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Can people afford to pay for health care?

New evidence
on financial protection
in Albania

Florian Tomini
Sonila M. Tomini



Albania

WHO Barcelona Office for Health Systems Strengthening

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Abstract & keywords

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.

ALBANIA
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 Strengthening, part of the Division of Health Systems and Public Health 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 the WHO Regional Office for 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?

WHO support to Member States for monitoring financial protection in Europe is underpinned by the Tallinn Charter: Health Systems for Health and Wealth, Health 2020 and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020, all of which include a commitment to work towards a Europe free of impoverishing out-of-pocket payments for health. Resolution EUR/RC65/R5 calls on WHO to provide Member States with tools and support for monitoring financial protection and for policy analysis, development, implementation and evaluation. 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. The Sustainable Development Goals (SDGs) adopted by the United Nations in 2015 also call for monitoring of, and reporting on, financial protection as one of two indicators for universal health coverage. Resolution EUR/RC67/R3 – a roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020 – calls on WHO to support Member States in moving towards universal health coverage.

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

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Abbreviations

EHIS	European Health Interview Survey
EU	European Union
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	Gross domestic product
GP	General practitioner
IDRA	Institute for Development, Research and Alternatives
INSTAT	Institute of Statistics
LSMS	Living Standards Measurement Study
MHIF	Mandatory Health Insurance Fund
OECD	Organisation for Economic Co-operation and Development
PPP	Purchasing power parity
SDG	Sustainable Development Goal
VHI	Voluntary health insurance

Executive summary

This review analyses financial protection in Albania. Drawing on microdata from household budget surveys carried out by the Albanian Institute of Statistics in 2009 and 2015, it finds that:

- in 2015, 12.5% of households experienced catastrophic out-of-pocket payments;
- catastrophic spending affects the poorest households the most: it is also heavily concentrated among people aged over 60 years and households with children; and
- outpatient medicines are the main driver of catastrophic spending for all except the richest fifth of the population.

Between 2009 and 2015, out-of-pocket payments grew substantially, driven largely by higher household spending on outpatient medicines. In 2016, out-of-pocket payments accounted for over 50% of total spending on health – a very high share that reflects limitations in the design of health coverage and low levels of public investment in the health system.

Health coverage in Albania is provided through the mandatory health insurance system administered by a single purchasing agency, the Mandatory Health Insurance Fund (MHIF). For employees and other economically active people, entitlement to MHIF benefits is linked to payment of contributions. The MHIF covers only around two thirds of the population.

Uninsured people are entitled to free emergency care (since 2013), a free basic health check-up once a year (since 2015) and free visits to general practitioners (GPs, since 2017). They must pay out of pocket for all other health services, including medicines and diagnostic tests and non-emergency specialist care.

For insured people, the MHIF benefits package is much more comprehensive. GP visits and outpatient specialist visits and inpatient care with referral are free at the point of use. The main gaps in coverage come from the exclusion of dental care for adults and from co-payments for outpatient prescribed medicines, medical products and some diagnostic tests.

Out-of-pocket payments also occur when people use private facilities or have to pay informally in public facilities. Informal payments are widespread, particularly for inpatient care, and are likely to impose a heavy financial burden on poorer households. There is some evidence to suggest they have fallen over time, however.

In addition to causing financial hardship for households, out-of-pocket payments also lead to high levels of unmet need for health and dental care.

To improve access and financial protection in Albania, policy should focus on:

- closing the significant gap in population coverage by delinking entitlement to MHIF benefits from payment of contributions: basing entitlement on payment of contributions is challenging given the large informal sector in Albania;
- reducing the financial hardship caused by out-of-pocket payments for outpatient medicines by: exempting low-income households from all co-payments; introducing an annual income-related cap on all co-payments; replacing percentage co-payments with low fixed co-payments; strengthening the way in which medicines are selected for coverage; and ensuring that physicians, pharmacists and people are able to prescribe, dispense and use the cheapest alternatives;
- monitoring and addressing informal payments in outpatient and inpatient public facilities; and
- supporting changes to coverage policy by investing more publicly in the health system: the share of the government budget allocated to health is low by European standards (9.5% in Albania in 2016, compared to 12.5% for the WHO European Region and 14.1% in European Union countries) and should be increased.

1. Introduction

This review assesses the extent to which people in the Republic of Albania experience financial hardship when they use health services, including medicines. Research shows that financial hardship is more likely to occur when public spending on health is low in relation to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; 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, however. Policy choices are also important.

Albania has experienced steady economic growth since its transition to a market economy and was classified as an upper middle-income country in 2009. The global financial crisis severely affected Albania, however; remittances and other inflows declined sharply, slowing the rate of growth in GDP.

Since the transition, Albania has endeavoured to advance its health system, with reforms mainly aiming to improve the quality and outcomes of service delivery, strengthen the financing, management and governance of the system, and enhance efficiency (Nuri, 2002). Despite these reform efforts, public spending on health has been consistently low, accounting for just under 3% of GDP in 2019; as a result, the out-of-pocket share of current spending on health has also consistently been among the highest in Europe, accounting for nearly 58% of total spending on health in Albania in 2016 (WHO, 2019).

Several studies have analysed out-of-pocket spending and informal payments in Albania, some focusing on Albania (Tomini et al., 2012a, 2012b, 2013, 2015; Vian & Burak, 2006; World Bank, 2011) and some including Albania as part of regional-level analysis (Mendola et al., 2007; Bredenkamp et al., 2011; Habibov & Cheung, 2017; World Bank, 2012). These studies generally show that out-of-pocket spending has increased over time, escalating the risk of financial hardship for households. They also suggest that informal payments are widespread. Earlier studies of financial protection in Albania used data from the World Health Survey carried out in 2002–2003 and from the Albania Living Standards Measurement Study (LSMS) up to 2008 (Yerramilli et al., 2018). This study is the first to use data from Albania's household budget survey. It is also the most up to date, drawing on data for 2009 and 2015.

The 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 of household budget survey data, 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 and Annex 3 regional and global financial protection indicators. Annex 4 contains a glossary of terms.

2. Methods

This section summarizes the study's analytical approach and its 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

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

Source: WHO Regional Office for Europe (2019)

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

2.2 Data sources

The study analysed anonymized microdata from the Albanian household budget survey conducted by the Institute of Statistics of Albania in 2008–2009 and 2015. Data were collected from 5599 households from October 2008 to September 2009 and from 6532 households from January to December 2015.

All currency units are presented in Albanian lek and converted into euro PPPs (purchasing power parity) where relevant.

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) and reviews the role played by voluntary health insurance (VHI). 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

The right to equal health care is embedded in the Albanian Constitution. Article 55 states that *"Citizens enjoy in an equal manner the right to health care from the state"* (Official Government of the Republic of Albania, 1998) and ensures the right to health insurance *"... with the procedure provided by the law"* (Official Government of the Republic of Albania, 1998).

The Mandatory Health Insurance Fund (MHIF) was established in 1995 as a single purchasing agency (Nuri, 2002). Primary care was the main type of service being purchased initially, but hospital care has also been purchased since 2010.

A new law on mandatory health-care insurance (Law 10383, dated 24 February 2011) took effect in 2013. It guarantees entitlement to MHIF benefits for economically active and inactive people. The MHIF is financed through a mix of payroll taxes and general tax revenues, which it pools and uses to purchase services from contracted public and private providers.

3.1.1 Population entitlement

The basis for entitlement to MHIF benefits is payment of contributions. The 2013 law specifies that MHIF membership is mandatory for employees and other economically active persons, who must pay contributions to the tax authority to obtain MHIF benefits. The Government transfers funds to the MHIF to cover people who are economically inactive, such as children aged under 18 years, students under 25 years, pensioners (the retirement age is 65 years for men and 60 years for women), people registered to receive social assistance or disability benefits, registered unemployed people, asylum seekers and a few other categories set out in special laws. MHIF membership is voluntary for self-employed people, small family businesses and farmers. The MHIF calculates and collects voluntary contributions for self-employed people and people who are not registered as social beneficiaries.

People covered by the MHIF are entitled to the full range of MHIF benefits and can access these benefits if they hold a valid health insurance card. The electronic health insurance card was introduced in 2015, replacing a paper booklet.

The MHIF does not cover more than two thirds of the population; a 2015 World Bank report put the figure at 61% of the population covered on average and 50% among the poorest quintile (World Bank, 2015). In

2019, contributions accounted for about a third of the MHIF's revenue. This level of population coverage is particularly low given Albania's very young population: people of working age accounted for 69% of the total population in 2019 (Institute of Statistics of Albania (INSTAT), 2018).

Uninsured people are entitled to publicly financed emergency care. Since 2015, people aged between 40 and 65 years have also been entitled to a free annual health check-up regardless of insurance status or possession of a health insurance card. In 2017, the check-up was extended to people aged between 35 and 70 years (around 1.2 million people or 41% of the total population) and in 2017, uninsured people were given entitlement to free visits to general practitioners (GPs).

Linking the basis for entitlement to payment of contributions rather than residence leads to a two-tier system of access to health care. Those not able to obtain MHIF benefits tend to be informal workers, poor people, minorities (Roma people) and people living in deprived areas (rural and peri-urban areas). These groups may face further disadvantages if they are not fully aware of their entitlements or encounter difficulties in navigating the health system.

3.1.2 The benefits package

The publicly financed benefits package is defined by the MHIF and includes services provided by a combination of public and contracted private primary-care centres and hospitals and contracted providers of medicines, medical products and other treatment.

Primary-care centres are contracted to provide emergency care, services for children and adults, services for women and reproductive health, services for older people, mental health services, health promotion and health education. The free annual check-up for people aged between 35 and 70 years (roughly 43% of the population), which became operational in 2015, aims to facilitate early detection of disease and tackle common risk factors. People in this age range receive an annual invitation to a check-up usually carried out by a nurse, which includes an assessment of risk factors, counselling and selected diagnostic tests for chronic conditions including cardiovascular disease, diabetes, chronic respiratory diseases and some types of cancer. People diagnosed with a condition can then either access inpatient care following the referral system or go directly to a specialist. In either case, user charges (co-payments) apply. The check-up is delivered through a private provider under a concession agreement with the Government. According to the MHIF, the total number of annual check-ups in 2019 was 483 000, which suggests that about 39% of the target population benefited. In 2017, free GP visits were extended to the whole population regardless of insurance status.

Access to publicly financed **outpatient specialist care** requires a GP referral. Most publicly financed outpatient specialist care is provided in outpatient clinics usually attached to hospitals, except in Tirana, where outpatient clinics are separate from the hospital.

Dental care is not covered for most adults. Children and young people aged under 18 years, students under 24 years and people receiving social assistance are entitled to dental care in public facilities; these mainly offer preventive services. Most dental treatment is provided in private facilities and people must pay the full cost of care.

The list of covered **outpatient medicines** is formulated by the MHIF and approved by governmental decree. The list has expanded over time, rising from 278 medicines in 1996 to 402 in 2005, 409 in 2008, 477 in 2014, 489 in 2015 and 540 in 2018 (Beci et al., 2015; MHIF, 2016, 2018). Although the MHIF obliges physicians to prescribe the cheapest generic alternatives available, pharmacists may influence patients to buy more expensive alternatives imported from European Union (EU) countries. Most medicines are imported from the EU, the United States of America, Canada and Israel and, since 2015, from Turkey and Balkan countries. All pharmacists are private facilities.

Access to some **inpatient care** services changed in 2014, with implementation of the 2011 law that extended coverage to selected health-care services provided in private facilities. These services cover nephrology and cardiac procedures and are grouped in 10 packages: dialysis, kidney transplantation, acute rejection therapy, definitive pacemaker placement, coronary angiography, angioplasty, valve interventions, congenital interventions, coronary bypass surgery and cochlear implant for children with hearing problems.

The MHIF benefits package is relatively comprehensive; the main gap in service coverage is dental care for adults. However, the health sector is characterized by informal payments, particularly in inpatient care settings, suggesting funding shortages and other problems in service delivery. Quality of care is another significant concern (Bredenkamp et al., 2011; Tomini et al., 2012a, 2012b, 2013; World Bank, 2015).

3.1.3 User charges (co-payments)

Changes in the legislation during the early transition years introduced user charges (co-payments) for services in primary care (excluding special categories) and prescribed outpatient medicines and medical products included in the list of covered medicines. User charges subsequently were extended to (some) expensive medical examinations and laboratory tests. Changes to coverage policy are summarized in Table 2.

Table 2. Changes to coverage policy, 2009–2020

Source: authors.

Year	Change	Health service	Population group affected
2009	Enforcement of user charges in primary care	Primary care	Whole population
2010	Introduction of user charges for inpatient care	Inpatient care	People without referral
2010	Introduction of user charges for selected diagnostic tests	Diagnostic tests	Whole population
2013	Basis for entitlement changed from residence to payment of contributions	MHIF benefits	Economically active people
2015	Free (basic) annual health check-up for all people aged 40–65 years regardless of insurance status	Primary care	Whole population
2015	Provision of some MHIF-financed specialist inpatient care through private providers	Inpatient care	Insured people
2017	Free (basic) annual health check-up for all people aged 35–70 years regardless of insurance status	Primary care	Whole population
2017	Removal of user charges for GP visits	Primary care	Whole population
2017	Diagnostic test prices reduced	Diagnostic tests	Insured people
2017	Co-payments for generic options reduced for medicines for some chronic conditions	Outpatient medicines	Insured people

Table 3 gives details of the current system of user charges. Since 2017, **GP visits** have been free of charge for the whole population irrespective of insurance status. **Outpatient specialist** visits with a GP referral are free of charge for people covered by the MHIF. People without a GP referral pay out of pocket based on tariffs set by the Ministry of Health; tariffs vary by service (Table 3).

Outpatient prescribed medicines fall into six therapeutic groups with different coverage levels. Percentage co-payments range from 0% to 50% of a reference price. The internal reference pricing system was set up in 2001. If the pharmacy retail price of the medicine exceeds its reference price (based on the lowest-priced generic option), the patient must pay the difference in addition to the percentage co-payment (WHO Regional Office for Europe, 2018). Pensioners, war veterans and children below 1 year of age are exempt from co-payment for the lowest-priced generic version of any covered medicine (Vogler et al., 2018). Additional measures to provide full coverage of outpatient medicines for some chronic conditions (based on the lowest-priced option) were introduced in 2017.

Most **diagnostic tests and paramedical services** are free of charge in public facilities with referral for people covered by the MHIF. Many people, however, turn to the private sector for these services due to the lack of well functioning equipment in public hospitals; anecdotal evidence suggests this may also be related to purposive action from health staff who work part-time or are paid under the table by private facilities to refer people.

Inpatient care in public facilities with referral is free of charge for people covered by the MHIF. Five private facilities are also contracted to deliver specialized services for free with referral: dialysis, cardiology and cardiosurgery services, haemodynamic services and cochlear implant.

Inpatient medicines are free of charge in public hospitals, but many people report having to pay out of pocket for medicines and supplies.

People not covered by the MHIF, those without a valid health insurance card and people accessing services without referral pay the full price of outpatient prescribed medicines, diagnostic tests, paramedical services and inpatient care and pay fixed co-payments for outpatient specialist visits. Adults who are not students under 25 years or receiving social assistance must pay for the full cost of dental care in private facilities.

There is a system of exemption from user charges for specific groups of people (Table 3), but there are no exemptions for low-income households and no annual caps on user charges for any publicly financed health services.

Studies show that **informal payments** are widely used to pay health workers; for example, in 2008, almost 19% of all patients visiting ambulatory services and 44% of patients visiting hospitals made an informal payment, while in 2010, 65.2% of patients paid informally when using public health facilities (Tomini et al., 2013, 2015; Habibov & Cheung, 2017). Some studies also indicate that people must pay out of pocket for medicines in hospitals, even though they are in theory free for people covered by the MHIF (Tomini et al., 2013, 2015). Informal payments are covered in more detail in section 4.2.

