

Can people afford to pay for health care?

Evidence on financial
protection in 40 countries
in Europe



Summary

Regional report 2023

WHO Barcelona Office for Health Systems Financing

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

A key part of the work of the Office is to assess country and regional progress towards UHC by monitoring financial protection – affordable access to health care. Financial protection is a core dimension of health system performance, an indicator for the Sustainable Development Goals, part of the European Pillar of Social Rights and central to the European Programme of Work, WHO/Europe's strategic framework. The Office supports countries to strengthen financial protection through tailored technical assistance, including analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience.

Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.



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Corrigendum

The Republic of Srpska was corrected to Republika Srpska and the name of the Member State (Bosnia and Herzegovina) was added after each of the entities (the Federation of Bosnia and Herzegovina and Republika Srpska) on page vii (under the countries and entities list) and page 11 (under the notes for Fig. 6). This correction was incorporated into the electronic file on 18 December 2023.

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Abstract

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

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Abbreviations

COVID-19	coronavirus disease
EU	European Union
OECD	Organisation for Economic Co-operation and Development
SHI	social health insurance
UHC	universal health coverage
VHI	voluntary health insurance

Countries and entities

ALB	Albania
ARM	Armenia
AUT	Austria
BEL	Belgium
BIH	Bosnia and Herzegovina
BIH-F	Federation of Bosnia and Herzegovina, Bosnia and Herzegovina
BIH-R	Republika Srpska, Bosnia and Herzegovina
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
IRE	Ireland
ISR	Israel
ITA	Italy
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MDA	Republic of Moldova
MKD	North Macedonia
MNE	Montenegro
NET	Netherlands (Kingdom of the)
POL	Poland
POR	Portugal
ROM	Romania
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SPA	Spain
SWE	Sweden
SWI	Switzerland
TUR	Türkiye
UKR	Ukraine
UNK	United Kingdom

Financial protection is central to universal health coverage

Ensuring access to health care is affordable for everyone – financial protection – is at the heart of universal health coverage (UHC). Financial protection is undermined by out-of-pocket payments for health care. Out-of-pocket payments can cause financial hardship for people using health services, leading to impoverishing and catastrophic health spending. They can also be a barrier to access, resulting in unmet need for health care.

Without financial protection people may be forced to choose between health care and other basic needs, which deepens poverty, erodes health and well-being and increases inequalities. For this reason, financial protection is widely regarded as a core dimension of health system performance (Papanicolas & Smith, 2013).

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

This document summarizes a study assessing financial protection in 40 countries in the WHO European Region (hereafter Europe), including the whole of the European Union (EU), in 2019 or the latest available year before the coronavirus disease (COVID-19) pandemic (WHO Regional Office for Europe, 2023a). The study updates an earlier report (WHO Regional Office for Europe, 2019) and provides a pre-pandemic baseline for Europe.

How financial protection is measured matters

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

Data on unmet need come from household surveys that ask people if there was a time in the last year when they needed health care but were not able to access it due to cost, distance or waiting time (health system factors).

To measure financial hardship – impoverishing and catastrophic health spending – the study uses metrics developed by the WHO Regional Office for Europe (Cylus, Thomson & Evetovits, 2018), building on established metrics, in response to concerns that the method used to measure

financial hardship in the Sustainable Development Goals (SDG indicator 3.8.2) does not adequately capture equity (WHO & World Bank, 2017). The Regional Office for Europe metrics are less likely to underestimate financial hardship among poorer people than the SDG 3.8.2 method because they account for differences in household capacity to pay for health care (WHO & World Bank, 2017; Cylus, Thomson & Evetovits, 2018).

All financial hardship metrics draw on household budget surveys; define out-of-pocket payments as formal and informal payments made at the time of using any health care good or service delivered by any type of provider; and measure financial protection at household level.

