Financial protection in high-income countries: a comparison of the Czech Republic, Estonia and Latvia

Report prepared by the WHO Regional Office for Europe
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The report draws on new evidence on financial protection in three countries commissioned by the WHO Barcelona Office for Health Systems Strengthening and prepared by national experts Daniela Kandilaki (Czech Republic), Andres Võrk (Estonia) and Maris Taube, Edmunds Vaskis and Oksana Nesterenko (Latvia).

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# Table of contents

Acknowledgements .................................................................................................................... ii

SUMMARY ................................................................................................................................. 1

THE ADDED VALUE OF WHO’S WORK ON FINANCIAL PROTECTION IN EUROPE ............................................................ 2

METHODS AND DATA SOURCES ............................................................................................... 5

COMPARING FINANCIAL PROTECTION IN THREE HIGH-INCOME COUNTRIES ............................................................ 6

UNMET NEED FOR HEALTH AND DENTAL CARE ........................................................................ 8

OUT-OF-POCKET PAYMENTS AS A SHARE OF HOUSEHOLD SPENDING ........................................ 10

FINANCIAL HARDSHIP: CATASTROPHIC AND IMPOVERISHING OUT-OF-POCKET PAYMENTS ........ 12

FACTORS THAT STRENGTHEN OR UNDERMINE FINANCIAL PROTECTION IN THESE COUNTRIES .......... 14

LOW PRIORITY TO HEALTH DRIVES HIGH OUT-OF-POCKET PAYMENTS ..................................... 16

WEAK COVERAGE DESIGN LEADS TO FINANCIAL HARDSHIP ..................................................... 19

IMPLICATIONS FOR POLICY ........................................................................................................ 24

REFERENCES .................................................................................................................................. 26

GLOSSARY ...................................................................................................................................... 28
Summary

Financial protection is central to universal health coverage and a core dimension of health system performance. The WHO Regional Office for Europe is generating evidence on financial protection using a new method of measuring catastrophic and impoverishing health spending. The aim is to monitor financial protection in a way that produces actionable evidence for policy; promotes pro-poor policies to break the link between ill health and poverty; and is relevant to all Member States in the WHO European Region.

This report illustrates the nature of the Regional Office’s work on financial protection and its relevance for policy by comparing financial protection across three high-income countries: the Czech Republic, Estonia and Latvia. The three countries are broadly similar in many ways but experience markedly different levels of financial hardship. The incidence of catastrophic and impoverishing out-of-pocket payments is very low in the Czech Republic, much higher in Estonia and among the highest in the European Region in Latvia.

Catastrophic spending on health is heavily concentrated among households in the poorest quintile in all three countries and heavily concentrated among pensioner households in Estonia and Latvia, but not in the Czech Republic. The degree of financial hardship experienced by catastrophic spenders varies across countries. On average, Estonian and Latvian households with catastrophic out-of-pocket payments are spending a much larger share of their budget on health than Czech households.

This analysis finds that differences in financial hardship are partly explained by variations in health spending across the countries, especially variation in the priority given to health when allocating government spending. An increase in public spending on health in Estonia and Latvia would help to lower the out-of-pocket share of total spending on health.

Coverage policy is an equally important explanatory factor, however. It is the primary mechanism through which households are exposed to out-of-pocket payments, and the design of coverage policy determines how out-of-pocket payments are distributed across income groups.

Coverage design in Estonia and Latvia – particularly the weak design of co-payments for outpatient medicines – shifts health care costs onto those who can least afford to pay out-of-pocket: poor people, people with chronic conditions and older people.

In contrast, the Czech Republic is one of the few countries in the European Union in which the design of user charges policy is relatively strong: user charges are a flat co-payment for health services and medicines, rather than a percentage of price; they are set at a low level; vulnerable people are exempt; and there is a cap on all user charges for everyone, with an even more protective cap for children under 18 and people aged 65 and over. As a result, catastrophic incidence is very low, outpatient medicines are accessible and pensioners do not experience undue financial hardship.
The added value of WHO’s work on financial protection in Europe

The policy issue
Financial protection is central to universal health coverage and a core dimension of health system performance (WHO, 2010). Financial hardship occurs when out-of-pocket payments for health are large in relation to a household's ability to pay. Out-of-pocket payments may not be an issue if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for treatment such as medicines on an ongoing basis. Where a health system provides weak financial protection, people may not have enough money to pay for health care or to meet other basic needs such as food and shelter. Weak financial protection can therefore undermine access to health care, lead to ill health and deprivation, and exacerbate inequalities.

What the WHO Regional Office for Europe is doing
In 2014, the Regional Office initiated a multi-year project to generate new evidence on financial protection using a new method of measuring catastrophic and impoverishing health spending and a comprehensive approach to monitoring (WHO Regional Office for Europe, 2017a; 2017b). The aim is to monitor financial protection in a way that produces actionable evidence for policy; promotes pro-poor policies to break the link between ill health and poverty; and is relevant to all Member States in the WHO European Region.

WHO’s support for monitoring financial protection in Europe is underpinned by the Tallinn Charter: Health Systems for Health and Wealth, Health 2020 and resolution EUR/RC65/R5 on priorities for health

Box 1. European Member States recognize the importance of financial protection

The Tallinn Charter: Health Systems for Health and Wealth states that “it is unacceptable that people become poor as a result of ill-health” (WHO Regional Office for Europe, 2008). In September 2015, the 65th session of the WHO Regional Committee for Europe adopted resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020, committing Member States to work towards a Europe free of impoverishing out-of-pocket payments for health (WHO Regional Office for Europe, 2015).