Table 3. User charges for publicly financed health services, 2020

Note: user charges for outpatient visits are for 2015.

Source: authors, based on information from the MHIF.

Service area	Type and level of user charge	Exemptions	Cap on user charges paid
Outpatient visits	None: insured people with referral Fixed co-payments: uninsured with referral pay 100 lek (€1.70 PPP) in policlinics or municipal or regional hospitals and 500 lek (€8.60 PPP) in tertiary hospitals Fixed co-payments: without referral, all patients regardless of insurance status pay: 1500 lek (€25.70 PPP) in policlinics or district hospitals; 2000 lek (€34.30 PPP) in regional hospitals; and 3000 lek (€51.50 PPP) in tertiary hospitals	No	No
Outpatient prescription medicines	Percentage co-payments ranging from 0% (Group I) to 50% (Group VI)	Pensioners, disabled people, children aged below 1 year, people with cancer, tuberculosis, blindness and other conditions (such as thalassaemia, multiple sclerosis, transplants, growth hormone deficiency), veterans and people invalidated through war	No
Diagnostic tests and other paramedical services	None: most examinations in public facilities Percentage co-payment: 10% for selected tertiary examinations (such as magnetic resonance imaging, other scans, lithotripsy, angiography, mammography, coronarography) Users pay the full price: uninsured people and people without referral	Pensioners, disabled people, children aged below 1 year, people with cancer, tuberculosis, blindness and other conditions (such as thalassaemia, multiple sclerosis, transplants, growth hormone deficiency)	No
Medical products	None: supplies on the positive list for medical aids Users pay the full price: supplies not on the positive list	As for outpatient prescription medicines	No
Dental care	Adult users pay the full price: treatment and materials	In public facilities: children aged under 18 years, students aged under 24 years and people receiving social assistance	No
Inpatient care	None: with referral in public facilities and in contracted private facilities for insured people Adult users pay the full price: uninsured people and people without referral (mostly for specialist visits for day treatment at outpatient clinics in hospitals; there are no tariffs for hospitalizations)	Few services are contracted from private providers (such as haemodialysis) and offered at no charge Additional health packages funded by the MHIF in private hospitals (angiography, angioplasty, aorta-coronary bypass, biological valve replacement, monovalve with mechanical prosthesis, monovalve with biological prosthesis, bivalve with mechanical prosthesis, kidney transplantation, acute rejection therapy, fistula placement, graph placement)	No
Inpatient prescription medicines	None: inpatients in public hospitals Adult users pay the full price: although there are no formal user charges, most patients report having to purchase their own medicines in hospital	No	No

3.1.4 The role of VHI

VHI plays almost no role in the health system. People prefer to pay providers out of pocket when they need health care rather than paying premiums for VHI on a regular basis.

Table 4 highlights key issues in the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

Table 4. Gaps in coverage

Source: authors.

	Population entitlement	The benefits package	User charges
Issues in the governance of publicly financed coverage	Entitlement depends on payment of contributions	Benefits not backed by adequate public funding, leading to informal payments	Complex co-payment policy, which lowers transparency Weak protection from co-payments: although exemptions are widespread, they are not based on income, so poor people are not automatically exempt, and there are no annual caps on co-payments
Main gaps in publicly financed coverage	People not covered by the MHIF tend to be informal workers, poor people, those from minority communities and people living in deprived areas; these people are entitled to publicly financed emergency care, GP visits and an annual basic health check-up	Dental care for adults; widespread informal payments for services and supplies that should be free of charge, which place a greater financial burden on poorer people	High percentage co-payments for outpatient prescribed medicines for covered people
Are these gaps covered by VHI?	No; the VHI market is neither developed nor comprehensive	No	No

3.2 Access, use and unmet need

Data on unmet need for health care (Box 1) come from the Albania LSMS carried out in 2005, 2008 and 2012 and, since 2017, from EU Statistics on Income and Living Conditions (EU-SILC).

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 when using 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 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).

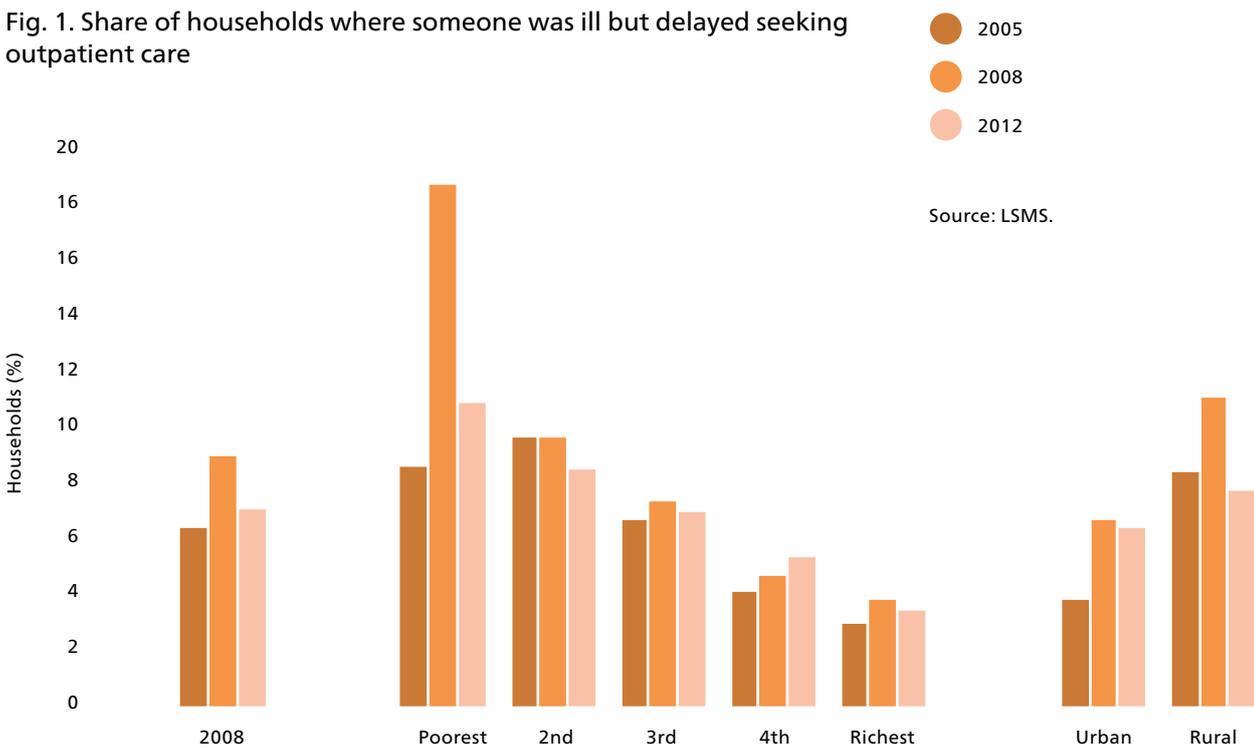
EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS), carried out every five years or so. The second wave of this survey was conducted in 2014. A third wave was launched in 2019.

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.

LSMS data indicate a small improvement in access to health care between 2008 and 2012, particularly for households living in rural areas, perhaps due to internal migration from rural to urban areas (Fig. 1, Fig. 2). There is a sharp socioeconomic gradient in access, with poorer households reporting much higher levels of unmet need than richer households. In 2012, 40% of respondents cited cost as the reason for unmet need for outpatient care and 53% of respondents cited cost as the reason for unmet need for hospital care.

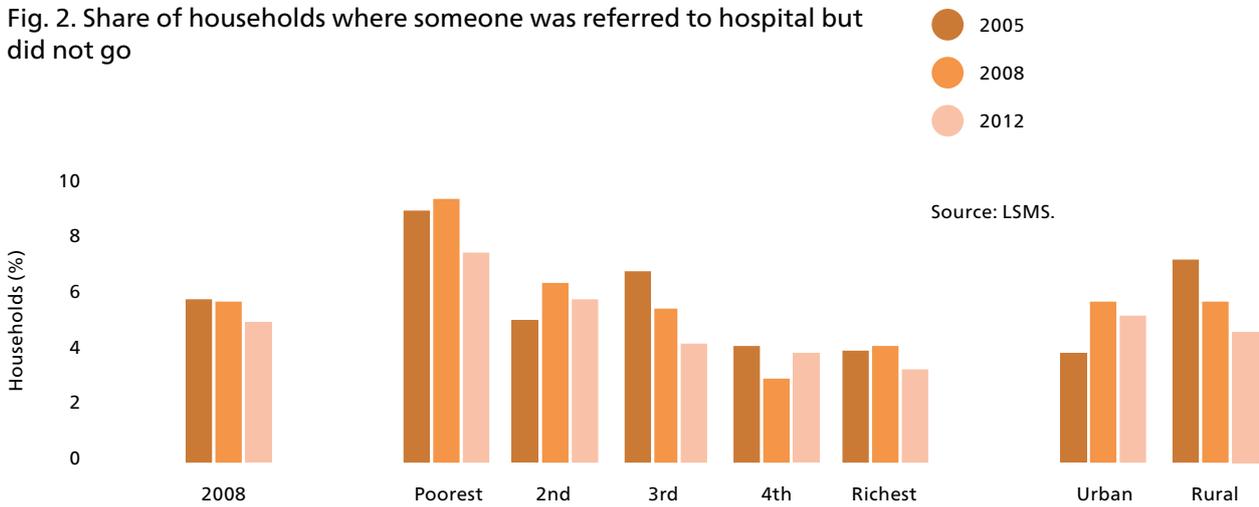
It is important to note that LSMS data on unmet need do not reflect the change in the basis for entitlement to MHIF benefits, which only came into effect in 2013.

Fig. 1. Share of households where someone was ill but delayed seeking outpatient care



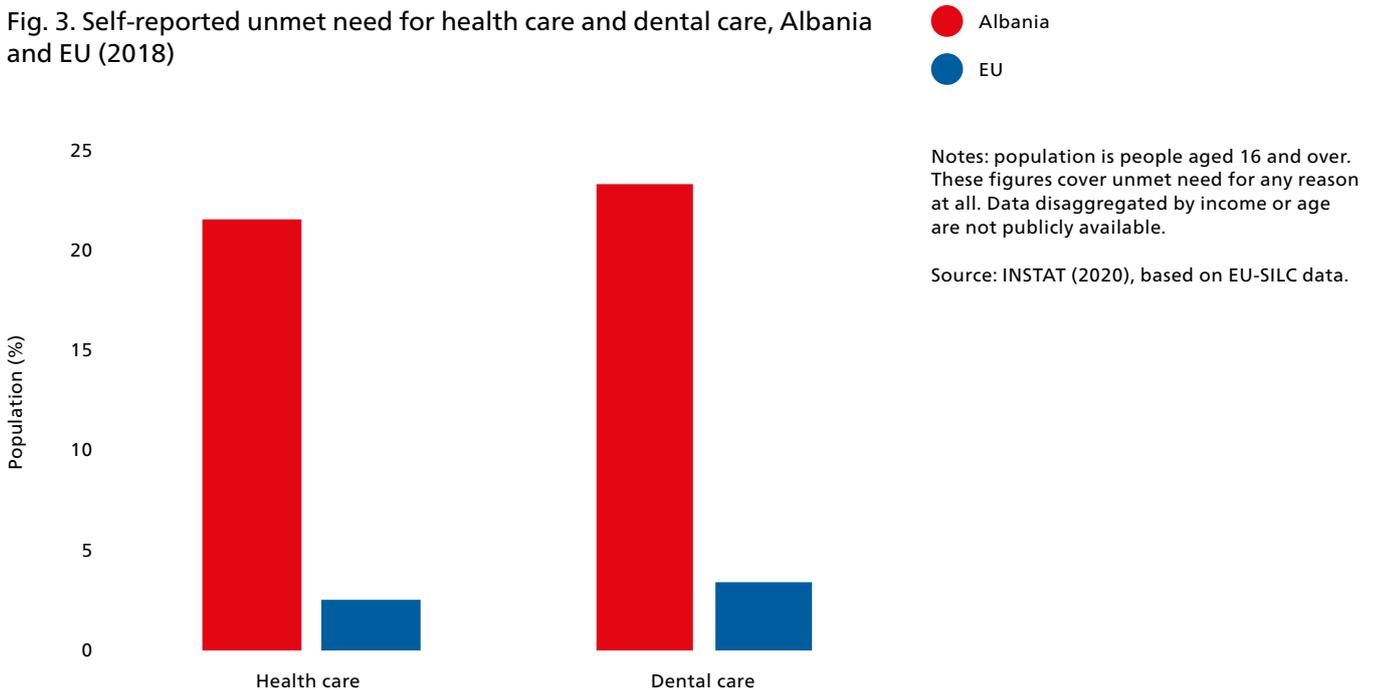
Source: LSMS.

Fig. 2. Share of households where someone was referred to hospital but did not go



Data on unmet need from EU-SILC were published in 2019. EU-SILC and LSMS data are not comparable. The EU-SILC data show that unmet need for health care grew from 19% in 2017 to 21.5% in 2018 and unmet need for dental care grew from 20.5% to 23.6% (Fig. 3). Unmet need is much higher in Albania than the EU average (3% for health care and 4% for dental care in 2018) (Fig. 3). The main cause of unmet need for health care and dental care is cost.

Fig. 3. Self-reported unmet need for health care and dental care, Albania and EU (2018)



Quality of care in public facilities is reported to be low, especially in primary care, and is highly variable across providers and geographic areas (World Bank, 2006). The delaying or foregoing of outpatient care is high in rural areas (Fig. 1), suggesting that service quality in rural facilities may be less good than in urban areas, which would increase out-of-pocket spending if people look for better-quality care and have longer journey times.

With growth in the number of private health-care providers, quality standards need to be strengthened and enforced, especially if the MHIF is to extend contracts to this sector. An accreditation system for public and private hospitals was established in 2018.

Administrative data suggest there were no major changes in the use of hospitals and outpatient services between 2009 and 2015 (INSTAT, 2018). There are no data on the use of medicines during the study period. Administrative data show that while the volume of imported medicines increased only marginally from 4100 tons to 4200 tons between 2008 and 2015, the value of these imports increased from 13.8 billion lek to 19.3 billion lek (INSTAT, 2018).

3.3 Summary

The MHIF only covers about two thirds of the population on average and about half of those in the poorest quintile. Uninsured people are entitled to free emergency care (since 2013), a free annual basic health check-up (since 2015) and free visits to GPs (since 2017). They must pay for everything else out of pocket, leading to substantial inequalities in access to health care and in financial hardship.

Although the publicly financed benefits package is relatively comprehensive, it does not cover dental care for adults; publicly financed coverage of dental care for children, students and people receiving social assistance is limited to treatment in public facilities, even though most dental care is provided by private dentists. The range of products on the list of covered medicines grew between 2009 and 2018 but remains low by European standards.

Outpatient specialist visits and inpatient care with referral are free at the point of use for insured people only. Co-payments are applied to outpatient prescribed medicines, medical products and some diagnostic tests. Although pensioners, people with disabilities, children aged under 1 year and people with selected conditions (cancer, tuberculosis, blindness and other conditions) are exempt from co-payments, there are no exemptions for poor people and no annual caps on co-payments.

The main gaps in coverage are:

- limited entitlement for people lacking MHIF coverage, especially to outpatient medicines and non-emergency specialist care;
- no entitlement to dental care for adults – entitlement for others is limited to public facilities, but most dental treatment takes place in private facilities; and
- extensive user charges in the form of percentage co-payments for outpatient prescribed medicines on the list of covered medicines, and for medical products, diagnostic tests and other paramedical services, with limited protection from co-payments.

VHI plays a very minor role and does not address gaps in publicly financed coverage.

Self-reported unmet need for health care and dental care is a significant problem, with much higher rates in Albania than the EU average and evidence of sharp socioeconomic inequality.