Out-of-pocket payments push people into poverty or make them even poorer

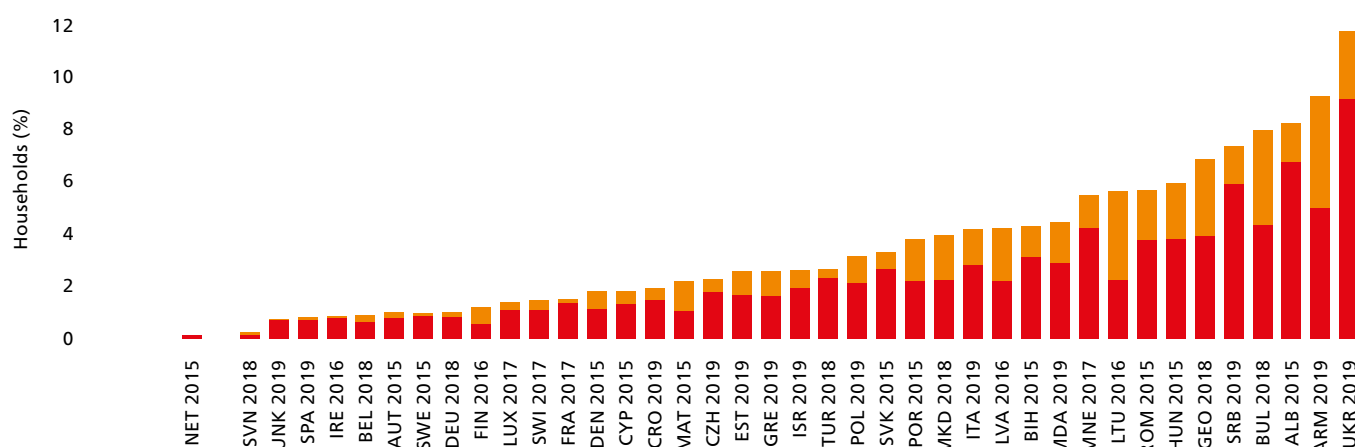
There is wide variation in the incidence of impoverishing health spending in Europe. The share of households that are impoverished or further impoverished after out-of-pocket payments ranges from under 1% of households in Belgium, Ireland, Spain, Slovenia and the United Kingdom to over 4% in Bosnia and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

Fig. 1. Share of households with impoverishing health spending, 2019 or latest available year before COVID-19

● Impoverished
● Further impoverished

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

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



The poorest households are most likely to experience financial hardship

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

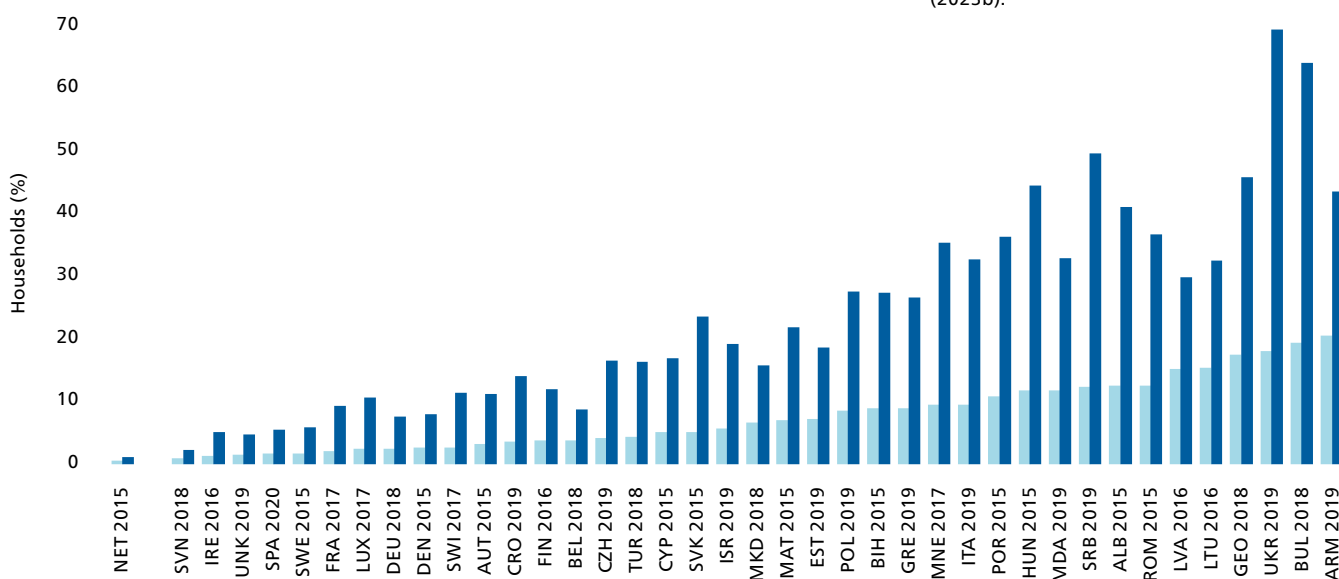
Country averages conceal major differences in impact. The incidence of catastrophic health spending in the poorest consumption quintile is two to five times higher than the national average). Households in the poorest consumption quintile are consistently most likely to experience financial hardship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

Fig. 2. Share of households with catastrophic health spending on average and in the poorest quintile, 2019 or the latest available year before COVID-19

● Average
● Poorest quintile

Notes: quintiles are based on per person consumption adjusted for household size and composition using the Organisation for Economic Co-operation and Development (OECD) equivalence scales. See the note on Netherlands (Kingdom of the) in Fig. 1.

