

Can people afford to pay for health care?

Evidence on financial
protection in 40 countries
in Europe



WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage (UHC). It works with Member States in Europe and Central Asia to promote evidence-informed policy making. It also offers training courses on health financing.

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Design by Aleix Artigal and Alex Prieto.

Abstract

Financial protection – affordable access to health care – is undermined when out-of-pocket payments for health care lead to financial hardship (impoverishing and catastrophic health spending) or create a barrier to access, resulting in unmet need for health care. This report summarizes the findings of a new study of financial protection in 40 countries in Europe, including the whole of the European Union, in 2019 or the latest available year before COVID-19. It finds that out-of-pocket payments lead to financial hardship and unmet need in every country in the study and are consistently most likely to affect households in the poorest fifth of the population. Financial hardship is largely driven by out-of-pocket payments for outpatient medicines, medical products and dental care – services that are commonly delivered or managed in primary care settings – indicating significant gaps in the coverage of primary care in many countries. The report identifies five coverage policy choices that countries should avoid because they undermine financial protection, equity, efficiency and resilience. It also identifies policy choices that have strengthened financial protection in countries with a low incidence of financial hardship and unmet need.

Keywords

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

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Albania: Sonila Tomini, Florian Tomini, *Genc Burazeri*

Armenia: *Saro Tsaturyan*, Anastas Aghazaryan

Austria: *Thomas Cypionka*, Gerald Röhring, Eva Six

Belgium: *Nicolas Bouckaert*, Charline Maertens de Noordhout, *Carine Van de Voorde*

Bosnia and Herzegovina: *Luka Vončina*, Vuk Čadenović, Anamarija Magazinović, Vlatka Martinović, Aleksandar Sekulić, Dejan Prošić

Bulgaria: *Antoniya Dimova*, Jorge García-Ramírez

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Cyprus: Antonis Kontemeniotis, *Mamas Theodorou*

Czechia: *Daniela Kandilaki*

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Ireland: *Sara Burke*, *Bridget Johnston*, Steve Thomas

Israel: *Ruth Waitzberg*, *Sharvit Fialco*

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Malta: *Kenneth Grech*, *Beatrice Farrugia*

Montenegro: *Milica Bakrač*

Netherlands (Kingdom of the): *Madelone Kroneman*

North Macedonia: *Vladimir Dimkovski*, Ilaria Mosca

Poland: *Marzena Tambor*, Milena Pavlova

Portugal: *Pedro Pita Barros*, Ana Rita Borges

Republic of Moldova: *Iuliana Garam*, Mariana Zadnipru, Valeriu Doronin, Denis Valac, Ala Negruta, Andrei Matei, Ilaria Mosca

Romania: *Silvia Gabriela Sîctee*, Christian Vlădescu, Ilaria Mosca

Serbia: Dragana Atanasijević, Nikola Križnik, Jovan Zubović, *Vesna Bjegovic-Mikanovic*

Slovakia: *Mária Pourová*

Slovenia: *Eva Šarec*, Dušan Jošar, Andrej Srakar

Spain: *Enrique Bernal-Delgado*, *Rosa Urbanos-Garrido*, Micaela Comendiro-Maaløe, Luz María Peña-Longobardo, Juan Oliva, Manuel Ridao-López

Sweden: *Anna Häger Glenngård*, Sixten Borg

Switzerland: Gabriela Flores Pentzke Saint-Germain, Catherine Korachais

Türkiye: Ali Riza Demirbas

Ukraine: *Alona Goroshko*, Natalia Shapoval, Nataliia Riabtseva, *Solomiya Kasyanchuk*

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Abbreviations

AME	<i>l'Aide Médicale de l'État</i> [the State Medical Aid scheme] (France)
AMP	affordable medicines programme (Ukraine)
CMU	<i>Couverture Universelle Maladie</i> [universal health coverage] (France)
COICOP	Classification of Individual Consumption according to Purpose
COVID-19	coronavirus disease
EHIS	European Health Interview Survey
EOPYY	<i>Εθνικός Οργανισμός Παροχής Υπηρεσιών Υγείας</i> [the National Organization for the Provision of Health Services] (Greece)
EU	European Union
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
IT	information technology
MISSOC	Mutual Information System on Social Protection
NHS	National Health Service
NHSU	National Health Service of Ukraine
OECD	Organisation for Economic Co-operation and Development
OTC	over the counter
SDGs	sustainable development goals
SHI	social health insurance
UHC	universal health coverage
VHI	voluntary health insurance

Countries and entities

ALB	Albania	KGZ	Kyrgyzstan
AND	Andorra	LTU	Lithuania
ARM	Armenia	LUX	Luxembourg
AUT	Austria	LVA	Latvia
AZE	Azerbaijan	MAT	Malta
BEL	Belgium	MDA	Republic of Moldova
BIH	Bosnia and Herzegovina	MKD	North Macedonia
BIH - F	Federation of Bosnia and Herzegovina	MNE	Montenegro
BIH - R	Republika Srpska	MON	Monaco
BLR	Belarus	NET	Netherlands (Kingdom of the)
BUL	Bulgaria	NOR	Norway
CRO	Croatia	POL	Poland
CYP	Cyprus	POR	Portugal
CZH	Czechia	ROM	Romania
DEN	Denmark	RUS	Russian Federation
EST	Estonia	SMR	San Marino
FIN	Finland	SRB	Serbia
FRA	France	SVK	Slovakia
GEO	Georgia	SVN	Slovenia
DEU	Germany	SPA	Spain
GRE	Greece	SWE	Sweden
HUN	Hungary	SWI	Switzerland
ICE	Iceland	TJK	Tajikistan
IRE	Ireland	TKM	Turkmenistan
ISR	Israel	TUR	Türkiye
ITA	Italy	UKR	Ukraine
KAZ	Kazakhstan	UNK	United Kingdom
		UZB	Uzbekistan

Foreword

Health systems in the European Region need to reduce their reliance on out-of-pocket payments. This report shows how this objective can be achieved.

1. DG NEAR: Directorate-General for Neighbourhood and Enlargement Negotiations; DG SANTE: Directorate-General for Health and Food Safety.

Progress towards universal health coverage (UHC) is held back by a major gap in the coverage of primary care. In both high- and middle-income countries in the Region financial protection is largely undermined by out-of-pocket payments for outpatient medicines, medical products (e.g. hearing aids) and dental care – types of care that should be an essential part of treatment in primary care settings. This gap has a particularly negative impact on people with low incomes and chronic conditions.

The report has a strong focus on how to improve financial protection. It identifies common coverage policy choices that countries should avoid and provides a good-practice checklist highlighting five policy choices that have been effective in countries with a low incidence of financial hardship and unmet need.

1. Entitlement to publicly financed health care is de-linked from payment of social health insurance contributions and the tax agency deals with non-payment (not the health system).
2. Refugees, asylum seekers and undocumented migrants are entitled to the same benefits as other residents and do not face administrative or other barriers to access.
3. User charges are applied sparingly and carefully designed to protect people with low incomes or chronic conditions through exemptions and caps and by replacing percentage co-payments with low, fixed co-payments.
4. Primary care coverage includes treatment, not just consultations and diagnosis, so that medicines, medical products and dental care are affordable for everyone.
5. Coverage policy is supported by an adequate level of public spending on health to ensure quality health services with minimal waiting times and no informal payments.

The report draws on data from 40 countries – including all European Union countries for the first time – and we are grateful to our partners at the European Commission (DG NEAR and DG SANTE)¹ for the collaboration and financial support that made this possible.

We call on countries to use the data and evidence we are generating through systematic country-level and comparative analysis to re-design those aspects of coverage policy that hold back progress. This evidence is now easily accessible on our new online platform, UHC watch, which tracks progress on affordable access to health care across the Region. In turn, we commit to standing by countries as they work to transform health systems with the aim of truly leaving no one behind.

Hans Henri P. Kluge

Director
WHO Regional Office for Europe

Natasha Azzopardi-Muscat

Director of the Division of Country
Health Policies and Systems
WHO Regional Office for Europe

Executive summary

Financial protection – affordable access to health care – is central to universal health coverage (UHC) and a core dimension of health system performance assessment. Without financial protection people may be forced to choose between health care and other basic needs, which can deepen poverty, erode health and well-being and increase inequalities.

This report summarizes the findings of a new study of financial protection in 40 countries in Europe, including the whole of the European Union (EU), in 2019 or the latest available year before the coronavirus disease pandemic.

Financial protection is undermined when out-of-pocket payments for health care lead to financial hardship (impoverishing and catastrophic health spending) or create a barrier to access, resulting in unmet need for health care.

Health systems need to reduce their reliance on out-of-pocket payments

Out-of-pocket payments lead to financial hardship and unmet need in every country in the study.

- The incidence of impoverishing health spending ranges from under 1% to 12% of households, with a median of 3% overall and 2% for the EU.
- Catastrophic health spending affects between 1% and 20% of households, with a median of 6% overall and 4% in the EU.

Country averages conceal major differences in impact. Financial hardship and unmet need are consistently most likely to affect households in the poorest fifth of the population.

In the majority of countries (28 out of 40) the incidence of catastrophic health spending has increased over time, with an average increase of 1.7 percentage points.

Financial hardship is largely driven by out-of-pocket payments for outpatient medicines, medical products and dental care – services that are commonly delivered or managed in primary care settings – indicating significant gaps in the coverage of primary care in many countries. In countries with a higher incidence of catastrophic health spending, financial hardship is overwhelmingly driven by outpatient medicines.

Out-of-pocket payments affect people differently.

- In poorer households, financial hardship is mainly driven by spending on outpatient medicines.
- Out-of-pocket payments for outpatient medicines result in both financial hardship and unmet need for poorer households.
- Out-of-pocket payments for dental care lead to financial hardship for richer households and unmet need for poorer households.

The incidence of catastrophic health spending is closely related to a health system's reliance on out-of-pocket payments. Across countries, public spending on health is shown to be much more effective in reducing out-of-pocket payments than voluntary health insurance (VHI).

Increases in public spending on health or reductions in out-of-pocket payments in general are not enough to improve financial protection in all contexts. Coverage policy – the way in which health coverage is designed and implemented – plays a key role in determining financial protection.

“Addiction” to bad ideas: the coverage policy choices that undermine financial protection and slow progress towards UHC

A country's reliance on out-of-pocket payments, and the distribution of those out-of-pocket payments across the population, are heavily influenced by coverage policy.

Some of the coverage policy choices countries make are “bad ideas” because:

- they have a disproportionately negative impact on people with low incomes or chronic conditions;
- they increase inefficiency in the use of health care;
- they weaken household and health system resilience to shocks;
- they do not reflect evidence; and
- better options are usually available.

The report highlights five coverage policy choices that countries should avoid.

1. Avoid linking entitlement to payment of contributions: This policy choice mainly occurs in countries with social health insurance (SHI) schemes. It penalizes people who do not pay the required contributions by restricting their access to some or all publicly financed health care. It leads to visible gaps in population coverage, particularly in countries with weak tax systems and a sizeable informal economy, and mainly harms people in precarious work. Precarious employment is a growing problem in Europe, so without action, this gap in coverage is likely to expand over time. The study finds that the median incidence of catastrophic health spending is three times lower in countries that cover over 99% of the population than in countries that cover less than 99%. In 16 out of the 17 countries that cover less than 99% of the population, the basis for entitlement is payment of contributions to a SHI scheme.

2. Avoid excluding people from coverage: This policy choice mainly harms undocumented migrants but can also harm refugees and asylum seekers. It leads to a less visible gap in population coverage because countries report covering the whole population even when they do not cover these groups of people and because these groups account for a very small share of the population. Entitlements for undocumented migrants are often limited to emergency care. All three groups are likely to face administrative and other barriers to accessing entitlements. Failing to cover the whole population undermines health system equity, efficiency and resilience.

3. Avoid applying user charges without effective protection mechanisms: A large body of evidence shows that user charges are not an effective way of directing people to use health services more efficiently. Even relatively small user charges can deter people from using needed health care, reduce adherence to treatment, increase the use of other health services, lead to financial hardship, increase the use of social assistance and adversely affect health, particularly among people with low incomes or chronic conditions. Despite this evidence, user charges are widely applied in Europe, most often to treatment in primary care settings. The study finds that countries that give greater protection from user charges to people with low incomes have lower levels of catastrophic health spending.

4. Avoid failing to cover treatment in primary care settings: This policy choice occurs in most countries in Europe. Countries often try to protect people from having to pay out of pocket for primary care consultations and diagnosis by including these services in the benefits package and

keeping them free from user charges. In contrast, most countries apply user charges to treatment in primary care settings (prescriptions, medical products like hearing aids, and dental treatment) and many exclude dental care for adults from the benefits package.

5. Avoid thinking VHI is the answer: VHI is often put forward as a solution to gaps in coverage, but in practice it increases inequality in access to health care and can undermine efficiency by skewing public resources away from need. In the few cases in which VHI plays a role in reducing financial hardship –covering user charges for most of the population in Croatia, France and Slovenia – inequalities in access to VHI persist, VHI is regressive and there are high transaction costs involved in managing a complex system. Other countries are unlikely to be able to replicate the relative success of VHI in Croatia, France and Slovenia, which comes at a cost to households and governments.

Progress is possible – a checklist for policy-makers

Drawing on evidence and good practice from across Europe, the report identifies policy choices that have been effective in strengthening financial protection in countries with a low incidence of financial hardship and unmet need.

Entitlement to publicly financed health care is de-linked from payment of SHI contributions and the tax agency deals with non-payment of SHI contributions and other taxes (not the health system).

Refugees, asylum seekers and undocumented migrants are entitled to the same benefits as other residents; everyone is aware of their entitlement; and there are no administrative barriers to accessing entitlements.

User charges are applied sparingly and are carefully designed so that people with low incomes or chronic conditions are automatically exempt from all user charges; there is an annual income-based cap on all user charges, which works automatically; there are no percentage co-payments; there is no balance billing or extra billing for medical services; and any co-payments in place are low and fixed and people know in advance exactly how much they have to pay when they see a doctor, undergo a diagnostic test, collect a prescription or are admitted to hospital.

Primary care coverage includes treatment, not just consultation and diagnosis, so that medicines, medical products (e.g. hearing aids) and dental care are affordable for everyone.

Coverage policy is supported by an adequate level of public spending on health so that there are no major staff shortages; no major issues with the quality and availability of services; no long waiting times for treatment; and no informal payments.

Many of the policies that undermine financial protection appear to be shaped more by historical and political factors than by evidence, reflecting the norms and assumptions of earlier eras. Today's context is different, however. It is now time for policy-makers to re-design those aspects of coverage policy that hold progress back.

Because the financial hardship and unmet need caused by out-of-pocket payments are heavily concentrated among people with low incomes, progress towards UHC means reducing out-of-pocket payments for the most disadvantaged people in society first – an approach known as progressive universalism. Progressive universalism is vital in contexts where public resources for health care are limited or under pressure. It also offers countries a way of strengthening their resilience to shocks: if coverage policy is designed to provide enhanced protection for those most in need, health systems and households will be better able to face economic or health crises.

There is huge variation in the health system starting point across the countries in the study. The actions countries take will reflect these differences. Countries with very low levels of catastrophic health spending may be able to strengthen financial protection without necessarily spending more on health. At the other end of the spectrum, however, countries with very high levels of catastrophic health spending will not be able to make progress without significant increases in public spending on health.

Limited fiscal space is a particular challenge for the middle-income countries in the study, making it more difficult to narrow the gap between countries quickly. But it is not impossible to do so. Countries that rely heavily on out-of-pocket payments can make progress by avoiding the coverage policy choices most likely to undermine financial protection, setting in place processes to identify priorities for action and taking consistent steps in the right direction.

Why monitor financial protection in Europe?

Financial protection: central to universal health coverage

Ensuring access to health care is affordable for everyone – financial protection – is central to universal health coverage (UHC).

Financial protection is undermined by out-of-pocket payments for health care. Out-of-pocket payments can be a barrier to access, resulting in unmet need for health care. They can also cause financial hardship for people using health services, leading to impoverishing and catastrophic health spending.

Without financial protection, people may be forced to choose between health care and other basic needs, which can deepen poverty, erode health and well-being and increase inequalities (WHO, 2010; WHO & World Bank, 2017; WHO Regional Office for Europe, 2019). For this reason, financial protection is widely regarded as a core dimension of health system performance assessment (Papanicolas & Smith, 2013).

Countries in the WHO European Region (hereafter Europe) first committed to strengthening financial protection through the Tallinn Charter on Health Systems for Health and Wealth, signed in 2008 (WHO Regional Office for Europe, 2008). This was followed by the Sustainable Development Goals (SDGs) in 2015 (SDG 3.8), the European Pillar of Social Rights (article 16) in 2017 and WHO's European Programme of Work (core priority 1) in 2020, all of which include a commitment to UHC (World Health Assembly, 2016; European Commission Secretariat-General, 2017; WHO Regional Office for Europe, 2021a).

Previous research has shown that a health system's reliance on out-of-pocket payments is a reasonably good indicator of financial hardship (Wagstaff et al., 2018; WHO Regional Office for Europe, 2019). We know from data on health accounts that all health systems involve a degree of out-of-pocket payment (Fig. 1) and that reliance on out-of-pocket payments is on average much higher for some types of health care – outpatient medicines, medical products and dental care – than others (Fig. 2).

Drawing on data from household surveys, quantitative analysis of financial protection adds value by shedding light on how out-of-pocket payments are distributed across the population; who is most likely to experience unmet need and financial hardship; and which services drive financial hardship. When combined with qualitative analysis of health financing policy, it also sheds light on what countries can do to mitigate the damage caused by out-of-pocket payments.

Fig. 1. Out-of-pocket payments as a share of current spending on health, Europe, 2021

Source: WHO (2023).

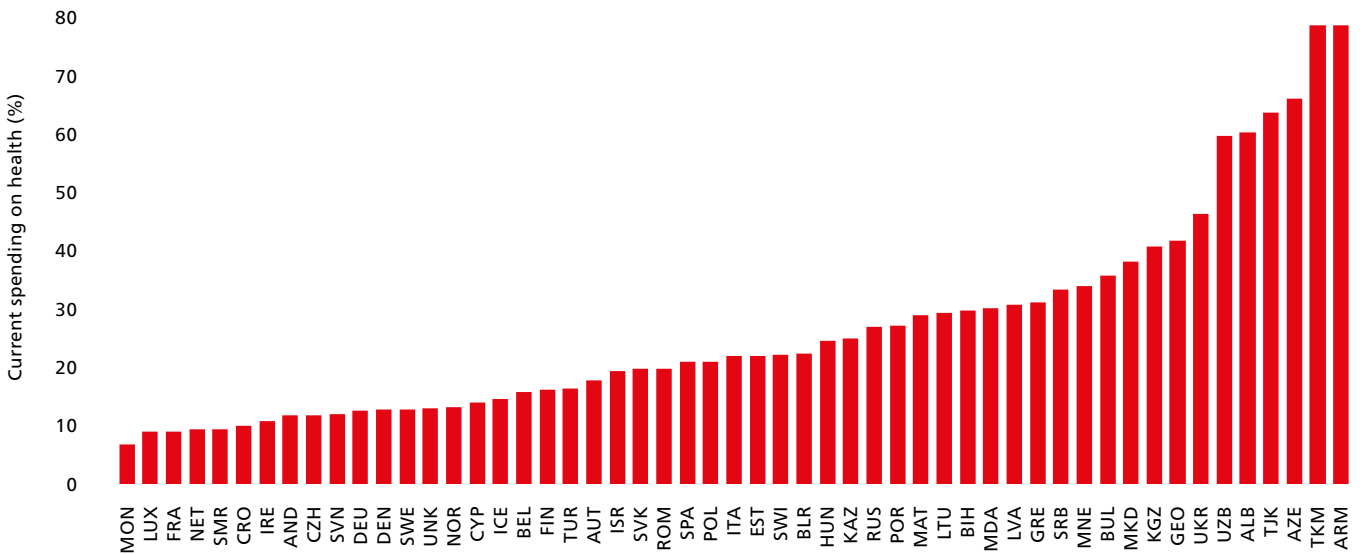
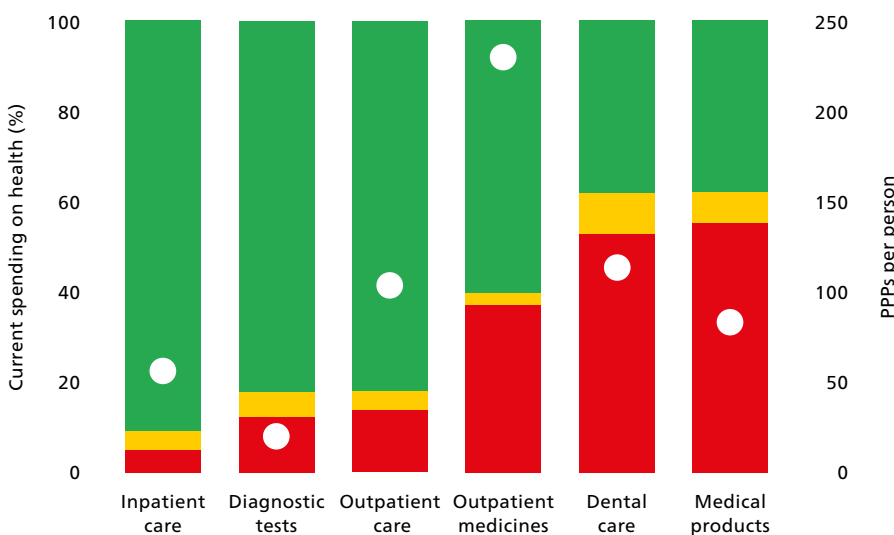


Fig. 2. Breakdown of current spending on health per person by type of health care and financing scheme (left axis) and out-of-pocket payments per person by type of health care (right axis), European Union countries, 2021

- Public spending on health (%)
- Voluntary health insurance (%)
- Out-of-pocket payments (%)
- Out-of-pocket payments (PPPs per person)



Notes: PPPs: purchasing power parities. Data are only available for European Union countries.

Source: Organisation for Economic Co-operation and Development (OECD, 2023a).

What is new in this report?

This study assesses financial protection in 40 countries in Europe in 2019 or the latest available year before the coronavirus disease (COVID-19) pandemic. It updates an earlier report (WHO Regional Office for Europe, 2019) to provide a pre-pandemic baseline for the Region.

We opted to use data from 2019 for two reasons.

- Household survey data collected during the pandemic (2020–2022) are unlikely to represent a “true” picture: some surveys were disrupted and patterns of household spending and health-seeking behaviour are likely to have been skewed by lockdowns and other factors, making them difficult to interpret from a comparative perspective.
- Post-pandemic survey data (2023) are not yet available for any country in Europe. For many countries, 2019 (or earlier) is the most recent year available for household budget survey data – the data used to monitor impoverishing and catastrophic health spending. These data have a typical time-lag of two years and many countries do not conduct the survey every year; even for European Union (EU) countries, 2020 data were not yet available from Eurostat at the time of press.

The earlier report included 23 of the countries in this study (Albania, Austria, Croatia, Cyprus, Czechia, Estonia, France, Georgia, Germany, Greece, Hungary, Ireland, Latvia, Lithuania, Poland, Portugal, Republic of Moldova, Slovakia, Slovenia, Sweden, Türkiye, Ukraine and the United Kingdom). This report adds 17 countries (Armenia, Belgium, Bosnia and Herzegovina, Bulgaria, Denmark, Finland, Israel, Italy, Luxembourg, Malta, Montenegro, Netherlands (Kingdom of the), North Macedonia, Romania, Serbia, Spain and Switzerland). It covers the whole of the EU for the first time. In 2019 29 of the 40 countries were classified as high income, nine as upper-middle income (Albania, Armenia, Bosnia and Herzegovina, Bulgaria, Georgia, Montenegro, North Macedonia, Serbia and Türkiye) and two as lower-middle income (Republic of Moldova and Ukraine).

The latest available year of data covered in the earlier report ranged from 2011 to 2016. In this report it ranges from 2015 to 2019. Numbers have been updated for countries participating in the original study except for Albania, Austria, Cyprus, Hungary, Ireland, Lithuania and Portugal.

As we now have at least two data points for each country, we include a simple analysis of the evolution of catastrophic health spending over time. We also include an exploratory analysis of catastrophic health spending during the COVID-19 pandemic for a small selection of countries for which data for 2020 and 2021 are available.

The chapter “New and updated numbers for Europe” summarizes the study’s findings on the incidence, distribution and drivers of financial hardship and unmet need and links them to levels of public and private spending on health. Drawing on evidence and good practice from across Europe, the chapter “The story behind the numbers” identifies and discusses the coverage policy choices that undermine financial protection.

A final chapter, “Progress is possible”, sets out a checklist for policy-makers based on coverage policy choices that have improved financial protection in countries with a low incidence of financial hardship and unmet need.

How financial protection is measured matters

Financial protection is measured using indicators of unmet need for health care and financial hardship due to out-of-pocket payments.

Data on unmet need come from household surveys that ask people if there was a time in the last year when they needed health care but were not able to access it due to cost, distance or waiting time (health system factors). We use data on unmet need for health care (medical examination or treatment) and dental care (dental examination or treatment) from European Union Statistics on Income and Living Conditions (EU-SILC), an annual survey carried out in EU countries and Albania, Montenegro, North Macedonia, Serbia, Switzerland and Türkiye. The latest available year of data is 2022. Data on unmet need for prescribed medicines due to cost are available from the European Health Interview Survey (EHIS) for EU countries and Serbia and Türkiye. The EHIS is carried out every 5–6 years and the latest available year of data is 2019.

Financial hardship is measured using two indicators.

- Impoverishing health spending provides information on the impact of out-of-pocket payments on poverty. A household is impoverished if its total spending (consumption) is below the basic needs line after out-of-pocket payments (i.e. it can no longer meet its basic needs – food, housing and utilities) and further impoverished if its total spending is below the basic needs line (i.e. it is already unable to meet its basic needs) and it incurs out-of-pocket payments.
- Catastrophic health spending occurs when the amount a household pays out of pocket is greater than its capacity to pay for health care, which may mean that the household can no longer afford to meet other basic needs (food, housing and utilities).

Impoverishing and catastrophic health spending can be calculated in different ways. This study uses metrics developed by the WHO Regional Office for Europe (Cylus, Thomson & Evetovits, 2018) building on established metrics (Wagstaff & van Doorslaer, 2003; Xu et al., 2003). We do not use the global measure of catastrophic health spending (SDG indicator 3.8.2) because it does not adequately capture equity (WHO & World Bank, 2017). SDG indicator 3.8.2 counts any household that spends more than 10% (or 25%) of its budget (its total consumption) on out-of-pocket payments as experiencing catastrophic health spending. It assumes that spending 10% of a budget on health care has the same effect on richer and poorer households. The WHO Regional Office for Europe measure accounts for differences in household capacity to pay for health

care and is therefore less likely than the SDG 3.8.2 method to overestimate financial hardship in richer households and underestimate it in poorer households (see WHO & World Bank, 2017; Cylus, Thomson & Evetovits, 2018; and WHO Regional Office for Europe, 2023a for a full explanation).

All financial hardship metrics draw on household budget surveys and define out-of-pocket payments as formal and informal payments made at the time of using any health care good or service delivered by any type of provider (OECD, WHO & Eurostat, 2017). Financial hardship is measured at household level. Efforts to capture financial hardship caused by out-of-pocket payments for specific types of health care (e.g. using SDG 3.b.3 on the affordability of medicines) or specific diseases (e.g. tuberculosis) are inappropriate.

See Box 1 for a summary of limitations with the household survey data we use to monitor financial protection.

To identify the factors that undermine financial protection, and to shed light on what countries can do to mitigate the damage caused by out-of-pocket payments, we link data on financial protection to coverage policy – the way in which health coverage is designed and implemented. Coverage policy is the primary mechanism through which people are exposed to out-of-pocket payments. It is a key determinant of the level and distribution of out-of-pocket payments in a country (WHO Regional Office for Europe, 2019).

Information on coverage policy comes from our series of country-based reports on financial protection and our new online platform, UHC watch (WHO Regional Office for Europe, 2023a), complemented in some cases by information from key informants from the European Financial Protection Network, the Mutual Information System on Social Protection (MISSOC) database (MISSOC, 2023) and Health Systems in Transition reports (European Observatory on Health Systems and Policies, 2023).

Throughout the report we present data for 2019 or the latest available year before the COVID-19 pandemic, for the reasons set out in the section “What is new in this report?”. Those interested in more recent data can:

- download health accounts data for 2021 (the latest year available) from the WHO Global Health Expenditure Database (WHO, 2023) or the Organisation for Economic Co-operation and Development (OECD) Health Statistics database (OECD, 2023a);
- download data on unmet need from EU-SILC for 2022 (the latest year available) or from EHIS for 2019 (the latest year available) from Eurostat (Eurostat, 2023a; 2023b);
- apply to Eurostat for access to harmonized microdata from national household budget surveys for 2020 (the latest year available) – according to Eurostat, these data will be available for 22 EU countries from December 2023 (Eurostat, 2023c); and
- download information on coverage policy for 2023 from UHC watch (WHO Regional Office for Europe, 2023a).

Box 1. The limitations of using household survey data to monitor financial protection

We use the most internationally comparable data available on unmet need and financial hardship, but the surveys they are derived from have some limitations.

The frequency of household budget surveys varies across countries. Only a few countries carry them out annually. Microdata are usually only available to researchers with a time lag of two years.

