

Can people afford to pay for health care?

New evidence
on financial protection
in Bulgaria

Antoniya Dimova
Jorge Alejandro García-Ramírez



Bulgaria

WHO Barcelona Office for Health Systems Financing

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Abstract

This review is part of a series of country-based studies generating new evidence on financial protection in European health systems. Financial protection is central to universal health coverage and a core dimension of health system performance. Bulgaria has a high incidence of impoverishing and catastrophic health spending compared to other countries in Europe. Catastrophic spending is almost entirely driven by out-of-pocket payments for outpatient medicines and has increased over time. It is heavily concentrated among poorer households, older people and people living in rural areas, reflecting significant gaps in all three dimensions of health coverage: population entitlement, service coverage and user charges (co-payments). Although public spending on health has grown in recent years, it remains low by European Union standards and has not kept pace with growth in out-of-pocket payments or been used to target unmet need and financial hardship. To reduce unmet need and financial hardship, the Government should focus on improving the affordability of outpatient medicines and strengthening protection from out-of-pocket payments for poorer households and people with chronic conditions. This can be done by: introducing exemptions from co-payments for these two groups of people; extending the annual cap on co-payments for inpatient care to all co-payments and linking the cap to household income; continuing to improve the way in which the National Health Insurance Fund purchases outpatient medicines; and finding ways to extend health insurance to the whole population.

Keywords

BULGARIA
HEALTHCARE FINANCING
HEALTH EXPENDITURES
HEALTH SERVICES ACCESSIBILITY
FINANCING, PERSONAL
POVERTY
UNIVERSAL COVERAGE

About the series

This series of country-based reviews monitors financial protection in European health systems by assessing the impact of out-of-pocket payments on household living standards. Financial protection is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection may reduce access to health care, undermine health status, deepen poverty and exacerbate health and socioeconomic inequalities. Because all health systems involve a degree of out-of-pocket payment, financial hardship can be a problem in any country.

How do country reviews assess financial protection? Each review is based on analysis of data from household budget surveys. Using household consumption as a proxy for living standards, it is possible to assess:

- how much households spend on health out of pocket in relation to their capacity to pay; out-of-pocket payments that exceed a threshold of a household's capacity to pay are considered to be *catastrophic*;
- household ability to meet basic needs after paying out of pocket for health; out-of-pocket payments that push households below a poverty line or basic needs line are considered to be *impoverishing*;
- how many households are affected, which households are most likely to be affected and the types of health care that result in financial hardship; and
- changes in any of the above over time.

Why is monitoring financial protection useful? The reviews identify the factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and

others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage. A limitation common to all analysis of financial protection is that it measures financial hardship among households who are using health services and does not capture financial barriers to access that result in unmet need for health care. For this reason, the reviews systematically draw on evidence of unmet need, where available, to complement analysis of financial protection.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate comparison across countries, the reviews follow a standard template, draw on similar sources of data (see Annex 1) and use the same methods (see Annex 2). Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by the WHO Regional Office for Europe and WHO headquarters. The country consultation includes regional and global financial protection indicators (see Annex 3).

What is the basis for WHO's work on financial protection in Europe?

The Sustainable Development Goals adopted by the United Nations in 2015 call for monitoring of, and reporting on, financial protection as one of two indicators of universal health coverage. WHO support to Member States for monitoring financial protection in Europe is also underpinned by the European Programme of Work, 2020–2025 (United Action for Better Health in Europe), which includes moving towards universal health coverage as the first of three core priorities for the WHO European Region. Through the European Programme of Work, the WHO Regional Office for Europe will work to support national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments for health. A number of other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

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Abbreviations

BGN	Bulgarian lev (currency)
EHIS	European Health Interview Survey
EU	European Union
EU28	EU Member States prior to 31 January 2020
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
GP	general practitioner
INN	international nonproprietary name
NHIF	National Health Insurance Fund
OECD	Organisation for Economic Co-operation and Development
SHI	social health insurance (scheme)
VAT	value-added tax
VHI	voluntary health insurance

Executive summary

In 2000 Bulgaria introduced a social health insurance (SHI) scheme managed by a single purchasing agency, the National Health Insurance Fund (NHIF). Since then several reforms have aimed to enhance the financial stability of the health system and improve access and financial protection for people. While there has been progress in some areas, the health system's very heavy reliance on out-of-pocket payments remains a key challenge. In 2019 out-of-pocket payments accounted for 39% of current spending on health, the second-highest share in the European Union (EU).

This study is the first comprehensive analysis of financial protection in Bulgaria. Drawing on data from household budget surveys carried out between 2005 and 2018, data on unmet need for health services up to 2020 and information on coverage policy (population entitlement, service coverage and user charges) up to 2022 it finds that:

- the incidence of impoverishing health spending and catastrophic health spending in Bulgaria is high compared to other EU countries: 8% of households experienced impoverishing health spending in 2018 and 19% experienced catastrophic health spending;
- catastrophic spending is heavily concentrated among poorer households, older people and people living in rural areas and is almost entirely driven by out-of-pocket payments for outpatient medicines;
- the incidence of catastrophic spending has grown over time, pushed up by a large increase in the poorest quintile; the share of households in the poorest quintile with catastrophic spending has grown from 55% in 2015 to 64% in 2018; and
- unmet need for health care and dental care has declined over time, reaching the EU average in 2018, but unmet need for prescribed medicines due to cost is higher than the EU average.

The factors that undermine financial protection, with a disproportionate impact on poorer and older households, include the following.

There are significant gaps in all three dimensions of health coverage.

A relatively large share of the population (15%) is uninsured and only has access to a few publicly financed health services. This is because access to NHIF benefits is based on payment of contributions; the Government pays contributions only for people in extreme poverty

and many people living below the poverty line cannot afford to pay contributions. People lose NHIF coverage if they have failed to pay more than three monthly contributions in the previous three years; to restore their health insurance rights they must pay any unpaid contributions accrued in the previous five years, a level of debt that many are unable to repay. Access to health insurance requires formal ID and a permanent address, which discriminates against minority groups such as Roma and homeless people.

NHIF coverage of dental care is limited, resulting in unmet need for poorer households and financial hardship for richer households.

A complex system of user charges (co-payments), involving heavy percentage co-payments for outpatient prescriptions, fails to provide sufficient protection for poorer people and people with chronic conditions. Although medicines for severe chronic conditions are available free of charge at the point of use for people covered by the NHIF, more than half of all NHIF-financed prescriptions incur a percentage co-payment of 50% or more of the reference price. There are no exemptions from these co-payments, which is particularly problematic for poorer households and people with chronic conditions. There is no overall annual cap on co-payments.

Medicine prices have fallen in response to efforts to control prices introduced in 2011 and 2013 but remain high compared to other EU countries. All medicines are subject to one of the highest value-added tax rates in the EU (20%). Physicians prescribe branded medicines and generic substitution by pharmacists is not allowed.

As a share of GDP, public spending on health is low compared to most EU and western Balkan countries. Although it has increased in recent years, it has not grown as fast as out-of-pocket payments.

To improve access and financial protection in Bulgaria, policy should focus on:

- finding ways to ensure the NHIF covers the whole population; as a first step, the Government can begin to pay SHI contributions for people living below the poverty line who are not entitled to social support;

- reviewing the costs and benefits of penalizing non-payment of SHI contributions by restricting access to health care; responsibility for enforcing the collection of taxes and mandatory contributions should lie with the National Revenue Agency, not the health system;
- strengthening co-payment policy design by introducing exemptions for poorer households and people with chronic conditions and an annual income-based cap; the 2012 decision by the Council of Ministers to replace percentage co-payments for outpatient and inpatient visits with fixed co-payments is a good model to follow for outpatient prescriptions;
- improving the way in which the NHIF purchases outpatient medicines: continuing to reduce medicine prices and ensuring that health care providers and pharmacies have incentives to prescribe and dispense the cheapest alternatives; and
- increasing government budget transfers to the NHIF in the coming years, with careful use of additional public investment to ensure it meets equity and efficiency goals.

1. Introduction

This review assesses the extent to which people in Bulgaria experience financial hardship when they use health services and medicines. It covers the period between 2005 and the present day (February 2022), drawing on data from household budget surveys carried out between 2005 and 2018 (the latest year available), data on unmet need for health services up to 2020 and information on coverage policy – the way in which health coverage is designed and implemented – up to 2022, with a focus on three key dimensions: population entitlement, service coverage and user charges (co-payments).

Research shows that financial hardship is more likely to occur when public spending on health is low relative 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.

In 2000 Bulgaria introduced a social health insurance (SHI) scheme managed by a single purchasing agency, the National Health Insurance Fund (NHIF), which pools mandatory SHI contributions and transfers from the government budget and purchases health services from contracted public and private providers (Dimova, 2018; Dimova et al., 2018). Since 2000 a number of health system reforms have aimed to enhance the financial stability of the health system and improve access and financial protection for people. While there has been progress in some areas, important gaps in all three dimensions of health coverage remain. For example, the NHIF covered only 85% of the population in 2019 (NHIF, 2020; National Statistical Institute, 2020); NHIF coverage of dental care, long-term nursing care and long-term rehabilitation is limited; and user charges are applied widely to NHIF benefits and are particularly heavy for outpatient prescribed medicines.

The introduction of the SHI scheme has not led to a significant increase in public spending on health as a share of GDP. Public spending on health was lower in 2019 (4.2% of GDP) than it had been in the early 2000s (4.4% in 2003) and at its peak of 4.5% of GDP in 2014 (WHO, 2022). It was among the lowest in the European Union (EU). This is one reason why Bulgaria's out-of-pocket payment share of current spending on health, at just under 39% in 2019, was the highest in the EU after Cyprus (WHO, 2022).

GDP has grown steadily since 2000, falling only in 2009, following the global financial crisis, and 2020, due to the COVID-19 pandemic (World Bank, 2021). The financial crisis did not have a significant effect on public spending on health, but income inequality has increased sharply since then, especially in the southwest region where the capital Sofia is situated.

This study is the first comprehensive analysis of financial protection in Bulgaria. Previous studies have produced estimates for Bulgaria drawing on household budget survey data for 2000 (Xu et al., 2003), 2003 (WHO & World Bank, 2017) and up to 2010 (WHO & World Bank, 2019) as part of global overviews. One national study used the Living Standards Measurement Survey to produce estimates for 2007 (World Bank, 2013). The analysis presented in this review draws on the most recent household budget survey data available and uses different metrics from those used in the earlier studies (Yerramilli et al., 2018; WHO Regional Office for Europe, 2019).

The review is structured as follows: Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of health coverage and access to health care. Sections 4 and 5 present the results of the statistical analysis, with a focus on out-of-pocket payments in Section 4 and financial protection in Section 5. Section 6 provides a discussion of the results of the financial protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy. Annex 1 provides information on household budget surveys; Annex 2 the methods used; Annex 3 regional and global financial protection indicators; and Annex 4 a glossary of terms.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found in Annexes 1–3.

2.1 Analytical approach

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus et al., 2018; WHO Regional Office for Europe, 2019), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003). Financial protection is measured using two main indicators: catastrophic out-of-pocket payments and impoverishing out-of-pocket payments. Table 1 summarizes the key dimensions of each indicator. For more information on how these indicators are calculated and relate to global indicators, see Annexes 2 and 3.

Table 1. Key dimensions of catastrophic and impoverishing spending on health

Note: see Annex 4 for definitions of words in italics

Source: WHO Regional Office for Europe (2019).

Impoverishing health spending	
Definition	The share of households <i>impoverished</i> or <i>further impoverished</i> after <i>out-of-pocket payments</i>
Poverty line	A <i>basic needs line</i> , calculated as the average amount spent on food, housing (rent) and <i>utilities</i> (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household <i>consumption</i> distribution who report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, basic needs for food, housing and utilities; this standard amount is also used to define a household's <i>capacity to pay for health care</i> (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at <i>risk of impoverishment after out-of-pocket payments</i> and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household <i>quintiles</i> by consumption and by other factors where relevant
Data source	Microdata from national <i>household budget surveys</i>
Catastrophic health spending	
Definition	The share of households with out-of-pocket payments that are greater than 40% of household <i>capacity to pay for health care</i>
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a <i>poverty line</i> (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using Organisation for Economic Co-operation and Development equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

2.2 Data sources

The study analyses anonymized microdata from the household budget surveys conducted by the National Statistical Institute of the Republic of Bulgaria for 2005, 2010, 2015, 2016, 2017 and 2018. The data sample consisted of 2870 households in 2005, 2982 in 2010, 2966 in 2015, 2959 in 2016, 2951 in 2017 and 2931 in 2018. Survey data for 2019 and 2020 were not available at the time of publication, so the review is not able to monitor the impact of COVID-19 on financial protection.

Income and expenditure variables are reported in three formats in the household budget survey: monetary, non-monetary (for items valued in kind) and total. This study uses total expenditure variables, which include both monetary and non-monetary values.

Household budget surveys collect information on health spending in a structured way, dividing health spending into six broad groups: medicines, medical products, outpatient care, dental care, diagnostic tests and inpatient care. Spending on mental health services is not assigned a specific category and may therefore be reported under most of these groups. Annex 1 provides further information on household budget surveys in Europe.

All currency units in the study are presented in Bulgarian lev (BGN) and converted into equivalent values in current purchasing power standard euros where relevant. In 2018 BGN 100 had the equivalent purchasing power of €102 in the average European Union (EU) country.

3. Coverage and access to health care

This section briefly describes the governance and dimensions of publicly financed health coverage (population entitlement, service coverage and user charges) in Bulgaria and reviews the role played by voluntary health insurance (VHI). It summarizes some key trends in rates of health service use, levels of unmet need for health care and inequalities in service use and unmet need.

3.1 Coverage

Coverage policy is based on the 1998 Law on Health Insurance, which led to the setting up of the NHIF and the SHI scheme in 1999. The 1998 law introduced a shift from universal access to health care financed directly by the government budget, without user charges (co-payments), to a new system financed mainly through earmarked SHI contributions, with co-payments for services in the benefits package offered by the NHIF. The NHIF is responsible for purchasing health services and goods provided by contracted public and private providers.

3.1.1 Population entitlement

According to the Law on Health Insurance, the following groups are compulsorily insured: Bulgarian citizens, including those who have dual citizenship but are permanently resident in Bulgaria; foreign citizens or people without citizenship but with a long-term residence permit; and refugees and people granted the right of asylum.

Entitlement to NHIF benefits is based on payment of contributions, which are set at a rate of 8% (raised from 6% in 2009) and levied on income (wages and other sources of income). Minimum and maximum income thresholds determine the contribution base. In 2022 the minimum monthly contribution base is set at BGN 710 (up from BGN 650 in 2021) and the maximum is set at BGN 3400. This means that regardless of actual income, all those paying contributions must pay at least 8% of BGN 710 a month, up to a monthly ceiling of BGN 3400. Having a minimum and maximum contribution base makes SHI contributions regressive.

Self-employed people are responsible for paying their own contributions. For employed people, contributions are generally paid both by employees (40%) and employers (60%), although for some employees (for example, people receiving compensation for temporary capacity loss due to illness, pregnancy, childbirth or maternity leave), contributions are paid by the employer only. People who have no declared income and who are not insured by the state, pay contributions set at 8% of the minimum contribution base. Contributions are collected by the National Revenue Agency, which transfers them to the NHIF.

The following groups of people are insured by the state and do not have to pay contributions themselves:

- pensioners: the official retirement age in 2022 is 61 years and ten months for women and 64 years and five months for men, increasing by two months every year for women and by one month for men up to 65 years for women and men;
- children up to 18 years old, school students up to 22 years, full-time university students up to 26 years and PhD students;
- social beneficiaries: people entitled to social support, which includes registered unemployed people with no income or people with very low income eligible for social support;
- parents or spouses caring for a disabled person who has lost over 90% of their capacity to work and who needs permanent help;
- people without income who are accommodated in homes for children and young people or social care establishments;
- war veterans, disabled military personnel and people who have become disabled while defending the country or fulfilling their official duty;
- people applying for refugee status or asylum;
- prisoners; and
- civil servants (people involved in state administration).

The amount the state transfers to the NHIF from the government budget is not equal to the full contribution for some of these categories, such as children, people with no or low income entitled to social support and refugees.

Before 2016 the state contribution rate was 8% of up to 50% of the minimum monthly contribution base. In 2016 the state's contribution base was increased to 55% of the minimum contribution base and scheduled to increase by five percentage points each subsequent year until reaching the full amount of the minimum contribution base for self-insured people by 2025. In 2022 the state's contribution base reached 85% of the minimum contribution base.

In 2018 most NHIF contribution revenue came from employers (38.4%), followed by the state (32.4%), employees (22.4%), self-insured people (4.3%) and others (2.5%) (National Audit Office, 2019). There are no official data on the number of individuals who are insured by the state, but in 2019 pensioners and children accounted for around 48% of the people covered by the NHIF, even though only 32% of NHIF revenue from contributions came from the state (NHIF, 2020).

People lose NHIF coverage if they have failed to pay more than three monthly contributions in the previous 36 months (extended from 15 months in 2010, see Table 2). To restore their health insurance rights, they must pay any unpaid contributions accrued in the previous 60 months (increased from 36 months in 2010).

At the end of 2019 more than 15% of the population (1 060 864 people) were uninsured (NHIF, 2020; National Statistical Institute, 2020; authors' estimation). This is an improvement from the situation in 2016, when uninsured people represented more than 25% of the population (Executive Agency Medical Audit, 2017). Some official sources suggest that around half of all uninsured people are Bulgarian citizens living abroad and about a quarter are permanently unemployed people, who cannot afford to pay contributions.

Although the Government transfers funds from the budget to the NHIF to cover people entitled to social support, the threshold for entitlement to social support is very stringent. For example, to be entitled to social support and health insurance by the state in 2021, a person living alone needed to have a monthly income of no more than BGN 195 (€99.7), which is far lower than the monthly national poverty line¹ of BGN 413 (€211.1). As a result, many people living below the national poverty line are responsible for paying their own contributions but cannot afford to do so.

In addition, to benefit from state support or to be insured people are required to have ID and a permanent address. This is another obstacle to being covered, particularly for minority groups such as Roma people.

3.1.2 Service coverage

The whole population, regardless of health insurance status, is entitled to services financed directly by the state, such as emergency care, inpatient mental health care, transfusions, in vitro fertilization, transplantations, addiction support through methadone programmes (since 2019), treatment of nonspecific pulmonary diseases (since 2019), medicines for HIV and other communicable diseases and vaccination. In addition, for uninsured people, the state covers intensive care, maternity and delivery care and, since 2019, outpatient mental care and services for people with dermatological conditions, sexually transmitted diseases and other infectious diseases.

All other publicly financed health services are available only to people covered by the NHIF.

When the NHIF was set up in 2000, it covered only outpatient services and outpatient medicines; inpatient care continued to be covered by the state and municipalities. NHIF coverage began to include some inpatient care in 2001 and was extended to include all inpatient care in 2006. Since then, the NHIF benefits package has gradually been extended to include new diagnostic and dental services. It now covers a wide range of outpatient and inpatient care, outpatient medicines and some medical devices.

Insured people have access to **primary outpatient consultations** provided by a general practitioner (GP). Access to **specialized outpatient and inpatient care** requires a referral from a GP or a specialist. Children and pregnant women have direct access to paediatricians and gynaecologists, respectively. There is a limited number of referrals to specialized outpatient care available to each GP, with quotas set on a quarterly basis

1. The national poverty line is an absolute poverty line reflecting a minimum basket of essential goods.

by the NHIF. This may increase waiting times for people who do not need urgent consultations. In general, however, waiting times are not an issue for outpatient or inpatient care and there are **waiting time guarantees**. Once issued, a referral to specialist outpatient care should take place within one month; a follow-up visit to a specialist should take place within one month from the first visit; and a hospital admission should be scheduled within two months. These limits regulate waiting times in outpatient and inpatient care.

Outpatient medicines (and co-payment levels) are listed in the Positive Drug List determined by the National Council on Prices and Reimbursement of Medicinal Products. The list has been extended gradually, nearly doubling from 1144 outpatient medicines in 2009 to 2161 in 2021.

The NHIF pays fully or partially for **medical products** such as devices and dietary foods for special medical purposes for defined diseases based on criteria set by the Ministry of Health.

Dental care coverage is limited to a few services only but has been extended over time. For example, the number of NHIF dental services has increased from six to 14 for children up to 18 years and from three to 11 for adults.

The NHIF benefits package and the state **do not cover**: long-term nursing care; long-term home-based rehabilitation; occupational health care and prevention; elective termination of pregnancy; contraception; spa treatment; alternative therapy; and elective cosmetic surgery.

Extra billing has always been permitted in NHIF-contracted hospitals for additional services, such as choice of physician or clinical team. Hospitals are free to determine their own additional fees, but since 2011 additional fees for choice of physician or team are regulated through maximum amounts defined by the Ministry of Health.

Informal payments are a problem in inpatient care, where they tend to be paid for services such as cleaning, food and personal hygiene (see section 4.2 for further information on informal payments).