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



Financial hardship is mainly driven by out-of-pocket payments for outpatient medicines

Outpatient medicines are the main driver of financial hardship across countries, accounting on average for 38% of out-of-pocket payments in households with catastrophic health spending, followed by outpatient dental care (18%), outpatient medical products (15%) and inpatient care (13%) (Fig. 3). In the poorest consumption quintile, the outpatient medicines share of catastrophic health spending rises to 60% and the share spent on the other types of care falls to 12% (medical products), 10% (dental care), 8% (outpatient care), 5% (diagnostic tests) and 4% (inpatient care).

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

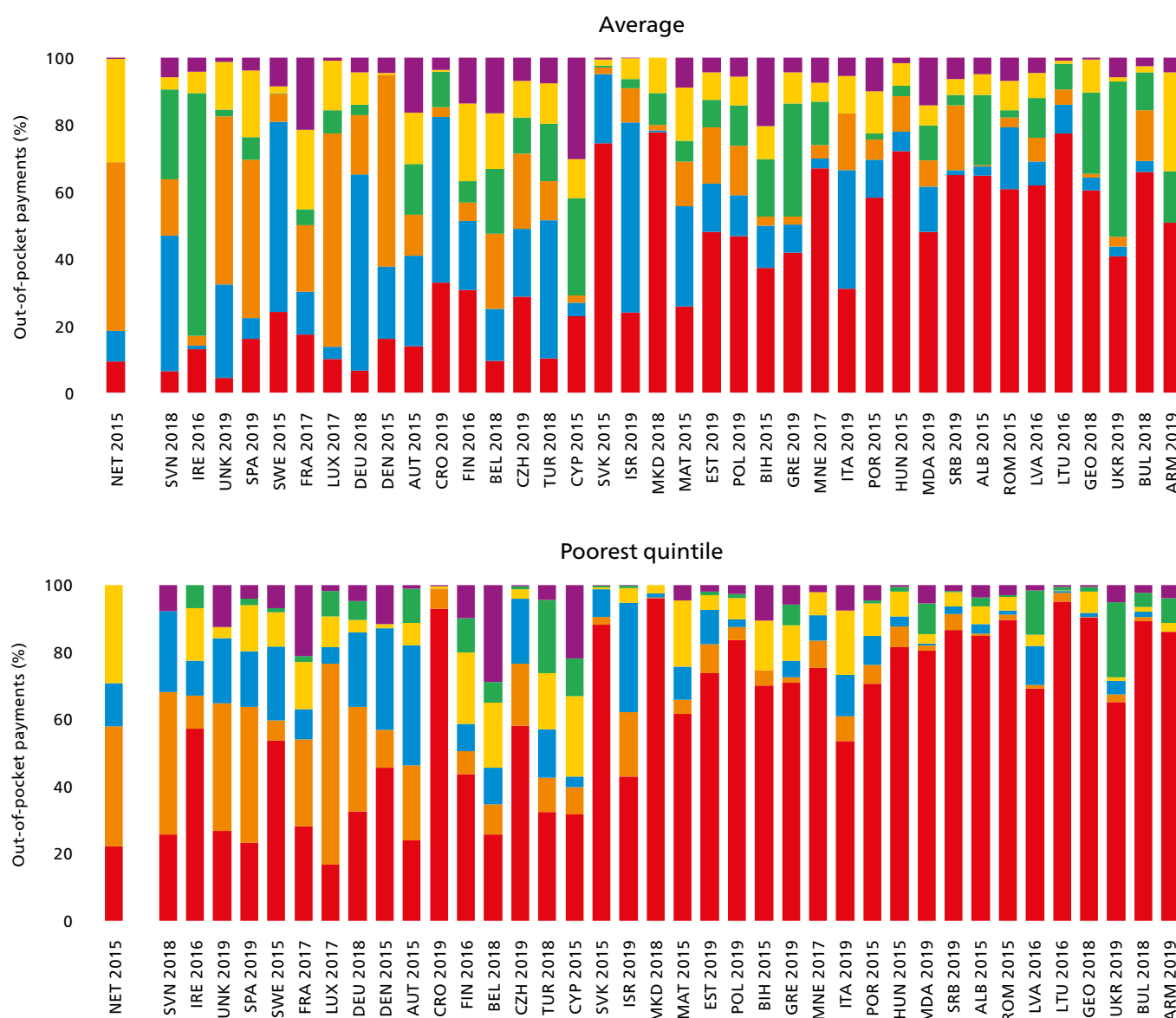
Within countries, drivers differ across quintiles. Outpatient medicines consistently account for a larger share of catastrophic health spending in the poorest quintile than in the other quintiles, while inpatient care and dental care usually account for a smaller share (Fig. 3).