Quality of care in public facilities is a cause for concern: it encourages people to use private facilities, for which they must pay out of pocket.

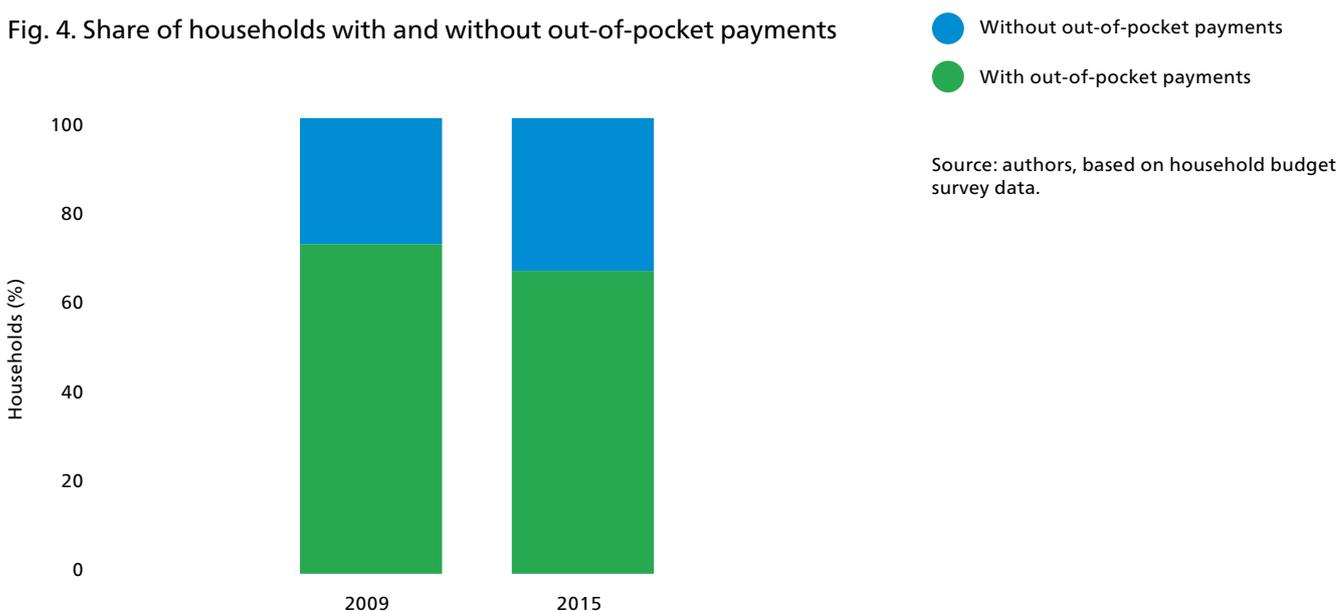
4. Household spending on health

In the first part of this section, data from the household budget survey are used to present trends in household spending on health – that is, out-of-pocket payments, the formal and informal payments made by people at the time of using any good or service delivered in the health system. The section also briefly presents the role of informal payments and the main drivers of change in out-of-pocket payments over time.

4.1 Out-of-pocket payments

In 2015, 66% of households reported out-of-pocket payments, down from 72% in 2009 (Fig. 4).

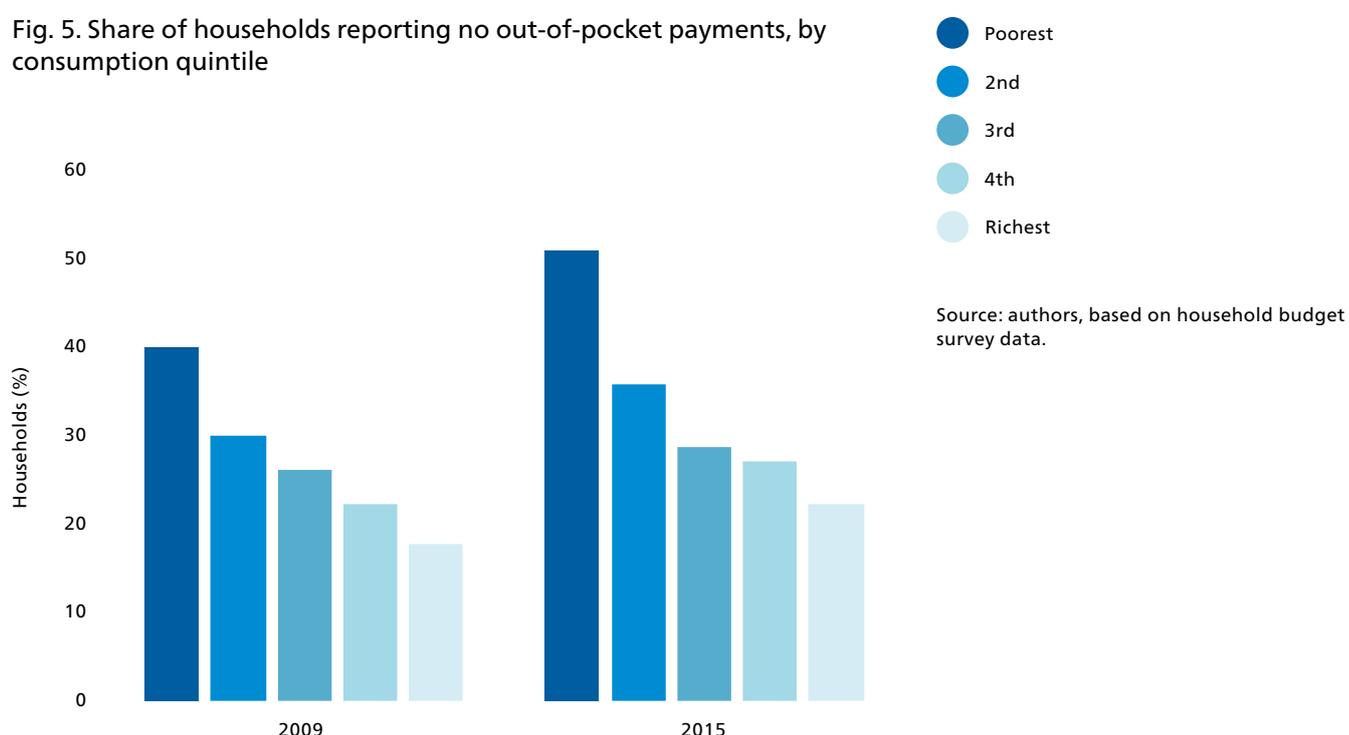
Fig. 4. Share of households with and without out-of-pocket payments



Source: authors, based on household budget survey data.

Households without out-of-pocket payments are more likely to be poor than rich (Fig. 5). In 2015, 52% of households in the poorest quintile had no out-of-pocket payments, compared to 23% in the richest quintile. All quintiles experienced an increase in the share of households without out-of-pocket payments over time, but the increase was largest for the poorest, richest and fourth quintiles.

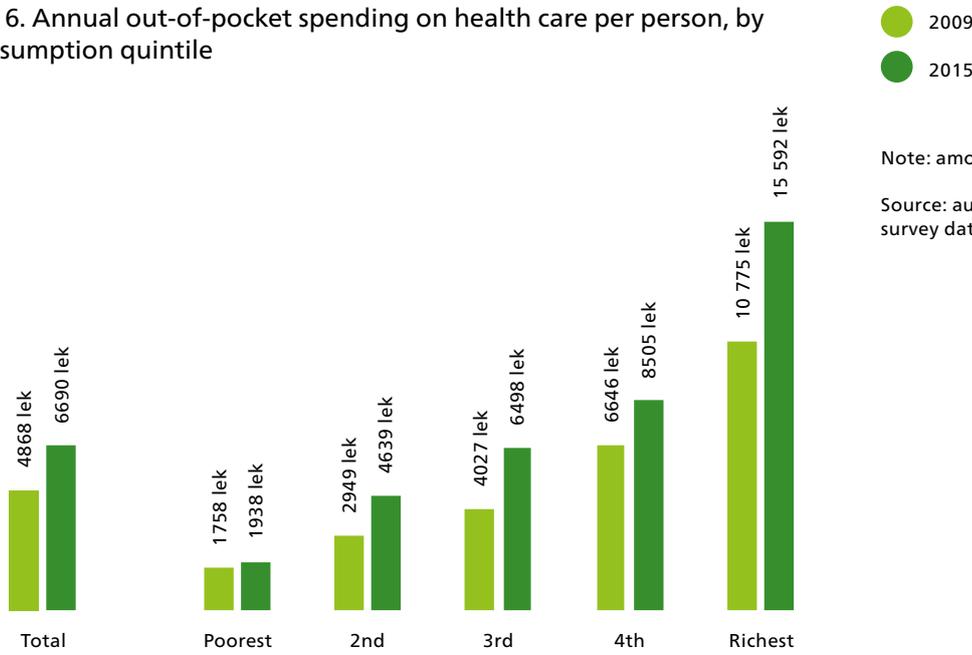
Fig. 5. Share of households reporting no out-of-pocket payments, by consumption quintile



The Albania household budget survey does not include questions on health status, health-service use or unmet need for health care, so it is not possible to say whether these households are not spending on health care due to lack of need for health services, due to exemptions from user charges, or because they face barriers to accessing health care. However, the increase in the share of households with no out-of-pocket payments over time occurred despite no obvious improvement in coverage policy being seen during the study period.

The average nominal annual amount spent out of pocket per person increased from 4400 lek in 2009 to 6690 lek in 2015. In real terms, this was an increase of about 37%, with an annual average growth rate of just over 5%. The increase in out-of-pocket payments was experienced by households in all quintiles, but was smallest for the poorest quintile (Fig. 6). As a result, although richer households spent much more out of pocket than poorer households in both years, the difference in spending between the poorest and richest quintiles was much higher in 2015 than in 2009.

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

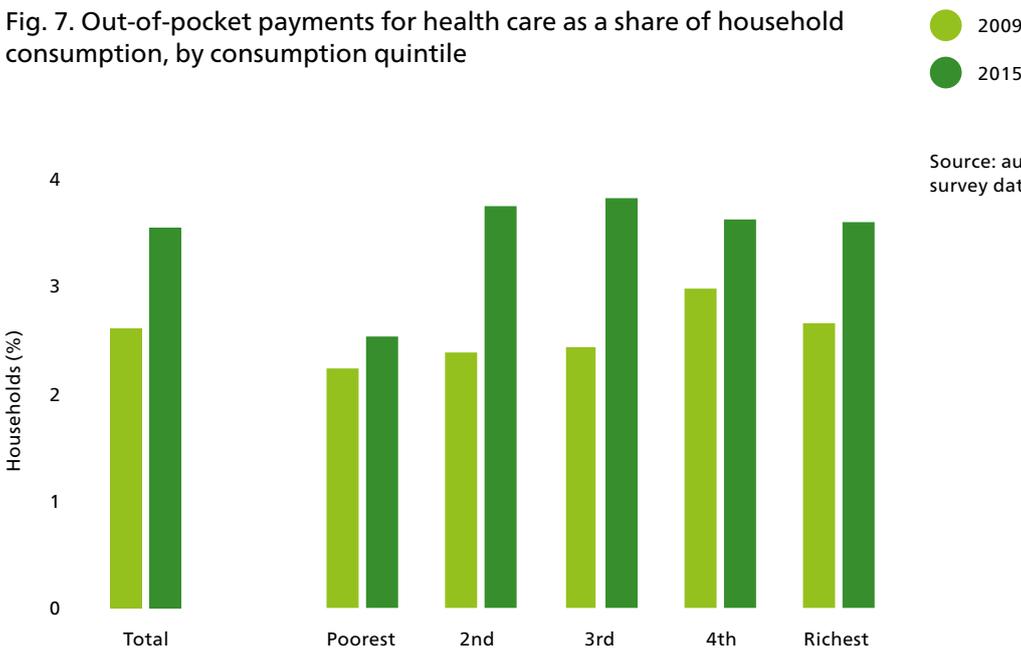


Note: amounts are shown in real terms.

Source: authors, based on household budget survey data.

Out-of-pocket payments also increased as a share of household spending (consumption) from 2.6% on average in 2009 to 3.6% in 2015 (Fig. 7). Once again, the smallest increase was experienced by the poorest quintile.

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



Source: authors, based on household budget survey data.

Outpatient medicines consistently account for the largest share of out-of-pocket spending (Fig. 7). The medicines' share rose sharply from 53% in 2009 to 77% in 2015, driven by a substantial increase in the average amount spent out of pocket on medicines, which doubled in real terms between 2009 and 2015 (Fig. 8). Inpatient care is the second-largest driver of out-of-pocket payments. Its share fell from 27% in 2009 to 11% in 2015 (Fig. 8), driven partly by a fall in real terms in the average amount spent out of pocket (Fig. 9).

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

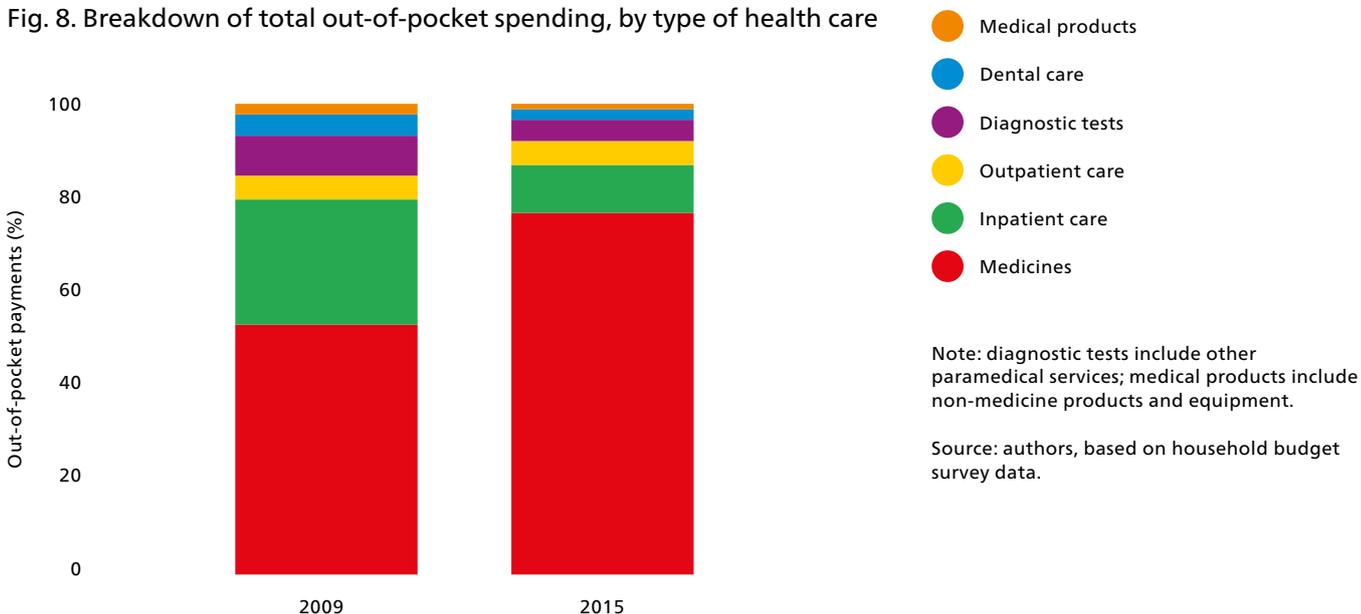
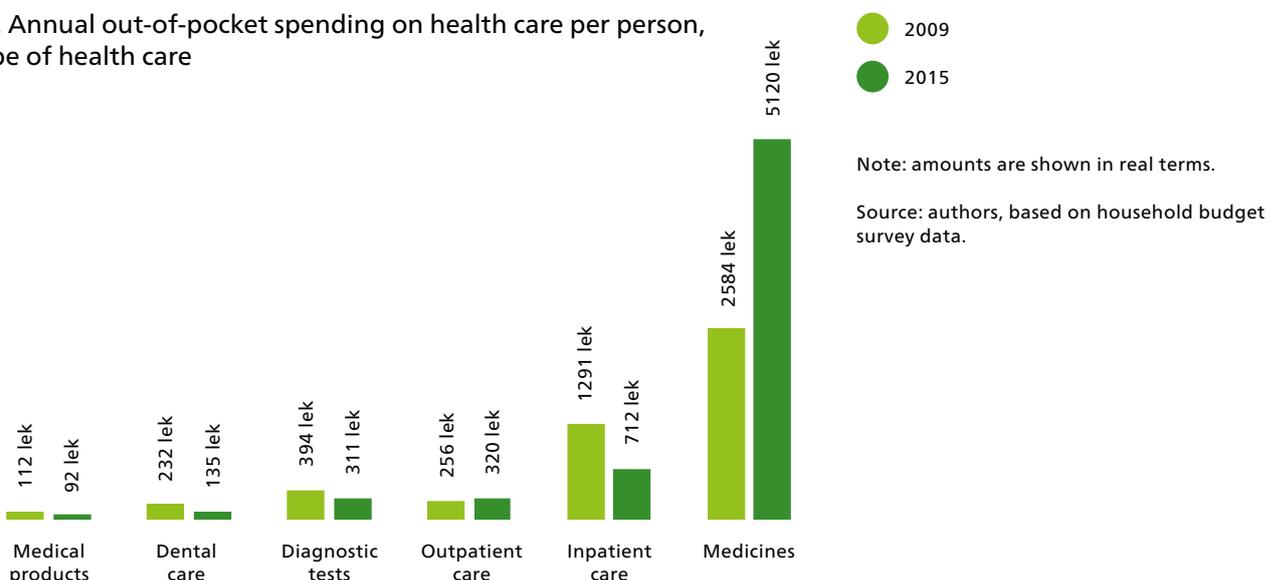


Fig. 9. Annual out-of-pocket spending on health care per person, by type of health care



Outpatient medicines are the main driver of out-of-pocket spending across all quintiles, as shown in Fig. 10. Their share has grown over time for all quintiles. The average amount households spend on outpatient medicines also increased substantially in real terms for all quintiles, although the increase was smallest for the poorest quintile (66%) and largest for the richest (124%) (Fig. 11).

