



World Health
Organization

REGIONAL OFFICE FOR Europe

Can people afford to pay for health care?

New evidence
on financial protection
in Georgia

Ketevan Goginashvili
Mamuka Nadareishvili
Triin Habicht



Georgia

WHO Barcelona Office for Health Systems Financing

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Abstract

This review is part of a series of country-based studies generating new evidence on financial protection in European health systems. Financial protection is central to universal health coverage and a core dimension of health system performance. Georgia has a relatively high incidence of impoverishing and catastrophic health spending compared to other countries in Europe. Catastrophic spending is driven mainly by out-of-pocket payments for outpatient medicines, but also for inpatient and outpatient care. It is heavily concentrated among the poorest households. Although reforms introduced since 2013 have improved access to health care and reduced the health system's reliance on out-of-pocket payments, public spending on health remains low and gaps in coverage persist. To strengthen financial protection, increased public investment in health – especially in primary health care – is necessary but not enough. The government should also address gaps in coverage by prioritizing better protection for poor households and people with chronic conditions; introduce stronger regulation of service volumes and prices (including medicine prices) to ensure resources are used efficiently; and improve the quality of primary health care.

Keywords

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

About the series

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

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

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

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

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

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

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

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

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

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

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Abbreviations

COICOP	Classification of Individual Consumption by Purpose
EHIS	European Health Interview Survey
EU	European Union
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
GEL	Georgian lari
GEOSTAT	National Statistics Office of Georgia
HUES	health, utilization and expenditure survey
MIP	Medical Insurance Programme
OECD	Organisation for Economic Co-operation and Development
SDG	Sustainable Development Goal
SSA	Social Service Agency
UHCP	Universal Health Care Programme

Executive summary

Georgia introduced the Universal Health Care Programme in 2013, dramatically increasing the share of the population with publicly financed health coverage. Supported by a large increase in public spending on health, the Universal Health Care Programme reduced financial barriers to access and increased the use of services, particularly among people who had previously lacked coverage. In spite of this much-needed investment in health and notable improvements in access to health care, public spending on health remains low by European standards. As a result, the out-of-pocket payment share of current spending on health (48% in 2018) continues to be above the average for countries in the WHO European Region (30%).

This review draws on data from the household budget survey carried out every year by the National Statistics Office of Georgia. It finds that between 2013 and 2018, out-of-pocket payments rose from 7% to 9% of household spending, suggesting that greater use of health care also increased households' exposure to out-of-pocket payments. In 2018, around 7% of households experienced impoverishing health spending and 17% experienced catastrophic health spending. This degree of financial hardship is among the highest in the European Region.

Medicines consistently account for the largest share of out-of-pocket payments (69% in 2018), followed by inpatient care (14%) and outpatient care (11%). There are large differences in the structure of out-of-pocket spending across households. In 2018, outpatient medicines accounted for 90% of out-of-pocket payments among the poorest households with catastrophic spending, compared to 24% among the richest. While the outpatient medicines share falls as household consumption increases, the shares spent on inpatient care, outpatient care and dental care increase with household consumption. Over time, the medicines share has grown, driven by rapid growth in out-of-pocket spending on medicines per person across all consumption quintiles between 2012 and 2016.

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

- **Levels of public spending on health** as a share of gross domestic product are low. Although the out-of-pocket payment share of current spending on health has fallen substantially in recent years – a remarkable achievement reflecting much-needed public investment in health – out-of-pocket payment is still the single largest source of health spending.

- **Persistent gaps in coverage** are linked to weaknesses in the design of coverage policy, including the prioritization of inpatient and emergency care over primary care; limited coverage of outpatient medicines; a complex system of user charges (co-payments), which lacks transparency and undermines predictability for users; the presence of a ceiling on what the state will cover and the absence of a cap on co-payments; the fact that poor people and people with chronic conditions are not exempt from co-payments for outpatient medicines; balance billing by health care providers; and bureaucratic procedures.
- **The absence of strong regulation of service prices and mechanisms to control service volume**, combined with activity-based payment for hospitals, encourages over-treatment and the use of more expensive services, which shifts costs on to households.
- **There are strong incentives for providers to increase revenue** by prescribing brand-name medicines and services that are not covered by the Universal Health Care Programme.
- **Lack of trust in primary care** increases out-of-pocket payments when people self-treat or bypass referral systems to visit specialists directly.

High out-of-pocket payments in Georgia reflect low public spending on health. To strengthen financial protection, continued public investment in the health system is necessary but not enough. New investment should address gaps in coverage by prioritizing better protection for poor households and regular users of health care. Stronger regulation of service prices (including medicine prices) and volumes will enable a more efficient use of existing resources. Any action to reduce the financial incentives that push people towards inpatient care should be accompanied by efforts to improve the quality of primary care.

1. Introduction

This review assesses financial protection in Georgia from 2010 to 2020. It examines the extent to which people in Georgia can afford to pay for health care, including medicine, or are at risk of experiencing financial hardship. Financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a high share of current spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019). Increases in public spending or reductions in out-of-pocket payments are not, in themselves, a guarantee of better financial protection. Policy choices are also important.

Georgia has a history of monitoring access to health care and financial protection using regular household budget surveys and health care use and expenditure surveys. This study applies different methods from previous studies (Zoidze et al., 2013; Gotsadze et al., 2009; WHO Regional Office for Europe, 2009), using an approach that enables comparison across countries in the WHO European Region. It draws on data from the household budget survey carried out every year by the National Statistics Office of Georgia (GEOSTAT), covering the period 2010–2018.

This period spans a time of profound changes in health coverage policy. From 2007 to 2012, publicly financed health benefits were limited to households living in poverty. The Medical Insurance Programme (MIP) offered poor households publicly financed coverage organized through private insurance companies. In late 2012, entitlements were extended to children aged 0–6 years and pensioners, but the MIP still covered less than half of the population. In February 2013, a new Universal Health Care Programme (UHCP) introduced a narrowly defined benefits package for those who were previously not covered, increasing the share of the population with publicly financed coverage to 98%. Most publicly financed benefits were subsequently purchased by the Social Service Agency (SSA). In 2017, UHCP benefits were removed from the richest 1% of households. At the same time, a limited list of medicines for a small group of the most prevalent chronic conditions was added to the benefits package for households living in poverty. Coverage of these medicines was extended to pensioners and people with disabilities in 2019.

Out-of-pocket payments fell from a high of 80% of current spending on health in 2005 to 66% in 2008, then grew to 76% in 2011, before falling to 48% in 2018 (WHO, 2020). The fall in the last few years reflects a significant increase in public spending on health since 2013. However, the out-of-pocket payment share of current spending on health remains well above the average for countries in the European Region (30% in 2018), and public spending on health is still low as a share of GDP (2.8% in Georgia compared to a European Region average of 4.9% in 2018) (WHO, 2020).

The out-of-pocket payment share of current spending on health has not fallen as fast as expected, in part because the health reforms succeeded in reducing financial barriers to access, which led to a substantial increase in the use of health services, particularly among people who had not been covered before. For example, the number of hospitalizations per 100 people more than doubled between 2010 and 2018. In addition, the first phase of reforms did not expand coverage of outpatient medicines, which is where out-of-pocket spending has increased in recent years,

compounded by medical inflation. A challenging economic environment, including depreciation of the national currency, combined with the absence of mechanisms to control prices, has increased the relative cost of medicines, most of which are imported. Limited coverage of medicines has been a key factor in out-of-pocket spending on health remaining high despite improved population coverage – a gap in coverage that is now being addressed through further reforms.

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

2. Methods

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

2.1 Analytical approach

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

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

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

Note: see Annex 4 for definitions of the words in italics.

Source: WHO Regional Office for Europe (2019).

2.2 Data sources

This study analyses anonymized microdata from the Georgian household budget survey from 2010 to 2018. These nationally representative surveys have been conducted by GEOSTAT since 1996.

All currency units in the study are presented in Georgian lari (GEL), with notes on inflation-adjusted spending where relevant. In 2016, 100 GEL had the equivalent purchasing power of €80 in the average European Union (EU) country.

3. Coverage and access to health care

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

3.1 Coverage

Coverage policy in Georgia is unusually complex, with entitlement to publicly financed benefits frequently linked to income, age and being part of a priority group (for example, veterans). There have been many changes in coverage policy in recent years (see Table 2 for an overview). The health system has also been marked by decades of chronic underfunding.

3.1.1 Population entitlement

Georgia introduced the UHCP in 2013. This marked a shift in policy from publicly financed benefits targeted at a narrow segment of the population through the MIP, which had been publicly financed but organized through private insurance companies, to a tightly defined package of benefits for legal residents who had not been previously covered, with benefits purchased by the SSA under the health ministry.

In February 2013, people who had not been covered previously were entitled to a *minimal benefits package* after registering with a primary care facility of their choice. This was changed in July 2013 to include elective surgery, cardiac surgery, chemotherapy, hormone and radiotherapy and childbirth, and the new *basic package* was available to any legal resident without any form of coverage. In September 2014, almost all state-funded programmes were united under the UHCP administered by the SSA. At this point, about 14% of the population (510 000 persons) was covered by private health insurance on a privately financed basis (most corporate and some individual) and financed by the state for military and law enforcement staff; everyone else was entitled either to the basic package under the UHCP or to a more comprehensive package for the poorest households.

Since May 2017, services provided under the UHCP have been stratified by income and other priority groups (Table 3). The highest income group (around 1% of the population) is excluded from most UHCP benefits but still entitled to services offered through vertical programmes. In 2020, about 9% of the population was covered by private health insurance and the remaining 0.3% of population did not have any form of coverage (UHCP or private health insurance).

Table 2. Changes to coverage policy, 2006–2020

Year	Population entitled to publicly financed coverage	Approximate share of the population covered (%)
2007	People living below the poverty line in two pilot regions (Tbilisi and Imereti) are provided with outpatient and inpatient care without user charges (co-payments). The government pays private insurers an annual fee (180 GEL per person in 2009) to cover all those registered as living below the poverty line through the MIP.	5
2008	The MIP expands to cover the whole country. Additional publicly financed schemes cover teachers, military personnel and laureates (same benefits as above).	20
2009	February 2009–July 2010: an additional publicly financed scheme encourages enrollment for people aged 3–60 years not yet covered by the MIP and already covered by private insurance; it covers outpatient and inpatient care up to a ceiling of 8000 GEL a year.	20
2010	Public spending on outpatient medicines under the MIP is limited to a ceiling of 50 GEL per person a year.	20
2012	September: the MIP is extended to cover pensioners, children aged 0–5 years and people with disabilities (MIP+); co-payments for hospital care for the MIP+ and public spending on outpatient medicines are limited to 50 GEL per person a year; the ceiling on outpatient medicines for the MIP is raised to 200 GEL a year.	45
2013	February: the UHCP is introduced with a <i>minimal benefits package</i> covering planned ambulatory care and emergency care (outpatient and inpatient) with co-payments for all legal residents previously not covered; it is managed by the SSA. July: the UHCP minimal benefits package is expanded into a basic package covering elective surgery, cancer treatment and childbirth (in addition to planned ambulatory care and emergency care), all with co-payments.	85
2014	September: the MIP and MIP+ are incorporated into the UHCP; former MIP+ coverage now includes all outpatient and inpatient care with co-payments and a ceiling on hospital care.	90
2017	May: UHCP beneficiaries are stratified by income (see Table 3); the highest income group (around 1% of the population) is excluded from most UHCP benefits but still entitled to services offered through vertical programmes. July: a limited list of outpatient medicines to treat four common chronic conditions (heart disease, chronic obstructive pulmonary disease, type 2 diabetes and thyroid conditions) is made available free of charge to households earning <17 000 GEL a year.	90
2019	A limited list of outpatient medicines to treat four chronic conditions is made available free of charge to all pensioners and people with disabilities. Outpatient medicines to treat Parkinson's disease and epilepsy are made available with 25% co-payment for people with those diseases.	90

Notes: this table refers to coverage policy under the MIP and UHCP. In addition, publicly financed vertical programmes offer universal entitlement to selected treatment for specific diseases. Different population estimates are used in Georgia. GEOSTAT counts 3.7 million people as officially registered residents. The Ministry of Justice counts 4.3 million people, some of whom have left the country but may still benefit from universal health and pension entitlements.

Source: Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs.

Table 3. UHCP beneficiaries by category, 2020

Group	Number of beneficiaries	Share of UHCP beneficiaries (%)	Share of the population (%)
I Households below the poverty line (<70 000 points on the social assistance scale), teachers, public artistes, children in foster care, settled internally displaced people	515 501	12	11
II Pensioners, children aged 0–5 years, students, people registered as disabled	1 176 665	27	25
III Veterans	27 475	1	1
IV Low-income households (70 000–100 000 points on the social assistance scale) and children aged 6–18 years	573 572	13	12
V Income groups: other individuals below pension age but scoring >100 000 points on the social assistance scale	2 001 297	47	42
(a) monthly income <1000 GEL	1 833 212	43	39
(b) monthly income >1000 GEL and annual income <40 000 GEL	107 491	3	2
(c) annual income >40 000 GEL	60 594	1	1
Total	4 294 510	100	91

Notes: different population estimates are used in Georgia. GEOSTAT counts 3.7 million people as officially registered residents. The Ministry of Justice counts 4.3 million people, some of whom have left the country but may still benefit from universal health and pension entitlements.

Source: Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs.

People in group V(c) are excluded from the UHCP and are expected to purchase private health insurance, although they are still entitled to selected services covered by the UHCP and services offered through vertical programmes (e.g. tuberculosis treatment).

If anyone in group V(a) or V(b) loses their private insurance coverage (because the contract terms end or job loss leads to loss of corporate insurance), they are eligible to receive services under the minimal package. If they are still not covered by private insurance after six months, they are once again entitled to some UHCP benefits. Households or people in groups I–IV may also benefit from private insurance purchased on a voluntary basis through individual or group contracts.

3.1.2 Service coverage

The **UHCP basic package** covers emergency care, outpatient services, elective surgery (with the necessary examinations and diagnostics), cancer treatment and childbirth, management of infectious diseases and some medicines for chronic conditions. Dental care is not covered under the UHCP. Until 2020, the list of covered outpatient medicines under the UHCP was limited to around 50 essential medicines for heart disease, respiratory diseases, gastrointestinal diseases and allergies as well as antibiotics and non-steroidal anti-inflammatory medicines.

In May 2017, UHCP benefits for people in income groups V(a) and V(b) were restricted. If people in these groups have private health insurance, the UHCP will still cover the cost of emergency services and cancer treatment, with user charges (co-payments). The only UHCP benefit

available to people in group V(c), regardless of private insurance status, is childbirth and management of infectious diseases.

Outpatient medicines for four major chronic conditions (heart disease, chronic obstructive pulmonary disease, type 2 diabetes and thyroid conditions) were added to the basic package for people registered as living below the poverty line in July 2017. In 2019, medicines for Parkinson's disease and epilepsy were added and the medicines programme was extended to all pensioners. In 2020, the Chronic Disease Treatment Drugs Programme was integrated into the UHCP.

In addition to the UHCP, the state also finances health services for all legal residents under 23 priority **public health protection programmes**. These aim to provide broad geographic coverage and access to disease prevention, immunization, early detection and screening, disease management and risk reduction counselling for the designated health conditions or services, including: mental health, diabetes management, paediatric leukaemia, dialysis and kidney transplantation, palliative care, certain rare diseases, ambulance services, village doctor services and referral services, tuberculosis control, malaria surveillance, viral hepatitis screening and HIV/AIDS management. Each vertical programme has its own scope of services, access criteria and volume limits, but the services they provide are usually free at the point of use. A new programme for the management of coronavirus disease (COVID-19) was launched in May 2020.

There are no formal processes for setting priorities for the range of health services to be publicly financed. To date, health technology assessment has not featured in decision-making about the UHCP or other publicly financed health programmes.

Due to the high capacity of health care providers and the absence of mechanisms to control the volume of services provided, waiting times for treatment are not an issue.

3.1.3 User charges (co-payments)

The UHCP has a highly complex system of user charges, with co-payments varying based on the type of health service and beneficiary category (Table 4).

A highly unusual feature among health systems in Europe is that specific health services are also subject to a monetary ceiling on how much the state will cover. The ceiling is set either per episode of care or on an annual basis. For example, the state will not cover services worth more than 15 000 GEL for each episode of emergency inpatient care or 15 000 GEL a year for elective surgery or 12 000 GEL a year for cancer treatment.

Another unusual feature is that health care providers are allowed to balance bill patients – that is, they are allowed to charge them more than the UHCP tariff for both outpatient and inpatient care. In both cases – ceiling and balance billing – the patient is expected to pay any costs exceeding the ceiling or the UHCP tariff out of pocket, on top of any UHCP co-payments. Most UHCP co-payments are in the form of percentage co-payments, where the user pays a share of the service price. For both outpatient and inpatient care, service prices may vary significantly by provider.

People living below the poverty line (group I) and veterans (group III) are exempt from co-payments for most health services but are not exempt from co-payments for covered outpatient medicines or from the ceiling or balance billing. As a result, although they do not pay formal co-payments for outpatient and inpatient care, they incur out-of-pocket payments through co-payments for UHCP outpatient medicines (a very limited list of around 50 essential medicines) and once they exceed the ceilings for inpatient care or if health care providers charge more than the UHCP tariff in outpatient and inpatient settings.

There is no cap on the amount a person in any group has to pay through co-payments.

Table 4. User charges for UHCP benefits, 2020

Notes: CT: computed tomography; EKG: electrocardiogram. Outpatient family doctor visits and outpatient specialist visits in primary care are referred to as planned ambulatory care. The income groups labelled I–V are defined in Table 3.

Source: Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs.