Resolution EUR/RC65/R5 also calls on the WHO Regional Office for Europe to provide tools and support to Member States for the monitoring of financial protection and to pursue the commitments agreed in the Tallinn Charter. The resolution requests the WHO Regional Director for Europe to report on implementation, focusing mainly on financial protection, in 2018.

Source: WHO Regional Office for Europe (2017a).
systems strengthening in the WHO European Region 2015–2020, all of which include a commitment to work towards a Europe free of impoverishing payments for health.

At the global level, support by WHO for the monitoring of financial protection is underpinned by World Health Assembly resolution WHA64.9 on sustainable health financing structures and universal coverage, which was adopted by Member States in May 2011.

How this approach to monitoring adds value

WHO/Europe has developed new metrics for measuring financial protection. The method used in this report to measure catastrophic out-of-pocket payments addresses some of the limitations of other methods (see Box 2). It builds on the capacity to pay approach used by WHO as part of a broader universal health coverage monitoring agenda (Xu et al., 2003), making it more sensitive to capturing financial hardship among poor households than other methods, and less likely to overestimate financial hardship among rich households than the Sustainable Development Goal method. It also classifies households according to their risk of being impoverished after out-of-pocket payments and draws attention to financial hardship among very poor households.

These new metrics are being used in systematic analyses of financial protection for policy development at the national level. WHO/Europe is working with national experts in 25 countries of the European Region to produce estimates of financial protection – often for the first time – that are embedded in detailed country-level reviews. The aim is to enhance policy relevance and support national policy development through in-depth, context-specific analysis over time. To ensure quality, comparability and consistency between countries, the country reviews use similar data sources (national household budget surveys), follow a standard format and are subject to external peer review.

The first phase of the project covers the following countries: Albania, Austria, Croatia, Cyprus, the Czech Republic, Estonia, France, Georgia, Germany, Greece, Hungary, Ireland, Kyrgyzstan, Latvia, Lithuania, the Netherlands, Poland, Portugal, the Republic of Moldova, Slovakia, Slovenia, Sweden, Turkey, Ukraine and the United Kingdom. The project will be extended to other countries in the European Region in a second phase.

This analysis identifies implications for policy at the regional level. In 2018, the 25 country-specific reports will form the basis for a regional monitoring report which will review trends in the incidence and drivers of financial hardship over time within countries; trends in inequalities in financial protection within and across countries; and issues around access, including unmet need for health care. The regional report will also highlight examples of good practice and implications for policy.

Aim and structure of this report

The aim of this report is to illustrate the nature of the Regional Office’s work on financial protection and its relevance for policy. To do this, it focuses on three high-income countries – the Czech Republic, Estonia and Latvia – with a view to comparing financial protection across countries that are broadly similar in many ways but experience markedly different levels of financial hardship. The incidence of catastrophic and impoverishing out-of-pocket payments is very low in the Czech Republic, much higher in Estonia and among the highest in the European Region in Latvia.

The following sections set out the report’s key sources of data and methods, highlight some of the similarities and differences between the three countries, and briefly review evidence on unmet need for health care. Then new evidence on financial protection in the three countries is presented, drawing on detailed country reports prepared by national experts for the Regional Office (Kandilaki, in press; Võrk, in press; Taube et al., in press). This is followed by a discussion on the factors that strengthen and undermine financial protection in the Czech Republic, Estonia and Latvia. The report closes with a summary of implications for policy.
Box 2. Different ways of measuring catastrophic spending on health

Some studies define out-of-pocket health expenditures as catastrophic when they exceed a given percentage (e.g. 10% or 25%) of income or consumption. This so-called budget share approach is the approach adopted in the Sustainable Development Goals (target 3.8.2). With the budget share approach, catastrophic expenditure is more likely to be concentrated among the rich than the poor (WHO & World Bank, 2015).

Other studies relate health expenditures not to total income or consumption but rather to consumption less a deduction for necessities. The argument is that everyone needs to spend at least some minimum amount on basic needs such as food and housing, and these absorb a larger share of a poor household’s consumption or income than that of a rich household. As a result, a poor household may not be able to spend much, if anything, on health care. By contrast, a rich household may spend 10% or 25% of its budget on health care and still have enough resources left over to avoid financial hardship.

So-called capacity to pay approaches deduct expenditures for basic needs in various ways. The main differences between them include: deducting actual spending versus a standard amount; using one item or a basket of items; the method used to derive the standard amount; and treatment of households whose actual spending is below the standard amount.

Some studies deduct all of a household’s actual spending on food (Wagstaff et al., 2003). However, although poor households often devote a higher share of their budget to food, food may not be a sufficient proxy for non-discretionary consumption. Also, spending on food reflects preferences, as well as factors linked to health spending: for example, households that spend less on food because they need to spend on health care will appear to have greater capacity to pay than households that spend more on food.