In recent years the Government has introduced various measures to reduce both informal and formal payments. Amendments to the ordinance on access to medical care in 2016 prevent health facilities from requesting or receiving any payment from patients for services covered by the NHIF. They also regulate the hospital services for which additional fees can be paid by patients and the circumstances under which patients can opt to pay for choice of physician or clinical team. From 2018 the NHIF has paid outpatient care physicians the difference between the reduced co-payment for pensioners and the normal co-payment if physicians have issued pensioners with a receipt.

Table 2 summarizes changes to coverage policy from 2000 to 2022.

Table 2. Changes to coverage policy, 2000–2022

Source: authors.

Year	Change	Health services targeted	People targeted
2000	Introduction of mandatory health insurance	Outpatient services	Insured people
2001	Extension of the NHIF benefits package with a limited number of inpatient services	Inpatient services	Insured people
2002	The state becomes responsible for paying NHIF contributions for some groups of people	NHIF-financed services	Children under 18 years, social beneficiaries etc.
2004	Introduction of the rule that people lose coverage after not paying contributions for three months in the last 15 months and have to pay all unpaid contributions	NHIF-financed services	People who do not pay contributions
2006	Extension of the NHIF benefits package to most hospital services	Inpatient services	Insured people
2008	Introduction of reduced user charges for outpatient visits for pensioners	Outpatient services	Pensioners
2010	Loss of coverage period increased from 15 to 36 months	NHIF-financed services	People who do not pay contributions
2011	Abolition of the reduction in user charges for pensioners	Outpatient services	Pensioners
	Introduction of reference prices for medicines	Outpatient medicines	Whole population
	Introduction of upper limits on extra billing for choice of physician or clinical team in NHIF-contracted hospitals	Inpatient services	Insured people
2012	Replacement of percentage co-payments (user charges set at 1% of the monthly minimum wage) with a fixed co-payment of BGN 2.90 (€1.50) for each outpatient visit and BGN 5.80 (€2.96) for each day of hospitalization for up to 10 days per year	Outpatient and inpatient services	Insured people
2013	The NHIF begins to receive funds from the state to cover some services for uninsured people (outpatient treatment of dermatological and venereal diseases, maternity care, intensive care)	Outpatient and inpatient services	Uninsured people
	Reduction in the maximum mark-up for wholesalers and retailers	Medicines	Whole population
2014	Reintroduction of reduced user charges for pensioners	Outpatient services (excluding medicines)	Pensioners
2015	The period for which people have to pay all unpaid contributions is extended from 36 to 60 months	NHIF-financed services	People who do not pay contributions
2016	Measures introduced to reduce informal payments and increase regulation of extra billing (changes and amendments to the ordinance on access to medical care)	Inpatient services	Whole population
	Increase in the contribution base for state contributions to the NHIF	NHIF-financed services	Children and students, social beneficiaries, refugees etc.
2017	NHIF benefits package expanded to include some additional services for people at high risk of heart disease, type 2 diabetes and various cancers (cervical, breast, colorectal, prostate)	Outpatient services	Insured people
2018	Measures introduced to reduce informal payments (the NHIF covers the difference between the reduced co-payment for outpatient visits for pensioners and the normal co-payment if the outpatient physician has issued a receipt)	Outpatient services	Insured people
2019	List of services covered by the state extended to include methadone programmes, treatment of some pulmonary diseases, infectious diseases, outpatient mental health care, dermatological conditions and sexually transmitted diseases	Outpatient services	Uninsured people
2020	COVID-19 diagnostics, immunization and inpatient treatment assured either by the state or the NHIF	Outpatient and inpatient services	Outpatient and inpatient services
2022	Inclusion of new services in the NHIF's benefit package: home-based health services for newborns up to 14 days after delivery performed by nurses, mid-wives and physicians' assistants; specialized and highly specialized immunological tests for diagnosis of primary immune deficiencies; physical therapy, rehabilitation and care of patients after active hospital treatment of COVID-19; small surgical interventions in outpatient settings	Outpatient services	Insured people

3.1.3 User charges (co-payments)

User charges (co-payments) were introduced with the beginning of the SHI scheme in 2000 and apply to almost all NHIF benefits. They are a combination of fixed co-payments, percentage co-payments and extra billing. Table 3 summarizes current co-payment policy for covered services based on referral or prescription by NHIF-contracted providers.

Outpatient visits and **inpatient care** are subject to fixed co-payments per visit (outpatient care) and per day (inpatient care), with a reduced co-payment for pensioners and exemptions for some other groups of people (see Table 3 for details). User charges for outpatient visits and inpatient care were initially defined as a percentage of the minimum wage (1% of the monthly minimum wage for an outpatient visit and 2% per day in hospital up to 10 bed-days per year). In 2012, following public opposition to rising user charges due to increases in the minimum wage, the Council of Ministers replaced these percentage co-payments with fixed co-payments of BGN 2.90 (€1.50) for each outpatient visit and BGN 5.80 (€2.96) for each day of hospitalization for up to 10 days per year. The fixed co-payments have not increased since then.

Outpatient prescribed medicines are subject to percentage co-payments set at a rate determined by the National Council on Prices and Reimbursement of Medicinal Products based on a set of criteria (such as indications for use, the social significance of the disease and the duration of treatment and outcomes) listed in an ordinance issued by the Council of Ministers. Depending on the overall assessment for a particular drug, it is assigned a co-payment rate of 0% of the reference price (953 medicines), 25% (111 medicines), 50% (705 medicines) or 75% (392 medicines). Medicines for long-term treatment of chronic conditions that have a severe impact on quality of life or lead to disability (for example, cancer, HIV/AIDS, communicable diseases, vaccines and some others) are fully covered by the State or the NHIF, without co-payment.

Since 2011 the reference price has been based on the lowest manufacturer price registered in 10 countries (Belgium, France, Greece, Italy, Latvia, Lithuania, Romania, Slovakia, Slovenia and Spain).

There are no exemptions from co-payments for outpatient prescribed medicines. More than half of all outpatient prescriptions have a percentage co-payment of 50% or more of the reference price. People have to pay the difference between the NHIF tariff and the retail price (which is equal to the reference price) and there is no mandatory international nonproprietary name (INN) prescribing or prescribing of the lowest-cost medicines.

People must pay fixed co-payments for most **dental care**. Children up to 18 years old are exempt or pay reduced co-payments and there are exemptions for some other groups of people (see Table 3 for details).

Diagnostic tests are subject to a fixed co-payment regardless of the number of tests per visit.

The NHIF covers some **medical products** up to a predefined tariff that is usually lower than the market price, so people must pay the difference between the NHIF's tariff and the actual market price.

Table 3. User charges for publicly financed health services, 2022

Source: authors.

Service area	Type and level of user charge	Exemptions	Cap on user charges paid
Outpatient visits	Fixed co-payment per visit: BGN 2.90 (€1.50); pensioners pay a reduced rate: BGN 1 (€0.51)	<ul style="list-style-type: none"> • children up to 18 years • poor people entitled to social support • unemployed people • pregnant women • people with listed chronic conditions (such as diabetes with complications, Crohn's disease with permanently decreased capacity to work, schizophrenia, Parkinson's disease and cancer) • people with a loss of earning capacity of more than 71% • veterans • prisoners and people in police custody • people living in specialized institutions • health professionals 	Annual cap on inpatient care (up to 10 days a year)
Diagnostic tests	Laboratories can collect either a fixed co-payment per visit regardless of the number of tests – BGN 2.90 (€1.50) reduced to BGN 1 (€0.51) for pensioners – or a fee for collection of biological material (which they set themselves); there are no exemptions from co-payments for collection of biological material		
Inpatient care	Fixed co-payment per day in hospital: BGN 5.80 (€2.96) Extra billing allowed for additional services such as choice of physician or clinical team		
Dental care	Fixed co-payment per visit: BGN 2.90 (€1.50); pensioners pay a reduced rate: BGN 1 (€0.51) Fixed co-payments for each dental service	Children up to 18 years are exempt from paying for some dental services Children and adults living in specialized institutions and children with mental illness are exempt from all co-payments for dental care The same patient groups as for outpatient visits are protected of paying user fees	No
Outpatient medicines	Percentage co-payments of 0%, 25%, 50% or 75% of the reference price People pay the difference between the NHIF tariff and the retail price	No	No
Medical products	People pay the difference between the NHIF tariff and the retail price	No	No

3.1.4 The role of VHI

VHI has been introduced by the 1998 Law on Health Insurance. It covers around 10% of the population and accounted for 0.7% of current spending on health in 2018 (WHO, 2021). VHI plays a complementary role, covering services that are not covered by the NHIF (such as some laboratory tests, dental services and medicines) and a supplementary role offering faster access to treatment and free choice of physician or clinical team in hospital. However, many VHI policies also cover services in the NHIF benefits package (such as visits to specialists, hospital treatment and preventive care), which means that people with VHI generally have double coverage (Dimova & Valkanova, 2018). VHI mainly covers employees through group policies.

Table 4 highlights key issues in the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

Table 4. Gaps in publicly financed and VHI coverage

Source: authors.

Coverage dimension	Population entitlement	Service coverage	User charges
Issues in the governance of publicly financed coverage	<p>Entitlement is linked to payment of contributions</p> <p>The state pays contributions only for people in extreme poverty; many people living below the poverty line are expected to pay contributions but cannot afford to</p> <p>Loss of insurance after not paying three contributions for the last 36 months and restoration of rights after payment of all contributions due in the last 60 months</p>	<p>The benefits package is broad but does not always include all services for a specific condition</p> <p>Extra billing is permitted in hospitals for additional services such as choice of physician or clinical team</p> <p>Informal payments, especially for inpatient care</p>	<p>Percentage co-payments for outpatient medicines</p> <p>No exemptions from co-payments for outpatient medicines</p> <p>Lack of exemption from other user charges for many poor households</p> <p>No cap on user charges for outpatient care, including outpatient medicines and medical products</p>
Main gaps in publicly financed coverage	15% of the population is estimated to be uninsured (NHIF, 2020; National Statistical Institute, 2020; authors' estimation)	Limited NHIF coverage of outpatient medicines, medical products, dental care, long-term nursing care and long-term rehabilitation	Heavy co-payments for outpatient medicines
Are these gaps covered by VHI?	No	To a limited extent	No; some VHI policies cover co-payments, but VHI accounts for less than 1% of current spending on health

3.2 Access, use and unmet need

The share of the population reporting unmet need for health services (Box 1) has fallen substantially over time. European Union Statistics on Income and Living Conditions (EU-SILC) data suggest unmet need for health care and dental care in Bulgaria was below the EU average in 2019 (Fig. 1). This decline may be attributed to a reduction in the uninsured share of the population and increases in service coverage, prompting increased use of health services (and higher out-of-pocket payments; see Section 4), as well as improvement in self-perceived health.

Box 1. Unmet need for health services

Source: WHO Regional Office for Europe (2019).

Financial protection indicators capture financial hardship among people who incur out-of-pocket payments through the use of health services. They do not, however, indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need for health care. Unmet need is an indicator of access, defined as instances in which people need health care but do not receive it because of access barriers.

Information on health care use or unmet need is not collected routinely in the household budget surveys used to analyse financial protection. These surveys indicate which households have not made out-of-pocket payments, but not why. Households with no out-of-pocket payments may have no need for health care, be exempt from user charges or face barriers to accessing the health services they need.

Financial protection analysis that does not account for unmet need could be misinterpreted. A country may have a relatively low incidence of catastrophic out-of-pocket payments because many people do not use health care, owing to limited availability of services or other barriers to access. Conversely, reforms that increase the use of services can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place. In such instances, reforms might improve access to health care but at the same time increase financial hardship.

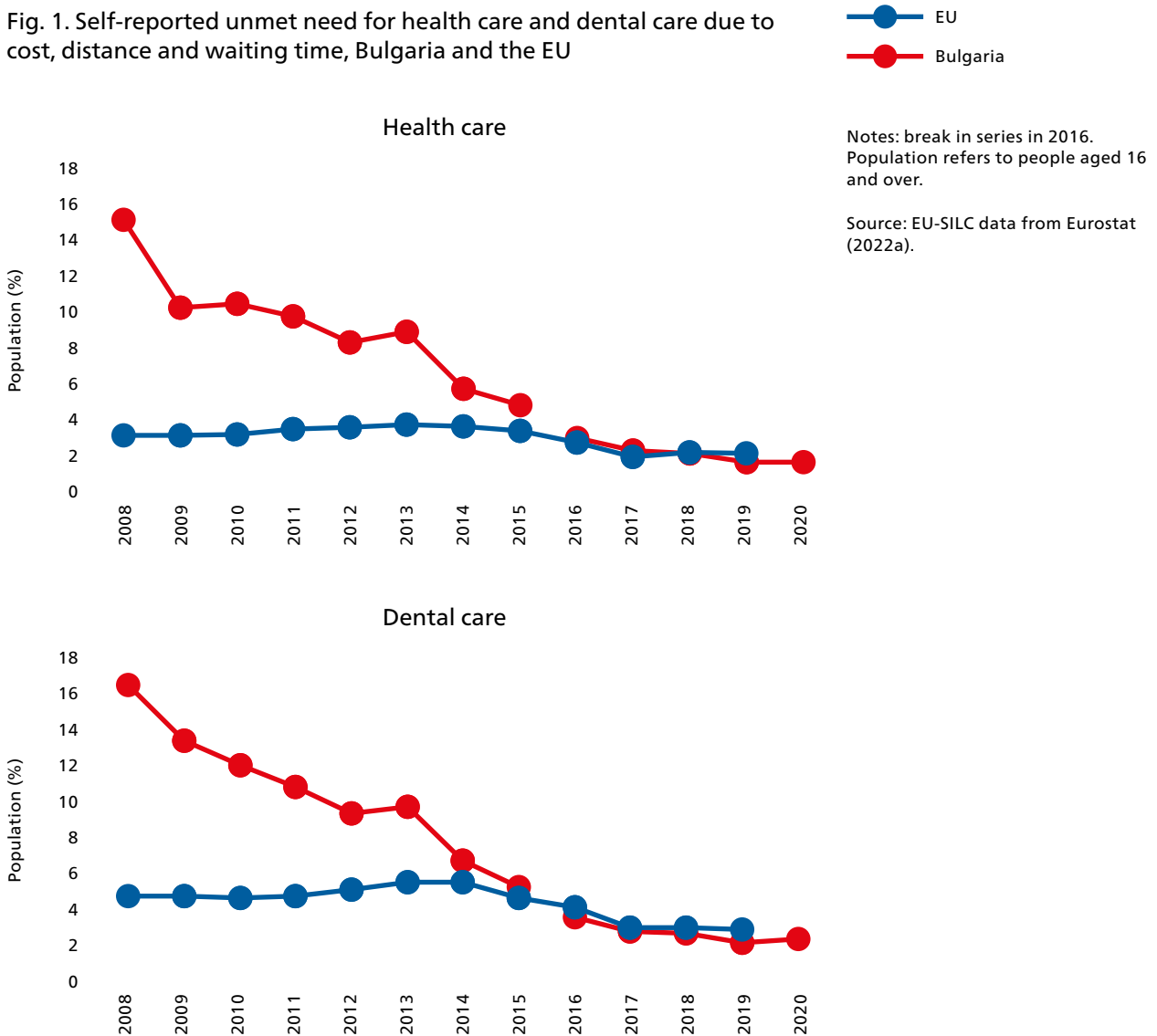
This review uses data on unmet need to complement the analysis of financial protection. It also draws attention to changes in the share and distribution of households without out-of-pocket payments. If increases in the share of households without out-of-pocket payments cannot be explained by changes in the health system – for example, enhanced protection for certain households – they may be driven by increases in unmet need.

Every year, EU Member States and other countries collect data on unmet need for health and dental care through the EU-SILC. These data can be disaggregated by age, gender, education level and income. Although this important source of data lacks explanatory power and is of limited value for comparative purposes because of differences in reporting by countries, it is useful for identifying trends over time within a country (Arora et al., 2015; European Commission Expert Panel on Effective Ways of Investing in Health, 2016, 2017).

EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS) carried out every five years or so. The second wave of this survey was conducted in 2014. A third wave was launched in 2019.

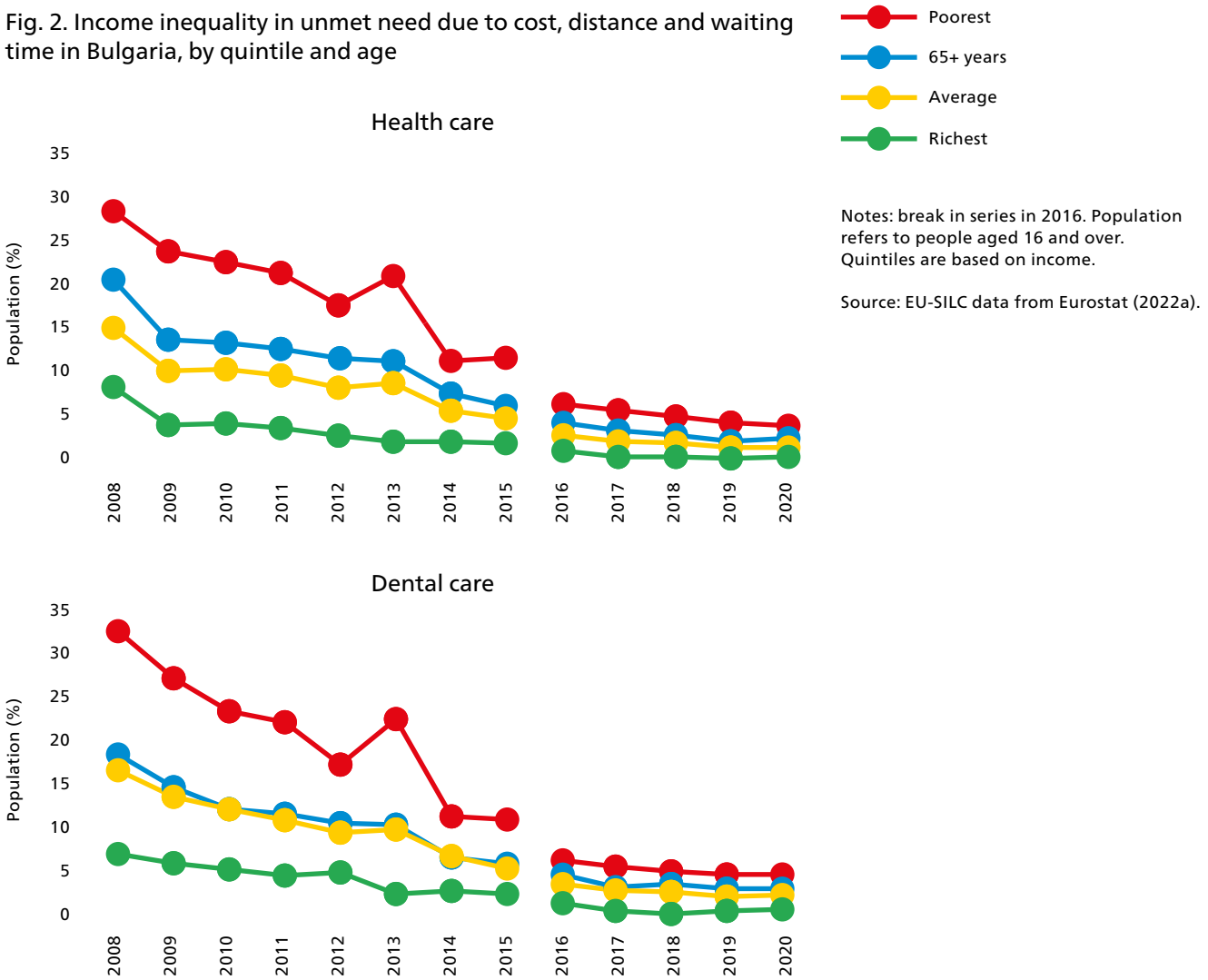
Whereas EU-SILC provides information on unmet need as a share of the population aged over 16 years, EHIS provides information on unmet need among those reporting a need for care. EHIS also asks people about unmet need for prescribed medicines.

Fig. 1. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, Bulgaria and the EU



Although levels of unmet need have fallen over time, income inequality in unmet need for health and dental care is substantial and has grown over time (Fig. 2). EU-SILC data indicate that income is a larger determinant of unmet need for health and dental care than age, particularly for dental care.

Fig. 2. Income inequality in unmet need due to cost, distance and waiting time in Bulgaria, by quintile and age



Socioeconomic inequalities in access reflect variation in the use of health and dental services across the country, which is in turn influenced by the uneven distribution of health professionals. For example, the number of NHIF-covered people registered with a single GP ranges from just over 1000 in some areas to over 2500 in others, and this gap has increased over time. Similarly, some regions have double the rate of dentists and use of dental services than others.

For prescribed medicines, EHIS data suggest that in 2014 unmet need due to cost was much higher in Bulgaria than the EU average, with considerable education and age-related inequalities (Fig. 3). EHIS data also indicate that the use of prescribed medicines is lower in Bulgaria than in most other EU countries, but the use of non-prescribed medicines is above the EU average (Fig. 4). This could reflect lack of coverage (such as uninsured people), people wanting to save time due to access barriers to prescribing physicians (co-payments) or use of dietary supplements.