Service area	Type and level of user charge (by group)	Ceiling on amount the state covers (a year unless otherwise stated)	Cap on user charges paid
Outpatient family doctor visits	I–V (b): none V (c): pay full price	No	No
Outpatient specialist visits in primary care	I–III: none IV–V (a): 30% of service price V (b) and (c): pay full price	No	No
Outpatient medicines	2013–2019 I–III: 50% of the medicine price IV–V: pay full price From 2020 Households with <100 000 points on the social assistance scale, pensioners, people with disabilities, veterans and people living in villages adjacent to the Administrative Boundary Line of the regions of Abkhazia and South Ossetia: free outpatient medicines for 4 chronic conditions Children aged 0–5 years: pay 50% of the price for antibiotics People with Parkinson's disease and epilepsy: pay 25% of the price for medicines for those conditions	2013–2019 I–III: 50 GEL Pensioners: 100 GEL Pensioners below the poverty line: 200 GEL From 2020 Households with <100 000 points on the social assistance scale, pensioners, people with disabilities, veterans and people living in villages adjacent to the Administrative Boundary Line of the Georgian regions of Abkhazia and South Ossetia/Tskhinvali: free outpatient medicines for chronic conditions: • chronic cardiovascular diseases: 200 GEL • chronic lung diseases: 300 GEL • diabetes (type 2): 40 GEL • chronic diseases of the thyroid gland: 20 GEL • Parkinson's disease: 400 GEL • epilepsy: 300 GEL Children aged 0–5 years: 50 GEL Children aged 0–5 years with disabilities: 100 GEL	No
Diagnostic tests: basic laboratory tests	I–III: none IV–V(a): 30% of service price V(b) and V(c): pay full price	No	No
Diagnostic tests: ultrasound, ECG, X-ray	I and III: none II: none for most; 10–20% of service price for a CT scan IV–V(a): 30% of service price V(b) and V(c): pay full price	No	No

Table 4 contd

Service area	Type and level of user charge (by group)	Ceiling on amount the state covers (a year unless otherwise stated)	Cap on user charges paid
Normal delivery, caesarean section	I–V: none	500 GEL per delivery 800 GEL per caesarean section	No
Elective surgery	I and III: none II: 10% (pensioners) or 20% (others) of service price IV: 30% of service price V(a): 500 GEL or 30% of service price V(b): 1000 GEL or 30% of service price V(c): pay full price	15 000 GEL per case	No
Chemotherapy, hormone and radiotherapy	I and III: none II: 10% (pensioners) or 20% (others) of service price IV–V(b): 20% of service price V(c): pay full price	I and III: 12 000 GEL II: 15 000 GEL IV–V(b): 12 000 GEL	No
Emergency outpatient care	I–IV: none V(a): 50% of service price V(b) and V(c): pay full price	No	No
Emergency intensive care	I–V(b): none V(c): pay full price	No	No
Emergency other inpatient care	I and III: none II: 10% (pensioners) or 20% (others) of service price IV: 30% of service price V(a): 500 GEL or 30% of service price V(b): 1000 GEL or 30% of service price	I–III: no cap IV–V(b): 15 000 GEL per case	No
Infectious diseases	I and III: none II: 10% (pensioners) or 20% (others) of service price IV–V(b): 20% V(c): 20%	No	No

3.1.4 The role of private health insurance

Private health insurance plays a minor role in the health system (Sagan & Thomson, 2016). In 2017, it accounted for 6% of current spending on health and 9% of private spending on health (WHO, 2020). It is provided by private insurance companies and covers around 9% of the population (438 302 people in 2020), mostly on a voluntary basis through group cover of employees and their families, but also on a mandatory basis for some groups of people (military staff) (Table 5). Some private insurance policies cover services excluded from the UHCP, such as dental care and some outpatient medicines. Excluding people in the highest income bracket from UHCP coverage in 2017 did not boost demand for private insurance.

Table 5. People covered by private health insurance, 2020

Categories	Number of people	Share of people with private health insurance (%)
People with state-funded private insurance (e.g. military staff)	151 476	35
People with voluntary private insurance (group or individual) not entitled to UHCP benefits	240 827	55
People with voluntary private insurance who are also covered under the UHCP	45 999	10
Total	438 302	100

Source: Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs.

Table 6 highlights key issues in the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of private health insurance in filling these gaps.

Table 6. Gaps in publicly financed and private health insurance coverage

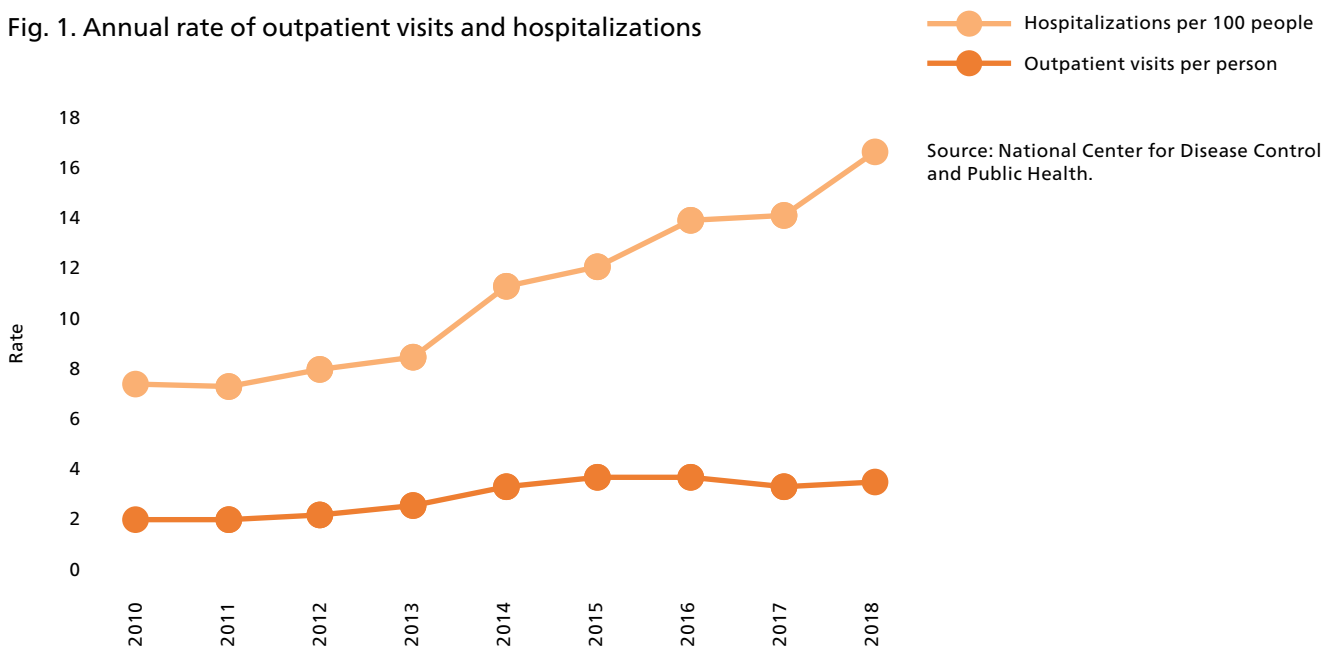
	Population entitlement	The benefits package	User charges
Issues in the governance of publicly financed coverage	Complex and based on income, age and priority status (veterans etc.)	No coverage of dental care and very limited coverage of outpatient medicines	Complex; use of percentage co-payments; ceilings on publicly financed benefits; balance billing allowed; no caps on co-payments or balance billing
Main gaps in publicly financed coverage	The highest income group (1% of the population) is excluded from almost all publicly financed benefits.	Dental care and outpatient medicines	Outpatient medicines for all groups; non-emergency inpatient care for all groups; heavy user charges for all health services for low-income households above the poverty line and children aged 6–18 years (group IV)
Are these gaps covered by private health insurance?	Private health insurance is available but take up is low	Private health insurance is available but take up is low	No

Source: authors.

3.2 Access, use and unmet need

Following the introduction of the UHCP in 2013, the use of outpatient and inpatient health services increased significantly, as shown in Fig. 1. This is attributed to the removal of financial barriers to inpatient care for people who were previously not covered, which reduced unmet need (Box 1).

Fig. 1. Annual rate of outpatient visits and hospitalizations



Box 1. Unmet need for health care

Source: WHO Regional Office for Europe (2019).

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

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

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

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

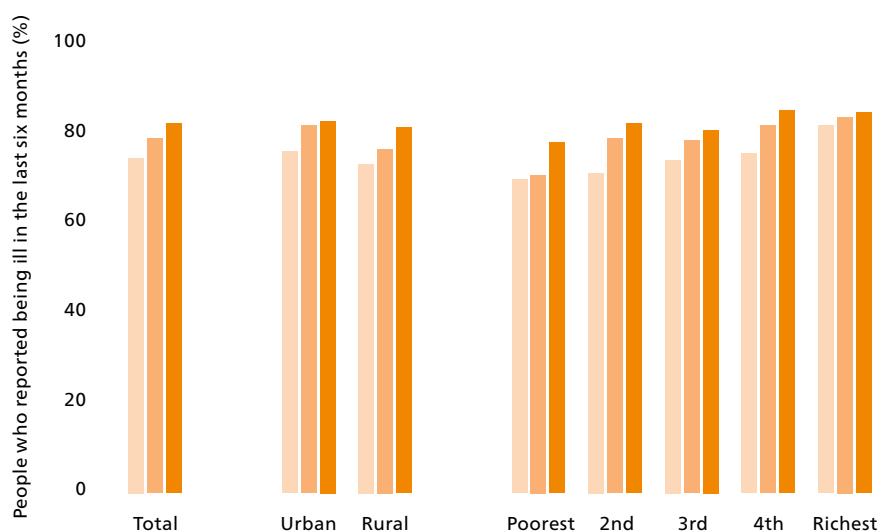
Every year, EU Member States collect data on unmet need for health and dental care through the European Union Statistics on Income and Living Conditions (EU-SILC). These data can be disaggregated by age, gender, educational level and income. Although this important source of data lacks explanatory power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

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

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

Data collected through the health, utilization and expenditure surveys (HUES) conducted in 2010, 2014 and 2017 show that people were more likely to visit health care providers when ill in 2017 compared to 2010 and 2014 (Fig. 2). The largest increase was among households in the second, third and fourth quintiles – people who were not covered before the introduction of the UHCP (Fig. 2). The increase in 2017 may be linked to expanded coverage of outpatient medicines for poor households. HUES data show that the availability of health facilities has increased since 2010, reflecting improvements in roads and public transport and growth in the number of health care facilities. For example, in 2017 there were 15 084 hospital beds, 280 primary health centres and 1277 rural doctors, compared to 11 178, 261 and 1203, respectively, in 2010.

Fig. 2. Share of people who reported being ill with any condition in the last six months who consulted a health care provider

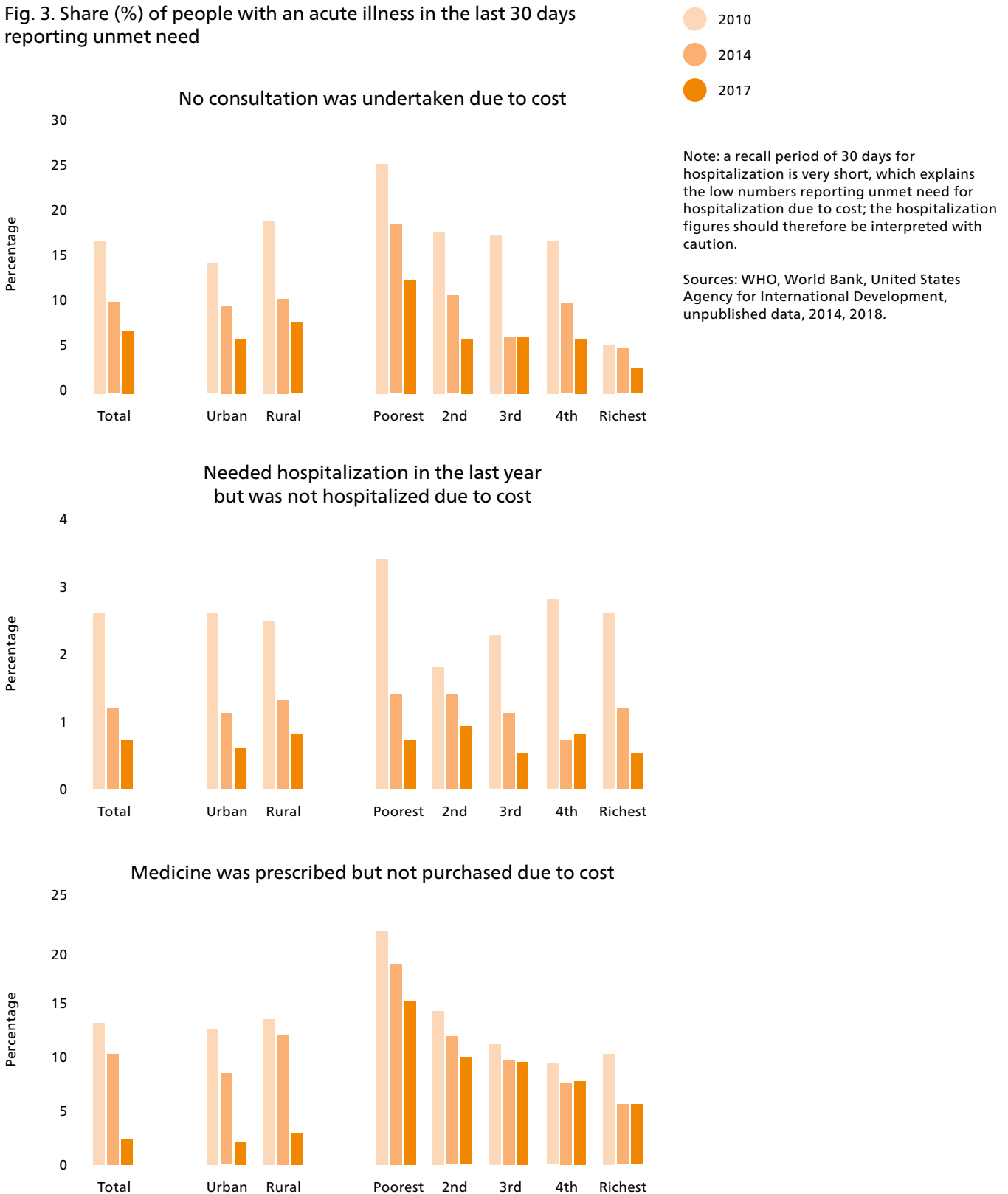


2010
2014
2017

WHO, World Bank, United States Agency for International Development, unpublished data, 2016, 2018.

HUES data also show that financial barriers to access declined between 2010 and 2017, mainly for outpatient visits and inpatient services covered under the UHCP. This led to a decrease in levels of unmet need between 2010 and 2017, particularly for poorer households (Fig. 3). Access to medicines has increased since 2010, but mainly among the urban population and households in the richest quintile (Fig. 3). However, between 2014 and 2017 inequalities between people living in rural and urban areas declined as access among people in the poorest and second quintile improved (Fig. 3).

Fig. 3. Share (%) of people with an acute illness in the last 30 days reporting unmet need



3.3 Summary

Georgia has a complex system of coverage with significant gaps. The UHCP introduced in 2013/2014 extended publicly financed coverage from just under half to nearly the whole population. This major reform, supported by a large increase in public spending on health, reduced financial barriers to access and contributed to greater use of health care across households in all quintiles in both urban and rural settings. In 2017, the UHCP was scaled back for the highest-income households (around 1% of the population), who are no longer eligible for most publicly financed health services.

The publicly financed benefits package – the UHCP basic package – covers emergency care, outpatient services, elective surgery (with the necessary examinations and diagnostics), cancer treatment and childbirth. There are two main gaps in the benefits package: dental care is not covered at all and coverage of outpatient medicines is limited, even after expansions in 2017 and 2019.

UHCP benefits are subject to a complicated system of user charges, with co-payments varying based on the type of health service and beneficiary category. For planned inpatient services, most co-payments are in the form of percentage co-payments, where the user pays a share of the UHCP maximum tariff and if the price of the service exceeds the maximum tariff, the patient pays the difference (balance billing). Although people living below the poverty line and veterans are exempt from co-payments for most health services, they are not exempt from balance billing and there is no cap on how much people have to pay out-of-pocket.

As a result of limited coverage of outpatient medicines, weaknesses in the design of co-payment policy and providers being allowed to balance bill patients, even poor households and people with chronic conditions are exposed to out-of-pocket payments when using publicly financed health services. This helps to explain why cost remains the main driver of unmet need for health care in Georgia, even though nearly the whole population benefits from coverage. Waiting times are not an issue due to the absence of mechanisms to control the volume of publicly financed health services.

Private health insurance plays a minor role in the health system, covering only around 9% of the population – mostly through group cover of employees and their families – and accounting for 6% of current spending on health in 2017. Excluding people in the highest income bracket from UHCP coverage in 2017 did not boost take up of private health insurance.

4. Household spending on health

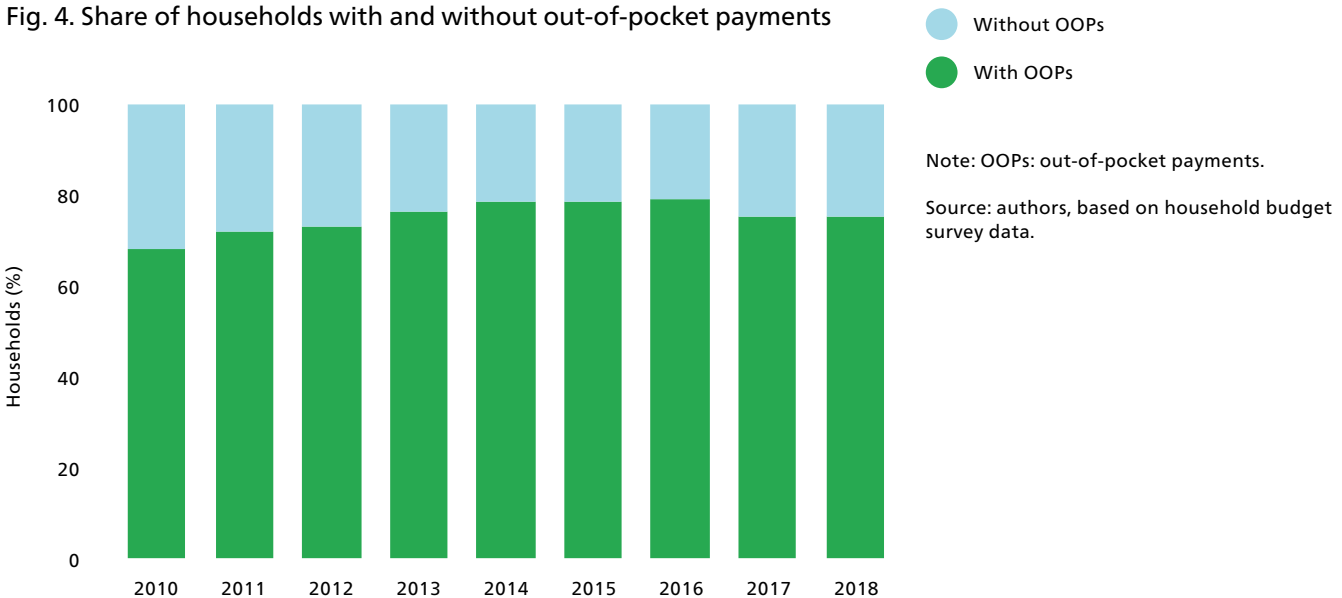
The first part of this section uses data from the household budget survey to present trends in household spending on health – that is, out-of-pocket payments, formal and informal payments made by people at the time of using any good or service delivered in the health system. The second part describes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

4.1 Out-of-pocket payments

Out-of-pocket payments consist of user charges (co-payments) and other payments (for example, through balance billing and costs above the ceiling) for UHCP and other publicly financed benefits, as well as direct payments to providers for services not covered by the state. They include all formal and informal payments.