In 2009, the inpatient-care share was broadly similar across quintiles (Fig. 10). By 2015, its share had fallen particularly sharply among the poorer quintiles, leaving the richest quintile with a share that was more than six times the share of the poorest quintile. This is also reflected in the average amounts households spend on inpatient care, with the largest reduction in spending in real terms among the poorest quintile (–89%) and the smallest among the richest quintile (–20%) (Fig. 11).

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

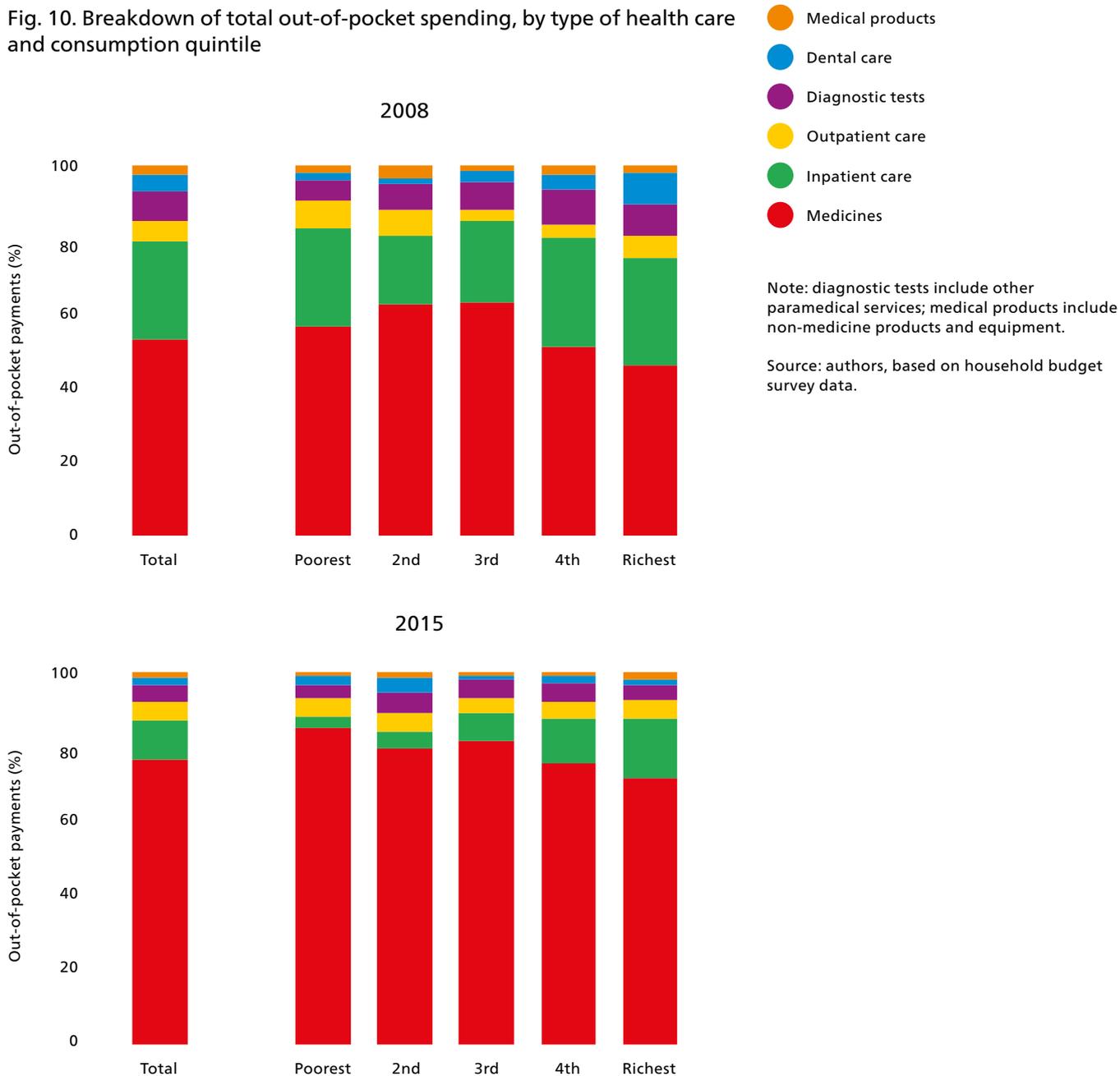
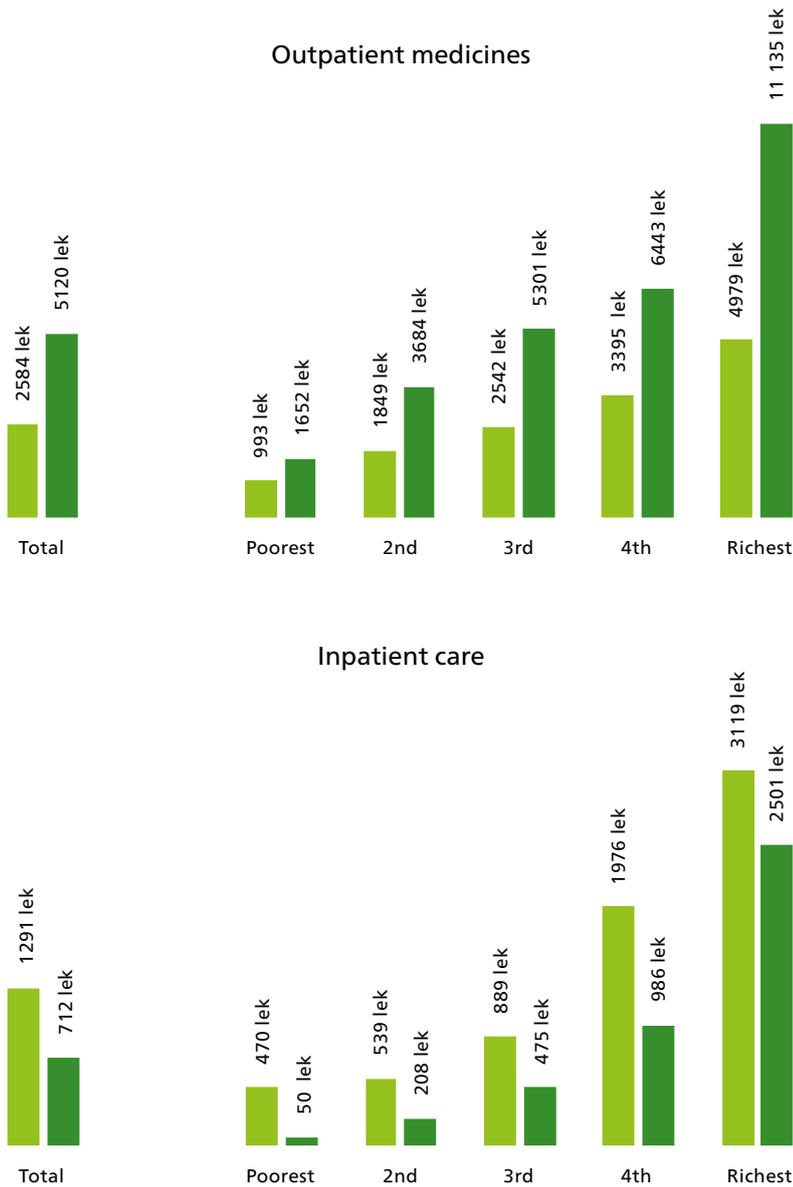


Fig. 11. Annual out-of-pocket spending on outpatient medicines and inpatient care, by consumption quintile

● 2009
● 2015

Note: amounts are shown in real terms.

Source: authors, based on household budget survey data.



There are two possible explanations for the sharp increase in spending on outpatient medicines between 2009 and 2015.

- The list of covered medicines expanded, rising from 409 in 2008 to 477 in 2014, 489 in 2015 and 540 in 2018 (Beci et al., 2015; MHIF, 2016, 2018). This increased access to outpatient prescribed medicines for insured people, but also increased their exposure to out-of-pocket payments through percentage co-payments.
- The price of medicines increased between 2009 and 2015, increasing out-of-pocket payments for covered medicines (through percentage co-payments, which expose people to changes in price) and non-covered medicines. This is supported by the large increase in the value of imported medicines between 2008 and 2015, even though import volumes were stable (INSTAT, 2018).

The decrease in out-of-pocket spending on inpatient care over time is more difficult to explain, as no major interventions that were likely to reduce out-of-pocket payments for inpatient care took place. Two changes, however, may have played a role: first, a campaign to reduce informal payments in 2013; and second, increased access to publicly financed inpatient care since 2014 through the purchasing of selected specialized services from private providers.

4.2 Informal payments

Informal payments reduce transparency in the health system, increase barriers to access and can lead to financial hardship (Gaál et al., 2010). They are also likely to exacerbate inequality in access and financial hardship because of the difficulty of protecting poor people and regular users of health care from exposure to out-of-pocket payments that are made informally.

The household budget survey does not distinguish between formal and informal (under-the-table) out-of-pocket payments. Other national and international surveys ask households specifically about informal payments. Although these surveys use different methods, they generally indicate that informal payments are an issue in Albania.

A 2013 survey placed Albania 126th out of 159 countries for perceptions of corruption in the health sector; the services perceived to be most susceptible to bribes in Albania were the judiciary (81%), health (80%), education (70%), the police (58%) and the civil service (52%) (Transparency International, 2014).

Informal payments are illegal but widespread, and are often paid to physicians or nurses, particularly in inpatient settings. A 2011 study found that around 19% of people using outpatient and 44% using inpatient care paid informally for health services in 2008 (Tomini & Maarse, 2011). Over time, however, perceptions of corruption in health seem to have decreased. The share of respondents offering a bribe to a physician or nurse fell from 33% in 2010 to around 13% in 2015 (Institute for

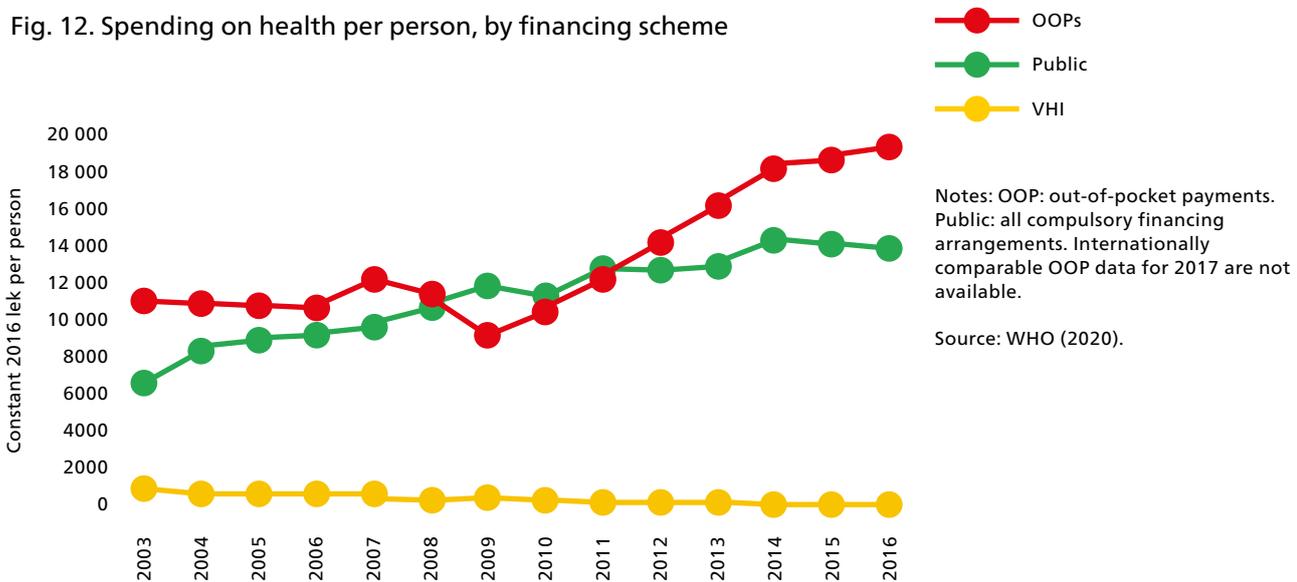
Development, Research and Alternatives (IDRA), 2010, 2016). One possible explanation for this may be the intensive information campaign against informal payments introduced by the Government in 2013.

In general, people in Albania find it hard to distinguish between formal and informal payments (Tomini et al., 2013), but the impact of informal payments is likely to be substantial, placing a particularly high financial burden on the poorest quintile (Tomini et al., 2015).

