Can people afford to pay for health care?

New evidence on financial protection in Romania

Silvia Gabriela Scîntee
Ilaria Mosca
Cristian Vlădescu

Romania
WHO Barcelona Office for Health Systems Financing

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The Office supports countries to develop policy, monitor progress and design reforms through health system problem diagnosis, analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience. It is also the home for WHO training courses on health financing and health systems strengthening for better health outcomes.

Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.
Can people afford to pay for health care?

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Abstract

This review is part of a series of country-based studies generating new evidence on financial protection in Europe. Financial protection is central to universal health coverage and a core dimension of health system performance. The incidence of catastrophic health spending is high in Romania compared to many countries in the European Union and higher than expected given Romania’s relatively low reliance on out-of-pocket payments to finance the health system. It is heavily concentrated among poorer households and older people, reflecting gaps in all three dimensions of health coverage (population entitlement, service coverage and user charges), weaknesses in purchasing policy and low levels of public spending on health. Financial hardship is mainly driven by out-of-pocket payments for outpatient medicines and has increased over time, particularly among poorer households. To reduce unmet need and financial hardship, the Government should focus on improving the affordability of outpatient medicines (including over-the-counter treatment) and dental care. This can be done by finding ways to: ensure the National Health Insurance House (NHIH) covers the whole population; introduce exemptions from co-payments for low-income households and people with chronic conditions; introduce an annual cap on all co-payments and link the cap to household income; improve NHIH purchasing policy; limit balance billing and extra billing; and pay attention to informal payments and service quality. These efforts will require sustained increases in public spending on health. Any new additional funds should be carefully allocated to meet equity and efficiency goals.

Keywords

HEALTHCARE FINANCING
HEALTH EXPENDITURES
HEALTH SERVICES ACCESSIBILITY
FINANCING, PERSONAL
POVERTY
ROMANIA
UNIVERSAL COVERAGE
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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WHO gratefully acknowledges funding from the Government of the Autonomous Community of Catalonia, Spain.
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<td>Eurasian Economic Community</td>
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<td>EHIS</td>
<td>European Health Interview Survey</td>
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<td>EU</td>
<td>European Union</td>
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<td>EU-SILC</td>
<td>European Union Statistics on Income and Living Conditions</td>
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<tr>
<td>GDP</td>
<td>gross domestic product</td>
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<td>HTA</td>
<td>health technology assessment</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>INN</td>
<td>international nonproprietary names</td>
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<td>NHIIH</td>
<td>National Health Insurance House</td>
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<td>NYHA</td>
<td>New York Heart Association functional classification</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>OTC</td>
<td>over-the-counter medicines</td>
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<td>PPS</td>
<td>purchasing power standards</td>
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<td>RON</td>
<td>Romanian leu</td>
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<tr>
<td>SHI</td>
<td>social health insurance</td>
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<td>VHI</td>
<td>voluntary health insurance</td>
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Executive summary

This review is the first comprehensive analysis of financial protection in the health system in Romania. Drawing on data from the household budget survey carried out in 2010 and 2015, data on unmet need for health services up to 2020 and information on coverage policy (population entitlement, service coverage and user charges) up to 2021, it finds that:

- the incidence of impoverishing health spending and catastrophic health spending is high in Romania compared to many other European Union (EU) countries and higher than expected given that the out-of-pocket payment share of current spending on health in Romania (19%) is below the EU average (22%);

- 5.6% of households experienced impoverishing health spending in 2015, up from 4.5% in 2010, and 12.5% experienced catastrophic health spending, up from 10.4% in 2010;

- catastrophic health spending is largely driven by out-of-pocket payments for outpatient medicines and is heavily concentrated among the poorest households and older households;

- the increase in the incidence of catastrophic spending over time was largest among poorer households; in 2015 36% of households in the poorest consumption quintile experienced catastrophic spending, up from 28% in 2010; and

- although unmet need for health care and dental care has fallen over time it remains well above the EU average, particularly for poorer people; unmet need for prescribed medicines due to cost is also above the EU average.

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

A large share of the population (12%) is uninsured and only has access to a few publicly financed health services. This is because access to National Health Insurance House (NHIH) benefits is based on payment of contributions, which is problematic because not everyone with a low income is exempt from paying contributions and low-income people may not be able to afford to contribute. Uninsured people are most likely to be Romanians living or working abroad but still domiciled in Romania, and people not registered for unemployment or social benefits.
NHIH coverage of dental care is limited in scope and very few dentists are contracted. As a result, almost all dental care is paid for out of pocket, leading to unmet need, particularly for poorer households, and financial hardship.

Other issues related to service coverage include concerns about informal payments (to health workers and for medicines and supplies), service quality, ageing infrastructure in public hospitals and limited access to services in rural areas owing to a shortage of health facilities and professionals.

User charges in the form of percentage co-payments are applied to outpatient medicines, dental care, spa treatment and rehabilitation. Although many outpatient medicines are exempt from co-payments (including medicines for specific diseases under national health programmes) and children, students and pregnant women are also exempt, there are no exemptions from co-payments specifically targeting low-income adults and there is no overall cap on user charges. The use of percentage co-payments is particularly problematic when prices are high or fluctuating and when physicians and pharmacists do not prescribe and dispense cheaper alternatives.

Weaknesses in the coverage and purchasing of medicines result in relatively high levels of spending on over-the-counter (OTC) medicines, which accounted for 66% of all spending on outpatient medicines in 2018. Most spending on OTC medicines is through out-of-pocket payments.

The increase in catastrophic health spending between 2010 and 2015 was driven by a substantial increase in out-of-pocket payments for outpatient medicines in the poorest quintile.

Deteriorating financial protection has coincided with levels of public spending on health that are low by EU standards, reflecting inadequate government budget transfers to the NHIH.

To strengthen access and financial protection, policy should focus on:

- ensuring the NHIH covers the whole population so that everyone has access to the same benefits: the Government can begin to pay social health insurance (SHI) contributions for people living below the poverty line who are not entitled to social support and consider de-linking entitlement from payment of contributions – penalizing non-payment of contributions by restricting access to health care is not consistent with the goals of universal health coverage;
• increasing protection from co-payments for low-income people and people with chronic conditions by extending exemptions from co-payments to low-income households and introducing an income-based cap on all co-payments;

• continuing to improve the way in which the NHIH purchases medicines, including over-the-counter (OTC) medicines;

• strengthening NHIH coverage and purchasing of dental care to address high levels of unmet need and financial hardship;

• monitoring and addressing the root causes of informal payments, limiting balance billing and extra billing and improving service quality in public facilities; and

• increasing government budget transfers to the NHIH and ensuring that any additional funds are carefully allocated to reduce socioeconomic inequalities in access and financial protection.
1. Introduction
This review assesses the extent to which people in Romania experience financial hardship when they use health services, including medicines. It covers the period from 2010 to 2021, drawing on data from the household budget survey in 2010 and 2015 (the latest available year), data on unmet need for health care up to 2020 and information on coverage policy – the way in which health coverage is designed and implemented – up to 2021. The focus is 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.

Public spending on health is low in Romania due to the relatively small share of government spending allocated to health (12.8% in 2019 versus a European Union (EU) average of 14%) and the very small size of government spending relative to GDP (36.2% in 2019 versus an EU average of 43.1%). As a result, public spending on health as a share of GDP (4.6% in 2019) is well below the EU average (6%) (WHO, 2021). Despite this, the out-of-pocket payment share of current spending on health (19% in 2018) is also below the EU average (22%) (WHO, 2021).

Romania’s economy was hit hard by the 2008 global financial crisis, although the shock to GDP was short-lived (Eurostat, 2021). The health budget, mainly staff wages, was cut in 2011 as part of wider austerity measures adopted by the Government in response to the crisis. The crisis also prompted reforms in the health sector, such as some rationalization of the hospital network and improved procurement of medicines (World Bank, 2021).

Public spending on health per person has grown in real terms since 2016, but there is scope for further public spending, particularly to counter the low level of government budget support to the National Health Insurance House (NHIH), the purchasing agency. In 2019 government budget transfers to the NHIH on behalf of the 64% of the NHIH insured who are exempt from paying contributions accounted for only 14% of NHIH revenue.