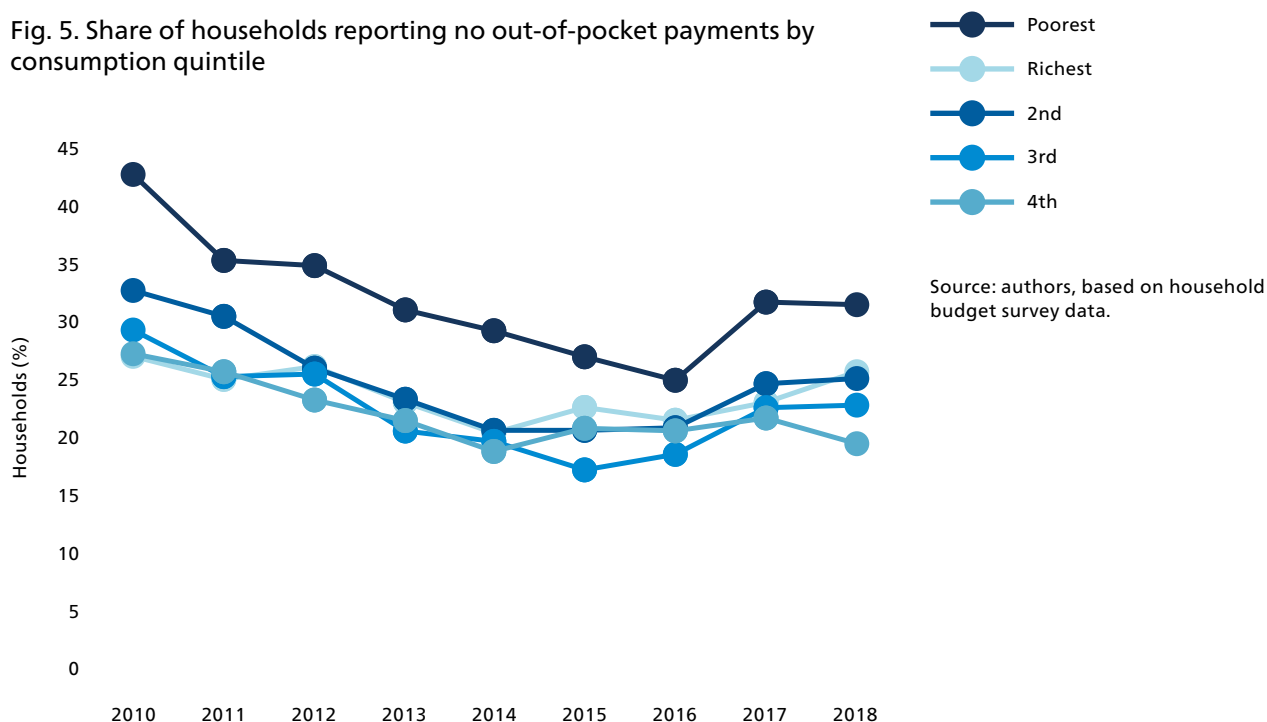
The share of households incurring out-of-pocket payments rose from 68% in 2010 to 79% in 2016 and then declined slightly to 75% in 2017 and 2018 (Fig. 4).

Fig. 4. Share of households with and without out-of-pocket payments



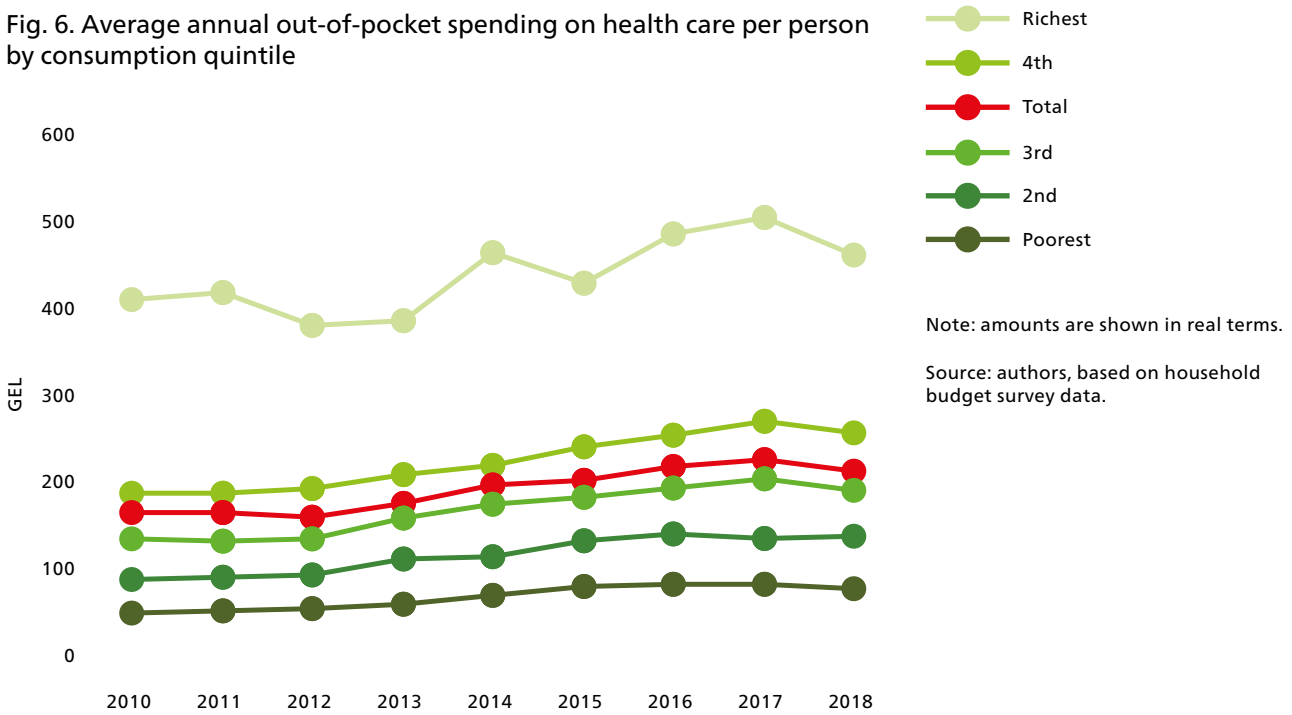
Across all years, households in the poorest quintile were most likely to report no out-of-pocket payments (Fig. 5). Household budget surveys do not usually include questions on health status, health service use and unmet need for health care, so it is not possible to determine whether changes in out-of-pocket spending on health care are due to lack of need for health care, exemptions from user fees or barriers in access to health services. However, the reduction in the share of households reporting no out-of-pocket payments observed between 2010 and 2016 took place against a background of falling unmet need for health care due to cost, which occurred among all quintiles (see Fig. 3).

Fig. 5. Share of households reporting no out-of-pocket payments by consumption quintile



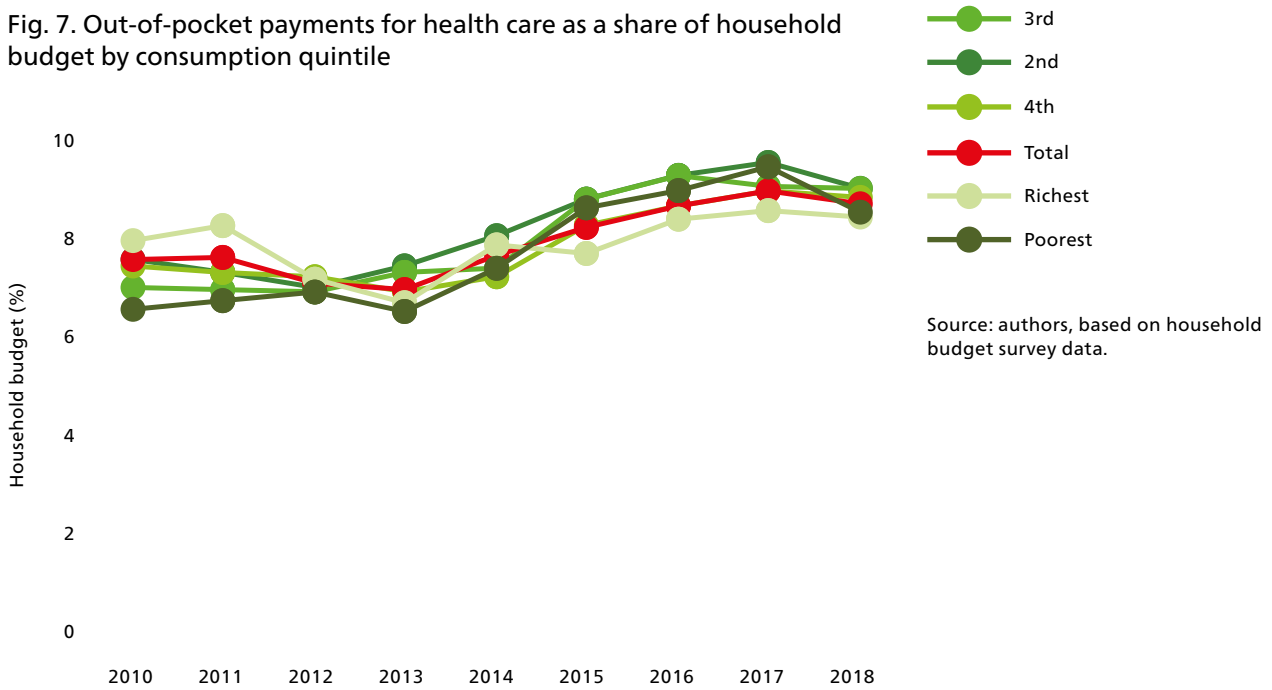
On average, out-of-pocket payments accounted for around 200 GEL per person annually in 2018, with a large difference in the amount spent in the poorest quintile (73 GEL) and the richest quintile (464 GEL) (Fig. 6). Out-of-pocket payments grew in real terms from 2010 to 2011 and from 2013 to 2017, falling slightly in 2012 and 2018. All quintiles experienced growth in out-of-pocket payments.

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



In 2018, out-of-pocket payments accounted for nearly 9% of total household spending (the household budget) on average (Fig. 7). This ratio is high compared to other countries in the WHO European Region (WHO Regional Office for Europe, 2019). The out-of-pocket payment share of the household budget fell between 2011 and 2013, and then rose sharply until 2017. Households in all quintiles experienced this increase. Over time, the out-of-pocket payment share has become more regressive, taking up a similar share of household budgets among the richest and poorest households.

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



Medicines consistently account for the largest share of out-of-pocket payments (69% in 2018), followed by inpatient care (14%) and outpatient care (11%) (Fig. 8). Other health services play a very minor role. The medicines share has grown over time, while the inpatient care share fell between 2013 and 2016, before growing in 2017.

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

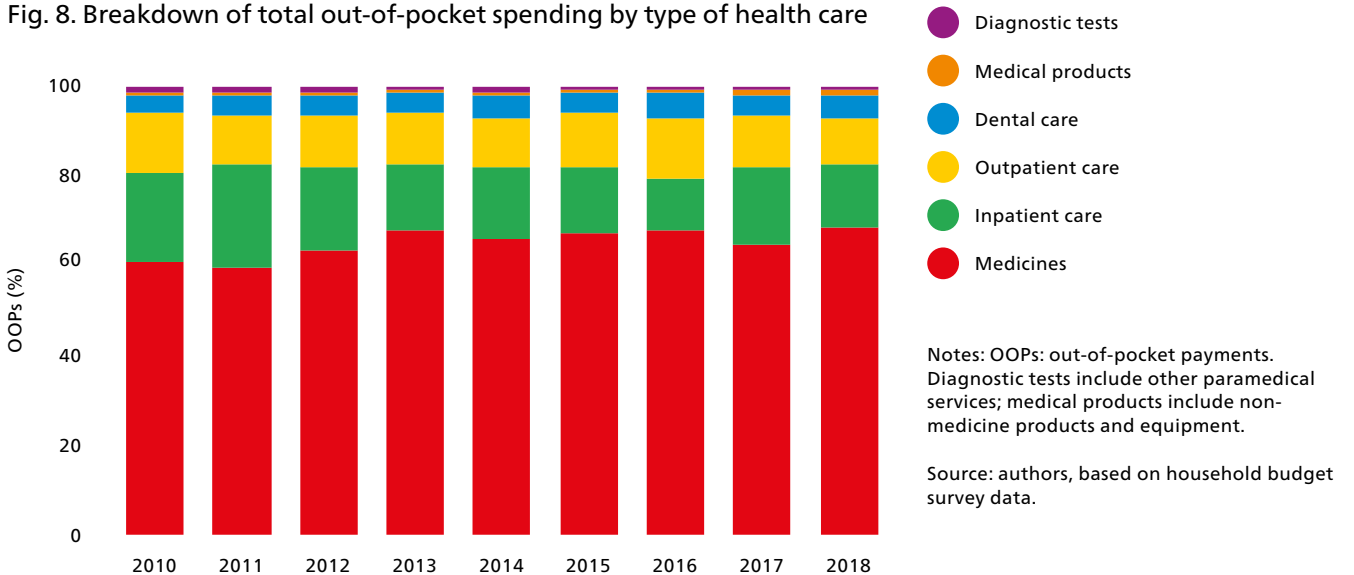
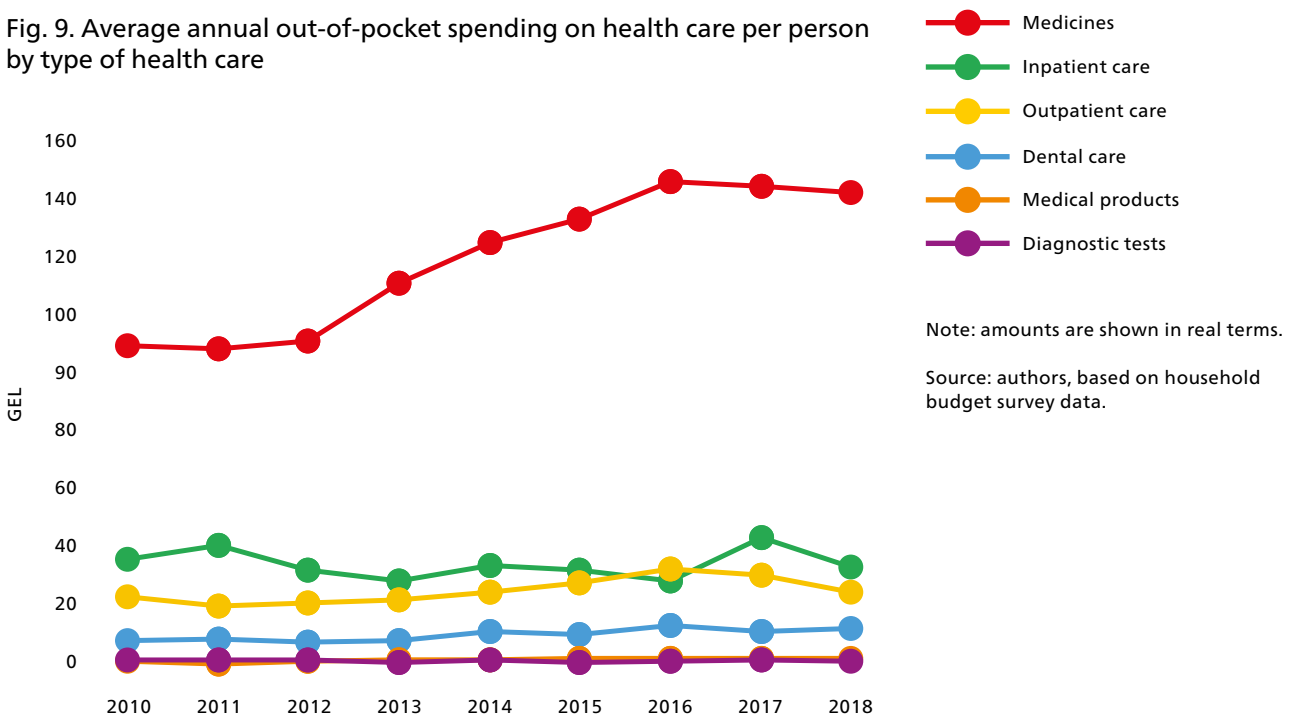


Fig. 9 shows that the increase in the medicines share was driven by rapid growth in real terms in out-of-pocket spending on medicines per person between 2012 and 2016. This rapid growth in out-of-pocket payments for medicines was experienced by all quintiles (data not shown). Spending on outpatient care and dental care also grew relatively rapidly, while spending on inpatient care fluctuated but fell overall.

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



The distribution of out-of-pocket payments by type of health care and quintile in 2018 shows that poorer households spent relatively more on medicines and richer households spent relatively more on inpatient care, outpatient care and dental care (Fig. 10). The pattern observed in 2018 became more marked over time (Fig. 11).

