Out-of-Pocket Health Spending and Financial Protection in ECA Concepts and Data



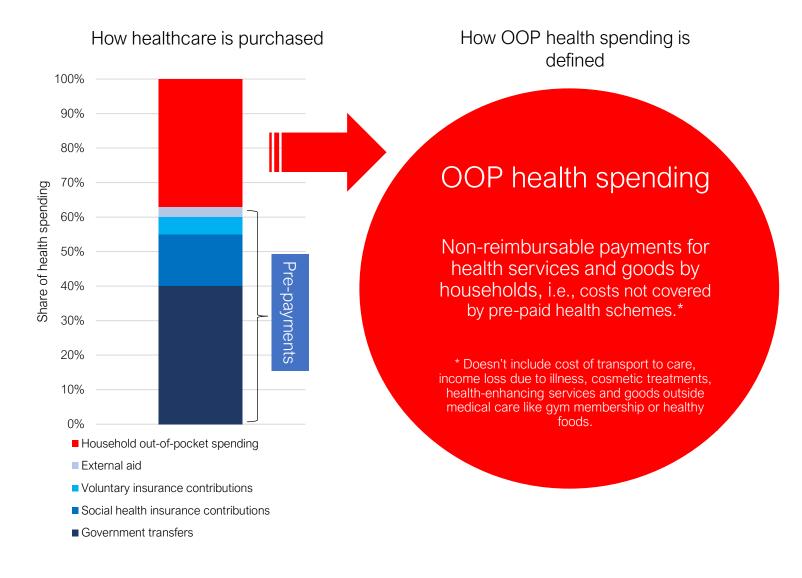
Sven Neelsen, World Bank, HNP, Europe and Central Asia Region

ECA Talk: Out-of-Pocket Health Expenditures - Challenges and Policies in ECA

March 21, 2024



### Defining OOP health spending



#### How OOP spending is incurred

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#### Populations not covered

by pre-payment schemes

• E.g., informal sector households outside social health insurance schemes

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#### Care not covered

by pre-payment schemes

- De jure not covered
- De facto not covered, e.g., informal payments, using non-covered services because covered services unavailable or of poor quality

Patient costsharing

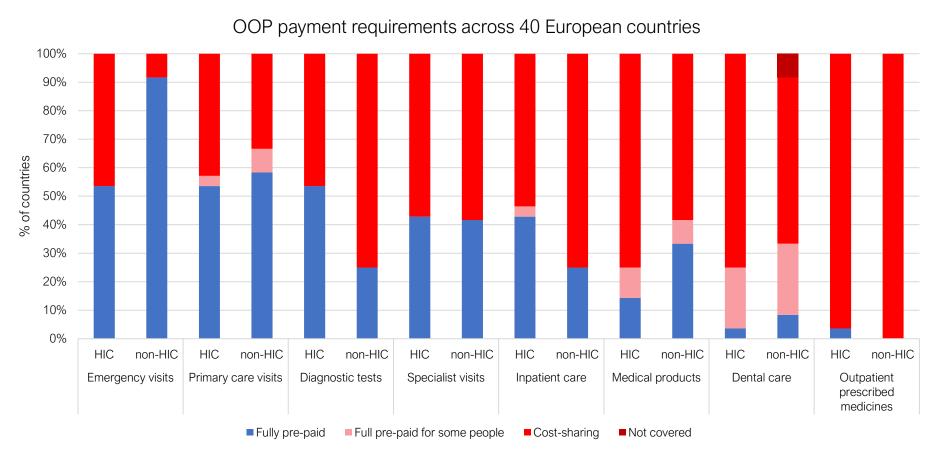
with pre-payment schemes

- Insurance deductibles
- Co-payments (fixed amount per service)
- Co-insurance (% of service cost)
- Balance billing /reference pricing