This review is the first comprehensive analysis of financial protection in Romania. Several global or European studies include data for Romania but do not provide context-specific analysis (Xu et al., 2003; Xu et al., 2007; WHO & World Bank, 2015, 2017; Organisation for Economic Co-operation and Development (OECD), 2019). The methods used in this study are different from those used in previous analysis (Yerramilli et al., 2018).

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 detailed 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

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<tr>
<td><strong>Definition</strong></td>
<td>The share of households impoverished or further impoverished after out-of-pocket payments</td>
</tr>
<tr>
<td><strong>Poverty line</strong></td>
<td>A basic needs line, calculated as the average amount spent on food, housing (rent) and utilities (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household consumption distribution who report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development (OECD) 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 capacity to pay for health care (see below)</td>
</tr>
<tr>
<td><strong>Poverty dimensions captured</strong></td>
<td>The share of households further impoverished, impoverished and at risk of impoverishment after out-of-pocket payments 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</td>
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<td><strong>Disaggregation</strong></td>
<td>Results can be disaggregated into household quintiles by consumption and by other factors where relevant</td>
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<td><strong>Catastrophic health spending</strong></td>
<td></td>
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<tr>
<td><strong>Definition</strong></td>
<td>The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Out-of-pocket payments</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>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 poverty line (basic needs line) to measure impoverishing health spending</td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>Results are disaggregated into household quintiles by consumption per person using OECD 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</td>
</tr>
<tr>
<td><strong>Data source</strong></td>
<td>Microdata from national household budget surveys</td>
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2.2 Data sources

The study analyses anonymized microdata from household budget surveys submitted to Eurostat every five years by the National Institute of Statistics of Romania in 2010 and 2015 (the latest year of available data validated by Eurostat). The data sample consisted of 31,336 households in 2010 and 30,625 in 2015 (National Institute of Statistics of Romania, 2010, 2015). Household budget survey data for 2020 have not yet been validated by Eurostat, so the report does not monitor the impact of COVID-19 on financial protection.

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 Romanian Leu (RON), with notes on inflation-adjusted spending where relevant. In 2019 RON 100 had the equivalent purchasing power of €PPS 40 (purchasing power standards) in the average EU country. The equivalent purchasing power was calculated using the World Bank GDP deflator indicator, with 2015 as the base year to obtain values in real terms.
3. Coverage and access to health care
This section briefly describes the governance and dimensions of publicly financed health coverage (population entitlement, the benefits package and user charges) in Romania 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

Publicly financed health coverage is regulated by Law 95/2006 on Health Care Reform (Parliament of Romania, 2006), a Governmental Decision known as “The Framework Contract” and a Common Order signed by the President of the NHIH and the Minister of Health representing “The application norms of the Framework Contract”.

The Framework Contract and its norms are issued periodically (annually before 2013 and every two years since then). They define the scope of the publicly financed benefits package, the terms under which providers deliver publicly financed health services, provider payment mechanisms and contracting terms such as quality criteria.

Established in 1999, the NHIH administers and regulates most publicly financed health services. Its budget is divided among the 43 district health insurance houses and the health insurance house of the military and law enforcement institutions, which are responsible for contracting public and private health providers.

Changes to coverage policy are summarized in Table 2.

3.1.1 Population entitlement

Health insurance is mandatory for all citizens and residents. The basis for entitlement to NHIH benefits is payment of contributions.

Employees, self-employed people, people with other taxable income and people without taxable income must pay contributions to be able to access NHIH health services. People with an income above the gross annual minimum wage (RON 27 600 in 2021) pay a contribution of 10% of their taxable income. People with no taxable income can opt to be covered for 12 months by paying a contribution of 10% on the equivalent of six months of gross minimum wages (about RON 1380 in 2021). Having a minimum contribution base makes social health insurance (SHI) contributions regressive.

The government transfers funds to the NHIH on behalf of 19 groups of people (Parliament of Romania, 2006):

- children aged under 18 years;
- students under 26 years or people coming from child protection institutions with no income;
- dependent spouses and parents of an insured person;

---

1. Between 2016 and 2019 different arrangements applied: people with no taxable income could either pay a monthly contribution of 5.5% on the gross national minimum wage (about RON 69 in 2016) or pay a contribution of 5.5% on seven national monthly minimum wages (approximately RON 480 in 2016).
• military veterans and their widows;
• victims of political persecutions between 1945 and 1989;
• people with disabilities;
• people without income with chronic conditions covered by national health programmes;
• women during pregnancy and post-partum;
• people on sick leave due to occupational illness or injury;
• people on maternity or adoption leave;
• registered unemployed people;
• people receiving social benefits, which includes all those with an income below the minimum wage;
• people under arrest or detention;
• people applying for refugee status;
• victims of human trafficking, for up to 12 months;
• pensioners with pensions or income from intellectual property;
• monks, nuns and other people living and working in monasteries;
• volunteers working in emergency services; and
• construction workers from 2019 to 2028.

In 2020 only about 36% of those covered by the NHIH paid contributions themselves, down from 41% in 2010.

The share of the population covered by the NHIH has grown slowly from 85.2% in 2010 to 87.2% in 2019. Uninsured people are most likely to be Romanians living or working abroad but still domiciled in Romania and people not registered for unemployment or social benefits (Vlădescu et al., 2016; Romanian Court of Accounts, 2020). There is no monitoring of uninsured people.

Before 2017 people were denied access to NHIH health services if their employers were not paying contributions. This barrier to access was addressed in 2018.

At the point of service delivery, people need to demonstrate their insurance status by:

• showing the electronic confirmation generated by the Electronic Information Health Insurance Platform on the basis of a valid health insurance card or the 13-digit national identification number;
• showing confirmation issued by the NHIH for people who lack or do not want to have an electronic health insurance card; or
• showing ID or a birth certificate for children under 14 years.

The electronic health insurance card was introduced in 2015. Some health care providers still require paper proof of having paid contributions or a document certifying that the person belongs to one of the categories exempt from contributing (Parliament of Romania, 2006).
### Table 2. Changes to coverage policy, 2000–2021

<table>
<thead>
<tr>
<th>Year</th>
<th>Change</th>
<th>Health services targeted</th>
<th>People targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>Number of covered medicines extended, particularly medicines with 0% co-payment</td>
<td>Outpatient prescribed medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td>2006</td>
<td>Negative list extended</td>
<td>All NHIH benefits</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Minimum benefits introduced for uninsured people</td>
<td>Life-threatening emergencies, some communicable diseases, family planning and care during pregnancy and childbirth</td>
<td>Uninsured people</td>
</tr>
<tr>
<td>2009</td>
<td>Percentage co-payment for list B reduced from 50% to 10% for low-income pensioners</td>
<td>Outpatient prescribed medicines</td>
<td>Pensioners with with a gross monthly income &lt; RON 1299 (in 2020)</td>
</tr>
<tr>
<td>2012</td>
<td>E-prescriptions introduced</td>
<td>Outpatient prescribed medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Extra billing for superior hospital accommodation capped</td>
<td>Inpatient care</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>SHI contributions paid by non-employed people collected by the tax agency rather than the NHIH</td>
<td>All NHIH benefits</td>
<td>Self-employed people</td>
</tr>
<tr>
<td>2013</td>
<td>Fixed co-payments introduced for hospital admissions with exemptions for children, students and other groups of people</td>
<td>Inpatient care</td>
<td>Insured people</td>
</tr>
<tr>
<td>2014</td>
<td>Health technology assessment (HTA) introduced to inform the selection of benefits</td>
<td>Outpatient and inpatient prescribed medicines</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>Coverage extended to selected groups of people</td>
<td>All NHIH benefits</td>
<td>Pensioners living in EU and Eurasian Economic Community (EEC) countries; EU and EEC citizens not insured in another Member State; cross-border workers (at own request)</td>
</tr>
<tr>
<td>2015</td>
<td>Electronic health insurance card introduced</td>
<td>All NHIH benefits</td>
<td>Insured people</td>
</tr>
<tr>
<td>2016</td>
<td>People entitled to buy needed supplies and be refunded by the hospital</td>
<td>Inpatient care</td>
<td>Insured people</td>
</tr>
<tr>
<td></td>
<td>NHIH benefits extended</td>
<td>Home care, speech therapy, psychological counselling, kinesitherapy</td>
<td>People receiving palliative care</td>
</tr>
<tr>
<td></td>
<td>Removal of referral from the family physician</td>
<td>Hospital oncology services</td>
<td>People enrolled in the National Cancer Treatment Programme</td>
</tr>
<tr>
<td></td>
<td>Cap on extra billing for superior hospital accommodation replaced with other constraints</td>
<td>Inpatient care</td>
<td>Insured people</td>
</tr>
<tr>
<td>2019</td>
<td>New exemptions from co-payments</td>
<td>Outpatient care, Diagnostic services</td>
<td>Romanian victims of human trafficking; detainees, arrested and imprisoned people without income</td>
</tr>
<tr>
<td>2020</td>
<td>NHIH benefits extended</td>
<td>Speech therapy, psychological counselling, kinesitherapy, breast reconstruction</td>
<td>People with autism, people with breast cancer surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teledicine in primary health care services and outpatient care services</td>
<td>Insured people</td>
</tr>
<tr>
<td>2021</td>
<td>New regulation of extra billing for publicly financed health services in private facilities</td>
<td>Inpatient care</td>
<td>Insured people</td>
</tr>
</tbody>
</table>
3.1.2 Service coverage