Fig. 10. Breakdown of total out-of-pocket spending by type of health care and consumption quintile, 2018

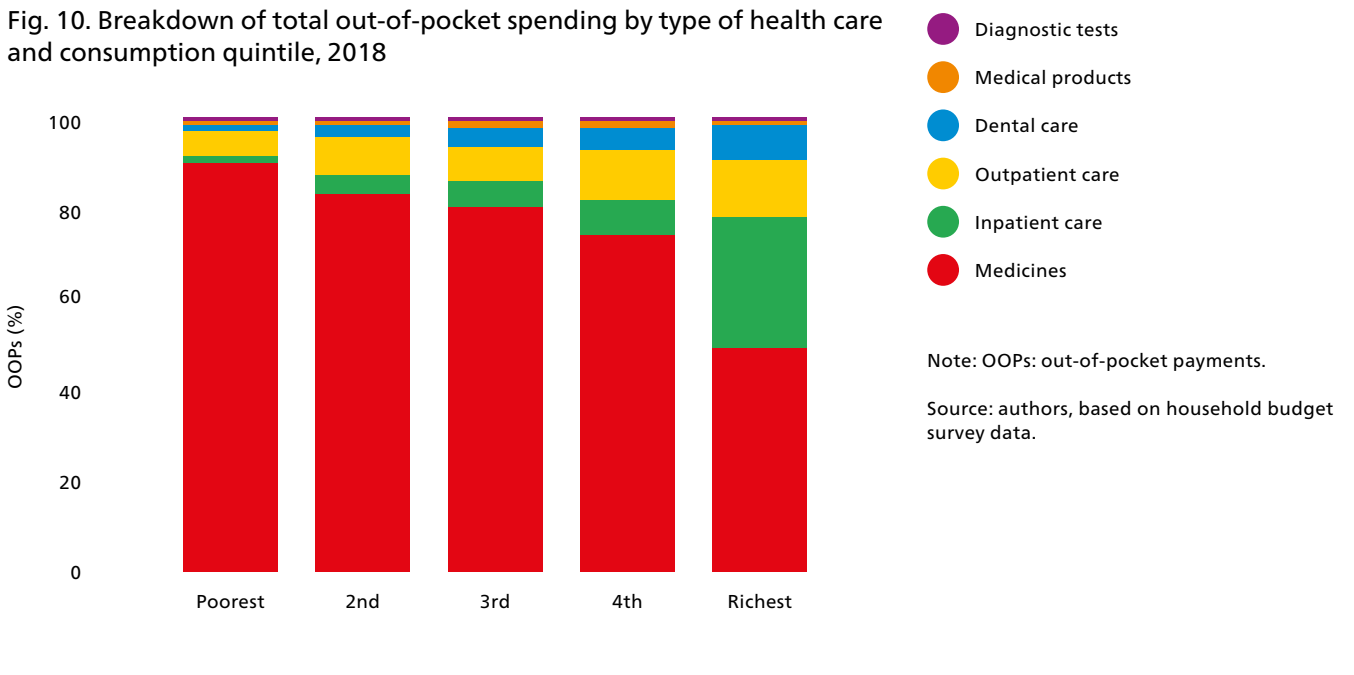


Fig. 11. Breakdown of out-of-pocket payments by type of health care and consumption quintile

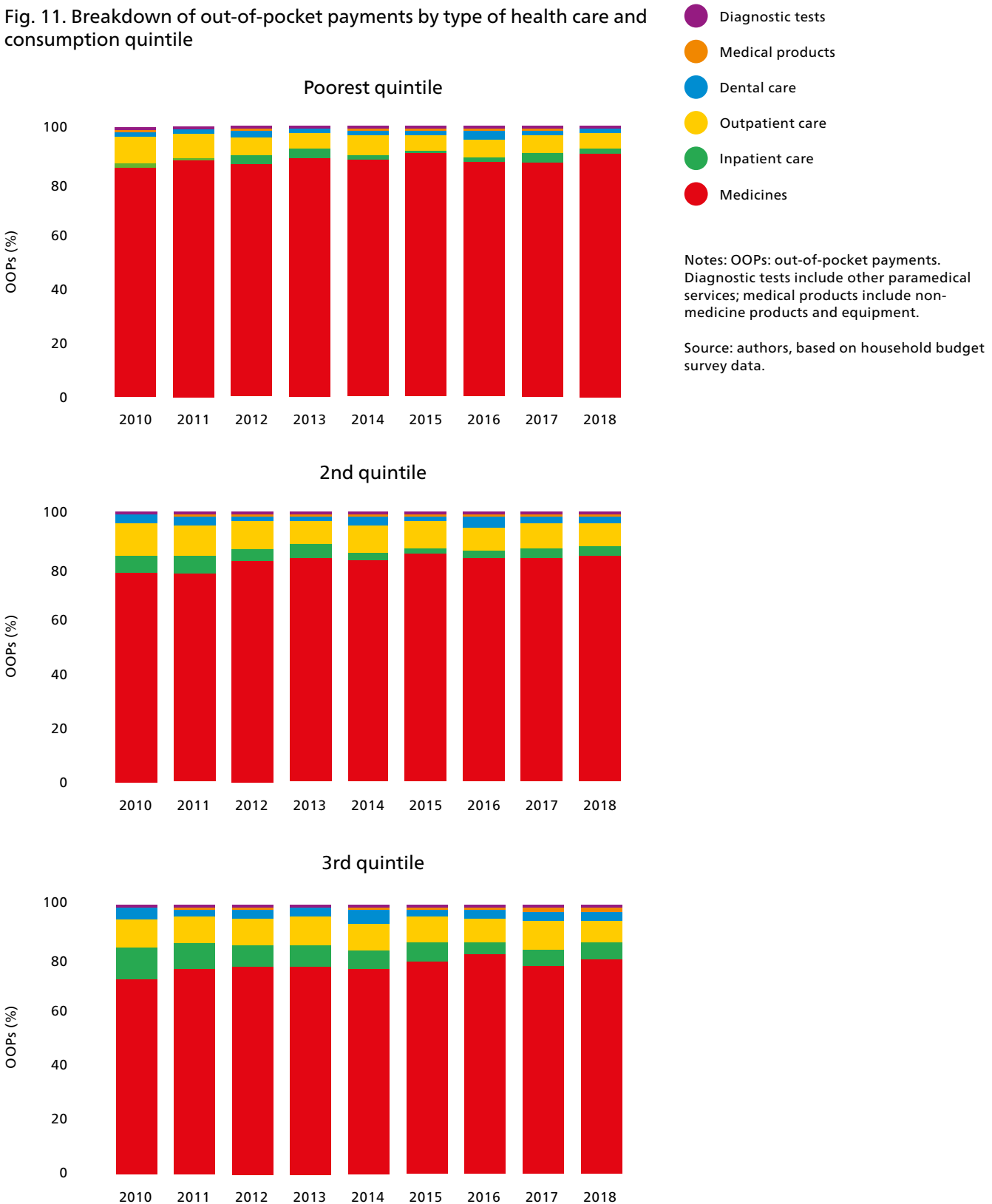


Fig. 11 contd



4.2 Informal payments

The incidence of informal payments appears to have declined in Georgia. Survey data indicate that the share of patients who obtained a receipt for all health care payments has increased considerably over time, rising from 45% in 2010 to 76% in 2014 (WHO, World Bank, United States Agency for International Development, unpublished data, 2016). In 2016, the share of people reporting having made unofficial payments or gifts in the last 12 months for health care in public facilities was relatively low in Georgia compared to other middle-income countries in the WHO European Region (EBRD, 2016).

4.3 Trends in public and private spending on health

Health financing reform led to a significant increase in real terms in public spending on health. Public spending on health per person rose dramatically from 110 GEL in 2011 to 288 GEL in 2016 and 313 GEL in 2018 (Fig. 12). Despite this significant increase, the public share of current spending on health remains low in comparison to other countries in the WHO European Region. As reforms reduced financial barriers to access, use of health services – and exposure to out-of-pocket payments – grew. Medical inflation may also have played a role (Fig. 13). As a result, although the out-of-pocket payment share of current spending on health has fallen substantially since 2011, it is still high in comparison to the WHO European Region average (Fig. 14).

Fig. 12. Health spending per person by financing scheme

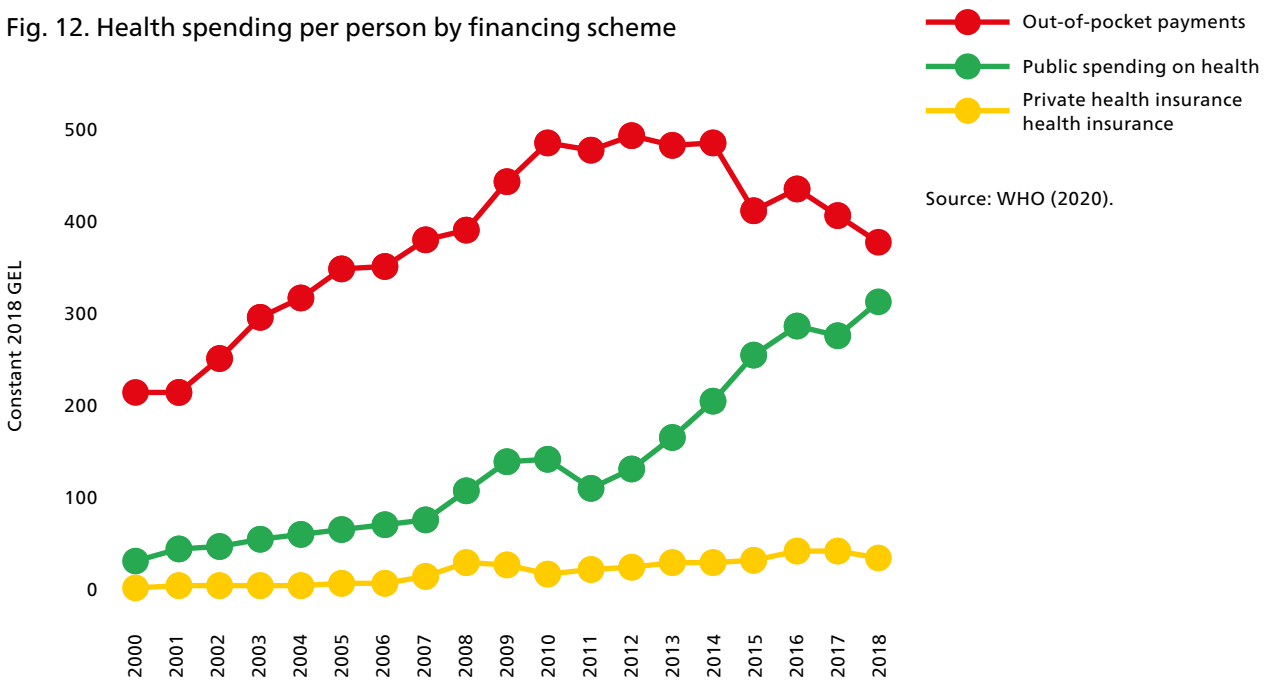


Fig. 13. Overall inflation and health care inflation

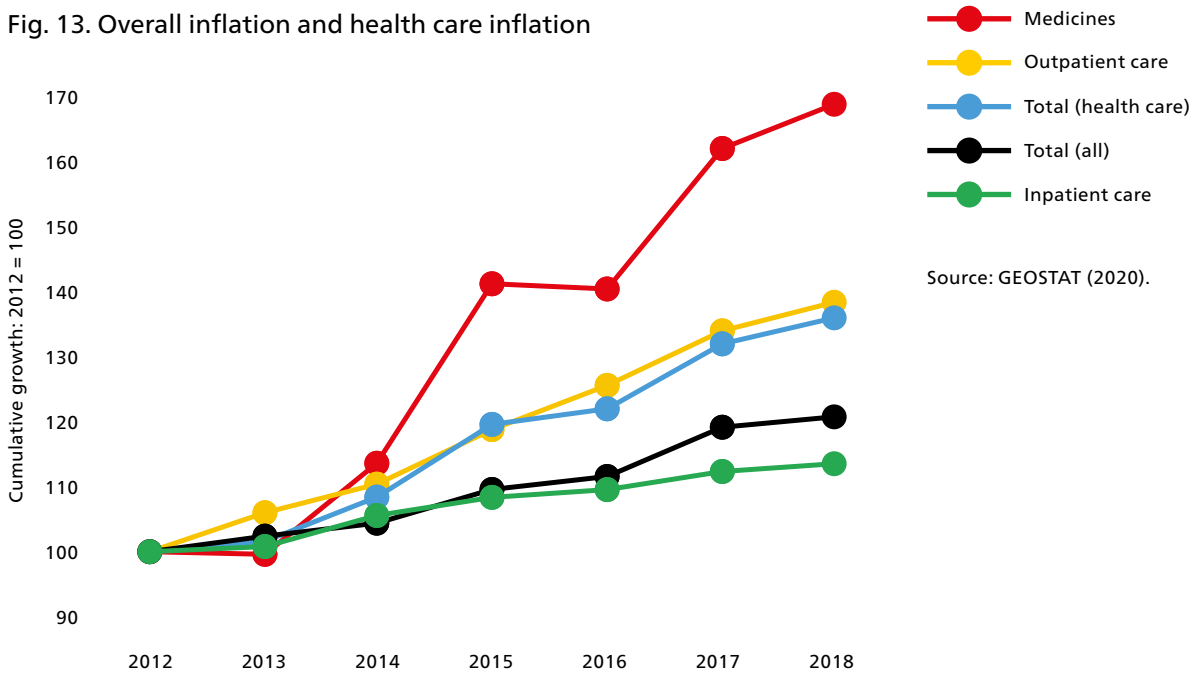
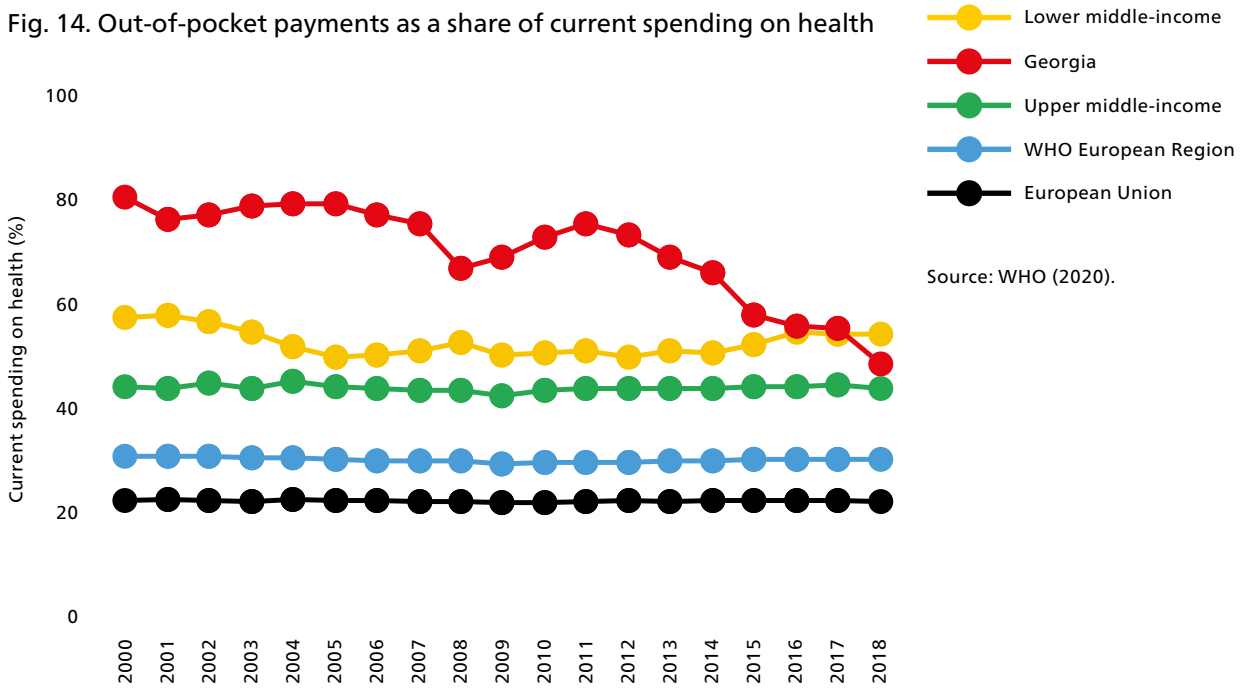


Fig. 14. Out-of-pocket payments as a share of current spending on health



4.4 Summary

Household budget survey data indicate that the share of households incurring out-of-pocket payments rose from 68% in 2010 to 79% in 2016, before declining slightly to 75% in 2017 and 2018. Out-of-pocket payments accounted for 9% of total household spending in 2018, up from 7% in 2013. These numbers suggest that although reforms removed barriers to access, leading to greater use of health services, they also increased households' exposure to out-of-pocket payments.

Medicines consistently account for the largest share of out-of-pocket payments (69% in 2018), followed by inpatient care (14%) and outpatient care (11%). There are large differences in the structure of out-of-pocket spending across quintiles. The outpatient medicines share falls as household consumption increases, while the shares spent on inpatient care, outpatient care and dental care increase with household consumption. This pattern became more marked over time. Over time, the medicines share has grown, driven by rapid growth in out-of-pocket spending on medicines per person across all quintiles.

Data from other surveys suggest that informal payments appear to have declined over time and are relatively low in Georgia compared to other middle-income countries in the European Region.

National health accounts data show that public spending on health per person rose dramatically from 2013 to 2018, pushing down the out-of-pocket payment share of current spending on health. The public share of spending on health remains low in comparison to other countries in the European Region, however.

5. Financial protection

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

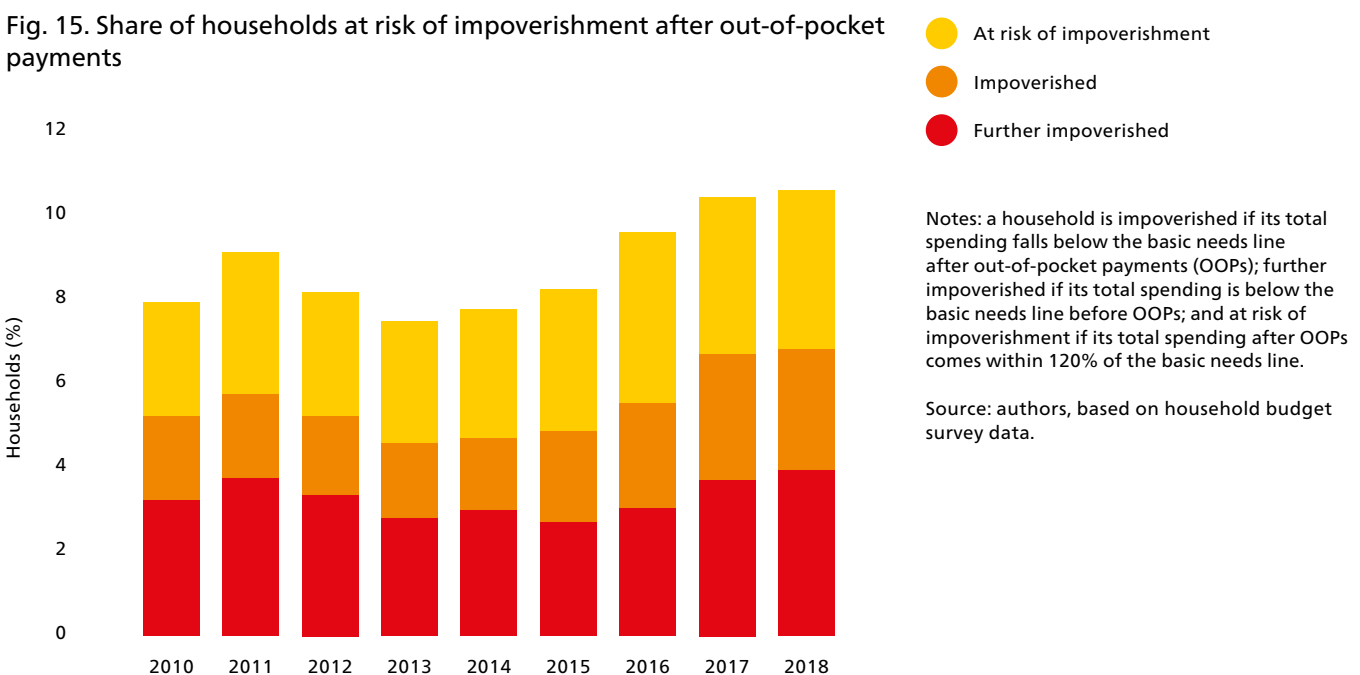
5.1 How many households experience financial hardship?

5.1.1 Out-of-pocket payments and risk of impoverishment

Fig. 15 shows the share of households at risk of impoverishment after out-of-pocket spending on health. The poverty line reflects the cost of spending on basic needs (food, rent and utilities) among a relatively poor part of the Georgian population (households between the 25th and 35th percentiles of the consumption distribution, adjusted for household size and composition). The monthly cost of meeting these basic needs – the basic needs line – was 227 GEL in 2018.

The share of households impoverished and further impoverished after out-of-pocket payments fell between 2011 and 2013 and rose between 2013 and 2018, reaching nearly 7% in 2018 (Fig. 15). The share of households at risk of impoverishment also increased.