# OOP health payment requirements are omnipresent even in high income (HIC) countries



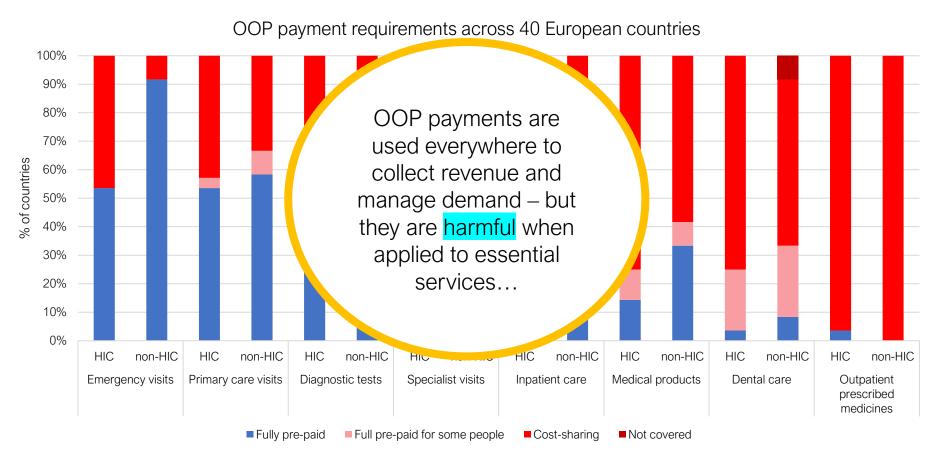


Source: Can people afford to pay for health care? Evidence on financial protection in 40 countries in Europe. Copenhagen: WHO Regional Office for Europe; 2023.



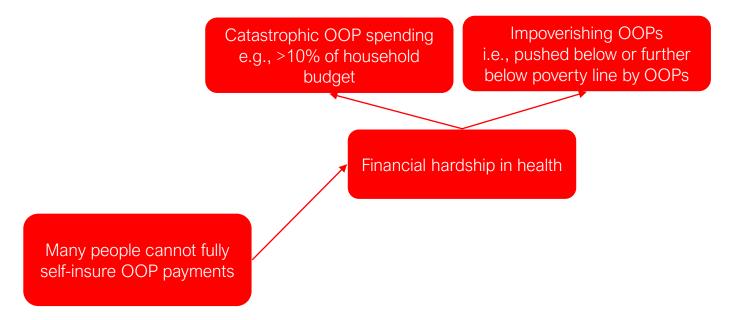
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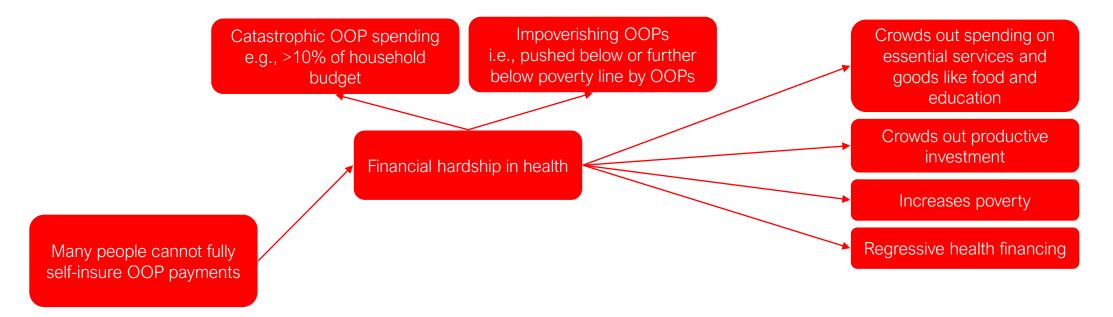


