5 Affordability and financial protection: Insights from Europe

High out-of-pocket payments for health care services can prevent patients from seeking needed care or can cause financial hardship among those who do. This chapter analyses the affordability of health care services in European countries and explores the extent to which poorer households are more likely to face financial hardship when seeking care. The chapter analyses possible gaps in coverage in EU and OECD countries that can lead to financial hardship and explores whether voluntary health insurance can compensate for gaps in publicly financed coverage. Gaps in coverage are explored from different dimensions, first looking into population groups that may go without coverage before comparing the scope and depth of coverage for different types of care across countries. This discussion will help to identify some key features of coverage that contribute to explaining differences in financial protection across different population groups and countries.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Note by Turkey:
The information in this document with reference to “Cyprus” relates to the southern part of the Island. There is no single authority representing both Turkish and Greek Cypriot people on the Island. Turkey recognises the Turkish Republic of Northern Cyprus (TRNC). Until a lasting and equitable solution is found within the context of the United Nations, Turkey shall preserve its position concerning the “Cyprus issue”.

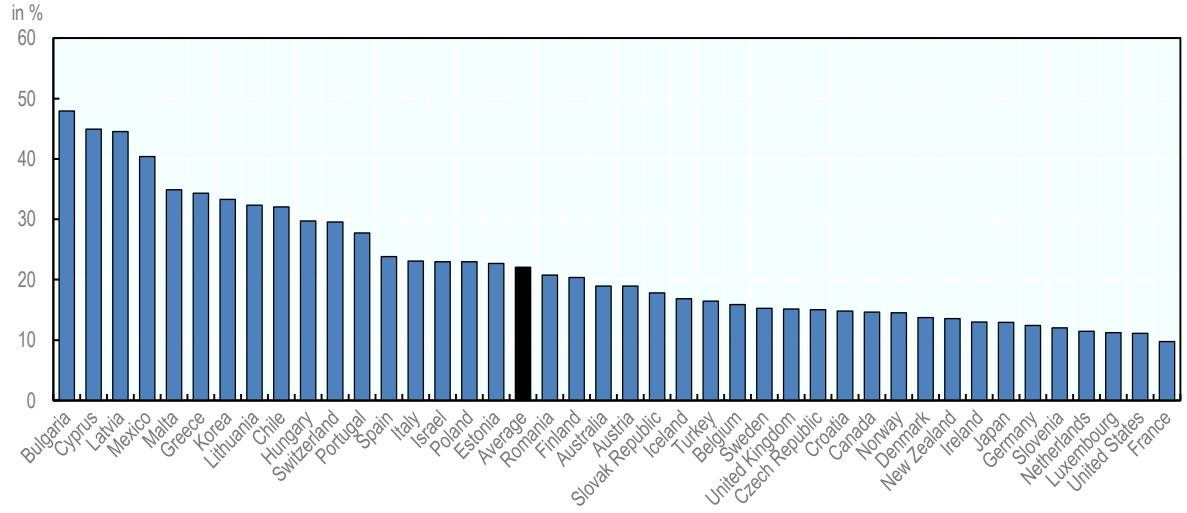
Note by all the European Union Member States of the OECD and the European Union:
The Republic of Cyprus is recognised by all members of the United Nations with the exception of Turkey. The information in this document relates to the area under the effective control of the Government of the Republic of Cyprus.

5.1. Introduction

Direct payments by patients for health –out-of-pocket payments– occur in all health systems. It is also the case in EU and OECD countries that all finance a range of health care goods and services collectively, available to the entire population or large parts thereof. With any form of collective coverage, a basket of health care goods and services is defined for which patients do not bear the cost fully at the point of care. These services can be availed free of charge or subject to compulsory user charges. Out-of-pocket payments can also be required to obtain care excluded from the benefit basket. Finally, some of these payments may be related to patients' choice for example if they want to benefit from a private room in a hospital or other complementary amenities.

The amount and nature of out-of-pocket spending varies considerably across health systems and households and largely depend on the way the collectively financed benefit basket is designed in a country. Across the EU and OECD, around a fifth of all health spending (22%) is borne directly by private households (Figure 5.1). This figure ranges from around 10% in France, the United States, Luxembourg or the Netherlands to 40% or more in Mexico, Latvia, Cyprus and Bulgaria.

Figure 5.1. Out-of-pocket spending as share of total health expenditure, 2016 or latest year



Source: OECD Health Statistics 2018; Eurostat Database.

Out-of-pocket spending for health weighs more on those with lower income. Faced with the need to pay, some patients may simply forgo needed care if costs are too high as shown in Chapter 4. Others may pay but suffer financial hardship as a result. Everything else being equal, and almost by definition, both scenarios are more likely to unfold in households with limited resources. The fact that people with lower income are generally in poorer health and have higher health care needs further reinforces the regressive nature of out-of-pocket payments.

High out-of-pocket payments have far-ranging societal implications. First, out-of-pocket payments can contribute to the less advantaged not having the same access as the better-offs which limits the ability of health systems to redress inequalities in outcomes. Additionally, as payments for care reduce disposable household income, they may force people to make choices between health and other important consumptions and investments and can even push households into poverty.

The fact that health systems, in addition to providing access to care, intrinsically contribute to households' social protection has gained increasing attention. The provision of financial protection for everyone, regardless of income, is a distinct health system goal and a dimension of universal health coverage, which is widely monitored, including within the framework of the Sustainable Development Goals (SDGs) of the United Nation. This commitment has been renewed recently in Europe: the European Commission has explicitly committed to mainstreaming SDGs into EU policies and initiatives. In 2018, the countries of the European region of the World Health Organisation (WHO) renewed their commitment to promoting shared values of solidarity, equity and participation through health policies with a specific focus on poor and vulnerable groups. In particular, they highlighted the importance of moving towards universal health coverage for a Europe free of impoverishing payments for health, and of specifying ways of improving coverage, access and financial protection for everyone (WHO/Regional Office for Europe, 2018[1]).

This final chapter explicitly turns to the financial angle of the access equation. Section 5.2 reviews the information available on the affordability of health care, mainly in European countries. It combines various approaches to determine the extent to which having to pay for care creates financial hardship and the extent to which this burden is higher on the poor. Section 5.3 analyses possible gaps in population coverage that can lead to financial hardship and explores how voluntary health insurance can compensate for lacks in coverage. Section 5.4 nuances the analysis by type of care, summarises some key features of coverage in EU and OECD countries and discusses how they contribute to these results. Section 5.5 concludes the findings of this chapter.

The chapter highlights the importance of monitoring indicators on the financial burden of health care costs to evaluate access to services. It makes the case that providing health care coverage and protecting people against high health care costs have far-reaching poverty-reducing implications that go beyond health systems. Discussions how to strengthen financial protection in health care should hence be on the agenda of all policy-makers who try to reduce poverty and social disparities in countries promoting a more integrative society and a well-functioning economy.

5.2. Affordability and financial protection are concerns in Europe, especially for the poor

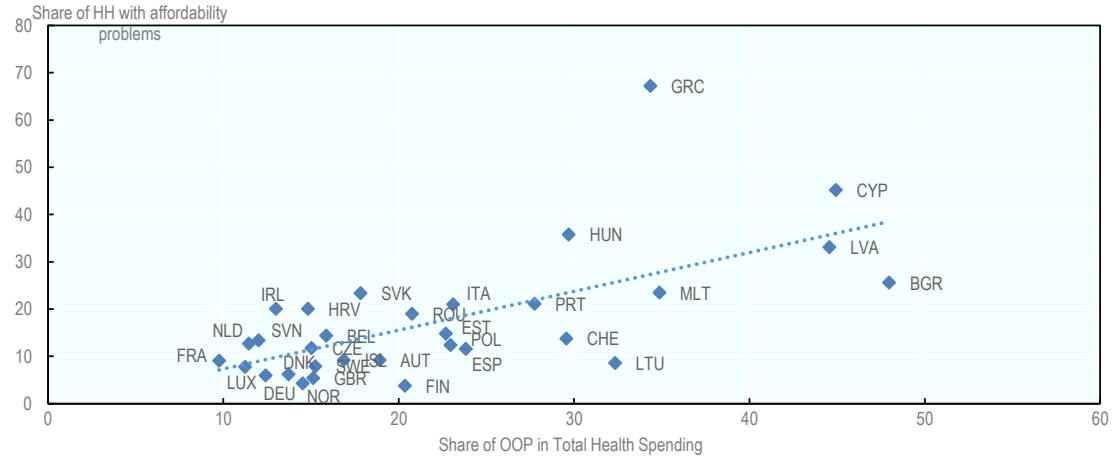
The extent to which accessing care creates a financial burden depends on the level of costs for care but also on household income. Different methods exist to evaluate this financial burden. A first one, somewhat subjective, is to elicit the views of patients on this issue. Household budget surveys can also provide more refined and objective results on the extent to which households face financial hardship.

5.2.1. On average thirty percent of households below the poverty line in Europe find it difficult to afford health services

One approach to assess the financial burden of health spending is to ask people whether out-of-pocket payments are affordable or not. This method was used in the one-off EU-SILC ad-hoc module of 2016. Within this module, people who had incurred payments for health care services were asked to assess whether these services were affordable with great difficulties, moderate difficulties, some difficulties, fairly easily, easily or very easily. On average across Europe, around 17% of all households were only able to make health care payments with moderate or great difficulties. This share varies between 67% in Greece and 4% in Finland and Norway. A correlation between the average share of households facing problems to afford health care and the share of out-of-pocket spending in total health spending in country can be observed (Figure 5.2).