Fig. 3. Breakdown of out-of-pocket payments by type of health care among households with catastrophic health spending, 2019 or latest available year before COVID-19



Notes: countries are ranked from left to right by the incidence of catastrophic health spending (lowest in Slovenia, highest in Armenia). Types of health care are sorted by the unweighted average across countries. "Medical products" refers to items like hearing aids, glasses and contact lenses, nebulisers and wheelchairs. "Diagnostic tests" include other paramedical services. In Spain dentures are classified as medical products rather than dental care in the household budget survey. In Ukraine the medicines category includes inpatient medicines as well as outpatient medicines. See the note on Netherlands (Kingdom of the) in Fig. 1.

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



Out-of-pocket payments affect people differently

Looking at financial hardship alongside data on unmet need underlines the way in which averages conceal major differences in impact.

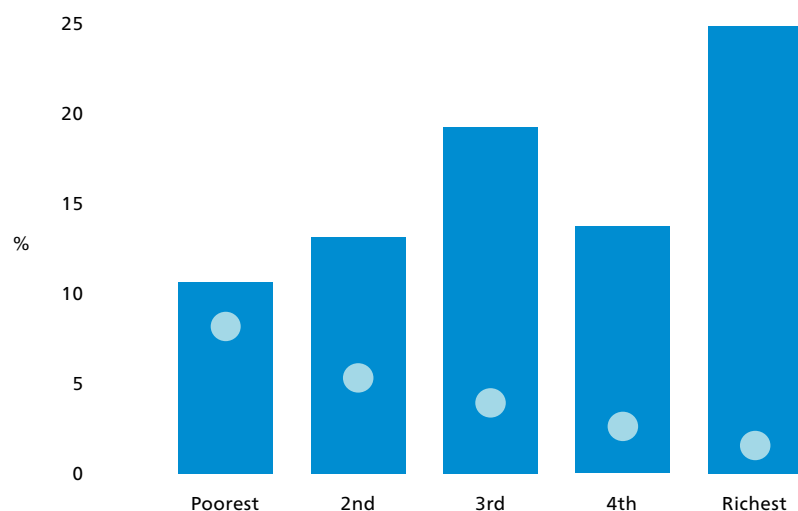
Where the incidence of catastrophic health spending is high, levels of unmet need for health care, dental care and prescribed medicines are generally also high, with higher levels of income inequality. This suggests that health care is not affordable in these countries.

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

In contrast to health care, unmet need for dental care and prescribed medicines – and income inequality in unmet need – are often quite high in countries with a low incidence of catastrophic health spending. This suggests that dental care and prescribed medicines are not as affordable as the financial hardship indicators imply, and especially so for poorer households. As a result, the barriers to access posed by out-of-pocket payments for dental care and prescribed medicines require policy attention and efforts to improve access should prioritize poorer households.

The idea that out-of-pocket payments for different types of health care affect richer and poorer people differently is clearly illustrated using the case of dental care (Fig. 4). Dental care is often a larger driver of financial hardship (the columns) in richer households, which reflects higher levels of unmet need for dental care (the dots) in poorer households.

Fig. 4. Dental care as a share of out-of-pocket payments in households with catastrophic health spending and the share of people reporting unmet need for dental care due to cost, distance and waiting time by quintile, 2019 or the latest available year before