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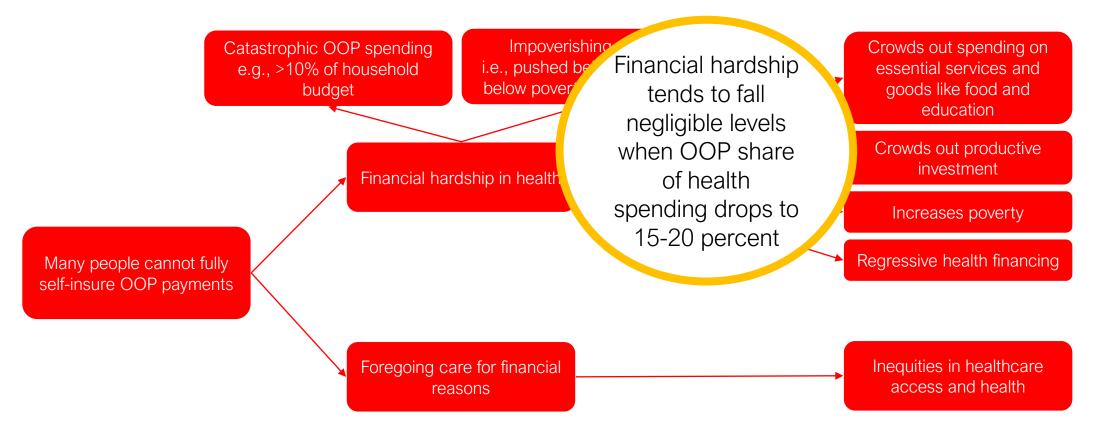