A second approach, aimed at addressing the role of preferences in food spending, is to deduct a standard amount from a household’s total resources to represent basic spending on food (Xu et al., 2003; Xu et al., 2007). In practice, it is a partial adjustment to the actual food spending approach because the standard amount is used only for households that spend more on food than the standard amount. For all other households, actual food spending is deducted instead of the higher, standard amount. Both the actual food and the standard food approaches therefore treat households whose actual food spending is below the standard amount in the same way. Nevertheless, with the standard food approach, catastrophic spending may be less concentrated among the rich than with the actual food spending approach.

A third approach is to deduct a poverty line, essentially an allowance for all basic needs (Wagstaff & Eozenou, 2014). Depending on the poverty line used, this could result in a greater concentration of catastrophic spending among the poor than the rich.

Building on the second and third approaches, WHO/Europe deducts an amount representing spending on three basic needs: food, housing (rent) and utilities (Thomson et al., 2016). It deducts this amount consistently for all households. As a result, catastrophic spending is more likely to be concentrated among the poor with this approach than with all of the other approaches.

Source: Adapted from WHO & World Bank (2017).
Methods and data sources

Data on unmet need for health and dental care come from the European Union (EU) Survey on Income and Living Conditions, which is carried out every year in EU countries. The survey asks people aged 16 and over if there has been a time in the last 12 months when they needed a medical or dental examination but did not receive it, and for what reason (due to cost, distance to facilities or waiting time). Self-reported data on unmet need for 2004–2016 are available from Eurostat’s online database (Eurostat, 2017a).

The financial protection results presented in this report (Table 1) are based on data from household budget surveys carried out by the national statistics office in each country and obtained by national experts. The most recent years of data are 2012 for the Czech Republic, 2013 for Latvia and 2015 for Estonia.\(^1\)

The unit of analysis is the household. Data that are broken down by income or that refer to income inequalities are in the form of quintiles based on per equivalent person consumption levels using the Organisation for Economic Cooperation and Development equivalence scales (1 for the first adult, 0.7 for subsequent adults and 0.5 for children under 13 years of age).

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

<table>
<thead>
<tr>
<th>Table 1. Key dimensions of catastrophic and impoverishing spending on health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Catastrophic out-of-pocket payments</strong></td>
</tr>
<tr>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
</tr>
<tr>
<td><strong>Impoverishing out-of-pocket payments</strong></td>
</tr>
<tr>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td><strong>Poverty line</strong></td>
</tr>
<tr>
<td><strong>Poverty dimensions captured</strong></td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
</tr>
</tbody>
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\(^1\) The data sources in this report are often the same as those used in global monitoring efforts; however, this report might use more recent data provided by national experts.
Comparing financial protection in three high-income countries

The Czech Republic, Estonia and Latvia share many similarities in a geopolitical context. They are located in central and eastern Europe; have a shared historical inheritance; underwent a social, political and economic transition following the collapse of communist regimes; and joined the EU at the same time, in 2004. They also share a similar starting point in terms of their health systems. Before the transition, all three countries offered universal population coverage, with good financial protection; however, they also experienced problems with efficiency and quality in health service delivery (Kutzin et al., 2010).

Today, there are important differences between the countries in terms of socioeconomic development. The Czech Republic is the wealthiest of the three, and scores highest in terms of inequality-adjusted human development, followed by Estonia, then Latvia (United Nations Development Programme, 2017). As Fig. 1 shows, poverty levels are much higher in Latvia and Estonia than in the Czech Republic, and much more likely to be concentrated among older than younger people.

All three countries experienced an economic shock following the financial crisis. In 2009, gross domestic product (GDP) fell by around 6% in the Czech Republic and Latvia and by around 9% in Estonia. While the crisis did not have much effect on poverty rates in the Czech Republic, it appears to have led to a substantial increase in poverty among people of working age in Estonia and Latvia.

2 In 2016 the Czech Republic was ranked in 14th place, Estonia in 23rd and Latvia in 36th.
Fig. 1. Trends in risk of poverty or social exclusion among younger people (16–64 years) and older people (aged 65 and over), 2005–2016

CZE: Czech Republic; EST: Estonia; LVA: Latvia.

* At risk of poverty refers to people with less than 60% of national median income.

Source: Eurostat (2017b).
Unmet need for health and dental care

People living in the Czech Republic enjoy good access to health and dental care, on a par with much richer countries like Denmark, Germany, the Netherlands and Sweden, and with little inequality between rich and poor (Fig. 2 and 3).

Unmet need for health and dental care is a significant problem in Estonia. Unmet need for health care is largely reported to be due to waiting times, while unmet need for dental care is mainly reported to be due to cost. Income inequalities in access to dental care are a growing challenge.

Access problems are greatest in Latvia, where they are almost entirely reported to be due to cost, and where income inequality in access to health and dental care is among the highest in the EU.

Unmet need has risen substantially in both Estonia and Latvia since 2009, reversing major improvements in access achieved before the economic crisis.
Fig. 2. Unmet need for health care due to cost, distance or waiting time, 2005–2015

CZE: Czech Republic; EST: Estonia; LVA: Latvia.

Poorest refers to the fifth income quintile; average refers to the population as a whole.

Fig. 3. Unmet need for dental care due to cost, distance or waiting time, 2005–2015

CZE: Czech Republic; EST: Estonia; LVA: Latvia.