Fig. 3. Self-reported unmet need for prescribed medicines due to cost by educational attainment and age, Bulgaria and the EU, 2014

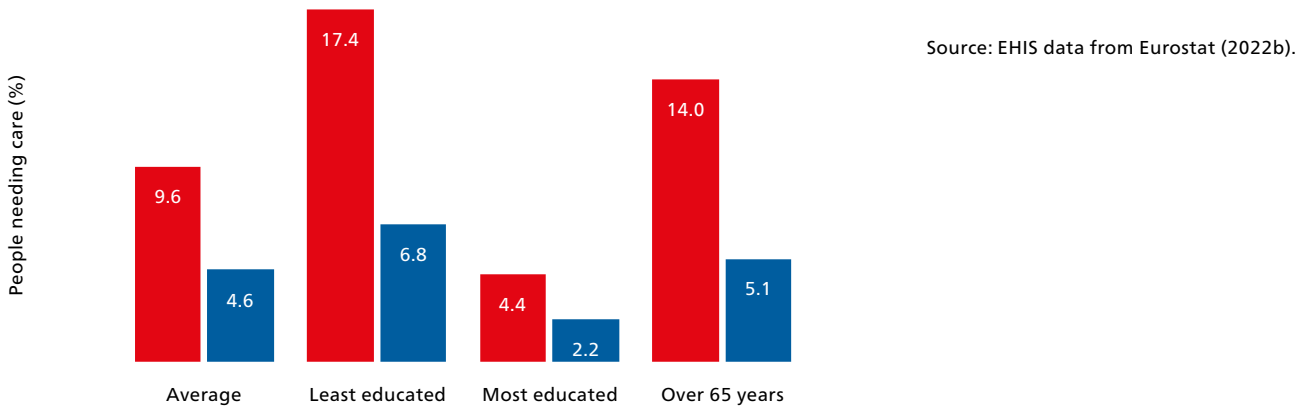
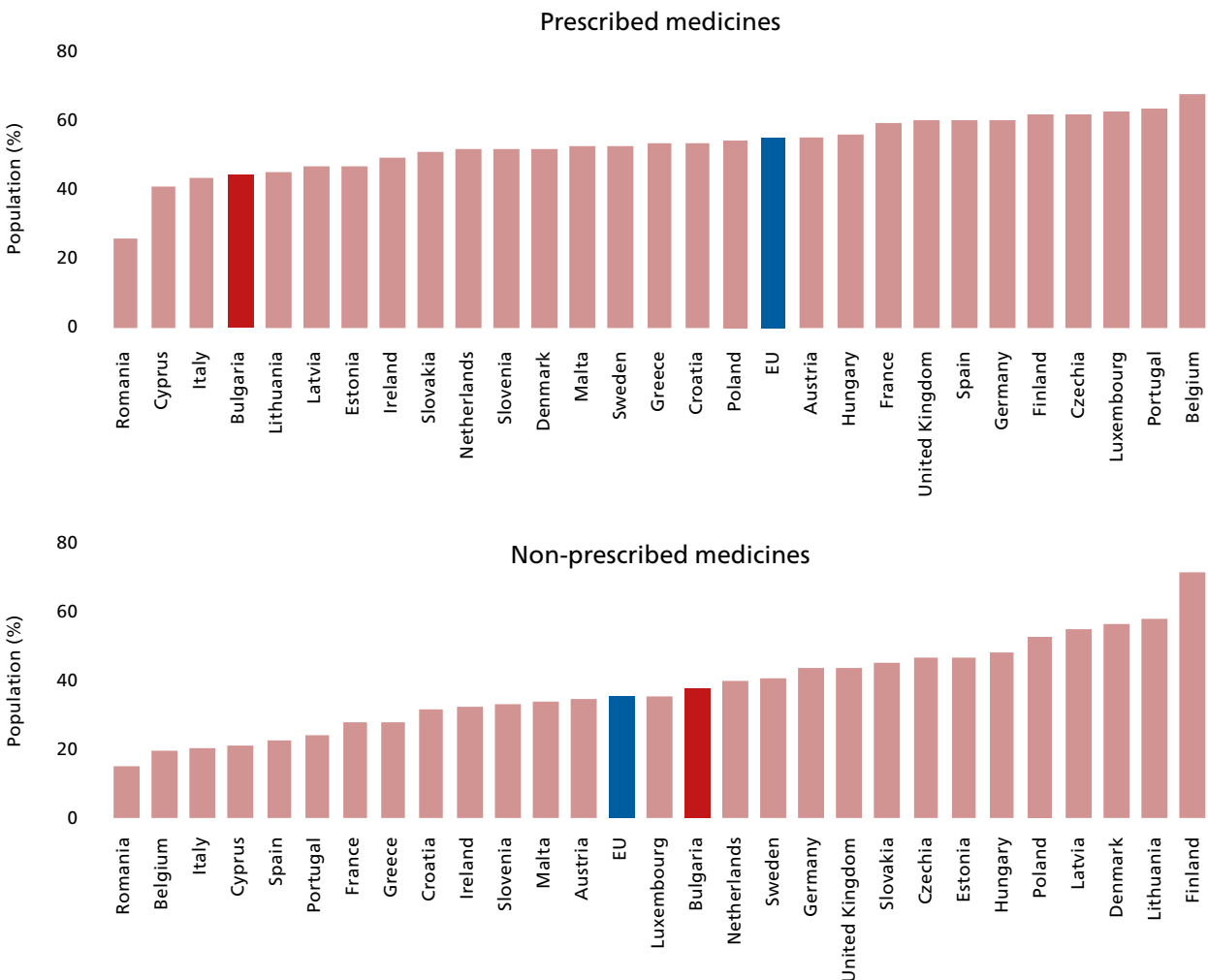


Fig. 4. Self-reported use of prescribed and non-prescribed medicines, EU, 2014

Source: EHIS data from Eurostat (2022b).



3.3 Summary

Entitlement to NHIF benefits is based on payment of contributions (health insurance status), which automatically leaves a part of the population uninsured. In 2019 15% of the population was uninsured and at least a quarter of these were long-term unemployed people. Although the Government pays contributions on behalf of poor people, the eligibility threshold is set far below the national poverty line, so many poor people do not benefit and cannot afford to pay their own contributions. Uninsured people are entitled only to a few publicly financed health services (emergency and maternity care, mental health treatment and some treatment of communicable diseases).

The NHIF benefits package covers a broad range of health services and goods, although exclusions are not always clearly set out and coverage of dental care, long-term nursing care and long-term rehabilitation is limited. Waiting times are not an issue. Extra billing is permitted in hospitals for additional services such as choice of physician or clinical team, up to a cap.

User charges (co-payments) are widely applied to NHIF benefits and are particularly heavy for outpatient prescribed medicines. In 2012 the Council of Ministers replaced percentage co-payments for outpatient and inpatient visits with fixed co-payments, but high percentage co-payments still apply to outpatient prescribed medicines – people pay 50% or more of the reference price for more than half of all outpatient prescriptions. Mechanisms to protect people from user charges are very limited: there are no exemptions from co-payments for many outpatient medicines and there is no overall cap on co-payments.

VHI's role in covering these gaps is insignificant. VHI covers only 10% of the population, mostly through group policies, and accounts for less than 1% of current spending on health.

The use of health services varies by district, reflecting an uneven distribution of health professionals and socioeconomic inequalities in access. Self-reported unmet need for health care and dental care has declined over time, reaching the EU average in 2018. Unmet need for prescribed medicines due to cost is higher than the EU average, however. Socioeconomic inequalities in unmet need persist but are much smaller than before for health and dental care.

4. Household spending on health

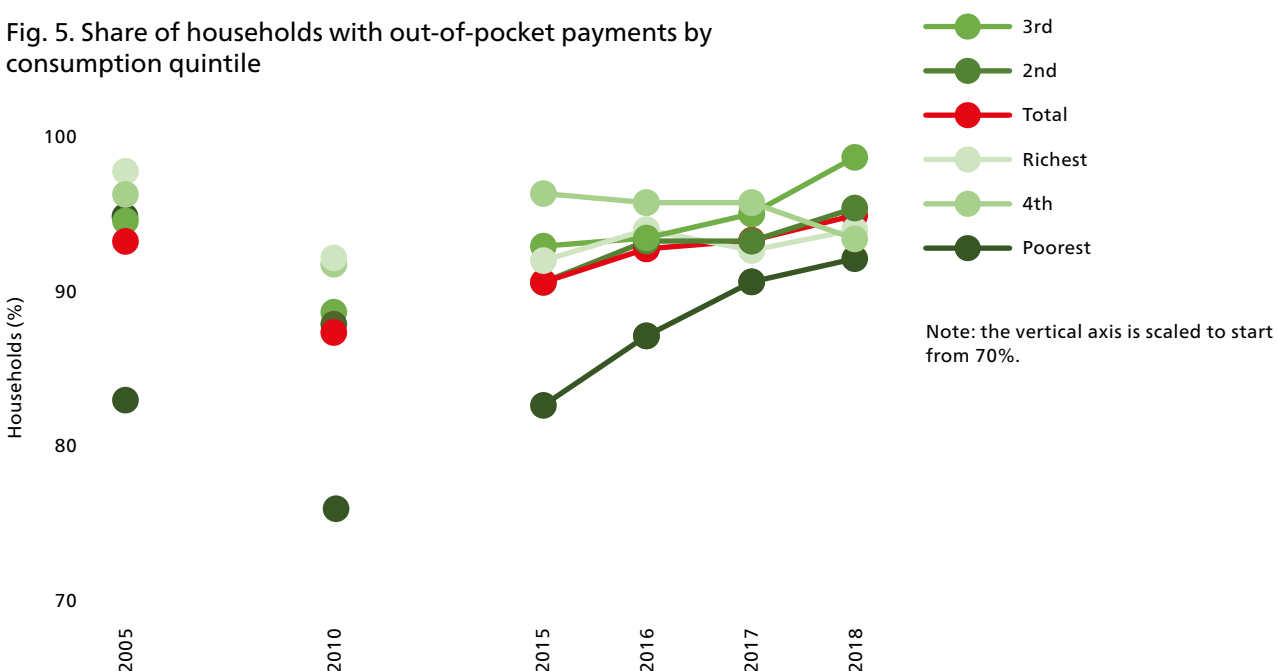
The first part of this section uses data from the household budget survey to present trends in household spending on health – that is, out-of-pocket payments, the formal and informal payments made by people at the time of using any good or service delivered in the health system. The second and third parts describe the role of informal payments and trends in public and private spending on health over time, respectively.

4.1 Out-of-pocket payments

Out-of-pocket payments consist of user charges and other payments for publicly financed benefits, as well as direct payments to providers for services not covered by the NHIF. They include all formal and informal payments.

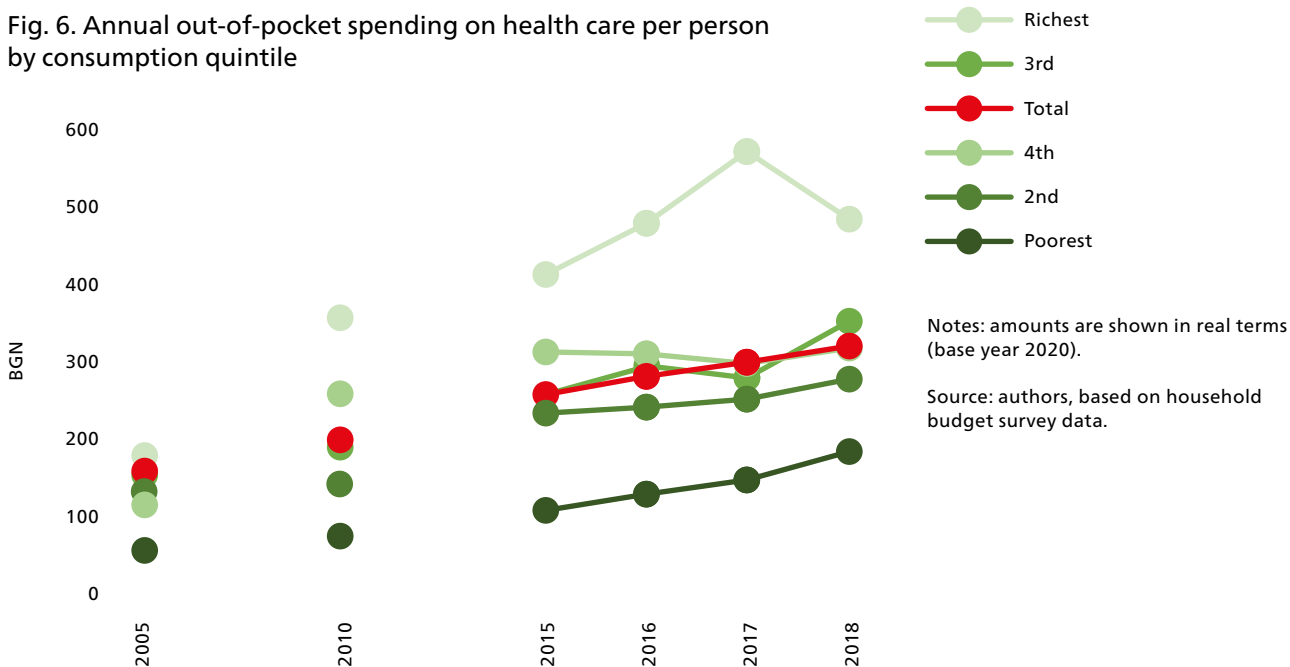
In 2018 on average 94% of households reported out-of-pocket payments (Fig. 5). The share of households reporting out-of-pocket payments fell between 2005 and 2010, rose between 2010 and 2015 and increased steadily between 2015 and 2018. Across all years, households in the poorest quintile were least likely to report out-of-pocket payments (Fig. 5). Between 2010 and 2018, the share of households with out-of-pocket payments increased in the three poorest quintiles, particularly the poorest quintile, narrowing the gap between richer and poorer households. The increase in the share of households with out-of-pocket payments observed between 2010 and 2018 took place against a background of falling unmet need for health care and dental care due to cost, distance and waiting time, which occurred among all quintiles (see Fig. 3).

Fig. 5. Share of households with out-of-pocket payments by consumption quintile



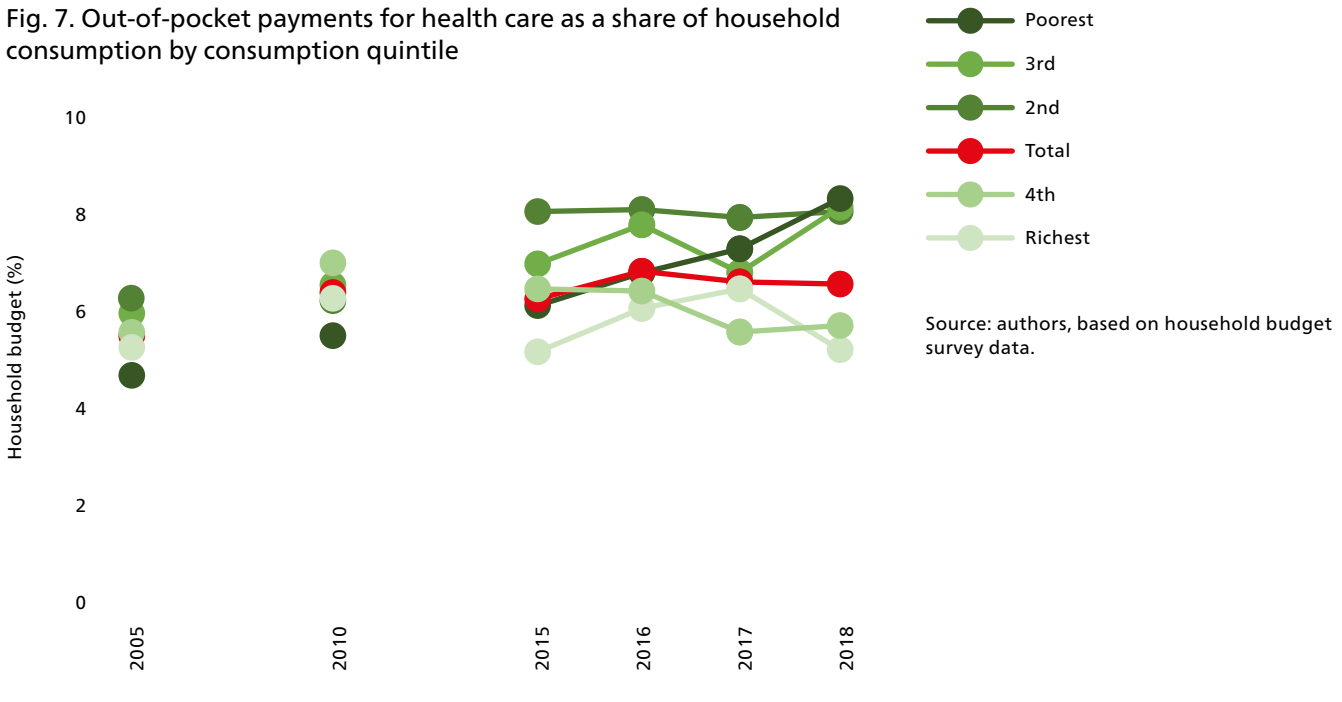
Out-of-pocket payments have increased steadily over time, nearly doubling in real terms between 2005 and 2018 (Fig. 6). All consumption quintiles experienced an increase in out-of-pocket payments, but the increase was sharpest for the three poorest quintiles. Out-of-pocket payments are generally higher among richer quintiles (Fig. 7).

Fig. 6. Annual out-of-pocket spending on health care per person by consumption quintile



In 2018 out-of-pocket payments accounted for 6.5% of total household spending (the household budget) on average (Fig. 7), which is very high compared to other EU countries (WHO Regional Office for Europe, 2019). Out-of-pocket payments accounted for a much higher share of household spending in the poorest quintile (8%) than the richest quintile (5%) in 2018 – a highly regressive distribution. This reflects the fact that the out-of-pocket payment share of total household spending rose in the three poorest quintiles between 2005 and 2018 but remained relatively stable in the two richest quintiles.

Fig. 7. Out-of-pocket payments for health care as a share of household consumption by consumption quintile



Outpatient medicines comprised the largest share of out-of-pocket spending (76%) in 2018, followed by medical products (8%) and dental care and inpatient care (both around 5%) (Fig. 8). The medicines share increased between 2005 and 2010 and decreased between 2010 and 2015, although actual spending on medicines grew steadily throughout the study period and rose particularly sharply among the poorest quintile. The fall in the medicines share in 2015 was prompted by an increase in household spending on inpatient care. In 2018 the medical products share increased and the inpatient care share fell.

Spending on medicines has increased steadily over time (Fig. 9) in all except the richest quintile (Fig. 10). The increase in the medical products share in 2018 (Fig. 8) was driven by a sharp increase in spending on medical products among the richest quintile (data not shown).