Figure 5.2. Affordability of health care services and its relationship to out-of-pocket spending

Share of households that responded being able to afford health care services only with moderate difficulties or with great difficulties and the share of out-of-pocket spending in total health spending per country

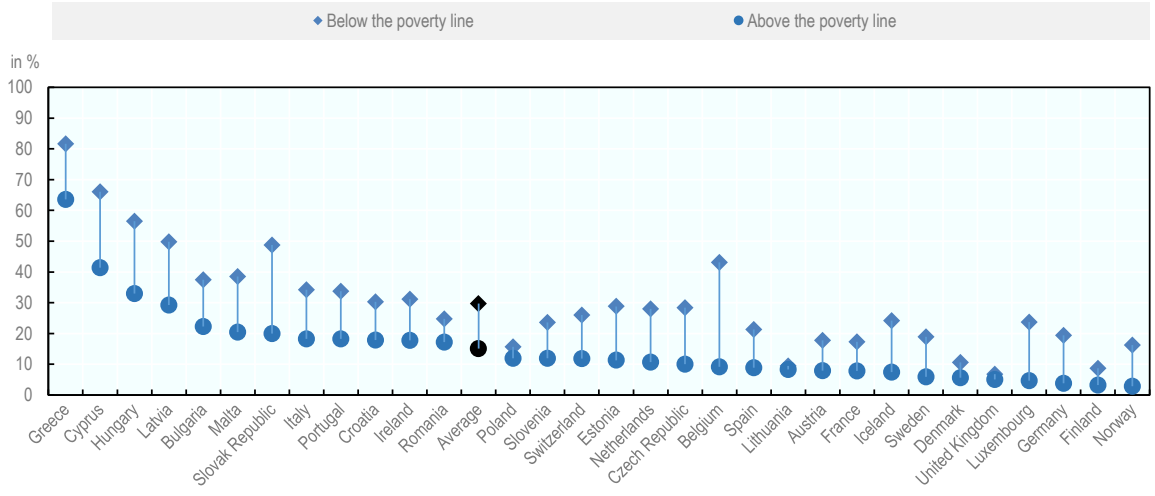


Source: EU-SILC ad-hoc module 2016; OECD Health Statistics 2018; Eurostat Database.

As expected, a clear social gradient is observable when analysing the households reporting affordability issues with health care costs. In all countries, households with low income systematically have more problems to afford health care than those with higher income (Figure 5.3). On average, 30% of households below the poverty line were facing these problems compared to 15% of households with income above that line. The probability that the poor will find care unaffordable is at least 20 percentage points higher than that of the rest of the population in Belgium, the Slovak Republic, Cyprus, Hungary and Latvia. On the other hand, differences are comparably small in Lithuania, the United Kingdom and Poland.

Figure 5.3. Share of households with difficulties to afford health care services, 2016

Share of households that responded being able to afford health care services only with moderate or great difficulties



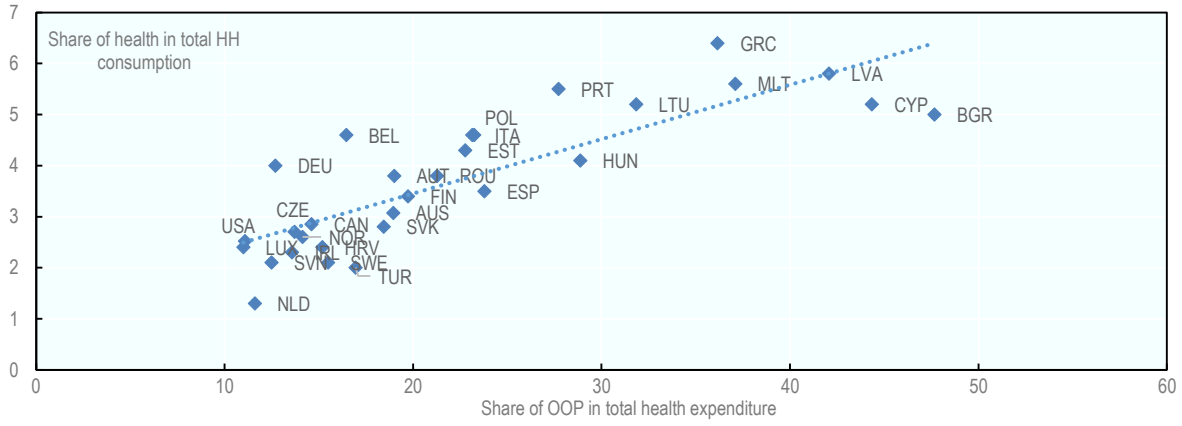
Note: Below the poverty line refers to households with 60% or less of median equalised income.
Source: EU-SILC ad-hoc module 2016.

5.2.2. In countries with high out-of-pocket spending, lower-income people spend a higher share of their household budget on health

More informative approaches to assess the financial burden that out-of-pocket spending for health can represent to people relate it either to their consumption expenditure or to income. The risk of incurring unsustainably high health care bills naturally depends on households' income and wealth. Capturing the impact of health spending at household level requires information from household budget surveys (HBS), regularly undertaken in all European and OECD countries.

Aggregate data confirm that the share of their budget people spend on health is higher in countries that display high levels of OOP[1] (Figure 5.4). The six countries (Bulgaria, Cyprus, Latvia, Malta, Greece and Lithuania) that record the highest shares of out-of-pocket spending (>30%) are also among those where the average share of household consumption dedicated to health care is the highest. In the six countries, this share stands at least at 5%. In many countries where out-of-pocket payments represents only a small fraction of health financing, the share of household consumption used for health care is substantially lower- for example, only slightly above 1% in the Netherlands.

Figure 5.4. Health care as a share in total household consumption compared to the share of out-of-pocket spending in total health spending

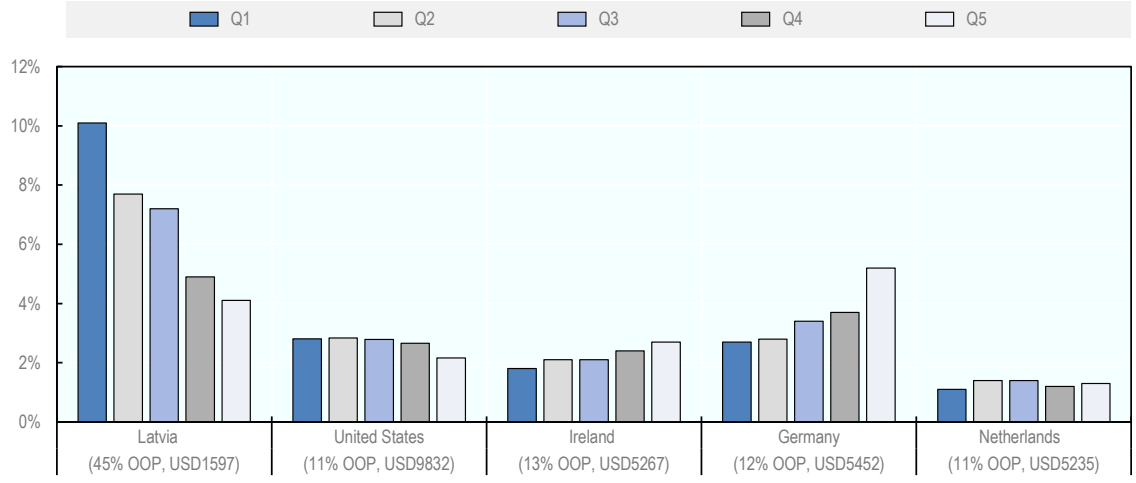


Note: For European countries, shares are measured with Household Budget Surveys using the COICOP classification. Health spending refers to class 06; total household consumption is the sum of classes 01 to 12. This does not include spending for long-care term services and also excludes premium payments for health insurance coverage. For the US, it refers to spending on healthcare (without insurance) as share of average annual expenditure. For Canada, it refers to direct health care costs to household as share of total current consumption. For Australia, it refers to medical care and health expenses (without insurance) as share of total goods and services expenditure.
Source: Eurostat Database; U.S. Bureau of Labor Statistics, Consumption Expenditure Survey 2017; Statistics Canada, Household spending by household income quintile 2017; Australian Bureau of Statistics; Household Expenditure Survey 2015-16; OECD Health Statistics 2018.

Countries do not only vary in the average proportions of household budgets used for health care, they also display different consumption patterns among groups with different socio-economic background. Figure 5.5 displays the share health spending represents by consumption quintile in selected EU and OECD countries. In Latvia, a country where overall spending is low and the share of out-of-pocket very high, the gradient is clear: as income rises, health represents a lower share of household spending. People in the lowest consumption quintile spend proportionally more on health than those in the highest consumption quintile (the share is at least twice as high for the former group). In the United States, the highest income group also spends less than the other population groups but differences are far less pronounced. In that country, the social disparities for premium payments are more explicit than for direct payments[2]. In Ireland and Germany,

health care consumption increases with rising income. Some features of the benefit baskets of collectively financed good may explain parts of the phenomenon: in Ireland, entitlement to free GP care is means-tested and accessible to only around 50% of the population. The better-off have to foot the bills themselves. In Germany, all co-payments in the social health insurance scheme are generally capped at 2% of gross income. This helps ensure the burden is proportionally distributed, all the more as co-payments are reduced for chronic or disabled patients (to 1% of gross income) – groups of people that typically have a lower income. Additionally, people who can opt out of social health insurance coverage in Germany (and who are then required to obtain private insurance coverage) typically have a higher income. Private insurance schemes do not cap out-of-pocket payments. The Netherlands stands out as being a country where all income groups spend the same share of their budget on health. In these three countries (Germany, Ireland, the Netherlands), the share funded out-of-pocket is relatively small and spending on health high.

Figure 5.5. Health spending as share of total household consumption by consumption quintile, selected countries



Note: For European countries, the bars represent the shares measured with Household Budget Surveys using the COICOP classification. Health spending refers to class 06; total household consumption is the sum of classes 01 to 12. For the US, it refers to spending on healthcare (without insurance) as share of average annual expenditure. The numbers in parenthesis indicate the 2016 country's share of health spending financed out-of-pocket and total spending per capita in USD PPP.
Source: Eurostat Database 2018; U.S. Bureau of Labor Statistics, Consumption Expenditure Survey 2017; OECD Health Statistics 2018.

5.2.3. Catastrophic and impoverishing health spending are issues in some European countries

With household budget survey micro-data, financial hardship is measured using the two indicators of "catastrophic health spending" and "impoverishing health spending". Spending is said to be catastrophic for households which spend more than a given proportion of their available resources on health. Spending is deemed impoverishing for households whose total consumption drops below the poverty line after they have paid for health care.