4.3 Trends in public and private spending on health

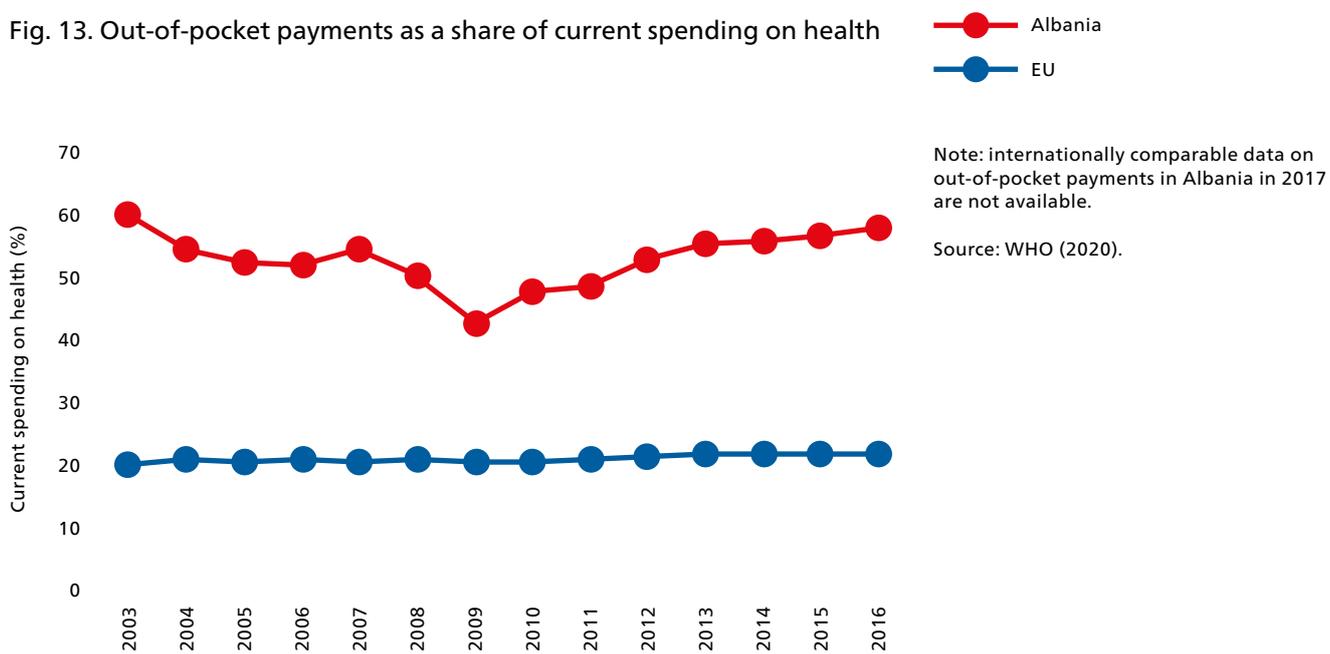
Out-of-pocket payments have almost always been the largest single source of funding for the health system in Albania (Fig. 12). Out-of-pocket payments per person fell in 2008 and 2009 and then grew sharply from 2010 to 2016, substantially outpacing growth in public spending on health (Fig. 12). Public spending on health per person grew rapidly between 2003 and 2009, fell in 2010 and then grew again from 2011 to 2014, but at a slower pace than before. It has fallen since 2014.

Fig. 12. Spending on health per person, by financing scheme



Out-of-pocket payments as a share of current (total) spending on health are very high in Albania compared to other countries in Europe (Fig. 13). In 2016, they accounted for 58% of total spending on health, which is very high compared to EU countries and high compared to several other upper middle-income countries in the European Region.

Fig. 13. Out-of-pocket payments as a share of current spending on health



4.4 Summary

Household budget survey data indicate that although the share of households with out-of-pocket payments fell between 2009 and 2015, out-of-pocket payments per person grew substantially, both in real terms and as a share of total household spending; the growth was smallest for the poorest quintile, however.

During the study period, there were no coverage changes likely to result in significantly lower out-of-pocket payments for poor people, and growth in public spending on health per person slowed after 2009 and has stalled since 2014. This suggests that the increase in the share of poorer households with no out-of-pocket payments, and the generally slower rate of increase in out-of-pocket payments among the poorest quintile, may reflect rising unmet need for health care, especially among poor people.

Outpatient medicines are the main driver of out-of-pocket spending, followed by inpatient care. The outpatient-medicine share of out-of-pocket spending rose sharply between 2009 and 2015, while the inpatient-care share fell. This shift was driven mainly by an increase in household spending on outpatient medicines and, to a lesser extent, by a reduction in household spending on inpatient care. Possible explanations for this large increase include: a reduction in access to publicly financed health services (including medicines); an expanded list of covered medicines coupled with high user charges, which increased access to medicines but also increased out-of-pocket payments; and increases in the price of medicines coupled with the use of percentage co-payments for outpatient prescriptions, which exposes people to changes in price.

Informal payments are widespread, particularly for inpatient care, and are likely to impose a particularly heavy financial burden on the poorest households. There is some evidence to suggest they have fallen over time, and this may reflect intensive information campaigns against informal payments introduced in 2013.

Data from National Health Accounts show that out-of-pocket payments per person grew at a faster rate than public spending on health between 2009 and 2016. The slow pace of growth in public spending on health per person since 2009 and the fall in this spending since 2014 are worrying trends.

5. Financial protection

This section uses data from the Albanian household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households who use health services, including medicines. It shows the relationship between out-of-pocket spending on health and risk of poverty, and presents estimates of the incidence, distribution and drivers of catastrophic out-of-pocket payments.

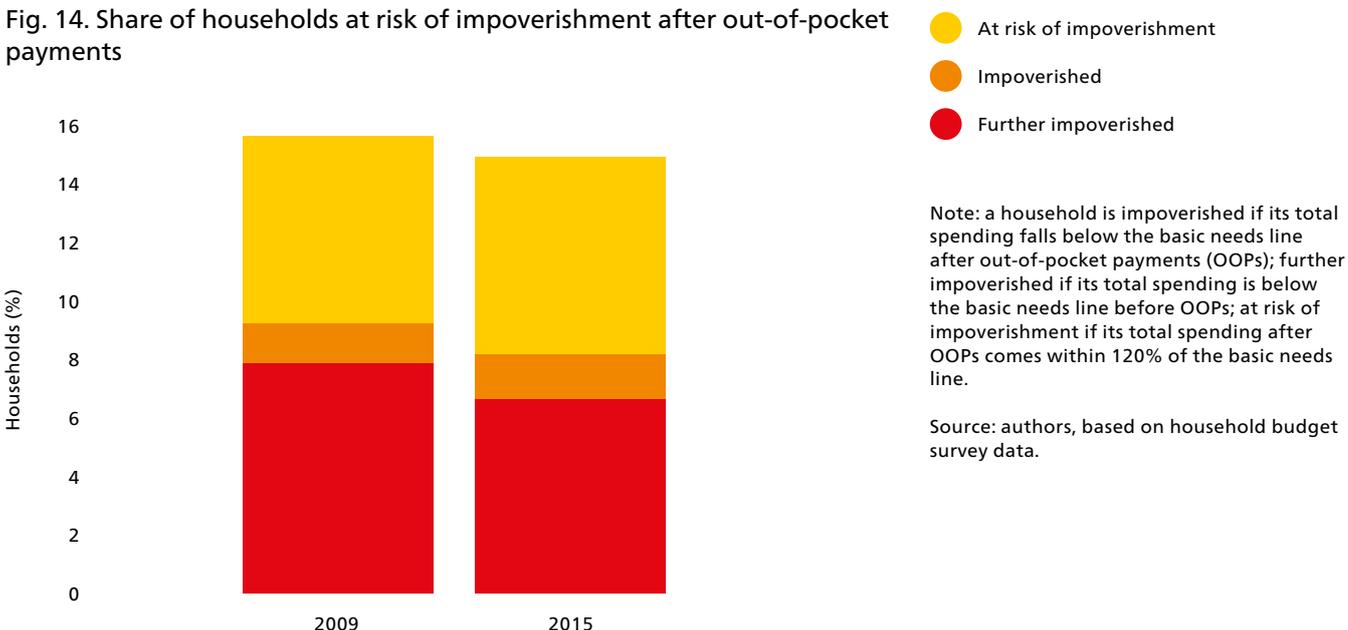
5.1 How many households experience financial hardship?

5.1.1 Out-of-pocket payments and risk of impoverishment

Fig. 14 shows the relationship between out-of-pocket spending on health and risk of impoverishment. The poverty line used here reflects the cost of spending on basic needs (food, rent and utilities) among a relatively poor part of the Albanian population (households between the 25th and 35th percentiles of the consumption distribution, adjusted for household size and composition). The average monthly cost of meeting these basic needs – the basic needs line – was 33 295 lek in 2009 and 35 798 lek in 2015.

The share of households impoverished and further impoverished after out-of-pocket payments decreased from 9% in 2009 to 8% in 2015 (Fig. 14). The decrease was entirely driven by a fall in the share of further impoverished households. The share of households at risk of impoverishment after out-of-pocket payments rose very slightly over time, from 6.4% in 2009 to 6.7% in 2015.

Fig. 14. Share of households at risk of impoverishment after out-of-pocket payments



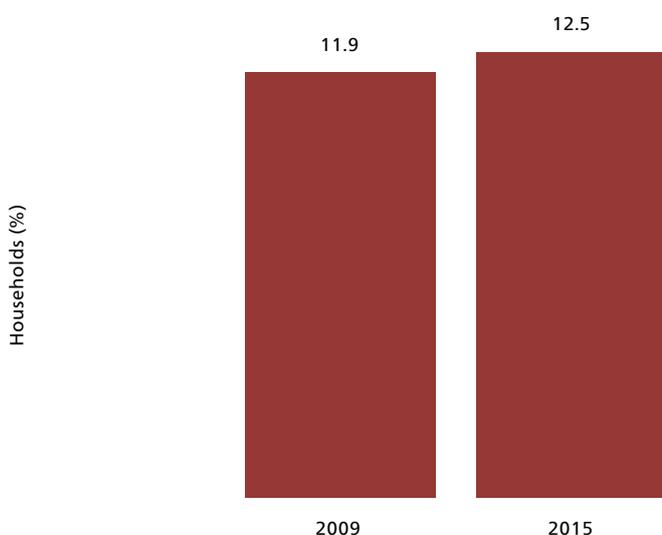
5.1.2 Catastrophic out-of-pocket payments

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 2015, over 12% of households – around 399 000 people – experienced catastrophic levels of spending on health care (Fig. 15). The incidence of catastrophic spending has remained stable over time, but the numbers affected rose from around 381 000 people in 2009 – an increase of around 5%.

Fig. 15. 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 further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 16). In 2015, the share of further impoverished households fell.

The incidence of catastrophic out-of-pocket payments is concentrated among the poorest quintile (Fig. 17) in both years. In 2015, it fell among the poorest quintile, but rose for the three middle quintiles.

It is also heavily concentrated among people aged over 60 years and households with children, who accounted for around 45% and 60% of all households with catastrophic spending in 2015, respectively (Fig. 18).

Fig. 16. Breakdown of households with catastrophic spending, by risk of impoverishment