Uninsured people are entitled to a minimal package of services covering treatment of life-threatening emergencies, some outpatient services, a few dental services, some communicable diseases and care during pregnancy and childbirth (OECD, 2019; Romanian Court of Accounts, 2020).

Insured people are entitled to a relatively comprehensive benefits package that has been updated every two years since 2014.

**Primary care** services are provided by family doctors and include emergency care, preventive services and health education, a general check-up every three years for people aged over 18 years, monitoring of people with chronic conditions, antenatal care, family planning and home visits for people with limited mobility and women after delivery. People need a family doctor referral to access laboratory and imaging diagnostics, outpatient care and inpatient care. **Emergency care** does not require referral.

**Outpatient specialist care** includes consultations for diagnostic services, referral to laboratory or imagistic investigations, referral to inpatient, palliative or home care, monitoring of discharged patients (two follow-up visits) and patients with chronic conditions (four visits per trimester per insured patient), different diagnostic, therapeutic or minor surgery procedures, rehabilitation services, non-medical services (psychology, kinesitherapy, logopaedic services) and breast and uterine cancer screening. The benefits package also includes a list of 98 laboratory services and 108 imagistic diagnostic procedures.

About 25 dental services are included in the NHIH benefits package and are provided by public or private NHIH-contracted dentists, with percentage co-payments (see section 3.1.3). Emergency dental services are fully covered. Because the level of public funding for dental care is low (accounting for less than 0.2% of the NHIH budget in 2021) and contracting requirements are not financially attractive to dentists (due to low tariffs and a monthly cap per dentist of RON 2000), people generally end up paying out of pocket for dental care provided by non-contracted private practices. This limits access to dental care and the protective effect of exemptions from co-payments for dental care, which apply only in public facilities.

**Inpatient care** includes hospital rehabilitation treatment, physical therapy, massage and medical gymnastics programmes, home care and transportation related to medical treatment.

There is a positive list of covered outpatient medicines. The list has expanded over time, rising from 1195 international nonproprietary names (INN) in 2008 to 1382 in 2020 (Government of Romania, 2020). A separate list (Order of the President of the NHIH) specifies the NHIH reference price, the specific products (commercial names) covered for each INN and user charges (co-payments). Since 2014 the health technology assessment (HTA) unit in the National Agency for Medicines and Medical Devices has advised the Ministry of Health on the selection of outpatient and inpatient medicines and on user charges (see section 3.1.3). Outpatient
medicines are prescribed by INN and pharmacists are obliged to inform people about the cheapest medicine within the INN group.

The NHIH benefits package covers medical devices to correct eyesight and hearing, for prostheses of the limbs, continence and oxygen therapy devices and other prescribed specialized medical products.

Other NHIH benefits include sick pay and hospital accommodation for people accompanying children up to 3 years of age and people with a severe disability if the physician considers this necessary.

Services that are not covered by the NHIH are on a negative list: occupational illness and injury (covered by other schemes), some expensive hospital services, some dental services, in vitro fertilization, cosmetic surgery and medical services without referral. The number of items on the negative list has expanded slightly over time.

Waiting times seem not to be an issue, although data are limited. Official waiting lists apply to diagnostic services such as computerized tomography scans and laboratory tests. There are no waiting time guarantees.

There are other issues with service coverage, however. For example, access to services is more limited in rural areas (see section 3.2). In addition, poor-quality service, particularly in public hospitals in rural areas, old infrastructure and informal payments to health workers are problematic, particularly in public facilities (mainly hospitals but also outpatient settings) (see section 4.2). People may also have to pay informally for medicines and supplies in hospitals. This practice was prohibited in 2015; from 2016 people have been entitled to buy the needed items and be refunded by the hospital (Government of Romania, 2016).

### 3.1.3 User charges

Most health services are free at the point of use. User charges are applied mainly to outpatient medicines, dental care, inpatient care and spa treatment and rehabilitation (Table 3).

**Outpatient prescribed medicines** are classified in four groups with different coverage levels (Table 4). User charges are in the form of percentage co-payments (0%, 10%, 50% and 80%) and, since 2003, reference pricing (people pay the difference between the tariff and the retail price). Many outpatient medicines are, however, in the 0% co-payment category – for example, medicines for some severe diseases and medicines in national health programmes for communicable diseases, cancer, diabetes and mental illness (see Table 4 for details). In 2020 just over 70% of all items on the positive list for outpatient medicines were exempt from co-payments. Children, students under 26 years old and pregnant women are also exempt.

Percentage co-payments also apply to covered dental care and spa treatment and rehabilitation. Fixed co-payments were introduced for inpatient care (hospital admissions) in 2013. Children, students under 26 years old and some other groups are exempt from these co-payments.
(see Table 3 for details). The exemption from dental care co-payments only applies to treatment in public facilities, however, of which there are very few.

**Balance billing** is allowed for publicly financed health services in private facilities (mainly in hospitals), which are relatively widespread. People pay out of pocket for any difference between NHIH and hospital tariffs. In July 2021 a new rule on balance billing was introduced to improve transparency by obliging all private NHIH-contracted hospitals to publish their tariffs online. This change also aims to encourage balance billing to be covered by VHI.

**Extra billing** is allowed for superior accommodation in NHIH-contracted hospitals (fewer than three beds in a room with a private toilet, bath facilities, domestic appliances such as TV and fridge and better meals). It is mainly applied in public hospitals. In 2013 extra billing was capped at RON 300 per day. The cap was replaced in 2018 with a different kind of constraint: hospitals can offer superior accommodation only if standard accommodation is guaranteed for all patients who need to be admitted. Given the poor condition of most public hospitals, it is rarely possible to find space for superior accommodation and at the same time offer standard accommodation to everyone else.

With the exception of the introduction of a fixed co-payment for hospital admissions in 2013, changes to user charges policy have mainly aimed to increase protection from co-payments (Table 2).

<table>
<thead>
<tr>
<th>Service area</th>
<th>Type and level of user charge</th>
<th>Exemptions</th>
<th>Cap on user charges paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic tests and other paramedical services</td>
<td>None</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Inpatient prescription medicines</td>
<td>None</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Medical products</td>
<td>People pay any difference between the reference price and the retail price</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>None in public facilities Balance billing in private facilities</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Outpatient prescribed medicines</td>
<td>Percentage co-payment: see Table 4 for details</td>
<td>Medicines for specific diseases, medicines in national health programmes, children &lt; 18 years, students &lt; 26 years and pregnant women (see Table 4 for details)</td>
<td>No</td>
</tr>
<tr>
<td>Dental care</td>
<td>Percentage co-payment: 40% of the price</td>
<td>In public facilities only: children &lt; 18 years, students &lt; 26 years, military veterans and revolution fighters</td>
<td>No</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>Fixed co-payment: RON 5–10 per hospital admission Extra billing for superior accommodation</td>
<td>Exemption from co-payments only: children &lt; 18 years; students &lt; 26 years; people covered by national health programmes; pregnant women without income; retired people with a gross monthly income &lt; RON 1299 (in 2020); Romanian victims of human trafficking; detainees and prisoners without income</td>
<td>No</td>
</tr>
<tr>
<td>Spa treatment and rehabilitation</td>
<td>Percentage co-payment: 35% of the tariff for 14–21 days; 100% of the tariff for stays &gt; 21 days Extra billing for superior accommodation</td>
<td>Exemption from co-payments only: military veterans and revolution fighters</td>
<td>No</td>
</tr>
</tbody>
</table>
3.1.4 The role of VHI

VHI plays a very minor role in the health system, accounting for 0.5% of current spending on health in 2018 (WHO, 2021). It mainly plays a supplementary role, offering people access to superior accommodation in (public) hospitals, choice of provider and access to treatment in private facilities. It is not known how many people are covered by VHI.