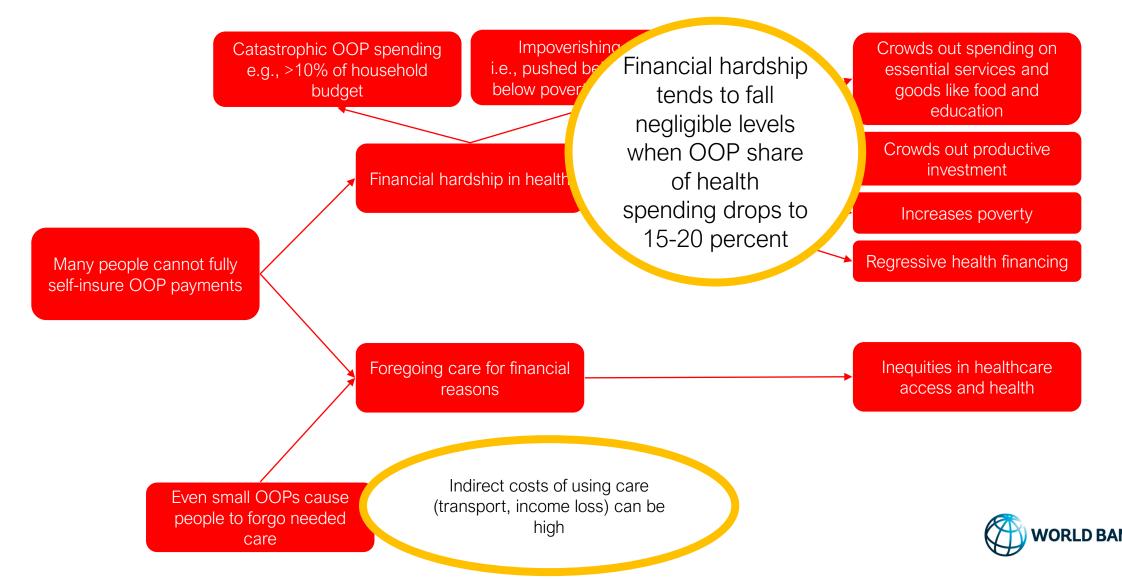




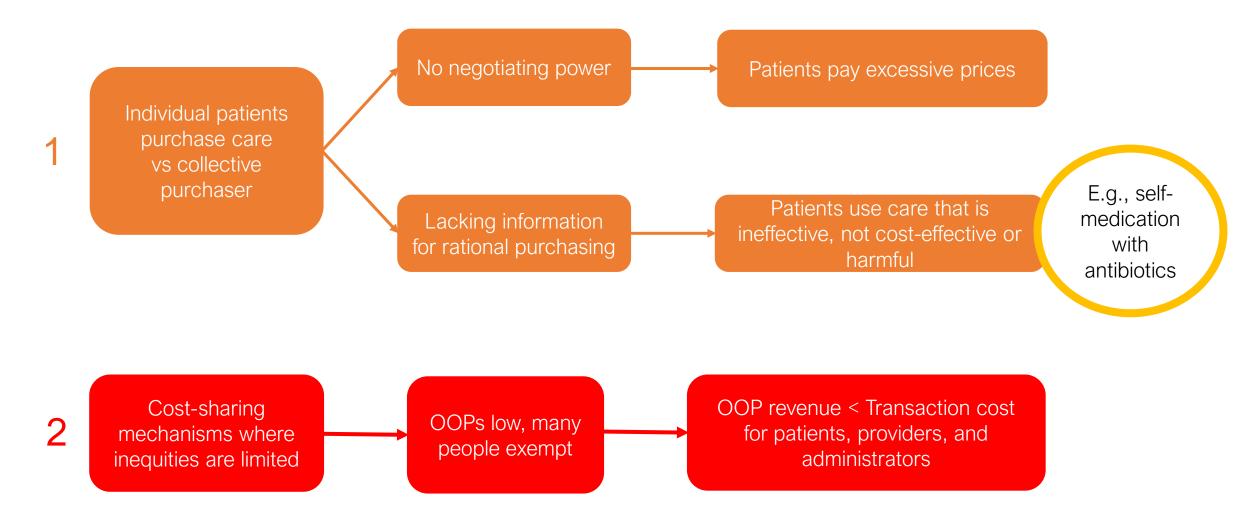






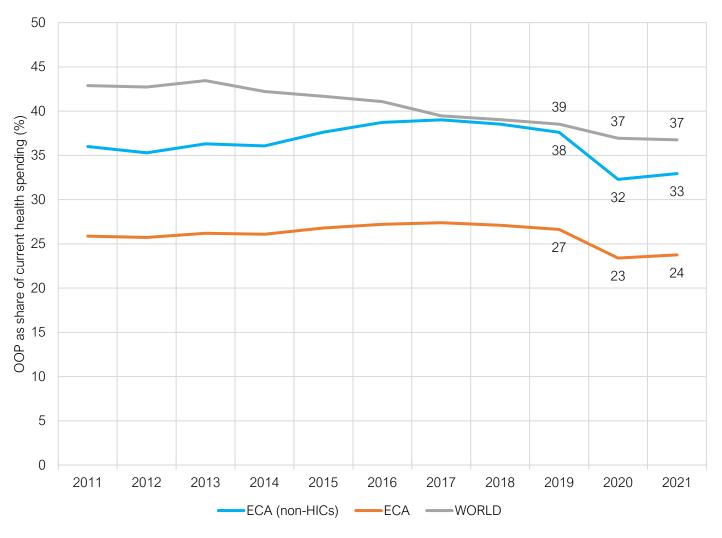


### OOP health payments are an inefficient way of purchasing





The OOP health spending share in the ECA region is below the global average but stagnated before the Covid19 pandemic. The Covid19 dip is receding

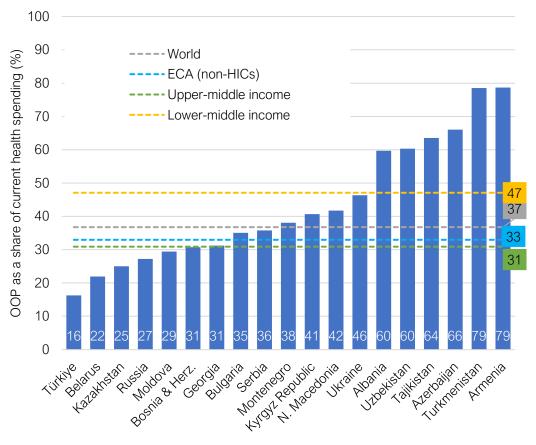






The OOP health spending share varies substantively across non-HIC ECA countries but remains above acceptable levels for most.