Classification tools such as the Classification of Individual Consumption according to Purpose (COICOP) and European COICOP support the standardization of household budget surveys across countries but do not fully address variation in instruments and implementation (United Nations Statistics Division, 2018; Eurostat, 2023c). Because financial hardship indicators measure household spending ratios rather than absolute amounts, however, we do not think this variation is a major issue.

COICOP captures out-of-pocket payments under the following categories: outpatient medicines; outpatient medical products (things like glasses, hearing aids, nebulizers and wheelchairs); outpatient care; outpatient dental care; outpatient diagnostic tests (services and products supplied by paramedical practitioners such as phlebotomists and physiotherapists); and inpatient care. It has recently introduced a separate category on long-term health care. National survey instruments do not routinely capture spending on long-term health care yet, and even when they do, it is likely to be underestimated because household budget surveys do not include people living in institutions. COICOP does not include a category on mental health care; this type of spending is reported under the other categories.

Self-reported data on unmet need should be interpreted with caution, especially across countries. However, research has found a positive relationship between unmet need and a subsequent deterioration in health (Gibson et al., 2019) and between unmet need and the out-of-pocket payment share of current spending on health (Chaupain-Guillot & Guillot, 2015), which suggests it can be a useful indicator of affordable access to health care.

The surveys we use focus on “private households” and do not adequately represent typically underserved groups of people, including undocumented migrants, homeless people and people living in institutions (Nicaise, Schockært & Bircan, 2019; Eurostat, 2023a; 2023b; 2023c), nor do they allow us to identify households with these characteristics. We have partly addressed this limitation by providing information on the types of publicly financed health care to which undocumented migrants are entitled (see Table 1 in “The story behind the numbers” chapter).

Despite these limitations, survey data enable valuable analysis. To improve data availability and quality, we encourage national statistics offices to carry out household budget surveys with greater regularity. We suggest

that EU-SILC could be improved by adding questions on unmet need for prescribed medicines and unmet need for selected medical products, in addition to health care and dental care. Countries that are not currently part of EU-SILC should join it or add EU-SILC questions on unmet need to their own surveys, so that it is possible to compare unmet need across more countries outside the EU.

New and updated
numbers for Europe

Financial hardship: impoverishing and catastrophic health spending

Out-of-pocket payments push people into poverty

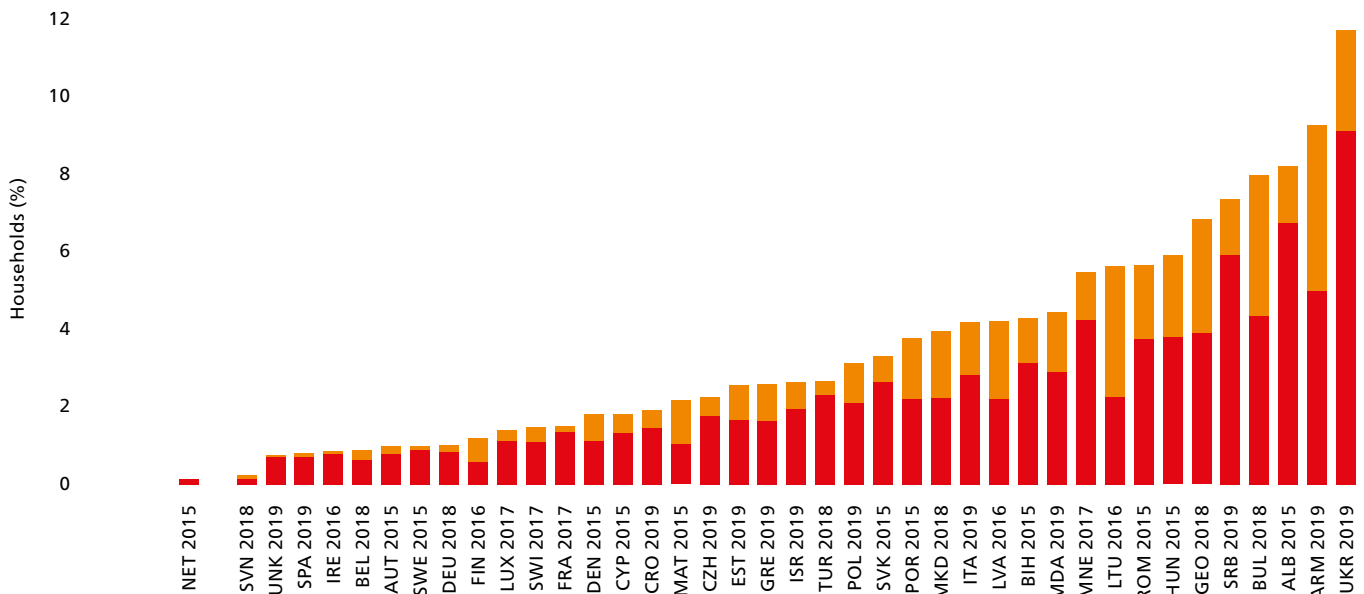
There is wide variation in the incidence of impoverishing health spending in Europe. The share of households that are impoverished or further impoverished after out-of-pocket payments ranges from under 1% of households in Belgium, Ireland, Spain, Slovenia and the United Kingdom to over 4% in Bosnia and Herzegovina, Georgia, Hungary, Italy, Latvia, Lithuania, Montenegro, the Republic of Moldova and Romania, and over 7% in Albania, Armenia, Bulgaria, Serbia and Ukraine, with a median value of 3% overall and 2% for the EU (Fig. 3).

Fig. 3. Share of households with impoverishing health spending, 2019 or the latest available year before COVID-19

- Impoverished
- Further impoverished

Note: Netherlands (Kingdom of the) cannot be compared to other countries because the Dutch household budget survey does not include the annual deductible amount households pay out of pocket for covered health care, biasing the results downwards.

Source: WHO Regional Office for Europe (2023a).



Out-of-pocket payments prevent people from meeting other basic needs and affect the poorest households the most

The incidence of catastrophic health spending ranges from under 2% of households in Ireland, Slovenia, Spain, Sweden and the United Kingdom to over 14% in Armenia, Bulgaria, Georgia, Latvia, Lithuania and Ukraine, with a median value of 6% overall and 4% for the EU (Fig. 4).

Country averages conceal major differences in impact. Households in the poorest quintile are consistently most likely to experience financial hardship due to out-of-pocket payments (Fig. 4). They account for at least 40% of households with catastrophic health spending in every country in the study and for over 70% in Croatia, Czechia, France, Hungary, Ireland, Luxembourg, Montenegro, Serbia, Slovakia, Sweden, Switzerland, Türkiye and Ukraine (data not shown). Within countries, the incidence of catastrophic health spending in the poorest quintile is two to five times higher than the national average (Fig. 5).

In 32 countries at least 20% of households with catastrophic health spending are also further impoverished after out-of-pocket payments – that is, they do not have enough to meet their basic needs but still incur out-of-pocket payments (Fig. 6). This share rises to over 40% in 15 of these countries.

Fig. 4. Share of households with catastrophic health spending by quintile, 2019 or the latest available year before COVID-19

- Richest
- 4th
- 3rd
- 2nd
- Poorest

Notes: quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales. The first quintile is labelled “poorest” and the fifth quintile “richest”. See the note on Netherlands (Kingdom of the) in Fig. 3.

Source: WHO Regional Office for Europe (2023a).

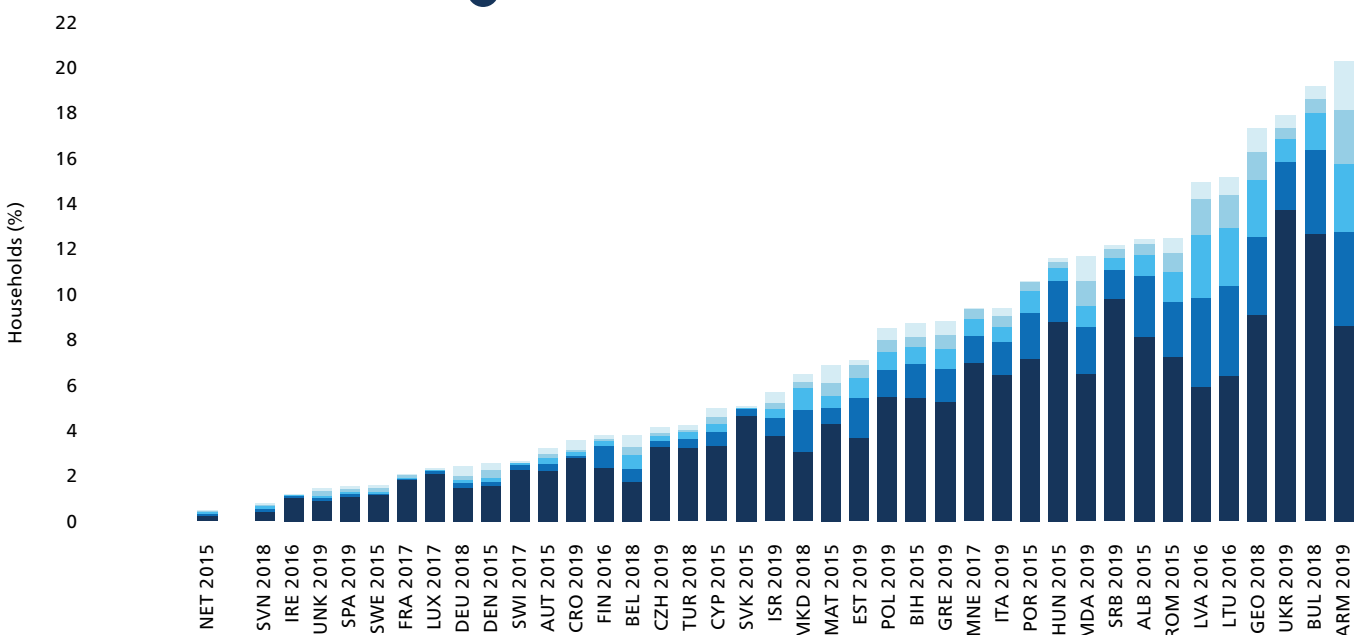


Fig. 5. Share of households with catastrophic health spending on average and in the poorest quintile, 2019 or the latest available year before COVID-19

- Average
- Poorest quintile

Notes: quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales. See the note on Netherlands (Kingdom of the) in Fig. 3.

Source: WHO Regional Office for Europe (2023a).

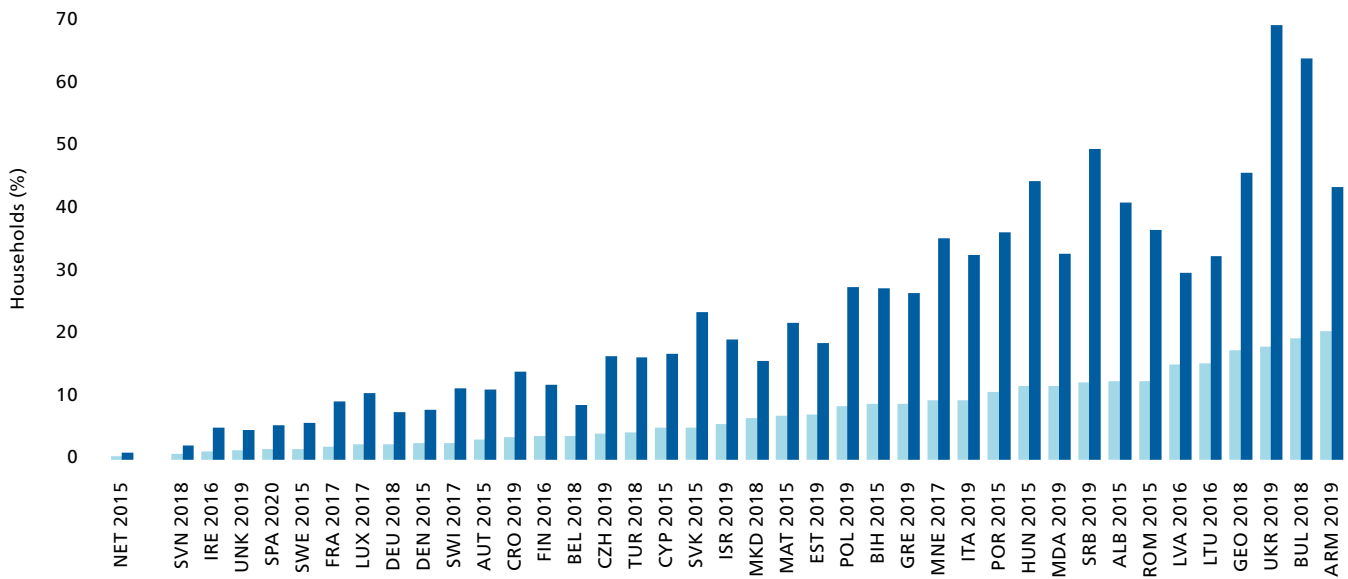
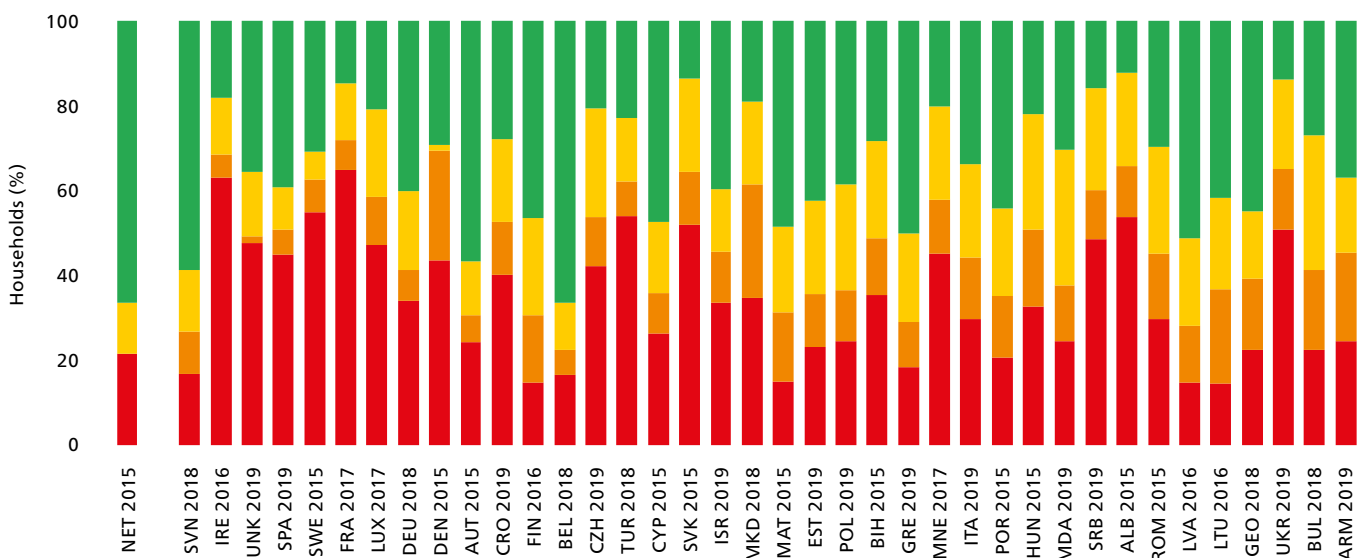


Fig. 6. Breakdown of households with catastrophic health spending by risk of impoverishment, 2019 or the latest available year before COVID-19

- Not at risk of impoverishment
- At risk of impoverishment
- Impoverished
- Further impoverished

Notes: countries are ranked from left to right by the incidence of catastrophic health spending (lowest in Slovenia, highest in Armenia). See the note on Netherlands (Kingdom of the) in Fig. 3.

Source: WHO Regional Office for Europe (2023a).



Financial hardship is mainly driven by out-of-pocket payments for outpatient medicines, dental care and medical products

Outpatient medicines are the main driver of financial hardship across countries, accounting on average for 38% of out-of-pocket payments in households with catastrophic health spending, followed by outpatient dental care (18%), outpatient medical products (15%) and inpatient care (13%) (Fig. 7, upper panel). In the poorest consumption quintile, the outpatient medicines share of catastrophic health spending rises to 60% and the share spent on the other types of care falls to 12% (medical products), 10% (dental care), 8% (outpatient care), 5% (diagnostic tests) and 4% (inpatient care) (Fig. 7, lower panel).

Across countries, drivers differ depending on the extent of catastrophic health spending. In countries with a lower incidence of catastrophic health spending (under the median value of 6% of households – countries on the left of Fig. 7, upper panel), the main drivers are dental care (26%), followed by medical products (22%) and outpatient medicines (19%). In countries with a higher incidence (on the right of Fig. 7, upper panel), the main driver is overwhelmingly outpatient medicines (55%), followed by inpatient care (13%), dental care (10%), outpatient care (9%) and medical products (8%).

Within countries, drivers differ across quintiles. Outpatient medicines consistently account for a larger share of catastrophic health spending in the poorest quintile than in the other quintiles, while inpatient care and dental care usually account for a smaller share (Fig. 8).

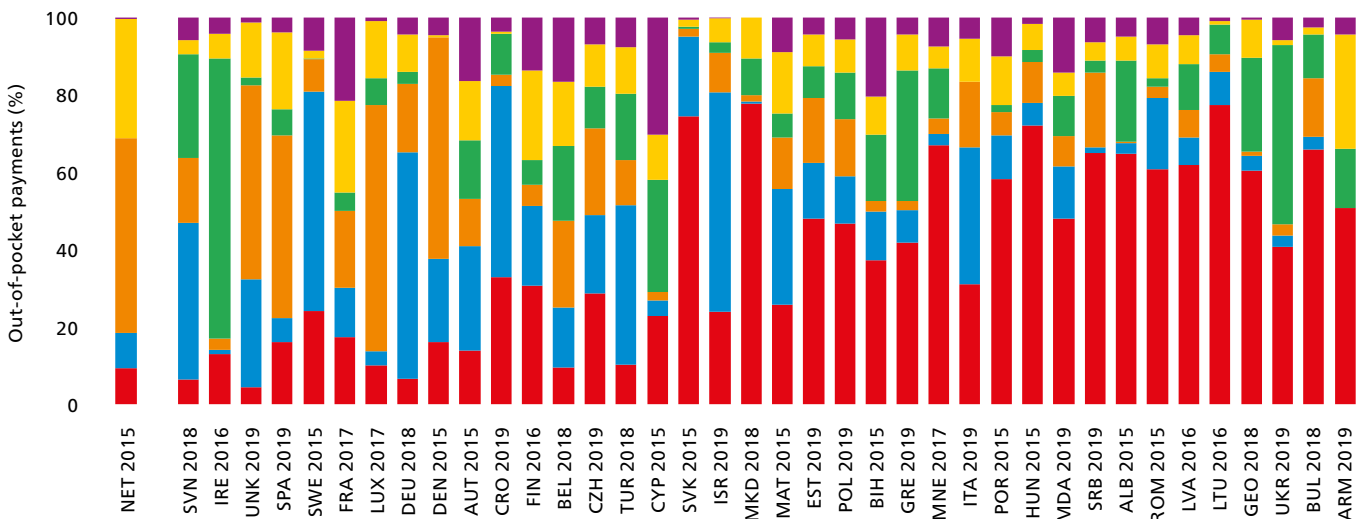
Fig. 7. Breakdown of out-of-pocket payments by type of health care in households with catastrophic health spending, 2019 or the latest available year before COVID-19

- Diagnostic tests
- Outpatient care
- Inpatient care
- Medical products
- Dental care
- Medicines

Notes: countries are ranked from left to right by the incidence of catastrophic health spending (lowest in Slovenia, highest in Armenia). See the note on Netherlands (Kingdom of the) in Fig. 3. Types of health care are sorted by the unweighted average across countries. "Medical products" refers to items like glasses, hearing aids, nebulizers and wheelchairs. "Diagnostic tests" include other paramedical services. In Spain dentures are classified as medical products rather than dental care in the household budget survey. In Ukraine the medicines category includes inpatient medicines as well as outpatient medicines.

Source: WHO Regional Office for Europe (2023a).

Average



Poorest quintile

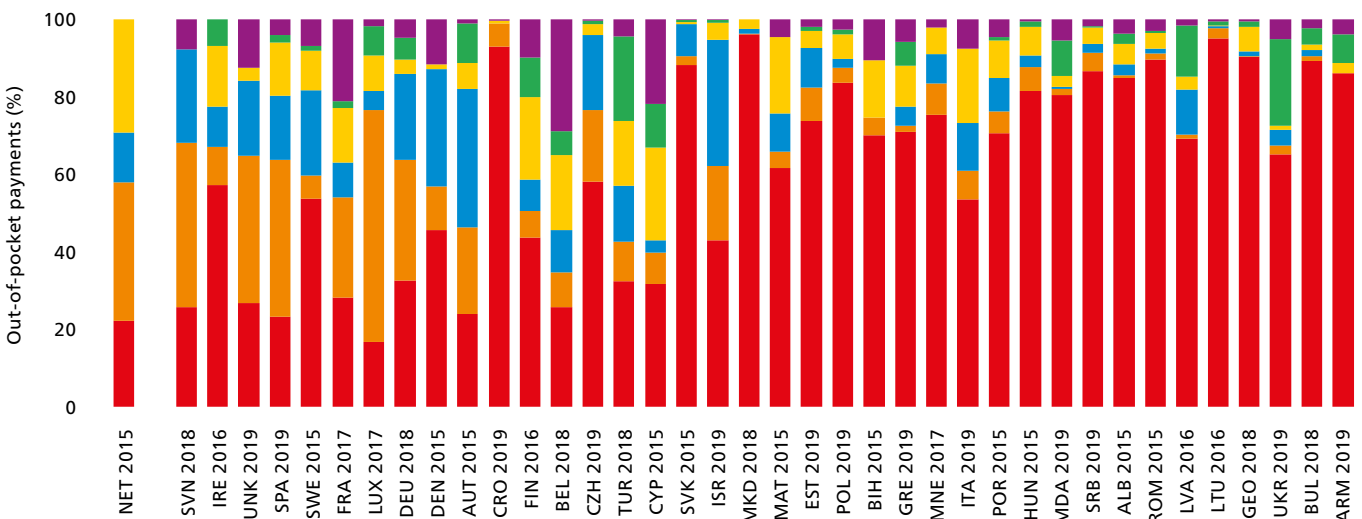
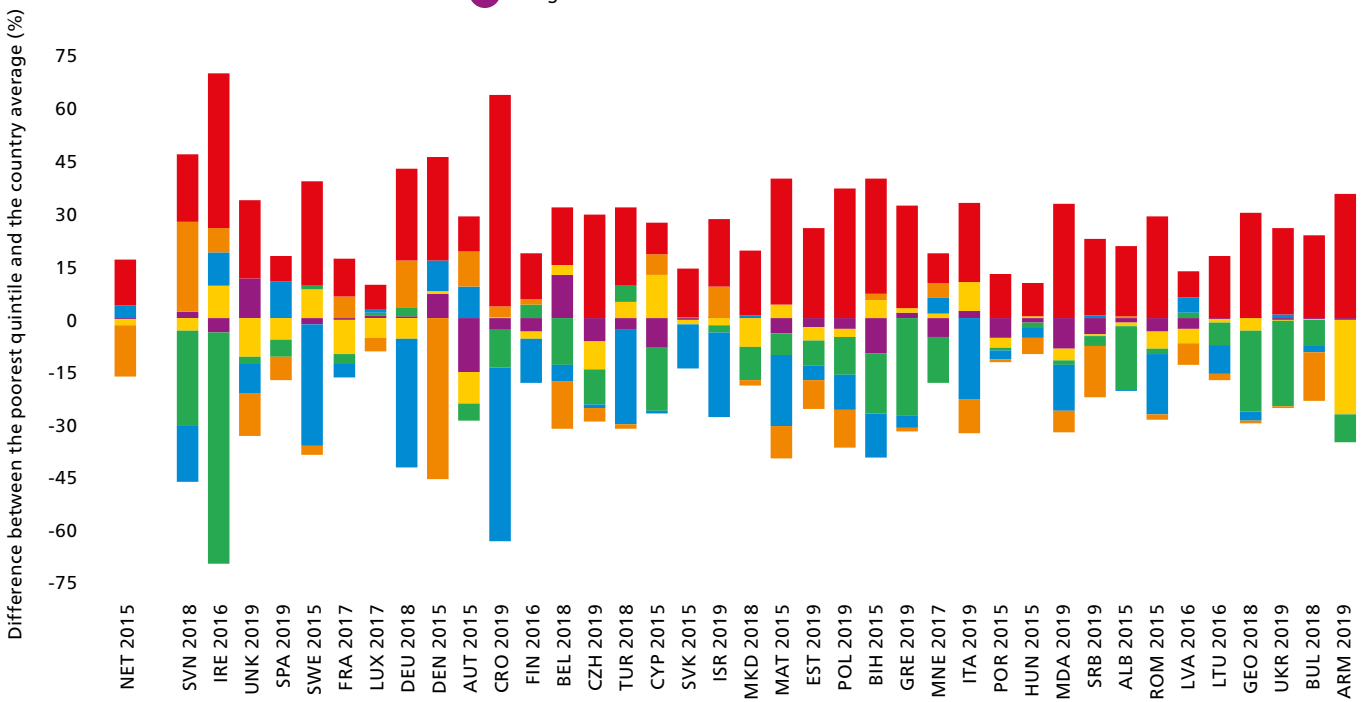


Fig. 8. Difference in the breakdown of catastrophic health spending in the poorest quintile compared to the country average, 2019 or the latest available year before COVID-19

- Medicines
- Medical products
- Dental care
- Inpatient care
- Outpatient care
- Diagnostic tests

Notes: countries are ranked from left to right by the incidence of catastrophic health spending (lowest in Slovenia, highest in Armenia). See the note on Netherlands (Kingdom of the) in Fig. 3.

Source: authors, using data from WHO Regional Office for Europe (2023a).



Unmet need for health care, dental care and prescribed medicines

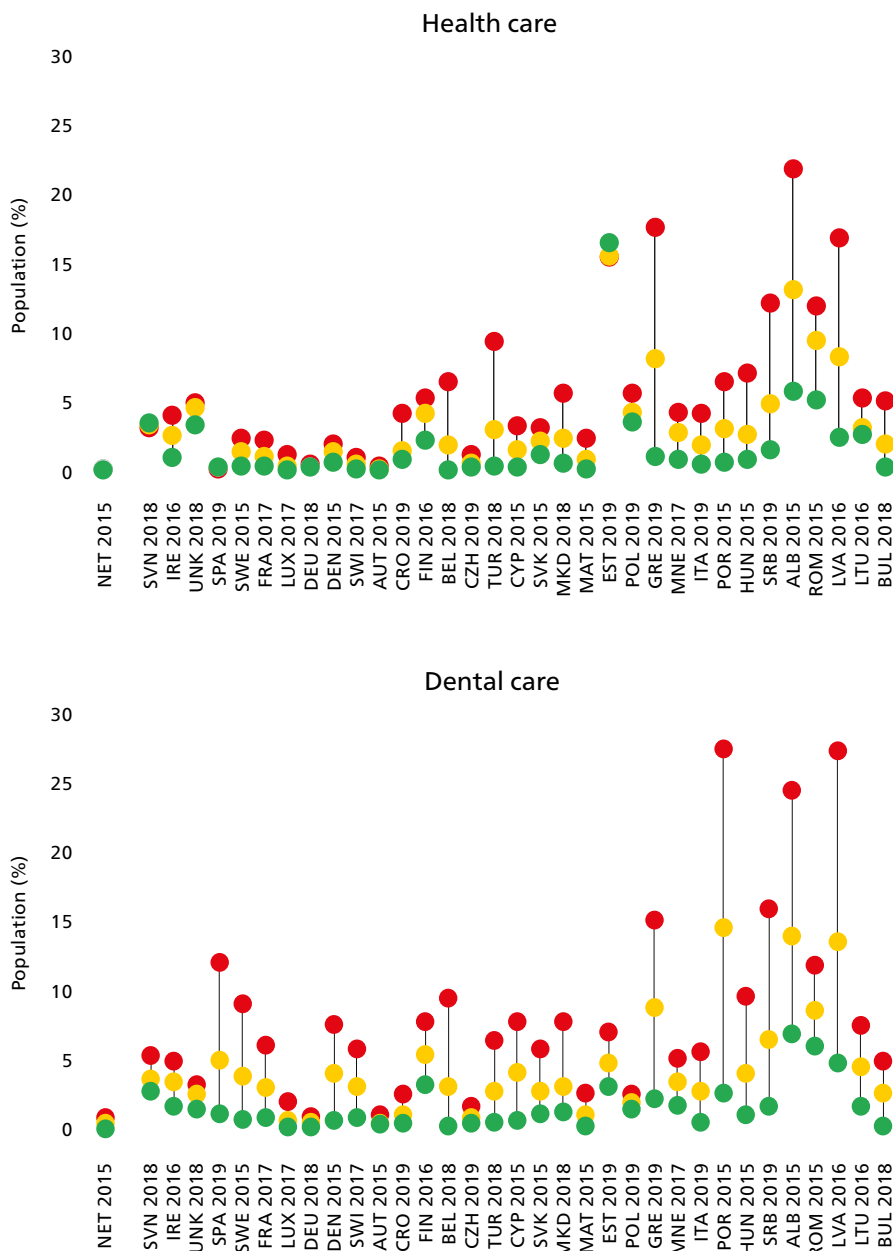
Fig. 9 and Fig. 10 show data on self-reported unmet need for health care (medical examination or treatment), dental care (dental examination or treatment) and prescribed medicines on average and by quintile.