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



5.1.2 Catastrophic out-of-pocket payments

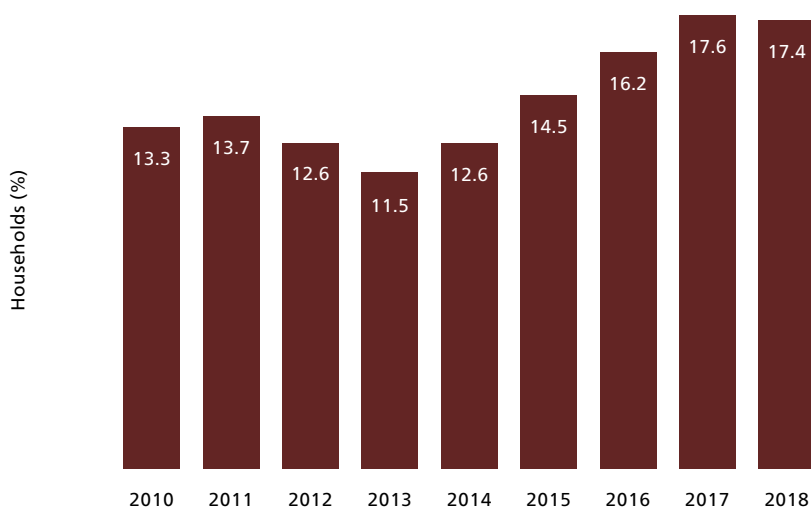
Households with catastrophic levels of out-of-pocket spending are defined (in this review) as those who spend more than 40% of their capacity to pay for health care. This includes households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further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

In 2018, 17% of households experienced catastrophic levels of spending on health (Fig. 16).¹ The incidence of catastrophic spending fell in 2012 and 2013 and rose between 2014 and 2017.

1. See Fig. A3.1 in Annex 3 for a comparison of catastrophic health spending in Georgia using the WHO European Region metric and the metric used in the Sustainable Development Goals (SDG 3.8.2).

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

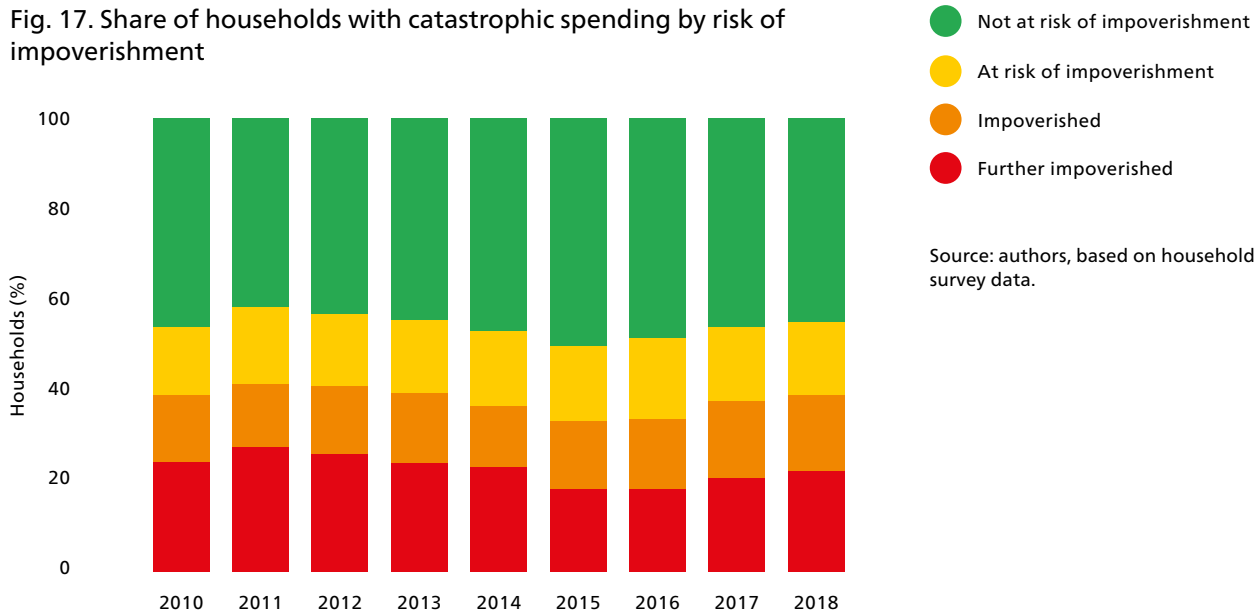
Source: authors, based on household budget survey data.



5.2 Who experiences financial hardship?

Catastrophic spending is concentrated among households who are at risk of impoverishment, impoverished and further impoverished after out-of-pocket payments (Fig. 17).

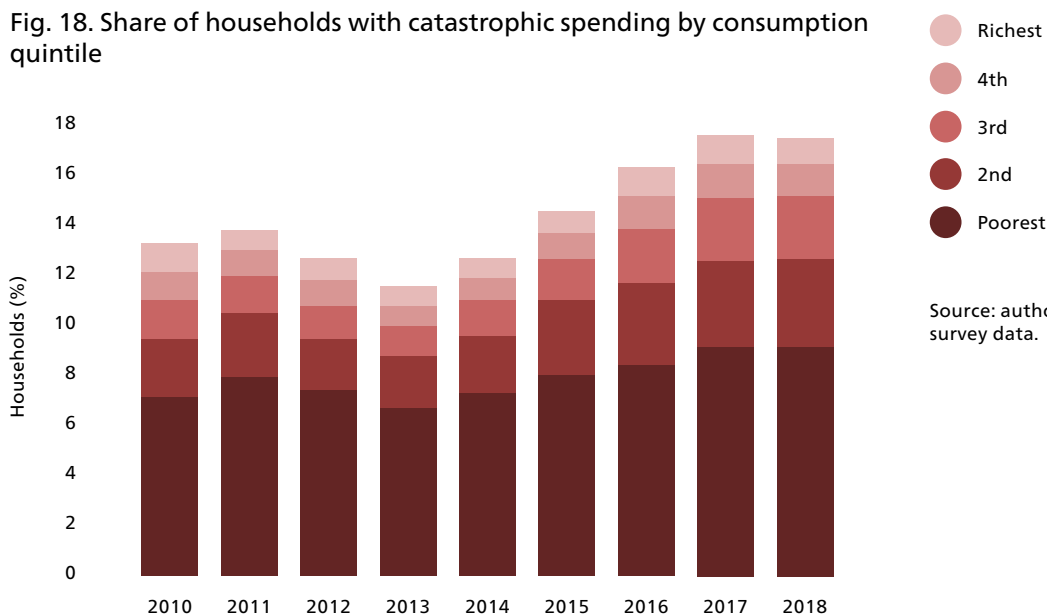
Fig. 17. Share of households with catastrophic spending by risk of impoverishment



Source: authors, based on household budget survey data.

The incidence of catastrophic out-of-pocket payments is concentrated among the two poorest quintiles (Fig. 18). In 2018, 45% of households in the poorest quintile and 17% of households in the second quintile experienced catastrophic spending, compared to only 5% in the richest quintile (data not shown). Increases in catastrophic spending over time have been largely driven by increases in incidence among the two poorest quintiles.

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

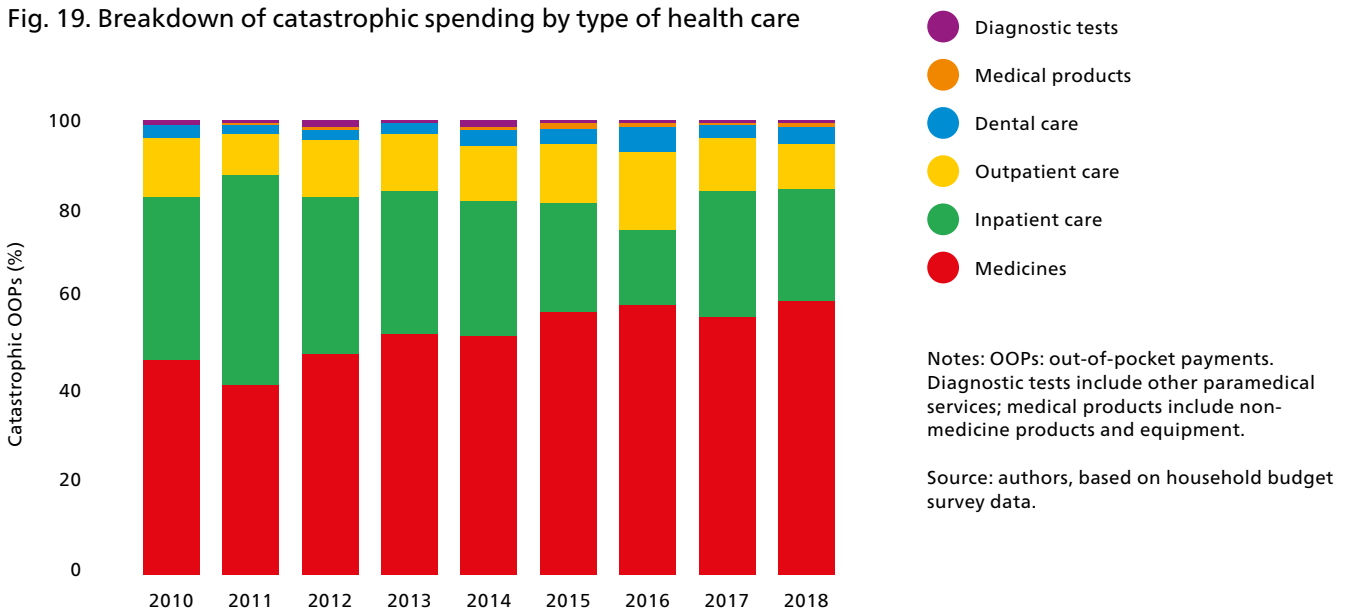


Source: authors, based on household budget survey data.

5.3 Which health services are responsible for financial hardship?

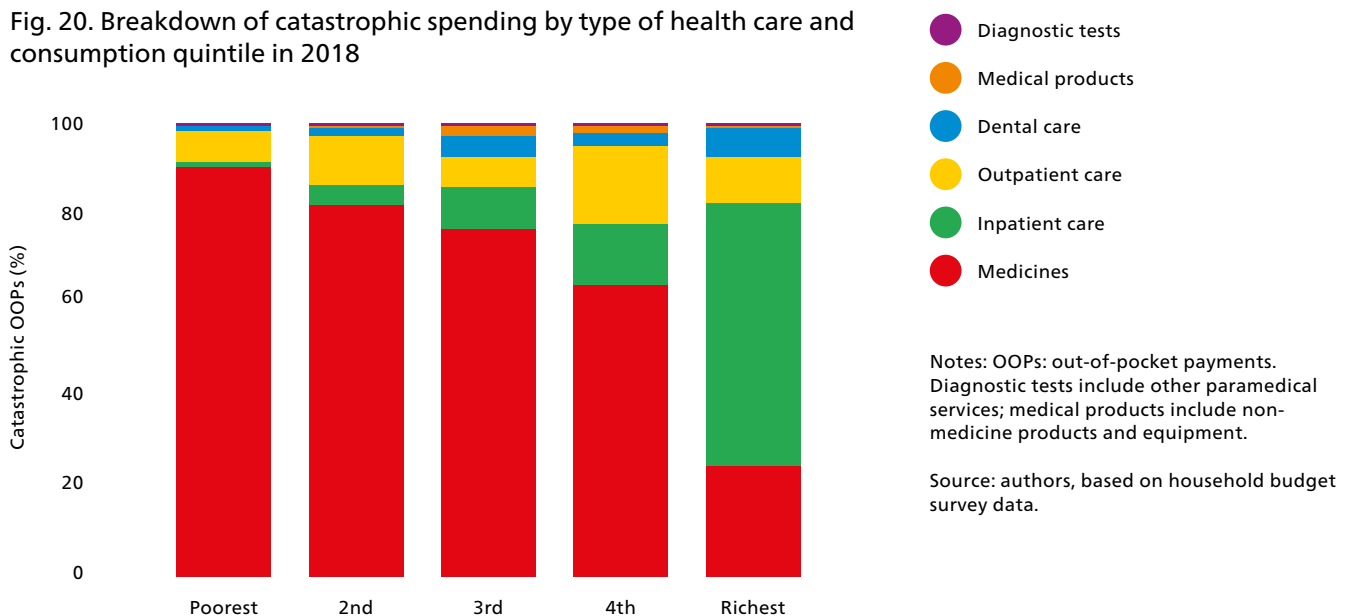
In all years except 2011, medicines are the single largest driver of catastrophic spending on average, followed by inpatient care and outpatient care (Fig 19). Over time, the medicines share has increased from 42% in 2011 to 61% in 2018. The inpatient care share has decreased from 46% in 2011 to a low of 16% in 2016, before rising to 28% in 2017.

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



Across quintiles, medicines are the main driver of catastrophic spending for all except the richest quintile, with the medicines share falling as household consumption increases (Fig. 20). Catastrophic spending in the richest quintile is mainly driven by inpatient care. The inpatient care share rises as household consumption rises. These patterns are seen across all years (Fig. 21).

Fig. 20. Breakdown of catastrophic spending by type of health care and consumption quintile in 2018



Limited coverage of outpatient medicines is the main driver of catastrophic spending in all except the richest quintile, but it disproportionately affects households in the poorest quintile. In 2018, medicines accounted for 90% of out-of-pocket payments among households in the poorest quintile with catastrophic spending, and 83% in the second quintile, compared to 24% in the richest quintile (Fig. 21). This suggests that the enhanced coverage of medicines for four chronic conditions introduced in 2017 was not enough to reduce financial hardship among poorer households.

The inpatient care share is very low for the two poorest quintiles, who do not have to pay co-payments under the UHCP. It is higher for the third and fourth quintiles and, in 2018, was the main driver of catastrophic spending for the richest quintile. For households in the richest quintile, the inpatient care share has fluctuated over time. The substantial increase in the inpatient care share in 2018 may reflect the restriction of UHCP benefits for richer households in 2017 (see Table 2 and Table 3).

The dental care share rises with household consumption. Because the UHCP does not cover dental care, unmet need for dental care is likely to be highest, especially among poorer households (WHO Regional Office for Europe, 2019).

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

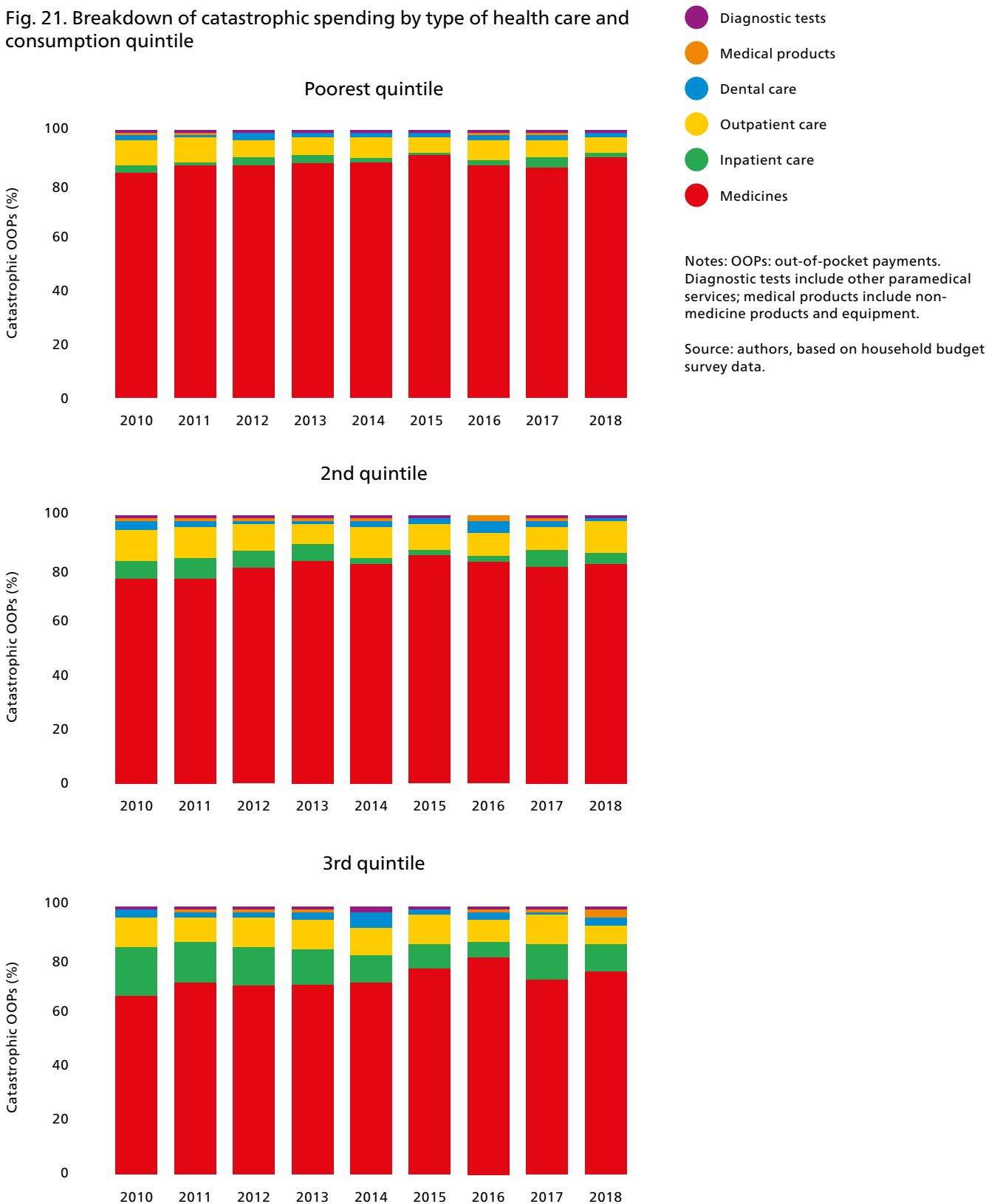
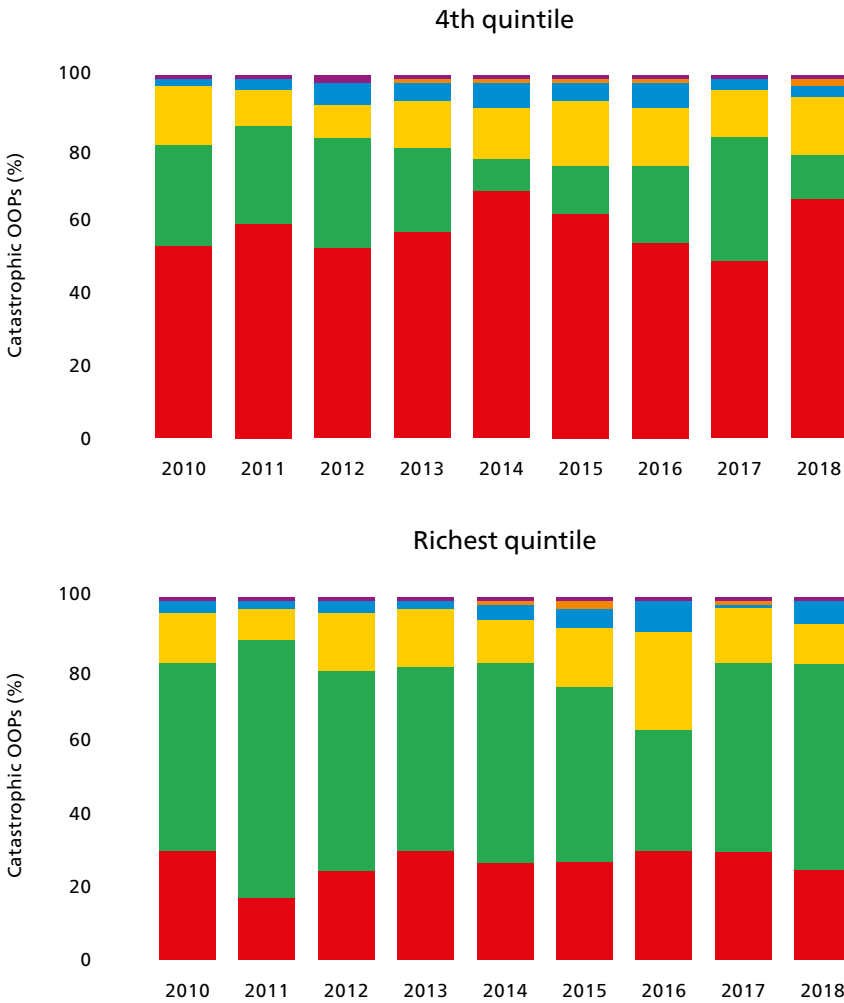


Fig. 21 contd



5.4 How much financial hardship?

The average share of total household spending on out-of-pocket payments has fluctuated over time among the very poorest households already living below the basic needs line – those that are further impoverished after out-of-pocket payments. It fell from close to 11% in 2010 to 8% in 2013 and had risen to nearly 14% by 2017 (Fig. 22).