Financial hardship falls to negligible levels once OOP health spending share falls to 15-20 percent – but in non-HIC ECA, only Türkiye fell into this category in 2021

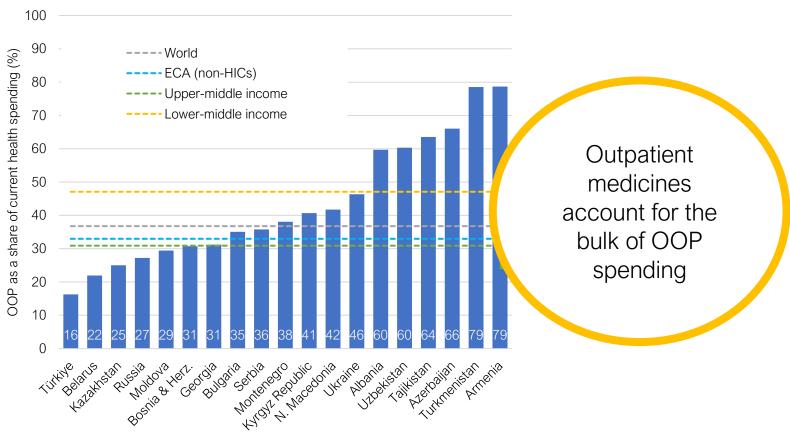






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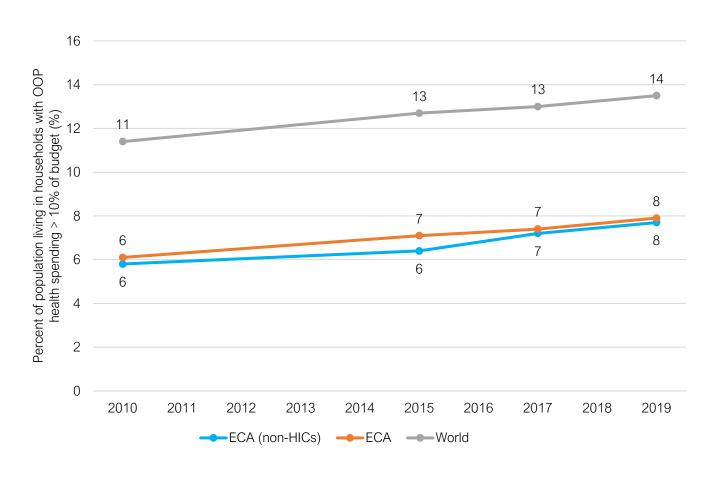
Source: WHO Global Health Expenditure Database



### The prevalence of catastrophic OOP spending is lower in ECA than globally, but it is on the rise like elsewhere in the world



#### Catastrophic spending rising globally and in ECA

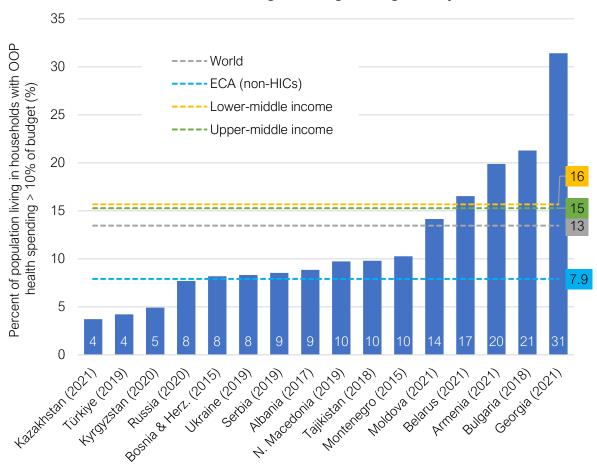




## The prevalence of catastrophic OOP spending varies substantively across non-HIC ECA countries



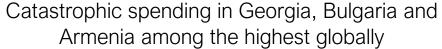
### Catastrophic spending in Georgia, Bulgaria and Armenia among the highest globally