Methodologies to estimate the share of the population facing catastrophic health spending or impoverished by it have been developed over the past 20 years (Xu et al., 2003[2]; Wagstaff et al., 2018[3]; Cylus, Thomson and Evetovits, 2018[4]), but they vary in the ways they calculate both indicators (Box 5.1). A recent and in-depth body of work led by the WHO Barcelona Office for Health Systems Strengthening has yielded detailed results for many European countries, and the relevant key findings for EU Member States and Turkey are presented here (WHO Regional Office for Europe, 2019[5]).

Box 5.1. Impoverishing and catastrophic health expenditure : main approaches

Two main indicators are used to calculate the proportion of the population that experiences financial hardship due to health care costs:

- The first one identifies households that are pushed below the poverty line as a result of having incurred health expenses,
- The second identifies households who incur a level of health expenditure that is considered to be high (catastrophic) compared to their available resources.

Both indicators can be calculated in different ways.

A range of approaches can be used to determine who is facing catastrophic spending:

- In the budget share approach, household out-of-pocket spending on health is typically related to household consumption. If the share of consumption spent on out of pocket exceeds a certain threshold, the household is considered to incur catastrophic health spending.
- The capacity to pay approach acknowledges that households also need to spend money on other necessities, which reduces their capacity to pay for health care. To measure the share of the population incurring catastrophic payments, expenditure for basic needs are deducted from consumption, and the share spent on health is computed with that denominator. Different approaches to computing expenditure on basic needs have been used in previous studies: (i) they can reflect actual spending on food; (ii) they can reflect a standard amount to represent basic spending on food; (iii) they can reflect a standard allowance for all basic needs represented by the poverty line or for a specific set of basic needs, e.g. as food, housing and utilities.

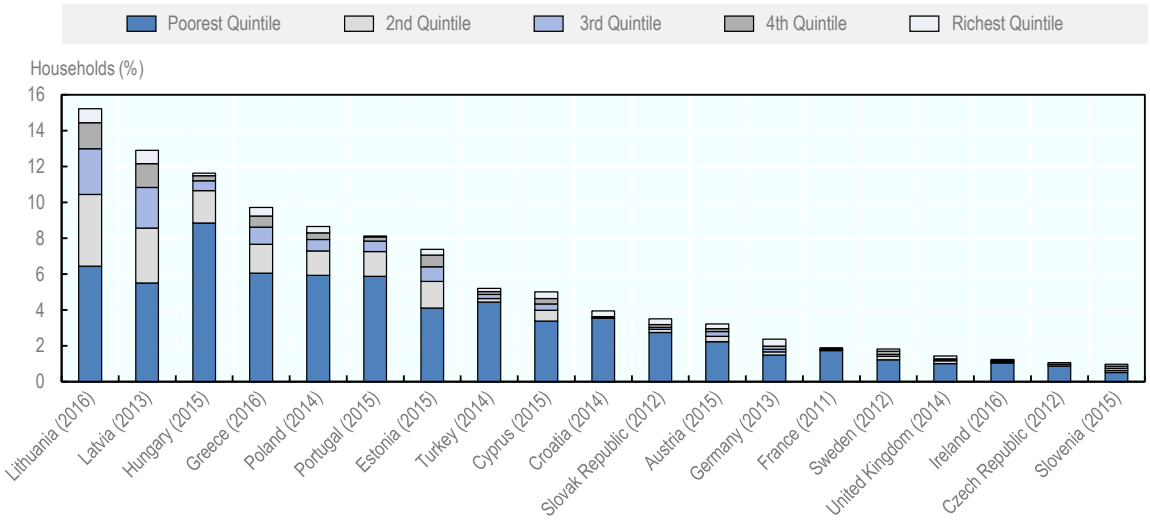
Global monitoring in the context of the SDGs uses the budget share approach to measure catastrophic spending, with a 10% and 25% threshold. It measures impoverishing spending using two absolute poverty lines of USD 1.90 and USD 3.10 in 2011 PPP per person per day, respectively (see Annex Table 5.A.1 for results for EU and OECD countries).

A recent study by the WHO Regional Office for Europe applies the capacity to pay approach to estimate the incidence of catastrophic spending, which it defines as out-of-pocket payments greater than 40% of household capacity to pay for health care. Capacity to pay for health care refers to total household consumption minus a standard amount representing basic needs for food, housing (rent) and utilities.

Source: WHO/World Bank (2017[6]), WHO Regional Office for Europe (2019[5]), Cylus, Thomson and Evetovits (2018[4]).

According to the WHO study, 5.5% of households face catastrophic health spending on average in 18 EU countries and Turkey. In the study, catastrophic spending on health is defined as out-of-pocket payments that exceed 40% of a household's capacity to pay for health care, with the latter, in turns, being measured as what is left of a household's budget after deducting a standard amount deemed necessary to meet basic needs (food, housing and utilities). There are large differences in the share of households facing catastrophically high costs across countries. This number is below 2% in six countries (Slovenia, Czech Republic, Ireland, United Kingdom, Sweden and France) but around 10% or above in Greece, Hungary, Latvia and Lithuania where it reaches 15% of the population. The incidence of catastrophic spending on health is much higher among the poor (Figure 5.6). In all countries, catastrophic spending is heavily concentrated among the lowest consumption quintiles.

Figure 5.6. Share of households with catastrophic out-of-pocket spending by consumption quintile, latest year available



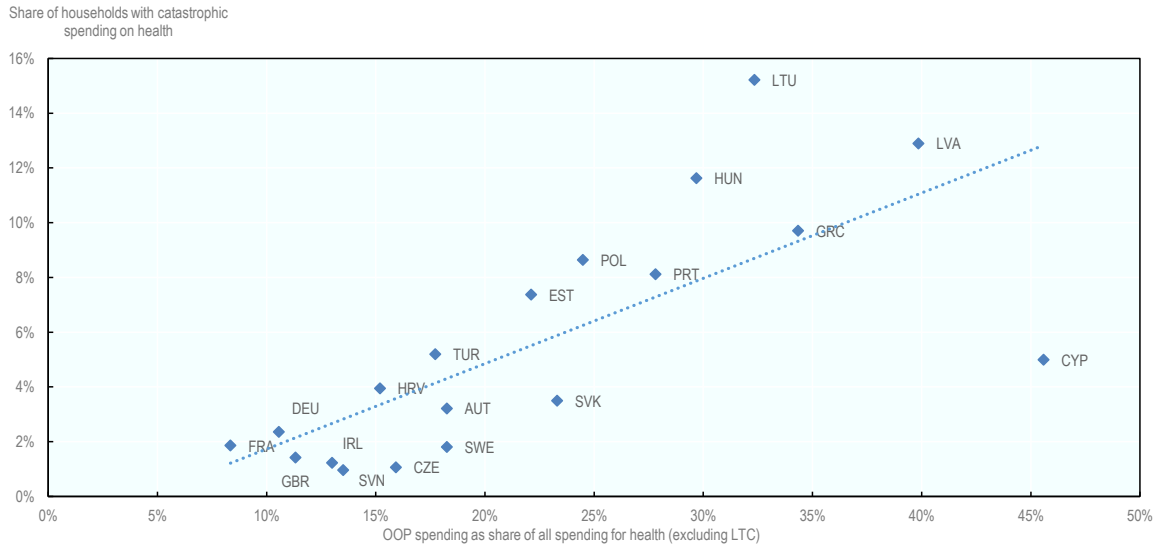
Source: WHO Regional Office for Europe 2019.

The population affected by catastrophic spending tends to be larger in countries where a high share of spending is financed out-of-pocket. Figure 5.7 shows the positive correlation between the share of out-of-pocket spending in overall health expenditure and the proportion of the population facing catastrophic health spending – across Europe. This is consistent with previous findings using data from around the world (Xu et al., 2003[2]). Despite this strong overall correlation, it is important to highlight that for a given level of out-of-pocket spending, some countries (e.g. Slovakia) are able to achieve much better results than others (e.g. Estonia). Cyprus also stands out as a country where high out-of-pocket spending does not translate into as high levels of catastrophic spending as could be anticipated. This indicates that the way the coverage of collectively financed health care goods and services is designed in a country has an impact on the share of households that have to incur catastrophic health expenditure (an issue further discussed below).

Out-of-pocket health spending can also have an impoverishing impact. The concept of “impoverishing health spending” highlights even more clearly the social dimension of financial protection in health care. The WHO Europe study estimated the proportion of households pushed into poverty because of out-of-pocket payments as well as households further impoverished by those payments. The latter group comprises households with resources below the poverty line which still incurred out-of-pocket payments for health services. According to the data of WHO Europe the share of households that are impoverished or further impoverished after out-of-pocket payments range from 0.3% to 6% across the EU and Turkey (Figure 5.8).

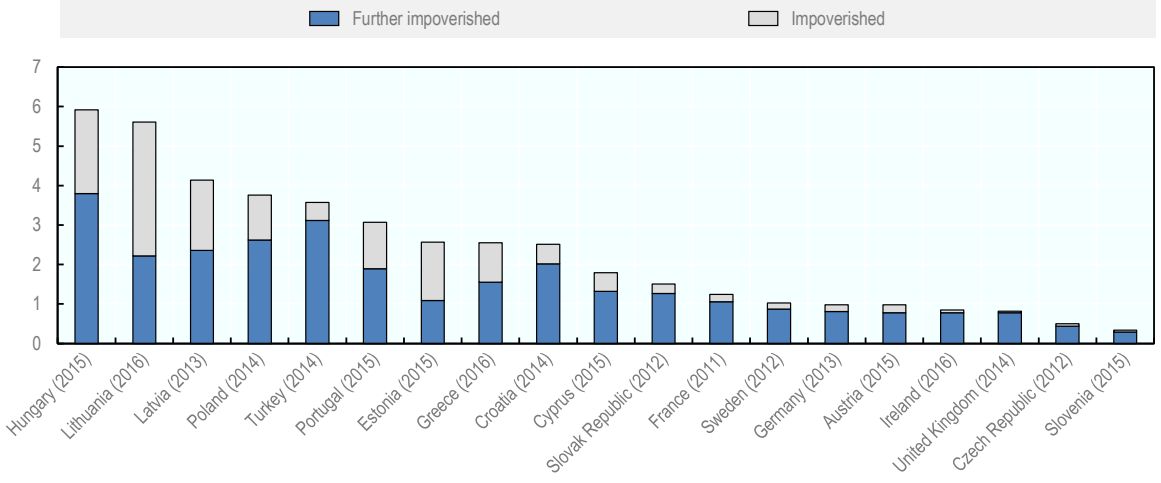
This highlights that beyond access to care, the lack of financial protection against health care costs can have a strong impact on the lives of people. It also shows that financial protection should be a concern to policy makers beyond health ministries and should be considered as one element in a wider agenda to tackle poverty in EU countries and beyond.