Among all households with catastrophic spending, the amount spent on health care as a share of total household spending rises progressively with income (Fig. 23).

Fig. 22. Out-of-pocket payments as a share of total household spending among further impoverished households

Source: authors, based on household budget survey data.

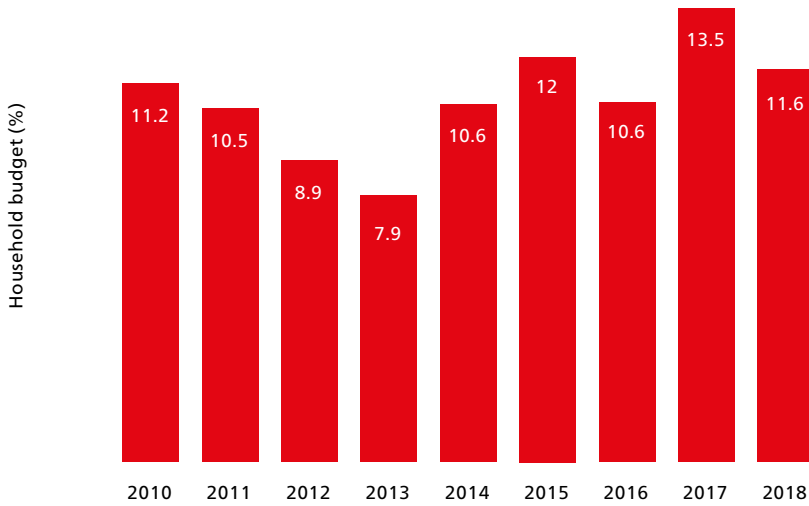
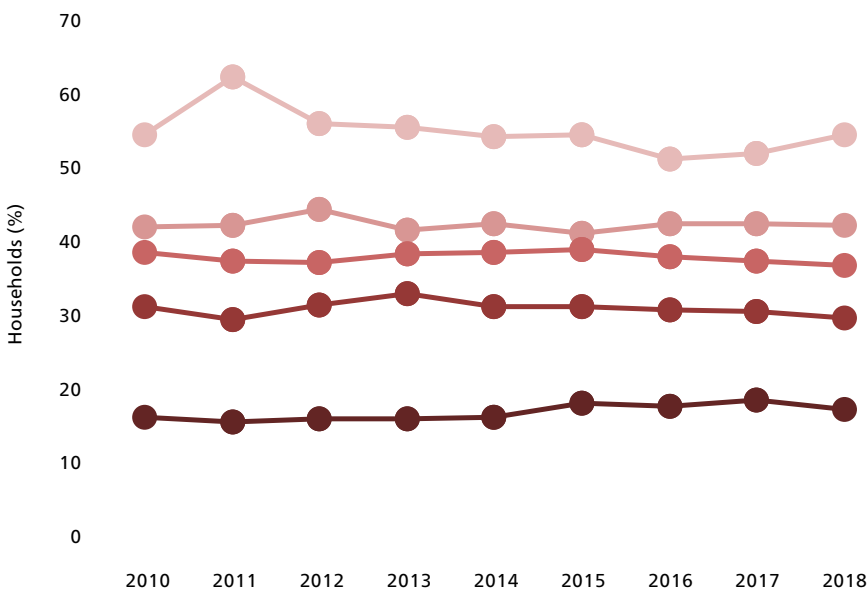


Fig. 23. Out-of-pocket payments as a share of total household spending among households with catastrophic spending by consumption quintile

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

Source: authors, based on household budget survey data.



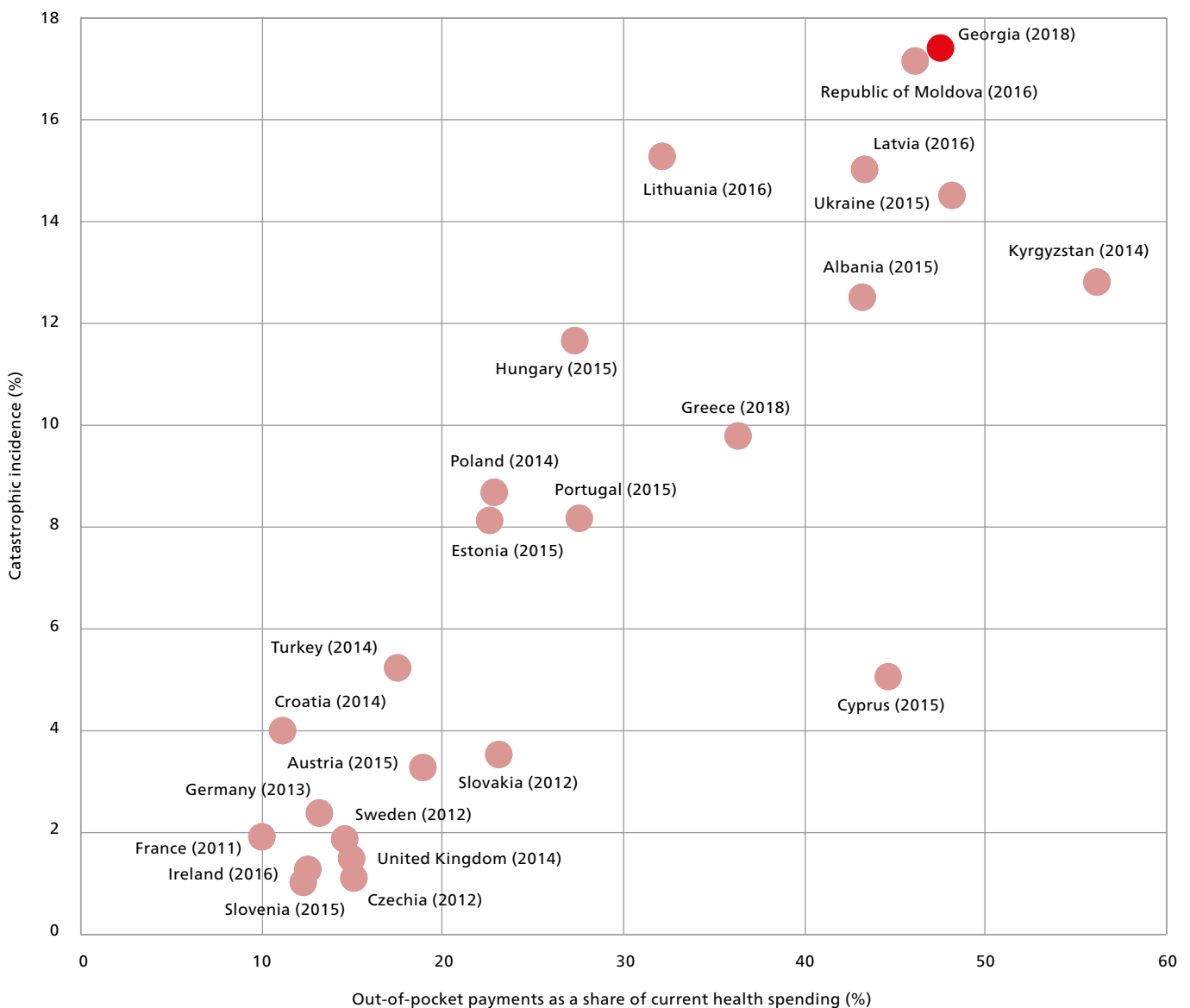
5.5 International comparison

The incidence of catastrophic health spending is high in Georgia in comparison to other countries in the WHO European Region (Fig. 24).

Fig. 24. Incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health in selected European countries, latest year available

Notes: data on out-of-pocket payments are for the same year as data on catastrophic health spending.

Sources: WHO Regional Office for Europe (2019); WHO (2020).



5.6 Summary

In 2018, around 7% of households experienced impoverishing health spending and 17% experienced catastrophic health spending. This degree of financial hardship is among the highest in the European Region.

Financial hardship is heavily concentrated among the two poorest quintiles in all years. In 2018, 45% of households in the poorest quintile and 17% of households in the second quintile experienced catastrophic spending, compared to only 5% in the richest quintile.

All quintiles experienced an increase in catastrophic health spending over time, but the bulk of the increase was driven by higher incidence in the two poorest quintiles.

Catastrophic spending is mainly driven by outpatient medicines in all except the richest quintile. In 2018, outpatient medicines accounted for 90% of out-of-pocket payments among households in the poorest quintile with catastrophic spending, compared to 24% in the richest quintile. This suggests that the enhanced coverage of medicines for four chronic conditions introduced in 2017 was not enough to reduce financial hardship among poorer households. The inpatient care share is very low for the two poorest quintiles, who are exempt from co-payments for inpatient care under the UHCP. The dental care share rises with household consumption, probably reflecting a high degree of unmet need for dental care among poorer households.

6. Factors that strengthen and undermine financial protection

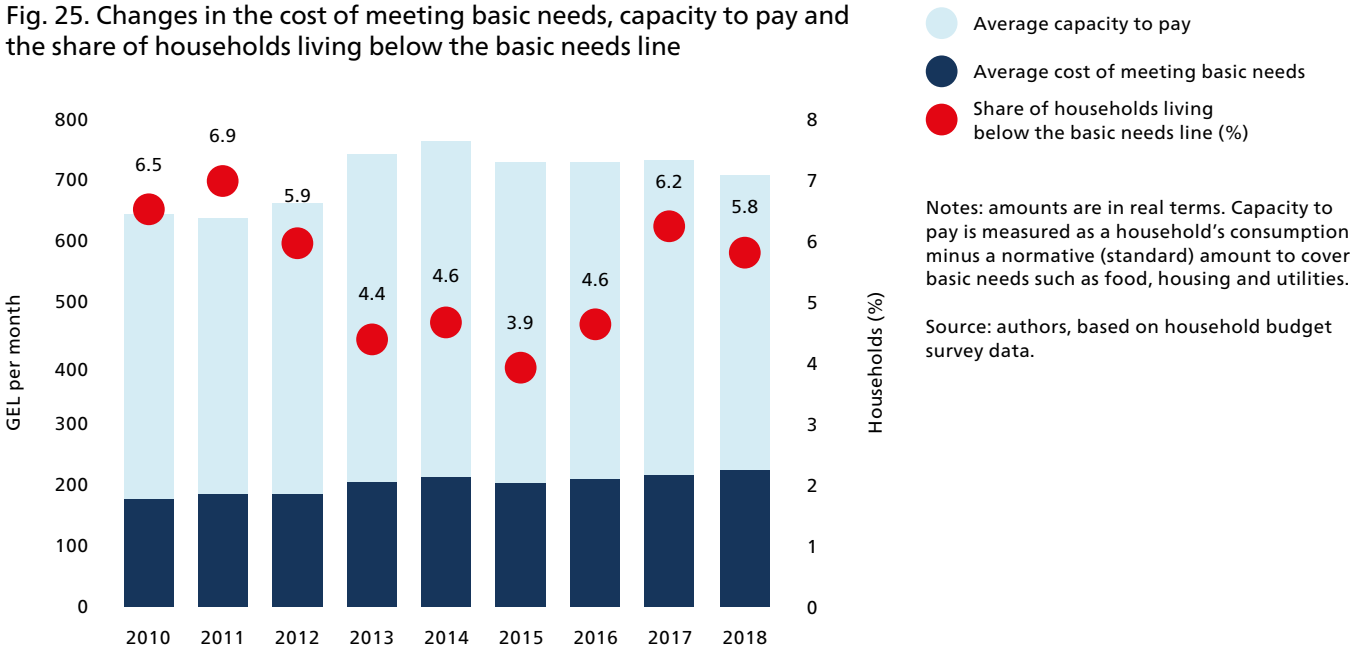
This section considers the factors that may be responsible for financial hardship caused by out-of-pocket payments in Georgia and which may explain the trend over time. It begins by looking at factors outside the health system affecting people’s capacity to pay for health care – for example, changes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

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

The following paragraphs draw on data from the household budget survey and other national sources to assess people’s capacity to pay for health care. Poverty among people more likely to need health care is a particular challenge for financial protection.

The economy bounced back quickly following the 2008 global financial crisis. Robust growth, averaging 5.6% of GDP a year from 2010 to 2014, allowed for increased government spending. However, the economy is vulnerable to external shocks, and a weakening in external demand since the end of 2014 has led to a slower rate of economic growth (World Bank, 2017). The value of the GEL has fallen since 2016, pushing up the price of imports, including medicines.

Fig. 25. Changes in the cost of meeting basic needs, capacity to pay and the share of households living below the basic needs line



During the study period, the cost of meeting basic needs remained relatively stable (Fig. 25). Average household capacity to pay for health care grew between 2011 and 2014, but has fallen since then, with a particularly large drop in 2018, which took it back to 2012 levels. The share of households living below the basic needs line fell sharply from 6.9% in 2011 to 4.4% in 2013, fluctuated a little and then rose to 6% in 2017. This indicates that poor households have become poorer in recent years.

The pattern shown in Fig. 25 is supported by national data on poverty. Fig. 26 shows the sharp decline in absolute poverty between 2010 and 2015. Since then, however, absolute poverty has stabilized. Throughout the study period, the subsistence minimum remained stable (and probably fell in real terms), in contrast to average earnings, which increased steadily (Fig. 27).

These data suggest that part of the decline in catastrophic incidence between 2011 and 2013, and part of the rise in catastrophic incidence between 2014 and 2017, can be attributed to changes in household capacity to pay for health care.

Fig. 26. Trends in absolute poverty

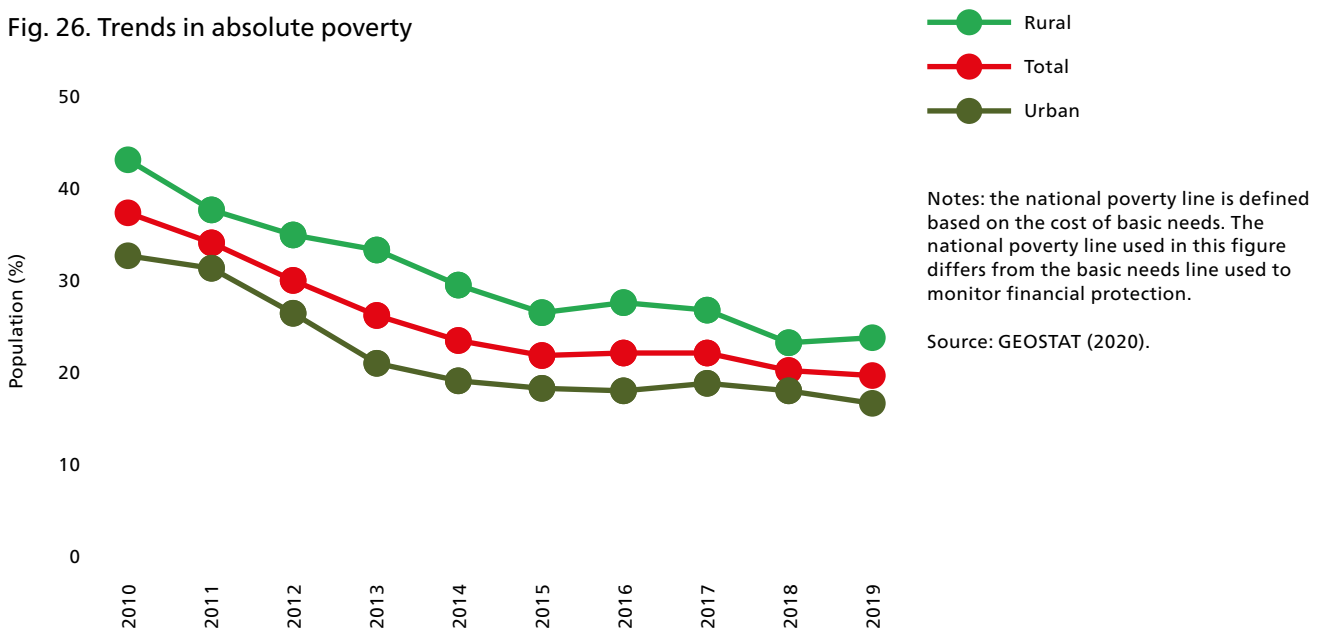
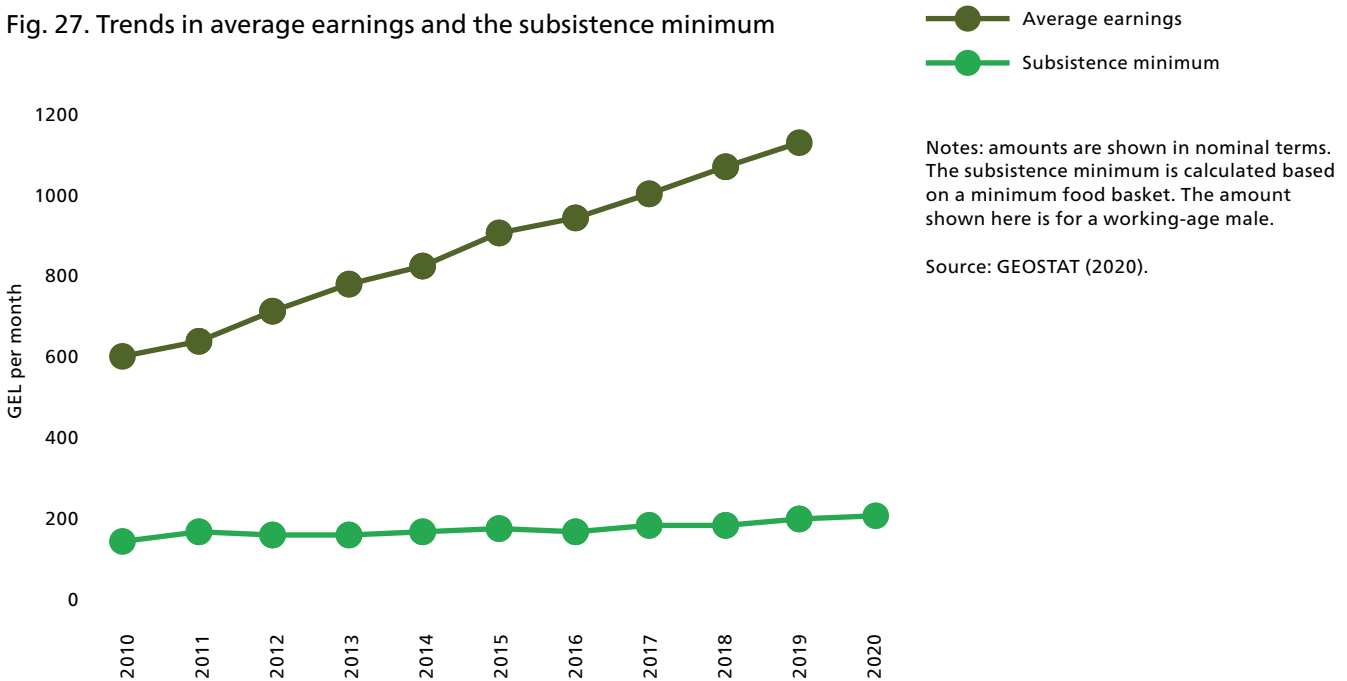