EU-SILC data on unmet need for health care and dental care due to cost, distance and waiting time indicate that dental care is a greater driver of unmet need than health care (Fig. 9). EHIS data on unmet need for health care, dental care and prescribed medicines due to cost also find dental care to be the largest driver of unmet need, followed by health care, prescribed medicines and mental health care (data not shown but available from Eurostat, 2023d).

Cost is usually the main reason people give for unmet need for health care, but in some countries waiting time is either the main reason (Czechia, Denmark, Estonia, Finland, Lithuania, Poland, Spain, Slovakia, Slovenia, Sweden and the United Kingdom) or on a par with cost (Germany) (data not shown but available from Eurostat, 2023d). Cost is the main reason given for unmet need for dental care in all except Finland and Slovenia, where the main reason is waiting time.

For all three types of care (health, dental and prescribed medicines), levels of unmet need are consistently higher among people in the poorest quintile (Fig. 9 and Fig. 10).

Fig. 9. Unmet need for health care and dental care due to cost, distance and waiting time by quintile, 2019 or the latest available year before COVID-19

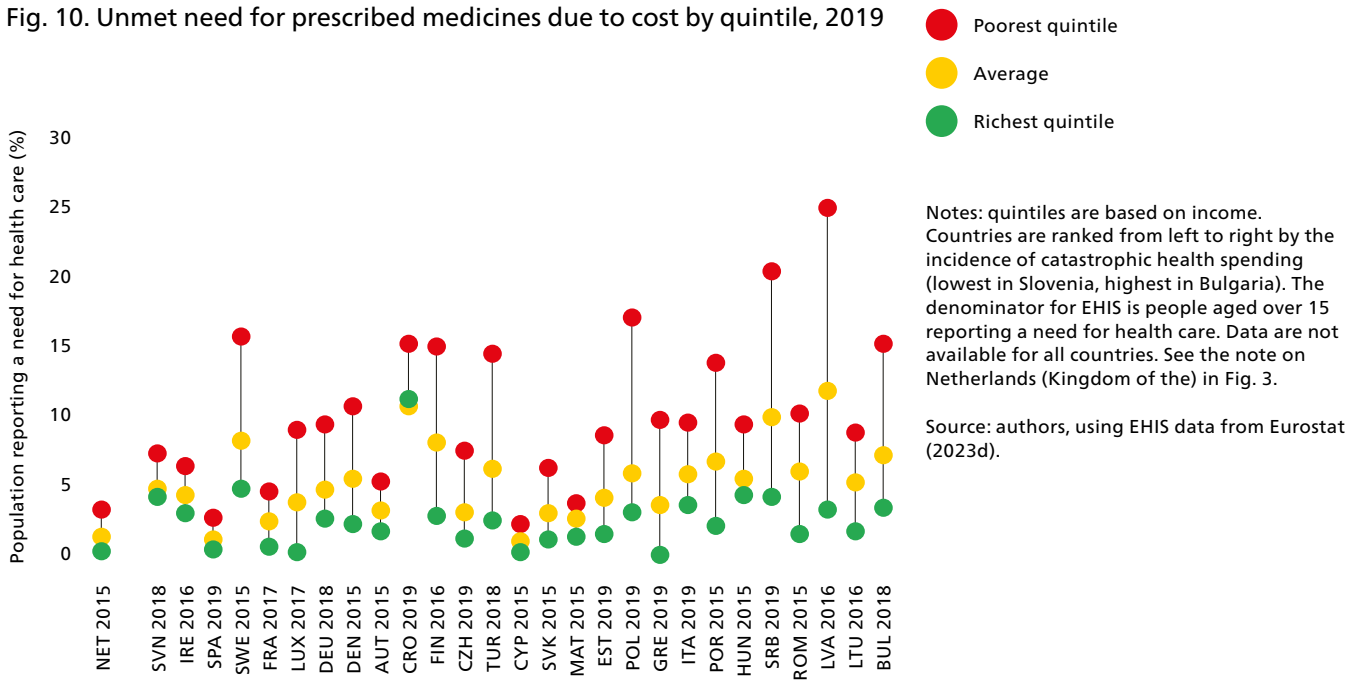


- Poorest quintile
- Average
- Richest quintile

Notes: quintiles are based on income. Countries are ranked from left to right by the incidence of catastrophic health spending (lowest in Slovenia, highest in Bulgaria). Data on unmet need for health and dental care are for the same year as data on catastrophic health spending, except for Albania (2017). The EU-SILC denominator for unmet need is people aged over 16. Data are not available for all countries. See the note on Netherlands (Kingdom of the) in Fig. 3.

Source: authors, using EU-SILC data from Eurostat (2023d).

Fig. 10. Unmet need for prescribed medicines due to cost by quintile, 2019



Out-of-pocket payments affect people differently

Looking at unmet need and financial hardship together underlines the way in which averages conceal major differences in impact.

Where the incidence of catastrophic health spending is high, levels of unmet need for health care, dental care and prescribed medicines are generally also high, with higher levels of income inequality (see Fig. 9 and Fig. 10). This suggests that health care is not affordable in these countries.

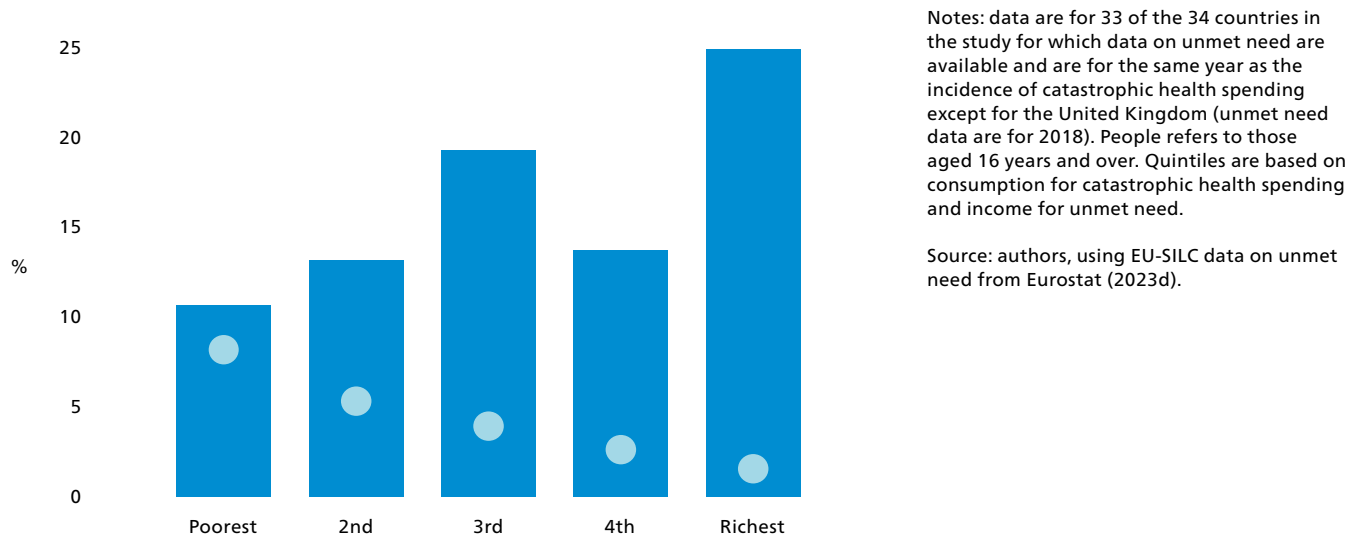
In countries with a low incidence of catastrophic health spending (under 3%), unmet need for health care tends to be low (except in Ireland, Slovenia and the United Kingdom; Fig. 9, upper panel), and without significant income inequality (except in Ireland), suggesting that doctor visits and inpatient care are affordable for most people in these countries. However, there is a concentration of financial hardship among poorer households, which requires policy attention.

In contrast to health care, unmet need for dental care and prescribed medicines – and income inequality in unmet need – are often quite high in countries with a low incidence of catastrophic health spending (see Fig. 9, lower panel and Fig. 10). This suggests that dental care and prescribed medicines are not as affordable as the financial hardship indicators imply, and especially so for poorer households. As a result, the barriers to

access posed by out-of-pocket payments for dental care and prescribed medicines require policy attention and efforts to improve access should prioritize poorer households.

The idea that out-of-pocket payments for different types of health care affect richer and poorer people differently is clearly illustrated using the case of dental care. Fig. 11 shows that dental care is often a larger driver of financial hardship (the columns) in richer households, which reflects higher levels of unmet need for dental care (the dots) in poorer households.

Fig. 11. Dental care as a share of out-of-pocket payments in households with catastrophic health spending and the share of people reporting unmet need for dental care due to cost, distance and waiting time by quintile, 2019 or the latest available year before COVID-19



- Dental care share of catastrophic health spending
- Share of people reporting unmet need for dental care

Notes: data are for 33 of the 34 countries in the study for which data on unmet need are available and are for the same year as the incidence of catastrophic health spending except for the United Kingdom (unmet need data are for 2018). People refers to those aged 16 years and over. Quintiles are based on consumption for catastrophic health spending and income for unmet need.

Source: authors, using EU-SILC data on unmet need from Eurostat (2023d).

Trends over time and the impact of COVID-19

Changes in catastrophic health spending over time: an exploratory analysis

We have at least two data points for each country in the study, which allows us to comment on changes in catastrophic health spending over time. The data points are not consistent across countries, however, so we only compare the difference between the first year of data available for a country and 2019 (or the latest available year before 2019). Some variability within countries may be due to changes in survey design rather than health system, economic or other policy-relevant factors. For this reason, we do not attempt to attribute trends over time to specific factors.

In the majority of countries (28) the incidence of catastrophic health spending increased over time. The largest increases were in Georgia, Hungary, Latvia, Lithuania and Ukraine (Fig. 12). The average increase was 1.7 percentage points, but in 16 countries it was less than 1 percentage point. Georgia, Lithuania and Ukraine are now each engaged in major efforts to improve financial protection.

The incidence of catastrophic health spending fell in 12 countries, by 1.8 percentage points on average. The largest decreases were in Montenegro, North Macedonia, the Republic of Moldova and Türkiye.

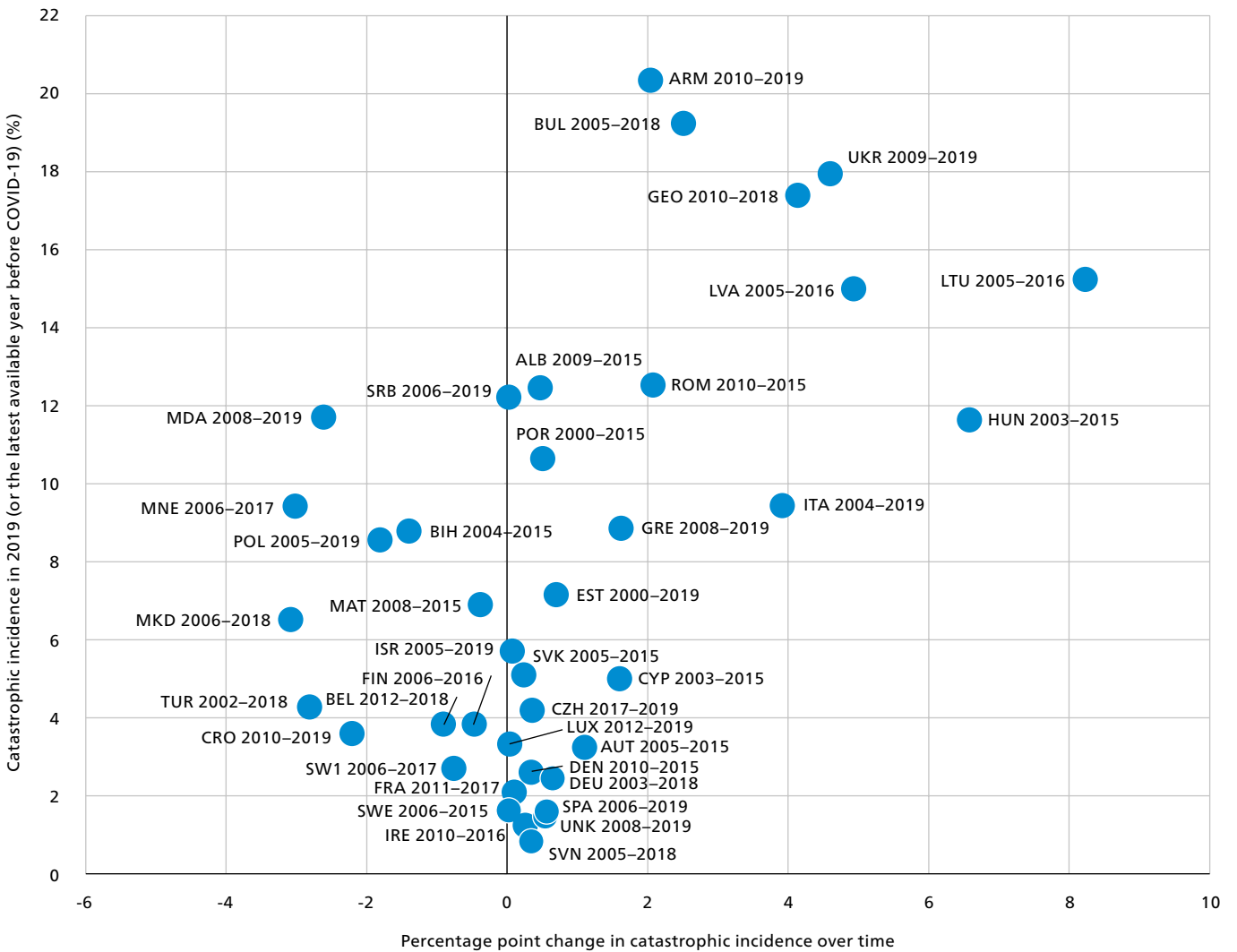
Changes in catastrophic health spending are largely driven by out-of-pocket payments in households in the poorest quintile – not surprising given that these households are the most likely to experience catastrophic spending. In 24 countries the incidence of catastrophic spending in the poorest quintile increased over time, with an average increase of 5.6 percentage points. Every country in which catastrophic spending fell experienced a fall in incidence in the poorest quintile. In a few countries, however, catastrophic spending fell in the poorest quintile but did not fall overall (Albania, Estonia, Latvia and Luxembourg).

Fig. 12. Change in catastrophic health spending over time

Note: the dates for each country show the earliest and latest available years of data before COVID-19.

Left of 0: Catastrophic incidence decreased
 Right of 0: Catastrophic incidence increased

Source: authors, using data from WHO Regional Office for Europe (2023a).



Catastrophic health spending and the COVID-19 pandemic: an exploratory analysis

Our analysis so far has focused on the pre-pandemic period because during the pandemic (2020–2022) some surveys were disrupted. In addition, as explained above, patterns of household spending and health-seeking behaviour were likely to have been skewed by lockdowns and other factors, making them difficult to interpret from a comparative perspective. Post-pandemic survey data (2023) are not yet available.

Here we show findings for nine countries for which we have data for 2020 or 2021 (Armenia, Belgium, Estonia, Greece, Italy, Poland, the Republic of Moldova, Spain and Ukraine) and compare them to findings for 2019 (2018 in the case of Belgium). These data should be interpreted with caution.

Changes in our estimate of the cost of meeting basic needs are a useful proxy for understanding changes in the cost of living and the risk of poverty, both of which affect a household's risk of catastrophic health spending. In four countries real (inflation adjusted) spending on basic needs per equivalent adult fell between 2019 and 2020 (Armenia by -21.6%, Estonia by -7.2%, Italy by -4.1% and Ukraine by -3.0%). This suggests that basic needs became less expensive or that households were less able to spend on them due to a fall in income or because lockdowns prevented them from spending as much as usual. In the remaining five countries the real cost of meeting basic needs per equivalent adult grew between 2019 and 2020 (Spain by 10.6%, Belgium by 2.7% (between 2018 and 2020), the Republic of Moldova by 2.0%, Poland by 1.8% and Greece by 1.6%).

Between 2019 (or 2018 in Belgium) and 2020, seven countries experienced an increase in the share of households living below the basic needs line. The largest increase was in Armenia (1.6 percentage points) and the smallest was in Greece (0.1 percentage points). In Estonia and Ukraine the share of households living below the basic needs line fell by 1.3 and 1.4 percentage points, respectively.

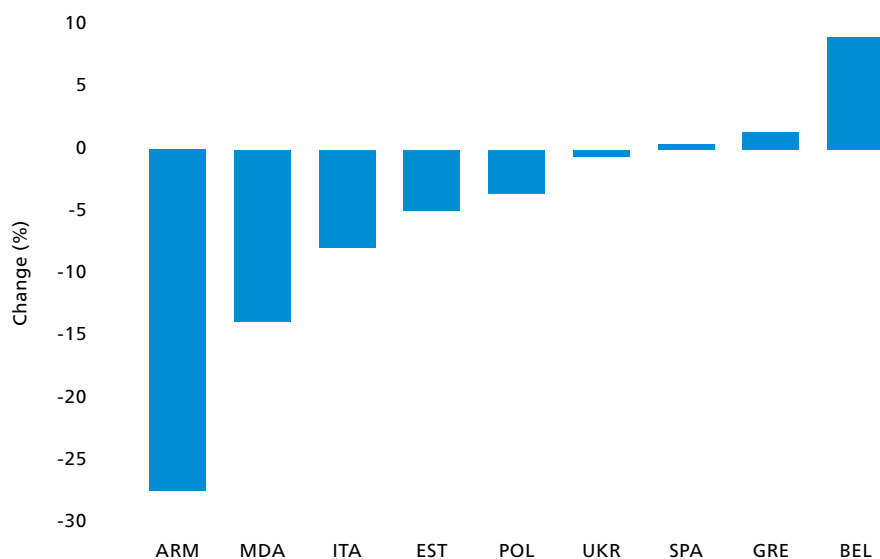
In the four countries with data for 2019 and 2021 (Armenia, Poland, the Republic of Moldova and Ukraine), our estimate of the cost of meeting basic needs was higher in 2021 than in 2019, suggesting a return to more "normal" patterns of consumption. In Armenia and Ukraine the share of households living below the basic needs line was lower in 2021 than in 2019 (by -0.3 and -1.0 percentage points, respectively), which may reflect a decrease in poverty. In Poland and the Republic of Moldova this share was higher (0.6 percentage points and 0.1 percentage points, respectively), suggesting an increase in poverty.

Between 2019 and 2020 real out-of-pocket payments per person fell in six of the nine countries (Fig. 13).

Fig. 13. Change in real out-of-pocket payments per person, 2019–2020

Note: data for Belgium are for 2018 and 2020.

Source: authors, using data from WHO Regional Office for Europe (2023a).

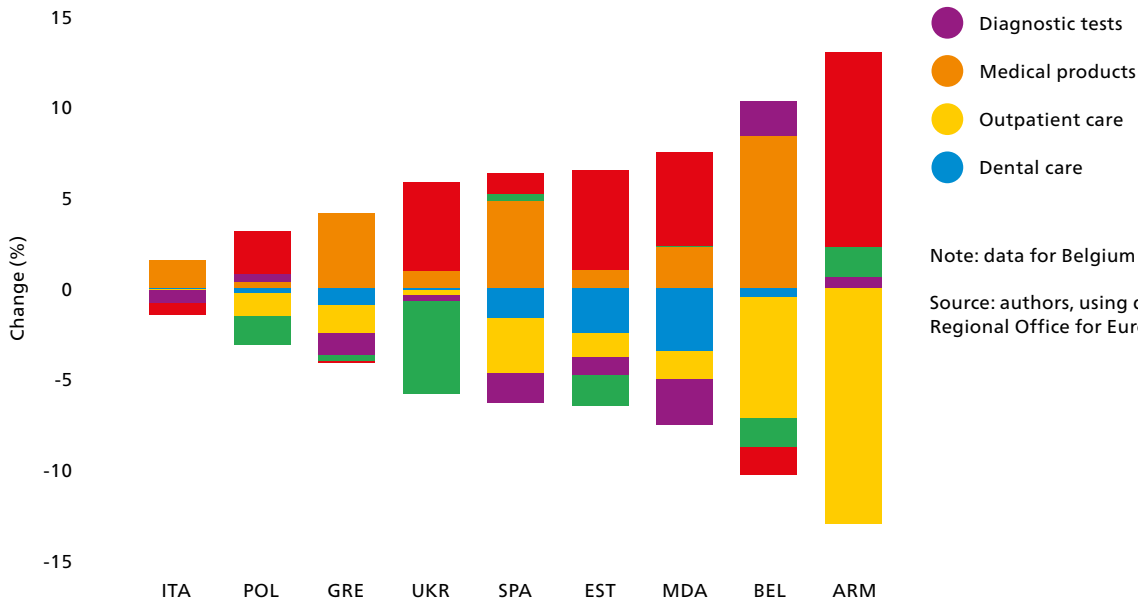


The breakdown of out-of-pocket payments by type of health care changed in all nine countries (Fig. 14). The share of out-of-pocket payments spent on inpatient care, outpatient care and dental care fell in every country. In all except Armenia the out-of-pocket payment share spent on medical products increased, which is likely to reflect spending on masks and other medical products used to reduce the risk of disease transmission. In six of the nine countries the share of out-of-pocket payments spent on medicines increased.

Although many households spent less per person out-of-pocket during the pandemic, the incidence of catastrophic health spending increased in six of the nine countries (Fig. 15). Catastrophic health spending fell in Armenia, Republic of Moldova and Ukraine.

The breakdown of out-of-pocket payments by type of health care in households with catastrophic health spending in 2020 varied across countries; within countries the main drivers were similar to those in 2019 (data not shown).

Fig. 14. Change in the breakdown of out-of-pocket payments by type of health care between 2019 and 2020



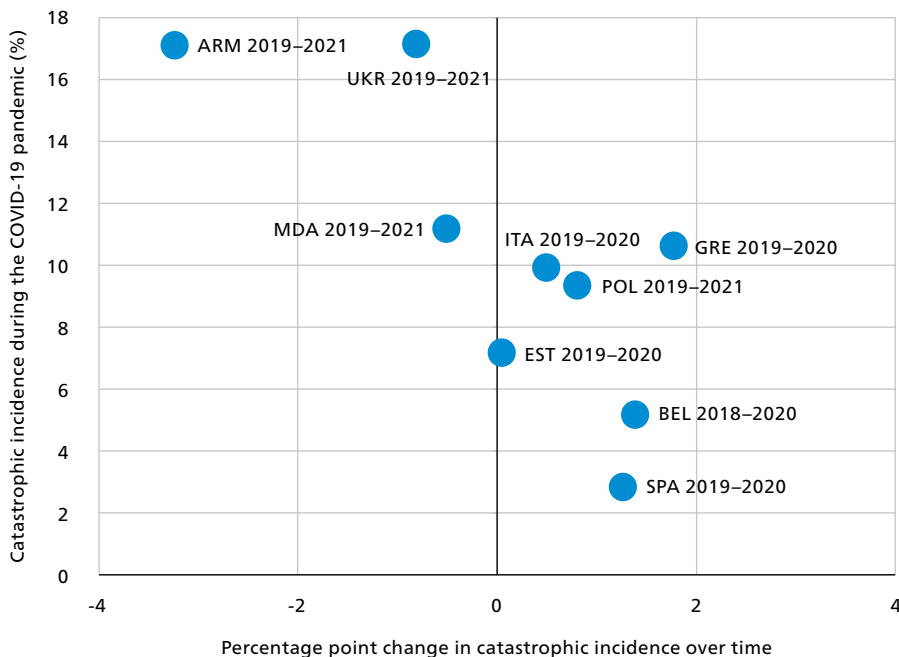
- Medicines
- Inpatient care
- Diagnostic tests
- Medical products
- Outpatient care
- Dental care

Note: data for Belgium are for 2018 and 2020.

Source: authors, using data from WHO Regional Office for Europe (2023a).

Fig. 15. Change in catastrophic health spending during the COVID-19 pandemic

Left of 0: Catastrophic incidence decreased
 Right of 0: Catastrophic incidence increased



Note: the dates for each country show the years of data before and during the COVID-19 pandemic.

Source: authors, using data from WHO Regional Office for Europe (2023a).

Health systems need to reduce their reliance on out-of-pocket payments

This section links financial hardship and unmet need to health accounts data on health spending.

Fig. 16 shows the relationship between the incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health. Across countries, catastrophic incidence rises as the out-of-pocket payment share rises. It is generally low in countries where the out-of-pocket share of current spending on health is less than or close to 15%. Out-of-pocket payments account for more than 15% of spending in most countries in Europe (including many EU countries) (see Fig. 1), which suggests that many need to reduce their reliance on out-of-pocket payments to improve financial protection.

Health accounts data indicate that public spending on health is much more likely to reduce out-of-pocket payments than voluntary health insurance (VHI). Measured as a share of gross domestic product (GDP), public spending on health is relatively strongly associated with a lower reliance on out-of-pocket payments (Fig. 17). In contrast, there is no relationship between VHI and out-of-pocket payments across countries in Europe (Fig. 18) or globally (Wagstaff et al., 2018), even though VHI plays a significant role in reducing out-of-pocket payments in three countries (Croatia, France and Slovenia; see the section “Avoid thinking VHI is the answer”).

Data on health spending do not fully explain differences in out-of-pocket payments and the incidence of catastrophic health spending across countries, however. There are large differences in reliance on out-of-pocket payments in countries with the same level of public spending on health as a share of GDP (see Fig. 17). There are also large differences in catastrophic health spending in countries with the same reliance on out-of-pocket payments (see Fig. 16). This suggests that increases in public spending or reductions in out-of-pocket payments are not necessarily enough to improve financial protection in all contexts. Policies play a key role in determining financial protection, not just patterns of spending on health, as we discuss in the next chapter.

Fig. 16. Catastrophic health spending and out-of-pocket payments, 2019 or the latest available year before COVID-19

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year. See the note on Netherlands (Kingdom of the) in Fig. 3.

Source: data on catastrophic health spending: WHO Regional Office for Europe (2023a); data on out-of-pocket payments: WHO (2023).

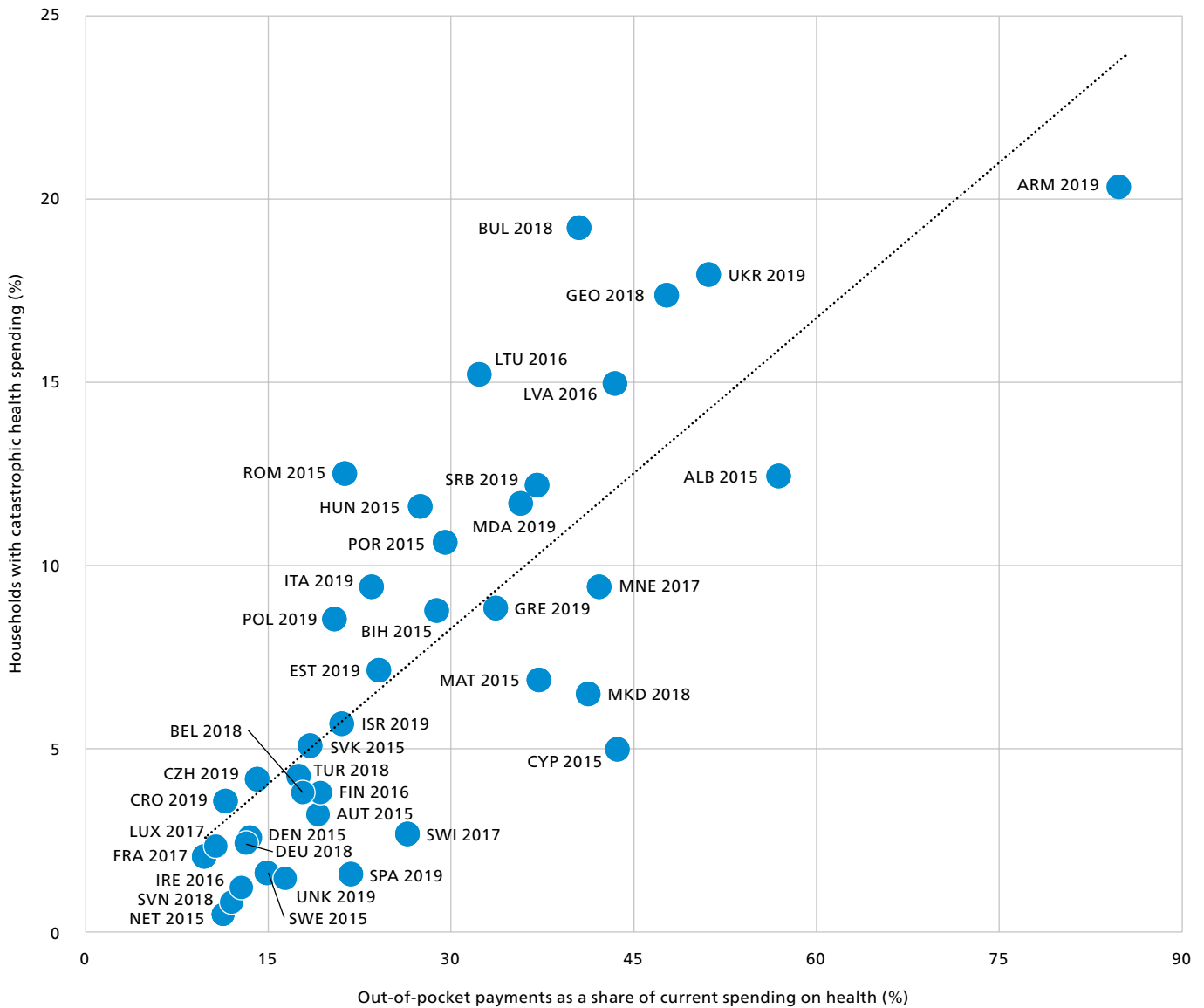


Fig. 17. Out-of-pocket payments and public spending on health, Europe, 2019

Notes: public spending on health is defined here as transfers from the government budget and social health insurance contributions. Out-of-pocket payment data for Albania are for 2014 (latest available data before 2019). The figure excludes Monaco.