VHI is subsidized by the Government; up to €400 spent on VHI can be deducted annually from taxable income.

Private providers offer “medical subscriptions packages”, which are often purchased by employers as an additional benefit for their employees. These packages initially covered occupational health services but are now purchased mainly to give people access to private facilities with better service quality and infrastructure compared to public hospitals. They

Table 4. User charges for covered outpatient medicines, 2021

<table>
<thead>
<tr>
<th>Category of medicine</th>
<th>Type and level of user charge</th>
<th>Service limits</th>
<th>Exemptions</th>
<th>Cap on user charges paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Generics (149 medicines in 2020)</td>
<td>10%</td>
<td>One or more prescriptions per month for up to seven different medicines</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>B Expensive generics and branded medicines (222 medicines in 2020)</td>
<td>50%</td>
<td>One or more prescriptions per month for up to seven different medicines</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>C (990 medicines in 2020)</td>
<td></td>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>C1 Medicines for specific diseases: heart failure stage III and IV NYHA; hepatitis; cirrhosis; leukaemia; epilepsy; Parkinson’s; multiple sclerosis; psychiatric diseases; polyarthritis; severe endocrine diseases; rare diseases</td>
<td>No</td>
<td>One or two prescriptions per month for each disease for up to three different medicines</td>
<td>NA</td>
<td>No</td>
</tr>
<tr>
<td>C2 Medicines in national health programmes: communicable diseases such as HIV, AIDS, tuberculosis and flu; cancer; multiple sclerosis; diabetes and other endocrine disorders; rare diseases; transplants; renal failure; treatment for addiction</td>
<td>No</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>C3 Medicines for children, students under 26 years old and pregnant women: these three groups of people are exempt from co-payments for all other prescribed medicines</td>
<td>No</td>
<td>One prescription per month for up to four different medicines</td>
<td>NA</td>
<td>No</td>
</tr>
<tr>
<td>D Medicines with a low HTA score (21 medicines in 2020)</td>
<td>80%</td>
<td>One or more prescriptions per month for up to seven different medicines</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

For all covered outpatient prescribed medicines people pay any difference between the reference price and the retail price. If service limits are exceeded (that is, people need more prescriptions per month), people have to pay in full out of pocket.

Source: authors.


Table 4. User charges for covered outpatient medicines, 2021
account for an additional 0.1% of current spending on health (Stranciu, 2017).

Table 5 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>
<thead>
<tr>
<th>Coverage dimension</th>
<th>Population entitlement</th>
<th>Service coverage</th>
<th>User charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues in the governance of publicly financed coverage</td>
<td>Entitlement to NHIH benefits depends on payment of contributions</td>
<td>Geographical variation in access to services due to lack of human and financial resources</td>
<td>Heavy percentage co-payments for some outpatient prescribed medicines and for dental care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service quality, particularly in public hospitals in rural areas</td>
<td>No exemption from percentage co-payments for low-income adults</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informal payments</td>
<td></td>
</tr>
<tr>
<td>Main gaps in publicly financed coverage</td>
<td>Around 12% of people entitled to NHIH coverage are uninsured</td>
<td>NHIH coverage of dental care is limited</td>
<td>Outpatient prescribed medicines</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dental care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Balance billing in private outpatient and inpatient facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Extra billing for superior accommodation in inpatient care</td>
</tr>
<tr>
<td>Are these gaps covered by VHI?</td>
<td>No – VHI accounts for only 0.5% of current spending on health, provides access to superior accommodation in hospital, choice of provider and coverage of services in private facilities, and does not cover NHIH co-payments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.2 Access, use and unmet need

EU data on unmet need (Box 1) show that access to health care and dental care is much more of a problem in Romania than in the EU on average (Fig. 1). Although the share of people with unmet need for health and dental care has fallen substantially in Romania over the last decade, from around 12% in 2011 to just under 5% in 2020, it remains well above the EU average.

There is marked income inequality in unmet need (Fig. 2). In 2020 the poorest people faced significantly higher levels of unmet need for health and dental care than the richest people. Unmet need for health and dental care has been growing in the poorest quintile and decreasing among the richest since 2018, increasing the gap between rich and poor. Age-related inequality in unmet need is also an issue, particularly for health care (Fig. 2).
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 routinely collected 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 collect data on unmet need for health and dental care through the European Union Statistics on Income and Living Conditions (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, 2018).

EU Member States also collect data on unmet need through European Health Interview Survey (EHIS), which is 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.
In 2014 Romania had the lowest self-reported use of prescribed and non-prescribed medicines in the EU. Around 23% of people in Romania reported using outpatient prescribed medicines compared to an EU average of 49%, and around 15% reported using non-prescribed medicines, compared to an EU average of 35% (Eurostat, 2021). This suggests there may be barriers to accessing medicines. European Health Interview Survey (EHIS) data show that unmet need for prescribed medicines due to cost was higher than the EU average in 2014 and was marked by sharp socioeconomic and age-related inequality (Fig. 3).

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

Notes: population is people aged over 16 years and over; bigger markers in 2010 and 2015 correspond to the available years of the household budget survey data.

Source: EU-SILC data from Eurostat (2021).
Fig. 2. Income and age inequality in unmet need for health care and dental care due to cost, distance and waiting time in Romania

Notes: population is people aged over 16 years and over; bigger markers in 2010 and 2015 correspond to the available years of the household budget survey data.

Source: EU-SILC data from Eurostat (2021).
Inequalities in unmet need can be partly explained by geographical variation in the supply of health-care workers and facilities and staff shortages. In 2019 Romania had the third lowest number of practising physicians per 1000 people in the EU (3.0 compared to an EU average of 3.8). The number of nurses per 1000 inhabitants (7.2) was also lower than the EU average (8.2).

Within Romania physician availability ranges from 5.5 physicians per 1000 inhabitants in Bucharest/Ilfov to 1.5 in South Muntenia (Eurostat, 2021), leading to significant differences in access between urban and rural areas. Fewer than a third of family doctors serve nearly half of the population that lives in rural areas. Rural areas also suffer from shortages of dentists, pharmacists and laboratory specialists and have high variations in the number of hospital beds per 100 000 people (Vlădescu et al., 2016). Barriers to access in rural areas may also be linked to distance to facilities, poor road quality, lack of public transport and high travel costs.

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

People needing care (%)  
Average  Least educated  Most educated  Over 65 years

Romania  
6.7  9.9  3.1  11.1

EU  
4.6  6.8  2.2  5.1

Note: least educated refers to people who left school at 16 or younger; most educated refers to people with tertiary education.

3.3 Summary

Health insurance is mandatory for all citizens and residents. The basis for entitlement to NHIH benefits is payment of contributions. In 2019 the NHIH covered only 87.5% of the population, up slightly from 86% in 2010. Uninsured people are most likely to be Romanians living or working abroad but still domiciled in Romania and people not officially registered for unemployment or social security benefits. There is no monitoring of uninsured people.

Uninsured people have access to a minimal package of services: treatment of life-threatening emergencies and some communicable diseases and care during pregnancy and childbirth.

The NHIH benefits package is relatively comprehensive for insured people, but coverage of dental care is limited in scope and few dentists are contracted. As a result, many people use non-NHIH contracted private dental services and pay the full cost out of pocket.

Most health services are free at the point of use. User charges in the form of percentage co-payments are applied to outpatient medicines, dental care and spa treatment and rehabilitation. Fixed co-payments for hospital admissions were introduced in 2013. Although many outpatient medicines are exempt from co-payments, as well as for children, students and pregnant women, there are no exemptions from any co-payments for low-income adults and there is no overall cap on user charges.