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

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

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

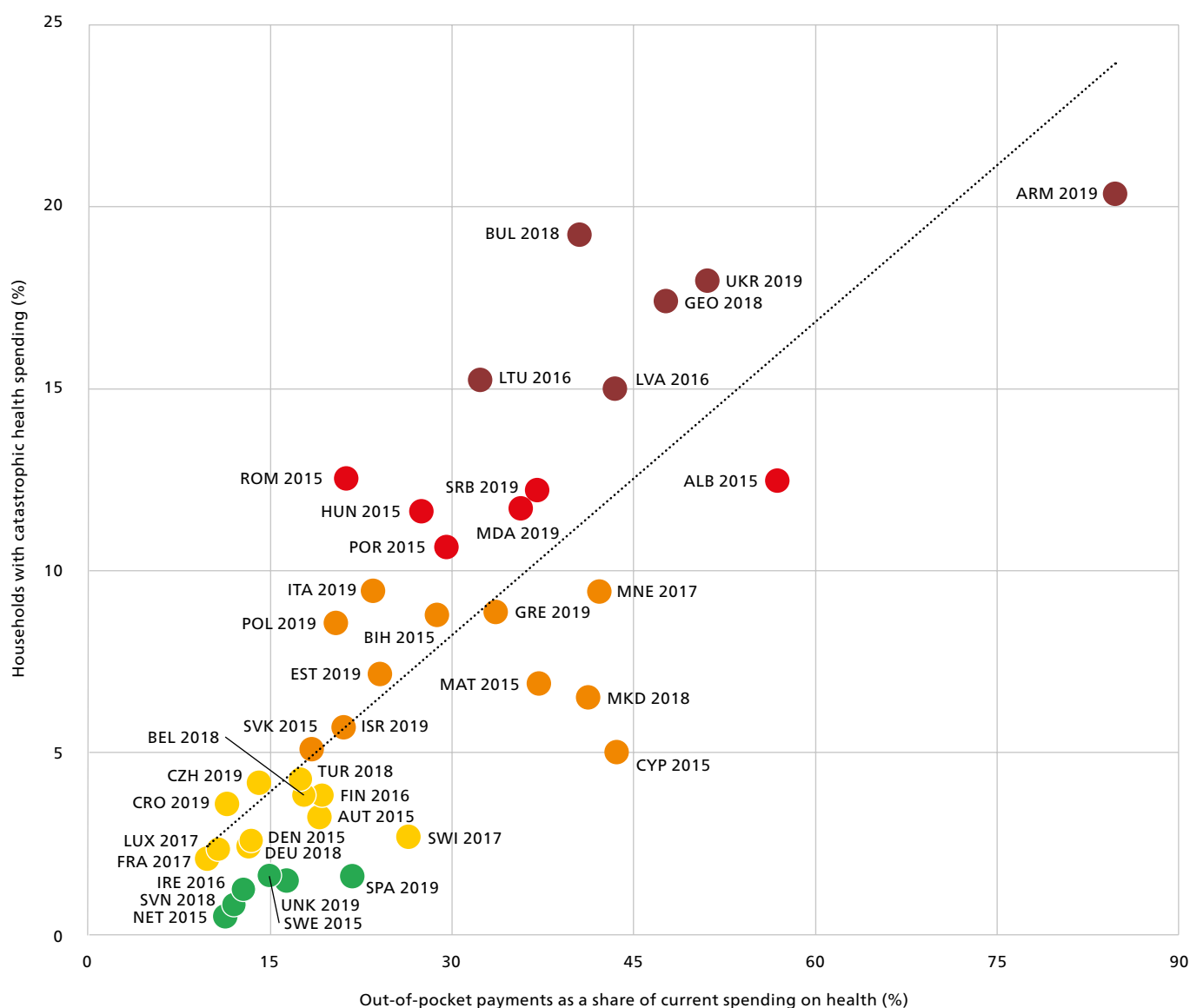
Health systems need to reduce their reliance on out-of-pocket payments

The incidence of catastrophic health spending is closely linked to a health system's reliance on out-of-pocket payments (Fig. 5). Research shows that countries can reduce their reliance on out-of-pocket payments by increasing public spending on health (Xu et al., 2007; WHO, 2010; Wagstaff et al., 2017; WHO Regional Office for Europe, 2019). Increases in public spending on health or reductions in out-of-pocket payments are not necessarily enough to improve financial protection in all contexts. Policy choices are also important.

Fig. 5. Share of households with catastrophic health spending and out-of-pocket payments as a share of current spending on health, 2019 or latest available year before COVID-19

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year. Dots are coloured by the incidence of catastrophic health spending: green < 2%, yellow < 5%, orange < 10%, red < 15%, dark red 15%+. See the note on Netherlands (Kingdom of the) in Fig. 1.

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



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

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

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

People can be exposed to out-of-pocket payments, financial hardship or unmet need when there are gaps in any of these three dimensions – for example, when:

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

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

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

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

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

1. Avoid basing entitlement on payment of contributions

Many countries in Europe have significant gaps in population coverage (Fig. 6). Only 23 of the countries in the study (those on the left of Fig. 6) report universal (100%) or near universal (99%) coverage. The rest (on the right of Fig. 6) show significant gaps in coverage.

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

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

Larger gaps in population coverage are heavily concentrated in countries with SHI schemes that choose to link entitlement to payment of contributions (the red columns in Fig. 6). These countries penalise people who do not pay the required contributions by restricting their access to some or all publicly financed health care. This approach is most likely to cause significant gaps in coverage in countries with weak tax systems and a sizeable informal economy (Yazbeck et al., 2020; Gabani Mazumdar & Suhrcke, 2023; Yazbeck et al., 2023). Non-covered people typically find it difficult to pay contributions because they lack work or their work is precarious – self-employed people, people working in the informal economy, unemployed people, migrants and homeless people. Precarious employment is a growing problem in Europe (Directorate-General for Internal Policies of the Union (European Parliament), Broughton & Eichhorst, 2016).