Source: WHO (2023).

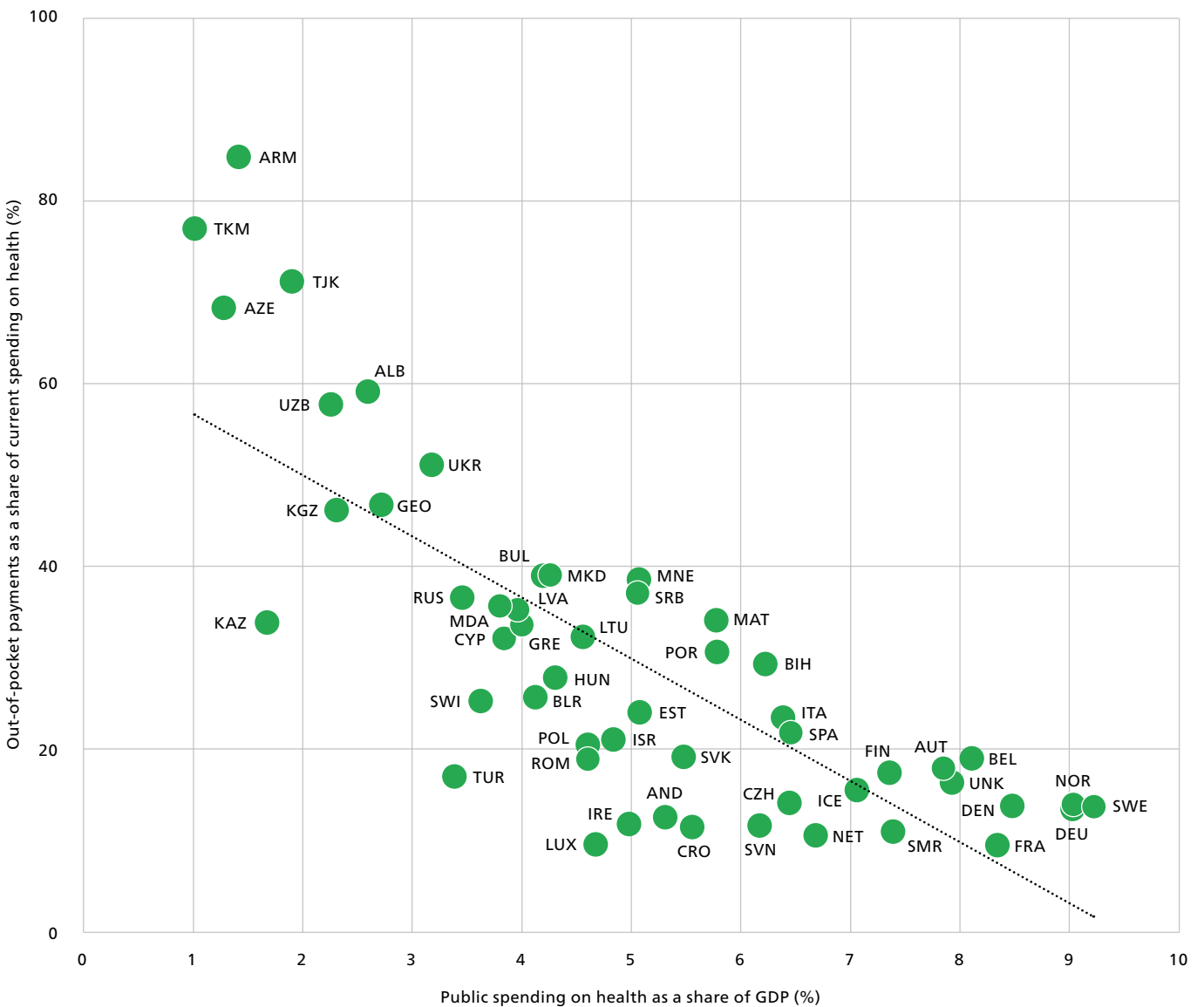
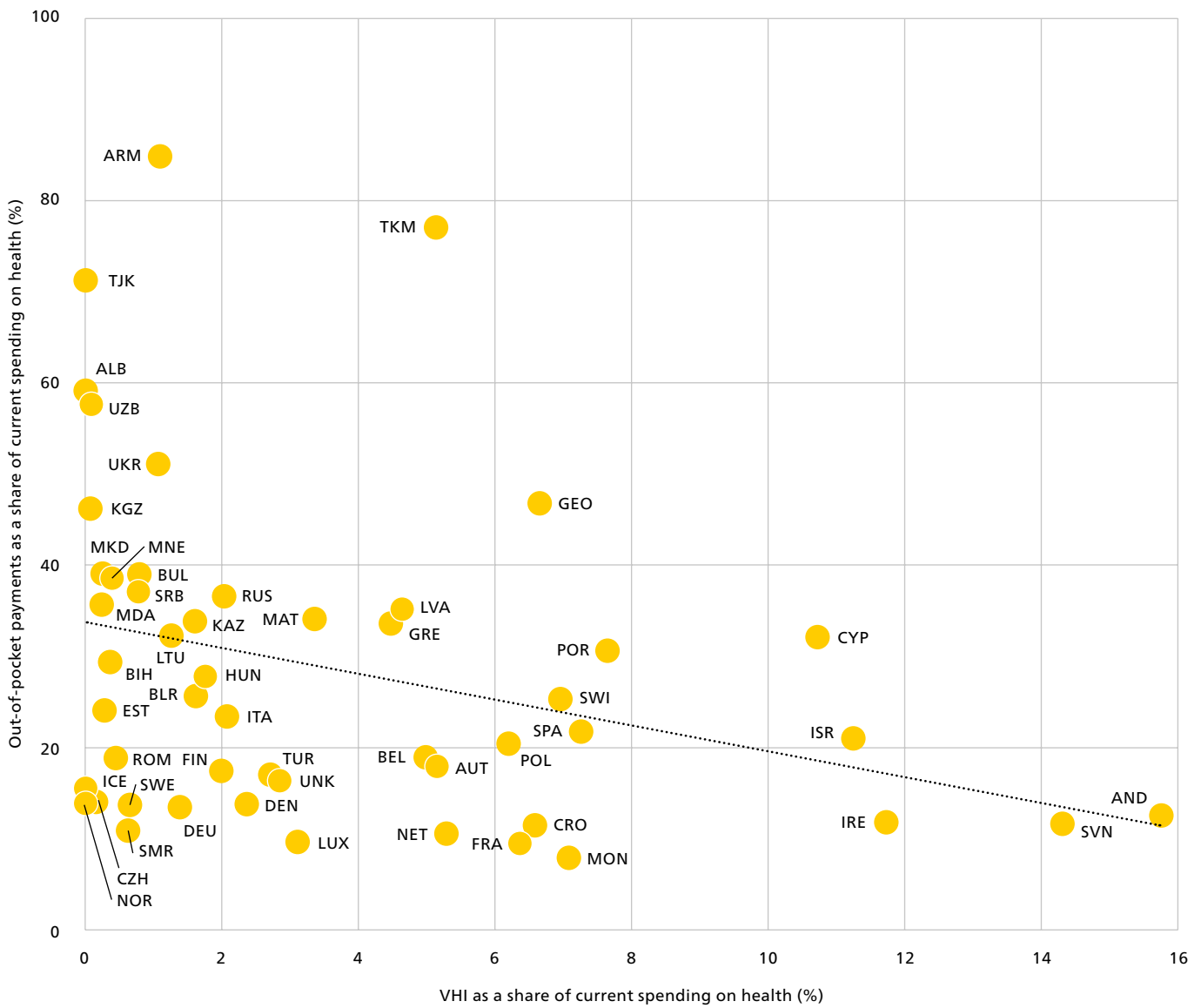


Fig. 18. Out-of-pocket payments and VHI, Europe, 2019

Notes: VHI is defined here as “VHI schemes” (HF2.1 in the System of Health Accounts classification (OECD, WHO, Eurostat, 2017)), so it does not include mandatory private insurance in France (around 7% of current spending on health, taking the total share spent on private insurance to around 13%) or in Germany (around 7% of current spending on health, taking the total share spent on private insurance to around 8%). No data available for Azerbaijan and Slovakia.

Source: WHO (2023).



The story behind
the numbers

“Addiction” to bad ideas: the coverage policy choices that undermine financial protection

Gaps in coverage lead to out-of-pocket payments, financial hardship and unmet need

A country’s reliance on out-of-pocket payments, and the distribution of those out-of-pocket payments across the population, are heavily influenced by coverage policy – the way in which health coverage is designed and implemented (WHO Regional Office for Europe, 2019).

Health coverage has three dimensions: people, services and costs. The goals of UHC are most likely to be met when the whole population is covered; the range and quality of services covered is sufficient to meet everyone’s health needs; and health care costs are largely financed through income-based pre-payment with risk pooling (WHO, 2010).

People can be exposed to out-of-pocket payments, financial hardship or unmet need when there are gaps in any of these three dimensions, as shown in Fig. 19.

Lessons learnt from the economic crisis that began in 2008, and from the COVID-19 pandemic, also point to the importance of coverage policy that strengthens household and health system resilience to shocks by providing extra protection for people with low incomes or chronic conditions and by being countercyclical – increasing as the economy contracts (Thomson et al., 2015; Thomson et al., 2022).

Rationing is inevitable, but some forms of rationing are more harmful than others

All health systems face budget constraints and need to ration access to publicly financed health care in some way.

Coverage policy choices explicitly ration access when:

- entitlement is based on criteria such as payment of contributions, legal residence, age or income, which means that some people are not covered and lack access to some or all publicly financed health care;
- the benefits package excludes whole areas of care or is not broad enough to meet population health needs; and
- user charges are applied to covered health care without putting in place protection mechanisms such as exemptions and caps.

Access is also rationed in more implicit ways – for example, through underfunding, staff shortages and an inequitable allocation of resources,

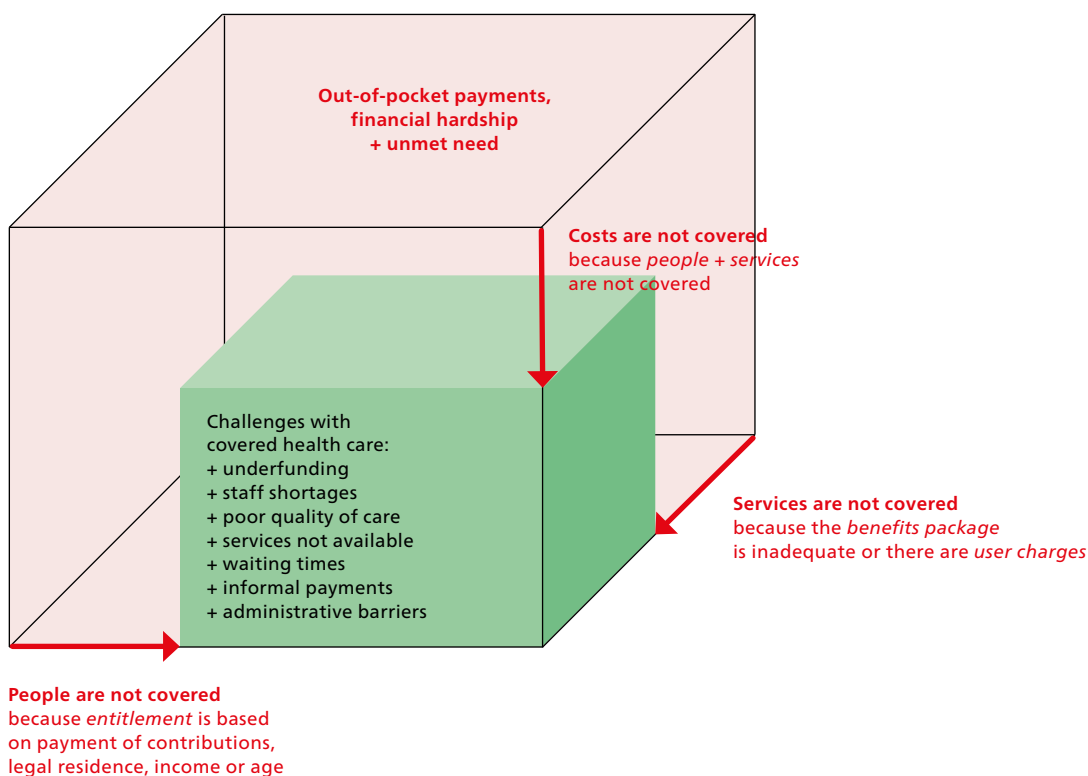
which erode the quality and availability of covered services and lead to waiting times and informal payments, as well as through administrative barriers that prevent people from taking up entitlements (see Fig. 19).

Although rationing inevitably places limits on coverage, its impact on financial protection – and on other aspects of health system performance – depend to a great extent on how it is carried out. The least harmful forms of rationing are those that are explicit and carefully designed.

Determining the scope of the benefits package offers countries an opportunity to engage in explicit priority-setting processes (Gopinathan, Dale & Evans, 2023). This can help to ensure that publicly financed health care is cost-effective, matches population health needs and reflects societal preferences. When informed by evidence, priority-setting processes can also help to address the out-of-pocket payments and other inefficiencies arising from inappropriate use of health care – use that is not needed, not effective or not cost-effective.

Fig. 19. Gaps in coverage and other factors that lead to out-of-pocket payments, financial hardship and unmet need

Source: adapted from WHO (2008, 2010) and WHO Regional Office for Europe (2019).



Coverage policy choices to avoid

Some of the coverage policy choices that countries make when rationing access to health care are “bad ideas” because:

- they do not reflect evidence;
- they undermine financial protection, have a disproportionately negative impact on people with low incomes or chronic conditions and increase inefficiency in the use of health care;
- they weaken household and health system resilience to shocks;
- they slow a country’s progress towards UHC; and
- better options for rationing are usually available.

In the following sections of this chapter we highlight five coverage policy choices that countries should avoid.

1. Avoid linking entitlement to payment of contributions

This policy choice mainly occurs in countries with social health insurance (SHI) schemes. It penalizes people who do not pay the required contributions by restricting their access to some or all publicly financed health care. It leads to visible gaps in population coverage, particularly in countries with weak tax systems and a sizeable informal economy, and mainly harms people in precarious work. Precarious employment is a growing problem in Europe, so without action, this gap in coverage is likely to expand over time.

2. Avoid excluding people from coverage

This policy choice mainly harms undocumented migrants but can also harm refugees and asylum seekers. It leads to a less visible gap in population coverage because countries report covering the whole population even when they do not cover these groups of people and because these groups account for a very small share of the population. Entitlements for undocumented migrants are often limited to emergency care. All three groups are likely to face administrative and other barriers to accessing entitlements. Failing to cover the whole population undermines health system equity, efficiency and resilience.

3. Avoid applying user charges without effective protection mechanisms

A large body of evidence shows that user charges are not an effective way of directing people to use health services more efficiently. Even relatively small user charges can deter people from using needed health care, reduce adherence to treatment, increase the use of other health services, lead to financial hardship, increase the use of social assistance and adversely affect health, particularly among people with low incomes or chronic conditions. Despite this evidence, user charges are widely applied in Europe, most often to treatment in primary care settings.

4. Avoid failing to cover treatment in primary care settings

This policy choice occurs in most countries in Europe. Countries often try to protect people from having to pay out of pocket for primary care

consultations and diagnosis by including these services in the benefits package and keeping them free from user charges. In contrast, most countries apply user charges to treatment in primary care settings (prescriptions for chronic conditions, medical products like glasses and hearing aids, and dental treatment) and many exclude dental care for adults from the benefits package.

5. Avoid thinking VHI is the answer

VHI is often put forward as a solution to gaps in coverage, but in practice it increases inequality in access to health care and can undermine efficiency by skewing public resources away from need. In the few cases in which VHI plays a role in reducing financial hardship –covering user charges for most of the population in Croatia, France and Slovenia – inequalities in access to VHI persist, VHI is regressive and there are high transaction costs involved in managing a complex system. Other countries are unlikely to be able to replicate the relative success of VHI in Croatia, France and Slovenia, which comes at a cost to households and governments.

Other factors can also lead to out-of-pocket payments, financial hardship and unmet need

Beyond coverage policy choices, other factors can expose people to financial hardship or unmet need. For example, when financial and human resources for health are not enough to meet population health needs, or are inappropriately allocated, people may have to pay out of pocket to obtain:

- faster access to treatment where there are long waiting times for covered services;
- better quality, ranging from better quality amenities to more effective treatment; and
- care or supplies that should be publicly financed but are not available at the point of use, such as medicines, 24-hour nursing care in hospital or services in rural areas.

These out-of-pocket payments are likely to involve a mix of formal and informal payments to health workers and health facilities. We would expect them to be counted under outpatient care and inpatient care in household budget surveys. With a few exceptions, however, these types of care are not the most important drivers of financial hardship in most countries in Europe, and even less so among households with low incomes (see Fig. 7 and Fig. 8). This suggests that informal payments are not a major driver of financial hardship in the countries in the study, although they are an important problem in several countries, including some EU countries (European Commission, 2023). It also suggests that these other factors may be more likely to result in unmet need than financial hardship for households with low incomes.

Even if informal payments do not appear to be a major source of financial hardship, they are an issue that needs to be addressed because they undermine almost every aspect of health system performance and point

to failures in health system governance (Kutzin, Cashin & Jakab, 2010). They are particularly problematic for people with low incomes since their informal nature makes it impossible to protect people through exemptions. Country experience indicates that it is possible to reduce informal payments, particularly when they are made for supplies, but that this requires a comprehensive strategy. User charges in any form, including balance billing and extra billing, are not effective in this respect because they fail to address the root causes of informal payments (Kutzin, Cashin & Jakab, 2010; Jakab, Akkazieva & Kutzin, 2016; WHO Regional Office for Europe, 2018; 2019).

1. Avoid basing entitlement on payment of contributions

Summary

Many countries in Europe have significant gaps in population coverage. Only 23 of the 40 countries in the study report universal (100%) or near universal (99%) coverage.

Failing to cover the whole population undermines health system equity, efficiency and resilience. Gaps in population coverage typically harm people with low incomes. They also lead to inefficiencies in the use of health care because people who lack coverage may be unable to adhere to treatment or benefit from coordinated care; self-treat with over-the-counter medicines; delay seeking care; or turn to resource-intensive emergency services.

Universal population coverage seems to be a prerequisite for financial protection. The median incidence of catastrophic health spending is three times lower in countries that report universal or near universal coverage (3%) than in the countries with larger gaps in coverage (9%). Population coverage alone does not guarantee financial protection, however.

Larger gaps in population coverage are heavily concentrated in countries with SHI schemes that choose to link entitlement to payment of contributions. Non-covered people typically find it difficult to pay contributions because they lack work or their work is precarious – self-employed people, people working in the informal economy, unemployed people, migrants and homeless people.

By choosing to exclude or limit coverage for people who do not pay SHI contributions, countries are using the health system to tackle a taxation problem. There is no evidence to suggest that the health sector is effective in addressing weaknesses in tax collection or reducing labour market informality. In countries that base entitlement on residence, responsibility for the non-payment of contributions and other taxes is delegated to the tax agency.

Linking entitlement to payment of contributions is cyclical, unfair and wastes resources. It is likely to limit coverage in a recession, undermining household and health system resilience to shocks. Most SHI schemes are supported by transfers from the government budget, which means that people are denied access to SHI benefits even though they are helping to finance the SHI scheme through taxes on goods, property or income. Having to define and administer two benefits packages – one for covered people and another for non-covered people – wastes resources.

The fact that this policy choice is so widespread, despite its many challenges, reflects historical factors – but it does not have to be this way. Some countries with SHI schemes have successfully broken the link between entitlement and payment of contributions (France). Others have managed to avoid linking entitlement to payment of contributions when reforming their health systems (Ukraine) or been able to reverse decisions (Cyprus and Spain).

Countries can break this link without changing the way in which they raise revenue or purchase health care.

Population coverage: a prerequisite for financial protection but not a guarantee

Gaps in population coverage are determined by the basis for entitlement to publicly financed health care. They occur when entitlement is based on criteria that are not broad enough to encompass everyone living in a country. The two criteria used most in Europe are payment of contributions and legal residence; only two countries use other criteria – income in Georgia and income and age in Ireland (WHO Regional Office for Europe, 2023a).

People who lack entitlement to the main publicly financed benefits package usually have access to emergency care, treatment of some communicable diseases and, in a few countries, some outpatient visits (Spencer & Hughes, 2015; WHO Regional Office for Europe, 2019, 2023a). As a result, gaps in population coverage are likely to lead to unmet need and financial hardship, slowing progress towards UHC.

Gaps in population coverage can also lead to inefficiencies in the use of health care. People who lack coverage may be unable to adhere to treatment or benefit from coordinated care; self-treat with over-the-counter medicines; delay seeking care; or turn to resource-intensive emergency services (Tamblyn et al., 2001; Goldman, Joyce & Zheng, 2007; Guindon et al., 2022; Fusco et al., 2023).

Fig. 20 combines information on population coverage, the principal basis for entitlement to publicly financed health care and the incidence of catastrophic health spending in 39 countries. It shows that 23 countries report universal (100%) or near universal (over 99%) population coverage (those on the left of the figure). In the remaining 16 countries (those on the right of the figure), the share of the population lacking coverage ranges from around 1.5% in Belgium and Türkiye to 15% in Bulgaria, 25% in Cyprus and 39% in Albania.

In countries that report universal or near universal coverage (on the left of the figure), the principal basis for entitlement is evenly divided between legal residence (the blue columns) and payment of contributions to a SHI scheme (the red columns). In contrast, in countries with lower levels of population coverage (on the right of the figure), entitlement is overwhelmingly linked to payment of SHI contributions (the red columns). The sole exception is Georgia, where people with high incomes do not have access to the full range of publicly financed health care (Goginashvili, Nadareishvili & Habicht, 2021).

The median incidence of catastrophic health spending is three times lower in countries that report universal or near universal coverage (3%) than in countries with larger gaps in population coverage (9%). This suggests that being legally entitled to publicly financed health care is a prerequisite for financial protection.

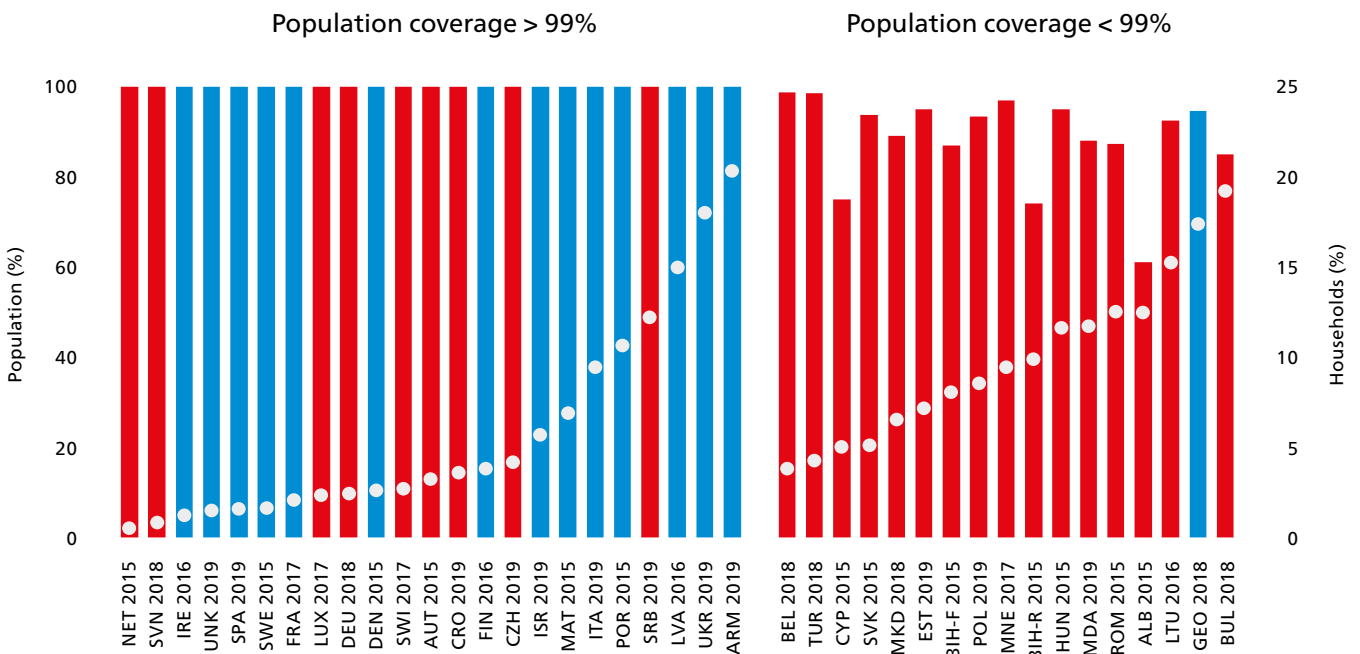
Even in countries that report covering the whole population, however, the incidence of catastrophic health spending ranges from under 1% of households to over 20%, which indicates that being covered is not enough to guarantee financial protection (Wagstaff et al., 2018; WHO Regional Office for Europe, 2019) – other aspects of coverage policy are likely to play a role too. It also shows that population coverage is not a good indicator of financial protection.

Fig. 20. Population coverage, the main basis for entitlement to publicly financed health care and catastrophic health spending, 2019 or the latest available year before COVID-19

- Population covered (payment of contributions)
- Population covered (residence)
- Households with catastrophic health spending

Notes: the share of the population covered is for the same year as catastrophic health spending and may not reflect the current situation. Bosnia and Herzegovina reports different levels of population coverage for the Federation of Bosnia and Herzegovina (BIH-F) and the Republic of Srpska (BIH-R). The figure excludes Greece because we could not find published data on the share of the population covered by the SHI scheme. See the note on catastrophic health spending in Netherlands (Kingdom of the) under Fig. 3.

Source: authors, using population coverage data from OECD (2023b) for OECD countries and WHO Regional Office for Europe (2023a) for non-OECD countries.



Linking entitlement to payment of contributions mainly excludes people with low incomes

Many countries with SHI schemes base entitlement on payment of contributions, which means that they penalize people who do not pay the required contributions by restricting their access to some or all publicly financed health care.

This approach is problematic for the following reasons.

- It leads to a gap in population coverage in many countries and the gap is likely to be larger in countries with weak tax systems and a sizeable informal economy (Yazbeck et al., 2020; Gabani, Mazumdar & Suhrcke, 2023; Yazbeck et al., 2023).
- Non-covered people are typically those who find it difficult to pay contributions because they lack work or their work is precarious – temporary, unpredictable, insecure, poorly paid, with little or no social protection and often informal. They include people who are unemployed, self-employed, migrants or experiencing homelessness. Precarious employment is a growing problem in Europe (Directorate-General for Internal Policies of the Union (European Parliament), Broughton & Eichhorst, 2016). Without action, this gap in coverage is likely to expand over time.
- It undermines household and health system resilience to economic shocks because it is cyclical, decreasing as the economy contracts. People may lose coverage when they need it most – for example, as their income is falling or they become unemployed (Thomson et al., 2022). See Box 2 on the experience of Greece during the economic crisis that began in 2008. In contrast, people do not have to worry about their coverage status when entitlement is based on residence.
- Having to define and administer two benefits packages – one for covered people and another for non-covered people – wastes resources.
- Linking entitlement to payment of contributions fosters unfairness among taxpayers in SHI schemes that are supplemented by transfers from the government budget. In 2021 government budget transfers accounted for more than 20% of SHI scheme revenue in three-quarters of the countries in Europe with a SHI scheme (WHO, 2023). This means that some taxpayers lack entitlement to SHI benefits even though they are helping to finance the SHI scheme through taxes on goods, property or income.
- By choosing to exclude or limit coverage for people who do not pay contributions, countries are using the health system to tackle a taxation problem despite a lack of any evidence to suggest that the health sector is effective in addressing weaknesses in tax collection or reducing labour market informality (Pagés, Rigolini & Robalino, 2013).

Box 2. Linking entitlement to employment and payment of contributions increased financial hardship and unmet need in Greece in the context of an economic shock

Source: adapted from WHO Regional Office for Europe (2019).

