apply to co-payments for outpatient medicines or medical products, however, which leaves a significant gap in coverage.

Financial protection has improved over time. Between 2006 and 2018 the incidence of catastrophic out-of-pocket payments fell, including among the poorest quintiles, and the incidence of impoverishing health spending almost halved. This improvement may reflect the introduction in 2009 of government contributions on behalf of people with low incomes.
Access to health and dental care is generally good, reflecting substantial improvement in recent years, although inequalities in access are still an issue. Unmet need for health and dental care have fallen over time to around the level of the EU average, but socioeconomic and age-related inequalities remain significant.

Policy attention should focus on reducing the gap in population coverage by de-linking entitlement from payment of contributions and by simplifying the complex design of user charges.

To improve the affordability of outpatient prescribed medicines, attention should be paid to strengthening the design of co-payment policy and the capacity of the Ministry of Health and the FZO to engage in strategic purchasing of medicines. Where medicine prices are not effectively negotiated, households will bear the financial burden of high or increased prices. The abolition of the pharmacy sales quotas in 2019 is likely to have improved access to outpatient medicines. However, other factors that continue to drive high out-of-pocket spending on outpatient medicines should be addressed, including the limited and unchanged positive list of medicines and the lack of measures to protect people from co-payments for outpatient medicines and medical products. In addition, the Ministry of Health and the FZO can improve the affordability of outpatient prescribed medicines by using formularies, standardized clinical guidelines and protocols for chronic conditions, more effective tendering and procurement of medicines and electronic prescribing to monitor individual prescribing patterns.

The persistent presence of informal payments – especially in gynaecological care – is a further cause for concern. Informal payments impose the heaviest financial burden on the poorest households and may lead people to forego care. Better monitoring via data collection (surveys) and analysis is needed to assess the magnitude of informal payments in North Macedonia and identify strategies to reduce them.

Stronger financial protection will require additional public investment in the health system. At about 4% of GDP, public spending on health is low compared to the EU average (6%), reflecting a decline in the priority given to health in allocating government spending. The Government should increase the share of public spending allocated to health and use the increase in public funds to reduce unmet need and financial hardship for poorer households – for example, by exempting low-income households from all co-payments and extending the annual cap on co-payments to include all co-payments.
References


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 consumption expenditure or income over a given time period.
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.
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