Fig. 27. Trends in average earnings and the subsistence minimum



6.2 Health system factors

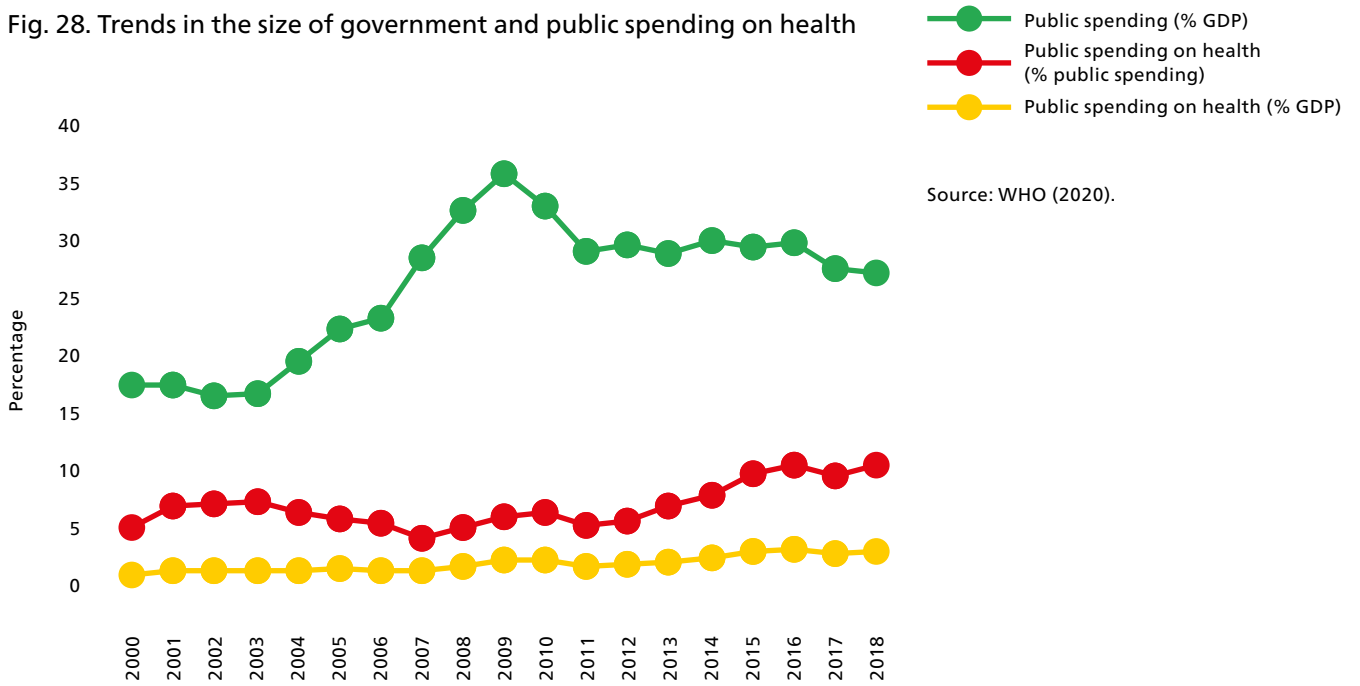
This section looks at health spending and health coverage, and then focuses on more detailed exploration of medicines coverage, prices and usage. Finally, health-seeking behaviour and the relationship between unmet need and financial protection are considered.

6.2.1 Health spending

Public spending on health and out-of-pocket payments have grown in absolute terms since 2000 (see Fig. 12). Between 2002 and 2013, out-of-pocket payments grew at a faster rate than public spending on health, however.

From 2014 to 2016, there were significant increases in public spending on health to finance the UHCP. Fig. 28 shows that the share of the government budget allocated to health rose from 5% in 2011 to 10% in 2018 (with a slight dip in 2017), leading to a doubling in public spending on health as a share of GDP, from 1.5% in 2011 to 2.8% in 2018.

Fig. 28. Trends in the size of government and public spending on health



This large and sustained increase in public investment in the health system helped to reduce the out-of-pocket payment share of current spending on health from 76% in 2011 to 48% in 2018 (see Fig. 14).

Fig. 29 shows that while Georgia invests more publicly in health, relative to GDP, than its neighbouring countries, public spending on health remains low compared to many other countries in the WHO European Region. Most higher-income countries invest more in health publicly, relative to GDP, than Georgia does.

Fig. 29. Public spending on health as a share of GDP and GDP per person in the WHO European Region, 2018

Notes: PPP: purchasing power parity. Public refers to all compulsory financing arrangements. The figure excludes Albania, Luxembourg, Monaco and Montenegro. Georgia is shown in red.

Source: WHO (2020).

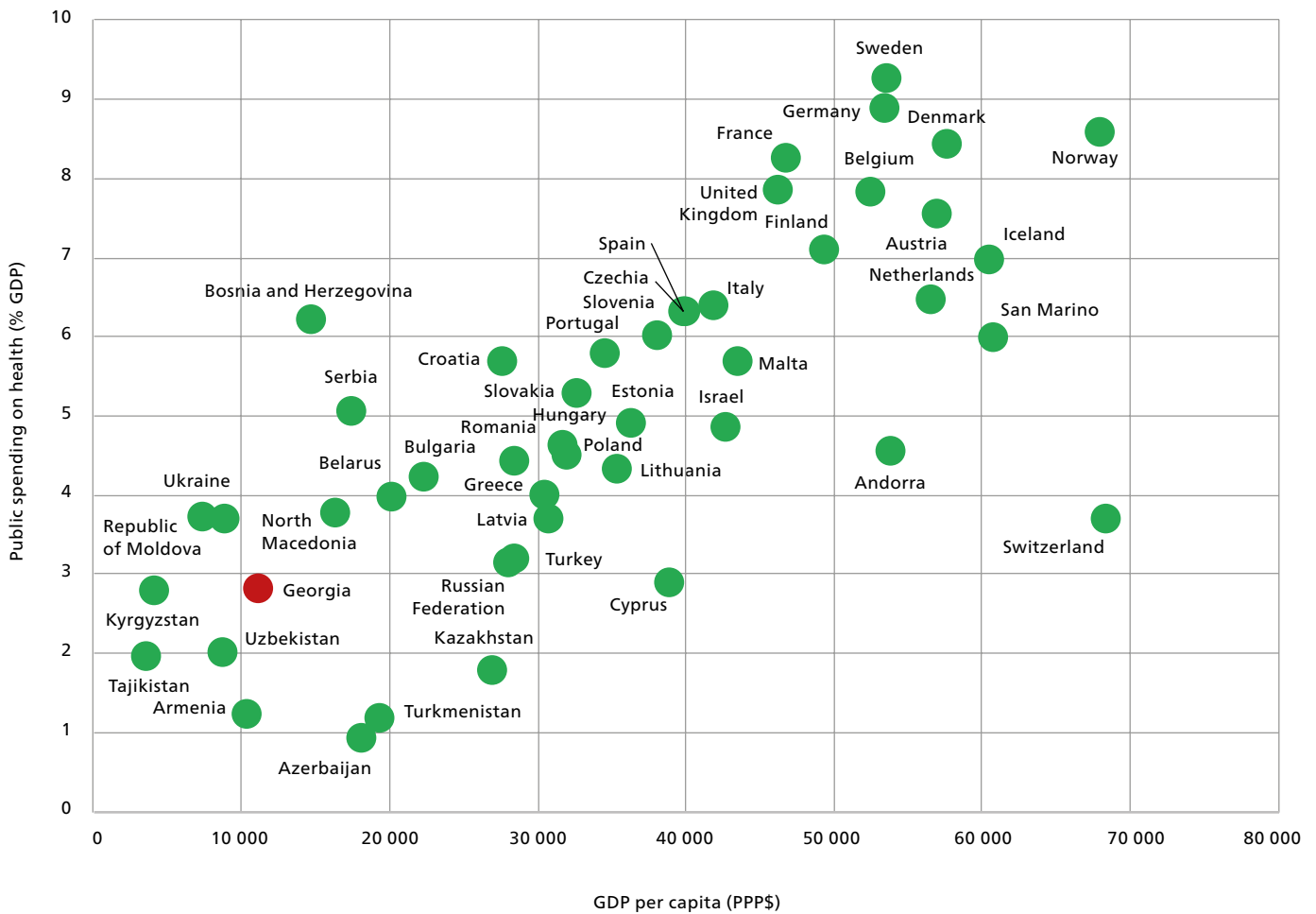
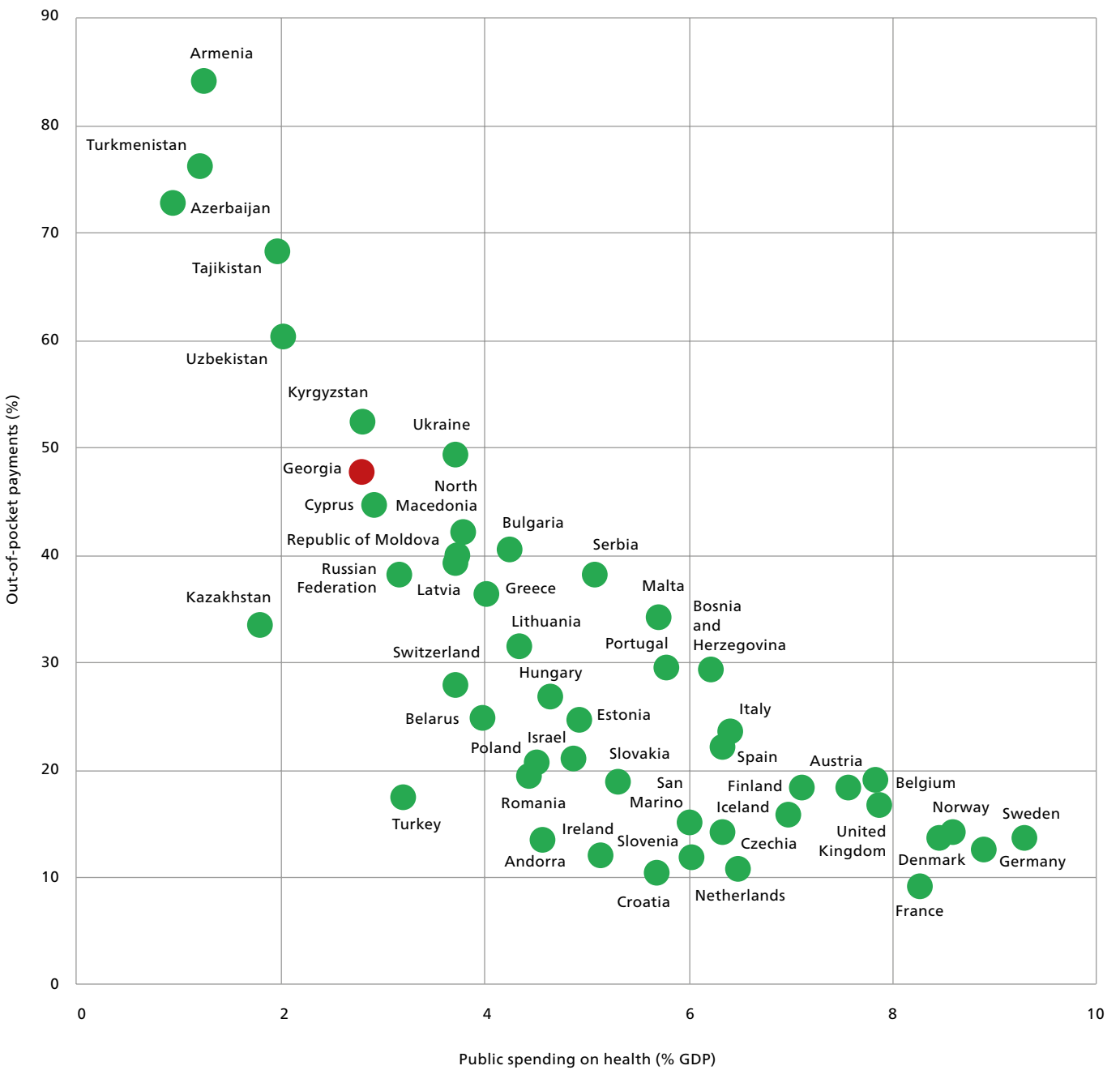


Fig. 30 shows how out-of-pocket payments continue to be high in Georgia in comparison to other countries that allocate a similar share of GDP publicly to health. This suggests that the increase in public spending on health has not fully achieved its potential to reduce out-of-pocket payments, and that other health system factors are likely to play an important role in explaining why the number of households facing financial hardship has grown (see Fig. 16).

Fig. 30. Public spending on health as a share of GDP and out-of-pocket payments, WHO European Region, 2018

Notes: the figure excludes Albania, Luxembourg, Monaco and Montenegro. Georgia is shown in red.

Source: WHO (2020).



6.2.2 Coverage policy

The design of coverage policy is unusually complex in Georgia.

Population entitlement to publicly financed health care is based not only on legal residence but also on income, age and priority status. The UHCP introduced in 2013 led to a massive expansion in publicly financed coverage, which rose from around 43% of the population at the end of 2012 to around 91% by 2017 (see Table 2). Vertical programmes provide some coverage for priority diseases and conditions to all legal residents. Around 9% of the population relies mainly on private health insurance for coverage.

The main gaps in the publicly financed **benefits package** are dental care and outpatient medicines. The UHCP excludes dental care and only covered around 50 medicines between 2013 and 2016. A limited list of medicines for four common chronic conditions was added in 2017, but for the poorest households, pensioners, veterans and people with disabilities only. Medicines are by far the largest driver of catastrophic health spending, particularly among poorer households. The fact that dental care is a relatively minor driver of financial hardship suggests that households prioritize other health care needs, potentially resulting in high levels of unmet need for dental care.

Long waiting times are not a concern as health care providers do not face caps on service volume and providers have been increasing their capacity since the introduction of the UHCP in 2013. In the absence of strong regulation of service prices, or any mechanism in place to control service volume, the government relies on coverage policy to manage health care expenditure growth. In the past, complicated administrative procedures were also used to control access to benefits, but these have gradually been replaced with more user-friendly digital solutions.

UHCP benefits are subject to a complicated system of **user charges (co-payments)** (see Table 4). Several aspects of the design of co-payments are worth highlighting as factors that are likely to undermine financial protection.

User charges are in the form of percentage co-payments, meaning people must pay a share of the medicine price or the full price. As a result, their exposure to out-of-pocket payments depends on the price and quantity of services they require. Unless the price is clearly known in advance, people may face uncertainty about how much they have to pay out of pocket.

The negative effect of this form of co-payment is magnified:

- for people who are regular users of health care (including medicines), such as people with chronic conditions;
- for people who have a condition that requires higher-cost treatment (including medicines);

- when prices are relatively high or subject to fluctuation; and
- when physicians and pharmacists are not required, or do not have incentives, to prescribe and dispense cheaper alternatives.

There are ceilings on some UHCP benefits, such as inpatient care and outpatient medicines, and on some of the benefits provided by vertical programmes. The use of ceilings is highly unusual in European health systems and is a key cause of financial hardship when treatment-related expenditures exceed the ceiling.

Balance billing is allowed for UHCP benefits. Health care providers are free to set their own prices, which should not exceed the historical value specified in the contract with insurance companies under older state health insurance programmes (2007–2012) by more than 10%. For elective services, patients are required to pay the difference between the price paid by the UHCP and the price set by the provider. Providers' ability to formally charge extra partly explains the minimal role of informal payments in Georgia. Balance billing can undermine transparency in the system, however, as well as making health spending less predictable for households and increasing financial hardship for some patients.

Mechanisms to protect people from co-payments are insufficient.

Although poor households are exempt from most co-payments, there is no explicit exemption from co-payments for people with common chronic conditions (see Table 4).