Balance billing is allowed for publicly financed health services in private facilities (mainly in hospitals), which are relatively widespread. Extra billing is allowed for superior accommodation in NHIH-contracted hospitals. It mainly applies in public hospitals.

VHI plays a very minor role in the health system, accounting for 0.5% of current spending on health in 2018. It mainly plays a supplementary role, offering people access to superior accommodation in (public) hospitals, choice of provider and access to treatment in private facilities. It is not known how many people are covered by VHI, which is subsidized by the Government.

There is significant regional variation in the availability of health services and health workers. Unmet need for health care and dental care due to cost, distance and waiting time has fallen over time but remains well above the EU average, particularly for poorer people. Unmet need for prescribed medicines due to cost is also above the EU average. Income inequality in unmet need for health care and dental care has grown in recent years. Age-related inequality is an issue for health care and prescribed medicines.
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.

### 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 NHIH. They include all formal and informal payments.

In 2015 on average 62% of households reported out-of-pocket payments, up from 54% in 2010 (Fig. 4). In both years households in the poorest consumption quintile were least likely to report out-of-pocket payments.

The annual average amount spent out of pocket per person rose from RON 325 (€PPS 130) in 2010 to RON 373 (€PPS 149) in 2015 (Fig. 5). Out-of-pocket payments increased in real terms for all except the richest quintile. The increase was sharpest in the poorest quintile. In both years there is a sharp social gradient in the amount spent out of pocket: richer households spend about three times more than poorer households.
Out-of-pocket payments also increased over time as a share of total household consumption (the household budget), rising on average from 4.5% in 2010 to 4.9% in 2015 (Fig. 6). All except the richest quintile experienced this increase. The increase was sharpest in the poorest quintile, rising from 2.6% to 3.7% (Fig. 6). In both years richer households spent proportionately more than poorer households but the gap between the quintiles became much more muted over time.

Fig. 5. Annual out-of-pocket spending on health care per person by consumption quintile

![Graph showing annual out-of-pocket spending on health care per person by consumption quintile from 2010 to 2015.]

Note: amounts are shown in real terms.
Source: authors, based on household budget survey data.

Fig. 6. Out-of-pocket payments for health care as a share of household consumption by consumption quintile

![Graph showing out-of-pocket payments for health care as a share of household consumption by consumption quintile from 2010 to 2015.]

Source: authors, based on household budget survey data.
Outpatient medicines accounted for the largest share of out-of-pocket payments (over 70%) in both years, followed by dental care (over 10%) (Fig. 7). Outpatient medicines dominate out-of-pocket spending in all quintiles, but their share rises with household consumption: in 2015 medicines accounted for 90% of out-of-pocket spending in the poorest quintile and 54% in the richest (Fig. 8). This difference across quintiles became more marked over time as a result of an increase in the dental care share among the three richest quintiles.

Fig. 7. Breakdown of total out-of-pocket spending by type of health care

Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data.
Over time the outpatient medicines share and inpatient care share decreased on average and the shares spent on all other types of health care increased (Fig. 7). The outpatient medicines share remained stable for the two poorest quintiles, however.

The overall shift in the composition of out-of-pocket spending was driven by a reduction in spending on inpatient care from RON 10 in 2010 to RON 3 in 2015, and increases in spending on most other types of health care.

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

Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data.
Although the increase in spending on outpatient medicines was rather small on average, about RON 20 (Fig. 9), it was driven by substantial increases in the two poorest quintiles – 53% in the poorest (about RON 40) and 32% in the second quintile (about RON 53) – in comparison to the richest quintile, where it fell by 17% (Fig. 10, top panel). Spending on dental care increased for all except the poorest quintile; the increase was substantial for the three middle quintiles (Fig. 10, middle panel). Spending on dental care is negligible in the two poorest quintiles, which is likely to reflect high levels of unmet need. Spending on outpatient care increased in all quintiles, but the increase was largest in the two poorest quintiles (Fig. 10, bottom panel).

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

Note: amounts are shown in real terms.
Source: authors, based on household budget survey data.
4.2 Informal payments

Informal payments are widespread and high in Romania. They occur mainly in public inpatient facilities and are more likely to be incurred by unemployed people and people living in rural areas (Horodnic et al., 2018).

A Eurobarometer report on corruption in 2019 found that 19% of survey respondents in Romania who had visited a public health care provider in the previous 12 months reported having had to make an extra payment, give a valuable gift to a nurse or doctor or make a donation to the hospital. This is far above the EU average of 5%, placing Romania at the top of EU countries (European Commission, 2020).
Measures to reduce informal payments in health care include a significant increase in health worker wages in public facilities; in 2018 wages rose by between 70% and 172% (Ministry of Health, 2018). There have also been several information campaigns to raise public awareness, criminal justice measures have targeted the embedded culture of informal payments, and a patient feedback questionnaire managed by the Ministry of Health that collects data on informal payments to health workers has been in place since 2016.

Informal payments reduce transparency, raise 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 (WHO Regional Office for Europe, 2019).

4.3 Trends in public and private spending on health

Data from national health accounts show that although public spending on health per person in real terms has increased over time (Fig. 11), growth slowed in the years after the 2008 global financial crisis, followed by a significant drop in 2011 and slow growth between 2013 and 2015 (Fig. 11). Part of the increase in public spending per person in 2013 was due to the payment of health system debts accumulated in 2011 and 2012 (a requirement of the International Monetary Fund (IMF)) and did not result in additional funds for patient care.

Out-of-pocket payments per person have also grown over time, but at a slower pace than public spending on health (Fig. 11). As a result, the out-of-pocket payment share has fallen slightly in recent years; at 18.9% in 2019, it was below the EU average of 20.9% and below comparator countries such as Bulgaria and Hungary (Fig. 12).

Broken down by health service and financing scheme, data from national health accounts show how the out-of-pocket payment share of current spending on health is substantially larger in Romania than the EU average for all types of health care except inpatient care (Fig. 13). In 2018 out-of-pocket payments accounted for 50% of current spending on outpatient medicines (compared to an EU average of 37%), 64% of current spending on medical products and 94% of current spending on dental care.
Fig. 11. Health spending per person by financing agent, in real terms


Fig. 12. Out-of-pocket payments as a share of current spending on health

Can people afford to pay for health care?

Fig. 13. Breakdown of current spending on health by health service and financing scheme, Romania and the EU, 2019

Notes: diagnostic tests refer to ancillary services, including laboratory services, imaging services and patient transportation. EU includes the United Kingdom.

Source: OECD (2021) for the EU and Eurostat (2021) and National Institute of Statistics (2020) for Romania.
4.4 Summary

Household budget survey data show that the share of households reporting out-of-pocket payments has grown over time, from 54% in 2010 to 62% in 2015. The increase was largest in the two poorest quintiles.

Poorer households are less likely to pay out of pocket than richer households, reflecting substantial socioeconomic inequality in unmet need for health and dental services, including prescribed medicines.

Out-of-pocket payments per person have grown in real terms and as a share of total household spending in all except the richest consumption quintile. By both measures, the increase was sharpest in the poorest quintile.

Outpatient medicines are the main driver of out-of-pocket spending in both years (over 70% of all out-of-pocket payments), followed by dental care (14% in 2015) and outpatient care (6% in 2015). Patterns of out-of-pocket payments vary across quintiles, however. Outpatient medicines dominate out-of-pocket spending in all quintiles but their share is much higher in the poorer quintiles, while the share spent on dental care is much higher in the richer quintiles.

Over time the increase in out-of-pocket payments was driven by a relatively small increase in spending on outpatient medicines overall, which was concentrated in the poorest quintiles, and by large relative increases in spending on outpatient care, dental care, diagnostic tests and medical products. Spending on inpatient care decreased.

Informal payments are an issue, particularly in inpatient care. Eurobarometer data consistently find the share of people reporting informal payments to be higher than in other EU countries. Informal payments reduce transparency, pose barriers to access and increase financial hardship. They are also likely to be regressive, placing the greatest financial burden on the poorest households.