Figure 5.7. Incidence of catastrophic health spending and the share of out-of-pocket in total health spending, latest available year



Note: Long-term care services are excluded from the OOP share to better correspond to the concept of catastrophic spending on health (where they are also excluded).
Source: WHO Regional Office for Europe 2019; OECD Health Statistics 2018; Eurostat Database.

Figure 5.8. Share of households impoverished or further impoverished after out-of-pocket payments, latest year available



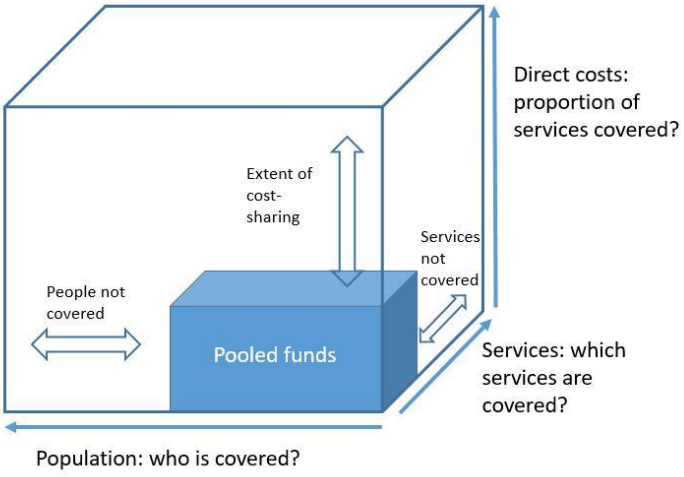
Source: WHO Regional Office for Europe 2019.

5.3. Most people in OECD and EU countries have access to publicly financed coverage

Financing schemes which cover people against the costs of health care are the alternative funding mechanisms to out-of-pocket payments. Prepayments – made in advance of illness – and pooling – the sharing of these prepayments among large segments of the population – are the fundamental mechanisms of these schemes which ensure people can access care when in need. The schemes providing coverage can be public or private, compulsory or voluntary, funded by tax contribution or premiums. In all of these cases, coverage can be characterised along three dimensions (Figure 5.9):

- the share of the population entitled to it;
- the range of goods and services covered; and
- the proportion of costs covered.

Figure 5.9. Three dimensions of health care coverage



Source: Adapted from WHO (2010[7]).

The size of the "cube" of health coverage defined by these three dimensions is the result of health policy choices in a country. In order to ensure that people access health care without enduring excessive financial hardship, OECD and EU countries publicly finance a range of health care goods and services. The more expansive this public coverage is, the less costs have to be borne by patients and other payers. Additionally, in most countries, households can supplement their public coverage by purchasing voluntary insurance limiting the health care costs they pay out-of-pocket.

At an aggregate level, the share of out-of-pocket spending in total health spending represents the share of spending which is not pooled in a country along the three dimensions of coverage. In other words, it measures the part of the cube which is not blue in Figure 5.9 and thus mirrors the degree of financial protection along the three dimensions above. The share of out-of-pocket payments is higher in those countries where significant groups of the population are excluded from collective coverage, important health services not included in the collectively-financed benefit package or where substantial cost-sharing with third-party payers exist for some services. In essence, the analysis presented in the previous section reviewed the extent to which people in Europe are not covered and its implications for affordability of care on a high level. The rest of the chapter delves into how this is mirrored by the different kinds of gaps in coverage. It discusses how the different dimensions of public coverage are organised in countries and highlights some design features

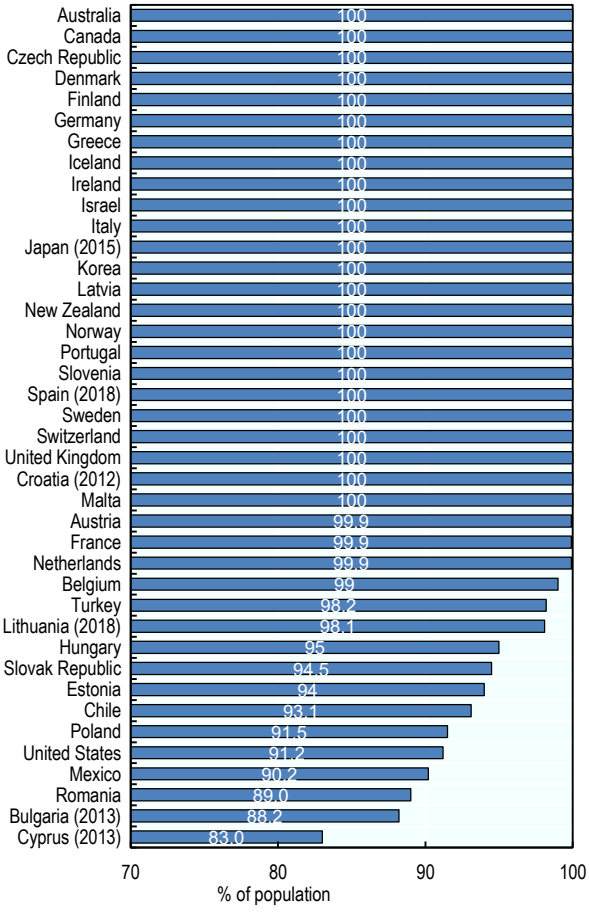
which appear to contribute to ensuring better affordability and financial protection overall. It will also discuss the role voluntary health insurance plays in filling public coverage gaps.

5.3.1. Access to publicly financed coverage is near-universal in many European and OECD countries

The first reason which might explain a high share of out-of-pocket payments in total health spending in a country is the absence of access to the basket of health goods and services financed collectively. All OECD and EU countries provide financial coverage for some key health services – financed either from government schemes or compulsory health insurance schemes (collectively called "public schemes" in the rest of this section) – but there is some variation in the extent to which this coverage spreads across the population (Figure 5.10).

Figure 5.10. Population coverage for a core set of services, 2016 (or latest year)

Share of the population covered by either government schemes, social health insurance or compulsory private health insurance or a combination thereof.



Note: This includes public coverage and compulsory private health coverage. Data for Luxembourg are not available.
Source: OECD Health Statistics 2018; Spanish Ministry of Health, Consumer Affairs and Social Welfare; Lithuanian Ministry of Health; European Observatory Health Systems in Transition (HiT) Series for non-OECD countries.

While population coverage is universal or near-universal in the majority of EU and OECD countries, a number of countries display substantial gaps. Cyprus, for example, has a tax-based system where coverage is currently linked to residency but from which people above a certain income threshold are excluded (Theodorou et al., 2012[8]). Legislation was passed in 2017 to transform the health system into one based on contributory payments providing access to services to everyone by 2020. In Bulgaria, around 12% of the population did not have coverage provided by the social health insurance scheme in 2013. In this country, people lose coverage it they fail to make three contribution payments in the previous 36 month which puts vulnerable groups such as long-term unemployed and the poor at risk (OECD/European Observatory on Health Systems and Policies, 2017[9]). Coverage rates are also low among ethnic minorities. Lack of coverage for parts of the Roma population is similarly problematic in Romania where in total only around 89% of the population are covered for the costs of health care. Other groups that may have to go without coverage are those that do not contribute to the social health insurance funds, such as people working in agriculture, "unofficial" workers in the private sector, the self-employed and unemployed persons not registered for benefits (OECD/European Observatory on Health Systems and Policies, 2017[10]).

Outside of the EU, coverage is only around 90% in Mexico, the United States and Chile. In the United States, the Patient Protection and Affordable Care Act included an "individual mandate" that required –with some exceptions- all residents from 2014 on to get insurance coverage if they are not covered by another scheme. Yet, people could also opt to pay a penalty if they preferred to stay uninsured. In 2016, more than 8% of the population still remained without coverage. The individual mandate was repealed in the Tax Cuts and Jobs Act of 2017 taking effect in 2019.

But even in those countries where coverage is near-universal, specific population groups may fall through the "cracks" of the social security nets or deliberately choose to remain uninsured. Table 5.1 shows how access to the key health financing scheme is attained in EU and OECD countries. In this regard countries can be roughly split in two groups:

- countries where coverage is automatic for the entire population based on residence;
- countries where coverage is based on payment of mandatory contributions to social or private health insurance schemes, frequently based on employment status.

A number of countries automatically cover the entire population. Among them, the majority do so by providing the entire resident population with access to public services financed out of taxations, following the tradition of the National Health Service in the United Kingdom. Many other countries such as the Scandinavian countries or Italy were inspired by this approach to coverage in the development of their health systems. The only persons in systems with residence-based coverage that may remain without protection typically are undocumented migrants – but they may still have access to emergency care services.

The second archetype of model is based on social health insurance principles, where health care coverage is typically linked to the employment status of the person or grounded on clearly delineated entitlements rules. Coverage is for instance typically extended to non-working family members. Other groups such as the unemployed, students, disabled and other people with low-income may be either automatically covered or exempted from making contributions payments to social health insurance funds with various government agencies sometimes contributing on their behalf. Countries that implemented a social health insurance system include Germany, Austria, Belgium, France, the Czech Republic, Slovenia, Chile, Japan, Korea and others. In such an "employment-focused" coverage model, some people may fall through the "cracks" and lack coverage: these are for example people with irregular employment status or those who work too few hours per week to be entitled to coverage (e.g., Poland and Estonia). In some countries, although entitlement for coverage is universal, some population groups are not automatically covered but have to opt-in – if they do not exercise this right they remain uncovered (e.g., Austria, Luxembourg). Finally, in Germany, where the purchase of private health insurance is compulsory for some population groups some people may not be able to afford this or default on their premium payments which may lead to a (temporary) loss of full coverage.