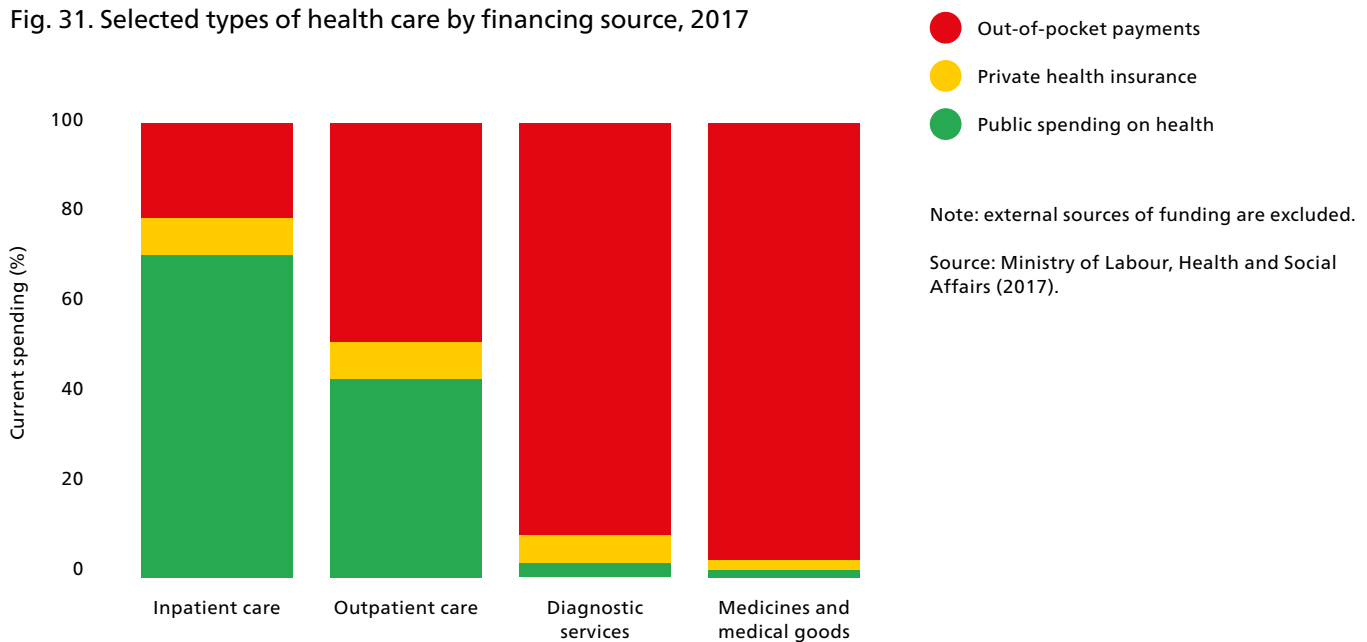
There is no overall annual cap on co-payments. This is especially worrying when user charges are in the form of percentage co-payments (rather than low flat-rate co-payments).

The co-payment system is complex and difficult for people to understand. Co-payments vary for different groups of people and by type of health care (see Table 4); providers can charge patients more than the tariff set by the government, and there is a ceiling on how much the state will cover for outpatient medicines and inpatient care. As a result, people may not be able to determine the actual amount that is covered by the UHCP and how much they will have to pay out-of-pocket. This contributes to financial uncertainty and increases the risk of catastrophic health spending.

6.2.3 Health services

In spite of increasing public investment in the health system, out-of-pocket payments play a major role in financing health services, particularly for outpatient services, including diagnostic tests, medicines and medical goods, as shown in Fig. 31.

Fig. 31. Selected types of health care by financing source, 2017



The affordability of **outpatient medicines** is a key policy concern. Out-of-pocket payments for medicines are the main driver of catastrophic spending for all groups in all years except the richest quintile in 2018, with the largest impact on poor households.

Outpatient medicines are almost entirely paid for out-of-pocket. In 2017, the state paid for only 1.2% of current spending on medicines and medical goods, while private health insurance paid for a further 2.4% (Fig. 31). As a result, medicines accounted for 36% of current spending on health and 62% of out-of-pocket spending, which is high by European standards.

Financial hardship caused by outpatient medicines is linked to the fact that, during the study period (2013–2019), the UHCP only covered 50% of the price of no more than 100 medicines and only up to a ceiling range of 50–200 GEL a year (see Table 4). In addition, purchasing agency data indicate that very few people have actually benefited from UHCP coverage of outpatient medicines: in 2017, the UHCP spent only 23 492 GEL on medicines (SSA, unpublished data, 19 November 2018). This very low amount of public spending on medicines reflects the bureaucratic procedure involved in obtaining covered medicines, low awareness among the target group, the limited and outdated selection of medicines and high co-payments.

Since May 2017, 23 medicines for four major chronic conditions (heart disease, chronic obstructive pulmonary disease, type 2 diabetes and thyroid conditions) have been provided free of charge for the poorest people as registered in the government's unified social database. In 2019, these free entitlements were extended to pensioners, veterans and people with disabilities and to medicines for epilepsy and Parkinson's disease. As with the original UHCP benefits, uptake has been very low; in 2019, public spending on UHCP medicines amounted to around 6 million GEL due to failures in the procurement process, stockouts of the most needed medicines, administrative barriers and low awareness among the target population. In February 2020, these two programmes were merged into one under the UHCP, keeping the focus on six chronic conditions and socially vulnerable people. As a result, the administrative procedure for patients to access covered medicines has been simplified and the strict programmatic budget cap for medicines eliminated. The planned budget for 2020 is still small – 10 million GEL – but if need is greater, it can be exceeded and any increase in need will be taken into account for the 2021 budget.

High out-of-pocket spending on medicines is also linked to the lack of price regulation, the frequent recommendation of brand-name medicines by physicians, and the limited availability of low-cost generic medicines in retail pharmacies (World Bank, 2017). Medicine prices are high compared to neighbouring countries and the cost-plus margin for pharmacies (frequently more than 100%) significantly exceeds margins established in EU countries (Gotsadze, 2011; Richardson & Berdzuli, 2017).

Before the introduction of the UHCP in 2013, the poorest households were already entitled to publicly financed outpatient and **inpatient care** under the MIP set up in 2007 and extended in 2012. The UHCP improved access to hospital services for the rest of the population. The number of hospitalizations per 100 population more than doubled between 2010 and 2018 (see Fig. 1). In 2018, there were 16.7 hospitalizations per 100 population, which is high compared to European rates.

High use of hospital care reflects the design of coverage policy and financial incentives for providers. First, coverage policy provides better financial protection for inpatient care than outpatient care, especially emergency inpatient care. At the same time, coverage of outpatient consultations and diagnostic services is limited and trust in primary care is low. Second, activity-based payment for hospitals, without any volume control mechanism, encourages hospitals to treat as many people and provide as many covered services as possible.

In 2018, out-of-pocket payments for inpatient care became the largest single driver of catastrophic health spending for the richest quintile (see Fig. 20). This may be the result of changes to coverage policy in 2017, which excluded the richest households from the UHCP.

Outpatient care is the third-largest driver of catastrophic spending. Once again, financial hardship reflects a combination of weaknesses in coverage policy and financial incentives for providers. From the outset, the UHCP has prioritized inpatient care over other types of health care. Patients often pay out of pocket to bypass primary care and seek care directly from specialists, partly due to the low level of trust in primary care providers,

but also due to gaps in coverage. For example, the early detection and screening programme covers organized screening for some cancers, but the UHCP only covers the diagnostic procedures needed to confirm a diagnosis of cancer if the diagnosis is followed by surgical intervention or treatment. In addition, the capitation payment for primary care is not adjusted for risk or updated regularly, resulting in discrepancies between population health needs and the resources available to meet these needs. Finally, providers have strong incentives to increase their revenue by prescribing non-covered diagnostic services, for which people have to pay out of pocket.

6.3 Summary

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

- Levels of public spending on health as a share of GDP are low by European standards. Although the out-of-pocket payment share of current spending on health has fallen substantially in recent years, out-of-pocket payments are still the single largest source of health spending.
- There are significant and persistent gaps in coverage and weaknesses in the design of coverage policy, including the prioritization of inpatient and emergency care over primary care; limited coverage of outpatient medicines; a complex system of user charges that lacks transparency and undermines predictability for users; the presence of a ceiling on what the state will cover and the absence of a cap on out-of-pocket payments; the fact that poor people and people with chronic conditions are not exempt from co-payments for outpatient medicines; balance billing by health care providers; and bureaucratic procedures.
- The absence of strong regulation of service prices and mechanisms to control service volume, combined with activity-based payment for hospitals, encourages over-treatment and the use of more expensive services, which shifts costs to households.
- Providers have strong incentives to increase revenue by prescribing brand-name medicines and services that are not covered under the UHCP.
- Lack of trust in primary care increases out-of-pocket payments due to self-treatment or bypassing referral systems when visiting specialists.

Financial protection has deteriorated over time. Data on GDP growth, poverty rates and household consumption suggest that part of the fall in catastrophic incidence between 2011 and 2013 and part of the rise in catastrophic incidence between 2014 and 2017 can be attributed to changes in household capacity to pay for health care. Shifts in the value of the GEL, contributing to higher medicine costs, have also played a role in pushing up household health spending.

7. Implications for policy

Recent health financing reforms have improved access to health care, but the out-of-pocket payment share of current spending on health has not fallen as fast as expected. The reforms have successfully reduced financial barriers to access and consequently increased the use of services, particularly among people who were not previously covered. However, out-of-pocket payments continue to be high as a share of household spending, accounting for around 7–9% across all income groups between 2010 and 2018.

Out-of-pocket payments lead to financial hardship for households using health services. In 2018, one in six households faced catastrophic out-of-pocket payments, up from one in nine households in 2013.

Catastrophic spending on health is heavily concentrated among the poorest households. In 2018, almost half of all households in the poorest quintile experienced financial hardship, compared to only 5% in the richest quintile. Lower-income households are much more likely to face catastrophic spending than higher income households.

Despite increased public investment in health since 2013, the level of public spending on health as a share of GDP remains low – 2.8% in 2018, compared to an average of 4.9% in the WHO European Region. As a result, out-of-pocket payments are still the single largest source of health spending.

Outpatient medicines are the main driver of financial hardship, reflecting limited coverage and high medicine prices. Among the poorest quintile, about 90% of catastrophic health spending can be related to out-of-pocket payments for medicines. For the richest quintile, the main driver of catastrophic spending is inpatient care; the richest households were excluded from the UHCP in 2017 and private health insurance does not seem to provide enough protection. Dental care does not drive catastrophic spending, even though it is excluded from the UHCP benefits package, probably reflecting a high degree of unmet need for dental care.

To strengthen financial protection, outpatient medicines need to be more affordable for people. In mid-2017, the government introduced an outpatient medicines programme targeting the poorest households, pensioners, veterans and people with disabilities, but uptake has been modest. Only around 1% of spending on outpatient medicines came from public sources in 2017. Low-cost generic medicines are generally less available in retail pharmacies than more expensive branded products. This is likely to skew consumption towards higher-priced medicines. To increase the affordability of medicines, the outpatient medicines programme should be extended significantly to cover both more medicines and more people. Stronger price regulation and steps to encourage the rational prescribing and use of medicines require immediate attention.

Weak regulation of health service prices and provider ability to charge patients extra (balance billing) also contribute to high out-of-pocket payments for inpatient and outpatient care. Despite significant progress made towards eliminating informal payments, providers in Georgia can set their own prices and require patients to pay the difference between the price and the UHCP tariff.

The co-payment system is complex and potentially confusing for patients. Protection mechanisms are ineffective. Annual ceilings on UHCP benefits, the use of percentage co-payments and provider ability to charge patients extra results in high out-of-pocket payments.

In the absence of strong regulation of service prices, or mechanisms to control service volume, the government relies on coverage policy to manage health care expenditure growth, which shifts costs on to households and increases their financial hardship – even more so when financial incentives in the health system push people to use more expensive services.

Additional public investment in health alone is not enough to strengthen financial protection. Better coverage policies, stronger price regulation and volume control mechanisms are also needed. Low public spending on health, heavy reliance on out-of-pocket payments (which accounted for 48% of current spending on health in 2018), significant gaps in coverage and lack of price regulation are the main factors undermining financial protection. Any additional investment in the health system should be used to prioritize stronger protection for poorer households and regular users of health care. Stronger regulation of health service prices, including medicine prices, accompanied by adequate volume control mechanisms, would enable a more efficient use of existing resources. Action to address financial incentives that push people towards inpatient care should be balanced by efforts to improve the quality of primary care.

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Annex 1. Household budget surveys in Europe

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

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

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

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

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

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

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

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

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

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

Are household budget surveys comparable across countries?

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

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

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

Source: United Nations Statistics Division (2018).

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

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Annex 2. Methods used to measure financial protection in Europe

Background

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

Data sources and requirements

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

The following variables are required at household level:

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

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

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

Defining household consumption expenditure variables

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

Total household consumption expenditure not including imputed rent

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

Food expenditure

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

Housing expenditure on rent and utilities

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

Health expenditure (out-of-pocket payments)

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

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

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

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

Defining a basic needs line

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

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

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

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

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

Calculating the basic needs line

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

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

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

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

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

Calculating basic needs expenditure levels for each household

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

Capacity to pay for health care

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

Estimating impoverishing out-of-pocket payments

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

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

Estimating catastrophic out-of-pocket payments

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

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

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

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

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

which health services are more or less responsible for catastrophic out-of-pocket payments.

Distribution of catastrophic out-of-pocket payments

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

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

Structure of catastrophic out-of-pocket payments

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

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Annex 3. Regional and global financial protection indicators

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

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

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

Note: PPP: purchasing power parity.

Sources: WHO headquarters and WHO Regional Office for Europe.

Regional indicators

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

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

Global indicators

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

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

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

The choice of global or regional indicator has implications for policy

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

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

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

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

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

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

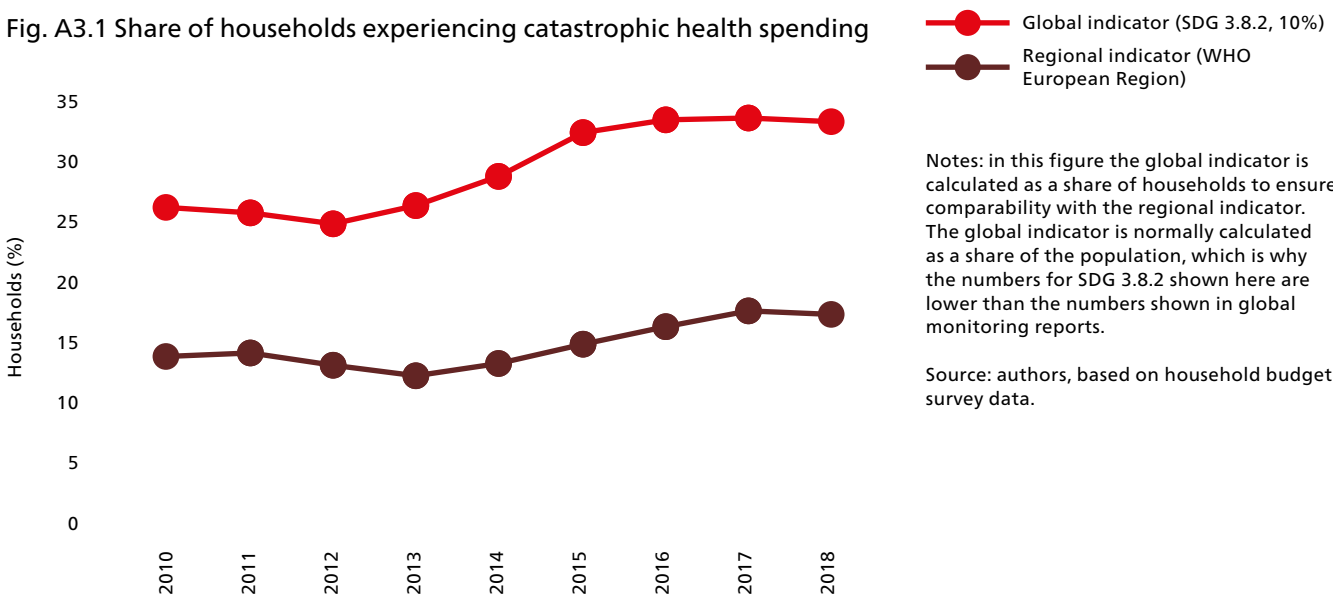
Recent global studies most commonly report impoverishing out-of-pocket payments using absolute poverty lines set at US\$ 1.90 or US\$ 3.10 a day in purchasing power parity (WHO & World Bank 2015; 2017). These poverty lines are found to be too low to be useful in Europe, even among middle-income countries.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

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

Comparison of global and regional indicators for Georgia

The figure below compares the incidence of catastrophic health spending in Georgia using global and regional indicators. The incidence of catastrophic out-of-pocket payments is consistently higher with the global indicator, but the trend over time is very similar for both indicators.

Fig. A3.1 Share of households experiencing catastrophic health spending



5. All websites last accessed on 12 March 2021.

—●— Global indicator (SDG 3.8.2, 10%)
—●— Regional indicator (WHO European Region)

Notes: in this figure the global indicator is calculated as a share of households to ensure comparability with the regional indicator. The global indicator is normally calculated as a share of the population, which is why the numbers for SDG 3.8.2 shown here are lower than the numbers shown in global monitoring reports.

Source: authors, based on household budget survey data.

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Annex 4. Glossary of terms

Ability to pay for health care: Ability to pay refers to all the financial resources at a household's disposal. When monitoring financial protection, an ability to pay approach assumes that all of a household's resources are available to pay for health care, in contrast to a capacity to pay approach (see below), which assumes that some of a household's resources must go towards meeting basic needs. In practice, measures of ability to pay are often derived from household survey data on reported levels of consumption expenditure or income over a given time period. The available data rarely capture all of the financial resources available to a household – for example, resources in the form of savings and investments.

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

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

Budget: See household budget.

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

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

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

Catastrophic out-of-pocket payments: Also referred to as catastrophic health spending. An indicator of financial protection. Catastrophic out-of-pocket payments can be measured in different ways. This study defines them as out-of-pocket payments that exceed 40% of a household's

capacity to pay for health care. The incidence of catastrophic health spending includes households who are impoverished and households who are further impoverished.

Consumption: Also referred to as consumption expenditure. Total household consumption is the monetary value of all items consumed by a household during a given period. It includes the imputed value of items that are not purchased but are procured for consumption in other ways (for example, home-grown produce).

Co-payments (user charges or user fees): Money people are required to pay at the point of using health services covered by a third party such as the government, a health insurance fund or a private insurance company. *Fixed co-payments* are a flat amount per good or service; *percentage co-payments* (also referred to as co-insurance) require the user to pay a share of the good or service price; *deductibles* require users to pay up to a fixed amount first, before the third party will cover any costs. Other types of user charges include *balance billing* (a system in which providers are allowed to charge patients more than the price or tariff determined by the third party payer), *extra billing* (billing for services that are not included in the benefits package) and *reference pricing* (a system in which people are required to pay any difference between the price or tariff determined by the third party payer – the reference price – and the retail price).

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

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

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

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

Further impoverished households: Poor households (those whose equivalent person total consumption is below the poverty line or basic needs line) who incur out-of-pocket payments.

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

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

Household budget survey: Usually national sample surveys, often carried out by national statistical offices, to measure household consumption over a given period of time. Sometimes referred to as household consumption expenditure or household expenditure surveys. European Union countries are required to carry out a household budget survey at least once every five years.

Impoverished households: Households who were non-poor before out-of-pocket payments, but are pushed below the poverty line or basic needs line after out-of-pocket payments.

Impoverishing out-of-pocket payments: Also referred to as impoverishing health spending. An indicator of financial protection. Out-of-pocket payments that push people into poverty or deepen their poverty. A household is measured as being impoverished if its total consumption was above the national or international poverty line or basic needs line before out-of-pocket payments and falls below the line after out-of-pocket payments.

Informal payment: a direct contribution made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services to which patients are entitled.

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

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

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

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

Universal health coverage: Everyone can use the quality health services they need without experiencing financial hardship.

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

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

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

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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