Fig. 8. Breakdown of total out-of-pocket spending by type of health care

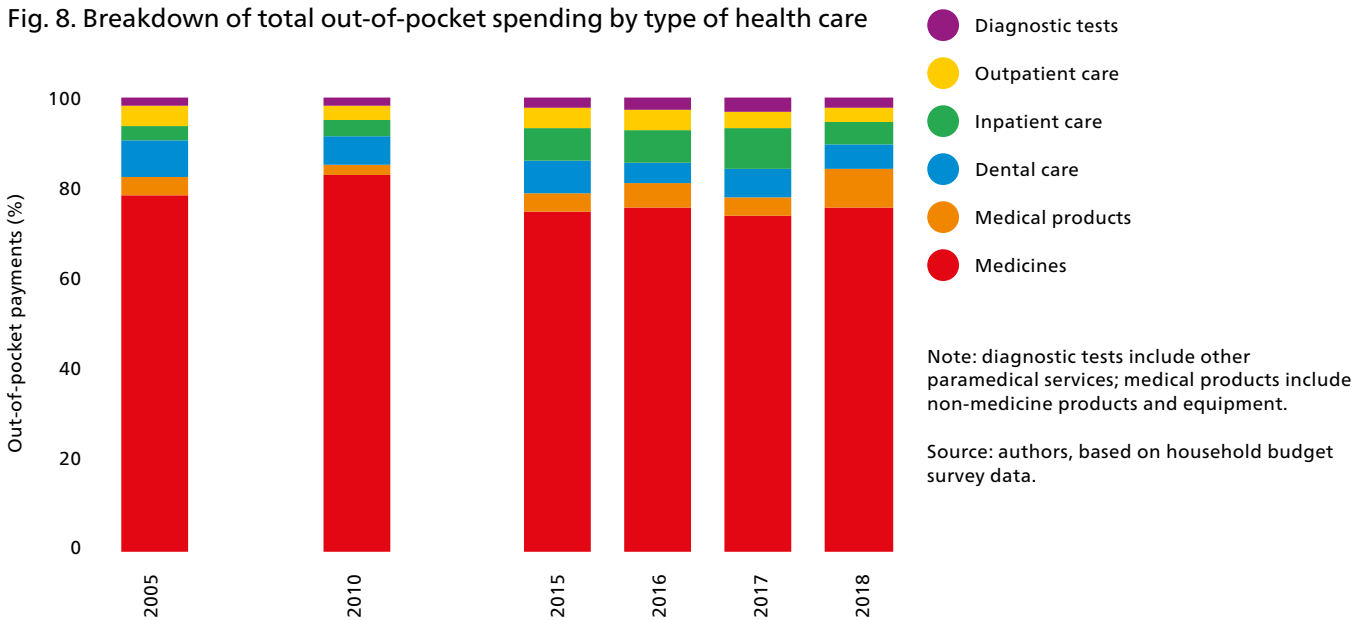


Fig. 9. Annual out-of-pocket spending on health care per person by type of health care

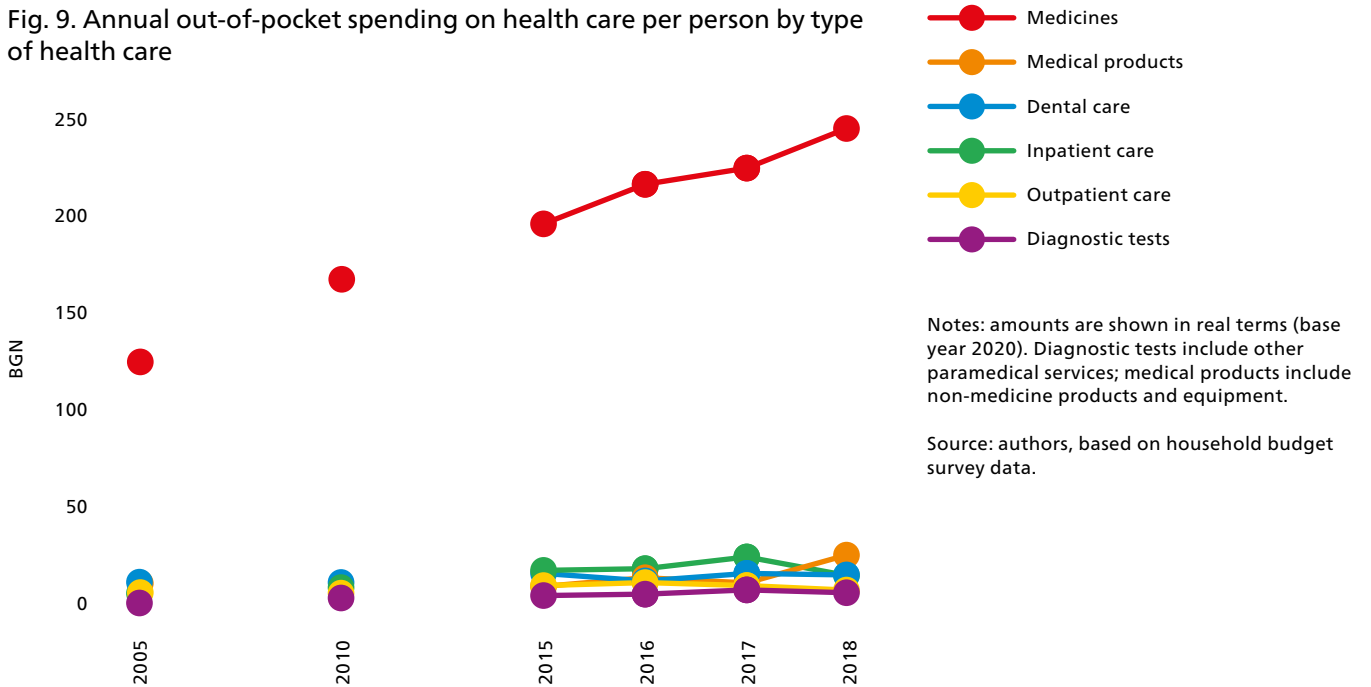


Fig. 10. Annual out-of-pocket spending on outpatient medicines per person by consumption quintile

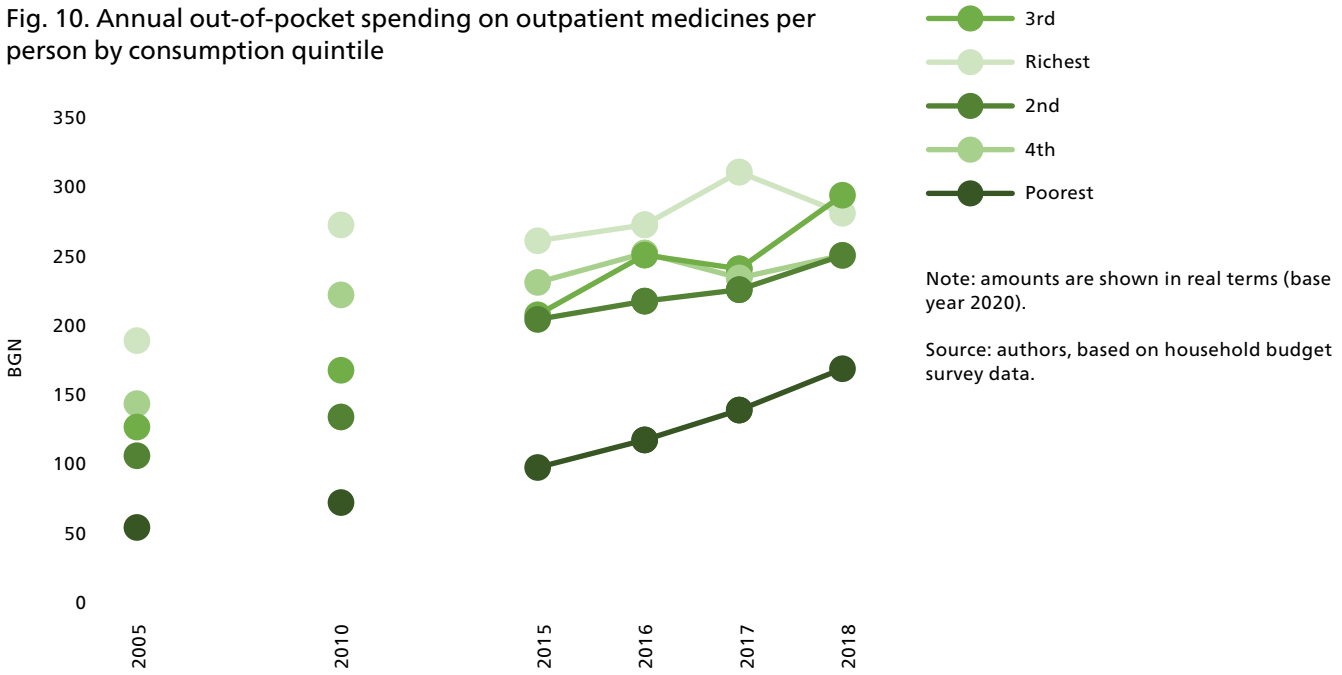
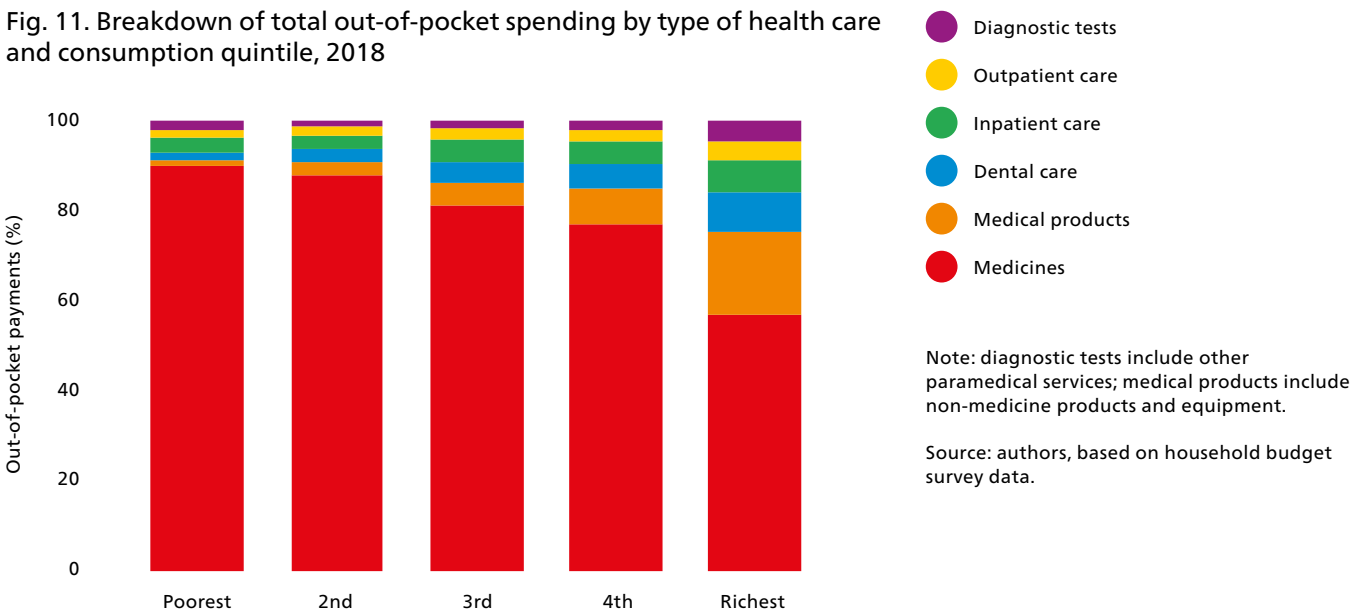


Fig. 11 shows that out-of-pocket spending by type of service varied significantly across quintiles in 2018. Medicines accounted for 90% of out-of-pocket spending for the poorest quintile, compared to 57% in the richest quintile. In contrast, richer quintiles spend more on all other types of health care. This difference in the breakdown of out-of-pocket payments across quintiles is evident in all years of the study.

Fig. 11. Breakdown of total out-of-pocket spending by type of health care and consumption quintile, 2018



4.2 Informal payments

International surveys suggest that informal payments are high in Bulgaria compared to other EU countries. In 2019 10% of those who had visited a public health care provider in the last 12 months incurred informal payments to a nurse, doctor or hospital in Bulgaria, compared to an EU average of 5% (European Commission, 2020). This share increased by 2 percentage points between 2017 and 2019 (European Commission, 2020). In the same 2019 survey, 53% of Bulgarians thought that taking bribes and the abuse of power were widespread in the health system compared to an EU average of 29%.

Analysis from 2010 and 2011 suggest that informal payments have been more common (and generally higher) in inpatient care than outpatient care (Atasanova et al., 2014; Stepurko et al., 2017). Since then, the Government has introduced various measures to reduce informal payments, notably in 2016 and 2018 (see section 3.1.2). It is likely that these measures have reduced some informal payments, but analysis is needed to understand the magnitude and drivers of informal payments today.

Informal payments reduce transparency, increase barriers to access and increase financial hardship. They are likely to be regressive and affect the poorest households most (Jakab et al., 2016). A major 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 from exposure to out-of-pocket payments.

4.3 Trends in public and private spending on health

National health accounts data show that out-of-pocket payments have consistently been only slightly lower than public spending on health in per person terms (Fig. 12). Both types of spending have grown in real terms since 2000 but public spending has fluctuated more than out-of-pocket payments. As a result, the out-of-pocket payment share of current spending on health grew from 40% in 2000 to a peak of 48% in 2012 and was at 39% in 2019, which is very high compared to other EU countries (Fig. 13). Relatively sharp growth in the out-of-pocket payment share between 2010 and 2012 reflects the lack of growth in public spending on health in the aftermath of the global financial crisis (Fig. 12).

Broken down by health service and financing scheme, national health accounts data for 2019 show how the out-of-pocket payment share of current spending on almost all types of health care is larger in Bulgaria than the EU average, particularly for outpatient medicines (73% in Bulgaria compared to an EU average of 40%) and outpatient care (43% compared to 13%) (Fig. 14). Bulgaria includes medical products under outpatient medicines, so it is not possible to compare across countries, but given that on average 61% of spending on medical products in the

EU comes from out-of-pocket payments, it seems likely that out-of-pocket payments are also the dominant source of spending on this type of health care in Bulgaria.

Fig. 12. Health spending per person by financing scheme

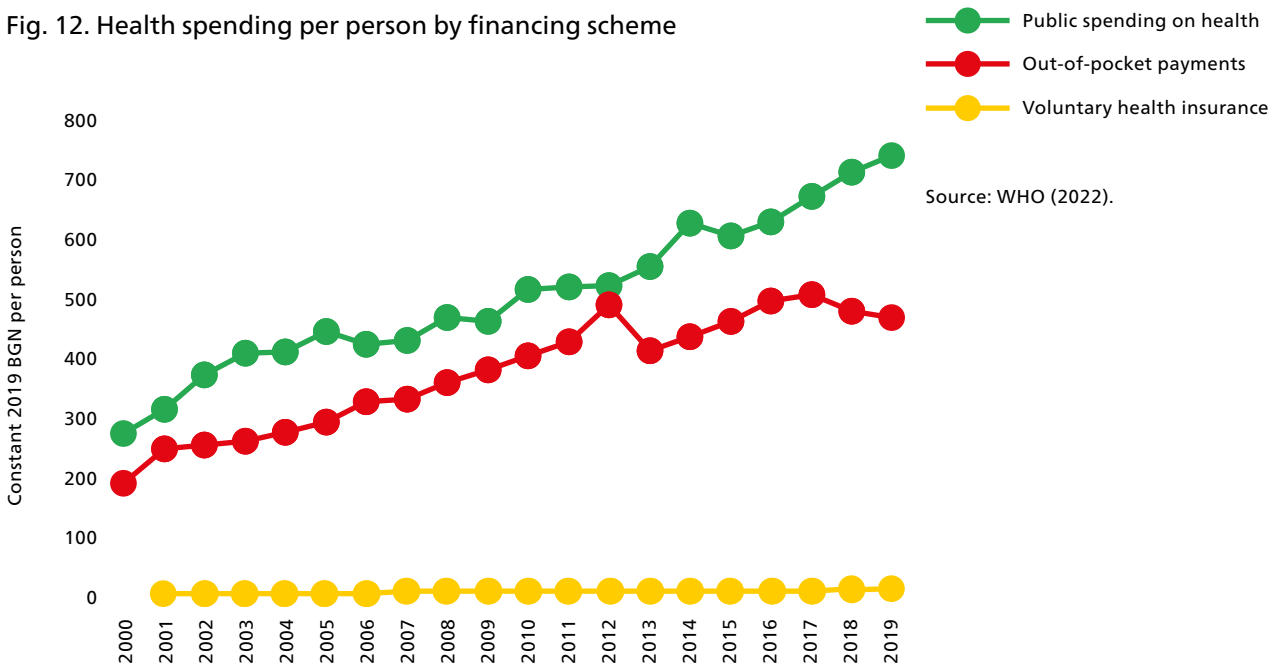


Fig. 13. Out-of-pocket payments as a share of current spending on health

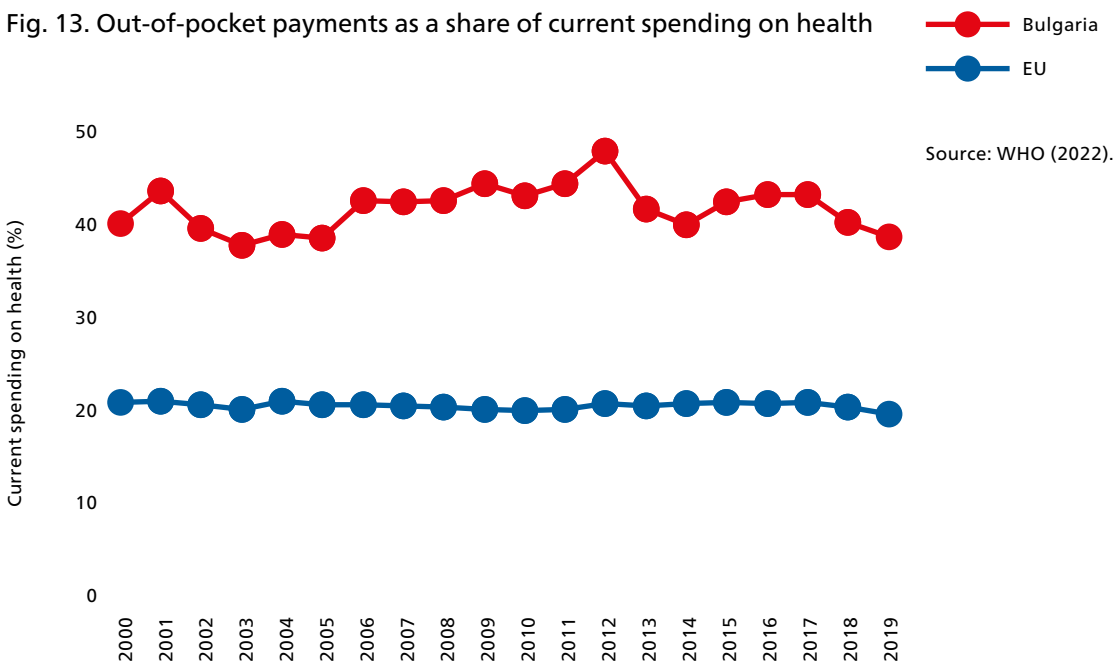
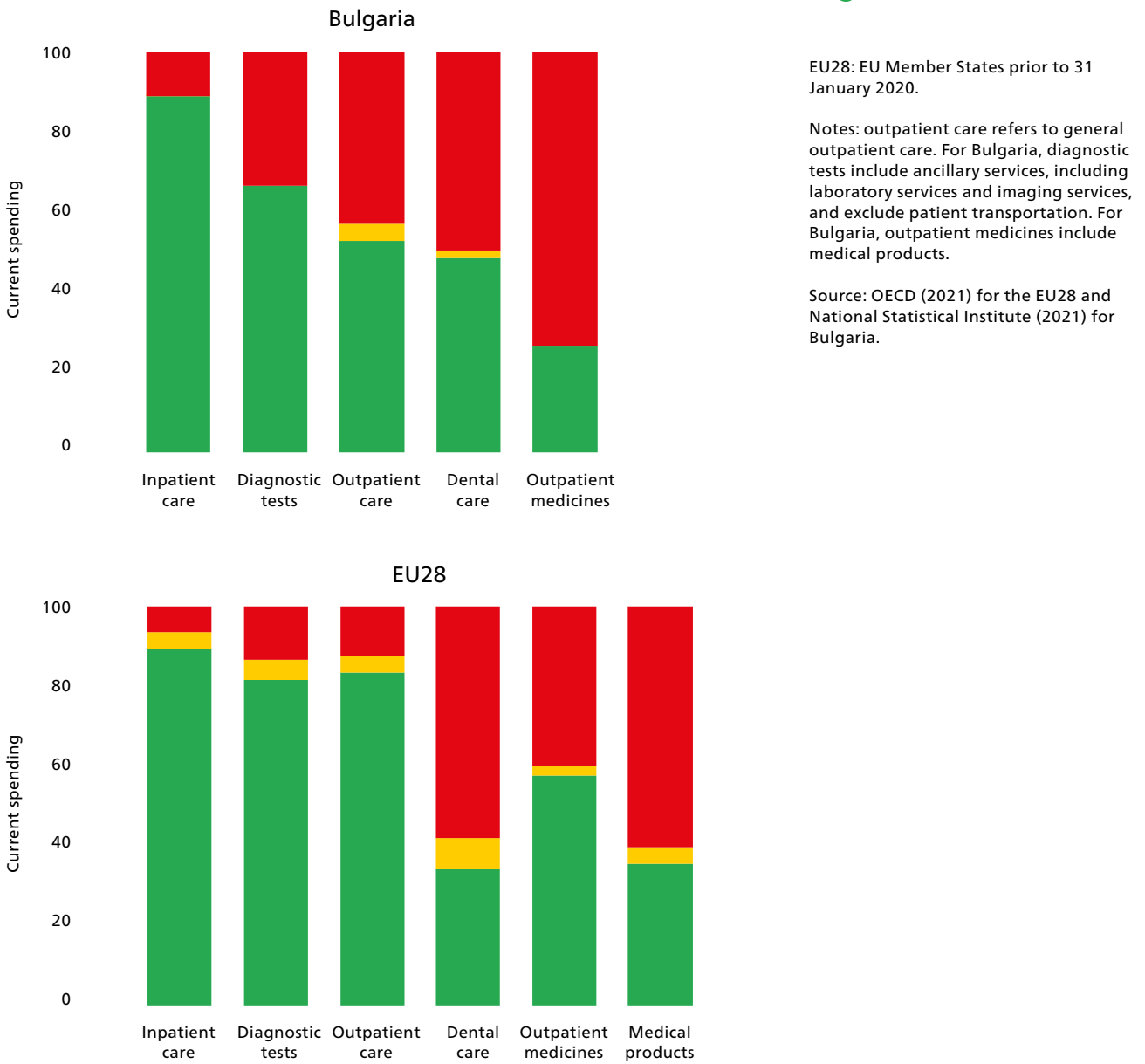


Fig.14. Breakdown of current spending on health by health service and financing scheme, Bulgaria and the EU, 2019



4.4 Summary

Household budget survey data show that in 2018 94% of households reported having out-of-pocket payments, up from 87% in 2010.

Out-of-pocket payments have grown steadily over time, nearly doubling in real terms between 2005 and 2018. They have also grown as a share of household spending, particularly among the poorer quintiles. In 2018 out-of-pocket payments accounted for 6.5% of total household spending on average (rising to 8% in the poorest quintile), which is high compared to other EU countries.

In 2018 outpatient medicines comprised the largest share of out-of-pocket spending on average (76%), followed by medical products (8%) and dental care and inpatient care (both around 5%). There is significant variation across 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.