Some countries that adopted a social health insurance model nevertheless base coverage on residency, including Croatia, the Czech Republic and France. In countries where population groups are not explicitly covered, they may still get access to a limited service package including emergency care.

Table 5.1. How is coverage attained in EU countries?

	Who is the key payer in the system?	Is coverage (beyond emergency care) automatic for the entire population?
Australia	Government scheme	yes
Austria	Health Insurance	no
Belgium	Health Insurance	no
Bulgaria	Health Insurance	no
Canada	Government scheme	yes
Chile	Health Insurance	no
Croatia	Health Insurance	yes
Cyprus	Government scheme	no
Czech Republic	Health Insurance	yes
Denmark	Government scheme	yes
Estonia	Health Insurance	no
Finland	Government scheme	yes
France	Health Insurance	yes
Germany	Health Insurance	no
Greece	Government scheme	no
Hungary	Health Insurance	no
Iceland	Government scheme	yes
Ireland	Government scheme	yes
Israel	Health Insurance	yes
Italy	Government scheme	yes
Japan	Health Insurance	no
Korea	Health Insurance	no
Latvia	Government scheme	yes
Lithuania	Health Insurance	no
Luxembourg	Health Insurance	no
Malta	Government scheme	yes
Mexico	Health Insurance	no
Netherlands	Health Insurance	no
New Zealand	Government scheme	yes
Norway	Government scheme	yes
Poland	Health Insurance	no
Portugal	Government scheme	yes
Romania	Health Insurance	no
Slovak Republic	Health Insurance	no
Slovenia	Health Insurance	no
Spain	Government scheme	yes
Sweden	Government scheme	yes
Switzerland	Health Insurance	no
Turkey	Health Insurance	no
United Kingdom	Government scheme	yes
United States	Health Insurance	no

Note: Information on the key payer refers to the financing scheme paying for most health services.
Source: OECD Health Statistics 2018 and authors' assessment on coverage based on various information sources.

5.3.2. Voluntary health insurance plays a marginal role except in a handful of countries

In addition to public schemes which provide automatic or mandatory coverage for all or large parts of the population, people can also benefit from voluntary coverage schemes[3] which contribute to increasing pooling at the level of a country (Box 5.2). The role that voluntary health insurance (VHI) plays in OECD and EU health systems varies greatly, in terms of the functions it performs (Sagan and Thomson, 2016[11]), the share of people covered by it and its importance in overall health financing.

Box 5.2. Voluntary health insurance vs private health insurance

This section does only consider voluntary health insurance schemes, typically provided by private health insurers. It does not consider compulsory private health insurance coverage as it exists, for example, in the Netherlands, Switzerland and the United States (before the repeal of the individual mandate stipulated in the Affordable Care Act) as well as in Germany and Chile where private health insurance coverage is required for those that opt out of public health insurance. In France, complementary private health insurance has become compulsory for some population groups in 2016, however the data for France provided in Figure 5.11 precedes this development and hence all private insurance is still considered as voluntary in that chart.

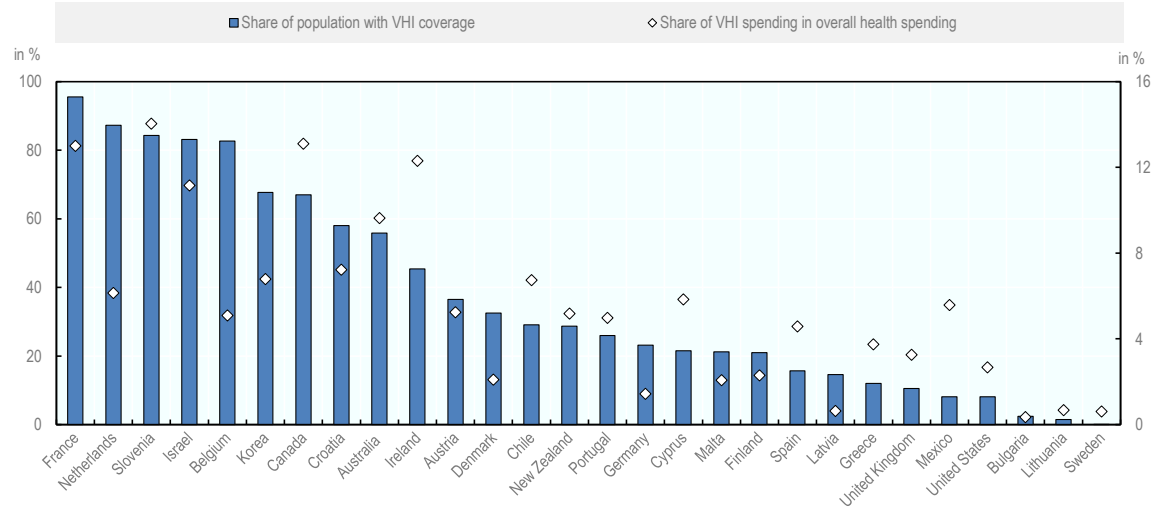
Figure 5.11 combines the latter two pieces of information. While in France, the Netherlands, Slovenia, Israel and Belgium large proportions of the population have VHI coverage to pay some health care costs, this share is much smaller in most other countries. Slovenia, France and Israel are also on top when analysing the overall share of spending pooled though VHI. In those three countries, VHI spending represents 11-14% of overall health spending, much more than in many other countries (4% on average across OECD and EU countries). In Canada, Ireland and Australia (10-13%) VHI is equally important. On the other hand, VHI plays virtually no role in some EU countries, including Sweden, Lithuania and Bulgaria.

While the existence of VHI in a country can reduce the financial burden of out-of-pocket payments for health it may come with its own equity issues, depending how VHI is designed and regulated in a country. In general, the purchase of voluntary coverage requires additional premium payments that can represent an extra burden to poorer households. As a result, access to VHI is often concentrated among the better-off.

Governments can subsidise the uptake of VHI among disadvantaged groups to address the fact that they would be less likely to afford additional coverage. This happens, for example, in France, where poor households obtain VHI coverage for free and other households with modest income receive a voucher (Chevreul, Berg Brigham and Perronnin, 2016[12]). In Croatia, some population groups such as people with a physical or mental disability, dependent people, organ donors, some blood donors, students and people with low income also have free VHI coverage (Lončarek, 2016[13]).

Figure 5.11. Voluntary health insurance in EU and OECD countries, 2016 or latest year

Share of population with additional health care coverage from voluntary health insurance and share of voluntary health insurance spending in overall health spending



Note: These data exclude compulsory PHI.
Source: OECD Health Statistics 2018; Eurostat Database; and Sagan and Thomson (2016) for non-OECD countries.

On the other hand, if governments promote the uptake of VHI coverage by providing financial incentives to purchase insurance via the tax system, then this will most likely benefit population groups with higher income more. As a result, VHI coverage will be concentrated among the better-off. To a certain extent this is the case in Ireland, where the purchase of duplicate VHI for quicker access for hospital treatment is concentrated among the better-off and take-up is incentivised by an income tax relief for premium payments (Turner, 2016[14]). Consequently, people with the resources to pay for VHI have more timely access to treatment.

In sum, whether VHI helps to reduce financial hardship due to health care costs or exacerbates existing inequalities in access to care depends how it is implemented in a country. Yet, public financing remains the main lever through which health systems facilitate access to care, particularly for the segments of the population which are not rich.

5.4. The design of coverage, particularly public, can improve affordability

Out-of-pocket payments, especially for the poor, most likely reflect gaps in the heights and depth of public coverage. Public population coverage is quasi-universal in most EU and OECD countries; private coverage is for the most part limited and typically concentrated among the better-offs. It is thus likely that the direct payments people (especially with low income) have to face, for the most part, reflect the exclusion of some services from public coverage (depth of the cube in Figure 5.9) and co-payments for services whose costs are not entirely covered (height).

This final section takes a closer lens to the question of affordability by type of service. The objectives are (i) to determine whether affordability issues are generally more prominent for certain types of services especially for the poor and (ii) whether country-level characteristics of coverage appear to improve the ability of the system to protect the population better.

Before that, it is important to recognise that there are gaps in the knowledge about the exact nature of the out-of-pocket payments households face. A comprehensive analysis of the financial burden of health care costs should ideally distinguish “necessary” out-of-pocket spending (e.g. a co-payment to access a physician if one is ill) from more “discretionary” costs related to “choice” (e.g. better amenities such as a single room in hospital). From an equity perspective, the absence of public coverage of the latter type of out-of-pocket spending may not be problematic. In reality, the extent to which out-of-pocket payments are discretionary is difficult to assess. Nevertheless, based on country-level information, health financing experts would probably agree that in most health systems, especially when overall spending on health is low and the out-of-pocket share high, discretionary out-of-pocket spending is considerably less prevalent than necessary out-of-pocket spending. Furthermore, discretionary out-of-pocket spending would probably be concentrated among well-off households. The examples presented in Figure 5.5 on how the burden is shared across households of varying income in different countries generally support these assumptions.