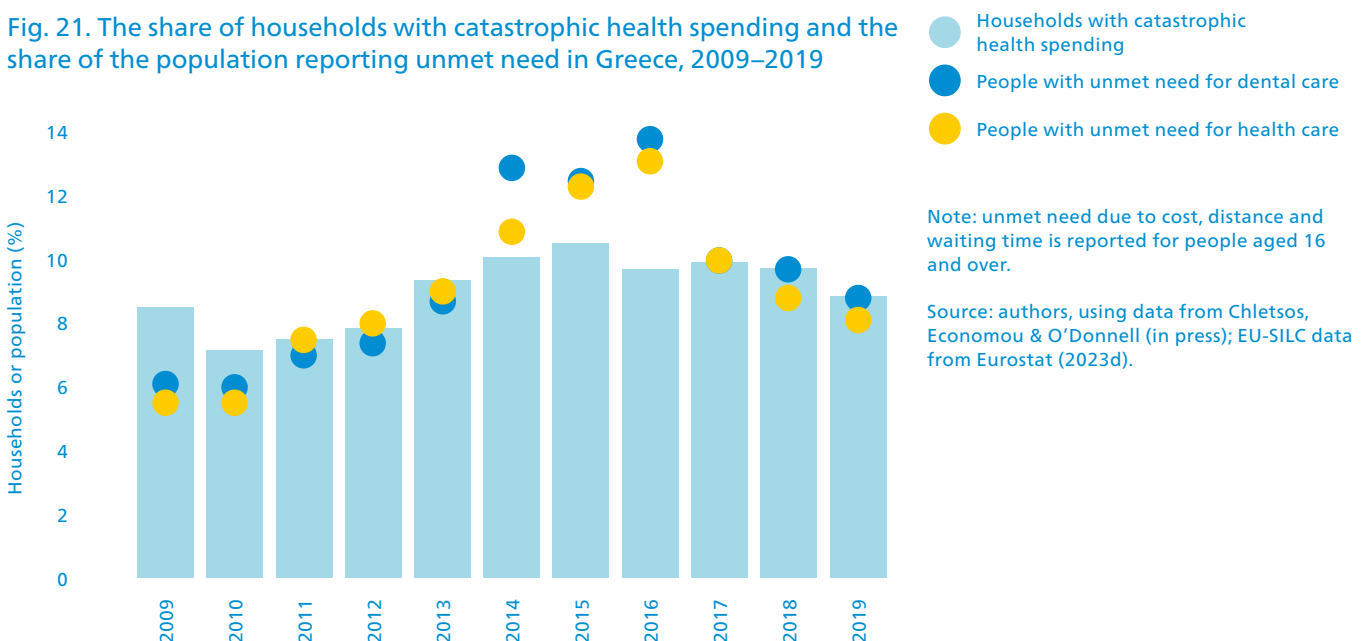
Greek residents who are unemployed for more than two years and self-employed people who do not pay their contributions lose their entitlement to health care financed through the SHI scheme known as *Εθνικός Οργανισμός Παροχής Υπηρεσιών Υγείας (ΕΟΠΥΥ)* [the National Organization for the Provision of Health Services]. EOPYY is jointly financed through earmarked contributions and transfers from the government budget.

The basis for entitlement became a major issue in the years following the 2009 debt crisis in Greece, when unemployment – and long-term unemployment – rose dramatically (Eurostat, 2023e). By the beginning of 2016, a quarter of the population was not entitled to EOPYY benefits (Economou et al., 2017).

In 2016 the government introduced a new law to ensure access to publicly financed health services for all residents not covered by EOPYY, self-employed people unable to pay contributions and other people in vulnerable situations, including refugees, children, pregnant women and those with chronic conditions or disabilities (WHO Regional Office for Europe, 2023b).

Fig. 21 shows that catastrophic health spending and unmet need rose sharply from 2011 to 2016. Following the introduction of the new law in 2016, unmet need began to fall and catastrophic health spending stabilized.

Fig. 21. The share of households with catastrophic health spending and the share of the population reporting unmet need in Greece, 2009–2019



Although the 2016 law was a major step forward, it has not addressed the root cause of the gap in population coverage – linking entitlement to employment and payment of contributions rather than to residence. In addition, inequalities in access to health care persist because people covered under the 2016 law do not enjoy the same entitlements as those covered by EOPYY: they are entitled to treatment in public facilities only, whereas people covered by EOPYY can use contracted private providers, including private diagnostic centres, in addition to public facilities. As a result, people reliant on public facilities continue to face financial and non-financial barriers to access due to underfunding, staff shortages, long waiting times, poor quality and lack of diagnostic equipment and supplies in public facilities (Economou et al., 2017; Chletsos, Economou & O'Donnell, in press).

A degree of unfairness among taxpayers also persists: EOPYY benefits are heavily subsidized by the government budget and yet many taxpayers are still not covered by EOPYY, among them people who may have paid contributions for many years but were unfortunate enough to experience long-term unemployment and lost their entitlement to EOPYY benefits.

Why do countries base entitlement on payment of contributions?

Given the many challenges that arise when entitlement is based on payment of contributions, why is this policy choice so widespread in Europe? We identify four main reasons.

First, history, in three waves (WHO Regional Office for Europe, 2019; 2021b).

- Publicly financed health care originated in employment-based schemes that aimed to compensate workers for loss of earnings when ill (Abel-Smith, 1988; Saltman, Busse & Figueras, 2004). At that time loss of earnings was the main financial risk associated with ill health, so there was some logic in basing health coverage on employment, levying contributions on wages and linking entitlement to payment of contributions. Germany was the first country to formalize these schemes, setting up a national SHI scheme in 1883. It was followed by the United Kingdom in 1911 and other countries in the first half of the 20th century. These schemes were not designed to be universal, even when they were mandated at national level.
- Following the Second World War, countries that wanted to extend health coverage to the whole population, going beyond workers, mainly set up schemes that were financed through the government budget. The United Kingdom took this path in 1946 and Norway in 1967, followed by Denmark, Greece, Iceland, Italy, Portugal and Spain in the 1970s and 1980s (WHO Regional Office for Europe, 2021b).
- Starting in 1990, countries in central and eastern Europe shifted away from universal schemes financed through the government budget. Many re-introduced the employment-based schemes they had had in earlier

years, partly to try and increase public spending on health through earmarked contributions and, in some cases, to overcome the rigidity of public financial management rules (Kutzin, Cashin & Jakab, 2010).

Second, a tendency to think in terms of health financing “models” like “Bismarck” and “Beveridge” (Kutzin, 2001). Many of the countries that re-introduced SHI schemes in the 1990s and early 2000s were attracted by the SHI model because they associated it with earmarked revenue for health, independence for the purchasing agency, a purchaser-provider split, new methods of provider payment and a defined benefits package (Kutzin, Cashin & Jakab, 2010). In many instances, however, it would have been possible to have introduced these features without basing entitlement on payment of contributions – just as it is possible for countries today to break this link without changing the way in which they raise revenue, purchase health care or define benefits.

Third, beliefs about fairness. In some countries it may be perceived as unfair that people who fail to pay SHI contributions when required to do should still have access to SHI benefits. However, the question is not whether non-payment of contributions should be ignored; it is whether denying people access to health care is an appropriate penalty for non-payment. Non-payment of income taxes – for example – may result in fines and imprisonment but does not result in denial of access to education or other public services.

Fourth, concerns about encouraging informal work. Some countries may regard SHI benefits as an incentive for people to pay taxes, but there is no evidence to support this view (Pagés, Rigolini & Robalino, 2013).

What can countries do to avoid or address problems?

It does not have to be this way. The experience of a diverse set of countries in the region shows that it is possible for countries to address this problem through adaptation (Box 3 on France) or by reversing earlier decisions (Box 4 on Spain and Box 5 on Cyprus).

It is also possible to avoid this problem. When Ukraine began to reform its health system in 2017, it resisted calls to base entitlement on payment of contributions (Box 6). As a result, it has managed to maintain near universal access to health care in the context of the disruption caused by COVID-19 and the Russian Federation’s invasion – something that would not have been possible if entitlement had been linked to contributions.

Following these examples of good practice, countries that currently base entitlement on payment of contributions can break this link by delegating responsibility for the non-payment of contributions to the tax agency – something that countries with residence-based entitlement do as a matter of course.

Box 3. France broke the link between entitlement to SHI benefits and payment of contributions by changing the basis for entitlement to residence

Source: Bricard (in press).

In 2000 France changed the basis for entitlement to SHI benefits from employment and payment of contributions to legal residence, under a new system known as *Couverture Universelle Maladie* (CMU) [universal health coverage]. The reform was driven by concerns about the growing number of young people who were not entitled to SHI benefits due to rising unemployment and other factors. In 2016 CMU was replaced by *Protection Universelle Maladie* [universal health protection], which grants all legal residents who work or have been in France for at least three months an individual, automatic and continuous right to health care, without the need for administrative formalities when their circumstances change. People who work in France no longer have to prove that they have a minimum level of activity. A person who is not in employment must be legally resident (i.e. spending at least six months of the year in France).

Box 4. Spain reversed a decision to base entitlement on payment of social security contributions

In 2012, during the economic crisis in Spain, the Government changed the basis for entitlement to National Health Service (NHS) benefits from residence to *asegurado* [being insured], meaning based on social security status (Ministry of the Presidency, 2012; Urbanos-Garrido et al., 2021). This change restricted access to health care for nearly a million people, including many undocumented migrants (Hernández-Quevedo, Jiménez-Rubio & Bernal-Delgado, 2018; Bernal-Delgado et al., 2018). Six years later, following a change of government in 2018, residence was re-established as the basis for entitlement for all residents, including undocumented migrants (Ministry of the Presidency, 2018), making Spain once again one of the only countries in Europe to give undocumented migrants similar entitlements to other residents (Urbanos-Garrido et al., 2021) (see also Box 9 below).

Box 5. Cyprus reversed a decision to base entitlement on payment of taxes and social security contributions

Source: authors, based on Kontemeniotis & Theodorou (2019).

Before the European economic crisis that began in 2008, entitlement to publicly financed health care in Cyprus was based on citizenship and income, leaving around 15% of the population without coverage. Following an Economic Adjustment Programme introduced in 2013, the Government of Cyprus added extra criteria to the basis for entitlement: payment of taxes and social security contributions for at least three cumulative years, submission of a personal tax declaration and, for civil servants, payment of contributions earmarked for health. As a result of this change, the share of the population without publicly financed coverage rose from 15% to 25%.

Between 2009 and 2015 the incidence of catastrophic health spending rose from 3.5% to 5.0% of households, reflecting changes in household capacity to pay for health care due to the economic crisis, gaps in coverage and a large drop in public spending on health per person. Catastrophic incidence in non-covered households nearly doubled, rising on average from 1.6% in 2009 to 2.8% in 2015, and from 7.6% to 9.5% in the poorest quintile. The below average catastrophic incidence in non-covered households may be because only 16% of non-covered households were in the poorest quintile. It may also reflect unmet need among some non-covered households.

In 2019 Cyprus reversed the restrictions imposed in 2013 and established residence as the sole basis for entitlement. All those legally resident in Cyprus are now covered by the new General Health System, regardless of citizenship, income or payment of contributions and other taxes (Petrou, 2021).

Box 6. Ukraine avoided problems by creating an independent purchasing agency that is financed by the government budget

Ukraine embarked on an ambitious reform of its health system in 2017. Previous reform plans had aimed to set up a conventional SHI scheme with a view to having a purchaser-provider split, new provider payment methods, a clearly defined benefits package financed through earmarked contributions and entitlement based on payment of contributions.

In 2017 the government created a single, national purchasing agency, the National Health Service of Ukraine (NHSU), to contract a mix of public and private providers using new methods of paying providers. It introduced explicitly defined benefits for outpatient medicines (the Affordable Medicines Programme) in 2017 (see Box 18) and for other health services (the Programme of Medical Guarantees) in 2018.

By deviating from convention, the reform strengthened the health system's resilience to shocks. The new, independent purchasing agency is financed through general revenues from the government budget and entitlement to NHSU benefits is based on residence. As a result, Ukraine has managed to ensure that access to publicly financed health care is near universal, even in the context of the severe disruption caused first by the COVID-19 pandemic and then by the Russian Federation's invasion. Under these circumstances, maintaining near universal access would not have been possible if entitlement had been based on payment of contributions.

Source: authors based on Bredenkamp et al. (2021), WHO Regional Office for Europe (2023c) and Goroshko A (WHO Barcelona Office for Health Systems Financing), personal communication, October 2023.

2. Avoid excluding people from coverage

Summary

Most countries in Europe base entitlement to publicly financed health care on legal residence. This policy choice is the norm not only in countries that base entitlement on residence but also in countries that link entitlement to payment of contributions. Although basing entitlement on legal residence is a much better option than linking entitlement to payment of contributions, it often excludes people from coverage.

Basing entitlement on legal residence mainly excludes undocumented migrants but can also harm refugees and asylum seekers. In many countries entitlements for undocumented migrants are limited to emergency care. Refugees and asylum seekers often have similar entitlements to other residents, but all three groups are likely to face administrative and other barriers to accessing entitlements.

Excluding refugees, asylum seekers and undocumented migrants leads to a less visible gap in population coverage. They account for a very small share of the population and countries often report covering the whole population even when they do not cover undocumented migrants.

This policy choice harms people with low incomes and undermines health system equity, efficiency and resilience – but it does not have to be this way. Countries like Spain and (to a lesser extent) France grant undocumented migrants similar benefits to other residents, setting an important example. Even in these countries, however, administrative and other barriers prevent people from accessing their entitlements.

Basing entitlement on legal residence mainly excludes undocumented migrants

Most countries in Europe, including those that base entitlement on payment of contributions, limit entitlement to people with formal residence status. Although basing entitlement on legal residence is a much better option than linking entitlement to payment of contributions, it often excludes people from coverage.

This policy choice mainly affects undocumented migrants but can also affect refugees, asylum seekers, Roma and homeless people (Spencer & Hughes, 2015; WHO Regional Office for Europe, 2019; 2023a).

The gap in population coverage this creates is not so easily visible because it is often small – undocumented migrants account for under 1% of the population in Europe (Connor & Passel, 2019); countries tend to report covering the whole population even when they do not cover refugees, asylum seekers or undocumented migrants (OECD, 2023b); and the household surveys used to assess financial protection do not ask respondents about their residence status.

Undocumented migrants are likely to experience significant unmet need and financial hardship for two main reasons.

First, they have low incomes. On average, migrants who are not EU citizens but live in the EU have a much higher risk of poverty and social exclusion (46% in 2022) than EU citizens living in another EU country (27%) and EU citizens living in their own country (19%) (Eurostat, 2023d). As a subset of the first group, the risk of poverty and social exclusion in undocumented migrants is likely to be even higher than in other migrants (Box 7).

Second, their entitlement to publicly financed health care is typically very limited, even in countries that report covering the whole population (Table 1).

Box 7. Evidence on affordable access to health care for undocumented migrants and homeless people in Europe

Source: authors.

The survey data we use in this study do not adequately account for undocumented migrants or homeless people because they are limited to private households that are typically sampled from a national register (Eurostat, 2023a; 2023b; 2023c).

Researchers from Belgium carried out a pilot satellite survey in 2010, using a simplified version of the EU-SILC questionnaire in a sample of undocumented migrants and homeless people (Nicaise, Schockaert & Bircan, 2019). They found that 72% of homeless people and 96% of undocumented migrants were at risk of poverty, compared to only 15% of the general population. Undocumented migrants seemed to be in slightly better health than the general population, but more than 25% had disabilities or were chronically ill, 22% were (very) limited in their daily activities for health reasons and 20% considered their health to be bad or very bad, while about half of homeless people reported having disabilities or being chronically ill. Almost half of undocumented migrants were not aware of their right to emergency care; of those who were aware, 74% had used emergency services. Around 16% of undocumented migrants and 10% of homeless people reported unmet need for health care, compared to 0.5% of the general population and 1.5% of households with an increased risk of poverty.

These findings provide some evidence of the very high risk of financial hardship and unmet need undocumented migrants and homeless people in Europe are likely to face. Although the Belgian researchers acknowledge the limitations of their study, describing it as a “rough sketch”, they also note how easy it is to carry out satellite surveys and urge all EU countries to do so on a regular basis.

Table 1 shows that entitlements for undocumented migrants are often restricted to emergency care, for which they may have to pay out of pocket. Some countries also grant entitlement to care for communicable diseases and public health programmes. A few grant entitlement to some primary care services and some to specialist care.

Only two countries grant all undocumented migrants entitlement to the same (or similar) benefits as other residents (Box 8 on France and Box 9 on Spain), although a few other countries extend this to other groups – most often children (Greece, Italy and Sweden). Even in France and Spain, however, administrative and other barriers prevent people from accessing entitlements.

On paper, refugees and asylum seekers in Europe benefit from a better level of coverage than undocumented migrants because they are often granted similar entitlements to other residents (WHO Regional Office for Europe, 2023a; 2023b). Since the EU's temporary protection mechanism was activated and extended, this is particularly true for people fleeing the Russian Federation's war of aggression in Ukraine (European Council, 2023). In practice, however, people can have trouble accessing entitlements (European Observatory on Health Systems and Policies & European Commission, 2023).

Countries may be reluctant to extend coverage to undocumented migrants or improve access to health care for refugees and asylum seekers due to concerns about the cost. Undocumented migrants, refugees and asylum seekers are a relatively small group of people, however, so extending coverage to them is unlikely to impose a significant financial burden on countries. Covering undocumented migrants also improves efficiency in the use of health care because covered people are less likely to forego care or use emergency services (Marsaudon et al., 2023).

Some countries may fear that access to health care encourages immigration, but there is no evidence to suggest that the health system is an effective instrument for managing immigration or policing borders. Survey data from France, where undocumented migrants with low incomes are granted similar entitlements to other residents, show that access to health care is not an important factor in the decision to migrate for most undocumented migrants (Jusot et al., 2019).

Table 1. Entitlements for undocumented migrants, 2023 or the latest year available

	Entitled to the same benefits as legal residents	Entitled to limited primary care and (in some cases) secondary care	Entitled to specific services (e.g. public health and communicable diseases)	Entitled to emergency care only
SPA	People after 90 days of stay			
FRA	Children < 18; adults with low incomes after 90 days of stay			
ALB				
CRO				
CZH				
DEU				
IRE				
NET				
POR				
UNK				
BEL	In some areas			
ITA	Children < 18			
POL	Detained people			
ROM	People living in special accommodation centres			
EST		In some areas		
AUT				
DEN				
HUN				
ISR				
LVA				
SVN				
LTU			Children < 18	
GRE	Pregnant people, children < 18, people with disabilities or mental health conditions			
SWE	Children < 18			
BIH				
BUL				
CYP				
FIN				
LUX				
MAT				
MKD				
SVK				
UKR				

Notes: entitlements may have changed in some countries. Dark blue: covered for all undocumented migrants. Medium blue: covered for some undocumented migrants. Light blue: not covered. Data are for 2023 except Finland (2021) and Bulgaria, Czechia, Denmark, Germany, Hungary, Ireland, Latvia, Luxembourg, Netherlands (Kingdom of the), Portugal, Slovakia and Slovenia (2014, based on Spencer & Hughes (2015)).

Source: authors, using data from Spencer & Hughes (2015) and WHO Regional Office for Europe (2023a).

Box 8. Undocumented migrants with low incomes are entitled to similar benefits to other residents in France but may face administrative barriers

Source: authors, based on Bricard (in press).

France has offered some undocumented migrants free access to health care through *l'Aide Médicale de l'État* (AME) [the State Medical Aid scheme] since 2000. AME is available to undocumented migrants with low incomes (below €9571 a year for a single person in 2023) who have lived in France for at least three consecutive months. It is available without conditions to the children of undocumented migrants.

AME only covers half of those who are eligible, however – in 2019 it covered around 300 000 people (Jusot et al., 2019; Wittwer et al. 2019). Low take-up may reflect lack of information and administrative barriers (Dourgnon et al., 2023). Applying for AME is not a simple process: people must show proof of duration in France and proof of income and the application must be repeated every year.

AME can also be granted, exceptionally, on humanitarian grounds. Those who are not eligible for AME can access health care in dedicated facilities for people in vulnerable situations or through hospital emergency departments.

Recent analysis has shown that when people have access to AME they are less likely to forego health care and are more likely to consult professionals in regular settings as opposed to using emergency care or charitable services (Marsaudon et al., 2023).

Box 9. All undocumented migrants are entitled to similar benefits to other residents in Spain but may face legal and administrative barriers

Source: authors.

Undocumented migrants in Spain can apply to access publicly financed health care if they are not able to export their right to coverage from their country of origin. The application process varies by region. People are typically required to prove a minimum stay of 90 days in Spain and must re-apply at regular intervals ranging from every six months to whenever a person moves from one region to another.

In general, undocumented migrants and other residents are entitled to the same range of services, but in most regions they are given a special health card or a paper document instead of the regular health card. This may limit their access to prescribed medicines and increase the likelihood of discrimination by health staff (Yo Sí Sanidad Universal, 2022). Undocumented migrants are not able to benefit from protection against user charges for covered services.

There are no official data on the number of undocumented migrants who lack coverage; nongovernmental organizations put this number in the thousands (Médicos del Mundo, 2023). Obstacles to being covered include lack of information, administrative barriers such as long waiting times in the application process and limited understanding

of the complexities of entitlement, and racist attitudes on the part of health staff (Ministry of Equality, 2020; Ministry of Health, 2022a; Yo Sí Sanidad Universal, 2022).

3. Avoid applying user charges without effective protection mechanisms

Summary

A large body of evidence shows that user charges (co-payments) are not an effective way of directing people to use health services more efficiently. Even relatively small user charges can deter people from using needed health care, reduce adherence to treatment, increase the use of other health services, lead to financial hardship, increase the use of social assistance and adversely affect health, particularly in people with low incomes or chronic conditions.

Despite this evidence, user charges are widely applied in Europe, most often to treatment in primary care settings. While many countries rightly avoid applying user charges to outpatient visits and inpatient care, all apply charges to outpatient prescribed medicines and most apply charges to medical products and dental care.

User charges are a source of financial hardship, especially when mechanisms to protect people are absent or poorly designed. Our analysis suggests that catastrophic health spending is lower in countries that give greater protection from user charges to people with low incomes through exemptions and caps.

In addition to failing to protect people with low incomes, user charges in many countries are complex and bureaucratic. This undermines transparency, leads to confusion and financial uncertainty and prevents people from accessing entitlements. Percentage co-payments, balance billing (including reference pricing) and extra billing are particularly non-transparent, shift financial risk from the purchasing agency to households and expose people to out-of-pocket payments arising from health system inefficiencies.

It does not have to be this way. User charges can be carefully re-designed to reduce the likelihood of financial hardship and unmet need in the following ways: exempting people with low incomes or chronic conditions from all user charges; applying an income-based cap to all user charges; replacing percentage co-payments with low fixed co-payments; avoiding or abolishing balance billing and extra billing; and being as simple as possible, protecting people rather than diseases and minimizing administrative barriers.

When user charges are carefully designed, people know exactly how much they must pay out of pocket before they visit a doctor, undergo a diagnostic test or collect a prescription; they know that they do not have to pay more than a certain amount a year; and they automatically benefit from reduced user charges, exemptions and caps, without having to apply for them.

Some countries may lack the administrative infrastructure to exempt people with low incomes or apply income-based caps. These countries should avoid introducing user charges in the first place. If they have them already, they should use very low, fixed co-payments instead of percentage co-payments.

User charges in any form, including balance billing and extra billing, are not effective in reducing informal payments. This is because they fail to address the root causes of informal payments.

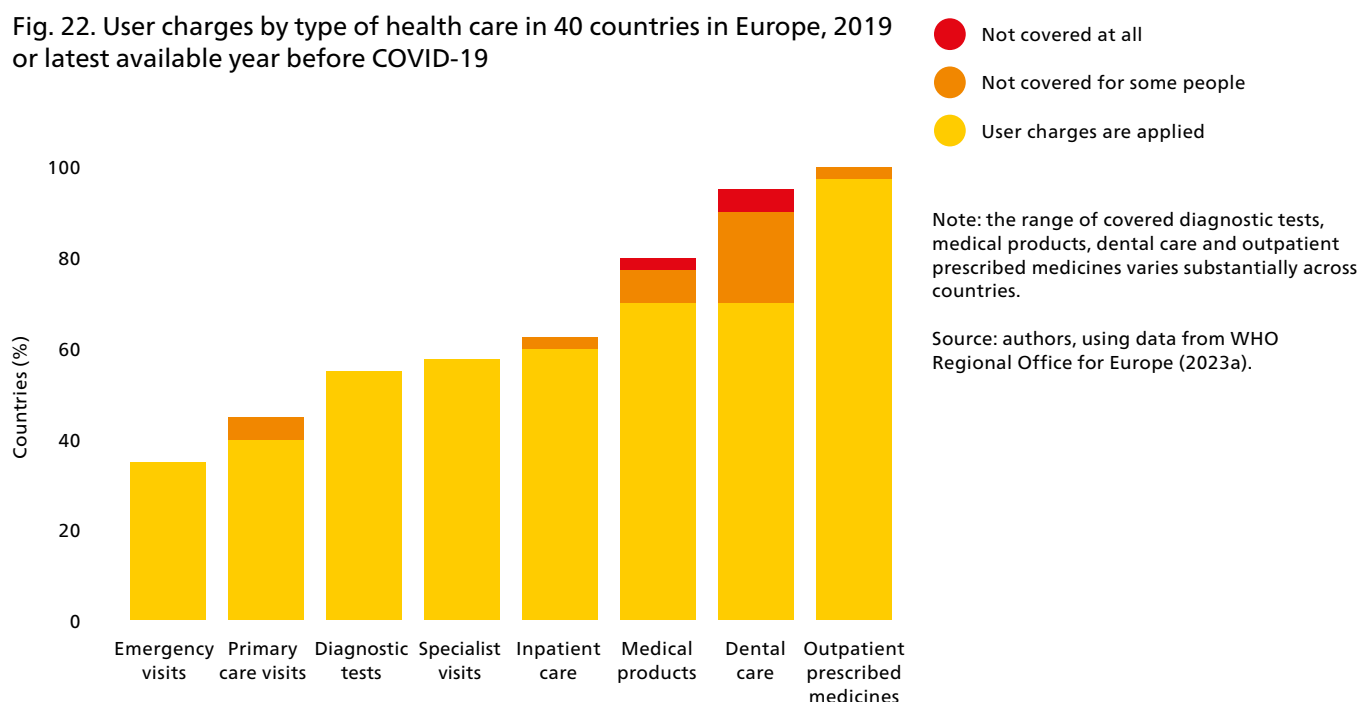
Despite the evidence against them, user charges are widely applied in Europe

A large body of evidence on the impact of user charges shows that:

- they are not an effective way of directing people to use health services more efficiently – faced with user charges, people reduce the use of essential and non-essential health care, including medicines, in equal measure (Newhouse & Insurance Experiment Group, 1993; Brook et al., 2006);
- people do not value interventions more highly when they have to pay for them out of pocket (Ashraf, Berry & Shapiro, 2010; Cohen & Dupas, 2010);
- even relatively small user charges can deter people from using needed health care, reduce adherence to essential medicines and other forms of treatment, increase the use of other health services, lead to financial hardship, increase the use of social assistance and adversely affect health, particularly in people with low incomes or chronic conditions (Tamblyn et al., 2001; Goldman, Joyce & Zheng, 2007; Chernew & Newhouse, 2008; Chandra, Gruber & McKnight, 2010; Persaud et al., 2019; Madden et al., 2021; Rättö & Aaltonen, 2021; Aaltonen, Niemelä & Prix, 2022; Guindon et al., 2022; Gross et al., 2022; Fusco et al., 2023); and
- user charges are not a good instrument for rationing because most decisions about health care use and costs are made by health care providers rather than patients (Chernew et al., 2021) – policy instruments targeting providers are therefore much more likely to be effective at achieving policy goals than user charges.

Despite this evidence, user charges are widely applied in Europe and are most likely to be applied to treatment in primary care settings: outpatient medicines, medical products and dental care (Fig. 22).

Fig. 22. User charges by type of health care in 40 countries in Europe, 2019 or latest available year before COVID-19



Poorly designed user charges undermine financial protection

The presence and design of user charges varies widely in Europe. This complexity makes it difficult to assess the gap in coverage they cause, especially across countries. We look at the incidence of catastrophic health spending in the study countries alongside information on the presence of user charges for different types of health care (Table 2) and information on the design of user charges for outpatient prescribed medicines – the main driver of financial hardship in Europe (Table 3).

Table 2 shows that there is considerable variation in the application of user charges and the incidence of catastrophic health spending across countries. This suggests that while user charges have a tendency to cause financial hardship and lead to unmet need, the harm done can be greatly reduced if countries pay careful attention to better design – the type of user charges in place, the presence and nature of mechanisms to protect people from user charges (e.g. exemptions and caps) and the extent to which these mechanisms explicitly aim to protect people with low incomes.

Table 3 shows that percentage co-payments (user charges defined as a share of the medicine price) are the most common type of user charge in place for outpatient prescribed medicines – applied in 29 of the 40 countries. Only four countries exclusively use fixed co-payments (user charges defined as a flat rate). All 40 countries attempt to protect people from co-payments for outpatient prescribed medicines, but the design of protection mechanisms – and the extent to which they aim to protect

people with low incomes – varies significantly. Although all 40 countries have exemptions from co-payments, only 14 explicitly exempt people with low incomes. While 13 countries have a cap on co-payments for medicines, only five link the cap to a person’s income, so that it is lower (more protective) for people with low incomes.

Countries that give greater protection from user charges to people with low incomes appear to have lower levels of catastrophic health spending: 14 of the 20 countries with a lower incidence of catastrophic health spending (below the median of 6% of households) exempt people with low incomes from co-payments or have a cap that is linked to income or (in rare instances) provide free VHI covering co-payments to people with low incomes (see the section “Avoid thinking VHI is the answer”). In contrast, there is no cap at all in 19 of the 20 countries with a higher incidence of catastrophic health spending (above the median).