Data from national health accounts indicate that public spending on health per person has increased over time in real terms, but there was almost no growth in the years after the 2008 global financial crisis, and growth only picked up again in 2016. Out-of-pocket payments per person have also grown steadily, but at a slower pace than public spending. In 2018 out-of-pocket payments accounted for about 20% of current spending on health, slightly below the EU average and well below comparator countries such as Bulgaria and Hungary. Broken down by health service and financing scheme, however, the out-of-pocket payment share of current spending on health is substantially higher in Romania than the EU average for all types of health care except inpatient care.
5. Financial protection
This section uses data from the Romanian 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.

5.1 How many households experience financial hardship?

5.1.1 Out-of-pocket payments and risk of impoverishment

Fig. 14 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 Romanian 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 RON 819 (€PPS 328) in real terms in 2015.

The risk of impoverishment increased between 2010 and 2015 (Fig. 14). The share of households impoverished and further impoverished after out-of-pocket payments rose from 4.5% of households in 2010 to 5.6% in 2015.

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Fig. 14. Share of households at risk of impoverishment after out-of-pocket payments

<table>
<thead>
<tr>
<th>Year</th>
<th>At risk of impoverishment</th>
<th>Impoverished</th>
<th>Further impoverished</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>8%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>2015</td>
<td>12%</td>
<td>6%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Notes: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments. It is further impoverished if its total spending is below the basic needs line before 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 spending are defined (in this review) as those that spend more than 40% of their capacity to pay for health care. This includes households that are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they had no capacity to pay before paying out of pocket for health care).

In 2015 12.5% of households experienced catastrophic levels of health spending, up from 10.4% in 2010 (Fig. 15).

Fig. 15. Share of households with catastrophic out-of-pocket payments

Source: authors, based on household budget survey data.

Catastrophic spending is concentrated among households that are further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 16). The share of further impoverished, impoverished and at risk of impoverishment households grew slightly over time.
5.2 Who experiences financial hardship?

Catastrophic spending is heavily concentrated among the poorest households. The increase in catastrophic spending over time was largely driven by increased incidence among the poorer quintiles. Catastrophic incidence in the poorest quintile grew from 28% in 2010 to 36% in 2015; it grew from 9% to 12% in the second quintile and fell in the richest quintile from 5% to 3% (Fig. 17).
The incidence of catastrophic health spending is much higher than average in households with at least one member over the age of 60 (Fig. 18). It has increased over time in older households, rising from 16% in 2010 to 20% in 2015, but the increase was not as pronounced in this group as in the poorest quintile.

Fig. 17. Share of households with catastrophic spending by consumption quintile

Fig. 18. Share of households with catastrophic spending on average, in households with older people and in the poorest quintile

Note: older households refers to households with at least one member aged > 60 years.

Source: authors, based on household budget survey data.
5.3 Which health services are responsible for financial hardship?

Outpatient medicines are the largest single driver of catastrophic health spending (Fig. 19). Their share decreased from 64% in 2010 to 61% in 2015. Dental care is the second largest driver of catastrophic spending; it increased over time from 15% to 18%. The shares spent on other services have also changed, but with varying patterns. The outpatient care share rose from 4% to 9%, while the inpatient care share fell from 8% to 2% (Fig. 20).

The outpatient medicines share of catastrophic spending is larger in poorer households than richer households for both years (Fig. 20). In 2015 outpatient medicines accounted for the largest share of catastrophic spending for all consumption quintiles except the richest. In the poorest quintile almost 90% of catastrophic spending is on outpatient medicines in both years. In the richest households the largest driver of catastrophic spending is dental care, which increased from 28% in 2010 to 38% in 2015 (Fig. 20).

Fig. 19. Breakdown of catastrophic spending by type of health care

![Diagram showing the breakdown of catastrophic spending by type of health care for 2010 and 2015.]

Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data.
5.4 How much financial hardship?

Among all households with catastrophic spending, the amount spent on health care as a share of total household spending rises progressively with income. These shares remained relatively stable over time. In 2015 the richest consumption quintile spent an average 46% of their budget on out-of-pocket payments, while the poorest quintile spent on average 9%.
The average out-of-pocket share among the very poorest households already living below the basic needs line – those further impoverished after out-of-pocket payments – increased from 6% in 2010 to 7% in 2015 (Fig. 21).

5.5 International comparison

The incidence of catastrophic spending on health in Romania is high compared to many EU countries, including central and eastern European countries such as Croatia, Czechia, Hungary, Poland, Slovakia and Slovenia, but below the level in some eastern countries, including Latvia and Lithuania (Fig. 22).
Fig. 22. Incidence of catastrophic spending on health and out-of-pocket share of total spending on health in selected European countries, latest year available

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

Source: WHO Regional Office for Europe (2019); WHO (2021).
In 2015 5.6% of households experienced impoverishing health spending (up from 4.5% in 2010) and 12.5% experienced catastrophic health spending (up from 10.4% in 2010).

Catastrophic spending was heavily concentrated in the two poorest consumption quintiles in both years and in older households and people living in the poorest geographical areas.

The increase in the incidence of catastrophic spending over time was largely driven by increased incidence in the poorest consumption quintile. The share of households in the poorest quintile with catastrophic spending rose from 28% in 2010 to 36% in 2015.

Outpatient medicines are the main driver of catastrophic spending overall. In both years the medicines share of catastrophic health spending is larger in poorer households than richer households. Dental care is the largest driver of catastrophic spending for the richest consumption quintile, reflecting unmet need for dental care in poorer households.

The share of households with catastrophic spending is high in Romania compared to many EU countries and much higher than expected in relation to the out-of-pocket payment share of current spending on health in Romania.
5. Summary

Financial protection is relatively strong in Sweden compared to many other EU countries, on a par with France, Germany and the United Kingdom.

In 2012, about 1% of households experienced impoverishing health spending (up from about 0.3% in 2006).

About 2% of households experienced catastrophic health spending in 2012, a share that has remained relatively stable over time.

Catastrophic health spending is heavily concentrated among households in the poorest quintile. Around 6% of households in the poorest quintile experienced catastrophic spending compared to around 1% in the other quintiles.

Overall, the largest contributors to catastrophic health spending are dental care and medical products. Among the poorest quintile, however, the largest contributor to catastrophic spending is outpatient medicines.

6. Factors that strengthen and undermine financial protection
This section considers the factors that may be responsible for financial hardship caused by out-of-pocket payments in Romania 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 health care – for example, changes in incomes and the cost of living – and then looks at factors in the health system.

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

Romania was hit hard by the 2008 global financial crisis but the shock was relatively short-lived (Duguleană, 2011). GDP fell sharply in 2009 and 2010 and unemployment rose (Eurostat, 2021). Since then GDP has grown strongly, especially from 2016 to 2019 (Eurostat, 2021). Income inequality has also grown, however, with the Gini coefficient rising from 34% in 2010 to 37% in 2015. It has fallen since then to 34% in 2020 but remains well above the EU average of around 30% (Eurostat, 2021).

Data from the household budget survey show very little change in average household capacity, the cost of meeting basic needs (food, housing, utilities) or the share of households living below the basic needs line between 2010 and 2015 (Fig. 23). In contrast, data on trends in disposable income show that while it grew during the study period, it has grown at a much faster rate since 2015 (Fig. 24). Measured in terms of disposable income, pensioners are relatively well-off compared to self-employed people, unemployed people and farmers (Fig. 24).

Fig. 23. Changes in the cost of meeting basic needs, capacity to pay and the share of households living below the basic needs line, in real terms

Note: capacity to pay for health care is measured as a household’s consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities.

Source: authors, based on household budget survey data.
Poverty rates are very high in Romania. At 31% in 2019, the share of people at risk of poverty or social exclusion was far above the EU average of 21% (Fig. 25). During the study period the share was much lower than average among older people in Romania and in the EU, reflecting rising unemployment during the economic crisis.
6.2 Health system factors

Gaps in coverage policy in Romania are likely to lead to both unmet need and financial hardship.

Although the number of uninsured people has decreased over time it remains very high compared to many other EU countries: in 2019 just
over 12% of the population was uninsured. The main reason for this is that population entitlement to NHIH benefits is based on payment of contributions, which is problematic because not everyone with a low income is exempt from paying contributions and low-income people may not be able to afford to contribute. Some people may also lack information on how to obtain access to NHIH benefits – something the NHIH has tried to address in 2021 through a new guide (NHIH, 2021). Romania’s minimum contribution base means that SHI contributions are regressive, imposing a proportionately heavier financial burden on poorer households than richer households.