By choosing to exclude or limit coverage for people who do not pay SHI contributions, countries are using the health system to tackle a taxation problem. There is no evidence to suggest that the health sector is effective in addressing weaknesses in tax collection or reducing labour market informality (Pagés, Rigolini & Robalino, 2013). In countries that base entitlement on residence (the blue columns in Fig. 6), responsibility for the non-payment of contributions and other taxes is delegated to the tax agency.

Linking entitlement to payment of contributions is cyclical, unfair and wastes resources. It is likely to limit coverage in a recession, undermining household and health system resilience to shocks. Most SHI schemes are supported by transfers from the government budget, which means that people are denied access to SHI benefits even though they are helping

to finance the SHI scheme through taxes on goods, property or income. Having to define and administer two benefits packages – one for covered people and another for non-covered people – wastes resources.

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

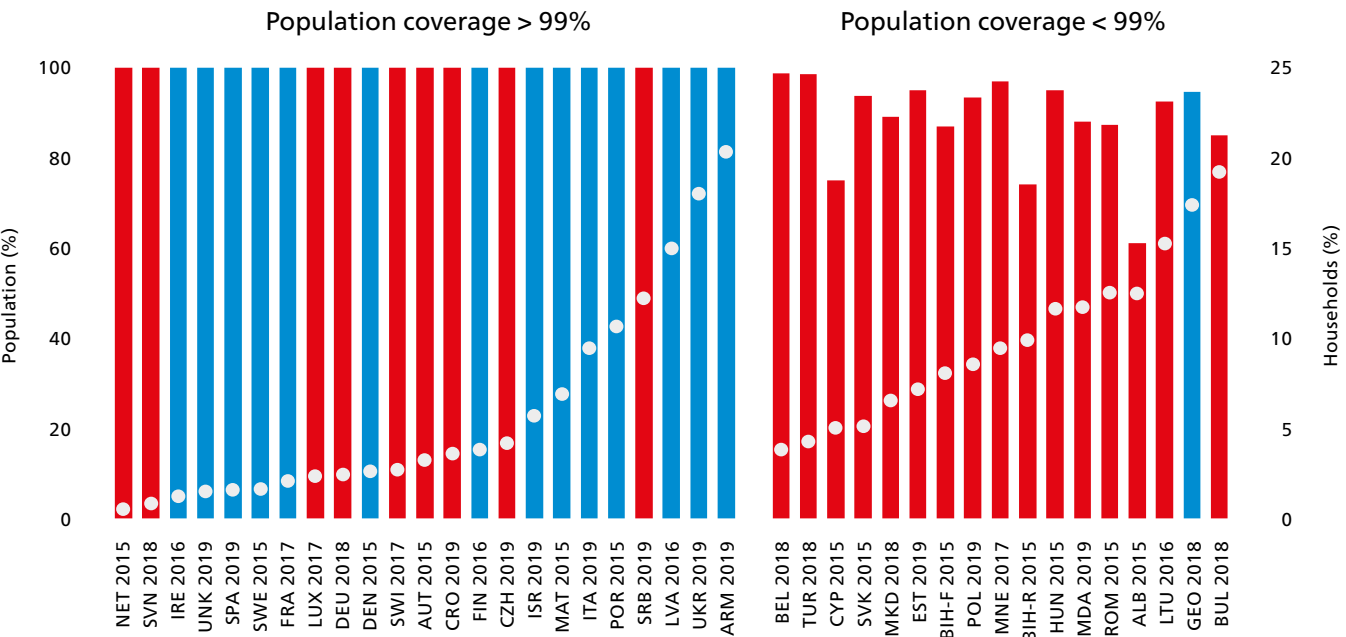
Countries can break this link without changing the way in which they raise revenue or purchase health care.

Fig. 6. Population coverage, the main basis for entitlement to publicly financed health care and catastrophic health spending, 2019 or latest available year before COVID-19

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

Notes: the share of the population covered is for the same year as catastrophic health spending and may not reflect the current situation. Authorities in Bosnia and Herzegovina report different levels of population coverage for the Federation of Bosnia and Herzegovina, Bosnia and Herzegovina (BIH-F) and Republika Srpska, Bosnia and Herzegovina (BIH-R). The figure excludes Greece because we could not find published data on the share of the population covered by the SHI scheme. See the note on catastrophic health spending in Netherlands (Kingdom of the) under Fig. 1.