Table 2. User charges for publicly financed health care by type of care and catastrophic health spending, 2019 or the latest available year before COVID-19

Notes: countries are sorted by the incidence of catastrophic health spending; see the note on Netherlands (Kingdom of the) under Fig. 3. Information on user charges is for the same year as data on catastrophic health spending and may not reflect the current situation. Varies: there are no user charges for some covered people, but other people must pay the full price out of pocket. Not covered: the type of care is not covered. Balance billing is treated as a type of user charge. The table does not capture extra billing. The range of covered diagnostic tests, medical products, dental care and outpatient prescribed medicines varies substantially across countries.

Source: authors, using data from WHO Regional Office for Europe (2023a) for most countries; information for Czechia, Denmark, Luxembourg, Netherlands (the Kingdom of), Poland, Slovakia, Slovenia and Türkiye come from European Observatory on Health Systems and Policies (2023) and MISSOC (2023).

Country	Year	Catastrophic health spending (% households)	Emergency visits	Primary care visits	Diagnostic tests	Specialist visits	Inpatient care	Medical products	Dental care	Outpatient prescribed medicines
NET	2015	0.5	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
SVN	2018	0.8	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
IRE	2016	1.2	Yes	Varies	No	No	Yes	Varies	Varies	Yes
UNK	2019	1.5	No	No	No	No	No	Yes	Yes	Yes
SPA	2019	1.6	No	No	No	No	No	Yes	Varies	Yes
SWE	2015	1.6	No	Yes	No	Yes	Yes	Yes	Yes	Yes
FRA	2017	2.1	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
LUX	2017	2.3	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DEU	2018	2.4	No	No	No	No	Yes	Yes	Yes	Yes
DEN	2015	2.6	No	No	No	No	No	Yes	Yes	Yes
SWI	2017	2.9	Yes	Yes	Yes	Yes	Yes	Yes	Varies	Yes
AUT	2015	3.2	No	Yes	No	Yes	Yes	Yes	Yes	Yes
CRO	2019	3.6	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FIN	2016	3.8	Yes	Yes	No	Yes	Yes	Varies	Yes	Yes
BEL	2018	3.8	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CZH	2019	4.2	Yes	No	No	No	No	Yes	Yes	Yes
TUR	2018	4.3	No	No	Yes	Yes	Yes	Yes	Yes	Yes
CYP	2015	5.0	Yes	Yes	Yes	Yes	Varies	No	Yes	Yes

Table 2. Contd

Country	Year	Catastrophic health spending (% households)	Emergency visits	Primary care visits	Diagnostic tests	Specialist visits	Inpatient care	Medical products	Dental care	Outpatient prescribed medicines
SVK	2015	5.1	Yes	No	No	No	No	Yes	Yes	Yes
ISR	2019	5.7	No	No	Yes	Yes	No	No	Yes	Yes
MKD	2018	6.5	No	No	Yes	Yes	Yes	Yes	Yes	Yes
MAT	2015	6.9	No	No	No	No	No	Varies	Varies	Varies
EST	2019	7.2	Yes	No	No	Yes	Yes	Yes	Yes	Yes
POL	2019	8.6	No	No	No	No	No	Yes	No	Yes
BIH	2015	8.8	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
GRE	2019	8.9	No	No	Yes	No	Yes	Yes	Yes	Yes
MNE	2017	9.4	No	Yes	Yes	Yes	Yes	Yes	Varies	Yes
ITA	2019	9.4	Yes	No	Yes	Yes	No	No	Yes	Yes
POR	2015	10.6	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
HUN	2015	11.6	No	No	No	No	No	Yes	Yes	Yes
MDA	2019	11.7	No	No	No	No	No	No	Varies	Yes
SRB	2019	12.2	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ALB	2015	12.5	No	No	Yes	No	No	No	Varies	Yes
ROM	2015	12.5	No	No	No	No	Yes	Yes	Yes	Yes
LVA	2016	15.0	No	Yes	Yes	Yes	Yes	Yes	Varies	Yes
LTU	2016	15.2	No	No	No	No	No	No	Varies	Yes
GEO	2018	17.4	Yes	Varies	Yes	Yes	Yes	No	Not covered	Yes
UKR	2019	18.0	No	No	No	No	No	No	No	Yes
BUL	2018	19.2	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ARM	2019	20.3	No	No	Yes	No	Yes	Not covered	Yes	Yes

Table 3. User charges for publicly financed outpatient prescribed medicines and catastrophic health spending, 2019 or the latest available year before COVID-19

Notes: countries are sorted by the incidence of catastrophic health spending; see the note on Netherlands (Kingdom of the) under Fig. 3. Information on user charges is for the same year as data on catastrophic health spending and may not reflect the current situation. D: deductible. FC: fixed co-payment. PC: percentage co-payment. RP: reference pricing. Malta has no user charges for covered outpatient prescribed medicines; people pay the full price out of pocket if they are not entitled to a “yellow” or “pink” card. The range of covered outpatient prescribed medicines varies across countries.

Source: authors, using data from WHO Regional Office for Europe (2023a) for most countries; information for Czechia, Denmark, Luxembourg, Netherlands (the Kingdom of), Poland, Slovakia, Slovenia and Türkiye come from European Observatory on Health Systems and Policies (2023) and MISSOC (2023).

Country	Year	Catastrophic health spending (% households)	Type of co-payment	Exemption from co-payments	Cap on co-payments
NET	2015	0.5	D, RP	Yes, but not based on income	No, but the deductible limits co-payments
SVN	2018	0.8	PC, RP	Yes, based on income	No, but VHI covers co-payments for > 90% of the population
IRE	2016	1.2	FC	Yes, but not based on income	Yes, based on income
UNK	2019	1.5	FC	Yes, based on income	Yes, but not based on income; only for people who request it in advance
SPA	2019	1.6	PC	Yes, based on income	Yes, based on income, but only for pensioners
SWE	2015	1.6	D, PC	Yes, based on income	Yes, but not based on income
FRA	2017	2.1	FC, PC	Yes, based on income for FC, but not based on income for PC	No, but VHI covers co-payments for > 90% of the population and is provided for free to people with low incomes
LUX	2017	2.3	PC, RP	Yes, but not based on income	Yes, based on income
DEU	2018	2.4	PC, RP	Yes, but not based on income	Yes, based on income
DEN	2015	2.6	D, FC, PC, RP	Yes, based on income	Yes, but not based on income
SWI	2017	2.9	D, PC	Yes, but not based on income	Yes, but not based on income
AUT	2015	3.2	FC	Yes, based on income	Yes, based on income
CRO	2019	3.6	FC, RP	Yes, but not based on income	No, but VHI covers co-payments for most people who have to make co-payments and is provided for free to people with low incomes
FIN	2016	3.8	D, PC	Yes, based on income	No, but there is a threshold for reduced co-payments
BEL	2018	3.8	FC, PC, RP	Yes, but not based on income	Yes, based on income
CZH	2019	4.2	RP	No	Yes, but not based on income
TUR	2018	4.3	FC, PC	Yes, but not based on income	No
CYP	2015	5.0	FC	No	No
SVK	2015	5.1	PC	Yes, but not based on income	Yes, but not based on income and only for people with disabilities, pensioners, and people above 60
ISR	2019	5.7	PC	Yes, but not based on income	Yes, but not based on income and only for people with chronic conditions
MKD	2018	6.5	PC, RP	Yes, but not based on income	No
MAT	2015	6.9	None for some covered people	NA	NA
EST	2019	7.2	FC, PC, RP	Yes, but not based on income	No, but there is a threshold for reduced co-payments
POL	2019	8.6	FC, PC, RP	Yes, but not based on income	No
BIH	2015	8.8	FC, PC, RP	Yes, based on income (some cantons)	No

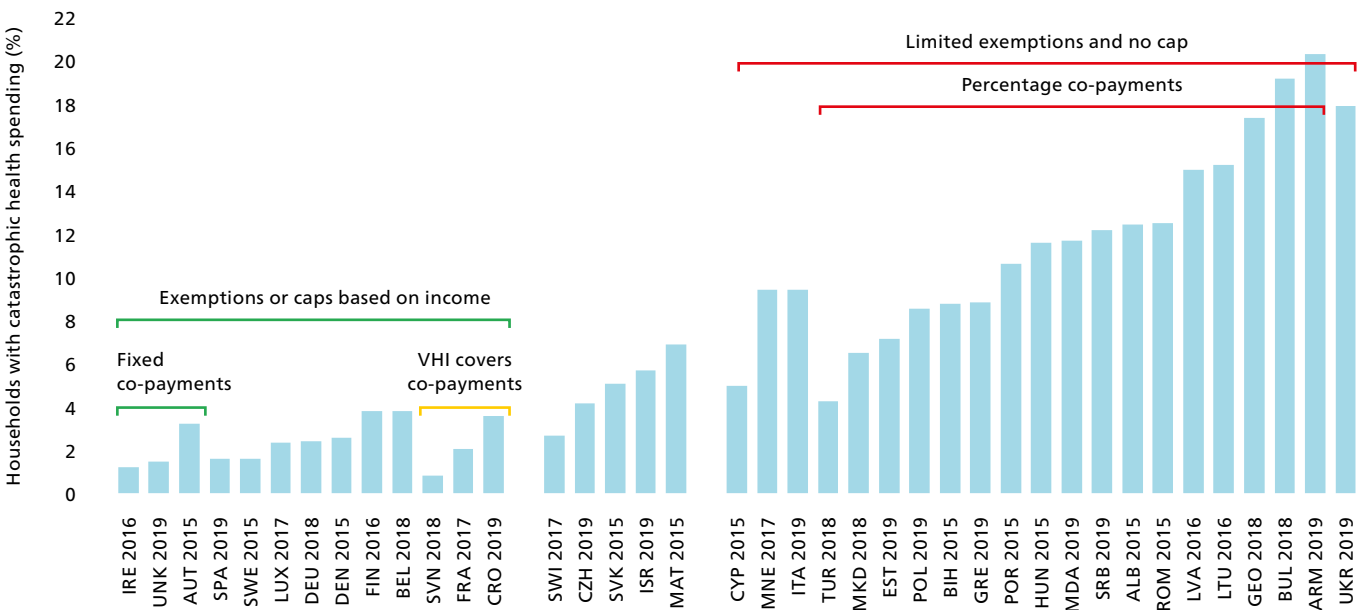
Table 3. Contd

Country	Year	Catastrophic health spending (% households)	Type of co-payment	Exemption from co-payments	Cap on co-payments
GRE	2019	8.9	FC, PC, RP	Yes, based on income	No
MNE	2017	9.4	FC	Yes, based on income	No
ITA	2019	9.4	FC, RP	Yes, based on income (some regions)	No
POR	2015	10.6	PC	Yes, but not based on income	No
HUN	2015	11.6	PC	Yes, but not based on income	No
MDA	2019	11.7	FC, PC, RP	Yes, based on income	No
SRB	2019	12.2	FC, PC	Yes, but not based on income	No
ALB	2015	12.5	PC, RP	Yes, but not based on income	No
ROM	2015	12.5	PC	Yes, but not based on income	No
LVA	2016	15.0	FC, PC, RP	Yes, based on income	No
LTU	2016	15.2	PC, RP	Yes, but not based on income	No
GEO	2018	17.4	PC	Yes, based on income	No
UKR	2019	18.0	RP	Yes, but not based on income	No
BUL	2018	19.2	PC, RP	Yes, but not based on income	No
ARM	2019	20.3	PC	Yes, based on income	No

What can countries do to avoid or address problems?

The design of user charges policy plays a critical role in determining the extent and distribution of out-of-pocket payments for covered health services. Our analysis suggests that user charges are an important source of financial hardship in many countries in Europe. They are most likely to undermine financial protection when they are applied without mechanisms to protect people or when protection mechanisms exist but are poorly designed, as shown in Fig. 23.

Fig. 23. The design of user charges for outpatient prescribed medicines and catastrophic health spending, 2019 or the latest available year before COVID-19



As a result, user charges should be applied sparingly and carefully designed to:

- exempt people with low incomes or chronic conditions;
- apply an income-based cap to all user charges;
- avoid percentage co-payments or replace them with low fixed co-payments;
- avoid or abolish balance billing and extra billing; and
- be as simple as possible, protect people rather than diseases and minimize administrative barriers.

The following paragraphs look at these evidence-based examples of good practice in more detail, with country examples. Changes to user charges should focus on all these issues rather than expecting one of them alone to be sufficiently effective.

Good practice 1: Exempt people with low incomes or chronic conditions

All countries with user charges exempt some groups of people from having to pay, indicating widespread acknowledgement of the potential for user charges to undermine financial protection. Only a minority explicitly exempt people with low incomes, however (see Table 3; WHO Regional Office for Europe, 2023a).

Exemptions can be applied first to people receiving social benefits, a group that is administratively easy to identify, and then progressively extended to other people with low incomes (e.g. long-term unemployed people) and people with chronic conditions. Even in contexts where social assistance is less effective, it makes sense to start by exempting social beneficiaries rather than creating a separate means-tested system for the health sector.

Spain and the United Kingdom, two countries with relatively low levels of catastrophic health spending (around 1.5% in 2019), highlight the importance of keeping user charges to a minimum and protecting people with low incomes and people with chronic conditions from user charges. In both countries, user charges are limited to outpatient prescribed medicines, medical products and dental care (see Table 2). The United Kingdom (Box 10) has a long history of protecting people from user charges, while Spain (Box 11) has improved protection for people with low incomes in the last couple of years.

Box 10. Over 90% of outpatient prescriptions are exempt from user charges in the United Kingdom – and exemptions focus on people, not just diseases

Source: authors, based on Cooke O’Dowd, Kumpunen & Holder (2018) and WHO Regional Office for Europe (2023a).

Northern Ireland, Scotland and Wales abolished user charges for outpatient prescribed medicines over a decade ago. Prescription charges continue to be applied in England, but people with low incomes, children under 18, pregnant people, people aged over 60 and people with selected chronic conditions are exempt. As a result, around 90% of all outpatient prescribed medicines in England are dispensed without user charges (Cooke O’Dowd, Kumpunen & Holder, 2018).

Importantly, people with one of the selected chronic conditions are exempt from all prescription charges, not just charges for the treatment of that condition. To be exempt people must apply for a medical exemption certificate every five years. In 2023 the selected conditions are fistulas, hypoadrenalism, diabetes, hypoparathyroidism, myasthenia gravis, myxoedema, epilepsy, cancer and having a continuing physical disability (not being able to go out without the help of another person) (NHS Business Services Authority, 2023).

Box 11. Spain has recently strengthened protection against user charges for outpatient prescriptions for people with low incomes

Source: authors, based on Cooke O'Dowd, Kumpunen & Holder (2018) and WHO Regional Office for Europe (2023a).

Despite worsening during the economic crisis, catastrophic health spending in Spain is relatively low and concentrated in the poorest quintile and households headed by people of working age (Urbanos-Garrido et al., 2021). On average, it is largely driven by out-of-pocket payments for dental care and medical products, which are not well covered by the NHS. In the poorest quintile, however, catastrophic health spending is driven by outpatient medicines; their role in driving financial hardship grew following an increase in user charges for outpatient prescriptions in 2012, at the height of the crisis, which suggests that the design of user charges has not been sufficiently protective for people with low incomes.

Heavy percentage co-payments (60% of the tariff) are applied to outpatient prescriptions but with several protection mechanisms in place: reduced co-payments for people with lower incomes (50% and 40% of the tariff, depending on household income); exemptions for disadvantaged groups of people; an income-based cap on co-payments for pensioners; and a cap of €4.24 per prescription item for most medicines for chronic conditions.

For working-age people, co-payments for outpatient prescriptions are high even after being reduced: those earning less than €18 000 a year (around 21.5 million people in 2020, or two-thirds of working-age people) still have to pay 40% of the tariff and do not benefit from a cap (unlike pensioners) (Ministry of Health, 2022b).

To address this gap, co-payment exemptions were extended to:

- working-age people receiving the “minimum vital income” (a means-tested benefit for people with an annual income < €16 614 for a person living alone) in 2020; and
- pensioners with very low incomes (< €5635 a year), children with moderate and severe disabilities, and households receiving child benefits, in 2021.

As a result of these changes, 7 million people were exempt from user charges for outpatient prescribed medicines in 2022, up from 2 million in 2020 (Ministry of Health, 2022b). The positive impact of these changes would be even greater, however, if administrative barriers were removed. While pensioners with very low incomes automatically benefit from the exemption, many working-age people with low incomes are unable to benefit due to administrative barriers that have hindered take-up of the minimum vital income scheme: at the end of 2022 only 65% of eligible households were receiving the minimum vital income.

Good practice 2: Apply an income-based cap to all user charges

Caps should apply to all user charges. Ideally, they should be set as a very low share of household income, so that they give more protection to people with low incomes. In contexts where this is less administratively feasible, having lower caps for people with lower incomes or people with chronic conditions can be more effective than having a single cap.

Most countries in Europe do not have any form of cap on user charges (WHO Regional Office for Europe, 2023a). In some countries, a cap is applied to outpatient visits or inpatient care but not to outpatient prescribed medicines (e.g. Bulgaria, Croatia and North Macedonia).

Very few countries have a cap on all user charges. Income-based caps are set as a share of household income in two countries only: Austria and Germany. More often there is simply a lower (more protective) cap for people with low incomes (e.g. Belgium, Cyprus, Ireland, Luxembourg and Spain). Spain's income-based cap only applies to pensioners.

As with all protection mechanisms, caps are most effective when they are applied automatically, using digital tools, as in Austria (Box 12).

Caps alone are unlikely to be sufficient to protect people with low incomes, however, which is why exemptions are also needed.

Box 12. Automation ensures high take-up of Austria's income-based cap on user charges for outpatient prescriptions

Source: adapted from WHO Regional Office for Europe (2019).

User charges apply to most health services in Austria and are a key gap in coverage. User charges for outpatient prescribed medicines are more carefully designed than user charges for other services, however, through the combination of two protective mechanisms: the use of a relatively low, fixed co-payment (€6.85 per prescription item in 2023) and an automatic income-based cap per household, which is set at 2% of the net annual income of the person who pays contributions to the SHI scheme.

The cap (known as *Rezeptgebührenobergrenze* [prescription fee cap] or REGO) has been popular since it was introduced in 2008, partly because it is automated and administratively easy to use. People show the doctor the electronic card (e-card) they need to access publicly financed health care and the doctor uses the card to access a secure health information network with information on prescription charges accrued so far and the level of the cap for that person. If the cap has been reached, the doctor ticks a box on the paper prescription indicating that the prescription is exempt from user charges.

Criticisms of the cap are that it does not apply to prescribed medicines that cost less than the fixed co-payment, it benefits large households who may reach the cap more quickly than small households and it does not apply to all user charges.

Good practice 3: Avoid percentage co-payments or replace them with low fixed co-payments

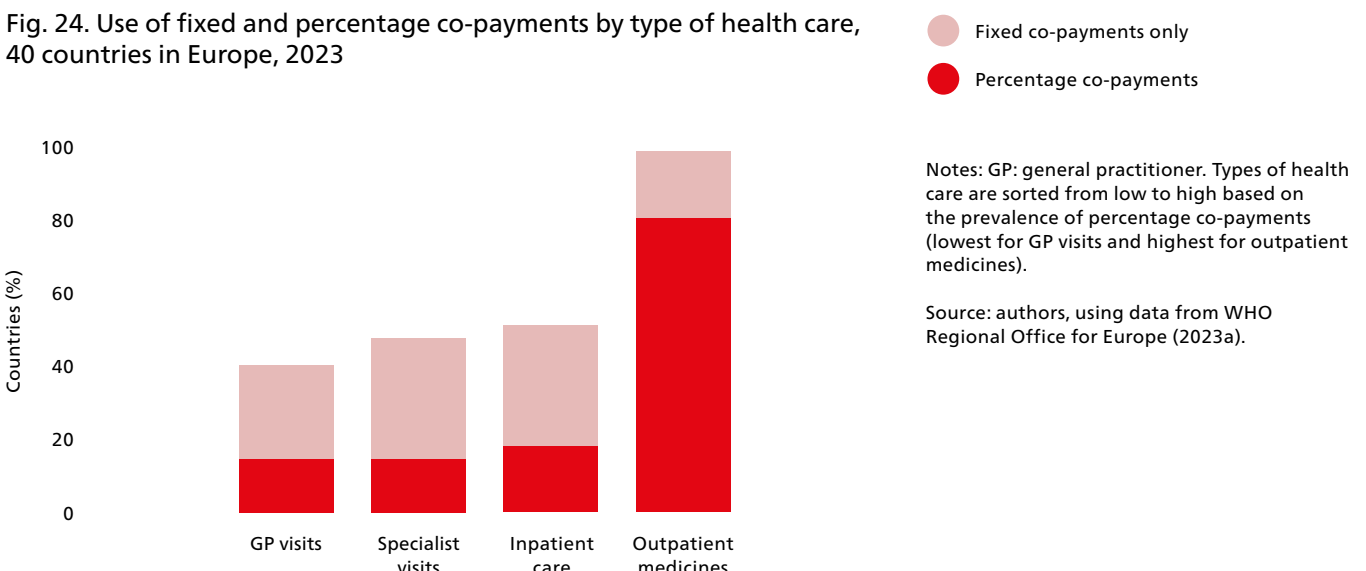
The type of co-payment used matters. When co-payments are low and fixed (i.e. people pay a flat amount) rather than set as a percentage of the tariff or price, people are more likely to know in advance how much they will have to pay out of pocket, enhancing transparency and financial certainty.

Percentage co-payments have serious disadvantages in comparison to low, fixed co-payments.

- They are less transparent, particularly when prices vary or are not easily known in advance (as is the case for medicines and medical products), leading to greater financial uncertainty for users (Salampessy et al., 2018).
- They shift financial risk from the purchasing agency to households and expose people to out-of-pocket payments arising from health system inefficiencies – for example, when doctors and pharmacists are not required or do not have incentives to prescribe and dispense cheaper alternatives (e.g. generic and biosimilar medicines).
- They are unfair, because people with illnesses that require more expensive treatment will have to pay more out of pocket than those with illnesses that can be treated more cheaply.

Fig. 24 suggests that many countries implicitly recognize the negative effects of percentage co-payments: fixed co-payments are more commonly used than percentage co-payments for outpatient consultations and inpatient care. In contrast, most countries use percentage co-payments for outpatient prescribed medicines, where they are often combined with fixed co-payments or reference pricing (see Table 3).

Fig. 24. Use of fixed and percentage co-payments by type of health care, 40 countries in Europe, 2023



Only a few countries use fixed co-payments alone for outpatient prescriptions: Austria, Cyprus, Ireland and England in the United Kingdom (Fig. 24 and Table 3). Germany applies a cap per prescription item (€10 in 2023) and Spain does the same for most medicines for chronic conditions (€4.24 per prescription in 2023), which makes percentage co-payments work more like fixed co-payments.

Box 13 discusses some of the reasons why countries continue to apply percentage co-payments, despite the evidence against their use.

Box 13. Why do countries use percentage co-payments?

Source: WHO Regional Office for Europe (2019).

Countries may use percentage co-payments for the following reasons.

They are a hangover from the days of retrospective reimbursement in SHI schemes, when patients would pay providers themselves, and purchasing agencies would reimburse both patients and providers based on an agreed percentage split. Continued use of percentage co-payments, as well as retrospective reimbursement, are out of keeping with efforts to move towards strategic purchasing involving prospective payment of providers and the provision of benefits in kind to patients. Today, only a handful of countries in Europe allow retrospective reimbursement of patients for publicly financed health care – Andorra, Belgium, France and Luxembourg – and Belgium and France are trying to reduce it (Bouckaert, Maertens de Noordhout & Van de Voorde, 2023; Bricard, in press; WHO Regional Office for Europe, 2023a).

Purchasing agencies may favour percentage co-payments because they believe that exposing people to the price of a good or service will encourage them to choose cheaper alternatives. This is questionable when applied to treatment prescribed by health professionals, given the extent of information asymmetry in health care, and when prices are not easily known in advance. It shifts financial risk from the purchasing agency onto households, particularly in contexts where the supply of health care is not adequately regulated and monitored.

Linking reimbursement to a percentage of price gives purchasing agencies flexibility to reduce coverage when there is a budget constraint – in other words, to shift more of the cost onto households. The same can be done with fixed co-payments, but changes to percentage co-payments may be less visible to the public.

All three reasons put the financial perspective of purchasing agencies above the interests of people needing health care.

Good practice 4: Avoid or abolish balance billing and extra billing

Balance billing occurs when contracted providers are allowed to charge people more than the price or tariff determined by the purchasing agency for covered services.

Extra billing occurs when contracted providers are allowed to charge people for services that are not included in the publicly financed benefits package within a publicly financed episode of care. It is most likely to be problematic when it occurs for clinical services such as medical devices or diagnostic tests.

Balance billing and extra billing typically result in highly non-transparent out-of-pocket payments that:

- increase financial uncertainty for people;
- are often confusing – in some countries people may mistake them for informal payments (Bouckaert, Maertens de Noordhout & Van de Voorde, 2023);
- can be a source of financial hardship, particularly for people with low incomes, because mechanisms to protect people from user charges do not usually apply (Viriyathorn et al., 2023); and
- are likely to skew health system resources away from need and towards people who can afford to pay more out of pocket.

Very few health systems in Europe allow balance billing and very few report extra billing; most of the countries that do allow them are trying to eliminate them (WHO Regional Office for Europe, 2023a). Their experience suggests that controlling balance and extra billing is not always easy due to opposition from health care providers.

Balance billing is widespread in Belgium and France (outpatient and inpatient care), but there have been multiple efforts to reduce it (see Box 14 and Box 15). It has recently been abolished in Georgia (Box 16). Although Romania passed a law to introduce balance billing in 2019, implementation has been repeatedly postponed and is now pushed back to 2025 (Scîntee, Mosca & Vlădescu, 2022).

Extra billing is reported as being allowed in Belgium, Bulgaria, Estonia, France, Romania and Ukraine but may occur more widely (WHO Regional Office for Europe, 2023a). As with balance billing, most of these countries are trying to limit it. Georgia abolished extra billing in 2023 (Box 16); Bulgaria introduced upper limits in contracted hospitals in 2011; and public hospitals in Romania can only offer superior accommodation if they are also able to guarantee standard accommodation for everyone requiring admission, which rarely occurs in practice.

Reference pricing is a form of balance billing applied to outpatient prescribed medicines. It requires users to pay the difference between the purchaser's tariff (reference price) and the retail price. Around half of the study countries apply reference pricing to outpatient prescriptions,

usually on top of fixed or percentage co-payments but sometimes without other co-payments (see Table 1). Reference pricing may not be harmful in contexts where it is mandatory for prescribers and dispensers to opt for medicines that do not cost more than the reference price and where these medicines are in good supply. If these conditions are not met, however, reference pricing is likely to be as non-transparent as other forms of balance billing and will expose people to health system inefficiencies and financial hardship.

Box 14. Efforts to reduce balance billing for inpatient care in Belgium

Source: authors, based on Bouckaert, Maertens de Noordhout & Van de Voorde (2023).

Balance billing is widespread in outpatient care, dental care and inpatient care (fee supplements) and extra billing is widespread in inpatient care (room supplements). In 2021 these payments occurred in around 20% of inpatient admissions, with an average payment of €2100 for a single room in addition to an average co-payment of €247.

Mechanisms to protect people from user charges do not apply to balance or extra billing. Although VHI covers some of these costs, take-up of VHI is heavily skewed towards richer people; 88% of people in the richest income quartile have VHI compared to only 42% of people at risk of poverty (Capéau et al., 2018).

Hospitals were initially free to set their own rules for balance and extra billing, resulting in large variation. However, balance billing was banned in shared hospital rooms for overnight stays in 2013 and forbidden in single rooms if the room is needed on clinical grounds. It was abolished in shared hospital rooms for day care in 2015. The maximum fee supplements allowed were frozen at hospital level in 2022. A new law passed in 2022, and expected to take effect in 2024, prohibits fee supplements in outpatient care for people eligible for reduced co-payments (mainly people with low incomes and children with disabilities).

Eurobarometer survey data consistently find informal payments to be above the EU average in Belgium (European Commission, 2014; 2017; 2020; 2023). Anecdotal evidence suggests that waiting times for outpatient and inpatient care are reduced in return for accepting balance billing and (in rare cases) informal payments. It is also possible that some people may mistake balance billing for an informal payment, perhaps due to a lack of information or uncertainty about whether balance billing will be charged, how much it will cost and whether it will be covered by VHI.

Box 15. Efforts to reduce balance billing for medical products in France

Source: authors, based on Bricard (in press).

Balance billing is permitted for some doctors and dentists in outpatient settings; doctors in contracted private hospitals; and medical products such as crowns, bridges and dentures, glasses and contact lenses, and hearing aids. Medical products are not subject to price limits, leading to significant balance billing. These payments are in addition to user charges, which are applied to most health care.

VHI covering user charges and some balance billing is taken up by around 95% of the population. Despite being free for people with very low incomes, and heavily subsidized by the government for people with low incomes, around 11% of people in the poorest quintile do not have any form of VHI.

Balance billing for doctor visits has not been permitted for people with free VHI since 2000 or people with heavily subsidized VHI since 2012. In 2015 VHI coverage of balance billing for doctor visits was capped for people with so-called responsible VHI contracts, to limit prices. In 2019, with gradual implementation up to 2021, the 100% santé [100% health] reform started to reduce out-of-pocket payments for medical products for these three groups of people by increasing government tariffs (to reduce co-payments) and capping retail prices for a basic set of medical products (to prevent balance billing).