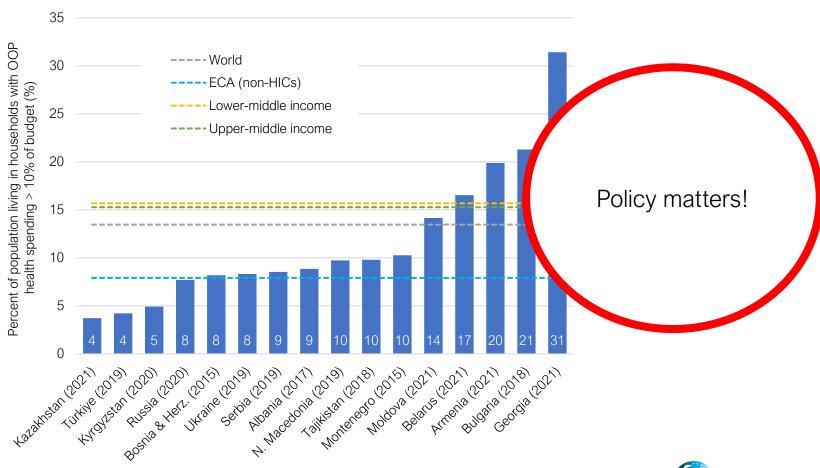


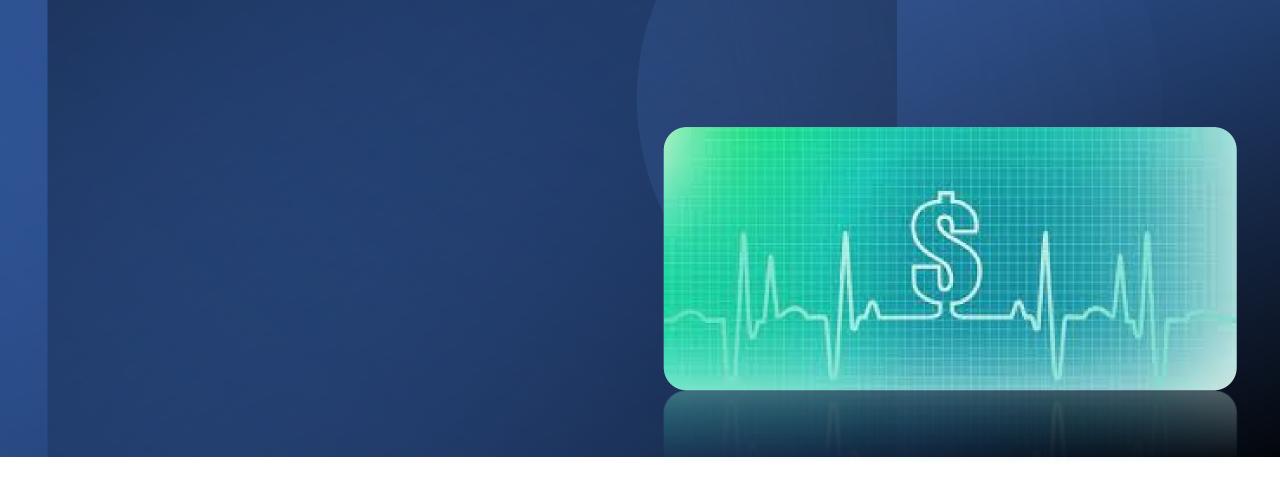


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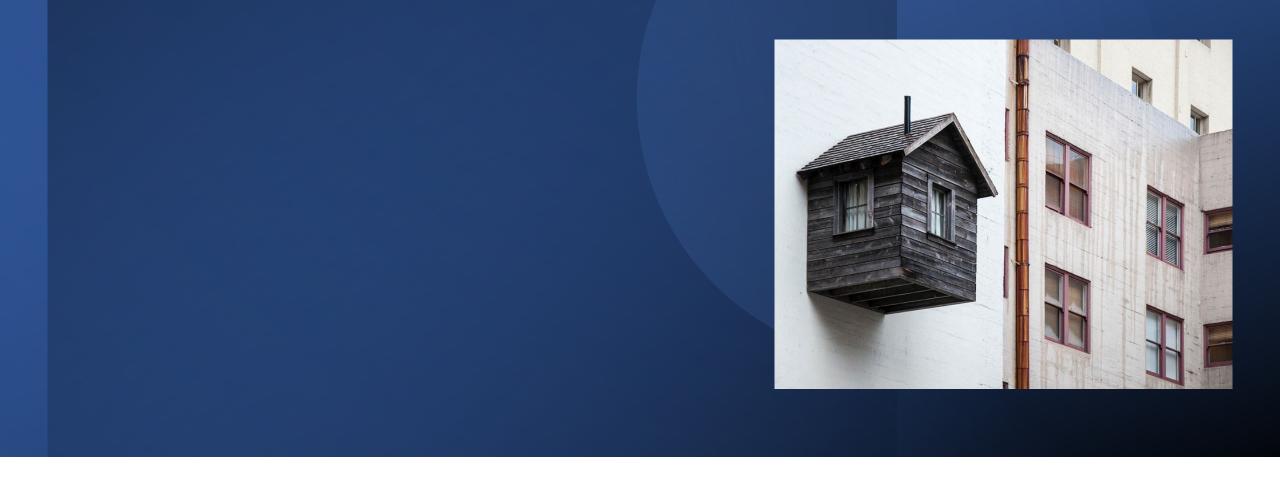