Poorest refers to the fifth income quintile; average refers to the population as a whole.
Out-of-pocket payments account for a higher share of total household spending in Latvia than the other two countries (Fig. 4–6). In the Czech Republic, the out-of-pocket share is similar across all income groups (consumption quintiles), whereas in Estonia and Latvia it tends to be higher among richer quintiles.

In the Czech Republic, the average out-of-pocket share increased slightly in 2008 but remained stable between 2008 and 2012. In Estonia, it fell slightly overall between 2006 and 2012, with a sharp fall among the two poorest quintiles, but had risen again in 2015. In Latvia, it rose overall between 2008 and 2013, but fell among the two poorest quintiles in 2009 and 2010.

More than half of all out-of-pocket payments are spent on outpatient medicines across the three countries. The outpatient medicines share tends to be highest for the poorest quintile and lowest for the richest quintile.

Fig. 4. Out-of-pocket payments as a share of total household spending by consumption quintile, Czech Republic
OUT-OF-POCKET PAYMENTS AS A SHARE OF HOUSEHOLD SPENDING

Fig. 5. Out-of-pocket payments as a share of total household spending by consumption quintile, Estonia

Source: Võrk (in press).

Fig. 6. Out-of-pocket payments as a share of total household spending by consumption quintile, Latvia

Source: Taube et al. (in press).
Financial hardship: catastrophic and impoverishing out-of-pocket payments

The share of households experiencing catastrophic out-of-pocket payments ranges from 1% in the Czech Republic to 7% in Estonia and 13% in Latvia (Fig. 7). In all three countries, catastrophic spending on health is heavily concentrated among households in the poorest quintile.

In the Czech Republic, catastrophic out-of-pocket payments are most likely to be experienced by economically inactive people of working age (Kandilaki, in press). Almost all households with catastrophic out-of-pocket payments are in the poorest quintile; half of them are also further impoverished by spending on health (people living below the basic needs line and incurring out-of-pocket payments), as shown in Fig. 8.

Catastrophic spending in Estonia is highly concentrated among pensioners; in 2015, 16% of single pensioner households and 12% of pensioner couple households experienced catastrophic out-of-pocket payments (Võrk, in press). The next highest incidence rate was among households of single people of working age (6%). Over half of all households with catastrophic out-of-pocket payments are in the poorest quintile (Fig. 7).

In Latvia, nearly one in three (29%) pensioner households experienced catastrophic out-of-pocket payments in 2013 (Taube et al., in press). Almost half of all catastrophic spenders are in the poorest quintile (Fig. 7).

The share of households who are further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments is highest in Latvia (close to 7%), followed by Estonia (just over 4%) and the Czech Republic (under 1%) (Fig. 8).

Fig. 9 shows how catastrophic out-of-pocket payments are spent. It breaks down catastrophic spending by type of health service for all households and for the poorest quintile. Across all households, the main driver of catastrophic spending is inpatient care in the Czech Republic and outpatient medicines in Estonia and Latvia. However, among the poorest quintile, outpatient medicines are the main driver of financial hardship in all three countries.
Fig. 8. Households with catastrophic out-of-pocket payments by risk of impoverishment

![Households with catastrophic out-of-pocket payments by risk of impoverishment](chart1.png)

CZE: Czech Republic; EST: Estonia; LVA: Latvia.
Sources: Kandilaki (in press), Taube et al. (in press), Võrk (in press).

Fig. 9. Breakdown of catastrophic spending by type of health service

![Breakdown of catastrophic spending by type of health service](chart2.png)

CZE: Czech Republic; EST: Estonia; LVA: Latvia; OOPs: out-of-pocket payments.

Poorest refers to the lowest consumption quintile.
Sources: Kandilaki (in press), Taube et al. (in press), Võrk (in press).
Financial protection may be influenced by factors beyond the health system that affect people’s capacity to pay for health care – for example, changes in living standards or in the cost of living. When capacity to pay falls, households may have to spend a greater share of their disposable resources on health, unless they forego care.

Following the economic shock of 2009, household capacity to pay and out-of-pocket payments remained stable in the Czech Republic, but in Estonia and Latvia out-of-pocket payments fell as a share of total household spending among households in the two poorest quintiles (Fig. 4–6).

During the years of the crisis, the share of households without any out-of-pocket payments rose by 10 percentage points among the two poorest quintiles in Latvia. In Estonia, this share was more than 20 percentage points higher among the two poorest quintiles in 2010 than in 2007.

Given the increase in poverty (Fig. 1) and unmet need (Fig. 2 and 3) seen in both countries from 2009, some of this reduction in household spending on health is likely to reflect people foregoing care.

Financial protection is also influenced by health system factors that shift health care costs onto households. Previous research has shown how financial hardship is more likely to occur when public spending on health is low in relation to GDP and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010). Fig. 10 plots catastrophic incidence (on the vertical axis) against the out-of-pocket share of total spending on health (on the horizontal axis) for the 25 countries in this study. It confirms the findings of earlier research, revealing a relatively strong association between financial hardship and a greater reliance on out-of-pocket payments across countries.

Catastrophic incidence in the Czech Republic is among the lowest in the European Region. In Estonia it is broadly in line with other EU13 countries, while in Latvia it is close to levels seen in non-EU countries that were part of the former Soviet Union.