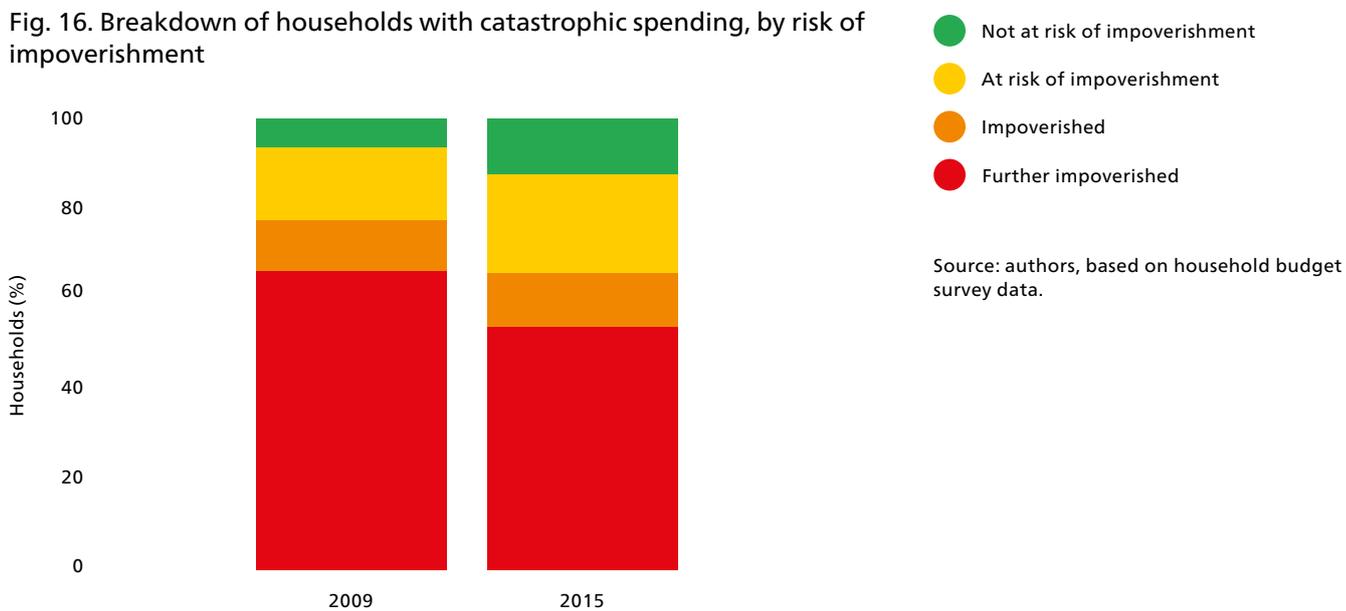


Fig. 17. Share of households with catastrophic spending, by consumption quintile

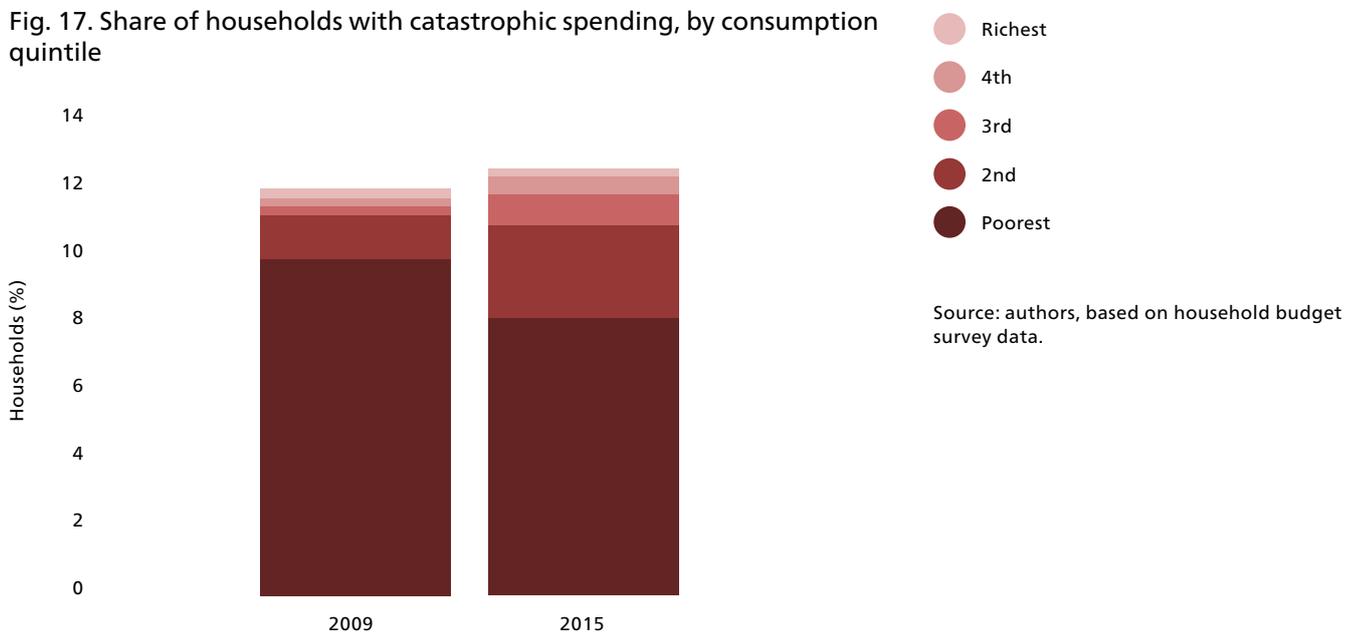
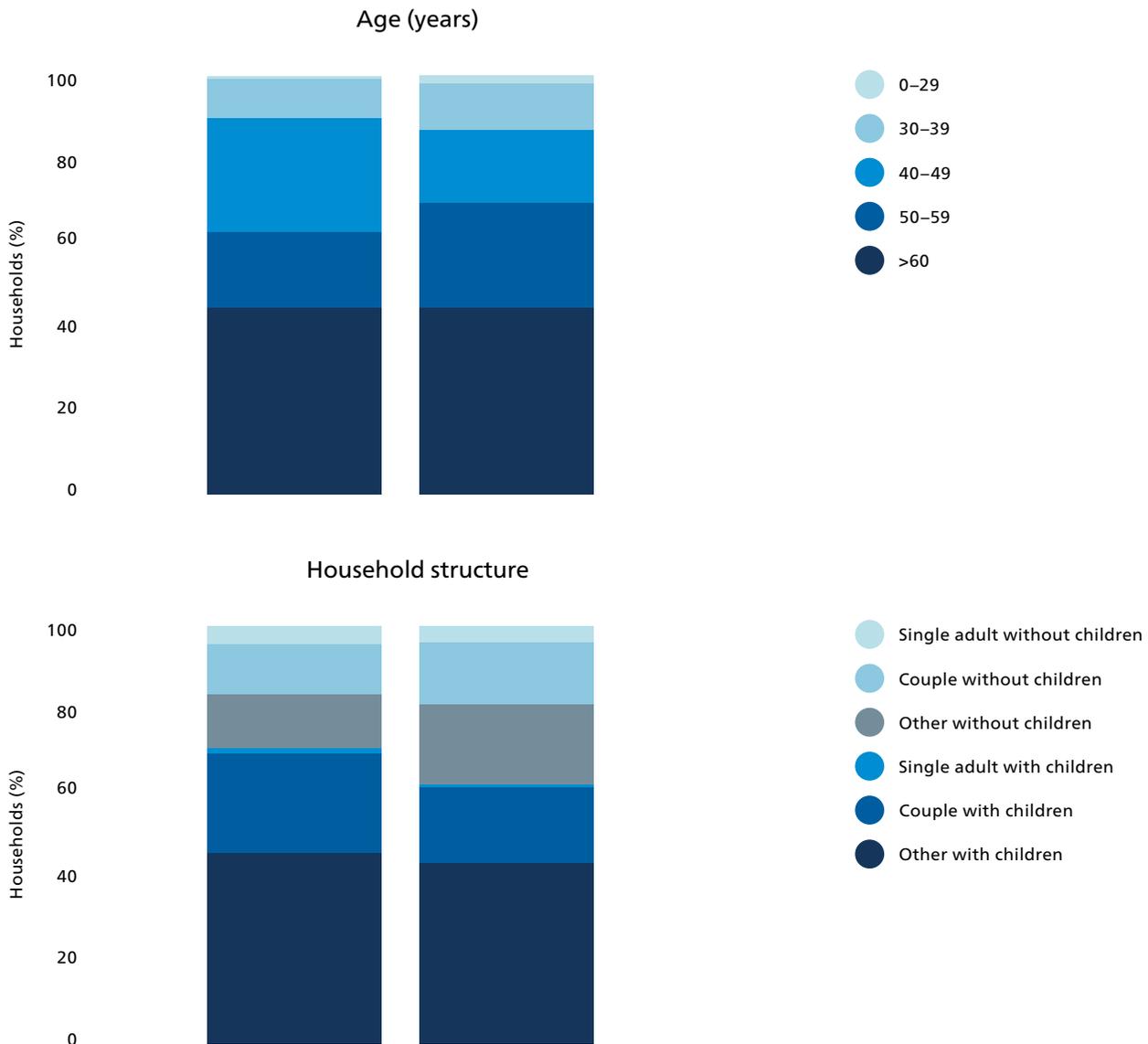


Fig. 18. Breakdown of households with catastrophic spending, by age and household structure

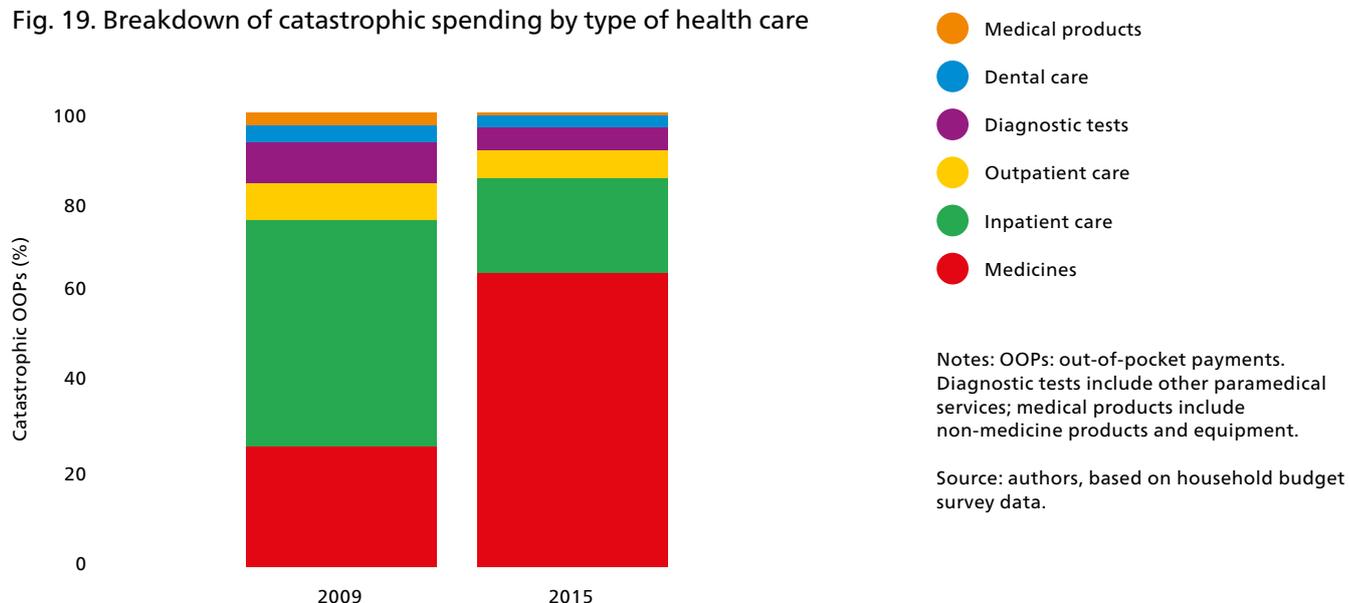
Source: authors, based on household budget survey data.



5.3 Which health services are responsible for financial hardship?

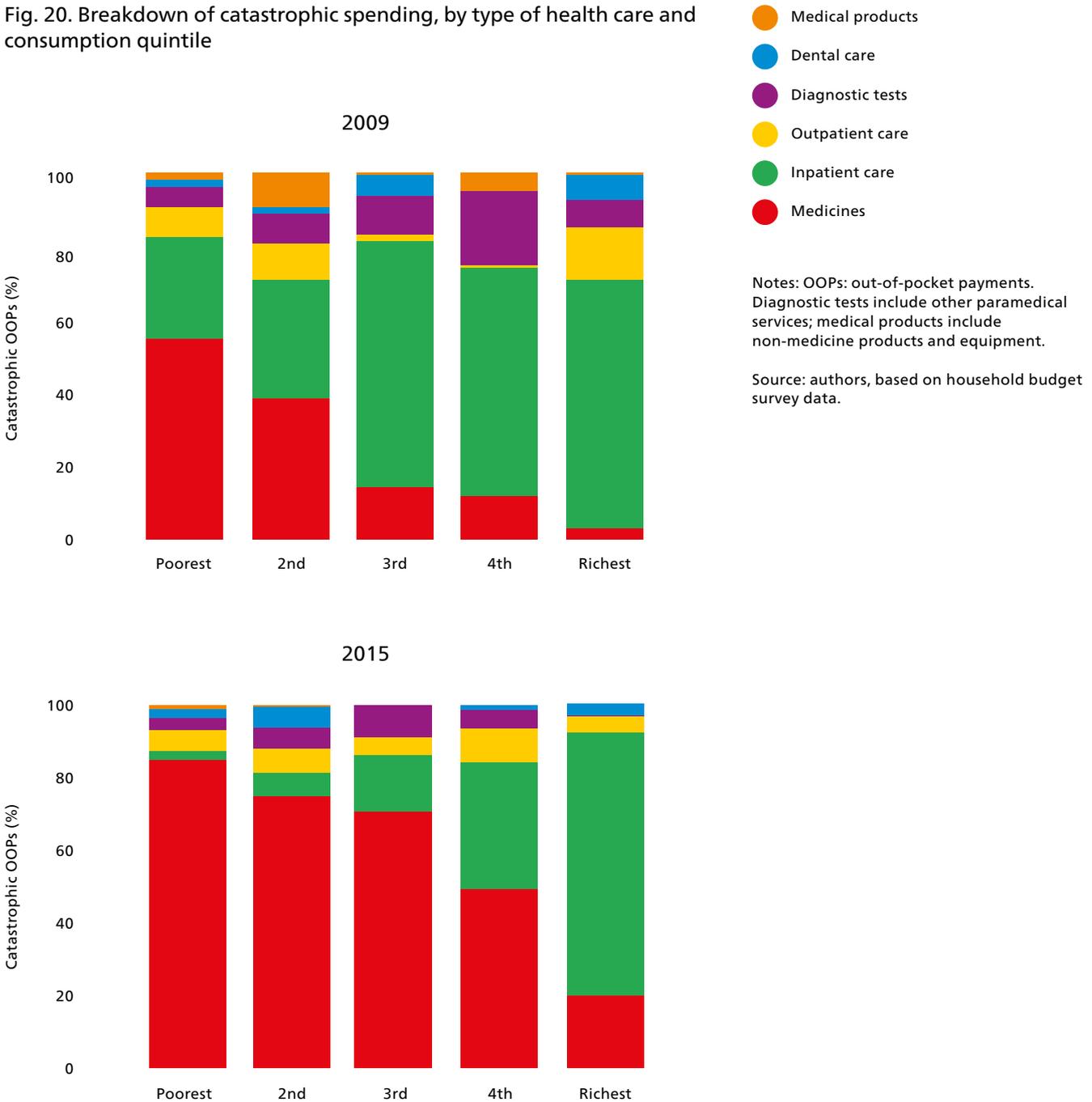
Inpatient care was the largest driver of catastrophic spending in 2009, followed by outpatient medicines and diagnostic tests; by 2015, however, the largest driver was outpatient medicines, followed by inpatient care and outpatient care (Fig. 19). The inpatient-care share fell substantially from 50% to 21% during this period, while the outpatient-medicine share increased from 26% to 65%.

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



This shift from inpatient care to outpatient medicines is reflected across all quintiles (Fig. 20). In 2009, outpatient medicines were the main driver of catastrophic spending for the two poorest quintiles only; by 2015, they were the main driver for all except the richest quintile. In 2015, inpatient care was the main driver of catastrophic spending for the richest quintile only.

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



5.4 How much financial hardship?

The average out-of-pocket share among the very poorest households already living below the basic needs line – those that are further impoverished after out-of-pocket payments – was 3.8% in 2012 and increased to 5.4% in 2015 (Fig. 21).

Fig. 21. Out-of-pocket payments as a share of total household spending among further impoverished households

Source: authors, based on household budget survey data.

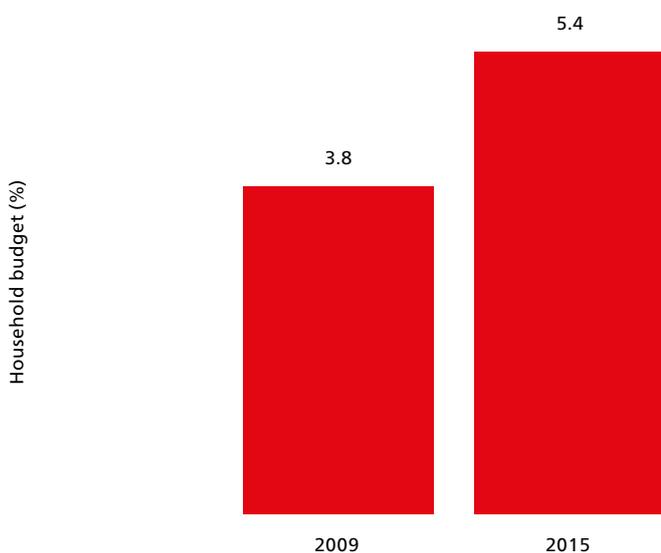
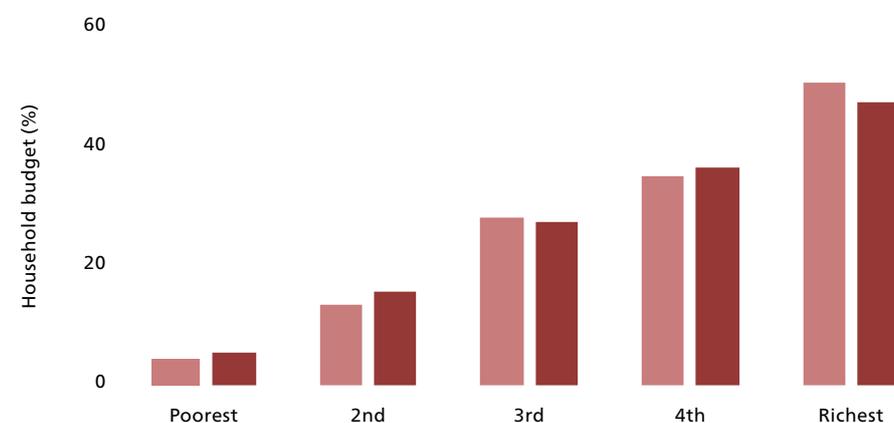


Fig. 22. Out-of-pocket payments as a share of total household spending among households with catastrophic spending, by consumption quintile

● 2009
● 2015



Source: authors, based on household budget survey data.

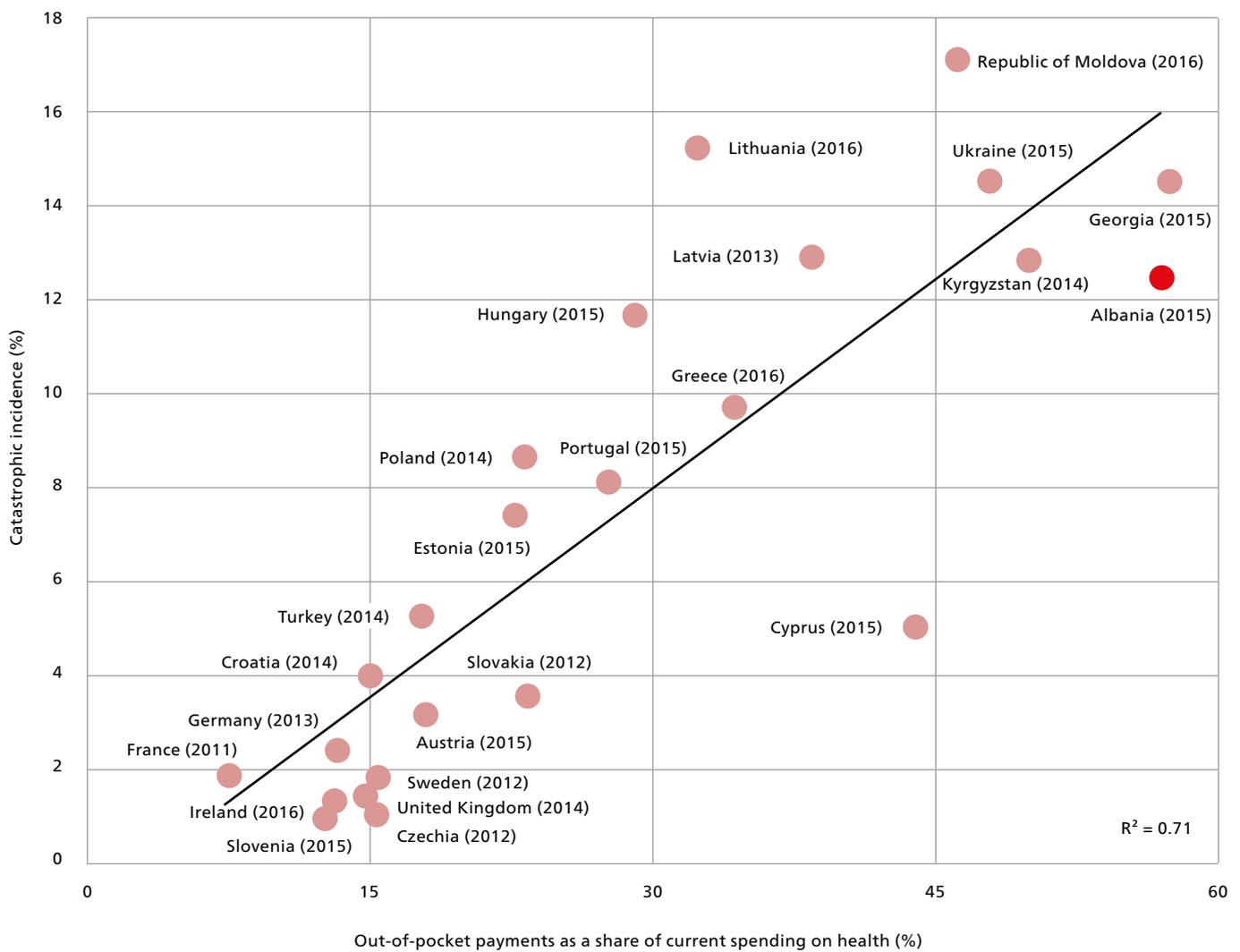
5.5 International comparison

The incidence of catastrophic spending on health in Albania is among the highest in Europe (Fig. 23).