5.4.1. Across the EU and OECD, hospital and outpatient care is better covered than pharmaceuticals and dental care

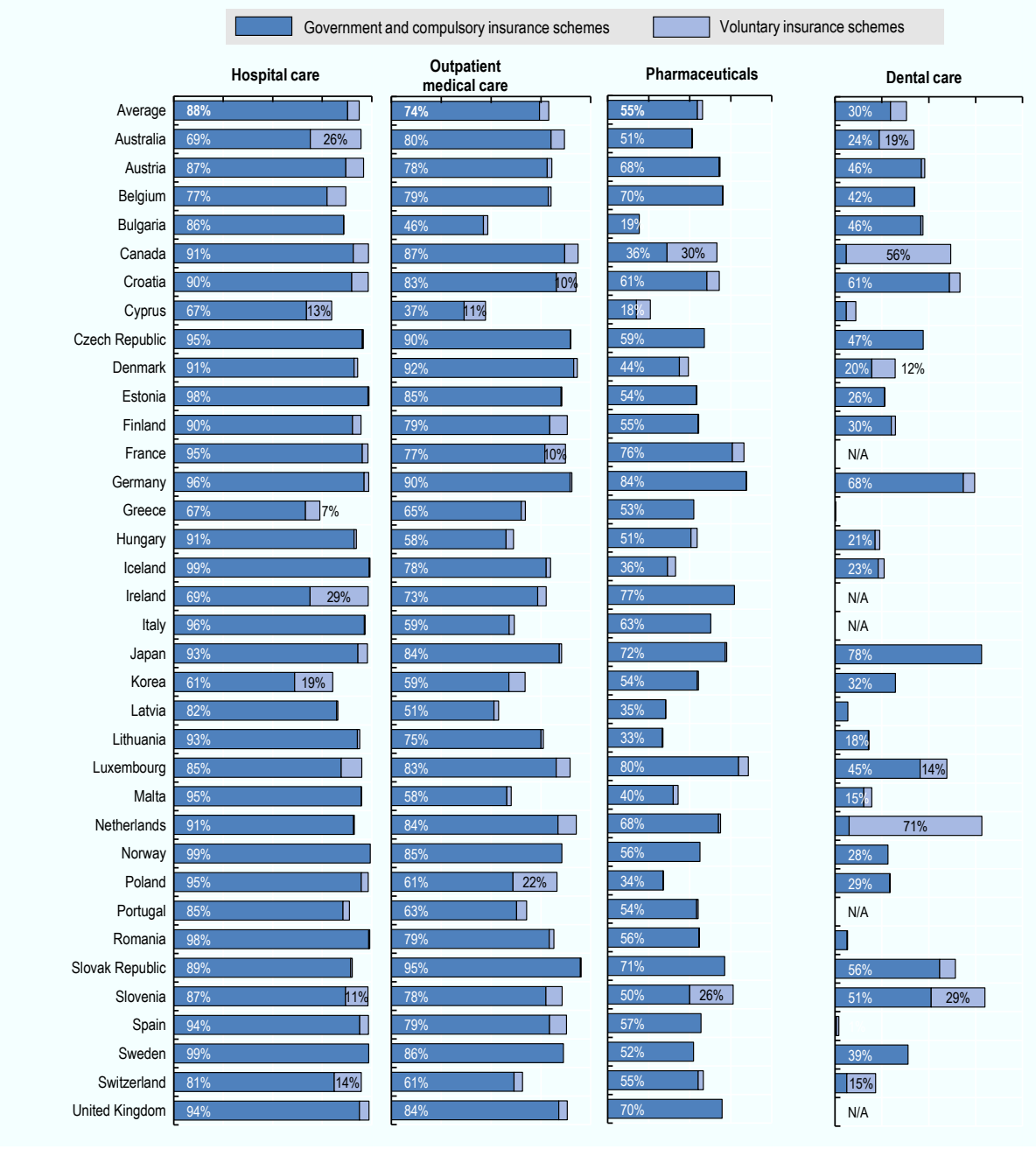
Breaking-down data on health spending for particular services according to who finances them provides some valuable insights into the extent to which service and cost coverage differs across countries. Figure 5.12 presents, for most EU and OECD countries and key categories of services, the share of spending pooled though public and private coverage. It highlights large differences:

- in the share of the total costs covered for similar services by public schemes and voluntary insurance schemes across countries; and
- in the share of total costs covered by third-party payers for different types of services within countries.

At a high level, across EU and OECD countries, hospital services is the category least likely to lead to financial hardship: 94% of all hospital spending is financed by third-party payers. These are mainly public schemes (with a small share of voluntary health insurance in some countries). For outpatient medical services, which generally refer to visits to general practitioners (GPs) or specialists, coverage by third party-payers is less comprehensive (79%). Coverage by third party-payers is even more limited for other goods and services: only around three-fifths (58%) of the costs of pharmaceuticals and 38% of dental care costs are covered by public or private prepayment schemes. The data also show that, on average across European and OECD countries, third-party coverage for key services is predominantly provided by public schemes with voluntary health insurance only playing an important role in a small number of countries for some services. As a result, in many countries a substantial fraction of the costs needs to be covered by patients themselves, particularly for pharmaceuticals and dental care.

Figure 5.12. Health care coverage for selected goods and services, 2016 or latest year

Government/compulsory insurance spending and spending by voluntary schemes as proportion of total health spending by type of service.



Note: Hospital care refers to inpatient or day care in hospitals. Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Spending by voluntary insurance schemes also includes direct health spending by employers and charities, which is negligible in most EU and OECD countries.

Source: OECD Health Statistics 2018; Eurostat Database.

5.4.2. Variation in the financial protection at service level can explain differences in the financial burden of health care costs

The extent to which high out-of-pocket payments may limit access and translate into unmet needs or catastrophic spending differs across income group. It also depends on the type of service considered, the organisation of public coverage, and the role private insurance plays in a given country. Systematically assessing these different factors goes beyond the scope of this report and is precisely the subject of the country-based studies included in the study by WHO Europe – see for example Estonia (Võrk and Habicht, 2018[15]) or Germany (Siegel and Busse, 2018[16]). Building on this work and the data presented in this report, some summary messages by type of service can nevertheless be drawn and examples presented which further illustrate the importance of (i) approaching the notion of access comprehensively and (ii) combining information on utilisation, unmet needs and financial hardship. To that effect, additional data showing which services drive catastrophic spending for different segments of the population are presented in Box 5.3 and discussed through this section.

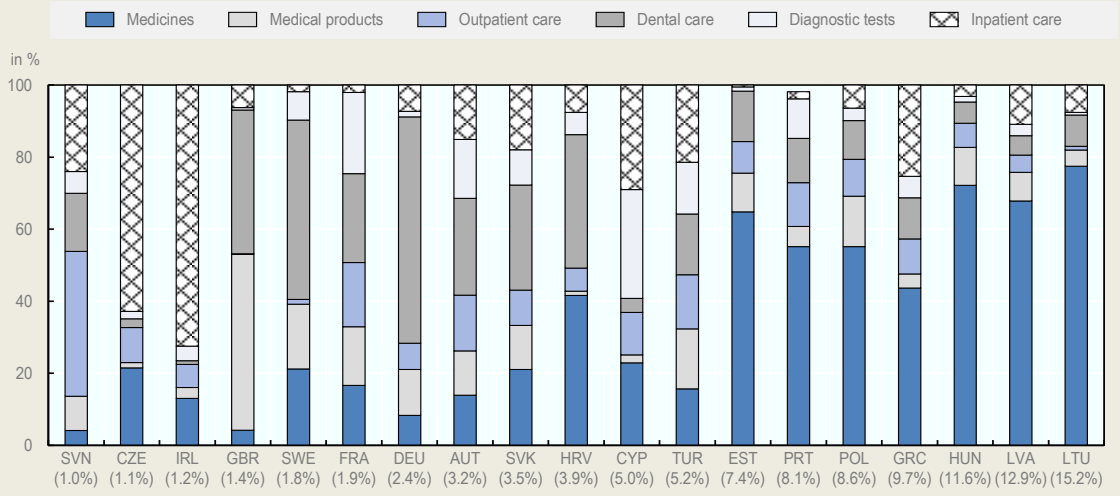
For ***hospital treatment***, financial coverage from public schemes is very comprehensive in most countries (as shown in Figure 5.12). Australia, Cyprus, Greece, Korea and Ireland stand out as having relatively low public coverage (below 70%). These countries are also among those for which the share of hospital costs covered by voluntary health insurance is the highest[4]. In Ireland, VHI facilitates access to private care in hospitals to avoid public waiting lists for diagnostic services or surgery. Since not everyone is privately covered, at population level, hospital care accounts for nearly three quarters of catastrophic spending in Ireland (see Box 5.3). The fact that hospital care only represents 7% of catastrophic spending in the first quintile probably means that, unlike people who are better-off, people in the lower income quintile do not exert the option to use private services and instead use the public services everyone is entitled to. Similarly, in Greece and Cyprus, hospital services represent a larger share of catastrophic spending at population level, but not for the people in the bottom quintile. Overall though, as seen in chapter 4, hospital service use does not appear to be differentiated across income in the EU.

For ***outpatient medical care***, third-party coverage which averages at 79% across EU and OECD countries is particularly low in Bulgaria, Latvia and Cyprus, at around 50% (see Figure 5.12). As seen in Chapter 4, Latvia has the highest proportion of people declaring forgoing medical care for financial reasons in Europe (around 23%, 37% among the poor). Although still high (11%), the proportion of people in the first quintile who forgo medical care for financial reason in Cyprus is much less worrying. In that country, for people below a certain level of income access to care in the public sector is either free or subject to co-payments which increase with income. Overall though, and despite being less comprehensively covered than inpatient care, outpatient care is a relatively modest contributor to catastrophic payments in EU countries, either at population level or among the poor (Box 5.3).

Box 5.3. Which goods and services drive catastrophic spending?

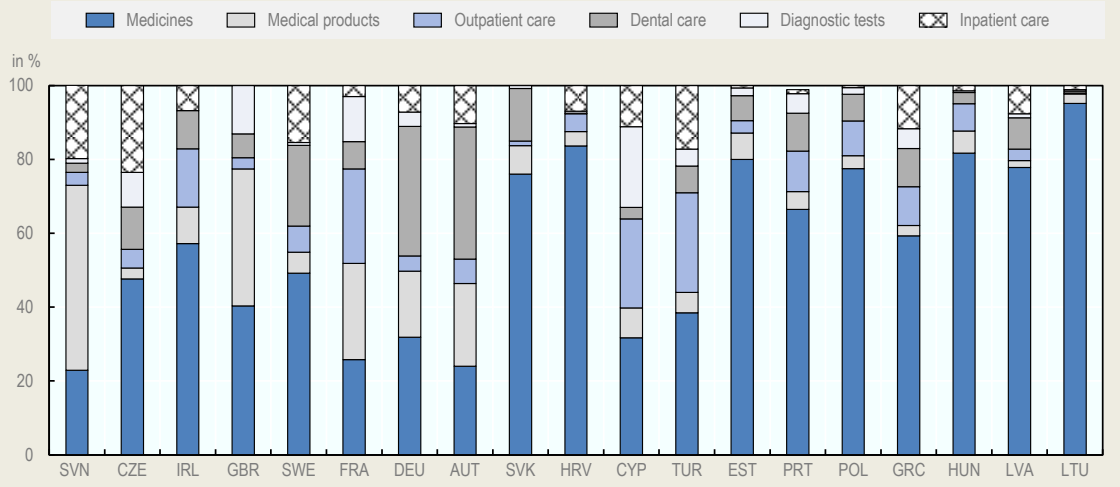
The two charts below break down out-of-pocket payments in households with catastrophic health spending by type of health care in 19 European countries for two different population groups. The upper chart displays the average composition for all households with catastrophic spending in each country. The lower chart shows the average composition for households with catastrophic spending in the lowest consumption quintile.