There are also issues with service coverage.

• The publicly financed benefits package is split: uninsured people have access to a very limited range of benefits, which exacerbates inequality in access to health services and encourages inefficiency in their use.

• Although some dental services are covered by the NHIH, the level of public spending on dental care is very low because few dentists are contracted by the NHIH, meaning most spending on dental care comes from out-of-pocket payments.

• Informal payments are a problem, mainly in public inpatient facilities and among people in relatively vulnerable situations – for example, unemployed people and people living in rural areas (Horodnic et al., 2018). Measures to tackle informal payments have been in place since 2018, after the study period.

User charges (co-payments) apply to outpatient prescribed medicines, dental care, spa treatment and rehabilitation and inpatient care. Balance billing is permitted in any private facility and extra billing is permitted for superior accommodation in hospitals and for spa treatment. The design of co-payment policy, combined with balance and extra billing, add to the complexity of coverage policy.

Co-payment policy has some protective features: there are no co-payments for outpatient primary care or specialist consultations and diagnostic tests with referral; around 70% of covered outpatient medicines on the positive list are exempt from co-payments; children and students under 26 years old are exempt from most co-payments; other groups of people (including pregnant women and military veterans) are exempt from some co-payments; and co-payments for hospital admissions are in the form of fixed rather than percentage co-payments.

However, the lack of exemptions from co-payments for low-income adults, the absence of an overall income-based cap on co-payments and the use of percentage co-payments are important weaknesses in the design of co-payment policy. These weaknesses, along with other factors, are likely to contribute to financial hardship and unmet need for prescribed medicines, particularly for poorer and older households.

Percentage co-payments can be both unfair and inefficient, 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 when prices are relatively high or fluctuating and when physicians and pharmacists are not encouraged to prescribe and dispense cheaper alternatives (WHO Regional Office for Europe, 2019). New legislation from 2021 recommends that doctors prescribe cheaper alternatives when initiating a new treatment and switch to generics in some cases when the treatment is already under way.

The health services most likely to drive financial hardship in the two poorest quintiles, which is where catastrophic spending is concentrated, are outpatient medicines, outpatient care, and diagnostic tests (see Fig. 21). Catastrophic spending in richer households is also driven by dental care, outpatient medicines, and, to a much lesser extent, outpatient care.

Outpatient medicines are by far the largest driver of financial hardship in all except the richest quintile, where it is second to dental care. This is likely to reflect co-payments for prescribed medicines. The use of over-the-counter (OTC) medicines is also likely to be an important driver of catastrophic spending, particularly for poorer households. National data show that OTC medicines accounted for about a third of the outpatient medicines dispensed by pharmacies in 2018 and for two-thirds (66%) of current spending on outpatient medicines (National Institute of Statistics, 2020b). OECD data indicate that measured in purchasing power parities per person, current spending on outpatient medicines in Romania is among the lowest in the EU, but current spending on OTC medicines is relatively high, on a par with Austria, Germany, and Sweden in 2018 (OECD & EU, 2021). Also, high rates of self-medication, particularly with antibiotics, explain the significant use of OTC medicines (Lescure et al., 2018).

Such high use of OTC medicines may be explained by the transaction costs (including waiting time) involved in obtaining a prescription from a general practitioner or specialist and the fact that prescriptions may incur co-payments of over 50% of the reference price, especially when the cheapest alternatives are not available. Although INN prescribing is a requirement and pharmacists must also point out the cheapest alternative, anecdotal evidence suggests that users opt for more expensive medicines because of perceived better quality and due to marketing by pharmaceutical companies (Ion et al., 2020) and dispensing behaviour. Medicine prices are generally lower in Romania than in other EU countries but are relatively high in the national context. A comparative study of medicine prices in EU countries between 2013 and 2015 found that the cheapest medicines were never available in the poorest countries, including Romania (Zaprutko et al., 2017).

Dental care results in both unmet need and financial hardship (see Fig. 2 and Fig. 21), reflecting very limited coverage of dental care, heavy co-payments and weaknesses in NHIH purchasing of dental services. In 2019 the NHIH spent only 0.4% of its budget on dental care (NHIH, 2019) because it contracts very few dental practices. As a result, most people have to use non-contracted dentists and pay the full price out of pocket. Heavy percentage co-payments (40% of the price) for covered dental care is likely to be a significant access barrier for people reliant on contracted dentists. Children, students under 26 years old and military veterans are
exempt from dental care co-payments in public facilities, but in 2019 only 0.2% of dental practices were public (33 out of 15 542) (National Institute of Statistics, 2021b).

Although there are no co-payments for covered outpatient care and diagnostic tests, these health services play a role in catastrophic health spending in all consumption quintiles. This may reflect: use among uninsured people, who have to pay the full price out of pocket; the bypassing of the referral system by insured people; waiting lists for some diagnostic tests, pushing people to pay out of pocket for faster access to private facilities; and balance billing for publicly financed health services in private facilities, which are widespread for outpatient specialist services in policlinics and individual practices. From July 2021 greater transparency around balance billing in private inpatient facilities may curb some out-of-pocket spending for covered services.

Catastrophic spending on inpatient care has declined over time and in 2015 it mainly occurred in the richest quintile. This may reflect public views on quality of care, informal payments and dual practice. Quality is regarded as an issue in public hospitals, pushing people to use private facilities, which are generally perceived as offering better service quality and tend to be used by richer people. Informal payments are particularly common in inpatient care, where they may be paid to health workers and for medicines and supplies. Dual practice is permitted, enabling physicians to work in both public and private sectors for inpatient and outpatient services. Both informal payments and dual practice are likely to have a detrimental effect on financial protection and access to health services, especially for poorer households and people in vulnerable situations.

The increase in catastrophic health spending between 2010 and 2015 was driven entirely by increased incidence in the three poorest quintiles, with particularly sharp increases in the two poorest quintiles (see Fig. 17). This was in turn driven by a substantial increase in spending on outpatient medicines in the poorest quintile (see Fig. 10, top panel).

Many of these issues are linked to Romania’s relatively low level of public spending on health. In 2019 – the latest year for which internationally comparable data are available – public spending on health as a share of GDP was below what would be expected given Romania’s level of GDP per person (Fig. 26). It is lower in Romania (4.6%) than the EU average (6%) and neighbouring countries with similar or lower levels of GDP per person.
This low level of public investment in health reflects three factors: the share of government spending allocated to health (12.8% in 2019) is below the EU average (14%) (Fig. 27); and overall government spending is very low as a share of GDP and one of the lowest in the EU (Fig. 28).

As a share of GDP, public spending on health peaked at 4.6% in 2010, fell to 3.5% in 2011 due to a substantial cut to the health budget as part of wider austerity measures imposed by the IMF and other international financial institutions (European Commission, 2010) and fell again between 2013 and 2016. Part of the increase in 2013 was due to the payment of health system debts accumulated in 2011 and 2012 (an IMF requirement) and did not therefore result in additional funds for patient care.

The GDP share of public spending on health grew steadily between 2016 and 2019 (Fig. 29). This pushed down the out-of-pocket payment share of current spending on health (see Fig. 12). However, the high
Incidence of catastrophic health spending in Romania compared to other countries with similar levels of out-of-pocket payments (see Fig. 22) clearly indicates a need for more public investment in health and good protective measures for the poorest households.

Fig. 27. Share of government spending allocated to health, EU, 2019


Fig. 28. Government spending as a share of GDP, EU, 2019

Government budget transfers to the NHIH are a potential channel for increased public investment in health. These transfers account for a much lower share of NHIH revenue in Romania compared to other EU countries with SHI schemes (Fig. 30). When the share of NHIH revenue coming from government budget transfers (14% in 2018) is compared to the share of NHIH insured people it is intended to cover (66%), the imbalance is clear.
Fig. 30. Breakdown of public spending on health in EU countries with SHI schemes, 2018

Source: adapted from WHO Regional Office for Europe (2021).
6.3 Summary

Romania’s high incidence of catastrophic health spending reflects gaps in all three dimensions of health coverage and other factors.