Thank you

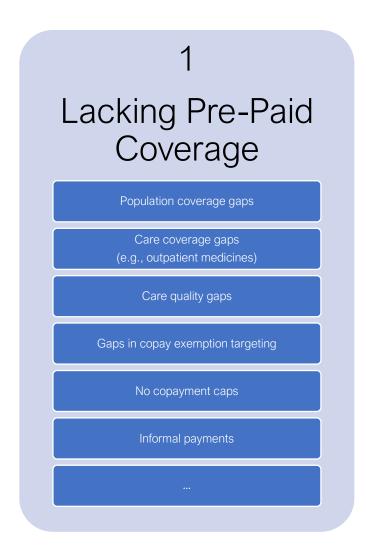




Annex slides



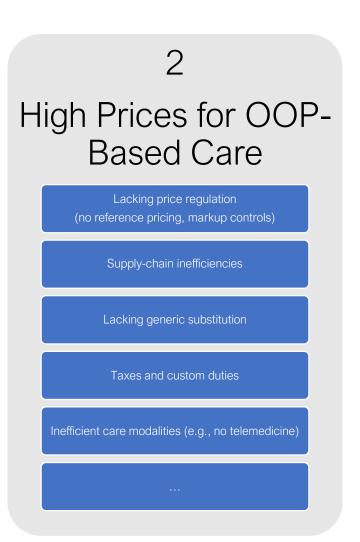
Drivers of OOP health spending can be organized into three categories – their relevance varies across contexts





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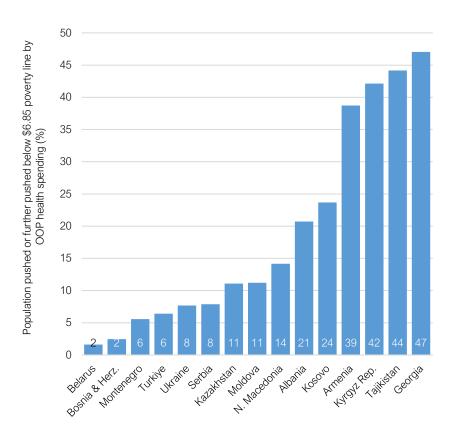
Lacking Pre-Paid Coverage Population coverage gaps Care coverage gaps (e.g., outpatient medicines) Care quality gaps Gaps in copay exemption targeting No copayment caps Informal payments

High Prices for OOP-**Based Care** Lacking price regulation (no reference pricing, markup controls) Supply-chain inefficiencies Lacking generic substitution Taxes and custom duties Inefficient care modalities (e.g., no telemedicine)

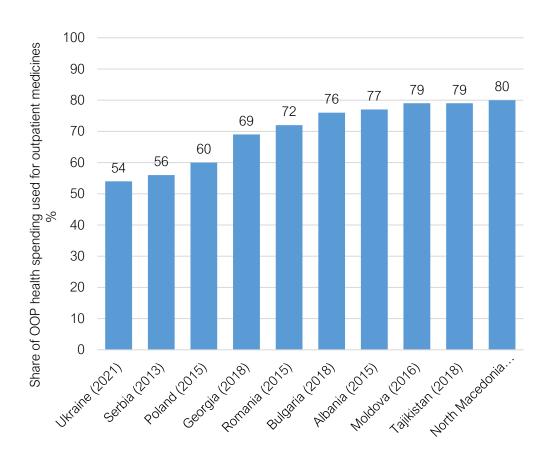
Overuse of OOP-**Based Care** Perverse provider incentives Lacking provider and patient knowledge Patient preferences Lacking gatekeeping