International surveys suggest that informal payments are a problem in Bulgaria, especially for inpatient care. A major 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 from exposure to out-of-pocket payments.

National health accounts data show how heavily Bulgaria relies on out-of-pocket payments to finance the health system. Out-of-pocket payments have grown relatively steadily since 2000, rising per person and as a share of current spending on health. In 2019 out-of-pocket payments accounted for 39% of current spending on health, far above the EU average of 21%. National health accounts data for 2019 show how the out-of-pocket payment share of current spending on almost all types of health care is larger in Bulgaria than the EU average, particularly for outpatient medicines (73% in Bulgaria compared to an EU average of 40%) and outpatient care (43% compared to 13%).

5. Financial protection

This section uses data from the Bulgarian household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households that use health services. The section shows the relationship between out-of-pocket spending on health and risk of impoverishment, and presents estimates of the incidence, distribution and drivers of catastrophic out-of-pocket payments.

2. In 2018 100 BGN had the equivalent purchasing power of €102 in the average EU country.

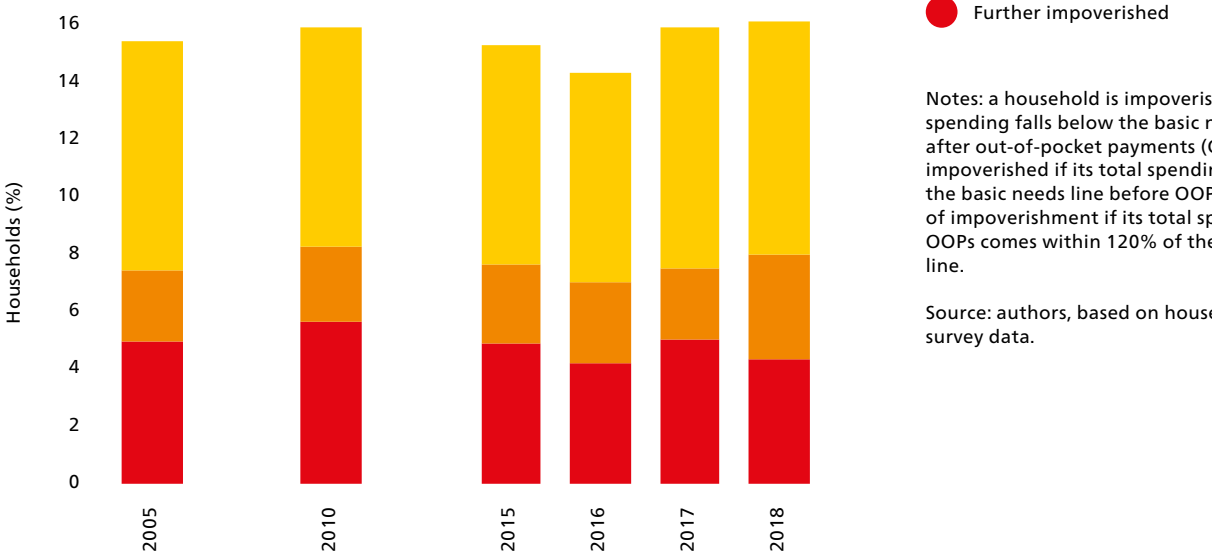
5.1 How many households experience financial hardship?

5.1.1 Out-of-pocket payments and risk of impoverishment

Fig. 15 shows the share of households at risk of impoverishment after out-of-pocket spending on health. The poverty line reflects the cost of spending on basic needs (food, rent and utilities) among a relatively poor part of the population (households between the 25th and 35th percentiles of the consumption distribution, adjusted for household size and composition). The monthly cost of meeting these basic needs – the basic needs line – was BGN 352 in 2018.² This compares to the national poverty line (an absolute poverty line based on a minimum basket of essential goods), which was set at BGN 363 in 2021 (€185.60).

In 2018 8% of households experienced impoverishing out-of-pocket payments and a further 8% were at risk of impoverishment after out-of-pocket payments (Fig. 15). The share of households impoverished after out-of-pocket payments rose from 2.5% in 2005 to 3.6% in 2018.

Fig. 15. Share of households at risk of impoverishment after out-of-pocket payments



- At risk of impoverishment
- Impoverished
- Further impoverished

Notes: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments (OOPs); further impoverished if its total spending is below the basic needs line before OOPs; and at risk of impoverishment if its total spending after OOPs comes within 120% of the basic needs line.

Source: authors, based on household budget survey data.

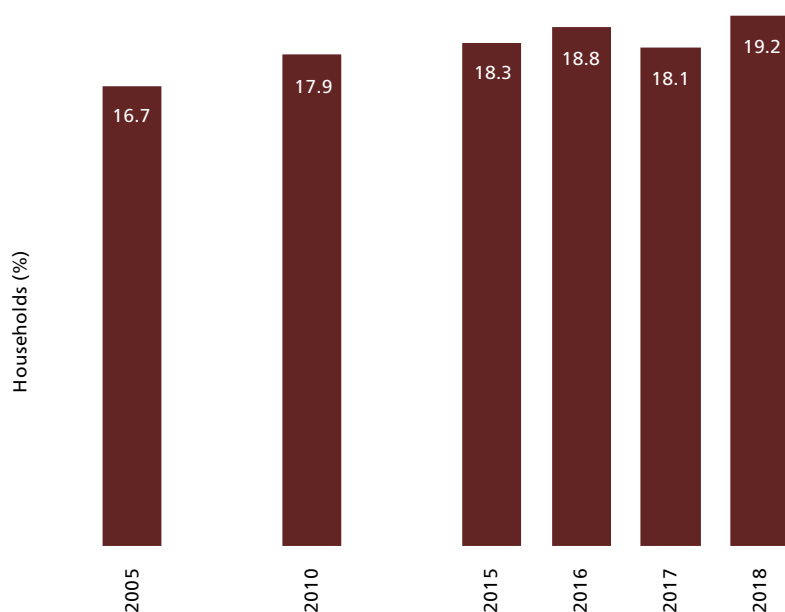
5.1.2 Catastrophic out-of-pocket payments

Households with catastrophic levels of out-of-pocket payments are defined (in this review) as those who spend more than 40% of their capacity to pay. This includes households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they have no capacity to pay).

In 2018 19% of households experienced catastrophic health spending, up from 17% in 2005 (Fig. 16).

Fig. 16. Share of households with catastrophic out-of-pocket payments

Source: authors, based on household budget survey data.



5.2 Who experiences financial hardship?

Catastrophic health spending is heavily concentrated among households at risk of impoverishment after out-of-pocket payments (Fig. 17) and households in the two poorest quintiles (Fig. 18). In 2018 the two poorest quintiles accounted for 86% of households with catastrophic health spending. Over 60% of households in the poorest quintile experienced catastrophic spending, compared to 17% in the second quintile and 3% in the richest quintile. The increase in catastrophic incidence over time is almost entirely driven by increasing incidence in the poorest quintile, which rose steadily from 10% to 13% of all households between 2005 and 2018.

Fig. 17. Share of households with catastrophic spending by risk of impoverishment

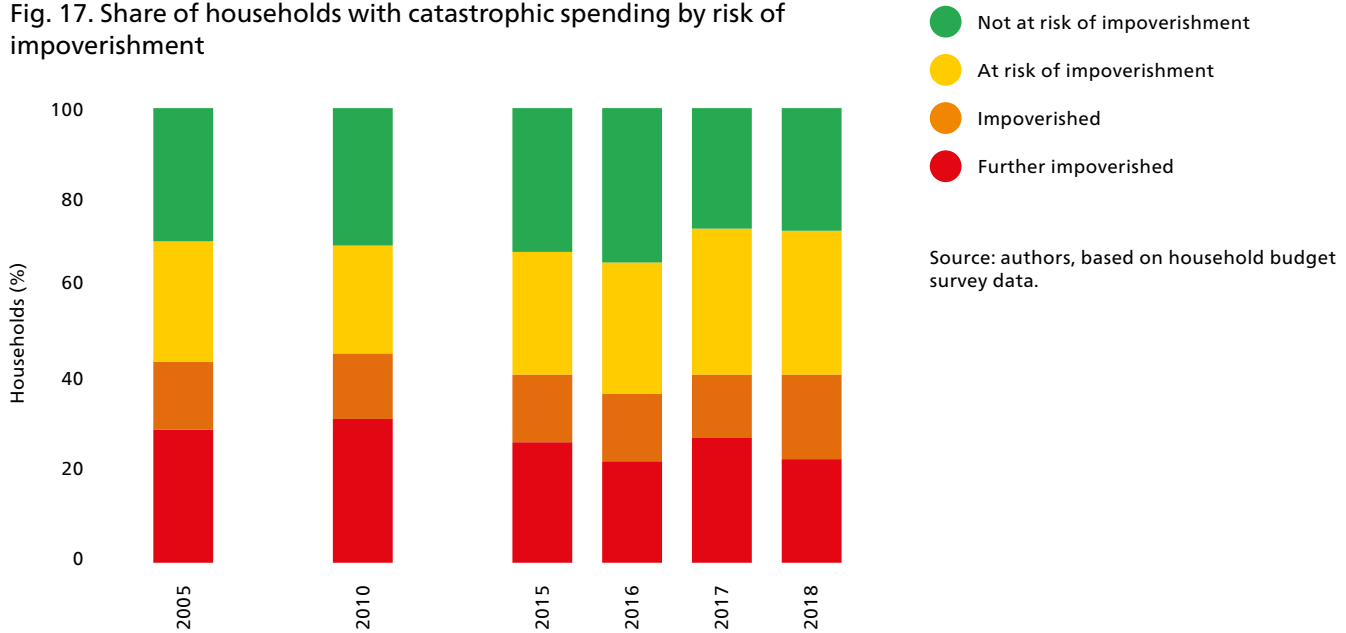


Fig. 18. Share of households with catastrophic spending by consumption quintile

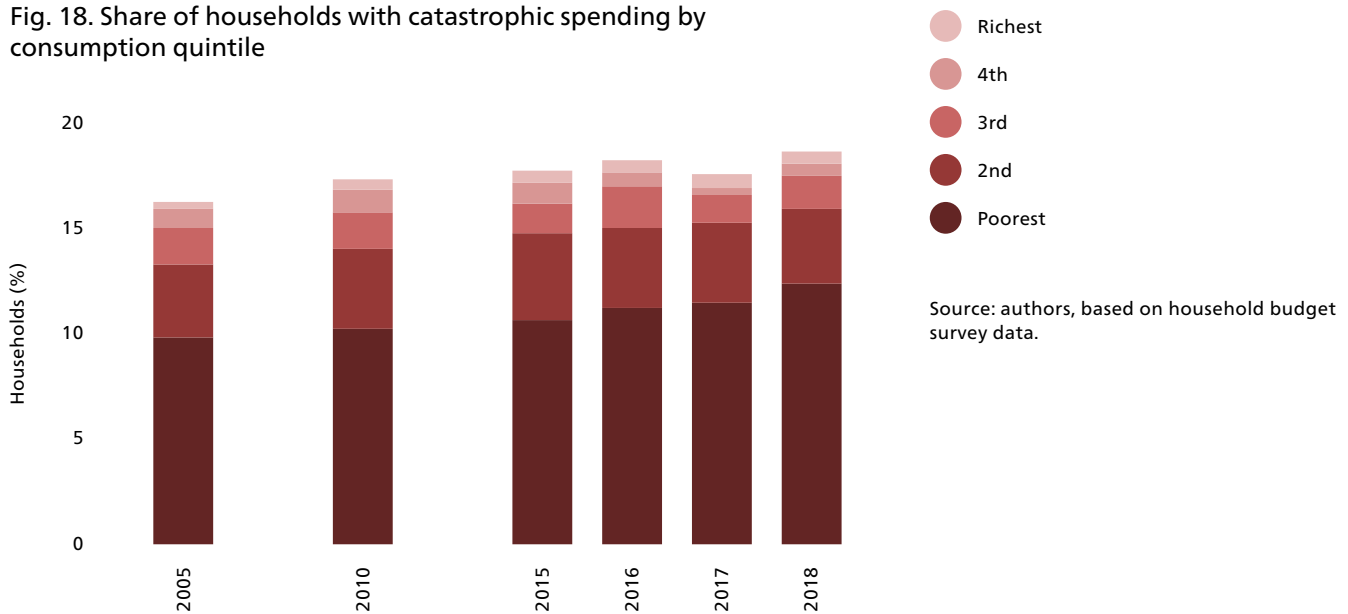
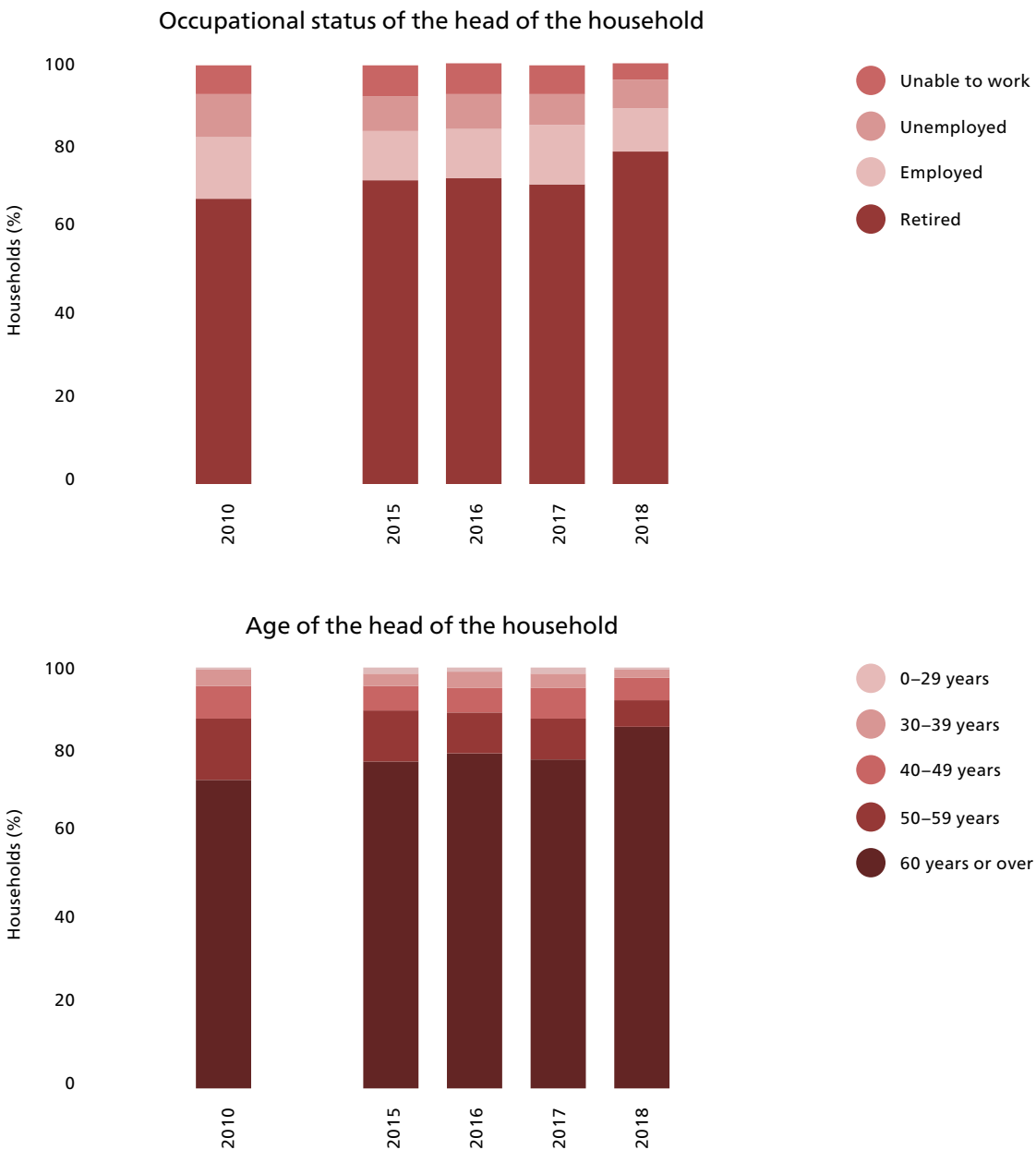


Fig. 19 shows how catastrophic spending is also heavily concentrated among older people, a pattern that has increased over time. In 2018 nearly 80% of all households with catastrophic spending were headed by a retired person, up from 67% in 2010 (top panel of Fig. 19), while 86% were headed by someone aged over 60 years, up from 63% (bottom panel of Fig. 19).

Catastrophic incidence is high among households headed by a person aged over 60 – 27% in 2018. Although unemployed people account only for a small share of all households with catastrophic spending (top panel of Fig. 19), catastrophic incidence is also high within this group of people – 29% in 2018. By far the highest incidence of catastrophic spending is in the poorest quintile, however – close to 64% in 2018.

Fig. 19. Share of households with catastrophic spending by occupational status and age of the head of the household

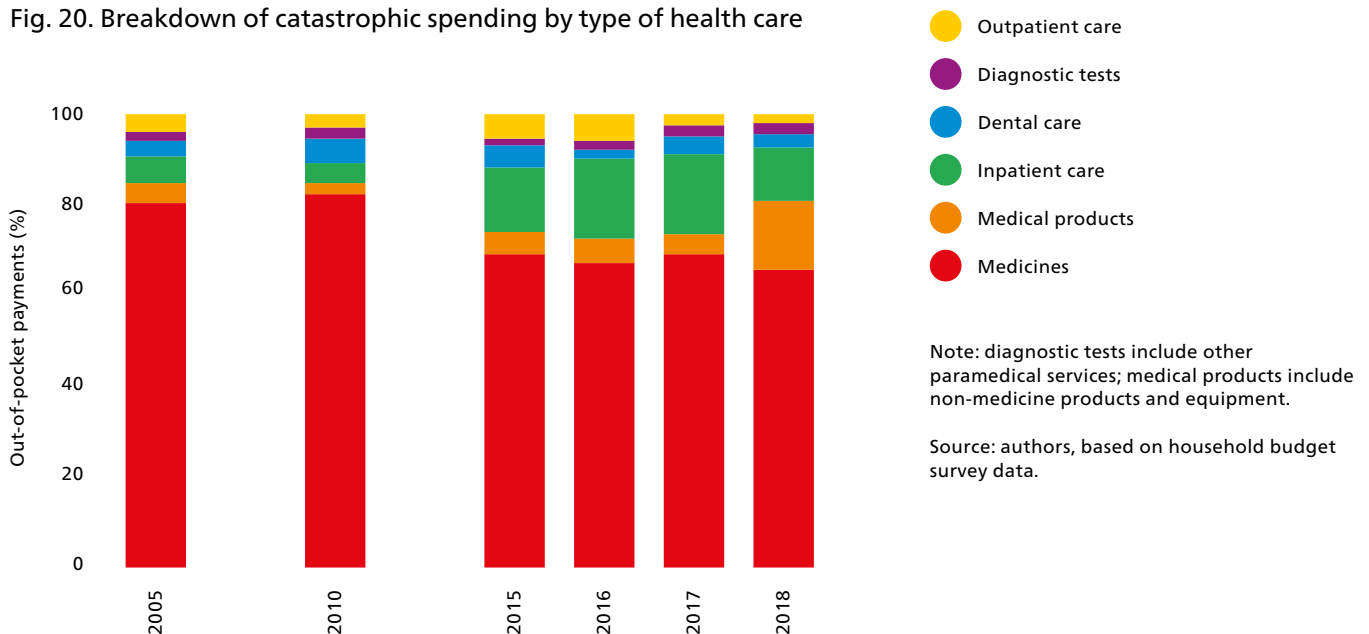
Source: authors, based on household budget survey data.