Factors that strengthen or undermine financial protection in these countries

3 Countries that joined the EU after 2004: Bulgaria, Croatia, Czech Republic, Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia.
The incidence of catastrophic health spending rises steadily as the out-of-pocket share of total spending on health increases. This suggests that the difference in catastrophic incidence across the three countries is partly explained by differences in levels of public spending on health care.

Voluntary health insurance plays a minor role in most countries in the European Region, including in the EU, so the vast majority of private spending on health comes from out-of-pocket payments (Sagan & Thomson 2016).
Low priority to health drives high out-of-pocket payments

Public spending on health accounts for a much larger share of GDP – and a much larger share of total spending on health – in the Czech Republic than in Estonia and Latvia (Fig. 11).

Over time, public spending on health has matched GDP growth and remained relatively stable as a share of GDP in the Czech Republic, Estonia and the EU28\(^4\) (Fig. 12). In Latvia, however, it fell in absolute terms in 2009 and did not reach pre-crisis levels again until 2013. As a share of GDP, public spending on health declined steadily between 2006 and 2012.

The main reason for the low level of public spending on health in Latvia, and its decline over time, is the low priority accorded to health when determining the allocation of government spending. Fig. 13 shows how public spending on health fell as a share of government spending in Latvia between 2007 and 2010 and was still two percentage points below its 2007 peak in 2014.

Because of low levels of public spending on health, the out-of-pocket share of total spending on health is very high in Latvia and close to the EU28 average in Estonia (Fig. 14). The out-of-pocket share fell in all three countries after the economic crisis, as the financial pressure facing households rose, especially in Estonia and Latvia, where unemployment rates nearly tripled between 2008 and 2010 (Eurostat, 2017a).

\(^4\) The EU28 are the 28 countries of the European Union.
Fig. 11. Spending on health as a share of GDP, 2014

CZE: Czech Republic; EST: Estonia; LVA: Latvia.

Fig. 12. Public spending on health as a share of GDP, 2005–2014

Fig. 13. Public spending on health as a share of government spending, 2005–2014

Government spending (%)

EU28
Czech Republic
Estonia
Latvia


Fig. 14. Out-of-pocket payments as a share of total spending on health, 2005–2014

Total spending on health (%)

EU28
Latvia
Estonia
Czech Republic

Weak coverage design leads to financial hardship

Coverage policy plays a vital role in determining the extent of out-of-pocket payments in a country and - crucially - in determining their distribution across the population. A comparison of different dimensions of health coverage – population entitlement, service coverage and user charges – and of the role of voluntary health insurance across the three countries reveals major variation, with the Czech Republic on one side and Estonia and Latvia on the other (see Table 2).

The Czech Republic has a gap in coverage due to user charges, but the gap is small because user charges policy has been carefully designed; and protection against user charges has been strengthened over time.

The Government of the Czech Republic introduced user charges for all health services at the beginning of 2008, which may explain the doubling in the incidence of catastrophic health spending between 2007 and 2008 (see Fig. 15).

The gap created by user charges is small because the design of the new user charges policy was relatively strong from the outset.

- The user charges were set as a flat co-payment rather than as a percentage of the service price.
- These co-payments were relatively low: around €1 per doctor visit, per dentist visit and per outpatient prescription item; €2 per day in hospital; and €3 for emergency care.
- There was a cap on how much people had to pay in user charges, set at around €180 a year.

The user charges policy was improved in 2009.

- Exemptions from co-payments were introduced for poor households receiving income support, children in care and people with disabilities.
- The cap was lowered to around €90 a year for children under 18 and people aged 65 and over.

In 2012, the co-payment for outpatient prescriptions was lowered to €1 per prescription, regardless of how many items the prescription contains. This last change may explain the slight fall in the incidence of catastrophic out-of-pocket payments in 2012.

Finally, in 2015, user charges were abolished for all non-emergency care, including outpatient medicines.

Fig. 15. Catastrophic incidence in the Czech Republic by consumption quintile over time

Source: Kandilaki (in press).
Estonia has gaps in all three dimensions of coverage, but has recently begun to reduce the size of these gaps.

Around 6% of the population is uninsured (about 10% of the working age population) due to the link between entitlement to health services covered by the health insurance fund and payment of contributions.

In terms of service coverage, there are long waiting times for specialist care and dental care was not covered for adults during the study period.

While primary care visits are protected, user charges apply to prescribed outpatient medicines and to specialist care, without an overall cap.

The design of user charges policy is especially weak when it comes to outpatient medicines.

- User charges for prescribed outpatient medicines are in the form of co-insurance (a percentage of the medicine price) in addition to co-payments.
- They follow a complicated schedule, with different co-payments and co-insurance rates depending on the type of prescribed medicine, how much a person has already paid out-of-pocket and a person’s age.

- There are no exemptions from prescription charges for poor or regular users, only for children under 4 years old.
- During most of the study period, to protect the health insurance fund’s budget, there was a maximum amount the health insurance fund covered per person for some commonly prescribed medicines; this feature, which is highly unusual in EU health systems, was abolished in late 2012.

The lack of exemption from user charges for poor and regular users, as well as the absence of an overall cap on user charges, may explain why outpatient medicines are such a large driver of financial hardship in Estonia, especially among poor households (see Fig. 9). As Fig. 16 shows, the two poorest quintiles consistently account for the vast majority of catastrophic spenders.