Figure 5.13. Breakdown of spending among households with catastrophic spending, all households



Note: Percentage in brackets indicates the share of households incurring catastrophic spending in a country. Countries are thus ranked by increasing share of households with catastrophic spending.
Source: WHO Regional Office for Europe 2019.

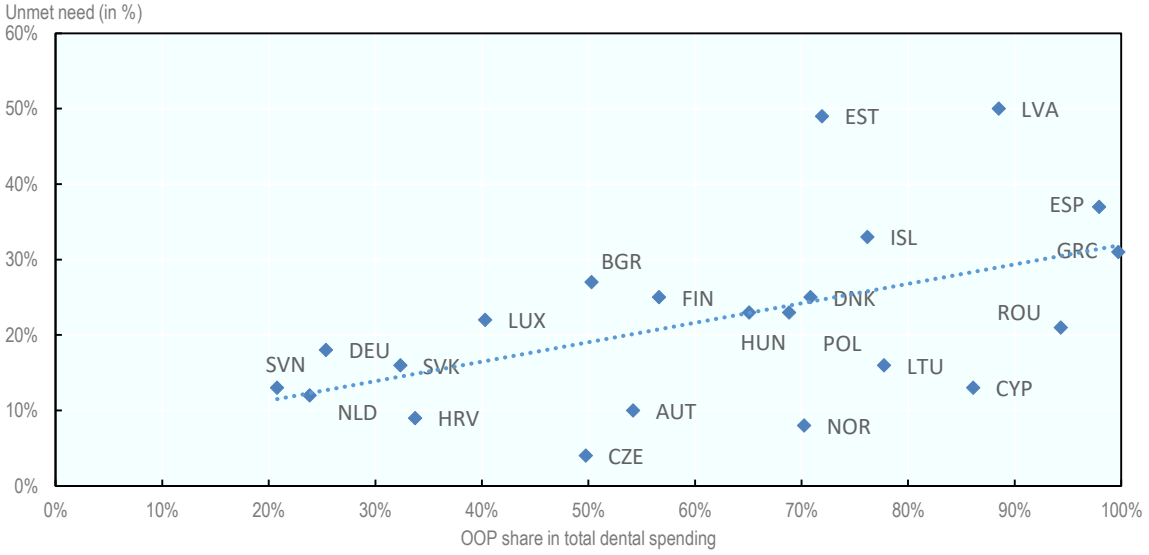
Figure 5.14. Breakdown of spending among households with catastrophic spending, lowest consumption quintile



Source: WHO Regional Office for Europe 2019.

The variation in the share of ***pharmaceutical*** spending covered publicly in EU and OECD countries is particularly large: it ranges between less than 20% in Cyprus and Bulgaria to 80% or more in Luxembourg and Germany (see Figure 5.12). In many countries, the market for over-the-counter (OTC) medicines is an important factor explaining lower coverage shares (in Poland, for example, half of pharmaceutical expenditure are due to OTC medicines). In Canada (30%) and Slovenia (26%), voluntary health insurance finances more than a quarter of the entire medicines bill. VHI also plays a role in covering pharmaceuticals in Cyprus (8%), France (7%), Luxembourg and Denmark (both 6%). Nevertheless, across the EU and OECD, co-payments for pharmaceuticals are generally more substantial than for acute inpatient and primary care (OECD, 2016[17]; Paris et al., 2016[18]). Unsurprising, pharmaceutical spending is the key contributor to catastrophic out-of-pocket payments at population level in all EU countries where catastrophic spending affects more than 5% of the population (Estonia, Portugal, Poland, Greece, Hungary, Latvia and Lithuania) (see Box 5.3). The costs of medicines is the single-most important driver of catastrophic spending among the poor in most (15 out of 19) countries.

Figure 5.15. Unmet needs for dental care due to cost in the first quintile compared to the share of out-of-pocket spending in dental spending



Note: In this chart unmet need is only displayed for the 1st income quintile.
Source: EHIS-2; Eurostat Database; OECD Health Statistics 2018.

Finally, there are important differences in coverage for ***dental care*** across EU and OECD countries (Paris et al., 2016[18]; Auraaen et al., 2016[19]). In some countries, such as Canada, Cyprus, Greece, Latvia, the Netherlands, Romania, Spain and Switzerland, less than 10% of total costs are covered by public schemes (see Figure 5.12). In those countries, dental care is generally not included in the benefit package but some dental services for particular groups of patients might be. In countries with low public coverage for dental care, supplementary insurance to cover dental costs can play a big role, as can be seen in the Netherlands, where voluntary health insurance covers more than 70% of all dental costs, or in Canada (56%), Slovenia (29%) and Australia (19%). Yet, third-party financing for dental consultations and dental prosthesis is relatively limited in many European countries. As a consequence, out-of-pocket payments for dental care can cause financial hardship. Indeed, across all population groups, spending for dental care is the main contributor of catastrophic health spending in five countries where the prevalence of catastrophic spending is otherwise moderate (Sweden, France, Germany, Austria, and the Slovak Republic) (see Box 5.3). In the lowest income quintile, dental spending is much less likely to drive catastrophic spending. However, this does not mean that the poor are better protected against the cost of dental services. The more reasonable

assumption is that they forgo care. In fact, Figure 5.15 shows that the higher the share of out-of-pocket spending for dental care in overall dental costs is, the higher is the share of people with unmet needs for dental care due to financial reasons among the population with the lowest income.

In sum, in most EU countries, pharmaceuticals are the single largest driver of catastrophic spending for people in the lowest income quintile as well as for the entire population in most countries where catastrophic spending affects more than 5% of households (WHO Regional Office for Europe, 2019[5]). When it comes to dental care, coverage by third-party payers is much lower (around 30% public and 8% private) and unmet needs for financial reasons are generally higher, especially among the poor, but for those who seek care in the general population, dental spending can still be a source of financial hardship.

5.4.3. Policy levers can help reduce financial hardship of households, especially for the poor

The previous section showcases a large variation in the share of costs covered for a number of key health services across EU and OECD countries. In general, the higher the share of all costs left for patients to pay the more likely it is that it causes financial hardship or represent a barrier to access to care leading to unmet needs, and countries where out-of-pocket represent less than 15% of the total cost have much lower levels of financial hardship. But the data also show that given comparable levels of out-of-pocket spending some countries fare better than others in avoiding financial hardship for their populations, especially the poor. One core element explaining the difference in the financial protection in EU countries is related to coverage design (WHO Regional Office for Europe, 2019[5]).

First and foremost, ensuring the entire population has access to public coverage is a prerequisite to guaranteeing they can turn to the health system when in need. While this is the case in many EU and OECD countries, pockets of populations remain uncovered in some countries, even among legal residents. Those excluded are generally more vulnerable and although they may have access to emergency services, it would be preferable to ensure they are covered and have more options to access care regularly.

Beyond that, there are ways in which public coverage can be organised to limit financial hardship, especially among the poor.

- Co-payment design: countries where co-payments are fixed rather than set as a percentage of the cost generally have lower levels of co-payments overall which translates into better financial protection.
- Another way to reduce the level of catastrophically high out-of-pocket spending is to exempt vulnerable population groups from having to make co-payments. Based on the information for 21 EU countries participating in the 2016 OECD Health System Characteristics Survey, all countries exempt children from cost-sharing and the vast majority extend this (total or partial) exemption to disabled people and those with certain medical conditions. Yet, only around half of the countries make total or partial co-payment exemptions for people with low income, beneficiaries of social benefits and senior citizens (OECD, 2016[17]).
- Another effective tool to limit co-payments is to define a co-payment ceiling either for specific services or for all co-payments. Such instruments are in place in many countries, with the ceiling being defined either as a nominal amount (e.g. Denmark, Sweden) or as a share of annual income as seen, for example, in Austria, Germany or Luxembourg (Paris et al., 2016[18]).

The examples of Croatia, France and Slovenia suggest that voluntary health insurance can be leveraged to reduce the impact of out-of-pocket payments on access and financial hardship if it explicitly covers co-payments. This requires widespread access to private coverage, however, and extensive measures to ensure it is accessible and affordable for low-income groups (WHO Regional Office for Europe, 2019[5]).

The importance of pharmaceutical spending in explaining financial hardship and the fact that more than 7% of adults across the EU decide not to purchase the medicines prescribed by physicians because of the cost (see chapter 4) warrants more attention from policy makers. Pharmacotherapies play a key role in both primary and secondary prevention of many diseases. Several studies have also shown that financial barriers to accessing necessary medicines are strongly correlated not only with poorer health outcomes but also increased use and cost of other health services (Kesselheim et al., 2015[20]). Coverage policies clearly have a role to play in improving access and reducing financial hardship, in tandem with policy levers to improve the take-up of generics and biosimilars, reduce the overall costs of medicines and promote their rational prescribing, dispensing and use – by working with physicians and pharmacists as well as patients.

5.5. Conclusion

The first chapter of this report highlighted the importance of combining different approaches to assess a health system's ability to provide affordable access to quality care. The two previous chapters (Chapter 3 and Chapter 4) showed that in most countries the poorer citizens are less likely to use care and more likely to face barriers and delay or forgo care. Having to pay for care out-of-pocket is one of the main reasons why this happens. But when turning to the health system it can also put an excessive strain on their budget and generate financial hardship. This chapter turns more explicitly to the affordability angle of the access equation.