5.3 Which health services are responsible for financial hardship?

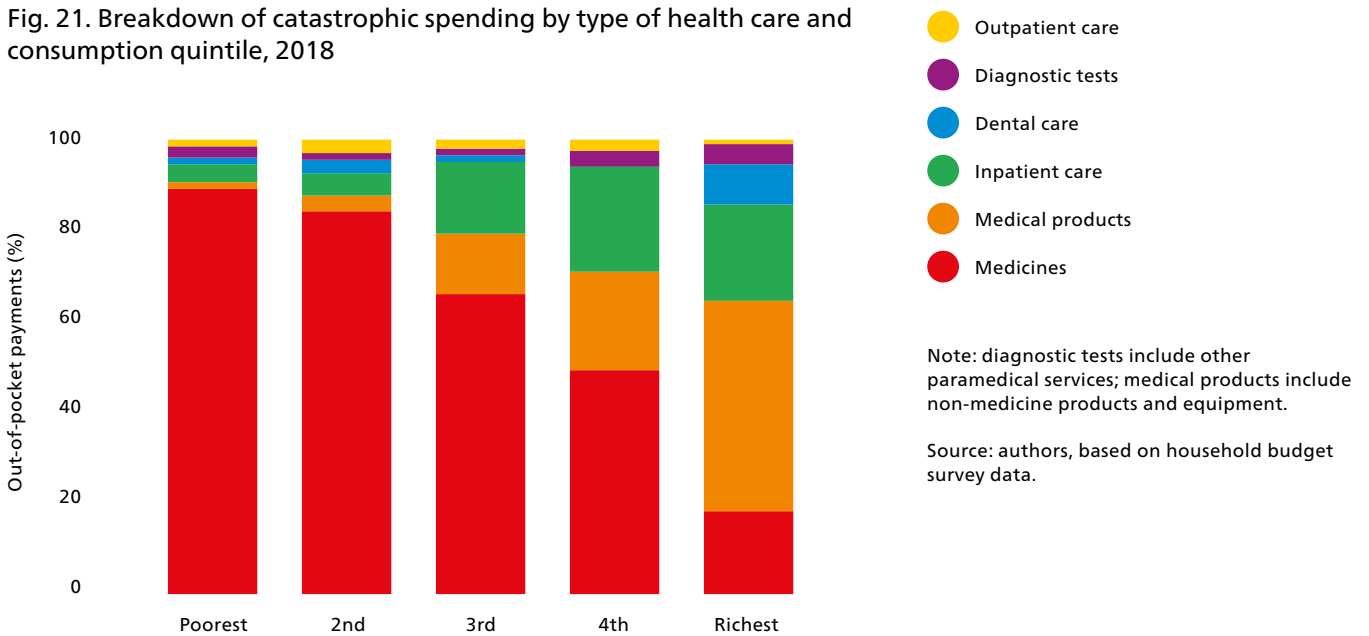
Outpatient medicines are the main driver of catastrophic health spending in all years (Fig. 20). Their share fell between 2010 and 2015, possibly reflecting various policies introduced to reduce the price of medicines and the gradual extension of the Positive Drug List. From 2015 onwards spending on inpatient care and medical products has also driven catastrophic spending. The inpatient care share grew sharply in 2015 and the medical products share grew sharply in 2018.

Fig. 20. Breakdown of catastrophic spending by type of health care



The breakdown of catastrophic health spending by type of health care varies substantially by quintile, with the outpatient medicines share decreasing with consumption and the shares spent on other types of health care increasing with consumption (Fig. 21).

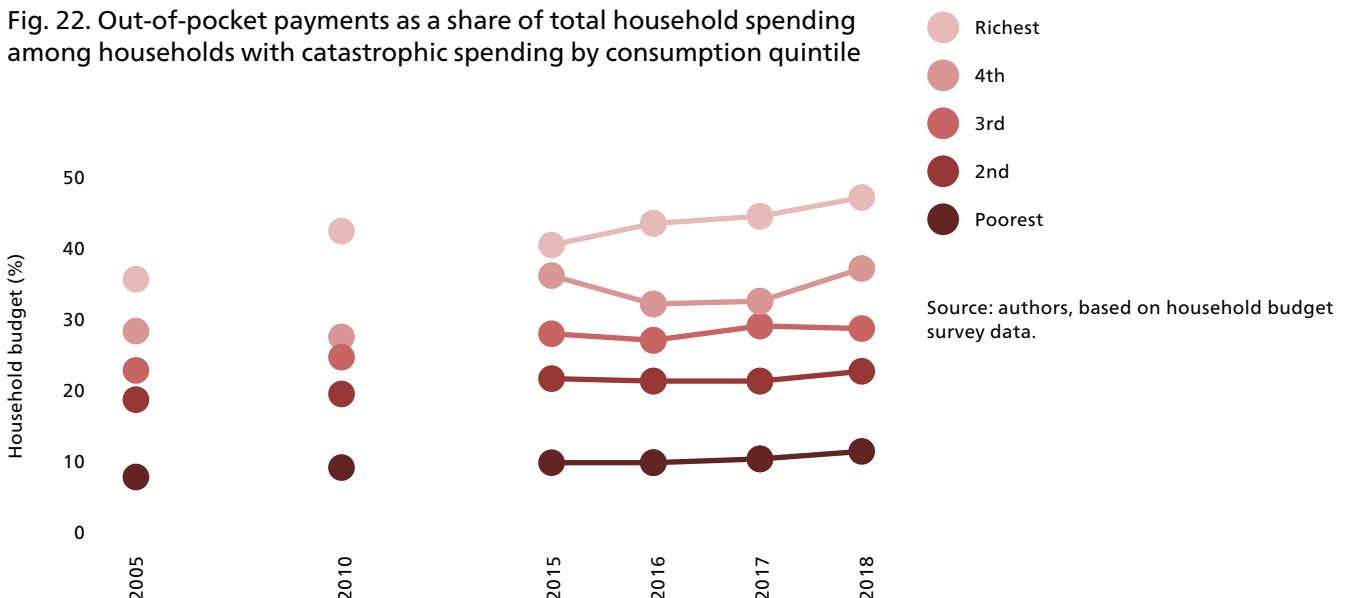
Fig. 21. Breakdown of catastrophic spending by type of health care and consumption quintile, 2018



5.4 How much financial hardship?

Fig. 22 shows how out-of-pocket payments as a share of total household spending rise progressively with household consumption among households with catastrophic spending. Over time, the share has increased for all quintiles.

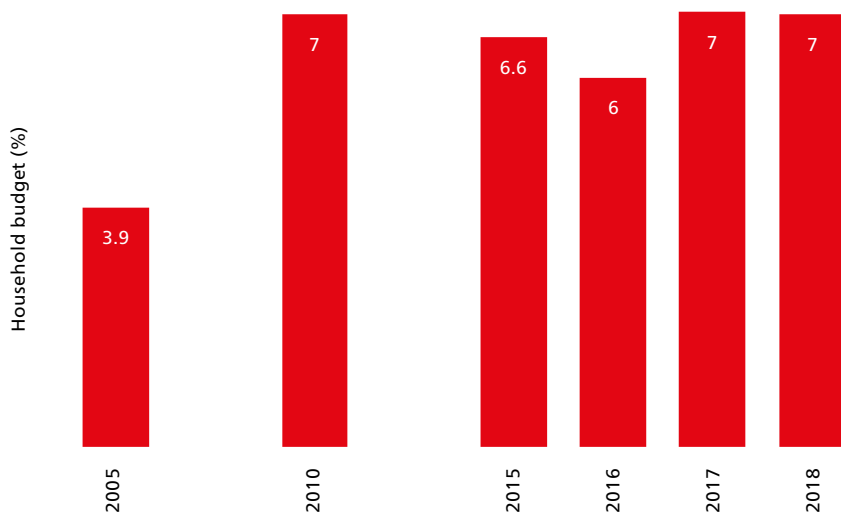
Fig. 22. Out-of-pocket payments as a share of total household spending among households with catastrophic spending by consumption quintile



Among the poorest households already living below the basic needs line – those further impoverished after out-of-pocket payments – the out-of-pocket payment share of total household spending grew sharply from 4% in 2005 to 7% in 2010 and has remained relatively stable since then (Fig. 23). This is higher than the average for all households in 2018 (6.5%) and households in the richest quintile (5.2%) but slightly below the average for households in the poorest quintile (8.2%) (see Fig. 7).

Fig. 23. Out-of-pocket payments as a share of total household spending among further impoverished households

Source: authors, based on household budget survey data.



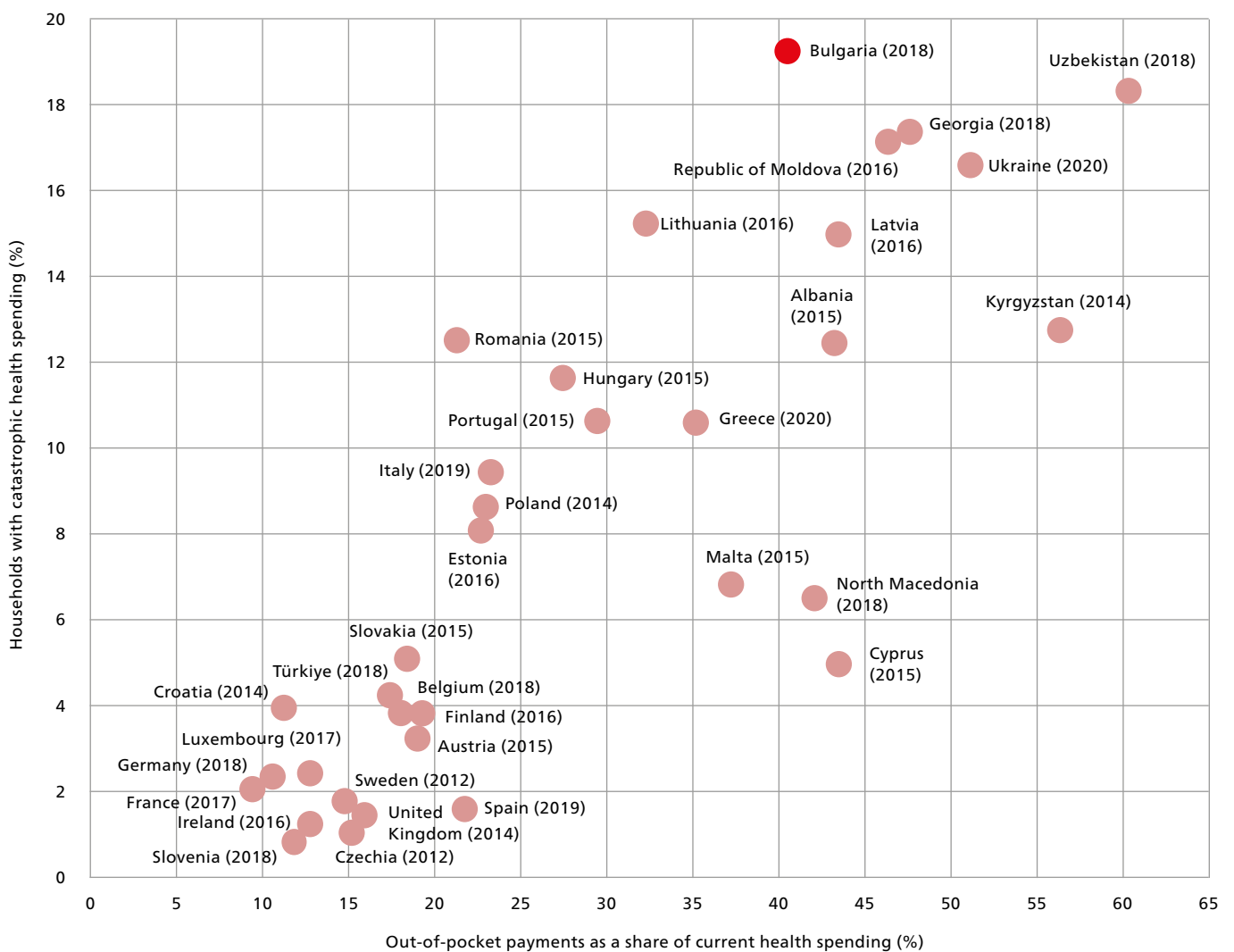
5.5 International comparison

The incidence of catastrophic health spending in Bulgaria is higher than in other EU countries (Fig. 24).

Fig. 24. Incidence of catastrophic spending on health and the out-of-pocket share of total spending on health in the WHO European Region, latest year available

Notes: out-of-pocket payment data are for the same year as those on catastrophic health spending except for Greece and Ukraine (out-of-pocket payment data are for 2019, the latest available year). Bulgaria is highlighted in red.

Sources: WHO Regional Office for Europe (2019), WHO (2022) and WHO Barcelona Office for Health Systems Financing



5.6 Summary

Financial protection is weak in Bulgaria, reflecting very heavy reliance on out-of-pocket payments to finance the health system.

In 2018 8% of households experienced impoverishing health spending and 19% of households experienced catastrophic health spending.

Catastrophic spending is heavily concentrated among the two poorest quintiles. It is higher in rural areas, small towns and suburbs than in cities and much higher among older than younger households.

The incidence of catastrophic spending has grown over time, rising from 17% on average in 2005 to 18% in 2010 and 19% in 2018, driven by a steady increase in incidence in the poorest quintile. Catastrophic incidence in the poorest quintile rose from 53% in 2010 to 64% in 2018.

Outpatient medicines are the main driver of catastrophic spending across all years; their share fell between 2010 and 2015, possibly reflecting various policies introduced to reduce the price of medicines. The breakdown of catastrophic health spending by type of health care varies substantially by quintile, with the outpatient medicines share decreasing with consumption and the shares spent on other types of health care increasing with consumption.

6. Factors that strengthen and undermine financial protection

This section considers the factors which may be responsible for financial hardship caused by out-of-pocket payments in Bulgaria and which may explain the trend over time. It begins by looking at factors outside the health system affecting people's capacity to pay – for example, changes in incomes and the cost of living – and then considers factors in the health system.

6.1 Factors affecting people's capacity to pay for health care

This section draws on data from the household budget survey and other sources to review changes in people's capacity to pay for health care, focusing on those who face the highest risk of falling into poverty.

Bulgaria has experienced relatively strong economic growth since 2000, with a sharp contraction in GDP (–3%) in 2009 only, owing to the global financial crisis (World Bank, 2020). Unemployment doubled in the years after the economic crisis but started to fall again in 2014 until it was lower in 2019 (4%) than it had been in 2008 (6%) (National Statistical Institute, 2020).

Poverty rates have followed a similar pattern, rising on average after the crisis and then falling (Fig. 25). In 2020 around 32% of the population was at risk of poverty or social exclusion, on a par with levels in Romania and Greece, but much higher than in most other EU countries.

Although poverty has fallen on average, income has grown faster than average among the richest households and people living in urban areas, leading to a substantial increase in income inequality; the Gini index rose from 36 in 2008 to 41 in 2019 (National Statistical Institute, 2020a). In 2020 the difference in poverty rates between older and younger people and urban and rural areas was particularly stark, with around 23% of the urban population at risk of poverty or social exclusion compared to 47% of the rural population and 48% of people aged 65 and over (Fig. 25).

Household budget survey data show that household capacity to pay grew faster than the cost of meeting basic needs (food, housing and utilities) during the study period. As a result, the share of households living below the basic needs line fell from 8% in 2010 to 5% in 2018 (Fig. 26). This was matched by a fall in the share of households further impoverished by out-of-pocket payments (see Fig. 15 and Fig. 17). Over time, however, the incidence of catastrophic health spending has grown substantially in the poorest quintile (see Fig. 18), reflecting sharp increases in income inequality and in out-of-pocket payments in the poorest quintile between 2015 and 2018 (see Fig. 6).

Fig. 25. Share of the population at risk of poverty or social exclusion by age and degree of urbanization

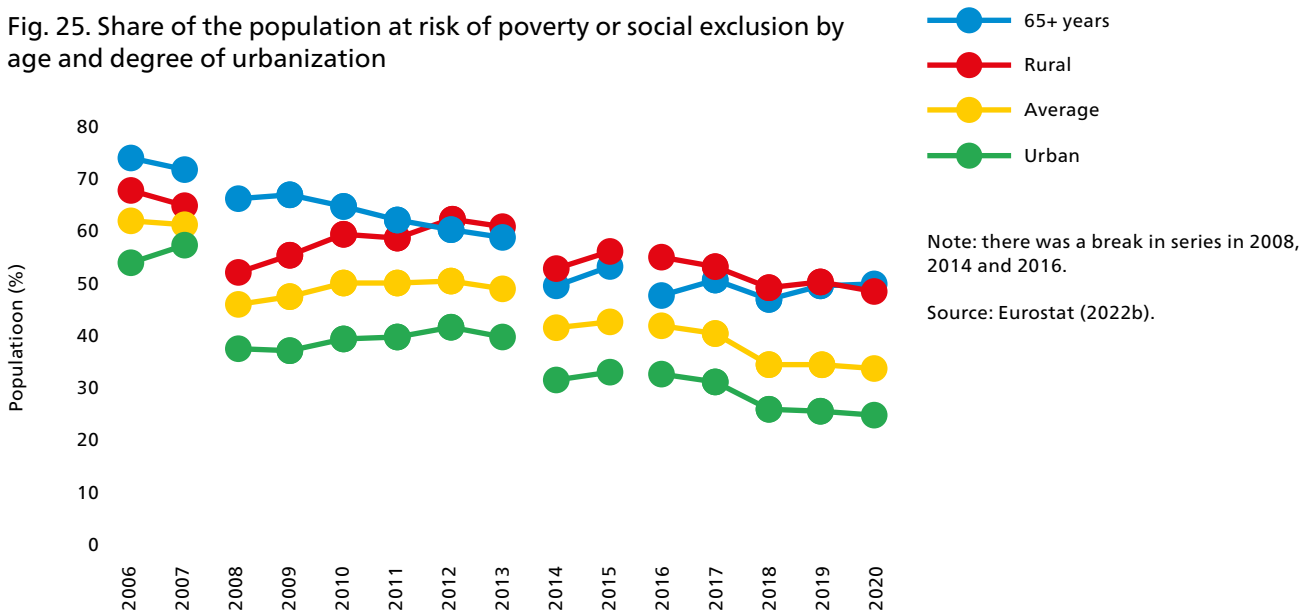
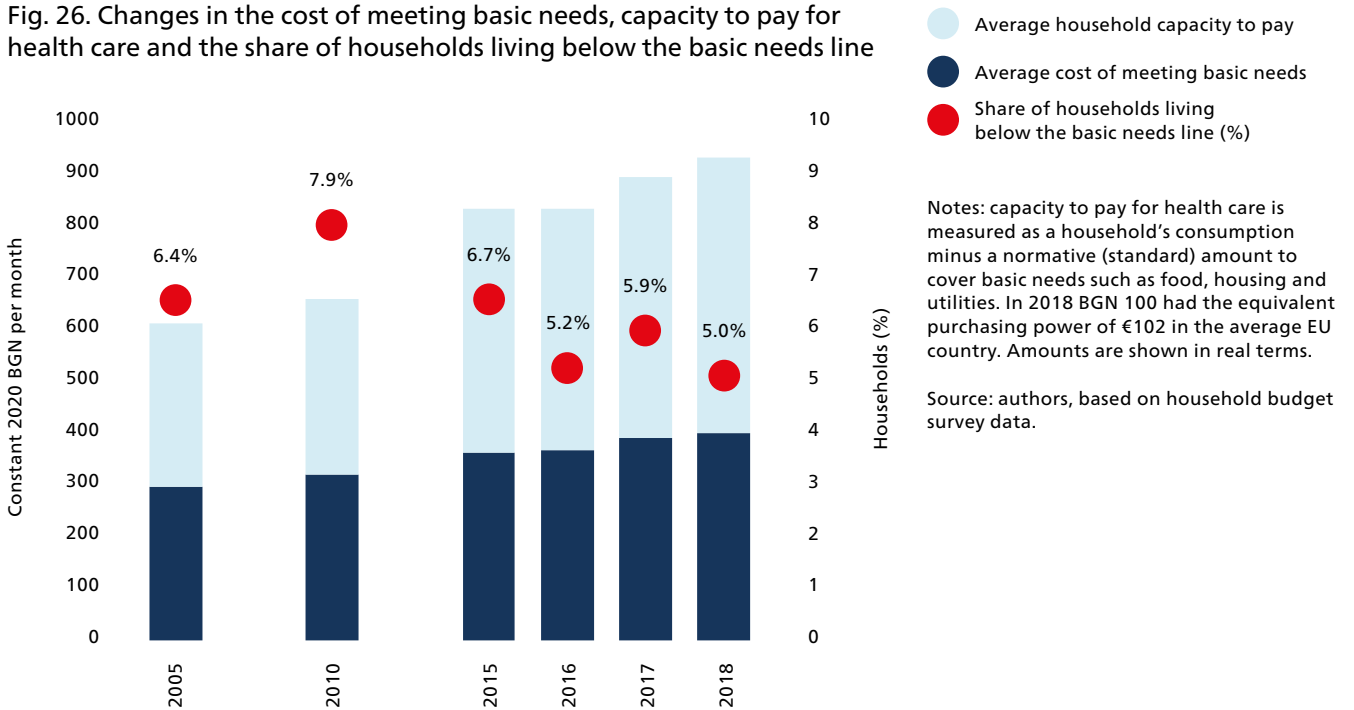


Fig. 26. Changes in the cost of meeting basic needs, capacity to pay for health care and the share of households living below the basic needs line



6.2 Health system factors

The following paragraphs look at the role of coverage policy in driving financial hardship and unmet need for health services, focus in more detail on the health services that account for the greatest share of catastrophic health spending and then discuss trends in spending on health.

6.2.1 Coverage policy

Significant gaps in all three dimensions of coverage in Bulgaria are likely to lead to both unmet need and financial hardship.

Although the number of permanently uninsured people has decreased over time, it remains high compared to other EU countries: in 2019 around 15% of the population was uninsured. The main reason for this is that **population entitlement** to the benefits provided by the NHIF is based on payment of contributions and people in relatively vulnerable situations do not have the capacity to contribute. At least a quarter of all uninsured people are long-term unemployed. Although the Government pays contributions on behalf of social beneficiaries, eligibility for social benefits and health insurance is limited to people living on less than BGN 195 a month (compared to the monthly national poverty line of BGN 413); as a result, many people living well below the national poverty line must pay contributions but cannot afford to do so.