Recognizing the magnitude of the gaps in its coverage policy, in 2017 the Estonian Government began to take steps to improve access to dental care for adults. It is also introducing a cap on user charges for outpatient medicines. Set at €300 a year, the cap in Estonia is less protective than the cap in the Czech Republic (€90) but more protective than the cap in Latvia (€569).

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5 For example, once a person had received more than about €13 in reimbursement from the health insurance fund for medicines covered at the 50% co-insurance rate, they would not receive any further reimbursement for 50% medicines.

**Fig. 16.** Catastrophic incidence in Estonia by consumption quintile over time

Source: Võrk (in press).
Table 2. Main gaps in publicly financed coverage and the role of voluntary health insurance (VHI) in the Czech Republic, Estonia and Latvia

<table>
<thead>
<tr>
<th>Czech Republic</th>
<th>Estonia</th>
<th>Latvia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population coverage: what is the basis for entitlement to publicly financed health services?</strong></td>
<td><strong>Service coverage: what is the scope of the publicly financed benefits package and are waiting times a problem?</strong></td>
<td><strong>User charges: are there co-payments for publicly financed health services?</strong></td>
</tr>
<tr>
<td>• Entitlement is linked to payment of contributions but access to health care is guaranteed by the state</td>
<td>• Adult dental care was excluded from coverage during the study period, but extended in 2017</td>
<td>• Low user charges introduced for all health services in 2008</td>
</tr>
<tr>
<td>• Population coverage is very close to universal</td>
<td>• Waiting times for elective specialist treatment</td>
<td>• User charges design is strong and simple: flat-rate co-payments set at low levels; exemptions for vulnerable people; an overall cap on user charges</td>
</tr>
<tr>
<td></td>
<td>• Lack of waiting time guarantees</td>
<td>• Protection mechanisms strengthened over time</td>
</tr>
<tr>
<td><strong>Are any of these gaps covered by VHI?</strong></td>
<td><strong>User charges: are there co-payments for publicly financed health services?</strong></td>
<td>• VHI covers some gaps, but is mainly purchased by wealthier people, so it exacerbates inequalities in access and financial protection; in 2014 it accounted for 1.6% of total spending on health</td>
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<td>• Heavy user charges for all health services, without an overall cap, but children are exempt</td>
<td><strong>Are any of these gaps covered by VHI?</strong></td>
</tr>
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<td></td>
<td>• Design of user charges for outpatient medicines is weak and complex: co-insurance rather than flat-rate co-payments; insufficient exemptions; the cap is set very high and does not include user charges for outpatient medicines</td>
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Sources: Kandilaki (in press), Taube et al. (in press), Võrk (in press); VHI data from Sagan & Thomson (2016).
Latvia has major gaps in coverage due to high user charges for outpatient medicines and inpatient care, user charges for adults for all other health services, the exclusion of adult dental care from the benefits package and long waiting times for specialist care.

User charges apply to all health services in Latvia. The user charge per primary care visit is quite low (around €1.50) and children under 18 are exempt from many user charges. Beyond these positive features, however, the design of user charges policy is weak, especially for outpatient medicines.

- **Flat co-payments are relatively high** for inpatient care: €7 per day in hospital in 2008, rising to €17 per day in 2009 and reduced to €10 per day from 2015.
- **The cap on user charges for health services is set very high**: €569 per year and €356 per hospitalization.
- User charges for outpatient prescribed medicines are in the form of co-insurance (a percentage of the medicine price) and follow a fairly complicated schedule, with different co-insurance rates depending on the type of prescribed medicine and the severity of disease.
- There are **no exemptions** from prescription charges for poor or regular users.
- There is **no cap for prescribed outpatient medicines**.

In response to the economic crisis, the Latvian Government introduced a safety net in 2009 that temporarily exempted very poor households (those with an income less than half of the minimum wage) from user charges for outpatient visits and inpatient care. There was no exemption from user charges for outpatient prescriptions. In 2010, the exemptions were extended to more households, but in 2012 the safety net was abolished. Looking at catastrophic incidence over time in Latvia (see Fig. 17), the introduction of the safety net in 2009, its extension in 2010 and its abolition in 2012 coincides with a reduction and then subsequent increase in catastrophic out-of-pocket payments among the two poorest quintiles.

Between 2008 and 2010, tight annual volume controls for publicly financed hospital services, including outpatient specialist services, in combination with major restructuring of the hospital sector led to very long waiting times for inpatient care. The inpatient admission rate fell from 236 per 1000 people in 2008 to 180 in 2010. Public spending on hospitals per person fell by 22% between 2008 and 2013 and the number of hospitalized people paid for by the Latvian Government fell from 234 000 in 2011 to 230 000 in 2013.

**Significant differences in coverage policy result in very different levels of financial hardship across the three countries. They also have an impact on the degree of financial hardship households experience.**

Among households with catastrophic out-of-pocket payments, the average amount spent out-of-pocket as a share of total household spending is much higher in Estonia and Latvia (over 25%) than in the Czech Republic (15%), as shown in Fig. 18. This means that, on average, catastrophic households in Estonia and Latvia are spending one in every four euros on health services.

Among households who are further impoverished by spending on health – people living below the basic needs or poverty line and incurring out-of-pocket payments – the average amount spent out-of-pocket as a share of total household spending is also very high in Estonia and Latvia (around 7%) compared to the Czech Republic (1%).