High rates of medical impoverishment, especially in poorer countries



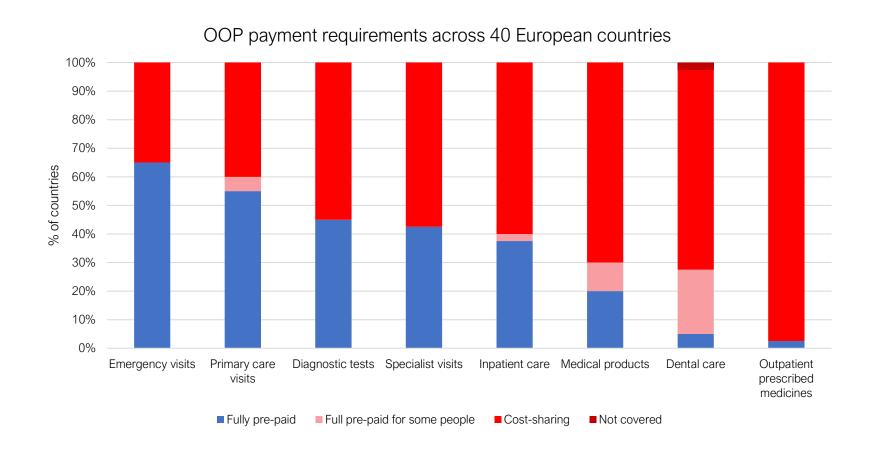
#### Outpatient medicines account for the bulk of OOP spending



Source: Can they afford to pay for healthcare series

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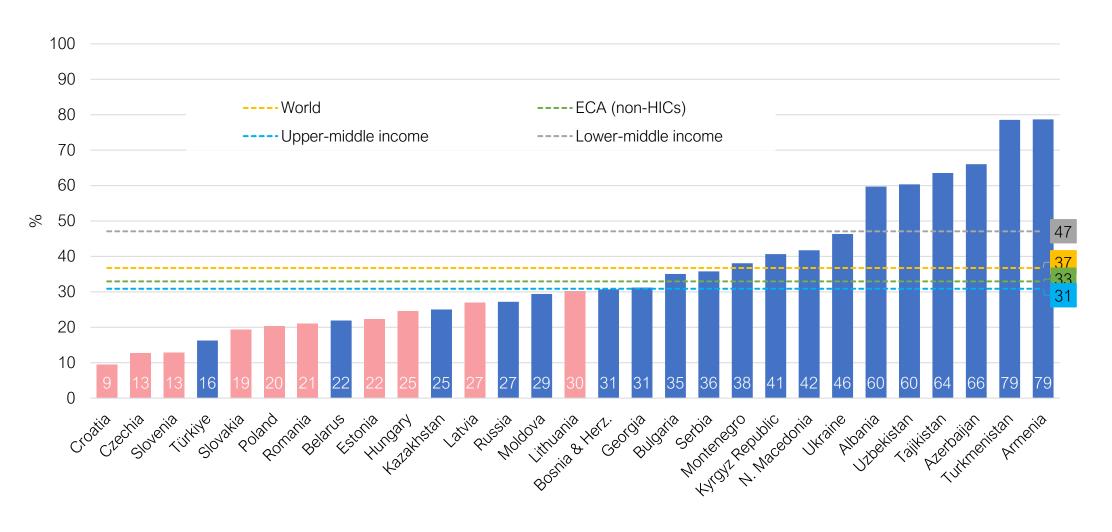




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### OOP/CHE, incl. former socialist HICs



Population with catastrophic OOP health spending (>10% of household budget), latest available data