Other factors restricting access to health insurance relate to:

- the lack of affordability of contributions being exacerbated by the fact that there is a minimum contribution base of BGN 710 a month, even for people with incomes below this; having a minimum and maximum contribution base means that SHI contributions are regressive overall, imposing a proportionately heavier financial burden on poorer households than richer households;
- people losing NHIF coverage if they fail to pay more than three monthly contributions in the previous three years; to restore their health insurance rights they must pay any unpaid contributions accrued in the previous five years, a level of debt that many would be unable to repay; and
- entitlement to health insurance requiring formal ID and a permanent address, which discriminates against minority groups such as Roma and homeless people.

In the past, policy debates about reducing the number of uninsured people have been usually motivated by concerns about generating revenue for health – finding ways to make uninsured people pay contributions – rather than concerns about covering more people, particularly people in vulnerable situations.

There are several issues with **service coverage**.

- The publicly financed benefits package is split: insured people have access to a much wider range of benefits than uninsured people, exacerbating inequality in access to health services.

- Coverage of dental care is very limited for adults and children, leading to financial hardship for richer households (see Fig. 21) and unmet need for poorer households (see Fig. 2).
- It is not always easy for people to know which services are explicitly excluded from the NHIF benefits package, resulting in confusion. This lack of clarity is exacerbated by the presence of extra billing in NHIF-contracted hospitals for additional services such as choice of physician or clinical team.
- Informal payments mainly occur in inpatient care, where they tend to be paid for auxiliary services such as cleaning, food and personal hygiene.

User charges (co-payments) apply to almost all publicly financed health services and are likely to play a major role in driving financial hardship. The design of co-payment policy is relatively complex, particularly for dental care, which involves different fixed co-payments for each service, and outpatient medicines, which involves percentage co-payments (people pay a share of the price).

Percentage co-payments can be problematic, especially when applied to medicines, because people's exposure to out-of-pocket payments will depend on the price and quantity of medicines they need. Unless the price is clearly known in advance, people may face uncertainty about how much they have to pay out of pocket. The negative effect of percentage co-payments is magnified for people with chronic conditions or a condition that requires higher-cost treatment, when prices are relatively high or subject to fluctuation, and when physicians and pharmacists are not required, or do not have incentives, to prescribe and dispense cheaper alternatives (WHO Regional Office for Europe, 2019).

Protection from co-payments is limited. For example, although there are several exemptions from fixed co-payments for health services, there are no exemptions from percentage co-payments for outpatient prescribed medicines. This is very unusual among EU countries (WHO Regional Office for Europe, 2019). Also, while people receiving social benefits are exempt from fixed co-payments, the threshold for entitlement to social support is very stringent; as a result, many people living below the poverty line are not exempt from co-payments. Finally, there is no overall annual cap on co-payments, just a cap on co-payments for inpatient care (which does not apply to extra billing).

It is clear from the results of the financial protection analysis that the mechanisms in place to protect people from co-payments and other out-of-pocket payments do not seem to be enough to prevent financial hardship among poorer people and older people.

6.2.2 Health services

Financial hardship is overwhelmingly driven by out-of-pocket payments for outpatient medicines, followed by medical products and inpatient care (see Fig. 20). Out-of-pocket payments for outpatient medicines account for almost all out-of-pocket payments among households in the two poorest quintiles with catastrophic health spending, two thirds of out-of-pocket payments in

the third quintile and half in the fourth quintile (see Fig. 21). Over time, the outpatient medicines share grew in the poorest households and decreased in the richest households as the role of inpatient care and medical products grew in the richer quintiles.

National health accounts data indicate that more than 70% of all spending on **outpatient medicines** is through out-of-pocket payments (see Fig. 14), reflecting various factors.

- **Heavy co-payments for outpatient medicines covered by the NHIF, with limited mechanisms to protect people.** Although medicines for severe chronic conditions are available free of charge at the point of use for people covered by the NHIF, more than half of all NHIF-financed prescriptions incur a percentage co-payment of 50% or more of the reference price. In addition, there are no exemptions from these co-payments at all, which is unusual internationally; and there is no annual cap. The absence of any protection from co-payments is particularly problematic for poorer households and people with chronic conditions.
- **Weaknesses in medicines policy and purchasing.** During the study period the list of outpatient medicines covered by the NHIF was extended to include new medicines and more conditions, and medicine prices have fallen in response to the introduction of the external reference price scheme in 2011 and the reduction in the mark-up of wholesalers and retailers in 2013. Prices remain high, however, in comparison to other EU countries (International Bank for Reconstruction and Development, 2015) and all medicines and medicinal products are subject to value-added tax (VAT) set at 20% – one of the highest VAT rates on prescribed medicines in the EU (European Federation of Pharmaceutical Industries and Associations, 2021). Physicians prescribe branded medicines (there is no requirement for INN prescribing) and generic substitution by pharmacists is not allowed. These limitations in the purchasing function also contribute to financial hardship and unmet need.

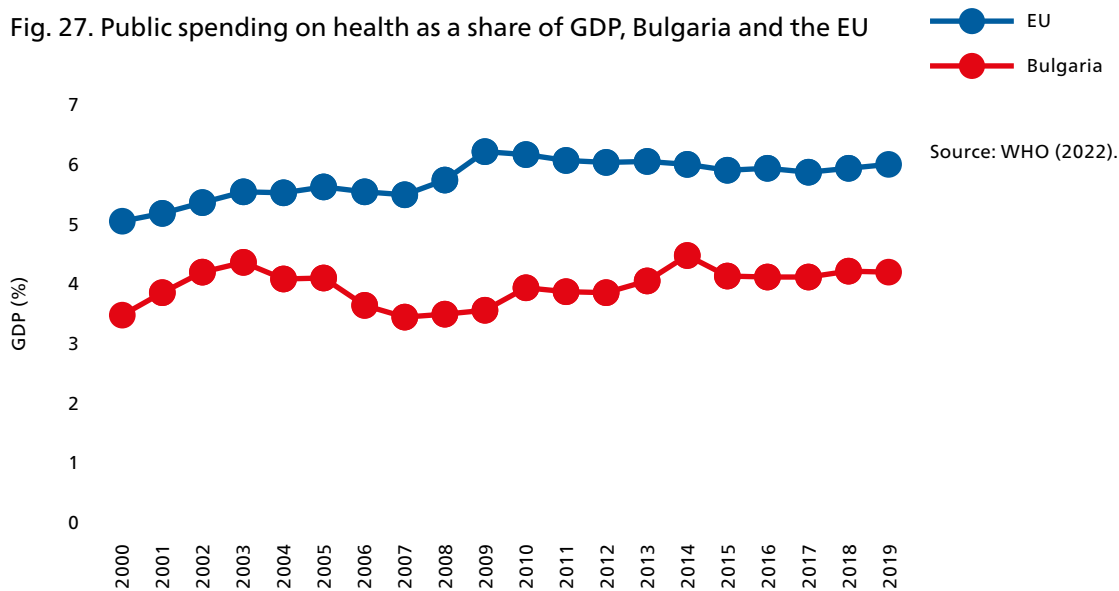
The NHIF does not cover some **medical devices used in hospitals**; for those it covers, it pays only up to a reference price (frequently well below the retail price) or it pays only for the cheapest alternative (which physicians often avoid). As a result, much of the cost of medical devices is pushed onto households. Household budget survey data show that household spending on medical products is very small overall (under 10% in all years of the study; see Fig. 8), with a strong social gradient: less than 2% of household spending in the poorest quintile in 2018, rising to 18% in the richest quintile (see Fig. 11). Although medical products were the second-largest driver of catastrophic health spending overall in 2018 (see Fig. 20), they were only a significant driver of financial hardship among the three richer quintiles (see Fig. 21). This suggests that out-of-pocket payments for medical products mainly lead to unmet need for poorer households and financial hardship for richer households – a pattern that seems likely to also be present for **dental care**.

Extra billing and informal payments may account for a significant share of out-of-pocket payments for inpatient care. The Government has recently introduced various measures to reduce informal payments and control extra billing. For example, in 2016 health facilities were prohibited from requesting or receiving any payment from patients for services covered by the NHIF and the services for which extra billing is allowed were more clearly defined. Since 2018 the NHIF has paid outpatient care physicians the difference between the reduced co-payment for physician visits for pensioners and the normal co-payment if physicians have issued patients with a receipt. There is no formal evaluation of these measures, but they may have led to some reduction in informal payments.

6.2.3 Health spending

The introduction of the SHI scheme in 2000 did not lead to a sustained increase in public spending on health as a share of GDP. This ratio grew from 3.5% in 2000 to 4.4% in 2003 and has fluctuated at around 4% of GDP since then, well below the EU average of around 6% (Fig. 27).

Fig. 27. Public spending on health as a share of GDP, Bulgaria and the EU



Low levels of public spending on health reflect the low share of the government budget allocated to health. At 11.6% in 2019, the health share of government spending in Bulgaria is one of the lowest among EU and western Balkan countries (Fig. 28). This ratio has fluctuated over time, reaching a peak of 11.8% in 2016, but the size of the government budget has also fluctuated, which is why public spending on health as a share of GDP has not changed much over time (WHO, 2022).

Fig. 28. Spending on health as a share of government spending, EU and western Balkans, 2019

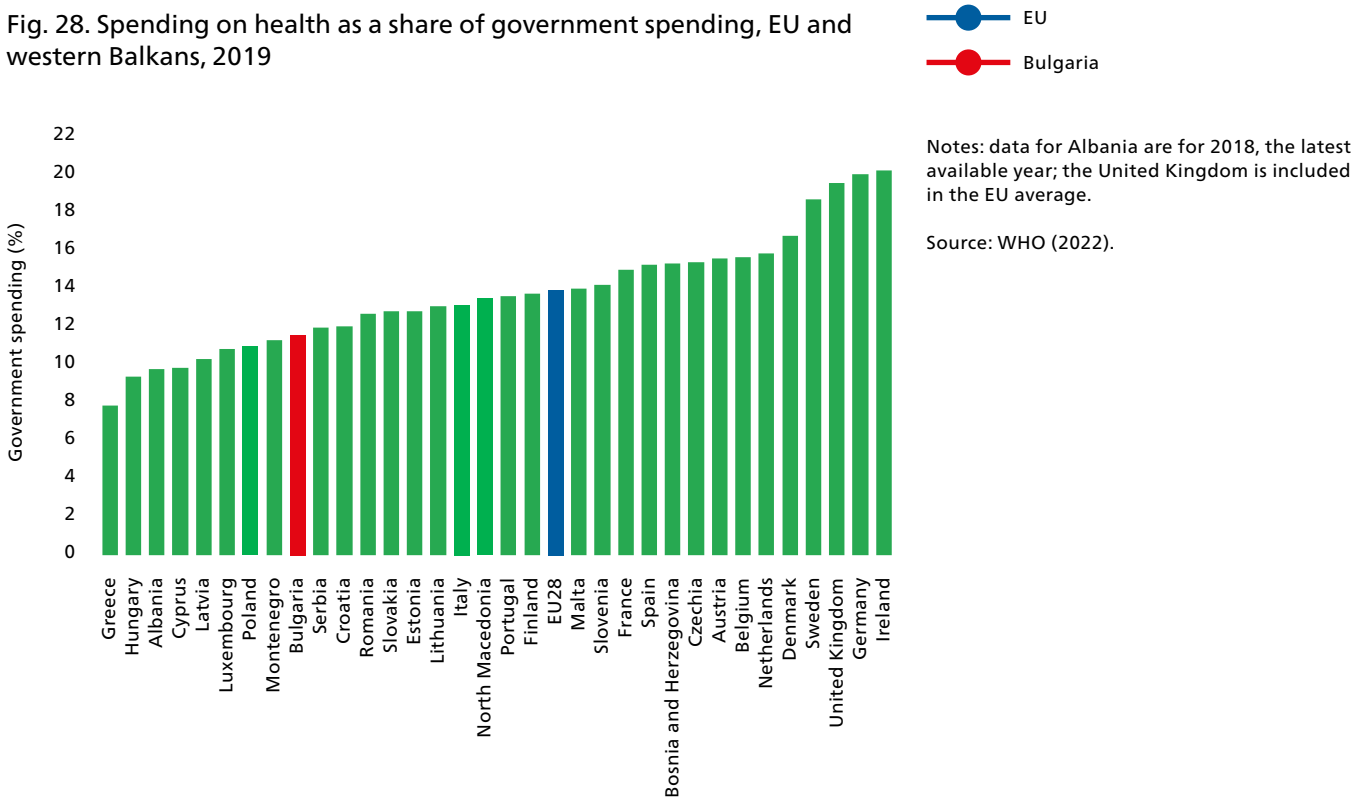


Fig. 29 shows the relatively strong relationships between GDP, public spending on health and out-of-pocket payments in EU and western Balkan countries. Although public spending on health in Bulgaria is very low as a share of GDP compared to many of these countries, it is broadly in line with what would be expected given Bulgaria’s level of GDP per person (top panel of Fig. 29).

Bulgaria’s out-of-pocket payment share is substantially higher than expected given its level of public spending on health as a share of GDP, however (bottom panel of Fig. 29). This suggests there is scope to reduce out-of-pocket payments through stronger policies and increased public investment in health.

Fig. 29. Relationships between GDP, public spending on health and out-of-pocket payments, EU and western Balkans, 2019

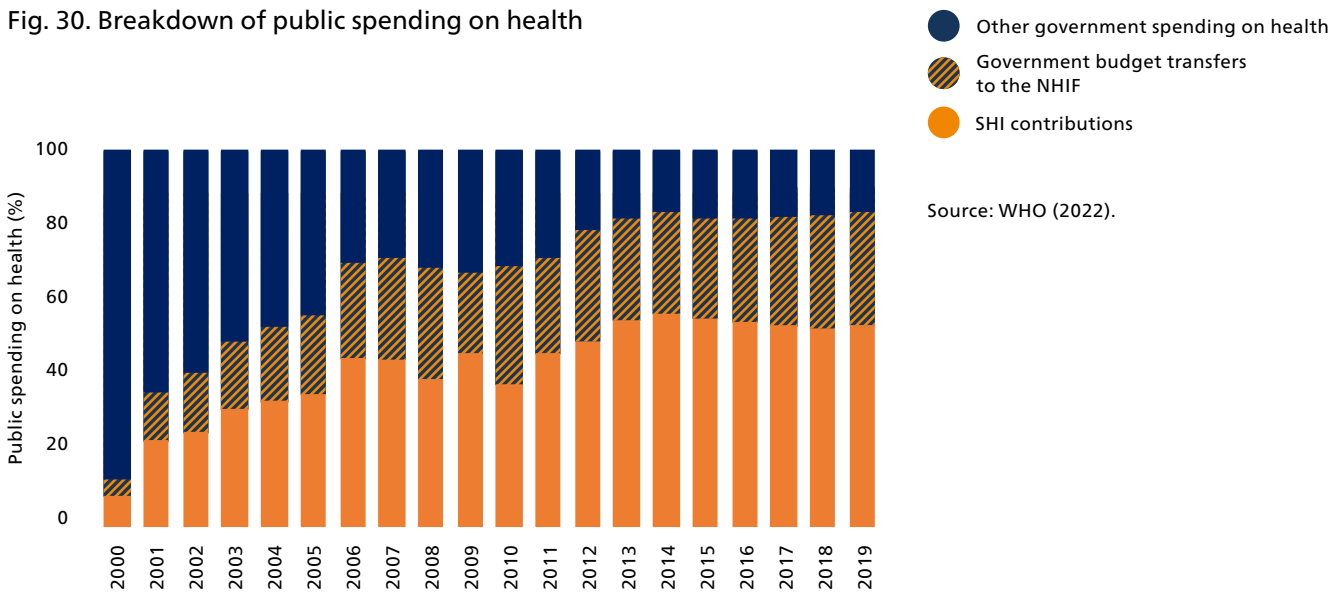
Notes: data for Albania are for 2018, the latest available year; the figure excludes Ireland and Luxembourg.

Source: WHO (2022).



Government budget transfers to the NHIF provide a potential channel for increased public investment in health. These transfers had been falling as a share of NHIF revenue after 2010 but have slowly increased since 2016 (Fig. 30). The increase since 2016 reflects the Government’s decision to gradually increase the base for the contributions it pays from 50% of the contribution base in 2015 to 100% by 2025 (see section 3.1.1).

Fig. 30. Breakdown of public spending on health



Further increases in government budget transfers to the NHIF, combined with policy changes to increase access and financial protection for poorer households and efforts to strengthen the way in which the NHIF purchases medicines, would help to lessen reliance on out-of-pocket payments and reduce unmet need and financial hardship.

6.3 Summary

The high incidence of impoverishing and catastrophic health spending in Bulgaria reflects a range of factors.

Significant gaps in all three dimensions of coverage, driven by weaknesses in the design of coverage policy, are likely to lead both to unmet need and financial hardship.

- A relatively large share of the population (15%) is uninsured and has access only to a few publicly financed health services (mainly emergency and maternity care and treatment of communicable diseases). Access to NHIF benefits is based on payment of contributions; many people cannot afford to pay and the Government only pays contributions for very poor people (those with a monthly income under BGN 195, far below the national monthly poverty line of BGN 413).
- NHIF coverage of dental care is limited, which results in unmet need for poorer households and financial hardship for richer households. Extra billing and informal payments for inpatient care are also likely to contribute to financial hardship.
- A complex system of co-payments fails to provide sufficient protection for poorer people and people with chronic conditions. There are very few exemptions from co-payments for poor people and there is no overall annual cap on co-payments.

Catastrophic health spending is heavily driven by out-of-pocket payments for outpatient medicines, reflecting weaknesses in the design of co-payment policy and the way in which the NHIF purchases medicines.

- Although medicines for severe chronic conditions are available free of charge at the point of use for people covered by the NHIF, more than half of all NHIF-financed prescriptions incur a percentage co-payment of 50% or more of the reference price. There are no exemptions from these co-payments, which is unusual internationally, and no annual cap. The absence of any protection from co-payments is particularly problematic for poorer households and people with chronic conditions.
- Medicine prices have fallen in response to efforts to control prices introduced in 2011 and 2013 but remain high compared to other EU countries. All medicines are subject to one of the highest VAT rates in the EU (20%). Physicians prescribe branded medicines (there is no requirement for INN prescribing) and generic substitution by pharmacists is not allowed.

Public spending on health as a share of GDP is low compared to most EU and western Balkan countries. Although public spending on health has increased in recent years, it has not grown as fast as out-of-pocket payments, which grew in absolute terms and as a share of current spending on health between 2014 and 2017. Out-of-pocket payments are higher than expected given Bulgaria's level of public spending on health, which suggests that there is scope to reduce them through stronger policies and increased public investment in the health system.

Financial protection has deteriorated over time, driven largely by an increase in catastrophic spending in the poorest quintile, which in turn reflects sharp increases not just in income inequality since 2010, but also in out-of-pocket payments in the poorest quintile.

7. Implications for policy

Financial protection is weaker in Bulgaria than in many other countries in Europe and has deteriorated over time. The incidence of catastrophic health spending rose from 17% of households in 2005 to 18% in 2010 and 19% in 2018.

Access to health care, measured in terms of unmet need for health and dental care due to cost, distance and waiting time, has improved substantially and is now on a par with the EU average. Unmet need for prescribed medicines due to cost is higher than the EU average, however. Socioeconomic inequalities in unmet need for health and dental care persist but are much smaller than before.

Catastrophic spending mainly affects poorer households, people living in rural areas and older people. There is likely to be significant crossover between these three groups as older people and people living in rural areas are at much higher risk of poverty or social exclusion than others. The increase in catastrophic incidence over time has been driven by an increase in the poorest quintile.

Outpatient medicines are the main driver of catastrophic spending across all years for all except the richest households. Among richer households, financial hardship is mainly driven by spending on medical products (since 2018) and inpatient care (since 2015).

Significant gaps in all three dimensions of coverage have different effects on poorer and richer households. Limited coverage of health services such as dental care and medical products seems to result in unmet need for poorer households and financial hardship for richer households. However, gaps in the coverage of outpatient medicines result in both unmet need *and* financial hardship for poorer households.

Efforts to reduce unmet need and financial hardship should give priority to two key policy areas: improving the affordability of outpatient medicines and strengthening protection from out-of-pocket payments for poorer households and people with chronic conditions.

Co-payment policy design can be strengthened through exemptions for poorer households and people with chronic conditions and an annual income-based cap. The lack of exemptions from co-payments for outpatient medicines is unusual by international standards. Outpatient medicines account for 90% of catastrophic spending in the poorest quintile and exemptions would therefore lead to a significant reduction in financial hardship for poorer people covered by the NHIF. At present there is only a cap on co-payments for inpatient care. Extending this annual cap to all co-payments would enhance financial protection, and the impact on the NHIF's budget could be minimized by linking the cap to income so it is more protective for poorer than richer households.

Improving the way in which the NHIF purchases outpatient medicines will also reduce financial hardship. The NHIF should continue to reduce medicine prices and ensure that health care providers and pharmacies have incentives to prescribe and dispense the cheapest alternatives. This is particularly important where co-payments are in the form of percentage co-payments and therefore linked to prices. Reducing the very high rate of VAT imposed on medicines (at 20%, one of the highest rates in the EU) would also help to reduce out-of-pocket payments.