Key findings include:

- Health care is less affordable for households with low income than those with higher income. On average, 17% of European households are only able to make health care payments under difficulties or great difficulties. For households below the poverty line this share is 30%.
- Across the EU, around 5.5% of households on average face catastrophically high out-of-pocket spending for health, which is concentrated among the poor in all countries.
- There is a strong correlation between the share of households with catastrophic health spending and the share of out-of-pocket spending in total health spending in a country.
- Hospital care and medical outpatient care are covered relatively well in most EU and OECD countries. This is not necessarily the case for pharmaceuticals and dental care. High out-of-pocket costs for pharmaceuticals is the main reason why poor people face catastrophically high health care costs. Faced with high costs of dental treatment, people with low income may forego care altogether because they cannot afford it in countries with low coverage for this type of care.
- The design of collectively financed health coverage affects the level of spending left for the patients to pay and can reduce or exacerbate inequalities in the financial protection against the costs of health care.

References

Auraaen, A. et al. (2016), "How OECD health systems define the range of good and services to be financed collectively", *OECD Health Working Papers*, No. 90, OECD Publishing, Paris, https://dx.doi.org/10.1787/5jlnb59ll80x-en. [19]

Chevreul, K., K. Berg Brigham and M. Perronnin (2016), "France", in Sagan A and Thomson S (eds.), *Voluntary health insurance in Europe: Country experience*. [12]

Cylus, J., S. Thomson and T. Evetovits (2018), "Catastrophic health spending in Europe: equity and policy implications of different calculation methods", *Bulletin of the World Health Organization*, Vol. 96/9, pp. 599-609, http://dx.doi.org/10.2471/BLT.18.209031. [4]

Kesselheim, A. et al. (2015), "Prescription drug insurance coverage and patient health outcomes: a systematic review.", *American journal of public health*, Vol. 105/2, pp. e17-30, http://dx.doi.org/10.2105/AJPH.2014.302240. [20]

Lončarek, K. (2016), "Croatia", in Sagan, A. and S. Thomson (eds.), *Voluntary health insurance in Europe: Country experience*, European Observatory on Health Systems and Policies, http://www.euro.who.int/__data/assets/pdf_file/0011/310799/Voluntary-health-insurance-Europe-country-experience.pdf. [13]

OECD (2016), *Health Systems Characteristics Survey*, https://qdd.oecd.org/subject.aspx?Subject=hsc (accessed on 19 October 2018). [17]

OECD/European Observatory on Health Systems and Policies (2017), *Bulgaria: Country Health Profile 2017*, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://dx.doi.org/10.1787/9789264283305-en. [9]

OECD/European Observatory on Health Systems and Policies (2017), *Romania: Country Health Profile 2017*, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://dx.doi.org/10.1787/9789264283534-en. [10]

Paris, V. et al. (2016), "Health care coverage in OECD countries in 2012", *OECD Health Working Papers*, No. 88, OECD Publishing, Paris, https://dx.doi.org/10.1787/5jlz3kbf7pzv-en. [18]

Sagan, A. and S. Thomson (2016), *Voluntary Health Insurance in Europe: Role and Regulation*, European Observatory on Health Systems and Policies, http://www.euro.who.int/__data/assets/pdf_file/0005/310838/Voluntary-health-insurance-Europe-role-regulation.pdf. [11]

Siegel, M. and R. Busse (2018), *Can people afford to pay for health care? New evidence on financial protection in Germany*, http://www.euro.who.int/__data/assets/pdf_file/0004/373585/Can-people-afford-to-payGermany-WHO-FP-008-4.pdf (accessed on 30 June 2019). [16]

Theodorou, M. et al. (2012), *Cyprus: Health System Review*, http://www.euro.who.int/__data/assets/pdf_file/0017/174041/Health-Systems-in-Transition_Cyprus_Health-system-review.pdf?ua=1 (accessed on 17 October 2018). [8]

Turner, B. (2016), "Ireland", in Sagan, A. and S. Thomson (eds.), *Voluntary Health Insurance in Europe: Country Experience*, European Observatory on Health Systems and Policies, http://www.euro.who.int/__data/assets/pdf_file/0011/310799/Voluntary-health-insurance-Europe-country-experience.pdf?ua=1. [14]

Võrk, A. and T. Habicht (2018), *Can people afford to pay for health care? New evidence on financial protection in Estonia*, WHO Regional Office for Europe, http://www.euro.who.int/__data/assets/pdf_file/0004/373576/Can-people-afford-to-pay-for-health-careEstonia-WHO-FP-004.pdf?ua=1 (accessed on 28 November 2018). [15]

Wagstaff, A. et al. (2018), "Progress on catastrophic health spending in 133 countries: a retrospective observational study", *The Lancet Global Health*, Vol. 6/2, pp. e169-e179, http://dx.doi.org/10.1016/S2214-109X(17)30429-1. [3]

WHO (2010), *The World Health Report: Health System Financing - The path to universal coverage*, http://apps.who.int/iris/bitstream/handle/10665/44371/9789241564021_eng.pdf (accessed on 18 October 2018). [7]

WHO Regional Office for Europe (2019), *Can people afford to pay for health care? New evidence on financial protection in Europe*, WHO Regional Office for Europe, Copenhagen, https://apps.who.int/iris/bitstream/handle/10665/311654/9789289054058-eng.pdf. [5]

WHO/Regional Office for Europe (2018), *Health Systems for Prosperity and Solidarity: leaving no one behind. Outcome statement of the Tallinn High-level Meeting*, http://www.euro.who.int/__data/assets/pdf_file/0008/373688/tallinn-outcome-statement-eng.pdf (accessed on 7 November 2018). [1]

WHO/World Bank (2017), *Tracking Universal Health Coverage: 2017 Global Monitoring Report*, http://documents.worldbank.org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC.pdf (accessed on 3 May 2018). [6]

Xu, K. et al. (2003), "Household catastrophic health expenditure: a multicountry analysis", *The Lancet*, Vol. 362/9378, pp. 111-117, http://dx.doi.org/10.1016/s0140-6736(03)13861-5. [2]

Annex 5.A. Data on financial protection using indicators for global monitoring

The following table presents data on financial protection for EU Member States and OECD countries using global indicators defined by WHO and the World Bank in the context of the Sustainable Development Goals (SDGs).

Annex Table 5.A.1. Data on financial protection using indicators for global monitoring in the context of the SDGs

	SDG-UHC indicator 3.8.2: Incidence of catastrophic expenditure (%)			Incidence of impoverishment due to out-of-pocket health spending (%)		
	data year	at 10% of households total consumption or income	at 25% of households total consumption or income	data available	Poverty line: at 2011 PPP USD 1.90-a-day	Poverty line: at 2011 PPP USD 3.10-a-day
Australia	2010	3.71	0.50	yes	0.00	0.00
Austria	1999	4.31	0.66	no	---	---
Belgium	2010	11.45	1.39	yes	0.00	0.00
Bulgaria	2010	12.84	0.76	yes	0.00	0.13
Canada	2010	2.64	0.51	yes	0.03	0.03
Chile	2006	33.07	11.52	yes	0.65	2.59
Croatia	2010	2.80	0.26	yes	0.00	0.00
Cyprus	2010	16.07	1.50	yes	0.00	0.00
Czech Republic	2010	2.22	0.05	yes	0.00	0.00
Denmark	2010	2.93	0.49	yes	0.00	0.00
Estonia	2010	8.79	1.19	yes	0.00	0.08
Finland	2010	6.35	0.97	yes	0.00	0.00
France	--	--	--	no	---	---
Germany	1993	1.41	0.07	yes	0.00	0.00
Greece	2010	14.64	1.78	yes	0.00	0.00
Hungary	2010	7.38	0.31	yes	0.00	0.03
Iceland	1995	6.90	0.94	yes	0.00	0.00
Ireland	2010	6.40	0.69	yes	0.00	0.00
Israel	2012	6.72	0.95	yes	0.00	0.00
Italy	2010	9.29	1.08	yes	0.00	0.00
Japan	2008	6.17	2.01	no	---	---
Korea	2008	13.53	4.01	yes	0.00	0.04
Latvia	2006	10.91	1.83	yes	0.04	0.11
Lithuania	2010	9.79	1.64	yes	0.00	0.01
Luxembourg	2010	3.38	0.15	yes	0.00	0.00
Malta	2010	15.93	2.81	yes	0.00	0.00
Mexico	2012	7.13	1.91	yes	0.28	0.69
Netherlands	--	--	--	no	---	---
New Zealand	--	--	--	no	---	---
Norway	1998	5.09	0.50	yes	0.00	0.00
Poland	2012	13.93	1.61	yes	0.00	0.09
Portugal	2010	18.38	3.31	yes	0.00	0.00

	SDG-UHC indicator 3.8.2: Incidence of catastrophic expenditure (%)			Incidence of impoverishment due to out-of-pocket health spending (%)		
	data year	at 10% of households total consumption or income	at 25% of households total consumption or income	data available	Poverty line: at 2011 PPP USD 1.90-a-day	Poverty line: at 2011 PPP USD 3.10-a-day
Romania	2012	11.99	2.29	yes	0.00	0.30
Slovak Republic	2010	3.77	0.44	yes	0.00	0.02
Slovenia	2012	2.90	0.26	yes	0.00	0.00
Spain	2010	5.73	1.21	yes	0.00	0.00
Sweden	1996	5.53	0.69	yes	0.00	0.00
Switzerland	--	--	--	no	--	--
Turkey	2012	3.10	0.32	yes	0.09	0.20
United Kingdom	2013	1.64	0.48	yes	0.00	0.00
United States	2013	4.77	0.78	yes	0.00	0.00

Source: WHO/World Bank (2017[6]).

Notes

[1] On an aggregate level, data on OOP spending as a share of total health spending are based on the System of Health Accounts (SHA) accounting framework. Depending how countries have implemented this framework HBS can be a data source to measure aggregate OOP spending but other data sources, e.g. administrative records or provider statistics, also exist. However, HBS need to be used to distinguish household spending on health by different household characteristics, for example income

[2] In the US, costs for health insurance represents 6.8% of average annual expenditure for people in the lowest income quintile while they only account for 4.6% for people in the highest income quintile.

[3] Voluntary coverage most typically refers to private insurance, but also includes employer-based financing schemes or charities whose role is negligible in most European and OECD countries.

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