Many of these very poor households, who are spending a significant share of their budget on health care, would not be counted as catastrophic in the method used to monitor financial protection for the Sustainable Development Goals.
Fig. 17. Catastrophic incidence in Latvia by consumption quintile over time

![Graph showing catastrophic incidence in Latvia by consumption quintile over time.](image)

Source: Taube et al. (in press).

Fig. 18. Out-of-pocket payments as a share of total household spending among households with catastrophic health spending

![Graph showing out-of-pocket payments as a share of total household spending.](image)

CZE: Czech Republic; EST: Estonia; LVA: Latvia.

Sources: Kandilaki (in press), Taube et al. (in press), Võrk (in press).
There are substantial differences in financial protection across high-income countries with universal or near universal population coverage. The share of households experiencing catastrophic out-of-pocket payments ranges from 1% in the Czech Republic to 7% in Estonia and 13% in Latvia.

Catastrophic spending on health is heavily concentrated among households in the poorest income quintile in all three countries and heavily concentrated among pensioner households in Estonia and Latvia, but not in the Czech Republic.

The degree of financial hardship experienced by catastrophic spenders varies across countries. On average, Estonian and Latvian households with catastrophic out-of-pocket payments are spending a much larger share of their budget on health than Czech households.

This analysis finds that differences in financial hardship are partly explained by variations in health spending across the countries – especially variation in the priority given to health when allocating government spending. The Latvian Government allocates less than 10% of its budget to health, while governments in the other two countries allocate around 13% (Estonia) and 15% (the Czech Republic). As a result, public spending on health as a share of GDP is significantly lower in Latvia, and the out-of-pocket payment share significantly higher, than in the other countries. An increase in public spending on health in Estonia and Latvia would help to lower the out-of-pocket share of total spending on health.

Coverage policy is an equally important explanatory factor, however. It is the primary mechanism through which households are exposed to out-of-pocket payments. Gaps in coverage mean households must spend out of pocket or, if this is not possible, forego the use of health services.

The design of coverage policy determines how out-of-pocket payments are distributed across income groups. It is also one determinant of the level of household exposure to out-of-pocket payments; other determinants include service prices and the volume of service use, which can in turn be influenced by user and provider behaviour.

Coverage design in Estonia and Latvia – particularly the weak design of co-payments for outpatient medicines – shifts health care costs onto those who can least afford to pay out of pocket: poor people, people with chronic conditions and older people. In these countries, financial hardship is largely driven by spending on outpatient medicines; it is highly concentrated among pensioners, many of whom are at risk of poverty or social exclusion, and it is substantial. The linking of entitlement to payment of contributions in Estonia, and the exclusion of dental care for adults from the benefits package in both countries, are also problematic.

In contrast, the Czech Republic is one of the few countries in the EU in which the design of user charges policy is relatively strong: user charges are a flat co-payment for health services and medicines (rather than a percentage of price); they are
set at a low level: €1 per general practitioner visit or prescription item (later changed to €1 per prescription); vulnerable people are exempt: children in care, disabled people and people with low incomes; and there is a cap on all user charges for everyone (€180 a year) and a more protective cap for children under 18 and people aged 65 and over (€90 a year). As a result, catastrophic incidence is very low, outpatient medicines are accessible and pensioners do not experience undue financial hardship.

**When coverage design is weak, inefficiencies in the health system can exacerbate financial hardship.** For example, if people have to pay a percentage of the price of prescribed medicines, their exposure to out-of-pocket payments will increase as prices rise or where prescribers and dispensers do not face appropriate or aligned incentives.

**Unmet need for health and dental care is high in Estonia and Latvia, and has grown since the economic crisis.** Given the widespread application of user charges in both countries, without adequate protection for poor and regular users, it is possible that if more people had been able to use health services during the study period, the out-of-pocket payment burden would have been even higher, and the extent of financial hardship even worse, than the current analysis indicates.
References


6 Websites accessed on 30 November 2017.


Glossary

**Ability to pay for health care**: Ability to pay refers to all the financial resources at a household’s disposal. When monitoring financial protection, an ability to pay approach assumes that all of a household’s resources are available to pay for health care, in contrast to a capacity to pay approach (see below), which assumes that some of a household’s resources must go towards meeting basic needs. In practice, measures of ability to pay are often derived from household survey data on consumption expenditure or income and may not fully capture all of a household’s financial resources—e.g., for example, savings and investments.

**Basic needs**: The minimum resources needed for sustenance, often understood as the consumption of goods such as food, clothing and shelter.

**Basic needs line**: A measure of the level of personal or household income or consumption required to meet basic needs such as food, housing and utilities. Basic needs lines, like poverty lines, can be defined in different ways. They are used to measure impoverishing out-of-pocket payments. In this study the basic needs line is defined as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, adjusted for household size and composition. Basic needs line and poverty line are used interchangeably. See poverty line.

**Budget**: See household budget.

**Cap on benefits**: A mechanism to protect third party payers such as the government, a health insurance fund or a private insurance company. A cap on benefits is a maximum amount a third party payer is required to cover per item or service or in a given period of time. It is usually defined as an absolute amount. After the amount is reached, the user must pay all remaining costs. Sometimes referred to as a benefit maximum or ceiling.