Gaps in coverage are driven by weaknesses in policy design.

A large share of the population (12%) is uninsured and only has access to a few publicly financed health services. This is because access to NHIH benefits is based on payment of contributions, which is problematic because not everyone with a low income is exempt from paying contributions and low-income people may not be able to afford to contribute. Some people may also lack information on how to obtain NHIH benefits.

Access to publicly financed dental care is undermined by the limited scope of the benefits package and low levels of public spending, resulting in very few dentists being contracted by the NHIH. Dental care accounts for less than 1% of the NHIH budget, so almost all dental care is paid for out of pocket. This leads to unmet need, particularly for poorer households, and financial hardship.

Other issues related to service coverage include concerns about informal payments (to health workers and for medicines and supplies), service quality and ageing infrastructure in public hospitals and limited access to services in rural areas owing to a shortage of health facilities and professionals.

User charges in the form of percentage co-payments are applied to outpatient medicines, dental care, spa treatment and rehabilitation. Although many outpatient medicines are exempt from co-payments, as are children, students and pregnant women, there are no exemptions from co-payments specifically targeting low-income adults and there is no overall cap on user charges. The use of percentage co-payments is particularly problematic when prices are high or fluctuating and when physicians and pharmacists do not prescribe and dispense cheaper alternatives.

Weaknesses in NHIH medicines and purchasing policy result in relatively high levels of spending on OTC medicines, which account for 66% of all spending on outpatient medicines. Most spending on OTC medicines is through out-of-pocket payments.

The increase in catastrophic health spending between 2010 and 2015 was driven entirely by increased incidence in the three poorest quintiles, with particularly sharp increases in the two poorest quintiles. This was in turn driven by a substantial increase in out-of-pocket payments for outpatient medicines in the poorest quintile.

Deteriorating financial protection has coincided with a decline in public spending on health. This is low by EU standards, reflecting inadequate government budget transfers to the NHIH.
7. Implications for policy
Financial hardship linked to out-of-pocket payments is high in Romania compared to many EU countries and higher than expected given Romania’s share of out-of-pocket payments to finance the health system. Financial hardship has grown over time.

Catastrophic health spending is heavily concentrated in the two poorest consumption quintiles and among older households. The increase in the incidence of catastrophic spending between 2010 and 2015 was driven by an increase in the poorest quintile.

Outpatient medicines are the largest single driver of catastrophic spending for all except the richest quintile. For the richest households, dental care is the main driver of catastrophic spending. Almost all dental care is paid out of pocket, resulting in unmet need, particularly for poorer people, as well as financial hardship.

Although unmet need for health and dental care has fallen in recent years, it remains above the EU average, with significant income inequalities in access.

Deteriorating financial protection coincided with a decline in public spending on health between 2008 and 2016. As a share of GDP, public spending on health is low, reflecting the low share of government spending allocated to health (well below the EU average) and the very low share of GDP allocated to government spending (one of the lowest in the EU).

Efforts to reduce unmet need and financial hardship should focus on improving the affordability of outpatient medicines and dental care, particularly for poorer households and people with chronic conditions.

NHIH benefits should cover the whole population. Although the share of uninsured people has decreased over time, it remains high: around 12% of the population still lack NHIH coverage. Some of them are likely to be people who cannot afford to pay contributions but are not entitled to SHI contributions paid by the Government because they are not registered for unemployment or other social benefits. Some may also be people who lack information about how to obtain NHIH benefits. The Government can do several things to ensure everyone is covered:

- map uninsured people, who they are and how many, to understand why people lack coverage;
- provide better information and simplify the process of obtaining coverage;
- pay SHI contributions for people living below the poverty line who are not entitled to social support; and
- consider de-linking entitlement from payment of contributions: penalizing non-payment of SHI contributions by restricting access to health care is not consistent with the goals of universal health coverage.
Mechanisms to protect households from co-payments should benefit low-income households and people with chronic conditions. Many outpatient medicines are exempt from co-payments and children, students and pregnant women are also exempt from most co-payments. There are no exemptions from co-payments specifically targeting low-income adults, however, and there is no cap on co-payments.

Extending exemptions from co-payments to low-income households would reduce financial hardship for poorer people covered by the NHIH.

Introducing a cap on all co-payments would also enhance financial protection. The impact on the NHIH’s budget could be minimized by linking the cap to household income so it is more protective for poorer than richer households.

The NHIH should continue to invest in improving the way in which it purchases medicines, including OTC medicines. This could include strategies to ensure health-care providers and pharmacists dispense cheaper alternatives, reduce the transaction costs involved in obtaining prescriptions from general practitioners and specialists and improve the regulation of prescribed and OTC medicine prices.

NHIH coverage and purchasing of dental care should be strengthened to address high levels of unmet need, particularly among poorer households. This could be achieved by increasing the NHIH budget to contract dental practices, expanding entitlement to dental care, starting with low-income households, and through better contracting of dental services by the NHIH.

Other actions to reduce financial hardship include monitoring and addressing the root causes of informal payments, limiting balance billing and extra billing and improving service quality in public facilities.

Strengthening access and financial protection will require sustained increases in public spending on health. This could be achieved by increasing government budget transfers to the NHIH and ensuring that any additional funds are carefully allocated to address socioeconomic inequalities in access and financial protection, in line with equity and efficiency goals.
References


2. All references accessed 16 December 2021.


Government of Romania (2020). Hotărâre nr. 720 din 9 iulie 2008 (republicată) pentru aprobarea Listei cuprinzând denumirile comune internaționale corespunzătoare medicamentelor de care beneficiază asigurații, cu sau fără contribuție personală, pe bază de prescripție medicală, în sistemul de asigurări sociale de sănătate, precum și denumirile comune internaționale corespunzătoare medicamentelor care se acordă în cadrul programei naționale de sănătate) [Decision no. 720 from 9 July 2008 (republished) on approval of the list of International Nonproprietary Names of medicines to be fully or partially covered within health insurance system and medicines prescribed within the national health programmes – re-publication]. Official Gazette of the Government of Romania No. 479 (http://legislatie.just.ro/Public/DetaliiDocument/95556) (in Romanian).


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

<table>
<thead>
<tr>
<th>COICOP codes</th>
<th>Includes</th>
<th>Excludes</th>
</tr>
</thead>
<tbody>
<tr>
<td>06.1 Medical products, appliances and equipment</td>
<td>This covers medications, 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.</td>
<td>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).</td>
</tr>
<tr>
<td>06.1.1 Pharmaceutical products</td>
<td></td>
<td></td>
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<tr>
<td>06.1.2 Other medical products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06.1.3 Therapeutic appliances and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06.2 Outpatient services</td>
<td>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 outpatients 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.</td>
<td>Medical, dental and paramedical services provided to inpatients by hospitals and the like are included in hospital services (06.3).</td>
</tr>
<tr>
<td>06.2.1 Medical services</td>
<td></td>
<td></td>
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<tr>
<td>06.2.2 Dental services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06.2.3 Paramedical services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06.3 Hospital services</td>
<td>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.</td>
<td>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).</td>
</tr>
<tr>
<td>06.4 Inpatient services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


References


3. All references accessed 16 December 2021.


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:
equivalent household size = 1 + 0.7*(number of adults – 1) + 0.5*(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.

References


WHO Regional Office for Europe (2019). Can people afford to pay...


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

<table>
<thead>
<tr>
<th>Regional indicators</th>
<th>Global indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impoverishing out-of-pocket payments</td>
<td>Changes in the incidence and severity of poverty due to household expenditure on health using:</td>
</tr>
<tr>
<td>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)</td>
<td>• an extreme poverty line of PPP-adjusted US$ 1.90 per person per day</td>
</tr>
<tr>
<td></td>
<td>• a poverty line of PPP-adjusted US$ 3.10 per person per day</td>
</tr>
<tr>
<td></td>
<td>• a relative poverty line of 60% of median consumption or income per person per day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Catastrophic out-of-pocket payments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The proportion of households with out-of-pocket payments greater than 40% of household capacity to pay for health care</td>
<td>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)</td>
</tr>
</tbody>
</table>

### 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
All references accessed 16 December 2021

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).

References


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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