The Government should find ways to ensure the NHIF covers the whole population. Although the share of uninsured people has decreased over time, around 15% of the population still lack NHIF coverage. About a quarter of the uninsured are long-term unemployed people who cannot afford to pay contributions but are not entitled to SHI contributions paid by the Government. As a first step, the Government can begin to pay SHI contributions for people living below the poverty line who are not entitled to social support. It is also worth reviewing the costs and benefits of penalizing non-payment of SHI contributions by restricting access to health care; enforcing the collection of taxes and mandatory contributions should be the responsibility of the National Revenue Agency and not the health system.

Public spending on health has increased in recent years, but it remains low by EU standards and has not kept pace with increases in out-of-pocket payments or been used to target unmet need and financial protection, especially for poorer people. Efforts to strengthen coverage policy, reduce out-of-pocket payments and improve access and financial protection will not only require sustained increases in public spending in the coming years, but also careful use of any additional public investment to ensure it meets equity and efficiency goals.

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Annex 1. Household budget surveys in Europe

What is a household budget survey? Household budget surveys are national sample surveys that aim to measure household consumption of goods and services over a given period of time. In addition to information about consumption expenditure, they include information about household characteristics.

Why are they carried out? Household budget surveys provide valuable information on how societies and people use goods and services to meet their needs and preferences. In many countries, the main purpose of a household budget survey is to calculate weights for the Consumer Price Index, which measures the rate of price inflation as experienced and perceived by households (Eurostat, 2015). Household budget surveys are also used by governments, research entities and private firms wanting to understand household living conditions and consumption patterns.

Who is responsible for them? Responsibility for household budget surveys usually lies with national statistical offices.

Are they carried out in all countries? Almost every country in Europe conducts a household budget survey (Yerramilli et al., 2018).

How often are they performed? EU countries conduct a household budget survey at least once every five years, on a voluntary basis, following an informal agreement reached in 1989 (Eurostat, 2015). Many countries in Europe conduct them at more frequent intervals (Yerramilli et al., 2018).

What health-related information do they contain? Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP). A new European version of COICOP known as ECOICOP, intended to encourage further harmonization across countries, was introduced in 2016 (Eurostat, 2016).

Information on health-related consumption comes under COICOP code 6, which is further divided into three groups, as shown in Table A1.1. In this study, health-related information from household budget surveys is divided into six groups (with corresponding COICOP codes): medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3).

In a very small minority of countries in Europe (Belgium, France, Luxembourg and Switzerland), people entitled to publicly financed health care may pay for treatment themselves, then claim or receive reimbursement from their publicly financed health insurance fund (OECD, 2019). In a wider range of countries, people may also be reimbursed by entities offering voluntary health insurance – for example, private insurance companies or occupational health schemes.

To avoid households reporting payments that are subsequently reimbursed, many household budget surveys in Europe specify that household spending on health should be net of any reimbursement from a third party such as the government, a health insurance fund or a private insurance company (Heijink et al., 2011).

Some surveys ask households about spending on voluntary health insurance. This is reported under a different COICOP code (12.5.3 Insurance connected with health, which covers "Service charges for private sickness and accident insurance") (United Nations Statistics Division, 2018).

Are household budget surveys comparable across countries?

Classification tools such as COICOP (and ECOICOP in Europe) support standardization, but they do not address variation in the instruments used to capture data (e.g. diaries, questionnaires, interviews, registers), response rates and unobservable differences such as whether the survey sample is truly nationally representative. Cross-national variation in survey instruments can affect levels of spending and the distribution of spending across households. It is important to note, however, that its effect on spending on health in relation to total consumption – which is what financial protection indicators measure – may not be so great.

An important methodological difference in quantitative terms is **owner-occupier imputed rent**. Not all countries impute rent and, among those that do, the methods used to impute rent vary substantially (Eurostat, 2015). In this series, imputed rent is excluded when measuring total household consumption.

Table A1.1. Health-related consumption expenditure in household budget surveys

Source: United Nations Statistics Division (2018).

COICOP codes	Includes	Excludes
06.1 Medical products, appliances and equipment 06.1.1 Pharmaceutical products 06.1.2 Other medical products 06.1.3 Therapeutic appliances and equipment	This covers medicaments, prostheses, medical appliances and equipment and other health-related products purchased by individuals or households, either with or without a prescription, usually from dispensing chemists, pharmacists or medical equipment suppliers. They are intended for consumption or use outside a health facility or institution.	Products supplied directly to outpatients by medical, dental and paramedical practitioners or to inpatients by hospitals and the like are included in outpatient services (06.2) or hospital services (06.3).
06.2 Outpatient services 06.2.1 Medical services 06.2.2 Dental services 06.2.3 Paramedical services	This covers medical, dental and paramedical services delivered to outpatients by medical, dental and paramedical practitioners and auxiliaries. The services may be delivered at home or in individual or group consulting facilities, dispensaries and the outpatient clinics of hospitals and the like. Outpatient services include the medicaments, prostheses, medical appliances and equipment and other health-related products supplied directly to outpatients by medical, dental and paramedical practitioners and auxiliaries.	Medical, dental and paramedical services provided to inpatients by hospitals and the like are included in hospital services (06.3).
06.3 Hospital services	Hospitalization is defined as occurring when a patient is accommodated in a hospital for the duration of the treatment. Hospital day care and home-based hospital treatment are included, as are hospices for terminally ill persons. This group covers the services of general and specialist hospitals; the services of medical centres, maternity centres, nursing homes and convalescent homes that chiefly provide inpatient health care; the services of institutions serving older people in which medical monitoring is an essential component; and the services of rehabilitation centres providing inpatient health care and rehabilitative therapy where the objective is to treat the patient rather than to provide long-term support. Hospitals are defined as institutions that offer inpatient care under the direct supervision of qualified medical doctors. Medical centres, maternity centres, nursing homes and convalescent homes also provide inpatient care, but their services are supervised and frequently delivered by staff of lower qualification than medical doctors.	This group does not cover the services of facilities (such as surgeries, clinics and dispensaries) devoted exclusively to outpatient care (06.2). Nor does it include the services of retirement homes for older people, institutions for disabled people and rehabilitation centres providing primarily long-term support (12.4).

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Annex 2. Methods used to measure financial protection in Europe

Background

The indicators used for monitoring financial protection in Europe are adapted from the approach set out in Xu et al. (2003, 2007). They also draw on elements of the approach set out in Wagstaff & Eozenou (2014). For further information on the rationale for developing a refined indicator for Europe, see Thomson et al. (2016) and WHO Regional Office for Europe (2019).

Data sources and requirements

Preparing country-level estimates for indicators of financial protection requires nationally representative household survey data that includes information on household composition or the number of household members.

The following variables are required at household level:

- total household consumption expenditure;
- food expenditure (excluding tobacco and alcohol if possible);
- housing expenditure, disaggregated by rent and utilities (such as water, gas, electricity and heating); and
- health expenditure (out-of-pocket payments), disaggregated by type of health care good and service.

Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP) (United National Statistics Division, 2018).

If the survey includes a household sampling weight variable, calculations should consider the weight in all instances. Information on household or individual-level characteristics such as age, sex, education and location are useful for additional equity analysis.

Defining household consumption expenditure variables

Survey data come in various time units, often depending on whether the reporting period is 7 days, 2 weeks, 1 month, 3 months, 6 months or 1 year. It is important to convert all variables related to household consumption expenditure to a common time unit. To facilitate comparison with other national-level indicators, it may be most useful to annualize all survey data. If annualizing survey data, it is important not to report the average level of out-of-pocket payments only among households with out-of-pocket payments, as this will produce inaccurate figures.

Total household consumption expenditure not including imputed rent

Household consumption expenditure comprises both monetary and in-kind payment for all goods and services (including out-of-pocket payments) and the money value of the consumption of home-made products. Many household budget surveys do not calculate imputed rent. To maintain cross-country comparability with surveys that do not calculate imputed rent, imputed rent (COICOP code 04.2) should be subtracted from total consumption if the survey includes it.

Food expenditure

Household food expenditure is the amount spent on all foodstuffs by the household plus the value of the family's own food production consumed within the household. It should exclude expenditure on alcoholic beverages and tobacco. Food expenditure corresponds to COICOP code 01.

Housing expenditure on rent and utilities

Expenditure on rent and utilities is the amount spent by households on rent (only among households who report paying rent) and on utilities (only among households who report paying utilities) including electricity, heating and water. These data should be disaggregated to correspond to COICOP codes 04.1 (for rent) and 04.4 and 04.5 (for utilities). Care should be taken to exclude spending on secondary dwellings. Imputed rent (COICOP code 04.2) is not available in all household budget surveys and should not be used in this analysis.

Health expenditure (out-of-pocket payments)

Out-of-pocket payments refer to formal and informal payments made by people at the time of using any health service provided by any type of provider (COICOP code 06). Health services are any good or service delivered in the health system. These typically include consultation fees, payment for medications and other medical supplies, payment for diagnostic and laboratory tests and payments occurring during hospitalization. The latter may include a number of distinct payments such as to the hospital, to health workers (doctors, nurses, anaesthesiologists etc.) and for tests. Both cash and in-kind payments should be included if the latter are quantified in monetary value. Both formal and informal payments should also be included. Although out-of-pocket payments include spending on alternative or traditional medicine, they do not include spending on health-related transportation and special nutrition. It is also important to note that out-of-pocket payments are net of any reimbursement to households from the government, health insurance funds or private insurance companies.

Estimating spending on basic needs and capacity to pay for health care

Basic needs expenditure is a socially recognized minimum level of spending considered necessary to ensure sustenance and other basic personal needs. This report calculates household-specific levels of basic needs expenditure to estimate a household's capacity to pay for health care.

Households whose total consumption expenditure is less than the basic needs expenditure level generated by the basic needs line are deemed to be poor.

Defining a basic needs line

Basic needs can be defined in different ways. This report considers food, utilities and rent to be basic needs and distinguishes between:

- households that do not report any utilities or rent expenses; their basic needs include food;
- households that do not report rent expenses (households that own their home outright or make mortgage payments, which are not included in consumption expenditure data), but do report utilities expenses; their basic needs include food and utilities;
- households that pay rent, but do not report utilities expenditure (for example, if the reporting period is so short that it does not overlap with billing for utilities and there is no alternative reporting of irregular purchases); their basic needs include food and rent;
- households that report paying both utilities and rent, so that their basic needs include food, utilities and rent.

Adjusting households' capacity to pay for rent (among renters) is important. Household budget surveys consider mortgages to be investments, not consumption expenditure. For this reason most do not collect household spending on mortgages. Without subtracting some measure of rent expenditure from those who rent, renters will appear to be systematically wealthier (and have greater capacity to pay) than identical households with mortgages.

To estimate standard (normative) levels of basic needs expenditure, all households are ranked based on their per (equivalent) person total consumption expenditure. Households between the 25th and 35th percentiles of the total sample are referred to as the representative sample for estimating basic needs expenditure. It is assumed that they are able to meet, but not necessarily exceed, basic needs for food, utilities and rent.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household's consumption and affect household ranking. Where this is an issue, it may be preferable to rank households by per equivalent person non-out-of-pocket payment consumption expenditure.

Calculating the basic needs line

To begin to calculate basic needs, a household equivalence scale should be used to reflect the economy scale of household consumption. The Organisation for Economic Co-operation and Development equivalence scale (the Oxford scale) is used to generate the equivalent household size for each household:

$$\text{equivalent household size} = 1 + 0.7 * (\text{number of adults} - 1) + 0.5 * (\text{number of children under 13 years of age})$$

Each household's total consumption expenditure (less imputed rent), food expenditure, utilities expenditure and rent expenditure is divided by the equivalent household size to obtain respective equivalized expenditure levels.

Households whose equivalized total consumption expenditure is between the 25th and 35th percentile across the whole weighted sample are the representative households used to calculate normative basic needs levels. Using survey weights, the weighted average of spending on food, utilities and rent among representative households that report positive values for food, utilities and rent expenditure, respectively, gives the basic needs expenditure per (equivalent) person for food, utilities and rent.

Note again that households that do not report food expenditure are excluded as this may reflect reporting errors. For households that do not report any rent or utilities expenses, only the sample-weighted food basic needs expenditure is used to represent total basic needs expenditure per (equivalent) person. For households that report utilities expenditures but do not report any rent expenses, the two basic needs expenditure sample-weighted averages for food and utilities are added to calculate total basic needs expenditure per (equivalent) person. For households that report rent expenditures but do not report any utilities expenses, the two basic needs expenditure sample-weighted averages for food and rent are added to calculate total basic needs expenditure per (equivalent) person. For households that report both rent and utilities, the three basic needs expenditure sample-weighted averages for food, utilities and rent are added to calculate total basic needs expenditure per (equivalent) person.

Calculating basic needs expenditure levels for each household

Calculate the basic needs expenditure specific to each household by multiplying the total basic needs expenditure per (equivalent) person level calculated above by each household's equivalence scale. Note that a household is regarded as being poor when its total consumption expenditure is less than its basic needs expenditure.

Capacity to pay for health care

This is defined as non-basic needs resources used for consumption expenditure. Some households may report total consumption expenditure that is lower than basic needs expenditure, which defines them as being poor. Note that if a household is poor, capacity to pay will be negative after subtracting the basic needs level.

Estimating impoverishing out-of-pocket payments

Measures of impoverishing health spending aim to quantify the impact of out-of-pocket payments on poverty. For this indicator, households are divided into five categories based on their level of out-of-pocket spending on health in relation to the poverty line (the basic needs line):

- no out-of-pocket payments: households that report no out-of-pocket payments;
- not at risk of impoverishment after out-of-pocket payments: non-poor households (those whose equivalent person total consumption exceeds the poverty line) with out-of-pocket payments that do not push them below 120% of the poverty line (i.e. households whose per equivalent person consumption net of out-of-pocket payments is at or above 120% of the poverty line);
- at risk of impoverishment after out-of-pocket payments: non-poor households with out-of-pocket payments that push them below 120% of the poverty line; this review uses a multiple of 120%, but estimates were also prepared using 105% and 110%;
- impoverished after out-of-pocket payments: households who were non-poor before out-of-pocket payments, but are pushed below the poverty line after out-of-pocket payments; in the exceptional case that capacity to pay is zero and out-of-pocket payments are greater than zero, a household would be considered to be impoverished by out-of-pocket payments; and
- further impoverished after out-of-pocket payments: poor households (those whose equivalent person total consumption is below the poverty line) who incur out-of-pocket payments.

Estimating catastrophic out-of-pocket payments

Catastrophic out-of-pocket payments are measured as out-of-pocket payments that equal or exceed some threshold of a household's capacity to pay for health care. Thresholds are arbitrary. The threshold used most often with capacity to pay measures is 40%. This review uses 40% for reporting purposes, but estimates were also prepared using thresholds of 20%, 25% and 30%.

Households with catastrophic out-of-pocket payments are defined as:

- those with out-of-pocket payments greater than 40% of their capacity to pay; i.e. all households who are impoverished after out-of-pocket payments, because their out-of-pocket payments are greater than their capacity to pay for health care; and
- those with out-of-pocket payments whose ratio of out-of-pocket payments to capacity to pay is less than zero (negative); i.e. all households who are further impoverished after out-of-pocket payments, because they do not have any capacity to pay for health care.

Households with non-catastrophic out-of-pocket payments are defined as those with out-of-pocket payments that are less than the pre-defined catastrophic spending threshold.

For policy purposes it is useful to identify which groups of people are more or less affected by catastrophic out-of-pocket payments (equity) and which health services are more or less responsible for catastrophic out-of-pocket payments.

Distribution of catastrophic out-of-pocket payments

The first equity dimension is expenditure quintile. Expenditure quintiles are determined based on equivalized per person household expenditure. Household weights should be used when grouping the population by quintile. Countries may find it relevant to analyse other equity dimensions such as differences between urban and rural populations, regions, men and women, age groups and types of household.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household's consumption and affect household ranking. Where this is an issue, it may be preferable to calculate quintiles based on non-health equivalized per person household expenditure.

Structure of catastrophic out-of-pocket payments

For households in each financial protection category, the percentage of out-of-pocket payments on different types of health goods and services should be reported, if the sample size allows, using the following categories, with their corresponding COICOP categorization: medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3). Where possible, a distinction should be made between prescription and over-the-counter medicines.

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Annex 3. Regional and global financial protection indicators

WHO uses regional and global indicators to monitor financial protection in the European Region, as shown in Table A3.1.

Table A3.1. Regional and global financial protection indicators in the European Region

Regional indicators	+	Global indicators
Impoverishing out-of-pocket payments		
Risk of poverty due to out-of-pocket payments: the proportion of households further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment after out-of-pocket payments using a country-specific line based on household spending to meet basic needs (food, housing and utilities)		Changes in the incidence and severity of poverty due to household expenditure on health using: <ul style="list-style-type: none"> • an extreme poverty line of PPP-adjusted US\$ 1.90 per person per day • a poverty line of PPP-adjusted US\$ 3.10 per person per day • a relative poverty line of 60% of median consumption or income per person per day
Catastrophic out-of-pocket payments		
The proportion of households with out-of-pocket payments greater than 40% of household capacity to pay for health care		The proportion of the population with large household expenditure on health as a share of total household consumption or income (greater than 10% or 25% of total household consumption or income)

Note: PPP: purchasing power parity.

Sources: WHO headquarters and WHO Regional Office for Europe.

Regional indicators

The regional indicators reflect a commitment to the needs of European Member States. They were developed by the WHO Barcelona Office for Health Systems Financing (part of the Division of Country Health Policies and Systems in the WHO Regional Office for Europe), at the request of the WHO Regional Director for Europe, to meet demand from Member States for performance measures more suited to high- and middle-income countries and with a stronger focus on pro-poor policies, in line with Regional Committee resolutions (see Annex 2).

At the regional level, WHO's support for monitoring financial protection is underpinned by the Tallinn Charter: Health Systems for Health and Wealth, Health 2020 and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020, all of which include the commitment to work towards a Europe free of impoverishing payments for health.

Global indicators

The global indicators reflect a commitment to global monitoring. They enable the performance of Member States in the European Region to be

easily compared to the performance of Member States in the rest of the world.

At the global level, support by WHO for the monitoring of financial protection is underpinned by World Health Assembly resolution WHA64.9 on sustainable health financing structures and universal coverage, which was adopted by Member States in May 2011. More recently, with the adoption of the 2030 Agenda for Sustainable Development and its concomitant Sustainable Development Goals (SDGs) in 2015, the United Nations has recognized WHO as the custodian agency for SDG3 (Good health and well-being: ensure healthy lives and promote well-being for all at all ages) and specifically for target 3.8 on achieving universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Target 3.8 has two indicators: 3.8.1 on coverage of essential health services and 3.8.2 on financial protection when using health services.

The choice of global or regional indicator has implications for policy

Global and regional indicators provide insights into the incidence and magnitude of financial hardship associated with out-of-pocket payments for health, but they do so in different ways. As a result, they may have different implications for policy and suggest different policy responses.

For example, the global indicator defines out-of-pocket payments as catastrophic when they exceed a fixed percentage of a household's consumption or income (its budget). Applying the same fixed percentage threshold to all households, regardless of wealth, implies that very poor households and very rich households spending the same share of their budget on health will experience the same degree of financial hardship.

Global studies find that this approach results in the incidence of catastrophic out-of-pocket payments being more concentrated among richer households (or less concentrated among poorer households) (WHO & World Bank 2015; 2017). With this type of distribution, the implication for policy is that richer households are more likely to experience financial hardship than poorer households. The appropriate policy response to such a finding is not clear.

In contrast, to identify households with catastrophic out-of-pocket payments, the regional indicator deducts a standard amount representing spending on three basic needs – food, housing (rent) and utilities – from each household's consumption expenditure. It then applies the same fixed percentage threshold to the remaining amount (which is referred to as the household's capacity to pay for health care). As a result, although the same threshold is applied to all households, the amount to which it is applied is now significantly less than total household consumption for poorer households but closer to total household consumption for richer households. This implies that very poor households spending small amounts on out-of-pocket payments, which constitute a relatively small share of their total budget, may experience financial hardship, while wealthier households are assumed to not experience hardship until they

have spent a comparatively greater share of their budget on out-of-pocket payments.

The approach used in the European Region results in the incidence of catastrophic out-of-pocket payments being highly concentrated among poor households in all countries (Cylus et al., 2018). For countries seeking to improve financial protection, the appropriate response to this type of distribution is clear: design policies that protect poorer households more than richer households.

Recent global studies most commonly report impoverishing out-of-pocket payments using absolute poverty lines set at US\$ 1.90 or US\$ 3.10 a day in purchasing power parity (WHO & World Bank 2015; 2017). These poverty lines are found to be too low to be useful in Europe, even among middle-income countries. For example, the most recent global monitoring report suggests that in 2010 only 0.1% of the population in the WHO European Region was impoverished after out-of-pocket payments using the US\$ 1.90 a day poverty line (0.2% at the US\$ 3.10 a day poverty line) (WHO & World Bank, 2017).

European studies make greater use of national poverty lines or poverty lines constructed to reflect national patterns of consumption (Yerramilli et al., 2018). While national poverty lines vary across countries, making international comparison difficult, poverty lines constructed to reflect national patterns of consumption – such as that which is used as the poverty line for the regional indicator – facilitate international comparison (Saksena et al., 2014).

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6. All weblinks accessed 27 July 2021.

Annex 4. 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 WHO Regional Office for Europe

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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