Fig. 23. Incidence of catastrophic spending on health and the out-of-pocket share of total spending on health in selected European countries, latest year available

Notes: R^2 : coefficient of determination. The out-of-pocket payment data are for the same year as those for catastrophic spending. Albania is highlighted in red.

Source: WHO Regional Office for Europe (2019).



5.6 Summary

Between 2009 and 2015, the share of households impoverished and further impoverished after out-of-pocket payments decreased from 9.3% to 8.2%. The decrease was entirely driven by a fall in the share of further impoverished households. While this share fell, however, the average amount spent out of pocket by this group of very poor households increased from 3.8% of household spending in 2009 to 5.4% in 2015.

In 2015, 12.5% of households experienced catastrophic out-of-pocket payments, up slightly from 11.9% in 2009. The overall increase in the incidence of catastrophic spending was driven by increases in the three middle quintiles; incidence fell in the poorest quintile.

Catastrophic spending affects the poorest households the most. It is also heavily concentrated among older households and households with children.

The main driver of catastrophic spending was inpatient care in 2009 and outpatient medicines in 2015. In 2009, outpatient medicines were the main driver of catastrophic spending for the poorest quintile only. By 2015, it was the main driver for all except the richest quintile.

6. Factors that strengthen and undermine financial protection

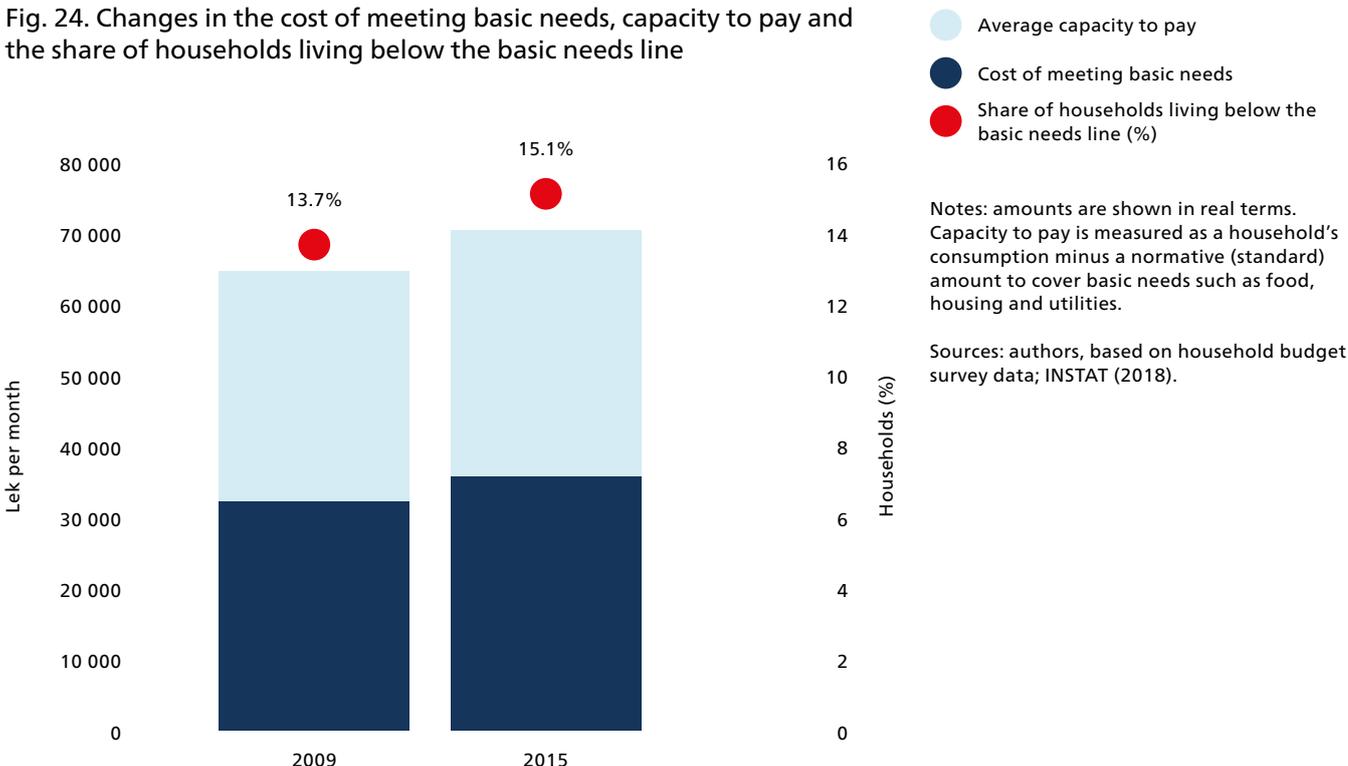
This section considers the factors that may be responsible for financial hardship caused by out-of-pocket payments in Albania and which may explain the trend over time. It begins by looking at factors outside the health system affecting people's capacity to pay – for example, changes in incomes and the cost of living – and then examines 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 sources to review changes in people's capacity to pay for health care. Poverty among people more likely to need health care is a particular challenge for financial protection.

Household budget survey data show that between 2009 and 2015, the cost of meeting basic needs (food, housing and utilities) increased by about 7.5%, while household capacity to pay for basic needs increased by 7.7% (Fig. 24). The share of households living below the basic needs line increased from 13.7% in 2009 to 15.1% in 2015.

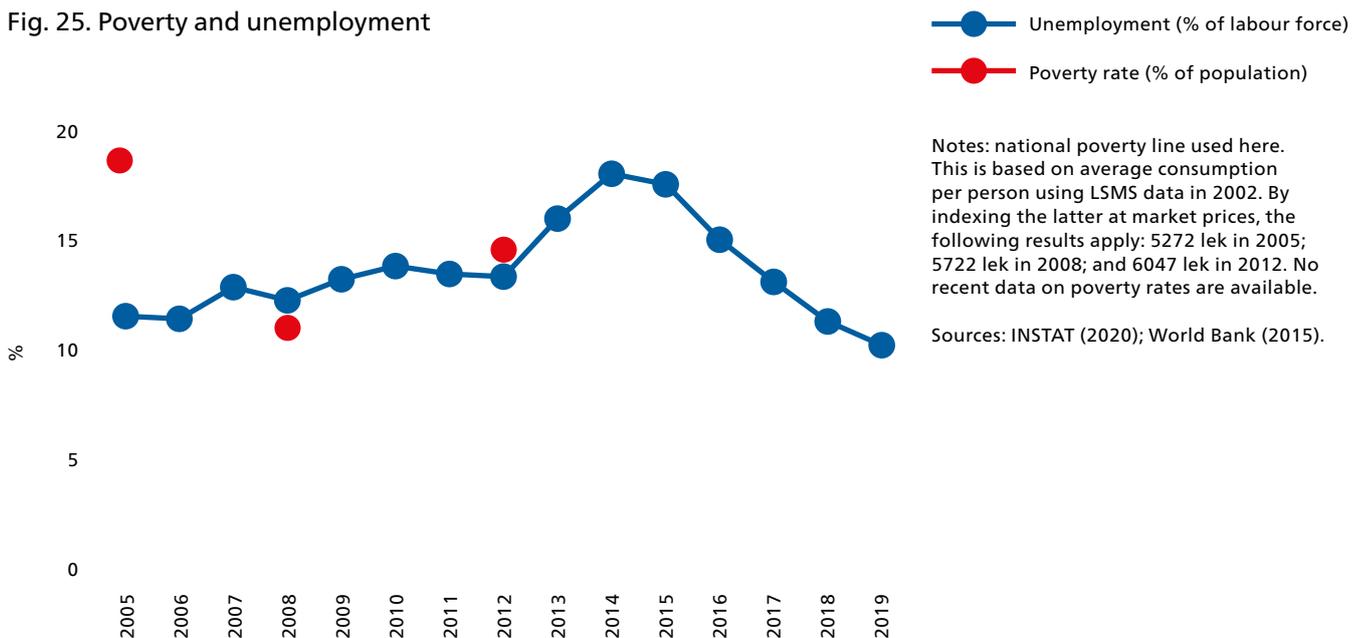
Fig. 24. Changes in the cost of meeting basic needs, capacity to pay and the share of households living below the basic needs line



GDP growth in Albania slowed significantly in the years following the economic crisis, particularly from 2012 to 2014, which is likely to have pushed more households into poverty, in part due to a significant increase in unemployment from 2012 to 2015 (Fig. 25). Before the crisis, poverty fell from 18.5% in 2005 to 12.4% in 2008, but by 2012, it had increased to 14.3%.

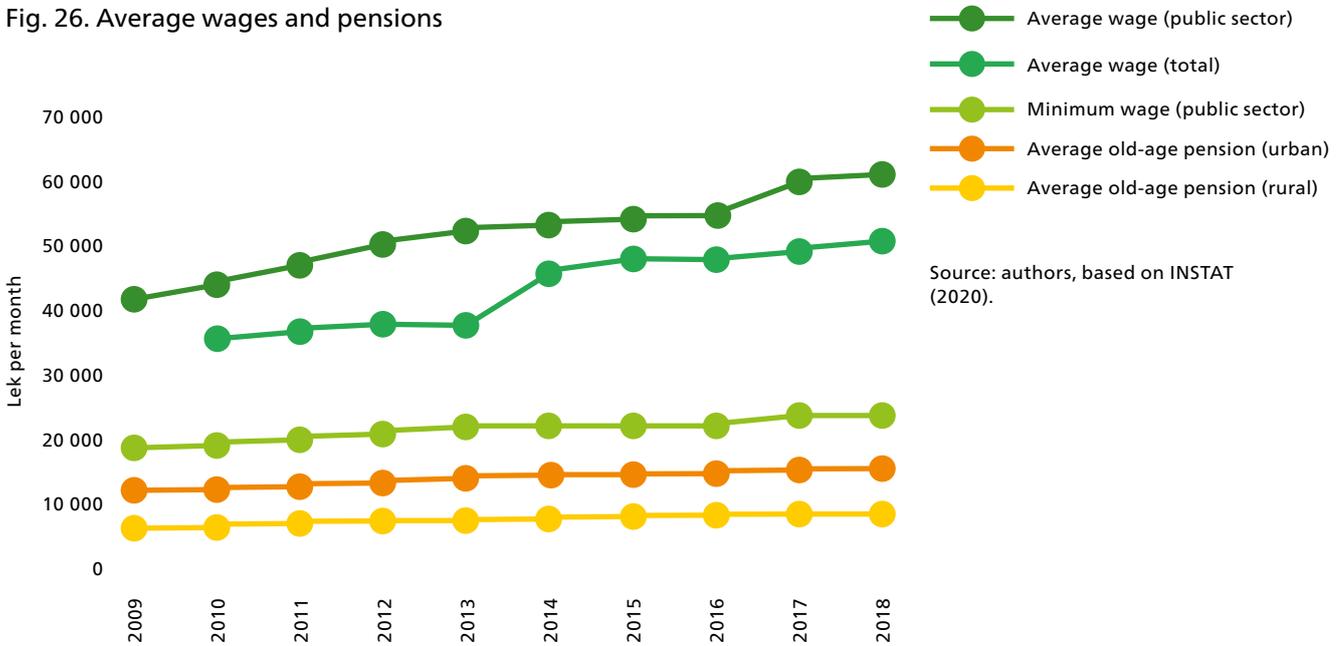
Although labour-force participation rose from 55% in 2010 to 59% in 2018 (INSTAT, 2018), young people (15–24 years) and people with lower levels of education are the most affected by unemployment. Employment informality is also persistently high, accounting for more than 50% of GDP (Muca et al., 2015). Job creation in the private sector has been weak; most formal employment is therefore in the public sector.

Fig. 25. Poverty and unemployment



Between 2009 and 2015, there were no significant changes in wages and pensions. Pensions in rural areas have consistently been below the national poverty line. Pensions have been kept at very low levels due to declining labour-force participation and increasing informal employment (Fig. 26).

Fig. 26. Average wages and pensions



Rising unemployment and the lack of growth in wages and pensions may in part explain the increase in the share of households without out-of-pocket spending between 2009 and 2015 (Fig. 4), the increase in the out-of-pocket share of household spending (Fig. 7) and the fact that growth in out-of-pocket spending was lowest among the poorest quintile (Fig. 6).

6.2 Health-system factors

The following paragraphs look at spending on health, coverage policy and the health services driving financial hardship in Albania.

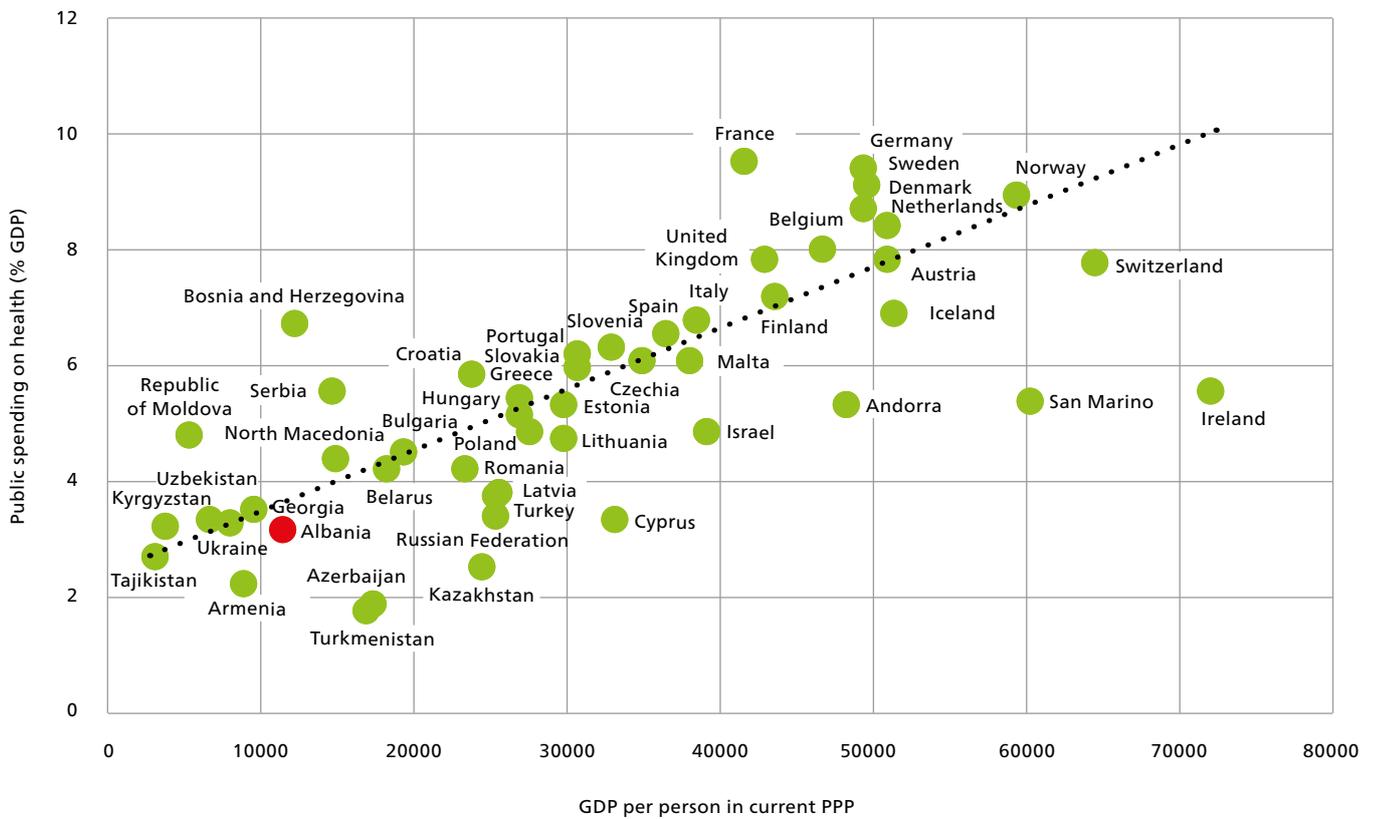
6.2.1 Spending on health

Public spending on health consistently is very low in Albania. In 2016, public spending on health as a share of GDP was lower in Albania (2.8%) than in most south-eastern European countries, upper middle-income countries in the WHO European Region and the EU (Fig. 27).