**Cap on user charges (co-payments)**: A mechanism to protect people from out-of-pocket payments. A cap on user charges is a maximum amount a person or household is required to pay out of pocket through user charges per item or service or in a given period of time. It can be defined as an absolute amount or as a share of a person’s income. Sometimes referred to as an out of pocket maximum or ceiling.

**Capacity to pay for health care**: In this study capacity to pay is measured as a household’s consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. This amount is deducted consistently for all households. It is referred to as a poverty line or basic needs line.

**Catastrophic out-of-pocket payments**: Also referred to as catastrophic spending on health. An indicator of financial protection. Catastrophic out-of-pocket payments can be measured in different ways. This study defines them as out-of-pocket payments that exceed 40% of a household’s capacity to pay for health care. The incidence of catastrophic health spending includes households who are impoverished (because they no longer have any capacity to pay after incurring out-of-pocket payments) and households who are further impoverished (because they have no capacity to pay from the outset).

**Consumption**: Also referred to as consumption expenditure. Total household consumption is the monetary value of all items consumed by a household during a given period. It includes the imputed value of items that are not purchased but procured for consumption in other ways (e.g., home-grown produce).
Co-payments (user charges or user fees): Money people are required to pay at the point of using health services covered by a third party such as the government, a health insurance fund or a private insurance company. Fixed co-payments are a flat amount per good or service; percentage co-payments (also referred to as co-insurance) require the user to pay a share of the good or service price; deductibles require users to pay up to a fixed amount first, before the third party will cover any costs. Other types of user charges include extra billing (a system in which providers are allowed to charge patients more than the price or tariff determined by the third party payer) and reference pricing (a system in which people are required to pay any difference between the price or tariff determined by the third party payer – the reference price – and the retail price).

Equivalent adult: To ensure comparisons of household spending account for differences in household size and composition, equivalence scales are used to calculate spending levels per equivalent adult in a household. This review uses the Oxford scale (also known as the Organisation for Economic Co-operation and Development equivalence scale), in which the first adult in a household counts as one equivalent adult, subsequent household members aged 13 or over count as 0.7 equivalent adults and children under 13 count as 0.5 equivalent adults.

Exemption from user charges (co-payments): A mechanism to protect people from out-of-pocket payments. Exemptions can apply to groups of people, conditions, diseases, goods or services.

Financial hardship: People experience financial hardship when out-of-pocket payments are large in relation to their ability to pay for health care.

Financial protection: The absence of financial hardship when using health services. Where health systems fail to provide adequate financial protection, households may not have enough money to pay for health care or to meet other basic needs. Lack of financial protection can lead to a range of negative health and economic consequences, potentially reducing access to health care, undermining health status, deepening poverty and exacerbating health and socioeconomic inequalities.

Further impoverishing out-of-pocket payments: An indicator of financial protection. Out-of-pocket payments made by households living below a national or international poverty line or a basic needs line. A household is further impoverished if its total consumption is below the line before out-of-pocket payments and if it incurs out-of-pocket payments.

Health services: Any good or service delivered in the health system, including medicines, medical products, diagnostic tests, dental care, outpatient care and inpatient care. Used interchangeably with health care.

Household budget: Also referred to as total household consumption. The sum of the monetary value of all items consumed by the household during a given period and the imputed value of items that are not purchased but procured for consumption in other ways.

Household budget survey: Usually national sample surveys, often carried out by national statistical offices, to measure household consumption over a given period of time. Sometimes referred to as household consumption expenditure or household expenditure surveys. European Union countries are required to carry out a household budget survey at least once every five years.
**Impoverishing out-of-pocket payments:** An indicator of financial protection. Out-of-pocket payments that push people into poverty or deepen their poverty. A household is measured as being impoverished if its total consumption was above the national or international poverty line or basic needs line before out-of-pocket payments and falls below the line after out-of-pocket payments.

**Out-of-pocket payments:** Also referred to as household expenditure (spending) on health. Any payment made by people at the time of using any health good or service provided by any type of provider. Out-of-pocket payments include: (a) formal co-payments (user charges or user fees) for covered goods and services; (b) formal payments for the private purchase of goods and services; and (c) informal payments for covered or privately purchased goods and services. They exclude pre-payment (for example, taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company.

**Poverty line:** A level of personal or household income or consumption below which a person or household is classified as poor. Poverty lines are defined in different ways. This study uses basic needs line and poverty line interchangeably. See basic needs line.

**Quintile:** One of five equal groups (fifths) of a population. This study commonly divides the population into quintiles based on household consumption; the first quintile is the fifth of households with the lowest consumption, referred to in the study as the poorest quintile; the fifth quintile has the highest consumption, referred to in the study as the richest quintile.

**Risk of impoverishment due to out-of-pocket payments:** After paying out of pocket for health care, a household may be further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment. A household is at risk of impoverishment (or not at risk of impoverishment) if its total spending after out-of-pocket payments comes close to (or does not come close to) the poverty line or basic needs line.

**Universal health coverage:** All people are able to use the quality health services they need without experiencing financial hardship.

**Unmet need for health care:** An indicator of access to health care. Instances in which people need health care but do not receive it due to access barriers.

**User charges:** Also referred to as user fees. See co-payments.

**Utilities:** Water, electricity and fuels used for cooking and heating.