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



2. Avoid excluding people from coverage

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

Basing entitlement on legal residence mainly excludes undocumented migrants but can also harm refugees and asylum seekers. In many countries entitlements for undocumented migrants are limited to emergency care (Spencer & Hughes, 2015). Refugees and asylum seekers often have similar entitlements to other residents, but all three groups are likely to face administrative and other barriers to accessing entitlements (WHO Regional Office for Europe, 2023b).

Excluding refugees, asylum seekers and undocumented migrants leads to a less visible gap in population coverage. They account for a very small share of the population (Connor & Passel, 2019) and countries often report covering the whole population even when they do not cover undocumented migrants (OECD, 2023).

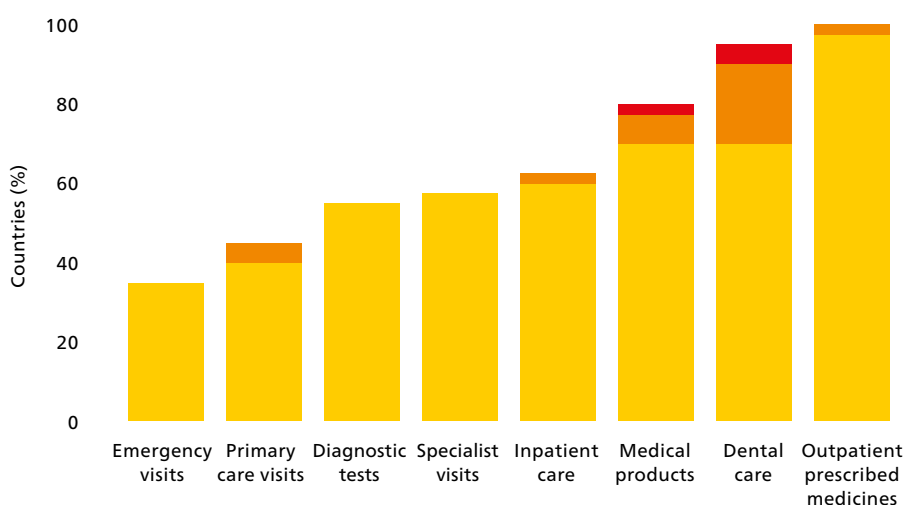
This policy choice harms people with low incomes and undermines health system equity, efficiency and resilience – but it does not have to be this way. Countries like Spain and (to a lesser extent) France grant undocumented migrants similar benefits to other residents, setting an important example. Even in these countries, however, administrative and other barriers prevent people from accessing their entitlements (Bricard, in press; Urbanos-Garrido et al., 2021).

3. Avoid applying user charges without effective protection mechanisms

A large body of evidence shows that user charges (co-payments) are not an effective way of directing people to use health services more efficiently. Even relatively small user charges can deter people from using needed health care, reduce adherence to treatment, increase the use of other health services, lead to financial hardship, increase the use of social assistance and adversely affect health, particularly in people with low incomes or chronic conditions (Tamblyn et al., 2001; Goldman, Joyce & Zheng, 2007; Chernew & Newhouse, 2008; Chandra, Gruber & McKnight, 2010; Persaud et al., 2019; Madden et al., 2021; Rättö & Aaltonen, 2021; Aaltonen, Niemelä & Prix, 2022; Guindon et al., 2022; Gross, Layton & Prinz, 2022; Fusco et al., 2023).

Despite this evidence, user charges are widely applied in Europe, most often to treatment in primary care settings. While many countries rightly avoid applying user charges to outpatient visits and inpatient care, all apply charges to outpatient prescribed medicines and most apply charges to medical products and dental care (Fig. 7).

Fig. 7. User charges for health care in 40 countries in the WHO European Region, 2019 or latest available year before COVID-19



- Not covered at all
- Not covered for some people
- User charges are applied

Note: the range of covered diagnostic tests, medical products, dental care and outpatient prescribed medicines varies substantially across countries.

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

User charges are a source of financial hardship, especially when mechanisms to protect people are absent or poorly designed. Fig. 8 shows that catastrophic health spending is lower in countries that give greater protection from user charges to people with low incomes. Almost all countries with a lower incidence of catastrophic health spending (below the median of 6% of households) exempt people with low incomes from co-payments or have a cap that is linked to income (so that it is more protective for people with low incomes) or (in three cases only) provide free voluntary health insurance covering co-payments to people with low incomes. In contrast, there is no cap at all in most of the countries with a higher incidence of catastrophic health spending.

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

It does not have to be this way. User charges can be carefully re-designed to reduce the likelihood of financial hardship and unmet need in the following ways:

- exempting people with low incomes or chronic conditions from all user charges;
- applying an income-based cap to all user charges;
- replacing percentage co-payments with low fixed co-payments;
- avoiding or abolishing balance billing and extra billing; and
- being as simple as possible, protecting people rather than diseases and minimizing administrative barriers.