Box 16. Abolishing balance billing and extra billing for publicly financed inpatient care in Georgia

Source: authors, based on Goginashvili et al. (2021), Ministry of Labor, Health and Social Protection of internally displaced people from Occupied Territories of Georgia (2023) and Tomas Roubal and Mari Tvaliashvili (WHO Country Office in Georgia), personal communication, November 2023.

Until recently health care providers in Georgia were allowed to set their own prices for inpatient care and to charge users more than the government tariff, in addition to the percentage co-payments many users already had to pay. This meant that out-of-pocket-payments for a given hospital service varied widely across providers, making it difficult for people to know in advance how much they would have to pay out of pocket. Users were also able to pay extra for non-covered services in an episode of publicly financed care (extra billing), including non-covered medical services such as more expensive inputs for a hip replacement or cataract surgery.

In early 2023 the Government introduced a system of diagnosis-related groups to pay contracted hospitals for covered services and increased public spending on inpatient care. Provider prices are now unified and providers are no longer allowed to ask people to pay anything in addition to the co-payment; if users want non-covered medical services they must forego publicly financed coverage and pay for the full cost out of pocket. The Government also introduced a cap on co-payments for inpatient care. The cap is lower (more protective) for pensioners and other priority age groups.

Out-of-pocket payments for a given hospital service no longer vary across providers, which enhances transparency and reduces financial uncertainty. The Government also introduced a cap on co-payments for inpatient care; the cap is lower (more protective) for pensioners and other priority age groups. Government reports indicate that because of these changes co-payments fell from 27% of the total cost of inpatient care in 2022 to 10% in 2023.

Good practice 5: Be as simple as possible, protect people rather than diseases and minimize administrative barriers

User charges policy in many countries is complex and bureaucratic, which undermines transparency, leads to confusion and financial uncertainty and prevents people from accessing entitlements. Country-level analysis suggests that it is best to design user charges so that they are as simple as possible, protect people rather than diseases and use automation to avoid administrative barriers.

User charges policy in many countries is complex and bureaucratic, which undermines transparency, leads to confusion and financial uncertainty and prevents people from accessing entitlements. In a simply designed system, people will know exactly how much they will have to pay out of pocket before they visit a doctor, undergo a diagnostic test or collect a prescription.

Reduced user charges and exemptions often focus on treatment for specific diseases, which means – for example – that people are exempt from paying for prescriptions for a specific condition but must pay for any other prescriptions they may need. It is better to follow the approach taken in the United Kingdom and exempt people with chronic conditions from all prescription charges (see Box 10) – and from all user charges – because they are likely to develop more than one condition and to need care more frequently.

Although many countries aim to protect people from user charges through reduced co-payments, exemptions or caps, sub-optimal implementation of these protection mechanisms can create financial and administrative barriers that prevent take-up.

If people have to pay user charges first and then apply retrospectively to benefit from a protection mechanism, some people may not be able to afford to pay the charges up front, some may not know about the additional benefit and some may find it difficult to apply for it because of the paperwork involved – for example, the requirement to provide proof of income, proof of health status or pharmacy receipts.

Survey data from Belgium show that when people with low incomes have to apply for reduced user charges, take-up is low: in 2019 only 30% of eligible people of working age and 60% of eligible people over 65 applied for the additional benefit (Goedemé, Bolland & Janssens, 2022).

To avoid these barriers, protection mechanisms should be applied automatically, with the help of digital tools where necessary. Analysis from Estonia shows that applying reduced user charges automatically in the pharmacy, using the pharmacy information technology (IT) system, increased take-up from 40% to 100% (Box 17).

Finally, countries need to monitor co-payment policy, to ensure that protection mechanisms are adequate and effective.

Box 17. Automating and increasing protection from user charges for outpatient medicines had a dramatic impact on high out-of-pocket payments in Estonia

Source: WHO Regional Office for Europe (2023d).

The incidence of catastrophic health spending is relatively high in Estonia and largely driven by out-of-pocket payments for outpatient medicines and dental care. Household spending on medicines reflects in part a complex system of fixed co-payments, percentage co-payments and reference pricing.

The protection mechanisms in place include an annual spending threshold (known in Estonia as the additional medicines benefit), which reduces co-payments for people who spend over a defined amount on co-payments per year. Historically, however, only a few people benefited from reduced co-payments because the eligibility threshold was high, many were not aware they were eligible for the benefit and the application process was administratively cumbersome – people had to keep pharmacy receipts and submit them to the purchasing agency at the end of the year.

In 2018 the threshold was lowered from €300 to €100 a year, so that more people were eligible for reduced co-payments. It was also automated, so that everyone eligible could benefit automatically at the pharmacy, through the pharmacy IT system.

Lowering the threshold increased the number of people entitled to benefit from 8000 to 134 000. Digitalizing the system meant everyone who was eligible benefited, representing a significant increase in take-up from 38% before the reform. As a result of both changes, the share of people with a prescription who benefited from reduced co-payments rose from 0.4% in 2017 to 15.6% in 2018, while the number of people spending more than €250 on outpatient prescribed medicines a year fell from 24 000 to 1000.

4. Avoid failing to cover treatment in primary care settings

Summary

Gaps in the coverage of primary care undermine financial protection in every country in the study. Households with catastrophic health spending are mainly paying out of pocket for outpatient medicines, outpatient medical products (items like glasses, hearing aids, nebulizers and wheelchairs) and outpatient dental care – services that are commonly delivered or managed in primary care settings.

Many countries recognize the importance of good access to primary care and try to protect people from out-of-pocket payments for consultations and diagnosis. Primary care visits and diagnostic tests are typically included in the benefits package and are often free from user charges.

People are much less protected from out-of-pocket payments for treatment in primary care settings, however, suggesting that countries do not always think of medicines, medical products and dental care as part of primary care. Many countries have significant gaps in the benefits package for medicines, medical products and dental care and most countries apply user charges to these types of care, often in the form of percentage co-payments.

Covering higher cost specialist care is not enough to secure financial protection. The use of lower cost primary care services is a major driver of unmet need and financial hardship. In Europe, it is the main driver of financial hardship in households with low incomes.

Failing to include primary care treatment in the benefits package, or applying poorly designed user charges, increases rather than prevents inefficient patterns of use. Policy-makers may have valid concerns about inappropriate use of health care, but these concerns are more effectively addressed through policy instruments that target the way in which health care is supplied.

Primary care is more than consultation and diagnosis: it cannot be seen as complete if it does not offer good access to treatment.

Medicines, medical products and dental care are necessities, not luxuries, and should be affordable for everyone.

Financial protection is undermined by gaps in the coverage of primary care

Households with catastrophic health spending are mainly paying out of pocket for outpatient medicines, outpatient medical products (items like glasses, hearing aids, nebulizers and wheelchairs) and outpatient dental care (see Fig. 7).

This suggests that catastrophic health spending is largely driven by gaps in the coverage of primary care. A significant share of these out-of-pocket payments are likely to be spent in primary rather than secondary care settings because:

- they are spent on medicines and medical products purchased by people for use outside health care facilities – medicines and medical products supplied by health care providers, which are more likely to be specialist in nature, are classified as outpatient or inpatient care in household budget surveys (United Nations Statistics Division, 2018);
- dental care and the treatment of vision and hearing problems are typically managed by professionals providing first contact care – in this sense, they are (or should be) an essential part of primary care; and
- international definitions of primary care spending count spending on these three types of outpatient care (Mueller & Morgan, 2018; WHO, 2022; WHO Regional Office for Europe, 2022).

These gaps reflect policy choices and mainly harm people with low incomes or chronic conditions

Looking at coverage policy for primary care in Europe shows two things (WHO Regional Office for Europe, 2023a).

First, many countries try to protect people from out-of-pocket payments for primary care visits and diagnostic tests, suggesting that they recognize the importance of affordable access to primary care. Primary care visits and diagnostic tests are typically included in the benefits package (although the scope of diagnostic tests covered may vary significantly across countries) and, along with emergency care, are more likely to be free from user charges than other types of health care (see Fig. 22).

Second, people are much less protected from out-of-pocket payments for outpatient medicines, medical products and dental care, which suggests that countries do not always think of these services as part of primary care – or are less concerned about ensuring affordable access to them. Some high- and middle-income countries exclude dental care (Winkelmann, Gómez Rossi & van Ginneken, 2022) and medical products like glasses and hearing aids from the benefits package, particularly for adults, or cover a limited range of these services (WHO Regional Office for Europe, 2023a). Middle-income countries tend to have significant gaps in the benefits package for medicines as well (WHO Regional Office for Europe, 2019). At the same time, user charges are applied to covered outpatient medicines, medical products and dental care in most countries (see Fig. 22).

Failing to see medicines, medical products and dental care as part of primary care is most likely to harm people with low incomes or chronic conditions. Richer households are likely to be able to afford to pay for outpatient care, even if it is needed on a regular basis. In contrast, households with low incomes may be forced to prioritize spending on outpatient medicines and experience financial hardship; outpatient medicines are a consistently larger driver of financial hardship in the poorest households (see the lower panel of Fig. 7 and Fig. 8). Households with low incomes are also likely to forego care and experience unmet need (see Fig. 9 and Fig. 10) or struggle to adhere to treatment. This in turn fosters inefficiency in the use of health care (see the subsection “Population coverage: a prerequisite for financial protection but not a guarantee”).

Why do countries fail to see medicines, medical products and dental care as part of primary care?

Given the importance of outpatient medicines, medical products and dental care in treating acute and chronic conditions and addressing problems with vision, hearing and oral health, why are these services not as well covered as other types of health care in so many countries in Europe?

It could be that:

- they are not regarded as a potential source of financial hardship because they often cost less than specialist care;
- they are viewed as being of lower value or lower priority than other types of health care;
- there are concerns about “unnecessary” or “discretionary” use of these services;
- there are concerns about supplier-induced demand, particularly in dental care, so co-payments are used to encourage provider restraint; and
- it may be hard to control prices due to resistance on the part of dentists, pharmacies, manufacturers and pharmaceutical companies, so co-payments are used to reduce financial risk for the purchasing agency.

What can countries do?

Countries need to re-think assumptions about the nature of primary care and the value – to individuals and to health system performance – of covering treatment in primary care settings.

We now have evidence to show that covering higher cost specialist care is not enough to secure financial protection: the use of lower cost primary care services is a major driver of unmet need and financial hardship. In Europe, it is the main driver of financial hardship in households with low incomes.

Primary care is more than consultation and diagnosis. It should not be seen as complete if it does not offer affordable access to treatment, including the medicines and medical products used to treat dental, vision and hearing problems. These types of care are necessities rather than luxuries and should be affordable for everyone.

Dental care is inherently valuable in its ability to prevent and alleviate pain, facilitate better nutrition and foster wider benefits to physical and mental health. In this respect, it is no different from other types of health care. Again, it is a necessity, not a luxury.

Policy-makers may have valid concerns about inappropriate use of health care, especially when it increases out-of-pocket payments, but there is a large body of evidence showing that user charges are not a good instrument for addressing this issue (see the subsection “Despite the evidence against them, user charges are widely applied in Europe on user charges”). Failing to include primary care treatment in the benefits package, or applying poorly designed user charges, will increase rather than prevent inefficient patterns of use.

Concerns about inappropriate use are more effectively addressed through policy instruments that target the way in which health care is supplied, including better training of professionals, the use of care pathways, effective referral systems, other forms of regulation and careful monitoring. In addition to these instruments, countries can use the benefits package to engage in explicit priority-setting processes that help to ensure publicly financed health care is cost-effective, matches population health needs as closely as possible and reflects societal preferences (Gopinathan, Dale & Evans, 2023).

In the following sections we highlight aspects of the coverage of outpatient medicines, medical products and dental care that require policy attention. We also comment on the potential for out-of-pocket payments for mental health care and long-term health care to undermine financial protection and flag some of the challenges involved in monitoring affordable access to these types of care.

Outpatient medicines

Publicly financed benefits packages offer limited coverage of outpatient medicines in some of the middle-income countries in the study, including Georgia, the Republic of Moldova and Ukraine (Garam et al., 2020; Goginashvili et al., 2021; WHO Regional Office for Europe, 2023c).

Ukraine has recently taken steps to address this problem (Box 18). Its experience shows how countries with limited coverage can improve financial protection by defining a benefits package that provides outpatient medicines for priority conditions and is systematically expanded over time.

Box 18. The introduction and expansion of a defined benefits package improves affordable access to outpatient medicines in Ukraine

Source: authors, based on Health Index (2020), NHSU (2021, 2023), USAID (2023) and WHO Regional Office for Europe (2023a).

Until recently the coverage of outpatient prescribed medicines in Ukraine was not clearly defined or supported by an adequate level of public spending on health. As a result, out-of-pocket payments accounted for 99% of spending on outpatient medicines in 2016.

To address this problem, Ukraine set up the affordable medicines programme (AMP) in 2017. The AMP defines a small set of outpatient medicines for priority conditions and provides them with no or relatively low user charges. Initially covering medicines for cardiovascular disease, bronchial asthma and type 2 diabetes, the AMP was expanded in 2021 to cover rheumatic disorders, diabetes mellitus (insulin), diabetes insipidus, mental health disorders and epilepsy. The AMP continues to be expanded in scope, even in the context of the Russian Federation's invasion. New conditions and some medical products were added in 2022 and 2023.

Over time, the use of AMP medicines has grown; in 2023 4.2 million people benefited from the AMP (up from 0.3 million in 2019) and 85% of people with a chronic condition received a prescribed medicine under the AMP. In 2023 75% of people benefiting from the AMP said that it had made medicines more affordable for them.

Take-up remains a challenge, however, for several reasons, including the lack of awareness among the general population and among health care professionals, and the limited participation of pharmacies in some areas.

In most of the study countries, gaps in the coverage of outpatient medicines are largely caused by user charges. User charges are applied to outpatient prescriptions in every country in the study (see Table 2) except Malta, where a third of the population is entitled to publicly financed outpatient prescriptions and the remainder pay the full price out of pocket. For the reasons set out above (see the subsection "Despite the evidence against them, user charges are widely applied in Europe"), applying user charges to outpatient prescriptions serves no useful health system purpose beyond raising revenue.

User charges for outpatient prescriptions are mostly in the form of percentage co-payments (see Fig. 24). Percentage co-payments have many disadvantages compared to low, fixed co-payments (WHO Regional Office for Europe, 2019). When they are used:

- people's exposure to out-of-pocket payments will depend on the price of the goods or services they require;
- unless the price is clearly known in advance, people may face uncertainty about how much they must pay out of pocket; and

- people with conditions that require more expensive treatment will have to pay more out of pocket than those with conditions that can be treated more cheaply.

These disadvantages are magnified:

- when prices are relatively high (e.g. due to inadequate regulation) or prone to fluctuation (e.g. when there is reliance on imports);
- when inefficiencies in health service delivery lead to inappropriate use – for example, doctors and pharmacists are not required or do not have incentives to prescribe and dispense cheaper alternatives (e.g. generic and biosimilar medicines), which shifts financial risk from the purchasing agency to households; and
- for people with low incomes or chronic conditions.

Percentage co-payments are a particularly inappropriate form of user charge to apply to medicines and medical products. As Box 13 suggests, their widespread application reflects history rather than evidence. Countries wanting to enhance transparency and improve financial protection should replace percentage co-payments with low fixed co-payments, so that there is no difference in co-payments across outpatient prescribed medicines.

Out-of-pocket payments for over-the-counter (OTC) medicines are another cause for concern. Health accounts data indicate that OTC medicines often account for a high share of out-of-pocket payments for outpatient medicines (Fig. 25). In countries where outpatient medicines are not a large driver of financial hardship among people with low incomes (e.g. Austria, France, Luxembourg, Slovenia, Spain and the United Kingdom – see Fig. 7), this may indicate relatively good coverage of outpatient prescribed medicines. In other countries it may suggest that OTC medicines are a source of financial hardship. We are not able to assess the role of OTC medicines in driving financial hardship across countries, however, because the household budget survey data used to measure financial hardship do not generally distinguish between OTC and prescribed medicines.

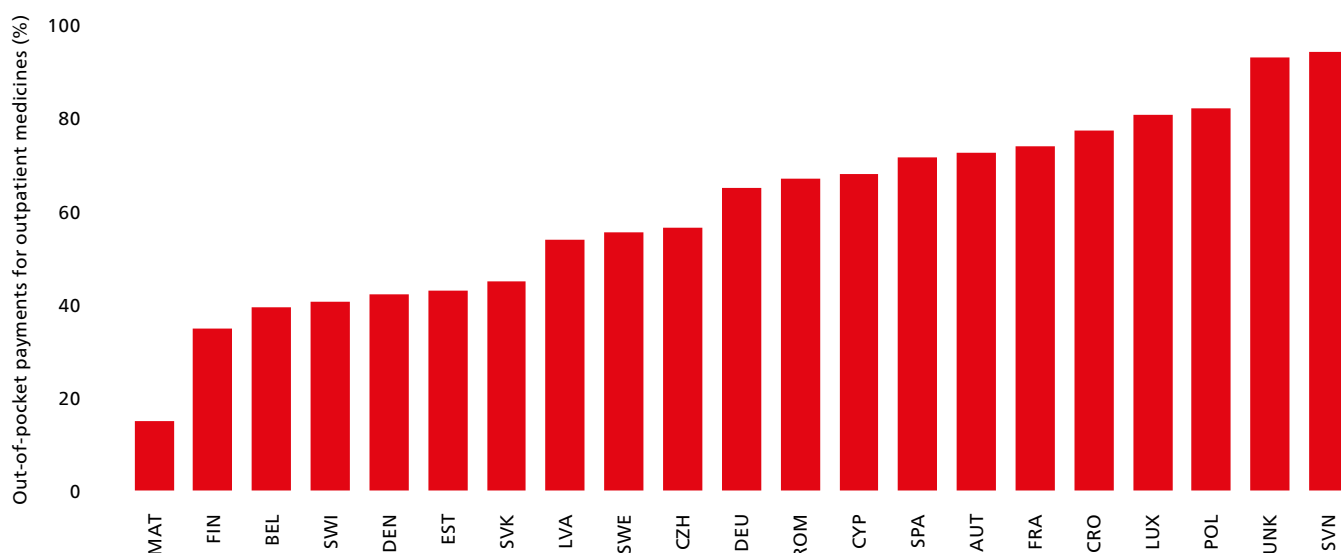
People may be spending on OTC medicines for several reasons: prescription medicines have been removed from the benefits package and shifted to OTC status; it is difficult to obtain prescriptions due to waiting times or user charges to see a doctor, so people are forced to self-treat using OTC medicines; or it is possible to buy medicines that should be prescription-only without a prescription and people pay the full price out of pocket. A recent study from North Macedonia shows that a large share of the medicines purchased in pharmacies is purchased without medical advice or prescription for treatment of conditions that require professional supervision (WHO Regional Office for Europe, 2023f). Similar findings have been reported for antibiotics in several EU countries (Paget et al., 2017).

Household spending on OTC medicines requires further analysis because it may be a source of financial hardship and undermine patient safety.

Fig. 25. OTC medicines as a share of out-of-pocket payments for outpatient medicines, 2019

Note: data are not available for all countries.

Source: OECD (2023a).



Medical products

Outpatient medical products include a wide range of items ranging from medical devices such as blood glucose tests and nebulizers used in the management of chronic conditions to assistive products for the treatment of vision and hearing problems (glasses, hearing aids and, communication aids) and problems with mobility and daily living (crutches, wheelchairs, prostheses and absorbent incontinence products).

WHO has published several priority lists for medical devices (see WHO (2021) for a recent example) and a priority list of 50 essential assistive products (WHO, USAID & International Disability Alliance, 2016). The list is not intended to be restrictive but rather to guide national lists and coverage policy.

A recent scoping review of access to assistive products in Europe found affordability to be one of the most important barriers to access, even for relatively low-cost items like glasses, due to gaps in publicly financed coverage (Mishra et al., 2022).

In many countries this is likely to reflect gaps in the benefits package, particularly for vision and hearing aids. In Spain, for example, glasses are not covered and hearing aids are only covered for young people aged up to 26 years (Urbanos-Garrido et al., 2021).

It is also likely to reflect the presence of heavy user charges. For example, France applies high percentage co-payments to medical products (40%) and allows balance billing. Because government tariffs for medical products are low, and prices are not regulated, out-of-pocket payments

are usually substantial (Bricard, in press). VHI covers user charges for most people, including some balance billing, but the lack of regulated prices means people still struggle to pay for medical products. Since 2019 the Government has tried to improve the affordability of a core set of medical products (crowns, dentures, glasses and hearing aids) for people with low incomes by increasing tariffs and controlling prices to prevent balance billing (see Box 15) (Bricard, in press).

Dental care

Coverage of dental care varies widely in Europe and is often very limited, even in high-income countries and countries with a relatively low incidence of catastrophic health spending (Winkelmann, Gómez Rossi & van Ginneken, 2022; WHO Regional Office for Europe, 2023a).

Every country in the study includes some dental care in the publicly financed benefits package – typically routine oral exams, basic diagnostic tests and basic procedures such as fillings and dentures – but covered dental care is often limited to specific groups of people (WHO Regional Office for Europe, 2023a). Across countries, more complex treatment is usually only covered for people with specific chronic conditions such as cancer.

Most countries apply user charges to covered dental care, using a mix of fixed co-payments and percentage co-payments (see Table 2) (WHO Regional Office for Europe, 2023a). Children are generally better covered than adults because they are often exempt from user charges for dental care visits and treatment. However, age limits for covering children and young people vary across countries, ranging from up to 12 years in Greece to up to 23 years in Sweden. In addition to children, many countries offer very basic dental care without user charges to specific groups of people, including people with low incomes, social beneficiaries, homeless people, pregnant people and people with a greater need for dental care because of a particular condition.

Looking at data on financial protection alongside information on coverage policy shows that gaps in dental care coverage affect people differently. Fig. 26 highlights the role of dental care in driving catastrophic health spending and unmet need for dental care in three countries – Greece, Romania and Germany – classified by level of dental care coverage.

Dental care is not covered for adults in Greece. Although there is some limited coverage for children under 12, health accounts data show that all spending on dental care was financed through out-of-pocket payments in 2019 (OECD, 2023a). In 2019 9% of households in Greece experienced catastrophic health spending, which is mainly driven by outpatient medicines. During the years of the economic crisis, household spending on health fell and there was a strong shift away from spending on dental care to spending on outpatient medicines in poorer households and spending on inpatient care in richer households (WHO Regional Office for Europe, 2019). Catastrophic health spending and unmet need for dental care increased (see Fig. 21).

Coverage of non-emergency dental care in Romania is limited to one visit a year for adults and one visit every 6 months for children under 18. Heavy percentage co-payments (40%) are applied to visits and treatment. Children under 18, students under 26 and war veterans are exempt from user charges for dental care in public facilities, but under 0.5% of dental facilities are public and, as a result, dental care accounts for less than 0.5% of the purchasing agency's budget (Scîntee, Mosca & Vlădescu, 2022). Health accounts data show that over 90% of all spending on dental care was financed through out-of-pocket payments in 2015 (OECD, 2023a). In the same year 12.5% of households experienced catastrophic health spending, which is mainly driven by outpatient medicines.

Coverage of dental care is relatively comprehensive for everybody in Germany. Check-ups and medically necessary preventive and conservative treatment are free at the point of use (Siegel & Busse, 2018). Adults must pay 50% of the cost of any other treatment, including crowns and dentures, but social beneficiaries, other people with low incomes and people in care homes or nursing homes are exempt from user charges. In addition, user charges for all covered services, including dental care, are capped at 2% of gross income a year (1% for people with a chronic condition). Health accounts data show that only 25% of spending on dental care was financed through out-of-pocket payments in 2018; the remainder came mainly from compulsory sources (68%), with a minor role for VHI (7%) (OECD, 2023a). In the same year only 2.4% of households experienced catastrophic health spending, which was mainly driven by dental care.

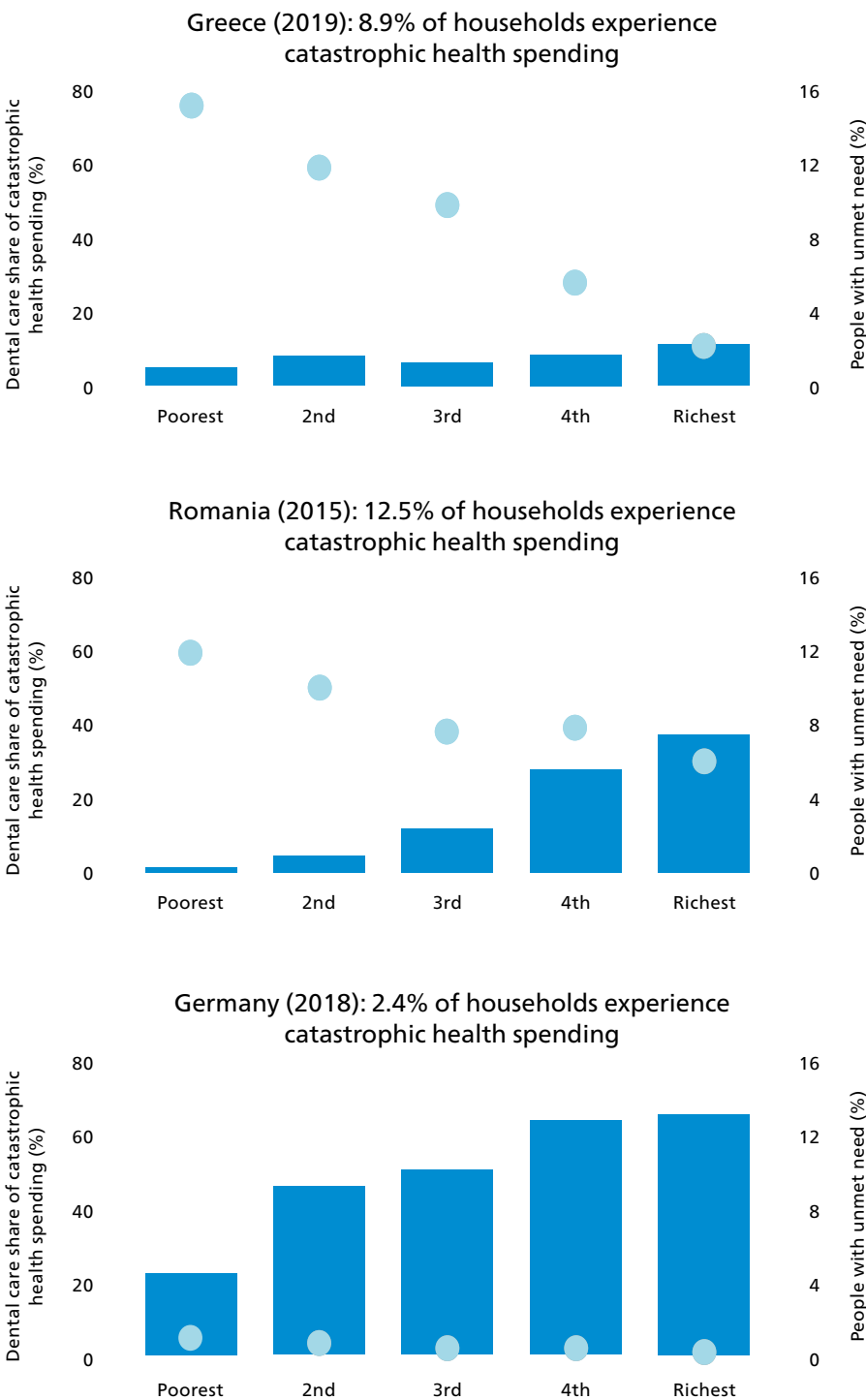
In all three countries out-of-pocket payments for dental care are a greater driver of financial hardship in richer than poorer households, while levels of unmet need for dental care are higher in poorer than richer households. This pattern is relatively consistent across the countries in the study (see Fig. 11) and reflects the greater ability of richer households to spend on dental care.

In Germany, however, the degree of income inequality in unmet need for dental care is very low, and the incidence of catastrophic health spending is also very low, showing what can be achieved when dental care is more comprehensively covered for adults as well as children; people with low incomes are exempt from user charges; there is an income-related cap on all user charges; and dental care is largely publicly financed.

Dental care is increasingly being recognized as an important gap in coverage in some countries. Belgium, France and Spain have recently taken steps to expand coverage of and increase public spending on dental care (Urbanos-Garrido et al., 2021; Bouckaert, Maertens de Noordhout & Van de Voorde, 2023; Bricard, in press).

Fig. 26. Dental care as a share of out-of-pocket payments in households with catastrophic health spending (the columns) and the share of people reporting unmet need for dental care due to cost, distance and waiting time (the dots) by quintile, 2019 or the latest available year before COVID-19

- Unmet need
- Out-of-pocket payments



Notes: countries classified by level of dental care coverage (lowest in Greece, highest in Germany). People refers to those aged over 16. Quintiles are based on consumption for catastrophic health spending and income for unmet need.

Source: authors, using data from Eurostat (2023d) for EU-SILC data on unmet need; WHO Regional Office for Europe (2023a) for data on catastrophic health spending.

Mental health care

Ensuring affordable access to mental health care is likely to be a major challenge in many countries in Europe, but it is a challenge that is hard to monitor for several reasons.

EHIS data on self-reported unmet need for mental health care due to cost, distance and waiting times (available every 5–6 years) suggest that unmet need is lower for mental health care than for health care, dental care or prescribed medicines, with no major difference between income quintiles (data not shown but available from Eurostat, 2023d). These counterintuitive findings may reflect challenges in measuring unmet need for mental health care, including stigma.