Fig. 27. Public spending on health and GDP per person, WHO European Region, 2016

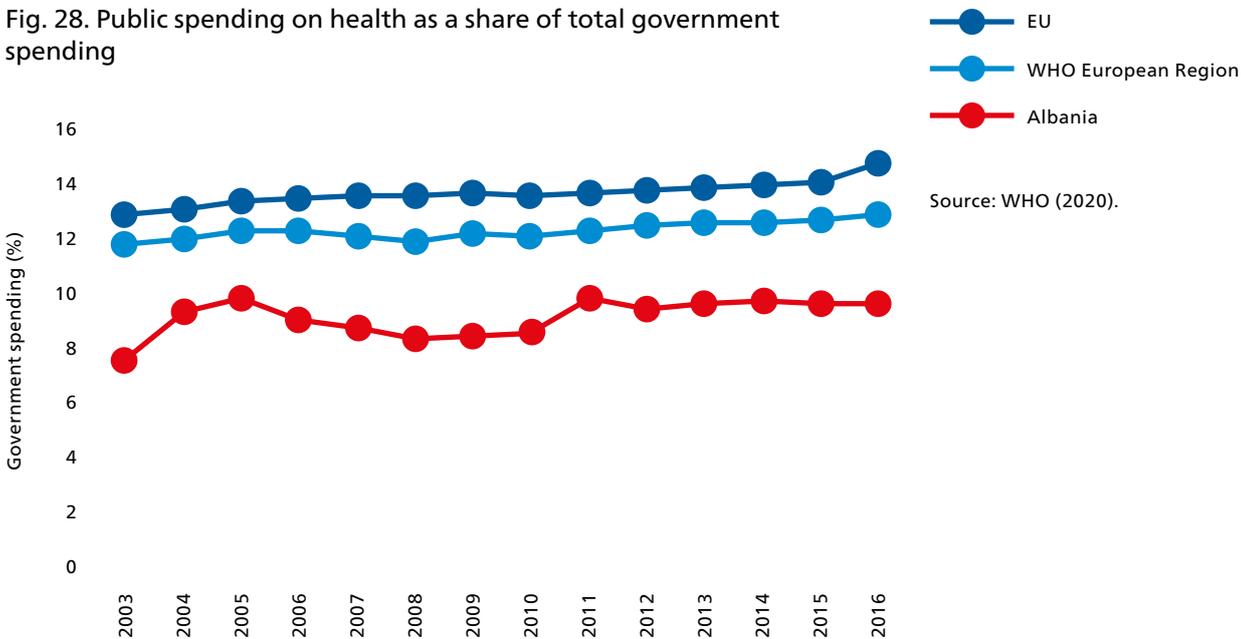
Note: PPP: purchasing power parity. Public refers to all compulsory financing arrangements. Albania is highlighted in red. The figure covers 51 countries in the WHO European Region; it excludes Luxembourg and Monaco.

Source: WHO (2020).



Low levels of public spending on health in Albania can be explained by the low priority given to the health sector in allocating the government budget. Fig. 28 shows how priority to health has consistently been low over time, fell between 2005 and 2009 and has not grown since 2012. In 2016, health accounted for only 9.5% of total government spending in Albania, compared to 14.1% for EU countries and 12.5% for the WHO European Region as a whole.

Fig. 28. Public spending on health as a share of total government spending



Since 2009, out-of-pocket payments per person have grown at a much faster rate than public spending on health per person, and public spending on health has fallen since 2014 (Fig. 12), which is a worrying trend.

6.2.2 Coverage policy

Public sources of data indicate that in 2015, the MHIF covered only around 60% of the population on average and around 50% of people in the poorest quintile (World Bank, 2015). This is one of the lowest levels of population coverage in Europe (WHO Regional Office for Europe, 2019).

Three policies are responsible for this low level of population coverage:

- entitlement to MHIF benefits is linked to payment of contributions, which is particularly challenging given Albania's large informal sector;
- MHIF membership is voluntary for self-employed people, small family businesses and farmers; and
- voluntary contributions are collected by the MHIF rather than the tax authority, which collects mandatory contributions.

Uninsured people have access to a very limited range of publicly financed health care: emergency services, the annual basic health check-up (since 2015) and free GP visits (since 2017). These entitlements do not extend to treatment in primary care (medicines or diagnostic tests) or to non-emergency specialist treatment. In addition, uninsured people tend to

be poor, come from minority groups and live in deprived areas (rural and peri-urban areas) where access to health services is limited, further exacerbating inequalities in health-care use and unmet need.

The main gap in the publicly financed **benefits package** is dental care. Dental care is not covered for adults. Dental care and pharmacies were among the first services to be privatized in Albania and although the network of private dental clinics and pharmacies is extensive, it is heavily concentrated in highly populated urban areas; as a result, physical access to dental care and pharmacies is limited in less populated and remote areas. The fact that dental care is not a major driver of catastrophic spending in Albania reflects high levels of unmet need (Fig. 3).

Uninsured people pay the full cost of most health services. Insured people also pay at the point of use through **user charges (co-payments)** for outpatient prescribed medicines and medical products, some diagnostic tests, and GP and specialist care without referral. Although selected vulnerable groups of people are exempt from user charges, the existence and design of the charges are important drivers of catastrophic spending on health and may partly be responsible for the large increase in catastrophic spending on outpatient medicines during the study period (see below).

6.2.3 Health services

Out-of-pocket payments for **outpatient medicines** are by far the largest source of financial hardship for households in all except the richest quintile. Uninsured people have to bear the full cost of outpatient medicines themselves, but many insured people also incur heavy out-of-pocket payments because user charges (co-payments) apply to many of the outpatient medicines on the list of covered medicines. This contrasts with the bulk of other health services, which largely are provided to those covered by the MHIF without formal user charges.

In addition, several aspects of the **design of co-payments** for outpatient medicines are worth highlighting as factors that are highly likely to undermine financial protection.

User charges for outpatient prescription medicines 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 medicines 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 user charge is magnified:

- for people who are regular users of medicines, such as people with chronic conditions;
- for people who have a condition that requires higher-cost medicines;
- when medicine 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.

Mechanisms to protect people from co-payments are inadequate.

Although pensioners, people with disabilities, those invalidated through war and people with some conditions are exempt, there is no explicit exemption from co-payments for people with common chronic conditions or for people with low incomes (Table 3).

There is no overall annual cap (ceiling) on out-of-pocket payments arising from user charges for outpatient medicines or for other health services. This is especially worrying when user charges are in the form of percentage co-payments.

Percentage co-payments expose people to changes in price. Where medicine prices are not effectively negotiated, households will bear the financial burden of high or increased prices. Some sources suggest that the prices of alternatives are often higher than the reference price on the list of covered medicines, and that about 50% of medicines on the list of covered medicines are expensive single-source medicines for which there are no alternatives (Gjeci, 2015).

Percentage co-payments also expose people to out-of-pocket payments linked to inappropriate prescribing or dispensing. Physicians must adhere to generic prescribing, but pharmacists may have incentives to promote more expensive medicines. The ability of physicians and pharmacists to prescribe and dispense appropriately may also be hampered by a lack of basic knowledge; a 2013 survey found that 85% of physicians and 56% of pharmacists were unsure about the bioequivalence of generics and 68% of physicians and 62% of pharmacists considered price to be an indicator of quality. Prescribing patterns also seem to be influenced by the pharmaceutical industry (Doracaj & Grabocka, 2014).

In summary, the design of policy on user charges in Albania is complex, potentially confusing for people, especially given widespread informal payments, and exposes people to out-of-pocket payments linked to inefficiencies such as inadequate regulation and inappropriate prescribing and dispensing.

Between 2009 and 2015, there was a substantial increase in the outpatient-medicine share of **catastrophic spending** overall and across all quintiles (Fig. 19), driven mainly by an increase in out-of-pocket spending on outpatient medicines (Fig. 10). This shift probably reflects reduced access to medicines among uninsured people, which is supported by the fact that MHIF spending on medicines fell between 2008 and 2015, at a time when the list of covered medicines was growing. It may also be linked to increases in medicine prices during the study period and the use of percentage co-payments (of up to 50%) for covered outpatient prescriptions, which exposes households to changes in price.

Inpatient care is the second-largest driver of financial hardship, driven by out-of-pocket payments among the richer quintiles. High out-of-pocket payments for inpatient care may be linked to inefficiencies in the **allocation and use of public resources** in the health system. Allocations

are based on inputs rather than population health needs and provider performance, and the overall level of public spending on health is low, leading to shortages in public facilities that mean people have to pay out of pocket for services in private facilities or informally for services that should be free in public facilities.

Informal payments warrant policy attention. They are widespread and are used to obtain specific favours, better care from nurses and physicians in outpatient and inpatient settings, or even to receive basic health services (Habibov & Cheung, 2017; Vian & Burak, 2006; Tomini & Maarse, 2011; Tomini et al., 2012a, 2012b). The poorest households are affected most by informal payments (World Bank, 2011). Informal payments contribute to complexity and undermine transparency in the health system. There is some evidence to suggest that informal payments fell during the study period (IDRA, 2016), perhaps in response to intensive information campaigns carried out after 2013, but they remain a problem.

Quality of care is also an issue, particularly in public primary-care facilities. It is highly variable across different providers and encourages use of private facilities. In recent years, there has been an **expansion of private facilities**, including hospitals, around the capital and some of the other main cities. Well-off people are more inclined to use private hospitals, where services are supposedly better than in public facilities, not only to benefit from better equipment and amenities, but also to avoid referral and informal payments. The role of the private sector has also increased in outpatient care and diagnostic centres.

6.3 Summary

Public spending on health is much lower in Albania than in any other south-eastern European country and in other upper middle-income countries in the Region. Low levels of public spending on health, combined with weaknesses in coverage policy, mean the out-of-pocket payment share of total spending on health is very high.

Poor households, households with older members and households with children are more vulnerable to financial hardship than other groups. This reflects a greater need for health care, the relative poverty of pensioners (particularly in rural areas) and gaps in coverage that persist even though pensioners and children are automatically covered by the MHIF and pensioners are exempt from user charges.

Under the policies in place during the study period, the main gaps in coverage were related to:

- the linking of entitlement to employment status and payment of contributions in 2013, MHIF membership being voluntary for self-employed people, small family businesses and farmers, and the fact that voluntary contributions are collected by the MHIF rather than the tax authority, which collects mandatory contributions: as a result, the MHIF covers a very low share of the population;

- lack of dental-care coverage for adults; and
- widespread and heavy user charges, particularly for outpatient medicines, with no exemptions from user charges for poor people and no annual cap on co-payments: poor people and those who have to pay for long-term treatment such as medicines for chronic illness face financial hardship and inadequate regulation leads to high prices, with inappropriate prescribing and dispensing also likely to contribute to financial hardship.

Although the MHIF does not cover dental care for adults, dental care is not a major driver of catastrophic spending, reflecting unmet need driven by the high cost to households of paying out of pocket for inpatient care and medicines.

Publicly financed health services suffer from poor quality and a high incidence of informal payments. The latter undermines collective financing, increases corruption, undermines transparency in the health system and places a particularly heavy financial burden on poor households.

Policy attention should focus on improving financial protection for poor households, who are also most at risk of delaying or foregoing care. There is some evidence to suggest that the apparent improvement in financial protection among the poorest households over time is the result of an increase in unmet need for health care.

7. Implications for policy

Financial protection in Albania is weak in comparison to many other European countries. In 2015, one in eight households incurred catastrophic out-of-pocket payments, with the payments being concentrated among the poorest quintile. Levels of unmet need for health care are also high.

Lack of financial protection can be attributed to low levels of public spending on health and weaknesses in the following aspects of coverage policy.

- The way in which entitlement to MHIF benefits is designed means that the MHIF only covers around two thirds of the population on average. Uninsured people have access to a very limited range of publicly financed health care; they are also more likely to be poor, come from minority groups and live in deprived areas. **Efforts to strengthen financial protection and reduce unmet need should start by delinking entitlement to MHIF benefits from payment of contributions so that the MHIF automatically covers the whole population.** Linking entitlement to payment of contributions is particularly challenging given Albania's large informal sector.
- The MHIF does not cover dental care for adults. **Lack of dental-care coverage results in high levels of unmet need.**
- **MHIF coverage is limited by a complex system of user charges,** which are particularly heavy for outpatient medicines.

Outpatient medicines are the main driver of financial hardship, reflecting gaps in coverage and inadequate regulation. The growing role of outpatient medicines in driving financial hardship is worrying because of the lack of mechanisms to protect poor people. Many people are not entitled to publicly financed outpatient medicines because they are not covered by the MHIF. In addition, the outpatient medicines covered by the MHIF are subject to high percentage co-payments and there are no exemptions explicitly targeting poor households, nor is there any annual cap on co-payments. To improve financial protection, international experience indicates the following protective features of coverage and co-payment policy for outpatient prescriptions: the use of low fixed co-payments rather than percentage co-payments; exemption from co-payments for low-income households; and an annual income-related cap covering all co-payments. Attention should also be paid to the way in which medicines are selected for coverage and to ensuring that physicians, pharmacists and people are able to prescribe, dispense and use the cheapest alternatives.

Informal payments are a problem in outpatient and inpatient public facilities and cause financial hardship. Their informal nature makes it impossible to ensure protection for poor people. They also add to complexity and undermine transparency in the health system.

Strengthening financial protection will require additional public investment in the health system and a greater focus on poor households. Low public spending on health (just under 3% of GDP in 2016), high reliance on out-of-pocket payments (58% of current spending on health in 2016), significant gaps in coverage and widespread informal payments are the main factors undermining financial protection. Any additional investment in the health system should be used to extend entitlement to MHIF benefits to the whole population, find ways to improve access and financial protection for poor households and frequent users of health services (for example, people with chronic conditions), and improve transparency. Better use of resources will also help.

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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.

³ All websites accessed on 28 July 2020

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 Strengthening (part of the Division of Health Systems and Public Health 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).

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⁴ All websites accessed on 28 July 2020

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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