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

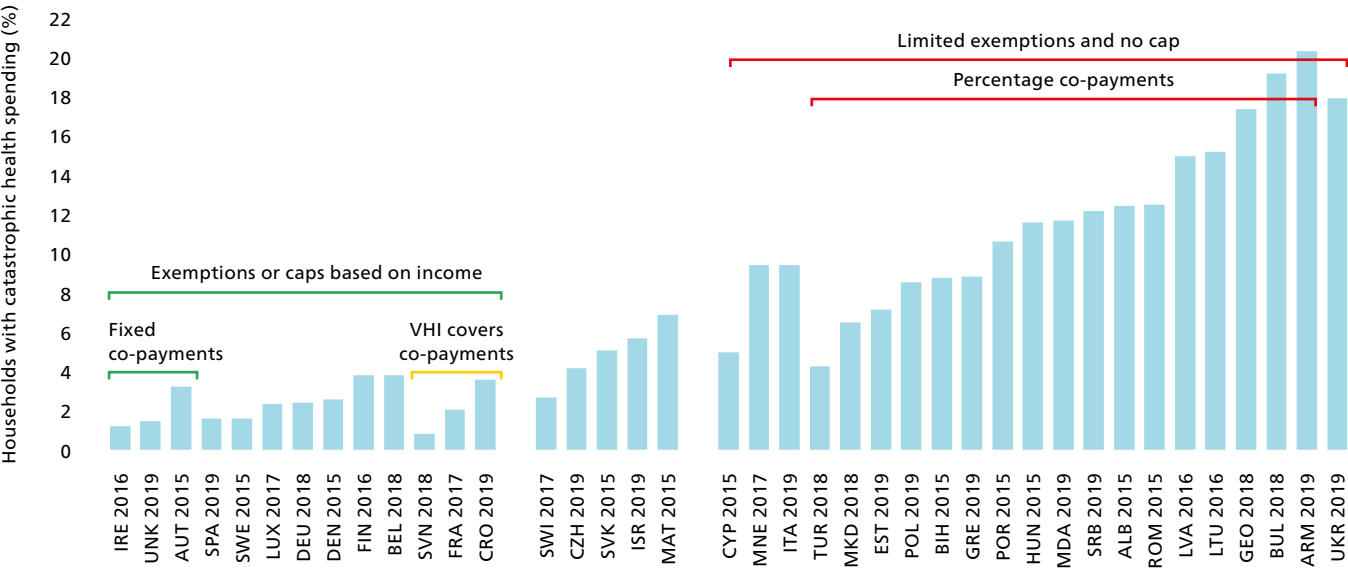
Some countries may lack the administrative infrastructure to exempt people with low incomes or apply income-based caps. These countries should avoid introducing user charges in the first place. If they have them already, they should use very low, fixed co-payments instead of percentage co-payments.

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

Fig. 8. The design of user charges for outpatient prescribed medicines and catastrophic health spending, 2019 or latest available year before COVID-19

Note: the design of co-payments is for the same year as catastrophic health spending and may not reflect the current situation.

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



4. Avoid failing to cover treatment in primary care settings

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

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

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

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

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

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

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

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

VHI generally increases inequality in access to health care. It is consistently more likely to be taken up by richer than poorer households (Sagan & Thomson, 2016; Thomson, Sagan & Mossialos, 2020).

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

Other countries are unlikely to be able to replicate the relative success of VHI covering user charges in Croatia, France and Slovenia, which comes at a cost. VHI is accessible due to extensive government intervention in all three countries. It is affordable for many because it is heavily subsidized by the government for people with low incomes in Croatia and France and heavily subsidized by employers in France. In Slovenia households with very low incomes are exempt from user charges and do not need VHI.

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

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

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

Progress is possible – a checklist for policy-makers

Drawing on evidence and good practice from across Europe, the report identifies policy choices that have been effective in strengthening financial protection in countries with a low incidence of financial hardship and unmet need (Table 1).

Table 1. A financial protection checklist for policy-makers

Source: authors.

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

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

Because the financial hardship and unmet need caused by out-of-pocket payments are heavily concentrated among people with low incomes, progress towards UHC means reducing out-of-pocket payments for the most disadvantaged people in society first – an approach known as progressive universalism (Gwatkin & Ergo, 2011). Progressive universalism is vital in contexts where public resources for health are limited or under pressure. It also offers countries a way of strengthening their resilience to shocks: if coverage policy is designed to provide enhanced protection for those most in need, health systems and households will be better able to face economic or health crises.

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

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

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