It is not easy to assess the comprehensiveness of mental health care coverage across countries (European Commission Directorate General for Health and Food Safety, Expert Group on Health Systems Performance Assessment, 2021). Efforts to do so have been at best partial – for example, focusing on the benefits package without accounting for user charges (OECD, 2021).

Looking at coverage policy alone may not be enough to identify gaps. The distance between entitlements on paper and in reality is likely to be particularly large for mental health care due to underfunding, staff shortages, lack of capacity and waiting times.

Even when it is possible to identify indicators to capture some of these other factors (e.g. the supply of mental health professionals or the number of people who accessed specialist mental health services per 1000 population) it is hard to find data for more than a handful of countries globally (OECD, 2021).

Qualitative analysis carried out in a small selection of countries in Europe suggests that care pathways for people with mental health disorders are less standardized across countries; several services that should be included in the care pathway are not covered in many countries; waiting times are an important barrier to access in most countries; and even when services are included in the benefits package, and have relatively low user charges, there are variations in capacity, waiting time and approaches to care (European Commission Directorate General for Health and Food Safety, Expert Group on Health Systems Performance Assessment, 2021).

Problems with affordable access to mental health care – like dental care – are likely to result in higher levels of unmet need for households with low incomes and higher levels of financial hardship for people who pay out of pocket.

Long-term health care

Spending on long-term health care is not visible in household budget survey data because until recently it was captured under the categories “outpatient care” and “inpatient care” and could not be distinguished from general forms of outpatient or inpatient care (United Nations Statistics Division, 1999; WHO Regional Office for Europe, 2019). From 2019 a new classification for household spending includes long-term health care in a separate category, but it is not yet clear how many countries are collecting this information (United Nations Statistics Division, 2018).

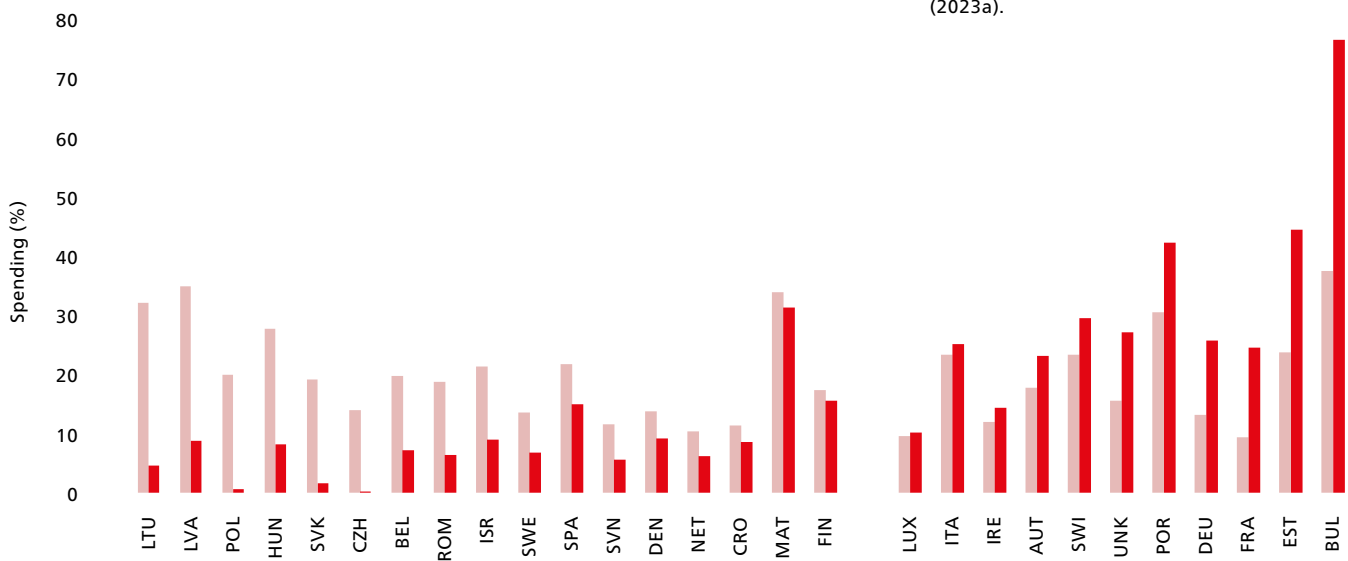
Health accounts data show that out-of-pocket payments sometimes account for a larger share of long-term care health spending than general health spending (Fig. 27). Long-term health care currently represents a very small share of GDP in most countries (OECD, 2023b), but heavy reliance on out-of-pocket payments means it could be a source of financial hardship in some countries (Box 19). There are many countries in which the out-of-pocket payment share of long-term health care is relatively low (Fig. 27), which may reflect unmet need for long-term health care.

Fig. 27. Out-of-pocket payments as a share of current spending on health and out-of-pocket payments as a share of current spending on long-term health care, 2019

- Health
- Long-term health care

Notes: spending on health includes spending on health-related long-term care. In countries on the right of the figure, out-of-pocket payments are a larger share of spending on long-term health care than spending on health. Data are not available for all countries.

Source: authors, using data from OECD (2023a).



Box 19. High out-of-pocket payments for long-term health care in Estonia reflect coverage policy choices

Source: authors, based on Vörk, Habicht & Köhler (2023).

Administrative data from Estonia show that 42% of all long-term health care was financed through out-of-pocket payments in 2021 – almost double the out-of-pocket payment share of current spending on health (22%) – and that long-term health care accounted for 18% of out-of-pocket payments.

These high out-of-pocket payments reflect coverage policy choices: heavy user charges are applied to long-term inpatient nursing care (a fixed co-payment of €2.50 per day for up to 10 days and a percentage co-payment of 15%) and there are no exemptions from these user charges and no cap (Vörk, Habicht & Köhler (2023). Someone requiring 30 days of long-term inpatient nursing care must pay €596 in co-payments, which is equal to 88% of the average monthly old-age pension or 177% of the national minimum monthly pension (Estonian Funded Pension Registry, 2023; Ministry of Social Affairs of the Republic of Estonia, 2023; Tervisekassa, 2023).

5. Avoid thinking voluntary health insurance (VHI) is the answer

Summary

VHI generally increases inequality in access to health care. It is consistently more likely to be taken up by richer than poorer households.

VHI is most likely to contribute to financial protection at health system level where it plays an explicitly complementary role covering user charges and succeeds in covering most people with low incomes. This only occurs in three countries globally: Croatia, France and Slovenia.

Other countries are unlikely to be able to replicate the relative success of VHI covering user charges in Croatia, France and Slovenia, which comes at a cost. VHI is accessible due to extensive government intervention in all three countries. It is affordable for many because it is heavily subsidized by the government for people with low incomes in Croatia and France and for employees in France.

VHI covering user charges is not an equitable or efficient way of improving financial protection. It is more regressive than public spending on health. Efficiency is undermined by the high administrative costs incurred by private insurers and by the heavy transaction costs involved in regulating a complex system. From 2024 Slovenia is abolishing user charges and VHI covering user charges.

Subsidising VHI wastes public resources. Unless subsidies exclusively target people with low incomes they are waste of public resources because they mainly benefit richer people and skew resources away from need.

Countries should lower their expectations about VHI's ability to contribute to UHC.

VHI generally increases inequality in access to health care

VHI is consistently more likely to be taken up by households with higher incomes, which means it generally increases inequality in access to health care (Sagan & Thomson, 2016; Thomson, Sagan & Mossialos, 2020).

The acceptability of this inequality reflects a range of factors, including the performance of the publicly financed health system, the share of the population with VHI and the clarity of boundaries between publicly and privately financed health care (Thomson, Sagan & Mossialos, 2020). If access to publicly financed health care is generally good and VHI covers a very small share of the population, then better access for people with VHI may not be a pressing policy issue. But if there are problems with access to health care, the share of people with VHI is growing and VHI draws financial and human resources away from publicly financed health care, then better access for people with VHI is very likely to undermine the performance of the health system as a whole.

VHI's ability to enhance financial protection depends on the role it plays in the health system, the extent of government intervention to ensure VHI is accessible and affordable for those who need it and the presence of subsidies exclusively targeting people with low incomes.

Globally, it is only shown to contribute to financial protection at health system level in Croatia, France and Slovenia, where it plays an explicitly complementary role covering user charges for publicly financed health care and succeeds in covering a large share of the population, including most people with low incomes (Sagan & Thomson, 2016; WHO Regional Office for Europe, 2019; 2023a).

The unique way in which VHI has been able to enhance financial protection in these three countries has been shaped by historical and political factors and is unlikely to be easily replicated in other countries. Despite their relative success, all three countries continue to face challenges with VHI.

VHI covering user charges enhances financial protection for many people in Croatia, France and Slovenia

VHI covering user charges is taken up by over 90% of those who pay user charges in Croatia and around 95% of the population in France and Slovenia (HZZO, 2023; Bricard, in press; Zver, Dugar & Srakar, in press). These high levels of take-up can be attributed to the following factors (WHO Regional Office for Europe, 2019; 2023a).

- People need this form of VHI because user charges are widely applied in all three countries and include heavy percentage co-payments for inpatient care (20% of the tariff). Although there are caps on user charges for inpatient care in Croatia and France, these caps are set at a very high level and only apply per episode of care; and in France they do not apply to balance or extra billing.
- VHI covering user charges is accessible to those who want to purchase it due to regulation in Croatia and Slovenia (open enrolment plus community-rated premiums). In France there are tax disincentives for VHI policies that risk-rate premiums or limit cover of pre-existing conditions and, since 2016, employers have had to provide VHI covering user charges for their employees.
- VHI covering user charges is affordable for most people because it is free for households with low incomes, people with disabilities and organ and blood donors in Croatia (around 13% of the population in 2021). In France it is free for people with very low incomes (around 10% of the population in 2021); subsidized by the government for some people with low incomes; since 2016, employers have had to cover at least 50% of the cost of an employee's VHI premium; and, since 2022, the government subsidizes VHI premiums for public employees. In Slovenia households with very low incomes are exempt from user charges and do not need VHI.

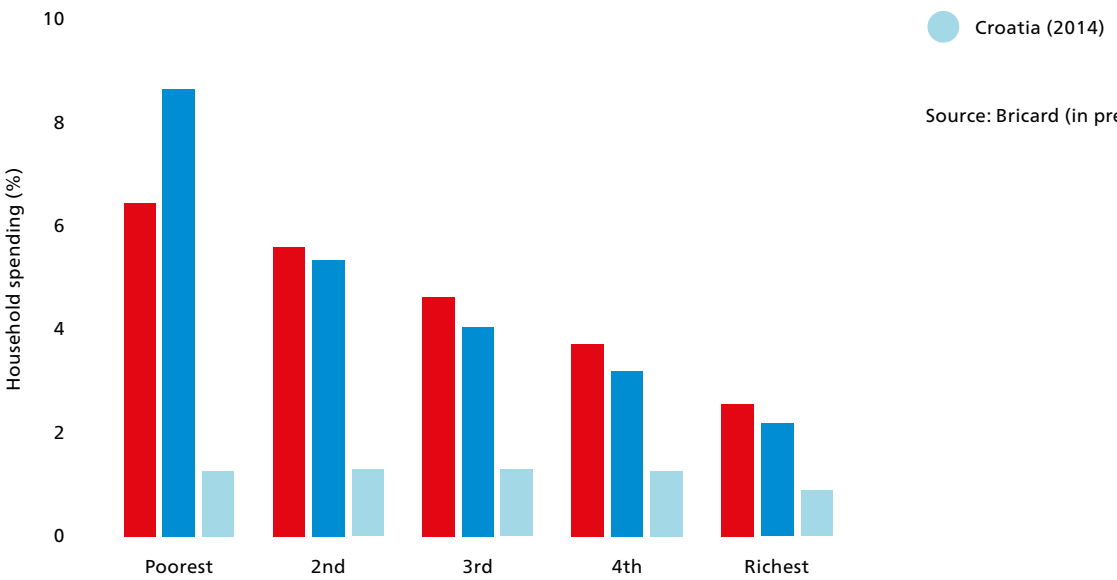
As a result of high take-up of VHI covering user charges, reliance on out-of-pocket payments is very low in all three countries and the incidence of catastrophic health spending is also very low in Slovenia (1%) and France (2%) and relatively low in Croatia (just under 4%) (see Fig. 16).

VHI in Croatia, France and Slovenia comes at a cost to households and governments

Despite this relative achievement, inequality in affordable access to VHI persists, particularly in France, where take-up of VHI covering user charges is lowest in the poorest quintile, even though it is free or subsidized for households with very low incomes (Fig. 28). This reflects low take-up of free and subsidized VHI – only 68% of eligible people benefit from free VHI and 28% from subsidized VHI (Government of France, 2022) – and may indicate that the threshold for free VHI is too high (Bricard, in press). The quality of VHI coverage also varies in France; analysis has found that higher-earning employees generally benefit from more generous VHI coverage, both in terms of the scope of services covered and the extent of the employer subsidy (Perronnin & Raynaud, 2020).

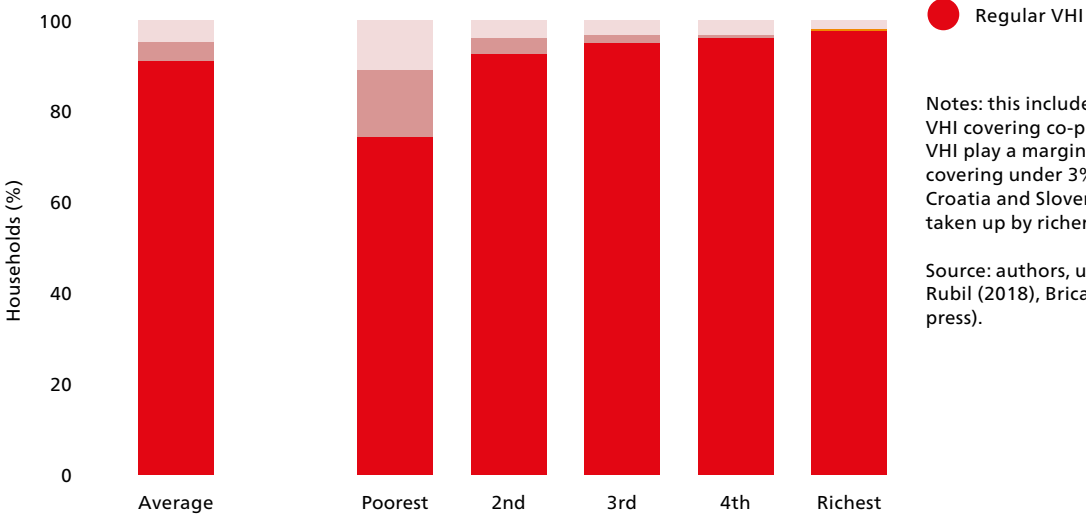
VHI premiums undermine equity in financing the health system. In France and Slovenia the distribution of VHI premiums across consumption quintiles is highly regressive (Fig. 29). VHI premiums are more evenly distributed across quintiles in Croatia, but households in the poorest quintile spend the same share of their budget on VHI as households in higher quintiles (Fig. 29).

Fig. 28. Breakdown of households by VHI status and consumption quintile in France, 2017



Source: Bricard (in press).

Fig. 29. VHI premiums as a share of household spending by consumption quintile



Notes: this includes all VHI premiums, not just VHI covering co-payments. Other forms of VHI play a marginal role in all three countries, covering under 3% of the population in Croatia and Slovenia, and are more likely to be taken up by richer households.

Source: authors, using data from Vončina & Rubil (2018), Bricard (in press), Zver et al. (in press).

The experience of these three countries suggests that VHI covering user charges is not an equitable or efficient way of improving financial protection.

Equity in financing the health system is weakened by the high financial burden imposed on poorer households compared to richer households, even where VHI is free for people with very low incomes.

Efficiency is undermined not only by the high administrative costs incurred by private insurers in all three countries compared to entities providing publicly financed health care but also by the high – and sometimes hidden – transaction costs involved in regulating a complex system (Law, Kratzer & Dhalla, 2014; Sagan & Thomson, 2016; Thomson, Sagan & Mossialos, 2020).

The exceptionally high take-up of VHI in France reflects more than two decades of effort by the government to ensure that VHI is accessible and affordable (Franc & Couffinal, 2020). These efforts include extensive regulation, substantial government subsidies for people with low incomes and, since 2016, compelling employers to provide and pay for 50% of the cost of VHI for all employees (Bricard, in press).

Successive governments in Slovenia have also struggled to make VHI accessible and affordable. In June 2023 the government passed a law abolishing all user charges and VHI covering user charges with effect from 2024 (Government of Slovenia, 2023). The revenue previously generated through user charges will come from a compulsory levy on all adults, with the government covering the cost of the levy for households with low incomes.

Progress is possible

1. Act on the evidence and re-design coverage policy

Monitoring financial protection provides actionable evidence for policy

The quantitative analysis in this report finds evidence of financial hardship and unmet need in every country in the study.

Financial hardship is largely driven by out-of-pocket payments for outpatient medicines, medical products and dental care – services that are commonly delivered or managed in primary care settings – indicating significant gaps in the coverage of primary care in many countries. In countries with a higher incidence of catastrophic health spending, the main driver is overwhelmingly outpatient medicines.

Country averages conceal major differences in impact. Financial hardship and unmet need are consistently most likely to affect households in the poorest fifth of the population.

Out-of-pocket payments affect people differently.

- In poorer households, financial hardship is mainly driven by spending on outpatient medicines.
- Out-of-pocket payments for outpatient medicines result in both financial hardship and unmet need for poorer households.
- Out-of-pocket payments for dental care lead to financial hardship for richer households and unmet need for poorer households.

The incidence of catastrophic health spending is closely related to a health system's reliance on out-of-pocket payments. Across countries, public spending on health is shown to be much more effective in reducing out-of-pocket payments than VHI.

Increases in public spending on health or reductions in out-of-pocket payments are not enough to improve financial protection in all contexts. Coverage policy plays a key role in determining financial protection.

The report's qualitative analysis of coverage policy at country level has identified five policy choices that undermine financial protection, reduce health system equity, efficiency and resilience, and slow progress towards UHC. The report also identifies concrete steps countries can take to strengthen financial protection (Box 20).

Box 20. Five policy choices that slow progress towards UHC and concrete steps countries can take to strengthen financial protection

Source: authors.

Coverage policy choices that undermine financial protection include:

- linking entitlement to payment of contributions
- excluding people from coverage
- applying user charges without effective protection mechanisms
- failing to see medicines, medical products and dental care as part of primary care
- thinking VHI is the answer.

Countries should avoid these policy choices because:

- they do not reflect evidence
- they have a disproportionately negative impact on people with low incomes or chronic conditions
- they increase inefficiency in the use of health care
- they weaken household and health system resilience to shocks
- better options are usually available.

To strengthen financial protection, countries can:

- de-link entitlement from payment of contributions;
 - grant refugees, asylum seekers and undocumented migrants the same entitlements as other residents;
 - apply user charges sparingly and carefully re-design them to reduce the likelihood of financial hardship and unmet need;
 - re-think assumptions about medicines, medical products and dental care as they are an essential part of primary care – necessities, not luxuries – and should be affordable for everyone; and
 - lower expectations about VHI's ability to contribute to UHC.
-

Are data from 2019 a good basis for action today?

The report's analysis mainly focuses on the situation in 2019, setting a pre-pandemic baseline for financial protection in Europe. Some may question whether data from 2019 are a good basis for decision-making today. We believe they are for several reasons.

First, the relatively strong relationship between the incidence of catastrophic health spending and a health system's reliance on out-of-pocket payments (Fig. 30) means that countries can use more recent health accounts data on out-of-pocket payments as a proxy indicator for financial hardship when household budget survey data are not available. The data in Fig. 30 should be interpreted alongside data on unmet need for health care, however, as some countries with low levels of catastrophic health spending have quite high levels of unmet need for health care (e.g. Ireland, Slovenia and the United Kingdom; see Fig. 9).

Second, we now know a lot about the coverage policy choices that are likely to undermine financial protection (see Box 20). Detailed country-level analysis of trends in financial protection and coverage policy over time – already available for over 20 countries in Europe (WHO Regional Office for Europe, 2023a) – provide a good basis for projecting changes in financial protection in response to changes in coverage policy.

Third, changes in coverage policy can be tracked in real time and used to indicate the direction in which a country is moving. UHC watch – a new online platform – provides detailed country-level information on coverage policy in 2023 and will be tracking changes in policy annually (WHO Regional Office for Europe, 2023a).

Reality differs in a diverse region

There is huge variation in the health system starting point across the countries in the study. In 2019 public spending on health ranged from 1% to 9% of GDP and reliance on out-of-pocket payments ranged from 9% to 85% (see Fig. 17).

The actions countries take will reflect these differences. Countries with very low levels of catastrophic incidence may be able to reduce out-of-pocket payments without necessarily spending more on health. At the other end of the spectrum, however, countries with very high levels of catastrophic incidence will not be able to make progress without significant increases in public spending on health.

Limited fiscal space is a particular challenge for the middle-income countries in the study, making it more difficult to narrow the gap between countries quickly. But it is not impossible to do so. Countries with higher levels of catastrophic health spending can make progress by avoiding the coverage policy choices most likely to undermine financial protection (see Box 20), setting in place processes to identify priorities for action (Gopinathan, Dale & Evans, 2023) and taking consistent steps in the right direction.

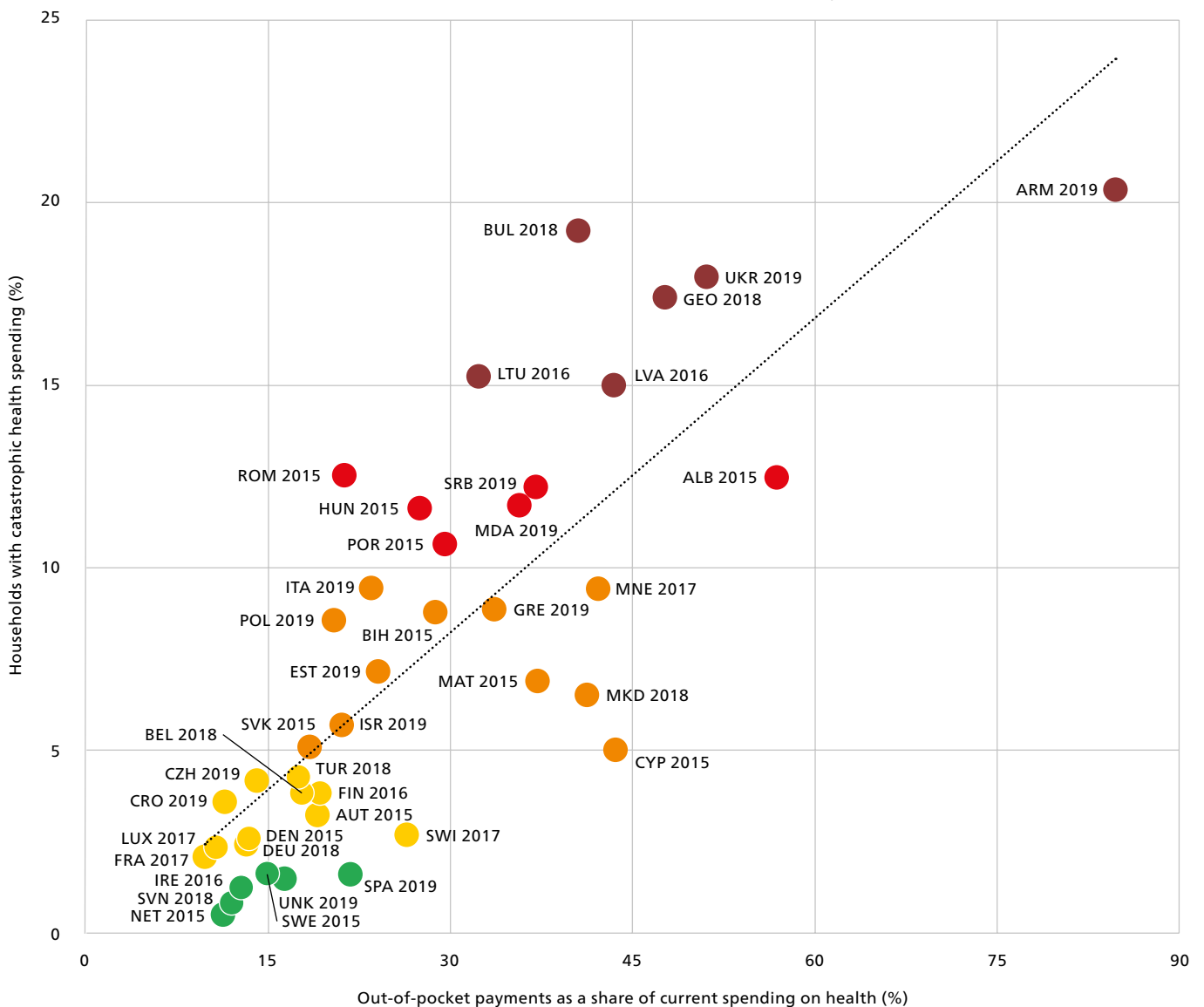
Enhancing efficiency allows countries to do more with available resources – but only in a very few cases does it have a direct impact on financial

protection. These cases include efforts to reduce prices where people pay percentage co-payments or there is reference pricing in place; and reducing hospital fixed costs where there is excess capacity, hospitals are underfunded and any savings gained are reinvested and reduce informal payments. Without efforts to improve coverage policy, however, efficiency gains may not reach those most in need of financial protection.

Fig. 30. The incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health, 2019 or the latest available year before COVID-19

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year. Catastrophic health spending incidence < 2% (green dots), < 5% (yellow dots), < 10% (orange dots), < 15% (red dots), > 15% (dark red dots).

Source: authors, using data on catastrophic health spending from WHO Regional Office for Europe (2023a) and data on out-of-pocket payments from WHO (2023).



Overcoming path dependency

Making changes to coverage policy may require effort to overcome path dependency. Many of the policy choices that undermine financial protection are shaped more by historical and political factors than by evidence, reflecting the norms and assumptions of earlier eras.

Today's context is different, however.

Changes in health care (more effective and more costly now than in the 19th and early 20th centuries) and in work (increasingly precarious for many) mean that designing coverage policy around employment or linking entitlement to payment of SHI contributions leaves too many people behind. It also weakens resilience to shocks.

In the last 15 years we have lived through two major shocks – the economic crisis that began in Europe in 2008 and the COVID-19 pandemic. We now face a third: the climate emergency. Lessons learnt from the earlier crises show how to build health system resilience. For financial protection, resilience means re-designing coverage policy so that it is countercyclical, increasing as the economy contracts.

The way we think about health financing has shifted over time (Kutzin, 2001). A move away from thinking in terms of “models” that no longer bear relation to reality means it is possible – for example – for SHI schemes to change the basis for entitlement to residence without changing revenue streams or purchasing arrangements.

2. Start by improving financial protection for the people who need it most

Because the financial hardship and unmet need caused by out-of-pocket payments are heavily concentrated among people with low incomes, progress towards UHC means reducing out-of-pocket payments for the most disadvantaged people in society first – an approach known as progressive universalism (Gwatkin & Ergo, 2011).

Progressive universalism is vital in contexts where public resources for health care are limited or under pressure. It allows countries to be selective, giving priority to improving financial protection for those who need it most.

It also offers countries a way of strengthening their resilience to shocks: if coverage policy is designed to provide enhanced protection for those most in need, health systems and households will be better able to face economic or health crises.

Adopting progressive universalism does not mean rowing back on universal entitlements. Rather it gives countries a clear signal about which gaps in coverage to prioritize.

3. Follow good practice: a checklist for policy-makers

Since the signing of the Tallinn Charter in 2008, countries across Europe have committed to UHC through multiple international resolutions. In response, the WHO Regional Office for Europe has generated a body of evidence on what countries can do to move closer to UHC – evidence that is grounded in systematic country-level and comparative analysis (WHO Regional Office for Europe, 2023a).

Drawing on evidence and examples of good practice from across Europe, the checklist in Table 4 highlights the policy choices that have improved financial protection in countries with a low incidence of financial hardship and unmet need.

Table 4. A financial protection checklist for policy-makers

Source: authors.

Entitlement to publicly financed health care is de-linked from payment of SHI contributions	✓
The tax agency deals with non-payment of SHI contributions (not the health system)	✓
Refugees, asylum seekers and undocumented migrants are entitled to the same benefits as other residents	✓
Everyone is aware of their entitlements	✓
There are no administrative barriers to accessing entitlements	✓
User charges are applied sparingly and are carefully designed so that:	✓
• people with low incomes or chronic conditions are automatically exempt from all user charges	✓
• there is an annual income-based cap on all user charges, which works automatically	✓
• there are no percentage co-payments	✓
• there is no balance billing or extra billing for medical services	✓
• any co-payments in place are low and fixed and people know in advance exactly how much they have to pay when they see a doctor, undergo a diagnostic test, collect a prescription or are admitted to hospital	✓
Primary care coverage includes treatment, not just consultation and diagnosis, so that the following types of care are affordable for everyone:	✓
• medicines	✓
• medical products	✓
• dental care	✓
Coverage policy is supported by an adequate level of public spending on health so that:	✓
• there are no major staff shortages	✓
• there are no major issues with the quality and availability of services	✓
• there are no long waiting times for treatment	✓
• there are no informal payments	✓

It is now time for policy-makers to re-design those aspects of coverage policy that hold progress back.

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World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.who.int/europe

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